

**Critical Incident Rapid Response Team Advisory Committee
Fourth Quarter Report for Calendar Year 2021**



Shevaun L. Harris
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
Fourth Quarter 2021**

I. Background

Section 39.2015, Florida Statutes, which outlines requirements for the Department of Children and Families' Critical Incident Rapid Response Team (CIRRT), requires the CIRRT Advisory Committee to submit a quarterly report to the Governor and Legislator of findings and recommendations.

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

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.

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 generally been offered every four months at various locations throughout the state. Additionally, quarterly statewide trainings were not scheduled during 2020 due to travel restrictions related to COVID-19. Training was provided to the department's six Regional Managing Directors in September 2020 in an effort to engage them in the process and utilize their leadership expertise on future reviews. To date, over 600 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).

Special Reviews

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, additional in-depth reviews that mirrors the CIRRT process, are completed on critical and fatality cases at the discretion of the Secretary, regardless of prior maltreatment findings. These reviews are referred to as *Special Reviews* and, like the CIRRT reports, are used to supplement the information contained in the Child Fatality Summary.

Team Composition

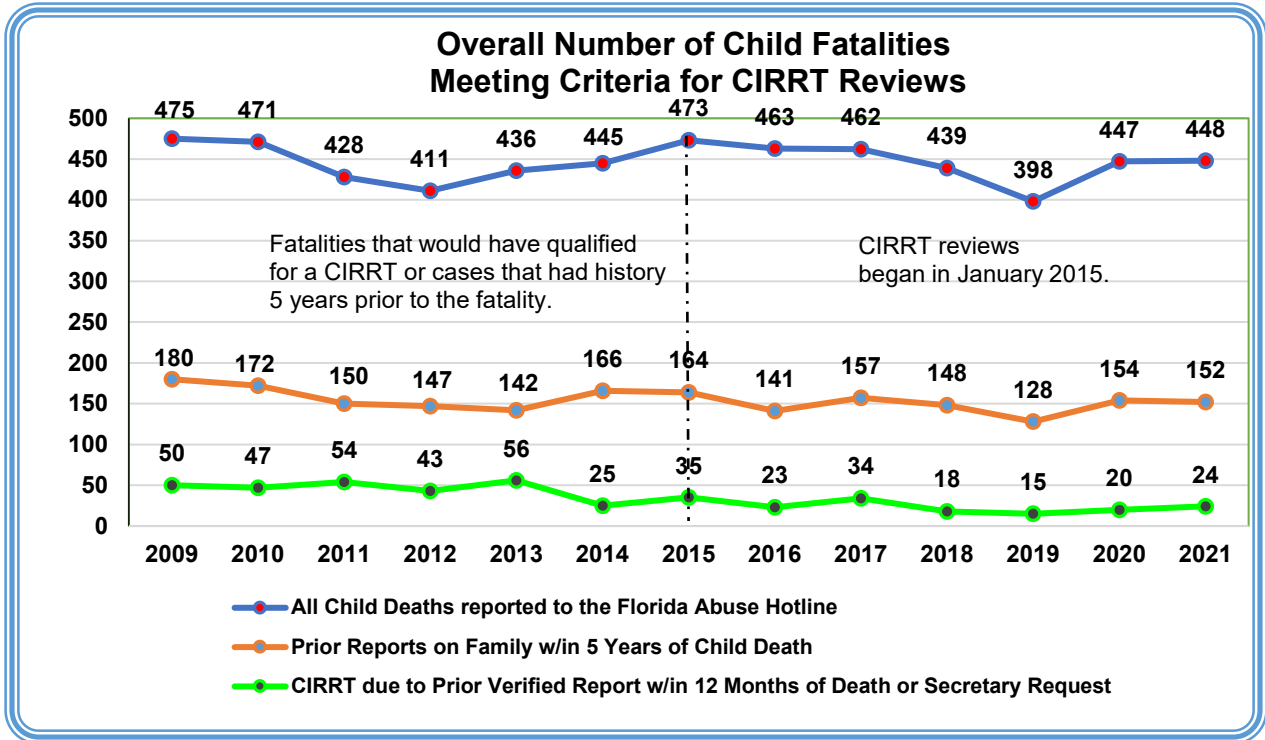
Each team deployed is comprised of individuals with expertise in the appropriate areas, as identified through a review of the family's prior history with the child welfare system. The team lead is responsible for guiding the process throughout the duration of the review.

