

# **FLORIDA CHILD ABUSE DEATH REVIEW PROGRAM**



**Guidelines for the State and Local Teams**

**September 2000**

**The Florida Department of Health provides oversight and assistance to the State and Local Child Abuse Death Review Teams.**

**These guidelines were developed by the Protocol and Guidelines Committee of the State Child Abuse Death Review Committee with assistance from the Department of Health support staff.**

**Special appreciation to the Michigan, Georgia and Arizona Child Fatality Review Programs for sharing their review protocols and data forms, all of which were reviewed and relevant information adapted for the State of Florida.**

**Revisions to this guide will be distributed to state and all local teams when changes in legislation require changes in the guide.**

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## TABLE OF CONTENTS

INTRODUCTION.....	1
<b>CHAPTER 1 PURPOSE OF CHILD ABUSE DEATH REVIEW TEAMS</b>	
1.1 Program Background and Description.....	2
1.2 Mission Statement .....	2
1.3 Operating Principle .....	2
1.4 Goal.....	2
1.5 Objectives.....	2
1.6 Achieving Objectives .....	2
1.7 How to Use This Guide .....	4
<b>CHAPTER 2 STATE REVIEW TEAM MEMBERSHIP AND DUTIES</b>	
2.1 Introduction .....	5
2.2 Statutory Membership .....	5
2.3 Term of Membership .....	5
2.4 Non-Statutory Consultants .....	6
2.5 Election of State Chairperson and Vice Chairperson.....	6
2.6 Removal/Resignation of the State Chairperson.....	6
2.7 Reimbursement .....	6
2.8 Terminating State Team Membership .....	6
2.9 State Review Team Duties .....	7
2.10 State Child Abuse Death Review Subcommittees.....	8
<b>CHAPTER 3 LOCAL REVIEW TEAM MEMBERSHIP AND DUTIES</b>	
3.1 Team Membership .....	9
3.2 Ad Hoc Members .....	9
3.3 Regional Review Teams .....	10
3.4 Local Review Team Duties.....	10
3.5 The Role of Team Members.....	11
3.6 Team Members .....	11
<b>CHAPTER 4 TYPES OF REVIEWS AND REVIEWABLE DEATHS</b>	
4.1 Introduction .....	15
4.2 Immediate Response Review .....	15
4.3 Periodic Reviews .....	15
4.4 Reviewable Deaths .....	15
4.5 Residence .....	15
<b>CHAPTER 5 ESTABLISHING A CHILD ABUSE DEATH REVIEW TEAM</b>	
5.1 Designate a Team Organizer.....	16
5.2 Contact State Child Abuse Death Review Coordinator .....	16
5.3 Study Team Materials .....	16
5.4 Contact an Existing Review Team .....	16
5.5 Contact the Local Core Member Agencies.....	16
5.6 Schedule an Organizational Meeting .....	17
5.7 Conduct an Organizational Meeting.....	17
5.8 Authorization of Local Child Abuse Death Review Teams.....	18
<b>CHAPTER 6 REVIEW TEAM TRAINING</b>	
6.1 Introduction .....	19
6.2 Orientation.....	19
6.3 Training and Technical Assistance for Local Teams.....	19
6.4 Program Promotion Activities.....	20

## TABLE OF CONTENTS (continued)

<b>CHAPTER 7 CONDUCTING AN EFFECTIVE REVIEW MEETING</b>	
7.1 Beginning the Meeting .....	21
7.2 Sharing Information .....	21
7.3 Clarification .....	22
7.4 Holdover Reviews .....	23
7.5 Agency Conflict Resolution.....	23
7.6 Media Relations .....	23
<b>CHAPTER 8 MAINTAINING AN EFFECTIVE REVIEW TEAM</b>	
8.1 Introduction .....	24
8.2 Respect Team Agreements.....	24
8.3 Participate and be Prepared for Meetings .....	24
8.4 Keep Regular Meeting Schedules.....	24
8.5 Provide an Educational Element at Team Meetings .....	24
8.6 Use Existing Teams .....	24
8.7 Publish a Local Child Abuse Death Review Report .....	25
8.8 Provide Other Members with Support.....	25
8.9 Do Not Lose Sight of the Team’s Purpose and Objectives .....	25
8.10 Team Membership Is a Long Term Commitment .....	25
8.11 Community Education and Prevention.....	25
8.12 Focus on Prevention.....	26
<b>CHAPTER 9 TEAM OPERATING PROCEDURES</b>	
9.1 Information Sharing .....	27
9.2 Team Coordinator .....	27
9.3 Member Designees and Meeting Attendance .....	27
9.4 Obtaining Names for Team Reviews .....	28
9.5 Child Abuse Death Information Distribution.....	28
9.6 Record Keeping.....	28
9.7 Child Abuse Death Review Information Sheet.....	28
9.8 Child Abuse Death Review Data Form .....	29
<b>CHAPTER 10 CONFIDENTIALITY AND ACCESS TO INFORMATION</b>	
10.1 Introduction .....	30
10.2 Access to Information.....	30
10.3 Confidentiality of Records and Informtion .....	31
10.4 Confidentiality Statements .....	31
10.5 Protecting Family Privacy.....	32
10.6 Document Storage and Security.....	32

## ATTACHMENTS

ATTACHMENT I	Section 383.402, F.S.
ATTACHMENT II	Local Child Abuse Death Review Team Membership
ATTACHMENT III	Child Abuse Death Review Signature Sheet
ATTACHMENT IV	Agency/Department Services Provided Information Sheet
ATTACHMENT V	Child Abuse Death Review Checklist
ATTACHMENT VI	Florida Child Abuse Death Review Information Sheet
ATTACHMENT VII	Florida Child Abuse Death Review Data Form
ATTACHMENT VIII	Child Abuse Death Review Data Information Guide
ATTACHMENT IX	Statement of Confidentiality - sample document

## INTRODUCTION

The death of a child is always difficult to accept. When a child dies from abuse or neglect it is especially tragic. Every child should not only have the right to grow up in a safe environment, but also have the expectation that they will thrive and flourish within that environment.

Over the past 15 years, there have been several highly publicized child deaths from abuse or neglect involving children who had previously received child protection services from the Department of Children and Families (formerly known as the Department of Health and Rehabilitative Services or HRS). These deaths prompted professionals and other individuals interested in the protection of children to carefully review the specific circumstances surrounding each death and to evaluate management and systemic issues within the Department of Children and Families. Some of these death studies and initiatives included:

- 1985 HRS Task Force Subsequent to the death of Corey Greer
- 1987 Protecting Florida's Children Task Force: A Blueprint for the Next Decade
- 1990 Child Welfare League of America Salary Study subsequent to the death of Bradley McGee
- 1991 Study Commission on Child Welfare (Barkett Commission)
- 1995 Governor's Panel on Child Protection Issues: A Review of the Lucas Ciambrone Case
- 1996 Task Force on Family Safety
- 1997 Governor's Child Abuse Task Force
- 1998 DCF Quality Assurance Review subsequent to the death of Kayla McKean
- 1999 District 7 Child Safety Strike Force

Over the years, the Florida Legislature and the Department of Children and Families have developed a number of initiatives and programs in an effort to address these issues. However, after the tragic death of a six-year-old child who was brutally murdered by her father in 1998, who had been the subject of three prior reports to the Abuse Hotline and who was receiving child protection services from a contracted agency at the time of her death – it became clear that these efforts fell short of their intended goal, which was to reduce child abuse and neglect deaths.

