Family Partnerships of Central Florida
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# PROCEDURE

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| **Series:** | **Operating Procedures** **COA: RPM 2** **CFOP: 215.6** |
| **Procedure Name:** | Critical Incident Reporting and Analysis System (IRAS) and the Critical Incident Rapid Response Team (CIRRT) |
| **Procedure Number:** | OP-1144 |
| **Reviewed Date:** | 01/08/13, 06/30/16, 4/16/24, 9/29/2025 |
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| **Effective Date:** | 04/05/12 |
| **Applicable to:** | All Family Partnerships of Central Florida Staff and Subcontracted Providers |
| PURPOSE: | This operating procedure establishes the guidelines for reporting and analyzing critical incidents as defined below. The analysis of incidents should be considered part of the overall risk management program and quality improvement process of Family Partnerships of Central Florida (FPOCF), its employees, and its licensed and contracted service providers. |

PROCEDURE:

**References**

Florida Statutes: Chapters 458, 459, 464
FPOCF Policies/Procedures: GOV202, GOV203, RQ502, RQ506, OP1181

**Scope**

A. This operating procedure applies to all critical incidents occurring within any FPOCF program or involving a FPOCF employee or involving a licensed or contracted provider serving clients of the FPOCF or involving an employee of a licensed or contracted provider serving clients of the FPOCF.

B. The Incident Reporting and Analysis System (IRAS) is a DCF system that allows for the timely notification to the department of critical incidents, provision of details of the critical incident, immediate actions taken and the ability to track and analyze critical incident related data.

C. The IRAS is not a case management system and cannot be utilized to capture ongoing and specific case management information, such as the progression of events and actions.

D. The incident reporting procedure does not replace:

1) The mandatory reporting requirements to the Florida Abuse Hotline for abuse, neglect, and exploitation reporting protocols, as required by law. Allegations of abuse, neglect, or exploitation must always be reported immediately to the Florida Abuse Hotline.

2) The investigation and review requirements provided for in CFOP 175-17, Child Fatality Review Procedures.

3) The reporting requirements provided in CFOP 175-85, Prevention, Reporting and Services to Missing Children.

4) The reporting requirements provided for in CFOP 180-4, Mandatory Reporting Requirements to the Office of the Inspector General.

It is the responsibility of all FPOCF personnel to promptly report all critical incidents to the FPOCF Incident Report Manager using the CIR function of Mindshare by 12:00 pm of the next business day after the incident.

It is the responsibility of all subcontracted providers to promptly report all critical incidents to the Case Management Agency first by phone and using the attached CIR form. and the CIR form will be emailed to the Case Management Agency as soon as possible and no later than 12:00 pm on the next business day of the incident. It is the Case Management Agency's responsibility to enter the CIR into the CIR function of Mindshare.

If the critical incident is being reported by a Licensing Specialist, the CIR shall also be submitted to the FPOCF Director of Licensing and Kinship at the same time as the FPOCF Incident Report Manager. The FPOCF Incident Report Manager will enter the CIR into IRAS within one (1) business day of the incident. Failure by Family Partnerships of Central Florida employees to comply with this operating procedure may lead to disciplinary action. Failure by a contracted provider to comply with this operating procedure constitutes a lack of compliance with contract service provisions.

**Definitions**

A. Abuse - Any willful or threatened act or omission that causes or is likely to cause significant impairment to a child or vulnerable adult's physical, mental, or emotional health.

B. Family Partnerships of Central Florida - Family Partnerships of Central Florida.

C. Department - The Department of Children and Families.

D. Hospital - A facility licensed under Chapter 395, Florida Statues (F.S.). This includes facilities licensed as specialty hospitals under Chapter 395, F.S.

E. Incident Report Manager - The designated Family Partnerships of Central Florida staff whose role is to add and update the incidents, create, and send initial and updated notifications, and change the status of the incident.

F. Neglect - The failure or omission on the part of the caregiver to provide the care, supervision, and services necessary to maintain the physical and mental health of a child or vulnerable adult; or the failure of a caregiver to make reasonable efforts

to protect a child or vulnerable adult from abuse, neglect, or exploitation by others.

