Critical Incident Rapid Response Team Advisory Committee
Third Quarter Report for Calendar Year 2019

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 2019

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 and 2 for more details).

II. Purpose

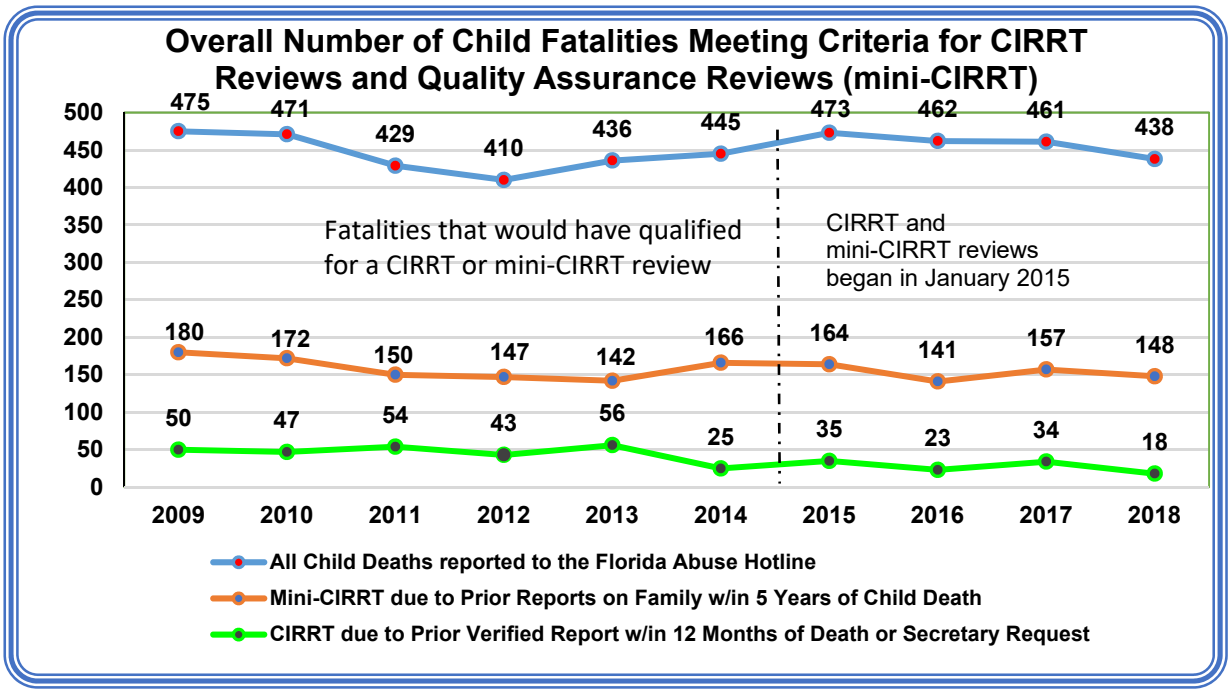
CIRRT reviews provide an immediate, multiagency investigation of child deaths that meet the statutory criteria for review or other serious incidents at the Secretary's discretion. Reviews are conducted in an effort to identify root causes, rapidly determine the need to change policies and practices related 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

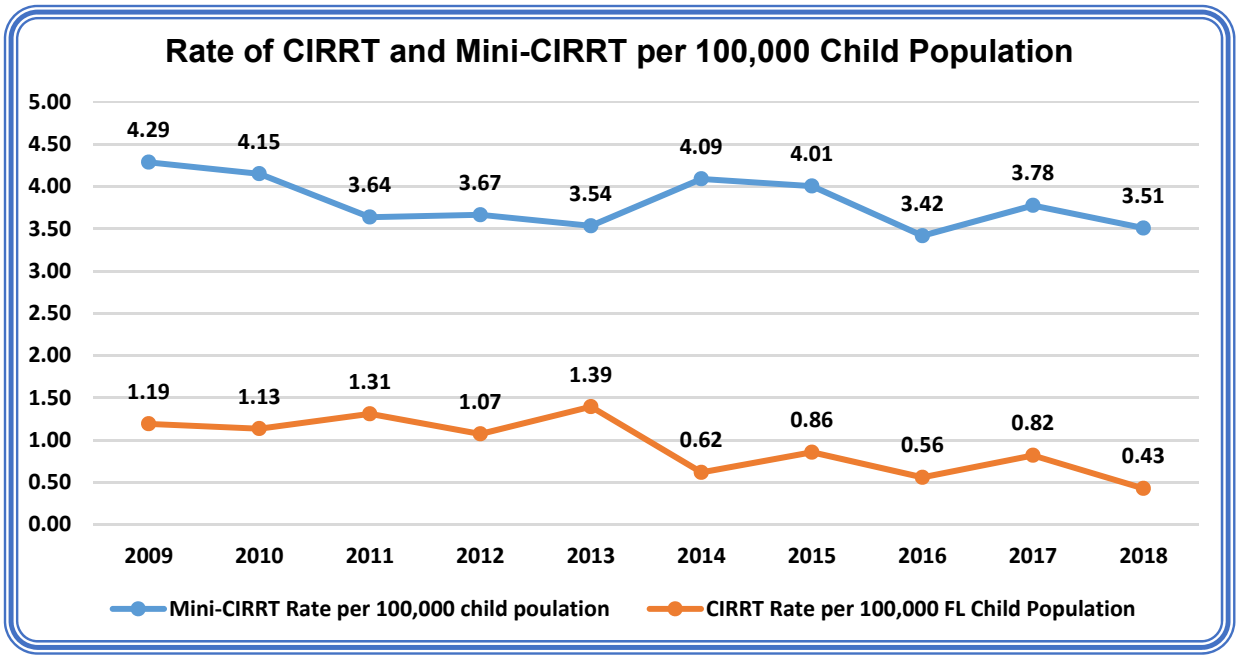
From January 1, 2015, through September 30, 2019, a total of 120 CIRRT teams were deployed involving 122 child deaths. Of those deployments, 114 met the CIRRT requirement of having a verified report within the previous 12 months, while the other six reviews were completed at the direction of the Secretary. Of the six remaining 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 six percent of the overall fatalities reported to the Department of Children and Families' (department) Florida Abuse Hotline (Hotline). An additional 33 percent of the fatalities reported to the Hotline met the criteria for a mini-CIRRT review (see Appendix 3). 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.

