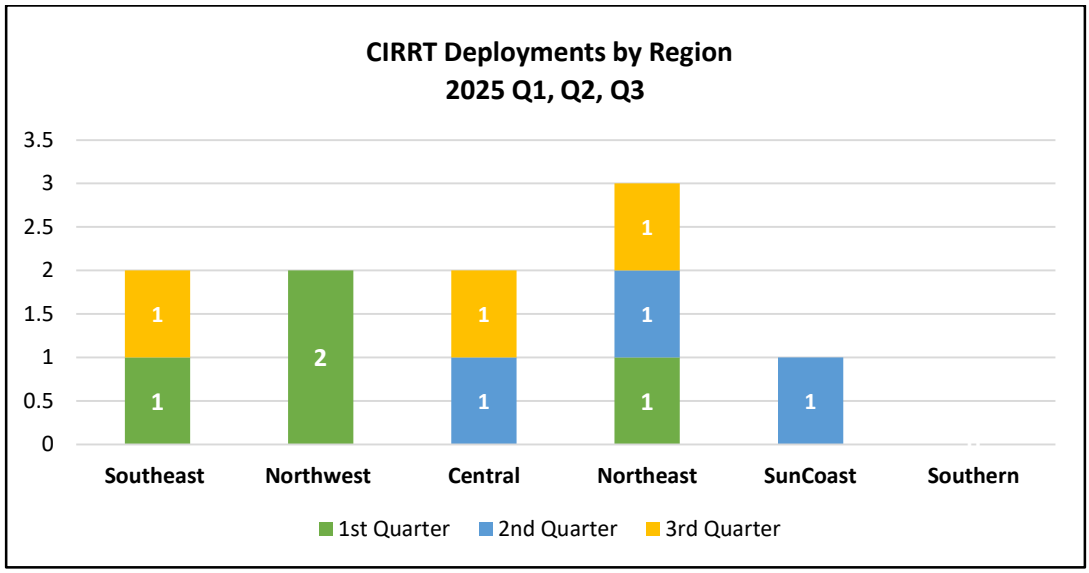
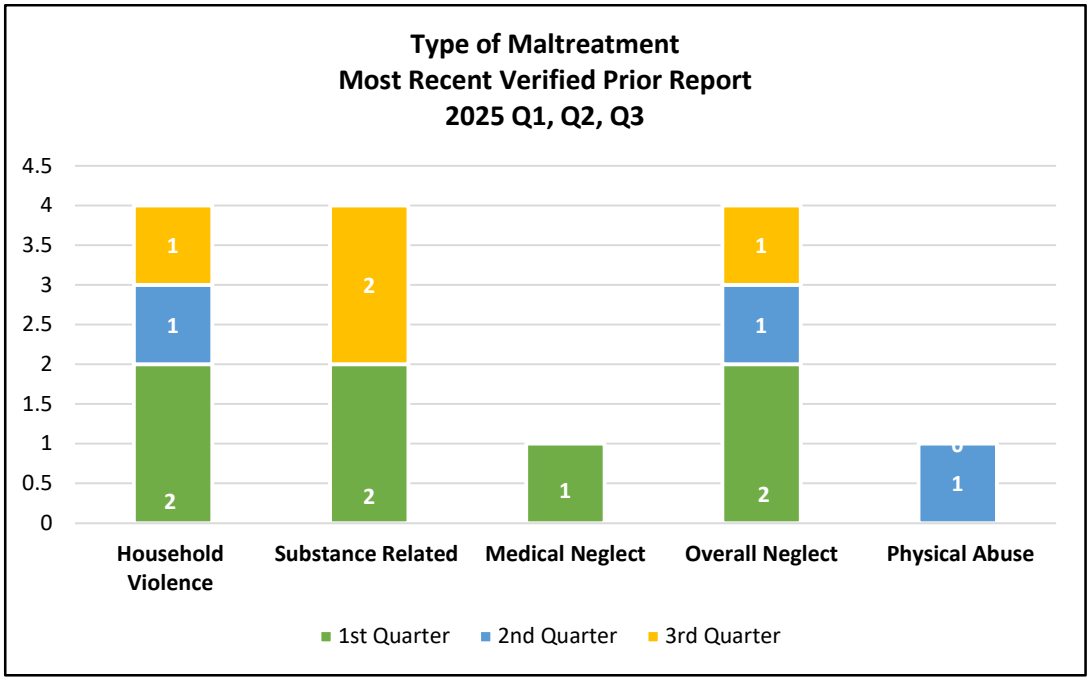
Florida Department of Children and Families
Critical Incident Rapid Response Team (CIRRT)
Advisory Committee Report Overview
2025-Quarter 3

From July 1, 2025, through September 30, 2025, 109 fatalities were reported to the Hotline. Of those, three met the criteria for a CIRRT deployment. In all three of the deployments, the decedents were six months of age or younger. In one of the deployments, the decedent had been a child victim in a prior verified investigation. In two of the deployment cases, the family was involved in-home non-judicial case management oversight at the time of the fatality incident. In the third case, the family received in-home non-judicial services within four months of the decedent's death.





Summary of CIRRT Deployments

Palm Beach County

A deployment was conducted following the death of three-week-old infant who was found unresponsive in an adult bed while in the care of his mother. The mother was positive for alcohol; however, she was not observed to be inebriated. The family was involved in two prior investigations since September 2024, which reflect a pattern of excessive alcohol use and family violence and resulted in in-home non-judicial case management oversight. The family originates from Guatemala and spoke Q'anjob'al, an indigenous Mayan language. The infant's death was subsequently determined to be the result of natural causes stemming from an illness.

Polk County

A deployment was initiated following the sleep-related death of a six-month-old infant who was found unresponsive in a bouncy-like chair where he was placed to sleep. The chair was positioned on the floor next to the parents' bed. When he was discovered, a relative assisted with life-saving mesaures until emergency services arrived. He was transported to the hospital where he was pronouced deceased. The parents declined a presumptive drug screen. However, law enforcement and staff did not observe the parents exhibiting any concerning behaviors. The manner and cause of death was determined as accidental suffocation. The family had been involved in one prior report that was received in February 2025, at the time of the decedent's birth when he and his mother tested positive for substances.The father agreed to a presumptive drug screen and was also positive for multiple substances. As a result, the case was transferred to ongoing in-home non-judicial case management oversight. Case management was actively working with the family when the death occurred.

Nassau County

A deployment was conducted following the death of a three-week-old infant who was found unresponsive in a bassinet with his face covered by a blanket. When he was discovered, he was transferred to the hospital where he was placed on life-support. He was subsequently pronounced deceased ten days later. At the time of the fatality incident, the family was receiving in-home non-judicial case management services which stemmed from a verified prior report in June 2025, due to ongoing environmental hazards. The infant's death was subsequently determined to be the result of natural causes stemming from an illness.

Summary of Special Review Deployments

No special review deployments were conducted during this quarter.

Overall Findings

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

Practice Assessment

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

- Practice improvement opportunities identified:
    - Ensure assessments reflect a comprehensive understanding of family dynamics, specifically around parental mental health, to provide the delivery of appropriate service interventions.
        - Include any barriers, such as language barriers, that may impede information collection to understand safety issues or household functioning.
    - Ensure completion of supervisory and second-level directives to provide thorough and sufficient assessments of family functioning and safety decisions.

Organizational Assessment

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

Service Array

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

- Identified Opportunity:
    - Nassau County (a rural area of the state) faces limited access to intervention services, such as parenting support, daycare, and diversion programs.
    - Limited intervention programs to those with rare languages or other barriers to traditional service interventions.