**State of Florida**
**Department of Children and Families**

**Rick Scott**
*Governor*

**Mike Carroll**
*Secretary*

**DATE:** November 7, 2016

**TO:** Regional Managing Directors
Florida Abuse Hotline Chiefs of Operations and Program Development
Community-Based Care Lead Agency Chief Executive Officers
Sheriff's Offices Conducting Child Protective Investigations

**THROUGH:** David L. Fairbanks, Deputy Secretary

**FROM:** JoShonda Guerrier, Assistant Secretary for Child Welfare
Vicki Abrams, Assistant Secretary for Operations

**SUBJECT:** CFOP 170-6, Chapter 1, Child Fatality Investigative Response
**Effective date: November 11, 2016**

**PURPOSE:** The purpose of this memorandum is to provide notification that CFOP 175-10 has been updated and converted to CFOP 170-6, Chapter 1. This operating procedure guides intake and investigative activities for all child fatality investigations.

**BACKGROUND:** The effort to establish a comprehensive set of child welfare operating procedures for the Hotline and Child Protective Investigation staff began early last year. Part of this process is updating and converting policies under the 175 series (Family Safety) to the 170 series (Child Welfare). In updating and converting 175-10 to the new numbering structure, the following significant changes and additions to policy were made:

- Clarification regarding the requirement for all child fatality investigations to be reviewed by the Regional Child Fatality Prevention Specialist prior to closure.
- Enhanced guidance on the use of Florida Safe Families Network tools in child fatality investigations.
- Clarification that for child fatality investigations, the investigator does not need to complete a Family Functioning Assessment unless there are surviving siblings whose safety must be determined. In circumstances where there are no surviving siblings, the investigator must still complete a full investigation into the alleged maltreatment and circumstances surrounding the alleged maltreatment using an "Other" investigation sub-type.

**ACTION REQUIRED:** Please share this memorandum with all Hotline personnel, child protective investigators and child fatality prevention specialists, and ensure that the new operating procedures are implemented effective November 11, 2016.

**CONTACT INFORMATION:** If you require additional information or have any questions, please contact Lisa Rivera, Child Fatality Prevention Specialist, Office of Child Welfare at 813-337-5881 or Lisa.Rivera@myflfamilies.com.

cc: Regional Family and Community Services Directors
Center for Child Welfare

CF OPERATING PROCEDURE
NO. 170-6

STATE OF FLORIDA
DEPARTMENT OF
CHILDREN AND FAMILIES
TALLAHASSEE, November 11, 2016

Child Welfare

# CHILD FATALITY RESPONSE

This operating procedure establishes the investigative response and review of child fatality investigations in the state of Florida. Requirements for notification, collaboration, consultation, and investigative activities specific to child fatality investigations are outlined.

BY DIRECTION OF THE SECRETARY:

*(Signed original copy on file)*

JOSHONDA GUERRIER
Assistant Secretary for
Child Welfare

SUMMARY OF REVISED, ADDED, OR DELETED MATERIAL

This operating procedure replaces CFOP 175-10 dated August 25, 2014 and has three significant changes:

1. Clarification regarding the requirement for all child fatality investigations to be reviewed by the Regional Child Fatality Prevention Specialist prior to closure.
2. Enhanced guidance on the use of Florida Safe Families Network tools in child fatality investigations.
3. Clarification that for child fatality investigations, the investigator does not need to complete a Family Functioning Assessment unless there are surviving siblings whose safety must be determined. In circumstances where there are no surviving siblings, the investigator must still complete a full investigation into the alleged maltreatment and circumstances surrounding the alleged maltreatment using an "Other" investigation sub-type.

OPR: Office of Child Welfare
DISTRIBUTION: X: OSEC; OSGC; OSFAH; ASGO; Regional Managing Directors; Region/Circuit Child Protective Investigators and Supervisors; Regional Child Fatality Prevention Specialist.

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# Chapter 1

## CHILD FATALITY INVESTIGATIVE RESPONSE

1-1. Purpose. This chapter provides uniform procedures for the investigation of child fatalities due to suspected maltreatment by a caregiver either at the time of the initial intake alleging death due to abuse or neglect or during the course of an active child protective investigation.

1-2. Scope. This chapter applies to the Hotline and all Department and Sheriff's child protective investigators (CPIs) and supervisors responsible for child protective investigations and regional and state level management responsible for the oversight of child fatality investigations.

1-3. Authority.

a. Section 39.01, Florida Statutes (F.S.), Definitions.

b. Section 39.2022, F.S., Public disclosure of reported child deaths.

c. Section 39.301, F.S., Initiation of protective investigations.

d. Section 39.303, F.S., Child protection teams; services; eligible cases.

e. Section 39.306, F.S., Child protective investigations; working agreements with local law enforcement.

