

DEATH REVIEW

ANNUAL REPORT
December 2010

**Child
Abuse
Death
Review
Committee**

Working to reduce preventable
child deaths in Florida



State Child Abuse Death Review Committee
4052 Bald Cypress Way, Bin A06
Tallahassee, Florida 32399
(850) 245-4200
www.flcadr.org.

FLORIDA CHILD ABUSE DEATH REVIEW COMMITTEE

December, 2010

Team Members

Connie Shingledecker

Chairperson

Alan Abramowitz, J.D.

Randy Alexander, M.D.

Karla Ramos-Arroyo

Kris Emden

Christie Ferris

Pamela Graham, LCSW

Michael Haney, Ph.D.

Lisa Herndon, J.D.

Carol McNally

Bill Navas, J.D.

Angela Osterhoudt

Michele Pollard

Barbara Rumberger, MD

Raquel Smith, RN, MSN

Kaisha Thomas, Ph.D.

Terry Thomas

Barbara Wolf, M.D.

Staff

Michelle Akins

The Honorable Rick Scott, Governor
The Honorable Mike Haridopolos
President of the Florida Senate
The Honorable Dean Cannon
Speaker of the Florida House of Representatives
The Capitol
Tallahassee, Florida 32399-0001

Dear Governor Scott, President Haridopolos, and Speaker Cannon:

Pursuant to Chapter 383.402 F.S., I am submitting, for your consideration, the 11th annual report of the State Child Abuse Death Review Committee. This has been a challenging year. The Committee has reviewed the deaths of 197 children whose deaths were verified to have been from child abuse or neglect. Of those deaths, 192 occurred in 2009 and 5 deaths occurred in the prior year.

The State Committee has identified key recommendations that we respectfully request that the Legislature and Governor Scott consider for action. In particular, we continue to advocate for the expansion of child death review to include all children or, at a minimum, all child deaths reported to the Florida Abuse Hotline. As the State of Florida faces economic hardships, the Committee would like to thank you for your commitment and continued investment in children and families.

We have many challenges ahead, including the goal to review all child deaths in Florida. We must continue to strengthen existing laws and increase collaboration with existing prevention groups, State leadership, the Legislature and Florida citizens to eliminate preventable child deaths. We look forward to achieving new levels in both death review and prevention by strengthening existing relationships, and capitalizing on new opportunities to ensure a brighter, safer future for Florida children and their families.

We ask for your support and action to protect and improve the lives of Florida's children.

Sincerely,



Major Connie Shingledecker
Chairperson
State Child Abuse Death Review Committee

*“We are guilty of many errors and many faults, but our worst crime is abandoning the children, neglecting the fountain of life. Many of the things we need can wait. The child cannot. Right now is the time... we cannot answer ‘Tomorrow’; his name is **today**.”*

Gabriela Mistral (pseudonym of Lucila de María del Perpetuo Socorro Godoy Alcayaga), 1945 Nobel Laureate for Literature

FLORIDA CHILD ABUSE DEATH REVIEW COMMITTEE

ANNUAL REPORT

DECEMBER 2010

Mission

“To Reduce Preventable Child Abuse and Neglect Deaths”

Submitted to:

**The Honorable Rick Scott, Governor of Florida
The Honorable Mike Haridopolos, President, Florida Senate
The Honorable Dean Cannon, Speaker, Florida House of Representatives**

TABLE OF CONTENTS

EXECUTIVE SUMMARY	1
KEY RECOMMENDATIONS FOR 2010.....	5
OVERVIEW OF ALL DEATHS.....	20
CHILD ABUSE AND NEGLECT DATA.....	23
ABUSE/NEGLECT.....	24
PRIOR INVOLVEMENT WITH THE DEPARTMENT OF CHILDREN AND FAMILIES	28
PREVENTABILITY.....	30
PERPETRATOR INFORMATION.....	32
SUBSTANCE ABUSE.....	39
DCF HISTORY.....	41
CRIMINAL HISTORY	42
DOMESTIC VIOLENCE	43
MENTAL HEALTH	46
MANNER OF DEATH	48
DROWNING.....	50
PHYSICAL INJURY	59
MURDER/SUICIDE.....	61
ABANDONED NEWBORN/OUT OF HOSPITAL BIRTH.....	64
SLEEPING ENVIRONMENT-RELATED DEATHS	72
VEHICLE-RELATED DEATHS	76
VEHICLE CRASHES.....	80
DROVE/ BACKED OVER	82
DRUG/POISONING RELATED DEATHS.....	85
PREMATURE AND DRUG EXPOSED NEWBORNS.....	87
MEDICAL NEGLECT RELATED DEATHS	89
FIREARM RELATED DEATHS.....	91
FIRE RELATED DEATHS.....	93
INADEQUATE SUPERVISION RELATED DEATHS.....	95
STATE COMMITTEE GOALS AND ACCOMPLISHMENTS FOR 2010.....	98
REFERENCES	100
STATE CHILD ABUSE REVIEW COMMITTEE	102
APPENDIX I	104
“Who’s Watching Your Child” Brochure	104
APPENDIX II	105

Child Abuse Deaths by County	105
APPENDIX III	106
Purpose of Child Abuse Death Review Committee	106
APPENDIX IV	108
Local Child Abuse Death Review Committees	108

**The most tragic consequence of child abuse and neglect is
a child's death.**

**The well being of a victim depends on the adults who are
willing to take action.**

DEDICATION

The State Child Abuse Death Review Committee (CADR) dedicates this report to 192 children who died as a result of child abuse. We remember them for their innocence and honor them by committing ourselves to work tirelessly to see that no child dies a preventable death.

The members of the State and Local review committees also deserve recognition for their indefatigable efforts to accomplish the work of these committees, which is, at times, draining, depressing, and overwhelming. Their unfaltering efforts help us through these challenging endeavors.

The State Child Abuse Death Review Committee would also like to acknowledge Dr. Michael Haney for his wisdom, dedication, services, and years of, commitment to Florida's children. Dr. Haney was a member of the State Death Review Committee since it's inception in 1999 to January 2011. The State Committee valued him as a colleague and friend, and he will be dearly missed.



EXECUTIVE SUMMARY

The Florida Child Abuse Death Review Committee (State Committee) was established by statute in s. 383.402 (1), F. S., in 1999. It is the mandated responsibility of the State Committee, administered by the Florida Department of Health's Children's Medical Services, to review cases of the children who died as a result of verified findings of child maltreatment. Additionally, the State Committee is required to submit an annual Child Abuse Death Review Report. The first report was submitted in September 2000 and annual reports have been submitted each year to the Governor and Legislature that included recommendations for changes in law, rules, and policies that support the safe and healthy development of children and reduce preventable child abuse deaths. Some of these past recommendations have been implemented resulting in improvements in policy and practice, other recommendations remain but have not yet been implemented, and some recommendations have been added as a result of this year's reviews. This 2010 Child Abuse Death Review Report, which represents the 11th annual report submitted to the Governor and Legislature, includes information on the 197 cases reviewed by the Committee this year. Annual and trend data is presented that examines how these children died, factors that contributed to the death caused by their caretakers, and data-driven recommendations for preventing future child abuse and neglect deaths.

Sadly, 2,638 children under the age of 18 lost their lives in Florida during 2009. Of these 1,538 were males, 1,098 were females and two were unknown. Of those children who died, 513 were reported to the Florida Abuse Hotline. Of the child deaths reported to the hotline, 192 were verified as child abuse or neglect, which was submitted to the State Committee during the review period (January – November, 2010). During 2010, the State Committee was able to review the 192 child abuse deaths from 2009. The State Committee reviewed an additional five child deaths that occurred in the previous year, bringing the total number of child deaths reviewed by the State Committee in 2010 to 197.

In 2009, there was a slight decrease in the number of child abuse deaths in Florida compared to 201 children who died from verified child abuse or neglect in 2008. Over the past ten years however, these numbers have varied with no consistent trend emerging, either for Florida or nationally. Definitions and procedures may change within a state over time, as well as statutory requirements for reporting, as they have in Florida, resulting in data that is difficult to compare across years or states.

Florida has a very active interdisciplinary State Committee administered by the Florida Department of Health. Committee members proactively work within local communities to educate the public and law enforcement on the importance of reporting to the Florida Abuse Hotline child deaths that may not have previously been regarded as the result of maltreatment.

Training on child abuse and neglect reporting requirements to law enforcement and other professionals such as teachers and physicians, and training to Florida's child protective investigators on vital aspects of the investigative process also impacts the number and type of cases reported and subsequently verified. These include deaths resulting from unsafe sleep, drowning and failure to restrain a child in a seat belt. As a result, we have seen the number of reported child deaths from these causes rise from 35 in 2005 to 88 in 2009. In

2009, almost 45% of all child abuse or neglect deaths involved drowning or unsafe sleep, most of which involved the presence of alcohol or drugs and lack of supervision.

The State Committee's authority to review only verified child abuse and neglect deaths limited the review to only 192 of the 2,638 children who died in Florida during 2009. Limiting the review restricts the Committee's ability to gain a greater understanding of the causes and contributing factors of all child deaths in Florida. As a result, the patterns and trends identified in this report are limited to verified child abuse and neglect deaths and may or may not be generalized to all the children who died in Florida during 2009.

From the period January 1, 2009 through December 31, 2009, the leading cause of the 192 verified child deaths reviewed was drowning 59 children (31%); followed by physical abuse 52 children (27%) and then unsafe sleep environments 42 children(22%). Of the 192 cases reviewed of children who died, 161(84%) were five years of age and under, 117(61%) were males and 75(39%) were females. This 2010 Annual Report provides extensive data on each of these categories of abuse and neglect child deaths.

Research shows that the added stress families face during economically depressed times contributes to an increase in child abuse and neglect. The risk of child abuse and neglect is even greater in families where the parent: abuses alcohol or drugs, is isolated from their families or communities, has difficulty controlling anger or stress, appears uninterested in the care, nourishment or safety of their children, or seems to be having serious mental health or personal problems. These factors were present in a significant percentage of the 192 child death cases reviewed.

Based on the data collected and analyzed from the 192 child deaths in 2009, the State Committee has identified three key recommendations and additional priority issues with recommendations. These are included in this report for the Governor and the Florida Legislature to consider and take appropriate action in an effort to prevent future child abuse and neglect deaths.

Key Recommendations

1 - Review All Child Deaths - Amend §383.402 (1), F. S to expand the State Child Abuse Death Review Committee's authority related to the review of child deaths in Florida to have a better understanding of why children die in Florida.

2 - Fully Fund Healthy Families Florida - Support the Department of Children and Families 2011-12 Legislative Budget Request to restore Healthy Families Florida funding to the 2009-10 funding Level.

3 – Prioritize Assessment of Substance Abuse in Child Abuse and Neglect Cases – Substance abuse, the illegal or excessive use of alcohol or drugs, should be strongly considered when evaluating and investigating all cases of child abuse and neglect. The presence of substance abuse should also be given a higher priority in the risk assessment activities of child protection organizations that come into contact with children and their families.

Priority Issues and Recommendations

Drowning - Children continue to die from drowning at an alarming rate as a result of inadequate supervision.

Recommendation: Implement a systemic approach to prevent drowning of children in Florida, with a focus on those under 5 years of age.

Physical Abuse - An alarming number of infant and toddler homicides are attributed to common triggers and risk factors for physical abuse.

Recommendation: Any entity providing federal or state funded services, whether it be child protection investigations or case management, child care, home visiting or other services, should be trained to identify the common triggers and risk factors that contribute to child abuse.

Unsafe Sleep Environments - Sudden unexplained infant deaths associated with unsafe sleep are tragic, but must be investigated thoroughly and consistently in order to prevent future infant deaths

Recommendation: Improvements in the investigation of child deaths and heightened public awareness and education should be implemented for the prevention of infant suffocation deaths related to unsafe sleeping conditions.

Accessible and Affordable Childcare - Waiting lists for subsidized child care are growing. Subsidized child care enables low income parents to work, but only 30% of eligible families were served 2009-10, leaving more than 90,000 children on waiting lists.

Recommendation: Support The Policy Group for Florida's Families and Children to expand child care subsidies by 20% annually until all eligible children have the opportunity to enroll in a child care program or family child care home, allowing parents to work.

Enhanced Data Collection and Analysis on Economic Factors- Without additional data and analysis by the State Committee on economic factors present in death review cases, a determination of whether these factors directly or indirectly contributed to these factors is unknown.

Recommendation: Economic factors should be considered as a part of the risk assessment and documented in the Florida Safe Families Network (FSFN) data system so they can be analyzed both locally and on a statewide level to determine the impact they have on child deaths.

Consistency and Communication - Communication between agencies and consistent evidence gathering protocol are crucial to the child death investigation and protection of other remaining children that are at risk.

Recommendation: Improved consistency, communication and coordinated response during investigations are needed among the various agencies involved in child abuse/neglect and child death investigations.

Quality Assurance Review - Understanding the thinking and decision-making process of the legal decisions made and/or the court action taken would assist in educational opportunities resulting in better outcomes for children.

Recommendation: There is a need for a Quality Assurance review as it pertains to the legal involvement when any child dies as a result of abuse.

Judicial Involvement - Informing judges, magistrates and court staff on the process and findings from the child death reviews will assist them to recognize key indicators of child endangerment.

Recommendation: Increase judicial awareness of Child Abuse Death Review Committee findings and trends through targeted training initiatives.

Public Awareness Campaigns - Research-based public awareness campaigns are effective in educating the public on strategies and actions that work to prevent child abuse and neglect before it ever occurs in the first place.

Recommendation: Enhance targeted public awareness campaigns related to child health, safety, and welfare, and other mechanisms for preventing child deaths.

The State Committee believes that implementing these recommendations for each priority issue will improve the child protection system by providing the knowledge, skills, and public awareness needed to reduce tragic child abuse and neglect deaths.

KEY RECOMMENDATIONS FOR 2010

Based on the review of 192 child abuse deaths in 2009, the State Child Abuse Death Review Committee (State Committee) has identified three key recommendations and additional priority issues with recommendations. Implementation of these recommendations will improve child protection by providing the knowledge, skills, and public awareness needed to prevent tragic child abuse deaths.

KEY RECOMMENDATIONS:

#1: Review All Child Deaths - Amend §383.402 (1), F. S. to expand the State Child Abuse Death Review Committee's authority to review all child deaths in two phases. This will allow Florida to have a better understanding of why children die in Florida.

- Phase I - expand the State's child abuse death review process to include the review of all child deaths reported to the Florida Abuse Hotline.
- Phase II - expand the State's child abuse death review process to include the review of all child deaths.

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 which include infant sleep related deaths, drowning, suicides, traffic crashes and poisoning.

The All Child Death Review process will 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. Recognizing the current economic limitations, the State Committee proposes that the Governor and Legislature support the expansion of child death review to include all child deaths reported to the Florida Abuse Hotline. Currently, 39 states have laws mandating a child death review process; four states have laws permitting child death review. Most programs (27) are coordinated by state health departments; others are found in social service agencies, attorney general's offices, universities or other settings. At the request of the State Committee, the Florida Department of Health has submitted a legislative proposal on behalf of the children of Florida for the expansion of all child deaths reported to the Florida Abuse Hotline. This is also a goal of the State Child Abuse Prevention and Permanency Plan adopted by the Governor's Advisory Council on Child Abuse Prevention and Permanency.

As stated in last year's annual report, a priority for the Centers for Disease Control and Prevention (CDC) and the Healthy People 2010 is that a child fatality review team reviews 100% of deaths of children aged 17 years and younger that are due to external causes. By

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

- A more thorough child death investigation by law enforcement and medical examiners
- Enhanced interagency cooperation
- Improved allocation of limited resources
- 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 children in the State of Florida
- 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
- Strict confidentiality protections which protect records by providing appropriate protections from public disclosure
- A thorough analysis of why children die that informs data driven prevention efforts

Finally, it is essential to protect the confidentiality of the parents and other surviving siblings, and any other protected records. Currently, Florida Statutes provide confidentiality protections for all protected records received by the State or Local Committee.

Confidentiality ensures that a family's feelings will be spared a public scrutiny as the State Committee carries out its work and that no family be further traumatized as a result of this process. To understand why one child dies may save the lives of countless others.

Expanding child death reviews is one of the key prevention strategies in Florida's Five-Year Child Abuse Prevention and Permanency Plan.

#2: Fully Fund Healthy Families Florida - Support the Department of Children and Families 2011-12 Legislative Budget Request to restore Healthy Families Florida funding to the 2009-10 funding level. Restoring the funding will reinstate services to 3,500 high risk families and their 5,800 children who live in the 12 counties where services were eliminated and in the remaining 55 counties that experienced significant cuts.

Should additional revenue become available:

- Increase funding to add high-risk specialists to the core staffing to better serve families experiencing domestic violence, mental health issues and substance abuse issues that are highly correlated to the occurrence of child abuse and neglect.
- Expand services county-wide in counties that provide services in only targeted zip codes

The State Committee recognizes that the Legislature is once again faced with difficult budget decisions due to the anticipated budget shortfall. With scarce resources, it is even more critical that the Governor and Legislature prioritize funding for programs and services that show consistent positive results and yield the greatest possible return for the recovery

and future economic prosperity of Florida and its citizens. Healthy Families Florida, the state's only nationally accredited, community-based home visiting program is one of these programs.

The prudent investment the Florida Legislature has made in the quality and proven child abuse prevention services that Healthy Families Florida has provided since its inception in 1998 should be continued, as addressing child abuse and neglect after the fact, especially during these economically depressed times, is far more costly in both human and budgetary terms. Florida's taxpayers pay an estimated \$64,377 a year to care for an abused or neglected child, while Healthy Families Florida prevents the costs of child abuse and neglect for only \$1,671 a year per child, saving taxpayers millions of dollars.

Ninety percent of brain development occurs in the first five years of life, the period when most abuse and neglect occurs. In order to stimulate healthy brain development there needs to be a positive parent-child relationship and healthy environment for a child to grow and develop to his or her full potential. When a child is maltreated, the brain architecture is affected leading to learning and behavioral problems. Without a positive parent child relationship, healthy child development and a safe home environment, children are more likely to experience traumatic injuries, be placed in foster care, require special education and eventually commit juvenile crime.

Healthy Families Florida services begin early, during pregnancy or shortly after the birth of a baby. Parents, who are assessed as having multiple, researched-based factors that place their children at high risk for abuse and neglect, volunteer to participate in the program. Trained family support workers are welcomed into the homes of their families and build trusting relationships, empowering families to recognize their strengths to help them overcome these risk factors. The family support workers use a comprehensive home visiting curriculum to help guide services and introduce topics and activities that support positive parent-child relationships, including basic care, cues and compassion, social and emotional development, play and stimulation, and brain development. By increasing the knowledge and skills of new parents, Healthy Families empowers parents to accept personal responsibility for their future and the future of their families.

A rigorous five-year independent study and follow up study shows that Healthy Families prevents child abuse and neglect, keeping families together and children out of the child welfare system -- 98 percent of the children served by Healthy Families are abuse free.

The goals of Healthy Families Florida are consistent with the goals of the Children and Youth Cabinet's strategic plan and the restoration, enhancement and expansion of Healthy Families is a major objective in Florida's Child Abuse Prevention and Permanency Five-Year plan.

3 Prioritize Assessment of Substance Abuse in Child Abuse and Neglect Cases -

Substance abuse, the illegal or excessive use of alcohol or drugs, should be strongly considered when evaluating and investigating all cases of child abuse and neglect. The presence of substance abuse should also be given a higher priority in the risk assessment activities of child protection organizations that come into contact with children and their families.

- Risk assessment instruments should be enhanced or new instruments developed to focus more directly on substance abuse indicators in these families. Upon identification of a problem, investigative protocols should be developed to prioritize engaging these parents in treatment.
- A “testing protocol” for drugs and alcohol should be developed and implemented for use by Law Enforcement and Child Protective Investigators with specific guidelines for use in all child deaths when a child is a victim of drowning, motor vehicle crash, infant co-sleeping related death and any other child neglect deaths.
- Training should be provided to Fire Rescue/EMS first responders and Fire Marshall Investigators to recognize the signs of substance abuse by caregivers.
- Training should be provided to Law Enforcement and Narcotics Officers on mandatory reporting of child abuse when narcotic investigations indicate that children were present during drug related sales, manufacturing or use by a caregiver. Protocols for handling these reports should be established between law enforcement and the Department of Children and Families at the local level.
- The Florida Alliance for Drug Endangered Children, the Department of Health and The Department of Children and Families Substance Abuse and Family Safety program offices should continue to revise the current pre-service child protection curriculum. Continued emphasis should be placed on child protective investigators, case managers and child legal service attorneys receiving training on how substance misuse contributes to or results in harm to infants and children whose caregivers use illicit substances or abuse alcohol. Additional training should be developed to focus specifically on the epidemic abuse of prescription medications by parents and caregivers in the home.
- The Department of Children and Family Substance Abuse and Family Safety program offices should develop a standardized protocol for screening, assessment, linkage and retention of substance abusing parents in substance abuse treatment. Essential elements should include required attendance at recovery/support groups, use of family intervention or substance abuse specialists, drug testing, and use of peer recovery specialists.
- Further legislative action should be considered to limit/regulate the use of oxycodone and other prescription pain medications to further prevent their misuse.

Substance Abuse is one of the most common risk factors present in child abuse or neglect deaths reviewed by the State Committee. Approximately 50% to 80% of all child abuse and neglect cases substantiated by child protective services involve some degree of substance abuse by the child's parents. At least two-thirds of patients in drug abuse treatment centers say they were physically or sexually abused as children. At least half of the individuals arrested for major crimes including homicide, theft, and assault were under the influence of illicit drugs around the time of their arrest. Exposure to stress is one of the most powerful triggers of substance abuse in vulnerable individuals and of relapse in former addicts (NIDA, 2008).

Substance abuse by the parent or caregiver continues to be one of the highest risk factors for child fatality. Successful intervention efforts are based first, on the accurate identification of an alcohol or drug problem and second, on the ability of the investigator, case manager and court system to engage and support the user in treatment.

Unfortunately, the State Committee continues to see a pattern where substance abuse by the parent or person responsible for the child was documented in prior reports or substances were discovered in the home at the time of the child's death but no on scene presumptive drug testing occurred as part of the child protective or law enforcement investigation protocol. Under-recognition of substance abuse is further evidenced in child deaths when substance abuse related maltreatment allegations are not fully addressed.

Substance abuse indicators are also not appropriately factored into risk assessment and case planning. Frequently, these families are not referred for services or are referred to voluntary services with a large number of parents refusing further assistance once the child protective investigation is closed. As acknowledged in last year's report, the State Committee recognizes that the Florida Appellate Courts have clearly put the burden of proof on the Department for demonstrating a nexus of harm between a parent's drug use and the documented harm to the child but this challenge should not be the guiding factor when making determinations for child safety.

PRIORITY ISSUES AND RECOMMENDATIONS FOR 2010

Drowning - Children continue to die from drowning at an alarming rate as a result of inadequate supervision.

Recommendation: Implement a systemic approach to prevent drowning of children in Florida, with a focus on those less than 5 years of age. This approach should include:

- Public awareness and education on drowning prevention with an emphasis on supervising children near or around water especially targeted at the five and under age group.
- Child Protective Investigators conducting a risk assessment of drowning risk factors when there is a pool on the premises or bodies of water close to the home.
- Law enforcement and medical professionals reporting all child-drowning deaths to the Florida Abuse Hotline therefore allowing investigations to occur to determine if the child's death is a result of neglect.
- The Florida Abuse Hotline accepting reports from law enforcement or medical professionals on child deaths that occurred as a result of drowning.
- Medical Professionals reporting all child-drowning deaths where the death has been delayed due to resuscitation or medical intervention, to the Medical Examiner's office since these deaths resulted from a complication of the drowning and therefore, are not natural deaths.
- Law Enforcement and DCF following a "testing protocol" for substance abuse and alcohol that determines whether illicit drug use, prescription drug abuse or alcohol consumption was a contributing factor to inadequate supervision in the drowning death.
- Legislative action to amend section §515.27 F.S. mandating at least one of the requirements relating to pool safety features be maintained in any new homes with a swimming pool, spa, or hot tub.
- Legislative action to amend §515.27 F.S. mandating that whenever a building permit is issued for remodeling of an existing pool or spa or hot tub, it shall meet and maintain at least one of the requirements relating to pool safety features.
- Legislative action to amend §515.27 F.S. Requiring that whenever residential property that has a swimming pool, spa, or hot tub is sold or ownership is transferred, the pool, spa or hot tub shall meet and maintain at least one of the requirements relating to pool safety features in Section 515.27, Florida Statutes

Often drowning deaths are not reported as neglect. It is felt that “the family has suffered enough”, or “it’s just a tragic accident.” While the drowning death of any child creates great suffering and is tragic, these deaths are often preventable and are due to a lack of or lapse in supervision and inadequate pool safety features.

Supervision is defined as a responsible adult, who is not under the influence of drugs or alcohol, is proximate to the child and has continuous view (eyes on) of the child. According to caregivers, most child drowning victims were missing from sight for less than five minutes. However, the State Committee has noted that when there has been a thorough investigation, the time the child is last seen is often longer than reported by the caregivers.

A lapse in supervision can occur for many reasons – washing dishes, answering the phone, using the bathroom, tweeting, using the computer, tending to other children, etc. Layers of protection (pool safety features such as pool fencing, functioning locks and alarms and other barriers) can help guard against such moments; however there is no substitute for adult supervision. The Florida Department of Health, National Drowning Prevention Alliance, Safe Kids USA and many other child safety organizations urge communities to prevent these tragedies by enacting and enforcing strict swimming pool barrier codes and by educating parents and pool owners to use multiple layers of protection to prevent--or at least delay--a toddler's unsupervised access to a swimming pool or spa.

The American Academy of Pediatrics (AAP) urges parents to consider swimming lessons for most children between ages 1 and 4, in new guidelines on drowning prevention and water safety. The guidance is a change from previous recommendations. Previously, the AAP discouraged swimming lessons for this age group, noting a lack of evidence on whether these children were developmentally ready. The new guidelines, however, do not extend to all children under 4. The AAP still does not recommend swimming lessons before age 1, and says children with motor or cognitive disabilities may not be ready for swimming lessons until a later age. The updated policy also outlines the danger of body entrapment and hair entanglement in a pool or spa drain. Special drain covers and other devices that release the pressure in a drain can prevent such incidents.

For additional information: <http://www.aap.org/advocacy/releases/may2410studies.htm>

In Florida, bathtub drownings made up 13 percent of the childhood drowning deaths for 2009. The State Committee reviewed eight bathtub drowning cases this year. These deaths are preventable through continuous and capable supervision by an adult caregiver. Bathtub drowning deaths should always be investigated to determine if the child's death was due to caretaker neglect.

The State Committee has identified two common themes in bathtub deaths. First, parents appear to have a false sense of security when placing more than one child in the bathtub, believing the other children will be able to protect younger siblings. Second, parents believe that once a child reaches an age where they can sit up on their own, they can be left in the bathtub unattended. However, regardless of age, a child might not be developmentally capable of being safe in a bathtub unsupervised.

The State Committee did not have the opportunity to review the deaths of all children who drowned due to inconsistencies in reporting of child drowning deaths by law enforcement and other first responders. In addition, inconsistencies in the verification of neglect by the

Department of Children and Families or Sheriff's Department child protective investigators contributed to the cases not meeting the requirements for review by the State Committee. .

In cases reviewed by the State Committee, there often was a lack of thorough death scene investigation by responsible agencies. Investigators failed to explore or ask for drug testing when there was a family history of substance abuse, drug paraphernalia at the scene, or suspicion of drug abuse at the time of the child's death. This resulted in missed opportunities to establish whether or not neglect had occurred as a result of the caregiver's substance use.

Physical Abuse – A disturbing number of infant and toddler homicides are attributed to common triggers and risk factors for physical abuse.

Recommendations:

- Any entity providing federal or state funded services, whether it be child protection investigations or case management, child care, home visiting or other services, should be trained to identify common triggers and risk factors that contribute to child abuse.
- Support efforts by the Florida Pediatric Society and their partners to develop and implement a "Coping with Crying" program for hospitals and pediatricians.
- "Coping with Crying" programs should emphasize approaches to male caregivers between the ages of 18 – 30.
- Programs should emphasize educating parents and caregivers on the importance of making informed, selective choices on "babysitters" for their children.
- Any agency investigating child abuse should make it a priority to document and collect information as to a parent's ability or inability to place their children in center-based child care as regrettably, they often leave their children with inappropriate caretakers.
- Support public awareness efforts developed and implemented by Prevent Child Abuse Florida that promotes the prevention of child abuse and neglect through a better understanding of child development, positive parenting practices and community action.
- Increase public awareness regarding the importance of reporting domestic violence or threats of violence.
- Fund training for law enforcement investigators and DCF Child Protective Investigators on physical child abuse investigations. Training should include:
 - Use of standardized Q & A (designed by FDLE) during investigations.
 - An emphasis on common risk factors and triggers pertaining to adult male caregivers between the ages of 18-30.
 - The dynamics of substance abuse, domestic violence and animal abuse and how they relate to maltreatment and risk in child abuse and neglect cases.

- Law Enforcement Investigators are encouraged to use doll re-enactments in cases of serious child injury and death investigations. This should include video recording of the doll re-enactments in suspected child physical abuse/ child homicide and infant death investigations.

Crying, toilet training and feeding are the most common triggers of physical abuse in young children. Additionally, the state committee identified common factors and characteristics that are present in the physical abuse deaths of these children. These factors include young males between the ages of 18-30 who are unemployed and often providing primary childcare while the biological mothers work. The fact that many of these males are unattached, non-biological fathers contributes to their inability to cope with crying and very often lack appropriate knowledge of child development and parenting skills. In addition, many of these perpetrators have histories of substance abuse, domestic violence, animal abuse or criminal history of aggressive or violent behavior.

In response to the numerous cases reviewed by the State Committee that involved physical abuse and neglect where the perpetrator was a non-biological caregiver, in most cases the boyfriend, Healthy Families Florida, in collaboration with the State Committee, recently reviewed and revised a brochure entitled "Who's Watching Your Child?" The brochure is designed to educate Healthy Families participants and other parents about carefully choosing an appropriate person to watch their children while they are away from home. The brochure which will be made available to the public via the CADR website provides a wealth of information about what steps a parent can take to ensure that their child is left in good hands, including a checklist of items to discuss with the babysitter prior to leaving the child.

Unsafe Sleep Environments - Improvements in the investigation of child deaths and heightened public awareness and education are essential for the prevention of infant suffocation deaths related to unsafe sleeping conditions.

