Critical Incident Rapid Response Team Advisory Committee
Third Quarter Report for Calendar Year 2021

Shevaun L. Harris
Secretary

Ron DeSantis
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
Third Quarter 2021

I. Background

Section 39.2015, Florida Statutes, which outlines requirements for the Department of Children and Families' Critical Incident Rapid Response Team (CIRRT), requires the CIRRT Advisory Committee to submit a quarterly report to the Governor and Legislator of findings and recommendations.

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 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 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.

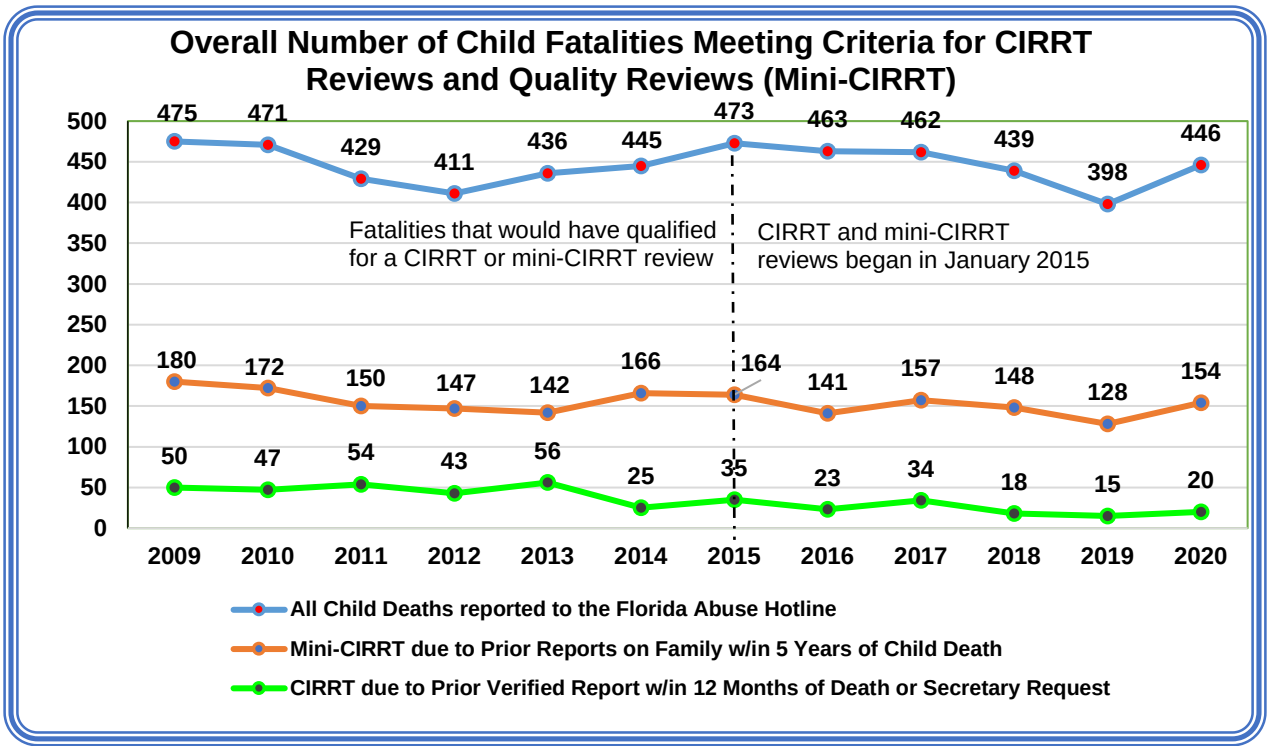
Team Composition
Each team deployed is comprised of individuals with expertise in the appropriate areas, as identified through a review of the family's prior history with the child welfare system. The team lead is responsible for guiding the process throughout the duration of the review.