Between January 1 and September 30, 2019, there were 105 child fatalities received that met the criteria for either a CIRRT deployment (12) or mini-CIRRT review (93). For the 12 CIRRT cases, there was no prior history involving the deceased child in three (25 percent) of the cases. In the 93 cases that met the criteria for a mini-CIRRT review, there was no prior history involving the deceased child in 36 (39 percent) of the cases.



The rate of occurrence for fatalities meeting the requirements for CIRRT deployments and mini-CIRRT reviews were lower in 2018 than 2017 and are currently tracking at or below the 2018 levels.

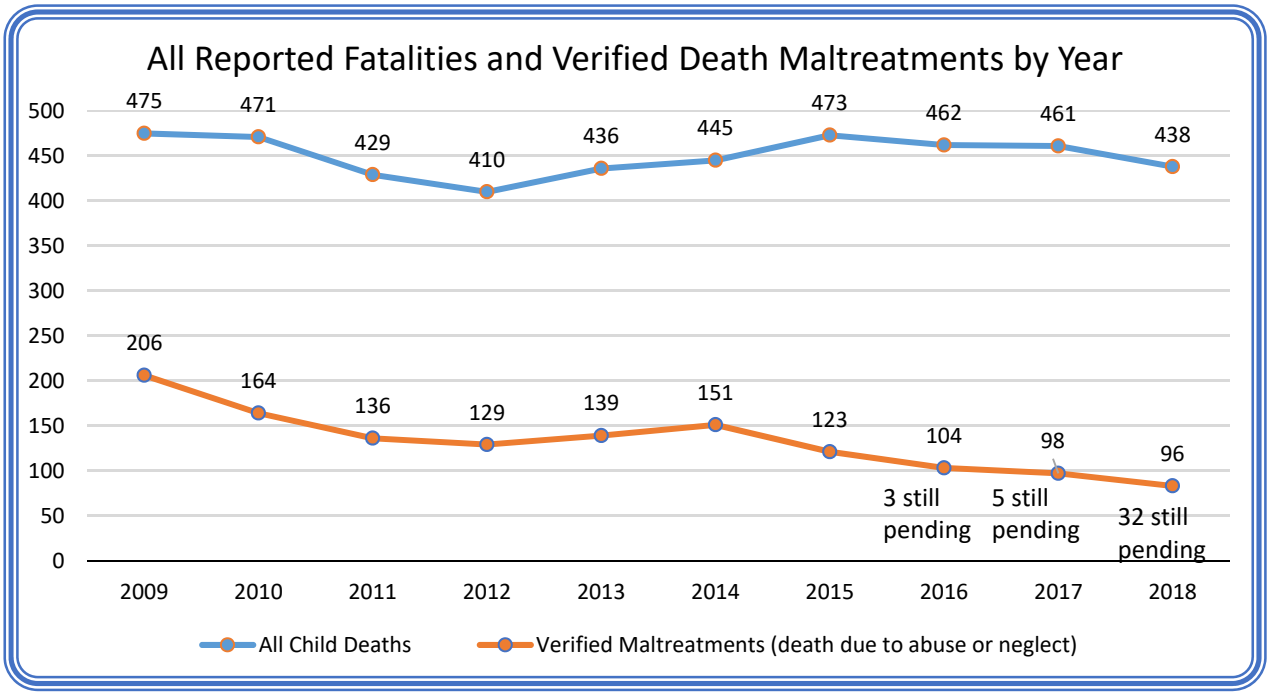


Standardized data is collected across all review types and entered into Qualtrics for further analysis and review. Reports on reviews conducted as a result of a child fatality (regardless of the type of review completed) are redacted according to Florida Statutes and posted for public review on the department's 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.

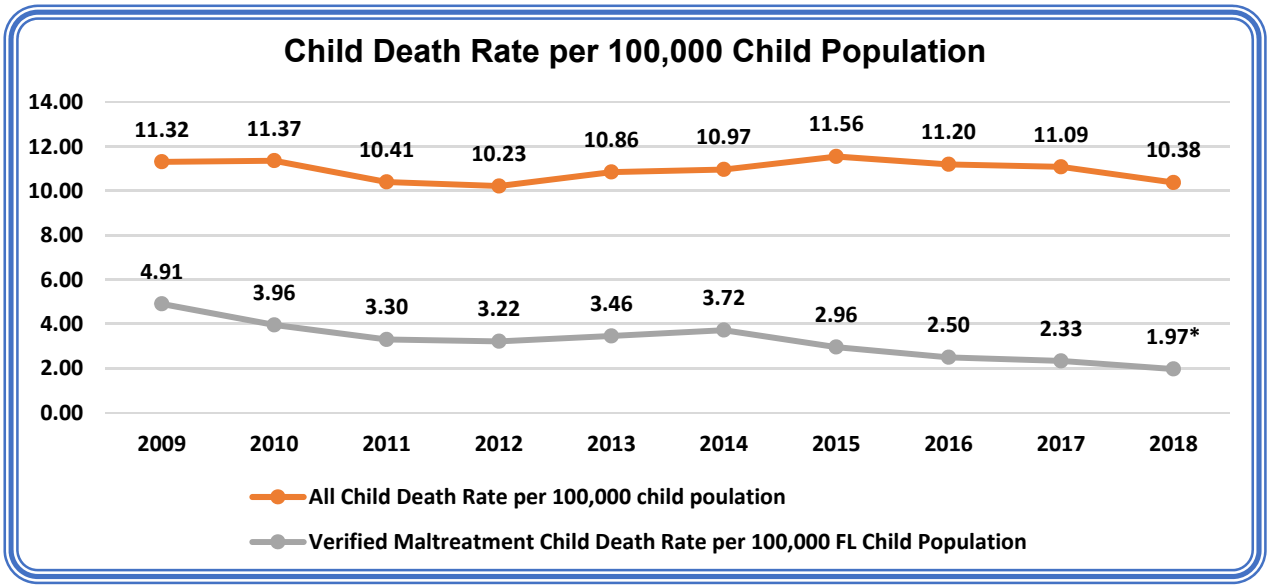
Child deaths in Florida typically involve a child age three or younger and may involve a variety of causal factors including, but not limited to: sleep-related deaths, drownings, natural causes, inflicted trauma, Sudden Infant Death Syndrome (SIDS)/Sudden Unexplained Infant Death (SUID), and accidental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

