

# FLORIDA CHILD ABUSE DEATH REVIEW



**ANNUAL REPORT  
December 2006**



State Child Abuse Death Review Committee  
4052 Bald Cypress Way, Bin A06  
Tallahassee, Florida 32399  
(850) 245-4200

# FLORIDA CHILD ABUSE DEATH REVIEW COMMITTEE



## Team Members

Robert Hodges, J.D.  
Chairman

Randy Alexander, M.D.

Pat Badland

Judith Cobb, R.N.

Kris Emden

Janet Goree

Michael Haney, Ph.D.

Trish Hardy

Miriam Firpo-Jimenez

Carol McNally

Bethany Mohr, M.D.

Bill Navas, J.D.

Wanda Philyor

Michele Polland

Connie Shingledecker

Terry Thomas

Barbara Wolf, M.D.

Sharon Youngerman,  
LCSW

## Staff

Michelle Akins

Johana Hatcher

The Honorable Jeb Bush  
Governor of Florida  
The Honorable Charlie Crist  
Governor Elect  
The Honorable Ken Pruitt  
President of the Florida Senate  
The Honorable Marco Rubio  
Speaker of the Florida House of Representatives  
The Capitol  
Tallahassee, Florida 32399-0001

Dear Governor Bush, Governor-Elect Crist, President Pruitt, and Speaker Rubio:

As Chairman of the State Child Abuse Death Review Committee, I am submitting this annual report on child abuse deaths in accordance with Chapter 383.402, Florida Statutes. This report summarizes information from case reviews of 94 Florida children whose deaths were determined to be due to child abuse or neglect and were verified as such by the Department of Children and Families in 2005.

Fatal child abuse and neglect is a nationwide problem and continues to be an issue for Florida's children. As a State Committee, we are in our 2<sup>nd</sup> year of reviewing all verified child abuse deaths and have seen children who were hanged, strangled, stabbed, shot, crushed, thrown, scalded, drowned, suffocated, or died by some other means; the previous four years we only examined cases where there was a prior report to the Department of Children and Families. We believe the work that we do is critical and ask for your participation as we continue to seek, identify, and mitigate the systemic problems that contribute to these tragic deaths. The death of any child has a profound effect. It is our task to recommend steps that we believe will improve interventions, educate responders, and hopefully prevent fatal child abuse in the future. With your partnership and leadership, we can turn these recommendations into concrete actions.

While we have made some progress, children are still dying at an unacceptable rate. We know that we cannot stop all child abuse deaths, however, I ask for your commitment and support of the work of this State Committee as we work together towards our ultimate goal to reduce preventable child abuse and neglect deaths.

Sincerely,

A handwritten signature in black ink that reads "Robert W. Hodges".

Robert W. Hodges  
Chairman  
State Child Abuse Death Review Committee



FLORIDA  
CHILD ABUSE DEATH REVIEW  
COMMITTEE

ANNUAL REPORT

DECEMBER 2006

**Mission**

***“To reduce preventable child abuse and neglect deaths”***

Submitted to:

The Honorable Jeb Bush, Governor of Florida  
The Honorable Charlie Crist, Governor Elect  
The Honorable Ken Pruitt, President, Florida Senate  
The Honorable Marco Rubio, Speaker, Florida House of Representatives



## DEDICATION

---

This report is dedicated to 94 children who died from Child Abuse and Neglect  
Some died quickly and some slowly, often painfully and usually preventable.

Profile Information	Date of Death	Cause of Death	Caregiver Responsible	Age
Crystal	12/26/05	Asphyxia due to Carbon Monoxide poisoning/ murder/suicide	Father	6 years
Lorenzo	11/29/05	Asphyxia due to Carbon Monoxide poisoning/ murder/suicide	Mother	7 years
Nathan	12/26/05	Asphyxia due to Carbon Monoxide poisoning/ murder suicide	Father	7 years
Giselle	5/18/05	Asphyxia/ Co-sleeping	Mother	1 month
Kierra	8/28/05	Asphyxia/ positional	Mother	1 month
Rashard	1/30/05	Asphyxia/positional	Father	1 month
Jesse	5/27/05	Asphyxia/positional	Parents	3 months
Kamari	7/7/05	Asphyxia/positional	Mother	2 months
Alondra	3/14/05	Asphyxia/positional	Babysitter	3 months
David	11/3/05	SIDS	Mother	3 months
Selina	11/8/05	Suffocation	Mother	5 months
Taylor	10/6/05	Suffocation by mechanical device Co-sleeping	Parents	3 months
D'Anna	10/4/05	Suffocation/co-sleeping	Mother	2 months
Cody	12/29/05	Undetermined	Undetermined	4 months
Sakowna	1/30/05	Undetermined/ sleeping with sibling	Mother	9 months
Erinisha	5/1/05	Undetermined/overlay	Father	2 years
Jalin	11/14/05	Undetermined/positional asphyxia	Mother	2 months
Ryan	6/11/05	Blunt abdominal trauma	Male paramour Undetermined	2 years
Kaylin	11/4/05	Blunt head injury	Undetermined	6 months
Deasia	3/27/05	Blunt head injury	Father	3 months
Gavin	8/11/05	Blunt head injury	Undetermined	2 months
Tyrone	1/9/05	Blunt head injury	Father	2 months
Isabella	7/8/05	Blunt head injury	Father	1 months
Devonte	5/20/05	Blunt head injury	Male paramour	2 years
Alejandro	9/13/05	Blunt head injury	Male paramour	4 years

Profile Information	Date of Death	Cause Of Death	Caregiver responsible	Age
Kamar	3/10/05	Blunt head injury	Father	3 months
Bryant	4/11/05	Blunt head Injury	Female paramour	7 years
Demetrius	8/3/05	Blunt head injury	Father	11 months
Taylor	5/7/05	Blunt head injury	Father	2 months
Zaconyae	4/12/05	Blunt head injury	Male paramour	6 months
Matthew	6/10/05	Blunt head injury	Male paramour	3 years
Autumn	6/18/05	Blunt injury to head and torso	Male paramour	8 months
Calvin	10/31/05	Blunt injury to torso	Father	3 months
Ja'Quan	7/4/05	Blunt injury to torso	Father	19 months
Marina	7/25/05	Mechanical asphyxia	Sibling	11 years
Joshua	2/10/05	Multiple blunt injuries	Male paramour	5 years
Elias	7/7/05	Multiple blunt injuries	Male paramour	3 years
Teon	5/29/05	Multiple blunt injuries	Undetermined	4 months
Ronnie	1/28/05	Multiple blunt injuries	Father	3 years
Courtney	10/4/05	Blunt head injury/TV fell on child	Mother	10 months
Michael	1/7/05	Blunt head injury/ vehicle accident	Non-relative	5 years
Kaylee	6/7/05	Blunt head trauma/Vehicle accident	Mother	19 months
Biran	2/14/05	Blunt head trauma/Vehicle accident	Mother	7 years
Paris	3/14/05	Blunt injury to head/ vehicle accident	Grandmother	4 years
Kayli	7/21/05	Heat stroke/ left in vehicle	Father	5 months
Jayda	10/18/05	Hyperthermia/ left in vehicle	Grandfather	8 months
Amy	2/19/05	Drowning/canal/vehicle accident	Aunt	2 years
Austen	10/12/05	Complications of maternal cocaine intoxication	Mother	1 month
Angel	9/12/05	Complications of maternal cocaine intoxication	Mother	0 day
Myrvin	8/26/05	Complications of maternal cocaine use	Mother	3 months
Thanh	1/26/05	Complications of peripartum neglect	Mother	0 day
Sidney	12/31/05	Drowning/ bathtub	Mother	10 months
Maddilynn	7/30/05	Drowning/ bathtub	Mother	1 year
Sean	7/21/05	Drowning/ bathtub	Father	3 months
Elijah	5/29/05	Drowning/ bathtub	Mother	1 year
Alejandro	3/28/05	Drowning/bathtub	Father	9 months

<b>Profile Information</b>	<b>Date of Death</b>	<b>Cause Of Death</b>	<b>Caregiver responsible</b>	<b>Age</b>
Brian	5/19/05	Drowning/bathtub	Mother	9 months
Star	7/5/05	Drowning/pool	Father and Grandparents	3 years
Sam	7/5/05	Drowning/pool	Uncle	5 years
Traven	8/10/05	Drowning/pool	Parents	2 years
Nickoy	3/27/05	Drowning/pool	Mother	4 years
Jaden	5/1/05	Drowning/pool	Parents	2 years
Jordan	5/2/05	Drowning/pool	Aunt	2 years
Brian	11/29/05	Drowning/pool	Parents	2 years
Lawrence	12/22/05	Drowning/pool	Uncle	2 years
Arianna	1/2/05	Drowning/pool	Father	19 months
Rina	5/14/05	Drowning/pool	Parents	2 years
Giovanni	4/13/05	Drowning/pool	Parents	15 months
Leina	6/26/05	Drowning/pool	Mother	17 months
Jack	11/4/05	Drowning/pool	Mother and Grandfather	14 months
Jeremiah	4/7/05	Drowning/pool	Babysitter	2 years
Anthony	11/13/05	Drowning/pool	Mother and relative	19 months
Navelyn	6/29/05	Drowning/pool	Mother	2 years
Kourtney	4/29/05	Drowning/pool	Father	2 years
Jessica	3/22/05	Drowning/ state park	Male paramour	5 years
Preston	6/10/05	Drowning/pond	Mother	2 years
Phillipe	3/16/05	Drowning/pond	Father	2 years
Ella	4/19/05	Gunshot / murder/suicide	Father	5 years
Garrett	12/1/05	Gunshot to head/suicide	Father	12 years
Brianna	7/20/05	Gunshot wound to head/ Homicide	Non relative	12 years
Ashley	1/30/05	Gunshot wound to head murder/suicide	Male paramour	12 years
Joanna	1/30/05	Gunshot wound to head murder/suicide	Male paramour	11 years
Philip	8/28/05	Gunshot wound to head/accident	Parents	2 years
Jovan	12/18/05	Gunshot wound to head/accident	Mother	4 years
Lauren	4/19/05	Gunshot/ murder/suicide	Father	1 year
Chelsey	11/11/05	Gunshot/ murder/suicide	Father	11 years
Kevin	3/31/05	Smoke inhalation due to Fire	Grandmother	2 years
Leonel	7/30/05	Hanging/ accident	Mother	3 years
Justin	2/17/05	Medical neglect	Mother	14 years

<b>Profile Information</b>	<b>Date of Death</b>	<b>Cause Of Death</b>	<b>Caregiver responsible</b>	<b>Age</b>
David	12/4/05	Overdose	Parents	15 years
John	7/14/05	Drug overdose	Aunt and uncle	15 years
Isaiah	9/3/05	Drug overdose	Mother	2 months
Denver	8/26/05	Poisoning	Aunt	11 years
Angela	3/6/05	Poly Drug overdose	Foster mother	3 months

## IN MEMORIAM: J. M. WHITWORTH, M.D.

---

The State Child Abuse Death Review Committee also dedicates this report to the memory of Dr. J. M. Whitworth. Dr. Whitworth was a member of the State Child Abuse Death Review Committee since its inception in 1999 to November 2003. Dr. Whitworth was one of the founding fathers of Children's Medical Services Child Protection Teams and served as the Statewide Medical Director from 1978 - 2003. We valued him as a colleague and friend, and admired his commitment and dedication to protecting Florida's children from child abuse. His untimely death while attending an international child abuse conference in York, England was truly a loss for his family and the children of Florida.



# TABLE OF CONTENTS

---

EXECUTIVE SUMMARY .....	1
DEFINITIONS .....	6
OVERVIEW .....	11
RISK FACTORS .....	14
CHILD ABUSE AND NEGLECT DATA .....	15
ABUSE/NEGLECT .....	16
PRIOR INVOLVEMENT WITH.....	17
PREVENTABILITY .....	18
PERPETRATOR INFORMATION.....	19
MANNER OF DEATH .....	22
DROWNING .....	23
PHYSICAL INJURY .....	25
SLEEPING ENVIRONMENT-RELATED DEATHS.....	26
GUNSHOT RELATED DEATHS .....	27
VEHICLE-RELATED DEATHS .....	28
PREMATURE AND DRUG EXPOSED NEWBORNS.....	29
OTHER TYPES OF DEATHS.....	30
CARBON MONOXIDE POISONING & DRUG OVERDOSE.....	30
MEDICAL NEGLIGENCE .....	30
HANGING.....	30
FIRE.....	30
RECOMMENDATIONS FOR 2006 .....	31
REFERENCES .....	36
APPENDIX I.....	37
APPENDIX II .....	39
APPENDIX III.....	41
APPENDIX IV.....	42
APPENDIX V .....	43
APPENDIX VI.....	44
APPENDIX VII.....	45
STATE CHILD ABUSE REVIEW COMMITTEE .....	62



# EXECUTIVE SUMMARY

---

The Florida Child Abuse Death Review Committee was established by statute in s. 383.402 (1), F. S., in 1999. The program is administered by the Florida Department of Health; and utilizes state and local multi-disciplinary teams to conduct detailed reviews of the facts and circumstances surrounding child abuse and neglect deaths reported to the Florida Abuse Hotline Information System within the Department of Children and Families (DCF) and verified as abuse or neglect by investigations. The major purpose of the program is to develop and implement data-driven recommendations for reducing child abuse and neglect deaths. The Committee is dedicated to reducing child abuse deaths.

In 2005, 97 children died as a result of abuse or neglect. This seventh annual report includes information from the review of only 94 of the children who died in 2005; two cases will not be reviewed until 2007 due to late reporting by Department of Children and Families, and one due to lack of available information. There were an additional 4 cases, reviewed of children who died in 2004, which were not received in time to review in 2005. Information from these cases was updated in the 2004 data.

There are clear patterns and trends noted for the state that are consistent with national data: however because of the limited population and scope of deaths reviewed there are variations, which are reflected in this report. It is widely acknowledged that many child abuse and neglect deaths go unreported and/or misclassified. The national data also reflect different systems, state laws, definitions, practices, policies and how the data is collected and reported. Scholars, professionals and officials around the nation agree that a system of comprehensive Child Death Review Teams could make a difference.

During 2004, an estimated 1,490 children died from abuse and neglect, compared to 1,460 children in 2003, according to national statistics; some of the increase may be due to improved reporting. This may also be true in Florida, as the State Committee, in conjunction with other agencies such as Florida Department of Law Enforcement, Department of Children and Families, and programs such as Healthy Families provided training throughout the state to increase awareness of mandatory reporting in cases such as murder/suicides, traffic crashes that involve drugs and alcohol and drowning deaths resulting from neglect and inadequate supervision. The Committee noted an increase in the number of child deaths resulting from murder/suicide; however this increase may be the result of these cases previously being under reported to the child abuse hotline and only handled by law enforcement as a homicide.

