Florida Child Abuse Death Review

ANNUAL REPORT

DECEMBER 2025

CHILD ABUSE DEATH REVIEW MISSION:

To eliminate preventable child abuse and neglect deaths

This annual report is dedicated to the memory of every child who lost their life in our state. Their stories remain at the heart of our work.

The information contained herein can be used to help prevent future harm to Florida's children.

Submitted to:

The Honorable Ron DeSantis, Governor, State of Florida
The Honorable Ben Albritton, President, Florida Senate
The Honorable Daniel Perez, 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, 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 goal of the CADR System is to work 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.

2023 Data: Case Review Analysis

In 2024, local CADR committees reviewed 390 child fatalities that occurred in 2023. Analysis of the case review data revealed that children under 5 years of age have the highest number of child deaths reported to the Florida Department of Children and Families' (DCF) Florida Abuse Hotline and continue to be at the greatest risk for preventable child death. The three leading causes of preventable child death in 2023 remain the same as the previous year's report and are listed below in order of greatest to least incidence.

1. **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 deaths represent 34.1% of 2023 child fatalities reviewed by the CADR System. Infants 4 months of age and younger constitute 78.2% of all 2023 sleep-related fatalities. Infants placed to sleep on adult beds, couches, and other soft surfaces, as well as infants sharing a sleep surface with another child or adult, are at significant risk of suffocation and sleep-related death.

2. **Unintentional Drowning** is the second leading cause of preventable child death, representing 21.3% of all child fatalities reviewed by the CADR System. Children 3 years of age and younger make up 69.3% of all 2023 drowning-related fatalities reviewed by the CADR System. Ineffective physical barriers and inadequate supervision continue to be primary contributing factors to drowning incidents in young children. Inadequate supervision can include caregivers who are present but distracted and caregivers who are not within visible or audible range when a child is in or near water.

3. **Inflicted Trauma** is the third leading cause of preventable child death, representing 8.5% of child fatalities reviewed by the CADR System. Children 11 years of age and older now represent the largest proportion of inflicted trauma fatalities (45.5%), followed by children 5 years of age and younger (42.4%) and those 6-10 years of age (12.1%). Inflicted trauma includes suicide and abuse to a child by bodily force, such as the use of hands, fists, and feet, or use of firearms and other weapons.

Prevention Recommendations

The following prevention recommendations developed by the Florida CADR Committee provide an overview of strategies and approaches intended to address preventable child fatalities in the state (complete details of these recommendations are in Section Four):

- Continue to promote evidence-based drowning prevention strategies through the implementation and dissemination of statewide guidelines and best practices
- Continue to promote and educate the public on the importance of safe sleep practices for infants through the ongoing implementation and evaluation of data-driven programs and initiatives
- Continue to ensure all local CADR committees consistently report hazardous consumer products to the U.S. Consumer Product Safety Commission (CPSC), in alignment with CPSC's reporting requirements
- Continue to assess and adapt approaches to suicide prevention and postvention through community and state-level partnerships
- Continue efforts to relay timely information to caregivers and community supports regarding the safety of children

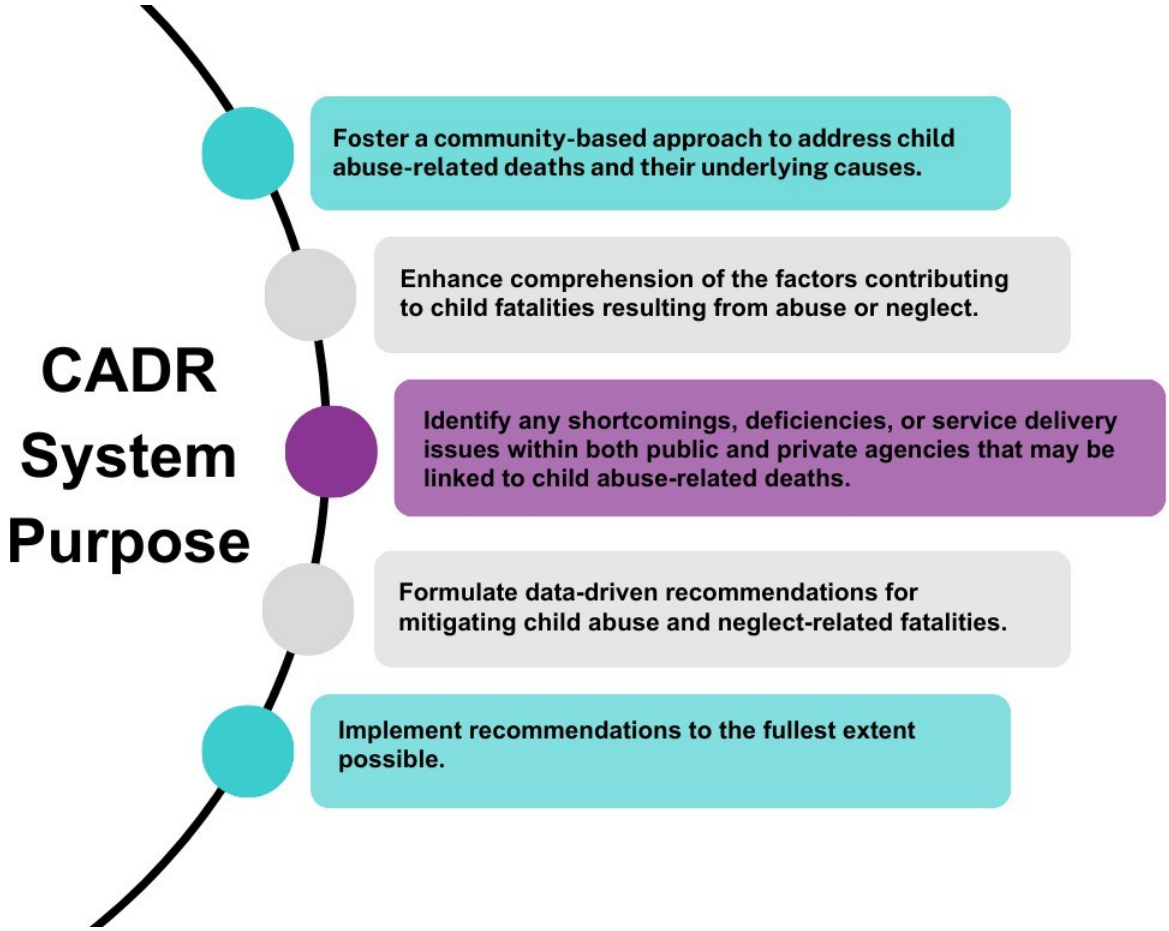
SECTION ONE: 2024 CADR BACKGROUND

System Description

The Florida Department of Health (Department), Division of Children's Medical Services, Bureau of Child Protection and Special Technologies, CADR Unit, administers this system, which utilizes local CADR committees to conduct comprehensive evaluations of the circumstances surrounding child fatalities reported to DCF's Florida Abuse Hotline and accepted for investigation. These committees employ a public health approach to examine child fatality cases with reported suspicions of abuse or neglect. Subsequently, the Florida CADR Committee aggregates and analyzes data from these local reviews to produce an annual statistical report.

Statutory Authority

The CADR System operates under the legal framework of section 383.402, F.S., as detailed in Appendix A.



Florida CADR Committee

The Florida CADR Committee oversees the activities of local CADR committees and engages in a comprehensive analysis of statewide data. This analysis informs evaluations of the adequacy of existing laws, rules, training programs, and services. Recommendations for necessary changes are developed to reduce the incidence of child abuse-related deaths. Strategies are devised, and partnerships are forged at both the state and local levels to implement these changes.

The Florida CADR Committee comprises seven agency-specific representatives appointed by the respective agency heads and 12 representatives appointed by the Department's State Surgeon General. These 12 members represent various disciplines dedicated to the well-being of children and families. Members of the CADR Committee, as outlined in Appendix B, serve staggered two-year terms. Reappointment is permitted, but members may not exceed three consecutive terms. The committee selects a chairperson from among its members to serve a two-year term.

The agencies responsible for appointing members to the Florida CADR Committee are:

- Florida Department of Health
- Florida Office of the Attorney General
- Florida Department of Children and Families
- Florida Department of Law Enforcement
- Florida Department of Education
- Florida Prosecuting Attorneys Association, Inc.
- Florida Medical Examiners Commission, with the requirement that the representative be a forensic pathologist

In addition to the above members, the State Surgeon General appoints the following individuals based on recommendations from the Department and the other agencies listed above, ensuring varied representation:

- Florida Department of Health's Statewide Child Protection Team Medical Director
- Public health nurse
- Mental health professional specializing in children or adolescents
- DCF employee responsible for supervising family services counselors, with at least five years of experience in child protective investigations
- Medical director of a child protection team
- Member of a child advocacy organization
- Social worker experienced in working with child abuse victims and perpetrators
- Paraprofessional trained in patient resources employed in a child abuse prevention program

- Law enforcement officer with a minimum of five years of experience in children's issues
- Representative from a Florida domestic violence organization
- Representative from a private provider of programs addressing child abuse and neglect prevention
- Substance abuse treatment professional

