

**Critical Incident Rapid Response Team Advisory Committee
First 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
Fourth Quarter 2018**

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

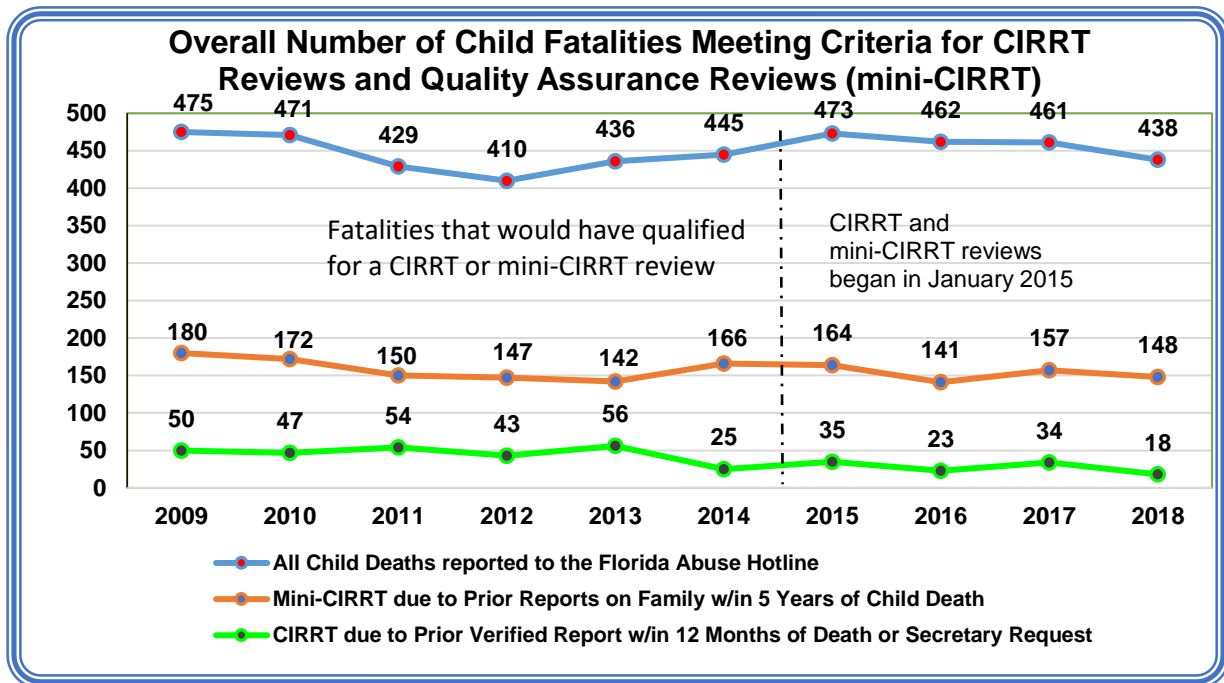
CIRRT reviews provide an immediate, multiagency investigation of child deaths that meet the statutory criteria for review or other serious incidents at the Secretary's discretion. Investigations are conducted in an effort to identify root causes, rapidly determine the need to change policies and practices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

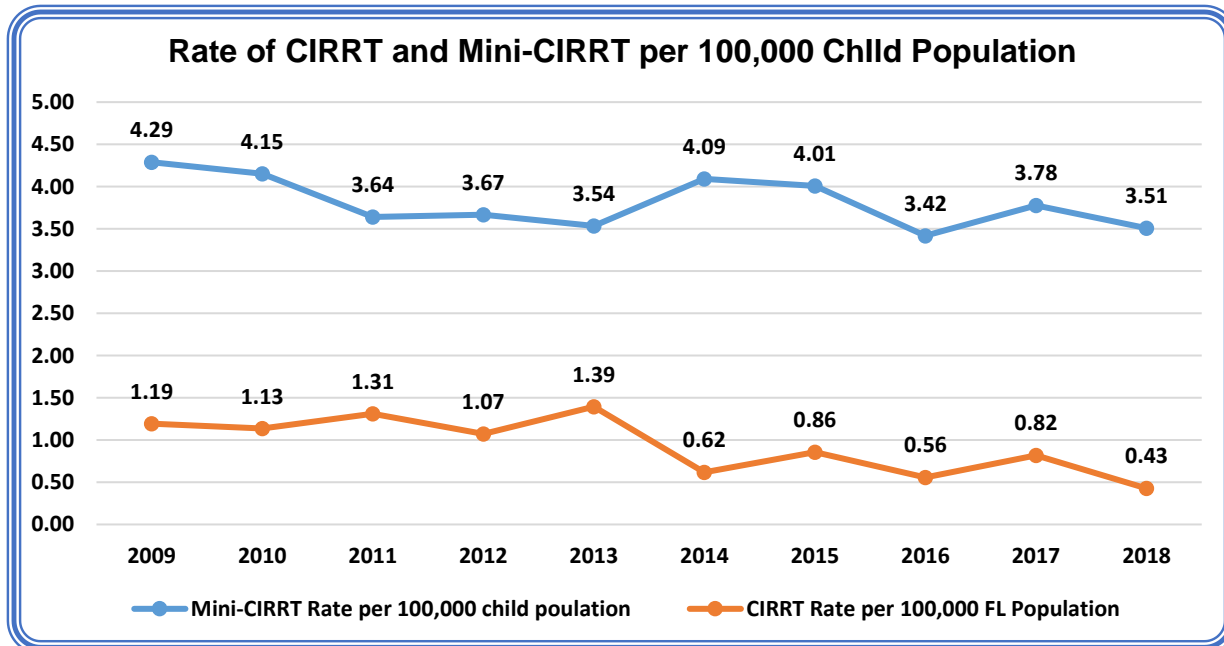
From January 1, 2015 through March 31, 2019 a total of 113 CIRRT teams were deployed involving 114 child deaths. Of those deployments, 107 met the CIRRT requirement of having a verified report within the previous 12 months, while the other six reviews were completed at the direction of the Secretary. 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 March 31, 2019, there were 34 child fatalities received that resulted in a CIRRT deployment (four) or mini-CIRRT review (30); the deceased child had no prior history in 13 of the cases reviewed. For the four CIRRT cases, there was no prior history involving the deceased child in two (50 percent) of the cases. In the 30 cases that met the criteria for a mini-CIRRT review, there was no prior history involving the deceased child in 11 (37 percent) of the cases.



