

FLORIDA CHILD ABUSE DEATH REVIEW



**ANNUAL REPORT
DECEMBER 2005**



State Child Abuse Death Review Team
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The Honorable Jeb Bush
Governor of Florida
The Honorable Tom Lee
President of the Florida Senate
The Honorable Allan Bense
Speaker of the Florida House of Representatives
The Capitol
Tallahassee, FL 32399-0001

Dear Governor Bush, President Lee, and Speaker Bense:

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 111 Florida children who were verified by the Department of Children and Families to have died in 2004 due to child abuse or neglect. Additionally, it highlights major issues and trends for 278 child deaths reviewed over a six-year period since the inception of the State Child Abuse Death Review Team.

With your support, the Florida Legislature restored the confidentiality protections in Chapter 383.412 F.S., in 2005, and as a result, the Team has been able to move forward and gather necessary and critical information that enables us to better understand the tragic deaths of these children. We are hopeful that, in addition to our other recommendations, the Legislature will consider our on-going recommendation to expand the Team's ability to review all child deaths. As our work progresses, I am optimistic that we can build on the lessons learned and the end result will be better interventions and understanding of the circumstances and contributing factors of those deaths.

I ask for your commitment and support of the work of this State Team as we work together towards our ultimate goal 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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**FLORIDA
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 Tom Lee, President, Florida State Senate
The Honorable Allan Bense, Speaker, Florida State House of Representatives

DEDICATION

This report is dedicated to 111 children who died from verified Child abuse and neglect- sometimes quickly, sometimes slowly, often painfully and usually preventable.

Profile Information	Date of Death	Cause of Death	Caretaker Responsible	Prior Reports
0 day old female	6/3/2004	Asphyxia - Abandonment	Mother	0
0 day old female	7/22/2004	Amniotic Fluid Aspiration	Mother	0
0 day old female	7/27/2004	Premature Birth	Paramour/Mother	0
1 day old male	1/14/2004	Complications of Prematurity	Mother	0
2 day old female	7/6/2004	Prematurity - Maternal Drug Use	Mother	0
5 day old male	11/18/2004	Multiple Blunt Force Trauma	Paramour/Mother	0
2 week old male	4/11/2004	Malnutrition and Dehydration	Mother/Father	0
1 month old male	11/8/2003	Asphyxia - Compression of Chest	Father	0
1 month old male	1/21/2004	Blunt Head Trauma	Father	0
1 month old male	9/17/2004	Hyperthermia	Father	0
1 month old male	11/27/2004	Undetermined	Mother/Father	0
1 month old male	12/2/2004	Closed Head Injury	Mother/Father	0
1 month old male	12/30/2004	Asphyxia - Positional	Mother	0
2 month old female	8/11/2004	Blunt Head Trauma	Male Paramour	0
2 month old female	12/8/2004	Blunt Head Trauma	Father	1
2 month old male	12/23/2004	Asphyxia - Positional	Mother/Father	0
2 month old male	1/14/2003	Blunt Head Trauma	Mother	2
4 month old female	12/8/2004	Asphyxia - Positional	Mother	0
4 month old male	9/22/2004	Asphyxia - Positional	Father	0
4 month male	7/29/2004	Blunt Head Trauma -	Male Paramour	1
4 month male	12/13/2004	Asphyxia - Positional	Father	1

Profile Information	Date of Death	Cause of Death	Caretaker Responsible	Prior Reports
4 month old female	5/30/2004	Marked Bronchoiloiditis and Multifocal Pneumotitis	Daycare Provider	0
5 month old female	1/21/2004	Multiple Injuries	Father	1
5 month old female	3/10/2004	Hyperthermia	Mother	0
5 month old female	4/7/2004	Blunt Impact to Torso	Father	0
5 months old female	10/29/2004	Undetermined	Mother	1
5 month old male	7/29/2004	Blunt Abdominal Trauma	Mother/Father	0
5 month old male	6/3/2004	Blunt Head Trauma	Mother/Father	0
5 month old male	8/3/2004	Asphyxia – Plastic Bag	Mother	0
5 month old male	1/17/2004	Blunt Head Trauma	Father	0
6 month old female	5/11/2004	Lobar Pneumonia	Mother	1
6 month old female	5/21/2004	Asphyxia - Positional	Mother	0
6 month old female	12/8/2004	Shaken and Blunt Head Trauma	Babysitter	0
6 month old male	10/26/2003	Blunt Head Trauma	Mother	2
7 month old female	11/15/2004	Fire	Mother	2
7 month old male	2/15/2004	Drowning	Mother	2
9 month old female	2/15/2004	Hyperthermia	Father	0
9 month old female	10/17/2004	Drowning	Father	0
10 month old male	4/8/2004	Closed Head Injury –Battered Child Syndrome	Mother	0
10 month old male	last seen 4/22/04	No body was found	Father	2
11 month old male	1/11/2004	Asphyxia - Positional	Mother	2
11 month old male	1/17/2004	Drowning	Male Paramour	3
11 month old female	1/4/2004	Blunt Head Trauma	Mother	0
1 year old female	1/16/2004	Drowning	Mother	0

Profile Information	Date of Death	Cause of Death	Caretaker Responsible	Prior Reports
1 year old female	5/24/2004	Blunt Abdominal Trauma	Father	2
1 year old female	6/4/2004	Undetermined	Mother	1
1 year old female	8/3/2004	Drowning	Father	0
1 year old female	12/5/2004	Drowning	Grandfather/Father	0
1 year old male	8/15/2003	Blunt Head Trauma	Male Paramour	0
1 year old male	12/29/2003	Drowning	Mother	0
1 year old male	2/9/2004	Asphyxia - Positional	Paramour/Mother	1
1 year old male	8/6/2004	Drowning	Mother	0
1 year old male	10/1/2004	Hyperthermia	Male Paramour	0
1 year old male	10/10/2004	Drowning	Mother/Father & Relatives	5
1 year old male	10/23/2004	Drowning	Father	0
17 month old female	5/11/2004	Drowning	Nanny	0
20 month old female	11/26/2004	Drowning	Father	0
20 month old male	10/14/2004	Fire	Mother	3
23 month old male	8/23/2004	Drowning	Mother	0
23 month old male	7/28/2004	Drowning	Mother	0
2 year old female	2/16/2004	Blunt Head Trauma/Strangulation	Male Paramour	1
2 year old female	5/23/2004	Blunt Trauma	Father	3
2 year old female	6/2/2004	Stab Wounds	Mother	1
2 year old female	1/2/2003	Blunt Head Trauma	Male Paramour	1
2 year old male	1/8/2004	Blunt Abdominal Trauma	Male Paramour	0
2 year old male	3/5/2004	Drowning	Father	1

Profile Information	Date of Death	Cause of Death	Caretaker Responsible	Prior Reports
2 year old male	4/10/2004	Blunt Head Trauma	Male Paramour	0
2 year old male	5/1/2004	Hyperthermia	Mother	
2 year old male	5/22/2004	Drowning	Mother	0
2 year old male	7/11/2004	Hyperthermia	Mother/Father	0
2 year old male	8/18/2004	Drowning	Mother	3
2 year old male	11/25/2004	Drowning	Mother/Father & Grandmother	0
2 year old male	12/13/2004	Drowning	Male Paramour	0
2 year old male	12/04/04	Carbon Monoxide Poisoning	Father	1
2 year old male	5/12/2004	Drowning	Mother	3
2 year old male	7/3/2004	Drowning	Mother	3
2 year old male	9/24/2004	Blunt Head Trauma	Mother	3
2 year old male	11/3/2004	Blunt Head Trauma	Male Babysitter	0
3 year old female	1/21/2004	Blunt Abdominal Trauma	Father	4
3 year old female	6/2/2004	Blunt Head Trauma	Female Paramour	0
3 year old female	6/30/2004	Blunt Force Head Trauma	Male Paramour	3
3 year old female	7/1/2004	Gunshot Wound to Head	Male Paramour	0
3 year old male	8/7/2004	Gunshot Wound of Head	Father	2
3 year old male	4/6/2004	Pneumonia-Acute Bacterial Meningitis	Father	0
3 year old male	4/19/2004	Drowning	Family Friends	0
3 year old male	7/21/2004	Hyperthermia	Mother	0
3 year old male	3/5/2004	Hanging	Grandfather	0
3 year old male	3/15/2004	Drowning	Mother	0
3 year old male	5/25/2004	Gunshot Wound to Head	Mother/Father	0
3 year old female	8/27/2004	Multiple Blunt Traumas	Mother/Father	0

Profile Information	Date of Death	Cause of Death	Caretaker Responsible	Prior Reports
4 year old female	4/11/2004	Hyperthermia	Father	0
4 year old female	8/29/2004	Blunt Head Trauma	Sibling/Father	5
4 year old female	11/1/2004	Blunt Head Trauma	Mother/Father	5
4 year old male	7/15/2004	Blunt Head Trauma	Father	2
4 year old male	8/21/2004	Blunt Head Trauma	Male Paramour	1
5 year old female	9/17/2004	Status Epilepticus	Adoptive Mother	1
5 year old female	11/10/2004	Suffocation & Alprazolam Toxicity	Mother	3
5 year old male	3/4/2004	Fire	Mother	5
6 year old female	4/2/2004	Fire	Mother	2
6 year old female	12/23/2004	Suffocation & Alprazolam Toxicity	Mother	3
7 year old male	5/11/2004	Asphyxia - Suffocation	Mother	1
9 year old female	3/13/2004	Blunt Trauma	Grandmother	2
9 year old male	12/8/2004	Blunt Head Trauma	Mother	1
10 year old female	5/11/2004	Suffocation & Alprazolam Toxicity	Mother	3
12 year old female	2/15/2004	Fire	Mother	2
13 year old male	4/7/2004	Ligature Strangulation	Mother/Step-Father	1
14 year old male	7/1/2004	Status Epilepticus	Father	1
14 year old female	9/6/2004	Multiple Drug Toxicity	Father	3
15 year old male	12/10/2004	Hanging	Non Relative	12
15 year old male	3/24/2003	Multiple Drug Toxicity	Paramour/Mot her	5
16 year old female	10/12/2004	Multiple Drug Toxicity	Mother	2
17 year old male	2/15/2004	Fire	Mother	2

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

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

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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. In 2004, the Florida Legislature expanded the role of the team to include the review of all verified child abuse and neglect deaths.

“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 sixth annual report includes information from the review of the 108 children who died in 2004. (*Note: three of the deaths in 2004 will be reviewed in 2005 due to additional documentation required.*) Additionally, it highlights major issues and trends for the 275 deaths reviewed over the six-year period since the inception of the Florida State Child Abuse Death Review Team. It is important for the reader to put the total reviews of these child deaths in perspective. For the recent five years, the population reviewed has been statutorily limited in scope and because of this; 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 six-year period include the following:

- Echoing national trends, neglect deaths (56 %) were more common than abuse (44 %).
- Of 275 deaths, 158 (57 %) were male, 117 (43%) were female; 164 (60%) of the children were white, 104 (38.0%) percent were black, 2 (.07%) was multi-racial, 1(0.4%) American Indian, and 4 (1.4%) were Asian Pacific.
- For those deaths that identified specific ethnicity, a total of 30 (11%) were identified as Hispanic and 13 (5%) were identified as Haitian.
- Fathers or male paramours were responsible in 87 (26%) of the deaths. The majority of the deaths in which the father or male paramour was the sole caretaker responsible were caused by abuse.
- Mothers were responsible in 129 (40%) 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 identified caretaker responsible ranged in age from seventeen to seventy-nine, with 72 (21.8%) under the age of thirty years.

-
- One Hundred and one (93.5%) of 108 cases identified in 2004 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 (76.9% of the deaths)
 - A pattern of escalation or frequency of incidents of abuse or neglect (34.3% of deaths)
 - Parent or caregiver unable to meet children's immediate needs (38% of deaths)
 - Children in the home had limited community visibility (44.4% of deaths)
 - Parent or caregiver's age, mental health, alcohol or substance abuse affected their ability to adequately care for child (38.9% of deaths)
 - Parent or caregiver's criminal history presented a potential threat of harm to the child (38% of deaths)
 - Pattern of escalating and/or continuing incidents of domestic violence (14.8 % of deaths)
 - Living conditions were physically hazardous to the health of the child (24.1% of deaths)
 - Parent or caregiver was unable or unwilling to protect the child from abusive caregivers/paramours (20.4% of deaths)

Of the 108 deaths from 2004 reviewed by the team, the causes and contributing factors included:

Neglect (66 deaths) -

- 22 children drowned. Of the 22 deaths, eleven children accidentally drowned in swimming pools, seven children drowned in a canal, pond or creek, lake, river and one in an inlet, three children drowned in a bathtub and one in a bucket. Inadequate supervision by the caretaker responsible contributed to these deaths.
- 10 children died due to hyperthermia, left in cars or entering vehicles that were not locked. Inadequate supervision contributed to all of these deaths.
- 10 children died by co-sleeping with their parent(s), family or others, or were left in unsafe environments
- 5 children died in vehicle related accidents. Of the five deaths, one child was run over by a mail truck, a concrete pump fell on another, one died as a result of the mother driving under the influence of alcohol, one ran out in front of a truck trailer, and one was hit by a car being driven by a 12 year old. Inadequate supervision contributed to these deaths.
- 2 children died due to medical neglect. One child was residing in a detention facility where the facility and staff failed to provide proper medical care, the other by lack of care by the father.
- 2 children died from gunshot wounds - the children's siblings accidentally shot them. The guns were left in open areas unlocked.
- 2 children died as a result of malnourishment/dehydration.
- 2 children died in a house fire. They were left alone and were playing with a lighter.
- 2 teenagers died from poisoning/ overdose. In both cases the parents also had history of drug use and were aware of the children abusing drugs.

