**Critical Incident Rapid Response Team Advisory Committee**
**First 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

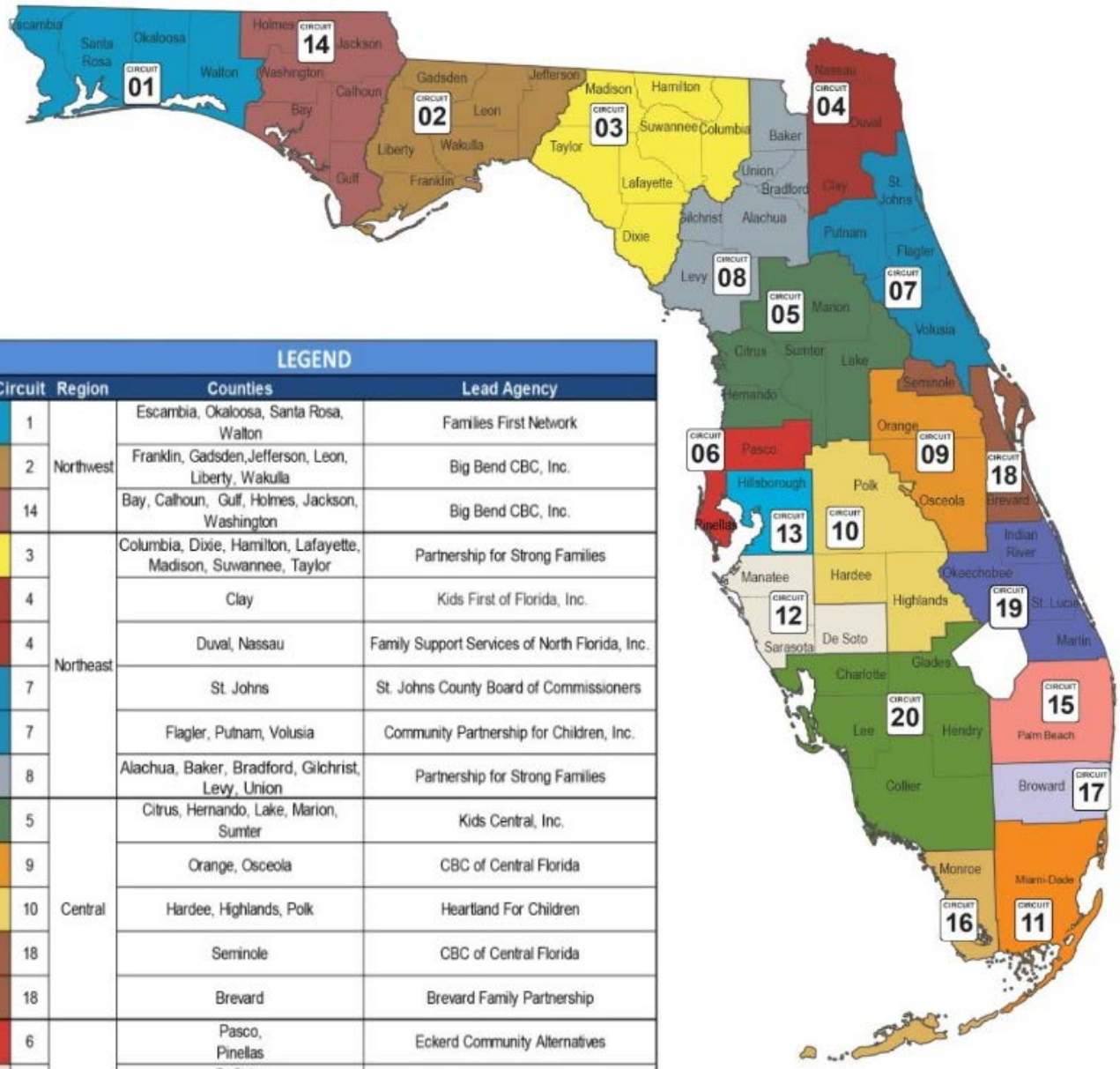
**Florida Department of Children and Families**
**Critical Incident Rapid Response Team**
**Advisory Committee Report**
**April 2016**