The rate of occurrence for fatalities meeting the requirements for CIRRT deployments and mini-CIRRT reviews reflect downward trends.

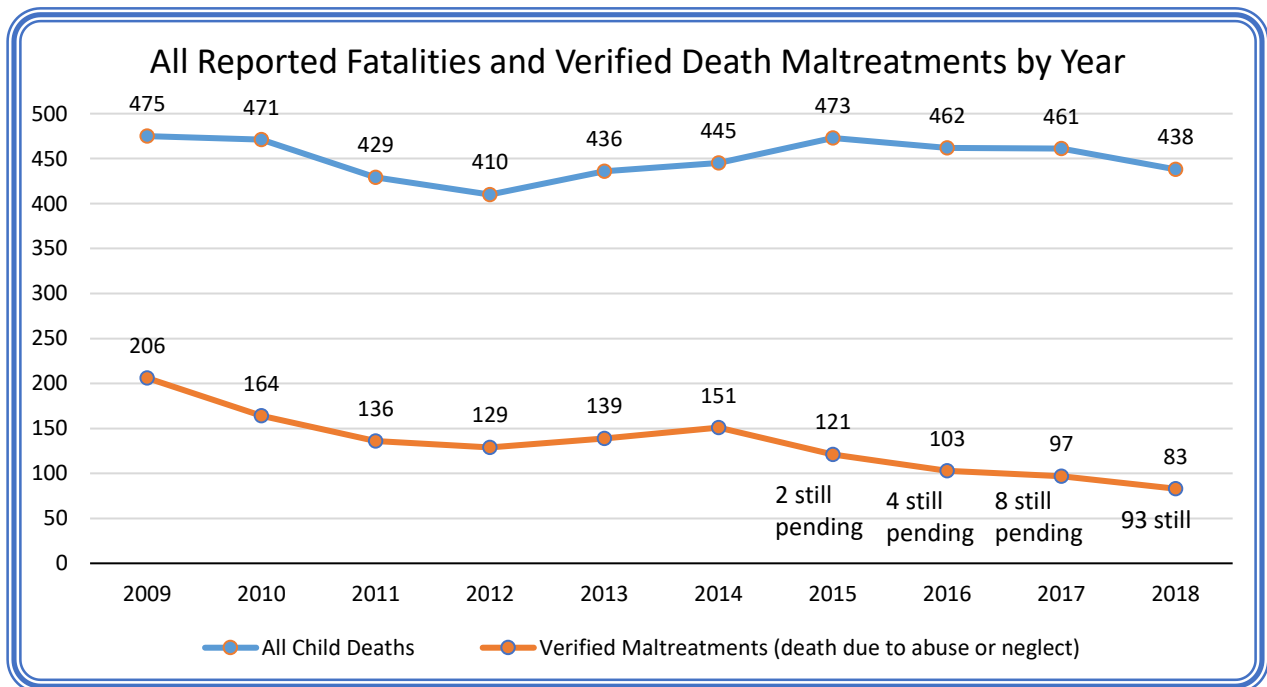


Standardized data is collected across all review types and entered into Qualtrics for further analysis and review. Reports on reviews conducted as a result of a child fatality (regardless of the type of review completed) are redacted according to Florida Statutes and posted for public review on the department's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

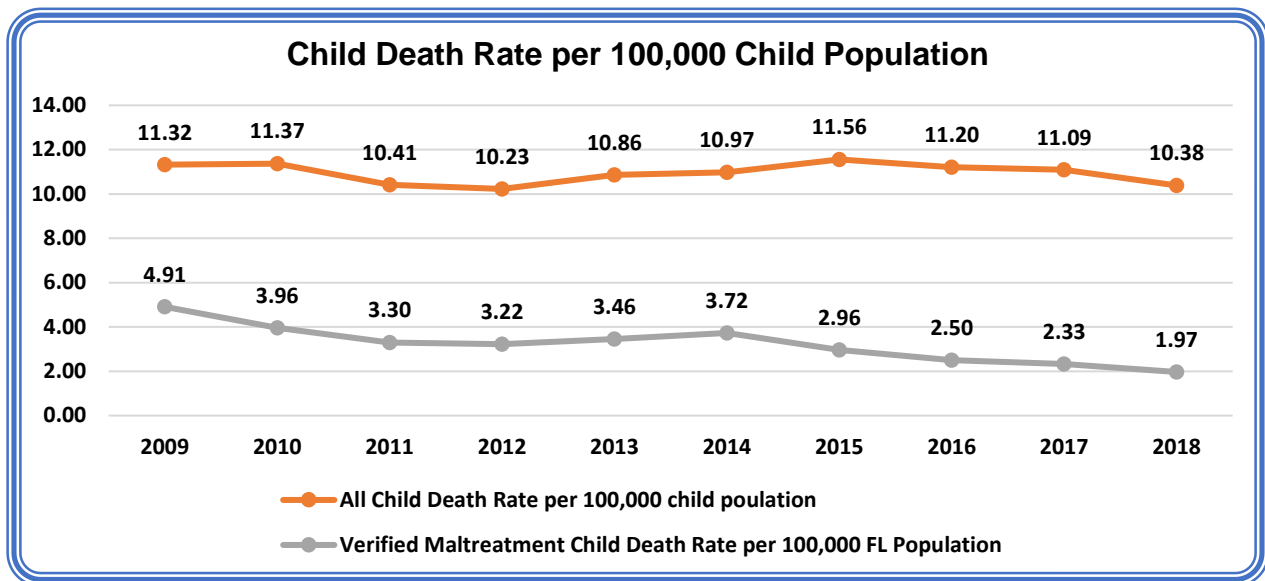
Child deaths in Florida typically involve a child age three or younger and may involve a variety of causal factors including, but not limited to: sleep-related deaths, drownings, natural causes, inflicted trauma, Sudden Infant Death Syndrome (SIDS)/Sudden Unexplained Infant Death (SUID), and accidental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

