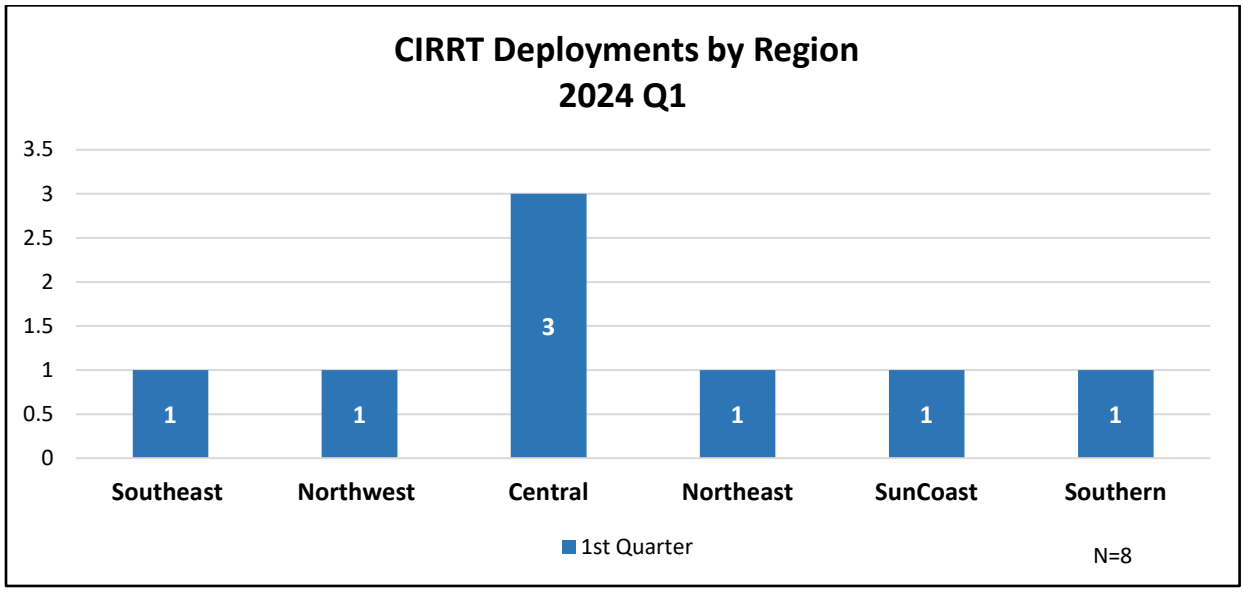
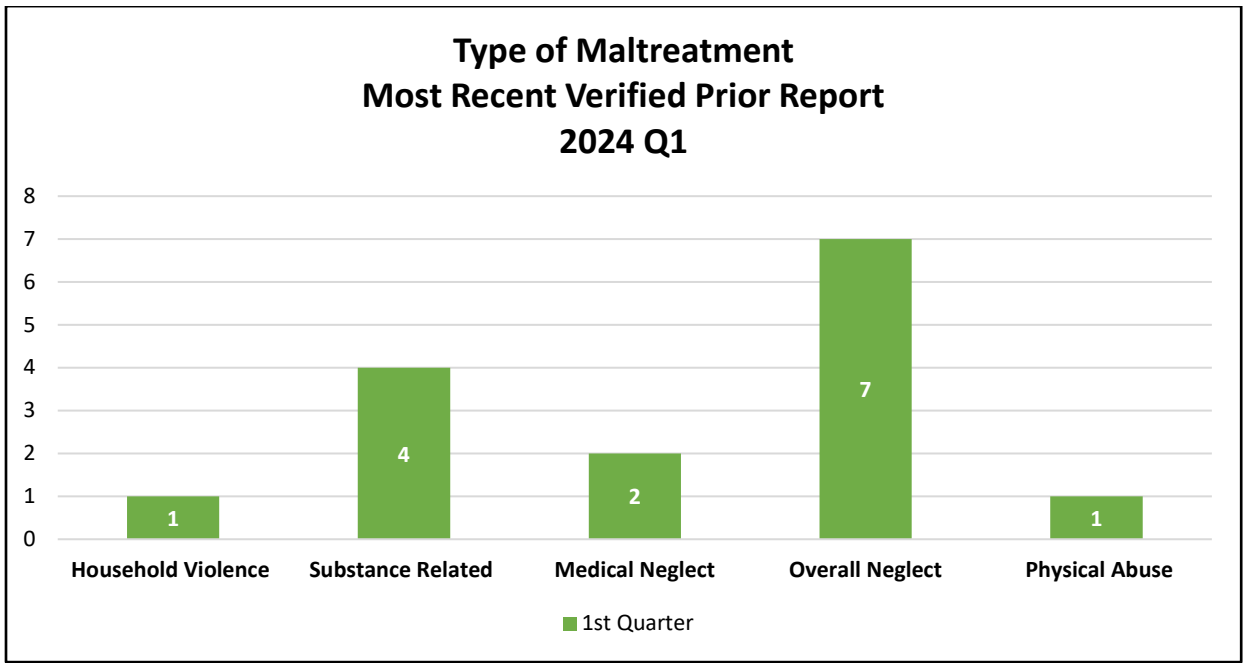
Florida Department of Children and Families
Critical Incident Rapid Response Team (CIRRT)
Advisory Committee Report Overview
2024-Quarter 1