Recommendations:

- Law enforcement agencies, the Department of Children and Families (DCF) and Florida's medical examiner districts (through the Medical Examiners Commission) adopt and participate in standardized guidelines and multidisciplinary approaches for the investigation of the unexpected deaths of infants and children. This includes adopting the Sudden Unexplained Infant Death Investigation (SUIDI) protocol, developed for and in conjunction with the Center for Disease Control and Prevention (CDC). <http://www.cdc.gov/sids/SUIDHowtoUseForm.htm>
- Law enforcement agencies and medical examiner's offices should include doll re-enactments, when appropriate, as part of their protocols for the investigation of the unexpected deaths of infants and children.
- Law enforcement agencies and DCF should perform field drug testing of caregivers, when indicated, as part of their protocols for the investigation of the unexpected deaths of infants and children.
- The Florida Legislature should provide funding to expand public awareness and education efforts on infant suffocation due to unsafe sleep environments. Materials should be available to child protective investigators, law enforcement agencies,

hospital medical personnel and other medical providers, parents and caregivers with newborn children and the public.

- Agencies and organizations that provide home visiting services should use the home safety checklist and prevention education topic sheets developed by Healthy Families Florida in partnership with the State Committee. Contact Healthy Families Florida at: www.healthyfamiliesfla.org
- Provide infant safe sleep education for caregivers providing out of home care

Sudden Infant Death Syndrome (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.” In subsequent years, however, it has been recognized that factors related to infant sleeping position and infant sleeping environments, including the prone sleeping position, bed sharing (co-sleeping, particularly with those under the influence of drugs and/or alcohol, those that are obese or that are exhausted) and soft bedding increase the risk of infant death from asphyxia due to position or overlay.

Recognizing these risk factors, the American Academy of Pediatrics published a position paper in 2005 on the subject of safe infant sleeping conditions ((see link <http://aappolicy.aappublications.org/cgi/content/full/pediatrics;116/5/1245>) Additionally, because of the realization that many deaths that formerly might have been classified as SIDS actually have specific, preventable causes, the term SUID (Sudden Unexplained Infant Death) has been designated to refer to all unexpected infant deaths, including those that are determined to be suffocation, SIDS, metabolic error, undetermined, etc. 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 circumstances, the CDC has launched a nationwide initiative to improve the quality of these infant death investigations. The Florida Department of Health is spearheading the investigation of Sudden Unexpected Infant Deaths as part of the nationwide initiative.

Issues of unsafe sleep practices have not only been recognized as a major priority by the State Committee, but also by many of Florida's state agencies and organizations. The State Committee is currently supporting Florida's Investigation of Sudden Unexpected Infant Deaths (SUID) by the Department of Health. The purpose of this investigation is 1) to measure the impact of SUID in Florida, 2) to assess the quality of SUID investigations at the local level, and 3) to estimate the impact of unsafe sleep practices on SUID. The State Committee's support for the investigation includes formal endorsement of the investigation, especially with other organizations needing to be involved. In addition, several of the State Committee members are actually participating in the investigation in their other job-related duties. Committee member involvement includes being one of the primary investigators, serving on the investigation's advisory committee, and being a member of the expert case review team. The findings from this investigation will be critical to both the State Committee and the Department in advancing their efforts to identify, improve surveillance of, and reduce SUID and sleep-related deaths; which are responsible for 200-300 infant deaths each year in Florida.

Accessible and Affordable Childcare - Waiting lists for subsidized child care are growing. Subsidized child care enables low income parents to work, but only 30% of eligible families were served 2009-10, leaving more than 90,000 children on waiting lists.

Recommendation: Support *The Policy Group for Florida's Families and Children* to expand child care subsidies by 20% annually until all eligible children have the opportunity to enroll in a child care program or family child care home, allowing parents to work.

The placement of children in a licensed child care setting provides child visibility, enrichment activities and the opportunity for parents to develop a relationship with a caregiver who can model proper behavior. Early and extensive enrollment in child care or an early education setting has become the norm in our state and country. It is the quality of care and in particular, the quality of the daily transactions between providers and the children for whom they are responsible, that carry the weight of the influence of child care/early education on children's development. The positive relationship between child care/early education quality and virtually every facet of children's development that has been studied is one of the most consistent findings of developmental science.

Florida serves less than 25% of poor infants and toddlers eligible for federally sponsored Early Head Start, a comprehensive, high-quality program with positive outcomes. The ongoing economic down turn has heightened parents' need for affordable childcare so they can work. "Similar to roads, public works, and bridges, child care is one of the economic infrastructures that enable parents' labor force participation. Providing the infrastructure so that all adults who wish to work outside the home can find and sustain employment is critical to meeting workforce demands for an economically competitive region. It offers the economy an untapped labor force in those who wish to work outside the home but who are unable to do so because they are caring for children."

Graham, M. & Stowell, K. (2010). *Investing in Florida's Children: Good Policy, Smart Economics*. Auburndale, FL: The Policy Group for Florida's Families and Children.

Data Collection and Analysis on Economic Factors - Without additional data and analysis by the State Committee on economic factors present in death review cases, a determination of whether these factors directly or indirectly contributed to these factors is unknown.

Recommendation: Economic factors should be considered as a part of the risk assessment and documented in the Florida Safe Families Network (FSFN) data system so they can be analyzed both locally and on a statewide level to determine the impact they have on child deaths.

Research shows that the added stress families face during economically depressed times contributes to an increase in child abuse and neglect. The decline in the economic conditions of Florida has resulted in the rise of unemployment. The State Committee has noted during the reviews that when the primary caregiver is employed, they may choose to leave their children with household members who have lost their employment rather than seek licensed child care. These substitute caregivers may not have the same commitment or ability to properly care for children as the primary caregiver. The placement of children in a licensed child care setting provides child visibility, enrichment activities and the opportunity for parents to develop a relationship with a caregiver who can model proper behavior. The State Committee did not find any consistent method for data collection on

access to affordable child care to assist in determining what options were available to the primary caregivers.

Public Awareness and Education - Research-based public awareness campaigns are effective in educating the public on strategies and actions that work to prevent child abuse and neglect from occurring.

Recommendation: Enhance targeted public awareness campaigns related to child health, safety, and welfare, and other mechanisms for preventing child abuse and neglect, and preventable child deaths to include the following topics:

- Reinforcement of Mandatory Reporting Requirements
- Risks to Children in Unattended Cars
- Murder Suicide Prevention

Universal public awareness is the processes of informing the general population, increasing levels of consciousness about risks and how people can act to reduce their exposure to hazards. Public awareness is a fundamental strategy in addressing the prevention of child abuse and neglect. Effective campaigns can increase awareness, teach skills, build community support, change attitudes, and reinforce healthy behaviors.

The State Committee recognizes the importance of public awareness and the need to increase efforts in communities that will help keep children safe. This involves public information, dissemination, education, radio or television broadcasts, use of printed media, as well as the establishment of information networks and community participation. Public awareness and education is recognized as a need and included in Florida's Child Abuse Prevention and Permanency Plan: January 2010 – June 2015 to ensure that Florida's children are raised in safe, stable, and nurturing environments.

Public awareness efforts for the prevention of child abuse and neglect in Florida have shifted from placing a heavy emphasis on recognizing and reporting child abuse and neglect to promoting a better understanding of child development and safety, positive parenting practices and community action. These efforts are meant to educate the public on strategies and actions that work to prevent child abuse and neglect from occurring.

Local communities also recognize the critical need to implement public awareness campaigns; yet few have resources to develop materials and deliver public service announcements through paid advertising. Some local communities have implemented public awareness campaigns.

- Broward County Children's Services Council and Healthy Mothers, Healthy Babies have taken action to raise awareness on several topics to prevent child deaths. Their campaign, *Keeping Children Safe in the Summer*, focuses on drowning prevention and the risks of unattended children in hot cars.
- The Healthy Start Coalition of Hillsborough County has developed a community campaign called *Safe Baby* to educate and empower parents. The aim is to teach parents how to choose a safe caregiver for their children, prevent Shaken Baby Syndrome, and promote safe infant sleep. The ultimate goal is to prevent infant mortality and protect their community's children. Similar efforts are underway in communities throughout the state.

The State Committee recognizes the benefits a statewide infrastructure can have in communicating a consistent message: reinforcing healthy behaviors and preventing child deaths. Through Prevent Child Abuse Florida, the *Pinwheels for Prevention* campaign is delivered throughout the state during Child Abuse Prevention Month. This campaign provides statewide distribution of community resource packets, broadcast of television and radio public service announcements (PSAs) in English, radio PSAs in Spanish, and coordination of community involvement and advertisement of community events based on a central statewide theme.

Consistency and Communication - Communication between agencies and consistent evidence gathering protocols are crucial to the protection of children.

Recommendation: Improve consistency and communication among the various agencies involved in child abuse cases and child death cases.

- A multidisciplinary staffing should be required when there is a change in the child's placement that differs from the recommendation made by the Child Protection Team and/or the Department of Children Families (DCF).
 - Law enforcement, medical personnel and other appropriate mandatory reporters should continue to improve the consistency in reporting child neglect deaths involving drowning, unsafe sleep, traffic related incidents, murder/suicides and homicides.
 - Training should be provided on recognizing, investigating and reporting the above related deaths.
 - Data analysis should include the potential under-reporting of maltreatment types, most noticeably drowning deaths due to inadequate supervision and unsafe sleep deaths.
 - Reporter type (i.e., professional vs. family member) should be reviewed to help identify patterns of reporting by maltreatment, and to assess for under-reporting by first responders.
 - When feasible, DCF and law enforcement should conduct joint investigations on child death scenes.
 - Joint training is encouraged to determine roles and responsibilities when conducting joint investigations.
 - DCF should continue their efforts to improve consistency in verifying findings in child neglect death cases related to drowning and unsafe sleep.
 - Comparative data (by circuit) should be collected on maltreatment allegations and verification rates of all child deaths reported to the child abuse hotline.
 - The overall verification rate (i.e., ratio of confirmed child deaths to all alleged child deaths investigated) should also be analyzed to detect individual or unit bias in the handling of child death investigations.
 - Provide cross training between disciplines to improve consistency in the collection and documentation of critical evidence at child death scenes.

Communication and information-sharing between agencies involved in the investigation of child deaths must occur timely to ensure the safety of surviving siblings and promote preservation of evidence and accurate findings in child death investigations.

Cases are staffed monthly by DCF to identify system gaps so that child welfare practice can be improved. DCF is taking steps to further expand the review of child abuse deaths to learn from these tragedies. The information gleaned from these deaths is critical to the development of community-based initiatives and strategies to reduce avoidable child maltreatment fatalities.

In September 2009, the Department of Children and Families and the Department of Health, Children's Medical Services jointly agreed to a staffing policy that required a Child Protection Team staffing on all high risk cases or cases with children who had three or more prior reports, regardless of findings. As a result, the number of Child Protection Team (CPT) staffings more than doubled statewide. While this is great progress, the percentage of CPT cases receiving a staffing is still only 7%, and additional data collection and analysis is needed to determine if the policy is being uniformly enforced.

Quality Assurance Review - Understanding the thinking and decision-making process of the legal decisions made and/or the court action taken would assist in educational opportunities resulting in better outcomes for children.

Recommendations:

- There is a need for a Quality Assurance review by Child Legal Services when any child dies as a result of child abuse and the case was either staffed with CLS or under the jurisdiction of the court.
- Child Legal Service should appoint a representative to participate on every local Committee.

In all instances where a child dies while under the jurisdiction of dependency court, child protection or case management staff should timely notify the designated judge of the child's death, so that the court can make an informed decision regarding the ongoing safety of surviving siblings.

While the State Committee is not making a direct nexus between the death of the child and lack of court action, it does believe that the judicial process should be reviewed in a manner similar to other child protection quality improvement reviews. Understanding the thinking and decision-making process of the legal decisions made and or the court action taken would be extremely valuable. The lessons learned from such reviews could contribute significantly to an educational initiative for child protective investigators, child legal services, and or dependency court judges, which would inform their decision making process leading to better outcomes for children.

The Department has updated the process for reviewing any prior history in child death cases to include a focus on the determination of legal sufficiency for court-ordered intervention. This includes ensuring cases were properly staffed with Children's Legal Services (CLS), CLS completed a proper review and made an appropriate determination and/or recommendations, and case workers followed up on any CLS recommendations. In addition, a review of the involvement of CLS in child protective investigations is one of the

standards reviewed as part of the Department's regular Quality Assurance protocol. State-wide legal staffing forms have been developed and implemented with plans to conduct CLS training statewide.

Judicial Involvement: - Informing judges, magistrates and court staff on the process and findings from the child deaths reviews will assist them to recognize key indicators of child endangerment.

Recommendations:

- Increase judicial awareness of the State Committee findings and trends through targeted training initiatives.
- The Office of Court Improvement (within the Office of the State Courts Administrator) should arrange for a representative from the Child Abuse Death Review Committee to present case review findings and trends to judges and magistrates at one of the monthly "lunch and learn" webinars in 2011.
- The Office of Court Improvement should disseminate relevant Child Abuse Death Review Committee information to judges, magistrates, and court staff on an ongoing basis.

Implementing these recommendations will assist the court in information gathering as well as decision making. In addition, feedback from the courts to the child death review committee through training initiatives will allow the committee to identify legal barriers. In as much as the committee can recommend necessary revisions in the law or strategies to work within the existing laws to keep children safe, the collaboration would be a great benefit. When at risk families are under the jurisdiction of the courts it is imperative that the courts have all the relevant information on the individual families in order to make the best decision possible. While the death review committee would not be able to assist in individual cases before the court, the findings of the multidisciplinary body can help guide some of the court's information gathering functions and decision making by knowing the lessons learned in tragic child deaths. The trends exhibited and red flags identified would be of great use to courts as general guidelines in child abuse and neglect scenarios.

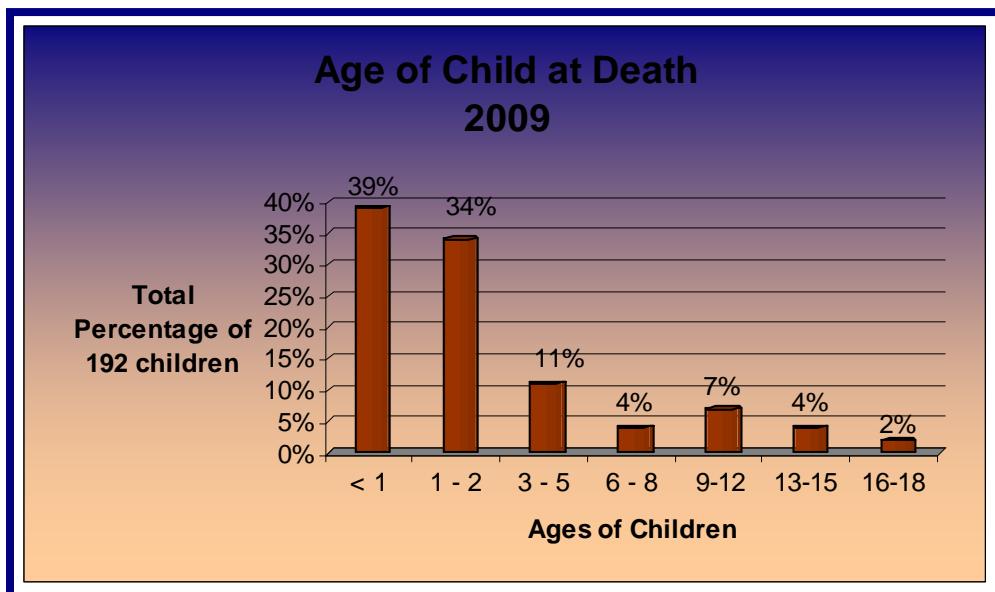
OVERVIEW OF ALL DEATHS

There were 192 infant/child deaths (under the age of 18) reviewed during 2010 that met the criteria for the State Child Abuse Death Review Committee. The following graphs show the total, age, gender-specific and race-specific child abuse deaths for Florida in 2009. This year the State Committee noted that 9 children who died were a twin.

Age of Child

- 75 (39%) children were <1
- 65 (34%) children were 1-2
- 21 (11%) children were 3-5
- 7 (4%) children were 6-8
- 13 (7%) children were 9-12
- 7 (4%) children were 13-15
- 4 (2%) children were 16-17

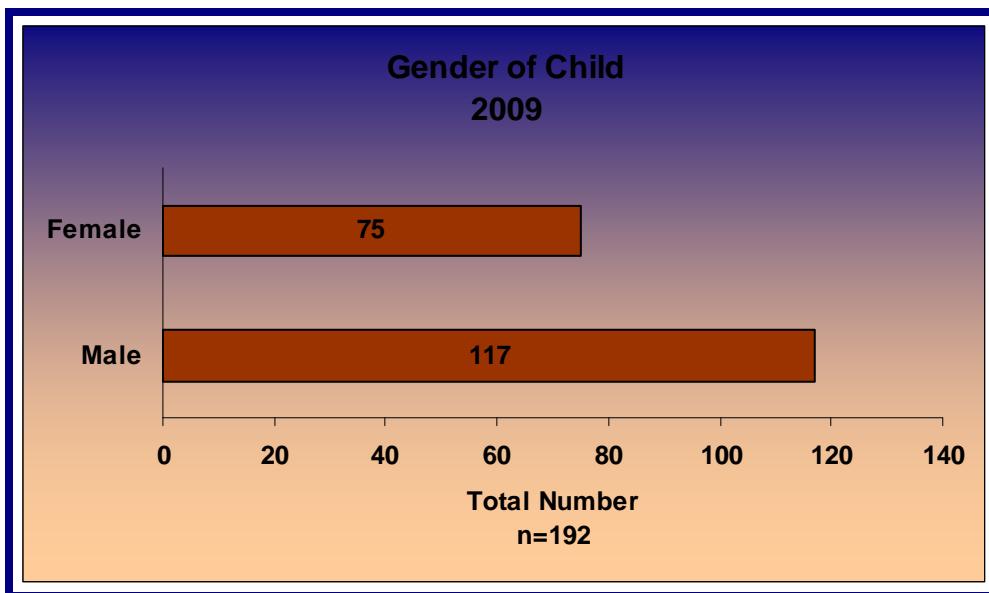
161 (84%) of the children were 5 and under



According to the US Department of Health and Human Services (DHHS)³, Child Maltreatment 2009, more than four-fifths (80.8%) who were killed were younger than 4 years of age, 46.2% of child fatalities were younger than 1 year, 17.8% were 1 year olds, and 10.3% were 2 years of age, 6.5% were 3 years old.

Gender of Child

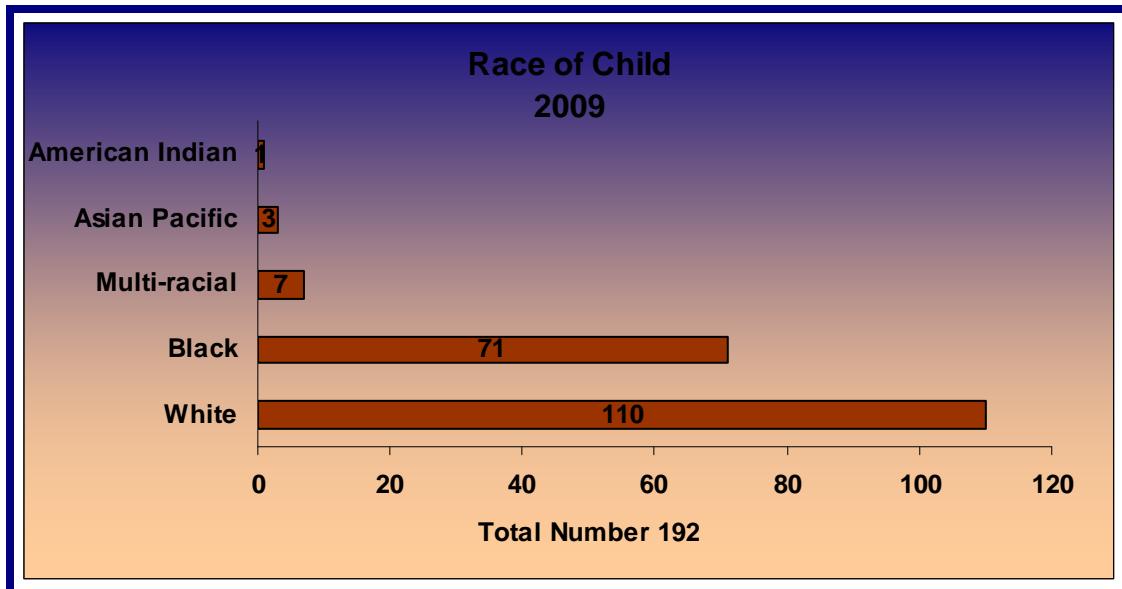
- 117 (61%) were male children
- 75 (39%) were female children



According to the US Department of Health and Human Services (DHHS)³, Child Maltreatment 2009, infant boys (younger than 1 year) had a fatality rate 2.36 per 100,000 and girls 2.12 per 100,000.

Race of Child

- 110 (57%) were white
- 71 (37%) were black
- 7 (4%) were multi-racial
- 3 (1%) were Asian Pacific
- 1 (.1%) were American Indian



According to the US Department of Health and Human Services (DHHS)³, Child Maltreatment 2009, nearly two-fifths were white (39.2%) nearly one-third (29.1%) were African-American, and nearly one-fifth (17%) were Hispanic. Children of American Indian, Native Alaska, Asian, Multiple race and Pacific Islander racial categories collectively accounted for 3.6% of child fatalities.

CHILD ABUSE AND NEGLECT DATA

There were 513 child deaths reported to the Florida Abuse Hotline in 2009, however there were 495 unduplicated reports of a child's death. Of those 513 reported deaths due to allegations of abuse or neglect, 50 occurred in a prior year, 18 were closed with no jurisdiction or as a duplicate, 186 were closed as no indicators, 42 were closed as some indicators, 54 were closed as non substantiated, 14 remain open, and 192 were verified and sent to the State Committee for review. Of the child deaths reported to the hotline, 192 were verified as child abuse or neglect, which was submitted to the State Committee during the review period (January – November, 2010). There were additional cases verified which will be sent to the Committee in 2011 for review.

In December of 2009 the Department of Children and Families modified the descriptor of "Some Indication" to "Not Substantiated". This was to align with the Family Centered Practice approach by reducing the family's concern over how a report is closed and redirecting their focus to working with child protection staff to identify a course of action leading to more positive outcomes.

In 2009, the Department of Children and Families initiated prevention initiatives to better serve families who were reported to the Florida Abuse Hotline but the allegation did not meet the statutory criteria for a child abuse or neglect report. These calls are accepted as "prevention referrals" and involve situations that do not meet the statutory criteria for an intake, but the family or individual may need services. The intent is to prevent child maltreatment by helping families or individuals through a family and/or community centered approach before that occurs.

The following chart shows the number of all child deaths that occurred in Florida, the number of reports called into the Florida Hotline and how many of these reports were prevention referrals. This chart also shows the number of reports that involved child deaths and how many of these child deaths had some indicator findings of child abuse or neglect or verified findings of child abuse or neglect. The verified child death reports are the only reports reviewed by the State Committee, which only gives a limited understanding of why children are dying in Florida.

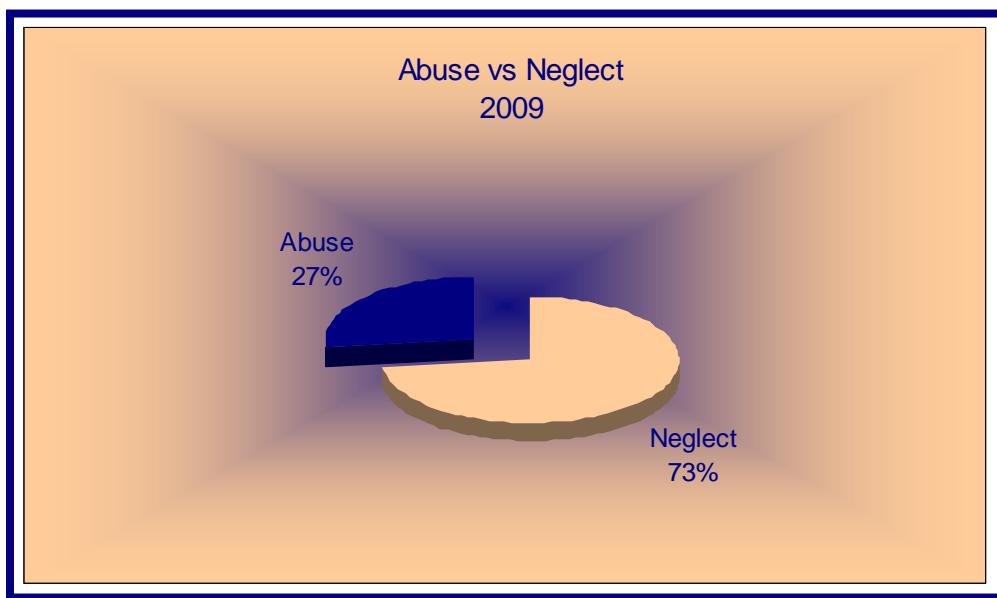
FLORIDA CHILD DEATHS - 2009	
Number of child deaths regardless of residency	2,638
Number of Florida resident child deaths	2,586
DCF REPORTS RECEIVED & ABUSE/NEGLECT DEATHS	
Number of initial reports	217,382
Number of reports involving child deaths	513
Number of child death cases with no indicators	196
Number of child abuse death's with some indicator findings/not substantiated	96
Number of verified child abuse death reports	192**
National estimate for 2009 ³	1770***

***U.S. Department of Health and Human Services: [Child Maltreatment 2008: Reports from the States National Center on Child Abuse Prevention Research](#).

**192 cases are from review period January- November 2010, additional cases have been verified in 2009 however, they will be addressed in next years report.

ABUSE/NEGLECT

In 2009, there were 192 child abuse and neglect deaths reviewed. Of those, 52 (27%) were from abuse and 140 (73%) were neglect.



The U.S. Department of Health and Human Services Administration for Children and Families released its 20th issue of "Child Maltreatment 2009" and it shows a steady decrease in the number of victims who suffered maltreatment for the third consecutive year. Analyses of the number and rate of victimization for the past 5 years show and over all decrease regardless of whether the duplication or unique analyses are examined. The decrease may be attributed to several factors including a decrease in the number of children who received a CPS response and an increase in the number of States with alternative response dispositions. States with larger populations such as California, Florida and Texas have a larger effect on the national numbers. All three states reported a decrease in the number of maltreatment victims for FFY 2009. During recent years, Florida changed its policy for victim dispositions and this change was reflected in the victimization decrease for FFY 2007.

Recent National reports and media events have drawn attention to Florida's child death rate which, according to 2009 federal data, is the fourth highest in the nation.

States have different standards, varying data collection methodologies, and different statutory requirements for reporting and substantiating child abuse. These definitions and procedures also may change within a state over time, as they have in Florida. The Center for Public Policy Priorities, a Texas think tank that does extensive work on issues involving child abuse and child poverty, confirms that such comparisons are difficult and misleading and states that have rates that look high

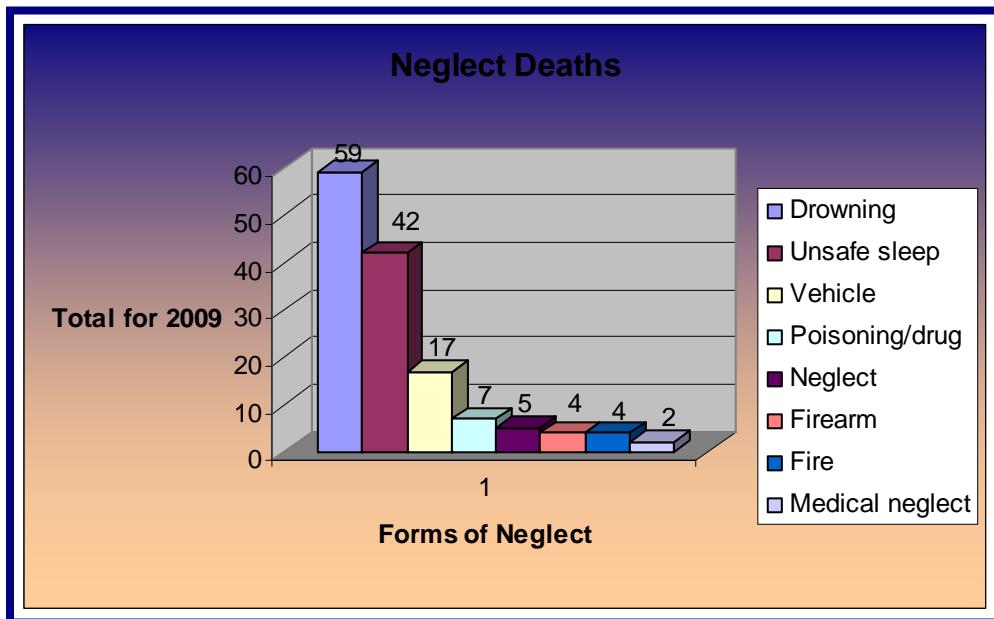
simply may be more diligent about finding such deaths and counting them. Or, as Mark Chaffin, professor of pediatrics at the University of Oklahoma Health Sciences Center, and one of the nation's leading experts on child abuse fatalities puts it: "The better the job you do in getting your data, the worse you look." Comparing rates of child maltreatment fatalities among states actually penalizes states like Florida, which takes pride in diligently analyzing and learning from child maltreatment fatalities.

Research indicates that child fatalities are under reported. Studies in Colorado and North Carolina have estimated that as many as 50 to 60 percent of child deaths resulting from abuse or neglect are not recorded as such (Crume, DiGuiseppi, Byers, Sirotnak & Garrett, 2002; Herman-Giddens et al., 1999)⁸ A recent study funded by the Centers for Disease Control and Prevention, have suggested that more accurate counts of maltreatment deaths are obtained by linking multiple reporting sources, including death certificates, crime reports, child protection services reports and child death review records(Mercy, Baker & Frazier, 2006)⁹

- Issues affecting the accuracy and consistency of child fatality data include:
- Variation among reporting requirements and definitions of child abuse and neglect and other terms
- Variation in death investigative systems and in training for investigations
- Variation in State child fatality review processes
- The amount of time (as long as a year, in some cases) it may take to establish abuse or neglect as the cause of death
- Inaccurate determination of the manner and cause of death, resulting in the miscoding of death certificates; this includes deaths labeled as accidents, sudden infant death syndrome (SIDS), or "manner undetermined" that would have been attributed to abuse or neglect if more comprehensive investigations had been conducted (Hargrove & Bowman, 2007)
- Limited coding options for child deaths, especially those due to neglect or negligence, when using the *International Classification of Diseases* to code death certificates
- The ease with which the circumstances surrounding many child maltreatment deaths can be concealed
- Lack of coordination or cooperation among different agencies and jurisdictions

In cases of fatal neglect, the child's death is not a result of anything the caregiver did, but rather the result of a caregiver's failure to act. The neglect may be chronic (e.g., extended malnourishment) or acute (e.g., an infant who drowns because she is left unsupervised in the bathtub). NCANDS (National Child Abuse and Neglect Data System) show that in 2009, 66.7% of child maltreatment fatalities were associated with neglect alone or in combination with another maltreatment type, and 44.8% were associated with physical abuse either exclusively or in combination with another maltreatment type.³ Analyzing the children by exclusive types of maltreatment reveals that 36.7% of all child fatalities suffered from multiple maltreatment types. Another 35.8% of children died exclusively from neglect and 23.2% died exclusively from physical abuse. Neglect has been the leading cause of child maltreatment deaths in Florida over the past nine years. Below is a graph of years 2004-2009.

