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

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Secretary

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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 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 improve 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.

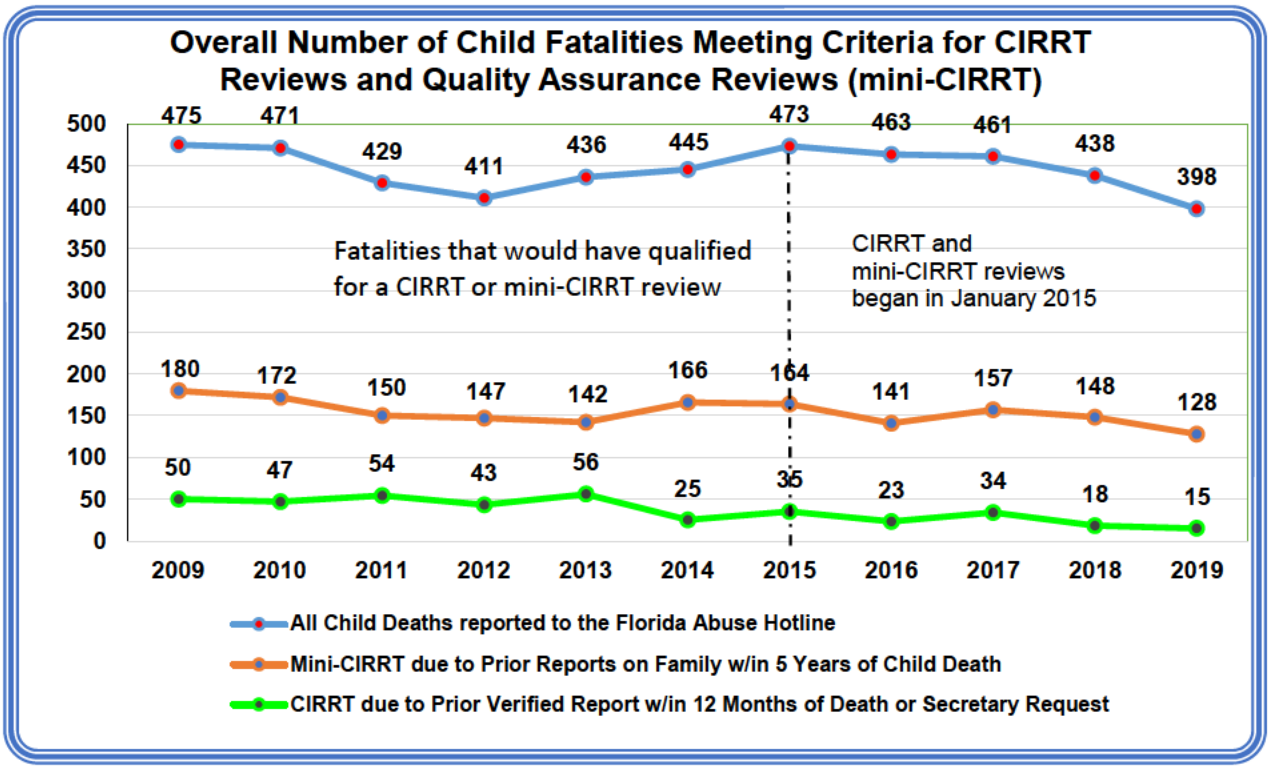
III. Review of Child Fatality Data

From January 1, 2015, through June 30, 2020, a total of 132 CIRRT teams were deployed involving 134 child deaths. Of those deployments, 126 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.

