



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

**Rick Scott**  
*Governor*

**Esther Jacobo**  
*Interim Secretary*

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**MEMORANDUM**

**DATE:** Nov. 5, 2013

**TO:** Community Based Care CEOs  
DCF Regional Managing Directors  
Pete Digre, Assistant Secretary for Operations  
Stephen Pennypacker, Assistant Secretary for Programs  
Mary Cagle, Director of Children's Legal Services

**FROM:** Esther Jacobo, Interim Secretary

**SUBJECT:** Casey Family Programs Review of Child Fatalities

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Less than a week after being named Interim Secretary, I called for a thorough review of all child fatalities due to abuse and neglect in 2013 where there was prior involvement by the department. As cases were being compiled for the review, it was clear that in order to receive the most objective feedback, we would need to enlist a third party. Casey Families Programs (CFP), a privately endowed nonprofit organization and national leader in child welfare policy, agreed to conduct the review at no cost to the state. The final CFP review is attached.

The report identified many shortcomings and potential improvements to our protective investigative practice, as we expected it would. However, we recognize that we must be open about our failures in order to improve. As we review these cases in the aggregate, we cannot lose sight of the fact that each individual case represents a young life that was tragically cut short. These innocent victims should serve as our inspiration as we work to implement the recommendations in the report and improve our practices to keep children safe.

Child safety is our shared responsibility and in order to ensure that we are working together to address the findings identified in the report, I have outlined below the specific actions we will be taking in response to the 13 recommendations listed in the report.

1. I am calling on all CBC lead agencies to conduct a comprehensive gap analysis of the services available in the communities they serve with special attention to services for children with disabilities, substance abuse, mental health issues and domestic violence—key factors highlighted in the report. Following the gap analysis, I will ask each CBC to implement a process for reviewing and evaluating the effectiveness of these services to ensure they are adequate to meet the community needs and provide a return on investment for our families.

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

DCF will engage critical partners such as Healthy Families Florida, Early Learning Coalitions, the Florida Coalition Against Domestic Violence and the Florida Council Against Sexual Abuse to strengthen their outreach and service delivery.

2. The Family Functioning Assessment, which is part of the new Safety Methodology, will require Child Protective Investigators (CPI) to thoroughly analyze the protective capacities of the parent or caregiver. Training around this new tool will be ongoing as part of the phased rollout of the Safety Methodology.
3. DCF will identify additional staffing resources needed to ensure CPIs can adequately follow up on safety plans and home visits. Additionally, on Nov. 12 new safety planning tools will be launched in FSFN which will prohibit CPIs from closing safety plans without supervisor approval or the engagement of CBC services.
4. In September, DCF—with partners from across the state—launched The Safe Sleep Campaign. The Safe Sleep Campaign expands on successful programs implemented by Ft. Lauderdale Fire-Rescue and Healthy Mothers Healthy Babies of Broward County and Manatee County Sheriff's Office. The campaign provides free online continuing education training to first responders about how to identify unsafe sleep situations and take preventative measures. The campaign also encourages the public to donate new Pack 'n Plays (portable cribs) to designated fire, emergency and law enforcement stations. The cribs will be distributed by Healthy Start Coalitions. I have directed staff in each of the DCF regions to promote the campaign to increase awareness around safe sleep practices for infants and toddlers.
5. DCF is continuing with the implementation of an automatic alert function in FSFN so CPIs are directed to take extra precautions in cases where the key risk factors as identified in this report are present.
6. DCF will incorporate into its Child Welfare Operating Procedures a requirement that supervisors must approve all safety plans within 24 hours and support this new requirement with integrated FSFN alerts. This will further enhance the new safety planning model being launched later this month.
7. DCF Regional Managing Directors will implement the Rapid Safety Feedback protocol for all high-risk cases and continue to train CPI supervisors and management staff on the ChildStat approach to increase child safety. Rapid Safety Feedback is currently being used in the Suncoast Region and is designed to flag key risk factors in open child welfare cases that could gravely impact a child's safety. ChildStat is a data-driven, systemic leadership initiative that will use specific indicators and randomly selected cases to engage regional and statewide leadership in dialogue and team problem-solving about urgent issues impacting frontline practice and the child protection system as a whole.
8. DCF will incorporate internal dispute resolution staffing into standard operating procedures to ensure we are questioning one another's observations and conclusions in

order to make the best decisions for at-risk children who come into our care.