## **RECOMMENDATIONS:**

Based on the review of the 2005 Child Deaths, the State Child Abuse Death Review Committee makes the following recommendations:

- 1. Recommendation: The Florida Legislature should expand the child abuse death review process to include the review of all child deaths.**

Chapter 383.402 F.S. limits the review of child deaths to those that are verified as child abuse by the Department of Children and Family Services. This has limited the

Committee's ability to determine why many children in Florida die, simply because the majority of child deaths are never reviewed. As a result, the committee's recommendations weaken or are limited by not analyzing other causes of death that could potentially be reduced, and our prevention efforts suffer due to this lack of information. The Committee strongly recommends that the Governor and Legislature take steps to expand the review of child deaths beyond those caused by abuse and neglect, to include all child deaths. The benefits would include better death investigations at the local levels, enhanced interagency cooperation, better epidemiological data on the causes of death, and improved accuracy of death certificates.

The State Committee believes this can be accomplished in a way that minimizes intrusion and is protective of family rights to privacy.

- 2. Recommendation: A multi-disciplinary staffing is required in all child abuse or neglect cases when there is a child under the age of five in the home and there have been three or more prior reports, irrespective of the findings of the prior reports.**

There were several cases reviewed that had three or more prior reports to the Department of Children and Families, where little to no services had been provided or the risk was not adequately assessed and it appeared that no multi-disciplinary staffing were held. A multi-disciplinary staffing can significantly improve the assessment of risk and help identify needed services.

- 3. Recommendation: The Medical Examiner's Commission should recommend that all Florida Medical Examiner districts participate in the National MDI Log registry ([www.mdilog.net](http://www.mdilog.net)) for sudden unexplained infant deaths.**

This year the Committee looked at 13 child deaths attributed to infant sleep environments. Nationally, forensic pathologists consider the information on the Sudden Unexplained Infant Death Investigations (SUIDI) form critical to the determination of the cause and manner of death in infant death investigations.

- 4. Recommendation: Law Enforcement agencies should adopt and participate in domestic violence training and advanced training for Sudden Unexplained Infant Death Investigations, which should include a drug-testing component.**

The State Committee noted on several of the child abuse death investigations that there was insufficient detailed crime scene investigation and information was inconsistent throughout the state on how infant deaths were investigated. Drug testing and suspicion of drug use were handled differently across the state.

- 5. Recommendation: The Florida Department of Law Enforcement through the Standards and Training Commission should work with county sheriffs and local police chiefs to develop a standardized protocol for investigating child deaths or at a minimum adopt the SUIDI protocol statewide.**

The State Committee found that there is no comprehensive or consistent statewide training on child death investigations. Many cases lacked thorough crime scene investigation and documentation, drug testing was not requested or ordered

even when drug paraphernalia was observed at the scene, and not all witnesses were interviewed.

- 6. Recommendation: The State Committee urges The Florida Legislature to undertake a special project, in cooperation with Florida's Drug Endangered Children Alliance, to address the presence of illegal substances in the home as child abuse and amend Chapter 39 F. S., to address this issue.**

The Committee has identified a pattern where investigative findings indicated that substance abuse by the parent or person responsible for the child was documented in prior reports. For these cases where the investigator convened a meeting with child welfare legal services, the substance abuse allegation does not appear to have been appropriately factored into the risk assessment. Subsequently, these families are either referred to voluntary services or receive no services.

- 7. Recommendation: The Department of Children and Families should look into the process whereby Child Welfare Legal Services and child protective investigators review critical child safety decisions in determining what court action should be taken, and that the family's full history with the Department of Children and Families should be considered.**

The Committee found that in those cases in which there were prior reports to the Department of Children and Families and where Child Welfare Legal Services had determined that there was "insufficient evidence for court action," it often appeared as though that decision was made without taking the full family history into consideration.

- 8. Recommendation: The Florida Legislature should support increased funding for Healthy Families Florida, a proven prevention program.**

There is strong evidence and national research that home visiting programs are effective in preventing child abuse and neglect before it ever occurs. A five-year independent evaluation of Healthy Families Florida, a voluntary home visiting program designed to prevent abuse, found 20 percent less abuse and neglect in families participating in the program than all families in the target service areas.

- 9. Recommendation: It is essential that preventative measures be taken to decrease the number of children drowning in Florida. These measures should include, at a minimum:**
  - a) An emphasis on drowning risk factors in all risk assessments, conducted by the Department of Children and Families; DCF has begun to implement this in their training curriculum.**
  - b) Continued public awareness and education on drowning prevention especially targeted at the under five-age group.**

According to data published by the Center of Disease Control, Florida has the highest unintentional drowning death rate of toddlers ages 1-4 in the US in the 5 years between 1999 and 2003 (CDC WISQARS). Florida had the 3<sup>rd</sup> highest overall unintentional drowning death rate of children in the US in the 5 years between 1999 and 2003. (CDC WISQARS).

- 10. Recommendation: A case should be considered “high risk” whenever a caregiver has threatened to harm children, regardless of whether the non-offending caregiver obtains an injunction for protection. The Department of Children and Families should remain vigilant in monitoring the parties’ behavior and court actions to ensure that the injunction is not violated or dissolved.**

After reviewing the eight murder/suicide cases this year, the Committee found that a previous history of domestic violence had been noted in almost every case. Many times the non-offending caregiver had previously obtained an injunction for protection against domestic violence, which the Department of Children and Families viewed as lowering the risk to the children. However, an injunction alone offers little protection to children if it is violated or dissolved by a caregiver.

- 11. Recommendation: The Florida Legislature should provide recurring funding for prevention education activities such as the Coping with Crying. This education should be targeted at males between the ages of 20-30.**

The Kimberlin West Act of 2002 requires that hospitals educate new parents on the dangers of shaking a baby. Crying is the most common trigger for the violent shaking of a child. This team has also identified crying as a trigger in a majority of the abuse deaths we reviewed.

- 12. Recommendation: The Department of Children and Families should review their policies and procedures for determining whether in child death investigations the finding is verified or some indication; and investigators should be trained to ensure consistency throughout the state.**

The Committee found that there were inconsistencies, depending on the county where the death was reviewed, as to whether a death was verified or had a “some indication” finding by the Department of Children and Families.

- 13 Recommendation: The State committee adopted the recommendations regarding safe sleeping of the American Academy of Pediatrics released on November 5, 2005. (See Appendix VI). It is recommended that training on safe sleep practices be provided to all hospital nurses and other medical personal throughout the state.**

There has been a nation-wide campaign since 1992, “Back to Sleep”, to educate the public about the importance of placing children on their backs. The National Institute of Child Health and Human Development, the Maternal and Child Health Bureau, the American Academy of Pediatrics, the SIDS Alliance, and the Association of SIDS and Infant Mortality Programs sponsored this campaign. Although this has reduced such deaths nearly in half, the State Child Abuse Death Review Committee continues to see an ongoing problem where parents make poor choices to co-sleep with children when clearly they present risks to the child (obesity, under the influence of alcohol or drugs, exhausted, etc.) Many of these deaths have the potential to be classified as SIDS deaths instead of positional asphyxia.

As a State Committee, we believe implementation of these recommendations will improve the child protection system by providing the knowledge, skills and public awareness needed to reduce tragic child abuse deaths.

## DEFINITIONS

---

### ❖ **Cases that meet the criteria for review**

In accordance with s. 383.402, F.S., the Committee must conduct detailed reviews of the facts and circumstances surrounding child abuse and neglect deaths in which a report of abuse or neglect was accepted by the Florida Abuse Hotline and verified through a child protective investigation.

**Verified** - When a preponderance of the creditable evidence results in a determination that the specific injury, harm, or threatened harm was the result of abuse or neglect.

**Some Indication** - When there is credible evidence, which does not meet the standard of being a preponderance, to support that the specific injury, harm, or threatened harm was the result of abuse or neglect.

### ❖ **Cause of Death**

As used in this report, the term cause of death refers to the underlying cause of death. The underlying cause of death is the disease or injury/action initiating the sequence of events that leads directly to death, or the circumstances of the accident or violence that produced the fatal injury.

### ❖ **Manner of Death**

This is one of the five general categories (Accident, Homicide, Suicide, Undetermined and Natural) that are found on the death certificate.

### ❖ **Preventable death**

Based on the information provided, the Committee shall determine whether the child's death was preventable.

**Definitely preventable:** The information provided demonstrates clearly that steps or actions could have been taken that would have prevented the death from occurring.

**Possibly preventable:** There is insufficient information to determine if the death was preventable.

**Not Preventable:** No current amount of medical, educational, social or technological resources could prevent the death from occurring.

## ❖ Physical Abuse

Physical abuse is the most visible form of child abuse and is defined in *Florida Statute* 39.01 (2) as "...any willful act or threatened act that results in any physical, mental, or sexual injury or harm that causes or is likely to cause the child's physical, mental, or emotional health to be significantly impaired. Abuse of a child includes acts or omissions..."

## ❖ Neglect

According to Section 39.01(45), *Florida Statutes*, "neglect occurs when a child is deprived of, or is allowed to be deprived of, necessary food, clothing, shelter, or medical treatment or a child is permitted to live in an environment when such deprivation or environment causes the child's physical, mental, or emotional health to be significantly impaired or to be in danger of being significantly impaired"

## ❖ Harm

Chapter 39.01 F.S.

(31) "Harm" to a child's health or welfare can occur when any person:

(a) Inflicts or allows to be inflicted upon the child physical, mental, or emotional injury. In determining whether harm has occurred, the following factors must be considered in evaluating any physical, mental, or emotional injury to a child: the age of the child; any prior history of injuries to the child; the location of the injury on the body of the child; the multiplicity of the injury; and the type of trauma inflicted. Such injury includes, but is not limited to:

1. Willful acts that produce the following specific injuries:
  - a. Sprains, dislocations, or cartilage damage.
  - b. Bone or skull fractures.
  - c. Brain or spinal cord damage.
  - d. Intracranial hemorrhage or injury to other internal organs.
  - e. Asphyxiation, suffocation, or drowning.
  - f. Injury resulting from the use of a deadly weapon.
  - g. Burns or scalding.
  - h. Cuts, lacerations, punctures, or bites.
  - i. Permanent or temporary disfigurement.
  - j. Permanent or temporary loss or impairment of a body part or function.

As used in this subparagraph, the term "willful" refers to the intent to perform an action, not to the intent to achieve a result or to cause an injury.

2. Purposely giving a child poison, alcohol, drugs, or other substances that substantially affects the child's behavior, motor coordination, or judgment or that results in sickness or internal injury. For the purposes of this subparagraph, the term "drugs" means prescription drugs not prescribed for the child or not administered as prescribed, and controlled substances as outlined in Schedule I or Schedule II of s. 893.03.

3. Leaving a child without adult supervision or arrangement appropriate for the child's age or mental or physical condition, so that the child is unable to care for the child's own needs or another's basic needs or is unable to exercise good judgment in responding to any kind of physical or emotional crisis.

4. Inappropriate or excessively harsh disciplinary action that is likely to result in physical injury, mental injury as defined in this section, or emotional injury. The significance of any injury must be evaluated in light of the following factors: the age of the child; any prior history of injuries to the child; the location of the injury on the body of the child; the multiplicity of the injury; and the type of trauma inflicted. Corporal discipline may be considered excessive or abusive when it results in any of the following or other similar injuries:

- a. Sprains, dislocations, or cartilage damage.
- b. Bone or skull fractures.
- c. Brain or spinal cord damage.
- d. Intracranial hemorrhage or injury to other internal organs.
- e. Asphyxiation, suffocation, or drowning.
- f. Injury resulting from the use of a deadly weapon.
- g. Burns or scalding.
- h. Cuts, lacerations, punctures, or bites.
- i. Permanent or temporary disfigurement.
- j. Permanent or temporary loss or impairment of a body part or function.
- k. Significant bruises or welts.

(b) Commits, or allows to be committed, sexual battery, as defined in chapter 794, or lewd or lascivious acts, as defined in chapter 800, against the child.

(c) Allows, encourages, or forces the sexual exploitation of a child, which includes allowing, encouraging, or forcing a child to:

1. Solicit for or engage in prostitution; or
2. Engage in a sexual performance, as defined by chapter 827.

(d) Exploits a child, or allows a child to be exploited, as provided in s. 450.151.

(e) Abandons the child. Within the context of the definition of "harm," the term "abandons the child" means that the parent or legal custodian of a child or, in the absence of a parent or legal custodian, the person responsible for the child's welfare, while being able, makes no provision for the child's support and makes no effort to communicate with the child, which situation is sufficient to evince a willful rejection of parental obligation. If the efforts of the parent or legal custodian or person primarily responsible for the child's welfare to support and communicate with the child are only marginal efforts that do not evince a settled purpose to assume all parental duties, the child may be determined to have been abandoned. The term "abandoned" does not include an abandoned newborn infant as described in s. 383.50.

(f) Neglects the child. Within the context of the definition of "harm," the term "neglects the child" means that the parent or other person responsible for the child's welfare fails to supply the child with adequate food, clothing, shelter, or health care, although financially able to do so or although offered financial or other means to do so. However, a parent or legal custodian who, by reason of the legitimate practice of religious beliefs, does not provide specified medical treatment for a child may not be considered abusive or neglectful for that reason alone, but such an exception does not:

1. Eliminate the requirement that such a case be reported to the department;
2. Prevent the department from investigating such a case; or
3. Preclude a court from ordering, when the health of the child requires it, the provision of medical services by a physician, as defined in this section, or treatment by a duly accredited practitioner who relies solely on spiritual means for healing in accordance with the tenets and practices of a well-recognized church or religious organization.

(g) Exposes a child to a controlled substance or alcohol. Exposure to a controlled substance or alcohol is established by:

1. Use by the mother of a controlled substance or alcohol during pregnancy when the child, at birth, is demonstrably adversely affected by such usage; or
2. Continued chronic and severe use of a controlled substance or alcohol by a parent when the child is demonstrably adversely affected by such usage.

As used in this paragraph, the term "controlled substance" means prescription drugs not prescribed for the parent or not administered as prescribed and controlled substances as outlined in Schedule I or Schedule II of s. 893.03.

(h) Uses mechanical devices, unreasonable restraints, or extended periods of isolation to control a child.

(i) Engages in violent behavior that demonstrates a wanton disregard for the presence of a child and could reasonably result in serious injury to the child.

(j) Negligently fails to protect a child in his or her care from inflicted physical, mental, or sexual injury caused by the acts of another.

(k) Has allowed a child's sibling to die as a result of abuse, abandonment, or neglect.

(l) Makes the child unavailable for the purpose of impeding or avoiding a protective investigation unless the court determines that the parent, legal custodian, or caregiver was fleeing from a situation involving domestic violence.

