Critical Incident
Rapid Response Team

Florida Department of Children and Families
March 9, 2015
Critical Incident Rapid Response Team

Southeast Region
Circuit 17
Broward County, Florida

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Executive Summary

On the morning of January 13, 2015, two and a half year old [redacted] was rushed to Broward General Hospital after he was found by his mother, face down and lifeless, in his bed. Later that same day, efforts to maintain him on life support were discontinued after he was medically determined to be brain dead. [redacted] was born in July of 2012 with a chromosomal disorder that typically causes severe learning disabilities, severe oral communication problems, heart, muscle, breathing, eye problems and structural abnormalities of the brain that often bring about seizures. The medical examiner ruled the death due to natural causes and declined to conduct an autopsy, due to [redacted] known medical condition.

It appears that [redacted] death is a result of his complex medical condition and is not linked to the family’s prior involvement with the child welfare system. Prior child protection investigations concerning the care of [redacted], however, triggered a statutorily required Critical Incident Rapid Response Team (CIRRT) to review our history with this family. The family was involved in a child protection investigation in February of 2014 that resulted in a Verified finding of Family Violence and an investigation that yielded No Indicators of Medical Neglect in September of 2014.

On February 2-3, 2015, a team convened at the Broward Sheriff’s Office to review non-redacted case information, electronic and paper copies of child protective history, case management services, law enforcement reports and legal documents. In addition to file reviews, the team interviewed BSO child protective investigators, supervisors and a services specialist, ChildNet case managers and supervisors, a domestic violence liaison, lawyers with the Office of the Attorney General, Child Protection Team coordinators and Department of Health Children’s Medical Services staff.

Even though the CIRRT did not link the child’s death to prior child welfare involvement, the team did review all areas of the local child welfare system. These findings are presented in three categories that serve to describe the foundational components of our child welfare system: Practice, Organization and Services. Following is a summary of the findings:

Practice Assessment

1. Child Protective Investigations
   A. The investigations on this family were incident-driven and did not include an assessment of other presenting dynamics such as family violence.
   
   B. The BSO child protection investigators made minimal use of outside expertise that is readily available and required by law.

2. Case Management
   A. Since birth, [redacted] had been receiving Care Management through the Early Steps Program of Children’s Medical Services; however, case management did not engage their expertise or historical knowledge concerning the parent’s follow through on the various specialists involved in [redacted] medical care.
3. Children’s Legal Services
   A. Children’s Legal Services did not follow protocol of completing Legal Sufficiency for Dependency documentation and did not staff the case to discuss the addition of an infant in the home during case services upon the birth of

**Organizational Assessment**

   A. There appeared to be critical gaps, overall, in multi-agency communications between the professionals who knew this family.

**Service Array**

   A. While co-located domestic violence and substance abuse expertise is available to investigators and case management, it does not appear that they are consistently engaged on case assignments. In addition to these expert resources, an impressive listing of available supports and resources is updated on a weekly basis and available to investigators and case managers. However, it is unclear how the local system of care selects and assesses appropriate referrals for families.

Subsequent to the death, Broward County Sheriff’s Office, ChildNet, the Child Protection Team, the Office of the Attorney General Children’s Legal Services and Children’s Medical Services conducted their own internal assessment of current practice to see where improvements can be made. A new protocol specifically related to the monitoring of medically complex children has been identified for implementation by ChildNet, Children’s Medical Services, Agency for Persons with Disabilities and Children’s Legal Services.
Introduction

On the morning of January 13, 2015, two and a half year old [redacted] was rushed to Broward General Hospital after he was found by his mother, face down and lifeless, in his bed. Later that same day, efforts to maintain him on life support were discontinued after he was medically determined to be brain dead. [redacted] was born in [redacted] of 2012 with a chromosomal disorder that typically causes severe learning disabilities, severe oral communication problems, heart, muscle, breathing, eye problems and structural abnormalities of the brain that often bring about seizures. Due to his existing medical condition, the medical examiner ruled the death due to natural causes and declined to conduct an autopsy.

[redacted] was born on [redacted] with a non-genetic chromosomal. He and his 19 month old sister, [redacted] had been cared for in the home of their parents, [redacted] and [redacted]. Because of his special medical needs, [redacted] had been receiving ongoing care management through Children’s Medical Services Early Steps Program for physical, respiratory and occupational therapy. Recently, a duty nurse tended to [redacted] several nights a week. Both parents were employed outside of the home and also attended community college. On the day of [redacted] death, the nurse left the home at seven in the morning and the father left shortly before nine after checking on [redacted]. The mother checked on [redacted] an hour later and found him on his stomach, unresponsive.

