Critical Incident Rapid Response Team Advisory Committee
Third Quarter Report for Calendar Year 2018

Chad Poppell
Secretary

Ron DeSantis
Governor

Mission: Work in Partnership with Local Communities to Protect the Vulnerable, Promote Strong and Economically Self-Sufficient Families, and Advance Personal and Family Recovery and Resiliency

Florida Department of Children and Families
Critical Incident Rapid Response Team
Advisory Committee Report
Third Quarter 2018

I. Background

In 2014, the Florida Legislature passed section 39.2015, Florida Statutes, which established requirements for creating a Critical Incident Rapid Response Team (CIRRT), effective January 1, 2015 (see Appendix 1-2 for more details).

II. Purpose

CIRRT reviews 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 in an effort to identify root causes, rapidly determine the need to change policies and practices related to child protection and improving Florida's child welfare system. CIRRT reviews take into consideration the family's entire child welfare history, with specific attention to the most recent child welfare involvement and events surrounding the fatality, including the most recent verified incident of abuse or neglect.

III. Review of Child Fatality Data

From January 1, 2015 through September 30, 2018 a total of 104 CIRRT teams were deployed. Of those deployments, 98 met the CIRRT requirement of having a verified report within the previous 12 months, while the other six reviews were completed at the direction of the DCF Secretary. Of the six special reviews, three involved a recent history of physical abuse, two involved a recent history of substance misuse, and one team was deployed as there was an active investigation when the fatality occurred.

In 2016, 22 cases, involving 23 children, either met the criteria for a CIRRT deployment, due to having a verified report within 12 months of the reported death, or the Secretary requested a team be deployed. One of the CIRRT deployments involved two victims. Although these 23 children represent five percent of the overall fatalities reported to the Department of Children and Families' (department) Florida Abuse Hotline (Hotline), it is important to note there were 141 additional cases that met the criteria for a mini-CIRRT review (see Appendix 3). In total for 2016, in-depth quality assurance reviews were conducted on 163 cases with 164 victims, representing just fewer than 36 percent of all reported child deaths.

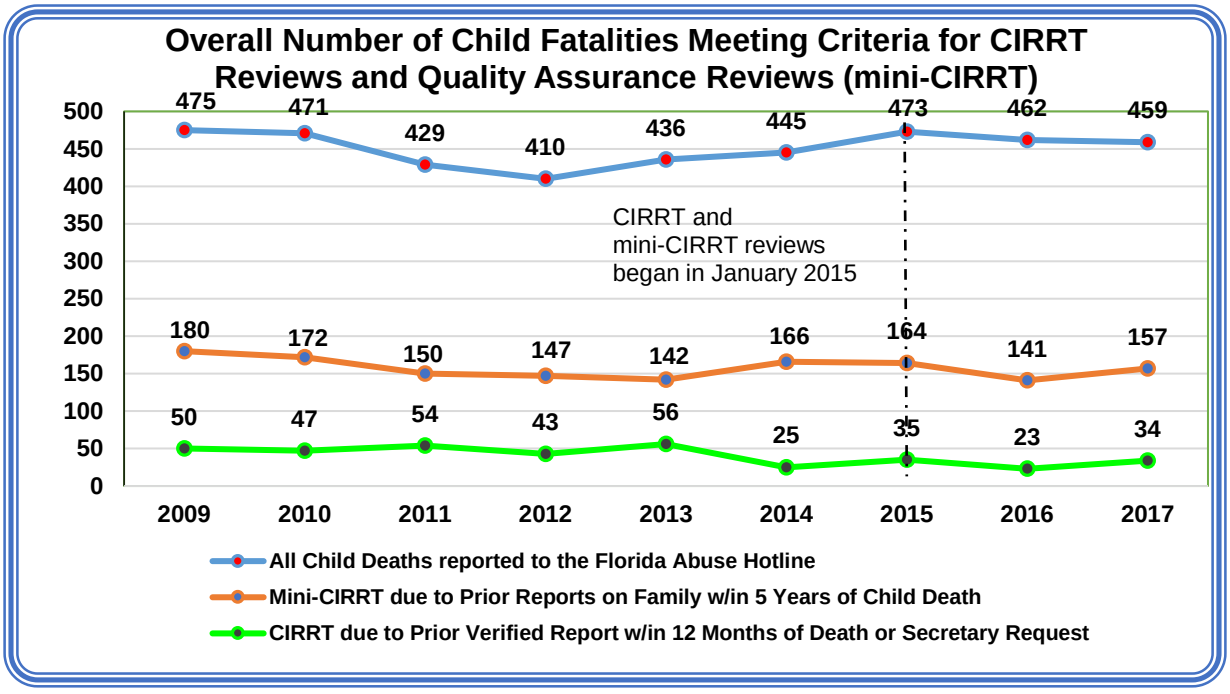
Of the 164 child fatalities received in 2016 where there was a CIRRT deployment or a mini-CIRRT review, the deceased child had no prior history in 72 (44 percent) of the cases reviewed. There is, however, a difference in percentages when comparing CIRRT and mini-CIRRT cases. For the 22 CIRRT cases involving 23 children, there was no

prior history involving the deceased child in six (27 percent) of the cases reviewed. In the 141 mini-CIRRT cases, there was no prior history involving the deceased child in 66 (47 percent) of the cases reviewed.

Of the 191 child fatalities received between January 1 and December 31, 2017 where there was a CIRRT deployment or mini-CIRRT review, the deceased child had no prior history in 86 (46 percent) of the cases reviewed. For the 34 CIRRT cases, there was no prior history involving the deceased child in four (12 percent) of the cases. In the 157 cases that met the criteria for a mini-CIRRT review, there was no prior history involving the deceased child in 82 (53 percent) of the cases.

Of the 123 child fatalities received between January 1 and September 30, 2018, where there was a CIRRT deployment or mini-CIRRT review, the deceased child had no prior history in 51 (41 percent) of the cases reviewed. For the 13 CIRRT cases, there was no prior history involving the deceased child in two (15 percent) of the cases. In the 110 cases that met the criteria for a mini-CIRRT review, there was no prior history involving the deceased child in 49 (45 percent) of the cases.

Based on the historical data, it is likely that in-depth quality assurance reviews will continue to be conducted on more than 40 percent of the child death cases received in a given year. Data in the chart below is based on the number of child victims, not by report received as there may be multiple victims in a report. It should be noted that the overall number of child fatalities for 2017 increased by one due to a report being received by the Hotline in the 2018 calendar year.