1-4. Notification to Law Enforcement. The CPI shall forward allegations of known or suspected criminal conduct to the municipal or county law enforcement agency of the municipality or county in which the alleged child fatality has occurred (section 39.301(2)(b)2, F.S.). The CPI must coordinate with the designated law enforcement agency to determine joint investigative activities, unless otherwise instructed by law enforcement.

1-5. Consultation with the Child Protection Team (CPT). When one or more children have been pronounced dead on arrival at a hospital or other health care facility, or have been injured and later died as a result of suspected abuse, abandonment, or neglect, and a sibling or other child remains in the home where the suspected abuse, abandonment, or neglect occurred, the CPI must consult with the Child Protection Team for additional assessment and follow-up support services for these children.

1-6. Notification to the Department Managers. The Hotline Director or designee shall provide notification of a child fatality via email within two (2) hours of receipt and provide information required pursuant to CFOP 215-7 to the parties listed in section 65C-30.020, Florida Administrative Code.

1-7. Notification to the Regional Child Fatality Prevention Specialist. The Statewide Child Fatality Prevention Specialist will ensure notification to the applicable Regional Child Fatality Prevention Specialist. The Regional Child Fatality Prevention Specialist is the single point of contact for child fatality incident reporting in the Department's Incident Reporting and Analysis System (IRAS). Within 72 hours of notification from the Hotline, the Specialist will create the IRAS entry regarding the child fatality following the procedures set forth in CFOP 215-7, Child Fatality Notification Requirements.

a. Information must be summarized and not taken directly from Florida Safe Families Network (FSFN) so that the public and media are able to gain insight into child fatalities without releasing information that is confidential pursuant to section 39.202, F.S.

b. The incident report is a summary of what is known at the time of the completion of the report. Therefore, updates or additional information must be documented in FSFN.

c. The CPI must notify the Regional Child Fatality Prevention Specialist of all child fatality review staffings and Multidisciplinary Team Staffings scheduled during the course of the investigation.

1-8. Reports to the Medical Examiner. Section 39.201(3), F.S., provides: "Any person required to report or investigate cases of suspected child abuse or neglect that 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 shall accept the report for investigation and shall 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 are not subject to the confidentiality requirements provided for in Section 39.202."

1-9. Public Disclosure of Child Fatalities. The CPI must ensure the Regional Child Fatality Prevention Specialist has all information needed for public disclosure. Public disclosure will provide the basic facts of all deaths of children from birth through 18 years of age which occur in this state and which are reported to the department's central abuse hotline. Disclosure must include (section 39.2022(2)(a-f), F.S.):

a. The date of the child's death.

b. Any allegations of the cause of death or the preliminary cause of death, and the verified cause of death, if known.

c. The county where the child resided.

d. The name of the community-based care lead agency, case management agency, or out-of-home licensing agency involved with the child, family, or licensed caregiver, if applicable.

e. Whether the child has been the subject of any prior verified reports to the department's central abuse hotline.

f. Whether the child was younger than 5 years of age at the time of his or her death.

1-10. Second Tier Consultation. A second tier consultation is mandatory and must follow the requirements in Chapter 65C-29, Florida Administrative Code and CFOP 170-5, Chapter 27.

1-11. Review of Investigative Findings. Prior to closure of any fatality investigation, the CPI and Regional Child Fatality Prevention Specialist must discuss the findings and be in agreement. If agreement cannot be reached, the investigation must be elevated to the State Child Fatality Specialist and the Regional Family and Community Services Director or designee. The Regional Family and Community Services Director or designee will make the final decision regarding findings and investigative closure.

1-12. Investigative Time Period. The CPI may extend the standard 60 day closure timeframe required by section 39.301(16)(a-b), F.S., when a medical examiner report has not been received or upon a request by law enforcement during an active criminal investigation. The name of the law enforcement agent requesting the extension must be documented in a FSFN case note.

a. The CPI supervisor shall notify the Family and Community Services Director or designee when an investigation will not be closed within 60 days of receipt. The Family and Community Services Director will review the circumstances for extending the statutorily required 60 day closure date and approve the extension as appropriate.

b. If the investigation remains open over 60 days for any reason, the CPI Supervisor must conduct a monthly consultation and determine if there is additional investigative activities needed based

on the current available information. This consultation must include, at a minimum, whether the CPI needs to see and/or interview the surviving children again and the status of the law enforcement investigation and medical examiner findings. The consultation must be documented using the consultation functionality in FSFN.

c. If the hard copy of the medical examiner findings is not received within 90 days of receipt of the child fatality investigation, the Family and Community Services Director or designee will determine, in consultation with law enforcement, the medical examiner and the local Child Protection Team Medical Director, as applicable, whether the final report from the medical examiner is necessary in order to determine if the child's death is verified due to abuse, neglect or abandonment.