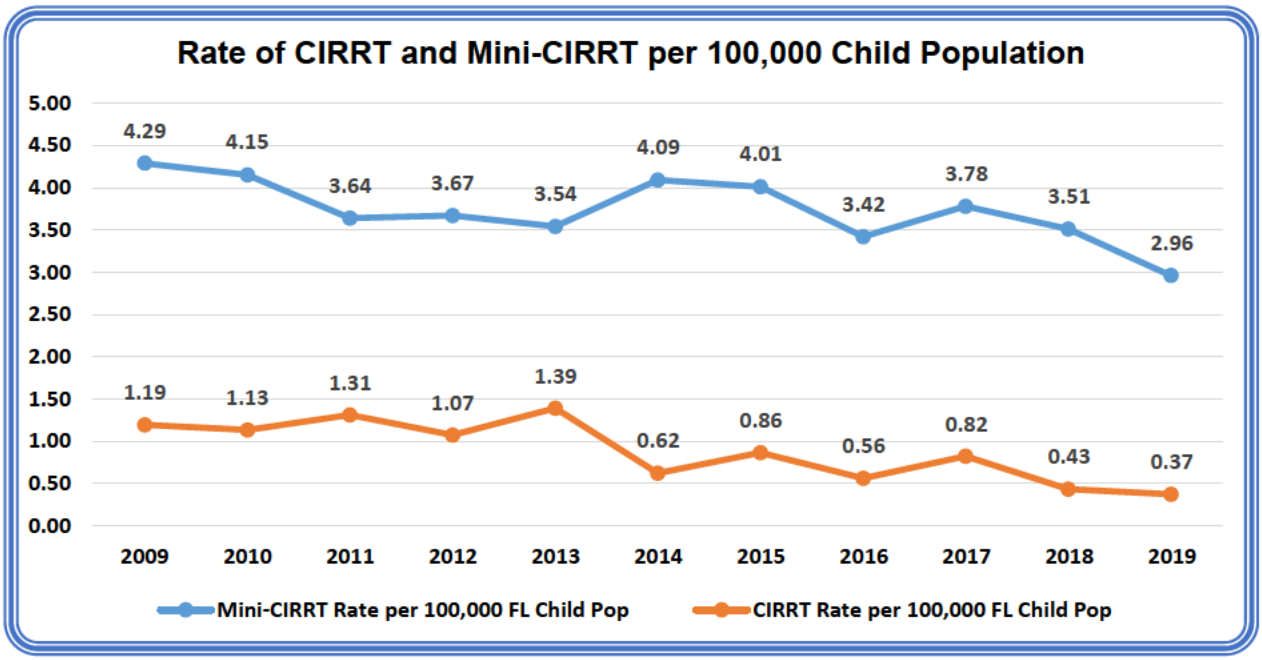
Since January 1, 2015, the fatalities resulting in a CIRRT deployment represent five percent of the overall fatalities reported to the Department of Children and Families' (department) Florida Abuse Hotline (Hotline). An additional 33 percent of the fatalities reported to the Hotline met the criteria 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 April 1 and June 30, 2020, there were 121 fatalities called in to the Florida Abuse Hotline. Of those 121 cases, 45 met the criteria for either a CIRRT deployment (6) or mini-CIRRT or special review (39). Because two of the CIRRT deployments did not occur prior to the end of the second quarter, they are not included in this report; instead, the case information will be included as a part of the third quarter report. In the

four CIRRT deployments that occurred during the second quarter, there was no prior history involving the deceased child in two (50 percent) of the cases. In the 39 cases that met the criteria for a mini-CIRRT or special review, there was no prior history involving the deceased child in 18 (46 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.

