Critical Incident Rapid Response Team Advisory Committee
Fourth 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
Fourth 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.

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 in an effort 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).

Mini-CIRRT 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, 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.

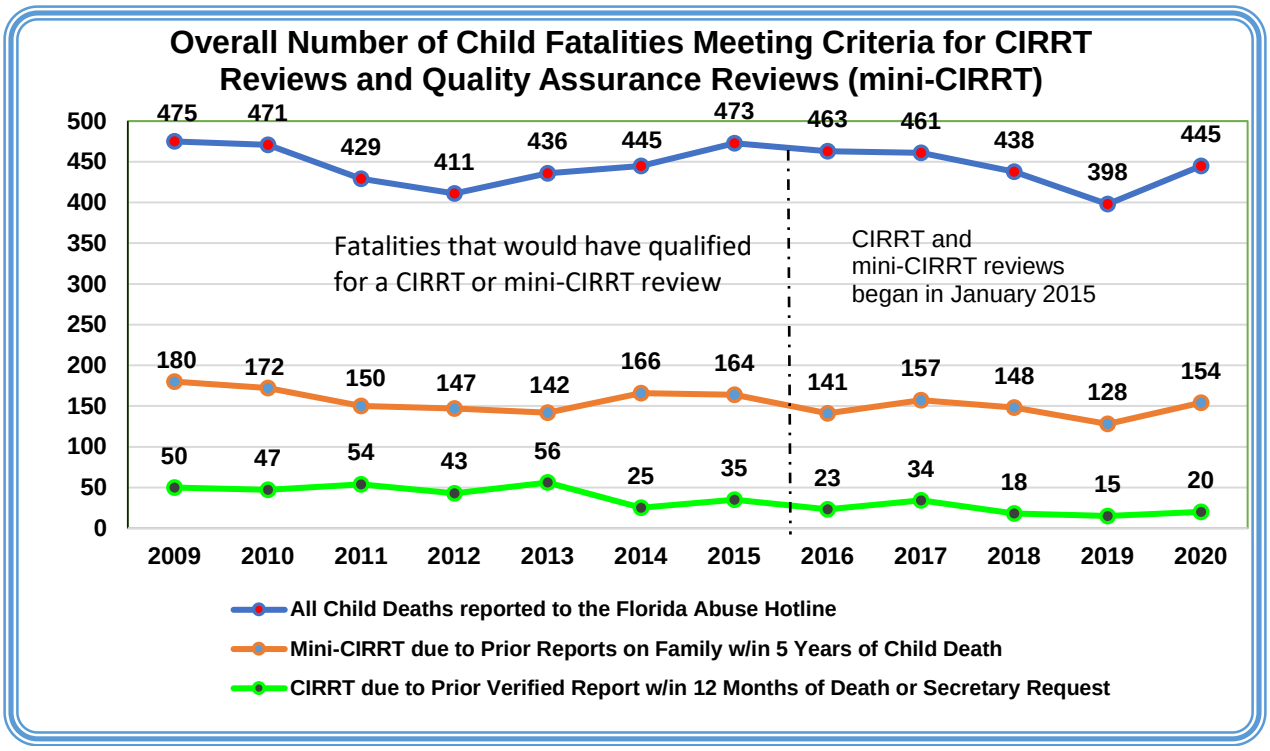
Team Composition
Each team deployed is comprised of individuals with expertise in the appropriate areas, as identified through a review of the family's prior history with the child welfare system. The team lead is responsible for guiding the process throughout the duration of the review.

III. Review of Child Fatality Data

Between October 1 and December 31, 2020, there were 104 fatalities called in to the Hotline. Of those 104 cases, eight met the criteria for either a CIRRT deployment (five) or special review (three). In two of the CIRRT deployments that occurred during the fourth quarter, there was no prior history involving the deceased child (40 percent) of the cases. All three of the cases that met the criteria for a special review had prior history involving the deceased child.

From January 1, 2015, through December 31, 2020, a total of 143 CIRRT teams were deployed involving 145 child deaths. Of those deployments, 137 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.

