



**State of Florida  
Department of Children and Families**

**Rick Scott**  
Governor

**Mike Carroll**  
Secretary

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**DATE:** October 27, 2016

**TO:** Mike Carroll, Secretary

**THROUGH:** David L. Fairbanks, Deputy Secretary

**FROM:** JoShonda Guerrier, Assistant Secretary for Child Welfare

**SUBJECT:** Legislatively Mandated Report: Critical Incident Rapid Response Team  
Advisory Committee Third Quarter 2016 Report

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**PURPOSE:** The purpose of this memorandum is to submit a statutorily required report to the Governor and Legislature. The report is due to the Governor and Legislature on a quarterly basis.

**BACKGROUND:** Quarterly, the Critical Incident Rapid Response Team (CIRRT) Advisory Committee shall submit a report to the Secretary of the Department which includes findings and recommendations. The Secretary shall submit the report to the Governor, President of the Senate and Speaker of the House of Representatives.

**ACTION REQUIRED:** Please review and provide signatures on the attached cover letters addressed to the Governor, President of the Senate and Speaker of the House of Representatives.

**CONTACT INFORMATION:** Should you have questions on this matter, please contact Traci Leavine, Director of Child Welfare Practice, Office of Child Welfare, at (850) 717-4760 or by email at [Traci.Leavine@myflfamilies.com](mailto:Traci.Leavine@myflfamilies.com).

Attachments

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1317 Winewood Boulevard, Tallahassee, Florida 32399-0700

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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



**State of Florida  
Department of Children and Families**

**Rick Scott**  
*Governor*

**Mike Carroll**  
*Secretary*

November 16, 2016

The Honorable Rick Scott  
Governor  
PL 05, The Capitol  
Tallahassee, FL 32399-0001

Dear Governor Scott:

In accordance with section 39.2015(11), F.S., our department respectfully submits the report titled, "Critical Incident Rapid Response Team Advisory Committee Report" for the third quarter of 2016.

The report can be viewed by visiting the Department of Children and Families at:  
<http://www.dcf.state.fl.us/programs/childwelfare/lmr.shtml>.

If you have any questions, please contact me at your convenience. If your staff has any questions, please have them contact Ms. Traci Leavine, Director of Child Welfare Practice, at (850) 717-4760 or by email at [Traci.Leavine@myflfamilies.com](mailto:Traci.Leavine@myflfamilies.com).

Sincerely,

Mike Carroll  
Secretary

Attachments

cc: Ms. Cynthia Kelly, Director, Office of Policy and Budget



**State of Florida  
Department of Children and Families**

**Rick Scott**  
*Governor*

**Mike Carroll**  
*Secretary*

November 16, 2016

The Honorable Andy Gardiner  
President of the Florida Senate  
409 The Capitol  
404 South Monroe Street  
Tallahassee, FL 32399-1100

Dear Mr. President:

In accordance with section 39.2015(11), F.S., our department respectfully submits the report titled, "Critical Incident Rapid Response Team Advisory Committee Report" for the third quarter of 2016.

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Sincerely,

Mike Carroll  
Secretary

**Attachments**

cc: The Honorable Tom Lee, Chair, Committee on Appropriations  
The Honorable René Garcia, Chair, Appropriations Subcommittee on Health and Human Services  
The Honorable Eleanor Sobel, Chair, Committee on Children, Families, and Elder Affairs

1317 Winewood Boulevard, Tallahassee, Florida 32399-0700

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**State of Florida  
Department of Children and Families**

**Rick Scott**  
Governor

**Mike Carroll**  
Secretary

November 16, 2016

The Honorable Steve Crisafulli, Speaker  
Florida House of Representatives  
420 The Capitol  
402 South Monroe Street  
Tallahassee, FL 32399-1300

Dear Mr. Speaker:

In accordance with section 39.2015(11), F.S., our department respectfully submits the report titled, "Critical Incident Rapid Response Team Advisory Committee Report" for the third quarter of 2016.

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Sincerely,

Mike Carroll  
Secretary

**Attachments**

cc: The Honorable Richard Corcoran, Chair, Committee on Appropriations  
The Honorable Matt Hudson, Chair, Appropriations Subcommittee on Health Care  
The Honorable Jason Brodeur, Chair, Committee on Health and Human Services  
The Honorable Gayle Harrell, Chair, Subcommittee on Children, Families and Seniors

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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