### ❖ **System**

The organization of agencies, associations and other entities that are responsible for the oversight and implementation of services, resources and laws designed to protect children who are reported to the Florida Abuse Hotline System. (....Judiciary, Law Enforcement,)

### ❖ **Caregiver**

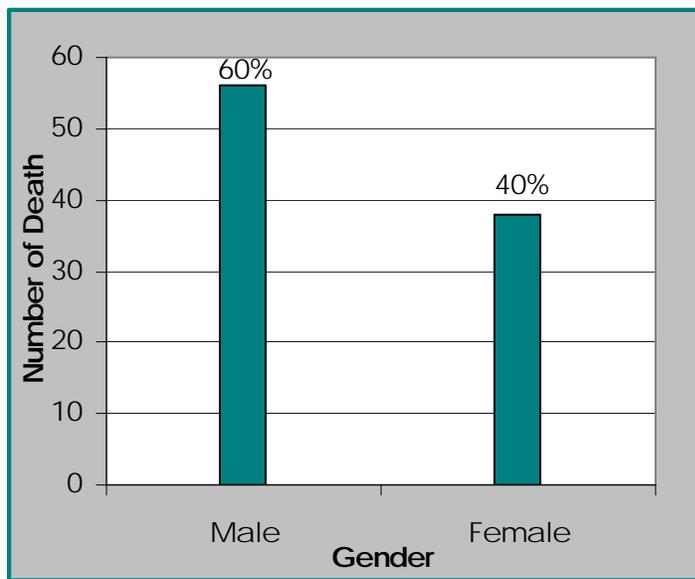
Means the parent, legal custodian, permanent guardian, adult household member or other person responsible for a child's welfare, which included foster parent, and employee of any private school, public or private child day care center, residential home, institution, facility, or agency, or any other person legally responsible for the child's welfare in a residential setting; and also includes an adult sitter or adult relative entrusted with a child's care F.S. 39.01 (10) and (46)

## OVERVIEW

---

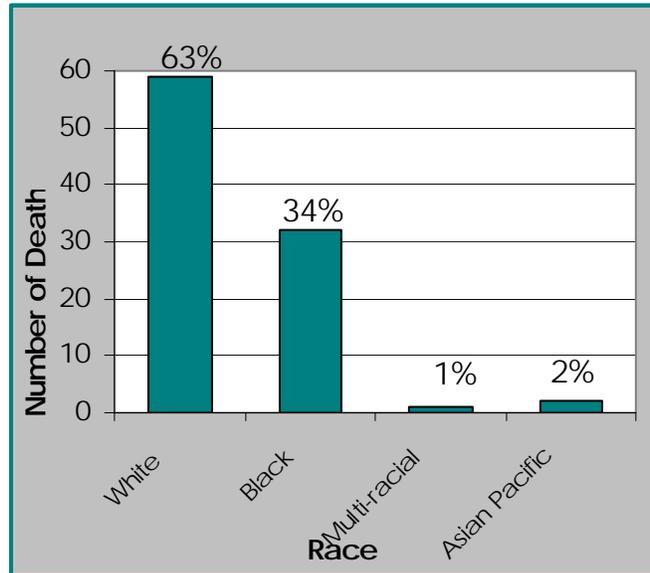
Ninety-four (94) infant/child deaths (under the age of 18) during 2005 met the criteria for review by the Child Abuse Death Review Committee. The following graphs show the total, race-specific and gender-specific child deaths for 2005.

56 (60%) were male  
38 (40%) were female

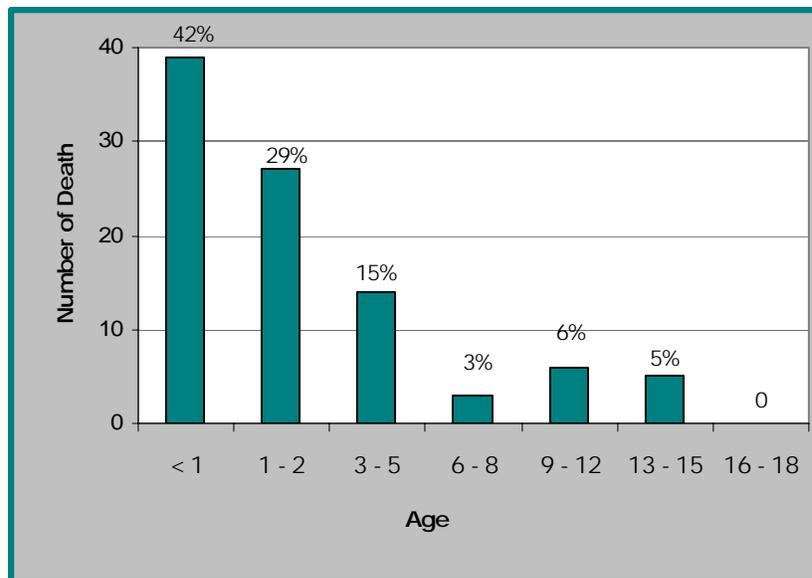


Youngest children experienced the highest rates of fatalities. Infant boys (younger than 1 year) had a fatality rate of 18 deaths per 100,000 boys of the same age. Infant girls (younger than 1 year) had a fatality rate of 17 deaths per 100,000 girls of the same age according to the US Department of Health and Human Services (DHHS), 2004.

59 (63%) were white  
32 (34%) were black  
2 (2%) were Asian Pacific  
1 (1%) was multi-racial



39 (42%) were under the age of one  
27 (29%) were between the age of 1 and 2 years  
14 (15%) were ages 3-5



During 2004, and estimated 1,490 children died in the US (compared to 1,460 children for 2003) from abuse or neglect, at a rate of 2.03 deaths per 100,000 children. (DHHS, Child Maltreatment 2004)

In data from 32 States, 81.0% of children who were killed were younger than 4 years of age. White children accounted for 43.2. % of all child fatalities, African-American children accounted for 27.2% and Hispanic children accounted for 18.6 %. (DHHS Chapter 4- Fatalities, Child Maltreatment 2004)

Research studies of infant death data estimate that the actual rate of infant deaths attributed to abuse or neglect is more than twice as high as the official reported rates. The actual incidence of abuse and neglect is estimated to be three times greater than the number reported to authorities. There is no uniform system for the investigation of infant and child deaths in the State, although this has been a recommendation by the Committee for the last two years. It is essential that there are complete autopsies, thorough investigations to include the circumstances of the death, a review of the child's and family medical history, as well as a review of information from relevant agencies. This was also a recommendation from the American Academy of Pediatrics in November 1999.

**\*Helen  
Bathtub drowning**

The father of this nine-month-old child placed her in the bathtub with the water running. He then lay down to take a nap and fell asleep while the child was left in the bathtub. He slept approximately a half hour and awoke to find the child floating in the bathtub with the water still running. He was charged with aggravated manslaughter.

\*alias

## RISK FACTORS

---

Household risk factors include prior history of child abuse and neglect, child under age of 4, parent's criminal history, parent's use of drugs and/or alcohol, parent's mental health and age, domestic violence and parent's inability to protect the child from harm.

Below are the totals for the risk factors for 2004 and 2005.

Risk Factors in 2004 & 2005 Child Abuse Deaths			
	2004	2005	Total
One or more children in the household age 4 or younger	83	72	155
A pattern or escalating and/or frequency of incidents of abuse or neglect	37	35	72
Parent or caregiver is unable to meet child(rens) immediate needs	42	31	73
Child(ren) in the home have limited community visibility	48	37	85
Parent's or caregiver's age, mental health, alcohol or substance abuse affects ability to parent	42	42	84
Criminal history on any household member	41	39	80
Conditions in the home are hazardous to child's health	25	27	52
Parent or caregiver is unable or unwilling to protect the child(ren)	21	19	40
Other child(ren) in home exhibit behaviors indicative of abuse or neglect	15	14	29
Domestic violence in the home	16	18	34
Parent or caregiver has unrealistic expectations of child(ren)	23	19	42
	393	353	746

**\*Stacy  
Shaken Baby**

Two-month-old child presented at E/R with retinal hemorrhage and subdural hematoma. Father said the child woke up fussy and he tried to give her a bottle. Grandmother later stated the father admitted to shaking the child. Father was charged with murder.

\*alias

## CHILD ABUSE AND NEGLECT DATA

---

The State Committee appreciates the Legislature's and Governor's support to expand the review authority to include all verified child abuse deaths; however, there are still limitations that come with that statutory expansion. In essence, we are still reviewing subsets of larger populations of children who die and this limits the Committee's ability to fully meet the statutory charge of achieving a greater understanding of the causes and contributing factors of deaths resulting from child abuse, because not all deaths meeting that larger scope, (i.e.: some indicators cases) meet the criteria for review. The patterns and trends identified are subsequently limited to the population set reviewed and may or may not have generalizability to larger populations. The essential outcome is to be able to derive meaningful conclusions and provide concrete recommendations that can be implemented in hopes of preventing the child abuse death of additional children.

The following chart provides a better understanding of the current subset of the cases reviewed by The Child Abuse Death Review Team, and how it compares to the overall number of child deaths, as well as compared to the overall number of child abuse and neglect cases received in the state of Florida. (Department of Health Vital Statistics, the Department of Children and Family Services HomeSafenet Information System, Department of Children And Families Quality Assurance Child Death database, and DHHS, Chapter 4 Fatalities, Child Maltreatment 2004.)

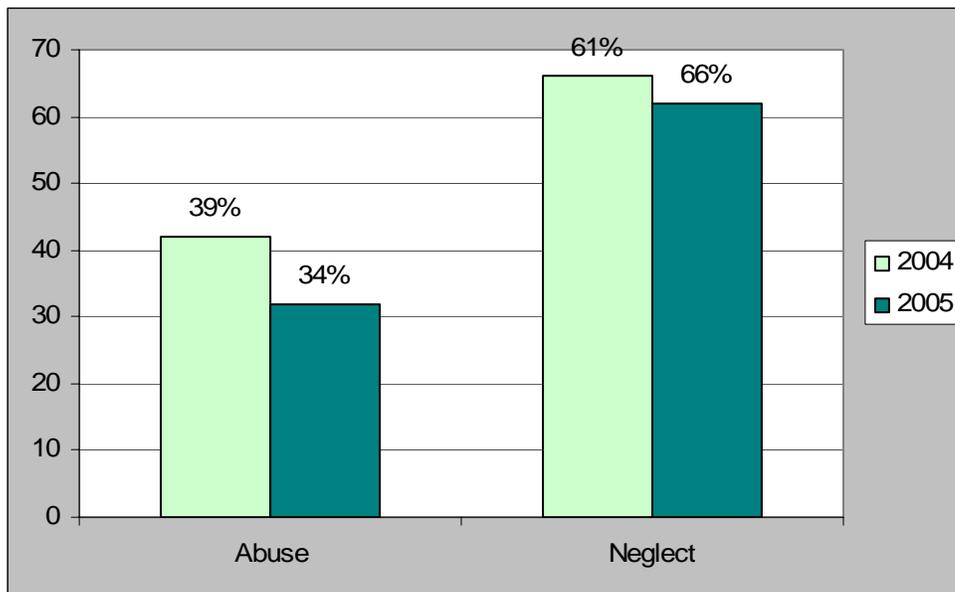
ALL CHILD DEATHS - 2005	
Number of child deaths (1)	2924
Hsn REPORTS RECEIVED & ABUSE/NEGLECT DEATHS	
Number of initial reports	308,010
Number of reports involving child deaths	305
Number of child death's with verified or some indicator findings	146
Number of verified child death reports	97
National estimate for 2004	1,490

\*Three additional death reports are pending review by the Child Abuse Death Review Team. The 2004 death cases were reviewed in 2006 however the data for 2004 has been updated to reflect those 4 deaths

## ABUSE/NEGLECT

---

In 2005 there were 97 child abuse deaths and 94 of those were reviewed. Of those 32, (34%) were from abuse and 62 (66%) were neglect. The graph below compares the two years that the committee has had the opportunity to review all verified deaths.



### **\*Mike Vehicle accident**

Six-year-old child was spending the night with a friend. He was in a car with an adult caregiver. The caregiver had a blood alcohol content of .166. The caregiver had an open case and was under supervision of the Department of Children and Families at the time of the accident. She was arrested and charged with DUI manslaughter.

\*alias

# PRIOR INVOLVEMENT WITH THE DEPARTMENT OF CHILDREN AND FAMILY SERVICES

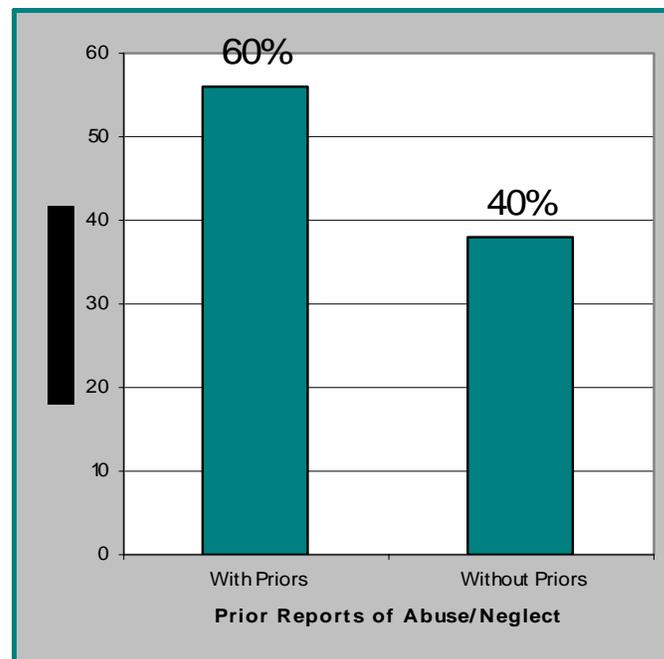
---

## Key Findings

According to the US Department of Health and Human Services, children whose families had received family preservation services in the past 5 years accounted for 12.4% of child fatalities. Nearly 2 percent (1.7%) of the children who died had previously been in foster care and were reunited with their families in the past 5 years. This reporting period cases, which had prior involvement, have significantly increased compared to last year.

There were 56 cases in 2005 in which the child had prior involvement with the Department of children and Families, which is 60%.

Thirty-eight cases did not have any prior involvement with the Department of Children and Families, which is 40%.



# PREVENTABILITY

---

The State Committee is charged with the responsibility to determine, based on the information provided, whether the child's death was preventable; and uses the following categories:

**Definitely preventable:** The information provided demonstrates clearly that steps or actions could have been taken that would have prevented the death from occurring.

**Possibly preventable:** There is insufficient information to determine if the death was preventable.

**Not Preventable:** No current amount of medical, educational, social or technological resources could prevent the death from occurring.

