**Critical Incident Rapid Response Team Advisory Committee**
**First Quarter Report for Calendar Year 2018**


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**
**First Quarter 2018**

## I. Background

In 2014, the Florida Legislature passed section 39.2015, Florida Statutes (F.S.), 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 March 31, 2018, 99 CIRRT teams were deployed. Of those deployments, 93 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 children represent 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 36 percent of all reported child deaths.

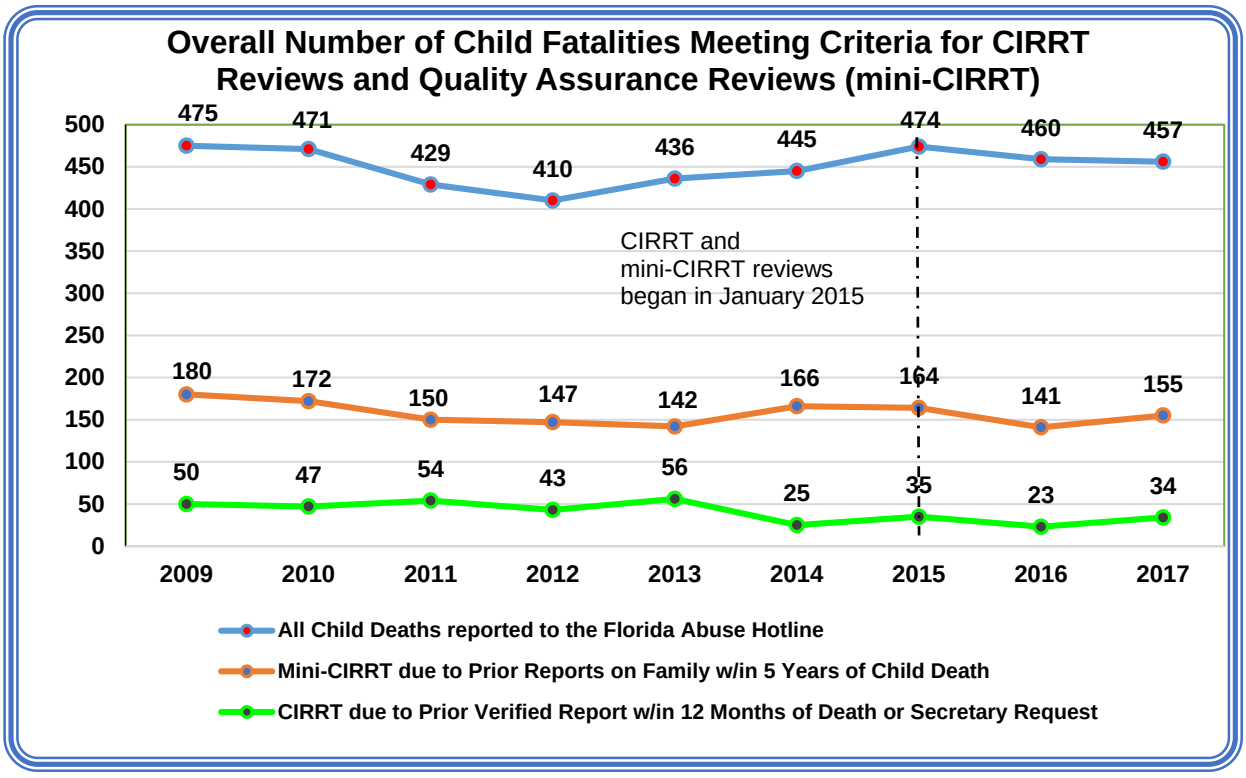
Of the 164 child fatalities received in 2016, where there was a CIRRT deployment or a mini-CIRRT review, the deceased child had no prior history in 72 (44 percent) of the cases reviewed. There is, however, a difference in percentages when comparing CIRRT and mini-CIRRT cases. For the 22 CIRRT cases involving 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).

Of the 38 child fatalities received between January 1 and March 31, 2018, where there was a CIRRT deployment or mini-CIRRT review, the deceased child had no prior history in 17 (45 percent) of the cases reviewed. For the eight CIRRT cases, there was no prior history involving the deceased child in two of the cases (25 percent). In the 30 cases that met the criteria for a mini-CIRRT review, there was no prior history involving the deceased child in 15 of the cases (50 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 is noted that the overall number of child fatalities for both 2016 and 2017 increased by one fatality each. This is due to the reports being recently received by the Hotline, both in the 2018 calendar year.

