

The Florida Senate
COMMITTEE MEETING EXPANDED AGENDA

CHILDREN, FAMILIES, AND ELDER AFFAIRS
Senator Sobel, Chair
Senator Hays, Vice Chair

MEETING DATE: Tuesday, November 5, 2013
TIME: 9:00 a.m.—12:00 noon
PLACE: *Mallory Horne Committee Room, 37 Senate Office Building*

MEMBERS: Senator Sobel, Chair; Senator Hays, Vice Chair; Senators Altman, Braynon, Clemens, Dean, Detert, Diaz de la Portilla, Grimsley, and Thompson

TAB	BILL NO. and INTRODUCER	BILL DESCRIPTION and SENATE COMMITTEE ACTIONS	COMMITTEE ACTION
1	Panel Discussion on Recent Child Abuse Deaths	<p>Esther Jacobo, Interim Secretary, Department of Children and Families</p> <p>Kurt Kelly, Chief Executive Officer, Florida Coalition for Children</p> <p>The Honorable Katherine Essrig, Circuit Judge, 13th Judicial Circuit, Dependency Court Improvement Panel</p> <p>Barbara Wolf, M.D., Child Abuse Death Review Committee</p> <p>Pam Graham, Associate Professor, Florida State University, School of Social Work</p> <p>Christina Spudeas, Executive Director, Florida's Children First</p>	Discussed
2	Other Related Meeting Documents		

THE FLORIDA SENATE

Tallahassee, Florida 32399-1100

COMMITTEES:
Children, Families, and Elder Affairs, *Chair*
Ethics and Elections, *Vice Chair*
Health Policy, *Vice Chair*
Appropriations
Appropriations Subcommittee on Health
and Human Services
Appropriations Subcommittee on Transportation,
Tourism, and Economic Development
Regulated Industries
Rules

SELECT COMMITTEE:
Select Committee on Patient Protection
and Affordable Care Act, *Vice Chair*

SENATOR ELEANOR SOBEL

33rd District

August 1, 2013

Esther Jacobo, Interim Secretary
Department of Children and Families
1317 Winewood Boulevard
Tallahassee, FL 32399

Dear Secretary Jacobo:

The Department of Children and Families is responsible for the most challenging and important duties in state government. Your appointment comes at a moment when those challenges are under special scrutiny due to the tragic deaths of several children. We appreciate your commitment to child safety and welcome your leadership and fresh perspectives on how best to protect vulnerable children and support Florida's families. The purpose of this letter is to outline several areas of concern that will be the focus of upcoming meetings of the Senate Committee on Children and Families. We request your participation in these meetings and we request your help in compiling information for the Committee members. Finally, we want to alert you to specific issues of concern that we will be evaluating in order to determine what legislative action, if any, is needed to clarify child safety policies, define programmatic priorities, and set new directions for the future.

The Committee meetings will focus on at least four specific areas of concern. Each of these areas is described below along with a list of questions that the Committee will be considering. In some cases, you may be able to provide written materials in advance of the meeting or refer to pertinent materials that department staff already shared with us. In other instances, it may be necessary for you to provide new information. We would appreciate receiving all written material no later than August 30th.

1. **Review of recent child deaths.** At least seven children, previously investigated or served by the department and its contractors, died between May 16, 2013 and July 25, 2013; understandably, these deaths have received considerable media attention. Please be prepared to review the facts of these cases and discuss the department's actions both before and after the children died.
 - a) Were there any other deaths in the past year that warrant additional investigation? How many child deaths in total (including those caused by

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DON GAETZ
President of the Senate

GARRETT RICHTER
President Pro Tempore

- abuse) have occurred in the past year in families under investigation by the department?
- b) What was the department's involvement with these families?
 - c) Did DCF staff evaluate the families' service needs? If so, what services were provided to the families prior to the children's deaths? If no services were provided, why not?
 - d) Did the department conduct a root cause analysis of these events?
 - e) If so, what factors were identified that contributed to these tragic outcomes? Please describe both the analysis process and the results.
 - f) What issues are common to all these cases that may indicate systemic problems?
 - g) Is there a difference in outcomes between child welfare investigations conducted by the department and investigations conducted by Sheriff's Departments? If so, what do you feel contributes to greater success by one or the other?
 - h) Do you feel the department's technology systems are sufficient to adequately keep track of all child welfare investigations in Florida? What improvements, if any, do you feel need to be made?
 - i) What percentage of children in the dependency system are under 5 years old, and what percentage of child deaths that have been investigated have involved children under 5 years old? Do you feel special practices should be in place to handle the cases of younger children? If so, what kinds of techniques would you recommend? If not, why?
 - j) Do you feel the Children's Legal Services program is adequately funded to best represent children in this state? Why or why not? What other improvements would you recommend for Children's Legal Services?
 - k) If the "transformation" process was complete, what specifically would have changed about the department's interaction with these families?
 - l) What statewide data do we have that is consistent across cases throughout the state that could help us?
 - m) Why do we have waitlists for services in the state? What kind of waitlists for services does the Department currently have, how many individuals are on the various waitlists, and how do the waitlists vary in different parts of the state?
 - n) Are there any new demographic trends the Department has noticed among children and families in the dependency system that you can share with the Committee that would predict future problems?

2. **Transformation and assessment process.** Since 2011, the department has been working to change numerous components of the child welfare system. These changes include enhancing the skills and qualifications of investigators, modifying the supervisory structure for investigative work, promoting greater integration of investigations and case work, implementing a new, statewide assessment tool, and making various technology improvements aimed at improving efficiency in recordkeeping as well as investigators' access to information. Please be prepared to present an overview of these changes, describe the process for designing, testing, and implementing various changes, and report on the status of implementation.
 - a) Describe the current training and experience for child protective investigators. If these qualifications are changing, explain those changes.
 - b) In one recent case, media reports indicate that the investigator did not complete the requirements necessary for certification. Is this correct? How does the department monitor and enforce compliance with training and certification requirements? What is the cause of failures in monitoring and enforcement of these requirements? How will the department avoid similar failures in the future?
 - c) The department is launching a new assessment tool for investigators. How was the tool developed? Is the tool being used in other jurisdictions; if so, which ones and for how long? Has the tool been tested and validated? If so, what procedures were used for testing and validation?
 - d) The transformation has been described in some documents as development of a focus on child safety. What is the evidence that child protective investigators have not been previously focused on safety and what are the elements of transformation that will address these indicators?
 - e) Child welfare experts describe at least three fundamental and distinct concepts that must be considered: 1) safety, which refers to the immediate danger to the child; 2) risk, which refers to the probability of danger to the child in the future; and 3) need, which refers to the ongoing support services that are essential for the family to reduce risk and avoid any future danger to the child. Describe how the department's transformation initiative will address each of these distinct areas.

3. **Community based care.** CBCs were created by the Legislature to provide for local involvement and ownership of the child welfare system. Lately, many members have been hearing from the CBCs in their districts that the partnership is being disrupted in favor of more centralized decision-making and uniform procedures.

- a) What is your view of the relationship between the department and the CBCs?
- b) What specific areas or types of decisions need to be centralized and uniform and why? If uniformity is imposed in these specific areas, how will CBCs and their subcontractors cope with the real and meaningful differences—such as demographics, culture, and service availability—among many parts of the state.
- c) Other than defining minimum qualifications, do you think the department should have a say in the hiring or firing of key personnel in the CBCs? Why?
- d) Florida statutes provide for competitive procurement of CBCs but give the department considerable flexibility in determining when to initiate the procurement process. What are the key factors that you will consider in deciding to initiate a new competitive procurement cycle?
- e) The department has created a scorecard for CBCs. Describe the methodology underlying the scorecard and the department's intended uses of the results.
- f) What is the research or evidence supporting the standards for the performance measures? For example, the standard for the safety measure of "no verified maltreatment within 6 months of termination of family support services" is set at 99.5%. Why is 99.5% the right level (as opposed to 99.2 or 99.8 or any other such number)? How was this standard determined?
- g) Scorecards are published each month and comparisons of the reports reveal considerable volatility. For example in May 2013, 16 of the 20 CBCs were reported as meeting the above referenced standard but just one month later only two CBCs met the standard. Month to month rankings of CBCs were observed to rank a single agency as #2 in one month but #14 the next. This change in ranking occurred with only a change of three-tenths of one percent difference in the measured performance and was calculated based on less than 20 cases. Is this change statistically significant? Other CBCs were measured on as few as one case. Describe why the department believes these scorecards are valid and reliable measures of performance.

4. **Medically complex children.** The State of Florida is being sued by the U. S. Department of Justice based on their assessment that Florida lacks an adequate system of care for medically complex children and their determination that too many such children have been placed in nursing homes. Several state agencies are involved in these issues. Describe DCF's role in assessing the needs of families with medically complex children; explain any special assessment methods or other decision frameworks that are focused on

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medically complex children; and outline the services DCF can offer that help families continue to care for these children at home.

- a) Does the department provide any special training or guidance for investigators or case workers who are interacting with these families?
- b) What are the barriers to providing services to enable medically complex children to remain at home?

Thank you for your assistance in responding to these important issues and the committee's questions. As we continue to work through this process, other questions may arise; we appreciate your ongoing support and cooperation. We look forward to working with you to improve the department's ability to keep children safe and to support Florida's families.

With Best Regards,



Eleanor Sobel, Chair
Committee on Child, Families, and Elder Affairs
The Florida Senate

Cc: Senate President Don Gaetz
House Speaker Will Weatherford
Senator Alan Hays, Vice-Chair
Senator Thad Altman
Senator Oscar Braynon, II
Senator Jeff Clemens
Senator Charles S. "Charlie" Dean, Sr.
Senator Nancy C. Detert
Senator Miguel Diaz de la Portilla
Senator Denise Grimsley
Senator Geraldine F. "Geri" Thompson



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

Rick Scott
Governor

Esther Jacobo
Interim Secretary

September 6, 2013

Senator Eleanor Sobel
Chair, Senate Children, Families and Elder Affairs Committee
The "Old" Library, First Floor
410 Senate Office Building
Tallahassee, FL 32399-1100

Dear Senator Sobel:

In response to your letter of August 1st, I am pleased to submit the information you requested for the upcoming meetings of the Senate Children, Families and Elder Affairs Committee.

We have responded to each of the questions in your letter in the attached document and included several attachments with additional detail.

I hope this information is helpful to you, your staff and the other members of the Committee. As you know, I have also directed my staff to conduct a review of the child fatalities that have occurred so far in 2013. I have also asked child safety experts with Casey Family Programs to conduct their own review and analysis of child deaths in Florida. We hope to have the results of those two reviews in time for the committee meetings in October.

In the meantime, if you have any questions about the materials attached or if you would like additional information, please don't hesitate to contact me at (850) 921-8533.

We truly appreciate the time and attention you are directing to child safety issues and we look forward to working with you to identify any ways we can improve our child welfare policies and practices to keep children safe from harm.

Sincerely,

A handwritten signature in black ink, appearing to read "Esther Jacobo".

Esther Jacobo
Interim Secretary

1317 Winewood Boulevard, Tallahassee, Florida 32399-0700

Mission: Protect the Vulnerable, Promote Strong and Economically Self-Sufficient Families, and Advance Personal and Family Recovery and Resiliency

Senator Sobel Response

1. Review of recent child deaths. At least seven children, previously investigated or served by the department and its contractors, died between May 16, 2013 and July 25, 2013; understandably, these deaths have received considerable media attention. Please be prepared to review the facts of these cases and discuss the department's actions both before and after the children died.

a) Were there any other deaths in the past year that warrant additional investigation? How many child deaths in total (including those caused by abuse) have occurred in the past year in families under investigation by the department?

The Department investigates all child deaths reported to the hotline.

- *285 child death allegations were reported to the hotline between January 1 and July 31, 2013.*
- *194 cases are under investigation.*
- *The Department made findings on 92 of the cases.*

Findings	Definitions
<i>19 were verified for abuse or neglect.</i>	<i>"Verified" is a 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.</i>
<i>26 were not substantiated for abuse or neglect.</i>	<i>"Not substantiated" is finding used when there is credible evidence, which does not meet the standard of preponderance, to support that the specific harm was the result of abuse, abandonment or neglect.</i>
<i>46 were found to have no indicators of abuse or neglect</i>	<i>"No indicators" is a finding used when there is no credible evidence to support the allegations of abuse, abandonment or neglect.</i>

b) What was the department's involvement with these families?

Please see Attachment A.

c) Did DCF staff evaluate the families' service needs? If so, what services were provided to the families prior to the children's deaths? If no services were provided, why not?

Please see Attachment A.

d) Did the department conduct a root cause analysis of these events?

The Department conducted an analysis to identify common factors and trends among the child deaths that occurred in 2013. Additionally, Casey Family Programs, the nation's largest operating foundation focused entirely on improving child welfare systems, has been engaged to review child deaths and provide expert analysis on our investigative services and practices. Their focus is specific to families that have been involved in child protective investigations prior to the death of a child. In addition, the Child Welfare League of America, a coalition of private and public agencies serving vulnerable children and families since 1920, will provide further analysis and recommendations for preventing future child deaths in Florida.

Senator Sobel Response

As a point of information, section 383.402, Florida statutes establishes “a statewide multidisciplinary, multiagency child abuse death assessment and prevention system that consists of state and local review committees.” The state and local review committees are charged with reviewing the “facts and circumstances of all deaths of children from birth through age 18 which occur in this state as the result of verified child abuse or neglect.”

All child deaths reported to DCF are subject to a death review process by a regional Death Review Coordinator including a review of all known facts from law enforcement, the Medical Examiner, the State Attorney, the Child Protective Investigators and our own CPIs and an analysis of how practices can be improved to prevent future recurrence. Case files for all verified abuse and neglect deaths are provided to the Statewide Child Abuse Death Review committee for additional analysis and recommendations. The committee’s findings are included in their annual report.

*The Department’s Internal Protocol for reviewing child deaths is defined within Children and Families Operating Procedure Number 175-17 (see **Attachment B**).*

- e) If so, what factors were identified that contributed to these tragic outcomes? Please describe both the analysis process and the results.**

Recurring factors identified in our death reviews include unsafe sleeping arrangements, lack of security for pools and retaining ponds, extreme poverty (most of the families involved relied on public assistance for food, housing and medical assistance), lack of proper medical care, and infants and toddlers in homes where there are patterns of family violence and/or substance abuse. In many circumstances, a paramour is involved. These issues were identified during the internal review conducted by a team of subject matter experts within the department.

- f) What issues are common to all these cases that may indicate systemic problems?**

In many of these cases, we found that the CPIs were focused on complying with reporting requirements and time standards, but may not have given adequate attention to general safety issues and risks within the home. We also found that CPI Supervisors were not following up on cases in a timely and thorough manner to examine decisions made by the CPI and evaluate whether the best decisions were made for the child’s safety.

- g) Is there a difference in outcomes between child welfare investigations conducted by the department and investigations conducted by Sherriff’s Departments? If so, what do you feel contributes to greater success by one or the other?**

***Attachment C** contains the CPI Scorecard outcomes for calendar year 2012 and the first 5 months of 2013 that rank all CPI units in order of performance. We have also attached two separate OPPAGA research memorandums (**Attachments D & E**) on this subject.*

- h) Do you feel the department’s technology systems are sufficient to adequately keep track of all child welfare investigations in Florida? What improvements, if any, do you feel need to be made?**

Senator Sobel Response

The FSFN system adequately tracks all investigations; however we are making major improvements to our FSFN system which will increase child safety:

- In July we introduced our FIS Notes and Alerts so that CPIs and Case Managers will be notified when parents fail to engage in drug treatment. We also introduced major simplifications to FSFN which save CPIs and Case Managers considerable time.*
- In November 2013, we will be introducing a vastly improved Safety Assessment and Safety Planning process which requires continued verification and prevents case closure until the danger is resolved.*
- Also in November, we will also be introducing a vastly improved Family Functioning Assessment which will give CPIs and Case Managers a much deeper understanding of parental protective capacities and the vulnerabilities of the children.*
- Finally, in November FSFN will require a transfer of case responsibility from the CPI to the CBC when the CPI is unable to eliminate the danger that the child is facing.*
- Shortly after the first of the year, we will be introducing an enhanced risk assessment scaling tool which will identify case at high risk so we can require services.*

This implementation schedule is purposely being phased in over time to allow sufficient opportunity for input and adjustments as needed.

Florida is also working toward attaining full State Automated Child Welfare Information System (SACWIS) compliance by the end of 2014. We have already addressed many (36.6%) of the efficiencies needed for SACWIS compliance. We have created at-a-glance views, reduced the redundant data entry and overall improved the usability of the system. Once we implement the enhancements for the decision making model, we will have addressed 75.6% of the SACWIS compliance issues identified in the 2010 assessment. The remaining issues are on schedule to be addressed by the end of the fiscal year.

- i) What percentage of children in the dependency system are under 5 years old, and what percentage of child deaths that have been investigated have involved children under 5 years old? Do you feel special practices should be in place to handle the cases of younger children? If so, what kinds of techniques would you recommend? If not, why?**

*(See **Attachment F.**) Supervisors and our “second party reviewers” must actively engage in reviewing cases and coaching CPIs when infants and toddlers are involved, particularly where there is evidence of family violence and/or addiction or a paramour is involved. We are also piloting in several areas of the state a “CPI Pairing” model where two investigators will respond as a team on cases with children 5 and under where certain factors such as Domestic Violence, Substance Abuse, Mental Illness and other risk factors are present in the home.*

- j) Do you feel the Children’s Legal Services program is adequately funded to best represent children in this state? Why or why not? What other improvements would you recommend for Children’s Legal Services?**

Children’s Legal Services (CLS) will play a larger role in determining appropriate interventions if a child is found to be high risk using the evidenced based risk assessment tool. The fiscal and operational impact of this policy change cannot be determined until it is fully implemented.

Senator Sobel Response

k) If the “transformation” process was complete, what specifically would have changed about the department’s interaction with these families?

