Critical Incident Rapid Response Team

[redacted]

Department of Children and Families
September 13, 2023

Critical Incident Rapid Response Team

[redacted]
Central Region
Circuit 5
Citrus County, Florida
2023-240654

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Executive Summary

On August 01, 2023, the Department of Children and Families (the Department) was notified of the death of 2 1/2-month-old, [redacted], after he was found unresponsive by his legal paternal grandmother, [redacted] (51 years). [redacted] reported when she picked him up earlier that morning, he was limp. She called for her husband, [redacted], (59 years) who started cardiopulmonary resuscitation (CPR), while she called for emergency services. The infant was transported to the local hospital where he was pronounced deceased.

An autopsy was completed at which time no injuries or other evidence of trauma was observed. Both the cause and manner of death were classified as undetermined, and the fatality investigation was subsequently closed with no findings of maltreatment.

The death occurred during an open judicial case stemming from the child's removal in June of 2023 due to the mother and [redacted] testing positive for cocaine at his birth. Additionally, both parents, [redacted], ages 39 and 35 years, respectively, have an extensive history with patterns of substance use and domestic violence. Upon [redacted] discharge from the hospital, he was placed with the paternal legal grandparents, who were caring for his half siblings.

Due to the circumstances around the fatality and the family's history, DCF Secretary Shevaun Harris deployed a Critical Incident Rapid Response Team (CIRRT) to Citrus County. This report presents the team's findings, a summary of the family's child welfare history, the family's composition, and an analysis of Citrus County's child welfare service providers. The team reviewed the family's prior interventions in the child welfare system to assess for any potential systemic matters within the local system of care.

The review team consisted of representatives from the Department's Office of Family Wellbeing, Office of Quality and Innovation, children's legal services (CLS), leadership from Directions for Living, a supervisor from Family Support Services North Florida (a case management organization in the Northeast Region) and the Associate Statewide Child Protection Team (CPT) Medical Director.

The team reviewed case records involving all key case participants and conducted interviews with child welfare professionals involved in the recent interventions. The following agencies were interviewed during the review: DCF Child Protective Investigations (CPI) frontline and leadership staff, DCF Behavioral Health Consultant (BHC), the Guardian Ad Litem (GAL), Family Intervention Specialists (FIS) and Youth and Family Alternatives Case Management (CM).

A summary of the team's findings is outlined in the following sections.

Summary of findings:

<u>Practice Assessment</u>

- The assessment of present and impending danger was found to be appropriate for the infant. However, given the mother's lack of cooperation and the hospitals inability to provide a safety service, an in-home present danger safety plan should not have been implemented. While this circumstance is not uncommon around the state, it presents a

conflict with the Department's operating procedure which requires specific activities to occur regardless of where the child is residing. It should be noted that the Department is in the process of revising this procedure to account for and provide better guidance for cases involving hospitalized infants/children.

- During the medical neglect investigation, the child protection team appropriately determined there was indeterminate findings of medical neglect due to the lack of medical records provided and the inability to assess medical neglect solely on the caregiver's statements.

Organizational Assessment

- The case manager is new and is still pursuing his certification; however, he feels supported by his supervisor and the senior case manager. The Investigative staff also described being supported by leadership and peers. The staff receive ongoing training and express having great relationships between each other and with community providers.

Service Array

- Interviews reflected there are adequate services available within Citrus County to meet the community's needs. In this case, investigations identified and referred the mother to FIS timely.

Case Participants

Name	Age at the Time of Incident	Relationship
[redacted]	3-Months	Decedent
[redacted]	2-Years	Half Sibling
[redacted]	7-Years	Half Sibling
[redacted]	12-Years	Half Sibling
[redacted]	16 Years	Half Sibling
[redacted]	35-Years	Mother
[redacted]	39-Years	Legal Father
[redacted]	51-Years	Court Ordered Legal Paternal Grandmother
[redacted]	59-Years	Court Ordered Legal Paternal Grandfather

Child Welfare Summary

History as to the immediate family:

Between 2010 and 2023, the parents were involved in eight investigations with the Department to include patterns of domestic violence, substance use, and overall neglect. The reports reflected that as of 2023, the parents' older children resided with the legal paternal grandparents.

The only report with verified findings involved [redacted] in May of 2023. Upon [redacted] birth at 35 weeks gestation, he and his mother tested positive for cocaine resulting in his admission to the neonatal intensive care unit (NICU). The mother was offered an FIS worker to address her substance use; however, she was neither cooperative nor followed up on any referrals. Additionally, the mother did not visit [redacted] while he was hospitalized, and while the father did meet with the CPI staff, he refused to participate in a drug screen. During the shelter hearing, the court implemented a no-contact order between [redacted] and his parents. Upon the approval of a home study and his discharge from the hospital, [redacted] was placed with his legal paternal grandparents.