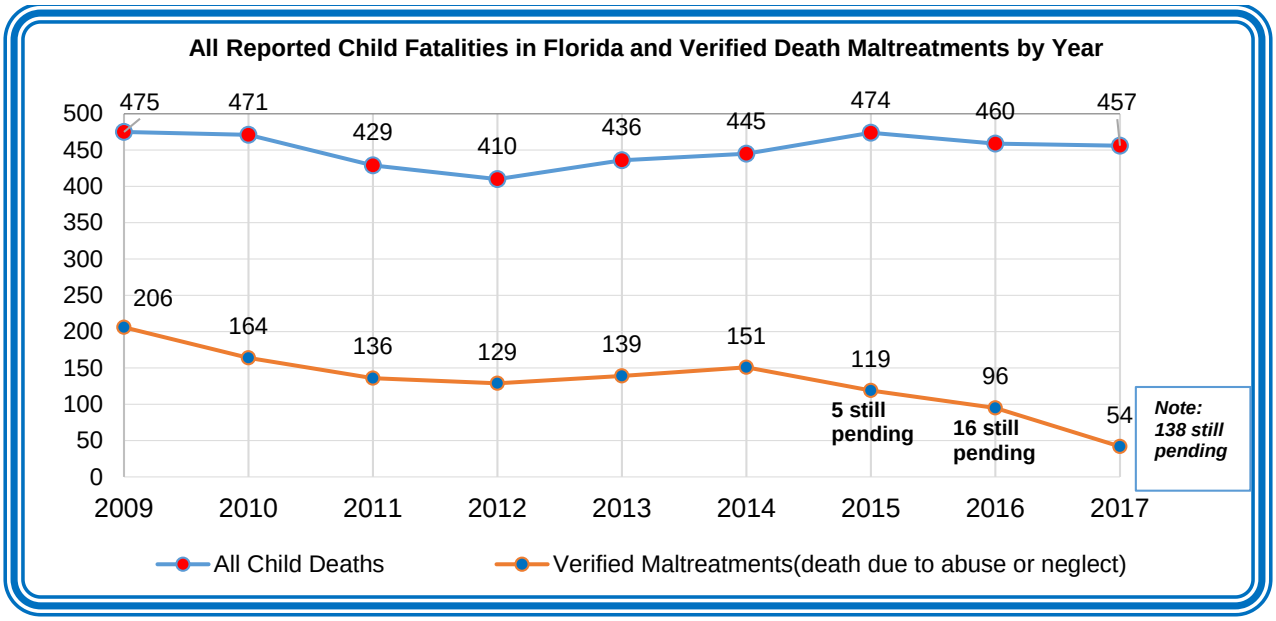


It should be noted that the chart on the previous page is a reflection of the number of actual child fatalities. Some cases involve multiple victims; however, only one respective review would be conducted. For example, while there were 23 child fatalities in 2016, there were only 22 deployments as one 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, five investigations remain open. Of the five investigations from 2015 that remain open, three were at the request of law enforcement/state attorney due to on-going criminal proceedings; and two were due to the pending reports from the medical examiner's office. For the 460 child fatalities that occurred in 2016 and that were reported to the Hotline, 16 remain open. Of the 16 investigations from 2016 that remain open, eight were at the request of law enforcement/state attorney due to on-going criminal proceedings, six were pending closure in the field, one required additional information from the medical examiner's office, and one was just recently reported in 2018. 96 of the 444 closed 2016 child fatality investigations had verified findings for the death maltreatment. Lastly, 54 of the 319 closed 2017 child fatality investigations 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.




## III. Review of CIRRT Data

### a. Summary of First Quarter CIRRT Reports

During the first quarter, there were a total of eight CIRRT deployments involving four of the six department regions. There were three deployments to the Northwest Region, two deployments to the Central and Southeast regions, and one deployment to the Northeast Region. Seven of the eight deployments occurred in counties where the department is responsible for completing child protective investigations and one deployment occurred in Broward County, where the sheriff's office is responsible for completing child protective investigations.

Five of the eight victims in the cases requiring a CIRRT deployment during the first quarter involved children less than one-year-old who were found unresponsive. There were no overt signs of physical injury or trauma to the victims noted in any of the five fatalities. The remaining three CIRRT deployments involved a nine-year-old who was accidentally shot by a neighbor boy with a high-power pellet gun, a six-year-old who perished in an apartment fire, and a 22-month-old who suffered an inflicted head injury.

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

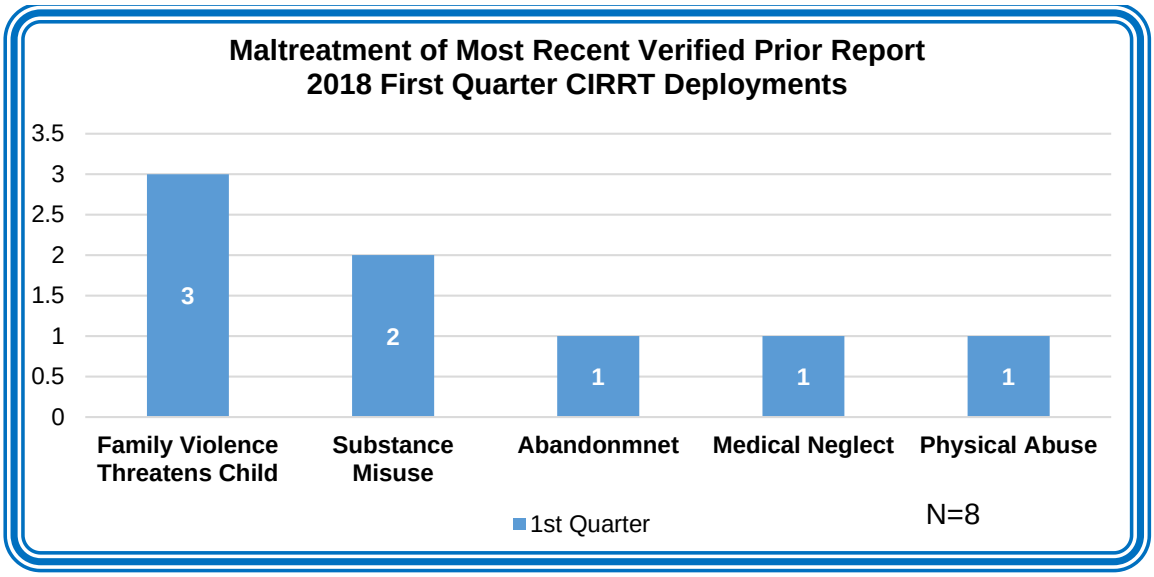
- one victim was the subject of an open child protective investigation;
- two victims were placed in out-of-home care with relatives; and
- in two cases, there was an in-home, non-judicial service case on the victim.

