Critical Incident Rapid Response Team Advisory Committee
2015 Fourth Quarter Report

Mike Carroll
Secretary

Rick Scott
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
January 2016

I. Background

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

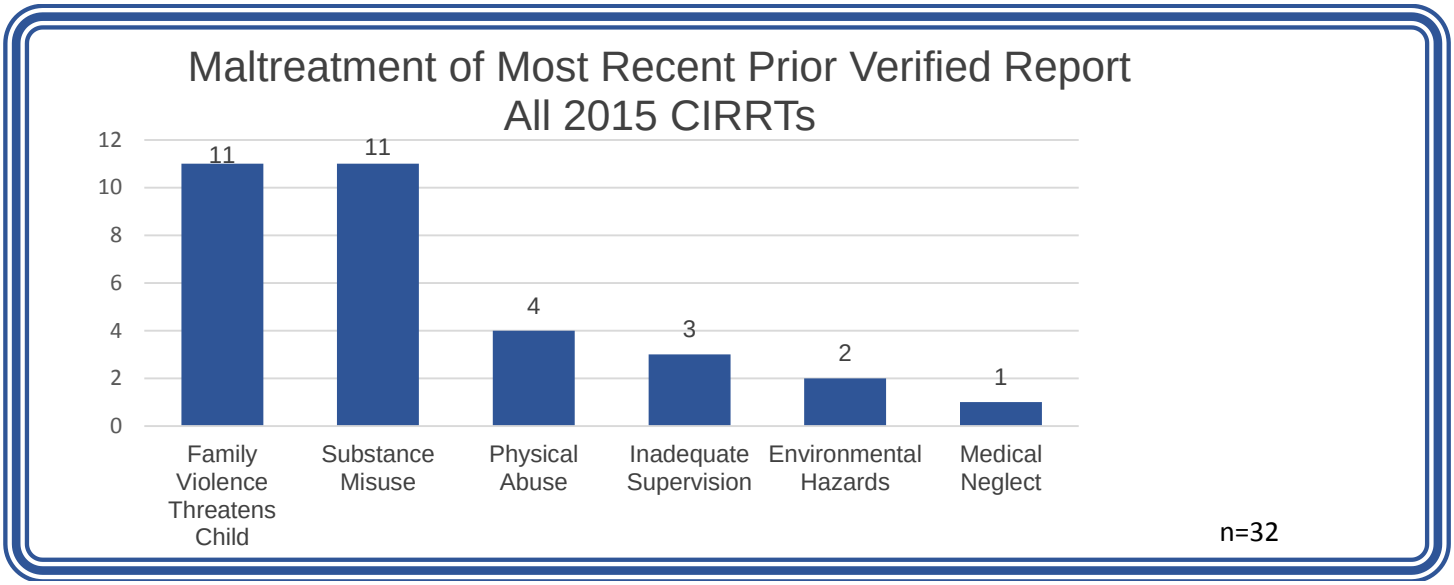
- An immediate onsite investigation by a critical incident rapid response team for all child deaths reported to the Department if the child or another child in his or her family was the subject of a verified report of suspected abuse or neglect during the previous 12 months.
- The investigation shall be initiated as soon as possible, but no later than two business days after the case is reported to the Department.
- Each investigation shall be conducted by a multiagency team of at least five professionals with expertise in child protection, child welfare, and organizational management. The majority of the team must reside in judicial circuits outside the location of the incident. The Secretary is required to assign a team leader for each group assigned to an investigation.
- A preliminary report on each case shall be provided to the Secretary no later than 30 days after the investigation begins.
- The Secretary may direct an immediate investigation 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 CIRRT advisory 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.

II. Purpose

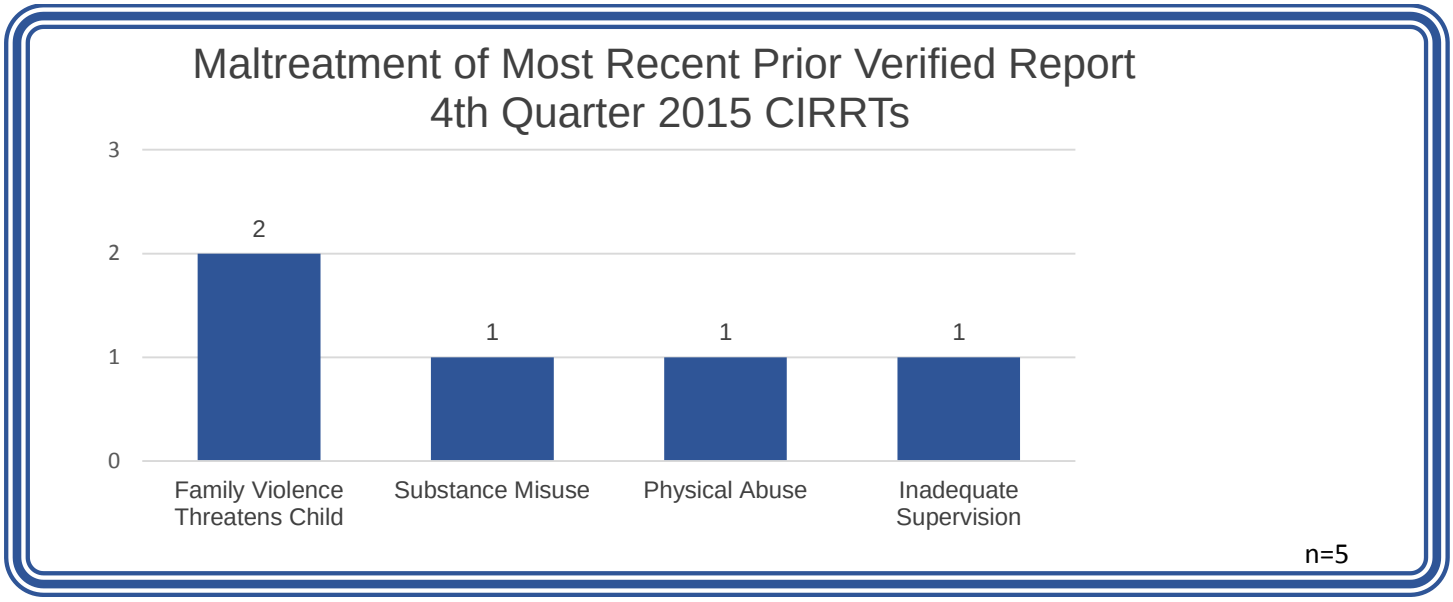
Critical Incident Rapid Response Teams provide an immediate, multiagency investigation of child deaths that meet the statutory criteria for review or of other serious incidents at the Secretary's discretion. Investigations are conducted in an effort to identify root causes, rapidly determine the need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

CIRRT reviews take into account 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. During the 2015 calendar year, teams

reviewed 35 child fatalities. Of those, 32 met the CIRRT requirements of a having a verified maltreatment within the previous 12 months. Three of the 35 special reviews did not have a verified maltreatment within the previous 12 months, but were completed at the request of Secretary Mike Carroll.



