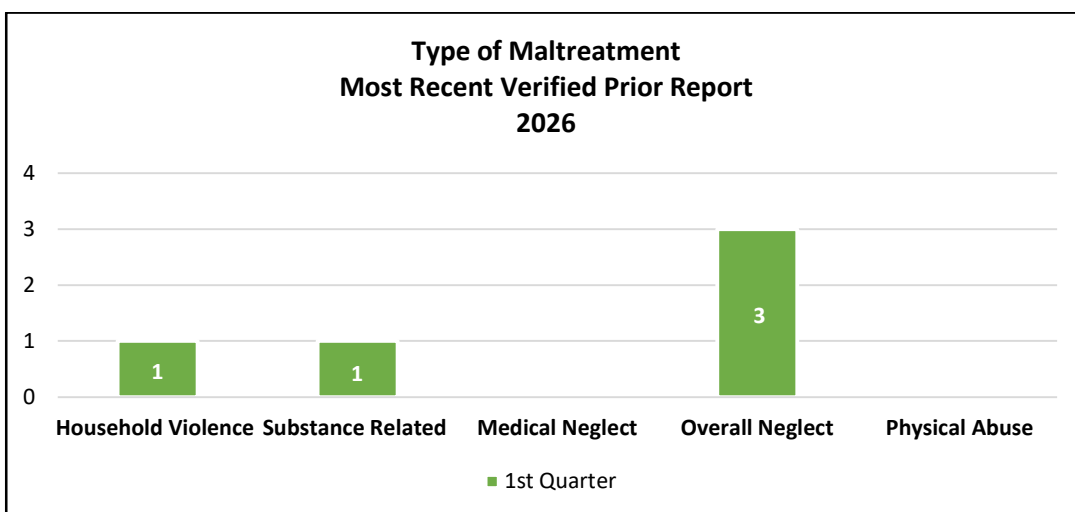
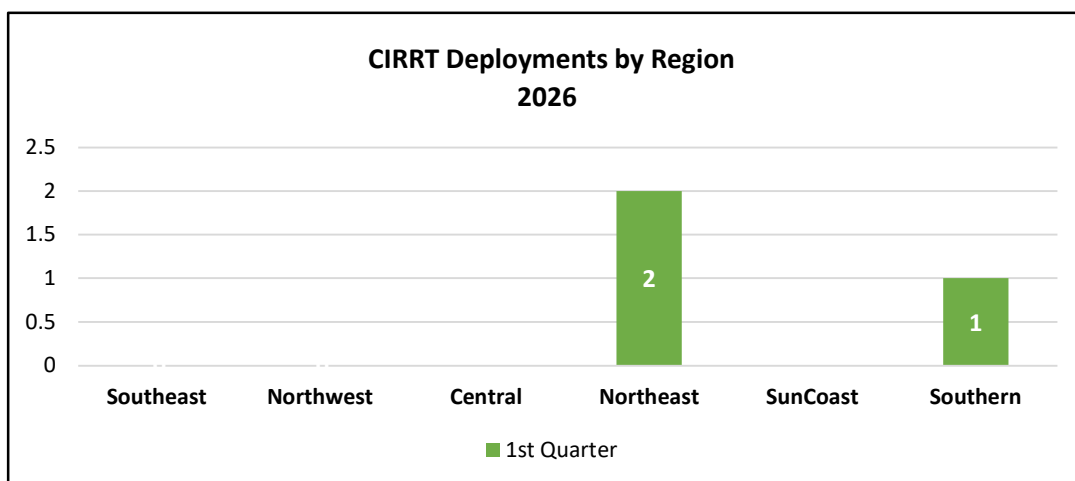




Florida Department of Children and Families Critical Incident Rapid Response Team (CIRRT) Advisory Committee Report Overview 2026-Quarter 1

From January 1, 2026, through March 31, 2026, 117 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 six months of age or younger, with the remaining deployment involving a three-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.

In addition to the three CIRRT reviews, two teams were deployed to conduct special reviews on two cases (in the Northeast and Southern regions) that did not meet statutory requirements for a CIRRT review. In both cases, the children were under the age of 5. The decedents were not involved in case management oversight.



Summary of CIRRT Deployments

Volusia County

A deployment was conducted following the death of a six-month-old while in the care of his father. The father reported that the infant was sick, and that he was administering cold medication. The infant was placed to sleep with a thick blanket in the bassinet and was later discovered unresponsive. The fatality incident occurred during an active in-home non-judicial case management services oversight stemming from a verified prior involving household violence. The manner and cause of death is listed as accidental asphyxia complicated by an upper respiratory tract infection.