9. DCF is developing a data analysis system with the goal of identifying trends and predictive patterns that can inform future practice by CPIs and case management.
10. DCF currently conducts staffings when we are informed that a mother whose parental rights have been terminated has a new baby. A CPI will visit and determine if the new baby is safe. However, DCF is often not aware when a mother whose parental rights have been terminated gives birth to a new child. In Michigan, the vital statistics file for births is periodically matched with the child welfare TPR file to identify births to these mothers, and a CPI is dispatched to determine whether the mother has the capacity to adequately protect her newborn. This practice will help assure the safety of newborns to parents with TPRs. DCF will investigate how Florida can implement this model and whether legislative action will be required to implement it.
11. DCF will develop a protocol for protecting siblings and other children in a household following a suspected child maltreatment fatality.
12. In two recent cases, DCF conducted multiagency reviews to analyze the action or inaction of agencies involved prior to the child's death. DCF will make this a standard practice following a fatality whenever multiple state or local agencies are involved. The Legislature can also consider codifying a policy that agencies involved are required to participate in this review.
13. DCF and our CBC lead agency partners will make training on the new Safety Methodology a continuous process in order to ensure fidelity to the model as it is implemented throughout the state. DCF will continue with the current training schedule and expand those efforts to include additional staff and stakeholders.



## **Casey Family Programs**

# **Review of Child Fatalities Reported to the Florida Department of Children and Families**

**October, 2013**

## **Review of Child Fatalities Reported to the Florida Department of Children and Families**

### **I. INTRODUCTION**

The Florida Department of Children and Families (DCF) requested that Casey Family Programs (CFP) review summaries of recent child fatalities completed by DCF Quality Assurance (QA) staff. These child deaths constitute slightly more than a third of reports of child fatalities possibly related to child maltreatment received by DCF during the first seven months of 2013.

The purpose of CFP review of these child fatalities is to provide DCF leadership with feedback on Florida child protection practices described in these summaries, and to offer recommendations regarding policies and practices that can potentially reduce future child maltreatment deaths.

The only information regarding these child deaths available to CFP staff who conducted the review was contained in the QA child fatality review summaries. These summaries vary greatly in the amount and quality of information regarding the incident in which a child died and the family's CPS case history.

The QA summaries provided factual information regarding the circumstances and events that led to child deaths, as well as brief accounts of prior CPS reports/ investigations. The QA reviewers used the following child fatality summary format:

- Circumstances surrounding death
- Status of child death Investigation
- Actions taken to insure the safety of surviving siblings
- Summary of prior investigations
- Analysis of prior investigation/ service history for the previous two years
- Thoroughness in use of prior history in determining safe or unsafe children
- Criminal history was appropriately considered during the assessment of parental protective capacities
- Thoroughness of the assessment for legal sufficiency
- Summary of appropriateness of safety plan
- Proper identification of services
- Consultation with Child Protection Team (CPT) or Children's Legal Services (CLS)
- Engagement of law enforcement
- Use of multidisciplinary team staffing
- Case transfer practices from investigations to services
- Follow-up on referrals to services/services engagement by families
- Overall analysis of essential principles of practice to ensure child safety

In many of the summaries, QA reviewers applied the conceptual framework from the new Florida Safety Methodology to Child Protection Investigator (CPI) and Case Manager (CM) case

practice, decision-making and actions to evaluate what could have and should have been done to protect children compared to what actually occurred.

CFP reviewers had no information regarding the context of CPS investigations in these cases, such as the workloads and experience levels of the CPIs and CMs. CFP also had no information regarding the extent of inter-agency communication and information sharing and the availability of resources and services at the time of CPS investigations. These are often key issues that influence child protection practice. Therefore, the practice challenges described in this report should be tempered by the understanding that these contextual factors may have made it difficult for CPIs and CMs to engage in other, possibly more effective, child protection practices.

In several QA summaries, DCF reviewers demonstrated an excellent understanding of the new DCF Safety Methodology and made a compelling case that CPIs and CMs failed to take into account safety threats or to develop and implement safety plans based on guidelines in the Safety Methodology. However, nearly all CPIs and all CMs (with the possible exception of CPI staff in one or two pilot counties) had not been trained in the use of the Safety Methodology at the time of these child deaths. The same caveat applies to CPI actions in most prior CPS investigations critically analyzed in the QA summaries and in this review.