**(Note some cases have more than one finding)**

The findings for preventability are as follows:

- Not Preventable 10 (11%)
- Possibly preventable by the system 9 (10%)
- Possibly preventable by the caregiver 4(4%)
- Definitely preventable by the caregiver 60 (64%)
- Definitely preventable by the system 1 (1%)
- Definitely preventable by the caregiver and system 19 (20%)

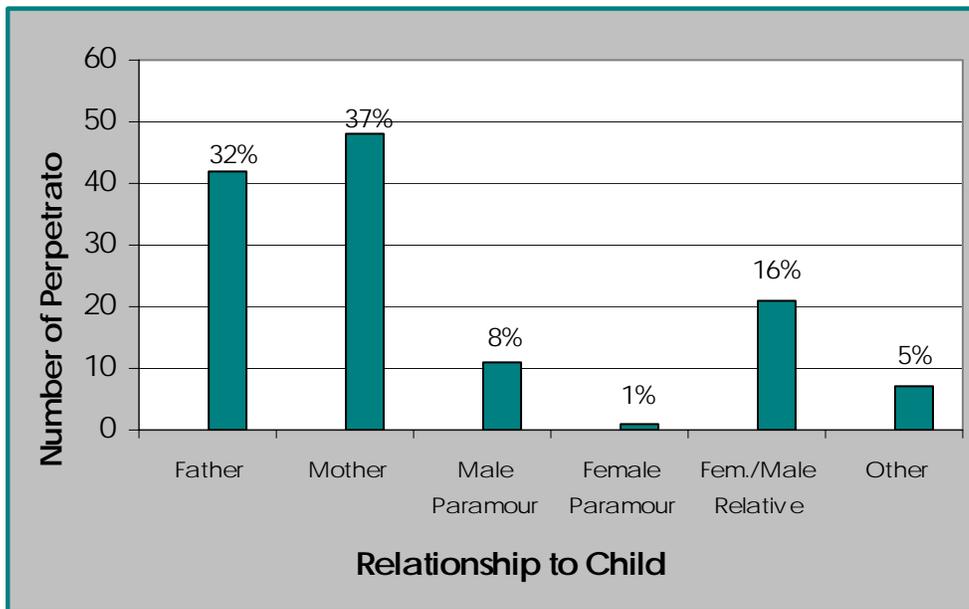
# PERPETRATOR INFORMATION

---

Child protection professionals have identified the relationship of caregivers as one of the factors to consider when evaluating risk. Children in the care of their parent's paramours are generally considered at higher risk.

## Relationship of caregivers to child

- 32% were fathers
- 37% were mothers
- 8% were male paramour
- 16% were relatives
- 1% was female paramour
- 5% were others

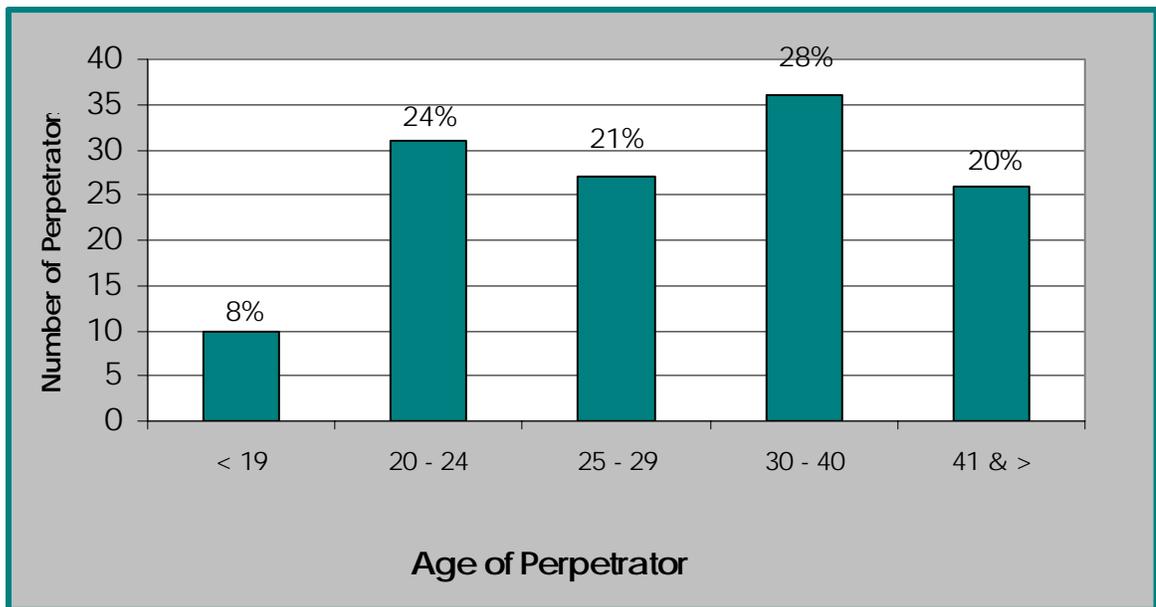


The percentage may not equal to 100 due to the rounding.

## Age of Perpetrator/Caregiver

Frequently the perpetrator is a young adult in their mid-20's without a high school diploma, living at or below the poverty level, depressed and who may experience violence. Fathers and other male caregivers cause most fatalities from physical abuse. Female perpetrators, who were generally biological mothers, were typically younger than male perpetrators. Women also comprised a larger percentage of all perpetrators than men: 58 percent compared to 42 percent. However, in some cases this may be because women are most often responsible or assumed to be responsible for the children's care. (National Clearinghouse on Child Abuse and Neglect Information, 2005).

- 10(8%) were under the age of 19
- 31(24%) were 20-24
- 27(21%) were 25-29
- 36(28%) were 30-40
- 26(20%) were 41 & >



The percentage may not equal to 100 due to the rounding.

## Risk Factors of Perpetrator/Caregiver

Risk factors were identified for both male and female caregivers:

- 4% had a history of mental illness
- 9% were perpetrators of domestic violence
- 8% were victim of domestic violence
- 6% had been a victim of abuse/neglect
- 17% had previously been a perpetrator of abuse/neglect
- 25% had substance and alcohol abuse history
- 23% had criminal history

Perpetrator information by males and females

Perpetrator History						
2005						
	Male		Female		Total	
	#	%	#	%	#	%
Mental Health	6	4%	7	4%	13	4%
Domestic Violence/Perpetrator	21	15%	8	5%	29	9%
Domestic Violence/Victim	5	4%	21	12%	26	8%
Victim of Abuse/Neglect	6	4%	14	8%	20	6%
Prior Perpetrator Abuse/Neglect	18	13%	34	20%	52	17%
Substance/alcohol abuse	35	25%	41	24%	76	25%
Criminal History	35	25%	35	20%	70	23%
Handicaps	4	3%	4	2%	8	3%
None	9	6%	7	4%	16	5%
	139	100%	171	100%	310	100%

**\*Sarah  
Murder/suicide**

Eleven-year-old child and her mother were at home. The father wanted to move back into the home but, when the mother refused to let him, he shot the child, mother and himself. There was a history of domestic violence. The mother had an injunction in place. The father had a history of alcohol abuse.

\*alias

# MANNER OF DEATH

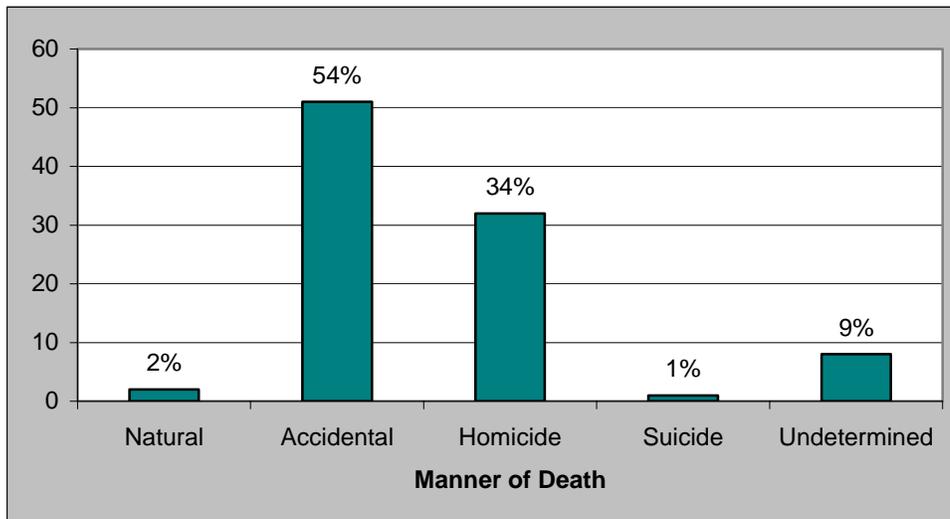
---

For each child death, there is a determination of the manner of death. The manner of death includes five general categories (Accident, Homicide, Suicide, Undetermined and Natural). The determination is made after an autopsy by the medical examiner.

## Key findings

**Of the 94 child abuse deaths reviewed by the State Committee they had the following classifications**

- Thirty two homicides
  - 75% were 5 and under
- One suicide
- Fifty one accidental
- Eight undetermined
- Two natural



# DROWNING

---

Florida has the highest unintentional drowning death rate of toddlers ages 1-4 in the United States in the 5 years between 1999 and 2003. In addition, Florida had the 3<sup>rd</sup> highest overall unintentional drowning death rate of children in the US in the 5 years between 1999 and 2003. (CDC WISQARS).

In Florida drowning is the leading cause of child deaths again this year, as reported in recent years. The vast majority of children who drown are toddlers. Most children drown in swimming pools. From 2002 to 2004, 229 children ages 0-4 drowned. Sixty four percent were in swimming pools. Thirty children age 5-9 drown and thirty-two ages 10-14 drown.

According to Florida's Office of Vital Statistics, 353 persons died due to drowning in 2005. Of those deaths 80 were ages 0-10 and of those 71 were ages 0-4. The Committee reviewed 26 of those children's deaths, which is an increase of four from last year's review.

The State Committee did not have the opportunity to review the deaths of all children who drowned due to inconsistencies in the reporting of child drowning deaths by law enforcement and other first responders, as well as the inconsistencies in the determination of findings by the Department of Children and Families. Often drowning deaths are not reported as neglect. It is felt that "the family has suffered enough", or "it's just a tragic accident." Which is true – the death of any child creates great suffering and they are tragic, but more often they are preventable. The State Committee has never reviewed the drowning death of a child who was being watched.

In cases reviewed by the Committee often there is a lack of thorough death scene investigation by responsible agencies, including not exploring or asking for drug testing when there is a family history of substance abuse and suspicion of substance abuse at the time of the child's death. This results in missed opportunities to establish whether or not substance abuse and neglect contributed to the death.

## Key Findings

- Twenty-six drowning cases were reviewed
- Inadequate supervision was found in all drowning deaths
- Six children drowned in a bathtub
  - All were age one year and younger
  - Four were males and two female
  - Parents were responsible for the supervision

- Seventeen children drowned in a swimming pool (66%)
  - 13 were males and 7 were females
  - Fourteen were between the ages of 1 and 2
  - Three were between the ages of 3-5

All were supposed to be supervised by either parents or a relative with the exception of one who was being supervised by a babysitter.

- Two children drowned in a pond
- One child drowned at a state park

All the deaths were found to be preventable

**\*Ben  
Drowning**

The father was watching the two and an half year old and his sibling. He put on a movie for them and went to sleep. The father has a history of alcohol abuse, has been in drug rehabilitation centers in the past, and did admit to drinking 2 beers that day. The child was found in the pond and it was determined that the fence to the pond was not locked.

# PHYSICAL INJURY

---

Head injury is the leading cause of death among children who have been abused. This has been the second leading cause among Florida child abuse deaths for the last two years.

## Key Findings

- Twenty-two children died as a result of abusive injury
- Fourteen of the children were under the age of one
- Eleven were a result of head trauma
- Nine were under the age of one
- Eight died as a result of multiple trauma
- Three died from abdomen/torso trauma
- Sixteen were males, six were females
- Thirteen were African American and nine were white
- Eleven deaths were caused by the biological father
- Six were from a male paramour
- One from a sibling
- One from a female paramour
- One from a mother
- Three unknown perpetrators
- One child, under the age of one, died from an object (TV) falling on top of them

### **\*Steven Blunt Head Trauma**

Two-month-old child was brought to the E/R with a skull fracture. Both parents denied that anything had happened. The father later confessed to throwing the child on the floor and causing the injuries. He stated he had been frustrated with the child's crying and had slammed him against the floor. He was arrested for 1st degree murder

\*Alias

# SLEEPING ENVIRONMENT-RELATED DEATHS

---

Having a safe sleep environment can be a matter of life and death for an infant. Unsafe sleep environments include a sleep surface not designed for an infant, (i.e. couch, sofa, adult bed, chair), excessive bedding, toys or decorative bumper guards, sleeping with head or face covered, or sharing a sleep surface with multiple persons or with a person who is overly tired, obese, or under the influence drugs or alcohol.

The State Committee has identified this issue as an ongoing problem over the past five years. National statistics point to the need for training and/or education for parents, hospitals, medical examiners, pediatricians and law enforcement investigating these types of deaths.

## Key Findings

- Fourteen children died as a result of an unsafe sleep environment-related death
- Nine were attributed to co-sleeping/overlay
  - Three were from fathers and five from mothers, one from a sibling
- Seven were African American and seven were white
- The age range was from 27 days to four years
- Nine were two months and younger
- Ten of the caregivers were in their 20's

### **\*Candice Co-sleeping**

The mother and child were on a waterbed. The baby had been crying, so the mother fed the child and fell asleep with the child in the waterbed. There was a crib next to the bed. There were illegal drugs used in the home and the mother tested positive for marijuana. There had been prior involvement with the Department of Children and Families.

\*alias

# GUNSHOT RELATED DEATHS

---

Caregivers, family members, or others must ensure that firearms are secured, preferably with gunlocks to prevent them from being accidentally discharged. Florida law already requires individuals to ensure that firearms are secured and kept in locations away from children.

## Key Findings

- Nine children died as a result of gunshot wounds, an increase over three in 2004
- One child died as a result of a suicidal gunshot wound
- Five children were killed by the father/paramour in a murder suicide
  - Of those four perpetrators had a history of domestic violence
- Four children died as a result of accident
  - Of those three involved guns left in an area where the child had access
- All four accidental cases were found to have inadequate supervision of the children
- In five of the cases the caregiver had a prior criminal history

### **\*Jermaine Gun**

The two-year-old child found a gun on the entertainment center. The parents were sleeping. Both parents were aware that the gun was loaded. The gun discharged and killed the child. The father had a criminal history. The father was charged with manslaughter.

