Critical Incident Rapid Response Team Advisory Committee
Second 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

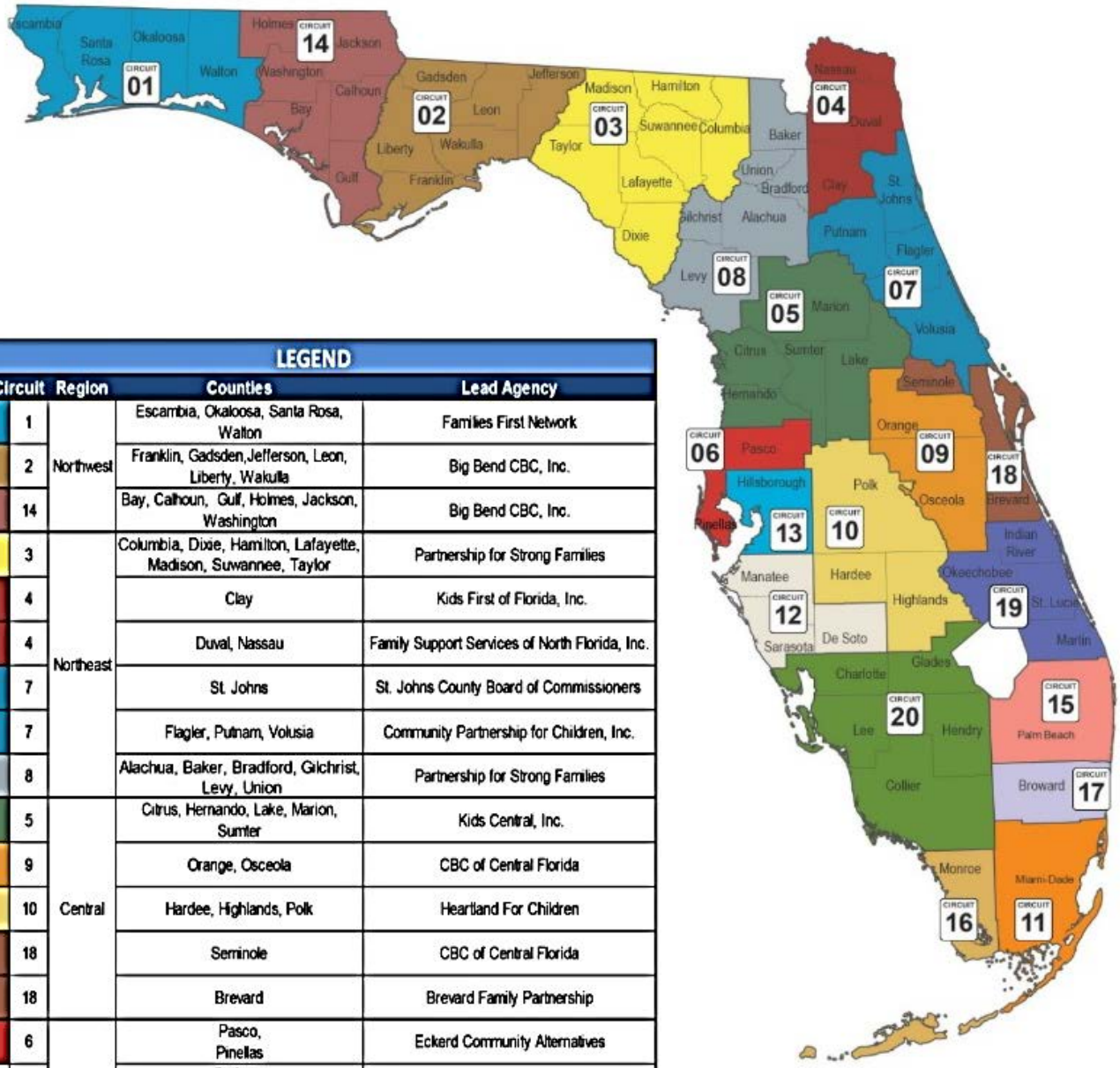
Florida Department of Children and Families
Critical Incident Rapid Response Team
Advisory Committee Report
Second Quarter 2016

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, 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, F.S., the Department of Children and Families transferred all responsibility for child protective investigations to the sheriff's office 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