Neglect covers a broad section of maltreatments and may have no outward signs, so is often missed. Child neglect deaths are often overlooked and coded as "just a tragic accident" by law enforcement, first responders and child protective investigators, feeling that the family has suffered enough. With emotions clouding the investigator's judgment and ability to look for facts and contributing factors of neglect, they close the case accidental. There is a lack of training to both law enforcement officers as well as Protective Investigators on child death investigations. There is no standardization in these investigations; allowing for inconsistencies in information collected by law enforcement and inconsistencies in child death verification by DCF. The graph below shows the child deaths reviewed caused by a form of neglect



Blunt Head Injury and sexual assault

Naomi

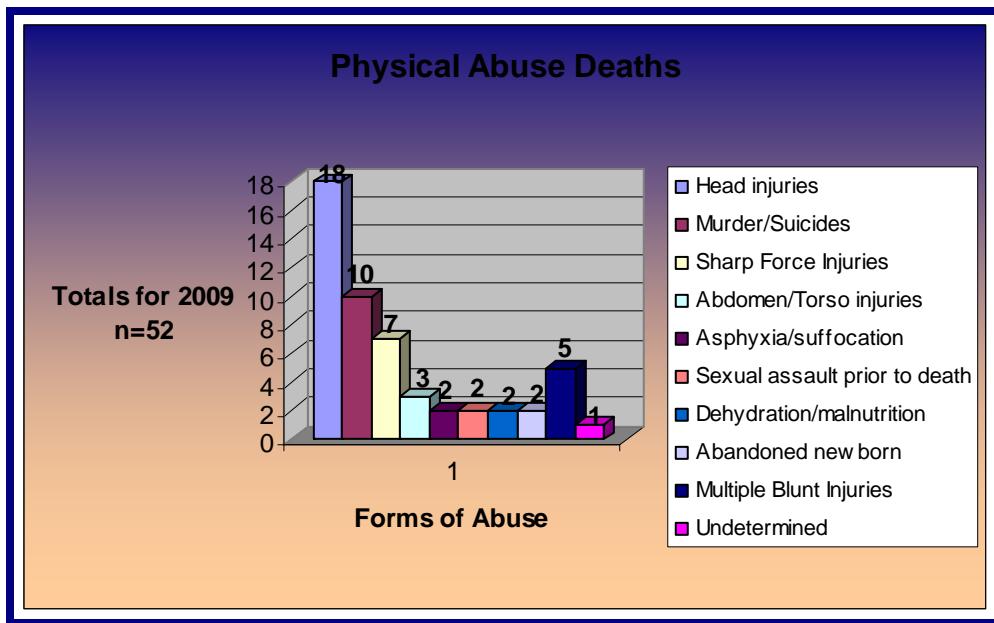
Naomi, 3 years old was reported to have fallen down stairs while in the care of her mother's boyfriend, age 27. The boyfriend had reportedly left bruises on her butt a month earlier which the mother, age 32 was aware of and did not take any action. The night of the fatal incident the mother left Naomi alone with her boyfriend who was passed out after using Xanax. When the mother came home from work she noted the child had vomited and her lip to be swollen. The mother and the boyfriend attempted to drive the child to the hospital but were stopped by law enforcement. She was noted to have had severe bruising to her face, blunt head trauma and evidence of sexual abuse. The home was noted to be filthy. Naomi's sibling had been injured previously however the mother blamed a babysitter. The mother had previous children removed from her care due to her substance abuse. The boyfriend had an extensive criminal history that included drug related charges and he had an active domestic violence injunction against him. He was charged with the murder.

Physical abuse is often the most easily spotted form of abuse. It may be any form of hitting, shaking, burning, pinching, biting, choking, throwing, beating, and other action that causes physical injury, leaves marks, or produces significant physical pain. No one single triggering event has been identified that explains the occurrence of all cases of physical abuse.

Angleo Giardino and Eileen Giardino, Ph.D. have suggested that there are circumstances that may contribute to physical abuse injuries of a child. They have been organized into a typology with the following five subtypes: (1) caregiver's angry and uncontrolled disciplinary response to actual or perceived misconduct of the child; (2) caregiver's psychological impairment, which causes resentment and rejection of the child by the caregiver and a perception of the child as different and provocative; (3) child left in care of a baby-sitter who is abusive; (4) caregiver's use of substances that disinhibit appropriate behavior; and (5) caregiver's entanglement in a domestic violence situation.¹⁰

Specific factors that may place the child at higher risk for physical maltreatment include prematurity, poor bonding with caregiver, medical fragility, various special needs (attention deficit hyperactivity disorder), and the child being perceived as different (physical, developmental, and/or behavioral/emotional abnormalities) or difficult based on temperament .

The numbers confirm that 2009 was another deadly year for Florida Children. The number of traumatic injuries remained steady from last year compared to the 45 physical abuse deaths in 2007. The graph below shows the 52 child deaths reviewed caused by a form of physical abuse.



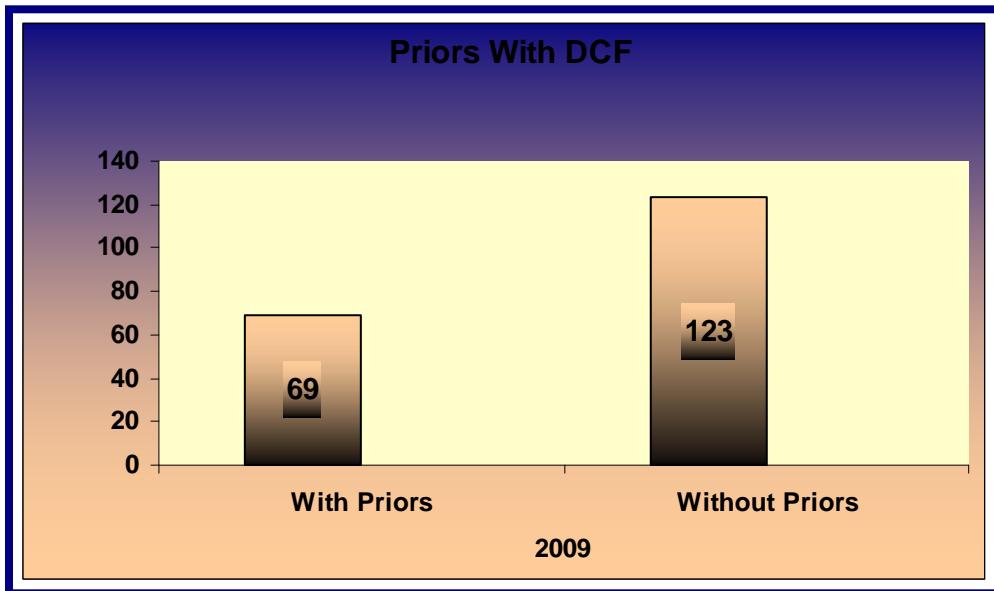
PRIOR INVOLVEMENT WITH THE DEPARTMENT OF CHILDREN AND FAMILIES

According to the US Department of Health and Human Services³, children who had been abused or neglected and whose families had received family preservation services in the past five years accounted for 11.9 percent of child fatalities. Nearly 2 percent (1.9%) of the children who died had previously been in foster care and were reunited with their families in the past five years. (NASCADDS REF)

One of the best predictors of future behavior is past behavior. The following graphs demonstrate a number of deaths with priors and without priors as well as the number of priors on each child who died.

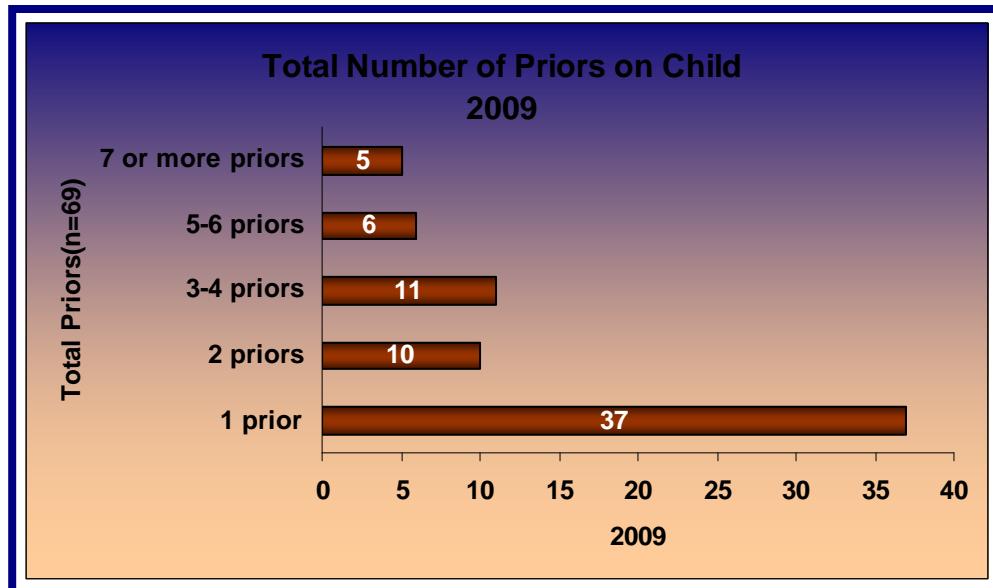
In 69(36%) of the 2009 child death cases reviewed, the child had prior involvement with the Department of Children and Families.

123(64%) of the 2009 child death cases did not have any prior involvement with the Department of Children and Families.



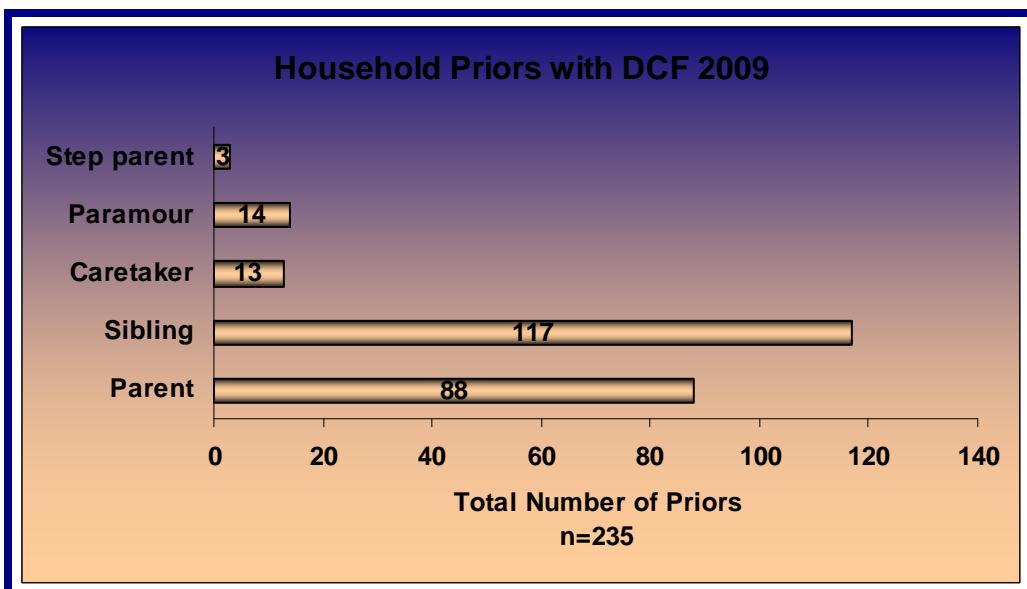
Fourteen (7%) of the child death cases reviewed had an open report at the time of the child's death. Of the sixty nine children who had prior reports, the number of prior reports ranged from one to seven.

The graph below depicts the number child abuse death cases by the number prior reports.



There are a significant number of cases where the family or caretakers had been involved with the Department of Children and Families prior to the child's death, which is shown in the chart below. (Note some of the priors are from other states) Often the history of the parents is overlooked and opportunities to provide services are missed. Many of these young parents were neglected as children and parent as they were parented, allowing the cycle of abuse and neglect to continue.

The graph below shows the number of prior reports on household members of the deceased child with the Department of Children and Families prior to the child's death. (Household member: parent, grandparent, sibling, paramour, or other person living in the home.)



PREVENTABILITY

Preventable deaths

The State Committee is charged with the responsibility of determining whether the child's death was preventable, based on the information provided, using the following categories:

Definitely preventable by caretaker or system or both

The information provided demonstrates clearly that steps or actions could have been taken that would have prevented the death from occurring. A system can be agencies such as Department of Health, Department of Children and Families, Community Based Care, Healthy Families, Healthy Start, Law Enforcement, the Judicial system, or relatives just to name a few.

Deaths resulting from homicidal violence are classified as "not preventable" unless the information provided clearly demonstrates that actions taken by the community or and individual other than the perpetrator could definitely have prevented the death or could possibly have prevented the death

Possibly preventable by caretaker or system or both

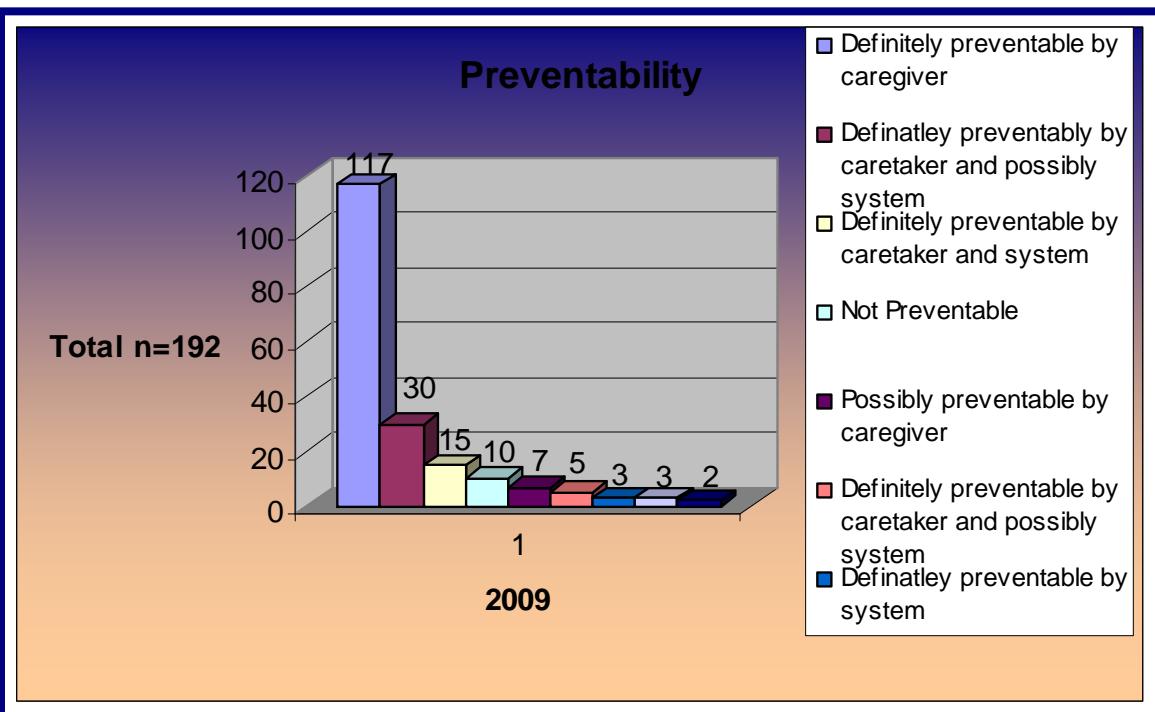
There is insufficient information to determine if the death was preventable.

Not Preventable by caretaker or system

No current amount of medical, educational, social or technological resources could prevent the death from occurring.

Of the abuse reports reviewed:

- 117 (61%) were definitely preventable by caretaker
- 30 (16%) were definitely preventable by caretaker and possibly system
- 15 (8%) were definitely preventable by caretaker and system
- 10 (5%) were not preventable
- 7 (4%) were possibly preventable by caretaker
- 5 (3%) definitely preventable by system and possibly by caretaker
- 3 (2%) were possibly preventable by system
- 2 (1%) were possibly preventable by caretaker and system
- 2 (1%) undetermined
- 1 (.5%) was definitely preventable by system



PERPETRATOR INFORMATION

The State Committee has seen common factors in numerous cases that seem to be contributing factors in the death of children. Frequently, the perpetrator is a young adult in his or her mid-20's without a high school diploma, living at or below the poverty level, depressed and who may have experienced violence first-hand. Fathers and other male caregivers were responsible for the majority of the physical abuse fatalities. These factors include young males between the ages of 18-30 who are unemployed and are often providing primary child care while the biological mothers work. The fact that many of these males are unattached non-biological fathers contributes to their impatience and lack of parenting skills. In addition, some male caregivers had histories of substance abuse, domestic violence, criminal history of aggressive or violent behavior or history of involvement in the child protection system.

Female perpetrators were generally responsible for the majority of the neglect fatalities. However there were many instances where mothers also failed to protect their children from the male perpetrator of the physical child abuse fatality. Many of the mothers were aware of the abuse occurring, yet left their child in the care of abuser. In addition, the female caregivers had histories of substance abuse, domestic violence, criminal history and history of involvement in the child protection system.

Any partner in the child protection system should be aware of and sensitive to these male and female related risk factors when investigating an allegation of child abuse. Families with these risk factors, irrespective of the findings, should be considered at the highest risk for child maltreatment. In many of the deaths, the State Committee found more than one person to be responsible for the child's death, whether they committed the act intentionally or failed to protect the child.

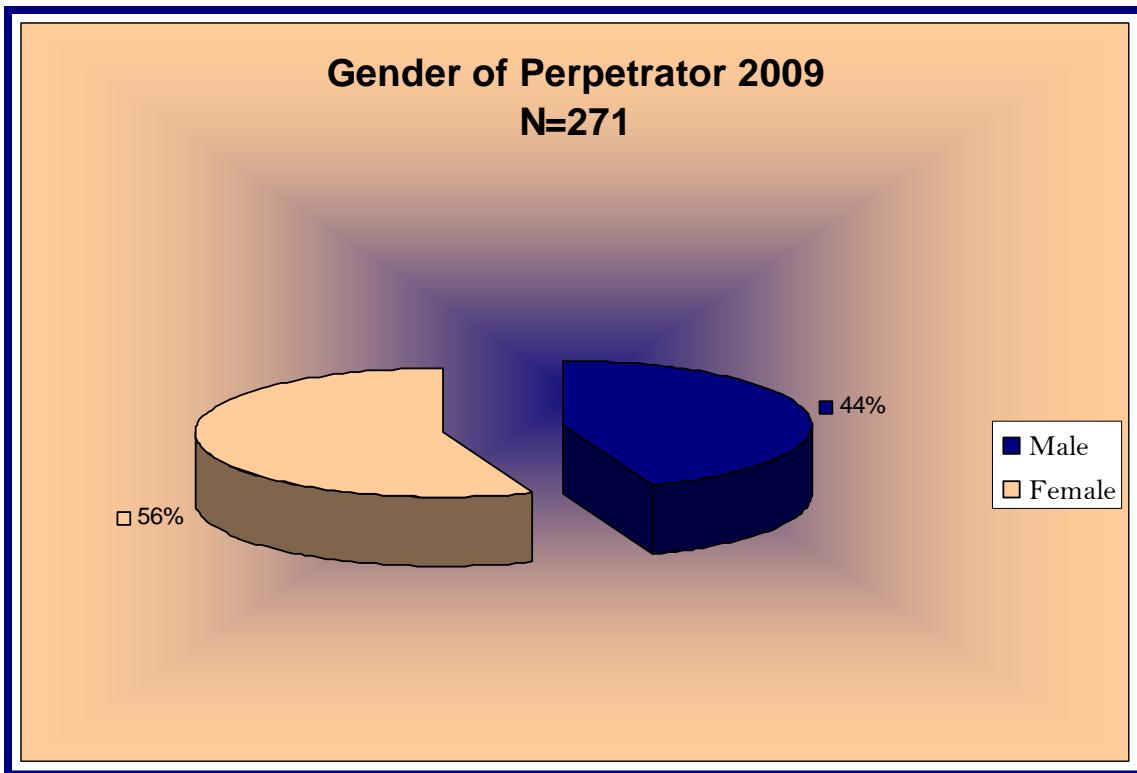
The total numbers of identifiable perpetrators responsible for the 192 child deaths were 271. One of the 192 deaths involved an unknown perpetrator.

Note: more than one perpetrator may be identified in a case

Gender of Perpetrator/ Caregiver

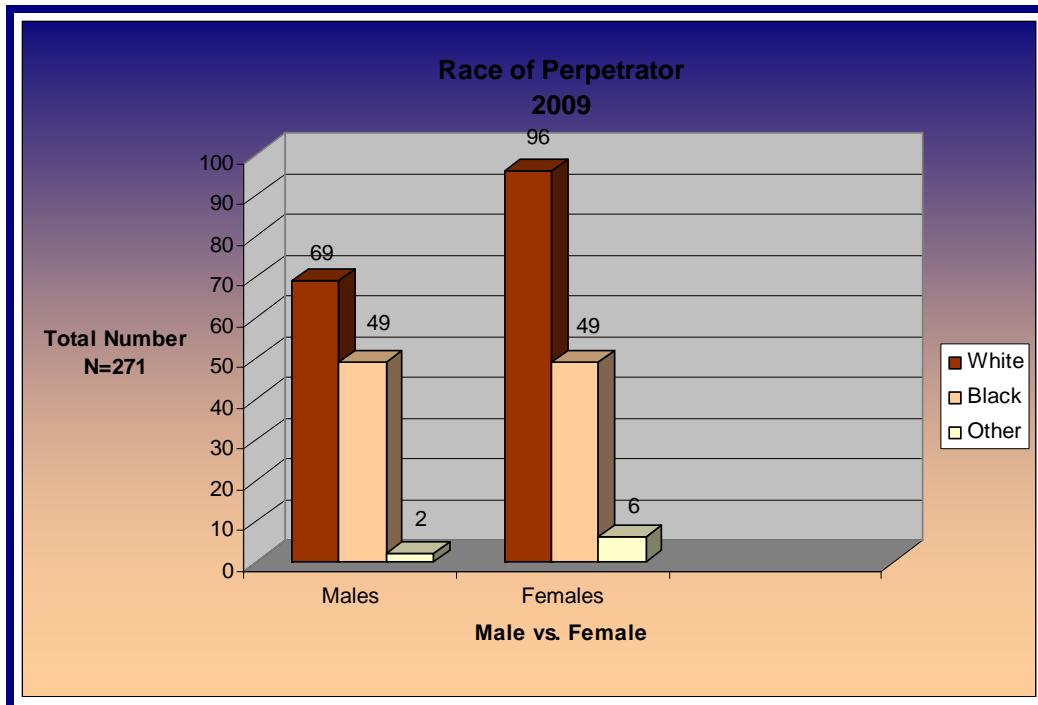
Of the 271 perpetrators identified:

- 151 (56%) were females
- 120 (44%) were males



Race of Perpetrator

- 165 (61%) perpetrators were white
- 98 (36%) perpetrators were black
- 8 (3%) perpetrators were other

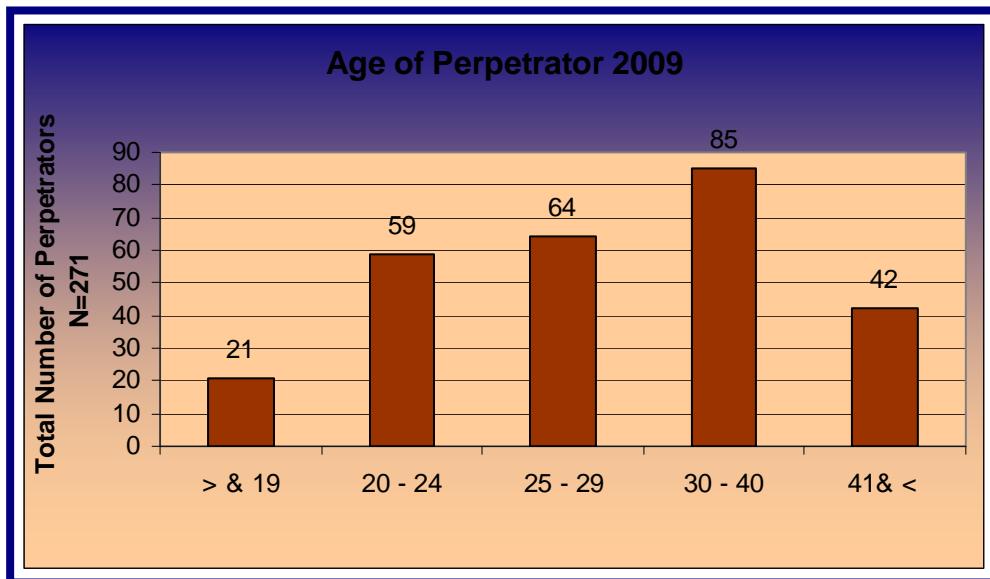


Age of Perpetrator

- 21 (8%) were under the age of 19
- 59 (22%) were 20-24
- 64 (24%) were 25-29
- 85 (31%) were 30-40
- 42 (15%) were > 41

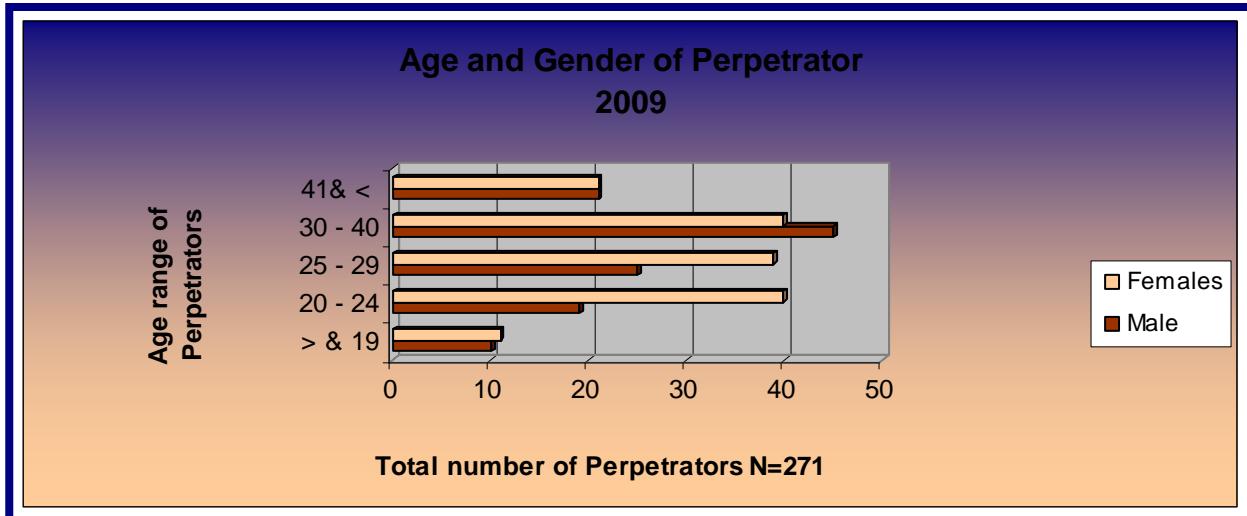
The majority of the perpetrators were under the age of 30.

144 (53%) were 29 and younger



Age and Gender

The graph below shows the breakdown of age and gender

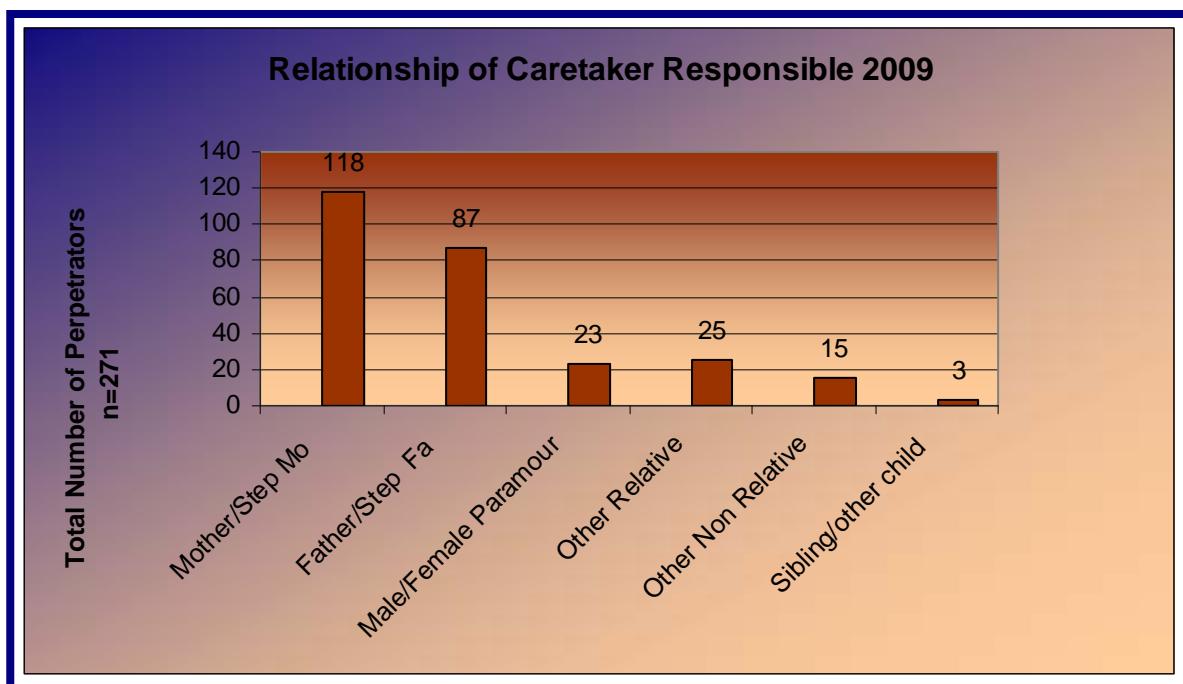


Relationship of Caregivers to Child

- 117 (44%) Mother/Adoptive Mother
- 84 (31%) Father/Adoptive Father/Step Father
- 23 (9%) Male and Female Paramour
- 31 (12%) Other Relatives **
- 9 (4%) Other non-relative
- 5 (2%) Babysitter
- 2 (1%) Other Child/Stranger

**Other relatives included grandparents, aunts, uncles, step parents, siblings and other relatives.

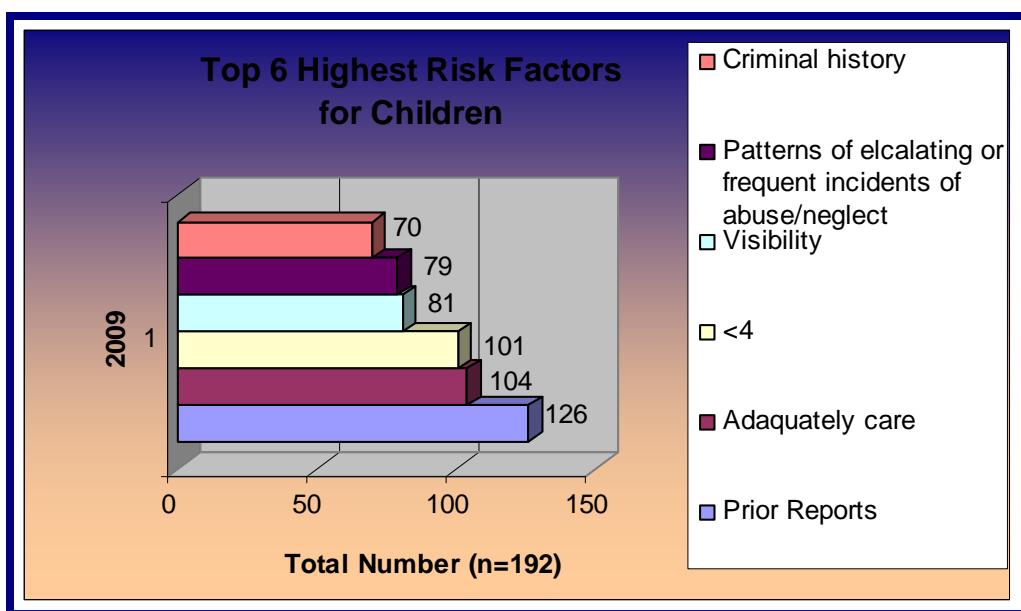
The graph below shows the relationship of the caregivers responsible.



