

**Critical Incident Rapid Response Team Advisory Committee
First Quarter Report for Calendar Year 2020**



Chad Poppell
Secretary

Ron DeSantis
Governor

Mission: Work in Partnership with Local Communities to Protect the Vulnerable,
Promote Strong and Economically Self-Sufficient Families, and Advance Personal and
Family Recovery and Resiliency

**Florida Department of Children and Families
Critical Incident Rapid Response Team
Advisory Committee Report
First Quarter 2020**

I. Background

In 2014, the Florida Legislature passed section 39.2015, Florida Statutes, which established requirements for creating a Critical Incident Rapid Response Team (CIRRT), effective January 1, 2015 (see Appendix 1-2 for more details).

II. Purpose

CIRRT reviews provide an immediate, multiagency investigation of child deaths that meet the statutory criteria for review or other serious incidents at the Secretary's discretion. Reviews are conducted in an effort to identify root causes, rapidly determine the need to change policies and practices related to child protection and improving Florida's child welfare system. CIRRT reviews take into consideration the family's entire child welfare history, with specific attention to the most recent child welfare involvement and events surrounding the fatality, including the most recent verified incident of abuse or neglect.

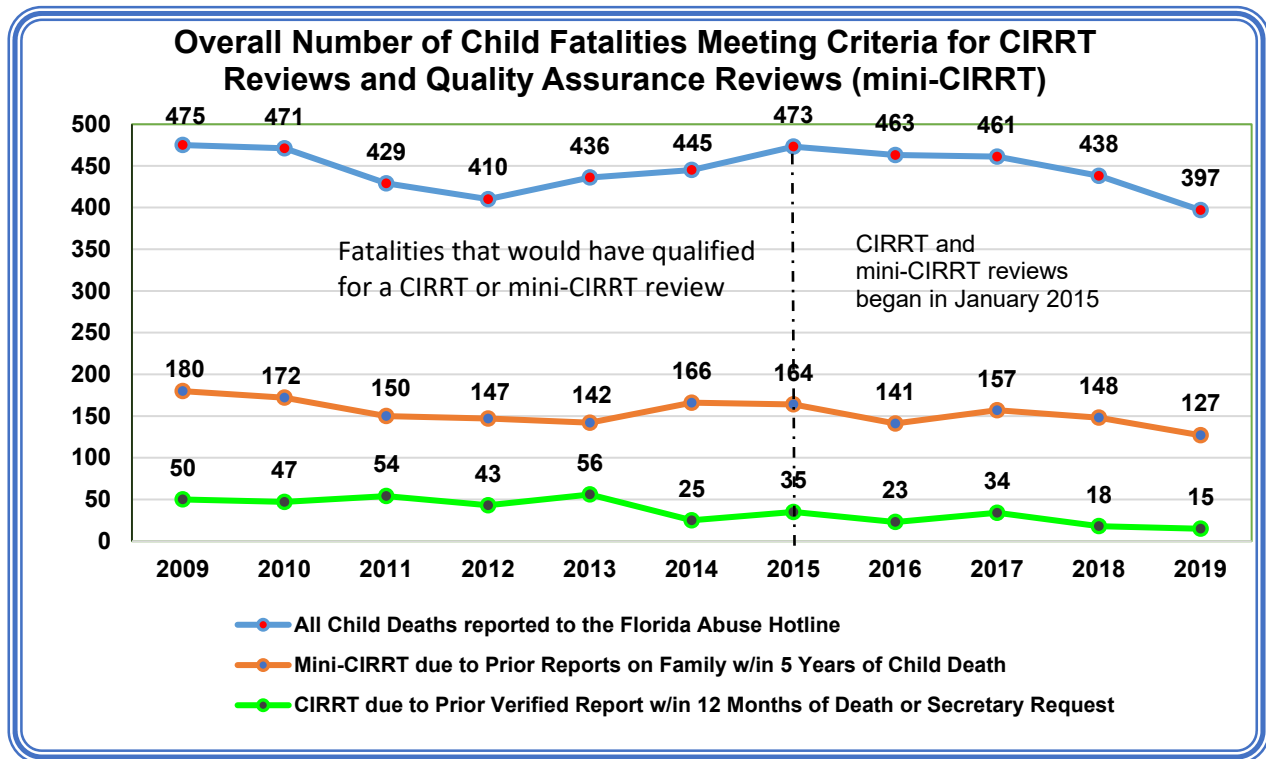
III. Review of Child Fatality Data

From January 1, 2015, through March 31, 2020, a total of 128 CIRRT teams were deployed involving 130 child deaths. Of those deployments, 122 met the CIRRT requirement of having a verified report within the previous 12 months, while the other six reviews were completed at the direction of the Secretary. Of the six remaining deployments, three involved a recent history of physical abuse, two involved a recent history of substance misuse, and one team was deployed as there was an active investigation when the fatality occurred.