In two of the remaining three cases, there was a prior verified report involving the victim; and in one case, a sibling of the fatality victim was the subject of the prior abuse investigation verified for medical neglect.

A review of the prior history for the eight cases requiring a CIRRT deployment during the first quarter reflects substance misuse by the biological parents in five of the cases. Prescription drugs was the most common abuse used by the parents, as noted in five cases. Cocaine, marijuana, methamphetamine, and alcohol abuse were each present in three cases. Additionally, five cases involved family violence between the parents.

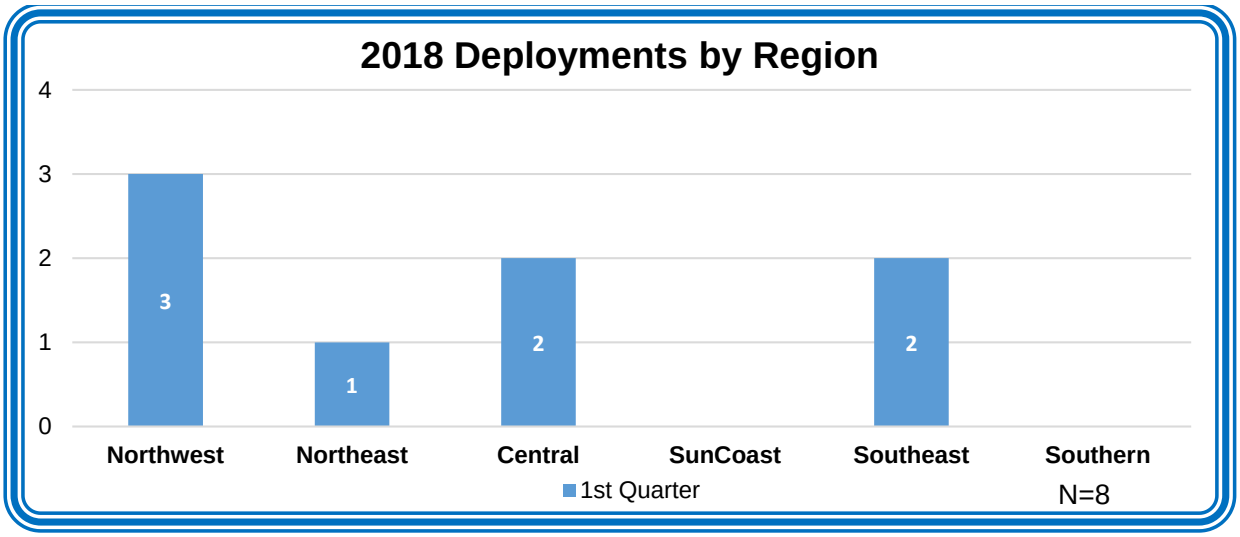
### b. Past Maltreatment

During the first quarter (January to March) of 2018, there were eight 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 family violence threatens child, two deployments with a verified maltreatment of substance misuse, and one deployment each with a verified maltreatment of medical neglect, abandonment, and physical abuse.

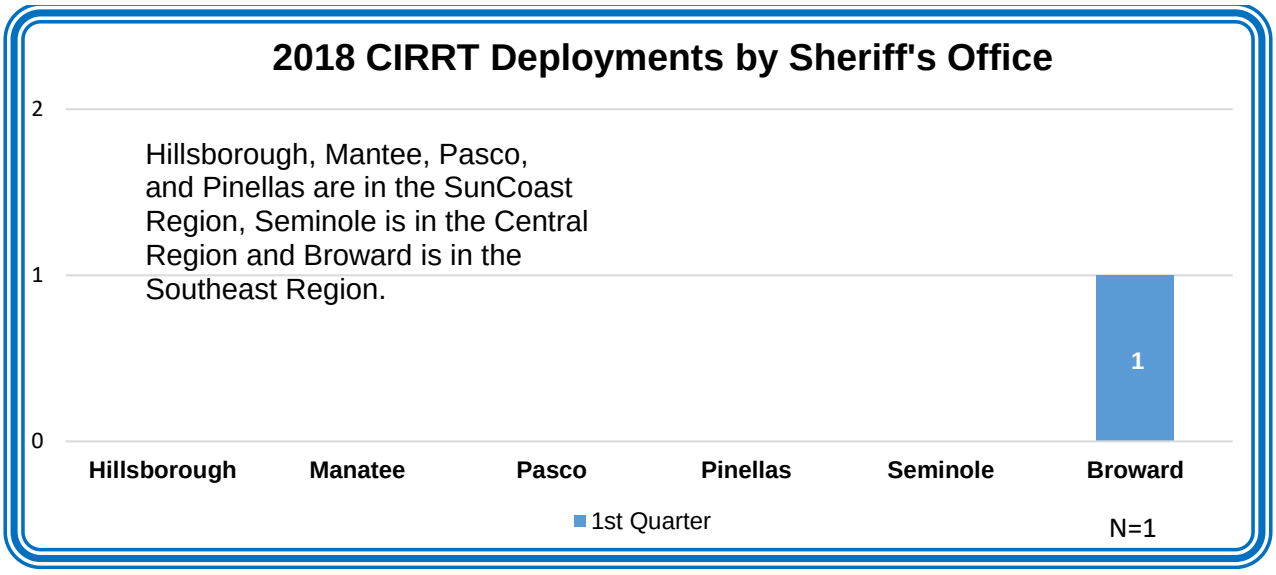


### c. CIRRT Data by Region

From January 1, 2018, through March 31, 2018, there were a total of eight CIRRT deployments, occurring in four of the six regions. There were three deployments to the Northwest Region, two deployments to the Central and Southeast regions and one deployment to the Northeast Region. One of the deployments during the quarter occurred in Broward 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.