Perpetrator/Caregiver risk factors

The total identified perpetrators responsible for the 192 child deaths were 271. It should be noted that one of the 192 child deaths reviewed did not have a perpetrator identified. Eighty (42%) of the child deaths reviewed involved more than one perpetrator.

The State Committee review identified the top perpetrator risk factors; Criminal Record, Substance Abuse history, DCF history, , Alcohol Abuse, Domestic Violence History and Mental Health history. The graph below shows the risk factors for the 271 perpetrators in the 192 child abused death cases reviewed.



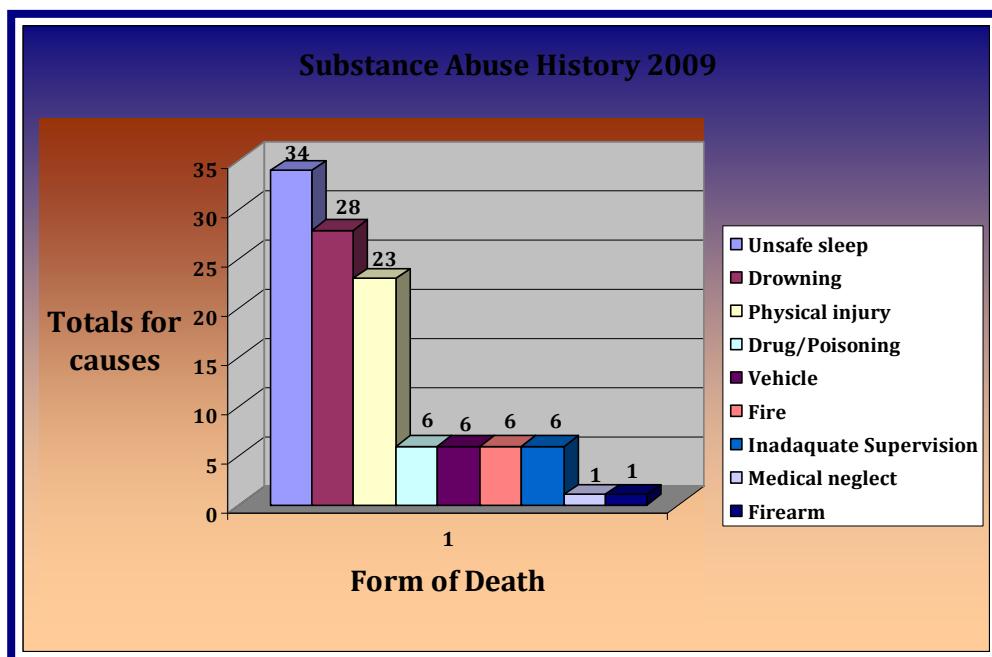
SUBSTANCE ABUSE

Substance Abuse is one of the most common risk factors present in child abuse or neglect deaths reviewed by the State Committee. Approximately 50% to 80% of all child abuse and neglect cases substantiated by child protective services involve some degree of substance abuse by the child's parents. At least two-thirds of patients in drug abuse treatment centers say they were physically or sexually abused as children. At least half of the individuals arrested for major crimes including homicide, theft, and assault were under the influence of illicit drugs around the time of their arrest. Exposure to stress is one of the most powerful triggers of substance abuse in vulnerable individuals and of relapse in former addicts (NIDA, 2008).

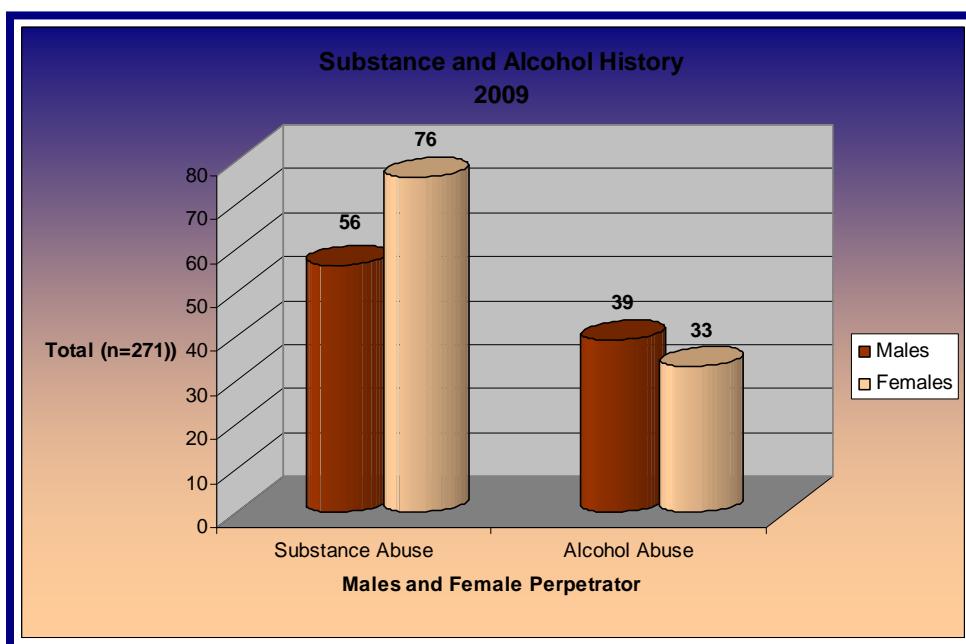
Substance abuse by the parent or caregiver continues to be one of the highest risk factors for child fatality. Successful intervention efforts are based first, on the accurate identification of an alcohol or drug problem and second, on the ability of the investigator, case manager and court system to engage and support the user in treatment. Unfortunately, the State Committee continues to see a pattern where substance abuse by the parent or person responsible for the child was documented in prior reports or substances were discovered in the home at the time of the child's death but no on scene presumptive drug testing occurred as part of the child protective or law enforcement investigation protocol. Under-recognition of substance abuse is further evidenced in child deaths when substance abuse related maltreatment allegations are not fully addressed.

Substance abuse indicators are also not appropriately factored into risk assessment and case planning. Frequently, these families are not referred for services or are referred to voluntary services with a large number of parents refusing further assistance once the child protective investigation is closed. As acknowledged in last year's report, the State Committee recognizes that the Florida Appellate Courts have clearly put the burden of proof on the Department for demonstrating a nexus of harm between a parent's drug use and the documented harm to the child, but this challenge should not be the guiding factor when making determinations for child safety.

The graph below shows the substance abuse history identified by the State Committee by the causes of deaths.



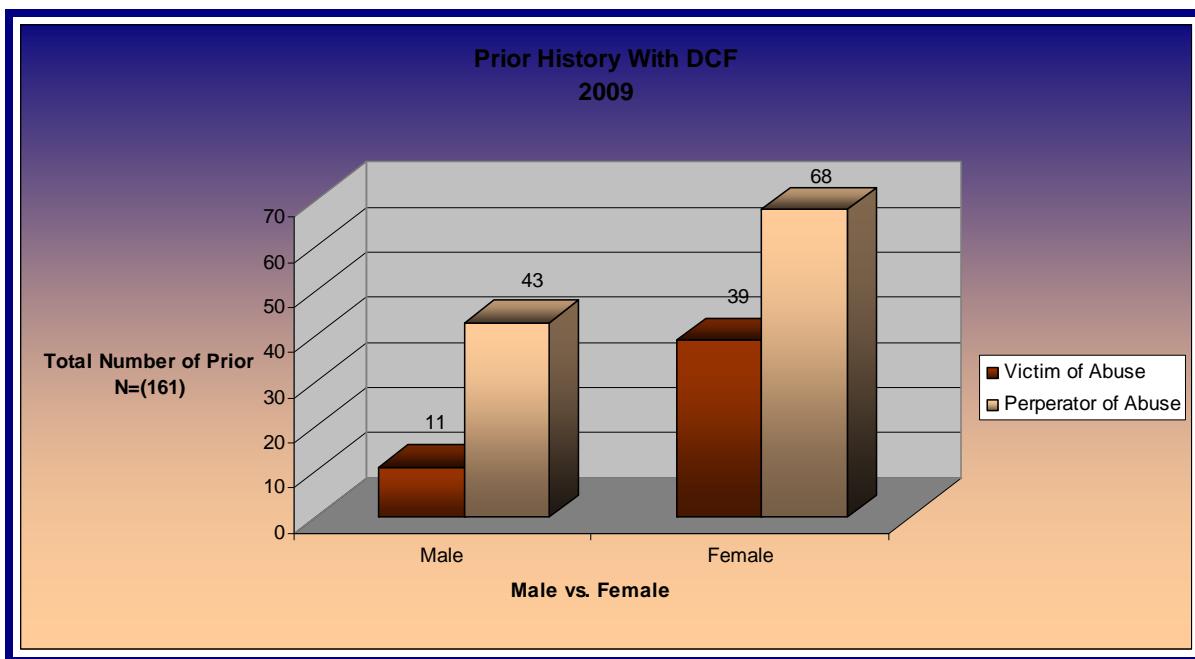
The State Committee identified the substance abuse history by gender of the perpetrator shown in the graph below. There were more females that had drug abuse history than males. Females are more responsible for majority of the neglect cases. Some perpetrators have drug abuse history as well as alcohol abuse history.



DCF HISTORY

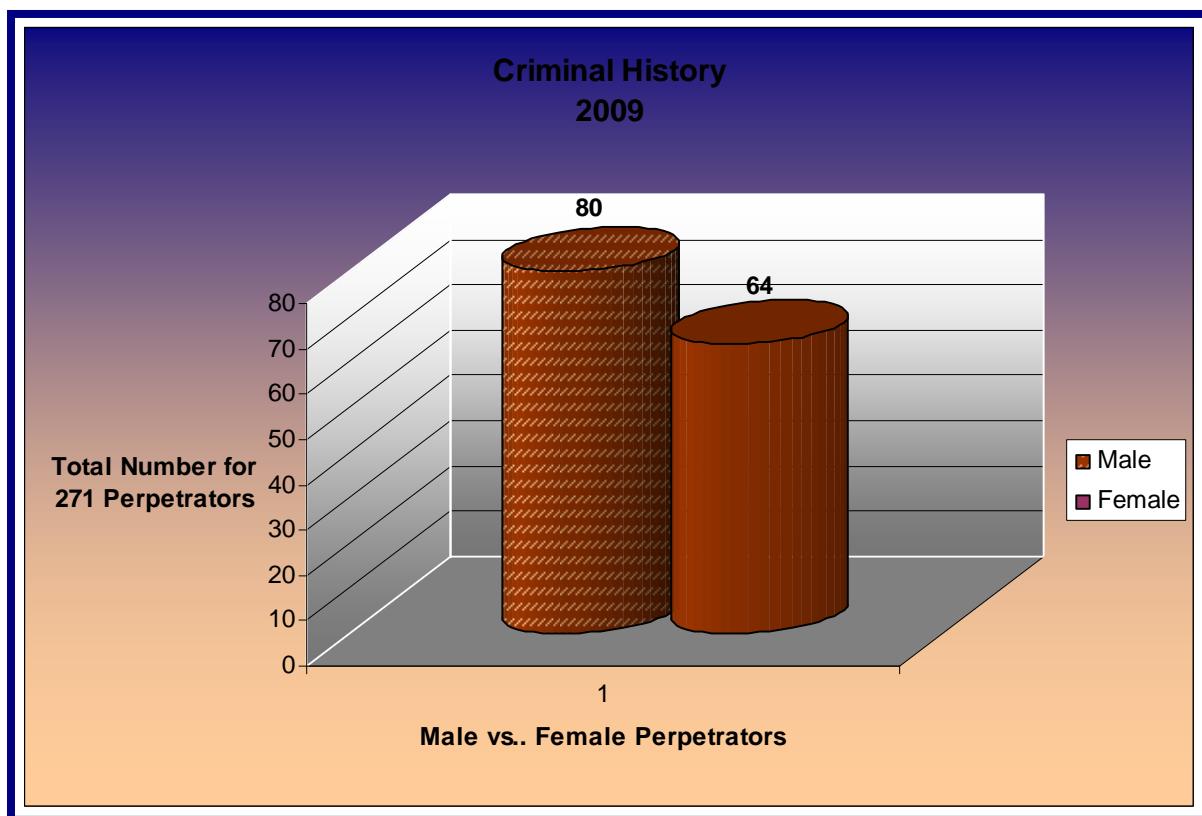
Caretakers who abuse or neglect children are most often acting upon beliefs and experiences from their own childhood. Many of the caretakers were victims of child abuse and neglect. Research suggests that about one-third of all individuals who are maltreated as children will subject their children to maltreatment, further contributing to the cycle of abuse. The State Committee often finds that this risk factor is not considered thus missing opportunities to intervene with appropriate services. The graph shown below represents the total Prior History with DCF.

The graph below represents the type of history the perpetrators had with DCF.



CRIMINAL HISTORY

The best predictor of future behavior is past behavior. It is important that investigators look and take into consideration the criminal history of the caretakers, when the history involves violent behavior and drug related offences. The graph below shows the total number of perpetrators by gender that had prior criminal history. Out of the 271 perpetrators, 144 (53%) had criminal histories.



DOMESTIC VIOLENCE

Child abuse and domestic violence are closely related. Fifteen and a half million children in the United States live in families in which partner violence occurred at least once in the past year, and seven million children live in families in which severe partner violence occurred. (1) Slightly more than half of female victims of intimate partner violence live in households with children under twelve. (2). In homes where partner abuse occurs, children are 6-15 times more likely to be abused¹⁷. According the Florida Governor's Task Force on Domestic and Sexual Violence, Florida Mortality Project, 27% of domestic homicide victims were children¹. It is incorrect to assume that children are in less danger once couples separate. In fact, the opposite is often true. Therefore, if we are to reduce child deaths at the hands of perpetrators, it is critical that systems improve their mechanisms for holding batterers accountable for the violence they commit¹⁶.

Agencies working with children of domestic violence survivors should participate in ongoing training about perpetrator's coercive control, safety planning tools and services provided by Florida's certified domestic violence centers. There are 42 certified domestic violence centers in the state of Florida and each center provides core services including but not limited to: information and referral services; counseling and case management services; temporary emergency shelter; 24-hour crisis hotline; assessment and appropriate referral of resident children; educational services for community awareness relative to the incidence of domestic violence and the prevention of such violence; and safety planning and lethality assessments.

It is also important that Child Protective Investigators attend workshops that focus on survivor strengths and actions they take to promote the safety of their children. A successful partnership with the non-offending parent is one of the best ways to keep the children safe. Experts in the field of domestic violence have long considered Batterers Intervention Programs (BIP) to be best equipped to handle the needs of batterers. The State Committee has noted that in several cases anger management programs were sometimes referred by Child Protection in place of Batterer's Intervention. Anger management programs do not meet the needs of batterers and their families.

The Department of Children and Families has reported that of the batterers that are exited from BIP for non-compliance, 79% of those were non-compliant for non participation. According to The Family Violence Prevention Fund statistics, "Many abusive men are concerned about the effect of violence on their children and the children of their partners. Some may be motivated to stop using violence if they understand the devastating effects on their children." (3)Therefore to ensure the safety of children it is imperative that we engage fathers in changing their behavior to promote the safety and well being of the children in their homes.

Children can be exposed to domestic violence by:

- o Directly witnessing or forced to participation in assaults/homicides
- o Hearing the violence, (i.e. name calling, intimidation, and threats)

- Feeling the tension in the home
- Seeing the aftermath of the violence (i.e. broken furniture, bruises on their victim parent, or the offender being taken away by police)
- Intervening in the violence to protect the victim parent
- Being threatened by batterer
- Forced participation in relaying messages, keeping tabs on mother
- Being seriously injured or killed during an assault

Children may experience emotional, cognitive, behavioral, social and physical effects of abuse. These effects may include:

- Higher levels of aggression
- Lack of conflict resolution skills
- Hostility
- Disobedience
- Poor peer, sibling and social relationships

Despite the increased risk, not all child observers of domestic violence become batterers or victims of abuse. Children react to their environment in different ways. Children's responses are also impacted by age and gender.

Factors that influence children's response to domestic violence:

- Their interpretation of the violence
- Support within the family system
- Support outside of the family system

Continued public awareness and batterer accountability is important to prevent future homicides and child abuse fatalities.

The Florida Coalition of Domestic Violence (FCADV) has partnered with Healthy Families Florida (HFF) to develop, implement and evaluate a strength-based curriculum designed to prevent intimate partner violence by educating participants about healthy relationships.

The curriculum seeks to prevent intimate partner violence by increasing participants' knowledge and understanding of healthy relationships, increasing participants' self-awareness regarding the choices they have made in relationships, comparing values and belief systems to past and current behaviors and empowering participants to make healthy decisions for themselves and their children. The curriculum will include many interactive application exercises and activities that are primarily targeted toward the participant, although some activities may involve the participant's partner, if applicable and appropriate. As this is a generational, systemic issue, some of the prevention activities may involve the children in the home as well.

The development of this curriculum dovetails nicely into FCADV's 8-year strategic plan to address domestic violence. One of the goals of the plan is to integrate Intimate Partner Violence Prevention efforts into existing prevention efforts (such as child abuse prevention). By partnering with HFF, the FCADV is developing a curriculum that could potentially be replicated in other programs/prevention efforts.

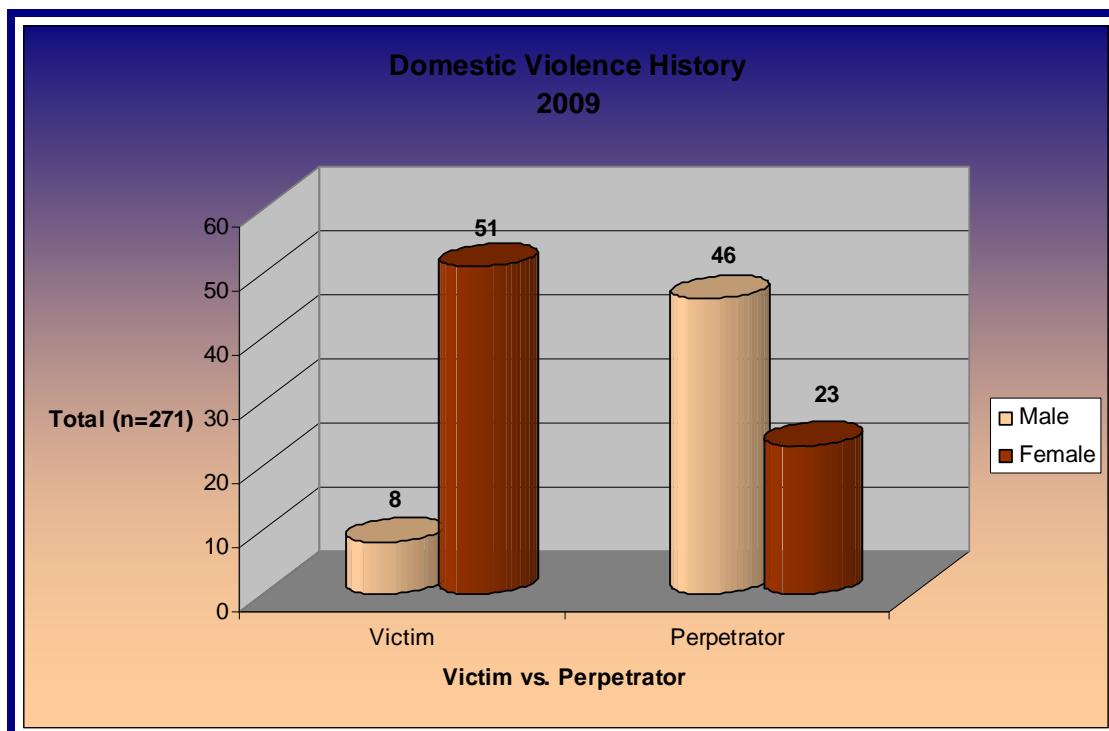
Florida Department of Law Enforcement reported that domestic violence accounted for 232 (19%) of the state's 1,186 homicides, including manslaughter in 2009. The state's 2009 Annual Uniform Crime Report showed significant reductions in every major category of crime but domestic violence. Overall, domestic violence represented 40.7% of all comparably reported violent crimes last year. Last year 232 people were killed by someone they once trusted, someone they once loved.

The Florida Department of Law Enforcement (FDLE) reflects a stunning 15.6% increase in domestic violence-related murders and a 71.4% increase in domestic violence manslaughters. The domestic violence-related murders account for one out of every five murders statewide. Additionally, the FDLE report highlighted an increase of almost 32% in stalking, a typical precursor to homicide. More than 116,500 individuals reported a domestic violence crime during the past calendar year. . Last year, Florida's 42 certified domestic violence centers were forced to turn away more than 7,100 survivors and their children in need of emergency shelter due to a lack of beds, and hundreds more had to be sheltered at hotels.

Of the 271 perpetrators identified in the 192 cases reviewed by the State Committee:

- 69 (36%) of perpetrators had history of being a perpetrator of domestic violence
- 59 (31%) had been victims of domestic violence, 51(27%) of those were women. Of the 192 cases 14 (7%) had an increase in frequency just prior to the child's death.

The graph below breaks down the domestic violence history by victim, perpetrator and gender.



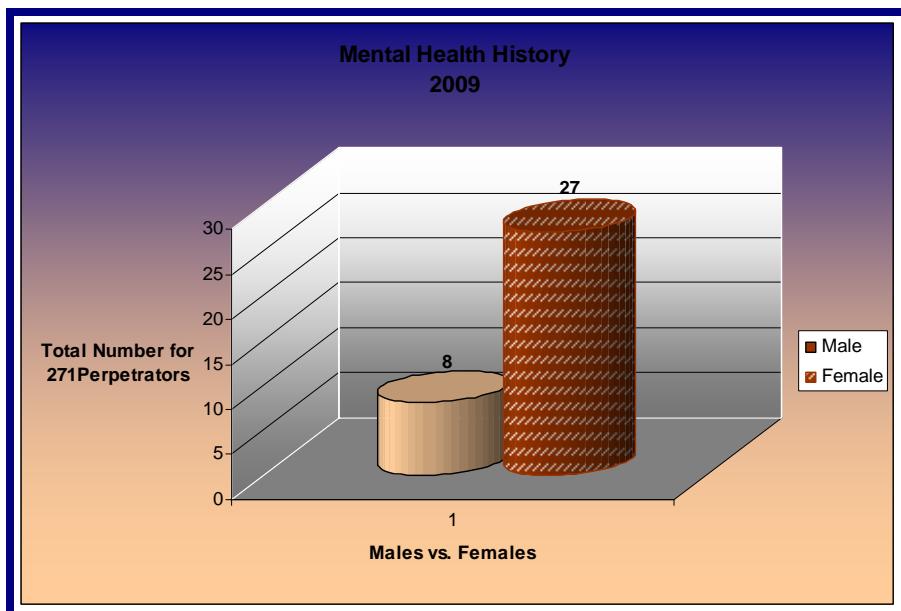
MENTAL HEALTH

Mental Health records continue to be critical sources of information when assessing child safety, and essential to the review process when a child has died from abuse or neglect. While mental health issues are not strongly correlated with child abuse, the State Committee recognizes the need to assure that mental health history is incorporated in the overall risk assessment process when indicators are present at the time of an abuse report. Community mental health providers are often reluctant to release information to child abuse death review committees. However, these records often contain essential information that helps to better understand the dynamics and circumstances related to the death of a child.

Not all people with mental health conditions put their children at risk; however, individuals who are non-compliant with treatment have chronic mental disorders that are difficult to manage, or are uncooperative with treatment providers and family members, potentially place children at higher risk. Often co-morbid with mental health conditions are substance abuse issues, which also must be addressed.

Child protection workers must include mental health and substance abuse professionals in the risk assessment and case planning process to build the best possible safety plan and service delivery for the individual and their children. Access to competent mental health professionals who are familiar with the child protection system and its nuances is vital to protecting children.

The graph below shows the total number of perpetrators (35) with mental health history by gender.



Child Protective Investigators must make every effort to access mental health records and consider them in the over-all risk assessment, including seeking judicial intervention if necessary.

Community Mental Health providers should be participants and members of the local child abuse death review committees and assist with guiding recommendations to provide better interventions in child abuse cases where mental health factors are involved.

Child Protective Investigators must have mental health experts available for consultation and receive training on mental health conditions, medications, and risk to children.

MANNER OF DEATH

The state of Florida accepts five possible manners of death (natural, homicide, suicide, accidental and undetermined). In many cases of natural death, the patient's treating physician prepares the death certificate. However, Florida State Statute 406.11 specifies certain types of deaths and circumstances fall under the jurisdiction of the District Medical Examiner. Such deaths include those due to trauma or accident, deaths occurring under suspicious or unusual circumstances and cases of sudden, unexplained deaths of individuals in apparent good health. Therefore, any death of a child in the state of Florida that is suspected to be related to accident, abuse or neglect, as well as the sudden death of a child who did not have a previously diagnosed potentially terminal disease, is by statute to be investigated by Medical Examiner's Office.

It is the responsibility of the medical examiner to certify the cause and manner of death of a decedent. 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 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.

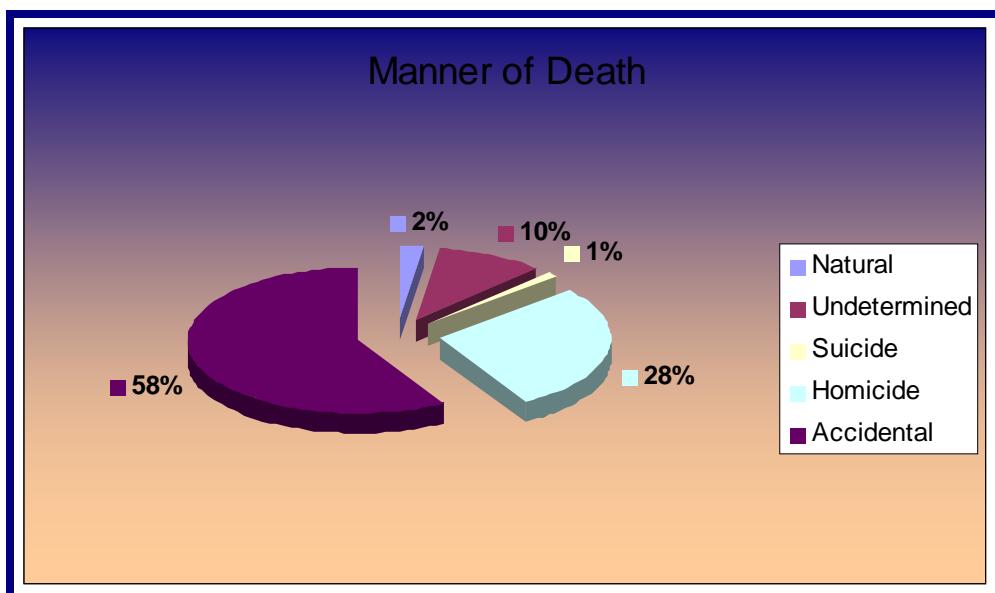
The cause and/or manner of an individual's death are certified as 'undetermined' if the death is unexplained by postmortem examination, laboratory studies, scene investigation and medical history. A certification of a death as 'undetermined' most frequently results when insufficient information is available 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.

Note: In eight cases the State Committee was unable to concur with the cause and/or manner of death as determined by the certifying medical examiner. These included 4 that the State Committee felt should be classified as homicides, 2 accidents, 1 undetermined and 1 that was believed to be either an accident or a homicide. It was not clear to the State Committee whether their questions pertaining to the medical examiners' conclusions were the result of additional information being available to the medical examiners and investigating law enforcement agencies that was not available to the State Committee.

The State Committee reviewed 192 child abuse and neglect deaths, which were classified as follows:

- 112 (58%) Accidental
- 54 (28%) Homicides
 - 39(20%) were 5 and under
- 20 (11%) Undetermined
- 4 (.2%) Natural
- 2 (.1%) Suicide



DROWNING

Often drowning deaths are not reported as neglect. It is felt that “the family has suffered enough”, or “it’s just a tragic accident.” While the drowning death of any child creates great suffering and is tragic, these deaths are often preventable and are due to a lack of or lapse in supervision and inadequate pool safety features.

Supervision is defined as a responsible adult, who is not under the influence of drugs or alcohol, is proximate to the child and has continuous view (eyes on) of the child. According to caregivers, most child drowning victims were missing from sight for less than five minutes. However, the State Committee has noted that when there has been a thorough investigation, the time the child is last seen is often longer than reported by the caregivers.