\*alias

## VEHICLE-RELATED DEATHS

---

In 2004, 10 children died after being left in vehicles, compared to two in 2005, which is a significant reduction in this type of child death. This reduction may be the result of public awareness campaigns, media attention, and the prosecution of individuals who have left children unattended in vehicles. These efforts must continue to ensure that no young child is left alone in a vehicle for any period of time.

### Key Findings

- Two children died after being left in vehicles
- Both were under one year
- Both were left by males
- Both forgot the child was in the backseat
- One caregiver was charged with manslaughter, and in the other case no charges were filed

### Vehicle Crashes

The State Committee made a recommendation in 2005 that training should be given to Florida Highway Patrol Officers on the mandatory reporting of child abuse. Many crashes were not being reported to the Florida Abuse Hotline. The Florida Highway Patrol has been very responsive and receptive to education of its officers on the reporting requirements set forth in Chapter 39 F.S. The State Committee commends them for their timely and enthusiastic response to the issue.

- Five children died in moving vehicle deaths
- One child drowned in a canal trapped in a car
- Three of the drivers were under the influence of alcohol and or drugs

#### **\*Jacob**

#### **Vehicle accident**

Two-year-old child was in the vehicle. Mom was driving one vehicle and the father in another vehicle. Friends noticed that the mom was impaired and said to the father they could not believe he would let her drive. She had been prescribed medication that included several controlled substances. Mom crashed into a motorcycle. She did admit to smoking crack and marijuana 48 hours before the crash. Toxicology reports showed she had heroin, oxycodone, cocaine and alprazolam in her system. Mom was charged with driving under the influence and serious bodily injury to another in addition to three other traffic offenses. She had a criminal history to include drug related charges, driving with suspended license, drug possession including cocaine and other controlled substances, and burglary.

**\*alias**

# PREMATURE AND DRUG EXPOSED NEWBORNS

---

Nearly three percent of pregnant women use illicit drugs such as marijuana, cocaine, ecstasy, heroin and other amphetamines, according to a 2003 study by the Centers for Disease Control and Prevention. Drug use may pose various risks for these pregnant women and their unborn children. The drugs can cause the woman to go into premature labor and may cause the baby to have developmental delay and adverse health effects during their life. The State Committee is recommending that the Florida Legislature form a special project committee to explore the impact of substance abuse in the home, as well as maternal substance use and its impact on the unborn.

## Key Findings

- There were a total of four newborns born prematurely in combination with being exposed to the mothers' drug use
- The mother's age range was from 27 to 39
- All mothers were white
- All had a history of substance and/or alcohol history
- All had a prior history with Department of Children and Family Services relating to substance abuse

### **\*Eii**

The mother delivered at 23-24 weeks gestation. She was using cocaine and marijuana in a motel when she went into pre-term labor. She delivered the child and wrapped him in a towel and EMS responded to the scene. The mother has had 3 other children removed from her care due to her substance abuse history. The 4th child she delivered had drugs in his system. This child died as a result of drug toxicity.

\*alias

## OTHER TYPES OF DEATHS

---

### CARBON MONOXIDE POISONING & DRUG OVERDOSE

Poisoning refers to the type of poisoning agent that resulted in the child's death. This can be anything from over the counter medicines to cleaning agents commonly found in the home

- Seven children died from carbon monoxide or drug overdoses
- Three were intentional from a parent in a murder/suicide
- One child was given adult cold medicine
- Three children died from drug overdoses
  - The adults had not secured the drugs/ medication

### MEDICAL NEGLIGENCE

- Two children died as a result of medical neglect.
  - A 14 year old child had diabetes and the mother failed to give him his medication
  - One child died shortly after birth when a mother delivered at home and wrapped the child up and put it in a shopping bag.

### HANGING

- One case involved a four year old child who accidentally hung himself with a rope that was being used to hold a door open

### FIRE

- One child died as a result of a grease fire after being left unattended in a mobile home.

# RECOMMENDATIONS FOR 2006

---

## 1. All Child Death Review

Florida's limited review criteria affect the ability of the team to fully accomplish the statutory purposes of their reviews. Approximately 19 states review all child deaths, and of the states that only review sudden, unexpected or unexplained deaths, none require a verified report from the Department of Children and Families. For example, the committee does not review the total number of child drowning or deaths attributed to unsafe sleep environments. Many of these are either not called into the Abuse Hotline or, if they have been reported to the Hotline, the classification issue discussed earlier varies between investigation units. The benefits would include better death investigations at the local levels, enhanced interagency cooperation, improved allocation of limited resources, better epidemiological data on the causes of death, and improved accuracy of death certificates.

**Recommendation: The Florida Legislature should expand the child abuse death review process to include the review of all child deaths.**

## 2. Multi-disciplinary staffing

The State Committee reviewed several cases where families had extensive histories with the Department of Children and Family Services or other service agencies. One family had 18 prior reports. During the course of their history, there were little or no services provided. Some of the priors were verified, others some indications, and other no indications. Based on the information provided, there was no documentation that suggested these cases had a multi-disciplinary staffing, where options, ideas, and concrete recommendations could be discussed, or the case could be red-flagged for review by legal staff, or finally, ensuring that the complete history would be available to the next investigator. Risk to the child was overlooked.

**Recommendation: The Department of Children and Family Services should require a multi-disciplinary staffing when there is a child abuse report and there is any child under the age of five in the home and there have been three or more prior abuse reports, irrespective of the findings of the prior reports.**

## 3. Medical Examiners Commission

Nationally, Forensic Pathologists consider the information on the Sudden Unexplained Infant Death Investigations form critical to the determination of the cause and manner of death with regard to infant death investigations. This form provides a standardized consistent format for information gathering by law enforcement and medical examiner investigators. This year the Committee looked at 13 child deaths that were attributed to infant sleep environments.

**Recommendation: The Medical Examiners' Commission should recommend that all Florida Medical Examiner districts participate in the National MDI Log registry ([www.mdilog.net](http://www.mdilog.net)) for sudden unexplained infant deaths.**

#### **4. First Responders and Law Enforcement**

The State Committee noted on several of the child abuse death investigations that there was an insufficient detailed crime scene investigation and information was inconsistent throughout the state on how infant deaths were investigated. Drug testing and suspicion of drug use were handled differently across the state. Many of these deaths are determined to be “tragic accidents” and “parents have already suffered enough.” The State Committee is not unsympathetic to any family who has lost a child; however these deaths are tragic and virtually always preventable. It is essential that law enforcement conduct thorough, competent death scene investigations that are sympathetic yet complete. Officers and emergency responders must be provided the necessary tools and skills needed to deal with this demanding work.

**Recommendation: Law enforcement agencies and emergency responders should adopt and participate in domestic violence training and advanced training for Sudden Unexplained Infant Death Investigations.**

#### **5. Investigations of Child Deaths**

The committee found that there is no comprehensive or consistent statewide training on child death investigations. The cases reviewed lacked little if any crime scene documentation, drug testing was ignored even when paraphernalia was observed, and not all witnesses were interviewed.

**Recommendation: The Standards and Training Commission should work with sheriffs and local chiefs of police to develop a standardized protocol for investigating child deaths, or at a minimum adopt the SUIDI protocol statewide.**

#### **6. Chapter 39, Florida Statutes**

The Committee has identified a pattern in child abuse deaths where investigative findings indicate that substance abuse by the parent or person responsible for the child was documented in prior reports. For these cases where the investigator convened a meeting with child welfare legal services, the substance abuse allegation does not appear to have been appropriately factored into the risk assessment. Subsequently, cases are either referred to Voluntary Services or no services.

**Recommendation: The Florida Legislature should create a special project, in coordination with Florida’s Drug Endangered Children Alliance, to address the presence of illegal substances in the home and the risk and effects on children. The State Committee recommends that the Legislature amend Chapter 39 F.S. to include a category that classifies the presence of illegal drugs in the home child abuse.**

## 7. Child Welfare Legal Service

The Committee found that in those cases in which there were prior reports to the Department of Children and Families and where Child Welfare Legal Services had determined that there was “insufficient evidence for court action,” it often appeared as though that decision was made without taking the full family history into consideration.

**Recommendation: The Department of Children and Families should look into the process whereby Child Welfare Legal Services and child protective investigators review critical child safety decisions in determining what court action should be taken, and that the family’s full history with the Department of Children and Families should be considered.**

## 8. Healthy Families Florida

There is strong evidence and national research that indicate that home visiting programs are effective in preventing child abuse and neglect. A five-year independent evaluation of Healthy Families Florida, a voluntary home visiting program designed to prevent abuse, found 20 percent less abuse and neglect in families participating in the program than all families in the target service areas.

**Recommendation: The Florida Legislature should support increased funding for Healthy Families Florida, a proven prevention program.**

## 9. Drowning

Florida has the highest unintentional drowning death rate of toddlers ages 1-4 in the United States in the 5 years between 1999 and 2003. In addition, Florida had the 3<sup>rd</sup> highest overall unintentional child drowning death rate in the US in the five years between 1999 and 2003(CDC WISQARS).

In Florida drowning is the leading cause of child deaths again this year, as reported in recent years. The vast majority of children who drown are toddlers. Most occur in swimming pools. From 2002 to 2004, 229 children ages 0-4 drown. Sixty four percent were in swimming pools. Thirty children age 5-9 drown and thirty- two ages 10-14 drown.

According to Florida’s Office of Vital Statistics in 2005, there were 80 drowning cases of children ages 0-10, and of those 71 were ages 0-4. The Committee reviewed 26 of those children’s deaths, which is an increase of four from last years review.

**Recommendation: It is essential that preventative measures be taken to decrease the number of children drowning in Florida. These measures would include, at a minimum:**

- **Emphasis on drowning risk factors in all risk assessments, the Department of Children and Families has begun to implement this in their training curriculum.**
- **Continue public awareness and education on drowning prevention especially targeted at the under-five age group.**

## 10. Domestic Violence

After reviewing the eight murder/suicide cases this year, the Committee found that a previous history of domestic violence had been noted in almost every case. Many times the non-offending caregiver had previously obtained an injunction for protection against domestic violence, which the Department of Children and Families viewed as lowering the risk to the children. However, an injunction alone offers little protection to children if it is violated or dissolved by a caregiver.

**Recommendation:** A case should be considered “high risk” whenever a caregiver has threatened to harm children regardless of whether the non-offending caregiver obtains an injunction for protection. The Department of Children and Families should remain vigilant in monitoring the parties’ behavior and court actions to ensure that the injunction is not violated or dissolved.

## 11. Abusive Head Trauma/Shaken Baby Syndrome

The Kimberlin West Act of 2002 requires that hospitals educate new parents on the dangers of shaking a baby. Crying is the most common trigger for the violent shaking of a child. This committee has also identified crying as a trigger in a majority of the abuse deaths reviewed.

**Recommendation:** The Florida Legislature should consistently fund child abuse prevention education activities such as the Coping with Crying. This education should be targeted at males between the ages of 20-30. Some of the head trauma cases may be potentially related to Shaken Baby Syndrome, however because of the inconsistencies in data collection, it is difficult to determine the exact number of children who died from being shaken.

## 12 Verification of cases

The State Committee found that there were inconsistencies determining whether a death received a verified or some indication finding. The determination seemed to vary by county. This discrepancy directly affects the number of child abuse deaths that are reported to the State Committee and potentially skews the results of these reviews.

**Recommendation:** The Department of Children and Families should review their policies and procedures for determining whether the finding is verified or some indication, and train investigators to ensure consistency throughout the state.

## 13. Unsafe sleep Environment

There has been a nation-wide campaign since 1992, “Back to Sleep”, to educate the public about the importance of placing children on their backs. The National Institute of Child Health and Human Development, the Maternal and Child Health Bureau, the

American Academy of Pediatrics, the SIDS Alliance, and the Association of SIDS and Infant Mortality Programs sponsored this campaign. Although this has reduced such deaths nearly in half, the State Child Abuse Death Review Committee continues to see an ongoing problem where parents make poor choices to co-sleep with infants. This activity clearly presents risks to the infant when the caregiver is obese, under the influence of alcohol or drugs, exhausted, etc. Many of these deaths have been classified as SIDS deaths rather than positional asphyxiation/suffocation.

**Recommendations:**

- **The State committee adopted the recommendations of the American Academy of Pediatrics released on November 5, 2005.**
- **Training on safe sleep practices should be provided to all hospital nurses throughout the state.**

## REFERENCES

---

1. Section 383.402, *Florida Statutes*
2. Section 39.01, *Florida Statutes*
3. U.S. Department of Health and Human Services: Child Maltreatment 2004: Reports from the States National Center on Child Abuse Prevention Research.
4. Florida Department of Children and Family Services: Child Abuse and Neglect Deaths: Calendar Year 2005.
5. Department of Health Vital Statistics Annual Report 2005
6. American Academy of Pediatrics: Policy Statement, The Changing Concept of Sudden Infant Death Syndrome: Diagnostic Coding Shifts, Controversies Regarding the Sleeping Environment, and New Variable to Consider in Reducing Risk. *Pediatrics* Vol. 116 No. 5, November 2005
7. 1999-2003, Centers for Disease Control - Web-based Injury Statistics Query and Reporting System (CDC WISQARS)
8. National Clearinghouse on Child Abuse and Neglect Information, 2005.

## APPENDIX I

---

### **PURPOSE OF CHILD ABUSE DEATH REVIEW COMMITTEE**

#### **Program Background and Description**

The Florida Child Abuse Death Review Committee was established by statute in Chapter 383.402, F. S., in 1999. The program is administered by the Florida Department of Health, and utilizes state and locally developed multi-disciplinary teams to conduct detailed reviews of the facts and circumstances surrounding child abuse and neglect deaths in which a verified report of abuse or neglect was accepted by the Florida Abuse Hotline Information System within the Department of Children and Families (Department of Children and Families). The major purpose of the program is to develop and implement data-driven recommendations for reducing child abuse and neglect deaths.

#### **Mission Statement**

The mission statement of the Child Abuse and Neglect Death Review Program is:  
“To reduce preventable child abuse and neglect deaths”

#### **Goal**

The goal of the child abuse death review committees is to improve our understanding of how and why children die, to demonstrate the need for and to influence policies and programs to improve child health, safety and protection, and to prevent other child deaths.

#### **Achieving Objectives**

- Accurate identification and uniform reporting of the cause and manner of child abuse and neglect deaths
- Improved communication and linkages among agencies and enhanced coordination of efforts
- Improved agency responses in the investigation of child abuse and neglect deaths and the delivery of services
- Design and implementation of cooperative, standardized protocols for the investigation of child abuse and neglect deaths
- Identification of needed changes in legislation, rules, policy and practices, and expanded efforts in child health and safety to prevent child abuse and neglect deaths
- Achieve a greater understanding of the causes and contributing factors of deaths resulting from child abuse and neglect.