III. Review of Child Fatality Data

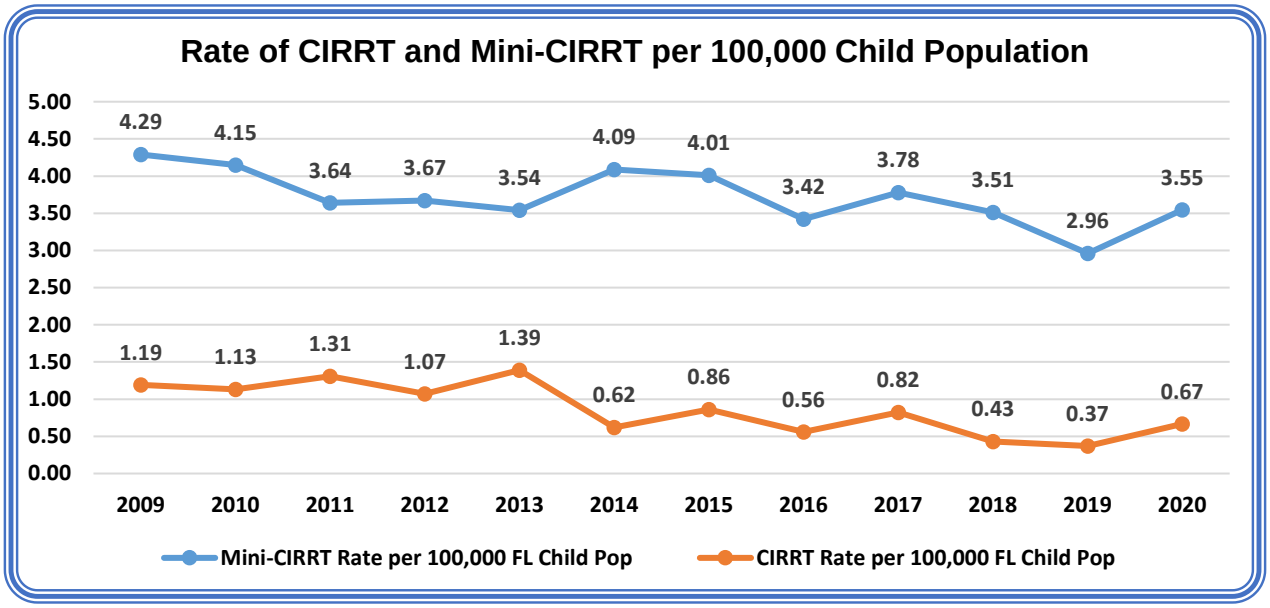
Between July 1 and September 30, 2021, there were 112 fatalities reported to the Hotline. Of those 112 cases, nine met the criteria for a CIRRT deployment. In six of the CIRRT deployments that occurred during the third quarter, there was prior history involving the deceased child (66 percent of the cases).

From January 1, 2015, through June 30, 2021, a total of 161 CIRRT teams were deployed involving 164 child deaths. Of those deployments, 155 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 38 percent of the fatalities reported to the Hotline met the Department's 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 per case.

