

FLORIDA CHILD ABUSE DEATH REVIEW PROGRAM



Guidelines for the State and Local Committee's

The Florida Department of Health provides administrative support and oversight to the State and Local Child Abuse Death Review Committee's.

The Protocol and Guidelines Committee of the State Child Abuse Death Review Committee developed these guidelines with assistance from the Department of Health support staff.

Special appreciation and acknowledgement is given to the Michigan, Georgia and Arizona Child Fatality Review Programs for sharing their review protocols and data forms.

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

Funding for the publication of this guide is provided by the Department of Health.

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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
- 2002-Blue Ribbon Task Force (Rylia Wilson)
- 2002-Jamie Cotter Death Review
- 2003- I-75 Child Death (Alfonzo Montes) Special Assignment
- 2005- Hillsborough Kids Inc (Ronnie Parrish)

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 Committee 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 COMMITTEES

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 Committees to conduct detailed reviews of the facts and circumstances surrounding child abuse and neglect deaths in which a verified 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 Committees 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 Committees 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 Committee's multidisciplinary membership enables all Committee members to better understand how and why a child has died and

facilitates more accurate reporting. When child abuse death review Committees 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 Committee members are informed of all child abuse deaths or learn about deaths sooner than usual and are thus able to take action in a timelier 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 Committees 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 Committees 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. Committees can

focus their discussion on short and long-term interventions relating to statute, policy, programs and practice. Committees should identify the best way to translate prevention recommendations into action. Individual agencies or Committee 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 Committees.

Revisions to this guide will be distributed to all local Committee 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 (850-245-4217) or the Quality Assurance Coordinator for the State Child Abuse Death Review at (772-467-6012 X 114).

CHAPTER 2

STATE REVIEW COMMITTEE MEMBERSHIP AND DUTIES

2.1 Introduction

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

2.2 Statutory Membership

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

- Department of Health
- 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 Surgeon General is responsible for appointing the following members based on recommendations from the Department of Health and affiliated agencies, and ensuring that the Committee 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 Committee
- 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 Surgeon General appoints the members of the State Child Abuse Death Review Committee for staggered two (2) year terms. Members are eligible for reappointment and must comply with the attendance requirements for State Committee Members. It is important that all appointees attend Child Abuse Death Review Meetings. In extenuating circumstances, a single pre-appointed designee may attend a Committee meeting, participate in discussions, and vote in absence of the appointee. Members must attend meetings in person.

Agency representatives who leave their agency during their term must notify the agency head and the CADR Committee chairperson immediately. The members standing on the state Committee expires upon the effective date of their departure from the agency and the chair of the state Committee will request that the agency appoint a new member. An attendance record of meetings shall be maintained in accordance with the records retention.

Surgeon General appointees who resign from their current position must notify the Surgeon General, the Chair of the State Committee and DOH Child Abuse Death Review Coordinator immediately. At the discretion of the Surgeon General, they may remain on the state Committee 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 Surgeon General, DOH Death Review Coordinator and the chair of the state Committee. The members standing on the state Committee expires upon the effective date of their departure and the Surgeon General will appoint a replacement as soon as possible.

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

2.4 Non-Statutory Consultants

The State Child Abuse Death Review Committee 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 Committee. They may not use their participation on the Committee 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 Committee is elected for a two (2) year term beginning January of the calendar year, by a majority vote of the members of the State Child Abuse Death Review Committee. The chairperson may serve no more than two (2) consecutive two (2) year terms. The chair elect is elected to begin a two-year term at the end of the term of the chairperson. The State chairpersons are eligible for re-election after a one (1) year out of office. Florida DOH Child Abuse Death Review Coordinator shall serve as the Parliamentarian on behalf of the State Child Abuse Death Review Committee.

2.6 Removal/Resignation of the State Chairperson

The State Child Abuse Death Review Committee 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 Committee. 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 Committee 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 Committee Membership

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

In cases where members resign from the State Child Abuse Death Review Committee, the state Committee 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 Surgeon General for approval.

A Committee member or consultant may be removed for good cause by a majority vote of the entire membership of the Committee. 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 Committee member.

Members not appointed by the Surgeon General cannot be removed by a vote of the state Committee. 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 Committee's request.

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

2.9 State Review Committee Duties

The duties of the state committee 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 Committees 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 maintaining local child abuse death review committee's and provide consultation on individual cases to local Committees upon request.

- Develop guidelines, standards and protocols, including a protocol for data collection for local child abuse death review committee's, and provide training and technical assistance to local committee's.
- 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 Committee includes the following subcommittees:

Education and Training Subcommittee

The Education and Training Subcommittee provides technical assistance to local Committees, 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)(I)].

