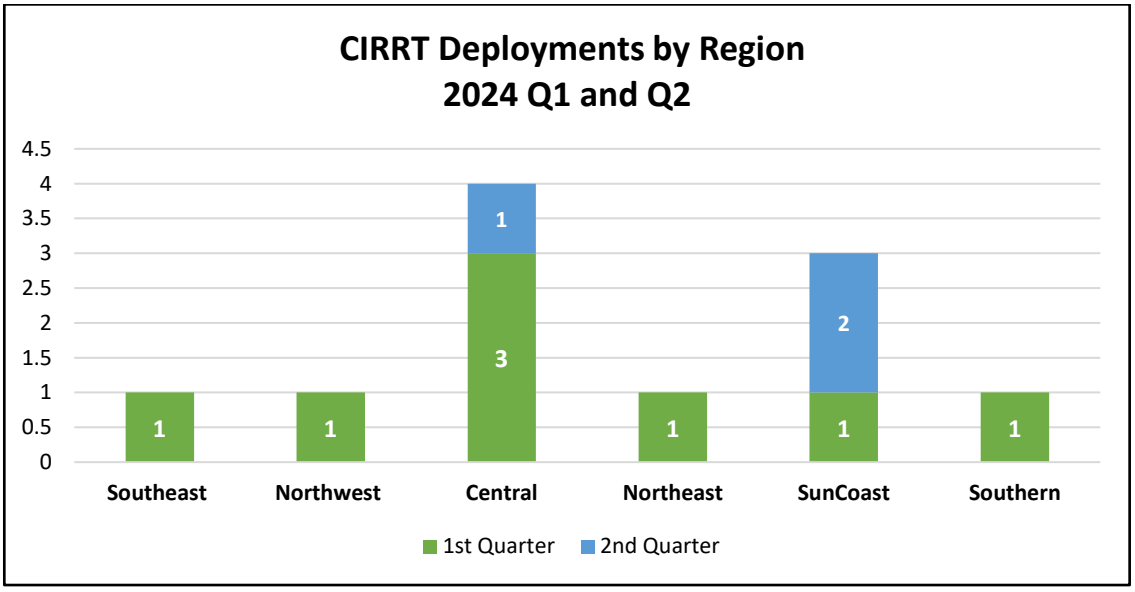
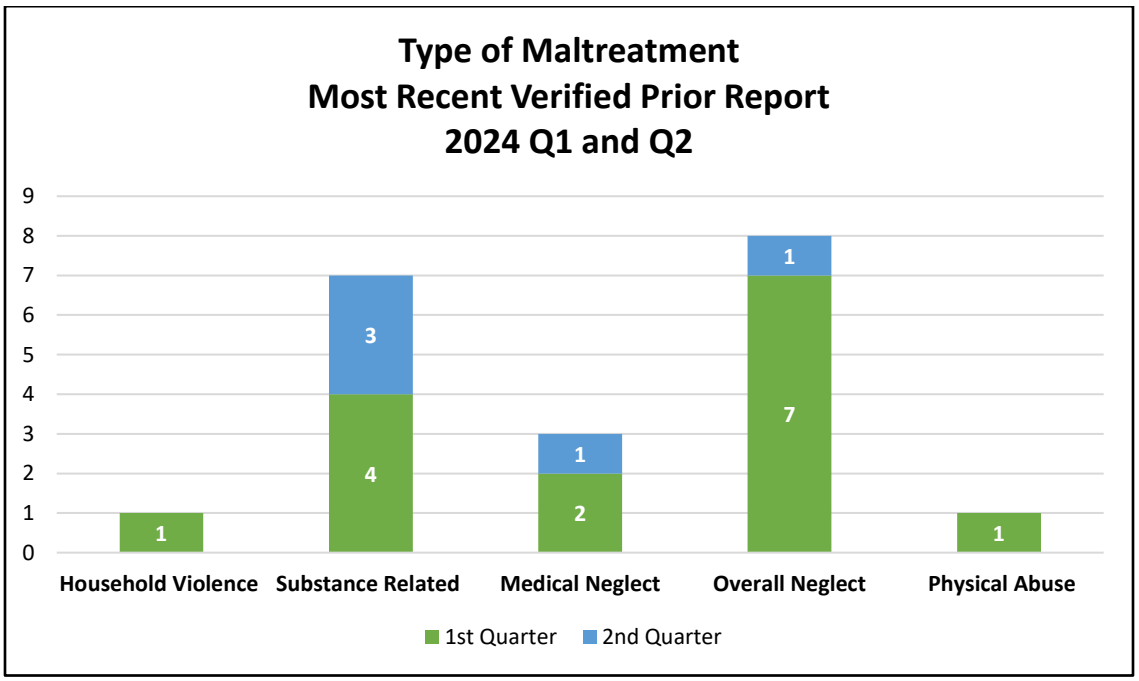
Florida Department of Children and Families (DCF)
Critical Incident Rapid Response Team (CIRRT)
Advisory Committee Report Overview
2024-Quarter 2