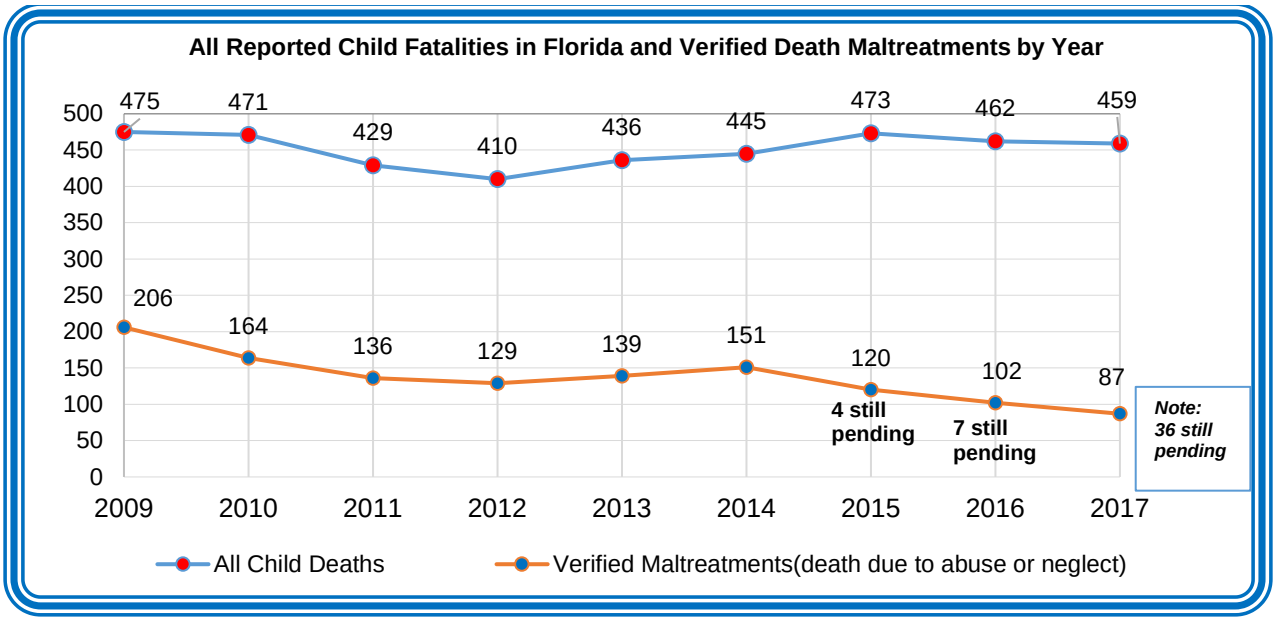
It should be noted that the chart above is a reflection of the number of actual child fatalities. Some cases involve multiple victims; however, only one respective review was

conducted. For example, while there were 23 child fatalities in 2016, there were only 22 deployments as one case involved two child fatalities. Likewise, while there are a specific number of child fatalities that meet the criteria for a mini-CIRRT, if there were multiple victims in the same case, only one review is completed.

Standardized data is collected across all review types and entered into Qualtrics for further analysis and review. Reports on reviews conducted as a result of a child fatality (regardless of the type of review completed) are redacted according to Florida Statutes and posted for public review on the department's Child Fatality Prevention website (http://www.dcf.state.fl.us/childfatality/) after the death investigation has been completed. According to Florida Statutes, the information redacted is based on whether the death maltreatment has been verified by the department as a result of caregiver abuse or neglect. Reports listed on the website as "pending" are awaiting closure of the death investigation and, at times, the medical examiner's findings.

Child deaths in Florida typically involve a child age three or younger and may involve a variety of causal factors including, but not limited to: sleep-related deaths, drownings, natural causes, inflicted trauma, Sudden Infant Death Syndrome (SIDS)/Sudden Unexplained Infant Death (SUID), and accidental trauma.

Of the 473 child fatalities that occurred in 2015 and were reported to the Hotline, four investigations remain open. Of the four investigations from 2015 that remain open, three were at the request of law enforcement/state attorney due to on-going criminal proceedings; and one was due to the pending reports from the medical examiner's office. For the 462 child fatalities that occurred in 2016 and were reported to the Hotline, seven remain open. Of the seven investigations from 2016 that remain open, five were at the request of law enforcement/state attorney due to on-going criminal proceedings, and two were pending closure in the field. Of the 455 closed 2016 child fatality investigations, 102 had verified findings for the death maltreatment. For the 459 child fatalities that occurred in 2017, 36 remain open. Of the 423 closed 2017 child fatality investigations, 87 had verified findings for the death maltreatment. It should be noted that findings for open cases have not yet been determined and may give the appearance of a decline in the number of verified reports until the official findings have been rendered.



III. Review of CIRRT Data

a. Summary of Third Quarter CIRRT Reports

During the third quarter, there were a total of two CIRRT deployments involving the Northeast and Southeast Regions. One of the two deployments occurred in Duval County, where the department is responsible for completing child protective investigations, and the other deployment occurred in Broward County, where the sheriff's office is responsible for completing child protective investigations.

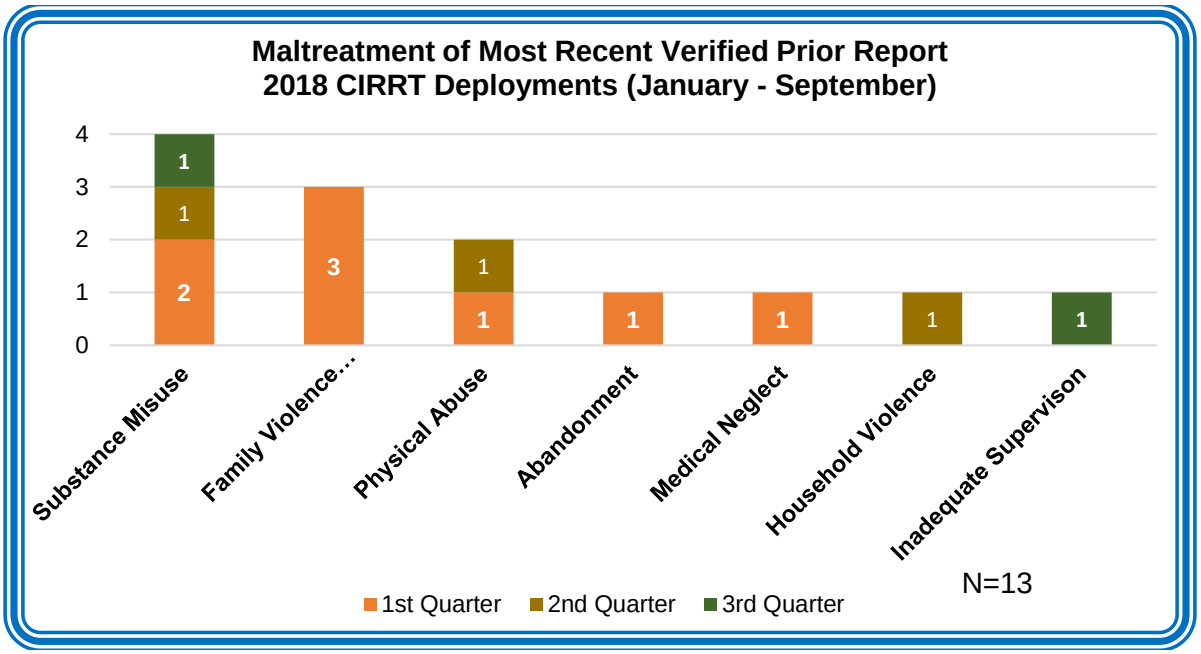
Both victims in cases requiring a CIRRT deployment during the third quarter involved children one year of age. One child was found unresponsive in a child care facility and the other was pronounced deceased after accidently being left in the car while his mother was at work.