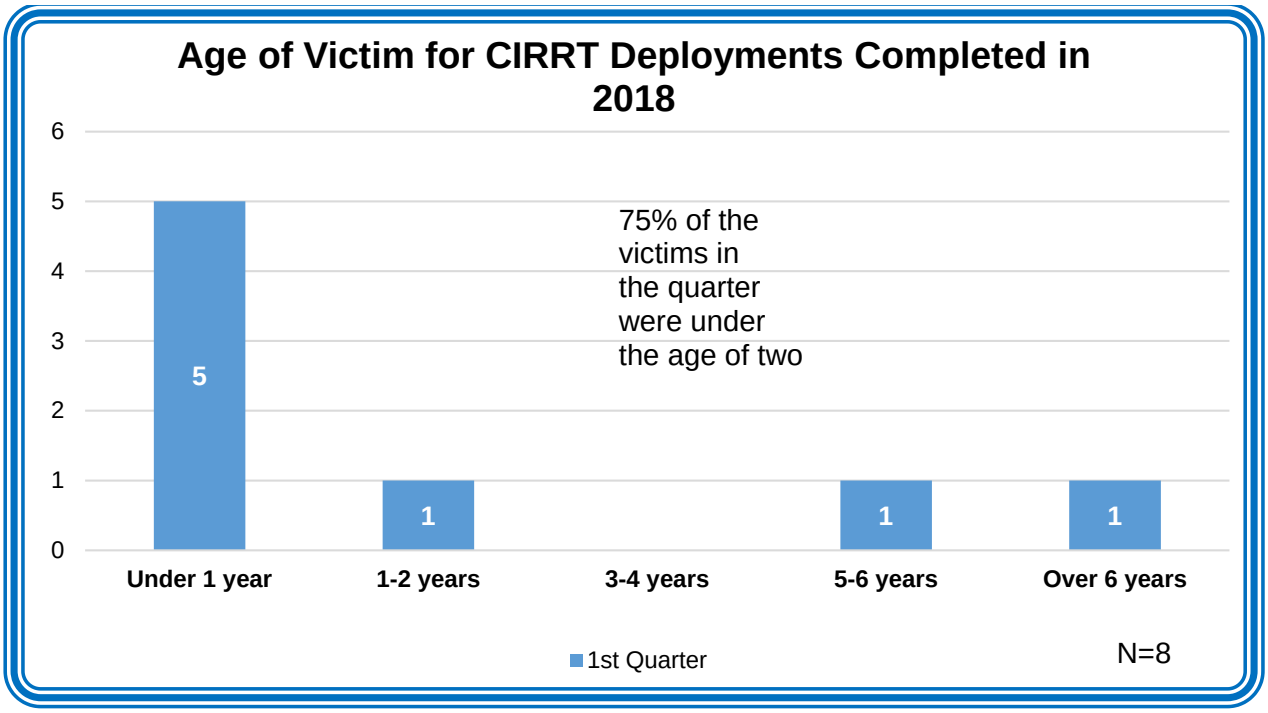



During the first quarter of 2018, there was one CIRRT deployment to a sheriff's office (Broward County).

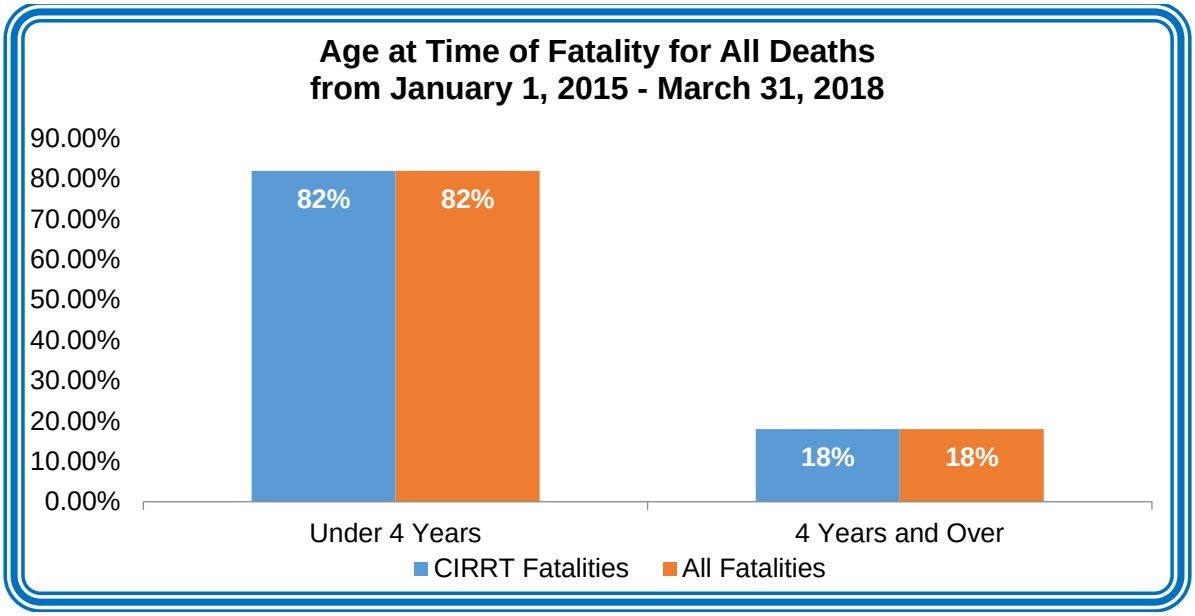


### d. Age of Victim

There were eight CIRRT deployments in the first quarter of 2018, with six of the eight victims under the age of two.

