Critical Incident Rapid Response Team Advisory Committee
First Quarter Report for Calendar Year (CY) 2017

Mike Carroll
Secretary

Rick Scott
Governor

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

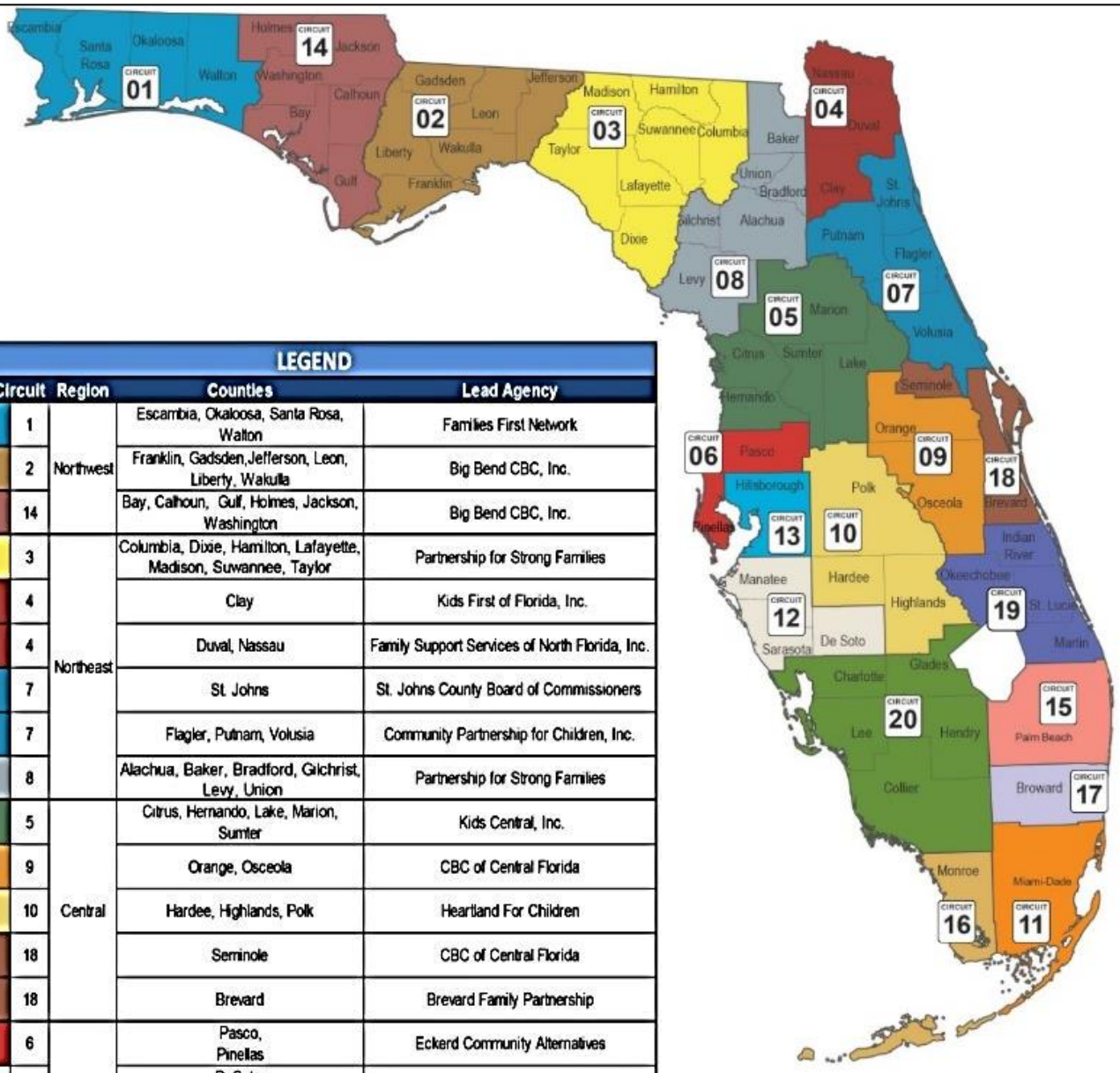
Florida Department of Children and Families
Critical Incident Rapid Response Team
Advisory Committee Report
First Quarter 2017

I. Background

In 2014, the Florida Legislature passed Senate Bill 1666 (Chapter 2014-224, Laws of Florida), 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 of Children and Families (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 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 CIRRT advisory 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 Manatee, Pasco, Pinellas, Hillsborough, Broward, and Seminole counties. The Department is responsible for child protective investigations in the remaining 61 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 for each of the 20 judicial circuits in the state.

Community Based Care Lead Agencies by Circuit and County



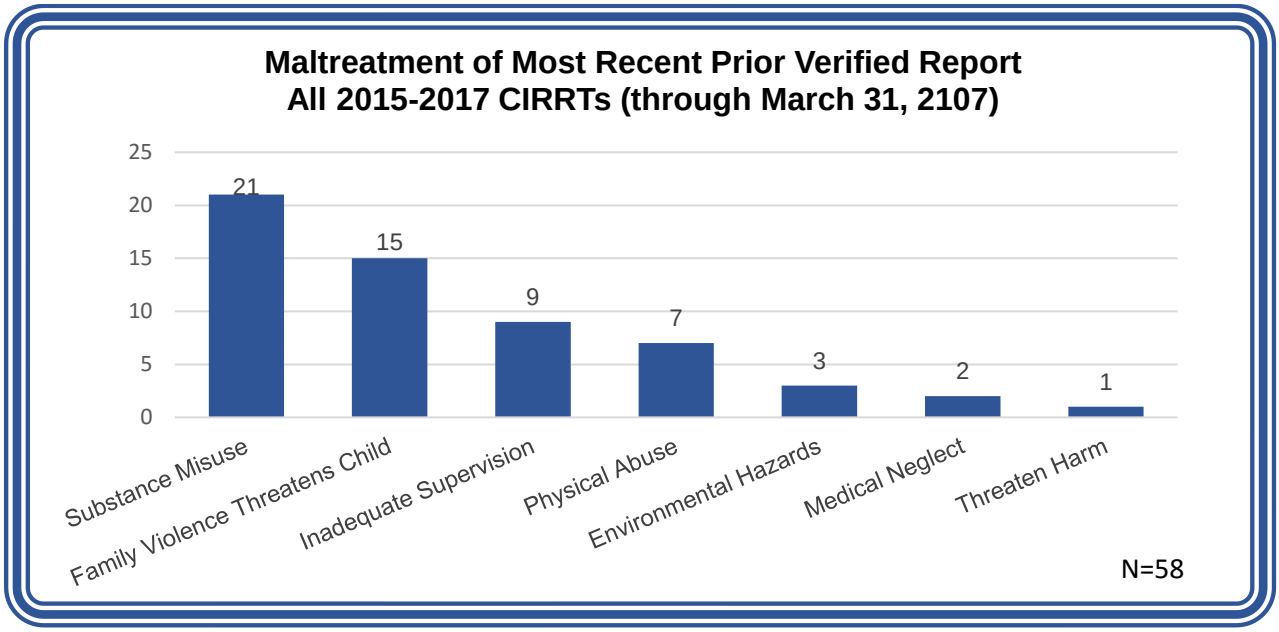
LEGEND				
Circuit		Region	Counties	Lead Agency
	1	Northwest	Escambia, Okaloosa, Santa Rosa, Walton	Families First Network
	2		Franklin, Gadsden, Jefferson, Leon, Liberty, Wakulla	Big Bend CBC, Inc.
	14		Bay, Calhoun, Gulf, Holmes, Jackson, Washington	Big Bend CBC, Inc.
	3	Northeast	Columbia, Dixie, 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	CBC of Central Florida
	10		Hardee, Highlands, Polk	Heartland For Children
	18		Seminole	CBC of Central Florida
	18		Brevard	Brevard Family Partnership
	6	SunCoast	Pasco, Pinellas	Eckerd Community Alternatives
	12		DeSoto, Manatee, Sarasota	Sarasota Family YMCA, Inc.
	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	Devereux CBC
	11	Southern	Miami-Dade	Our Kids of Miami-Dade/Monroe, Inc.
	16		Monroe	Our Kids of Miami-Dade/Monroe, Inc.

