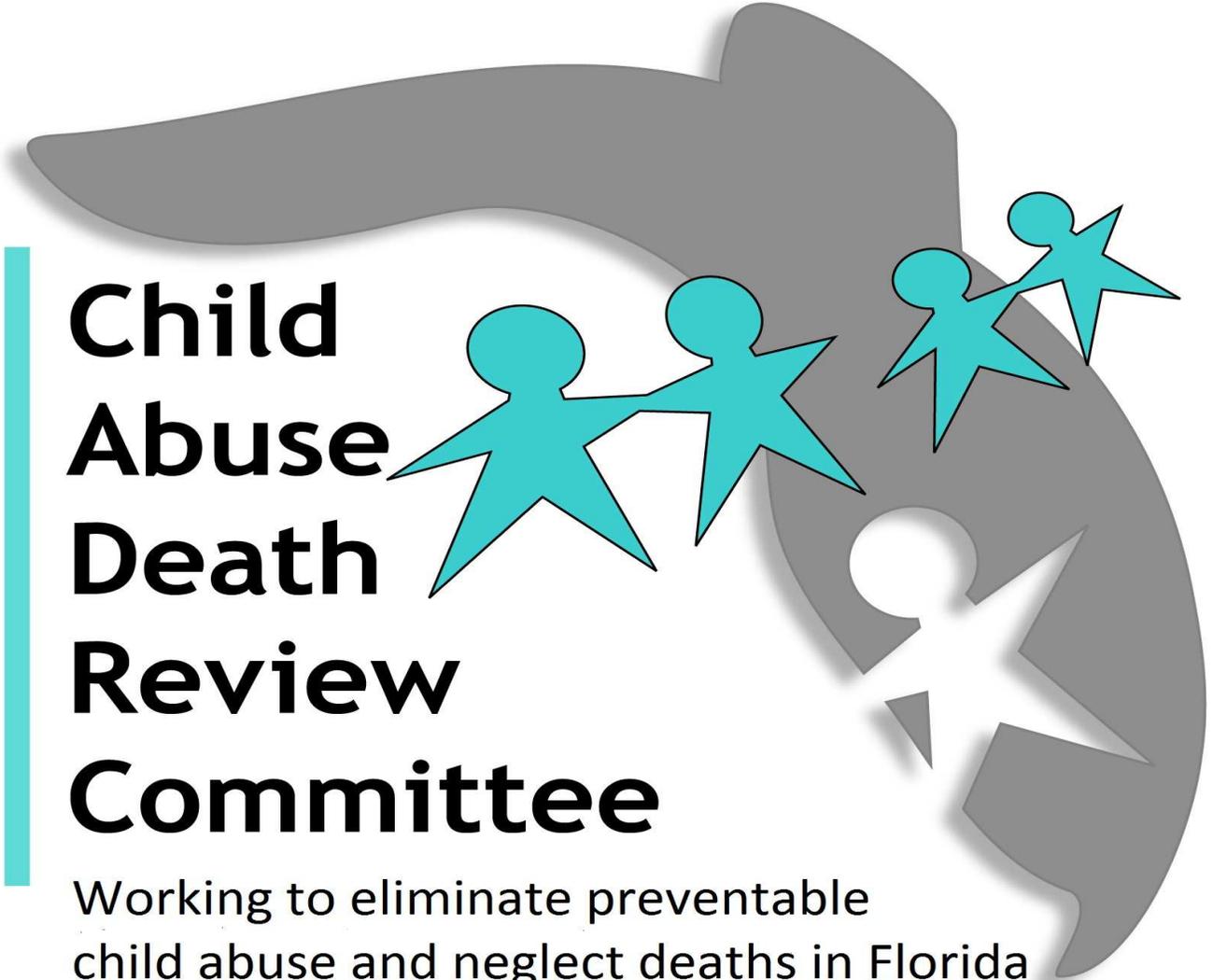


ANNUAL REPORT
December 2013

A large, light gray silhouette of the state of Florida is centered in the background. Overlaid on the map are several stylized human figures. Four teal-colored figures are arranged in a line across the middle of the state, holding hands. A white figure is positioned in the lower right portion of the state, appearing to be in a protective or supportive stance. A vertical teal bar is located to the left of the main title text.

**Child
Abuse
Death
Review
Committee**

Working to eliminate preventable
child abuse and neglect deaths in Florida

**FLORIDA
CHILD ABUSE DEATH REVIEW COMMITTEE
ANNUAL REPORT**

MISSION

To eliminate preventable child abuse and neglect deaths

Submitted to:

The Honorable Rick Scott, Governor, State of Florida
The Honorable Don Gaetz, President, Florida State Senate
The Honorable Will Weatherford, Speaker, Florida State House of Representatives

TABLE OF CONTENTS

SUMMARY OF CURRENT PREVENTION INITIATIVES	1
SUDDEN UNEXPECTED INFANT DEATH (SUID) INITIATIVES	1
THE SAFE SLEEP CAMPAIGN	2
DROWNING PREVENTION INITIATIVES.....	3
DRUG-ENDANGERED CHILDREN INITIATIVES	4
PHYSICAL ABUSE AND NEGLECT -RELATED INITIATIVES.....	6
BACKGROUND	7
PROGRAM DESCRIPTION.....	7
STATUTORY AUTHORITY.....	7
PROGRAM PURPOSE	7
MEMBERSHIP OF THE STATE COMMITTEE.....	7
LOCAL CHILD ABUSE DEATH REVIEW COMMITTEES	8
CHILD ABUSE AND NEGLECT DATA.....	9
CAUSES OF DEATH.....	10
AGE AT DEATH.....	12
RACE AND GENDER.....	12
AGE AND RELATIONSHIP OF CAREGIVER(S) RESPONSIBLE	13
FAMILY RISK FACTORS.....	14
PREVENTION RECOMMENDATIONS	15
IN CONCLUSION	19
APPENDIX I	20
COUNTY MAP WITH VITAL STATICS.....	20
APPENDIX II	21
DEFINITIONS.....	21
APPENDIX III	23
CASEY FAMILY PROGRAM REVIEW OF CHILD FATALITIES.....	23

SUMMARY OF CURRENT PREVENTION INITIATIVES

The Florida State Child Abuse Death Review Committee (CADR), through its analyses of child deaths over the years, has identified several common risk factors that are frequently present when a child fatality occurs due to abuse or neglect. In response, the State Committee has identified strategies and developed recommendations for policy and practice changes that will contribute to the prevention of child maltreatment and the tragic deaths of Florida's most vulnerable children. The following are some of the child abuse prevention initiatives that were derived from the findings and recommendations of the State Committee.

Sudden Unexpected Infant Death (SUID) Initiatives

One of the most difficult problems inherent in the medicolegal investigation of infant deaths is the differentiation of a death seemingly fitting the criteria for sudden infant death syndrome (SIDS) from the intentional or accidental suffocation of an infant. SIDS was defined in 1989 by the National Institute of Child Health and Human Development as "the sudden death of an infant less than one year of age which remains unexplained after a thorough case investigation including performance of a complete autopsy, examination of the death scene and review of the clinical history." However, there has been a significant decrease in the numbers of infant deaths certified as SIDS in Florida and nationally in recent years since it has been recognized that unsafe sleeping conditions put infants at a greater risk for sudden death.

Data derived from numerous national initiatives and supported by analysis of data resulting from the State Committee's case reviews have led to the recognition that factors related to infant sleeping positions and sleeping environments, including the prone sleeping position, bed sharing (co-sleeping, particularly with individuals who are under the influence of drugs and/or alcohol, those who are obese or who are exhausted) and soft bedding increase the risk of infant death from asphyxia due to suffocation or overlay. Because the elucidation of these preventable causes requires the accurate determination of the cause and manner of death in such cases, and therefore a thorough investigation of the scene and the circumstances of the death, the Centers for Disease Control and Prevention (CDC) launched a nationwide initiative in 2006 to improve the quality of infant death investigations. The term Sudden Unexpected Infant Death (SUID) has been designated to refer to all sudden and unexpected deaths of infants under one year of age of natural or unnatural causes.

SUID Legislation

The State Committee's Annual Report has for many years emphasized the importance of a multidisciplinary investigation and standardized investigative and autopsy protocols in cases of sudden unexpected infant death. Members of the State Committee participated in the CDC's training academy and were tasked with the responsibility of perpetuating the goals of the national initiative throughout the State of Florida. Pursuant to that task, the State Committee proposed legislative changes to s. 383.3362, F.S. (Sudden Infant Death Syndrome). The 2013 legislative session passed Committee Substitute for Senate Bill No. 56 as CHAPTER 2013-62, Infant Death. The revision broadened the statute, which formerly addressed only SIDS, to include all SUID deaths, with the goal of fostering training and education that will lead to improvements in the investigation of infant deaths in Florida and heightened public awareness,

both of which are essential for the prevention of infant suffocation deaths related to unsafe sleeping conditions.

The 2013 statutory revision mandates standard infant death investigative protocols and that all first responders and law enforcement personnel receive training in the recognition and causes of sudden unexpected infant death. To facilitate such training, members of the State Committee have partnered with statewide law enforcement and emergency medical training coordinators to develop training protocols and have started pilot programs to launch these trainings. Additionally, because of the increasingly widespread recognition of the importance of public and caregiver awareness of hazards and risk factors associated with preventable infant deaths derived from State Committee data, many other agencies in the State of Florida have launched SUID prevention initiatives.

SUID Initiatives in Partnership with the Florida Medical Examiners Commission

The State Committee has long recognized the difficulties inherent in elucidating the incidence, demographics and risk factors associated with unsafe sleep-related infant deaths in Florida. There had been a lack of uniformity among investigative agencies in the thoroughness of the investigations performed in such cases and a lack of consistency among Florida's medical examiners in the terminology used to certify the cause and manner of death. In 2011, the Florida Medical Examiners Commission (MEC), in collaboration with members of the State Committee, authored changes to the sections pertaining to infant death investigation in Florida Administrative Code 11G, which governs the activities of Florida medical examiners. These changes, subsequently passed by the legislature, reflect amendments to the Practice Guidelines for Florida Medical Examiners that were adopted in 2010 by the Florida Association of Medical Examiners (F.A.M.E.) and were designed to strengthen infant death investigations throughout the state. Additionally, the MEC adopted changes to the Annual Workload Report that is prepared by each of Florida's medical examiner districts. The changes, which go in to effect January 1, 2014, expand the classification of sudden unexpected infant deaths from simply SIDS to include infant suffocation deaths resulting from unsafe sleeping environments and bed-sharing. These changes will facilitate the collection of data that will enable the State Committee to make data-driven recommendations for safe infant sleeping, with the goal of preventing unsafe sleep-related infant deaths in Florida.