Of the 1,396 child fatalities that occurred during the 2015-2017 calendar years and were reported to the Hotline, 16 remain open; 13 at the request of law enforcement/state attorney due to on-going criminal proceedings and three were pending closure in the field. During this three-year period, the death maltreatment was verified in 23 percent of the closed cases. For the 438 child fatalities that occurred in 2018 and were reported to the Hotline, 93 currently remain open. Of the 355 closed 2018 child fatality investigations, 83 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 flat over the past ten years, the number of verified child death maltreatments per 100,000 child population reflects a downward trend.



III. Review of CIRRT Data

a. Summary of First Quarter CIRRT Reports

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

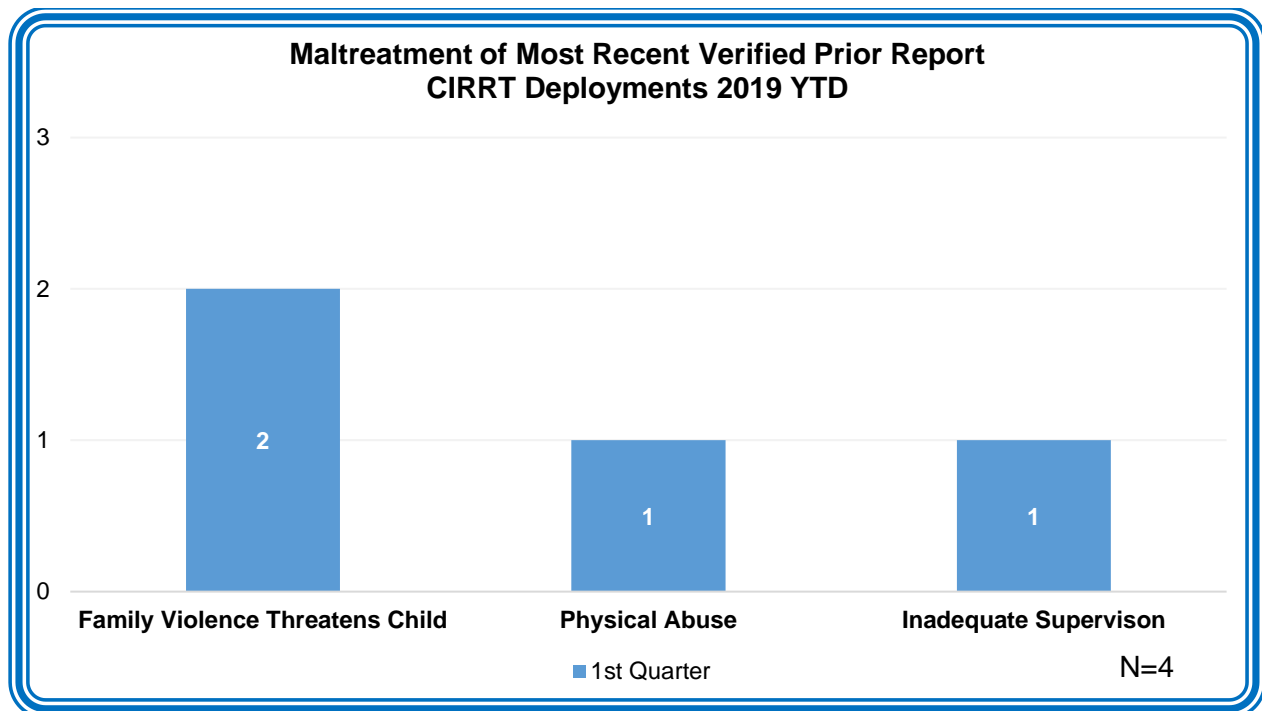
At the time of the fatality, two of the four families were receiving in-home non-judicial child welfare services. In one of the deployments, in-home non-judicial services were open on the child and sibling due to inadequate supervision and the five-month-old infant was found unresponsive in the bed he was sharing with his mother and siblings. The family also had an open abuse investigation, received approximately three weeks earlier. The remaining case was open to in-home non-judicial services for the siblings only, due to physical injury on a sibling and the and the three-month-old passed away eight days after receiving unexplained head injuries.

In one the two remaining cases, there was a verified prior report on a sibling for family violence threatens harm, prior to the birth of the fatality victim, who at the age of six months, was found unresponsive while sleeping in bed with her father. The remaining case involved a 10-month-old infant found unresponsive in his playpen. The infant was previously identified as victim in an investigation verified for family violence threatens

harm. At the time of the fatality, there was an open abuse investigation, received four days prior.