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. 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.

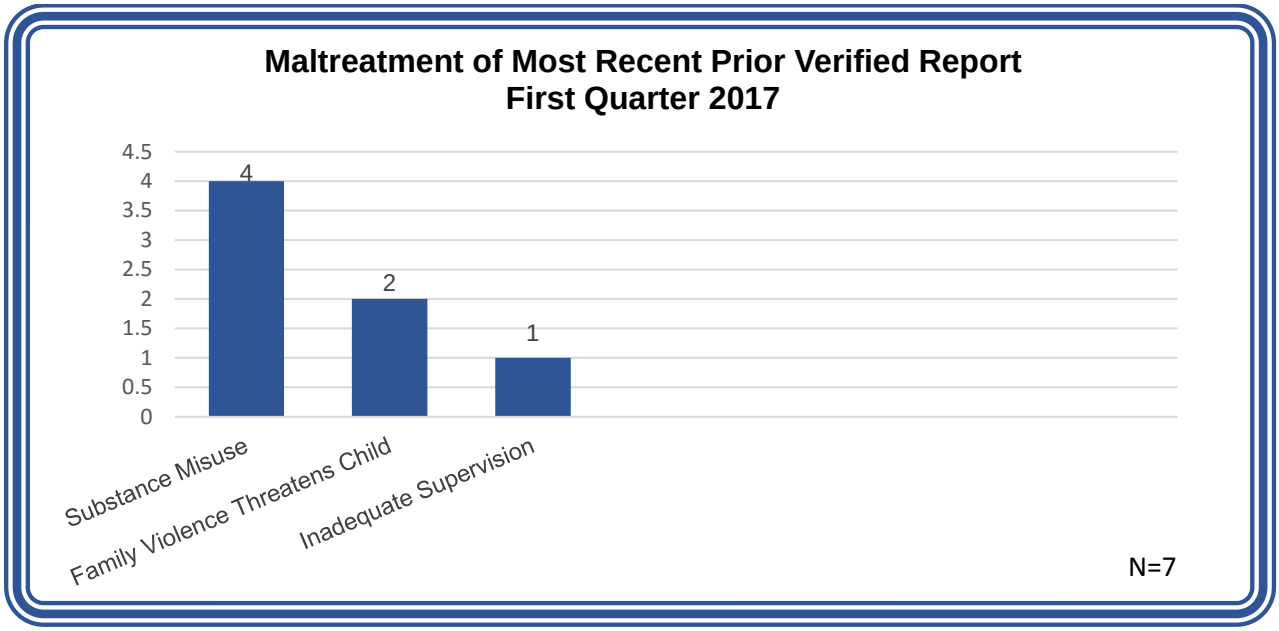
CIRRT reviews take into account the family's entire child welfare history, with specific attention to the most recent child welfare involvement and events surrounding the fatality, including the most recent verified incident of abuse or neglect. From January 1, 2015 through March 31, 2017, CIRRT teams reviewed 64 child fatalities. Of those deployments, 58 met the CIRRT requirements, having a verified report within the previous 12 months, while the other six reviews were completed at the direction of Secretary Mike Carroll. Of the six special reviews, 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.

Of the 58 cases meeting the requirements for CIRRT deployment, the most common maltreatment noted in the verified prior report was substance misuse, followed by family violence threatens child. Additional maltreatment categories are outlined in the chart below. Untreated caregiver mental health issues are often found to be co-occurring; however, mental health issues of caregivers are not considered maltreatments.



During the first quarter (January - March) of 2017, there were seven CIRRT deployments, with each having a verified prior within the previous 12 months. There were four deployments with a prior verified maltreatment of substance misuse, two

deployments with a verified maltreatment of family violence threatens child and one deployment with a prior verified maltreatment of inadequate supervision. These seven reports are a subset of the 64 child fatalities mentioned above.



III. CIRRT Process

Prior to conducting CIRRT reviews, in November 2014, the Department began actively recruiting staff from partnering agencies. Since that time, training has been offered every three months at various locations throughout the state. To date, a total of 421 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. The most recent training for team leads was held in Tampa in October 2016. In addition, specialized one-day training was created specifically for the Child Protection Team medical directors to meet the statutory requirement effective July 1, 2015, requiring medical directors to be a team member on all CIRRTs (section 39.2015(3), Florida Statutes).

Total numbers of individuals trained include the following areas of expertise:

Expertise	Trained
Adult Protective Investigations (DCF)	4
Child Protective Investigations (DCF) (includes Office of Child Welfare, Team Leads and Report Writers)	116
Child Protective Investigations (Sheriff's Office)	28
Florida Abuse Hotline	7
Community-Based Care Lead Agencies (CBC)	76
Case Management Organizations (CMO)	10
Diversion	5
Domestic Violence	25
Guardian ad Litem (GAL)	2
Human Trafficking	2
Substance Abuse/Mental Health	60
Children's Legal Services	30
Law Enforcement Sworn Officers	9
Department of Health	3
Healthy Start	3
Healthy Families	2
Child Protection Team	32
Child Protection Team Medical Directors	5
Advisory Committee Members	2

Team Composition

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

Child Fatality Review Process

Every case involving a child fatality receives a specified level of a quality assurance review. A child fatality review is completed by the region's child fatality prevention specialist on every case involving a child fatality, followed by a written Child Fatality Summary that outlines the circumstances surrounding the incident. For cases in which

there is no prior child welfare history involving the family within the five years preceding the child's death, this limited review is the only report that is written.