- *Using the new Safety Framework, CPIs would have been required to ask more questions about each family to gain a more complete understanding of the dynamics in the child’s home and any risks to the child’s safety that may not have been directly associated with the incident prompting the investigation.*
- *A pre-consultation would have occurred between the CPI and the CPI Supervisor prior to the CPIs first visit with the family to develop an appropriate plan for interacting with the family. The plan may have called for the inclusion of other experts in the case deemed necessary by the information received from the Hotline.*
- *In cases where the CPI determined that a family could benefit from services outside the court system, the CPI would make a referral to the CBC to provide those services. Those non-court ordered services will be tracked in FSFN and CBCs will be evaluated based on the occurrence of re-abuse after the services were received.*
- *In cases where a CPI assesses a child to be safe, but there are still risks in the home, there will be a secondary evaluation of that determination by the CPI, CBC and CLS before the investigation is closed.*

L) What statewide data do we have that is consistent across cases throughout the state that could help us?

DCF maintains a fairly sophisticated data tracking system that allows us to examine trends and outcomes for all child welfare cases in the state. The data is tracked by county, circuit, DCF Region and CBC for the following trends that may be helpful in examining root causes of child deaths due to abuse and neglect:

- *Number of investigations by type of maltreatment (verified, not substantiated, no indicators)*
- *Reasons for child removals by maltreatment type*
- *Child Removal rates and child discharge rates*
- *Age of children in investigations*
- *Cause of child death*
- *Presence of substance abuse or mental health issues*
- *Number of children in Out of Home Care, In Home Care and Relative Placements*
- *Number of children in family-based licensed foster care, facility-based licensed care, subsidized Independent Living*

M) Why do we have waitlists for services in the state? What kind of waitlists for services does the Department currently have, how many individuals are on the various waitlists, and how do the waitlists vary in different parts of the state?

There are no waitlists for court-ordered services for children in the child welfare system. Services are typically paid for by the local CBC, Medicaid, the local Early Learning Coalition or insurance, if applicable. There may be “waits” for certain services, depending on the availability of providers and the time involved in processing referrals, but no waiting lists. For services that are not court-ordered, there may be waiting lists in some parts of the state for such things as child care vouchers, Medicaid waiver services or adult substance abuse and mental health services. These wait lists vary depending upon the availability of local resources relative to the demand for services.

Senator Sobel Response

N) Are there any new demographic trends the Department has noticed among children and families in the dependency system? That you can share with the Committee that would predict future problems?

We have not noticed that specific demographic trends are reliable predictors of child abuse and neglect. We have seen that the presence of substance abuse, mental illness and domestic violence in households are the most common predictors of child abuse and neglect. We have found that the state has made considerable progress in eliminating pill mills and parental addiction due to prescription medication such as opiates. However, at the same time, we are seeing a resurgence of meth and cocaine addictions.

2. Transformation and assessment process. Since 2011, the department has been working to change numerous components of the child welfare system. These changes include enhancing the skills and qualifications of investigators, modifying the supervisory structure for investigative work, promoting greater integration of investigations and case work, implementing a new, statewide assessment tool, and making various technology improvements aimed at improving efficiency in recordkeeping as well as investigators' access to information. Please be prepared to present an overview of these changes, describe the process for designing, testing, and implementing various changes, and report on the status of implementation.

a) Describe the current training and experience for child protective investigators. If these qualifications are changing, explain those changes.

The requirements to join the Department of Children and Families as an investigator remain unchanged. Minimum qualifications for a Child Protective Investigator are:

- *A bachelor's degree from an accredited college or university;*
- *Preferred qualifications:*
 - *Bachelor's degree in social work, behavioral science, criminal justice, nursing or education field;*
 - *Individuals who have or are successfully completing the Department's Child Protection Internship*
- *Must obtain certification as a Florida Child Protective Investigator within 12 months of hire*

All newly hired child protective investigators must complete a six week pre-service training course and pass a written competency exam upon completion of the course. Following the exam, new investigators must receive: a minimum of six field observations and case consultations; 20 hours of individual supervision; 10 hours of group supervision; and an additional 10 hours of individual, group, or a combination of the two. On-going training requirements include a minimum of 20 hours of training each 12 months. The continuing education must relate to the core competencies for the job.

b) In one recent case, media reports indicate that the investigator did not complete the requirements necessary for certification. Is this correct? How does the department monitor and enforce compliance with training and certification requirements? What is the cause of failures in monitoring and enforcement of these requirements? How will the department avoid similar failures in the future?

Senator Sobel Response

The CPI in question had an official extension to complete the certification and was on schedule to complete it on the extended time frame. Each region has a manager responsible for making sure that each CPI is fully compliant with certification requirements. Every CPI in DCF is compliant with certification requirements. We do not allow CPIs to carry cases if they are not fully compliant and we terminate their employment if they are not diligent in completing certification requirements. The Florida Certification Board also conducts a third-party review of the status of all CPI certification requirements and reports to DCF Regional staff.

- c) The department is launching a new assessment tool for investigators. How was the tool developed? Is the tool being used in other jurisdictions; if so, which ones and for how long? Has the tool been tested and validated? If so, what procedures were used for testing and validation?**

We are improving the type and amount of information our Child Protective Investigators gather to make decisions about a child's safety to inform a full family assessment. The improvements to our practice model include improved tools that support the assessment of safety and risk.

*The safety assessment model was developed by experts at ACTION for Child Protection, the federally designated resource center for child protection services. ACTION for Child Protection's "Safety Framework" has been implemented in 17 states (see **Attachment G** for listing of states). Casey Family Programs has conducted a preliminary review of the safety assessment tools and is writing a report with recommendations that will consider best practices from across the country. The safety assessment tools have been customized, in partnership with ACTION for Child Protection, to align with Florida statute. It should also be noted that the National Council for Juvenile and Family Court Judges adopted the Safety Framework in 2009 and it has been incorporated in the Florida Bench Book.*

*The tool used to assess risk is the Structured Decision Making (SDM) Risk Assessment from the Children's Research Center (see **Attachment H**.) The SDM Risk Assessment is an actuarial risk assessment. The SDM Risk Assessment is used in 23 states (see **Attachment G**.) It should be noted that there are five other states that use tools from both models (Alaska, New England, New Mexico, Washington and Wisconsin).*

- d) The transformation has been described in some documents as development of a focus on child safety. What is the evidence that child protective investigators have not been previously focused on safety and what are the elements of transformation that will address these indicators?**

Florida's current child safety assessment process did not ensure CPIs throughout the state were using a consistent methodology to make decisions about child safety. We believe this new safety decision-making methodology will result in more informed assessments and better decisions for the vulnerable children who come into our care. (Please see response to "c" above.)

- e) Child welfare experts describe at least three fundamental and distinct concepts that must be considered: 1) safety, which refers to the immediate danger to the child; 2) risk, which refers to the probability of danger to the child in the future; and 3) need, which refers to the ongoing support services that are essential for the family to reduce risk and avoid any future danger to the child. Describe how the department's transformation initiative will address each of these distinct areas.**

Senator Sobel Response

As a result of our new approach to Safety decision-making, the following practice improvements will be implemented:

1. **Safety** – Child Protective Investigators will be required to ask questions and gather information around a variety of domains – or aspects – of a family situation. They will no longer focus solely on the incident that was the subject of the call to the Hotline; they will be evaluating the entire family and any environmental risks that may threaten a child’s safety. We will be using a national model that has been deployed in 17 other states.
 2. **Risk** – The actuarial assessment estimates the likelihood of future harm to children in the household, and assists investigation workers in determining which cases should be continued for ongoing services and which may be closed at the end of an investigation. We will be using the Structured Decision Making risk assessment tool which is used by 23 other states.
 3. **Need** – the enhanced assessment tools and processes will provide better information to CPIs and case managers about the types of services that would most benefit a family and reduce both the immediate risks to a child’s safety that prompted the call to the Hotline as well as other factors that impact a family’s instability or capacity to protect a child beyond the immediate crisis. In Florida’s privatized child welfare system, each Community Based Care agency is responsible for developing interventions that meet the need of the families in their communities. As a result, there is no uniform array of services that will be provided statewide.
3. **Community based care. CBCs were created by the Legislature to provide for local involvement and ownership of the child welfare system. Lately, many members have been hearing from the CBCs in their districts that the partnership is being disrupted in favor of more centralized decision-making and uniform procedures.**

a) What is your view of the relationship between the department and the CBCs?

The relationship is a collaborative and dynamic one. A combined mix of state and federal funding enables DCF to provide the CBCs with the financial resources to meet the child welfare needs of their community. Each CBC in turn determines how they will deliver those services. DCF is responsible for ensuring the CBCs comply with all state and federal mandates and expectations, and over time it has proven to be a very effective model that has produced many innovative and effective programs and partnerships.

b) What specific areas or types of decisions need to be centralized and uniform and why? If uniformity is imposed in these specific areas, how will CBCs and their subcontractors cope with the real and meaningful differences—such as demographics, culture, and service availability—among many parts of the state.

Any federal or state mandates must be uniformly applied and enforced for all CBCs. Beyond that, CBCs function best when they are responsive to and a reflection of their local communities.

c) Other than defining minimum qualifications, do you think the department should have a say in the hiring or firing of key personnel in the CBCs? Why?

DCF should monitor the outcomes and performances of CBCs as a whole, but should not control personnel decisions.

Senator Sobel Response

- d) Florida statutes provide for competitive procurement of CBCs but give the department considerable flexibility in determining when to initiate the procurement process. What are the key factors that you will consider in deciding to initiate a new competitive procurement cycle?**

Procurements for CBCs occur according to a statutorily dictated schedule unless there are significant performance issues that threaten child safety, which would necessitate an emergency procurement.

- e) The department has created a scorecard for CBCs. Describe the methodology underlying the scorecard and the department's intended uses of the results.**

The Scorecard is intended to drive performance in the right direction by making performance visible and by promoting competition among lead agencies. The Scorecard's indicators were selected, among the many indicators available, to provide balance among the goals of safety, permanency, well-being, and cost. Some indicators are based on familiar CBC contract and federal permanency measures, but other indicators were newly created to measure important aspects of child welfare, using a combination of existing reports generated by the Florida Safe Families Network (FSFN), and recurring ad hoc reports using data contained in FSFN. Most are outcome indicators, but some process indicators are also included. Most indicators are under the direct control of the CBC lead agency, but a few are based on the recognition that community-based child welfare is a collaborative effort.

*We have asked Casey Family Programs to examine the current Scorecard methodology. **What is the research or evidence supporting the standards for the performance measures? For example, the standard for the safety measure of "no verified maltreatment within 6 months of termination of family support services" is set at 99.5%. Why is 99.5% the right level (as opposed to 99.2 or 99.8 or any other such number)? How was this standard determined?***

We will be examining the Scorecard methodology more closely in partnership with Casey Family Programs, along with the CBCs and other child welfare stakeholders, including the judiciary. We will be able to provide answers to those questions when that review is completed and the updated Scorecard framework is finalized.

- f) Scorecards are published each month and comparisons of the reports reveal considerable volatility. For example in May 2013, 16 of the 20 CBCs were reported as meeting the above referenced standard but just one month later only two CBCs met the standard. Month to month rankings of CBCs were observed to rank a single agency as #2 in one month but #14 the next. This change in ranking occurred with only a change of three-tenths of one percent difference in the measured performance and was calculated based on less than 20 cases. Is this change statistically significant? Other CBCs were measured on as few as one case. Describe why the department believes these scorecards are valid and reliable measures of performance.**

We are still studying the reliability and appropriateness of the measures. Our goal is to find measures that truly drive better outcomes and are less likely to be subject to manipulation. It is also important that while CBCs strive for particular measures they do not have unintended consequences. To that end, we have asked Casey Family Programs to examine the following issues:

Senator Sobel Response

- *Do the Scorecard measures adequately capture the right outcomes and the best practices?*
- *Which practice steps, gauged by which measures, actually result in improved outcomes?*
- *How can the Scorecard be used to motivate values that inform outcome measures?*
- *What are the process measures that support each outcome measure?*
- *How can the department better align the multiple reports that are currently produced to evaluate performance? (Weekly Key Indicators, Monthly Scorecard, CBC Contract Managers Monthly Scorecard, DCF Performance Dashboard, Quarterly Federal Measures, Contract Oversight Unit Reports)*

- 4. Medically complex children. The State of Florida is being sued by the U. S. Department of Justice based on their assessment that Florida lacks an adequate system of care for medically complex children and their determination that too many such children have been placed in nursing homes. Several state agencies are involved in these issues. Describe DCF's role in assessing the needs of families with medically complex children; explain any special assessment methods or other decision frameworks that are focused on medically complex children; and outline the services DCF can offer that help families continue to care for these children at home.**

- a) Does the department provide any special training or guidance for investigators or case workers who are interacting with these families?**

The Agency for Health Care Administration has begun providing nurse case management services to all families with medically complex children. These nurses will work alongside Dependency Case Managers and CPIs to provide medical guidance in making placement decisions for medically complex children.

- b) What are the barriers to providing services to enable medically complex children to remain at home?**

At this time, families with medically complex children are eligible to receive up to 24-hours of in-home nursing services paid for by Medicaid. These services will allow children with complex needs to remain at home.

However if it is necessary for a medically complex child to be removed from their biological parents, it is imperative that CBC have enough trained medical foster parents at their disposal for placement. Historically this has been a barrier and a continuing struggle. Recruitment of qualified foster parents must be one of the top priorities for CBC.

Child Fatalities – January – July 2013

First Name/age	Date of death / Age	County	Cause / Manner of Death	Circumstances Surrounding Child's Death	Services and Supports / Actions	Findings
TB	01-14-13/ 4 ½ mos	Miami – Dade	Natural	TB died of congenital heart failure associated with Trisomy 21. Mother found him in bassinet not breathing.	Case closed 07-30-13; no referrals to services	No indicator for Death; No Indicators of Inadequate Supervision
SB	01-12-13/ 18 mos.	Marion	Impact trauma	SB was hit by a car in front of her babysitter's house while mother was running errands and did not return for child; claimed she fell asleep.	Sibling (1YOA) removed due to mother's substance misuse	Not Substantiated for Death, Verified for Inadequate Supervision, and Substance Misuse
AC	02-28-13/ 4 mos	Manatee	Asphyxiation	Father placed child in bed with him at midnight. He awoke at 4AM and found AC nonresponsive.	Grief counseling offered.	Not Substantiated for Death, Inadequate Supervision and Substance Misuse
MC	02-15-13/ 1 year	Lake	Drowning	MC was placed in tub; father in kitchen and mother initially in bathroom. 9 year old discovered MC floating 20 minutes later. Mother tested positive for illegal drugs	Siblings (9 and 11 years) were sheltered for court ordered services	Verified for Death; Verified for Lack of Supervision and Substance Misuse
ID	03-22-13/ 13 mos.	Hernando	Natural	ID, born premature, had a tracheostomy tube and oxygen. Mother placed him in crib, checked periodically through the night, and he was found unresponsive with trachea tube out in the morning	ID had many medical supports, including medical day care six days a week. He had no siblings. No services or actions	No Indicators for Death; Verified for Medical Neglect and Failure to Thrive. Not substantiated for Inadequate Supervision
MD	02-11-13/ 6 mos.	Broward	Undetermined	Born prematurely at 23 weeks, MD had a history of lung problems. On the night of his death, he was fussy in his crib so the parents brought him to their bed. Father fell asleep with MD resting on his chest; woke up at 4AM and the baby was not	The three remaining siblings, (3, 6, 7 years) and parents were offered grief counseling; requested drug screens which were not followed up on.	Verified for Death; Verified for Inadequate Supervision

Child Fatalities – January – July 2013

First Name/age	Date of death / Age	County	Cause / Manner of Death	Circumstances Surrounding Child's Death	Services and Supports / Actions	Findings
				breathing.		
TD	06-13-13/ 2 days	Pinellas	Natural	TD, born premature at 25 weeks, tested positive for cocaine at birth. He had a poor prognosis for survival at the onset. Mother elected to remove life support. Mother tested positive for cocaine and opiates as well.	There are three siblings; one living with his father in Ohio, one with maternal grandmother and an adult child.	No Substantiated for Death; Verified for Substance Misuse and Threatened Harm
DD	02-10-13/ 3 mos	Volusia	Sudden Unexpected Infant Death	When the father returned from work at 3AM, he found mother and DD together in bed. DD was lying face down on the mattress with his head between two pillows, unresponsive.	No indication of services offered to the family. The mother planned to seek grief counseling for the seven year old half-sibling through her insurance plan.	No Indicators for Death, Inadequate Supervision or Substance Misuse
SF	04-20-13/ 15 yrs, 11 mos	Pinellas	Sepsis Natural	SF had a fever and showed her father a boil she had on upper inner thigh. He rushed her to the hospital; she underwent surgery and was later pronounced brain dead – blood poisoning death	SF was the only child in the father's care.	No indicators for Death; Not Substantiated for Medical Neglect, Substance Misuse and Threatened Harm
KF	05-27-13/ 4 ½ years	Lee	Drowning	Ten to 15 adults were watching eight children swim in pool. KF could not swim. Mother went to store and thought adults would watch her child, who was found at bottom of the pool.	Siblings (2 and 6 YOA) were referred to CPT for exam; no indication of abuse or neglect. Grief counseling referral made but mother declined.	Verified for Death
WG	05-27-13/ Just hours after birth	Duval	Natural	WG was born prematurely at 23 weeks. Mother tested positive for prescription drugs and cocaine at his birth.	Records indicate mother has had parental rights terminated in CA.	Not Substantiated for Death, Substance Misuse or Threatened Harm

Child Fatalities – January – July 2013

First Name/age	Date of death / Age	County	Cause / Manner of Death	Circumstances Surrounding Child's Death	Services and Supports / Actions	Findings
NG	03-11-13/ 3 ½ mos.	Pinellas	Asphyxiation	Mother fed NG at night and propped him up on a pillow in her room at 9PM and found him not breathing the next morning. Evidence suggests the child may have been face down.	Mother has a 9-year old child who is in the custody of his biological father following removal from mother in 2008 due to substance misuse. Mother is on a case plan trying to regain custody.	Verified for Death; Verified for Lack of Supervision; Verified for Substance Misuse
KG	01-25-13/ 8 weeks	Marion	Asphyxiation	In an attempt to comfort KG, the mother moved him from his bassinet to her bed. Two other children were also sleeping with the mother in bed. When the mother awoke in the morning, she found KG cold and unresponsive.	The two siblings, (2 and 9 years) and family were provided grief counseling and protective supervision services in the home.	No Indicators on Death or Inadequate Supervision
TG	02-23-13/ 4 yrs, 11 mos	Columbia	Drowning	Mother checked on TG in his room at 6AM. She went back to bed, woke up at 10 and noticed front door open and child missing. She called LE; Tobias was found in backyard pond.	A sibling, 6 years, is in the custody of his biological father and resides in his home. No notation of other services.	No Indicators for Death and Not Substantiated for Lack of Supervision
EH	06-10-13/ 5 ½ years	Duval		LH had a history as a cardiac patient. He was picked up from school due to fever, taken to the ER where he suffered a stroke while still hospitalized.	Four siblings remain in the care of their mother (20 mos, 2, 3, 7 years), who lives with paternal grandparents. No notation of other services outside of assistance from a healthcare agency to assist the mother in	No Indicators for Death, Medical Neglect or Hazardous Environment

