Critical Incident Rapid Response Team Advisory Committee
Fourth Quarter Report for Calendar Year (CY) 2016

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

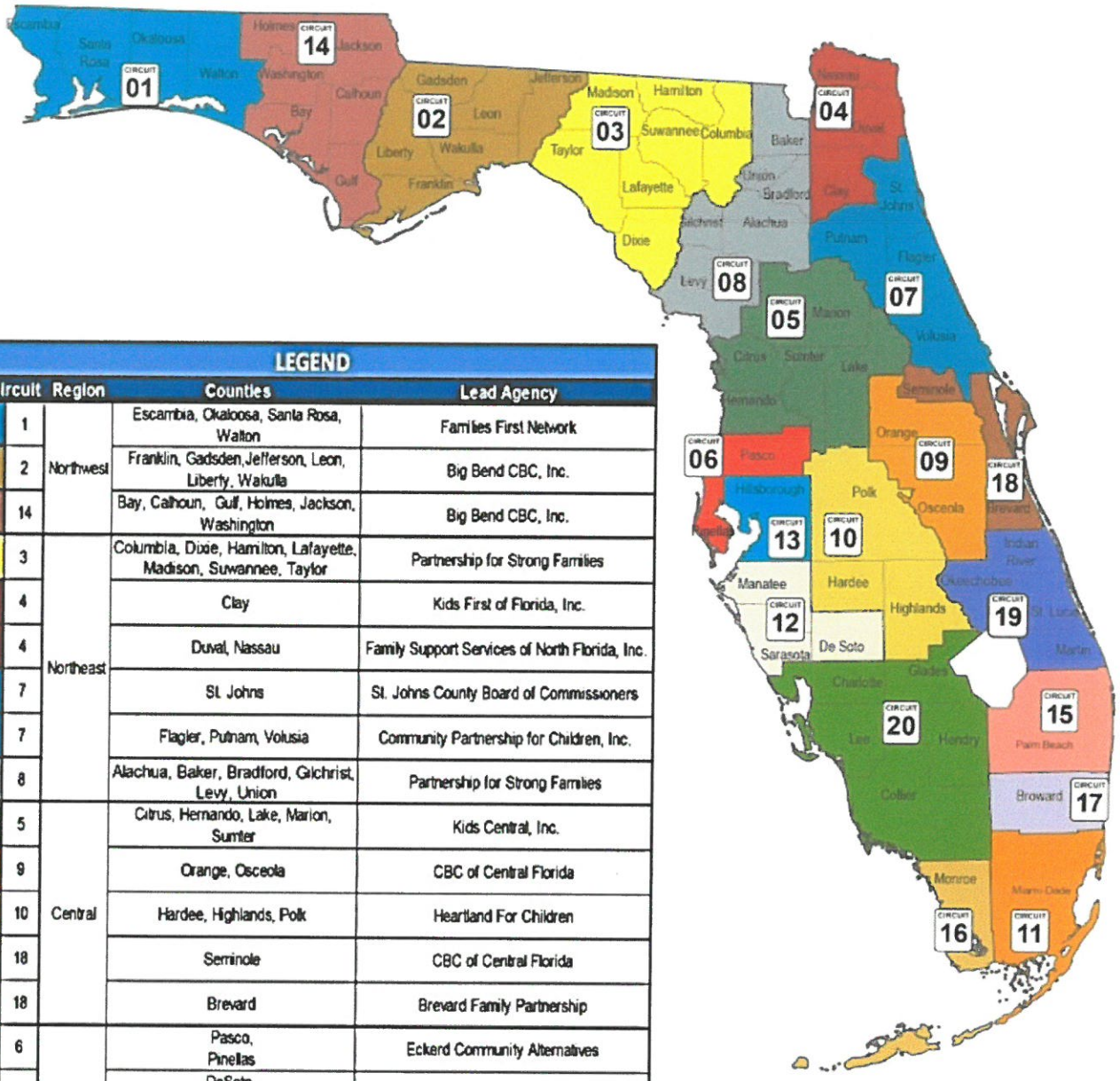
Florida Department of Children and Families
Critical Incident Rapid Response Team
Advisory Committee Report
Fourth Quarter 2016

I. Background

In 2014, the Florida Legislature passed Senate Bill 1666 (Chapter 2014-224, Laws of Florida), 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 of Children and Families (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.
- Beginning in the 1998-1999 fiscal years and under section 39.3065, Florida Statutes, the Department transferred all responsibility for child protective investigations to the sheriffs' offices in Manatee, Pasco, Pinellas, Hillsborough, Broward, and Seminole counties. The Department is responsible for child protective investigations in the remaining 61 counties.
- As intended in section 409.986, Florida Statutes, the Department provides child welfare services to children through contracts with community-based care lead agencies for each of the 20 judicial circuits in the state.

