# Critical Incident Rapid Response Team

Joshua O’Mara

Florida Department of Children and Families
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# Critical Incident Rapid Response Team

**Northwest Region**
**Circuit 1**
**Okaloosa County, Florida**
**2025-041884**

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## Executive Summary

On February 5, 2025, the Department was notified of the death of 8-month-old Joshua O'Mara after he was found unresponsive in his pack n' play. Environmental hazards were found throughout the inside and outside of the home and the information from each party interviewed was inconsistent. The cause of death was determined to be accidental, and the manner of death is positional asphyxia.

At the time of the fatality incident, the family was involved in in-home non-judicial case management which stemmed from a verified report closed in December 2024 due to severe domestic violence on behalf of the mother as well as concerns for her abuse of alcohol. As a result, the father filed an injunction against the mother with Joshua and his two older siblings, [redacted], ages four and six, residing with their father.

Due the family being involved in a verified investigation within 12 months of the fatality incident, DCF Secretary Shevaun Harris deployed a Critical Incident Rapid Response Team to Escambia and Okaloosa Counties. This report presents the team's findings, a summary of the family's child welfare history, the family's composition, and an analysis of child welfare service providers. The team reviewed the family's prior interventions in the child welfare system to assess for any potential systemic matters within the local system of care.

The review team consisted of representatives from DCF's Office of Quality and Innovation, Substance Abuse and Mental Health (SAMH) Program Office in the Central Region, Office of Child and Family Wellbeing in the Suncoast and Northeast Region, Children's Legal Services, Kids Central Inc., and the Associate Statewide Child Protection Team (CPT) Medical Director.

The team reviewed case records involving all key case participants and conducted interviews with child welfare professionals involved in the recent interventions. The following agencies provided records and information during the review: Escambia and Okaloosa Counties Child Protective Investigations, Families First Network (FFN), Northwest Florida (NWF) Health Network, In Home Support Services (IHSS), First City Outreach Safety Management Services (SMS), Lakeview Centers (substance abuse and mental health provider), NWF Health Network Fatherhood Initiative, Favor House of Northwest Florida, Inc. (DV advocacy center), Department of Children and Families Office of Substance Abuse and Mental Health, and Children's Legal Services (CLS).

This report represents the team's findings, including the child welfare history, the family composition, and a summary of the local child welfare services providers as well as an analysis of the system of care.

**Summary of findings:**

<u>Practice Assessment</u>

- The September 2024 investigation warranted a higher level of intervention; however, the case was transferred to in-home non-judicial services despite the parents' history and repeated violations of the no-contact order in both the current and past cases. In November 2024, the children were again exposed to family violence when the father allowed the mother into the residence.

- While multiple service providers were referred to and involved, the extent of progress in strengthening the father's ability to provide a safe and stable environment for the

children remains unclear. Additionally, his willingness and capacity to do so were uncertain as he often disclosed frustration with caring for the children.

Organizational Assessment

- Interviews highlighted collaboration between FFN, DCF, and the agencies involved. Staff demonstrated significant experience in child welfare, and caseloads were reported to be manageable. While collaboration between agencies was a noted strength, information was not always shared collectively and, instead, was usually limited to the referral source. This limitation hindered the ability to determine the most effective support and/or intervention strategies with which to engage the father.

Service Array

- Okaloosa County offered a range of services to support the community's needs. While under case management and investigative oversight, the father was referred to In-Home Support Services, The Fatherhood Initiative, Bed for Me, Share Your Heart, ELC, Care Portal, Bridgeway, and First City Outreach Safety Management Services. The mother was referred to Lakeview's Family Intensive Treatment (FIT) program and Favor House for domestic violence advocacy.

**Case Participants**

| Name | Age at Time of Incident | Relationship |
|---|---|---|
| Joshua O'Mara | 8 months old | Decedent |
| [redacted] | 4 years old | Sibling |
| [redacted] | 6 years old | Sibling |
| Trenton O'Mara | 29 years old | Father |
| [redacted] | 27 years old | Father's Girlfriend |
| Diamond Wright | 26 years old | Mother |

## Child Welfare Summary

The family has a significant history between 2018 and 2024 with the Department that reflects a pattern and escalation of household violence and substance use which ultimately resulted in case management services. At the time of the fatality incident, the family was involved in an active in-home non-judicial case in which the three children resided with the father.

