Critical Incident Rapid Response Team Advisory Committee
Fourth Quarter Report for Calendar Year 2017

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
Fourth Quarter 2017

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 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.

III. Review of Child Fatality Data

From January 1, 2015, through December 31, 2017, 91 CIRRT teams were deployed. Of those deployments, 85 met the CIRRT requirements, having a verified report within the previous 12 months, while the other six reviews were completed at the direction of Secretary Mike Carroll. 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.

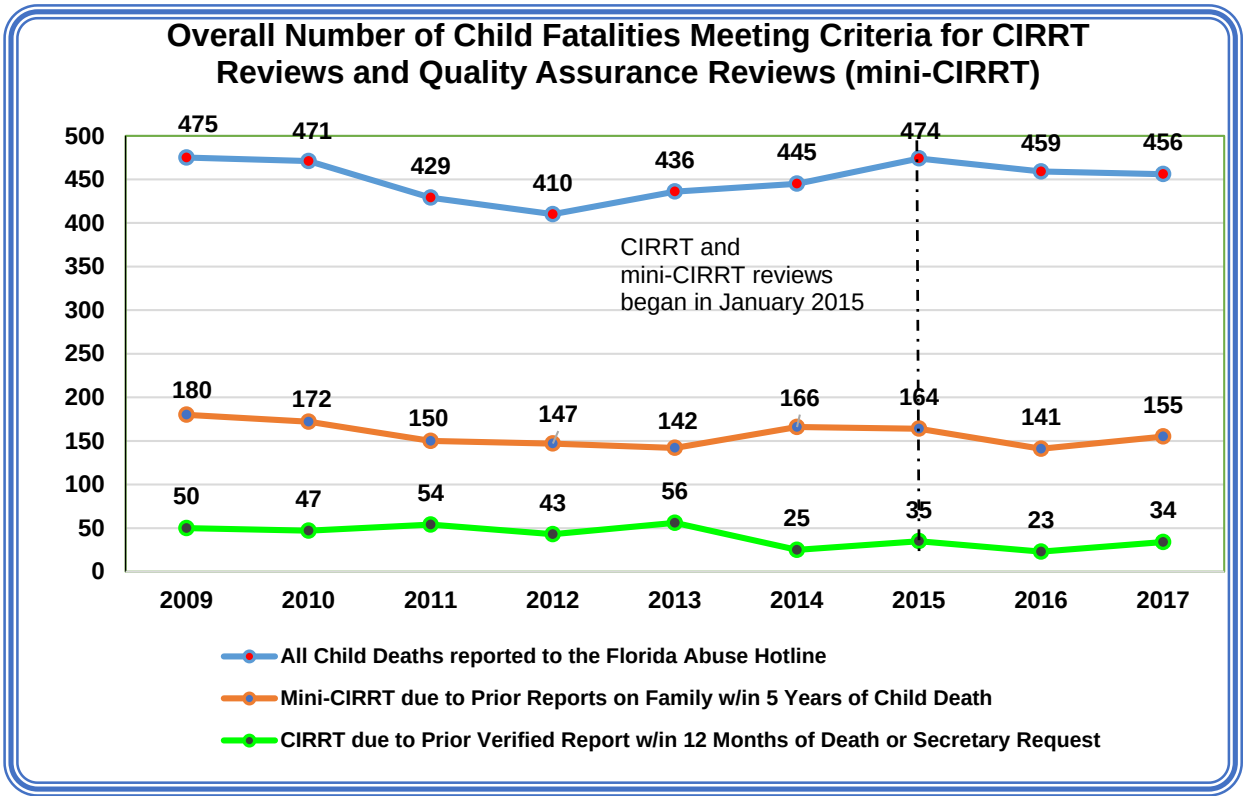
In 2016, 22 cases, involving 23 children, either met the criteria for a CIRRT deployment, due to having a verified report within 12 months of the reported death, or the Secretary requested a team be deployed. One of the CIRRT deployments involved two victims. Although these 23 cases represent less than 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 35 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 189 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 of the cases (12 percent). In the 155 cases that met the criteria for a mini-CIRRT review, there was no prior history involving the deceased child in 82 of the cases (53 percent).

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.

