DEATH REVIEW

ANNUAL REPORT
December 2009

State Child Abuse Death Review Committee
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FLORIDA CHILD ABUSE
DEATH REVIEW COMMITTEE

December 31, 2009

The Honorable Charlie Crist, Governor
The Honorable Jeff Atwater
President of the Florida Senate
The Honorable Larry Cretul
Speaker of the Florida House of Representatives
The Capitol
Tallahassee, Florida 32399-0001

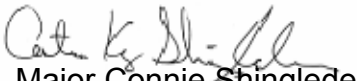
Dear Governor Crist, President Atwater, and Speaker Cretul:

Pursuant to Chapter 383.402 F.S., I am submitting, for your consideration, the annual report of the State Child Abuse Death Review Committee. This has been a challenging year. The Committee has reviewed the deaths of 204 children whose deaths were confirmed to have been from verified child abuse or neglect. Of those deaths, 198 occurred in 2008 and 6 deaths occurred in prior years.

The State Committee has identified several recommendations that we respectfully request that the Legislature and Governor Crist consider for action. In particular, we continue to advocate for the expansion of child death review to include all children or, at a minimum, all child deaths reported to the Florida Abuse Hotline. We have made great strides with training, education, and outreach to child protection partners and have seen increased reporting and identification of children whose deaths may have previously gone unrecognized. Identification and recognition of all child abuse deaths helps formulate better recommendations and actions to prevent these tragic needless deaths.

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

Sincerely,



Major Connie Shingledecker
Chairperson

FLORIDA CHILD ABUSE DEATH REVIEW COMMITTEE

ANNUAL REPORT

DECEMBER 2009

Mission

"To Reduce Preventable Child Abuse and Neglect Deaths"

Submitted to:

The Honorable Charlie Crist, Governor of Florida
The Honorable Jeff Atwater, President, Florida Senate
The Honorable Larry Cretul, Speaker, Florida House of Representatives

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The most tragic consequence of child abuse and neglect is a child's death.
The well being of a victim depends on the adults who are willing to take action.

DEDICATION

The State Child Abuse Death Review Committee (CADR) dedicates this report to 198 children who died as a result of child abuse. We remember them for their innocence and honor them by committing ourselves to work tirelessly to see that no child dies from a preventable death.

Also, we recognize and commend the Department of Children and Families Child Death Review Coordinators, Denise Conus, Lisa Rivera, Meghan Grove, Chris Houston, Linda Swan, Frank Perry, Kirby Morgan, David Martine and Laverne Sumter. Without their expertise, dedication, and commitment to the State and local Child Abuse Death Review Committees, we would not be able to effectively review child abuse death cases. We value them and the work they do in their efforts to protect Florida's children from child abuse.

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

A special acknowledgement:

Finally, we would like to acknowledge Charles and Pat Badland who gave time and effort to assist the State Committee with the creation of a new logo; and a special thank you to the entire professional and support staff who assist with the creation of this report

EXECUTIVE SUMMARY

Sadly, 2,843 children under the age of 18 lost their lives in Florida during 2008. Of those children who died, 465 were reported to the Florida Abuse Hotline. Of the 465 child deaths reported to the hotline, 201 were the result of verified child abuse or neglect. During 2009, the State Committee reviewed 198 of the 201 child abuse deaths. The remaining three deaths will be reviewed upon completion of the child death review process during 2010. The State Committee reviewed an additional six child deaths that occurred in previous years, bringing the total number of child deaths reviewed by the State Committee in 2009 to 204.

In 2008, there was a substantial increase in the number of child abuse deaths in Florida from 2007 where 163 children died from verified child abuse or neglect. A recent study cited, Every Child matters Education fund and is titled "We can do Better: Child Abuse and Neglect deaths in the U.S." that Florida has one of the highest per capita rates of child deaths reported to the Florida Abuse Hotline in the country. While one child death is one too many, there are a variety of reasons why Florida's child abuse death rate is higher than other states. Florida has a centralized, state-run protective investigations system that has standardized reporting requirements and procedures for child protective investigations. These processes lead to better identification and reporting of child deaths. For example, child deaths resulting from unsafe sleep environments, drowning, suicide, and auto accidents are reportable in Florida and not reportable in other states. Secondly, research shows that added stress low-income families face during economically depressed times contributes to an increase in child abuse and neglect. The risk of child abuse and neglect is even greater in families where the parent abuses alcohol or drugs, is isolated from their families or communities, has difficulty controlling anger or stress, appears uninterested in the care, nourishment or safety of their children, or seems to be having serious personal problems.

In 2008, the unemployment rate in Florida went from 4.1 percent to 6.2 percent. This accounted for a loss of approximately 339,600 jobs in Florida during the year.[1] A recent national study found that among unemployed adults aged 18 or older in 2008, 19.6 percent were current illicit drug users, which was higher than the 8.0 percent of those employed full time and 10.2 percent of those employed part time. In addition, an estimated 8.3 million adults (3.7 percent) had serious thoughts of suicide in the past year. The rate was highest among young adults aged 18 to 25 (6.7 percent) compared with adults 26 to 49 (3.9 percent) and adults aged 50 or older (2.3 percent).[2]

[1] Florida Labor Market Trends. Florida Agency for Workforce Innovation, Labor Market Statistics Center, November 2008.

[2] National Survey on Drug Use and Health: National Findings. U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Office of Applied Studies, 2008.

It is the mandated responsibility of the State Child Abuse Death Review Committee, administered by the Florida Department of Health's Children's Medical Services to review cases of the 201 children who died in 2008 as a result of verified findings of child maltreatment. Additionally, the State Committee is mandated to submit an annual Child Abuse Death Review Report. This 2008 Child Death Review Report, which represents the 10th annual report submitted to the Governor and Legislature, includes information on how these children died, factors that contributed to the death caused by their caretakers and data-driven recommendations for preventing future child abuse and neglect deaths. The State Committee believes the increase in verified child deaths from 2007 may also be attributed to the extensive training provided by the State Committee. Training on child abuse and neglect reporting requirements to law enforcement and other professionals such as teachers and physicians, and training to Florida's child protective investigators on vital aspects of the investigation process has led to a more consistent statewide practice.

It is important to note that the State Committee's mandate is limited to the review of the 201 children (198 of which were reviewed) who died as a result of a verified finding of child abuse or neglect, which is a subset of the 2,843 children who died in Florida during 2008. Limiting the review restricts the Committee's ability to gain a greater understanding of the causes and contributing factors of all child deaths in Florida. As a result, the patterns and trends identified in this report are limited to the verified child abuse and neglect deaths and may or may not be generalizable to all the children who died in Florida during 2008.

From the period January 1, 2008 through December 31, 2008, the leading cause of the 198 verified child deaths reviewed was from physical abuse (59 children or 30%); followed by unsafe sleep environments (54 children or 27%) and then drowning (48 children or 24%). Of the 198 cases reviewed of children who died, 93% were five years of age and under, 53% were males and, 47% were females. This 2008 Annual Report provides extensive data on each of these categories of abuse and neglect child deaths.

Based on the review of the 198 children who died in 2008, the State Child Abuse Death Review Committee has identified key recommendations and priority issues for the Florida Legislature to consider and take appropriate action in an effort to prevent future child abuse and neglect deaths. Other topic specific issues and recommendations can be found in the body of the report.

Key Recommendations

1 – All Child Death Review - A Commitment to Prevention

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

2 - Healthy Families Florida Prevention Funding

Recommendation: The Florida Legislature should fully fund Healthy Families Florida, an evidence-based home visiting program that prevents child abuse and neglect before it ever occurs.

Priority Issues

Physical Abuse

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

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

Unsafe Sleep Environments

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

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

Drowning

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

Recommendation: Implement a systemic approach to prevent drowning of children in Florida, particularly those under the age of 5.

Substance Abuse

One of the most common risk factors present in child abuse or neglect deaths reviewed by the State Committee.

Recommendation: Substance abuse should be given a higher priority in the risk assessment activities of child protection organizations that come into contact with children and their families.

Consistency and Communication

Communication between agencies and consistent evidence gathering protocol are crucial to the protection of children.

Recommendations: Improved consistency and communication among the various agencies involved in child abuse cases and child death cases.

Quality Assurance Review

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

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

The State Committee believes that implementation of these recommendations will improve the child protection system by providing the knowledge, skills, and public awareness needed to reduce tragic child abuse deaths.

RECOMMENDATIONS FOR 2009

Based on the review of 198 Child Abuse Deaths in 2008, the State Child Abuse Death Review Committee has identified eight priority issues with recommendations. Other topic specific issues and recommendations can be found in the body of the report. The State Committee believes that implementation of these recommendations will improve the child protection system by providing the knowledge, skills, and public awareness needed to reduce tragic child abuse deaths.

KEY RECOMMENDATIONS:

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

- **Expand the child abuse death review process to include the review of all child deaths reported to the Florida Abuse Hotline for abuse, neglect or abandonment.**

- **Expand authority to provide for the voluntary review of all child deaths by local communities, within their resources, under the direction of the State Child Abuse Death Review Committee.**

One of Governor Charlie Crist's Healthcare priorities is a commitment to prevention. Identifying the causes of and developing strategies to reduce avoidable child deaths is the essence of prevention. While the State Committee acknowledges concerns that this process is somehow intrusive, that is not the case. No family will be contacted or interviewed as result of this proposal. An All Child Death Review process will place Florida on the path to provide a safe place for children to live, grow and become healthy contributing citizens. The All Child Death Review process will allow the Department of Health and other agencies to develop appropriate strategies to reduce the occurrence of child deaths from preventable situations. Recognizing the current economic limitations, the State Committee proposes that the Governor and Legislature support the expansion of child death review to include allegations of the death of any child due to child abuse reported to the Florida Abuse Hotline Information System.

The Florida Department of Health has submitted a legislative proposal on behalf of the children of Florida and the State Child Abuse Death Review Committee for the expansion of all child deaths reported to the Florida Abuse Hotline.

A priority for the Centers for Disease Control and Prevention (CDC) and the Healthy People 2010 is that a child fatality review team reviews 100% of deaths of children aged 17 years and younger that are due to external causes. Currently, 42 states authorize review of all child deaths in some manner, either mandated or permissive. By monitoring the occurrence of all childhood deaths and performing an appropriate review when deaths occur, child death review teams have a unique ability to gather the detailed information that is necessary for effective injury/disease prevention activities. The benefits of a comprehensive all child death review process includes:

- A more thorough child death investigation by law enforcement and medical examiners
- Enhanced interagency cooperation
- Improved allocation of limited resources
- Consistency in the certification of the cause and manner of death, which would provide more accurate epidemiologic data as to risk factors that may play a role in the deaths of children in the State of Florida
- Consistency and congruence in data collection by incorporating elements from all existing death reviews
- Establishment of standards for accountability and partnerships with Fetal Infant Mortality Review, Pregnancy Affected Mortality Review, Child Abuse Death Review, Domestic Violence Fatality Review, and the Sudden Infant Death Syndrome program in Family Health Services Florida Department of Health
- Provides for flexibility for local communities to conduct reviews
- Provides strict confidentiality protections and protects records by providing appropriate protections from public disclosure
- Enables a thorough analysis of why children die and informs data driven prevention efforts

Many lives can be saved by identifying local factors related to mortality, heightening local awareness of these factors and mobilizing communities to enact changes needed to decrease the incidence of preventable child deaths. Florida lags behind 42 other States conducting child death review. In Florida, death certificates are the primary source of information and they do not provide a complete picture of why children die. Vital information that can better inform prevention efforts can be collected through a thorough record review.

The child death review process is a record review, focusing on critical areas such as sleeping related deaths, drowning, injury prevention, traffic crashes, poisoning, to name a few. Families are not interviewed as part of the death review process, unless it is a protocol already in place, such as Fetal Infant Mortality Review, where consent is obtained from the family for an interview. Otherwise, no family will be contacted as a result of this process. Of the 42 states conducting some form of child death review, all have indicated that families are not impacted by these reviews.

In order to ensure the confidentiality of the parents and other surviving siblings, all records will be protected. All confidentiality protections currently cover the information sent to the State and Local Death Review Committees affording them the ability to protect information they receive, including their dialogue regarding the circumstances surrounding a child's death. Confidentiality ensures that family's feelings will be spared a public scrutiny as the Committee carries out its work and that no family be further traumatized as a result of this process; but that understanding how children die and how that might be prevented adds extra meaning to each child's death.

The proposed amendment to the current Florida law would authorize the State Child Abuse Death Review Committee to review all child deaths that were reported to the Florida Hotline and to review all other child deaths based on the availability of resources.

The amendment would also expand the membership of the State Child Abuse Death Review Committee in response to the broader scope of responsibility to include additional departmental/agency representatives and professional experts. Membership will be expanded to include the Department of Highway Safety, the Department of Health State Epidemiologist, The Office of Adoption and Child Protection, the Department of Juvenile Justice, a representative from the Florida Pediatric Society, a professional licensed in a mental health field who is knowledgeable concerning deaths of children, a social worker who is knowledgeable concerning deaths of children, a representative from the Florida Hospital Association, the Registrar for Vital Statistics, a perinatal expert, and a representative from the health insurance industry.

2: Recommendation: The Florida Legislature should fully fund Healthy Families Florida, an evidence-based home visiting program that prevents child abuse and neglect before it ever occurs.

- **Sustain Healthy Families Florida at the 2009-10 Level**

- **Should additional revenue become available:**
  - **Increase funding to add high-risk specialists to the core staffing to better serve families experiencing domestic violence, mental health issues and substance abuse issues that are highly correlated to the occurrence of child abuse and neglect.**
  - **Expand services county-wide in the 22 counties that currently provide services in only targeted zip codes**

The State Child Abuse Death Review Committee recognizes the difficult budget decisions facing the Florida Legislature this session due to the anticipated budget shortfall. However, the prudent investment the Florida Legislature has made in the quality and proven prevention services that Healthy Families Florida has provided

since its inception in 1998 should be continued, as addressing child abuse and neglect after the fact, especially during these economically depressed times, is far more costly in both human and budgetary terms.

Research shows that child abuse and neglect can be prevented and shows that families can overcome factors that place their children at risk and can learn to provide safe, nurturing, and loving homes where children can not only survive but thrive. Healthy Families Florida, the state's only nationally accredited, community-based, voluntary home visiting program is proven to prevent child abuse and neglect by keeping families together and working to ensure that children are raised in safe, stable and nurturing homes. Services begin early, during pregnancy or shortly after the birth of a baby for parents who are voluntarily assessed as having factors that place their children at high risk for abuse and neglect.

Trained family support workers are welcomed into the homes of their families and build trusting relationships, empowering families to recognize their strengths to help them overcome difficult life situations. The family support workers use a comprehensive home visiting curriculum to help guide services and introduce topics and activities that support positive parent-child relationships, including basic care, cues and compassion, social and emotional development, play and stimulation, and brain development. In addition, home visitors teach problem solving skills and methods to cope with stress, conduct screenings for developmental delays, educate on prevention topics such as safe sleep, water safety, shaken baby and car safety, provide social support, connect parents and children to medical providers, and make referrals to other family support services as needed. By increasing the knowledge and skills of new parents, Healthy Families empowers parents to accept personal responsibility for their future and the future of their families.

A rigorous, independent five-year evaluation concluded that Healthy Families Florida has a significant impact on preventing child abuse and neglect. The evaluation showed that children in families who completed the program or received long-term, intensive Healthy Families Florida services experienced 58 percent less child abuse and neglect than did comparison groups with little or no services. Since the program's inception, Healthy Families Florida has consistently met or exceeded the child abuse and neglect participant outcome, the key measure of success -- 98percent of children were free from verified abuse and neglect one year after the family completed the program.

The goals of Healthy Families Florida are consistent with the goals of the Governor's Children and Youth Cabinet and the Governor's Child Abuse Prevention and Permanency strategic plan.

PRIORITY ISSUES

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

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

- **The State Committee supports efforts by the Florida Pediatric Society and their partners to develop and implement a "Coping with Crying" program for hospitals and pediatricians.**
  - **"Coping with Crying" programs should emphasize approaches to male caregivers between the ages of 18 – 30.**
  - **Programs should also emphasize educating parents and caregivers on the importance of making informed, selective choices on "babysitters" for their children.**
- **The Florida Legislature should fully fund quality Early Learning (Child Care) to meet the needs particularly of the poor and working poor so that it is available and affordable especially given the state of the economy.**

- **Any agency investigating child abuse should make it a priority to document and collect information as to a parent's ability or inability to place their children in center- based child care as often they regrettably leave their children with inappropriate caretakers.**

- **The State Committee supports public awareness efforts developed and implemented by Prevent Child Abuse Florida that promotes the prevention of child abuse and neglect through a better understanding of child development, positive parenting practices and community action.**

- **Healthy Families Florida, Healthy Start, Early Steps and other early education and child care programs continue to provide caregivers with basic child development and behavior education designed to address the common risk factors and triggers for child physical abuse and neglect.**

- **Training should be provided to Fire Rescue/EMS first responders and Fire Marshall Investigators on child injury and death investigations related to neglect by caregivers (i.e. drowning, infant suffocation, fire related, traffic crash related).**

- **Law Enforcement and DCF should consider drug testing when there is a history or suspicion of substance abuse by the caregiver at the time of the child's death.**

- **Increase public awareness regarding the importance of reporting domestic violence or threats of violence.**

- **Fund training for law enforcement investigators and DCF Child Protective Investigators on physical child abuse investigations. Training should include:**

  - **Use of standardized Q & A (designed by FDLE) during investigations.**
  - **An emphasis on common risk factors and triggers pertaining to adult male caregivers between the ages of 18-30.**
  - **The dynamics of domestic violence and animal abuse occurring in the homes of child abuse and neglect cases.**

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

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

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

Recommendation: The State Child Abuse Death Review Committee recommends that:

- **Law enforcement agencies, the Department of Children and Families (DCF) and Florida's medical examiner districts (through the Medical Examiners Commission) adopt and participate in standardized guidelines and multidisciplinary approaches for the investigation of the unexpected deaths of infants and children. This includes adopting the Sudden Unexplained Infant Death Investigation (SUIDI) protocol, developed for**

and in conjunction with the Center for Disease Control and Prevention (CDC). http://www.cdc.gov/sids/SUIDHowtoUseForm.htm)

- **Law enforcement agencies and medical examiner's offices include doll re-enactments, when appropriate, as part of their protocols for the investigation of the unexpected deaths of infants and children.**

- **Law enforcement agencies and DCF should perform field drug testing of caregivers, when indicated, as part of their protocols for the investigation of the unexpected deaths of infants and children.**

- **The Florida Legislature should provide funding to expand public awareness and education efforts on infant suffocation due to unsafe sleep environments. Materials should be available to child protective investigators, law enforcement agencies, hospital medical personnel and other medical providers, parents and caregivers with newborn children and the public.**

- **Agencies and organizations that provide home visiting services should use or adapt the home safety checklist and prevention education topic sheets developed by Healthy Families Florida in partnership with the State Child Abuse Death Review Committee (see Best Practices section_).**

- **Provide infant safe sleep education for caregivers providing out of home care**

Sudden Infant Death Syndrome (SIDS) was defined in 1989 by the National Institute of Child Health and Human Development as "the sudden death of an infant less than one year of age which remains unexplained after a thorough case investigation including performance of a complete autopsy, examination of the death scene, and review of the clinical history." In subsequent years, however, it has been recognized that factors related to infant sleeping position and infant sleeping environments, including the prone sleeping position, bed sharing (co-sleeping, particularly with those under the influence of drugs and/or alcohol, those that are obese or that are exhausted) and soft bedding increase the risk of infant death from asphyxia due to position or overlay.

Recognizing these risk factors, the American Academy of Pediatrics published a position paper in 2005 on the subject of safe infant sleeping conditions (see Appendix VI). Additionally, because of the realization that many deaths that formerly might have been classified as SIDS actually have specific, preventable causes, the term SUID (Sudden Unexplained Infant Death) has been designated to refer to all unexpected infant deaths, including those that are determined to be suffocation, SIDS, metabolic error, undetermined, etc. Because the elucidation of these preventable causes requires the accurate determination of the cause and manner of death in such cases, and therefore a thorough investigation of the

scene and circumstances, the CDC has launched a nationwide initiative to improve the quality of these infant death investigations.

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

Recommendation: Implement a systemic approach to prevent drowning of children in Florida, particularly those under the age of 5. The State Child Abuse Death Review Committee recommends this approach include:

- **Public awareness and education on drowning prevention with an emphasis on supervising children near or around water especially targeted at the five and under age group.**
- **All risk assessments conducted by child protective investigators should include drowning risk factors when there is a pool on the premises or bodies of water close to the home.**
- **Law enforcement and medical professionals should report all child-drowning deaths to the Florida Abuse Hotline therefore allowing investigations to occur to determine if the child's death is a result of neglect.**
- **The Florida Abuse Hotline should accept reports from law enforcement or medical professionals on child deaths that occurred as a result of drowning.**
- **Medical Professionals should report all child-drowning deaths where the death has been delayed due to resuscitation or medical intervention, to the Medical Examiner's office since these deaths resulted from a complication of the drowning and therefore, are not natural deaths.**

In 2008, the Florida Abuse Hotline received 73 reports of child drowning deaths, ages 0-17. However, only 48 cases were verified and thus were reviewed by the State Committee.

In 2008, the number of drowning deaths among Florida's children less than five years old decreased for the first time since 2004. In 2008, the Florida Abuse Hotline received 73 reports of child drowning deaths, ages 0-17. Of the 73 reports, 48 cases were verified and thus were reviewed by the State Committee. This number decreased from the 77 verified child drowning deaths in 2007. Between 2002 and 2006, Florida had the 3rd highest overall drowning death rate in the nation and the highest unintentional drowning rate for children 0-4 years old; with a rate of 7.3 per 100,000 Population. The top five counties statewide for child drowning ages 0-4 for 2008 were: 1. Broward with 8, 2. Lee with 6, 3. Miami-Dade with 5, 4. Orange with 3 and 5 Sarasota with 3.

- During 2005 there were 72 deaths, 77 in 2006, and 77 in 2007, and 65 in 2008 for children under age 5, which represents a 7% and 0% increase and 11% decrease respectively.(Florida Vital Statistics)
- In 2008, there were 101 drowning deaths in Florida among children ages 0-18.(Florida Vital Statistics)
- In 2008, most childhood drowning of children under five occurred from April through September.
- In 2008, males of all ages, especially those under five, were more likely to drown than females.
- Despite local ordinances and a state statute requiring safety features for backyard swimming pools, swimming pools are the location of approximately 75 percent of the drowning deaths among Florida's children under age five. (Florida Vital Statistics)
- On October 1, 2000, Florida enacted the Residential Swimming Pool Safety Act (Pool Act), which requires all residential pools built after this date to meet specific safety requirements. However, over 90% of Florida's residential swimming pools were built prior to October 1, 2000, and are not subject to the Pool Act.

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

Supervision can fail for many reasons – washing dishes, answering the phone, using the bathroom, tweeting, using the computer, tending to other children, etc. When supervision fails, only layers of protection (pool safety features such as pool fencing and other barriers) can guard against such moments. The Florida Department of Health, National Drowning Prevention Alliance, Safe Kids USA and many other child safety organizations urge communities to prevent these tragedies by enacting and enforcing strict swimming pool barrier codes and by educating parents and pool owners to use multiple layers of protection to prevent--or at least delay--a toddler's unsupervised access to a swimming pool or spa.

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

More than 10 percent of childhoods drowning deaths occur in bathtubs. The State Committee reviewed six bathtub drowning cases this year. These deaths are preventable through continuous supervision by an adult caregiver. Bathtub

drowning deaths should always be investigated to determine if the childs death was due to caretaker neglect.

The State Committee has identified two key issues related to parental supervision in bathtub deaths. First, parents appear to think that by placing more than one child in the bathtub gives them a false sense of security, believing the other children will be able to protect younger siblings. Second, parents believe that once a child reaches an age they can sit up on their own, they can be left in the bathtub unattended. However, they may not be developmentally capable of being safe in a bathtub.

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

In cases reviewed by the State Committee there often is a lack of thorough death scene investigation by responsible agencies, including not exploring or asking for drug testing when there is a family history of substance abuse, drug paraphernalia at the scene, or suspicion of drug abuse at the time of the child's death. This results in missed opportunities to establish whether or not neglect has occurred as a result of the caregivers substance use.

The AMERICAN ACADEMY OF PEDIATRICS POLICY STATEMENT on Prevention of Drowning in Infants, Children, and Adolescents recommends that children are generally not developmentally ready for formal swimming lessons until after their fourth birthday. However, because some children develop skills more quickly than others, not all children will be ready to learn to swim at exactly the same age. For example, children with motor or cognitive disabilities may not be developmentally ready for swimming lessons until a later age. Ultimately, the decision of when to start a child in swimming lessons must be individualized. Parents should be reminded that swimming lessons will not provide "drown proofing" for children of any age.

Substance Abuse – One of the most common risk factors present in child abuse or neglect deaths reviewed by the State Committee.

Recommendation: Substance abuse should be given a higher priority in the risk assessment activities of child protection organizations that come into contact with children and their families.

- **Law Enforcement and Child Protective Investigators should develop a protocol to test for substance abuse of all caregivers when a child is a victim of drowning, motor vehicle crash, infant co-sleeping related death**

and any other child neglect death where substance abuse by the caregiver is suspected.

- **Training should be provided to Fire Rescue/EMS first responders and Fire Marshall Investigators to recognize the signs of substance abuse by caregivers.**

- **Training should be provided to Law Enforcement and Narcotics Officers on mandatory reporting of child abuse when narcotic investigations indicate that children were present during drug related sales, manufacturing or use by a caregiver. Protocols for handling these reports should be established between law enforcement and the Department of Children and Families at the local level.**

- **The Office of Drug Control and Policy and the Department of Children and Families Substance Abuse and Family Safety program offices should establish an interdisciplinary workgroup to review the current pre-service child protection curriculum to make recommendations for specific training on the identification and assessment of substance abuse problems in families. The training should focus on how substance misuse contributes to or results in harm to infants and children whose caregivers use illicit substances, abuse alcohol, or allow children inappropriate access to prescription drugs. In addition, training for Child Legal Services, in regards to these issues, should also be reviewed and revised, as needed.**

- **Improve the early recognition, identification and referral of substance abuse issues for intervention by formalizing linkages between child welfare staff and substance abuse family intervention specialists at the front end of the child welfare system. Require the use of in-service cross-training curriculum(s) for child protective investigators/case mangers and substance abuse counselors**

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

Substance abuse continues to be one of the highest risk factors for child fatality. Of concern is the lack of identification of substance abuse/use as a contributing factor in child abuse deaths because of lack of on-scene presumptive drug testing as part of the child protective or law enforcement investigation protocol. The

State Committee continues to see a pattern where investigative findings indicate that substance abuse by the parent or person responsible for the child was documented in prior reports or substances were discovered in the home at the time of the child's death and no drug testing occurred. Substance abuse allegations or indicators do not appear to have been appropriately factored into the risk assessment. Frequently, cases are either referred to voluntary services or no services are offered. As acknowledged in last year's report, the State Committee recognizes that the Florida Appellate Courts have overturned the sheltering of children due to the lack of statutory authority in cases involving substance abuse as the nexus for sheltering child victims. However, this should not be the guiding factor when making determinations for child safety.

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

Recommendations: Improved consistency and communication among the various agencies involved in child abuse cases and child death cases.

- **A multidisciplinary staffing should be required when there is a change in the child's placement that differs from the recommendation made by the Child Protection Team and/or DCF. See Best Practice section for example**

- **Improve the reporting and consistency in findings in child death cases.**
  - **Comparative data (by circuit) should be collected on both the reporting and verification rates of all alleged child deaths due to abuse or neglect.**
  - **Data analysis should include the potential under-reporting of maltreatment types, most noticeably drowning deaths due to inadequate supervision and unsafe sleep deaths.**
  - **The overall verification rate (i.e., ratio of confirmed child deaths to all alleged child deaths investigated) should also be analyzed to detect individual or unit bias in the handling of child death investigations.**
  - **Reporter type (i.e., professional vs. family member) should be reviewed to help identify patterns of reporting by maltreatment, and to assess for under-reporting by first responders.**

- **Provide cross training between disciplines to improve consistency in the collection and documentation regarding critical evidence at child death scenes.**

Consistency in reporting suspicious deaths is critical to determining the extent and causes of abuse and neglect related deaths. It is also essential to identifying strategies for future prevention of these deaths. During 2008, the statewide rate of alleged maltreatment deaths per 100,000 children was 10.6 (this represented all reported deaths regardless of findings). Of the five counties with the largest child

population (Dade. Orange, Palm Beach, Broward, and Hillsborough) the rate of alleged maltreatment deaths ranged from a high of 18% in Hillsborough County to a low of 16% in Dade County. Further analysis of the reported deaths statewide is necessary to determine whether low reporting trends exist; and if so, how best to address these.

In addition to consistency in reporting deaths due to alleged maltreatment, determination of accurate findings in investigations of maltreatment related fatalities is essential to promoting an understanding of the extent and causes of these deaths. In 2008, Dade, Orange, Palm Beach, Broward and Hillsborough Counties (those counties with the highest child population) "Verified" child death rates ranged from a high of 65% in Broward to a low of 30 % in Orange and Palm Beach Counties. Ongoing analysis of findings by circuit, county and unit should facilitate identification of patterns and areas that would benefit from additional training and assist the Department in crafting training to address specific issues and needs.

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

Recommendation: There is a need for a Quality Assurance review by Child Legal Services when any child dies as a result of child abuse and the case was either staffed with CLS or under the jurisdiction of the court.

- **That Child Legal Service should appoint a representative to participate on every local Committee.**

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

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

Other recommendations are to have state wide legal staffing forms- which they have implemented and we should refer to them as well as their new CLS training that is to be done statewide.

Judicial update from 2008 recommendation:

Last year the State Committee made a recommendation that the Florida Supreme Court or the Florida Legislature should establish an independent review process for judicial cases when a child dies from child abuse and was under the supervision of the court.

The State Committee has opened a dialog with the Court Administration and they have agreed to appoint someone as an ad hoc member to the committee to assist in developing a more comprehensive review of child abuse deaths where the courts have had involvement.

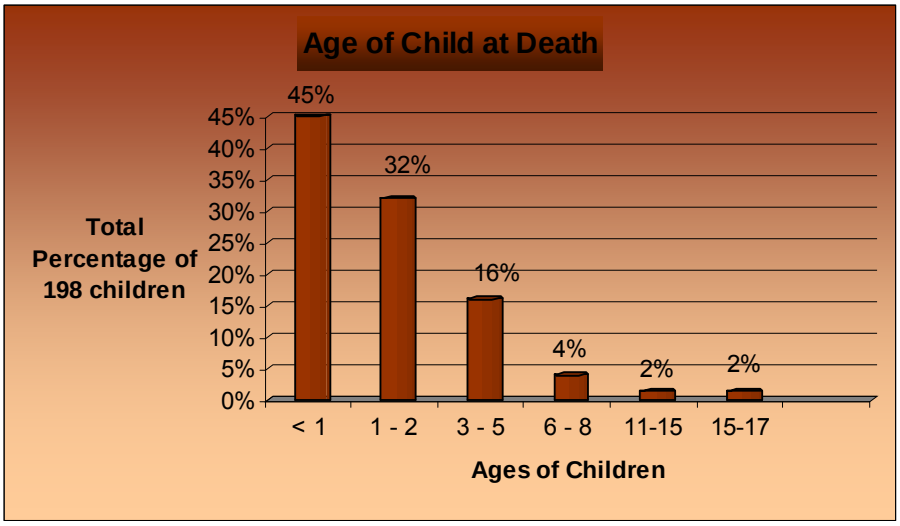
OVERVIEW OF ALL DEATHS

There were 198 infant/child deaths (under the age of 18) reviewed during 2008 that met the criteria for the State Child Abuse Death Review Committee. The following graphs show the total, age, gender-specific and race-specific child abuse deaths for Florida in 2008. This year the State Committee noted that 13 children who died were a twin.

