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 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.

II. Purpose

Critical Incident Rapid Response Teams provide an immediate, multiagency investigation of child deaths that meet the statutory criteria for review or 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.
Maltreatment of Most Recent Prior Verified Report

Of the 30 child fatalities reviewed by CIRRTs as of September 2015, domestic violence and substance misuse were the main maltreatments on the most recent verified report prior to the death report. Although mental health issues are not considered a maltreatment, untreated mental health issues are often found to be co-occurring.

III. CIRRT Process

To begin conducting CIRRT reviews, the Department of Children and Families (DCF) began actively recruiting staff from partnering agencies in November 2014. Training has been offered throughout the state every three months. More than 200 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 process. Training consists of one day of specialized training on the new child welfare practice for our external partners, along with two additional days for the specialized CIRRT training.

Advanced training was developed and provided for individuals identified as report writers and team leads. In addition, a specialized one-day training was created for the Child Protection Team Medical Directors in order to meet the statutory requirement effective July 1, 2015, requiring Medical Directors to be on all CIRRT teams (s.39.2015(3), F.S.).
Individuals trained include the following areas of expertise:

<table>
<thead>
<tr>
<th>Expertise</th>
<th>Trained</th>
</tr>
</thead>
<tbody>
<tr>
<td>Child Protective Investigations (DCF)</td>
<td>58</td>
</tr>
<tr>
<td>Child Protective Investigations (Sheriff's Office)</td>
<td>7</td>
</tr>
<tr>
<td>Florida Abuse Hotline</td>
<td>3</td>
</tr>
<tr>
<td>Community Based Care Lead Agency (CBC)</td>
<td>40</td>
</tr>
<tr>
<td>Case Management Organization (CMO)</td>
<td>5</td>
</tr>
<tr>
<td>Domestic Violence</td>
<td>15</td>
</tr>
<tr>
<td>Substance Abuse/Mental Health</td>
<td>37</td>
</tr>
<tr>
<td>Children's Legal Services</td>
<td>25</td>
</tr>
<tr>
<td>Law Enforcement</td>
<td>2</td>
</tr>
<tr>
<td>Department of Health</td>
<td>3</td>
</tr>
<tr>
<td>Healthy Start</td>
<td>1</td>
</tr>
<tr>
<td>Child Protection Team</td>
<td>17</td>
</tr>
</tbody>
</table>

**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 leader is responsible for guiding the process throughout the duration of the review.

**Team Assignment**

In March 2015, the Department began utilizing Everbridge, an automated notification system, for CIRRT deployments. This emergency notification system enables blast notifications to be sent to all potential team members. Once activated, the system will continue sending notifications until a reply is received from each possible team member who has been notified. Utilizing the system enables the coordinator to quickly assemble teams based on the expertise needed for the case.
Report Format

All reports are written using a standardized template and include the following:

Executive Summary – The executive summary provides a brief overview along with a summary of the findings.

Introduction – This section provides a brief summary of the current situation, including the circumstances that led to the deployment of the team.

Child Welfare Summary and Genogram – The child welfare summary provides a brief description of the family’s history with the child welfare system and provides an analysis of the prior reports, criminal history, and child welfare services. The genogram provides a pictorial display of family relationships and the family system.

System of Care Review – The system of care review is designed to provide an assessment of the child welfare system’s interactions with the family and to identify issues that may have influenced the system’s response and decision-making. The review team identifies areas of strength as well as opportunities for improvement within the child welfare system in three main categories: practice assessment, organizational assessment, and service array.

- Practice assessment – The practice assessment examines whether the child welfare professionals’ actions and decision-making regarding the family were consistent with the Department’s policies and procedures.
- Organizational assessment – This section examines the level of staffing, experience, caseload, training and performance as potential factors in the management of the case.
- Service array – The service array section assesses the inventory of services within the local child welfare system of care where the family’s case originated.

In addition, the report may include an immediate operational response section that addresses what, if any, immediate actions were taken by DCF/CBC leadership in response to the case. There also is a section for system issues if systemic issues were identified.