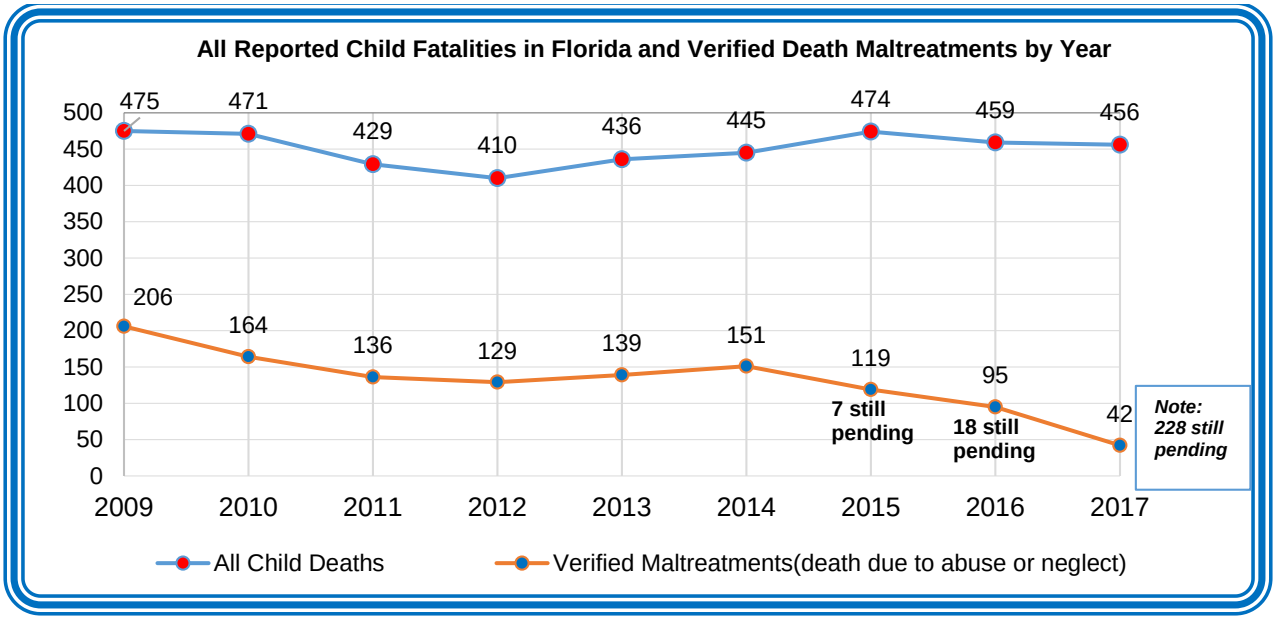


It should be noted that the chart above is a reflection of the number of actual child fatalities. Some cases involve multiple victims; however, only one respective review would be conducted. For example, while there were 23 child fatalities in 2016, there were only 22 deployments as one case involved 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 or not 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 474 child fatalities that occurred in 2015 and were reported to the Hotline, seven investigations remain open including five at the request of law enforcement/state attorney due to on-going criminal proceedings and two awaiting reports from the medical examiner's office. For the 459 child fatalities that occurred in 2016 and that were reported to the Hotline, 18 remain open. Ninety-five of the 441 closed 2016 child fatality investigations had verified findings for the death maltreatment. Findings for open cases have not yet been determined, giving the appearance of a decline in the number of verified reports.



III. Review of CIRRT Data

a. Summary of Fourth Quarter CIRRT Reports

During the fourth quarter, there were a total of five CIRRT deployments involving four of the six department regions. Two deployments were to the Northeast Region, and one deployment each to the SunCoast, Central, and Northwest regions. Four of the five deployments occurred in counties where the department is responsible for completing child protective investigations and one deployment occurred in Pinellas County, where the sheriff's office is responsible for completing child protective investigations.

All five victims in the cases requiring a CIRRT deployment during the fourth quarter involved children less than two-years-old who were found unresponsive. Four of the five victims were under the age of three-months, who were found unresponsive after being laid down to sleep. The remaining victim, an 18-month-old, was found unresponsive in his bed. There were no overt signs of physical injury or trauma to the victims noted in any of the five fatalities requiring a CIRRT deployment during the quarter.

At the time of the fatality, four of the five families were open to child welfare:

- one victim was the subject of an open child protective investigation;
- one victim was placed in out-of-home care; and
- in two cases, there was an open services case on a sibling or half-sibling to the victim.

In the two cases involving a sibling, the fatality victim was not the subject in any prior abuse investigations. In the case that did not have open child welfare involvement at the time of the fatality, the victim was the subject of the prior verified report received shortly after his birth.

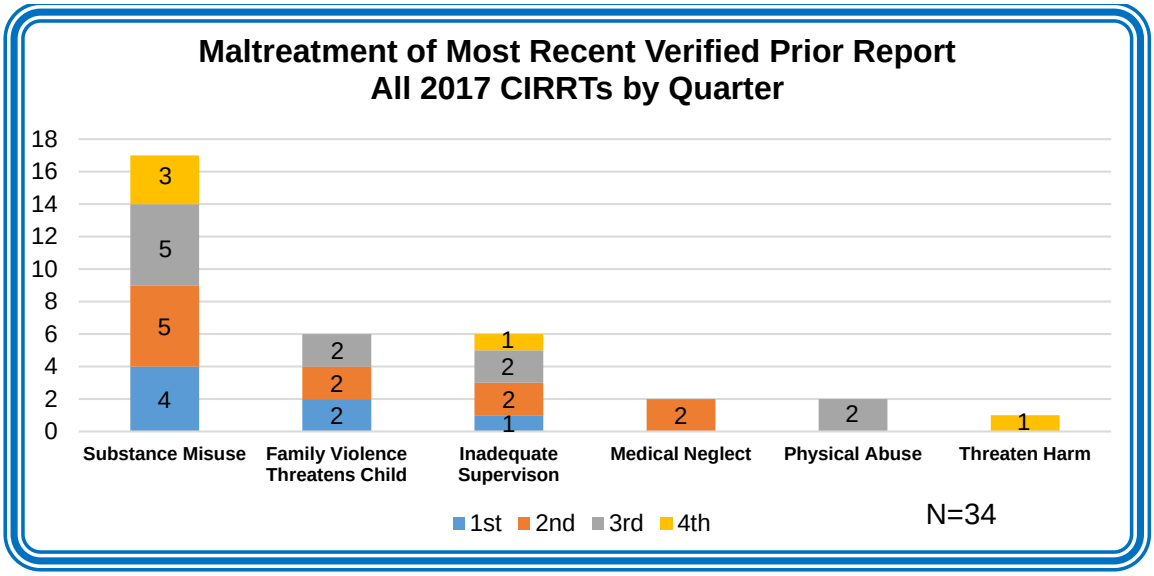
A review of the prior history for the five cases requiring a CIRRT deployment during the fourth quarter reflects substance abuse (cocaine, marijuana, and methamphetamine) by the biological parents in three of the cases. In the remaining two cases, the mothers had extensive histories of mental health issues.