At the time of the fatality, one of the two families was open to child welfare. In that case, there was an out-of-home case with the victim and siblings placed with relatives; however, the fatality occurred at the childcare center. In the remaining case, there was one prior investigation closed with verified findings of inadequate supervision.

b. Past Maltreatment

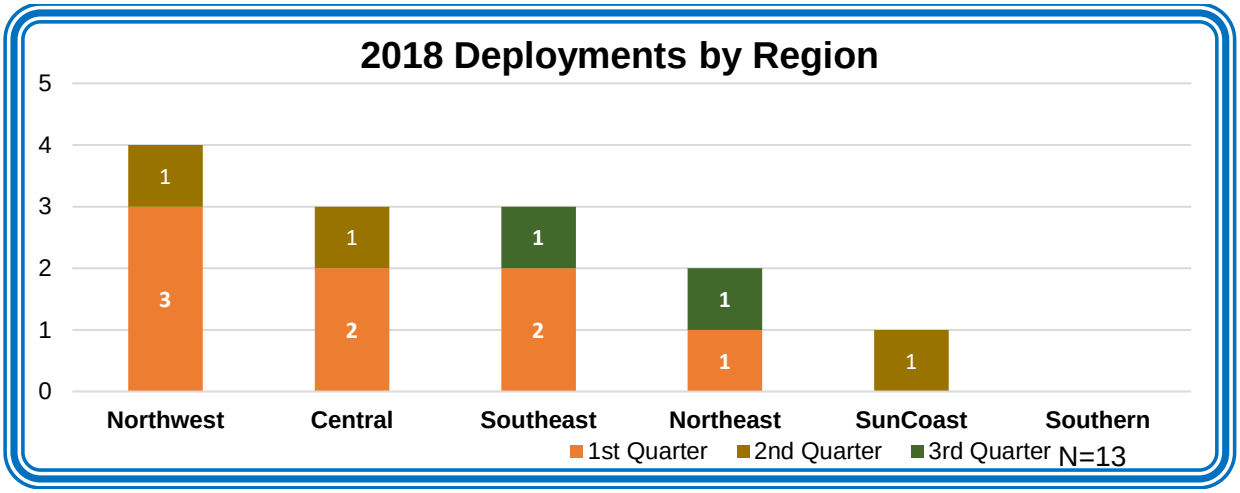
During the first three quarters (January through September) of 2018, there were 13 CIRRT deployments, with each having a verified prior report on the victim or a sibling within the previous 12 months. There were four deployments with a prior verified maltreatment of substance misuse, three deployments with a prior verified maltreatment of family violence threatens child, two deployments with a verified maltreatment of

physical abuse, and one deployment each of a verified maltreatment of abandonment, medical neglect, household violence threatens child, and inadequate supervision.

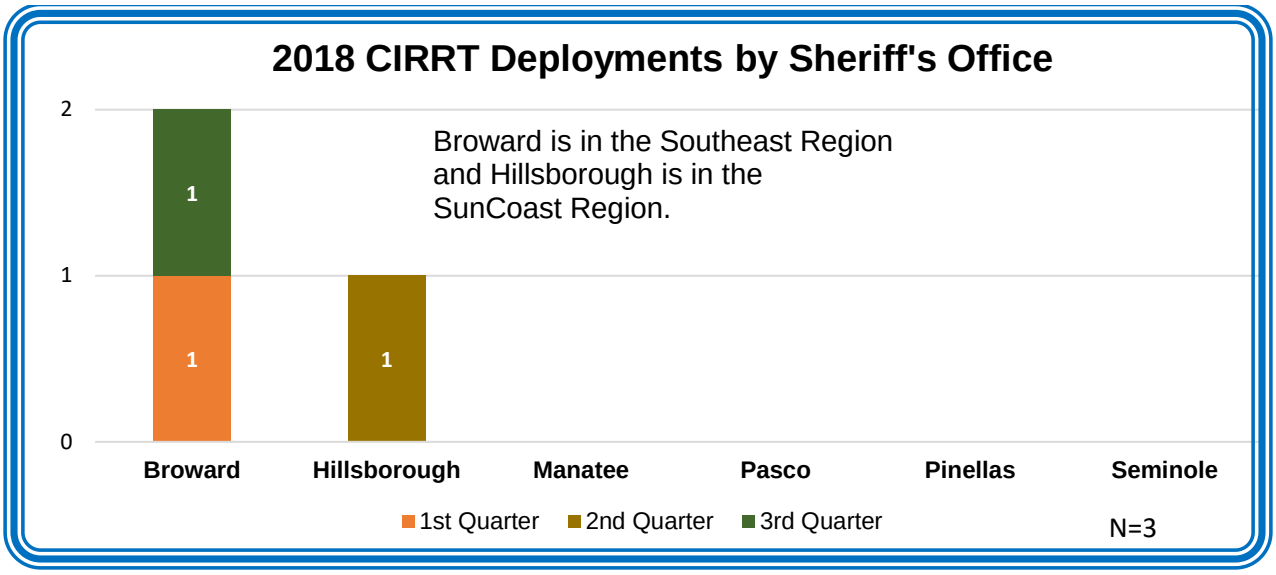


CIRRT Data by Region

From January 1, 2018, through September 30, 2018, there were a total of 13 CIRRT deployments occurring in five of the six regions. There were four deployments to the Northwest Region, three deployments each to the Central and Southeast Regions, two deployments to the Northeast Region, and one deployment to the SunCoast Region. Three deployments occurred in counties where the sheriffs' offices conduct child protective investigations; two deployments to Broward County and a deployment to Hillsborough County. The department is responsible for the completion of child protective investigations in the other counties where teams were deployed.

