State of Florida
Department of Children and Families

Rick Scott
Governor

Mike Carroll
Secretary

DATE: January 26, 2015

TO: Regional Managing Directors
Regional Family and Community Services Directors

FROM: Pete Digre, Deputy Secretary
Janice Thomas, Assistant Secretary for Child Welfare

SUBJECT: Minimum Requirements to Conduct Specified Reviews of All Child Fatalities

PURPOSE: The purpose of this Memorandum is to advise staff of the minimum requirements to conduct specified types of Child Fatality Reviews for:

- All child fatalities reported to the Florida Abuse Hotline (Hotline);
- All child fatalities that occur during the course of an open investigation;
- All child fatalities that occur during ongoing case management services provided by a contracted Community Based Care (CBC) provider, including sub-contracted Case Management Organizations (CMOs).

BACKGROUND: In the ongoing effort to prevent future child fatalities; apply lessons learned from past fatalities; improve safety and risk assessments to increase and maintain the safety of children during protective investigations and/or case management services; and to further support transparency and accountability with the comprehensive release of information and data regarding child fatalities, the following minimum requirements will apply to *all* child fatalities that come to the attention of the Department or a contracted CBC/CMO provider.

Effective immediately for any child fatality reported to the Hotline since January 1, 2015 or having occurred since that date during an open investigation or period of ongoing case management services:

A. <u>All child fatalities reported to the Hotline as the result of suspected Abuse or Neglect:</u>

1. Those with <u>no</u> prior history on the decedent, siblings or other children in the household: A Child Fatality Review pursuant to Children and Families Operating Procedure (CFOP) 175-17, <u>Child Fatality Review Procedures;</u> Effective Date March 3, 2011.

2. Those <u>with</u> prior history (regardless of Findings of Maltreatment) on the decedent, siblings or other children in the household, that occurred within five (5) years preceding the child's death:

    a. A Child Fatality Review pursuant to CFOP 175-17, <u>Child Fatality Review Procedures;</u> Effective Date March 3, 2011; ***and***

b. A Quality Assurance Review of all prior investigative and case management history. The specified process and reporting format for this review will be provided under separate cover on January 30, 2015.

3. Those with a "Verified" finding of any maltreatment regarding the decedent or siblings, in an investigation conducted within the 12 months preceding the child's death:

   a. A Child Fatality Review pursuant to CFOP 175-17, Child Fatality Review Procedures; Effective Date March 3, 2011, ***and***

   b. An immediate review by an assigned Critical Incident Rapid Response Team (CIRRT), pursuant to the requirements set forth in Chapter 39.2015, F.S.

B. All child fatalities that occur during the course of an open investigation, *with no additional allegations that the death is the result of alleged abuse or neglect*:

1. A Child Fatality Review pursuant to CFOP 175-17, Child Fatality Review Procedures; Effective Date March 3, 2011.

   Note: If during the course of the investigation and/or this review there arises any knowledge or suspicion that the fatality was or may be the result of alleged abuse or neglect, the individual first developing this knowledge or suspicion shall *immediately* report these concerns to the Hotline, pursuant to Chapter 39.201(1), F.S. If an Intake is generated based on these circumstances, the review process for Sections A. (1), (2) or (3) shall be initiated, pursuant to the requirements set forth in those sections.

C. All fatalities that occur while ongoing case management services are being provided by a contracted CBC provider, including sub-contracted CMOs, *with no allegations that the death is the result of alleged abuse or neglect*:

1. A Child Fatality Review pursuant to CFOP 175-17, Child Fatality Review Procedures; Effective Date March 3, 2011.

   Note: If during the course of ongoing case management and/or this review there arises any knowledge or suspicion that the fatality was or may be the result of alleged abuse or neglect, the individual first developing this knowledge or suspicion shall *immediately* report these concerns to the Hotline, pursuant to Chapter 39.201(1), F.S. If an Intake is generated based on these circumstances, the review process for Sections A. (1), (2) or (3) shall be initiated, pursuant to the requirements set forth in those sections.

ACTION REQUESTED: Please disseminate this memorandum to all Regional Child Fatality Prevention Specialists and Regional Quality Assurance Managers.

CONTACT INFORMATION: For additional information, please contact Lisa Rivera at (813) 337-5881 or (850) 294-4765, or email Lisa.Rivera@myflfamilies.com.

cc: Traci Leavine, Director of Child Welfare Practice
Lisa Rivera, Statewide Child Fatality Prevention Specialist
Eleese Davis, Statewide Child Welfare CQI Manager
Pat Badland, Director of Operations

Attachment: CFOP 175-17, Child Fatality Review Procedures