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



Mike Carroll  
Secretary

Rick Scott  
Governor

Mission: Work in Partnership with Local Communities to Protect the Vulnerable,  
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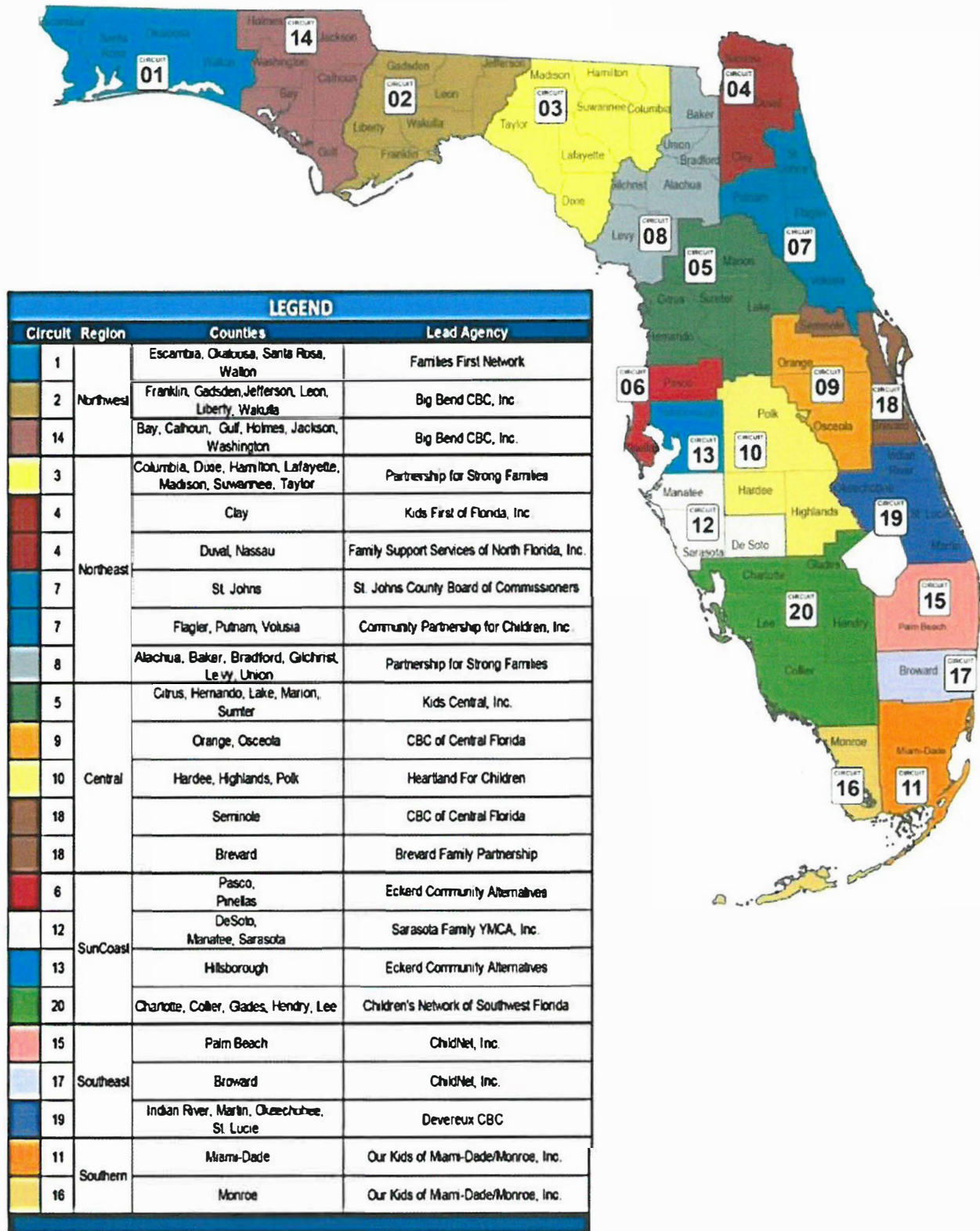
**Florida Department of Children and Families  
Critical Incident Rapid Response Team  
Advisory Committee Report  
Third Quarter 2016**

**I. Background**

In 2014, the Florida Legislature passed Senate Bill 1666, establishing requirements for creating a Critical Incident Rapid Response Team (CIRRT), effective January 1, 2015. Section 39.2015, F.S., 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, F.S., the Department of Children and Families 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 contracting with community-based care lead agencies for each of the twenty judicial circuits in the state.

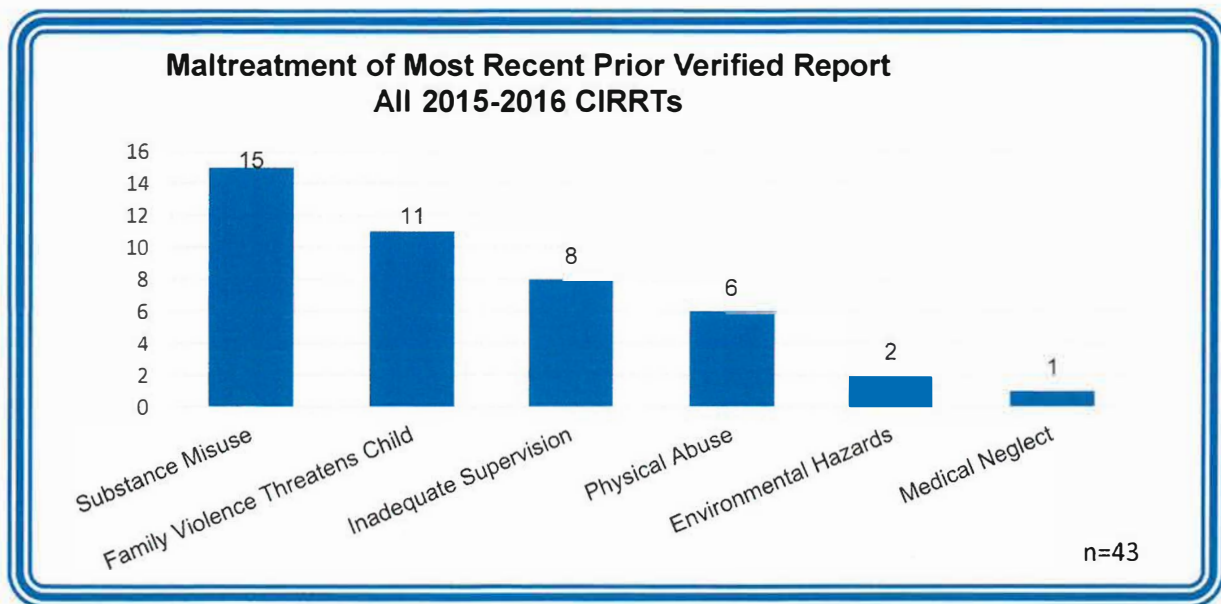
## Community Based Care Lead Agencies by Circuit and County



## II. Purpose

Critical Incident Rapid Response Teams 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 September 30, 2016, CIRRT teams reviewed 49 child fatalities. Of those deployments, 43 met the CIRRT requirements of having a verified maltreatment within the previous 12 months, while the other six were completed at the direction of Secretary Mike Carroll. Of the 43 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 was deployed as there was an active investigation when the death incident occurred.

