

# FLORIDA CHILD ABUSE DEATH REVIEW

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**FIRST ANNUAL REPORT  
SEPTEMBER 2000**



Florida Department of Health  
Child Abuse Death Review Program  
Children's Medical Services  
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Jeb Bush  
Governor

Robert G. Brooks, M.D.  
Secretary

September 11, 2000

The Honorable Jeb Bush  
Governor of Florida  
The Honorable Toni Jennings  
President of the Florida Senate  
The Honorable John Thrasher  
Speaker of the Florida House of Representatives  
The Capitol  
Tallahassee, FL 32399-0001

Dear Governor Bush, Madam President, and Mr. Speaker:

In accordance with Chapter 383.402, Florida Statutes, I am submitting this first annual report of child deaths due to abuse and neglect for your review and information. This report highlights major issues and trends identified from the case review of 29 children, all of whom had at least one prior report of abuse or neglect filed with the Department of Children and Families and died in Florida at the hands of their caregivers during 1999.

In 383.402, Florida Statutes, the Department of Health was given the responsibility to establish a statewide multidisciplinary, multi-agency child abuse death assessment and prevention system. The purpose of the review process is to conduct detailed analysis of the facts and circumstances surrounding child abuse and neglect deaths where at least one prior report of abuse or neglect was accepted by the Florida Abuse Hotline Information System.

During this first year, the State Child Abuse Death Review Team and Department of Health staff, in collaboration with local communities, worked diligently to create partnerships for the purpose of conducting child abuse and neglect death reviews. There have been many challenges encountered and accomplishments made in the effort to begin addressing the State Child Abuse Death Review Team's mission of working together to reduce preventable child abuse and neglect deaths.

As our work progresses, we are optimistic that we will gain a better understanding of the circumstances and contributing factors to these deaths.

Sincerely,

A handwritten signature in black ink that reads "Robert G. Brooks". The signature is written in a cursive style with a large, prominent "R" and "B".

Robert G. Brooks, M.D.  
Secretary, Department of Health

RGB/ja





September 11, 2000

Dear Friends of Florida Children:

As chairman of the State Child Abuse Death Review Team, I am proud to present our first annual report. This law, section 383.402, Florida Statutes, establishes state and local child abuse death review teams. The State Child Abuse Death Review Team is multidisciplinary and multi-agency and reviews the facts and circumstances of all child abuse or neglect deaths when the Department of Children and Families previously knew the family. Our goal is to better understand the causes of child deaths, identify service delivery improvements that will support the safe and healthy development of children, and reduce preventable child abuse deaths. This report summarizes our review of children with prior abuse or neglect reports who died of abuse or neglect during 1999.

The Florida State Child Abuse Death Review Team is a dedicated group of professionals with expertise in many areas of child welfare. Each team member has sacrificed time and worked hard to review these deaths and look for ways to prevent the needless death of other children. I would also like to recognize the staff of the Department of Health, Children's Medical Services' Child Protection Unit for their support of the State Team and their dedicated efforts in preparing this report.

We have accomplished a great deal in our first year, but more work is required. We need your continued support to realize our goal of reducing the number of preventable child abuse and neglect deaths in Florida.

Respectfully Submitted,

A handwritten signature in cursive script that reads "Michael Bell".

Dr. Michael Bell, Chairman  
State Child Abuse Death Review Team

MB/ja



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**FLORIDA  
CHILD ABUSE DEATH REVIEW TEAM  
FIRST ANNUAL REPORT  
SEPTEMBER 2000**

**MISSION**

*To reduce preventable child abuse and neglect deaths*

Submitted to

The Honorable Jeb Bush, Governor, State of Florida  
The Honorable Toni Jennings, President, Florida State Senate  
The Honorable John Thrasher, Speaker, Florida State House of Representatives

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## DEDICATION

Twenty-nine children who had prior involvement with child protection services died from abuse and neglect during 1999. This report is dedicated to these children.

<b>Profile Information</b>	<b>Date of Death</b>	<b>Cause of Death</b>	<b>Responsible Caretaker</b>	<b>Number Prior Reports</b>
<i>11-month-old male</i>	<i>1/12/1999</i>	<i>Drowned in family swimming pool/child unsupervised</i>	<i>Mother and Father</i>	<i>1</i>
<i>21-month-old male</i>	<i>2/5/1999</i>	<i>Massive injuries to head and abdomen</i>	<i>Mother's Paramour</i>	<i>1</i>
<i>2-year-old male</i>	<i>2/10/1999</i>	<i>Asphyxiation from head being lodged between car window and window frame/child unsupervised</i>	<i>Mother</i>	<i>2</i>
<i>5-year-old male</i>	<i>2/13/1999</i>	<i>Smoke inhalation and burns sustained in house fire/child unsupervised,</i>	<i>Mother and Paramour</i>	<i>2</i>
<i>4-year-old female</i>	<i>2/13/1999</i>	<i>Smoke inhalation and burns sustained in house fire/child unsupervised</i>	<i>Mother and Paramour</i>	<i>2</i>
<i>2-year-old male</i>	<i>2/17/1999</i>	<i>Smoke inhalation and burns sustained in house fire/child unsupervised</i>	<i>Mother and Father</i>	<i>2</i>
<i>2-year-old male</i>	<i>2/21/1999</i>	<i>Aspirin overdose</i>	<i>Foster Parent</i>	<i>1</i>
<i>8-year-old male</i>	<i>3/6/1999</i>	<i>Massive injuries sustained from being struck by two separate vehicles/child unsupervised</i>	<i>Father</i>	<i>2</i>
<i>6-year-old male</i>	<i>4/12/1999</i>	<i>Combined effects of morphine and carbon monoxide/child left unsupervised in running vehicle</i>	<i>Mother</i>	<i>2</i>
<i>8-year-old female</i>	<i>5/9/1999</i>	<i>Massive head injuries</i>	<i>Mother</i>	<i>3</i>

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## DEDICATION CONTINUED

<i>Profile Information</i>	<i>Date of Death</i>	<i>Cause of Death</i>	<i>Responsible Caretaker</i>	<i>Number Prior Reports</i>
<i>3-year-old female</i>	<i>5/19/1999</i>	<i>Multiple injuries to head and body</i>	<i>Mother's Paramour</i>	<i>2</i>
<i>3-year-old female</i>	<i>5/23/1999</i>	<i>Massive intra-abdominal hemorrhage</i>	<i>Mother's Paramour</i>	<i>2</i>
<i>17-year-old male</i>	<i>5/23/1999</i>	<i>Gunshot to head and chest</i>	<i>Father</i>	<i>1</i>
<i>6-year-old female</i>	<i>6/7/1999</i>	<i>Life sustaining medication and medical treatment withheld</i>	<i>Grandmother</i>	<i>1</i>
<i>9-year-old male</i>	<i>6/26/1999</i>	<i>Gunshot to head and neck</i>	<i>Father</i>	<i>1</i>
<i>8-year-old male</i>	<i>6/26/1999</i>	<i>Gunshot to head</i>	<i>Father</i>	<i>1</i>
<i>6-year-old female</i>	<i>6/26/1999</i>	<i>Gunshot to head</i>	<i>Father</i>	<i>1</i>
<i>2-year-old male</i>	<i>6/26/1999</i>	<i>Crushing injuries to head and chest from being run over by a truck/child unsupervised at outdoor event</i>	<i>Mother and Father</i>	<i>1</i>
<i>2-year-old male</i>	<i>7/7/1999</i>	<i>Drowned in canal/child unsupervised</i>	<i>Mother</i>	<i>1</i>
<i>4-month-old female</i>	<i>7/18/1999</i>	<i>Shaken to death</i>	<i>Father</i>	<i>1</i>
<i>10-month-old male</i>	<i>7/21/1999</i>	<i>Carbon monoxide poisoning/child left in running vehicle in murder-suicide attempt</i>	<i>Father</i>	<i>1</i>
<i>2-year-old female</i>	<i>8/8/1999</i>	<i>Multiple skull fractures</i>	<i>Mother and Paramour</i>	<i>1</i>
<i>14-year-old female</i>	<i>9/19/1999 (estimated)</i>	<i>Child found deceased in park-cause of death undetermined/child unsupervised</i>	<i>Mother</i>	<i>3</i>

