



# Critical Incident Rapid Response Team

**Phoebe Jonchuck**

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**Phoebe Jonchuck**  
SunCoast region  
Circuit 13  
Hillsborough County, Florida

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## **Executive Summary**

Early on the morning of January 8, 2015, 5-year-old Phoebe Jonchuck was dropped by her father, John Nicholas Jonchuck, Jr., over the edge of the Sunshine Skyway Bridge in Tampa. She fell approximately 60 feet and drowned in the water below. In the days preceding this, there were 2 calls screened out by the Florida Abuse Hotline in which concerns had been raised about Mr. Jonchuck, Jr. – one on December 29, 2014 that raised concerns about past physical violence, and another less than 12 hours before Phoebe’s death that raised concerns about his behavior earlier that day. In Hillsborough County, child protective investigations are conducted by the Hillsborough County Sheriff’s office child protection division. At the time of incident the sheriff’s office had an open child welfare investigation regarding Phoebe’s non-custodial mother, Michelle Kerr. The allegations in that investigation included Family Violence, Inadequate Supervision, and Substance Misuse.

The CIRRT completed a review of all current and past investigative records concerning Phoebe’s family as well as all related law enforcement, court and mental health records that could be obtained. The team also interviewed hotline personnel, local child protective investigations staff and local service providers utilized by the child welfare system. The team has identified preliminary findings in 3 categories designed to assist in the ongoing efforts to make our child welfare system as effective as possible. Following is a summary of the findings:

## **Practice Assessment**

1. Florida Abuse Hotline
  - A. On December 29, 2014 the Florida Abuse Hotline received a call regarding Phoebe Jonchuck that was screened out due to failure to follow Florida Abuse Hotline established practice. In addition, a subsequent call was received on January 7, 2015 that was not accepted as result of a gap in the then existing maltreatment index.
2. Child Protective Investigations
  - A. The investigation initiated on June 7, 2013 (Intake # 2013-160117-01) should have resulted in a referral for services. The belief that the separation of the parents had remediated the primary safety threats for the family significantly impacted the direction of the investigation, while insufficient examination or interpretation of family functioning and lack of follow-up contributed to the investigation being closed without services in place.

## **Organizational Assessment**

1. Florida Abuse Hotline
  - A. The Florida Abuse Hotline is in the midst of a reorganization and alignment with Florida’s new child welfare practice model that will impact every part of its operation; however, it does not currently have a consistent quality assurance

process to evaluate screened out reports or a training plan to build internal expertise regarding mental health, substance abuse and domestic violence.

## 2. Child Protective Investigations

- A. The rate at which new cases are received and the number of ongoing staff vacancies impact protective investigators' abilities to effectively carry out thorough pre-commencement activities, uniformly effective consultation and timely documentation.

### **Service Array**

#### 1. Child Protective Investigations

- A. The team identified a robust service array that includes domestic violence, substance abuse and mental health providers co-located with the protective investigations staff in Hillsborough County; however, they are used primarily as service resources rather than as subject matter experts or collaborative partners available for consultation during challenging investigations.

In response to this tragedy, effective Friday, January 9th the Department updated the Inadequate Supervision portion of the official Maltreatment Index to allow for the presence of obvious mental health symptoms to more easily be categorized as problematic and therefore accepted. The Department also amended related protocol to facilitate immediate response priority and a law enforcement well-being check of the child. Notice was distributed to all relevant staff on January 9, and a mandate was included that all Department staff verify that they had reviewed the new protocol by January 23.

That any child's life would end as Phoebe's did – at the hands of her own parent – is terrible beyond words. And we are reminded yet again that every process within our system should be critically examined at every opportunity to ensure that the role it plays is carried out effectively. Our commitment to the ongoing strengthening of our overall practice model and its individual components will continue as we work to fulfill our mission.

## **Introduction**

Early on the morning of January 8, 2015, 5-year-old Phoebe Jonchuck was dropped by her father, John Nicholas Jonchuck, Jr., over the edge of the Sunshine Skyway Bridge in Tampa. She fell approximately 60 feet and drowned in the water below.