Policy and Protocol Subcommittee

This committee reviews state and local Child Abuse Child Abuse Death Review Committee 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.

2:11 Quality Improvement Coordinator

The Quality Improvement Coordinator is responsible for providing staff support to the State Child Abuse Death Review Committee (CADR), liaison with the Department of Children and Family Services (DCF), including but not limited too coordinating the bi-monthly State CADR meetings, facilitating the review of verified child abuse deaths, either through the local committee system or by members of the State Committee. In addition, the QI Coordinator is responsible for providing technical assistance, training, and quality improvement feedback to local committees in collaboration with the Committee's partners, such as, the Florida Department of Law Enforcement, the Medical Examiner's Commission, and DCF, etc. The QI Coordinator also has lead in development of the annual report, analyzing the data and assist in putting the information into graphs as well as reports for the State Committee.

The State Child Abuse Death Review Committee Chairperson may appoint ad hoc Committees as necessary to carry out the duties of the Committee.

CHAPTER 3

LOCAL REVIEW COMMITTEE MEMBERSHIP AND DUTIES

3.1 Committee Membership

A child abuse death review Committee is not a new official organization. The authority and responsibility of participating agencies do not change. Rather, Committees 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 Committees should, at a minimum include representatives from the:

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

Other Committee 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 Committee. 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 Committee shall be appointed to two-year terms and may be reappointed.

3.2 Ad Hoc Members

Committees may designate ad hoc members. Because ad hoc members are not permanent, they do not regularly receive Committee notices. They attend meetings only when they have been directly involved in a case scheduled for review or to provide information on Committee related activities. Ad hoc members provide valuable information without increasing the number of permanent Committee 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 Committees

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

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

Every county covered by a review Committee should be represented on the Committee. 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 Committees to receive information from professionals directly involved with a death while strengthening Committee relationships with various local agencies. Establishing and maintaining such relationships is critical if Committee prevention, training and education objectives are to be achieved.

3.4 Local Review Committee Duties

The duties of the local child abuse death review Committee are:

- Review all deaths resulting from child abuse and neglect with a verified 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 Committee.
- Maintain a record of attendance from the case review meetings.
- Notify the Quality Assurance Coordinator for the State Committee of any changes in membership and provide a short bibliography for any new members. The changes should be updated on the roster and submitted to the Quality Assurance Coordinator for the State CADR.
- Agency representatives who leave their agency must notify the agency they represent and the Committee chairperson immediately
- Submit written reports to the state Committee as directed. The reports are to include steps taken by the local Committee to implement necessary changes and improve the coordination of services and investigations.
- Submit all records requested by the State Child Abuse Death Review Committee 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 Committee in the conduct of child abuse death reviews.

- On a case-by-case basis, request that the State Child Abuse Death Review Committee review the data of a particular case.
- Designate a Committee chairperson who oversees the activities of the local Committee and calls meetings of the Committee when necessary.
- Designate a member of the local Committee, if there is not a state Committee member also on the local Committee, to be the liaison to the state Committee for the purpose of child abuse death case presentations to the state Committee.

3.5 The Role of Committee Members

The role of Committee members can be flexible to meet the needs of particular communities. The individual abilities of members should be tapped to enhance Committee 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 Committee 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, Committee 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 Committee Members

The Medical Examiner

Medical examiners are central to the functions of both child abuse death review Committees 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 Committees better understand a cause of death ruling.

Law Enforcement

Law enforcement Committee members provide information on criminal investigations of child abuse deaths under Committee 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 Committee. Law enforcement Committee members serve as liaisons between the Committee 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 Committee 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 Committee 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 Committee effectiveness.

State Attorney

Prosecutors educate child abuse death review Committees 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 cannot 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 Committee 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 Committees 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 Committee members experienced in treating victims

of child abuse and neglect. If a pediatrician is unavailable, Committees 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 Committees can be emergency room staff, quality assurance officers, social workers or key administrators. Their participation can facilitate the sharing of medical records with a Committee. When a child is transported to an emergency room, hospital representatives can provide a review Committee 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 Committee 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 Committees 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 Committees 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 Committee prevention recommendations and facilitate training to educators regarding recognition and reporting of child abuse.