For all CIRRTs completed in 2015, domestic violence and substance misuse were the primary maltreatments on the most recent verified report prior to the death report. Untreated caregiver mental health issues are often found to be co-occurring; however, mental health issues of caregivers are not considered maltreatments.



Of the five child fatalities reviewed in the 4th Quarter of 2015, domestic violence was identified as the primary maltreatment on the most recent verified prior for two of the five reviews. Untreated caregiver mental health issues were identified as a factor in two of the prior reports.

III. CIRRT Process

Prior to conducting CIRRT reviews, the Department of Children and Families (DCF) in November 2014 began actively recruiting staff from partnering agencies. Since that time, training has been offered throughout the state every three months. More than 260 professionals with expertise in Child Protection, Domestic Violence, Substance Abuse and Mental Health, Law Enforcement, Children's Legal Services and the Child Protection Team have been trained on the process. Training consists of one day of specialized training on the new child welfare practice model for our external partners, along with two additional days of specialized CIRRT training.

Advanced training was developed and is provided for individuals identified as report writers and team leads. In addition, a specialized one-day training was created specifically for the Child Protection Team Medical Directors to meet the statutory requirement effective July 1, 2015, requiring Medical Directors to be a team member on all CIRRTs (s.39.2015(3),F.S.).

Individuals trained include the following areas of expertise:

Expertise	Trained
Child Protective Investigations (DCF)	75
Child Protective Investigations (Sheriff's Office)	18
Florida Abuse Hotline	3
Community-Based Care Lead Agencies (CBC)	46
Case Management Organizations (CMO)	8
Domestic Violence	18
Substance Abuse/Mental Health	43
Children's Legal Services	25
Law Enforcement	10
Department of Health	3
Healthy Start	1
Child Protection Team/Medical Directors	26

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.

Review Expanded to all Child Fatalities

In addition to the mandated CIRRT reviews of cases with prior history and verified findings in the 12 months preceding the child's death, Secretary Mike Carroll issued a directive in January 2015 that all child fatalities be formally reviewed based on a core set of data elements. This directive has subsequently been codified into Department operating procedure. It requires:

- quality assurance reviews on cases that involve families with child welfare history within the five years preceding the child's death, regardless of findings. These reviews use a tool and process that mirrors the CIRRT review process and are commonly referred to as "mini CIRRTs."
- a limited review to be conducted by the region's child fatality prevention specialist on cases that involve families with no prior history for the five years preceding the child's death.

Standardized data is collected across all review types and entered into a database (Qualtrics) for further analysis and review. Reviews conducted as a result of a child fatality (regardless of the type of review completed) are redacted according to statute 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. The level of redaction completed is based on whether or not the death maltreatment has been verified. Reports listed on the website as "pending" are awaiting closure of the death investigation and the medical examiner's findings.

Between January 1, 2015, and December 31, 2015, a total of 167 cases statewide met the criteria for completion of a "mini CIRRT" review. Of those cases, 46.11% have been completed.

Special Reviews (Mini CIRRTs)

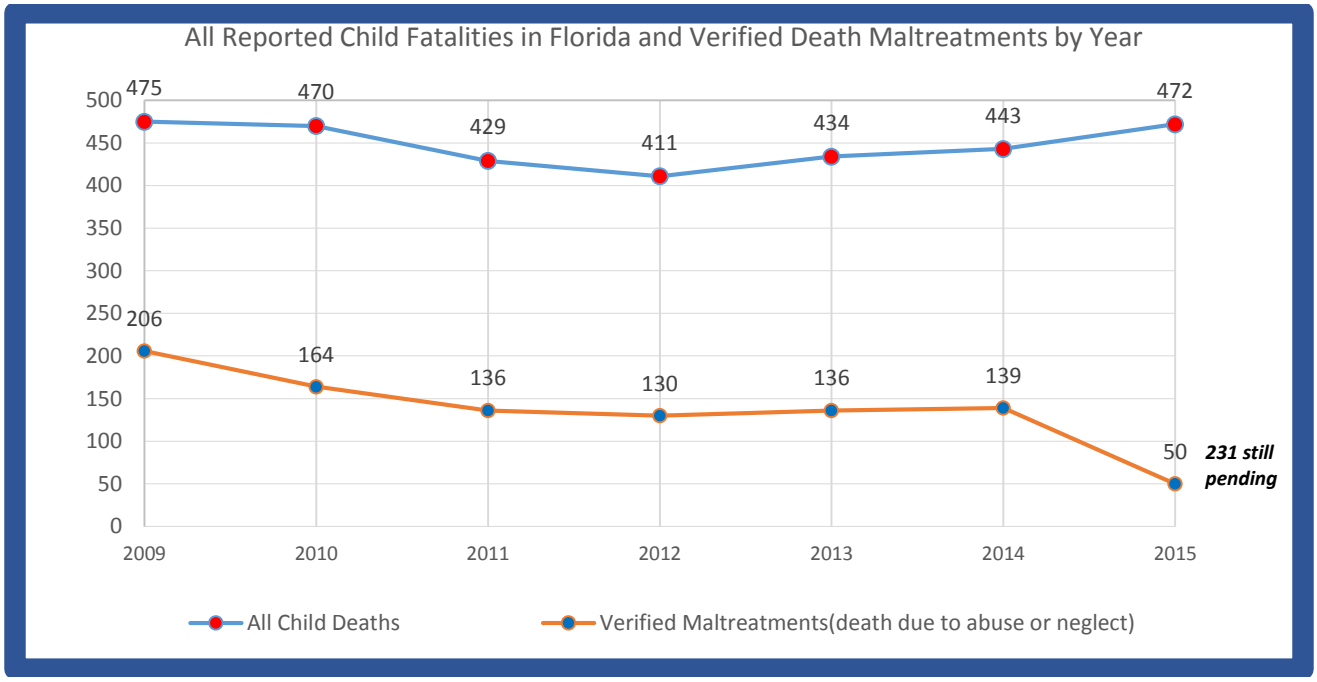
Region	Review Required	Reports Completed	Reports Pending	Percentage Complete
Northwest	20	3	17	15.00%
Northeast	30	15	15	50.00%
Central	55	37	18	67.27%
Central Sheriffs	2	0	2	0.00%
Suncoast	13	9	4	69.23%
SC Sheriffs	24	1	23	4.17%
Southeast	9	6	3	66.67%
SE Sheriffs	10	5	5	50.00%
South	4	1	3	25.00%
Statewide	**167**	**77**	**90**	46.11%

