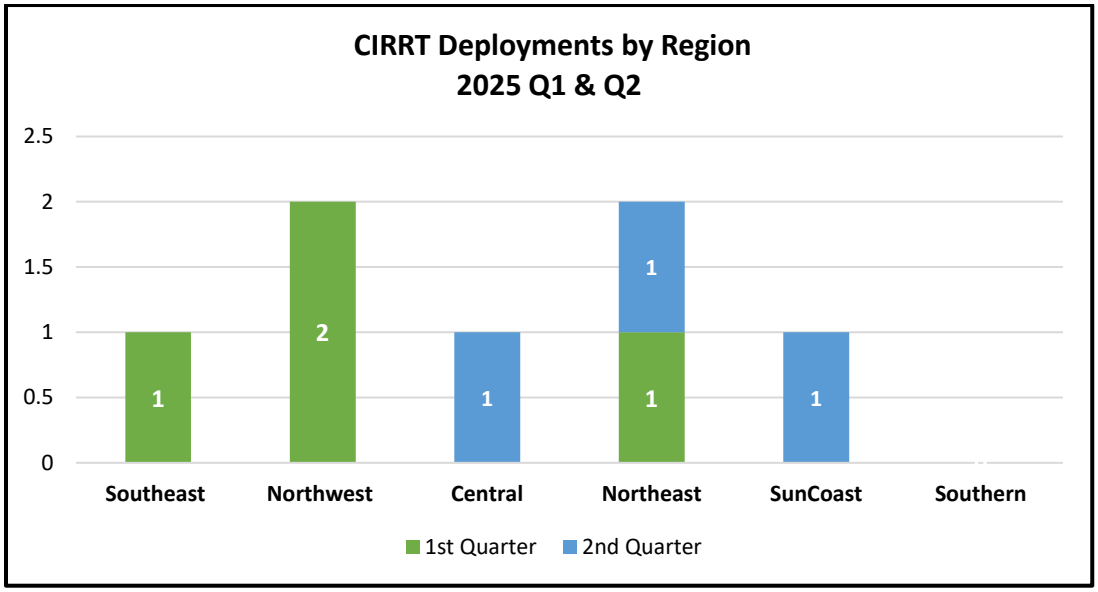
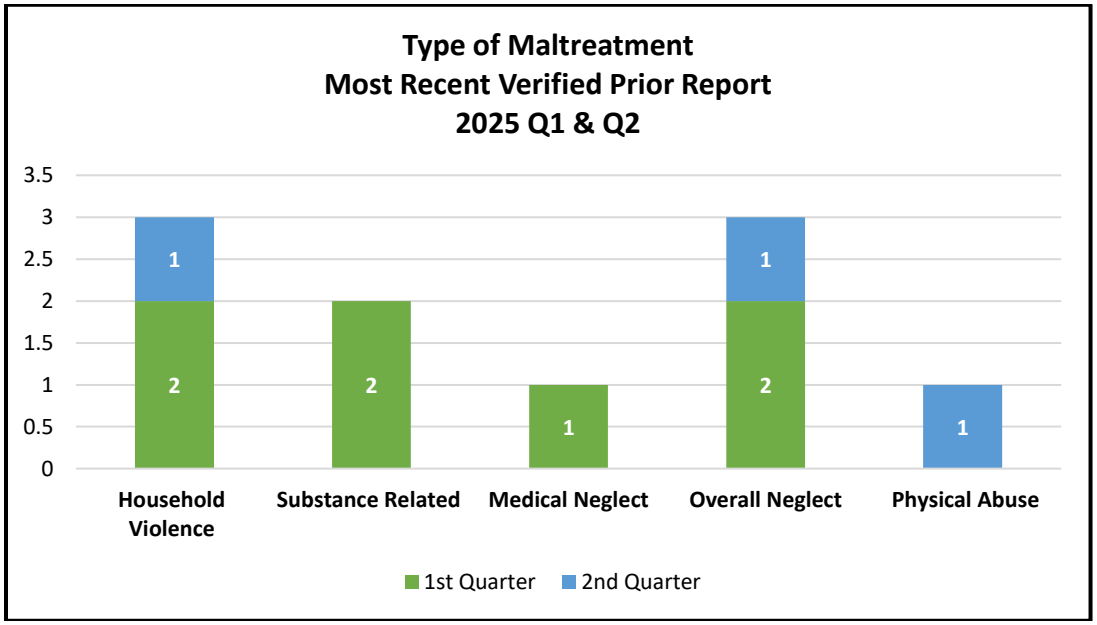
Florida Department of Children and Families
Critical Incident Rapid Response Team (CIRRT)
Advisory Committee Report Overview
2025-Quarter 2

From April 1, 2025, through June 30, 2025, 121 fatalities were reported to the Hotline. Of those, three met the criteria for a CIRRT deployment. In one of the deployments, the decedent had been a child victim in a prior verified investigation. In all three of the deployments, the decedents were under six months of age. In one of the deployment cases, the family was involved in-home non-judicial case management oversight.