Community Based Care Lead Agencies by Circuit and County

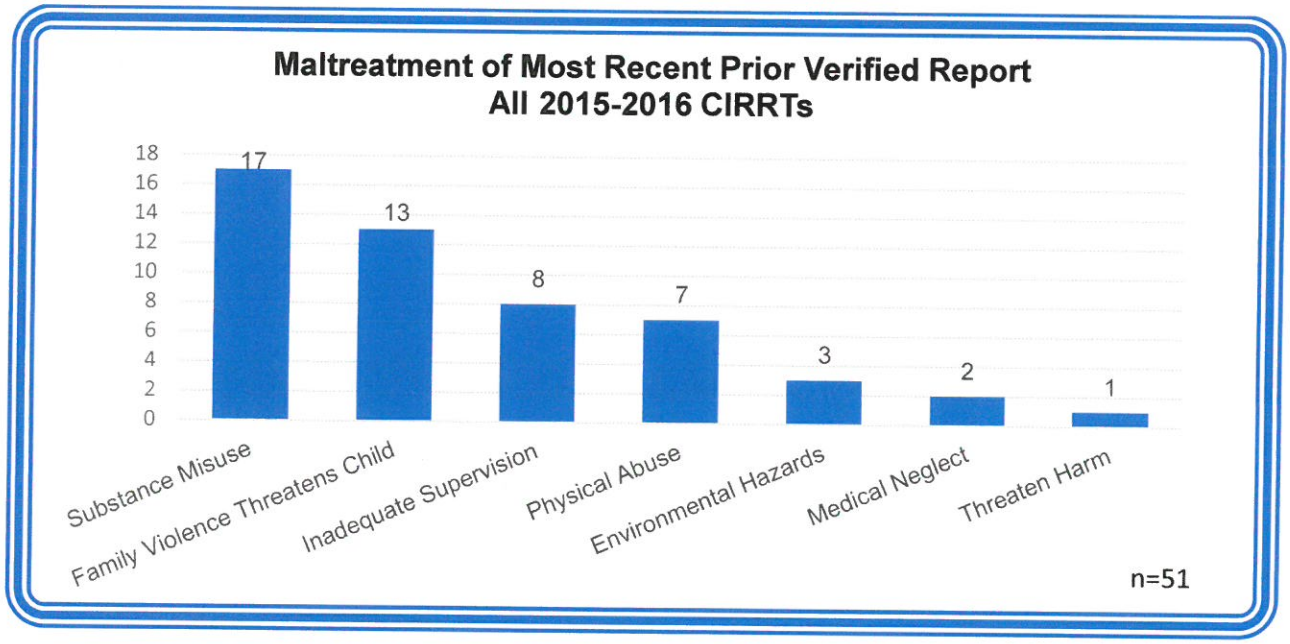


LEGEND				
Circuit	Region	Counties	Lead Agency
1	Northwest	Escambia, Okaloosa, Santa Rosa, Walton	Families First Network
2		Franklin, Gadsden, Jefferson, Leon, Liberty, Wakulla	Big Bend CBC, Inc.
14		Bay, Calhoun, Gulf, Holmes, Jackson, Washington	Big Bend CBC, Inc.
3	Northeast	Columbia, Dixie, Hamilton, 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.

II. Purpose

CIRRT reviews 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. From January 1, 2015 through December 31, 2016, CIRRT teams reviewed 57 child fatalities. Of those deployments, 51 met the CIRRT requirements of 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 51 cases meeting the requirements for deployment, the most common maltreatment noted in the verified prior report was substance misuse, followed by family violence threatens child. Additional maltreatment categories are outlined in the chart below.



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.

For all CIRRTs completed since January 2015, substance misuse and domestic violence were the primary maltreatments in 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.

During the fourth quarter (October - December) of 2016, there were eight CIRRT deployments, with each having a verified prior within the previous 12 months. There were two reports each with a prior verified maltreatment of family violence threatens harm and substance misuse. There was one deployment each with a prior verified maltreatment of physical injury, environmental hazards, medical neglect and threatened harm. These eight reports are a subset of the 57 child fatalities mentioned above.

III. CIRRT Process

Prior to conducting CIRRT reviews, in November 2014, the Department began actively recruiting staff from partnering agencies. Since that time, training has been offered every three months at various locations throughout the state. The most recent training was completed in June 2016 in Tampa. To date, a total of 365 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 report writers and team leads. The most recent training for report writers and team leads was held in Tampa in October 2016. 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 (section 39.2015(3), Florida Statutes).

Total numbers of individuals trained include the following areas of expertise:

Expertise	Trained
Adult Protective Investigations (DCF)	4
Child Protective Investigations (DCF) (includes Office of Child Welfare, Team Leads and Report Writers)	101
Child Protective Investigations (Sheriff's Office)	23
Florida Abuse Hotline	7
Community-Based Care Lead Agencies (CBC)	68
Case Management Organizations (CMO)	8
Diversion	4
Domestic Violence	20
Guardian ad Litem (GAL)	2

Expertise	Trained
Human Trafficking	2
Substance Abuse/Mental Health	49
Children's Legal Services	24
Law Enforcement Sworn Officers	9
Department of Health	3
Healthy Start	2
Healthy Families	2
Child Protection Team	30
Child Protection Team Medical Directors	5
Advisory Committee Members	2

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 for the five years preceding the child's death, this limited review is the only report that is written.

