FLORIDA CHILD ABUSE DEATH REVIEW

THIRD ANNUAL REPORT

DECEMBER 2002

State Child Abuse Death Review Team
4052 Bald Cypress Way, Bin A06
Tallahassee, Florida 32399
(850) 245-4200

FLORIDA CHILD ABUSE DEATH REVIEW TEAM

The Honorable Jeb Bush
Governor of Florida
The Honorable Jim King
President of the Florida Senate
The Honorable Johnnie Byrd
Speaker of the Florida House of Representatives
The Capitol
Tallahassee, FL 32399-0001

Dear Governor Bush, Mr. President, and Mr. Speaker:

In accordance with Chapter 383.402, Florida Statutes, as chairman of the State Child Abuse Death Review Team, I am submitting this annual report of child deaths due to abuse and neglect on behalf of the team for your review and information. This report includes information from the case reviews of the 35 children who died in 2001, and had at least one prior report of abuse or neglect filed with the Department of Children and Families. Additionally, it highlights major issues and trends for the 95 deaths reviewed over the three-year period since the inception of the Florida State Child Abuse Death Review Team.

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

I believe this report justifies the need for a continued review of child abuse deaths in Florida and for data-driven policymaking to prevent further avoidable child abuse and neglect deaths. There have been many challenges encountered and accomplishments made by the State Team and the Department of Children and Families. As our work progresses, I am optimistic that the end result will be a better understanding of the circumstances and contributing factors, supporting our ultimate goal of continuing the mission of working together to reduce preventable child abuse and neglect deaths.

Sincerely,

Michael Bell

Michael Bell, M.D., Chairman
State Child Abuse Death Review Team

FLORIDA
CHILD ABUSE DEATH REVIEW TEAM

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MISSION

To reduce preventable child abuse and neglect deaths

Submitted to

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

DEDICATION

The cases of thirty-five children who had prior involvement with child protection services and who subsequently died from abuse or neglect during 2001 were presented to the Child Abuse Death Review Team for review. This report is dedicated to these children.

Profile Information	Date of Death	Cause of Death	Perpetrator or Caretaker Responsible	Number Prior Reports
23 day old female	*7/25/2001*	*Blunt Impact Injuries to Torso*	*Mother and Father*	*1*
2-month-old female	*3/31/2001*	*Asphyxia due to Overlay*	*Mother's paramour*	*1*
4-month-old female	*4/20/2001*	*Shaken Baby Syndrome*	*Father*	*1*
6-month-old male	*6/27/2001*	*Trauma to Head*	*Step Aunt*	*1*
7-month-old male	*3/16/2001*	*Suffocation due to Overlay*	*Mother*	*1*
10-month-old male	*4/2/2001*	*Abusive Head Injury/Battered Child Syndrome*	*Father*	*1*
13-month-old male	*12/6/2001*	*Blunt Force Trauma to Head*	*Father*	*1*
15-month-old female	*5/18/2001*	*Blunt Abdominal Trauma*	*Babysitter*	*2*
17-month-old male	*11/18/2001*	*Environmental Hyperthermia-Child left in day care van*	*Day Care Owner and Staff*	*1*
17-month-old female	*7/18/2001*	*Drowning due to abuse*	*Foster Mother*	*4*
19-month-old male	*4/13/2001*	*Cerebral Edema due to Multiple Head Trauma*	*Mother's paramour*	*1*
22-month-old female	*11/16/2001*	*Drowning*	*Mother*	*4*
23-month-old female	*4/3/2001*	*Blunt Craniocerebral Trauma (due to vehicle tire rolling over child)*	*Mother*	*1*
2-year-old male	*10/9/2001*	*Blunt Force Trauma to Head*	*Mother and Father*	*2*

DEDICATION (continued)

Profile Information	Date of Death	Cause of Death	Perpetrator or Caretaker Responsible	Number Prior Reports
2-year-old male	*9/18/2001*	*Complications of Multiple Blunt Trauma*	*Mother's paramour*	*2*
2-year-old male	*5/11/2001*	*Blunt Head Trauma*	*Mother's paramour*	*1*
2-year-old female	*5/20/2001*	*Drowning – Lack of Supervision*	*Mother and Father*	*1*
2-year-old male	*1/21/2001*	*Craniocerebral Trauma – Blunt Impact to Head*	*Mother*	*1*
2-year-old female	*9/25/2001*	*Blunt Impact to Chest and Abdomen*	*Mother's paramour*	*1*
2-year-old female	*8/10/2001*	*Hyperthermia –Child left in a day care van*	*Day Care Employee*	*1*
2-year-old female	*8/7/2001*	*Drowning – Lack of Supervision*	*Mother and Father*	*2*
2-year-old male	*6/3/2001*	*Mechanical Asphyxia associated with Blunt Trauma*	*Step father*	*4*
2-year-old male	*9/2/2001*	*Inflicted Abdominal Trauma*	*Father*	*6*
3-year-old male	*10/20/2001*	*Blunt Impact to Head and Abdomen*	*Mother's paramour*	*5*
3-year-old female	*12/24/2001*	*Hanging*	*Father*	*1*
3-year-old female	*7/12/2001*	*Blunt Trauma to Head and Abdomen*	*Mother's paramour*	*1*
4-year-old female	*5/19/20011*	*Gunshot to head*	*Uncle and Mother*	*1*
4-year-old female	*7/26/2001*	*Multiple Blunt Force Trauma*	*Father's paramour*	*4*

DEDICATION (continued)

Profile Information	Date of Death	Cause of Death	Perpetrator or Caretaker Responsible	Number Prior Reports
5-year-old male	*9/6/2001*	*Gunshot to Head*	*Mother and sibling*	*6*
9-year-old male	*7/14/2001*	*Positional Asphyxia*	*Parents*	*6*
11-year-old male	*10/30/2001*	*Hanging - Suicide*	*Institutional Employee*	*9*
11-year-old female	*6/4/2001*	*Vehicle Related Death*	*Mother*	*3*
12-year-old male	*1/14/2001*	*Vehicle Related Death*	*Mother and other non-relative*	*7*
14-year-old male	*11/11/2001*	*Probable Septicemia*	*Mother*	*14*
17-year-old male	*6/3/2001*	*Blunt Force Trauma to Head as a result of Traffic Accident*	*Other relative*	*3*

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

William Wordsworth (1770-1850)
We are Seven

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EXECUTIVE SUMMARY

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

"The purpose of the reviews shall be to:

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

This third annual report includes information from the review of the 35 children who died in 2001. Additionally, it highlights major issues and trends for the 95 deaths reviewed over the three-year period since the inception of the Florida State Child Abuse Death Review Team. It is important for the reader to put the review of these child deaths in perspective. Because the population reviewed is limited in scope and representation of the total number of abuse and neglect deaths in Florida, the recommendations and comments made throughout this report are subject to those limitations when generalizations are made. There are clear patterns and trends noted for the state that are consistent with national data; however, because of the limited population there are variations, which are reflected in this report. Findings for this three-year period include the following:

- Abuse deaths occurred more frequently (52%) than neglect deaths included in this report.

- The majority of the abuse deaths involved direct attacks resulting in physical trauma. Of the 31 trauma-related deaths, 16 of the children died from head trauma, six from abdominal trauma, and nine from beatings and multiple traumas.

- Five children died from trauma resulting from shaken infant impact.

- Drowning was, the leading cause of neglect deaths, with 17 child deaths for the three-year period.

- Nine of the children died from a fatal gunshot wound. Six children were intentionally shot by an adult. One child died as a result of being shot in the head by her mother, wrapped in a blanket and placed in a dumpster. Another child died when his older sibling found a gun in the house and accidentally shot him, while being inadequately supervised.

- National statistics reported that the majority of children who suffered maltreatment related deaths in 2000 were young. The results of the 2000 Reports from the States to the National Child Abuse and Neglect Data System (NCANDS) indicated that 43% were under 12 months of age and 85% were younger than 6 years.[3] Results from this review indicated a lower percentage of children in these age groups, 14% of the children who died from abuse and neglect were under a year old and 76% of the children were younger than six years. One reason for this may have been that the review included only those deaths in which the victim had been the subject of a prior report to the Florida Abuse Hotline, and very young children, particularly infants, were less likely to have been reported to the abuse hotline than older children. Had the review included child victims whose older siblings or other household members had been the subject of a prior report, the number of deaths in this age range may have been higher. Figure 6 of the report provides a specific breakdown of age at death for these 95 children.

- Males represented 60% of the deaths and females represented 40%. Fifty-nine (59%) percent of the children were white, 40% percent were black and 1% were American Indian. For those deaths that identified specific ethnicity, a total of 14 (15%) were identified as Hispanic and 2 (2%) were identified as Haitian.

- Fathers or male paramours were responsible in 56 (59%) of the deaths. Mothers were responsible in 34 (41%) of the deaths. Neglect was the primary cause of death in the majority of cases in which the mother was the only perpetrator/caretaker responsible. The majority of the deaths in which the father or male paramour was the sole perpetrator/caretaker responsible were caused by abuse.

- The identified perpetrator/caretaker responsible ranged in age from 17 to 79, with a median age of 31.4 years. This conflicts with national estimates, which report that perpetrator/caretaker responsible of maltreatment fatalities are generally younger than 30 years of age. This may be the result of the case criteria for this review as young parents with first time infants having no prior reports were not included.

- 83 (87%) of the 95 children had three or more risk factors present at the time of death. Major risk factors for these children and the percent of deaths in which these factors were present included:

    - One or more children in the household were age four or younger (78% of deaths)
    - A pattern of escalation or frequency of incidents of abuse or neglect (48% of deaths)
    - Parent or caregiver unable to meet children's immediate needs (43% of deaths)
    - Children in the home had limited community visibility (42% of deaths)
    - Parent or caregiver's age, mental health, alcohol or substance abuse affected their ability to adequately care for child (43% of deaths)
    - Parent or caregiver's criminal history presented a potential threat of harm to the child (33% of deaths)
    - Pattern of escalating and/or continuing incidents of domestic violence (26%)
    - Living conditions were physically hazardous to the health of the child (25% of deaths)
    - Parent or caregiver were unable or unwilling to protect the child from abusive caregivers/paramours (23% of deaths)

Data for 2001 indicated that of the 35 deaths reviewed by the team, the causes and contributing factors included:

Abuse (19 deaths)

- The majority of the abuse deaths involved direct attacks resulting in physical trauma. Of the 15 trauma related deaths, 8 of the children died from head trauma, 3 from abdominal trauma, 2 from multiple traumas, and 2 from beatings.
- 1 child was intentionally drowned in a bathtub.
- 1 child died from shaken infant impact.
- 1 child died from a gunshot, homicide.
- 1 child died from hanging.

Neglect (16 deaths)

- 5 children died in vehicle related accidents, none were wearing appropriate vehicle restraints. Two children died together when the perpetrator/caretaker responsible (parent/uncle) lost control of the car due to a blown tire. Another child was left unrestrained and unattended in a car with the engine running, and died when the car engaged and rolled over her.
- 3 children accidentally drowned in swimming pools. Inadequate supervision by the perpetrator/caretaker responsible contributed to these deaths.
- 2 children died in separate incidents of being left on day care buses for extended periods of time and dying from hyperthermia. Inadequate supervision in a daycare setting was a contributing cause in these deaths.
- 2 children suffocated while co-sleeping with an adult or sibling. In addition to the neglect allegations, substance abuse related allegations were verified in both cases.
- 2 children with severe disabilities died due to medical neglect and inadequate supervision.
- 1 child died from a gunshot wound caused when a sibling located a gun in the home that was not properly secured and fired the gun striking his younger sibling.
- 1 child died by hanging himself, due to inadequate supervision in a facility.