Consequently, as a result of this death, and the deaths of other children due to abuse and neglect, the Florida Legislature, inspired by several prominent legislators and an outraged community, enacted legislation in 1999 establishing a statewide child abuse death review team and encouraging the development of local multidisciplinary committees to conduct detailed review of the facts and circumstances surrounding child abuse and neglect deaths in which at least one prior report of abuse or neglect was accepted by the Florida Abuse Hotline. The intent of the legislature was to facilitate a better understanding of these deaths and to develop enhanced strategies for preventing future deaths by developing a panel of individuals at the state and local level who had expertise in the fields directly impacting the health and welfare of children and families.

## CHAPTER I

### PURPOSE OF CHILD ABUSE DEATH REVIEW TEAMS

#### 1.1 Program Background and Description

The Florida Child Abuse Death Review Program was established by statute in s. 383.402, F.S., (Attachment I) in 1999. The program is administered by the Florida Department of Health, and utilizes state and locally developed multi-disciplinary teams to conduct detailed reviews of the facts and circumstances surrounding child abuse and neglect deaths in which at least one report of abuse or neglect was accepted by the Florida Abuse Hotline Information System within the Department of Children and Families (DCF). The major purpose of the program is to develop and implement data-driven recommendations for reducing child abuse and neglect deaths.

#### 1.2 Mission Statement

The mission statement of the Child Abuse and Neglect Death Review Program is: To reduce preventable child abuse and neglect deaths.

#### 1.3 Operating Principle

The death of a child is a community problem. The circumstances involved in most child abuse and neglect deaths are too multidimensional for responsibility to rest in any one place.

#### 1.4 Goal

The goal of child abuse death review teams is to improve our understanding of how and why children die, to demonstrate the need for and to influence policies and programs to improve child health, safety and protection and to prevent other child deaths.

#### 1.5 Objectives

- Accurate identification and uniform reporting of the cause and manner of child abuse and neglect deaths.
- Improved communication and linkages among agencies and enhanced coordination of efforts.
- Improved agency responses in the investigation of child abuse and neglect deaths and the delivery of services.
- Design and implementation of cooperative, standardized protocols for the investigation of child abuse deaths.
- Identification of needed changes in legislation, policy and practices, and expanded efforts in child health and safety to prevent child abuse and neglect deaths.

#### 1.6 Achieving Objectives

- **Accurate identification and uniform reporting of the cause and manner of child abuse and neglect deaths.**

Child abuse death review teams provide a forum to ensure that relevant information is shared and available to determine why a child has died and to better understand all the contributing factors leading to a death. A team's multidisciplinary membership enables all team members to better understand how and why a child has died and facilitates more

accurate reporting. When child abuse death review teams identify a lack of sufficient information to accurately determine how a child has died, the systematic collection of more information is agreed upon. Reviews also ensure that team members are informed of all child abuse deaths or learn about deaths sooner than usual and are thus able to take action in a more timely manner.

- **Improved communication and linkages among agencies and enhanced coordination of efforts.**

Meeting regularly to talk about child abuse and neglect deaths can significantly improve interagency cooperation and coordination. The benefits of sharing information and clearly understanding agency responsibilities can make the process worthwhile even if new information does not surface at a review.

- **Improved agency responses in the investigation of child abuse and neglect deaths and the delivery of services.**

Local child abuse death reviews can help identify problems regarding the coordination of investigations or the investigative responsibilities of different agencies. Reviews can identify ways a community can better conduct and coordinate investigations and can help improve investigative resources.

Local review teams may decide to conduct their reviews within a short period of time after the death, so that the review becomes a part of the investigative process. Other teams may choose to conduct more retrospective reviews, and use the review not as an investigative tool for a specific death, but as a way to improve future investigations.

Child abuse death reviews can enhance criminal investigations and improve the response of the criminal justice system to child homicides. Local reviews can improve the delivery of services to families and others in a community following a child death by identifying barriers to services available in a community or a lack of specific needed services. Additionally, the identification of common risk factors present in child abuse and neglect deaths will help those involved in the investigation of serious child abuse and neglect cases to better determine the potential for fatal harm to a child and/or siblings.

- **Design and implementation of cooperative, standardized protocols for the investigation of child abuse and neglect deaths.**

Child abuse death investigations vary greatly across the state, depending on the resources available to counties and levels of coordination among agencies. Reviews can assist agencies in developing statewide-standardized guidelines for the investigation of child abuse deaths. Standardized guidelines within and among counties can clearly define roles and standardized procedures, resulting in more accurate reporting of child abuse deaths statewide.

- **Identification of needed changes in legislation, policy and practices, and expanded efforts in child health and safety to prevent child abuse and neglect deaths.**

The Child Abuse Death Review Program's ultimate purpose is to prevent additional child abuse deaths. Every review of every child abuse death concludes with a discussion of what, if any, systemic issues were identified as a result of the review and what prevention activities are recommended to work towards resolution of the issues. Teams can focus their discussion on short and long-term interventions relating to statute, policy, programs

and practice. Teams should identify the best way to translate prevention recommendations into action. Individual agencies or team members can assume responsibility and work with existing prevention coalitions or establish new ones.

## **1.7 How to Use This Guide**

This guide provides guidelines for the development, implementation, and management of the Child Abuse Death Review Program. The guide is a reference and information resource for the state and local child abuse and neglect death review teams.

Revisions to this guide will be distributed to all local team members and other agencies and individuals that are on the Florida Child Abuse Death Review Program distribution list. Revisions will be released at least thirty days prior to the effective date of any change.

Questions or concerns should be directed to the DOH State Child Abuse Death Review Coordinator at (850) 245-4200.

## CHAPTER 2

### STATE REVIEW TEAM MEMBERSHIP AND DUTIES

#### 2.1 Introduction

This chapter describes the general standards for the State Child Abuse Death Review Team membership, and outlines general duties and responsibilities of team members.

#### 2.2 Statutory Membership

The State Child Abuse Death Review Team is composed of representatives of the following departments, agencies or organizations:

- Department of Legal Affairs
- Department of Children and Families
- Department of Law Enforcement
- Department of Education
- Florida Prosecuting Attorneys Association
- Florida Medical Examiners Commission, whose representative must be a Forensic Pathologist

In addition, the Secretary of the Department of Health is responsible for appointing the following members based on recommendations from the Department of Health and affiliated agencies, and ensuring that the team represents to the greatest possible extent, the regional, gender, and ethnic diversity of the state:

- A board certified pediatrician
- A public health nurse
- A mental health professional who treats children or adolescents
- An employee of the Department of Children and Families who supervises family services counselors and who has at least five years of experience in child protective investigations
- A medical director of a child protection team
- A member of a child advocacy organization
- A social worker who has experience in working with victims and perpetrators of child abuse
- A person trained as a paraprofessional in patient resources who is employed in a child abuse prevention program
- A law enforcement officer who has at least five years of experience in children's issues
- A representative of the Florida Coalition Against Domestic Violence
- A representative from a private provider of programs on preventing child abuse and neglect

#### 2.3 Term of Membership and Attendance

The Secretary of Health appoints the members of the State Child Abuse Death Review Team for staggered two (2) year terms. Members are eligible for reappointment. Members must attend meetings in person and not by proxy.

Agency representatives who leave their agency during their term must notify the agency head and the CADR team chairperson immediately. The members standing on the state team expires upon the effective date of their departure from the agency and the chair of the state team will request that the agency appoint a new member.

Secretary of Health appointees who resign from their current position must notify the Secretary immediately. At the discretion of the Secretary, they may remain on the state team provided they are still active in their appointed discipline and continue to be employed in the specific job category where indicated. All appointees who leave their employment and otherwise cease to be active in their designated discipline must notify the DOH Secretary, DOH Death Review Coordinator and the chair of the state team. The members standing on the state team expires upon the effective date of their departure and the Secretary of Health will appoint a replacement as soon as possible.

All replacements to the state team will serve the remainder of the appointment they replace.