## 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



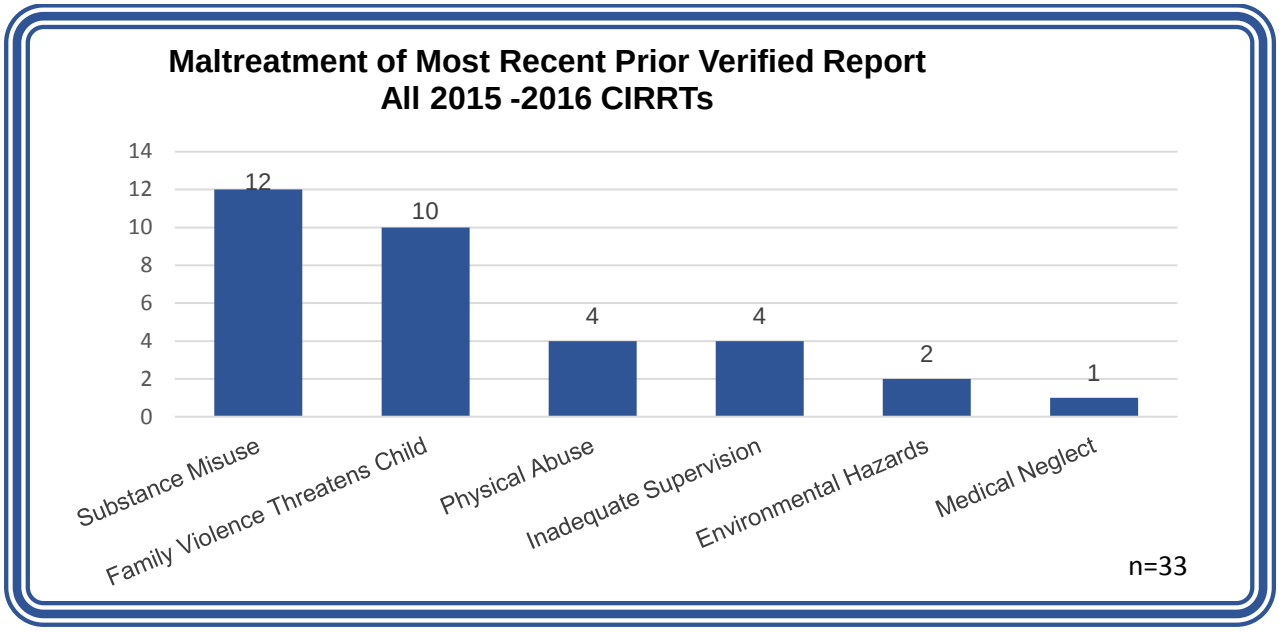

**LEGEND**

| 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 March 31, 2016, CIRRT teams reviewed 37 child fatalities. Of those deployments, 33 met the CIRRT requirements of a having a verified maltreatment within the previous 12 months. Four of the 37 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. The 33 reports meeting the CIRRT requirements for deployment are captured in the chart below.




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 first quarter (January-March) of 2016, there were two CIRRT deployments, with one of the two being a special review which did not have a verified prior within the previous 12 months. For the review with a verified prior within the past 12 months, the maltreatment was inadequate supervision. Inadequate supervision was also the

maltreatment of the most recent prior in the special review which was closed with not substantiated findings. These two reports are a subset of the 37 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 March 2016, in Miami. To date, a total of 342 professionals with expertise in Child Protection, Domestic Violence, Substance Abuse and Mental Health, Law Enforcement, Children's Legal Services, 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 number of individuals trained include the following areas of expertise:

| Expertise | Trained |
|---|---|
| Adult Protective Investigations (DCF) | 1 |
| Child Protective Investigations (DCF) | 95 |
| Child Protective Investigations (Sheriff's Office) | 22 |
| Florida Abuse Hotline | 7 |
| Community-Based Care Lead Agencies (CBC) | 62 |
| Case Management Organizations (CMO) | 8 |
| Domestic Violence | 19 |
| Guardian ad Litem (GAL) | 2 |
| Substance Abuse/Mental Health | 48 |
| 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 March 31, 2016, a total of 185 cases statewide met the criteria for completion of a "mini-CIRRT" review. DCF regional staff has taken on the responsibility of completing the mini-CIRRTs for the sheriff's office cases and are working on completing these reviews.

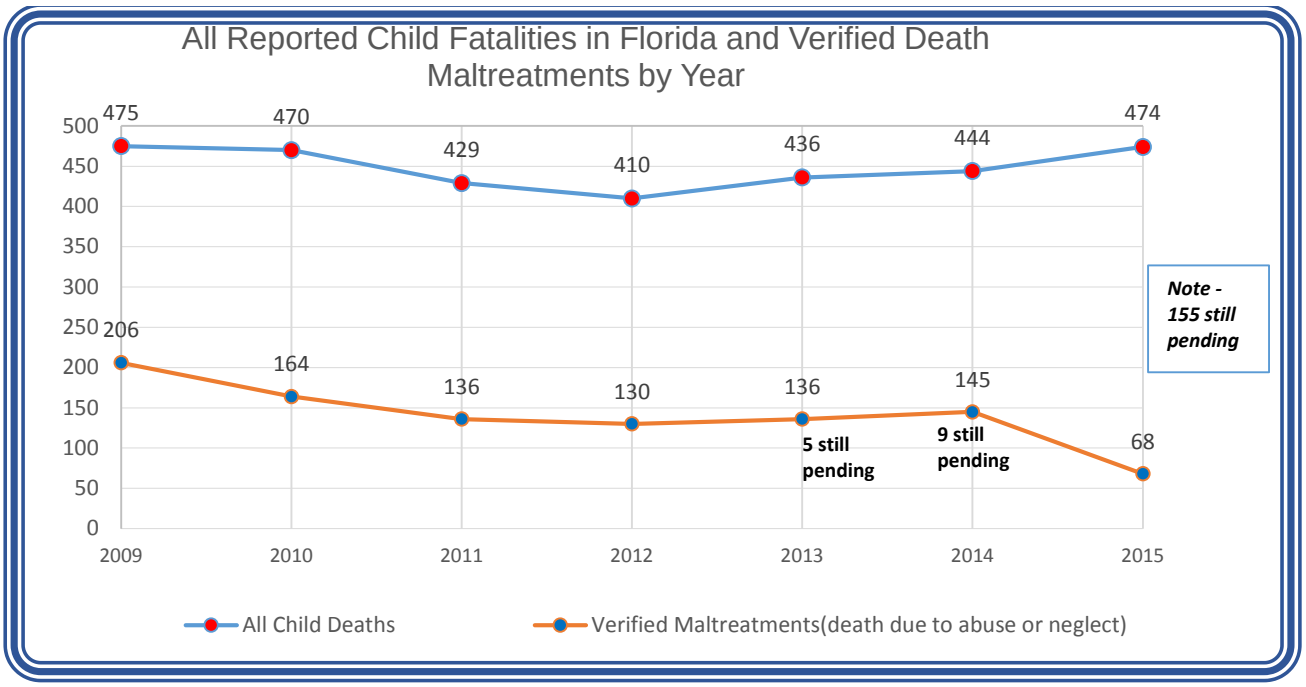
| Special Reviews (Mini-CIRRTs) | | | | |
|---|---|---|---|---|
| **Region** | **Review Required** | **Reports Completed** | **Reports Pending** | **Percentage Complete** |
| Northwest | 23 | 20 | 3 | 86.96% |
| Northeast | 39 | 16 | 23 | 41.03% |
| Central | 57 | 44 | 13 | 77.19% |
| Central Sheriffs | 3 | 2 | 1 | 66.67% |
| Suncoast | 14 | 11 | 3 | 78.57% |
| SC Sheriffs | 22 | 9 | 13 | 40.91% |
| Southeast | 12 | 6 | 6 | 50.00% |
| SE Sheriffs | 10 | 7 | 3 | 70.00% |
| South | 5 | 3 | 2 | 60.00% |
| **DCF Totals** | **150** | **100** | **50** | 66.67% |
| **Sheriff's Total** | **35** | **18** | **17** | 51.43% |
| **Statewide** | **185** | **118** | **67** | 63.78% |