Local CADR Committees

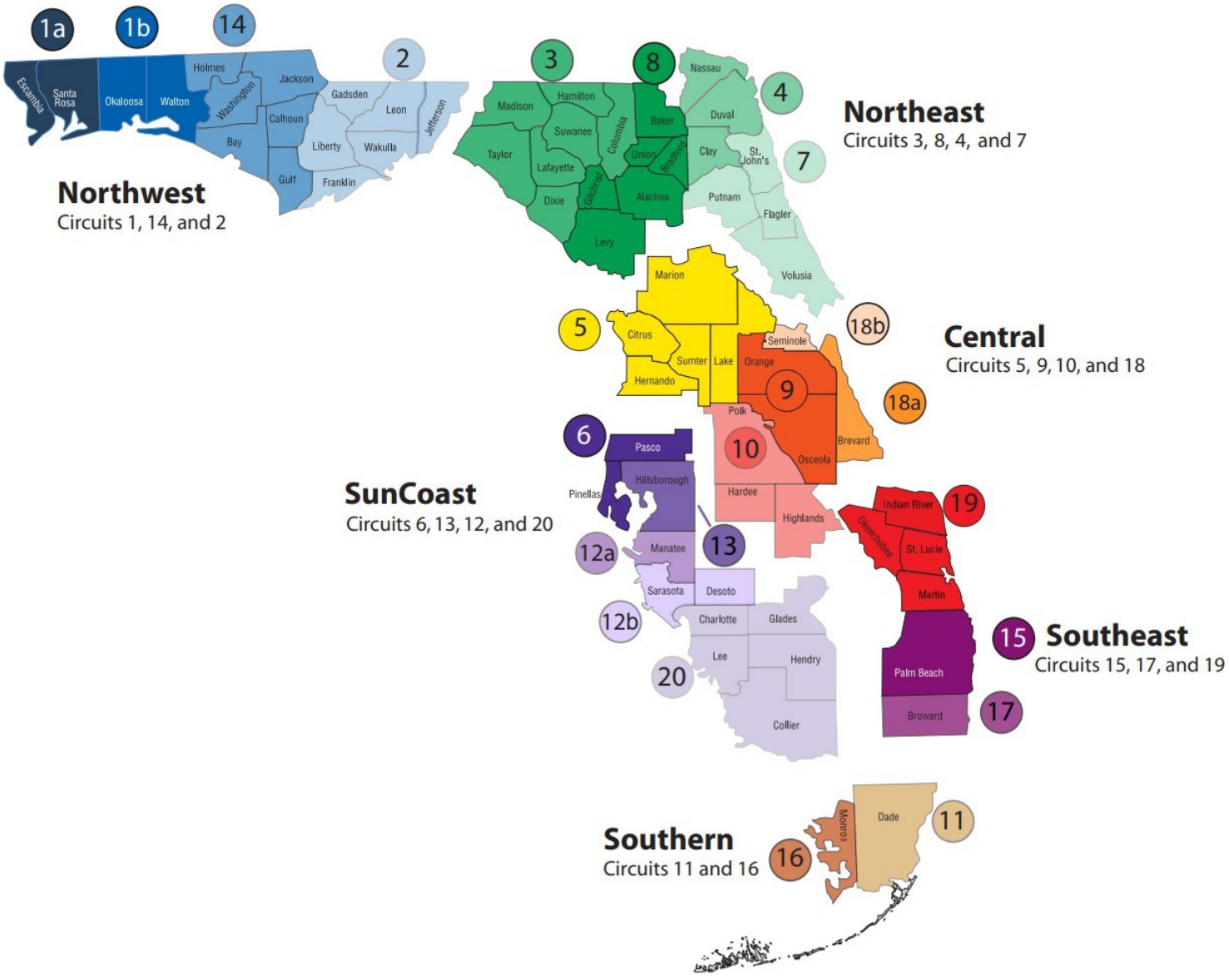
Local CADR committees are responsible for reviewing all closed cases involving alleged child abuse and neglect deaths reported to the DCF Florida Abuse Hotline, then present relevant information to the Florida CADR Committee. Comprising members from various community agencies within Florida's judicial circuits, local CADR committees share a common interest in promoting, safeguarding, and improving the well-being of children. Details about local CADR committee membership can also be found in Appendix B.

County health department directors, designated as CADR Health Officer, appoint, convene, and support these committees. At a minimum, representatives from the following organizations are appointed by CADR Health Officers and voluntarily serve on local CADR committees:

- State Attorney's Office
- Medical Examiner's Office
- Local DCF Child Protective Investigations Unit
- Department's Child Protection Team
- Community-based care lead agency
- State, county, or local law enforcement agencies
- School district
- Mental health treatment provider
- Certified domestic violence center
- Substance abuse treatment provider
- Any other members specified in guidelines developed by the State CADR Committee

Due to the strong partnership between the Department and DCF within the CADR System, local CADR committees are structured to align with both Florida's Judicial Circuits and the six DCF regions across the state, as illustrated below.*

Figure 1: Map of Local CADR Committees and DCF Regions



**Local CADR committees across Florida align with Judicial Circuits; however, circuits 1, 12, and 18 each have two distinct local CADR committees.*

SECTION TWO: METHOD

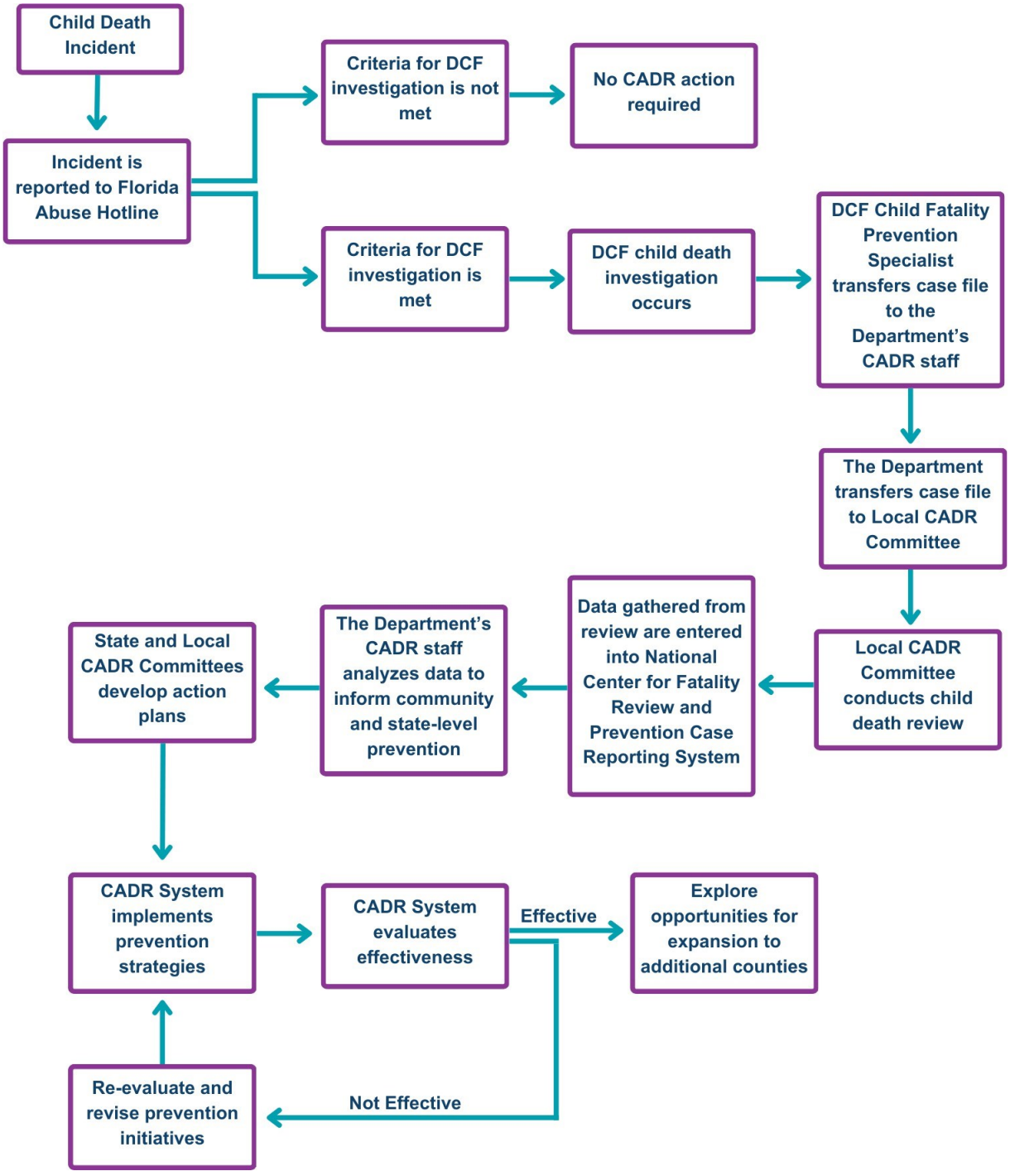
CADR Process Overview

The CADR process includes numerous essential steps, guiding CADR stakeholders from the initial child fatality incident through the execution of state and community-level prevention initiatives. The Florida CADR committee encourages local CADR committees to adopt a holistic, community-wide approach in addressing the root causes and contributing factors behind child maltreatment-related deaths. Moreover, the committees are urged to proactively implement identified strategies to the fullest extent possible. It is crucial to acknowledge that local CADR committees explore solutions beyond the confines of the child welfare system when identifying and executing prevention strategies.

The flowchart presented in Figure 2 delineates the intricate, multiagency CADR process. This visual representation serves as a framework that embodies the collective commitment to building upon the insights gained and advancing the endeavors of CADR. The CADR System remains unwavering in ensuring that all decision-making is underpinned by relevant data, enabling informed and impactful strategies.

The method and process in Florida aims to enhance child safety, deepen the understanding of child abuse and neglect, and drive systemic improvements to protect children and support families effectively.

Figure 2: Multiagency CADR Process



SECTION THREE: DATA

Case Review Statistics

This report includes information on closed child fatality cases with an element of suspected maltreatment, which were reviewed and entered into the National Fatality Review-Case Reporting System (NFR-CRS) by August 29, 2025.

There were 432 child fatality review cases available for analysis, of which 390 were completed and thus included in this report. Cases not included in this report consist of those that remain open to DCF for investigation, cases under investigation by the Florida State Attorney's Office, or cases where a local CADR committee was explicitly advised not to review until further notice.

Judicial circuits continue to experience a backlog of cases impacting data made available for CADR; specifically, cases of inflicted trauma and child homicide. To address case review delays, local CADR committees are responsible for developing a plan to complete the review of backlogged cases following the completion of the annual reporting year's cases.

Child maltreatment findings are based on the following criteria:

- **Verified** – A preponderance of the credible evidence results in a determination that the specific harm or threat of harm was the result of abuse, abandonment, or neglect.
- **Not Substantiated** – There is credible evidence, which does not meet the standard of being a preponderance, to support that the specific harm was the result of abuse, abandonment, or neglect.
- **No Indicators** – There is no credible evidence to support the allegations of abuse, abandonment, or neglect.

References are made to unknown and missing data in certain graphs, charts, and tables throughout this section of the report.

- **Unknown** – A value selected in the NFR-CRS when the answer to a given question is not known, despite efforts by the local CADR committee to obtain the information.

- **Missing** – Questions that were not answered when a child fatality case was entered into the NFR-CRS, result in a missing data value.

Child Death Trends

Counts and rates of all causes of child death derived from the Department's Bureau of Vital Statistics and verified child maltreatment deaths from CADR are displayed in Table 1.

