

FLORIDA CHILD ABUSE DEATH REVIEW



**FOURTH ANNUAL REPORT
DECEMBER 2003**



State Child Abuse Death Review Team
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FLORIDA CHILD ABUSE DEATH REVIEW TEAM



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The Honorable Jeb Bush
Governor of Florida
The Honorable Jim King
President of the Florida Senate
The Honorable Johnnie Byrd
Speaker of the Florida House of Representatives
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Dear Governor Bush, President King, and Speaker Byrd:

As chairman of the State Child Abuse Death Review Team, I am submitting this annual report of child abuse and neglect deaths in accordance with Chapter 383.402, Florida Statutes. This report summarizes information from the case reviews of the 29 children who died in 2002 that had at least one prior report of abuse or neglect filed with the Department of Children and Family Services. Additionally, it highlights major issues and trends for the 124 deaths reviewed over the four-year period since the inception of the State Child Abuse Death Review Team.

During this fourth year, the State Child Abuse Death Review Team, in collaboration with local communities, continued to work diligently to improve the review process, and train additional local teams on conducting child abuse and neglect death reviews. While we have accomplished a great deal, more work is required. In particular, more local child abuse death review teams need to be established or encouraged to be active.

I believe this report justifies the need for an expanded review of child abuse and neglect deaths in Florida and for data-driven policymaking to prevent further avoidable child abuse and neglect deaths. As our work progresses, I am optimistic that the end result will be a better understanding of the circumstances and contributing factors of those deaths, which will support our ultimate goal of continuing the mission of working together to reduce preventable child abuse and neglect deaths.

Sincerely,

A handwritten signature in black ink, appearing to read "Robert W. Hodges".

Robert W. Hodges, Chairman
State Child Abuse Death Review Team

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CHILD ABUSE DEATH REVIEW TEAM
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MISSION

To reduce preventable child abuse and neglect deaths

Submitted to

The Honorable Jeb Bush, Governor, State of Florida
The Honorable Jim King, President, Florida State Senate
The Honorable Johnnie Byrd, Speaker, Florida State House of Representatives

DEDICATION

The cases of twenty-nine children who had prior involvement with child protection services and subsequently died from abuse or neglect during 2002 were presented to the Child Abuse Death Review Team for review. This report is dedicated to these children.

Profile Information	Date of Death	Cause of Death	Caretaker Responsible	Prior Reports
<i>2-month-old male</i>	<i>12/13/2002</i>	<i>Asphyxiation</i>	<i>Parent/Male Paramour</i>	<i>2</i>
<i>3-month-old male</i>	<i>7/20/2002</i>	<i>Drowning</i>	<i>Mother</i>	<i>2</i>
<i>4-month-old male</i>	<i>1/16/2002</i>	<i>Shaking/Impact Syndrome</i>	<i>Father</i>	<i>1</i>
<i>4-month-old female</i>	<i>8/21/2002</i>	<i>Shaking/Impact Syndrome</i>	<i>Father</i>	<i>3</i>
<i>7-month-old male</i>	<i>8/9/2002</i>	<i>Heat Stroke</i>	<i>Other</i>	<i>1</i>
<i>9-month-old male</i>	<i>4/1/2002</i>	<i>Shaking/Impact Syndrome</i>	<i>Father</i>	<i>1</i>
<i>11-month-old male</i>	<i>6/19/2002</i>	<i>Drowning</i>	<i>Mother</i>	<i>2</i>
<i>20-month-old female</i>	<i>9/5/2002</i>	<i>Poison/Overdose</i>	<i>Aunt</i>	<i>1</i>
<i>21-month-old female</i>	<i>6/8/2002</i>	<i>Blunt Force Head/Body Trauma</i>	<i>Parent/Male Paramour</i>	<i>1</i>
<i>22-month-old male</i>	<i>8/28/2002</i>	<i>Head Trauma</i>	<i>Father</i>	<i>2</i>
<i>2-year-old female</i>	<i>11/12/2002</i>	<i>Drowning</i>	<i>Aunt</i>	<i>1</i>
<i>2-year-old female</i>	<i>7/27/2002</i>	<i>Drowning</i>	<i>Mother</i>	<i>1</i>
<i>2-year-old female</i>	<i>3/22/2002</i>	<i>Drowning</i>	<i>Mother</i>	<i>1</i>
<i>2 year old male</i>	<i>11/1/2002</i>	<i>Blunt Force Head Trauma</i>	<i>Parent/Male Paramour</i>	<i>2</i>
<i>2-year-old male</i>	<i>7/1/2002</i>	<i>Homicidal Violence (physical abuse)</i>	<i>Acquaintance</i>	<i>6</i>
<i>2-year-old male</i>	<i>1/2/2002</i>	<i>Blunt Head Trauma</i>	<i>Parent/Male Paramour</i>	<i>1</i>

Profile Information	Date of Death	Cause of Death	Caretaker Responsible	Prior Reports
<i>3-year-old male</i>	<i>11/6/2002</i>	<i>Blunt Head Trauma (vehicle related)</i>	<i>Mother</i>	<i>2</i>
<i>3-year-old female</i>	<i>2/21/2002</i>	<i>Drowning</i>	<i>Parent/ Female Paramour</i>	<i>2</i>
<i>4-year-old female</i>	<i>4/4/2002</i>	<i>Drowning</i>	<i>Mother</i>	<i>1</i>
<i>4-year-old male</i>	<i>8/29/2002</i>	<i>Multiple Blunt Trauma</i>	<i>Stepfather</i>	<i>3</i>
<i>5-year-old male</i>	<i>6/12/2002</i>	<i>Drowning</i>	<i>Adoptive Mother</i>	<i>6*</i>
<i>5-year-old female</i>	<i>7/15/2002</i>	<i>Drowning</i>	<i>Mother</i>	<i>2</i>
<i>5-year-old male</i>	<i>12/23/2002</i>	<i>Drowning</i>	<i>Mother</i>	<i>15</i>
<i>6-year-old female</i>	<i>3/29/2002</i>	<i>Blunt Head Trauma</i>	<i>Parent/male Paramour</i>	<i>7</i>
<i>6-year-old male</i>	<i>6/13/2002</i>	<i>Multiple Trauma</i>	<i>Mother</i>	<i>1</i>
<i>6-year-old male</i>	<i>2/3/2002</i>	<i>Gunshot to Head</i>	<i>Father</i>	<i>1</i>
<i>10-year-old male</i>	<i>7/5/2002</i>	<i>Drug Overdose</i>	<i>Mother</i>	<i>5</i>
<i>12-year-old female</i>	<i>8/1/2002</i>	<i>Cerebral Palsy</i>	<i>Mother</i>	<i>2</i>
<i>15-year-old male</i>	<i>7/12/2002</i>	<i>Acute Combined Drug Intoxication</i>	<i>Mother</i>	<i>5</i>

*Some prior to adoption

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

***William Wordsworth (1770-1850)
We are Seven***

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EXECUTIVE SUMMARY

In 1999, the Florida Legislature mandated that the Department of Health establish a statewide multidisciplinary, multi-agency child death review system, consisting of state and local review teams, to conduct reviews of the facts and circumstances surrounding child abuse and neglect deaths in which the Department of Children and Family Services, Florida Abuse Hotline accepted at least one prior report of abuse or neglect. Chapter 383.402 (1) Florida Statute, (FS) identifies the purpose of these child abuse death reviews as follows:

“The purpose of the reviews shall be to:

- Achieve a greater understanding of the causes and contributing factors of deaths resulting from child abuse or neglect.
- Whenever possible, develop a community-based approach to address child abuse deaths and contributing factors.
- Identify any gaps, deficiencies or problems in the delivery of services to children and their families by public and private agencies that may be related to deaths that are the result of
- child abuse.
- Make and implement recommendations for changes in law, rules, and policies, as well as develop practice standards that support the safe and healthy development of children and reduce preventable child abuse deaths.”¹

This fourth annual report includes information from the review of the 29 children who died in 2002. Additionally, it highlights major issues and trends for the 124 deaths reviewed over the four-year period since the inception of the Florida State Child Abuse Death Review Team. It is important for the reader to put the review of these child deaths in perspective. Because the population reviewed is limited in scope and representation of the total number of abuse and neglect deaths in Florida, the recommendations and comments made throughout this report are subject to those limitations when generalizations are made. There are clear patterns and trends noted for the state that are consistent with national data; however, because of the limited population there are variations, which are reflected in this report. Findings for this four-year period include the following:

- Abuse and neglect deaths occurred equally (50%).
- The majority of the abuse deaths involved direct attacks resulting in physical trauma. Of the 37 trauma-related deaths, 19 of the children died from head trauma, 6 from abdominal trauma, and 12 from beatings and multiple traumas.
- Eight children died from trauma resulting from shaking/impact.
- Drowning was the leading cause of neglect deaths with 27 child deaths for the four-year period.
- Ten of the children died from a fatal gunshot wound. Seven children were intentionally shot by an adult. One of these children died as a result of being shot in the head by his father, who then committed suicide.

-
- According to national statistics, the majority of children who suffered maltreatment related deaths in 2001 were young. The results of the 2000 Reports from the States to the National Child Abuse and Neglect Data System (NCANDS) indicated that 43% were under twelve months of age and 85% were younger than six years.³ Results from this review indicated a lower percentage of children in these age groups. Sixteen percent (16%) of the children who died from abuse and neglect were under twelve months of age and 77% of the children were younger than six years. 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, the number of deaths in this age range may have been higher. Figure 6 of the report provides a specific breakdown of age at death for these 124 children.
 - Of the 124 deaths, 75 (60%) were male and 49 (40%) were female. Seventy-five (60%) of the children were white, 47 (38%) percent were black, 1 (1%) was multi-racial and 1 (1%) was American Indian. For those deaths that identified specific ethnicity, a total of 16 (20%) were identified as Hispanic and 2 (2%) were identified as Haitian.
 - Fathers or male paramours were responsible in 67 (46%) of the deaths. Mothers were responsible in 53 (36%) of the deaths. Neglect was the primary cause of death in the majority of cases in which the mother was the only caretaker responsible. The majority of the deaths in which the father or male paramour was the sole caretaker responsible were caused by abuse.
 - The identified caretaker responsible ranged in age from seventeen to seventy-nine, with 76 (52%) under the age of thirty years. Florida's data are inconsistent with national estimates, which report that caretakers responsible of maltreatment fatalities are generally younger than thirty years of age. This may be the result of the case criteria for this review as young parents with first time infants having no prior reports were not included.
 - Seventy-three (59%) of the 124 children had five or more risk factors present at the time of death. Major risk factors for these children and the percent of deaths in which these factors were present included:
 - One or more children in the household were age four or younger (79% of deaths)
 - A pattern of escalation or frequency of incidents of abuse or neglect (47% of deaths)
 - Parent or caregiver unable to meet children's immediate needs (44% of deaths)
 - Children in the home had limited community visibility (44% of deaths)
 - Parent or caregiver's age, mental health, alcohol or substance abuse affected their ability to adequately care for child (42% of deaths)
 - Parent or caregiver's criminal history presented a potential threat of harm to the child (31% of deaths)
 - Pattern of escalating and/or continuing incidents of domestic violence (25% of deaths)
 - Living conditions were physically hazardous to the health of the child (23% of deaths)
 - Parent or caregiver were unable or unwilling to protect the child from abusive caregivers/paramours (25% of deaths)

Data for 2002 indicated that of the 29 deaths reviewed by the team, the causes and contributing factors included:

Abuse (13 deaths)

- The majority of the abuse deaths involved direct attacks resulting in physical trauma. Of the 6 trauma related deaths, 3 of the children died from head trauma and 3 from multiple traumas.
- 3 children died from shaking/impact.
- 2 children died with their mother as a result of intentional drowning (murder-suicide).
- 1 child died as a result of intentional suffocation.
- 1 child died from a gunshot, homicide.