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## DEDICATION CONTINUED

<i>Profile Information</i>	<i>Date of Death</i>	<i>Cause of Death</i>	<i>Responsible Caretaker</i>	<i>Number Prior Reports</i>
<i>4-year-old male</i>	<i>10/4/1999</i>	<i>Gunshot to head/child shot by juvenile relative while unsupervised</i>	<i>Aunt</i>	<i>3</i>
<i>1-year-old male</i>	<i>11/1/1999 (estimated)</i>	<i>Life sustaining medication and food withheld</i>	<i>Mother</i>	<i>3</i>
<i>3-year-old male</i>	<i>11/13/1999</i>	<i>Massive head injuries</i>	<i>Mother's Paramour</i>	<i>1</i>
<i>4-year-old female</i>	<i>11/15/1999</i>	<i>Smoke inhalation and burns sustained in house fire/child unsupervised</i>	<i>Aunt</i>	<i>1</i>
<i>16-year-old male</i>	<i>11/16/1999</i>	<i>Gunshot to head</i>	<i>Stepfather</i>	<i>1</i>
<i>4-year-old female</i>	<i>11/20/1999</i>	<i>Head and neck injuries sustained in vehicle accident/intoxicated driver</i>	<i>Mother</i>	<i>1</i>

***“A simple child,  
That lightly draws its breath,  
And feels its life in every limb,  
What should it know of death?”***

**William Wordsworth**

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## **ACKNOWLEDGEMENTS**

We wish to thank the many individuals who helped make the work of the State Child Abuse Death Review Team and the production of this document possible. These include:

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From the Department of Children and Families, Office of Family Safety – Phyllis West, State Death Review Coordinator, and the Death Review Coordinators from Districts 1-15 for their assistance in gathering the case information necessary for the state and local teams to conduct reviews of the child deaths.

From the Department of Children and Families, Professional Development Center – Christine O'Riley, State Child Abuse Death Review Team member, for authoring a section of this report.

From the Child Protection Team – Matthew Seibel, M.D., State Child Abuse Death Review Team member, for authoring a section of this report.

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## EXECUTIVE SUMMARY

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. The purpose of the process was to conduct reviews of the facts and circumstances surrounding child abuse and neglect deaths in which at least one prior report of abuse or neglect was accepted by the Florida Abuse Hotline within the Department of Children and Families (DCF). This legislative mandate, which demonstrated Florida's commitment to the health and welfare of its most vulnerable citizens, was the result of legislative concern that, of the 80 children who died from substantiated child abuse or neglect in Florida during 1998, almost one third (32%) had prior contact with the child protection system.<sup>1</sup>

During this first year, the State Child Abuse Death Review Team, in collaboration with other agencies and local communities, made significant strides in its efforts to establish a multidisciplinary approach to the review of these child deaths. Specifically, the state team, in conjunction with the Department of Health:

- Developed draft policy and procedure guidelines relevant to the Florida Child Abuse Death Review process.
- Designed a data collection instrument and instructional guide.
- Developed an informational brochure outlining the Child Abuse Death Review System and encouraged the development of local fatality review teams.
- Reviewed 29 child abuse and neglect deaths that occurred in 1999 and met the statutory criteria for review. This was done by the State Child Abuse Death Review Team in the absence of local teams.
- Developed an automated data system for collecting statewide data on the results of the review of child abuse and neglect deaths meeting the statutory criteria.
- Presented an overview of the child abuse death review process at the Child Protection Team Statewide Meeting and discussed the role of the Child Protection Teams in facilitating the development of local fatality review teams.
- Provided information on local child death review teams to all county health departments and responded to requests from communities interested in establishing local teams.

Through the review of the 29 child abuse and neglect deaths, the state team identified the following data and trends.

- Abuse was a factor in 52% of the deaths and neglect on the part of the parent or caretaker was a factor in 48% of the deaths included in this study.
- Six (21%) of the children died from a fatal gunshot wound, which was the leading cause of death for the 29 children included in this report. Three of the children who died from gunshot wounds were siblings, and their deaths were the result of a murder–suicide perpetrated by their biological father. Death from smoke inhalation or burns sustained in a house fire accounted for the second highest number of deaths in this population. Poisoning, head trauma and vehicle related deaths were among the other leading causes of death for these 29 children.

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- Ten percent (10%) of the children who died from abuse and neglect were under a year old and 62% of the children were less than five-years-old. This differs from national statistics that reported the majority of children who suffered maltreatment related deaths in 1998 were young (37.7% were under twelve months of age and 77.5% were under five-years-old).<sup>2</sup> Team members surmised that one reason for this may have been that the review included only those deaths in which the victim had been the subject of a prior report to the Florida Abuse Hotline, and very young children, particularly infants, were less likely to have been reported to the Abuse Hotline than older children.
  - Fifty-five percent (55%) of the children who died were white and 45% were black. Males represented 62% and females 38% of the population included in the review.
  - Mothers were responsible for 7 (24%) of the deaths, while fathers and male paramours were responsible for 11 (38%) of the 29 child deaths. In all 11 of the deaths in which fathers and paramours were identified as the perpetrator, the deaths were a result of physical abuse. This is in contrast to the 7 deaths in which mothers were identified as being the responsible caretaker, and neglect was the primary factor in 5 of the 7 deaths.
  - The persons responsible for the child abuse and neglect deaths ranged in age from 20 to 81, with a median age of 34.5 years. This conflicts with national estimates, which report that perpetrators of maltreatment fatalities are generally young. "In 1998 nearly two thirds (62%) of the persons responsible for child abuse and neglect deaths nationally were younger than 30 years of age...."<sup>3</sup> An explanation may be that, since the victims in this study tended to be older than other children who suffered fatal maltreatment, their parents or caregivers might also be older than other perpetrators of fatal maltreatment.
  - Twenty-five of the 29 children (86%) had three or more family risk factors present at the time of death. Major family risk factors for these children included:
    - ◆ One or more children in the home age 5 or younger in 19 (66 %) of the cases
    - ◆ Domestic violence involving any household members in 14 (48%) of the cases
    - ◆ Criminal history for any household members in 13 (45%) of the cases
    - ◆ Children in the home had limited community visibility in 12 (41%) of the cases
    - ◆ Parent or caregiver was unable to meet child(rens) needs in 11 (40%) of the cases
    - ◆ Parent or caregiver's age, mental health, alcohol or substance abuse affected their ability to adequately parent the child(ren) in 10 (36%) of the cases
    - ◆ A pattern of escalating and/or frequency of incidents of abuse or neglect was found in 12 (41%) of the cases
    - ◆ Prior abuse or neglect reports involving any household members in 29 (100%) of the cases
  - In 23 of the 29 child deaths, the victim either received direct services from the Department of Children and Families or was referred for community services by DCF staff prior to their death. The State Child Abuse Death Review Team determined that the previous services were adequate in 7 (30%) of these cases and inadequate in 3 (13%) of the cases. The most striking finding was that in 13 (57%) of the cases, reviewers were unable to determine the appropriateness or adequacy of prior services due to a lack of available information at the time of the review.