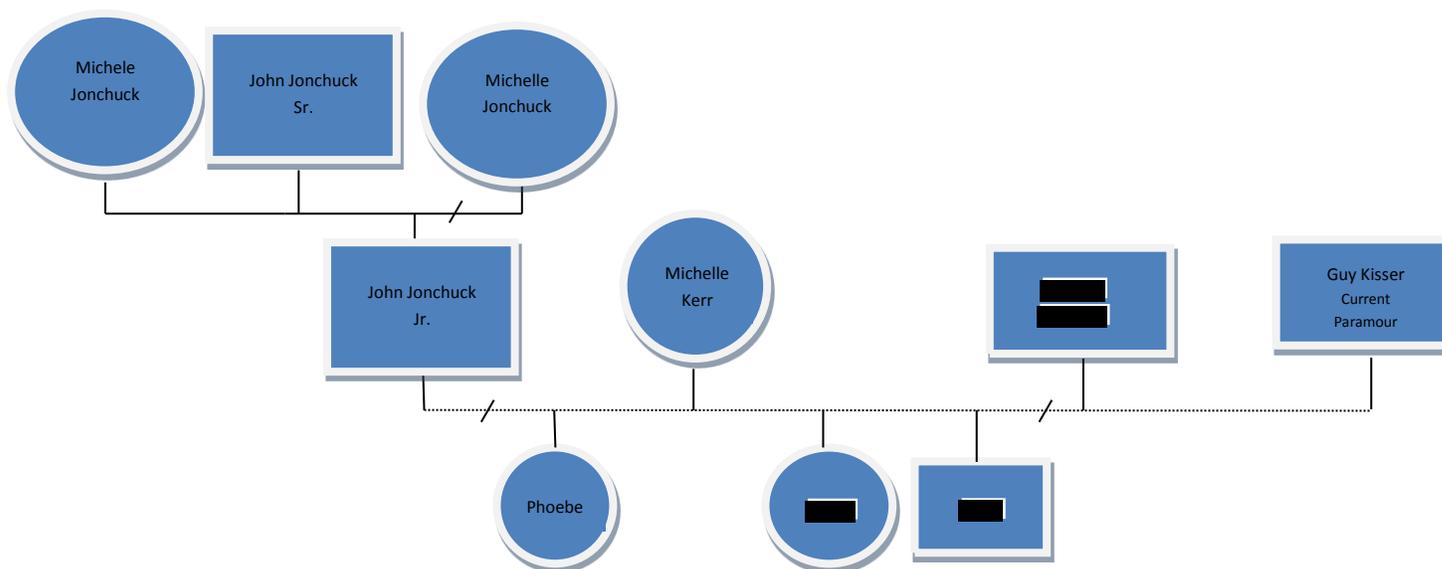
At the time of the incident, there was also an open child welfare investigation regarding Phoebe's non-custodial mother, Michelle Kerr. The allegations in that investigation included Family Violence, Inadequate Supervision, and Substance Misuse, and it had been initiated following a call received by the hotline on December 30. Though Phoebe had been living with her father, she had recently visited with Ms. Kerr for the holidays and was one of the children named as a potential victim in that investigation.

As a result of the circumstances, Secretary Mike Carroll of the Florida Department of Children and Families deployed a Critical Incident Rapid Response Team (CIRRT) to the SunCoast Region, Circuit 13 to determine the nature and efficacy of child welfare system involvement with Phoebe's family and to assess potential systemic issues within the local system of care. The team consisted of representatives from DCF's Office of Child Welfare, Substance Abuse and Mental Health (SAMH) Program Office and Children's Legal Services, as well as the Northwest Region SAMH Managing Entity, Seminole County Sheriff's Office and Harbor House of Central Florida (domestic violence service provider).

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 comprehensive system-of-care analysis.