CIRRT Advisory Committee

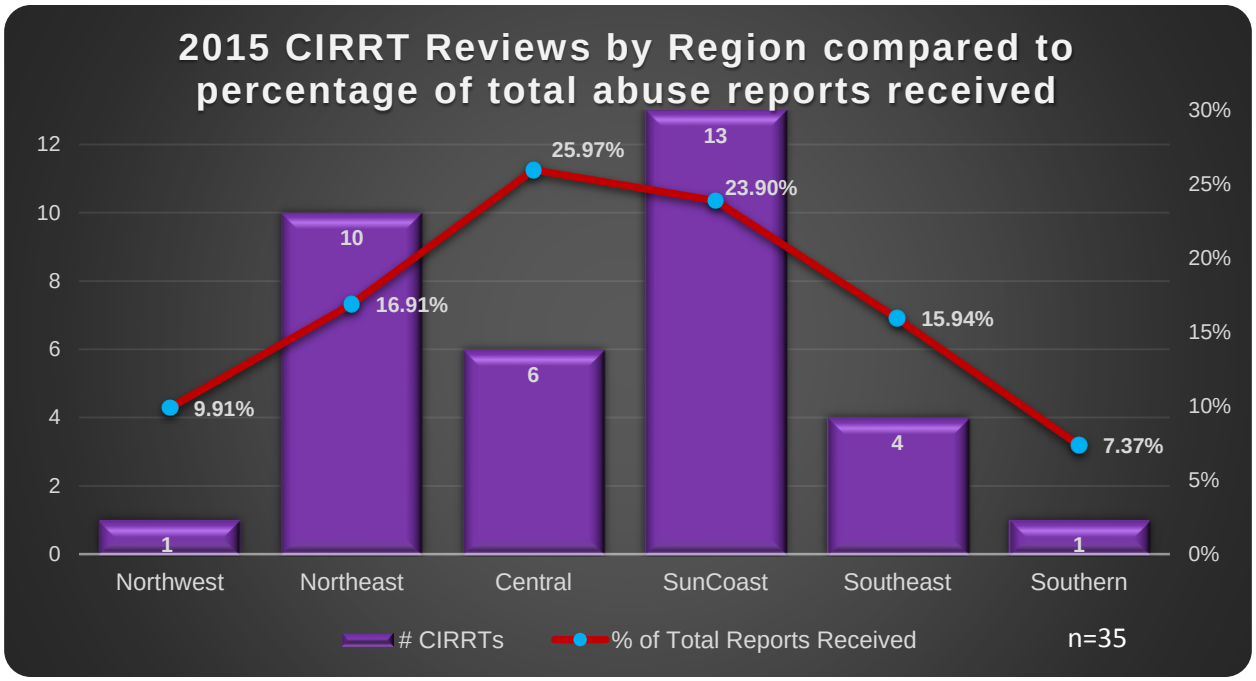
The CIRRT advisory committee is statutorily required to meet on a quarterly basis. The committee met on May 26, 2015, August 26, 2015 and November 30, 2015. Advisory committee members may participate via conference call, but are encouraged to attend in person. The meeting notices are published, and the meetings are open to the public. The primary focus of the advisory committee is to identify statewide systemic issues and provide recommendations to the Legislature that will improve policies and practices related to child protection and child welfare services. Meetings facilitated by DCF Regional Managing Directors are convened in each jurisdiction where a CIRRT has been conducted within 30 days of receiving the CIRRT report to review the findings and develop any immediate corrective action steps necessary.

Review of Child Fatality Data

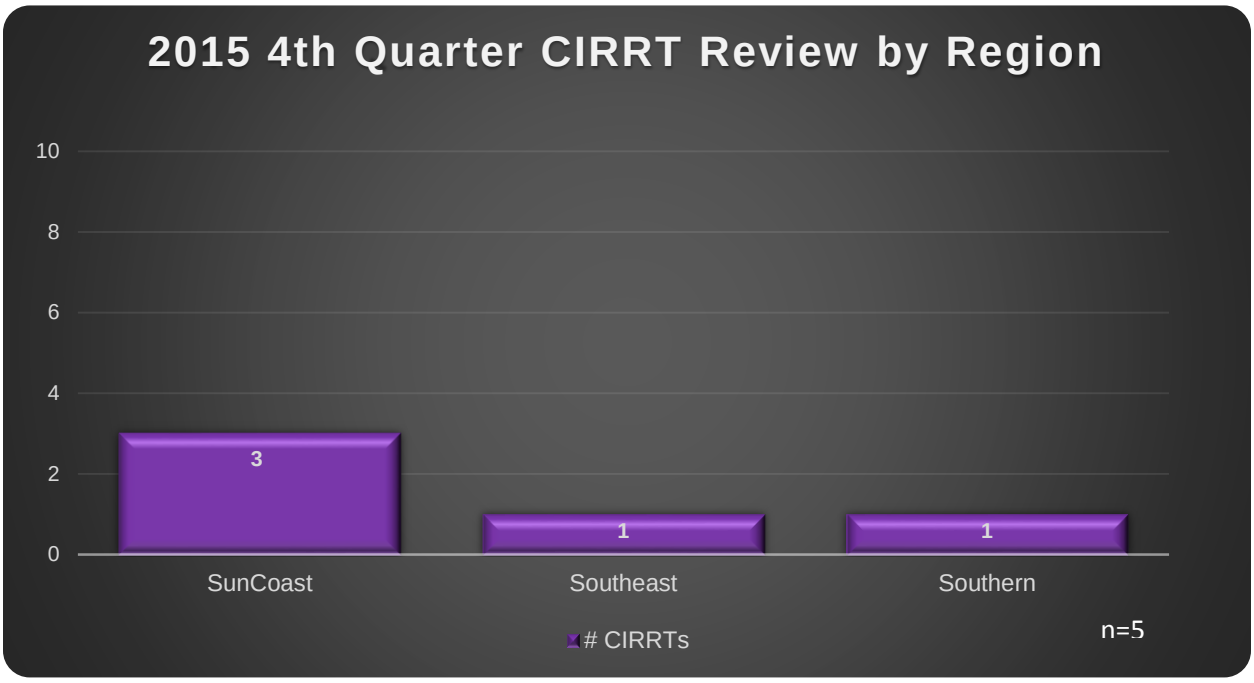
Overall, child deaths in the State of Florida typically involve a child age 3 or younger and involve a variety of different manners of death, ranging from unsafe sleeping, drownings, natural causes, inflicted traumas, Sudden Infant Death Syndrome (SIDS)/Sudden Unexplained Infant Death (SUID), and accidental trauma.