b. Past Maltreatment

Of the 34 cases meeting the requirements for deployment in 2017, the most common maltreatment noted in the verified prior report was substance misuse, followed by family violence threatens child, and inadequate supervision. Additional maltreatment categories are outlined in the chart on the next page. Untreated caregiver mental health issues are often found to be co-occurring, which are not considered maltreatments.

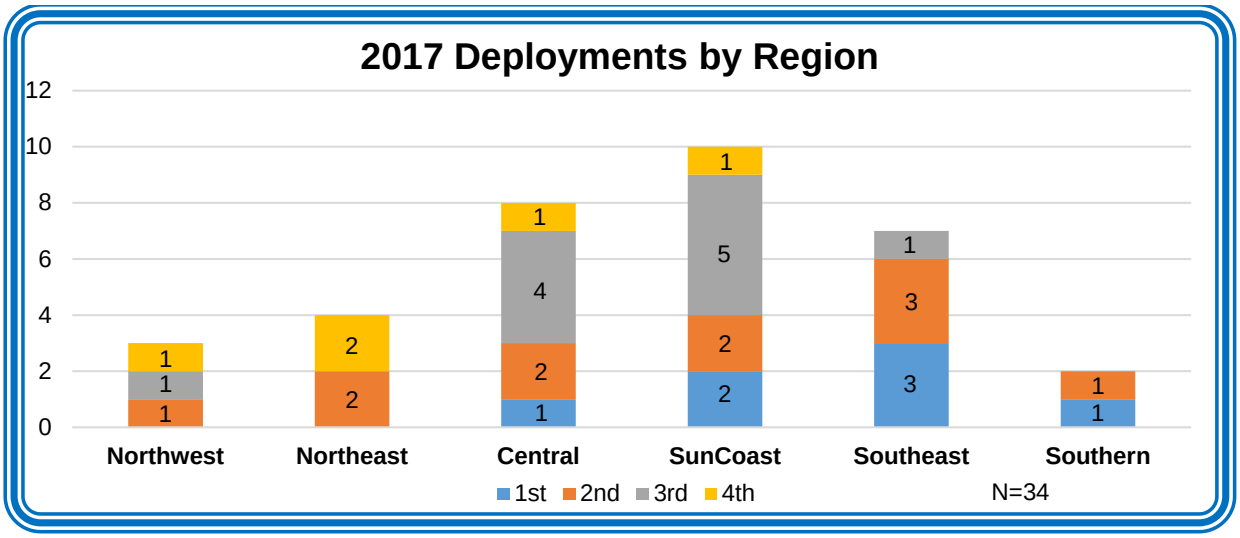
During the fourth quarter (October to December) of 2017, there were five CIRRT deployments, with each having a verified prior report on the victim or a sibling within the previous 12 months. There were three deployments with a prior verified maltreatment of substance misuse. There was one deployment with a verified maltreatment of

threatened harm and one deployment with a verified maltreatment of inadequate supervision. In both cases, co-occurring mental health issues of the caregiver was identified as a contributing factor.