Of the 1,396 child fatalities that occurred during the 2015-2017 calendar years and were reported to the Hotline, eight remain open; seven at the request of law enforcement/state attorney due to on-going criminal proceedings and one is pending closure in the field. During this three-year period, the death maltreatment was verified in 322 (23 percent) of the closed cases. For the 438 child fatalities that occurred in 2018 and were reported to the Hotline, 32 currently remain open. Of the 395 closed 2018 child fatality investigations, 96 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

While the child death rate per 100,000 child population has remained relatively flat over the past ten years, the rate of verified child death maltreatments per 100,000 child population reflects a downward trend.



*It is important to note that there are still 32 outstanding investigations for 2018 which, when closed, may impact the overall verification rate for that year.

III. Review of CIRRT Data

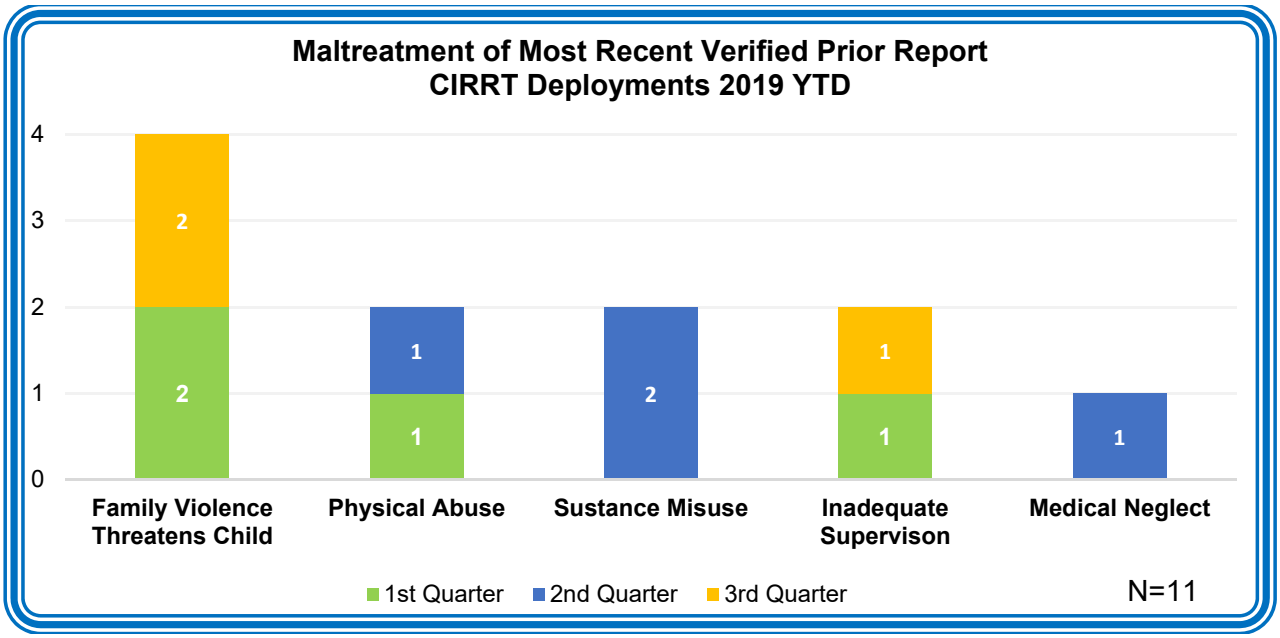
a. Summary of Third Quarter CIRRT Reports

During the third quarter, there were three CIRRT deployments in three different regions, Northeast, Northwest, and SunCoast. One deployment, to Pinellas County in the SunCoast Region, was in a county where the sheriff's office is responsible for completing child protective investigations. The remaining deployments, to Escambia and Putman Counties, were areas where the department was responsible for child protective investigations.

At the time of the fatality, one of the three families were receiving child welfare services. The case involved an 11-year-old who, after overdosing on his medication, had been removed from his father's custody and placed in the care of his mother under in-home, judicial supervision. The child was pronounced deceased after he was transported to the hospital following complaints that his stomach was hurting and he began vomiting while he was at his grandmother's home. In one of the remaining deployments, another 11- year old was pronounced deceased three days after he suffered an asthma attack. In-home non-judicial case management services closed five months earlier with a Chapter 39 injunction in place. The remaining case involved a three-year-old who was pronounced deceased the day after she was shot in the head by her father, who then shot and killed himself. There was one prior investigation that did not involve the biological father.