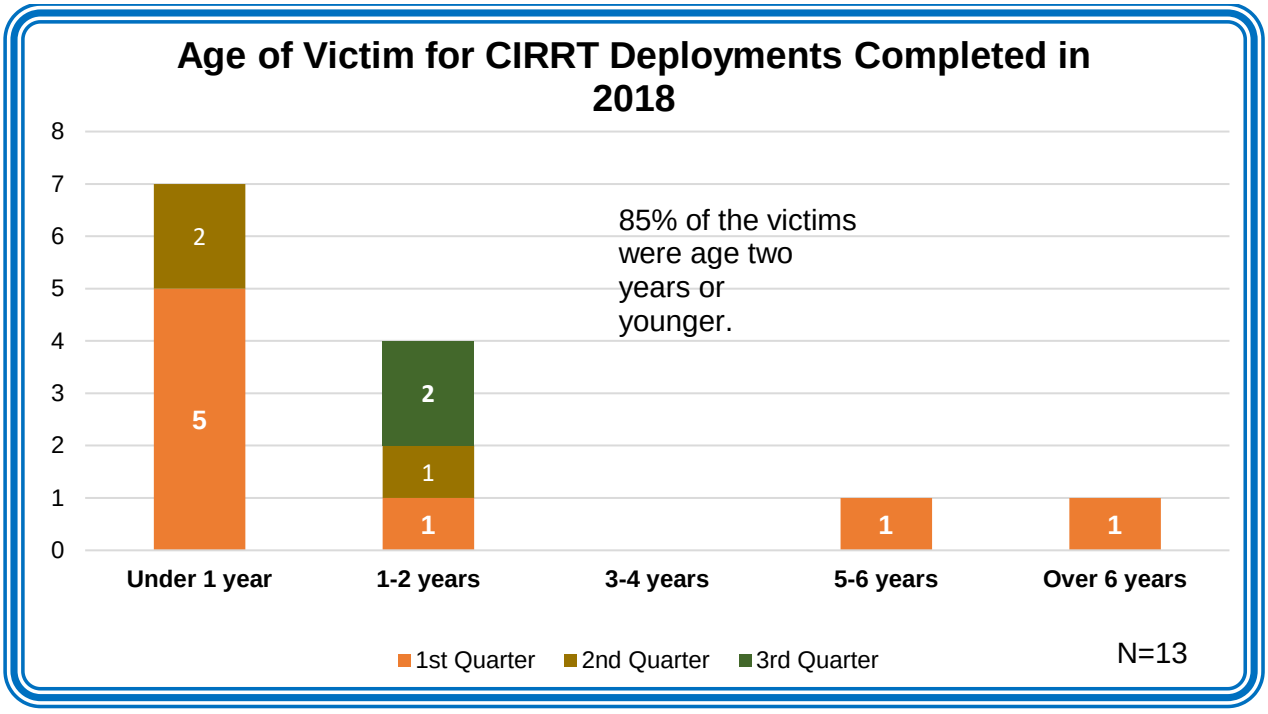


During the first three quarters of 2018, there were three CIRRT deployments to counties where sheriffs' offices are responsible for protective investigations.

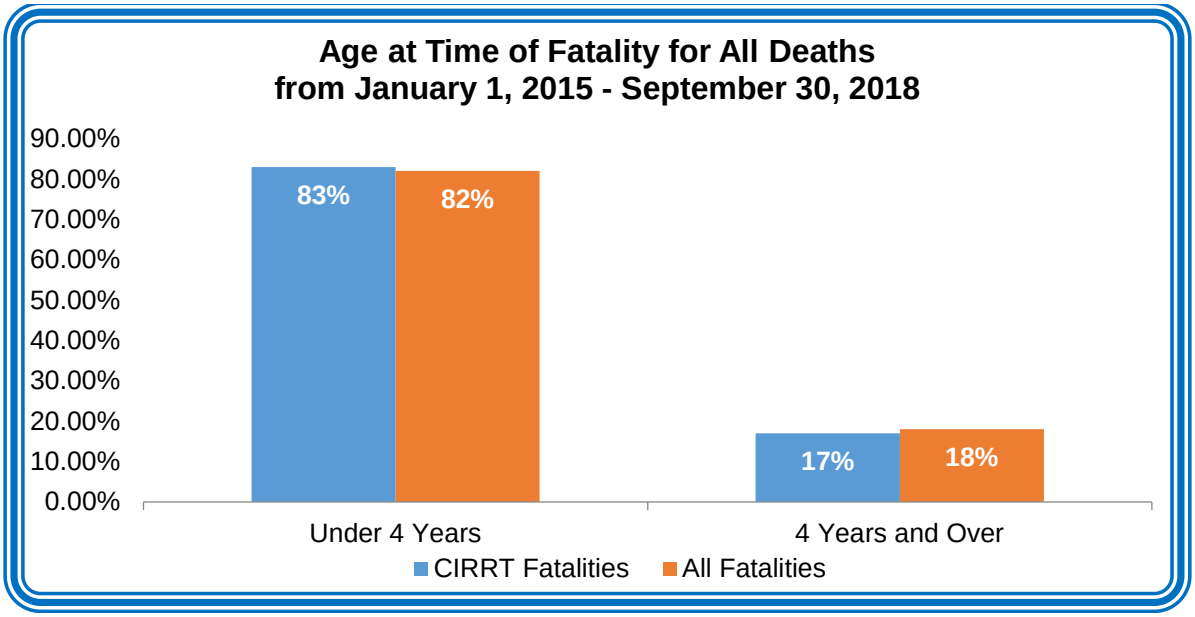


c. Age of Victim

There were 13 CIRRT deployments in the first three quarters of 2018, with 11 of the 13 victims age two years or younger.