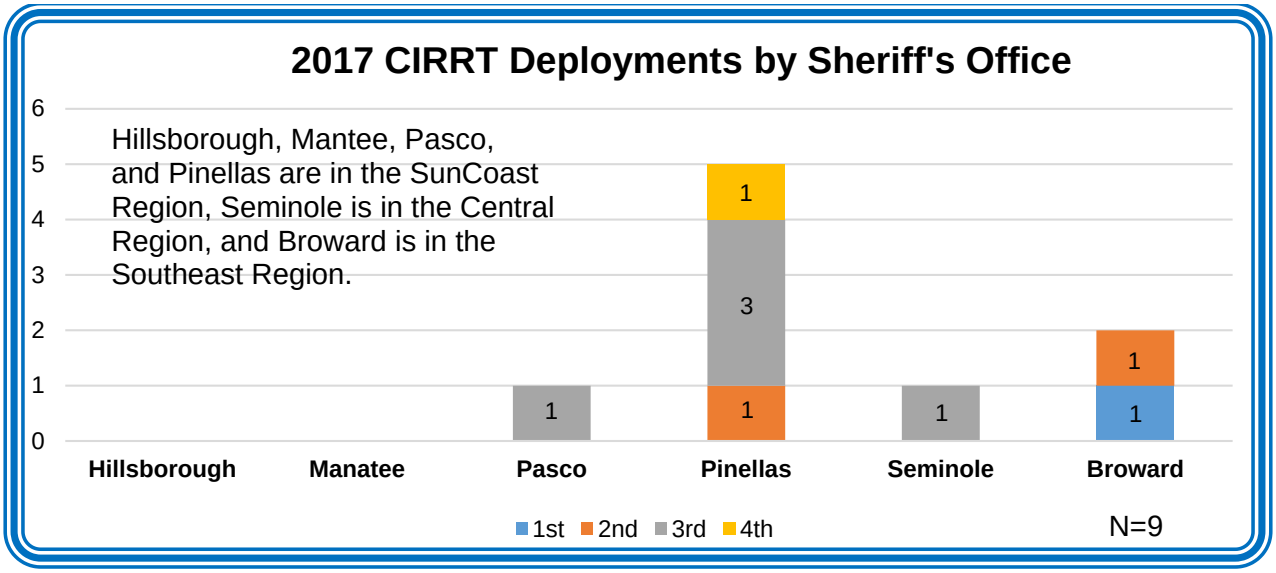


c. CIRRT Data by Region

From January 1, 2017, through December 31, 2017, there were a total of 34 CIRRT deployments, with at least one deployment occurring in each of the six regions. There were five CIRRT deployments during the fourth quarter of 2017, two in the Northeast and one each in the SunCoast, Central, and Northwest regions. One of the deployments during the quarter occurred in Pinellas County, where the sheriff's office conducts child protective investigations. The department is responsible for the completion of child protective investigations in the other four counties where teams were deployed.



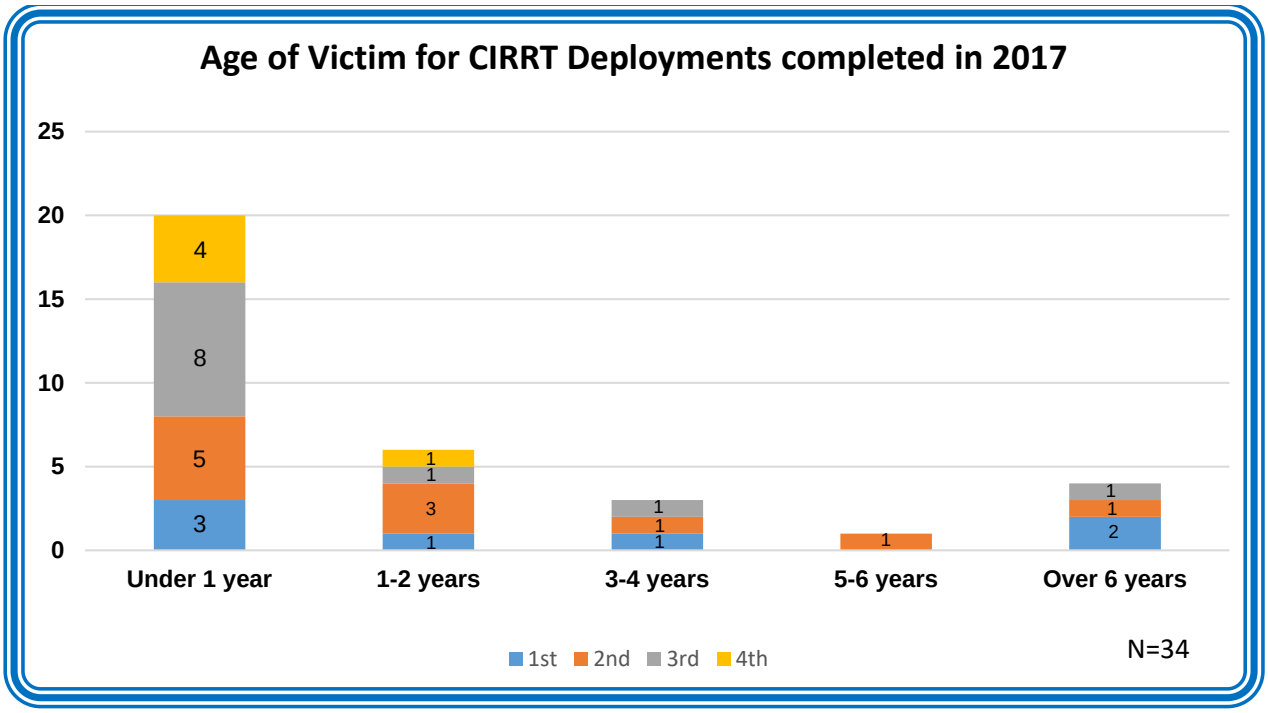
From January 1, 2017, through December 31, 2017, nine of the 34 CIRRT deployments involved four of the six counties where child protective investigations are conducted by sheriffs' offices. During the fourth quarter of 2017, there was one CIRRT deployment to a sheriff's office (Pinellas County).