Review Expanded to all Child Fatalities

In addition to the mandated CIRRT reviews 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 with data collected on a core set of data elements across all types of review. This directive has subsequently been codified into department operating procedure. It requires quality assurance reviews on cases that involve families with prior child welfare history within the previous 5 years preceding the child’s death regardless of findings. These reviews use a tool and process that mirrors the CIRRT review process. Cases that involve families with no prior history for the 5 years preceding the child’s death would require a limited review to be conducted by the region’s child fatality prevention specialist. Data collected across all review types would be entered into a standard database for further analysis and review. Reviews conducted as a result of a child fatality (regardless of the type of review completed) are posted for public review of the state’s Child Fatality Prevention site. These reports are redacted according to statute.
CIRRT Advisory Committee Appointments

The advisory committee is required to include the Statewide Medical Director for Child Protection under the Department of Health, a representative from the Florida Institute for Child Welfare established pursuant to s.1004.615, F.S., an expert in organizational management, and an attorney with experience in child welfare. The current committee is as follows:

<table>
<thead>
<tr>
<th>Name</th>
<th>Title</th>
<th>Agency</th>
<th>Committee Role per s. 39.2015(11), F.S.</th>
<th>Region/City</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patricia Babcock, Ph.D.</td>
<td>Interim Director</td>
<td>Florida Institute for Child Welfare</td>
<td>Representative from the Institute</td>
<td>Statewide/ Tallahassee</td>
</tr>
<tr>
<td>Dr. Walter F. Lambert</td>
<td>Interim Statewide Medical Director for Child Protection</td>
<td>Department of Health/ University of Miami Child Protection Team</td>
<td>Statewide Medical Director for Child Protection</td>
<td>Statewide/ Miami</td>
</tr>
<tr>
<td>Lynne Drawdy</td>
<td>Master Examiner and Chair of the Examination Committee</td>
<td>Department of Health/ Sterling</td>
<td>Expert in Organizational Management</td>
<td>Central/ Orlando</td>
</tr>
<tr>
<td>Marquita Green</td>
<td>Senior Attorney</td>
<td>Court Education, Office of State Courts Administration</td>
<td>Attorney with experience in child welfare</td>
<td>Northwest/ Tallahassee</td>
</tr>
<tr>
<td>April Lott</td>
<td>President and CEO</td>
<td>Directions for Living</td>
<td>Substance Abuse and Mental Health expert</td>
<td>Suncoast/ Clearwater</td>
</tr>
<tr>
<td>Kelley Parris</td>
<td>Executive Director</td>
<td>Children’s Board of Hillsborough County</td>
<td>Children’s Services Council representative</td>
<td>Suncoast/ Tampa</td>
</tr>
<tr>
<td>Lorita Shirley</td>
<td>Chief of Program Services</td>
<td>Eckerd Community Alternatives</td>
<td>Community-Based Care Lead Agency</td>
<td>Suncoast/ Clearwater</td>
</tr>
<tr>
<td>Dr. Robin Perry</td>
<td>MSW Associate Professor</td>
<td>Florida A&amp;M University, Department of Social Work</td>
<td>Academia Representative</td>
<td>Northwest/ Tallahassee</td>
</tr>
<tr>
<td>Dr. Diane Clarke</td>
<td>Chief Operating Officer</td>
<td>Operation PAR</td>
<td>Substance Abuse expert</td>
<td>SunCoast/ Pinellas Park</td>
</tr>
</tbody>
</table>

The advisory committee first met on May 26, 2015, in Tampa and then again on August 26, 2015. The focus of the advisory committee is identification of statewide systemic issues that will then be used to help inform statute, policy and practice changes. Much of their early work has focused on the refinement of the review tools and identification of consistent data elements to be used for further review and analysis. Local review teams led by DCF Regional Managing Directors have been convened in each jurisdiction to review CIRRT findings and develop any immediate corrective action steps necessary.