The Safe Sleep Campaign

From January through November of 2013, 143 reports of babies believed to have died because of unsafe sleeping environments were received by the Florida Abuse Hotline. These were preventable deaths. To combat such tragedies, Florida government agencies, state officials, non-profit organizations and first responders came together on Sept. 25, 2013 to launch the Safe Sleep Campaign. The campaign includes public outreach, as well as free online trainings and materials for Florida's first responders to utilize during routine calls and interactions with the public, in an effort to prevent unsafe sleep. The campaign also encourages the public to donate new pack n plays (portable cribs) to designated locations, which will be distributed to needy families by local Healthy Start coalitions. More information is available online at: www.myflfamilies.com/safesleep.

The Florida Department of Health (DOH) partnered with the Ounce of Prevention Fund of Florida to help accomplish the safe sleep campaign. Two public service announcements (PSAs)

were developed on infant safe sleep and aired on radio and television statewide in English and Spanish. To increase the amount of exposure, the DOH required a three to one match when purchasing airtime. The PSAs can be viewed on the *Safety* link and *Twins* link: http://www.ounce.org/safe_sleep_videos.html.

Accomplishments:

- More than 65 partners statewide
- More than 75 fire, EMS and law enforcement stations designated as pack n play drop off locations
- More than 256,000 printed materials distributed statewide
- 40 free Safe Sleep PSA spots
- More than 30 articles and television and radio broadcasts about safe sleep
- Free Safe Sleep billboard

Based on the results of a statewide needs assessment, the Department of Health Maternal and Child Health leadership team, with input from a Stakeholder Advisory Group, selected the promotion of safe and healthy infant sleep conditions and environments as one of five state priorities.

DOH also analyzed potential factors that contribute to SUID and created a plan to address these risk factors with goals to measure strategy effectiveness. To help facilitate this initiative, the DOH formed a SUID workgroup. The workgroup provides input on the DOH State Health Improvement Plan to reduce sleep-related infant deaths. The workgroup is currently developing a questionnaire to administer to Florida hospitals, pediatricians and family physicians to assess their policies and practices pertaining to safe sleep education for parents.

DOH provided a statewide informational webinar on SUID to its Maternal and Child Health bureau professionals and partners that provided an overview of sudden unexpected infant death. The webinar included information about the prevalence of risk and protective safe sleep behaviors, the results of an active surveillance study on sleep-related deaths and federal/state initiatives to reduce sleep-related infant deaths. Over 300 practitioners participated in the webinar-guided interactive discussion with a panel of experts on the subject. DOH is currently developing a second informational webinar for healthcare professionals and paraprofessionals on the subject of effective community interventions to improve the competency of healthcare staff to deliver safe sleep education.

Drowning Prevention Initiatives

Department of Health WaterproofFL

Florida leads the Nation for children ages 1-4 who drown in pools. According to DOH, Bureau of Emergency Medical Oversight, Health Information and Policy Analysis Program, there were 79 children ages 0-5 who drowned in 2012. During the summer of 2012, the Department of Health championed *WaterproofFL*, targeted at child drowning prevention public awareness campaigns. Materials were distributed to 74 community partners throughout the state including each of the 67 county health departments and seven Safe Kids organizations. The 10 Florida counties with

the highest rates of childhood drowning between the ages of one and four were targeted by the campaign. These counties were: Brevard, Broward, Charlotte, Hillsborough, Miami-Dade, Orange, Osceola, Palm Beach, Pinellas, and Polk Counties.

Accomplishments:

Distributed 60,389 printed materials

- 40,100 brochures
- 1,942 posters
- 17,779 water watcher tags
- 568 recruitment packets

Summer Prevention PSA Series

The State of Florida loses more children under the age of five to drowning than any other state in the nation. Additionally there are children who die every year after having been left in hot cars. According to the advocacy group, KIDSANDCARS.ORG, Florida is second in the nation for these fatalities. To address these issues, the Department of Children and Families (DCF) launched a summer series of weekly public service announcement (PSA) videos online to promote prevention and awareness. Fifteen television stations aired the PSAs at no cost during the summer months. A website with summer safety tips and the PSAs was launched at www.myflfamilies.com/summer-safety.

Drug-Endangered Children Initiatives

Data derived from case reviews by the State Committee have shown that substance abuse on the part of caregivers affects the quality of children's lives on many levels. Drug-endangered children include those who were exposed to drugs or alcohol in utero as well as those who have access to illicit or prescription drugs in the home. Substance abuse on the part of caregivers is also a strong risk factor for child neglect and abuse.

Born Drug-Free Florida

Every year, many babies are born to drug-dependent mothers in Florida. According to Agency for Health Care Administration (AHCA) 1,654 newborns were diagnosed with neonatal abstinence syndrome in 2012. These babies are at-risk for withdrawal symptoms, congenital abnormalities, developmental delays and learning disabilities. On May 10, 2013, Attorney General Pam Bondi, DCF, DOH and other members of the Statewide Task Force on Prescription Drug Abuse and Newborns launched a statewide educational campaign designed to prevent babies from being born exposed to prescription drugs. Newborns exposed to prescription drugs while in the womb may suffer from neonatal abstinence syndrome, a painful withdrawal from the drugs, after birth. The campaign educates expectant mothers about the importance of discussing prescription drug use with their doctors and provides ways to assist women. The campaign includes a helpline at 1-877-233-5656, a website at BornDrugFreeFL.com, video and radio spots, billboards, web ads, printed materials and partnerships with medical, mental health and substance abuse treatment facilities and community organizations.

Accomplishments:

- As of November 2013, 332 calls have been received by the Born Drug-Free Florida hotline. The phone line has helped at least 60 pregnant women begin treatment.
- As of December 3, 2013, BornDrugFreeFL.com had received 7,510 page views.
- More than 22 billboards were posted in Pensacola, Tallahassee, Orlando, Tampa, Jacksonville and Gainesville.
- More than 22,000 local, network affiliate radio and iHeart radio spots ran statewide.
- More than 80 sites ran website ads.
- More than 77,120 printed materials distributed statewide.

Methadone-Related Infant Death Initiative in Partnership with the Parental Awareness and Responsibility (PAR) and Medication Assisted Patient Services (MAPS) Programs

In 2012 Manatee County Child Death Review Team had two infant death cases that were verified for abuse/neglect, where the common factors were DCF involvement and the mother being a PAR MAPS client receiving methadone treatment. The Manatee County Sheriff's Office organized a work group, Substance Abuse Related Child Injury/Death (SARCID), to work on a prevention strategy for the Parental Awareness and Responsibility (PAR) Medication Assisted Patient Services (MAPS) pregnant women whose infants were most at risk; women taking methadone and testing positive for other illicit drugs during and after pregnancy.

A review of PAR MAPS pregnant clients that had given birth in 2011, 2012 and 2013 revealed eight infant deaths for those clients in Manatee, Charlotte and Pinellas counties, seven of which had prior DCF involvement. Four of the infant deaths were the result of asphyxia due to bed sharing. Additional data revealed that there were 306 pregnant women in PAR MAPS programs in 2011, 274 in 2012, and 137 by May of 2013. The SARCID came up with the following criteria for Manatee County PAR clients who are under Child Protective Investigator (CPI)/Child Welfare supervision and who delivered a child in the last six months and/or those who had a positive drug screen result in the last trimester of their pregnancy.

- All Manatee County PAR clients who fall into the above category, who have signed a release of information for Child Protective Services, will have two observed full screen random urine drug screens per week. This will be in addition to the regularly scheduled monthly full screen required by DCF regulations.
- These additional drug screens will be done on the first day of the week that a client presents at the clinic, then again later in the week.
- Positive results will be reported to the Manatee Sheriff's Office CPI supervisor immediately.
- Clients refusing to do a drug screen will be reported to Manatee Sheriff's Office CPI.

A partnership with Healthy Start Manatee was also created as a part of this collaboration. A Healthy Start Manatee caseworker was assigned to work at the PAR clinic to provide information to clients related to infant safe sleep, infant and child development and safety tips. This program is designed to identify which infants are most at risk, allows for immediate action to be taken to protect those infants, and leads to the prevention of injury or death. It should be replicated by DCF/sheriff's offices performing child protective investigations in partnership with PAR MAPS, throughout the state where PAR clinics are serving pregnant clients.

Physical Abuse and Neglect -Related Initiatives

“Who’s Watching Your Child?” Brochure

Children living in households with unrelated adults are nearly 50 times as likely to die of inflicted injuries as children living with two biological parents (American Academy of Pediatrics, 2005). Mothers with limited options may leave their children with boyfriends or other caregivers who may lack the necessary knowledge of how to care for a baby, who feel no attachment or love for the child, resulting in potentially dangerous situations.

In response to the numerous cases reviewed by the State Child Abuse Death Review Committee that involved physical abuse and neglect cases where the perpetrator was a non-biological caregiver - in most cases the boyfriend - Healthy Families Florida, in collaboration with the Child Abuse Death Review Committee developed a brochure entitled “Who’s Watching Your Child?” The brochure is designed to educate Healthy Families participants and other parents about the importance of carefully choosing appropriate individuals to watch their children while they are away from home. The brochure provides a wealth of information about steps that a parent can take to ensure that their children are left in good hands, including a checklist of items to discuss with the babysitter prior to leaving the child. Kiwanis, a civic organization with a goal of improving the lives of Florida’s most vulnerable children and families and DOH have donated funding to have the brochure printed for distribution.

BACKGROUND

Program Description

The Florida Child Abuse Death Review Committee was established by statute in 1999. The program is administered by the Florida Department of Health and utilizes state and locally developed multidisciplinary committees to conduct detailed reviews of the facts and circumstances surrounding child abuse and neglect deaths.