In 2023, the all-cause death rate for children aged 0-17 was 52.8 deaths per 100,000 child population (FL Health CHARTS, 2025). This rate has fluctuated annually over the last 12 years and does not indicate a particular trend or pattern.

Every year, more than 2,000 Florida children die. Of these deaths, a proportion are reported to and investigated by DCF and reviewed by local CADR committees, and some are found to be maltreatment related.

In 2023, 445 of the total child deaths in the state were investigated by DCF, with 78 of these investigated deaths determined to be verified maltreatment cases.

Table 1: Child Deaths: All Causes and Maltreatments, Florida, 2011-2023

Year	Resident Child Deaths (All Causes)	Resident Child Death Rate per 100,000 Population	Total Cases (Child Deaths Called into Hotline)	Verified Child Maltreatment Deaths	Cases Pending (DCF)*	Cases Pending (Local Review)**
2011	2,191	54.2	428	136	-	-
2012	2,046	50.9	411	129	-	-
2013	2,105	52.5	436	137	-	-
2014	2,131	52.9	445	156	-	-
2015	2,249	55.4	473	123	-	-
2016	2,217	54.1	463	110	-	-
2017	2,236	54.1	462	113	-	-
2018	2,128	50.7	440	119	1	4
2019	2,107	49.7	398	91	3	14
2020	2,107	49.2	446	104	6	40
2021	2,227	51.6	450	66	27	68
2022	2,272	51.7	472	83	28	9
2023	**2,301**	**52.8**	**445**	**78**	**13**	**42**

**Cases Pending (DCF) includes cases that are still open for investigation or recently closed.*
***Cases Pending (Local Review) includes cases available, but are not yet reviewed.*

2023 Case Status Summary

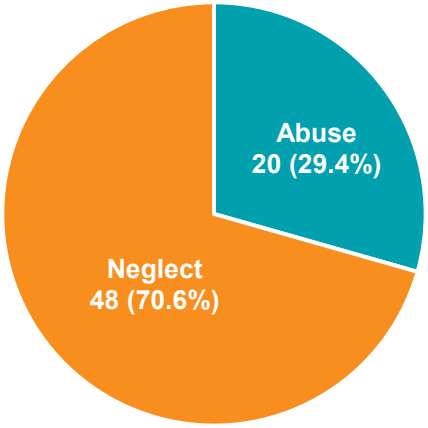
Table 2 details the distribution of 2023 child fatalities assigned to each local CADR committee, including child fatalities reported to the Florida Abuse Hotline, cases that were not available for review, cases awaiting review, and cases reviewed and analyzed as of August 29, 2025.

Table 2: Case Review Status of Child Deaths by Local CADR Committees				
Circuit	**Total Cases (Child Deaths Called into Hotline)**	**Cases Not Available for Review (Open Investigation/Case in Processing)**	**Cases Closed by DCF**	**Cases Completed and Available for Annual Report**
1a	12	1	11	11
1b	8	1	7	6
2	9	0	9	9
3	9	1	8	8
4	43	2	41	41
5	24	0	24	24
6	28	3	25	21
7	18	0	18	2
8	12	0	12	12
9	38	0	38	38
10	29	0	29	29
11	23	0	23	23
12a	9	0	9	9
12b	9	0	9	9
13	43	0	43	43
14	7	0	7	6
15	21	1	20	20
16	0	0	0	0
17	23	3	20	20
18a	19	0	19	19
18b	14	0	14	14
19	14	1	13	12
20	33	0	33	14
Total	**445**	**13**	**432**	**390**

By the end of 2023, 445 child fatalities were reported to the Florida Abuse Hotline. Of these fatality cases:

- 432 cases were closed by DCF, in which 390 (90.3%) were completed.
    - The remaining cases available are scheduled for review after August 29, 2025.
- 13 cases were still open for DCF investigation, or were recently closed, therefore case information was unavailable for review by August 29, 2025. Findings may change once all available cases of child fatalities for 2023 are reviewed.
- Of the 68 verified maltreatment deaths reviewed, 48 (70.6%) were the result of neglect, and 20 (29.4%) were the result of abuse (Figure 3).

Figure 3: Verified Maltreatment Deaths by Type of Maltreatment (n=68)

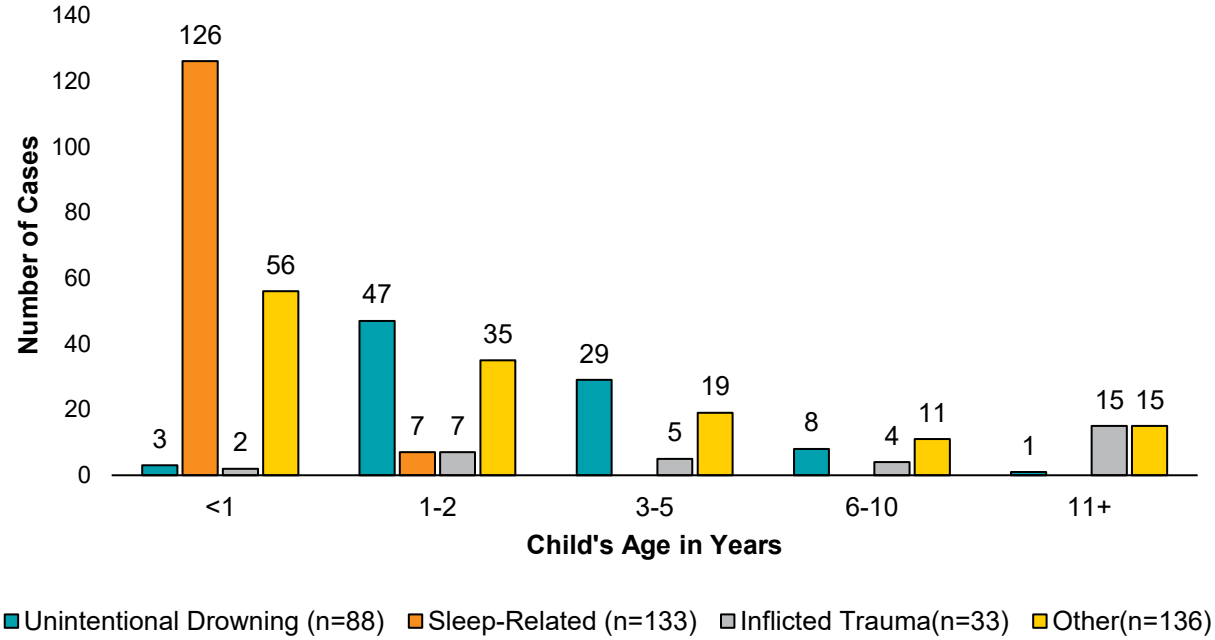


Child Demographic Characteristics

Child's Age

Children aged 5 and under comprised the majority of all fatalities, representing 366 of 390 (86.2%) cases reviewed.

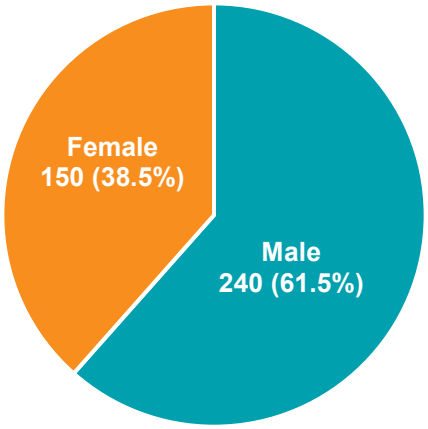
Figure 4: Age of Children by Primary Cause of Death (N=390)



Child's Sex

Figure 5 shows the distribution of sex in the 390 reviewed cases. Males were disproportionately represented among child fatalities, accounting for 61.5% of all reviewed cases. Males also represented 1,340 (58.2%) of the 2,301 Florida's residential deaths ages 17 and younger in 2023.

Figure 5: Child's Sex (N=390)



Child Demographic Characteristics Data Summary
• 47.9% of all child fatality cases received by CADR involved children who were less than 1 year old. • 61.5% of all child fatality cases received by CADR involved male children.

Location of Child Deaths

The incident county refers to the county where the incident that led to the death took place, which may be different from the child's residence county or the county where the child was declared deceased. The distribution of cases by incident county is shown in Table 3.

Table 3: County of Death Incident (N=390)					
Incident County (Circuit)*	Leading Causes of Death				Total
	Unintentional Drowning	Sleep-Related	Inflicted Trauma	Other	
Alachua (8)	2	2	1	3	8
Baker (8)	0	2	0	1	3
Bay (14)	0	1	0	0	1
Bradford (8)	0	1	0	2	3
Brevard (18a)	3	8	1	7	19
Broward (17)	6	9	2	3	20
Calhoun (14)	0	0	0	1	1
Charlotte (20)	2	0	0	1	3
Citrus (5)	0	2	1	1	4
Clay (4)	1	0	2	1	4
Collier (20)	2	0	0	0	2
Columbia (3)	0	2	0	3	5
De Soto (12b)	0	1	0	1	2
Duval (4)	7	9	2	14	32
Escambia (1)	0	5	0	2	7
Flagler (7)	1	0	0	0	1
Gadsden (2)	0	0	0	1	1
Hamilton (3)	0	1	0	0	1
Hardee (10)	0	1	0	0	1
Hernando (5)	4	1	0	0	5
Hillsborough (13)	6	16	2	19	43
Holmes (14)	0	0	0	2	2
Indian River (19)	0	2	0	0	2
Jackson (14)	0	1	0	0	1
Lake (5)	1	3	0	1	5
Lee (20)	0	3	0	6	9
Leon (2)	1	1	3	0	5
Manatee (12a)	2	6	0	1	9
Marion (16)	2	2	2	2	8
Martin (19)	0	0	0	1	1
Miami-Dade (11)	5	1	4	13	23
Nassau (4)	0	0	0	2	2
Okaloosa (1b)	1	1	1	1	4
Okeechobee (19)	0	1	0	0	1
Orange (9)	4	6	4	15	29
Osceola (9)	4	3	1	1	9
Palm Beach (15)	7	7	0	5	19
Pasco (6)	3	5	1	1	10
Pinellas (6)	4	2	0	5	11
Polk (10)	9	8	4	7	28
Saint Johns (7)	0	0	0	1	1
Saint Lucie (19)	1	5	0	3	9
Santa Rosa (1a)	1	2	0	1	4
Sarasota (12b)	2	3	1	1	7
Seminole (18a)	5	3	0	6	14
Sumter (5)	0	2	0	0	2
Suwannee (3)	0	1	0	0	1
Taylor (3)	1	0	0	0	1
Union (8)	0	1	0	0	1
Wakulla (2)	1	1	1	0	3
Walton (1b)	0	1	0	1	2
Washington (14)	0	1	0	0	1
Total	**88**	**133**	**33**	**136**	**390**