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- The State Child Abuse Death Review Team concluded that 27 (93%) of the 29 deaths were definitely preventable and that the other two deaths were probably preventable. This was not surprising since all of the children included in this report died from abuse or neglect. Because their deaths were either the result of physical assault by their caregivers or as a consequence of caregiver failure to provide reasonable care to prevent their death, their deaths were generally seen as preventable.

After a careful analysis of data, the state team offered the following recommendations to address issues identified during the review of the deaths of children who had previously received child protection services from the Department of Children and Families:

1. The Department of Children and Families should coordinate and, if necessary, redistribute 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 child death reviews.
2. The Department of Children and Families should revise departmental operating procedures to address the quality and timeliness of the district death review report, to require local multidisciplinary staffings for all child abuse deaths with prior DCF involvement and to better define the roles and responsibilities of the state and local death review coordinators.
3. The State Child Abuse Death Review Team, in collaboration with the Department of Health and the Department of Children and Families, should consider the facilitation, development and training of local death review teams a priority for calendar years 2000-2001.
4. The Department of Children and Families should continue to implement the District 7 Family Safety Strike Force recommendations.
5. The Department of Health should propose a legislative amendment revising the due date of the annual report from September 30 to December 31 to allow the time to gather relevant case information, particularly in situations involving complex child deaths.
6. During the next year, the State Child Abuse Death Review Team should coordinate with local death review teams and relevant professional organizations to develop guidelines to ensure the thoroughness and integrity of child death investigations.
7. 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.
8. The Florida Legislature should expand the Child Abuse Death Review Process to include the review of all child deaths.



## SUMMARY OF EARLY INITIATIVES

The death of a child is always difficult to accept. When a child dies from abuse or neglect it is especially tragic. Every child should not only have the right to grow up in a safe environment, but also have the expectation that they will thrive and flourish within that environment. Unfortunately, for the children in this report and the 377 other Florida children who died due to abuse or neglect between calendar years 1994-1998, this was not the case. Of greater concern was that close to one-third of these children were known to the child protection system prior to their deaths.<sup>4</sup> Although this is slightly lower than national statistics that report 36% of the children who suffered maltreatment related deaths had prior contact with child protection services, this number is still unacceptable to the citizens of Florida and to individuals and agencies involved in the health and welfare of children.<sup>5</sup>

Over the past 15 years, there have been several highly publicized child deaths from abuse or neglect involving children who had previously received child protection services from the Department of Children and Families (formerly known as the Department of Health and Rehabilitative Services or HRS). These deaths prompted professionals and other individuals interested in the protection of children to carefully review the specific circumstances surrounding each death and to evaluate management and systemic issues within the Department of Children and Families. This was done in an effort to determine why these children died despite the fact that the Department of Children and Families had previously been involved with their families. Some of these death studies and initiatives included:

- 1985 HRS Task Force Subsequent to the Death of Corey Greer
- 1987 Protecting Florida's Children Task Force: A Blueprint for the Next Decade
- 1990 Child Welfare League of America Salary Study Subsequent to the Death of Bradley McGee
- 1991 Study Commission on Child Welfare (Barkett Commission)
- 1995 Governor's Panel on Child Protection Issues: A Review of the Lucas Ciambrone Case
- 1996 Task Force on Family Safety
- 1997 Governor's Child Abuse Task Force
- 1998 DCF Quality Assurance Review Subsequent to the Death of Kayla McKean
- 1999 District 7 Child Safety Strike Force

### **Adam\***

His mother left the two-year-old unattended in a running car while she went inside to visit a friend. Adam triggered the power window and got his head and neck trapped between the window and the window frame. He died from asphyxiation. The family was under the protective supervision of the Department of Children and Families at the time of the incident because Adam had ingested cocaine three months earlier during a family gathering.

\*Alias

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After careful review of these studies it became increasingly clear that each study identified a number of the same or similar problematic case-specific or systemic issues, including:

- Significant staff turnover rates among DCF staff
- High DCF caseloads
- Lack of a career ladder and competitive salaries within the discipline necessary to attract and retain qualified professionals
- Insufficient communication between DCF staff in different child protection programs and between DCF staff and staff from other agencies
- Lack of thoroughness in the child protective investigation process, including gathering complete family assessment information during the investigations
- Inadequate case planning for families receiving ongoing child protection services
- Inadequate training for DCF staff

Over the years, the Florida Legislature and the Department of Children and Families have developed a number of initiatives and programs in an effort to address these issues. However, after the tragic death of six-year-old Kayla McKean – a child who was brutally murdered by her father in 1998, who had been the subject of three prior reports to the Abuse Hotline and who was receiving child protection services from a contracted agency at the time of her death – it became clear that these efforts fell short of their intended goal, which was to reduce child abuse and neglect deaths.

Consequently, as a result of this death, and the deaths of other children due to abuse and neglect, the Florida Legislature, inspired by several prominent legislators and an outraged community, enacted legislation in 1999 establishing the development of statewide and locally developed multidisciplinary committees to conduct detailed reviews of the facts and circumstances surrounding child abuse and neglect deaths in which at least one prior report of abuse or neglect was accepted by the Florida Abuse Hotline. The intent of the legislature was to facilitate a better understanding of these deaths and to develop enhanced strategies for preventing future deaths by developing a panel of individuals at the state and local level who had expertise in the fields directly impacting the health and welfare of children and families.

**Christina\***

Four-month-old Christina died from being violently shaken by her 19-year-old father. A prior report of medical neglect, alleging Christina's parents had removed the jaundiced newborn from the hospital before doctors could complete a bilirubin test, was not investigated as the Department of Children and Families Counselor was unable to locate the family. Two months prior to Christina's death, the 16-year-old mother filed a Petition for Injunction for Protection Against Domestic Violence with the Circuit Court. That petition, which provided an address for the family, contained statements that the father was physically abusive towards both the mother and Christina. No report was made to the Abuse Hotline and the mother subsequently withdrew the restraining order.

\*Alias

## INTRODUCTION

### **Program Background and Description**

The Florida Child Abuse Death Review Program was established by statute in 1999 in response to the tragic death of a six-year-old child. 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 at least one report of abuse or neglect was accepted by the Florida Abuse Hotline within the Department of Children and Families.

### **Statutory Authority**

Section 383.402, Florida Statutes

### **Program Purpose**

The purpose of the child abuse death review process is to:

- Develop a community-based approach to address child abuse deaths and contributing factors.
- Achieve a greater understanding of the causes and contributing factors of deaths resulting from child abuse or neglect.
- Identify gaps, deficiencies or problems in service delivery to children and families by public and private agencies that may be related to child abuse deaths.
- Develop and implement data-driven recommendations for reducing child abuse and neglect deaths.

### **State Child Abuse Death Review Team**

The State Child Abuse Death Review Team was established in statute to ensure oversight of the child abuse death review process.

### **Membership of the State Team**

The State Child Abuse Death Review Team consists of seven agency representatives and eleven appointments from various disciplines related to the health and welfare of children and families. Members of the State Child Abuse Death Review Team are appointed by the Secretary of Health for staggered two (2) year terms. All members are eligible for reappointment. A representative of the Department of Health, appointed by the Secretary of Health, serves as the state committee coordinator.