For all CIRRTs completed since January 2015, substance misuse and domestic violence were the primary maltreatments on 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 third quarter (July - September) of 2016, there were seven CIRRT deployments, with one of the seven being a special review that did not have a verified prior report within the previous 12 months. For the reviews with a verified prior report within the past 12 months, there were two reports each with a maltreatment of physical injury, substance misuse and inadequate supervision. The primary maltreatment of the most recent prior report in the special review was physical injury and the report was closed with not substantiated findings as to the allegations. These seven reports are a subset of the 49 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. 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 (s. 39.2015(3), F.S.).

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
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.

### Review Expanded to all Child Fatalities

In addition to the mandated CIRRT review of cases with prior history and verified findings in the 12 months preceding the child's death, Secretary Mike Carroll issued a directive in January 2015 that all child fatalities be formally reviewed based on a core set of data elements. This directive has subsequently been codified into Department operating procedure, requiring the following:

- A quality assurance review on cases that involve families with child welfare history within the five years preceding the child's death, regardless of findings. These reviews use a tool and process that mirrors the CIRRT review process and are commonly referred to as "mini-CIRRTs."
- A limited review to be conducted by the region's child fatality prevention specialist on cases that involve families with no prior history for the five years preceding the child's death.

Standardized data is collected across all review types and entered into a database 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 statute 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 statute, 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.

Between January 1, 2015 and September 30, 2016, a total of 262 cases statewide met the criteria for completion of a “mini-CIRRT” review. During the third quarter of 2016, 34 cases statewide met the criteria for completion of a “mini-CIRRT” review. Department regional staff has responsibility for completion of mini-CIRRTs for the sheriff’s office cases and are working on completing these reviews.

Special Reviews (Mini-CIRRTs)				
Region	Review Required	Reports Completed	Reports Pending	Percentage Complete
Northwest	32	30	2	93.75%
Northeast	53	46	7	86.79%
Central	71	54	17	76.06%
Central Sheriffs	6	3	3	50.00%
Suncoast	19	17	2	89.47%
SC Sheriffs	39	27	12	69.23%
Southeast	18	7	11	38.89%
SE Sheriffs	14	9	5	64.29%
Southern	10	9	1	90.00%
<b>DCF Totals</b>	<b>203</b>	<b>163</b>	<b>40</b>	<b>80.30%</b>
<b>Sheriff's Total</b>	<b>59</b>	<b>39</b>	<b>20</b>	<b>66.10%</b>
<b>Statewide</b>	<b>262</b>	<b>202</b>	<b>60</b>	<b>77.10%</b>

### CIRRT Advisory Committee

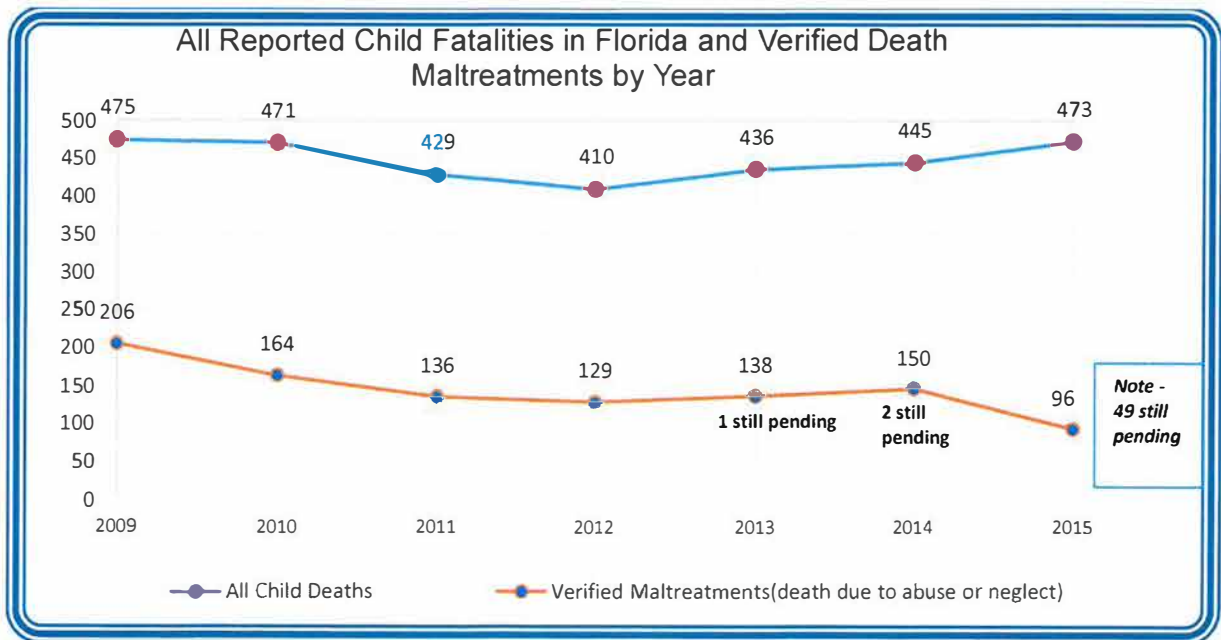
The CIRRT advisory committee is statutorily required to meet on a quarterly basis. The committee has met a total of four times, most recently on August 17, 2016. Advisory committee members may participate via conference call but are encouraged to attend in person. The meeting notices are published and 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 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