Between April 1, 2024, and June 30, 2024, there were 133 fatalities reported to the Hotline. Of those 133 cases, three met the criteria for a CIRRT deployment. At the time of two fatality incidents, the family was involved in case management oversight, one with out-of-home services and another with in-home services. In all three deployments, the decedent was a child victim in the prior verified investigation. Additional details are included in the Summary of Deployments section.





Summary of Deployments

- The deployment to Highlands County involved the sleep-related death of a 2 ½ month old after she was found unresponsive while bed-sharing with her parents, and two older siblings (ages 2 and 4 years). At the time of the fatality incident, the family was involved in an out-of-home judicial case, placing the decedent in the maternal cousin's care, which stemmed from a verified prior report related to the mother's ongoing severe substance use. Despite being advised that the maternal cousin was required to supervise contact between the decedent and her parents, she allowed the child to stay with her parents. The cause and manner of death are pending.

- The deployment to Pinellas County involved the death of a 17 ½ year old after he was found unresponsive due to what was believed to be a drug overdose. The decedent had a significant substance use history for which he had been in treatment and therapy. He resided with his parents and a 14-year-old sibling. At the time of the fatality incident, the decedent and his parents were involved in an active in-home non-judicial case, which stemmed from a verified prior report related to the mother's ongoing alcohol use. The death was determined to be accidental due to fentanyl toxicity, with ethanol intoxication as another significant condition.

- The Pasco County deployment involved the sleep-related death of a 9-month-old who was discovered unresponsive after he and his babysitter fell asleep on a recliner. At the time of the fatality incident, there were no active services being provided to the family. The prior verified report was related to the mother's substance use for which she engaged in a treatment program. The family was active with in-home non-judicial case management services until they relocated to another county. The cause and manner of death are pending.

Overall Findings

During this quarter, there were findings around practice and organizational assessment areas:

Practice Assessment

- In the majority of reviews, the assessment of present and impending danger properly aligned with DCF's policies and procedures and sufficient information was obtained to support the final safety determination.

- The following opportunities were identified to improve practice:
    - Ensure sufficient information is gathered to appropriately identify and support safety decisions and actions as to all children in the home.
    - Ensure safety plans are developed with actions that provide safety at times when the danger threats are manifesting.
    - Escalate any barriers or safety concerns to ensure appropriate services are implemented.

Organizational Assessment

- In one of the reviews, there was an identified need to ensure effective communication and coordination between Office of Quality and Innovation Quality Review Unit (QRU) staff and designated case management organizations regarding Immediate Child Safety

Assessment Response (ICSAR), including implementation and follow-up of actions by case management staff.

- The QRU followed the proper guidelines, and the ICSAR was escalated to the Office of Child and Family Wellbeing (OCFW), which was closed as unresolved after multiple attempts to resolve with the lead agency and CMO were unsuccessful. There were opportunities for a case consultation with the lead agency and the QRU staff regarding the ICSAR, but this was not acted upon by the lead agency.