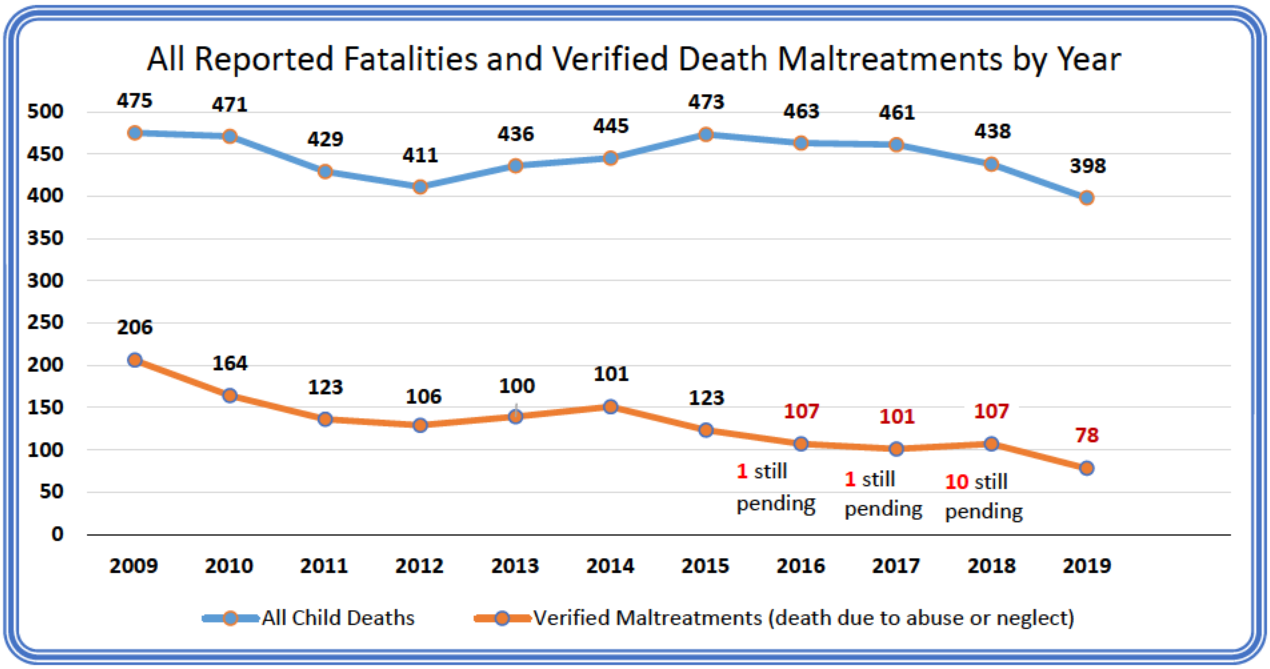


Standardized data is collected across all review types and entered Qualtrics for further analysis and review. Reports on reviews conducted as a result of a child fatality (regardless of the type of review completed) are redacted according to Florida Statutes and posted for public review on the department's 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.

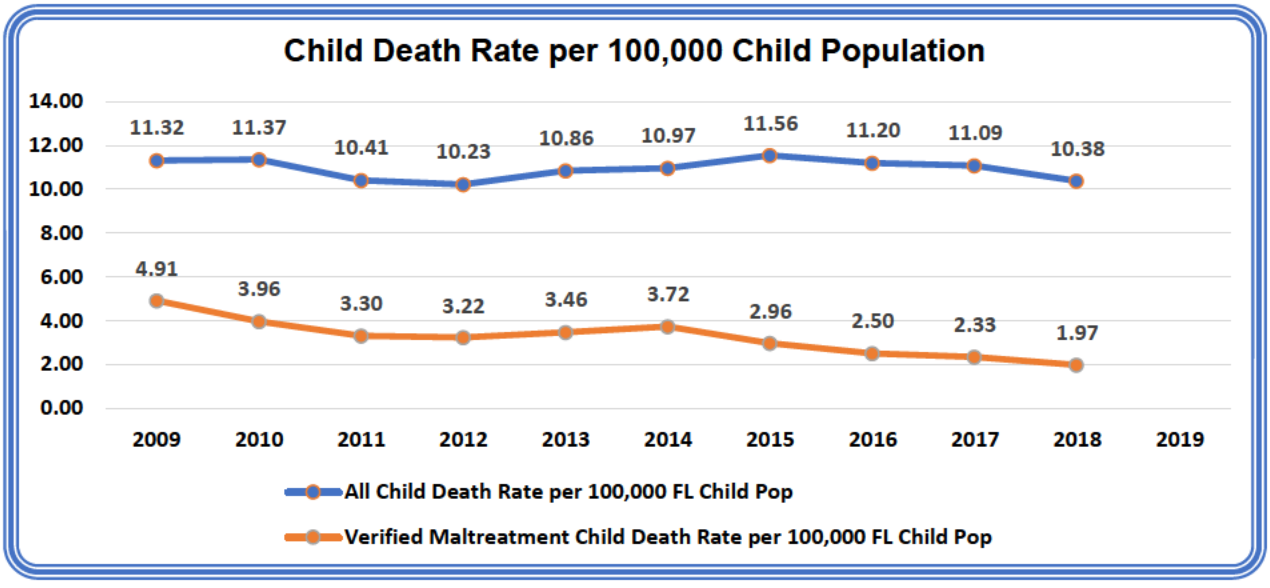
Child deaths in Florida typically involve a child age 3 or younger and may involve a variety of causal factors including, but not limited to: sleep-related deaths, drownings, natural causes, inflicted trauma, Sudden Infant Death Syndrome (SIDS)/Sudden Unexplained Infant Death (SUID), and accidental trauma.

Of the 1,397 child fatalities that occurred during the 2015-2017 calendar years and were reported to the Hotline, two 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, seven 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 there are still 25 cases that remain open for 2019 that, when closed, will likely show the overall percentage of verified cases for that year to be in the same range.*

* 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 seven 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 Second Quarter CIRRT Reports

During the second quarter, there were four CIRRT deployments in two different regions: three in the Northeast Region and one in the SunCoast Region. The deployment to the SunCoast Region was in Pinellas County where the sheriff's office is responsible for completing child protective investigations. The remaining three deployments occurred in Volusia, Duval, and Alachua Counties where the department is responsible for child protective investigations.