## **Membership of the State Committee**

The State Child Abuse Death Review Committee consists of seven agency representatives and eleven appointments from various disciplines related to the health and welfare of children and families. Agency representatives of The State Child Abuse Death Review Committee are appointed for staggered two-year terms, and all are eligible for reappointment. The representative of the Florida Department of Health, appointed by the Secretary of Health, serves as the State Committee Coordinator.

The State Child Abuse Death Review Committee is composed of representatives of the following departments, agencies or organizations:

- Department of Health
- Department of Legal Affairs
- Department of Children and Family Services
- Department of Law Enforcement
- Department of Education
- Florida Prosecuting Attorneys Association
- Florida Medical Examiners Commission, whose representative must be a forensic pathologist

In addition, the Secretary of the Department of Health is responsible for appointing the following members based on recommendations from the Department of Health and affiliated agencies, and for ensuring that the team represents to the greatest possible extent, the regional, gender, and ethnic diversity of the state:

- A board certified pediatrician
- A public health nurse
- A mental health professional who treats children or adolescents
- An employee of the Department of Children and Family Services who supervises family services counselors and who has at least five years of experience in child protective investigations
- A medical director of a child protection team
- A member of a child a domestic violence advocacy organization
- A social worker who has experience in working with victims and caregivers responsible of child abuse
- A person trained as a paraprofessional in patient resources who is employed in a child abuse prevention program
- A law enforcement officer who has at least five years of experience in children's issues
- A representative of the Florida Coalition Against Domestic Violence
- A representative from a private provider of programs on preventing child abuse and neglect

## APPENDIX II

---

### **Membership of the Local Committee**

A local child abuse death review team is not a new official organization. The authority and responsibility of participating agencies does not change. Rather, teams enable various disciplines to come to the same table on a regular basis and pool their expertise to better understand and take action on child abuse deaths in their jurisdictions.

Local review teams should, at a minimum, include representatives from the:

- District medical examiner's office
- Child Protection Team
- County health department
- Department of Children and Families
- State Attorney's office
- Local law enforcement
- School district representative

Other team members may include representatives of specific agencies from the community that provide services, other than mentioned above, to children and families. Local child abuse death review core members may identify appropriate representatives from these agencies to participate on the team. Suggested members include:

- The Department of Children and Families district child death review coordinator
- A board-certified pediatrician or family practice physician
- A public health nurse
- A mental health professional who treats children or adolescents
- A member of a child a domestic violence advocacy organization
- A social worker who has experience in working with victims and perpetrators of child abuse
- A person trained as a paraprofessional in patient resources who is employed in a child
- A representative from an abuse prevention program
- A representative from a domestic violence organization
- A representative from a private provider of programs on preventing child abuse and neglect.
- 

The members of a local team shall be appointed to two-year terms and may be reappointed.

#### Ad Hoc Members

Teams may designate ad hoc members. Because ad hoc members are not permanent, they do not regularly receive team notices. They attend meetings only when they have been directly involved in a case scheduled for review or to provide information on team related activities. Ad hoc members provide valuable information without increasing the number of permanent team members. They may be Department of Children and Families

child protective investigators or family services counselors involved in a specific case, law enforcement officers from a police agency that handled a case, or a child advocate who worked with a family.

## APPENDIX III

---

### Goals and Accomplishments for 2005

#### **Accomplishments:**

Training was provided to over 1,251 professionals on child death investigations as well as key findings from the State Committee, risk factors, and prevention strategies. Professionals included, Law Enforcement, Department of Children and Families, Community Based Care, Child Protection Teams, Federal Probation, Child Advocacy Centers, local child death review committees, Healthy Families and Healthy Start, Medical Examiners' Commission, Florida Highway Patrol, and others.

Provided education and support to the Florida Highway Patrol regarding mandatory reporting on cases where children are killed or seriously injured as a result of the caregivers being under the influence or driving in a reckless manor.

Trained and set up a system with the Department of Children and Families child death review coordinators to assure accuracy of obtaining the verified reports to the local chairperson.

Twenty-two Local Child Abuse Death Review Committees were established.

Reviewed 94 of the 97 child abuse death cases that met the criteria for review.

Created web site for the State Child Abuse Death Review Committee <http://www.flcadr.org/>

#### **GOALS:**

Establish and sanction the remaining rural counties as a local child abuse death review committee

Continue to train professionals on child death investigations as well as prevention efforts

Increase verified child abuse death reporting compliance to 99% for the 2006 deaths from the Department of Children and Families.

Collaborate with relevant organizations and partners to develop a statewide conference on serious child injury and child fatality.

Support the child death investigation guide provided by Florida Department of Law Enforcement, for all law enforcement officers, first responders, and Department of Children and families, and other professionals.

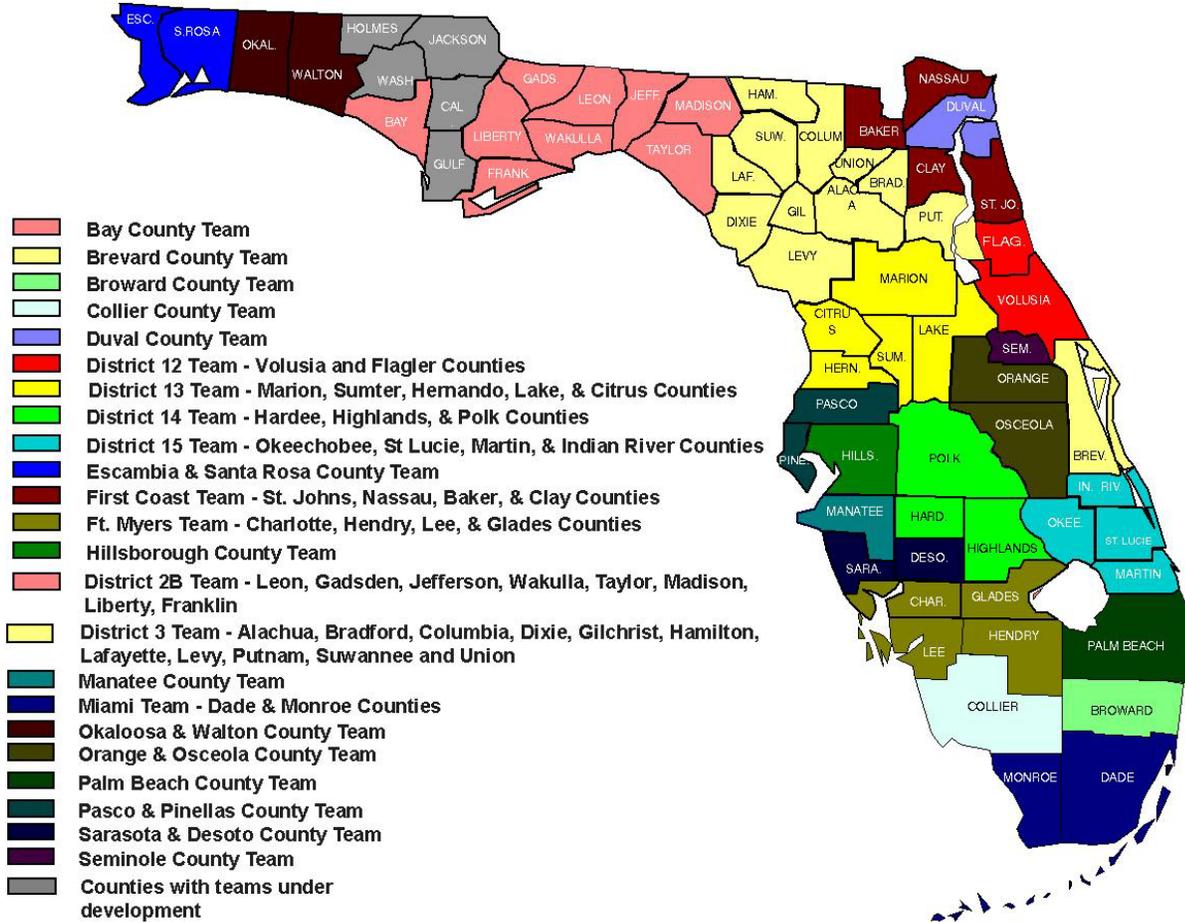
## APPENDIX IV

### Child Abuse Death Review Committee Deaths

The following map, statistical reports, graphs and charts are based on a review of the child abuse and neglect deaths that occurred from 2004-2005. The table below indicates the counties in which the deaths occurred and the number of deaths per county by year.

Number of Deaths by County							
County	Year		Total # of Deaths	County	Year		Total # of Deaths
	2004	2005			2004	2005	
Alachua	1	3	4	Lee	5	4	9
Baker	1	1	2	Leon	2	0	2
Bay	0	1	1	Manatee	1	0	1
Bradford	0	1	1	Marion	4	6	10
Brevard	7	5	12	Orange	5	8	13
Broward	13	9	22	Osceola	1	1	2
Charlotte	2	0	2	Palm Beach	6	6	12
Citrus	4	0	4	Pasco	2	1	3
Clay	1	0	1	Pinellas	2	5	7
Dade	13	5	18	Polk	7	7	14
Duval	16	9	25	Santa Rosa	2	2	4
Escambia	1	0	1	Sarasota	1	1	2
Gadsden	0	1	1	Seminole	0	2	3
Glades	1	0	1	St. John	2	1	3
Hernando	1	2	3	Sumter	0	2	2
Highlands	0	1	1	Suwannee	1	0	1
Hillsborough	2	6	8	Union	0	1	1
Indian River	2	0	2	Volusia	1	2	3
Jackson	1	1	2	Walton	0	2	2

## APPENDIX V



One of the goals for the State Committee was to establish local teams throughout the State. In 2005 the committee was able to sanction twelve additional committees. Two additional committees have been sanctioned in 2006, leaving one rural area consisting of five counties with a team, remaining to be formed. This brings the total of 22 local committees active in the State.

The local Committees did an excellent job of getting the cases reviewed in a timely manor and making valuable recommendations for the State Committee to consider.

## APPENDIX VI

---

### **American Pediatrics Policy Statement**

The National Institute of Child Health and Human Development (NICHD) embraces the [October 2005 American Academy of Pediatrics \(AAP\) Policy Statement](#) on reducing the risk of Sudden Infant Death Syndrome (SIDS). The NICHD is working to incorporate the new risk-reduction messages into all *Back to Sleep* campaign materials.

- The American Academy of Pediatrics has released a new recommendation that babies should be offered pacifiers at bedtime, and they should sleep in their parent's room – but not in their beds- in order to lessen the risk of sudden infant death syndrome.
- It is recommended that pacifier introduction for breastfed infants be delayed until one month of age to ensure that breastfeeding is firmly established
- Infants should be placed for sleep in a supine (wholly on back position) for every sleep.
- Use a firm sleep surface: A firm crib mattress, covered by a sheet, is the recommended sleeping surface.
- Keep soft objects and loose bedding out of the crib: Pillows, quilts, comforters, sheepskins, stuffed toys and objects should be kept out of the infant's bed.
- A separate but proximate sleeping environment such as a separate crib in the parent's bedroom; sharing during sleep is not recommended.
- Consider offering a pacifier at nap time and bedtime.
- Avoid overheating: The infant should be lightly clothed for sleep and the bedroom temperature should be comfortable for a lightly clothed adult.
- Avoid commercial devices marketed to reduce the risk of SIDS - such devices are of no proven value
- Do not use home monitors as a strategy to reduce the risk of SIDS:
- Do not smoke during pregnancy: Also avoiding an infant's exposure to second-hand smoke is advisable to reasons in addition to SIDS risk.
- There is a need for on going training of first responders/law enforcement officers, Department of Children and Families, and any person/agency handling these cases to document specific details of the child's position, where the child was found, and potential substance abuse by the caregiver/parent.<sup>12</sup>

## APPENDIX VII

---

### **History and Overview of the State Child Abuse Death Review Committee**

In 1985 the first Health and Services Rehabilitative Task Force was established to review the death of Corey Greer and subsequent task forces were enacted year after year to evaluate specific child deaths that had been previously known to the Department of Children and Families (formally known as Health and Rehabilitative Services).

In 1998 the tragic death of a child named Kayla McKean, who was brutally murdered by her father, who had been the subject of three prior reports to the Hotline and who was receiving child protection services from a contract agency at the time of her death, outraged the community as well as legislators. This initiated legislative action to mandate the establishment of the State Child Abuse Death Review Committee. Although the original bill proposed included all child deaths, it was adopted by a Senator who saw fit to change the requirement of child death reviews to specifically those children who had a prior report with the Department of Children and Families and a verified death.

In 1999 the Florida Legislature mandated that the Department of Health establish a statewide multidisciplinary, multi-agency child abuse death assessment and prevention system that consisted of state and local review committees.

### **Summary of the Years:**

The first three years, as you will see, are focused on the organization and functionality of the team's ability to review the cases that met the criteria. There was little focus on prevention in the beginning as the team struggled to obtain the necessary documentation as well as determining whose job it was to gather the documents in a timely manner. The team was able to establish guidelines and determine through the years what data needed to be collected. The team did develop a brochure outlining the child abuse death review system and did encourage the development of local teams. The team recommended almost every year the need to establish local teams as well as the importance of providing a liaison to the State Committee as between the State and local committee. In 2002 a shift from the organizational issues went towards prevention recommendations.

There are three themes that the team has consistently recommended through out the annual reports. They are as follows:

- The Florida Legislature should expand the Child Abuse Death Review process to include the review of all child deaths.
- The State Committee should coordinate with professionals to develop guidelines to ensure the thoroughness and integrity of child death investigations as well as facilitate training specific to child death investigations.
- Training should be provided to various professional agencies on mandated reporting of child abuse and neglect.

Listed below are the recommendations of the annual reports, what has been accomplished, what is still to be completed, or what follow up is still needed.

## **Annual Report 2000**

First year there were 29 cases that met the criteria for review. There were five sanctioned local teams.

**Six issues were identified and the following recommendations were made as a result.**

**Issue 1:** Sparse data, quality and timeliness of the Department of Children and Families Death Review Reports.

**Recommendation:** Department of Children and Families should coordinate and if necessary, realign resources on the state and local level in an effort to maximize the time and attention provided to the child death review process and to ensure the quality and timeliness of the child death review process.

A Staff person was assigned to the State Committee case review to assist in the timeliness of the process.

The Department of Children and Families should revise departmental Operating Procedures (OP) to address the quality and timeliness of the district death review report, to require local multidisciplinary staffing for all child abuse death with prior DCF involvement and to better define the roles and responsibilities of the State and local death review coordinators.

The OP was revised October 15, 2001 and again to note it is being revised again in 2005-2006.

**Issue 2:** The low number of local death review teams.

**Recommendation:** The State Committee in collaboration with the Department of Health and Department of Children and Families should consider the facilitation, development and training of local death review teams a priority for calendar years 2000-2001.