## **II. THE CHILD FATALITY REVIEW SAMPLE**

The 40 child fatality summaries in the sample reviewed by CFP were selected by DCF managers. These managers stated that they purposely chose cases with complex dynamics whose analysis would provide the most opportunity for organizational learning. Cases were selected according to the following criteria:

- cases with prior investigations that may or may not have been factored into casework practice following a child fatality
- case information that indicated the need for expert consultation (medical, domestic violence, substance abuse, law enforcement ).
- cases that included safety plans
- cases that involved referrals to services
- cases in which internal resources - supervisors, managers, legal services – were engaged

DCF managers appeared to select a sample of cases with significant DCF case histories and multiple risk factors for CFP review.

It is uncertain whether the cases reviewed by CFP are representative of suspected child maltreatment deaths in Florida. However, these child deaths reflect trends commonly identified in studies of child maltreatment deaths. Infants, aged 0-1, comprised 55% of the sample and 90% of deceased children were less than 5 years of age at the time of their death. Parental substance abuse, chronic mental health problems and domestic violence were common in families of children who died due to suspected maltreatment.

Most of the cases selected for CFP review had prior investigated CPS reports within 2-3 years prior to the child's death, and a few of the families of deceased children had been reported to DCF within a few days or weeks prior to a child's death. In some cases, parents received services from a case management agency prior to or at the time of the fatality. Some of these child deaths were still being investigated by law enforcement and DCF authorities at the time the summaries were completed by QA staff, and in a number of cases, the cause of a child's death had not been determined.

Therefore, this review is not strictly speaking a review of child maltreatment deaths as officially determined by DCF or law enforcement agencies. Rather, it is a review of child fatalities in which the child's family had at some point been investigated by DCF, and which were suspected at the time the child's death was reported to the DCF child abuse hotline to have been due to child maltreatment.

### III. FINDINGS

#### A. Causes of Child Deaths

##### *Finding #1*

*Asphyxia due to unsafe sleeping arrangement and practices was the most common cause of death in the sample. Co- sleeping of a parent or parents and a child was frequently involved in these deaths, but some children died after being placed face down on mattresses, or placed in cribs with pillows, comforters and other soft objects.*

*Several children died from drowning or from physical abuse. A few children died in unusual ways, for example, from gunshot wounds inflicted by a sibling, or from being placed overnight in restraints by residential care staff, or from a drug overdose.*

##### **Asphyxia**

The most common cause of death for children in the sample was asphyxia, suffocation of an infant by an adult or, in two instances, by an older sibling sleeping in the same bed or on a sofa. Almost a third of children in this sample died in co- sleeping incidents. Children who died in co-sleeping incidents, or who were sleeping alone in beds or cribs, were often placed face down on a mattress or couch with pillows, blankets and other items that violated safe sleeping guidelines developed by the American Academy of Pediatrics.

Most of the parents or caregivers in these “roll-over” deaths had histories of substance abuse and/or tested positive for drugs following the child death. In addition, many of these families had been reported to CPS in the past 2-3 years for Threat of Harm to children associated with domestic violence incidents. Very few of the parents with substance abuse issues involved in these deaths and in those resulting from other causes, appeared to be in recovery, or even enrolled in treatment programs. Most of the parental substance abuse associated with child deaths was not relapse-related; rather parents with ongoing substance abuse issues, and often family violence, were attempting to raise babies and other young children.

The most common safety action previously taken by CPIs or CMs with parents of infants who subsequently died in “roll- over” deaths or in other unsafe sleep arrangements was to provide the mother (but often not the father) with information regarding the danger of co-sleeping and to elicit from the mother a written and/or verbal promise not to engage in co-sleeping with her infant. Nevertheless, mothers, fathers and boyfriends frequently ignored professional advice, or broke their promises, regarding co-sleeping. Giving information regarding co-sleeping (once) to drug addicted parents, or to substance abusing parents not established in a recovery process, and having these parents sign agreements to refrain from co-sleeping with infants, is a highly risky and questionable basis for safety planning.

##### **Drowning**

This sample included five children who drowned in bath tubs, swimming pools or ponds. Two of these young children were diagnosed with autism. The lack of functioning safety locks on doors or gates, or fences around pools stands out in the drowning cases. However, egregious lack of adult supervision was also a factor in some of these child deaths. One young child who drowned lived with parents who had been previously reported to CPS for a wide range of neglect related concerns, including lack of supervision, as well as for sibling sexual contact.