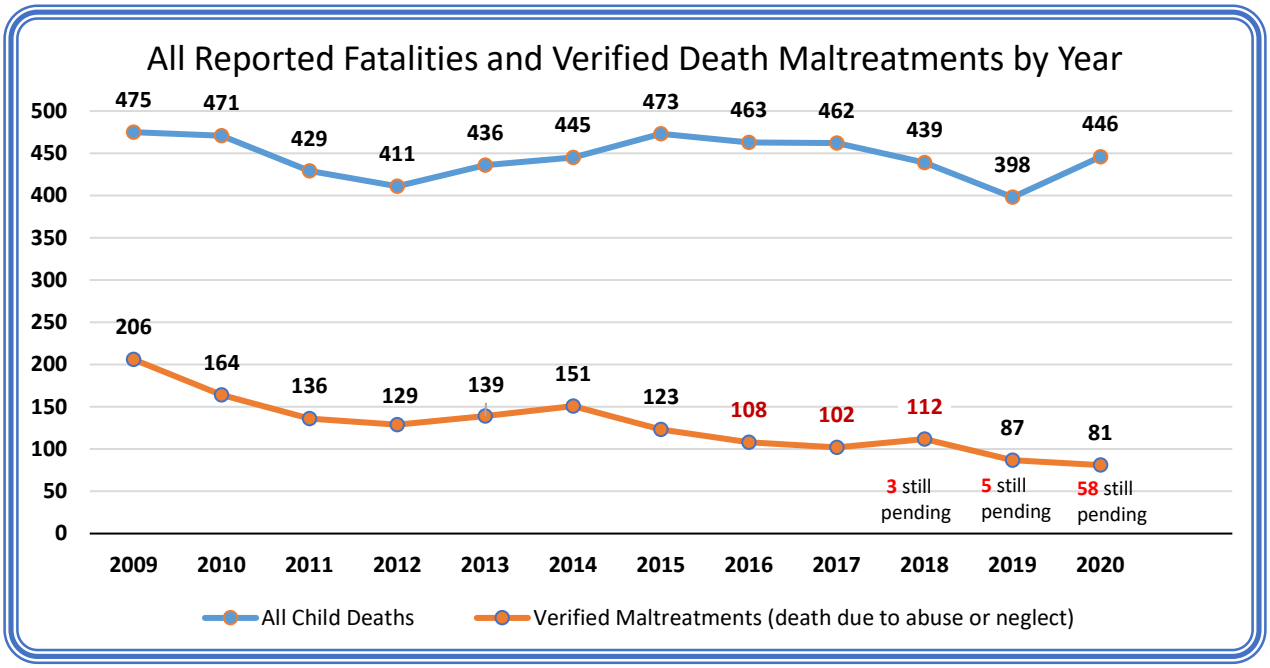


The rate of occurrence for fatalities meeting the requirements for CIRRT deployments and mini-CIRRT reviews, as compared to the overall number of fatalities reported to the Hotline, has remained relatively the same over the years. While there are slight decreases and increases, they are not statistically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

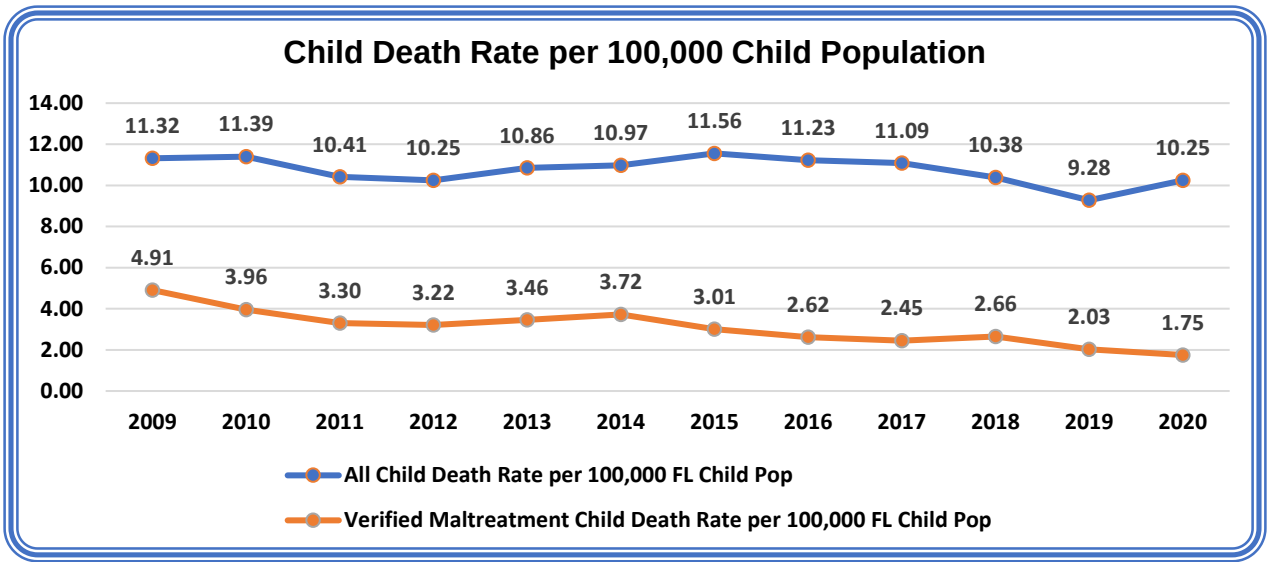


Reports on reviews conducted as a result of a child fatality (regardless of the type of review completed) are redacted according to Florida Statutes and posted on the Department's Child Fatality Prevention website (http://www.dcf.state.fl.us/childfatality/) after the death investigation has been completed.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



While the child death rate per 100,000 child population slightly increased between 2019 and 2020, the rate of verified child death maltreatments per 100,000 child population reflects a downward trend.



