State of Florida
Department of Children and Families

Charlie Crist
Governor

Robert A. Butterworth
Secretary

DATE: May 14, 2007

TO: District Administrators and Sheriff's Offices

FROM: George Sheldon, Assistant Secretary for Operations
David Fairbanks, Acting Assistant Secretary for Programs

THROUGH: Patricia Badland, Director of Office of Family Safety

SUBJECT: Protective Investigations – Child Death Protocol

Purpose: Chapters 65C-29 and 65C-30 of the Florida Administrative Code set forth requirements for the special handling of child deaths which occur during the course of an active child protective investigation. Specific procedures are required in the assignment of a death maltreatment code and the closure of these types of reports. The purpose of this memorandum is to reinforce consistent, statewide practice in this area.

Action Required: This document should be disseminated to all child protective investigators, child protective investigator supervisors, and those in management or specialist positions responsible for reviewing child deaths. Any need for clarification or questions on policy should be directed to John Harper, Child Protective Investigations, at (850) 922-3862 (sc 292-3862), email: john_harper@dcf.state.fl.us.

Addition of Death Maltreatment Code to CSA: Child protective investigators are not to add a death maltreatment code to an open CSA at any time. Florida Administrative Code 65C-29.002(7)(f)1 requires child protection staff to call the Florida Abuse Hotline immediately upon the suspicion that a child victim may have died from abuse or neglect at any point in time during an open investigation. Depending upon the specific circumstances (i.e., CSA is over 30 days old, the death is not related to the originally listed maltreatments, etc.) Hotline staff will either add the appropriate death maltreatment code of 99 A/N to the existing report or generate a new report containing the code. This practice is required because the Abuse Hotline has an automated notification process in place for alerting local death review coordinators and district management when these types of reports occur.

Death Due to Abuse or Neglect – Appropriate Findings: All reports involving verified child deaths due to abuse or neglect are reviewed by the statewide Child Abuse Death Review Team. The most frequently identified issue the team brings to the attention of the Family Safety Program Office is the disconnect between a verified finding of "Death Due to

Abuse or Neglect" (99A/N) and the corresponding maltreatment type that best describes the cause of death. For instance, for a child drowning death resultant of lack of supervision investigators will verify 99N (Death Due to Neglect) but will have a finding of 'Some Indication' on the Inadequate Supervision (50N) maltreatment which directly led to the drowning death. Similarly, when an unattended infant dies in a house fire investigators will occasionally verify the Inadequate Supervision (50N) maltreatment but not the actual child death (99N) maltreatment itself. More emphasis needs to be placed on reviewing findings for accuracy and completeness prior to closure so there is consistency between the allegation finding(s) attributable to the child's death and the resultant verification of the 99 Death Code.

Date of Death: For deaths under review in 2006, eighteen (18) of the victims did not have a date of death for the child listed on the HomeSafenet 'Person Detail' screen – Birth and Death' field. Frequently, the child's date of death coincides with the 'Incident Date' recorded for the maltreatment in the CSA. However, this is not always the case and in many instances the child's death occurs after the abuse or neglect event. Additionally, child deaths can be reported several years after the fact or investigations can carry over from one reporting year to the next. Documenting the precise date of death ensures the accurate recording of child death data and enables the department to reconcile death statistics more completely with the Department of Health. Effective immediately, the date of every child death should be entered in the HomeSafenet 'Person Detail' screen prior to closure of the CSA.

Review and Closure of Child Death Reports: In an effort to improve statewide performance in this area, it is imperative that Florida Administrative Code 65C-30.020(5)(f) be followed which requires that child death reports not be closed until the death has been reviewed by the local death review coordinator and the coordinator has advised the supervisor that the death report has been approved for closure. Careful adherence to this practice should identify both coding and consistency of findings errors prior to closure, and ensure that the child's date of death is accurately recorded. Contact information for Death Review Coordinators, including counties served, is included under separate attachment.