Child Fatalities – January – July 2013

First Name/age	Date of death / Age	County	Cause / Manner of Death	Circumstances Surrounding Child's Death	Services and Supports / Actions	Findings
					obtaining SSI.	
LH	01-28-13/ 6 weeks	Pasco	Asphyxiation	LH was placed in his crib to nap. The parents were visiting with neighbors on front porch; checking LH every 20 minutes. Father and neighbor went to check and found his son face down in crib. Although neighbors were drinking alcohol, parents were not as confirmed by neighbors	A half-sibling (3 years) had been in legal custody of maternal grandmother since April 2011. DCF was not involved in this legal arrangement.	No indicators for Death, Lack of Supervision; or Threatened Harm
JJ	04-22-13/ 1 yr, 4 mos	Volusia	Asphyxiation	JJ was placed to sleep in bed next to wall with 7 year old sibling. JJ was discovered by another sibling wedged under the mattress and between the bed frame by the wall, partially covered by the sibling she shared the bed with.	Siblings (7 and 9 years) were referred to Boys/Girls club; family referred and participated in grief counseling; mother purchased new beds for children.	Not Substantiated for Death; Inadequate Supervision or Hazardous Environment
TJ	02-19-13/ 18 days	Santa Rosa	Asphyxiation	Mother placed her new born child in bed with her for the night; when she awoke the following morning, TJ was not breathing. Mother admitted to taking a pain medication that had been prescribed to her following the child's birth.	Two siblings (5 and 6 years) live with paternal grandparents who intend to adopt them. Mother is not responding to offers for services.	No Indicators for Death; Verified for Substance Misuse
SM	05-02-13/ 6 weeks	Marion	Undetermined	Mother placed child on the sofa after his morning feeding; the father prepared a bottle for him in the early afternoon and found SM unresponsive.	A two year old sibling had been removed from the parents in 2012 and the family was working on reunification.	No Indicator for Death or Inadequate Supervision
MM	05-19-13/ 4 ¾ mos	Polk	Asphyxiation	The child was co-sleeping with both parents in bed.	The parents each have another child by	No Indicators for Death or Inadequate

Child Fatalities – January – July 2013

First Name/age	Date of death / Age	County	Cause / Manner of Death	Circumstances Surrounding Child's Death	Services and Supports / Actions	Findings
					other partners. The two children do not reside in the home with the parents, who were offered services but declined.	Supervision
EM	01-17-13/ 6 weeks	West Palm	Asphyxiation	Mother found EM in her crib unresponsive at 9:30 in the morning and went to a neighbor for help. The baby's death was related to sleeping with her face against bedding	No grief counseling was offered the mother. There are no other children in the home. Mother previously had her parental rights terminated on three other children.	Verified for Death, Inadequate Supervision and Substance Misuse
CN	03-03-13/ 15 mos	Manatee	Asphyxiation	The father's paramour fell asleep on the couch with the baby. The paramour, who tested positive for illegal substances, claims that she moved the child to the crib; however, the medical examiner report documents fabric pattern marks on baby's face.	Father is offered grief counseling	Verified for Death and Substance Misuse; No Indicators for Inadequate Supervision
WP	02-01-13/ 3 months	Hillsborough	Asphyxiation	WP woke up crying and mother moved him from his crib to sleep with her in bed at 3AM. She and the father woke up at 5AM and child was not responsive.	The family was already under protective supervision services in the home as an older half-sibling had been reunified with the mother. Services and supports continued.	Not Substantiated for Death and Inadequate Supervision; No Indicators for Threatened Harm
DP	04-19-13/ 3 ¾ years	Alachua	Drowning	DP, who lived with an uncle, was playing with neighborhood	Two siblings (3 and 4 years) were referred	Verified for Death and Inadequate

Child Fatalities – January – July 2013

First Name/age	Date of death / Age	County	Cause / Manner of Death	Circumstances Surrounding Child's Death	Services and Supports / Actions	Findings
				children when he was found near his uncle's home in a community pool.	to play therapy. One sibling resides with an aunt and one with the mother.	Supervision.
JR	03-25-13/ 3 ½ mos	Lee	Undetermined	Mother had recently taken JR to his pediatrician for a cold and was on breathing treatment. She placed him in bed with her, positioned under her arm. She woke up at 6:30 to find him not breathing.	Two siblings (4 and 10 years) and mother were referred to and engaged in grief counseling.	Not substantiated Death, Inadequate Supervision or Substance misuse
BR	01-09-13/ 6 mos	Clay	Sudden Unexplained Infant Death	BR was placed in his crib; he had been fussy and was scheduled to go to pediatrician for 6 month check up on the day of his death. When mother checked on him at 6:30 he was fine; at 9AM she found him face down and unresponsive.	Sibling (2 years) remains with both parents and the family receives services from community-based care.	No Indicators for Death; Inadequate Supervision; Threatened Harm or Substance Misuse
DR	01-08-13/ 9 mos	Broward	Drowning	Mother left 9 month baby and 2 year old child in a room to use the bathroom. Upon return, she found DR in the family pool. The sliding glass door that led to the pool was open.	No notation of services offered.	Verified for Death, Inadequate Supervision and Threatened Harm
KS	05-07-13/ 4 ½ mos	Franklin	Impact trauma	KS was run over in the driveway of the family home by one of the mother's friends who was visiting. The mother was outside with her children talking to her friend, who sat in her car during the visit.	Three siblings (3,6,8 years) were placed voluntarily with relatives upon mother's arrest for possession and sale of drugs.	No Indicators for Death, Inadequate supervision or Threatened Harm
ES	03-17-13/ 1 yr, 8 mos	Polk	Drowning	Mother was in front yard with child; father was in house with infant; they lost track of ES. He	Child Protection Team saw the two siblings (6 mos. and	Not Substantiated for Death; Verified for Inadequate

Child Fatalities – January – July 2013

First Name/age	Date of death / Age	County	Cause / Manner of Death	Circumstances Surrounding Child's Death	Services and Supports / Actions	Findings
				was found in the family pool, having been missing for 15 minutes. There was no fence around the pool but the home had functioning alarms on exit doors that were not activated at time of drowning.	4 years) as well as two cousins who live in the home. The family closed the pool and had it cemented following Elijah's death.	Supervision and Hazardous Environment
DT	01-14-13/ 4 ¾ mos	Palm Beach	Asphyxiation	At 10:30PM after a feeding, mother placed her twin girls in a crib which they shared, sleeping head to toe in different directions. DT was placed on her stomach with a pillow under her head, as this was her preferred way to sleep according to the mother. When mother checked on them at 3:45, she found DT cold to the touch.	Two siblings (surviving twin and 14 year old brother) were not provided services. The mother was provided additional guidance on safe sleep for infants. Grief counseling was offered and denied.	Verified for Death; Inadequate Supervision and Threatened Harm
BW	03-05-13/ 5 weeks	Escambia	Asphyxiation	BW became fussy in the early morning hours so the mother made him a bottle and placed him bed with her. Another adult household member found the baby face down on a pillow next to the sleeping mother, curled up on her side.	There is a maternal half-sibling (4 years). Grief counseling was offered but it is unknown if they were accessed.	No Indicators for Death; Verified for Inadequate Supervision and Hazardous Environment

Source: DCF Child Death Review Database

For Closed Investigations as of 07/31/13

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.

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This operating procedure supersedes CFOP 175-17 dated June 1, 2002

OPR: PDFS

DISTRIBUTION: OSES; OSLs; ASGO; PDFS; Region Family Safety staff.

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/FSP0 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. FSN Death Investigation – This includes all documentation from FSN regarding the investigation of the child's death (e.g., Investigative Summary, Updated/Final Safety Assessment, Case Notes, etc).
3. FSN Prior Investigation History – This includes documentation from FSN regarding prior intakes/investigations.
4. FSN Services Information – This includes documentation from FSN 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.

Child Protective Investigations Monthly Scorecard

Overall Rank

Reg	Circuit/ SO	Counties	2012												2013				
			1	2	3	4	5	6	7	8	9	10	11	12	1	2	3	4	5
NW	1	Escambia, Okaloosa, Santa Rosa, Walton	15	15	16	13	12	17	18	18	9	17	17	12	10	8	13	20	19
NW	14	Bay, Calhoun, Gulf, Holmes, Jackson, Washington	19	14	19	18	16	20	22	24	17	21	19	13	18	17	10	1	15
NW	2	Leon, Gadsden, Jefferson, Wakulla, Liberty, Franklin	22	16	20	17	17	23	23	17	18	11	21	21	13	18	5	21	23
NE	3	Columbia, Dixie, Hamilton, Lafayette, Madison, Suwannee, Taylor	24	24	24	24	24	15	19	16	12	16	3	8	10	2	11	12	
NE	8	Alachua, Baker, Bradford, Gilchrist, Levy, Union	16	21	21	21	19	15	19	11	11	16	12	14	1	6	8	13	8
NE	4	Clay, Duval, Nassau	11	18	17	16	18	15	20	15	15	6	8	10	14	12	15	10	9
NE	7	Flagler, Putnam, St. Johns, Volusia	14	20	18	22	22	19	13	13	13	10	11	4	6	3	9	8	7
*	C	5-CSO Citrus	4	7	9	2	10	13	9	9	4								
	C	5 (Citrus,) Hernando, Lake, Marion, Sumter	6	8	1	4	1	3	2	8	10	1	5	4	10	7	4	4	6
	C	9 Orange, Osceola	8	12	5	8	6	6	7	7	6	5	4	7	2	2	1	6	2
*	C	18-SSO Seminole	2	1	6	6	4	4	11	10	19	9	14	17	23	19	16	23	22
	C	18-DCF Brevard	7	9	11	11	9	5	5	5	2	4	9	1	2	1	6	4	1
	C	10 Hardee, Highlands, Polk	3	5	8	5	8	1	8	6	7	7	13	9	5	4	17	3	11
*	SC	6-PaSO Pasco	23	19	14	23	23	22	24	23	22	23	23	23	22	23	21	16	5
*	SC	6-PISO Pinellas	12	13	15	14	14	10	17	21	20	20	20	18	20	9	12	7	14
*	SC	13-HSO Hillsborough	18	23	23	20	21	21	21	22	21	22	22	22	19	22	23	22	20
*	SC	12-MSO Manatee	10	4	4	1	11	11	14	12	11	8	9	19	9	16	11	14	13
	SC	12-DCF Sarasota, DeSoto	20	10	12	14	14	14	10	14	14	18	7	16	7	14	20	16	16
	SC	20 Charlotte, Collier, Glades, Hendry, Lee	20	22	22	19	20	18	16	19	24	19	18	20	20	20	19	18	21
	SE	19 Indian River, Martin, Okeechobee, St. Lucie	1	3	2	6	3	2	4	3	5	3	2	6	12	11	6	2	2
	SE	15 Palm Beach	13	11	13	10	7	8	2	4	8	14	3	2	4	5	3	9	10
*	SE	17-BSO Broward	17	17	10	12	13	9	12	16	23	15	15	15	17	21	18	19	18
	S	11 Miami-Dade	9	6	6	9	2	7	1	1	3	2	6	11	15	13	14	12	17
	S	16 Monroe	5	2	3	3	5	12	6	2	1	13	1	8	16	14	22	15	4

* Child Protective Investigations are the responsibility of Sheriffs in these counties

Overall rank is the relative performance in a composite of indicators, including statutory time standards and recurrence of maltreatment. #1 is the highest performer and shaded green. Lower performers have higher numbers and shaded red.



The Florida Legislature

OFFICE OF PROGRAM POLICY ANALYSIS AND GOVERNMENT ACCOUNTABILITY



RESEARCH MEMORANDUM

Sheriffs' Offices Have Advantages for Conducting Child Abuse Investigations, but Quality Cannot be Directly Compared to DCF

February 26, 2010

Summary

As requested, OPPAGA compared the costs, processes, and outcomes of child protective investigations conducted by the sheriffs' offices with those conducted by the Department of Children and Families (DCF). Legislative appropriations to sheriffs' offices have historically exceeded the funding per investigation provided to DCF for child protective investigations. DCF and sheriffs generally use similar investigative processes and procedures, although the higher level of funding for the sheriffs results in their investigators having greater resources than typically available to DCF investigators. Due to their law enforcement affiliation, child abuse investigators working for sheriffs also generally have greater access to training and specialists, as well as enhanced cooperation and community respect not always afforded to DCF investigators. Sheriffs' offices and the department have similar outcomes on measures of investigation timeliness; information is not yet available to assess whether there are differences between the two groups in their investigation decisions, recommendations and outcomes. We examined four organizational options for child protective investigations.

Program Purpose, Organization, and Responsibilities

Florida's child protective investigations units are responsible for receiving and responding to reports of child abuse and neglect. As required by Ch. 39, *Florida Statutes*, child protective investigators must respond to reports of a child's maltreatment, assess risk to the child, initiate removal or provide in-home services to ensure the child's safety, and make a determination regarding the allegations of child maltreatment. Protective investigators perform these functions in partnership with several other entities such as local law enforcement, Child Protection Teams, Guardians ad Litem, Children's Legal Services, the courts, and community-based care case management agencies.

DCF performs child protective investigations in 60 counties statewide through its organizational structure, which includes regional directors, circuit administrators, operational program administrators, program operations administrators, child protective investigation supervisors and child protective investigation units. Sheriffs' offices perform child protective investigations under grant agreements with DCF in the remaining seven counties: Broward, Citrus, Hillsborough, Manatee, Pasco, Pinellas, and Seminole.

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Sheriffs administer this function either as a separate division within their office or a bureau within their investigations division. These units are supported and supervised by a combination of civilian (non-sworn) and sworn law enforcement personnel in most of the sheriffs' offices, although the Pasco County child protective investigation unit is run solely by civilian personnel. Child protective investigators and their immediate supervisors are civilian personnel in all seven counties. Appendix A describes the history of these sheriffs' offices becoming responsible for child protective investigations.

All child protective investigations, regardless of entity administering this function, must be done in accordance with state and federal laws and regulations. Specifically, the department and the sheriffs' offices must

- investigate all reports of child abuse, neglect, abandonment, and special conditions (e.g., child-on-child sexual abuse);
- respond to all out-of-town inquires on or requests pertaining to alleged child abuse;
- provide child protective investigations 24 hours a day, seven days a week;
- begin investigations within 24 hours of report receipt;
- complete investigations within 60 days;
- use the department's decision support tools for investigators;
- complete the paperwork necessary to determine a child's eligibility for Temporary Assistance for Needy Families (TANF) funding;
- provide testimony and support to enable judicial or administrative hearings;
- conduct supervisory reviews of all cases within established timeframes; and
- comply with legislative performance measures and standards.

However, sheriffs' grant agreements with the department provide some discretion to create their own operating policies and procedures for the investigative function, provided that sheriffs carry out all mandatory functions and requirements for protective investigations specified in Ch. 39, *Florida Statutes*, Ch. 65C, *Florida Administrative Code*, and the grant agreements.

For Fiscal Year 2009-10, the Legislature appropriated \$98 million and 1,586.5 FTEs to the department for its child protective investigative function and \$47 million to the seven sheriffs performing this function.¹ Sheriffs' offices conducted 27% of the state's child protective investigations in Fiscal Year 2008-09.

State costs for sheriffs' offices generally exceed DCF costs for child protective investigations

Legislative appropriations to sheriffs' offices historically have exceeded the funding per investigation provided to the department for child protective investigations. (Please see Appendix B for a history of appropriations for child protective investigations.)

DCF's allocation for child abuse investigations includes its direct costs for this function, such as salaries and benefits for investigators, associated expenses, and risk management insurance.² As

¹ Appropriations for the sheriffs' offices include funding for administrative overhead and salary and benefits for supervisors, investigators, and aides.

² Investigators also receive \$800 per year to cover their vehicle insurance costs.

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shown in Exhibit 1, the state cost per DCF investigation in Fiscal Year 2008-09 was \$733 when calculated using the direct allocation for this function. As shown in Exhibit 2, the average cost per investigation conducted by the sheriffs' offices (\$957) was \$224 higher than the state's cost for DCF, although it was lower for one sheriff (Pasco).

Exhibit 1

Estimated Fiscal Year 2008-09 Cost per DCF Investigation Ranges from \$733 to \$873

Method of Calculation	Estimated Cost per Investigation
Direct allocation	\$733 ¹
Including administrative overhead based on approved federal indirect cost rate	\$873 ²
Difference in Cost	\$140

¹ DCF's Fiscal Year 2008-09 allocation for child protective investigations was a total of \$98,182,943 (direct appropriations and allowance for investigators' vehicle insurance), and it investigated 133,871 reports of maltreatment statewide.

² DCF's federal indirect cost rate for its regional and circuit operations was 19%.

Source: OPPAGA analysis based on DCF's Fiscal Year 2008-09 Approved Operating Budget and information provided by the department.

Exhibit 2

State Cost per Investigation Is Higher for Most Sheriffs' Offices Compared to DCF

Sheriffs' Office	Average Cost per Investigation ¹	Difference in Cost Compared to \$733—DCF Direct Allocation	Estimated Difference in Cost Compared to \$873—DCF Cost Including Overhead
Broward	\$951	\$218	\$78
Citrus	1,299	566	426
Hillsborough	1,082	349	209
Manatee	915	182	42
Pasco	727	(6)	(146)
Pinellas	965	232	92
Seminole	826	93	(47)
Total for Sheriffs	\$957	\$224	\$84

¹ Estimated based on 49,641 investigations conducted.