G. Restraint - Any manual method or physical or mechanical device, materials, or equipment attached or adjacent to the individual's body so that he or she cannot easily remove the restraint, and which restricts freedom of movement or normal access to one's body.

H. Seclusion -The physical segregation of a person in any fashion, or involuntary isolation of a person in a room or area from which the person is prevented from leaving. The prevention may be by physical barrier or by a staff member who is acting in a manner, or who is physically situated, to prevent the person from leaving the room or area.

I. Treatment Facility - Any state-owned, state-operated, or state-supported hospital, center, or clinic designated by the Department for extended treatment and hospitalization, beyond that provided for by a receiving facility, of persons who have a mental illness. This includes public facilities and any private facility designated by the Department when rendering such services to a person.

## Critical Incidents to Be Reported

A. Altercation - A physical confrontation occurring between a client and employee or two more clients at the time services are being rendered or when a client is in the physical custody of Family Partnerships of Central Florida, which results in one or more clients or employees receiving medical treatment by a licensed health care professional.

B. Child-on-Child Sexual Abuse - Any sexual behavior between children which occurs without consent, without equality, or as a result of coercion. This applies only to children receiving services from the Department or by a licensed contract provider, e.g., children in foster care placements, residential treatment.

C. Child Arrest - The arrest of a child in the custody of the Department.

D. Child Death - (Immediate Notification to respective agency Executive, and President and Chief Executive Officer or designee. Child deaths are not entered into IRAS by the FPOCF Incident Report Manager. An individual less than 18 years of age whose life terminates while receiving services or when a death review is required pursuant to CFOP 175-17, Child Fatality Review Procedures. The manner of death is the classification of categories used to define whether a death is from intentional causes, unintentional causes, natural causes, or undetermined causes. If a child's death involves a suspected overdose from alcohol and/or drugs or seclusion and/or restraint, additional information about the death will need to be reported in IRAS. The final classification of a child's death is determined by the medical examiner, however, in the interim, the manner of death will be reported as one of the following:

1. Accident – A death due to the unintended actions of oneself or another.

2. Homicide - A death due to the deliberate actions of another.
3. Natural Expected - A death that occurs as a result of, or from complications of a diagnosed illness for which the prognosis is terminal.
4. Natural Unexpected - A sudden death that was not anticipated and is attributed to an underlying disease either known or unknown prior to death.
5. Suicide - The intentional and voluntary taking of one's own life.
6. Undetermined – The manner of death has not yet been determined.
7. Unknown – The manner of death was not identified or made known.

E. Adult Death - **(Immediate Notification to respective agency leadership, President and Chief Executive Officer or designee.** An individual 18 years old or older whose life terminates while receiving services. The manner of death is the classification of categories used to define whether a death is from intentional causes, unintentional causes, natural causes, or undetermined causes. If an adult's death involves a suspected overdose from alcohol and/or drugs, or seclusion and/or restraint, additional information about the death will need to be reported in IRAS. The final classification of an adult's death is determined by the medical examiner, however, in the interim, the manner of death will be reported as one of the following:

1. Accident -A death due to the unintended actions of oneself or another.
2. Homicide- A death due to the deliberate actions of another.
3. Suicide- The intentional and voluntary taking of one's own life.
4. Undetermined - The manner of death has not yet been determined.
5. Unknown- The manner of death was not identified or made known.

F. Serious injury, or serious illness of a child - **(Immediate Notification to respective agency leadership and President and Chief Executive Officer or designee)** - A medical condition of a client requiring medical treatment by a licensed health care professional sustained or allegedly sustained due to an accident, act of abuse, neglect or other incident occurring while in the presence of an employee, in a FPOCF subcontracted facility or service center.

G. Elopement – The unauthorized absence of any individual in a department contracted or licensed residential substance abuse and/or mental health program.

H. Escape – The unauthorized absence of a client who is committed by the court to a state mental health treatment facility pursuant to Chapter 916 or Chapter 394, Part V, FL Statutes.