**Table 3 does not depict all 67 Florida counties, as it only comprises reviewed cases available for this annual report. Thus, counties with cases that have not been closed or reviewed are excluded.*

Of the top three primary cause of death categories:

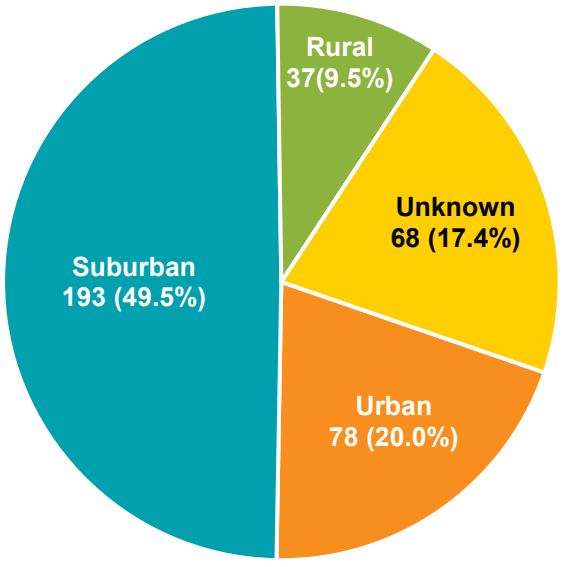
- 57 of 133 (42.9%) sleep-related deaths occurred in six counties: Hillsborough (16), Broward (9), Duval (9), Brevard (8), Polk (8), and Palm Beach (7). Hillsborough County accounted for 12.0% of these cases.
- 40 of 88 (45.5%) unintentional drowning deaths occurred in six counties: Polk (9), Duval (7), Palm Beach (7), Hillsborough (6), Broward (6), and Seminole (5). Polk County accounted for 10.2% of these cases in 2023.
- Inflicted trauma deaths (33) occurred across 17 counties: Polk (4), Miami-Dade (4), Orange (4), Leon (3), Duval (2), Hillsborough (2), Broward (2), Marion (2), Clay (2), Osceola (1), Brevard (1), Pasco (1), Sarasota (1), Alachua (1), Okaloosa (1), Wakulla (1), and Citrus (1).

Incident Area Type

Figure 6 displays the type of area where child death incidents occurred. Of the 390 cases reviewed, 193 (49.5%) took place in suburban areas. The remaining incidents included 78 (20.1%) that occurred in urban areas and 37 (9.5%) in rural areas.

Suburban is defined as a residential district located on the outskirts of a city. Urban is defined as a large city or densely populated area. A rural area is a community with low population densities and can include agricultural and recreational land.

Figure 6: Type of Area where Incident Occured (N=390)

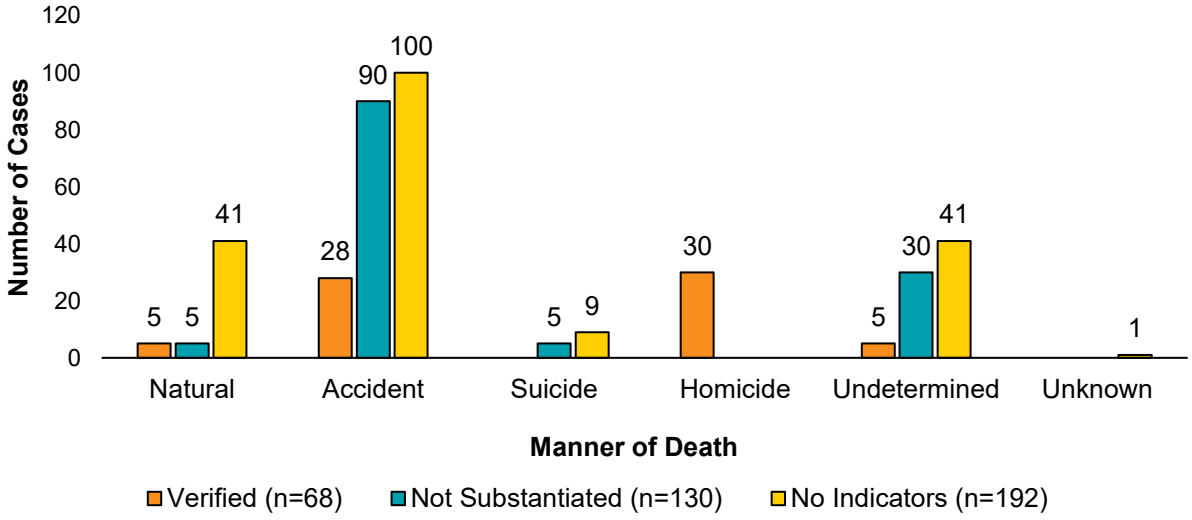


Official Manner of Death

Child fatality reviews document the official manner and cause of death as recorded on the child's death certificate, as well as the maltreatment verification finding that results from DCF investigation.

Figure 7 displays the official manner of death for all child fatalities reviewed in this report.

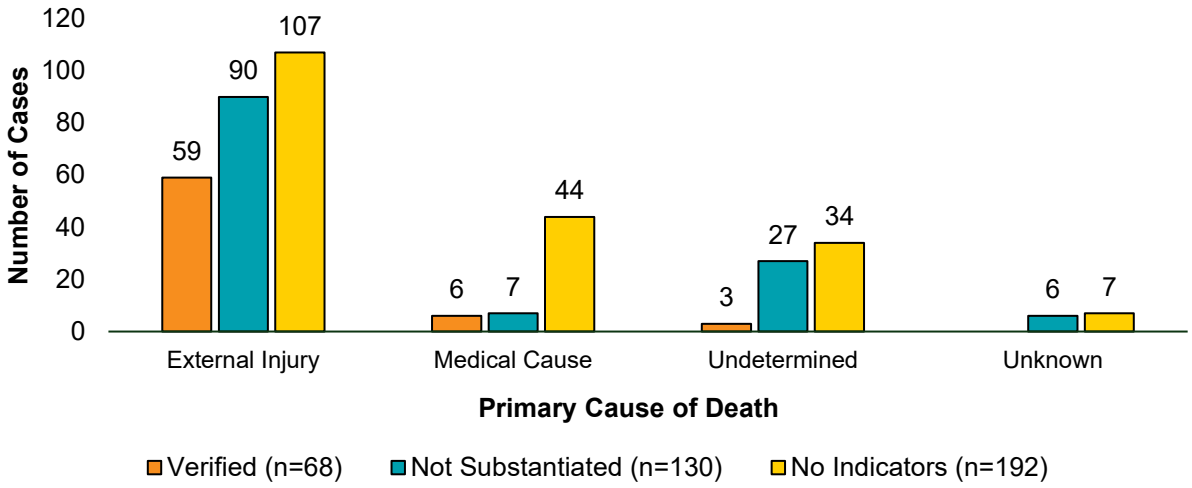
Figure 7: Manner of Death by Maltreatment Verification Status (N=390)



Primary Cause of Death

The distribution of primary cause of death by maltreatment verification status is displayed in Figure 8.

Figure 8: Primary Cause of Death by Maltreatment Verification Status (N=390)



The distribution of manner of death by leading cause of death is displayed in Figure 9.

- Unintentional drownings accounted for 88 of the 390 (22.5%) reviewed cases.
- Among the 133 sleep-related death cases, the manner of death was accidental in 82 cases (61.7%), whereas 44 deaths (33.1%) were classified as undetermined, and seven (5.3%) were due to a natural manner of death.
- Homicidal manner accounted for 19 (57.6%) of the 33 inflicted trauma cases. The remaining cases of inflicted trauma include suicide (30.3%), accidental (9.1%), and undetermined (3.0%) manner.
- The other cause of death category comprises deaths caused by other external injuries (not sleep-related, drowning, or inflicted trauma), medical conditions, and undetermined and unknown causes. Most of these cases were identified as having an accidental manner of death (33.1%), followed by natural (32.4%), and undetermined (22.8%). The remaining 15 cases in this category include 11 homicides and four suicides.

Figure 9: Manner of Death by Leading Cause of Death Category (N=390)