The Volusia County deployment involved the death of a 10½ year old due to a gunshot wound inflicted by his mother's paramour. The Duval County deployment involved the death of a newborn, who lived approximately two minutes and there were concerns for maternal substance use. The Pinellas County deployment involved the death of a four-year-old who was found unresponsive in a pool while attending a birthday party. The Alachua County deployment involved the death of a 4-month-old after he was found unresponsive while sleeping on an air mattress with his mother and sibling.

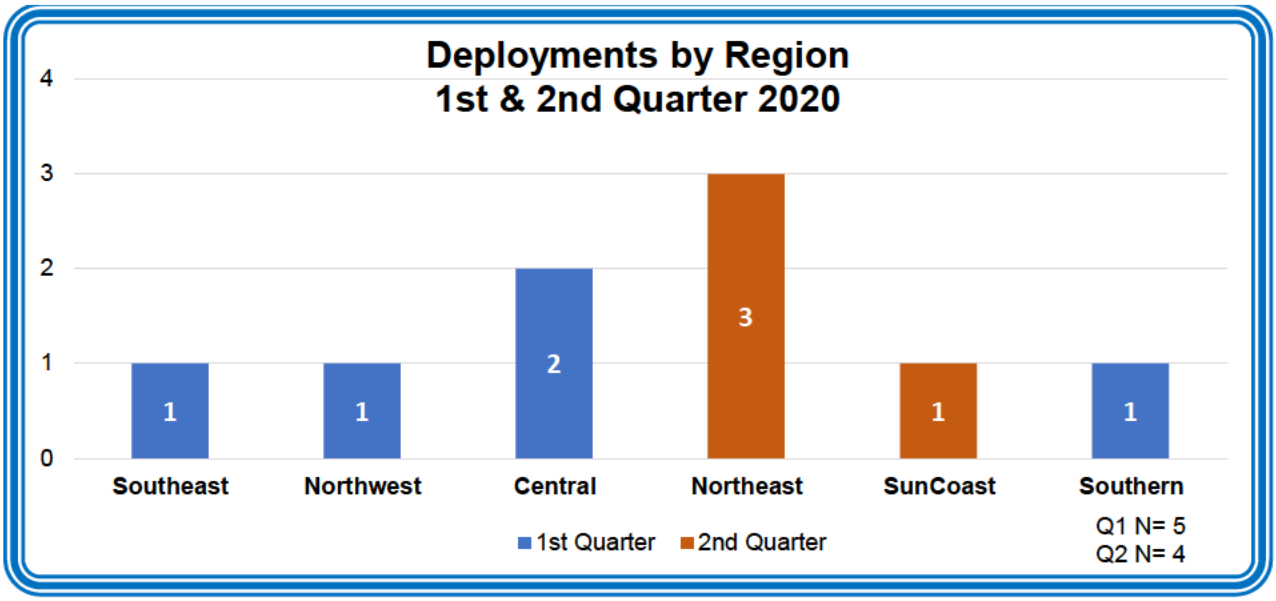
In one of the four cases, child welfare services were involved at the time of the respective fatality, and only two of the decedents were the subjects of a prior verified report.

b. Past Maltreatment

During the second quarter of 2020, there were four CIRRT deployments, involving four victims, with each having a verified prior report on the victim or a sibling within the previous 12 months. Two deployments each had a prior verified maltreatment of family violence threatens child, one deployment with a prior verified maltreatment of substance misuse, and one deployment with prior verified maltreatments of substance misuse, substance exposed newborn, and family violence threatens child.