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

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- Department of Legal Affairs
  - Department of Children and Families
  - 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 Families 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 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 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

### **Roles and Responsibilities of the State Team**

The duties of the state team are to:

- Develop a standard protocol for the uniform collection of data that uses existing and tested data collection systems to the greatest extent possible.
- Provide training to cooperating agencies, individuals and local child abuse death review teams on the use of the child abuse death data protocol.
- Prepare an annual statistical report on the incidence and causes of death resulting from child abuse in the state during the prior calendar year to submit to the Governor, the President of the Senate, and the Speaker of the House of Representatives by September 30 of each year (first report 9/30/2000). The report must include recommendations for state and local action, including specific policy, procedural, regulatory, or statutory changes, and any other recommended preventative action.
- Encourage and assist in developing local child abuse death review teams and providing consultation on individual cases to local teams, upon request.
- Develop guidelines, standards and protocols, including a protocol for data collection for local child abuse death review teams, and provide training and technical assistance to local teams.

- 
- Develop guidelines for reviewing child abuse deaths, including guidelines to be used by law enforcement agencies, prosecutors, medical examiners, health care practitioners, health care facilities and social service agencies.
  - Study the adequacy of laws, rules, training and services to determine what changes are needed to decrease the incidence of child abuse deaths and develop strategies and recruit partners to implement these changes.
  - Educate the public regarding the incidence and causes of child abuse death, and the ways to prevent such deaths.
  - Provide continuing education for professionals who investigate, treat and prevent child abuse or neglect.
  - Recommend, when appropriate, the review of the death certificate of a child who is suspected to have died of abuse or neglect.

### **Local Child Abuse Death Review Teams**

Local child abuse death review teams are the cornerstone of the death review process. These teams have the primary responsibility for conducting the initial child abuse and neglect death reviews.

### **Membership of Local Death Review Teams**

Local child abuse death review teams are comprised of individuals from the community who either have some responsibility when a child dies from abuse or neglect or share an interest in improving the health and welfare of children. Local child abuse death review teams are, at a minimum, composed of the head of the following departments, agencies, or associations or that person's designee:

- District medical examiner
- Child Protection Team
- County Health Department
- Department of Children and Families
- State Attorney's Office
- Local law enforcement agency

The chairperson of the local team may appoint the following members to the local team as necessary:

- 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 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 abuse prevention program
- A representative of the Florida Coalition Against Domestic Violence
- A representative from a private provider of programs on preventing child abuse and neglect

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## Roles and Responsibilities of Local Teams

The duties of the local child abuse death review team are to:

- Review all deaths resulting from child abuse and neglect with at least one report of abuse or neglect accepted by the central abuse hotline within the Department of Children and Family Services. The local team, however, is not limited to reviewing the above mentioned child abuse deaths. Local teams can choose to expand the child death review process to include all child deaths in their jurisdiction.
- Assist the state team in collecting data on applicable child abuse deaths.
- Submit written reports to the state team as directed. The reports are to include information on individual cases, and steps taken by the local team to implement necessary changes and improve the coordination of services and investigations.
- Submit all records requested by the State Child Abuse Death Review Team at the conclusion of its review of a death resulting from child abuse or neglect.
- Abide by standards and protocols established by the State Child Abuse Death Review Team in the conduct of child abuse death reviews.
- On a case-by-case basis, request that the State Child Abuse Death Review Team review the data of a particular case.

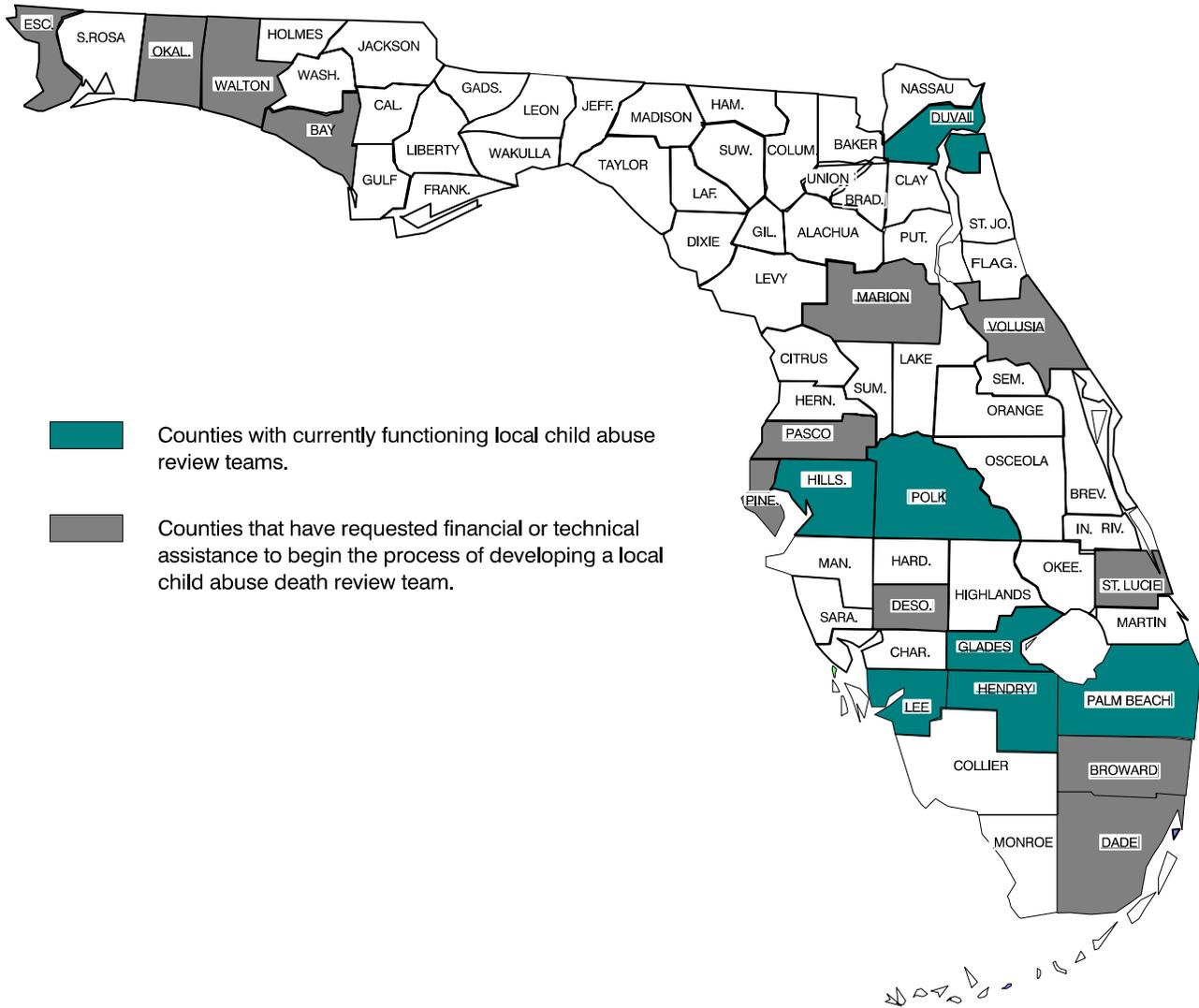
### **Justin\***

Eleven-month-old Justin died after falling into the family swimming pool. At the time of the incident, his great-grandmother was the adult in the home as his parents had gone to the store. It was unclear, however, whether the great-grandmother had been made aware of Justin's location, or her responsibility to care for the infant, prior to the parent's leaving the home. Four months earlier, paramedics had responded to the residence due to Justin nearly drowning in the same swimming pool. The safety gate the family had installed subsequent to that incident had broken and was found leaning against the side of the house.