III. Review of Child Fatality Data

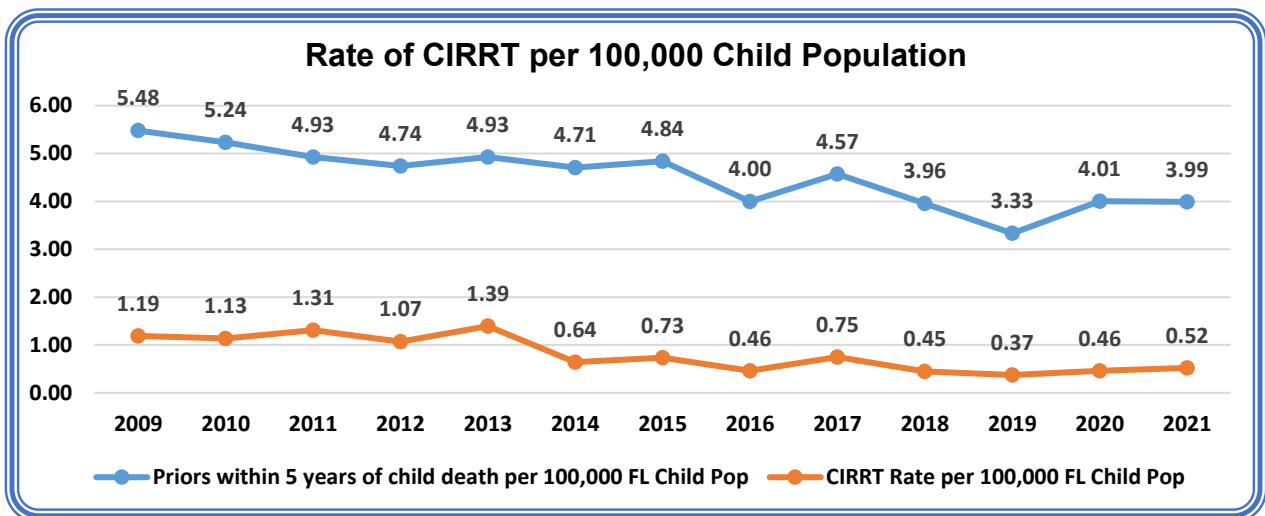
Between October 1 and December 31, 2021, there were 111 fatalities reported to the Hotline. Of those 111 cases, four met the criteria for a CIRRT deployment. All four of the CIRRT deployments that occurred during the fourth quarter, there was prior history involving the deceased child.

From January 1, 2015, through December 31, 2021, a total of 165 CIRRT teams were deployed involving 168 child deaths. Of those deployments, 159 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 Secretary. Of the six discretionary deployments, 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.

Since January 1, 2015, the fatalities resulting in a CIRRT deployment represent approximately five percent of the overall fatalities reported to the Department of Children and Families' (Department) Florida Abuse Hotline (Hotline). In 34 percent of the fatalities reported to the Hotline, the family had a prior history within the previous five years. It should be noted that the chart below reflects the number of actual child fatalities. Some cases involve multiple victims; however, only one respective review was conducted per case.



