## **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