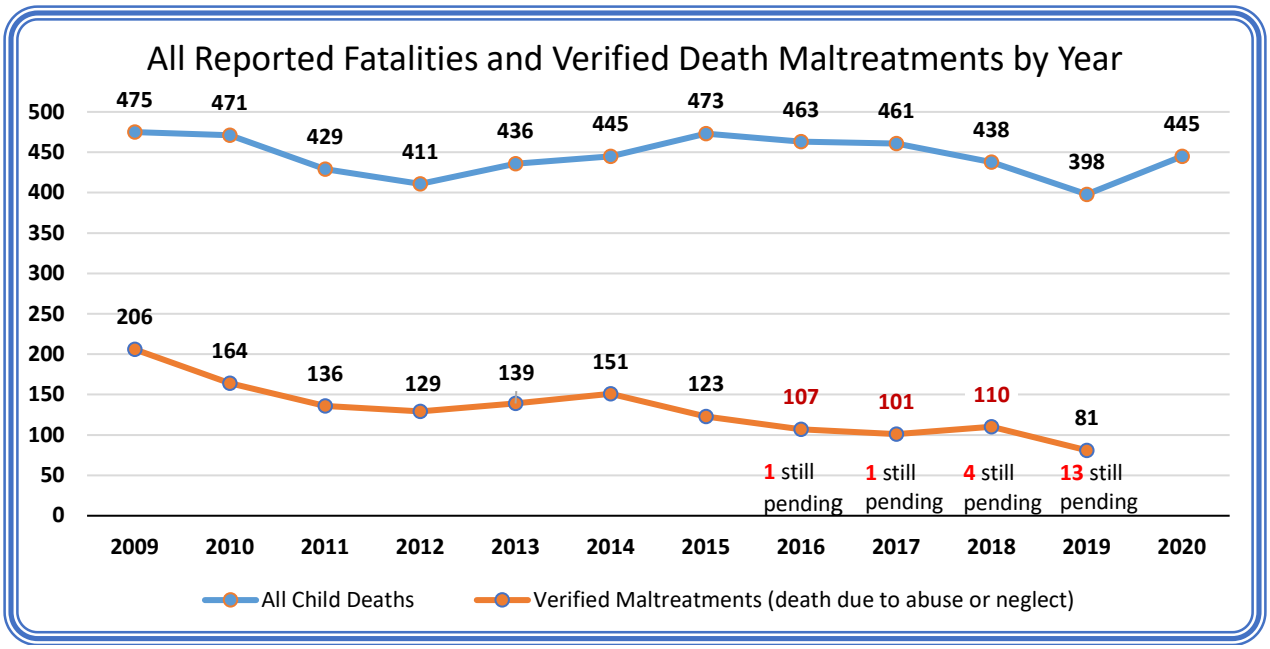
Since January 1, 2015, the fatalities resulting in a CIRRT deployment represent approximately five percent of the overall fatalities reported to the Department of Children and Families' (Department) Florida Abuse Hotline (Hotline). An additional 33 percent of the fatalities reported to the Hotline met the criteria for a mini-CIRRT or special review. 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.



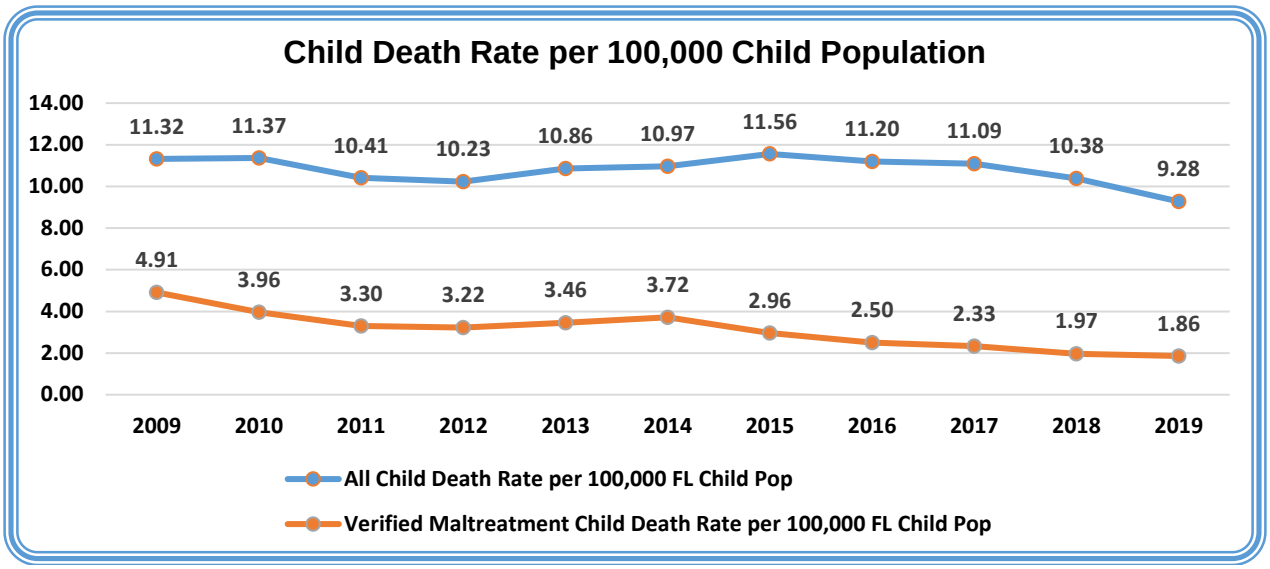
The rate of occurrence for fatalities meeting the requirements for CIRRT deployments and mini-CIRRT reviews as compared to the overall number of fatalities reported to the Hotline has remained relatively the same over the years. While there are slight decreases and increases, they are not statistically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