Age of Child

- 90 (45.7%) children were <1
- 63 (31.8%) children were 1-2
- 31(15.7%) children were 3-5
- 8 (4.1%) children were 6-8
- 1 (5%) children were 9-12
- 1(1%) children were 13-15
- 3 (1.5%) children were 16-17

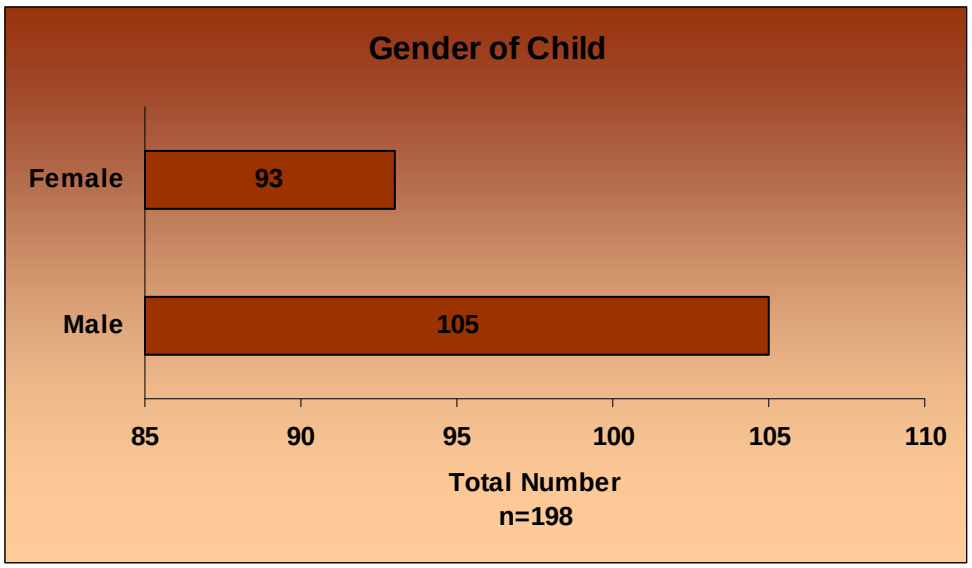
184 (93%) of the children were 5 and under



According to the US Department of Health and Human Services (DHHS)[3], Child Maltreatment 2007, more than three-quarters (75.7%) who were killed were younger than 4 years of age, 16.5 were younger than one, and 10.7% were 2 years of age.

Gender of Child

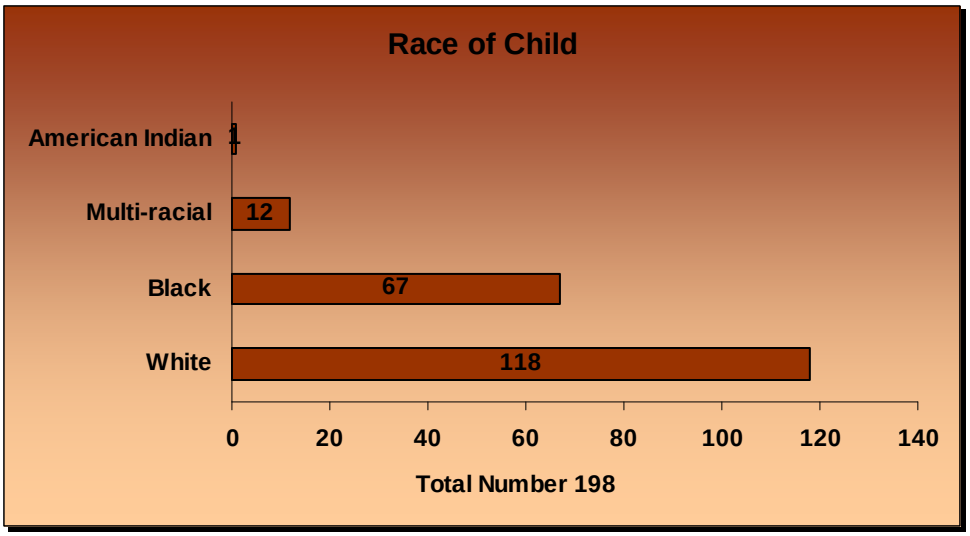
- 105 (53.%) were male children
- 93 (47.%) were female children



According to the US Department of Health and Human Services (DHHS)[3], Child Maltreatment 2007, infant boys (younger than 1 year) had a fatality rate of 18.85 deaths per 100,000 boys of the same age. Infant girls (younger than 1 year) had a fatality rate of 15.39 deaths per 100,000 girls of the same age.

Race of Child

- 118 (60%) were white
- 67 (34%) were black
- 12 (6%) were multi-racial
- 1 (.5%) were American Indian



According to the US Department of Health and Human Services (DHHS)[3], Child Maltreatment 2007, nearly one-half (41.1%) off all fatalities were White children. More than one-quarter were African-American (26.1%) and nearly one-fifth 16.9%) were Hispanic children. Children of other race categories collectively accounted for 4.8% percent of fatalities.

CHILD ABUSE AND NEGLECT DATA

The State Committee's review of death cases only includes a verified child abuse death by the Department of Children and Families, which is a subset of the larger population of children who die. This limits the Committee's ability to fully meet the statutory charge of achieving a greater understanding of the causes and contributing factors of deaths resulting from child abuse. As a result, the patterns and trends identified are subsequently limited to the population set reviewed and may or may not be generalizable to larger populations. The essential outcome is to be able to derive meaningful conclusions and provide concrete recommendations that can be implemented in hopes of preventing the death of additional children.

There were 525 child deaths reported to the Florida Abuse Hotline in 2008, however there were 465 unduplicated reports of a child's death. Also there were an additional 60 calls for the following reasons: 17 were reported in 2008 and the child's death occurred in a prior year or and in one case the death occurred on 1/1/ 2009, 40 cases were closed as no jurisdiction (i.e. death of out state, nonviable birth, no deceased child, etc.) Of those, 201 had a verified finding of abuse or neglect and six remain open and under investigation.

In 2007, the Department of Children and Families initiated prevention initiatives to better serve families who were reported to the Florida Abuse Hotline (Hotline) but the allegation did not meet the statutory criteria for a child abuse or neglect report. These calls are accepted as 'prevention referrals' and involve situations that do not meet the statutory criteria for an intake, but the family or individual may need services. The intent is to prevent child maltreatment by helping families or individuals through a family and/or community centered approach before that occurs.

The Department of Children and Families also piloted an Alternative Response System/Differential Response System in three areas of the state (Bay, Duval, and Seminole Counties). These systems models tend to lower the workload of child protective investigators by reducing the number of low risk reports that require a full blown investigation. This allows for child protective investigators to focus more time and attention to those reports that involve serious harm, criminal prosecution, or dependency action. The results showed that child safety was almost always enhanced; not compromised, because families generally disclose much more accurate information when they are successfully engaged.

Department of Children and Families is exploring the feasibility of expanding these pilots statewide. The State Committee will be looking the pilots to see how they affect child deaths.

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

FLORIDA CHILD DEATHS - 2008[5]	
Number of child deaths regardless of residency	2,843
Number of Florida resident child deaths	2,732
DCF REPORTS RECEIVED & ABUSE/NEGLECT DEATHS[4]	
Number of initial reports Number of cases for 'alternative response'	220,354 *210
Number of reports involving child deaths	525
Number of child abuse death's with some indicator findings	78
Number of verified child abuse death reports	**201
National estimate for 2007[3]	***1,760

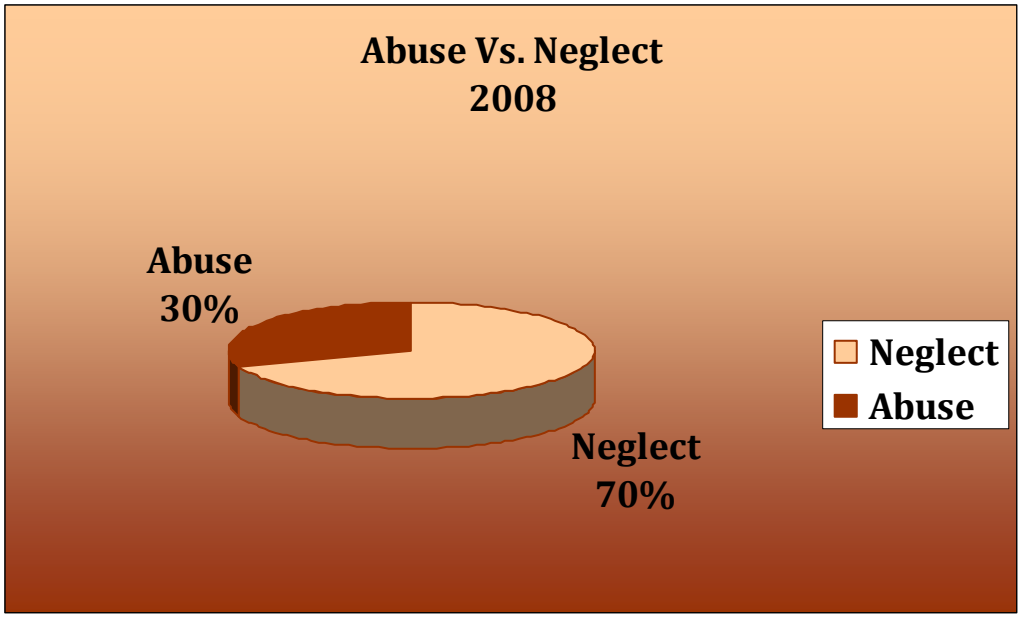
* Three cases from 2008 will be reviewed next year due to either pending criminal investigations or delay in local committee's ability to review.

**The alternative response was a pilot for Bay, Duval, and Seminole counties from April –October 2008

***U.S. Department of Health and Human Services: Child Maltreatment 2007: Reports from the States National Center on Child Abuse Prevention Research.

ABUSE/NEGLECT

In 2008, there were 198 child abuse and neglect deaths reviewed. Of those, 60 (30%) were from abuse and 138(70%) were neglect.



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

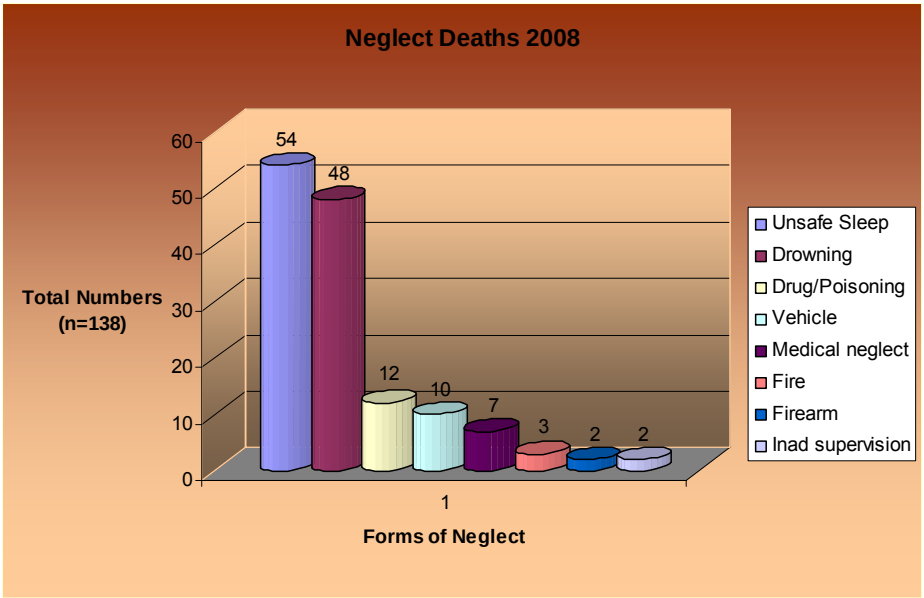
- Issues affecting the accuracy and consistency of child fatality data include:
- Variation among reporting requirements and definitions of child abuse and neglect and other terms
- Variation in death investigative systems and in training for investigations
- Variation in State child fatality review processes
- The amount of time (as long as a year, in some cases) it may take to establish abuse or neglect as the cause of death
- Inaccurate determination of the manner and cause of death, resulting in the miscoding of death certificates; this includes deaths labeled as accidents, sudden infant death syndrome (SIDS), or "manner undetermined" that would have been attributed to abuse or neglect if more comprehensive investigations had been conducted (Hargrove & Bowman, 2007)

- Limited coding options for child deaths, especially those due to neglect or negligence, when using the *International Classification of Diseases* to code death certificates
- The ease with which the circumstances surrounding many child maltreatment deaths can be concealed
- Lack of coordination or cooperation among different agencies and jurisdictions

In cases of fatal neglect, the child's death is not a result of anything the caregiver did, but rather the result of a caregiver's failure to act. The neglect may be chronic (e.g., extended malnourishment) or acute (e.g., an infant who drowns because she is left unsupervised in the bathtub). NCANDS (National Child Abuse and Neglect Data System) show that in 2007, 34.1% of child maltreatment fatalities were associated with neglect alone[3]. Neglect has been the leading cause of child abuse deaths in Florida over the past eight years. Below is a graph of years 2004-2008. Neglect covers a broad section of maltreatments and may have no outward signs, so is often missed.

Child Neglect deaths are often over looked and coded as "just a tragic accident" by law enforcement, first responders and Child Protective Investigators, feeling that the family has suffered enough. With emotions clouding the investigator's judgment and ability to look for facts and contributing factors of neglect, they close the case accidental. There is a lack of training to both law enforcement officers as well as Protective Investigators on child death investigations. There is no standardization in these investigations; allowing for inconsistencies in information collected by law enforcement and inconsistencies in child death verification by DCF.

The graph below shows the 138 child deaths reviewed caused by a form of neglect



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

Angleo Giardion and Elieen Girardino, PHD have suggested that there are circumstances that may give rise to the occurrence of a child's injury via physically abusive actions have been organized into a typology having the following 5 subtypes: (1) caregiver's angry and uncontrolled disciplinary response to actual or perceived misconduct of the child; (2) caregiver's psychological impairment, which causes resentment and rejection of the child by the caregiver and a perception of the child as different and provocative; (3) child left in care of a baby-sitter who is abusive; (4) caregiver's use of substances that disinhibit appropriate behavior; and (5) caregiver's entanglement in a domestic violence situation.[10]

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

The numbers confirm that 2008 was a deadly year for Florida Children. The number of traumatic injuries has increased 23% there were 45 physical abuse deaths in 2007 and 59 physical abuse deaths in 2008. The graph below shows the 59 child deaths reviewed caused by a form of physical abuse.

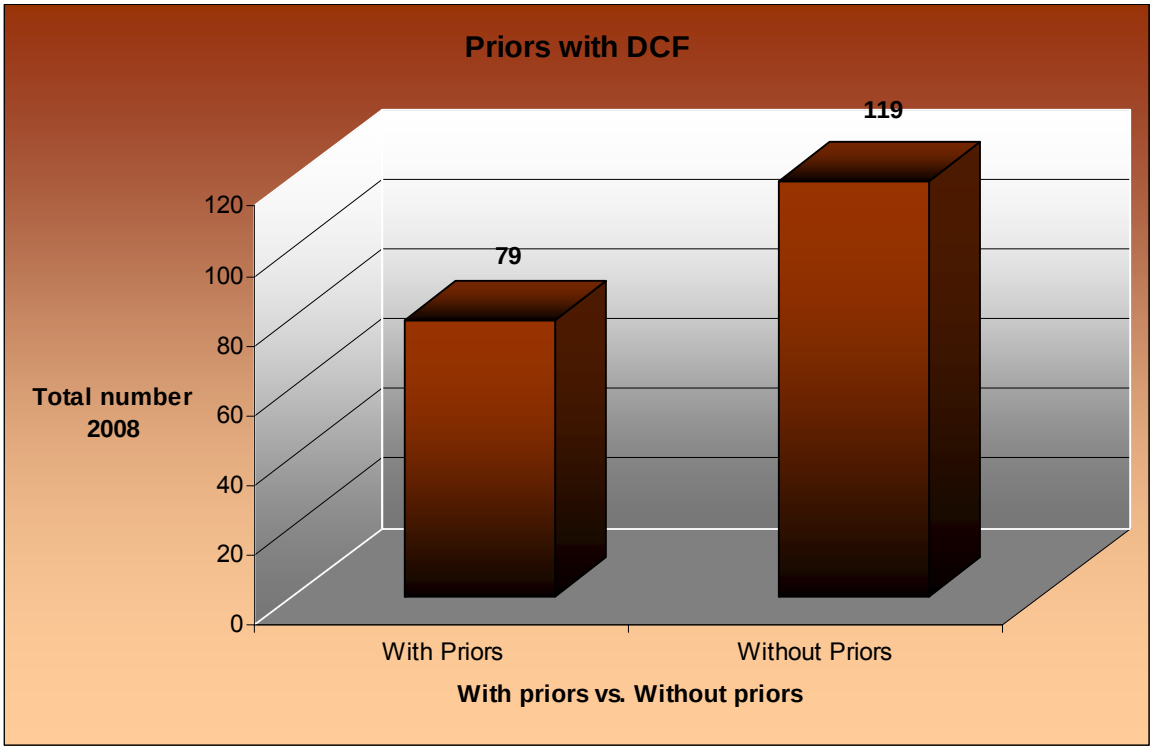
PRIOR INVOLVEMENT WITH THE DEPARTMENT OF CHILDREN AND FAMILIES

According to the US Department of Health and Human Services[3], children who had been abused or neglected and whose families had received family preservation services in the past five years accounted for 13.7 percent of child fatalities. Nearly 2 percent (2.3%) of the children who died had previously been in foster care and were reunited with their families in the past five years. (NASCADDS REF)

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

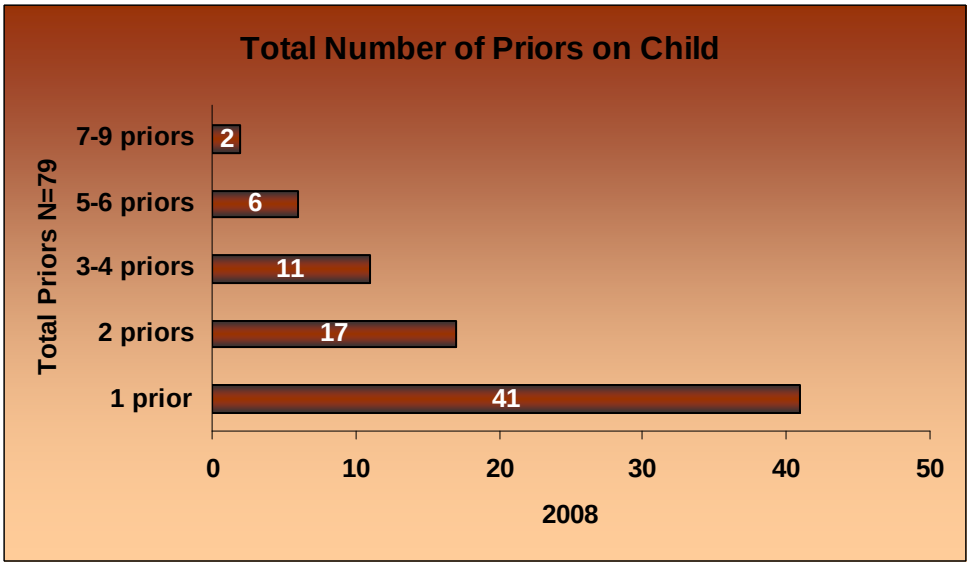
There were 79(40%) cases in 2008 where the child had prior involvement with the Department of Children and Families.

119 (60%) did not have any prior involvement with the Department of Children and Families.



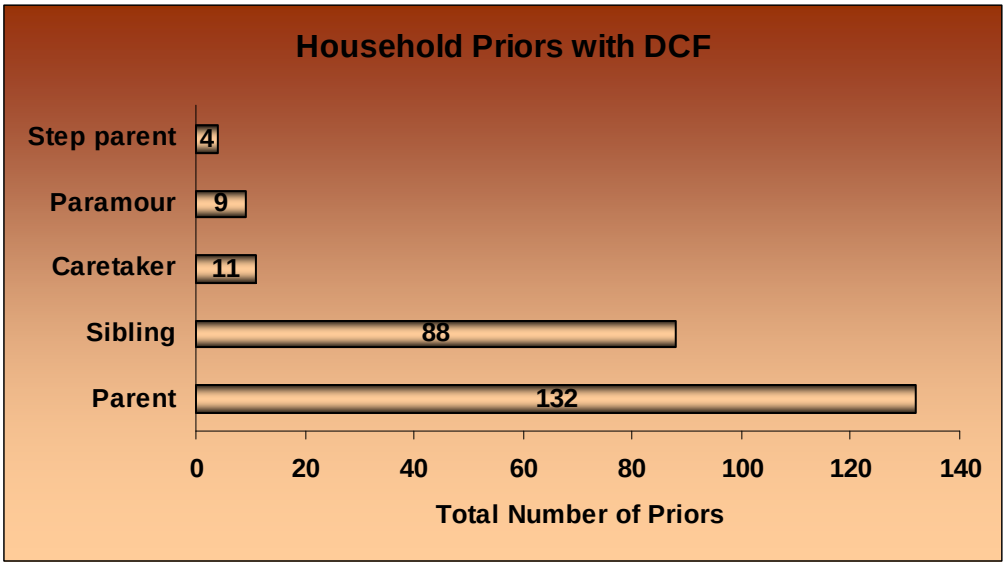
There were 22(11%) cases where there was an open report at the time of the death of the child.

The graph below depicts the number child abused death cases that had one or more prior reports.



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

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



PREVENTABILITY

Preventable deaths

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

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

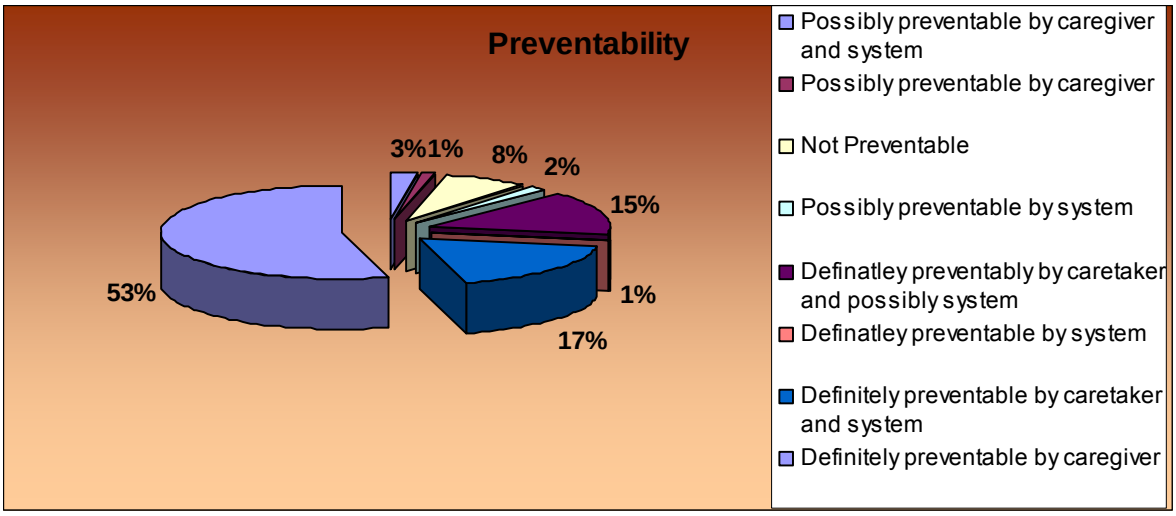
Deaths resulting from homicidal violence are classified as "not preventable" unless the information provided clearly demonstrates that actions taken by the community or and individual other than the perpetrator could definitely have prevented the death or could possibly have prevented the death

Possibly preventable by caretaker or system or both: There is insufficient information to determine if the death was preventable.

Not Preventable by caretaker or system: No current amount of medical, educational, social or technological resources could prevent the death from occurring.

Of the abuse deaths reviewed:

- 107 (54.0%) were definitely preventable by caretaker
- 35 (17.6.%) were definitely preventable by caretaker and system
- 30 (15.0%) were definitely preventable by caretaker and possibly system
- 5 (2.5%) was possibly preventable by caretaker and system
- 3 (1.5%) were possibly preventable by system
- 2 (1%) were possibly preventable by caretaker
- 1 (.05%) was definitely preventable by system
- 15 (7.5%) were not preventable


Preventability
3%
1%
8%
2%
15%
1%
17%
53%
Possibly preventable by caregiver and system
Possibly preventable by caregiver
Not Preventable
Possibly preventable by system
Definatley preventably by caretaker and possibly system
Definatley preventable by system
Definitely preventable by caretaker and system
Definitely preventable by caregiver

PERPETRATOR INFORMATION

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

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

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

The total perpetrators responsible for the 198 child deaths were 275.

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

***Kaytlin**

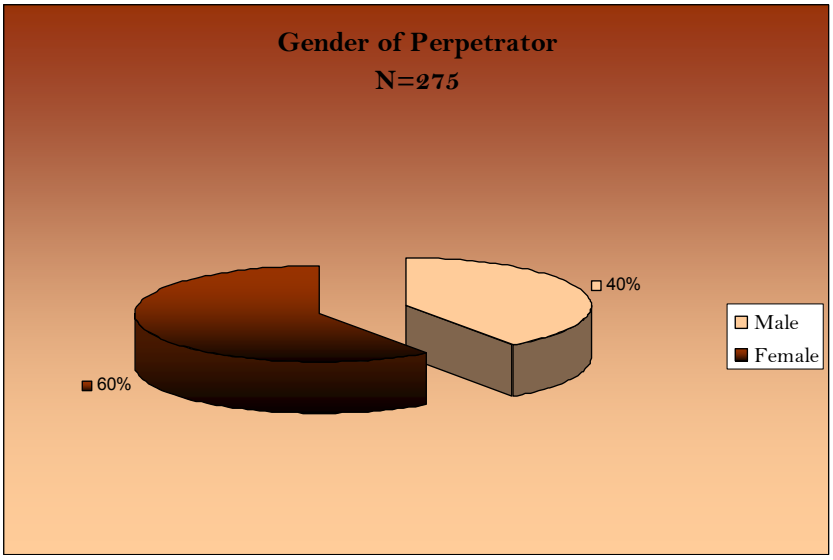
Blunt impacts to torso and laceration of heart

Kaytlin, age 2, was brought to the hospital by her mother's boyfriend, age 36. He stated that she fell in the bathtub. The mother, age 25 was at work leaving her boyfriend to care for her three children, ages 6 and 4. Kaytlin had burn scars on her thigh and back. The mother was aware that he often smoked marijuana, drank beer and was violent. The siblings had bruises and marks on their bodies and begged the nurses not to let them hurt them any more. Although he was charged with the murder the mother continued to say he could not have hurt Kaytlin. There are priors with DCF as well as a history of domestic violence.

Gender of Perpetrator/ Caregiver

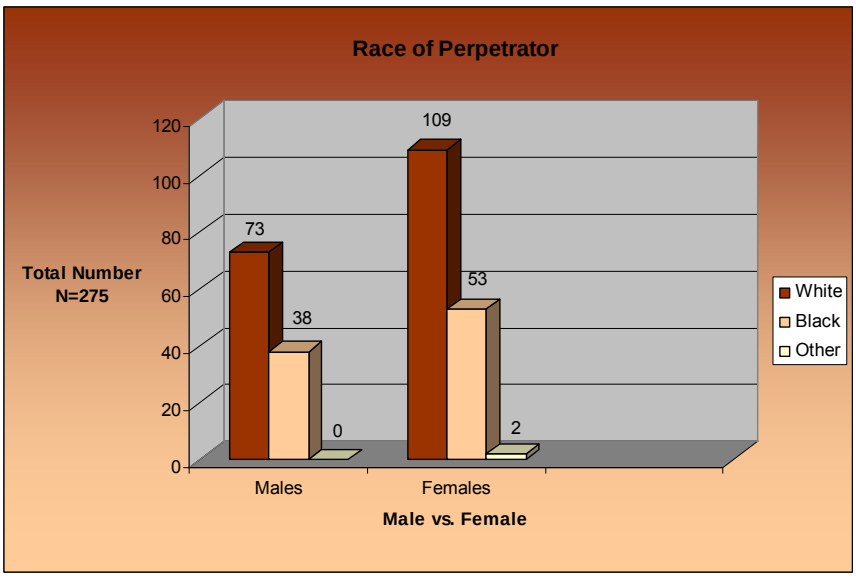
Of the 275 perpetrators identified

- 164 (60%) were females
- 111(40%) were males



Race of Perpetrator

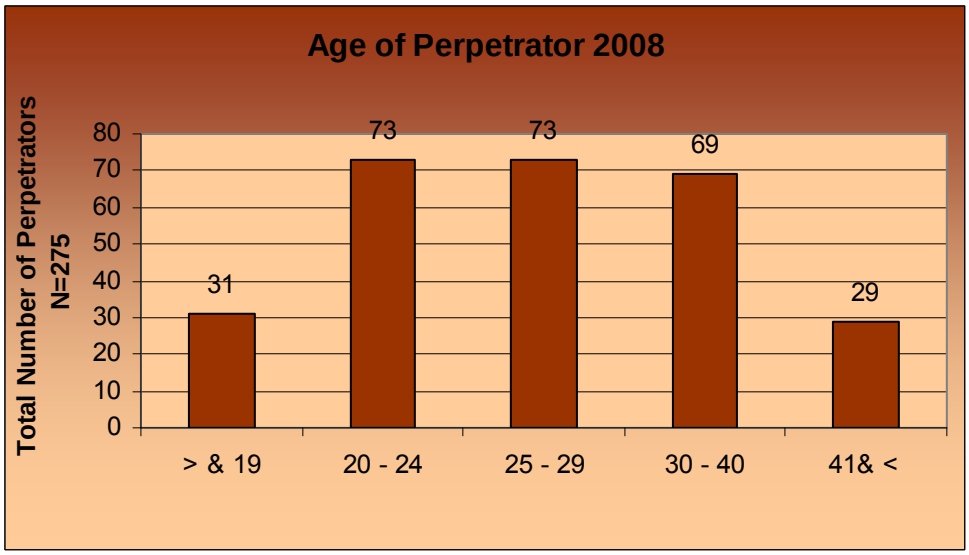
- 182 (66.2%) perpetrators were white
- 91 (33.1%) perpetrators were black
- 2 (.07%) perpetrators were other



Age of Perpetrator

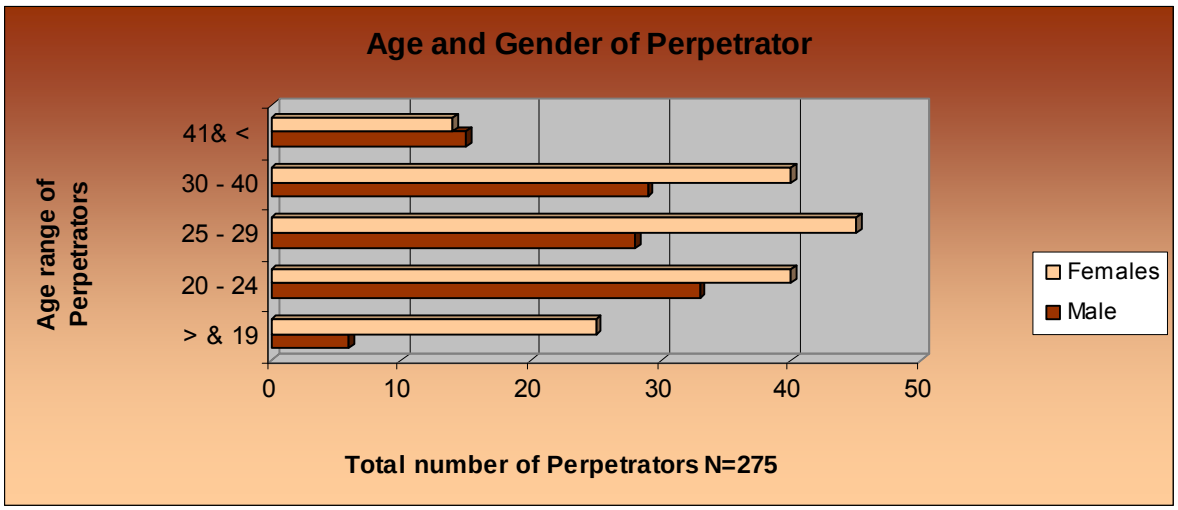
- 31 (11%) were under the age of 19
- 73 (27%) were 20-24
- 73 (27%) were 25-29
- 69 (25%) were 30-40
- 29 (11%) were > 41

53% were in their 20's



Age and Gender

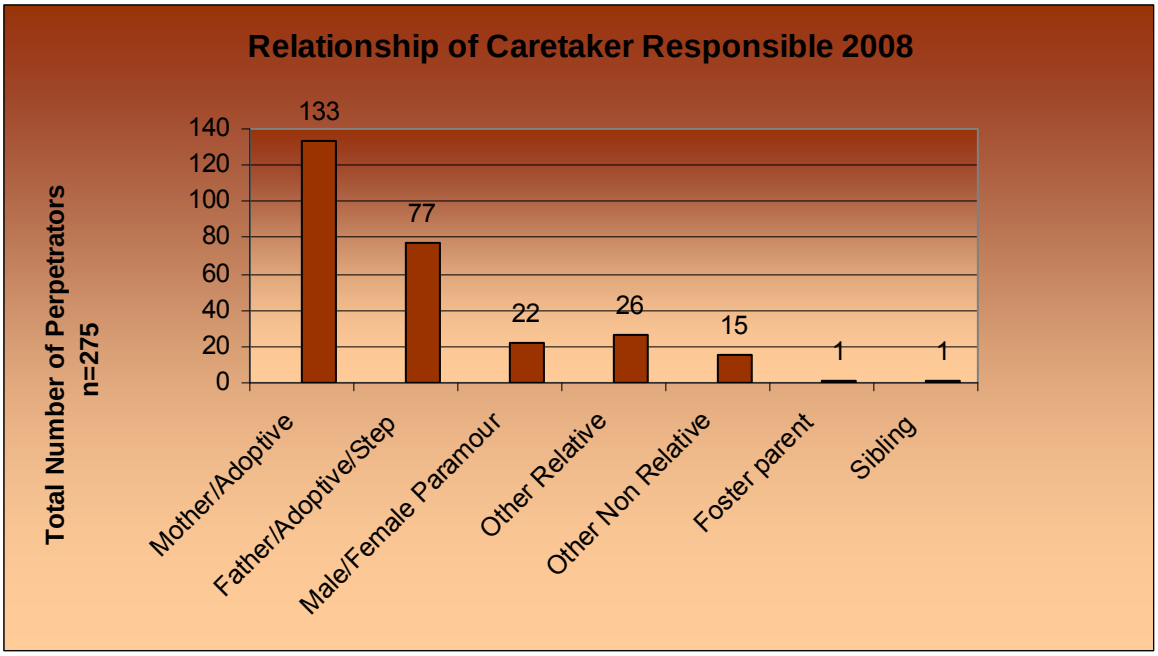
Below is a graph that shows the breakdown of age and gender



Their relationship to the deceased child is shown below.