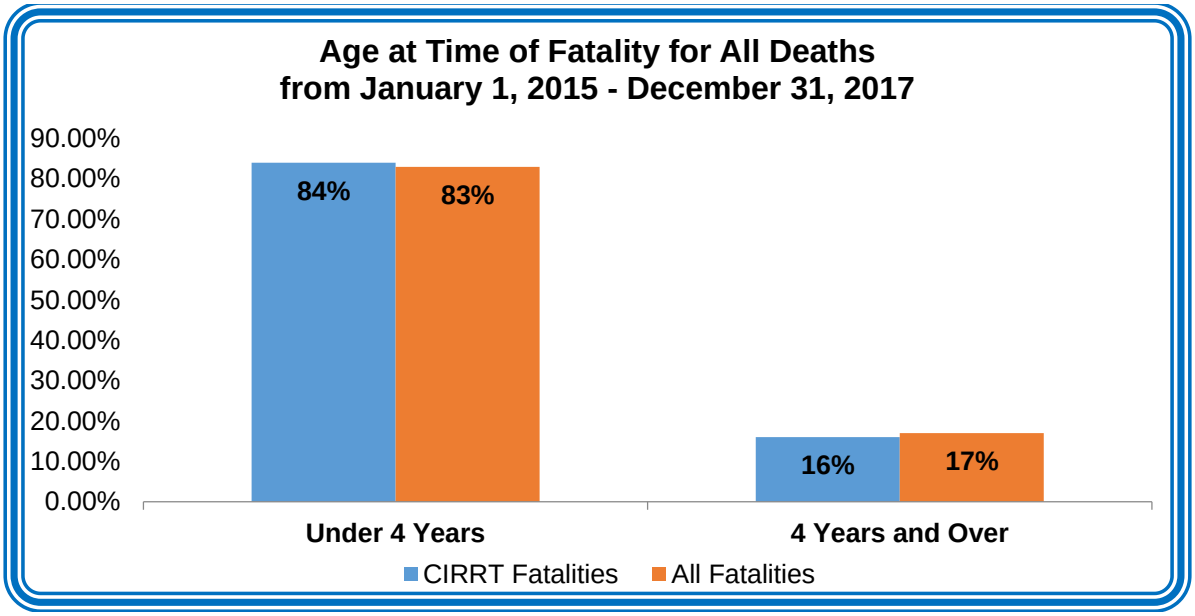
d. Age of Victim

From January 1, 2017, through December 31, 2017, 34 CIRRT reviews were completed. Eight-eight percent of the deployments involved a victim six years of age or younger. In 76 percent of the reviews, the victim was under the age of three. 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 fourth quarter of 2017, with four of the five victims under age one.



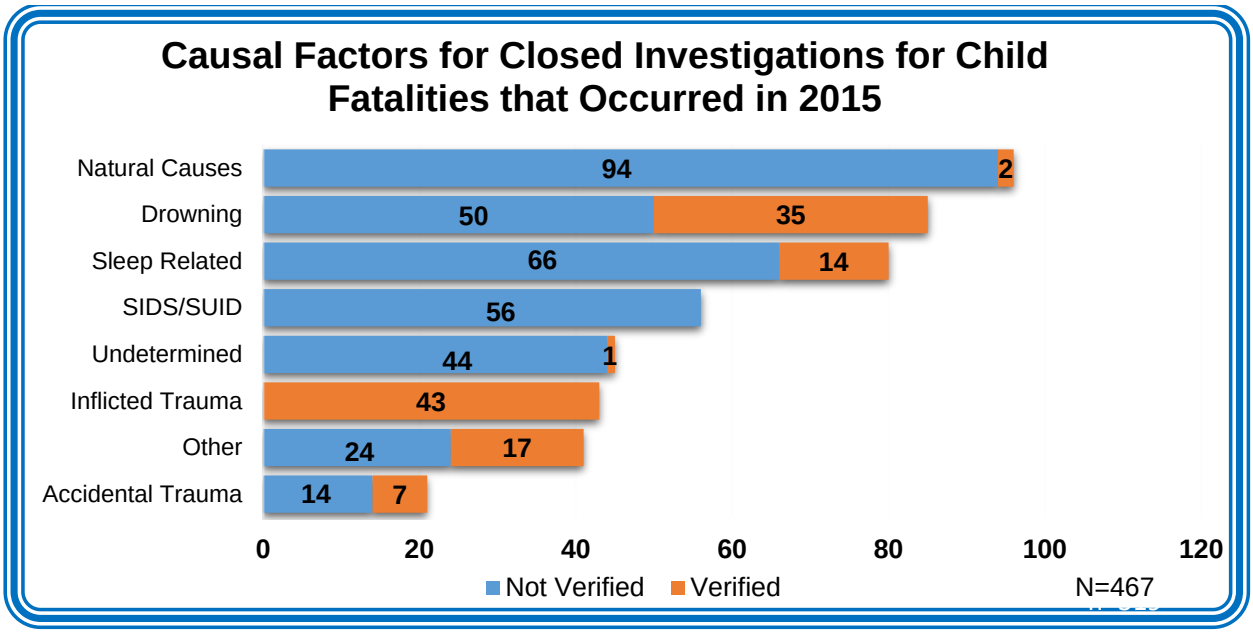
Of those child fatalities reported to the Hotline occurring from January 2015 through December 2017, 84 percent involved a child under the age of four. Similarly, 83 percent of all CIRRT deployments involved children in this age range.