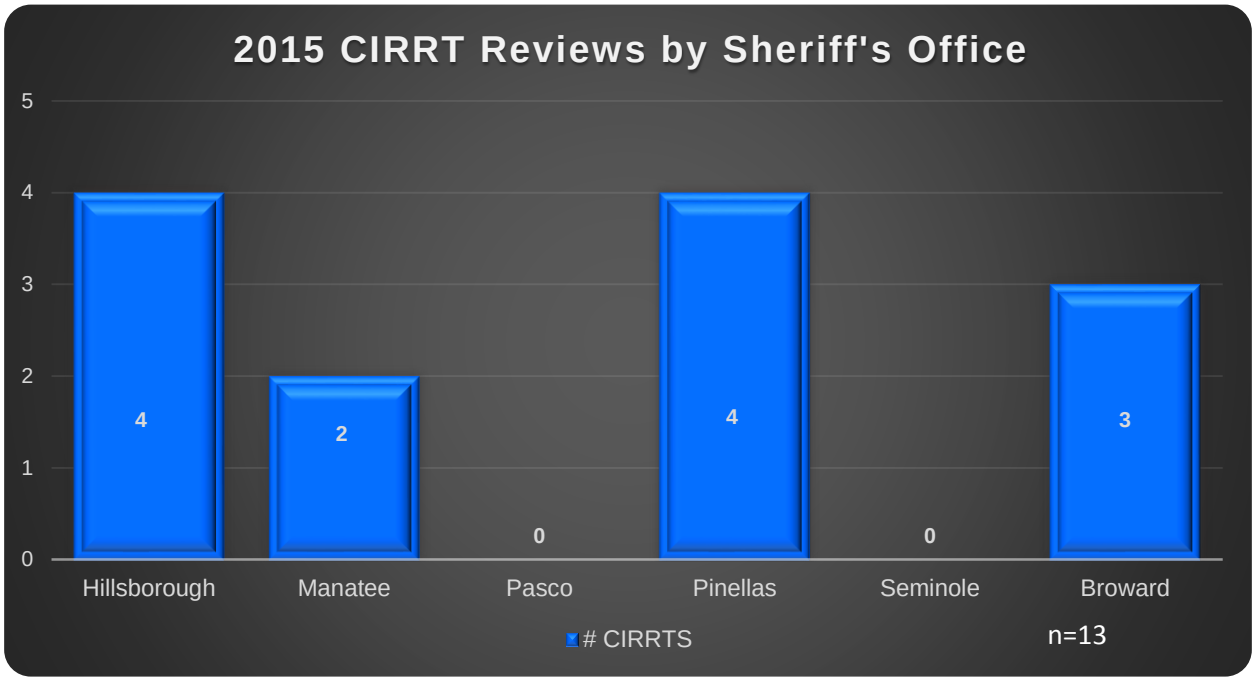
Of the 472 child death investigations received in 2015, 231 investigations remain open and findings have not yet been determined, which accounts for the appearance of a decline in the number of verified reports.



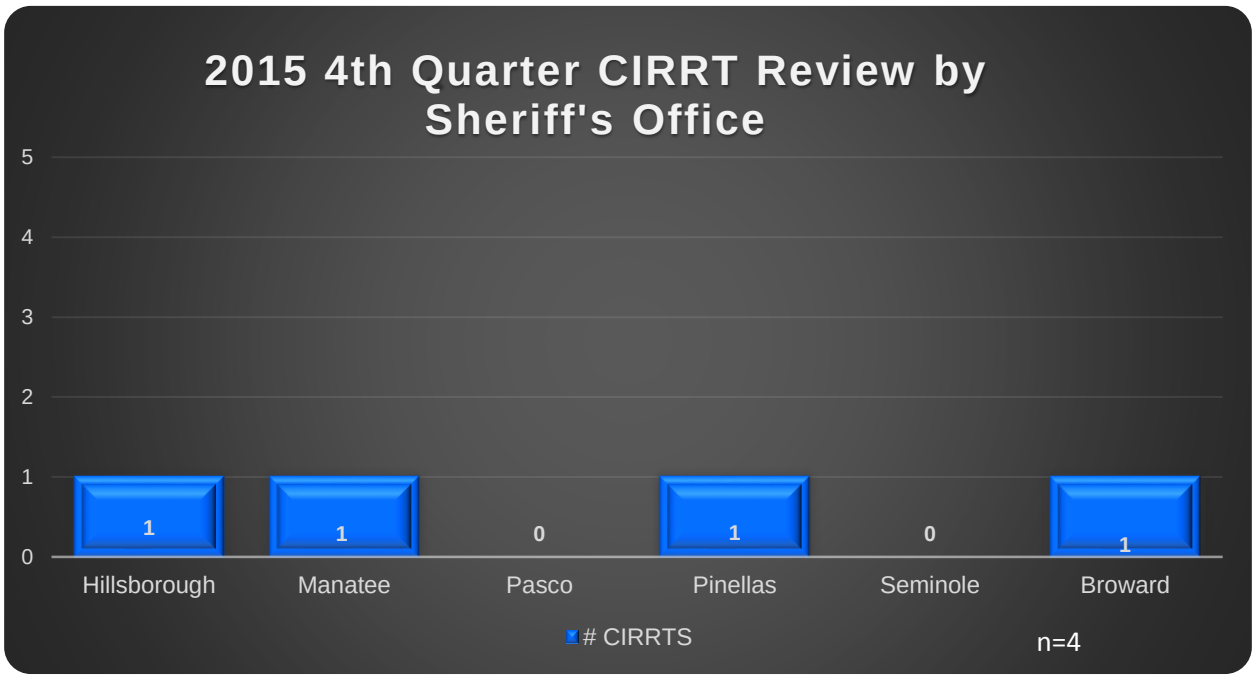
During the 2015 calendar year, there were a total of 35 CIRRT deployments, with at least one deployment in each of the six regions. The SunCoast and Northeast Regions accounted for 66% of the deployments while receiving 41% of all abuse investigations during the calendar year.