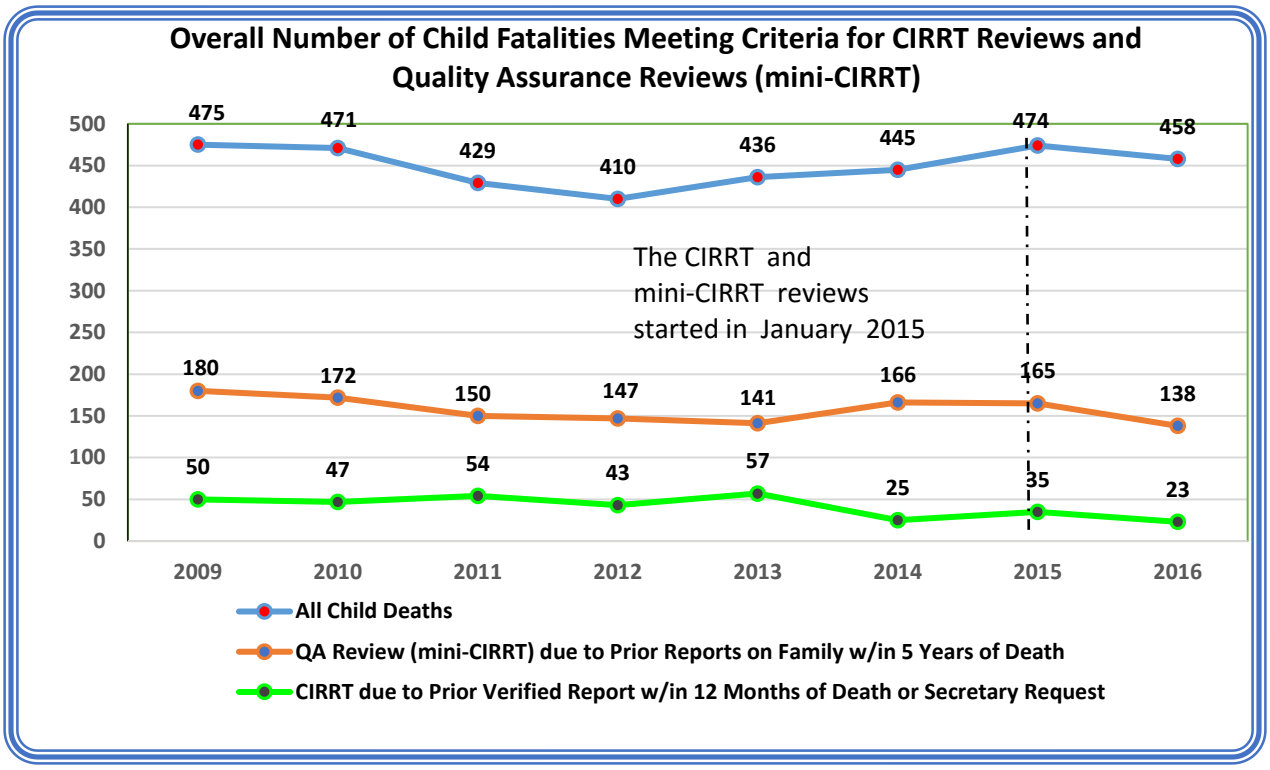
For cases in which there was a verified prior report involving the deceased child or a sibling within 12 months of the death, a review is conducted utilizing the CIRRT process. While only a small percentage of cases meet the criteria for this extensive review, an in-depth review that mirrors the CIRRT 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, they are used to supplement the information contained in the Child Fatality Summary. These reviews use a tool and process that mirrors the CIRRT review process.

In calendar year 2016, 22 cases, involving 23 children, either met the criteria for a CIRRT deployment due to having a verified report within 12 months of the reported death or the Secretary requested a team be deployed. One of the CIRRT deployments involved two victims. Although this represents less than 5% of the overall fatalities called to the Department's Florida Abuse Hotline (hotline), it's important to note that there were 138 additional cases that met the criteria for a mini-CIRRT review. In total, for the 2016 calendar year, in-depth quality assurance reviews were conducted on 160 cases, with 161 victims, representing just under 35% of all cases received.

Of the 161 child fatalities received in 2016, where there was a CIRRT deployment or a mini-CIRRT review, the deceased child had no prior history in 42.5% (68) of the cases reviewed. There is, however, a difference in percentages when comparing CIRRT and mini-CIRRT cases. For the 22 CIRRT cases, involving 23 children there was no prior history involving the deceased child in six (27%) of the cases reviewed; whereas in the 138 mini-CIRRT cases, there was no prior history involving the deceased child in 62 (45%) of the cases reviewed. Data in the chart on page 8 is based on the number of child victims, not by report received as there may be multiple victims in a report.

During the first quarter of 2017, there were a total of 108 child fatality victims, and 47 of those met the requirements to receive a CIRRT deployment or mini-CIRRT review. Seven children required a CIRRT deployment and 40 children required a mini-CIRRT review. Of the 47 child fatalities that required an in-depth review during the first quarter of 2017, the deceased child had no prior history in 36.2% (17) of the cases, all of which required a mini-CIRRT review. The child victims in the seven CIRRT deployments all had a prior abuse history.

Based on the historical data, it is likely that in-depth quality assurance reviews will continue to be conducted on more than 40% of the cases received in a given year.



It should be noted that the chart above is a reflection of the number of actual child fatalities, and not the number of cases. Some cases involve multiple victims, however, only one respective review would be conducted. For example, while there were 23 child fatalities in 2016, there were only 22 deployments as one case involved two co-occurring fatalities. Likewise, while there are a specific number of fatalities that meet the criteria for a "mini-CIRRT", if there were multiple victims in the same case, only one report would be completed.

Between January 1, 2015 and March 31, 2017, a total of 334 cases met the criteria for completion of a "mini-CIRRT" review due to there being prior involvement with the family within the previous five years. In addition, there were eight additional cases that while met the criteria, did not require a review to be conducted as the fatality incident occurred in a facility (e.g., day care, juvenile detention center, etc.) in which a review of previous involvement with the family would have no bearing on the fatality given that it occurred outside of the family's control. During the first quarter of 2017, 35 cases statewide met the criteria for completion of a "mini-CIRRT" review. Department regional staff members have the responsibility for completion of mini-CIRRTs for the sheriffs' offices cases and are working on completing those reviews.

Standardized data is collected across all review types and entered into Qualtrics for further analysis and review. Reports on reviews conducted as a result of a child fatality (regardless of the type of review completed) are redacted according to Florida Statutes and posted for public review on the Department's Child Fatality Prevention website (http://www.dcf.state.fl.us/childfatality/) after the death investigation has been completed. According to Florida Statutes, the information redacted is based on whether

or not the death maltreatment has been verified by the Department as a result of 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.

The following chart represents the breakdown of mini-CIRRTs by region and sheriff's office.