-
- 2 children died as a result of hanging. One child was hung by a mini blind and the other committed suicide.
 - 1 child died from alcohol toxicity, the parents intentionally put alcohol in his formula.
 - 1 child died when the adoptive parents administered adult cold medication to the baby.
 - 1 child died when a babysitter administered a higher dose of medication than was prescribed.
 - 2 children died prematurely due to maternal drug use.
 - 1 child was found dead in the bed after the parents had been consuming drugs for three days.
 - 1 newborn was found wrapped in a blanket in the corner of the bedroom.

Abuse (42 deaths) -

- The majority of the abuse deaths involved direct attacks resulting in physical trauma.
- Of the 23 trauma related deaths, 10 of the children died from head trauma and 13 from multiple traumas.
- 5 children died from shaking/impact.
- 1 child died from a gunshot wound to his head.
- 5 children died in house fires intentionally started by the parents.
- 1 child was stabbed to death.
- 1 child was placed in a garbage bag and the body never found.
- 1 teenager overdosed - the father had a drug history and drugs were found in the home.
- 1 child hung himself and had been a victim of abuse by his father.
- 1 child died from the mothers' paramour intentionally suffocating the child.
- 1 child died from the mother suffocating him, she then shot herself.
- 1 child died when mom wrapped the newborn in a blanket and put it in a cupboard.
- 1 child died from complications of prematurity related to mothers drug use.

ISSUES AND RECOMMENDATIONS

The State Child Abuse Death Review Team has evolved over the past six years. In the initial years, the team built a foundation for a child abuse death review process at the state level and focused on advocacy for the development of local teams. This early work supported the development of a multidisciplinary approach to a specific population of child abuse and neglect deaths with prior reports in order to achieve a better understanding of the causes and contributing factors and to recommend better approaches for prevention. Once the foundation was built, additional local teams were established, multidisciplinary protocols were developed, and data was gathered and analyzed for the development and implementation of recommendations.

It remains important for the reader to put the overall analysis of these child deaths in perspective. For the past five years, the team has looked at a limited population of child abuse deaths, those in which there was a prior report to the Florida Abuse Hotline. 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. This year (2004) will be the first time state and local teams reviewed all verified child abuse death cases. At this time, the aggregated data is too limited to analyze the patterns and trends for all verified child abuse deaths in Florida. Without more definitive

comprehensive data, the team is reluctant to draw conclusions until they have at least another year reviewing all verified child abuse deaths

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

Recommendations

Issue 1: Public Awareness - Prevention Education

The State Team identified the need for public awareness education as a common theme throughout the 108 reviews completed for 2004 child abuse deaths. Educational campaigns are essential to raise public awareness of the seriousness of the problem of children dying tragically preventable deaths. The goal would be to move the public beyond the generation of awareness and concern to actual engagement in prevention, including behavior change. Out of 108 cases, it was determined that 94 (87%) could have been prevented.

A. Drowning

Drowning deaths are often called “tragic accidents” while they should be called “tragic deaths” that could have been prevented. There were 355 deaths ages 0-85 related to drowning in 2004. Of those cases, 56 were ages 1-4 and 74 were between the ages of 0-10. Of the 108 cases reviewed in 2004, 22 were drowning deaths, taking note that not one child drowned while they were supervised⁹.

Action/Recommendation:

Since 2001, the State Team has made the recommendation for education, training and pool safety equipment. It is essential that preventative measures be taken to decrease the number of children drowning in Florida. Public Awareness should include at a minimum:

- Emphasis on training for risk factors in all risk assessments conducted by the Department of Children and Families and Community Based Care providers related to water safety, pools or other bodies of water.
- Emphasize to parents and caretakers that they should never leave a child unsupervised in or around any body of water, no matter how small, including a bucket, not even for a moment.
- Enact and enforce pool fencing ordinances, as well as, multiple layers of protection around pools.

B. Co-Sleeping and Unsafe Sleeping

The State Team has identified this issue as an on going problem over the past 4 years. The number of children dying as a result of unsafe sleeping environments, or by placing the children in positions that can cause the child to suffocate or caretakers co-sleeping with the children continues unabated. This year there were 17 cases of co-sleeping deaths and the children were all 2 months and younger. National statistics point to the need for training and/or

education for parents, hospitals, medical examiners, pediatricians and law enforcement investigating those types of deaths.

There has been a nation-wide campaign since 1992, "Back to Sleep", to educate the public about the importance of placing children on their backs. (This campaign is sponsored by the National Institute of Child Health and Human Development, the Maternal and Child Health Bureau, the American Academy of Pediatrics, the SIDS Alliance, and the Association of SIDS and Infant Mortality Programs). Although this has reduced such deaths nearly in half, the State Child Abuse Death Review Team continues to see an ongoing problem where parents make poor choices to co-sleep with the children when clearly they present risks to the child (obesity, under the influence of alcohol or drugs, exhausted, etc.) Many of these deaths have the potential to be classified as SIDS deaths instead of positional asphyxiation.

The National Institute of Child Health and Human Development (NICHD) embrace the [October 2005 American Academy of Pediatrics \(AAP\) Policy Statement](#) on reducing the risk of Sudden Infant Death Syndrome (SIDS). The NICHD is working to incorporate the new risk-reduction messages into all *Back to Sleep* campaign materials.

- The American Academy of Pediatrics has released a new recommendation that babies should be offered pacifiers at bedtime, and they should sleep in their parent's room – but not in their beds- in order to lessen the risk of sudden infant death syndrome.
- It is recommended that pacifier introduction for breastfed infants be delayed until one month of age to ensure that breastfeeding is firmly established
- Infants should be placed for sleep in a supine (wholly on back position) for every sleep.
- Use a firm sleep surface: A firm crib mattress, covered by a sheet, is the recommended sleeping surface.
- Keep soft objects and loose bedding out of the crib: Pillows, quilts, comforters, sheepskins, stuffed toys and objects should be kept out of the infant's bed.
- A separate but proximate sleeping environment such as a separate crib in the parent's bedroom, sharing during sleep is not recommended.
- Consider offering a pacifier at nap time and bedtime.
- Avoid overheating: The infant should be lightly clothed for sleep and the bedroom temperature should be comfortable for a lightly clothed adult.
- Avoid commercial devices marketed to reduce the risk of SIDS :such devices are of no proven value
- Do not use home monitors as a strategy to reduce the risk of SIDS:
- Do not smoke during pregnancy: Also avoiding an infant's exposure to second-hand smoke is advisable to reasons in addition to SIDS risk.
- There is a need for on going training of first responders/law enforcement officers, DCF, and any person/agency handling these cases to document specific details of the child's position, where the child was found, and potential substance abuse by the caretaker/parent.¹²

Home visitors in Healthy Families Florida educated parents on the risks associated with co-sleeping and safe sleeping as a part of their home visiting curriculum. Healthy Start home visitors are required to provide pregnant women and new parents with information on safe sleep for infants. Staff training has been updated to include additional information to help parents to follow the safe sleep recommendations. It includes information on types of sleeping difficulties infants experience and strategies for how to help babies get to sleep. This information will give parents alternatives to unsafe sleep practices such as co-sleeping when they are having difficulty getting their infants to sleep. The training is provided twice a year to Healthy Start providers and can also be accessed at any time via the internet.

Action Needed/Recommendations:

- The State Team adopted the recommendations of the American Academy of Pediatrics released on November 5, 2005.
- It is recommended that training on safe sleep practices be provided to all hospital nurses throughout the state. Many nurses are still placing babies on their sides to sleep. Side sleeping is no longer recommended because many babies roll over onto their stomachs from this position. Studies have shown that nurses are not following the safe sleep recommendations and many parents then continue these practices once the babies are discharged, putting them at greater risk for suffocation.
- Training should also be provided to law enforcement officers and medical examiners on death scene investigations to assure that the necessary information is collected regarding the circumstances of an infant's death.
- The State Team recommends that the Medical Examiners' Commission and the Florida Association of Medical Examiners establish and publish a position for the uniform certification of cause and manner of death in cases of SIDS, co-sleeping, positional asphyxia and other deaths potentially related to unsafe sleeping conditions.

C. Kids and Cars

In 2004, there were at least thirty-five infants and children who died in the U.S from hyperthermia after being left in hot cars, trucks, vans, and SUV's. Some of these occurred on days with relatively mild (i.e., 70 degrees F) temperatures. There have been at least nineteen child fatalities in vehicles due to hyperthermia in 2005. In 2003, there was a record of 42 such needless tragedies. The total number of hyperthermia deaths of children left in cars, 1998-2004, is 230 compared to the number of hurricane deaths in the US, 1998-2004: 178. In one study (Guard, A. & Gallagher, S.S. Heat-related deaths to young children in parked cars: an analysis of 171 fatalities- U.S., 1995-2002. Injury Prevention 11, 33-37) the circumstances that led to child hyperthermia fatalities were examined.

- 39% - child "forgotten" by caregiver
- 27% - child playing in unattended vehicle
- 20% - child intentionally left in vehicle by adult
- 4% - circumstances unclear

"Parents and caretakers need to get the word out that a car is not a babysitter but can easily become an oven." This year the State Team reviewed 10 deaths of children left in vehicles or who entered unlocked vehicles.

Actions/ Recommendations:

- The State Team Supports Senator Hillary Clinton's Bill, the Cameron Gulbranson Kids and Cars Safety Act of 2005. The State Team recommends that Public Service Announcement's around the State be initiated and that the legislation fund the resources.
- Emphasize to parents and family that you should NEVER leave your child unattended in a motor vehicle, even with the windows down.
- Always lock car doors and trunks even at home and keep keys out of children's reach.

-
- Place an unmistakable reminder where you will be sure to see it before you leave the vehicle. Too many parents have forgotten about their precious children and the results have been fatal. Reminders can include placing a teddy bear in the passenger seat or a diaper bag, hanging a tag on the rear view mirror, placing your purse or brief case next to the car seat so that you will have to go to the backseat to take the item out. These simple reminders can save the life of a child.

D. “Safe Haven for Newborns”

Florida Statue, 383.50, known as the Abandoned Baby Legislation, went into effect in July of 2000 in response to an increasing number of newborn infants being abandoned and left to die. The legislation was passed to provide parents with a safe alternative to abandoning their infant and allows the parent of an unharmed child up to 3 days old to anonymously leave the baby with personnel at a hospital, fire department, or emergency medical services station without fear of prosecution for abandonment. Since the inception of the law, the following numbers of infants have been safely turned over to emergency personnel:

2000 – 1
2001 - 3
2002 - 7
2003 - 8
2004 - 5
2005 - 13 infants thus far.

There is anecdotal evidence that more newborns are being brought to hospitals throughout the state, but are not being reported due to perceived HIPPA confidentiality constraints.

For the last three years, the Florida Legislature allocated funding to the Florida Department of Health to support activities to increase public education and awareness about the legislation. Awareness activities included the development of printed educational materials with distribution throughout the state, advertising in movie theaters, restaurants, newspapers, bus stations, on bill boards, and posters placed in a drug store chain throughout the state. Funding was not continued during the 2005-2006 fiscal year.

The Gloria M. Silverio Foundation established an organization in 2001, called “A Safe Haven for Newborns” <http://www.asafehavenfornewborns.com/main.asp> The founding purpose and continuing mission of “A Safe Haven for Newborns” is to save the lives of newborns in danger of abandonment and to help preserve the health and future of their mothers. The foundation supports a 24 hour hotline as well as and is active in educating the emergency medical providers as well as the public about this legislation. The foundation also assists local Safe Haven Chapters to promote education and outreach in their communities. Currently Florida has 41 local chapters run by community volunteers.

Unfortunately, not all abandoned babies are identified, and the ones that are recovered are not tracked in a central data base. Last year, for example, an infant’s body was found on a conveyor belt of a recycling factory in West Palm Beach. It makes one wonder whether other babies have been discarded in garbage bins, dumps, ponds, etc., and never recovered. The number of babies who are saved are generally known and reported under this law, not those who fall through the cracks. As noted below, the number of babies rescued may be under reported due to confidentiality concerns. The Department of Health, in collaboration with The Safe Haven for Newborns and Healthy Start Coalitions, has led a public health awareness

campaign on the "Abandoned Baby Legislation" for the past 4 years. This campaign has sponsored advertising in the form of print materials, advertising via bus kiosks, bill boards, newspapers, movie theaters, and via posters in a drug store chain. In addition, education has been provided to community providers and stakeholders. As of December 2005, 41 infants have been saved by this initiative.

Action/Recommendation:

The State Team recommends to DOH that there be a continued public awareness campaign on "Safe Haven" through out the State and that the Legislature fund this outreach.

E. Shaken Baby Prevention Initiatives

The State Team has recognized that one of the leading causes of children being shaken/beaten to death is crying. Upon reviewing the statements of the perpetrators often the reason given for the abuse is because the child/baby would not stop crying.

The Kimberlin West Act of 2002 requires Shaken Baby Syndrome education at the time of birth. Part of this education includes how to cope with crying. We believe the intent of the legislature was that every new parent would receive this education prior to leaving the hospital. Research has shown many hospitals are not disseminating this information around the state of Florida. A pilot project was conducted in Pinellas County in 2004 in which nurses in birth hospitals participated in a Coping with Crying Train the Trainer. Follow up research was done with new parents who had received the training. They created a safety plan for when they became frustrated with the crying baby. The majority of the parents polled had put their safety plan into place within the first six months of the child's life.

Action/Recommendation

The State Team recommends that Coping with Crying education be implemented statewide.

Issue 3: Training and education to professionals on Child Abuse and Neglect

Law Enforcement:

The State Team recommends that there be death scene investigation training that considers the potential elements in the investigations which the caretakers could be under the influence of alcohol, drugs or both and that there be a standard requirement to require drug testing to rule out if it was a contributing factor in the death and if they refuse the agency obtain a court order. Serious injury or death could often be avoided by the proper use of child restraints. Children are also placed at risk as passengers in vehicles driven by impaired or reckless drivers. These incidents are often unreported because law enforcement officers only identify them as traffic violations

Action/Recommendation:

The State team recommends that the Florida Department of Law Enforcement, in conjunction with the State Team Coordinator provide training to local Law Enforcement Officers agencies and Florida Highway Patrol Troopers on recognizing and reporting child neglect and abuse during traffic related incidents.