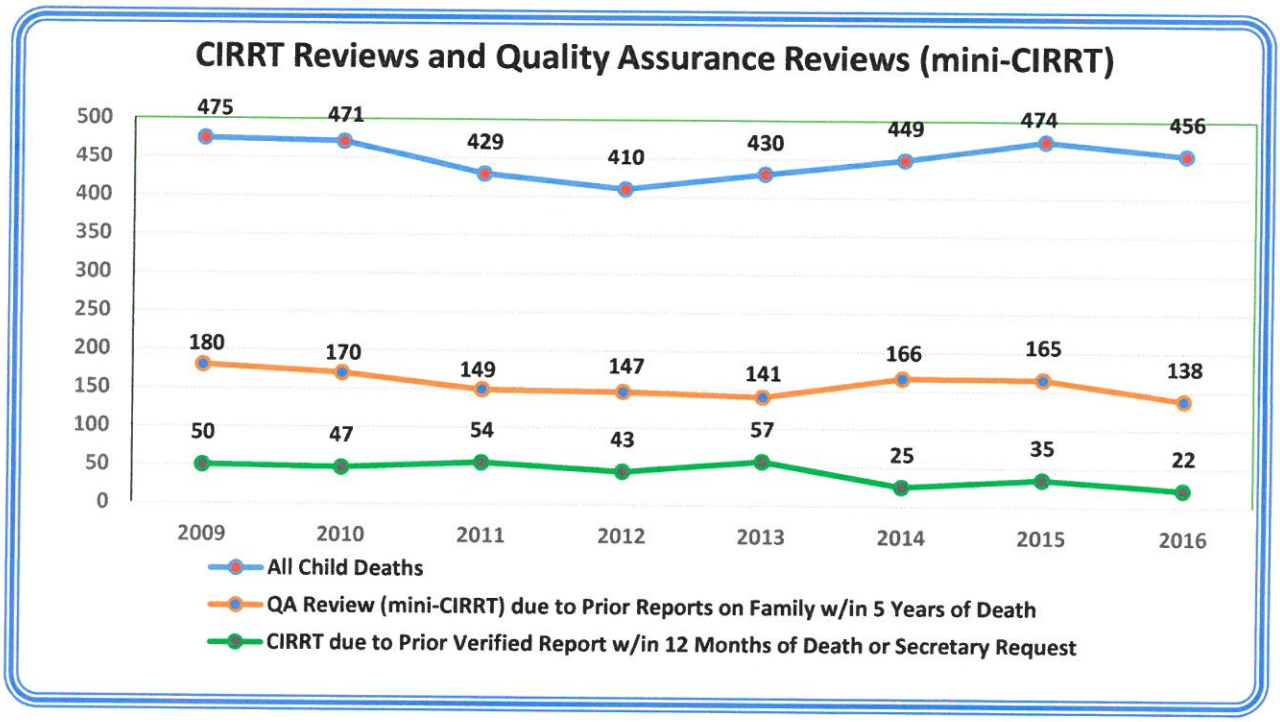
For cases in which there was a verified prior report involving the deceased child or a sibling within 12 months of the death, a review is conducted utilizing the CIRRT process. While only a small percentage of cases meet the criteria for this extensive review, an in-depth review that mirrors the CIRRT 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, they 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.

In calendar year 2016, 22 cases either met the criteria for a CIRRT deployment due to having a verified report within 12 months of the reported death or the Secretary requesting a team be deployed. One of the CIRRT deployments involved two victims. Although this represents less than 5% of the overall fatalities called to the Department's Florida Abuse Hotline (hotline), it's important to note that there were 138 additional

cases that met the criteria for a mini-CIRRT review. In total, in-depth quality assurance reviews were conducted on 160 cases, more than 35% of all cases received.

Of the 160 cases that received an in-depth review in 2016, the deceased child had no prior history in 42.5% (68) of the cases reviewed. There is, however, a difference in percentages when comparing CIRRT and mini-CIRRT cases. For CIRRT cases, there was no prior history involving the deceased child in six (27%) of the cases reviewed; whereas in mini-CIRRT cases, there was no prior history involving the deceased child in 62 (45%) of the cases reviewed.

Based on the historical data, it is likely that in-depth quality assurance reviews will continue to be conducted on more than 40% of the cases received in a given year.



Between January 1, 2015 and December 31, 2016, a total of 299 cases statewide met the criteria for completion of a mini-CIRRT review. Between January 1, 2015 and December 31, 2016, a total of 303 cases met the criteria for completion of a mini-CIRRT review due to there being prior involvement with the family within the previous five years. Of those cases, however, four did not require a review to be conducted as the fatality incident occurred in a facility (e.g., day care, juvenile detention center, etc.) in which a review of previous involvement with the family would have no bearing on the fatality as it occurred outside of the family's control. During the fourth quarter of 2016, 33 cases statewide met the criteria for completion of a mini-CIRRT review. Department regional staff members have responsibility for completion of mini-CIRRTs for the sheriff's office cases and are working on completing those reviews.

Special Reviews (Mini-CIRRTs)				
Region	**Review Required**	**Reports Completed**	**Reports Pending**	**Percentage Complete**
Northwest	39	34	5	87.18%
Northeast	60	53	7	88.33%
Central	76	55	21	72.37%
Central Sheriffs	6	3	3	50.00%
Suncoast	26	20	6	76.92%
Suncoast Sheriffs	44	37	7	84.09%
Southeast	22	16	6	72.73%
Southeast Sheriffs	15	13	2	86.67%
Southern	11	11	0	100.00%
DCF Totals	**234**	**189**	**45**	80.77%
Sheriffs' Total	**65**	**53**	**12**	81.54%
Statewide	**299**	**242**	**57**	80.94%

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 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.