Regional Child Death Review Coordinator

Each Regional Director of the Department of Children and Families must appoint a child abuse death review coordinator for the region. The coordinator must have knowledge and expertise in child abuse and neglect. The region district death review coordinator has specific mandated

responsibilities relative to child abuse deaths and child abuse death review Committees. These include responsibilities to:

- Coordinate with the local child abuse death review Committee within that region.
- Ensure the appropriate implementation of the child abuse death review process and all region activities related to the review of child abuse deaths.
- Work with the State Child Abuse Death Review Committee and local Committees 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 record check of the Department of Children and Families statewide-automated 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 Regional Director, 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 thirty (30) working days 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 Committee are brought to the attention of the Regional Director and the Secretary of Children and Families.
- Provide technical assistance to the local child abuse death review Committee 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 Committees 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 Committee reviews information immediately and affects the processes and procedures used during active investigation of a death. Because immediate response review meetings are usually unscheduled, a designee who contacts all Committee members can arrange them. Review Committees 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 Committee wishes to conduct this type of review, the decision to assume this responsibility must be made jointly by the Committee, 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 Committee 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., Committees must conduct detailed reviews of the facts and circumstances surrounding child abuse and neglect deaths in which a report of abuse or neglect was accepted by the Florida Abuse Hotline within the Department of Children and Families and subsequently verified as child abuse.

4.5 Residence

Child abuse death review Committees 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 Committee reviews a non-resident occurrence, the coordinator should notify the resident county review coordinator (if the county has a local Committee) 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 COMMITTEE

5.1 Designate a Committee Organizer

Review Committees 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 Committee in your community, one person must be willing to commit the time and effort required to form a Committee. Individuals interested in organizing review Committees can come from any profession.

5.2 Contact State Child Abuse Death Review Coordinator

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

5.3 Study Committee Materials

The Committee organizer should become thoroughly familiar with the operation of a review Committee 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 Committees”
- 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 Committee

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

5.5 Contact the Local Core Member Agencies

The Committee organizer should contact the directors of local core member agencies to discuss establishing a Committee. Before meeting with various agencies, Committee organizers need to become familiar with agency roles and the need for their participation on the Committee. In recruiting Committee members, request that the highest possible level of agency staff join the Committee 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 Committee 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 Committee 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 Committees are actually ready to begin reviewing deaths.

- Introduce potential members
- Provide overview of the purpose for and history of child abuse death review Committees in Florida
- Describe how a review Committee 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 Committee 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 Committees 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

Committees 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 Committee 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 Committee reviews.

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

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

- Select a Committee coordinator

5.8 Authorization of Local Child Abuse Death Review Committees

Agencies or community groups that desire to be recognized as the Child Abuse Death Review Committee 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 Committee 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 Committee. After review and approval, a letter will be sent to the local Committee confirming recognition as the local child abuse death review Committee for the specified geographical area.

CHAPTER 6

REVIEW COMMITTEE TRAINING

6.1 Introduction

Orientation and ongoing training of review Committees 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 Committee shall provide a comprehensive orientation to the Child Abuse Death Review Program to each incoming Committee member or consultant. This orientation shall take place prior to the Committee member or consultant's participation in any phase of the review process.

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

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
- Committee 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 Committees

The State Child Abuse Death Review Committee recognizes the importance of consistency and accuracy in the information provided by local child abuse death review Committees. 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 Committee will provide training and technical assistance for local Committee members.

Local Committees may request technical assistance directly from the State Child Abuse Death Review Committee. Requests should be directed to the DOH State Child Abuse Death Review Coordinator at (850-245-4217) or to the Quality Assurance Coordinator for the State Child Abuse Death Review at (772-467-6012 X 114).

Any orientation, training, or technical assistance provided for state or local Committees 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 Committees. The brochure is available by contacting the State Child Abuse Death Review Coordinator.

The State Child Abuse Death Review Committee and local Committee 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 Committee members and required for other meeting attendees should be kept at each meeting by the Committee coordinator.

Committee members are reminded by the coordinator that:

- The review Committee 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 Committee or a local Committee may hold periodic public meetings to discuss non-confidential information or issues.
- All participants agree to keep Committee discussions relating to specific child abuse deaths confidential.
- Meeting notes, if kept, will not indicate any case specific information.
- Committee members and ad hoc members come and leave with only their own records on specific cases.
- The purpose of the Committee 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 Committee 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 Committee 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 Committee 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 Committee 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 Committee coordinator should then lead the Committee discussion on the “Committee Conclusion” section of the child abuse death data form. This section must be completed by the Committee 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 Committee review, and statement of the specific issue(s).
- Identification of problems encountered during the review.

The Committee 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 Committee and a review date agreed upon by all.

7.5 Conflict Resolution for Local Committee's

The local Committee may have concerns, issues or disagreements concerning the case(s) that they are reviewing, that for whatever reason cannot be resolved within the local Committee and the members.