## Case Participants

Name	Age at Time of Incident	Relationship
Phoebe Jonchuck	5	Decedent
John Nicholas Jonchuck, Jr.	25	Father
John Nicholas Jonchuck	57	Paternal Grandfather
Michele Jonchuck	51	Paternal Step-Grandmother
Michelle Kerr	29	Mother
Michelle Jonchuck	52	Paternal Grandmother
Guy Kisser	30	Mother's Current Paramour
[REDACTED]	30	Mother's previous Paramour and father to her oldest two children.
[REDACTED]	9	Half Sibling
[REDACTED]	12	Half Sibling



## Child Welfare Summary

The Jonchuck family has a history of generational reports with the Department of Children and Families beginning in 1994 when Mr. John Jonchuck Jr. was a young child. The Jonchuck family struggled with John Jonchuck Jr.'s mental health issues, [REDACTED], self-injurious behaviors and delinquency during his teen years, until he went to live with family friends at age 17 in 2006. During his childhood, the family was reported to the department on four separate occasions, with all investigations resulting in no verified findings of maltreatments.

In Mr. Jonchuck Jr.'s adult life, he was involved in three separate calls to the Florida Abuse Hotline from June 2013 to January 2015, all involving Phoebe Jonchuck as the child victim. Only the June 2013 call was accepted by the Florida Abuse Hotline and investigated by the Hillsborough County Sheriff's Office. The 2013 investigation resulted in verified findings of family violence threatens child with no service interventions put in place. In conjunction with this investigation, Mr. Jonchuck Jr. and Phoebe left the family home where they resided with

Phoebe's mother Michelle Kerr and her children. Mr. Jonchuck filed and was granted an injunction that prohibited Michelle Kerr from contacting him for the next year.

Phoebe Jonchuck was also listed as the child victim in two other reported and accepted investigations, first in April 2012 (no verified finding of maltreatment) and again in December 2014, a week preceding her death. The alleged perpetrator in these investigations was her mother Michelle Kerr, with allegations involving substance misuse and family violence.

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

Mr. Jonchuck Jr.'s criminal history involves multiple law enforcement responses and arrests for battery and domestic violence. Mr. Jonchuck Jr. was also both a petitioner and a respondent in multiple domestic violence/battery injunctions with the court system, and had been attempting to establish legal custody of Phoebe since July, 2013.

- 2008 – John Jonchuck, Jr. is arrested for Battery.
- May 2, 2010– John Jonchuck Jr. is arrested for Battery/ Domestic Violence.
- Feb 8, 2012– John Jonchuck Jr. is arrested for Battery/ Domestic Violence.
- January 30, 2013 – Michelle Kerr files and is denied a domestic violence injunction against Mr. Jonchuck Jr.
- January 30, 2013– John Jonchuck Jr. is arrested for Battery/ Domestic Violence.
- May 27, 2013 – John Jonchuck Jr. is arrested for Battery/ Domestic Violence.
- June 6, 2013 – John Jonchuck Jr. files and is granted a domestic violence injunction against Michelle Kerr. The injunction remains in place until June of 2014 and prohibits Michelle Kerr from contacting him.
- July 25, 2013 – John Jonchuck, Jr. filed a petition to establish his paternity as to Phoebe; dismissed in April 2014 and again in October 2014 for lack of service.
- November 6, 2013– John Jonchuck Jr. is arrested for Battery/ Domestic Violence.
- April 24, 2014 – Linda Mattos files and is denied an injunction against John Jonchuck, Jr.
- July 14, 2014 – John Jonchuck, Jr. files and is denied a domestic violence injunction against Bridget Martindale.
- December 31, 2014 – John Jonchuck Jr. files and is denied a domestic violence injunction against Michelle Kerr.
- December 31, 2014 – John Jonchuck, Jr. files and is denied a stalking injunction against Michelle Kerr.
- January 7, 2015 – Law Enforcement dispatched to local church to assess Mr. Jonchuck Jr. for Baker Act criteria. It is determined that he did not meet criteria for involuntary evaluation.