III. Review of CIRRT Data

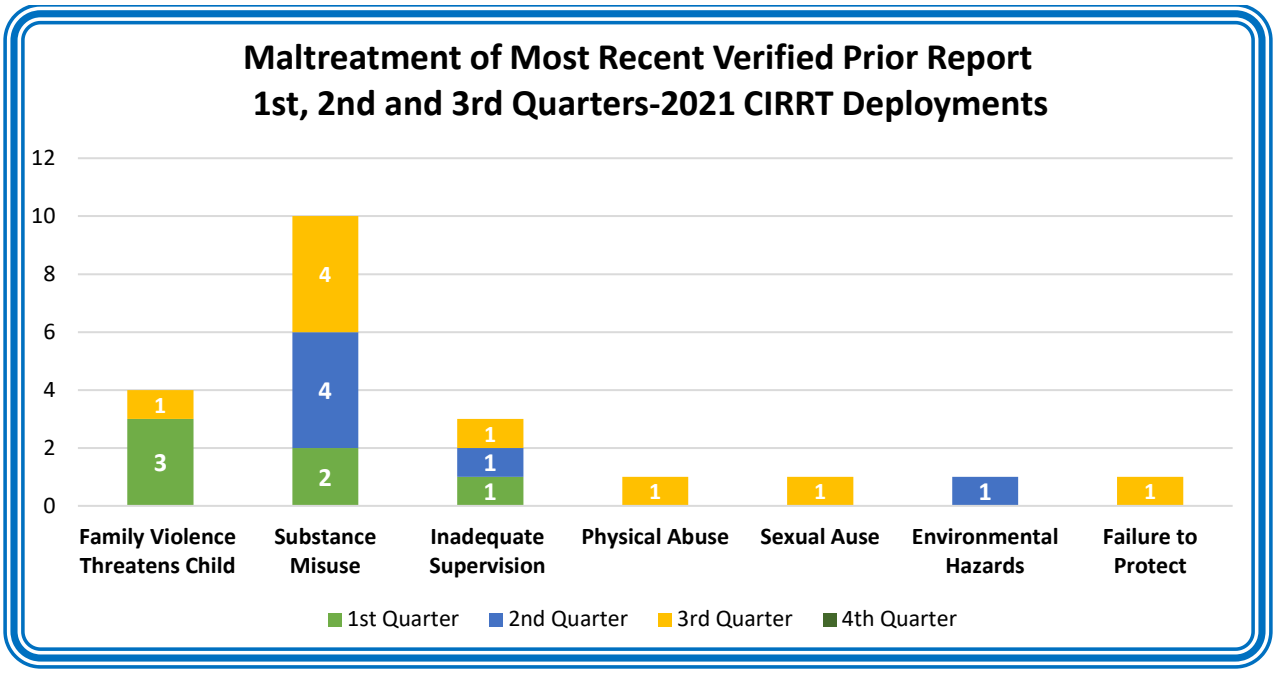
a. Summary of Third Quarter CIRRT Reports

The deployment to Santa Rosa County involved a 1-year-old who was discovered unresponsive in the family's pool. The Okaloosa County deployment involved the death of a 3-week-old who was found unresponsive while bed-sharing with his grandmother who inadvertently fell asleep while consoling the infant. The deployment to Orange County involved the death of a 3-month-old who was found unresponsive with numerous inflicted injuries while in the care of his parents. The Brevard County deployment involved the death of a 4-year-old due to inflicted injuries she received while in the care of her foster parent. The deployment to Putnam County involved a sleep-related death of a 2-month-old after he was placed on his stomach on a couch by his grandmother. The Duval County deployment involved the death of a 6-week-old substance exposed newborn who was born premature at 25 weeks gestation. The deployment to Dade County involved the sleep-related death of a 2-month-old after he was discovered unresponsive while bed-sharing with his parents. The Lee County deployment involved a sleep-related death of a 3-month-old after he and his mother fell asleep on a couch. The deployment to Hillsborough County involved the death of a 3-month-old who was found unresponsive while bed-sharing with his mother and siblings.

