Sexual Assault Nurse Examiner Program Guidance Document

Consent: Diminished Capacity/Inability to Consent

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CONSENT GUIDANCE

Every competent patient has a right to make informed decisions regarding his/her health care. This includes the right to consent or refuse medical treatment, procedures or other services. There may be, however, circumstances that may cause a patient to be unable to consent to a medical forensic examination (MFE), such as young age, mental illness, cognitive disorders, ingestion of drugs and/or alcohol (voluntary or involuntary), acute medical or traumatic events, neurological disease/disorders. (The list is not exhaustive).

This guidance document addresses obtaining consent for a sexual assault MFE for patients with diminished capacity/ability to consent. Consent is not implied for a MFE. For a patient to provide informed consent the patient must: (1) possess the mental capacity or competence to make such decisions; (2) understand sufficient information about options available to make informed decisions; and (3) allow the opportunity to make the decision freely without duress or coercion. The responsibility of obtaining informed consent lies with, and only with, the person conducting the MFE (i.e. not the advocate, not law enforcement).

This document provides guidelines for sexual assault nurse examiners (SANE) in assessing a patient (adults and minors) with diminished capacity/ability to consent to a sexual assault MFE.

We hope you find this guidance useful and informative in providing care to patients of sexual assault.

To conduct a medical forensic examination the following should be present:

1. There is an indication that a sexual assault / sex crime occurred; and
2. The person conducting the exam obtains written consent from the patient, legal guardian, proxy, health care surrogate or court order; and
3. The patient has the ability to understand the consent request; and
4. The patient assents to the exam. (The patient is the only person that may assent and if assent does not exist, the exam should not be done.)

LACKING CAPACITY

A. ADULT

1. If the SANE determines the adult patient lacks the capacity to give informed consent a legal guardian or power of attorney may sign on the patient’s behalf. The power of attorney document must give authority for this person (the patient’s agent) to act and sign legal documents on their behalf when it is determined the patient is incapacitated. NOTE: some power of attorney documents are limited in scope of authority.
2. When an adult patient lacks the capacity to give informed consent due to being unconscious, the SANE is presented with a most complex situation. In order to protect the patient’s right to self-determination the SANE must not collect evidence unless there is a legal guardian or power of attorney (see # 1 above).

NOTE: obtaining evidence without consent could be considered sexual battery and places the nurse’s license in jeopardy. However, from the perspective that a crime has been, or possibly, committed law enforcement may choose to seek a court order or search warrant for the purpose of collecting forensic evidence. If a judge signs the requested court order or search warrant, the SANE, hospital, Certified Rape Crisis Center (RCC) leadership and agency (hospital, RCC) general counsel may collaborate to determine who will collect the evidence.

NOTE: A medical proxy, Section 765.401, F.S. (Appendix I), is not appropriate to use in the case of a sexual assault medical forensic exam since it is not a medically necessary procedure.

3. If a practitioner has reasonable cause to suspect a vulnerable adult has been a victim of sexual assault she/he is required to report the suspicion to Department of Children and Families, Section 415.1034 (Appendix II).

ADULT AND MENTAL ILLNESS

1. If a person is “Baker Acted” involuntary, or voluntary, they must be deemed competent by a physician to consent for a medical forensic exam (a physician is the only professional that may determine competency). The physician must certify that the person is able to make well reasoned, willful and knowing decisions about his/her health and health care (the definition of competence to consent) before permitting the individual to consent to treatment or a MFE. (Department of Children and Families, Mental Health: Express and Informed Consent)

2. If consent is obtained by a “Baker Acted” deemed competent individual or by a legally authorized substitute decision-maker (court appointed guardian, an advance directive naming a health care surrogate or health care proxy) the medical forensic exam may be conducted.

ADULT AND COGNITIVE IMPAIRMENT

Discussion exists regarding an individual who is, by age, an adult and by cognitive development, a minor and if a forensic interview by a qualified pediatric forensic interviewer should take place in lieu of a sexual assault history by a SANE. The decision as to who obtains the sexual assault history or interview is currently up to each program / SART.

Per The Victims with Disabilities: The Forensic Interview (Office for Victims of Crime, 2011)

1. Cognitive impairment (or disability) is unrelated to the reliability of memory. People with severe intellectual disabilities, for example can describe in exquisite detail the
crimes that have been committed against them, including the name of the perpetrator (if known) and the details of the case. Like most of the population, however, they do not have excellent recall of unimportant details of daily life such as the breakfast meal they had a few days prior.

2. Cognitive impairment (or disability) is unrelated to the ability to distinguish the truth from a lie. Children learn to distinguish the truth from a lie early in their developmental process. This ability is intact in most people who have cognitive disabilities.

3. Someone with a cognitive disability, however, may take longer to obtain a history. They may become too upset or tire easily, be prepared to spend more time or divide the history taking into short time periods.

B. MINOR

1. If a patient lacks capacity due to age, obtain the informed consent to perform a sexual assault MFE from a parent or legal guardian. EXCEPTION: a minor may consent for medical services to determine the presence of, or to treat, pregnancy and conditions associated with sexually transmitted infections (the consent of no other is necessary). The professional may inform the parent or legal guardian of the minor patient of any treatment given or needed where failure to inform the parent or guardian would seriously jeopardize the health of the minor.

a. If a minor provides consent for medical services to treat pregnancy and conditions associated with sexually transmitted infections, and is under the age of 15, and the practitioner has reasonable cause to suspect that the child is the victim of childhood sexual abuse she/he is required to report the suspicion to Department of Children and Families (F.S. 39.201, Appendix II).

b. A minor may give informed consent to her own health care when pregnant, is married, or is 16 or 17 and has been legally emancipated in Florida (Section 743.015, F.S., Appendix IV).

c. A minor may not receive a MFE and / or have pictures taken without parental or guardian consent.

d. Medical care or treatment may be received if it falls under the definition of emergency care as outlined in Section 743.064, F.S. (Appendix V), any minor “....may receive emergency medical care or treatment without parental consent who has been injured in an accident or who is suffering from an acute illness, disease, or condition, if a delay in treatment would endanger the health or physical well-being of the minor....”

NOTE: A MFE or evidence collection is not considered emergency medical care or treatment; therefore, these procedures do not fall under the definition of emergency care. (A MFE is a voluntary medical assessment of the patient to ensure there is no life threatening emergency care needed and forensic evidence is collected.)
e. Unaccompanied homeless youth are permitted to consent to a forensic exam, but they must meet the definition in Section 743.067, F.S. (Appendix VI): they must be 16 years of age+ and be certified as an unaccompanied homeless youth via documentation developed by Department of Children and Families (Appendix VII).

f. Per Section 39.303 F.S. (Appendix VIII), “The Department of Health and the Department of Children and Families (DCF) shall maintain an interagency agreement that establishes protocols for oversight and operations of child protection teams and sexual abuse treatment programs.” The Florida Department of Health’s Child Protection Team (CPT) program is a medically directed, multidisciplinary program that works with local Sheriff’s offices and the Department of Children and Family (DCF) Services in cases of child abuse and neglect to supplement investigation activities. Initial contact comes primarily from Child Protective Investigators (CPIs) employed by either DCF or the local sheriff’s office (SO). However, a CPT may initially be contacted by another source, such as law enforcement.

i. Consent for a MFE may be provided by a sworn law enforcement officer in Florida (regular criminal law enforcement) and any child protective investigator that works for either DCF or one of the six sheriff offices (of Pasco County, Manatee County, Broward County, Seminole, Hillsborough and Pinellas County) that also have the responsibility to conduct all child protective investigations as Per Section 39.3065(3)(a) and (b), F.S. (Appendix IX)

ii. If the minor has been sexually abused by a parent and DCF has been called, the CPI or the sworn law enforcement officer may give consent pursuant to Section 39.304 F.S. (Appendix X), “........the person required to investigate may cause the child to be referred for diagnosis to a licensed physician or an emergency department in a hospital without the consent of the child’s parents or legal custodian.”