CIRRT Advisory Committee

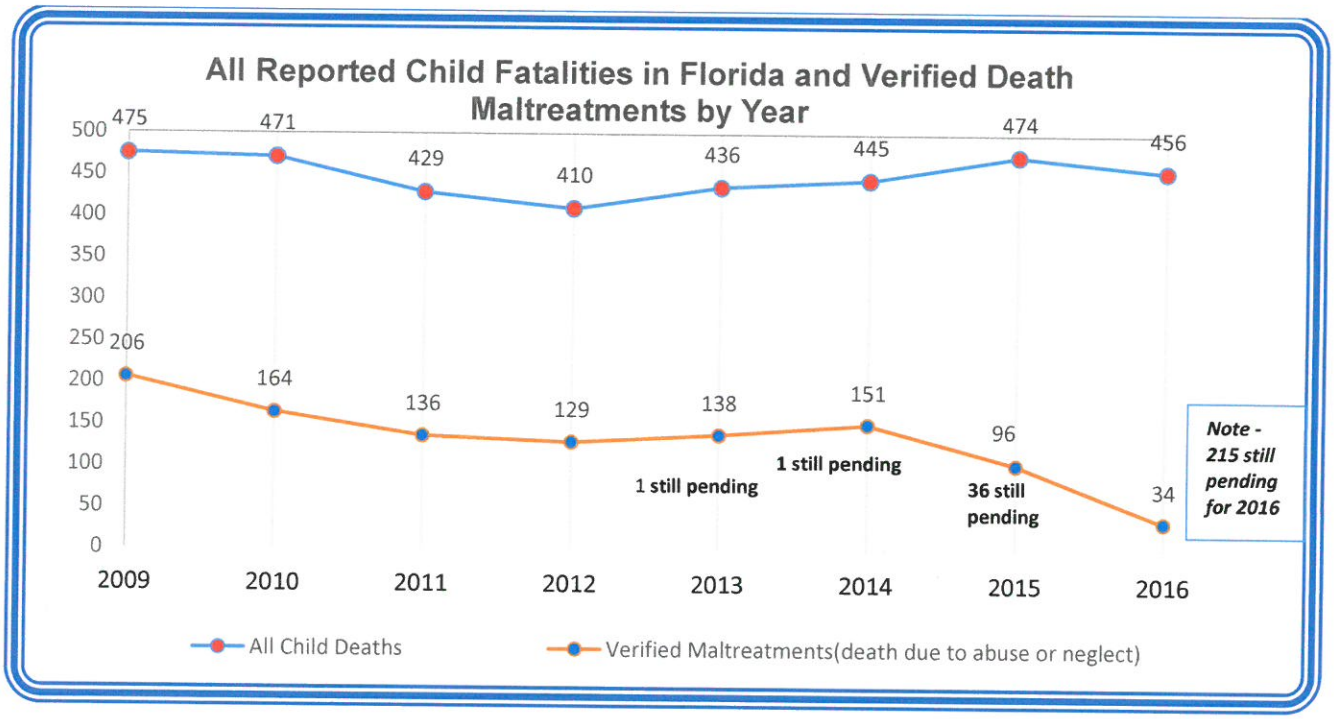
The CIRRT advisory committee is statutorily required to meet on a quarterly basis. The committee has met a total of four times, most recently on November 16, 2016. Advisory committee members may participate via conference call but are encouraged to attend in person. The meeting notices are published and 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 the Department's Regional Managing Directors are convened in each jurisdiction where a CIRRT review has been conducted within 30 days of receiving the CIRRT report to review the findings and develop any immediate corrective action steps that are deemed necessary.

Review of Child Fatality Data

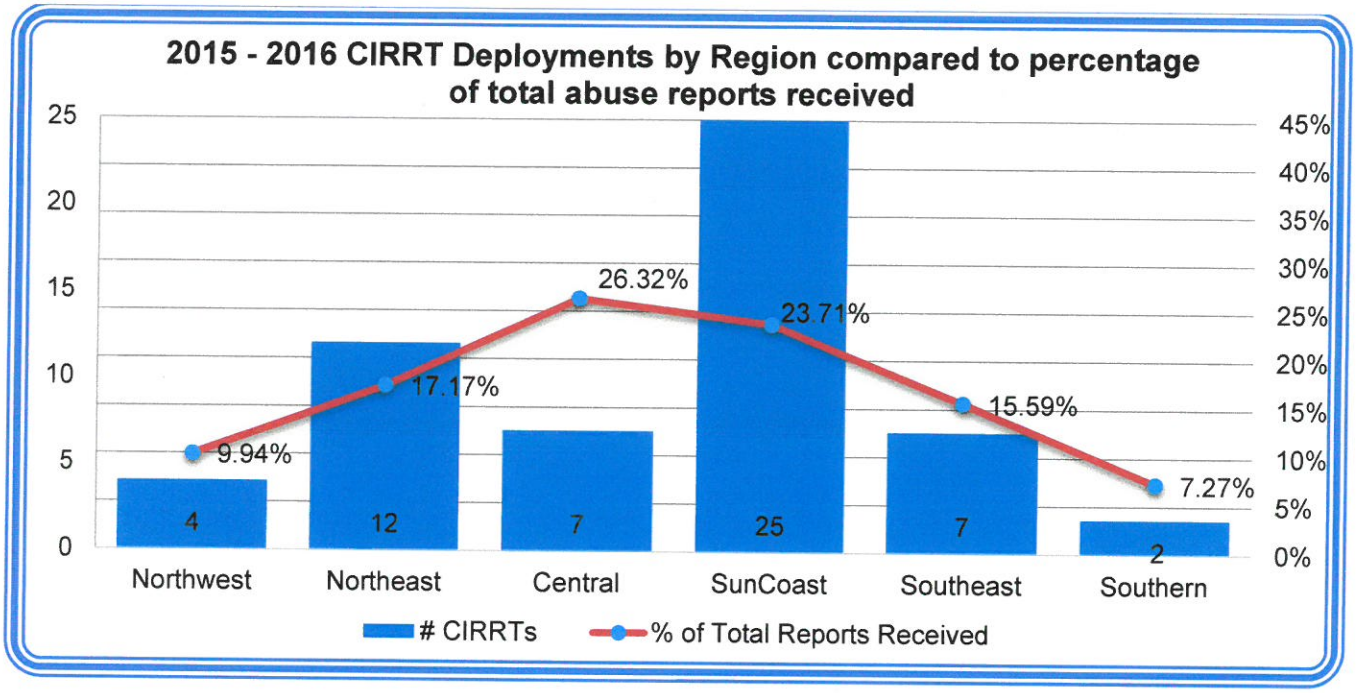
Overall, child deaths in Florida typically involve a child age 3 or younger and may involve a variety of causal factors, including but not limited to sleep related deaths, drownings, natural causes, inflicted trauma, Sudden Infant Death Syndrome (SIDS)/Sudden Unexplained Infant Death (SUID), and accidental trauma.

Of the 474 child fatalities that occurred in 2015 and were reported to the hotline, 36 investigations remain open. For the 456 child fatalities that occurred in 2016 and that were reported to the hotline, 215 remain open. Thirty-four of the 241 investigations that have been closed 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. Two child death investigations, one each from 2013 and 2014, remain open at the request of law enforcement officials due to ongoing criminal investigations.