\*Alias

## Map of Existing and Planned Local Teams

Local review teams represent the cornerstone of the child abuse death review process. These teams have the primary responsibility for reviewing all child abuse and neglect deaths and for presenting information relevant to these deaths to the State Child Abuse Death Review Team. The map below indicates those counties with existing local death review teams and those areas where teams are in the early stages of development. It should be noted that these local teams review all child deaths in their jurisdiction.



## PROGRESS TOWARDS LEGISLATIVE MANDATES

During the first year, the State Child Abuse Death Review Team worked diligently to develop a foundation for the child abuse death review process. This year brought both challenges and insight in the efforts to develop a multidisciplinary approach to review these deaths, achieve a better understanding of why these children died and create better approaches for preventing future deaths.

### Accomplishments to Date

- Developed draft policy and procedure guidelines relevant to the Florida Child Abuse Death Review process.
- Designed a data collection instrument and instructional guide.
- Developed an informational brochure outlining the Child Abuse Death Review System and encouraged the development of local fatality review teams.
- Reviewed the 29 child abuse and neglect deaths that occurred in 1999 and met the statutory criteria for review. This was done by the State Child Abuse Death Review Team in the absence of local teams.
- Developed an automated data system for collecting statewide data on the results of the review of child abuse and neglect deaths meeting the statutory criteria.
- Presented an overview of the child abuse death review process at the Child Protection Team Statewide Meeting and discussed the role of the Child Protection Teams in facilitating the development of local fatality review teams.
- Provided information on local child death review teams to all county health departments and responded to requests from communities interested in establishing local teams.

### Future Goals

- Establish additional local death review teams in every county in the state.
- Work with existing local death review teams to accomplish the review of applicable calendar year 2000 child abuse deaths.
- Develop additional training materials for cooperating agencies, individuals and local child abuse death review committees.
- Assist local teams in the development of protocols for review of child abuse deaths to be used by law enforcement agencies, prosecutors, medical examiners, health care professionals, health care facilities and social service agencies.

#### **Keisha\***

Eight-year-old Keisha died after her mother hit her in the head with an aluminum baseball bat for wetting her pants. The mother failed to seek medical attention for Keisha for more than 14 hours. The beating occurred in the presence of the child's siblings. There were numerous prior reports to the Abuse Hotline regarding Keisha and her siblings and extensive service provision to the family, including family preservation services, protective supervision and foster care services.

\*Alias

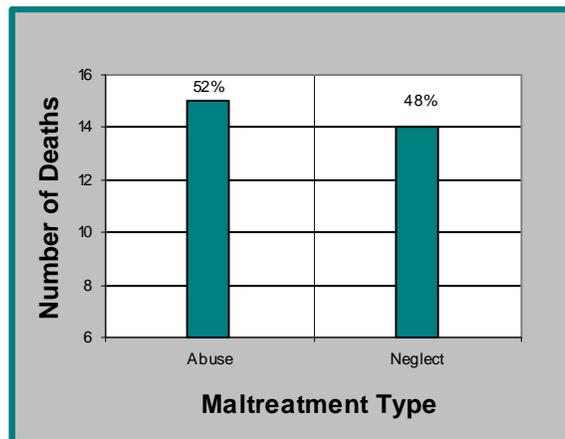
## 1999 CHILD ABUSE AND NEGLECT DEATH DATA

The following statistical reports, graphs and charts are based on a review of the 29 known child abuse and neglect deaths that occurred in 1999 and met the criteria for review by the State Child Abuse Death Review Team.

### Cause of Death

According to national estimates, 51% of maltreatment fatalities are from abuse, 45% from neglect and 4% from multiple forms of maltreatment.<sup>6</sup> For the children included in this study, abuse was a factor in 52% of the deaths and neglect on the part of the parent or caretaker was a factor in 48% of the deaths, as shown in Figure 1.

**Figure 1: Abuse & Neglect Deaths**



Child neglect, which accounted for over 45% of all substantiated cases of child maltreatment nationally in 1998, is defined as a “type of maltreatment that refers to the failure to provide needed age-appropriate care, such as shelter, food, clothing, education, supervision, medical care and other basic necessities needed for development of physical, intellectual and emotional capacities.”<sup>7</sup>

Of the 29 children whose deaths were reviewed as part of this study, neglect by a parent or other caretaker was a factor in 14 (48%) of the cases. The fact that neglect played a role in a slightly higher number of these deaths as compared to national statistics may be due to the population included in this study. Since the child deaths that were reviewed involved children who had previously been the subject of a report to the Abuse Hotline, the prior report, which in many instances involved similar allegations of neglect, may have served to substantiate the death maltreatment by revealing a pattern of caregiver failure to provide reasonable care to the child.

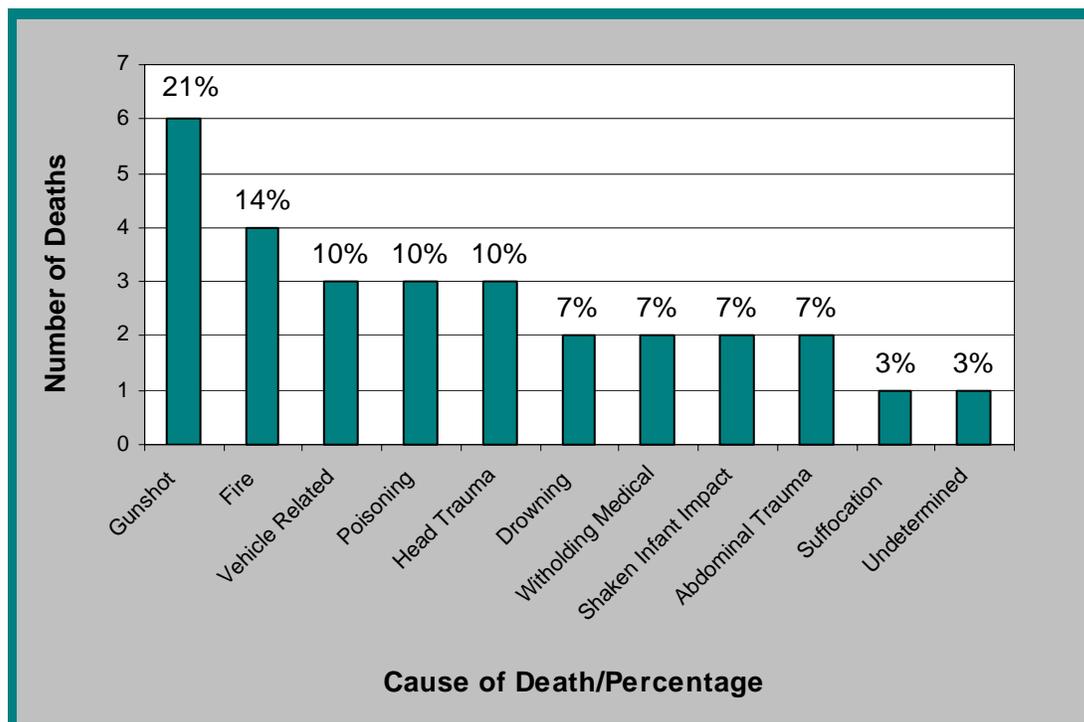
In the majority of neglect deaths reviewed during this first year, the children died due to inadequate supervision by a caretaker, resulting in their dying from drowning, asphyxiation or in

a house fire. However, there were at least two deaths in which children died from illness or medication toxicity secondary to medical neglect by their caretakers.