NOTE: In regards to the timing of a MFE, per the Office of the Attorney General’s Adult and Child Sexual Assault Protocols, a forensic interview “should precede a forensic medical exam in most cases,......” The CPT under the guidance of the Department of Health practices per this protocol. However, it does not negate the importance of a MFE, if it is indicated.

2. It is best practice and advised not to restrain or sedate a child / minor for a MFE. However, there may be a situation where a Court Order is obtained requiring a MFE be done (with or without sedation).

a. If a court order exists requiring a MFE be done, it is prudent to seek legal counsel’s advice and direction.

b. If a court order exists authorizing a MFE be done this is an order giving permission or authority for the MFE, it is not an order.
ADMINISTRATIVE NOTE:
STOP Violence Against Women Formula Grant Program, awarded to states and territories, enhances the capacity of local communities to strengthen victim services. The STOP funding will only pay for services that serve or focus on adult and youth over the age of 11 (eleven) and the services must be related to a sexual assault / battery / rape that is not committed by a caretaker. Additionally, STOP funding will not pay for health care costs (including a MFE) related to child abuse (with or without sexual assault/battery/rape).
APPENDIX I

Title XLIV      Chapter 765      View Entire Chapter
CIVIL RIGHTS    HEALTH CARE ADVANCE DIRECTIVES

765.401 The proxy.—
(1) If an incapacitated or developmentally disabled patient has not executed an advance directive, or designated a surrogate to execute an advance directive, or the designated or alternate surrogate is no longer available to make health care decisions, health care decisions may be made for the patient by any of the following individuals, in the following order of priority, if no individual in a prior class is reasonably available, willing, or competent to act:
(a) The judicially appointed guardian of the patient or the guardian advocate of the person having a developmental disability as defined in s. 393.063, who has been authorized to consent to medical treatment, if such guardian has previously been appointed; however, this paragraph shall not be construed to require such appointment before a treatment decision can be made under this subsection;
(b) The patient’s spouse;
(c) An adult child of the patient, or if the patient has more than one adult child, a majority of the adult children who are reasonably available for consultation;
(d) A parent of the patient;
(e) The adult sibling of the patient or, if the patient has more than one sibling, a majority of the adult siblings who are reasonably available for consultation;
(f) An adult relative of the patient who has exhibited special care and concern for the patient and who has maintained regular contact with the patient and who is familiar with the patient’s activities, health, and religious or moral beliefs; or
(g) A close friend of the patient.
(h) A clinical social worker licensed pursuant to chapter 491, or who is a graduate of a court-approved guardianship program. Such a proxy must be selected by the provider’s bioethics committee and must not be employed by the provider. If the provider does not have a bioethics committee, then such a proxy may be chosen through an arrangement with the bioethics committee of another provider. The proxy will be notified that, upon request, the provider shall make available a second physician, not involved in the patient’s care to assist the proxy in evaluating treatment. Decisions to withhold or withdraw life-prolonging procedures will be reviewed by the facility’s bioethics committee. Documentation of efforts to locate proxies from prior classes must be recorded in the patient record.
(2) Any health care decision made under this part must be based on the proxy’s informed consent and on the decision the proxy reasonably believes the patient would have made under the circumstances. If there is no indication of what the patient would have chosen, the proxy may consider the patient’s best interest in deciding that proposed treatments are to be withheld or that treatments currently in effect are to be withdrawn.
(3) Before exercising the incapacitated patient’s rights to select or decline health care, the proxy must comply with the provisions of ss. 765.205 and 765.305, except that a proxy’s decision to withhold or withdraw life-prolonging procedures must be supported by clear and convincing evidence that the decision would have been the one the patient would have chosen had the patient
been competent or, if there is no indication of what the patient would have chosen, that the
decision is in the patient’s best interest.

(4) Nothing in this section shall be construed to preempt the designation of persons who may
consent to the medical care or treatment of minors established pursuant to s. 743.0645.
History.—s. 5, ch. 92-199; s. 12, ch. 94-183; s. 32, ch. 99-331; s. 15, ch. 2000-295; s. 7, ch. 2001-
415.1034 Mandatory reporting of abuse, neglect, or exploitation of vulnerable adults; mandatory reports of death.—

(1) MANDATORY REPORTING.—
(a) Any person, including, but not limited to, any:
1. Physician, osteopathic physician, medical examiner, chiropractic physician, nurse, paramedic, emergency medical technician, or hospital personnel engaged in the admission, examination, care, or treatment of vulnerable adults;
2. Health professional or mental health professional other than one listed in subparagraph 1.;
3. Practitioner who relies solely on spiritual means for healing;
4. Nursing home staff; assisted living facility staff; adult day care center staff; adult family-care home staff; social worker; or other professional adult care, residential, or institutional staff;
5. State, county, or municipal criminal justice employee or law enforcement officer;
6. Employee of the Department of Business and Professional Regulation conducting inspections of public lodging establishments under s. 509.032;
7. Florida advocacy council or Disability Rights Florida member or a representative of the State Long-Term Care Ombudsman Program; or
8. Bank, savings and loan, or credit union officer, trustee, or employee, who knows, or has reasonable cause to suspect, that a vulnerable adult has been or is being abused, neglected, or exploited shall immediately report such knowledge or suspicion to the central abuse hotline.
(b) To the extent possible, a report made pursuant to paragraph (a) must contain, but need not be limited to, the following information:
1. Name, age, race, sex, physical description, and location of each victim alleged to have been abused, neglected, or exploited.
2. Names, addresses, and telephone numbers of the victim’s family members.
3. Name, address, and telephone number of each alleged perpetrator.
4. Name, address, and telephone number of the caregiver of the victim, if different from the alleged perpetrator.
5. Name, address, and telephone number of the person reporting the alleged abuse, neglect, or exploitation.
6. Description of the physical or psychological injuries sustained.
7. Actions taken by the reporter, if any, such as notification of the criminal justice agency.
8. Any other information available to the reporting person which may establish the cause of abuse, neglect, or exploitation that occurred or is occurring.

(2) MANDATORY REPORTS OF DEATH.—Any person who is required to investigate reports of abuse, neglect, or exploitation and who has reasonable cause to suspect that a vulnerable adult died as a result of abuse, neglect, or exploitation shall immediately report the suspicion to the appropriate medical examiner, to the appropriate criminal justice agency, and to the department, notwithstanding the existence of a death certificate signed by a practicing physician. The medical examiner shall accept the report for investigation pursuant to s. 406.11 and shall report the findings of the investigation, in writing, to the appropriate local criminal justice agency, the appropriate state
attorney, and the department. Autopsy reports maintained by the medical examiner are not subject to the confidentiality requirements provided for in s. 415.107.

History.—s. 96, ch. 95-418; s. 10, ch. 97-98; s. 42, ch. 97-264; s. 256, ch. 98-166; s. 21, ch. 2000-263; s. 2, ch. 2000-318; s. 28, ch. 2000-349; s. 29, ch. 2015-31.
39.201 Mandatory reports of child abuse, abandonment, or neglect; mandatory reports of death; central abuse hotline.—

(1)(a) Any person who knows, or has reasonable cause to suspect, that a child is abused, abandoned, or neglected by a parent, legal custodian, caregiver, or other person responsible for the child’s welfare, as defined in this chapter, or that a child is in need of supervision and care and has no parent, legal custodian, or responsible adult relative immediately known and available to provide supervision and care shall report such knowledge or suspicion to the department in the manner prescribed in subsection (2).