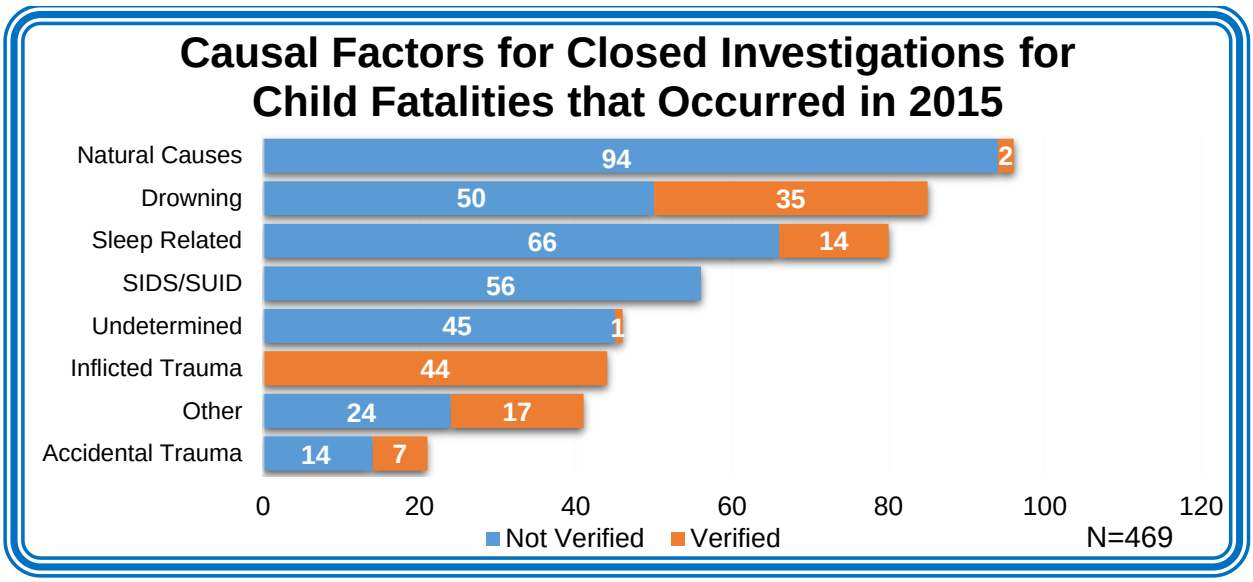


Of those child fatalities reported to the Hotline occurring from January 2015 through September 2018, 82 percent involved a child under the age of four. Similarly, 83 percent of all CIRRT deployments also involved children in this age group.

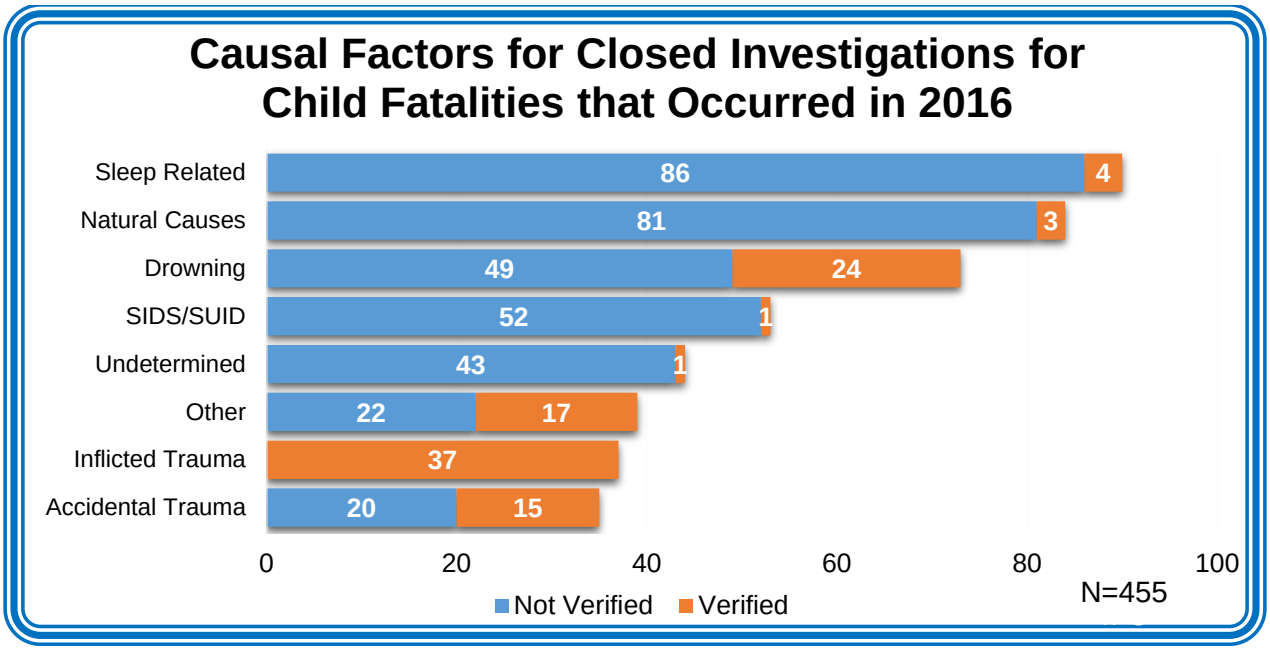


d. Causal Factors

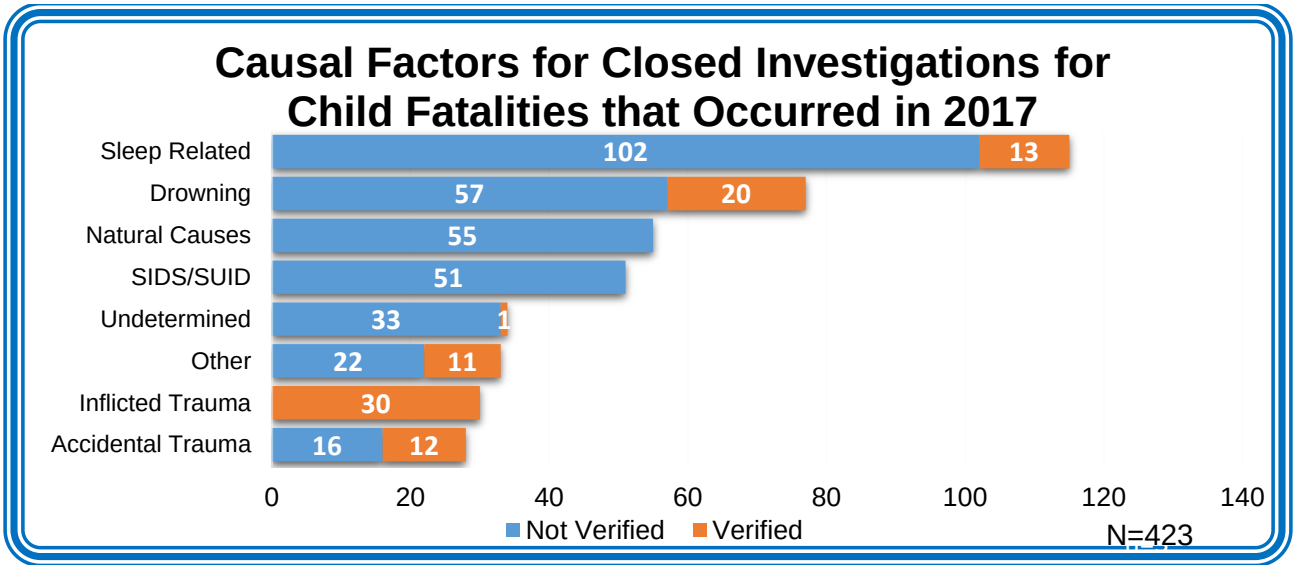
Of the 469 closed child fatalities that occurred in 2015, the four primary causal factors were natural causes, drowning, sleep-related, and SIDS/SUID. There are four child fatality investigations received during this time period that remain open. When finalized, they will impact the overall numbers and possibly the causal factor rankings.