Physical abuse, which accounted for 52% of the deaths in this study, is the most visible form of child abuse and is defined as "...any act which results in non-accidental trauma or physical injury. Inflicted physical injury most often represents unreasonable, severe corporal punishment or unjustifiable punishment. This usually happens when a frustrated parent strikes, shakes or throws a child."<sup>8</sup>

Six (21%) of the children died from a fatal gunshot wound, which was the leading cause of death for the 29 children included in this report. Three of the children who died from gunshot wounds were siblings, and their deaths were the result of a murder–suicide perpetrated by their biological father. House fires, poisoning, head trauma and vehicle related deaths were among the other leading causes of death, as seen in Figure 2.

**Figure 2: Cause of Child's Death**

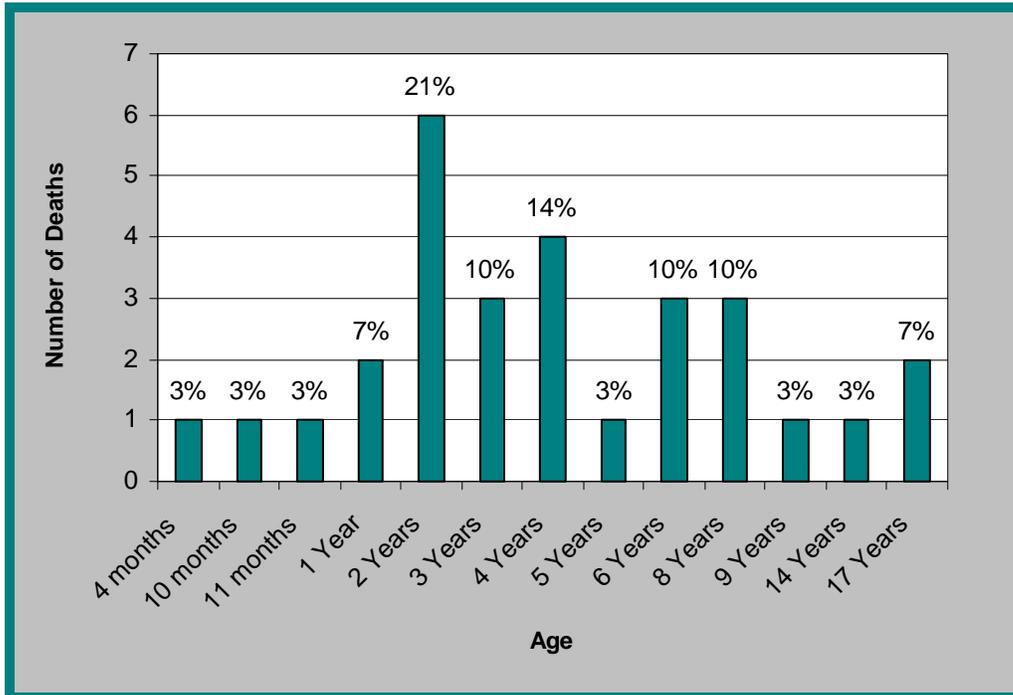


### Age at Death

National statistics reported that the majority of children who suffered maltreatment related deaths in 1998 were young (37.7% were under twelve months of age and 77.5% were under five-years-old).<sup>9</sup> Team members noted that results from this review were inconsistent with the national data in that only 10% of the children who died from abuse and neglect were under a year old and 61% of the children were less than five-years-old. Team members surmised that one reason for this may have been that the review included only those deaths in which the victim had been the subject of a prior report to the Florida Abuse Hotline, and very young

children, particularly infants, were less likely to have been reported to the Abuse Hotline than older children. Had the review included child victims whose older siblings or other household members had been the subject of a prior report to the Abuse Hotline, the number of deaths in this age range may have been higher. Figure 3 provides a specific breakdown of age at death for these 29 children.

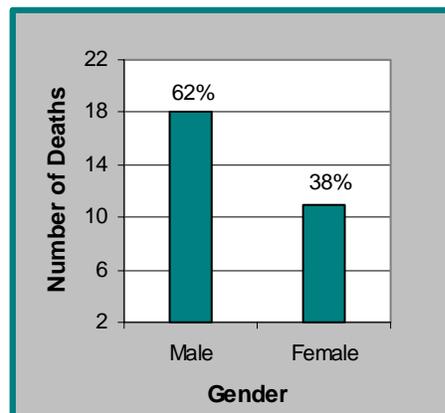
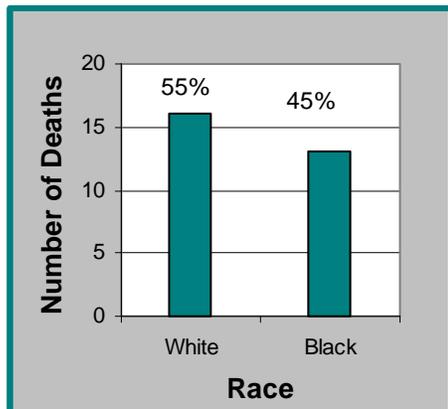
**Figure 3: Age of Child at Death**



**Race and Gender**

Fifty-five percent (55%) of these children were white and 45 percent were black, as seen in Figure 3. Males represented 62% and females 38% of the population included in the review, as seen in Figure 4.

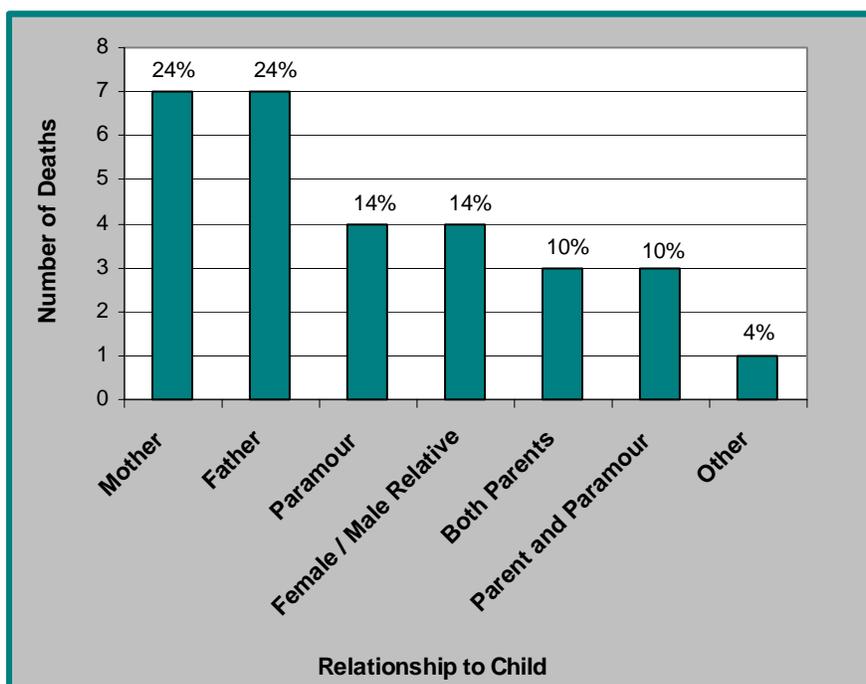
**Figures 4 & 5: Race and Gender of Children**



## Relationship of Responsible Caretaker

Mothers were responsible for 7 (24%) of the deaths, while fathers and male paramours were responsible for 11 (38%) of the 29 child deaths. In all 11 of the deaths in which fathers and paramours were identified as the perpetrator, the deaths were a result of physical abuse. This is in contrast to the 7 deaths in which mothers were identified as being the responsible caretaker, and neglect was the primary factor in 7 of the 5 child deaths. A breakdown, by category, of the person responsible for the child's death is shown in Figure 6.