(b) Any person who knows, or who has reasonable cause to suspect, that a child is abused by an adult other than a parent, legal custodian, caregiver, or other person responsible for the child’s welfare, as defined in this chapter, shall report such knowledge or suspicion to the department in the manner prescribed in subsection (2).

(c) Any person who knows, or has reasonable cause to suspect, that a child is the victim of childhood sexual abuse or the victim of a known or suspected juvenile sexual offender, as defined in this chapter, shall report such knowledge or suspicion to the department in the manner prescribed in subsection (2).

(d) Reporters in the following occupation categories are required to provide their names to the hotline staff:
1. Physician, osteopathic physician, medical examiner, chiropractic physician, nurse, or hospital personnel engaged in the admission, examination, care, or treatment of persons;
2. Health or mental health professional other than one listed in subparagraph 1.;
3. Practitioner who relies solely on spiritual means for healing;
4. School teacher or other school official or personnel;
5. Social worker, day care center worker, or other professional child care, foster care, residential, or institutional worker;
6. Law enforcement officer; or
7. Judge.

The names of reporters shall be entered into the record of the report, but shall be held confidential and exempt as provided in s. 39.202.

(e) A professional who is hired by or enters into a contract with the department for the purpose of treating or counseling any person, as a result of a report of child abuse, abandonment, or neglect, is not required to again report to the central abuse hotline the abuse, abandonment, or neglect that was the subject of the referral for treatment.

(f) An officer or employee of the judicial branch is not required to again provide notice of reasonable cause to suspect child abuse, abandonment, or neglect when that child is currently being investigated by the department, there is an existing dependency case, or the matter has previously been reported to the department, provided there is reasonable cause to believe the information is already known to the department. This paragraph applies only when the information has been provided to the officer or employee in the course of carrying out his or her official duties.

(g) Nothing in this chapter or in the contracting with community-based care providers for foster care and related services as specified in s. 409.987 shall be construed to remove or reduce the duty and responsibility of any person, including any employee of the community-based care provider, to
report a suspected or actual case of child abuse, abandonment, or neglect or the sexual abuse of a child to the department’s central abuse hotline.

(h) An officer or employee of a law enforcement agency is not required to provide notice to the department of reasonable cause to suspect child abuse by an adult other than a parent, legal custodian, caregiver, or other person responsible for the child’s welfare when the incident under investigation by the law enforcement agency was reported to law enforcement by the Central Abuse Hotline through the electronic transfer of the report or call. The department’s Central Abuse Hotline is not required to electronically transfer calls and reports received pursuant to paragraph (2)(b) to the county sheriff’s office if the matter was initially reported to the department by the county sheriff’s office or another law enforcement agency. This paragraph applies only when the information related to the alleged child abuse has been provided to the officer or employee of a law enforcement agency or Central Abuse Hotline employee in the course of carrying out his or her official duties.

(2)(a) Each report of known or suspected child abuse, abandonment, or neglect by a parent, legal custodian, caregiver, or other person responsible for the child’s welfare as defined in this chapter, except those solely under s. 827.04(3), and each report that a child is in need of supervision and care and has no parent, legal custodian, or responsible adult relative immediately known and available to provide supervision and care shall be made immediately to the department’s central abuse hotline. Such reports may be made on the single statewide toll-free telephone number or via fax, web-based chat, or web-based report. Personnel at the department’s central abuse hotline shall determine if the report received meets the statutory definition of child abuse, abandonment, or neglect. Any report meeting one of these definitions shall be accepted for the protective investigation pursuant to part III of this chapter. Any call received from a parent or legal custodian seeking assistance for himself or herself which does not meet the criteria for being a report of child abuse, abandonment, or neglect may be accepted by the hotline for response to ameliorate a potential future risk of harm to a child. If it is determined by a child welfare professional that a need for community services exists, the department shall refer the parent or legal custodian for appropriate voluntary community services.

(b) Each report of known or suspected child abuse by an adult other than a parent, legal custodian, caregiver, or other person responsible for the child’s welfare, as defined in this chapter, shall be made immediately to the department’s central abuse hotline. Such reports may be made on the single statewide toll-free telephone number or via fax, web-based chat, or web-based report. Such reports or calls shall be immediately electronically transferred to the appropriate county sheriff’s office by the central abuse hotline.

(c) Reports involving juvenile sexual abuse or a child who has exhibited inappropriate sexual behavior shall be made and received by the department. An alleged incident of juvenile sexual abuse involving a child who is in the custody of or protective supervision of the department shall be reported to the department’s central abuse hotline.

1. The central abuse hotline shall immediately electronically transfer the report or call to the county sheriff’s office. The department shall conduct an assessment and assist the family in receiving appropriate services pursuant to s. 39.307, and send a written report of the allegation to the appropriate county sheriff’s office within 48 hours after the initial report is made to the central abuse hotline.

2. The department shall ensure that the facts and results of any investigation of child sexual abuse involving a child in the custody of or under the protective supervision of the department are made known to the court at the next hearing or included in the next report to the court concerning the child.
(d) If the report is of an instance of known or suspected child abuse, abandonment, or neglect that occurred out of state and the alleged perpetrator and the child alleged to be a victim live out of state, the central abuse hotline shall not accept the report or call for investigation, but shall transfer the information on the report to the appropriate state.

(e) If the report is of an instance of known or suspected child abuse involving impregnation of a child under 16 years of age by a person 21 years of age or older solely under s. 827.04(3), the report shall be made immediately to the appropriate county sheriff’s office or other appropriate law enforcement agency. If the report is of an instance of known or suspected child abuse solely under s. 827.04(3), the reporting provisions of this subsection do not apply to health care professionals or other persons who provide medical or counseling services to pregnant children when such reporting would interfere with the provision of medical services.

(f) Reports involving known or suspected institutional child abuse or neglect shall be made and received in the same manner as all other reports made pursuant to this section.

(g) Reports involving surrendered newborn infants as described in s. 383.50 shall be made and received by the department.

1. If the report is of a surrendered newborn infant as described in s. 383.50 and there is no indication of abuse, neglect, or abandonment other than that necessarily entailed in the infant having been left at a hospital, emergency medical services station, or fire station, the department shall provide to the caller the name of a licensed child-placing agency on a rotating basis from a list of licensed child-placing agencies eligible and required to accept physical custody of and to place newborn infants left at a hospital, emergency medical services station, or fire station. The report shall not be considered a report of abuse, neglect, or abandonment solely because the infant has been left at a hospital, emergency medical services station, or fire station pursuant to s. 383.50.

2. If the call, fax, web-based chat, or web-based report includes indications of abuse or neglect beyond that necessarily entailed in the infant having been left at a hospital, emergency medical services station, or fire station, the report shall be considered as a report of abuse, neglect, or abandonment and shall be subject to the requirements of s. 39.395 and all other relevant provisions of this chapter, notwithstanding any provisions of chapter 383.

(h) Hotline counselors shall receive periodic training in encouraging reporters to provide their names when reporting abuse, abandonment, or neglect. Callers shall be advised of the confidentiality provisions of s. 39.202. The department shall secure and install electronic equipment that automatically provides to the hotline the number from which the call or fax is placed or the Internet protocol (IP) address from which the report is received. This number shall be entered into the report of abuse, abandonment, or neglect and become a part of the record of the report, but shall enjoy the same confidentiality as provided to the identity of the reporter pursuant to s. 39.202.