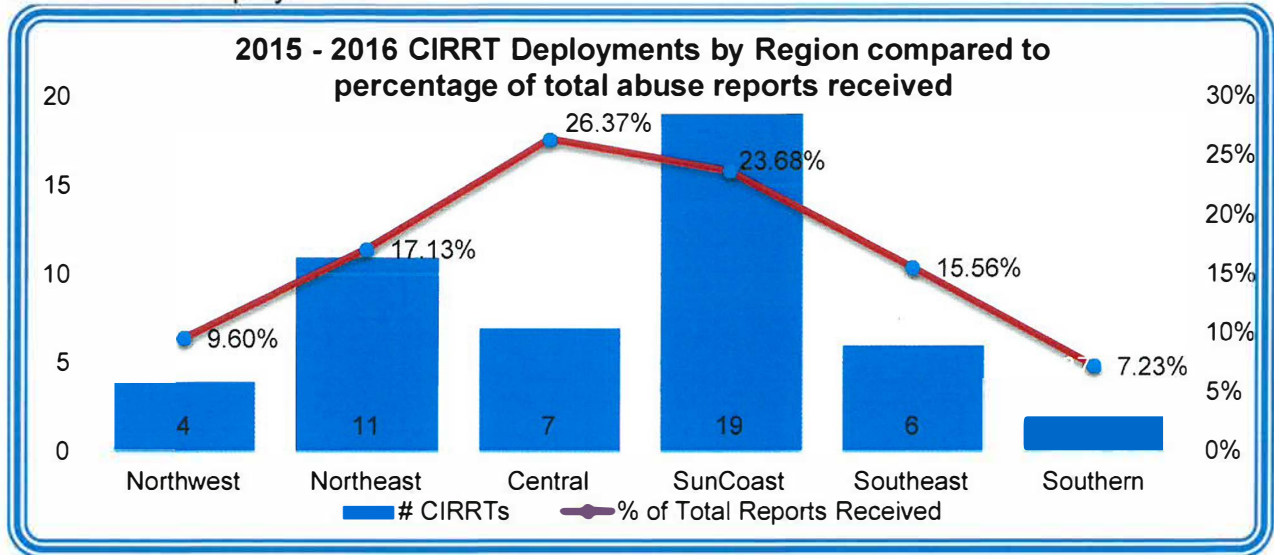
Overall, child deaths in Florida typically involve a child age three or younger and may involve a variety of causal factors including but not limited to sleep related deaths, drownings, natural causes, inflicted trauma, Sudden Infant Death Syndrome (SIDS)/Sudden Unexplained Infant Death (SUID), and accidental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

Of the 473 child fatalities that occurred in 2015 and were reported to the hotline, 49 investigations remain open. Findings for these cases have not yet been determined, giving the appearance of a decline in the number of verified reports. One child death investigation from 2013 remains open at the request of law enforcement officials due to the on-going criminal investigation. Two child death investigations from 2014 remain open at the request of the State Attorney's Office and/or law enforcement due to on-going criminal proceedings.