Neglect (16 deaths)

- 5 children accidentally drowned in swimming pools, and 3 children drowned in their bathtubs. Inadequate supervision by the caretaker responsible contributed to these deaths.
- 3 children died in vehicle related accidents, none were wearing appropriate vehicle restraints.
- 2 children died due to drug overdose. Inadequate supervision contributed to these deaths.
- 1 child with severe disabilities died due to medical neglect.
- 1 child died from a gunshot wound caused when a sibling located a gun in the home that was not properly secured and fired the gun striking his younger sibling.
- 1 child died by hanging himself, inadequate supervision in a facility was a contributing cause in this death.

ISSUES AND RECOMMENDATIONS

The State Child Abuse Death Review Team has evolved over the past four years. In the initial years, the team built a foundation for the child abuse death review process at the state level, and began to recruit local teams. This early work focused on developing a multidisciplinary approach to this specific population of child abuse and deaths, to achieve a better understanding of the causes and contributing factors and recommend better approaches to prevention. Once the foundation was built, the focus expanded to the further development of local teams, multidisciplinary protocols, data gathering and analysis, and the development and implementation of recommendations.

It remains important for the reader to put the overall analysis of these child deaths in perspective. In addition to the limitations in the information used to analyze individual cases, the population reviewed is limited in scope and representation of the total number of abuse and neglect deaths in Florida. Therefore, although there are some clear patterns reflective of national trends, the specifics may vary.

The Child Abuse Death Review Team identified both case specific and overall systemic issues in the child protection system. After a careful analysis of the data, the state team presents the following recommendations to address critical issues identified during their reviews.

ISSUE 1: NOT ALL VERIFIED CHILD DEATHS REVIEWED

The Child Abuse Death Review Team identified a major problem in the scope of the deaths reviewed. Currently, verified child deaths are only reviewed if the child had a prior abuse or

neglect report with the Department of Children and Family Services, thereby excluding many child victims. If all verified child abuse and neglect deaths were reviewed, the teams would have a better understanding of causes and contributing factors, thereby enhancing their ability to make effective preventive recommendations.

Florida's criteria for child abuse and neglect death review are significantly more restrictive than any other state in the nation. Approximately 19 states review all child deaths, and of the states that only review sudden, unexpected or unexplained deaths none require the existence of a previous report to the child abuse hotline. Florida's limited review criterion not only affects the ability of the team to fully accomplish the statutory purposes of their reviews, but also significantly limits the recruitment of local review teams. Many counties in the state have expressed an interest in developing a local team if the review criterion is expanded.

The State Child Abuse Death Review Team has recommended expansion to all child death review in each of its previous three reports and continues to support that recommendation. During this past year, the Chairman of the team met with the Department of Health and Department of Children and Family Services Secretaries requesting support for the review of all verified child abuse and neglect deaths and received support from both department leaders. The Chairman also wrote a letter to Governor of Florida on behalf of the team requesting support for expanded review. Per Mr. Hodges' letter: "...The majority of child abuse and neglect deaths that occur in this state are children who have never received services through the child protection system. Reviewing these deaths will help us build a broader picture and better understand the dynamics of why children are dying from senseless acts perpetrated on them by family members or caretakers...."

Action Needed/Recommendation: The Florida Legislature should expand the child abuse death review process to include the review of all verified abuse or neglect deaths, with no requirement for prior reports to the child abuse hotline.

ISSUE 2: DROWNING DEATHS

The Child Abuse Death Review Team identified drowning as a major concern. Florida is a peninsula saturated by lakes, rivers, retention ponds, and swimming pools. Additionally, most homes have bathtubs that pose drowning risk to children who are inadequately supervised.

As of 12/8/2003, figures for 2002 indicate that 78 children died as a result of verified abuse or neglect. Of these 78 children, 14 died as a result of drowning, representing 21% of all verified child abuse/neglect deaths in the state. As some 2002 cases remain under investigation, this figure is subject to increase. The Department of Children and Family Services predicts that, based on the numbers available at this time, even more children will have died as a result of drowning in 2003.

Action Needed/Recommendation: It is essential that preventative measures be taken to decrease the number of children drowning in Florida. These measures would include, at a minimum:

- Emphasis on drowning risk factors in all risk assessments
- Incorporate drowning prevention into checklists and educational material used by home visiting programs

ISSUE 3: CASE SPECIFICITY/CASE PLANS

Individualized and specific case plans were identified as a priority need by the Child Abuse Death Review Team. It was discovered that often, psychological evaluations and reports were not case specific, and case plans did not require follow-up on the psychological evaluation recommendations.

Action Needed/Recommendation: Sufficient information should be provided to the evaluating psychologist to ensure the development of a case specific evaluation and report. The caseworker responsible for drafting the case plan with the family should be encouraged to avoid standard, non-specific requirements, which obfuscate the primary problem and cause delays in compliance, and to “close the loop” by requiring follow-up on recommendations.

Additionally, requirements for “anger management” and “parenting classes” should be case specific. In cases of domestic violence, the caretaker responsible should be referred to a certified batterer’s intervention program instead of anger management.

ISSUE 4: TRAINING NEEDS

Additional training is needed for various professional and paraprofessional positions. Training needs include recognizing signs and symptoms of child abuse and neglect, risk assessment, and mandatory reporting requirements.

Action Needed/Recommendation:

Law Enforcement

The team recommends that law enforcement and 911 operators receive additional training in suicide prevention and intervention, and recognition of risk factors by means of lethality assessments. Because telephone 911 operators and law enforcement officers are usually the first people exposed to potentially lethal situations they need to be highly trained to recognize these risk factors and take appropriate action.

Law enforcement should also be required to immediately report to the Hotline when a child is injured or dies due to being improperly or not restrained in motor vehicle crashes. It is only through the reporting mechanism that a true picture of this behavior’s repercussions can be studied and prevented. The team also strongly encourages the enforcement of child automobile restraint laws.

Training should be provided to law enforcement officers on indicators of child abuse and neglect, including mandatory reporting. They should fully understand the implications of risk and the need for reporting in cases of drug offenses, and cases of domestic violence where children are involved.

The team recommends that the law enforcement training on child abuse and neglect, as well as domestic violence, take place at the academy level and at local agency level. It is recommended that the Standards and Training Commission require specific time frames and curriculum.

Department of Children and Family Services Staff

The team recommends that child protective investigators receive training on critical decision-making. This training should include actual case scenarios whose lessons learned could be applied in the field. Domestic violence is another area in which additional training is needed. It is further recommended that Child Welfare Legal Services (CWLS) and child protective investigators review the process for child safety decision-making; and that CWLS attorneys receive training on the risk to children in domestic violence situations, as well as strategies for court intervention.

Judiciary

The team recommends that the judiciary receive training in domestic violence issues and the concurrent risk to children.

School Personnel

The team recommends that all school personnel receive training on child abuse and neglect. Training should include recognizing the signs and symptoms of abuse and neglect, mandatory reporting and the child protective investigative process.

ISSUE 5: FACILITATION OF COMMUNICATION

With the increased number of agencies involved in the child protection system, communication regarding the status and transfer of cases is problematic. Case planning can be difficult without valuable input and information from the various caseworkers involved with a family and result in gaps in services that leave children at risk.

Action Needed/Recommendation: The team recommends that the Department of Children and Family Services and its community based care providers review and if necessary, revise their policies and procedures regarding their interagency communication, including a review of policies regarding the closure of cases in which in-home services are being provided. The team recommends that the Department of Children and Family Services also consider Child Protection Team recommendations prior to case closure.

ISSUE 6: ACCESSIBILITY OF CRIMINAL HISTORY

Although the Department of Children and Family Services has some access to criminal information, improvement is needed in the speed and accuracy of this information.

Action Needed/Recommendation: The team recommends that the Department of Children and Family Services be granted access to all criminal histories, both local and national, in an expedient and consistent manner statewide. This may require stronger language in working agreements between the Department and law enforcement. It is further recommended that specialized Criminal Intelligence Analysts (CIA's) be utilized for this function statewide, to insure greater reliability on the completeness and accuracy of the criminal history information.

ISSUE 7: PROTECTIVE INVESTIGATIONS STAFF RETENTION

Due to the increasing turnover rate in protective investigations, legislation was recently passed to appoint a Protective Investigator Retention Workgroup, to address the issues surrounding

turnover and to make recommendations for alternative responses to investigations, staff recruitment and training, and staff retention. The workgroup's report is due to the legislature by the end of the calendar year.

Action Needed/Recommendation: The team recommends that the legislature and the Department of Children and Family Services support and implement the recommendations of the Protective Investigator Retention Workgroup.

ISSUE 8: SUBSIDIZED CHILD CARE

Families with children at risk of abuse and neglect have an ever-increasing need for adequate, affordable daycare. Parents with multiple daily living needs often leave their children inadequately supervised due to the lack of appropriate, available caretakers.

Action Needed/Recommendation: The team recommends that at risk children be prioritized for subsidized childcare.

PURPOSE OF CHILD ABUSE DEATH REVIEWS

Every child death is tragic, however when a child dies from abuse or neglect, especially if that death could have been prevented, it is seemingly incomprehensible. To better understand how and why these children die requires in-depth review of the causes and circumstances surrounding these deaths. To prevent further deaths requires a multidisciplinary approach designed to improve service delivery and linkage among the various disciplines, agencies and community partners that work with children and their families on both local and statewide levels.