Judicial:

A letter was written to the Chief Justice of the Florida Supreme Court by the Chair of the State Team asking for her assistance to partner with us to help increase the Judiciary's understanding of the dynamics of child abuse and its underlying variables, including substance abuse and domestic violence. Dependency and family courts serve as vital components of the child protection system. Unfortunately, we have seen several cases where children have died at the hands of an abuser after judges had returned them to their homes against the recommendations of child protection workers.

Action/Recommendation:

While the State Team recognizes the tremendous responsibility that rest with the judiciary and the many complex legal issues that often arise in child dependency cases, we believe it is imperative that judges receive sound training so that they can make the most informed decisions. With the current judicial rotations, it is essential that this is an ongoing process of education. The state team recommends that the judicial branch continue to further expand the unified family court model to enable judges to gain a fuller expertise on safety issues for children that are present and equally important to judicial decision-making regardless of the type of docket that comes before the court. The state team has reviewed cases where judges have made decisions related to child custody and visitation that contradict previously existing court orders for the same family. It is recommended that the judicial education offerings coordinated through the office of the state courts administrator invite opportunities for experts from the statewide task force to develop workshops and other instructional materials that illustrate the benefits of the unified family court as a child safety issue. The State Team recommends that the Judges should be trained by a certified" Florida Coalition Against Domestic Violence (FCADV) advocate or center.

DCF:

The State team found that there are no Standardized High Risk assessments through out the State, and that each district has different assessments and tracking mechanisms. Currently, DCF data on reports involving broken bones allegations indicate that the current child safety assessment process may not facilitate full identification of the safety threats to children, as well as the underlying conditions or causative factors which create such threats. Subsequently, the department's ability to identify the appropriate services and interventions needed to keep children safe is critically impacted.

Action Recommendation:

It is recommended that the department conduct an analysis of its current safety and risk assessment processes, from the investigative response through service intervention. The analysis should focus on the identification of safety threats and related ongoing risk determination, leading to the identification of services and interventions needed to improve parental protective capacities, as well as ameliorate the causative factors present. This analysis should also identify the report/case tracking needs to ensure appropriate oversight of these high risk reports/cases, including ongoing reviews to determine case progress.

Issue 4: The State Team supports the American Academy of Pediatrics finding that home visiting is a successful approach to preventing child abuse:

Home Visiting prevents Child Maltreatment - Recent national studies, including studies from the American Academy of Pediatrics and the Center for Disease Control present similar findings that home visiting programs can be an effective strategy to improve the health and well-being of children, particularly if they are embedded in comprehensive community services to families at risk. An independent evaluation of the Healthy Families Florida program, released in February 2005, concluded that Healthy Families Florida has a significant impact on preventing child maltreatment. Healthy Families Florida participants had 20 percent less child maltreatment than all families in their target service areas. The evaluation also shows that children in families who completed or has long-term intensive Healthy Families intervention experienced significantly less child maltreatment than did comparison groups with little or no services. The program also has a positive impact on participant self-sufficiency, maternal and child health and parent-child interaction in some of Florida's highest risk families.

Healthy Families Florida provides home visiting services through 36 community-based projects in 53 of Florida's 67 counties 30 county-wide and 23 in high-risk targeted zip codes.

Actions/Recommendations:

The State Team recommends taking home visiting programs with proven results, like Healthy Families Florida, to scale so that it is available to all families at risk of child abuse and neglect, and that the legislator fund the program.

Issue 5: Child Death Investigations and Crime Scenes

The State Team reviewed several cases where it was noted that there was a lack of crime scene investigations. Typically the child deaths were called tragic accidents and no crime scene was conducted. The State Team recognizes the need for shared information and coordinated investigations, and thorough crime scene documentation. Out of the 108 cases reviewed, eleven cases specifically addressed the lack of investigations and or crime scene.

Action/Recommendation:

The State Team proposes to provide to Medical Examiners, law enforcement agencies, State Attorneys, Child Protection Investigators, the necessity for a multi-agency and multidisciplinary approach to the investigation of child death cases. The State Team recommends that FDLE and Law Enforcement Training Standards include training that specifically addresses child death scene investigations.

Issue 6: The State Team recommends that *Florida Statutes* be amended to provide for the review of all child deaths.

According to the National Center for Child Death Review CDR is mandated or enabled by law in 39 states. Forty Eight states review deaths through at least age 17, and one state to age 15

and two states up to age 24. Five States review only maltreatments and half the states review deaths to all causes. Florida's criteria for child abuse and neglect death review are significantly more restrictive than any other state in the nation. Florida's limited review not only affects the ability of the team to fully accomplish the statutory purposes, would enable the team to better understand the contributing factors and causes thus enabling us to focus on prevention. The Child Abuse Death Review Team identified a major problem in the scope of the deaths reviewed. Currently, verified child deaths are only reviewed, thereby excluding many children through out the State of Florida.

Action/Recommendation:

The Florida Legislature should expand the child abuse death review process to include the review of all child deaths.

Issue 7: DCF Staff support for the State Child Abuse Death Review Team

The State Child Abuse Death Review Team (CADR) has had a long and productive working relationship with the Department of Children and Family Services. Our success has been dependent on the ability to access critical information regarding the death of children that the Department has verified as having died from abuse or neglect. We have relied on staff support from the Florida Department of Health (DOH), through the establishment of a Quality Improvement Coordinator position, and the Department of Children and Families Child Abuse Death Review liaison. Due to reorganizations within DCF, the CADR team lost their liaison representative. This significantly impaired the CADR team's ability to access case information in a timely manner. As a result, the Team sent a request to Secretary Luci Hadi, respectfully asking for DCF's assistance to make staff support from DCF a high priority within their agency.

Action/Recommendation:

Secretary Hadi responded to the Team expressing her support for the teams work. The responsibilities for DCF staff support and coordination will be handled by a recently created Quality Management Unit. In addition the Department is committed to establishing protocols for the DCF regional death review coordinators to ensure the provision of necessary documents to the State or local CADR teams.

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. According to Florida Office of Vital Statistics 2,722 children ages 0 to 18 died in 2004. Vital Statistics shows that 1,823 child deaths were 0 to 4 years of age.⁷ 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. The cases of 111 children who were reported to the Department of Children and Families and died from verified child abuse during 2004 were presented to the State Child Abuse Death Review team for review. Three of the 111 cases will be reviewed in 2006. There are seven deaths that occurred late in 2003 that were reviewed in 2004 and are included in the data presented in this report.

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.

In the past two years with the movement to Community Based Care the Department of Children and Families has reorganized into regions and zones. Death review coordinators have been reduced to accommodate this restructuring. With the changes in administration and staffing the annual child abuse death report for 2004 was not prepared by the Department.

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*¹, (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

Summary of First Six 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. During the past six years, the Child Abuse Death Review Team concluded that the deaths were preventable in approximately 83.8% 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 six 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 reviews the data of a particular case.

Patty*

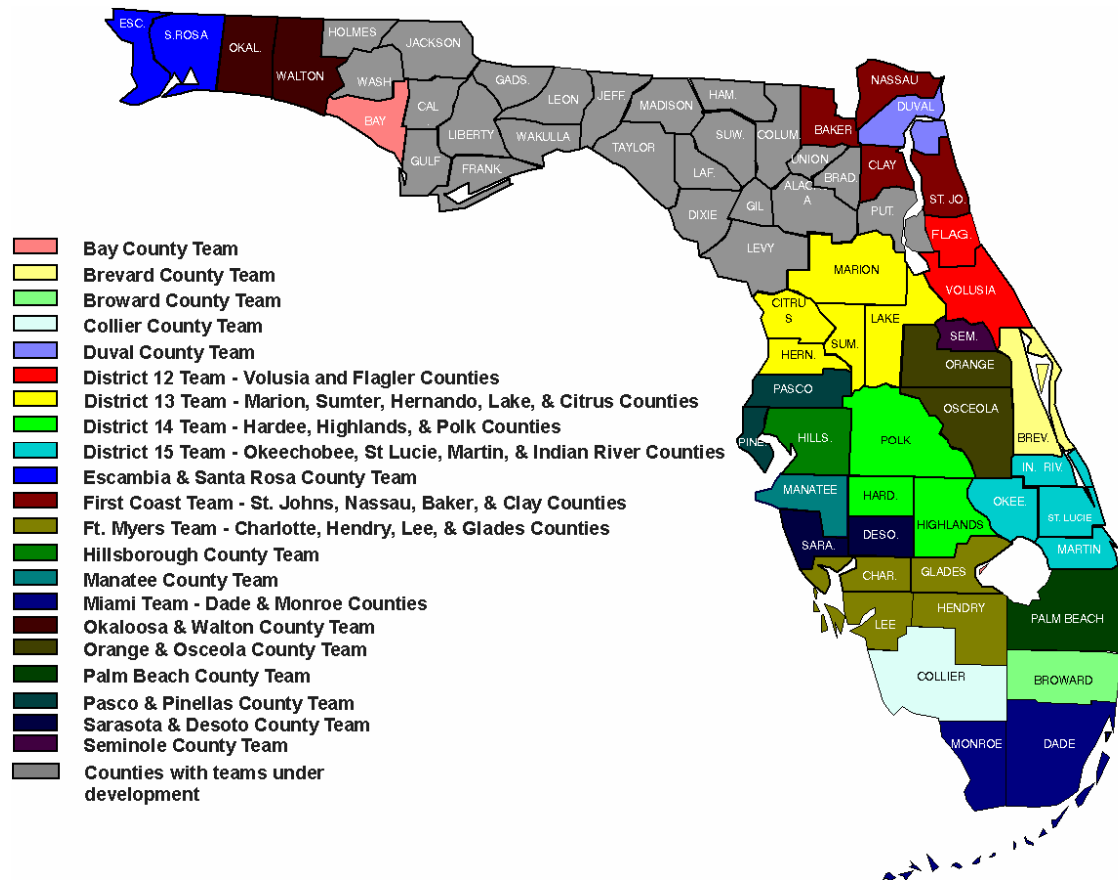
Four month old Patty was observed in the car by a by-stander. The mother was passed out behind the steering wheel. 911 was called. The mother left went back home with the child and fell asleep. The child was found unresponsive inside the car. The mother was charged with Aggravated Manslaughter. The mother's lab tests showed she had benzodiazepines cocaine and methadone present in her system.

*Alias

Existing and Planned Local Teams

The State Team recognized that there would be a need to establish more local teams in order to meet the new statutory change which expanded the criteria for case reviews. Recruitment and establishment of new local teams was a primary focus for the State Team this year. Numerous trainings were provided in an effort to promote the mission of Child Abuse Death Reviews and encourage collaboration among the numerous agencies. This effort has resulted in twelve additional teams being sanctioned by the State Child Abuse Death Review team. This brings the total of local teams to 20 which is a significant increase from 2004 where there were only seven active teams providing case reviews. In addition there is one team that is currently in the process of being sanctioned. There are three districts that are rural and have few deaths, one district has eleven counties and the other has fourteen counties. The team anticipates establishing three additional teams from the remaining counties where a local team does not exist. The goal of the State Child Abuse Death Review Team is to have Local Regional Teams active by the March 2006. 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 2004



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 a 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 six years, resulting in an analysis of a larger sample of cases. There was statutory change effective July 2004, where the team will now has the authority to review all verified cases of abuse and neglect. This will greatly enhance the team's ability to analyze the factors contributing to the child deaths.

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, and the Department of Children and Family Services HomeSafenet Information System and Quality Assurance Child Death database.⁷

ALL CHILD DEATHS - 2004	
Number of child deaths	2,722
Hsn REPORTS RECEIVED & ABUSE/NEGLECT DEATHS	
Number of Initial Reports	147,914
Number of reports involving child deaths	236
Number of child death's with verified or some indicator findings	139
Number of verified child death reports	107
Number of child deaths for 2004	111

*Three additional death reports are pending review by the Child Abuse Death Review Team
The 2003 death cases were reviewed in 2004 however the data for 2003 has been updated to reflect those 7 deaths

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 2004. Two hundred and seventy eight (278), child deaths met the criteria for review by the State Child Abuse Death Review Team; however 3 reviews were not completed in 2004 and will be included in the 2005. 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 (1999-2004)

