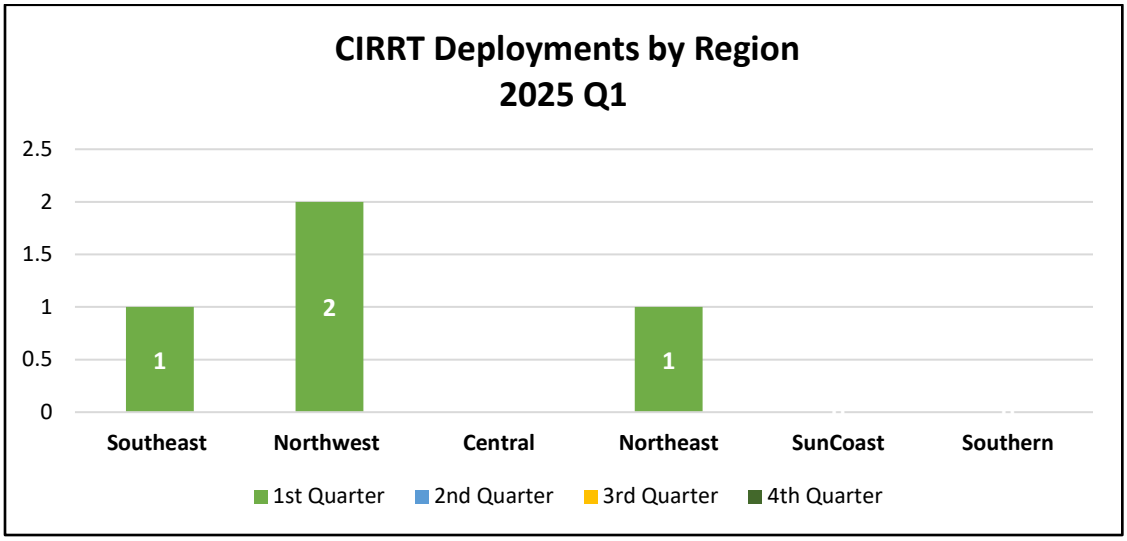
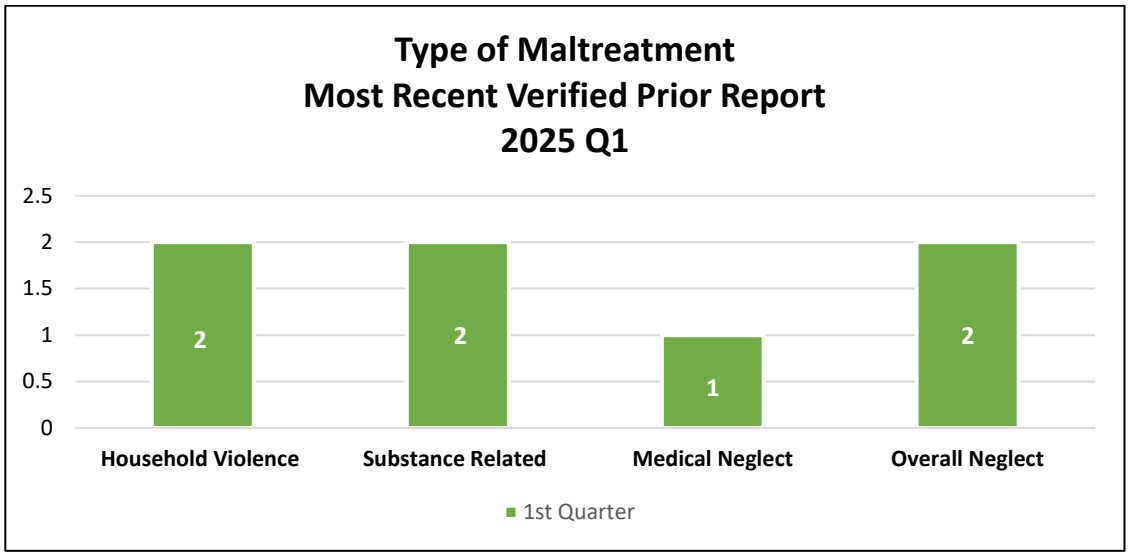
Florida Department of Children and Families
Critical Incident Rapid Response Team (CIRRT)
Advisory Committee Report Overview
2025-Quarter 1

Between January 1, 2025, and March 31, 2025, there were 104 fatalities reported to the Hotline. Of those 104 cases, four met the criteria for a CIRRT deployment. In three of the deployments, the decedent was a child victim in the prior verified investigation. In three of the deployments, the decedents were 1 years of age or younger, and in the remaining deployment, the decedent was 17 years old. In all four deployments, the family was involved in case management oversight, with two cases under out-of-home judicial services and two under in-home non-judicial services, when the fatality occurred.