ISSUES AND RECOMMENDATIONS

During the first two years, The State Child Abuse Death Review Team worked diligently to develop a foundation for the child abuse death review process at both state and local levels. The first year brought both challenges and insight in the efforts to develop a multidisciplinary approach to review these deaths, achieve a better understanding of why these children died, and create better approaches for preventing future deaths. The challenges of the second and third years focused on the development of local teams, the establishment of protocols for receiving the necessary information for review from the various agencies involved in child death investigations, the development of various tracking mechanisms to collect short and long-term data, the development of protocols for analyzing the data, and agreeing upon conclusions and recommendations.

It remains important for the reader to put the overall analysis of these child deaths in perspective. In addition to the limitations in the information used to analyze individual cases, the population reviewed is limited in scope and representation of the total number of abuse and neglect deaths in Florida. Consequently, the recommendations and comments made throughout this report are subject to those limitations when generalizations are made. There are clear patterns and trends noted for the state that are consistent with national data; however,

because of the limited population there are variations, which are reflected in this report. The issues and recommendations below stem from the review of these deaths:

The Child Abuse Death Review Team identified both case specific and overall systemic issues in the child protection system. During the course of the year, the team identified some issues requiring immediate team action or recommendations directly to the individuals or groups involved. After a careful analysis of the data, the state team presents the following recommendations to address critical issues identified during the reviews and discussions of the deaths.

ISSUE 1: LACK OF LOCAL TEAMS

The lack of local teams continues to challenge the state team to find adequate means to review these deaths. Without the participation of local investigators and service providers who had direct input with the child and family, the state team had to base their review on the written records provided. As a result, the review team often lacked valuable information, affecting both the reliability of conclusions and any resulting recommendations.

One of the primary causes for lack of local team development is the strict criterion for cases. It is difficult to maintain interest with such a limited scope of review. Another cause is the lack of connection between the state and local teams. Without a designated liaison, teams often lose interest and momentum.

Action Taken: The state team previously recommended that their reviews be expanded to all child deaths. This year the team sent a letter to the Speaker of the House of Representatives, President of the Senate and the heads of the statutorily designated agencies for the child abuse death reviews providing specific amendment language and requesting support for expansion of the criteria.

To address the immediate need, during the past year the state team created a formal Case Review Committee to review the deaths that occurred in areas without a local team.

Action Needed/Recommendation: Continuation of recruitment efforts should remain a priority for the state team. The Florida Legislature should expand the child abuse death review process to include the review of all abuse or neglect deaths, with no requirement for prior reports to the child abuse hotline. Local teams should be granted discretionary authority to review all child deaths based on local interest and resources.

ISSUE 2: LACK OF REVIEW CONSISTENCY

Reviews by local teams and by the state team lacked consistency in the analysis of preventability and in the adequacy of prior services.

Action Taken: Along with the development of a formal case review committee, state team liaisons were identified for each of the local teams. The liaison responsibilities include providing training and technical assistance to local teams to help achieve consistency across the state in the review process. The state team determined that each locally reviewed case would be assigned to a member of the case review committee to review and present to the full case review committee. They developed a protocol for their reviews and for their secondary review and acceptance of local review team findings. All findings and recommendations of the case review committee are then presented to the full team for concurrence.

Action Needed/Recommendation: Further development of the data collection form and guide is needed to include a requirement for additional information related to risk assessment, prior service adequacy and abuse preventability and to clarify questions related to these areas. The Case Review Committee should formalize the process for presentation of their findings to the full team for discussion and concurrence, to cover all areas of findings and recommendations.

ISSUE 3: RECEIVING INFORMATION NECESSARY FOR ADEQUATE REVIEW

The committee experienced difficulty in identifying prior service provision and assessing the adequacy of the prior services, in part due to their dependence on local death review teams or DCF death review coordinators to provide them with the information needed, some of which they may not have available. Additionally, the committee determined that to adequately review these cases without benefit of the investigator and local service providers, they required the entire investigative file as well as the files of all prior investigations and services. The time lag involved in receiving this information impeded the team's ability to adequately review the files and make appropriate recommendations.

Action Taken: The Department of Children and Families staff liaison, with the concurrence of the department's state team representative, was made a member of the case review subcommittee and worked directly with the state team staff to facilitate early receipt of these records. A standard letter was developed that outlines the information needed from local teams and DCF District Death Review Coordinators, and a process put in place to facilitate early identification of the any additional records needed from other agencies or service providers.

Action Needed/Recommendation: Further clarification is needed regarding the responsibilities of the local death review teams and the Department of Children and Families District Death Review Coordinators. The local and internal death review process should include providing information to The State Child Abuse Death Review Team as statutorily required, including the collection of information from other local providers. An interagency memorandum of understanding should be agreed upon and signed by the heads of all agencies represented.

ISSUE 4: FAILURE TO REPORT CHILD ABUSE OR NEGLECT TO THE HOTLINE, AND INADEQUATE COMMUNICATION BETWEEN CHILD PROTECTION STAFF AND IN-HOME SERVICE PROVIDERS

It is not uncommon for providers of in-home prevention services to be told about, or directly observe inappropriate parenting, neglect or abuse. Without specific child abuse expertise, it is sometimes difficult for these providers to determine when an incident, disclosed by a family member or witnessed directly, crosses this line and requires a call to the child abuse hotline. Providers are also concerned with violating the trust of their clients and therefore damaging their ability to assist the family.

Additionally, child abuse investigators frequently make referrals for voluntary in-home services when risk is identified and either:

- Insufficient evidence is available to support judicial action, or
- The family has acknowledged the problem and agreed to work cooperatively to resolve the risk-associated issues.

Because the child abuse investigator closes these cases after referral, the provider has no direct contact if the family fails to cooperate with the service plan. If no new reportable incident

has occurred and the service provider lacks the knowledge or information regarding whom to call, the child may be left in a high-risk environment.

Action Taken: The Department of Health and the Department of Children and Families worked cooperatively during the past year to address these issues. Accomplishments during the year included:

- A satellite training entitled "Common Sense and the Assessment of Child Abuse Injuries" was provided to Healthy Start and Healthy Families providers in May 2002. Videotape copies of this training have been sent to all the County Health Departments and Healthy Start Coalitions.

- Meetings were held between the Healthy Start and DCF program offices to brainstorm ideas for stronger collaborative efforts.

- Development has begun on additional child abuse and neglect training. Input from Healthy Start Coalitions and Healthy Start service providers has been solicited regarding their training needs on child abuse and neglect. Resources are being explored for a training module on neglect. Training on case management is also planned. Workshops on child abuse will be provided at the Sharing Solutions Conference in May 2003.

- Language has been added to the Healthy Start Standards and Guidelines that:

    - Requires care coordination providers to receive pre-service training on recognizing and reporting child abuse and neglect

    - Requires that care coordination providers demonstrate knowledge of child abuse and neglect indicators and the responsibility to report suspected abuse or neglect to the Florida Abuse Hotline

    - Reinforces the requirement to report suspected child abuse and neglect to the Florida Abuse Hotline

    - Includes a listing of the characteristics of the parent at risk for child maltreatment

    - Requires supervisors to co-sign documentation of closure in case record for substance involved families or families with known or suspected child maltreatment

    - Requires written notification of case closure to the referral source and/or the Department of Children and Families if the referral reason was risk of child maltreatment

    - Requires paraprofessionals to immediately contact a supervisor for guidance when a family has safety concerns or immediate needs

    - Includes the question "Were indicators of child maltreatment recognized and reported accurately?" in the programs Quality Improvement/Quality Assurance activities.

Action Needed/Recommendations: That all in-home service providers working with families in their homes providing coordination of care, linkages, referrals, and direct services have a mandatory child abuse and neglect training requirement. That other in-home service providers adopt the Healthy Start standards and guidelines listed above.

Stricter penalties should be enacted for professionals identified by statute as mandated reporters who fail to report child abuse and neglect.

ISSUE 5: FAILURE TO REPORT CHILD VEHICLE RESTRAINT NEGLECT, OR OTHER TRAFFIC OFFENSE RELATED ABUSE/NEGLECT

Serious injury or death could often be avoided by the proper use of child restraints. Children are also placed at risk as passengers in vehicles driven by impaired or reckless drivers. These incidents are often unreported because law enforcement officers only identify them as traffic violations. Although drivers are fined for child restraint violations, these are not strong enough deterrents.

Action Needed/Recommendations: The Department of Law Enforcement, in conjunction with the Department of Children and Families, should provide training to local law enforcement agencies and the Florida Highway Patrol on recognizing and reporting child neglect and abuse during traffic related incidents.

Enhanced penalties for violation of child vehicular restraint requirements.

ISSUE 6: CHILDREN ABUSED IN DAYCARE SETTINGS

Parents can unknowingly place their children at risk in daycare settings that have previously been sanctioned or closed for abuse or neglect related violations. While daycare licensure files are public record, the knowledge and ability of the general public on accessing these files for review is limited.

Of the cases reviewed for 2001, two children died in separate incidents as a result of being left in day care buses for extended periods of time. Inadequate supervision in a daycare setting was a contributing factor in these deaths.

Action Needed/Recommendation: The Department of Children and Families should maintain a list that identifies daycares that have been closed or sanctioned for abuse or neglect related violations.

ISSUE 7: DEATHS CAUSED BY UNSAFE SLEEPING ENVIRONMENT

In the deaths reviewed for 2001, two children suffocated while co-sleeping with an adult or sibling. In both these incidents, substance abuse was involved. Co-sleeping, use of improper bedding, and other environmental hazards create potential risk to children. Parents are often unaware of these hazards and risks.

Action Taken: The Department of Health and the Department of Children and Families worked cooperatively with their contracted providers of in home prevention services during the past year to develop an educational brochure on these issues. The brochure is currently in the final stages of development.

Action Needed/Recommendations: The Department of Health, in conjunction with the Department of Children and Families, should develop and provide safe sleeping educational activities through the media and through training for staff and clients.