A lapse in supervision can occur for many reasons – washing dishes, answering the phone, using the bathroom, tweeting, using the computer, tending to other children, etc. Layers of protection (pool safety features such as pool fencing, functioning locks and alarms and other barriers) can help guard against such moments; however there is no substitute for adult supervision. The Florida Department of Health, National Drowning Prevention Alliance, Safe Kids USA and many other child safety organizations urge communities to prevent these tragedies by enacting and enforcing strict swimming pool barrier codes and by educating parents and pool owners to use multiple layers of protection to prevent--or at least delay--a toddler's unsupervised access to a swimming pool or spa.

The American Academy of Pediatrics (AAP) urges parents to consider swimming lessons for most children between ages 1 and 4, in new guidelines on drowning prevention and water safety. The guidance is a change from previous recommendations. Previously, the AAP discouraged swimming lessons for this age group, noting a lack of evidence on whether these children were developmentally ready. The new guidelines, however, do not extend to all children under 4. The AAP still does not recommend swimming lessons before age 1, and says children with motor or cognitive disabilities may not be ready for swimming lessons until a later age. The updated policy also outlines the danger of body entrapment and hair entanglement in a pool or spa drain. Special drain covers and other devices that release the pressure in a drain can prevent such incidents.

For additional information: <http://www.aap.org/advocacy/releases/may2410studies.htm>

In Florida, bathtub drownings made up 13 percent of the childhood drowning deaths for 2009. The State Committee reviewed eight bathtub drowning cases this year. These deaths are preventable through continuous and capable supervision by an adult caregiver. Bathtub drowning deaths should always be investigated to determine if the child’s death was due to caretaker neglect.

The State Committee has identified two common themes in bathtub deaths. First, parents appear to have a false sense of security when placing more than one child in the bathtub, believing the other children will be able to protect younger siblings. Second, parents believe that once a child reaches an age where they can sit up on their own, they can be left in the

bathtub unattended. However, regardless of age, a child might not be developmentally capable of being safe in a bathtub unsupervised.

The State Committee did not have the opportunity to review the deaths of all children who drowned due to inconsistencies in reporting of child drowning deaths by law enforcement and other first responders. In addition, inconsistencies in the verification of neglect by the Department of Children and Families or Sheriff's Department child protective investigators contributed to the cases not meeting the requirements for review by the State Committee.

In cases reviewed by the State Committee there often was a lack of thorough death scene investigation by responsible agencies. Investigators failed to explore or ask for drug testing when there was: a family history of substance abuse, drug paraphernalia at the scene, or suspicion of drug abuse at the time of the child's death. This resulted in missed opportunities to establish whether or not neglect had occurred as a result of the caregiver's substance use.

Local communities also recognize the critical need to implement public awareness campaigns; such as the initiative "Project Get Alarmed", a project of the Drowning Prevention Initiative of Broward County Health Department, is a multi faced project that includes barriers to water hazards (i.e.: alarms), water safety lessons and CPR training to families considered "at risk" in Broward County. It is anticipated that the services offered by the project will result in a decrease of calls to EMS and significantly reduce the number of fatal drowning and non fatal near drowning in Broward County. The Drowning Prevention Initiative (DPI) in partnership with Broward Sheriff's Office (BSO) Fire Rescue provides training of Fire Rescue personnel county-wide on the survey process; and information on home safety resources that are available in our community to persons considered "at risk."

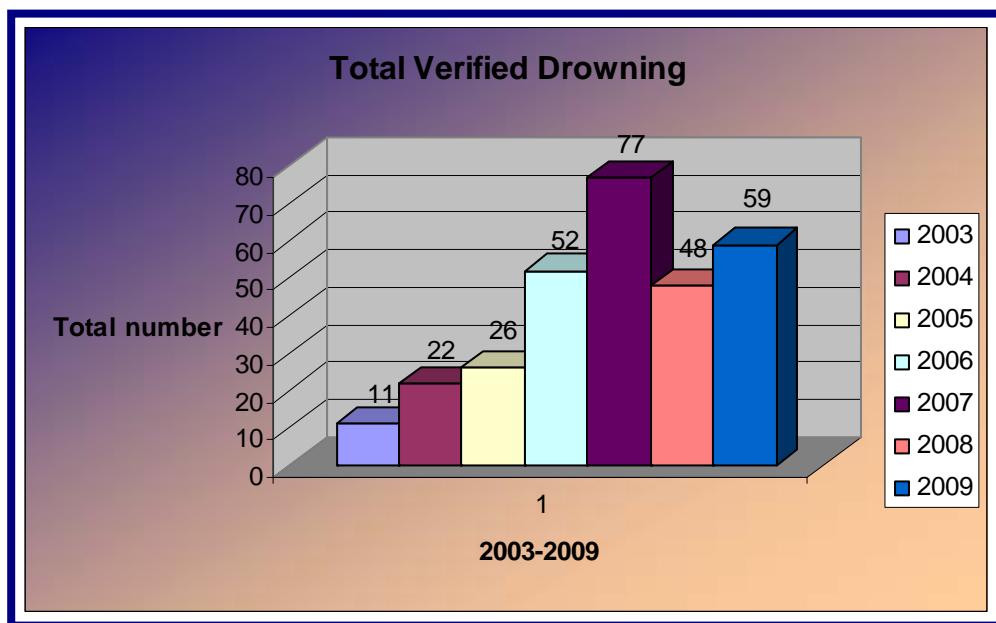
One trend depicts a correlation between drowning and child abuse/neglect. In a review of all investigated drowning deaths from Jan 01, 2006-March 30, 2009, almost 70% of the families of children that had drowned had a prior criminal, domestic violence, drug, abuse/neglect, etc. charge in their past. Of the homes investigated, the majority of pools at homes where there was a drowning were "green" (dirty, not chemically treated and murky) and in poor repair. Ninety percent of the children that had drowned went out a door without any one noticing they had left. None of the children had had water safety lessons. More than 50% of the families reported that they had never taken CPR training and not one home had rescue equipment on hand, near the pool. The Broward County Death Review Committee reviewed every case CPIS had investigated and noted that every case had a varying degree of neglect and every case was preventable.

CPIS Investigators complete a water safety survey for every family that they investigate that has children under the age of nine, as part of the Drowning Prevention Initiative in Broward County. During the survey the CPIS investigator discusses the importance of water/pool safety. If a family agrees and signs the survey form, Fire Rescue in their city will come into their home and provide an in home safety evaluation and plan for the family. Part of the safety plan that is developed by Fire Rescue is to install door alarms leading to a water hazard.

The Department of Health's Office of Injury Prevention, in collaboration with Ron Sachs Advertising, launched the **WaterproofFL** - "Pool safety is everyone's responsibility" campaign this past summer and fall. The campaign emphasizes: Supervision, Barriers and Emergency Preparedness. The campaign can be

access on the new website: <http://www.waterprooffl.com>. The website has downloadable materials, and a 10-minute video- <http://www.youtube.com/watch?v=VMjEwGGXDkg> A Satellite Broadcast and webinar is scheduled in March 2011. This new campaign can be used statewide by many partners and follows national recommendations for pool safety-layers of protection

The graph below shows by year the total number of drowning deaths reviewed by the State Committee.



Bathtub drowning *Samatha*

Aunt, age 26, filled the bathtub 6-10 inches and placed Samantha, age 18 months, and her 3 year old in the tub. She went to answer the phone and stated she was only gone 5 minutes. A neighbor noted the computer was on when she went into the home but noticed when EMS arrived it was shut off. She was charged with culpable manslaughter, pled guilty and was jailed for 1 year and 1 day. She had neither history with DCF nor any Criminal history.

Key Findings

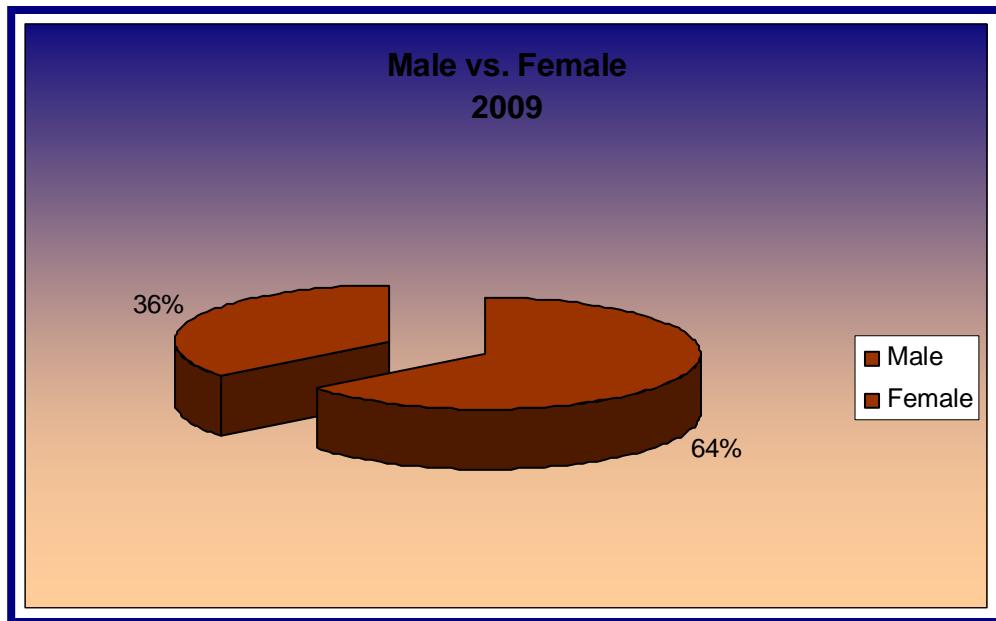
Inadequate supervision was found in all drowning deaths
Of the 59 drowning cases reviewed:

Age

- 43 (73%) were 2 and under
- 53 (90%) were 5 and under
 - 8 children were noted to have autism, down syndrome, or some disability

Gender

- 38 (64%) were males
- 21 (36%) were females



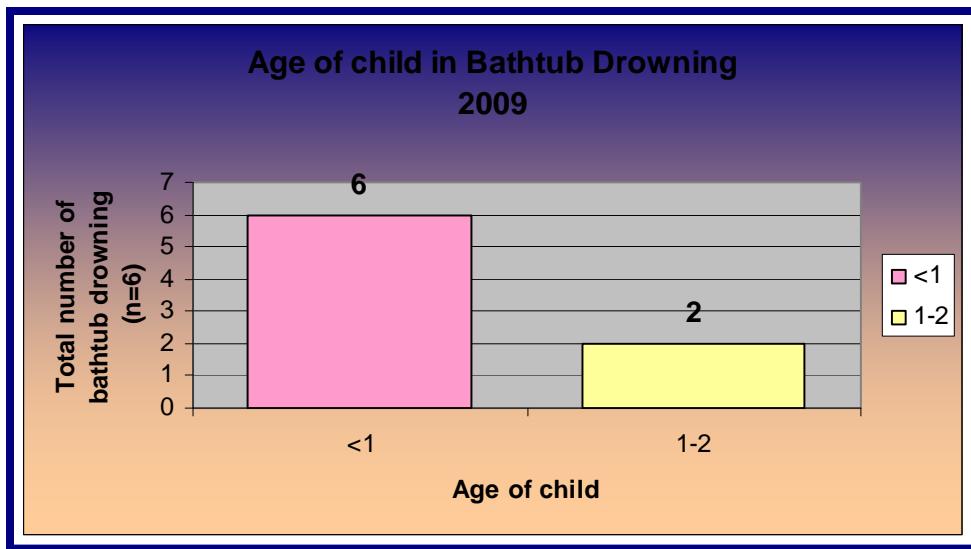
Race

- 26 (44%) were white
- 13 (22%) was black
- 11 (19%) were Hispanic
- 5 (8%) were Haitian
- 3 (5%) were multi-racial
- 1 (2%) was Asian

Eight (13.5%) children drowned in a bathtub. Of the bathtub drowning deaths:

- The age range was from 4 months to 18 months
 - 6 of the children were males and 2 children were females
 - 4 of the children were left unsupervised with other siblings/cousin in the tub- two children were age 2 and one was 3 years of age
- 4 were white
- 2 were Hispanic
- 1 was black
- 1 was Asian

The graph below shows the age of child in bathtub drowning



Bathtub drowning perpetrator related factors

- 6 Mothers were responsible
- 1 father was responsible
- 1 Aunt was responsible
 - 1 Female non-relative was responsible

Bathtub drowning perpetrator risk factors

- 3 perpetrators had substance abuse history
- 4 drug tests were requested:
 - One was the day after death
 - Two were requested on the day of death. One tested negative and in the other, the mother refused that day; however, when tested the next day was positive for THC
 - In the fourth, the mother admitted to abusing several prescription medications and no test was administered

5 of the perpetrators were charged. Of those the State Attorney declined or not prosecuted the cases

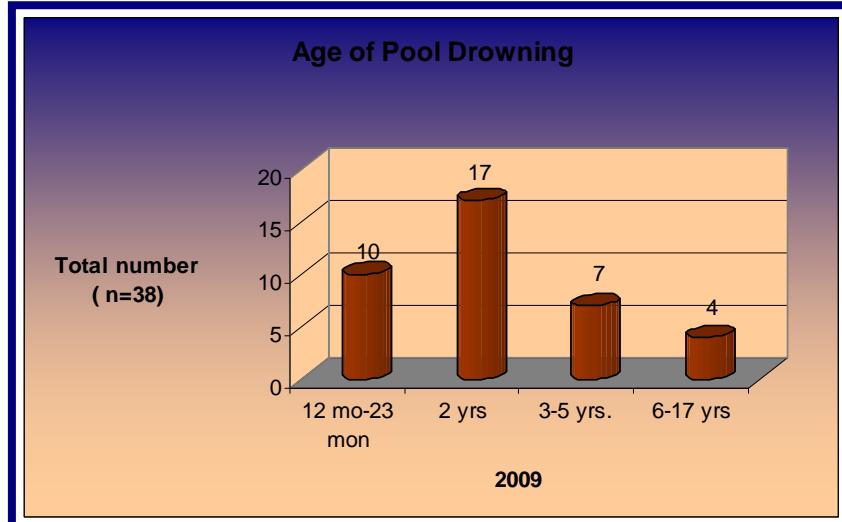
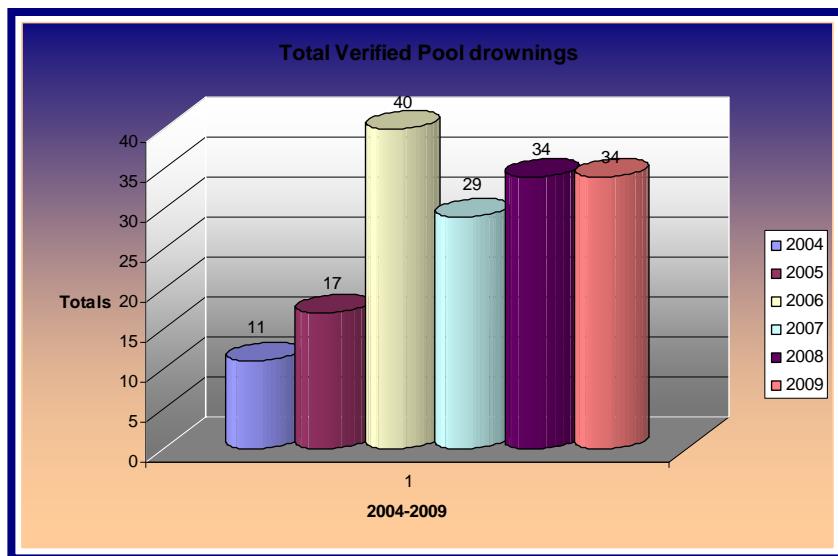
The graph below shows the total verified pool drownings from 2004 – 2009

- 38 (64%) children drowned in a swimming pool.
 - 25 (66%) were males
 - 13 (34%) were females

Ages ranged from 11 month to 7 years

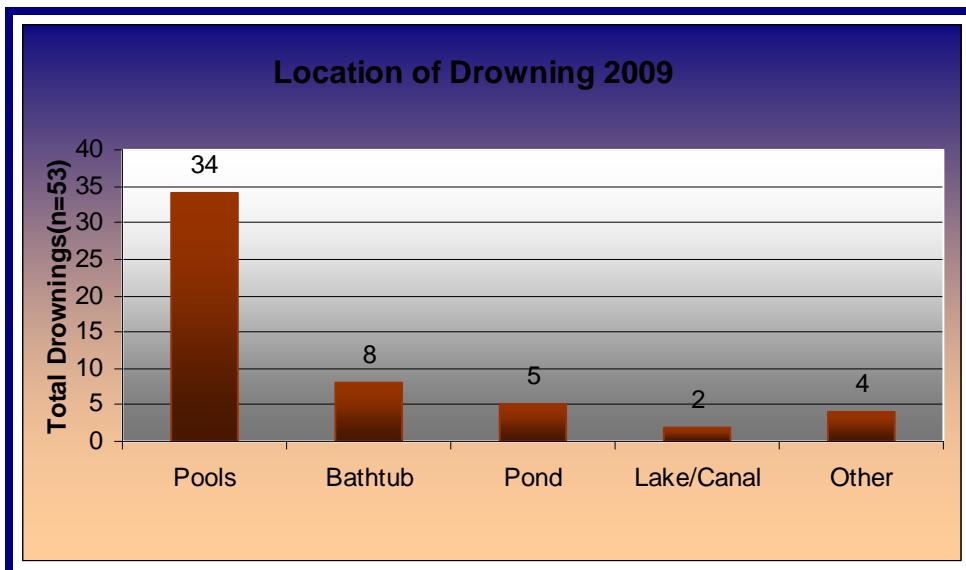
- 10 (26%) children were between the ages of 12 months to 23 months
- 17 (45%) children were 2 years old
- 7 (18%) children were between the ages of 3-5
- 4 (11%) children died between the ages of 6-17
- **34 (89%) were age 5 and younger**

All were supposed to be supervised by either parents or a relative with the exception of one who was being supervised by a babysitter.



Location of drowning

- 5 children drowned in a pond/retention pond
- 2 child drowned in a canal/lake
- 2 children died in wadding/inflatable pool
- 1 child drown in a bucket
- 1 child drown in a ditch
- 1 child drown in a Jacuzzi
- 1 child drown in a septic tank



Perpetrator Factors

There were 72 total perpetrators identified. Of those:

- 30 (50%) were mothers
- 26 (27%) were fathers
- 9 (16%) were relatives
- 4 (3%) were non relatives
- 2 (2%) was a nanny/sitter
- 1 (2%) was a female paramour

Age of Perpetrators/Caretakers (72)

- 6 (8%) caregivers were between ages of 16-19.
- 21 (29%) caregivers were between ages of 20-29
- 26 (36%)caregivers were between ages of 30-39
- 12 (17%)caregivers were between ages of 40-49
- 5 (7%)caregivers were between ages of 50-59
- 3 (4%)caregivers were between ages of 60-68

- 47 (65%) caregivers were between the ages of 20 – 39.
- 20 (28%) caregivers were ages 40 and older

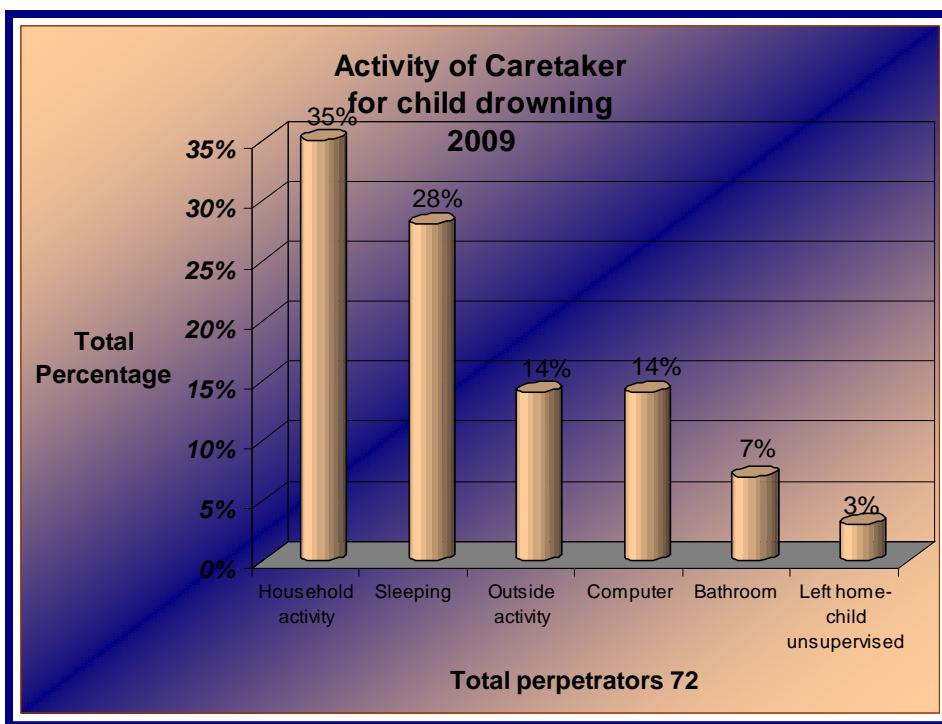
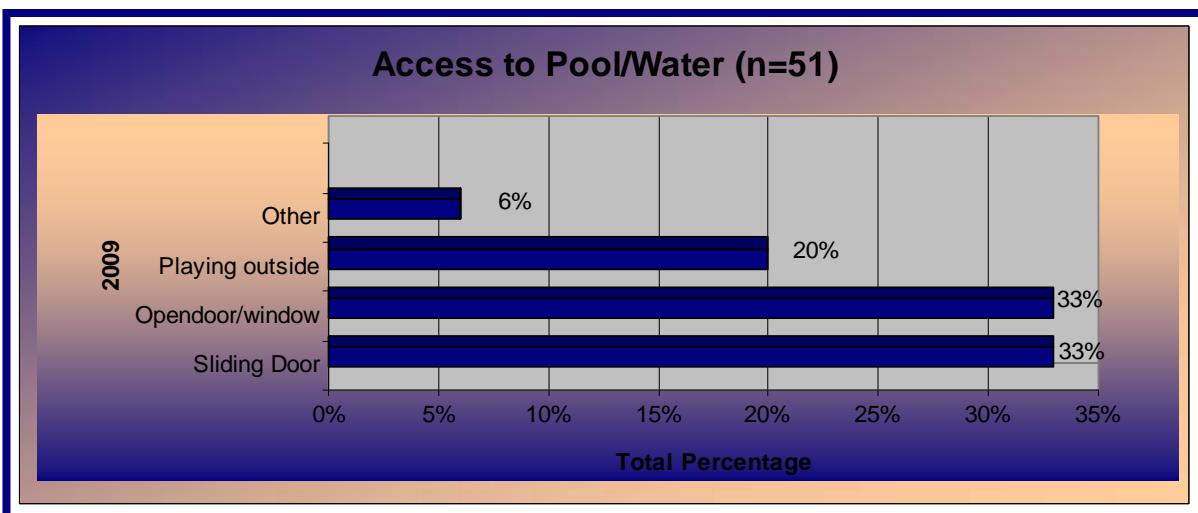
Gender of Perpetrators

- 42(58%) were Females
- 30 (42%) were Males

Drowning Perpetrator risk factors

- 25 of the caretakers had no history of substance abuse
 - 5 were asked to submit to a drug test
 - 2 tested positive for THC/prescription medications
 - 2 tested negative
 - 1 refused drug test
- 25 of the caretakers had a history of Substance abuse
 - 13 were asked to submit to a drug test
 - 7 of the request were on day of death
 - 6 tested positive for drugs
 - 1 refused to submit to drug test
 - 4 were requested from 1 day to 3 months after the death
 - 2 tested positive for drugs
 - 1 negative(3months later)
 - 1 refused
- 1 caretakers substance abuse history was unknown
 - Drug test was requested 7 days after the death
 - No documentation for results

The Committee found trends in how the child gained access to the pool as well as the activity of the caretaker at the time of the incident, as shown in the graphs below. The sliding door or the door that leads directly to the pool is the kiss of death to children.



Pool Drowning
Amy

Amy, 2 ½ years, and her mother, age 28, and the Grandmother, age 55, were vacationing at a rental home on Marco Island. Amy was last seen in the kitchen with her Grandmother. There were 6 adults and 5 children at the rental all involved in some type of activity such as watching TV and an adult was napping. The door to the bathroom which led directly to the pool was not locked. There were no door alarms or any pool safety measures in place. A beach ball was noted to be in the pool. The length of time the child was missing was not determined.

PHYSICAL INJURY

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

Intentional physical injury has components that the State Committee found noteworthy to separate into three categories: Physical injury, Murder/suicide, and Abandoned newborns. This section will provide an analysis of the child deaths from these three categories and provide perpetrator risk factors discovered by the State Committee during the death reviews.

According to a study of Missouri abuse reports published in the journal of the American Academy of Pediatric in 2005, 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. Lack of a relationship or attachment to the child can cause a non-relative to become frustrated and irritated when there is a perceived problem with the child. Many unrelated males have little to no experience in parenting, yet they are often trusted to care for the child while the mother works. Some non-abusing mothers chose not to intervene in abusive situations for a myriad of reasons, some unknown, and allow the abuse to continue with no intervention. Children are supposed to learn everything they need to thrive in this world from their caretakers, however abusive caretakers provide the opposite of what children need. Instead of teaching and nurturing growth, they distort and destroy.

Recognizing the warning signs of abuse can save some children's lives. Medical studies have shown that a child with a bruise on the ear is at higher risk of becoming a fatality; the force that it takes to cause a bruise to the ear also can cause damage to a child's brain.

Several child abuse experts believe many deaths could be averted if people who come in contact with young children understood that bruises — especially to the face, ear and trunk —should be reported as signs of possible abuse. Health care professionals can play an important role in abuse prevention. Seen as credible sources for information, health care professionals can teach parents what to expect in their child's development, how to build a strong relationship with their child, and where to go for help if they need it.

Crying, toilet training and feeding are the most common triggers of physical abuse in young children. Additionally, the state committee identified common factors and characteristics that are present in the physical abuse deaths of these children. These factors include young males between the ages of 18-30 who are unemployed and often providing primary childcare while the biological mothers work. The fact that many of these males are unattached, non-biological fathers contributes to their inability to cope with crying and very often lack appropriate knowledge of child development and parenting skills. In addition, many of these perpetrators have histories of substance abuse, domestic violence, animal abuse or criminal history of aggressive or violent behavior.

In response to the numerous cases reviewed by the State Committee that involved physical abuse and neglect where the perpetrator was a non-biological caregiver, in most cases the boyfriend, Healthy Families Florida, in collaboration with the State Committee, recently reviewed and revised a brochure entitled "Who's Watching Your Child?" The brochure is designed to educate Healthy Families participants and other parents about carefully choosing an appropriate person to watch their children while they are away from home. The brochure which will be made available to the public via the CADR website provides a wealth of information about what steps a parent can take to ensure that their child is left in good hands, including a checklist of items to discuss with the babysitter prior to leaving the child.

The State Committee has found that a majority of the mothers, not responsible for the actual abuse but who may have been aware are not held accountable or charged criminally.

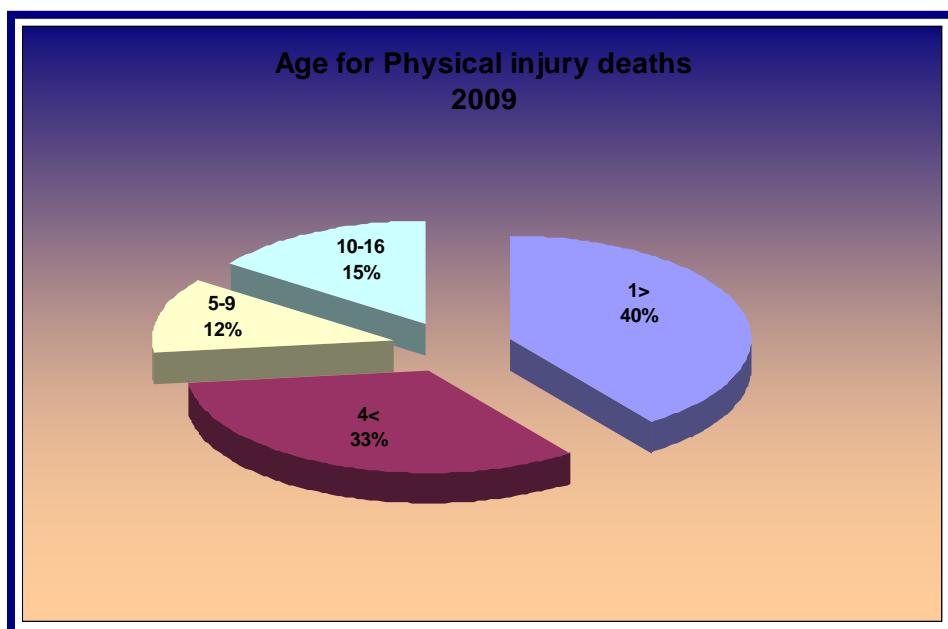
Key Findings

52 children died as a result of abusive injury

- 17 (33%) of the cases had prior DCF involvement
- 23 (44%) of the cases had prior DCF involvement with a household member
- 16 of the children had evidence of prior trauma at autopsy

Age of Child

- 38 (73%) of the children were 4 and younger
 - 21 (40%) of the children were under the age of one
 - 6 (12%) of the children were ages 5-9
 - 8 (15%) of the children were ages 10-16
- The graph below shows the age of the child at the time of injury



Gender of Child

- 28(53%) were males
- 24(46%) were females

Race of Child

- 21 (40%) were white
- 18 (35%) were black
- 7 (13%) were Hispanic
- 5 (10%) were Haitian
- 1 (2%) was Asian

Of the 52 children that died as a result of abusive injury:

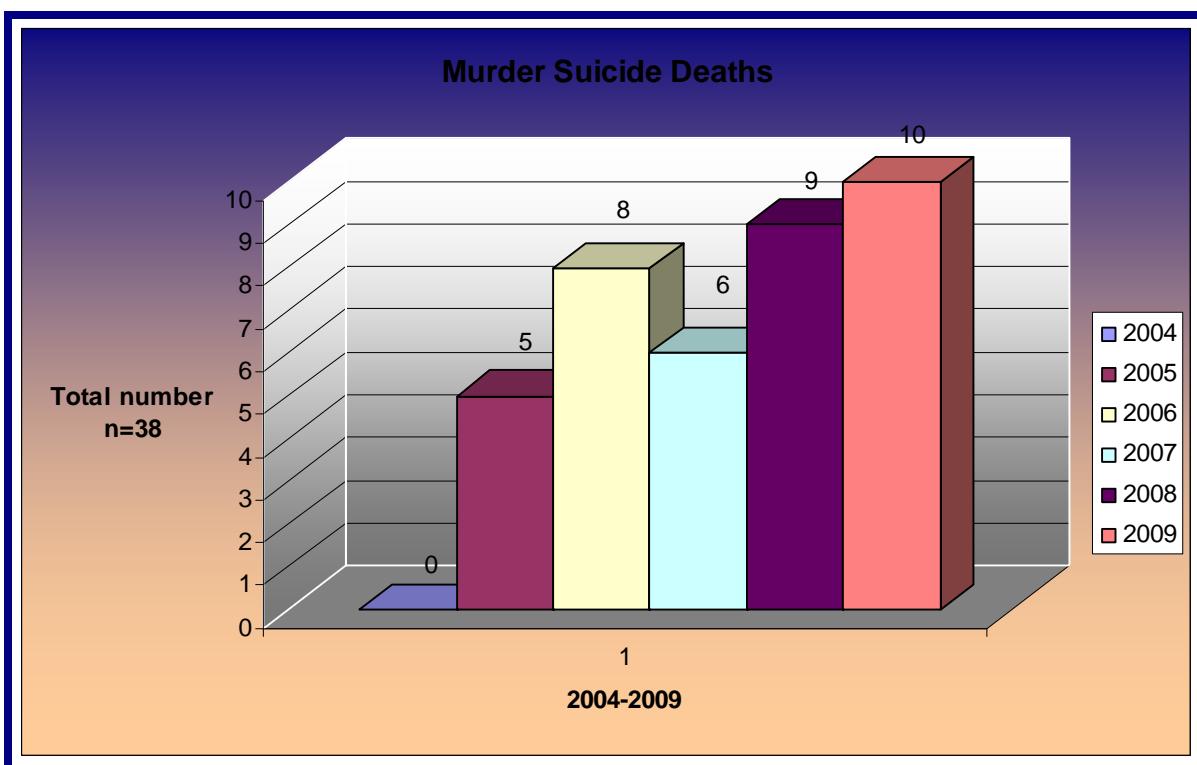
- 20 died as a result of head trauma
 - 2 children's deaths involved a sexual assault prior to injuries
- 7 died as a result of sharp force injuries
- 5 died as a result of multiple blunt trauma
 - 2 died as a result of head, trunk and failure to thrive
 - 1 died as a result of multiple trauma
 - 1 died as a result of blunt traumatic injuries and burns over 30% of body
 - 1 died as a result of head and torso trauma
- 3 died as a result of abdominal/torso trauma
- 2 died as a result of dehydration/malnutrition
- 2 died as a result of asphyxia/suffocation
- 1 was undetermined
- 10 died as a result of a Murder suicide
 - 9 children were killed by gunfire
 - 1 child was killed by manual asphyxia
- 2 children were abandoned newborns at birth

MURDER/SUICIDE

The murder/suicide deaths involve cases where the child(s) was intentionally murdered by their parent. The parent then took their own life or attempted to: hence the term murder/suicide. Although not necessarily predictors, domestic violence or mental health issues such as depression, schizophrenia, bi-polar disorder etc, were present in many cases.