## **2.4 Non-Statutory Consultants**

The State Child Abuse Death Review Team may use consultants with special expertise, experience or involvement with concerned agencies/organizations within the community. Consultants must be able to provide important information, experience, and expertise to the team. They may not use their participation on the team to discover, identify, acquire or use information for any purpose other than the stated purpose of conducting approved child abuse death review activities.

## **2.5 Election of State Chairperson and Chair Elect**

The chairperson of the State Child Abuse Death Review Team is elected for a two (2) year term in June or the first meeting thereafter, by a majority vote of the members of the State Child Abuse Death Review Team. The chair elect is elected for a two year term staggered with the term of the chairperson. The Department of Health Child Abuse Death Review Coordinator serves as the co-chair and is appointed by the Secretary of the Department of Health.

## **2.6 Removal/Resignation of the State Chairperson**

The State Child Abuse Death Review Team may remove the state chairperson for good cause by a two thirds (2/3) majority vote of the members of the State Child Abuse Death Review Team. Examples of good cause removal include, but are not limited to, violation of confidentiality, non-attendance at three consecutive meetings without notice or good reason, or inability to participate or fulfill duties as the state chairperson.

The state chairperson shall resign if unable or unwilling to fulfill the duties of the position. The co-chairperson shall act as interim chairperson when the state chairperson has resigned or been removed until a new state chairperson is elected. Election of a new state chairperson must occur within ninety days (90) of the removal or resignation of the state chairperson.

## **2.7 Reimbursement**

Members of the state team serve without compensation but are entitled to reimbursement for per diem and travel expenses incurred in the performance of their duties as provided in s. 112.061, F.S., and to the extent that funds are available. Consultants can be hired and reimbursed reasonable expenses to extent that funds are available. Requests for funding must be reviewed and approved by the State Child Abuse Death Review chair and co-chair.

## **2.8 Terminating State Team Membership**

A member or a consultant of the State Child Abuse Death Review Team may resign at any time. A written resignation shall be submitted to the State Child Abuse Death Review Team chairperson.

In cases where members resign from the State Child Abuse Death Review Team, the state team shall meet within 90 days of the resignation to recommend a designee to replace the resigning member. The recommendation must be forwarded to the Office of the Secretary of Health for approval.

A team member or consultant may be removed for good cause by a majority vote of the entire membership of the team. Examples of good cause removal include, but are not limited to, violation of confidentiality, non-attendance at three consecutive meetings without notice or good reason, or inability to participate or fulfill duties as a team member.

Members not appointed by the Secretary of Health cannot be removed by a vote of the state team. Should action be required, a letter shall be addressed to the respective agency or organization head requesting the designation of a new representative. The letter must outline the reasons for the state team's request.

If the member in non-attendance at three consecutive meetings is a designee for the statutory member, the state team shall request that another designee be appointed.

## **2.9 State Review Team Duties**

The duties of the state team are to:

- Develop a standard protocol for the uniform collection of data that uses existing and tested data collection systems to the greatest extent possible.
- Provide training to cooperating agencies, individuals and local child abuse death review teams on the use of the child abuse death data protocol.
- Prepare an annual statistical report on the incidence and causes of deaths resulting from child abuse and neglect in the state during the prior calendar year. This report shall be submitted to the Governor, the President of the Senate, and the Speaker of the House of Representatives by December 31 of each year. The report must include recommendations for state and local action, including specific policy, procedural, regulatory, or statutory changes, and any other recommended preventative action.
- Encourage and assist in developing local child abuse death review teams and provide consultation on individual cases to local teams upon request.
- Develop guidelines, standards and protocols, including a protocol for data collection for local child abuse death review teams, and provide training and technical assistance to local teams.
- Develop guidelines for reviewing child abuse deaths, including guidelines to be used by law enforcement agencies, prosecutors, medical examiners, health care practitioners, health care facilities and social service agencies.
- Study the adequacy of laws, rules, training and services to determine what changes are needed to decrease the incidence of child abuse deaths and develop strategies and recruit partners to implement these changes.

- Educate the public regarding the incidence and causes of child abuse death, and the ways to prevent such deaths.
- Provide continuing education for professionals who investigate, treat and prevent child abuse or neglect.
- Recommend, when appropriate, the review of the death certificate of a child who is suspected to have died of abuse or neglect.

## **2.10 State Child Abuse Death Review Subcommittees**

The State Child Abuse Death Review Team includes the following subcommittees:

### **Data Procurement and Analysis Subcommittee**

This committee reviews and analyzes data obtained from child abuse death reviews, assists in preparation of annual report and reviews and updates standardized data forms.

### **Education and Training Subcommittee**

The Education and Training Subcommittee provides technical assistance to local teams, and develops plans for community-based education regarding the incidence and causes of child abuse death and the ways by which such deaths may be prevented [s. 383.402 (3)(l)].

### **Policy and Protocol Subcommittee**

This committee reviews state and local Child Abuse Child Abuse Death Review Team protocols and policies to determine the need for clarification or changes and monitors the protocol procedures, and policies used to conduct statewide child abuse death review activities.

### **Case Review Subcommittee**

This committee reviews all abuse deaths meeting criteria that have occurred in areas without existing local or regional review teams. The committee consists of representatives required for local teams, follows the guidelines of a local team and presents its findings to the state team for review.

The DOH State Child Abuse Death Review Team Coordinator may appoint ad hoc teams as necessary to carry out the duties of the team.

## CHAPTER 3

### LOCAL REVIEW TEAM MEMBERSHIP AND DUTIES

#### 3.1 Team Membership

A child abuse death review team is not a new official organization. The authority and responsibility of participating agencies do not change. Rather, teams enable various disciplines to come to the same table on a regular basis and pool their expertise to better understand and take action on child abuse deaths in their jurisdictions.

Local review teams should, at a minimum include representatives from the:

- District medical examiner's office
- Child Protection Team
- County health department
- Department of Children and Families
- State Attorney's office
- Local law enforcement
- School district representative

Other team members may include representatives of specific agencies from the community that provide services, other than mentioned above, to children and families. Local child abuse death review core members may identify appropriate representatives from these agencies to participate on the team. Suggested members include:

- The DCF district child death review coordinator
- A board-certified pediatrician or family practice physician
- A public health nurse
- A mental health professional who treats children or adolescents
- A member of a child advocacy organization
- A social worker who has experience in working with victims and perpetrators of child abuse
- A person trained as a paraprofessional in patient resources who is employed in a child abuse prevention program
- A representative from a domestic violence organization
- A representative from a private provider of programs on preventing child abuse and neglect.

The members of a local team shall be appointed to two year terms and may be reappointed.

#### 3.2 Ad Hoc Members

Teams may designate ad hoc members. Because ad hoc members are not permanent, they do not regularly receive team notices. They attend meetings only when they have been directly involved in a case scheduled for review or to provide information on team related activities. Ad hoc members provide valuable information without increasing the number of permanent team members. They may be DCF child protective investigators or family services counselors involved in a specific case, law enforcement officers from a police agency that handled a case, or a child advocate who worked with a family.

### 3.3 Regional Review Teams

While counties with large populations may have their own review teams, regional review teams may consist of representatives from more than one county. Such teams are recommended among counties with populations of 55,000 or less.

When building regional teams, organizers should consider inter-county collaborative agencies that cross county jurisdictions, for example DCF districts.

Every county covered by a review team should be represented on the team. An agency regional director or other professional whose jurisdiction or responsibilities include all of the counties can fulfill this requirement.

To ensure that the concept of community involvement is met, reviews should be attended by at least one representative from a core member agency in the county where the injury that caused the child abuse death occurred. This allows regional teams to receive information from professionals directly involved with a death while strengthening team relationships with various local agencies. Establishing and maintaining such relationships is critical if team prevention, training and education objectives are to be achieved.