There were teams established through out the years, some became inactive or dismantled however in 2005 there were 21 sanctioned local teams and the goal of the State Committee will be to complete the remaining three areas by March 2006.

**Issue 3:** the small number of cases reviewed.

**Recommendation:** The Department of Children and Families should continue to implement the District 7 Child Safety Strike Force recommendations.

According to the Status update in 2001 this was accomplished.

**Issue 4:** The inability to gather data necessary to meet timeliness of the CADR annual report.

**Recommendation:** was that Department of Health should propose a legislative amendment revising the due date of the annual report from September 30 to December 31.

The legislative change was passed and implemented.

**Issue 5:** The quality of the Child Death Investigation.

**Recommendation:** During the next year, the State Child Abuse Death Review Committee should coordinate with local death review teams and relevant professional organizations to develop guidelines to ensure the thoroughness and integrity of child death investigations.

**Recommendation:** The Florida Department of Law Enforcement, in collaboration with the Department of Children and Families, the Medical Examiners Association and The Child Protection Teams, should develop and facilitate training specific to child abuse death investigations.

In 2001 the Status, the training subcommittee was to present to the State Committee a document to distribute as well as train child death investigators. This to date is a recommendation the State Committee has made as to the lack of thorough investigations.

**Issue 6:** The limited focus of the child death review process.

**Recommendation:** The Florida Legislature should expand the Child Abuse Death Review process to include the review of all child deaths.

No Legislation as to all deaths but it was expanded to all verified child abuse deaths in July 2004.

## **Annual Report 2001**

There were 30 children who met the criteria for review. There were six sanctioned local teams.

Six recommendations were made after issues were identified. Note there was an accomplishments and progress section as to the team growth as well as a status of previous year recommendations section.

**Issue 1:** Local teams and other local reviewers lack consistency in their approach to the review and identification of preventable deaths and prevention strategies.

**Recommendation:** The State Committee should clarify the concept of preventability as it relates to child abuse deaths, and provide training and technical assistance to local teams so that determinations made by the local review teams will be accurate and consistent across the state.

This was accomplished in May 2004 when the Quality Assurance Coordinator for the State Child Abuse Death Review position was filled, having the responsibility of establishing local teams, providing technical assistance, gathering the cases for review and assisting in gathering the necessary documents.

**Issue 2:** Drowning occurs most frequently in swimming pools. Among the most significant risk factors are: inadequate supervision of young children, children's inability to swim, alcohol or other substance misuse by supervising caregivers, inadequate pool fencing and easy access to unsupervised areas.

**Recommendation:** The State Committee should evaluate the state requirements related to pools and pool safety and make recommendations for additional safety requirements as indicated. The State Committee, in conjunction with Department of Health and Department of Children and Families should provide drowning prevention educational activities through the media and through training for staff and clients.

In 2004 Healthy Families Florida and Healthy Start programs have checklists that are filled out at home visits. Department of Children and Families required foster families who have a pool to take an approved water safety course and public service announcements have continued through out the state. In 2004 Department of Children and Families was changing the core curriculum that was supposed to emphasize water safety and drowning prevention. The scheduled date was July 2005. Drowning prevention recommendations were made in 2001, 2003, 2004 and 2005 reports.

**Issue 3:** During the course of child death investigations, it is not uncommon for relatives, school officials, neighbors and other witnesses to disclose information known prior to the current report that constituted a reason to suspect abuse or neglect that should have been reported to the hotline.

**Recommendation:** Department of Children and Families should update their information packet for professionally mandated reporters to include identifiable risk factors and indicators of abuse and neglect. They should in conjunction with Child Protection Team facilitate training for local professionals etc. Department of Children and Families should also resume their public service announcements regarding risk factors and reporting requirements.

In the 2002 report, Department Of Health and Department of Children and Families worked together to provide training to Healthy Start and Healthy Families, A workshop was held in May 2003 on child abuse and language was added to the Healthy Start standards and guidelines to address reporting child abuse/neglect and signs and symptoms. There was a continued action to provide this to all in-home service providers. Recommendations in reference to reporting training to various professionals' recommendations have been made from 2001-2005.

**Issue 4:** Stricter guidelines are needed for determining case plans involving serious cases of abuse and neglect. Informal referrals are often made during case closure with no follow up and Voluntary Protective Services (VPS) are sometimes offered in lieu of court action.

**Recommendations:** Department of Children and Families should develop Operating Procedures (OP) with strict guidelines for determining when petitions must be filed in lieu of Voluntary Protective Services. These OP's should require the same evidence collection and

documentation as court cases and establish mandatory time frames for case follow up on all Voluntary Protective Services to ensure that more stringent action can be taken if necessary.

This has been an on-going recommendation from 2001-2005 in one form or another. In 2004 the status was that Department of Children and Families was revising the core training by July 2005 and this was going to address case plans and appropriate referrals to Voluntary Protective Services. There have been memos off and on though out the years addressing what should and should not be Voluntary Protective Services as well as the F. S 39 speaks of high risk. Each district has the discretion to implement tracking high-risk cases. In 2005 this was raised and a recommendation for Department of Children and Families to address.

**Issue 5:** Domestic Violence posing a risk of harm to children often goes unreported to the hotline. Investigative staffs often do not have knowledge of domestic violence to assess the risk and make appropriate services are made.

**Recommendation:** Florida Department of Law Enforcement in conjunction with FCADV should provide training to local law enforcement agencies to ensure they recognize the crossover between domestic violence and child abuse and the requirements for reporting domestic violence to the hotline when threatened harem to a child is suspected. This training should also be provided statewide to all child protective staff and domestic violence service providers.

There have been several trainings offered through out the state to Department of Children and Families and Providers in reference to domestic violence. In the 2004 report it refers to this specific training being addressed with the new core training that was to be developed in 2005. There have been continuous issues raised in the last few years as to Child Welfare Legal Services specifically needing risk to children exposed to domestic violence.

**Issue 6:** The criteria for the cases reviewed should be expanded.

**Recommendation:** The Florida Legislature should expand the child abuse death review process to include the review of all deaths, or at a minimum to include all abuse or neglects in which some indicators of the death maltreatment were found, and at least one prior abuse report was received involving the member of the victim's immediate family or other household member.

No Legislation as to all deaths but it was expanded to all verified deaths in July 1 2004.

## **Annual report 2002**

There were 35 child deaths that met the criteria for review. There were 10 sanctioned local teams covering 18 counties.

Seven recommendations were made after issues were identified. There was no section on the status of the past years recommendations, some were incorporated into this years recommendations.

**Issue 1:** Lack of local teams continues to challenge the State Committee to find adequate means to review the deaths. One of the primary causes for lack of local team development is the strict criterion for cases. Another cause is the lack of connection between the state and local teams. With out a designated liaison, teams often lose interest and momentum.

**Action Taken:** The State Committee previously recommended that the reviews be expanded. This year a letter was sent to the Speaker of the House of Representatives, President of the Senate and the heads of the statutorily designated agencies for the child abuse death reviews providing specific amendment language and requesting support of expansion of the criteria.

**Remaining Action:** Continuation of recruitment efforts should remain a high priority for the State Committee. The Florida Legislature should expand the child death review process to include all abuse or neglects with no requirement for prior reports to the hotline. Local teams should be granted discretionary authority to review all child deaths based on local interest and resources.

No legislation as to all deaths but it was expanded to all verified deaths in July 1 2004.

**Issue 2:** Lack of review consistency in the analysis of preventability and in the adequacy of prior services.

**Action Taken:** A formal case review committee was established and liaisons were identified for each of the local teams.

**Remaining Action:** Further development of the data collection form and guidance is needed to include a requirement for additional information related to risk assessment, prior service adequacy and abuse preventability.

This goal was accomplished and the team's new goal for 2006 is to update the data form to meet the needs of the expanded criteria.

**Issue 3:** Receiving information necessary for adequate review especially on prior service provision and assessing the adequacy of the prior services.

**Action Taken:** Department of Children and Families staff liaison, with the concurrence of the Department's State Committee representative, was made a member of the case review subcommittee and worked directly with the State Committee staff to facilitate early receipt of these records. A standard letter was developed that outlines the information needed from local teams.

**Remaining Action:** Further clarification is needed regarding the responsibilities of the local death review teams and Department of Children and Families coordinators. An interagency memorandum of understanding should be agreed upon and signed by the heads of all agencies represented.

This has been accomplished with the QA Coordinator position filled in May 2004.

**Issue 4:** Failure to report child abuse or neglect to the hotline, and inadequate communication between child protection staff and in-home service providers.

**Action Taken:** Department of Children and Families worked cooperatively during the past year to address these issues. There were several accomplishments regarding working with Healthy Start and Healthy Families in reference to child abuse training.

**Remaining Action:** All in home service providers working with families in their homes providing coordination of care, linkages, referrals and direct services have a mandatory child abuse and neglect training requirement. Stricter penalties should be enacted for professionals identified by statute as mandated reporters who fail to report child abuse and neglect.

In the 2002 report, Department of Health and Department of Children and Families worked together to provide training to Healthy Start and Healthy Families. A workshop was held in May 2003 on child abuse and language was added to the Healthy Start standards and guidelines to address reporting child abuse/neglect and signs and symptoms. There was a continued action to provide this to all in-home service providers.

In 2005 staff from the Statewide Child Abuse and Neglect Death Review Committee (CADR) collaborated with Healthy Families Florida to develop an instructor-led training curriculum on Child Abuse and Neglect prevention strategies and strategies for working with families that have to be reported to the abuse hotline.

Recommendations in reference to reporting training to various professionals have been made from 2001-2005.

**Issue 5:** Failure to report child vehicle restraint neglect or other traffic offense related abuse/neglect.

**Remaining Action:** Florida Department of Law Enforcement in conjunction with Department of Children and Families should provide training to local law enforcement and Florida Highway Patrol (FHP) on recognizing and reporting child abuse and neglect during traffic related incidents.

This issue has come to the team's attention every year. There is a plan for the QA Coordinator and Florida Department of Law Enforcement to meet with FHP to offer this training to their agency in 2006.

**Issue 6:** Children abused in daycare settings.

**Remaining Action:** Department of Children and Families should maintain a list that identifies daycare facilities that have been closed or sanctioned for abuse or neglect related violations.

Department of Children and Families has a web site that the public can view daycare issues.

Jacksonville news has a local report card on 17 health and safety issues that they glean from our reports and then they rank their local child care programs. It is not specific to abuse of children in care.

Department of Children and Families has all child care providers on the Department of Children and Families website and the public can view the inspection reports that will contain all compliance and noncompliance issues. Individuals can go to [www.myflorida.com/childcare](http://www.myflorida.com/childcare) and then select "PROVIDER SEARCH", then enter the county and whatever other search criteria they would like to search by to see the issues. They can also see the voluntary pre-kindergarten profiles. Department of Children and Families will shortly have all administrative actions on-line as well.

**Issue 7:** Deaths caused by unsafe sleep environments.

**Action Taken:** Department of Health and Department of Children and Families worked cooperatively with contracted providers of in home prevention services during the past year to develop an educational brochure on these issues. The brochure is currently in the final stages.

**Remaining Action:** Department of Health in conjunction with the Department of Children and Families should develop and provide safe sleeping educational activities through the media and through training for staff and clients.

A brochure was created by Department of Health in conjunction with Department of Children and Families as well as media activities in the status of 2004. There is still a need for continued education and training to professionals and it is a recommendation in 2005.

## **Annual Report 2003**

There were 29 child death reviews. There were 11 local teams covering 16 counties.

There were seven recommendations made.

**Issue 1:** Not all verified child deaths reviewed.

**Action Needed:** Florida Legislature should expand the child abuse death review process to include the review of all verified abuse or neglect deaths with no requirement of a prior report to Department of Children and Families.

No legislation as to all deaths but it was expanded to all verified deaths in July 1 2004.

**Issue 2:** Drowning Deaths

**Action Taken:** It is essential that preventative measures be taken to decrease the number of children drowning in Florida. They should include emphasis on drowning risk factors in all risk assessments.

Incorporate drowning prevention into checklists and educational material used by home visiting programs.

In 2004 Healthy Families Florida and Healthy Start programs have checklists that are filled out at home visits. Department of Children and Families required foster families who have a

pool to take an approved water safety course and public service announcements have continued through out the state. In 2004 Department of Children and Families was changing the core curriculum that was supposed to emphasize water safety and drowning prevention. The scheduled date was July 2005. Drowning prevention recommendations were made in 2001, 2003, 2004 and 2005 reports.

**Issue 3:** Case Specificity/Case Plans need to be individualized and specific.

Action Needed: The caseworker responsible for the development of a case plan should be encouraged to avoid standard, nonspecific requirements. Sufficient information should be provided to the evaluation psychologist to ensure the development of a case specific evaluation and report.

This has been an on-going recommendation from 2001-2005 in one form or another. In 2004 the status was that Department of Children and Families was revising the core training by July 2005 and this was going to address case plans and appropriate referrals to Voluntary Protective Services. The Department is in the process of revising all current administrative rules including the Protective Investigator rule and "in-home" procedures, which are going to be found in the General Rules, re-write. Additionally, there was a Voluntary Protective Supervision Program Directive written in January 2003 that guides practice in this area that will be reviewed for assimilation into the administrative guidelines as appropriate. The recommendations of the team will also be forwarded to the Department's Quality Management office as well, with the Family Safety Office's recommendation that future monitoring focus more in depth in the area of voluntary supervision practices.

**Issue 4:** Training needs for various professionals and paraprofessional positions, i.e. mandatory reporting, recognizing signs and symptoms of child abuse and neglect, and risk assessment

**Action Needed:**

**LAW ENFORCEMENT:** 911 operators should receive additional training on suicide prevention and intervention. Law enforcement should report to the hotline immediately when a child is injured or dies due to being improperly or not restrained in vehicles. Training on indicators of child abuse and neglect, drug offenses and cases of domestic violence (DV) is needed. The Standards and Training Commission requires specific time frames and curriculum on domestic violence and Child Abuse and Neglect.

**DEPARTMENT OF CHILDREN AND FAMILIES Staff:** Staff to be trained on critical decision making as well as domestic violence. Child Welfare Legal Services and Child Protective Investigators review the process for child safety decision-making and that Child Welfare Legal Service attorneys receive training on the risk to kids in domestic violence situations.

There have been several trainings offered through out the state to Department of Children and Families and Providers in reference to domestic violence. In the 2004 report it refers to this specific training being addressed with the new core training that was to be developed in 2005. There have been continuous issues raised in the last few years as to Child Welfare Legal Service specifically ignoring the risk to children exposed to domestic violence.

**Judiciaries** receive training in domestic violence issues and the concurrent risk to children.

This issue was raised in the last 3 annual reports. The State Committee wrote a letter to the Chief Justice expressing the concerns identified in the case reviews and offered to assist in providing training. The issue of judges rotating in and out of the dependency court has been brought to light, especially in cases where recommendations are made by the Department and the court chooses not to follow them, placing children at risk of harm or death such as the cases the State Committee has reviewed.