Summary of Early Initiatives

While many agencies may have been involved with a child who dies as a result of abuse or neglect, the Department of Children and Family Services (DCF), because of its' statutory mandate to investigate abuse and neglect, is most often the focus of inquiries or reviews into such deaths. Over the past 15 years, there have been at least ten such reviews of child deaths by independent panels, task forces, and Grand Juries. Five of these reviews were conducted in response to the death of a specific child, all of whom had some contact with DCF prior to their deaths. The reviews that focused on specific children also focused primarily on acts or omissions by DCF and found similar, ongoing systemic issues within DCF that were thought to have contributed to the ultimate death of the children involved. The reviews also noted concerns with other agencies or individuals involved with the deceased child. Changes in statute and internal policies within DCF and other agencies were often initiated as a result of these reviews. All of these reviews, and their findings and recommendations can be viewed on the Internet at the following address: http://www.state.fl.us/cf_web/news/cwtfsummary.pdf

The Department of Children and Family Services began tracking and analyzing child abuse and neglect deaths in 1988. Using an elaborate database to identify cases needing review, quality assurance staff and the 14 district and regional child abuse death review coordinators now analyze every report made to the Abuse Hotline that alleges that a child's death was due to abuse or neglect. The results of these reviews are published annually, and information learned through this process has helped in the development of policies and procedures, as well as investigative tools such as the department's Initial Child Safety Assessment. The data in the DCF internal death review database are used by the state Child Abuse Death Review team to identify cases for review.

STATE CHILD ABUSE DEATH REVIEW TEAM

The Florida Legislature and the Department of Children and Family Services has developed a number of initiatives and programs to address the issues identified as a result of previous reviews of child abuse and neglect deaths. However, after the tragic death of a six year old who was brutally murdered by her father in 1998, it became clear that these efforts fell short of their intended goal, which was to reduce child abuse and neglect deaths.

As a result of this death, and the deaths of other children due to abuse and neglect, the 1999 Florida Legislature authorized the development of independent, multidisciplinary statewide and local child abuse death review teams to review child abuse and neglect deaths in which the Florida Abuse Hotline had accepted at least one prior report of abuse or neglect. 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 multidisciplinary 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.¹

Program Purpose

The State Child Abuse Death Review Team was established in statute to ensure oversight of the child abuse death review process. Chapter 383.402 (1) Florida Statute, (FS) identifies the purpose of the child abuse death reviews as follows:

“The purpose of the reviews shall be to:

- Achieve a greater understanding of the causes and contributing factors of deaths resulting from child abuse or neglect.
- Whenever possible, develop a community-based approach to address child abuse deaths and contributing factors.
- Identify any gaps, deficiencies or problems in the delivery of services to children and their families by public and private agencies, which may be related to deaths that are the result of child abuse.
- Make and implement recommendations for changes in law, rules, and policies, as well as develop practice standards that support the safe and healthy development of children and reduce preventable child abuse deaths.”¹

The child death review criteria for the state team limits the number of child deaths for the team to review for the purposes of identifying patterns and trends. As a result, it is necessary to present cumulative data to better identify patterns and trends regarding these child deaths to better address the legislative requirements of the team.

Summary of First Three Years

Under current legislation, The Child Abuse Death Review Team has limited jurisdiction. It is empowered to review child deaths only when the death resulted from a verified abuse or neglect maltreatment and when the deceased child had previously been referred to the Department of Children and Family Services child abuse hotline. Over the past four years, the deaths reviewed by the Child Abuse Death Review team represent approximately one-third of the total number of child maltreatment deaths verified in each of those years.

During the past three years, the Child Abuse Death Review Team concluded that the deaths were preventable in approximately 80% of the cases reviewed. In those cases, the team found that the deaths could have been prevented if appropriate action had been taken, by either the Department of Children and Family Services or sheriff's office staff responsible for protective investigations, by other state agencies or private service providers, or by parents, relatives, neighbors or other individuals or agencies associated with the child. The team found that some of the deaths, although due to abuse or neglect, were not preventable by anyone other than the identified caretaker responsible.

In the past three reports the Child Abuse Death Review Team made recommendations, to agencies responsible for protective investigations, and to other state and community agencies providing a variety of services to families. Many of these recommendations focused on improvement of training and/or changes in policies and practices, such as the necessity to implement a training program to increase the level of understanding of the co-existence of child maltreatment and domestic violence. Some of these recommendations have been adopted and implemented, while others have not been implemented and continue to be emphasized in the annual recommendations. The team also made recommendations pertaining to its own operations and scope of jurisdiction. A summary of all prior recommendations is available by contacting the chair.

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. Agency representatives of The State Child Abuse Death Review Team are appointed for staggered two-year terms, and all are eligible for reappointment. The representative of the Florida 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:

- Department of Health
- Department of Legal Affairs
- Department of Children and Family Services
- 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 Family Services 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 caretaker responsible 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

The names of the current members of the State Child Abuse Death Review Team are included in Attachment 1.

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 December 31 of each year. 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 an integral part of the death review process. These multidisciplinary teams have the primary responsibility for conducting the initial child abuse and neglect death reviews and forwarding their findings to the state team for review and inclusion in the annual report.

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 should include, at a minimum, representatives from the following departments, agencies, or associations:

- District Medical Examiner's Office
- Child Protection Team
- County Health Department
- Department of Children and Family Services
- State Attorney's Office
- Local Law Enforcement Agency
- School District Office

The chairperson of the local team may also 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 caretaker responsible 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

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 Florida central abuse hotline
- Collect data on applicable child abuse deaths for The State Child Abuse Death Review Team.

-
- 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.
 - Designate a team chairperson who oversees the activities of the local team and calls meetings of the team when necessary.
 - Designate a member of the local team, if there is not a state team member on the local team, to liaison to the state team for the purpose of ensuring consistency in review protocols, to present case information when requested, and to request as needed on a case-by-case basis, that the state team review the data of a particular case.

Carolyn*

Four-year-old Carolyn died as a result of drowning in a community pool. Her 31-year-old mother had left her in the living room, while she nursed the baby in another room. When she checked the living room, Carolyn was not there. Her mother discovered her floating in the community pool.

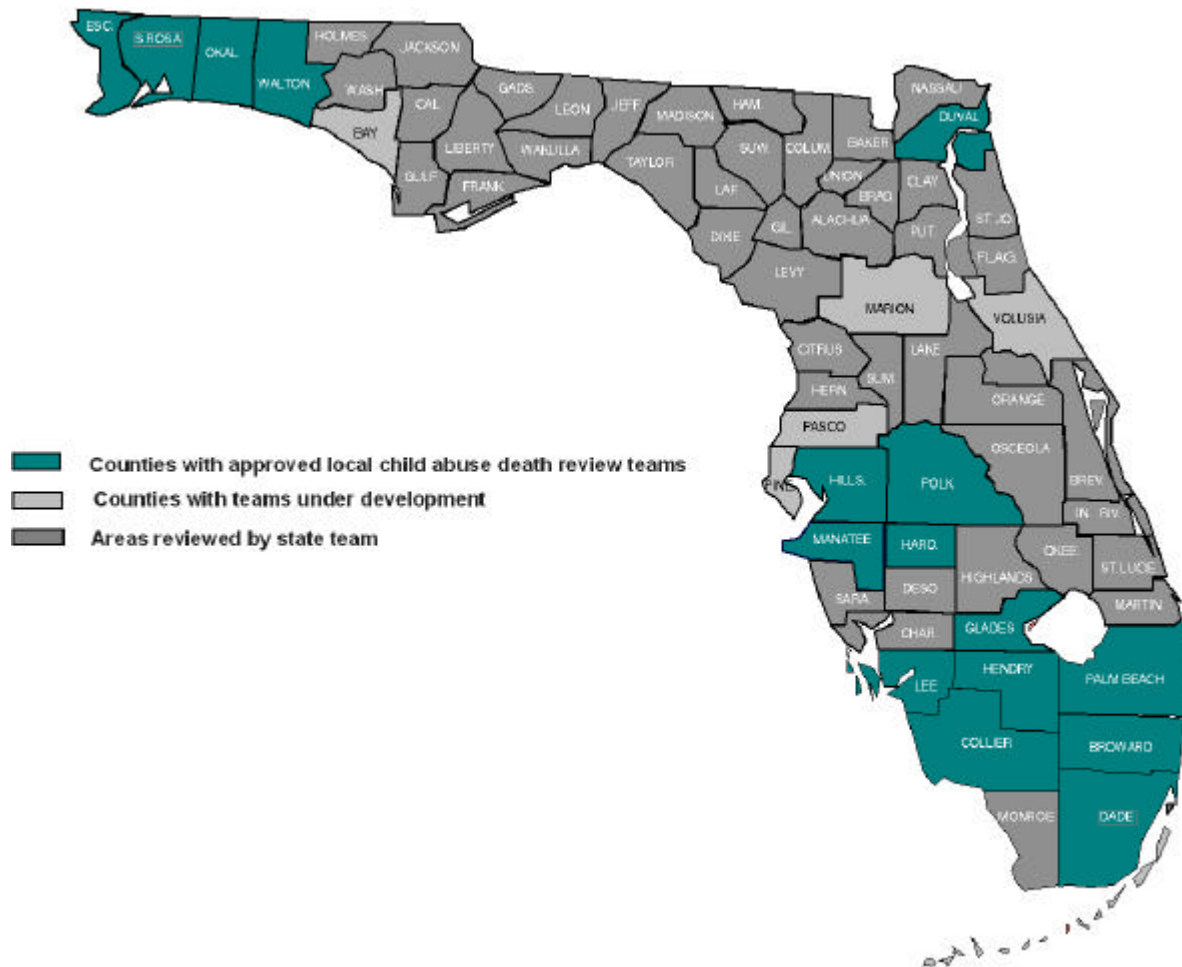
There was one prior neglect report on the family, 7 months before the drowning. During that investigation, neighbors noted that the children were frequently unsupervised. The family placed locks at the top of the doors as a safety precaution, and the report was closed with some indicators of inadequate supervision. At the time of the drowning, the living room door was unlocked.

****Alias***

Existing and Planned Local Teams

Recruitment efforts in local areas have resulted in the establishment of 11 local teams covering 16 counties. Figure 1 identifies counties with existing local death review teams and those areas where teams are in various stages of development. State team members have attended community meetings and death review meetings providing information and technical assistance to both existing and emerging local teams. Figure 1 shows those counties with existing local death review teams and those areas where teams are in various stages of development.

Figure 1: Existing and Planned Local Teams as of 2003



CHILD ABUSE AND NEGLECT DATA

Due to the limitations of the team's statutory jurisdiction, the child deaths reviewed by the state and local child abuse death review teams include only verified child abuse and neglect deaths in which the Department of Children and Family Services Child Abuse Hotline received at least one prior report. The Child Abuse Death Review Team, in its previous reports, identified this as a limitation in its ability to fully meet the statutory charge of achieving a greater understanding of the causes and contributing factors of deaths resulting from child abuse, because not all deaths meeting that larger scope meet the criteria for review. This smaller sample also limits the team's ability to identify patterns and trends and derive meaningful conclusions from them. In order to overcome some of the limitations discussed above, in addition to analyzing the data available for the current year, the team's annual report compiles and aggregates the data from the deaths reviewed by the team over the past four years, resulting in an analysis of a larger sample of cases.