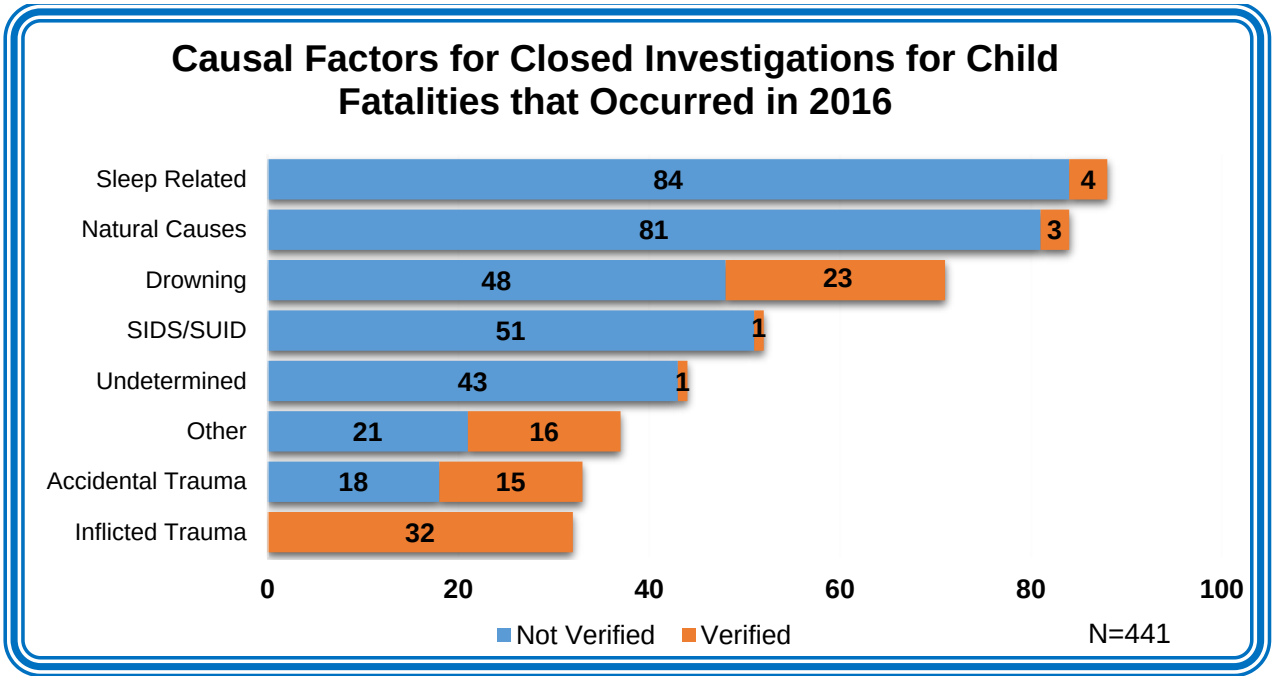
e. Causal Factors

Of the 467 closed child fatalities that occurred in 2015, the four primary causal factors were natural causes, drowning, sleep related, and SIDS/SUID. There were a total of

seven child fatality investigations received during this time period that remain open. When finalized, they will impact the overall numbers and causal factor sequencing.



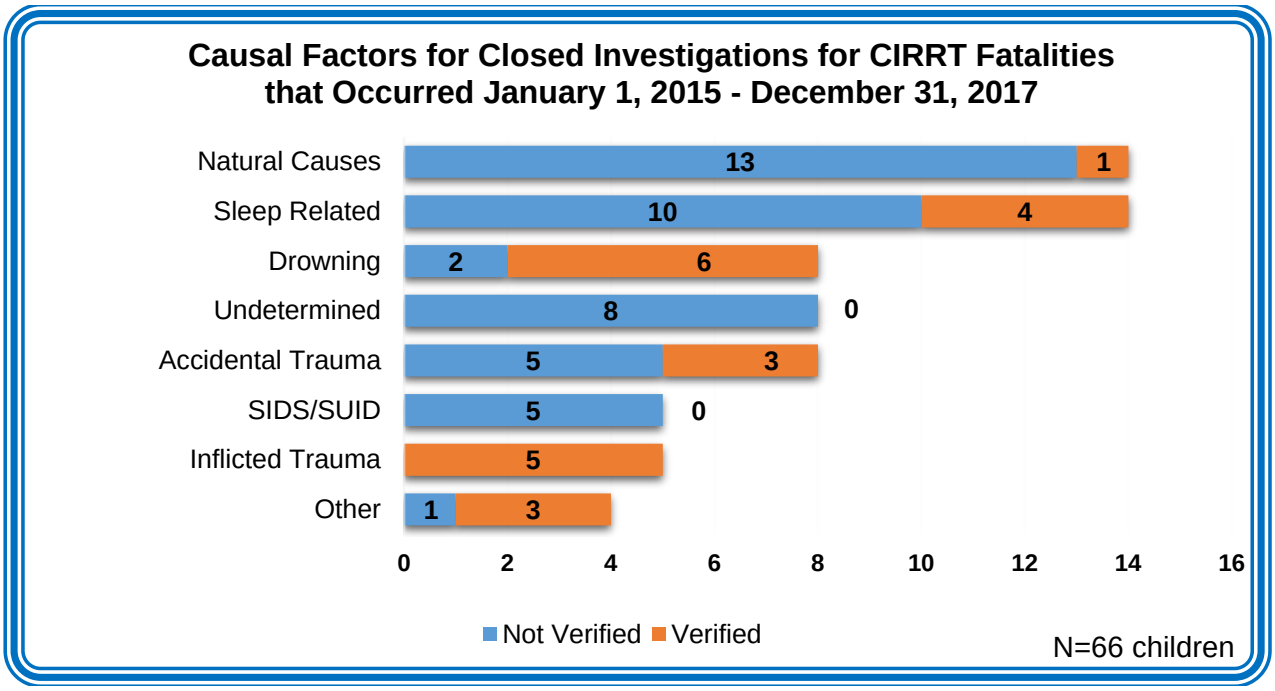
Of the 441 closed child fatalities that occurred in 2016, the four primary causal factors were sleep related, natural causes, drowning, and SIDS/SUID. One SIDS/SUID case was verified as the parents were arrested in connection with the fatality. There are a total of 18 child fatality investigations received during this time period that remain open. When finalized, they will impact the overall numbers and causal factor sequencing.