PURPOSE OF CHILD ABUSE DEATH REVIEWS

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

Summary of Early Initiatives

Over the past 15 years, there have been at least ten reviews of the Department of Children and Families (DCF) by independent panels, task forces, and Grand Juries. Five of these reviews were conducted in response to the death of a specific child, all of whom had some contact with DCF prior to their deaths. The reviews that focused on specific children found similar, ongoing systemic issues within DCF that were thought to have contributed to the ultimate death of the children involved, including:

- Significant staff turnover rates among staff
- High caseloads
- Lack of a career ladder and competitive salaries within the discipline necessary to attract and retain qualified professionals
- Insufficient communication between DCF staff in different child protection programs and between DCF staff and staff from other agencies
- Lack of thoroughness in the child protective investigation process, including gathering complete family assessment information such as criminal history, prior agency involvement and family social history during the investigations
- Inadequate case planning and supervision for families receiving ongoing child protection services
- Inadequate training for staff

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

STATE CHILD ABUSE DEATH REVIEW TEAM

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

As a result of this death, and the deaths of other children due to abuse and neglect, the 1999 Florida Legislature authorized the development of independent, multidisciplinary statewide and local child abuse death review teams to review child abuse and neglect deaths in which the Florida Abuse Hotline had accepted at least one prior report of abuse or neglect. The intent of the legislature was to facilitate a better understanding of these deaths and to develop enhanced strategies for preventing future deaths by developing a multidisciplinary panel of individuals at the state and local level who had expertise in the fields directly impacting the health and welfare of children and families.[1]

Program Purpose

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

"The purpose of the reviews shall be to:

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

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

Summary of First Two Years

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

In approximately 83% of the cases reviewed during the first two years, The Child Abuse Death Review Team concluded that the deaths were preventable. In those cases, the team found that the deaths could have been prevented if appropriate action had been taken, by either the Department of Children and Families or sheriff's office staff responsible for protective investigations, by other state agencies or private service providers, or by parents, relatives, neighbors, or other individuals or agencies associated with the child. The team found that some of the deaths, although due to abuse or neglect, were not preventable by anyone other than the identified perpetrator/caretaker responsible.

In the past two prior reports The Child Abuse Death Review Team made recommendations, some of which were specific to the Department of Children and Families. Some of these recommendations have been adopted and implemented, while others have not been implemented because the legislature has not elected to allocate the funds necessary to do so. The team also made recommendations directed at law enforcement and other agencies, focusing on improvement of training and/or changes in policies and practices, such as the necessity to implement a training program to increase the level of understanding of the co-existence of child maltreatment and domestic violence. The team also made recommendations pertaining to its own operations and scope of jurisdiction. The team maintains a summary of all prior recommendations and the status of each that is available by contacting the Chair.

Membership of the State Team

The State Child Abuse Death Review Team consists of seven agency representatives and eleven appointments from various disciplines related to the health and welfare of children and families. Agency representatives of The State Child Abuse Death Review Team are appointed for staggered two-year terms, and all are eligible for reappointment. A representative of the Department of Health, appointed by the Secretary of Health, serves as the State Committee Coordinator.

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

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

In addition, the Secretary of the Department of Health is responsible for appointing the following members based on recommendations from the Department of Health and affiliated agencies, and for ensuring that the 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 Families who supervises family services counselors and who has at least five years of experience in child protective investigations
- A medical director of a child protection team
- A member of a child advocacy organization
- A social worker who has experience in working with victims and perpetrator/caretaker responsible of child abuse
- A person trained as a paraprofessional in patient resources who is employed in a child abuse prevention program
- A law enforcement officer who has at least five years of experience in children's issues
- A representative of the Florida Coalition Against Domestic Violence
- A representative from a private provider of programs on preventing child abuse and neglect

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

Roles and Responsibilities of the State Team

The duties of the state team are to:

- Develop a standard protocol for the uniform collection of data that uses existing and tested data collection systems to the greatest extent possible.
- Provide training to cooperating agencies, individuals and local child abuse death review teams on the use of the child abuse death data protocol.
- Prepare an annual statistical report on the incidence and causes of death resulting from child abuse in the state during the prior calendar year to submit to the Governor, the President of the Senate, and the Speaker of the House of Representatives by December 31 of each year. The report must include recommendations for state and local action, including specific policy, procedural, regulatory, or statutory changes, and any other recommended preventative action.
- Encourage and assist in developing local child abuse death review teams and providing consultation on individual cases to local teams, upon request.
- Develop guidelines, standards and protocols, including a protocol for data collection for local child abuse death review teams, and provide training and technical assistance to local teams.
- Develop guidelines for reviewing child abuse deaths, including guidelines to be used by law enforcement agencies, prosecutors, medical examiners, health care practitioners, health care facilities and social service agencies.
- Study the adequacy of laws, rules, training and services to determine what changes are needed to decrease the incidence of child abuse deaths and develop strategies and recruit partners to implement these changes.
- Educate the public regarding the incidence and causes of child abuse death, and the ways to prevent such deaths.
- Provide continuing education for professionals who investigate, treat and prevent child abuse or neglect.
- Recommend, when appropriate, the review of the death certificate of a child who is suspected to have died of abuse or neglect.

LOCAL CHILD ABUSE DEATH REVIEW TEAMS

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

Membership of Local Death Review Teams

Local child abuse death review teams are comprised of individuals from the community who either have some responsibility when a child dies from abuse or neglect or share an interest in improving the health and welfare of children. Local child abuse death review teams should include, at a minimum, representatives from the following departments, agencies, or associations:

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

The chairperson of the local team may also appoint the following members to the local team as necessary:

- A board-certified pediatrician or family practice physician
- A public health nurse
- A mental health professional who treats children or adolescents
- A member of a child advocacy organization
- A social worker who has experience in working with victims and perpetrator/caretaker responsible of child abuse
- A person trained as a paraprofessional in patient resources who is employed in a child abuse prevention program
- A representative of the Florida Coalition Against Domestic Violence
- A representative from a private provider of programs on preventing child abuse and neglect

Roles and Responsibilities of Local Teams

The duties of the local child abuse death review team are to:

- Review all deaths resulting from child abuse and neglect with at least one report of abuse or neglect accepted by the Florida central abuse hotline
- Collect data on applicable child abuse deaths for The State Child Abuse Death Review Team.

- Submit written reports to the state team as directed. The reports are to include information on individual cases, and steps taken by the local team to implement necessary changes and improve the coordination of services and investigations.
- Submit all records requested by The State Child Abuse Death Review Team at the conclusion of its review of a death resulting from child abuse or neglect.
- Abide by standards and protocols established by The State Child Abuse Death Review Team in the conduct of child abuse death reviews.
- Designate a team chairperson who oversees the activities of the local team and calls meetings of the team when necessary.
- Designate a member of the local team, if there is not a state team member on the local team, to liaison to the state team for the purpose of ensuring consistency in review protocols, to present case information when requested, and to request as needed on a case-by-case basis, that the state team review the data of a particular case.

Max and David*

Three-year-old Max and his seventeen year old uncle David both died as a result of injuries they received when Max's step-father lost control of his car after the left rear tire deflated. Three other passengers in the car, including Max's mother, did not suffer fatal injuries. The car overturned several times ejecting the occupants. According to law enforcement, it hit the embankment at 70 miles per hour, and had to be traveling between 90 to 100 miles an hour when the tire deflated. Witnesses to the accident reported that the car passed them "like they were standing still." None of the passengers were wearing safety belts, and three-year-old Max was not in a proper child restraint. Max died of multiple blunt force injuries and David died from blunt force trauma to the head. There were a total of seven prior reports on Max and David. None were open at the time of their death.

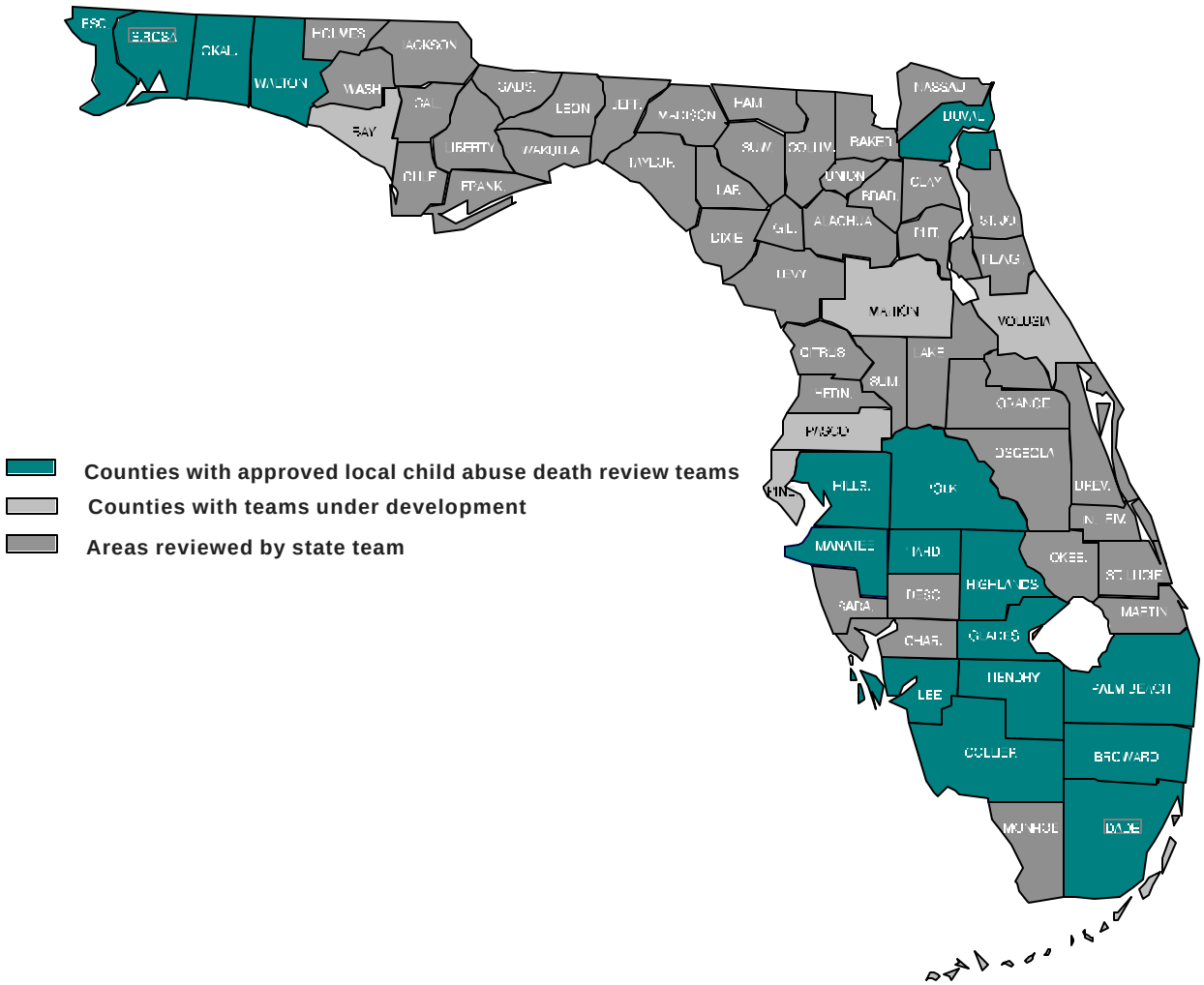
Max's mother and stepfather had a total of sixteen traffic offenses registered with the Department of Highway Safety and Motor Vehicles. Their records included prior seat belt and child restraint violations.

****Alias***

Existing and Planned Local Teams

Recruitment efforts in local areas have resulted in the establishment of 10 local teams covering 18 counties. Figure 1 identifies counties with existing local death review teams and those areas where teams are in various stages of development. State team members have attended community meetings and death review meetings providing information and technical assistance to both existing and emerging local teams. Figure 1 shows those counties with existing local death review teams and those areas where teams are in various stages of development.