Special Reviews (Mini-CIRRTs)				
Region	**Review Required**	**Reports Completed**	**Reports Pending**	**Percentage Complete**
Northwest	39	35	4	89.74%
Northeast	68	60	8	88.24%
Central	90	57	33	63.33%
Central Sheriffs	5	4	1	80.00%
Suncoast	27	20	7	74.07%
Suncoast Sheriffs	54	38	16	70.37%
Southeast	22	17	5	77.27%
Southeast Sheriff	17	13	4	76.47%
Southern	12	10	2	83.33%
DCF Totals	**258**	**199**	**59**	77.13%
Sheriffs' Total	**76**	**55**	**21**	72.37%
Statewide	**334**	**254**	**80**	76.05%

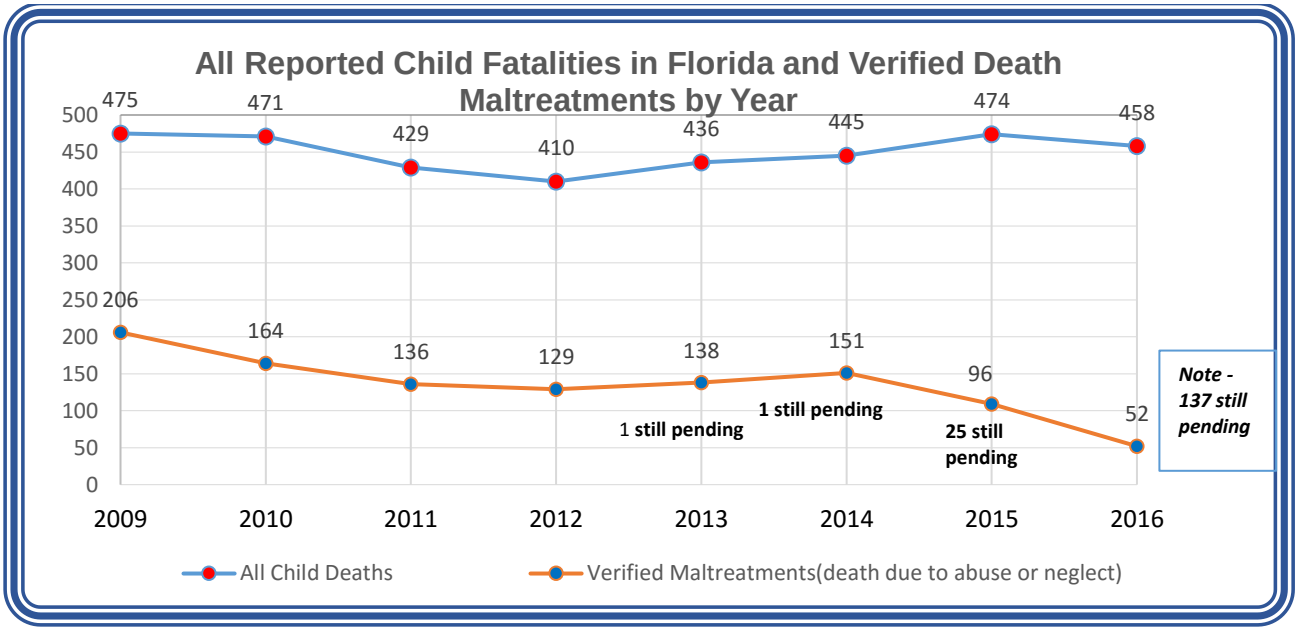
CIRRT Advisory Committee

The CIRRT Advisory Committee is statutorily required to meet on a quarterly basis. The committee has met a total of five times, most recently on February 14, 2017. Advisory committee members may participate via conference call but are encouraged to attend in person. The meeting notices are published and are open to the public. The primary focus of the advisory committee is to identify statewide systemic issues and provide recommendations to the legislature that will improve policies and practices related to child protection and child welfare services.

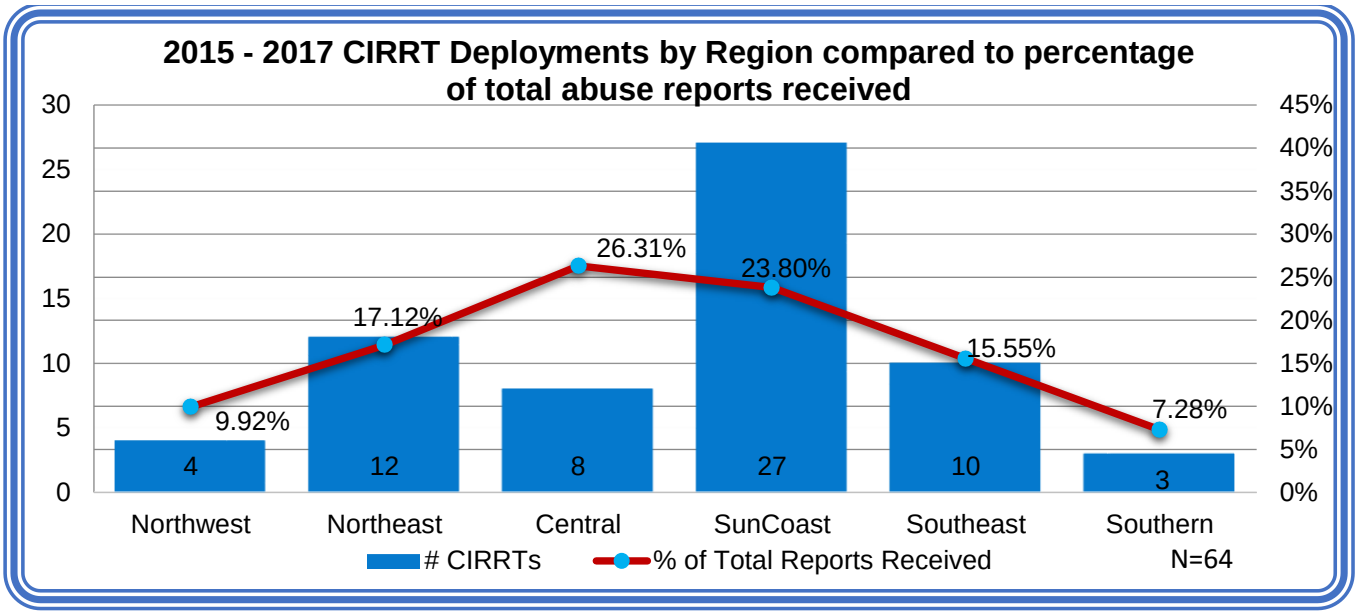
Review of Child Fatality Data

Overall, 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.