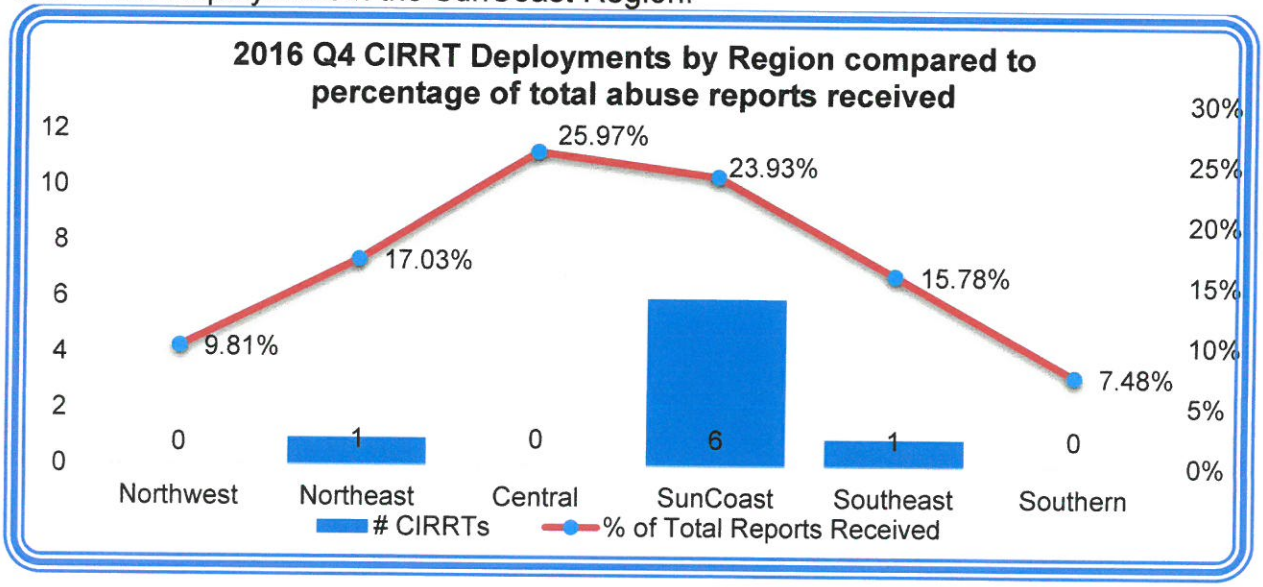


Since January 2015, there have been a total of 57 CIRRT deployments, with at least one deployment occurring in each of the six regions. The SunCoast Region accounts

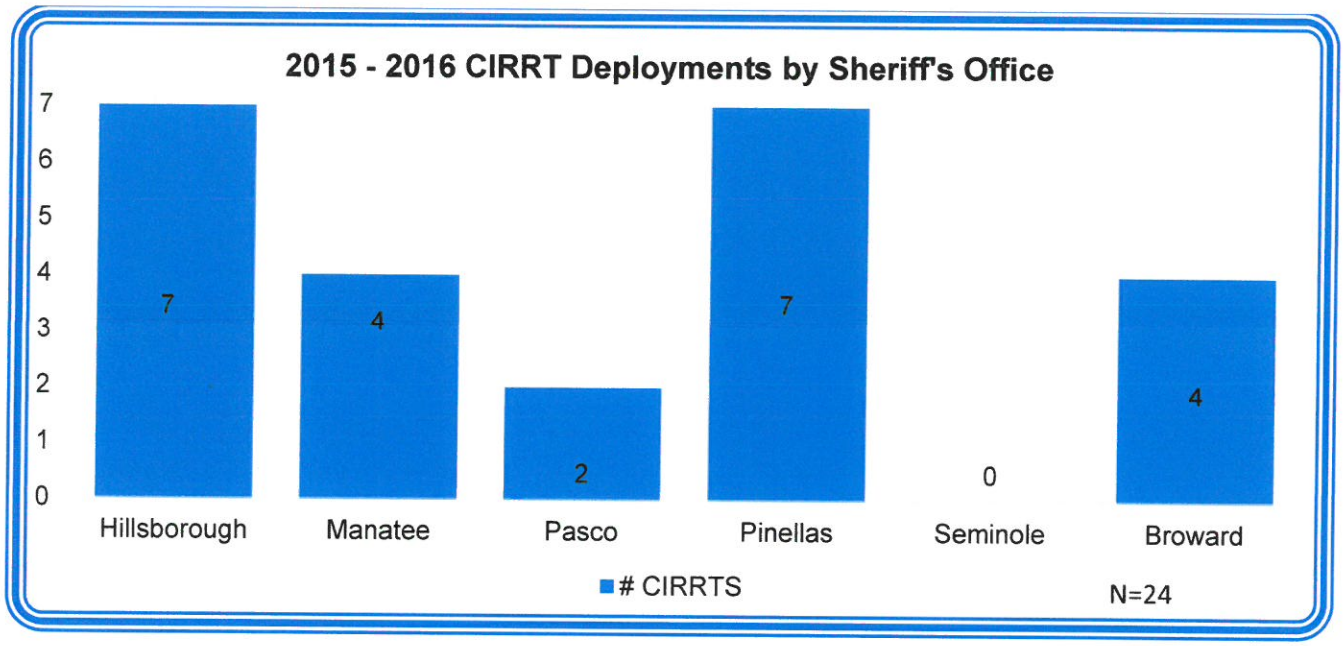
for 44 percent of the deployments while receiving 24 percent of the statewide abuse investigations during the past two years. Conversely, the Central Region, which at 26 percent accounts for the largest percentage of abuse reports received during the time period, was involved in 12 percent of the CIRRT deployments.