The following chart provides a better understanding of the current subset of the cases reviewed by The Child Abuse Death Review Team, and how it compares to the overall number of child deaths, as well as compared to the overall number of child abuse and neglect cases received in the state of Florida. The data source for this chart is the Department of Health vital statistics, the Florida Abuse Hotline Information System (FAHIS), and the Department of Children and Family Services HomeSafenet Information System and Quality Assurance Child Death database.

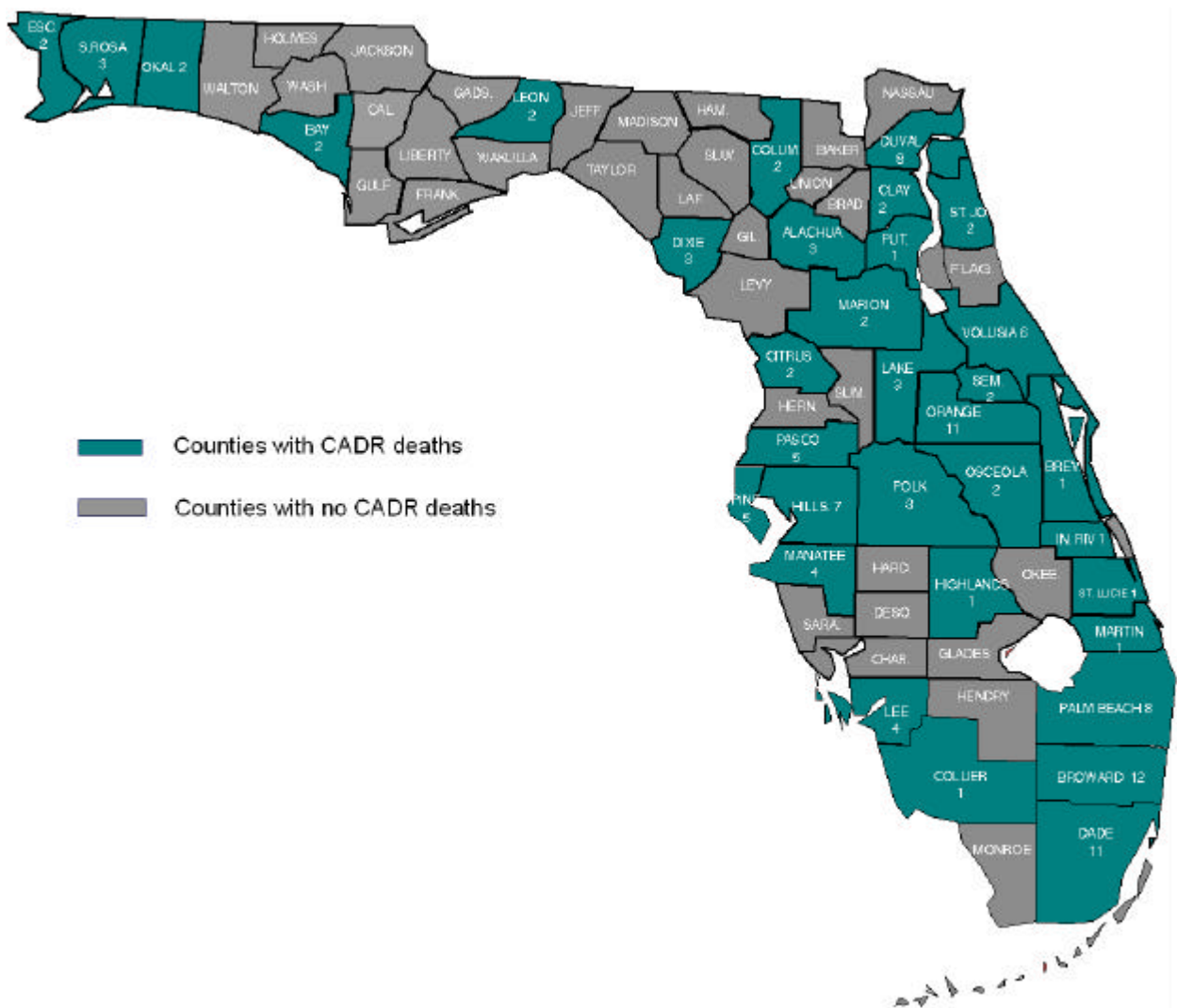
ALL CHILD DEATHS - 2002	
Number of child deaths	2,545
FAHIS REPORTS RECEIVED & ABUSE/NEGLECT DEATHS	
Number of Initial Reports	188,257
Number of reports involving child deaths	260
Number of child death reports with verified or some indicator findings	129
Number of verified child death reports	79
Number of verified child death reports with at least one prior report, presented to the Child Abuse Death Review Team for review (to date)	29*

*One additional death report is pending review by the Child Abuse Death Review Team

CHILD ABUSE DEATH REVIEW TEAM DEATHS

The following map, statistical reports, graphs and charts are based on a review of the child abuse and neglect deaths that occurred from 1999 through 2002. One hundred and twenty-four (124) child deaths met the criteria for review by the State Child Abuse Death Review Team. Figures 2 and 3 below indicate the counties in which the deaths occurred, and the number of deaths per county by year.

**Figure 2: Location of Child Deaths
(1999-2002)**



**Figure 3: Number of Child Deaths by County/Year
(1999 – 2002)**

Number of Deaths by County											
County	Year				Total # of Deaths	County	Year				Total # of Deaths
	1999	2000	2001	2002			1999	2000	2001	2002	
Alachua	1	-	1	1	3	Leon	-	-	1	1	2
Bay	1	-	1	-	2	*Manatee	-	4	-	-	4
Brevard	-	-	-	1	1	Marion	-	2	-	-	2
*Broward	2	2	7	1	12	Martin	-	1	-	-	1
Citrus	-	-	1	1	2	*Okaloosa	-	1	1	-	2
Clay	-	1	-	1	2	Orange	4	2	3	2	11
*Collier	-	-	-	1	1	Osceola	2	-	-	-	2
Columbia	-	1	-	1	2	*Palm Beach	4	-	1	2	7
*Dade	3	3	-	5	11	Pasco	1	-	1	3	5
Dixie	3	-	-	-	3	Pinellas	1	3	1	-	5
*Duval	3	2	3	-	8	*Polk	-	2	-	1	3
*Escambia	-	1	-	1	2	Putnam	-	1	-	-	1
Highlands	-	-	-	1	1	*Santa Rosa	-	1	-	1	2
*Hillsborough	-	2	4	1	7	Seminole	-	-	-	2	2
Indian River	-	-	-	1	1	St. John	1	-	1	-	2
Lake	1	-	2	-	3	St. Lucie	1	-	-	-	1
*Lee	1	-	3	-	4	Volusia	1	-	4	1	6

* = Counties with local CADR teams

Louis* and Harry*

Ten-year-old Louis and his 15-year-old brother, Harry, had been depressed since their father's death in late 2001. At approximately 8AM, seven months after their father's death, Harry discovered Louis's body, in a living room recliner. Louis had told his mother he wanted to die, but had refused mental health counseling. His brother, Harry, was seeing a mental health professional and was on prescribed medication.

Louis was buried six days after his death. His 35-year-old mother allowed Harry to sleep in her bed that night. Mother thought Harry was sleeping late, but discovered he was dead.

The mother had a history of poly-substance abuse, and took methadone, which she kept under her pillow. Law enforcement discovered that approximately 84 pills were missing. Although she stated she gave them to two of her friends, they denied this. Both boys had methadone in their systems. Their cause of death was acute combined drug intoxication.

The family had 5 prior neglect reports. In 1998, both children were removed from the parents, but had been returned home when the parents complied with the requirements of their case plan.

*Alias

CHILD ABUSE DEATH REVIEW DATA

In the following sections, data are presented from the findings of the local and state child abuse death review teams over the past three years. Graphs depict the three-year aggregate data, and are accompanied by charts that provide the breakdown of the data by year of death. National data is included when available, however, differences in review processes, policies, state laws, and child abuse and neglect definitions affect the ability to compare state and national data and presents challenges in trend analysis.

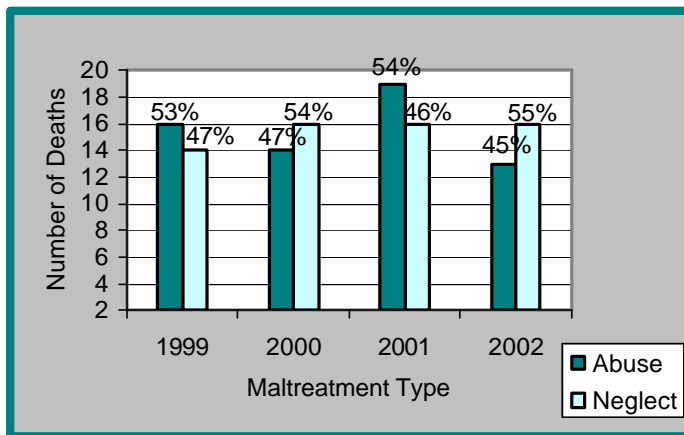
Number of Child Abuse and Neglect Deaths

Physical abuse is the most visible form of child abuse and is defined in Florida Statute 39.01 (2) as "...any willful act or threatened act that results in any physical, mental, or sexual injury or harm that causes or is likely to cause the child's physical, mental, or emotional health to be significantly impaired. Abuse of a child includes acts or omissions..."²

According to Section 39.01(45), Florida Statutes, "neglect occurs when a child is deprived of, or is allowed to be deprived of, necessary food, clothing, shelter, or medical treatment or a child is permitted to live in an environment when such deprivation or environment causes the child's physical, mental, or emotional health to be significantly impaired or to be in danger of being significantly impaired"²

A high representation of neglect deaths in Florida's child abuse death reviews 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 may have served to substantiate the death maltreatment by revealing a pattern of failure to provide reasonable care or supervision. The number of deaths by category for the aggregate four-year period is shown in Figure 4.

