Critical Incident Rapid Response Team Advisory Committee
Second Quarter Report for Calendar Year 2022

Shevaun L. Harris
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 2022

I. Background

Section 39.2015, Florida Statutes, requires the Department of Children and Families' Critical Incident Rapid Response Team (CIRRT) to submit a quarterly report to the Governor and Legislature of findings and recommendations.

II. Purpose

Reviews by the CIRRT 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 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 on the most recent child welfare involvement and events surrounding the fatality, including the most recent verified incident of abuse or neglect.

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.

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 generally been offered every four months at various locations throughout the state. Additionally, quarterly statewide trainings were not scheduled during 2020 due to travel restrictions related to COVID-19. Training was provided to the Department's six Regional Managing Directors in September 2020 to engage them in the process and utilize their leadership expertise on future reviews. 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).

Special Reviews

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, additional in-depth reviews that mirror the CIRRT process, are completed on critical and fatality cases at the discretion of the Secretary, regardless of prior maltreatment findings. These reviews are referred to as *Special Reviews,* and, like the CIRRT reports, are used to supplement the information contained in the Child Fatality Summary.

Team Composition

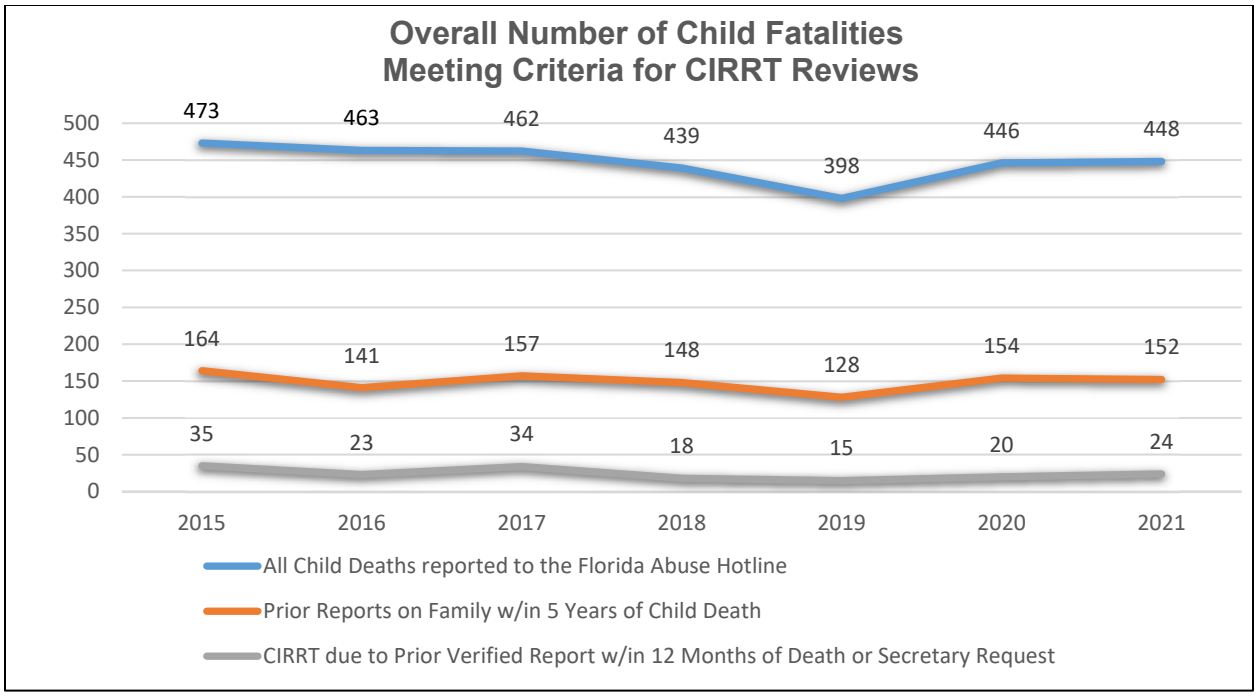
Each team deployed comprises individuals with expertise in the appropriate areas, as identified through a review of the family's prior history with the child welfare system. The team lead is responsible for guiding the process throughout the duration of the review.