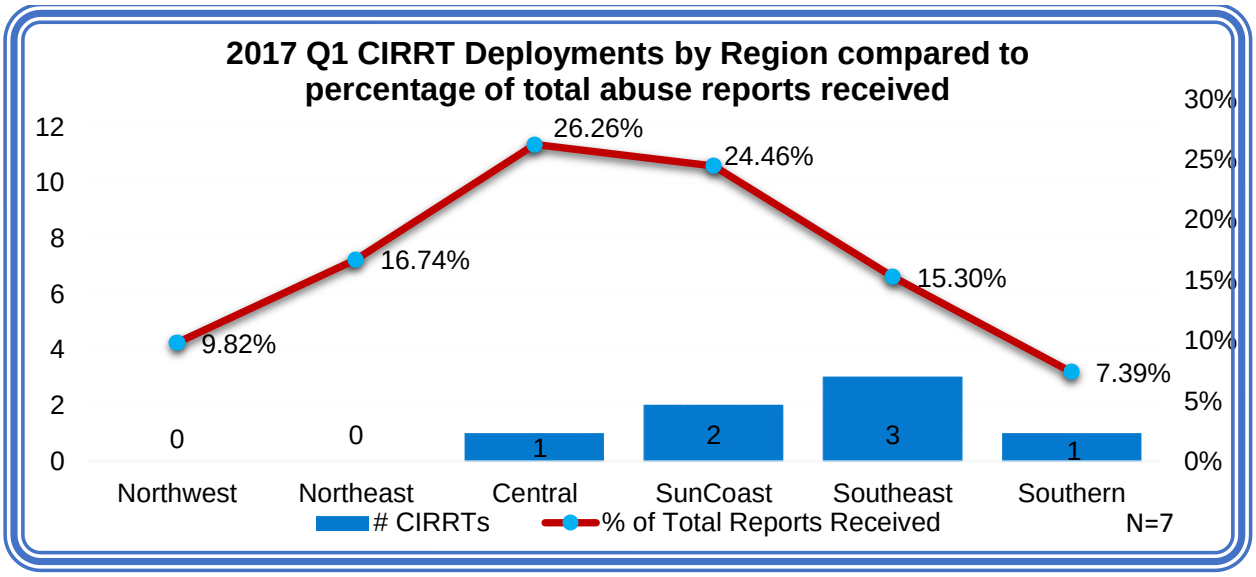
Of the 474 child fatalities that occurred in 2015 and were reported to the hotline, 25 investigations remain open. For the 458 child fatalities that occurred in 2016 and that were reported to the hotline, 137 remain open. Fifty-two of the 321 investigations that have been closed had verified findings for the death maltreatment. Findings for open cases have not yet been determined, giving the appearance of a decline in the number of verified reports. Two child death investigations, one each from 2013 and 2014, remain open at the request of law enforcement officials due to on-going criminal investigations.



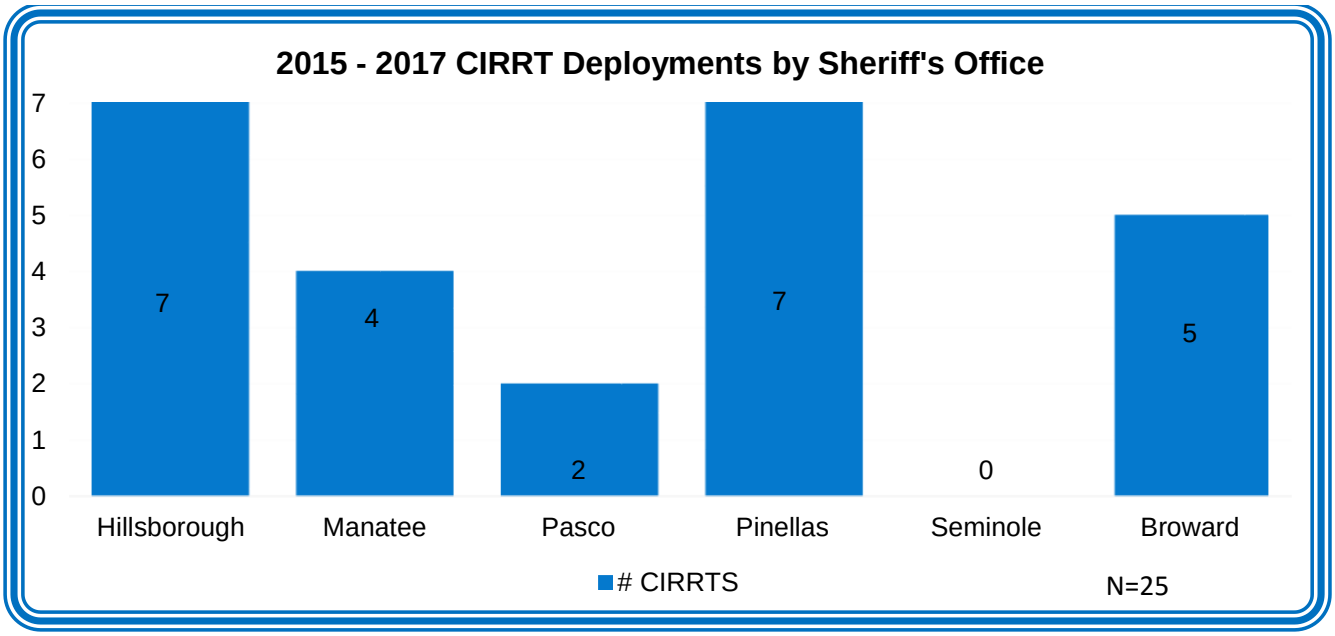
Since January 2015, there have been a total of 64 CIRRT deployments, with at least one deployment occurring in each of the six regions. The SunCoast Region accounts for 42 percent of the deployments while receiving 24 percent of the statewide abuse investigations during the past two years. Conversely, the Central Region, which at 26 percent accounts for the largest percentage of abuse reports received during the time period, was involved in 12.5 percent of the CIRRT deployments.



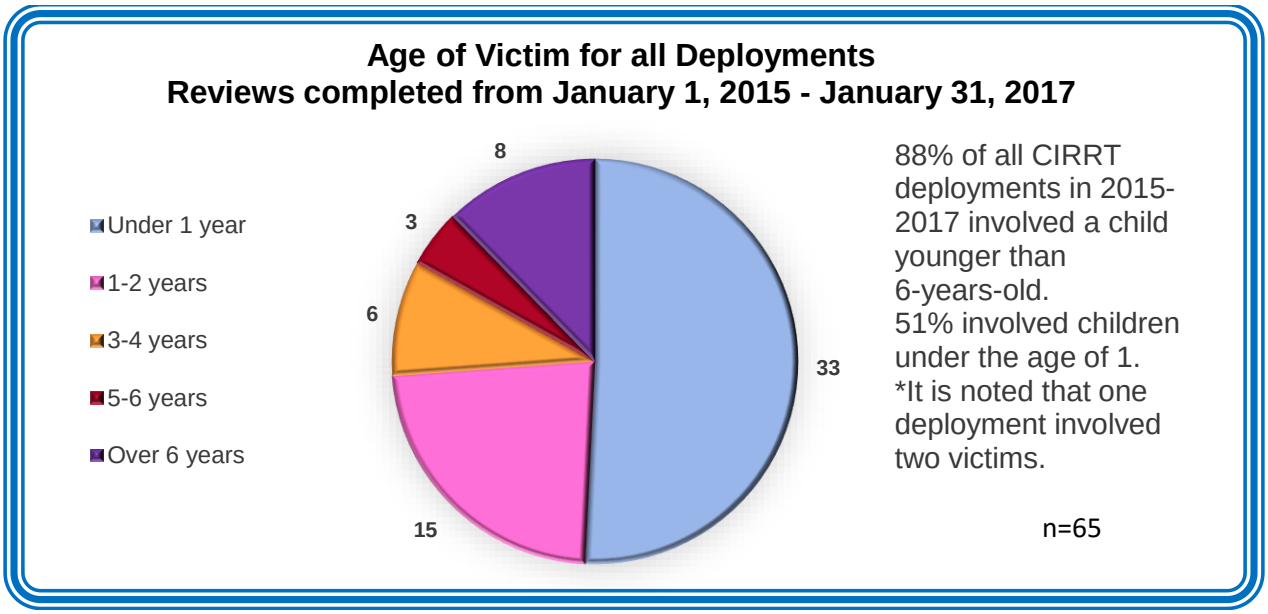
There were seven CIRRT deployments during the first quarter of 2017, three in the Southeast Region, two in the SunCoast Region and one each in the Central and Southern Regions. One of the three deployments to the Southeast Region occurred in Broward County, where the sheriff's office conducts child protective investigations. The Department was responsible for the completion of child protective investigations in the other six deployments across the state.