**CIRRT Advisory Committee**

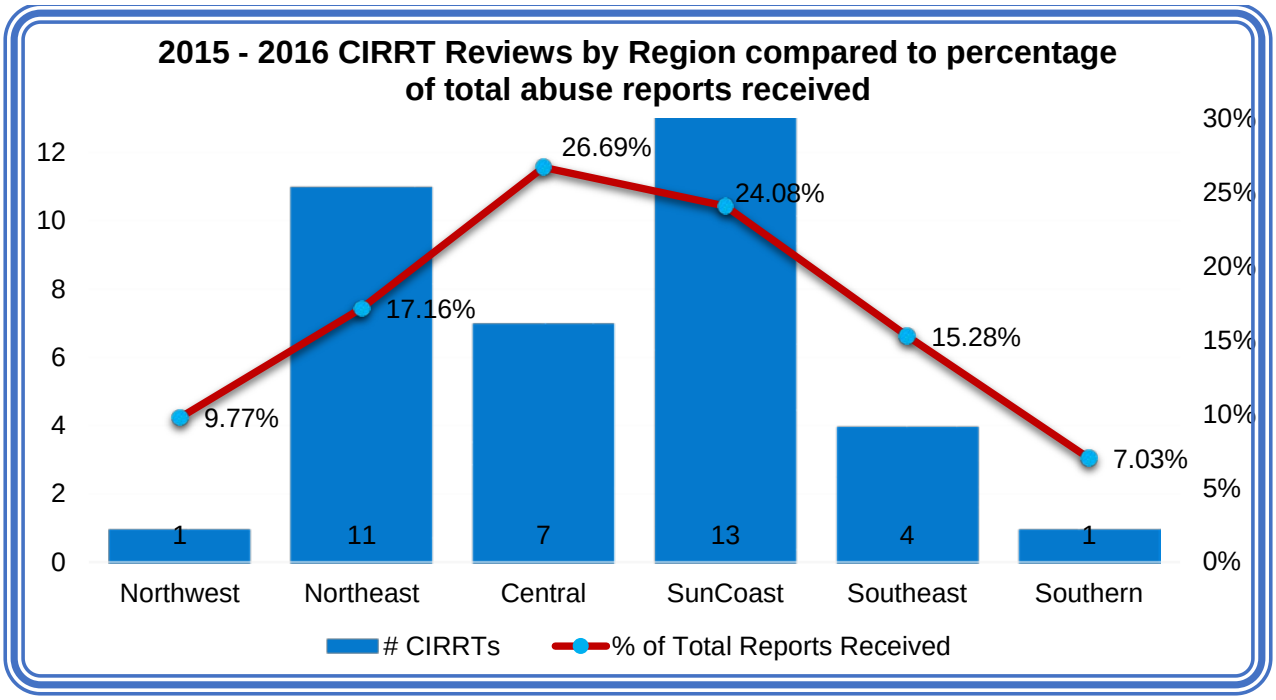
The CIRRT advisory committee is statutorily required to meet on a quarterly basis. The committee met on May 26, 2015, August 26, 2015, November 30, 2015, and February 29, 2016. Advisory committee members may participate via conference call, but are encouraged to attend in person. The meeting notices are published and the meetings are open to the public. The primary focus of the 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 3 or younger and may involve a variety of causal factors, including, but not limited to, sleep related deaths, drownings, natural causes, inflicted trauma, Sudden Infant Death Syndrome (SIDS)/Sudden Unexplained Infant Death (SUID), and accidental trauma.

