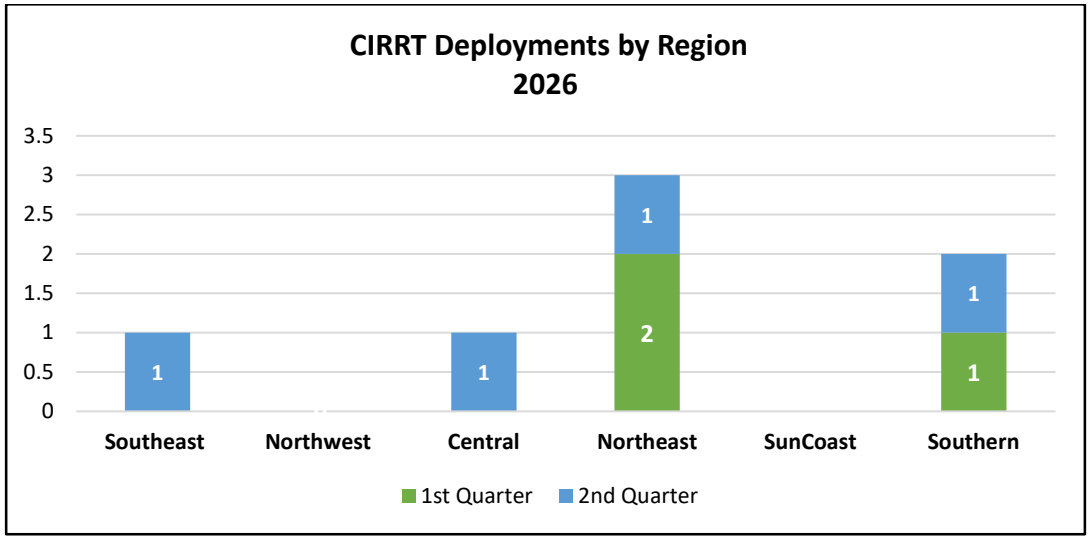
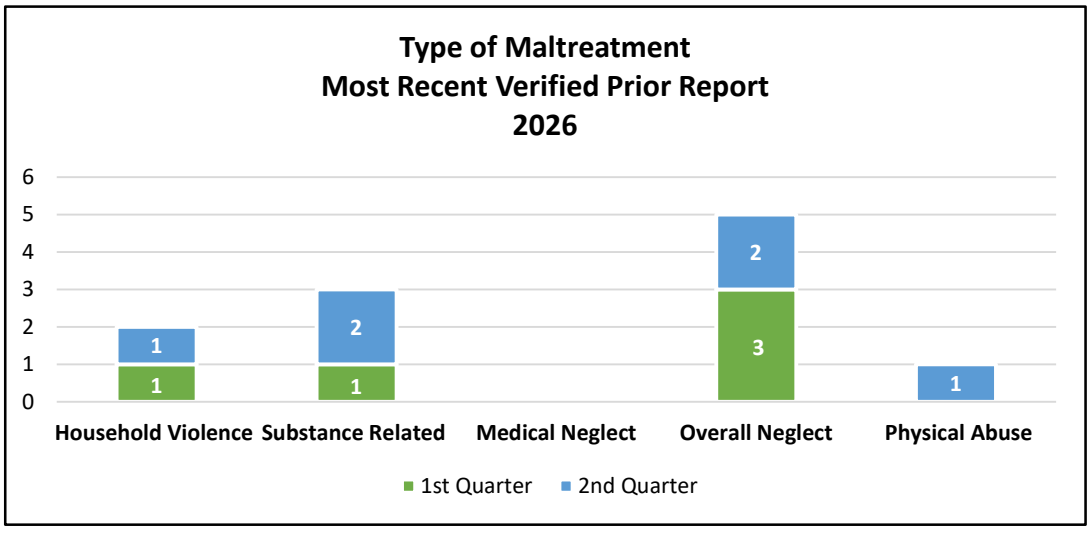
Florida Department of Children and Families
Critical Incident Rapid Response Team (CIRRT)
Advisory Committee Report Overview
2026-Quarter 2

From April 1, 2026, through June 30, 2026, 138 fatalities were reported to the Hotline. Of those, four met the criteria for CIRRT deployment. In two of the deployments, the decedent was a child victim in a prior verified investigation. In three of the deployments, the decedents were six months of age or younger, with the remaining deployment involving a one-year-old. In all four of the cases, the family was involved in case management oversight at the time of the fatality incident; two were involved in in-home non-judicial case management oversight, and two were involved in out-of-home judicial oversight.

In addition to the two CIRRT reviews, two teams were deployed to conduct special reviews on two cases (in the Northeast and Central regions) that did not meet statutory requirements for a CIRRT review. In both cases, the children were under the age of three. In one case, the family was involved in in-home non-judicial case management oversight.





Summary of CIRRT Deployments

Brevard County

A deployment was conducted following the death of a 1-hour-old infant after she was born underdeveloped with anencephaly, a severe and fatal birth defect in which a child is born without parts of the brain and skull. The mother has a significant substance use history and admitted to current use of several substances including heroin, fentanyl, and methamphetamine. The family had been involved in numerous investigations since 2014, reflecting a pattern of ongoing substance use. As a result, the mother's older children were removed from her care in 2014, 2023, and 2025. At the time of the fatality, the family was involved in an open out-of-home judicial case, which stemmed from a verified investigation closed in December 2025 due to the mother's active substance use and the father's violence. The manner of death could not be determined, and the cause of death is listed as Anencephaly and complications with other significant conditions, including maternal substance use.