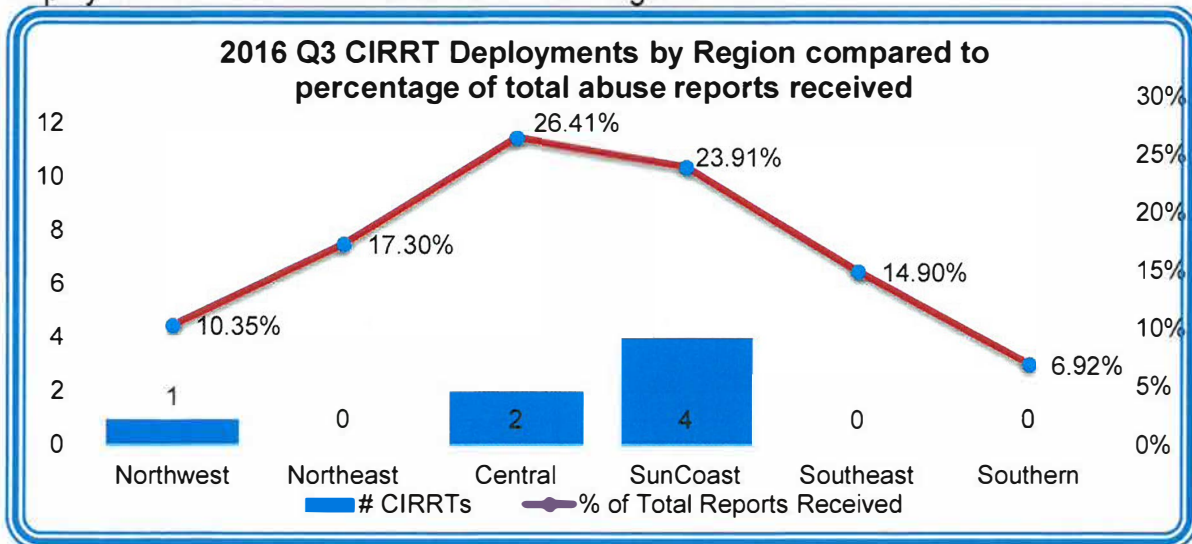




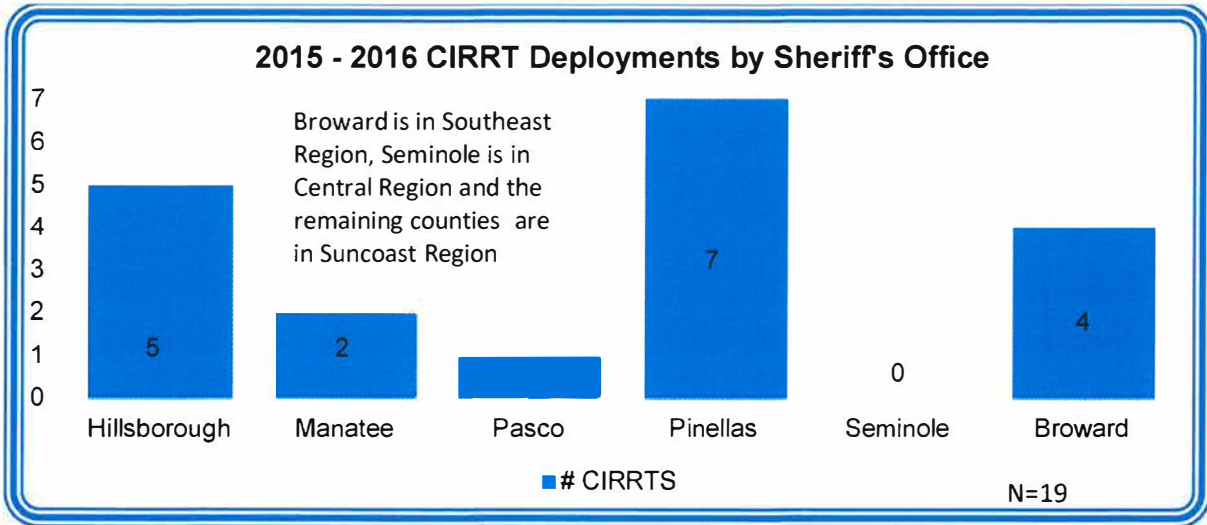
Since January 2015, there have been a total of 49 CIRRT deployments, with at least one deployment occurring in each of the six regions. The SunCoast and Northeast Regions account for 39 percent and 22 percent of the deployments respectively, while receiving 24 percent and 17 percent of all abuse investigations during the past 18 months. Conversely, the Central Region, which at 26 percent, accounts for the largest percentage of abuse reports received during the time period, was involved in 14 percent of the CIRRT deployments.



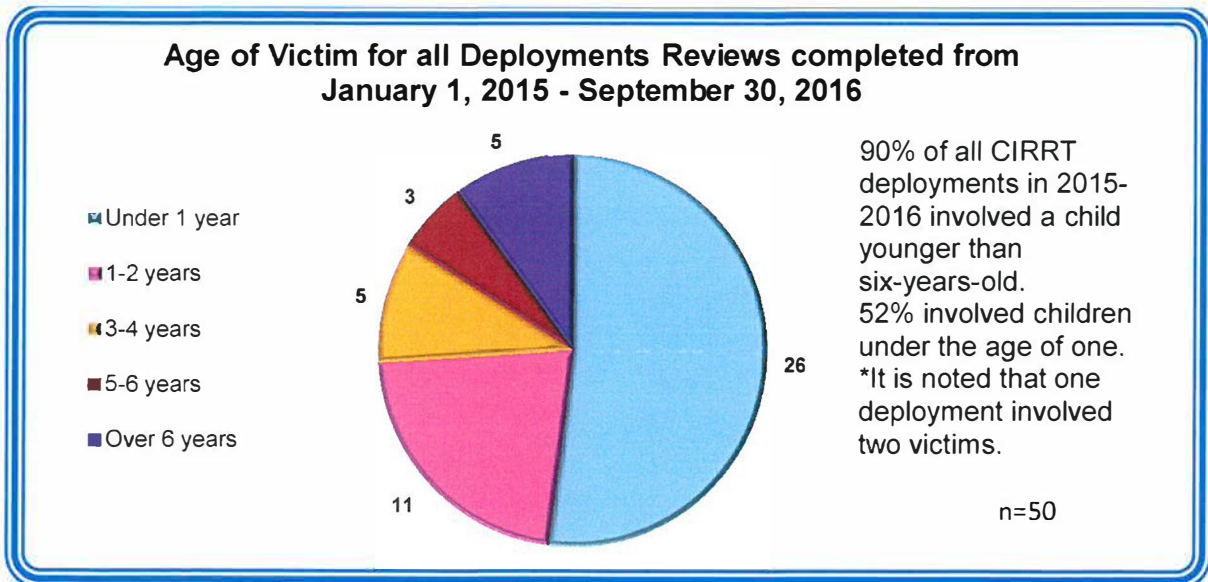
There were seven CIRRT deployments during the third quarter of 2016, four in the SunCoast Region, two in the Central Region and one in the Northwest Region. The four deployments to the SunCoast Region occurred in counties where the sheriffs' office conduct child protective investigations (Pinellas and Hillsborough), and the Department was responsible for the completion of child protective investigations in the three deployments to the Central and Northwest Region.