(i) The department shall voice-record all incoming or outgoing calls that are received or placed by the central abuse hotline which relate to suspected or known child abuse, neglect, or abandonment. The department shall maintain an electronic copy of each fax and web-based report. The recording or electronic copy of each fax and web-based report shall become a part of the record of the report but, notwithstanding s. 39.202, shall be released in full only to law enforcement agencies and state attorneys for the purpose of investigating and prosecuting criminal charges pursuant to s. 39.205, or to employees of the department for the purpose of investigating and seeking administrative penalties pursuant to s. 39.206. Nothing in this paragraph shall prohibit the use of the recordings, the electronic copies of faxes, and web-based reports by hotline staff for quality assurance and training.
(j)1. The department shall update the web form used for reporting child abuse, abandonment, or neglect to:
   a. Include qualifying questions in order to obtain necessary information required to assess need and a response.
   b. Indicate which fields are required to submit the report.
   c. Allow a reporter to save his or her report and return to it at a later time.
2. The report shall be made available to the counselors in its entirety as needed to update the Florida Safe Families Network or other similar systems.
(k) The department shall conduct a study to determine the feasibility of using text and short message service formats to receive and process reports of child abuse, abandonment, or neglect to the central abuse hotline.
(3) Any person required to report or investigate cases of suspected child abuse, abandonment, or neglect who has reasonable cause to suspect that a child died as a result of child abuse, abandonment, or neglect shall report his or her suspicion to the appropriate medical examiner. The medical examiner shall accept the report for investigation and shall report his or her findings, in writing, to the local law enforcement agency, the appropriate state attorney, and the department. Autopsy reports maintained by the medical examiner are not subject to the confidentiality requirements provided for in s. 39.202.
(4) The department shall operate and maintain a central abuse hotline to receive all reports made pursuant to this section in writing, via fax, via web-based reporting, via web-based chat, or through a single statewide toll-free telephone number, which any person may use to report known or suspected child abuse, abandonment, or neglect at any hour of the day or night, any day of the week. The department shall promote public awareness of the central abuse hotline through community-based partner organizations and public service campaigns. The central abuse hotline is the first step in the safety assessment and investigation process. The central abuse hotline shall be operated in such a manner as to enable the department to:
   a. Immediately identify and locate prior reports or cases of child abuse, abandonment, or neglect through utilization of the department’s automated tracking system.
   b. Monitor and evaluate the effectiveness of the department’s program for reporting and investigating suspected abuse, abandonment, or neglect of children through the development and analysis of statistical and other information.
   c. Track critical steps in the investigative process to ensure compliance with all requirements for any report of abuse, abandonment, or neglect.
   d. Maintain and produce aggregate statistical reports monitoring patterns of child abuse, child abandonment, and child neglect. The department shall collect and analyze child-on-child sexual abuse reports and include the information in aggregate statistical reports. The department shall collect and analyze, in separate statistical reports, those reports of child abuse and sexual abuse which are reported from or occurred on the campus of any Florida College System institution, state university, or nonpublic college, university, or school, as defined in s. 1000.21 or s. 1005.02.
   e. Serve as a resource for the evaluation, management, and planning of preventive and remedial services for children who have been subject to abuse, abandonment, or neglect.
   f. Initiate and enter into agreements with other states for the purpose of gathering and sharing information contained in reports on child maltreatment to further enhance programs for the protection of children.
(5) The department shall be capable of receiving and investigating, 24 hours a day, 7 days a week, reports of known or suspected child abuse, abandonment, or neglect and reports that a child is in need of supervision and care and has no parent, legal custodian, or responsible adult relative immediately known and available to provide supervision and care. If it appears that the immediate
safety or well-being of a child is endangered, that the family may flee or the child will be unavailable for purposes of conducting a child protective investigation, or that the facts otherwise so warrant, the department shall commence an investigation immediately, regardless of the time of day or night. In all other child abuse, abandonment, or neglect cases, a child protective investigation shall be commenced within 24 hours after receipt of the report. In an institutional investigation, the alleged perpetrator may be represented by an attorney, at his or her own expense, or accompanied by another person, if the person or the attorney executes an affidavit of understanding with the department and agrees to comply with the confidentiality provisions of s. 39.202. The absence of an attorney or other person does not prevent the department from proceeding with other aspects of the investigation, including interviews with other persons. In institutional child abuse cases when the institution is not operating and the child cannot otherwise be located, the investigation shall commence immediately upon the resumption of operation. If requested by a state attorney or local law enforcement agency, the department shall furnish all investigative reports to that agency.

(6) Information in the central abuse hotline may not be used for employment screening, except as provided in s. 39.202(2)(a) and (h) or s. 402.302(15). Information in the central abuse hotline and the department’s automated abuse information system may be used by the department, its authorized agents or contract providers, the Department of Health, or county agencies as part of the licensure or registration process pursuant to ss. 402.301-402.319 and ss. 409.175-409.176. Pursuant to s. 39.202(2)(q), the information in the central abuse hotline may also be used by the Department of Education for purposes of educator certification discipline and review.

(7) On an ongoing basis, the department’s quality assurance program shall review calls, fax reports, and web-based reports to the hotline involving three or more unaccepted reports on a single child, where jurisdiction applies, in order to detect such things as harassment and situations that warrant an investigation because of the frequency or variety of the source of the reports. A component of the quality assurance program shall analyze unaccepted reports to the hotline by identified relatives as a part of the review of screened out calls. The Program Director for Family Safety may refer a case for investigation when it is determined, as a result of this review, that an investigation may be warranted.

History.—ss. 1, 2, 3, 4, 5, 6, ch. 63-24; s. 941, ch. 71-136; ss. 1, 1A, ch. 71-97; s. 32, ch. 73-334; s. 65, ch. 74-383; s. 1, ch. 75-101; s. 1, ch. 75-185; s. 4, ch. 76-237; s. 1, ch. 77-77; s. 3, ch. 77-429; ss. 1, 2, ch. 78-322; s. 3, ch. 78-326; s. 22, ch. 78-361; s. 1, ch. 78-379; s. 181, ch. 79-164; s. 1, ch. 79-203; s. 7, ch. 84-226; s. 37, ch. 85-54; s. 68, ch. 86-163; s. 34, ch. 87-238; s. 21, ch. 88-337; s. 33, ch. 89-294; s. 6, ch. 90-50; s. 51, ch. 90-306; s. 7, ch. 91-57; s. 17, ch. 91-71; s. 6, ch. 93-25; s. 59, ch. 94-164; ss. 22, 44, ch. 95-228; s. 9, ch. 95-266; s. 51, ch. 95-267; s. 133, ch. 95-418; s. 1, ch. 96-215; s. 14, ch. 96-268; s. 14, ch. 96-402; s. 271, ch. 96-406; s. 1041, ch. 97-103; s. 43, ch. 97-264; s. 257, ch. 98-166; s. 31, ch. 98-403; s. 4, ch. 99-168; s. 10, ch. 99-193; s. 41, ch. 2000-419; s. 3, ch. 2000-188; s. 1, ch. 2000-217; s. 1, ch. 2001-53; s. 1, ch. 2003-127; s. 7, ch. 2006-86; s. 2, ch. 2008-90; s. 5, ch. 2008-245; s. 3, ch. 2009-43; s. 1, ch. 2012-155; s. 4, ch. 2012-178; s. 6, ch. 2013-15; s. 4, ch. 2013-219; ss. 5, 50, ch. 2014-224; s. 1, ch. 2016-58; s. 1, ch. 2016-238.