The committee found that often in these types of deaths the case files did not contain the mental health records of the perpetrator even though family members identified that there was past or on going history of mental health concerns.

A domestic violence case should be considered “high risk” whenever a parent has threatened to harm their children regardless of whether the non-offending parent obtained an injunction for protection. In cases where the Department of Children and Families are involved DCF should be vigilant in monitoring the parties’ behavior and court actions to ensure an injunction is not violated or dissolved.



Key Findings

Of the 52 physical abuse deaths

- 10 children died as a result of a murder/suicide by the parent
 - 9 children were killed by gunfire
 - 1 child was killed by manual asphyxia

Perpetrator related factors

- 1 child was killed by the mother and she attempted to commit suicide
- 6 children (were siblings) were killed by their fathers
 - 4 mothers were also killed by the father

- o 2 the father attempted to other siblings but they escaped

Murder/suicide Perpetrator risk factors

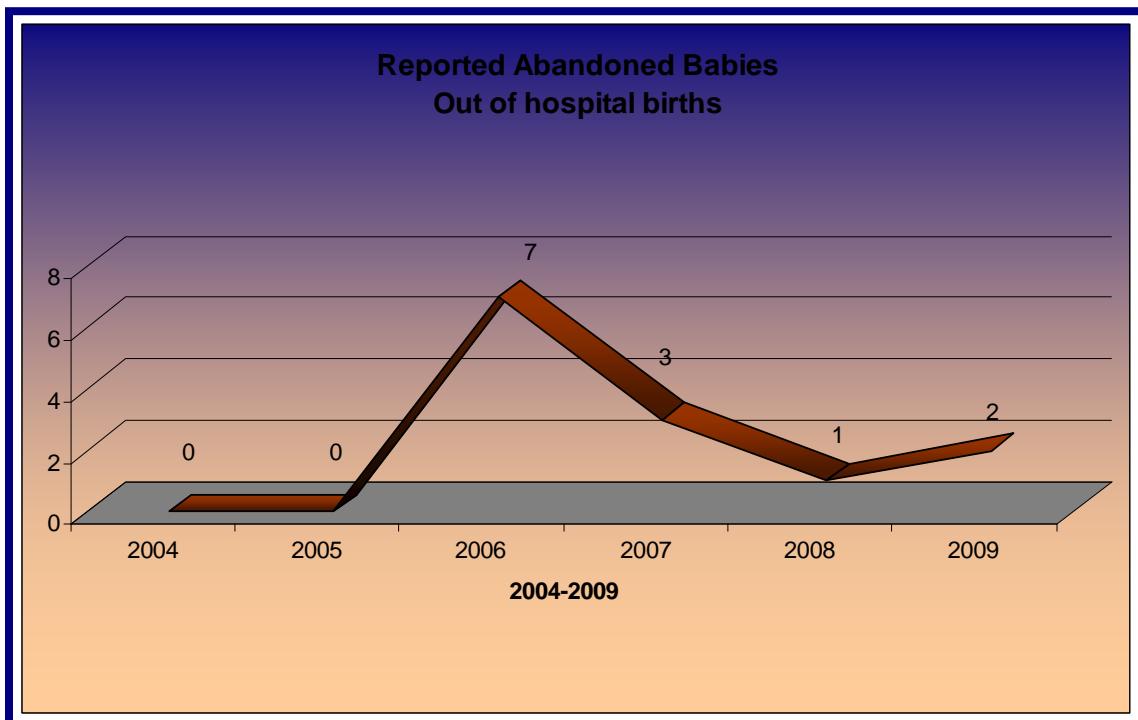
- 4 had substance abuse history
- 7 had issues relating mental health and/or depression
- 3 had issues of domestic violence history

Recent Stressors noted in the cases

- 3 had financial problems
- 2 had marital/relationship issues
- 1 had of sexual abuse allegations becoming public

ABANDONED NEWBORN/OUT OF HOSPITAL BIRTH

Baby abandonment is a tragedy that is happening in the United States - It does not have to happen. Hundreds of newborns likely die undiscovered every year after being abandoned by their mothers in trash dumpsters, unoccupied dwellings, alleys etc. Many deaths are unreported to the child abuse hotline, but statewide training has resulted in notable improvement in reporting and verification. A Safe Haven for Newborns began in response to the tragedy of infant abandonment in Florida. We see and read about abandoned babies all too often – it is heart breaking. The Safe haven law is a safety net for both the mother and the newborn infant. Instead of abandoning a newborn to an almost sure death, it allows mothers, fathers or whoever is in possession of an unharmed newborn, approximately seven days old or less, to leave them at a Safe Haven facility: Any Hospital, Staffed 24/7 Fire Rescue Station, or Staffed 24/7 Emergency Medical Service Station, with no questions asked, totally anonymous, free from fear of prosecution..... A compassionate approach which is saving lives. According to Nick Silverio, founder of a Safe Haven for newborns in Florida, their records for 2009 show that there were a total of: 3 abandoned newborns found in unsafe environments, 1 was found deceased and two were alive. They report that the incident of abandoned babies is less and less each year as more babies are being left at a Fire station or Hospital, as allowed for in the “Safe Haven Program” authorized by Florida State Statute: 383.50.



Key Findings

The State Committee reviewed two death cases where a newborn was abandoned by the mother immediately after birth.

- One was brought to the hospital in a garbage bag
- One was thrown out with the trash and the body never located

Perpetrator related factors

- Age 28 and 38
 - The one mother not identified as a perpetrator was 16
- Both hid and denied the pregnancy to family and friends
- Both there was no documentation as to whether they were aware of the Safe Haven Law
- One was charged with murder and pled to aggravated manslaughter
- The other the Grandmother who induced the pregnancy was charged with unlawful termination of a pregnancy, practicing medicine with out a license and other additional charges

Recommendations:

- A. Continued training for law enforcement and Department of Children and Families staff on mandatory reporting of these types of deaths.
- B. Provide continuing education on the Safe Haven Law, target family and friends who suspect pregnancy and the female denies.

Intentional Physical Injury Perpetrator Risk Factor

Of the 40 deaths attributed to intentional physical injury:

- The total perpetrators identified in the intentional physical injury was 41
- - One case involved both parents as the perpetrators
 - One case the perpetrator is undetermined
- 21 (53%) of the 40 cases had substance abuse history

Male Perpetrator related factors

- 36(90%) were caused by male perpetrators
 - 17 deaths were caused by the biological father
 - 1 also killed the mother of the five children

- 16 deaths were caused by a male paramour
- 2 deaths were caused by the step father
- 1 was caused by an uncle

Age of male Perpetrators

- 24 (66%) of the male perpetrators were between the ages of 19-29
- 10 (28%) of the male perpetrators were between ages of 30-39
- 2 (6%) of the male perpetrators were ages 41 and 51
- 26 (72%) of the male perpetrators had criminal history
- 16 (44%) of the male perpetrators had substance abuse history
- 25 (69%) of the male perpetrators had a domestic violence history (includes documented and undocumented)
- 19 (53%) of the male perpetrators were not employed
 - One was noted to deal drugs as a form of employment
 - Two had no documentation

**Murder suicide
*Jessie and James***

Father, 34 and mother 31 were having an argument over a bike. The father had been drinking. And the mother was attempting to leave with the children, ages 8 years 5 months. The father was on the couch, aimed a rifle and shot at the mother, killed the other 2 children. An older child who was in a bedroom ran out of the home and was able to escape as his father shot at him. The father then committed suicide. There was one documented domestic violent incident, the mother was the one charged, however a report was never called into the hotline. The father was seeing a therapist for depression and there were some possible financial issues. The father's criminal history was several years ago.

Female Perpetrator related factors

- 4(10%)deaths were caused by mothers

Age of female Perpetrator

- The ages were two age 20,21 and 25
- 3 had criminal history
- 3 had substance abuse history
- 2 had domestic violence history
- 3 were criminally charged with the death

Non-Offending caregiver/parent

Is defined as individuals who resided in the household and were not aware of the abuse

Secondary perpetrators (23)

Is defined as some one who “Fails to protect” which is defined as being aware that abuse was occurring but failing to take any action to prevent it. These individuals are caregivers who resided in the household or were aware of injuries and failed to protect.

Gender of Secondary Perpetrators

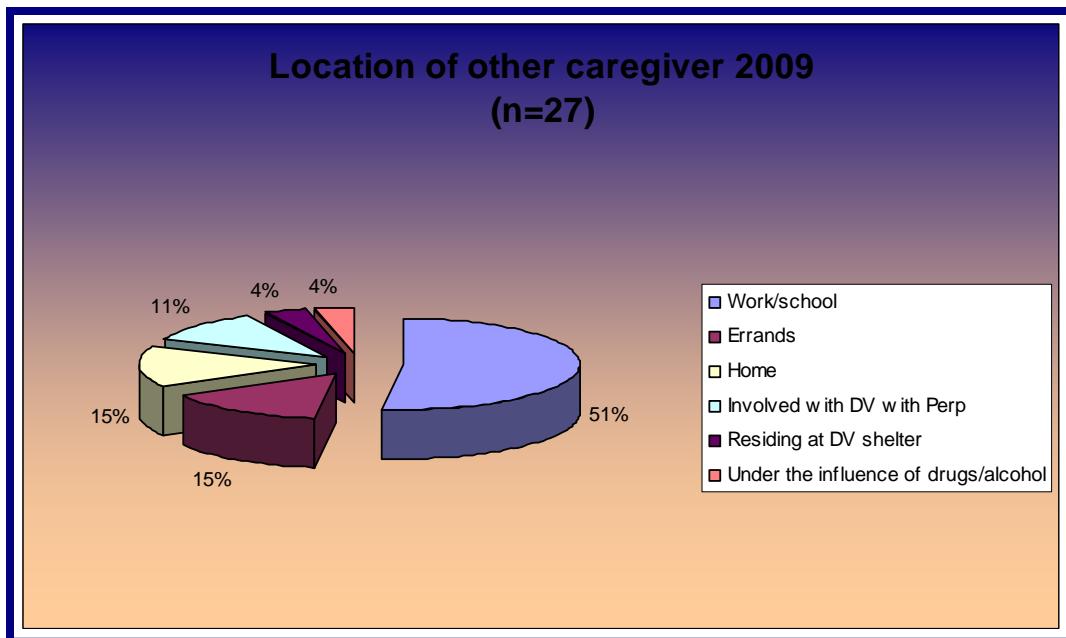
- All 23 were female
- 19 (83%) of the mothers, who were not the perpetrator, failed to protect their children
- 3 female paramours
- 1 aunt
- 4 of the female caretakers who failed to protect were criminally charged
 - One mother was killed

Age of Secondary Perpetrators

- 12 of the female caregivers who failed to protect were in 19-24
- 7 of the female caregivers who failed to protect were between the ages of 25-29
- 4 of the female caregivers who failed to protect were between the ages 30-38

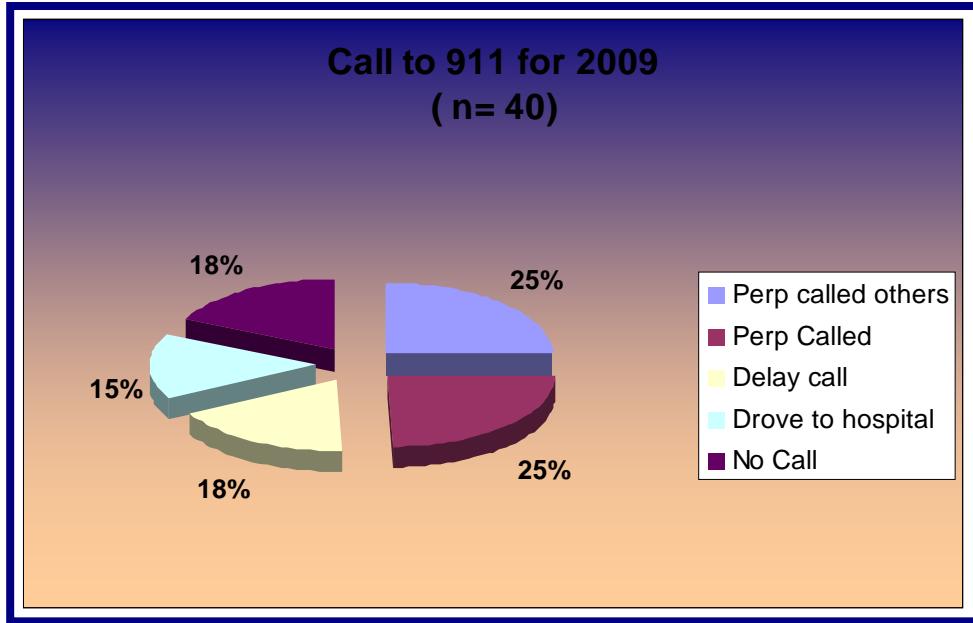
Location of non offending Caregiver/parent or secondary perpetrator:

- 14 of the caregivers were at work or school leaving male perpetrator as the caretaker
- 4 were running errands or with other people at time of injury
- 4 were home at the time of injury
- 1 was involved with drugs and or alcohol
- 3 were involved in a domestic violent altercation with perpetrator
 - One was killed
- 1 was residing at a domestic violent shelter



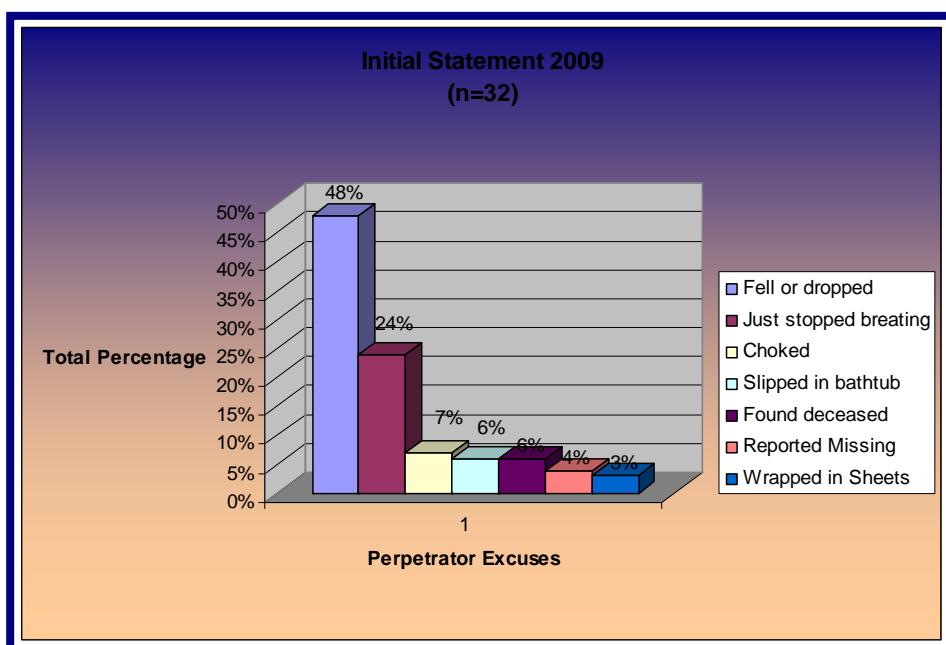
The Committee examined perpetrator responses in the physical injury deaths:

- 10 No call by the perpetrator but waited for others to call
 - 6 were to mothers who then called 911
 - 2 were to neighbors who then called 911
 - 2 were to Grandmothers who then called 911
- 10 Perpetrator called 911
- 7 Perpetrator delayed the to call 911
- 7 no call was made by the perpetrator
 - 2 of the perpetrator's killed the mother's
 - 1 the perpetrator was attempting to kill the mother
- 6 Drove the injured child to hospital
 - 3 perpetrators called mothers prior to driving to hospital



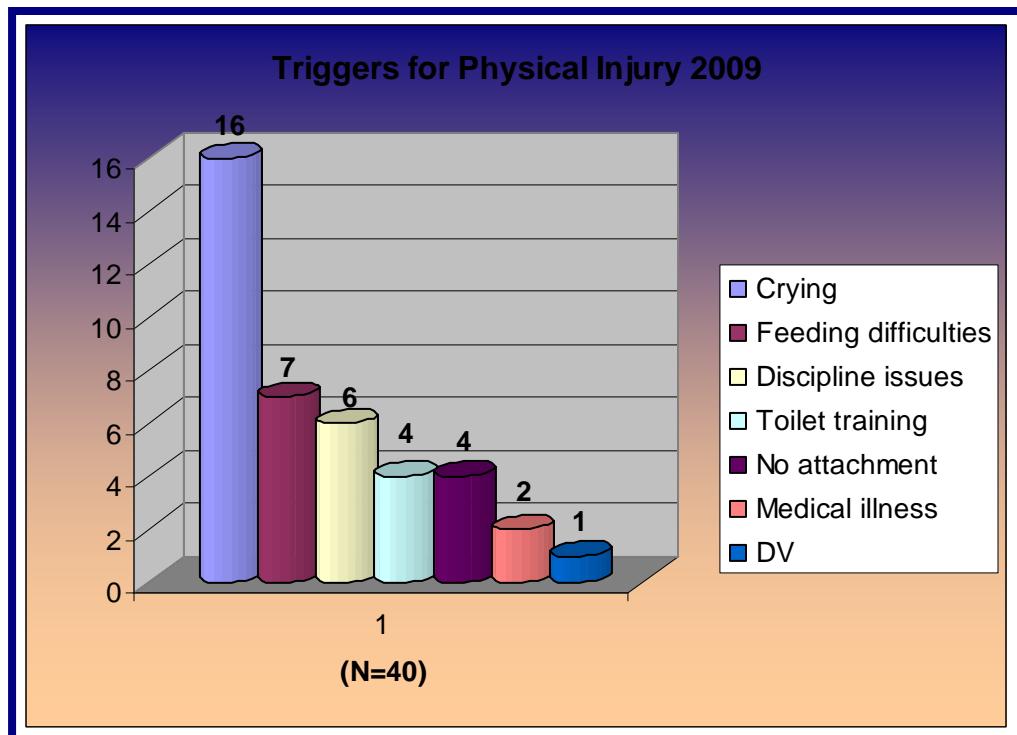
Perpetrator statements:

- 11 gave statements that the child fell or was dropped
- 15 gave an initial statement that the child “just” stopped breathing and/or was unresponsive and vomited
- 2 gave initial statements that the child was found dead in bed
- 1 gave initial statements that the child choked then stopped breathing
- 1 found wrapped in sheets not breathing
- 1 child reported missing
- 1 slipped in bathtub

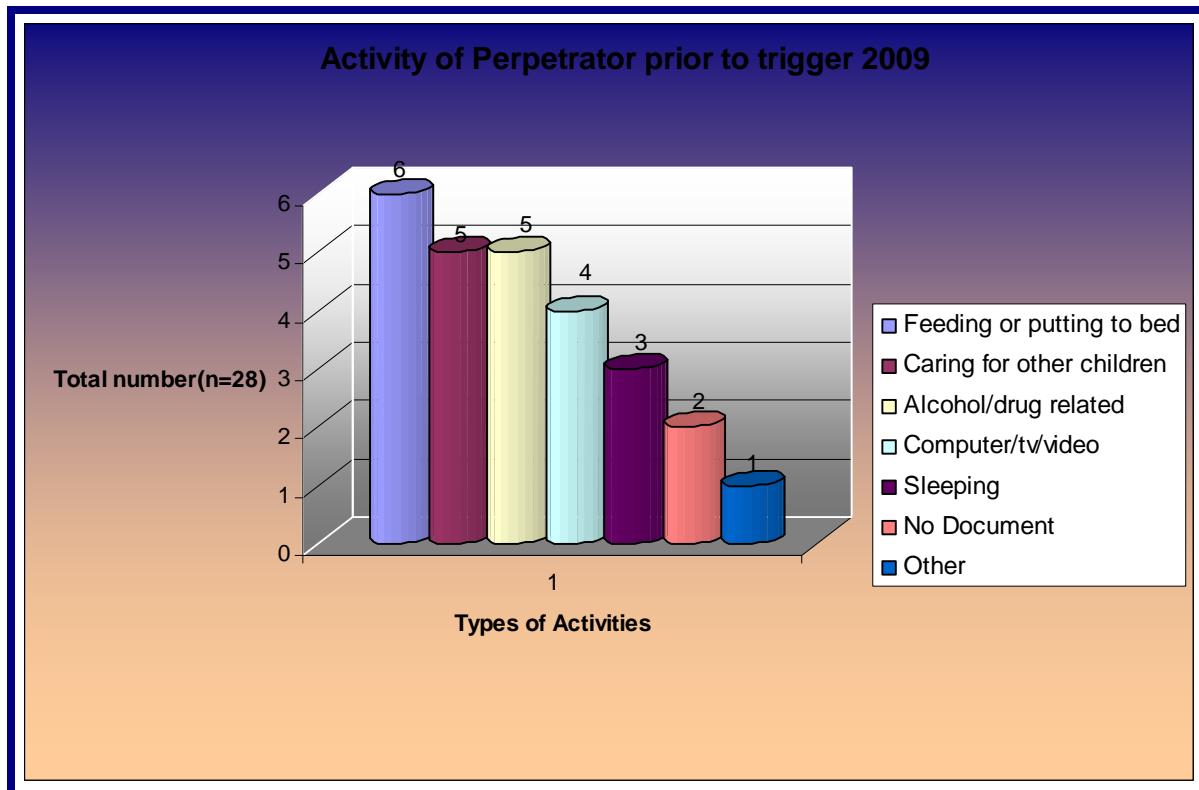


Trigger's (could be a combination of more than one)

- 16 had issues related to the child crying
- 1 engaged in domestic violence with the mother prior to her leaving child
- 2 had medical illness/disability
- 4 had no attachment to child
 - 1 had drugs/alcohol as a contributing factor
- 4 had issues with toilet training
- 6 had discipline issues
- 2 had no documentation
- 7 had feeding difficulties
 - 1 had drugs/alcohol as a contributing factor
 - 2 had sleep related issues



Activity of Perpetrator just prior to trigger



SLEEPING ENVIRONMENT-RELATED DEATHS

Sudden Infant Death Syndrome (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.” In subsequent years, however, it has been recognized that factors related to infant sleeping position and infant sleeping environments, including the prone sleeping position, bed sharing (co-sleeping, particularly with those under the influence of drugs and/or alcohol, those that are obese or that are exhausted) and soft bedding increase the risk of infant death from asphyxia due to position or overlay.

Recognizing these risk factors, the American Academy of Pediatrics published a position paper in 2005 on the subject of safe infant sleeping conditions (see link <http://aappolicy.aappublications.org/cgi/content/full/pediatrics;116/5/1245>).

Additionally, because of the realization that many deaths that formerly might have been classified as SIDS actually have specific, preventable causes, the term SUID (Sudden Unexplained Infant Death) has been designated to refer to all unexpected infant deaths, including those that are determined to be suffocation, SIDS, metabolic error, undetermined, etc. 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 circumstances, the CDC has launched a nationwide initiative to improve the quality of these infant death investigations. The Florida Department of Health is spearheading the investigation of Sudden Unexpected Infant Deaths as part of the nationwide initiative.

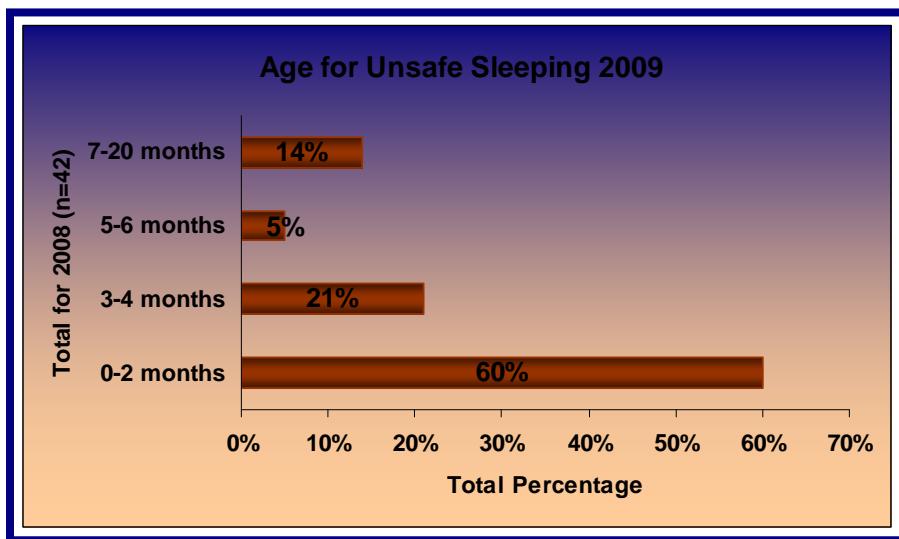
Issues of unsafe sleep practices have not only been recognized as a major priority by the State Committee, but also by many of Florida's state agencies and organizations. The State Committee along with several of its members are currently supporting Florida's Investigation of Sudden Unexpected Infant Deaths (SUID) by the Department of Health. The purpose of this investigation is 1) to measure the impact of SUID in Florida, 2) to assess the quality of SUID investigations at the local level, and 3) to estimate the impact of unsafe sleep practices on SUID. The State Committee's support for the investigation includes formal endorsement of the investigation, especially with other organizations needing to be involved. In addition, several of the State Committee members are actually participating in the investigation in their other job-related duties. Committee member involvement includes being one of the primary investigators, serving on the investigation's advisory committee, and being a member of the expert case review team. The findings from this investigation will be critical to both the State Committee and the Department in advancing their efforts to identify, improve surveillance of, and reduce SUID and sleep-related deaths; which are responsible for 200-300 infant deaths each year in Florida.

Key Findings

- 42 children died as a result of suffocation due to an unsafe sleep environment

Age of Child

- Ages ranged from 5 days to 30 months
 - 25 (60%) were ages 0-2 months
 - 9 (21%) were ages 3-4 months
 - 2 (5%) were ages 5-6 months
 - 6 (14%) were 7-30 months
- **36 (85%) were 6 months of age and younger**



Gender of Child

- 24 (57%) were males
- 18 (43%) were females

Race of Child

- 21 (50%) were white
- 15 (36%) were African American
- 2 (5%) were Hispanic
- 2 (5%) were multi racial
- 1 (2%) was Haitian
- 1 (2%) was Indian

Perpetrator Factors

There were 62 total perpetrators identified. Of those:

- 31 (50%) were mothers

- 17 (27%) were fathers
- 10 (16%) were relatives
- 2 (3%) were non relatives
- 1 (2%) was a daycare/sitter
- 1 (2%) was a male paramour

Age of Perpetrators/Caretakers

- 25 (40%) caregivers were between ages of 16-25. Of those:
 - 14 were mothers
 - 5 were fathers
- 18 (29%) caregivers were between the ages of 26 – 30.
- 19 (31%) caregivers were ages 31 and older

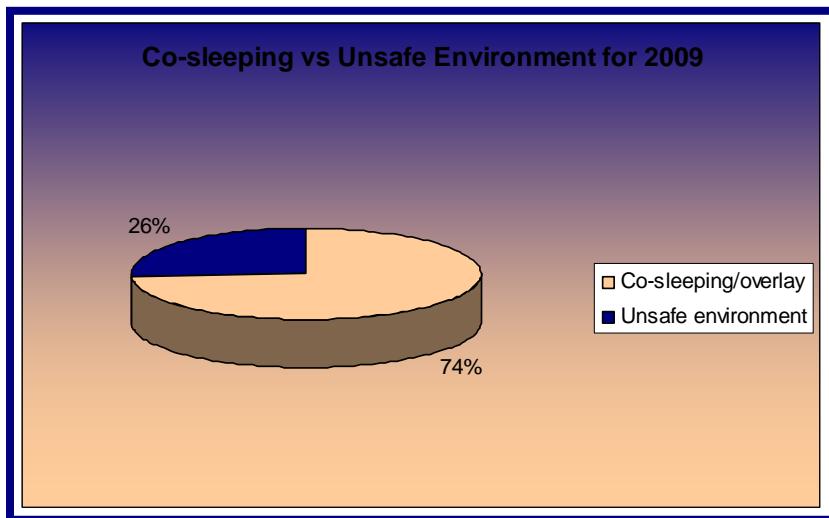
Gender of Perpetrators

- 41 (66%) were Females
- 21 (34%) were Males

Location of infant sleeping related suffocation deaths:

Cribs are the safest sleep environment for a child, of the 42 cases reviewed, of the cases 25 had cribs, bassinets or a playpen noted in the home that were not being used and or had various items in the cribs/bassinets. 9 of the cases had no crib at all and in 7 of the cases there was no documentation related to a crib.