Statutory Authority

Section 383.402, Florida Statutes

Program Purpose

The purpose of the child abuse death review process is to

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

Membership of the State Committee

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

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

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

- Department of Education
- Florida Prosecuting Attorneys Association
- Florida Medical Examiners Commission, whose representative must be a forensic pathologist

In addition, the Secretary of the Department of Health is responsible for appointing the following members based on recommendations from the Department of Health and affiliated agencies, and for ensuring that the Committee represents to the greatest possible extent, the regional, gender, and ethnic diversity of the state:

- A board certified pediatrician
- A public health nurse
- A mental health professional who treats children or adolescents
- An employee of the Department of Children and Families who supervises family services counselors and who has at least five years of experience in child protective investigations
- A medical director of a child protection team
- A member of a child advocacy organization
- A social worker who has experience in working with victims and perpetrators of child abuse
- A person trained as a paraprofessional in patient resources who is employed in a child abuse prevention program
- A law enforcement officer who has at least five years of experience in children's issues
- A representative of the Florida Coalition Against Domestic Violence
- A representative from a private provider of programs on preventing child abuse and neglect

Local Child Abuse Death Review Committees

Local review committees are the cornerstone of the child abuse death review process. These committees have the primary responsibility for reviewing all verified child abuse and neglect deaths and for presenting information relevant to these deaths to the State Child Abuse Death Review Committee. Local committees 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. A map identifying the location of each local committee is available online at www.flcadr.com.

CHILD ABUSE AND NEGLECT DATA

In Florida the estimated population of children ages 0-17 was 4,024,968 in calendar year 2012. Of those, 868,895 were under the age of one year and 1,077,930 were under the age of five. The following chart shows the number of children under the age of 18 in Florida and the number of all child deaths that occurred in Florida for a two year period. The DCF data on the number of reports to the Abuse Hotline section of the chart shows the number of reports that involved child deaths and how many of these child deaths had “no indicators”, “not substantiated/some indication” or “verified findings” of child abuse or neglect.* Florida Statute currently authorizes the State Committee to review only verified child death cases, which limits the committee’s ability to assess other causes of child deaths in Florida.

* See definitions section for clarification of these terms.

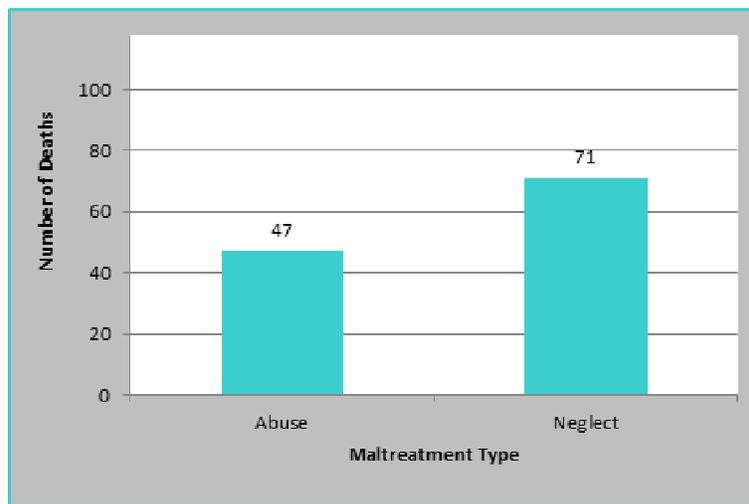
Department of Health Data on all Children Ages 0-17 years 2009 – 2012				
	2009	2010	2011	2012
Florida population for children ages 0 – 17years	4,150,374	4,123,708	3,999,132	4,024,968
Number of child deaths regardless of residency	2,638	2,282	2,241	2,111
Number of Florida resident child deaths	2,586	2,178	2,586	2,046
Department of Children and Families Data on Reports to the Abuse Hotline				
Number of reports to the Abuse Hotline	217,382	223,082	186,579	178,451
Number of reports involving child deaths	513	507	474	432
Number of child death cases closed with no indication of abuse or neglect	196	199	218	166
Number of child death cases closed with some indication of abuse or neglect	96	107	101	102
Number of child deaths verified due to abuse or neglect	200	155	130	122
Number of verified child abuse deaths provided to CADR for review	192	136	126	118

The following statistical reports, graphs and charts are based on a review of the 118 known child abuse and neglect deaths that occurred in 2012 and were reviewed by the State Child Abuse Death Review Committee. There were four cases that have not been provided to the Committee for review.

Causes of Death

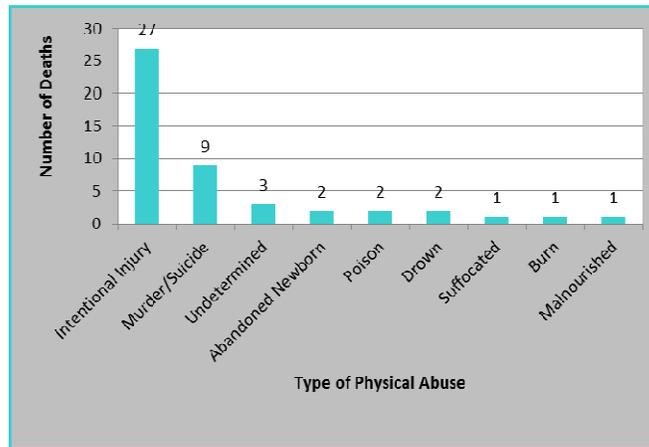
According to the U.S. Department of Health and Human Services Children's Bureau *Child Maltreatment 2012 publication* an estimated 44.3% of maltreatment fatalities nationally are from physical abuse either exclusively or in combination with maltreatment and 69.9% from neglect. Of the 118 Florida child deaths included in this report, abuse was a factor in 47(40%) of the deaths and neglect on the part of the parent or caregiver was a factor in 71 (60%) of the deaths, as shown in Figure 1.

Figure 1: Florida Abuse & Neglect Deaths



Physical abuse, which accounted for 47 of the deaths in this report, is the most visible form of child abuse and is defined in Florida statute 39.01 (2). "Abuse" means any willful act or threatened act that results in any physical, mental, or sexual abuse, 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. Corporal discipline of a child by a parent or legal custodian for disciplinary purposes does not in itself constitute abuse when it does not result in harm to the child.

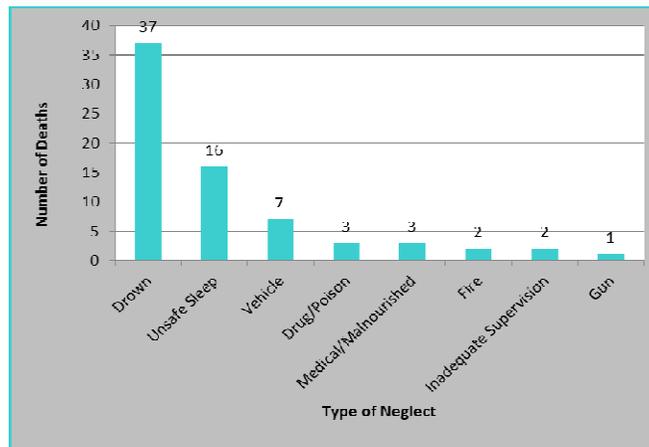
Figure 2: Florida Abuse Causes of Child’s Death



“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. Neglect of a child includes acts or omissions” as defined by Florida Statute 39.01 (44).

Neglect by a parent or other caregiver was a factor in 71 of the cases. In the majority of these cases, inadequate supervision by a caregiver was the causative factor, resulting in death due drowning or asphyxia.

Figure 3: Florida Neglect Causes of Child’s Death



Age at Death

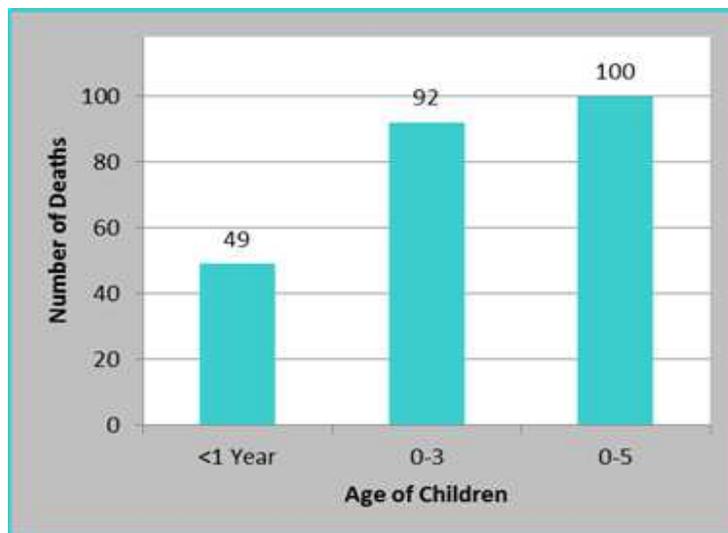
National statistics reported in Child Maltreatment 2012 indicate that the youngest children are the most vulnerable for death as a result of abuse or neglect. The majority of children who suffered maltreatment-related deaths in 2012 were less than three years of age.

- 44.4% were less than one year of age
- 70.3% were younger than three

The Florida State Committee noted that results from this review were consistent with the national data in that (42%) of the children who died from abuse and neglect were under a year old and (78%) of the children were younger than three years of age.

- 49 (42%) were less than one year of age
- 92 (78%) were less than three years of age
- 100 (85%) were less than five years of age

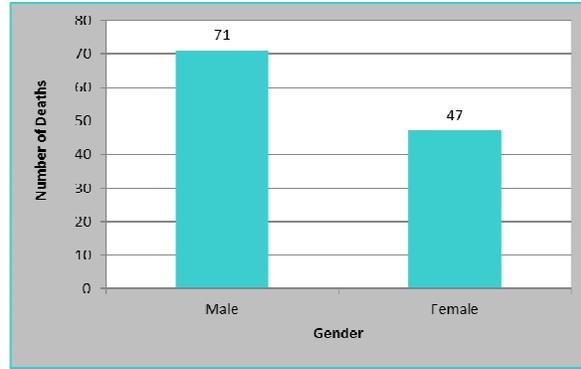
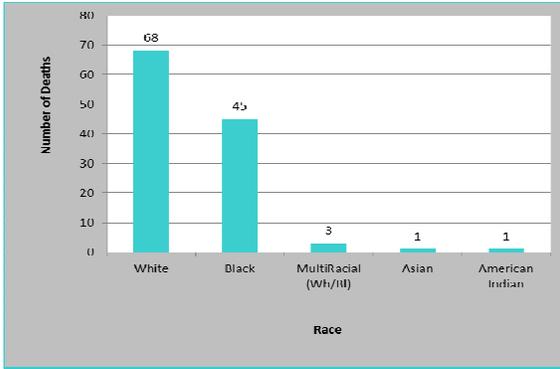
Figure 4: Florida Age at Death



Race and Gender

Of the 118 reviewed by the Committee, 68 (58%) of these children were white and 45 (38%) were black 3 (3%) multiracial, 1 (1%) American Indian and 1 (1%) Asian, as seen in Figure 5. Males represented 71 (60 %) and females 47 (40%) of the population included in the review, as seen in Figure 6.