**Infusion of Data Analytics and Technology**

The Department is working to improve and update technology, moving away from a manual tracking system of child fatalities to a system that allows for consistent data collection statewide. Qualtrics, a software data collection program, was purchased to gather demographic and qualitative information on all child fatalities reported to the Florida Abuse Hotline. The advisory committee had extensive input into the development of the Qualtrics tool and the data to be collected by the review teams.

CIRRT Advisory Committee Report
October 2015
For the first time in the Department's history, consistent data is now being collected on all child deaths known to the child welfare system using a standardized approach. There are a total of 73 questions electronically posed for each child fatality. Each question can generate up to 20 responses per question per review. Qualtrics can then be used to produce charts and graphs for greater in-depth analysis.

Minimum requirements were established that apply to all child fatalities that come to the attention of the Department or a contracted CBC/CMO provider. These requirements are in an ongoing effort to:

- Prevent child fatalities
- Apply lessons learned from past fatalities
- Improve safety and risk assessments to maintain the safety of children during protective investigations and/or case management services
- Further support transparency and accountability with the comprehensive release of information and data regarding child fatalities.

In addition, the Department has recently begun using Tableau Software. Tableau is an application that allows users to create a visual representation of their data that provides for simple comparison, analysis and insight. It also has a dashboard capacity that allows sharing of critical information with staff at all levels of an organization, at their level of organizational need. Separate dashboards can be created to meet the needs of frontline staff and supervisors, through executive leadership.

**Review of Child Fatality Data**

Overall, child deaths in the State of Florida typically involve a child age 3 or younger and involve a variety of different manners of death, ranging from unsafe sleeping, drownings, natural causes, inflicted traumas, SIDS/SUID, and accidental trauma.

*Data from DCF's Child Fatality Website ([www.myffamilies.com/childfatality](http://www.myffamilies.com/childfatality))*
Since January 1, 2015, the Department has deployed 30 CIRRTs across the state.

Nine CIRRT deployments involved areas where child protective investigations are conducted by Sheriff's Offices.
93% of all CIRRT deployments have involved a child less than 6 years old.

77.3% of all child death reports received at the Hotline involve children under the age of 3. 67.57% of all CIRRT deployments involve children under the age of 3.
Of the 108 closed child fatality investigations that were received between January 1, 2015 and September 30, 2015, the four primary causal factors were Natural Causes, Unsafe Sleep, SIDS/SUID and Drowning. However, there are still 249 child fatality investigations received during the same time period that remain open, which, when finalized, will impact the overall numbers and causal factor sequencing. Cases that were closed with verified findings of death maltreatment were based on the actions or inactions of the caregiver.

Between January 1, 2015 and September 30, 2015, there were a total of 30 cases that met the statutory criteria for CIRRT deployment. Of the 30 deployments, 16 (just over half) of the investigations involved children age 1 year or younger who were found unresponsive in their crib/bassinet or after sleeping with an adult caregiver and/or siblings. Although the primary causal factor noted at this time is Natural Causes, it is reasonable to expect an increase in the deaths attributed to unsafe sleep and possibly drowning.
Between 2009 and 2015, the four leading causal factors of child fatalities reported to the abuse hotline were Unsafe Sleep (589 deaths), Drowning (486 deaths), Natural Causes (480 deaths), and Inflicted Trauma (304 deaths).

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 the medical examiner's finding of fact. The Department's ability to verify a death maltreatment is contingent upon the findings of the medical examiner. If a medical examiner does not identify a specific cause of death, the death maltreatment cannot be verified.

In addition, there were four Inflicted Trauma investigations that were closed with no indicators of maltreatment as opposed to "No Jurisdiction". In three of those cases, the individual responsible for the fatalities was not a caregiver of the child, and the fourth case involved a death of a child as a result of an incident that occurred in another state.
Emerging Themes

The CIRRT reports have identified emerging themes in each of the three main categories:

Practice Assessment

- Child protective investigators continue to struggle with gathering, reconciling and analyzing information regarding families.
- In many of the cases, information sharing between agencies serving the same families was not timely or thorough.
- A lack of adequate safety planning to control identified danger threats was a common theme.