- 31 (74%) were attributed to co-sleeping/overlay
 - 19 were co-sleeping in beds
 - 5 were co-sleeping in sofas
 - 4 co-sleeping with some form of pallet/mattress
 - 2 had no documentation as to the type of bed
 - 1 was co-sleeping on oversized chair
- 11 (26%) were placed in un safe sleep environments
 - 2 children were placed in either a crib, bassinet or playpens with pillows, blankets or other unsafe items
 - 3 children were placed on adult beds with pillows surrounding
 - 2 children placed on floor with mattress and pillows surrounding
 - 3 children placed on sofas/recliner
 - 1 child was wedged between the wall and a bunk bed
 - 2 children were unattended from 11 to 16 hours



Perpetrators involved in 31 co-sleep related suffocation deaths:

- 8 (25%) deaths were attributable to mothers
- 7 (22%) deaths were attributed to both parents
- 3 (9%) death was attributable to fathers
- 4 (13%)deaths were attributed to relatives
 - 2 were grandmothers and grandfathers
 - 1 was an uncle and aunt
 - 1 was an adult cousin
- 8 (25%) deaths were from sharing with a parent, sibling and/or other adult
- 2 (6%) deaths were from sharing with a non relative

Risk Factors attributed to the 42 infant sleep related suffocation deaths:

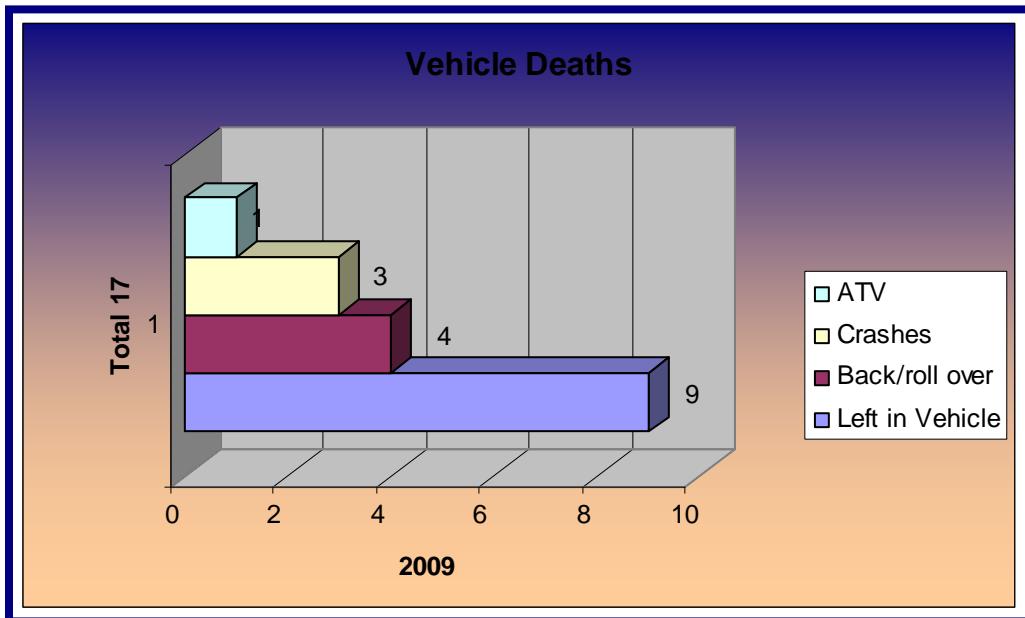
- Substance abuse histories were noted in 34 (81%) of the 42 sleep related cases
 - 10 drug tests were requested by DCF on the day of death
 - 10 drug tests were requested by DCF days later and administered
 - 3 drug tests were requested by DCF either on day of death or days after the death but were refused
 - 13 had history of drugs but no drug tests were requested by DCF
- Obesity of the adult was noted in 2 of the co-sleeping cases
- Inadequate supervision was a factor in 2 of the suffocation deaths
- One death involved a heart monitor that was not used by the caregivers.

**Co-Sleeping
*Danielle***

Danielle, 1 month old, was sleeping on her mother's chest on the couch along with the 4 year old sibling. The mother, age 34 stated she frequently co-slept. Mom was 5'4 and weighed 200 lbs. The mother said she put the baby between her legs and had a blanket over the child. She admitted she had rolled over the baby. The mother admitted to drinking and that she had an alcohol dependency. She drinks a six pack a day. There are 8 priors with DCF. The mother had other children removed and her rights terminated due to domestic violence, substance abuse and physical abuse.

VEHICLE-RELATED DEATHS

The State Committee reviewed 17 child deaths related to vehicles.



Hyperthermia-Vehicle

Mark and Melinda

The Father, age 26, was caring for Melinda, 18 months and Mark 5 years old, while the mother, age 24 worked. The mother stated she called the father during the day to check on the children. The father had taken the children with him to visit friends, returned home and said he put the children down for a nap. He checked on them and found white stuff coming out of their mouths so he drove them to the hospital. The hospital staff noted his speech to be slurred, he appeared confused and he kept falling asleep. Law enforcement obtained a search warrant for the vehicle and found marijuana, seeds and pills. Law enforcement discovered that the father had been with his friends using drugs, went home and fell asleep forgetting the children in the car. The father has criminal history, and the family had priors with DCF that involved drug allegations. The mother refused a drug screen. The father was charged with manslaughter

CHILDREN LEFT IN VEHICLES

Hyperthermia, in its advanced state referred to as heat stroke or sunstroke, is an acute condition which occurs when the body produces or absorbs more heat than it can dissipate. It is usually caused by prolonged exposure to high temperatures. The heat-regulating mechanisms of the body eventually become overwhelmed and unable to effectively deal with the heat, causing the body temperature to climb uncontrollably. Hyperthermia is a medical emergency which requires immediate treatment.

Fifty children died in Florida from 1998 to 2009 as a result of being left in vehicles. Florida is the second highest state for child deaths related to hyperthermia, with a total of 33 child deaths in the US that happened in 2009. Florida had 9 of those children whose were left in vehicles. This is a significant increase from 2008 in which there were only 3 deaths.

Public awareness campaigns such as the ones by Safe Kids USA (www.safekids.org) "Never leave you child alone **Beat the Heat, Check the Backseat**" continue to work towards reducing the deaths. Having safety tips such as:

- Be sure that all occupants leave the vehicle when unloading. Don't overlook sleeping babies.
- Always lock your car and ensure children do not have access to keys or remote entry devices. If a child is missing, check the car first, including the trunk. Teach your children that vehicles are never to be used as a play area.
- Keep a stuffed animal in the car seat and when the child is put in the seat place the animal in the front with the driver.
- Or place your purse or briefcase in the back seat as a reminder that you have your child in the car.
- Make "look before you leave" a routine whenever you get out of the car.
- Have a plan that your childcare provider will call you if your child does not show up for school
- Set your cell phone or BlackBerry to prompt you to be sure you dropped your child off
- Program your computer calendar to pop up an alert, "Did you drop off at day care today?"
- Write yourself a sticky note and paste it where you will see it when you get out of the vehicle
- Make it a point never to leave a child alone in a vehicle, even with the windows down.

Media attention and the prosecution of individuals who have left leave children unattended in vehicles have occurred. These efforts must continue to ensure that no young child is left alone in a vehicle for any period of time

In 2009 there were nine deaths and the State Committee was able to review all of the deaths.

Key Facts

- Nine children were left in vehicles ages 2 months to 23 months
- 4 were African American, 3 were Hispanic and 2 were White
- 6 were males and 3 were females

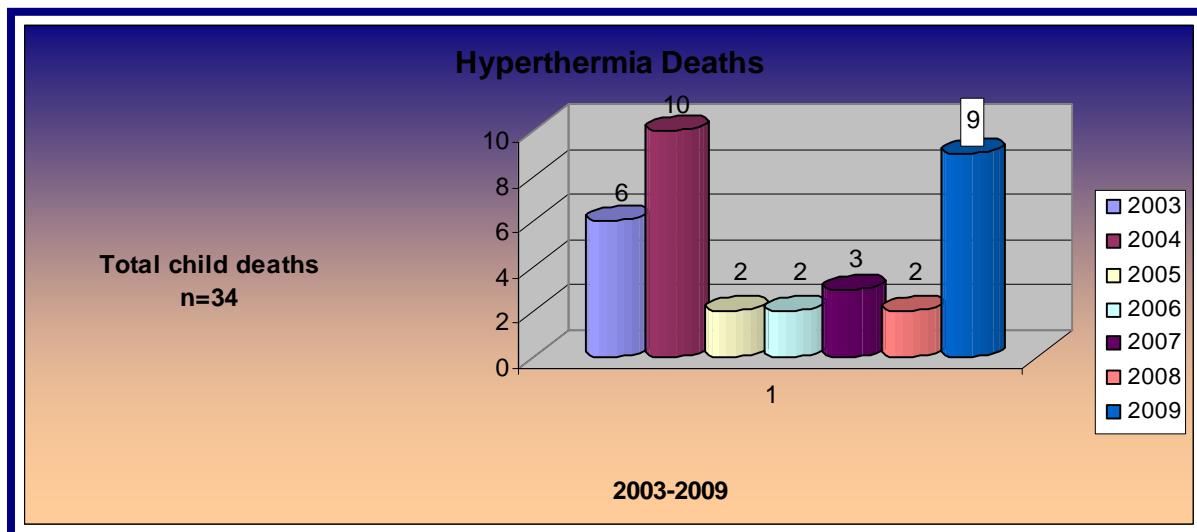
Perpetrator factors- total 12

- 3 were mothers
- 3 were both parents
- 1 was a father
- 1 was a grandmother
- 1 was an unlicensed day care provider
 - o had priors with DCF
 - o 2 had drug history
 - 1 Test requested day of death- they refused
 - One perpetrator was Baker Acted
 - o Ten of the caretakers were charged

An Associated Press (AP) study "Wide disparity exists in sentences for leaving kids to die in hot cars" examined both the frequency of prosecutions and length of sentences in hyperthermia deaths

- Charges were filed in 49% of all the deaths. 81% resulted in convictions.
- In cases with paid caregivers (i.e., childcare workers, babysitters) 84% were charged and 96% convicted
- Only 7% of the cases involved drugs or alcohol

The graph below shows the total number of children from 2003-2009, that died from hyperthermia, that the State Committee reviewed.



Recommendations:

- A. There should be continuing education for law enforcement on reporting these deaths to the Florida Abuse Hotline.
- B. The Department of Children and Families should establish maltreatment guidelines and craft state wide training on these types of deaths to provide consistency in investigation to provide for accurate findings.
- C. The Local Child Abuse Death Review Committees should continue to invite Florida Highway Patrol to participate in local child abuse death reviews.
- D. Campaigns should focus on "Families do not let Families Drive Drunk" Ads should consider having mother's driving vehicles with children in the car.
- E. The legislature pass a booster seat belt law that meets NHTSA national recommendations which states: any driver of a motor vehicle, when transporting a child under the age of eight (8) years who is between forty (40) inches and fifty-seven (57) inches in height, and weighing less than eighty (80) pounds, in a motor vehicle operated on the roadways, streets, and highways of this state, shall have the child properly secured in a child booster seat.

VEHICLE CRASHES

The CDC Child injury Report: Patterns of Unintentional Injuries among 0-19 Year Olds in the United States-2006, states that injuries due to transportation were the leading cause of death for children.

In a new report on drug use by drivers involved in America's fatal crashes, the National Highway Traffic Safety Administration (NHTSA) reported post-mortem testing results showing an increase in the level of drug involvement among fatally injured drivers over a five-year period from 2005 to 2009.

Drug involvement does not mean the driver was impaired or that drug use was the cause of the crash.

According to data compiled by NHTSA, 63 percent of the 21,798 drivers who were killed in motor vehicle crashes in 2009 were tested for drugs. Of these, 3,952 tested positive for drug involvement, representing 18 percent of the total for that year. The report also showed drug use reported by the states among fatally injured drivers increasing from 13 percent in 2005, to 15 percent in 2006, 16 percent in 2007, and 18 percent in 2008.

The drug data released today was collected by NHTSA as part of its Fatality Analysis Reporting System (FARS) and included information collected from the states under three broad categories: whether the driver was tested, the type of test conducted, and the test results. The types of drugs recorded in FARS include narcotics, depressants, stimulants, hallucinogens, cannabinoids, phencyclidines (PCPs), anabolic steroids, and inhalants. The groups include illicit drugs, as well as legally prescribed drugs and over-the-counter medicines. In announcing today's drug findings, Administrator Strickland did offer some cautions, including the fact that drug test results are unavailable for a large portion of fatally injured drivers. He noted also that there was a wide variance among states regarding the extent of drug testing conducted.

He added that state drug testing techniques and procedures are evolving and that currently states, as well as jurisdictions within a state, may test for different drugs, use different test types, and/or employ different concentration thresholds for determining whether a test was positive or not.

The National Highway Traffic Safety Administration (NHTSA) refers to drunk driving crashes as "alcohol-impaired-driving" accidents. In 2008, a total of 1,347 children age 14 and younger were killed in motor vehicle driving crashes. Out of those 216 deaths, about half (99) were occupants of a vehicle with a driver who had a blood alcohol concentration (BAC) level of .08 or higher. In 2008 drugs other than alcohol (e.g., marijuana and cocaine) are involved in about 18% of motor vehicle driver deaths. These other drugs are often used in combination with alcohol.

Infants and children who are seated in places other than the back seat account for nearly 48% of child fatalities in Florida, and those seated in the back seat without proper restraints account for an additional 26% of child fatalities. Drinking drivers are more likely than other drivers to transport children improperly. Traveling in a child seat reduces the chance of a

crash death by an estimated 71% for infants and 54% for children aged 1-4. The average child seat costs approximately \$45 but avoids nearly \$1,600 in injury costs. Florida is one of only 3 states that do not have a booster seat law. The National Transportation Safety Board recommends this because children 4-7 years old are often too small for a regular seat belt. AAA Auto Club South, which supports the bill, is touting the fact that the Official Journal of American Pediatrics said children ages 4-7 are four times more likely to suffer head or brain injuries, and three times more likely to suffer severe abdominal injuries, when wearing only a seat belt instead of a booster seat.

AAA also said booster seats reduce the rate of fatal injury for children by 59 percent compared to the seat belt alone. A booster seat bill would require a child to be in a booster seat after they out grow a regular car seat around the age of 3 to 4. Under current Florida law a child at 4 years can be restrained by a seat belt.

A recent analysis by researchers found that an estimated 2.5 million adult drivers with children living in their households reported that they had recently driven while under the influence of alcohol. The analysis also showed that, for adults in all age groups, the presence of children in the home does not decrease drivers' likelihood of alcohol-impaired driving. These findings suggest that many children live with adults who engage in alcohol-impaired driving. The results highlight the need for increased use of proven, evidence-based strategies to reduce the number of alcohol-impaired drivers on the roads. In addition, it is important for adults who transport children to make a daily commitment to not drink and drive and consistently use proper safety belts, or restraints. Boyd R, Kresnow M, Dellinger AM. Alcohol-impaired driving and children in the household. *Family and Community Health* 2009; 32(2): 167–174.

According to FBI research, there was an increasing trend among women driving impaired in a number of states. Overall there are about 2,500 fatalities a year involving an impaired female driver. The State Committee, with the few cases reviewed, has seen this trend as well as the mothers who drive intoxicated with their children in the vehicle.

Unfortunately vehicle related child deaths are rarely reported to the Florida Abuse Hotline.

The State Committee made a recommendation in 2005 and has continued to recommend that training should be given to Florida Highway Patrol Officers on the mandatory reporting of child abuse. Many crashes with serious injury or death of children were due to negligent behavior of the driver/caregiver and were not being reported to the Florida Abuse Hotline. This still continues to be an issue. The Committee has written letters to FHP addressing the requirement for mandatory reporting as well as offering to provide training. FHP has also been encouraged to participate in local committee reviews. The State Committee was contacted by FHP in a couple of areas and was able to provide training in 2009 to approximately 200 Troopers.

Vehicle accident

Kyle

Mother, age 33, step father, age 31, Kyle , age 4 and his step-sibling, age 4 were driving on dirt roads in a wooded area on a military base that they were trespassing on . The children were seated in the back of a truck in car seats, unstrapped, that were unsecured on a bench seat. Kyle fell out of the truck and was run over. The step father had a blood alcohol of .014. The mother had criminal history of drug possession and the step father had criminal history of negligent homicide, drug charges and domestic violence. The mother tested positive for opiates, oxycodin, benzo's and THC. The step father tested positive for THC. The family had a prior with DCF involving substance abuse. The home was noted to have drugs, pills and was extremely messy. There were no criminal charges filed.

Key Findings

- 3 children died in moving vehicle crashes
 - Ages 2 months, 3 year and 9 years
 - 2 children died in one crash
 - All were white children
 - 2 were males and one female

Perpetrator factors

- 1 of the crashes were caused by mother/step-mother, age 27
- 1 was the father, age 30
- The father was charged and convicted of vehicular manslaughter
- The other case is pending

Vehicle Perpetrator risk factors

- All Children were improperly restrained or no restraints used
- Both were under the influence of drugs/alcohol
- Both had substance abuse history
 - Drug tests requested on date of death
 - Both tested positive, the father for alcohol and the mother/step mother was positive for THC, cocaine and oxycodone

DROVE/ BACKED OVER

In the US fifty children are being backed over by vehicles every week. Forty-eight are treated in hospital emergency rooms and at least two children are fatally injured every week. These unthinkable tragedies are happening most often in the driveway of the child's home and in 70% of the incidents the driver of the vehicle is their parent, grandparent, aunt, uncle or older sibling. According to "Janette E. Fennell, Founder & President, KIDS AND CARS, She has uncovered in the last four years between 100-150 of the 2,500 children are backed over each year are killed. The Centers for Disease Control estimates that from the years 2001-2003 almost 7,500 children were treated in emergency rooms for injuries caused by back over accidents. But if the injured went to a private doctor or the hospital record did not reflect the cause of the accident, those incidents were not counted. Kids and Cars has the only national database of deaths from back overs, but they only know about accidents that get media attention or that they are told about. Public awareness and education should continue and should have safety tips like:

- Walk around a vehicle before getting in to make sure that children are not near.

- Make sure children are supervised
- If children are playing outside, put them in the car with you until you are finished moving your vehicle
- Teach children not to play near vehicles
- Adjust the driver's seat as high as needed to clearly see through the rear window and adjust all mirrors for maximum range of visibility
- Roll windows down so you can hear children

Key Findings

- 4 children died as a result of being run or backed over
 - Ages, two 2 year olds, a 4 year old and one 10 year old
 - 3 were African American and one white
 - 2 were females and two males
 - All were not supervised by their parents

Perpetrator Factors

- 3 were parents, ages ranged 30-38
- 1 was the mother, age 38
- 1 was a stranger, age 29
- 2 had substance abuse history
- 2 had priors with DCF

The State Committee found inadequate supervision by the parents was the contributing factor.

ATV DEATHS

Nationwide, ATVs seriously injure and kill over 40,000 of children under age 16 every year. The following facts highlight a growing problem and the very real costs to families and society at large, and underscore the need to enact common sense safety standards that keep children under age 16 from driving these powerful vehicles.

- The American Academy of Pediatrics (AAP) and American Academy of Orthopedic Surgeons (AAOP) have adopted formal policies recommending that children under age 16 not drive ATVs. See appendix XIII

- The American Academy of Pediatrics states: "Laws should prohibit the use of ATVs, on- or off-road, by children and adolescents younger than 16 years. An automobile driver's license, and preferably some additional certification in ATV use, should be required to operate an ATV. The safe use of ATVs requires the same or greater skill, judgment, and experience as needed to operate an automobile."(AAP, *Policy Statement, All-Terrain Vehicle Injury Prevention: Two-, Three-, and Four-Wheeled Unlicensed Motor Vehicles*, 2000)
- The American Academy of Pediatrics also describes child ATV use as "the perfect recipe for tragedy." (AAP press release, July 13, 2005)
- The American Academy of Orthopedic Surgeons explains: "***In light of statistics that show an inordinate number of injuries and deaths resulting from the use of ATVs, the American Academy of Orthopaedic Surgeons considers ATVs to be a significant public health risk.*** . . . The minimum age of 16 for operating an ATV on or off the road should be enforced. Children under the age of 12 generally possess neither the body size and strength, nor the motor skills and coordination necessary for the safe handling of an ATV. Children under age 16 generally have not yet developed the perceptual abilities or the judgment required for the safe use of highly powered vehicles."(emphasis in original) (AAOS, *Position Statement, All-Terrain Vehicles*, 1992).

Key Facts

- 1 white male child age 10
- He was not wearing helmet
- He was speeding and driving reckless

Perpetrator Factors:

- The Grandmother, age 52 allowed him to ride unsupervised

The State Committee found that inadequate supervision by the parents was also a contributing factor for allowing their children to ride unsafely.

ATV

Joseph

Joseph, age 10, was visiting at his grandmother's house with his siblings, age 8 and 12. His brother was taking the trash to the road with an ATV, while his siblings rode with him. Only one child had a seat belt on. The mule weighted 1214 lbs and was not designed to be driven by anyone under 16 years of age. The Grandmother, age 52 was mowing the lawn and not directly supervising the children. The brother was doing donuts and flipped the vehicle over, which landed on top of Joseph. FHP stated the Grandmother was in violation of FS 827 however the State Attorney declined to prosecute.

DRUG/POISONING RELATED DEATHS

Poisoning refers to the type of poisoning agent that resulted in the child's death. This can be anything from over the counter medicines to cleaning agents commonly found in the home. . The Florida Office of Drug Control reports that the rate of deaths from prescription drugs is more than three times that of deaths from all illicit drugs combined. Prescription drug overdoses caused 1,720 deaths in 2006, up about 40% from three years earlier. People in their 40s were the most likely to die from prescription drugs, followed by those in their 20s and 30s. Teens were the fastest-growing group. Approximately 50% to 80% of all child abuse and neglect cases substantiated by child protective services involve some degree of substance abuse by the child's parents

The State Committee anticipates that these types of deaths will increase given the increase in the number of drug related deaths noted by the Medical Examiners report for 2008. The report contains information compiled from autopsies performed by medical examiners across the state in 2008. During that period, there were approximately 171,800 deaths in Florida. Of those, 8,556 individuals were found to have died with one or more of the drugs specified in this report in their bodies. The report also indicates that prescription drugs continued to be found more often than illicit drugs both as a causal factor and merely present in the decedent. Prescription drugs account for 75 percent of all drug occurrences in this report when Ethyl Alcohol is excluded.

Key Findings

- 2 children died from morphine overdose
- 1 child died from Methadone Intoxication
- 1 child died from Oxycodone toxicity
- 1 combined drug toxicity
- 1 died from Reyes Syndrome
 - The State Committee feels the death was due to acetmethine poison toxicity

Age of Child

- 6 children from 13 months to 15 years died as a result of drug toxicity
 - 5 children were four and younger
 - 1 child was 15 years
- 3 were ruled accidental, 1 was undetermined, and 1 was a Homicide and 1 was ruled natural
 - The State Committee felt it should be classified as an accident

Perpetrators related factors

- 2 were mothers and their male paramour
- 1 was a mother
- 2 were fathers
- 1 was the mother and the father

Age of Perpetrator's

- Ages ranged from 20-52 years
 - 3 were ages 20, 26 and 27
 - 2 were age 31
 - 2 were ages 43 and 45

Drug/poison Perpetrator risk factors

- 3 had previous reports with DCF involving drug allegations
- parents were aware of child's substance use or had consumed and failed to seek treatment
- 5 of the cases there was evidence of drug use by either admissions, history, or noted at the crime scene
- Of those 3 cases drug testing was requested on three
 - Two were on the day of death and one was months later
 - One was positive for oxycodone, THC and opiates and the other no documentation found for results
 - The late test was positive for THC

5 cases prescription medications were noted to be of concern.

Recommendations:

- A. That there is a standardized on-scene presumptive drug testing as part of the child protective or law enforcement investigation protocol.
- B. There should be training provided to Child Protective Investigators that should focus on how substance misuse contributes to or results in harm to infants and children whose caregivers use illicit substances, abuse alcohol, or allow children inappropriate to prescription drugs.
- C. In addition, training for Child Legal Services, in regards to these issues, should also be reviewed and revised, as needed.

PREMATURE AND DRUG EXPOSED NEWBORNS

According to a 2005 Study by National Center on Addiction and Substance Abuse, 4.0% of pregnant women ages 15-44 reported illicit drug use. In a 2003 study by the Center for Disease Control and Prevention, nearly three percent of pregnant women use illegal drugs including marijuana, cocaine, Ecstasy and other amphetamines, and heroin. The use of illegal drugs during pregnancy, as well as the inappropriate use of prescription medications may pose serious risks for both the pregnant woman and her unborn child. Possible risks to the fetus include premature birth as well as developmental delays and adverse health effects later in life. This is an emerging issue that merits further study. The magnitude of the problem in the state of Florida has not yet been defined. There are several obstacles inherent in attempts to collect epidemiologic data related to drug abuse during pregnancy and possible adverse effects on the developing child. Most notably, there is inconsistency among the medical examiner districts as to whether jurisdiction should be assumed in cases of intrauterine deaths and deaths in the neonatal period when maternal substance abuse are suspected. Additionally, there is no consensus among medical examiners as to the certification of the cause and manner of death in these cases. The State Committee is recommending that the Florida legislature form a special project committee to explore the impact of substance abuse in the home, as well as maternal substance abuse and its impact on the unborn child..

Key Findings

One case was verified for substance exposure

- 1 child, male multi-racial, 13 days old

Perpetrator Information

- Mom age was 28 years ,

Premature and Drug Exposed Newborn Perpetrator risk factors

- Mothers tested positive for cocaine at birth
 - She also admitted to THC use
- She had an extensive criminal history of substance abuse
- She did not seek prenatal care
- She had priors with DCF and had previous removals of siblings

Recommendations:

- A. Provide training to hospitals and emergency personnel on mandatory child abuse reporting.
- B. Provide statutory authority to hospitals to test mothers and babies for substances when there is suspected drug use.

**Substance Exposed
*Maxcine***

Maxcine, 13 days old, was born at 26 weeks and only weighed 2 lbs. The mother, age 28, tested positive for cocaine at the delivery as well as Maxcine. The mother stated she had used marijuana and it must have been laced with cocaine. The mother did not seek any prenatal care. The mother has had other children removed from her car due to her substance abuse and she had another child that died a result of shaken baby. The mother had a history of domestic violence and she was unemployed.

MEDICAL NEGLECT RELATED DEATHS

Medical neglect is the refusal or failure on the part of the person responsible for the child's care to seek, obtain, and/or maintain those services for necessary medical, dental, or mental health care, withholding medically indicated treatment from disabled infants with life-threatening conditions.

Medical neglect means that even minimal health care is not being obtained for a child. This lack of health care can lead to serious harm and even death. For example, an untreated cold or flu can result in pneumonia, which can be fatal. Signs of medical neglect include:

- Adult does not use emergency services at all, even with severe injury or illness
- When medicine is prescribed, the prescription is not filled
- Dental needs go untreated
- Regimens recommended for treatment of chronic illness not followed
- Prescribed psychological help not obtained

Failure to thrive: Failure to thrive is a significantly underweight child, usually less than 18-months-old. Any child suffering from failure to thrive should be reported as a potential victim of neglect. Approximately 30 percent of failure to thrive cases have an organic cause and require the adult to seek medical attention for the child.

Key Findings

- 2 children died as a result of medical neglect
- Ages 12 years and 16 years
- Both had involvement with Children's Medical Services

- Both children had known medical complications
- Both cases the mothers did not seek medical care

Perpetrator Facts

- Both were mothers
- Ages 39 and 50

- Both had priors with DCF
- Neither cases had multidisciplinary staffings
- 1 mother had history of substance abuse
 - one had requests for drug tests
 - request was made the day after death and the result was positive for cocaine

Recommendation:

- A. A multidisciplinary staffing should be required when children have medically complex issues to include agencies such as Children's Medical Services to insure the child's medical needs are met.

FIREARM RELATED DEATHS

Florida's Child Access Prevention Law is one of only three such laws allowing felony prosecution of violators and this appears to have significantly reduced unintentional firearm deaths of children. Recent surveys indicate that 33 to 40 percent of US households have a gun in them. Caregivers, family members, or others must remember that firearms must be secured, preferably with gunlocks to ensure that they cannot be accidentally discharged. Florida law already requires individuals to ensure that firearms are secured and kept in locations away from children. The State Committee reviewed the cases of 2 children who died as a result of gunshot wounds in 2008.

Key Findings

- 4 children died as a result of gunshot wounds
 - 3 were ruled homicides
 - 1 ruled a suicide
- 3 were white and 1 was African American
- All were males
- Ages 11 years, 2 were 12 years olds, and one 17 year old

Actual Perpetrator Factors

- 2 were children ages 9 year friend and 15 year old brother and
- 18 year old cousin
- Supervision was a factor in the 3 cases of accidental shootings
 - Perpetrators were parents ages 39 and 38 and mom age 40 and non related male age 18
- Failure to follow through with mental health treatment as a factor on the suicide
 - Perpetrator was the father age 30

Gunshot perpetrator risk factors

- One of children had a history of substance abuse
- 2 cases had prior history with DCF
- All cases the guns were not stored safely in the homes

Recommendation:

- A. The American Academy of Pediatrics recommends pediatricians counsel parents about risk associated with keeping guns in the home and how to store guns safely when they are in the environment of children.

- B. Education to parents about the risk associated with family members whose lifestyle involves drug and gang activity

FIRE RELATED DEATHS

Children playing with fire cause hundreds of injuries and deaths each year. Preschoolers and kindergartners often start these fires, usually by playing with matches and lighters, and are most likely to die in them.

Facts & figures

- In 2006, children playing with fire started an estimated 14,500 structure fires that were reported to U.S. fire departments, causing an estimated 130 civilian deaths, 810 civilian injuries and \$328 million in direct property damage.
- Nearly two-thirds (63%) of all fatal victims of fires by playing are children 5 years old and younger.
- Nearly two out of every three child-playing fires — and four out of five associated deaths and injuries — involve matches or lighters.
- The items ignited by home fire-play are principally mattresses, bedding or clothing.