I. Missing Child - When the whereabouts of a child is under the supervision of FPOCF are unknown and attempts to locate the child have been unsuccessful.

J. Abuse/ Neglect/ Abandonment/ Threat of Harm -A founded occurrence of abuse, neglect, or abandonment by a FPOCF employee or subcontracted provider on a client, or client on a FPOCF employee or subcontracted provider as evidenced by medical evidence, law enforcement involvement or DCF investigation.

K. Employee Arrest - **(Immediate Notification to President and Chief Executive Officer or designee)** The arrest of an employee of FPOCF or its contracted or licensed service provider for a civil or criminal offense.

L. Employee Misconduct - **(Immediate Notification to President and Chief Executive Officer or designee)** Work- related conduct or activity of an employee of FPOCF or its contracted or licensed service provider that results in potential liability for FPOCF; death or harm to a client, abuse, neglect, or exploitation of a client; or results in a violation of statute, rule, regulation, or policy. This includes, but is not limited to, misuse of position or state property; falsification of records; failure to report suspected abuse or neglect; contract mismanagement; or improper commitment or expenditure of state funds.

M. Security Incident Unintentional - An unintentional action or event that results in compromised data confidentiality, a danger to the physical safety of personnel, property, or technology resources; misuse of state property or technology resources; and/or denial of use of property or technology resources. This excludes instances of compromised client information.

N. Significant Injury to Clients - Any severe body trauma received by a client in a treatment/service program that requires immediate medical or surgical evaluation or treatment in a hospital emergency department to prevent permanent damage or loss of life.

O. Significant Injury to Staff - Any severe body trauma received by a FPOCF employee as a result of a work-related activity that requires immediate medical or surgical evaluation or treatment in a hospital emergency department to prevent permanent damage or loss of life.

P. Sexual Abuse/Sexual Battery. – (Immediate Notification to President and Chief Executive Officer or designee)

Any unsolicited or non-consensual activity by one client to another client, a FPOCF or service provider employee or other individual to a client, or a client to an employee regardless of the consent of the client. This may include sexual battery as defined in Chapter 794 of the Florida Statutes as "oral, anal or vaginal penetration by, or union with, the sexual organ of another or the anal or vaginal penetration of another by any other object; however, sexual battery does not

include an act done for a bona fide medical purpose." This includes any unsolicited or non-consensual sexual battery by one client to another client, DCF or service provider employee or other individual to a client, or a client to an employee regardless of the consent of the client.

Q. Suicide Attempt - A potentially lethal act which reflects an attempt by an individual to cause his or her own death as determined by a licensed mental health professional or other licensed healthcare professional.

R. Threat to Employee – Any potential threat to an employee that is communicated verbally, written, or implied. This could include the threat of physical harm, harassment or revenge, or anything else that makes an employee feel unsafe due to the actions or words of another person in the course of their job duties.

S. Potential Media Coverage - (Immediate Notification to President and Chief Executive Officer or designee). Any incident that may result in negative media coverage, including law enforcement being summoned to any FPOCF site, licensed placement, or home where case management services are being delivered.

T. Other - Any major event not previously identified as a reportable critical incident but has or is likely to have a significant impact on client(s), FPOCF, or its provider(s). These events may include, but are not limited to:

1) Human acts that jeopardize the health, safety, or welfare of clients such as kidnapping, riot, or hostage situation.

2) Bomb or biological/chemical threat of harm to personnel or property involving an explosive device or biological/chemical agent received in person, by telephone, in writing, via mail, electronically, or otherwise.

3) Theft, vandalism, damage, fire, sabotage, or destruction of state or private property of significant value or importance. This may include instances when a foster child steals a foster parent's vehicle or intentionally damages the home.

4) Death or significant injury of an employee or visitor while on the grounds of FPOCF or one of its contracted or licensed providers.

5) Significant Injury of a visitor (who is not a client) while on the grounds of any FPOCF.

6) Instances when the court makes a decision contrary to Case Management recommendation.