The case was transferred to Youth and Family Alternatives for ongoing judicial case management oversight on June 13, 2023.

History as to the legal paternal grandparents include:

Between 2014 and 2023, the legal paternal grandparents were involved in six investigations that reflected patterns of physical injury and inadequate supervision that appear to stem around their teenage sons and a teenage grandson's (sibling of the decedent), substance use issues, and challenges in parenting. None of the reports were verified for maltreatment.

One report was received during the time [redacted] was placed with the grandparents. In June of 2023, a report was received with concerns that the legal paternal grandparents were not seeking medical treatment or following up for his hand which was swollen and red. The paternal grandparents reported that [redacted] hand was observed red and swollen when he was discharged from the hospital; however, it had improved. The grandmother reported seeking

treatment with the pediatrician and an X-Ray was prescribed by the pediatrician. The CPT conducted a medical evaluation and interviewed the paternal grandmother which resulted in indeterminate findings of medical neglect. The CPT further recommended that the Department provide additional medical records from [redacted] stays at local hospitals and the emergency room visit to further assess. The report was closed with no indicators of medical neglect on July 30, 2023.

System of Care Review

This review is designed to provide an assessment of the child welfare system's interactions with the [redacted] family and to identify matters that may have influenced the system's response and decision making. It should be noted that the review team determined that there was no correlation between the Department's previous involvement with the family and the circumstances surrounding the infant's death.

Practice Assessment

PURPOSE: This practice assessment examines whether the child welfare professionals' actions and decision making regarding the family were consistent with the Department's policies and protocols.

FINDING A: The assessment of present and impending danger was found to be appropriate for the infant. However, given the mother's lack of cooperation and the hospitals inability to provide a safety service, an in-home present danger safety plan should not have been implemented. While this circumstance is not uncommon around the state, it presents a conflict with the Department's operating procedure which requires specific activities to occur regardless of where the child is residing. It should be noted that the Department is in the process of revising this procedure to account for and provide better guidance for cases involving hospitalized infants/children.

Present danger was appropriately identified at the onset of the investigation, on May 16, 2023. The CPI gathered upfront information, to include in part, speaking to the prior CPI and completing an emergency out of town inquiry (OTI) to see [redacted] at the hospital. After a failed attempt to see the mother at the hotel, where she was allegedly resided, the CPI called the mother. The mother agreed to meet with the CPI the following day at the hospital, when she visited the infant. When the mother failed to contact the CPI the following day, the CPI called the hospital who then informed the CPI the mother had not been to the hospital to visit the child. The CPI accurately determined there was a threat of severe harm to the infant given that the mother had only called the hospital once to check on the infant, she was not cooperating with the investigation, she had a documented historical and current substance use, and [redacted] tested positive for cocaine at his birth. While creating a safety plan when a child resides in a secondary location (i.e., hospital, shelter, or residential facility) which is common practice around the state, it doesn't align with the Department's operating procedure. CFOP 170-7 defines an informal safety provider as a responsible adult identified by a parent who agrees to provide safety management services as specified in the safety plan. The present danger safety plan indicated the hospital staff would care for the baby's basic and essential needs and take the baby to a safe location and contact the CPI if the mother appeared to be under the influence. There was no documentation to support a conversation took place with the hospital staff, detailing the present danger safety plan. There was no indication the hospital staff were made aware of the safety plan and the expectations of their involvement.

While CFOP 170-7 states the informal safety provider should be interviewed it also directs the child welfare professional to conduct background screening to include Florida child abuse history, Florida sexual offenders and predators' registration, and local criminal history. Conducting said background screening creates barriers for staff to implement least intrusive safety plans versus taking court action when a child is in the hospital.

Given the conflict between the requirements of the current operating procedures and cases involving infants/children who are hospitalized (and shelter actions not recommended until the child is ready for discharge), the Department is in the process of revising this procedure to account for and provide better guidance for cases involving hospitalized infants/children.

FINDING B: During the medical neglect investigation, the child protection team appropriately determined there was indeterminate findings of medical neglect due to the lack of medical records provided and the inability to assess medical neglect solely on the caregiver's statements.