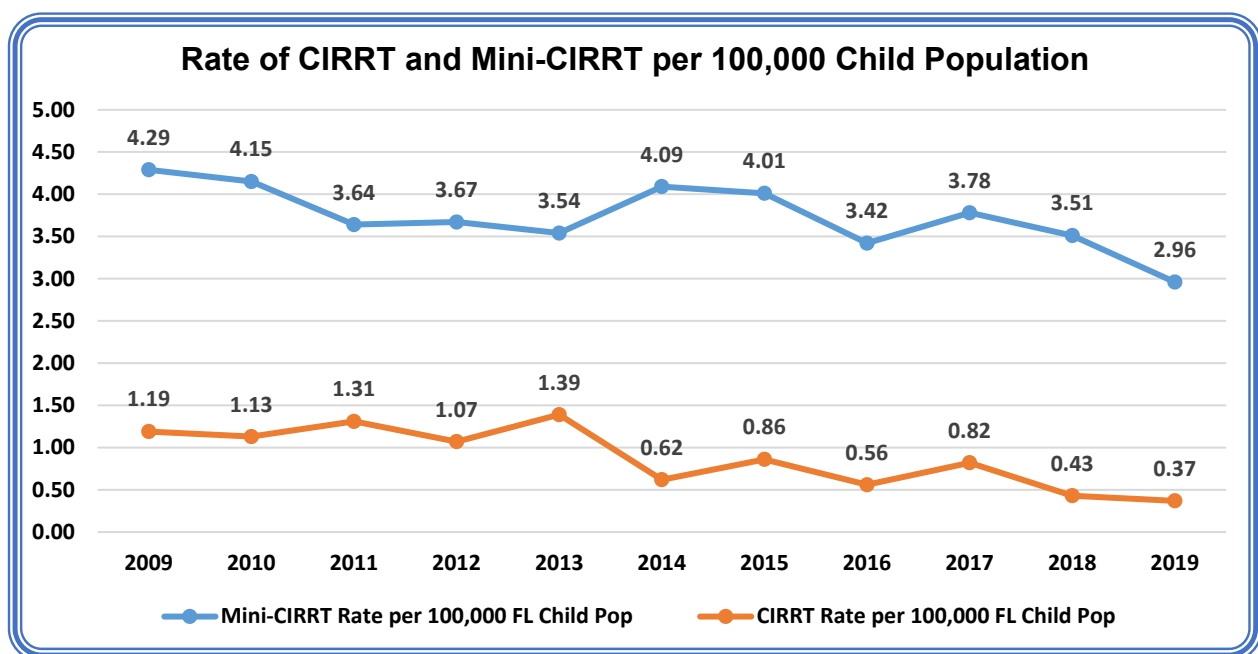
Since January 1, 2015, the fatalities resulting in a CIRRT deployment represent five percent of the overall fatalities reported to the Department of Children and Families' (department) Florida Abuse Hotline (Hotline). An additional 33 percent of the fatalities reported to the Hotline met the criteria for a mini-CIRRT or special review (see Appendix 3). It should be noted that the chart below reflects the number of actual child fatalities. Some cases involve multiple victims; however, only one respective review was conducted.

Between January 1 and March 31, 2020, there were 116 fatalities called in to the Florida Abuse Hotline. Of those 116 cases, 44 met the criteria for either a CIRRT deployment (5) or mini-CIRRT or special review (39). For the five CIRRT cases, there was no prior history involving the deceased child in only one (20 percent) of the cases. In the 39

cases that met the criteria for a mini-CIRRT review, there was no prior history involving the deceased child in 20 (51 percent) of the cases.



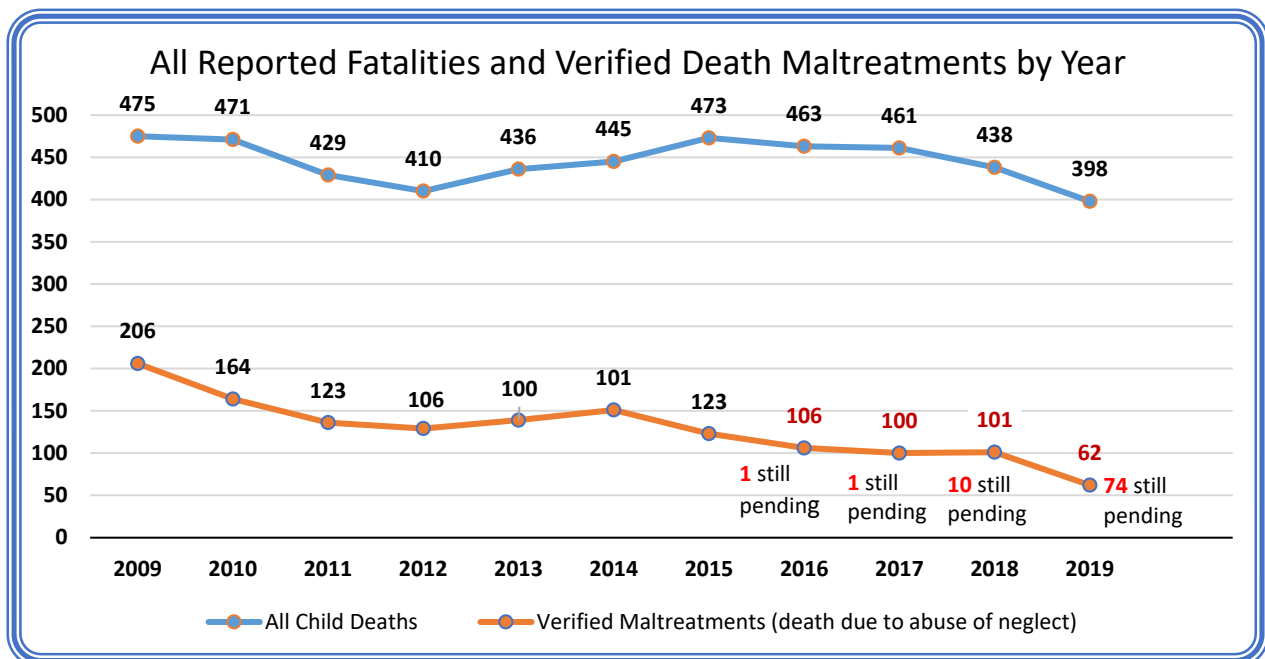
The rate of occurrence for fatalities meeting the requirements for CIRRT deployments and mini-CIRRT reviews has shown a slight but continual decrease since 2017.