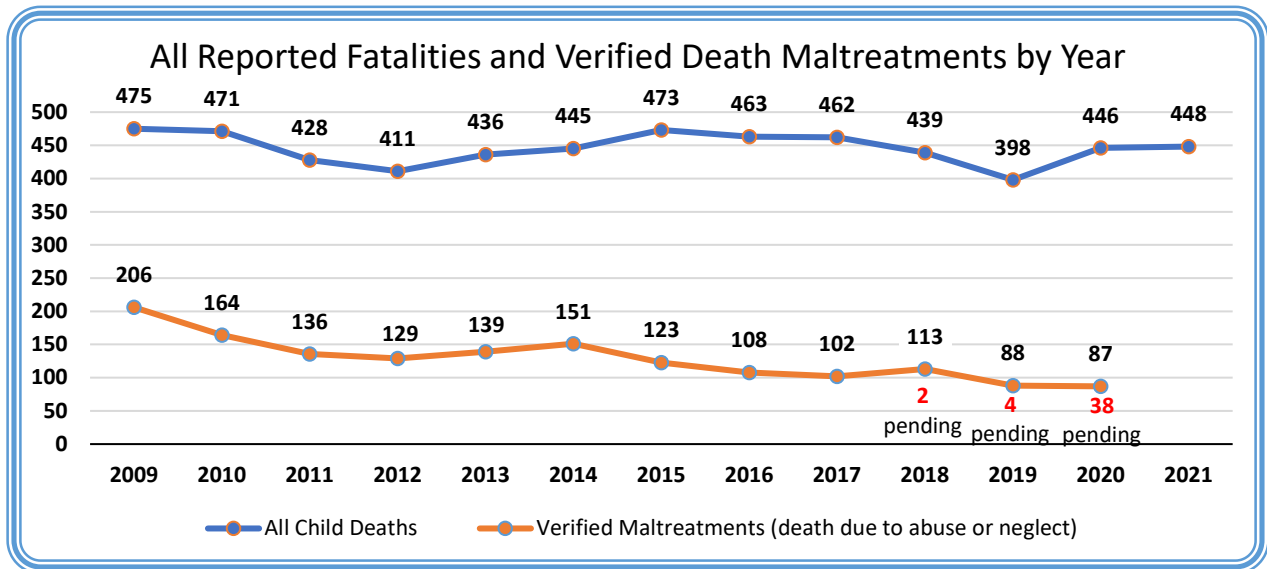
The rate of occurrence for fatalities meeting the requirements for CIRRT deployments and mini-CIRRT reviews, as compared to the overall number of fatalities reported to the Hotline, has remained relatively the same over the years. While there are slight decreases and increases, they are not statistically significant to support any noted trends.



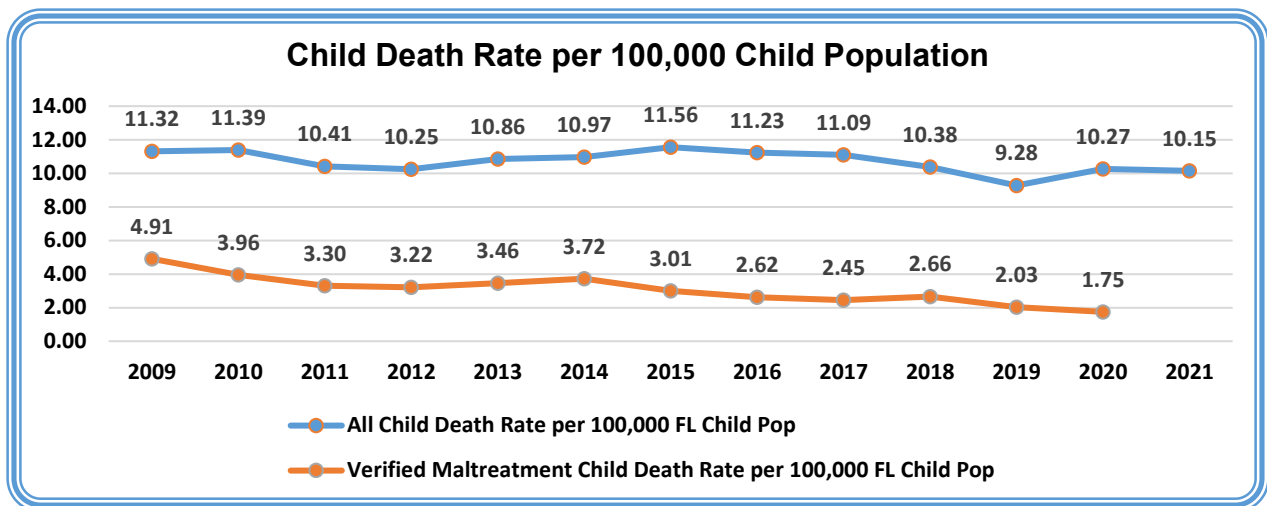
Reports on reviews conducted as a result of a child fatality (regardless of the type of review completed) are redacted according to Florida Statutes and posted on the Department’s Child Fatality Prevention website (<http://www.dcf.state.fl.us/childfatality/>) after the death investigation has been completed. 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 the medical examiner’s findings.