**Figure 4: Abuse & Neglect Deaths
(1999-2002)**



Type of Death			
	Abuse	Neglect	Total
1999	16	14	30
2000	14	16	30
2001	19	16	35
2002	13	16	29
Total	62	62	124

Aggregate data indicates that the deaths were equally caused by abuse and neglect. For each of the annual periods, the difference between deaths due to abuse and those due to neglect

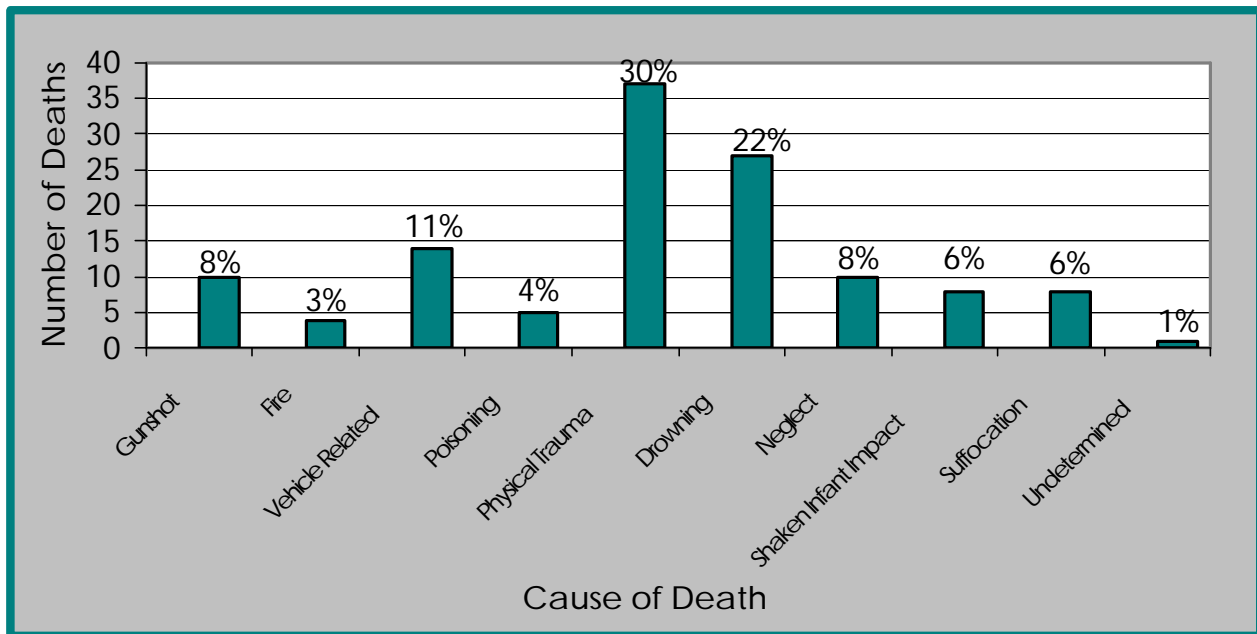
varied from 55% to 45%, with the major cause of death alternating annually. These differences were not statistically significant.

National data from the 2000 Fifty State Survey indicates that of the maltreatment deaths for the three-year period of 1998-2000, abuse deaths (51%) were slightly higher than neglect deaths (43%). The remaining 6% were attributed to a combination of abuse and neglect.

Cause of Death

Abuse and neglect are broad categories of child endangerment, each including multiple specific maltreatments. The review team analyzed the specific maltreatment breakdown within the abuse and neglect categories. The number of deaths by maltreatment is included in Figure 5.

Figure 5: Cause of Child's Death (1999-2002)



Cause of Child's Death						
	1999	2000	2001	2002	Total	%
Gunshot	6	1	2	1	10	8%
Fire	4	0	0	0	4	3%
Vehicle Related	3	3	5	3	14	11%
Poisoning	3	0	0	2	5	4%
Physical Trauma	5	11	15	6	37	30%
Drowning	3	10	4	10	27	22%
Neglect	2	1	4	3	10	8%
Shaking/impact	2	2	1	3	8	6%
Suffocation	1	2	4	1	8	6%
Undetermined	1	0	0	0	1	1%
	30	30	35	29	124	100%

Aggregate data includes the following trends:

- The leading cause of deaths (30%) was physical trauma.
- The second leading cause of deaths (22%) was drowning, some due to abuse and some due to neglect.
- The majority of the neglect deaths reviewed for the four-year period were attributed to inadequate supervision, resulting in deaths from drowning, asphyxiation, house fire, or accidental gunshot wounds.
- There were at least 10 additional deaths in which children died from illness or medication toxicity, both medical neglect and lack of supervision contributed to these deaths.
- Gunshot wounds were the cause of 10 deaths. This cause of death peaked in 1999, and declined in subsequent years.

Data for 2002 indicated that of the 29 deaths reviewed by the team, the causes and contributing factors included:

Abuse (13 deaths)

- The majority of the abuse deaths involved direct attacks resulting in physical trauma. Of the 6 trauma related deaths, 3 of the children died from head trauma and 3 from multiple traumas.
- 3 children died from shaking/impact.
- 2 children died with their mother as a result of intentional drowning (murder-suicide).
- 1 child died as a result of intentional suffocation.
- 1 child died from a gunshot, homicide.

Neglect (16 deaths)

- 5 children accidentally drowned in swimming pools, and 3 children drowned in their bathtubs. Inadequate supervision by the caretaker responsible contributed to these deaths.
- 3 children died in vehicle related accidents, none were wearing appropriate vehicle restraints.
- 2 children died due to drug overdose. Inadequate supervision contributed to these deaths.
- 1 child with severe disabilities died due to medical neglect.
- 1 child died from a gunshot wound caused when a sibling located a gun in the home that was not properly secured and fired the gun striking his younger sibling.
- 1 child died by hanging himself, inadequate supervision in a facility was a contributing cause in this death.

Cassandra*

12-year-old Cassandra suffered from severe scoliosis and cerebral palsy, and was admitted to the hospital due to malnutrition. Her 40-year-old mother had not taken her to the doctor to have her feeding tube reinserted, as she had been instructed to do 19 days prior to the hospital admission. Upon admission, the tube could not be reinserted due to an infection. A “do not resuscitate order” was signed, and the child died 5 weeks after her admission. The causes of death were respiratory failure, cerebral palsy, and pneumonia.

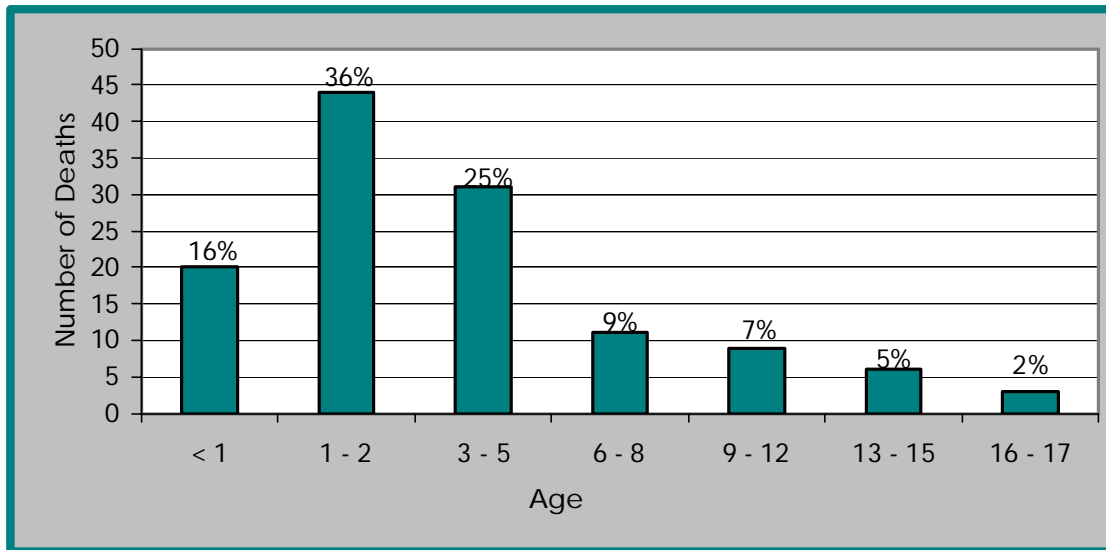
The family had three prior neglect reports alleging medical neglect and inadequate supervision. The family was receiving services from Developmental Disabilities and Children’s Medical Services. Prior to the child’s death, a report was called in alleging malnutrition; this report was open when the child died.

****Alias***

Age at Death

Age is a factor in the analysis of risk due to abuse or neglect. Florida statute identifies children under the age of six as being at greater risk by requiring professional medical evaluation on any child under this age with alleged injuries. Figure 6 provides a specific breakdown of age at death for these 124 children.

**Figure 6: Age at Death
(1999-2002)**



Age of Child at Death						
	1999	2000	2001	2002	Total	%
< 1	3	4	6	7	20	16%
1 - 2	9	10	16	9	44	36%
3 - 5	8	9	7	7	31	25%
6 - 8	6	2	0	3	11	9%
9 - 12	1	3	3	2	9	7%
13 - 15	1	2	2	1	6	5%
16 - 17	2	0	1	0	3	2%
	30	30	35	29	124	100%

Reviews by The Child Abuse Death Review Team in Florida for the 1999 through 2002 four-year period indicate that, of the children who died, 95 (77%) were under the age of six, 75 (61%) were between the ages of one and five, and 20 (16%) were under the age of one year.

Of the child deaths reviewed for 2002, 23 (20%) were under the age of six, 16 (56%) were between the ages of one and five, and 7 (80%) were under the age of one year.

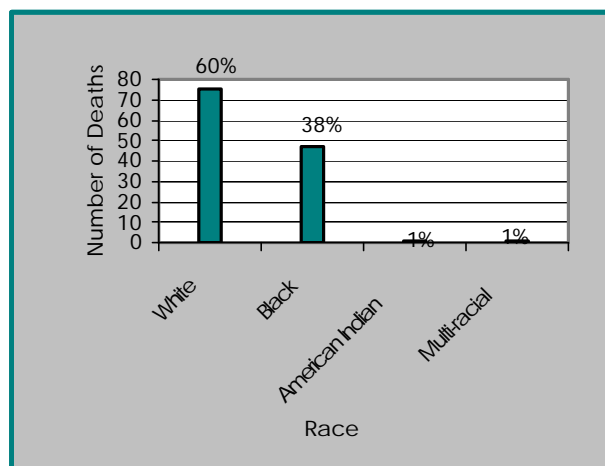
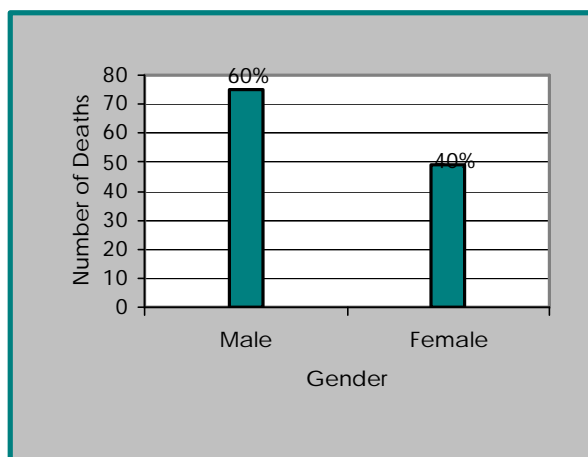
National statistics reported in The 2000 Fifty State Survey: Current Trends in Child Abuse Prevention and Fatalities indicated that young children are at the highest risk of death by causes related to abuse and neglect. Based on data collected in 1998 through 2000, they report 78% of these children were under the age of five and 40% were under the age of one at the time of their death.⁵ The number of deaths involving children under the age of one reviewed by Florida's child abuse death review team is significantly lower than the national average. This

may be related to the statutory requirement of a prior report on the victim to the child abuse hotline, because children under one year are less likely to have been previously reported.