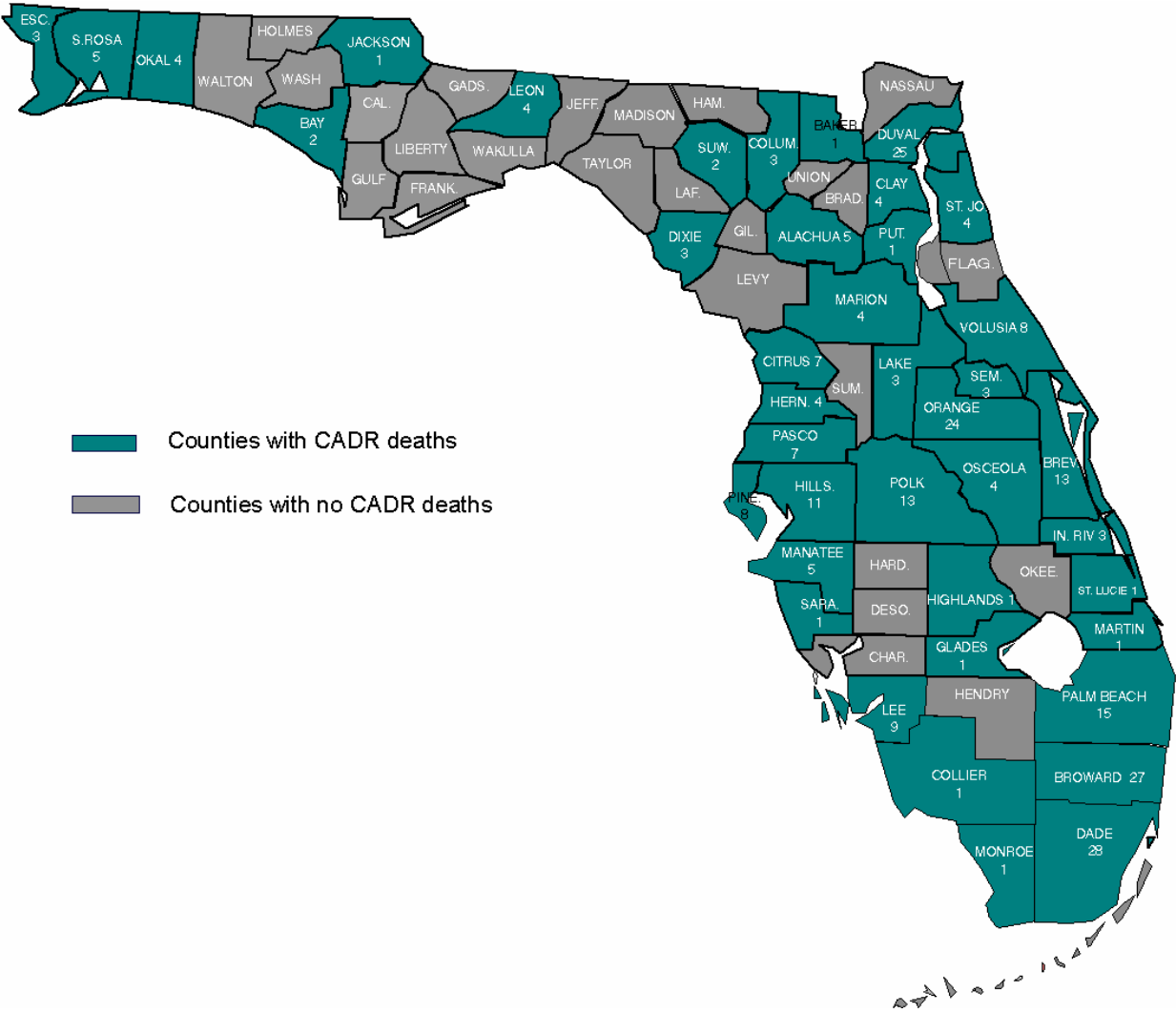


Figure 3: Number of Child Deaths by County/Year (1999 – 2004)

Number of Deaths by County															
County	Year						Total # of Deaths	County	Year						Total # of Deaths
	1999	2000	2001	2002	2003	2004			1999	2000	2001	2002	2003	2004	
Alachua	1	0	1	1	1	1	5	*Lee	1	0	3	0	0	5	9
Baker	0	0	0	0	0	1	1	Leon	0	0	1	1	0	2	4
*Bay	1	0	1	0	0	0	2	*Manatee	0	4	0	0	0	1	5
*Brevard	0	0	0	1	5	7	13	*Marion	0	2	0	0	1	4	7
*Broward	2	2	7	1	2	13	27	*Martin	0	1	0	0	0	0	1
Charlotte	0	0	0	0	0	2	2	*Monroe	0	0	0	0	1	0	1
*Citrus	0	0	1	1	1	4	7	*Okaloosa	0	1	1	1	1	0	4
*Clay	0	1	0	1	1	1	4	*Orange	4	2	3	2	8	5	24
*Collier	0	0	0	1	0	0	1	*Osceola	2	0	0	0	1	1	4
Columbia	0	1	0	1	1	0	3	*Palm Beach	4	1	1	2	1	6	15
*Dade	3	3	0	5	4	13	28	*Pasco	1	0	1	3	0	2	7
Dixie	3	0	0	0	0	0	3	*Pinellas	1	3	1	0	1	2	8
*Duval	3	2	3	0	1	16	25	*Polk	0	2	0	1	3	7	13
*Escambia	0	1	0	1	0	1	3	Putnam	0	1	0	0	0	0	1
Glades	0	0	0	0	0	1	1	*Santa Rosa	0	1	0	2	0	2	5
*Hernando	0	0	0	0	3	1	4	*Sarasota	0	0	0	0	0	1	1
*Highlands	0	0	0	1	0	0	1	*Seminole	0	0	0	2	1	0	3
*Hillsborough	0	2	4	1	2	2	11	*St. John	1	0	1	0	0	2	4
*Indian River	0	0	0	1	0	2	3	*St. Lucie	1	0	0	0	0	0	1
Jackson	0	0	0	0	0	1	1	Suwannee	0	0	0	0	1	1	2
*Lake	1	0	2	0	0	0	3	*Volusia	1	0	4	1	1	1	8

* = Counties with local CADR teams

*Note: 1999-2003 = verified child abuse with prior reports. 2004 = all verified child abuse deaths.

. Joanne,* Rose,* Dwight* and Kyla*

These children, ages 16, 13, 7 years and their 7month old sibling died of smoke inhalation during a house fire; their mother died at the hospital. Bars on the windows precluded fireman from accessing the children in a timely manner. It was discovered that the mother intentionally started the fire.

*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 six years. Graphs depict the six-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

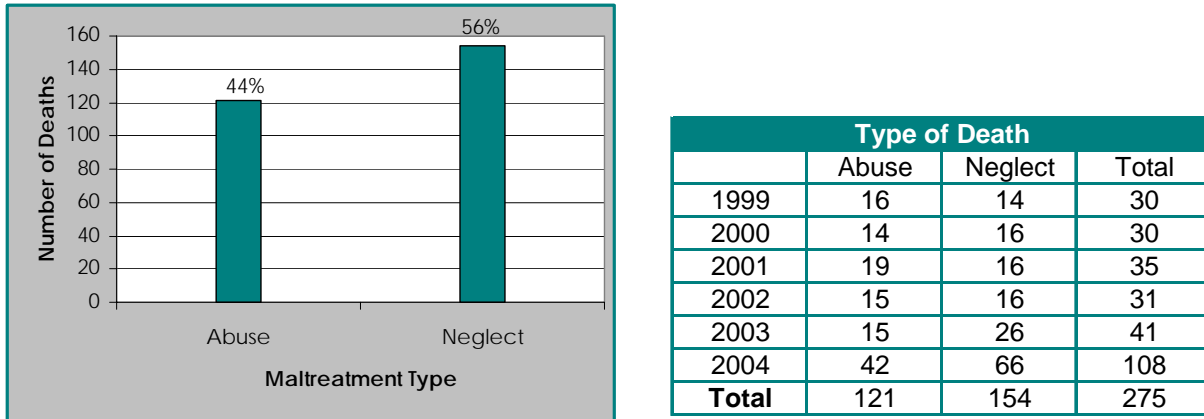
Number of Child Abuse and Neglect Deaths

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

- The National Child Abuse and Neglect Data System (NCANDS) reported and estimated 1,500 child fatalities in 2003. This translates to a rate of 2.00 children per 100,000 children in general population, which is comparable to the rate of 1.98 children per 1000,000 in the national population for 2002. Research indicates very young children (ages 4 and younger) are the most frequent victims of child fatalities. NCANDS data for 2003 demonstrated children younger than 1 year accounted for 43.6% percent of the fatalities, while children younger than 4 years accounted for 78.7% percent of fatalities. Infant boys (younger than 1 year old) had the highest rat of fatalities, nearly 18 deaths per 100,000 boys of the same age in the national population. Infant girls had a rate of 14 deaths per 100,000 girls of the same age. The overall rate of child fatalities was 2 deaths per 1000,000 children. The population of children is the most vulnerable for many reasons, including their dependency, small size and inability to defend themselves In 2003 Neglect Data System (NCANDS) indicated that three main categories were related to fatalities were neglect (35.6) Combinations of maltreatment types (28.4%) and physical abuse (28.4 %) of reported fatalities⁵.
- . The number of deaths by category for the aggregate six-year period is shown in Figure 4.

Figure 4: Abuse & Neglect Deaths (1999-2004)



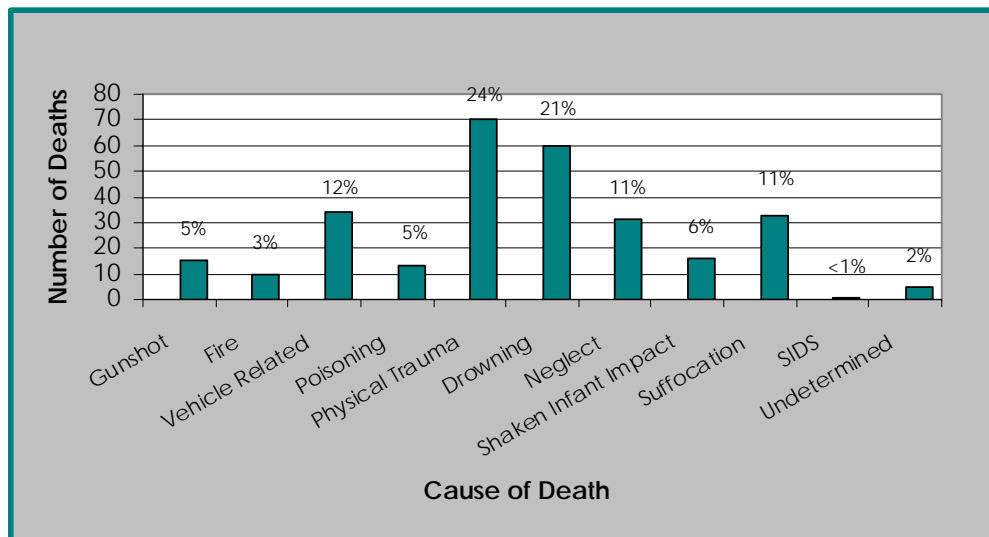
Aggregate data indicates that the deaths were equally caused by abuse and neglect for the first five years. For the first five annual periods, the difference between deaths due to abuse and those due to neglect varied slightly with the major cause of death alternating annually. This year’s review however, neglect (56%) maltreatment was significantly larger than abuse (44%), which is more in line with the National statistics.

The NACANDS data for 2003 indicates that 35.6 percent of child maltreatment fatalities were associated with neglect alone. Physical abuse alone was cited in 28.4 percent of reported fatalities. Another 28.9 percent of fatalities were the result of multiple maltreatment types⁵.

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 (1999-2004)



Cause of Child's Death								
	1999	2000	2001	2002	2003	2004	Total	%
Gunshot	6	1	2	1	2	3	15	5%
Fire	4	0	0	0	0	6	10	3%
Vehicle Related	3	3	5	3	4	16	34	12%
Poisoning	3	0	0	2	2	6	13	5%
Physical Trauma	5	11	15	7	8	24	70	24%
Drowning	3	10	4	10	11	22	60	21%
Neglect	2	1	4	3	6	15	31	11%
Shaken Infant Impact	2	2	1	4	2	5	16	6%
Suffocation	1	2	4	1	5	20	33	11%
SIDS	0	0	0	0	1	0	1	0%
Undetermined	1	0	0	0	0	4	5	2%
	30	30	35	31	41	121	288	100%

Aggregate data includes the following trends:

- The leading cause of deaths (24%) was physical trauma.
- The second leading cause of deaths (21%) was drowning, some due to abuse and some due to neglect.
- The majority of the neglect deaths reviewed for the six-year period were attributed to inadequate supervision, resulting in deaths from drowning, asphyxiation, house fire, or accidental gunshot wounds.
- This year there was a significant increase in the suffocation deaths from 11 over the 5 yr period to 20 deaths just 2004. Note: This increase is largely due to the change in the statute for cases meeting the criteria; they no longer need a prior from the Department of Children and Families.
- There was a rise in the vehicle related deaths 10 of which are from children being left in vehicles or entering vehicles unattended, this rise again is a reflection in the cases meeting the new criteria.
- Gunshot wounds were the cause of 3 deaths. This cause of death peaked in 1999, and declined in subsequent years.

Data for 2004 indicated that of the 108 deaths reviewed by the team, the causes and contributing factors included:

Neglect (66 of the deaths)

- 22 children drown. Of the 22 deaths, eleven children accidentally drowned in swimming pools, and seven children drowned in a canal, pond or creek, lake, river and one in an inlet, three children drown in a bathtub and one in a bucket. Inadequate supervision by the caretaker responsible contributed to these deaths.
- 10 children died due to hyperthermia, left in cars or entering vehicles that were not locked. Inadequate supervision contributed to all of these deaths.
- 10 children died by co-sleeping with their parent(s), family or others or were left in unsafe environments
- 2 children died due to medical neglect, one child was residing in a detention facility where the facility and staff failed to provide proper medical care and the other by the father
- 2 children died from gunshot wounds. Two, where the children's siblings accidentally shot them. The guns were left in open areas unlocked

-
- 5 children died in vehicle related accidents. Of the five deaths, one child was run over by a mail truck, a concrete pump fell on the child, one resulted from the mother being under the influence of alcohol and caused an accident, one ran out in front of a truck trailer, one was hit by a care being driven by a 12 year old. Inadequate supervision contributed to these deaths.
 - 2 children died as a result of malnourishment/dehydration
 - 2 children died in a house fire. They were left alone and were playing with a lighter
 - 2 teenagers died from poisoning/ overdose. Both cases the parents also had history of drug use and were aware of the children abusing drugs.
 - 2 children died as a result of hanging. One child was hung by a mini blind and the other committed suicide.
 - 1 child died from alcohol toxicity, the parents intentionally put alcohol in his formula.
 - 1 child died when the adoptive parents administered adult cold medication to the baby
 - 1 child died when a babysitter administered a higher dose of medication that was prescribed
 - 2 children died prematurely due to maternal drug use
 - 1 child was found dead in the bed after the parents had been consuming drugs for three days
 - 1 newborn was found wrapped in a blanket in the corner of the bedroom

Abuse (42 of the deaths)

- The majority of the abuse deaths involved direct attacks resulting in physical trauma. Of the 23 trauma related deaths, 10 of the children died from head trauma and 13 from multiple traumas.
- 5 children died from shaking/impact.
- 1 child died from a gunshot wound to his head, the gun was left in an open area
- 5 children died in house fires where the parents intentionally started it
- 1 child was stabbed to death.
- 1 child was placed in a garbage bag and the body never found
- 1 teenager overdosed , the father had a drug history and drugs were found in the home
- 1 child hung himself and had been a victim of abuse by his father
- 1 child died from the mothers paramour intentionally suffocating the child
- 1 child died from the mother suffocating him and then shot herself
- 1 child died when mom wrapped the newborn in a blanket and put it in a cupboard
- 1 child died from complications of prematurity related to mothers drug use

