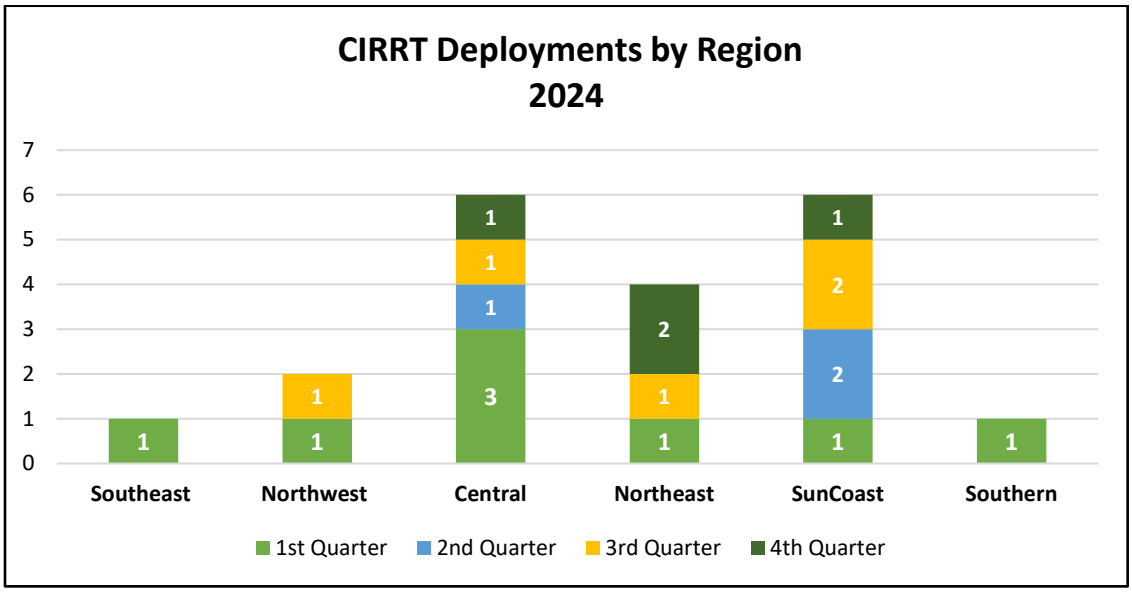
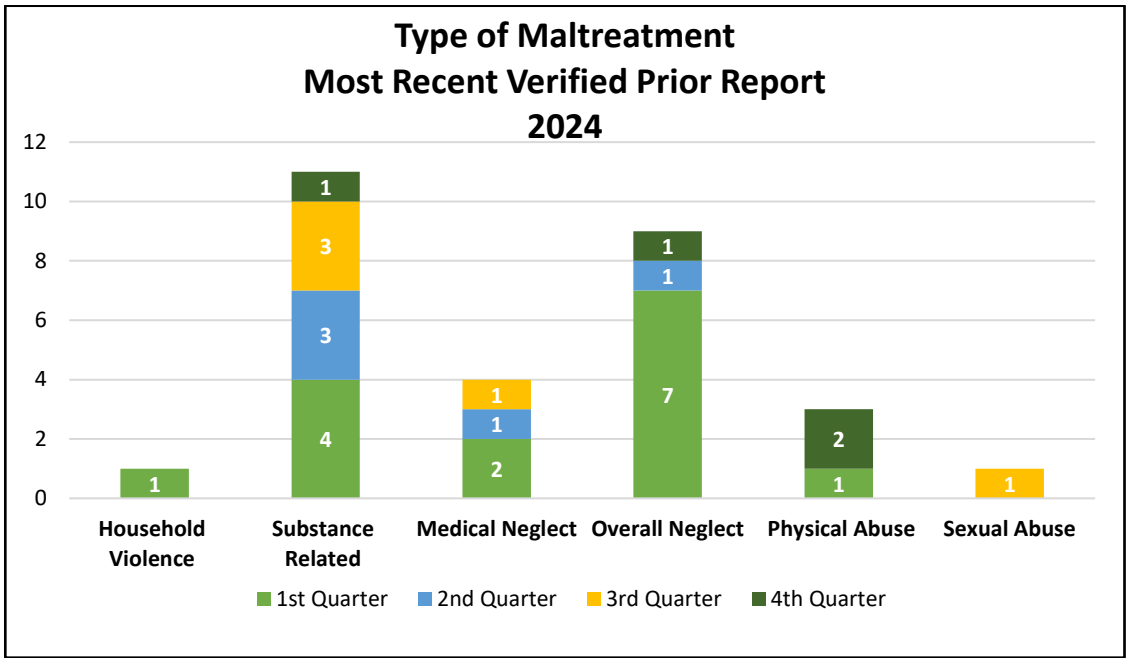
Florida Department of Children and Families
Critical Incident Rapid Response Team (CIRRT)
Advisory Committee Report Overview
2024-Quarter 4