Two reports were received in 2018.

[redacted]

[redacted]

Two reports were received in 2020.

[redacted]

[redacted]

[redacted]

[redacted].

There were five reports involving the family in 2022.

[redacted]

[redacted]

[redacted]

[redacted]

[redacted]

[redacted]

[redacted].

[redacted]

The family was involved in three reports in 2024 which resulted in in-home non-judicial case management.

In May 2024, a report was received after the mother gave birth to Joshua in which he was positive for marijuana. The mother reported to smoking Delta-8 while the father disclosed smoking marijuana [redacted] The mother reported that Joshua was born a bit early, and all her pregnancies were high risk. She advised that she had postpartum depression after the birth of her first two children and has begun to experience some symptoms that she had before. She feels that she able to identify it and get help. She reported that the father had been very helpful and supportive. Safe sleep practices were discussed with both parents. The family was referred to Healthy Start. The report was closed with no indicators of substance exposed newborn.

In July 2024, a report was received after the parents engaged in a verbal altercation. The mother reported that the father hit her, leaving a “goose egg” on her forehead. The father denied any physical altercation and advised that he left the residence during the argument. No arrests were made. The report was closed with no indicators of household violence.

A September 2024 investigation was received after the mother was drinking and physically assaulted the father. Both [redacted] and [redacted] report that their mother fights and says bad words to

their father. He reported that both parents drink adult drinks but his mother acts differently when she drinks them. Additionally, they will fight if they have been drinking alcohol. The father reported that the mother does not hit the children but does yell and scream at them. As a result, the father filed an injunction against the mother. However, in November the mother was arrested for violation of the injunction as she was found with the father and children. The investigation was closed with verified findings of household violence and substance misuse-alcohol with the mother as a caregiver responsible and verified findings of threatened harm with the father as the caregiver responsible. Due to the unmanaged mental health concerns for the mother and ongoing violence between the parents, the children were deemed unsafe and transferred to case management for continued oversight.

The case was transferred to Northwest Florida Health Network (NWF)/Families First Network (FFN) on December 10, 2024, for implementation of in-home non-judicial services. FFN CWCM ensured the family continued with IHSS, which began their involvement with the family in October 2024. Referrals were made for SMS, FIT, the Fatherhood Initiative program, and Bridgeway. The last home visit to the home was completed on February 3, 2025, and there were no concerns presented for the children at that time.

## System of Care Review

This review is designed to provide an assessment of the child welfare system's interactions with the O'Mara family and to identify issues that may have influenced the system's response and decision making. The areas of focus for the review were on practice assessment, organizational assessment, and local service array.

### ***Practice Assessment***

PURPOSE: This practice assessment examines whether the child welfare professionals' actions and decision making regarding the family were consistent with the Department's policies and protocols.

**FINDING A**: The September 2024 investigation warranted a higher level of intervention; however, the case was transferred to in-home non-judicial services despite the parents' history and repeated violations of the no-contact order in both the current and past cases. In November 2024, the children were again exposed to family violence when the father allowed the mother into the residence.

The Senior Child Protective Investigator (CPI) conducted a comprehensive review of the family's history, gathering information that underscored ongoing concerns. The Assessment Response Teams (ART) assessment reinforced the long-standing pattern of domestic violence and substance use by the parents, with a particular focus on the mother due to the September 2024 allegations against her. When evaluating the totality of the history, several key concerns emerged.

There was a clear escalation of domestic violence, beginning with reports in 2018 and increasing in severity through 2024. Initially involving verbal altercations, these incidents frequently escalated to physical violence, often witnessed and disclosed by the children. Despite legal interventions such as arrests and injunctions, the cycle of conflict persisted, indicating that previous interventions were ineffective in preventing recurring violence.