A medical neglect investigation was received on June 15, 2023, alleging the legal paternal grandparents were not properly caring for [redacted] injury to his hand. [redacted] was observed and the legal paternal grandmother, [redacted], was interviewed at the CPT in Gainesville on June 23, 2023. [redacted] reported during her CPT interview that [redacted] was placed with her through dependency court after he was born at 32 weeks gestation, weighing four pounds, and testing positive for cocaine. When she picked him up from the hospital, she noticed his left arm was red and swollen, and was informed by the hospital doctors that an intravenous (IV) placed in his hand so they could inject calcium into his body, had leaked and caused a burn on his hand. [redacted] also indicated she asked at discharge if there were any special instructions for his hand and arm, which the hospital replied, "no." The only discharge instructions were for her to work on his range of motion and follow up with [redacted] primary care physical (PCP) for his regular well child checkup.

[redacted] informed the CPT that [redacted] was seen by his PCP on June 12, 2023, for his first well child checkup and had gained three pounds since birth. The PCP didn't have any concerns for [redacted] hand; however, the PCP did request his hand get X-Rayed, which never occurred. The CPT determined there were indeterminate findings of medical neglect due to a lack of medical records provided and the inability to assess for medical neglect solely on [redacted] statements.

While the CPI did speak to several collaterals, to include, the GAL, CM, CPT, prior CPI, prior child protective supervisor (CPIS), and PCP, there was no follow up to ensure the CPT had the requested medical records. In Citrus County, if the CPT has indeterminate findings, because they're waiting on medical records, investigations may close their investigation while waiting for the requested records. Once the CPT receives the requested medical records, the CPT may write an addendum and complete a medical neglect staffing, if needed.

Organizational Assessment

PURPOSE: This section examines the level of staffing, experience, caseload, training, and performance as potential factors in the management of this case.

FINDING A: The case manager is new and is still pursuing his certification; however, he feels supported by his supervisor and the senior case manager. The Investigative staff also described being supported by leadership and peers. The staff receive ongoing training and express having great relationships between each other and with community providers.

The CPI assigned to the verified investigation started her career with the Department as a family support worker (FSW) and within a year was promoted to a CPI. She became fully certified in

June of 2023. Reportedly, investigations feel supported by leadership and described an open-door policy. The staff disclosed during interviews and both investigations provided examples of how the staff support each other and work well as a team. The primary CPI and the FSW worked together to ensure emergency OTIs were completed timely to ensure all the children were seen. The staff also work together by strategizing their daily field work to assist seeing victims for each other. Currently there are two supervisors actively taking cases. While this limits the number of supervisors available to the investigative staff, given there are six vacancies in Citrus County, having more staff receiving cases is a priority. While the program administrator (PA) has only been in her current role for one year, she has a combined 13 years of experience as a CPI and CPIS. Investigative staff described receiving on-going training, however, they would like more training around safety planning.

While the CM is still going through the certification process and learning the county's services and the nuances of the CM position, he described a strong relationship with the case manager supervisor (CMS). At the completion of pre-service training, the CM was assigned two families with a total of six children. His caseload has gradually increased to include 10 families to include 20 children. Several of the children on his current caseload reside out of county and are receiving courtesy supervision in the county they reside in. While the CM describes managing his caseload by prioritizing his activities, he described struggling with having to balance judicial and non-judicial cases. The judicial cases require more paperwork and documentation, which pulls the CM away from the non-judicial cases. The CMS has three years' experience as a CM and two years as a CMS. All staff, including providers, described the CMS as being helpful and always readily available. All staff reported having great inner agency relationships, and with community providers and partners.

Service Intervention/Array

PURPOSE: This section assesses the inventory of services within the child welfare system of care.

FINDING A: Interviews reflected there are adequate services available within Citrus County to meet the community's needs. In this case, investigations identified and referred the mother to FIS timely.

Citrus County utilizes Connect to ensure the families are linked with the proper services. Connect is a universal screening system that helps families with young children by providing a one-stop entry point for needed services, such as (in part) parenting, child development, food and nutrition, mental health, and financial self-sufficiency. This coordinated streamlined referral process helps in the reduction of duplicated services and ensures each family receives their desired services. Connect completes weekly calls with providers, to ensure they are kept abreast of the status of the referrals made. Investigations utilized Connect for the mother, however she did not respond to Connect.

In addition, the FSW referred the mother to an FIS. FISs are child welfare professionals who support both CPIs and CMs, by ensuring a child welfare client has the appropriate substance use treatment and recovery plan. An FIS's responsibilities include, in part: screening, referring, and linking an individual to the proper substance use and/or mental health provider, while working with the CM to ensure there is compatibility between the substance use treatment goals and the child welfare case plan. Citrus County's FISs cover three counties to include Sumter,

Lake, and Citrus. Currently they are not on a waiting list with 21 active cases, however, they can no longer accept referrals after 35 cases. Both the mother and father were referred to a FIS, within a week of receiving the investigation, however neither one engaged.