##### **Physical Abuse**

At least five children in the sample died due to physical abuse. A few other children whose cause of death had not yet been determined were suspicious for physical abuse given the child’s age, circumstances of the child’s death and a parent’s comments or past behavior which suggested underlying hostility toward the child. Histories of domestic violence were present in all of the child deaths resulting from physical abuse, along with substance abuse in most of the families. In all but one case, children were killed by their fathers or by their

mothers' paramours. One child's death may have been caused by physical abuse perpetrated by both the mother and her paramour.

Several of these families had prior histories of CPS reports alleging both physical abuse and neglect. The safety and risk issues indicated by credible reports of multiple types of child maltreatment in the same family were rarely, if ever, noted by either CPIs or QA reviewers. The children in these families lived in a "sea of risk" which created difficult challenges for CPIs and service providers given the difficulty in anticipating how these multiple risk factors might eventually endanger children.

### **Other Causes of Death**

One child was shot by a sibling with a gun left in a car. A disabled child died after being placed overnight in restraints by residential care staff. One young child was shot by her mother who then committed suicide. A teenager died of a probable drug overdose while living with a mother and siblings, all of whom were abusing the parent's prescription drugs. The common factor in most of these deaths was the failure of caregivers to take prudent precautions.

## **B. Child Vulnerability**

### ***Finding #2***

*The vulnerability of infants, other young children and disabled children who died was greatly increased in families with multiple risk factors, including combinations of substance abuse, mental health conditions, family violence, criminal histories and several prior CPS reports. Multiple risks in families created difficult challenges for CPIs who were often unable to anticipate which specific risk factor would develop into a clearly identifiable safety threat.*

Children who appear to be unusually vulnerable to severe child maltreatment in this sample included:

- infants, especially those born to mothers with histories of substance abuse
- disabled children who required unusual levels of parental attention and care, for example children with autism or children with chronic and demanding physical health problems;
- children living with parents who had been reported for multiple types of child maltreatment; and
- children whose parent or parents were hostile or rejecting toward them, for whatever reason.

In a number of cases, prior CPS investigations had focused on specific safety threats indicated by a particular incident only to have a child in the family, often the youngest child, die of other causes. In families with multiple risk factors, including several CPS reports and investigations, children were vulnerable in a variety of unpredictable ways, independent of specific safety threats.

## **C. Safety Assessment**

### ***Finding #3***

*Assessments of safety during previous CPS investigations of families of children who subsequently died were usually narrowly focused on the reported allegations in the most recent report. These safety assessments often did not appear to consider the family's prior CPS history or to explore domestic violence, substance abuse and other family dynamics which increase risk to vulnerable children.*

In many of the QA summaries, reviewers were critical of the CPI's safety assessments and safety plans (or lack of safety plans) both preceding and following a child death. One reviewer made the following comments which apply to a number of the sample cases:

*"While the cause of the child's death was not related to any of the ... prior child protection activities with this family, these prior investigations provided ample opportunity for assessment and services to be*



*brought into the home which may ultimately have prevented this child's death. Domestic violence and substance abuse dynamics were woefully underexplored. ... The overall thoroughness of the investigations leading up to the child's death is highly questionable."*

Investigations of CPS reports prior to a child's death were often narrowly focused on alleged incidents of abuse or neglect. If a CPS report on a family alleged Threat of Harm associated with domestic violence, CPIs usually appeared to be solely concerned with domestic violence issues while not addressing substance abuse or other safety threats or risk factors. A number of babies in these families later died from asphyxia resulting from co-sleeping with parents under the influence of drugs or alcohol.

Safety assessments and safety plans were often directed at preventing specific types of events which had endangered children from re-occurring, for example driving a car under the influence of drugs or alcohol with children in the car. Safety and risk assessments rarely demonstrated an appreciation of the wide range of safety and risk issues associated with substance abuse, chronic mental health problems and family violence.