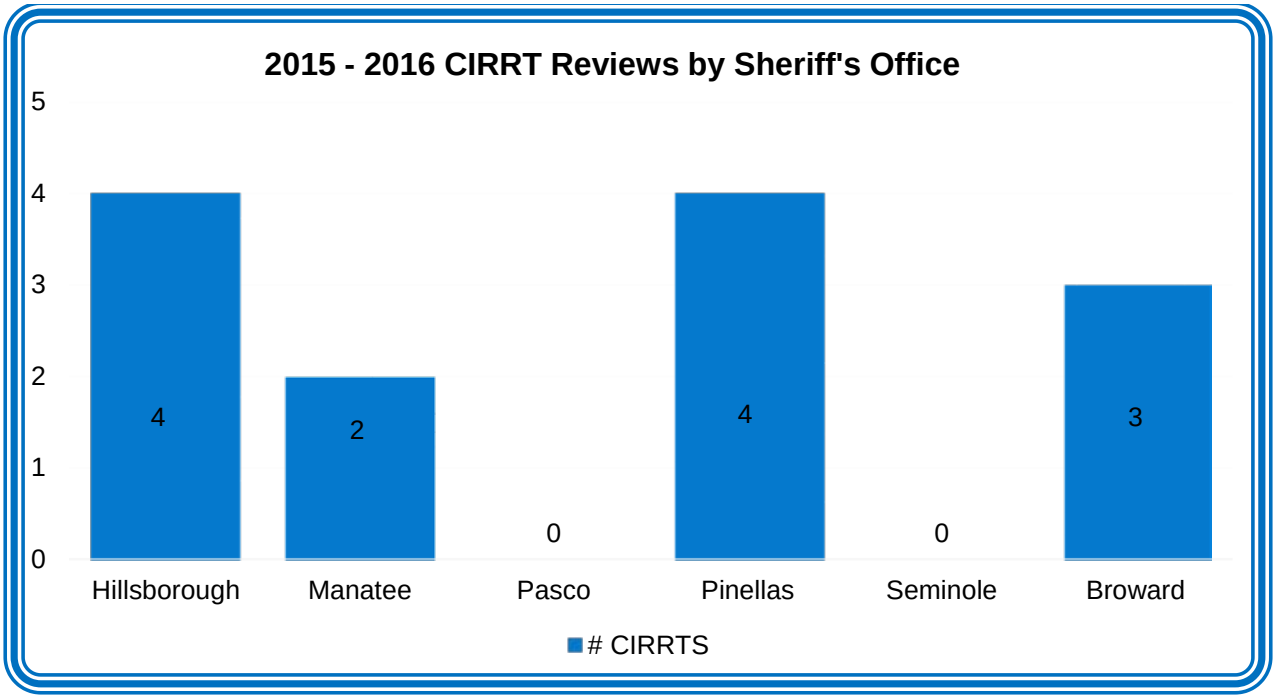



Of the 474 child fatalities that occurred in 2015 and were reported to the hotline, 155 investigations remain open and findings have not yet been determined, which accounts for the appearance of a decline in the number of verified reports. There are five child death investigations from 2013 that remain open. Two of the cases were not reported to the hotline until 2016 and three of the cases remain active at the request of law enforcement officials due to on-going criminal investigations. Additionally, there are nine child death investigations from 2014 that remain open. Four of the cases remain active at the request of the State Attorney's Office and/or law enforcement due to on-going criminal proceedings; another four cases remain active as the medical examiner's report is pending; and one case needs to be staffed for closure, which had not yet occurred at the time of this report.