CIRRT Data by Region

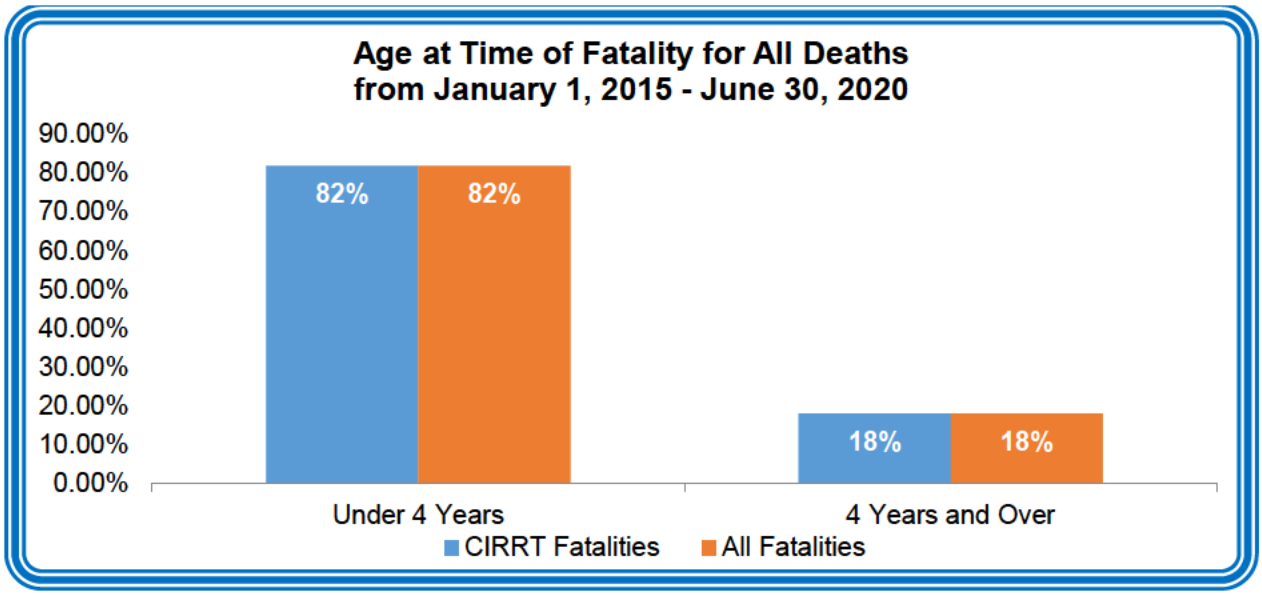
From April 1 through June 30, 2020, there were four CIRRT deployments, involving four victims, occurring in two of the six regions. There were three deployments to the Northeast Region, and one deployment to the Suncoast Region. The deployment to the Suncaost Region (Pinellas County), is an area where the respective sheriffs' office conducts child protective investigations. The department is responsible for the completion of child protective investigations in the other three counties in the Northeast Region where teams were deployed.



c. Age of Victim

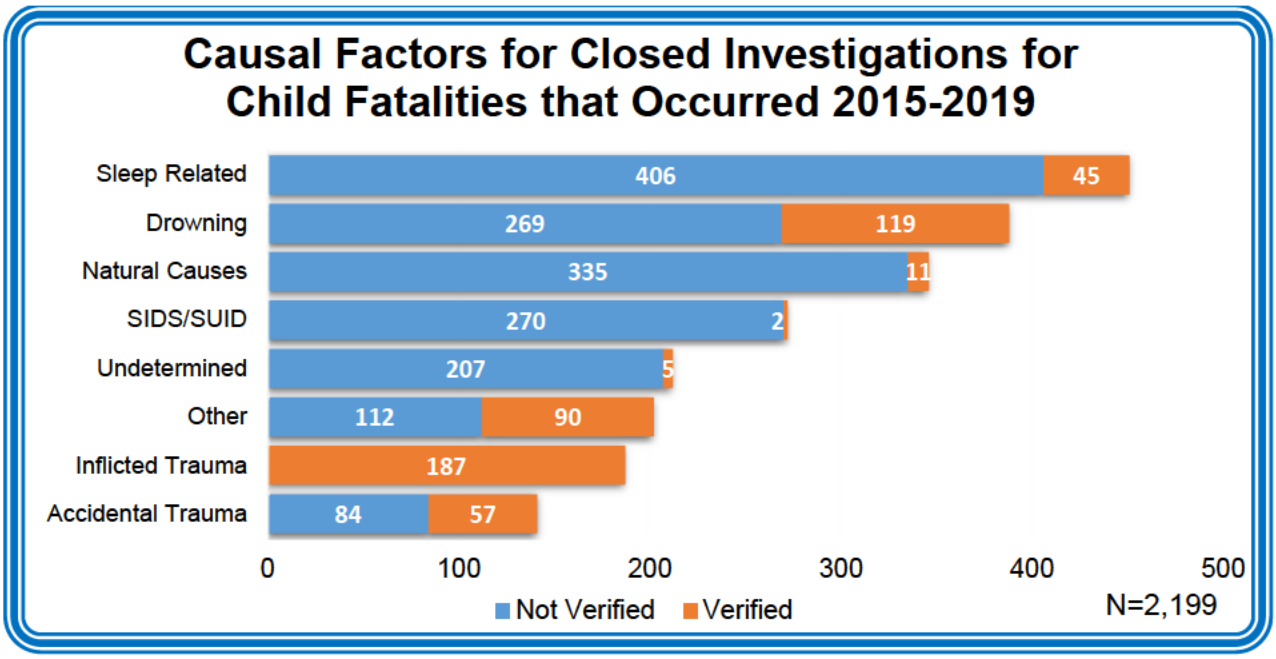
During the second quarter in 2020, there were a total of four CIRRT deployments involving four victims. Two victims were under the age of 6 months, one victim was 4 years of age and one victim was 10 years of age.