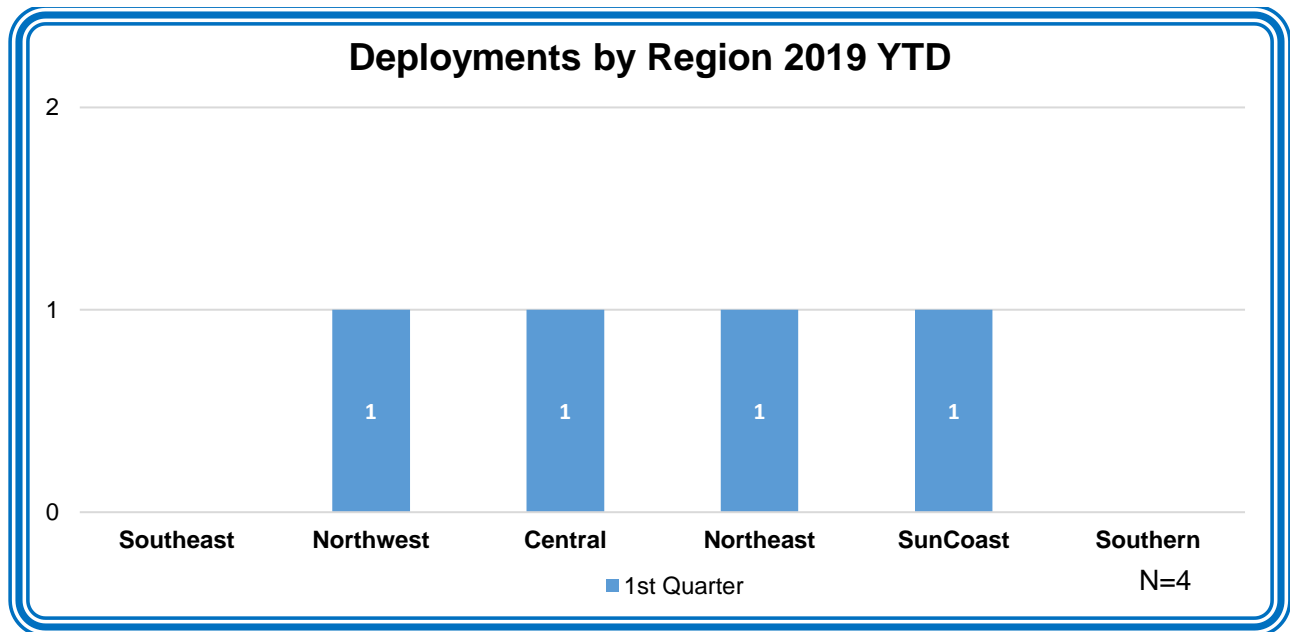
b. Past Maltreatment

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

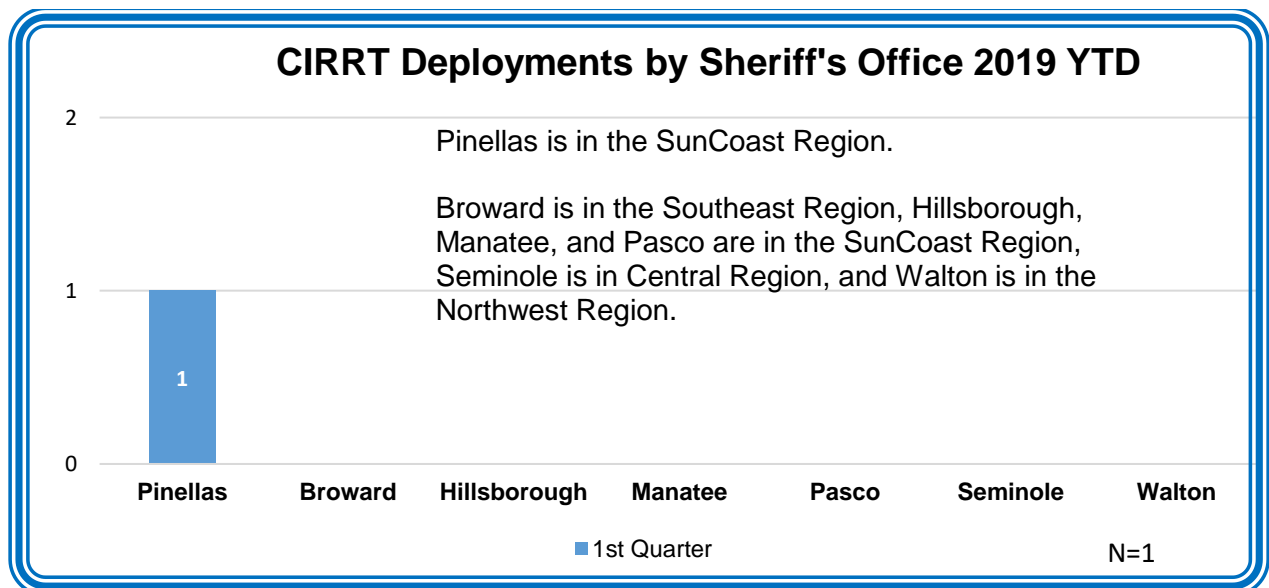


CIRRT Data by Region

From January 1 through March 31, 2019, there were four CIRRT deployments, each occurring in a different region. There was one deployment to the Northwest Region, Central Region, Northeast Region and SunCoast Region. The SunCoast Region deployment occurred in Pinellas 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.