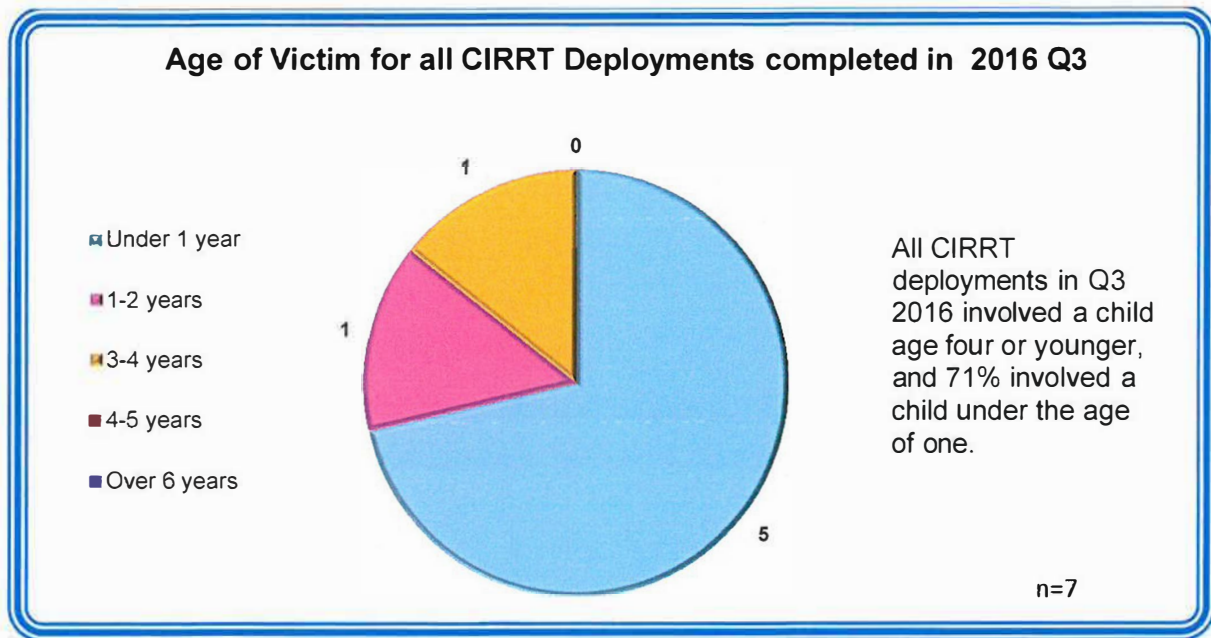
From January 1, 2015 through September 30, 2016, 19 of 49 CIRRT deployments involved five of the six counties where child protective investigations are conducted by sheriffs' offices. To date, there have not been any CIRRT deployments to Seminole county. During the third quarter of 2016, there were three CIRRT teams deployed to Pinellas County and one deployment to Hillsborough County, all in the SunCoast Region.



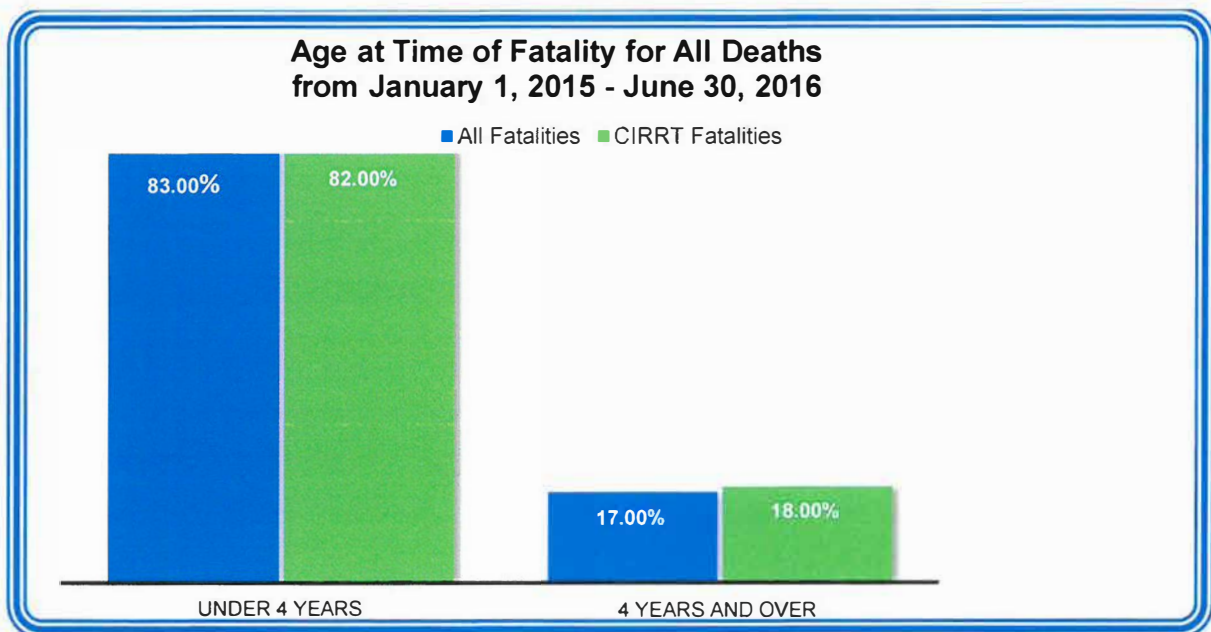
During the 2015 calendar year and the first three quarters of 2016, 49 CIRRT reviews were completed involving a total of 50 victims. Ninety percent of the deployments involved a victim under the age of six. In 74 percent of the reviews, the victim was under the age of three. This is consistent with child deaths statewide in which younger children are more vulnerable to being victims of abuse and neglect.



There were seven CIRRT deployments in the third quarter of 2016. Five of the seven victims were under the age one.