Reports on reviews conducted as a result of a child fatality 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. Per 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 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.



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.



III. Review of CIRRT Data

a. Summary of Fourth Quarter CIRRT Reports

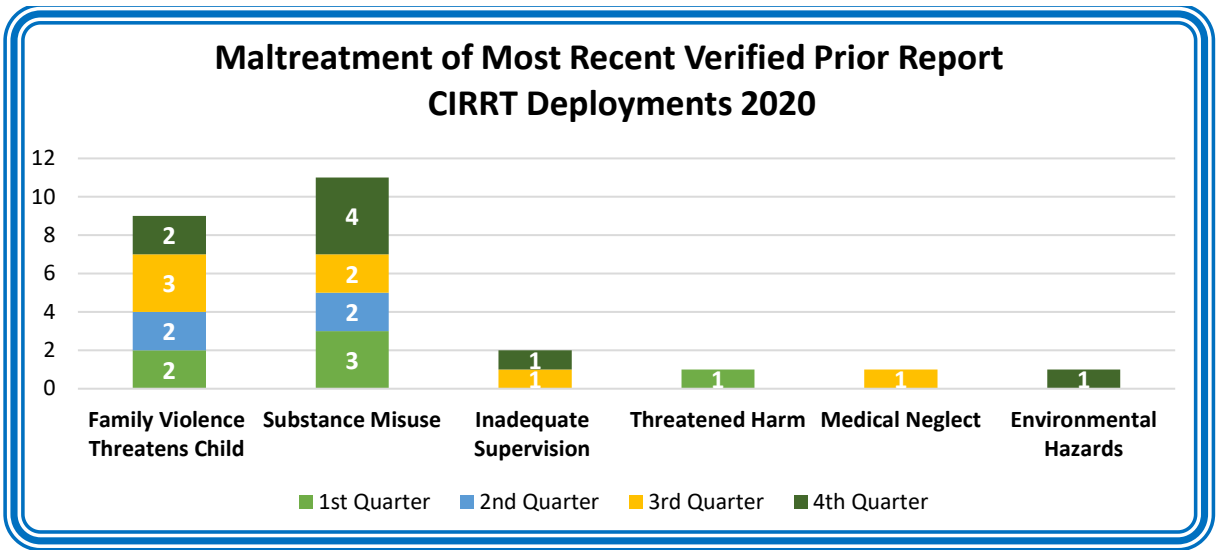
The two reviews that were deployed to Pinellas County involved children (ages 1½ years and 3 months) that were discovered unresponsive while bed-sharing with their parents. The Pasco County deployment involved the death of a 3-month-old that was

found unresponsive after being placed on an adult bed to sleep. The deployment to Columbia County involved the death of a newborn after she was delivered at home at 28 weeks gestation. The Duval County deployment involved a 3-week-old after he was discovered unresponsive while bed-sharing with his mother.

In three of the five deployments (Columbia, Pinellas, and Pasco Counties), child welfare services were involved at the time of the respective fatality; in the Pinellas and Pasco County cases (three of the five cases), the decedents were the subjects of a prior verified report.