Figures 5 & 6: Race and Gender of Children change chart

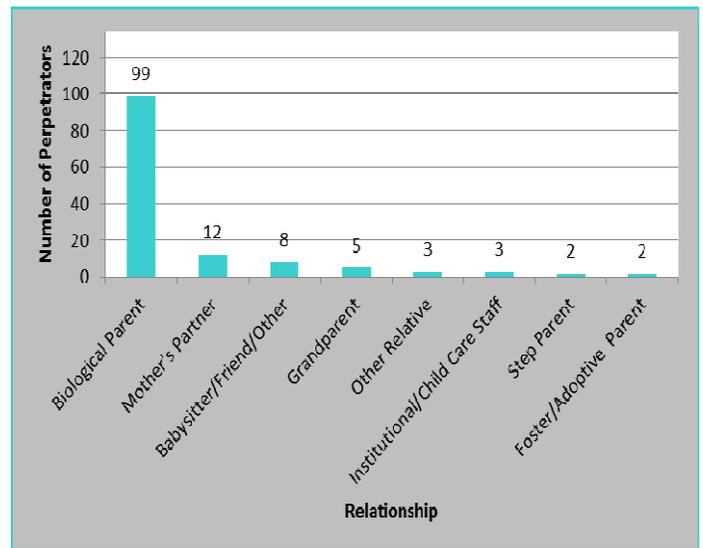
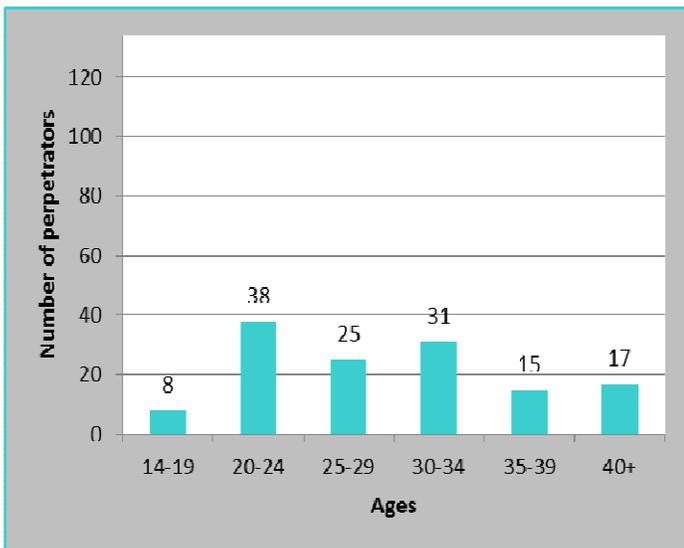


Age and Relationship of Caregiver(s) Responsible

For the 118 child abuse deaths reviewed, there were a total of 134 individuals responsible for the child's death. This included cases in which more than one person was responsible for the death. The individuals responsible for these deaths ranged in age from 14 to 74, with a median age of 29 years. There were also five perpetrators that killed more than one child.

Figure 7 & 8 shows a breakdown of the age of the caregivers responsible and their relationship to the child.

Figure 7 & 8: Florida Age and Relationship of Caregiver(s) Responsible



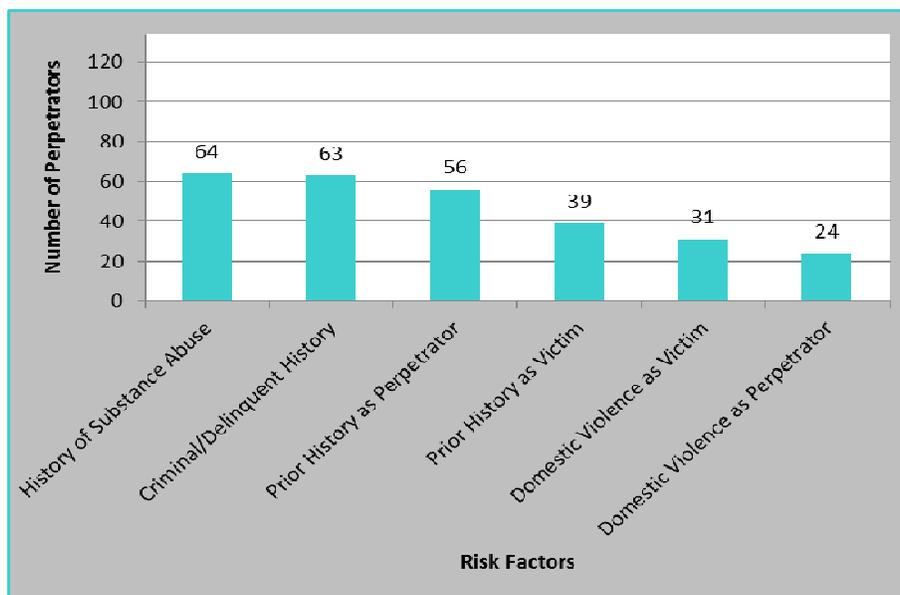
Family Risk Factors

Of the 118 child deaths reviewed by this committee, each family had two or more risk factors present that most likely contributed to the death of these children. Studies indicate that no single risk factor is responsible in the majority of serious or fatal child abuse and neglect cases.

According to “Risk factors in child maltreatment: A meta-analytic review of the literature” by Stith et al, 2009, the presence of multiple risk factors can impact a parent’s ability to be a nurturing caregiver, putting a child at greater risk of abuse and neglect. The following are some research-based risk factors that are associated with the occurrence of serious or fatal child abuse or neglect:

- Limited knowledge about parenting and unrealistic expectations about child development
- Victim or perpetrator of domestic violence
- Substance abuse
- Mental health problems
- Prior involvement in the Child Protection System as a victim or perpetrator
- Children with medical, behavioral, and developmental problems
- Multiple children under the age of five living in the household
- Household composition made up of one or more adults unrelated to the child (primarily an adult male)
- Live near or below the poverty level
- Low education level (no high school diploma)
- Social isolation, without a healthy support system

The chart below illustrates some of the family risk factors that were present in the 118 child death cases reviewed.



PREVENTION RECOMMENDATIONS

New Recommendations

- **Florida lawmakers consider amending the statute governing the State Child Abuse Death Review Committee to change the due date of the Annual Report to March 31.**

Each year many cases are received by the State Committee for review late in the year, near the time when the Annual Report is currently due. This has resulted in the Committee's inability to fully analyze the data garnered from a given year's case reviews. An additional three months would allow the Committee adequate time to analyze the data from reviews finalized late in the year, including trends, which are essential for assessing the efficacy of prevention campaigns.

- **DCF and Florida Department of Law Enforcement (FDLE) should establish a "field drug testing protocol" for law enforcement and CPI's to follow for alcohol/substance abuse that determines whether illicit drug use, prescription drug abuse or alcohol consumption was a contributing factor in child neglect deaths.**

Over the years, the CADR has identified substance abuse and impairment as a significant contributing factor in many child neglect deaths related to drowning, infant suffocation due to bed sharing, motor vehicle crashes, hyperthermia deaths of children left in cars, and other neglect deaths. A field drug testing protocol for use by law enforcement and Child Protective Investigators, with specific guidelines for use in child death and injury cases where substance abuse is indicated would allow for consistency in identifying substance abuse as a factor, recommending appropriate services and preventing future injuries and deaths.

Ongoing Recommendations

- **The DOH central office, DCF, Community Based Care, hospitals, the Florida Pediatric Society, county health departments, Healthy Families Florida, Healthy Start and similar programs should continue to support public awareness and education initiatives targeted at prevention campaigns specific to drowning in residential pools and bath tubs.**

An alarming number of pool drownings occur annually despite CADR recommendations in many previous Annual Reports of the installation of various security mechanisms. Pool alarms, fences, locked gates and other protective barriers represent some of the best intentions for protection, but are rendered useless when not used or used improperly. Many investigations have revealed that the caregivers were distracted, using the Internet or other computer-related activities, and/or were impaired by substance abuse. Bath tubs are the second most common bodies of water to claim children by drowning and can occur with very little standing water. Infants and toddlers should never be left unattended in tubs.

- **The DOH central office, DCF, Community Based Care, hospitals, the Florida Pediatric Society, county health departments, Healthy Families Florida, Healthy Start and similar programs should continue to support public awareness and education initiatives targeted at promoting safe sleep practices.**

Infant deaths due to unsafe sleeping environments are preventable. Understanding the information that is being provided to parents and caregivers will assist in determining the inconsistencies, deficiencies and missed opportunities regarding infant safe sleep education and provide opportunities to ensure messages are culturally appropriate for a variety of populations. A review of the current practices and identification of limitations to the various avenues for teaching safe infant sleeping should be conducted.

- **The Florida Department of Law Enforcement (FDLE), Florida Sheriff's Association (FSA) and Florida Police Chief's Association (FPCA) should recommend Domestic Violence training at the academy level and in-service training, to include law enforcement's requirement to report to the Child Abuse Hotline persons engaging in violent behavior in the presence of a child per s. 39.01(32)(i), FS.**

The State CADR, in reviewing the child death cases this year, found numerous instances where law enforcement officers had failed to report to the Child Abuse Hotline instances of domestic violence that had occurred when children were present. Law Enforcement Officers are mandated reporters to the Child Abuse Hotline, per s. 39.201,FS and therefore should be reporting when persons engage in violent behavior in the presence of a child s.39.01(32)(i),FS. Law enforcement personnel are often the first responders to calls of violence that are occurring in the home. Officers are required to take reports, arrest when a crime has occurred, provide victims with information as to their rights and remedies and provide aid to the injured.

Domestic violence is a learned behavior. Children who are exposed to domestic violence are at greater risk of being injured and of becoming future victims or perpetrators of domestic violence. Reporting domestic violence to the Hotline will satisfy the statutory reporting requirement, allow for a dependency investigation and appropriate social services to be provided, which are designed to prevent the exposure of children to future violence.

- **Local DCF offices and subcontracted Community-Based Care (CBC) agencies should develop formal partnerships and referral processes with local certified domestic violence centers to enhance the safety of families experiencing domestic violence and establish Memoranda of Understanding (MOUs) with those agencies including law enforcement agencies, state attorney's offices, courts, and local probation offices to increase the level of perpetrator accountability.**

- Agencies should partner with child welfare in an effort to ensure seamless tracking of the perpetrator, engagement and completion of a reputable batterer intervention program (BIP) and to ensure that any violations of court orders or additional acts of violence are reported to the court.
- Agencies should partner with survivors of domestic violence to enhance child safety, and begin filing Chapter 39 Injunctions for Protection instead of requiring, via case plans, that survivors obtain Chapter 741 Injunction for Protection.

