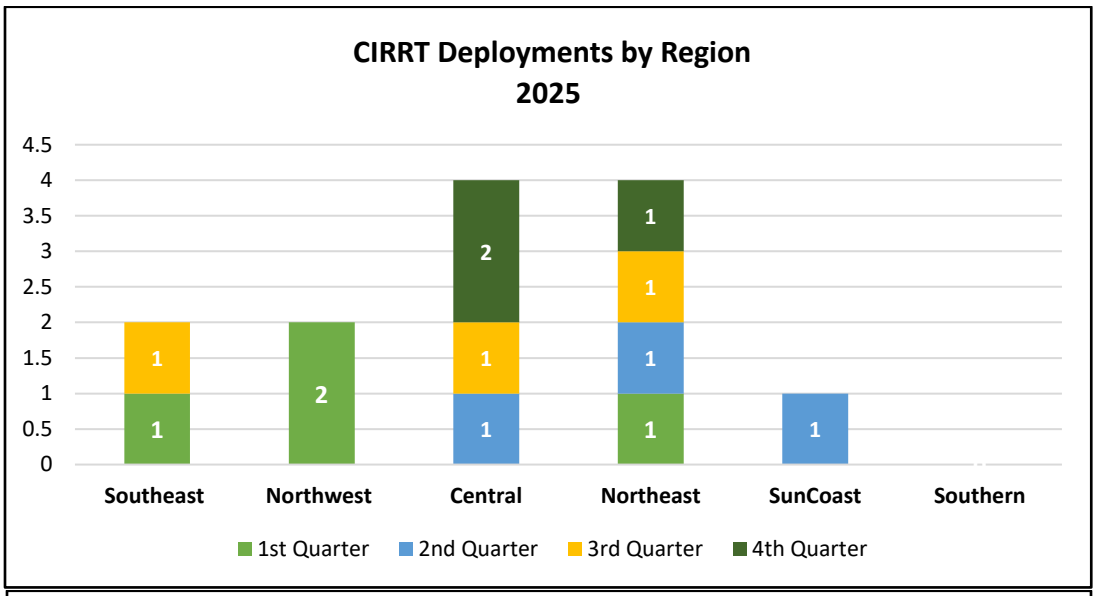
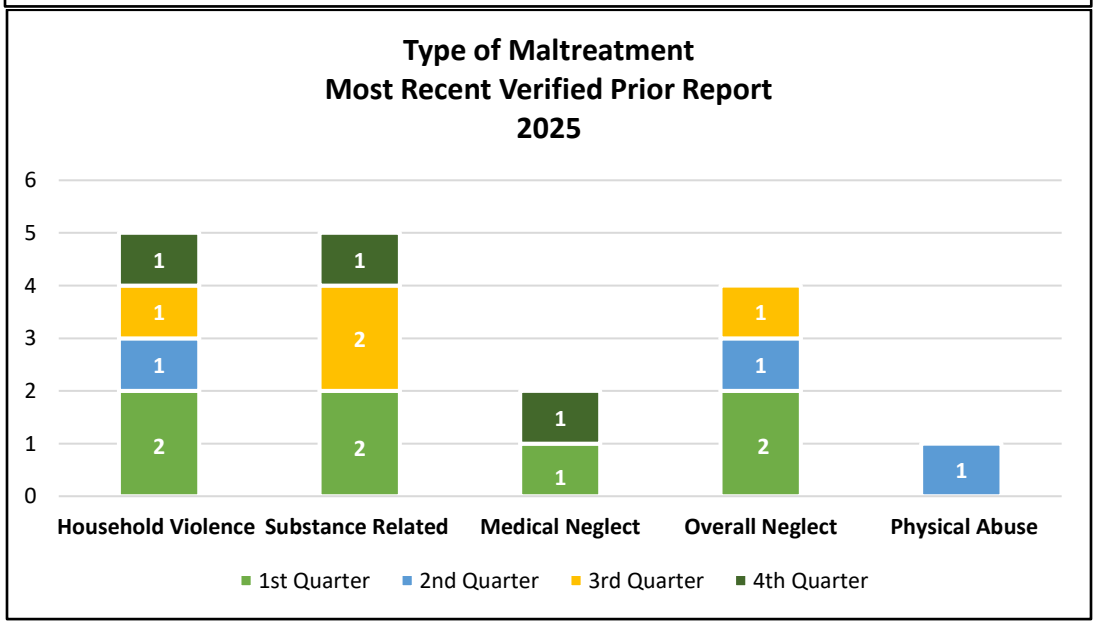
Florida Department of Children and Families
Critical Incident Rapid Response Team (CIRRT)
Advisory Committee Report Overview
2025-Quarter 4

From October 1, 2025, through December 31, 2025, 91 fatalities were reported to the Hotline. Of those, three met the criteria for a CIRRT deployment. In two of the deployments, the decedent was a child victim in a prior verified investigation. In two of the deployments, the decedents were three months of age or younger, with the remaining deployment involving a five-year-old. In all three of the deployment cases, the family was involved in case management oversight at the time of the fatality incident; two were involved in in-home non-judicial oversight, and one was involved in out-of-home judicial oversight.