Pursuant to statute, a Critical Incident Rapid Response Team (CIRRT) was deployed to Broward County to review the case. CIRRT representatives included Department of Children and Families Office of Child Welfare headquarter and regional staff; a child protective investigator supervisor with a law enforcement agency; children’s legal services attorney; domestic violence advocate and a quality assurance manager from a community based care agency. This report presents the CIRRT’s findings, including the child welfare history, the family composition, a summary of the local child welfare service providers and a system-of-care analysis.
Case Participants

<table>
<thead>
<tr>
<th>Name</th>
<th>Age at Time of Incident</th>
<th>Relationship</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2 yr 8 mos</td>
<td>Decedent</td>
</tr>
<tr>
<td></td>
<td>19 months</td>
<td>Sibling</td>
</tr>
<tr>
<td></td>
<td>23 YOA</td>
<td>Mother</td>
</tr>
<tr>
<td></td>
<td>25 YOA</td>
<td>Father</td>
</tr>
</tbody>
</table>

Child Welfare Summary

came to the attention of child protective investigations on three previous occasions due to allegations of medical neglect. There were concerns that these young parents were placing in jeopardy for failing to consistently follow up on medical appointments. The investigations generally described cooperative parents who were both very engaged in learning about their child’s special medical needs and how best to care for him. There were prior criminal records for the mother including a battery charge in 2010. The father’s records included a forged driver’s license in 2009, traffic violations in 2010, and a battery, domestic violence and hit-and-run charge in 2012.

As a result of the Verified Medical Neglect finding in 2013, court ordered case management services were initiated and the family entered into a Case Plan that was successfully completed in early 2014.

Approximately two weeks prior to the judicial case closure, an investigation was commenced which resulted in Verified findings of Domestic Violence against the mother. She and her husband had an argument about her late arrival to the home one day and it resulted in the mother brandishing a knife and cutting the father’s hand. The investigative case notes indicated that there were no visible injuries to the father’s hand and no judicial action was pursued. ChildNet case management services were not engaged because both parents cooperated with an additional referral made for behavioral health services.

System of Care Review

This 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 the quality of decision-making.

Practice Assessment

PURPOSE: This practice assessment examines whether the documented observations and assessments of the child welfare professionals involved with the family were consistent with policies and protocols.
**Child Protection Investigations**

**FINDING A.** The investigations on this family were incident-driven and did not include an assessment of other presenting dynamics such as family violence.

**FINDING B.** The BSO child protection investigators made minimal use of outside expertise that is readily available and required by law.

**PRACTICE ISSUES**

As reflected in case documentation and through interviews with professionals who worked with the family, the Broward County child welfare system is still transitioning from an “incident-based” investigative approach to a holistic family assessment. Investigators knew that both parents had criminal records, including domestic violence allegations against each other. Exploring this dynamic with the co-located domestic violence expert may have offered a better understanding of the needs of these young parents. Both policy and law require child protective investigators to reach out to subject matter experts such as domestic violence professionals to assist with assessing the needs of a family. Case documentation indicated that the parents were referred to couples counseling on a number of occasions. With respect to this type of referral, it is cautioned that domestic violence experts need to be consulted to determine the most appropriate service intervention specific to the needs of the parents.

In addition to the domestic violence incidents, other facets of the various investigations described a mother whose family members reported that she was resistant to information about her son concerning the practical realities of his medical struggles and developmental limitations. A wealth of information was available concerning Children’s Medical Services Early Steps interaction with the mother shortly after birth and throughout his life. Case documentation related to the BSO child protective investigations indicates minimal engagement of the medical professionals who had extensive interaction with the family.

The Child Protection Team (CPT) resources appeared to be ineffectively utilized as well. Because the referral to CPT in late 2014 occurred on the day the investigation was closed, a medical opinion as to findings of Medical Neglect was not available. Investigative notes also included a prior recommendation from the CPT that the mother could benefit from attending a support group for parents with children who have a chromosomal disorder. There was no information on follow up to this recommendation.

**Case Management**

**FINDING A.** Since birth, had been receiving care management through the Early Steps Program of Children’s Medical Services; however, case management did not engage their expertise or historical knowledge concerning the parent’s follow through on the various specialists involved in medical care.

**PRACTICE ISSUES**

was referred to the Children’s Medical Services Early Steps Children’s Diagnostic and Treatment Center shortly after his birth while he was still in neonatal intensive care. The
Family was involved with case management services through Child Net for almost one year from the time that the investigative case of February 2013 was transferred for services to the conclusion of judicial action in February 2014.

During the time that the parents were receiving case management services through ChildNet, it is well established through documentation that the parents were eager to comply with the Case Plan and follow through on medical needs.