- Agencies should consider replicating The Florida Coalition Against Domestic Violence Child Protective Investigators (CPI) Initiative in areas where it does not currently exist. This highly successful pilot program staffs co-located domestic violence advocates in child welfare offices to provide expert consultation in cases involving domestic violence.

➤ **Florida lawmakers continue to invest in successful prevention programs to prevent child abuse and neglect.**

The 2014 Florida Legislature should consider the continued investment in Healthy Families, Healthy Start and other prevention programs that have been proven to be successful in improving the health, safety and well-being of Florida's children and avoid the costly short-term and long-term consequences of child abuse and neglect.

➤ **Florida lawmakers consider amending the statute governing the State Child Abuse Death Review Committee to provide confidentiality for the case review process.**

Currently, Florida Statutes do not provide confidentiality protections for protected records received by the State or Local Committees. Confidentiality ensures that a family's feelings will be spared a public scrutiny as the Committees carry out their work and that no family will be further traumatized as a result of death review process. To understand why one child dies may save the lives of countless others. It is essential to protect the privacy of parents and other surviving family members, as well as protected records from public disclosure.

➤ **Florida lawmakers consider amending the statutes governing the scope of responsibilities of the State Child Abuse Death Review Committee to review all child fatalities reported to the Florida Abuse Hotline.**

Identifying the causes of and developing strategies to reduce avoidable child deaths is the essence of prevention. Regrettably, the State of Florida has not made much progress in accomplishing this goal. Since 1999, the State Committee has been articulating a need to better understand why children in our state die. The State Committee acknowledges there are individuals concerned that this process would be intrusive; however, that is not the case. Families will not be contacted or interviewed as result of this proposed legislative change. Of the states conducting some form of child death review, all have indicated that families are not impacted by these reviews. The child death review process is a review of records and reports, focusing on critical areas that include infant sleep related deaths, drowning, suicides, traffic crashes and poisoning. For example, under the current statute, the State Committee reviews only a handful of infant deaths related to unsafe infant sleeping environments. The ability to access a much broader group of cases will allow the State Committee to better elucidate risk factors associated with infant sleep-related deaths, including caregiver substance abuse, with the goal of the preventing such deaths in the future.

Through the monitoring of childhood deaths and performing an appropriate review when deaths occur, child death review teams have the unique opportunity to gather the detailed information that is necessary for effective injury/disease prevention activities. The benefits of a more comprehensive child death review process include:

- A more complete analysis of why children die that leads to data-driven prevention efforts
- A more thorough child death investigation by law enforcement and medical examiners

- Consistency in the certification of the cause and manner of death, which would provide more accurate epidemiologic data as to risk factors that may play a role in the deaths of Florida's children
- Enhanced interagency cooperation
- Improved allocation of limited resources
- Consistency and congruence in data collection by incorporating elements from all existing death reviews
- Establishment of standards for accountability and partnerships with Fetal Infant Mortality Review, Pregnancy Affected Mortality Review, Child Abuse Death Review, Domestic Violence Fatality Review and the Sudden Infant Death Syndrome program in Family Health Services Florida Department of Health
- Flexibility for local communities to conduct reviews

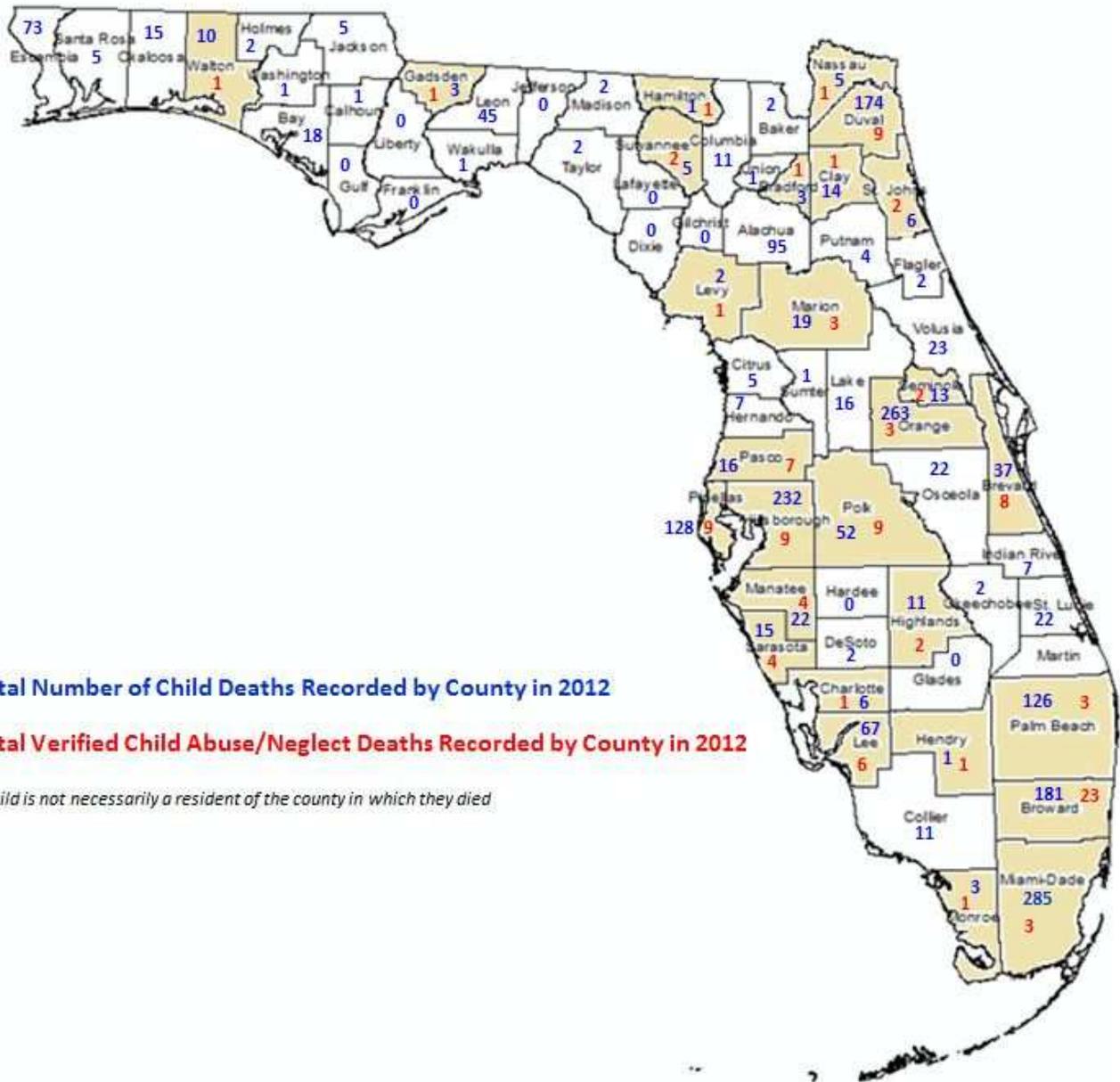
The ability to review the deaths of all children in Florida would allow the Florida Department of Health and other agencies to develop appropriate strategies to reduce the occurrence of Florida child deaths attributed to preventable situations. However, recognizing the current economic limitations, the State Committee proposes that the Governor and Legislature support the expansion of the child death review process to include all child deaths reported to the Florida Abuse Hotline.

IN CONCLUSION

The State Child Abuse Death Review Committee is pleased to see that many of the prevention strategies they have recommended in previous reports have been implemented or are under development. In particular, the State Committee commends the Department of Children and Families for enlisting the assistance of the Casey Foundation, a national leader in child welfare to complete a review of the 2013 child fatalities and make recommendations for changes to policy and practice (see attached report). The State Committee supports the recommendations of the Casey Foundation, many of which mirror those previously made by the Committee.

Appendix I

County Map with Vital Statics



Total Number of Child Deaths Recorded by County in 2012

Total Verified Child Abuse/Neglect Deaths Recorded by County in 2012

Child is not necessarily a resident of the county in which they died

Source: Department of Health Vital Statistics

Source: Department of Children and Families Data Report

Appendix II

Definitions

❖ Cases That Meet the Criteria for Review

In accordance with s. 383.401, F.S., the Committee must conduct detailed reviews of the facts and circumstances surrounding child abuse and neglect deaths in which the Florida Abuse hotline within the DCF accepted a report of abuse or neglect and verified it.

- Verified: a preponderance of credible evidence exists to determine that the specific harm or threat of harm was a result of abuse, abandonment or neglect
- Not Substantiated: there is credible evidence, but it does not meet the standard of being a “preponderance” to support the harm or threat of harm
- No Indicators: no credible evidence to support a finding

❖ Cause of Death

As used in this report, the term cause of death refers to the underlying cause of death. The underlying cause of death is the disease or injury/action initiating the sequence of events that leads directly to death or the circumstances of the accident or violence that produced the fatal injury.

❖ Manner of Death

This is one of the five general categories (Accident, Homicide, Suicide, Undetermined and Natural) that are found on the death certificate. It is the responsibility of the medical examiner to certify the cause and manner of death. The cause and manner of death are the certifying medical examiner's opinions, based on an accumulation of information pertaining to the circumstances surrounding the death, in conjunction with the autopsy findings and other ancillary procedures. The term 'cause of death' is defined as "the injury, disease, or combination of the two responsible for initiating the train of physiological events, whether brief or prolonged, which produced the fatal termination". The length of time between the injury that led to death and the actual death has no bearing on the certification of the cause of death. For example, if a child is the victim of a near drowning, survives for a period of time, and dies of a natural disease process such as pneumonia that is determined to be a complication of the near drowning, the cause of death is still certified as complications of the episode of near drowning, even if the death occurred weeks, months or even years later.

The term 'manner of death' refers to whether a death was a natural one or an accident, suicide or homicide, or in occasional cases, undetermined. The manner of death determined by the medical examiner is sometimes a source of confusion. The manner of death of 'homicide,' when used by a forensic pathologist refers to a death that resulted from an intentional act committed by one individual and directed at another (death at the hands of another). A homicidal manner of death may also refer to a death that resulted from criminal negligence or wanton disregard for the well-

being of another. Homicide is a medical diagnosis, not a legal term. The certification of a death as a homicide does not necessarily imply legal culpability. On the other hand, the certification of a death as natural, accidental or undetermined by the medical examiner does not prohibit criminal prosecution if the death resulted from or was contributed to by negligence, neglect and/or substance abuse on the part of the caregiver.