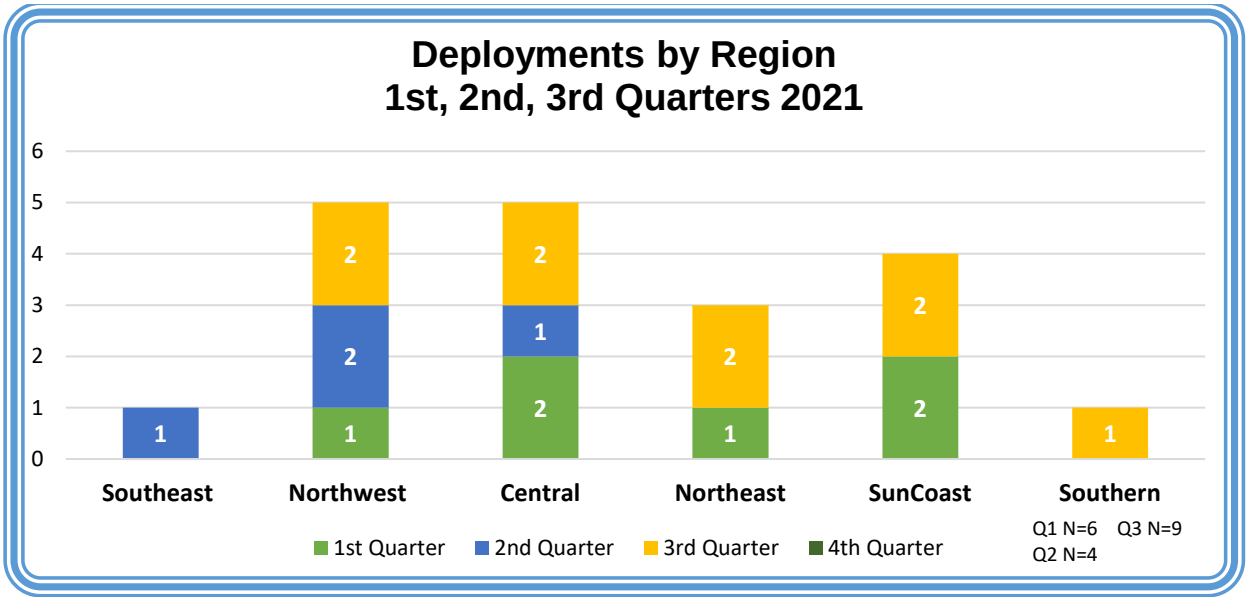
In six of the nine deployments (Putnam, Lee, Orange, Okaloosa, Duval, and Brevard counties), child welfare services were involved at the time of the respective fatality; in six of the nine deployments (Santa Rosa, Orange, Okaloosa, Hillsborough, Duval, and Brevard Counties) the decedents were the subjects of a prior verified report.

b. Past Maltreatment

During the third quarter of 2021, the nine CIRRT deployments involved nine victims with six of the victims being the subject of a verified prior report; in the remaining instance, the verified prior report was verified as to a sibling or child in the home other than the decedent. There were a variety of prior verified maltreatments in the nine CIRRT deployments: four involved substance use maltreatments, one involved physical abuse maltreatments, one involved sexual abuse, one involved domestic violence, one involved inadequate supervision, and one involved failure to protect.