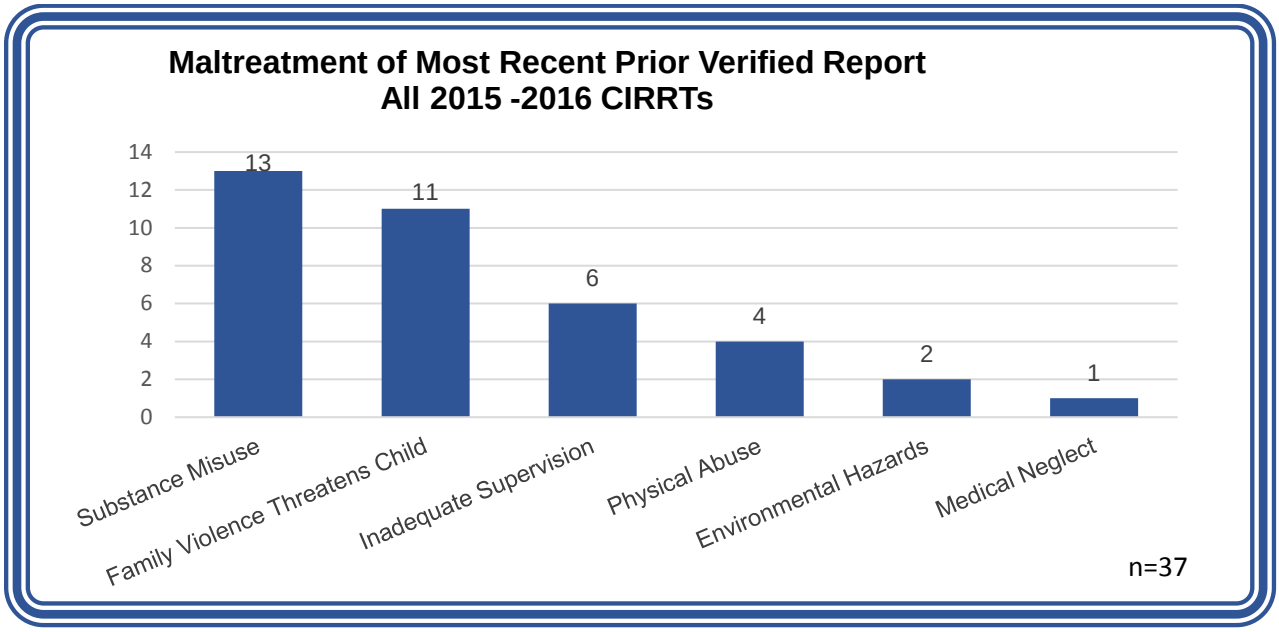
LEGEND

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

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 June 30, 2016, CIRRT teams reviewed 42 child fatalities. Of those deployments, 37 met the CIRRT requirements of a having a verified maltreatment within the previous 12 months. The 37 reports meeting the CIRRT requirements for deployment are captured in the chart below.



Five of the 42 were special reviews and did not have a verified maltreatment within the previous 12 months; these reviews were completed at the direction of Secretary Mike Carroll. Two of the five special reviews involved a recent history of substance misuse while another two involved a recent history of physical abuse. Although there had not been a prior closed abuse investigation with regards to the final special CIRRT review, 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 second quarter (April - June) of 2016, there were five CIRRT deployments, involving six victims, with one of the five being a special review which did not have a verified prior within the previous 12 months. For the reviews with a verified prior within the past 12 months, there were two reports with a maltreatment of physical injury and one each with maltreatments of substance misuse and family violence threatens child. The primary maltreatment of the most recent prior in the special review was substance misuse and the report was closed with no indicators as to the allegations. These five reports are a subset of the 42 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 new 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)	100
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
Report Writer	1

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. 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 June 30, 2016, a total of 231 cases statewide met the criteria for completion of a "mini-CIRRT" review. During the second quarter of 2016, 40 cases statewide met the criteria for completion of a "mini-CIRRT" review. DCF regional staff have 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	30	29	1	96.67%
Northeast	48	28	20	58.33%
Central	66	48	18	72.73%
Central Sheriffs	4	3	1	75.00%
Suncoast	17	13	4	76.47%
SC Sheriffs	31	16	15	51.61%
Southeast	14	7	7	50.00%
SE Sheriffs	12	9	3	75.00%
South	9	5	4	55.56%
DCF Totals	**184**	**130**	**54**	70.65%
Sheriff's Total	**47**	**28**	**19**	59.57%
Statewide	**231**	**158**	**73**	68.39%