Between October 1, 2024, and December 31, 2024, there were 101 fatalities reported to the Hotline. Of those 101 cases, four met the criteria for a CIRRT deployment. In three of the deployments, the decedent was a child victim in the prior verified investigation. In three of the deployments, the decedents were 4 years of age or older, and in the remaining deployment, the decedent was less than 6 months old. In two deployments, the family was involved in case management oversight through in-home non-judicial services when the fatality occurred.





Summary of Deployments

- There were two deployments to Volusia County.
    - The first deployment involved the death of a 5-year-old who was hospitalized after being involved in a vehicle accident that occurred eight days earlier. At the time of the accident, the mother was under the influence of substances. The family was previously involved in two separate in-home non-judicial case management cases, with the most recent case having closed successfully on July 18, 2024. An autopsy was completed, and the manner of death was determined to be accidental, with the cause as multiple traumatic injuries.

    - The second deployment involved the drowning death of a 4-year-old, who was previously diagnosed with autism, after he eloped from his father while at the park with siblings. At the time of the fatality incident, the family was involved with ongoing in-home non-judicial case management services, while also being investigated for physical injury, due to the decedent being observed with bruising to his back. An autopsy was completed, and the manner and cause of death was determined to be accidental drowning.

- The deployment to Manatee County involved the sleep-related death of a 3-month-old after she was found unresponsive in her crib. The verified prior report concerned the father physically abusing an older sibling. An autopsy was completed, and the cause of death is pending.

- The deployment to Polk County involved the drowning death of a 5-year-old, who was discovered in a knee-deep puddle of mud on the family's farm. The family has a significant history with the Department between 2018 and 2024, which included the 5-year-old's removal from his parents in 2019 and reunification with his father in 2020. An autopsy was completed, and the cause of death was determined as drowning.

Overall Findings

During this quarter, there were findings around practice assessment:

Practice Assessment

- In most 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 case trajectory, safety actions, and interventions are appropriate given a family's history or circumstances in the case to include that trajectories are congruent with supervisory guidance.
    - Ensure safety plans are developed with actions that do not restrict parental access and that safety providers are fully assessed.
    - Ensure subject matter expert consultations are completed in accordance with CFOP to better inform intensity and types of services.
    - Ensure supervisory guidance (CPI and CM) is provided at critical junctures to help support decision making.

- Ensure assessments are based on a full analysis of the family's functioning and circumstances and not on a heightened focus on law enforcement's actions or inactions.

CIRRT Advisory Committee Recommendations

- Create and implement a formalized process to deliver data points from CIRRT reviews to frontline staff.

- Establish an Ad Hoc committee to:
  - Explore historical CIRRT data and recommend more advanced analysis of the top recurring themes.
  - Support the CIRRT-Sexual Abuse program in developing a tailored data analysis plan.

- Update the Child Protection Team (CPT) policy regarding medical reports awaiting additional information to reflect CPT reports as "pending," as opposed to "indeterminate," until all medical records and information are obtained.

- Develop and implement frontline-staff training on understanding the CPT definition of indeterminate findings.