Standardized data is collected across all review types and entered into Qualtrics for further analysis and review. Reports on reviews conducted as a result of a child fatality (regardless of the type of review completed) are redacted according to Florida Statutes and posted for public review on the department's Child Fatality Prevention website (<http://www.dcf.state.fl.us/childfatality/>) after the death investigation has been completed. According to Florida Statutes, the information redacted is based on whether the death maltreatment has been verified by the department as a result of caregiver abuse or neglect. Reports listed on the website as "pending" are awaiting closure of the death investigation and, at times, the medical examiner's findings.

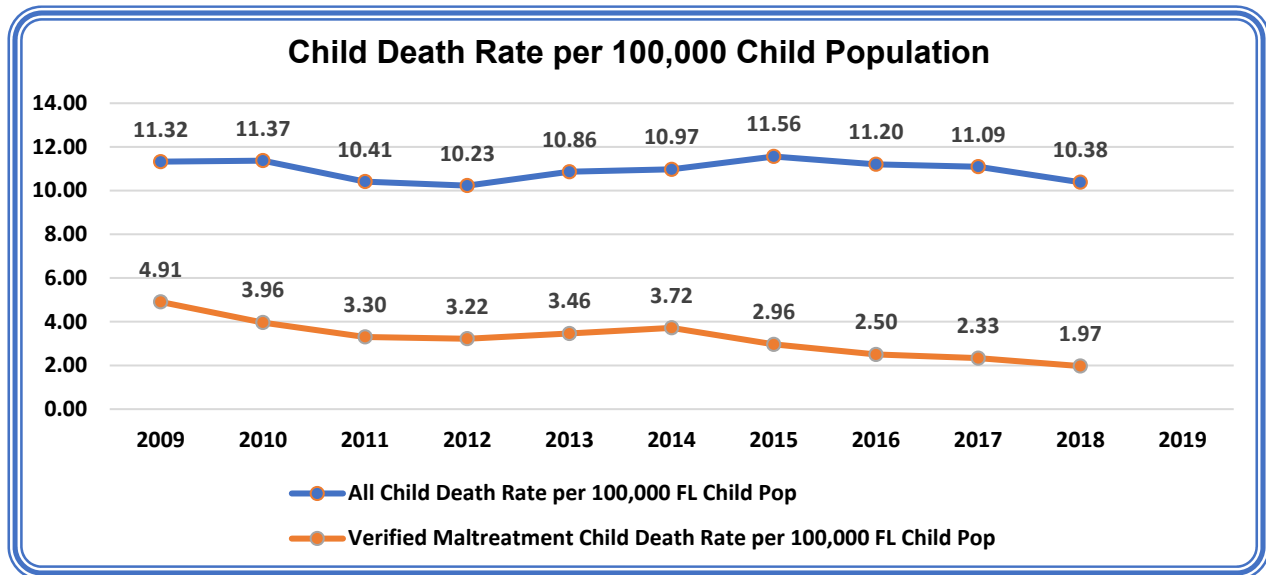
Child deaths in Florida typically involve a child age three or younger and may involve a variety of causal factors including, but not limited to: sleep-related deaths, drownings, natural causes, inflicted trauma, Sudden Infant Death Syndrome (SIDS)/Sudden Unexplained Infant Death (SUID), and accidental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

Of the 1,397 child fatalities that occurred during the 2015-2017 calendar years and were reported to the Hotline, two (2) remain open at the request of law enforcement/state attorney due to on-going criminal proceedings. For the 438 child fatalities that occurred in 2018 and were reported to the Hotline, 10 currently remain open. The death maltreatment verification rate has ranged between 22 percent and 26 percent of cases received for the given year. It should be noted that current year 2019 is not included in those averages, as there are still 74 cases that remain open that, when closed, will likely have an impact on the overall percentage for that year.*



* 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. This is especially true for the 2019 data given the number of cases that currently remain open.

While the child death rate per 100,000 child population has remained flat over the past ten years, the rate of verified child death maltreatments per 100,000 child population reflects a downward trend.



*It is important to note that there are still 10 outstanding investigations for 2018 which, when closed, may impact the overall verification rate for that year. The data for 2019 is not yet reflected given the number of cases that currently remain open.

III. Review of CIRRT Data

a. Summary of First Quarter CIRRT Reports

During the first quarter, there were five CIRRT deployments in four different regions, two in Central, and one in each of the following regions: Southeast, Southern and Northwest. Two deployments (one in Broward County in the Southeast Region and one in Walton County in the Northwest Region), were in counties where the sheriff's office is responsible for completing child protective investigations. The remaining three deployments occurred in Marion, Polk, and Miami-Dade Counties where the department is responsible for child protective investigations.