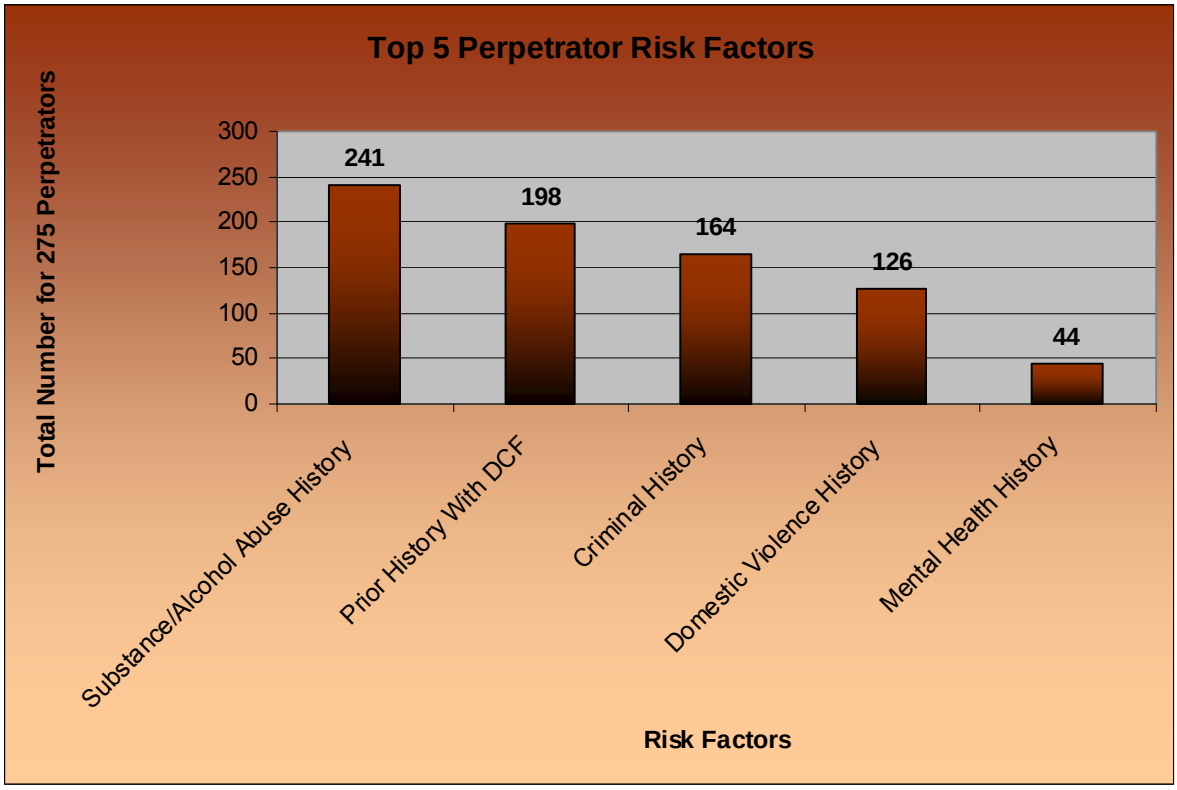
Relationship of Caregivers to Child

- 133 (48%) Mother/Adoptive Mother
- 77 (28%) Father/Adoptive Father/Step Father
- 22 (8%) Male and Female Paramour
- 26(9%) Other Relatives
- 15 (5%)Other non-relative
- 1 (.3%) Foster mother
- 1 (.3%)Sibling



Perpetrator/Caregiver risk factors

The total perpetrators responsible for the 198 child deaths were 275. There maybe more than one perpetrator identified in a case. The State Committee identified the top perpetrator risk factors, Substance abuse history, DCF history, Criminal history, Domestic Violence History and Mental Health history. The graph below shows the risk factors for the 275 perpetrators in the 198 child abused death cases reviewed.



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SUBSTANCE ABUSE

The relationship between substance abuse and child maltreatment is recognized as "compelling and undeniable" by the U.S. Department of Health and Human Services. The National Survey on Drug Use and Health estimates that 8.3 million children under the age of 18 live with at least one parent who was dependent on or abused alcohol (7.3 million) or an illicit drug (2.1 million) in the past year. The highest percentages of these children are under the age of five, and have limited ability to self protect or provide for their daily needs.

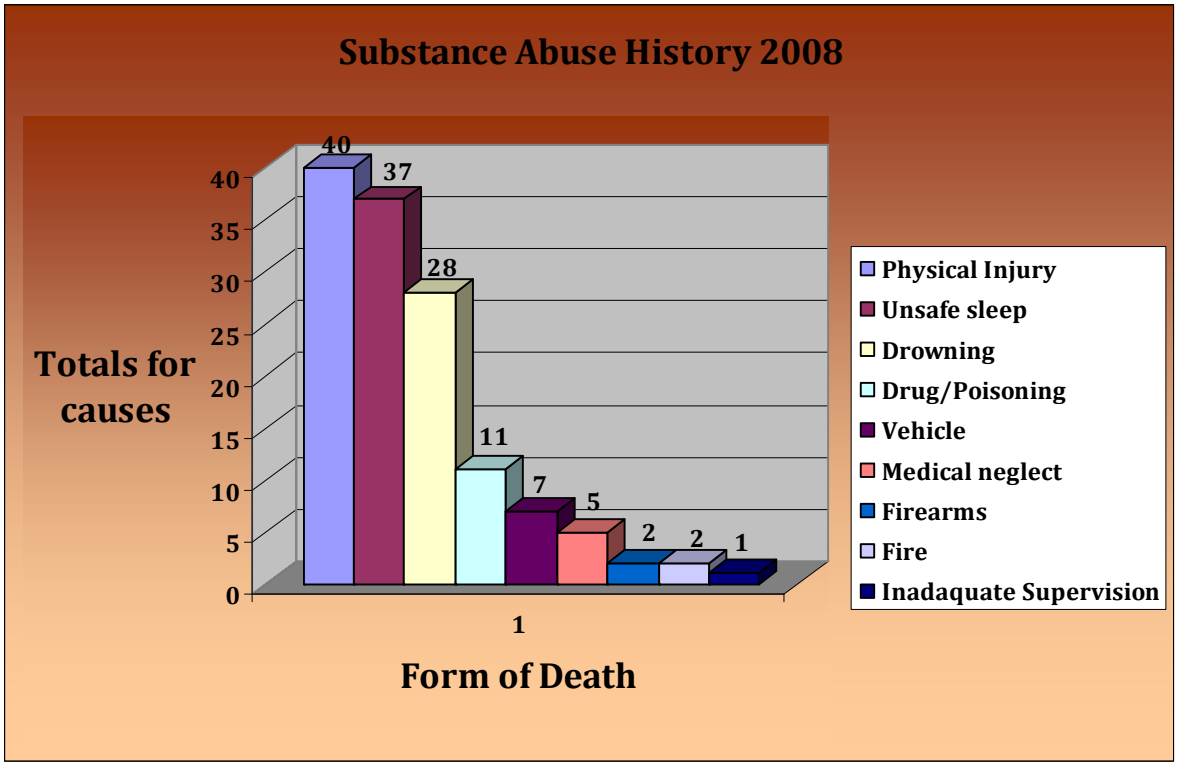
Substance abuse and addiction severely impacts parental judgment, influences types and consistency of discipline, and contributes significantly to generalized neglect. Many substance abusers are living in poverty due to either their inability to maintain employment, or the use of financial resources to acquire drugs or alcohol. Additionally, children of parents with substance abuse history are more likely to experience intellectual, physical and emotional problems, increasing their risk of maltreatment and harm.

More than one million children are confirmed each year as victims of child abuse and neglect by state child protective service agencies. Every day at least three to five children die as a result of abuse and neglect according to various sources. State child welfare records indicate that substance abuse is one of the top two problems exhibited by families in 81% of the reported cases. The relationship between parental alcohol or other drug problems and child maltreatment is becoming increasingly evident. The risk to the child increases in a single parent household where there is no supporting adult to diffuse parental stress and protect the child from the effects of the parent's problem. Substance use often serves as a coping tool when other parental skills fall short and can quickly lead to abuse. It contributes to deficits in decision making and reduces a parent's ability to properly parent their children.

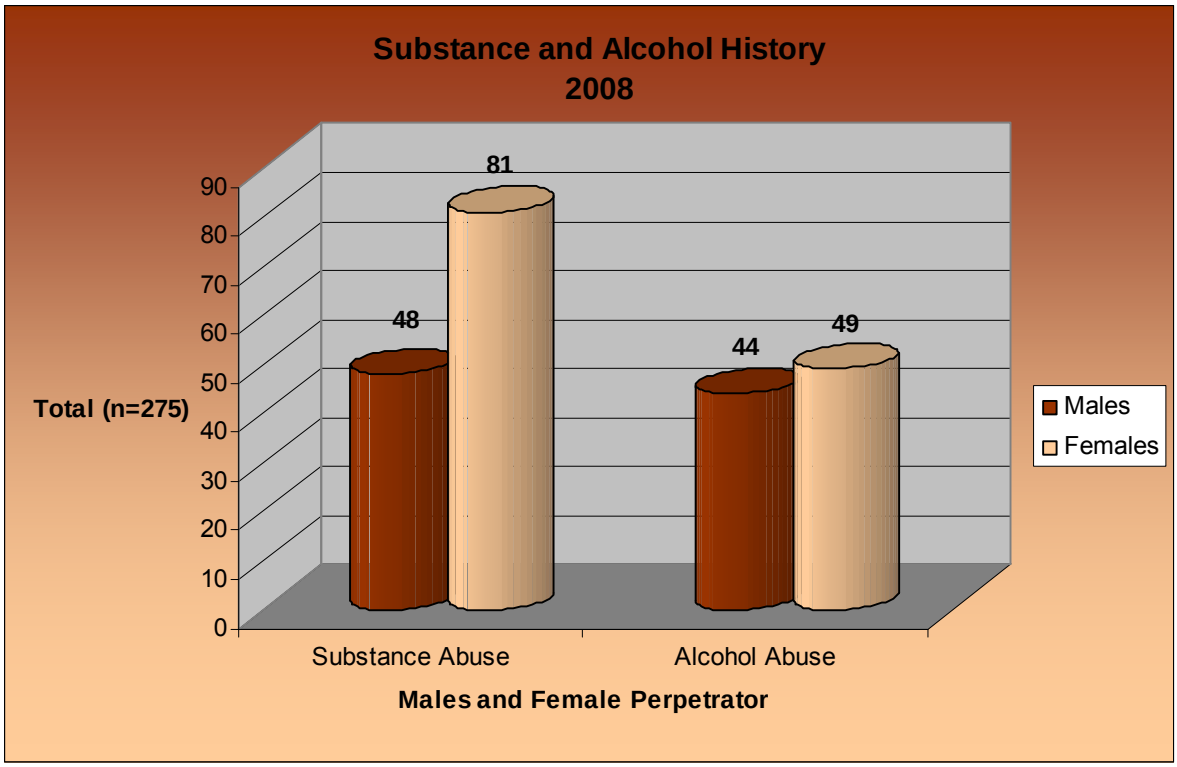
Of concern is the continued lack of identification of substance abuse/use as a contributing factor in child abuse deaths because of lack of on-scene presumptive drug testing as part of the child protective or law enforcement investigation protocol. While some areas of the Department of Children and Families Circuits have implemented presumptive drug testing, it is not utilized statewide. The State Committee continues to see a pattern where investigative findings indicate that substance abuse by the parent or person responsible for the child was documented in prior reports or substances were discovered in the home at the time of the child's death and no drug testing occurred, nor was there any follow up on the case. Substance abuse allegations or indicators do not appear to have been appropriately factored into the risk assessment. Subsequently, cases are either referred to voluntary services or no services are offered. As acknowledged in a previous report, courts have ruled against sheltering of children due to the lack of statutory authority in cases involving substance abuse as the nexus for sheltering child victims.

However, this should not be the guiding factor when making determinations for child safety. Substance abuse assessments should be an integral part of a complete comprehensive child protective investigation that takes into consideration all risk factors to the child and takes appropriate steps to ensure appropriate interventions aimed at protecting the child and supporting the family.

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



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



***Jeffery**
Pool drowning

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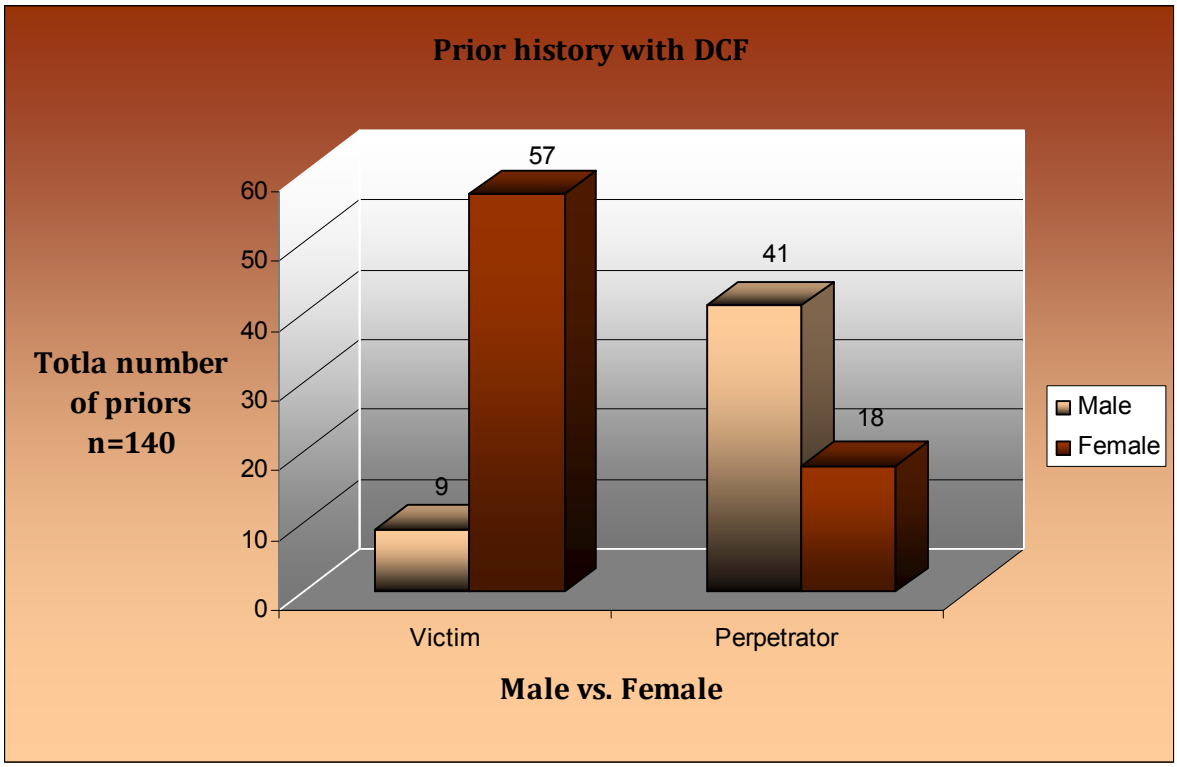
Mom, age 21, left Jeffery, 23 months, and his sibling, 8 months, in the care of their Grandfather age 53. The mother was aware that the Grandfather and a friend of his had been drinking all day. The Grandfather and his friend were sitting outside smoking marijuana leaving the child unsupervised. The sliding door leading to the pool was left open. Jeffery was discovered in the pool after 20 minutes had passed with him being unnoticed. There were no drug tests requested. The mother was charged with child neglect.

DCF HISTORY

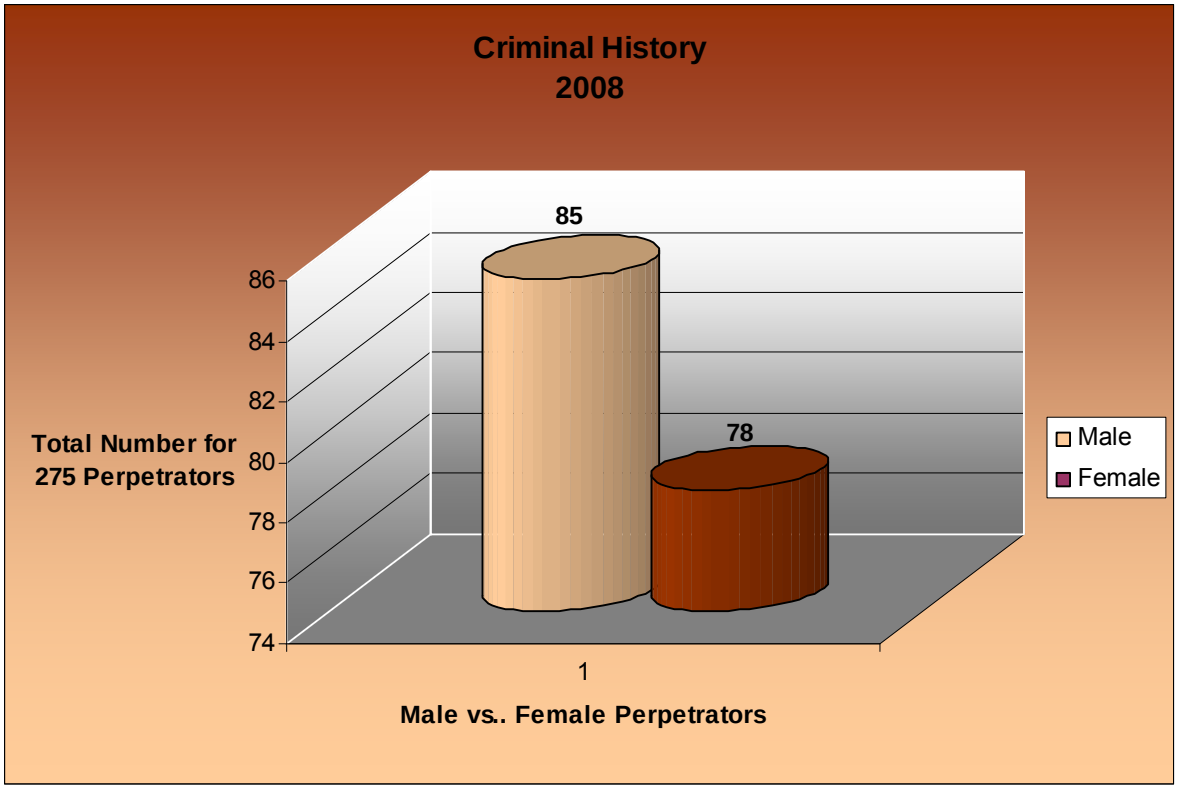
Caretakers who abuse or neglect children are most often acting upon beliefs and experiences from their own childhood Many of the caretakers were victims of child abuse and neglect. Research suggests that about one-third of all individuals who are maltreated as children will subject their children to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

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



CRIMINAL HISTORY

The best predictor of future behavior is past behavior. It is important that investigators look and take into consideration the criminal history of the caretakers, when the history involves violent behavior and drug related offences. The graph below shows the total number of perpetrators by gender that had prior criminal history. Out of the 275 perpetrators, 164 (83%) had criminal history.



DOMESTIC VIOLENCE

Child abuse and domestic violence are closely related. Child Abuse occurs in 30% - 60% of family violence cases that involve families with children[17]. In homes where partner abuse occurs, children are 6-15 times more likely to be abused[17]. According the Florida Governor's Task Force on Domestic and Sexual Violence, Florida Mortality Project, 27% of domestic homicide victims were children[3]. It is incorrect to assume that children are in less danger once couples separate. In fact, the opposite is often true. Therefore, if we are to reduce child deaths at the hands of perpetrators, it is critical that systems improve their mechanisms for holding batterers accountable for the violence they commit[16].

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

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

Children can be exposed to domestic violence by:

- Directly witnessing or the forced to participation in assaults/homicides
- Hearing the violence, (i.e. name calling, intimidation, and threats)
- Feeling the tension in the home
- Seeing the aftermath of the violence (i.e. broken furniture, bruises on their Non Offending Parent, or the offender being taken away by police)
- Intervening in the violence to protect the Non Offending Parent
- Being threatened by batterer
- Forced participation in relaying messages, keeping tabs on mother

- Being seriously injured or killed during an assault

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

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

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

Factors that influence children's response to domestic violence:

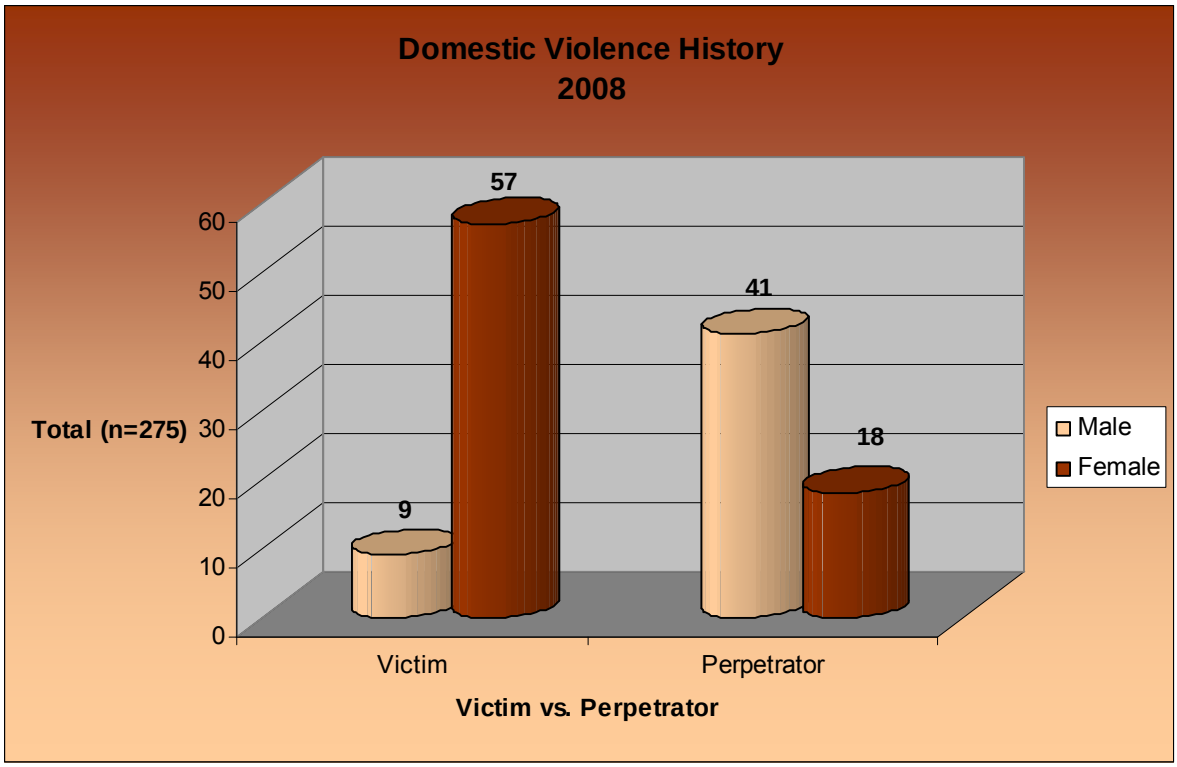
- Their interpretation of the violence
- Support within the family system
- Support outside of the family system

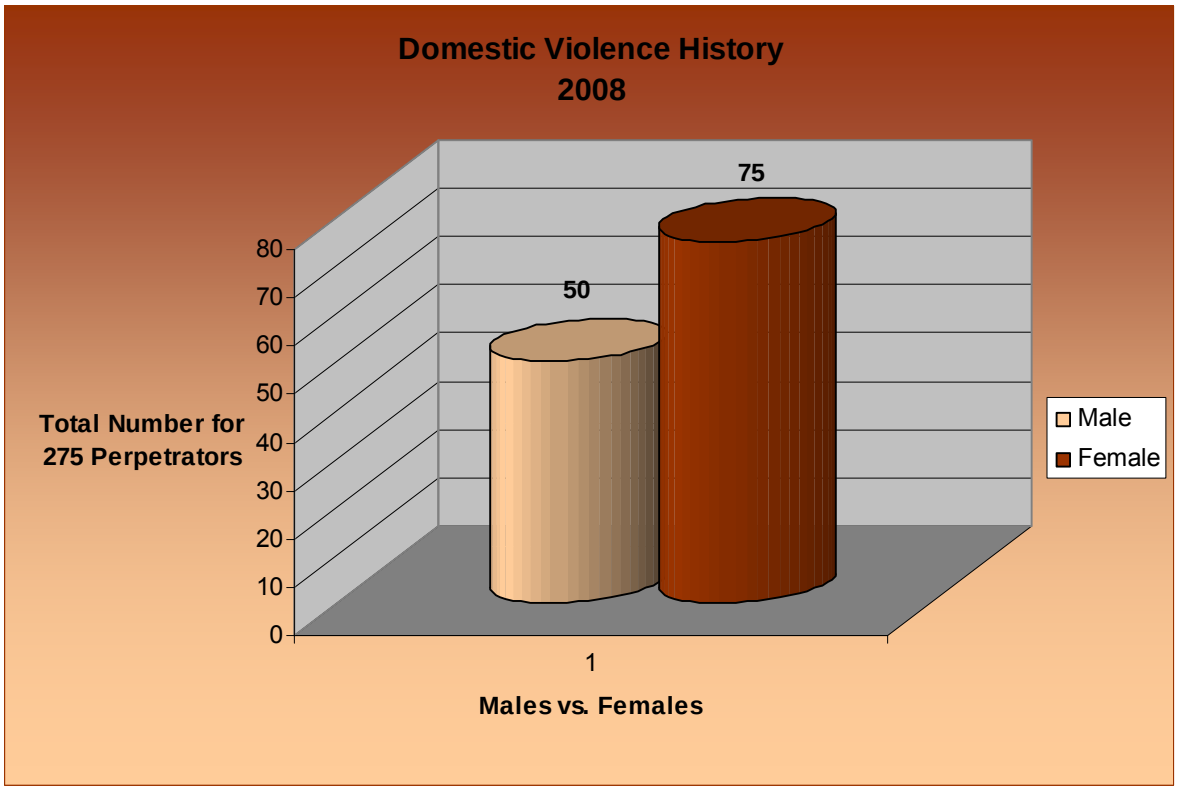
Continued public awareness and batterer accountability is important to prevent future homicides and child abuse fatalities

Florida Department of Law Enforcement reported that Domestic Violence accounted for 180(15%) of the state's 113,123 homicides in 2008.

Of the 275 perpetrators identified in the 198 cases reviewed by the State Committee, 30% of perpetrators had history of being a perpetrator of domestic violence. Of the 275 identified, 34% had been victims of domestic violence; 86% of those were women. Of the 184 cases 22 (11.1%) had an increase in frequency just prior to the child's death.

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


Domestic Violence History
2008
Total (n=275)
60
50
40
30
20
10
0
57
41
18
9
Victim
Perpetrator
Victim vs. Perpetrator
Male
Female


Domestic Violence History
2008
Total Number for
275 Perpetrators
80
70
60
50
40
30
20
10
0
75
50
1
Males vs. Females
Male
Female

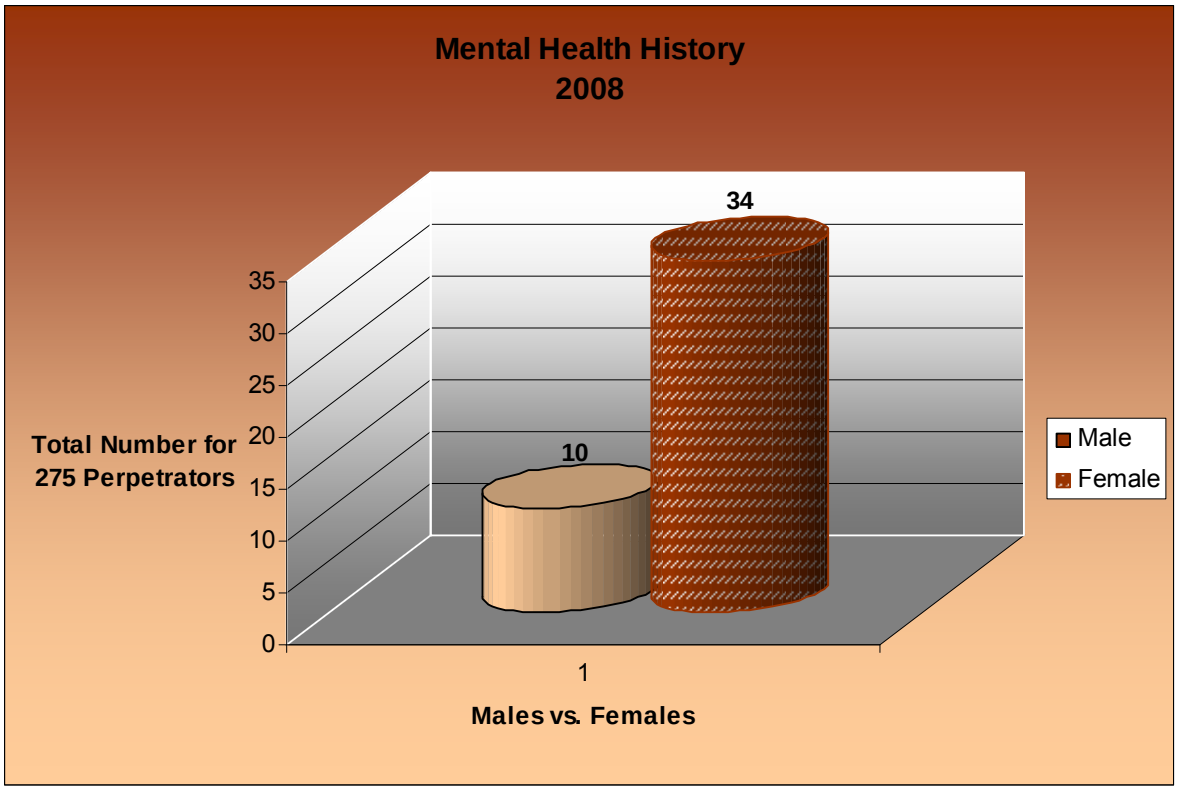
MENTAL HEALTH

Mental Health records are critical sources of information when assessing child safety and essential to the review process when a child has died from abuse or neglect. The State Committee recognizes the need for confidentiality and the reluctance of many providers to release information to child abuse death review committees. However, often there is essential information that helps to better understand the dynamics and circumstances related to the death of a child. The State Committee recognizes that not all persons with mental health conditions put their children at risk, but there are times when individuals are non-compliant with treatment and uncooperative with family members that children may be placed at higher risk. Cases where there are allegations of abuse should be staffed with competent mental health professionals to assist with the development of safety plans to protect both at-risk children, as well as non-compliant adults. It is vital that Child Protection workers are sensitized to mental health issues and have access to knowledgeable staff or consultants and ensure that mental health history is considered as a factor in child abuse investigations.
The graph below shows the total number of perpetrators (273) with mental health history identified by the State Committee.