Summary of CIRRT Deployments

Duval County

A deployment was conducted following the death of a two-week-old after she was found unresponsive while swaddled and sleeping next to her court-ordered relative caregiver. The newborn was placed into relative care following her removal from both parents upon her birth. At the time of the fatality, the family was involved in an active out-of-home judicial case stemming from a verified prior report concerning the mother's substance use. At the time of the removal episode, the biological father was incarcerated. The manner of death could not be determined, and the cause of death was listed as sudden unexplained infant death.

Polk County

A deployment was conducted following the death of a three-month-old after he was found unresponsive while bedsharing with his mother and five-year-old half-sibling. The night prior, the mother inadvertently fell asleep while breastfeeding the infant. When she woke the following morning, she discovered that the pregnancy pillow was on Jaxon's forehead, and that he was cold to the touch. At the time of the incident, the father was at work. The cause and manner of death are pending.

Marion County

A deployment was conducted following the death of a medically complex 5-year-old after she was discovered unresponsive by her parents. The child was non-verbal, non-ambulatory, and required a gastrostomy tube for feeding. The parents agreed to a presumptive drug screen, with the mother testing positive for THC and the father testing positive for THC, opiates, and cocaine. Both parents have a medical marijuana card. In February 2025, the family engaged with in-home non-judicial case management services as the result of a verified prior report concerning medical neglect, failure to thrive/malnutrition, and substance misuse. Case management oversight was terminated in May 2025. An autopsy was not performed. The cause and manner of death is pending.

Summary of Special Review Deployments

No special review deployments were conducted during this quarter.

Overall Findings

The reviews analyze practice assessment, organizational assessment, and service array. During this quarter, findings were identified across all three areas.

Practice Assessment

- Assessments of present and impending danger properly aligned with Department policies and procedures, with sufficient information obtained to support the final safety determination.
    - In the Polk County review, child protective investigation and case management staff collaborated and effectively engaged a family after they expressed reluctance to work with service providers.
    - In the Duval County review, the family finder program collaborated with child protective investigative staff to immediately identify and thoroughly vet the relative caregiver.
        - The family finder program clearly communicated and engaged the caregiver in discussions to ensure the caregiver's commitment to providing a safe and supportive placement.
    - In the Duval County review, case management staff worked in a timely and diligent manner to locate additional placement options when the primary placement dissolved.
- Identified Opportunities to Enhance Practice:
    - In the Marion County review, several opportunities to enhance practice related to assessment, safety planning, and case management were identified:
        - Assessments should consistently include a thorough analysis of current and historical mental health and substance use concerns, including consideration of how these factors may impact child safety.
        - Safety plans should be implemented with careful consideration, ensuring that safety providers are appropriately assessed and that plans are actively managed and monitored.
        - Additional information gathering may be necessary when evaluating safety providers to fully understand any factors that may affect their ability to fulfill their role, including the use of prescribed substances.
        - Ongoing case management should include consistent follow-up on all safety plan actions to ensure requirements are being met and child safety is maintained, including a regular review of all required documentation and outreach to safety providers who may be assisting.
        - Promote the use of multidisciplinary staffings for complex cases, particularly those involving multiple systems or specialized needs, to support information sharing, collaborative decision-making, and the identification and resolution of barriers.

Organizational Assessment

- In two of the three reviews, effective collaboration within the Department and with community partners, as well as staff knowledge and experience, were noted as strengths.

Service Array

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

- Identified Opportunities to Enhance Service Provision:
  - The Polk County review identified a gap in domestic violence advocacy and perpetrator accountability services needed to support lasting behavioral change and ensure family safety. During the intervention, services were provided through an in-house provider; however, the approach primarily emphasized general education for both the survivor and perpetrator. Expanding the use of evidence-based practices that focus on perpetrator accountability may further enhance outcomes. The Lead Agency recognized this opportunity and began engaging additional providers to broaden and strengthen service options in this area.
  - In the Polk and Marion County reviews, opportunities were identified to strengthen service intensity and alignment to better address family dynamics, support meaningful behavior change, and enhance child safety outcomes.