In a number of cases, QA reviewers commented that histories of child maltreatment, as reflected in multiple prior reports and CPS investigations, had not been taken into account or given the weight they deserved when assessing the child's safety. For example, a QA reviewer stated about a case with 10 prior CPS reports that:

*"...overall, the relevance of prior history was not taken into full account during this investigation", and as a consequence "All of the unresolved issues ... point to the family's likely need for ongoing services and ongoing safety management" which were not provided."*

In a case in which a 3 year old child died as a result of physical abuse, there was an open CPS investigation at the time of death, a history of prior injury to the child, a recent unexplained injury to the child that required stitches, criminal history of a caregiver that included assaults, ongoing domestic violence and a caregiver who protected the perpetrator of family violence. The QA summary states that there was enough information to warrant a staffing with CLS to determine legal sufficiency for filing a dependency petition, and that *"the safety action was not sufficient."*

In another case that involved a 2 month old child who died of Shaken Baby Syndrome, the family had an extensive CPS history in another state that included the removal of three older children from the home. A CPS investigation in Florida was closed six weeks prior to the infant's death. The QA summary notes that:

*"It does not appear the prior history of this mother was thoroughly used" and the QA reviewer added "The prior history of families' needs to be taken into account when completing assessments ... and not solely looking at the isolated incident of the case."*

A history of multiple CPS reports was sometimes minimized even when children in the family had suffered extreme harm. In one case with 37 prior CPS reports, a 3 year old child had almost died from severe malnutrition when she was a baby, and the parents had attempted to trade another of their children for housing. According to the QA reviewer, *"it does not appear that these (priors) were taken into account in this investigation."*

In many of the QA summaries, it is difficult to ascertain whether parents demonstrated "protective capacities" that led the CPI to conclude that children would be safe in homes with multiple risk factors, or whether CPIs were more influenced by other types of information in making their safety determinations. In cases involving substance abuse and domestic violence, the QA summaries rarely identify behaviors demonstrated by the parents or other caregivers during the investigation that might have convinced a CPI that a child or sibling group would be safe in the home.

## **D. Safety Planning**

### ***Finding #4***

*In many CPS investigations prior to a child's death, an in-home safety plan appeared to be clearly warranted. However, no safety plans were developed in a number of these cases. Completed safety plans were usually not adequate to control safety threats to children in that they were inadequately resourced and highly dependent on parents' promises. In most cases, CPIs did not follow up on safety plans to assess their effectiveness.*

### ***Finding #5***

*In some cases, the CPI did not adequately assess or address the safety of other children in the household following a suspicious child death. Assessment and decision making processes regarding sibling safety appeared highly variable and unstructured.*

Many cases lacked in-home safety plans either during investigations prior to a child's death, or following a child's death when there were surviving siblings. In-home safety plans were used infrequently during investigations which occurred prior to a child's death, possibly because CPIs viewed children as safe despite multiple risk factors, or because of the narrow focus on specific incidents as noted above, or possibly because of a lack of confidence in safety plans.

When in-home safety plans were documented, the plans were sometimes general and non-specific (e.g., "the parent will keep the child safe and meet all of the child's needs") or promissory, i.e., parents or caregivers promised to refrain from specific actions such as co-sleeping or driving under the influence of drugs and alcohol. With few exceptions, in-home safety plans did not utilize resources or safety management services such as child care, respite care, safety networks, poverty-related services or home visitors. As a consequence, most in-home safety plans were incommensurate with the safety threats they attempted to control or ameliorate.

However, the single most questionable practice in the use of in-home safety plans was the lack of follow-up by CPIs to evaluate child safety and to assess whether parents were keeping their promises. CFP reviewers found only one QA summary that praised a CPI for conscientious follow-up on a safety plan. Another contained positive comments regarding a CPI's follow up on a service plan.

A few of the parents of deceased children appeared to have been active partners in prior safety planning, but in many cases, the motivation and capacity of parents to protect their children was unclear or clearly lacking.

### **Parental Hostility towards the Child**

No in-home plan could have possibly protected a small number of children in the sample due to their parent's hostility or possible homicidal intent. One young child died from unknown causes during the third overnight visit with the mother during a reunification process. The QA summary states that the mother had attempted to suffocate the child with a pillow in 2011 prior to the child's removal from the home. The QA summary goes on to say that this incident had not been "verified" at the time, but that it was highly likely to have actually occurred, based on a relative's account.

Medical experts stated that this child may have been dead for 10-15 hours before the mother contacted the authorities. What may have been the attempted murder of this child in 2011 was disregarded because the child, less than 3 years old at the time of the attempted suffocation, did not "disclose" that the incident had occurred during a CPT forensic interview.