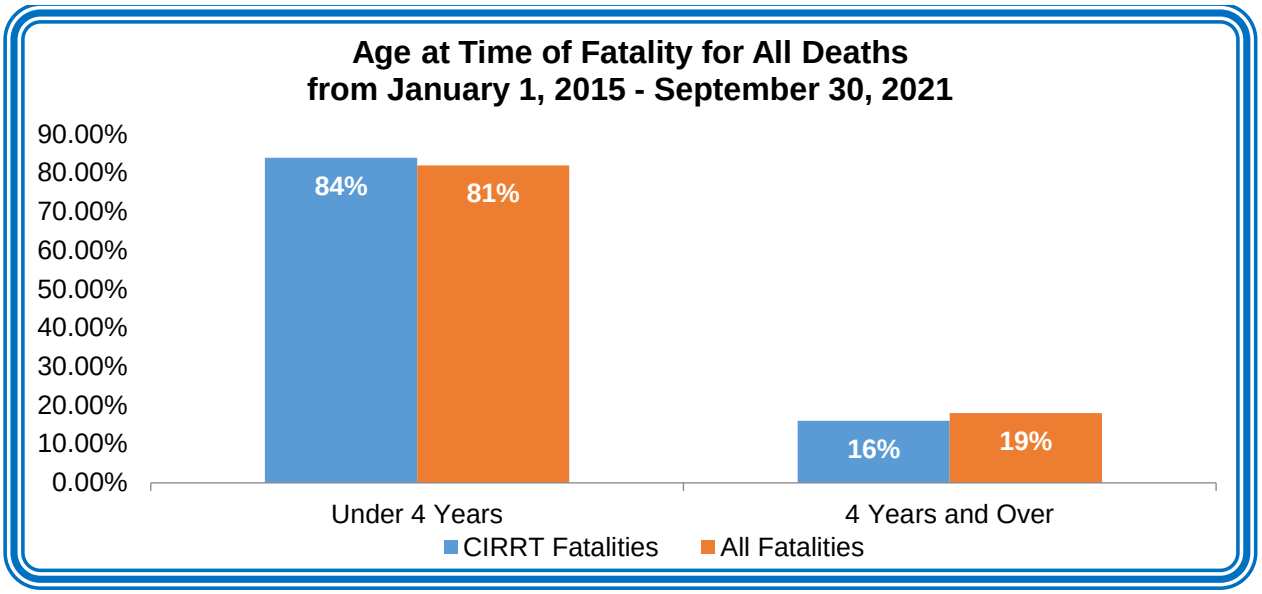
CIRRT Data by Region



c. Age of Victim

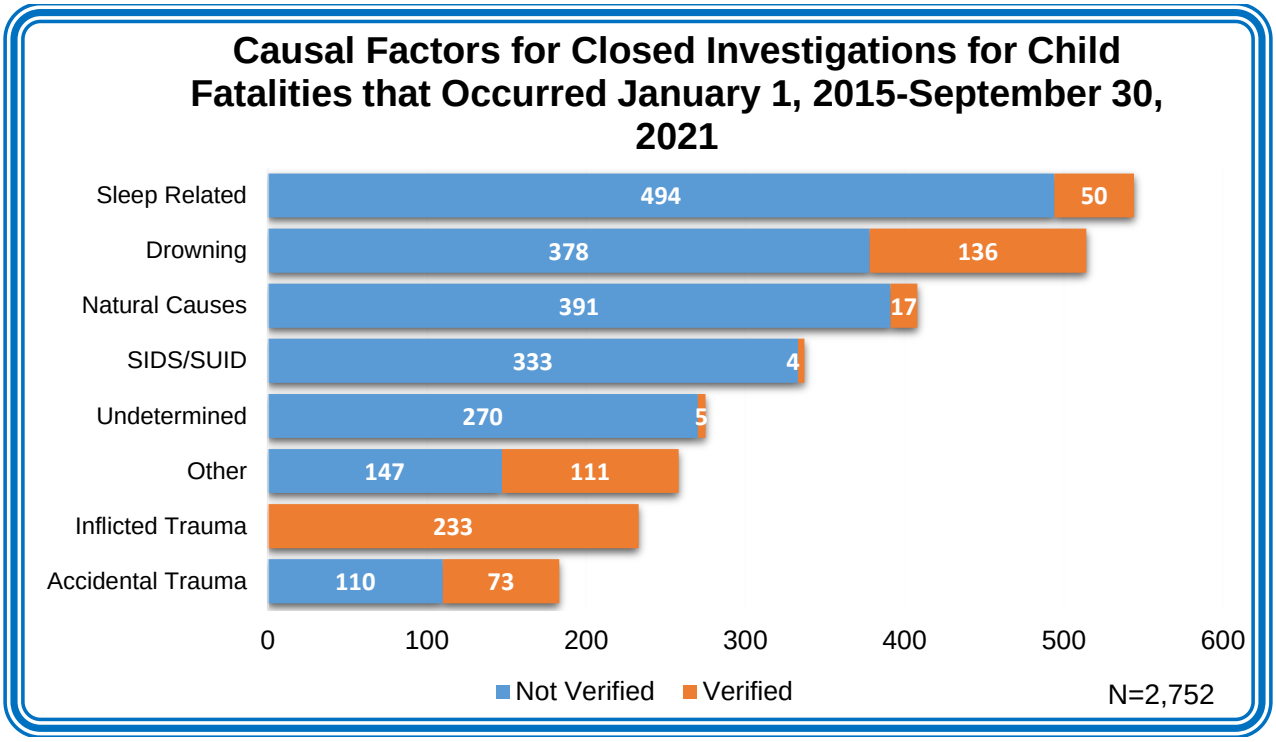
All nine victims involved in the nine CIRRT deployments during this quarter were under four years of age, with seven of the victims aged three months or younger.

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.



d. **Causal Factors All Fatalities**

Of the 2,752 closed child fatalities that occurred from January 1, 2015, to September 30, 2021, the four primary causal factors were sleep-related, drowning, natural causes, and SIDS/SUID. There are still 226 child fatality investigations, the majority of which were received in 2021, that remain open.