Of the 455 closed child fatalities that occurred in 2016, the four primary causal factors were sleep-related, natural causes, drowning, and SIDS/SUID. One SIDS/SUID case was verified as the parents were arrested in connection with the fatality. There are seven child fatality investigations received during this time period that remain open. When finalized, they will impact the overall numbers and causal factor ranking.



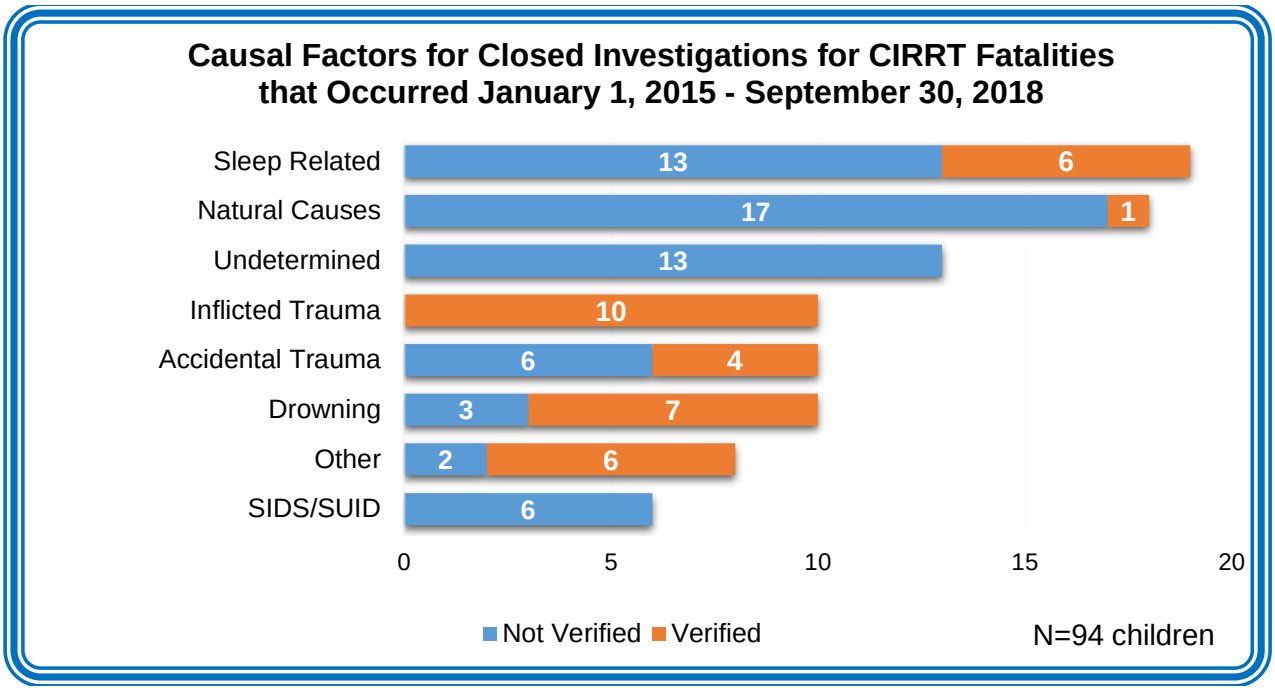
Of the 423 closed child fatalities that occurred in 2017, the four primary causal factors were sleep-related, drowning, natural causes, and SIDS/SUID. There are 36 child fatality investigations received during this time period that remain open. When finalized, they will impact the overall numbers and causal factor ranking.



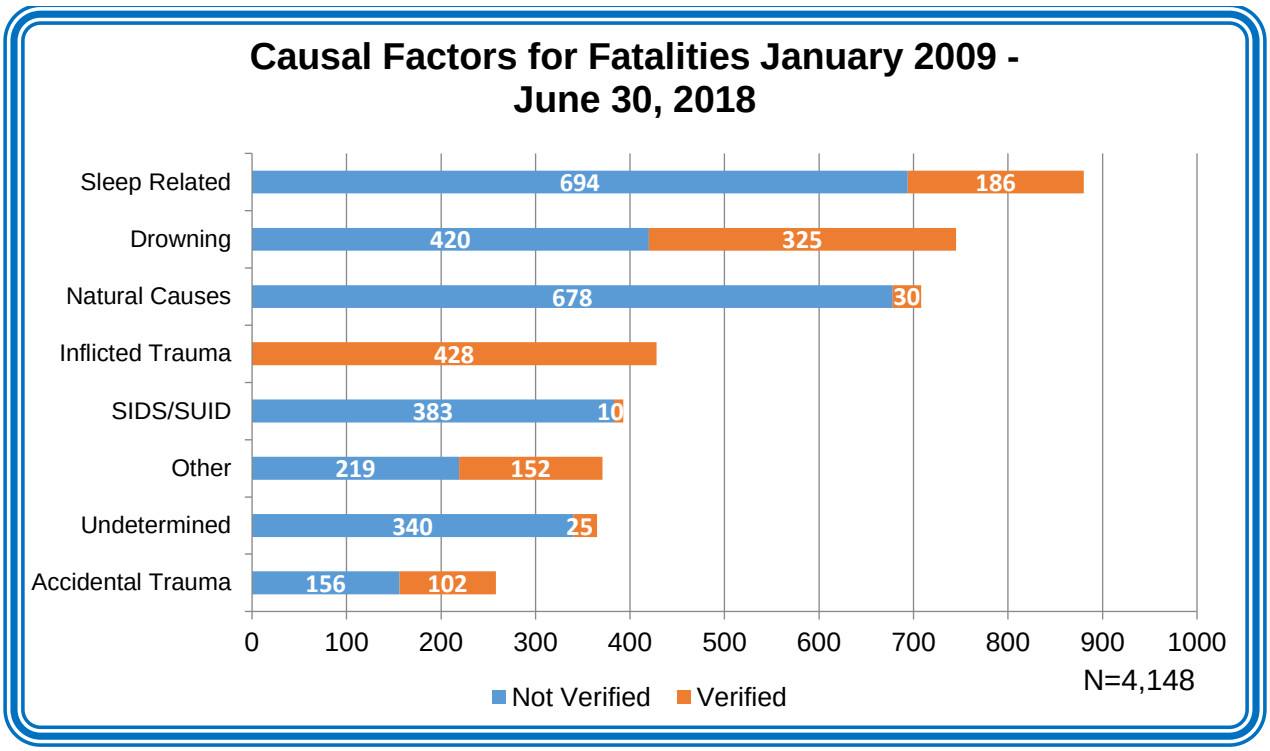
The death maltreatment cannot be used as a stand-alone maltreatment; therefore, the underlying maltreatment that may have caused or contributed to the child death is noted. For an investigation to be closed with verified findings for the death maltreatment, there must be a preponderance of credible evidence that the child died as a result of a direct, willful act of the caregiver(s), or the caregiver(s) failed to provide or make reasonable efforts to provide essential care or supervision for the child. Credible evidence used to determine verified findings for the death maltreatment includes the medical examiner report, law enforcement reports, and medical records when necessary. For example, there were two deaths attributed to natural causes that were subsequently closed with verified findings of maltreatment. One case involved an infant who died due to complications of prematurity in which the baby's pre-term birth could be directly linked to the mother's cocaine use. The other case involved an infant who died of malnutrition as a result of the caregiver's actions/inactions.