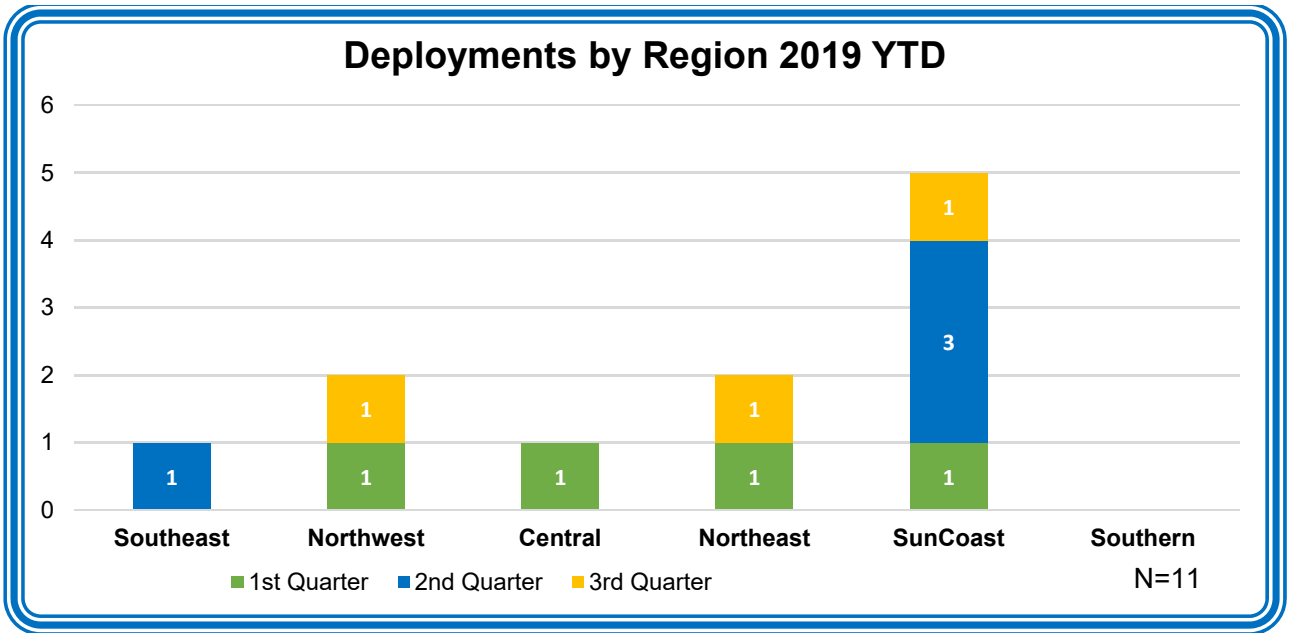
b. Past Maltreatment

During the 2019 calendar year, there were 11 CIRRT deployments, involving 12 victims, with each having a verified prior report on the victim or a sibling within the previous 12 months. There were four deployments with prior verified maltreatment of family violence threatens child and two deployments, each with a verified prior of substance misuse, inadequate supervision, and physical abuse.

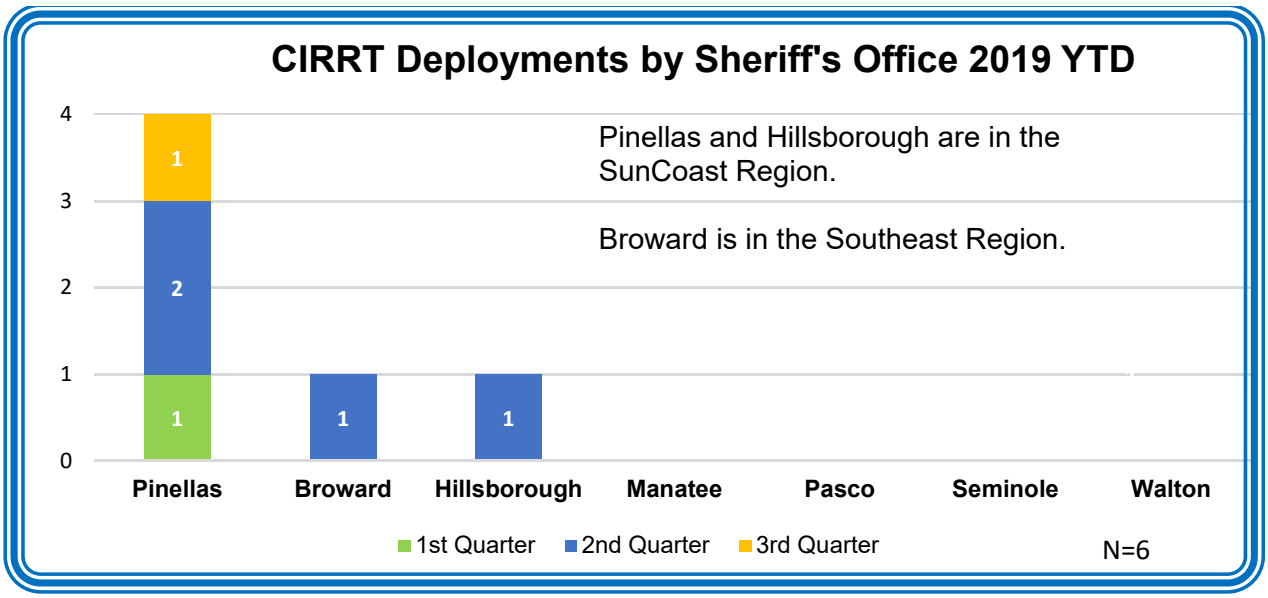


CIRRT Data by Region

From January 1 through September 30, 2019, there were 11 CIRRT deployments, involving 12 victims, occurring in five of the six regions. Five of the CIRRT deployments have been to the SunCoast Region. There were two deployments, each, to the Northwest and Northeast regions and one deployment, each, to the Southeast and Central regions. Four of the SunCoast Region deployments occurred in Pinellas County and one in Hillsborough County, both of which have child protective investigations conducted by the sheriff's office. Additionally, the deployment in the Southeast Region was to Broward County, where the sheriffs' office conducts child protective investigations. The department is responsible for the completion of child protective investigations in the other counties where teams were deployed.