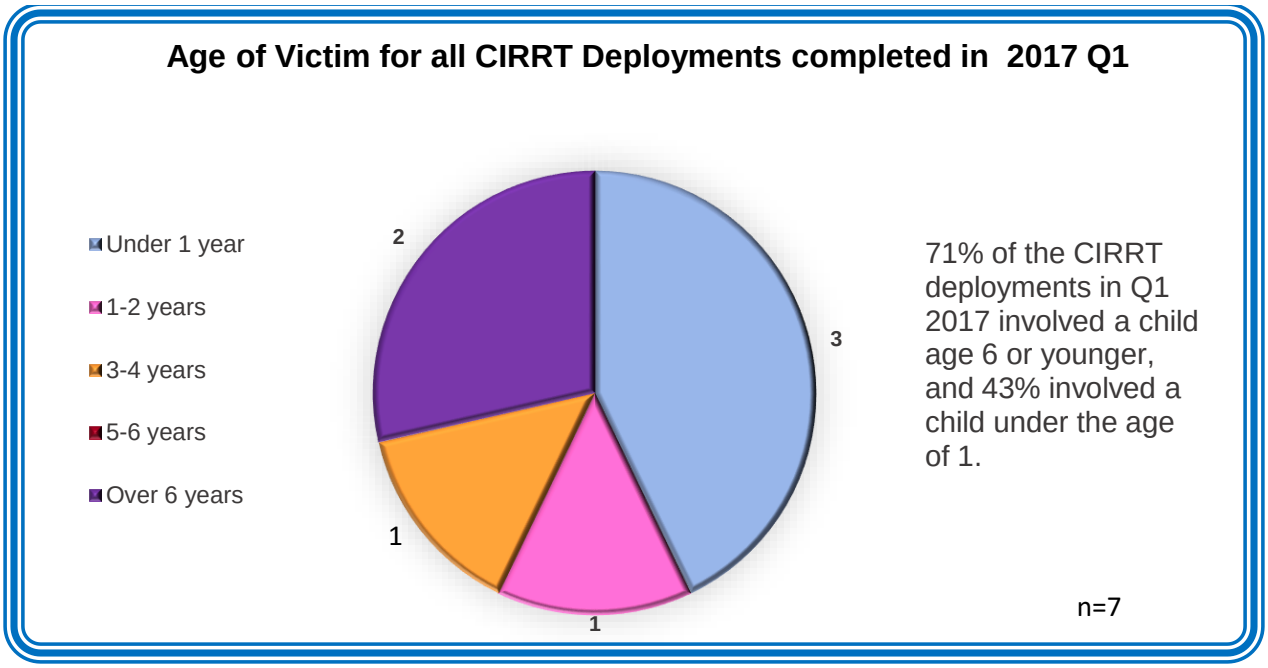
From January 1, 2015 through March 31, 2017, 25 of 64 CIRRT deployments involved five of the six counties where child protective investigations are conducted by sheriffs' offices. To date, there have not been any CIRRT deployments to Seminole County. During the first quarter of 2017, there was one CIRRT team deployed to Broward County, in the Southeast Region.



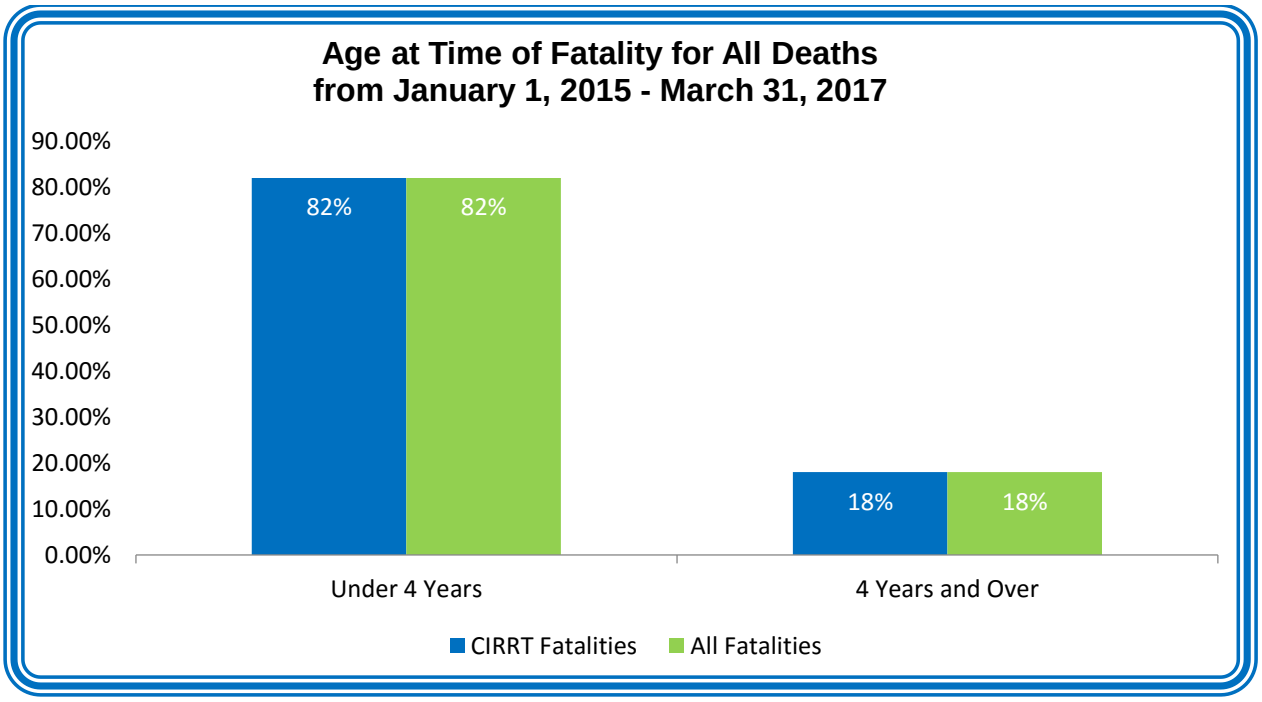
From January 1, 2015 through March 31, 2017, 64 CIRRT reviews were completed, involving a total of 65 victims. Eighty-eight percent of the deployments involved a victim under the age of six. In 74 percent of the reviews, the victim was under the age of 3. This is consistent with child deaths statewide in which younger children are more vulnerable to being victims of abuse and neglect.