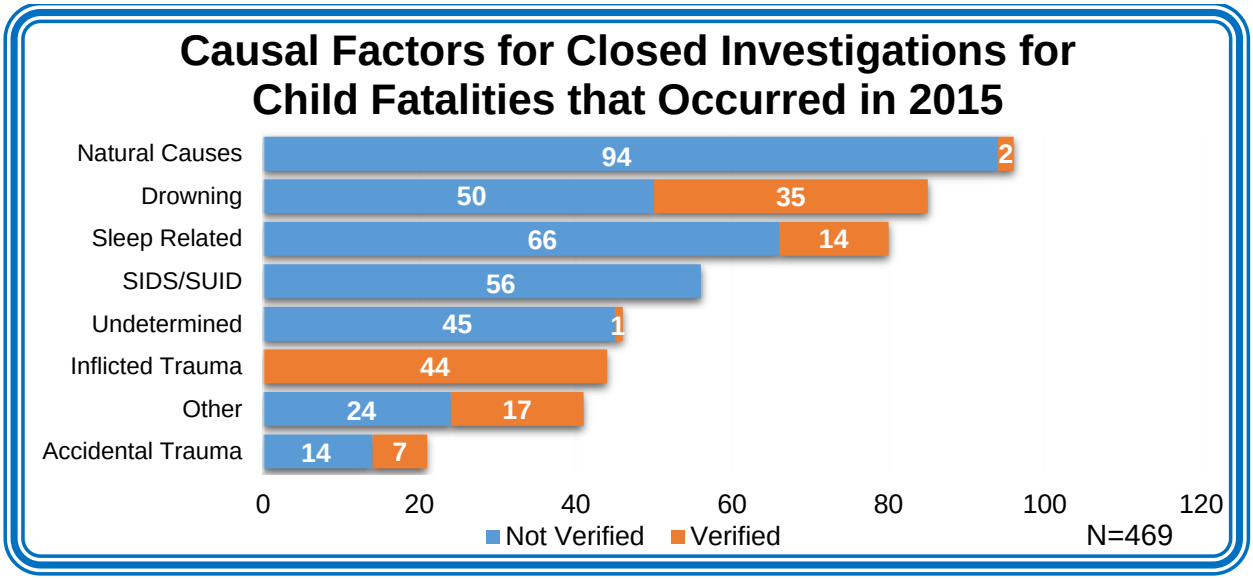



Of those child fatalities reported to the Hotline occurring from January 2015 through March 2018, 82 percent involved a child under the age of four. Similarly, 82 percent of all CIRRT deployments also involved children in this age range.