### 3.4 Local Review Team Duties

The duties of the local child abuse death review team are to:

- Review all deaths resulting from child abuse and neglect with at least one report of abuse or neglect accepted by the central abuse hotline within the Department of Children and Families.
- Collect data on applicable child abuse deaths for the State Child Abuse Death Review Team.
- Submit written reports to the state team as directed. The reports are to include steps taken by the local team to implement necessary changes and improve the coordination of services and investigations.
- Submit all records requested by the State Child Abuse Death Review Team at the conclusion of the review of a death resulting from child abuse or neglect.
- Abide by standards and protocols established by the State Child Abuse Death Review Team in the conduct of child abuse death reviews.
- On a case-by-case basis, request that the State Child Abuse Death Review Team review the data of a particular case.
- Designate a team chairperson who oversees the activities of the local team and calls meetings of the team when necessary.
- Designate a member of the local team, if there is not a state team member also on the local team, to be the liaison to the state team for the purpose of child abuse death case presentations to the state team.

### 3.5 The Role of Team Members

The role of team members can be flexible to meet the needs of particular communities. The individual abilities of members should be tapped to enhance team effectiveness. Each member should:

- Contribute information from his or her records
- Serve as a liaison to respective professional counterparts
- Provide definitions or professional terminology
- Interpret agency procedures and policies
- Explain the legal responsibilities or limitations of his or her profession

All team members must have a clear understanding of their own and other professional and agency roles and responsibilities in their community's response to child abuse and neglect fatalities. In addition, team members need to be aware of and respect the expertise and resources offered by each profession and agency. The integration of these roles is key to well coordinated community child abuse death response systems.

### 3.6 Team Members

#### The Medical Examiner

Medical examiners are central to the functions of both child abuse death review teams and child death investigations. Medical examiners have the responsibility and the right to determine cause and manner of death. Medical examiners lay the groundwork for discussion by presenting basic information about cause and manner of death, including findings from the scene investigation, autopsy and medical history. Medical examiners can legally obtain records from other investigating agencies. Medical examiners have the right to access information from police, paramedics, hospitals, DCF and others to determine cause of death. Usually, no other agency has such wide latitude. The state attorney's office can obtain these records, but only for deaths the office is pursuing for criminal prosecution. The medical examiner's office can obtain such records for any death that falls under the medical examiner's jurisdiction, whether due to homicide, accident, suicide, or natural causes. Medical examiners can also interpret clinical findings and provide additional details that help teams better understand a cause of death ruling.

#### Law Enforcement

Law enforcement team members provide information on criminal investigations of child abuse deaths under team review. They also check criminal histories of child and/or family members and of suspects in child abuse or neglect death cases. To ensure sufficient representation, both the sheriff's department and the police department with the largest jurisdictions should have members on the team. Law enforcement team members serve as liaisons between the team and other local law enforcement departments. They assist in persuading officers from other agencies to participate in reviews of deaths in their jurisdictions. Law enforcement professionals are usually the team members best trained in scene investigation and interrogation, essential skills for determining how a child died. Such expertise provides useful information and training to other members.

## Department of Children and Families

DCF has the legal authority and responsibility to investigate child deaths alleged to have occurred as a result of abuse and neglect and to provide protection to siblings who might be at risk. As team members, DCF representatives can provide detailed information on families and on their investigations into child abuse deaths. DCF may have prior agency contact information including reports of neglect or abuse on a child or siblings and of services previously or currently provided to a family. They may be able to provide information on a family's history and sociological factors that influence family dynamics, such as unemployment, divorce, previous deaths, history of domestic violence or drug abuse, and previous child abuse. When reviews indicate a need, DCF representatives can provide services to surviving family members. Their knowledge on issues related to child abuse and neglect cases is essential to team effectiveness.

## State Attorney

Prosecutors educate child abuse death review teams on criminal law and provide information about criminal and civil actions taken against those involved in the child abuse deaths reviewed. They can also explain when a case can or can not be pursued and provide information about previous contact or criminal prosecutions of family members or suspects in child abuse deaths.

## Public Health

County health departments facilitate and coordinate prevention health services and community health education programs. Public health child abuse death review team members can provide vital records and epidemiological risk profiles of families for early detection and prevention of child abuse deaths, as well as information on county public health services. Public health doctors or nurses help identify public health issues that arise in child abuse and neglect deaths. If a child was treated in a local public health facility or received home visits, they can provide medical history and explain previous treatments, especially helpful in the review of infant deaths. Health department staff can provide information on risk factors and services available to high-risk pregnant women and their families.

## Pediatrician

Pediatricians provide child abuse death review teams with medical explanations and the benefit of their perspective, gained by having examined thousands of living children. They can access medical records from hospitals and from other doctors. If a pediatrician testifies regularly in child abuse trials, his or her expert opinion regarding medical evidence can be useful. It is preferable to have pediatrician team members experienced in treating victims of child abuse and neglect. If a pediatrician is unavailable, teams can select a physician who specializes in family practice or has a general practice.

## Emergency Medical Services

EMS is frequently first at the scene and observes critical information regarding the scene and circumstances of a child abuse death, including the behavior of witnesses. The EMS report can also be useful in determining body position at death and identification of other evidence that may have been moved before an investigator's arrival at a scene. EMS has established relationships with local hospitals and can provide a perspective from these agencies.

## Hospitals

Local hospital representatives on child abuse death review teams can be emergency room staff, quality assurance officers, social workers or key administrators. Their participation can facilitate the sharing of medical records with a team. When a child is transported to an emergency room, hospital representatives can provide a review team with pertinent information. They can also obtain valuable information from reviews to help improve hospital practices.

## Community Mental Health

The mental health representative on a child abuse death review team provides information and insight regarding psychological issues related to events that caused a child abuse death. Although federal guidelines preclude community mental health from sharing case-specific information unless consent is obtained, they can suggest when counseling or other mental health service referrals may be appropriate. Their participation at the review can provide valuable insight into their own agency policies and practices.

## Department of Juvenile Justice

Department of Juvenile Justice (DJJ) staff can provide child abuse death review teams with information on crimes and delinquencies involving older children. A large number of teenagers die as a result of suicide and homicide. Records from DJJ counselors can assist in reviews of such deaths.

## Education

School district representatives can provide child abuse death review teams with perspective on child health, growth and development. Their presence at reviews enhances the delivery of support services and interventions. This is especially true in cases of traumatic death, particularly in developing school support services in the event of suicides and homicides. They also provide leadership in implementing review team prevention recommendations and facilitate training to educators regarding recognition and reporting of child abuse.

## District Child Death Review Coordinator

Each district administrator of the Department of Children and Families must appoint a child abuse death review coordinator for the district. The coordinator must have knowledge and expertise in child abuse and neglect. The district death review coordinator has specific mandated responsibilities relative to child abuse deaths and child abuse death review teams. These include responsibilities to:

- Coordinate with the local child abuse death review team within that district.
- Ensure the appropriate implementation of the child abuse death review process and all district activities related to the review of child abuse deaths.
- Work with the State Child Abuse Death Review Team and local teams to ensure that the reviews are thorough and that all issues are appropriately addressed.
- Maintain a system of logging child abuse deaths covered by this guide and track cases during the child abuse death review process.

- Conduct or arrange for a Florida Abuse Hotline Information System (FAHIS) record check on all child abuse deaths covered by this procedure to determine whether there were any prior reports concerning the child or concerning any siblings, other children, or adults in the home.
- Coordinate child abuse death review activities, as needed, with individuals in the community and the Department of Health.
- Notify the district administrator, the Secretary of the Department of Children and Families, the Deputy Secretary of Children's Medical Services, and the Department of Health's Child Abuse Death Review Coordinator of all child abuse deaths meeting criteria for review as specified in this guide within one (1) working day after verifying the child's death was due to abuse, neglect or abandonment.
- Ensure that all critical issues identified by the local child abuse death review team are brought to the attention of the district administrator and the Secretary of Children and Families.
- Provide technical assistance to the local child abuse death review team during the review of any child abuse death.