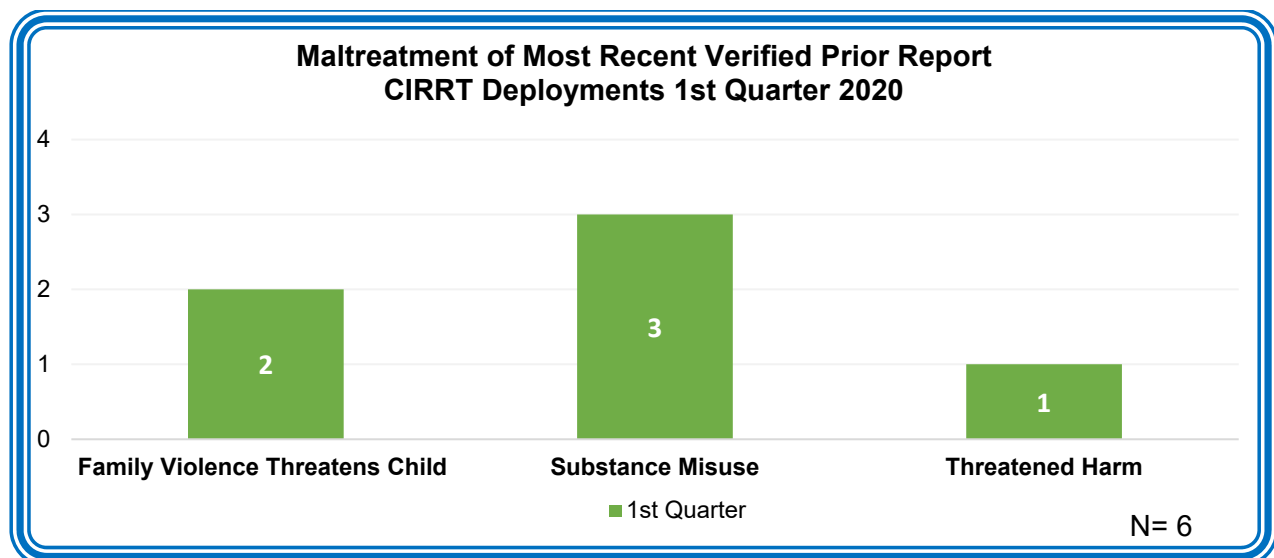
Four of the five deployments involved infants that were found unresponsive. The Marion County deployment involved a 3-month-old infant who was found unresponsive while sleeping in a play-pen underneath a blanket. The Miami-Dade deployment involved a 3-month-old infant who was found unresponsive while sleeping with his 9-year-old sibling.

The Walton County deployment involved a 4-month-old infant who was found unresponsive on an adult bed where he was placed to sleep alone. The Polk County deployment involved a 2-month-old infant who was discovered unresponsive in an infant

swing where she was placed to sleep. The Broward County deployment involved a 7-month-old who sustained unexplained injuries while in the care of a court-ordered non-relative caregiver. In four of the five cases, the infants were receiving child welfare services at the time of the respective fatality; however, only one decedent was the subject of a prior verified report.

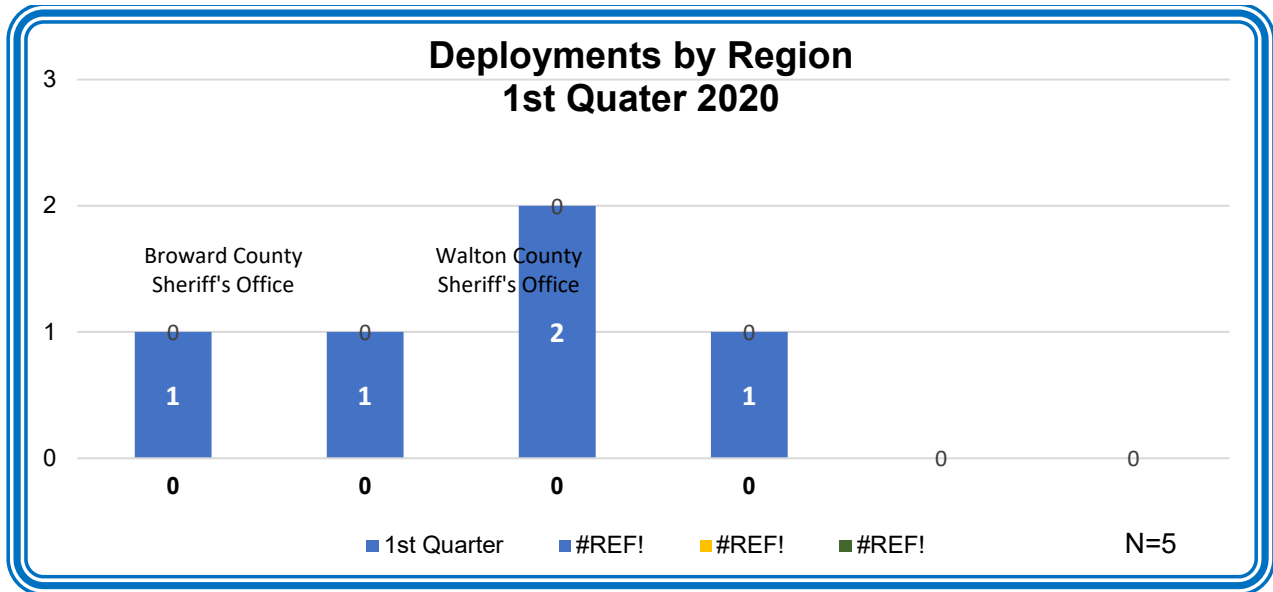
b. Past Maltreatment

During the first quarter of 2020, there were five CIRRT deployments, involving five victims, each with a verified prior report on the victim or a sibling within the previous 12 months. There was one deployment with a prior verified maltreatment of threatened harm, one deployment with a prior verified maltreatment of family violence threatens child, two deployments each with a prior verified maltreatment for substance exposed newborn, and one deployment with prior verified maltreatments of substance misuse and family violence threatens child.