Source: OPPAGA analysis based on Fiscal Year 2008-09 appropriations to sheriffs and information provided by the department.

The cost difference is not as significant when DCF's administrative overhead costs are taken into account. DCF's grants to the sheriffs and its appropriations include the costs of overhead, including salaries and benefits for sworn officer management staff, employee recruitment benefits, and non-child welfare-related training, as well as the direct costs for investigations.³ We estimated DCF overhead costs for this function using DCF's federal indirect rate of 19% for regional and circuit operations.⁴ As shown in Exhibit 1, the estimated DCF cost including administrative overhead was \$873 per investigation when based on the federal indirect rate, and thus, when overhead is included, the estimated statewide average cost per investigation conducted by the sheriffs (\$957) was \$84 higher than DCF's cost (see Exhibit 2). The cost per investigation varies among sheriffs' offices, and two offices (Pasco and Seminole) receive funding per investigation that is lower than the funding for DCF when overhead costs are considered.

³ Retirement benefits for sworn law enforcement officers are higher than civilian county and state employees, thereby increasing overhead costs for sheriffs.

⁴ We applied the department's federal negotiated indirect cost rate for regional/circuit administration of 19% to the investigative appropriation.

DCF and sheriffs generally use similar investigative processes, but sheriffs' investigators have access to greater resources and other advantages due to their law enforcement affiliation

DCF and the sheriffs' offices generally follow similar investigative processes and procedures. However, the higher level of funding for the sheriffs results in their investigators having enhanced resources not always available to DCF investigators. Sheriffs' office investigators, due to their law enforcement affiliation, also have greater access to training, and an enhanced degree of cooperation and community respect not always afforded to DCF investigators.

There is limited variation in investigative processes and procedures between DCF and the sheriffs' offices. All child protective investigations, regardless of entity performing the function, must be done in accordance with state and federal laws and regulations. To compare the operations of sheriff and DCF child protective investigation units, we analyzed units in seven counties—three operated by sheriffs' offices (Broward, Hillsborough, and Manatee) and four operated by DCF (Sarasota, Palm Beach, Duval and St. Johns). We selected these counties based on their population size, caseload (number of child abuse cases investigated), and demographics. We conducted site visits to the selected counties, examined procedure documents, and interviewed a range of stakeholders including case managers, Children's Legal Services attorneys, child protection team administrators, and judges. For the remaining counties in which sheriffs' offices conduct child protective investigations, we conducted telephone interviews with administrators.

We found little variation between the sheriffs and DCF in the processes and procedures used for child protective investigations. For example, both routinely interview the alleged victim and siblings, observe interactions between children and parents, and obtain additional information from others such as family members, neighbors, and teachers.

One difference between sheriffs and the department is that some sheriffs have created a special unit with investigators who attend dependency court hearings in place of the investigator assigned to a case. This practice frees investigators to pursue cases rather than attend numerous and lengthy court hearings. However, some stakeholders reported that the persons attending court were not always familiar with case details and could not answer questions, resulting in delays and additional hearings.

Greater funding provides sheriffs' office investigators with enhanced resources not always available to department investigators. Our visits to sheriffs and DCF child protective offices showed that their differing funding levels resulted in different resources to support and reward investigators. The additional resources available to sheriffs' offices enhanced their investigators' ability to perform job duties and the offices ability to attract and retain experienced investigators. These differences included those described below.

- *Sheriffs have slightly lower overall investigator caseloads.* The department data on total caseloads for 2008-09 indicates that sheriffs' investigators have an average caseload of 13 cases and DCF investigators have an average caseload of 14 cases.⁵ However, sheriffs' staff members reported that their investigators' average caseloads ranged from 10 in Citrus to 24 in Hillsborough and staff in four DCF districts (Duval, Palm Beach, St. Johns, and Sarasota)

⁵ The Child Welfare League of America recommends a caseload size of 12 active cases per investigator in the workdays available during a designated 30-day period or month, and s. 20.19(5)(c), F.S., requires that caseloads not exceed this standard by more than two cases.

reported that their investigators' average caseloads ranged from 14 in St. Johns to 30 in Sarasota. These variations may reflect several factors such as philosophical differences between sheriffs and DCF in keeping cases open, the availability of investigative aides to assist with case activities, and the number of removal and shelter cases handled by the two types of units. Also, due in part to their lower caseloads, sheriff's office investigators have lower turnover; 19% compared to 25% for DCF investigators. Higher turnover reduces DCF's level of staff experience and increases its need to spend time and resources training new investigators.

- *Sheriffs tend to have more investigative aides and support staff positions.* Although one sheriff's office reported having one aide for every 20 investigators, the remainder ranged from one aide for every five investigators to one aide for every 14 investigators. DCF has similar support positions, but has a ratio of one aide for every 20 investigators. These support staff free investigators from performing clerical tasks such as compiling information as well as supervising children awaiting placement, conducting home studies, searching for parents or relatives, and coordinating appointments for children such as medical exams. This allows investigators to focus on their core duties of investigating allegations.
- *Sheriffs provide vehicles for investigators.* Sheriffs assign vehicles to their investigators and provide maintenance services and fuel for these cars. In contrast, DCF investigators use their personal vehicles and are reimbursed for mileage at the state rate, plus an insurance stipend of up to \$800 per year to cover their car insurance costs.
- *Sheriffs provide investigator uniforms.* These uniforms include khaki pants and polo or oxford cloth shirts with the sheriff's logo, which enhances investigators' professional appearance, provides credibility and authority, and helps create the sense of being a part of a team. Some but not all sheriffs' offices also cover the costs of dry cleaning.
- *Sheriffs provide additional equipment to investigators.* While both sheriffs and DCF investigators are provided laptops, cell phones, and digital cameras, sheriffs also provide each investigator with police radios, GPS systems, digital voice recorders, and infant and toddler seats for each car. In contrast, DCF investigators are provided a pool of infant and toddler seats shared among investigators. The items provided by sheriffs make investigators' jobs easier to perform and reduces their stress when they need to remove children from their homes.
- *Sheriffs provide supplies for children awaiting placement,* including diapers, formula, food, clothes. DCF offices have these items only if they were donated or purchased by staff with their personal funds.
- *Sheriffs have well-equipped visitation rooms* with furniture, rugs, toys, television, games, kitchens, and bathrooms to provide children with a comfortable and safe environment after removal, further enabling investigators to perform their job more easily. In contrast, only one DCF office we visited had such a room. DCF investigators reported having to keep children with them in their cars or offices while awaiting placement and also using their personal funds to buy food for the children.
- *Sheriffs provide investigators with office space* either in the sheriff's office or collocated with or near community-based care lead agencies, which facilitates communication between supervisors and investigators and enhances accountability. In contrast, DCF has started to use 'hoteling', in which investigators share offices on a space-available basis, in some counties to

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reduce expenses. Investigators and supervisors in these offices reported that this practice was not conducive to day-to-day supervision or consulting with Children's Legal Services attorneys about cases.

- *Sheriffs often provide higher salaries for investigators*, which enhances morale and also contributes to lower turnover. In addition to higher salaries, sheriffs' child protective investigators are normally awarded merit and cost-of-living raises; Fiscal Year 2008-09 was the first year in which sheriffs' office investigators were not given raises. In contrast, DCF investigators have not received merit or cost-of-living raises over the last three years. Our comparison of DCF minimum investigator salaries with those offered by three sheriff's offices (Hillsborough, Manatee, and Pasco) showed that DCF's salary minimum was \$4,800 to \$10,000 lower than that offered by the sheriffs. DCF's pay and benefit package for investigators is dictated by state personnel laws and policies and appropriations; sheriff protective investigators are county employees and their pay plan and benefit package varies by county size and geographical location.

Due to their law enforcement affiliation, sheriffs' offices can perform child abuse investigations with greater access to training and specialists, as well as enhanced cooperation and community respect not always afforded to DCF investigators. Child protective investigation units administered by sheriffs' offices also have advantages that are not entirely due to their higher state funding. Because sheriff's offices are law enforcement agencies, they can provide protective investigators with access to training and resource specialists, and a higher degree of cooperation with local law enforcement agencies and the community. When compared to DCF child protective investigation units, sheriffs' offices receive the advantages listed below.

- *Sheriffs often have better cooperation with local law enforcement agencies.* This cooperation helps ensure investigators' safety and facilitates the investigation of maltreatment cases with possible criminal charges, such as sexual abuse. DCF's relationships with local law enforcement vary. Investigators can call local law enforcement to accompany them if they feel unsafe and they also conduct joint investigations. Some DCF investigators report that response time for both is often delayed, while other investigators reported that relationships with local law enforcement agencies had greatly improved in recent years.
- *Sheriffs provide investigators with some of the same training provided to law enforcement officers.* This training includes forensic interviewing and interrogation techniques, which enhances investigators' knowledge and skills and thus may improve the quality of investigations. Although DCF provides many training opportunities to its investigators, investigators reported that they would benefit from training that is more pertinent to the skills required to carry out their job (e.g., illegal drug use and what to look for, investigative report writing, etc.).
- *Sheriffs provide more structured field training for investigators prior to assigning a caseload.* This training may include shadowing a protective investigator before and during pre-service training, working alongside an experienced investigator on cases, and weekly evaluation and feedback on their casework. DCF has maintained a mentoring program for new investigators, but this program is less structured than that provided by some sheriffs.
- *Sheriffs provide more stringent background and other screening for prospective investigators.* The sheriffs' offices use screening methods including psychological and medical exams, polygraphs, credit history, drug tests, criminal background checks, and personal and

professional references, which help assure that civilian investigators meet the background requirements of law enforcement officers. These techniques are more extensive than those used by DCF, although the department has increased its screening requirements for investigators to include some of these elements, such as drug tests, criminal background, and personal and professional references.

- *Sheriffs have a domestic violence specialist/liaison funded by the Florida Coalition Against Domestic Violence for each office.* These positions help investigators understand the dynamics of domestic violence and access to services for the victim and his or her children. The Florida Coalition provided these funds only to the sheriffs' offices using grant funds DCF provided to the coalition. While DCF investigators are trained on domestic violence, few work with a domestic violence specialist on a routine basis or are collocated with such staff.
- *Sheriffs provide access to resource specialists.* Sheriffs' offices are more likely than DCF to collocate other resource specialists with investigators to help with cases involving mental health or substance abuse problems, technical assistance in how to handle specific cases, and technical assistance in linking families with services.
- *Sheriffs have enhanced relationships with the community.* Community stakeholders, department and sheriffs child protective investigators, and managers and supervisors indicate that the culture and attitude of sheriffs' offices enhances the community's view of the investigative function and fosters more respect from the families being investigated. DCF is working to change its relationships with community stakeholders by developing better relationships with local child welfare agencies, creating more professional-appearing badges and a dress code for employees. However, it still struggles to acquire and maintain respect in local communities.

Sheriffs' offices and DCF have similar compliance with timeliness measures; information is not yet available to assess whether sheriffs differ from DCF in their investigation quality and outcomes

During Fiscal Year 2008-09, sheriffs' offices and the department had similar performance on critical timeliness measures. As DCF and the sheriffs' offices use different external quality assurance systems to assess investigation quality, the results of these reviews are not comparable. We have recently received data from DCF's case management information system to evaluate other program measures such as investigators' decisions and outcomes for children. Our analysis is ongoing, and we will provide the results when available to House and Senate committees.

Sheriffs and the department have similar compliance with timeliness measures. As shown in Exhibit 3, there are minimal differences between sheriffs' offices and the department in compliance with timeliness standards. DCF tracks four timeliness measures on its performance dashboard—whether child victims are seen within 24 hours, whether investigations are commenced within 24 hours, whether investigations are reviewed by supervisors within 72 hours, and whether cases are closed within 60 days.

As shown in Exhibit 3, only one of these measures—the percentage of child victims seen within 24 hours—varied substantially across areas of the state. This measure can be affected by factors beyond

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the control of the investigator, such as when the child and family are not at home or the family's address is inaccurate.

Exhibit 3

Sheriffs' Offices and DCF Performed Similarly on Timeliness Measures in Fiscal Year 2008-09

Location ^{1, 2}	Percentage of Child Victims Seen Within the First 24 Hours	Percentage of Investigations Commenced Within 24 Hours	Percentage of Investigations Reviewed by Supervisors Within 72 Hours	Percentage of Investigations Completed Within 60 Days
Seminole	90.3%	99.0%	100.0%	99.9%
Broward	85.7%	99.0%	99.0%	99.7%
Hillsborough	90.5%	98.0%	99.0%	98.0%
Manatee	87.3%	98.0%	98.9%	99.3%
Pasco	84.9%	98.0%	97.2%	98.9%
Pinellas	86.9%	99.0%	98.7%	99.6%
Sheriffs' Average	87.6%	98.6%	98.8%	99.2%
District 1	83.6%	98.0%	99.3%	98.6%
District 2	81.8%	97.0%	96.9%	95.8%
District 3	83.1%	99.0%	96.4%	96.8%
District 4	83.5%	99.0%	97.8%	99.3%
District 7	90.3%	99.0%	99.3%	99.8%
District 8	78.4%	99.0%	97.0%	99.0%
District 9	83.1%	99.0%	96.8%	97.1%
District 11	77.1%	98.0%	98.3%	99.0%
District 12	87.6%	99.0%	97.8%	99.5%
District 13	90.4%	99.0%	99.3%	96.6%
District 14	88.0%	99.0%	97.9%	97.2%
District 15	92.3%	99.0%	99.3%	99.6%
Suncoast Region	87.3%	99.0%	98.3%	98.8%
Department Average	85.7%	98.8%	98.2%	98.5%
State Average	85.8%	98.7%	98.3%	98.6%

¹ Although DCF has realigned its district operations into circuits, performance for Fiscal Year 2008-09 was reported at the district level.

² Child protective investigations in Citrus County transitioned to the Sheriff's office in 2006. DCF has not yet included Citrus County on its performance dashboard for child protective investigations.

Source: OPPAGA analysis of DCF Performance Dashboard.

Quality assurance reviews are not comparable. Although the sheriffs' offices report higher quality assurance ratings than DCF, the ratings of the two types of organizations are not comparable. The sheriffs were authorized by s. 39.3065(3)(d), *Florida Statutes*, to develop their own quality assurance review system to assess the quality of work performed by child protective investigators.⁶ The sheriffs developed a set of standards and a review methodology that differs from the department's quality assurance reviews. Due to these differences, the outcomes of the sheriffs and DCF cannot be compared.

While the department's and sheriff's quality assurance reviews examine many of the same investigative steps and decisions, DCF's ratings are based on different and more factors. For example, DCF has established 28 quality standards for the initial response of investigators, while the sheriff's process has 18 standards. Similarly, DCF has 9 standards addressing emergency removal of children while the sheriffs have 4 standards for this area. In addition, the sheriffs' quality assurance process focuses on statutory requirements, while the department also includes requirements established by Florida Administrative Code and federal performance requirements. As a result, DCF's quality assurance reviews place more emphasis on procedural compliance.

Also, the sheriffs' quality assurance reviews are conducted as peer review teams of other sheriff's offices while the department's reviews are conducted by an internal quality assurance unit.⁷ Because some of the ratings are based on the reviewers' judgment, using different quality assurance processes can limit the comparability of the ratings.

Data to evaluate investigators' decisions and differences in outcomes is not yet available. To address these differences in the quality assurance reviews used by DCF and the sheriffs, we requested data from the department's case management information system, the Florida Safe Families Network (FSFN) on investigation decisions, recommendations, and outcomes. We chose these indicators based on input from subject area experts at DCF headquarters, the Florida Mental Health Institute at the University of South Florida, and sheriffs' offices. However, we encountered delays in obtaining data (over 1.3 million investigation records) for the analysis because our request required special programming to extract specific data elements from FSFN. DCF provided these data on January 22, 2010, and our analysis is ongoing. We will provide a separate memorandum to applicable House and Senate committees on the outcomes of our analysis.

Options for Legislative Consideration

We examined four options for the organizational placement of child protective investigations: (1) retain the current arrangements in which seven sheriffs perform child protective investigations, (2) encourage additional sheriffs to take over this function, (3) reduce funding for sheriff's to the level provided to DCF, and (4) discontinue contracting with sheriffs and returning responsibility for all child protective functions to DCF.

⁶ The law requires that the quality assurance evaluation tool and methodology be based on criteria upon which the sheriffs and the department have agreed.

⁷ The sheriffs' peer review teams include at least one DCF quality assurance staff member.

Option 1: Retain the current system in which sheriffs perform child protective investigations in seven counties while DCF performs these investigations in 60 counties. The current system has the advantage of testing two service delivery systems. As discussed earlier, the sheriffs receive higher funding levels that enhance their investigators' ability to perform job duties. The sheriffs' offices are generally better able to attract and retain experienced investigators, avoiding the need for these units to spend time and resources training new investigators. Due to their law enforcement affiliation, sheriffs' offices can perform this function with greater access to training and resource specialists, and an enhanced degree of cooperation and community respect not always afforded to DCF investigators.

However, this system is more expensive to the state than solely having DCF perform this function, and it could result in service disruptions should sheriffs opt out of performing the function.

Option 2: Encourage additional sheriffs to take on child protective investigations. This option has the same benefits and drawbacks as Option 1. However, most sheriffs have indicated that they will not consider taking on this function without a guarantee that they will receive adequate funding. A DCF manager indicated that one sheriff was interested in taking over this function but wanted a 40% increase over the current DCF budget for that area of the state.

Option 3: Reduce sheriff's funding per case to that provided to DCF. The estimated savings for this option is \$2 million in general revenue.⁸ However, it would likely result in some sheriffs' offices discontinuing this function.

Option 4: Return responsibility for all child protective functions back to the department. As with Option 3, this action could potentially save the state \$2 million in general revenue.⁹ However, there would be offsetting short-term costs to building DCF's infrastructure to handle this responsibility, including leasing office space, transferring inventory purchased with grant funds, and purchasing needed equipment. As staff currently employed by the sheriffs may not transfer to DCF, particularly if their salaries are reduced as a result of this move, DCF could need to quickly hire and train a substantial number of new investigators in order to avoid service disruptions.