Figure 1: Existing and Planned Local Teams as of 2001



CHILD ABUSE AND NEGLECT DATA

Due to the limitations of the team's statutory jurisdiction, the child deaths reviewed by the state and local child abuse death review teams include only those in which the death was verified to have been caused by abuse or neglect and in which at least one prior report was received by the Department of Children and Families Child Abuse Hotline. The Child Abuse Death Review Team, in both of its previous reports, identified this as a limitation in its ability to fully meet the statutory charge of achieving a greater understanding of the causes and contributing factors of deaths resulting from child abuse, because not all deaths meeting that larger scope meet the criteria for review. This smaller sample also limits the team's ability to identify patterns and trends and derive meaningful conclusions from them. In order to overcome some of the limitations discussed above, in addition to analyzing the data available for the current year, the team's annual report compiles and aggregates the data from the deaths reviewed by the team over the past 3 years, resulting in an analysis of a larger sample of cases.

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

ALL CHILD DEATHS - 2001	
Number of child deaths	2,776
FAHIS REPORTS RECEIVED & ABUSE/NEGLECT DEATHS	
Number of Initial Reports	154,465
Number of reports involving child deaths	325
Number of child death reports with verified or some indicator findings	128
Number of verified child death reports	83
Number of verified child death reports with at least one prior report, presented to The Child Abuse Death Review Team for review (to date)	35

CHILD ABUSE DEATH REVIEW TEAM DEATHS

The following map, statistical reports, graphs and charts are based on a review of the child abuse and neglect deaths that occurred from 1999 through 2001. Ninety-five (95) child deaths met the criteria for review by the State Child Abuse Death Review Team. Figures 2 and 3 below indicate the counties in which the deaths occurred, and the number of deaths per county by year.

Figure 2: Location of Child Deaths (1999-2001)

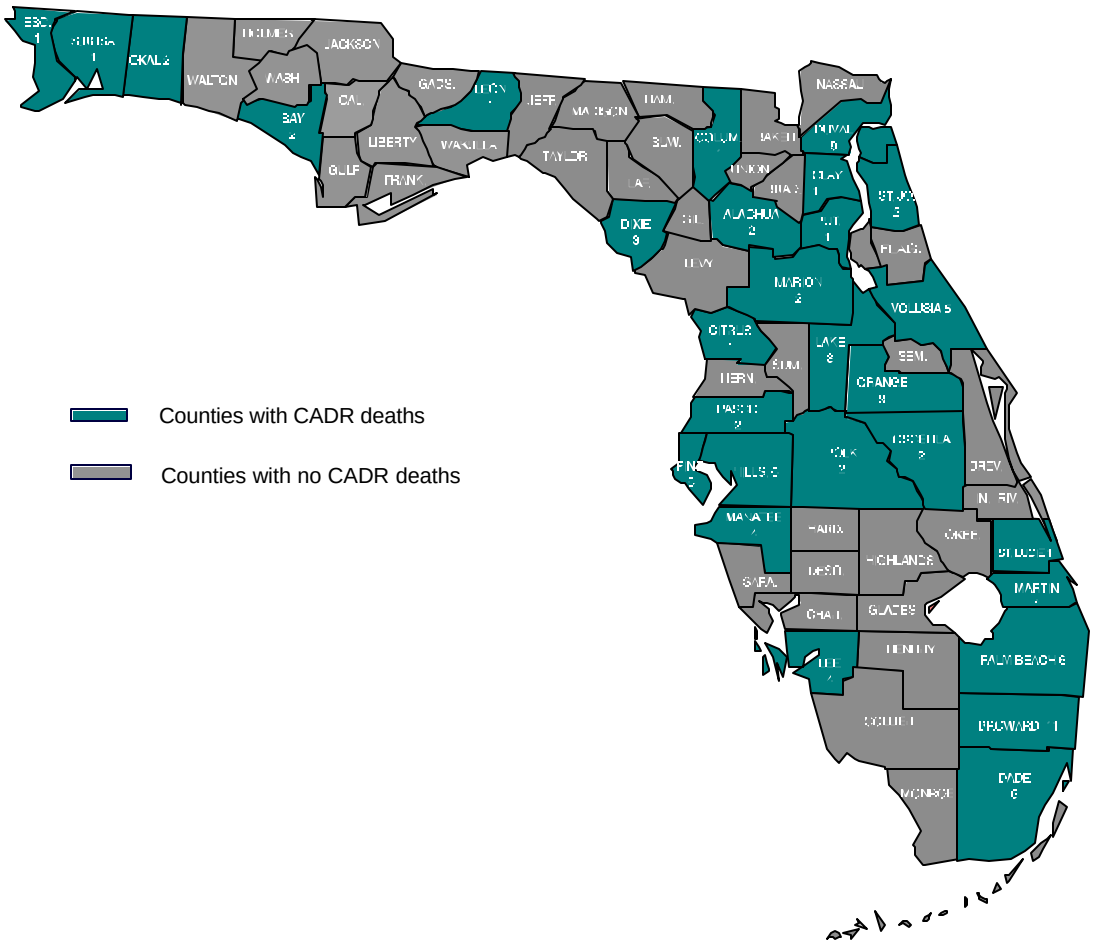


Figure 3: Number of Child Deaths by County/Year (1999 – 2001)

Number of Deaths by County									
County	Year			Total # of Deaths	County	Year			Total # of Deaths
	1999	2000	2001			1999	2000	2001	
Alachua	1	-	1	2	Marion	-	2	-	2
Bay	1	-	1	2	Martin	-	1	-	1
Broward*	2	2	7	11	Okaloosa*	-	1	1	2
Citrus	-	-	1	1	Orange	4	2	3	9
Clay	-	1	-	1	Osceola	2	-	-	2
Columbia	-	1	-	1	Palm Beach*	4	-	1	5
Dade*	3	3	-	6	Pasco	1	-	1	2
Dixie	3	-	-	3	Pinellas	1	3	1	5
Duval*	3	2	3	8	Polk*	-	2	-	2
Escambia*	-	1	-	1	Putnam	-	1	-	1
Hillsborough*	-	2	4	6	Santa Rosa*	-	1	-	1
Lake	1	-	2	3	St. John	1	-	1	2
Lee*	1	-	3	4	St. Lucie	1	-	-	1
Leon	-	-	1	1	Volusia	1	-	4	5
Manatee*	-	4	-	4	* = Counties with local CADR teams				

Holly*

Three year old Holly died while on an over night visit with her father. The father originally had the child for the day but had called her mother and requested she spend the night. He called the mother the next day and told her that he had left written a poem for her and left it on her car. The mother became alarmed upon reading the poem that indicated the father wanted to be buried next to his child. She called the father and told him she wanted to pick up the child, but he became angry and hung up on her. She then called the police who responded to the home and found the child and father hanging in the bedroom. The father had placed a chain around the child's neck and over the top of a weight bench stand. After killing the child, he then placed a chain around his own neck and killed himself. There were two prior reports. One involved the mother as a day care employee that was closed with no indicators of abuse or neglect, and the other report involved allegations of domestic violence between the parents that was closed with some indicators of threatened harm.

**** Alias***

CHILD ABUSE DEATH REVIEW DATA

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

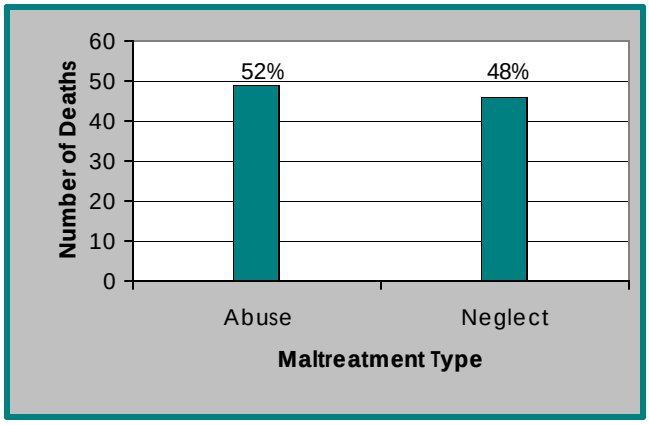
Number of Child Abuse and Neglect Deaths

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

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

A high representation of neglect deaths in Florida's child abuse death reviews may be due to the population included in this study. Since the child deaths that were reviewed involved children who had previously been the subject of a report to the abuse hotline, the prior report may have served to substantiate the death maltreatment by revealing a pattern of failure to provide reasonable care or supervision. The number of deaths by category for the aggregate three-year period is shown in Figure 4.

Figure 4: Abuse & Neglect Deaths (1999-2001)



Type of Death			
	Abuse	Neglect	Total
1999	16	14	30
2000	14	16	30
2001	19	16	35
Total	49	46	95

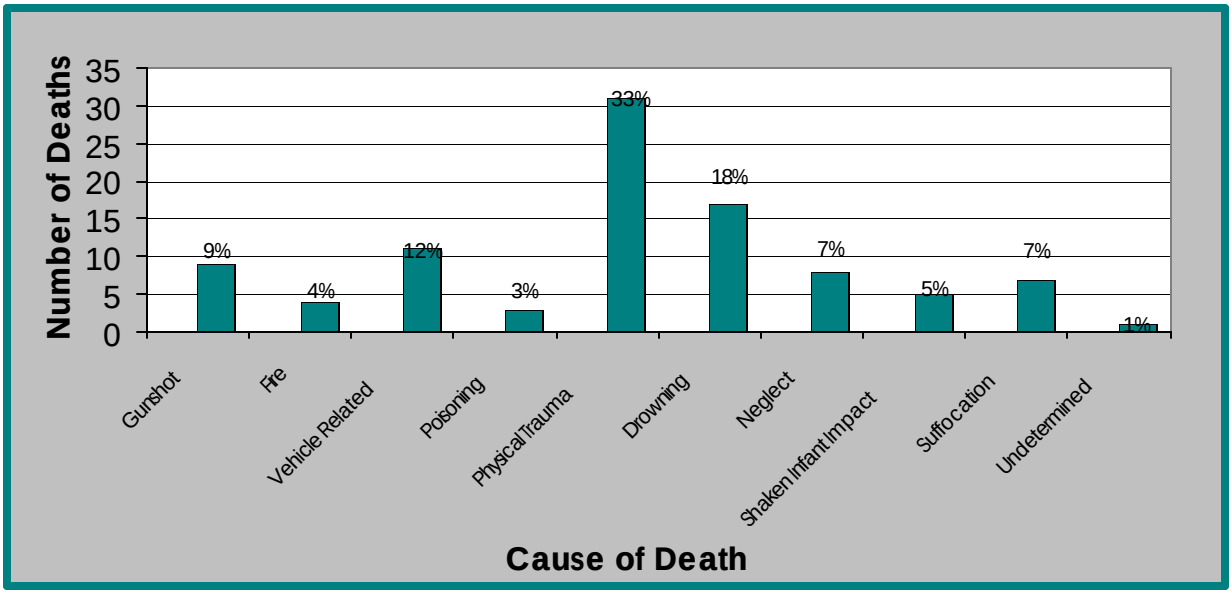
Aggregate data indicates that abuse deaths (52%) were slightly higher than neglect deaths (48%). Of the child deaths reviewed for 2001, abuse deaths (54%) were also slightly higher than neglect deaths (46%). These differences were not statistically significant.