Sam*

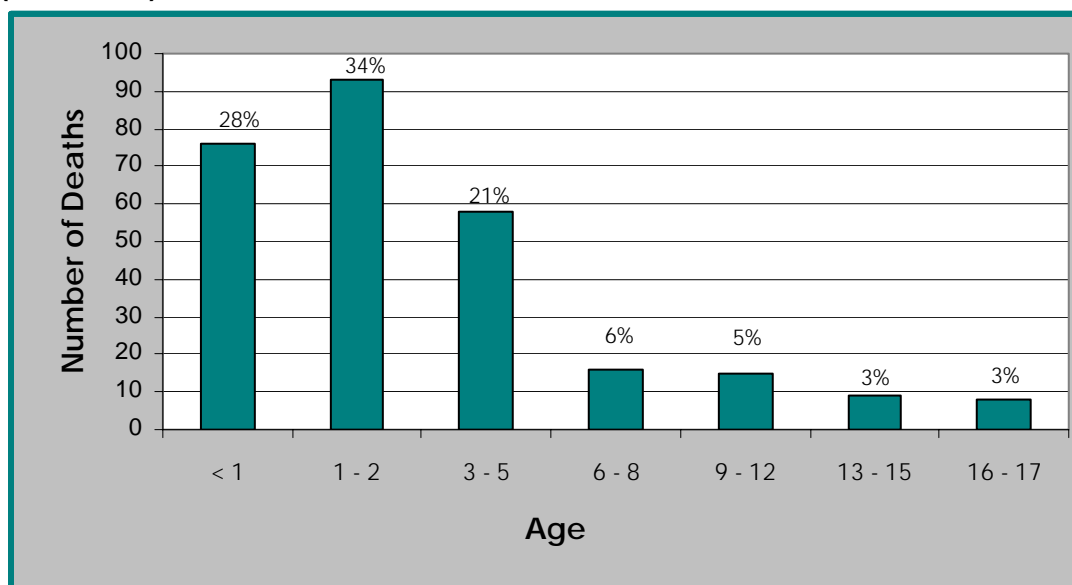
11 month old "Sam" drowned in a bathtub. The mother's boyfriend had left the child in the tub, with the water running, while he went to make coffee. He stated that he had checked on the child approximately 6 minutes before Sam's sibling informed him that the child was floating in the water. .

*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 108 children.

Figure 6: Age at Death (1999-2004)



Age of Child at Death							
	1999	2000	2001	2002	2003	2004	Total
< 1	3	4	6	7	11	45	76
1 - 2	9	10	16	11	13	34	93
3 - 5	8	9	7	7	11	16	58
6 - 8	6	2	0	3	1	4	16
9 - 12	1	3	3	2	3	3	15
13 - 15	1	2	2	1	0	3	9
16 - 17	2	0	1	0	2	3	8
	30	30	35	31	41	108	275

Reviews by The Child Abuse Death Review Team in Florida for the 1999 through 2004 Six-year period indicate that, of the children who died, 227 (83%) were under the age of six, 151 (55%) were between the ages of one and five, and 28% were under the age of one year.

Of the child deaths reviewed for 2004, 74% were under the age of six, 46.3% were between the ages of one and five and 41.7% were under the age of one year.

The research indicates very young children (ages 4 and younger) are the most frequent victims of child Fatalities. NACANDS data for 2004 demonstrated children younger than 1

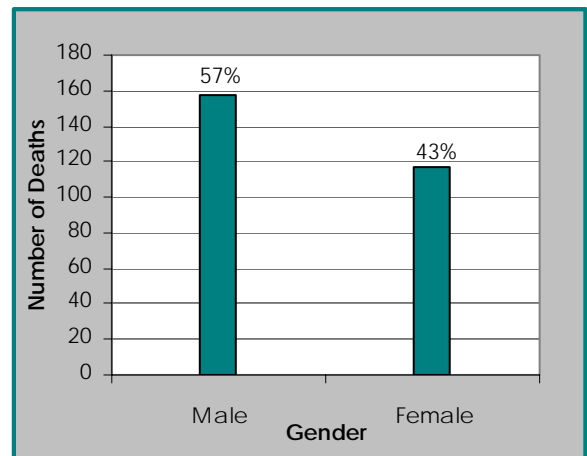
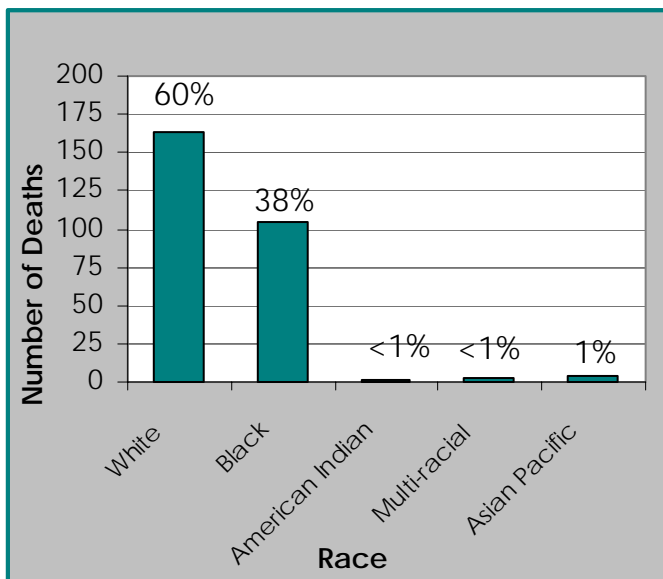
year accounted for 43.6 percent of fatalities, while children younger than 4 years accounted for 78.7 percent of the fatalities. This population of children is the most vulnerable for many reasons, including their dependency, small size and inability to defend themselves⁵.

Race and Gender

NCANDS research indicates that white children accounted for 43.1percent of all child fatalities. African-American children accounted for 30.9 percent and Hispanic children accounted for 14.8 percent of child fatalities. Children of American Indian or Alaska Native, Asian, Pacific Islander, other or multiple race descent accounted for less than 2 percent of the fatalities for each race or ethnicity.⁶

For the 275 deaths reviewed during the six-year period, 158 (57 %) were male, and 117 (43 %) were female. For these deaths 164 (60%) of the children were white, 104 (38.0%) percent were black, 2(0.7%) was multi-racial and 1 (.04%) was American Indian 4 (1.4%) were Asian Pacific. When a specific ethnicity was identified, a total of 30 (11%) were identified as Hispanic and 13 (5%) 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 (1999-2004)



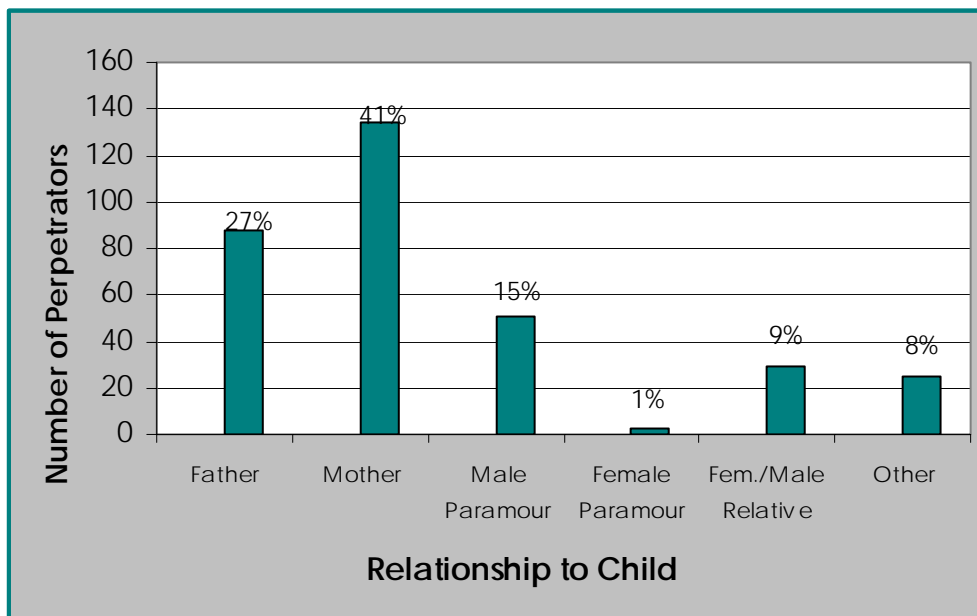
Race of Children						
	White	Black	Amer. Indian	Multi-racial	Asian Pacific	Total
1999	16	14	0	0	0	30
2000	23	7	0	0	0	30
2001	17	17	1	0	0	35
2002	19	10	0	1	1	31
2003	22	16	0	1	2	41
2004	67	40	0	0	1	108
Total	164	104	1	2	4	275
%	60%	38%	0.4%	0.7%	1%	100%

Gender of Children			
	Male	Female	Total
1999	20	10	30
2000	18	12	30
2001	19	16	35
2002	18	13	31
2003	23	18	41
2004	60	48	108
Total	158	117	275
%	57%	43%	100%

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. NCANDS found in 2004 one or both parents were involved in three-quarters (78.2%) of child fatalities. Almost One-third (30.5%) of fatalities was perpetrated by the mother acting alone. A breakdown of the number of deaths by caretaker responsible is shown in Figure 8.⁶

**Figure 8: Caretaker Responsible for Abuse or Neglect
Relationship to Child
(1999-2004)**



Relationship of Caretaker Responsible to Child								
	1999	2000	2001	2002	2003	2004	Total	%
Father	9	11	9	7	10	42	88	27%
Mother	13	11	15	14	19	62	134	41%
Male Paramour	9	8	10	6	7	11	51	15%
Female Paramour	0	0	0	1	0	2	3	1%
Fem./Male Relative	5	6	4	2	4	8	29	9%
Other	1	1	5	2	7	9	25	8%
	37	37	43	32	47	134	330	100%

For the 275 deaths reviewed during the six-year period, 330 perpetrators/caretakers responsible were identified. Mothers were involved in or responsible for 134 (41%) of the 275 deaths reviewed, fathers for 88 (27%) of the deaths, and male paramours for 51 (15%)

of the deaths and female paramour 3 (1%). 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 2004, mothers were involved in or responsible for 62 (46%), fathers for 42 (31%) of the deaths, and male paramours for 11 (8%) of the deaths, female paramours for 2 (1.5%) of the deaths. This does not significantly differ from the aggregate data.

Mika*

Two year old "Mika" was found in the family swimming pool. The mother stated she was at home with her 6 children. She allowed the 6 and 4 year olds to swim in the pool, while she supervised them through a window. According to the mother, she was on the telephone or in the bathroom when the two year old left the room. Mika drowned.

*Alias

Age of Caretaker Responsible for Abuse or Neglect

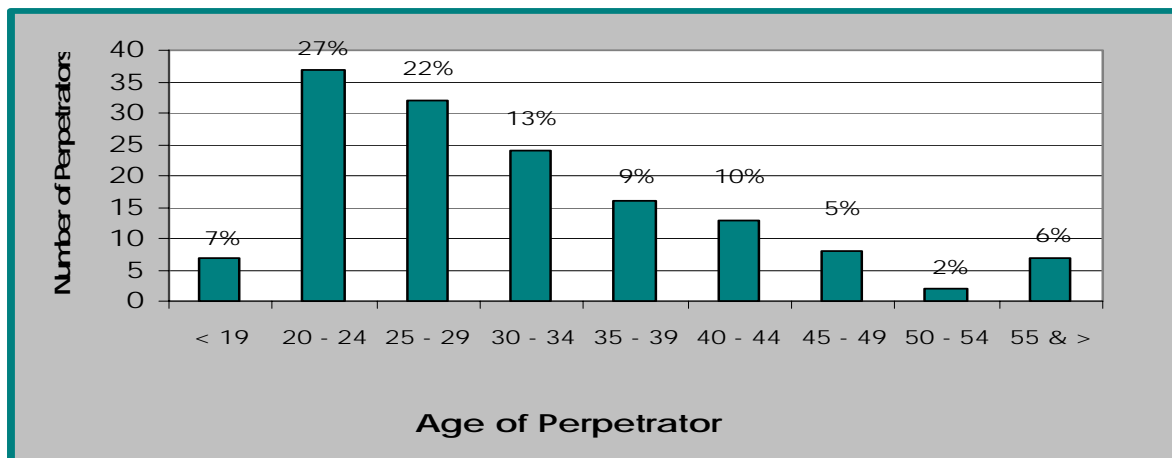
Data for six-year period (275 deaths) indicated that the 330 perpetrators/caretakers responsible ranged in age from 17 to 79, with 183 (56%) under the age of 30 years.

For the year 2004, the 134 perpetrators/caretakers responsible of the 108 deaths ranged in age from 19 to 44, with 56 % under the age of 30 years.

Frequently the perpetrator is a young adult in his or her mid-20's without a high school diploma, living at or below the poverty level, depressed and who may experience violence first-hand. Most fatalities from physical abuse are caused by fathers and other male caretakers. However, in some cases this may be because women are most often responsible (or assumed to be responsible) for children's care. (U.S. Advisory Board on Child Abuse and Neglect, 1995) Female perpetrators, who were mostly mothers, were typically younger than male perpetrators, who were mostly fathers. Women also comprised a larger percentage of all perpetrators than men: 58 percent compared to 42 percent. (National Clearinghouse on Child Abuse and Neglect Information, 2005)⁶ However, in some cases this may be because women are most often responsible or assumed to be responsible for the children's care⁵.