In another case, a mother had made it widely known that she did not want to raise a child with a serious disability. The parents' disabled child (with a cleft palate) died from unknown causes soon thereafter. The QA summary states that "*there is a general consensus that (the mother) was responsible for the child's death.*"

## **Surviving Siblings**

When children died as a result of physical abuse, their surviving siblings were sometimes legally “sheltered” or allowed to be temporarily placed with a relative absent legal action. Siblings of a deceased child were also legally removed from the home or (more often) in a few instances following co-sleeping or drowning deaths, were allowed to stay temporarily with relatives through parents’ voluntary agreement.

In one case involving the possible homicide of a 15 year-old with a six-year old surviving sibling, there had been six prior CPS reports with allegations of physical injuries including bruises, welts, cuts, punctures, and bites, as well as family violence. All allegations had been ‘unverified’. The mother’s paramour, who was in the home at the time of the death, was listed on the Florida Department of Law Enforcement’s Career Offender website as a Habitual Violent Felony Offender. However, it appears that the CPI did not meet with the mother or the six-year-old surviving sibling for over eight days following the older child’s death. There was no indication that child safety was assessed or that services were discussed or implemented for the mother or the surviving sibling. A report was received 16 days after the death that the mother had absconded with her younger child. A CPT and CLS were involved in this case, but the case notes are unclear regarding what decisions were made or what actions were taken following these consultations.

The QA summaries often are unclear as to whether or how long surviving siblings remained out of the parent’s home in these cases. However, surviving siblings usually remained living with parents (sometimes in the home of a relative) following child deaths, often without a safety plan or services.

## **Legal Consultation**

It should be noted that CPIs and their supervisors were often in contact with CLS following a child death. Decisions regarding whether to file legal action were (at the least) greatly influenced, or possibly determined, by the CLS attorney’s opinion regarding legal sufficiency. In one chronic neglect case in which a child died from drowning 3 months after the close of a CPS investigation, CLS approved a DCF request to “shelter” the children in the family, only to then insist that non-judicial voluntary services be tried before proceeding with legal action. .

In some cases, CLS and/or courts were resistant to legally sheltering babies born to mothers with a long and severe history of substance abuse. Some mothers whose babies died in co-sleeping incidents had older children legally placed in kin or non-kin foster care due to substance abuse and child maltreatment at the time of their infant’s death. It appears that the safety threats to infants resulting from a long and severe history of maternal substance abuse were sometimes minimized by CPI and CLS staff and courts.

### **E. Role of the Supervisor**

#### ***Finding #6***

*The role the CPI supervisor played in consulting on and approving safety assessments and safety plans in prior CPS investigations of families with a subsequent child death was unclear.*

Information in the QA summaries indicates that DCF has developed a variety of formats for review of CPI decisions, including Child Protection Team (CPT) staffing, other multi-disciplinary staffings, second level management reviews and consultation with CLS. However, the role of supervisors in guiding and assisting CPIs in CPS investigations and in approving safety plans was unclear in many of these summaries. It was usually difficult for CFP reviewers to ascertain whether supervisors agreed with case decisions or were responsible for decisions to close cases.

### **F. New Florida Safety Methodology**

#### ***Finding #7***

*The new Florida Safety Methodology that DCF is in the process of developing appears well designed to address many of the problematic child protection practices identified in this review. It requires that CPIs*

*conduct a comprehensive assessment of safety, risk and family functioning during CPS investigations. However, since full statewide implementation of the model may take two to three years, it is critical that new and existing DCF, CBC, case management and legal staff receive safety assessment and safety planning training in the interim.*

*The new Safety Methodology has the potential to reduce the number of future child maltreatment fatality tragedies. However, there are formidable challenges to protecting endangered children through in-home safety plans. An effective safety practice model requires the availability of safety management services and resources to strengthen safety plans, and CPIs and case managers who have the time and are highly mobilized to thoroughly implement and follow up on safety plans.*

Implementation of the recommendations in Casey Family Program's September, 2013 "Review of Florida Safety Methodology and Front-End Assessment Tools", especially the recommendations to give added emphasis to risk, rethink the model's approach to child vulnerability and require frequent follow-up on in-home safety plans will strengthen the model's ability to improve child protection practice.