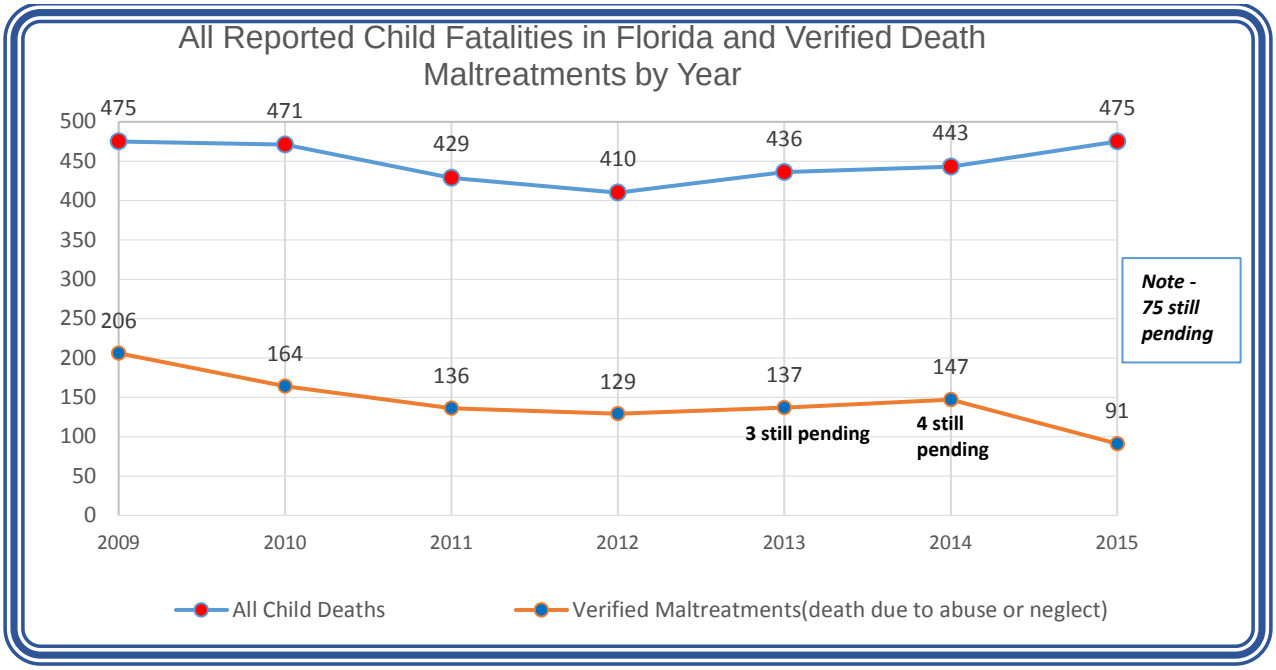
CIRRT Advisory Committee

The CIRRT advisory committee is statutorily required to meet on a quarterly basis. To date, the committee met a total of four times, most recently on May 10, 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 necessary.

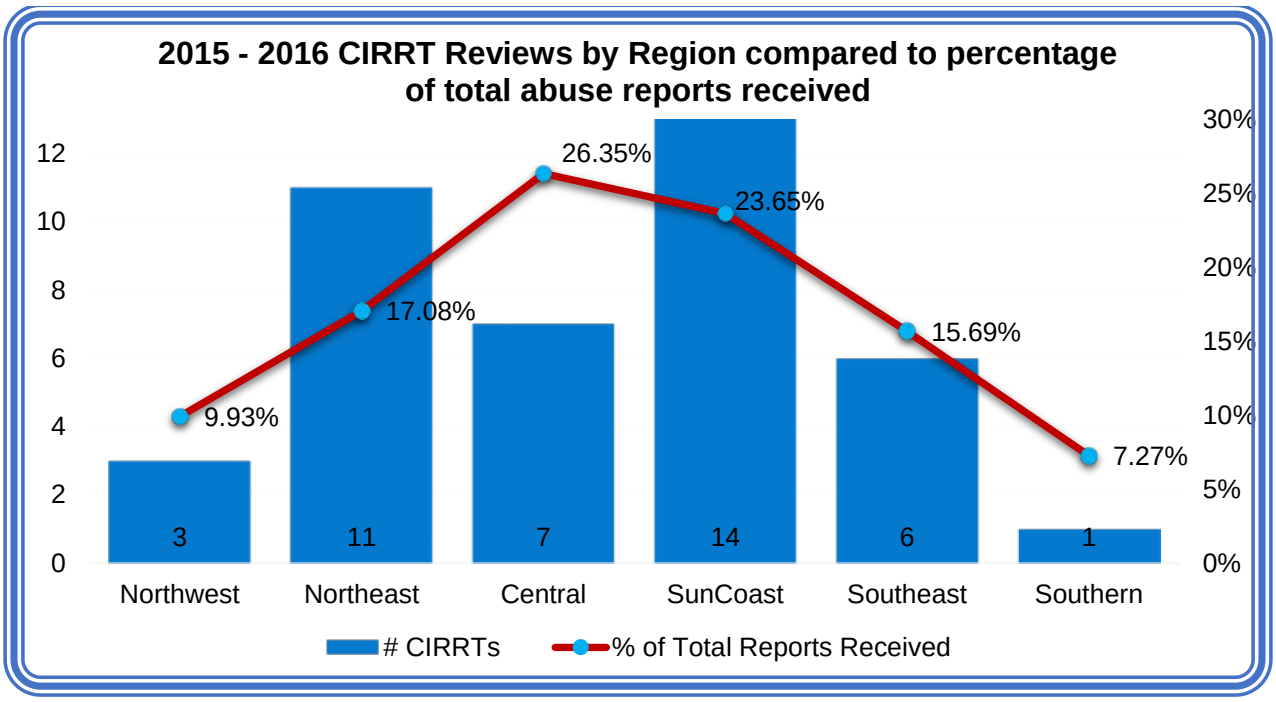
Review of Child Fatality Data

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.