**Figure 6: Relationship of Responsible Caretaker to Child**

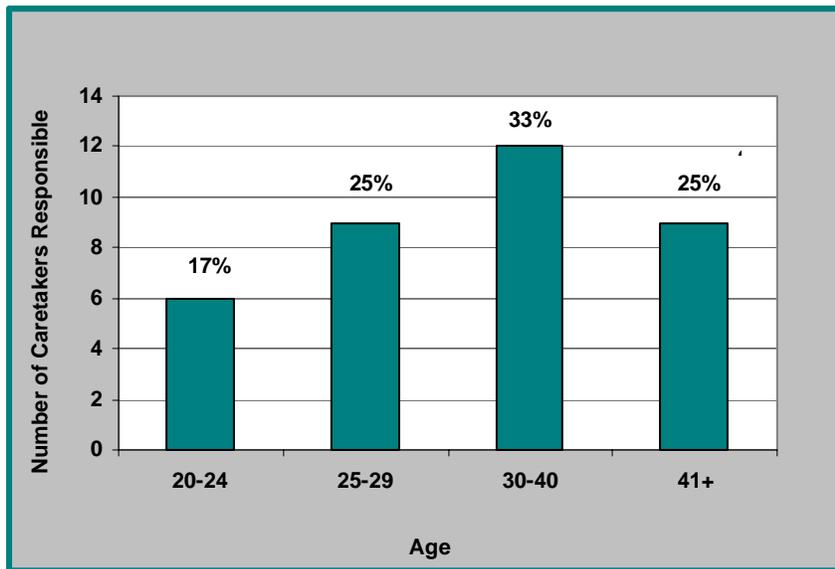


## Age of Responsible Caretaker

For the 29 child abuse deaths reviewed, there were a total of 36 persons responsible for the child's death. This included 7 cases in which more than one person was responsible for the death. The persons responsible for these deaths ranged in age from 20 to 81, with a median age of 34.5 years. This conflicts with national estimates, which report that perpetrators of maltreatment fatalities are generally young. "In 1998 nearly two thirds (62%) of the persons responsible for child abuse and neglect deaths nationally were younger than 30 years of age..."<sup>10</sup> An explanation may be that, since the victims in this study tended to be older than other children who suffered fatal maltreatment, their parents or caregivers might also be older than other perpetrators of fatal maltreatment.

Figure 7 shows a breakdown, by category, of the age of the caretakers responsible for these deaths.

**Figure 7: Age of Responsible Caretaker**



## Family Risk Factors

While no totally reliable predictors exist to determine which children among the millions reported are at the highest risk of death, there are some common factors professionals have found in families where children have suffered serious, even fatal, maltreatment.<sup>11</sup> According to national research, "...the children most vulnerable to serious or fatal abuse and neglect are those whose parents or other caretakers are ill-equipped to care for them, who live in social isolation and poverty, and who are virtually invisible to the larger community. They tend to live in environments that have few supports for parents (and) they may not know their neighbors well enough to ask for help."<sup>12</sup>

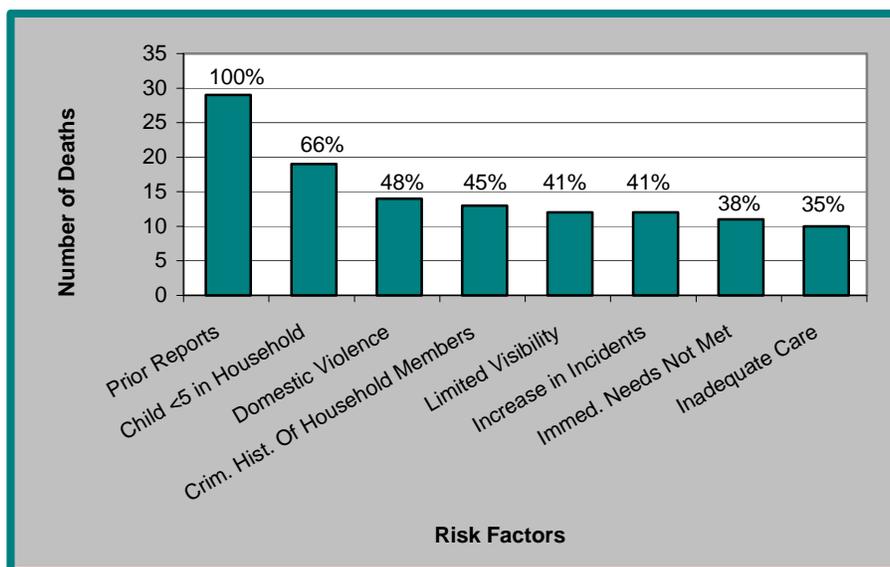
### **Anna\***

The mother and her boyfriend were arguing over the color of the mother's fingernail polish. Three-year-old Anna "looked at the boyfriend funny" and in his anger he punched her in the stomach at least 24 times. Anna suffered severe internal injuries and died. The paramour had a violent history including domestic violence and rape. At the time of Anna's death, the family was under voluntary protective supervision from the Department of Children and Families because of suspicious injuries this child had sustained several months earlier.

\*Alias

All 29 of the children included in this study had been the victim of a prior report to the Florida Abuse Hotline. Figure 8 shows the major family risk factors for these children.

**Figure 8: Family Risk Factors for Child Victims**



Factors	Cases
Prior abuse or neglect reports involving any household members	29
One or more children in the household age 5 or younger	19
Domestic Violence in the home	14
Criminal history on any household members	13
Child(ren) in the home have limited community visibility	12
A pattern of escalating and/or frequency of incidents of abuse or neglect	12
Parent or caregiver unable to meet child(rens) immediate needs	11
Parent or caregiver's age, mental health, alcohol or substance abuse affects	10

It should also be noted that 25 of the 29 children had three or more family risk factors present at the time of death.

### Adequacy of Prior Services

In 23 of the 29 child deaths, the victims either received direct services from the Department of Children and Families or were referred for community services by DCF staff prior to their death. The State Child Abuse Death Review Team determined that the previous services were adequate in 7 (30%) of these cases and inadequate in 3 (13%) of the cases. The most striking finding was that in 13 (57%) of the cases, reviewers were unable to determine the appropriateness or adequacy of prior services based on the information available at the time of the review.

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## Degree of Preventability

The State Child Abuse Death Review Team concluded that 27 (93%) of the 29 deaths were definitely preventable and that the other two deaths were probably preventable. This was not surprising since all of the children included in this report died from abuse or neglect. Because their deaths were either the result of physical assault by their caregivers or as a consequence of caregiver failure to provide reasonable care or supervision, their deaths were generally seen as preventable. Additionally, the child deaths that were reviewed involved children who had previously been the subject of a report to the Florida Abuse Hotline, thus all of these children had received some level of intervention from the Department of Children and Families prior to their death.

Team members felt uncomfortable developing specific prevention strategies regarding these complex cases due to the limited family information available on the 29 children and the low number of cases included in the review. However, the State Child Abuse Death Review Team concluded that many of the issues found in the review of these deaths were also found in the District 7 Child Safety Strike Force Report. The report, which included a review of two child deaths that were also part of this study, contained comprehensive recommendations regarding DCF management issues and service provision. Team members believed that continued implementation of these recommendations might result in a reduction of deaths among this population.