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

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

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

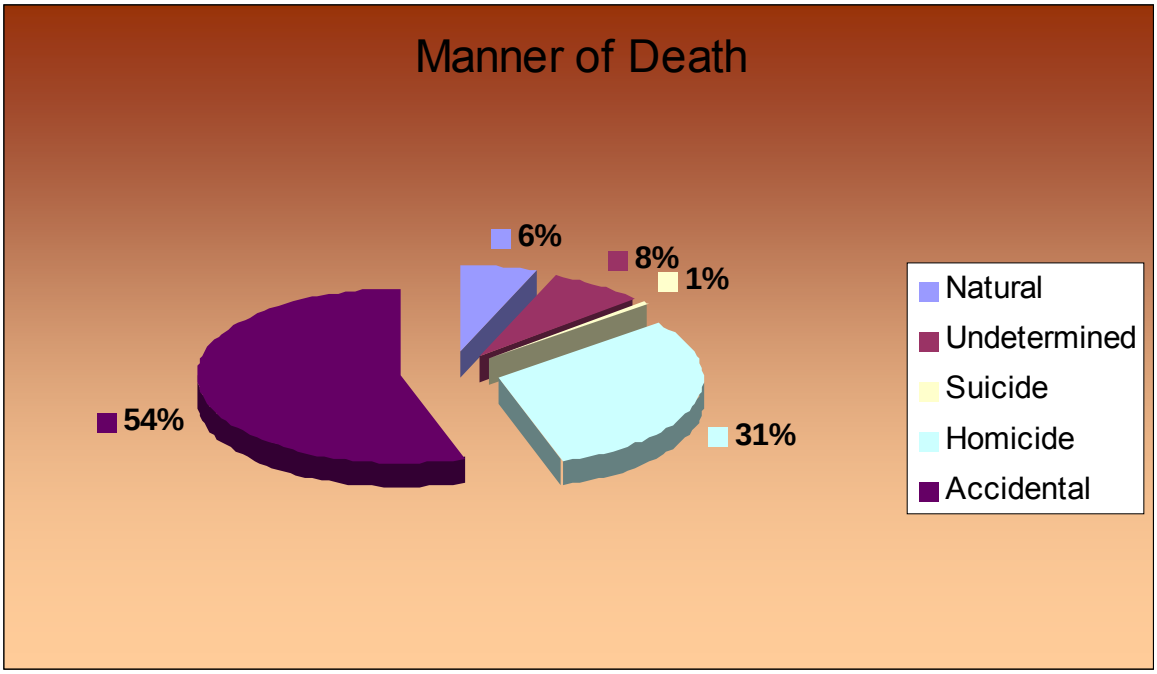

Mental Health History
2008
Total Number for
275 Perpetrators
35
30
25
20
15
10
5
0
34
10
1
Males vs. Females
Male
Female

MANNER OF DEATH

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

The State Committee reviewed 198 child abuse deaths, which were classified as follows:

- 109 (55.1%) Accidental
- 61 (30.8%) Homicides
  - 58 (95%) were 5 and under
- 15 (7.6%) Undetermined
- 12 (6.1%) Natural
- 1 (.5%) Suicide



PHYSICAL INJURY

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

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

According to a study of Missouri abuse reports published in the journal of the American Academy of Pediatric in 2005, children living in households with unrelated adults are nearly 50 times as likely to die of inflicted injuries as children living with two biological parents. Lack of a relationship or attachment to the child can cause a non-relative to become frustrated and irritated when there is a perceived problem with the child. Many unrelated males have little to no experience in parenting, yet they are often trusted to care for the child while the mother works. Some non-abusing mothers chose not to intervene in abusive situations for a myriad of reasons, some unknown, and allow the abuse to continue with no intervention. Children are supposed to learn everything they need to thrive in this world from their caretakers, however abusive caretakers provide the opposite of what children need. Instead of teaching and nurturing growth, they distort and destroy.

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

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

Reports show that incidences of child abuse/neglect increase during a poor economy. Stress levels are one of the biggest predictors of child abuse. When one parent/caregiver loses a job, the result is often financial stress. In many cases when a parent/caregiver has lost a job they are no longer able to pay for child care.

The financially stressed parent/caregiver spends more time in the home with increased access to the children which can place the children at increased risk for abuse/neglect.

Florida's domestic violence centers have seen a jump in demand of more than 40 percent since last fall, the Florida Coalition Against Domestic Violence reported.

Head injury is the leading cause of death among children who have been physically abused. Many of the children who died from head trauma also suffered multiple injuries to other areas of their bodies.

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

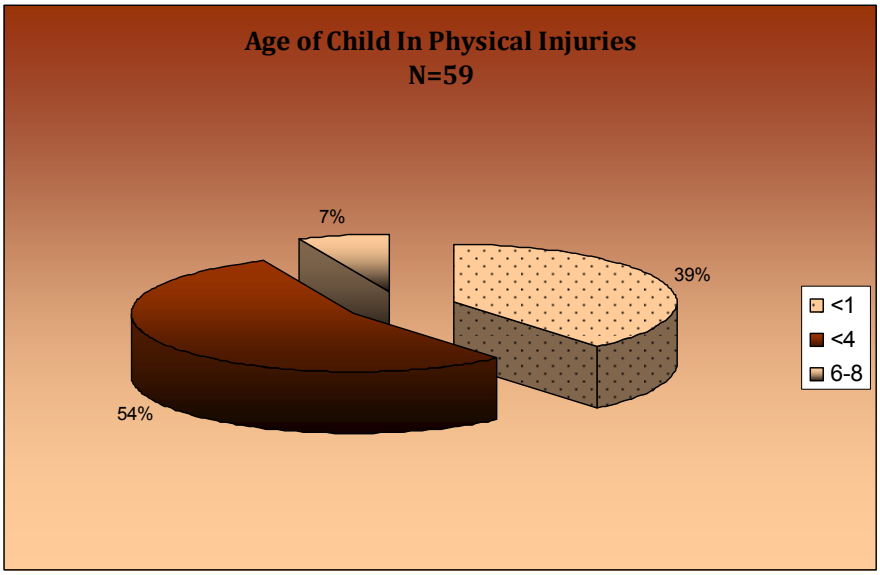
Key Findings

- **59 children died as a result of abusive injury**
  - 18 (40%) of the cases had prior DCF involvement
  - 22 of the children had evidence of prior trauma at autopsy

Age of Child

- 32(54%) of the children were 4 and younger
- 23 (39%) of the children were under the age of one
- 4(6%) of the children were ages 6-8

- The graph below shows the age of the child at the time of injury



Gender of Child

- 33(56%) were males
- 26(44%) were females

Race of Child

- 25(42%) were white
- 18 (30%) were black
- 11 (19%) were Hispanic
- 3 (5%) was multi racial
- 2 (3%) Hindu Indian

Of the 59 children that died as a result of abusive injury:

- 29 died as a result of head trauma
  - 3 died as a result of abdominal/torso trauma
  - 11 died as a result of multiple trauma
  - 2 stabbed multiple times
  - 1 child's deaths involved sexual assault prior to head injury
  - 1 child died of complications of prematurity from father kicking pregnant mother in stomach
  - 1 child death was undetermined and had numerous bruises and bite marks all about the body
  - 1 child was killed by homicidal violence- cause undetermined
- `9 died as a result of a Murder suicide
  - 6 children were killed by gunfire
  - 2 child was killed by thermal burns
  - 1 child was killed by asphyxia
- 1 child was an abandoned newborn at birth

***Craig**
Asphyxia and sexual assault

Craig, 5 months old, was sleeping in bed with his father, age 28. They were visiting family in Florida. The father yelled for someone to call 911 and stated his child was not breathing due to falling between the bed and dresser. The father was extremely intoxicated at the scene and was subsequently "Baker Acted." Craig was found to have rectal tears, abdominal injuries as well as old and new rib fractures. The father subsequently fled the state, however he was apprehended. The father was charged with first degree murder and aggravated child abuse. The case is still pending. There were no priors with DCF.

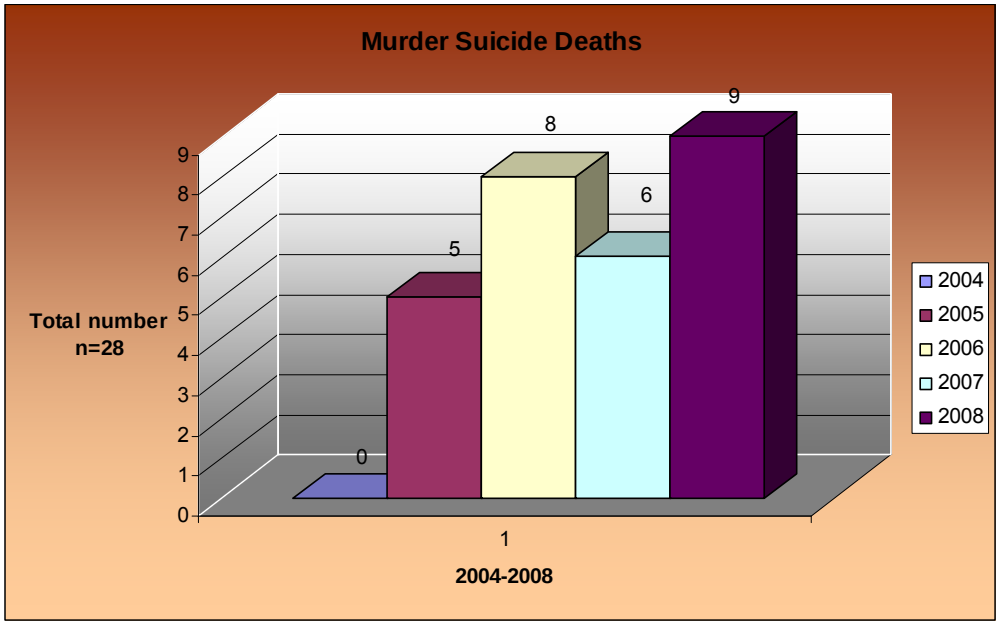
MURDER/SUICIDE

The murder/suicide deaths involve cases where the child(s) was intentionally murdered by their parent. The parent then took their own life or attempted to: hence the term murder/suicide. Although not necessarily predictors, domestic violence or

mental health issues such as depression, schizophrenia, bi-polar disorder etc, were present in many cases.

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

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



Key Findings

Of the 59 deaths physical abuse deaths

- 9 children died as a result of a murder/suicide by the parent
    - 6 children were killed by gunfire
    - 2 child was killed by thermal burns
    - 1 child was killed by asphyxia

Perpetrator related factors

- 6 children were killed by their mothers

- 3 children (2 were siblings) were killed by their fathers
  - 2 mothers were also killed by the father
  - 1 the father attempted to kill the mother but she escaped

Murder/suicide Perpetrator risk factors

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

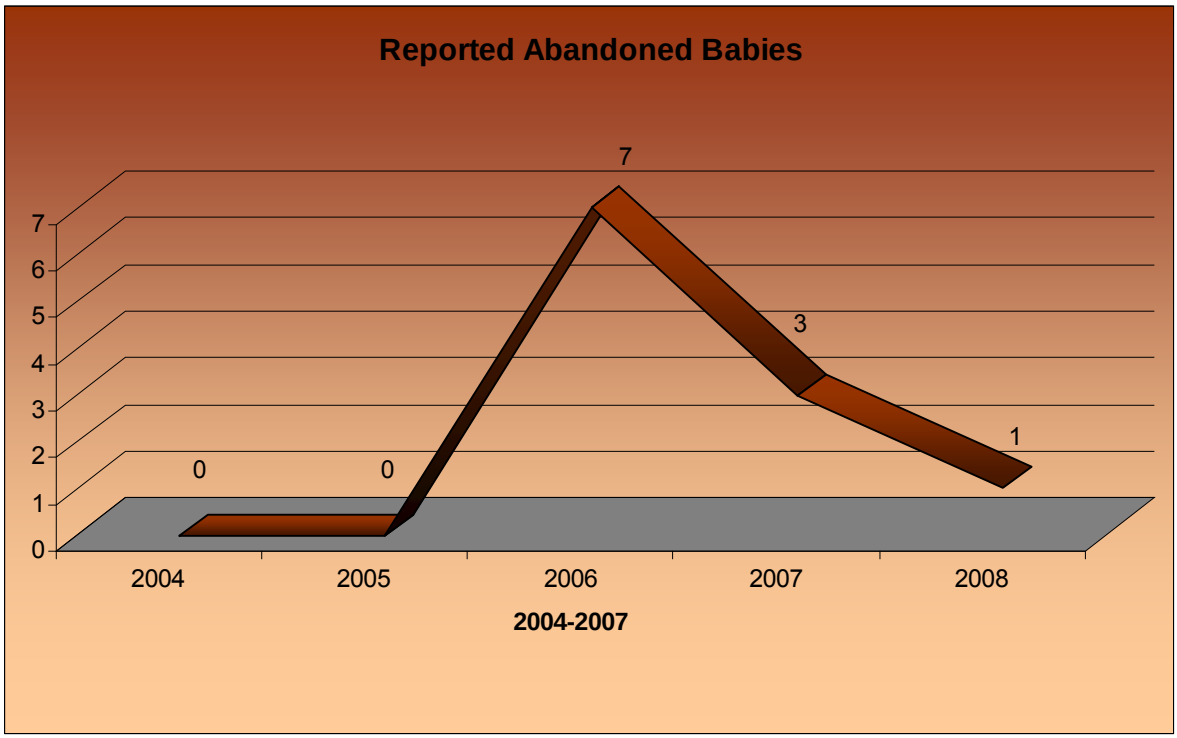
***Olivia**
Murder suicide

Mom, age 25, received a call at work from the father, age 33, to come to his home stating that their child, Olivia, age 4, was sick. Believing that the mother was having an affair, he threatened her with a knife and said he would kill her in front of Olivia. The mother convinced him to take her to the store, leaving the Olivia at home asleep. She was able to get away and call law enforcement – the father returned home. When law enforcement arrived, they had to break down the door and found the father and child with gunshot wounds to the head. The father left a suicide note stating he had planned to kill all three. Cocaine was found in his system. Two weeks prior law enforcement had arrested the father for domestic violence, which the child was present. The hotline was not contacted at that time. The mother had a stay away order but had asked for a dismissal, stating he was not violent and to allow him to come home. The father had just recently lost his job.

ABANDONED NEWBORN

Neonaticide, the killing of a child under one month, generates strong public reaction. Hundreds of newborns likely die undiscovered every year after being abandoned by their mothers in trash dumpsters, unoccupied dwellings, alleys etc. Many deaths are unreported to the child abuse hotline, but statewide training has resulted in notable improvement in reporting and verification.

According to Nick Silverio, founder of a Safe Haven for newborns in Florida, their records for 2008 show that there were a total of: 6 abandoned newborns, 2 were found deceased and four were alive. They report that the incident of abandoned babies is less and less each year as more babies are being left at a Fire station or Hospital, as allowed for in the "Safe Haven Program" authorized by Florida State Statute:383.50.



Key Findings

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

- One was thrown in the garbage at her home

Perpetrator related factors

- Age 27
- Hid and denied the pregnancy to family and friends
  - Said she did not want to burden family with another child
- Past history of drug use
- Stated she was not aware of the Safe Haven Law
- Charged with murder
  - Convicted 25 years and 10 years probation

Recommendations:

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

***Baby Steve**
Abandoned Baby

Baby Steve was found in the garbage can outside of the home. The mother, age 27, denied to her friends and family that she was pregnant. She confessed that the baby was born alive and that she put the baby in a plastic bag to keep him from crying. She was raising a 9 year old child, with the assistance of her family, and did not want to burden them with another child. She was charged with first degree murder and pled to 25 years prison and 10 years probation.

Intentional Physical Injury Perpetrator Risk Factor

Of the 49 deaths attributed to intentional physical injury:

- 13(27%) of the cases drugs were a contributing factor
- 36(73%) of the 49 cases had substance abuse history

Male Perpetrator related factors

- 39 (80%) were caused by male perpetrators
  - 17 deaths were caused by a male paramour
    - 1 also killed the mother of children
  - 15 deaths were caused by the biological father
  - 5 deaths were caused by non-related persons
  - 3 death were caused by other relatives

Age of male Perpetrators

- 20 (51%) of the male perpetrators were between the ages of 15-24

- 11 (28%) of the male perpetrators were between ages 25-28

- 33 (84%) of the male perpetrators had criminal history
- 32(82%) of the male perpetrators had substance abuse history
- 23 (60%)of the male perpetrators had a domestic violence history
- 24 (62 %) of the male perpetrators were not employed

Female Perpetrator related factors

- 9 (18%) were caused by female perpetrators
  - 3 babysitters/day care provider
  - 2 deaths were caused by mothers
  - 1 death was caused by adoptive mother
  - 1 death was caused by a female paramour
  - 1deaths were caused by a female non-relative
  - 1 death was caused by a 9 year old sibling

Age of female Perpetrator

- 5(56%) were between the ages of 21-29
- 3(34%)Were between the ages of 34-38

Non-Offending caregiver/parent

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

Secondary perpetrators (37)

Is defined as some one who "Fails to protect" which is defined as being aware that abuse was occurring but failing to take any action to prevent it. These individuals are caregivers who resided in the household or were aware of injuries and failed to protect. This year we have both female and male caregivers who failed to protect.

Gender of Secondary Perpetrators

- 33(90%) were female
- 4(10%) were males

- 27 (73%) of the mothers, who were not the perpetrator, failed to protect their children
- 4 female non relatives
- 2 Fathers
- 1 female relative

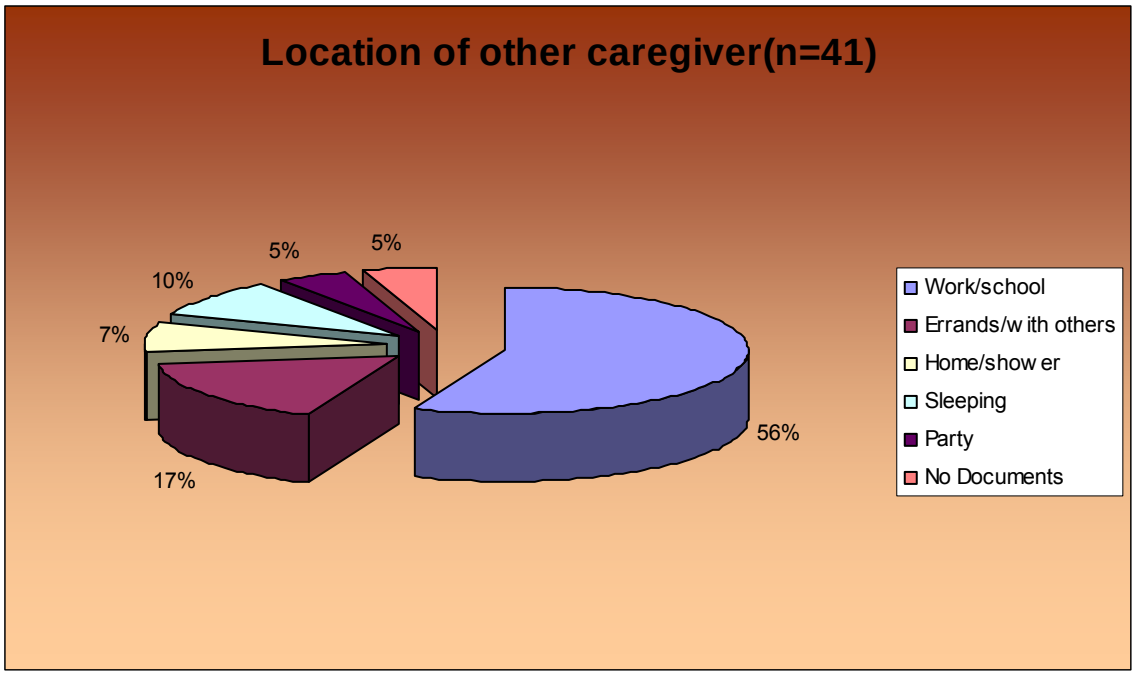
- 1 was an Adoptive father
- 1 was a Grandfather
- 1 was a Grandmother
- 6 of the mothers who failed to protect were criminally charged
  - 2 of the mothers LEO filed but SA declined

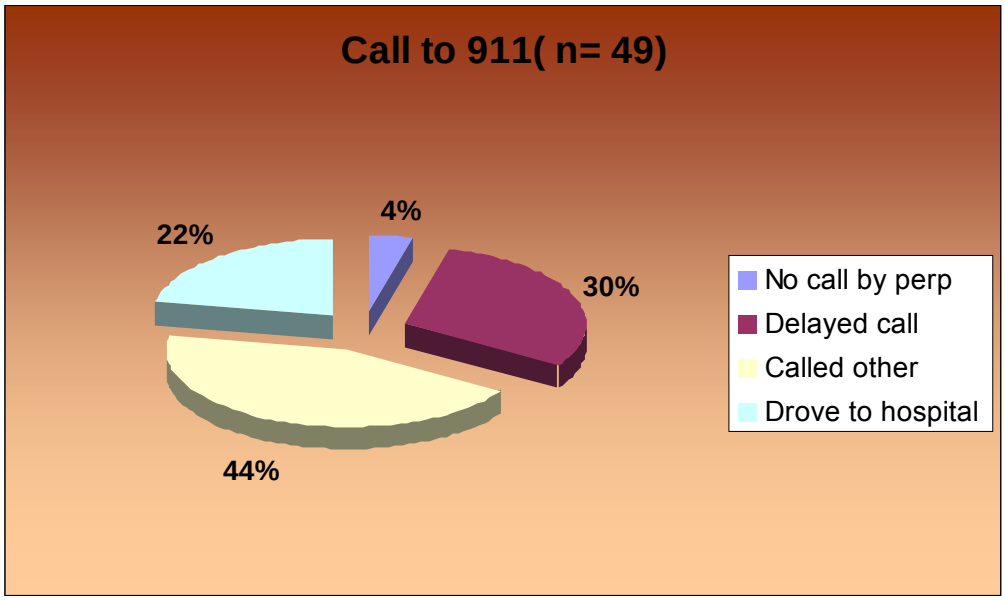
Age of Secondary Perpetrators

- 16 of the mothers who failed to protect were in 17-24
- 10 of the female caregivers who failed to protect were between the ages of 25-29
- 7 of the female caregivers who failed to protect were between the ages 30-47
- 4 of the males who failed to protect were ages 31-58

Location of non 0ffending Caregiver/parent or secondary perpetrator:

- 23 of the caregivers were at work or school leaving male perpetrator as the caretaker
- 7 were running errands or with other people at time of injury
- 4 of the caregivers were sleeping at the time of injury
- 3 were home and or in shower at the time of injury
- 2 were involved with drugs and or alcohol
- 2 had no documentation



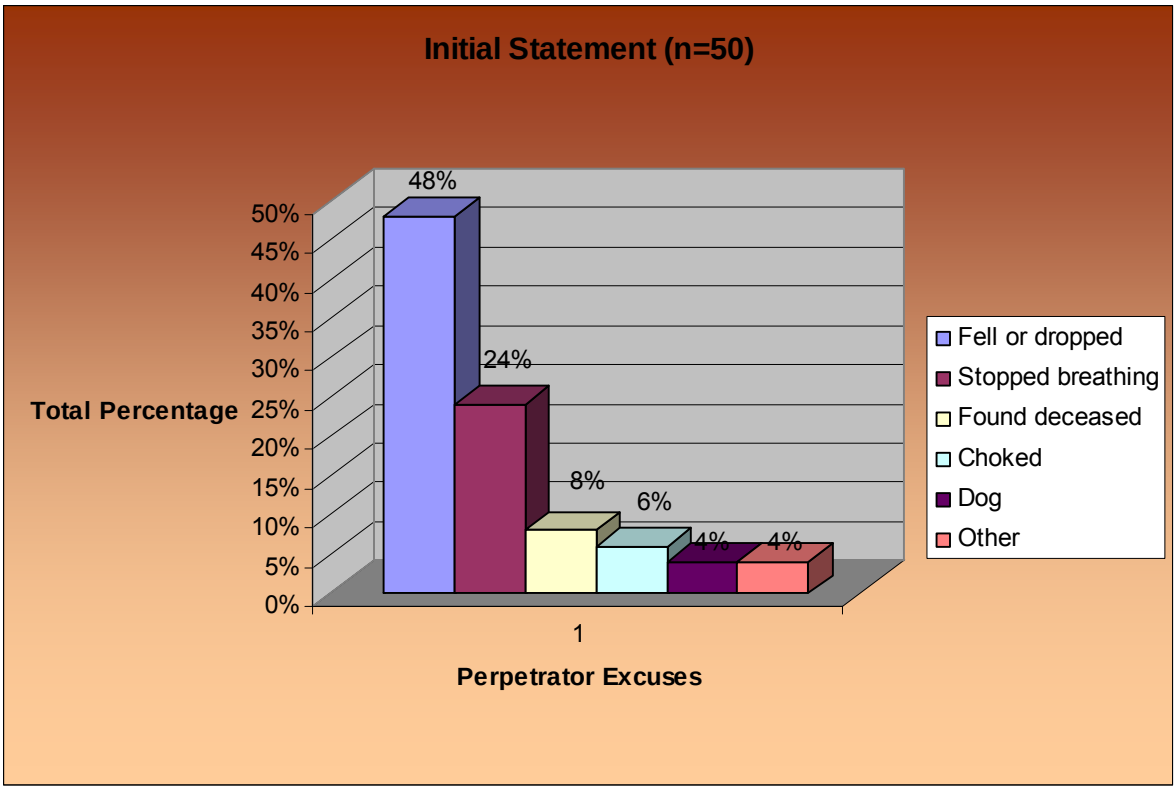


The Committee examined perpetrator responses in the physical injury deaths:

- 22 Caregivers intentionally delayed calling 911
- 16 Others made the call to 911
- 15 Delayed the to call 911
- 11 Drove the injured child to hospital
- 4 Never called 911

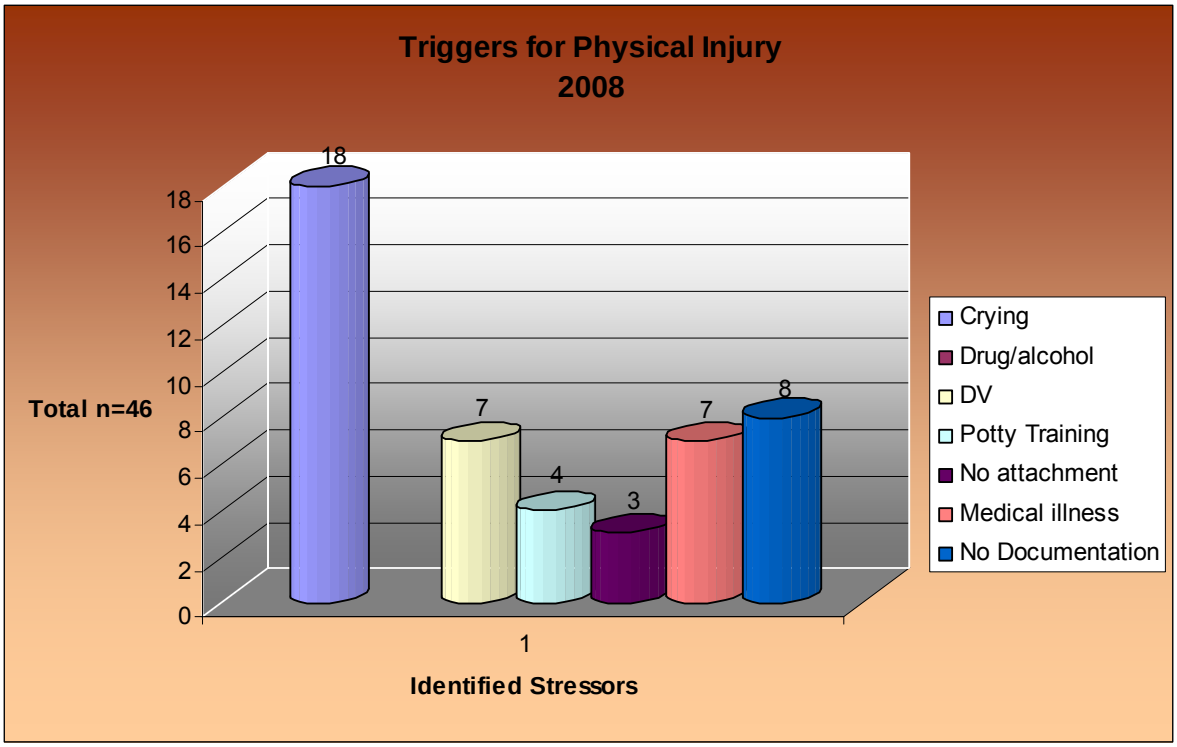
Perpetrator statements:

- 24 gave statements that the child fell or was dropped
- 12 gave an initial statement that the child "just" stopped breathing and/or was unresponsive and vomited
- 4gave initial statements that the child was found dead in bed
- 3 gave initial statements that the child choked then stopped breathing
- 2 gave initial statements that the dog caused it
- 1 gave initial statement the sitter took the child
- 1 Wedged between bed and wall

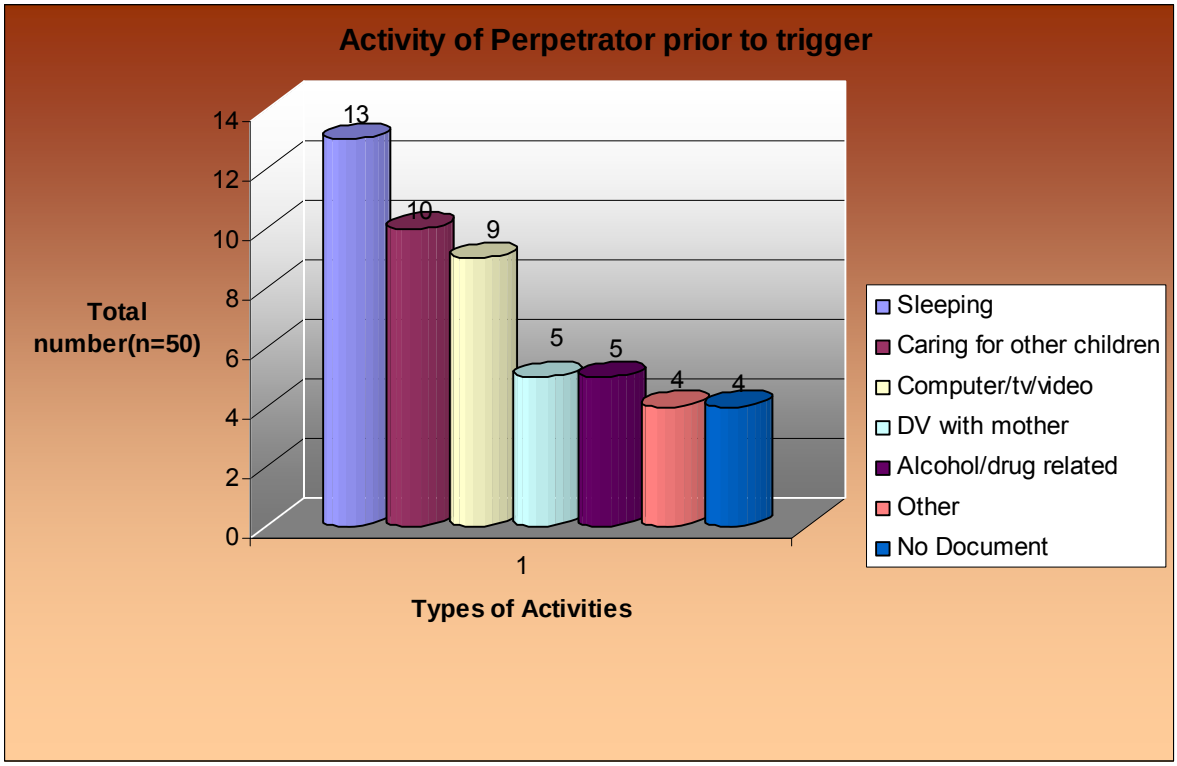


Trigger's

- 18 had issues related to the child crying
  - 4 had drugs/alcohol as a contributing factor
- 7 engaged in domestic violence with the mother prior to her leaving child
  - 4 had drugs/alcohol as a contributing factor
- 7 had medical illness
- 3 had no attachment to child
- 4 had issues with toilet training
- 2 had discipline issues
- 8 had no documentation
  - 4 had drugs/alcohol as a contributing factor



Activity of Perpetrator just prior to trigger



SLEEPING ENVIRONMENT-RELATED DEATHS

The issue of the unintentional deaths of infants resulting from unsafe sleeping practices is gaining wide-spread recognition throughout Florida and across the nation. In Florida, bed sharing and unsafe sleep environments were the leading cause of death in children under one year of age and the second leading cause of all verified child abuse and neglect deaths. Not all sleep related deaths are considered abuse. In fact, the hotline received 118 calls in 2008 related to unsafe sleeping. Of the 118 sleep-related deaths, 54 were verified due to abuse or neglect. Alcohol and/or legal or illegal drugs were factors in the majority of these cases.

Unsafe sleep environments include inappropriate sleep surfaces (i.e. couch, sofa, adult bed, and chair), excessive bedding, toys or decorative bumper guards, and sleeping with head or face covered. High risk infant sleep conditions also include bed sharing with other persons; such as parents, other adults, other children and even pets. Co-sleeping is most dangerous when an infant is sharing a sleeping surface with an adult who is overly tired, obese, and/or under the influence drugs or alcohol (according to American Academy of Pediatrics, Appendix VI).

Although bed-sharing rates are increasing in the United States for a number of reasons, including facilitation of breastfeeding, the Task Force on Sudden Infant Death Syndrome concludes that the evidence is growing that bed sharing, as practiced in the United States and other Western countries, is more hazardous than the infant sleeping on a separate sleep surface and, therefore, recommends that infants not bed share during sleep.

Some studies suggest that an infant who sleeps on his or her stomach gets less oxygen and does not eliminate carbon dioxide as well. This is due to the infant “rebreathing” its own expired air from a small pocket of bedding pulled up around the nose and/ or mouth. In addition, certain regions of the brain may be underdeveloped in infants, prohibiting sleeping babies from waking up and removing themselves from this danger if developmentally capable.

Researchers funded by the National Institutes of Health have identified three principal factors linked to the caregivers’ practice of placing infants to sleep on their backs or not. Those three factors are: whether they received a physician's recommendation to place infants only on their backs for sleep, fear that the infant might choke while sleeping on the back, and concerns for an infant’s comfort while sleeping on the back.

A higher percentage of African-American infants die suddenly and unexpectedly each year than do white or Hispanic infants. The study mentioned above also reported that African-American infants are placed to sleep on their backs less frequently than are white or Hispanic infants. These researchers found that maternal attitudes about issues such as comfort, choking, and physicians recommendations for back sleeping contributed to much of the disparity in back

placement between African-Americans and other groups. Thus, the need for training and/or education for parents, hospitals, nurses and pediatricians pertaining to safe infant sleeping are apparent.