III. Review of Child Fatality Data

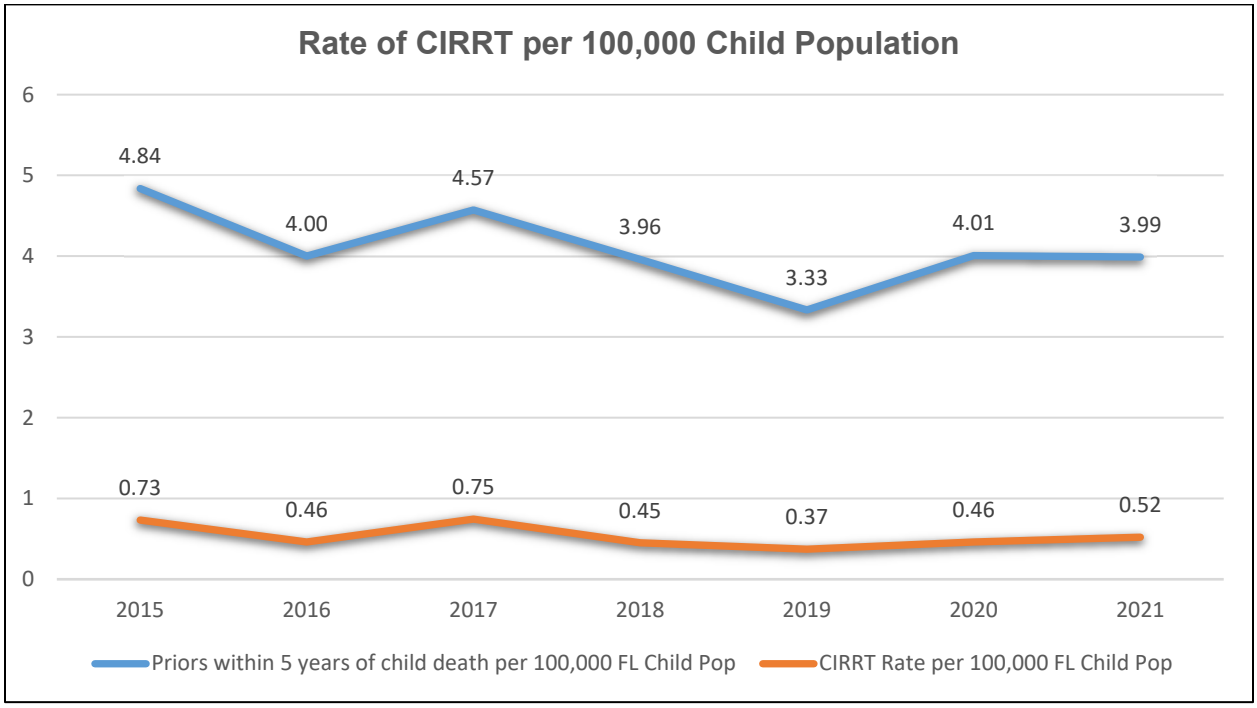
Between April 1 and June 30, 2022, there were 110 fatalities reported to the Hotline. Of those 110 cases, five met the criteria for a CIRRT deployment and in four of the CIRRT deployments, there was prior history involving the deceased child.

From January 1, 2015, through June 30, 2022, a total of 175 CIRRT teams were deployed involving 179 child deaths. Of those deployments, 169 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 discretionary 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 approximately five percent of the overall fatalities reported to the Department of Children and Families' (Department) Florida Abuse Hotline (Hotline). In 34 percent of the fatalities reported to the Hotline, the family had a prior history within the previous five years. 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 per case.