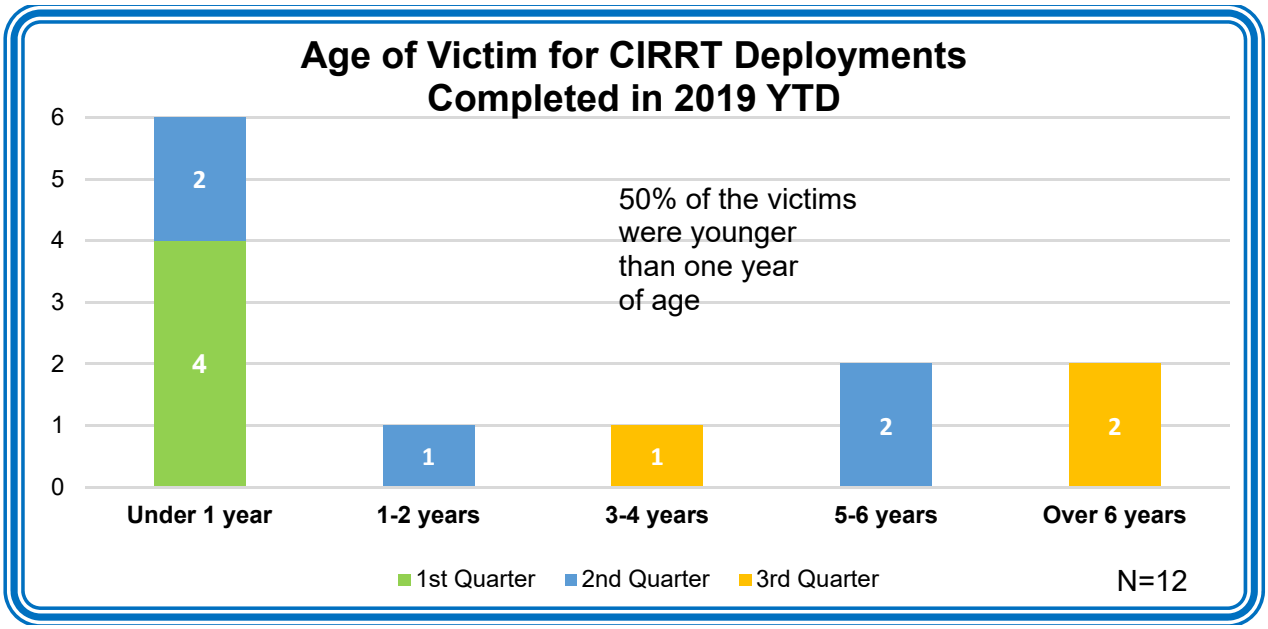


During the first three quarters of the 2019 calendar year, six of the 11 CIRRT deployments have occurred in counties where a sheriffs' office is responsible for protective investigations.

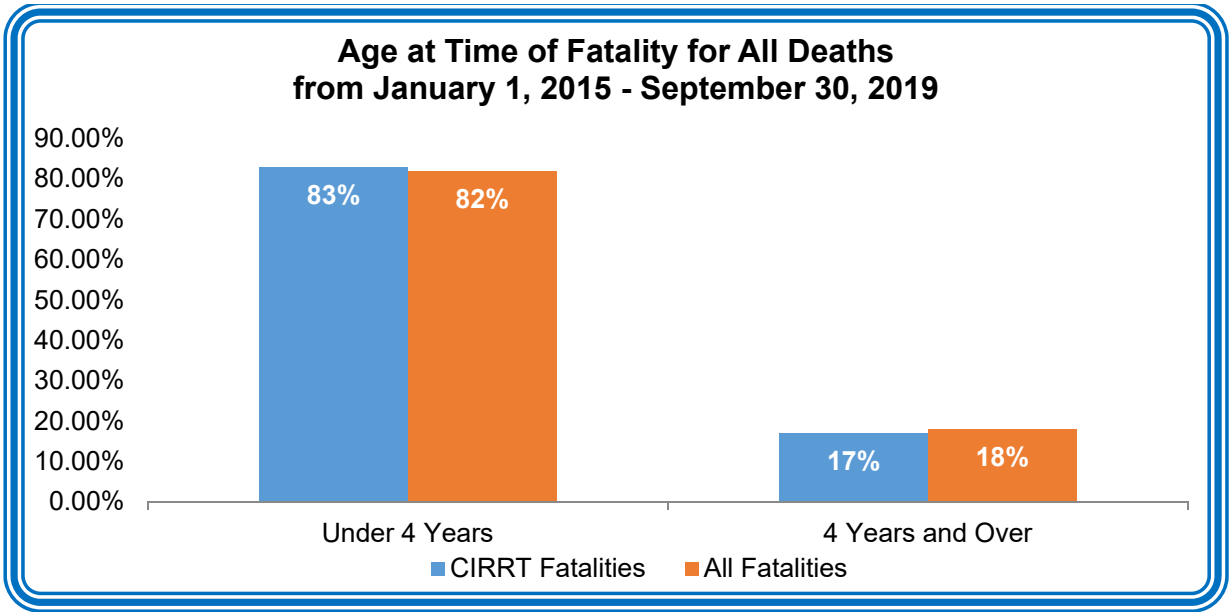


c. Age of Victim

There were 11 CIRRT deployments, involving 12 victims, during the first two quarters of the 2019 calendar year, with six of the 12 victims under the age of 1 year old. During the third quarter, two of the victims were 11 years old, and the remaining victim was 3 years old.