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

Cause of Death

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

Figure 5: Cause of Child's Death (1999-2001)



Cause of Child's Death					
	1999	2000	2001	Total	%
Gunshot	6	1	2	9	9%
Fire	4	0	0	4	4%
Vehicle Related	3	3	5	11	12%
Poisoning	3	0	0	3	3%
Physical Trauma	5	11	15	31	33%
Drowning	3	10	4	17	18%
Neglect	2	1	4	7	7%
Shaken Infant Impact	2	2	1	5	5%
Suffocation	1	2	4	7	7%
Undetermined	1	0	0	1	1%
	30	30	35	95	100%

Aggregate data includes the following trends:

- The highest percentage of deaths was caused by physical trauma.
- The majority of the neglect deaths reviewed for the three-year period were attributed to inadequate supervision of the children that resulted in death from drowning, asphyxiation, house fire, or accidental gunshot wounds.

- There were at least 7 additional deaths in which children died from illness or medication toxicity secondary to medical neglect by their caregivers.
- Gunshot homicides perpetrated by an adult perpetrator/caretaker responsible were the cause of 7 deaths.

Data for 2001 indicated that of the 35 deaths reviewed by the team, the causes and contributing factors included:

Abuse (19 deaths)

- The majority of the abuse deaths involved direct attacks resulting in physical trauma. Of the 15 trauma related deaths, 8 of the children died from head trauma, 3 from abdominal trauma, 2 from multiple traumas, and 2 from beatings.
- 1 child was intentionally drowned in a bathtub.
- 1 child died from shaken infant impact.
- 1 child died from a gunshot, homicide.
- 1 child died from hanging.

Neglect (16 deaths)

- 5 children died in vehicle related accidents, none were wearing appropriate vehicle restraints. Two children died together when the perpetrator/caretaker responsible (parent/uncle) lost control of the car due to a blown tire. Another child was left unrestrained and unattended in a car with the engine running, and died when the car engaged and rolled over her.
- 3 children accidentally drowned in swimming pools. Inadequate supervision by the perpetrator/caretaker responsible contributed to these deaths.
- 2 children died in separate incidents of being left on day care buses for extended periods of time and dying from hyperthermia. Inadequate supervision in a daycare setting was a contributing cause in these deaths.
- 2 children suffocated while co-sleeping with an adult or sibling. In addition to the neglect allegations, substance abuse related allegations were verified in both cases.
- 2 children with severe disabilities died due to medical neglect and inadequate supervision.
- 1 child died from a gunshot wound caused when a sibling located a gun in the home that was not properly secured and fired the gun striking his younger sibling.
- 1 child died by hanging himself, due to inadequate supervision in a facility.

Johnny*

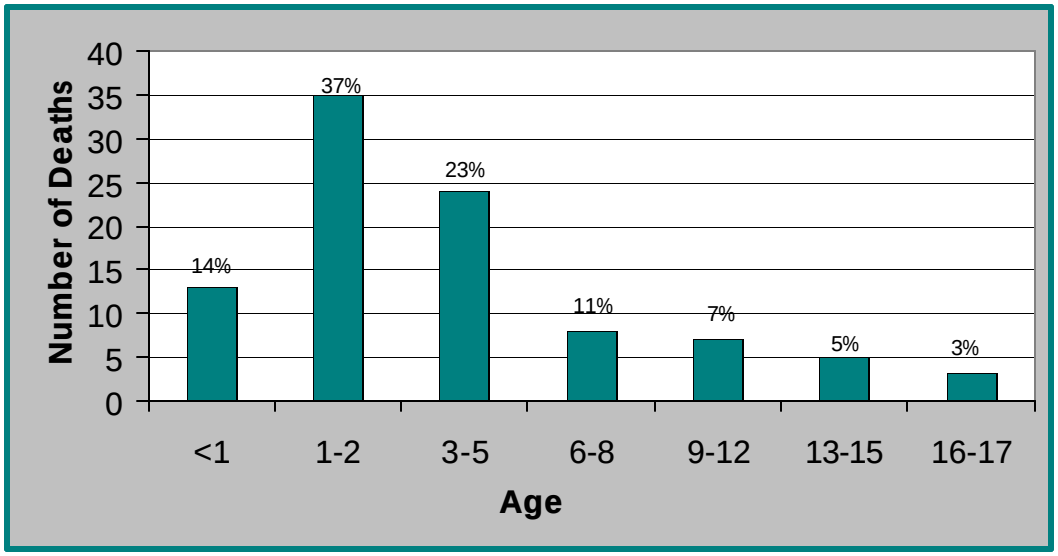
Three-year-old Johnny died from blunt impact to the head and abdomen causing liver laceration and skull fracture. The child was in the care of his mother's male paramour when the injuries occurred. The paramour was arrested and charged with 1st degree murder and is incarcerated awaiting trial. The younger sibling was removed and placed with relatives under protective services supervision. There were five prior reports involving this child and mother, consisting of substance abuse and inadequate supervision, as well as a history of domestic violence with the paramour.

****Alias***

Age at Death

Age is a factor in the analysis of risk due to abuse or neglect. Florida statute identifies children under the age of six as being at greater risk by requiring professional medical evaluation on any child under this age with alleged injuries. Figure 6 provides a specific breakdown of age at death for these 95 children.

Figure 6: Age at Death
(1999-2001)



Age of Child at Death					
	1999	2000	2001	Total	%
< 1	3	4	6	13	14%
1 - 2	9	10	16	35	37%
3 - 5	8	9	7	24	25%
6 - 8	6	2	0	8	8%
9 - 12	1	3	3	7	7%
13 - 15	1	2	2	5	5%
16 - 17	2	0	1	3	3%
	30	30	35	95	100%

Reviews by The Child Abuse Death Review Team in Florida for the 1999 through 2001 three-year period indicate that of the children who died, 72 (76%) were under the age of six, 59 (62%) were between the ages of one and five, and 13 (14%) were under the age of one year.

Of the child deaths reviewed for 2001, 29 (83%) were under the age of six, 23 (66%) were between the ages of one and five, and 6 (17%) were under the age of one year.

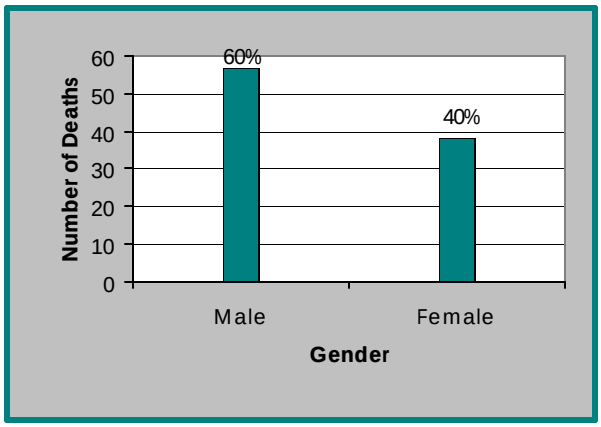
National statistics reported in The 2000 Fifty State Survey: Current Trends in Child Abuse Prevention and Fatalities indicated that young children are at the highest risk of death by causes related to abuse and neglect. Based on data collected in 1998 through 2000, they report 78% of these children were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

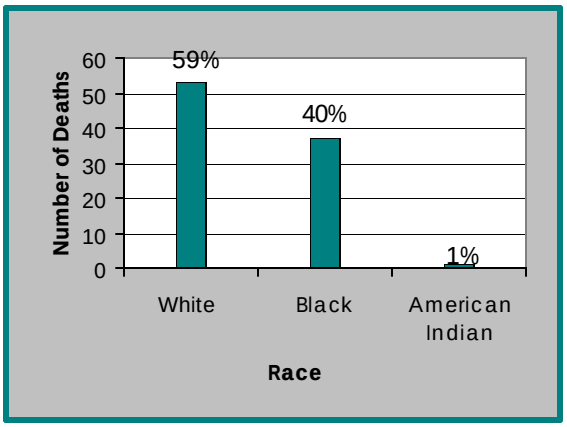
may be related to the statutory requirement of a prior report on the victim to the child abuse hotline, because children under one year are less likely to have been previously reported.

Race and Gender

For the 95 deaths reviewed during the three-year period, 57 (60%) were male, and 38 (40%) were female. For these deaths 56 (59%) of the children were white, 38 (40%) percent were black, and 1 (1%) was American Indian. When a specific ethnicity was identified, a total of 14 (15%) were identified as Hispanic and 2 (2%) were identified as Haitian. Figure 7 provides the aggregate data and breakdown by year for these factors.

Figure 7: Race and Gender of Child at Death (1999-2001)





Gender of Children			
	Male	Female	Total
1999	20	10	30
2000	18	12	30
2001	19	16	35
Total	57	38	95
Percentage	60%	40%	100%

Race of Children				
	White	Black	American Indian	Total
1999	16	14	0	30
2000	23	7	0	30
2001	17	17	1	35
Total	56	38	1	95
Percentage	59%	40%	1%	100%

Michelle*

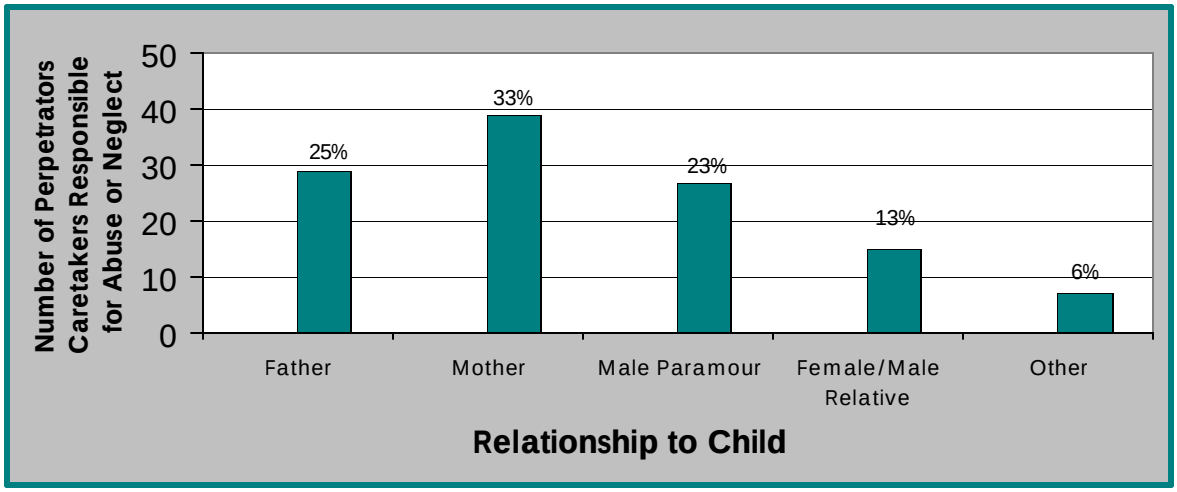
Two-year-old Michelle died as a result of drowning in the family pool. Both her mother and father were home at the time of the incident. Michelle's mother was sleeping and her father was playing games with her two siblings. When he father noticed the child was missing he went to look for her and found her in the pool. The pool had no safeguards around it and both parents indicated that they knew the children could unlock the doors to go outside. Michelle was transported to the hospital where she was pronounced dead. There were two prior reports regarding this child. The first report involved verified neglect and substance exposure and the child was placed on protective supervision. The second report involved physical abuse of two siblings in the home and was closed with no indicators of abuse. There were other prior reports involving the older siblings.