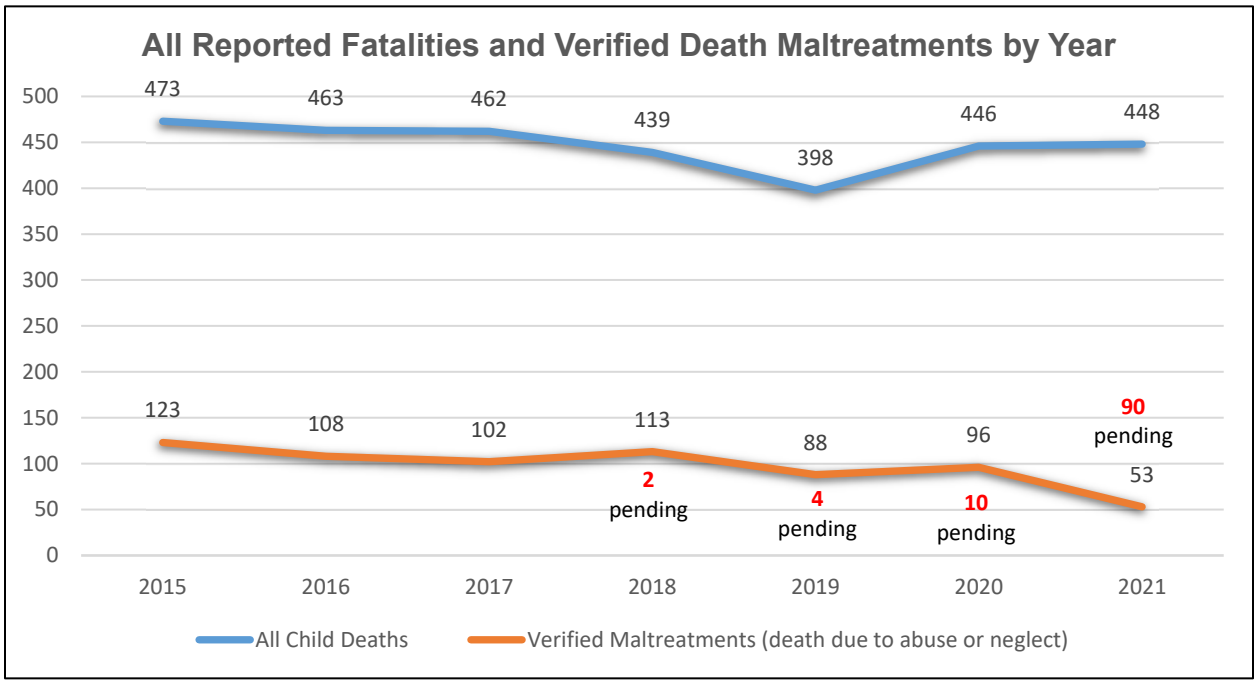


The rate of occurrence for fatalities meeting the requirements for CIRRT deployments and/or special reviews, as compared to the overall number of fatalities reported to the Hotline, has remained relatively the same over the years. While there are slight decreases and increases from year to year, they are not statistically significant to support any noted trends.

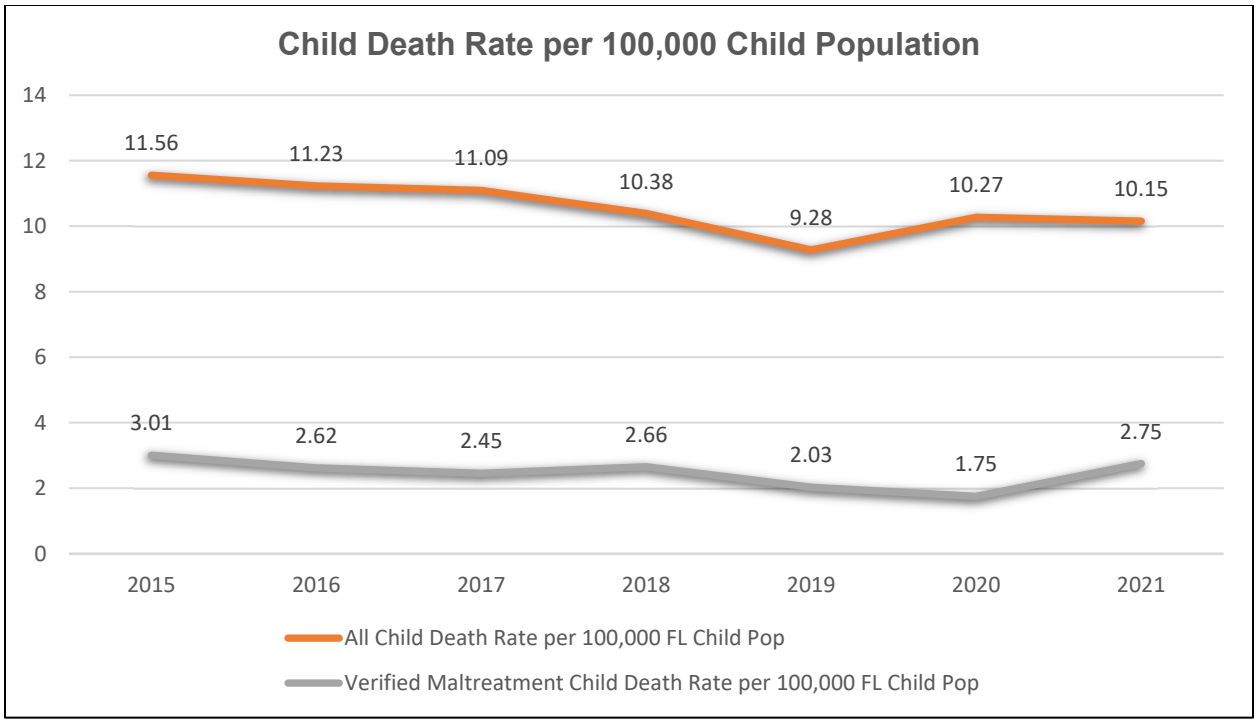


Reports on reviews conducted as a result of a child fatality (regardless of the type of review completed) are redacted, according to Florida Statutes and posted on the Department's Child Fatality Prevention website (http://www.dcf.state.fl.us/childfatality/) after the death investigation has been completed. 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 reported to the Hotline 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.