Substance use was also a recurring issue, as evidenced by all three children being substance-exposed at birth to marijuana. Parental substance use often coincided with domestic disputes and environmental neglect, further exacerbating concerns for the children's well-being. From 2018 to the present, repeated reports highlighted unsafe living conditions, including excessive filth, hazardous items within the children's reach, and structural issues that were not addressed in a timely manner. The family frequently required temporary alternative living arrangements due to the home's deteriorating conditions.

Mental health and parental functioning also emerged as significant concerns. While the father was positioned as the primary caregiver in recent investigations, he remained implicated in cycles of conflict and repeated violations of court-ordered injunctions. The mother engaged in services intermittently; however, these interventions were short-lived, and concerns reemerged shortly after. By 2024, the children were able to verbalize their awareness of parental substance use and conflict, signaling the emotional toll of their unstable home environment. The cumulative effects of chronic instability, recurring violence, and substance use posed significant risks for their long-term developmental and psychological well-being. Despite multiple service referrals, including Healthy Start, IHSS, Bridgeway, and Embrace, concerns persisted, and these interventions failed to mitigate ongoing risks. Despite these findings, the case was

transferred to in-home non-judicial (IHNJ) services, even though the severity of the situation warranted a higher level of intervention.

Both the four- and six-year-old children were able to articulate the frequent conflicts between their parents, describing how their mother and father fought often, and that law enforcement was regularly called to their home. Additionally, the father displayed a pattern of filing injunctions against the mother but failing to appear in court, while the mother was consistently required to be present. Despite multiple court orders, the parents repeatedly violated both current and previous no-contact injunctions, a pattern that has persisted from 2018 through November 2024.

Prior investigations revealed a significant history of unaddressed mental health concerns for both parents. Prior to the case transfer to in-home non-judicial services, these concerns were not fully assessed or reconciled. During the Family Team Conference, the father disclosed that [redacted], preventing him from accessing necessary medical care for [redacted] and ongoing mental health needs. Although he reported seeking therapy [redacted] and using telehealth services [redacted], this information was not verified before the case transfer.

According to the initial Family Functioning Assessment (FFA) from the September 2024 investigation, both children provided detailed accounts of the volatility in their home, as well as their parents' substance use. However, the investigation did not explore the parents' own childhood experiences or how their upbringing may have influenced their parenting behaviors. [redacted]. This inconsistency was not addressed before determining the appropriateness of non-judicial intervention and transferring the case to Families First Network (FFN).

Further concerns arose regarding the father's substance use. [redacted], raising questions about potential impairment and continued use within the home. Given the history of substance use, domestic violence, and mental health concerns, the decision to transfer the case to IHNJ services rather than a more structured intervention plan may not have adequately addressed the risks to the children.

**FINDING B:** While multiple service providers were referred to and involved, the extent of progress in strengthening the father's ability to provide a safe and stable environment for the children remains unclear. Additionally, his willingness and capacity to do so were uncertain as he often disclosed frustration with caring for the children.

From the onset of the in-home non-judicial case in December of 2024, the Senior Child Welfare Case Manager (CM) maintained thorough and detailed documentation in the Florida Safe Families Network (FSFN). Efforts were made to support the father in keeping the children in the home with him and the great-grandfather, as evidenced by multiple referrals to service providers. However, despite these interventions, the father continued to express an inability to care for the children, frequently sending messages to relatives and the CM indicating his distress and suggesting self-harm if the children remained in his care.

During home visits, the CM observed multiple concerns within the household, including soiled diapers upon arrival, various environmental hazards, and one child with severely matted hair.

The outdoor conditions also raised concerns, with reports describing hazards and accumulated trash in the yard, as well as the presence of many roaches and gnats inside the home, as documented by both case management and service providers.

Additional concerns arose regarding the father's reliance on and the parentification of the six-year-old child to care for the infant. Case notes indicate that the father instructed the child to prepare bottles and place them in the Pack ‘n Play for the infant. This was particularly concerning given that the mother had previously disclosed that the six-year-old child might be on the autism spectrum. Despite this, the father continued to place caregiving responsibilities on him.