Child deaths reported to the Hotline 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.



While the child death rate per 100,000 child population slightly increased between 2019 and 2020, the rate of verified child death maltreatments per 100,000 child population reflects a downward trend. Due to the significant number (200+) of fatality investigations that remain open for 2021, data for verified maltreatments were not reflected.



III. Review of CIRRT Data

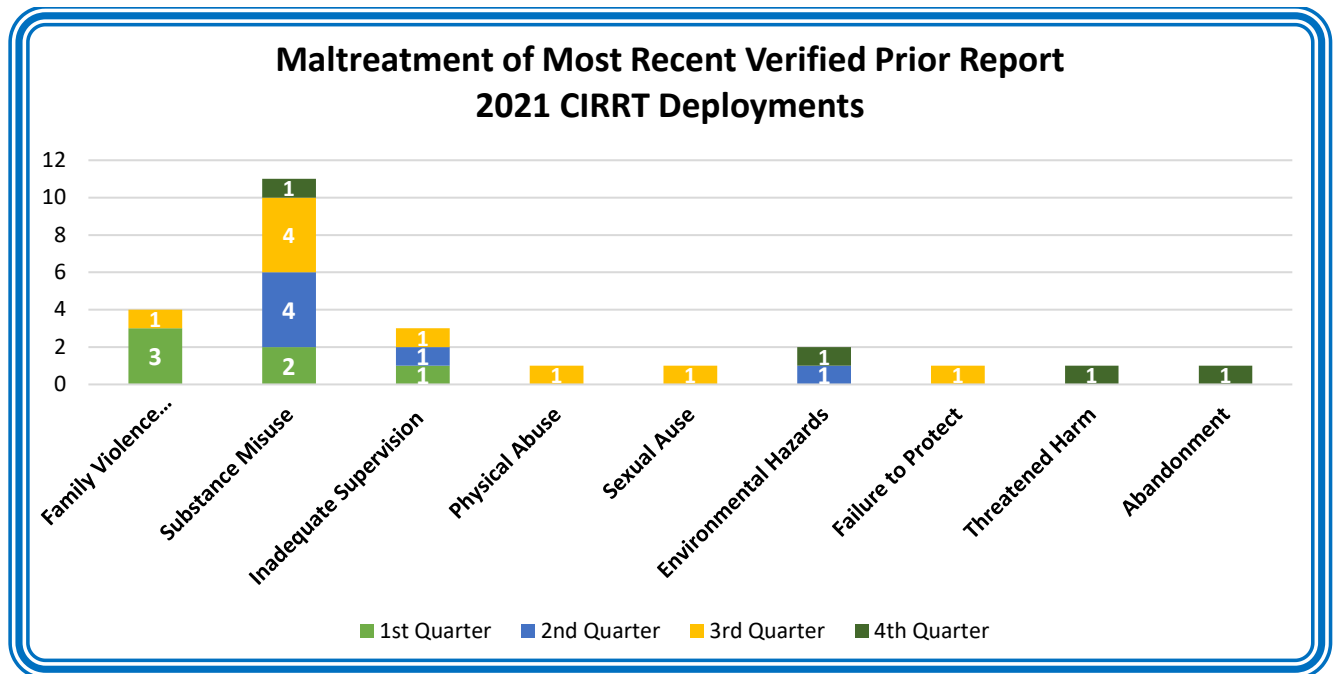
a. Summary of Fourth Quarter CIRRT Reports