Miami Dade County

A deployment was conducted following the death of a 2 ½ week old infant after he was found unresponsive in his bassinet while in the care of his mother, which occurred the day prior. The infant was born prematurely and remained in the hospital for two weeks after his birth. He was discharged from the hospital on April 9, 2026. At the time of the fatality, the mother and the 5-year-old sibling were involved in judicial case management services which stemmed from a verified prior report closed in May of 2025 due to inadequate supervision and resulted in out-of-home placement with relatives. The sibling was subsequently reunified with the mother in March 2026, two weeks prior to the decedent's birth. The mother and older sibling had been involved in seven prior investigations that reflected a pattern of maternal substance use, inadequate supervision, and physical abuse. The older sibling was removed from his mother's care on two separate occasions, in May 2021 and May 2025, and he was last reunified with her in March 2026. The cause and manner of death are pending.

Putnam County

On April 21, 2026, the Department was notified of the drowning death of an almost 2-year-old child who was in the care of his paternal grandmother while his father was at work. The toddler wandered out of the home undetected and was later discovered in the family pool. The family had one prior verified investigation which resulted in in-home non-judicial case management services that were active at the time of the fatality. The prior verified report was closed in March of 2026 due to an injury that the toddler sustained by his mother. The criminal investigation resulted in his mother's arrest, a no contact order being implemented, and the toddler residing with his father at the paternal grandmother's home. The cause and manner of death are pending.

Broward County

On May 15, 2026, the Department was notified of the death of a 4-month-old infant after she was found unresponsive in her crib while in the care of her licensed foster parent. The decedant and her twin were born prematurely. Both twins and the mother tested positive for cocaine at delivery. The newborns remained in the NICU for 20 days, and upon discharge, were placed into licensed foster care. The family had resided in Florida for six months and had one prior investigation that was closed with verified findings of substance misuse- illicit drugs with the father as the caregiver responsible and substance-exposed newborn with the mother as the caregiver responsible. As a result, the twins were removed

from the parents' care and placed into licensed foster care with ongoing judical case management oversight. The cause and manner of death are pending.

Summary of Special Review Deployments

Duval County

A deployment was conducted following the death of 2 ½-year-old child after he was shot by the mother's boyfriend during an argument with the mother. The family had been involved in four investigations within 10 months; however, none of the investigations were verified for maltreatment. At the time of the fatality, the family was working with in-home non-judicial case management due to concerns that the parents were not adequately caring for a medically complex child. The cause and manner of death are pending.

Orange County

A deployment was conducted following the deaths of siblings aged 11 months and 2 years, respectively. The children were shot by their father after he engaged in a physical altercation with the mother. The father then shot himself and later died. The family was involved in one prior investigation that was closed in December 2025 with non-substantiated findings of household violence threatens child. 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

- 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 Brevard County review, collaborative discussions between Child Protective Investigations (CPI) and Quality Review staff resulted in additional information collection and the appropriate identification of safety determination and case trajectory.
    - In the Broward County review, coordination between CPI, Behavioral Health Consultant, and adult protective investigations staff contributed to proper decision-making and case trajectory.
    - In the Brevard, Putnam, Broward, and Duval County reviews, proactive case management oversight was highlighted regarding engagement, overall casework, and the provision of appropriate services to enhance parental capacity.

- Identified Opportunities to Enhance Practice Assessment:
    - In the Miami-Dade County review, the following opportunities by case management (CM) were identified to enhance assessments, engagement, and interventions.
        - Ongoing 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

        - Consideration of the addition of new household members, including a newborn, is necessary to identify opportunities for further support and intervention.
        - Consistent utilization of qualified interpreter services is needed to ensure engagement, understanding, and thorough assessments.

    - In the Putnam and Orange County Reviews, collaboration with subject matter experts, such as domestic violence specialists, is needed to ensure comprehensive assessments and understanding of family dynamics and impacts on child safety.

Organizational Assessment

- In Brevard, Putnam, Broward, and Duval County reviews, the following strengths were identified:
    - Collaborative teaming and a holistic approach between DCF programs and with case management staff increased engagement with families and unified efforts.
        - Of note, as identified in the Broward County review, specialized units comprised of experienced staff concentrate expertise and resources on the most complex cases. Additionally, the creation of a Community Based Care funded jail liaison position has filled a critical gap by engaging incarcerated parents, providing support and coordination of service planning.
    - Caseloads were noted to be manageable.

- Identified Opportunities to Enhance Organizational Assessment:
    - In the Miami-Dade County review, the transition between case management organizations resulted in increased caseloads, impacting the adequacy and promptness of casework and oversight.

Service Array

- The reviews indicated that community providers were available to meet the needs of families. In the majority of cases, the level of intervention and service providers were appropriate.

- Identified Opportunities to Enhance Service Provision:
    - In the Miami-Dade review, the alignment of services was insufficient to address child safety concerns presented such as substance use and unmanaged mental health conditions.
    - In the Orange County review, the following were identified:
        - Diversion staff had limited knowledge of appropriate service provision regarding cases involving domestic violence.
        - Funding for a local domestic violence provider was reduced, leading to the elimination of one of the two domestic violence advocate positions. This change impacted consultations and service engagement.