**School Personnel** receive training on child abuse and neglect to recognize the signs and symptoms, mandatory reporting as well as the PI process.

The resource book that was sent to all the districts has accomplished this.

**Issue 5:** Facilitation of communication among agencies involved in the child protection system.

**Action Needed:** Department of Children and Families and its community based care providers review and if necessary, revise their policies and procedures regarding their interagency communication. Department of Children and Families should consider Child Protection Team recommendations prior to case closure.

This was recommended in 2003 and 2004, the status in 2005 was a “best practice” regarding interagency collaboration and communication that is being encouraged for statewide replication in the use of the Neighborhood Partnership programs and family team conferencing model for intervention and case management activities. Family conferencing facilitates communication and collaboration by placing key stakeholders (including both investigative and services staff) and the family around the table together when devising a plan to address safety concerns and family needs. This style of intervention fosters partnerships for safety between the family, investigator and service counselor that lead to more positive outcomes for the family and improved networking between and among agency representatives.

**Issue 6:** Accessibility of criminal history.

Action Needed. Department of Children and Families staff be granted access to all criminal histories, both local and national in an expedient and consistent manner statewide and that criminal intelligence analysts be utilized for this function.

Department of Children and Families was allowed access to NCIC for the limited purpose for emergency placement of children taken into custody. Department of Children and Families had analysis employed in every district; however with the zones the positions were reassigned to the hotline to expedite the procedure for the protective investigators.

**Issue 7:** Protective Investigations staff retention.

Action Needed. Legislature and Department of Children and Families support and implement the recommendations of the PI retention work group.

This was accomplished and the recommendations from the group have been initiated.

**Issue 8:** Subsidized child care for children at risk of abuse and neglect.

Action needed: At risk children are prioritized for subsidized childcare.

The Status in 2004 was that Department of Children and Families was able to access subsidized care for some of the children they serve. This was again another recommendation in 2005 as the issue is still of concern to the team. Funding is a source of the problem.

## **Annual Report 2004**

There were 35 children that met the criteria. Eleven teams were in various stages of being sanctioned. Some teams that were sanctioned were inactive or completely dismantled. There were only 11 teams, which included 2 new teams providing data to the State Committee.

There were eight recommendations. There was a section on the status of the prior year's recommendations. With the exception of the confidentiality and prevention recommendations all the other recommendations and responses were the same from 2003.

**Issue 1:** Confidentiality, 383.41 F. S was sunset on 10/2/04. The loss of confidentiality section has significantly impeded the State Committee's ability to carry out its statutory function.

**Action Needed.** Legislature works in partnership with the Governor's office to restore the confidentiality protection necessary for the thorough and unbiased review of all these cases.

Accomplished July 2005

**Issue 2:** Drowning Deaths.

**Action Needed:** Preventative measures need to be taken to decrease the number of children drowning in Florida.

**Issue 3:** Training Needs: Enhancing knowledge and skills of professional and paraprofessionals who work in the discipline of child abuse and neglect is essential as recommended in the 2003 annual report.

**Issue 4: Facilitation of Communication**

**Action Needed**

Recommendation is the same as in the 2003 annual report.

**Issue 5: Subsidized childcare.**

**Action Needed.**

Recommendation: The recommendation is the same as in the 2003 report.

**Issue 6: Voluntary placements -** Some families are allowed to arrange voluntary placement with relatives and or non-relatives without any court involvements. There is no follow up. There is inconsistency as to what cases are appropriate for Voluntary Protective Services.

Action Needed. Department of Children and Families needs to address these deficiencies by either a written policy or a quality assurance procedure, to ensure a reduction of risk and the safety of the children.

**Issue 7: Co-Sleeping/Unsafe environment**

**Action Needed:** Training is need for first responders, law enforcement, Department of Children and Families, medical examiners and others handling these cases in the documentation of specific details of the sleeping environment to include infant's initial position found at the time of death, bed etc and the parent's potential substance abuse.

Continue community awareness efforts on safe sleeping and the risk and dangers of sleeping with their child.

Home visitors in Healthy Families Florida continue to educate parents on the risks associated with co-sleeping and unsafe sleeping as a part of their home visiting curriculum.

**Issue 8: Child abuse and neglect prevention efforts.**

Action Needed. The Department of Children and Families will participate in the development of statewide child abuse prevention task force in the oversight of the development and implementation of statewide and local child abuse prevention efforts.

Department of Children and Families will contract for a statewide display of roadside billboards dedicated to the message that a baby should never be shaken.

The Florida legislature is encouraged to provide funding to supplement the Federal Child Abuse and Prevention funds that the state currently receives.

The State Committee encourages the Florida Pediatric Society and the Florida Medical Examiners Commission to develop and issue position papers on the prevention of Shaken Baby Syndrome and deaths resulting from unsafe sleeping and co-sleeping.

A reduction in Florida's per capita child abuse rate is a key indicator in both on the Secretary's Performance Dashboard measures and the focus of the Inter-Agency Prevention Task Force which is currently reviewing all district prevention implementation

plans for consistency with Florida's Five-Year State Plan for the Prevention of Child Abuse, Abandonment, and Neglect.

Additionally, the Department currently has a major initiative underway that supports best-case practice in this area. The eleven (11) Neighborhood Partnership project sites are established in local neighborhoods and combine prevention activities, such as community development and education, with the use of Family Team Conferencing as the primary case management response to addressing family needs. The goal is to prevent abuse before a report has to be made to the abuse hotline. In several sites Neighborhood Partnership staff is co-located with protective investigators and community-based care case management staff to help engage families at the earliest point possible in the helping continuum.

### Healthy Families Staff

Staff from the Statewide Child Abuse Death Review Committee (CADR) collaborated with Healthy Families Florida to develop an instructor-led training curriculum on child abuse and neglect prevention strategies and strategies for working with families that have been reported to the abuse hotline. CADR staff also provided train-the-trainer programs so that Healthy Families trainers could provide training to Healthy Families project staff. The training allows participants to engage in role-playing, share challenges and experiences, and brainstorm prevention strategies to be used with families. The training includes an overview of mandated reporting and focuses on educational areas that may be addressed with families to prevent child abuse and neglect. Prevention topics include: infant safe sleep practices, appropriate supervision of children, safety planning for families involved in domestic violence and drowning prevention and home safety.

## **Annual Report 2005**

### **Issue 1: Public Awareness Prevention Education:**

The State Committee identified the need for public awareness education as a common theme throughout the 108 reviews completed for 2004 child deaths that could be prevented.

Out of the 108 cases it was determined that 94 (87%) could have been prevented. Those areas included:

#### **A. Drowning**

##### **Action/Recommendation:**

Since 2001, the State Committee has made the recommendation for education, training and pool safety equipment.

Emphasis on training for risk factors in all risk assessments which identified pool safety, bodies of water etc. which the Department and Community Based Care providers.

- Emphasize to parents and caregivers that they should never leave a child unsupervised in or around water in the home or outdoors, even for a moment.
- Enact and enforce pool fencing ordinances as well as multiple layers of protection around pools.

## **B. Co-Sleeping and unsafe sleeping**

### **Action Needed/Recommendations:**

The State Committee adopted the recommendations of the American Academy of Pediatrics released on November 5, 2005.

It is recommended that training on safe sleep practices be provided to all hospital nurses throughout the state.

Training should be provided to law enforcement and medical examiners on death scene investigations to assure that the necessary information is collected regarding the circumstances of the infant's death.

The State Committee recommends that the Medical Examiners' Commission and the Florida Association of Medical Examiners establish and publish a position for the uniform certification of cause and manner of death in cases of SIDS, co-sleeping, positional asphyxia and other deaths potentially related to unsafe sleeping conditions.

## **C. Kids and Cars**

### **Actions/ Recommendations:**

The State Committee supports Senator Hillary Clinton's bill, the Cameron Gulbranson Kids and Cars Safety Act of 2005. The State Committee recommends that Public Service Announcement's around the State be initiated and that the legislation fund the resources.

## **D. "Safe Haven for Newborns"**

### **Action/Recommendation:**

The State Committee recommends to Department of Health that there be public awareness campaigns on the "Safe Haven" through out the State and that the legislature fund this project.

## **Issue 2: Shaken Baby Prevention Initiatives**

### **Action/Recommendation**

The State Committee recommends that "Coping with Crying" education be implemented statewide.

### **Issue 3: Training and education to professionals on Child Abuse and Neglect**

#### **Law Enforcement -**

##### **Action/Recommendation:**

The State Committee recommends that Florida Department Law Enforcement in conjunction with the State Committee Coordinator provide training to local law enforcement agencies and Florida Highway Patrol on recognizing and reporting child neglect and abuse during traffic related incidents.

#### **Judicial -**

##### **Action/Recommendation:**

The State Committee recommends that the judicial branch continue to further expand the unified family court model to enable judges to gain a fuller expertise on safety issues for children that are present and equally important to judicial decision-making regardless of the type of docket that comes before the court. It is recommended that the judicial education offerings coordinated through the Office of the State Courts administrator invite opportunities for experts from the statewide task force to develop workshops and other instructional materials that illustrate the benefits of the unified family court as a child safety issue. The State Committee recommends that the judges receive training from certified Florida Coalition Against Domestic Violence (FCAD V) domestic violence shelters or centers.

#### **Department of Children and Families -**

##### **Action Recommendation:**

It is recommended that the Department conduct an analysis of its current safety and risk assessment processes, from the investigative response through service intervention. The analysis should focus on the identification of safety threats and related ongoing risk determination, leading to the identification of services and interventions needed to improve parental protective capacities, as well as to ameliorate the causative factors present. This analysis should also identify the report/case tracking needs to ensure appropriate oversight of these high-risk reports/cases, including ongoing reviews to determine case progress.

**Issue 4: State Committee supports the American Academy of Pediatrics finding that home visiting is a successful approach to preventing child abuse:**

**Actions/Recommendations:**

The State Committee recommends taking home visiting programs with proven results, such as Healthy Families Florida, to scale so that it is available to all families at risk of child abuse and neglect, and that the legislator fund the program.

**Issue 5: Child Death Investigations and Crime Scenes**

The State Committee reviewed several cases where there was a lack of crime scene investigations. Typically the child deaths were called tragic accidents and no crime scene was conducted. The State Committee recognizes the need for shared information and coordinated investigations, and thorough crime scene documentation. Out of the 108 cases reviewed, eleven cases specifically addressed the lack of adequate crime scene investigation.

**Action/Recommendation:**

The State Committee proposes to provide to medical examiners, law enforcement agencies, State Attorneys, Child Protection Investigators, training in the necessity for a multi-agency and multidisciplinary approach to the investigation of child death cases. The State Committee recommends that Florida Department of Law Enforcement and Law Enforcement Training and Standards include training that specifically addresses child death scene investigations.

**Issue 6: The State Committee recommends that Florida Statutes be amended to provide for the review of all child deaths.**

According to the National Center for Child Death Review, Child Death Review is mandated or enabled by law in 39 states. Forty-Eight states review deaths through at least age 17, and one state to age 15 and two states up to age 24. Five States review only maltreatments and half the states review deaths to all causes. Florida's criteria for child abuse and neglect death review are significantly more restrictive than any other state in the nation.

**Action/Recommendation:**

The Florida Legislature should expand the child abuse death review process to include the review of all child deaths.

**Issue 7: Department of Children and Families staff support for the State Child Abuse Death Review Committee**

**Action/Recommendation:**

Department of Children and Families Secretary Hadi replied to the Committee and indicated that she had assigned the responsibilities for support to a new Quality Management Unit. She committed to supporting the Team's work; including

establishing protocols for the Department of Children and Families regional death review coordinators to ensure the provision of necessary documents to the local CADR teams as well as requests from the State Committee.

# STATE CHILD ABUSE REVIEW COMMITTEE

---

## **Robert W. Hodges, J.D., Chairperson**

**Assistant State Attorney, 5<sup>th</sup> Circuit**

**Representing: Florida Prosecuting Attorney's Association**

Michael L. Haney, Ph.D., NCC, LMHC  
State Child Abuse Death Review Coordinator  
Division Director, Children's Medical Services  
Representing: Department of Health

Randy Alexander, M.D.  
Statewide Medical Director  
Child Protection Team  
Representing: Board-Certified Pediatricians

Bill Navas  
Office of the Attorney General  
Representing: Department of Legal Affairs

Kris Emden  
Department of Children and Family Services  
Representing: Family Services Supervisors

Pat Badland  
Director, Office of Family Safety  
Representing: Department of Children and Family Services

Bethany Mohr, M.D.  
Child Protection Team Medical Director  
Representing: Child Protection Team Medical Directors

Terry Thomas  
Special Agent  
Representing: Florida Department of Law Enforcement

Carol M. McNally  
Healthy Families Florida- Executive Director  
Representing: Child Advocacy Organizations

Michele Polland  
Educational Policy Analysis  
Representing: Department of Education

Major Connie Shingledecker  
Commander – Manatee County  
Representing: Law Enforcement

Wanda G. Philyor  
Healthy Families Temple Terrace

Miriam Firpo-Jimenez, Ed.S., LMHC  
Children's Services Administration  
Representing: Mental Health Professional

Representing: Paraprofessional

Judith Cobb, R.N., M.S.P.H.  
Palm Beach County Health Department  
Representing: Public Health Nurse

Janet Goree  
Shaken Baby Alliance  
Representing: Child Abuse Prevention Program

Barbara Wolf, M.D.  
District 21-Medical Examiner  
Representing: Florida Medical Examiners Commission

## **STAFF**

Johana Hatcher  
Quality Mgmt. Unit Director  
Department of Children and Family Services

Stephenie Gordy  
Staff Assistant  
Division of Prevention and Intervention  
Department of Health

Michelle Akins  
QA Coordinator State Child Abuse Death Team  
Child Protection Unit/Children's Medical Services  
Department of Health

Mia Filmore  
Staff Assistant  
Child Protection Unit/Children's Medical Services  
Department of Health

## **COMMITTEES**

### **TRAINING COMMITTEE**

Terry Thomas, Chairperson  
Michael Haney, Ph.D.  
Janet Goree  
Barbara Wolf, M.D.  
Miriam Firpo-Jimenez, Ed.S  
Connie Shingledecker

### **PROTOCOL AND GUIDELINES COMMITTEE**

Michael Haney, Ph.D., Chairperson  
Randy Alexander, M.D.  
Robert Hodges, J.D.

### **REPORT COMMITTEE**

Robert Hodges, J.D., Chairperson  
Connie Shingledecker  
Carol McNally  
Janet Goree  
Pat Badland  
Miriam Firpo-Jimenez, Ed.S.