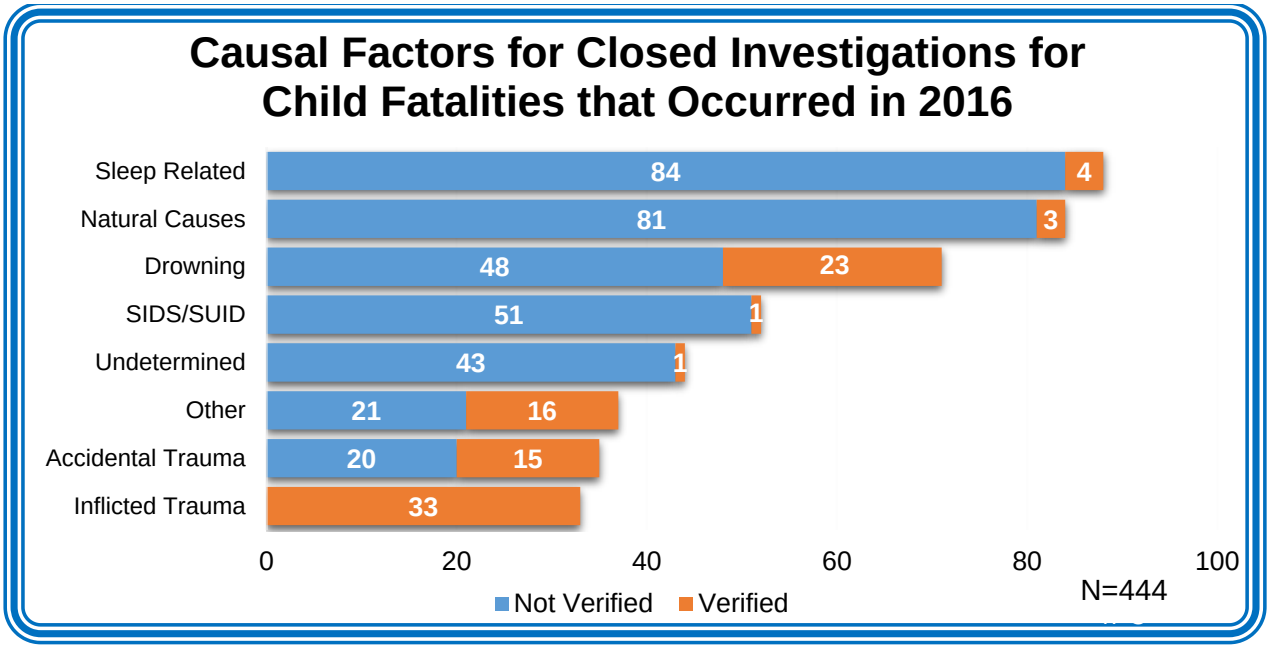


### e. Causal Factors

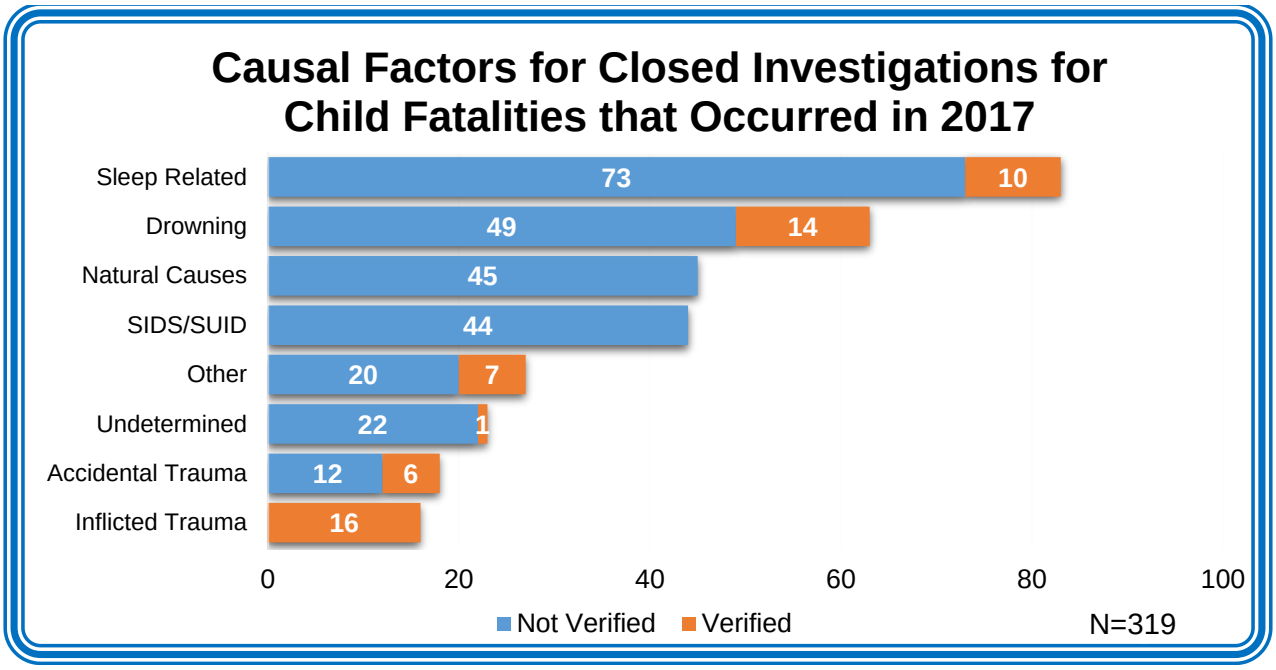
Of the 469 closed child fatalities that occurred in 2015, the four primary causal factors were natural causes, drowning, sleep-related, and SIDS/SUID. There were a total of five child fatality investigations received during this time period that remain open. When finalized, they will impact the overall numbers and causal factor sequencing.




Of the 444 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 16 child fatality investigations received during this time period that remain open. When finalized, they will impact the overall numbers and causal factor sequencing.



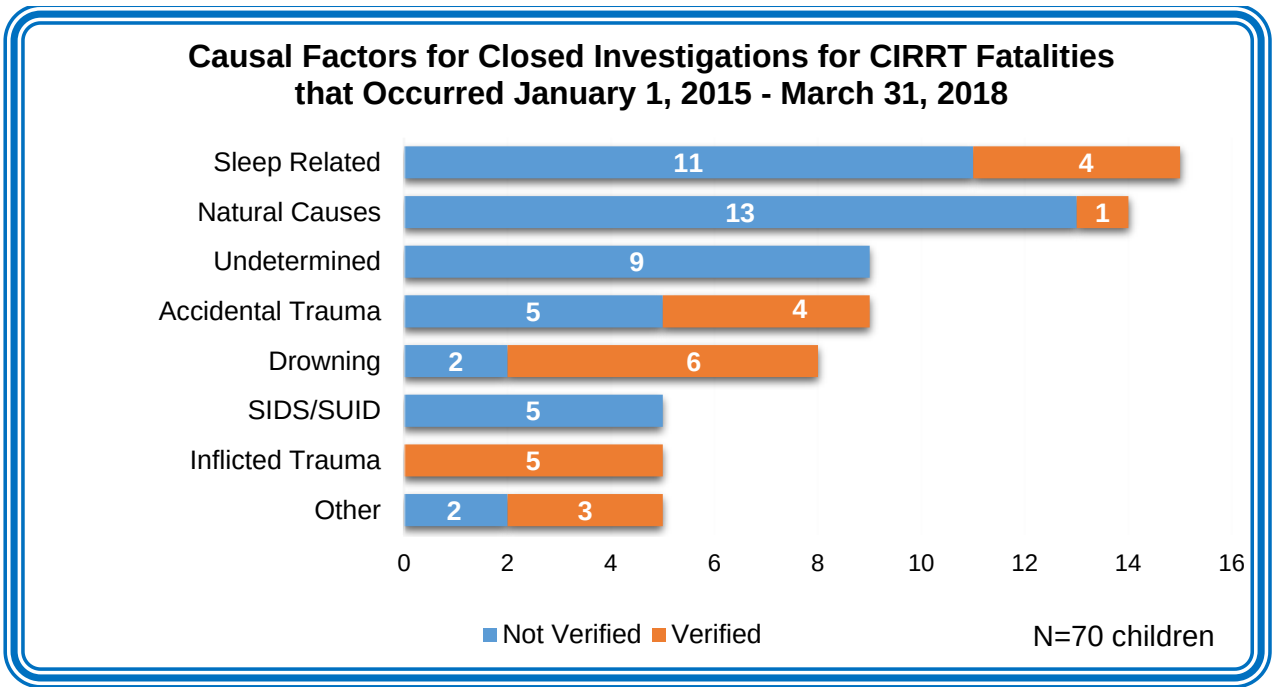
Of the 319 closed child fatalities that occurred in 2017, the four primary causal factors were sleep-related, drowning, natural causes, and SIDS/SUID. There are a total of 138 child fatality investigations received during this time period that remain open. When finalized, they will impact the overall numbers and causal factor sequencing.