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

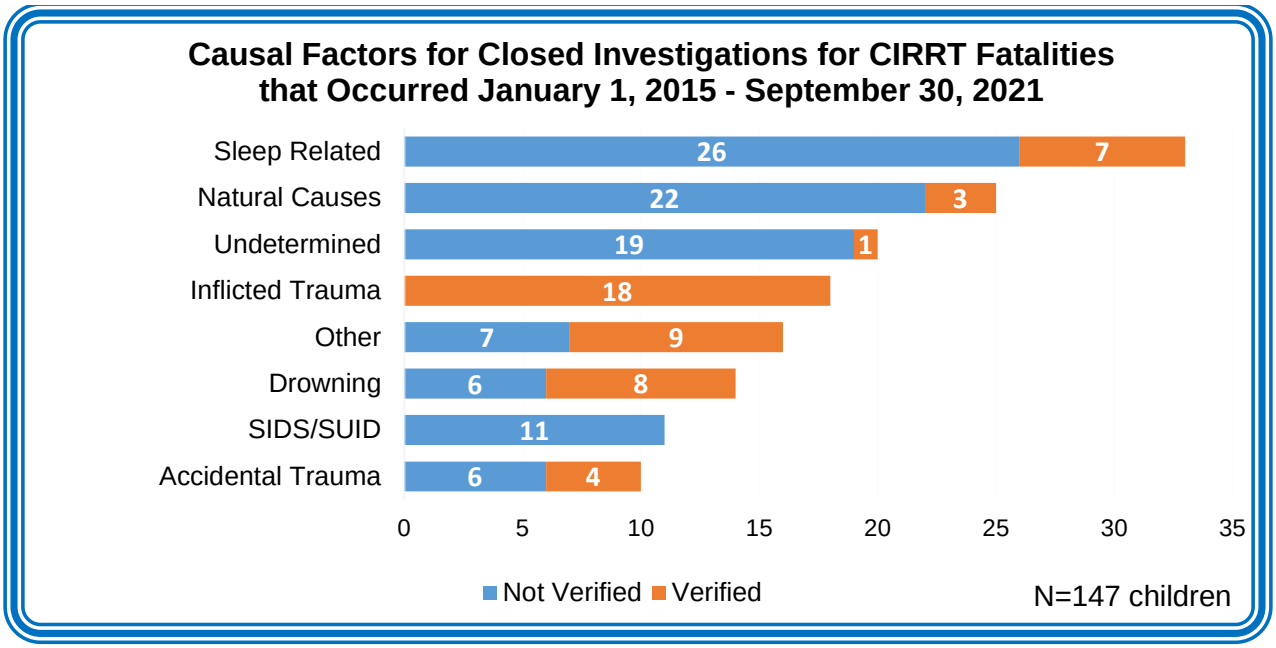
solely on the surrounding circumstances (e.g., possible unsafe sleep environment, bedding, position, etc.) as opposed to a medical examiner's finding of fact. However, in one of the cases with a SIDS/SUID maltreatment, the causal factor was verified due to the incident occurring while the parents were bed-sharing and both were under the influence of substances.

The death maltreatment cannot be used as a stand-alone maltreatment; therefore, the underlying maltreatment that may have caused or contributed to the child's death is noted. For an investigation to be closed with verified findings for the death maltreatment, there must be a preponderance of credible evidence that the child died as a result of a direct, willful act of the caregiver(s), or the caregiver(s) failed to provide or make reasonable efforts to provide essential care or supervision for the child. Credible evidence used to determine verified findings for the death maltreatment includes the medical examiner report, law enforcement reports, and medical records when necessary. For example, there were two deaths attributed to natural causes that were subsequently closed with verified findings of maltreatment. One case involved an infant who died due to complications of prematurity in which the baby's pre-term birth could be directly linked to the mother's cocaine use. The other case involved an infant who died of malnutrition as a result of the caregiver's actions/inactions.

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

e. **Causal Factors CIRRT Fatalities**

Between January 1, 2015, and September 30, 2021, there were a total of 161 CIRRT deployments involving 164 child fatalities. Of the 145 investigations (involving 147 children) that were closed, the four primary causal factors were sleep-related, natural causes, undetermined, and inflicted trauma. In addition, 47 investigations (31 percent) involving 49 victims had verified findings for the death maltreatment. Nine of the investigations (involving 10 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 15 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 September 30, 2021.

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 September 30, 2021 meeting, the CIRRT deployments from the 2021 second quarter were reviewed with a focus on child behavioral health assessments and the identification of services for children coming into care. Additional discussions were held around the expansion of the department's CIRRT unit and CIRRT Advisory Committee advisory committee members. Further discussions regarding future CIRRT Advisory Committee meetings to include action planning.

