Family Partnerships of Central Florida
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PROCEDURE

Series:	**Operations**	**COA: RPM 2.03** **CFOP:**
Procedure Name:	Internal Review of Serious Incidents including a serious injury, threat of harm, or death	
Procedure Number:	OP1181	
Reviewed Date:	04/16/24, 9/29/25	
Revision #/Date:	01/06/17, 04/13/2020	
Effective Date:	10/01/14	
Applicable to:	Family Partnerships of Central Florida (FPOCF) Staff	

PURPOSE:

The purpose of this protocol is to outline FPOCF's staff responsibilities that will be used for each incident, serious occurrence, accident, and grievance that involves the threat of actual harm, serious injury, or death that occurs involving a child or family served through FPOCF.

References: Critical Incident Report Procedure # OP1144 and 2015 Communication Protocol, Florida Administrative Code 65C-30.020, Section 39.2015, Florida Statutes

Definitions:

Child or family known to FPOCF is a deceased child or member of the deceased immediate family who has a case open with FPOCF or has been placed by CPI in foster home or residential placement subcontracted through FPOCF prior to the Dependency Case being opened.

Special Review is an internal quality review of a case file and FSFN or other electronic database such as PSAM and/or Argos regarding the child or family fatality.

Immediately means without undue delay.

Protocol Meeting is the term used when a critical event or issue has occurred, and a meeting is called regarding this. Staff understand this is a meeting of importance and every effort to attend this meeting is made.

Fatality Review is a meeting scheduled by the Department of Children and Families to review a child or family fatality and incudes the Sheriff's office or Police Department, DCF CPI staff, Case Management Staff, FPOCF staff, Child Protective Team staff, and a Physician from CPT, and others as appropriate.

NOTIFICATION PROCESS

When a FPOCF staff member first becomes aware of a serious incident or fatality of a child or family, they immediately contact their direct supervisor. The direct supervisor will then contact their Program Director within Case Management and if the staff person is within FPOCF, they notify their Program Director who will notify the Senior Executive of their Division. The Senior Executive of the Division will then immediately contact the Administrator of the Department who will notify the Chief Executive

Officer and Vice President of Operations in person or by phone. All other Chiefs will be notified by the CEO if deemed appropriate. An incident report will then be immediately completed by the appropriate FPOCF staff and sent to those identified in the Incident Reporting Operational Procedure. (Also See 2015 FPOCF Communication Protocol).

NOTIFICATION TO DCF

Pursuant to F.A.C 65C-30.020, any FPOCF staff member who has knowledge of a child fatality and reasonable cause to suspect that the child died as a result of abuse, neglect or abandonment shall immediately report the death to the Florida Abuse Hotline, if a report has not already been made.

Whenever a care manager learns that a child under supervision has died, that care manager shall immediately orally report the occurrence through the established chain of command to the FPOCF Chief Executive Officer or designee. Upon learning of the death, the FPOCF Chief Executive Officer or designee shall immediately orally notify the regional managing director and regional child fatality prevention specialist. Written notice shall be made within 24 hours of the death.

INITIAL PROTOCOL MEETING

The Administrator of Performance, Quality and Training or their designee will be assigned to serve as the lead/champion for the duration of the Independent Review Process. Upon completion of the initial communication as noted above, a “Protocol” meeting will be called by the Administrator of Performance, Quality and Training to share initial details regarding the recent child or family fatality. This initial meeting will initiate the investigation of the incident and will occur within 24 hours of the incident being reported. During this meeting, the Administrator of Performance, Quality and Training will ensure documentation is kept beginning with defined roles and include latitude and limitations of FPOCF staff during this Independent Review Process. At this meeting, a request for a “Special Review” will be made and staff will be identified from the Performance, Quality and Training Division to review the case file and provide a “Special Review Draft Report.” In addition, areas for discussion at the initial meeting will include the identification of any present safety concerns that exist for any other children if appropriate, what immediate support is needed for the child and/or family members or Provider staff who have been working with the child or family, such as MRT services or EAP services in order to provide an immediate trauma debriefing as appropriate for those incidents where a fatality occurred. A Communication Strategy for FPOCF will also be discussed at the initial meeting if the fatality occurs involving a child or family known to FPOCF. The Administrator of Performance, Quality and Training will request the Case Record related to the child or family involved in the incident to be secured and sensitized. Sensitizing a case record requires restricting access to the information. The Administrator of Performance, Quality and Training will identify staff allowed access to the case record and limit the staff allowed access. A copy of the case file will also be sent by the Senior Director of Operations - Child Welfare as soon as possible, to the Administrator of Performance, Quality and Training for the purpose of the internal review and in anticipation of a request of copy of the file by DCF as part of their Internal Review Process for a fatality of a child in out of home care. As part of this review process and until the process is completed, a daily debriefing will be required through conference calls with all appropriate FPOCF staff, led by the Administrator of Performance, Quality and Training. The purpose of these calls will be to update everyone regarding any additional details that were not available at the time of the first meeting as well as provide information regarding outside external requests for information or attendance at a meeting