In cases where there may be insufficient evidence to support a verified finding of the death maltreatment, the investigation may still be closed with verified findings of other maltreatments.

Between January 1, 2015, and September 30, 2018, there were a total of 104 CIRRT deployments involving 105 child fatalities. Of the 93 investigations (involving 94 children) that were closed, 33 (35 percent) investigations involving 34 victims had verified findings for the death maltreatment. An additional 21 (23 percent) investigations were closed with verified findings for maltreatment other than the death maltreatment.



Between 2009 and September 30, 2018, the four leading causal factors of child fatalities reported to the Hotline were sleep-related (880), drowning (745), natural causes (708), and inflicted trauma (428).



Causal factors of child fatalities include the factors or situations leading to the death of the child. Sleep-related deaths include children found unresponsive, co-sleeping, or roll-overs. Causal factors for child fatalities due to natural causes include previously known medical issues or medically-complex children, as well as deaths due to previously undiagnosed medical issues. Reports are accepted by the Hotline for investigation when a child under the age of five is found deceased outside of a medical facility, and there is no indication of a known medical condition or a clear reason for trauma, such as a car accident. When a child dies in a hospital and abuse or neglect is suspected or, if the circumstances surrounding the death are unclear, a report of the death maltreatment will be accepted by the Hotline for investigation. The most common contributing factors of child fatalities coded as “other” are suicide, drug toxicity, accidental strangulation/choking, and house fires.

Although maltreatment findings were noted to be appropriate for the majority of the investigations, the investigations with a causal factor of SIDS/SUID and several of the investigations with a causal factor of *Undetermined* were inappropriately closed with a verified finding of the death maltreatment. In those cases, the findings were based solely on the surrounding circumstances (e.g., possible unsafe sleep environment, bedding, or position, etc.) as opposed to a medical examiner’s finding of fact.

IV. CIRRT Advisory Committee

The CIRRT Advisory Committee (Committee) is statutorily-required to meet on a quarterly basis. The Committee met most recently on September 18, 2018. Committee members may participate via conference call but are encouraged to attend in person. The meeting notices are published, and the meetings are open to the public. The primary focus of the Committee is to identify statewide systemic issues and provide recommendations to the department and Legislature that will improve policies and law related to child protection and child welfare services.

At the September 18, 2018 meeting, there was discussion regarding cases that required a deployment where there was no relationship between the family involved in the prior investigation and the child fatality. Examples included families that were involved in a prior verified report within the past twelve months; however, the fatality that occurs in a child care setting, prior reports involving a half-sibling whom never lived in the household with the victim, and cases where children were deemed unsafe, removed from the home, and a fatality occurs.

The Committee discussed cases where the most recent involvement with the family occurred while the mother was pregnant; prior to the birth of the child victim, as an opportunity to impact child welfare practice through enhanced conversations and possible use of YouTube videos to discuss safe sleep practices with caregivers and parents of child bearing age. The Committee reviewed and discussed safety actions and safety plans which address safe sleep for parents with substance issues. Moreover, the Plan of Safe Care Policy as it relates to substance abusing mothers was discussed. The plan involves multiple partner agencies including Healthy Start and Healthy Families.

Findings from special reviews – which involve cases that do not meet the requirements for a CIRRT deployment, however, an in-depth review is requested and completed – were discussed. Sharing of information between agencies including substance abuse, mental health providers, and domestic violence providers was noted as a barrier that may need addressed through various statutory changes.

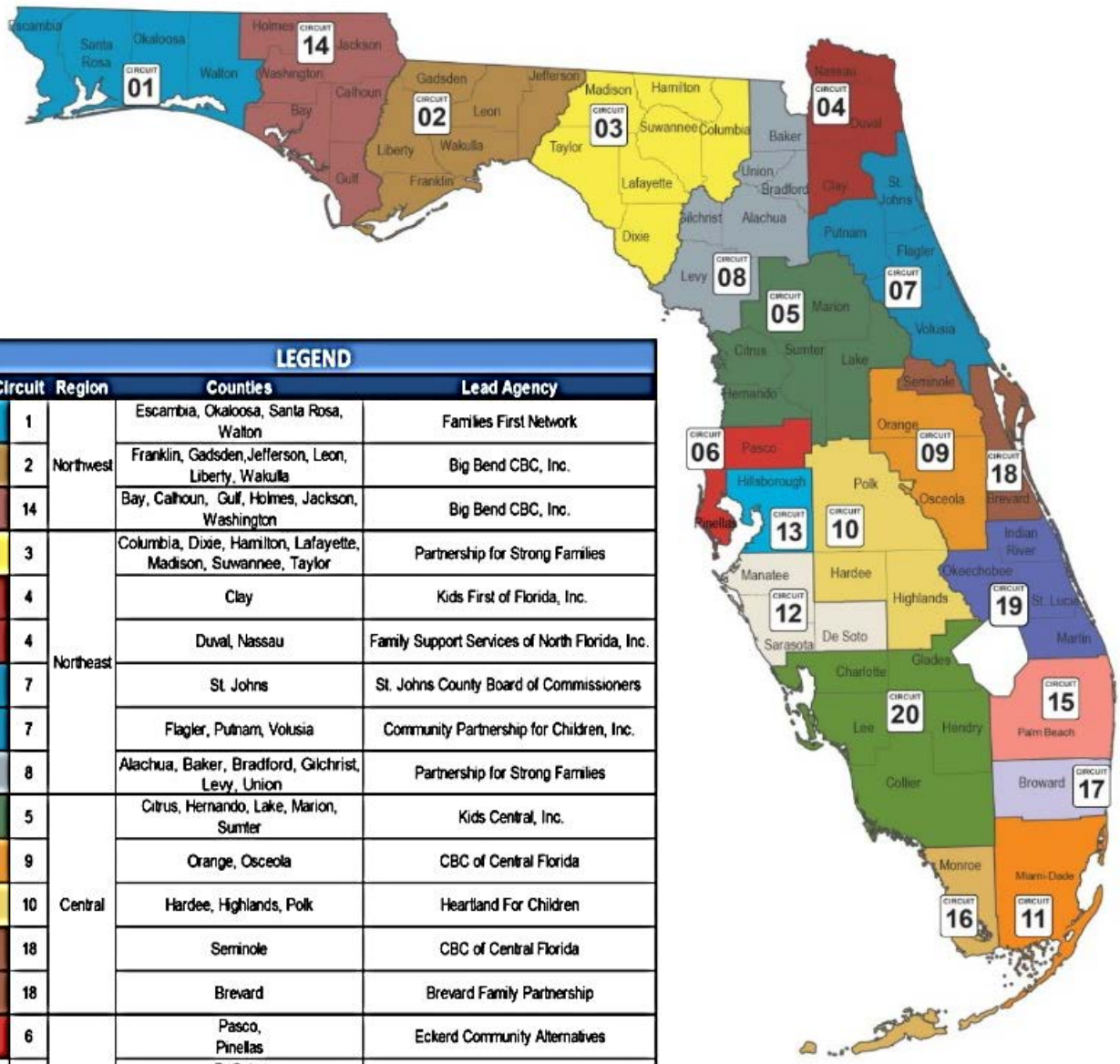
APPENDIX 1 – Section 39.2015, Florida Statutes