The father was referred to Bridgeway for mental health services and adult case management; however, he repeatedly stated that the paperwork required for enrollment was discouragingly lengthy. Multiple providers made efforts to facilitate his access to services, but he remained reluctant to engage.

Although there was information suggesting that both parents had serious mental health concerns, the provided information was not fully corroborated. The CM raised the possibility of seeking judicial intervention against the father on a couple occasions, but no further discussions took place with Children's Legal Services (CLS).

Despite the involvement of multiple service providers and agencies, no multi-disciplinary team (MDT) meeting was convened to coordinate efforts and ensure a comprehensive approach. While service providers and case management staff were able to articulate concerns regarding the household environment, there was a lack of clarity regarding which provider was responsible for addressing or reporting specific issues for further intervention. Interviews and documentation indicate that roles and responsibilities among service providers were not fully defined, contributing to uncertainty in addressing the father’s capacity to create a safe and stable home for the children.

***Organizational Assessment***

PURPOSE: This section examines the level of staffing, experience, caseload, training, and performance as potential factors in the management of this case.

**FINDING A**: Interviews highlighted collaboration between FFN, DCF, and the agencies involved. Staff demonstrated significant experience in child welfare, and caseloads were reported to be manageable. While collaboration between agencies was a noted strength, information was not always shared collectively and, instead, was usually limited to the referral source. This limitation hindered the ability to determine the most effective support and/or intervention strategies with which to engage the father.

Over the three months preceding the September investigation, the primary Child Protective Investigator (CPI) managed an average of twelve investigations. The primary CPI Supervisor (CPIS) maintained a 4:1 staff to supervisor ratio, which was determined to be manageable.

The primary CPI had over five years of experience in child welfare, while the primary CPIS had over sixteen years of experience. The secondary CPI had three years of experience in child welfare, with one year specifically at the Department of Children and Families (DCF). The secondary CPIS had over fifteen years of experience in the field.

Between September 2024 and February 2025, the Family Case Manager (FCM) managed an average caseload of thirteen children and twelve families. Both the FCM and the Unit Manager (UM) had over eight years of experience in child welfare. Additionally, the FCM aided other counties that were not fully staffed during this time period.

All service providers reported having a positive working relationship with the Department of Children and Families and Families First Network (FFN). The Family Intervention Team (FIT) noted that their relationship with the Department and FFN had improved recently and that they often are in contact regarding mutual clients. The family navigator (FN) also expressed having a strong relationship with FFN, having previously worked with the organization before transitioning into the FN role.

Northwest Florida Health's Fatherhood Initiative reported a positive working relationship with DCF and case management, emphasizing effective collaboration in supporting families.

Although there was collaboration between DCF, FFN, and the referring agencies, information was not shared collectively among all agencies but rather only with the referring entity. As a result, service providers lacked a comprehensive understanding of the family's dynamics, and the concerns identified by other agencies. This limited access to information hindered their ability to fully assess the father's parental capacity and determine the most effective strategies for support and intervention.

***Service Intervention/Array***

PURPOSE: This section assesses the inventory of services within the child welfare system of care in Okaloosa County.

**FINDING A:** Okaloosa County offered a range of services to support the community's needs. While under case management and investigative oversight, the father was referred to In-Home Support Services, The Fatherhood Initiative, Bed for Me, Share Your Heart, ELC, Care Portal, Bridgeway, and First City Outreach Safety Management Services. The mother was referred to Lakeview's Family Intensive Treatment (FIT) program and Favor House for domestic violence advocacy.

At the start of the September 2024 investigation, the Department's Family Navigator facilitated a staffing and subsequently provided multiple referrals to support the father and children. Family Navigators play a vital role in assisting families early in the investigation process by building partnerships, assessing needs, setting meaningful goals, and connecting them with essential services. Their guidance helps families work toward safe, long-term independence while ensuring that those facing the highest risks have a voice in the process. A key aspect of the role is empowering families to make necessary changes, navigate challenges, and achieve stability and self-sufficiency.