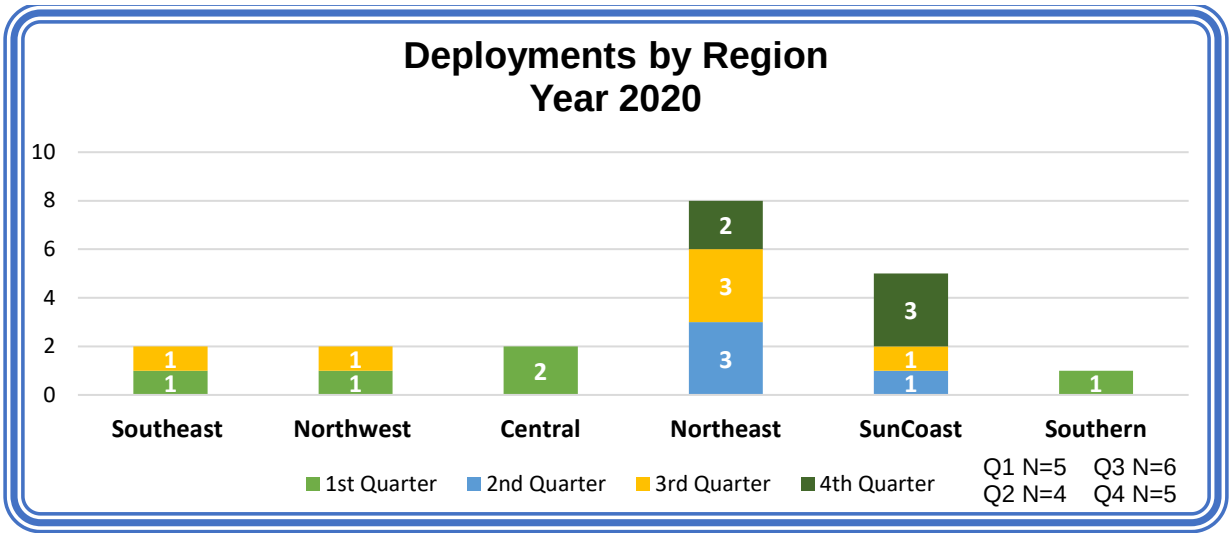
b. Past Maltreatment

During the fourth quarter of 2020, there were five CIRRT deployments, involving five victims, with three victims being the subject of a verified prior report; in the two remaining instances, the verified prior reports were verified as to a sibling or child in the home other than the decedent. Two deployments each had a prior verified maltreatment of substance exposed newborn and substance misuse, and three deployments had prior verified maltreatments of household violence, inadequate supervision, and environmental hazards.