## CHAPTER 4

### TYPES OF REVIEWS AND REVIEWABLE DEATHS

#### 4.1 Introduction

There are two types of reviews: immediate response review and periodic review. Child abuse death review teams may develop mechanisms for conducting both types. Each requires a different meeting format.

#### 4.2 Immediate Response Review

Immediate response reviews occur within 24 to 48 hours of a specific death and are designed to assist the death investigation and delivery of services. A team reviews information immediately and affects the processes and procedures used during active investigation of a death. Because immediate response review meetings are usually unscheduled, they can be arranged by a designee who contacts all team members. Review teams should establish criteria to identify deaths that require immediate response reviews. These deaths can be reviewed again at a periodic review meeting to identify additional recommendations.

If a local team wishes to conduct this type of review, the decision to assume this responsibility must be made jointly by the team, DCF and local law enforcement as these agencies are legally responsible for child abuse death investigations.

#### 4.3 Periodic Reviews

Periodic reviews are scheduled meetings to discuss all deaths during a designated time period that meet review team criteria. Reviews of such deaths usually occur after most of the information is gathered and the investigation is either complete or almost complete. Periodic reviews are often scheduled routinely, e.g., monthly or less often, based on the number of deaths in a county. Periodic review findings and proceedings are used primarily to influence systems and procedures for future death investigations, although they may also influence investigations of deaths under review, and to meet all other review objectives.

#### 4.4 Reviewable Deaths

In accordance with s. 383.402, F.S., teams must conduct detailed reviews of the facts and circumstances surrounding child abuse and neglect deaths in which at least one report of abuse or neglect was accepted by the Florida Abuse Hotline within the Department of Children and Families.

#### 4.5 Residence

Child abuse death review teams should review all applicable deaths that occur in their counties and attempt to review deaths to children who are residents of their counties but die elsewhere.

If a team reviews a non-resident occurrence, the coordinator should notify the resident county review coordinator (if the county has a local team) of the death in the event that the resident county will want to review the death as well. This is particularly important in rural counties whose children are often transported to tertiary care centers where they are pronounced dead.

## CHAPTER 5

### ESTABLISHING A CHILD ABUSE DEATH REVIEW TEAM

#### 5.1 Designate a Team Organizer

Review teams are created through individual efforts and voluntary cooperation among agencies and professionals involved with child death. To establish a multi-agency, multi-disciplinary child abuse death review team in your community, one person must be willing to commit the time and effort required to form a team. Individuals interested in organizing review teams can come from any profession.

#### 5.2 Contact State Child Abuse Death Review Coordinator

The review team organizer can contact the Child Abuse Death Review Coordinator with the Department of Health or a State Child Abuse Death Review Team representative to obtain team information and this guide to assist in the development of a local team. State team members may be contacted to attend a local meeting and provide technical assistance.

#### 5.3 Study Team Materials

The team organizer should become thoroughly familiar with the operation of a review team by studying the informational material supplied by the state program. Supplemental information regarding other professions and how they function should also be studied. The material available from the Department of Health Program Office includes the following:

- The Florida Child Abuse Death Review “Guidelines for the State and Local Teams”
- An information pamphlet regarding the child abuse death review system in Florida
- The child abuse death review data form and guide
- The child abuse death review data system

#### 5.4 Contact an Existing Review Team

The team organizer should contact the team coordinator of a successful operating team and request to attend a review meeting. It is recommended that the team organizer visit a team that has been conducting reviews for at least one year. Observing an existing review team will answer many questions regarding how teams operate and may also provide direction on recruiting team members.

#### 5.5 Contact the Local Core Member Agencies

The team organizer should contact the directors of local core member agencies to discuss establishing a team. Before meeting with various agencies, team organizers need to become familiar with agency roles and the need for their participation on the team. In recruiting team members, request that the highest possible level of agency staff join the team they will have the authority to implement changes, if necessary, and to commit their agencies to cooperative projects and protocols. When an agency head is not available, a staff member authorized to make agency decisions can be recruited. Designate an individual who is knowledgeable about and experienced with direct and routine involvement with child abuse deaths to represent the agency.

## 5.6 Schedule an Organizational Meeting

All organizational issues should be addressed prior to the child abuse death review process. After all core agencies have been contacted, the team organizer should schedule an organizational meeting after offering a choice of dates and times with two or three weeks notice. Organizational meetings should be held when most of those invited are able to attend. Request that the state child abuse death review coordinator or a member of the state team attend your first meeting to provide guidance and request that child abuse death data for your county or region be provided.

## 5.7 Conduct an Organizational Meeting

The following can be used as a sample agenda for your first meeting. Several organizational meetings may be necessary before teams are actually ready to begin reviewing deaths.

- Introduce potential members
- Provide overview of the purpose for and history of child abuse death review teams in Florida
- Describe how a review team operates
- Present child abuse death statistics for the county or region
- Discuss local actions currently taken when a child dies

This works well if you begin with a 911 call scenario. Have each agency describe the role it plays in responding to an unexpected child abuse death. It helps to begin with EMS and proceed in chronological order. Also consider how things are different if a 911 call is not received, but a child is still taken to a hospital. A review of current procedures helps everyone understand how local systems interact. Many attending an initial meeting may be unfamiliar with the procedures a community follows when a child dies.

- Discuss the benefits of team involvement for participating agencies

Allow time for each person attending to express concerns or raise issues. Make sure each person has an opportunity to ask questions and participate. If you do not have the answers to all the initial questions, explain that you will find out what other teams are doing and report back to the group.

- Determine the type(s) of reviews to conduct: immediate response or periodic
- Decide how to identify cases through both the medical examiners office and DCF
- Establish a meeting schedule

Teams should schedule regular meeting times based on the type of review they choose to conduct and, if applicable, a process for calling immediate response reviews. If a county or region has very few deaths, its team can decide to meet only in the event of a death meeting criteria. In this case, a person should be designated to call meetings as needed. If no additional organizational meetings are required, schedule the first meeting to review deaths. (Attendance will be higher if a regular time and place is agreed upon for meetings.)

- Select additional members

Compile a list of potential additional members and develop a plan for enlisting their participation.

- Discuss, review and agree on an Interagency Agreement to Participate and on a Confidentiality Agreement

These documents must be signed prior to conducting team reviews.

- Agree on materials to distribute to team members at the first meeting

Materials should include basic information about child abuse death review teams, the authorizing legislation, the data collection form and the preliminary agreements made at the initial meeting.

- Select a team coordinator

## **5.8 Authorization of Local Child Abuse Death Review Teams**

Agencies or community groups that desire to be recognized as the Child Abuse Death Review Team for a local area should submit a request in writing to the State Child Abuse Death Review Coordinator. The letter should indicate the following:

- An outline of the group's proposal for conducting child abuse and neglect death reviews;
- Community partners involved and community resources identified to help support the process;
- Indicate the geographical area to be covered; and
- Confirm that arrangements have been made with the DCF district child death review coordinator to receive notification of applicable child abuse deaths.

Attach the completed Local Child Abuse Death Review Team Membership list (Attachment II) to the letter. The letter should be mailed to the statewide child abuse death review coordinator at the following address:

State Child Abuse Death Review Coordinator  
Children's Medical Services  
Child Protection Unit  
4052 Bald Cypress Way, Bin A06  
Tallahassee, Florida 32399-1707

The request will be reviewed by the state team. After review and approval, a letter will be sent to the local team confirming recognition as the local child abuse death review team for the specified geographical area.