Race and Gender

For the 124 deaths reviewed during the four-year period, 75 (60%) were male, and 49 (40%) were female. For these deaths 75 (60%) of the children were white, 47 (38%) percent were black, 1(1%) was multi-racial and 1(1%) was American Indian. When a specific ethnicity was identified, a total of 16 (15%) were identified as Hispanic and 2 (2%) were identified as Haitian. Figure 7 provides the aggregate data and breakdown by year for these factors.

**Figure 7: Race and Gender of Child at Death
(1999-2002)**



Gender of Children			
	Male	Female	Total
1999	20	10	30
2000	18	12	30
2001	19	16	35
2002	18	11	29
Total	75	49	124
%	60%	40%	100%

Race of Children					
	White	Black	American Indian	Multi-racial	Total
1999	16	14	0	0	30
2000	23	7	0	0	30
2001	17	17	1	0	35
2002	19	9	0	1	29
Total	75	47	1	1	124
%	60%	38%	1%	1%	100%

Darren*

8-month-old Darren died from injuries sustained six months earlier. His 25-year-old father admitted shaking him. A medical examination revealed that additionally, Darren weighed below the 5th percentile and that his overall condition was diagnostic of parental neglect.

The father was incarcerated and the 29-year-old mother subsequently signed surrenders for Darren's two-year-old sister, allowing the grandparents to adopt her.

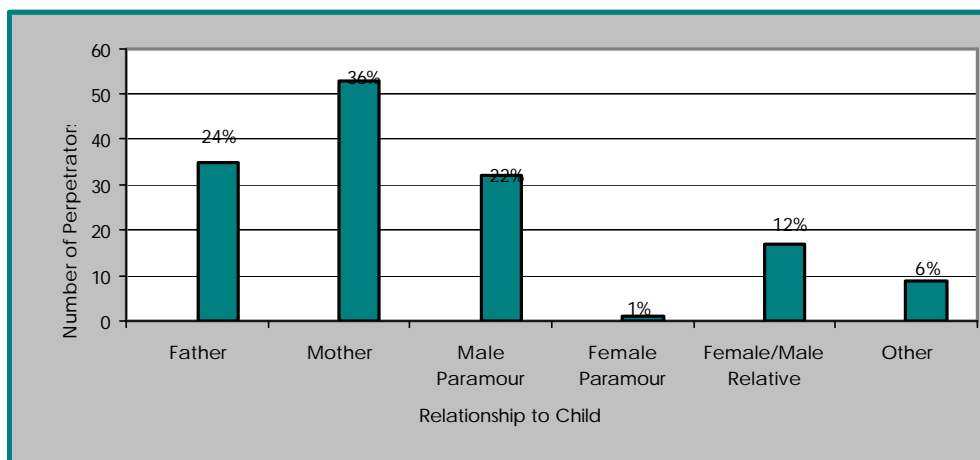
The family had two prior neglect reports. Both were closed with no indicators of neglect or threatened harm.

***Alias**

Relationship of Caretaker Responsible for Abuse or Neglect

Child protection professionals have identified the relationship of caretakers as one of the factors to consider when evaluating risk. Children in the care of their parent's paramours are generally considered at higher risk. A breakdown of the number of deaths by caretaker responsible is shown in Figure 8.

Figure 8: Caretaker Responsible for Abuse or Neglect
Relationship to Child
(1999-2002)



Relationship of Caretaker Responsible to Child						
	1999	2000	2001	2002	Total	%
Father	9	11	9	6	35	24%
Mother	13	11	15	14	53	36%
Male Paramour	9	8	10	5	32	22%
Female Paramour	0	0	0	1	1	1%
Female/Male Relative	5	6	4	2	17	12%
Other	1	1	5	2	9	6%
	37	37	43	30	147	100%

For the 124 deaths reviewed during the four-year period, 147 perpetrators/caretakers responsible were identified. Mothers were involved in or responsible for 53 (36%) of the 124 deaths reviewed, fathers for 35 (24%) of the deaths, and male paramours for 32 (22%) of the deaths. The majority of the deaths in which the mother was the sole caretaker responsible were caused by neglect. The majority of the deaths in which the father or male paramour was the sole caretaker responsible were caused by abuse.

For the deaths reviewed in 2002, mothers were involved in or responsible for 14 (47%), fathers for 6 (20%) of the deaths, and male paramours for 5 (17%) of the deaths. This does not significantly differ from the aggregate data.

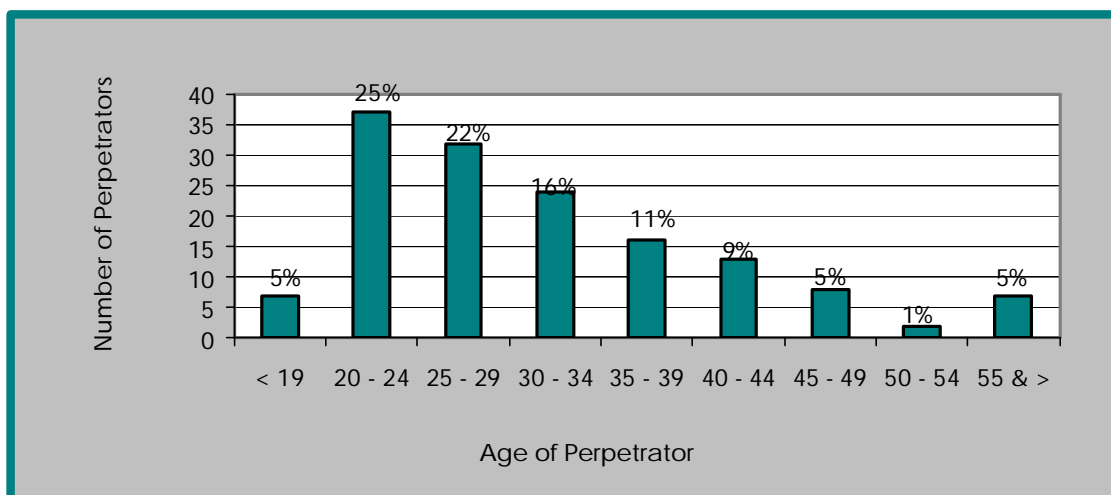
Age of Caretaker Responsible for Abuse or Neglect

Data for four-year period (124 deaths) indicated that the 146 perpetrators/caretakers responsible ranged in age from 17 to 79, with 76 (52%) under the age of 30 years.

For the year 2002, the 30 perpetrators/caretakers responsible of the 29 deaths ranged in age from 19 to 55, with 18 (60%) under the age of 30 years.

Florida's 2002 and aggregate data varies slightly higher than national reports that indicate the perpetrators/caretakers responsible 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..."⁵ This factor may also be affected by the narrow criteria for Florida's reviews. Very young children who died due to abuse or neglect, but did not meet the criteria for review because they had no prior reports, may also have had a higher percentage of young parents who were the caretaker responsible. Figure 9 shows the age, by category, of the caretaker responsible for these deaths.

Figure 9: Age of Caretaker Responsible for Abuse or Neglect (1999 – 2002)



Age of Perpetrator						
	1999	2000	2001	2002	Total	%
19 and <	1	0	5	1	7	5%
20 thru 24	8	6	10	13	37	25%
25 thru 29	10	9	9	4	32	22%
30 thru 34	4	3	14	3	24	16%
35 thru 39	7	6	2	1	16	11%
40 thru 44	2	3	2	6	13	9%
45 thru 49	2	4	1	1	8	5%
50 thru 54	1	1	0	0	2	1%
55 & >	2	4	0	1	7	5%
Total	37	36	43	30	146	100%

Caretaker Responsible for Abuse or Neglect History

Specific data regarding caretaker responsible history of domestic violence, alcohol and substance abuse, and criminal activity was gathered over the four-year period. Based on the information gathered:

- 75 (61%) of the perpetrators/caretakers responsible had criminal records.
- 45 (36%) of the perpetrators/caretakers responsible had a history of substance abuse.
- 27 (22%) of the perpetrators/caretakers responsible had a history of alcohol abuse.

Domestic violence is often a factor in child abuse deaths. Domestic violence was known to have been occurring in the home at the time of the child's death, in 66 (53%) of the cases reviewed. This type of abuse can begin with the battering of a spouse, then spread to include other household members, including children. A review of the caretaker responsible history for the aggregate period indicated that:

- 50 (40%) of the perpetrators/caretakers responsible were also perpetrators of domestic violence.
- 33 (31%) of the perpetrators/caretakers responsible were also victims of domestic violence.

David*

10-week-old David was discovered in his mother's paramour's freezer. There had been two prior reports involving the baby. One was generated when the 24-year-old paramour hit the 19-year-old mother. She was transported to a domestic violence center, but subsequently left Hillsborough County with David.

The second report was generated in Duval County when the mother was picked up by law enforcement for driving a car the paramour had reported as stolen. She and David were taken to a homeless shelter, until the paramour picked them up and returned them to his apartment.

The mother and child were seen in the paramour's apartment. The mother explained that he wasn't living there, but was allowing her to use it. Approximately a month after the second report, the mother's body was found in Volusia County.

The paramour admitted killing the mother and suffocating the child. The mother was involved in six prior neglect/abuse reports and had been in foster care.

****Alias***

Family Risk Factors

According to national research, "...the children most vulnerable to serious or fatal abuse and neglect are those whose parents or other caregivers 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."⁶

The purpose of the protective investigation, triggered by a call to the child abuse hotline is to gather information from a variety of sources to evaluate the safety of the child and determine if removal is necessary to protect the child from further harm. Information gathered should be used to assess:

- A history of criminal conduct
- Whether law enforcement should take the lead, or be involved in the investigation
- If maltreatment has occurred
- The likelihood that the problem will continue or escalate
- Immediate measures necessary to ensure child safety, including the need for removal and placement
- Whether follow up visits or protective supervision is necessary
- Intervention strategies needed if the child remains in the home

All cases meeting the criteria for this review involved a prior report of abuse or neglect. Other specific risk factors identified during the review process included:

- Child in the home under the age of five years (79%)
- Patterns of escalating and/or increased frequency of incidents of abuse or neglect (47%)
- Children with limited community visibility (44%)
- Parent/Caretaker has not met or is unable to meet immediate needs for food/clothing/shelter/medical care, or protect from harm (44%)
- Parental limitations in ability to adequately parent due to age, mental capacity or substance abuse (42%)
- Criminal history of caretaker responsible or other adult in the home (31%)

Cornelius*

Cornelius's father, who subsequently shot and killed himself, shot and killed this 6-year-old. Approximately seven months prior to the incident, a neglect report was generated on the family. It alleged that his 39-year-old father and 35-year-old mother were engaged in a domestic dispute.