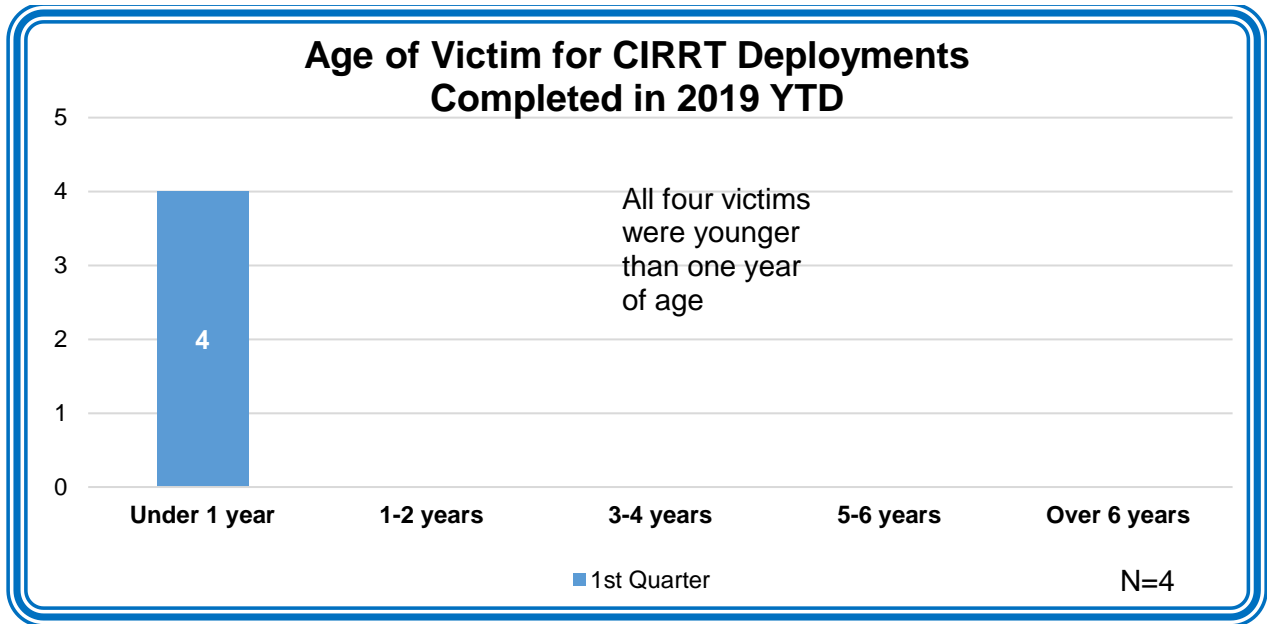


During the first quarter of the 2019 calendar year, there was one CIRRT deployment in, Pinellas County, where a sheriffs' office is responsible for protective investigations.

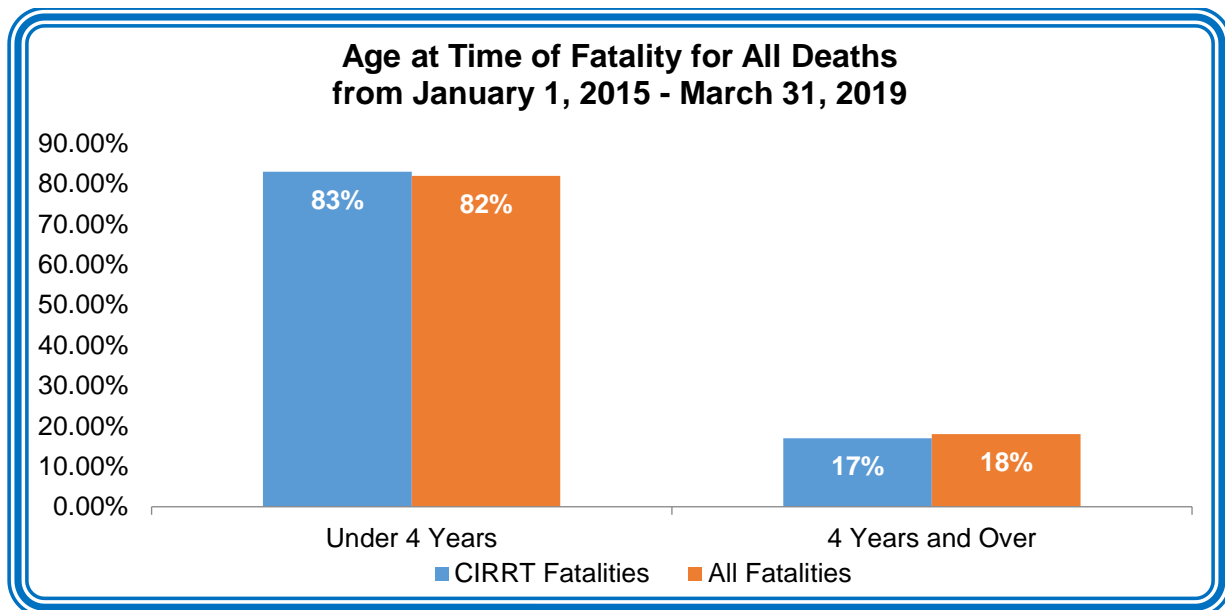


c. Age of Victim

There were four CIRRT deployments during the first quarter of the 2019 calendar year, with all four of the victims under the age of one year old.