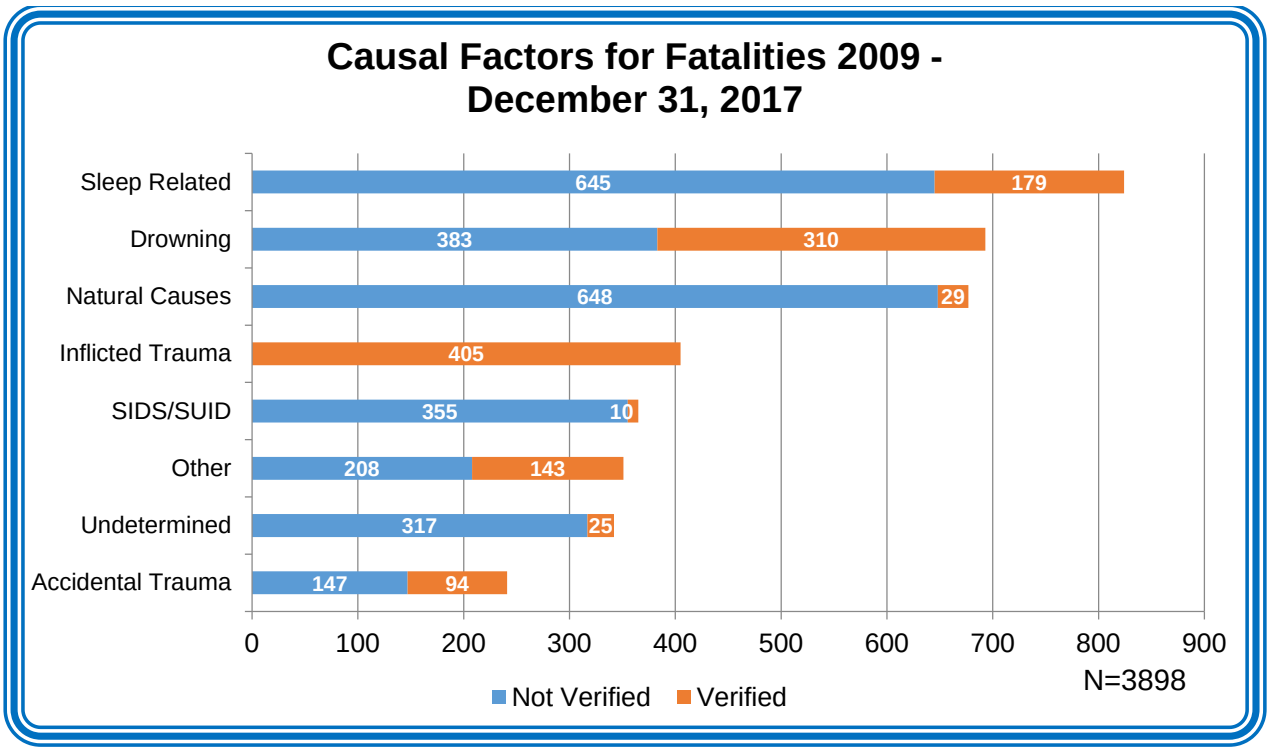

The death maltreatment cannot be used as a stand-alone maltreatment; therefore, the underlying maltreatment that may have caused or contributed to the child death is noted. For an investigation to be closed with verified findings for the death maltreatment, there must be a preponderance of credible evidence 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 March 31, 2018, there were a total of 99 CIRRT deployments involving 100 child fatalities. Of the 69 investigations (involving 70 children) that were closed, 22 (32 percent) investigations involving 23 victims had verified findings for the death maltreatment. An additional 17 (25 percent) investigations were closed with verified findings for maltreatment other than the death maltreatment. A review of the 99 deployments indicates that 47 cases (47 percent) involved children under the age of one who were found unresponsive in their crib/bassinet, or after sleeping with an adult caregiver, and/or sibling.



Between 2009 and December 31, 2017, the four leading causal factors of child fatalities reported to the Hotline were sleep-related (824), drowning (693), natural causes (677), and inflicted trauma (405).




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 six times, most recently on February 26, 2018. 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.