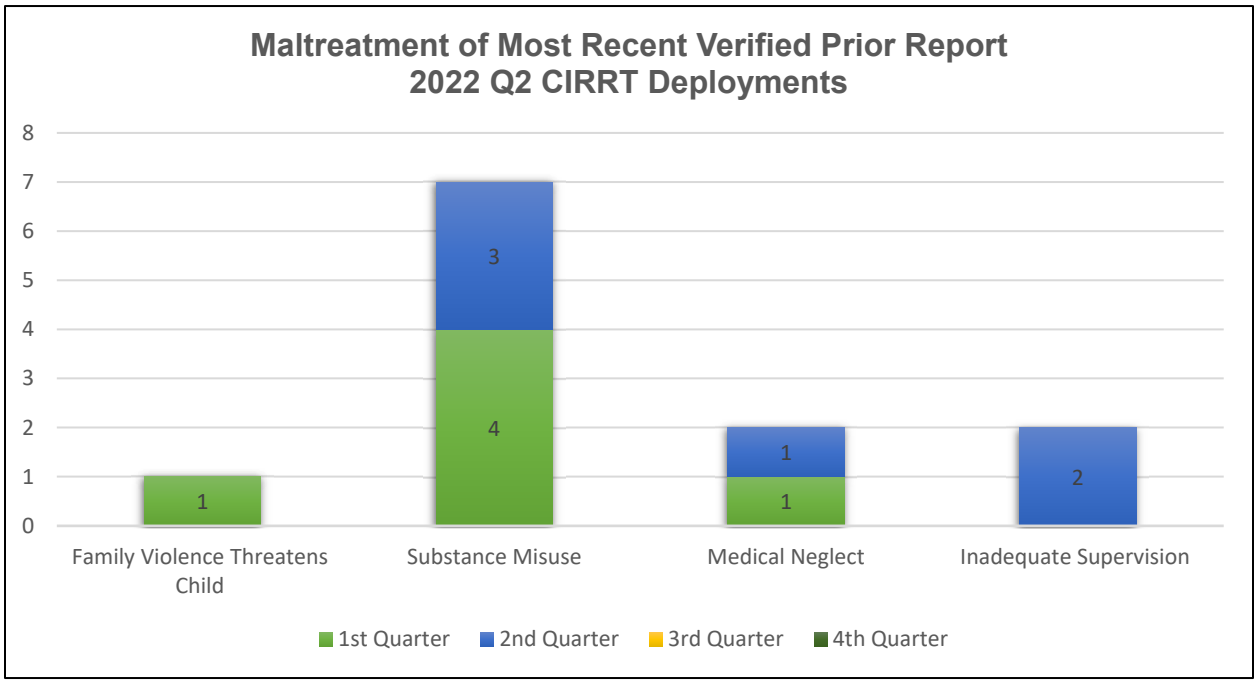


The child death rate per 100,000 child population slightly increased between 2019 and 2020, while the rate of verified child death maltreatments per 100,000 child population reflects an upward trend between 2020 and 2021. Due to the significant number (90) of fatality investigations that remain open for 2021, data for verified maltreatments may be impacted when those investigations are closed.



III. Review of CIRRT Data

a. Summary of Second Quarter CIRRT Reports



A total of five CIRRTs were deployed in the second quarter of 2022. The deployment to Miame-Dade County involved the death of two siblings, ages 3 and 5, due to inflicted