**** Alias***

Relationship of Perpetrator/Caretaker Responsible for Abuse or Neglect

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

Figure 8: Perpetrator/Caretaker Responsible for Abuse or Neglect Relationship to Child (1999-2001)



Perpetrator/Caretaker Responsible for Abuse or Neglect Relationship to Child					
	1999	2000	2001	Total	Percentage
Father	9	11	9	29	25%
Mother	13	11	15	39	33%
Male Paramour	9	8	10	27	23%
Female/Male Relative	5	6	4	15	13%
Other	1	1	5	7	6%
Total Number of Perpetrator/caretaker responsible	37	37	43	117	100%

For the 95 deaths reviewed during the three-year period, 117 perpetrators/caretakers responsible were identified. Mothers were involved in or responsible for 39 (33%) of the 95 deaths reviewed, fathers for 29 (25%) of the deaths, and male paramours for 27 (23%) of the deaths. The majority of the deaths in which the mother was the sole perpetrator/caretaker responsible were caused by neglect. The majority of the deaths in which the father or male paramour was the sole perpetrator/caretaker responsible were caused by abuse.

For the deaths reviewed in 2001, mothers were involved in or responsible for 15 (35%), fathers for 9 (21%) of the deaths, and male paramours for 10 (23%) of the deaths. This closely matches the aggregate data.

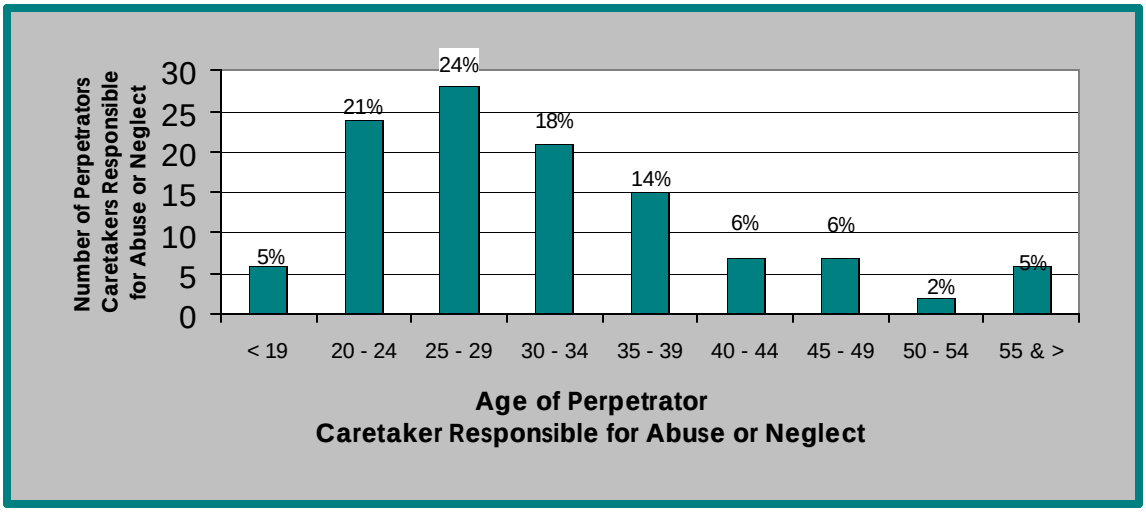
Age of Perpetrator/Caretaker Responsible for Abuse or Neglect

Data for three-year period (95 deaths) indicated that the 117 perpetrators/caretakers responsible ranged in age from 17 to 79, with 58 (50%) under the age of 30 years.

For the year 2001, the 43 perpetrators/caretakers responsible of the 35 deaths ranged in age from 17 to 47, with 24 (56%) under the age of 30 years.

Florida's 2001 and aggregate data varies slightly higher than national reports that indicate the perpetrators/caretakers responsible of maltreatment fatalities are generally young. "In 1998 nearly two thirds (62%) of the persons responsible for child abuse and neglect deaths nationally were younger than 30 years of age…."[5] This factor may also be affected by the narrow criteria for Florida's reviews. Very young children who died due to abuse or neglect, but did not meet the criteria for review because they had no prior reports, may also have had a higher percentage of young parents who were the perpetrator/caretaker responsible. Figure 9 shows the age, by category, of the perpetrator/caretaker responsible for these deaths.

Figure 9: Age of Perpetrator/Caretaker Responsible for Abuse or Neglect (1999 – 2001)



Age of Perpetrator Caretaker Responsible for Abuse or Neglect					
	1999	2000	2001	Total	%
19 and <	1	0	5	6	5%
20 thru 24	8	6	10	24	21%
25 thru 29	10	9	9	28	24%
30 thru 34	4	3	14	21	18%
35 thru 39	7	6	2	16	14%
40 thru 44	2	3	2	7	6%
45 thru 49	2	4	1	7	6%
50 thru 54	1	1	0	2	2%
55 & >	2	4	0	6	5%
Total	37	36	43	117	100%

Perpetrator/Caretaker Responsible for Abuse or Neglect History

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

- 58 of the perpetrators/caretakers responsible (61%) had criminal records.
- 35 of the perpetrators/caretakers responsible (36%) had a history of substance abuse.
- 21 of the perpetrators/caretakers responsible (22%) had a history of alcohol abuse.

Domestic violence is often a factor in child abuse deaths. Domestic violence was known to have been occurring in the home at the time of the child's death, in 25 (26%) of the cases reviewed. This type of abuse can begin with the battering of a spouse, then spread to include other household members, including children. A review of the perpetrator/caretaker responsible history for the aggregate period indicated that:

- 41 of the perpetrators/caretakers responsible (43%) were also perpetrators of domestic violence.
- 33 of the perpetrators/caretakers responsible (35%) were also victims of domestic violence.

Timmy*

Eighteen-month-old Timmy died from multiple head trauma. Timmy's mother allowed her male paramour to care for him and witnessed the abuse but failed to intercede. The paramour hit the child with a belt in the living room and then grabbed him by the arm and threw him on a loveseat where he secured him on his stomach with a blanket. The mother was instructed to leave the room. When she next saw her child her paramour had carried him into the bedroom indicating that he was dead. A prior report of lack of supervision and abandonment was closed with some indicators of neglect, and a referral was made for parenting classes.

The child's mother was charged with third degree murder. She pled guilty and received five years probation with special conditions. Her paramour was charged with first-degree murder. He was found guilty of aggravated manslaughter and domestic battery, and was sentenced to life in prison.

**** Alias***

Family Risk Factors

According to national research, "…the children most vulnerable to serious or fatal abuse and neglect are those whose parents or other caregivers are ill-equipped to care for them, who live in social isolation and poverty, and who are virtually invisible to the larger community. They tend to live in environments that have few supports for parents (and) they may not know their neighbors well enough to ask for help."[6]

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

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

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

- Child under the age of five years
- Prior reports of domestic violence, perpetrator/caretaker responsible history of violence, pattern of abusive relationships, or pattern of escalating violence
- Parental limitations in ability to adequately parent due to age, mental capacity or substance abuse
- Criminal history of perpetrator/caretaker responsible or other adult in the home
- Hazardous conditions in the home
- Behavioral indicators of abuse

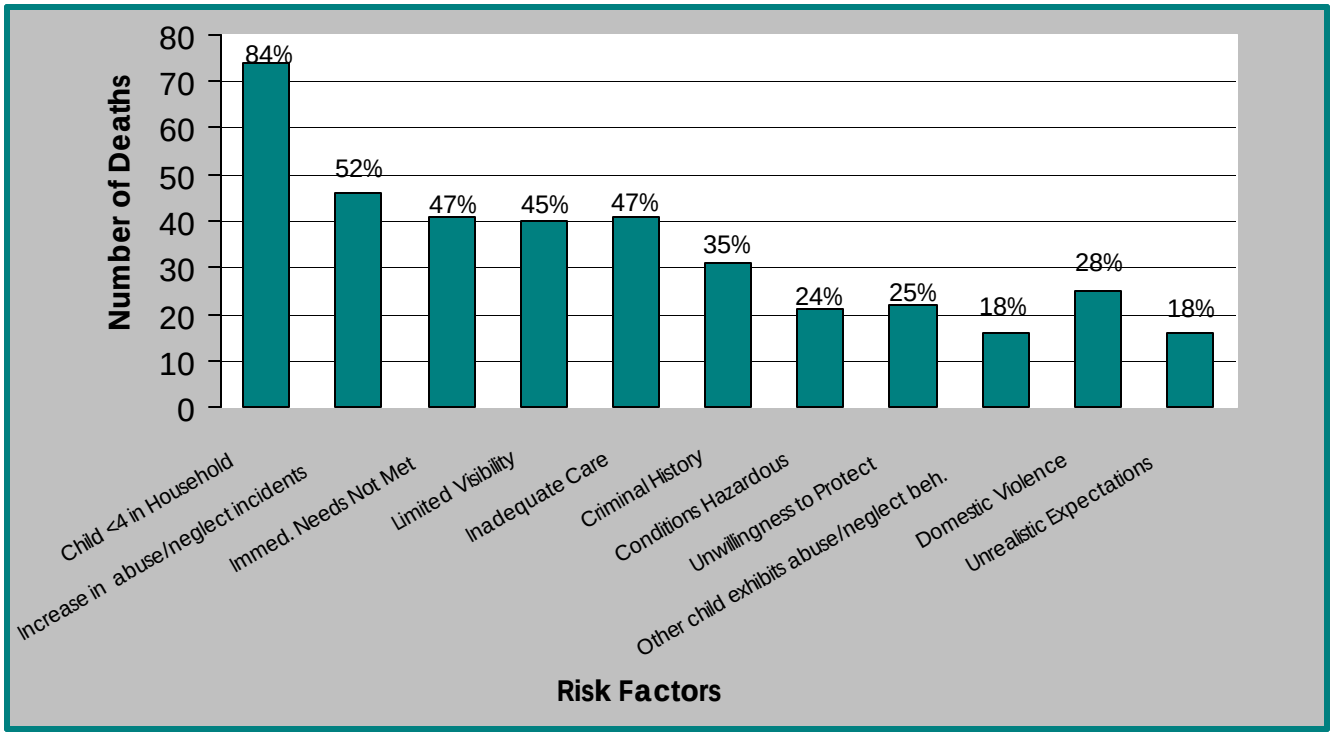
Heather*

Fifteen-month-old Heather died as a result of injuries she received while in the care of her mother's male paramour. The paramour had picked her up from the babysitter's house on the day in question and was alone with her for several hours prior to her mother's return. When her mother returned home, she became aware of the abuse and Heather was transported to the hospital where she subsequently died from blunt abdominal trauma. There was a prior report of medical neglect that was closed with no findings of abuse or neglect.