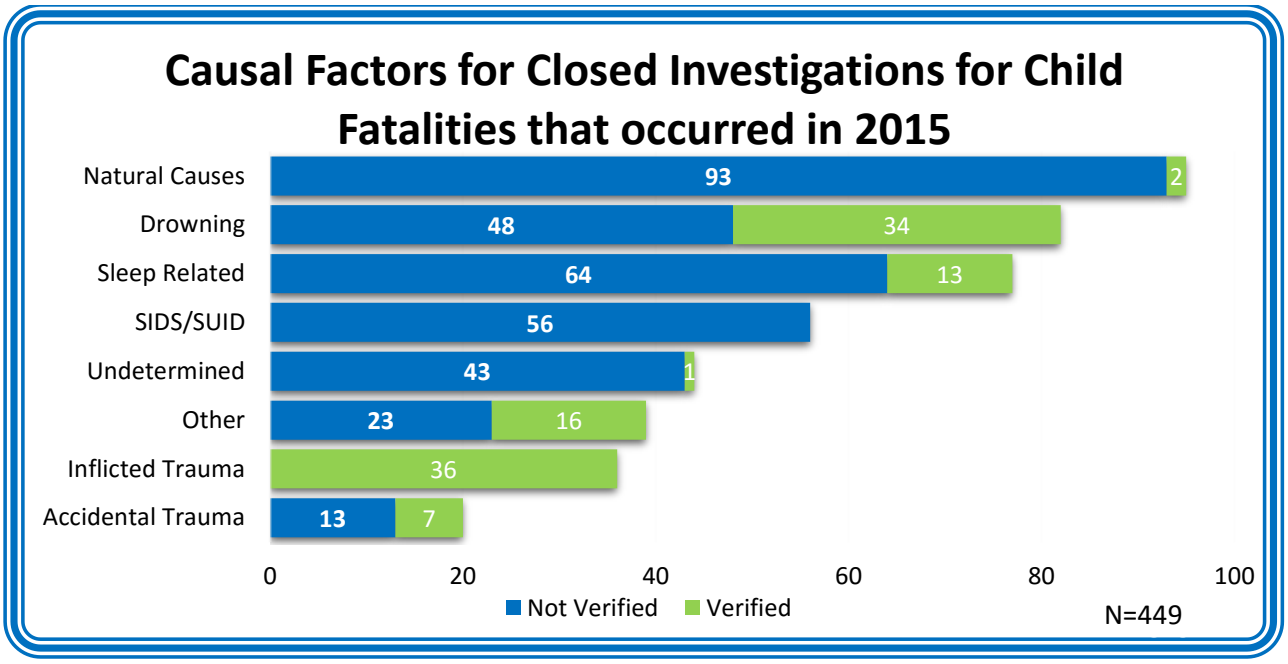
There were 7 CIRRT deployments in the first quarter of 2017 with three of the seven victims under age 1. During the quarter, there were two victims over the age of 13; one committed suicide and the other was a victim in a double homicide, perpetrated by the step-father.



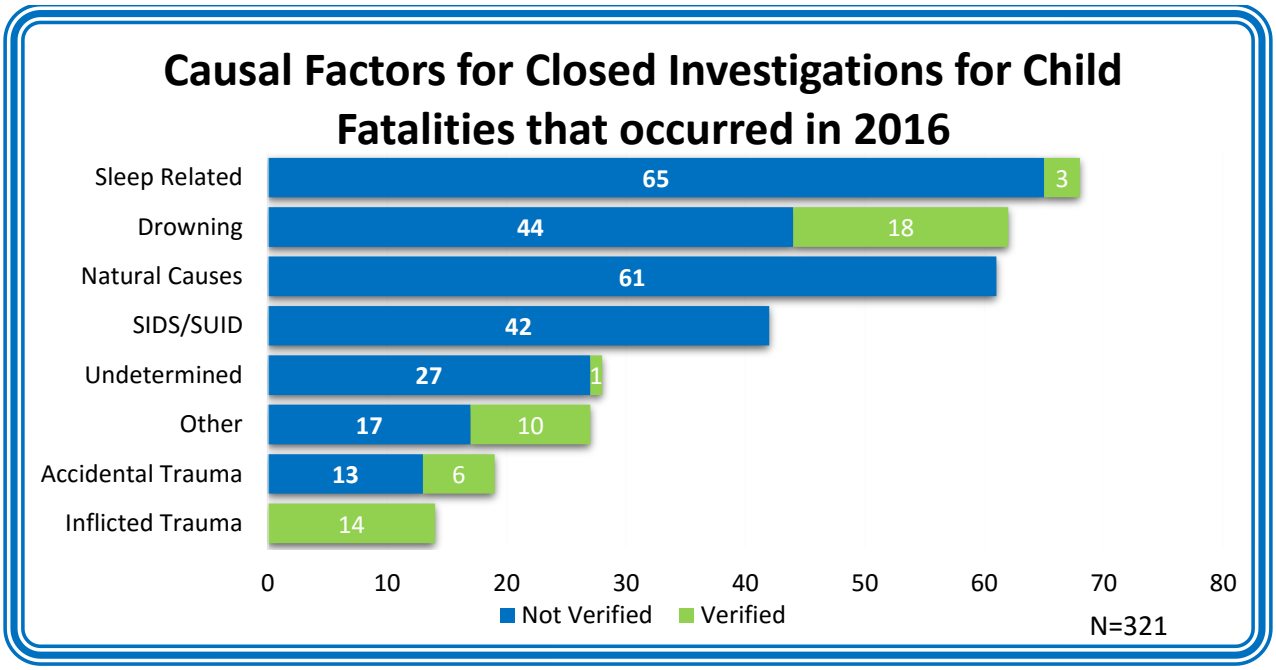
Of those child fatalities reported to the hotline occurring from January 2015 through March 2017, 82 percent involved a child under the age of 4. Similarly, 82 percent of all CIRRT deployments involved children in this age range.



Of the 449 closed child fatalities that occurred in 2015, the four primary causal factors were Natural Causes, Drowning, Sleep Related, and SIDS/SUID. There are a total of 25 child fatality investigations received during this time period that remain open; when finalized, they will impact the overall numbers and causal factor sequencing.



Of the 321 closed child fatalities that occurred in 2016, the four primary causal factors were Sleep Related, Drowning, Natural Causes and SIDS/SUID. There are a total of 137 child fatality investigations received during this time period that remain open; when finalized, they will impact the overall numbers and causal factor sequencing.