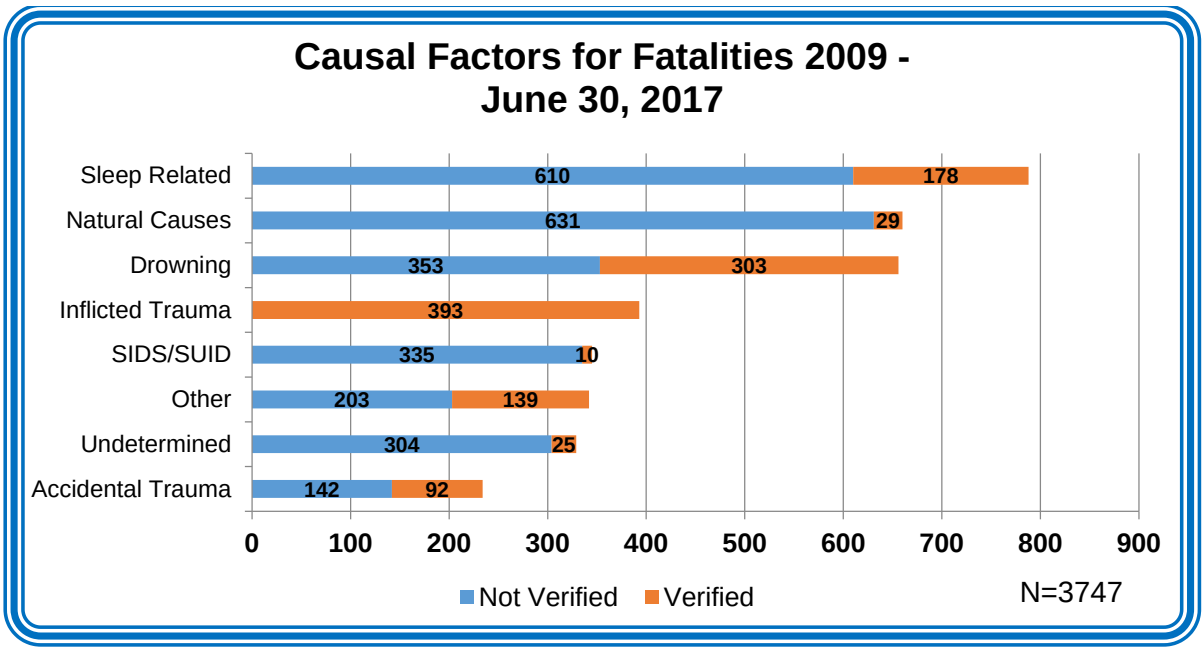
The death maltreatment cannot be used as a stand-alone maltreatment; therefore, the underlying maltreatment that may have caused or contributed to the child death is noted. For an investigation to be closed with verified findings for the death maltreatment, there must be a preponderance of credible evidence 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 December 31, 2017, there were a total of 91 CIRRT deployments involving 92 child fatalities. Of the 65 investigations that were closed, 21 (32 percent) investigations involving 22 victims had verified findings for the death maltreatment. An additional 15 (23 percent) investigations were closed with verified findings for maltreatment other than the death maltreatment. A review of the 91 deployments indicates that 42 cases (46 percent) of the deployments involved children under the age of one who were found unresponsive in their crib/bassinet, or after sleeping with an adult caregiver, and/or siblings.



Between 2009 and June 30, 2017, the four leading causal factors of child fatalities reported to the Hotline were sleep related (788), natural causes (660), drowning (656), and inflicted trauma (393).



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 investigations 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 has met a total of five times, most recently on November 15, 2017. 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 department and Legislature that will improve policies and law related to child protection and child welfare services.