Note.—Former ss. 828.041, 827.07(3), (4), (9), (13); s. 415.504.
743.015 Disabilities of nonage; removal.—

(1) A circuit court has jurisdiction to remove the disabilities of nonage of a minor age 16 or older residing in this state upon a petition filed by the minor’s natural or legal guardian or, if there is none, by a guardian ad litem.

(2) The petition shall contain the following information:

(a) The name, address, residence, and date of birth of the minor.

(b) The name, address, and current location of each of the minor’s parents, if known.

(c) The name, date of birth, custody, and location of any children born to the minor.

(d) A statement of the minor’s character, habits, education, income, and mental capacity for business, and an explanation of how the needs of the minor with respect to food, shelter, clothing, medical care, and other necessities will be met.

(e) Whether the minor is a party to or the subject of a pending judicial proceeding in this state or any other jurisdiction, or the subject of a judicial order of any description issued in connection with such pending judicial proceeding.

(f) A statement of the reason why the court should remove the disabilities of nonage.

(3) If the petition is filed by the natural or legal guardian, the court must appoint an attorney ad litem for the minor child, and the minor child shall be brought before the court to determine if the interest of the minor will be fully protected by the removal of disabilities of nonage. The attorney ad litem shall represent the child in all related proceedings.

(4) If the petition is filed by the guardian ad litem or next friend, service of process must be perfected on the natural parents.

(5) If both parents are not jointly petitioning the court for the removal of the disabilities of nonage of the minor, service of process must be made upon the nonpetitioning parent. Constructive service of process may be used, provided the petitioning parent makes an actual, diligent search to discover the location of, and provide notice to, the nonpetitioning parent.

(6) The court shall consider the petition and receive such evidence as it deems necessary to rule on the petition. If the court determines that removal of the disabilities of nonage is in the minor’s best interest, it shall enter an order to that effect. An order removing the disabilities of nonage shall have the effect of giving the minor the status of an adult for purposes of all criminal and civil laws of the state, and shall authorize the minor thereafter to exercise all of the rights and responsibilities of persons who are 18 years of age or older.

(7) The court shall consider the petition and, if satisfied that the removal of the disabilities is in the minor’s best interest, shall remove the disabilities of nonage; and shall authorize the minor to perform all acts that the minor could do if he or she were 18 years of age.

(8) The judgment shall be recorded in the county in which the minor resides, and a certified copy shall be received as evidence of the removal of disabilities of nonage for all matters in all courts.

History.—s. 25, ch. 92-287; s. 5, ch. 93-230; s. 1064, ch. 97-102. Note.—Former s. 39.016.
APPENDIX V

Title XLIII DOMESTIC RELATIONS
Chapter 743 DISABILITY OF NONAGE OF MINORS REMOVED

743.064 Emergency medical care or treatment to minors without parental consent.—
(1) The absence of parental consent notwithstanding, a physician licensed under chapter 458 or an osteopathic physician licensed under chapter 459 may render emergency medical care or treatment to any minor who has been injured in an accident or who is suffering from an acute illness, disease, or condition if, within a reasonable degree of medical certainty, delay in initiation or provision of emergency medical care or treatment would endanger the health or physical well-being of the minor, and provided such emergency medical care or treatment is administered in a hospital licensed by the state under chapter 395 or in a college health service. Emergency medical care or treatment may also be rendered in the prehospital setting by paramedics, emergency medical technicians, and other emergency medical services personnel, provided such care is rendered consistent with the provisions of chapter 401. These persons shall follow the general guidelines and notification provisions of this section.

(2) This section shall apply only when parental consent cannot be immediately obtained for one of the following reasons:
(a) The minor’s condition has rendered him or her unable to reveal the identity of his or her parents, guardian, or legal custodian, and such information is unknown to any person who accompanied the minor to the hospital.
(b) The parents, guardian, or legal custodian cannot be immediately located by telephone at their place of residence or business.

(3) Notification shall be accomplished as soon as possible after the emergency medical care or treatment is administered. The hospital records shall reflect the reason such consent was not initially obtained and shall contain a statement by the attending physician that immediate emergency medical care or treatment was necessary for the patient’s health or physical well-being. The hospital records shall be open for inspection by the person legally responsible for the minor.

(4) No person as delineated in subsection (1), hospital, or college health service shall incur civil liability by reason of having rendered emergency medical care or treatment pursuant to this section, provided such treatment or care was rendered in accordance with acceptable standards of medical practice.

History.—s. 1, ch. 79-302; s. 66, ch. 86-220; s. 1, ch. 90-42; s. 1066, ch. 97-102.
743.067 Certified unaccompanied homeless youths.—
(1) For purposes of this section, an “unaccompanied homeless youth” is an individual who is 16 years of age or older and is:
(a) Found by a school district’s liaison for homeless children and youths to be an unaccompanied homeless youth eligible for services pursuant to the McKinney-Vento Homeless Assistance Act, 42 U.S.C. ss. 11431-11435; or
(b) Believed to qualify as an unaccompanied homeless youth, as that term is defined in the McKinney-Vento Homeless Assistance Act, by:
1. The director of an emergency shelter program funded by the United States Department of Housing and Urban Development, or the director’s designee;
2. The director of a runaway or homeless youth basic center or transitional living program funded by the United States Department of Health and Human Services, or the director’s designee; or
3. A continuum of care lead agency, or its designee.
(2)(a) The State Office on Homelessness within the Department of Children and Families shall develop a standardized form that must be used by the entities specified in subsection (1) to certify qualifying unaccompanied homeless youth. The front of the form must include the circumstances that qualify the youth; the date the youth was certified; and the name, title, and signature of the certifying individual. This section must be reproduced in its entirety on the back of the form.
(b) A certified unaccompanied homeless youth may use the completed form to apply at no charge for an identification card issued by the Department of Highway Safety and Motor Vehicles pursuant to s. 322.051(9).
(c) A health care provider may accept the written certificate as proof of the minor’s status as a certified unaccompanied homeless youth and may keep a copy of the certificate in the youth’s medical file.
(3) A certified unaccompanied homeless youth may:
(a) Petition the circuit court to have the disabilities of nonage removed under s. 743.015. The youth shall qualify as a person not required to prepay costs and fees as provided in s. 57.081. The court shall advance the cause on the calendar.
(b) Notwithstanding s. 394.4625(1), consent to medical, dental, psychological, substance abuse, and surgical diagnosis and treatment, including preventative care and care by a facility licensed under chapter 394, chapter 395, or chapter 397 and any medical forensic examination for the purpose of investigating any felony offense under chapter 784, chapter 787, chapter 794, chapter 800, or chapter 827, for:
1. Himself or herself; or
2. His or her child, if the certified unaccompanied homeless youth is unmarried, is the parent of the child, and has actual custody of the child.
(4) This section does not affect the requirements of s. 390.01114.
History.—s. 4, ch. 2012-186; s. 1, ch. 2014-173; s. 36, ch. 2017-151.
APPENDIX VII

Unaccompanied Homeless Youth Certificate
For the Purposes of Accessing Eligible Services* in the State of Florida

Re: ______________________________ Date of Birth: ____________________
(Name of Youth, please type or print clearly) (Month/Day/Year)

Current Mailing Address of Youth (if none, please list name, phone number, and mailing address of current contact):

________________________________________________________
(Address) (City) (State) (Zip) (Telephone)

Per Section 743.067, Florida Statutes, I am authorized to determine that this youth is an unaccompanied homeless youth who is 16 years of age or older and is eligible for services pursuant to the McKinney-Vento Homeless Assistance Improvements Act, 42 U.S.C. §11431-11435, and am providing this form of certification as the (please check):