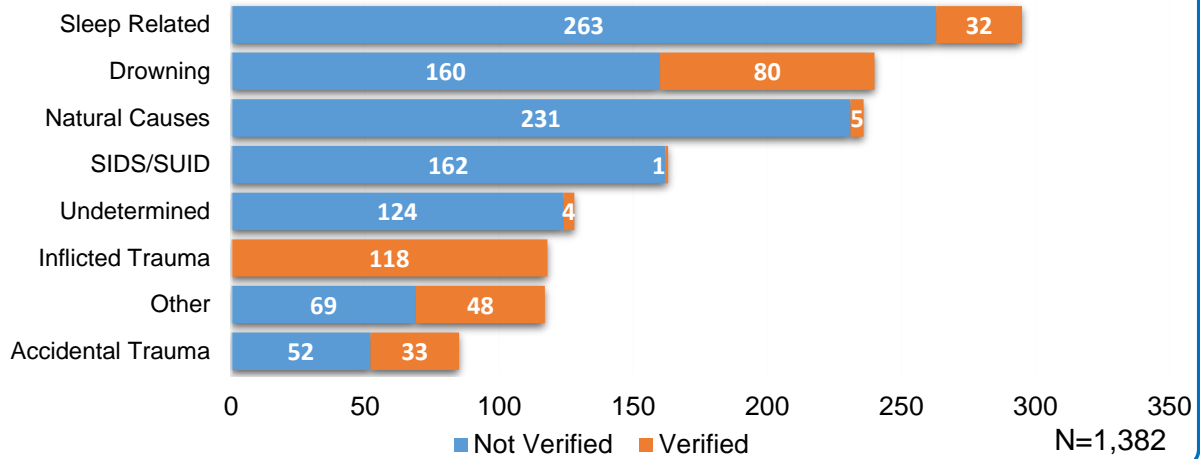
Of those child fatalities reported to the Hotline occurring from January 2015 through March 2019, 82 percent involved a child under the age of four. Similarly, 83 percent of all CIRRT deployments also involved children in this age group.



d. Causal Factors

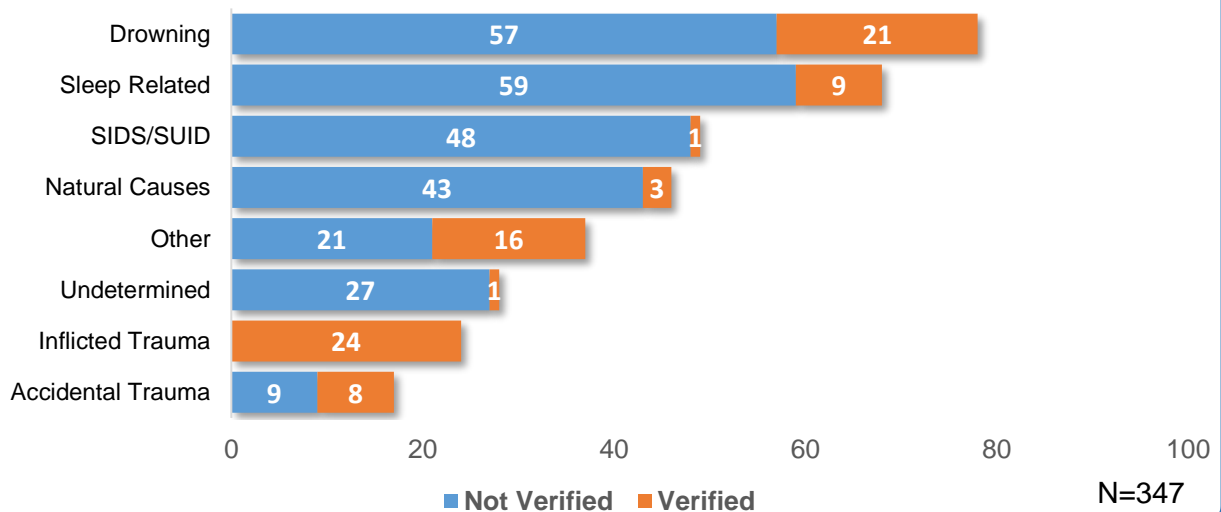
Of the 1,382 closed child fatalities that occurred from January 1, 2015 and December 31, 2017, the four primary causal factors were sleep-related, drowning, natural causes, and SIDS/SUID. There are 14 child fatality investigations received during that time period that remain open. When finalized, they will have a slight impact on the overall numbers; however, there will be no change regarding to the four primary causal factors.

Causal Factors for Closed Investigations for Child Fatalities that Occurred 2015-2017



Of the 347 closed child fatalities that occurred in 2018, the four primary causal factors were drowning, sleep-related, SIDS/SUID, and natural causes. There are still 91 child fatality investigations received during this time period that remain open which, when finalized, will impact the overall numbers and causal factor ranking.

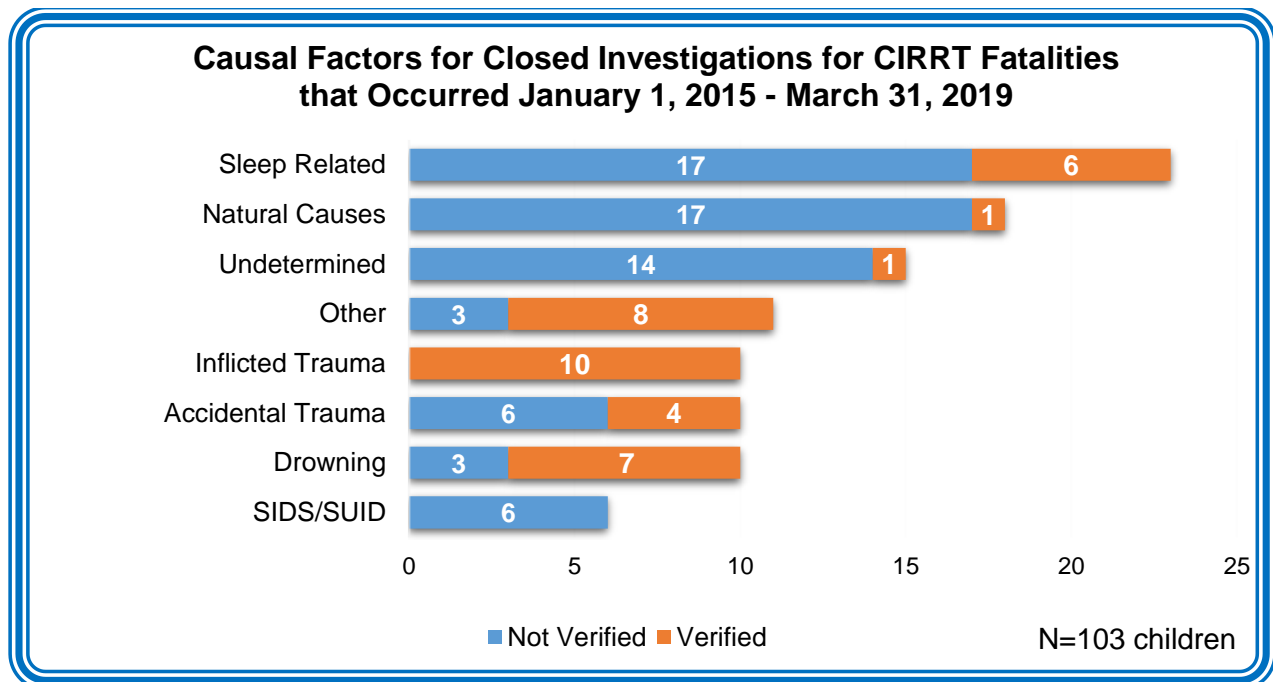
Causal Factors for Closed Investigations for Child Fatalities that Occurred in 2018