A total of four CIRRTs were deployed in the fourth quarter of 2021. The deployment to Santa Rosa County involved a 4-year-old foster child that was discovered unresponsive in a pond located on the licensed care’s property. The Palm Beach County deployment involved the death of a 2-month old after she was discovered unresponsive in her bassinet while in the care of her godmother and partner. The deployment to Polk County involved the death of a 2-month-old who was found unresponsive in his crib while placed with a licensed foster parent. The Duval County deployment involved the death of a 8-month-old after he was discovered unresponsive in his pack-n-play by his mother.

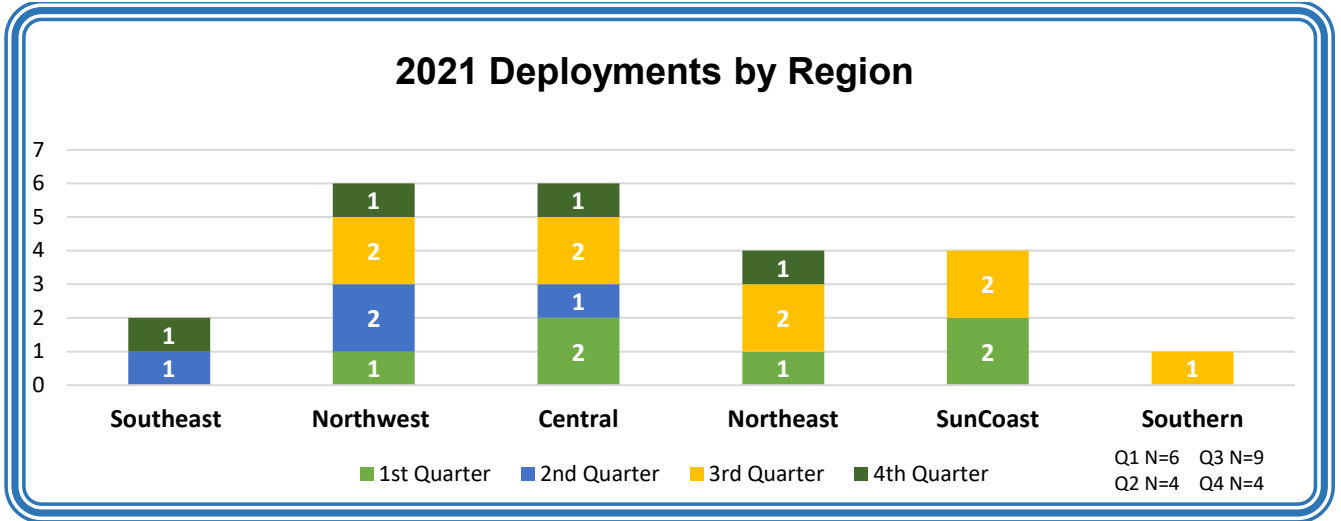
In three of the four deployments (Santa Rosa, Palm Beach, and Polk counties), child welfare services were involved at the time of the respective fatality; in all of deployments the decedents were the subjects of a prior verified report.

b. Past Maltreatment

During the fourth quarter of 2021, the four CIRRT deployments involved four victims with all of the victims being the subject of a verified prior report. There were a variety of prior verified maltreatments in the deployments: one involved an abandonment maltreatment, one involved a substance use maltreatment, one involved a threatened harm maltreatment, and one involved an environmental hazards maltreatment.