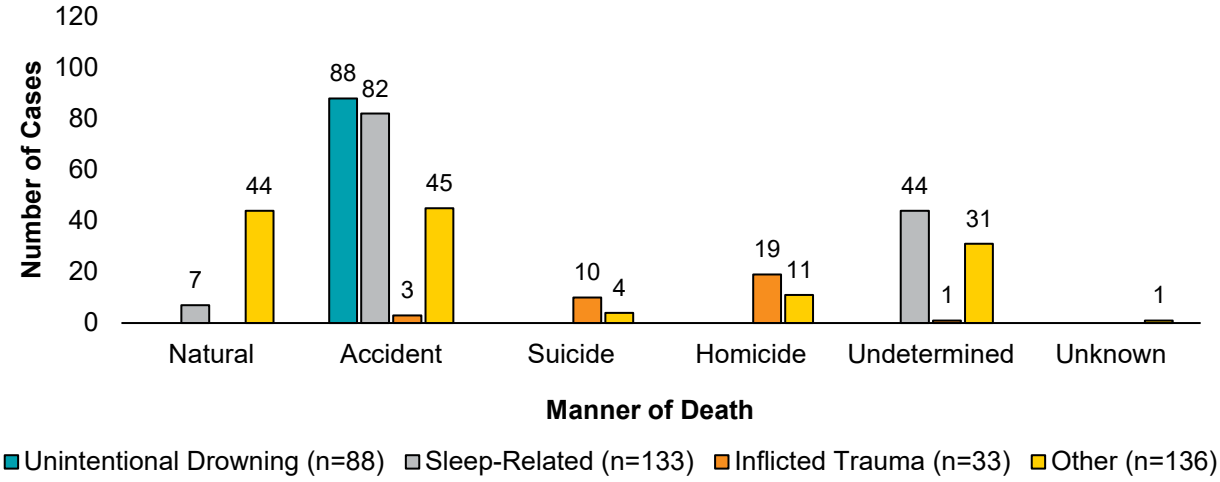
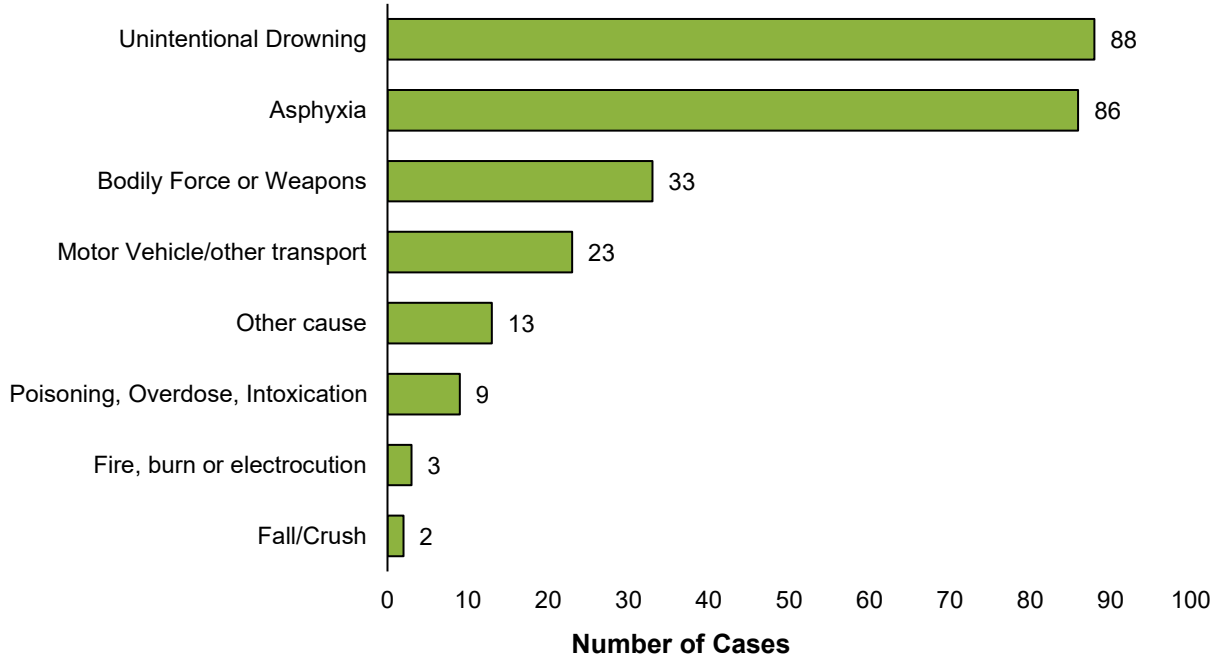


Figure 10 displays specific primary causes of death resulting from an external injury.

Figure 10: External Injury Cause of Death (n=257)



Tables 4 and 5 show the specific injury causes of death among homicide and suicide cases.

In 2023, there were 30 homicide deaths. In 18 of these cases, the cause of death was inflicted trauma through bodily force or the use of a weapon. There were nine homicides that involved the use of a firearm as a weapon. In eight cases, the use of bodily force was involved. In the remaining 12 cases, the external cause of death was reported as poisoning, overdose, or intoxication (2); fire, burn or electrocution (1); asphyxia (1); other cause (7); and unknown (1) (Table 4).

Of the 14 suicide incidents, 10 cases used firearms; two cases involved asphyxia; and two cases involved poisoning, overdose, or intoxication (Table 5).

Table 4: Cause of Death Among Homicide Cases (n=30)

Injury Cause	Number of Cases
Weapon	10
Bodily force	8
Poisoning, overdose, or intoxication	2
Fire, burn, or electrocution	1
Asphyxia	1
Other	7
Unknown	1

Table 5: Cause of Death Among Suicide Cases (n=14)

Injury Cause	Number of Cases
Weapon	10
Asphyxia	2
Poisoning, overdose, or intoxication	2
Total	14

Table 6 displays specific primary causes of death resulting from a medical condition.

Table 6: Medical Cause of Death (n=57)

Specific Medical Cause of Death	Number of Cases
Asthma/respiratory	11
Cancer	2
Cardiovascular	2
Congenital Anomaly	2
Influenza	1
Neurological/Seizure Disorder	1
Pneumonia	9
Prematurity	1
SIDS	1
Other Infection	6
Other Perinatal Condition	1
Other Medical Condition	20

Sleep-Related Deaths

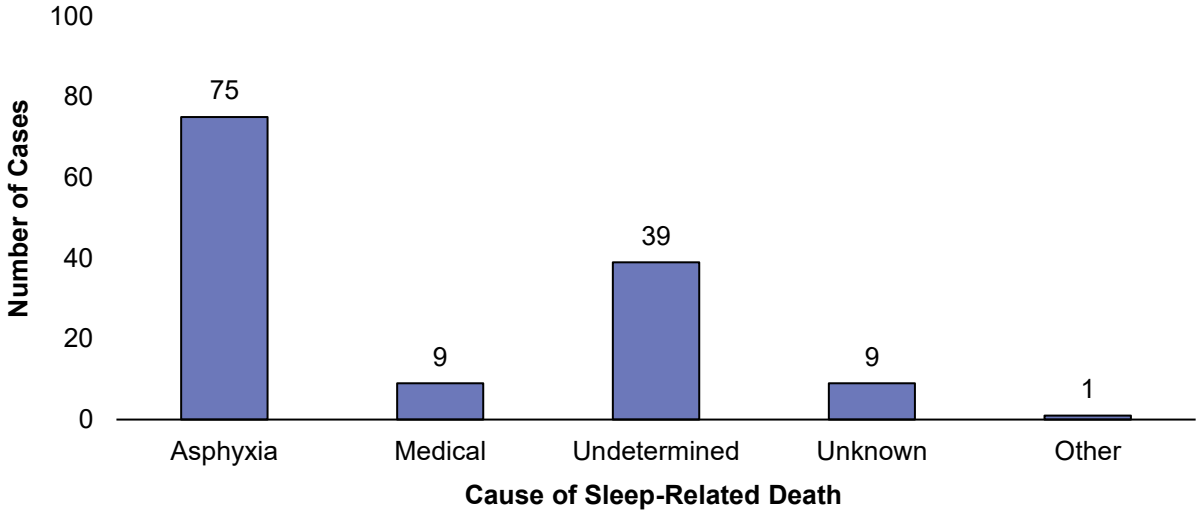
Sleep-related deaths remain the primary category of child deaths reviewed by local CADR committees. All sleep-related information in this report pertains to children under 5 years of age. Of the 133 sleep-related incidents, 126 (94.7%) occurred in infants under 1 year of age.

Sleep-related deaths account for 133 (34.1%) of all 2023 CADR case entries, with 75 (56.4%) due to asphyxia, 9 (6.8%) due to medical cause, 39 (29.3%) undetermined, nine (6.8%) unknown, and one (0.8%) due to other cause (Figure 11).

In sleep-related deaths, determining a clear cause of death is often challenging for medical examiners. Death scene investigations for sleep-related incidents at the place of the incident were completed for 120 of 133 (90.2%) reported cases. Of the 120 cases with a completed death scene investigation, 61 (50.8%) included doll reenactments and the findings were shared with local CADR committees in 37 of the 61 (60.7%) cases.

As a result, some of these deaths may be classified as unknown or undetermined, even after an investigation or autopsy. Death scene investigations involving sleep-related incidents provide valuable information regarding sleep environment risk factors, such as sleeping location and position in which the child was placed to sleep. These narratives can be used in conjunction with autopsy results to provide a more comprehensive view of the incident.

Figure 11: Sleep-Related Deaths by Cause (n=133)



Local CADR committees collect information on the details of the child's sleep environment. Figures 12 through 14 and Table 7 provide an overview of important factors in sleep-related death cases.

Figure 12 details sleep position among cases that were classified as sleep-related, including how the child was placed to sleep and their sleep position when found deceased.

Figure 12: Sleep Position Among Sleep-Related Deaths (n=133)

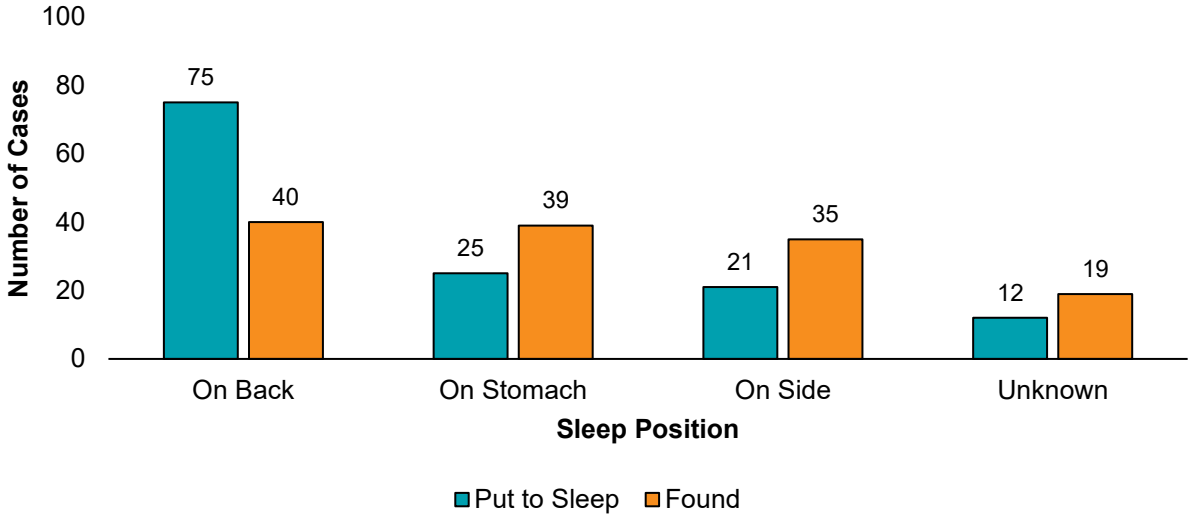


Figure 13 shows the distribution of sleep location among cases that were classified as sleep-related. Of all sleep-related deaths, 82 (61.7%) took place in an adult bed.