Viewing the combined collection of law enforcement, legal and child welfare-related events connected to this family reveals an established pattern of domestic violence, and concerns

regarding substance use and mental health issues that should have been viewed as indicators of maladaptive family functioning requiring more in-depth assessment and service intervention. The belief that the separation of the parents had remediated the primary safety threats for the family significantly impacted the direction of the 2013 investigation, while insufficient examination or interpretation of family functioning and lack of follow-up contributed to the investigation being closed without services in place. The appearance that subsequent reports were related as much to custody struggles as child welfare concerns contributed to future decision making throughout the remainder of this case.

## **System of Care Review**

This review is designed to provide a comprehensive assessment of the child welfare system's interactions with the Jonchuck family and to identify issues that may have influenced the system's response and the quality of the decision-making.

### ***Practice Assessment***

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

### **Florida Abuse Hotline:**

**FINDING A:** On December 29, 2014 the Florida Abuse Hotline received a call regarding Phoebe Jonchuck that was screened out due to a failure to follow Florida Abuse Hotline established practice. In addition, a subsequent call was received on January 7, 2015 that was not accepted as result of a gap in the then existing maltreatment index.

### **PRACTICE ISSUES**

A December 29, 2014 call to the hotline (Intake # 2014-339309) alleged past physical harm to Phoebe and current concerns regarding her living arrangements. The report was received by an experienced (4 years' experience) hotline counselor who informed the caller that the report was being accepted, but then terminated the call before verifying the address that had been given for Mr. Jonchuck. The counselor was subsequently unable to verify using the standard methods, and therefore closed the intake as screened out. Though the original reason was recorded as "Non-jurisdictional", the counselor acknowledged in an interview with the CIRRT that she should have coded the reason as "No Means to Locate".

Pre-service training and standard protocol dictates that a means to locate should be identified prior to a call terminating. This allows for clarifying information to be obtained in the event that verification is difficult. That protocol was not followed in this instance. It is also protocol that when a reporter is told that a call would be accepted, and the call is subsequently screened out for any reason, the counselor calls the reporter back to inform them of the final status. In this instance, such a call back would have provided another opportunity to get clarification regarding the address.

## SYSTEM ISSUES

A January 7, 2015 call to the hotline (Intake # 2015-005305-01) alleged that Mr. Jonchuck, Jr. had made multiple statements to the caller earlier that morning that sounded delusional and caused the caller to be alarmed. The caller indicated that they had already made a 911 call but that law enforcement personnel had determined that Mr. Jonchuck, Jr. did not meet criteria for involuntary hospitalization. This call was screened out.

In an interview with the CIRRT, the hotline counselor stated that she had placed the caller on hold to both review policy and protocol and review prior history. She said that she had identified the potential maltreatment as inadequate supervision, but concluded that criteria to accept the call were not met. She indicated that she had understood that the caller was concerned about Mr. Jonchuck, Jr.'s state of mind but also noted that the caller was unable to describe concerns that the child might be harmed; she stated that the fact that Phoebe was reported to be with her step-grandmother - and not with Mr. Jonchuck, Jr. - at the time of the call led her to conclude that the child was not in danger. Though the caller had stated that there was a current investigation, which was accurate, the counselor indicated in her interview that she had been unable to locate an open report. The counselor did not consult with a supervisor.

The lack of clarity in the Maltreatment Index at the time of the call regarding the impact of mental health issues on a parent's ability to provide adequate supervision contributed strongly to the counselor reaching the conclusion that Phoebe was not in danger. The counselor also appears to have placed too much value on the fact that the child was with the step-grandmother.

The counselor's relative inexperience, the limiting descriptions in the Maltreatment Index at the time, and the general lack of mental-health specific training provided for hotline counselors were all contributing factors in the failure to accept this call. The changes that have already been made to the Index will help provide more effective guidance for future situations that include individuals with presenting mental health symptoms.

## **Child Protective Investigation**

**FINDING A:** The investigation initiated on June 7, 2013 (Intake # 2013-160117-01) should have resulted in a referral for services. The belief that the separation of the parents had remediated the primary safety threats for the family significantly impacted the direction of the investigation, while insufficient examination or interpretation of family functioning and lack of follow-up contributed to the investigation being closed without services in place.