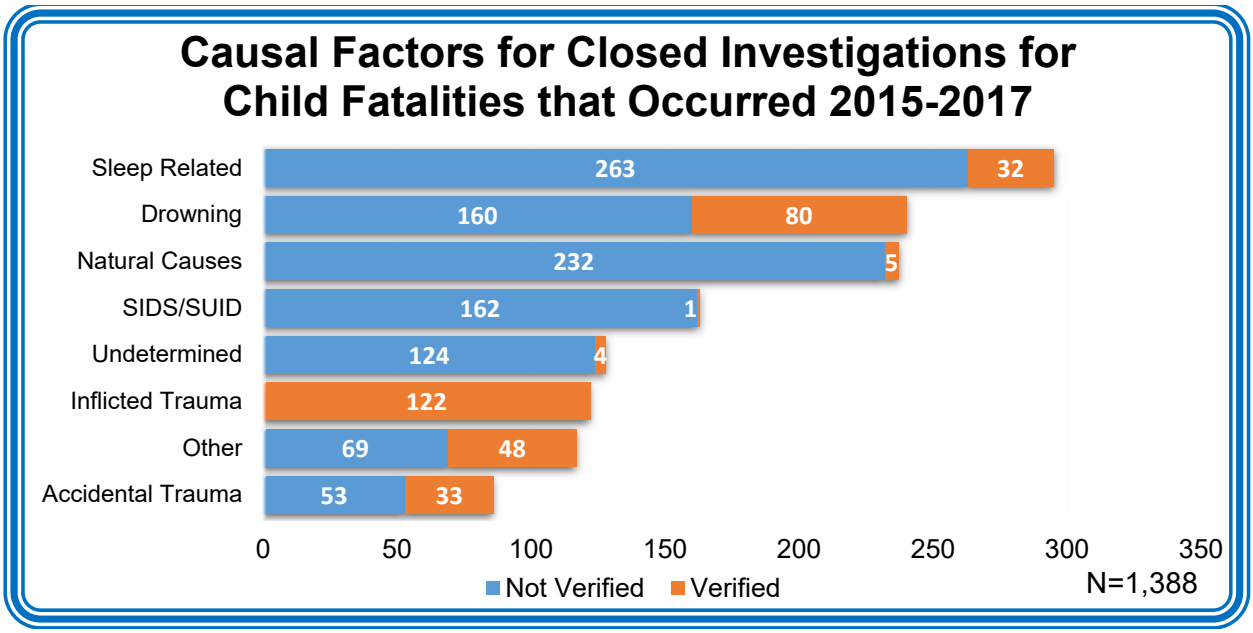


Of those child fatalities occurring from January 2015 through September 2019 that were reported to the Hotline, 82 percent involved a child under the age of 4 years old. Similarly, 83 percent of all CIRRT deployments also involved children in this age group.

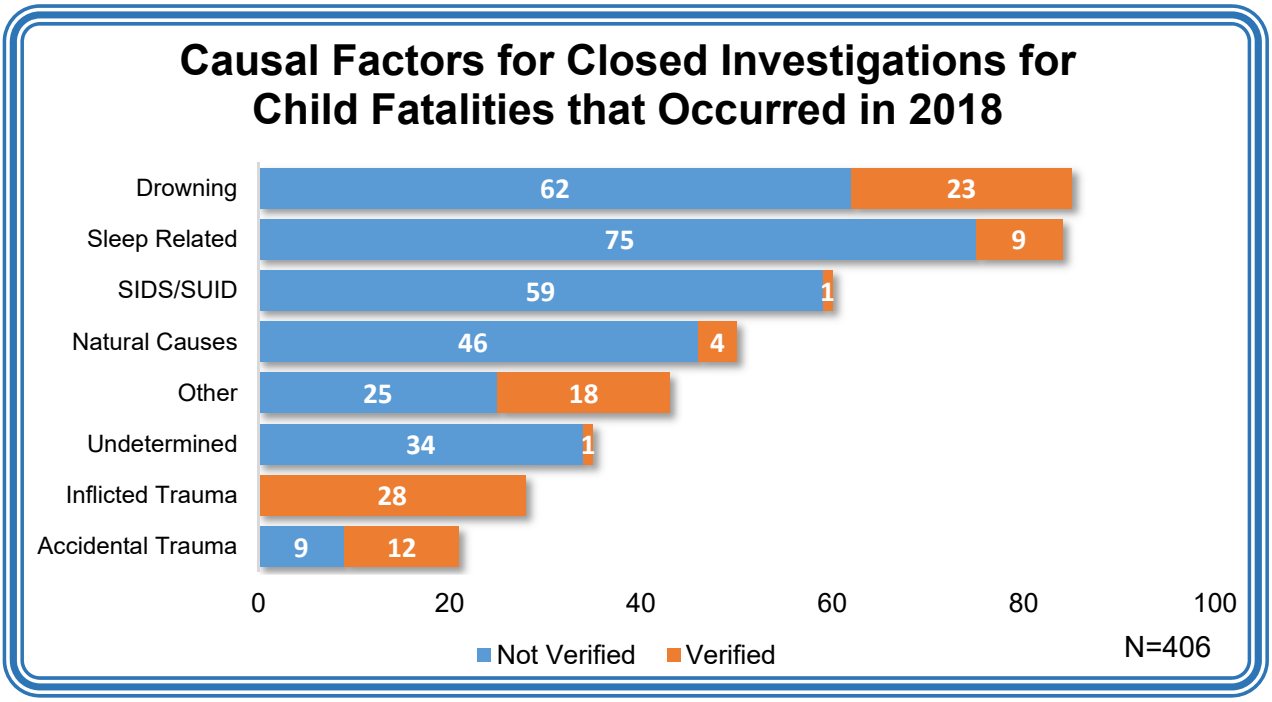


d. **Causal Factors**

Of the 1,388 closed child fatalities that occurred from January 1, 2015, to December 31, 2017, the four primary causal factors were sleep-related, drowning, natural causes, and SIDS/SUID. There are eight child fatality investigations received during that time period that remain open. When finalized, they will have a slight impact on the overall numbers; however, there will be no change regarding the four primary causal factors.