Section 39.2015, Florida Statutes, effective January 1, 2015, requires:

- An immediate onsite investigation by a CIRRT 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 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 CIRRT investigation begins.
- The Secretary may direct an immediate investigation for 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.
- Legislative changes, effective July 1, 2015, require the Committee to meet and submit reports quarterly to the Secretary. The Secretary will submit the quarterly reports to the Governor, the Speaker of the House, and the President of the Senate.
- Beginning in the 1998-1999 fiscal years and under section 39.3065, Florida Statutes, the department transferred all responsibility for child protective investigations to the sheriffs' offices in Manatee, Pasco, Pinellas, Hillsborough, Broward, and Seminole counties*. The department is responsible for child protective investigations in the remaining 61 counties*.
- As intended in section 409.986, Florida Statutes, the department provides child welfare services to children through contracts with community-based care lead agencies for each of the 20 judicial circuits in the state.

*The sheriff's office in Walton county assumed responsibility for child protective investigations effective July 1, 2018. With this change, child protective investigations are conducted by the department in the remaining 60 counties.

APPENDIX 2 – Community Based Care Lead Agencies by Circuit and County



LEGEND

Circuit	Region	Counties	Lead Agency
1	Northwest	Escambia, Okaloosa, Santa Rosa, Walton	Families First Network
2		Franklin, Gadsden, Jefferson, Leon, Liberty, Wakulla	Big Bend CBC, Inc.
14		Bay, Calhoun, Gulf, Holmes, Jackson, Washington	Big Bend CBC, Inc.
3	Northeast	Columbia, Dixie, Hamilton, Lafayette, Madison, Suwannee, Taylor	Partnership for Strong Families
4		Clay	Kids First of Florida, Inc.
4		Duval, Nassau	Family Support Services of North Florida, Inc.
7		St. Johns	St. Johns County Board of Commissioners
7		Flagler, Putnam, Volusia	Community Partnership for Children, Inc.
8		Alachua, Baker, Bradford, Gilchrist, Levy, Union	Partnership for Strong Families
5	Central	Citrus, Hernando, Lake, Marion, Sumter	Kids Central, Inc.
9		Orange, Osceola	CBC of Central Florida
10		Hardee, Highlands, Polk	Heartland For Children
18		Seminole	CBC of Central Florida
18		Brevard	Brevard Family Partnership
6	SunCoast	Pasco, Pinellas	Eckerd Community Alternatives
12		DeSoto, Manatee, Sarasota	Sarasota Family YMCA, Inc.
13		Hillsborough	Eckerd Community Alternatives
20		Charlotte, Collier, Glades, Hendry, Lee	Children's Network of Southwest Florida
15	Southeast	Palm Beach	ChildNet, Inc.
17		Broward	ChildNet, Inc.
19		Indian River, Martin, Okeechobee, St. Lucie	Devereux CBC
11	Southern	Miami-Dade	Our Kids of Miami-Dade/Monroe, Inc.
16		Monroe	Our Kids of Miami-Dade/Monroe, Inc.

APPENDIX 3 – CIRRT Process

Prior to conducting CIRRT reviews, the department began actively recruiting staff from partner agencies to receive CIRRT training in preparation for participating in CIRRT reviews. Since that time, training has been offered every three months at various locations throughout the state, which includes the recent training in Ocala in August 2018. To date, a total of 538 professionals with expertise in child protection, domestic violence, substance abuse and mental health, law enforcement, Children's Legal Services, human trafficking, and the Child Protection Team have been trained on the CIRRT process. Training consists of one day of specialized training on the child welfare practice model for external partners, along with two additional days of specialized CIRRT training.

Advanced training was developed and is provided for individuals identified as team leads. In addition, specialized one-day training was created specifically for the Child Protection Team medical directors to meet the statutory requirement that went into effect July 1, 2015, requiring medical directors to be a team member on all CIRRTs (section 39.2015(3), Florida Statutes).

Team Composition

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 lead is responsible for guiding the process throughout the duration of the review.

Child Fatality Review Process

Every case involving a child fatality receives a specified level of a quality assurance review. A child fatality review is completed by the region's child fatality prevention specialist on every case involving a child fatality, followed by a written Child Fatality Summary that outlines the circumstances surrounding the incident. For cases in which there is no prior child welfare history involving the family within the five years preceding the child's death, this is the only report that is written.

For cases in which there was a verified prior report involving the deceased child or a sibling within 12 months of the death, a review is conducted utilizing the CIRRT process. While only a small percentage of cases meet the criteria for this extensive review, an in-depth review that mirrors the CIRRT process is completed on all other cases involving families with child welfare history within the five years preceding the child's death, regardless of findings. These reviews are commonly referred to as *mini-CIRRTs* and, like the CIRRT reports, are used to supplement the information contained in the Child Fatality Summary.