Florida
How to take action from case reviews
2008 Statistics on child deaths in Florida

• 2,718 children died according to Vital Statistics

• 473 reports involving child deaths were made to the Florida Abuse Hotline

• 94 deaths were related to unsafe sleep environment
Total SUIDI 2004-2008
(as of March 08)
2003-2007 Unsafe sleep environment deaths

- 2003: 4
- 2004: 10
- 2005: 14
- 2006: 22
- 2007: 41
Issues we identified

- Age of child
- Type of sleep arrangements
- Availability of a crib
- Perpetrators of co-sleeping
- Top risk factor
Age of Child

Age for Unsafe Sleeping

- 1-2 months: 0.42
- 3-4 months: 0.33
- 5-6 months: 0.27

Total (n=33)
Location of child

Location of child deaths 2007

- Co-sleeping: 68%
- Unsafe environment: 32%
Was there a safe sleep environment?

![Bar chart showing the number of cribs in different conditions: 19 had a crib, 11 had no crib, 3 had a broken crib, and 5 had no documentation. Total (n=38).]
Who is the Perpetrator?
Perpetrators of co-sleeping

Co-Sleeping
n=26

- 63% Parents
- 22% Relatives
- 15% Parent and Siblings
Substance Abuse as a factor

- History was noted in 25 of the 38 sleep related deaths
- 7 drug tests were requested after the death
- 5 drug tests were requested days later
- 3 were requested and refused
- 10 had no request for tests
State and Local Changes
FDLE Visor

**FATALITIES INVESTIGATIONS**

- Investigation should be based on physical and/or circumstantial evidence, establishing a timeline, and the possible confession.
- Must prove that the suspect had care, custody, and control over the child victim.
- Must establish that the suspect was the person with the child at the time the injuries occurred.
- Must establish that the injuries were not accidental.
- In cases of accidental deaths, law enforcement and child protective services must conduct a complete and thorough investigation.
- Consider tools such as re-enactment skills; have the suspect demonstrate how the injuries occurred.
- Involve the medical community in establishing accidental versus intentional, as well as the timeline.
- Many abusive injuries are not visible without the aid of X-Rays, CT Scans, MRI’s, or by a Forensic Autopsy.

The Medical Examiner will play a pivotal role. Be prepared to attend all autopsies.

**HOW DO CHILD FATALITIES DIFFER FROM OTHER HOMICIDES?**

- These cases generally involve blunt trauma, internal injuries to the chest or abdomen or severe burns.
- The child often develops infection, or other complications arising from injuries and dies from the complications.
- Most abuse and homicides of children occur in a private location such as the family’s home and eyewitnesses are rare.
- Homicides of children rarely involve firearms, most child murders are accomplished by the offender using his/her hands.
- Often very small children are violently shaken, resulting in death.
- Older children are often struck by a fist or other blunt force object.
- These cases often involve the presence of identifiable and patterned injuries such as bite marks, circumferential lacerations, or belt buckle marks.

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**Characteristics of Sudden Infant Death Syndrome (SIDS)**

| History of | Consistent with SIDS | Red Flags |
| death | Healthy infant, red put to bed, silent death | Unexplained history, prolonged interval between bedtime and discovery |
| Age at death | 2-4 months old, most common; 20% of cases the child is 1-12 months old | Child older than 12 months |
| Physical exam at death | Pink, watery mucus, mild respiratory distress, no skin trauma, well nutrition | Injuries, trauma, bruises, indications of manipulation, neglect, fractures |
| History of pregnancy | Cigarette smoke by parents; premature or low birth weight; multiple births, illness requiring hospitalization | Unwanted pregnancy; no health checks; drug/alcohol use during pregnancy |
| Death scene | Calm in good condition, firm sleep surface, no dangers or toxins, good ventilation | Appearances of chaotic, unsanitary, crowded living conditions; drug/alcohol; struggles in crib; bloodstained bedclothes; hostility by caregivers; discord, accusations |
| Previous deaths | One unexplained infant death | More than one unexplained infant death |
| Previous child protective services or law enforcement involvement | None | Previous child protective services calls; family members suspected of violent behavior; previous sudden unexpected infant death |

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CHILD DEATH / INJURY INTERVIEW AND DOCUMENTATION GUIDE

CRIMES AGAINST CHILDREN PROGRAM

Florida Department of Law Enforcement
Legislative changes

• DCF cannot close their investigation until the autopsy is complete.
Florida Police Chief’s Association

After a presentation by CADR chair, they passed and adopted the CDC SUIDI initiative stressing the multidisciplinary approach as well as using the doll re enactments making it resolution 2008-5.
Policy Changes