V. Closing Summary

Throughout the deployments and with input from the statewide Committee, additional qualitative data elements have been identified. Data from prior CIRRT reviews have been tracked and data from other similar reviews are being tracked to compare trends and emerging themes.

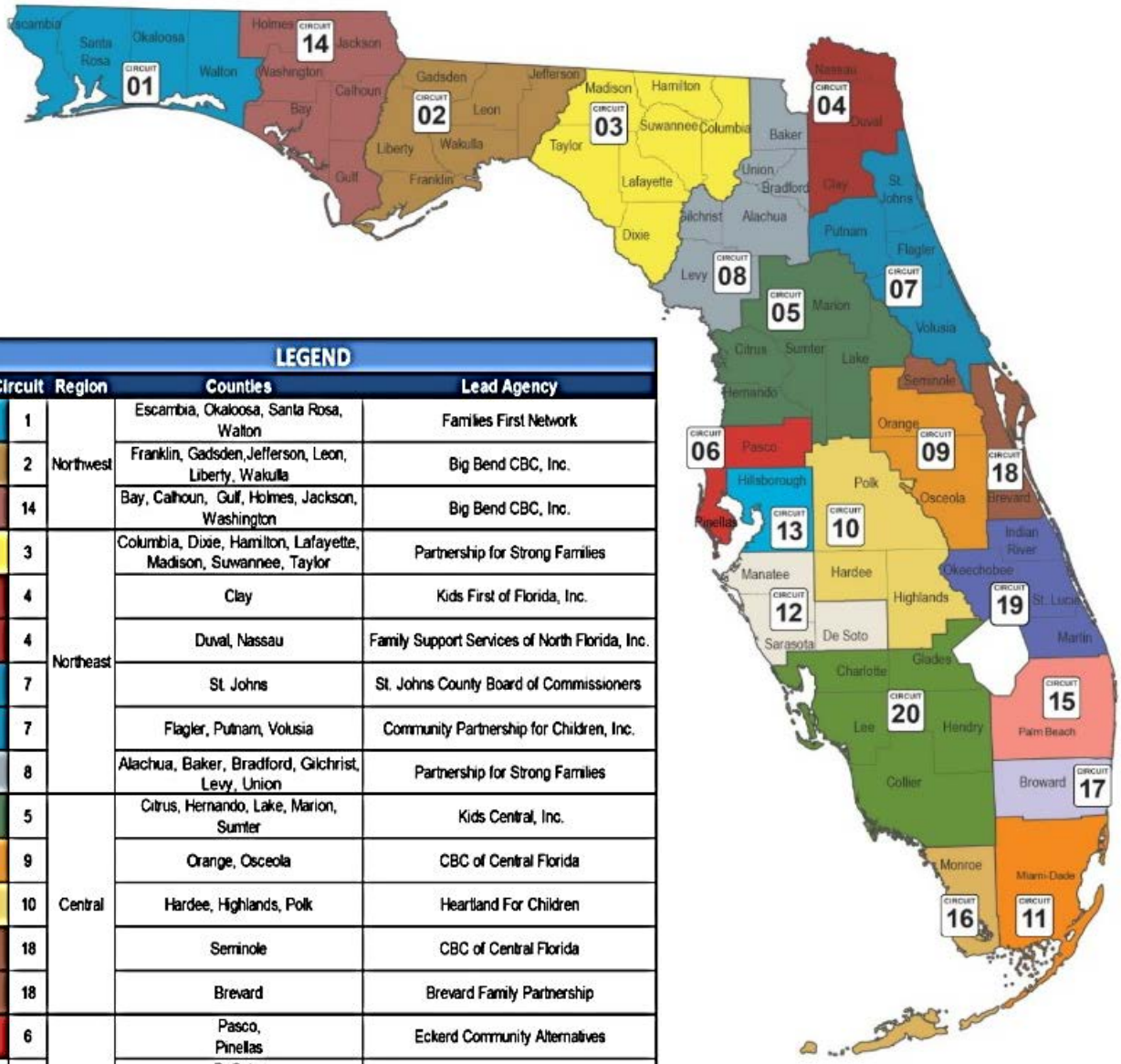
A Harvard Fellow, working with the Government Performance Lab, has been working with the department on child fatality prevention, specifically through the CIRRT process. The Government Performance Lab is an organization that provides technical assistance to state and local governments and focuses on using data-driven practices to advance solutions to some of the nation's most challenging social problems. One area the Harvard Fellow has focused on has been data restructuring to help the department more efficiently share and report data with the end goal of improving policy and practice around fatality prevention. Additional work is focused on advancing the data and insights provided to the Committee to drive improvements in their understanding of factors contributing to child fatalities and craft solutions and interventions for reducing the number of child deaths in Florida. This process has started with having one-on-one interviews with Committee members about their experiences serving on the Committee and their views on its strengths and opportunities for growth.

APPENDIX 1 – Section 39.2015, F.S.

Section 39.2015, F.S., 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, F.S., 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, F.S., 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.

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 partnering 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 Miami in December 2017. To date, a total of 485 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 effective July 1, 2015, requiring medical directors to be a team member on all CIRRTs (section 39.2015(3), F.S.).

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. These reviews use a tool and process that mirrors the CIRRT review process.