The State Child Abuse Death Review Committee has reviewed deaths occurring in home placements where the subject of safe infant sleeping arrangements was not addressed. Sadly, children have died as a result of unsafe sleeping practices. In Manatee County a Placement Notice has been formulated that potential caregivers are required to sign. (See Recommended Practices Section).

Infant deaths are tragic, but must be investigated thoroughly and consistently in order to prevent future infant deaths. The Scripps Howard report showed inconsistencies across the United Sta tes in both the extent and adequacy of infant death investigations. The State Committee has identified this issue as an on going problem over the past seven years. It is understandable that medical professionals, law enforcement agencies and child protection agencies would tread gently when dealing with caregivers of an infant who had died unexpectedly. The Center for Disease Control and Prevention (CDC) has provided the Sudden Unexplained Infant Death Investigation training (SUIDI) training academies throughout the country for child death investigation professionals from every state. The CDC has encouraged that each state adopt the SUIDI protocol as a standardized approach to infant death scene investigation by all coroner/medical examiner's offices, as well as law enforcement agencies. The State Committee views this project as a high priority and is supportive of identifying resources to initiate a statewide approach to implement the SUIDI training.

The State Committee has observed a striking lack of uniformity among Florida's medical examiners in how infant deaths are investigated and in the terminology used in certifying the cause and manner of death in cases of sudden and unexpected infant deaths. This has hampered the State Committee in its efforts to identify causes of infant mortality in the state of Florida, and in identifying risk factors that could aid in preventing future infant deaths. With the support and participation of the State Committee and the Florida Medical Examiners Commission, William M. Sappenfield, M.D., State MCH Epidemiologist with the Florida Department of Health, has launched a study of sudden and unexpected deaths in Florida over a one year period, to elucidate these variations among medical examiner districts. Although in Florida the death rate of Sudden Infant Death Syndrome (SIDS) has been decreasing over time, the rate of other types of sudden unexpected infant deaths (SUID) have increased 205% since 1990 to 2005. Additionally, the overall rate of SUID in the state has remained relatively consistent since 1998. The stable SUID rate coupled with the decreasing SIDS rate and increasing rates of other types of SUID may be attributable to a wide variation in the way SUID cases are classified by Florida's medical examiners. A death certificate study conducted at the Florida Department of Health in 2007 demonstrated that the classification of SIDS for Florida's 24 medical examiner districts, from 1990-1997, were consistent; however, from 2002-2005, there were clear discrepancies in the

preference of reporting SUID as either SIDS, unknown/undetermined, or asphyxia/strangulation/suffocation.
When these findings were presented by the Florida Department of Health in 2007, the Florida Medical Examiner Commission advised that the death certificate coding pattern was a medical examiner training issue and recommended that the Department take the Medical Examiner reports and classify the deaths as the Department believes is best. Based on these recommendations, the Florida Department of Health proposes to investigate the rates and risk factors for SUIDS in Florida. Valid and reliable SUID information would be helpful to Florida and its communities in understanding the problem and developing SUID prevention messages and strategies.

During the initial home visit the Healthy Families Florida home visitors educate parents and caregivers on safe and unsafe sleep and continue to address the issue if they observe or become aware of any unsafe sleep practices.

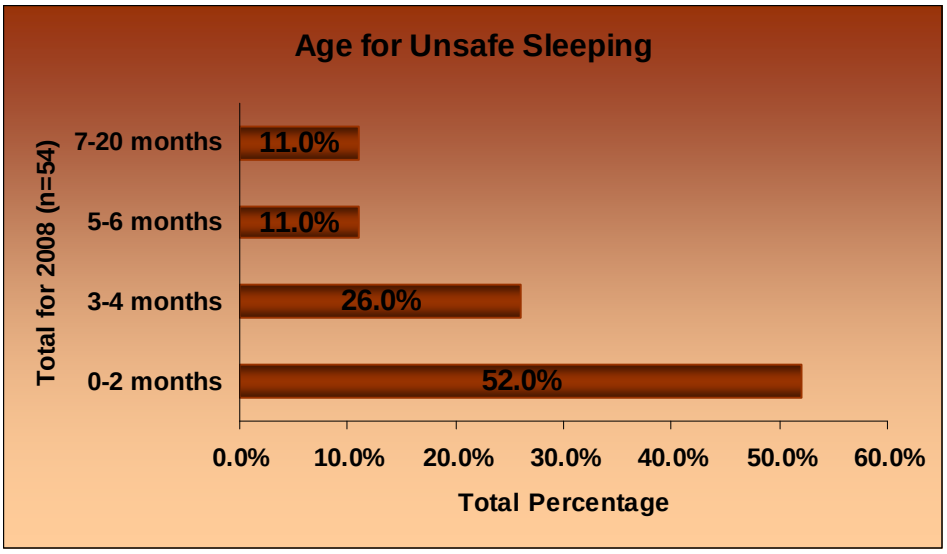
Key Findings

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

Age of Child

- Ages ranged from 8 days month to 20 months
  - 28 were ages 0-2 months
  - 14 were ages 3-4 months
  - 6 were ages 5-6 months
  - 6 were 7-20 months

- **48(89%) were 6 months and younger**



***Cameron**
Co-Sleeping

Parents, ages 23 and 28, resided in a home which consisted of 9 people, to include their 3 children, ages 2, 3, and Cameron 2 months. The mother arrived home from work at 7 am and found Cameron, who was sleeping with the father and 2 siblings in a full size bed, unresponsive. The father placed a pillow between himself and the baby. There was no crib in the home and the home was found to be hazardous. Law enforcement found cocaine in the bedroom. The father admitted he smokes marijuana and was seeking drug treatment. The father had criminal history that included drug charges. There were no drug tests requested.

Gender of Child

- 26 were males
- 28 were females

Race of Child

- 26 were white
- 20 were African American
- 6 was Hispanic
- 2 multi racial

Perpetrator Factors

- 43 were mothers
- 25 were fathers
- 5 were relatives
- 1 Foster mother
- 1 male paramour

Age of Perpetrators/Caretakers (75)

- 55 (73%) caregivers were between ages of 15-29
  - 37 were mothers
  - 18 were fathers

Gender of Perpetrators

- 47 63(%) were Females
- 28(37%) were Males

Location of infant sleeping related suffocation deaths:

Cribs are the safest sleep environment for a child, of the 54 cases reviewed, of the cases 22 had cribs, bassinets or a playpen noted in the home that were not being

used, 13 of the cases had no crib at all and in 7 of the cases there was no documentation related to a crib.

- 34 were attributed to co-sleeping/overlay
  - 20 were co-sleeping in beds
  - 6 were co-sleeping in sofas
  - 8 had no documentation as to the type of bed

- 20 were placed in un safe sleep safe environments
  - 11 children were placed in either a crib, bassinet or playpens with pillows, blankets or other unsafe items
  - 7 children were placed on adult beds with pillows surrounding
  - 1 child placed on air mattress with pillows surrounding
  - 1 child placed on the floor with pillows surrounding
    - 4 children were unattended from 11 to 16 hours

Perpetrators involved in co-sleep related suffocation deaths:

- 10 deaths were attributable to mothers
- 8 from sharing a sleep environment with parents and sibling(s)
- 5 deaths were attributed to both parents
- 4 death was attributable to fathers
- 3 deaths were attributed to relatives
  - 2 were grandmothers
  - 1 was an uncle
- 3 from sharing with a parent, sibling and other adult
- 1 from sharing with a foster mother and possibly sibling

Risk Factors attributed to infant sleep related suffocation deaths:

- Substance abuse histories were noted in 37 of the 54(69%) sleep related cases
  - 8 drug tests were requested by DCF on the day of death
  - 6 drug tests were requested by DCF days later and administered
  - 3 drug tests were requested by DCF either on day of death or days after the death but were refused
  - 21 had history of drugs but no drug tests were requested by DCF

- Obesity of the adult was noted in 2 of the co-sleeping cases
- Inadequate supervision was a factor in 4 of the suffocation deaths
- Bottle propping was noted in 2 of the cases
- Pacifier being held in their mouths by objects was noted in 2 of the cases

***Jade**
Unsafe sleep environment

Jade, 5 weeks old, was placed in her bassinet. Her parents, ages 18 and 22 years, had not checked on her for over 15 hours. The parents were known to play on the computer for hours. The child was found in her bassinet, urine soaked diaper, with a blanket, roaches, dirty diaper, adult comforter, and an adult neck pillow. The home was found to be hazardous. The mother appeared to be suffering post partum depression. Services had been provided however, the parents did not follow through. No charges were filed.

DROWNING

In 2008, the Florida Abuse Hotline received 73 reports of child drowning deaths, ages 0-17. However, only 48 cases were verified and thus were reviewed by the State Committee

In 2008, the number of drowning among Florida's children under age five decreased for the first time since 2004. Even so, in the five years between 2002 and 2006, Florida had the 3rd highest overall drowning death rate in the nation and the highest drowning rate for the 0-4 year old group with a rate of 7.3 per 100,000 population. In 2006, Florida lost more children ages 0-4 to drowning than any other state, even California. (CDC WISQARS) Florida loses enough children every year to fill four preschool classrooms. The top five counties statewide for child drowning ages 0-4 for 2008 were: 1. Broward with 8, 2. Lee with 6, 3. Miami-Dade with 5, 4. Orange with 3 and 5 Sarasota with 3.

- During 2005 there were 72 deaths, 77 in 2006, and 77 in 2007, and 65 in 2008 for children under age 5, which represents a 7% and 0% increase and 11% decrease respectively(Florida Vital Statistics.
- In 2008, there were 101 drowning deaths in Florida among children ages 0-18.(Florida Vital Statistics)
- In 2008, most childhood drowning of children under five occurred from April through September.
- In 2008, males of all ages, especially those under five, were more likely to drown than females.
- Despite local ordinances and a state statute requiring safety features for backyard swimming pools, swimming pools are the location of approximately 75 percent of the drowning deaths among Florida's children under age five. (Florida Vital Statistics)
- On October 1, 2000, Florida enacted the Residential Swimming Pool Safety Act (Pool Act), which requires all residential pools built after this date to meet specific safety requirements. However, over 90% of Florida's residential swimming pools were built prior to October 1, 2000, and are not subject to the Pool Act.

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

Supervision can fail for many reasons – washing dishes, answering the phone, using the bathroom, tweeting, using the computer, tending to other children etc. When supervision fails, only layers of protection (pool safety features such as pool fencing and other barriers) can guard against such moments. The Florida Department of Health, National Drowning Prevention Alliance, Safe Kids USA and

many other child safety organizations urge communities to prevent these tragedies by enacting and enforcing strict swimming pool barrier codes and by educating parents and pool owners to use multiple layers of protection to prevent--or at least delay--a toddler's unsupervised access to a swimming pool or spa.

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

More than 10 percent of childhoods drowning deaths occur in bathtubs. The State Committee reviewed six bathtub drowning cases this year. These deaths are preventable through continuous supervision by an adult caregiver. Bathtub drowning deaths should always be investigated to determine if the childs death was due to caretaker neglect.

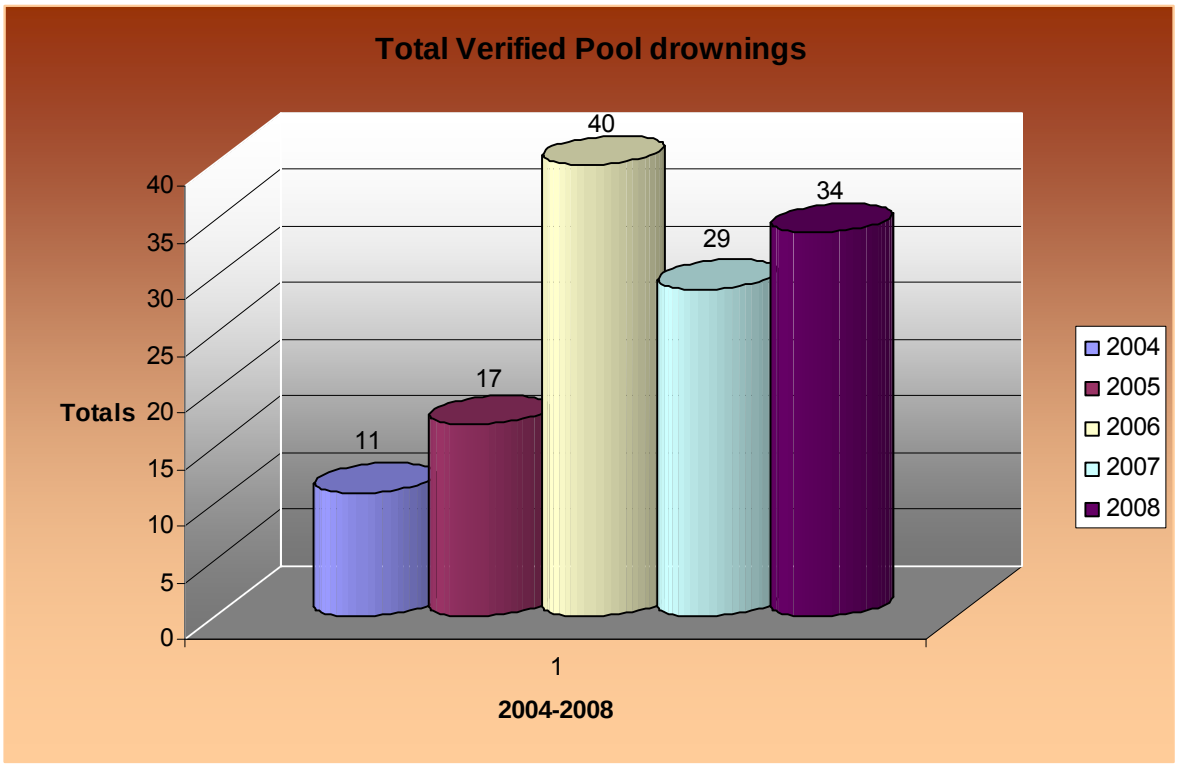
The State Committee has identified two key issues related to parental supervision in bathtub deaths. First, parents appear to think that by placing more than one child in the bathtub gives them a false sense of security, believing the other children will be able to protect younger siblings. Second, parents believe that once a child reaches an age they can sit up on their own, they can be left in the bathtub unattended. However, they may not be developmentally capable of being safe in a bathtub.

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

In cases reviewed by the State Committee often there is a lack of thorough death scene investigation by responsible agencies, including not exploring or asking for drug testing when there is a family history of substance abuse, drug paraphernalia at the scene, or suspicion of drug abuse at the time of the child's death. This results in missed opportunities to establish whether or not neglect has occurred as a result of the caregivers substance use.

The AMERICAN ACADEMY OF PEDIATRICS
POLICY STATEMENT on Prevention of Drowning in Infants, Children, and Adolescents
Recommends that Children are generally not developmentally ready for formal swimming lessons until after their fourth birthday. However, because some children develop skills more quickly than others, not all children will be ready to learn to swim at exactly the same age. For example, children with motor or cognitive disabilities may not be developmentally ready for swimming lessons until a later age. Ultimately, the decision of when to start a child in swimming lessons must be individualized. Parents should be reminded that swimming lessons will not provide “drown proofing” for children of any age.

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



Key Findings

- 48 drowning cases were reviewed

  - 43 (89%) were 5 and under
  - 5 children were noted to have autism and or downs syndrome
  - 28 Were males
  - 20 Were females

Inadequate supervision was found in all drowning deaths

- 6 (12%) children drowned in a bathtub
- The age range was from 2 months to 3 years
  - 4 of the children were males and 2 children were females
  - 4 of the children were left unsupervised with other siblings in the tub
  - 3 of the children were twins

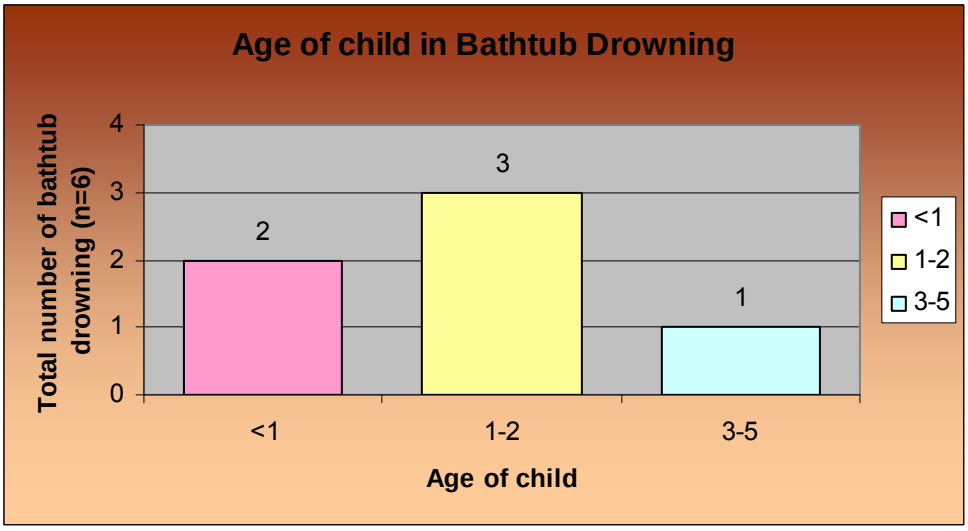
Perpetrator related Factors

- 4 Mothers were responsible
- 1 father was responsible
- 1 Grandmother was responsible
  - One Grandmother left a 16 yr old to watch the children who was using the computer

Bathtub drowning perpetrator risk factors

- 5 had substance abuse history
- 3 tests were requested
  - 2 were day after death
  - One was day of death but Grandmother refused

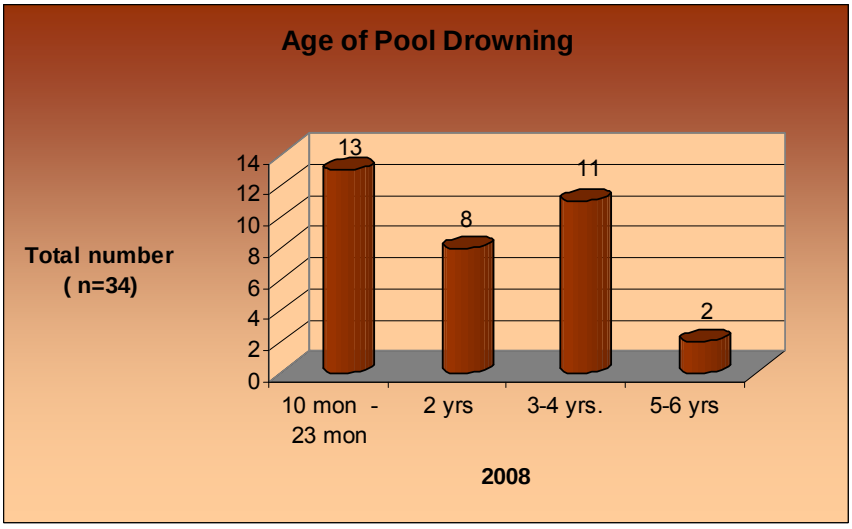
The graph below shows the age of child in bathtub drowning



- 34 (71%) children drowned in a swimming pool
- children were 19 males and 15 children were females
  - 13 (38%) children were between the ages of 10 month- 23 months
  - 8 (24%) children were 2 years old
  - 11(32%) children were between the ages of 3-4
  - 2(5%) children died between the ages of 5-6
  - **94% were 4 and younger**

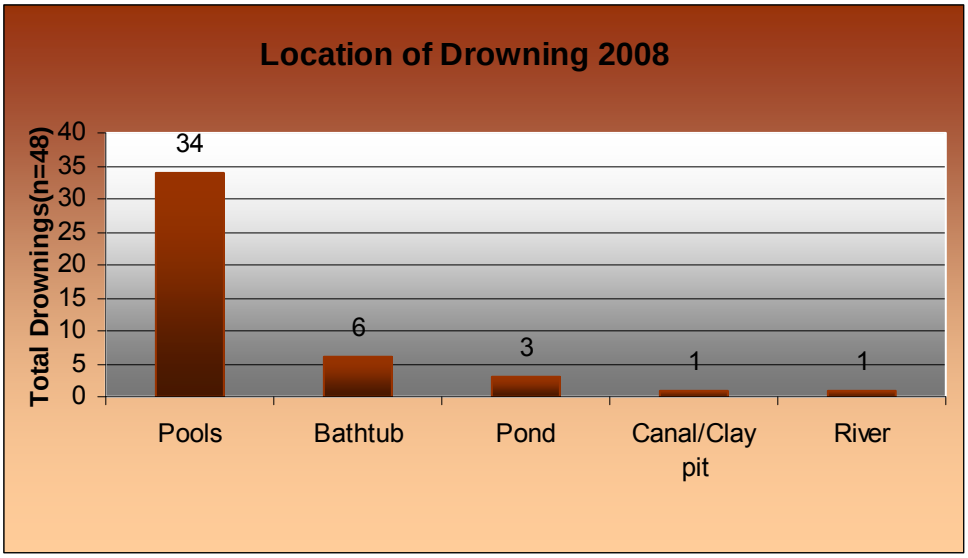
***Devin**
Bathtub drowning

The Mom, age 27, placed her children, ages 1 and 2, in the master tub upstairs. The mother left the bathroom to answer the phone. According to mom, she returned after 4 or 5 minutes and found Devin, age one, lying face down in the tub. The mother admitted to using marijuana a few days earlier, drank wine and took Ambien that day. Her drug test revealed a small amount of alcohol in her system.



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

- 3 children drowned in a pond
- 3 child drowned in a canal/clay pit
- 1 child drown in a storage bin
- 1 child drown in a river



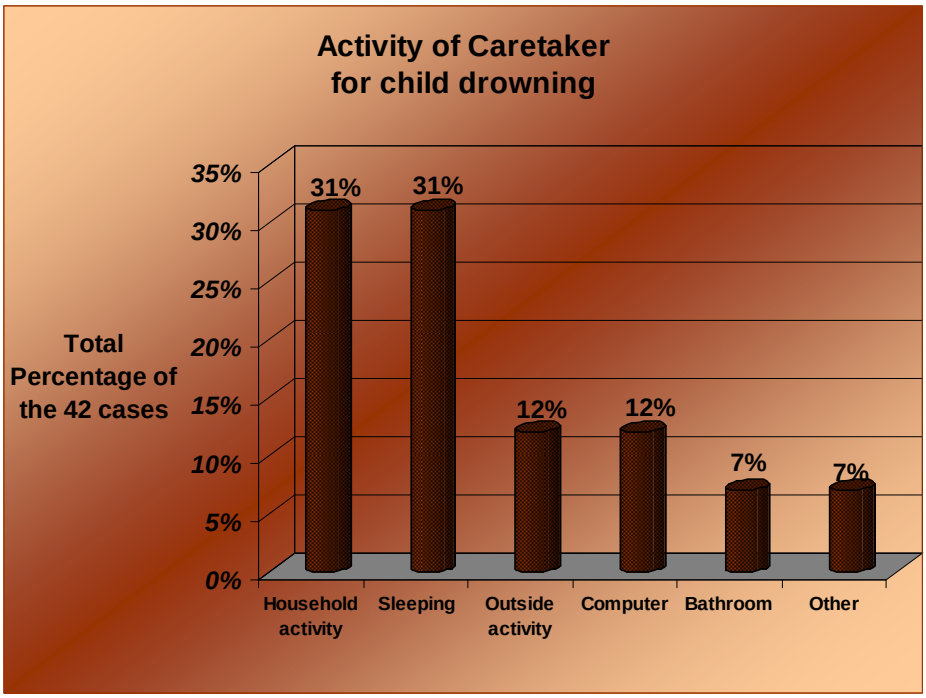
Drowning Perpetrator risk factors

- 23 of the caretakers had a history of Substance abuse
  - The caretaker was asked to submit to a drug test in 10 of the cases.
    - 7 of the requests were on the day of death

- 3 were requested 8 days, 3 months and one no documentation to date

- Results of drugs tests requested timely
  - 5 tested positive for drugs
  - One the caretaker refused

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



***Jessica and Missy**
Pool drowning

An aunt, age 22, was babysitting her niece, age 4. Also in the home was a friend of the aunt, age 24, and her daughter, age 4. The women both assumed the other was watching the girls. They stated it was over 30 minutes before they checked on the children. Law enforcement determined the children accessed the pool through an open sliding door. They also determined that the door was much too difficult for the children to open on their own. The Medical Examiner determined that the girls had been in the pool for at least 3 hours. The aunt admitted using marijuana in the weeks prior the deaths. Drug tests were requested but were refused. There were prior reports for inadequate supervision.

DRUG/POISONING RELATED DEATHS

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

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

Key Findings

- 3 children died from Multi drug toxicity
- 1 child died from Probable dextromethorphan toxicity
- 1 child died from intentionally given Combined acetaminophen and diphenhydramine toxicity
- 1 child died from Albuterol intoxication due to latrogenic treatment of bronchial asthma
- 1 child died from Acute Fentanyl Toxicity
- 1 child died from Methadone Intoxication
- 1 child died from Oxycodone toxicity
- 1 child died from global hypoxic/ischemic encvephalopathy with focal venous thrombosis and infarction

Age of Child

- 10 children from 7 months to 17 years died as a result of drug toxicity
  - 7 children were 2 and younger
  - 3 children were ages 15-17 years

- 6 were ruled accidental, 2 were undetermined, 1 a suicide and 1 was a Homicide

Perpetrators related factors

- 4 were mothers
- 3 were fathers
- 3 were both parents

Age of Perpetrator's

- Ages ranged from 19-54 years
  - 6 were ages 19-29
  - 3 were ages 30-38
  - 4 were ages 42-50

Drug/poison Perpetrator risk factors

- 8 had previous reports with DCF involving drug allegations
- 3 parents were aware of child's substance use and all failed to seek treatment
- 9 cases there was evidence of drug use by either admissions, history, or noted at the crime scene
- Of those 9 cases drug testing was requested on two
  - One there is no evidence that the test was ever taken
  - One the test was only given to the mother as the father stated he would be positive

Recommendations:

A. **That there is a standardized on-scene presumptive drug testing as part of the child protective or law enforcement investigation protocol.**

B. **There should be training provided to Child Protective Investigators that should focus on how substance misuse contributes to or results in harm to infants and children whose caregivers use illicit substances, abuse alcohol, or allow children inappropriate to prescription drugs.**

C. **In addition, training for Child Legal Services, in regards to these issues, should also be reviewed and revised, as needed.**

***Christian**

Combine drug toxicity/overdose

Christian, age 15, and a friend came home and Christian appeared to have been drinking. The father, age 47, checked on him around 3:30 am and heard him snoring - hours later he found him not breathing. The father was on disability for a terminal illness and had multiple prescriptions, which were not locked up. The drugs discovered in the Christians system were the same ones that the father was prescribed. Christian's friend stated the father gave Christian his pills to teach him to party. The father was charged with doctor shopping as well as 3rd degree murder and child neglect. Christian had prior history of abusing drugs in school. Father has and extensive criminal history, including DUI, disorderly intoxication, and battery. Christian's autopsy toxicology report showed he had methadone, hydrocodone, and oxycodone in his system. A request for a drug test was made however; the father declined and stated he would be positive due to his prescriptions. There were old priors with DCF related to the father's alcohol abuse

PREMATURE AND DRUG EXPOSED NEWBORNS

According to a 2005 Study by National Center on Addiction and Substance Abuse, 4.0% of pregnant women ages15-44 reported illicit drug use. In a 2003 study by the Center for Disease Control and Prevention, nearly three percent of pregnant women use illegal drugs including marijuana, cocaine, Ecstasy and other amphetamines, and heroin. The use of illegal drugs during pregnancy, as well as the inappropriate use of prescription medications may pose serious risks for both the pregnant woman and her unborn child. Possible risks to the fetus include premature birth as well as developmental delays and adverse health effects later in life. This is an emerging issue that merits further study. The magnitude of the problem in the state of Florida has not yet been defined. There are several obstacles inherent in attempts to collect epidemiologic data related to drug abuse during pregnancy and possible adverse effects on the developing child. Most notably, there is inconsistency among the medical examiner districts as to whether jurisdiction should be assumed in cases of intrauterine deaths and deaths in the neonatal period when maternal substance abuse are suspected. Additionally, there is no consensus among medical examiners as to the certification of the cause and manner of death in these cases. The State Committee is recommending that the Florida legislature form a special project committee to explore the impact of substance abuse in the home, as well as maternal substance abuse and its impact on the unborn child..

Key Findings

Two cases were verified for substance exposure

- All three children were less than a day old

Perpetrator Information

- Mom ages were 24, 27, and 37

Premature and Drug Exposed Newborn Perpetrator risk factors

- All three mothers tested positive for cocaine at birth
- All three had a long history of substance abuse either criminal or with DCF
- All three mothers did not seek prenatal care

Recommendations:

A. **Provide training to hospitals and emergency personnel on mandatory child abuse reporting.**

B. **Provide statutory authority to hospitals to test mothers and babies for substances when there is suspected drug use.**

***Brianna**
Substance Exposed

Mom, age 24, had been residing with her mother and her one year old. The Grandmother was not aware that the mother was pregnant. The mother did not obtain any prenatal care and continued to use cocaine weekly. The child was born at 37- 38 weeks gestation by c-section. The mother tested positive for cocaine at delivery. The mother has a history of drug use and her other 2 children had been removed from her because of her substance abuse.

VEHICLE-RELATED DEATHS

VEHICLE CRASHES

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

The National Highway Traffic Safety Administration (NHTSA)[1914] refers to drunk driving crashes as "alcohol-impaired-driving" accidents. In 2008, a total of 1,347 children age 14 and younger were killed in motor vehicle driving crashes. Out of those 216 deaths, about half (99) were occupants of a vehicle with a driver who had a blood alcohol concentration (BAC) level of .08 or higher. In 2008 drugs other than alcohol (e.g., marijuana and cocaine) are involved in about 18% of motor vehicle driver deaths. These other drugs are often used in combination with alcohol.

Infants and children who are seated in places other than the back seat account for nearly 48% of child fatalities in Florida, and those seated in the back seat without proper restraints account for an additional 26% of child fatalities. Drinking drivers are more likely than other drivers to transport children improperly. Traveling in a child seat reduces the chance of a crash death by an estimated 71% for infants and 54% for children aged 1-4. Child safety seat laws like Florida's typically reduce occupant fatalities of children age 4 and under by approximately 15% and their alcohol-involved deaths by a similar amount. The average child seat costs approximately $45 but avoids nearly $1,600 in injury costs.

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

According to FBI research, there was an increasing trend among women driving impaired in a number of states. overall there are about 2,500 fatalities a year involving an impaired female driver. The State Committee, with the few cases

reviewed, has seen this trend as well as the mothers who drive intoxicated with their children in the vehicle.

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

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

The State Committee reviewed 10 child deaths related to vehicles.

Key Findings

- 3 children died in moving vehicle crashes
  Ages 10 months, 5 year and 13 years

Perpetrator factors

- All crashes were caused by mothers
- Age of mothers ranged from 20, 23, and 31
- All three mothers where charged

Vehicle Perpetrator risk factors

- All Children were improperly restrained or no restraints used
- All three mothers were under the influence of drugs/alcohol
- Two mothers had substance abuse history
- One mother had priors with DCF

***Tyler**
Vehicle accident

Mother, age 31, was driving a vehicle with six teenagers at 2 am, one being Tyler, age 13. The vehicle had three more passengers then it could hold; therefore, some of the teenagers were sitting on other teens laps. She was the only one wearing a seatbelt. She was driving 100 mph in a 65 mph zone and lost control, ejecting 4 of the seven teens out of the vehicle. Tyler had a blood alcohol lever of .05 and marijuana in his system. She had a blood alcohol of.111. She was charged with DUI manslaughter, 3 counts of contributing to minors, 5 counts of persons under 18 not in seatbelts and one count of open container. She was sentenced to 9 years prison. She has an extensive history of alcohol and substance abuse both criminally and with DCF. She had previously been to treatment facilities with no success.