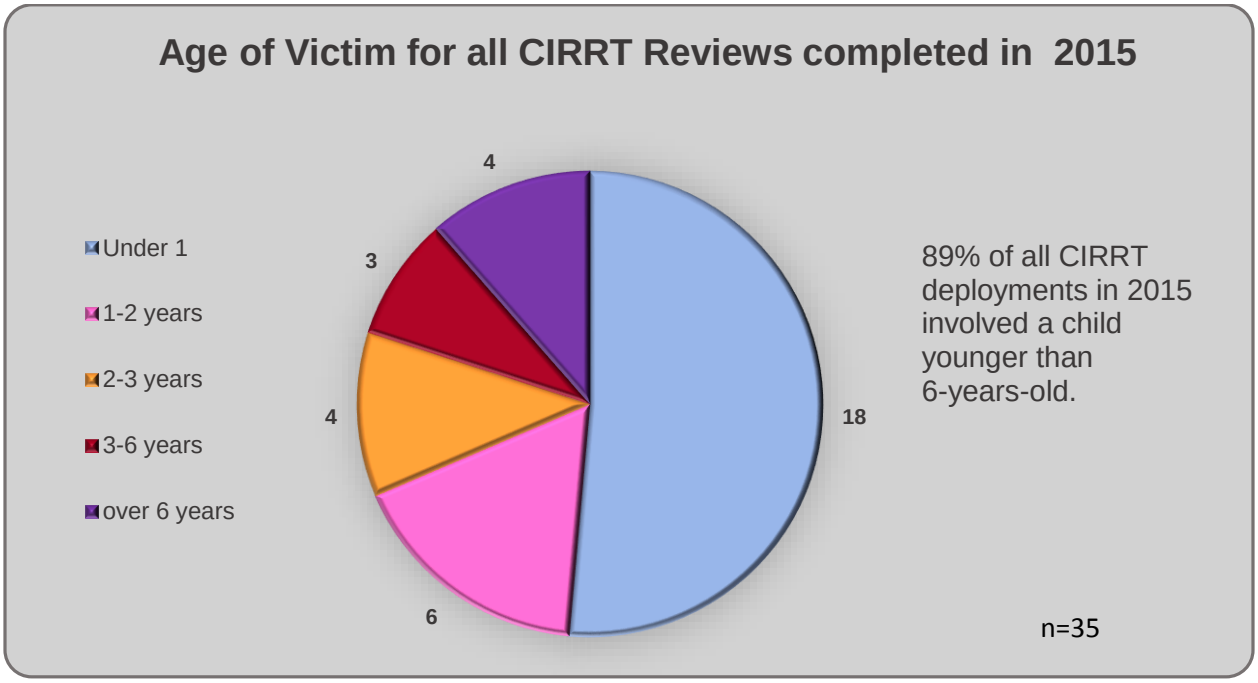
There were five CIRRT deployments during the 4th quarter of 2015. Three of the five occurred in the SunCoast Region, in counties where child protective investigations are conducted by sheriff's offices.



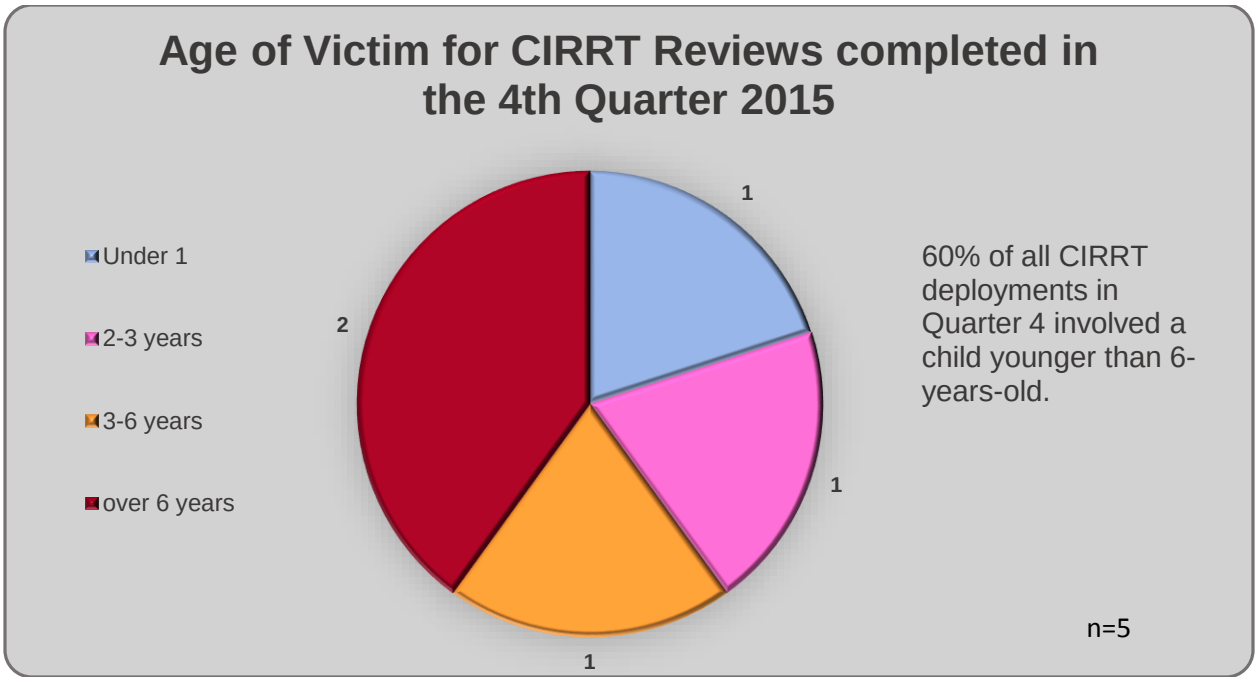
During the 2015 calendar year, 13 of 35 CIRRT deployments involved four of the six counties where child protective investigations are conducted by sheriff's offices.