It's interesting to note that the age percentages between all 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 4 years are the majority



d. Causal Factors All Fatalities

Of the 2,199 closed child fatalities that occurred from January 1, 2015, to December 31, 2019, the four primary causal factors were sleep-related, drowning, natural causes, and SIDS/SUID. There are still 34 child fatality investigations received (25 of which were received in 2019) that remain open. When finalized, they will have a slight impact on the overall numbers; however, there will be no change regarding the top two primary causal factors.



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, if the circumstances surrounding the death are unclear, a report of the death maltreatment will be accepted by the Hotline for investigation. The most common contributing factors of child fatalities coded as "other" are suicide, drug toxicity, accidental strangulation/choking, and house fires.

Although maltreatment findings were noted to be appropriate for the majority of the investigations, the investigations with a causal factor of SIDS/SUID and several of the investigations with a causal factor of *Undetermined* were inappropriately closed with a verified finding of the death maltreatment. In those cases, the findings were based solely on the surrounding circumstances (e.g., possible unsafe sleep environment, bedding, or position, etc.) as opposed to a medical examiner's finding of fact. However,

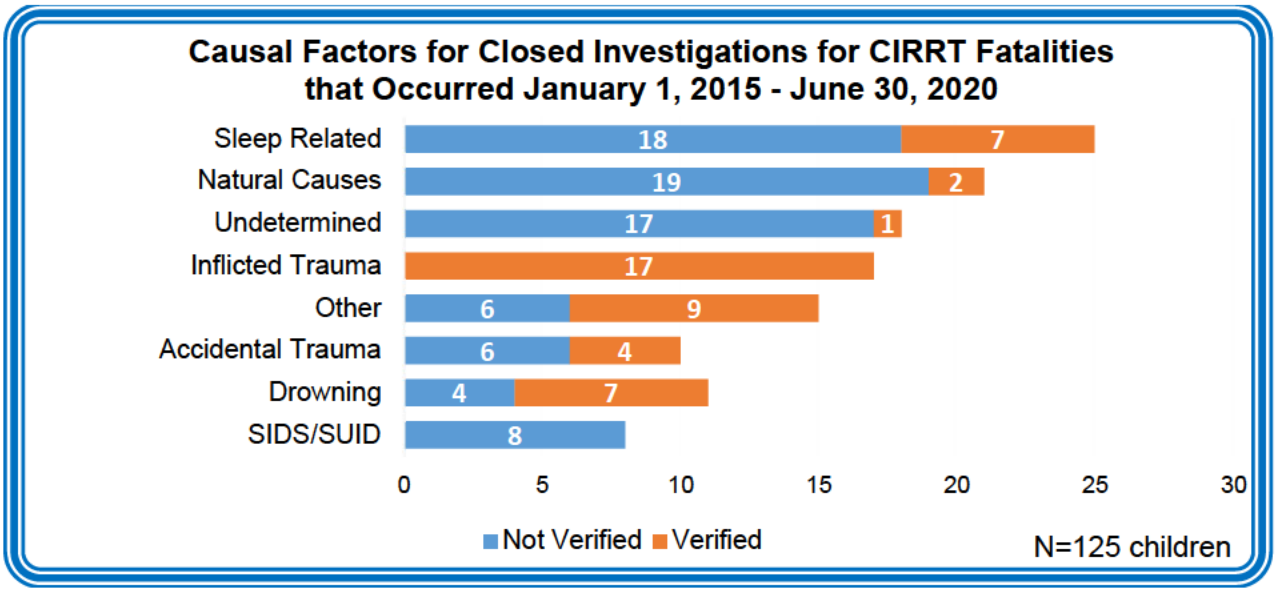
in one of the cases with a SIDS/SUID causal factor was verified due to the incident occurring while the parents were bed sharing, and both were under the influence of substances.

