Child Abuse Death Review Committee

Working to eliminate preventable child abuse and neglect deaths in Florida

Annual Report

December 2022

CHILD ABUSE DEATH REVIEW MISSION:

To eliminate preventable child abuse and neglect deaths

This Annual Report is dedicated to the memory
of all the children who lost their lives in our state in 2021.

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 Kathleen Passidomo, President, Florida Senate
The Honorable Paul Renner, Speaker, Florida House of Representatives

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EXECUTIVE SUMMARY

Florida's Child Abuse Death Review System

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

2021 Data: Case Review Analysis

Throughout 2022, Local CADR Committees reviewed records related to 216 child fatalities which occurred in 2021. Analysis of the 2021 child fatality case review data revealed that regardless of Department of Children and Families (DCF) maltreatment classification, children under the age of five have the highest number of child deaths called into the Florida Abuse Hotline and continue to be at the greatest risk of preventable child death. The three leading causes of preventable child death in 2021, identified through CADR case reviews and subsequent analysis, are listed below in order of greatest to least incidence.

- **Sleep-related Infant Death** is the leading cause of preventable child death in Florida and is often the result of unsafe sleep practices. Sleep-related infant deaths represent 34.3% of 2021 child fatalities reviewed by the CADR System. Of this total, infants four months of age and younger constitute 71.6% of all 2021 sleep-related fatalities. Infants placed to sleep on adult beds, couches, and other soft surfaces, as well as an infant sharing a sleep surface with another child and/or adult, are at significant risk of suffocation and sleep-related death.

- **Drowning** is the second leading cause of preventable child death, representing 33.8% of all child fatalities reviewed by the CADR System. Children four years of age and younger make up 86.3% of all 2021 drowning related fatalities reviewed by the CADR System. According to the American Academy of Pediatrics (2021), nearly 70% of child drowning occurs during unexpected, unsupervised access to bodies of water, which includes children younger than five who were not expected to be at or in a pool at the time of the drowning incident. Ineffective physical barriers and inadequate supervision continue to be primary contributing factors for drowning incidents in young children. Inadequate supervision can include caregivers who are present but distracted, as well as caregivers who are not within visible and audible range when a child is in or near water.

- **Inflicted Trauma** is the third most frequent cause of preventable child death, representing 5.1% of child fatalities reviewed by the CADR System. Children five years of age and younger represented 63.6% of these fatalities, whereas the remaining inflicted trauma incidents were found in children 11–15 years of age (18.2%) and 16 years of age or older (18.2%). Inflicted trauma includes abuse to a child by way of bodily force, such as the use of hands, fists, and feet, or by the use of firearms and other weapons.

Child Characteristics

Children five years of age and younger account for 90.3% of preventable child death cases reviewed by the CADR System. The most vulnerable children are less than one year of age, representing 47.7% of cases reviewed. Children under the age of five, and to a greater extent, children under the age of one are in critical need of developmentally appropriate supervision, care, and support to ensure their safety.

Data Sample Limitation

Judicial circuits continue to experience a significant backlog of cases due to the temporary delay in court proceedings, impacting data made available for CADR, specifically cases of inflicted trauma and child homicide.

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 (complete details of these recommendations are in Section Seven):

- Continue efforts to relay timely information to caregivers and community supports regarding the safety of children.
- Continue to develop strategies to ensure consistent and coordinated prevention-related messaging across local and state agencies, business and industry leaders, and other relevant private and public sector groups.
- Expand efforts to collect data related to co-occurring substance abuse and mental health disorders in caregivers.
- Analyze efforts to improve data collection and assessment of factors contributing to preventable child fatalities which are currently underrepresented in CADR data.
- Continue to support the development and dissemination of messaging around appropriate supervision and barriers of protection as primary factors in drowning prevention, as well as establish age-appropriate expectations and swimming capabilities for young children, that are consistent with recommendations from the American Academy of Pediatrics (AAP).
- Effectively advocate for strengthened partnerships and collaborations between state agencies to ensure families are referred to evidence-based parent coaching and support programs.
- Advocate for statewide training of first responders on the consistent use of Sudden Unexpected Infant Death Investigation Reporting Forms (SUIDIRF) and doll reenactments by death scene investigators for all sleep-related infant deaths and explore opportunities to mandate statewide use of the form.

- Continue to support and encourage the development and evaluation of pilot projects and initiatives focused on community-based child fatality prevention.
- Explore collaborative partnerships with entities which may be currently examining child and adolescent suicide to better inform targeted prevention initiatives.