Source: NFPA's "[Children Playing with Fire](#)"

Key Findings

- 3 died as a result of smoke inhalation and one died as a result of thermal burns 80% of the body and smoke inhalation

Age, race and gender of children

- Age of children, one 8 months. Two 3 year olds and one 6 year old ,
- 21 were females and 2 were males
- 3 were white and 1 African American
- all were ruled accidental
-

Perpetrator Facts:

- 2 were from mothers
- 1 was from both parents
- 1 was uncle and his female paramour
- Ages 19 years to 28 years
- Race

- All the caretakers had a substance abuse history
 - 3 had drug test requested 2 were requested on the day of death, one 2 days after the death
 - One tested positive for THC, one tested positive for Methadone, TCH, opiates and benzodines, and one tested positive for opiates, THC and oxycodone
- 3 cases had priors, 2 involving substance abuse

Recommendations:

- A. There should be continuing education for Fire Marshals on reporting these deaths to the Florida Abuse Hotline.
- B. That there is a standardized on-scene presumptive drug testing as part of the child protective or law enforcement investigation protocol
- C. The Local Child Abuse Death Review Committees should continue to invite Local Fire Marshals or law enforcement agencies that investigate fire related deaths to participate in local child abuse death reviews

INADEQUATE SUPERVISION RELATED DEATHS

5 Children died as a result of inadequate supervision

- 2 siblings died from asphyxiation, they were found in a wooden box
- 1 child died from Asphyxia by constriction of a snake
- 1 child died from hanging herself in a tree
- 1 child died as a result of asphyxia including neck compression

Key Findings

Age, race and gender of children

- Age of children one 2 year old and one 14 year old
- 4 females, one male
- 4 white and one African American

Perpetrator factors

- 4 were mothers and one male paramour
- Ages ranged from 19 years to 39

- 3 had priors with DCF
- all had substance abuse history
 - 2 requested drug test
 - One on day of death- result was positive for THC
 - One was days later and the results were positive for cocaine
 - 2 no drug request made

2 perpetrators were charged however one was dropped by the State Attorney's office

CASES REVIEWED IN 2010 THAT OCCURRED IN 2008

5 children died in 2008

3 of the cases were caused by physical injury which would bring the total from last year to 62 physical injury deaths, one was an unsafe sleep environment which brings that total to 55 and the other was a inadequate supervision related to a gun incident which brings that total to 3 for 2008 deaths.

Age of Children

- Age range from 2 months to 10 years
- All were females
- Three were African American, one Haitian and one Hispanic

Causes

- 3 died as a result of blunt head trauma
- 1 died from a gunshot wound to head
- 1 was ruled SUID as a cause of death

Manner

- 3 were ruled a homicide
- 2 were ruled undetermined

Perpetrator Factors:

- 1 was the mother
 - Age 28, had alcohol history and criminal history
 -
- 3 were the biological fathers
 - Ages, 17, 24 and 35
- 1 had domestic violent history
- 2 stated child stopped breathing
- 1 stated child hit head on the floor
- 2 the perpetrator did not call 911

Non Offending parent

- Ages ranged from 15 and 33
 - One was the mother and the other was an aunt

- o Neither were charged

TRAINING

Every year the State Committee has made a recommendation for training in a variety of aspects of child abuse and neglect and particularly child death investigations. The Committee has the opportunity to review child abuse deaths that occur all over the state of Florida. It is important that the lessons learned from the many cases reviewed are learned locally so that the child's death serves as a valuable tool to improve child protection and law enforcement procedures and practices. The Committee believes that a national standard with a high level of multi-agency involvement and information gathering is the way to effectively establish how and why a child died and what can be done to prevent the next child death.

The State Committee therefore took the responsibility to make training a top priority, specifically, the Sudden Unexplained Infant Death Investigation (SUIDI). The Centers for Disease Control conducted 5 SUIDI academies over the states in 2006 and 2007. They trained 5 people from each state from varying disciplines involved in child abuse. Those individuals were charged with the responsibility to take the training and provide it to those investigative agencies charged with investigating child deaths. The State Committee was fortunate to have two members sent to this training, Major Connie Shingledecker and Dr. Barbara Wolf. Through out the last couple of years they have trained thousands.

The State Committee has also provided training on investigating physical abuse, neglect deaths, mandatory reports of child deaths, and the opportunities of making good risk assessments and what they can mean to the protection of children. These trainings have contributed to the increased reports to the hotline. For example deaths related to murder/suicides and abandoned newborns are now being called in to the hotline. The documentation of crime scenes, request or information of drug history and the request for testing has been noted in the case files. There is still training needed to Protective Investigators and their Supervisors on child deaths to take into consideration all the facts in order to make a better and consistent classification statewide.

STATE COMMITTEE GOALS AND ACCOMPLISHMENTS FOR 2010

Goals:

- Continue to train professionals on child death investigations and in particular following the recommendations from the Center for Disease Control. The Center for Disease Control has encouraged all states to adopt a standardized approach to infant death scene investigation by all Medical Examiner Districts as well as law enforcement agencies. The State Child Abuse Death Review Committee views this project as a high priority and is supportive of identifying resources to initiate a statewide approach to training and outreach.
- The State Committee set up an annual meeting with the Chairperson from each local Committee to a joint meeting with the Department of Children and Families Child Death Review Coordinators and Family and Safety Staff to address the process of reviews and to standardize them statewide. Our goal will be to have 100% attendance from the local chairs.
- Continue to train and set up a system with the Department of Children and Families child death review coordinators to assure accuracy of obtaining the verified reports to the local chairperson as well as getting this information to the State Committee timely.
- Collaborate with relevant organizations and partners to develop a statewide conference on serious child injury and child fatality.
- Continue to provide training to Protective Investigators throughout the state on child death investigations
- Provide training at the Dependency Court Improvement Summit on issues related to child fatalities identified by the State Training Committee.

Accomplishments:

- Dr. William Sappenfield addressed the Florida Medical Examiners Commission (M.E.C.) on the subject of the difficulties inherent in elucidating the incidence of unsafe sleep-related infant deaths in Florida. He presented a proposal for a new Department of Health study to evaluate Florida death certificate terminology and coding pertaining to sudden unexpected infant

deaths. The MEC passed a resolution to support this study, which is currently in progress.

- Dr. Barbara C. Wolf worked with a committee representing the membership of the Florida Association of Medical Examiners (F.A.M.E.) to draft changes to the sections pertaining to infant death investigation in the Practice Guidelines for Florida Medical Examiners, which are sponsored by F.A.M.E. and to Florida Administrative Code 11G, which governs the activities of Florida medical examiners. The changes to the Practice Guidelines, which included a recommendation for the performance of doll re-enactments, were adopted at the F.A.M.E. meeting in July, 2010. The proposed changes to the Administrative Code are currently under consideration by the MEC. The State Committee supports these changes and hopes that the new guidelines will strengthen infant death investigations throughout the state.
- The State Committee was designated as one of the Florida's citizens review panels by Alan Abramowitz on June 10, 2009.
- Members from the State Committee were appointed to the Domestic Violence Fatality Review Steering Committee.
- Members from the State Committee serve on the Governors child abuse Prevention and permanency advisory counsel.
- After recommendations by the State committee as to multidisciplinary staffings on children with three or more reports, the Child Protection Team issued a memo, September 2009, requiring a Child Protection staffing on all high risk cases and children who have three or more reports on cases that meet the CPT requirement.

REFERENCES

1. Section 383.402, *Florida Statutes*
2. Section 39.01, *Florida Statutes*
3. U.S. Department of Health and Human Services: Child Maltreatment 2009: Reports from the States National Center on Child Abuse Prevention Research.
4. Florida Department of Children and Families: Child Abuse and Neglect Deaths: Calendar Year 2009.
5. Department of Health Vital Statistics Annual Report 2009
6. American Academy of Pediatrics: Policy Statement, The Changing Concept of Sudden Infant Death Syndrome: Diagnostic Coding Shifts, Controversies Regarding the Sleeping Environment, and New Variable to Consider in Reducing Risk. *Pediatrics* Vol. 116 No. 5, November 2005
7. 1999-2003, Centers for Disease Control - Web-based Injury Statistics Query and Reporting System (CDC WISQARS)
8. Crume, DiGuiseppi, Byers, Sirotnak & Garrett, 2002: Herman-Giddens et al., 1999)
9. (Mercy, Baker & Frazier, 2006)
10. Angelo P Giardino, MD, PhD, Clinical Associate Professor, Department of Pediatrics, Baylor College of Medicine; Medical Director, Texas Children's Health Plan, Inc
Eileen R Giardino, PhD, RN, MSN, FNP-BC, ANP-BC, Associate Professor of Nursing, Department of Acute and Continuing Care, University of Texas Health Sciences Center Houston School of Nursing,
11. ¹Tjaden, Patricia & Thoennes, Nancy. National Institute of Justice and the Centers of Disease Control and Prevention, "Extent, Nature and Consequences of Intimate Partner Violence: Findings from the National Violence Against Women Survey," (2000).
12. Edelson, J.L. (1999). "The Overlap Between Child Maltreatment and Woman Battering." *Violence Against Women*. 5:134-154.
13. American Academy of Pediatric in 2005
14. *Florida Statute*:383.50.
15. *Florida Statute* 406.11

16. Florida Governor's Task Force on Domestic and Sexual Violence, Florida Mortality Project, 1997
17. Edelson, J.L. (1999). "The Overlap Between Child Maltreatment and Woman Battering." *Violence Against Women*. 5:134-154.
18. Department of Justice, Bureau of Justice 1993

STATE CHILD ABUSE REVIEW COMMITTEE

**Connie Shingledecker, Chairperson
Major for the Manatee Sheriff's Department
Representing: Law Enforcement**

Michael L. Haney, Ph.D, NCC, LMHC
State Child Abuse Death Review Coordinator
Division Director, Children's Medical Services
Representing: Florida Department of Health

Bill Navas, J.D.
Office of the Attorney General
Representing: Department of Legal Affairs

Alan Abramowitz
State Director, Office of Family Safety
Representing: Florida Department of Children and Families

Terry Thomas - Special Agent,
Representing: Florida Department of Law Enforcement

Lisa Herndon, JD - Assistant State Attorney – 5th Judicial Circuit
Representing: The Florida Prosecuting Attorneys Association

Michele Polland
Educational Policy Analysis
Representing: Department of Education

Karla Ramos-Arroyo
Healthy Families Polk
Representing: Paraprofessional in Child Abuse Prevention

Raquel Smith, RN,MSN
Children's Medical Service
Representing: Public Health Nurse

Randell Alexander, M.D., Ph.D
Statewide Medical Director
Child Protection Teams
Representing: Child Protection Team Medical Directors

Kris Emden
Florida Department of Children and Families
Representing: Family Services Supervisors

Barbara Rumberger, M.D
Child Protection Team Medical Director
Representing: Board-Certified Pediatricians

Carol M. McNally - Healthy Families Florida
Executive Director
Representing: Child Advocacy Organization

Pamela Graham
Director of MSW Program, FSU
Representing: Licensed Clinical Social Workers

Major Connie Shingledecker
Commander – Manatee County Sheriff's Dept.
Representing: Law Enforcement

Kaisha Thomas
The Gratitude House
Representing: Mental Health Professional

Angela Osterhoudt – Florida Coalition Against Domestic Violence
Representing: Domestic Violence Specialist

Christie Ferris –Director of Prevent Child Abuse
Florida
Representing: Child Abuse Prevention Program

Barbara Wolf, M.D. – District 5 Medical
Examiner Office
Representing: Florida Medical Examiner's
Commission

STAFF

Stephenie Gordy
Administrative Assistant II
Division of Prevention and Intervention
Children's Medical Services
Department of Health

Michelle Akins
QA Coordinator State Child Abuse Death Review
Committee
Children's Medical Services
Department of Health

COMMITTEES

TRAINING COMMITTEE

Terry Thomas, Chairperson
Michael Haney, Ph.D
Connie Shingledecker
Barbara Wolf, M.D.
Michelle Akins

PROTOCOL AND GUIDELINES COMMITTEE

Michael Haney Ph.D, Chairperson
Randell Alexander, M.D., Ph.D

REPORT COMMITTEE

Connie Shingledecker, Chairperson
Christie Ferris
Carol McNally
Alan Abramowitz
Mike Haney, Ph. D
Barbara Wolf, M.D.
Michelle Akins

APPENDIX I

“WHO’S WATCHING YOUR CHILD” BROCHURE

<h2>What Your Partner/Babysitter Needs to Know When Caring for Your Child</h2> <p>Crying</p> <ul style="list-style-type: none"> What works best to help your baby stop crying. Show your partner/babysitter how to soothe your baby before you leave. Put the baby in a safe place and call right away if your baby will not stop crying. What your child likes to do and what toys he likes to play with. Show your partner/babysitter how you and your baby like to play together. <p>Sleep</p> <ul style="list-style-type: none"> Your baby always sleeps alone and should never sleep with an adult or another child. Your baby always sleeps on their back in a crib/bassinet/Pack'n Play® and should never be put to sleep on a couch, chair, waterbed or any other kind of soft bedding. <p>Water Safety</p> <ul style="list-style-type: none"> Always watch your child while in the bathtub, at the swimming pool, near any bodies of water or other things filled with water. <p>Discipline</p> <ul style="list-style-type: none"> Never spank, yell, throw things, shake or hit your child. <p>Diapering/Totting</p> <ul style="list-style-type: none"> How to toilet or diaper your child. Let them know it is ok if your child has an accident. Have clean clothes and diapers on hand. <p>Eating</p> <ul style="list-style-type: none"> How much your child usually eats and that it is okay if your child does not eat everything. That food messes are okay! 	<h2>RESOURCES</h2> <p>For more parenting tips and information on local resources, call the Parent Helpline at 1-800-FLA-LOVE, (1-800-352-5683). Calls are free and confidential.</p> <p>For free, confidential information and services on domestic violence, call the Domestic Violence hotline at 1-800-500-1119.</p> <p>To report suspected child abuse and neglect, call the Child Abuse and Neglect hotline at 1-800-962-2873.</p> <p>LOCAL RESOURCES:</p> <hr/> <hr/> <hr/> <hr/>	 <p>Who's Watching Your Child?</p> <hr/> <p>The person you choose to watch your child is one of your most important decisions.</p> <div style="display: flex; justify-content: space-around; margin-top: 10px;">   </div>
---	--	--



Did you know?

- When you leave your child with your partner or babysitter, you expect them to care for your child just like you would, but that is **not always the case**.
 - Children who live with adults not related to them are nearly 50 times as likely to die of inflicted injuries as children living with two biological parents.
 - Many children who die from physical abuse are killed by the mother's boyfriend.
 - People under the influence of drugs/alcohol, who are very tired or stressed out, can get angry over minor things that all children do, like crying or spilling something. This anger can put your child at risk of being hurt.
 - When someone lets anger get out of control, it only takes one hard shake or one hard hit to the head or body to kill an infant or small child.

You could
be making a
deadly mistake.

Spend time observing your partner/babysitter with your child before leaving them alone together. Watch the interaction. Make sure you and your child are comfortable and the interaction is appropriate.

Does your partner/babysitter:

- Expect your child to do things that are not realistic for his/her age?
 - Overreact when your child breaks rules or does not follow directions?
 - Show anger or impatience when your child cries or throws a tantrum?
 - Call your child bad names or say mean things to your child?
 - Think it is funny to scare your child?
 - Say you are a bad parent and not strict enough?
 - Hurt your child?
 - Handle guns and knives around your child?
 - Think your child is a bother and gets in the way?
 - Drink alcohol in excess or use drugs around your child?

If you have answered yes to even one of these questions, your child could be at risk. Do the right thing—carefully choose who you allow to watch your child.

**What You
Can Do**

In case of an emergency and before you

- leave home:**
- Leave your cell phone number and other emergency numbers.
 - Let your partner/babysitter know it is okay

While you are away.

- Ask your partner/babysitter what they did while you were away.
 - Ask your child if they liked your partner/babysitter after they leave.
 - Observe your child's behavior, especially an infant or toddler. Does your child seem peaceful and happy?
 - If you suspect something is wrong with your child or if they have been hurt, get help right away.

Teach your child:

- The name of a trusted neighbor close to home who they can call or go to if they think they are in danger.
 - How to call 911 in an emergency.
 - That it is okay to talk to you about any problems or concerns they might have about your partner/husband.

APPENDIX II

CHILD ABUSE DEATHS BY COUNTY

Number of Deaths by County												Number of Deaths by County																			
County	Year	2004					2005					2006					2007					2008					Total # of Deaths				
		2004	2005	2006	2007	2008	2009	Total # of Deaths	2004	2005	2006	2007	2008	2009	Total # of Deaths	2004	2005	2006	2007	2008	2009	Total # of Deaths	2004	2005	2006	2007	2008	2009	Total # of Deaths		
Alachua	1	3	2	2	1	2	9	Lake	0	0	1	4	7	3	13																
Baker	1	1	1	1	1	2	5	Lee	5	4	4	3	8	2	24																
Bay	0	1	0	1	3	2	6	Leon	2	0	0	1	1	0	5																
Bradford	0	1	1	0	0	0	2	Levy	0	0	0	0	1	1	1																
Brevard	7	5	11	8	10	7	41	Liberty	0	0	0	0	0	0	0																
Broward	13	9	14	11	26	20	74	Madison	0	0	0	2	1	0	3																
Calhoun	0	0	0	0	0	0	0	Manatee	1	0	4	1	5	7	11																
Charlotte	2	0	2	0	0	1	4	Marion	4	6	7	7	12	7	37																
Citrus	4	0	1	2	6	3	13	Monroe	0	0	1	0	0	1	1																
Clay	1	0	0	2	0	4	3	Martin	0	0	2	0	0	0	1																
Collier	0	0	3	2	1	9	6	Nassau	0	0	0	0	0	3	0																
Columbia	0	0	1	0	0	2	1	Okeechobee	0	0	2	2	0	2	4																
Dade	14	5	11	6	11	6	48	Orange	5	9	9	10	12	5	45																
Dixie	0	0	0	0	1	0	1	Osceola	1	1	3	4	1	4	10																
Desoto	0	0	0	0	0	1	0	Palm Beach	6	6	14	18	9	10	54																
Duval	16	9	12	8	10	19	55	Pasco	2	0	4	8	2	3	16																
Escambia	1	0	4	2	0	4	7	Pinellas	2	5	6	7	6	5	25																
Flagler	0	0	1	0	0	0	1	Polk	7	8	17	16	14	14	62																
Franklin	0	0	0	0	0	0	0	Putman	0	0	3	0	1	2	4																
Gadsden	0	1	0	1	1	0	3	Randall	2	2	3	1	1	1	9																
Glades	1	0	0	0	0	0	0	Santa Rosa	2	2	3	1	1	1	9																
Gilchrist	0	0	0	0	0	0	0	Sarasota	1	1	1	4	5	2	12																
Gulf	0	0	0	0	0	0	0	Seminole	3	2	4	3	3	4	15																
Hamilton	0	0	0	0	0	0	0	St. John	2	1	0	1	1	1	5																
Hardee	0	0	0	0	1	1	1	St. Lucie	0	0	1	3	7	0	11																
Hendry	0	0	0	0	0	0	0	Sumter	0	2	1	1	1	1	5																
Hernando	1	2	3	0	4	5	7	Suwannee	1	0	0	1	2	1	3																
Highlands	0	0	1	6	1	2	8	Taylor	0	0	0	0	0	0	0																
Hillsborough	2	6	9	8	12	13	37	Union	0	1	7	2	0	0	10																
Holmes	2	0	0	1	0	0	3	Volusia	1	2	1	4	4	4	12																
Indian River	3	0	0	2	1	2	6	Walton	0	2	1	0	1	2	4																
Jackson	1	4	1	0	0	1	6	Wakulla	0	0	0	1	0	1	1																
Jefferson	0	0	0	0	1	1	0	Washington	0	0	1	0	0	0	1																
Lafayette	0	0	1	0	0	0	1																								
	70	47	79	63	92	107	350		45	52	98	105	109	85	411																

APPENDIX III

PURPOSE OF CHILD ABUSE DEATH REVIEW COMMITTEE

Program Background and Description

The Florida Child Abuse Death Review Committee was established by statute in s. 383.402, F. S., in 1999. The program is administered by the Florida Department of Health, and utilizes state and locally developed multi-disciplinary teams to conduct detailed reviews of the facts and circumstances surrounding child abuse and neglect deaths in which a verified report of abuse or neglect was accepted by the Florida Abuse Hotline Information System within the Department of Children and Families (Department of Children and Families). The major purpose of the program is to develop and implement data-driven recommendations for reducing child abuse and neglect deaths.

Mission Statement

The mission statement of the Child Abuse and Neglect Death Review Program is: To reduce preventable child abuse and neglect deaths.

Goal

The goal of the child abuse death review committees is to improve our understanding of how and why children die, to demonstrate the need for and to influence policies and programs to improve child health, safety and protection, and to prevent other child deaths.

Achieving Objectives

- Accurate identification and uniform reporting of the cause and manner of child abuse and neglect deaths
- Improved communication and linkages among agencies and enhanced coordination of efforts
- Improved agency responses in the investigation of child abuse and neglect deaths and the delivery of services
- Design and implementation of cooperative, standardized protocols for the investigation of child abuse and neglect deaths
- Identification of needed changes in legislation, rules, policy and practices, and expanded efforts in child health and safety to prevent child abuse and neglect deaths
- Achieve a greater understanding of the causes and contributing factors of deaths resulting from child abuse and neglect.

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. Agency representatives of The State Child Abuse Death Review Committee are appointed for staggered two-year terms, and all are eligible for reappointment. The representative of the Florida Department of Health, appointed by the Secretary of Health, serves as the State Committee Coordinator.

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

- Department of Health
- Department of Legal Affairs
- Department of Children and Family Services
- Department of Law Enforcement
- Department of Education
- Florida Prosecuting Attorneys Association
- Florida Medical Examiners Commission, whose representative must be a forensic pathologist

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

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

APPENDIX IV

LOCAL CHILD ABUSE DEATH REVIEW COMMITTEES

Committee 1

Escambia and Santa Rosa Counties

Phyllis Gonzalez, Chairperson
Randy Flemming-Co-Chair
Families Count
Director of Services
5139 Elmira St.
Milton FL 32570.
Office: 850-393-6332
Fax:
Email: p_gonzalez@familiescount.net

Committee 2

Okaloosa and Walton Counties

Terry Light - Chairperson
Okaloosa/Walton Regional CADRT
Child Protection Team
401 McEwen Road
Niceville, Florida 32578
Office: 850- 833-9237
Fax:
Email: Terry_Light@doh.state.fl.us

Committee 3

Bay, Calhoun, Gulf, Holmes, Jackson, Washington Counties

Monique Gorman –Chair
Christi Bazemore-Co-Chair
Gulf Coast Children's Advocacy Center,
Inc
Child Protection Team
700 West 23rd Street, Bldg E Suite 40
Panama City, Florida 32405
Office: (850) 872-7760 x 205
Fax:
Email: Monique_Gorman@doh.state.fl.us
Email: Christi_Bazemore@doh.state.fl.us

Committee 4

Franklin, Gadsden, Jefferson, Leon, Liberty, Madison, Taylor, Wakulla

Evelyn Goslin, Ph.D Chairperson

Chris Hirst, FDLE, Co-Chair

Children's Home Society
1801 Miccosukee Commons Drive
Tallahassee, FL 32308
Office: 850-487-2838
Fax: 850-414-2494
E-mail: evelyn.goslin@chsfl.org
[Email:Chrishirst@fdle.state.fl.us](mailto:Chrishirst@fdle.state.fl.us)

Committee 5

Alachua, Bradford, Columbia, Dixie, Gilchrist, Hamilton, Lafayette, Levy, Putman, Suwannee, Union Counties

Stephanie Cox, Chairperson
Lauren Dean- Co-Chair
University of Florida Dept of Pediatrics
1701 SW 16th Ave. Bld. A
Gainesville, FL 32608-1173
Office: 352-334-1308
Fax: 352-334-0998
E- mail: coxsg@peds.ufl.edu

Committee 6

Baker, Clay, Nassau, St. Johns Counties

Dr. Bruce McIntosh-Chair
Vicki Whitfield- Co-Chair
UF First Coast Child Protection Team
4539 Beach Blvd.
Jacksonville, FL 32207
Office : 904-633-0326(Dr. McIntosh)
Office: 904-633-0314(Vicki Whitfield)
Fax: 904-633-0301
Email: Bruce_McIntosh@doh.state.fl.us
Email : Vicki_Whitfield@doh.state.fl.us

Committee 7

Duval County

Carol Synkewecz, Chairperson
Ken Jones, Co-Chair
Dept. Of Health
515 West 6th Street

Jacksonville, FL 32206
Office: 904-253-1021
Fax:
E-mail: Carol_Synkewecz@doh.state.fl.us
E-mail: Ken_Jones@doh.state.fl.us

Committee 8
Volusia and Flagler Counties

Mary Taylor- Chair
Child Protection Team
Children' Advocacy Center
1011 West International Speedway Blvd.
Daytona, FL 32114
Office :- [386 238-3830](tel:3862383830)
Fax : 386-238-3831
E-mail: MTaylor@childrensadvocacy.org

Committee 9
Seminole County

Nancy D. Crawford, Chairperson
Diane Green- Co- Chair
Kids House, Inc. Executive Director
5467 North Ronald Regan Blvd. Sanford,
Florida 32773-6332
Office 407-302-4442 X227
E-mail: Crawford@kidshouse.org
Email: diane.greene@cbcseminole.org

Committee 10
Brevard County

Julia Lynch, Chairperson
Chuck Biehl Co-Chair
State Attorney's Office, District 18
2725 Judge Fran Jamison
Building D
Viera, Florida 32940
Office: 321- 617-7510
Email: jlynch@sa18.state.fl.us
E-mail: Charles.Biehl@Wuesthoff.org

Committee 11
**Indian River, Martin, Okeechobee, St.
Lucie Counties**

Kerry Bartley-Chair
Child Protection Team Coordinator
1111 SE Federal Highway
Floor: 03 Room: 326

Stuart, FL 34994
Office: 772- 287-8009
Fax:
Email: Kerry_Bartley@doh.state.fl.us

Committee 12
Palm Beach County

Susan E. Larson
Victim Services Program Specialist
Office of the Attorney General
1515 North Flagler Drive
9th Floor
West Palm Beach, Florida 33401-3432
Office:561- 837-5025 Ext.168
Fax: 561- 837-5108
Email: susan.larson@myfloridalegal.com

Committee 13
Broward County

Deborah Hill, Chairperson
Local Child Death Review Coordinator
Children's Services Administrator Division
780 S 24TH Street
Ft. Lauderdale, FL 33315
Office : 954-467-4814
Fax :
Email: Deborah_Hill@doh.state.fl.us

Committee 14
Miami-Dade and Monroe Counties

Isabel Perez-Morina, Ph.D.-Chair
Chief Program Officer,
Advocate Program, Inc
1200 NW 78th Ave, Suite 300A,
Doral, FL 33126
Office(305) 704-0114 (Doral)
Office (305) 704-0141 (East Dade
Fax: 305) 704-0199
Email: ipmorina@advocateprogram.com
John Feliu- Support staff
Email: JFeliu@jud11.flcourts.org

Committee 15
Collier County

Jackie Stephens, MA, Chairperson
Collier County Child Death Review Team

C/o Child Protection Team of Collier County
1034 Sixth Avenue North
Naples, FL 34102
Office: 239- 263-8383 x 28
Email: Jackie_Stephens@doh.state.fl.us

Committee 16
Charlotte, Glades, Hendry, Lee Counties

Vacant

Committee 17
Sarasota and DeSoto Counties

Kathleen Wiggs-Stayner-Chairperson
Jean Shoemaker- Co-Chair
All Children's Hospital
801 Sixth Street Sough
St. Petersburg, FL 33701
Office (727) 767-4751
Fax -727-767-8500
Email:staynerk@allkids.org
Email:ShoemakJ@allkids.org

Committee 18
Hardee, Highlands, Polk Counties

Stephen Nelson, M.D., Chairperson
Linda Kurtzweil- Co-Chair
CPT Program Supervisor
1021 Jim Keene Blvd.-Dr. Nelson
Winter Haven, FL 33880
Children's Advocacy Center- Linda
Kurtzweil
1260 Golfview Ave,
Bartow, FL 33830
Office: 863- 519-3900 Ext. 231
Fax: 863- 519-3912
Office: 863- 298-4600
Email: stephennelson@polk-county.net
Email: Linda_Kurtzweil@doh.state.fl.us

Committee 19
Manatee County

Major Connie Shingledecker, Chairperson
Manatee County Child Fatality Review Committee

C/o Manatee County Sheriff's Office
515 11th Street West
Bradenton, FL 34205
Office: 941- 747-3011 ext. 2241
Fax: 941-749-5401
Email:connie.shingledecker@co.manatee.fl.us

Committee 20
Hillsborough County

Andrew Strope, -Chair
Child Protection Team
Clinical Supervisor
2806 N. Armenia Avenue
Tampa, FL 33607
Office: 813-250-6655
Office Cell: 813-476-4105
Email: astrophe@hsc.usf.edu

Committee 21
Pinellas County

Laura Eastman-Chair
Laura Pizzi- Co-Chair
Suncoast Center INC
P.O. Box 10970
St. Petersburg, FL 33733
4000 Gateway Centre BLVD Suite 200
Pinellas Park FL 33782
Office 727-544-3900 x145
Fax 727-544-5577
Email: lauraeastman@helpachild.org
Email: laurapizzi@helpachild.org

Committee 22
Pasco County

Jon Wisenbaker-Chair
7615 Little Road
New Port Richey, FL 34654
Office: 727-845-8080
Fax: 727-848-1292
Email: Jon_Wisenbaker@doh.state.fl.us

Committee 23
Orange and Osceola Counties

Michael Hardman- Chair
Joy Chuba-Co-Chair

Child Advocacy Center
Howard Philips Center
601 W. Michigan Ave.
Orlando, FL 32805
Office: 407-317-7430 x2104
Fax:
Email:
Michael.Hardman@orlandohealth.com
Email: jchuba@osceolakids.com

Committee 24
Citrus, Hernando, Lake, Marion,
Sumter Counties

Edie Neal, Chairperson
FDLE Special Agent
Lt. Dave DeCarlo- Citrus S/O- co-chair
19245 Cortez Blvd
Brooksville, Florida 34601
Office: 352-279-1822
Fax: 352-544-2384
Email: edithneal@fdle.state.fl.us
Email: ddecarlo@sheriffcitrus.org

Local Child Abuse Death Review Committees