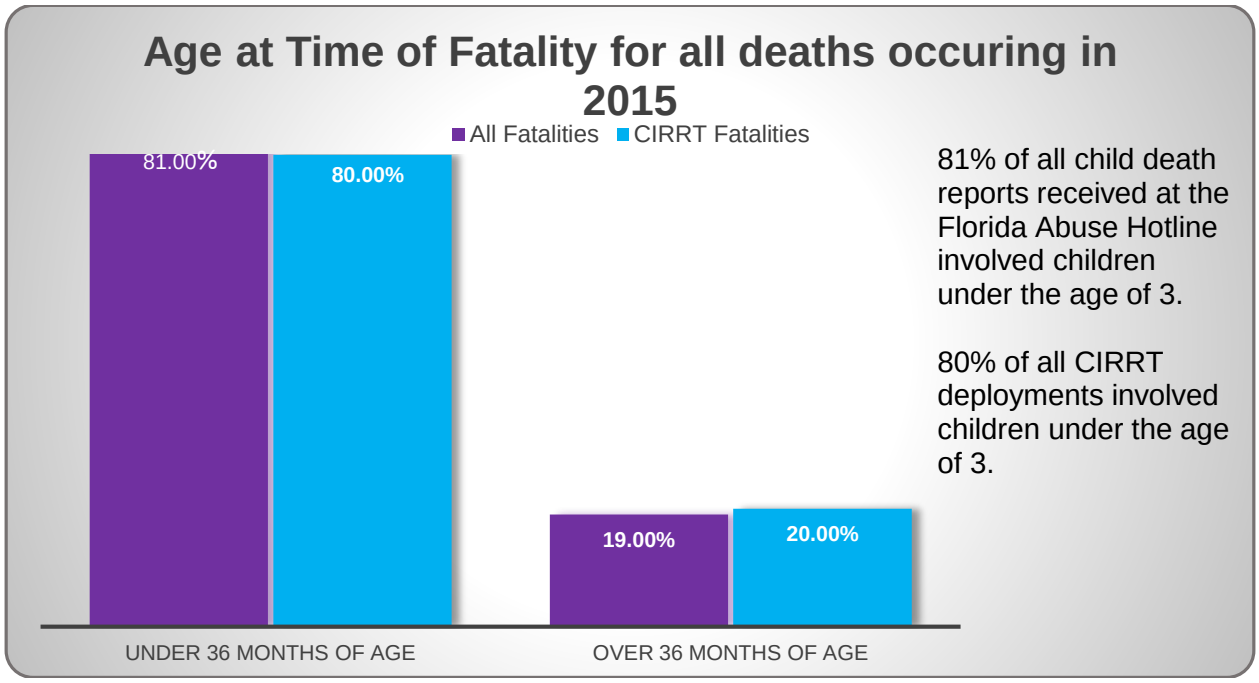
During the 4th quarter of 2015, four of the five CIRRT deployments involved counties where sheriff's offices conduct child protective investigations.



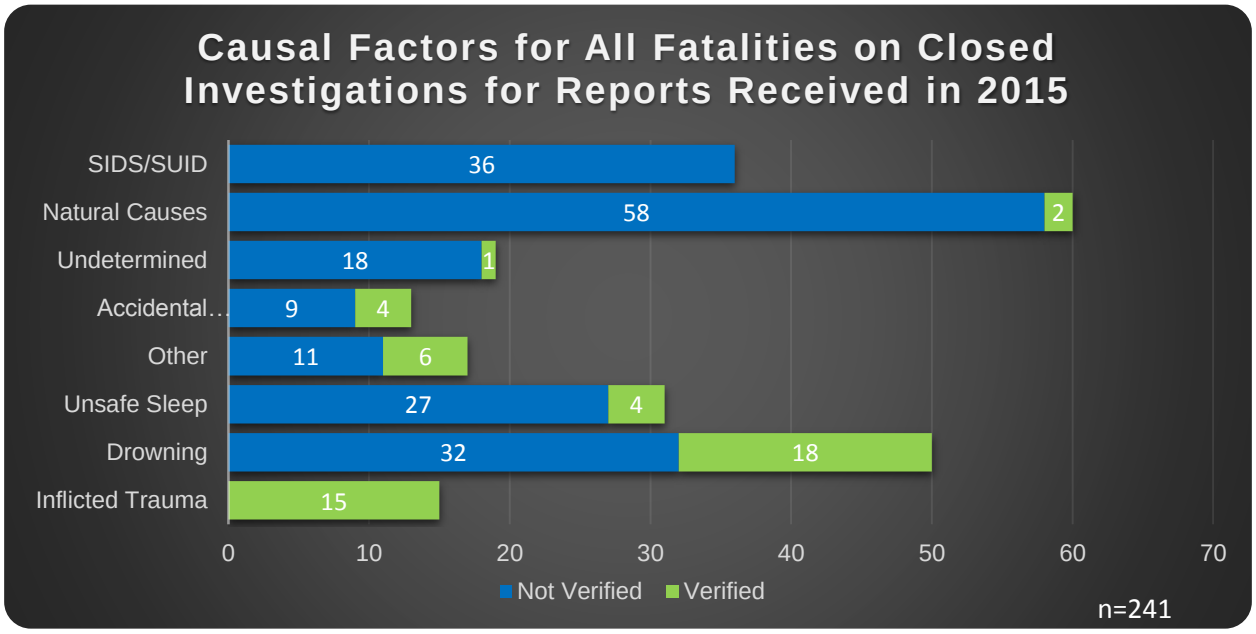
During the 2015 calendar year, 35 CIRRT reviews were completed, and 89 percent of those deployments involved a victim under the age of 6. This is consistent with child deaths statewide in which younger children are more vulnerable to being victims of abuse and neglect.



There were five CIRRT deployments in the 4th quarter; three of the five involved children under the age of 6.