There were eight CIRRT deployments during the fourth quarter of 2016 – six in the SunCoast Region, and one each in the Northeast and Southeast Regions. Five of the six deployments to the SunCoast Region occurred in counties where the sheriff's office conducts child protective investigations (two each in Manatee and Hillsborough and one in Pasco County). The Department was responsible for the completion of child protective investigations in the deployments to the Northeast and Southeast regions, and in one deployment in the SunCoast Region.

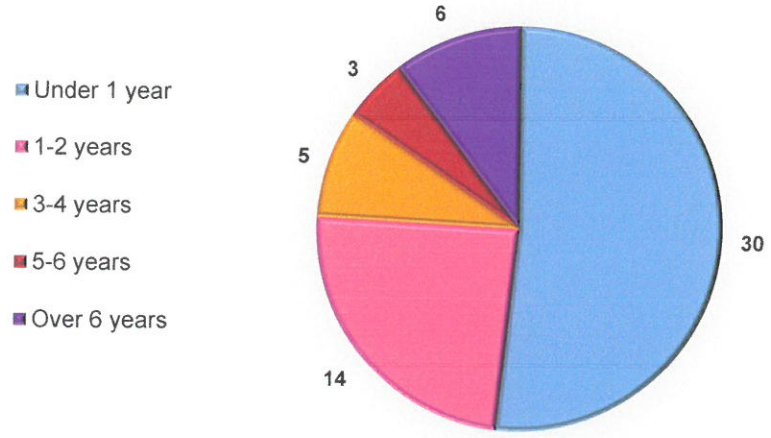


During the past two calendar years (January 1, 2015 through December 31, 2016), 24 of 57 CIRRT deployments involved five of the six counties where child protective investigations are conducted by sheriffs' offices. To date, there have not been any CIRRT deployments to Seminole County. During the fourth quarter of 2016, there were two CIRRT teams deployed to Manatee and Hillsborough counties and one team deployed to Pasco County, all in the SunCoast Region.



During the 2015 - 2016 calendar years, 57 CIRRT reviews were completed, involving a total of 58 victims. Ninety percent of the deployments involved a victim under the age of 6. In 74 percent of the reviews, the victim was under the age of 3. This is consistent with child deaths statewide in which younger children are more vulnerable to being victims of abuse and neglect.

Age of Victim for all Deployments
Reviews completed from January 1, 2015 - December 31, 2016

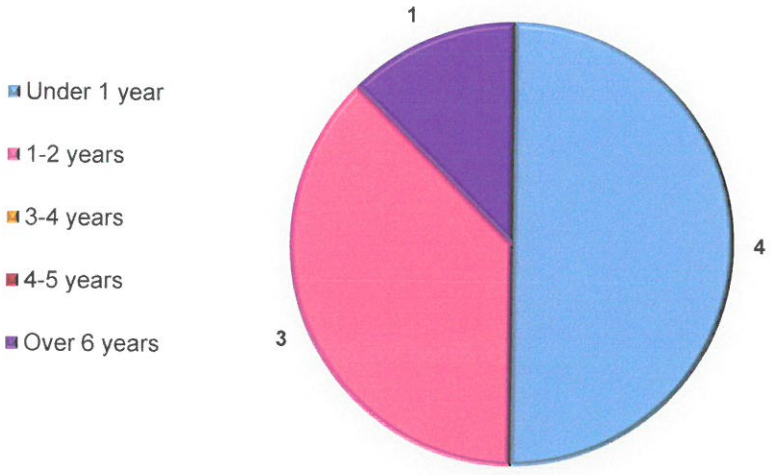


90% of all CIRRT deployments in 2015-2016 involved a child younger than 6-years-old.
52% involved children under the age of 1.
*It is noted that one deployment involved two victims.

n=58

There were eight CIRRT deployments in the fourth quarter of 2016. Five of the eight victims were under age 1.

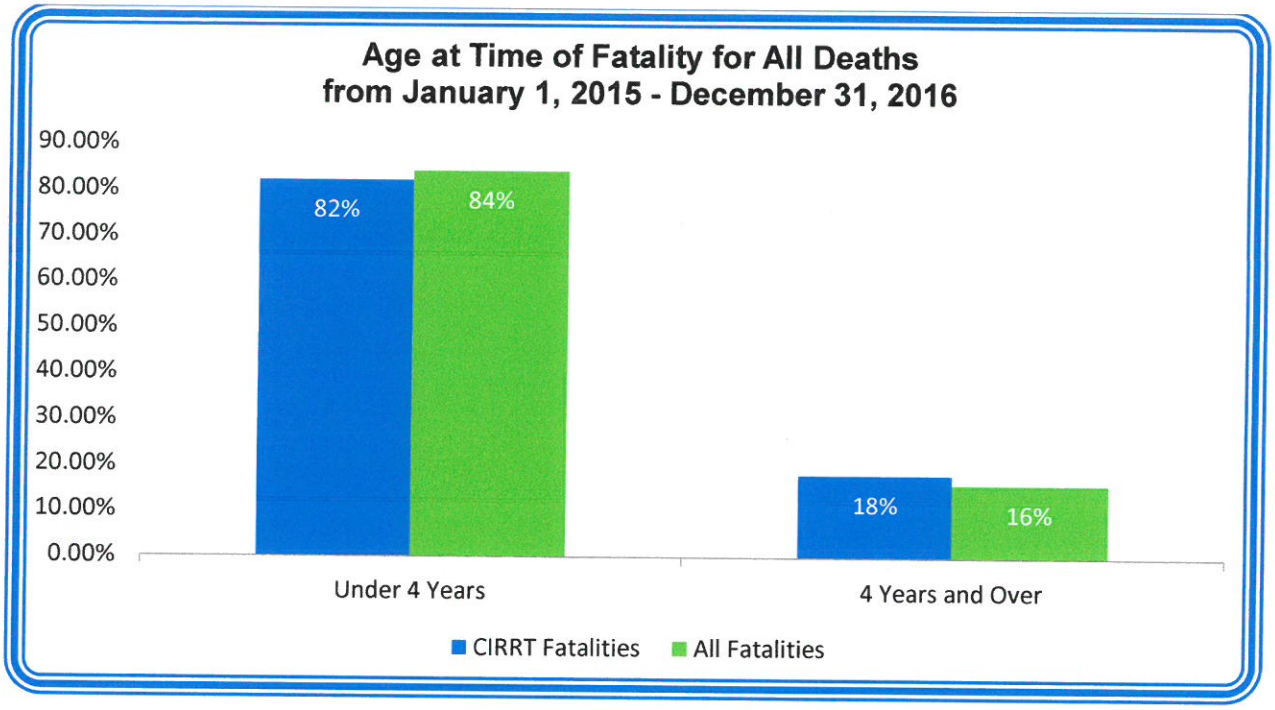
Age of Victim for all CIRRT Deployments completed in 2016 Q4