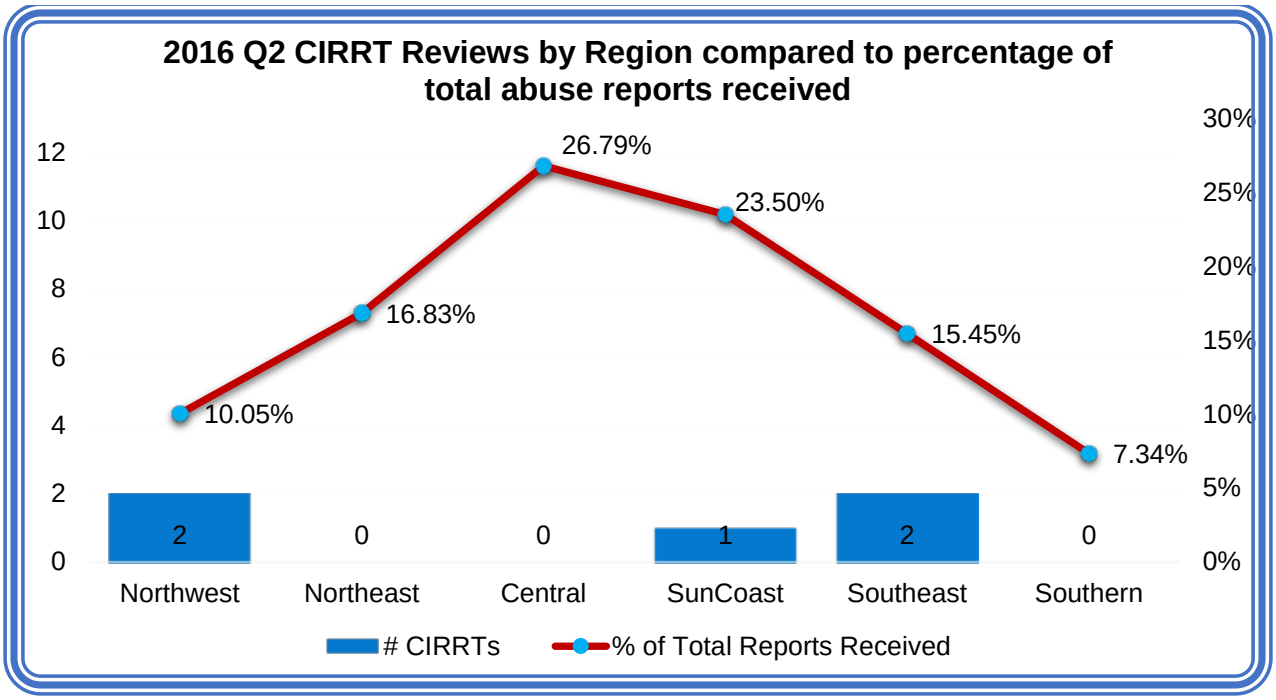
Of the 475 child fatalities that occurred in 2015 and were reported to the hotline, 75 investigations remain open. Findings for these cases have not yet been determined, giving the appearance of a decline in the number of verified reports. Three child death investigations from 2013 remain open. Two of the cases weren't reported to the hotline until 2016 and the other case remains open at the request of law enforcement officials due to the on-going criminal investigation. Four child death investigations from 2014 remain open. Two of the cases are open at the request of the State Attorney's Office and/or law enforcement due to on-going criminal proceedings; one case remains open as the medical examiner's report is still pending; and one case needs to be staffed for closure, which had not yet occurred at the time of this report.