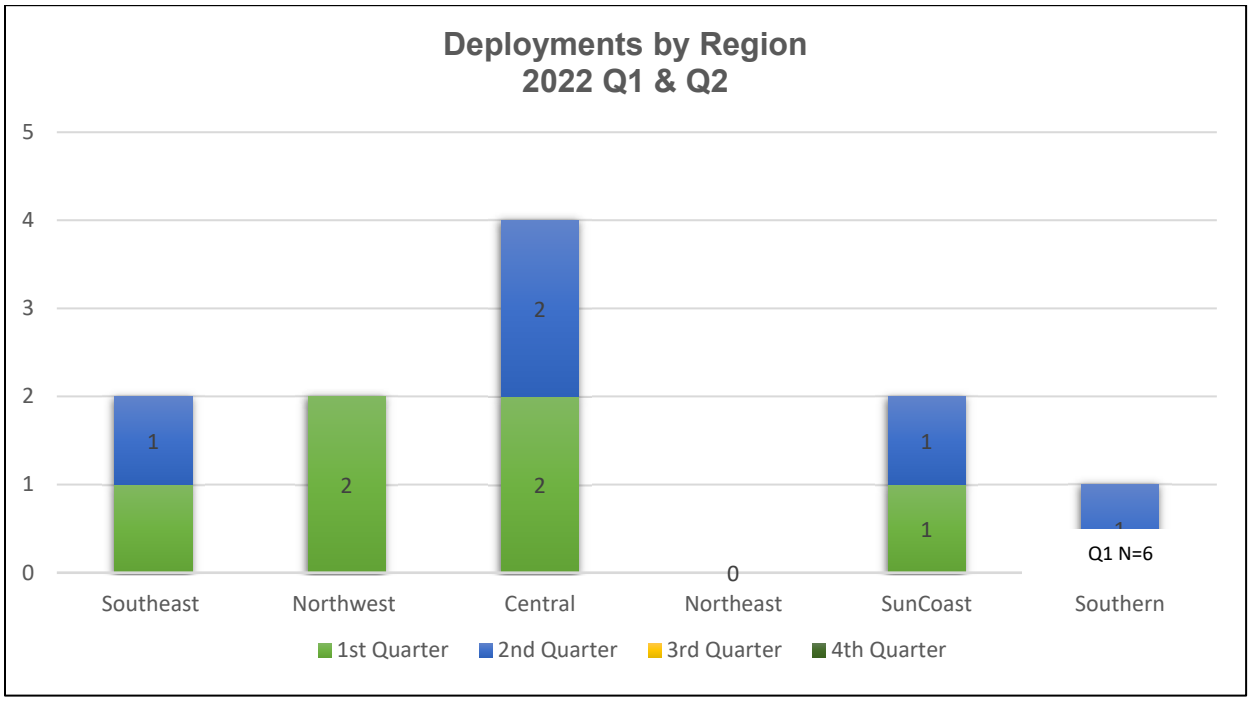
injury by their mother. A deployment to Sumter County involved the death of a two-month-old after she was discovered unresponsive while in the bed with her maternal aunt, a court ordered caregiver. The Hillsborough County deployment involved the drowning death of a two-year-old after she was able to get out of the home undetected. The deployment to Orange County involved the death of a one-year-old, who was recently sick, was found unresponsive while in the care of the mother's boyfriend. The Indian River County deployment involved the death of a one-year-old who was found unresponsive while in the bed with the mother.

In four of the five deployments (Miami-Dade, Hillsborough, Orange, and Sumter counties), child welfare services were involved at the time of the respective fatality; in four of the deployments, the decedents were the subjects of a prior verified report.

b. Past Maltreatment

During the second quarter of 2022, the five CIRRT deployments involved six victims with all the victims being the subject of a verified prior report. There were a variety of prior verified maltreatments in the deployments: one involved a medical neglect maltreatment, two involved inadequate supervision maltreatments (with one related to the parent's mental health), and three involved a substance use maltreatment.