## CHAPTER 6

### REVIEW TEAM TRAINING

#### 6.1 Introduction

Orientation and ongoing training of review teams is required to maintain consistency in application of review methods, data review and collection activities. One of the primary goals of this training is to develop consistent, accurate, and thorough application of program standards, and to help ensure that meaningful information can be obtained for identification of prevention strategies for reduction of child abuse and neglect deaths.

#### 6.2 Orientation

Each local child abuse death review team shall provide a comprehensive orientation to the Child Abuse Death Review Program to each incoming team member or consultant. This orientation shall take place prior to the team member or consultant's participation in any phase of the review process.

Local teams are encouraged to utilize support from the Department of Children and Families District Death Review Coordinator and the State Child Abuse Death Review Team for planning and conducting these training activities, especially during the first several meetings of the local team.

Orientation should include, at a minimum, the following:

- Review and signing of confidentiality statements
- Review of Child Abuse Death Review Program background, mission, and goals
- Review of Child Abuse Death Review Program Guidelines, with an emphasis on confidentiality of records and information
- Team membership requirements and duties
- Processes for requesting records and information
- Instructions for completing Child Abuse Death Review Data Forms

#### 6.3 Training and Technical Assistance for Local Teams

The State Child Abuse Death Review Team recognizes the importance of consistency and accuracy in the information provided by local child abuse death review teams. Without this consistency, information collected about the reasons for child abuse and neglect deaths may not be reliable or accurate. To this end, the State Child Abuse Death Review Team will provide training and technical assistance for local team members.

Local teams may request technical assistance directly from the State Child Abuse Death Review Team. Requests should be directed to the DOH State Child Abuse Death Review Coordinator at (850) 245-4200.

Any orientation, training, or technical assistance provided for state or local teams shall not involve the use of actual cases (even if names are deleted), or provide data or information that includes a name, situation, or incident that may be identifiable unless already made public.

## **6.4 Program Promotion Activities**

The State Child Abuse Death Review Program develops and distributes an informational brochure about the program. The informational brochure describes the purpose, function, and authority of the child abuse death review teams. The brochure is available by contacting the State Child Abuse Death Review Coordinator.

The State Child Abuse Death Review Team and local team may conduct informational seminars, training sessions, or other community-based promotion, press releases or public information in order to provide non-identifying information and statistics regarding the Child Abuse Death Review Program.

## CHAPTER 7

### CONDUCTING AN EFFECTIVE REVIEW MEETING

#### 7.1 Beginning the Meeting

New members and ad hoc members sign the Child abuse death Review Signature Sheet (Attachment III) regarding confidentiality prior to the start of their participation in review meetings. Each member agrees to keep meeting discussions and information regarding specific child abuse and neglect deaths confidential. Confidentiality is essential for each agency to fully participate in the meetings. A confidentiality agreement signed by team members and required for other meeting attendees should be kept at each meeting by the team coordinator.

Team members are reminded by the coordinator that:

- The review team is not an investigative body.
- Review meetings relating to child abuse death reviews where specific persons or incidents are discussed are confidential and exempt from the public meetings and records law, s. 286.011, F.S. The state team or a local team may hold periodic public meetings to discuss non-confidential information or issues.
- All participants agree to keep team discussions relating to specific child abuse deaths confidential.
- Meeting notes, if kept, will not indicate any case specific information.
- Team members and ad hoc members come and leave with only their own records on specific cases.
- The purpose of the team is to improve investigations, services and agency practices by identifying issues and trends related to child abuse deaths and provide recommendations to address these issues and prevent other child deaths.

#### 7.2 Sharing Information

Reviews are conducted by discussing each child abuse death individually. It can be helpful to establish the order in which information will be presented. This will help the meetings and reviews to run more smoothly and make completing the data form easier. Each participant provides information from their agency's records. If any information is distributed, it must be collected before the end of the meeting. Information can be shared in the following order:

- The medical examiner presents information on the autopsy and pending or final determination of cause and manner of death.
- The EMS provider presents their report and any other data.
- Hospital representative/physician from the emergency room present their medical report.
- Child Protection Team case coordinator/medical director presents information regarding their involvement with the child/family, past and present.

- The law enforcement officer presents information on the scene, criminal histories and other investigations.
- DCF protective investigator, or program designee, presents current investigative information and any prior history of reports they have on the family.
- DCF family service counselor or program designee presents information on their involvement with the family, e.g., supervision and services provided.
- Any other agencies that were identified and attending the meeting would then present information regarding their involvement with the child and family. Examples are: community counseling services, domestic violence programs, school representatives, if school age child.

Often team members may be unable to share information due to confidentiality restrictions or lack of information. If there is insufficient information available at the time of the review, the team may want to identify what additional information is needed, how much time is needed to get it and review the child abuse death again at a later date.

### 7.3 Clarification

After all information has been presented, review team members may next ask for clarification or raise questions about the information shared. Prior to moving on with a review, all members should feel confident that they understand all information as presented or ask for further clarification.

At the completion of the presentation of information, the team coordinator should then lead the team discussion on the “Team Conclusion” section of the child abuse death data form. This section must be completed by the team and address the following:

- Identification of agencies who provided services to the child and the child’s family and a determination of the adequacy of the services, based on the information provided.
- Identification of additional investigative activities by DCF, law enforcement or both.
- Identification of issues, e.g., investigative, provision of services, availability of community resources, department/agency policy and practices, local ordinance and state statute, as a result of the team review, and statement of the specific issue(s).
- Identification of problems encountered during the review.

The team will then discuss the “Prevention” section of the data form, which addresses:

- Degree to which the death was believed to be preventable.
- Identification of primary risk factors involved in child’s death.
- Whether the death could have been prevented.
- Identification of prevention activities proposed as a result of the death review.

Each prevention activity identified must be clearly stated with documentation as to what, if any, action needs to be taken at a state or local level.

## 7.4 Holdover Reviews

Cases may need to be discussed at more than one meeting, for a variety of reasons, e.g., investigation not complete, medical examiner final findings not available, information not available due to non-attendance by an agency representative or more information is needed from agencies. Identification of the time line needed in order to have all the information available to complete the child abuse death review should be decided by the team and a review date agreed upon by all.

## 7.5 Agency Conflict Resolution

Participating agencies may have individuals with concerns or disagreements regarding specific cases. Reviews are not opportunities for others to criticize or second-guess agency decisions in child abuse death cases. Issues with procedures or policies of particular agencies are sometimes identified; however, agency team members are responsible for any further action taken by their agencies on such issues.

Teams are not peer reviews. They are designed to examine system issues, not the performance of individuals. The team review is a professional process aimed at improving system response to child abuse deaths.

Many agencies involved in child abuse death review teams do not have an internal mortality review process. The Department of Children and Families conducts an internal review for child abuse deaths in which the child or family had prior contact with the agency and the Department of Health conducts Fetal Infant Mortality Reviews (FIMR). For most agencies, however, review teams provide the only forum for reviewing their actions, policies and procedures related to child abuse deaths.

When conflict among team members interrupts a review, the team coordinator should intervene so the review can progress. The team coordinator can contact the team members outside the meeting to discuss and help resolve conflicts. Sometimes disagreement is both productive and appropriate, but disruption of the review is not acceptable; reviews are to be conducted in a professional manner.

## 7.6 Media Relations

It is important that teams establish effective working relationships with the media. Media involvement is fundamental to a review team's ability to promote awareness and educate the public regarding child abuse and neglect deaths.

Each team should designate one team member to be the team's media contact. This person should contact various local media and provide information about the team, its purpose and operation. The media contact can provide the media with statistics and/or reports relating to team activities. Confidential case information is not to be disclosed to the media. Because the objectives and review process are frequently misunderstood by the media, the team coordinator and members need to reinforce that the team is "not a fault-finding panel."

By viewing the media as a useful tool for promoting child death prevention strategies, team members can more comfortably interact with media representatives. This allows teams to function more effectively and better serve the community.