CIRRT Data by Region

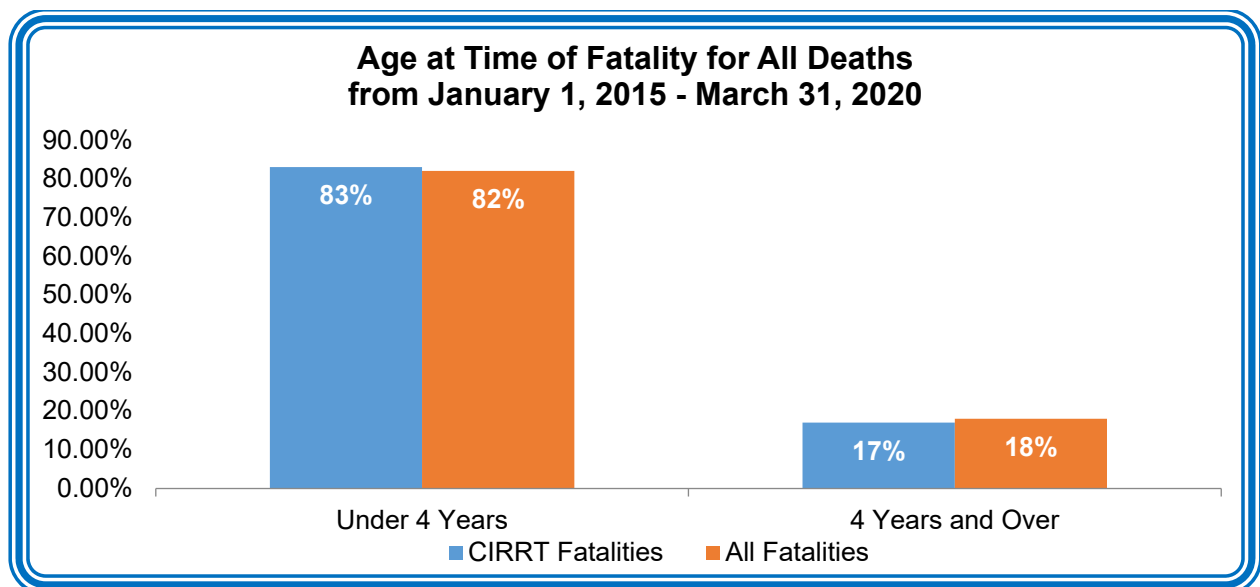
From January 1 through March 31, 2020, there were five CIRRT deployments, involving five victims, in four of the six regions. There were two deployments to the Central Region, and one deployment each, to the Northwest, Southeast, and Southern regions. The deployments to both the Northwest Region (Walton County) and the Southeast Region (Broward County), were areas where the respective sheriffs' office conducts child protective investigations. The department is responsible for the completion of child protective investigations in the other three counties where teams were deployed.



c. Age of Victim

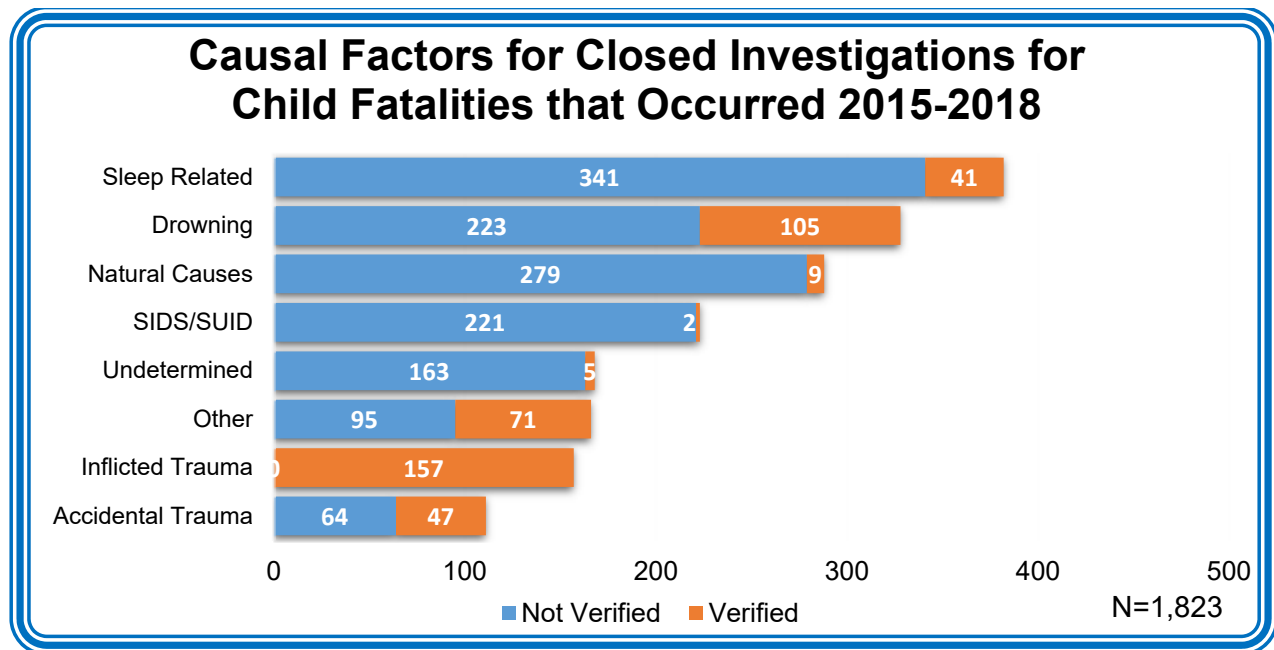
During the first quarter of 2020, there were a total of five (5) CIRRT deployments involving five victims. All five victims were under the age of one year and ranged between two (2) and seven (7) months of age.

It is interesting to note that the percentage of child fatalities reported to the hotline and those meeting the requirement for a CIRRT review remain extremely close, if not the same, of which children under the age of four years are the majority.