or phone call. These calls will also ensure timely implementation and documentation of all actions taken. In addition to the independent review of the case file, the review may require solicitation of statements from all involved individuals. These interviews will be assigned to a member of the Quality Assurance Division.

SPECIAL REVIEW PROCESS

Once the initial "Special Review Draft" is completed by the Quality Management Staff assigned, the draft will be forwarded to the Administrator of Performance, Quality and Training for initial review. Whom will in turn forward this first draft for review by the Chief Executive Officer and Vice President of Operations for comments and feedback. The "Special Review" will be watermarked as "Draft" prior to its submission and must be maintained in the QA Team file on the one drive. The Special Review must be password protected. An email will be sent to the review parties with the attached review. Once the Special Review report has been fully reviewed and all comments by the CEO addressed will the report be deemed "Final." The Final Report will be forwarded back to the Chief Executive Officer for final approval and watermarked as "Final." This report will identify ongoing monitoring timeframes if actions are required and require oversight to determine their effectiveness as well as address applicable future reporting requirements

RESPONSE TO EXTERNAL INQUIRES

As part of the Review Process, any and all requests made by the Department of Children and Families will be directed to the Administrator of Performance, Quality and Training. In the absence of the Administrator of Performance, Quality and Training, the Vice President of Operations will be the contact person for the Department during this Independent Review Process. All communication and requests for FPOCF staff involvement regarding a Child Fatality review process from the Department of Children and Families will be communicated to the Chief Executive Officer immediately for direction and subsequent approvals of all requests for documentation and FPOCF staff involvement. All media requests regarding the child fatality (example: media, community, deceased child's extended family) will be immediately communicated to the Chief Executive Officer and the Vice President of Operations who will develop and approve any plan to address external inquires. FPOCF will cooperate with any law enforcement requests related to an investigation of the child's death.

PARTICIPATION WITH DCF ON SPECIAL REVIEW AND FATALITY STAFFING

Upon request by the Department of Children and Families for assistance in the review of a child or family fatality, staff must direct this request to the Administrator of Performance, Quality and Training who in turn will notify the Chief Executive Officer of this request for their approval and identification of FPOCF who will participate in this collaborative effort. As part of this process, all requests will be provided to the CEO, and all documentation will be reviewed by the CEO prior to it being provided to the Department to ensure its accuracy. All written documentation provided to the Department by FPOCF must be provided through a DCF approved shared drive. No information should be sent by email. Documentation regarding any meetings or call with the Department should be completed by the FPOCF staff approved to provide information and should be provided to the Administrator of Performance, Quality and Training and the Chief Executive Officer by the end of the business day of the meeting or phone call.

Pursuant to Section 39.2015, Florida Statutes, an immediate onsite investigation conducted by a Critical Incident Rapid Response Team (CIRRT) is required 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 regional DCF Child Fatality Prevention Specialist shall conduct a case review on all child fatalities in which it is alleged that abuse, neglect or abandonment was or may have been a factor in the child's death, and in situations where a child died while participating on an active investigation or while receiving ongoing services without concerns of abuse, neglect or abandonment. The appropriate designated FPOCF staff shall cooperate with the Department of Children and Families Critical Incident Rapid Response Team and/or Child Fatality Specialist and participate as needed on the Department of Health local Child Abuse Death Review team.

BY DIRECTION OF THE PRESIDENT AND
CHIEF EXECUTIVE OFFICER:

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

APPROVAL DATE: 10/28/2025