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.

e. **Causal Factors CIRRT Fatalities**

Between January 1, 2015, and June 30, 2020, there were a total of 132 CIRRT deployments involving 134 child fatalities. Of the 124 investigations (involving 125 children) that were closed, the four primary causal factors were sleep-related, natural causes, undetermined, and inflicted trauma. Of the 124 closed investigations involving 125 children, 46 investigations (37 percent) involving 47 victims had verified findings for the death maltreatment; eight (8) of the investigations (involving nine children) remain open.



An additional 22 investigations (17 percent) were closed with verified findings for maltreatment other than the death maltreatment, with inadequate supervision being verified in 13 of the cases, and substance misuse was verified in eight of the cases. Multiple maltreatments can be verified in each investigation.

IV. CIRRT Advisory Committee

The CIRRT Advisory Committee (Committee) is statutorily-required to meet on a quarterly basis. The Committee met most recently on July 22, 2020. Although committee members are encouraged to attend in person, all participated via video conferencing 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 July 22, 2020 meeting, the CIRRT deployments from the 2020 first quarter were reviewed and discussed. There was a discussion around the challenge of obtaining out-of-state records and the difficulty in communicating with other states. Additional discussion was held around the lack of uniformity across the state in coding/ classification of cause of death on autopsy reports, therefore, skewing data.

Additionally, discussion was held around the Training Plan for the CIRRT team moving forward. The CIRRT team has pending trainings in September 2020 to train new DCF Regional Managing Directors and Family and Community Service Directors for their continued involvement in the CIRRT process. Trainings for additional trainings around critical trends from CIRRT delployments to frontline staff and supervisory staff are in the process of being developed and scheduled. These trainings will utilize video

conference platforms, such as Microsoft Teams, Skype for Business, Go To Meeting, etc.

V. Recommendations

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

The CIRRT Advisory 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; and*
d) *Cases in which a child is expected to die due to a prior diagnosed medical condition.*

It's 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.

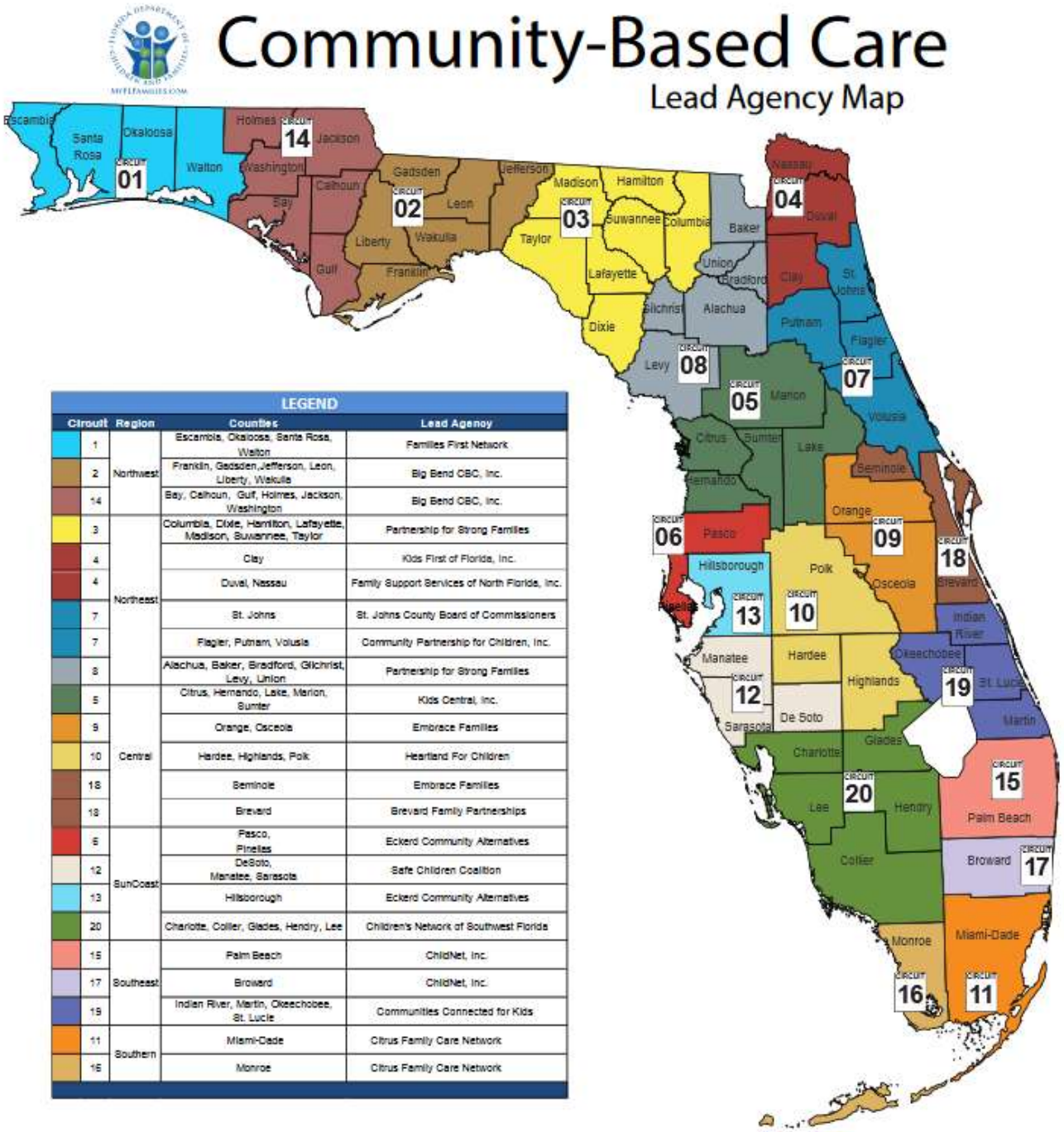
APPENDIX 1 – Section 39.2015, Florida Statutes