This investigation commenced approximately two weeks after an altercation between Mr. Jonchuck, Jr. and Ms. Kerr that resulted in Mr. Jonchuck being arrested, and after which he and Phoebe had moved out. This contributed to the situation being primarily viewed as rooted in the problematic relationship between the two adults, with the majority of safety concerns arising out of their altercations. By that view, the threat to Phoebe and [REDACTED] was substantially diminished when Mr. Jonchuck moved out. The review of local law enforcement records that was done as

part of this investigation included a history of arrests, but did not include either narrative from any of those arrests or incident reports from other types of law enforcement contact. It also did not include analysis of the burgeoning history of injunctions within the family or their relevance to safety considerations, or any attempt to obtain records that would support or clarify reports that such injunctions existed.

The Child Safety Assessment reflects that the CPI's analysis of important family factors appears to have resulted in several conclusions that are not supported by the documented facts. Further, it seemed to focus on meeting the basic needs of the children rather than addressing the histories of domestic violence, mental health, and substance abuse issues. An assessment of Mr. Jonchuck, Jr.'s use of domestic violence is also absent in the portion of the CSA dedicated to signs of present danger. The collateral interviews lacked thoroughness and the pursuit of clear supporting information to assist with the investigation.

There is also no documentation of Mr. Jonchuck, Jr. being offered any kind of services, despite the fact that the investigation was closed with a Verified finding and he had become the sole primary caretaker since the event that primarily led to that finding. This investigation should not have been closed without services being offered to Mr. Jonchuck, Jr. and Phoebe.

The CPI Supervisor interviewed by the CIRRT stated that the reason there had not been services provided to either parent was because they had been separated since the inception of the investigation, and this had been viewed as effectively addressing the domestic violence problem between them. The fact that this situation was viewed through an incident-focused lens rather than from a more comprehensive family functioning viewpoint led to inadequate action and a missed opportunity to potentially improve long term family safety.

## ***Organizational Assessment***

### **Florida Abuse Hotline:**

**FINDING A:** The Florida Abuse Hotline does not currently have a consistent quality assurance process to evaluate screened out reports or a training plan to build internal expertise regarding mental health, substance abuse and domestic violence; however, the Hotline began a reorganization in January to align with Florida's new child welfare practice model that will impact every part of its operation.

The Florida Abuse Hotline is a 24 hour central reporting center for allegations of abuse, neglect, and/or exploitation for all children and vulnerable adults in Florida. Over the last four years the Florida Abuse Hotline has averaged 456,568 reports per year. Of those intakes an average of 310,743 are child abuse reports. The hotline screens out, on average, 19% of all child abuse reports, accepting on average 81%. Florida Abuse Hotline call volume is typically second or third highest in the nation depending on the year.

The Florida Abuse Hotline is staffed with 220 Hotline counselor positions, 24 supervisor positions, 4 managers and 1 director. Three of the 24 supervisor positions and nine of the 220

counselor positions at the hotline have been reassigned to provide internal training and quality assurance. Counselors are expected to average 2 calls an hour over the course of a year, with qualitative reviews every quarter.

Historically Florida Abuse Hotline staff receive a 14 week pre-service training that prepares them to meet the basic requirements of their position; however, there are no individualized staff development plans to build internal capacity within the hotline to support staff in responding to complex situations involving substance abuse, mental health or domestic violence.

In 2014, the oversight of Hotline operations was shifted to Office of Child Welfare (OCW) within the Department of Children and Families. This shift created external quality assurance and practice specialist within OCW to better align hotline practice and quality assurance with Florida's new child welfare practice. Since that time, the hotline has restructured, enhanced new hotline counselor pre-service training, made available skill building opportunities with national experts, began work on updating the maltreatment index and began working on a more cohesive quality assurance plan.