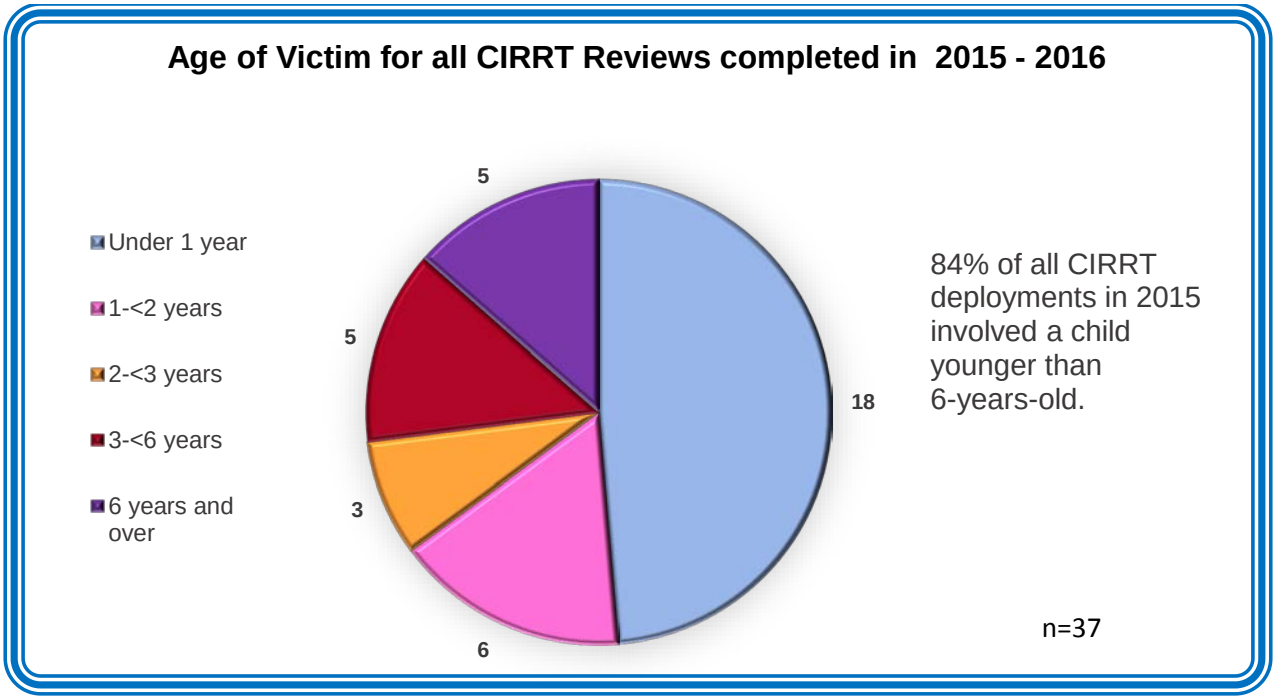



During the 2015 calendar year and first quarter of the 2016 calendar year, there were a total of 37 CIRRT deployments, with at least one deployment in each of the six regions. The SunCoast and Northeast Regions accounted for 65 percent of the deployments, while receiving 41 percent of all abuse investigations during the past 15 months.

There were two CIRRT deployments during the first quarter of 2016, one each in the Northeast and Central regions. Both deployments occurred in counties where the department was responsible for the completion of child protective investigations.

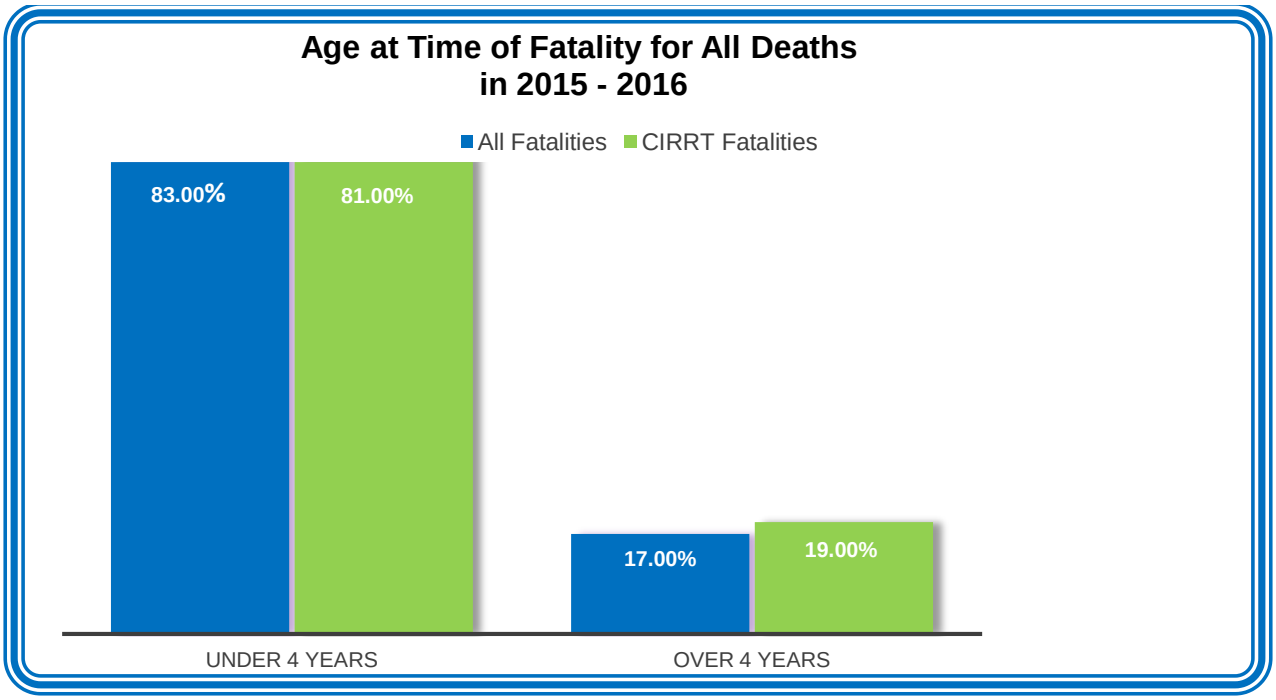



From January 1, 2015 through March 31, 2016, 13 of 37 CIRRT deployments involved four of the six counties where child protective investigations are conducted by sheriff's offices. To date, there have not been any CIRRT deployments in Pasco and Seminole counties. During the first quarter of 2016, CIRRT teams were not deployed to counties where sheriff's offices conduct child protective investigations.