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



LEGEND

Circuit	Region	Counties	Lead Agency
1	Northwest	Escambia, Okaloosa, Santa Rosa, Walton	Families First Network
2	Northwest	Franklin, Gadsden, Jefferson, Leon, Liberty, Wakulla	Big Bend CBC, Inc.
14	Northwest	Bay, Calhoun, Gulf, Holmes, Jackson, Washington	Big Bend CBC, Inc.
3	Northeast	Columbia, Dixie, Hamilton, Lafayette, Madison, Suwannee, Taylor	Partnership for Strong Families
4	Northeast	Clay	Kids First of Florida, Inc.
4	Northeast	Duval, Nassau	Family Support Services of North Florida, Inc.
7	Northeast	St. Johns	St. Johns County Board of Commissioners
7	Northeast	Flagler, Putnam, Volusia	Community Partnership for Children, Inc.
8	Northeast	Alachua, Baker, Bradford, Gilchrist, Levy, Union	Partnership for Strong Families
5	Central	Citrus, Hernando, Lake, Marion, Sumter	Kids Central, Inc.
9	Central	Orange, Osceola	Embrace Families
10	Central	Hardee, Highlands, Polk	Heartland For Children
18	Central	Seminole	Embrace Families
18	Central	Brevard	Brevard Family Partnerships
6	SunCoast	Pasco, Pinellas	Eckerd Community Alternatives
12	SunCoast	DeSoto, Manatee, Sarasota	Safe Children Coalition
13	SunCoast	Hillsborough	Eckerd Community Alternatives
20	SunCoast	Charlotte, Collier, Glades, Hendry, Lee	Children's Network of Southwest Florida
15	Southeast	Palm Beach	ChildNet, Inc.
17	Southeast	Broward	ChildNet, Inc.
19	Southeast	Indian River, Martin, Okeechobee, St. Lucie	Communities Connected for Kids
11	Southern	Miami-Dade	Citrus Family Care Network
16	Southern	Monroe	Citrus Family Care Network

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 and trainings have not been scheduled during the first and second quarters of 2020 due to travel restrictions related to COVID-19; therefore, 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 comprises individuals with expertise in the appropriate areas, as identified through a review of the family's prior history with the child welfare system. The team lead is responsible for guiding the process throughout the duration of the review.

Child Fatality Review Process

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

For cases in which there was a verified prior report involving the deceased child or a sibling within 12 months of the death, a review is conducted utilizing the CIRRT process. While only a small percentage of cases meet the criteria for this extensive review, an in-depth review that mirrors the CIRRT process is completed on all other cases involving families with child welfare history within the five years preceding the child's death, regardless of findings. These reviews are commonly referred to as *mini-CIRRTs* and, like the CIRRT reports, are used to supplement the information contained in the Child Fatality Summary.