

EXECUTIVE SUMMARY
ANNUAL REPORT
DECEMBER 2020

# CHILD ABUSE DEATH REVIEW MISSION:

# To eliminate preventable child abuse and neglect deaths

The 2020 Annual Report is dedicated to the memory of all the children who lost their lives in our state in 2019.

This Executive Summary is an excerpt from the original 2020 Annual Report which can be found in its entirety here: www.FLCADR.com

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

#### Submitted to:

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

# **EXECUTIVE SUMMARY**

## Florida's Child Abuse Death Review System

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

### 2019 Data: Case Review Analysis

Throughout 2020, Local CADR Committees reviewed records related to 250 child fatalities which occurred in 2019. Analysis of the 2019 case review data revealed that regardless of maltreatment verification status, children under the age of five have the highest number of child deaths called to the Florida Abuse Hotline. The three leading causes of child death in 2019 CADR cases are:

- Sleep-related Infant Death is the leading cause of preventable child death in Florida and is often the result of unsafe sleep practices. Sleep-related infant deaths represent 39.2% of 2019 child fatalities reviewed by the CADR system. Children placed to sleep on adult beds, couches and other soft surfaces are at significant risk of suffocation. An infant sharing a sleep surface with another child or an adult also poses a risk for sleep-related death.
- Drowning is the second leading cause of preventable child death, representing 16.8% of all reviewed child death cases. Children three years of age and younger make up 71.4% of all 2019 drowning related fatalities reviewed by the CADR system. According to the American Academy of Pediatrics, nearly 70% of child drowning occurs during nonswimming activities. Ineffective barriers of protection and failure to provide sufficient supervision to young children continue to be primary contributing factors.
- Inflicted Trauma is the third most frequent cause of preventable child death, representing 8% of child fatalities reviewed by the CADR system. Children under one year of age account for 35% of these child fatalities. Inflicted trauma includes abuse to a child by way of bodily force, such as the use of fists, hands and feet or by the use of weapons and firearms.

#### **Child Characteristics**

Of cases reviewed by the CADR system, children under the age of five account for 85.2% of preventable child death. The most vulnerable children are less than one year of age, representing 55.6% of cases reviewed. Children under the age of five, and to a greater extent, children under the age of one, are in need of developmentally appropriate supervision, care and support to ensure their safety.

### **Prevention Recommendations:**

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

- Continue efforts to relay timely information to caregivers regarding the safety of children.
- Develop strategies to ensure consistent and coordinated prevention-related messaging across local and state agencies.
- Expand efforts to collect data related to co-occurring substance abuse and mental health disorders.
- Explore efforts to collect data related to near fatalities in cases of near-drowning, near-fatal incidents of inflicted trauma and near-fatal sleep-related asphyxia.
- Increase messaging around appropriate supervision and barriers of protection as primary factors in drowning prevention, in addition to establishing age appropriate expectations related to young children and swimming capabilities consistent with recommendations of the American Academy of Pediatrics.
- Continue to support programs and practices that enhance parenting skills and coordinate services provided to expectant mothers and partners.
- Encourage the consistent use of Sudden Unexpected Infant Death Reporting Forms and doll reenactments by death scene investigators for all sleep-related infant death investigations.
- Continue to support and encourage the development and evaluation of pilot projects and initiatives focused on local and regional community-based child fatality prevention.
- Explore the expansion of the CADR Florida Statutes language to permit Local CADR Committees the ability to review child and adolescent suicides to better inform targeted prevention initiatives.