The cause and/or manner of an individual's death are certified as 'undetermined' if the death is unexplained by postmortem examination, laboratory studies, scene investigation and medical history. A certification of a death as 'undetermined' most frequently results when insufficient information is available to the medical examiner for classification with a reasonable degree of medical certainty. The State Committee has noticed an alarming increase in child deaths that are certified by Florida medical examiners as cause and/or manner of death undetermined. The State Committee feels that it is crucial to emphasize the importance of a thorough multidisciplinary investigation in all child deaths. In particular, the Committee emphasizes the importance of the utilization of doll re-enactments and the prompt testing of caregivers for substance abuse in appropriate cases to further its goal of identifying risk factors for preventing future avoidable child deaths.

❖ **Caregiver**

Means the parent, legal custodian, permanent guardian, adult household member or other person responsible for a child's welfare, which included foster parent, and employee of any private school, public or private child day care center, residential home, institution, facility, or agency, or any other person legally responsible for the child's welfare in a residential setting; and also includes an adult sitter or adult relative entrusted with a child's care *F.S. 39.01 (10) and (46), F.S.*

❖ **Adequate Supervision**

Adequate supervision is defined as being provided by an attentive functional person who is not under the influence of drugs or alcohol. The person must be proximate to the child (eyes on) and provide continuous supervision

❖ **Sudden Infant Death (SIDS)**

The sudden death of an infant under one year of age which remains unexplained after a thorough case investigation including performance of a complete autopsy, examination of the death scene, and review of the clinical history. By definition SIDS can be diagnosed ONLY after a thorough examination of the death scene, a review of the clinical history, and performance of an autopsy fail to find an explanation for the death. A SIDS diagnosis should NOT be assigned if the infant was found in the prone position and/or sleeping in an unsafe sleep environment.

❖ **Sudden Unexplained Infant Death (SUID)**

The sudden and unexpected death of an infant due to a variety of natural or unnatural causes.



**State of Florida
Department of Children and Families**

Rick Scott
Governor

Esther Jacobo
Interim Secretary

MEMORANDUM

DATE: Nov. 5, 2013

TO: Community Based Care CEOs
DCF Regional Managing Directors
Pete Digre, Assistant Secretary for Operations
Stephen Pennypacker, Assistant Secretary for Programs
Mary Cagle, Director of Children's Legal Services

FROM: Esther Jacobo, Interim Secretary

SUBJECT: Casey Family Programs Review of Child Fatalities

Less than a week after being named Interim Secretary, I called for a thorough review of all child fatalities due to abuse and neglect in 2013 where there was prior involvement by the department. As cases were being compiled for the review, it was clear that in order to receive the most objective feedback, we would need to enlist a third party. Casey Families Programs (CFP), a privately endowed nonprofit organization and national leader in child welfare policy, agreed to conduct the review at no cost to the state. The final CFP review is attached.

The report identified many shortcomings and potential improvements to our protective investigative practice, as we expected it would. However, we recognize that we must be open about our failures in order to improve. As we review these cases in the aggregate, we cannot lose sight of the fact that each individual case represents a young life that was tragically cut short. These innocent victims should serve as our inspiration as we work to implement the recommendations in the report and improve our practices to keep children safe.

Child safety is our shared responsibility and in order to ensure that we are working together to address the findings identified in the report, I have outlined below the specific actions we will be taking in response to the 13 recommendations listed in the report.

1. I am calling on all CBC lead agencies to conduct a comprehensive gap analysis of the services available in the communities they serve with special attention to services for children with disabilities, substance abuse, mental health issues and domestic violence—key factors highlighted in the report. Following the gap analysis, I will ask each CBC to implement a process for reviewing and evaluating the effectiveness of these services to ensure they are adequate to meet the community needs and provide a return on investment for our families.

1317 Winewood Boulevard, Tallahassee, Florida 32399-0700

Mission: Protect the Vulnerable, Promote Strong and Economically Self-Sufficient Families, and Advance Personal and Family Recovery and Resiliency

DCF will engage critical partners such as Healthy Families Florida, Early Learning Coalitions, the Florida Coalition Against Domestic Violence and the Florida Council Against Sexual Abuse to strengthen their outreach and service delivery.

2. The Family Functioning Assessment, which is part of the new Safety Methodology, will require Child Protective Investigators (CPI) to thoroughly analyze the protective capacities of the parent or caregiver. Training around this new tool will be ongoing as part of the phased rollout of the Safety Methodology.
3. DCF will identify additional staffing resources needed to ensure CPIs can adequately follow up on safety plans and home visits. Additionally, on Nov. 12 new safety planning tools will be launched in FSFN which will prohibit CPIs from closing safety plans without supervisor approval or the engagement of CBC services.
4. In September, DCF—with partners from across the state—launched The Safe Sleep Campaign. The Safe Sleep Campaign expands on successful programs implemented by Ft. Lauderdale Fire-Rescue and Healthy Mothers Healthy Babies of Broward County and Manatee County Sheriff's Office. The campaign provides free online continuing education training to first responders about how to identify unsafe sleep situations and take preventative measures. The campaign also encourages the public to donate new Pack 'n Plays (portable cribs) to designated fire, emergency and law enforcement stations. The cribs will be distributed by Healthy Start Coalitions. I have directed staff in each of the DCF regions to promote the campaign to increase awareness around safe sleep practices for infants and toddlers.
5. DCF is continuing with the implementation of an automatic alert function in FSFN so CPIs are directed to take extra precautions in cases where the key risk factors as identified in this report are present.
6. DCF will incorporate into its Child Welfare Operating Procedures a requirement that supervisors must approve all safety plans within 24 hours and support this new requirement with integrated FSFN alerts. This will further enhance the new safety planning model being launched later this month.
7. DCF Regional Managing Directors will implement the Rapid Safety Feedback protocol for all high-risk cases and continue to train CPI supervisors and management staff on the ChildStat approach to increase child safety. Rapid Safety Feedback is currently being used in the Suncoast Region and is designed to flag key risk factors in open child welfare cases that could gravely impact a child's safety. ChildStat is a data-driven, systemic leadership initiative that will use specific indicators and randomly selected cases to engage regional and statewide leadership in dialogue and team problem-solving about urgent issues impacting frontline practice and the child protection system as a whole.
8. DCF will incorporate internal dispute resolution staffing into standard operating procedures to ensure we are questioning one another's observations and conclusions in

order to make the best decisions for at-risk children who come into our care.

9. DCF is developing a data analysis system with the goal of identifying trends and predictive patterns that can inform future practice by CPIs and case management.
10. DCF currently conducts staffings when we are informed that a mother whose parental rights have been terminated has a new baby. A CPI will visit and determine if the new baby is safe. However, DCF is often not aware when a mother whose parental rights have been terminated gives birth to a new child. In Michigan, the vital statistics file for births is periodically matched with the child welfare TPR file to identify births to these mothers, and a CPI is dispatched to determine whether the mother has the capacity to adequately protect her newborn. This practice will help assure the safety of newborns to parents with TPRs. DCF will investigate how Florida can implement this model and whether legislative action will be required to implement it.
11. DCF will develop a protocol for protecting siblings and other children in a household following a suspected child maltreatment fatality.
12. In two recent cases, DCF conducted multiagency reviews to analyze the action or inaction of agencies involved prior to the child's death. DCF will make this a standard practice following a fatality whenever multiple state or local agencies are involved. The Legislature can also consider codifying a policy that agencies involved are required to participate in this review.
13. DCF and our CBC lead agency partners will make training on the new Safety Methodology a continuous process in order to ensure fidelity to the model as it is implemented throughout the state. DCF will continue with the current training schedule and expand those efforts to include additional staff and stakeholders.



Casey Family Programs

Review of Child Fatalities Reported to the Florida Department of Children and Families

October, 2013

Review of Child Fatalities Reported to the Florida Department of Children and Families

I. INTRODUCTION

The Florida Department of Children and Families (DCF) requested that Casey Family Programs (CFP) review summaries of recent child fatalities completed by DCF Quality Assurance (QA) staff. These child deaths constitute slightly more than a third of reports of child fatalities possibly related to child maltreatment received by DCF during the first seven months of 2013.

The purpose of CFP review of these child fatalities is to provide DCF leadership with feedback on Florida child protection practices described in these summaries, and to offer recommendations regarding policies and practices that can potentially reduce future child maltreatment deaths.

The only information regarding these child deaths available to CFP staff who conducted the review was contained in the QA child fatality review summaries. These summaries vary greatly in the amount and quality of information regarding the incident in which a child died and the family's CPS case history.

The QA summaries provided factual information regarding the circumstances and events that led to child deaths, as well as brief accounts of prior CPS reports/ investigations. The QA reviewers used the following child fatality summary format:

- Circumstances surrounding death
- Status of child death Investigation
- Actions taken to insure the safety of surviving siblings
- Summary of prior investigations
- Analysis of prior investigation/ service history for the previous two years
- Thoroughness in use of prior history in determining safe or unsafe children
- Criminal history was appropriately considered during the assessment of parental protective capacities
- Thoroughness of the assessment for legal sufficiency
- Summary of appropriateness of safety plan
- Proper identification of services
- Consultation with Child Protection Team (CPT) or Children's Legal Services (CLS)
- Engagement of law enforcement
- Use of multidisciplinary team staffing
- Case transfer practices from investigations to services
- Follow-up on referrals to services/services engagement by families
- Overall analysis of essential principles of practice to ensure child safety

In many of the summaries, QA reviewers applied the conceptual framework from the new Florida Safety Methodology to Child Protection Investigator (CPI) and Case Manager (CM) case

practice, decision-making and actions to evaluate what could have and should have been done to protect children compared to what actually occurred.

CFP reviewers had no information regarding the context of CPS investigations in these cases, such as the workloads and experience levels of the CPIs and CMs. CFP also had no information regarding the extent of inter-agency communication and information sharing and the availability of resources and services at the time of CPS investigations. These are often key issues that influence child protection practice. Therefore, the practice challenges described in this report should be tempered by the understanding that these contextual factors may have made it difficult for CPIs and CMs to engage in other, possibly more effective, child protection practices.

In several QA summaries, DCF reviewers demonstrated an excellent understanding of the new DCF Safety Methodology and made a compelling case that CPIs and CMs failed to take into account safety threats or to develop and implement safety plans based on guidelines in the Safety Methodology. However, nearly all CPIs and all CMs (with the possible exception of CPI staff in one or two pilot counties) had not been trained in the use of the Safety Methodology at the time of these child deaths. The same caveat applies to CPI actions in most prior CPS investigations critically analyzed in the QA summaries and in this review.