⁸ The estimated savings calculation is based on the federal administrative overhead rate of 19% applied to the \$98.2 million allocation for child protective investigations in Fiscal Year 2008-09. The savings calculations assume 50% general revenue funding.

⁹ Ibid.

Appendix A

County Sheriffs' Offices Have Been Authorized to Conduct Child Protective Investigations for 17 Years



Florida Legislature authorizes DCF (then the Department of Health and Rehabilitative Services) to enter into agreements, within existing resources, with county sheriffs' office or local police departments to assume the lead role in conducting criminal investigations of child maltreatment, and partial or full responsibility of conducting certain components of child protective investigations.



Manatee County Sheriff's Office begins conducting investigations of more serious cases of child maltreatment, as authorized by the 1993 Legislature.



Florida Legislature requires DCF to transfer the responsibility for all child protective investigations in Manatee, Pasco, and Pinellas counties to county sheriffs' offices by July 1999.



Florida Legislature adds the Broward County Sheriff's Office to those sheriffs authorized to conduct child protective investigations.



Florida Legislature transfers child protective investigations in Seminole County to the sheriffs' offices that conduct these investigations. The Legislature also gives DCF general authorization to enter into grant agreements with other sheriffs to perform child protective investigations in their respective counties.



Florida Legislature provides funding to the Hillsborough County Sheriff's Office to assume responsibility for child protective investigations.



Florida Legislature provides funding to the Citrus County Sheriff's Office to assume responsibility for child protective investigations.

Appendix B

Appropriations History for Child Protective Investigations Conducted by Sheriffs' Offices

As shown in Table B-1, legislative appropriations to the sheriffs' offices increased every year until Fiscal Year 2006-07.

Table B-1
Sheriffs' Offices Received Increases in Appropriations Until Fiscal Year 2006-07

Fiscal Year	County						
	Manatee	Pasco	Pinellas	Broward	Seminole	Hillsborough	Citrus
1999-2000	\$1,930,425	\$1,486,709	\$5,590,992	\$5,272,874	N/A	N/A	N/A
2000-2001	2,100,045	2,363,855	7,212,817	10,226,626	\$3,251,216	N/A	N/A
2001-2002	2,178,403	3,187,607	7,551,721	10,673,738	2,845,681	N/A	N/A
2002-2003	2,305,714	3,441,504	8,252,915	11,085,007	3,122,776	N/A	N/A
2003-2004	2,453,337	3,661,843	8,781,301	12,258,634	3,322,709	N/A	N/A
2004-2005	3,138,047	4,001,038	9,131,158	12,307,058	3,335,698	N/A	N/A
2005-2006	3,619,941	4,189,840	10,656,488	13,337,160	3,527,155	\$1,000,000	N/A
2006-2007	3,619,941	4,189,840	10,656,488	13,337,160	3,527,155	15,503,339	\$500,000
2007-2008	3,619,941	4,189,840	10,656,488	13,337,160	3,527,155	13,091,844	1,984,715
2008-2009 ¹	3,410,532	3,947,463	10,040,024	12,565,623	3,323,114	12,334,498	1,869,903
2009-2010	3,410,532	4,591,619	10,040,024	12,565,623	3,323,114	12,054,683	1,505,562

¹ Represents a 5.78% reduction during Fiscal Year 2007-08.

Source: Department of Children and Families.



The Florida Legislature

OFFICE OF PROGRAM POLICY ANALYSIS AND GOVERNMENT ACCOUNTABILITY



RESEARCH MEMORANDUM

Sheriffs' Offices and DCF Perform Similarly in Conducting Child Protective Investigations

May 28, 2010

Summary

As requested, OPPAGA compared the performance of child protective investigations conducted by sheriffs' offices with those conducted by the Department of Children and Families (DCF). Our analyses showed that both sheriffs' offices and DCF perform well on measures of investigative timeliness. Sheriffs had slightly higher performance on four of these measures than DCF and were comparable to DCF in the percentage of cases in which investigations were commenced within 24 hours. We found no meaningful difference between sheriffs' offices and DCF in terms of whether allegations of child maltreatment were substantiated or their recommendations of actions needed to reduce risks to children. Although cases handled by sheriffs' offices had slightly more positive outcomes than those handled by DCF, this difference was not meaningful.

Background

This is the second of two research memoranda comparing child protective investigations conducted by sheriffs' offices with those conducted by DCF.¹ It assesses whether there are performance differences between sheriffs' offices and DCF in the timeliness of their investigations, the types of critical decisions and recommendations made by their child protective investigators, and the short-term outcomes of their investigations.

To evaluate the timeliness of the child protective investigations, we used data available on the department's Performance Measures Dashboard and data from the Florida Safe Family Network (FSFN), which is the department's child welfare information system. We also used FSFN data to evaluate investigators' critical decisions and the outcomes of investigations. It should be noted that FSFN data has some limitations, as it was designed as a case management system to

¹ An earlier memorandum compared costs, investigative processes and procedures, resources, and quality of child protective investigations conducted by sheriffs and DCF. It concluded that legislative appropriations to sheriffs' offices for child protective investigations historically have exceeded the funding per investigation provided to DCF. Both entities generally use similar investigative processes and procedures, although the higher level of funding for the sheriffs resulted in their investigators having greater resources than typically available to DCF investigators. Due to their law enforcement affiliation, child protective investigators working for sheriffs also generally have greater access to training and specialists, as well as enhanced cooperation and community respect not always afforded to DCF investigators.

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meet the needs of caseworkers and their supervisors rather than researchers.² As a result, contextual information about the decisions made by investigators and case managers is contained in chronological case notes that are not readily accessible for data analysis purposes. In addition, FSFN is an evolving information system and DCF continues to identify instances in which data has not been entered into required data fields, which reduces the reliability of the data in the system, or users are not interpreting data fields as intended.

DCF conducts child protective investigations in 60 Florida counties. Sheriffs' offices, which conduct child protective investigations under grant agreements with DCF, are responsible for this function in the remaining seven counties: Broward, Citrus, Hillsborough, Manatee, Pasco, Pinellas, and Seminole.

All child protective investigations, regardless of the entity administering this function, must be conducted in accordance with state and federal laws and regulations. Florida's child protective investigation units are responsible for receiving and responding to reports of child abuse and neglect, which involves gathering forensic evidence and making a formal determination of whether child maltreatment occurred or the child is at risk of abuse or neglect, and providing the child with protection if needed. As required by Ch. 39, *Florida Statutes*, child protective investigators must respond to reports of child maltreatment, assess risk to the child, initiate removal or provide in-home services to ensure the child's safety, and make a determination regarding the allegations of child maltreatment. Each of these responsibilities represents a key decision point in the investigative process. Protective investigators perform these functions in partnership with several other entities such as local law enforcement, Child Protection Teams, Guardians ad Litem, Children's Legal Services, the courts, and case managers employed or contracted by community-based care lead agencies.

For Fiscal Year 2009-10, the Legislature appropriated \$98 million and 1,586.5 FTEs to the department for its child protective investigative function and \$47 million to the seven sheriffs performing this function. Sheriffs' offices conducted 27% of the state's child protective investigations in Fiscal Year 2008-09.

Sheriffs' offices and DCF perform similarly in meeting investigation time requirements

There is little difference between the performance of sheriffs' offices and DCF on investigation timeliness measures. However, most sheriffs' offices close cases more quickly than DCF, using less time than allowed by statute.

DCF's performance dashboard contains data on five key timeliness measures: percentage of investigations commenced within 24 hours, percentage of child victims seen within 24 hours, percentage of Child Safety Assessments submitted within 48 hours of the child being seen, percentage of investigations reviewed by supervisors within 72 hours, and percentage of cases closed within 60 days.³ Three of these measures have legislative standards (percentage of investigations commenced within 24 hours, percentage of investigations reviewed by supervisors within 72 hours, and percentage of cases closed within 60 days) while the other two are internal measures DCF uses to help monitor its performance.

² Unless otherwise noted, we used FSFN data from July 1, 2007 to June 30, 2009.

³ A Child Safety Assessment is an in-home assessment investigators use to document factors such as signs of present danger to the child, the child's vulnerability, and the safety plan developed by the investigator with the family.

As shown in Exhibit 1, sheriffs performed slightly higher than DCF on four of these measures but performed slightly lower than DCF on the percentage of cases in which investigations were commenced within 24 hours.

Exhibit 1

Sheriffs' Offices and DCF Performed Similarly on Timeliness Measures in Fiscal Year 2008-09

Location ¹	Percentage of Child Victims Seen Within the First 24 Hours	Percentage of Investigations Commenced Within 24 Hours ²	Percentage of Child Safety Assessments Submitted Within 48 Hours	Percentage of Investigations Reviewed by Supervisors Within 72 Hours ³	Percentage of Investigations Completed Within 60 Days ⁴
Sheriffs' Average	87.6%	98.6%	97.4%	98.8%	99.2%
DCF Average	85.0%	98.9%	96.0%	98.1%	98.4%

¹ Child protective investigations in Citrus County transitioned to the sheriff's office in 2006. DCF has not yet included Citrus County in its performance dashboard for child protective investigations.

² Legislative Standard = 100%.

³ Legislative Standard = 98%.

⁴ Legislative Standard = 100%.

Source: OPPAGA analysis of data from DCF's Performance Dashboard.

We also found that most sheriffs' offices close cases more quickly than DCF, using less time than allowed by statute. Section 39.301(17), *Florida Statutes*, requires DCF to close investigation cases within 60 days after receiving the initial report.⁴ The department reports performance for this requirement as the percentage of cases meeting the time standard, which does not show the actual time each office takes to close cases. Using data from FSFN, we calculated the average and median time to complete investigations.

As shown in Exhibit 2, sheriffs' offices consistently closed cases more quickly than the department, taking a median of five fewer days to close cases over the time period from Fiscal Years 2004-05 to 2008-09. For example, in Fiscal Year 2008-09, five of seven sheriffs' offices closed cases in an average of 40 days or less compared to 15 of 60 DCF investigative units.⁵ Several factors may contribute to these results. Administrators in two sheriffs' offices (Manatee and Seminole) told us that they strive to close cases within 30 days, which affects the mean and median time to close cases for the sheriffs as a whole.⁶ Another factor is that sheriffs' offices have lower caseloads and more aides to assist with clerical tasks, giving investigators more time to focus on conducting investigations.

Exhibit 2

Sheriffs' Offices Close Child Protective Investigations More Quickly Than the Department

Number of Days Cases Were Open	Mean	Median
DCF	43.3	45.0
Sheriffs' Offices	36.3	40.1

Source: OPPAGA analysis of FSFN data for Fiscal Years 2004-05 to 2008-09.

⁴ Section 39.301(17), *F.S.* provides exceptions to completing the investigation within the 60-day timeframe; e.g., a concurrent criminal investigation.

⁵ The five sheriffs' offices that closed cases within 40 days are Broward, Citrus, Manatee, Pinellas, and Seminole.

⁶ The average length of time cases were open for Manatee and Seminole sheriffs' offices was 19 days.

There is little difference between sheriffs' offices and DCF in whether investigators substantiate allegations of maltreatment and the decisions they make to protect children and provide services

We also examined whether there are differences between sheriffs' offices and DCF in the critical decisions investigators make during the investigative process, which include determining whether there is sufficient evidence to substantiate allegations of child maltreatment and deciding how to prevent further harm to children. We found no meaningful differences in the critical decisions made by sheriffs' offices compared to the department regarding how frequently they substantiate allegations of child abuse and neglect. There were also no significant differences between DCF and sheriffs' offices in their response to instances of maltreatment and recommendations to protect children. For each of these critical decision points, we further evaluated results by the major types of maltreatment to verify that sheriffs' office and DCF investigators made similar decisions for similar types of cases, but found no meaningful differences between the two entities.⁷

Substantiating maltreatment allegations. A critical case decision is whether an investigation substantiates the allegation of child maltreatment. Investigators substantiate allegations of child maltreatment if they find that a child was harmed in a manner that meets Florida's definition of child maltreatment and there is sufficient evidence to support the allegation of maltreatment.⁸

Our analyses did not find meaningful differences between the two investigative entities in the extent to which investigators substantiate abuse allegations. As shown in Exhibit 3 below, although sheriffs' investigators substantiated child maltreatment in a slightly higher percentage of cases than DCF, this difference is not meaningful. Moreover, there were no meaningful differences in substantiation rates for different types of cases. Overall, the total investigators' substantiation rates for sheriffs' offices and DCF were 18.1% and 17.8%, respectively.

**Exhibit 3
 Sheriff and DCF Protective Investigators Substantiate Allegations at a Similar Rate**

Allegation	Sheriffs	DCF
Abuse ¹	10.9%	12.7%
Neglect ²	11.9%	11.8%
Threatened Harm ³	19.1%	18.2%
Total Rate of Substantiation for All Investigations	18.1%	17.8%

¹ Abuse includes allegations of physical injury, sexual abuse, mental injury, bone fracture, death, bizarre punishment, burns, asphyxiation, internal injuries, and human trafficking.

² Neglect includes allegations of inadequate supervision, medical neglect, abandonment, failure to thrive, and malnutrition/dehydration.

³ Threatened harm includes allegations of family violence, substance misuse, threatened harm, environmental hazards, failure to protect, and caregiver unavailable.

Source: OPPAGA analysis of FSN data.

⁷ We also examined whether sheriff and DCF investigators responded differently to the same risk factors, such as whether there were prior maltreatment reports, serious injury, increased incidents of maltreatment, or children had limited visibility to non-family members in the community. However, since these analyses also found no meaningful differences, the results are not presented.

⁸ Florida's definition of child maltreatment includes abuse, abandonment, and neglect.

Deciding how to respond to maltreatment and reduce risk to children. When investigators substantiate maltreatment or find situations that put children at risk of maltreatment, they make critical decisions about how to best protect the children. When commencing investigations, investigators may decide children are at imminent risk of further harm and must be immediately removed from their homes or receive emergency services to try to prevent removal.⁹ At the conclusion of investigations, investigators may also decide that children must be removed from their homes, or may recommend court-ordered in-home services, voluntary in-home services, or that no services are needed. In some cases, investigators decide services are needed because they verified that child maltreatment occurred. In other instances, they may decide a family should be offered services because of a perceived risk of maltreatment in the future.

We assessed whether there was any difference between sheriffs' offices and DCF in the extent to which investigators immediately removed children from their homes or put emergency services in place due to imminent risk of serious harm. We did not find meaningful differences between sheriffs' offices and DCF in investigators' response to emergency situations. As shown in Exhibit 4, sheriff protective investigators made the decision to immediately remove children from their homes in 18.4% of investigations that substantiated allegations maltreatment, compared to 17.7% for DCF. A similar pattern occurred for emergency services, as shown in Exhibit 5. Both sheriff and DCF protective investigators provided emergency services in 4.3% of investigations that substantiated maltreatment had occurred. We also did not find meaningful differences between sheriffs' offices and DCF when conducting this evaluation for major types of verified maltreatment. Exhibits 4 and 5 show these results by type of maltreatment.

Exhibit 4

Sheriff and DCF Protective Investigators Conduct Emergency Removals at Similar Rates

Rate of Emergency Removal for Investigations that Substantiated:	Sheriffs	DCF
Abuse	16.1%	16.3%
Neglect	31.5%	30.5%
Threatened Harm	18.5%	18.4%
Rate of Emergency Removal for All Investigations that Substantiated Maltreatment	18.4%	17.7%

Source: OPPAGA analysis of FSN data.

Exhibit 5

Sheriff and DCF Protective Investigators Provided Emergency Services at Similar Rates

Rate of Providing Emergency Services for Investigations that Substantiated:	Sheriffs	DCF
Abuse	3.2%	4.1%
Neglect	4.3%	5.1%
Threatened Harm	4.5%	4.1%
Rate of Providing Emergency Services for All Investigations that Substantiated Maltreatment	4.3%	4.3%

Source: OPPAGA analysis of FSN data.

⁹ An allegation of child maltreatment is often not an isolated problem; many families experience multiple and complex problems, often at crisis levels. During the initial risk assessment, the investigator may determine that a family is in a crisis situation and arrange for emergency services for the child and family, such as food and shelter or crisis counseling, to try to prevent having to remove a child from home.

We also examined the recommendations that investigators made at the conclusion of investigations, but found no significant differences between sheriffs' offices and DCF. When investigators concluded maltreatment occurred, both investigative entities recommended out-of-home placement in approximately 14% of cases, court-ordered in-home services in approximately 7% of cases, voluntary in-home services in approximately 40% of cases, and no services from the child welfare system in approximately 40% of cases (see Exhibit 6).

Exhibit 6

Sheriff and DCF Protective Investigators Made Similar Recommendations for Investigations with Verified Maltreatment

Recommendation in Cases with Substantiated Maltreatment	Sheriffs	DCF
Out of Home Placement	14.3%	14.1%
Court-Ordered In-Home Services	6.8%	7.1%
Voluntary In-Home Services	38.7%	39.6%
No Child-Welfare Services	40.2%	39.2%

Source: OPPAGA analysis of FSN data.

It should be noted that our analyses of investigators' critical decisions have some caveats due to data limitations. For example, available data did not show what, if any, services the family was already receiving at the time of the investigation. According to department administrators, investigators would not recommend a service that was already being provided, such as in-home services. As a result, these numbers reflect investigators' recommendations and not necessarily the types of services the family actually received.¹⁰ In addition, while investigators are responsible for making recommendations about removal, out-of-home placement, and court involvement, the final decision in a case of child maltreatment involves other parties in the dependency system such as investigation supervisors, Children's Legal Services attorneys, and judges.

Sheriffs' office and DCF investigations resulted in similar outcomes for children

We did not find meaningful differences between sheriffs' offices and DCF in short-term investigation outcomes for children as measured by subsequent maltreatment within three and six months when an investigator did not originally substantiate maltreatment. We focused on unsubstantiated allegations to isolate short-term investigation outcomes that can be more directly linked to the investigation process rather than the influence of other stakeholders in the child welfare system such as case managers and service providers.

As shown in Exhibit 7, cases investigated by sheriffs had slightly more positive short-term outcomes, but this difference is not meaningful. For both groups, in approximately 3% of cases where the investigator did not substantiate maltreatment, a later investigation substantiated maltreatment within three months regardless of which entity conducted the initial investigation. At six months, this rate increased to approximately 4.5% for both groups.