Figure 13: Incident Sleep Location in Sleep-Related Deaths (n=133)

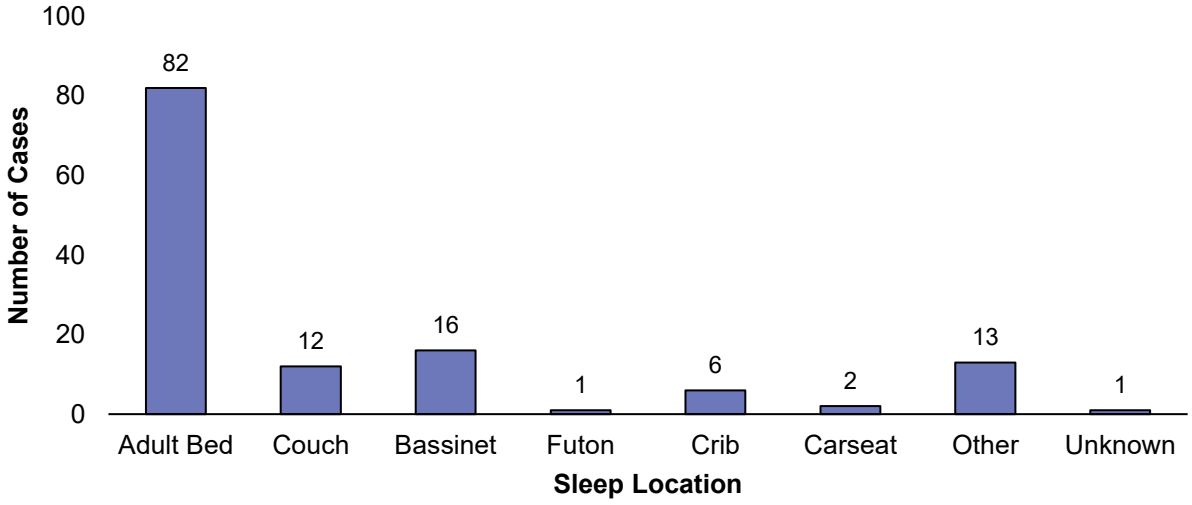


Table 7 provides counts of specific objects (including persons) that were found in a child's sleep environment, in sleep-related death cases. More than one object may have been present in the sleep environment. In 89 (67.0%) cases, an adult was present in the sleep environment, and in 27 (20.3%) cases, one or more children were present in the sleep environment.

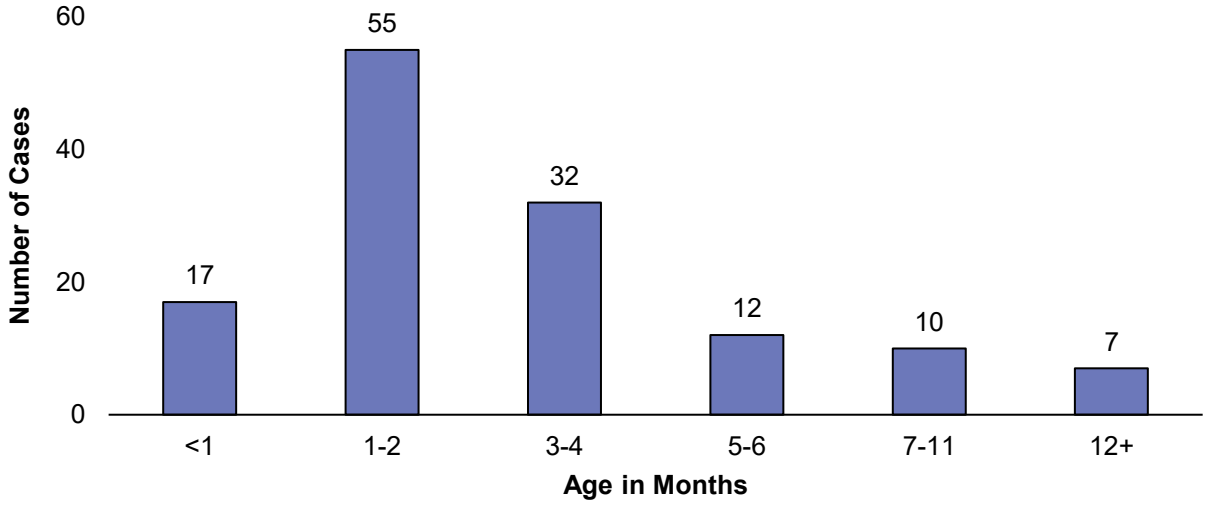
Table 7: Objects in Sleep Environment Among Sleep-Related Deaths (n=133)

Object(s) Present in Sleeping Environment	Cases	Percentage (%)*
Mattress	94	70.7%
Pillow or Cushion	96	72.2%
Adult	89	66.9%
Comforter, quilt or other	61	45.9%
Thin blanket/flat sheet	51	38.3%
Fitted sheet	65	48.9%
Child(ren)	27	20.3%
Bottle	9	6.8%
Nursing or U-shaped pillow	12	9.0%
Clothing	16	12.0%
Wall	16	12.0%
Toy(s)	7	5.3%
Animal(s)	1	0.8%
Crib railing/side	6	4.5%
Bumper pads	3	2.3%
Sleep Positioner	5	3.8%
Other	12	9.0%

**Percentage reflects the proportion of cases out of the total number of sleep-related deaths for each row item in the table.*

Figure 14 provides the age distribution of sleep-related deaths. Of the 133 sleep-related death incidents in 2023, 72 (54.1%) involved infants 2 months of age and younger, while 32 (24.1%) involved infants between 3 and 4 months of age, and 12 (9.0%) involved infants who were between 5 and 6 months of age.

Figure 14: Age Distribution of Sleep-Related Deaths (n=133)



Key Points of 2023 Sleep-Related Data
• 61.7% of all sleep-related deaths took place in an adult bed. • 78.2% of all sleep-related deaths were children less than 5 months old. • 60.9% of all sleep-related deaths involved male children. • 56.4% of children were placed on their back to sleep and 29.3% were found on their stomach. • 66.9% of the 133 sleep-related deaths had another adult in the bed, whereas 20.3% had another child or children in the bed at the time of incident.

Unintentional Drowning Death Incident Information

Local CADR committees collect detailed information on the circumstances and environmental factors associated with child drowning fatalities, including the location of the incident and whether a barrier was in place to prevent access to a water source.

Table 8 displays the location of unintentional drowning deaths. Pools, hot tubs, or spas accounted for most total drowning incidents (73.9%), followed by open water or ponds (14.8%), and bathtubs (5.7%).

Table 8: Drowning Location (n=83)

Drowning Location	Number of Cases	Percent (%)
Open Water or pond	13	14.8%
Pool, Hot Tub, or Spa	65	73.9%
Bathtub	5	5.7%
Other	5	5.7%

Figure 15 shows the location where children were last seen before drowning. Children were most likely to be last seen in the house (55.7%) or in water (12.5%) prior to drowning.

Figure 15: Where Child Was Last Seen Before Drowning (n=83)

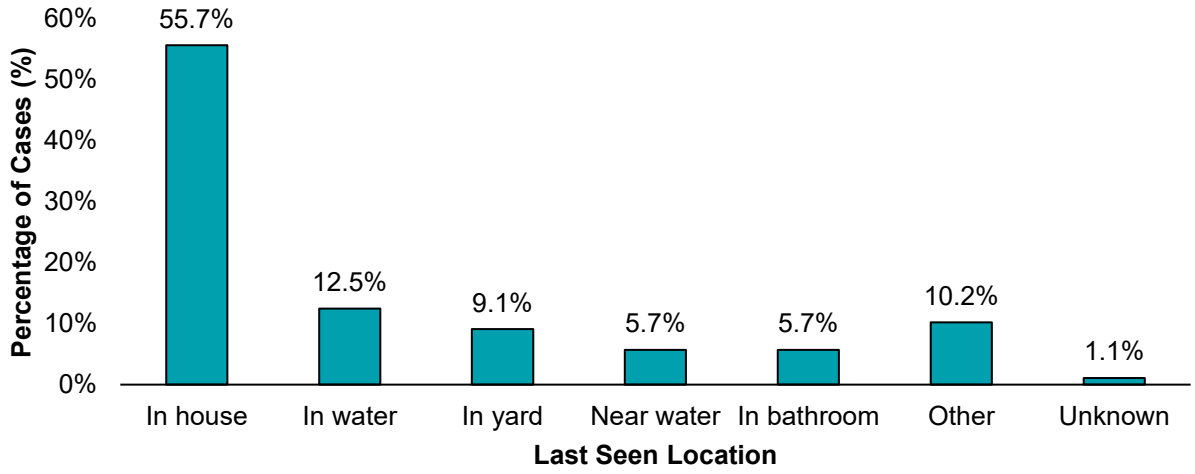


Figure 16 details the physical barriers and other protection layers that were in place at the time of the unintentional drowning incident. Barriers are physical structures, such as a door or a fence, that help limit access to potentially hazardous bodies of water. More than one barrier type can be present in individual drowning cases. Incidents involving bathtubs are excluded.