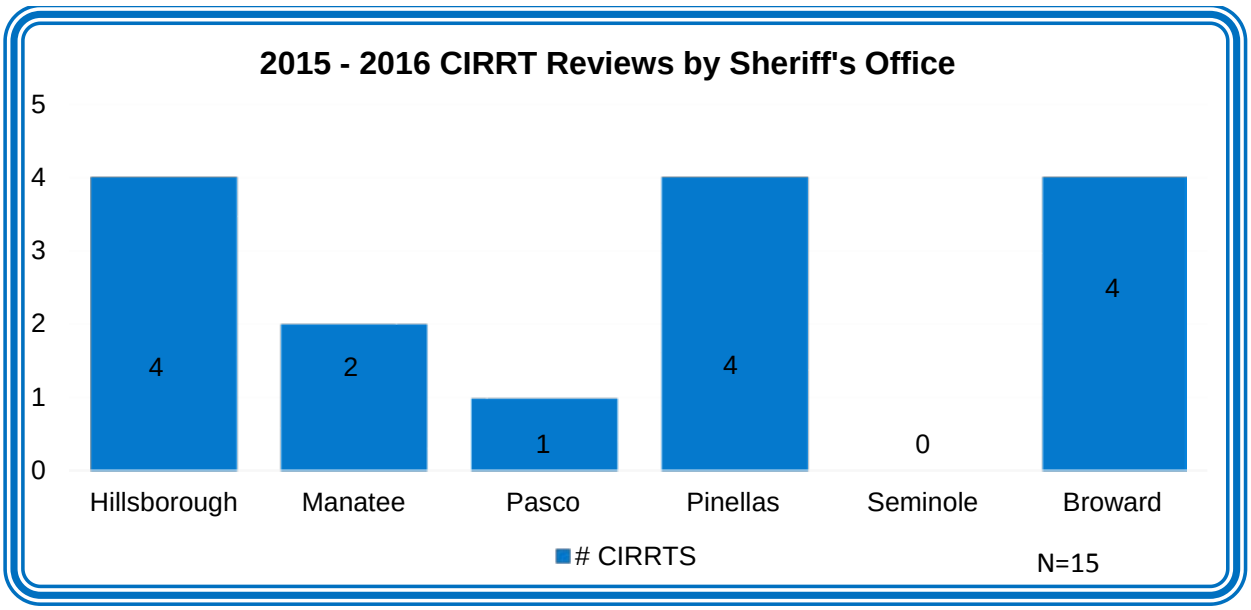
Since January of 2015, there have been a total of 42 CIRRT deployments, with at least one deployment occurring in each of the six regions. The SunCoast and Northeast Regions account for 33 and 26 percent of the deployments respectively, while receiving 24 and 17 percent of all abuse investigations during 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 17 percent of the CIRRT deployments.



There were five CIRRT deployments during the second quarter of 2016, two each in the Northwest and Southeast regions and one in the SunCoast Region. Three of the deployments occurred in counties where the department was responsible for the completion of child protective investigations and two involved counties where the sheriff's office conducts child protective investigations (Pasco and Broward).

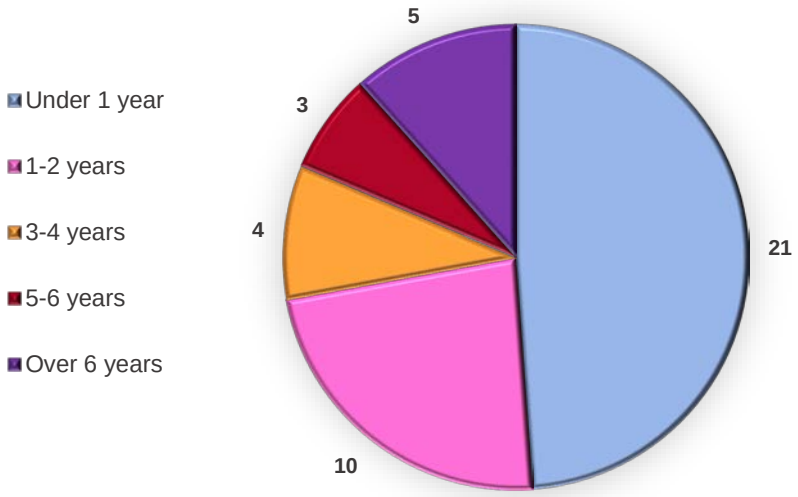


From January 1, 2015 through June 30, 2016, 15 of 42 CIRRT deployments involved five of the six counties where child protective investigations are conducted by sheriff's offices. To date, there have not been any CIRRT deployments to Seminole county. During the second quarter of 2016, CIRRT teams were deployed to both Pasco and Broward counties.