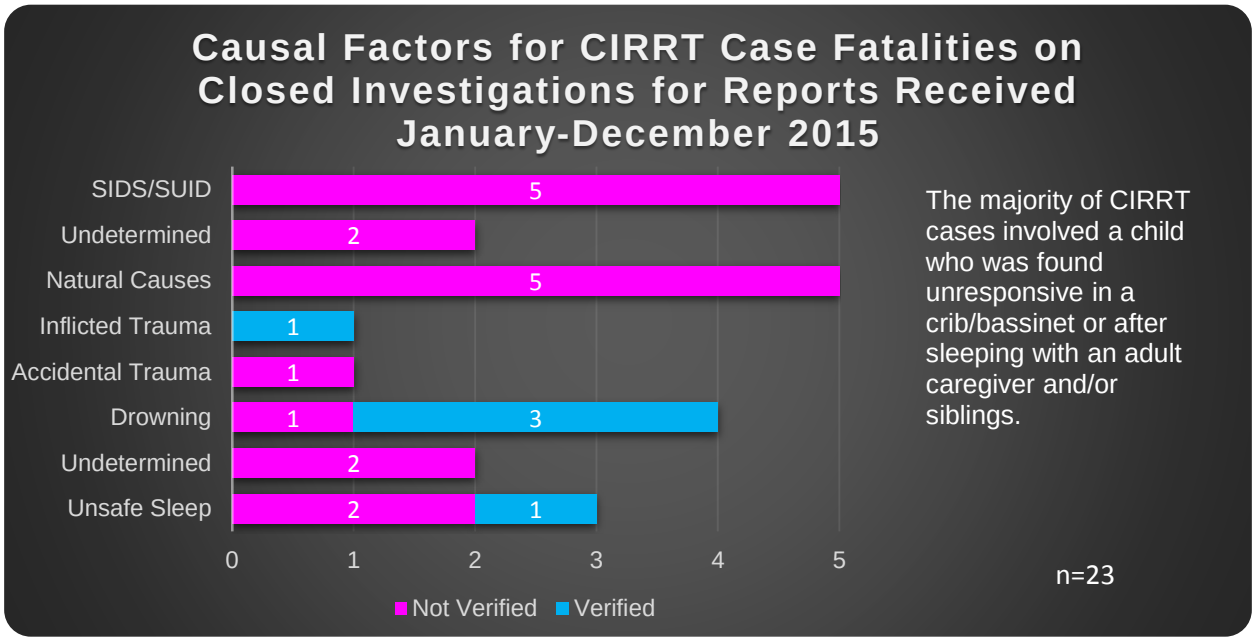


The majority of child death reports to the Florida Abuse Hotline in 2015 involved children under the age of 3. Similarly, 80 percent of all CIRRT deployments involved infants and toddlers.

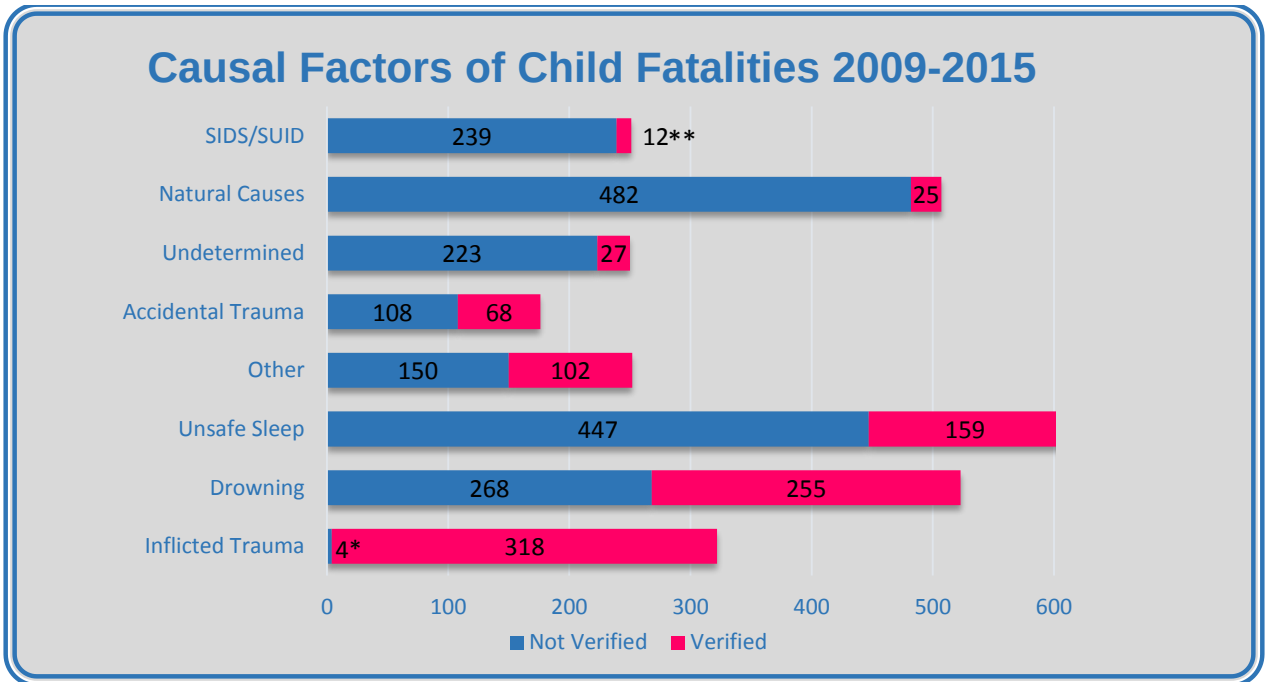


Of the 241 closed child fatality investigations that were received between January 1, 2015 and December 31, 2015, the four primary causal factors were Natural Causes, Unsafe Sleep, SIDS/SUID and Drowning. An additional 231 child fatality investigations received during this time period remain open, which, when finalized, will impact the overall numbers and causal factor sequencing. The death maltreatment cannot be used as a stand-alone maltreatment, therefore the Florida Abuse Hotline includes the underlying maltreatment that may have caused

or contributed to the child death. In order for an investigation to be closed with verified findings for the death maltreatment, there must be a preponderance of the 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, police reports and medical records. In cases where there may be insufficient evidence to support a verified finding of the death maltreatment, the investigation may still close with verified findings of other maltreatments.