## 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.

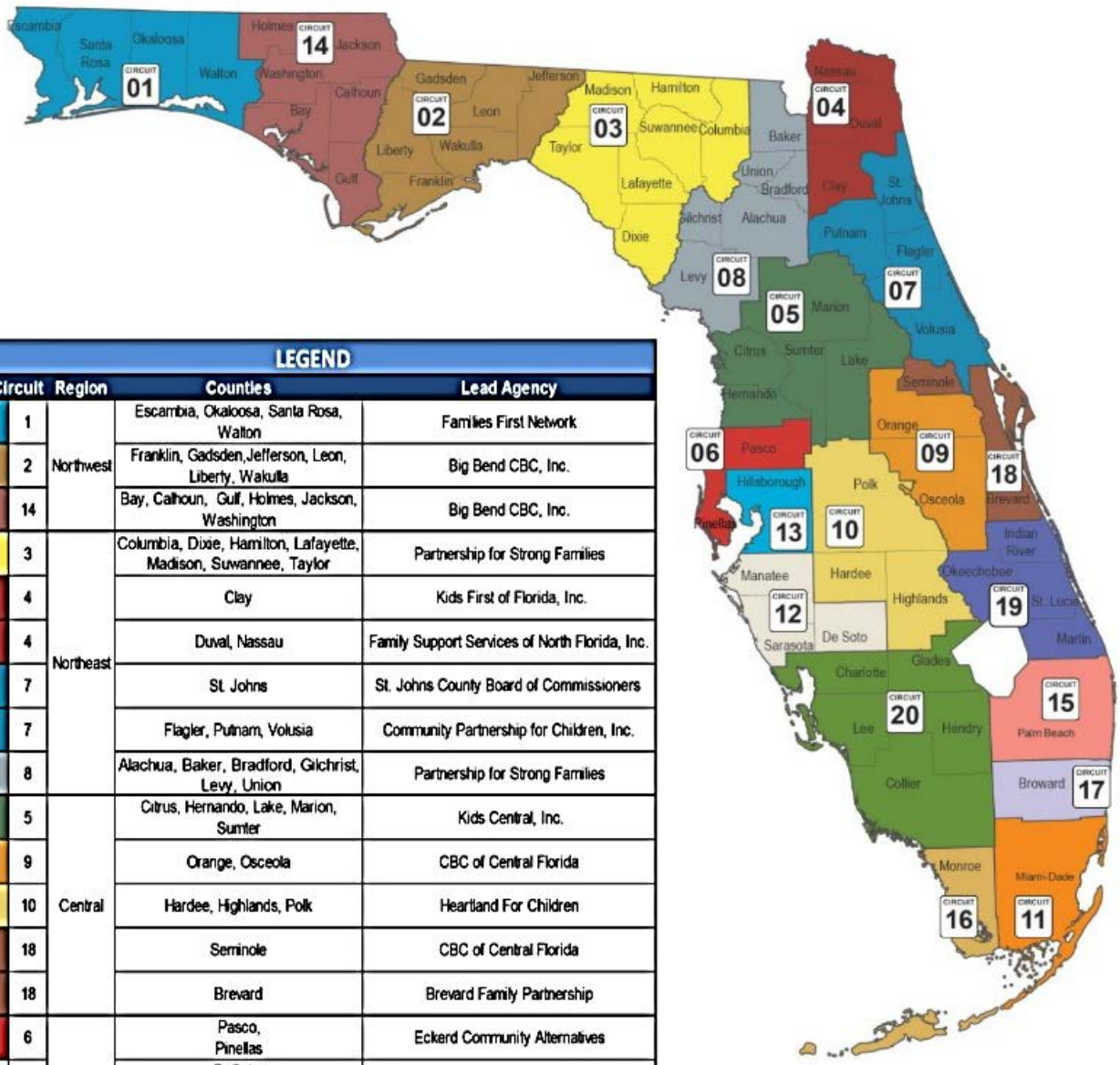
A Harvard Fellow working with the Government Performance Lab, has been working with the department on child fatality prevention, specifically through the CIRRT process. The Government Performance Lab is an organization that provides technical assistance to state and local governments and focuses on using 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. In the last quarter, the department fine-tuned their CIRRT and mini-CIRRT data collection tool and consolidated past data into one Qualtrics survey which can be used to more easily pull data to meet requests and keep regions updated. 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 continued with a focus on "deep dives" into areas the Committee requests more information on. This quarter, the department designed a tool which can be used to collect information on families seen before a fatality and is working with the regional child fatality specialists to collect this data to present back to the Committee and to inform other stakeholders.

## 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.

# NOTICE OF FILING

| | |
|---|---|
| **Reporting Agency:** | Department of Children and Families |
| **Recipient Agency:** | Governor<br>Speaker of the House of Representatives<br>President of the Senate |
| **Subject:** | Quarterly Report on Critical Incident Rapid Response Team Advisory Committee 2018 First Quarter Report |
| **Report Due Date:** | Quarterly |
| **Statutory Requirement:** | s. 39.2015(11), F.S. |

**Abstract:**

(11) The secretary shall appoint an advisory committee made up of experts in child protection and child welfare, including the Statewide Medical Director for Child Protection under the Department of Health, a representative from the institute established pursuant to s. 1004.615, an expert in organizational management, and an attorney with experience in child welfare, to conduct an independent review of investigative reports from the critical incident rapid response teams and to make recommendations to improve policies and practices related to child protection and child welfare services. The advisory committee shall meet at least once each quarter and shall submit quarterly reports to the secretary which include findings and recommendations. The secretary shall submit each report to the Governor, the President of the Senate, and the Speaker of the House of Representatives.

Copies of this report may be obtained by contacting Traci Leavine at (850) 717-4760 or by email at Traci.Leavine@myflfamilies.com. Lawful recipients will not be charged for copies. Charges for copies requested by others will conform to requirements of Department of Children and Families CFOP 15-9, Requests for Public Records.

# LEGISLATIVELY MANDATED REPORT – STATUTORY REQUIREMENT

| REPORT TITLE | STATUTORY REFERENCE | SPECIFICATIONS |
|---|---|---|
| Critical Incident Rapid Response Team Advisory Committee 2018 First Quarter Report | s. 39.2015(11), F.S. | 39.2015(11) Critical incident rapid response team.— (11) The secretary shall appoint an advisory committee made up of experts in child protection and child welfare, including the Statewide Medical Director for Child Protection under the Department of Health, a representative from the institute established pursuant to s. 1004.615, an expert in organizational management, and an attorney with experience in child welfare, to conduct an independent review of investigative reports from the critical incident rapid response teams and to make recommendations to improve policies and practices related to child protection and child welfare services. The advisory committee shall meet at least once each quarter and shall submit quarterly reports to the secretary which include findings and recommendations. The secretary shall submit each report to the Governor, the President of the Senate, and the Speaker of the House of Representatives. |