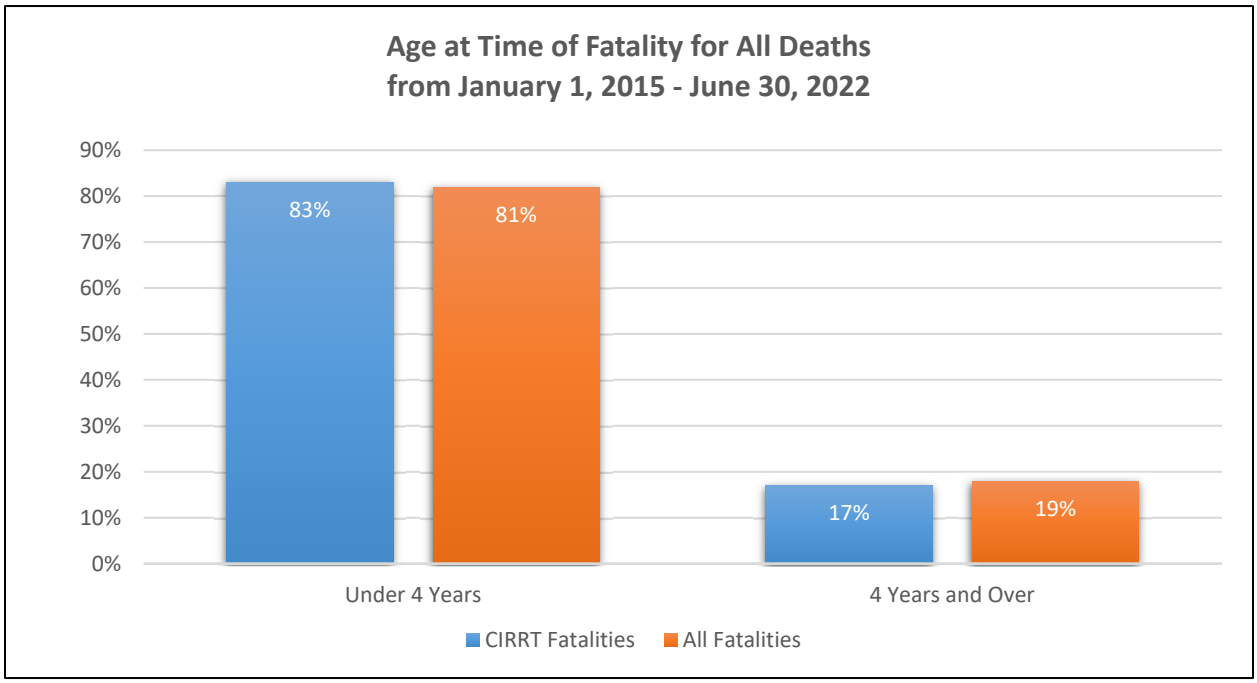
c. CIRRT Data by Region



d. Age of Victim

Three of the six victims involved in the five CIRRT deployments during this quarter were one year-old or younger.

The age percentages between all child fatalities reported to the Hotline and those meeting the requirements for a CIRRT review remain extremely close, if not the same. Children under the age of four are the majority.



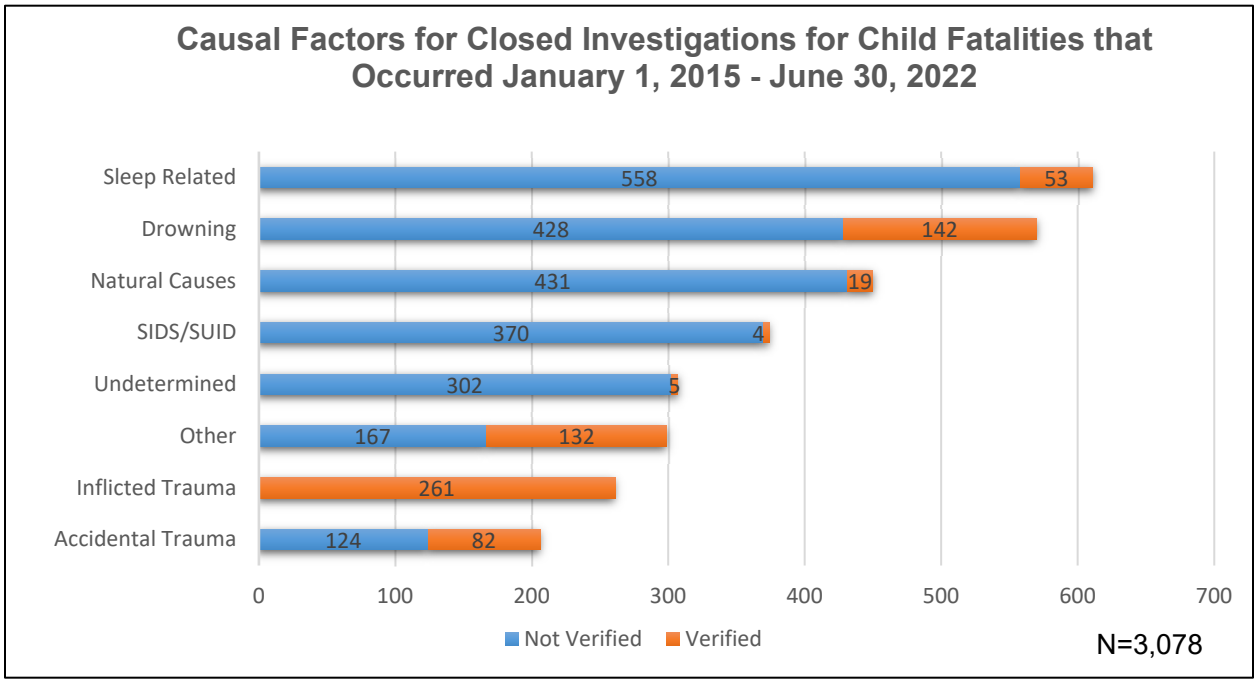
e. Causal Factors All Fatalities

Of the 3,078 closed child fatalities that occurred from January 1, 2015, to June 30, 2022, the four primary causal factors were sleep-related, drowning, natural causes, and SIDS/SUID. There are still 267 child fatality investigations that remain open; most were received in 2021 and 2022.

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 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 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, position, etc.) as opposed to a medical examiner's finding of fact. However, in one of the cases with a SIDS/SUID maltreatment, the causal factor was verified due to the incident occurring while the parents were bed-sharing, and both were under the influence of substances.