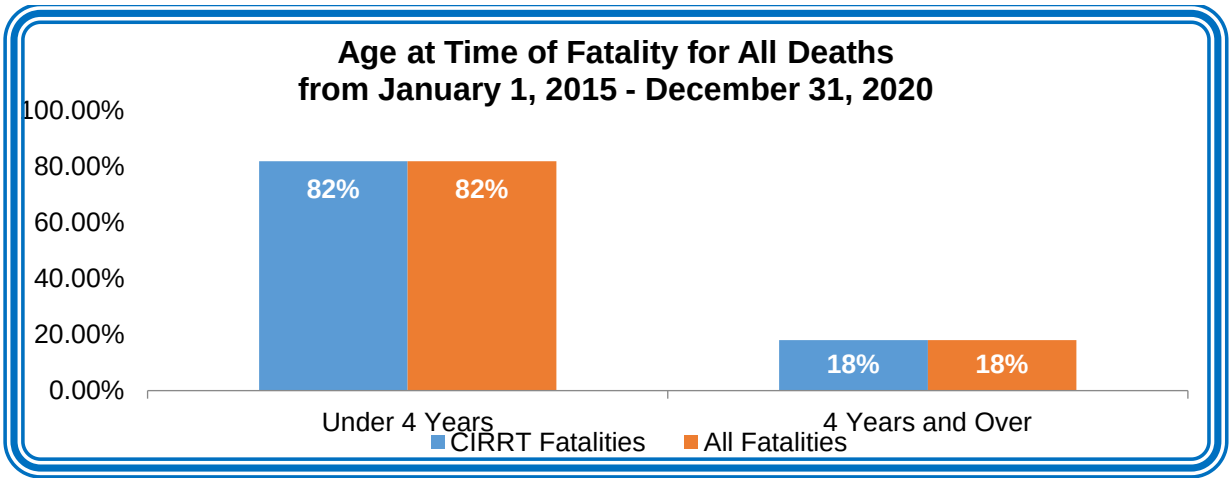
CIRRT Data by Region

From October 1 through December 31, 2020, there were five CIRRT deployments, involving five victims, occurring in two of the six regions. There were three deployments to the Suncoast Region and two to the Northeast Region. The deployments to the Suncoast Region (Pinellas and Pasco Counties) are areas where the respective sheriffs' office conducts child protective investigations. The department is responsible for the completion of child protective investigations in the Northeast Region where teams were deployed Columbia and Duval Counties.



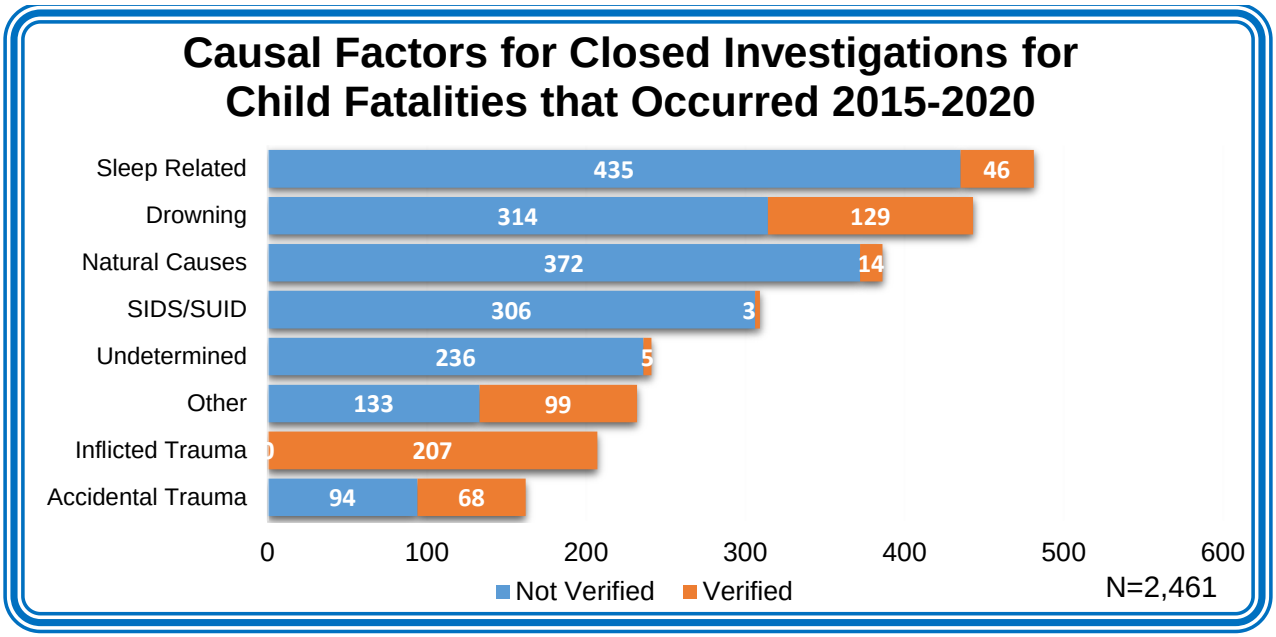
c. Age of Victim

During the fourth quarter in 2020, there were a total of five CIRRT deployments involving five victims. All five victims were under 3 years of age, with four of the victims being age 3 months or younger, and one victim under the age of 2 years.



d. Causal Factors All Fatalities

Of the 2,461 closed child fatalities that occurred from January 1, 2015, to December 31, 2020, the four primary causal factors were sleep-related, drowning, natural causes, and SIDS/SUID. There are still 217 child fatality investigations that remain open, the majority of which were received in 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, 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 bedsharing, and both were under the influence of substances.