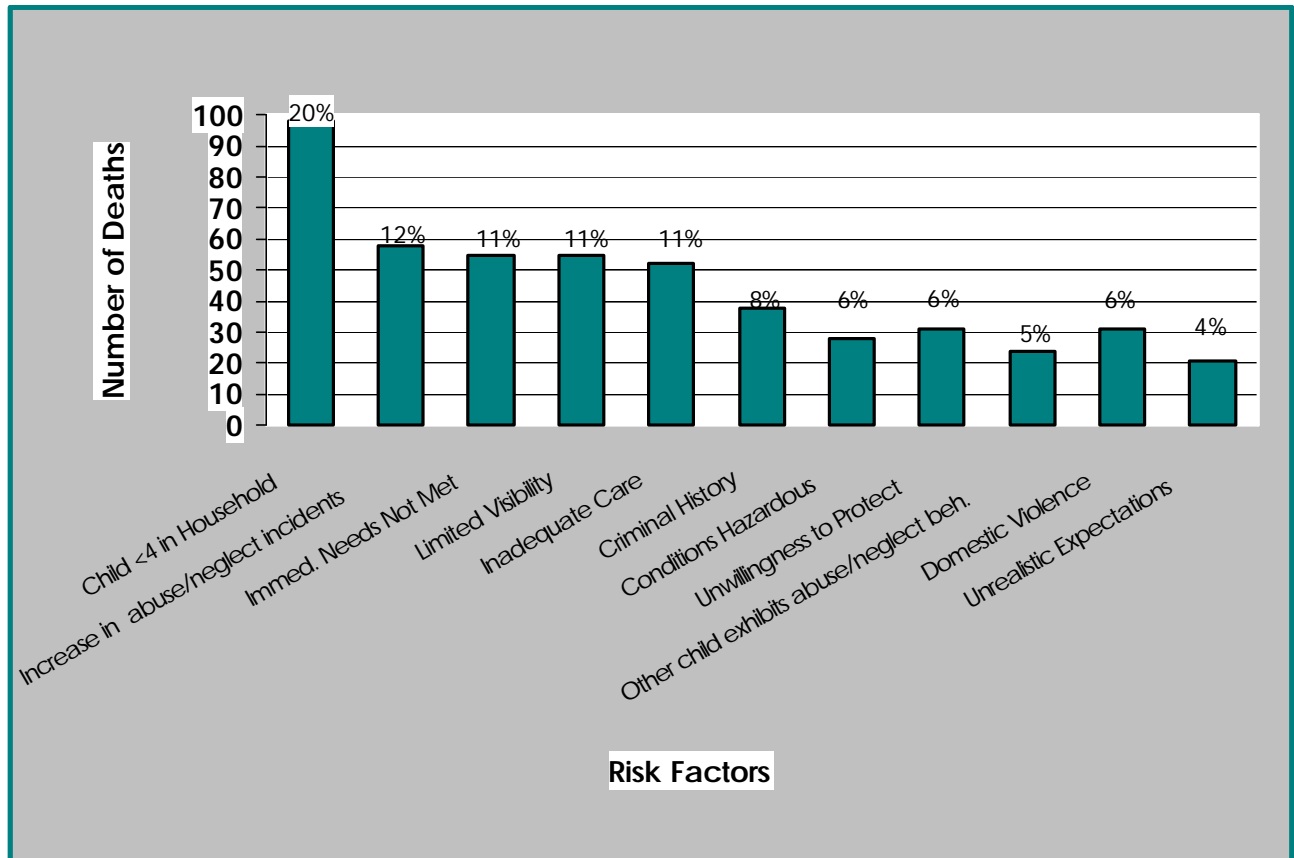
The report was closed after the mother acquired a restraining order and the father started attending anger management classes. Mother continued to maintain a separate residence, which she shared with her paramour and her two children.

On the night of the incident, the mother went to the father's home to retrieve Cornelius. She found him and his father on the father's bed. Both were deceased. The family had no other abuse/neglect reports.

*** Alias**

Fifty-four (56%) of the 95 children had five or more family risk factors present at the time of death. Of the children who died in 2001, 20 children (57%) had five or more family risk factors. Figure 10 shows the major family risk factors identified for the deaths reviewed by The Florida Child Abuse Death Review Team.

Figure 10: Family Risk Factors for Child Victims (1999-2002)



Risk Factors in 2002 Child Abuse Deaths					
	1999	2000	2001	2002	Total
One or more children in the household age 4 or younger	20	25	29	24	98
A pattern or escalating and/or frequency of incidents of abuse or neglect	13	14	19	12	58
Parent or caregiver is unable to meet child(rens) immediate needs	12	14	15	14	55
Child(ren) in the home have limited community visibility	12	12	16	15	55
Parents or caregiver's age, mental health, alcohol or substance abuse affects ability to parent	10	12	19	11	52
Criminal history on any household member	6	12	13	7	38
Conditions in the home are hazardous to child's health	8	7	6	7	28
Parent or caregiver is unable or unwilling to protect the child(ren)	4	8	10	9	31
Other child(ren) in home exhibit behaviors indicative of abuse or neglect	6	6	4	8	24
Domestic violence in the home	5	6	14	6	31
Parent or caregiver has unrealistic expectations of child(ren)	2	8	6	5	21

Team Conclusions/Adequacy of Prior Interventions

Review teams were asked to identify the interventions and services provided prior to the child's death, to identify needed improvement in these services. In determining adequacy, the team looked at whether the services provided addressed the needs of the family at the time of the service provision.

For the 29 child deaths in 2002, in addition to the prior investigations, 23 victims received a total of 50 direct services from either the Department of Children and Family Services, or community service providers, including but not limited to substance abuse treatment, mental health treatment, parenting classes or domestic violence intervention classes. Of the services provided to these victims or their families:

- 65% were found to have been adequate
- 19% were found to have been inadequate
- 17% were of unknown adequacy (some of which were unanswered, perhaps due to a lack of information)

The breakdown of services by agency/organization is as follows:

- Department of Children and Family Services in 21 cases
Found to have been adequate in 11 cases (52%) and inadequate in 7 cases (33%)
- Department of Health in 5 cases
Found to have been adequate in 4 cases (80%) and inadequate in 1 case (20%)
- Child Protection Teams in 15 cases
Found to have been adequate in 12 cases (80%) and inadequate in 2 cases (13%)
- Department of Juvenile Justice in 3 cases
Found to have been adequate in 2 cases (67%) and inadequate in 0 cases (0%)
- Mental Health Agencies in 4 cases
Found to be adequate in 2 cases (50%) and inadequate in 0 cases (0%)
- Other Service Providers in 6 cases
Found to be adequate in 4 cases (67%) and inadequate in 0 cases (0%)

In 9 (17%) of these 54 provisions of services, reviewers were unable to determine the adequacy based on the information made available to the team for review. Information in the files provided, both from the service providers and the case managers, was at the time either missing or incomplete.

Team Conclusions/Issues Identified

In analyzing the data available for the 29 deaths reviewed for 2002, the state and local teams identified issues in the following areas, some of which had been identified by the Department of Children and Family Services internal death review teams and were taken directly from their reports:

- Protective investigations, which included the following concerns:
 - Standards are needed regarding collateral contact requirements, such as determining needed contacts based on the complexity of the case, making appropriate contact with law enforcement, and requiring multi-disciplinary staffings for children who are substance exposed or who have special health care needs.
 - Standards for investigation are needed for cases involving domestic violence, and domestic violence safety assessments are needed.
 - Protective investigators need quick and reliable access to all criminal history information, and should obtain and include essential law enforcement information to assess child safety.
 - Protective investigators should follow policy to ensure reports are referred to the Child Protection Team, and should review all recommendations of the team prior to case closure.
 - Removal or other intense intervention should be carefully considered in cases with numerous priors.
 - Cases involving numerous priors, domestic violence, substance abuse and mental health issues, or other high risk factors should be staffed with the dependency attorney. Multi-disciplinary staffings should be held when the attorney determines additional evidence is needed for legal sufficiency to file a dependency petition.
 - Requests for psychological evaluations and other professional assessments should be case specific and the recommendations stemming from these assessments should be incorporated into the case plan when appropriate.
 - Supervisory case review should be timely.

Local law enforcement agencies are currently responsible for protective investigations in Manatee, Pinellas, Broward, Pasco and Seminole counties. The Department of Children and Family Services is responsible for protective investigations in the remaining counties.

- Law enforcement, which included the following concerns:
 - Reporting issues, i.e. lack of training on reporting and failure to report child abuse or neglect to the child abuse hotline by Florida Highway Patrol officers.
 - Need for training on suicide prevention and lethality assessment.
 - Need for increased enforcement of vehicle child restraints, and need for increased reporting child neglect hotline for unrestrained minor involved in traffic violations and accidents.
 - Lack of referral for criminal prosecution.
- Provision of Services, which included the following concerns:
 - Lack of cooperation in voluntary cases should prompt updated risk assessment and legal staffing to determine necessary action.
 - Improvement is needed in communication within and between agencies regarding service provision and case closure.

-
- Department Policies/Practices, which included the following concerns:
 - Child Protection Teams should develop policy regarding medical evaluation to ensure that client history and social assessment information is available to medical staff and included in the assessment determination.
 - Department of Health service providers, including but not limited to Healthy Start, should require initial and ongoing training on recognizing and reporting child abuse and neglect for staff working with children.
 - Medical Examiners failure to complete cause of death and/or date of injury.

Degree of Preventability

The sample reviewed was limited to deaths resulting from physical abuse or neglect in which at least one prior report to the abuse hotline on the victim had been received. Therefore, all of these children had received some level of intervention from either the Department of Children and Family Services or local law enforcement agency responsible for protective investigations. Additionally, because of the investigations, many of these children had been referred for other community services provided by the Department of Health, Child Protection Teams, or other community based care providers.

Based on the information provided, the team determined whether the child's death was preventable, by either a caregiver, or the "system", which could include the child protection system or other various service agencies involved with the family. To determine a death was definitely preventable, the information provided had to demonstrate clearly that steps or actions could have been taken, either by the various agencies previously involved with the family, the non-offending caretaker responsible for the child, or by family members or other individuals who may have had knowledge of the abuse or neglect, that could have prevented the death from occurring. In this instance, predictability is a strong factor in evaluating preventability. It is important to look, not only at what actions may have prevented the incident leading to the death, but to also determine whether a reasonable person should have anticipated the need for such action.

The State Child Abuse Death Review Team assessed preventability, by both the caregiver and the system in 28 of the 29 deaths reviewed and concluded that:

- 22 (79%) were definitely preventable by a caretaker not responsible for the death
- 11 (39%) were definitely preventable by the system
- 3 (11%) were possibly preventable by a caretaker not responsible for the death
- 3 (11%) were possibly preventable by the system
- 3 (11%) were not preventable

Of the cases determined to be definitely preventable, 11 were found to have been preventable by both the caregiver and the system.