As a result of the restructure, the hotline has begun a time study to ascertain the level of effort and staffing requirements necessary to align with new practice, reduce wait times, reduce abandon call rates, and move the Florida Abuse Hotline from a "call center" mentality to an "assessment center."

### **Child Protective Investigations:**

**FINDING B:** The rate at which new cases are received and the number of ongoing staff vacancies impact protective investigators' abilities to effectively carry out thorough pre-commencement activities, uniformly effective consultation and timely documentation.

Child Protective Investigations staff in Hillsborough County are employed by the Hillsborough County Sheriff's Office. The program is structured so that 3 General Managers - who are law enforcement personnel - supervise a group of 15 supervisors, who in turn each supervise a unit of 4 to 6 CPIs when fully staffed. The CPIs and CPI Supervisors are all civilians. The total number of full time employees allocated to this program is 101.

Supervisory staff estimated that each CPI in the Hillsborough program is receiving between 5 and 7 new cases each week and carrying an average of 25 open investigations at any given time. The CPI assigned to the most recently opened investigation involving Phoebe - initiated December 30 - had 27 open cases as of an interview on January 13.

As of the interviews conducted on January 13, the program had 25 vacancies, and supervisory staff indicated that this was representative of what the vacancy rate has been for some time. An examination of the length of employment of the CPIs in the program revealed that there are plenty of experienced employees - 25% had been employed for 5 or more years, and another 24% had been there for 2 years or more. But 30% had been on the job for less than a year, and evidence suggests that the retention rate is particularly low for these newest employees.

Supervisory staff indicated that many do not make it through the entire training program, and of those that do turnover rates remain high for employees during their first year.

This personnel shortage is compounded by the actual hiring process. Due to the fact that the CPI staff are employed by a law enforcement agency, they are subject to strenuous background checks, personality inventories and lie detector tests. Additionally, the entire hiring process can take up to 4 months. A recent change has made it so that potential employees no longer need to use the Civil Service process to apply, and this is expected to reduce the time involved by up to a month. This may be a contributing factor in what appears to be a understaffing issue.

Staff who were interviewed indicated that they receive a robust amount of information upon being assigned a new case, and that their practice is to review all of it as fully as possible before attempting initial contacts. But these efforts are impacted by numerous factors, including how quickly they must make contact, how many open cases they are already assigned, where they are when they receive the case, how many new cases they receive at a time, and what the response demands are for the other new cases. Though CPIs have laptops and are able to access web-based information when they are in the field, this does not overcome the challenges created by the lack of time.

It is also important to note that none of the investigations conducted by the Hillsborough County Sheriff's office involving Phoebe and her family utilized Florida's new child welfare practice which was passed by the legislature and signed by the Governor in 2014. As of CIRRT interviews on January 13, approximately 40% of the program's staff were practicing the new Safety Methodology. As a result of this tragedy, the CIRRT was notified by Hillsborough County Sheriff's Office that due to increased intakes they were suspending continued implementation efforts at this time.

Given all of the above, it appears that on an individual basis, CPIs possess many of the tools, training and information necessary to be able to effectively assess situations and carry out related investigations. But they are significantly impeded in this effort as long as they continue to be overwhelmed and understaffed.

### ***Service Intervention/Array***

**PURPOSE:** This section assesses the inventory of services within the child welfare system of care in Hillsborough County, where the Jonchuck family's case originated.

**FINDING A:** The team identified a robust service array that includes domestic violence, substance abuse and mental health providers co-located with the protective investigations staff in Hillsborough County; however, they are used primarily as service resources rather than as subject matter experts or collaborative partners available for consultation during challenging investigations.

Along with multiple CPI staff, the CIRRT interviewed an array of service providers who are co-located with them at the Hillsborough County Sheriff's Office:

Gulf Coast and Grace Point each provide an Intensive In-Home service that includes case management, family advocacy, traditional mental health services, substance abuse counseling and linkage to domestic violence services. The primary targeted recipients are Safe/High Risk or Safe/Very High Risk families; the programs typically run 8 weeks and include bi-weekly staffings with the involved CPIs and the availability of continued services as necessary upon program completion.