1-13. Child Fatality During an Open Investigation.

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 CPI will notify the Hotline to request that a new report be generated.

b. Given that the death of a child during an open investigation can traumatize a CPI, the CPI supervisor should, through consultation with the CPI, assess the need for administrative leave. The CPI can take up to two days of Administrative Leave with Pay. The Secretary or authorized representative may approve additional administrative leave not to exceed 20 days. The CPIS should discuss with the CPI the services available through the Employee Assistance Program. The local human resource office should be contacted to assist with placing the employee on administrative leave in accordance with rules and policies.

1-14. Responsibilities of Regional Managing Directors. The Regional Managing Director shall:

a. Notify the Deputy Secretary using the procedures outlined in CFOP 215-7, Child Fatality Notification Requirements.

b. Establish an environment that provides emotional support for child protection staff and supervisors who have been directly involved in a case in which a child has died. The trauma associated with a child's death may inhibit their ability to cope with the tragedy and perform their duties.

c. Provide periodic in-service trainings to ensure that all staff involved in child fatality investigations understand the procedures and are informed of referral sources to assist with trauma.

1-15. Law Enforcement Interagency Agreements. Each Region and Sheriff's office conducting child protective investigations shall develop procedures with local law enforcement agencies for the purpose of carrying out joint investigations involving the death of a child due to alleged abuse, neglect, or abandonment. These procedures shall:

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

b. Ensure criminal investigations and child protective investigations are commenced concurrently, whenever possible.

1-16. Child Death Maltreatment. A death maltreatment cannot be a "stand-alone" maltreatment and must be used in conjunction with the underlying maltreatment(s) which caused or contributed to the death.

a. The CPI must determine that the cause of death was the result of abuse as defined in section 39.01(2), F.S., or neglect as defined in section 39.01(44), F.S., in order to reach a verified finding.

b. The event resulting in the child's death must have occurred in Florida for the maltreatment of "Death" to be added to a report.

1-17. Drug Screening. To accurately assess the correlation between substance misuse and child maltreatment, the alleged maltreating caregiver will be asked to voluntarily submit to a drug screen on all child deaths related to inadequate supervision, unsafe sleep, and drowning. This does not preclude the CPI asking the alleged maltreating caregiver to voluntarily submit to a drug screen during other investigations when substance misuse is suspected and may be a contributing cause to a child's death. Exceptions to this requirement will be made when law enforcement has already obtained the drug screen.

1-18. Supervisor Pre-Commencement Responsibilities. The supervisor must evaluate the circumstances of the report prior to case assignment to ensure the CPI assigned has the requisite skills and experience needed. To the extent possible, intentional case assignment to the most experienced, senior CPI or the use of paired/team assignments (i.e., assigning two CPIs) should be considered in a child fatality case. A pre-commencement face-to-face or telephonic supervisory consultation between the supervisor or designee and the CPI is mandatory for all intakes involving a suspected child fatality.

1-19. Completion of a Family Functioning Assessment. The CPI must complete a family functioning assessment in all child fatality investigations, unless there are no surviving children in the home. In those circumstances, the CPI will complete the investigation as an "Other" sub-type and will document information gathered around the maltreatment and circumstances surrounding maltreatment domains.

1-20. Other Investigative Activities. All other investigative activities are covered by the requirements in CFOP 170-5, Child Protective Investigations.

1-21. Supporting Documentation. The CPI must obtain copies of additional information necessary to determine whether the child fatality was due to child maltreatment, including:

a. Child Protection Team reports.

b. Medical records for the child prior to the incident that led to the death.

c. Preliminary, supplemental, and final law enforcement reports pertaining to the child's death, including 911 dispatch tapes.

d. Documentation or photographic evidence of injuries related to the death.

e. Photographic evidence of the physical environment related to the death.

f. Information obtained from Emergency Medical Services or other first responders.

g. Drug screen results.

h. Court documents.

i. The medical examiner's final autopsy report.

1-22. Establishing the Maltreatment Finding. The CPI must use the evidentiary standards established in CFOP 170-4, Child Maltreatment Index, when determining findings for the child death and any associated maltreatments. These standards include definitions, assessment factors, excluding factors, other maltreatments possibly correlated with the primary maltreatment identified, and the type of documentation needed to support the determination of a maltreatment finding for each of the specific maltreatments.

# Chapter 2

Draft Pending