**Guidelines for Reporting Incidents**

A. Notification/Reporting and Actions Taken -Staff Discovery of an Incident

1) Any employee of FPOCF, or one of its subcontracted or licensed providers, who discovers that a reportable critical incident, as described herein, has occurred, will report the incident as outlined in this operating procedure.

2) The employee's first obligation is to ensure the health, safety, and welfare of all individuals involved.

3) The employee must immediately ensure contacts are made for assistance as dictated by the needs of the individuals involved. These types of contact may include but are not limited to emergency medical services (911), law enforcement, or the fire department. When the incident involves suspected abuse, neglect, or exploitation, the employee must call the Florida Abuse Hotline to report the incident. The employee must ensure that the client's guardian, representative or relative is notified, as applicable.

4) Once the situation is stabilized and the staff has addressed any immediate physical or psychological service needs of the person(s) involved in the incident, the following must occur:

   i. Employee must investigate by gathering and reviewing details of the incident and statements from all involved parties within 24 hours of the incident and must provide written notification of the incident to the FPOCF Incident Report Manager, by 12 noon the next business day after the incident using the attached CIR Form or using the Mindshare system.
   ii. Network providers shall immediately notify the Case Management staff, including on-call case management staff, of all reportable critical incidents.
   iii. Case Management staff shall notify the parents, Guardian Ad Litem and Attorney Ad Litem as soon as possible after the critical incident.
   iv. Immediate verbal notification is required for a client death, serious injury or serious illness of a child, potential media involvement and employee misconduct.
   v. The FPOCF Incident Report Manager will enter all necessary CIR's into IRAS within one (1) business day of the incident.

5) When a FPOCF staff person first becomes aware of a serious incident or fatality of a child or family, they must immediately contact their direct supervisor. The direct supervisor will then contact their respective supervisor who will notify senior management. Senior management will then immediately contact the respective agency Executive who will then notify the President and

Chief Executive Officer or designee in person or by phone. A critical incident report will then be immediately completed by the appropriate FPOCF staff using the CIR function of Mindshare and/or Argos (Also See 2015 FPOCF Communication Protocol).

B. Notifications/Reporting and Actions Taken by the FPOCF Incident Report Manager or designee

1) FPOCF has a designated Incident Report Manager. This staff manages the incident notification process and serves as an independent reviewer. Additional staff may be designated to enter incident information into the IRAS at the discretion of the FPOCF Director of Contracts and Compliance.

2) When a supervisor is informed of a critical incident, that person shall verify what has occurred, confirm the known facts with the discovering employee, and ensure that appropriate and timely notifications and actions occurred. The service provider/facility shall develop internal procedures regarding reporting incidents to the Incident Report Manager or designee within the service provider's agency/facility.

3) If the incident qualifies as a critical incident according to the definitions contained in this operating procedure, FPOCF's Incident Report Manager will review the incident information and clarify or obtain any necessary information before forwarding the incident report to the Department's designated Incident Coordinator or designee via the IRAS.

4) The service provider will ensure timely notification of critical incidents is made to appropriate individuals such as emergency medical services (911), law enforcement, the Florida Abuse Hotline, or Agency for Health Care Administration (AHCA). The IRAS reporting process does not replace the reporting of incidents to other entities as required by statute, rules, or operating procedure.

5) Critical Incidents involving clients receiving services in a Central FL Cares Health System (CFCHS) funded program are required to be reported to DCF IRAS within one business day of incident occurrence. Once entered, CFCHS will receive notification of entry and will report into IRMS. Entry in IRAS or IRMS does not substitute for a direct phone call to CFCHS Risk Manager within 4 hours of discovery when the incident type or severity warrants such contact.

6) When no incidents related to CFCHS funded programs (i.e., individuals served, staff, or facilities) have been reported the Director of Contracts and Compliance or designee shall submit into IRMS a “No Incidents to Report

Attestation" by the 5th of the following month.