The Springs provides a domestic violence advocate who assists with service linkage, transition planning, shelter planning and shelter placement for victims of domestic violence.

DACCO provides In-Home substance abuse services that include assessment and ongoing treatment for parents with substance abuse issues. They primarily serve Safe/Low Risk and Safe/Moderate Risk families and are capable of entering notes directly into FSFN.

Northside provides In-Home mental health services to Safe/Low Risk and Safe/Moderate Risk families. Their program typically runs for approximately 6 to 8 weeks.

In addition, Eckerd – the local Lead Agency – provides a team of 5 resource specialists who assist with service matching, linkage and referral coordination related to all of these services.

Staff from each of these providers was interviewed, and all indicated that they felt as if their relationship with the CPI staff is positive and that communication in both directions pertaining to service delivery is effective. Each provider also indicated that they have consistently maintained sufficient capacity to provide for the number of referrals they receive, and that they are not aware of any waiting list or accessibility issues. Separate interviews with CPI staff corroborated all of these concepts.

But all of these services are utilized as resources for referral, with CPIs pursuing access after a determination has been made that the related services are necessary for a family who is part of an investigation. None of them are utilized as staffing resources who might assist by lending topic-specific insight or serving as collaborative partners during the assessment and determination process. Though the nature of the arrangements by which these providers come to be present in the building may be specific to providing services, the abundant expertise could be utilized as part of critical decision-making for complex cases seems to be a missed opportunity.

## **SUMMARY**

Though there was a well-documented history of concerns related to this family, there was nothing in the preceding several years that could have reasonably been interpreted as predictive of such an event.

Portions of Phoebe's family had come to the attention of the child welfare system on multiple occasions, and as noted above it appears that there were points at which further intervention or examination were warranted.

Regarding Mr. Jonchuck, Jr. specifically, though there were prior indicators that he was manipulative, controlling, vindictive and aggressive, there were also repeated collateral contacts that he was an appropriate parent who provided for Phoebe's well-being and actively sought to protect and care for her. In fact, the primary stressor that could be identified in the weeks/months leading up to January 7 is the emergence of custody and visitation questions which had previously been absent for more than a year. There was also no recent evidence prior to that date that he was experiencing significant mental health issues or might be at risk for severe decompensation. Predicting the extreme nature of the events that manifested in the hours leading up to Phoebe's death would have been virtually impossible.

### **Immediate Operational Response**

In response to this tragedy, effective Friday, January 9<sup>th</sup> the Department updated the Inadequate Supervision portion of the official Maltreatment Index to allow for the presence of obvious mental health symptoms to more easily be categorized as problematic and therefore accepted. The Department also amended related protocol to facilitate immediate response priority and a law enforcement well-being check of the child. Notice was distributed to all relevant staff on January 9, and a mandate was included that all Department staff verify that they had reviewed the new protocol by January 23.

The instructions in the new protocol are as follows:

"All calls to the Florida Abuse Hotline that are accepted as reports alleging inadequate supervision when a caregiver is present shall be coded as an immediate response priority when the circumstances present are significant, clearly observable and actively occurring. In addition, the hotline will transfer the caller to the appropriate law enforcement agency and request a well-being check of the child."

The changes to the Maltreatment Index include the following:

An addition to the "Definition" portion of the Index that states, "This maltreatment would also apply when a parent/caregiver is present but has a history of or is currently exhibiting signs of mental health issues, delusional behavior, immaturity, developmental delays or other limitations that have resulted in harm or pose a threat of harm to the child."

Two additions to the "Examples" portion of the index: "A caregiver whose mental health issues have caused them to not attend to a child's daily needs" and "A caregiver who is exhibiting serious signs of mental health issues or cognitive delays while acting as caregiver".

A list of 7 new screening questions that must be asked by a hotline counselor or child protective investigator who is assessing a caregiver whose mental health issues may be impacting their capacity to provide care. They include a list of common symptoms with descriptions and

examples as well as several questions designed to help determine whether the symptoms constitute a threat to a child.