## CHAPTER 8

### MAINTAINING AN EFFECTIVE REVIEW TEAM

#### 8.1 Introduction

A child abuse death review team follows three stages of development to achieve its goal of reducing the number of preventable child abuse and neglect deaths in the community.

- Organization
- Operation
- Initiation of prevention efforts and strategies developed from team findings

Once a team has been established and its operating procedures are thoroughly understood, maintenance of the team is essential. Some recommendations for maintaining a functional review team follow.

#### 8.2 Respect Team Agreements

For a team to operate effectively, it is essential that team agreements be recognized and followed by all team members.

#### 8.3 Participate and be Prepared for Meetings

Reviews require regular attendance and participation by all team members. Members should become acquainted with the questions that will be addressed at every review and come prepared to present their agencies information and perspectives. Prior to each meeting, team members should gather relevant information on each case on the agenda.

#### 8.4 Keep Regular Meeting Schedules

Regularly scheduled meetings allow team members to make long-term plans and allow for better attendance. Canceling scheduled meetings diminishes a team's ability to gather information and hinders the cooperative networking of the members. A team can only achieve its objectives by meeting routinely.

#### 8.5 Provide an Educational Element at Team Meetings

Keep members informed of team-related training, changes in laws regarding their professions and new child death or injury prevention programs. Ongoing education should be an integral part of every review team's operation. Periodical presentations and informative handouts enhance a team's ability to accomplish its objectives.

#### 8.6 Use Existing Teams

Contact with established review teams can assist in the following ways:

- Sharing information on innovative team efforts
- Sharing information on prevention activities they have completed
- Sharing problem solving approaches
- Providing technical assistance

## **8.7 Publish a Local Child Abuse Death Review Report**

Local teams should consider publishing an annual report of team activities and information on child abuse deaths reviewed. This report becomes your county's database on child abuse deaths. By completing it accurately, you will develop a rich source of information on your county's child abuse deaths. This information will help your county and state in recommending policy, practice and programs for child health, safety and protection.

## **8.8 Provide Other Members with Support**

Each professional brings to the review team its perspective, professional knowledge and expertise. It is support, not criticism that will encourage change and foster improvements. Realize that disagreement between members is sometimes unavoidable but, if handled appropriately, can help the team to function effectively. It is the responsibility of the team coordinator to reinforce productive exchanges and discourage dialogue disruptive to the review process. Each member must acknowledge and respect the professional role of each participating agency. Improvement will come through cooperative efforts.

## **8.9 Do Not Lose Sight of the Team's Purpose and Objectives**

A periodic review of a team's stated purpose, goals and objectives will provide direction to the team and remind members why the team was originally formed.

## **8.10 Team Membership Is a Long Term Commitment**

A review team is not an ad hoc committee that collects data on child abuse deaths for a designated period. It is a panel of professionals dedicated to establishing a better understanding of the causes of child abuse deaths in their community. Discovering the patterns that cause or contribute to preventable child abuse deaths is an ongoing process. Patterns change over time within a community. The aggregate knowledge acquired by team members provides structure for achieving effective results.

## **8.11 Community Education and Prevention**

By participating on a child abuse death review team, local professionals who take responsibility for the protection, health and safety of their community's children communicate their pledge to better understand child abuse deaths. Their participation represents their commitment to eliminating obstacles to integrated community responses, to child abuse deaths and to creating opportunities to prevent deaths to other children.

The state and local child abuse death review teams review and analyze information on the nature of child abuse deaths in Florida. Local teams identify trends in child abuse death statistics for their own communities, and develop and implement community education and prevention plans.

Information obtained from the statewide data collection system is critical to identifying the nature and cause of child abuse and neglect deaths in Florida. State and local teams, and other public and community organizations can analyze information relative to the cause of death, circumstances leading up to the death, and other factors to identify possible prevention strategies that are data-driven.

## 8.12 Focus on Prevention

The key to good prevention is leadership at the local level. Review team members can provide this leadership by serving as catalysts for community action. Prevention efforts can range from simply changing one agency practice or policy or setting up more complex interventions like an intensive home visitation program for high risk parents.

Review teams should work with local community programs involved in child death, safety and protection. Some communities have child safety coalitions, prevention coalitions or active citizen advocacy groups. Connect your review team findings to these groups to ensure results. Also, assist these groups in accessing state and national resources in the prevention areas targeted by your community.

## CHAPTER 9

### TEAM OPERATING PROCEDURES

#### 9.1 Information Sharing

It is not the role of the child abuse death review teams to criticize or second-guess any agency decisions; they are a forum for the sharing of information essential to the improvement of a community's response to child fatalities.

Teams can request information and records regarding a deceased child as needed to carry out their duties. Background and current information from team members' records and other sources is necessary to assess circumstances of death.

Teams can institute standing requests for records and information to facilitate the gathering of information for death reviews. Such requests should be addressed to the "custodians of the records" or agency director and should include the review team authorizing statute, information regarding the team's operation and purpose, and a copy of the team's interagency agreement. These requests are particularly useful for acquiring information from agencies that are not represented on the team. Such requests can enhance a team's ability to gather required medical information, especially those that deal with numerous hospitals.

In reviewing deaths of child residents of other counties, team members should contact their corresponding agencies in those counties and request information.

#### 9.2 Team Coordinator

A team coordinator should be selected at the organizational meeting prior to the first review meeting. The team coordinator, who can be one of the team members, serves at the discretion of the team. Teams can decide to rotate the position.

Team coordinator duties:

- Call and chair team meetings.
- Send meeting notices to team members.
- Obtain names and compile the summary sheet of child abuse deaths to be reviewed for distribution to team members two weeks prior to each meeting.
- Submit completed child abuse death review data forms with attached materials to the Department of Health, Child Protection Unit, Tallahassee.
- Ensure that the team operates according to protocols as adapted by the team.
- Ensure that all new team members and ad hoc members sign a confidentiality agreement.

#### 9.3 Member Designees and Meeting Attendance

Team members can designate another representative of their agency to replace them at meetings they are unable to attend. Team members must recognize the importance of regular attendance as a means of sharing the expertise and knowledge for which they were recruited. Local teams should consider developing a policy such as the following to address non-attendance of team members:

"Team members who have three consecutive non-attendance without notice or good reason will be subject to removal by the team."

## 9.4 Obtaining Names for Team Reviews

The team coordinator should work closely with the DCF district child death review coordinator to ensure notification of all child abuse deaths meeting the mandatory criteria for review by the team.

## 9.5 Child Abuse Death Information Distribution

The team coordinator should compile and send to all review team members a list of child abuse deaths to be reviewed. To assist in preparing for the review, the team coordinator may also attach the Agency/Department Services Provided Information Sheet (Attachment IV) to be completed once the agency has researched their records for information pertaining to each death.

## 9.6 Record Keeping

Team members should come to each meeting with their own records. No other copies will be provided. Except for providing the specific information required on the Child Abuse Death Review Checklist (Attachment V), team members can complete the Agency/Department Services Provided Information Sheet (mentioned above), which summarizes their agency's contact and involvement with the child and family.

All records (e.g., completed data forms with attachments, copies of agency department files) must be maintained in a secure area. Additionally, any meeting notes that directly relate to a specific child must also be secured and separate from general meeting notes.