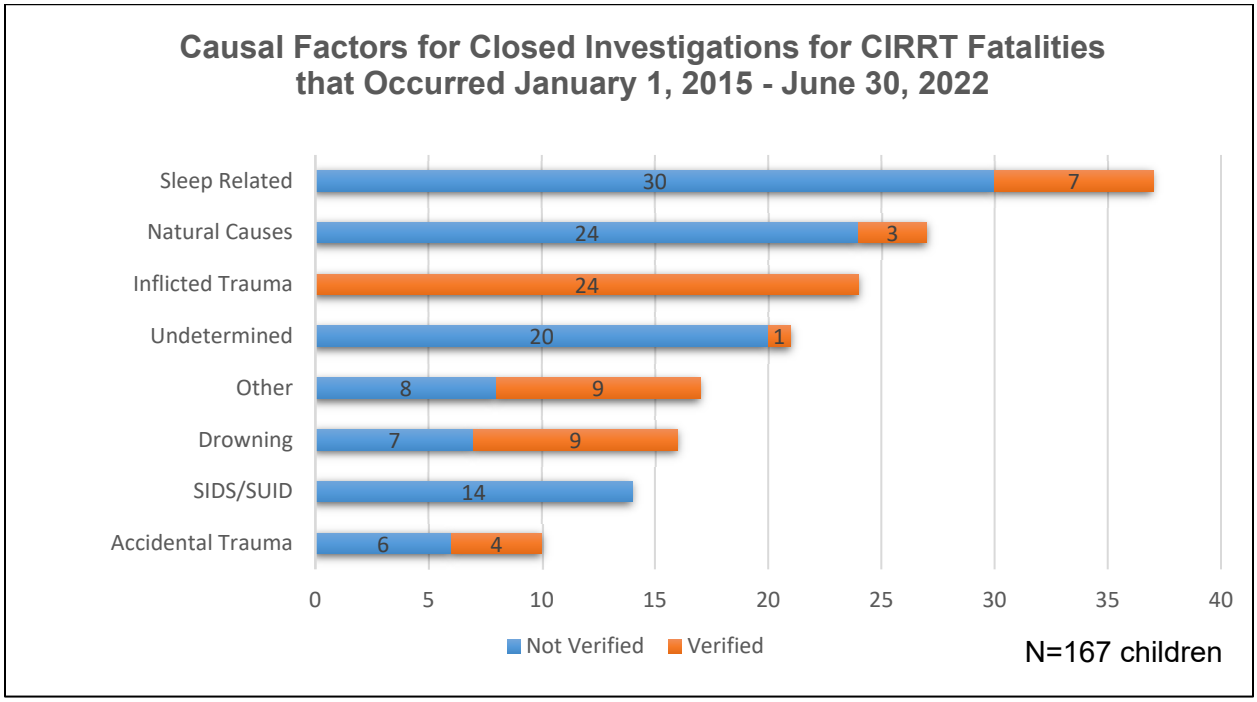


The death maltreatment cannot be used as a stand-alone maltreatment; therefore, the underlying maltreatment that may have caused or contributed to the child's death is noted. For an investigation to be closed with verified findings for the death maltreatment, there must be a preponderance of credible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

f. Causal Factors CIRRT Fatalities

Between January 1, 2015, and June 30, 2022, there were a total of 175 CIRRT deployments involving 179 child fatalities. Of the 164 investigations (involving 167 children) that were closed, the four primary causal factors were sleep-related, natural causes, inflicted trauma, and undetermined. In addition, 54 investigations (33 percent) involving 57 victims had verified findings for the death maltreatment. Twelve of the investigations (involving 13 children) remain open.



An additional 34 investigations (20 percent) were closed with verified findings for maltreatment other than the death maltreatment, with inadequate supervision being verified in 19 of the cases, and 18 of the cases verified as to substance use related maltreatments. 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 June 8, 2022.

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 June 8, 2022, meeting, the CIRRT Advisory Committee First Quarter Report and CIRRT deployments from the 2022 first quarter were reviewed. The following are noted discussions:

- Update on the CIRRT unit's expansion and successful state-wide roll-out of the CSA team and additional fatality coordinators. (SB 96 expanded the scope of the CIRRT team to assist with investigations involving Sexual Abuse allegations for children in an out of home placement).
- The CIRRT process provides a comprehensive understanding of cases that has a meaningful impact on the child welfare system. Notably, each report is individualized to the case and identifies core issues or programmatic complexities. Recommendation that the CIRRT process be presented at a national conference as it would be valuable to similar organizations.
- Updates as to the Child Welfare Task Force which has been redesigned to the Child and Family Well-Being Council. This council will bring partners of multiple agencies on a statewide basis to build bridges between systems and programs.
- Updates as to the up-coming Family Navigator Program, which will assist with bridging the gap between families and community service providers.
- Review of Qualtrics database and efforts to make data more meaningful.

V. Recommendations

The CIRRT Advisory Committee continues to recommend the statutory requirement for the CIRRT Advisory Committee Report be changed from quarterly to annually.