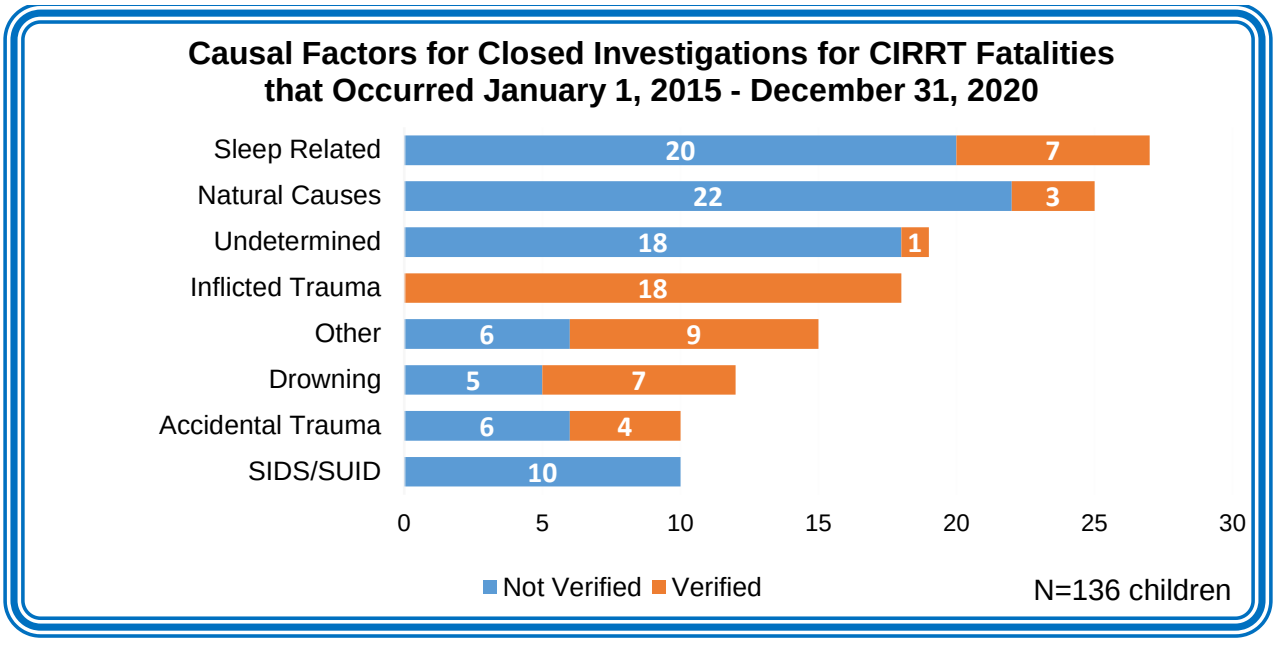
The death maltreatment cannot be used as a stand-alone maltreatment; therefore, the underlying maltreatment that may have caused or contributed to the child's death is noted. For an investigation to be closed with verified findings for the death

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 December 31, 2020, there were a total of 143 CIRRT deployments involving 145 child fatalities. Of the 135 investigations (involving 136 children) that were closed, the four primary causal factors were sleep-related, natural causes, undetermined, and inflicted trauma. In addition, 48 investigations (36 percent) involving 49 victims had verified findings for the death maltreatment; eight of the investigations (involving nine children) remain open.



An additional 28 investigations (21 percent) were closed with verified findings for maltreatment other than the death maltreatment, with inadequate supervision being verified in 14 of the cases, and 12 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 December 8, 2020.

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 December 8, 2020 meeting, the CIRRT deployments from the 2020 third quarter were reviewed and discussed with a focus on the lack of additional assessments as to substance use and mental health. There was discussion on transitioning from onsite deployments to utilizing virtual formats. The ability to have extra processing time to review the case prior to interviews and prior to the discussions around findings due to the virtual format has been beneficial.

Additionally, discussion was held around the expansion of the DCF CIRRT Unit to include a specialized team to complete comprehensive reviews of sexual abuse cases involving licensed care to address recommendations as to additional licensing and placement of children in these homes and to provide guidance to field staff. Additional training around sexual abuse was developed as part of DCF's Learning Management System for all staff .