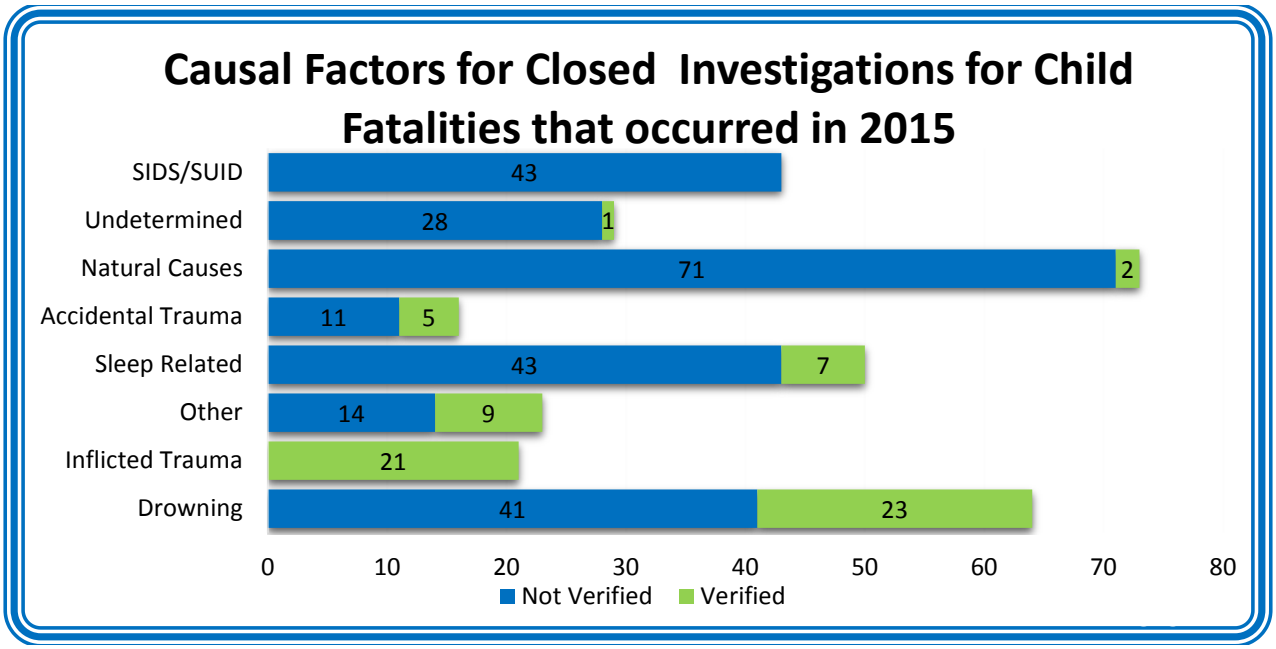


During the 2015 calendar year and first quarter of 2016, 37 CIRRT reviews were completed, and 84 percent of those deployments involved a victim under the age of six. In 73 percent of the reviews, the victim was three years of age or younger. This is consistent with child deaths statewide in which younger children are more vulnerable to being victims of abuse and neglect.

There were two CIRRT deployments in the first quarter of 2016 involving children age one or younger.