☐ McKinney-Vento School District Liaison for Homeless Children and Youths
☐ The director of an emergency shelter program funded by the United States Department of Housing and Urban Development, or the director’s designee
☐ The director of a runaway or homeless youth basic center or transitional living program funded by the United States Department of Health and Human Services, or the director’s designee
☐ A continuum of care lead agency, or its designee

I also hereby certify that the above-named youth (please check):

☐ WAS IDENTIFIED AS AN UNACCOMPANIED HOMELESS YOUTH ON __________________
(Month/Day/Year)

Should you have additional questions or need more information about this youth, please contact me at the following number: ________________________________(include area code and extension)

I, ________________________, hereby attest that the information provided by me is true to the best of my knowledge

________________________________________________________
Signature of Certified Unaccompanied Youth Date Signed

________________________________________________________
Print Name of Certifying Individual Signature Title Agency

*Certified homeless youth may use the completed form to apply at no charge for an identification card issued by the Department of Highway Safety and Motor Vehicles. A health care provider may accept the written certificate as proof of the minor’s status as a certified unaccompanied homeless youth and make a copy of the certificate to keep in the youth’s medical file.
39.303 Child protection teams and sexual abuse treatment programs; services; eligible cases.—

(1) The Children’s Medical Services Program in the Department of Health shall develop, maintain, and coordinate the services of one or more multidisciplinary child protection teams in each of the service circuits of the Department of Children and Families. Such teams may be composed of appropriate representatives of school districts and appropriate health, mental health, social service, legal service, and law enforcement agencies. The Department of Health and the Department of Children and Families shall maintain an interagency agreement that establishes protocols for oversight and operations of child protection teams and sexual abuse treatment programs. The State Surgeon General and the Deputy Secretary for Children’s Medical Services, in consultation with the Secretary of Children and Families and the Statewide Medical Director for Child Protection, shall maintain the responsibility for the screening, employment, and, if necessary, the termination of child protection team medical directors in the 15 circuits.

(2)(a) The Statewide Medical Director for Child Protection must be a physician licensed under chapter 458 or chapter 459 who is a board-certified pediatrician with a subspecialty certification in child abuse from the American Board of Pediatrics.

(b) Each child protection team medical director must be a physician licensed under chapter 458 or chapter 459 who is a board-certified physician in pediatrics or family medicine and, within 2 years after the date of employment as a child protection team medical director, obtains a subspecialty certification in child abuse from the American Board of Pediatrics or within 2 years meet the minimum requirements established by a third-party credentialing entity recognizing a demonstrated specialized competence in child abuse pediatrics pursuant to paragraph (d). Each child protection team medical director employed on July 1, 2015, must, by July 1, 2019, either obtain a subspecialty certification in child abuse from the American Board of Pediatrics or meet the minimum requirements established by a third-party credentialing entity recognizing a demonstrated specialized competence in child abuse pediatrics pursuant to paragraph (d). Child protection team medical directors shall be responsible for oversight of the teams in the circuits.

(c) All medical personnel participating on a child protection team must successfully complete the required child protection team training curriculum as set forth in protocols determined by the Deputy Secretary for Children’s Medical Services and the Statewide Medical Director for Child Protection.

(d) Contingent on appropriations, the Department of Health shall approve one or more third-party credentialing entities for the purpose of developing and administering a professional credentialing program for child protection team medical directors. Within 90 days after receiving documentation from a third-party credentialing entity, the department shall approve a third-party credentialing entity that demonstrates compliance with the following minimum standards:

1. Establishment of child abuse pediatrics core competencies, certification standards, testing instruments, and recertification standards according to national psychometric standards.

2. Establishment of a process to administer the certification application, award, and maintenance processes according to national psychometric standards.

3. Demonstrated ability to administer a professional code of ethics and disciplinary process that applies to all certified persons.
4. Establishment of, and ability to maintain, a publicly accessible Internet-based database that contains information on each person who applies for and is awarded certification, such as the person’s first and last name, certification status, and ethical or disciplinary history.

5. Demonstrated ability to administer biennial continuing education and certification renewal requirements.

6. Demonstrated ability to administer an education provider program to approve qualified training entities and to provide precertification training to applicants and continuing education opportunities to certified professionals.

(3) The Department of Health shall use and convene the child protection teams to supplement the assessment and protective supervision activities of the family safety and preservation program of the Department of Children and Families. This section does not remove or reduce the duty and responsibility of any person to report pursuant to this chapter all suspected or actual cases of child abuse, abandonment, or neglect or sexual abuse of a child. The role of the child protection teams is to support activities of the program and to provide services deemed by the child protection teams to be necessary and appropriate to abused, abandoned, and neglected children upon referral. The specialized diagnostic assessment, evaluation, coordination, consultation, and other supportive services that a child protection team must be capable of providing include, but are not limited to, the following:

(a) Medical diagnosis and evaluation services, including provision or interpretation of X rays and laboratory tests, and related services, as needed, and documentation of related findings.
(b) Telephone consultation services in emergencies and in other situations.
(c) Medical evaluation related to abuse, abandonment, or neglect, as defined by policy or rule of the Department of Health.
(d) Such psychological and psychiatric diagnosis and evaluation services for the child or the child’s parent or parents, legal custodian or custodians, or other caregivers, or any other individual involved in a child abuse, abandonment, or neglect case, as the team may determine to be needed.
(e) Expert medical, psychological, and related professional testimony in court cases.
(f) Case staffings to develop treatment plans for children whose cases have been referred to the team. A child protection team may provide consultation with respect to a child who is alleged or is shown to be abused, abandoned, or neglected, which consultation shall be provided at the request of a representative of the family safety and preservation program or at the request of any other professional involved with a child or the child’s parent or parents, legal custodian or custodians, or other caregivers. In every such child protection team case staffing, consultation, or staff activity involving a child, a family safety and preservation program representative shall attend and participate.
(g) Case service coordination and assistance, including the location of services available from other public and private agencies in the community.
(h) Such training services for program and other employees of the Department of Children and Families, employees of the Department of Health, and other medical professionals as is deemed appropriate to enable them to develop and maintain their professional skills and abilities in handling child abuse, abandonment, and neglect cases.
(i) Educational and community awareness campaigns on child abuse, abandonment, and neglect in an effort to enable citizens more successfully to prevent, identify, and treat child abuse, abandonment, and neglect in the community.
(j) Child protection team assessments that include, as appropriate, medical evaluations, medical consultations, family psychosocial interviews, specialized clinical interviews, or forensic interviews.
A child protection team that is evaluating a report of medical neglect and assessing the health care needs of a medically complex child shall consult with a physician who has experience in treating children with the same condition.

(4) The child abuse, abandonment, and neglect reports that must be referred by the department to child protection teams of the Department of Health for an assessment and other appropriate available support services as set forth in subsection (3) must include cases involving:
   (a) Injuries to the head, bruises to the neck or head, burns, or fractures in a child of any age.
   (b) Bruises anywhere on a child 5 years of age or under.
   (c) Any report alleging sexual abuse of a child.
   (d) Any sexually transmitted disease in a prepubescent child.
   (e) Reported malnutrition of a child and failure of a child to thrive.
   (f) Reported medical neglect of a child.
   (g) Any family in which one or more children have been pronounced dead on arrival at a hospital or other health care facility, or have been injured and later died, as a result of suspected abuse, abandonment, or neglect, when any sibling or other child remains in the home.
   (h) Symptoms of serious emotional problems in a child when emotional or other abuse, abandonment, or neglect is suspected.