DROVE/ BACKED OVER

In the US fifty children are being backed over by vehicles every week. Forty-eight are treated in hospital emergency rooms and at least two children are fatally injured every week. These unthinkable tragedies are happening most often in the driveway of the child's home and in 70% of the incidents the driver of the vehicle is their parent, grandparent, aunt, uncle or older sibling. According to "Janette E. Fennell, Founder & President, KIDS AND CARS

She has uncovered in the last four years between 100-150 of the 2,500 children are backed over each year are killed. The Centers for Disease Control estimates that from the years 2001-2003 almost 7,500 children were treated in emergency rooms for injuries caused by backover accidents. But if the injured went to a private doctor or the hospital record did not reflect the cause of the accident, those incidents were not counted. Kids and Cars has the only national database of deaths from backovers, but they only know about accidents that get media attention or that they are told about. Public awareness and education should continue and should have safety tips like:

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

Key Findings

- 4 children died as a result of being run or backed over
  - Ages 10 month and 14 month, and 8 year old
    - Children were not supervised by their parents
  - The 17 year old was under the influence of alcohol and drugs and was hit while walking on a road
    - Drugs and alcohol were provided to the child by the mother

Perpetrator Factors

- Three were mothers, ages 25,34, and 40
- Two were fathers, ages 22 and 33
- Two had substance abuse history
- Two had priors with DCF as to substance abuse

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

ATV DEATHS

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

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

- The American Academy of Pediatrics states: “Laws should prohibit the use of ATVs, on- or off-road, by children and adolescents younger than 16 years. An automobile driver’s license, and preferably some additional certification in ATV use, should be required to operate an ATV. The safe use of ATVs requires the same or greater skill, judgment, and experience as needed to operate an automobile.”*(AAP, Policy Statement, All-Terrain Vehicle Injury*

Prevention: Two-, Three-, and Four-Wheeled Unlicensed Motor Vehicles, 2000)

- The American Academy of Pediatrics also describes child ATV use as "the perfect recipe for tragedy." (*AAP press release, July 13, 2005*)

- The American Academy of Orthopedic Surgeons explains: "***In light of statistics that show an inordinate number of injuries and deaths resulting from the use of ATVs, the American Academy of Orthopaedic Surgeons considers ATVs to be a significant public health risk. . .*** *The minimum age of 16 for operating an ATV on or off the road should be enforced.* Children under the age of 12 generally possess neither the body size and strength, nor the motor skills and coordination necessary for the safe handling of an ATV. Children under age 16 generally have not yet developed the perceptual abilities or the judgment required for the safe use of highly powered vehicles."(emphasis in original) *(AAOS, Position Statement, All-Terrain Vehicles, 1992).*

Key Facts

- 2 male children, ages 3 and 8
- Neither were wearing helmets or restrained
- One had a prior

Perpetrator Factors:

- Both drivers were friends of the parents
- Both drivers were males, ages 23 and 51
- Both drivers were under the influence of alcohol
- One tested 1.21 and the other 1.28
- Both were charged with manslaughter

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

***Christopher**
ATV

Christopher's family was on an outing. The father, age 31, had a couple of children on his ATV and a relative, age 23, had a couple of children, including Christopher, age 8, on his ATV. Both men had been drinking. The relative lost control and hit a tree, throwing the children off the ATV. None of the children were wearing helmets or were restrained properly. The relative's blood alcohol lever was 1.21. He was charged with manslaughter. The relative had a criminal history of DUI in 2006, for which he lost his drivers license.

CHILDREN LEFT IN VEHICLES

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

Twenty-Five children died in Florida from 2003 to 2008 as a result of being left in vehicles. Florida is the second highest state for child deaths related to hyperthermia, with a total of 49 child deaths from 1998-2009.
Public awareness campaigns such as the ones by Safe Kids USA (www.safekids.org) “Never leave you child alone” have helped in reducing the deaths. Having safety tips such as:

- Be sure that all occupants leave the vehicle when unloading. Don't overlook sleeping babies.
- Always lock your car and ensure children do not have access to keys or remote entry devices. If a child is missing, check the car first, including the trunk. Teach your children that vehicles are never to be used as a play area.
- Keep a stuffed animal in the car seat and when the child is put in the seat place the animal in the front with the driver.
- Or place your purse or briefcase in the back seat as a reminder that you have your child in the car.
- Make "look before you leave" a routine whenever you get out of the car.
- Have a plan that your childcare provider will call you if your child does not show up for school

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

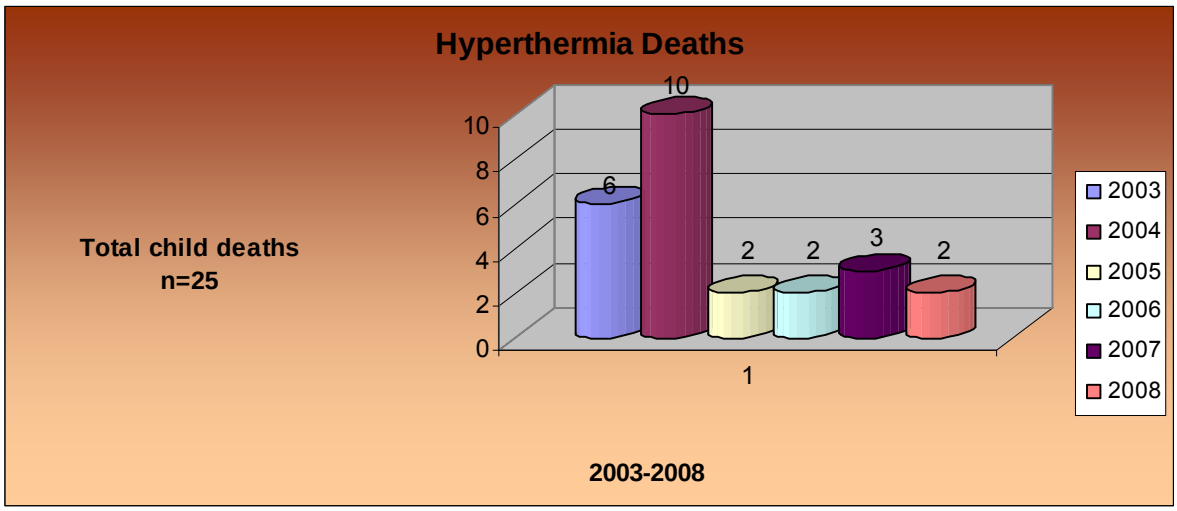
In 2008 there were two deaths however the State Committee was only able to review one of the deaths.

Key Facts

- One child was 8 months old was left in a vehicle
    - The parents both assumed the other had taken the child out of the vehicle
    - No priors
    - No drug history

- Test requested day of death- results were negative

The graph below shows the total number of children from 2003-2008, that died from hyperthermia, that the State Committee reviewed.



Recommendations:

A. There should be continuing education for law enforcement on reporting these deaths to the Florida Abuse Hotline.

B. The Department of Children and Families should establish maltreatment guidelines and craft state wide training on these types of deaths to provide consistency in investigation to provide for accurate findings.

C. The Local Child Abuse Death Review Committees should continue to invite Florida Highway Patrol to participate in local child abuse death reviews.

D. Campaigns should focus on" Families do not let Families Drive Drunk" Ads should consider having mother's driving vehicles with children in the car.

***Liz**
Hyperthermia-Vehicle

The mother, age 17 and father age 23, and their 8 month old returned home after picking Liz up from daycare. The mother thought the father brought the child in. The mother went to the kitchen to cook and the father took a shower and played video games. Two hours later the mother went to check on the child only to discover the child in the vehicle. The father made the statement that it is the mothers' job to take care of the child. No charges were filed.

MEDICAL NEGLECT RELATED DEATHS

Key Findings

- 7 children died as a result of medical neglect
- Ages from 1 month to 11 years
- Two had involvement with Children's Medical Services

- Three children had known medical complications
- Two children died from dehydration and or malnutrition
- 1 child was under care for a successful heart transplant
- 1 child died from sepsis

Perpetrator Facts

- Ten were from mothers and one with both parents
- Ages range from 22-36
    - 4 were ages 22-26
    - 4 were ages 30-36

- Six had priors with DCF, and the seventh the siblings had priors with DCF
    - 4 mothers had children removed from their custody

- 3 mothers were noted to have mental health issues
- Five caretakers had history of substance abuse
    - Two had requests for drug tests
    - One 2 days after death, results were invalid and one 17 days after death, positive for marijuana

Recommendation:

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

***Joshua**
Medical Neglect

Mom, age 26, had 15 prior reports with the DCF, many of which involved medical neglect, inadequate supervision, and hazardous conditions. She had lost custody of 2 other children, been involved with the dependency court, and had been under voluntary protective supervision in the past. Joshua was 4 months old and born premature; he was diagnosed with inguinal hernia, a hole in his heart, had sleep apnea and failure to thrive. David had been treated in the hospital 2 times for malnourishment and during his stays in the hospital, he would gain weight. His physicians could not find any medical reasons for his malnourishment and gave Mom instructions to follow up with his care. The mother never followed up on his medical appointments. She stated that she placed him on a pillow found him not breathing. At his death he only weighed 7 lbs. The mother was bi-polar and not in treatment; she had a substance abuse history. No drug tests were requested.

FIREARM RELATED DEATHS

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

Key Findings

- 2 children died as a result of gunshot wounds
  - Both were the result of accidental shootings
- Both were African American males
- Ages 2 and 3 years

Perpetrator Factors

- One was a father, age 24
- One was an uncle, age 37

Gunshot perpetrator risk factors

- Caretakers in both cases had a history of substance abuse
  - Neither had requests for drug testing
- One cases had prior history with DCF
- Both cases the guns were not stored safely in the homes
- The father was a convicted felon
- Both were charged

Recommendation:

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

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

***Gabriel**

Gun/Inadequate supervision

Gabriel, age 2, was visiting his father, age 24. The father fell asleep and assumed the child was as well. The father awoke to his child holding a loaded Smith & Wesson .38 caliber pistol, pointed at the child's face. The father attempted to get the gun away but the gun went off. The father was a convicted felon with an extensive criminal history of drugs and burglaries. Law Enforcement found baggies with marijuana and what appeared to be cocaine in the home. There was no drug test requested, although the child's autopsy toxicology report found evidence of cocaine in his system. The father was charged with aggravated manslaughter and pled guilty and was sentenced to 13 years.

FIRE RELATED DEATHS

Key Findings

- 3 children, ages, 1, 4, and 5 years died as a result of smoke inhalation
- All were females
- Two were ruled accidental
- One was ruled a homicide

Perpetrator Facts:

- Two were from mothers
- One was from both parents
- Ages 25-36 years
- Two Cases had caretakers with substance abuse history
  - One drug test requested 2 days after test, taken 4 days later and positive for marijuana
- Two cases had priors involving substance abuse

Recommendations:

A. There should be continuing education for Fire Marshals on reporting these deaths to the Florida Abuse Hotline.

B. That there is a standardized on-scene presumptive drug testing as part of the child protective or law enforcement investigation protocol

C. The Local Child Abuse Death Review Committees should continue to invite Local Fire Marshals or law enforcement agencies that investigate fire related deaths to participate in local child abuse death reviews

***Cassidy**
Fire

Father, age 31, had been awarded custody of Cassidy, age 4, a twin, and her 2 siblings, due to the mother's abuse of drugs and continuous neglect. He allowed them an unsupervised visit with their mother, age 36. Around 11:30 pm, a fire was reported and was in the bedroom where the children were sleeping. The mother ran out and yelled for someone to call 911. Her daughter, age 16, and her daughter's boyfriend got out of the home. Neighbors and firefighters were able to get 2 of the children out. The mother had a strong smell of alcohol at the scene and admitted her use of alcohol and substances. The mother has been to treatment in the past however, it was unsuccessful. The mother has criminal history, including drug related charges. There were priors with DCF related to substance abuse and there were no smoke detectors in home.

INADEQUATE SUPERVISION RELATED DEATHS

- 1 child died from aspiration from choking on a dime when left unsupervised for several hours

- 1 died from Asphyxia by plastic bag left near the child while in a car seat

Key Findings

Age of children

- One 9 months old
- One 3 months old

Perpetrator factors

- One was a father, age 31
- One was a mother, age 18

- One had a prior
- One had substance abuse history
    - No drug test requested

***Jasmine**
Inadequate supervision

Mom, age 22, came home from work and found Jasmine, 9 months, on the floor unresponsive. She woke the father, age 31, who was suppose to be watching the child along with 2 other siblings, ages 3 and 6. The child was discovered to have swallowed a dime which got logged in her throat. The father was unable to explain what he had done for 3 hours. The parents had a history of drug use. A drug test was given to the father days later, which showed traces of marijuana and alcohol. There was a prior report with DCF related to domestic violence. The father has criminal history, including cocaine charges.

CASES REVIEWED IN 2008 FROM PREVIOUS YEARS

5 children died in 2007

Age of Children

- Age range from 2 months to 21 months
- All were less than 2 years
    - One child had medical complications

- 3 died as a result of blunt head trauma
- 1 died from Asphyxiation
- 1 died from Oxycodone toxicity and bronchopneumonia contributory

- 4 were ruled a homicide
- 1 was ruled undetermined

Perpetrator Factors:

- 1 was the mother
    - Age 19
- 2 were male paramours
    - Ages 27 and 34
- 1 was a male friend
    - Age 39
- 1 was the biological father
    - Age 38
- Three had substance abuse history
- One had violent history
    - Also killed the mother
    - Motivating factor: did not want paternity established

- Four males were charged with the murders
    - One was Aquitted on murder, guilty of aggravated child abuse
    - One found guilty and received a life sentence
    - Two are pending

- Two stated child stopped breathing
- One stated child fell
- One called the mother before calling 911

Non Offending parent

- Ages ranged from 21 to 39
  - One mother had a low IQ
  - She allowed friend to watch child for days with out checking on child
- Three knew the perpetrator less than 5 months
- Two were at work and left in care of perpetrator
- Four were aware of the abuse and failed to protect

One child died in 2006

- 4 month old female
- Suffocation
  - Co-sleeping with the mother
  - Child had a pack and play but filled with clothes
- Ruled an accident

Perpetrator Facts

- Mother age 25
- History of substance abuse
  - Tested positive for marijuana
- Baby had a monitor but the mother was not using it

DCF SECTION

The State Committee has been fortunate to work in partnership and collaboration with the Department of Children and Families. The DCF Office Of Inspector General conducted an evaluation of the Child Death Review process and released a report with recommendations that the State Committee supports and endorses. See Appendix. VIII. DCF has responded to the recommendations by the State Committee from the 2008 report:

Dear Major Shingledecker:

During the past year I have had the opportunity to represent the Department of Children and Families on the state Child Abuse Death Review Committee. It is one of the most important functions in child welfare that I share with this very important committee.

It has been recommended that the Department expand the comprehensive child death review process to include cases where there was not a verified finding of abuse or neglect. The Department supports and is open to reviewing additional cases by those members of the committee that want to focus on a particular maltreatment which caused a child's death beyond those that are verified findings of abuse or neglect. This will give the committee an opportunity to study not-verified child deaths related to drowning, co-sleeping, or other area and make recommendations for statewide prevention efforts that impact child safety.

It is understood that the more we know about all child deaths the better we can make recommendations and decision that will have a positive impact on child safety.

As you know, the Department is in the process of reorganizing the Family Safety Program Office and plan to substantially change the current duties of the statewide child death review coordinator. I am also committed to the following actions that need to be undertaken to address the recommendations in the 2008 CADR Report.

- Development and adoption of standardized guidelines and multidisciplinary approaches for the investigation of the unexpected deaths of infants and children.

- Development of clearer guidelines for field drug testing of caregivers as part of their protocols for the investigation of the unexpected deaths of infants and children.

- Expansion of risk assessments conducted by child protective investigators to include drowning risk factors when there is a pool on the premises or bodies of water close to the home.

- Ensuring a multidisciplinary staffing held when there is a change in the child's placement that differs from the recommendation made by the Child Protection Team and/or DCF.

- Addressing reporting and consistency in child death findings through on-going comprehensive data analysis that includes comparative data by circuit, potential under-reporting of maltreatment types, verification rates, and reporter types.

- Supporting training and risk assessment initiatives for law enforcement investigators, DCF Child Protective Investigators, and case managers on physical child abuse investigations to include:

    - Adding the Florida Department of Law Enforcement (FDLE) standardized questions and answers for use by child protective investigators and to our current training materials.

    - Adding requirements to educate child protective investigators and case managers on common risk factors and triggers pertaining to adult male caregivers between the ages of 18-30 and the dynamics of domestic violence, animal abuse, and criminal history as they relate to child abuse and neglect cases.

    - Developing training protocols to ensure child protective investigators and case managers are provided critical thinking skills to enhance decision-making.

    - Establishment of an interdisciplinary workgroup to review the current pre-service child protection curriculum to make recommendations for specific training on the identification and assessment of substance abuse problems in families. The purpose will be to ensure that training has a focus on how substance misuse contributes to or results in harm to infants and children whose caregivers use illicit substances, abuse alcohol, or allow children inappropriate to prescription drugs. The workgroup will include representatives from Child Legal Services.

    - Soliciting technical assistance through the National Resource Center on Substance Abuse and Child Welfare to review assessment processes related to family and child factors as well as the development of processes for early and ongoing identification of needs and supports for children and families struggling with substance abuse problems.

Other collaboration and supporting changes:

Issued a Memo about the release of records to the Committee, see Appendix VIIII

Made changes to the hotline matrix related to taking reports of child deaths

Included several members of the Committee to serve on a work group that is updating the maltreatment guide used by child protective investigators

Established a statewide legal staffing form- see Recommended Practices.

Established a statewide training model for Child Legal Services- see Recommended Practices.

TRAINING

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

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

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

RECOMMENDED PRACTICES

1. **Manatee Sheriff's Office Child Protection Placement Notice**
2. **Manatee County Sheriff's Office Drug Screen Testing Policy**
3. **Healthy Families Florida home safety check list and Prevention Education Topics including a topic on Safe Sleep**
4. **Protocol for Immediate Staffings-4th Judicial Circuit**
5. **Brevard County Protocol For Drug Endangered Children(DEC)**
6. **DCF Marion County Child Death Investigation Protocol**
7. **DCF Legal Staffing form**
8. **DCF Legal Training model**
9. **Orange County: "Who is Watching Your Children" brochure**
10. **State Committee Facts to consider investigating child deaths**
11. **Prevent Child Abuse Brochure: How well do you know your lover?**

MANATEE COUNTY SHERIFF'S OFFICE

Child Protection Placement Notice

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

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

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

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

_____ _____
Signature/Firma Date/Fecha

_____ _____
Witnessed By/testigo ID#

Case#_____

MANATEE COUNTY SHERIFF'S OFFICE
CHILD PROTECTIVE INVESTIGATION DIVISION
Drug Screen Testing Policy

I. PURPOSE

The purpose of this Operating Procedure is to establish criteria and procedures for administering drug screening tests on individuals who are the subjects of an open child protection investigation.

II. DISCUSSION

The welfare of a child is often endangered due to a caretaker's excessive use of alcohol or the use of other drugs. Child protection investigators must have a means of obtaining an effective assessment of an investigative subject's abuse of drugs if they are to make accurate evaluations and recommendations to the courts regarding the welfare of children in the care of those individuals. Therefore, the Manatee County Sheriff's Office Child Protection Investigation Division has established a method for obtaining such information involving on-site testing of urine samples obtained from the investigative subjects.

III. PROCEDURES

A. Basis for Administering a Presumptive Drug Test.

1. A presumptive drug test shall be administered by a CPS to those subjects of a child protection investigation who are in a caregiver or supervisory position of a child, and whom the CPS has reasonable grounds to believe that the individual has been or is using drugs illegally, and that such use could adversely affect the care of the child. Information sources, provided they establish reasonable grounds, may include, but are not limited to:

> a. Allegations of illegal drug use in the original report, or from other individuals interviewed during the investigation.
> b. Observations within the investigative subject's residence that lead the CPS to believe that illegal drug use or the excessive use of alcohol is taking place; i.e., odor of burned marijuana, burned marijuana cigarette butts or other drugs observed in the home, large number of empty beer cans, etc.

2. A presumptive drug test shall be given in every case involving the death of a child, as well as any case involving known or suspected great bodily harm to a child when the death or harm could have been the result of the caregiver being impaired. A presumptive drug test shall be given to any caregiver or person who may have been in a supervisory position to the child at the time of the death or great bodily harm.

B. Administering a Presumptive Drug Test

Once a CPS is able to establish the reasonable grounds to justify requiring a presumptive drug test from the subject of an investigation, the following procedures are to be followed.

1. The CPS will obtain the drug test from the CPID Analysts. The analyst in charge of the inventory log will log the case number and the test ID number on the log. The analyst will then give the CPS however many tests are needed for the case.

2. Complete the Presumptive Drug Test Form. Advise the subject that a presumptive drug test is being offered to him/her. Read the introductory paragraph completely to the subject, making sure that the person understands the nature and use of the document that is being executed.

3. Have the subject check the appropriate box indicating whether or not he/she will submit a urine sample at that time. If the subject wishes to write additional comments explaining why he/she will not submit a urine sample, he/she may do so in the appropriate location on the form.

4. When a subject states that he or she is currently taking prescription drugs that have been medically prescribed for that person, have the individual indicate such in the "Comments" section of the form. The reverse side may be used if additional writing space is needed.

5. The subject must also check the appropriate box indicating whether or not he/she knows or has reason to believe that blood may be present in his/her urine. The individual must then sign the Presumptive Drug Test Form in the appropriate location. If the subject refuses to sign the form, write, "REFUSED TO SIGN," on the subject's signature line.

6. If the subject admits to recent drug use, record such on the form and in the case file. You may still want to test the subject, as they may not admit to all the substances in their system.

7. If the subject claims to be drug-free and agrees to submit a urine sample for the presumptive drug test, proceed with the following steps.

a. Ensure the expiration date (EXP) on the foil pouch containing the urine test cup has not passed.

b. Open the sealed foil pouch and inspect the test cup to make sure the label is still intact.

c. Inspect the restroom to ensure the subject will be alone. The subject must wash his/her hands thoroughly while being observed by the CPS.

d. Show the subject the minimum level of urine required as indicated on the side of the test cup. Tell the subject to recap the test cup before exiting the restroom.

e. Wait outside the restroom and put on protective latex gloves.

f. When the subject exits the restroom, take the cup from him/her and immediately record the urine temperature on the Presumptive Drug Test Form. Any temperatures below 90.5º Fahrenheit must be considered adulterated.

g. The label, which reveals the drug test strips, should be peeled after waiting a full five minutes before completing a final reading. Any double lines, including a faint

line is supposed to be assumed as a negative reading. Interpret the results and record them on the Presumptive Drug Test Form.

h. Once the test has been read and the Presumptive Drug Test Form has been completed, the subject should dispose of the urine in the toilet in the restroom and flush the toilet, provided that the CPS is confident that having the subject do so will be non-confrontational and safe. Other-wise, the CPS should dispose of the urine.

(1) It should be noted that according to the United States Center for Disease Control (CDC), urine is not classified as a body fluid that could reasonably transmit blood borne pathogens unless there is blood visibly present or the subject has a medical condition that would lead to blood in the urine.

(2) However, CPID members should take reasonable precautions when disposing of the urine sample so as to avoid contact with it. Care should be exercised to avoid any "splash-back" of the urine when pouring it out.

(3) The test cup should be resealed and returned to the foil pouch. The protective latex gloves may then be removed. They must not be reused. The CPI shall dispose of the gloves and the foil pouch containing the test container in an appropriate trash container at a location other than the subject's residence, taking care to ensure that the subject will not be able to retrieve it.

C. Results of a Presumptive Drug Test

1. Once a presumptive drug test has been completed and the results recorded, the CPS may inform the subject of the test results, provided he/she believes that doing so will not result in an antagonistic confrontation with the subject. An alternative to personal notification of the test results is telephonic notification by the CPI or supervisor.

2. If the test result indicates a positive or adulterated test, the CPS shall attempt to get an explanation from the subject for such results. The subject's explanation, as well as any admissions or denials, shall be included in the case file.

3. If the test result indicates a positive or adulterated test, and there are extenuating circumstances that would indicate that the potential for violence or other irrational behavior directed toward the CPS exists if the test results are disclosed immediately, the CPSI may choose to wait until another time to disclose the results.

4. The CPS shall explain to the subject that a presumptive drug test is not absolutely conclusive, but that a positive or adulterated result may result in an order from the court for a more controlled and scientific test.

5. If a presumptive drug test gives a positive result for the presence of drugs, and the subject claims that the reading was caused by a prescription drug that has been medically prescribed for the subject, instruct the person to write that information in the "Comments" section of the form.

6. If the presumptive drug test is either positive or indicates an adulterated result, or the subject refused to submit a urine sample for testing, document such in the case file and

place the original Presumptive Drug Test Form in the case file. The Office of the Attorney General attorney should be notified as soon as practical and a copy of the form should be routed to that attorney.

7. Upon returning to the CPID office, the results of the drug test will be given to the analyst who is in charge of the inventory log. The following information will need to be recorded on the log: test results, what type of drug, allegations, relationship to the child.

D. Disputing the Results

1. If the test kit reveals a positive result, and the Subject disputes the result. Advise the Subject that they may submit another sample at a lab of their own choosing, at their own expense.

2. The Sheriff's Office will only incur the cost of a lab-verified drug test when approved by Director/Lieutenant or above on a case by case basis.

E. Miscellaneous Provisions

1. The only persons authorized to administer a presumptive drug test are those members of the Manatee County Sheriff's Office Child Protection Investigation Division who have been trained on the use and interpretation of the presumptive drug test kit that is currently in use by the Division.

2. CPID members are not to store presumptive drug test kits in their assigned vehicles, as the high temperatures reached in a closed vehicle will affect the reliability and shelf life of the test kit. The CPS shall sign a drug test kit out from the appropriate staff member prior to going to meet with the investigative subject.

E. Submission to a Certified Laboratory

In the rare instance where a urine sample must be submitted to a certified laboratory, the CPS must use the appropriate laboratory form and the packaging provided by the lab. The entire test kit, to include the urine must be sent to the appropriate lab.

1. A seal for the test cup's lid is attached to the form as a peel-away label. It must be removed and placed over the lid. Ensure the bar code number on the seal matches the "Specimen ID Number" on the laboratory form.

2. Complete the laboratory form. Both the subject who submitted the urine sample and the CPI must sign the form.

3. Attach a copy of the Presumptive Drug/Alcohol Test form, if appropriate.

4. Mail the sample via the provided mailer as soon as possible.

Manatee County Sheriff's Office Child Protective Investigations Field Drug Testing Log

Case Number	Date of Test	Subject Tested Name-Last/First	Subject D.O.B.	Relation to A/V	Test Kit Number	Allegations	Results Pos / Neg Findings (See Key)	
08-	/ /		/ /				+ —	
08-	/ /		/ /				+ —	
08-	/ /		/ /				+ —	
08-	/ /		/ /				+ —	
08-	/ /		/ /				+ —	
08-	/ /		/ /				+ —	

Positive Results Totals

AMP	BAR	BZD	COC	THC	MTD	mAMP	OPI	PCP	MDMA

Key: AMP (amphetamine) BAR (barbiturate) BZD (benzodiazepine) COC (cocaine) THC (marijuana) MTD (methadone) mAMP (methamphetamine) OPI (opiate) PCP (Phencyclidine) MDMA (methylenedioxymethamphetamine

Safe Infant Sleeping

(Tool used by home vistors)

Questions:

What can you tell me about the safest way for a baby to sleep? Where does your baby sleep at night? Where does your baby sleep for naps?

Facts:

- Babies are safest when sleeping on their backs on a firm mattress in a crib that meets current safety standards.
- Each year in the United States, more than 4,500 infants die suddenly of no obvious cause. These deaths are called Sudden Unexpected Infant Deaths or SUIDs.
- Suffocation and strangulation in bed is the leading cause of injury-related death for infants under age 1.
- Infant deaths due to suffocation, strangulation and Sudden Infant Death Syndrome (SIDS) are highest among infants 1 to 3 months of age.
- The risk for suffocation among infants who sleep in adult beds is **40 times higher** than the risk for suffocation in cribs.
- Babies laid down to sleep without a pacifier in their mouth are more than twice as likely to die of SIDS.
- Soft bedding or lying on or next to an adult or child can lead to suffocation. This could also cause overheating which increases the risk of SIDS.
- The risk of SIDS is 3 times higher for mothers who smoke while pregnant and 2-3 times higher for babies living in smokers' households. After pregnancy, the risk rises depending on the number of smokers in the household and the number of cigarettes smoked by each person.
- The SIDS rate has been declining significantly since the early 1990s. However, Centers for Disease Control (CDC) research has found that the decline in SIDS since 1999 can be explained by increases in other SUID rates (e.g., deaths attributed to someone rolling over on top of the infant, suffocation and wedging).
- Babies that are placed on their stomachs to sleep when they are used to sleeping on their backs are 18 times more likely to die of SIDS.
- Bottle propping (such as using a pillow or something else to “prop” a bottle for feeding) or allowing a baby to bottle-feed alone can causing choking or suffocation.

Tips:

- Babies should never sleep with an adult or another child.
- Babies should sleep alone, on their back, on a firm, flat surface.
- The safest place a baby can sleep is in a crib, bassinet, Pack ‘n’ Play or cradle located in the same room as the caregiver.
- Cover the mattress with a tightly fitted sheet that tucks well under the mattress pad.
- Babies should never sleep in an adult bed, on a couch, pillow, chair, bean bag, air mattress, waterbed or any other piece of furniture not made for babies.

- Do not put anything in the baby's bed. Pillows, quilts, comforters, sheepskin, stuffed animals, bumper pads and other soft products are not safe for sleeping babies. Use a sleeper or sleep sack, instead of a blanket.
- Always take off a bib before the baby goes to sleep.
- Babies should sleep on their backs during naps and at night until age 1, unless the baby's doctor says another position is better.
- Babies learn to sleep in the position they are placed from birth. It is important for the baby to start sleeping on their back. This may be hard at first, but parents should not give up. Babies will learn to sleep on their backs!
- Parents should talk about safe sleeping with everyone that takes care of their baby.
- Babies should always sleep in an area with no smoke.
- Offer a pacifier until the baby is one-year-old using the following steps:
  - The pacifier should be used when placing the baby down to sleep and should not be put back in the baby's mouth after the baby falls asleep.
  - If the baby does not want the pacifier, do not force it.
  - If breastfeeding, do not use a pacifier until the baby is one-month-old.
- Hold the baby when feeding, since propping a bottle up can cause the baby to choke and possibly die.

References:

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Kendall, Callaghan, Lock, Mahoney, Payne, and Verrier. (2005) "Association Between Pacifier Use and Breast-feeding, Sudden Infant Death Syndrome, Infection and Dental Malocclusion." *International Journal of Evidence-Based Healthcare* 3(6)
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http://pediatrics.aappublications.org/content/vol112/issue4/index.shtml

Safe Infant Sleeping

(discussed and left with parents and caregivers)

Tips:

- Babies should never sleep with an adult or another child.
- Babies should sleep alone, on their back, on a firm, flat surface.
- The safest place a baby can sleep is in a crib, bassinet, Pack 'n' Play or cradle located in the same room as the caregiver.
- Cover the mattress with a tightly fitted sheet that tucks well under the mattress pad.
- Babies should never sleep in an adult bed, on a couch, pillow, chair, bean bag, air mattress, waterbed or any other piece of furniture not made for babies.
- Do not put anything in the baby's bed. Pillows, quilts, comforters, sheepskin, stuffed animals, bumper pads and other soft products are not safe for sleeping babies. Use a sleeper or sleep sack, instead of a blanket.
- Always take off a bib before the baby goes to sleep.
- Babies should sleep on their backs during naps and at night until age 1, unless the baby's doctor says another position is better.
- Babies learn to sleep in the position they are placed from birth. It is important for the baby to start sleeping on their back. This may be hard at first, but parents should not give up. Babies will learn to sleep on their backs!
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- Babies should always sleep in an area with no smoke.
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  - The pacifier should be used when placing the baby down to sleep and should not be put back in the baby's mouth after the baby falls asleep.
  - If the baby does not want the pacifier, do not force it.
  - If breastfeeding, do not use a pacifier until the baby is one-month-old.
- Hold the baby when feeding, since propping a bottle up can cause the baby to choke and possibly die.

References:

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http://pediatrics.aappublications.org/content/vol112/issue4/index.shtml

Additional Resources:

The Back to Sleep Information Line: **1-800-505-CRIB**
Florida SIDS Alliance: **1-800-SIDSFLA**
Florida Tobacco Quit-For-Life Line: **1-877-U-CAN NOW**

Home Safety Checklist (home visitor and parents/caregivers walk through house together to conduct this home safety check)

Parent's Name: _____ Date: _____

Please check the appropriate interval:

_____ Initial: Within first three months of services
_____ 4-6 months-old: Getting ready for crawling
_____ 9 to 12-months-old: Increased mobility
_____ 24-months-old
_____ Annually, after 24-months-old
_____ New Home

Circle the appropriate answers, based on your observations.