#### **IV. RECOMMENDATIONS**

CFP reviewers believe that implementation of the following recommendations will improve the safety of children with open child welfare cases and could reduce the number of future child maltreatment fatalities:

1. Develop a comprehensive array of resources and safety management services, such as child care, respite care, safety network facilitators, public health home visitors, parent mentors and poverty related services that can "power up" in-home safety plans in all areas of the state.
2. Emphasize in Florida Safety Methodology policy and training that in-home safety plans cannot be effective in cases with parents who are hostile to or rejecting of their children due to a child's disabilities or for other reasons.
3. Ensure that CPIs, case managers and other involved professionals have the time and willingness to be actively involved in the implementation of in-home safety plans through frequent home visits, case staffings and mobilization of all available resources. "Touch lightly" information oriented safety plans, or promissory plans, are unlikely to be effective for children in present or impending danger or for children living in high risk families.
4. Develop a new more comprehensive programmatic response to co-sleeping and other unsafe sleeping practices. Ideally, public health nurses, or parent mentors, would be available to make regular and frequent home visits during at-risk infants' first 3-4 months of life to remind parents of safe sleep guidelines and help parents with a wide range of child care challenges. .
5. Develop an automated way of flagging families cases with prior CPS investigations based on explicit criteria such as age of child(ren), numbers of CPS reports within a certain timeframe and information regarding alleged parental substance abuse, mental health problems and/ or domestic violence. These cases should receive a heightened review at the beginning of the investigation and at case closure, especially if the case is to be closed without case management and/or other services. Review teams should have the authority to require additional investigative activities or referral to case management services.
6. Clarify the responsibility of supervisors to approve all safety plans, in-home and out-of-home, within 24 hours of a written agreement with the parent, or law enforcement action, or court order (at the latest).

7. Train supervisors in clinical supervision skills that develops their ability to elicit information from their CPIs regarding risk and safety issues, to guide their CPIs in assessment and safety planning in a way that transcends tools and practice and policy guidelines, and to recognize biases (such as confirmation bias) that influence CPI decision making.
8. Develop policy that requires that in cases where CPIs, supervisors and middle managers disagree with CLS's refusal to file legal action on behalf of endangered children, both DCF and CLS managers meet promptly to resolve the dispute.
9. DCF QA should implement a prevention-focused maltreatment fatality/ near fatality review process to collect, aggregate and analyze statewide data in order to identify patterns and common factors in these cases. Priority should be given to determining contextual factors which influenced how CPIs and supervisors responded to both child fatalities and "near misses" and to developing policy and practice recommendations to reduce child fatalities and serious injuries in the future.
10. DCF QA managers should meet periodically with public health officials to discuss possible child fatality prevention strategies that can be implemented regionally and across the state.
11. Develop and implement a policy that mandates a structured assessment and decision making process regarding the safety of siblings and other children in a household following a suspected child maltreatment fatality.
12. Following child maltreatment fatalities, DCF should utilize multi-agency staffings to analyze the roles and actions of each agency prior to the death, the response to the family's needs and to perceived safety threats, to ensure that the response going forward is adequate to meet the needs of the surviving children, and to make recommendations to agency leadership and community stakeholders regarding coordination and service improvement.
13. Since it will take two to three years to fully implement the new Florida Safety Methodology statewide, provide ongoing training and coaching for new and existing CPI, CLS, and case management staff and court staff on safety assessment and safety planning.

## **V. CONCLUSION**

DCF is in the process of developing and implementing a safety practice model that involves a strong focus on safety assessment and safety planning. The child fatality cases in this sample demonstrate the severity of risk and safety issues in many families with accepted CPS reports and the formidable challenges involved in effective utilization of in-home safety plans. The new Florida Safety Methodology is a systematic approach to addressing these challenges.

However, the effectiveness of the model in protecting children is likely to depend largely on contextual factors such as CPI and CM workloads, the capacity of DCF to retain experienced staff, quality of supervision and community resources that can be used to support safety and service plans. The ability of child protection investigators to apply critical thinking skills to issues of safety and risk is especially important.

The importance of carefully evaluating the effectiveness of the safety practice model in accurately and consistently assessing danger to children and guiding the development of safety plans during the early phases of implementation cannot be stressed too strongly. In addition, opportunities for CPIs and CMs to learn from their experiences with safety planning, and for organizational learning regarding the characteristics of effective in-home safety plans should be maximized.