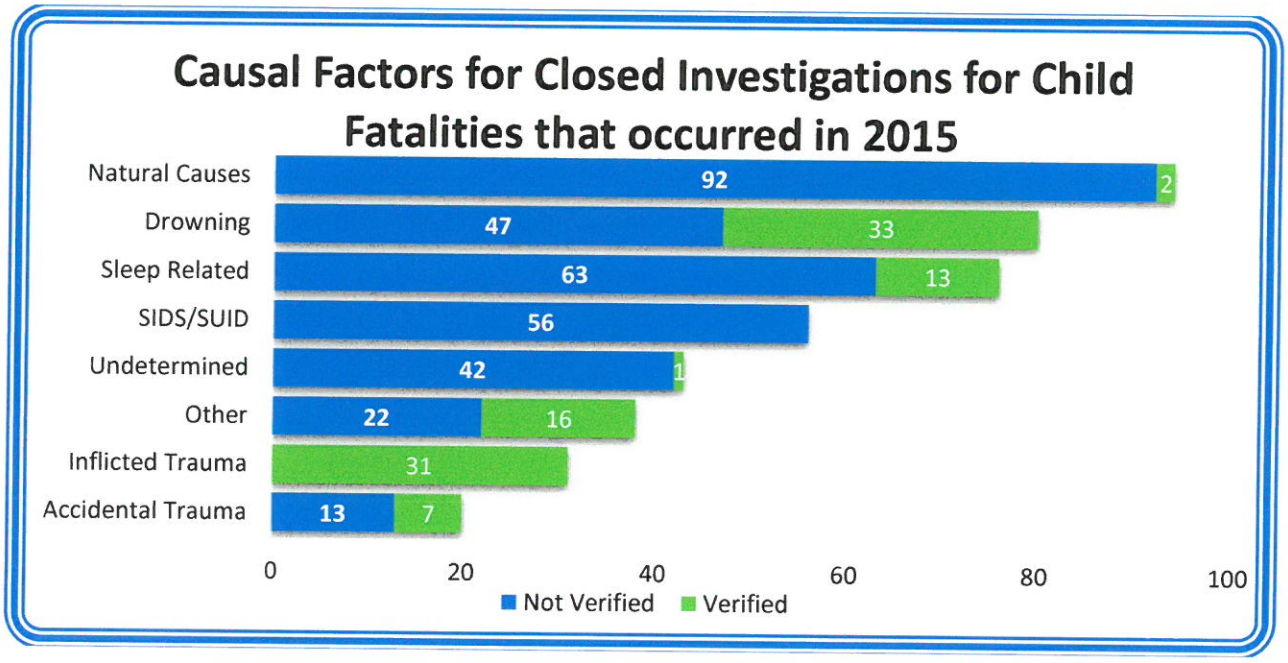
88% of the CIRRT deployments in Q4 2016 involved a child age 2 or younger, and 50% involved a child under the age of 1.

n=8

Of those child fatalities reported to the hotline occurring from January 2015 through December 2016, 84 percent involved a child under the age of 4. Similarly, 82 percent of all CIRRT deployments involved children in this age range.



Of the 438 closed child fatalities that occurred in 2015, the four primary causal factors were Natural Causes, Drowning, Sleep Related, and SIDS/SUID. There are a total of 36 child fatality investigations received during this time period that remain open; when finalized, they will impact the overall numbers and causal factor sequencing.