## 9.7 Child Abuse Death Review Information Sheet

The Child Abuse Death Review Information Sheet (Attachment VI) was developed to assist team coordinators in the identification of agencies/contacts relating to a specific child abuse death. The information sheet is designed to provide, at a glance, information concerning the agencies or departments involved in the current investigation surrounding the child's death so that these individuals can be contacted and requests for information made. The "Other Agency" section of the information sheet can be used to identify other agencies that have had prior involvement with the family so they can be requested to attend the child abuse death review staffing and provide information concerning their agency's involvement with the family. The following information is compiled on the child abuse death review information sheet:

- Deceased child's name
- Address
- Child's gender
- Child's date of birth, date of death and age at death
- Medical examiner's name and case number
- Cause and manner of death
- Law enforcement agency and investigating officer's name
- State attorney's name and criminal court case number
- Child Protection Team case coordinator's name
- Department of Children and Families FAHIS report number and contact person
- Department of Health
- Other agencies involved
- Mother's and father's names

## 9.8 Child Abuse Death Review Data Form

The Florida Child Abuse Death Review Data Form (Attachment VII) must be completed on all child abuse deaths reviewed. A copy of the completed data form with required attachments is then mailed to the Department of Health, Children's Medical Services Program Office, for data input into the statewide child abuse death data base. The team coordinator should review the data form, the checklist and attachments to ensure that all information is accurate and complete prior to mailing. The team coordinator may start filling out the data form prior to the meeting. If the team coordinator's responsibilities at the meeting prohibit their ability to accurately fill the form out, they should designate another team member to complete the data form during the review.

The chairperson of the local child abuse death review team is responsible for monitoring the quality of all Child Abuse Death Review Data Forms submitted to the State Child Abuse Death Review Team. Local teams must develop and implement a protocol for reviewing the completeness, accuracy, and legibility of each data form prior to its submission. The local team chairperson's signature on the form indicates that it has been reviewed.

Local teams should make every attempt to have the review and data form completed within three to four months of the date of the child's death. The local teams should complete all the reviews of child abuse deaths occurring in the calendar year and submit the data forms to the Department of Health, State Child Abuse Death Review Coordinator within 30 days following the review of the child's death. Data must be received prior to March 30th of the year following the child's death to be included in the annual statistical report that is due September 30.

The Child Abuse Death Review Data Information Guide (Attachment VIII) provides instructions for completing the data form. Please contact the DOH State Child Abuse Death Review Coordinator if you need additional forms or information about how to complete the forms.

## CHAPTER 10

### CONFIDENTIALITY AND ACCESS TO INFORMATION

#### 10.1 Introduction

As provided in s. 383.410, F.S., all information and records that are confidential or exempt from public records shall retain that status throughout the child abuse death review process, including, but not limited to:

- Requests for and receipt of information for case reviews;
- Use of information, documents and records to collect data for child abuse death reviews;
- Storage of information and records related to a deceased child or the child's family;
- Presentation of records, documents, or information during case reviews;
- Discussions during review of individual cases; and,
- Maintenance of the Child Abuse Death Review Database.

Pursuant to s. 383.410, F.S., a person who violates the confidentiality provisions of this statute is guilty of a First Degree Misdemeanor. Violation of confidentiality provisions by mandated members should be referred to the representative agency/organization for appropriate disciplinary action, including replacement. Administrative and support staff (at the state and local levels) who violate confidentiality provisions may be subject to employee sanctions or other disciplinary action by their respective agencies.

Specific questions regarding confidentiality of child abuse death review information can be directed to the Department of Health, Child Abuse Death Review Team Coordinator.

#### 10.2 Access to Information

The State Child Abuse Death Review Team Coordinator and all local child abuse death review team coordinators have access to relevant information and records regarding a child whose death is under review. Agencies or organizations that are required to provide information per s. 383.402(8) and s. 383.402(9), F.S., include, but are not limited to:

- Patient records in the possession of a public or private provider of medical, dental, or mental health care, including, but not limited to, a facility licensed under chapter 393, chapter 394, or chapter 395, or a health care practitioner as defined in s. 456.001, F.S.
- Information or records of any state agency or political subdivision which might assist a committee in reviewing a child's death, including, but not limited to, information or records of the Department of Children and Families, the Department of Health, the Department of Education, or the Department of Juvenile Justice.
- Medical examiner reports.
- All information of a law enforcement agency which is not the subject of an active investigation and which pertains to the review of the death of a child.

A law enforcement agency may withhold investigative records that might interfere with an active investigation. Once the investigation has been completed, or resolved, however, the information is no longer subject to being withheld. Local teams should have a procedure for periodic reassessment or follow-up on the status of these pending cases in order to update information on child abuse and neglect deaths. Once updated, the information should be

forwarded to the State Child Abuse Death Review Coordinator for input into the child abuse death database.

The Chairperson of the State Child Abuse Death Review Team may, through the Department of Legal Affairs, request a subpoena as necessary to compel the production of books, records, documentation and other evidence related to a child abuse death review.

### **10.3 Confidentiality of Records and Information**

Section 383.410, F.S., outlines the following regarding the state and local child abuse death review teams:

- All information obtained by the State Child Abuse Death Review Team or a local team that is confidential and exempt from public records requirements, shall retain that status.
- Confidential information provided by the State Child Abuse Death Review Team or a local team to a hospital or a health care practitioner shall retain that status and is exempt from public records requirements.
- Reports or records generated by the State Child Abuse Death Review Team or a local team that identifies names, addresses or telephone numbers or information that would identify any surviving siblings, family members, or others living in the home is confidential and exempt from public record requirements.
- All or any portion of a State Child Abuse Death Review Team or a local team meeting in which specific child abuse deaths are discussed are confidential and exempt from public record requirements.
- All records and information acquired by the State Child Abuse Death Review Team or a local team are confidential and not subject to subpoena, discovery or introduction into evidence in any civil or criminal proceedings. Exceptions to this are information, documents, and records otherwise available from other sources are not immune from subpoena, discovery, or introduction into evidence from those sources solely because they were presented to or reviewed by a team.
- Information regarding case reviews shared between the state and local child abuse death review teams remains confidential and exempt from the public record requirements.

At a review team meeting, all data and information regarding the death of an identified child is confidential. Any person who violates these provisions commits a misdemeanor of the first degree, punishable as provided in s. 775.082, F.S. or s 775.083, F.S. Meetings where specific child abuse death information is shared is also closed to the public. However, the state team or a local team may hold periodic public meetings to discuss non-confidential information or issues. Team members will post a notice of the public meeting in their respective work places.

### **10.4 Confidentiality Statements**

Any person who may have access to any information or records regarding review of a child abuse death are required to sign a statement of confidentiality. A sample copy has been provided (Attachment IX) for teams to utilize in developing their own form. Persons who may have access to this information shall include state and local team chairpersons, state and local team members, administrative and support staff for the state and local teams who open or

handle mail, birth or death certificates, records, or any other components required in the preparation of a child abuse death review case.

Each child abuse and neglect death review team shall maintain a file with signed copies of the member's confidentiality statement. Other confidentiality statements must be obtained for non-team member participants, as needed, on a case-by-case basis. These should be maintained in the local team's file.

### **10.5 Protecting Family Privacy**

A member or consultant of a state or local child abuse death review team shall not contact, interview, or obtain information by request or subpoena from a member of the deceased child's family, except that a member or consultant of a state or local team who is otherwise a public officer or employee may contact, interview, or obtain information from a family member, if necessary, as part of the public officer's or employee's other official duties. Such public officer or employee shall make no reference to his/her role or duties with the Child Abuse Death Review Program.

Information obtained and results of child abuse death reviews may otherwise be disclosed only in summary, statistical, or other form that does not identify the deceased child or family.

### **10.6 Document Storage and Security**

All information, records and documents for child abuse death review cases shall be stored in locked files. Persons who have access to the locked files or information contained therein shall be required to sign a confidentiality statement.

Copies of documents provided for team meetings shall not be taken from team meetings. At the conclusion of the team meeting, the copies shall be collected and destroyed.

Data about the circumstances surrounding the death of child is entered into the Child Abuse Death Review Data System from the Child Abuse Death Review Data Form. This secure database is used to generate summary or management reports and statistical summaries or analyses.