Figure 16: Barriers in Place Among Unintentional Drowning Deaths (n=83)

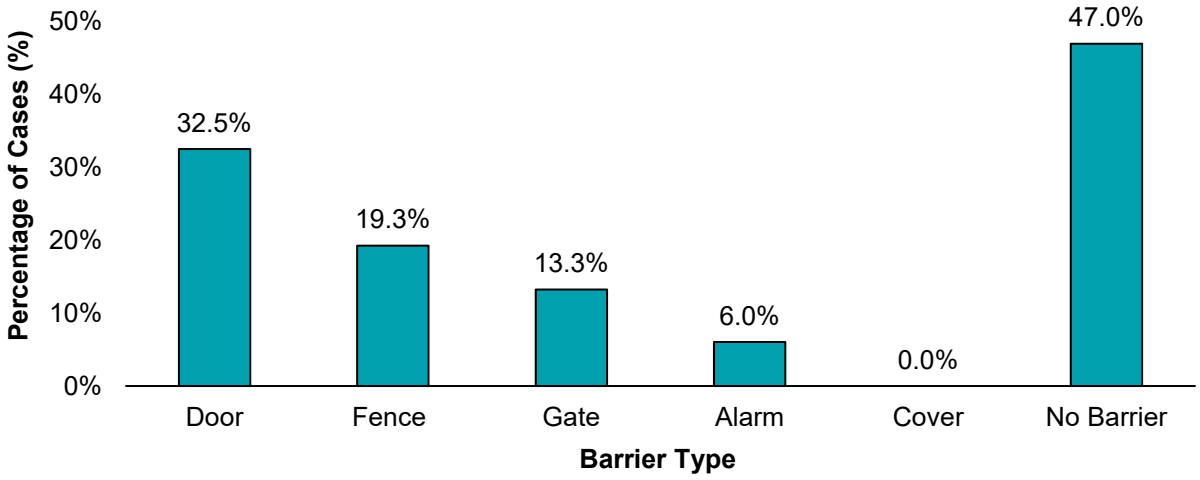
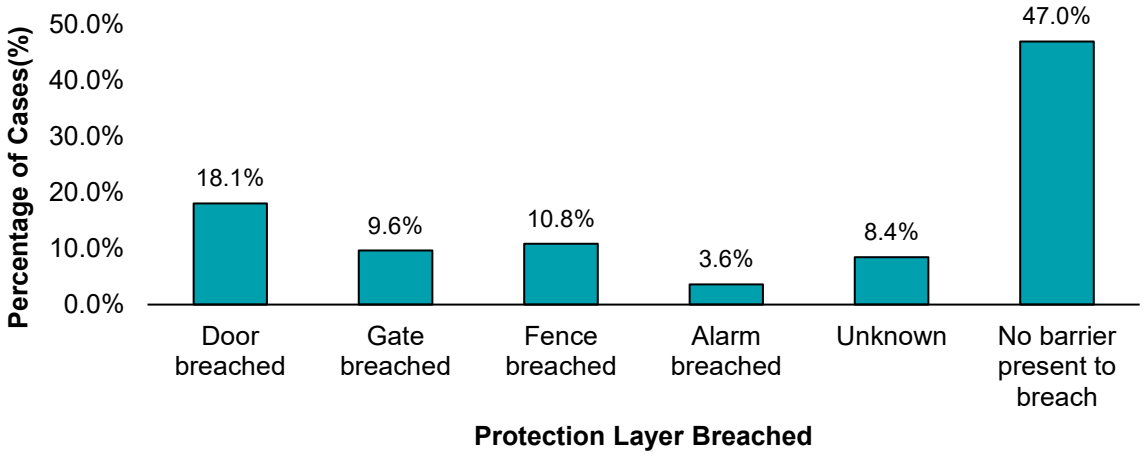


Figure 17 details physical barriers and other protection layers that were breached. A breached barrier is defined as opened, broken, or not functioning. Therefore, the presence of a barrier does not imply that the barrier is always effective in preventing a child from accessing a water source and may also not be applicable in certain water sources, such as an open beach.

Figure 17: Protection Layers Breached Among Unintentional Drowning Deaths (n=83)



The most prevalent barriers breached were doors (18.1%), fences (10.8%), and gates (9.6%). However, there were no layers of protection indicated to prevent access to water in 39 (47.0%) of the unintentional drowning cases.

Unintentional Drowning Data Summary

- Drowning deaths occurring in a pool, hot tub, or spa account for 73.9% of all 2023 drowning fatalities.
- Children 3 years of age and younger make up 69.3% of all 2023 drowning fatalities. This percentage increases to 81.8% when including children 4 years of age and younger.
- 72.7% of children did not know how to swim at the time of the incident.
- 69.3% of all 2023 drowning-related fatalities involved male children.
- 55.7% of children were last seen in the home prior to the drowning incident.
- Of all protection layers that were present among reviewed drowning cases, 32.5% were identified as being a door.
- 47.0% of cases had no barrier in place.
- Doors and gates accounted for 27.7% of all protection layers breached prior to drowning incidents.

Inflicted Trauma Death Incident Information

The intentional infliction of physical harm using bodily force or other weapons remains a leading cause of preventable child death. Inflicted trauma deaths can include both homicide and suicide deaths. Weapon types include firearms, bodily force, or body parts, such as fists, hands, or feet, and any other items that can be used to inflict bodily harm. At the time data were analyzed for this report, several cases were not yet available for review. Many of these cases remain open due to pending law enforcement investigations or judicial action and may be classified as weapon-related deaths. It is expected that figures presented on weapons or bodily force will increase when all 2023 deaths are reviewed. Figure 18 displays the type of force used in inflicted trauma cases. The manner of death in inflicted trauma cases is displayed in Table 9

Figure 18: Mechanism of Injury Among Inflicted Trauma Cases (n=33)

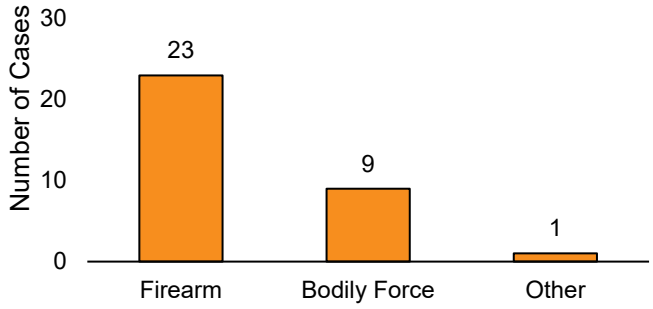


Table 9: Inflicted Trauma Cases by Manner of Death (n=33)

Manner	Number of Cases	Percent (%)
Homicide	19	57.6%
Suicide	10	30.3%
Accident	3	9.1%
Undetermined	1	3.0%

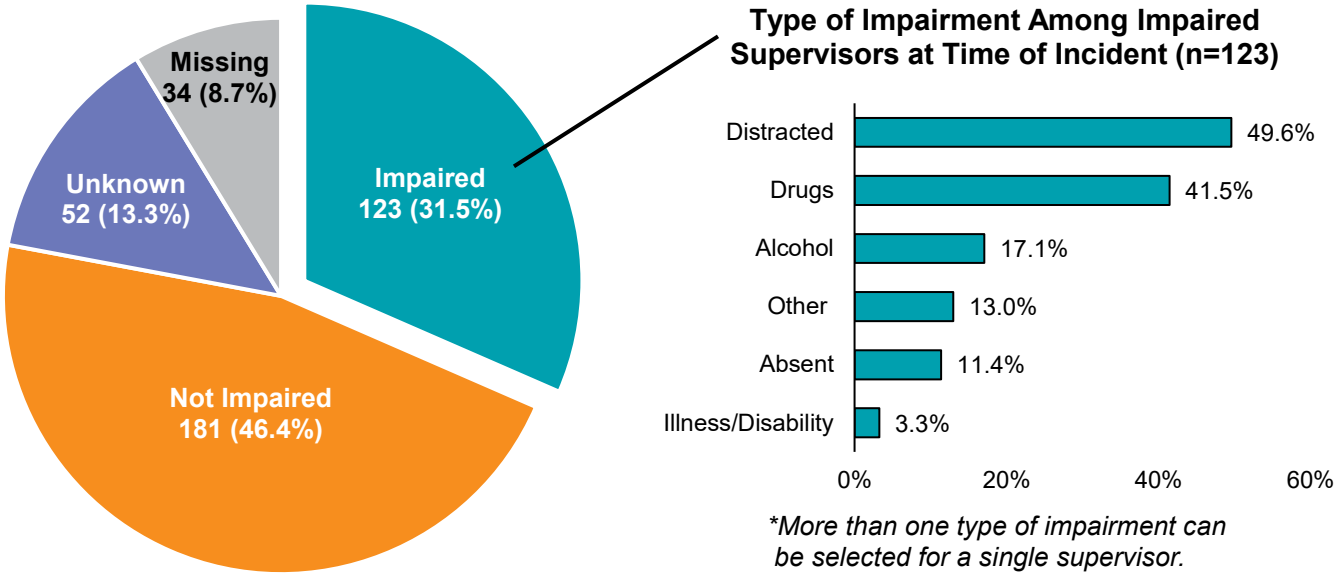
Inflicted Trauma Data Summary

- 63.3% of the 30 homicide incidents were the result of inflicted trauma.
- 69.7% of the 33 inflicted trauma deaths involved the use of firearms.
- In cases where a firearm was used, nine out of 23 were homicide incidents, followed by 10 suicides, three accidents, and one undetermined.
- 27.3% of the 33 inflicted trauma deaths involved the use of body parts or bodily force.
- Children 11 and older comprised of 45.5% of inflicted trauma deaths, followed by children 5 and under (42.4%), and children ages 6-10 (12.1%).
- Use of firearms was the primary mechanism of injury for children over 6 years old.

Supervisor Impairment

Information is collected regarding whether the person responsible for supervising the child at the time of the death incident was impaired. Supervisors were found to be impaired in 123 (31.5%) cases and not impaired in 181 (46.4%) cases; impairment status was unknown or missing in 86 (22.1%) cases. Among supervisors who were impaired, the causes of impairment are shown in Figure 19. More than one type of impairment can be present at the time of the incident.

Figure 20: Supervisor Impairment at Time of Incident (N=390)



More than one type of impairment can be selected for a single supervisor.

Supervisor Types of Impairment Data Summary
• At the time of incident: 123 out of 390 supervisors (31.5%) were impaired. • Most supervisors who were impaired were either under the influence of drugs (41.5%) and/or distracted (49.6%). • 17.1% of supervisors were found to be under the influence of alcohol. • 11.4% of supervisors were found to be absent.

SECTION FOUR: 2025 PREVENTION RECOMMENDATIONS

2025 Prevention Recommendations Developed by the Florida CADR Committee:

Continue to promote evidence-based drowning prevention strategies through the implementation and dissemination of statewide guidelines and best practices.

Recognizing the critical role of evidence-based strategies in drowning prevention, the Florida CADR Committee strongly emphasizes the promotion of drowning prevention awareness and education through data-driven initiatives and collaborative efforts. These efforts are supported by initiatives such as Keep Kids Safe from Drowning (see Appendix C) and the Florida Department of Health's WaterSmartFL campaign, which provides practical guidance and resources on water safety.