The President and Chief Executive Officer or Vice President and Chief Operating Officer or designee shall, as soon as possible but no later than the first normal workday following the occurrence, inform the Central Region Director of Child and Family Well Being, Secretary, Deputy Secretary, and/or appropriate assistant secretary of all client deaths as defined in this operating procedure, and other reportable incidents which are likely to have adverse departmental impact or statewide media coverage.

**Critical Incident Rapid Response Team (CIRRT)**

A. Background
In 2014, the Florida Legislature passed Senate Bill 1666, establishing requirements for creating a Critical Incident Rapid Response Team (CIRRT), effective January 1, 2015. Section 39.2015, Florida Statutes, requires:

- An immediate onsite investigation by a critical incident rapid response team for all child deaths reported to the Department if the child or another child in his or her family was the subject of a verified report of suspected abuse or neglect during the previous 12 months.
- The investigation shall be initiated as soon as possible, but no later than two business days after the case is reported to the Department.
- Each investigation shall be conducted by a multiagency team of at least five professionals with expertise in child protection, child welfare, and organizational management. The majority of the team must reside in judicial circuits outside the location of the incident. The Secretary is required to assign a team leader for each group assigned to an investigation.
- A preliminary report on each case shall be provided to the Secretary no later than 30 days after the investigation begins.
- The Secretary may direct an immediate investigation into other cases involving serious injury to a child and those involving a child fatality that occurred during an active investigation.
- The Secretary, in conjunction with the Florida Institute for Child Welfare, is required to develop guidelines for investigations and provide training to team members.
- The Secretary shall appoint an advisory committee made up of experts in child protection and child welfare.

**B. Purpose**

Critical Incident Rapid Response Teams provide an immediate, multiagency investigation of child deaths that meet the statutory criteria for review or other serious incidents at the Secretary's discretion. Investigations are conducted to identify root causes, rapidly determine the need to change policies and practices related to child protection and improve Florida's child welfare system.

**C. CIRRT Process:**

When the Secretary has determined that a CIRRT review will be conducted on a family served through FPOCF or one of its subcontractors, the FPOCF Executive team will participate in the introduction process to take place within 2 days of the incident with the team deployed by DCF. The introduction provides a summary of the current situation, including the circumstances that led to the deployment of the team. Each team deployed is comprised of individuals with expertise in the appropriate areas, as identified through a review of the family's prior history with the child welfare system. The team leader is responsible for guiding the process throughout the

duration of the review. FPOCF Executive Team and identified staff members will participate as required in the following components of the review:

a. Child Welfare Summary and Genogram – The child welfare summary provides a brief description of the family's history with the child welfare system and provides an analysis of the prior reports, criminal history, and child welfare services. The genogram provides a pictorial display of family relationships and the family system.

b. The SOC review is designed to provide an assessment of the child welfare system's interactions with the family and to identify issues that may have influenced the system's response and decision-making. The review team identifies areas of strength as well as opportunities for improvement within the child welfare system in three main categories: practice assessment, organizational assessment, and service array.

c. Practice assessment – The practice assessment examines whether the child welfare professionals' actions and decision-making regarding the family were consistent with the Department's policies and procedures.

d. Organizational assessment – This section examines the level of staffing, experience, caseload, training, and performance as potential factors in the management of the case.

e. Service array – The service array section assesses the inventory of services within the local child welfare system of care where the family's case originated.

At the conclusion of the CIRRT Review, FPOCF will participate in a debriefing Exit Interview within 48 hours of CIRRT Advisory Team deployment where preliminary findings will be shared. FPOCF will then receive an Executive Summary that provides a brief overview along with a summary of the final findings of the incident written by the CIRRT Advisory Committee. All recommendations including immediate operational responses to address any deficiencies as well as long term strategies, and implications for practice changes and operating procedures will be addressed by the FPOCF Executive Team within 7 days of the receipt of the Executive Summary.

BY DIRECTION OF THE PRESIDENT AND
CHIEF EXECUTIVE OFFICER:

PHILIP J. SCARPELLI
President and Chief Executive Officer
Family Partnerships of Central Florida

APPROVAL DATE: 10/31/2025