¹⁰ Although investigators did not recommend services in approximately 40% of the investigations that substantiated maltreatment, this does not necessarily mean the family did not receive services. The family may already have been receiving services at the time of the investigation, may have been referred for services by a source outside of the child welfare system, or may have received services from the child welfare system regardless of the protective investigator's recommendations.

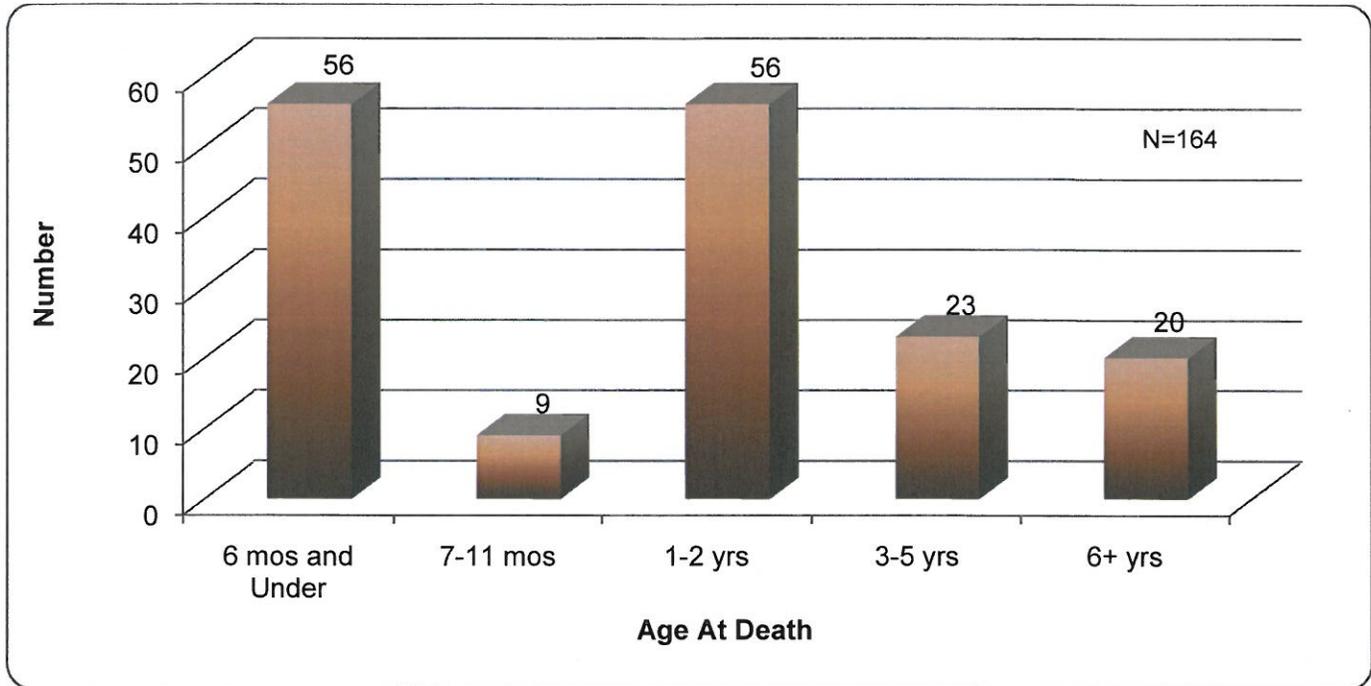
Exhibit 7

Subsequent Verified Maltreatment Occurred at the Same Rate for Investigations Conducted by Sheriffs and DCF

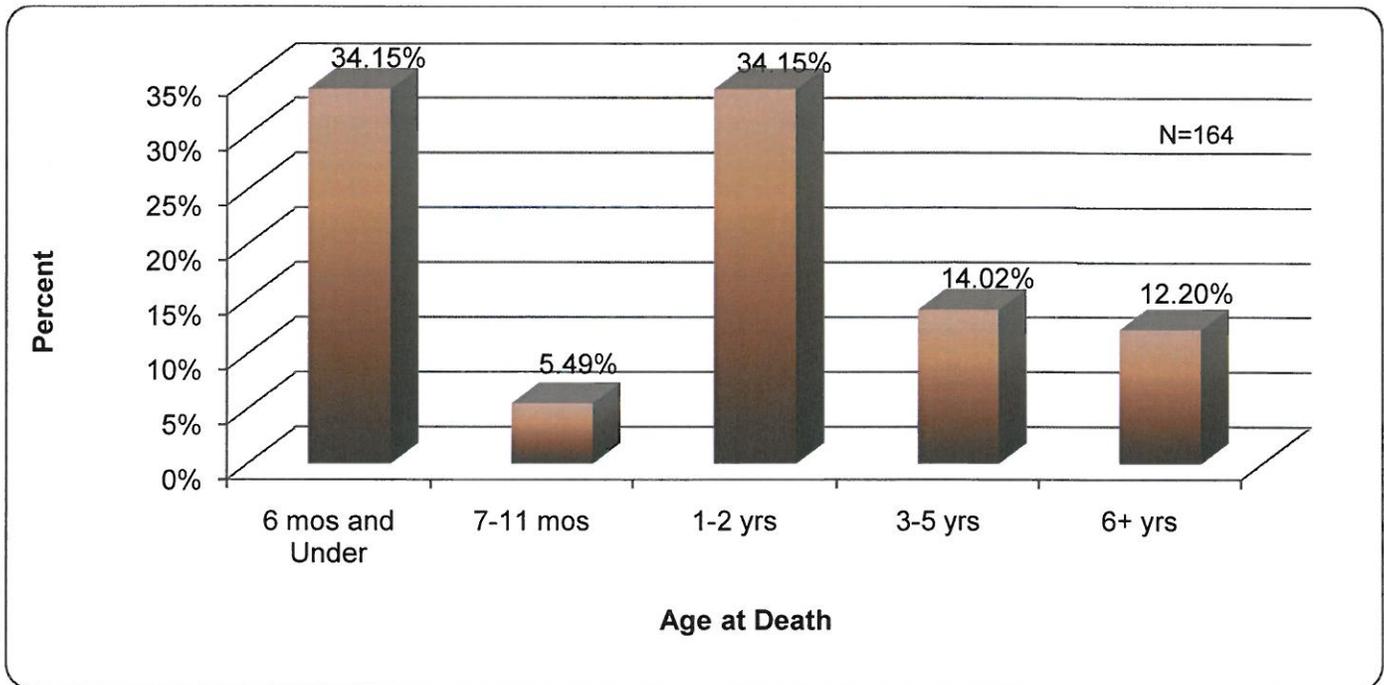
Subsequent Maltreatment Within Three and Six Months	Sheriff	DCF
Investigations with subsequent verified maltreatment within three months when original alleged maltreatment was unsubstantiated	2.6%	2.8%
Investigations with subsequent verified maltreatment within six months when original alleged maltreatment was unsubstantiated	4.4%	4.5%

Source: OPPAGA analysis of FSN data.

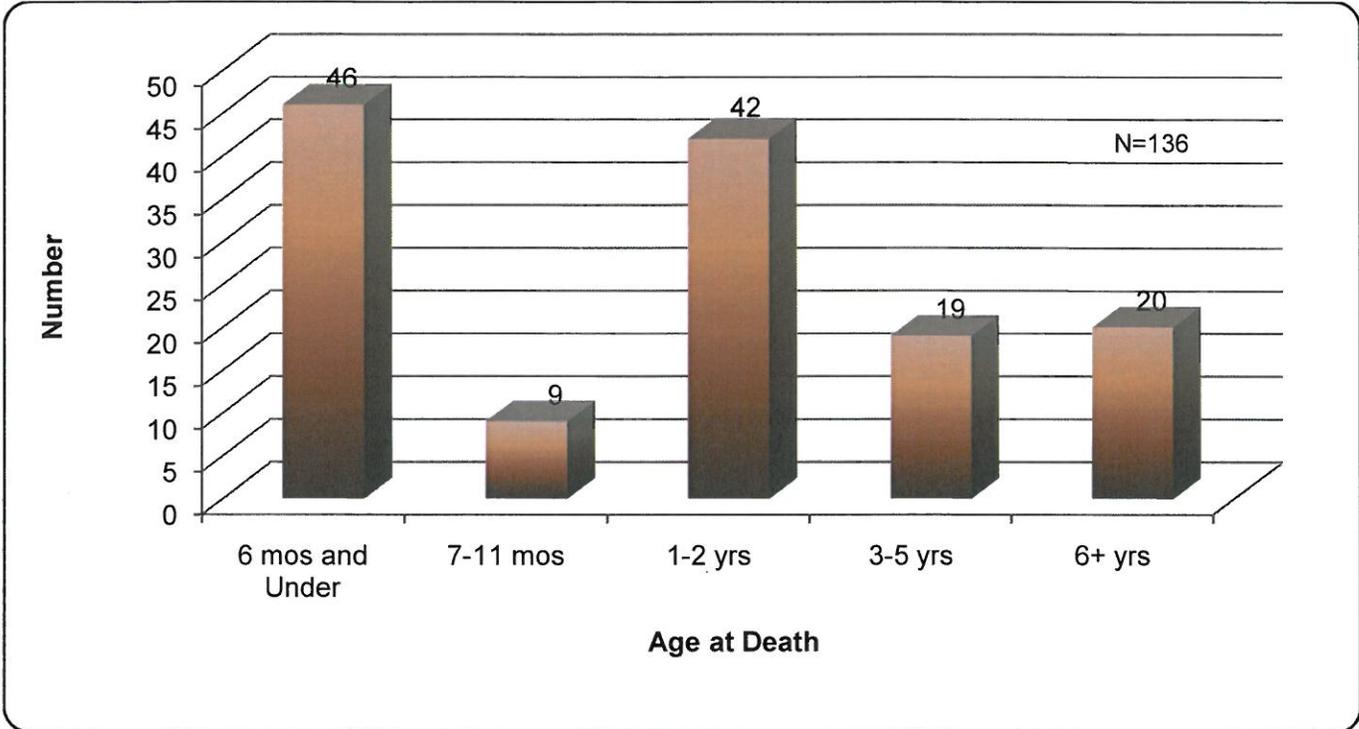
**Age at Death for Children Ages 5 Years and Under vs. 6+ Years
Numbers for Calendar Year 2010**



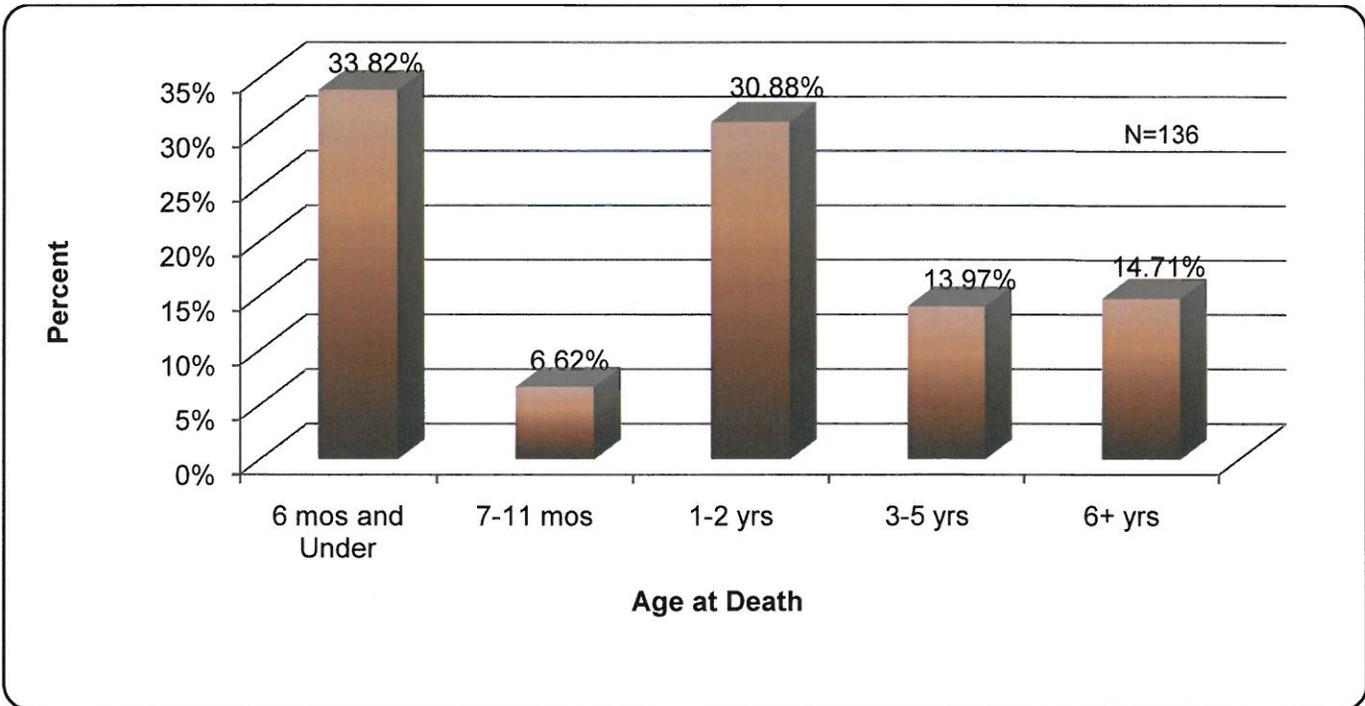
**Age at Death for Children Ages 5 Years and Under vs. 6+ Years
Percentages for Calendar Year 2010**



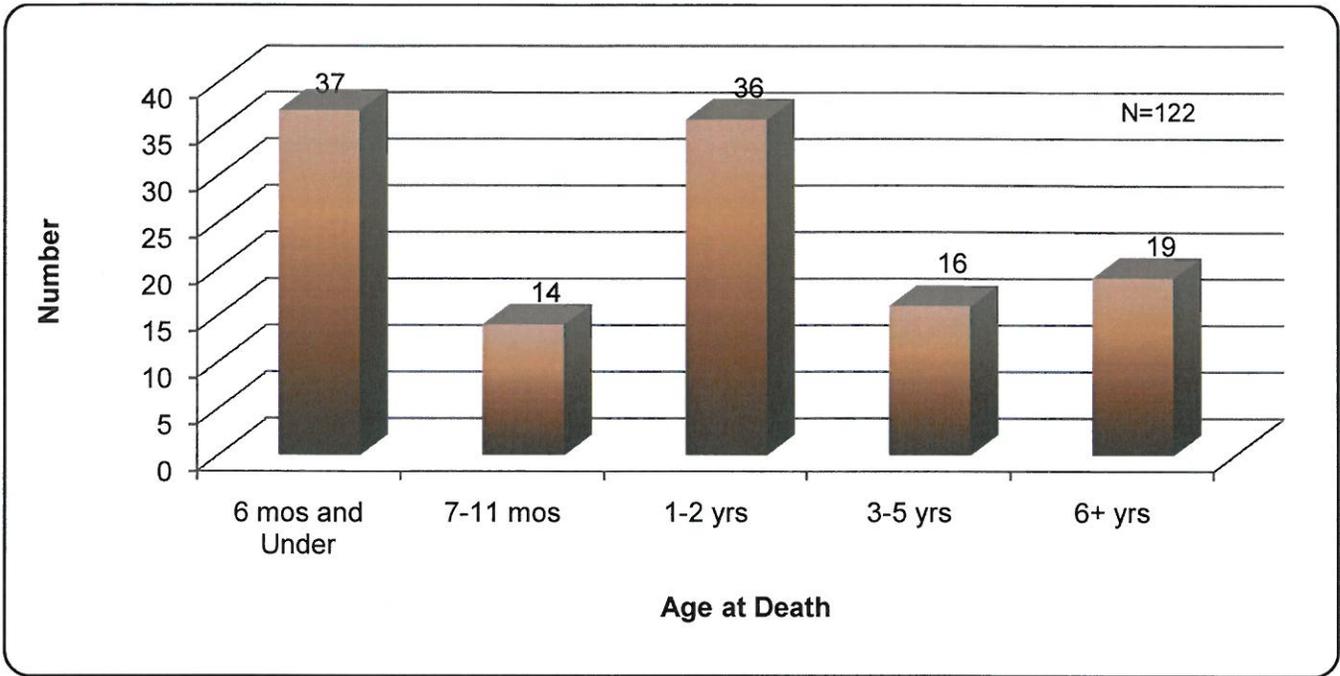
**Age at Death for Children Ages 5 Years and Under vs. 6+ Years
Numbers for Calendar Year 2011**



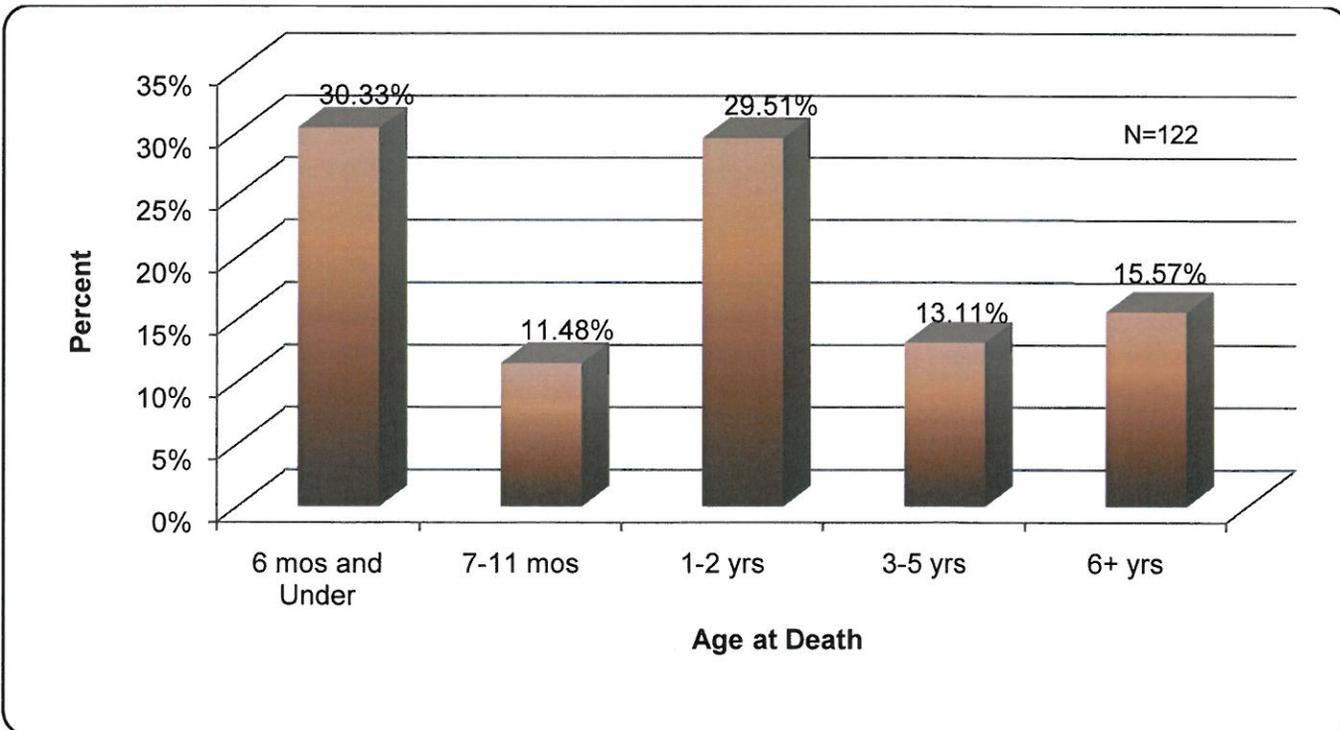
**Age at Death for Children Ages 5 Years and Under vs. 6+ Years
Percentages for Calendar Year 2011**