During the 2015 calendar year and first two quarters of 2016, 42 CIRRT reviews were completed. Eighty-four percent of the deployments involved a victim under the age of six. In 73 percent of the reviews, the victim was three years of age or younger. 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 CIRRT Reviews completed from January 1 2015 - June 30, 2016

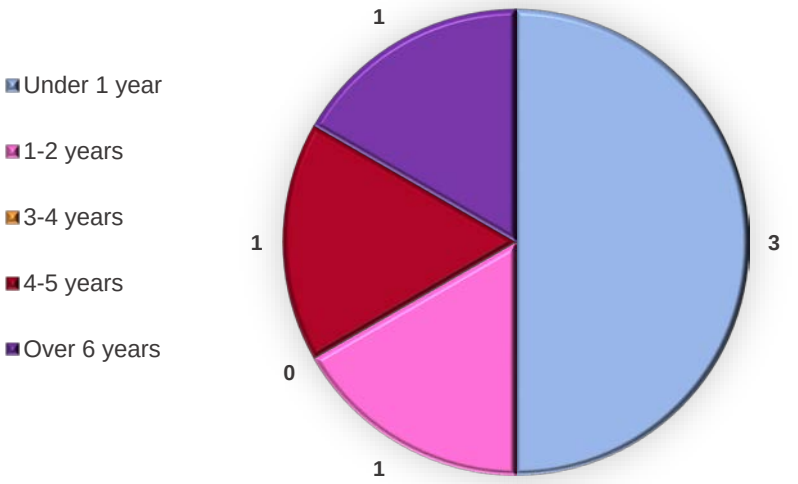


84% of all CIRRT deployments in 2015-2016 involved a child younger than 6-years-old. 49% involved children under the age of one. It is noted that one deployment involved two victims.

n=43

There were five CIRRT deployments in the second quarter of 2016 involving a total of six children age one or younger.

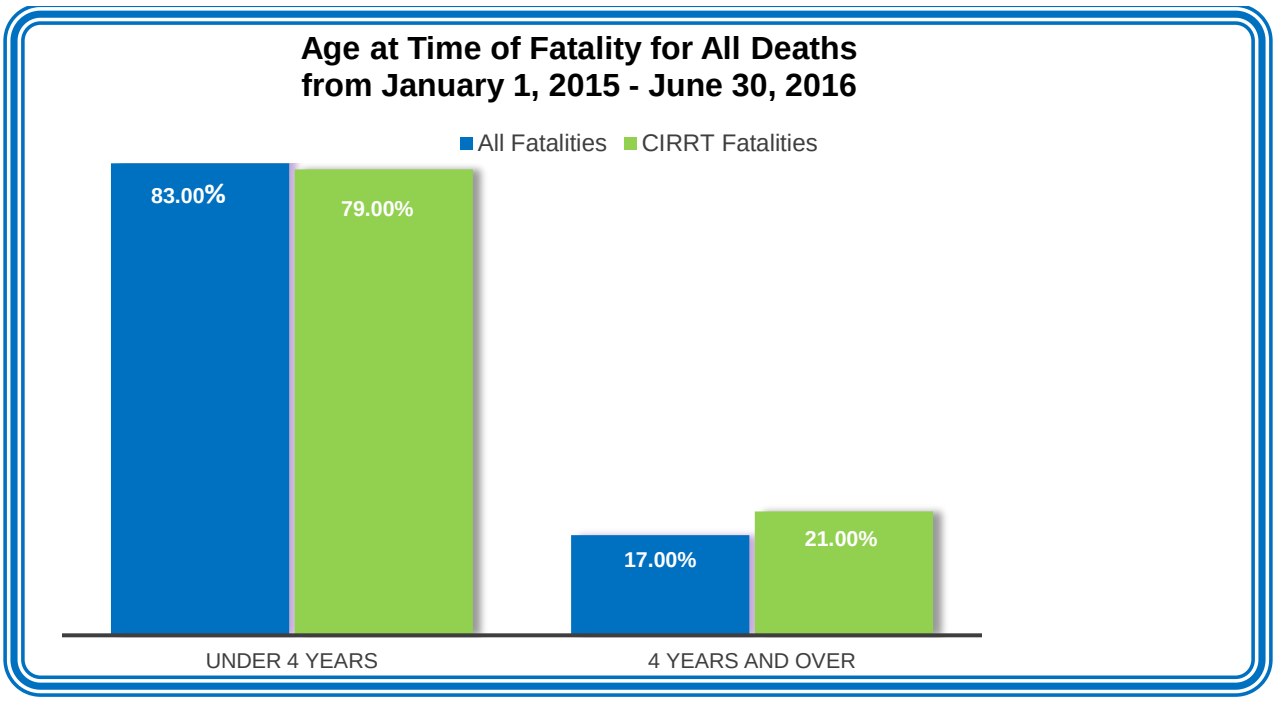
Age of Victim for all CIRRT Reviews completed in 2016 Q2