Miami-Dade County

A deployment was conducted following the drowning death of a three-year-old while in the care of her father. The toddler exited the home, a short-term rental, undetected after the father fell asleep while watching a movie with the toddler. The father tested positive for marijuana and alcohol. The fatality incident occurred during an open investigation involving concerns about one of the older children's health. In addition, the family was involved in an active in-home non-judicial case stemming from a verified prior report related to the conditions of the home and lack of supervision. The cause and manner of death are pending.

Duval County

A deployment was conducted following the death of a two-week-old after he was discovered unresponsive in his bassinet, where he was swaddled and placed to sleep. Both parents tested positive for substances: the mother for THC and alcohol, and the father for THC. At the time of the fatality, the family was involved in an open out-of-home judicial case which stemmed from a verified prior report closed in July of 2025 due to the parents' use of substances, household violence, and inadequate supervision for their older three children. At the time of the fatality, there was an open investigation received on January 6, 2026, when the mother tested positive for THC at the infant's birth. The infant remained in the parents' care and was not added to the in-home case and was not under case management oversight as the family was moving towards reunification with the older children.

Summary of Special Review Deployments

Miami-Dade County

A deployment was conducted following the death of a three-week-old after he was found unresponsive in the maternal grandmother's home. It was reported that the infant was put down for a nap after feeding and was discovered unresponsive approximately 10 minutes later. At the time of the infant's death, his mother, age 16, was in a licensed foster home, and the infant was in the care of his maternal grandmother under a family-made arrangement (no court order). The manner and cause of death are pending.

Lafayette County

A deployment was conducted following the death of a severely medically complex two-year-old after he was found unresponsive while in the care of the mother. At the time of the fatality, the family was involved in an open investigation received in December 2025, with neglect concerns for the decedent and physical abuse concerns for one of his siblings due to the infant sustaining several fractures. During the investigation, the other twin was also determined to have numerous fractures. The fractures to the

infants were determined to be non-accidental child abuse. An in-home safety plan was implemented, and the family was residing with relatives. The cause and manner of death are pending.

Overall Findings

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

Practice Assessment

- Identified Opportunities to Enhance Practice:
 - In Volusia, Lafayette, and Duval County reviews, the following opportunities to enhance assessments 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.
 - Collaboration with subject matter experts is needed to ensure comprehensive assessments and understanding of family dynamics and impacts on child safety.
 - In Lafayette and Miami-Dade-County CIRRT reviews, opportunities for effective and sufficient safety planning were identified.
 - 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 informal 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.
 - In Volusia and Miami-Dade-Special Review County reviews, minimal supervisory oversight and guidance by case management led to incomplete assessments and limited follow-through on service interventions, which impacted the trajectory of the case.
 - In Lafayette and Miami-Dade-Special Review County reviews, factors, information, and safety analysis supported more intrusive interventions than in-home safety planning.

Organizational Assessment

- In Volusia, Miami-Dade-Special Review, and Lafayette County reviews, staff knowledge and experience were noted as strengths.
 - Of note, in the Volusia review, Neighbor to Family staff had substantial child welfare experience and specific training related to domestic violence, which assisted their ability to navigate and assist the family with appropriate service interventions.
- Identified Opportunities to Enhance Organizational Assessment:
 - In Miami-Dade-CIRRT and Duval County reviews, staff highlighted positive relationships and communication with the Department personnel and community partners. Building on these

- strengths, enhancing the quality and purposefulness of communication may further support collaborative efforts, timely interventions, and improved outcomes for children and families.
- In the Volusia and Miami-Dade-Special Review County reviews, transitions within the local case management organization and high turnover with investigative staff created gaps in collaboration and impacted the quality of assessments and interventions.
 - In the Lafayette County review, there was confusion as to when to staff a case for removal when concerns were identified. As a result of this review, CPI and CLS leadership indicated that in situations involving immediate safety concerns, cases will be staffed regardless of whether paternity has been established, fathers have been located, or if the Request for Legal Sufficiency form has been completed.

Service Array

- The reviews indicated community providers were available to meet the needs of families.
- Identified Opportunities to Enhance Service Provision:
 - In the Volusia and Duval County reviews, when community providers were engaged with the family, there was insufficient coordination by case management staff to assess adequacy, effectiveness, and overall progress of service delivery.