Criminal Status

As part of the process of gathering data on child abuse deaths, the state team began to track these cases through the criminal justice system. Criminal prosecution of the caretaker responsible charged does not always occur quickly, some cases take several years to reach disposition. The Department of Children and Family Services Quality Assurance Unit currently tracks criminal history information in their death database. Based on this information, and information gathered from the other sources, The State Child Abuse Death Review Team has collected the following highlights:

- In 42 of the 124 cases there was either no charges filed or the case was nol-prossed
 - 10 of the caretakers responsible committed suicide at the time of the child's death
 - 1 caretaker responsible was found incompetent
- 67 were criminally charged, of those
 - 42 were charged with murder
 - 15 were charged with manslaughter
 - 10 were charged with negligence or other charges

Criminal cases have been completed on 15 of the individuals charged and resulted in:

- 4 convictions of murder
- 5 convictions of manslaughter
- 6 convictions of child abuse, negligence or other charges

Note: Overlap exists in the criminal data because some individuals were charged and convicted for multiple offenses.

The State Child Abuse Death Review Team voted not to complete a detailed analysis of criminal convictions due to the limited data available, however the state team will continue to track this information for future analysis.

Alphonso*

33-month-old Alphonso was discovered, in advanced stages of decomposition, in a wooded area alongside I-275. His body was wrapped in a child's blanket.

Alphonso's mother had left him in the care of a couple that had their own children removed in another state. The male caretaker subsequently admitted to beating the child and disposing of his body.

Alphonso's 21-year-old mother had been involved in 6 prior neglect reports that included beatings, conditions hazardous to health, inadequate supervision, alcohol exposure, and substance exposure/misuse. The family was under supervision at the time of the incident.

****Alias***

CONCLUSIONS AND RECOMMENDATIONS

The State Child Abuse Death Review Team has evolved over the past four years. In the initial years, the team built a foundation for the child abuse death review process at the state level, and began to recruit local teams. This early work focused on developing a multidisciplinary approach to this specific population of child abuse and deaths, to achieve a better understanding of the causes and contributing factors and recommend better approaches to prevention. Once the foundation was built, the focus expanded to the further development of local teams, multidisciplinary protocols, data gathering and analysis, and the development and implementation of recommendations.

It remains important for the reader to put the overall analysis of these child deaths in perspective. In addition to the limitations in the information used to analyze individual cases, the population reviewed is limited in scope and representation of the total number of abuse and neglect deaths in Florida. Therefore, although there are some clear patterns reflective of national trends, the specifics may vary.

The Child Abuse Death Review Team identified both case specific and overall systemic issues in the child protection system. After a careful analysis of the data, the state team presents the following recommendations to address critical issues identified during their reviews.

ISSUE 1: NOT ALL VERIFIED CHILD DEATHS REVIEWED

The Child Abuse Death Review Team identified a major problem in the scope of the deaths reviewed. Currently, verified child deaths are only reviewed if the child had a prior abuse or neglect report with the Department of Children and Family Services, thereby excluding many child victims. If all verified child abuse and neglect deaths were reviewed, the teams would have a better understanding of causes and contributing factors, thereby enhancing their ability to make effective preventive recommendations.

Florida's criteria for child abuse and neglect death review are significantly more restrictive than any other state in the nation. Approximately 19 states review all child deaths, and of the states that only review sudden, unexpected or unexplained deaths none require the existence of a previous report to the child abuse hotline. Florida's limited review criterion not only affects the ability of the team to fully accomplish the statutory purposes of their reviews, but also significantly limits the recruitment of local review teams. Many counties in the state have expressed an interest in developing a local team if the review criterion is expanded.

The State Child Abuse Death Review Team has recommended expansion to all child death review in each of its previous three reports and continues to support that recommendation. During this past year, the Chairman of the team met with the Department of Health and Department of Children and Family Services Secretaries requesting support for the review of all verified child abuse and neglect deaths and received support from both department leaders. The Chairman also wrote a letter to Governor of Florida on behalf of the team requesting support for expanded review. Per Mr. Hodges' letter: "...The majority of child abuse and neglect deaths that occur in this state are children who have never received services through the child protection system. Reviewing these deaths will help us build a broader picture and

better understand the dynamics of why children are dying from senseless acts perpetrated on them by family members or caretakers....”

Action Needed/Recommendation: The Florida Legislature should expand the child abuse death review process to include the review of all verified abuse or neglect deaths, with no requirement for prior reports to the child abuse hotline.

ISSUE 2: DROWNING DEATHS

The Child Abuse Death Review Team identified drowning as a major concern. Florida is a peninsula saturated by lakes, rivers, retention ponds, and swimming pools. Additionally, most homes have bathtubs that pose drowning risk to children who are inadequately supervised.

As of 12/8/2003, figures for 2002 indicate that 78 children died as a result of verified abuse or neglect. Of these 78 children, 14 died as a result of drowning, representing 21% of all verified child abuse/neglect deaths in the state. As some 2002 cases remain under investigation, this figure is subject to increase. The Department of Children and Family Services predicts that, based on the numbers available at this time, even more children will have died as a result of drowning in 2003.

Action Needed/Recommendation: It is essential that preventative measures be taken to decrease the number of children drowning in Florida. These measures would include, at a minimum:

- Emphasis on drowning risk factors in all risk assessments
- Incorporate drowning prevention into checklists and educational material used by home visiting programs

Dennis*

11 ½- month- old Dennis and his three- year-old sister were left unattended in a bathtub. Water was running into an open drain when the mother left; the sister plugged it. When Dennis fell into the water, his sister ran to get their mother. Emergency medical personnel revived Dennis on the way to the hospital, however, he died the following morning.

The 27-year-old mother and 40-year-old father had two other children. The three surviving children were removed from the home and placed with relatives. The family had four prior neglect reports. The family had been under supervision since the first report was received.

****Alias***

ISSUE 3: CASE SPECIFICITY/CASE PLANS

Individualized and specific case plans were identified as a priority need by the Child Abuse Death Review Team. It was discovered that often, psychological evaluations and reports were not case specific, and case plans did not require follow-up on the psychological evaluation recommendations.

Action Needed/Recommendation: Sufficient information should be provided to the evaluating psychologist to ensure the development of a case specific evaluation and report. The caseworker responsible for drafting the case plan with the family should be encouraged to avoid standard, non-specific requirements, which obfuscate the primary problem and cause delays in compliance, and to “close the loop” by requiring follow-up on recommendations.

Additionally, requirements for “anger management” and “parenting classes” should be case specific. In cases of domestic violence, the caretaker responsible should be referred to a certified batterer’s intervention program instead of anger management.

ISSUE 4: TRAINING NEEDS

Additional training is needed for various professional and paraprofessional positions. Training needs include recognizing signs and symptoms of child abuse and neglect, risk assessment, and mandatory reporting requirements.

Action Needed/Recommendation:

Law Enforcement

The team recommends that law enforcement and 911 operators receive additional training in suicide prevention and intervention, and recognition of risk factors by means of lethality assessments. Because telephone 911 operators and law enforcement officers are usually the first people exposed to potentially lethal situations they need to be highly trained to recognize these risk factors and take appropriate action.

Law enforcement should also be required to immediately report to the Hotline when a child is injured or dies due to being improperly or not restrained in motor vehicle crashes. It is only through the reporting mechanism that a true picture of this behavior’s repercussions can be studied and prevented. The team also strongly encourages the enforcement of child automobile restraint laws.

Training should be provided to law enforcement officers on indicators of child abuse and neglect, including mandatory reporting. They should fully understand the implications of risk and the need for reporting in cases of drug offenses, and cases of domestic violence where children are involved.

The team recommends that the law enforcement training on child abuse and neglect, as well as domestic violence, take place at the academy level and at local agency level. It is recommended that the Standards and Training Commission require specific time frames and curriculum.

Department of Children and Family Services Staff

The team recommends that child protective investigators receive training on critical decision-making. This training should include actual case scenarios whose lessons learned could be applied in the field. Domestic violence is another area in which additional training is needed. It is further recommended that Child Welfare Legal Services (CWLS) and child protective investigators review the process for child safety decision-making; and that CWLS attorneys receive training on the risk to children in domestic violence situations, as well as strategies for court intervention.

Judiciary

The team recommends that the judiciary receive training in domestic violence issues and the concurrent risk to children.

School Personnel

The team recommends that all school personnel receive training on child abuse and neglect. Training should include recognizing the signs and symptoms of abuse and neglect, mandatory reporting and the child protective investigative process.

ISSUE 5: FACILITATION OF COMMUNICATION

With the increased number of agencies involved in the child protection system, communication regarding the status and transfer of cases is problematic. Case planning can be difficult without valuable input and information from the various caseworkers involved with a family and result in gaps in services that leave children at risk.

Action Needed/Recommendation: The team recommends that the Department of Children and Family Services and its community based care providers review and if necessary, revise their policies and procedures regarding their interagency communication, including a review of policies regarding the closure of cases in which in-home services are being provided. The team recommends that the Department of Children and Family Services also consider Child Protection Team recommendations prior to case closure.

ISSUE 6: ACCESSIBILITY OF CRIMINAL HISTORY

Although the Department of Children and Family Services has some access to criminal information, improvement is needed in the speed and accuracy of this information.

Action Needed/Recommendation: The team recommends that the Department of Children and Family Services be granted access to all criminal histories, both local and national, in an expedient and consistent manner statewide. This may require stronger language in working agreements between the Department and law enforcement. It is further recommended that specialized Criminal Intelligence Analysts (CIA's) be utilized for this function statewide, to insure greater reliability on the completeness and accuracy of the criminal history information.

ISSUE 7: PROTECTIVE INVESTIGATIONS STAFF RETENTION

Due to the increasing turnover rate in protective investigations, legislation was recently passed to appoint a Protective Investigator Retention Workgroup, to address the issues surrounding

turnover and to make recommendations for alternative responses to investigations, staff recruitment and training, and staff retention. The workgroup's report is due to the legislature by the end of the calendar year.

Action Needed/Recommendation: The team recommends that the legislature and the Department of Children and Family Services support and implement the recommendations of the Protective Investigator Retention Workgroup.

ISSUE 8: SUBSIDIZED CHILD CARE

Families with children at risk of abuse and neglect have an ever-increasing need for adequate, affordable daycare. Parents with multiple daily living needs often leave their children inadequately supervised due to the lack of appropriate, available caretakers.

Action Needed/Recommendation: The team recommends that at risk children be prioritized for subsidized childcare.

REFERENCES

1. Section 383.402, Florida Statutes
2. Section 39.01, Florida Statutes
3. U.S. Department of Health and Human Services: Child Maltreatment 2000: Reports from the States National Center on Child Abuse Prevention Research.
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5. National Center on Child Abuse Prevention Research: The 2000 Fifty State Survey: Current Trends in Child Abuse Prevention and Fatalities”
6. National Exchange Club Foundation, Abuse Publication, 2000.

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