Home Safety – ***Ask the parent(s) if they would like to walk around their home with you to assess the safety of the home (bathroom, kitchen, bedroom, etc.) by answering the questions below.***				
1.	Yes	No		Are electrical cords intact and away from the reach of children?
2.	Yes	No		Are electrical appliances away from a filled tub, sink or running water?
3.	Yes	No		Are painted surfaces (including walls and furniture) free from chalking, flaking and peeling, which could indicate the presence of lead-based paint?
4.	Yes	No		Are all exterior doors, including pet doors if applicable, childproofed (latches, high locks or alarms, etc.)?
5.	Yes	No		Are all stairways and floor space for walking clear from obstruction and in a non-slippery condition?
6.	Yes	No	N/A	Is there railing protecting all stairways and elevated landings (top and bottom of stairs)?
7.	Yes	No	N/A	If there are railing slats greater than 2 and 3/8 inches apart, are they covered with a piece of wood or hard plastic?
8.	Yes	No		Is there a safe place for the child to sleep?
9.	Yes	No	N/A	If there is a crib, are the gaps between the slats on the crib 2 and 3/8 inches or less?
10.	Yes	No	N/A	If there is a child under 1 year of age, is the sleeping area free of soft bedding (including bumper pads), pillows, blankets and stuffed animals?
11.	Yes	No	N/A	If there is a crib, does the crib sheet and mattress fit tightly to avoid entrapment and suffocation?
12.	Yes	No	N/A	Are all houseplants out of the reach of children?
13.	Yes	No	N/A	Are all ashtrays out of the reach of children?
14.	Yes	No	N/A	Are emergency numbers readily accessible? (See list of phone numbers)
15.	Yes	No		Are knives and other sharp objects out of the reach of children or in a childproofed drawer?
16.	Yes	No		Are plastic bags out of the reach of children?
17.	Yes	No		Are sharp edges and corners covered (i.e., fireplace, tables, etc.)?
18.	Yes	No		Are there safety plugs in all unused electrical outlets?
19.	Yes	No	N/A	Are hair dryers and curling irons out of the reach of children?
20.	Yes	No	N/A	Are the iron and ironing board out of the reach of children?
21.	Yes	No		Are all chemicals and cleaning supplies stored in original containers? (Some examples of dangerous products include paint thinner, antifreeze, gasoline, turpentine, bleach, insect spray, fertilizer, poison.)
22.	Yes	No		Are all chemicals and cleaning supplies stored out of the reach of children or

				in a childproofed cabinet?
23.	Yes	No		Are all vitamins, over-the-counter and prescription medication stored out of the reach of children or in a childproofed drawer/cabinet?
24.	Yes	No	N/A	Are all alcoholic beverages stored out of the reach of children or in a childproofed cabinet?
25.	Yes	No	N/A	Are cosmetics stored out of the reach of children or in a childproofed drawer/cabinet?
26.	Yes	No	N/A	Are curtain and blind cords kept out of the reach of children?
27.	Yes	No	N/A	If residence is not on the ground floor, is furniture that a child could climb on away from windows, or are there window guards installed?
Guns/Weapons Safety - ***If applicable, verify the location and method of storage.***				
28.	Yes	No	N/A	Are all guns and ammunition stored/locked out of sight and reach of children?
29.	Yes	No	N/A	Are guns and ammunition stored separately?
Fire Safety - ***Ask the parent(s) to show you the smoke alarm(s) and unrestricted exits.***				
30.	Yes	No		Are smoke alarm(s) in working order and located on every floor?
31.	Yes	No	N/A	Are space heaters in good repair and are they at least 4 feet from clothing, curtains/drapes or any flammable material?
32.	Yes	No		Are there two unrestricted exits (windows or doors) that can be used in case of fire?
Water Safety - ***If applicable, ask the parent(s) to show you all areas with water (pool, hot tub, retention pond and/or fountain). Measurements are based on current Florida Building Code 424.2.17.***				
33.	Yes	No	N/A	If there is an in-ground pool, is there at least a 4-foot barrier with gaps of no more than 4 inches?
34.	Yes	No	N/A	If there is an in-ground pool, is there two inches or less between the ground and the bottom of the pool barrier?
35.	Yes	No	N/A	If there is a door from the house that leads into an area with water, is there an exit alarm or a lock located at least 54 inches above the floor?
36.	Yes	No	N/A	If there is a barrier around the pool, are large objects outside of the barrier (such as tables, chairs or ladders) far enough away from the barrier to prevent children from using them to climb over the barrier and into the pool area?
37.	Yes	No	N/A	If there is a gate into the area with water, is there a latch on the gate that closes automatically? Is the latch located on the side with the water? Is the latch located at least 54 inches above the bottom of the gate?
38.	Yes	No	N/A	If there is a window that is accessible to the area with water, is there an exit alarm and/or is the base of the window at least 48 inches from the interior floor (can be 42 inches if there is a cabinet beneath a screened or protected pass-through window)?
39.	Yes	No	N/A	Are toys and objects that may attract children kept out of the water when not in use?
40.	Yes	No	N/A	Are there life saving devices near the pool such as a hook, pole or flotation device?
41.	Yes	No	N/A	Are pool chemicals kept away from heat sources and out of the reach of children?
42.	Yes	No		Is the property free from containers of water or other fluid left uncovered or accessible to a child (i.e., inflatable “kiddie pool”, buckets, etc.)?

Safety concerns resolved:

_____

_____

_____

_____

_____
_____

Plans for follow-up:
_____
_____
_____
_____
_____
_____
_____
_____

Parent's Signature:
_____

Protocol for Immediate Staffings
4th Judicial Circuit
Clay, Duval, & Nassau Counties
December 12, 2008

Agency Representatives
Department of Children & Families
First Coast Child Protection Team
Family Support Services
Community Based Care Agencies (Daniel & Jewish Family Services in attendance)
Guardian Ad Litem
Children's Medical Services

Agencies listed above (and additional attendance by Children's Legal Services) is paramount to the success of following child abuse victims & their families through the investigative and services process in order to ensure child safety. These agencies are the "Core Agencies." Attending representatives from each agency must include the following or designee:

DCF	Operations Manager, Program Administrator, Supervisor, & Protective Investigator
CPT	Team Coordinator, Asst. Team Coordinator, Case Coordinator, Dr. Vallely (Team Psychologist) and Medical Provider (when appropriate)
FSS	Supervisor
CBC	Individual Agencies' supervisors and assigned family counselor
GAL	Assigned GAL & Supervisor or Director
CMS	Assigned Nurse &/or Social Worker (If involved)
CLS	Assigned CLS and Managing Attorney

Staffings will be scheduled as soon as possible for the following:

- Upon request of any agency involved with the family/child during the life of the case when significant concerns arise
- When Egregious Abuse or Critical Injuries have occurred
- When a child death has occurred and additional services are needed
- When the investigative recommendation by DCF or CPT is either expedited TPR or TPR
- When original investigative recommendations by DCF or CPT are changed resulting in less restrictive case plans/goal development and implementation or reunification of the family

Staffings will be conducted at the UF First Coast Child Protection Team Offices located at 4539 Beach Blvd., Jacksonville, FL 32207.

Please notify UF CPT of your request for reserving the conference room. Invitations will be faxed to all agency representatives involved with the family. Every effort should be taken to attend these staffings.

This protocol was developed by the following agency representatives on December 3 & 12, 2008 and will be implemented immediately by the community agencies, reflected by signatures that follow.

_____
_____
Department of Children & Families (Date)
(Date)

Children's Legal Services

_____
_____
UF First Coast Child Protection Team (Date)
(Date)

Family Support Services

Community Based Care Agencies

_____
_____
Children's Medical Services (Date)
(Date)

Guardian Ad Litem

Brevard County Protocol for Drug Endangered Children (DEC)

1. **Joint Investigation**
   It is recommended that Drug Endangered Children (DEC) investigations be worked jointly by the Department of Children and Families (DCF), the appropriate law enforcement (LE) agency having criminal jurisdiction, the appropriate emergency medical agency (Emergency Medical Services (EMS) and Fire Department), and follow-up treatment agencies. All agencies will share information, and respond in a coordinated, collaborative effort throughout the investigative process.

   a. Known/suspected Clandestine Drug Laboratory

   1. **When DCF receives the initial DEC report,** they will notify the appropriate law enforcement agency and provide them with all known information. Information should include all prior DCF reports on members of the household. Law enforcement should request a call history of the current address and any available criminal intelligence, and share all information with the responding DCF investigator. LE should notify EMS or the Fire Department to be available to respond to any emergency situation that may arise.

   2. **When law enforcement receives the initial DEC report,** they will notify the Abuse Registry/Hotline and request an immediate DCF response. This call may be expedited by calling the dedicated law enforcement line 1-866-LEABUSE. Law enforcement should request a call history of the current address, coordinate with their Narcotics Unit (if available) for any prior narcotics intelligence, and share all pertinent information with the DCF investigator. The DCF investigator should provide law enforcement with all current and previous DCF report information on members of the household. (Law enforcement should make initial contact at the residence, ensuring safety and security of the law enforcement operation)

   3. **If possible** and prior to making initial contact, the law enforcement and DCF representatives should develop an investigative plan based on all available information. Once it is determined a DEC situation exists, law enforcement will notify and coordinate with EMS and the Fire Department. When appropriate and without compromising the criminal investigation, EMS and Fire Department personnel should be ready to immediately respond to the site of drug activity. This is important because of the hazardous nature of these drug sites which may endanger investigators, perpetrators or victims.

   b. Unknown Clandestine Drug Site Discovered on Unrelated Complaint

1. **DCF Discovery -** If children are present, children should be taken to a safe environment outside the home if possible. Law enforcement should be notified immediately and the home should not be re-entered.
2. **Law enforcement Discovery -** all individuals should be immediately removed from the home and the crime scene should be secured. The appropriate narcotics unit, medical personnel, and the DCF Abuse Hotline should be notified, requesting an immediate response from DCF Investigations.

2. **Immediate procedures at the scene of clandestine drug sites or when chemicals or paraphernalia are present.**

It is recommended that when children are found at the scene, or are known to have been present at the scene of a suspected or working clandestine drug site that the following steps are taken for their safety and protection, as well as the safety and protection of responding investigative/medical personnel:

a. All investigative/medical personnel responding at the scene of a clandestine drug site should follow their agency safety procedures when dealing with or coming in contact with hazardous materials (HAZMAT).

b. All persons inside the home should be immediately removed. Law enforcement should take the lead in removing occupants from the home, ensuring their safety while preserving the integrity of the crime scene.

c. Appropriate emergency personnel (EMS and Fire Department) should be notified by law enforcement and respond to the scene. Emergency personnel may be needed to respond to chemical hazards, explosions or fires caused by the hazardous nature of drug sites. They also may be needed to respond to medical emergencies of victims, perpetrators or investigators.

d. Law enforcement should immediately notify their Narcotics Unit. If the responding law enforcement agency does not have an internal Narcotics Unit, then they should notify the appropriate law enforcement agency for assistance.

3. **DCF Investigation (On-Scene)**

a. Children located at the scene, or known to have been present at the scene of a clandestine drug site should be placed in protective custody by DCF.

b. To minimize contamination, no personal items should be removed from the scene. If cleared medically by EMS at the scene, DCF will transport the children to the designated fire station for decontamination to include a shower and change of clothes. Every precaution should be taken to minimize exposure to contaminated materials. Disposable seat covers should be utilized for transport of the children and their clothing should be bagged for decontamination following removal. DCF and Fire Department personnel should coordinate their activities for

decontaminating children. Whenever possible, a witness should be present during this process.

c. Children, if age appropriate, should be interviewed regarding their home situation and any information they may have regarding the drug lab. Relevant information should be provided to the appropriate LE agency. DCF will help the child understand why he is being separated from his parents and ensure ongoing services will be provided to the child and his parents. Forensic interviews should be conducted on all verbal children. This may be performed by LE or CPT. The need for forensic interviews will be determined in collaboration with LE, CPT, and DCF, subsequent to the field interview conducted by LE and/or DCF. Forensic interviews should be conducted at the Children's Advocacy Center (CAC) or similar facility.

d. The child's medical history should be obtained from the caregiver at the scene if possible. CPT should be contacted to arrange for forensic medical evaluation.

e. Parents and other caregivers should be interviewed regarding relatives and social history at the time the children are removed. DCF will need to obtain information for the removal packet, Health Insurance Portability and Accountability Act (HIPAA) , Temporary Assistance for Needy Families (TANF), etc. Any other interviews with the parents or caregivers should be coordinated with the involved law enforcement agency.

f. Copies of photographs, evidence sheets and law enforcement reports should be obtained in order to ensure that dependency action can be documented for judicial purposes.

4. **Law Enforcement Investigation (On-Scene)**

a. Photographs should be taken if children are present or if evidence exists that children resided at the location. Photographs should include:

1. Location of the incident.
2. Interior living conditions of the home.
3. Children's ability to access drugs, chemicals, drug paraphernalia and by-products. Measurements of furniture height should be taken into consideration based on the age and developmental stages of the children.
4. Play area/yard where the children may have been exposed.
5. Children's bedroom or sleeping area, including evidence of attempts to reduce exposure to chemical residue such as blocked air vents, etc.
6. Conditions of the bathroom(s).
7. Food supply in kitchen cabinets, pantry, refrigerator or freezer.
8. Proximity of food to chemicals, paraphernalia, fire and chemical hazards, and where discovered.
9. Drug lab components, associated chemicals, paraphernalia, fire and chemical hazards, and locations discovered.

10. All evidence collected by law enforcement personnel.
11. Physical condition of the children and all other occupants of the residence.
12. Indication of any fires caused as a result of the clandestine production of drugs within the residence.
13. All injection sites or other methods of intake of the drug.

b. Law Enforcement personnel will be responsible for the collection and preservation of all evidence according to Drug Enforcement Agency (DEA) and Florida Department of Law Enforcement evidence collection protocol.

c. Law Enforcement personnel will document and attempt to identify all chemicals located at the residence and provide the information to DCF and medical personnel. If large quantities of chemicals are present in the form of 55-gallon drums or 5-gallon buckets, the Department of Environmental Protection (DEP), Division of Law Enforcement should be notified via the state warning point (1-800-320-0519). An on-call agent supervisor will contact the reporting officer or agent to discuss the potential environmental impact.

d. Law Enforcement will conduct criminal interviews with individuals present (suspects, witnesses and children):

    1. Field interviews of the children may be performed by LE and/or DCF.
    2. Forensic interviews with children should be conducted at a Children's Advocacy Center (CAC) or similar type facility. They will be conducted by either CPT or LE. (Refer to attached interview guidelines.)
    3. Videotaped interviews of the children should be conducted whenever possible, utilizing age appropriate methods.
    4. Interviews with parents and witnesses should include targeted questions which address their knowledge of the dangers to children, admissions that children were near lab hazards, or disregard for the danger posed to children, the kinds of chemicals used in production, number of times manufactured, and frequency of occurrences in the presence of the children.

e. Reports/Documentation:

    1. All occupants in the home (full-time and part-time residents) should be identified and included in the report.
    2. Agency reports regarding drug exposure (manufacture, sale and /or possession) should be documented.
    3. A listing of all chemicals discovered at the site should be immediately reported and provided to DCF for their dependency action.
    4. Upon discovery and verification of a drug lab at a residence, it is strongly recommended that law enforcement notify the following agencies:

        a. Health Department (community safety)
        b. Property Owner (responsible for HAZMAT clean-up)
        c. Property Appraisal Office (require disclosure to future residents)

f. The Drug Enforcement Agency will be responsible for the coordination of the removal of the chemicals and by-products at the drug site.

5. Medical Assessment of Children Removed from Locations in which Methamphetamine Manufacture is Suspected

a. Initial medical assessment will be provided by emergency medical services (EMS) at the scene. Children should be evaluated at the emergency department where a urine drug screen should be collected to identify any level of exposure.
b. If significant problems are identified, EMS should transport child to the hospital emergency department.
c. If no emergency problems are noted or EMS is not on the scene, DCF will transport child to the designated Fire Department for decontamination as soon as possible. Entire body and hair should be washed with soap and water and the child should be dressed in clean clothes.
d. Subsequent to the decontamination, DCF will transport the child to the emergency department for evaluation and collection of urine drug screen. DCF should proceed with placement after children have been decontaminated and medically cleared in the emergency department.
e. Disposable seat covers should be used by DCF personnel if child is transported before decontamination.
f. All DEC children should be referred to CPT. Determination will then be made as to the appropriate CPT services to be utilized. CPT will provide necessary services depending on the circumstances of each case. This could include medical examination (if there are additional allegations of abuse and neglect), medical consultation, and/or forensic interview.
g. All children should be seen by their primary care provider within 72 hours after placement as with all children in DCF custody.
h. CPT will provide information regarding drug endangered children to the physician who will be providing primary care for the child including:

    1. Consideration of laboratory evaluation including chemistry panel and complete blood count
    2. Need for developmental evaluation
    3. Need for referral to dentist
    4. Need for mental health services

6. Child Protection Team (CPT)

a. The role of the CPT is to assist in child abuse investigations.
b. All drug endangered children should be referred to CPT.
c. CPT will provide necessary services depending on the circumstances of each case. This may include medical examination (if there are additional allegations of abuse and/or neglect), medical consultation, and/or forensic interview.

d. CPT will provide follow-up case management to include referral to Early Steps or Child Find for developmental services and referral for mental health services.
e. CPT will provide information regarding the drug-endangered child to the physician who will be providing primary care for the child.
f. CPT will arrange multidisciplinary staffings as necessary.

7. Fire Department/EMS

a. Fire rescue personnel are an essential part of the response to drug sites because of the hazardous nature of these sites resulting from the presence of volatile chemicals and the potential for fire and explosions. They are also vital first responders to provide emergency medical care to investigators, victims or perpetrators.
b. Emergency Medical Services personnel will provide initial medical evaluation of children found at drug sites. They will transport children to an emergency department for treatment when indicated.
c. They will provide support to law enforcement agencies and DCF representatives at the site in any way possible based on the capabilities of units, equipment, and personnel currently on the scene of the incident.
d. Fire Department personnel will provide decontamination support to children removed from drug sites at designated fire stations.
e. Fire Department and EMS reports, including identification of responding personnel, should be made available by appropriate request and forwarded to the requesting agency.

8. Safety Procedures

We are facing an unprecedented epidemic of clandestine drug sites in the United States. Seizures of drug sites continue to rise putting police and first responders at risks for a variety of hazards. First responders and children residing in the home are at risk for exposures to the chemical hazards, fire, explosion, and safety hazards inherent with clandestine manufacturing of methamphetamines. Responding investigative, and medical personnel should follow their agency safety procedures and corresponding OSHA requirements.

9. Team Coordination /Review

There are several agencies and organizations that participate in the DEC protocol. First responders to an investigation scene include law enforcement, DCF investigators, EMS personnel, Fire Department personnel, and HAZMAT teams. It is essential that all agencies work together, share information, and respond in a coordinated, collaborative effort. In general, law enforcement should take the lead role at the scene. Law enforcement should be responsible for securing the scene and conducting the criminal investigation. Whenever children are found at the scene or are suspected of exposure to toxic chemicals, DCF should be notified and children should be taken into protective custody. EMS should perform a field medical assessment and if required, transport them to nearest medical facility. HAZMAT teams should be responsible for removal of toxic waste.

10. Training

As part of this protocol, it is planned that a formal Brevard County Protocol for Drug Endangered children training program will be formulated. Presenters of this training program will be comprised of Law Enforcement, Department of Children and Families, the Child Protection Team, and Emergency Services/Fire Department personnel. It is anticipated that once the training program has been finalized it will be presented to family provider agencies such as (but not limited to) Community Based Care staff, law enforcement personnel, Department of Children and Families personnel, in home service providers, etc.

To: All DCF staff in the Marion County Service Center

From: Kimberly Grabert, Program Administrator

Date: January 6, 2010

Re: MARION COUNTY DEATH INVESTIGATION PROTOCOL

Effective January 1, 2007, the following protocol is in place for all staff at the Marion County Service Center.

Notification

Upon receipt of a death case, the Child Protective Investigator will immediately notice their Supervisor who will in turn immediately notice the Program Administrator. The Program Administrator will send notification to the Circuit Operations Manager, the Circuit Administrator, the Public Information Office and the Death Review Coordinator.

The Investigative Supervisor will ensure that incident and media reports are sent out within 5 hours of the commencement of the death investigation. It will be copied to the Program Administrator, the Operations Manager, the Circuit Administrator, the Public Information Officer, and the Death Review Coordinator.

Initial Contact with the Family

The Child Protective Investigator will use the Sudden Unexplained Infant Death (SUID) tool for victim children 24 months and younger. The SUID form will apply for the deceased child.

In any child death, the Child Protective Investigator will provide a drug screen to all parents and/or caregivers of the child immediately upon initial contact.

The Child Protective Investigator will obtain a timeline of caregivers for the deceased child for a period of 72 hours prior to the child's death.

The Child Protective Investigator has the right to request that their Supervisor meet the Investigator at the scene to assist with the initial contact. If the Supervisor is unable to respond, the Child Protective Investigator should contact the Program Administrator who will respond to the scene.

Follow up

The Child Protective Investigator and Supervisor will staff the case with the Program Administrator within 24 hours of receipt of case to identify current status, risk/safety issues and identify follow up tasks.

If there are any additional siblings in the home, a CPT referral will be made within 24 hours of commencement of the case. An exception or consult will not be considered appropriate and, depending on the maltreatment allegations and age/verbal skills, the siblings should be referred for a medical examination and/or forensic interview.

By day 5 of the case, the file will be copied and forwarded with all current notes, pictures, drug screen results, priors, and FDLE to the Medical Examiners Office. Redact all confidential information (SSN and Reporter).

By day 30, CPIS will request an appointment with the Death Review Coordinator to conduct a Death Review Staffing. The case must be submitted and reviewed for disposition prior to the request for an appointment. The Investigator is to copy the file and send to the Death Review Coordinator. This staffing is to be completed by day 45.

If the final autopsy is not received until after the report is closed, the original report will be placed in the case file with copies going to Program Administrator and the Death Review Coordinator. If there is any information that conflicts with the original findings of case, it should be staffed with the Child Protective Investigator, Supervisor, Program Administrator and (by phone) the Death Review Coordinator.

The Program Administrator is to maintain a log of death cases for ongoing analysis.

NO COURT ACTION SUMMARY FORM
Work Product/Confidential Information/Not For Public Disclosure

NOTE: OTHER THAN SIGNATURES, DO NOT HANDWRITE THIS FORM

CLS Attorney: FSFN Case/Investigation #:

CPI/Caseworker: Date of Report: Date of Staffing:

Name/Age of Child(ren): - Mother's Name:

- Father's Name:

-

LEGAL ACTION BEING CONSIDERED *(underline one):* **SHELTER PETITION** **DEPENDENCY PETITION**

CLS DECISION *(underline one)***:** **DENY ACTION**

DELAY ACTION PENDING FURTHER INFORMATION
If you request additional information, you must re-staff within 14 days which is:

LEVEL OF RISK AS CORROBORATED BY PI OR OTHER APPROPRIATE SOURCE:

RELEVANT CASE FACTS AND LEGAL ANALYSIS SUPPORTING DECISION TO DENY/DELAY COURT ACTION :

CLS Attorney must submit signed form with any attachments to a Supervising Attorney for review and signature.

NO COURT ACTION SUMMARY FORM
Work Product/Confidential Information/Not For Public Disclosure

Attorney Name and Signature **Date of Submission**

Supervising Attorney Name and Signature **Date of Review**

DOCUMENTS REVIEWED BY CLS ATTORNEY
(this section may be checked off by hand, if you prefer)

☐ CPI Staffing/Duty/Case Opening Form etc.	☐ School/guidance reports, attendance records,
☐ Up to date PI chronos VPS/VFS)	☐ Prior Department case files (PI, PS, FC, ARS,
☐ Up to date PS chronos perpetrator)	☐ FPSS/FAHIS reports, including all priors (family and
☐ Child Protection Team reports agencies)	☐ LE reports (NCIC, FDLE, Sheriff's Office, local
☐ Medical reports and/or hospital records injunctions, etc.	☐ Criminal court orders, adjudications,
☐ Current FAHIS report updated to include and/or progress all household members	☐ Psychological/psychiatric evaluations, records notes
☐ Service provider progress notes and/or prior reports termination summaries Healthy Start, etc.)	☐ CSA on the current report and all ICSA/CSA from (e.g. Family Builders, ICCP, Homemakers,
☐ Drug/alcohol screens, including record progress of refusals	☐ Substance abuse evaluations and/or treatment notes
☐ Photographs (taken by Department, CPT, Child Protection Law Enforcement, etc.)	☐ Audiotapes/videotapes (obtain copies from Team, law enforcement, etc.)
☐ Expert witnesses (professionals likely addresses, phone to support significant impairment testimony. and/or prospective abuse or neglect) disprove the	☐ Complete witness list, including names, numbers, and a brief synopsis of relevant Anyone with knowledge that may prove or allegations must be included.

State of Florida
Department of Children and Families

Charlie Crist
Governor

Robert A. Butterworth
Secretary

Mary Cagle
Statewide Director,
Children's Legal Services

DATE: January 16, 2009

TO: Children's Legal Services Attorneys

THROUGH: George Sheldon, Assistant Secretary for Operations

FROM: Mary Cagle, Statewide Director, Children's Legal Services

SUBJECT: Children's Legal Services Model

Children's Legal Services represents the State of Florida, by and through the Department of Children and Families to ensure the health and safety of children and the integrity of families. The State of Florida has the awesome responsibility of protecting children who have been abused, abandoned and/or neglected by their parents. The CLS attorneys, together with the State's lead agencies, case management providers and protective investigators, are charged with carrying out that responsibility. Children's Legal Services (CLS) is the prosecution arm of the dependency system.

The CLS Model can be analogized to that of the prosecutor. Both prosecutors and CLS attorneys have a higher ethical obligation than other lawyers. Each is expected to pursue justice rather than simply seeking victory for their clients. For prosecutors, that direction is explicit in Florida Rules of Professional Conduct; for CLS lawyers, the duty is expressed in the chapter 39 directive to ensure the health and safety of children and the integrity of families.

The critical witnesses in a criminal prosecution are the police officers who are in the field. The critical witnesses in the CLS lawyer's case are the case managers and child protective investigators who work with the children and their families to provide services to help families reunify, to seek and implement other permanency options for the child, or where necessary to work toward the termination of the parent's rights. Both are the critical eyes and ears of the attorney in the field.

The case managers and child protective investigators are the experts in assessing risk and determining which clinical and/or other types of services are needed and are critical partners and witnesses in every case.

This understanding of the role of CLS will be extremely effective in the Community-Based Care service delivery model. CLS, the lead agencies, the full case management providers and the protective investigators must work together at every stage of a child's case. All must feel the urgency to ensure that the child's safety and well-being is paramount and that permanency is a constant focus. One of the most critical components of the CLS Model is true collaboration and partnership between the Department, the lead agencies and the providers. All are responsible for the safety and well-being of our children.

Questions To Ask Before you leave your children with anyone.

Does that person...

- → Enjoy being around children?
- → Have previous experience with children?
- → Have a sense of humor?
- → Have patience and self control?
- → Listen and talk with children?
- → Provide directions for children they can understand?
- → Provide care and support for his or her own children?
- → Seem capable of having a sharing, caring relationship?

To Report Suspected
Child Abuse & Neglect (Hotline)
1-800-962-2873

DOMESTIC VIOLENCE
To Report Suspected
Domestic Violence (Hotline)
1-800-500-1119

Harbor House
A Domestic Violence Shelter for Orange County
(407) 886-2244

Safe House of Seminole
A Domestic Violence Shelter for Seminole County
(407) 330-3011

Help Now of Osceola
A Domestic Violence Shelter for Osceola County
(407) 847-3260

The Salvation Army
A Domestic Violence Shelter for Brevard County(North & Central)
(407) 631-2764

Serene Harbor
A Domestic Violence Center for Brevard County (South)
(407) 726-8282

INFORMATION & REFERRAL
Community Services Network for Orange, Osceola & Seminole Counties - (407) 897-6465
Crisis Helpline Brevard County - (407) 631-8944

Who's Watching Your Kids?

WARNING: Leaving Your Child With The Wrong Person May Result In Injury Or Death Of Your Child.

If you pick the wrong person to watch your child, you could be making a

deadly mistake.

Did you know...

- **Many children who die from abuse are killed by the mother's boyfriend.**
- **Often boyfriends who use drugs or alcohol become very stressed out and get angry over minor things that all kids do, like crying, spilling something or soiling themselves.**
- **When someone lets their anger get out of control, it only takes one hard shake or one hard hit to the head or body to kill an infant or small child.**
- **It could happen to you. Over the past year, 14 children in District 7 died from abuse or neglect.**
- **Over the past year, 72 children in Florida died from abuse or neglect. Don't let your child be one of these statistics.**

Don't let this happen to your child!

Cindy, one-month old

Cindy was crying. To get her to stop, her mother's boyfriend shook her. She died from injuries to her brain.

Tarsha, two-years old

Tarsha soiled her pants, as children sometimes do at her age. But her mother's boyfriend got so angry, he beat her to death.

Ryan, six-months old

Ryan's mother threatened to kill her baby at birth. Ryan was placed in the custody of his grandmother, who left Ryan alone with his mother. Ryan's mother threw him out the apartment window and he was killed instantly.

Sally, nineteen months old

This non-responsive child was taken to the hospital by EMS where she subsequently died. Medical personnel at the hospital indicated she had enlarged anal and vaginal openings and her body was covered with bruises. The mother's boyfriend was identified as having inflicted the injuries that caused the child's death. When questioned, the mother stated that she had turned the disciplining of the child over to her boyfriend and did not realize he was hitting her that hard.

Teach Your Children...

- The name of a neighbor or safe place, close to home, where they can go if they think they are in danger.
- How to call 911 in an emergency.
- To talk to you about any problems or concerns they may have.

Questions to ask after your child has been left with a boyfriend or other caretaker.

- Ask your child what they did while you were away?
- Observe your child's behavior, especially an infant or toddler. Does the child seem peaceful and happy when you return?
- Ask yourself, "Do I feel comfortable with what I saw when I left my child and when I returned?"

Facts to consider on Drowning/ Inadequate supervision

Was the pool in a safe condition? Was the pool murky water or un kept?
Were there layers of protection i.e., locks on doors that are out of reach of the child, pool alarm, pool fence?
Were the locks/ layers of safety being used?
How did the child access the water, pool?
Was the child physically capable of unlocking doors, opening sliding doors
Was this the child's residence or relative, friend, vacationing home, etc?
Was the caregiver under the influence of drugs (prescribed or otherwise)/alcohol?
Is there a criminal history of drugs/alcohol?
Is there evidence of alcohol or drug/paraphernalia observed?
Has the child gotten into the pool area alone before?
Does the parent have developmental impairment?
Does child have any delays or impairment ie autism?
Are there DCF priors of inadequate supervision and or substance misuse?
Collateral contacts of neighbors on supervision issues in past-unreported
If the parent was sleeping, had they been diagnosed as depressed and taking medication past or present? Note what time it is they are sleeping?
Were the parents doing shift work?
Was the caretaker on the computer- can find out the amount of time
What was the activity of the parent when child went missing?
What is the time of event?
How long does caretaker say they were missing?
Who was designated to watch the child? Especially in cases of parties, BBQ's.
Has code enforcement been involved?
Is this a rented home or owned?
Did caretaker know how to swim?
Did caretaker know CPR?

Facts to consider on unsafe sleeping related cases

Is this the normal residence for the child?
Was the parent under the influence of drugs/alcohol?
Is there evidence of alcohol or drug/paraphernalia observed?
Is there a DCF or criminal history of drugs and or alcohol?
Age of parent
Were parents working different shifts, rather than daycare?
What type of sleep surface was the child on? Was it a shared sleep surface? If so with whom and how many? Height, weight, age, relationship, etc.
Was there a crib/bassinet for the child, if so was it being used?
If the crib was used were there unsafe items in the crib i.e. blankets, clothes, toys

Were the parents advised of the danger in placing the child on the stomach to sleep and if so by who?
If a blanket or covering was used over the child's face, how much did it weigh and type of material?
Were they bottle propping, and what was used to hold bottle, blanket etc?
Was the bed in poor condition i.e. no board underneath to keep it hard and flat?
Was the child sleeping in a car seat? Note what the position of the head.
What was the location of the car seat?
When was the last time they checked on the child?
When was the last time they fed the child?
Has there been a SIDS death in the family in the past?
Ask how many children have they had, not how many do they have
Was the child recently sick and if so was the child on medication?
Document the type of medication and dose given.

Facts to consider Poisoning related cases

Log types of medications in home at time, dosage and milligrams, number of pills left in container. Is the amount left appropriate to the prescribed dose?
Take a photo of the pills.
What was the reason given for being prescribed the medication?
Were they in a locked container?
Were household members under any treatment- ie methadone clinic?
Names of prescribing physicians
Were the physicians aware of the different prescriptions?
Was caretaker under influence?
Do they have criminal offenses or arrest history related to drug use?
Are there DCF priors of inadequate supervision, and or drugs involved?

Overdose or Suicide, especially the teens

If the child intentionally took the medication or drugs and died of an overdose, was caretaker aware of drug misuse?
If yes, did they seek treatment for child?
Was anyone aware of child's drug use? Friends, relatives etc.
Was the child under DJJ or history with DJJ?
Was the school aware of problems or issues?

Facts to consider on intentional physical injury

Who called 911?
Was it delayed? Did perp call someone other before calling 911?
Check cell phone and text records
Did they drive to hospital?
If yes, what is the distance- how long would it take for EMS to arrive?
Initial statement, child stopped breathing, found unresponsive e, sick, accidentally dropped or fell on child
Where was mom, at work?
What type of work does mom do?

Did perp have employment, or was perp full time caretaker?
Were they working in shifts?
Were finances for day care an issue?
How long had mom know perp?
What was motivating factor- crying, toilet training, illness?
What was the activity of the perp right before the crying started?
Did he have a dv history, criminal history?
Did he have substance abuse history, to include charges?
Was he on probation past or current?
Was mom aware of abuse or suspect?
Has she seen any previous bruises while in perps care, or child fearful?
What was her reason for him watching child, no day care, cannot afford, work schedule?
Has she been a victim of DV in this situation or in past?