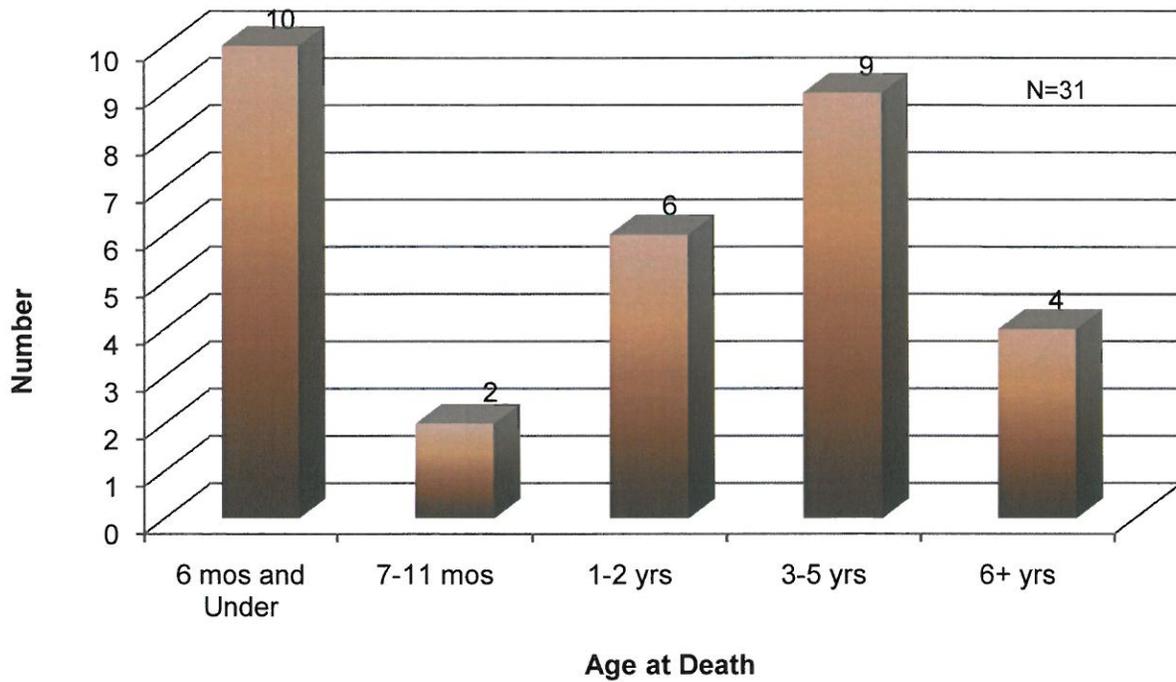
**Age at Death for Children Ages 5 Years and Under vs. 6+ Years
Numbers for Calendar Year 2012**



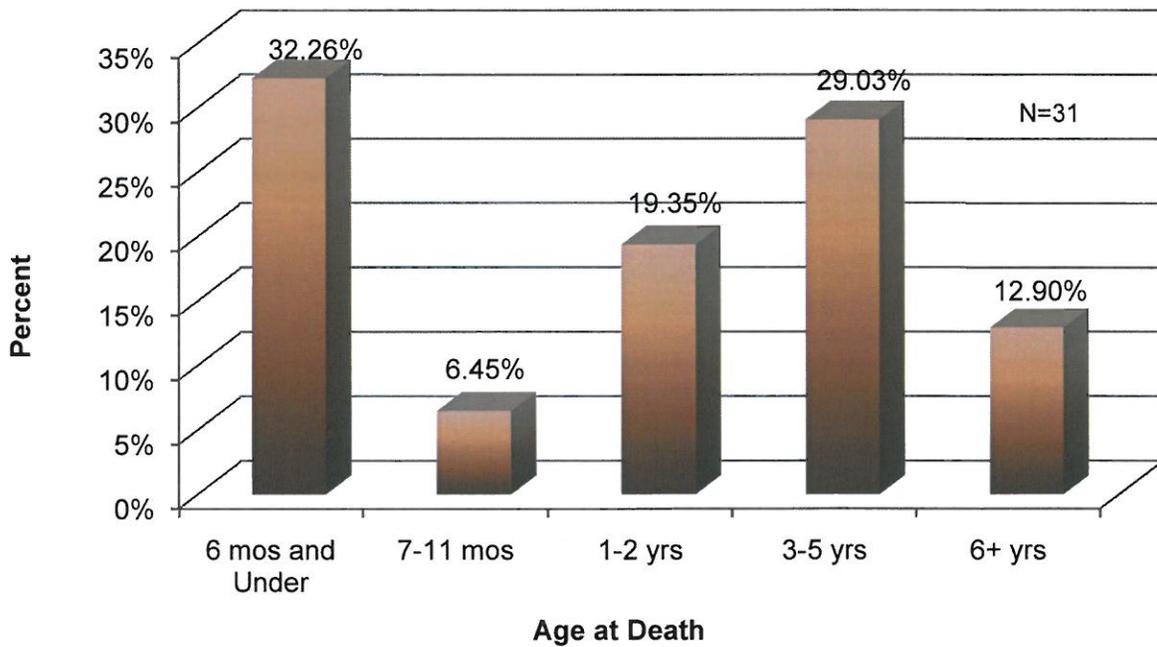
**Age at Death for Children Ages 5 Years and Under vs. 6+ Years
Percentages for Calendar Year 2012**



**Age at Death for Children Ages 5 Years and Under vs. 6+ Years
Numbers for 2013 Death Reports Closed as of 07/31/31**



**Age at Death for Children Ages 5 Years and Under vs. 6+ Years
Percentages for 2013 Death Reports Closed as of 07/31/31**



Age at Death / Calendar Years	6 months or Less	7-11 Months	1-2 Years	3-5 Years	6+ Years
2010	56 - 34.15%	9 – 5.49%	56 – 34.15%	23 – 14.02%	20 – 12.2%
2011	46 – 33.82%	9 – 6.62%	42 – 30.88%	19 – 13.97%	20 – 14.71%
2012	37 – 30.33%	14 – 11.48%	36 – 29.51%	16 – 13.11%	19 – 15.57%
01/01/13-07/31/13	10 – 32.26%	2 – 6.45%	6 – 19.35%	9 – 29.03%	4 – 12.90%

Casey Family Programs National Survey of Safety and Risk Assessment Tools, 2011

State	Is CW System State- or County-Administered?	Does State Have Tribal CW Programs?	Are SDM Tools Used in the State?	Which SDM Tools Are Used? **	Year SDM First Used	Is the ACTION / NRCCPS Model Used in the State?	Year ACTION Model First Used	Is the Signs of Safety Approach Used in the State?	Year SofS First Used	Other Safety or Risk Assessments Used, Additional Comments:
AL	State	Yes	No	N/A	N/A	No	N/A	No	N/A	Three counties are piloting tools from the ACTION model.
AK	State	Yes	Statewide	4	2002	Statewide	2005	No	N/A	
AZ	State	Yes	No	N/A	N/A	Statewide	2003	No	N/A	Risk Assessment tool from NRC on Family Centered Practice and Permanency Planning is used
AR	State	No	Statewide	3, 4	2010	No	N/A	No	N/A	Currently child protection assessors use SDM, in the future this approach will be used by staff providing ongoing services. The Signs of Safety approach is not currently used but is being considered.
CA	County	Yes	One or more counties, service regions, or tribal areas	1, 2, 3, 4, 5, 6, 7	1998	No	N/A	One or more counties, service regions, or tribal areas	2010	
CO	County	No	No	N/A	N/A	No	N/A	No	N/A	Counties required to use NCFAS plus family functioning tool; they may also be using additional tools
CT	State	No	Statewide	1, 2, 3, 4, 6	2006	No	N/A	No	N/A	
DE	State	No	No	N/A	N/A	Statewide	1987	No	N/A	DE is planning to implement SDM and has contracted with the Children's Research Center to begin with the Intake process.
DC										
FL	State	Yes	One or more counties, service regions, or tribal areas	1, 2, 3, 4, 5, 6	2010	No	N/A	One or more counties, service regions, or tribal areas	2010	FL uses the Child Safety Assessment, which was developed as part of SACWIS implementation. The ACTION/NRCCPS model was recommended by a statewide work group and will be implemented in six units to determine feasibility for statewide roll-out.

** SDM Tools Key: 1 = Screen-In/Intake; 2 = Response Priority; 3 = Safety Assessment; 4 = Risk Assessment; 5 = Case Reassessment; 6 = Family Strengths & Needs Assessment; 7 = Substitute Care Providers. Some states also use an SDM Reunification Assessment tool, not coded here.

Casey Family Programs National Survey of Safety and Risk Assessment Tools, 2011

State	Is CW System State- or County- Administered?	Does State Have Tribal CW Programs?	Are SDM Tools Used in the State?	Which SDM Tools Are Used? **	Year SDM First Used	Is the ACTION / NRCCPS Model Used in the State?	Year ACTION Model First Used	Is the Signs of Safety Approach Used in the State?	Year SofS First Used	Other Safety or Risk Assessments Used, Additional Comments:
GA	State	No	No	N/A	N/A	No	N/A	No	N/A	GA uses hybrid risk and safety assessments, simply titled 'safety assessment' and 'risk assessment', statewide. GA is currently in the process of choosing new safety and risk assessment tools.
HI	State	No	No	N/A	N/A	Statewide	2009	No	N/A	HI uses the Hawaii Comprehensive Assessment Model.
ID	State	Yes	No	N/A	N/A	No	N/A	No	N/A	A safety assessment developed with American Humane Association is used, and incorporates the standard signs of danger.
IL	State	No	No	N/A	N/A	No	N/A	No	N/A	
IN	State	No	Statewide	3, 4		No	N/A	No	N/A	CANS is used for child and family assessment for on-going cases. SDM is being developed for hotline intake decision making purposes.
IA	State	No	No	N/A	N/A	No	N/A	No	N/A	Iowa has created their own safety and risk tools and protocol, modeled after another state.
KS	State	No	No	N/A	N/A	Statewide	2009	No	N/A	Kansas implemented risk and safety assessment tools in 1999. The tools were developed with the University of Kansas and have been validated.
KY	State	No	No	N/A	N/A	No	N/A	No	N/A	A tool based on a risk framework and an ecological model is used throughout the life of the case, with on-going updates added.
LA	State	No	Statewide	1, 2, 3, 4, 5, 6, 7	2010	No	N/A	No	N/A	
ME	State	No	No	N/A	N/A	No	N/A	Statewide	2011	Maine uses a "Fact Finding" interview protocol developed by Deborah Poole.
MD	State	No	Statewide			No	N/A	No	N/A	

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Some states also use an SDM Reunification Assessment tool, not coded here.

Casey Family Programs National Survey of Safety and Risk Assessment Tools, 2011

State	Is CW System State- or County-Administered?	Does State Have Tribal CW Programs?	Are SDM Tools Used in the State?	Which SDM Tools Are Used? **	Year SDM First Used	Is the ACTION / NRCCPS Model Used in the State?	Year ACTION Model First Used	Is the Signs of Safety Approach Used in the State?	Year SofS First Used	Other Safety or Risk Assessments Used, Additional Comments:
MA	State	No	Statewide	3, 4	2008	No	N/A	Statewide	2009	
MI	County	Yes	Statewide	3, 4, 5, 6	2009	No	N/A	One or more counties, service regions, or tribal areas	2010	Saginaw county has found utilizing SDM and SOFS together to be quite effective. Safety measures have improved while between FY10-FY11 the children in care has been reduced by 10%.
MN	County	Yes	Statewide	1, 3, 4, 5, 6	1999	No	N/A	One or more counties, service regions, or tribal areas	2001	
MS	State	Yes	No	N/A	N/A	No	N/A	No	N/A	MS uses a Safety/Risk Assessment for regular investigations, and a Risk Assessment for Resource Homes.
MO	State	No	Statewide	1, 2, 4	2002	No	N/A	No	N/A	The Framework for Safety is used for safety assessment statewide
MT	State	Yes	No			Statewide	2011	No	N/A	The Montana Risk Assessment Model is used.
NE	State	Yes	One or more counties, service regions, or tribal areas	3, 4, 5	2011	Statewide	2008	No	N/A	Transition from ACTION (called Nebraska Safety Intervention System NSIS) to SDM planned for fall 2011 in the East and SE Areas. The rest of the state's 3 Service Areas continue to use the ACTION-based Nebraska Safety Intervention System (NSIS).
NV	Combination	No	No	N/A	N/A	One or more counties, service regions, or tribal areas	2006	No	N/A	ACTION assessments for Present and Impending Danger and for Parental Capacities are being rolled out statewide. The Nevada Safety Assessment and an SDM Risk Assessment have been used but will be discontinued.

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Some states also use an SDM Reunification Assessment tool, not coded here.

Casey Family Programs National Survey of Safety and Risk Assessment Tools, 2011

State	Is CW System State- or County- Administered?	Does State Have Tribal CW Programs?	Are SDM Tools Used in the State?	Which SDM Tools Are Used? **	Year SDM First Used	Is the ACTION / NRCCPS Model Used in the State?	Year ACTION Model First Used	Is the Signs of Safety Approach Used in the State?	Year SofS First Used	Other Safety or Risk Assessments Used, Additional Comments:
NH	State	No	Statewide	1, 2, 3, 4, 5, 6	2001	No	N/A	No	N/A	NH intends to begin to incorporate elements and principles of SofS in 2012 with Solution Based Casework as part of their Practice Model.
NJ	State	No	Statewide	1, 2, 3, 4, 5, 6	2004	No	N/A	No	N/A	NJ also uses the SDM Family Reunification Assessment
NM	State	Yes	Statewide	3, 4	1997	Statewide	2010	No	N/A	
NY	County	Yes	Statewide	1, 3, 4, 5, 6, 7	1991	No	N/A	One or more counties, service regions, or tribal areas	2009	
NC	County	No	Statewide	3, 4, 6	2002	No	N/A	One or more counties, service regions, or tribal areas		
ND	County	Yes	No	N/A	N/A	No	N/A	No	N/A	
OH	County	No	No	N/A	N/A	No	N/A	One or more counties, service regions, or tribal areas	2006	Ohio's safety and risk assessments are included in the SACWIS-based Comprehensive Assessment and Planning Model-Interim Solution (CAPMIS) tool, which is now used in all OH counties
OK	State	Yes	No	N/A	N/A	One or more counties, service regions, or tribal areas	2008	No	N/A	OK uses the Assessment of Family Functioning (also designed to assess risk); developed with consultation from Lorrie Lutz/NRC for FCP/PP
OR	State	Yes	No	N/A	N/A	No	N/A	No	N/A	
PA	County	No	No	N/A	N/A	Statewide	2009	No	N/A	
PR	State	No	No	N/A	N/A	No	N/A	No	N/A	PR uses the Inventory for the Scrutiny of Multiple Problems
RI	State	No	No	N/A	N/A	No	N/A	No	N/A	
SC	State	Yes	No	N/A	N/A	No	N/A	No	N/A	SC plans to begin implementation of SofS by the end of 2011

** SDM Tools Key: 1 = Screen-In/Intake; 2 = Response Priority; 3 = Safety Assessment; 4 = Risk Assessment; 5 = Case Reassessment; 6 = Family Strengths & Needs Assessment; 7 = Substitute Care Providers.

Some states also use an SDM Reunification Assessment tool, not coded here.

Casey Family Programs National Survey of Safety and Risk Assessment Tools, 2011

State	Is CW System State- or County- Administered?	Does State Have Tribal CW Programs?	Are SDM Tools Used in the State?	Which SDM Tools Are Used? **	Year SDM First Used	Is the ACTION / NRCCPS Model Used in the State?	Year ACTION Model First Used	Is the Signs of Safety Approach Used in the State?	Year SofS First Used	Other Safety or Risk Assessments Used, Additional Comments:
SD	State	Yes	No	N/A	N/A	Statewide	2002	No	N/A	
TN	State	No	Statewide	1, 2, 3, 4, 5, 6	2004	No	N/A	No	N/A	TN also uses the Family Assessment and Support Tool (FAST)
TX	State	No	No	N/A	N/A	Statewide	2010	No	N/A	Texas developed its own Risk and Safety Assessment and has been using a version of that since the mid-90s.
UT	State	No	No	N/A	N/A	No	N/A	No	N/A	UT will use the SDM safety and risk assessment tools in its SACWIS system beginning in 2012. The tools will be modified to fit the state's Practice Model.
VT	State	No	Statewide	3, 4, 5	2004	No	N/A	Statewide	2009	
VA	County	No	Statewide	1, 2, 3, 4	1997	No	N/A	No	N/A	
WA	State	Yes	Statewide	4	2007	Statewide	2011	No	N/A	Washington uses a safety assessment that was developed in 2002 as part of a Risk Assessment package. The ACTION safety assessment will replace this in November of 2011.
WV	State	No	No	N/A	N/A	Statewide	2009	No	N/A	
WI	Combination	Yes	One or more counties, service regions, or tribal areas	4, 6	1991	Statewide	1990	No	N/A	
WY	State	Yes	No	N/A	N/A	Statewide	2011	One or more counties, service regions, or tribal areas	2010	WY uses assessment tools based on the SDM model.