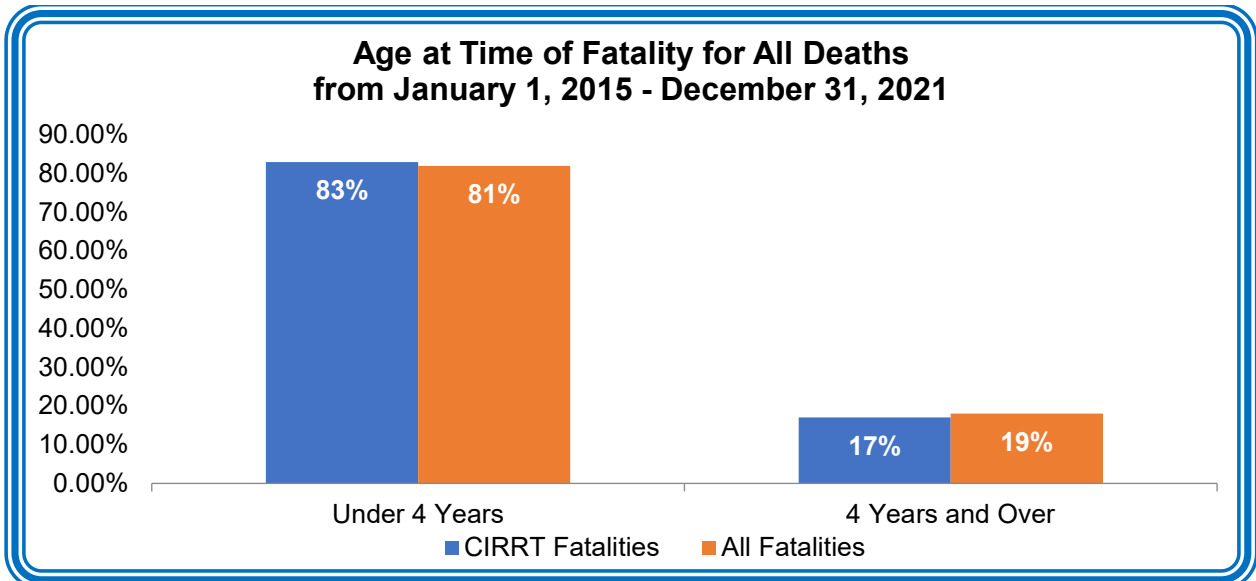
c. CIRRT Data by Region



d. Age of Victim

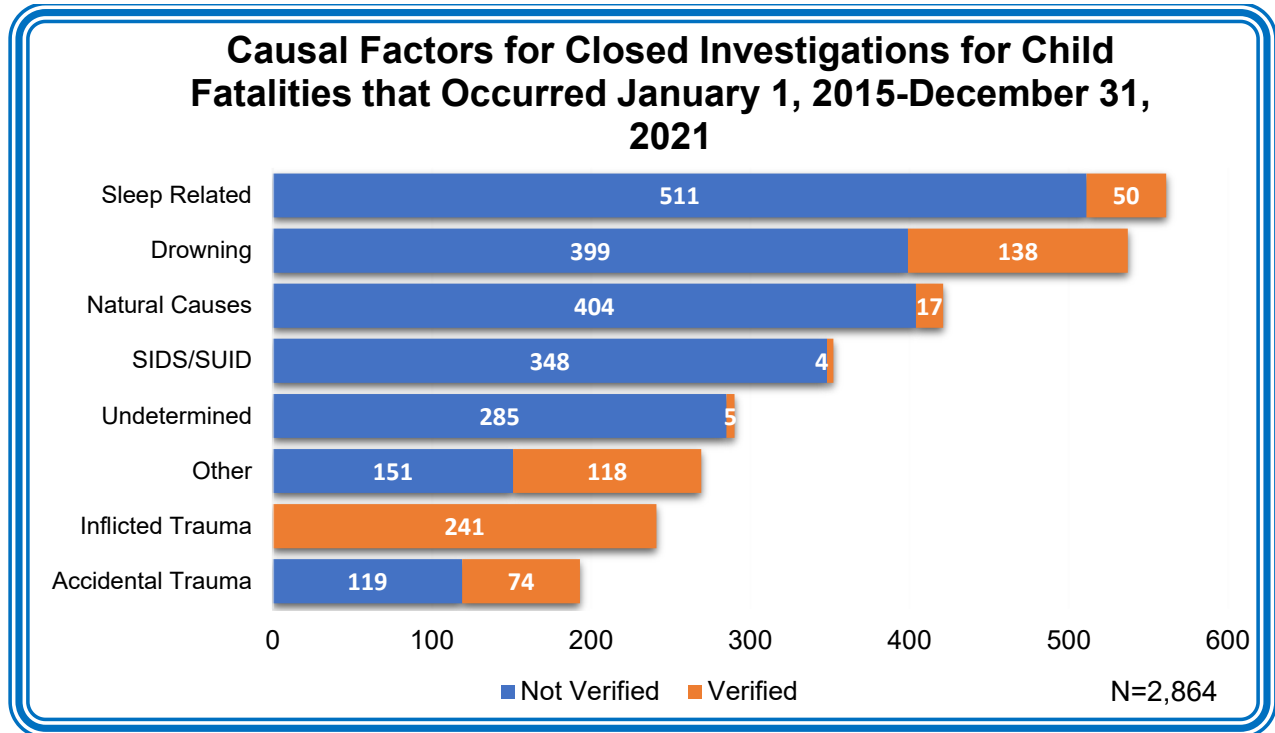
All four victims involved in the four CIRRT deployments during this quarter were under four years of age, with three of the victims aged eight months or younger.

The age percentages between all child fatalities reported to the Hotline and those meeting the requirements for a CIRRT review remain extremely close, if not the same. Children under the age of four are the majority.



e. Causal Factors All Fatalities

Of the 2,864 closed child fatalities that occurred from January 1, 2015, to December 31, 2021, the four primary causal factors were sleep-related, drowning, natural causes, and SIDS/SUID. There are still 266 child fatality investigations, the majority of which were received in 2021, that remain open.



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 5 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