Florida's 2004 and aggregate data 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 . . . 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 – 2004)



Age of Perpetrator								
	1999	2000	2001	2002	2003	2004	Total	%
19 and <	1	0	5	1	10	6	23	7%
20 thru 24	8	7	10	14	12	37	88	27%
25 thru 29	10	9	9	4	8	32	72	22%
30 thru 34	4	3	14	4	4	14	43	13%
35 thru 39	7	6	2	1	4	10	30	9%
40 thru 44	2	3	2	6	1	20	34	10%
45 thru 49	2	4	1	1	3	5	16	5%
50 thru 54	1	1	0	0	2	1	5	2%
55 & >	2	4	0	1	3	9	19	6%
Total	37	37	43	32	47	134	330	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 six-year period. Based on the information gathered:

- 170 (61.6%) of the perpetrators/caretakers responsible had criminal records.
- 101 (36.6%) of the perpetrators/caretakers responsible had a history of substance abuse.
- 63 (22.8%) of the perpetrators/caretakers responsible had a history of alcohol abuse.

Domestic violence is often a factor in child abuse deaths. 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:

- 92 (33.3%) of the perpetrators/caretakers responsible were also perpetrators of domestic violence.
- 70 (25.4%) of the perpetrators/caretakers responsible were also victims of domestic violence.

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

Child physical abuse deaths are the most baffling. But some answers are being provided by new research and analysis of data emerging from Child Death Review Teams. Teams in States such as Colorado and Oregon have identified specific "triggers" that occur just before many fatal parental assaults on infants and young children, including:

- An infant's inconsolable crying
- Feeding difficulties
- A toddler's failed toilet training
- Exaggerated parental perceptions of acts of "disobedience"

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
- 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

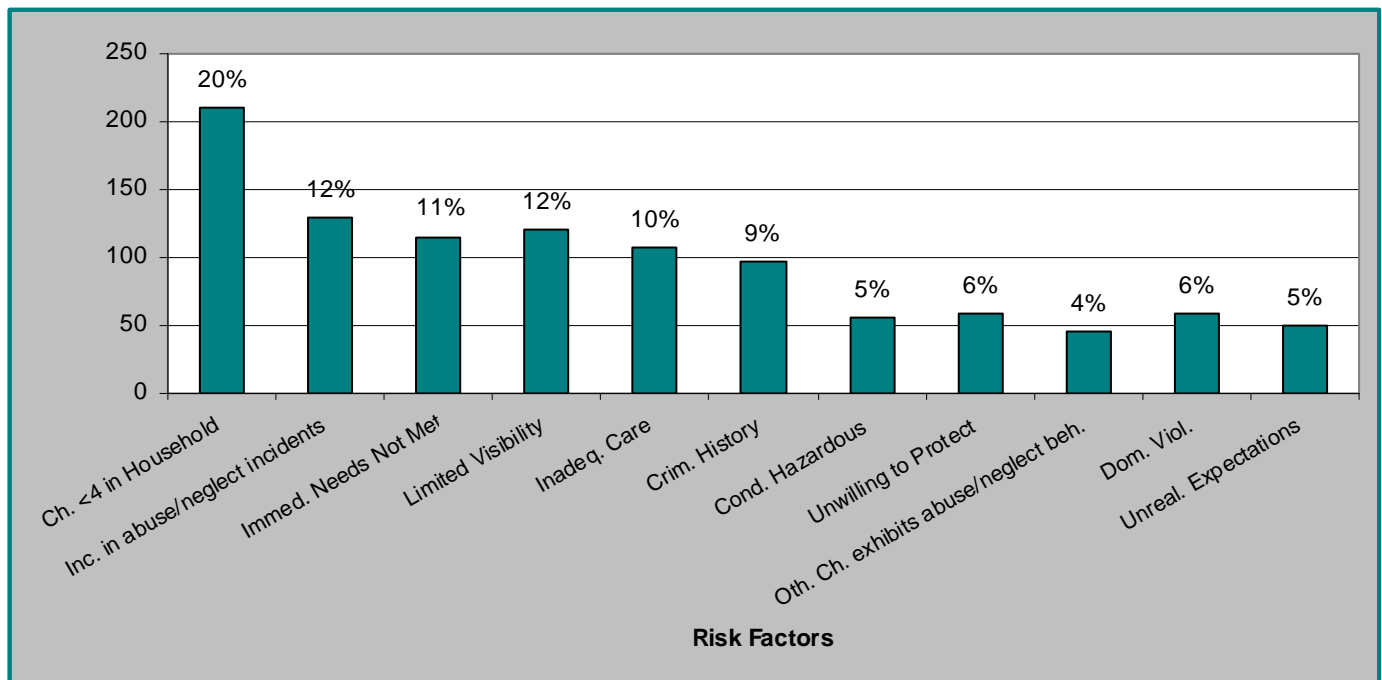
All cases meeting the criteria for this review involved all verified reports of abuse or neglect. Other specific risk factors identified during the review process included:

- Child in the home under the age of four years (20%)
- Patterns of escalating and/or increased frequency of incidents of abuse or neglect (12%)
- Children with limited community visibility (11%)
- Parent/Caretaker has not met or is unable to meet immediate needs for food/clothing/shelter/medical care, or protect from harm (11%)
- Parental limitations in ability to adequately parent due to age, mental capacity or substance abuse (10%)
- Criminal history of caretaker responsible or other adult in the home (9%)

Fifty two (52.2 %) of the 144 children had five or more family risk factors present at the time of death. Of the children who died in 2004, 50 children (46.3%) 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 (1999-2004)



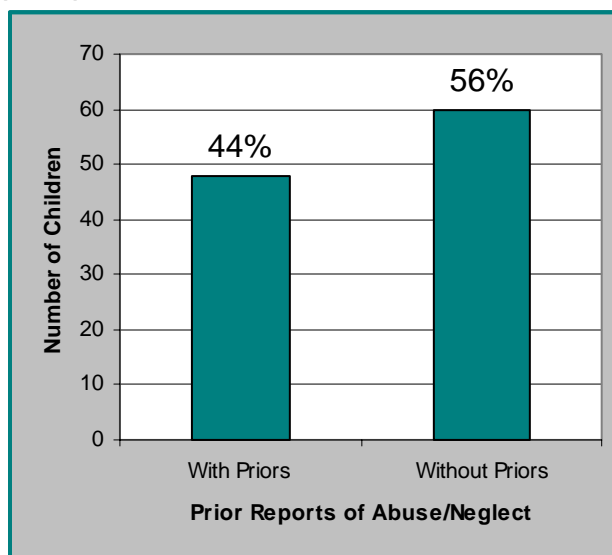
Risk Factors in 2004 Child Abuse Deaths							
	1999	2000	2001	2002	2003	2004	Total
One or more children in the household age 4 or younger	20	25	29	24	30	83	211
A pattern or escalating and/or frequency of incidents of abuse or neglect	13	14	19	12	34	37	129
Parent or caregiver is unable to meet child(ren) immediate needs	12	14	15	14	17	42	114
Child(ren) in the home have limited community visibility	12	12	16	15	18	48	121
Parents or caregiver's age, mental health, alcohol or substance abuse affects ability to pare	10	12	19	11	14	42	108
Criminal history on any household member	6	12	13	7	18	41	97
Conditions in the home are hazardous to child's health	8	7	6	7	3	25	56
Parent or caregiver is unable or unwilling to protect the child(ren)	4	8	10	9	7	21	59
Other child(ren) in home exhibit behaviors indicative of abuse or neglect	6	6	4	8	6	15	45
Domestic violence in the home	5	6	14	6	12	16	59
Parent or caregiver has unrealistic expectations of child(ren)	2	8	6	5	6	23	50

Priors for Period 1999 – 2003 and Priors for 2004

In 2004 the legislation was passed that expanded the criteria for Child Abuse Death Reviews to all verified child abuse deaths, compared to the last five years in which there was a requirement of a prior involving the family along with the verified child abuse death. This clearly made a significant difference in the numbers of cases statutorily mandated; the team went from 35 child abuse death reviews in 2003 to 108 child abuse death reviews for 2004.

In 2004 there were 48 (44%) cases with prior(s) and 60 (56%) cases with no prior involvement with the Department of Children and Families.

Figure 11: Prior Reports of Abuse/Neglect (2004)



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 108 child deaths in 2004, in addition to the prior investigations, 102 victims received a total of 140 direct services from either the Department of Children and Family Services, the Florida Department of Health, Community Based Care providers or other 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:

- 69 (50%) were found to have been adequate
- 55 (39%) were found to have been inadequate
- 13 (11%) 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 60 cases
Found to have been adequate in 23 cases (38.3%) and inadequate in 35 cases (58.3 %)
- Department of Health in 13 cases
Found to have been adequate in 10 cases (76.9%) and inadequate in 2 cases (15.4 %)
- Child Protection Teams in 21cases
Found to have been adequate in 16 cases (76.2%) and inadequate in 2 cases (9.5%)
- Department of Juvenile Justice in 5 cases
Found to have been adequate in 0 cases (0.0%) and inadequate in 3 cases (40.0%)
- Mental Health Agencies in 12 cases
Found to be adequate in 6 cases (50.0%) and inadequate in 2 cases (16.7%)
- Other Service Providers in 26 cases
Found to be adequate in 14 cases (53.8%) and inadequate in 11case (42.3%)

In 13 (9%) of these 140 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 108 deaths reviewed for 2004 the state and local teams identified issues in the following areas: Several of these issues/concerns have been identified repeatedly over the last two years.

- 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 staffing 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 staffing should be held when the attorney determines additional evidence is needed for legal sufficiency to file a dependency petition.
 - The Department of Children and Families should develop a procedure and written policy to assure the safety and risk to children are not compromised where voluntary placement and or supervision is made.
 - 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 Troopers, narcotic officers and homicide investigators
 - 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.
 - Need for training on child death scenes investigations to include doll reenactments
 - 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.

 - Policies/Practices, which included the following:
 - Child Protection Teams needs to ensure that client history and social assessment information is available to medical providers and included in the assessment determination.
 - Child Protection Team needs to provide a medical report to the Department of Children and Families that clearly documents the findings by the medical providers.
 - Department of Health service providers 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.
 - Medical Examiners Commission should collect on the circumstances data on co-sleeping or positional asphyxia infant deaths state wide.

Degree of Preventability

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 108 of deaths reviewed and concluded that:

- 65 (52%) were definitely preventable by a caretaker not responsible for the death
- 3 (2%) were definitely preventable by the system
- 6 (5%) were possibly preventable by a caretaker not responsible for the death
- 11 (9%) were possibly preventable by the system
- 10 (8 %) were not preventable

Of the cases determined to be definitely preventable, 29 were found to have been preventable by both the caregiver and the system (23 %).

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 53 of the 108 cases there was either no charges filed or the case was nol-prossed
 - 6 of the caretakers responsible committed suicide at the time of the child's death
 - 1 caretaker responsible was found incompetent
 - 37 cases are still pending disposition
 - 6 cases the investigation is active
- 45 were criminally charged, of those
 - 21 were charged with murder
 - 11 were charged with manslaughter
 - 13 were charged with negligence or other charges

Criminal cases have been completed on 8 of the individuals charged and resulted in:

- 1 conviction of murder
- 3 convictions of manslaughter
- 4 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.

Status of 2004 Report

The following recommendations were made in the 2004 report and the responses and action taken are as follows:

ISSUE 1: CONFIDENTIALITY

During the 2004 legislative session, the confidentiality section came up for Sunset Review. The Florida Senate unanimously passed Senate Bill 462 which ensured the retention of this confidentiality section. Regrettably, in the House, a similar Committee Bill (PCB 04-02) was held up in the State Administration Committee for unknown reasons. Thus, the bill was not

heard by the Administration Committee or given the opportunity to be voted upon by the full House of Representatives. Senate Bill 462 subsequently died in House messages.

As a result of this action, Chapter 383.410 F.S. was “sunset” on October 2, 2004. Without the confidentiality section, the State Committee cannot view important aspects of child abuse or neglect deaths. Consequently, the loss of the confidentiality section has significantly impeded the State Committee’s ability to carry out its statutory function.

Action needed/Recommendation in 2004:

It is imperative that the Florida Legislature work in partnership to restore the confidentiality protection necessary for a thorough and unbiased review of all these cases.

Action Taken in 2005:

House Bill 185 and Senate Bill 676 were introduced in the 2005 legislative session. The bills were conformed and HB 185 passed and became law on July 10, 2005, amending s. 383.412 to restore confidentiality protection for the Child Abuse Death Review process.

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. The Vital Statistics data for 2003 shows that 381 deaths ages 0-10, were related to drowning 99 of those reported drowning were between the ages of 0-10. Out of the 36 cases reviewed 10 were related to drowning.

Action needed/Recommendation in 2004:

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, which the Department of Children and Family Services has begun to implement this in their training curriculum.
- Continue public awareness and education on drowning prevention especially targeted at the under age five group.

Action Taken in 2005:

The Department of Children and Families training for Florida child welfare staff, including both protective investigations and service components is currently under revision. The team’s recommendation for emphasizing drowning deaths as a part of the risk assessment has been shared with the workgroup which is helping to design the new training curriculum.

Several representatives from the Office of Family Safety are also serving on the Interagency Prevention Task Force which is in the process of reviewing implementation of the district prevention plans in order to facilitate the sharing of best practices. One “best practices” that

has since come to light is the distribution of water safety pamphlets by Pasco County Sheriff child abuse investigators during open investigations to parents whose home have swimming pools or bodies of water in the neighborhood. This pamphlet will be reviewed by the department for possible state wide distribution and use.

ISSUE 3: TRAINING NEEDS

Training is an on-going need 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 in 2004:

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.

Action Taken in 2005:

The State team is not aware of any action taken by the Standards and Training Commission at this time. However, FDLE has provided training which has been established in partnership with Other Professional Agencies on topics which include the process and purpose of Child abuse death reviews, reporting child abuse and neglect, signs and symptoms of child abuse and others. These trainings have been scheduled through out the State with numerous agencies.

Department of Children and Family Services Staff

The team continues to recommend 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.