**** Alias***

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

Figure 10: Family Risk Factors for Child Victims (1999-2001)



Risk Factors in 2001 Child Abuse Deaths				
	1999	2000	2001	Total
One or more children in the household age 4 or younger	20	25	29	74
A pattern or escalating and/or frequency of incidents of abuse or neglect	13	14	19	46
Parent or caregiver is unable to meet child(rens) immediate needs	12	14	15	41
Child(ren) in the home have limited community visibility	12	12	16	40
Parents or caregiver's age, mental health, alcohol or substance abuse affects ability to parent	10	12	19	41
Criminal history on any household member	6	12	13	31
Conditions in the home are hazardous to child's health	8	7	6	21
Parent or caregiver is unable or unwilling to protect the child(ren)	4	8	10	22
Other child(ren) in home exhibit behaviors indicative of abuse or neglect	6	6	4	16
Domestic violence in the home	5	6	14	25
Parent or caregiver has unrealistic expectations of child(ren)	2	8	6	16

Team Conclusions/Adequacy of Prior Interventions

While no one factor other than the direct action of the perpetrator/caretaker responsible is solely responsible for an abuse death, review teams were asked to identify the interventions and services provided prior to the child's death, to identify needed improvement in these services. In determining adequacy, the team looked at whether the services provided addressed the needs of the family at the time of the service provision.

For the 35 child deaths in 2001, in addition to the prior investigations, 14 victims received a total of 51 direct services from either the Department of Children and Families, or community service providers, including but not limited to substance abuse treatment, mental health treatment, parenting classes or domestic violence intervention classes. Of the services provided to these victims or their families:

- 43% were found to have been adequate
- 31% were found to have been inadequate
- 8% were of unknown adequacy
- 9% were unanswered, perhaps due to the lack of available information

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

- Department of Children and Families in 15 cases
  Found to have been adequate in 5 cases (33%) and inadequate in 6 cases (40%)
- Department of Health in 7 cases
  Found to have been adequate in 3 cases (43%) and inadequate in 2 cases (29%)
- Child Protection Teams in 10 cases
  Found to have been adequate in 6 cases (60%) and inadequate in 1 case (10%)
- Department of Juvenile Justice in 2 cases
  Found to have been adequate in zero cases (0%) and inadequate in one case (50%)
- Mental Health Agencies in six cases
  Found to be adequate in 2 cases (33%) and inadequate in 3 cases (50%)
- Other Service Providers in 11 cases
  Found to be adequate in 6 cases (55%) and inadequate in 3 cases (27%)

In 13 (25%) of these 51 provisions of services reviewers were unable to determine the adequacy based on the information made available to the team for review. Information in the files provided, both from the service providers and the case managers, was at time missing or incomplete.

Sally*

Four-month-old Sally died as a result of Shaken Impact Syndrome. She resided with her mother and father. Both parents were home and the father was taking care of her when she became limp and stopped breathing. She was transported to the hospital and placed on life support. She died when life support was removed later the same day. There was a prior report that alleged drug and alcohol abuse and inadequate supervision. The case was closed with no indicators of abuse or neglect and no referrals for services.

****Alias***

Team Conclusions/Issues Identified

In analyzing the data available for the 35 deaths reviewed for 2001, the state and local teams identified issues in the following areas, some of which had been identified by the Department of Children and Families internal death review teams and were taken directly from their reports:

- Protective investigations, which included the following concerns:

  - Assignments should be based on the complexity of the case and number of priors (matching skill level to difficulty), and should be approved by secondary level supervisor for new probationary staff.
  - Supervisory case review should be timely.
  - Cases involving domestic violence, substance and alcohol abuse and mental health issues should be staffed with the attorney for the department.
  - Initial child safety assessments should be timely.
  - Protective investigators should obtain and include essential law enforcement information to assess child safety.
  - Protective investigators should follow policy to ensure reports are referred to the Child Protection Team.
  - Collateral contact issues such as determining needed contacts based on complexity of the case, making appropriate contact with law enforcement, and staffings for children who are substance exposed or who have special health care needs.
  - Standards for investigation needed for cases involving domestic violence, and domestic violence safety assessments are needed.
  - Removal or other intense intervention needed based on numerous priors.

Local law enforcement agencies are currently responsible for protective investigations in Manatee, Pinellas, Broward, Pasco and Seminole counties. Citrus and Hillsborough Counties are currently working on transitioning protective investigations to their Sheriff's Office. The Department of Children and Families is responsible for protective investigations in the remaining counties.

- Law enforcement, which included the following concerns:

  - Reporting issues, i.e. lack of training on reporting and failure to report child abuse or neglect to the child abuse hotline by Florida Highway Patrol officers.
  - Lack of referral for criminal prosecution.

- Provision of Services, which included the following concerns:

  - Lack of cooperation in voluntary cases should prompt updated risk assessment and legal staffing to determine necessary action.
  - Improvement is needed in communication within and between agencies regarding service provision and case closure.

- Department Policies/Practices, which included the following concerns:

  - Child Protection Teams should develop policy regarding medical evaluation to ensure that client history and social assessment information is available to medical staff and included in the assessment determination.

- Department of Health service providers, including but not limited to Healthy Start, should require initial and ongoing training on recognizing and reporting child abuse and neglect for staff working with children.
- Department of Juvenile Justice should improve the quality and availability of mental health services for children in their custody. Policy should be developed to require stronger guidelines for relaxing the observation requirements of children assessed as suicidal.
- Department of Corrections failure to report non-compliance with substance abuse treatment to the Department of Children and Families.
- Medical Examiners failure to complete cause of death and/or date of injury.

Degree of Preventability

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

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

The State Child Abuse Death Review Team assessed preventability in 32 of the 35 deaths and concluded that 26 (74%) were definitely preventable, 2 (6%) were possibly preventable and 4 (11%) were not preventable. Two of the 35 deaths are pending review upon receipt of the case files.

Predictability

It is important to note that many risk factors are associated with the increased likelihood that a child will be injured or killed by a parent or caretaker. While research suggests that the best predictor of future behavior is past behavior, there is no way to know for certain which child will be harmed and which will not. Making this judgment, often with limited information, is the challenge for all who work in the discipline of child protection.

To achieve further understanding of predictive factors, the state team analyzed the specific nature of the maltreatments leading to the child deaths, and the relationship of these maltreatments to allegations in the prior reports. Also examined was the frequency of particular maltreatments in prior reports. Further knowledge and understanding of predictability will assist child protection professionals determine the interventions necessary to reduce the risk of maltreatment-caused serious injury or death.

Slightly less than half (49%) of the deaths reviewed for 2001 had a factor of predictability based on similarity of maltreatment allegations in prior reports. This predictability factor was more prevalent in neglect deaths (67%) than in abuse deaths (29%). Specific findings include:

- Neglect was the primary maltreatment in 18 of the 35 deaths
  - The most prevalent maltreatment related to neglect was inadequate supervision.
  - 12 of the 18 children who died from neglect had prior allegations similar to those that led to their death.
  - 4 of the 12 had prior allegations that family violence posed a threat of harm to the child.
- Abuse was the primary maltreatment in 17 of the 35 deaths
  - The most prevalent maltreatments related to abuse were skull fracture, beatings, bruises/welts, and "other physical injuries."
  - 5 of the 17 children who died from abuse had prior allegations similar to those that led to their death.
  - 10 of the children who died from abuse had prior allegations that family violence posed a threat of harm to the child.

Ashley*

Three-week-old Ashley died from hepatic lacerations and rib fractures due to blunt impact to her torso. Ashley's father was watching her while her mother was bathing when, according to the father, she threw up on him and he reacted by throwing her across the room where she struck a dresser and fell to the floor. According to the autopsy report, the injuries were the result of a direct blow inflicted by a hand or a foot. Her liver was damaged so badly it was almost torn in half. The father was changed with first-degree murder and child abuse and sentenced to 24 years in prison. A prior report at Ashley's birth alleged family violence threatens child and substance abuse based on the father. This report was closed with some indicators of threatened harm and the family was referred for intervention and prevention services.

Alias

Criminal Status

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

- In 37 of the 95 cases there was either no charges filed or the case was nol-prossed.
- 6 of the identified perpetrator/caretaker responsible committed suicide at the time of the child's death.
- 1 perpetrator/caretaker responsible was found incompetent to stand trial.
- 34 were criminally charged and charges are pending,
- 32 perpetrator/caretaker responsible were charged with murder.
- 9 perpetrator/caretaker responsible were charged with manslaughter.

Note: Some overlap exists because perpetrator/caretaker responsible have multiple charges.

Of those whose criminal cases were completed:

- 4 were convicted of murder
- 3 were convicted of manslaughter
- 2 were convicted of child abuse or negligence.

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

CONCLUSIONS AND RECOMMENDATIONS

During the first two years, The State Child Abuse Death Review Team worked diligently to develop a foundation for the child abuse death review process at both state and local levels. The first year brought both challenges and insight in the efforts to develop a multidisciplinary approach to review these deaths, achieve a better understanding of why these children died, and create better approaches for preventing future deaths. The challenges of the second and third years focused on the development of local teams, the establishment of protocols for receiving the necessary information for review from the various agencies involved in child death investigations, the development of various tracking mechanisms to collect short and long-term data, the development of protocols for analyzing the data, and agreeing upon conclusions and recommendations.

It remains important for the reader to put the overall analysis of these child deaths in perspective. In addition to the limitations in the information used to analyze individual cases, the population reviewed is limited in scope and representation of the total number of abuse and neglect deaths in Florida. Consequently, the recommendations and comments made throughout this report are subject to those limitations when generalizations are made. There are clear patterns and trends noted for the state that are consistent with national data; however, because of the limited population there are variations, which are reflected in this report. The issues and recommendations below stem from the review of these deaths:

The Child Abuse Death Review Team identified both case specific and overall systemic issues in the child protection system. During the course of the year, the team identified some issues requiring immediate team action or recommendations directly to the individuals or groups involved. This section identifies the major issues, any actions taken during the course of the year, and remaining actions needed; as well as making additional statewide recommendations.

ISSUE 1: LACK OF LOCAL TEAMS

The lack of local teams continues to challenge the state team to find adequate means to review these deaths. Without the participation of local investigators and service providers who had direct input with the child and family, the state team had to base their review on the written records provided. As a result, the review team often lacked valuable information, affecting both the reliability of conclusions and any resulting recommendations.

One of the primary causes for lack of local team development is the strict criterion for cases. It is difficult to maintain interest with such a limited scope of review. Another cause is the lack of connection between the state and local teams. Without a designated liaison, teams often lose interest and momentum.

Action Taken: The state team previously recommended that their reviews be expanded to all child deaths. This year the team sent a letter to the Speaker of the House of Representatives, President of the Senate and the heads of the statutorily designated agencies for the child abuse death reviews providing specific amendment language and requesting support for expansion of the criteria.

To address the immediate need, during the past year the state team created a formal Case Review Committee to review the deaths that occurred in areas without a local team.

Remaining Action Needed/Recommendation: Continuation of recruitment efforts should remain a priority for the state team. The Florida Legislature should expand the child abuse death review process to include the review of all abuse or neglect deaths, with no requirement for prior reports to the child abuse hotline. Local teams should be granted discretionary authority to review all child deaths based on local interest and resources.

ISSUE 2: LACK OF REVIEW CONSISTENCY

Reviews by local teams and by the state team lacked consistency in the analysis of preventability and in the adequacy of prior services.

Action Taken: Along with the development of a formal case review committee, state team liaisons were identified for each of the local teams. The liaison responsibilities include providing training and technical assistance to local teams to help achieve consistency across the state in the review process. The state team determined that each locally reviewed case would be assigned to a member of the case review committee to review and present to the full case review committee. They developed a protocol for their reviews and for their secondary review and acceptance of local review team findings. All findings and recommendations of the case review committee are then presented to the full team for concurrence.