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 paralleled with non-CIRRT cases. These analyses will help determine whether a systemic or more targeted administrative interventions are needed to address practice assessment themes/issues.

Organizational Assessment

High turnover and the lack of an experienced workforce of both child protective investigators and case managers are common themes in the majority of the CIRRT reports.

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. This may be a general theme throughout the child welfare system and not a specific contributing factor associated with child fatalities, but it needs to be more rigorously studied. Further, there needs to be a more specific itemization of the factors associated with the recruitment and turnover of competent workers within the state of Florida that administrative interventions could target.

Service Array

Lack of identification of appropriate services and matching families to the appropriate level of service intervention were identified as issues. Failure to staff cases when families stop cooperating or fail to engage in services is an area needing improvement.

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/inability 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. 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, some statewide and local actions have already been implemented. The Spirit CIRRT identified issues around inadequate assessments of the family’s extensive history with the child welfare system, and the following actions were taken:

- All staff who handled the case were required to repeat the eight days of Safety Methodology training.
- Expanded consultative reviews were completed on all open child protective investigations for children ages 3 and under in Dixie and Gilchrist counties and on 272 additional cases throughout the state that were identified as having chronic, longstanding family history.
- Statewide, all Child Protective Investigators (CPIs) were required to complete 12 hours of training focused on assessing the family’s child welfare history.
- Secretary Carroll and Assistant Secretary of Child Welfare Thomas conducted face-to-face meetings with field staff in each Region to emphasize the importance of the Department’s mission and to stress that frontline staff are often a child’s last best hope.
- Practice experts were required to conduct monthly consultations with Child Protective Investigator Supervisors and CPIs to help them better understand patterns of behavior and current conditions.
- Policy was established requiring review by practice experts of 100 percent of cases meeting the Rapid Safety Feedback (RSF) requirements. RSF review is required when cases have certain high-risk factors.

One of the issues identified in the JonChuck case was the Hotline’s failure to accept for investigation a report alleging a caregiver was exhibiting signs of significant mental health issues while caring for a child. In response, the Department took the following actions:

- Policy was immediately implemented to require the Florida Abuse Hotline Counselors to accept reports alleging inadequate supervision when a caregiver is exhibiting signs of active mental health issues and to code them as an immediate response priority when the circumstances present are significant, clearly observable and actively occurring. In addition, the hotline will transfer the call to the appropriate law enforcement agency and request a well-being check of the child.
- The Maltreatment Index (Operating Procedure 175-28) was updated to allow for the presence of obvious mental health symptoms to more easily be categorized as problematic and, therefore, accepted by the Florida Abuse Hotline for the purpose of investigation.
- With the assistance of the Department’s Substance Abuse and Mental Health Office, a series of services questions were developed to be used by hotline counselors and child protective investigators to assist in assessing whether a caregiver’s mental health issues may be impacting the caregiver’s capacity to provide care to a child.

Local responses have included establishing new CPI leadership teams and development of more robust multidisciplinary protocols to enhance communication and collaboration. Assistant Secretary of Operations Abrams has required that local action plans are developed for each CIRRT.
Issues related to implementation of Florida's new child welfare practice have been a common theme in the majority of CIRRT reviews. In response to this, 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) positions. In July 2015, the Department contracted with Action for Child Protection to administer a proficiency process that was established to ensure Critical Child Safety Practice Experts are subject matter experts in the new safety 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.

Next Steps

Throughout deployments and with input from the statewide CIRRT advisory committee, additional qualitative data elements have been identified. Efforts to collect this data from prior CIRRTs and from other, similar reviews should be continued and entered into Qualtrics. Where possible, data collected through other qualitative reviews, such as 2nd level reviews and Rapid Safety Feedback reviews, should be used 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 over the coming months, 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.