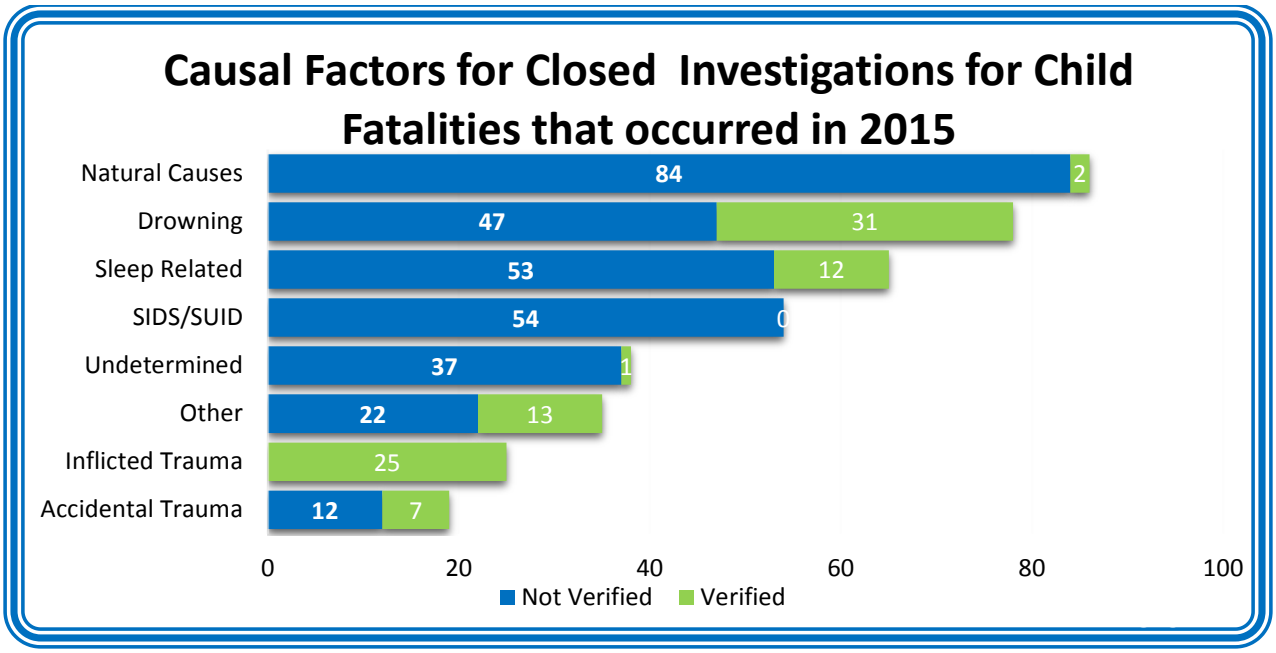
83% of all CIRRT deployments in Q2 2016 involved a child younger than 6-years-old. 50% involved a child under the age of one. It is noted that one deployment involved two victims.

n=6

Of those child fatalities reported to the Florida Abuse Hotline occurring from January 2015 through the second quarter of 2016, 83 percent involved a child under the age of 4. Similarly, 79 percent of all CIRRT deployments involved children in this age range.



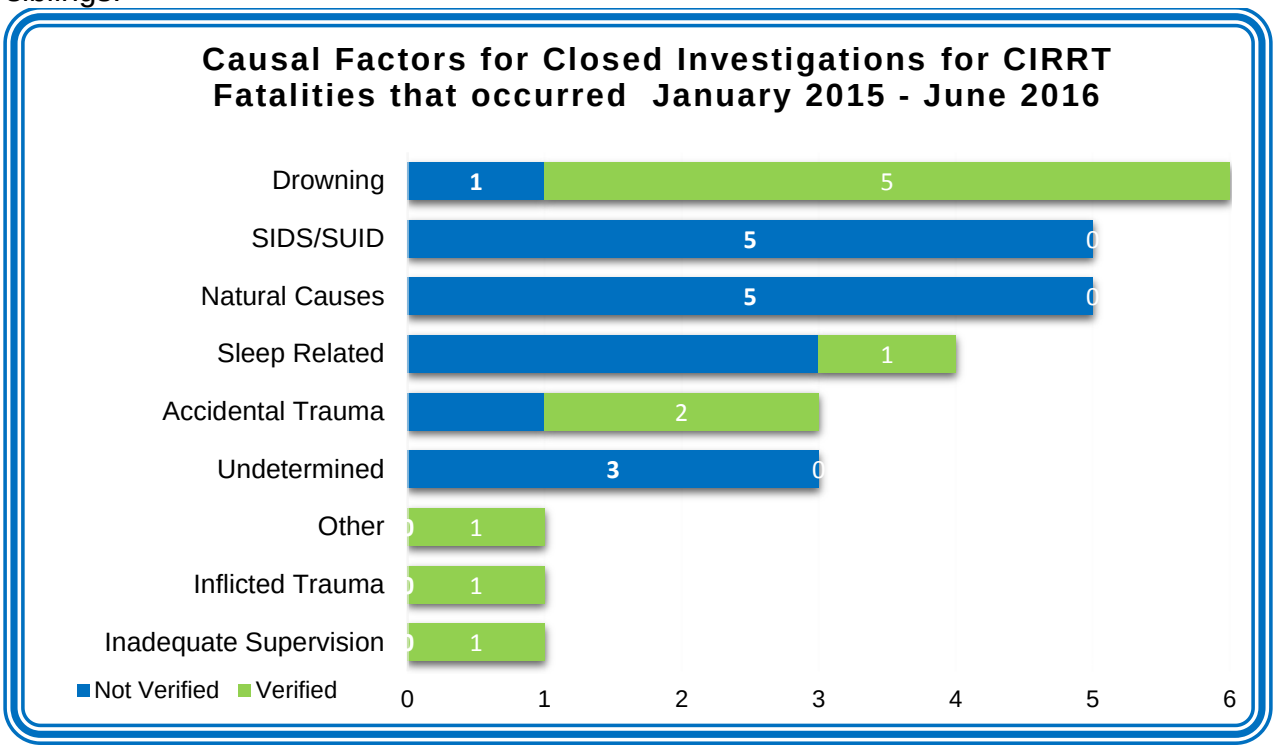
Of the 400 closed child fatalities that occurred in 2015, the four primary causal factors were Natural Causes, Drowning, Sleep Related, and SIDS/SUID. There are a total of 75 child fatality investigations received during this time period that remain open, which, when finalized, will impact the overall numbers and causal factor sequencing.