For this family, referrals included Share Your Heart for household essentials such as pots and pans, emotional support, food, and clothing. Additional referrals were made to Bed for Me for bedding, the Early Learning Coalition (ELC) for daycare assistance, and Care Portal, a faith-based program that connects families in need with local churches. Churches participating in the Care Portal program must complete training to learn how to engage effectively with families in a supportive and meaningful way.

Although the father never established contact during the most recent investigation and in-home non-judicial case, he was referred to Bridgeway for mental health care and medication management.

The father was referred to the Northwest Florida Fatherhood Initiative, a component of the broader Florida Fatherhood Initiative. This program was created to address challenges faced by fathers and strengthen parent-child relationships. It provides resources for rehabilitation, family engagement, and responsible parenting, particularly for fathers involved in the criminal justice system. The initiative also offers specialized support for incarcerated fathers, equipping them with tools to rebuild and maintain relationships with their children.

The father engaged with the Cares Program, which provided him essential cleaning supplies to maintain the home. The program conducted safe sleep education and supplied a pack 'n play, along with winter clothing, a blanket, and fitted sheets for the family. Additionally, the program completed another Early Learning Coalition (ELC) referral on behalf of the father, but he did not follow up. A Healthy Start referral was also initiated.

First City Outreach SMS provided safety management services to the family. The support coordinator noted that, despite being at full capacity, her caseload remained manageable. She expressed a positive working relationship with both the Department of Children and Families and Family First Network case management staff.

Multiple staff members provided the father and grandfather with a State Housing Initiatives Partnership (SHIP) program application to complete; however, they did not finish the process before the critical incident. The SHIP program was created in 1992 as part of the William E. Sadowski Affordable Housing Act, The SHIP program provides funds to local governments as an incentive to create partnerships that produce and preserve affordable homeownership and multifamily housing. The program was designed to provide very low, low, and moderate-income families with assistance to purchase a home, money to repair or replace a home, as well as other types of housing assistance. This assistance is in the form of a deferred payment loan with 0% interest and no monthly payments.

Throughout Circuit One, there are co-located Behavioral Health Consultants (BHCs) available to support families. In this case, the CPI completed a consultation with the BHC early in the investigation. Near the conclusion of the investigation, the BHC was consulted again and was informed that the case would be transitioning to in-home non-judicial services. The BHC advised the CPI to inform FFN case management staff that she remained available to conduct an assessment on the mother even after the case was transferred. The mother was referred to the Lakeview Center Family Intensive Treatment (FIT) program. The mother completed her FIT assessment on January 30, 2025, and had not begun a treatment plan with them as of the critical incident.

A Favor House referral was signed by the mother and provided to the collocated domestic violence (DV) advocate. The collocated DV advocate was able to articulate concerns regarding both parents and the ongoing violence between them. Additionally, they highlighted the father’s pattern of coercive behaviors, as well as his exertion of power and control within the relationship.

***Operational Response***

In response to the review findings, the Department has implemented the following immediate actions in the Northwest Region (NWR):

The northwest region of DCF initiated learning circles around safety planning and initial consultations for all supervisors in October and November of 2024. In addition, in December 2024, they implemented intense training for new supervisors (Strengthening Our Supervisors). This initiative provides support by providing supervisors one on one training with our regional expert around case reviews, consultants, safety planning, and operating procedures.

In January 2025, DCF of the northwest region implemented a review process within the region that requires supervisors to complete file reviews on recently closed cases and additional leadership completes a second level review to ensure the validity and integrity of the reviews. The sample that is provided for review is heavily skewed to capture "*Safe* but *High* or *Very High Risk*" and "*Verified* but *Safe*" closures. The data is shared monthly with each local area, and from the county, circuit, and regional perspectives. The tool mirrors questions from the Office of Quality and Innovation with an emphasis on supervisor consultations and ongoing support, as well as Risk Assessment and levels of service provision.