### **David, Tina and Richard\***

David, Tina and Richard, ages 2, 4 and 5, were put to bed in their home which had no electricity or running water. The parents left a candle burning in their bedroom and then left the home (the mother to take a shower at the neighbors' and the father to buy cigarettes). In the parent's absence the dwelling caught on fire, presumably from the burning candle. While the mother stated she had only been gone from the home for 5-10 minutes, fire investigators noted that the steel clamps holding the roof trusses together had melted, indicating that the fire had been burning for at least 30 minutes. David, Tina and Richard were found huddled between the bed and a wall. There were two prior reports to the Abuse Hotline involving these children -- one for medical neglect and another for inadequate supervision -- where David, Tina and Richard were all found wandering the neighborhood while the mother slept.

\*Alias

## CONCLUSIONS AND RECOMMENDATIONS

This first year, the State Child Abuse Death Review Team, in the absence of local teams, undertook the responsibility for reviewing the 29 child deaths that fit the criteria for review mandated in Florida Statutes. During this same time frame the State Team, and staff from the Department of Health, worked diligently to develop an infrastructure for the child abuse death review process, including evaluating the Department of Children and Families internal death review procedures. While data from the review of the deaths were limited, team members were able to identify some trends based on the case reviews. More significantly, the State Child Abuse Death Review Team gained valuable insights about the death review process during the first year through their study of, and participation in, death review activities.

**Issue: Sparse Data, Quality and Timeliness of the DCF Death Review Reports.** In all instances in which a child died from abuse or neglect and the child or their family had previously received child protection services, the Department of Children and Families staff in the district handling the death is responsible for completing a comprehensive death review. District death review reports were provided in 22 of the child deaths reviewed by the team. Two of the reports were preliminary, despite the fact that one of the children died over a year before the team reviewed the case. Some of the reports were very detailed and contained family history, circumstances of the death, DCF and community involvement with the family and recommended actions for prevention of similar deaths. However, 6 of the 22 reports were extremely sparse, generally providing only an account of the death incident. Team members noted a distinct disadvantage when reviewing those cases with no district death review report or in instances in which the district report contained limited information.

**Recommendation 1: The 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 child death reviews.**

**Recommendation 2: The Department of Children and Families should revise departmental operating procedures to address the quality and timeliness of the district death review report, to require local multidisciplinary staffings for all child abuse deaths with prior DCF involvement and to better define the roles and responsibilities of the state and local death review coordinators.**

**Issue: Low Number of Local Death Review Teams.** As earlier mentioned, the State Child Abuse Death Review Team assumed the daunting task of reviewing 29 child abuse and neglect deaths that occurred during 1999. This responsibility proved to be more difficult than originally anticipated. Team members noted that when additional or clarifying information was identified as being needed during the case reviews, the information was not easily accessible at the state level. Additionally, and perhaps more importantly, the State Child Abuse Death Review Team found that the review process was somewhat weakened by the absence of professionals who had previously worked with the family or who were currently involved in the death investigation.

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This led team members to the conclusion that it was critical for the initial death review process to occur at the local level.

**Recommendation 3: The State Child Abuse Death Review Team, in collaboration with the Department of Health and the Department of Children and Families, should consider the facilitation, development and training of local death review teams a priority for calendar years 2000-2001.**

**Issue: Small Number of Cases Reviewed.** The State Child Abuse Death Review Team determined that, although issues relevant to the Department of Children and Families' handling of prior investigations and service provision were identified in some of the cases, the data was based on review of only 29 deaths. Because of this, the team was not able to state with a comfortable degree of certainty that these issues represented trends within the Department of Children and Families. However, team members reviewed conclusions from the District 7 Child Safety Strike Force which was conducted in 1999, and included findings from an evaluation of management issues and the review of over 14,000 open child protection cases in Orange, Brevard, Seminole and Osceola Counties. Team members agreed that recommendations from the District 7 Child Safety Strike Force were comprehensive and based on findings from a representative number of case reviews, including the thorough evaluation of two high profile child deaths, which were a part of this review, as well.

**Recommendation 4: The Department of Children and Families should continue to implement the District 7 Child Safety Strike Force recommendations.**

**Issue: Ability to Gather Data Necessary to Meet Timeliness of Annual Report.** Child Abuse Death Review Team members noted that 8 of the 29 children died during the last quarter of calendar year 1999. When child deaths occurred late in the year, particularly if circumstances relevant to the death were complex, essential information about the death, such as copies of law enforcement reports, results from autopsies and other highly specialized medical reports were not available or timely enough for reviewers to include the data in the findings section of the annual report.

**Recommendation 5: The Department of Health should propose a legislative amendment revising the due date of the annual report from September 30 to December 31.**

**Issue: Quality of the Child Death Investigation.** The state team noted in several of the child deaths that the investigation of the death by law enforcement was not thorough. There was at least one case in which law enforcement failed to interview the sibling of the deceased child because relatives refused access to the child. In this instance that early interview was essential because the surviving child had been a party to the incident resulting in his brother's death. There were also a number of other cases in which team members believed that law enforcement had failed to interview all necessary individuals, gather appropriate evidence or aggressively pursue bringing criminal charges against the abuser.

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Also, in some cases it appeared that the medical examiner had limited information about the crime scene or the death incident. While the medical examiner is charged with determining the specific cause of death, the team believed that crime scene information and knowledge of the circumstances surrounding the child's death should be considered when determining manner of death.

**Recommendation 6: During the next year, the State Child Abuse Death Review Team 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 7: 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.**

**Issue: Limited Focus of the Child Death Review Process.** During the review process, State Child Abuse Death Review Team members noted several concerns regarding the limited focus of the Child Abuse Death Review Process. Several team members cited child deaths they had previously been asked to evaluate in their communities. While these deaths did not meet the criteria for review by the State Child Abuse Death Review Team or a local death review team, it was determined through the evaluation process that the deaths were suspicious, and may have been the result of fatal maltreatment by a caretaker. The following situations are provided to illustrate this point:

- One case involved the death of a two-month-old infant. The autopsy ruled that the death occurred as a result of Sudden Infant Death Syndrome (SIDS) even though the child was noted to have multiple fractured ribs (diagnostic of child abuse) as well as substantial bruising around the neck. No report was ever made to any agency regarding this child.
- A second death involved a one-year-old child who was suspected to have died from a lethal dose of the anti-seizure medication, Phenobarbital. An individual had witnessed the mother giving the child a large dose of this medication prior to death and had reported this fact to emergency medical services (EMS) and hospital staff. Despite this, the child's blood work was not evaluated for Phenobarbital and an autopsy was never performed. A report was made to the Florida Abuse Hotline six months after the child died.

In both of these cases, any surviving or future children of these parents might be at risk of harm while in their care. These are only two specific examples of cases in which childhood deaths can alert the community to the potential for serious harm or death to other children.

It should also be noted that existing local teams review the deaths of all children, regardless of cause of death. The majority of the local communities that have begun the process of developing local death review teams have also stated their intention to review the deaths of all children as well. This difference in focus between local teams and the State Child Abuse Death Review Team has resulted in a tenuous link, at best, between the two entities and may ultimately prove to constrain future development of local death review teams.

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In summary, the State Child Abuse Death Review Team concluded that, in order to ensure the effectiveness of the fatality review process, the deaths of all children in Florida should be evaluated, and prevention activities expanded to address these child deaths.

**Recommendation 8: The Florida Legislature should expand the Child Abuse Death Review Process to include the review of all child deaths.**

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