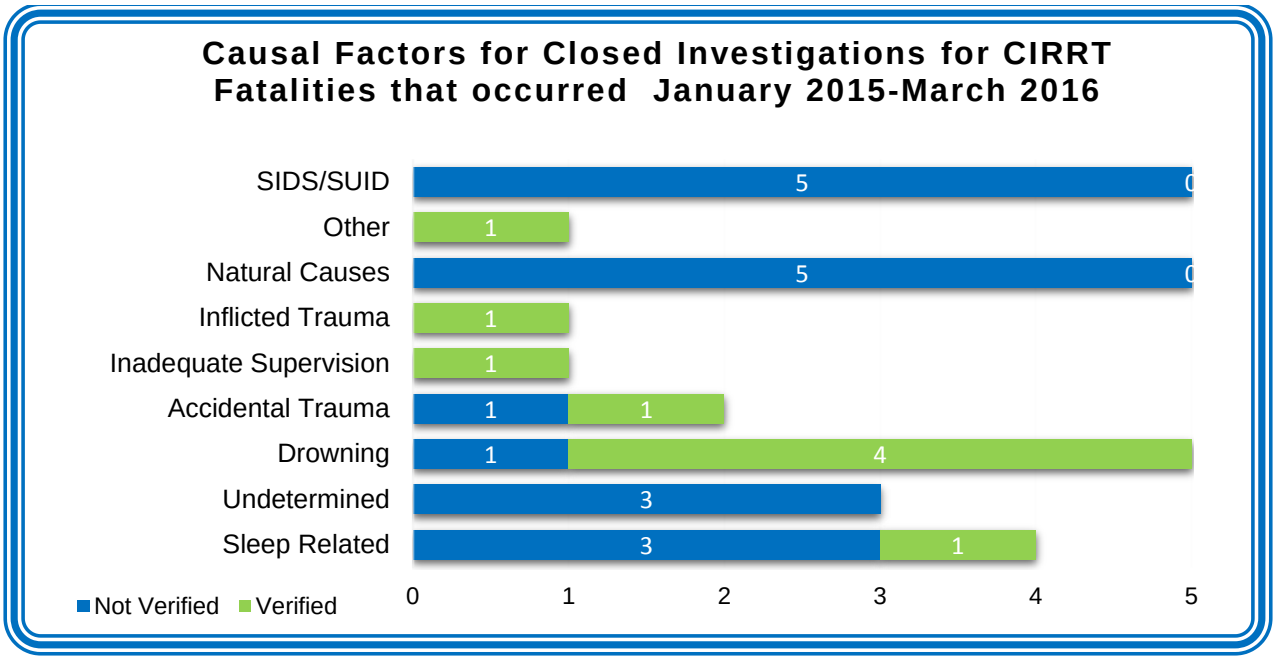



The majority, 83 percent, of child death reports to the Florida Abuse Hotline occurring from January 2015 through the first quarter of 2016, involved a child under the age of 4. Similarly, 80 percent of all CIRRT deployments involved children in this age range.

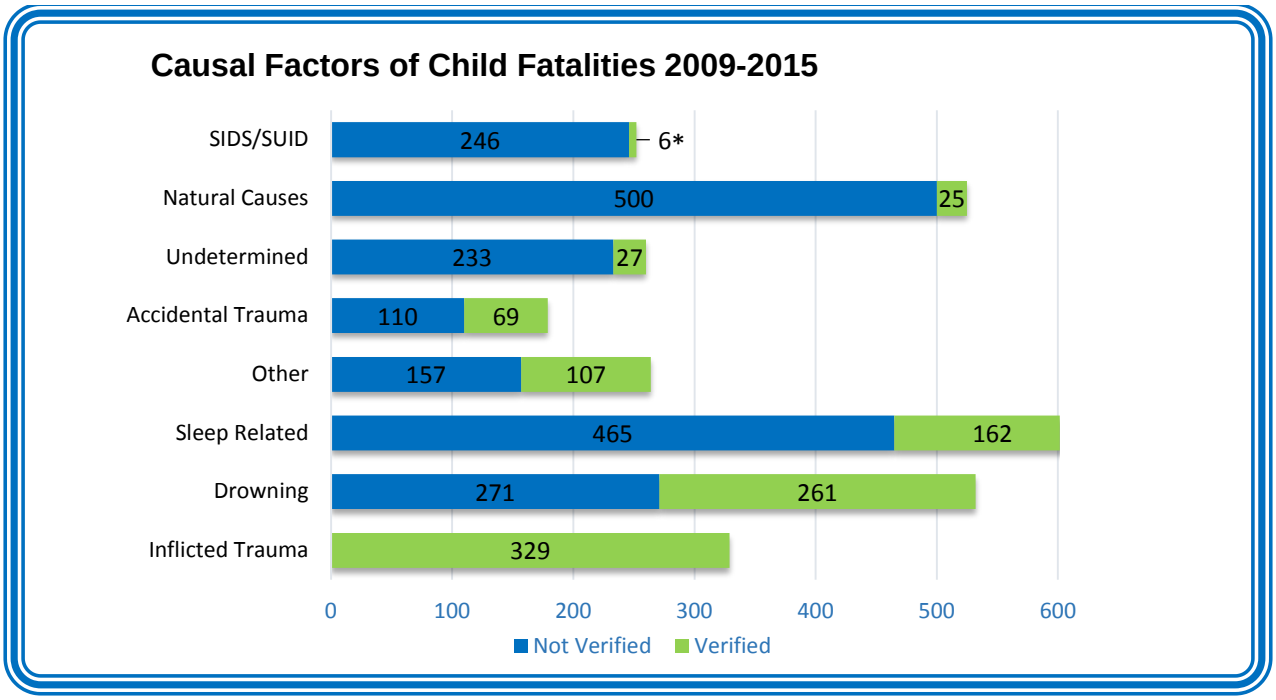



Of the 319 closed child fatalities that occurred in 2015, the four primary causal factors were Natural Causes, Drowning, Sleep Related, and SIDS/SUID. There are a total of 155 child fatality investigations received during this time period that remain open, which, when finalized, will impact the overall 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. 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 March 31, 2016, there were a total of 37 child fatalities that resulted in a CIRRT deployment. Of the 27 investigations that are closed, nine (33 percent) investigations had verified findings for the death maltreatment. An additional six investigations were closed with verified findings for maltreatment other than the death maltreatment. A review of the 37 deployments indicates that 17 cases, or 46 percent, of the deployments involved children under 1 year of age who were found unresponsive in their crib/bassinet or after sleeping with an adult caregiver and/or siblings.




Between 2009 and 2015, the four leading causal factors of child fatalities reported to the Florida Abuse Hotline were Sleep Related (627 deaths), Drowning (532 deaths), Natural Causes (525 deaths), and Inflicted Trauma (329 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-needy children, as well as deaths due to previously undiagnosed medical issues. Intake reports are accepted by the hotline for investigations when a child under the age of 5 is found deceased outside of a medical facility and there is no indication of a known medical condition or a clear reason for trauma, such as a car accident. When a child dies in a hospital and abuse or neglect is suspected, or if the circumstances surrounding the death are unclear, an intake report for "Death" will be accepted by the hotline for investigation. The most common contributing factors of child fatalities coded as "other" are suicide and infants accidentally left in a hot car.

* 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.