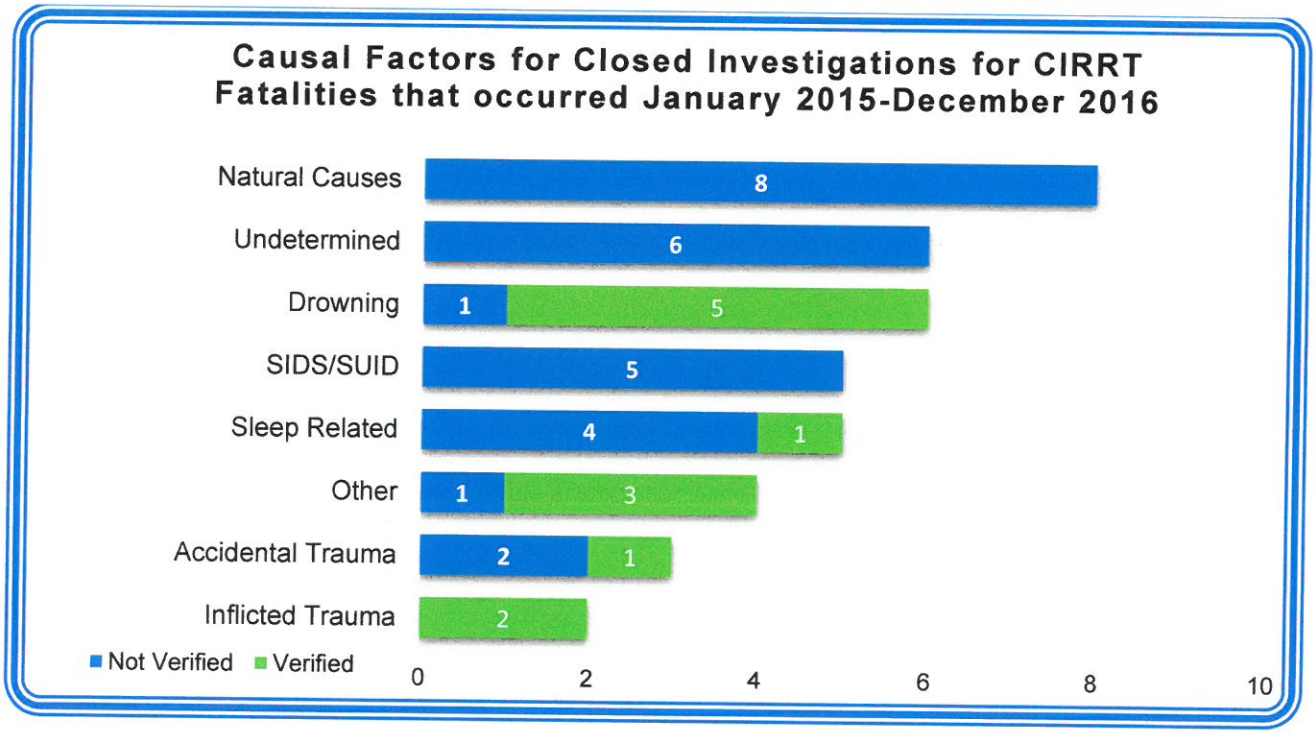


The death maltreatment cannot be used as a stand-alone maltreatment; therefore, the underlying maltreatment that may have caused or contributed to the child death is noted. In order for an investigation to be closed with verified findings for the death

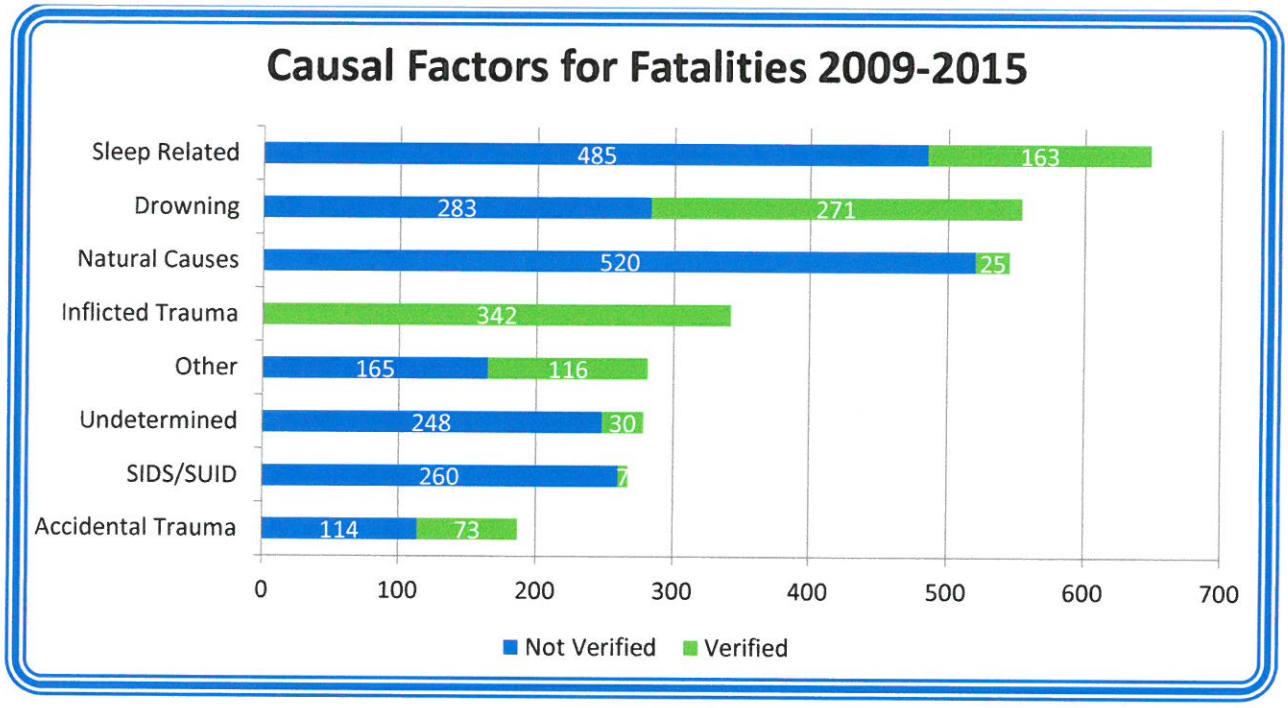
maltreatment, there must be a preponderance of the credible evidence that the child died as a result of a direct, willful act of the caregiver(s) or the caregiver(s) failed to provide or make reasonable efforts to provide essential care or supervision for the child. Credible evidence used to determine verified findings for the death maltreatment includes the medical examiner report, 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 30, 2016, there were a total of 57 child fatalities that resulted in a CIRRT deployment. Of the 39 investigations that were closed, 12 (31 percent) investigations had verified findings for the death maltreatment. An additional 11 investigations were closed with verified findings for a maltreatment other than the death maltreatment. A review of the 57 deployments indicates that 25 cases, or 44 percent, of the deployments 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.



Between 2009 and 2015, the four leading causal factors of child fatalities reported to the hotline were Sleep Related (648 deaths), Drowning (554 deaths), Natural Causes (545 deaths), and Inflicted Trauma (342 deaths).



Causal factors of child fatalities include the factors or situation 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 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 for "Death" 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.

Closing Summary

Throughout deployments and with input from the statewide CIRRT advisory 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.

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, 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.