Action Taken in 2005:

The Florida Department of Children and Families training for child welfare staff, including both protective investigations and service components is currently under revision. One of the recommendations for the core competencies is the ability to demonstrate critical decision-making skills throughout the life of the case. This recommendation will also be forwarded to the Office of the General Counsel for review with the hope that CWLS staff will be encouraged, if not mandated, to receive continuing education training in the area of domestic violence as well as strategies for appropriate court intervention. Recently the first class of the Child Welfare Leadership Program took on the issue of domestic violence and in addition to recommending changes in policies and procedures to the Secretary, the group devised a "Domestic Violence On-Going Assessment Tool" for potential use in the field by investigators and CWLS staff.

Judiciary

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

Action Taken in 2005:

The State Team is not aware of the judiciary providing this type of training

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. The Department of Education has in collaboration with many professional agencies developed a guide to Child Abuse and Neglect Mandated Reporting. This has been sent to all school personnel throughout the state. The web site is <http://www.firn.edu/doe/commhome/pdf/chiabuse.pdf>.

Action Taken in 2005:

The school continues to send out the guide to the School administrators.

ISSUE 4: 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 in 2004:

The team continues to recommend 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.

Action Taken in 2005:

The Family Safety office has been working closely with the new DCF office of Provider Relations to improve communication between the department and the community-based care provider agencies. For instance, a recent programmatic initiative was launched to review the Early Services Intervention (ESI) staffing process in order to examine how deep into the case Protective Investigators were continuing their involvement and to review how clearly investigative versus supervision roles were defined. Similarly, the Abuse Hotline workgroup is trying to clarify the role of PI's handling "placement disruptions" involving CBC protective supervision staff. Both issues are being addressed in the Administrative Rule re-write process as well. Finally the Program Office's Investigations Specialist is scheduled to participate in joint agency monitoring with the Child Protection Team which will specifically monitor for PI follow-through with CPT services and recommendations. A "best practice" regarding interagency collaboration and communication that is being encouraged for statewide replication is the use of the Neighborhood Partnership program's family team conferencing model for intervention and case management activities. Family conferencing facilitates communication and collaboration by placing key stakeholders (including both investigative and services staff) and the family around the table together when devising a plan to address safety concerns and family needs. This style of intervention fosters partnerships for safety between the family, investigator and service counselor that lead to more positive outcomes for the family and improved networking between and among agency representatives.

ISSUE 5: 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 in 2004:

The team recommends that at risk children be prioritized for subsidized childcare. There should be language to prioritize the at risk children. There needs to be additional funding to meet the needs of the working poor who are at risk of abuse and neglect. There should be priority for children who are domestic violent homes, substance abusers in rehab facilities, and families with a large number of children. The Team recommends that there be additional funding for universal subsidized child care and second for at risk children

Action Taken in 2005:

In December 2004, a special Legislature session passed the Voluntary Pre-Kindergarten law providing free child care to all 4 year olds. This was implemented in August 2005. Additional funding and prioritization of at-risk children must be addressed by the Legislature and facilitated by the Agency for Workforce Innovation as the lead agency for the Child Care and Development Fund as well as the school readiness program (subsidized child care.) There has been no additional federal funding for Florida for this program in at least three federal

fiscal years and no additional funding is anticipated in the immediate future. With the implementation and transition to local early learning coalitions as the determining entity for priority services, this issue will have to be addressed at a local level until such time as legislation is proposed and passed.

Issue 6: VOLUNTARY PLACEMENTS

The State Team recognized a deficiency in the process of voluntary placement by DCF staff. Children are determined to be at risk with their caregivers/parents and the DCF staff allows the parent/caregiver to make a voluntary placement with relatives and or non-relatives without any court involvement. There is no follow up on the cases if the family chooses not to continue with the voluntary case plan. There is also inconsistency as to what cases are appropriate for voluntary supervision.

Action needed/Recommendation in 2004:

The Department of Children and Families need to address these deficiencies by either a written policy or a Quality Assurance procedure to assure the safety and risk to these children is not compromised.

Action Taken in 2005:

The Department is in the process of revising all current administrative rules including the Protective Investigator rule and “in-home” procedures which are going to be found in the General Rules re-write. Additionally, there was a Voluntary Protective Supervision Program Directive written in January 2003 which guides practice in this area that will be reviewed for assimilation into the administrative guidelines as appropriate. The recommendations of the team will also be forwarded to the department’s Quality Management office as well, with the Family Safety Office’s recommendation that future monitoring focus more in depth in the area of voluntary supervision practices.

Issue 7: CO-SLEEPING/UNSAFE ENVIROMENT

The State Team identified a major problem in the number of children dying as a result of unsafe sleeping environments, by placing the children in positions that cause the child to suffocate or co-sleeping with the children. This year there were 4 cases of co-sleeping deaths and the children were all 2 month and younger. Nationwide the statistics point to the need for training and/or education for parents, hospitals, pediatricians and law enforcement investigating those types of deaths.

Action Needed/Recommendations in 2004:

The need for training of first responders/law enforcement officers, DCF, and any person/agency handling these cases need to document specific details of the child’s position, where the child was found, and potential substance abuse by the caretaker/parent.

Continue community awareness efforts on safe sleeping and the risk and dangers of sleeping with their child. The hospitals, pediatricians, and home visiting programs should address with the parents the risks associated with the co-sleeping.

Home visitors in Healthy Families Florida educated parents on the risks associated with co-sleeping and safe sleeping as a part of their home visiting curriculum.

Action Taken in 2005:

The information that the State Team wishes to have collected on co-sleeping infant deaths relates to the evidence gathering function of the investigative process and would be best addressed through the training that all PI's receive in the Child Welfare certification process. As stated earlier, the training curriculum is being revised and this recommendation will be passed on to the design team for review and inclusion in the new or updated curriculum.

Issue 8: Child Abuse and Neglect Prevention Efforts

The State Team recognizes the importance of providing on-going education for child welfare professionals in the child protection system. However, it is equally important to be proactive and advocate for prevention initiatives which ultimately led to a reduction of child abuse and neglect.

Action Needed/Recommendations in 2004:

Recognizing that the ultimate solution to the problems of child abuse and neglect is prevention, the Department of Children and Families has begun several new initiatives for FY 2004-2005. Through a contract with TEAM Florida, the Department will participate in the development of a statewide Child Abuse Prevention Task Force. Mandated by Chapter 39, *Florida Statutes*, this Task Force will provide assistance and oversight to the development and implementation of statewide and local child abuse prevention efforts.

Additionally, through an appropriation by the legislator in 2004, the Department will contract for a statewide display of roadside billboards dedicated to the message that a baby should never be shaken. This campaign will be modeled after a similar successful one conducted in 2003 in the Suncoast Region.

The Florida Legislature is encouraged to provide funding to supplement the Federal Child Abuse and Neglect Prevention Funds that the State Currently receives.

The State Team encourages the Florida Pediatric Society and the Florida Medical Examiners Commission to develop and issue position papers on the prevention of Shaken Baby Syndrome and deaths resulting from unsafe co-sleeping.

Action Taken in 2005:

A reduction in Florida's per capita child abuse rate is a key indicator in both on the Secretary's Performance Dashboard measures and the focus of the Inter-Agency Prevention Task Force which is currently reviewing all district prevention implementation plans for consistency with Florida's Five-Year State Plan for the Prevention of Child Abuse, Abandonment, and Neglect.

Additionally, the department currently has a major initiative underway that supports best case practice in this area. The eleven (11) Neighborhood Partnership project sites are located in local neighborhoods and combine prevention activities, such as community development and education, with the use of Family Team Conferencing as the primary case management response to addressing family needs. The goal is to prevent abuse before a report has to be made to the Abuser Hotline. In several sites Neighborhood Partnership staff is co-located with protective investigators and community-based care case management staff to help engage families at the earliest point possible in the helping continuum.

Healthy Families Staff

Staff from the Statewide Child Abuse and Neglect Death Review Team (CADR) collaborated with Healthy Families Florida to develop an instructor-led training curriculum on Child Abuse and Neglect prevention strategies and strategies for working with families that have to be reported to the abuse hotline. CADR staff also provided train-the-trainer so that Healthy Families trainers could provide training to Healthy Families project staff. The training allows participants to engage in role playing, share challenges and experiences, and brainstorm prevention strategies to be used with families. The training includes an overview of mandated reporting and focuses on educational areas that may be addressed with families to prevent child abuse and neglect. Prevention topics include: infant safe sleep practices, appropriate supervision of children, safety planning for families involved in domestic violence and drowning prevention and home safety.

CONCLUSIONS AND RECOMMENDATIONS

The State Child Abuse Death Review Team has evolved over the past six 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. For the past five years the team has looked at a limited population of child abuse deaths, those in which there was a prior report involving the Department of Children and Families. This year will be the first time for the team to review all verified child abuse death cases. There is not enough aggregated data for the team to draw conclusions until they have at least another year of all verified deaths to analyze the patterns and trends in Florida.

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.

Recommendations

Issue 1: Public Awareness Prevention Education:

The State Team identified the need for public awareness education as a common theme throughout the 108 reviews completed for 2004 child deaths. Educational campaigns are necessary to make the public aware of the seriousness of the problems and its implications as well how individuals can make a difference. The goal would be to move the public beyond the generation of awareness and concern to actual engagement in prevention, including behavior change. The State Team identified a common theme throughout the 108 reviews for 2004 the need for Public Awareness Education for deaths that could be prevented.

Out of the 108 cases it was determined that 94 (87%) could have been prevented. Those areas included:

A. Drowning

Drowning deaths are often called “tragic accidents” while they should be called “tragic deaths” that could have been prevented. There were 355 deaths ages 0-85 related to drowning in 2004⁷. Of those cases 74 were between the ages of 0-10 and 56 were ages 1-4.⁷ Out of 108 cases reviewed in 2004, 22-were related to drowning, taking note that not one child drowned while they were supervised. Each year, nationwide, more than 300 children under 5 years old drown in residential swimming pools, usually a pool owned by their family. In addition more than 2,000 children in that age group are treated in hospital emergency rooms for submersion injuries. Medical costs for submersion victims during the initial hospitalization alone can be quite high. Costs can range from an estimated \$2,000 for a victim who recovers fully to \$80,000 for a victim with severe brain damage. U.S. Consumer Product Safety Commission.)⁹ Drowning is a “silent killer”, contrary to what many people believe. Drowning is the second leading cause of injury related deaths among children ages 1 to 14. A child will lose consciousness two minutes after submersion, with irreversible brain damage occurring within four to six minutes. The majority of children who survive without neurological consequences are discovered within two minutes and most who die are found after ten minutes. Most drowning incidents among children 1- 4 years occur in residential swimming pools. It is important to note that most children can drown in as little as one inch of water; therefore, are at risk of drowning in numerous places such as buckets, toilets, wading pools, hot tubs, etc

Research shows that there is no one device or solution that can prevent all childhood drowning. Instead a multifaceted strategy, including active supervision by a designated adult, safe water environments and proper gear and education is required to ensure safety. Adequate supervision means not sitting poolside and reading or socializing with others, chatting on the phone, cooking on a grill etc.

Lack of supervision or a brief lapse in supervision is known to be a critical factor in child drowning.

Action/Recommendation:

Since 2001, the State Team has made the recommendation for education, training and pool safety equipment. It is essential that preventative measures be taken to decrease the number of children drowning in Florida. Public Awareness should include at a minimum:

- Emphasis on training for risk factors in all risk assessments which identified pool safety, bodies of water etc. which the Department and Community Based Care providers.
- Emphasize to parents and caretakers that they should never leave a child unsupervised in or around water in the home or outdoors, even for a moment.
- Enact and enforce pool fencing ordinances as well as multiple layers of protection around pools.

B. Co-Sleeping and unsafe sleeping

The State Team has identified this issue as an on going problem over the past 4 years. The number of children dying as a result of unsafe sleeping environments, or by placing the children in positions that can cause the child to suffocate or caretakers co-sleeping with the children continues unabated. This year there were 17 cases of co-sleeping deaths and the children were all 2 months and younger. Nationwide the statistics point to the need for training and/or education for parents, hospitals, Medical Examiners pediatricians and law enforcement investigating those types of deaths.

There has been a nation-wide campaign "Back to Sleep" since 1992, to educate the public about the importance of placing children on their backs. (This campaign is sponsored by the National Institute of Child Health and Human Development, the Maternal and Child Health Bureau, the American Academy of Pediatrics, the SIDS Alliance, and the Association of SIDS and Infant Mortality Programs). Although this has reduced the child deaths significantly, the State Child Abuse Death Review Team continues to see an ongoing problem where parents make poor choices to co-sleep with the children when clearly the parents are either obese, under the influence of alcohol or drugs, or exhausted, thereby causing positional asphyxia.

The National Institute of Child Health and Human Development (NICHD) embrace the [October 2005 American Academy of Pediatrics \(AAP\) Policy Statement](#) on reducing the risk of Sudden Infant Death Syndrome (SIDS). The NICHD is working to incorporate the new risk-reduction messages into all *Back to Sleep* campaign materials.¹²

- The American Academy of Pediatrics has released a new recommendation that babies should be offered pacifiers at bedtime, and they should sleep in their parent's room – but not in their beds- in order to lessen the risk of sudden infant death syndrome.
- It is recommended that pacifier introduction for breastfed infants be delayed until one month of age to ensure that breastfeeding is firmly established
- Infants should be placed for sleep in a supine (wholly on back position) for every sleep.
- Use a firm sleep surface: A firm crib mattress, covered by a sheet, is the recommended sleeping surface.
- Keep soft objects and loose bedding out of the crib: Pillows, quilts, comforters, sheepskins, stuffed toys and objects should be kept out of the infant's bed.
- A separate but proximate sleeping environment such as a separate crib in the parent's bedroom, sharing during sleep is not recommended.
- Consider offering a pacifier at nap time and bedtime.
- Avoid overheating: The infant should be lightly clothed for sleep and the bedroom temperature should be comfortable for a lightly clothed adult.
- Avoid commercial devices marketed to reduce the risk of SIDS: :such devices are of no proven value
- Do not use home monitors as a strategy to reduce the risk of SIDS:
- The need for on going training of first responders/law enforcement officers, DCF, and any person/agency handling these cases need to document specific details of the child's position, where the child was found, and potential substance abuse by the caretaker/parent.