In addition to the three CIRRT reviews, two teams were deployed to conduct special reviews on two cases (in the Northeast and Northwest regions) that did not meet statutory requirements for a CIRRT review. In both cases, the children were under the age of 5. Neither was involved in case management oversight.

Summary of CIRRT Deployments

Duval County

A deployment was conducted following the death of 3-month-old found unresponsive in her crib while in the care of her parents. Both parents tested negative on voluntary presumptive drug screens. The family was involved in one prior investigation, which led to in-home non-judicial services that closed in March 2025.

Pinellas County

This deployment followed the death of 5-month-old who was brought to bed by his mother for a bottle feeding. She inadvertently fell asleep while feeding and later awoke to find the infant unresponsive, not breathing, and wedged between the mattress and the wall. The family was involved in two investigations in March 2025, both stemming from the same incident. Each investigation focused on one parent's respective household. The mother was subsequently referred for in-home non-judicial case management oversight.

Orange County

A deployment was conducted following the sleep-related death of a 2-month-old found unresponsive and not breathing while bedsharing with her mother. The mother has an extensive Department history dating back to 2006, reflecting a pattern of physical injury, inadequate supervision, and household violence. Several reports were verified for maltreatment. From December 2016 through September 2017, the family received judicial case management due to family violence between the mother and one of the children's fathers. Between 2024 and the time of the fatality, the family was involved in four investigations.

Summary of Special Review Deployments

Dixie County

A deployment was conducted to review the death of a 2-year-old who was found unresponsive while in the care of his paternal grandmother. Hospital toxicology confirmed the presence of fentanyl in the toddler's system. The family had been involved in two prior investigations since 2023, both involving substance use concerns. The mother has an older child (4 years old) who was adopted by the maternal grandparents through family court.

Leon County

A deployment was initiated following the death of a 5-year-old reportedly found unresponsive by her mother and stepfather. Upon hospital admission, the child exhibited multiple signs of inflicted injury at various stages of healing. The mother and stepfather were arrested on charges of aggravated child abuse, child neglect with great bodily harm, and failure to report child abuse. The family had a total of four (4) investigations, three of which

were received in 2024 with concerns for substance use, sexual abuse, and domestic violence.

Overall Findings

The reviews conduct an analysis around practice assessment, organizational assessment, and service array. During this quarter, there were findings in all three areas.

Practice Assessment

- In most reviews, assessments of present and impending danger properly aligned with the Department policies and procedures, with sufficient information obtained to support final safety determination.

- Collaboration and communication were particularly strong in the Duval and Orange County reviews and clearly evident between multiple DCF staff and community partners.

- Identified opportunities to improve practice:
    - Ensure assessments reflect a comprehensive understanding of family functioning, circumstances, and history, and not solely focused on the alleged incident.
    - Provide sufficient supervisory oversight, including second-level reviews for complex dynamics.
    - When necessary, design safety plans that do not unnecessarily restrict parental access and ensure they are managed and monitored as required.
    - Conduct multi-disciplinary staffings for complex, multi-agency cases to share and coordinate critical information and determine appropriate next steps.

Organizational Assessment

- Strengths included effective collaboration within the Department and with community partners, as well as staff knowledge and experience.

- Identified Opportunity:
    - Staff turnover and low staffing levels in two reviews negatively impacted assessments, decision-making, and investigation management.
        - Staff from other counties were reassigned to the affected counties to provide additional support during staffing shortages, resulting in incident-focused investigative work with limited supervisory oversight. Staffing levels in the impacted counties have since returned to manageable levels.

Service Array

- Most of the reviews indicated community providers were available and collaborated with Department staff and between agencies to meet the needs of families.

- Identified Opportunity:
    - Dixie County (a rural area of the state) faces limited access to intervention-level services, such as parenting support, daycare, and diversion programs.
    - Telehealth services were hindered by limited/weak Wi-Fi connectivity.