In addition to the four CIRRT reviews, one team was deployed to conduct a special review on a case received in December 2024 that did not meet statutory requirements for a CIRRT review. In this case, the victim was 3 months old, and the family was not involved in case management oversight.

Summary of Deployments

- A deployment to conduct a special review in Pasco/Pinellas County occurred in January 2025; however, the report was received in December 2024. The review involved the death of a 3 ½ month old after she was hospitalized with severe injuries including a skull fracture and multiple brain bleeds. As a result, the mother was arrested in March 2025 on charges of first-degree murder.

- A deployment to Escambia County involved the death of a 17-year-old medically complex child while in the care of her mother and maternal grandmother. At the time of the fatality incident, the family was involved in an ongoing judicial case which stemmed from a verified report closed in February 2024 due to severe domestic violence between the mother and her husband (father to several of the younger siblings). The mother was in the process of full reunification with the children.

- The deployment to Okaloosa County involved the death of an 8-month-old. Information from household members was inconsistent, and the investigation is pending. The family has a significant history between 2018 and 2024 with the Department that reflects a pattern and escalation of household violence and substance use which ultimately resulted in case management services. At the time of the fatality incident, the family was involved in an active in-home non-judicial case in which the three children resided with the father.

- The deployment to Duval County involved the death of a 1-year-old, medically complex child, who was found unresponsive in her car seat by the mother. The family was involved in in-home non-judicial case management services which stemmed from a verified report closed in June of 2024 due to ongoing medical neglect. Another investigation was received in July 2024 with in-home non-judicial services continuing. Those services were closed in November of 2024.

- The deployment to Broward County involved the death of a 5-week-old after they were found unresponsive while bed-sharing with the licensed foster parent. The family was involved in out-of-home judicial case management, which stemmed from a verified report closed in June 2024 due to concerns for environmental hazards and inadequate supervision. When the decedent was born in February 2025, the decision was made to shelter the child and place in foster care, while home studies were pending on relatives/non-relatives.

Overall Findings

During this quarter, there were findings around practice assessment:

Practice Assessment

- In most of the reviews, the assessment of present and impending danger properly aligned with the Department's policies and procedures, and sufficient information was obtained to support the final safety determination.
    - In the Broward County review, collaboration and communication was evident between multiple agencies and community-based care organizations.

- The following opportunities were identified to improve practice:

- Ensure case trajectory, safety actions, and interventions are appropriate given a family's history or circumstances in the case. This includes that trajectories are congruent with supervisory guidance and following up on designated actions that support sufficient information is gathered for a full assessment and understanding of the family.
- Ensure safety plans are developed with actions that do not restrict parental access and are not implemented when the alleged perpetrator is unknown.
- Ensure multi-disciplinary staffing's are held on complex cases that involve multiple agencies to share critical information and determine appropriate next steps.
- Ensure assessments are based on a full analysis of the family's functioning and circumstances and not closed when critical information is pending.

- There was one statewide systemic opportunity identified:
  - In March 2025, there was a delay in fingerprinting due to FDLE system updates which impacted timely approval or disapproval of home studies. As of April 2025, FDLE system updates were completed, and delays were rectified.
  - Additionally, a lack of clarity and consistency has been identified in the current operating procedures regarding the authority of case management staff to conduct emergency criminal background checks when circumstances warrant. This has resulted in varied interpretations among staff.
    - Office of Child and Family Well-Being policy staff are actively working to enhance the language in operating procedures for better clarity and the Department is currently providing home study training to case management staff that reinforces their ability to conduct emergency background screens, when appropriate.