Home visitors in Healthy Families Florida educated parents on the risks associated with co-sleeping and safe sleeping as a part of their home visiting curriculum. Healthy Start home visitors are required to provide pregnant women and new parents with information on safe sleep for infants. Staff training has been updated to include additional information to help parents to follow the safe sleep recommendations. It includes information on types of sleeping difficulties infants experience and strategies for how to help babies get to sleep. This information will give parents alternatives to unsafe sleep practices such as co-sleeping when they are having difficulty getting their infants to sleep. The training is provided twice a year to Healthy Start providers and can also be accessed at any time via the internet.

Action Needed/Recommendations:

The State Team adopted the recommendations of the American Academy Pediatrics released on November 5, 2005.¹²

It is recommended that training on safe sleep practices be provided to all hospital nurses throughout the state. Many nurses are still placing babies on their sides to sleep. Side sleeping is no longer recommended because many babies roll over onto their stomachs from this position. Studies have shown that nurses are not following the safe sleep recommendations and many parents then continue these practices once the babies are discharged, putting them at great risk for suffocation.

Training should also be provided to law enforcement officers and medical examiners on death scene investigations to assure that the necessary information is collected regarding the circumstances of the infant's death.

The State Team recommends that the Medical Examiners' Commission and the Florida Association of Medical Examiners establish and publish a position for the uniform certification of cause and manner of death in cases of SIDS, co-sleeping, positional asphyxia and other deaths potentially related to unsafe sleeping conditions.

C. Kids and Cars

In 2004 there were at least thirty-five infants and children who died in the U.S from hyperthermia after being left in hot cars, trucks, vans, and SUV's. Some of these even occurred on days with relatively mild (i.e., 70 degrees F) temperatures¹⁰.

There have been at least nineteen child fatalities in vehicles due to hyperthermia in 2005. In 2003 there was a record of 42 such needless tragedies. "Parents and caretakers need to get the word out that a car is not a babysitter but can easily become an oven." The total number of hyperthermia deaths of children left in cars, 1998-2004 is 230 compared to the number of hurricane deaths in the US, 1998-2004: 178¹⁰.

In a study (Guard, A. & Gallagher, S.S. Heat-related deaths to young children in parked cars: an analysis of 171 fatalities- U.S., 1995-2002. Injury Prevention 11, 33-37) the circumstances that led to child hyperthermia fatalities were examined¹¹.

- 39% - child "forgotten" by caregiver
- 27% - child playing in unattended vehicle
- 20% - child intentionally left in vehicle by adult
- 4% - circumstances unclear

This year the State Team reviewed 10 deaths of children left in vehicles or who entered unlocked vehicles.

Actions/ Recommendations:

The State Team Supports Senator Hillary Clinton's Bill, the Cameron Gulbranson Kids and Cars Safety Act of 2005. The State Team recommends that Public Service Announcement's around the State be initiated and that the legislation fund the resources.

- Emphasize to parents and family that you should NEVER leave your child unattended in a motor vehicle, even with the windows down.
- Always lock car doors and trunks- even at home and keep keys out of children's reach.
- Place an unmistakable reminder where you will be sure to see it before you leave the vehicle, as too many parents have forgot about their precious children and the results have been fatal. Reminders can include placing a teddy bear in the passenger seat or a diaper bag, hanging a tag on the rear view mirror, placing your purse or brief case next to the car seat so that you will have to go to the backseat to take the item out. These simple reminders can save the life of a child.

D. "Safe Haven for newborns"

Florida Statue, 383.50, known as the Abandoned Baby Legislation, went into effect in July of 2000 in response to an increasing number of newborn infants being abandoned and left to die. The legislation was passed to provide parents with a safe alternative to abandoning their infant and allows the parent of an unharmed child up to 3 days old to anonymously leave the baby with personnel at a hospital, fire department, or emergency medical services station without fear of prosecution for abandonment. Since the inception of the law the following numbers of infants have been safely turned over to emergency personnel: 2000 - one, 2001- three, 2002 - seven, 2003 - eight, 2004 - five, and thus far in 2005 thirteen infants have been saved. There is anecdotal evidence that more newborns are being brought to hospitals throughout the state, but are not being reported due to perceived HIPPA confidentiality constraints.

For the last three years, the Florida Legislature allocated funding to the Florida Department of Health to support activities to increase public education and awareness about the legislation. Awareness activities included the development of printed educational materials with distribution throughout the state, advertising in movie theaters, restaurants, newspapers, bus stations, on bill boards, and posters placed in a drug store chain throughout the state this funding is not being continued during the 2005-2006 fiscal year.

The Gloria M. Silverio Foundation (A not for Profit 501 (c) 3 Corporation) established an organization in 2001, called "A Safe Haven for Newborns" <http://www.asafehavenfornewborns.com/main.asp> . The founding purpose and continuing mission of "A Safe Haven for Newborns" is to save the lives of newborns in danger of abandonment and to help preserve the health and future of their mothers. The foundation supports a 24 hour hotline as well as and is active in educating the emergency medical providers as well as the public about this legislation. The foundation also assists local Safe Haven Chapters to promote education and outreach in their communities. Currently Florida has 41 local chapters run by community volunteers.

Possible explanation for why DOH does not have death statistics:

Unfortunately, not all abandoned babies are identified, and the ones that are recovered are not tracked in a central data base. Last year, there was an infant body found on the conveyor belt of a recycling factory in West Palm Beach. We would have to assume that other babies have been discarded in the garbage or in other areas like ponds etc., and never recovered. When bodies are recovered it is usually a local news item, but not reported in a central data base, so the instances that Safe Haven or I would be aware of may not comprise all occurrences. The only data point we have is the number of babies who are saved and reported under this law, not those who fall through the cracks. As noted below, the number of babies rescued may be under reported due to confidentiality concerns. This is an issue that requires continued public education with the ultimate positive outcome when the law is utilized and a baby can be saved, but tracking remains difficult. DOH in collaboration with The Safe Haven for Newborns and Healthy Start Coalitions has led a public health awareness campaign on the "Abandoned Baby Legislation" for the past 4 years. This campaign has sponsored advertising in the form of print materials, advertising via bus kiosks, bill boards, newspapers, movie theaters, and via posters in a drug store chain statewide in addition to educating community and providers stakeholders. As of December 2005, 41 infants have been saved by this initiative.

Action/Recommendation:

The State Team recommends to DOH that there be public awareness campaign on the "Safe Haven" through out the State and that the legislator fund this project.

E. Shaken Baby Prevention Initiatives

The State Team has recognized that one of the leading causes of children being shaken/beaten to death is crying. Upon reviewing the statements of the perpetrators often the reason given for the abuse is because the child/baby would not stop crying.

The Kimberlin West Act of 2002 requires Shaken Baby Syndrome education at the time of birth. Part of this education includes how to cope with crying. We believe the intent of the legislature was that every new parent would receive this education prior to leaving the hospital. Research has shown many hospitals are not disseminating this information around the state of Florida. A pilot project was conducted in Pinellas County in 2004 in which nurses in birth hospitals participated in a Coping with Crying Train the Trainer. Follow up research was done with new parents who had received the training. They created a safety plan for when they became frustrated with the crying baby. The majority of the parents polled had put their safety plan into place within the first six months of the Child's life.

Action/Recommendation

The State Team recommends that Coping with Crying Education be implemented statewide.

Issue 3: Training and education to professionals on Child Abuse and Neglect

Law Enforcement

The State Team recommends that there be death scene investigation training that considers the potential elements in the investigations which the caretakers could be under the influence of

alcohol, drugs or both and that there be a standard requirement to require drug testing to rule out if it was a contributing factor in the death and if they refuse the agency obtain a court order. Serious injury or death could often be avoided by the proper use of child restraints. Children are also placed at risk as passengers in vehicles driven by impaired or reckless drivers. These incidents are often unreported because Law Enforcement Officers only identify them as traffic violations

Action/Recommendation:

The State team recommends that FDLE in conjunction with the State Team Coordinator provide training to local Law Enforcement Officer Agencies and Florida Highway Patrol Troopers on recognizing and reporting child neglect and abuse during traffic related incidents.

Judicial

A letter was written to the Chief Justice of the Florida Supreme Court by the Chair of the State Team asking for her assistance to partner with us to help increase the Judiciary's understanding of the dynamics of child abuse and its underlying variables, including substance abuse and domestic violence. Dependency and family courts serve as vital components of the child protection system. Unfortunately, we have seen several cases where children have died at the hands of an abuser after judges had returned them to their homes against the recommendations of child protection workers.

Action/Recommendation:

While the State Team recognizes the tremendous responsibility that rest with the judiciary and the many complex legal issues that often arise in child dependency cases, we believe it is imperative that judges receive sound training so that they can make the most informed decisions. With the current judicial rotations, it is essential that this is an ongoing process of education. The state team recommends that the judicial branch continue to further expand the unified family court model to enable judges to gain a fuller expertise on safety issues for children that are present and equally important to judicial decision-making regardless of the type of docket that comes before the court. The state team has reviewed cases where judges have made decisions related to child custody and visitation that contradict previously existing court orders for the same family. It is recommended that the judicial education offerings coordinated through the office of the state courts administrator invite opportunities for experts from the statewide task force to develop workshops and other instructional materials that illustrate the benefits of the unified family court as a child safety issue. The State Team recommends that the Judges receive training from certified Florida Coalition Against Domestic Violence (FCADV) advocates or centers.

DCF:

The State team found that there are no Standardized High Risk assessments through out the State, and that each district has different assessments and tracking mechanisms. Currently, DCF data on reports involving broken bones allegations indicate that the current child safety assessment process may not facilitate full identification of the safety threats to children,

as well as the underlying conditions or causative factors which create such threats. Subsequently, the department's ability to identify the appropriate services and interventions needed to keep children safe is critically impacted.

Action Recommendation:

It is recommended that the department conduct an analysis of its current safety and risk assessment processes, from the investigative response through service intervention. The analysis should focus on the identification of safety threats and related ongoing risk determination, leading to the identification of services and interventions needed to improve parental protective capacities, as well as ameliorate the causative factors present. This analysis should also identify the report/case tracking needs to ensure appropriate oversight of these high risk reports/cases, including ongoing reviews to determine case progress.

Issue 4: State Team supports the American Academy of Pediatrics finding that home visiting is a successful approach to preventing child abuse:

Home Visiting prevents Child Maltreatment - Recent national studies, including studies from the American Academy of Pediatrics and the Center for Disease Control present similar findings that home visiting programs can be an effective strategy to improve the health and well-being of children, particularly if they are embedded in comprehensive community services to families at risk. An independent evaluation of the Healthy Families Florida program, released in February 2005, concluded that Healthy Families Florida has a significant impact on preventing child maltreatment. Healthy Families Florida participants had 20 percent less child maltreatment than all families in their target service areas. The evaluation also shows that children in families who completed or has long-term intensive Healthy Families intervention experienced significantly less child maltreatment than did comparison groups with little or no services. The program also has a positive impact on participant self-sufficiency, maternal and child health and parent-child interaction in some of Florida's highest risk families.

Healthy Families Florida provides home visiting services through 36 community-based projects in 53 of Florida's 67 counties, 30 county-wide and 23 in high-risk targeted zip codes.

Actions/Recommendations:

The State Team recommends taking home visiting programs with proven results, like Healthy Families Florida, to scale so that it is available to all families at risk of child abuse and neglect, and that the legislator fund the program.

Issue 5: Child Death Investigations and Crime Scenes

The State Team reviewed several cases where it was noted that there was a lack of crime scene investigations. Typically the child deaths were called tragic accidents and no crime scene was conducted. The State Team recognizes the need for shared information and coordinated

investigations, and thorough crime scene documentation. Out of the 108 cases reviewed, eleven cases specifically addressed the lack of investigations and or crime scene.

Action/Recommendation:

The State Team proposes to provide to Medical Examiners, law enforcement agencies, State Attorneys, Child Protection Investigators, the necessity for a multi-agency and multidisciplinary approach to the investigation of child death cases. The State Team recommends that FDLE and Law Enforcement Training Standards include training that specifically addresses child death scene investigations.

Issue 6: The State Team recommends that *Florida Statutes* be amended to provide for the review of all child deaths.

According to the National Center for Child Death Review CDR is mandated or enabled by law in 39 states. Forty Eight states review deaths through at least age 17, and one state to age 15 and two states up to age 24. Five States review only maltreatments and half the states review deaths to all causes. Florida's criteria for child abuse and neglect death review are significantly more restrictive than any other state in the nation. Florida's limited review not only affects the ability of the team to fully accomplish the statutory purposes, would enable the team to better understand the contributing factors and causes thus enabling us to focus on prevention. The Child Abuse Death Review Team identified a major problem in the scope of the deaths reviewed. Currently, verified child deaths are only reviewed, thereby excluding many children through out the State of Florida.

Action/Recommendation:

The Florida Legislature should expand the child abuse death review process to include the review of all child deaths.

Issue 7: DCF Staff support for the State Child Abuse Death Review Team

The State Child Abuse Death Review Team (CADR) has had a long and productive working relationship with the Department of Children and Family Services. Our success has been dependent on the ability to access critical information regarding the death of children that the Department has verified as having died from abuse or neglect. We have relied on staff support from the Florida Department of Health (DOH), through the establishment of a Quality Improvement Coordinator position, and the Department of Children and Families Child Abuse Death Review liaison. Due to reorganizations within DCF, the CADR team lost their liaison representative. This significantly impaired the CADR team's ability to access case information in a timely manner. As a result, the Team sent a request to Secretary Luci Hadi, respectfully asking for DCF's assistance to make staff support from DCF a high priority within their agency.

Action/Recommendation:

Secretary Hadi replied to the Team and indicated that she had assigned the responsibilities for support to a new Quality Management Unit. She committed to supporting the Team's work; including establishing protocols for the DCF regional death review coordinators to ensure the provision of necessary documents to the local CADR teams as well as requests from the State Team.

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