** SDM Tools Key: 1 = Screen-In/Intake; 2 = Response Priority; 3 = Safety Assessment; 4 = Risk Assessment; 5 = Case Reassessment; 6 = Family Strengths & Needs Assessment; 7 = Substitute Care Providers. Some states also use an SDM Reunification Assessment tool, not coded here.

July 12, 2013

The National Council on Crime and Delinquency (NCCD) and its Children's Research Center (CRC) promote just and equitable social systems for individuals, families, and communities through research, public policy, and practice.

The Structured Decision Making® (SDM) model for child protection is designed to help workers gather and evaluate information about risk, safety, and family needs and strengths to make the best decisions for children and their families. When using the SDM® model to support decision making, all workers gather information on factors that have been demonstrated to consistently correlate with future abuse and neglect. Knowing the answers to those questions, in combination with sound clinical judgment, can help keep children safe.

An actuarial risk assessment is a core component of the SDM model. Actuarial risk assessments are used in many fields to estimate the likelihood of a particular event. In child protection, actuarial risk assessments estimate the likelihood of child abuse and neglect. These instruments are constructed by measuring the relationship between family characteristics that can be known within the first 30 days of a report, with outcomes over the next one to two years. When *reliable* (that is, consistent across different workers and families) and *valid* (can correctly distinguish between higher and lower risk families), actuarial risk assessments can help agencies discern higher-risk families so that they can target services to those families.

Actuarial risk assessments should be used in conjunction with professional judgment. A full child protection system requires a series of decisions, so a reliable and valid actuarial risk assessment is a piece of best practice, and there is more to best practice than a risk assessment alone.

When we work with a child welfare agency who wants to use the SDM model, or any part of it, we do not simply "install" it and move on. We collaborate for many months with the agency to put an SDM system into practice. Each system is developed locally, with input from workers in that jurisdiction. This is followed by training and coaching on how to use these assessments as part of the process of engaging with families.

While NCCD did determine to withdraw from participation in developing and implementing the overall practice in Florida, the Florida Department of Children and Families (DCF) has expressed interest in having permission to incorporate only the actuarial risk assessment into its transformation efforts. NCCD is currently in discussion with DCF to develop a certification process for use of a risk assessment instrument created by NCCD. As an initial step in supporting the integration of an unaltered valid and reliable instrument into Florida's child welfare system, we have agreed to review Florida DCF's policies and training curriculum related to the risk assessment at no cost.

The SDM model brings the best of research and evidence together with workers' skill and judgment. When research informs practice, families and communities can be assured that their children's safety and well-being are resting on a very solid foundation.



Fighting for Children's Rights

FCF Remarks to the Florida Senate Children, Families and Elder Affairs Committee November 5, 2013

1. **Increase Transparency: Require Real Time - Online Reporting of Child Abuse and Neglect Deaths and Near Fatalities and Public Reporting of Lawsuit Settlements.**
 - Child deaths and near fatalities should not be a secret - We shouldn't have to rely on local media reports as our source of information.
 - We have a system of community based care, yet the community cannot analyze the problem or help with solutions when the child's death / injuries are kept secret.
 - Florida has an excellent Child Death Review process¹ - but they report annually on deaths in the previous year - not as the incidents occur. (The most recent report issued in December 2012 reviews the 2011 deaths.)
 - **Arkansas provides a model for real-time reporting of all deaths and near fatalities on a website accessible by all - Florida should follow this example:**
<https://ardhs.sharepointsite.net/CFN/default.aspx>
 - **The resolution of lawsuits against community providers for death and serious injury should also be made available for public scrutiny.**
 - When private providers settle lawsuits concerning injuries or deaths to children in their care, as a condition of the settlement they require it be sealed so that it cannot be accessible to the public.
 - There cannot be community awareness or involvement when the facts of the death or serious injury are kept secret.
 - **CBCs and their subcontractors should report to DCF and the legislature on the resolution of these cases.**
2. **Restore / Improve Oversight and Accountability to both the Department and the Community Based Care Lead Agencies.**
 - a. The Legislature must ensure that DCF has adequate funds to fulfill its oversight responsibilities. DCF must restore/recreate a robust quality assurance/quality improvement process and employ enough contract management and district and central office staff to do the job.
 - In the past 5 years, DCF quality assurance staff has been reduced by 72%.² The Department's quality assurance/quality improvement process and contract oversight of the provision of child welfare services has been decimated.
 - When DCF saved money by cutting positions, it shifted a substantial portion of quality assurance responsibilities to the CBC Lead Agencies themselves. The results of these cutbacks are less than stellar:
 - The number of CPI cases subjected to quality assurance review was substantially cut back.

¹ Florida Statute 383.402

² DCF memo of July 29, 2013 reviewing changes in Quality Assurance from 2008-2013.

- Lead Agencies conduct their own quality assurance reviews.
- Lead Agencies are required to obtain an independent 3d party review, but few appear to have fulfilled the spirit of that requirement. Several CBCs contracted with each other to perform that review. (Our Kids/Children's Network of Southwest Florida; CBC of Central Florida/Community Partnership for Children; Family Support Services of N. Florida/Community Partnership for Children; Kids First Florida (Clay County)/Family Integrity Program (St. John's County).

b. The "Community Based Care" model necessarily requires there be community oversight of the Lead Agencies. The Legislature should commission an independent evaluation to determine if the statutory mechanisms put in place to promote community oversight of Community Based Care Lead Agencies are achieving that goal

- **Community Alliances:** The statute establishing Community Alliances (FS. 20.19(4)(a) requires that DCF establish a community alliance in each county to provide a focal point for community participation and governance of community-based services.
 - There is a wide divergence in the functionality of Community Alliances.
 - Each community should have an active and engaged Community Alliance. Each Community Alliance board should have specific training on what to look for and how to provide oversight of the service providers in their community who are receiving state funding.
- **CBC Lead Agency Boards:** Board members have a fiduciary duty to ensure that the organization that they govern is using their resources wisely and achieving the desired outcomes. In the case of Community Based Provider Boards of Directors, that duty should be heightened in the regard that they are responsible for the use of state dollars and more important, are responsible for the safety and well-being of the children in their care.
 - The CBC Lead Agency Boards should have adequate and appropriate training in order to be highly effective in their oversight of the activities of the lead agencies.
 - CBC Boards of Directors are often a list of the "who's who" in the community. They are good, caring people who are serving as volunteers on the boards of the private companies who are providing all of Florida's child welfare services.
 - Yet, many have no experience or knowledge of the child welfare system, and therefore do not know what to look for internally to see that the CBC is doing the best job.
 - The state should require annual mandatory training for CBC Lead Agency Boards.

3. **Promote Safe, Stable, Nurturing Relationships (SSNRs) to Break the Intergenerational Cycle of Abuse.**

- Many of the parents involved in child deaths were themselves victims of child maltreatment. Florida's 2011 Death report notes that 68% of child deaths involved parents with a prior DCF involvement as a child. That same report cites research that shows that 1/3 of the children who are maltreated will abuse or

neglect their own children.

<http://www.floridahealth.gov/alternatesites/flcadr/attach/2011CADRrpt.pdf>

- **The cycle can be broken.** The U.S. Centers for Disease Control has identified “Safe, Stable and Nurturing Relationships” as a key strategy to prevent child maltreatment.³

(a) DCF and the CBCs must work harder to provide children in out of home care with safe, stable and nurturing relationships.

- The current community based care system has not rectified the problems of children being moved from home to home, school to school, and being separated from siblings and other important relationships.
- The current community based care model has not stopped the trauma of the removal of the child and has not stopped group care for the older adolescents in care.
- Often we hear that a child needs to be placed in a group home because they cannot function within a family setting. However, that argument ignores the reality that in a few short years, that child may be creating a family and has no background or understanding of how a normal family is supposed to function, has not observed and learned good parenting skills or how to handle the difficulties that life has to offer within a family setting.
- **POSSIBLE SOLUTION: When siblings cannot be kept together require continued, quality visitation and communication. Also allow the child to maintain their relationships with other significant persons who were in their lives prior to their removal. Eliminate group care facilities. Eliminate unnecessary placement changes (e.g. removal from therapeutic foster home when doing well.)**

(b) The State Must Invest in Evidence Based Practices and Services for Parents.

- Most children who come to the attention of the Department can remain safely at home if we provide the right services at the right time to their families. If those services are not available, or if the state does not engage the families in the right services, children who are left at home will needlessly suffer and some will die. **CBCs must be appropriately engaged with families of those children and accountable for following through on needed services.**
- If the State is serious about protecting children from harm, it must invest in the programs that work: Evidence based parenting interventions; Healthy Start, Healthy Families, School Readiness (subsidized child care), Early Steps, APD services, and; along with the substance abuse, mental health and domestic violence services.

³ Examining the Role of Safe, Stable and Nurturing Relationships in the Intergenerational Continuity of Child Maltreatment. Journal of Adolescent Health 53 (2013) S1eS3, http://www.jahonline.org/webfiles/images/journals/jah/JAH9071_proof.pdf

THE FLORIDA SENATE
APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

11/5/13

Meeting Date

Topic Child Welfare Deaths

Bill Number _____
(if applicable)

Name Shelley Katz

Amendment Barcode _____
(if applicable)

Job Title Chief Operating Officer

Address 1485 S. Semoran Blvd.

Phone (321) 377-3000

Winter Park, FL 32792
Street City State Zip

E-mail Shelley.Katz@chsa.org

Speaking: For Against Information

Representing _____

Appearing at request of Chair: Yes No

Lobbyist registered with Legislature: Yes No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

This form is part of the public record for this meeting.

S-001 (10/20/11)



THE FLORIDA SENATE

Tallahassee, Florida 32399-1100

COMMITTEES:
Environmental Preservation and Conservation, *Chair*
Appropriations Subcommittee on Criminal and Civil Justice
Appropriations Subcommittee on General Government
Children, Families, and Elder Affairs
Criminal Justice
Gaming
Military Affairs, Space, and Domestic Security

SENATOR CHARLES S. DEAN, SR.
5th District

October 25, 2013

The Honorable Eleanor Sobel
410 Senate Office Building
404 South Monroe St.
Tallahassee, FL 32399-1100

RECEIVED

OCT 25 2013

Senate Committee
Children and Families

Dear Chairwoman Sobel,

The purpose of this letter is to seek your permission to be excused from the scheduled Children, Families, and Elder Affairs committee meeting scheduled for November 5, 2013 at 9:00 A.M. Due to unforeseen circumstances, I will not be able to attend.

Should you have any questions concerning this matter, please do not hesitate to contact me personally.

Sincerely,

Charles S. Dean
State Senator District 5

cc: Claude Hendon, Staff Director

REPLY TO:

- 405 Tompkins Street, Inverness, Florida 34450 (352) 860-5175
- 311 Senate Office Building, 404 South Monroe Street, Tallahassee, Florida 32399-1100 (850) 487-5005
- 315 SE 25th Avenue, Ocala, Florida 34471-2689 (352) 873-6513

Senate's Website: www.flsenate.gov

DON GAETZ
President of the Senate

GARRETT RICHTER
President Pro Tempore

CourtSmart Tag Report

Room: LL 37
Caption: Senate Children, Families, and Elder Affairs Committee

Case:

Type:
Judge:

Started: 11/5/2013 9:07:36 AM
Ends: 11/5/2013 12:00:08 PM **Length:** 02:52:33

9:07:38 AM Meeting called to order
9:07:50 AM Roll call
9:08:01 AM Quorum present
9:08:04 AM Senator Dean is excused from today's meeting
9:08:07 AM Chair Sobel's opening remarks
9:12:38 AM Tab 1 - Panel discussion on recent child abuse deaths
9:15:02 AM Esther Jacobo, Interim Secretary, Department of Children and Families
9:21:44 AM Chair Sobel's remarks and question
9:21:55 AM Interim Secretary Jacobo's response
9:22:28 AM Kurt Kelly, Chief Executive Officer, Florida Coalition for Children
9:27:18 AM Chair Sobel's question
9:27:28 AM Kurt Kelly's response
9:27:50 AM The Honorable Katherine Essrig, Circuit Judge, 13th Judicial Circuit, Dependency Court Improvement Panel
9:34:39 AM Barbara Wolf, M.D., Child Abuse Death Review Committee
9:39:13 AM Pam Graham, Associate Professor, Florida State University, School of Social Work
9:48:54 AM Chair Sobel's question and comments
9:49:15 AM Christina Spudeas, Executive Director, Florida's Children First
9:59:10 AM Chair Sobel's comment
9:59:18 AM Senator Braynon's question
9:59:54 AM Kurt Kelly's response
10:02:51 AM Kurt Kelly introduction of Shelley Katz, Chief Operating Officer, Children's Home Society
10:03:08 AM Chair Sobel's remarks
10:03:28 AM Senator Braynon's question
10:03:58 AM Shelley Katz's remarks
10:07:10 AM Chair Sobel's question
10:07:12 AM Shelley Katz's continued remarks
10:07:23 AM Senator Detert's remarks
10:10:16 AM Chair Sobel's remarks
10:10:24 AM Kurt Kelly's response
10:12:12 AM Senator Detert's question
10:12:17 AM Kurt Kelly's response
10:15:44 AM Chair Sobel's comments
10:15:47 AM Senator Detert's remarks and question
10:16:41 AM Interim Secretary Jacobo's response
10:18:02 AM Senator Detert's comment and question
10:18:10 AM Interim Secretary Jacobo's response
10:22:43 AM Senator Detert's comment and question
10:23:05 AM Interim Secretary Jacobo's response
10:24:13 AM Chair Sobel's comment
10:24:16 AM Senator Thompson's question
10:27:14 AM Chair Sobel's comment
10:27:26 AM Kurt Kelly's response
10:30:07 AM Chair Sobel's comment
10:30:50 AM Senator Thompson's follow up question
10:31:20 AM Interim Secretary Jacobo's response
10:33:23 AM Senator Clemens' questions
10:33:44 AM Christina Spudeas' response
10:37:36 AM Senator Detert's comments
10:37:52 AM Chair Sobel's remarks
10:38:08 AM Senator Clemens' remarks
10:38:20 AM Pam Graham's response

10:41:40 AM Dr. Wolf's remarks
10:42:21 AM Senator Hays' question
10:43:00 AM Dr. Wolf's response
10:43:48 AM Senator Hays' remarks
10:43:59 AM Chair Sobel's remarks
10:44:18 AM Dr. Wolf's response
10:44:27 AM Chair Sobel's question
10:44:33 AM Interim Secretary Jacobo's response
10:45:48 AM Senator Hays' remarks
10:46:32 AM Interim Secretary Jacobo's response
10:47:22 AM Senator Hays' remarks
10:48:11 AM Dr. Wolf's comments
10:50:05 AM Chair Sobel's remarks
10:50:10 AM Dr. Wolf's response
10:50:12 AM Chair Sobel's remarks
10:50:20 AM Dr. Wolf's response
10:50:32 AM Chair Sobel's remarks
10:50:52 AM Dr. Wolf's response
10:51:02 AM Chair Sobel's remarks
10:51:08 AM Judge Essrig's response
10:52:59 AM Senator Clemens' question
10:53:18 AM Interim Secretary Jacobo's response
10:53:34 AM Senator Clemens' follow-up question
10:53:40 AM Interim Secretary Jacobo's response
10:53:49 AM Senator Clemens' comments
10:54:15 AM Interim Secretary Jacobo's response
10:55:50 AM Senator Clemens' follow-up question
10:56:15 AM Interim Secretary Jacobo's response
10:57:44 AM Senator Clemens' question
10:58:11 AM Senator Altman's remarks
11:00:03 AM Chair Sobel's remarks
11:00:12 AM Dr. Wolf's response
11:01:19 AM Senator Altman's follow-up question
11:01:37 AM Senator Grimsley's questions
11:03:53 AM Interim Secretary Jacobo's response
11:09:40 AM Christina Spudeas' comments
11:12:06 AM Judge Essrig's comments
11:20:30 AM Chair Sobel's comments
11:20:36 AM Senator Hays' remarks and question
11:21:51 AM Chair Sobel's comments
11:21:59 AM Senator Hays' remarks
11:22:09 AM Interim Secretary Jacobo's response
11:25:16 AM Chair Sobel's question
11:25:27 AM Interim Secretary Jacobo's response
11:25:33 AM Chair Sobel's question
11:26:05 AM Chair Sobel's comments
11:26:10 AM Interim Secretary Jacobo's response
11:26:19 AM Chair Sobel's remarks
11:26:25 AM Interim Secretary Jacobo's response
11:27:03 AM Chair Sobel's question
11:27:15 AM Interim Secretary Jacobo's response
11:28:10 AM Chair Sobel's comments
11:28:43 AM Senator Altman's remarks
11:29:23 AM Chair Sobel's remarks
11:29:27 AM Senator Altman's continued remarks
11:30:05 AM Senator Clemens' comments and question
11:30:47 AM Interim Secretary Jacobo's response
11:31:08 AM Senator Detert's remarks
11:31:23 AM Chair Sobel's remarks
11:34:30 AM Senator Detert's remarks
11:34:45 AM Chair Sobel's comments
11:35:00 AM Kurt Kelly's response

11:36:58 AM Chair Sobel's remarks
11:37:07 AM Kurt Kelly's response
11:38:22 AM Chair Sobel's question and remarks
11:38:58 AM Senator Altman's remarks
11:39:41 AM Kurt Kelly's response
11:42:12 AM Judge Essrig's remarks
11:43:21 AM Dr. Wolf's remarks
11:44:55 AM Pam Graham's remarks
11:52:46 AM Chair Sobel's question
11:52:57 AM Pam Graham's response
11:54:59 AM Christina Spudeas' remarks
11:58:38 AM Chair Sobel's closing remarks
11:59:57 AM Meeting adjourned