Child Abuse Death Review Committee

Working to eliminate preventable child abuse and neglect deaths in Florida

Executive Summary
Annual Report
December 2021

CHILD ABUSE DEATH REVIEW MISSION:

To eliminate preventable child abuse and neglect deaths

This Annual Report is dedicated to the memory
of all the children who lost their lives in our state in 2020.

This Executive Summary is an excerpt from the original
2021 Annual Report which can be found
in its entirety here: www.FLCADR.com

The information contained herein can be used
to help prevent any future harm
to our most vulnerable citizens.

Submitted to:

The Honorable Ron DeSantis, Governor, State of Florida
The Honorable Wilton Simpson, President, Florida Senate
The Honorable Chris Sprowls, Speaker, Florida House of Representatives

EXECUTIVE SUMMARY

Florida's Child Abuse Death Review System

The Florida Child Abuse Death Review (CADR) System was established in Florida law in 1999. Per section 383.402, Florida Statutes (F.S.), CADR is a statewide multidisciplinary, multiagency, epidemiological child abuse death assessment and prevention system. State and Local CADR Committees are directed by statute to identify gaps, deficiencies, or problems in the delivery of services to children and their families, recommend changes needed to better support the safe and healthy development of children, and implement those changes to the extent possible. The essential goal of the CADR System is to eliminate preventable child fatalities in Florida by improving CADR members' collective understanding of the complexities of child maltreatment and leveraging data and evidence-based knowledge to support current and future prevention strategies. This statistical report is submitted annually to the Governor, President of the Florida Senate, and Speaker of the Florida House of Representatives.

2020 Data: Case Review Analysis

Throughout 2021, Local CADR Committees reviewed records related to 222 child fatalities which occurred in 2020. Analysis of the 2020 child fatality case review data revealed that regardless of maltreatment verification status, children under the age of five have the highest number of child deaths called into the Florida Abuse Hotline. The three leading causes of preventable child death in 2020, identified through CADR case reviews and subsequent analysis are listed below in order of greatest to least incidence.

- **Sleep-related Infant Death** is the leading cause of preventable child death in Florida and is often the result of unsafe sleep practices. Sleep-related infant deaths represent 35.1% of 2020 child fatalities reviewed by the CADR System. Children placed to sleep on adult beds, couches and other soft surfaces are at significant risk of suffocation. An infant sharing a sleep surface with another child or an adult also poses a risk for sleep-related death.
- **Drowning** is the second leading cause of preventable child death, representing 25.5% of all child fatalities reviewed by the CADR System. Children three years of age and younger make up 72.0% of all 2020 drowning related fatalities reviewed by the CADR System. According to the American Academy of Pediatrics, nearly 70% of child drowning occurs during non-swimming activities. Ineffective barriers of protection and failure to provide sufficient supervision to young children continue to be primary contributing factors.
- **Inflicted Trauma** is the third most frequent cause of preventable child death, representing 9.0% of child fatalities reviewed by the CADR System. Children under one year of age accounted for 26.7% of these fatalities. Inflicted trauma includes abuse to a child by way of bodily force, such as the use of hands, fists, and feet, or by the use of weapons and firearms.

Child Characteristics

Children 5 years old and under account for 83.8% of preventable child death cases reviewed by the CADR System. The most vulnerable children are less than 1 year of age, representing 51.8% of cases reviewed. Children under the age of 5, and to a greater extent, children under

the age of 1, are in critical need of developmentally appropriate supervision, care, and support to ensure their safety.

Prevention Recommendations:

The following prevention recommendations developed by the State CADR Committee provide an overview of strategies and approaches intended to address preventable child fatalities in Florida:

- Continue efforts to relay timely information to caregivers and community supports regarding the safety of children.

- Continue to develop strategies to ensure consistent and coordinated prevention-related messaging across local and state agencies, business and industry leaders, and other relevant private and public sector groups.

- Expand efforts to collect data related to co-occurring substance abuse and mental health disorders.

- Continue to explore efforts to collect data related to near fatalities in cases of near-fatal sleep-related asphyxia, near-drowning, and near-fatal incidents of inflicted trauma.

- Continue to support the development and dissemination of messaging around appropriate supervision and barriers of protection as primary factors in drowning prevention, in addition to establishing age-appropriate expectations related to young children and swimming capabilities consistent with recommendations of the American Academy of Pediatrics (AAP).

- Strongly support statewide drowning prevention programs and promote collaboration with the hospitality and tourism industry and all associated partners, in the development and dissemination of public messaging for water safety and drowning prevention.

- Effectively advocate for strengthened partnerships and collaborations between state agencies to ensure families are referred to evidence-based parent coaching and support programs.

- Train first responders on the consistent use of Sudden Unexpected Infant Death Investigation Reporting Forms (SUIDIRF) and doll reenactments by death scene investigators for all sleep-related infant deaths and explore opportunities to mandate statewide use of the form.

- Continue to support and encourage the development and evaluation of pilot projects and initiatives focused on local and regional community-based child fatality prevention.

- Explore collaborative partnerships with entities which may be currently examining child and adolescent suicide to better inform targeted prevention initiatives.