(5) All abuse and neglect cases transmitted for investigation to a circuit by the hotline must be simultaneously transmitted to the child protection team for review. For the purpose of determining whether a face-to-face medical evaluation by a child protection team is necessary, all cases transmitted to the child protection team which meet the criteria in subsection (4) must be timely reviewed by:
   (a) A physician licensed under chapter 458 or chapter 459 who holds board certification in pediatrics and is a member of a child protection team;
   (b) A physician licensed under chapter 458 or chapter 459 who holds board certification in a specialty other than pediatrics, who may complete the review only when working under the direction of the child protection team medical director or a physician licensed under chapter 458 or chapter 459 who holds board certification in pediatrics and is a member of a child protection team;
   (c) An advanced registered nurse practitioner licensed under chapter 464 who has a specialty in pediatrics or family medicine and is a member of a child protection team;
   (d) A physician assistant licensed under chapter 458 or chapter 459, who may complete the review only when working under the supervision of the child protection team medical director or a physician licensed under chapter 458 or chapter 459 who holds board certification in pediatrics and is a member of a child protection team; or
   (e) A registered nurse licensed under chapter 464, who may complete the review only when working under the direct supervision of the child protection team medical director or a physician licensed under chapter 458 or chapter 459 who holds board certification in pediatrics and is a member of a child protection team.

(6) A face-to-face medical evaluation by a child protection team is not necessary when:
   (a) The child was examined for the alleged abuse or neglect by a physician who is not a member of the child protection team, and a consultation between the child protection team medical director or a child protection team board-certified pediatrician, advanced registered nurse practitioner, physician assistant working under the supervision of a child protection team medical director or a child protection team board-certified pediatrician, or registered nurse working under the direct supervision of a child protection team medical director or a child protection team board-
certified pediatrician, and the examining physician concludes that a further medical evaluation is unnecessary;

(b) The child protective investigator, with supervisory approval, has determined, after conducting a child safety assessment, that there are no indications of injuries as described in paragraphs (4)(a)-(h) as reported; or

(c) The child protection team medical director or a child protection team board-certified pediatrician, as authorized in subsection (5), determines that a medical evaluation is not required.

Notwithstanding paragraphs (a), (b), and (c), a child protection team medical director or a child protection team pediatrician, as authorized in subsection (5), may determine that a face-to-face medical evaluation is necessary.

(7) In all instances in which a child protection team is providing certain services to abused, abandoned, or neglected children, other offices and units of the Department of Health, and offices and units of the Department of Children and Families, shall avoid duplicating the provision of those services.

(8) The Department of Health child protection team quality assurance program and the Family Safety Program Office of the Department of Children and Families shall collaborate to ensure referrals and responses to child abuse, abandonment, and neglect reports are appropriate. Each quality assurance program shall include a review of records in which there are no findings of abuse, abandonment, or neglect, and the findings of these reviews shall be included in each department’s quality assurance reports.

(9)(a) Children’s Medical Services shall convene a task force to develop a standardized protocol for forensic interviewing of children suspected of having been abused. The Department of Health shall provide staff to the task force as necessary. The task force shall include:

1. A representative from the Florida Prosecuting Attorneys Association.
2. A representative from the Florida Psychological Association.
3. The Statewide Medical Director for Child Protection.
5. The executive director of the Statewide Guardian Ad Litem Office.
6. A representative from a community-based care lead agency.
7. A representative from Children's Medical Services.
10. A representative from the Florida Network of Children’s Advocacy Centers.

(b) Children’s Medical Services must provide the standardized protocol to the President of the Senate and the Speaker of the House of Representatives by July 1, 2018.

(c) Members of the task force are not entitled to per diem or other payment for service on the task force.

(10) The Children’s Medical Services program in the Department of Health shall develop, maintain, and coordinate the services of one or more sexual abuse treatment programs.

(a) A child under the age of 18 who is alleged to be a victim of sexual abuse, his or her siblings, non-offending caregivers, and family members who have been impacted by sexual abuse are eligible for services.

(b) Sexual abuse treatment programs must provide specialized therapeutic treatment to victims of child sexual abuse, their siblings, non-offending caregivers, and family members to assist in recovery from sexual abuse, to prevent developmental impairment, to restore the children’s pre-abuse level of developmental functioning, and to promote healthy, non-abusive relationships.
Therapeutic intervention services must include crisis intervention, clinical treatment, and individual, family, and group therapy.

(c) The sexual abuse treatment programs and child protection teams must provide referrals for victims of child sexual abuse and their families, as appropriate.

History.—s. 9, ch. 84-226; s. 63, ch. 85-81; s. 23, ch. 88-337; s. 53, ch. 90-306; s. 24, ch. 95-228; s. 273, ch. 96-406; s. 1043, ch. 97-103; s. 4, ch. 97-237; s. 13, ch. 98-137; s. 31, ch. 98-166; s. 40, ch. 98-403; s. 9, ch. 99-168; s. 42, ch. 99-397; s. 5, ch. 2000-217; s. 2, ch. 2000-367; s. 9, ch. 2006-86; s. 4, ch. 2008-6; s. 13, ch. 2014-19; s. 9, ch. 2014-224; s. 2, ch. 2015-177; s. 1, ch. 2017-153.

Note.—Former s. 415.5055.
Title V
JUDICIAL BRANCH
Chapter 39
PROCEEDINGS RELATING TO CHILDREN

View Entire Chapter

APPENDIX IX

Sheriffs of certain counties to provide child protective investigative services; procedures; funding.—

(1) As described in this section, the Department of Children and Families shall, by the end of fiscal year 1999-2000, transfer all responsibility for child protective investigations for Pinellas County, Manatee County, Broward County, and Pasco County to the sheriff of that county in which the child abuse, neglect, or abandonment is alleged to have occurred. Each sheriff is responsible for the provision of all child protective investigations in his or her county. Each individual who provides these services must complete the training provided to and required of protective investigators employed by the Department of Children and Families.

(2) During fiscal year 1998-1999, the Department of Children and Families and each sheriff’s office shall enter into a contract for the provision of these services. Funding for the services will be appropriated to the Department of Children and Families, and the department shall transfer to the respective sheriffs for the duration of fiscal year 1998-1999, funding for the investigative responsibilities assumed by the sheriffs, including federal funds that the provider is eligible for and agrees to earn and that portion of general revenue funds which is currently associated with the services that are being furnished under contract, and including, but not limited to, funding for all investigative, supervisory, and clerical positions; training; all associated equipment; furnishings; and other fixed capital items. The contract must specify whether the department will continue to perform part or none of the child protective investigations during the initial year. The sheriffs may either conduct the investigations themselves or may, in turn, subcontract with law enforcement officials or with properly trained employees of private agencies to conduct investigations related to neglect cases only. If such a subcontract is awarded, the sheriff must take full responsibility for any safety decision made by the subcontractor and must immediately respond with law enforcement staff to any situation that requires removal of a child due to a condition that poses an immediate threat to the child’s life. The contract must specify whether the services are to be performed by departmental employees or by persons determined by the sheriff. During this initial year, the department is responsible for quality assurance, and the department retains the responsibility for the performance of all child protective investigations. The department must identify any barriers to transferring the entire responsibility for child protective services to the sheriffs’ offices and must pursue avenues for removing any such barriers by means including, but not limited to, applying for federal waivers. By January 15, 1999, the department shall submit to the President of the Senate, the Speaker of the House of Representatives, and the chairs of the Senate and House committees that oversee departmental activities a report that describes any remaining barriers, including any that pertain to funding and related administrative issues. Unless the Legislature, on the basis of that report or other pertinent information, acts to block a transfer of the entire responsibility for child protective investigations to the sheriffs’ offices, the sheriffs of Pasco County, Manatee County, Broward County, and Pinellas County, beginning in fiscal year 1999-2000, shall assume the entire responsibility for such services, as provided in subsection (3).