Key evidence-based strategies promoted through these initiatives include:

- Regular evaluation of children's drowning risk based on age, environmental factors, and underlying medical conditions
- Implementation of multiple layers of protection, including barriers such as pool fencing, self-closing gates, and alarms to prevent unsupervised access to water
- Close, constant, and capable adult supervision, with an emphasis on designated "Water Watchers" who remain focused and free from distractions
- Promotion of water safety education, including formal swim lessons to teach floating, treading, and basic swimming skills
- Encouraging consistent use of properly fitted Coast Guard-approved life jackets for children and adults in appropriate water settings
- Enhancing collaboration between local committees and community agencies to advance prevention initiatives through evidence-based practices, particularly those rooted in home visiting programs, ensuring alignment with statewide standards and strategic priorities
- Leveraging local committee action plans to expand outreach and systematically monitor the effectiveness of key messaging initiatives

The WaterSmartFL campaign reinforces these strategies by highlighting layers of protection such as barriers, supervision, and preparedness, including CPR training and emergency response planning. Resources like downloadable Water Watcher tags and checklists for pool barriers provide practical tools for families to enhance water safety.

By aligning messaging with evidence-based practices and leveraging the collective impact of initiatives such as Keep Kids Safe from Drowning and WaterSmartFL, the Florida CADR Committee remains committed to reducing child drowning fatalities. Through continued collaboration, education, and outreach, we can equip parents, caregivers, and communities with the tools needed to create safer water environments and prevent these tragic incidents.

Continue to promote and educate the public on the importance of safe sleep practices for infants through the ongoing implementation and evaluation of data-driven programs and initiatives.

Sleep-related infant deaths remain a pressing concern despite ongoing efforts to prevent these tragedies. The 2023 CADR data analysis reveals that, of the 390 total deaths reviewed by local CADR committees, 133 (34.1%) preventable child deaths were sleep-related. Among these, 82 (61.7%) occurred in an adult bed, and in 89 (66.9%) of these cases, an adult was reported to be sharing the sleep surface with the infant. These findings highlight a compelling need for continued safe sleep education for parents and caregivers, along with enhanced dissemination of educational resources.

The Florida CADR Committee is addressing this critical issue through initiatives such as Sleep Baby Safely, in collaboration with the Juvenile Welfare Board of Pinellas County. This initiative provides targeted education and resources to caregivers, emphasizing safe sleep practices.

Additionally, the Healthy Start Coalition programs complement these efforts by supporting families with tailored guidance and resources to promote safe sleep environments for infants.

Recognizing the importance of addressing the factors contributing to sleep-related infant deaths, the Florida CADR Committee emphasizes the ongoing promotion and public education regarding safe sleep practices. Through the implementation and evaluation of data-driven programs and initiatives, the committee seeks to increase awareness and understanding among caregivers and the broader community to reduce these preventable deaths.

Key elements of current safe sleep education efforts include:

- Using consistent terminology, such as sleep-related suffocations, to ensure clarity in messaging and accurate classification of infant deaths.
- Reinforcing the importance of placing infants on their backs, alone, and on non-inclined sleep surfaces, for every sleep. This guidance aims to address common misconceptions about choking risks and emphasizes the dangers of inclined sleep surfaces, which can compromise an infant's breathing and increase the risk of suffocation.
- Encouraging local partners to collaborate with labor and delivery units in hospitals.
- Performing targeted evaluations to gain deeper insights into the effectiveness of the Welcome Baby Bag initiative across participating counties.
- Continuing to promote safe sleep education through local partnerships to ensure that consistent messaging is being communicated throughout Florida.

These focused efforts underscore the need for consistent, evidence-based education that is clear and accessible to all caregivers, ensuring that infants are provided with the safest possible sleep environment.

Continue to ensure all local CADR committees consistently report hazardous consumer products in alignment with CPSC's reporting requirements.

Child fatalities resulting from hazardous or misused consumer products represent a serious and preventable public health concern. In many instances, such products pose hidden dangers to children, and these tragedies can occur without warning. Pillows, toys, nursery items, and household goods can pose risks if they are used improperly, defective, or mislabeled. CADR committees have a pivotal role in identifying, investigating, and preventing child deaths associated with such products.

Reporting hazardous consumer products to the CPSC is proactive and intended to prevent future tragedies by increasing awareness of hazardous or misuse of products. Systematic identification and reporting contribute to holding manufacturers accountable, prompting recalls, and improving effectiveness of product warning labels and safety standards. It is vital that local law enforcement agencies and scene investigators are documenting the use of products associated with the child fatality, to include photographs of product warning labels.

Continue to assess and adapt approaches to suicide prevention and postvention through community and state-level partnerships.

Child and adolescent deaths by suicide remain a critical public health concern in Florida, requiring ongoing attention and adaptation of prevention and postvention strategies. Building on last year's efforts, the Florida CADR Committee continues to prioritize partnerships with local agencies, mental health organizations, and schools to enhance targeted prevention efforts. This year, the committee recommends enhanced collaboration at both community and state levels to better understand and address the complex factors contributing to youth deaths by suicide.

According to FLHealth CHARTS, there was a 30.5% increase in the number of deaths by suicide among children 10-17 years of age between 2014-2023. This concerning increase reinforces the need for comprehensive case reviews to understand and mitigate risks such as bullying, mental health challenges, and access to lethal means.

By integrating mental health services with prevention efforts, the goal is to provide timely support to at-risk youth and implement data-driven, evidence-based interventions. These ongoing efforts reflect a commitment to reducing child and adolescent suicides, protecting the well-being of Florida's youth population, and working toward a future where such tragedies are prevented.

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

The Florida CADR Committee emphasizes the importance of ongoing efforts to promptly disseminate critical child safety information to caregivers and community support networks. To safeguard children from preventable deaths related to factors such as sleep-related infant death, drowning, and inflicted trauma, it is imperative that Florida's communities maintain a proactive stance in educating parents and families about these risks. The following aims to empower caregivers with the knowledge and resources needed to ensure the safety and well-being of children across Florida.

- **Pilot Projects and Initiatives:** The Florida CADR Committee supports the development and thorough evaluation of pilot programs that address child fatalities in high-risk communities. By focusing on local trends, these initiatives allow for trial and refinement of prevention strategies that are tailored to community needs. Ongoing assessments identify successful approaches that can be expanded statewide, ensuring the effective implementation of evidence-based practices to protect children across Florida.

- **Community Collaboration:** The Florida CADR Committee promotes strong collaboration among community resources, such as family resource centers, faith-based groups, childcare providers, and community-rooted organizations to co-design culturally responsive safety messaging. Leveraging their trusted influence enhances credibility of safety information, expands reach, and increases the likelihood that parents and caregivers will use this knowledge to make informed decisions about child safety.

- **Partnerships with Evidence-Based Home-Visiting Providers:** Partnering with evidence-based home-visiting programs offered by agencies, such as DCF, maternal and child health home-visiting programs, and Healthy Families Florida, provides a unique opportunity to engage with families in their homes. These trusted providers can assess potential risks, reinforce best practices, and offer tailored education and support to caregivers. By integrating child safety messaging into routine visits, these partnerships ensure that vital guidance reaches families effectively and consistently, strengthening prevention efforts across diverse communities.

- **Engagement of Expectant Mothers and Caregivers:** There is a persistent need for engaging expectant mothers, partners, grandparents, and other caregivers in discussions about maternal health, safe sleep practices, and the adverse effects of maternal substance misuse on both the fetus and newborn. Programs like the Period of PURPLE Crying and Florida’s Healthy Start Coalitions offer comprehensive support. Recognizing diverse birthing preferences, the Florida CADR Committee also promotes access to doula and midwife services. By providing anticipatory guidance during pregnancy and early caregiving, families receive actionable safety information when it is most impactful.

- **Communication with Medical Professionals:** Strengthen communication with pediatricians, OB/GYNs, and birthing hospitals to embed child safety education into clinical workflows, discharge materials, and screenings. Encourage OB/GYNs to discuss newborn safety, such as safe sleep and substance risks, with expectant parents. Promote consistent, evidence-based messaging and increase provider awareness of contributing factors in child fatalities, particularly drowning and unsafe sleep, to support families and prevent future loss.

- **Maternal Depression Screening:** Implementing maternal depression screening tools during well-child pediatric appointments can help identify potential concerns. A coordinated response should be in place to address any needs that are identified.

- **Home Safety Checklists:** Using home safety checklists designed to identify potentially hazardous conditions and serve as practical tools to enhance child safety. Disseminating standardized versions through outreach and partner agencies empowers caregivers to address common household risks effectively.

- **Insights from CADR Annual Summits:** The annual CADR Summit provides a vital platform for the Florida and local CADR committee members to explore innovative prevention strategies, foster collaboration, and strengthen their understanding of data-driven solutions to reduce child fatalities. Each summit offers a platform to share emerging trends, discuss challenges, and identify actionable approaches to enhance child safety initiatives. Attendees gain valuable insights into fostering multidisciplinary partnerships, forming sustainable prevention efforts, and utilizing data effectively to drive decision-making. Lessons learned from these convenings help refine messaging, elevate promising practices, and strengthen statewide alignment in child safety efforts—equipping members with the tools to enhance local strategies and drive impactful, evidence-based change.

- **Advancing Case Reporting for Child Fatality Reviews:** Continue to develop and submit recommendations to the National Center for Fatality Review and Prevention (NCFRP) regarding potential changes to the National Fatality Review-Case Reporting System (NFR-CRS) to incorporate fields that would better contribute to a deeper understanding of child fatalities in Florida.

SECTION FIVE: CONCLUSIONS AND NEXT STEPS

The findings of this report highlight significant public health concerns. Addressing these concerns requires careful consideration of system improvements to support vulnerable families and the challenges faced by the growing population. The protection of Florida's children should remain a top priority for all Floridians. Creating lasting change by positively influencing society will necessitate a broad, collaborative, multi-sector approach that covers all aspects of the Social Ecological Model for Change. Furthermore, these tragic deaths should inspire action, based on the data and recommendations presented in this report to ensure a safe future for Florida's children.

In addition to implementing data-driven prevention strategies, Floridians must actively seek out opportunities for early intervention. Every day, law enforcement officers, health care professionals, school system personnel, and others are presented with opportunities to provide potentially life-saving information to families with children long before child welfare services are involved.

The Florida CADR Committee strongly encourages readers of this report to act upon the prevention recommendations, as these are key to achieving positive outcomes for children. It is crucial to embrace evidence-based prevention programs and practices while also exploring innovative approaches. To eliminate preventable child fatalities and gain a deeper understanding of the complexities surrounding child maltreatment fatalities, Florida's state and local CADR committees will continue to use evidence-based knowledge and available data to shape current and future prevention strategies.

The only way to break the cycle of child abuse is through education, awareness, and intervention.