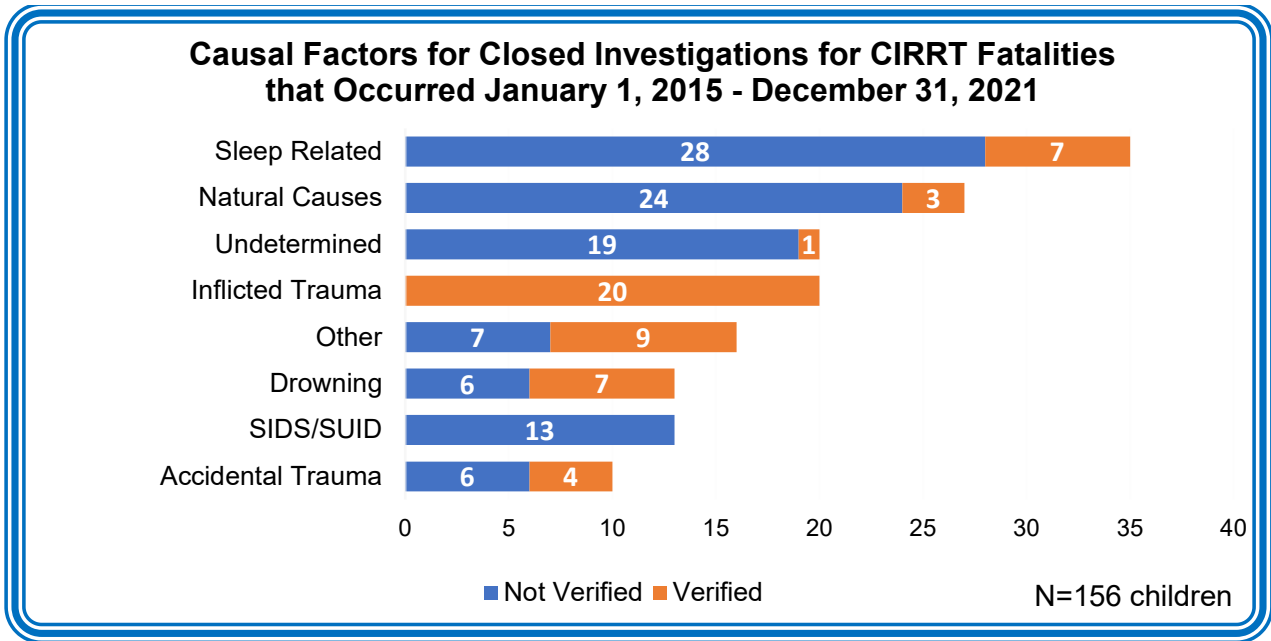
solely on the surrounding circumstances (e.g., possible unsafe sleep environment, bedding, position, etc.) as opposed to a medical examiner's finding of fact. However, in one of the cases with a SIDS/SUID maltreatment, the causal factor was verified due to the incident occurring while the parents were bed-sharing and both were under the influence of substances.

The death maltreatment cannot be used as a stand-alone maltreatment; therefore, the underlying maltreatment that may have caused or contributed to the child's 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.

f. Causal Factors CIRRT Fatalities

Between January 1, 2015, and December 31, 2021, there were a total of 166 CIRRT deployments involving 168 child fatalities. Of the 155 investigations (involving 156 children) that were closed, the four primary causal factors were sleep-related, natural causes, undetermined, and inflicted trauma. In addition, 47 investigations (31 percent) involving 49 victims had verified findings for the death maltreatment. Nine of the investigations (involving 10 children) remain open.



An additional 32 investigations (21 percent) were closed with verified findings for maltreatment other than the death maltreatment, with inadequate supervision being verified in 18 of the cases, and 17 of the cases verified as to substance use related maltreatments. Multiple maltreatments can be verified in each investigation.

IV. CIRRT Advisory Committee

The CIRRT Advisory Committee (Committee) is statutorily required to meet on a quarterly basis. During the last quarter of 2021, the Committee’s last meeting was December 2, 2021.

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 laws related to child protection and child welfare services.

V. Recommendations

The CIRRT Advisory Committee continues to recommend that the statutory requirement for the CIRRT Advisory Committee Report be changed from quarterly to annually.

The CIRRT Advisory Committee continues to recommend the following addition/change to the statutory language:

The Secretary will have the discretion whether to deploy a CIRRT team in circumstances that meet the criteria below:

- a) Cases in which there is no relationship between the fatality and the prior verified report (e.g., involves a separate household and perpetrator; and/or the decedent has had no contact with the caregiver/parent in the verified prior report);*
- b) Cases in which the death occurred in a daycare or other facility, including a hospital (e.g., an infant born extremely premature and never leaves the hospital);*
- c) Cases in which the death occurred in a foster home when it involves a separate incident and different perpetrator from the prior verified report; and*
- d) Cases in which a child's death is not unexpected due to a prior diagnosed medical condition.*

It is important to note that cases meeting any of the above criteria would not be automatically exempt from a CIRRT deployment. The determination of whether to deploy will be based on a collaborative analysis between the CIRRT Unit and Department leadership.

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 Broward, Hillsborough, Manatee, Pasco, Pinellas, Seminole, and Walton Counties*. The department is responsible for child protective investigations in the remaining 60 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 in 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.

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



Community-Based Care Lead Agency Map