Remaining Action Needed/Recommendation: Further development of the data collection form and guide is needed to include a requirement for additional information related to risk assessment, prior service adequacy and abuse preventability and to clarify questions related to these areas. The Case Review Committee should formalize the process for presentation of their findings to the full team for discussion and concurrence, to cover all areas of findings and recommendations.

ISSUE 3: RECEIVING INFORMATION NECESSARY FOR ADEQUATE REVIEW

The committee experienced difficulty in identifying prior service provision and assessing the adequacy of the prior services, in part due to their dependence on local death review teams or DCF death review coordinators to provide them with the information needed, some of which they may not have available. Additionally, the committee determined that to adequately review these cases without benefit of the investigator and local service providers, they required the entire investigative file as well as the files of all prior investigations and services. The time lag involved in receiving this information impeded the team's ability to adequately review the files and make appropriate recommendations.

Action Taken: The Department of Children and Families staff liaison, with the concurrence of the department's state team representative, was made a member of the case review subcommittee and worked directly with the state team staff to facilitate early receipt of these records. A standard letter was developed that outlines the information needed from local teams and DCF District Death Review Coordinators, and a process put in place to facilitate early identification of the any additional records needed from other agencies or service providers.

Remaining Action Needed/Recommendation: Further clarification is needed regarding the responsibilities of the local death review teams and the Department of Children and Families District Death Review Coordinators. The local and internal death review process should include

providing information to The State Child Abuse Death Review Team as statutorily required, including the collection of information from other local providers. An interagency memorandum of understanding should be agreed upon and signed by the heads of all agencies represented.

ISSUE 4: FAILURE TO REPORT CHILD ABUSE OR NEGLECT TO THE HOTLINE, AND INADEQUATE COMMUNICATION BETWEEN CHILD PROTECTION STAFF AND IN-HOME SERVICE PROVIDERS

It is not uncommon for providers of in-home prevention services to be told about, or directly observe inappropriate parenting, neglect or abuse. Without specific child abuse expertise, it is sometimes difficult for these providers to determine when an incident, disclosed by a family member or witnessed directly, crosses this line and requires a call to the child abuse hotline. Providers are also concerned with violating the trust of their clients and therefore damaging their ability to assist the family.

Additionally, child abuse investigators frequently make referrals for voluntary in-home services when risk is identified and either:

- Insufficient evidence is available to support judicial action, or
- The family has acknowledged the problem and agreed to work cooperatively to resolve the risk-associated issues.

Because the child abuse investigator closes these cases after referral, the provider has no direct contact if the family fails to cooperate with the service plan. If no new reportable incident has occurred and the service provider lacks the knowledge or information regarding whom to call, the child may be left in a high-risk environment.

Action Taken: The Department of Health and the Department of Children and Families worked cooperatively during the past year to address these issues. Accomplishments during the year included:

- A satellite training entitled "Common Sense and the Assessment of Child Abuse Injuries" was provided to Healthy Start and Healthy Families providers in May 2002. Videotape copies of this training have been sent to all the County Health Departments and Healthy Start Coalitions.

- Meetings were held between the Healthy Start and DCF program offices to brainstorm ideas for stronger collaborative efforts.

- Development has begun on additional child abuse and neglect training. Input from Healthy Start Coalitions and Healthy Start service providers has been solicited regarding their training needs on child abuse and neglect. Resources are being explored for a training module on neglect. Training on case management is also planned. Workshops on child abuse will be provided at the Sharing Solutions Conference in May 2003.

- Language has been added to the Healthy Start Standards and Guidelines that:

    - Requires care coordination providers to receive pre-service training on recognizing and reporting child abuse and neglect

- Requires that care coordination providers demonstrate knowledge of child abuse and neglect indicators and the responsibility to report suspected abuse or neglect to the Florida Abuse Hotline

- Reinforces the requirement to report suspected child abuse and neglect to the Florida Abuse Hotline

- Includes a listing of the characteristics of the parent at risk for child maltreatment

- Requires supervisors to co-sign documentation of closure in case record for substance involved families or families with known or suspected child maltreatment

- Requires written notification of case closure to the referral source and/or the Department of Children and Families if the referral reason was risk of child maltreatment

- Requires paraprofessionals to immediately contact a supervisor for guidance when a family has safety concerns or immediate needs

- Includes the question "Were indicators of child maltreatment recognized and reported accurately?" in the programs Quality Improvement/Quality Assurance activities.

Remaining Action Needed/Recommendations: That all in-home service providers working with families in their homes providing coordination of care, linkages, referrals, and direct services have a mandatory child abuse and neglect training requirement. That other in-home service providers adopt the Healthy Start standards and guidelines listed above.

Stricter penalties should be enacted for professionals identified by statute as mandated reporters who fail to report child abuse and neglect.

ISSUE 5: FAILURE TO REPORT CHILD VEHICLE RESTRAINT NEGLECT, OR OTHER TRAFFIC OFFENSE RELATED ABUSE/NEGLECT

Serious injury or death could often be avoided by the proper use of child restraints. Children are also placed at risk as passengers in vehicles driven by impaired or reckless drivers. These incidents are often unreported because law enforcement officers only identify them as traffic violations. Although drivers are fined for child restraint violations, these are not strong enough deterrents.

Remaining Action Needed/Recommendations: The Department of Law Enforcement, in conjunction with the Department of Children and Families, should provide training to local law enforcement agencies and the Florida Highway Patrol on recognizing and reporting child neglect and abuse during traffic related incidents.

Enhanced penalties for violation of child vehicular restraint requirements.

ISSUE 6: CHILDREN ABUSED IN DAYCARE SETTINGS

Parents can unknowingly place their children at risk in daycare settings that have previously been sanctioned or closed for abuse or neglect related violations. While daycare licensure files are public record, the knowledge and ability of the general public on accessing these files for review is limited.

Of the cases reviewed for 2001, two children died in separate incidents as a result of being left in day care buses for extended periods of time. Inadequate supervision in a daycare setting was a contributing factor in these deaths.

Remaining Action Needed/Recommendation: The Department of Children and Families should maintain a list that identifies daycares that have been closed or sanctioned for abuse or neglect related violations.

ISSUE 7: DEATHS CAUSED BY UNSAFE SLEEPING ENVIRONMENT

In the deaths reviewed for 2001, two children suffocated while co-sleeping with an adult or sibling. In both these incidents, substance abuse was involved. Co-sleeping, use of improper bedding, and other environmental hazards create potential risk to children. Parents are often unaware of these hazards and risks.

Action Taken: The Department of Health and the Department of Children and Families worked cooperatively with their contracted providers of in home prevention services during the past year to develop an educational brochure on these issues. The brochure is currently in the final stages of development.

Remaining Action Needed/Recommendations: The Department of Health, in conjunction with the Department of Children and Families, should develop and provide safe sleeping educational activities through the media and through training for staff and clients.

Angela

Two-month-old Angela died of asphyxia due to overlay. Her mother indicated that Angela was asleep in bed with her father for several hours when a friend came by and wanted to speak with him. When she went to awaken him, she observed his arm across Angela's face and noticed blood on her lips. Angela's mother indicated that she had been smoking marijuana and drinking at the time of Angela's death, and that Angela's father had also smoked marijuana prior to taking the child to bed.

A report was made to the child abuse hotline when Angela was born alleging that she and her mother tested positive for marijuana. A subsequent call had been made alleging great concern for the welfare of both Angela and her sibling, due to the substance abuse of their parents. The investigation was pending at the time of Angela's death. Referrals for voluntary services had been made, but failed to alleviate the risk to the child. When the mother again tested positive for marijuana, the investigator was told to file a petition for dependency. The child died the following day.

**** Alias***

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1. Section 383.402, Florida Statutes

2. Section 39.01, Florida Statutes

3. U.S. Department of Health and Human Services: Child Maltreatment 2000: Reports from the States National Center on Child Abuse Prevention Research.

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5. National Center on Child Abuse Prevention Research: The 2000 Fifty State Survey: Current Trends in Child Abuse Prevention and Fatalities"

6. National Exchange Club Foundation, Abuse Publication, 2000.

STATE CHILD ABUSE REVIEW TEAM

Michael Bell, M.D., Chairperson
Deputy Chief Medical Examiner
Broward Medical Examiner Office

Michael L. Haney, Ph.D., N.C.C., L.M.H.C
State Child Abuse Death Review Coordinator
Division Director, Children's Medical Services
Representing: Department of Health

Nancy Barshter, M.Ed.,Ed.S., J.D.
Special Counsel, Office Of Attorney General
Representing: Department of Legal Affairs

Mike Watkins
Director, Office of Family Safety
Representing: Department of Children and Families

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

Mary Jo Butler
Director, Intervention and Prevention Services
Representing: Department of Education

Bob Hodges, J.D.
Assistant State Attorney, 5th Judicial Circuit
Representing: Florida Prosecuting Attorneys Association

Judith Cobb, R.N.
Palm Beach County Health Department
Representing: Public Health Nurse

Stephenie Brinkley
Children's Home Society of Palatka
Representing: Child Abuse Prevention Program

J.M. Whitworth, M.D.
Statewide Medical Director
Child Protection Team
Representing: Board-Certified Pediatricians

Lorretta E. Glass, M.A.
Director of Foster Parent Support Services
Representing: Mental Health Professionals

Janice Thomas
Department of Children and Families
Representing: Family Services Supervisors

Matt Seibel, M.D.
Child Protection Team Medical Director
Representing: Child Protection Team Medical Directors

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

Major Connie Shingledecker
Commander – Manatee County
Representing: Law Enforcement

Jayne Johnson, M.S.W.
Child Protection Training Coordinator
Representing: Social Worker Experienced in Field of Child Abuse

Radonda Dobbins
Child Welfare Specialist
Representing: Domestic Violence Programs

DEPARTMENT OF CHILDREN AND FAMILIES LIAISONS

Eric Handler, M.D.
Chief Medical Officer
Department of Children and Families

Jim Spencer
Family Safety Child Death Review Coordinator
Department of Children and Families

STAFF

Peggy Scheuermann, M.Ed.
Unit Director
Child Protection Unit/Children's Medical Services
Department of Health

Susan E. McLauchlin
Operations Review Specialist
Child Protection Unit/Children's Medical Services
Department of Health

Stephenie Havard
Staff Assistant
Child Protection Unit/Children's Medical Services
Department of Health

Mia Filmore
Staff Assistant
Child Protection Unit/Children's Medical Services
Department of Health

COMMITTEES

TRAINING COMMITTEE
Terry Thomas, Chairpersons
Nancy Barshter
Mary Jo Butler

PROTOCOL AND GUIDELINES COMMITTEE
Nancy Barshter, Chairperson
Michael Haney
Michael Bell
Matt Seibel

REPORT COMMITTEE
Mary Jo Butler
Connie Shingledecker
Jim Spencer, DCF Liaison
Peggy Scheuermann, Staff

CASE REVIEW COMMITTEE
Michael Bell, Chairperson
Nancy Barshter
Terry Thomas
Bob Hodges
Stephenie Brinkley
Mary Jo Butler
J.M. Whitworth
Judith Cobb
Connie Shingledecker
Stephanie Brinkley
Jim Spencer, DCF Liaison
Peggy Scheuermann, Staff