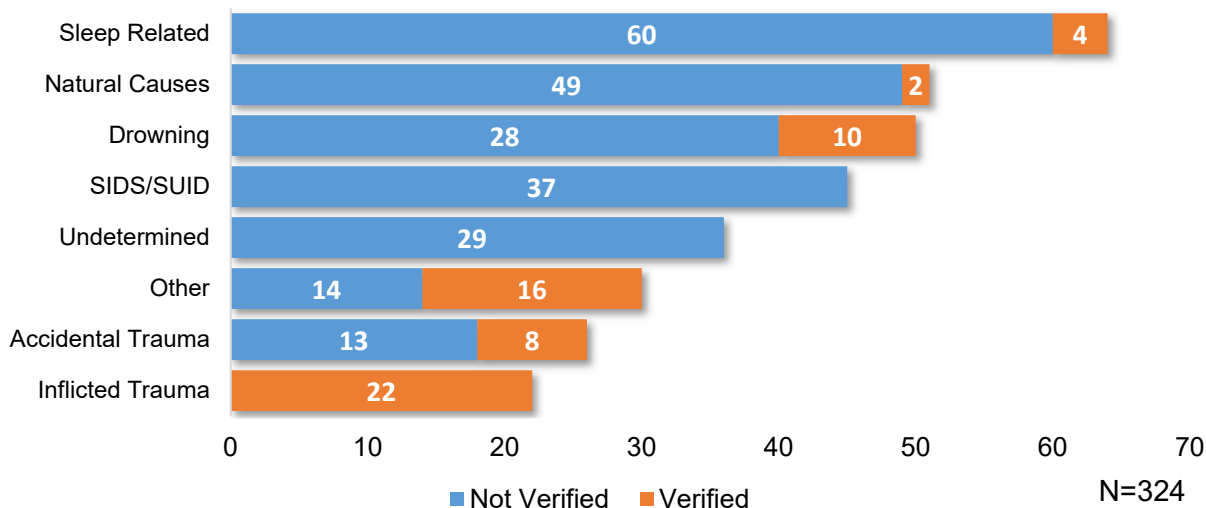
d. Causal Factors

Of the 1,823 closed child fatalities that occurred from January 1, 2015, to December 31, 2018, the four primary causal factors were sleep-related, drowning, natural causes, and SIDS/SUID. There are 12 child fatality investigations received during that time period that remain open. When finalized, they will have a slight impact on the overall numbers; however, there will be no change regarding the four primary causal factors.



Of the 324 closed child fatalities that occurred in 2019, the four primary causal factors were sleep-related, natural causes, drowning, and SIDS/SUID. There are still 74 child fatality investigations received during this time period that remain open, which, when finalized, will impact the overall numbers and causal factor ranking.

Causal Factors for Closed Investigations for Child Fatalities that Occurred in 2019

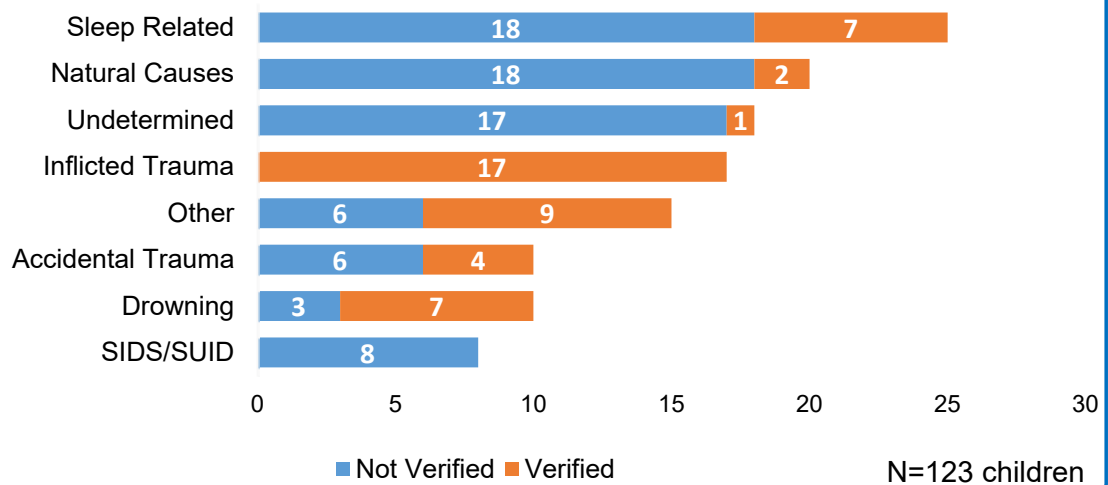


The death maltreatment cannot be used as a stand-alone maltreatment; therefore, the underlying maltreatment that may have caused or contributed to the child's death is noted. For an investigation to be closed with verified findings for the death maltreatment, there must be a preponderance of credible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

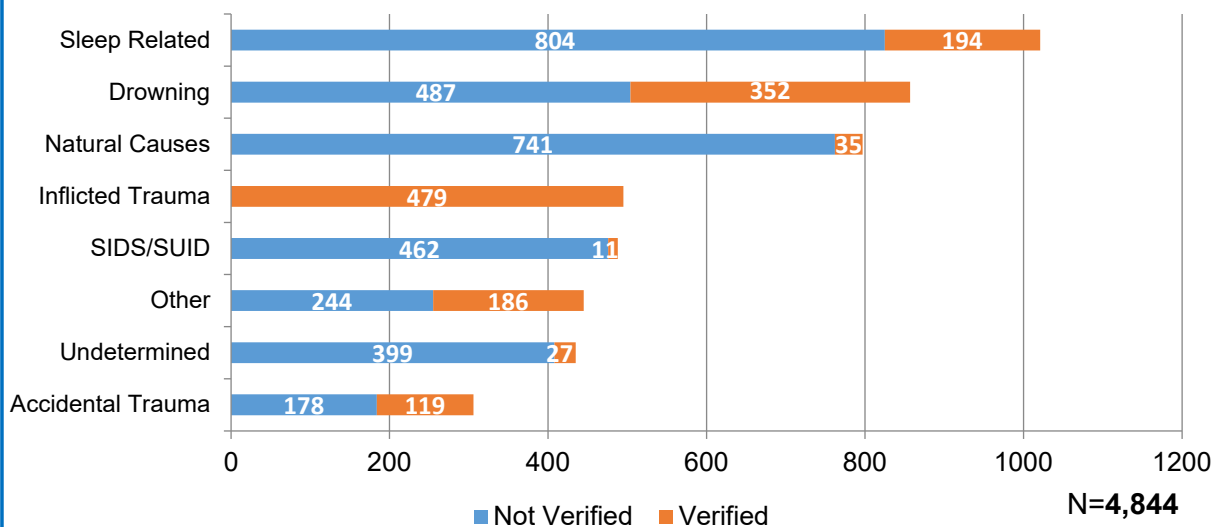
Between January 1, 2015, and March 31, 2020, there were a total of 128 CIRRT deployments involving 130 child fatalities. Of the 122 investigations (involving 123 children) that were closed, 46 investigations (36 percent) involving 47 victims had verified findings for the death maltreatment; six of the investigations remain open. An additional 22 investigations (17 percent) were closed with verified findings for maltreatment other than the death maltreatment, with inadequate supervision verified in 13 of the cases and substance misuse verified in eight of the cases. Multiple maltreatments can be verified in each investigation.