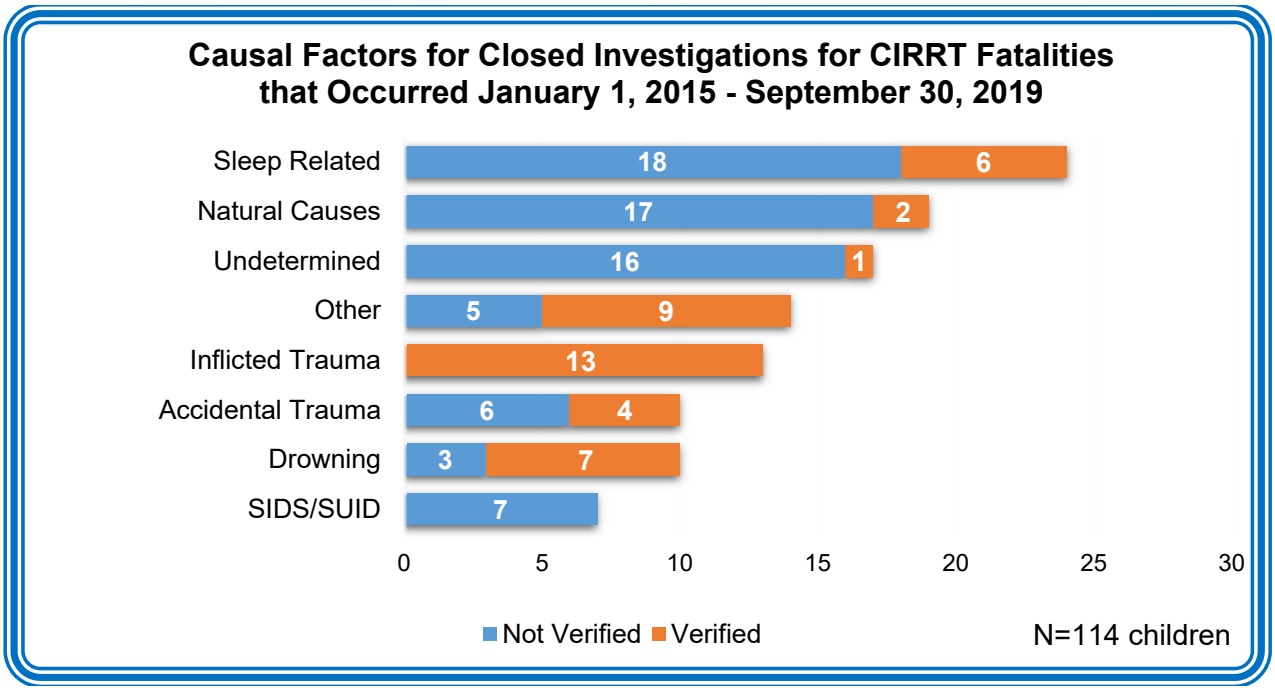
Of the 406 closed child fatalities that occurred in 2018, the four primary causal factors were drowning, sleep-related, SIDS/SUID, and natural causes. There are still 32 child fatality investigations received during this time period that remain open, which, when finalized, will impact the overall numbers and causal factor ranking.



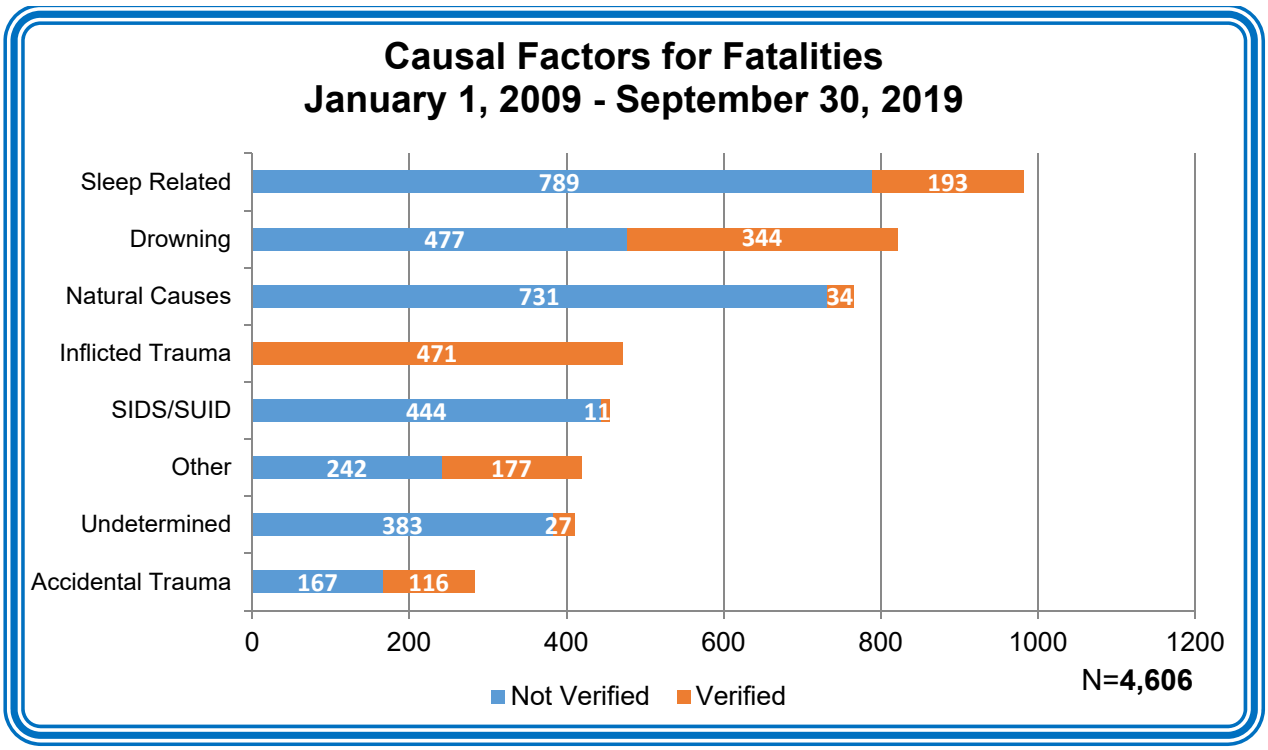
The death maltreatment cannot be used as a stand-alone maltreatment; therefore, the underlying maltreatment that may have caused or contributed to the child's death is noted. For an investigation to be closed with verified findings for the death maltreatment, there must be a preponderance of credible 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.

Between January 1, 2015, and September 30, 2019, there were a total of 120 CIRRT deployments involving 122 child fatalities. Of the 113 investigations (involving 114 children) that were closed, 41 investigations (36 percent) involving 42 victims had verified findings for the death maltreatment; nine of the investigations remain open. An additional 21 investigations (19 percent) were closed with verified findings for maltreatment other than the death maltreatment, with inadequate supervision being verified in 12 of the cases, and substance misuse was verified in eight of the cases. Multiple maltreatments can be verified in each investigation.



Between January 1, 2009, and September 30, 2019, the four leading causal factors of child fatalities reported to the Hotline were sleep-related (982), drowning (821), natural causes (765), and inflicted trauma (471).