## Emerging Themes

Emerging themes in each of the three main CIRRT report categories have been identified:

### Practice Assessment

- Child protective investigators continue to struggle with making thorough assessments based on gathering, reconciling, and analyzing all available information regarding families, including prior abuse and criminal history.
- In many of the cases, information-sharing between agencies, both internal and external, serving the same families were not timely or thorough and lacked the effective use of multi-agency staffings as a resource to share information. Internal agencies include child protective investigations, child legal services, and the hotline. External partners include case management organizations, out-of-county service providers, domestic violence, diversion, substance abuse, and mental health providers.
- Issues related to implementation of Florida's new child welfare practice and fidelity to the new practice, including a lack of adequate safety planning to control identified danger threats, have been a common theme in CIRRT reviews.

Recommendation: A more involved process evaluation associated with information collection, dissemination, and analyses should be conducted in those areas or units where these themes are identified and validated as an issue. It is important to determine if the same practice themes are manifested (or reported) in closed cases within the past 12 months for which there is no child fatality. Toward this end, it may be of value to engage in more critical statistical analyses using cohorts of cases for which maltreatment was verified within the previous 12 months to identify if themes denoted with CIRRT cases (where there is a child death) are parallel with non-CIRRT cases. These analyses will help determine whether systemic or more targeted administrative interventions are needed to address practice assessment themes/issues.

### Organizational Assessment

Overall, for CIRRTs completed in 2015, high turnover and an inexperienced workforce were common themes noted in the reviews. For the five CIRRTS completed during the fourth quarter of CY 2015, the experience and stability of the workforce was not an issue in the majority of the reviews.

Recommendation: A detailed analysis of this theme needs to take place so that there can be an identification of the representative validity of this theme associated (qualitatively) with CIRRT cases to non-CIRRT cases. There needs to be a more specific itemization of the factors associated with the recruitment and turnover of competent workers that administrative interventions could target.

## Service Array

Although appropriate services are generally available within the community and system of care, subject matter experts are underutilized, resulting in families not receiving the appropriate level of services to address complex family needs. A lack of effective communication and multi-agency staffings when families stop cooperating or engaging with service providers were also identified as an issue.

Recommendation: Given that these themes have been identified with CIRRT cases only, it may be that these themes are contributing factors to the system's ability to prevent select child fatalities or the discrete choices of staff and supervisors when deciding how and when to intervene, or continue with protective interventions, with select cases/families. Further analysis will need to be conducted. In addition, the department needs a process to accurately identify and track how many families have received Substance Abuse and Mental Health treatment. It would also be important to know more about these systems, such as date of referral, waiting lists, in-patient/out-patient service availability, begin date of service, and end date of service. Conducting a thorough service mapping throughout the state will be explored.

## Immediate Operational Response

Although continued collection and analysis of findings and data are needed regarding the CIRRTs completed during the past quarter, some local actions have already been implemented. One of the two CIRRTs completed during the current quarter resulted in immediate operational response. Actions taken included a review of all open second-level reviews pending by the Critical Child Safety Practice Experts in the area, as well as reviewing cases referred to a prevention program which is co-located with the child protective investigators. Additionally, relevant operating procedures, protocols, and the Memorandum of Agreement were reviewed and updated and weekly meetings between the provider and the department have been implemented to discuss outstanding cases.

Other local responses include establishing new child protective investigations leadership teams and development of more robust multidisciplinary protocols to enhance communication and collaboration. The department's Assistant Secretary of Operations Vicki Abrams has required that local action plans which address findings be developed for each CIRRT. Response and interventions are recorded and tracked for Practice, Organizational, and Service Array findings.

Issues related to implementation of Florida's new practice model and fidelity to the new practice continue to be common in the majority of CIRRT reviews. In response, the department has established a process to embed practice experts in each region to provide necessary decision-making support to frontline staff. A total of 38 existing positions were identified statewide to become Critical Child Safety Practice Experts (CCSPE). The department has contracted with Action for Child Protection to administer a proficiency process to ensure CCSPEs are subject matter experts in the new practice model and have the knowledge, skills, and abilities necessary for case analysis and

feedback. This process identifies a broad set of proficiency areas in the safety methodology, case consultation, feedback, and training.

The Office of Child Welfare will continue to work with SAS and North Highland to develop additional advanced analytics models to study maltreatment risk among the children known to the child welfare system. The work conducted so far has analyzed actual case data over five years to quantify the risks that children face and to understand how the agency can make policies and improve practice to mitigate, and where possible, remove those risks. Future work will include a strategy to incorporate analytics into daily practice to provide data-driven insights to child welfare workers in the field so they can make more-informed decisions, resulting in better outcomes for children.

## Process Towards Implementation

To ensure timely implementation of CIRRT findings, each region has included improvement actions into existing Child Welfare plans to address opportunities that were identified from state office regional site visits that assessed use of practice and service array.

In an effort to strengthen decision-making and critical thinking skills, each region is implementing a method for providing decision support to CPIs on high-risk cases and present danger cases through Decision Support Teams, which may include legal and external partners in the consultation.

Deputy Secretary Dr. David Fairbanks is chartering a project team to create a Client Data Link System policy which will allow department users to access client level data across programs and will address barriers in accessing client information.

## 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 also 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.