II. THE CHILD FATALITY REVIEW SAMPLE

The 40 child fatality summaries in the sample reviewed by CFP were selected by DCF managers. These managers stated that they purposely chose cases with complex dynamics whose analysis would provide the most opportunity for organizational learning. Cases were selected according to the following criteria:

- cases with prior investigations that may or may not have been factored into casework practice following a child fatality
- case information that indicated the need for expert consultation (medical, domestic violence, substance abuse, law enforcement).
- cases that included safety plans
- cases that involved referrals to services
- cases in which internal resources - supervisors, managers, legal services – were engaged

DCF managers appeared to select a sample of cases with significant DCF case histories and multiple risk factors for CFP review.

It is uncertain whether the cases reviewed by CFP are representative of suspected child maltreatment deaths in Florida. However, these child deaths reflect trends commonly identified in studies of child maltreatment deaths. Infants, aged 0-1, comprised 55% of the sample and 90% of deceased children were less than 5 years of age at the time of their death. Parental substance abuse, chronic mental health problems and domestic violence were common in families of children who died due to suspected maltreatment.

Most of the cases selected for CFP review had prior investigated CPS reports within 2-3 years prior to the child's death, and a few of the families of deceased children had been reported to DCF within a few days or weeks prior to a child's death. In some cases, parents received services from a case management agency prior to or at the time of the fatality. Some of these child deaths were still being investigated by law enforcement and DCF authorities at the time the summaries were completed by QA staff, and in a number of cases, the cause of a child's death had not been determined.

Therefore, this review is not strictly speaking a review of child maltreatment deaths as officially determined by DCF or law enforcement agencies. Rather, it is a review of child fatalities in which the child's family had at some point been investigated by DCF, and which were suspected at the time the child's death was reported to the DCF child abuse hotline to have been due to child maltreatment.

III. FINDINGS

A. Causes of Child Deaths

Finding #1

Asphyxia due to unsafe sleeping arrangement and practices was the most common cause of death in the sample. Co- sleeping of a parent or parents and a child was frequently involved in these deaths, but some children died after being placed face down on mattresses, or placed in cribs with pillows, comforters and other soft objects.

Several children died from drowning or from physical abuse. A few children died in unusual ways, for example, from gunshot wounds inflicted by a sibling, or from being placed overnight in restraints by residential care staff, or from a drug overdose.

Asphyxia

The most common cause of death for children in the sample was asphyxia, suffocation of an infant by an adult or, in two instances, by an older sibling sleeping in the same bed or on a sofa. Almost a third of children in this sample died in co- sleeping incidents. Children who died in co-sleeping incidents, or who were sleeping alone in beds or cribs, were often placed face down on a mattress or couch with pillows, blankets and other items that violated safe sleeping guidelines developed by the American Academy of Pediatrics.

Most of the parents or caregivers in these “roll-over” deaths had histories of substance abuse and/or tested positive for drugs following the child death. In addition, many of these families had been reported to CPS in the past 2-3 years for Threat of Harm to children associated with domestic violence incidents. Very few of the parents with substance abuse issues involved in these deaths and in those resulting from other causes, appeared to be in recovery, or even enrolled in treatment programs. Most of the parental substance abuse associated with child deaths was not relapse-related; rather parents with ongoing substance abuse issues, and often family violence, were attempting to raise babies and other young children.

The most common safety action previously taken by CPIs or CMs with parents of infants who subsequently died in “roll- over” deaths or in other unsafe sleep arrangements was to provide the mother (but often not the father) with information regarding the danger of co-sleeping and to elicit from the mother a written and/or verbal promise not to engage in co-sleeping with her infant. Nevertheless, mothers, fathers and boyfriends frequently ignored professional advice, or broke their promises, regarding co-sleeping. Giving information regarding co-sleeping (once) to drug addicted parents, or to substance abusing parents not established in a recovery process, and having these parents sign agreements to refrain from co-sleeping with infants, is a highly risky and questionable basis for safety planning.

Drowning

This sample included five children who drowned in bath tubs, swimming pools or ponds. Two of these young children were diagnosed with autism. The lack of functioning safety locks on doors or gates, or fences around pools stands out in the drowning cases. However, egregious lack of adult supervision was also a factor in some of these child deaths. One young child who drowned lived with parents who had been previously reported to CPS for a wide range of neglect related concerns, including lack of supervision, as well as for sibling sexual contact.

Physical Abuse

At least five children in the sample died due to physical abuse. A few other children whose cause of death had not yet been determined were suspicious for physical abuse given the child’s age, circumstances of the child’s death and a parent’s comments or past behavior which suggested underlying hostility toward the child. Histories of domestic violence were present in all of the child deaths resulting from physical abuse, along with substance abuse in most of the families. In all but one case, children were killed by their fathers or by their

mothers' paramours. One child's death may have been caused by physical abuse perpetrated by both the mother and her paramour.

Several of these families had prior histories of CPS reports alleging both physical abuse and neglect. The safety and risk issues indicated by credible reports of multiple types of child maltreatment in the same family were rarely, if ever, noted by either CPIs or QA reviewers. The children in these families lived in a "sea of risk" which created difficult challenges for CPIs and service providers given the difficulty in anticipating how these multiple risk factors might eventually endanger children.

Other Causes of Death

One child was shot by a sibling with a gun left in a car. A disabled child died after being placed overnight in restraints by residential care staff. One young child was shot by her mother who then committed suicide. A teenager died of a probable drug overdose while living with a mother and siblings, all of whom were abusing the parent's prescription drugs. The common factor in most of these deaths was the failure of caregivers to take prudent precautions.

B. Child Vulnerability

Finding #2

The vulnerability of infants, other young children and disabled children who died was greatly increased in families with multiple risk factors, including combinations of substance abuse, mental health conditions, family violence, criminal histories and several prior CPS reports. Multiple risks in families created difficult challenges for CPIs who were often unable to anticipate which specific risk factor would develop into a clearly identifiable safety threat.

Children who appear to be unusually vulnerable to severe child maltreatment in this sample included:

- infants, especially those born to mothers with histories of substance abuse
- disabled children who required unusual levels of parental attention and care, for example children with autism or children with chronic and demanding physical health problems;
- children living with parents who had been reported for multiple types of child maltreatment; and
- children whose parent or parents were hostile or rejecting toward them, for whatever reason.

In a number of cases, prior CPS investigations had focused on specific safety threats indicated by a particular incident only to have a child in the family, often the youngest child, die of other causes. In families with multiple risk factors, including several CPS reports and investigations, children were vulnerable in a variety of unpredictable ways, independent of specific safety threats.

C. Safety Assessment

Finding #3

Assessments of safety during previous CPS investigations of families of children who subsequently died were usually narrowly focused on the reported allegations in the most recent report. These safety assessments often did not appear to consider the family's prior CPS history or to explore domestic violence, substance abuse and other family dynamics which increase risk to vulnerable children.

In many of the QA summaries, reviewers were critical of the CPI's safety assessments and safety plans (or lack of safety plans) both preceding and following a child death. One reviewer made the following comments which apply to a number of the sample cases:

"While the cause of the child's death was not related to any of the ... prior child protection activities with this family, these prior investigations provided ample opportunity for assessment and services to be

brought into the home which may ultimately have prevented this child's death. Domestic violence and substance abuse dynamics were woefully underexplored. ... The overall thoroughness of the investigations leading up to the child's death is highly questionable."

Investigations of CPS reports prior to a child's death were often narrowly focused on alleged incidents of abuse or neglect. If a CPS report on a family alleged Threat of Harm associated with domestic violence, CPIs usually appeared to be solely concerned with domestic violence issues while not addressing substance abuse or other safety threats or risk factors. A number of babies in these families later died from asphyxia resulting from co-sleeping with parents under the influence of drugs or alcohol.

Safety assessments and safety plans were often directed at preventing specific types of events which had endangered children from re-occurring, for example driving a car under the influence of drugs or alcohol with children in the car. Safety and risk assessments rarely demonstrated an appreciation of the wide range of safety and risk issues associated with substance abuse, chronic mental health problems and family violence.

In a number of cases, QA reviewers commented that histories of child maltreatment, as reflected in multiple prior reports and CPS investigations, had not been taken into account or given the weight they deserved when assessing the child's safety. For example, a QA reviewer stated about a case with 10 prior CPS reports that:

"...overall, the relevance of prior history was not taken into full account during this investigation", and as a consequence "All of the unresolved issues ... point to the family's likely need for ongoing services and ongoing safety management" which were not provided."

In a case in which a 3 year old child died as a result of physical abuse, there was an open CPS investigation at the time of death, a history of prior injury to the child, a recent unexplained injury to the child that required stitches, criminal history of a caregiver that included assaults, ongoing domestic violence and a caregiver who protected the perpetrator of family violence. The QA summary states that there was enough information to warrant a staffing with CLS to determine legal sufficiency for filing a dependency petition, and that *"the safety action was not sufficient."*

In another case that involved a 2 month old child who died of Shaken Baby Syndrome, the family had an extensive CPS history in another state that included the removal of three older children from the home. A CPS investigation in Florida was closed six weeks prior to the infant's death. The QA summary notes that:

"It does not appear the prior history of this mother was thoroughly used" and the QA reviewer added "The prior history of families' needs to be taken into account when completing assessments ... and not solely looking at the isolated incident of the case."

A history of multiple CPS reports was sometimes minimized even when children in the family had suffered extreme harm. In one case with 37 prior CPS reports, a 3 year old child had almost died from severe malnutrition when she was a baby, and the parents had attempted to trade another of their children for housing. According to the QA reviewer, *"it does not appear that these (priors) were taken into account in this investigation."*

In many of the QA summaries, it is difficult to ascertain whether parents demonstrated "protective capacities" that led the CPI to conclude that children would be safe in homes with multiple risk factors, or whether CPIs were more influenced by other types of information in making their safety determinations. In cases involving substance abuse and domestic violence, the QA summaries rarely identify behaviors demonstrated by the parents or other caregivers during the investigation that might have convinced a CPI that a child or sibling group would be safe in the home.

D. Safety Planning

Finding #4

In many CPS investigations prior to a child's death, an in-home safety plan appeared to be clearly warranted. However, no safety plans were developed in a number of these cases. Completed safety plans were usually not adequate to control safety threats to children in that they were inadequately resourced and highly dependent on parents' promises. In most cases, CPIs did not follow up on safety plans to assess their effectiveness.