V. Recommendations

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

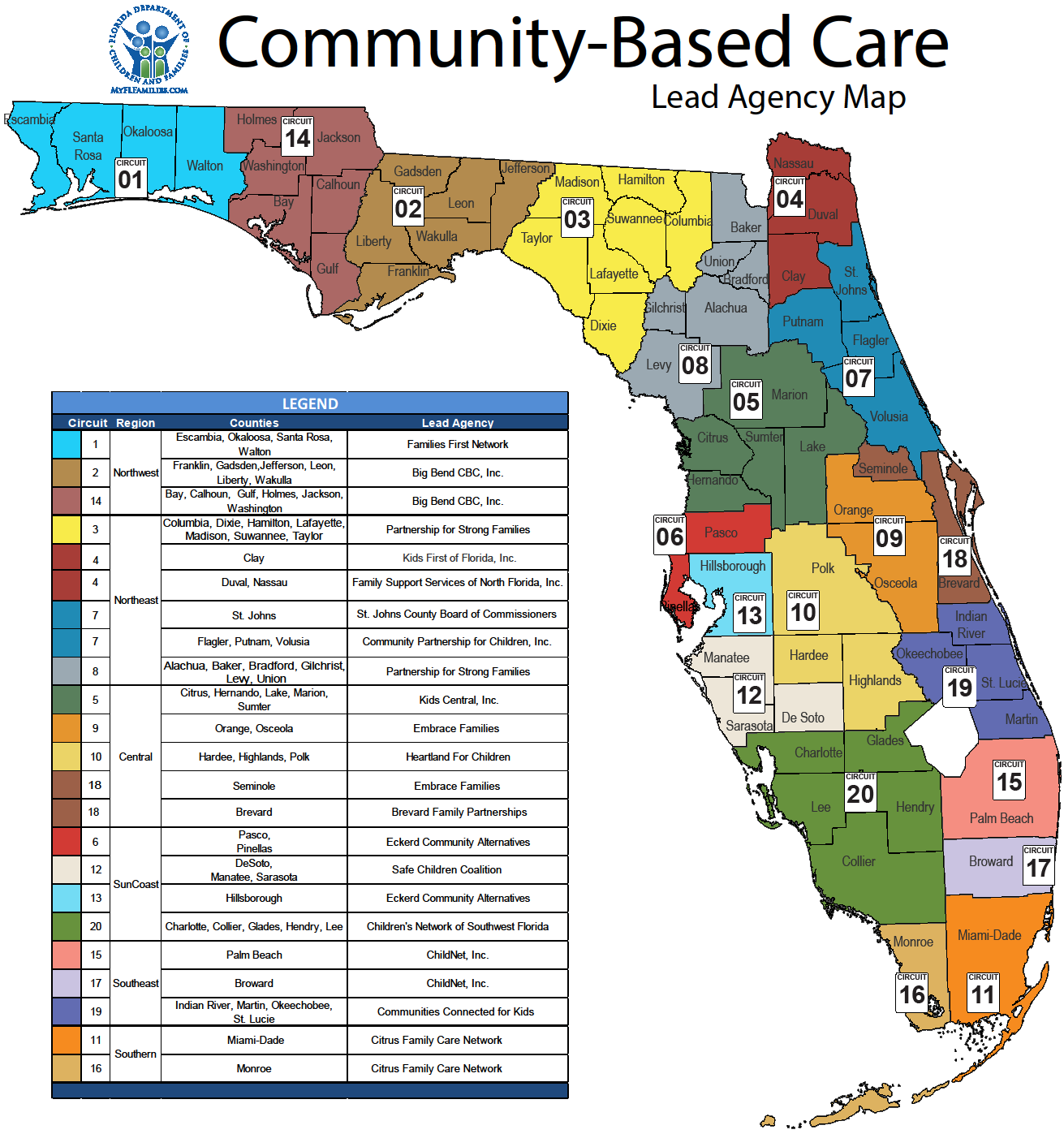
APPENDIX 1 – Section 39.2015, Florida Statutes

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		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	Eckerd Community Alternatives
	12		DeSoto, Manatee, Sarasota	Safe Children Coalition
	13		Hillsborough	Eckerd Community Alternatives
	20		Charlotte, Collier, Glades, Hendry, Lee	Children's Network of Southwest Florida
	15	Southeast	Palm Beach	ChildNet, Inc.
	17		Broward	ChildNet, Inc.
	19		Indian River, Martin, Okeechobee, St. Lucie	Communities Connected for Kids
	11	Southern	Miami-Dade	Citrus Family Care Network
	16		Monroe	Citrus Family Care Network