V. Recommendations

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

The CIRRT Advisory Committee continues to recommend the following addition/change to the statutory language:

The Secretary will have the discretion whether to deploy a CIRRT team in circumstances that meet the criteria below:

a) *Cases in which there is no relationship between the fatality and the prior verified report (e.g., involves a separate household and perpetrator; and/or the decedent has had no contact with the caregiver/parent in the verified prior report);*
b) *Cases in which the death occurred in a daycare or other facility, including a hospital (e.g., an infant born extremely premature and never leaves the hospital);*
c) *Cases in which the death occurred in a foster home when it involves a separate incident and different perpetrator from the prior verified report; and*
d) *Cases in which a child'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.

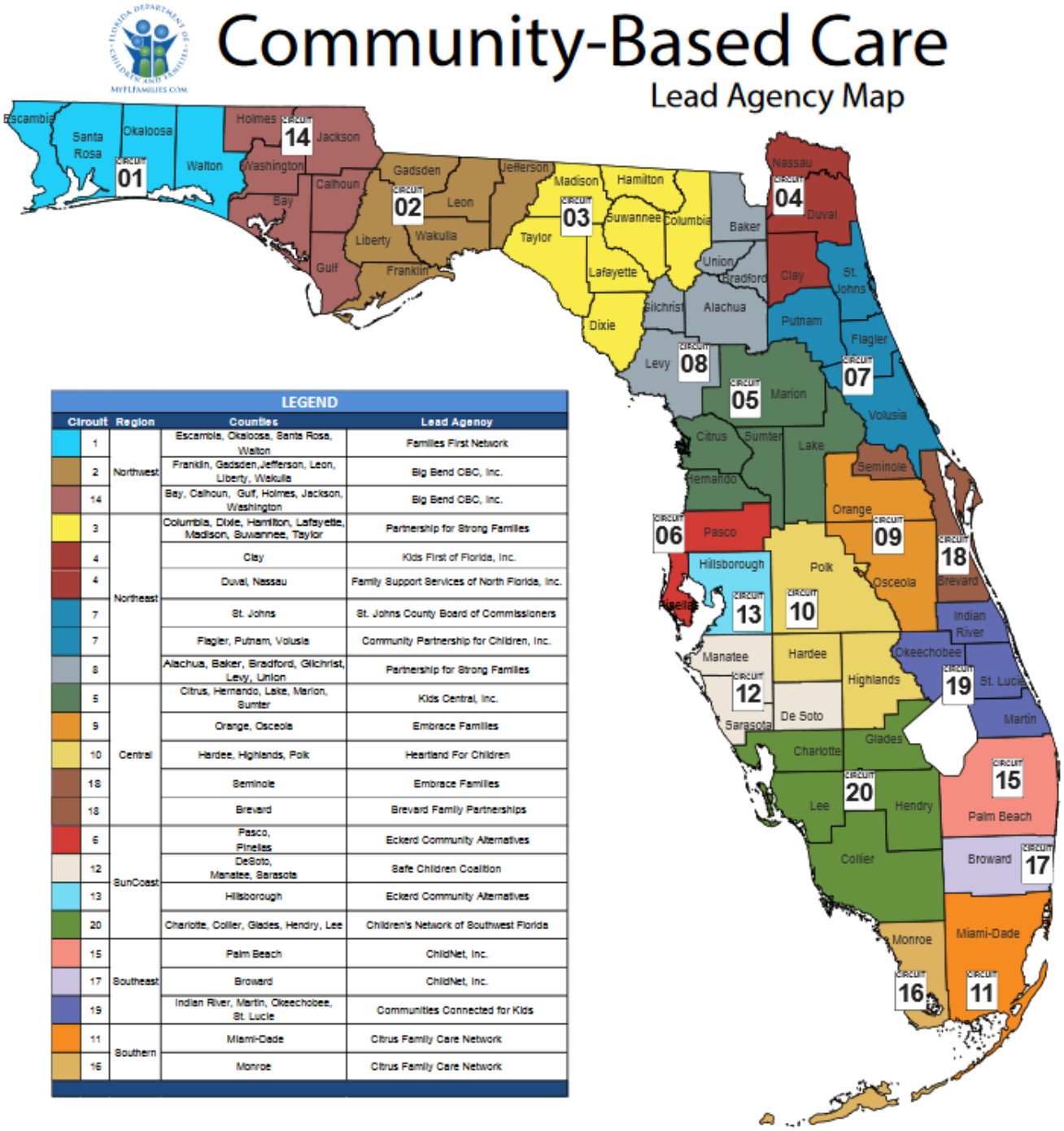
APPENDIX 1 – Section 39.2015, Florida Statutes

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