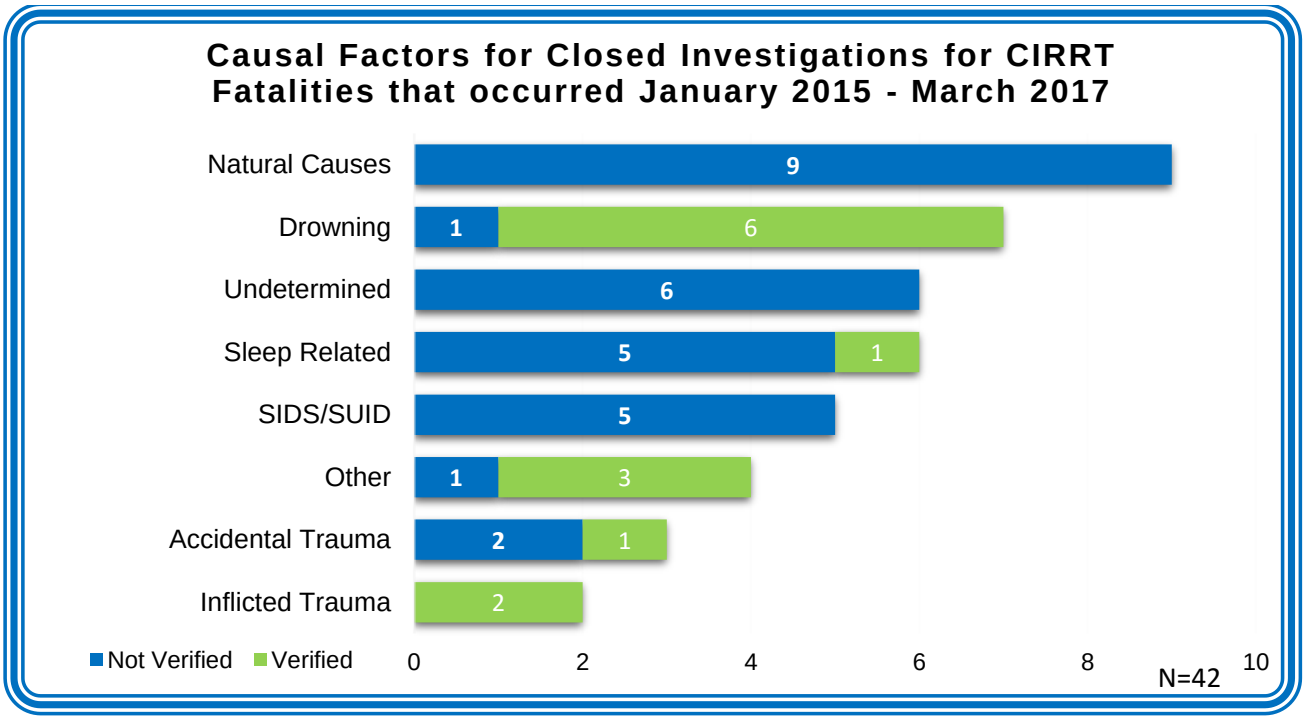


The death maltreatment cannot be used as a stand-alone maltreatment; therefore, the underlying maltreatment that may have caused or contributed to the child death is noted. For an investigation to be closed with verified findings for the death

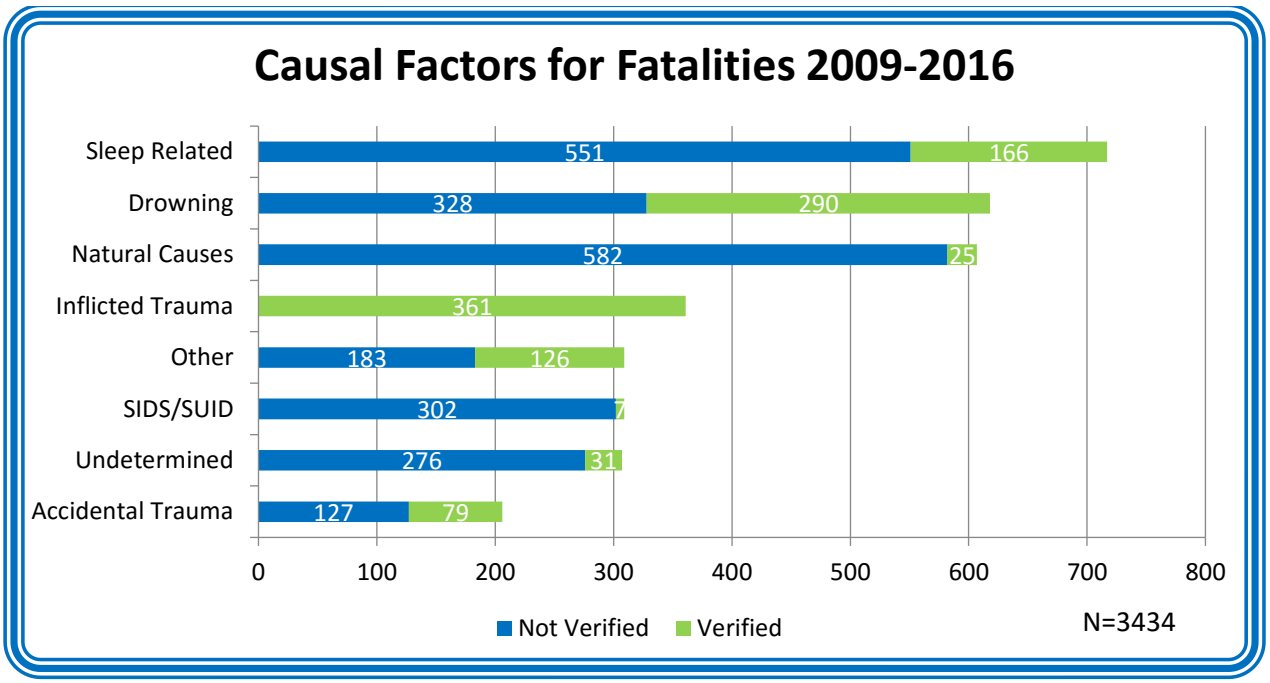
maltreatment, there must be a preponderance of the credible evidence that the child died as a result of a direct, willful act of the caregiver(s) or the caregiver(s) failed to provide or make reasonable efforts to provide essential care or supervision for the child. Credible evidence used to determine verified findings for the death maltreatment includes the medical examiner report, law enforcement reports, and medical records, when necessary. For example, there were two deaths attributed to natural causes that were subsequently closed with verified findings of maltreatment. One case involved an infant who died due to complications of prematurity in which the baby's pre-term birth could be directly linked to the mother's cocaine use. The other case involved an infant who died of malnutrition as a result of the caregiver's actions/inactions.

In cases where there may be insufficient evidence to support a verified finding of the death maltreatment, the investigation may still be closed with verified findings of other maltreatments.

Between January 1, 2015 and March 31, 2017, there were a total of 64 deployments involving 65 child fatalities that resulted in a CIRRT deployment. Of the 42 investigations that were closed, 13 (31 percent) investigations had verified findings for the death maltreatment. An additional 11 investigations were closed with verified findings for a maltreatment other than the death maltreatment. A review of the 64 deployments indicates that 30 cases, or 47 percent, of the deployments involved children under 1 year of age who were found unresponsive in their crib/bassinet or after sleeping with an adult caregiver and/or siblings.



Between 2009 and 2016, the four leading causal factors of child fatalities reported to the hotline were Sleep Related (717 deaths), Drowning (618 deaths), Natural Causes (607 deaths), and Inflicted Trauma (361 deaths).



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 investigations 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 for "Death" 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 7 verified investigations with a causal factor of SIDS/SUID and 25 of the 31 verified 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.

Closing Summary

Throughout deployments and with input from the statewide CIRRT advisory committee, additional qualitative data elements have been identified. Data from prior CIRRT reviews have been tracked and data from other similar reviews are being tracked 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, 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.