Causal Factors for Closed Investigations for CIRRT Fatalities that Occurred January 1, 2015 - March 31, 2020



Between January 1, 2009, and March 31, 2020, the four leading causal factors of child fatalities reported to the Hotline were sleep-related (1,021), drowning (857), natural causes (797), and inflicted trauma (495).

Causal Factors for Fatalities January 1, 2009 - March 31, 2020



Causal factors of child fatalities include the factors or situations leading to the death of the child. Sleep-related deaths include children found unresponsive, co-sleeping, or roll-overs. Causal factors for child fatalities due to natural causes include previously known medical issues or medically-complex children, as well as deaths due to previously undiagnosed medical issues. Reports are accepted by the Hotline for investigation when a child under the age of 5 is found deceased outside of a medical facility, and there is no indication of a known medical condition or a clear reason for trauma, such as a car accident. When a child dies in a hospital and abuse or neglect is suspected or 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, those with a causal factor of SIDS/SUID and several 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. However, in one of the cases, a SIDS/SUID causal factor was verified due to the incident occurring while the parents were bed sharing and both were under the influence of substances.

IV. CIRRT Advisory Committee

The CIRRT Advisory Committee (Committee) is statutorily-required to meet on a quarterly basis. The Committee met most recently on April 6, 2020. Although committee members are encouraged to attend in person, all participated via conference call for this meeting due to the travel restrictions resulting from COVID-19.

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 laws related to child protection and child welfare services.

At the April 6, 2020 meeting, the CIRRT deployments from the 2019 fourth quarter were reviewed and discussed. There was a discussion around the lack of assessment in totality regarding parental substance use and the impact on caregiving. Marijuana use is largely minimized, and poly-substance use is not fully assessed. The department is creating a process for case reviews involving substance use, which includes both historical and current use at the time of the child fatality.

Additionally, discussion was held around the Training Plan for CIRRT Teams prior to COVID-19 pandemic, which included talk books (pending edits), critical trends from CIRRT deployments being communicated to frontline staff, and training for frontline supervisors regarding unknown perpetrators.

V. Recommendations

The Committee continues to recommend that the quarterly requirement for the CIRRT Advisory Committee Report be changed to annual.

The Committee continues to recommend the following addition/change to the statutory language:

The Secretary will have the discretion whether to deploy a CIRRT team in circumstances that meet the criteria below:

- a) Cases in which there is no relationship between the fatality and the prior verified report (e.g., involves a separate household and perpetrator; and/or the decedent has had no contact with the caregiver/parent in the verified prior report);*
- b) Cases in which the death occurred in a daycare or other facility, including a hospital (e.g., an infant born extremely premature and never leaves the hospital);*
- c) Cases in which the death occurred in a foster home when it involves a separate incident and different perpetrator from the prior verified report.*
- d) Cases in which a child is expected to die due to a prior diagnosed medical condition.*

It is important to note that cases meeting any of the above criteria will not be automatically exempt from a CIRRT deployment. The determination whether to deploy will be based on a collaborative analysis between the CIRRT unit and department leadership.