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.*
d) *Cases in which a child's death is not unexpected due to a prior diagnosed medical condition.*

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

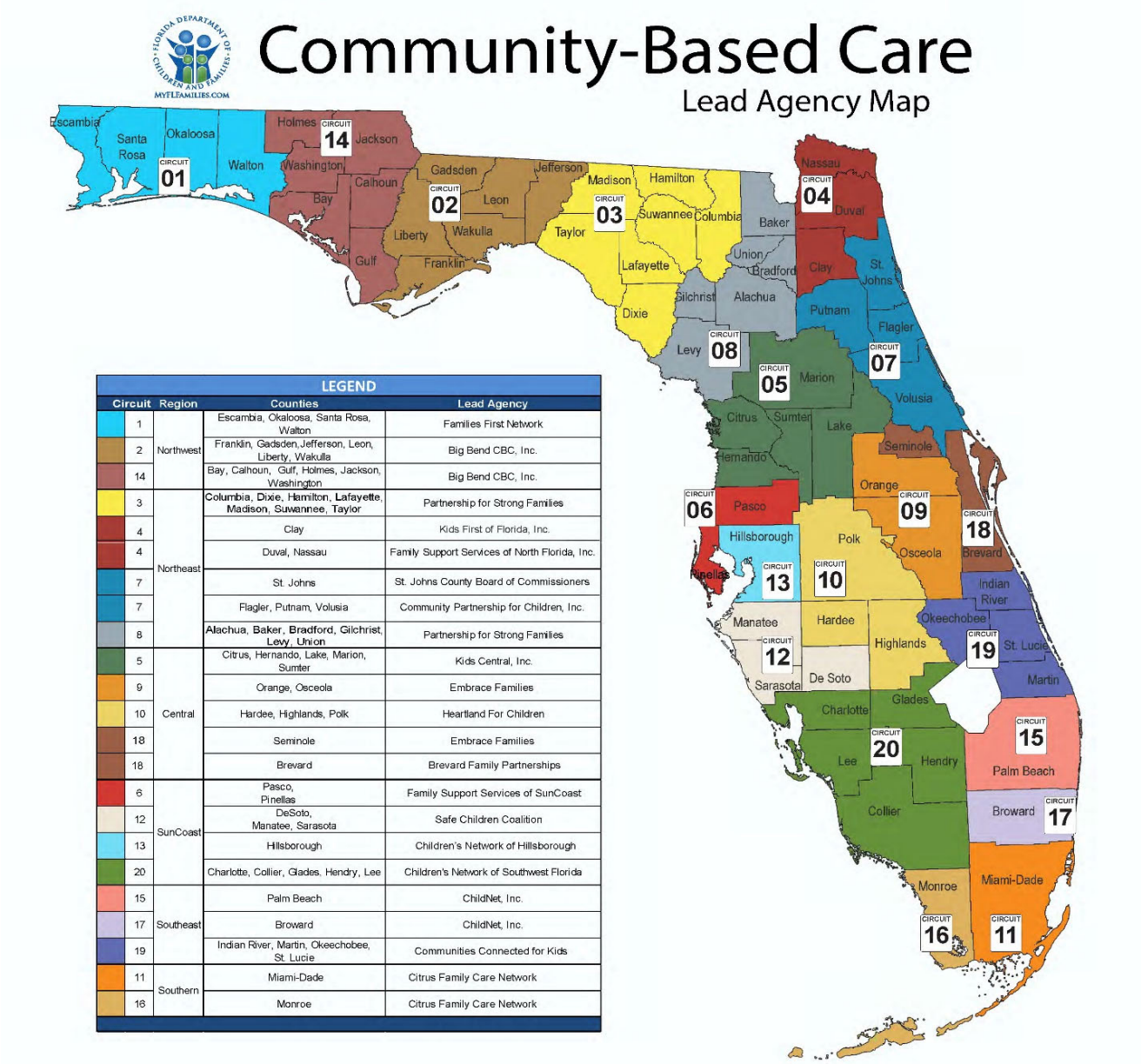
APPENDIX I – Section 39.2015, Florida Statutes

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 Fiscal Year 1998-1999, 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 II – 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	Embrace Families
	10		Hardee, Highlands, Polk	Heartland For Children
	18		Seminole	Embrace Families
	18		Brevard	Brevard Family Partnerships
	6	SunCoast	Pasco, Pinellas	Family Support Services of SunCoast
	12		DeSoto, Manatee, Sarasota	Safe Children Coalition
	13		Hillsborough	Children's Network of Hillsborough
	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	Communities Connected for Kids
	11	Southern	Miami-Dade	Citrus Family Care Network
	16		Monroe	Citrus Family Care Network