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 years old 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, 2019. 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 laws related to child protection and child welfare services.

At the September 18, 2019 meeting, the Committee discussed cost analysis and impact on data analysis when a CIRRT team is deployed for cases where there is no correlation between the child fatality and the previous verified abuse report. The Committee recommended follow-up with developing specific criteria and to draft language in order to recommend a statutory change to allow for teams not to be deployed, at the discretion of the Secretary, for cases involving fatalities in childcare settings or separate households, including children placed in licensed foster care.

The Committee reviewed and discussed statewide changes that were made as a result of findings from CIRRT deployments. Changes include: updating the Maltreatment Index regarding allegations of active mental health crisis of the caretaker to require an immediate response, pre-birth assessments for children born into open cases, a requirement for six months post-placement supervision after a child was reunified, updating policies around substance-exposed newborns, and requiring the courts to be notified when a dependent child is hospitalized under a Baker Act. In addition to changes at the statewide level, findings and lessons learned from CIRRT deployments frequently result in process changes at the local level. The Committee discussed the importance of sharing lessons learned from CIRRT deployments with staff at all levels, including front-line CPI and case management staff, and substance abuse and mental health providers. The Committee discussed developing a Talk Book as a method to share lessons learned from CIRRTs around the state.

The CIRRT deployments from the quarter were reviewed and discussed with the Committee. There was a discussion regarding the current interpretation of federal regulation regarding sharing records between agencies and the need to add language regarding consent. Additionally, there was discussion surrounding the lack of medical foster homes, which was identified as a statewide issue. The need for additional staff training and education surrounding the impact of marijuana and alcohol, as it relates to child safety, was discussed.

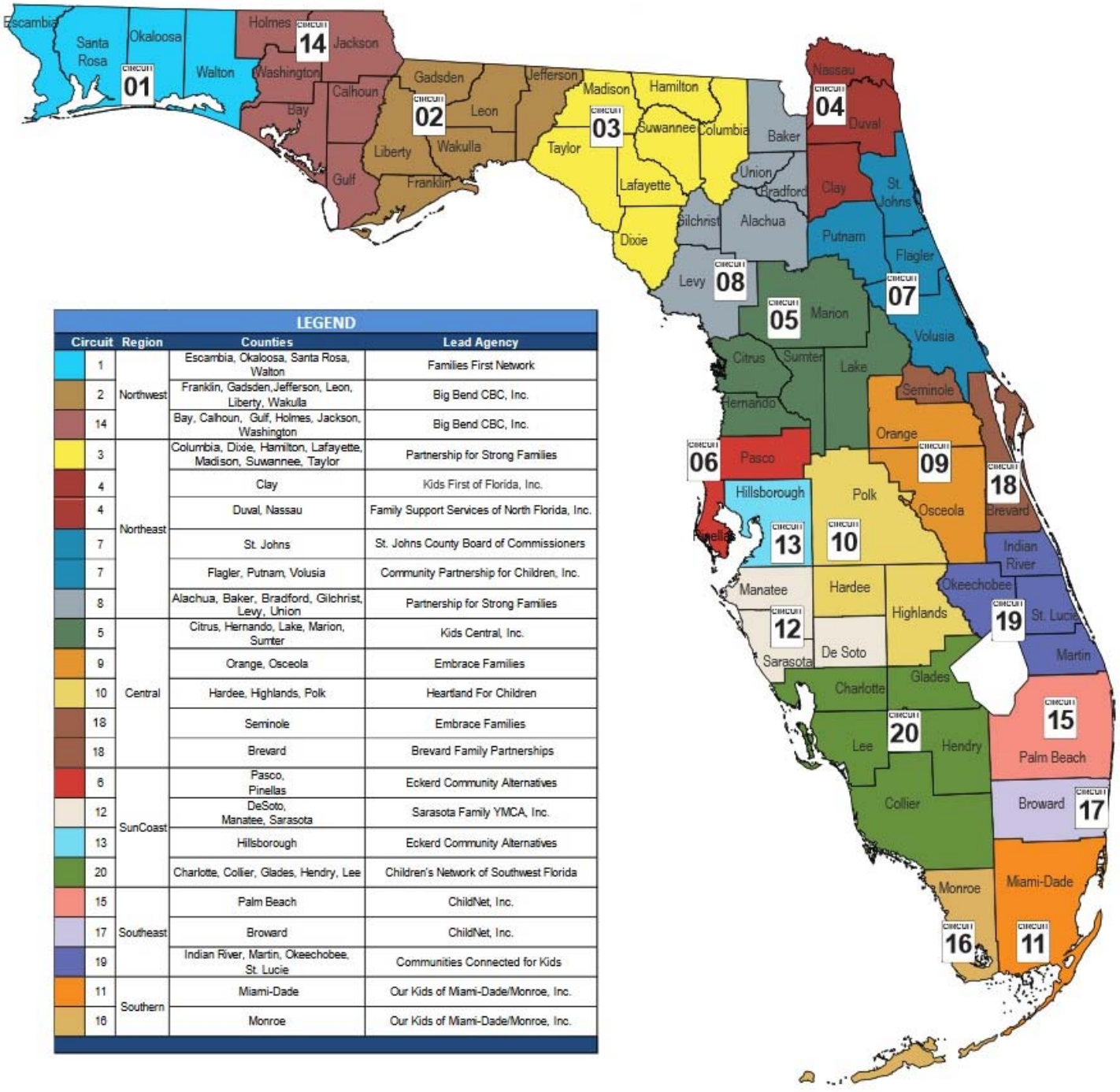
APPENDIX 1 – Section 39.2015, Florida Statutes

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 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.

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	Embrace Families
10		Hardee, Highlands, Polk	Heartland For Children
18		Seminole	Embrace Families
18		Brevard	Brevard Family Partnerships
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	Communities Connected for Kids
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, with the exception of the December 2018 training which was canceled due to travel restrictions. The most recent training was held in Ocala in August 2019. To date, a total of 594 professionals with expertise in child protection, domestic violence, substance abuse, 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.