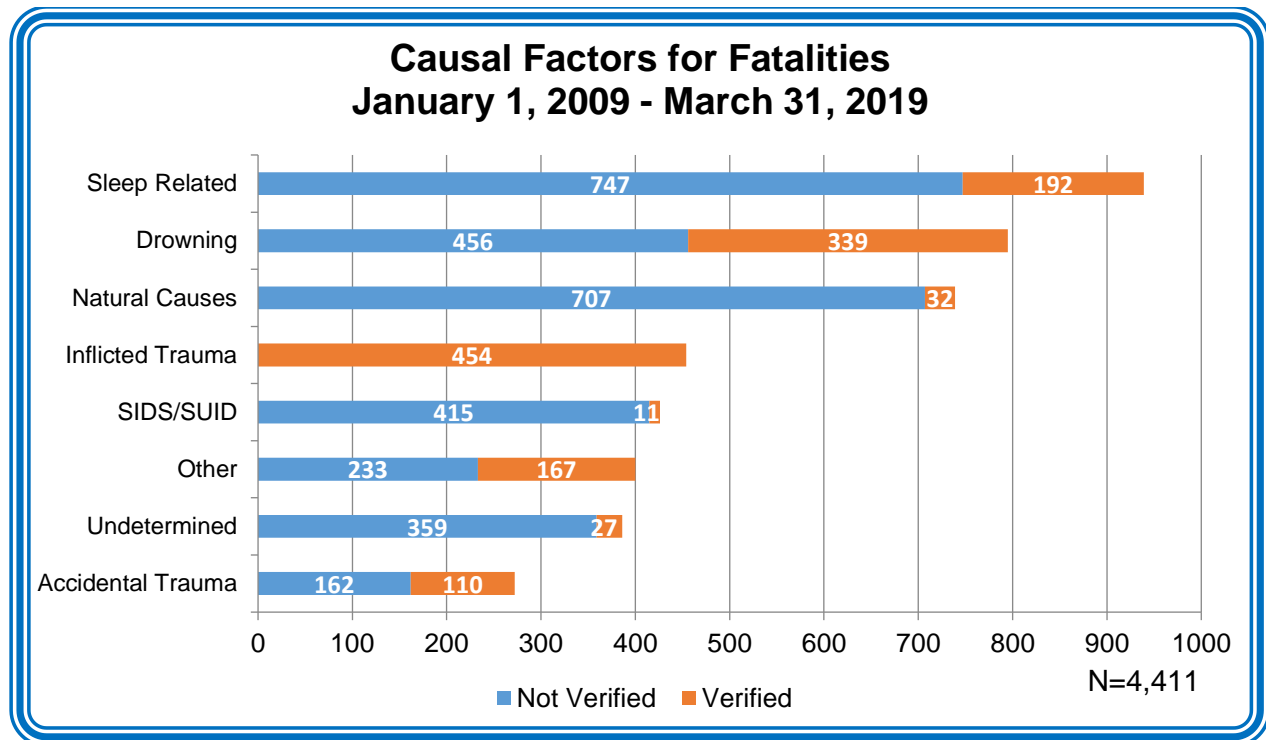
The death maltreatment cannot be used as a stand-alone maltreatment; therefore, the underlying maltreatment that may have caused or contributed to the child death is noted. For an investigation to be closed with verified findings for the death maltreatment, there must be a preponderance of credible evidence 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 March 31, 2019, there were a total of 113 CIRRT deployments involving 114 child fatalities. Of the 102 investigations (involving 103 children) that were closed, 37 investigations (36 percent) involving 38 victims had verified findings for the death maltreatment; nine of the investigations remain open. An additional 20 investigations (20 percent) were closed with verified findings for maltreatment other than the death maltreatment, with inadequate supervision being verified in 11 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 March 31, 2019, the four leading causal factors of child fatalities reported to the Hotline were sleep-related (939), drowning (795), natural causes (739), and inflicted trauma (454).



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, 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 March 28, 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 law related to child protection and child welfare services.

At the March 28, 2019 meeting, Secretary Poppell discussed his objectives with an emphasis on assessing tragic situations as an opportunity to drive change and make improvements. When a child fatality occurs during an open abuse investigation, and the case does not meet the statutory requirements for a CIRRT deployment, the Secretary will be notified and circumstances surrounding the fatality will be assessed to determine if a CIRRT or a special review is warranted.