When such a conflict arises among the local Committee, the chairperson of the Committee should contact the Quality Assurance Coordinator for the State Committee followed by a letter to the Chairperson of the State Committee addressing the conflict, and request the State Committee to assist in resolving the issue.

The State Committee will review the issue and make a recommendation. The State Child Abuse Death Review Chairperson will send this information to the local Committee Chairperson in writing.

7.5.1 Concerns identified by local Committee's: relating to law enforcement investigations, risk to surviving children as to DCF, CBC, or Child Legal Services

During the completion of a review the local Committee may identify concerns, issues or have disagreements concerning how a case(s) was handled.

When the local Committee cannot resolve their concerns, issues or disagreement, the chairperson of the Committee should send a letter to the Chairperson of the State Committee requesting a secondary review by the State Committee. The request should also be sent to the Florida Department of Health CADR Coordinator.

The State Committee will review the request and respond with recommendations in writing to the local Committee Chairperson

7.6 Media Relations and Public Records Request

It is important that Committee's establish effective working relationships with the media. Media involvement is fundamental to review a committee's ability to promote awareness and educate the public regarding child abuse and neglect deaths. Confidential case information is not to be disclosed to the media.

The State Committee chairperson is the designated spokes person for the Committee. If a member is contacted by the media regarding State CADR reports, purpose, mission, or specific case(s) etc, they must refer that person to the Chairperson or Florida Department of Health CADR Coordinator.

The local Chairperson or their designee may speak to their local media representative concerning their local committee efforts and statistics and should advise the State Chair person of the communication. However, if the request is in reference to the annual report they should be referred to the State Chairperson.

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

Public record request should be referred to the Florida Department of Health CADR Coordinator.

CHAPTER 8

MAINTAINING AN EFFECTIVE REVIEW COMMITTEE

8.1 Introduction

A child abuse death review Committee 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 Committee findings

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

8.2 Respect Committee Agreements

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

8.3 Participate and be Prepared for Meetings

Reviews require regular attendance and participation by all Committee 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, Committee members should gather relevant information on each case on the agenda.

8.4 Keep Regular Meeting Schedules

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

8.5 Provide an Educational Element at Committee Meetings

Keep members informed of Committee-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 Committee's operation. Periodical presentations and informative handouts enhance a Committee's ability to accomplish its objectives.

8.6 Use Existing Committees

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

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

8.7 Provide Other Members with Support

Each professional brings to the review Committee 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 Committee to function effectively. It is the responsibility of the Committee 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.

8.8 Do Not Lose Sight of the Committee's Purpose and Objectives

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

8.9 Committee Membership Is a Long Term Commitment

A review Committee 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 Committee members provides structure for achieving effective results.

8.10 Community Education and Prevention

By participating on a child abuse death review Committee, 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 Committees review and analyze information on the nature of child abuse deaths in Florida. Local Committees 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 Committees, 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.

8.11 Focus on Prevention

The key to good prevention is leadership at the local level. Review Committee 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 Committees 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 Committee 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

COMMITTEE OPERATING PROCEDURES

9.1 Information Sharing

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

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

Committees 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 Committee authorizing statute, information regarding the Committee's operation and purpose, and a copy of the Committee's interagency agreement. These requests are particularly useful for acquiring information from agencies that are not represented on the Committee. Such requests can enhance a Committee's ability to gather required medical information, especially those that deal with numerous hospitals.

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

9.2 Committee Chairperson

A Committee coordinator should be selected at the organizational meeting prior to the first review meeting. The chairperson, who can be one of the committee members, serves at the discretion of the committee. Committee's can decide to rotate the position.

Chairperson duties:

- Call and chair Committee meetings.
- Send meeting notices to Committee members.
- Obtain names and compile the summary sheet of child abuse deaths to be reviewed for distribution to Committee members two weeks prior to each meeting.
- Submit completed child abuse death review data forms with attached materials to the Department of Health, Quality Improvement Coordinator for the State CADR.
- Ensure that the Committee operates according to protocols as adapted by the Committee.
- Ensure that all new Committee members and ad hoc members sign a confidentiality agreement.
- Maintain attendance records, current roster, and bibliography of members

9.3 Member Designees and Meeting Attendance

Committee members can designate another representative of their agency to replace them at meetings they are unable to attend. Committee members must recognize the importance of regular attendance as a means of sharing the expertise and knowledge for which they were recruited. Attendance at Child Abuse Death Review meetings must be in person to ensure

maximum participation in the death review process. For confidentiality reasons, phone conferencing is not acceptable.