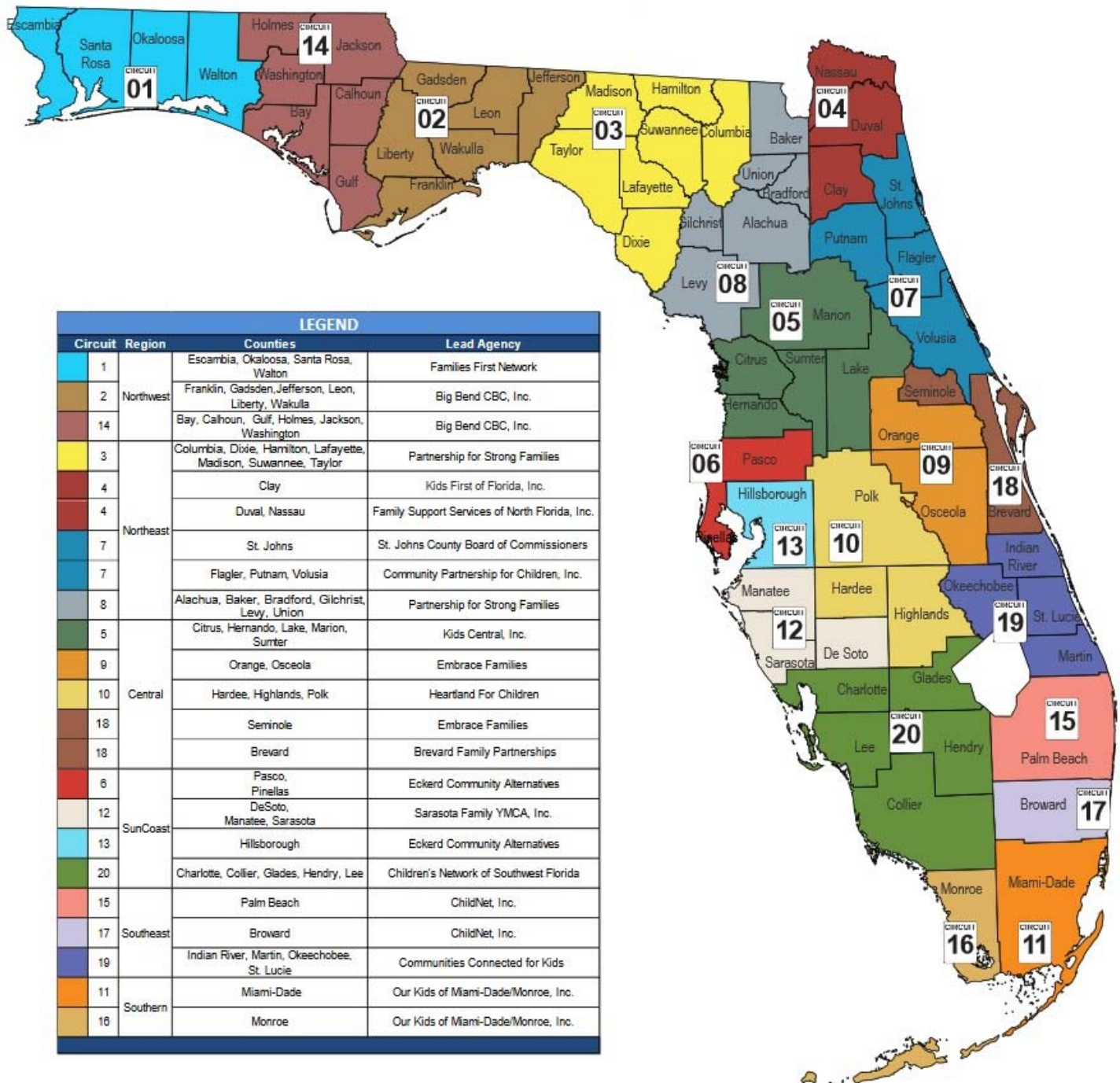
APPENDIX 1 – Section 39.2015, Florida Statutes

Section 39.2015, Florida Statutes, effective January 1, 2015, requires:

- An immediate onsite investigation by a CIRRT for all child deaths reported to the department if the child or another child in his or her family was the subject of a verified report of abuse or neglect during the previous 12 months.
- The investigation shall be initiated as soon as possible, but no later than two business days after the case is reported to the department.
- Each investigation shall be conducted by a multiagency team of at least five professionals with expertise in child protection, child welfare, and organizational management. The majority of the team must reside in judicial circuits outside the location of the incident. The Secretary is required to assign a team leader for each group assigned to an investigation.
- A preliminary report on each case shall be provided to the Secretary no later than 30 days after the CIRRT investigation begins.
- The Secretary may direct an immediate investigation for other cases involving serious injury to a child and those involving a child fatality that occurred during an active investigation.
- The Secretary, in conjunction with the Florida Institute for Child Welfare, is required to develop guidelines for investigations and provide training to team members.
- The Secretary shall appoint an advisory committee made up of experts in child protection and child welfare.
- Legislative changes, effective July 1, 2015, require the Committee to meet and submit reports quarterly to the Secretary. The Secretary will submit the quarterly reports to the Governor, the Speaker of the House, and the President of the Senate.
- Beginning in the 1998-1999 fiscal years, and under section 39.3065, Florida Statutes, the department transferred all responsibility for child protective investigations to the sheriffs' offices in Broward, Hillsborough, Manatee, Pasco, Pinellas, Seminole, and Walton Counties*. The department is responsible for child protective investigations in the remaining 60 counties.
- As intended in section 409.986, Florida Statutes, the department provides child welfare services to children through contracts with community-based care lead agencies in each of the 20 judicial circuits in the state.

* The sheriff's office in Walton county assumed responsibility for child protective investigations effective July 1, 2018.

APPENDIX 2 – Community Based Care Lead Agencies by Circuit and County



APPENDIX 3 – CIRRT Process

Prior to conducting CIRRT reviews, the department began actively recruiting staff from partner agencies to receive CIRRT training in preparation for participating in CIRRT reviews. Since that time, training has been offered every four months at various locations throughout the state, except for the December 2018 training which was canceled due to travel restrictions. The most recent training was held in Miami in December 2019. To date, over 600 professionals with expertise in child protection, domestic violence, substance abuse, and mental health, law enforcement, Children's Legal Services, human trafficking, and the Child Protection Team have been trained on the CIRRT process. Training consists of one day of specialized training on the child welfare practice model for external partners, along with two additional days of specialized CIRRT training.

Advanced training was developed and is provided for individuals identified as team leads. In addition, specialized one-day training was created specifically for the Child Protection Team medical directors to meet the statutory requirement that went into effect July 1, 2015, requiring medical directors to be a team member on all CIRRTs (section 39.2015(3), Florida Statutes).

Team Composition

Each team deployed is comprised of individuals with expertise in the appropriate areas, as identified through a review of the family's prior history with the child welfare system. The team lead is responsible for guiding the process throughout the duration of the review.

Child Fatality Review Process

Every case involving a child fatality receives a specified level of a quality assurance review. A child fatality review is completed by the region's child fatality prevention specialist on every case involving a child fatality, followed by a written Child Fatality Summary that outlines the circumstances surrounding the incident. For cases in which there is no prior child welfare history involving the family within the five years preceding the child's death, this is the only report that is written.

For cases in which there is 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.