Between January 1, 2015 and December 31, 2015, there were a total of 35 cases that met the statutory criteria for CIRRT deployment. Twenty-three of the 35 (22%) investigations have closed with verified findings for the death maltreatment. An additional four investigations were closed with verified findings for a maltreatment other than the death maltreatment. Of the 35 deployments, 17 (just under half) involved children under 1 year of age who were found unresponsive in their crib/bassinet or after sleeping with an adult caregiver and/or siblings. Although the primary causal factor noted at this time is Natural Causes, it is reasonable, based on preliminary investigative data to expect an increase in the deaths attributed to unsafe sleep and drowning.



Between 2009 and 2015, the four leading causal factors of child fatalities reported to the Abuse Hotline were unsafe sleep (606 deaths), drowning (523 deaths), natural causes (507 deaths), and inflicted trauma (322 deaths).

**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.

In addition, there were four inflicted trauma investigations that were closed with no indicators of maltreatment as opposed to "No Jurisdiction." In three of those cases, the individual responsible for the fatalities was not a caregiver of the child, and the fourth case involved a death of a child as a result of an incident that occurred in another state.

Emerging Themes

The CIRRT reports have identified emerging themes in each of the three main categories:

Practice Assessment

- Child protective investigators continue to struggle with making thorough assessments based on gathering, reconciling and analyzing all available information regarding families, including prior abuse and criminal history.
- In many of the cases, information-sharing between agencies serving the same families was not timely or thorough and lacked the effective use of multi-agency staffings as a resource to share information.
- Issues related to implementation of Florida's new child welfare practice and fidelity to the new practice, including a lack of adequate safety planning to control identified danger threats, have been a common theme in CIRRT reviews.

Recommendation: A more involved process evaluation associated with information collection, dissemination and analyses should be conducted in those areas or units where these themes are identified and validated as an issue. It is important to determine if the same practice themes are manifested (or reported) in closed cases within the past 12 months for which there is no child fatality. Toward this end, it may be of value to engage in more critical statistical analyses using cohorts of cases for which maltreatment was verified within the previous 12 months to identify if themes denoted with CIRRT cases (where there is a child death) are parallel with non-CIRRT cases. These analyses will help determine whether systemic or more targeted administrative interventions are needed to address practice assessment themes/issues.

Organizational Assessment

Overall, for CIRRTs completed in 2015, high turnover and an inexperienced workforce were common themes noted in the reviews. For the five CIRRTS completed during the fourth quarter, the experience and stability of the workforce was not an issue in the majority of the reviews.

Recommendation: A detailed analysis of this theme needs to take place so that there can be an identification of the representative validity of this theme associated (qualitatively) with CIRRT cases to non-CIRRT cases. This may be a general theme throughout the child welfare system and not a specific contributing factor associated with child fatalities, but it needs to be more rigorously studied. Further, there needs to be a more specific itemization of the factors associated with the recruitment and turnover of competent workers within the state of Florida that administrative interventions could target.

Service Array

Although appropriate services are generally available within the community and system of care, subject matter experts are underutilized, resulting in families not receiving the appropriate level of services to address complex family needs. A lack of effective communication and multi-agency staffings when families stop cooperating or engaging with service providers was also identified as an issue.

Recommendation: Given that these themes have been identified with CIRRT cases only, it may be that these themes are contributing factors to the system's ability/inability to prevent select child fatalities or the discrete choices of staff and supervisors when deciding how and when to intervene or continue with protective interventions with select cases/families. Further analysis will need to be conducted. In addition, the Department needs a process to accurately identify and track how many families have received Substance Abuse and Mental Health treatment. It would also be important to know more about these systems, such as: date of referral, waiting lists, in-patient/out-patient service availability, begin date of service and end date of service. Conducting a thorough service mapping throughout the state will be explored.

Immediate Operational Response

Although continued collection and analysis of findings and data are needed regarding the CIRRTs completed during the past quarter, some local actions have already been implemented. The Thomas CIRRT identified issues around inadequate assessments to ensure child safety when families were non-compliant with non-judicial services. The lead agency, Manatee Sheriff's Office and Children's Legal Services met to discuss protocols, procedures and processes related to all non-judicial cases and the escalation process in cases where agreements could not be reached on legal sufficiency. The local sheriff's office responsible for protective investigations has modified and strengthened its procedures regarding identification of all household members and verification of children who may be missing.

Other local responses include establishing new child protective investigations leadership teams and development of more robust multidisciplinary protocols to enhance communication and collaboration. Assistant Secretary of Operations Vicki Abrams has required that local action plans which address findings be developed for each CIRRT.

Issues related to implementation of Florida's new practice model and fidelity to the new practice continue to be common in the majority of CIRRT reviews. In response, the Department has established a process to embed practice experts in each region to provide necessary decision-making support to frontline staff. A total of 38 existing positions were identified statewide to become Critical Child Safety Practice Experts (CCSPE). The Department has contracted with Action for Child Protection to administer a proficiency process to ensure Critical Child Safety Practice Experts are subject matter experts in the new practice model and have the knowledge, skills and abilities necessary for case analysis and feedback. This process identifies a broad set of proficiency areas in the safety methodology, case consultation, feedback and training.

The Office of Child Welfare will continue to work with SAS and North Highland to develop additional advanced analytics models to study maltreatment risk among the children known to the child welfare system. The work conducted so far has analyzed actual case data over five years to quantify the risks that children face and to understand how the agency can make policies and improve practice to mitigate, and where possible, remove those risks. Future work will include a strategy to incorporate analytics into daily practice to provide data-driven insights to child welfare workers in the field so they can make more-informed decisions, resulting in better outcomes for children.

Closing Summary

Throughout deployments and with input from the statewide CIRRT advisory committee, additional qualitative data elements have been identified. Data from prior CIRRTs has been entered into Qualtrics and data from other, similar reviews (including 2nd-level reviews and Rapid Safety Feedback reviews) should be continued and entered into Qualtrics and utilized to compare trends and emerging themes.

Although analysis of the initial data collected provided some preliminary insights into root causes of child deaths in Florida, there is currently not sufficient data available to inform system changes. As additional data is collected over the coming months, the advisory committee will focus on developing an analysis plan to determine trends, projections, and cause-and-effect relationships that might not otherwise be evident. This analysis will be used to propose and validate policy and practice changes.