Finding #5

In some cases, the CPI did not adequately assess or address the safety of other children in the household following a suspicious child death. Assessment and decision making processes regarding sibling safety appeared highly variable and unstructured.

Many cases lacked in-home safety plans either during investigations prior to a child's death, or following a child's death when there were surviving siblings. In-home safety plans were used infrequently during investigations which occurred prior to a child's death, possibly because CPIs viewed children as safe despite multiple risk factors, or because of the narrow focus on specific incidents as noted above, or possibly because of a lack of confidence in safety plans.

When in-home safety plans were documented, the plans were sometimes general and non-specific (e.g., "the parent will keep the child safe and meet all of the child's needs") or promissory, i.e., parents or caregivers promised to refrain from specific actions such as co-sleeping or driving under the influence of drugs and alcohol. With few exceptions, in-home safety plans did not utilize resources or safety management services such as child care, respite care, safety networks, poverty-related services or home visitors. As a consequence, most in-home safety plans were incommensurate with the safety threats they attempted to control or ameliorate.

However, the single most questionable practice in the use of in-home safety plans was the lack of follow-up by CPIs to evaluate child safety and to assess whether parents were keeping their promises. CFP reviewers found only one QA summary that praised a CPI for conscientious follow-up on a safety plan. Another contained positive comments regarding a CPI's follow up on a service plan.

A few of the parents of deceased children appeared to have been active partners in prior safety planning, but in many cases, the motivation and capacity of parents to protect their children was unclear or clearly lacking.

Parental Hostility towards the Child

No in-home plan could have possibly protected a small number of children in the sample due to their parent's hostility or possible homicidal intent. One young child died from unknown causes during the third overnight visit with the mother during a reunification process. The QA summary states that the mother had attempted to suffocate the child with a pillow in 2011 prior to the child's removal from the home. The QA summary goes on to say that this incident had not been "verified" at the time, but that it was highly likely to have actually occurred, based on a relative's account.

Medical experts stated that this child may have been dead for 10-15 hours before the mother contacted the authorities. What may have been the attempted murder of this child in 2011 was disregarded because the child, less than 3 years old at the time of the attempted suffocation, did not "disclose" that the incident had occurred during a CPT forensic interview.

In another case, a mother had made it widely known that she did not want to raise a child with a serious disability. The parents' disabled child (with a cleft palate) died from unknown causes soon thereafter. The QA summary states that "*there is a general consensus that (the mother) was responsible for the child's death.*"

Surviving Siblings

When children died as a result of physical abuse, their surviving siblings were sometimes legally “sheltered” or allowed to be temporarily placed with a relative absent legal action. Siblings of a deceased child were also legally removed from the home or (more often) in a few instances following co-sleeping or drowning deaths, were allowed to stay temporarily with relatives through parents’ voluntary agreement.

In one case involving the possible homicide of a 15 year-old with a six-year old surviving sibling, there had been six prior CPS reports with allegations of physical injuries including bruises, welts, cuts, punctures, and bites, as well as family violence. All allegations had been ‘unverified’. The mother’s paramour, who was in the home at the time of the death, was listed on the Florida Department of Law Enforcement’s Career Offender website as a Habitual Violent Felony Offender. However, it appears that the CPI did not meet with the mother or the six-year-old surviving sibling for over eight days following the older child’s death. There was no indication that child safety was assessed or that services were discussed or implemented for the mother or the surviving sibling. A report was received 16 days after the death that the mother had absconded with her younger child. A CPT and CLS were involved in this case, but the case notes are unclear regarding what decisions were made or what actions were taken following these consultations.

The QA summaries often are unclear as to whether or how long surviving siblings remained out of the parent’s home in these cases. However, surviving siblings usually remained living with parents (sometimes in the home of a relative) following child deaths, often without a safety plan or services.

Legal Consultation

It should be noted that CPIs and their supervisors were often in contact with CLS following a child death. Decisions regarding whether to file legal action were (at the least) greatly influenced, or possibly determined, by the CLS attorney’s opinion regarding legal sufficiency. In one chronic neglect case in which a child died from drowning 3 months after the close of a CPS investigation, CLS approved a DCF request to “shelter” the children in the family, only to then insist that non-judicial voluntary services be tried before proceeding with legal action. .

In some cases, CLS and/or courts were resistant to legally sheltering babies born to mothers with a long and severe history of substance abuse. Some mothers whose babies died in co-sleeping incidents had older children legally placed in kin or non-kin foster care due to substance abuse and child maltreatment at the time of their infant’s death. It appears that the safety threats to infants resulting from a long and severe history of maternal substance abuse were sometimes minimized by CPI and CLS staff and courts.

E. Role of the Supervisor

Finding #6

The role the CPI supervisor played in consulting on and approving safety assessments and safety plans in prior CPS investigations of families with a subsequent child death was unclear.

Information in the QA summaries indicates that DCF has developed a variety of formats for review of CPI decisions, including Child Protection Team (CPT) staffing, other multi-disciplinary staffings, second level management reviews and consultation with CLS. However, the role of supervisors in guiding and assisting CPIs in CPS investigations and in approving safety plans was unclear in many of these summaries. It was usually difficult for CFP reviewers to ascertain whether supervisors agreed with case decisions or were responsible for decisions to close cases.

F. New Florida Safety Methodology

Finding #7

The new Florida Safety Methodology that DCF is in the process of developing appears well designed to address many of the problematic child protection practices identified in this review. It requires that CPIs

conduct a comprehensive assessment of safety, risk and family functioning during CPS investigations. However, since full statewide implementation of the model may take two to three years, it is critical that new and existing DCF, CBC, case management and legal staff receive safety assessment and safety planning training in the interim.

The new Safety Methodology has the potential to reduce the number of future child maltreatment fatality tragedies. However, there are formidable challenges to protecting endangered children through in-home safety plans. An effective safety practice model requires the availability of safety management services and resources to strengthen safety plans, and CPIs and case managers who have the time and are highly mobilized to thoroughly implement and follow up on safety plans.

Implementation of the recommendations in Casey Family Program's September, 2013 "Review of Florida Safety Methodology and Front-End Assessment Tools", especially the recommendations to give added emphasis to risk, rethink the model's approach to child vulnerability and require frequent follow-up on in-home safety plans will strengthen the model's ability to improve child protection practice.

IV. RECOMMENDATIONS

CFP reviewers believe that implementation of the following recommendations will improve the safety of children with open child welfare cases and could reduce the number of future child maltreatment fatalities:

1. Develop a comprehensive array of resources and safety management services, such as child care, respite care, safety network facilitators, public health home visitors, parent mentors and poverty related services that can "power up" in-home safety plans in all areas of the state.
2. Emphasize in Florida Safety Methodology policy and training that in-home safety plans cannot be effective in cases with parents who are hostile to or rejecting of their children due to a child's disabilities or for other reasons.
3. Ensure that CPIs, case managers and other involved professionals have the time and willingness to be actively involved in the implementation of in-home safety plans through frequent home visits, case staffings and mobilization of all available resources. "Touch lightly" information oriented safety plans, or promissory plans, are unlikely to be effective for children in present or impending danger or for children living in high risk families.
4. Develop a new more comprehensive programmatic response to co-sleeping and other unsafe sleeping practices. Ideally, public health nurses, or parent mentors, would be available to make regular and frequent home visits during at-risk infants' first 3-4 months of life to remind parents of safe sleep guidelines and help parents with a wide range of child care challenges. .
5. Develop an automated way of flagging families cases with prior CPS investigations based on explicit criteria such as age of child(ren), numbers of CPS reports within a certain timeframe and information regarding alleged parental substance abuse, mental health problems and/ or domestic violence. These cases should receive a heightened review at the beginning of the investigation and at case closure, especially if the case is to be closed without case management and/or other services. Review teams should have the authority to require additional investigative activities or referral to case management services.
6. Clarify the responsibility of supervisors to approve all safety plans, in-home and out-of-home, within 24 hours of a written agreement with the parent, or law enforcement action, or court order (at the latest).

7. Train supervisors in clinical supervision skills that develops their ability to elicit information from their CPIs regarding risk and safety issues, to guide their CPIs in assessment and safety planning in a way that transcends tools and practice and policy guidelines, and to recognize biases (such as confirmation bias) that influence CPI decision making.
8. Develop policy that requires that in cases where CPIs, supervisors and middle managers disagree with CLS's refusal to file legal action on behalf of endangered children, both DCF and CLS managers meet promptly to resolve the dispute.
9. DCF QA should implement a prevention-focused maltreatment fatality/ near fatality review process to collect, aggregate and analyze statewide data in order to identify patterns and common factors in these cases. Priority should be given to determining contextual factors which influenced how CPIs and supervisors responded to both child fatalities and "near misses" and to developing policy and practice recommendations to reduce child fatalities and serious injuries in the future.
10. DCF QA managers should meet periodically with public health officials to discuss possible child fatality prevention strategies that can be implemented regionally and across the state.
11. Develop and implement a policy that mandates a structured assessment and decision making process regarding the safety of siblings and other children in a household following a suspected child maltreatment fatality.
12. Following child maltreatment fatalities, DCF should utilize multi-agency staffings to analyze the roles and actions of each agency prior to the death, the response to the family's needs and to perceived safety threats, to ensure that the response going forward is adequate to meet the needs of the surviving children, and to make recommendations to agency leadership and community stakeholders regarding coordination and service improvement.
13. Since it will take two to three years to fully implement the new Florida Safety Methodology statewide, provide ongoing training and coaching for new and existing CPI, CLS, and case management staff and court staff on safety assessment and safety planning.

V. CONCLUSION

DCF is in the process of developing and implementing a safety practice model that involves a strong focus on safety assessment and safety planning. The child fatality cases in this sample demonstrate the severity of risk and safety issues in many families with accepted CPS reports and the formidable challenges involved in effective utilization of in-home safety plans. The new Florida Safety Methodology is a systematic approach to addressing these challenges.

However, the effectiveness of the model in protecting children is likely to depend largely on contextual factors such as CPI and CM workloads, the capacity of DCF to retain experienced staff, quality of supervision and community resources that can be used to support safety and service plans. The ability of child protection investigators to apply critical thinking skills to issues of safety and risk is especially important.

The importance of carefully evaluating the effectiveness of the safety practice model in accurately and consistently assessing danger to children and guiding the development of safety plans during the early phases of implementation cannot be stressed too strongly. In addition, opportunities for CPIs and CMs to learn from their experiences with safety planning, and for organizational learning regarding the characteristics of effective in-home safety plans should be maximized.