Between January 1, 2024, and March 31, 2024, there were 134 fatalities reported to the Hotline. Of those 134 cases, eight met the criteria for a CIRRT deployment. At the time of all eight fatality incidents, the family was involved in either case management oversight or an active investigation. In five of the deployments, the children were under 2-years old, and in the remaining three deployments, the children were 5-years-old or older.





Summary of Deployments

- The deployment to Lake County involved the sleep-related death of a 9-month-old after he was found unresponsive in his crib, that contained soft bedding, where he was placed to sleep for the night. The incident occurred during the provision of case management services. The decedent and his 7-year-old sibling were reunified with their parents two months prior. The cause of death was determined as accidental positional asphyxia-suffocation in soft bedding.

- The second deployment to Lake County involved the sleep-related death of a 2-month-old after he was wrapped in a blanket and placed to sleep. The incident occurred during the provision of case management services that involved the parents and the older siblings. The decedent was not added to the case, as the older siblings were in the process of being reunified. The cause of death was determined as accidental positional asphyxia-suffocation.

- The Leon County deployment involved the sleep-related death of a 2-month-old who was found unresponsive after his father fell asleep while feeding. At the time of the incident, the family was open to in-home non-judicial services to address parental substance use. The cause of death was due to alpha-pyrrolidinoisohexanophenone (a synthetic psychotropic) toxicity. The manner of death could not be determined.

- A Collier County deployment involved the death of a 5-year-old medically complex special needs child, which occurred six days after he was admitted to the hospital for concerns of pneumonia, dehydration, failure to thrive, and pulmonary hypertension. At the time of the fatality incident, the family was involved in in-home non-judicial case management which stemmed from parental substance use. The cause and manner of death is pending.

- A deployment to Palm Beach County involved the drowning death of a 5-year-old special needs child while in the care of his court ordered non-relative caregiver/licensed level 1 caretaker. The decedent and siblings were at the park when he was able to get away. A law enforcement marine unit recovered his body from the lake several hours later. The incident occurred during out-of-home judicial case management oversight. The cause of death was determined as accidental drowning.

- The Duval County deployment involved the death of a 6-year-old after she was found unresponsive while in the care of her father. The father reportedly gave the child Benadryl the night prior to the child being found unresponsive. The father was brought into law enforcement's custody for additional questioning. The incident occurred during an open investigation alleging physical abuse toward the 8-year-old sibling. The cause and manner of death is pending.

- The deployment to Marion County involved the death of a 1 1/2 -year-old, medically complex child, after she was found unresponsive in her crib by her court ordered non-relative caregiver. At the time of the incident, the family was open to out-of-home judicial case management which stemmed from a prior report that was verified for medical neglect. The cause and manner of death is pending.

- A deployment to Miami-Dade County involved the death of a 7-month-old after she was found unresponsive in her crib by her great-grandmother with whom she was placed after a removal episode related to parental substance use. The crib was observed free from any hazards, including pillows or blankets. At the time of the fatality incident, the family was open to out-of-home judicial case management. The cause and manner of death is pending.

Overall Findings

During this quarter, there were significant findings around all three assessment areas:

Practice Assessment

- In the majority 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.

- The following opportunities were identified to improve practice:
    - Ensure appropriate guidance is provided on an ongoing basis to include all available information for a full and thorough assessment, and follow-up actions are completed as directed prior to closure.
    - Ensure ongoing discussions occur between case management staff and supervisory staff are documented, and appropriate guidance is provided on an ongoing basis and at critical junctures.
    - Ensure safety plans are managed and monitored by investigative and case management staff at critical junctures.
    - Escalate safety concerns when identified.

Organizational Assessment

- Ensure effective communication and coordination during staff changes and case management transitions.

Service Array

- Ensure both parents are engaged, assessed and referred for appropriate services.