The committee discussed the number of cases, both child fatalities and inflicted injury, that were not prosecuted criminally due to lack of evidence or inability to determine who was responsible in cases involving multiple caretakers. There was discussion regarding the amount of evidence needed for a criminal prosecution and ways that the child welfare system could enhance the way we work with law enforcement on joint cases.

There was discussion regarding cases that required a CIRRT deployment where there was no relationship between the family involved in the prior investigation and the child fatality. Examples included families that were involved in a prior verified report within the past 12 months; however, the fatality occurred in a child care setting, prior reports involving a half-sibling whom never lived in the household with the victim, reports closed incorrectly with verified findings, and cases where children were deemed unsafe and removed from the home, and a fatality occurs.

The Northwest Region (NWR) provided the committee an overview of its Assessment Response Team (ART) pilot project which is responsible for completing assessments and pre-commencement activities on 24-hour intakes Monday through Friday. The pilot project was initially started in September 2017 to assist counties impacted by Hurricane Irma. The NWR created the ART team in December 2017 using existing resources. The assessors, who are experienced CPIs, research child welfare history, criminal and injunction history, household members, contact collateral contacts, and identify sources critical to completing an accurate assessment of the family. As a result, the ART team can close over 25 percent of the intakes without being assigned to a CPI for initial investigation. Since the implementation of the ART team, the NWR has noted an improvement in the percentage of victims seen within 24 hours and staff retention, while caseload size and overtime hours have been reduced. Dr. Babcock, Deputy Secretary, gave approval for the ART project to expand to the Pinellas County Sheriff's Office.

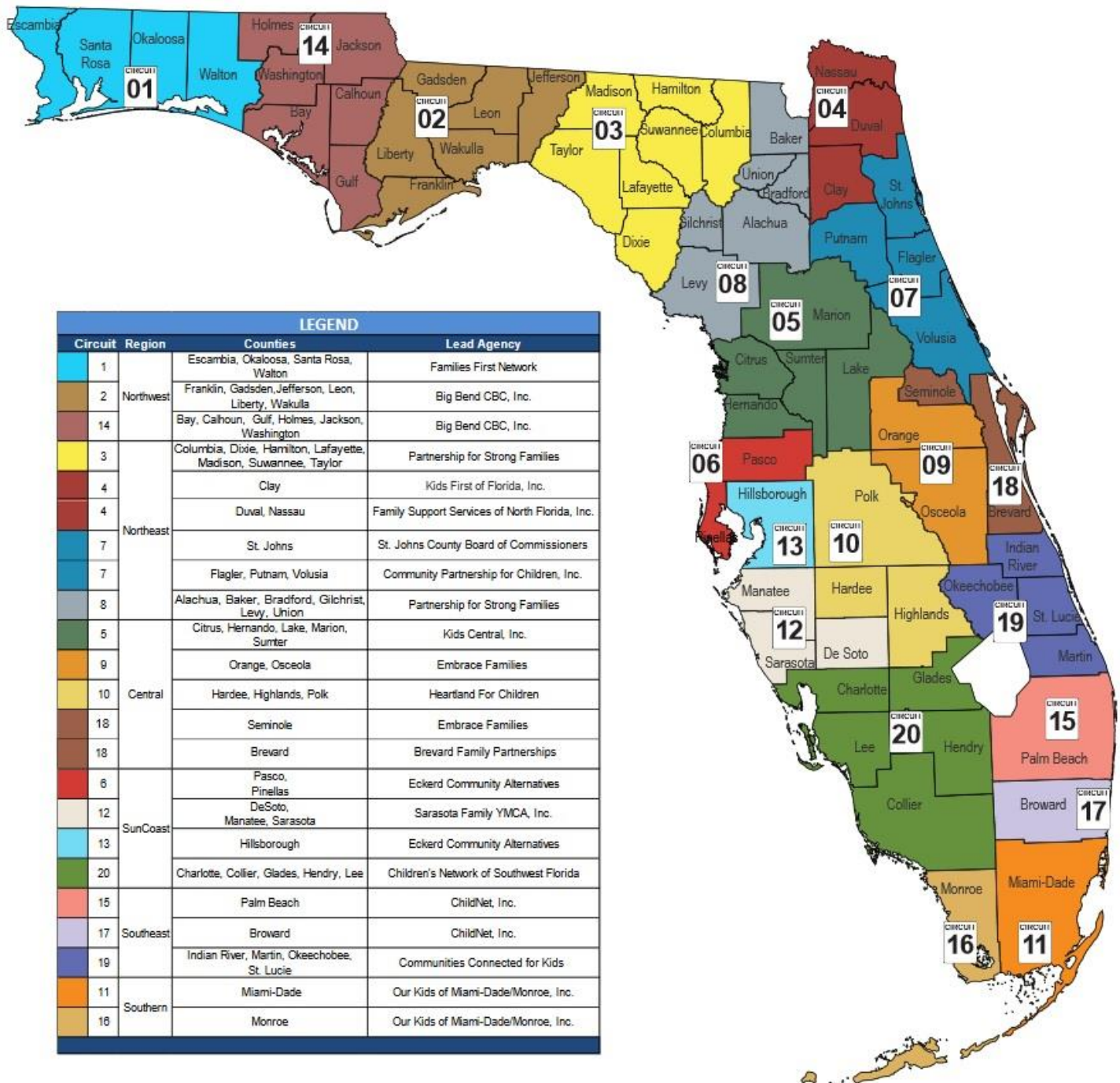
APPENDIX 1 – Section 39.2015, Florida Statutes

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



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 cancelled due to travel restrictions. The most recent training was held in Jacksonville in April 2019. To date, a total of 568 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).

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.