Local Committees should consider developing a policy such as the following to address non-attendance of Committee members:

“Committee members who have three consecutive non-attendance without notice or good reason will be subject to removal by the Committee.”

9.4 Obtaining Names for Committee Reviews

The Chairperson should work closely with the DCF district child death review coordinator and the Quality Insurance Coordinator for the State CADR to ensure notification of all verified child abuse deaths meeting the mandatory criteria for review by the Committee.

9.5 Child Abuse Death Information Distribution

The chairperson should compile and send to all review Committee members a list of child abuse deaths to be reviewed.

9.6 Record Keeping

Committee 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), Committee 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.

9.61 Record Retention

All correspondence, public records requests, letters, and communications with the State Chairperson or other Committee members must be copied to Florida Department of Health Child Abuse Death Review Coordinator.

- A. Pursuant to State of Florida Department of State Record Retention Schedule #34 the State Child Abuse Death Review Committee shall retain a permanent copy of each annual report, either electronically or written.
- B. State of Florida Department of State Record Retention Schedule #35 address copies of documents received from third parties (e.g. individuals, entities, and government agencies) by the State and Local Child Abuse Death Review Committees pursuant to the review of child abuse deaths and for the preparation of the annual incidence and causes of death report required by Section 383.402, F.S. Record copies must be maintained for a period of one year from the date of publication of the annual report. Permission must be obtained from the Florida Department of Health State Child Abuse Death Review Coordinator prior to the destruction of any record.
- C. Documents produced by the State of Local Child Abuse Death Review Committee (e.g., the data form, death summary report, or listing of records reviewed, etc.) must be maintained pursuant to State of Florida Department of State Record Retention Schedule GS1-S, item #186 for a period of two years. Permission must be obtained

from the Florida Department of Health State Child Abuse Death Review Coordinator prior to the destruction of any record.

9.7 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 database. The chairperson should review the data form, the checklist and attachments to ensure that all information is accurate and complete prior to mailing. Chairperson may start filling out the data form prior to the meeting. If the chairperson's responsibilities at the meeting prohibit their ability to accurately fill the form out, they should designate another committee member to complete the data form during the review.

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

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. The forms are located on the State Child Abuse Death Review Committee web site at www.flcadr.org.

9.8.1 Process of case reviews

The DCF Death Review Coordinator shall maintain a log of all verified deaths. The cases meeting the criteria shall be provided to the State CADR Quality Improvement Coordinator as well as the Local CADR Chairperson in their jurisdiction within 30 days of the verification.

The DCF Death Review Coordinator shall provide the Chairperson with a copy of the case(s) in a timely manner in order for the Chairperson to send meeting notice to their committee members.

After the local committee has reviewed the case, the chairperson is responsible for sending the appropriate materials, which are on the checklist, to the State CADR QI Coordinator within 30 days of the review. The checklist is located on the State Child Abuse Death Review Committee web site at www.flcadr.org.

CHAPTER 10

CONFIDENTIALITY AND ACCESS TO INFORMATION

10.1 Introduction

As provided in s. 383.412, 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. 383.412 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 Committee Coordinator.

10.2 Access to Information

The State Child Abuse Death Review Committee Coordinator and all local child abuse death review Committee 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 Committees 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 Committee 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 383.412, F.S., outlines the following regarding the state and local child abuse death review Committees:

- All information obtained by the State Child Abuse Death Review Committee or a local Committee that is confidential and exempt from public records requirements, shall retain that status.
- Confidential information provided by the State Child Abuse Death Review Committee or a local Committee 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 Committee or a local Committee that identifies names, addresses or telephone numbers or information that would identify any surviving siblings, family members, or others living in the home are confidential and exempt from public record requirements.
- All or any portion of a State Child Abuse Death Review Committee or a local Committee 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 Committee or a local Committee 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 Committee.
- Information regarding case reviews shared between the state and local child abuse death review Committees remains confidential and exempt from the public record requirements.

At a review Committee 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. A meeting where specific child abuse death information is shared is also closed to the public. However, the state Committee or a local Committee may hold periodic public meetings to discuss non-confidential information or issues. Committee 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 Committees to utilize in developing their own form. Persons who may have access to this information shall include state and local Committee chairpersons, state

and local Committee members, administrative and support staff for the state and local Committees 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 Committee shall maintain a file with signed copies of the member's confidentiality statement. Other confidentiality statements must be obtained for non-Committee member participants, as needed, on a case-by-case basis. These should be maintained in the local Committee's file.

10.5 Protecting Family Privacy

A member or consultant of a state or local child abuse death review Committee 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 Committee 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 Committee meetings shall not be taken from Committee meetings. At the conclusion of the Committee 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.