Most compelling from a case management perspective is the failure to bring the Early Steps Program Care Management team into development of the Case Plan. A summary of the records maintained by Early Steps describe the parent's sketchy participation in services to address needs, such as specialized day care, and respiratory and feeding therapy.

**Children’s Legal Services**

**FINDING A.** Children’s Legal Services did not follow protocol of completing a “No Legal Sufficiency” form and appears to have not staffed the case to discuss the addition of newborn sister, during case services and court ordered supervision.

**PRACTICE ISSUES**

Weeks before the family was due back in court to report on their Case Plan compliance and seek case closure, a new investigation involving family violence allegations was initiated. Case notes indicate that the BSO child protective investigator consulted with legal services about initiating a new dependency petition and was told that legal sufficiency could not be established to initiate court proceedings. Notes taken by an attorney who was consulted indicate that the child protective investigator was told that court action could be pursued if the parents did not comply with voluntary services. This essentially resulted in two different understandings of the outcome of this legal consultation.

Policy requires the legal staffing of a case upon the birth of a child to a family with either an active investigations or services case. Birth in during the time of court ordered services, should have prompted a legal staffing to discuss what additional services may be needed to safely support the new addition to the family. At an August 2013 case review meeting with CLS, case management documented the need for a newborn staffing to occur and this appears to not have been done.

**Organizational Assessment**

There are three entities contracted by the Department of Children and Families that establish Broward County’s child welfare system: Broward Sheriff’s Office, The Office of the Attorney General and community-based care organization, ChildNet.
Broward Sheriff’s Office (BSO)

Broward is one of six counties in the state where child protective investigations are conducted by law enforcement. A BSO major, captain and a lieutenant oversee a civilian workforce of managers, supervisors, investigators and all other civilians. Under optimal operations, all 100 CPI positions are filled. A receiving unit manned by 18 Investigative Aids handle approximately 60 new intakes daily by running the requisite background checks and preparing the case record for an investigation.

Although there were six CPI vacancies during the time of this case review, the interview and new hire process was well underway. By their own account, BSO stated that this recent twelve months have been particularly challenging, with as many as 25 CPI or CPI supervisors (CPIS) out of rotation for various reasons such as sick leave, pregnancy, etc. Caseloads have been in the high 20’s with as many as 20 new case assignments per CPI per month.

The Office of the Attorney General provides Children’s Legal Services (CLS) in Broward County though a contract that was renewed last year. There are 30 attorneys, five supervisors for the attorneys and one bureau chief. Caseloads range as low as 68 to a high of 82 for an attorney. Supervising as well as line attorneys carry a caseload and cover six courtrooms (four judicial and two general master dockets). It is notable that this assignment approach results in the same attorney assigned to a case from the initial judicial action to the termination of court jurisdiction. The most significant change in daily operations that has taken place in the last 18 months offers insight into the protracted delays in the 2013 court case involving the family. Over a year ago, the new bureau chief created a smaller intake unit to cover staffings and this has greatly improved processing time frames. Staffings are held every Tuesday and any identified outstanding issues are rolled onto the agenda for the following week to prevent a case from falling through the cracks.

As noted earlier, it took months for the case to proceed to a hearing from the time it was initially staffed with an attorney. While it appears that processing has been addressed, what remains unclear is the why this particular case was not escalated for a multi-disciplinary staffing when case management was alerted to the new child protective investigation. In addition, documentation is not available to provide a better understanding of why CLS reports that they objected in court to the motion filed by attorneys for the parents seeking case closure.

ChildNet provides case management services. Their offices are located in the same building plaza as BSO and this greatly facilitates the case transfer process. Their staffing compliment includes seven case managers per supervisor. ChildNet has worked very diligently to establish daily operations that serve to meet the immediate needs of a child and family. They report a rich intake system which includes school transportation to avoid academic disruptions and a speedy EPSDT referral process. The transfer of service process from child protective investigations to services incorporates many best practice features such as joint meetings at the home of a family for smooth transition of family supports and services. One key case practice requirement that continues to be refined is the completion of the Family Functioning Assessment by child protective investigators at the time of transfer to services.
Child Protective Investigations, Case Management and Children’s Legal Services

FINDING A. There appeared to be critical gaps, overall, in multi-agency communications between the professionals who knew this family.

ORGANIZATION ISSUES

Case record reviews and consultations with stakeholders suggest areas for improvement in the overall system collaboration and teaming together when a family is known to multiple agencies. A review of the time line of key events that is attached to this report indicates time frames when child protective investigations, case management and the courts are concurrently involved with the family.