• Many agencies adopted the protocol initiated by Manatee county which requires that on all placements the caretakers sign the agreement for providing a safe sleep environment

• Healthy Families has developed in partnership with CADR Safe sleep checklists for their workers

• Healthy Families has safe sleep tips for providers and parents

• Department of Children and Families (DCF) investigators assess the sleep environment on cases they investigate and assist families that do not have a crib for their child

• Many DCF investigators are equip with drug field tests
MANATEE COUNTY SHERIFF'S OFFICE
Child Protection Placement Notice

I________________________ understand that the Child Protection Division of the Manatee County Sheriff's Office recognizes that it is unsafe for infants to sleep with adults or other children, to sleep in adult beds, on couches or other such surfaces. I will not allow ____________________, who has been placed in my custody, to sleep with adults or other children, and will only use a crib/bassinet.

We recommend that infants be placed to sleep on their back in a crib, or in a bassinet if under 4 months of age. Any other sleep environment used is not approved by this agency.

Yo __________________________________________ entiendo que la Unidad de Protection a Ninos del Manatee County Sheriff's Office reconoce que no es seguro para un bebe dormir junto con adultos o otros niños, tampoco que duerma en camas para adultos, en sofas o alguna otra superficie similar. No permitire que ______________________ quien esta ahora bajo mi custodia, duerma con otros adultos u otros niños. Usare una cuna o cuna portatil.

Recomendamos que los bebes sean acostados en su espalda en una cuna, o en una cuna portatil si el bebe es menor de 4 meses de edad. Cualquier otro ambiente o condiciones para dormir no es aprobado por esta agencia.

________________________________________________________
Signature/Firma

________________________________________________________
Date/Fecha

________________________________________________________
Witnessed By/testigo

________________________________________________________
Case#
Local Initiatives

Belly up!
FOR A SAFE NIGHT’S SLEEP

HEALTHY START

FREE MATERNAL & INFANT SERVICES
ESCAMBIA: 595.6641 SANTA ROSA 626.6751
PROCLAMATION

Whereas, 18 years ago the Florida Legislature enacted the Healthy Start Coalition legislation to increase access to prenatal and infant care for Florida mothers and infants.

Whereas, the Escambia County Healthy Start Coalition has contributed to the reduction of our county’s infant mortality rate and increased risk screening rate of pregnant women and infants finding that the primary cause of infant death in the home is accidental suffocation;

Whereas, research shows that for every $1.00 invested in prevention of unhealthy births results in $6.00 of savings in future healthcare, education and social services costs;

Whereas, over 7,300 women and infants are screened each year through the Escambia County Healthy Start Coalition work, to identify health risks that may jeopardize pregnancies and maternal and infant health; more work necessary to prevent infant suffocations;

Whereas, it is estimated that over 37% women of child bearing age in Escambia County do not have healthcare insurance;

Whereas, Escambia County’s black infant mortality rate remains at 11.3% almost triple that of the white population at 4.8%;

Whereas, in 2007 there was 31 infant deaths in Escambia County; nearly 25% (7) of those deaths were accidental suffocation;

Whereas, research shows that always placing babies on their back to sleep will substantially reduce the risk of suffocation as well as SIDS;

Whereas, infant mortality is the best indicator of a healthy state, maternal and infant health must become and remain a priority of high value, and community education can help reduce the number of babies that die needlessly from accidental suffocation;

Therefore, be it resolved that the Escambia County Commissioners declare that April 25, 2009 as Infant Safe Sleeping Day and we support the American Academy of Pediatricians in that infants should always be placed on their back for sleep in a safe sleeping environment such as a crib or bassinet, without toys, bumper pads pillows or excessive soft blanketing.
Local Committee took action from a Child's death

- St. Francis House received formula donations from Nestle Good Start, the Good Start representative will provide the shelter with as much formula as they need.
- The Gainesville Parenting Magazine will be painting, decorating and equipping 3 rooms at SFH for families. Weecycle (local consignment shop in Gainesville) provided cribs, changing tables, rocking chairs, etc at a discounted rate.
- Channel 5 news will be at the shelter to film the transformation.
Training initiatives

• Two members from our CADR were part of the CDC’s train the trainer on SUIDI. (A Major and a Medical Examiner)
• They have trained thousands on the SUID initiative and requests continue for them
• Two of our LEO members are working on updating the mandated state training for law enforcement to include SUIDI
Future Trainings

- Hospital Delivery Nurses
- Pediatricians
- Gynecologists
- Health Clinics
- Social Service Programs
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