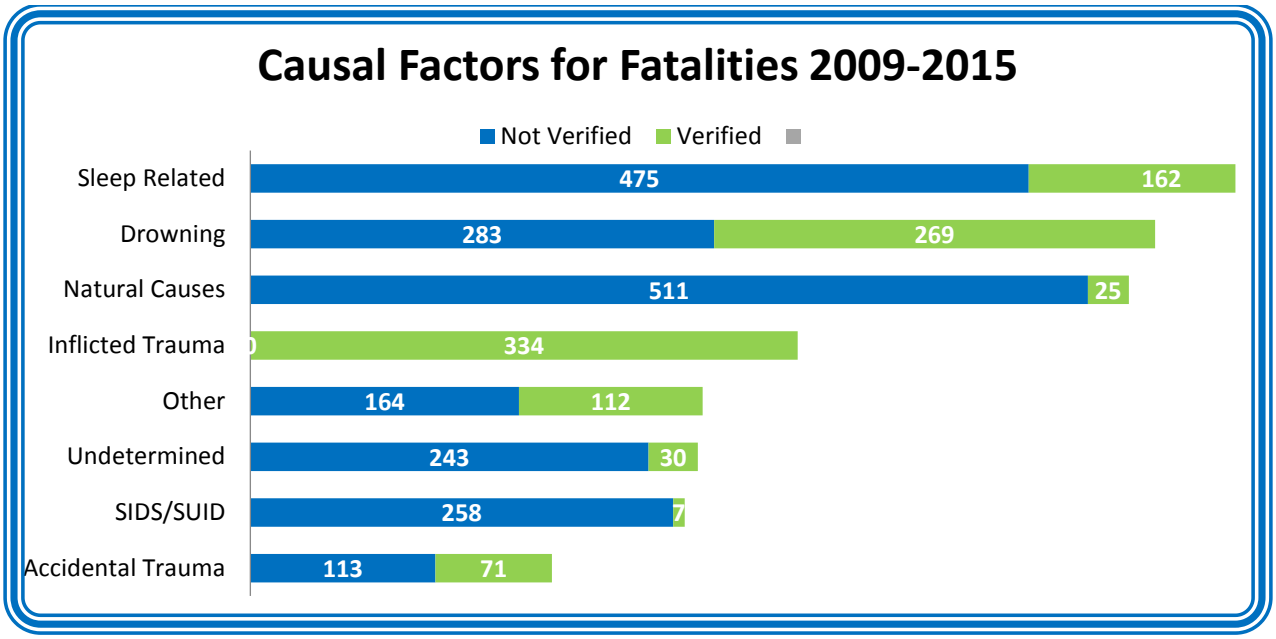
The death maltreatment cannot be used as a stand-alone maltreatment, therefore the underlying maltreatment that may have caused or contributed to the child death is noted. In order for an investigation to be closed with verified findings for the death maltreatment, there must be a preponderance of the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

Between January 1, 2015 and June 30, 2016, there were a total of 42 child fatalities that resulted in a CIRRT deployment. Of the 29 investigations that are closed, 11 (38 percent) investigations had verified findings for the death maltreatment. An additional six investigations were closed with verified findings for a maltreatment other than the death maltreatment. A review of the 42 deployments indicates that 18 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 (637 deaths), Drowning (552 deaths), Natural Causes (536 deaths), and Inflicted Trauma (334 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, complex, 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 should be 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.