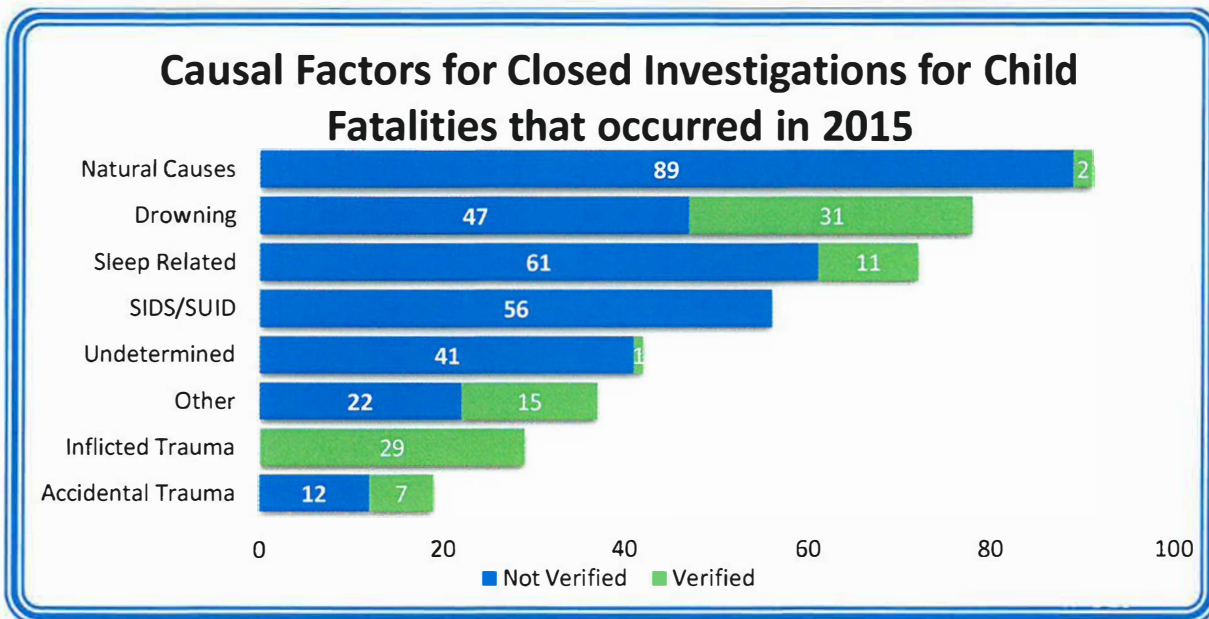


Of those child fatalities reported to the Florida Abuse Hotline occurring from January 2015 through the third quarter of 2016, 83 percent involved a child under the age of four. Similarly, 82 percent of all CIRRT deployments involved children in this age range.





Of the 424 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 49 child fatality investigations received during this time period that remain open, which, when finalized, will impact the overall numbers and causal factor sequencing.



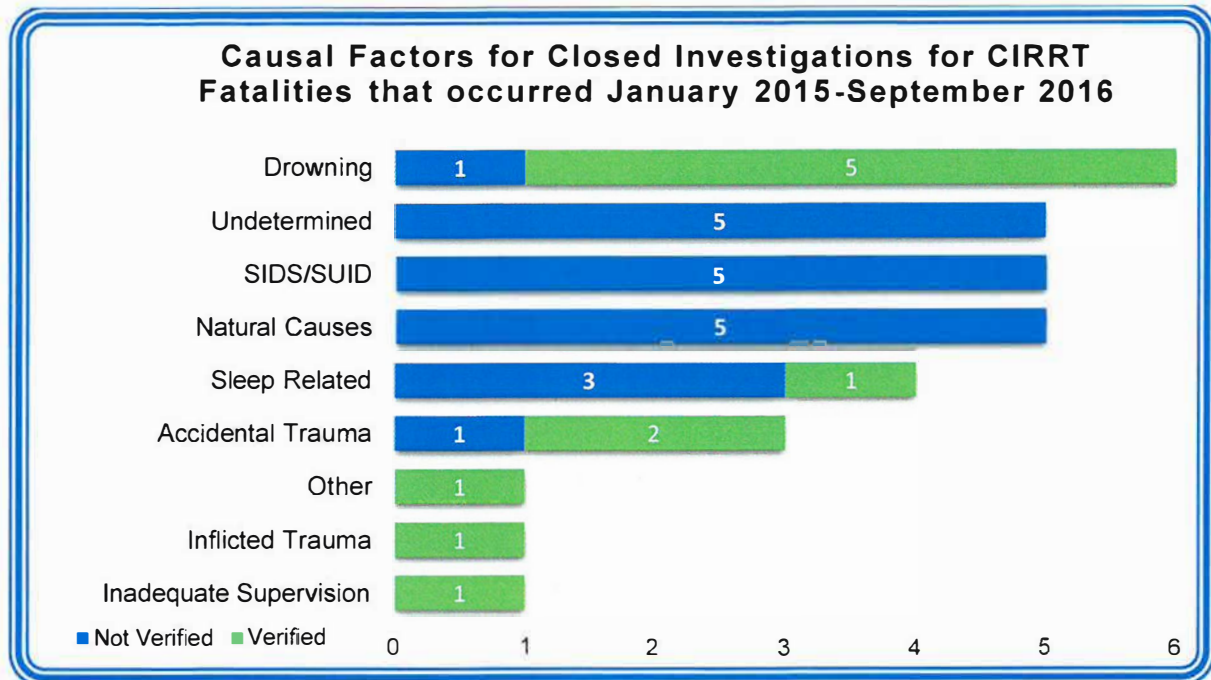
The death maltreatment cannot be used as a stand-alone maltreatment; therefore the underlying maltreatment that may have caused or contributed to the child death is noted. In order for an investigation to be closed with verified findings for the death maltreatment, there must be a preponderance of the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