(3)(a) Beginning in fiscal year 1999-2000, the sheriffs of Pasco County, Manatee County, Broward County, and Pinellas County have the responsibility to provide all child protective investigations in their respective counties. Beginning in fiscal year 2000-2001, the Department of Children and
Families is authorized to enter into grant agreements with sheriffs of other counties to perform child protective investigations in their respective counties.

(b) The sheriffs shall operate, at a minimum, in accordance with the performance standards and outcome measures established by the Legislature for protective investigations conducted by the Department of Children and Families. Each individual who provides these services must complete, at a minimum, the training provided to and required of protective investigators employed by the Department of Children and Families.

(c) Funds for providing child protective investigations must be identified in the annual appropriation made to the Department of Children and Families, which shall award grants for the full amount identified to the respective sheriffs’ offices. Notwithstanding the provisions of ss. 216.181(16)(b) and 216.351, the Department of Children and Families may advance payments to the sheriffs for child protective investigations. Funds for the child protective investigations may not be integrated into the sheriffs’ regular budgets. Budgetary data and other data relating to the performance of child protective investigations must be maintained separately from all other records of the sheriffs’ offices and reported to the Department of Children and Families as specified in the grant agreement.

(d) Program performance evaluation shall be based on criteria mutually agreed upon by the respective sheriffs and the Department of Children and Families. The program performance evaluation shall be conducted by a team of peer reviewers from the respective sheriffs’ offices that perform child protective investigations and representatives from the department. The Department of Children and Families shall submit an annual report regarding quality performance, outcome-measure attainment, and cost efficiency to the President of the Senate, the Speaker of the House of Representatives, and to the Governor no later than January 31 of each year the sheriffs are receiving general appropriations to provide child protective investigations.

39.304 Photographs, medical examinations, X rays, and medical treatment of abused, abandoned, or neglected child.—

(1) (a) Any person required to investigate cases of suspected child abuse, abandonment, or neglect may take or cause to be taken photographs of the areas of trauma visible on a child who is the subject of a report. Any child protection team that examines a child who is the subject of a report must take, or cause to be taken, photographs of any areas of trauma visible on the child. Photographs of physical abuse injuries, or duplicates thereof, shall be provided to the department for inclusion in the investigative file and shall become part of that file. Photographs of sexual abuse trauma shall be made part of the child protection team medical record.

(b) If the areas of trauma visible on a child indicate a need for a medical examination, or if the child verbally complains or otherwise exhibits distress as a result of injury through suspected child abuse, abandonment, or neglect, or is alleged to have been sexually abused, the person required to investigate may cause the child to be referred for diagnosis to a licensed physician or an emergency department in a hospital without the consent of the child’s parents or legal custodian. Such examination may be performed by any licensed physician or an advanced registered nurse practitioner licensed pursuant to part I of chapter 464. Any licensed physician, or advanced registered nurse practitioner licensed pursuant to part I of chapter 464, who has reasonable cause to suspect that an injury was the result of child abuse, abandonment, or neglect may authorize a radiological examination to be performed on the child without the consent of the child’s parent or legal custodian.

(2) Consent for any medical treatment shall be obtained in the following manner.

(a) 1. Consent to medical treatment shall be obtained from a parent or legal custodian of the child; or
   2. A court order for such treatment shall be obtained.

(b) If a parent or legal custodian of the child is unavailable and his or her whereabouts cannot be reasonably ascertained, and it is after normal working hours so that a court order cannot reasonably be obtained, an authorized agent of the department shall have the authority to consent to necessary medical treatment for the child. The authority of the department to consent to medical treatment in this circumstance shall be limited to the time reasonably necessary to obtain court authorization.

(c) If a parent or legal custodian of the child is available but refuses to consent to the necessary treatment, a court order shall be required unless the situation meets the definition of an emergency in s. 743.064 or the treatment needed is related to suspected abuse, abandonment, or neglect of the child by a parent or legal custodian. In such case, the department shall have the authority to consent to necessary medical treatment. This authority is limited to the time reasonably necessary to obtain court authorization.

In no case shall the department consent to sterilization, abortion, or termination of life support.

(3) Any facility licensed under chapter 395 shall provide to the department, its agent, or a child protection team that contracts with the department any photograph or report on examinations made or X rays taken pursuant to this section, or copies thereof, for the purpose of investigation or assessment of cases of abuse, abandonment, neglect, or exploitation of children.

(4) Any photograph or report on examinations made or X rays taken pursuant to this section, or copies thereof, shall be sent to the department as soon as possible and shall be preserved in permanent form in records held by the department.
(5) The county in which the child is a resident shall bear the initial costs of the examination of the allegedly abused, abandoned, or neglected child; however, the parents or legal custodian of the child shall be required to reimburse the county for the costs of such examination, other than an initial forensic physical examination as provided in s. 960.28, and to reimburse the department for the cost of the photographs taken pursuant to this section. A medical provider may not bill a child victim, directly or indirectly, for the cost of an initial forensic physical examination.

History.—ss. 1, 2, 3, 4, 5, 6, ch. 63-24; s. 941, ch. 71-136; ss. 1, 1A, ch. 71-97; s. 32, ch. 73-334; s. 65, ch. 74-383; s. 1, ch. 75-101; s. 1, ch. 75-185; s. 4, ch. 76-237; s. 1, ch. 77-77; s. 3, ch. 77-429; ss. 1, 2, ch. 78-322; s. 3, ch. 78-326; s. 22, ch. 78-361; s. 1, ch. 78-379; s. 181, ch. 79-164; s. 1, ch. 79-203; s. 75, ch. 86-220; s. 24, ch. 88-337; s. 35, ch. 89-294; s. 2, ch. 95-185; s. 133, ch. 97-101; s. 71, ch. 97-103; s. 42, ch. 98-403; s. 10, ch. 99-168; s. 17, ch. 99-193; s. 6, ch. 2000-217; s. 83, ch. 2000-318; s. 6, ch. 2009-43.

Note.—Former ss. 828.041, 827.07(5); s. 415.507.

ADD THIS TO NEXT REVISION, KA WRITES ON 11.14.18

Title XLIV  
CIVIL RIGHTS  
Chapter 765  
HEALTH CARE ADVANCE DIRECTIVES

765.105  Review of surrogate or proxy’s decision.—

(1) The patient’s family, the health care facility, or the primary physician, or any other interested person who may reasonably be expected to be directly affected by the surrogate or proxy’s decision concerning any health care decision may seek expedited judicial intervention pursuant to rule 5.900 of the Florida Probate Rules, if that person believes:

(a) The surrogate or proxy’s decision is not in accord with the patient’s known desires or this chapter;

(b) The advance directive is ambiguous, or the patient has changed his or her mind after execution of the advance directive;

(c) The surrogate or proxy was improperly designated or appointed, or the designation of the surrogate is no longer effective or has been revoked;

(d) The surrogate or proxy has failed to discharge duties, or incapacity or illness renders the surrogate or proxy incapable of discharging duties;

(e) The surrogate or proxy has abused his or her powers; or

(f) The patient has sufficient capacity to make his or her own health care decisions.
(2) This section does not apply to a patient who is not incapacitated and who has designated a surrogate who has immediate authority to make health care decisions or receive health information, or both, on behalf of the patient.

History.—s. 2, ch. 92-199; s. 4, ch. 94-183; s. 5, ch. 2015-153; s. 85, ch. 2016-10.
REFERENCES

Department of Children and Families. *Mental Health: Express and Informed Consent*


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