The communication gaps surrounding the court proceedings that coincided during the same time period of a new child protective investigation appears to have contributed to decisions made by the court to close a case while questions remained concerning care and medical supports, the new baby in the home that appears not to have been staffed by CLS, and unexplored incidents of family violence. The lack of effective partnering with Children’s Medical Services appears to also be a systemic issue from both an investigative, case management and legal perspective and not isolated to the family.

Service Intervention/Array

Child Protection Investigations and Case Management

FINDING A. While co-located domestic violence and substance abuse expertise is available to investigators and case management, their standing as an ongoing partner on a case assignment is unclear. In addition to these expert resources, an impressive listing of available supports and resources is updated on a weekly basis and available to investigations and case management. However, it is unclear how the local system of care selects and assesses appropriate referrals for families.

SERVICES ISSUES

An excellent model of a co-located domestic violence professional has been available to BSO child protective investigators for many years. Reviewers found, however, that the use of this expertise by investigators is limited to initial consultation and not seen as an ongoing resource for other facets of investigative activities and they were left with the impression that utilization of the domestic violence expert is primarily determined by whether a CPI supervisor supports and directs such use. In addition, case management use of this on-site resource is less clear. As the practice model is rolled out in this area, outreach to experts in domestic violence will undoubtedly lead to a consistent utilization of this valuable resource by both investigations and case management.

Another excellent resource for investigators is a weekly roster of available referrals for families. This roster contains information such as service description and location, target population and
wait list issues. The county funded Children’s Services Council appears to provide the majority of family support services and they are the source for determining the quality and value of such interventions. Because ChildNet does not develop resources as a part of their prevention efforts, they may be disadvantaged at properly identifying the most effective resources for families such as the

**SUMMARY**

The CIRRT professionals who participated in this review concur that it appears that death is not linked to the family’s prior involvement in the child welfare system. Notwithstanding, several key findings have been summarized that the Broward County child welfare system will find useful in their ongoing dedication to improving upon standards of practice and partnerships.

It is apparent that Broward County leadership between the three primary child welfare systems is committed to operating a successfully integrated response to child protection investigations and subsequent services. BSO, particularly, takes a proactive approach in identifying potential sources of conflict and bringing parties together to problem solve before an issue becomes a crisis. In addition, the Office of the Attorney General has continued to refine their legal staffing processes to be accessible to investigators to avoid delays in initiating court proceedings.

There are many outstanding examples of effective partnerships. For example, the CPT medical director conducted specialized training on Medical Neglect to all investigators subsequent to legislative mandate in July of 2014. In addition, in September of 2014, BSO established a CPI liaison to be co-located with the Child Protection Team to manage the flow of referrals for medical exams and enhance information sharing to medical professionals during child protective investigations.

Subsequent to the death, Broward County Sheriff’s Office, ChildNet, the Child Protection Team, the Office of the Attorney General Children’s Legal Services and Children’s Medical Services conducted their own internal assessment of current practice to see where improvements can be made. Among the systemic improvements will be establishment of regular meetings with the domestic violence advocate moving forward. In addition, the team learned that the CPT is finalizing plans for implementing the new law requiring specialized staffings for medical neglect cases. During on-site interviews, the CIRRT found all stakeholders to be forthcoming in acknowledging the ongoing need for continual review and assessment of processes and practices to refine improvements.
Timeline

This timeline features milestone events constructed by the review team during the joint review of case documents while on site. It contains the dates for commencement and closure of four separate child protective investigations, key events related to court proceedings and criminal arrest information. It offers a useful illustration why in cases such as this, it would have been critical to convene a multidisciplinary staffing during the 2013 / 2014 time frame when the family was involved concurrently with investigations, case management services and judiciary.

2010
July 2  Mother charged with battery against father; charges are dropped

2011
June 20  Father charged with possession of cannabis
July 18  Father charged with possession of cannabis

2012
July 2  is born
July 2  Father charged with battery and leaving the scene; No Contact Order issued against father on behalf of mother
July 15  First child protective investigation commenced
August 31  First investigation closed; Medical Neglect Not Substantiated
October  No Contact Order expires
November 26  Father charged with possession of controlled substance

2013
January 14  Second child protective investigation commenced
February 26  Second investigation closed; Medical Neglect Verified
March 5  CLS case staffing held; approved for filing Dependency Petition
May 8  Petition Alleging Dependency Filed in Court
June 10  is born
August 21  Judicial Disposition and Case Plan Accepted by the court
November 13  Judicial Review is held

2014
January 28  Status hearing
February 8  Third child protective investigation commenced
February 24  Order terminating case management supervision signed
March 3  CLS case staffing held; no legal sufficiency is determined
April 4  Third investigation closed; Family Violence Verified
September 4  Fourth child protective investigation commenced
November 3  Fourth investigation closed; Medical Neglect No Indicators