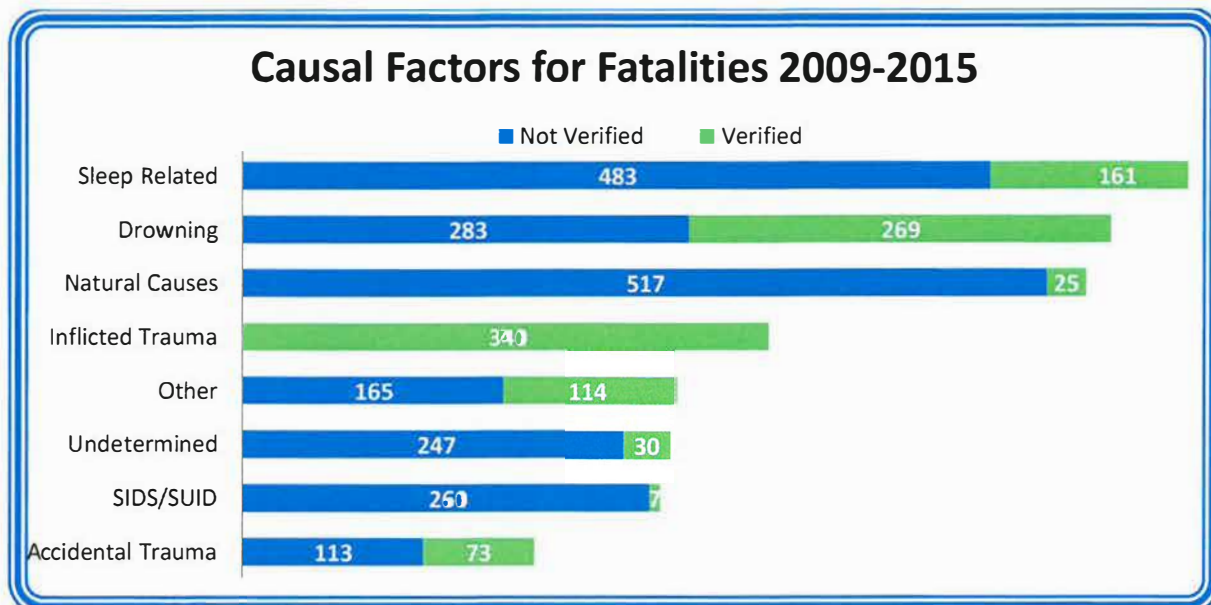
Between January 1, 2015 and September 30, 2016, there were a total of 49 child fatalities that resulted in a CIRRT deployment. Of the 31 investigations that were closed, 11 (35 percent) investigations had verified findings for the death maltreatment. An additional seven investigations were closed with verified findings for a maltreatment other than the death maltreatment. A review of the 49 deployments indicates that 21



cases, or 43 percent, of the deployments involved children under one 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 Florida Abuse Hotline were Sleep Related (644 deaths), Drowning (552 deaths), Natural Causes (542 deaths), and Inflicted Trauma (340 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 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 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.

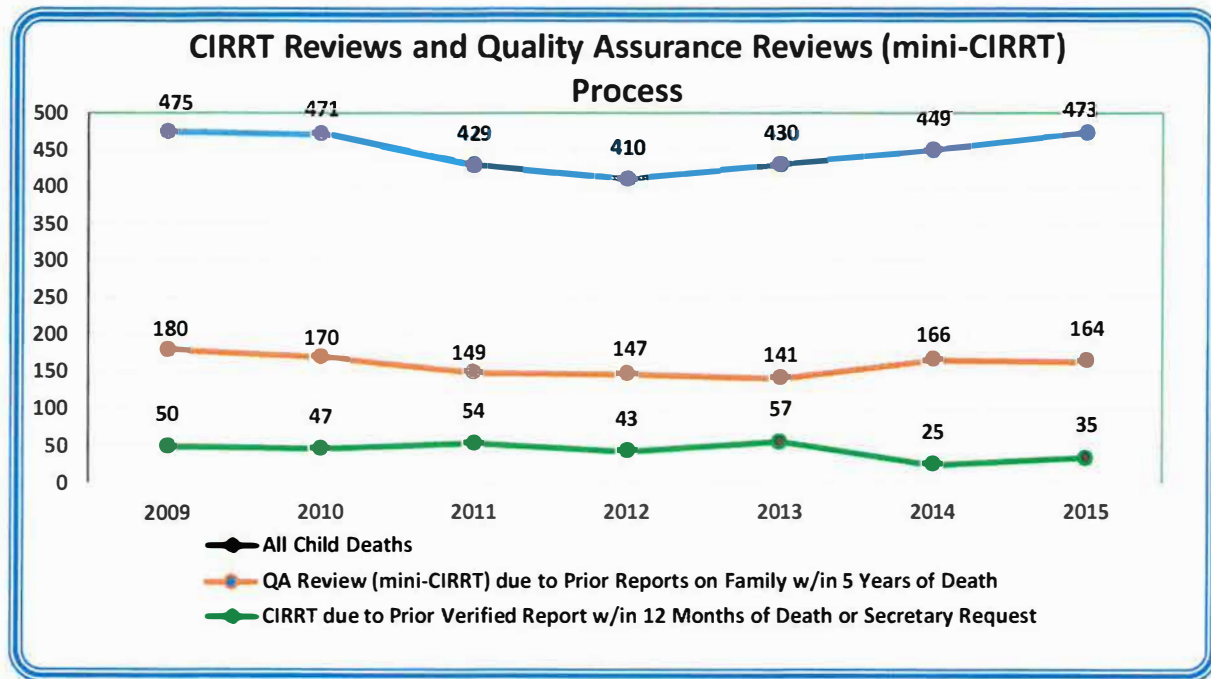
Although maltreatment findings were noted to be appropriate for the majority of the investigations, the investigations with a causal factor of SIDS/SUID and several of the investigations with a causal factor of "Undetermined" were inappropriately closed with a verified finding of the death maltreatment. 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 CIRRTs 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.

## Addendum



### Child Fatality Review Process

Every case involving a child fatality receives 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.

In calendar year 2015, 35 cases either met the criteria for a CIRRT deployment due to either having a verified report within 12 months of the reported death or when the Secretary requested a team to be deployed. Although this represents only seven percent of the overall fatalities called to the hotline, it's important to note that there were 164 additional cases that met the criteria for a mini-CIRRT review. In total, in-depth

quality assurance reviews were conducted on 199 cases, over 40% of all cases received.

Of the 199 cases that received an in-depth review in 2015, the deceased child had no prior history in 42% or 84 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 eight (23%) of the cases reviewed; whereas in mini-CIRRT cases, there was no prior history involving the deceased child in 76 (46%) of the cases reviewed.

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