Facts to consider on Murder/suicides

Was there DV history?
Was or had there been any injunctions?
Had pep been referred to batterer's classes or attended?
Had perp threatened to kill kids to anyone?
Was there a custody issue?
Did perp have criminal history?
What is most apparent motive? Custody, retaliation, finances, mental illness, drugs
If mental illness, had there been treatment?
Was there mental health history, on medication for depression or mental health disorder?
Look for or obtain any mental health records

Facts to consider on Traffic related

Was caretaker under influence or impaired?
Was child restrained appropriately?
Was this as a result of criminal activity-ie fleeing from LEO?
Had there been any prior traffic violations? To include citations, reckless driving?
Did any family members know of previous substance abuse/impairment and driving by the parent/caregiver?
Did anyone see the perpetrator drive off?
Any past history of substance abuse treatment?
Any criminal history of drug related offences?

Kids left in cars

Was there a change in routine?
Who normally takes child?
Type of vehicle, and visibility
Was there a car seat
Was this intentional- being used as the babysitter?
What was temp of child, temp outside, and temp in the car?
Were they under influence of drugs/alcohol?

Kids backed or run over

Who was supposed to be watching child?
Were they under influence of drugs/alcohol?
What type of event, i.e. birthday party etc?
Type of vehicle and visibility?
Prior history with DCF, supervision, drugs-alcohol?

Facts to consider on abandoned babies

Location found
Was mother identified?
Did mother have criminal history?
Did she have mental health issues?
Did she have substance abuse history?
Did she have other children? If yes, had they been removed? WHY?
Did she deny she was pregnant, if so to whom
What was the motivating factor- finances, culture, youth, issues with father, unwanted child?
Was she aware of services, safe haven, prenatal care, counseling etc?

Facts to consider on all cases

Were the caretakers on methadone treatment? Were they drug tested before given medication, when last given, how often do they obtain medication and how long have they been on this treatment, are they getting any other counseling with the methadone treatment.
Gang related activity- Are the parents or family members involved in gang activity when there are shootings and homicides in and around the homes where children are present.
Obtaining pediatric records on children 2 and under.
Have there been economic changes
Job loss
Housing loss and change
Day care changes, due to financial changes
When children are in the hospitals documentation of mom's interaction with child, how often she is there, what is her demeanor?
Does dad come to the hospital, what is his interaction, demeanor?
Referring the cases to CPT for a medical opinion and getting their findings- especially good for substance exposed premature babies who die, inadequate supervision issues related to unsafe sleep, drowning.

Preventing Child Abuse...We Can

SUCCEED

ONE MOM'S TRUE STORY

"I knew this man for 17 years. We grew up together. I had been living with him for five months when he offered to babysit while I was at work. That day I had a gut feeling maybe I should stay home, but I went to work anyway. My boyfriend killed my son that day.

If you feel like something isn't right, investigate! Pay attention to the little things, especially your child's behavior. If he or she begins to cry whenever they see the person or any other changes that cannot be explained, investigate! Even though I am not to blame and I did not hurt him, I will blame myself every day because I didn't know. Every day I replay what I could have done to prevent his death.

You can always find another job or babysitter, but you can never replace your child."

– Linda, age 37

You hold the key to your child's safety. Parents think their child will be safe in their own home. The reality is that many children every year are abused by their parent's lover and some even die.

A study that took place in November 2005 found that...

"Children living in homes occupied by their mother's boyfriends or other non-relatives are up to 48 times more likely to die from child abuse."

Pediatrics, November 2005
Dr. Bernard Ewigman

Remember your children look to you to keep them safe. Read on to see if your lover passes the test!

70119 Lover Danger Brochure.indd 1

SOME THINGS YOU CAN DO TO HELP KEEP YOUR CHILD SAFE

Listen to your child. Watch your child's behavior and reactions. Make sure you know your lover well before you let him or her be alone with your child. If it's safe, ask for help and talk honestly with your:

- friends
- family
- spiritual leader
- health care provider
- family support worker
- or anyone you trust

Call your local health department to find out about support groups and other parent resources in your area.

PREVENTING CHILD ABUSE... WE CAN SUCCEED!

Design and editing of this brochure donated by:
Abbott

Printing of this brochure supported by:
Sponsor Name Here
Sponsor Name Here

Prevent Child Abuse Illinois

Prevention Resource Development Project

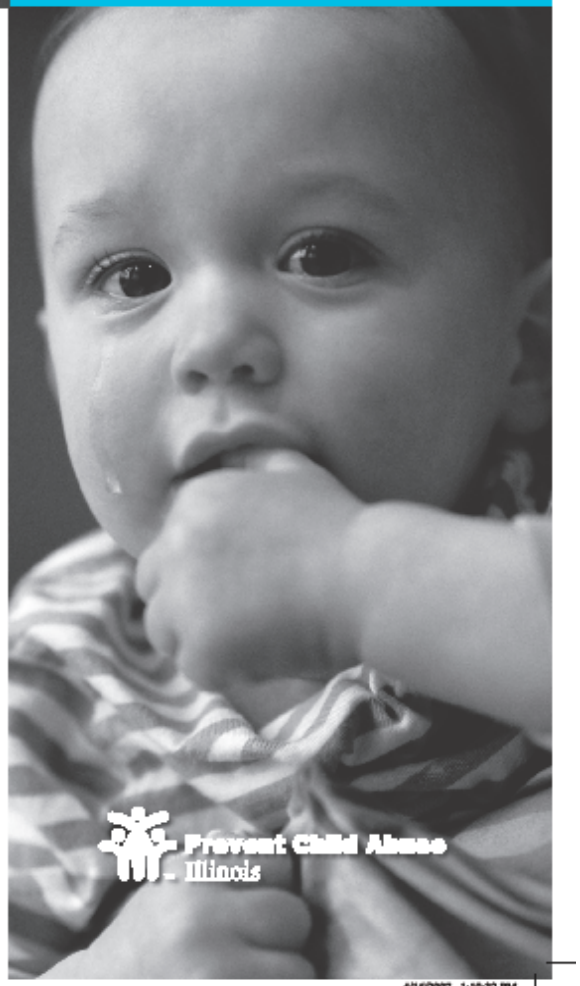
528 South 5th Street, Suite 211 • Springfield, Illinois 62701
217.522.1129 (office) • 217.522.0655 (fax)

www.preventchildabuseillinois.org

70119

How well do you know your lover?

CHILDREN IN DANGER



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DOES YOUR LOVER FAIL THE SAFE TEST?

DOES YOUR LOVER...

- ☐ Yell at your child?
- ☐ Hit your child?
- ☐ Not like your child?
- ☐ Talk bad about your child?
- ☐ Talk negatively to your child?
- ☐ Have secrets with your child?
- ☐ Touch your child in a way that makes you or them feel bad?
- ☐ Hurt you?
- ☐ Abuse alcohol or drugs?
- ☐ Have a criminal history?
- ☐ Get angry often?
- ☐ Lack experience in taking care of children?
- ☐ Have unrealistic expectations of your child?
- ☐ Criticize your parenting?

DOES YOUR CHILD...

- ☐ Cry when left alone with your lover?
- ☐ Cry when he/she has to go home and your lover is there?
- ☐ Act fearful in your home?
- ☐ Have unexplained bruises or injuries?
- ☐ Act different around your lover than he/she does around you?

If you answered yes to any of these questions, your child might be in danger.

There are many reasons you might want someone to live with you. You may:

- Be in love
- Want companionship
- Want someone to talk to
- Want someone to help you with your child
- Need a babysitter
- Need help paying bills
- Need help with transportation and a place to live

...BUT BE CAREFUL!

Any person you invite into your home will also impact the life of your child. They may be kind and loving to you and still be a danger to your child.

Here is something you should know. If your lover is hurting you, he or she may also be hurting your child. If your lover is hurting your child, you may be in danger too.

DOES YOUR LOVER PASS THE SAFE TEST?

DOES YOUR LOVER...

- ☐ Enjoy spending time with you and your child?
- ☐ Say nice things about your child?
- ☐ Talk to your child in a respectful way?
- ☐ Know your child's daily activities?
- ☐ Provide attention to your child through positive words and actions?
- ☐ Listen to your child and respect his/her feelings?
- ☐ Understand what children can do at different ages?
- ☐ Use positive discipline like time-outs?
- ☐ Make your child feel safe and secure?

DOES YOUR CHILD...

- ☐ Look forward to spending time with both of you?
- ☐ Enjoy being at home?
- ☐ Openly share feelings and concerns?
- ☐ Treat others with respect?

If you answered yes to these questions, there's a better chance that your child is safe.

Every child deserves a safe and healthy home!

STATE COMMITTEE GOALS AND ACCOMPLISHMENTS FOR 2009

Goals:

- Continue to train professionals on child death investigations and in particular following the recommendations from the Center for Disease Control. The Center for Disease Control has encouraged all States to adopt a standardized approach to infant death scene investigation by all Medical Examiner Districts as well as law enforcement agencies. The State Child Abuse Death Review Committee views this project as a high priority and is supportive of identifying resources to initiate a statewide approach to training and outreach.

- The State Committee will continue to have an annual meeting with the Chairperson from each local Committee to a joint meeting with the Department of Children and Families Child Death Review Coordinators and Family and Safety Staff to address the process of reviews and to standardize them statewide. Our goal will be to have 100% attendance from the local chairs.

- Increase verified child abuse death reporting compliance to 99% for the 2009 deaths from the Department of Children and Families.

- Continue to trained and set up a system with the Department of Children and Families child death review coordinators to assure accuracy of obtaining the verified reports to the local chairperson as well as getting this information to the State Committee timely.

- Collaborate with DCF workgroup for the updates to the maltreatment guide

- Collaborate with relevant organizations and partners to develop a statewide conference on serious child injury and child fatality.

- Continue to provide training to Protective Investigators throughout the state on child death investigations

- Provide training at the Dependency Court Improvement Summit on issues related to child fatalities identified by the State Training Committee.

Accomplishments:

- Major Connie Shingledecker and Dr. Barbara Wolf presented to the Medical Examiners Commission as a result the Medical Examiners made a resolution to support the State Committee, see Appendix X

- The State Committee was designated as one of the Florida's citizens review panels by Alan Abramowitz on June 10, 2009. See Appendix-XII.

- Members from the State Committee were appointed to the Domestic Violence Fatality Review Steering Committee.

- Members from the State Committee serve on the Governors child abuse Prevention and permanency advisory counsel.

- In support of the State Committee recommendation, during a difficult 2009 Legislative session wrought with significant cuts, the Florida Legislature recognized the value and wise investment in Healthy Families Florida by continuing the base funding for 2009-2010

- The State Committee provided training to over 200 Troopers and will continue to provided education and support to the Florida Highway Patrol regarding mandatory reporting on cases where children are killed or seriously injured as a result of the caregivers being under the influence or driving in a reckless manor. The State Committee has written letters to the Colonel of the Highway Patrol advising of the mandatory reporting and offered to provide training. See Appendix XI.

- Following a recommendation in the 2008 Child Abuse Death Review Annual Report, a public awareness and education campaign focusing on safe infant sleep was launched in the summer of 2009. The public awareness campaign, *Sleep Right, Sleep Tight,* included print campaign materials in English and Spanish and an accompanying eleven minute English language video of what a safe sleep environment requires; the importance of placing an infant to sleep in a safe environment; the risks associated with bed sharing and co-sleeping arrangements and risk factors associated with infant suffocation while sleeping. The materials were distributed in Miami-Dade, Hillsborough and Leon Counties through hospitals, county health departments, birthing facilities, pediatrician's offices, and obstetrician and gynecology offices. In addition, campaign materials were disseminated to all Healthy Families Florida projects and all Healthy Start Coalitions in Florida. All of the printed campaign materials included a culturally appropriate selection of

photographs and appealing graphic designs. In addition to sharing reasons why safe infant sleep is important, the video covered recommended practices that ensure a safer sleeping situation for an infant. New parents and their infants were included in the video and the recommended practices for safe infant sleep were shared by a paraprofessional home visitor.

- A survey of the Sleep Right, Sleep Tight campaign measured reactions to and use of the campaign materials among expecting, new or experienced parents and among the medical and social service providers that disseminated the materials. Based on the responses obtained through the parent survey, close to 90% thought the materials were very useful. Among those who indicated they were not currently practicing or planning to practice safe sleep with their infant, the campaign materials convinced them to start safe sleep practices with their infant. The survey of the medical and social service providers included staff in hospitals, pediatrician offices, OB/GYN offices, county health departments, and two home visiting programs. The vast majority of the providers (81.3%) indicated that they were sharing the campaign materials with parents face-to-face. Among the medical and social service providers who were with the parents when distributing the campaign materials, 31% indicated that after receiving the campaign materials, "most of" the parents asked questions about safe infant sleep and 78% indicated that "most of" the parents said they would practice safe infant sleep.

- After recommendations by the State committee as to multidisciplinary staffings on children with three or more reports, the Child Protection Team issued a memo, September 2009, requiring a Child Protection staffing on all high risk cases and children who have three or more reports on cases that meet the CPT requirement. (see Appendix VII)

- The State Committee invited the Chairperson from each local Committee to a joint meeting with the Department of Children and Families Child Death Review Coordinators and Family and Safety Staff to address the process of reviews and to standardize them statewide. There were 22 out of 23 active local Chair Committee's present.

- Reviewed 198 of the 201 child abuse death cases that met the criteria for review.

- Continue to educate and promote the use of the FDLE child investigation visor guide, which is available on the CADR website www.flcadr.org.

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Eileen R Giardino, PhD, RN, MSN, FNP-BC, ANP-BC, Associate Professor of Nursing, Department of Acute and Continuing Care, University of Texas Health Sciences Center Houston School of Nursing,

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Appendix I

Purpose of Child Abuse Death Review Committee

Program Background and Description

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

Mission Statement

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

Goal

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

Achieving Objectives

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

Membership of the State Committee

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

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

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

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

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

Appendix II

Membership of the Local Committee

A local child abuse death review team is not a new official organization. The authority and responsibility of participating agencies does not change. Rather, teams enable various disciplines to come to the same table on a regular basis and pool their expertise to better understand and take action on child abuse deaths in their jurisdictions.

Local review teams should, at a minimum include representatives from the:

. District medical examiner's office
. Child Protection Team
. County health department
. Department of Children and Families
. State Attorney's office
. Local law enforcement
. School district representative

Other team members may include representatives of specific agencies from the community that provide services, other than mentioned above, to children and families. Local child abuse death review core members may identify appropriate representatives from these agencies to participate on the team. Suggested members include:

. The Department of Children and Families district child death review coordinator
. A board-certified pediatrician or family practice physician
. A public health nurse
. A mental health professional that treats children or adolescents
. A member of a child a domestic violence advocacy organization
. A social worker that has experience in working with victims and perpetrators of child abuse
. A person trained as a paraprofessional in patient resources who is employed in a child abuse prevention program
. A representative from a domestic violence organization
. A representative from a private provider of programs on preventing child abuse and neglect.

The members of a local team shall be appointed to two-year term and may be reappointed.

Ad Hoc Members

Teams may designate ad hoc members. Because ad hoc members are not permanent, they do not regularly receive team notices. They attend meetings only when they have been directly involved in a case scheduled for review or to provide information on team related activities. Ad hoc members provide valuable information without increasing the number of permanent team members. They may be Department of Children and Families child protective investigators or family services counselors involved in a specific case, law enforcement officers from a police agency that handled a case, or a child advocate who worked with a family.

Appendix III

American Academy of Pediatrics Prevention of Drowning

Organizational Principles to Guide and Define the Child Health Care System and/or Improve the Health of All Children
Committee on Injury, Violence, and Poison Prevention

Prevention of Drowning in Infants, Children, and Adolescents

RECOMMENDATIONS

Pediatricians should alert parents to the dangers that water presents at different ages and in different situations.

For Newborn Infants and Children Through 4 Years of Age

1. Parents and caregivers need to be advised that they should never—even for a moment—leave children alone or in the care of another young child while in bathtubs, pools, spas, or wading pools or near irrigation ditches or other open standing water. They should also be reminded that infant bath seats or supporting rings are not a substitute for adult supervision.[11] They should remove all water from containers, such as pails and 5-gallon buckets, immediately after use. To prevent drowning in toilets, young children should not be left alone in the bathroom, and unsupervised access to the bathroom should be prevented.

2. Whenever infants and toddlers are in or around water, be it at their own home, the home of a neighbor, a party, or elsewhere, a supervising adult should be within an arm's length providing "touch supervision." The attention of the supervising adult should be focused on the child, and the adult should not be engaged in other distracting activities, such as talking on the telephone, socializing, or tending to household chores. 3. If a home has a residential swimming pool, it should be surrounded by a fence that prevents direct access to the pool from the house. Rigid, motorized pool covers, pool alarms, and other protective devices, which may offer some protection if used appropriately and consistently, are not a substitute for 4-sided fencing.

4. Children are generally not developmentally ready for formal swimming lessons until after their fourth birthday. However, because some children develop skills more quickly than others, not all children will be ready to learn to swim at exactly the same age. For example, children with motor or cognitive disabilities may not be developmentally ready for swimming lessons until a later age. Ultimately, the decision of when to start a child in swimming lessons must be individualized. Parents should be reminded that swimming lessons will not provide "drown proofing" for children of any age.

5. Parents, caregivers, and pool owners should learn CPR and keep a telephone and equipment approved by the US Coast Guard (eg, life preservers, life jackets, shepherd's crook) at poolside.

6. Parents should be cautioned not to use air-filled swimming aids (such as water wings) in place of personal floatation devices (life preservers).

7. Parents should be certain that all people who will be caring for their child or children understand the need for constant supervision of children when in or around water. If children are in out of-home child care, parents should inquire about exposure to water and water-related activities at the provider site, such as presence of a swimming pool at the home or visits to off-site pools. Recommendations for child-staff ratios while children are wading or swimming are available and vary with the age of the child and by jurisdiction. Some states include in their licensing requirements staffing ratios for water activities. Parents should be aware of the ratios at their child's site of care. National recommendations are available in *Caring for Our Children: National Health and Safety Performance Standards for Out-of-Home Child Care Programs*.[12]

8. Pediatricians are encouraged to identify familieswho have residential swimming pools and then schedule periodic counseling beginning in the perinatal period to ensure that parents remain aware of the risk of drowning and near-drowning. Families (and extended families and others visited by children) should be advised to install an isolation fence (also referred to as a 4-sided fence) that prevents direct access to the pool from the house. The fence should be at least 4 feet high (or greater if required by local ordinance). The fence should also be climb-resistant. For example, chain-link fences are easily scaled by young children, whereas ornamental iron bar fences are more difficult to climb.[13] The distance between the bottom of the fence and the ground should be less than

4 inches. The distance between vertical members of the fence also should be less than 4 inches. The gate is the single most important component of the fence. It should be self-latching and self-closing, should open away from the pool, and should be checked often to ensure good working order. Detailed guidelines for safety barriers for home pools are available online from the Consumer Product Safety Commission.[14] Families can also be advised to consider supplemental pool alarms and rigid pool covers as additional layers of protection; however, neither alarms nor pool covers are a substitute for adequate fencing. (Importantly, some types of pool covers, such as solar covers, should not be used as a means of protection, as detailed in the accompanying technical report.[8])

Appendix IV

Child Abuse Deaths by County

The following map, statistical reports, graphs and charts are based on a review of the child abuse and neglect deaths that occurred from 2004-2008. Below indicate the counties in which the deaths occurred and the number of deaths per county by year. This year the Committee reviewed 6 deaths that occurred in previous years. Their data has been updated and the numbers are reflected in the chart below.

Number of Deaths by County														
County	Year					Total # of Deaths	County	Year					Total # of Deaths	
	2004	2005	2006	2007	2008	Total # of Deaths		2004	2005	2006	2007	2008	Total # of Deaths	
Alachua	1	3	2	2	1	9	Lake	0	0	1	4	7	13	
Baker	1	1	1	1	1	5	Lee	5	4	4	3	8	24	
Bay	0	1	0	1	3	6	Leon	2	0	0	1	1	5	
Bradford	0	1	1	0	0	2	Levy	0	0	0	0	1	1	
Brevard	7	5	11	8	10	41	Liberty	0	0	0	0	0	0	
Broward	13	9	14	11	26	74	Madison	0	0	0	2	1	3	
Calhoun	0	0	0	0	0	0	Manatee	1	0	4	1	5	11	
Charlotte	2	0	2	0	0	4	Marion	4	6	7	7	12	37	
Citrus	4	0	1	2	6	13	Monroe	0	0	1	0	0	1	
Clay	1	0	0	2	0	3	Martin	0	0	2	0	0	2	
Collier	0	0	3	2	1	6	Nassau	0	0	0	0	3	3	
Columbia	0	0	1	0	0	1	Okaloosa	0	0	2	2	0	4	
Dade	14	5	11	6	11	48	Okeechobee	0	0	1	1	1	3	
Dixie	0	0	0	0	1	1	Orange	5	9	9	10	12	45	
Desota	0	0	0	0	1	1	Osceola	1	1	3	4	1	10	
Duval	16	9	12	8	10	55	Palm Beach	6	6	14	18	9	54	
Escambia	1	0	4	2	0	7	Pasco	2	0	4	8	2	16	
Flagler	0	0	1	0	0	1	Pinellas	2	5	6	7	6	25	
Franklin	0	0	0	0	0	0	Polk	7	8	17	16	14	62	
Gadsden	0	1	0	1	1	3	Putman	0	0	3	0	1	4	
Glades	1	0	0	0	0	1	Santa Rosa	2	2	3	1	1	9	
Gilchrest	0	0	0	0	0	0	Sarasota	1	1	1	4	5	12	
Gulf	0	0	0	0	0	0	Seminole	3	2	4	3	3	15	
Hamilton	0	0	0	0	0	0	St. John	2	1	0	1	1	5	
Hardee	0	0	0	0	1	1	St. Lucie	0	0	1	3	7	11	
Hendry	0	0	0	0	0	0	Sumter	0	2	1	1	1	5	
Hernando	1	2	3	0	4	7	Suwannee	1	0	0	1	2	3	
Highlands	0	0	1	6	1	8	Taylor	0	0	0	0	0	0	
Hillsborough	2	6	9	8	12	37	Union	0	1	7	2	0	10	
Holmes	2	0	0	1	0	3	Volusia	1	2	1	4	4	12	
Indian River	3	0	0	2	1	6	Walton	0	2	1	0	1	4	
Jackson	1	4	1	0	0	6	Wakulla	0	0	0	1	0	1	
Jefferson	0	0	0	0	1	0	Washington	0	0	1	0	0	1	
Lafayette	0	0	1	0	0	1								
	70	47	79	63	92	351		45	52	98	105	109	409	

Appendix V

Local Child Abuse Death Review Committees

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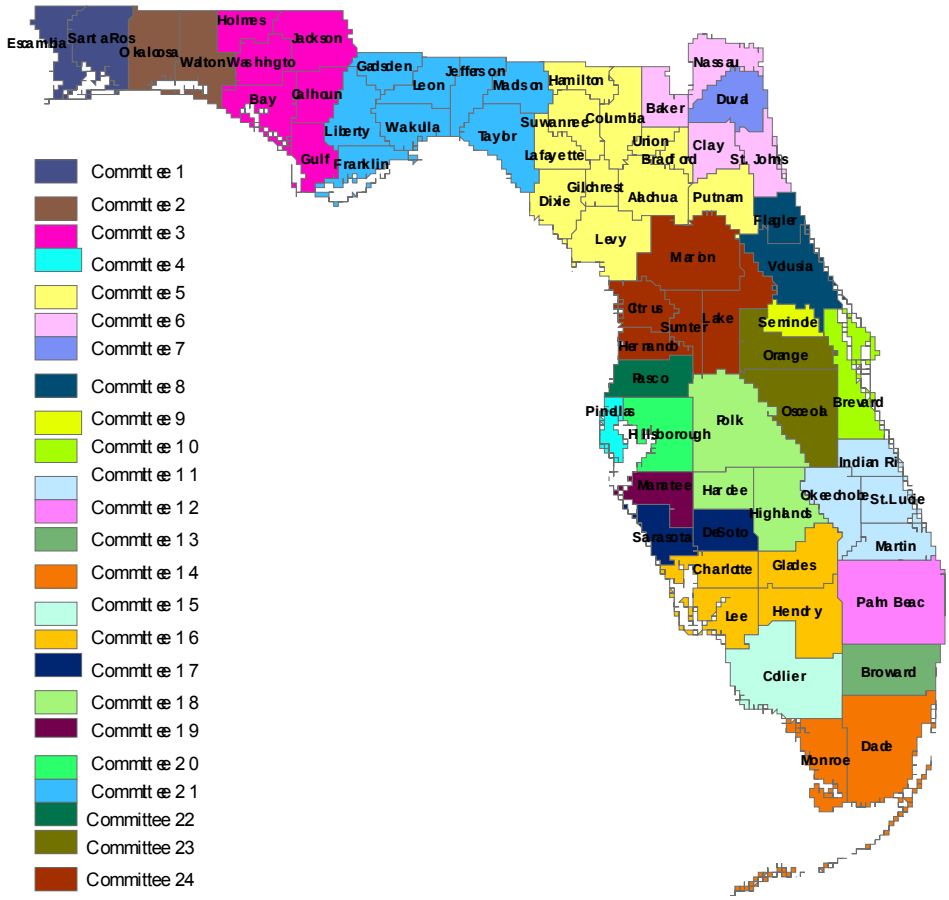
Local Child Abuse Death Review Committees



Appendix VI

American Pediatrics Policy Statement

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

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

APPENDIX VII

CPT STAFFING MEMO

FLORIDA DEPARTMENT OF HEALTH

Charlie Crist
Governor

Ana M. Viamonte Ros, M.D., M.P.H.
State Surgeon General

INTEROFFICE MEMO

DATE: September 29, 2009

TO: CPT Team Coordinators
CPT Medical Directors

FROM: Michael L. Haney Ph.D, NCC, LMHC
Division Director for Prevention and Intervention
Children's Medical Services

SUBJECT: Policy on Mandatory CPT Staffings FY 09-10

This policy provides clarification on referrals to the Child Protection Team (CPT) in which a staffing is required. The current CPT Handbook language provides guidelines for cases warranting a CPT staffing which includes but are not limited to:

- cases in which there is concern about placement and safety,
- cases in which there are legal issues needing clarification prior to dependency or criminal court
- cases in which professionals involved do not agree,
- any complex or high risk cases in which a multidisciplinary approach is needed for comprehensive case collaboration and intervention planning, and
- medically complex children.

Effectively immediately, the following cases will require a CPT staffing:

- All high risk cases
- Children who have three or more prior reports, regardless of findings, and the report meets the mandatory criteria for referral to the Child Protection Team.

Whenever possible the Child Protection Team should schedule and lead a CPT staffing; however, this is not to supersede written protocols in place between teams and their local Department of Children and Families or local Sheriff Office responsible for child protective investigations. The Child Protection Team will be responsible to ensure cases meeting the above criteria are staffed under the CPT Guidelines in the CPT Handbook.

While this may create a potential workload issue for teams, the benefit is the opportunity to continue to work together in the best interest of the children we serve.

If you have any questions or concerns, please contact me at (850)245-4217

4052 Bald Cypress Way • Tallahassee, FL 32399

Appendix VIII

Memo regarding release of Records

State of Florida
Department of Children and Families

Charlie Crist
Governor

George H. Sheldon
Secretary

DATE: September 21, 2009

TO: Regional Directors

THROUGH: Peter Digre, Assistant Secretary for Operations
David L. Fairbanks, Assistant Secretary for Programs

FROM: Alan F. Abramowitz, State Director, Office of Family Safety

SUBJECT: Release of Records to Child Abuse Death Review Committees

PURPOSE: This memo provides legal clarification regarding the release of medical information contained in child welfare records to state and local Child Abuse Death Review Committees.

BACKGROUND INFORMATION: The Region Child Death Review Coordinator has responsibility to oversee the completion of child death reviews conducted on all child deaths in which it is alleged that abuse, neglect or abandonment was or may have been a factor in the child's death and in situations where a child died while receiving ongoing services.

Chapter 383.402(8) F.S. states that "Not withstanding any other law, the chairperson of the State CADR committee or the chairperson of the local [CADR] committee, shall be provided with access to any information or records that pertain to a child whose death is being reviewed by the committee and that are necessary for the committee to carry out its duties, including information or records that pertain to the child's family as follows:"

a) Patient records in the possession of a public or private provider of medical, dental, or mental health care, including, but not limited to, a facility licensed under chapter 393, chapter 394, or chapter 395, or a health care practitioner as defined in s. 456.001.

b) Information or records of any state agency or political subdivision which might assist a committee in reviewing a child's death, including, but not limited to, information or records of the Department of Children and Family Services, the Department of Health, the Department of Education, or the Department of Juvenile Justice.

1317 Winewood Boulevard, Tallahassee, Florida 32399-0700

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

We have consulted with General Counsel's office. They reviewed the above statute and consulted with the Department's Health Insurance Portability Accountability Act (HIPAA) officers in the Civil Rights Office. This review determined that Department staff can copy and share HIPAA materials for business and operational purposes. This means staff can share these materials unredacted with state and local CADR committees so they can perform the job they are required to do under section 383.402, F.S. NOTE: Reporter information must always be redacted from the records that are provided to any CADR committee. This authority to release records also applies to reports received by the child protective investigator from the medical/health care provider and for which the parent has signed a Release of Information specifying to whom the medical information may be released.

ACTION REQUIRED: Please share this information with Child Death Review Coordinators and other applicable staff.

CONTACT INFORMATION: If further information is needed, please contact Eleese Davis, Chief or Systems Performance Management at 860-921-9857 or Selga Sakss, Statewide Death Review Coordinator, 727-527-9807 or by e-mail at Selga_Sakss@DCF.state.fl.us.

cc: Mary Ann Stiles, Interim General Counsel
John M. Jackson, Assistant General Counsel
Peggy Sanford, Deputy General Counsel
Michael L. Haney, Children's Medical Services, Florida Department of Health
Circuit Administrators
Regional Family Safety Program Administrators
Regional Death Review Coordinators

[redacted]

APPENDIX IX

DEPARTMENT OF CHILDREN AND FAMILIES

OFFICE OF INSPECTOR GENERAL

Enhancing Public Trust in Government

George H. Sheldon
Secretary

Sheryl G. Steckler
Inspector General

Project #A-0910DCF-018

December 1, 2009

Assurance Report
Evaluation of Child Death Review Process

PURPOSE AND OBJECTIVES

At the request of the Inspector General, we evaluated the control environment of the Department of Children and Families (DCF) Child Death Review process.[1]

Our **objectives** were:

- To determine if sufficient controls exist for the Death Review environment.
- To evaluate the way data related to child deaths is collected, distributed and utilized.
- To calculate how many systems contain data on child deaths.
- To determine whether there are possibilities for better coordination between DCF Death Review Coordinators **(DRC)**, the Child Abuse Death Review Committee **(CADR)** and other partners involved with child death review.
- To determine whether or not DCF is making optimal use of the information captured in DRC final reports.

METHODOLOGY

Our **methodology** included:

- Examining current death review procedures and practices.
- Interviewing DRC and CADR staff.
- Examining Death Review work products.
- Examining past recommendations regarding the Death Review process made by General Counsel staff and the CADR.
- Researching authoritative language and best practices.
- Examining child death data.

BACKGROUND

The review of a child death by the Department of Children and Families regional staff includes an evaluation of departmental, community based care or other contracted services that were provided to the child or family prior to the child's death. The review also includes monitoring the current protective investigation regarding the child death. The purpose of the internal review is to facilitate the identification of case-specific issues, systemic factors that were present at the time of the child's death and includes a written report of findings with recommendations

[1] A Child Abuse Death Review Committee (CADR) exists for the State of Florida and is administered by the Florida Department of Health. Processes for the CADR committee were not evaluated by DCF Internal Audit.

to address all critical issues identified as part of the review. The review of child deaths can be very simple (limited) or very complex (comprehensive), depending on the circumstances of an individual case. However, all child deaths covered by death review procedures must be reviewed to some extent by the region's/district's death review teams.[2]

In July 2007 the child death review function was placed within each region's Family Safety Program Office with some oversight by the Family Safety Central Program office.

In an October 2008 memo[3] to regional directors, several major goals were reported as accomplished for the Department's death review process and several new initiatives were slated to be completed for the remainder of Fiscal Year 2008-2009. One initiative listed in the memo included a goal to *"enhance and standardize the death review process, improve oversight and accountability for internal death reviews and promote communication and coordination with the local and State Child Abuse Death Review teams."* Other goals set forth in the memo were regarding data collection and meaningful trend analysis that would enhance the *"quality assurance component of child death activities."*

Based on our initial review of the death review process, we identified inconsistencies that may present barriers to Family Safety achieving its goals. Our review will recommend changes to overcome these barriers and assist DCF's death review process in becoming more focused on death prevention.

FINDINGS AND RECOMMENDATIONS

Multiple guidance exists in statute and policy for the Death Review environment; however, this guidance requires better integration and updating to avoid inconsistencies between regions.

Recent examination of current death review practices revealed numerous inconsistencies between DCF regions. Some examples include:

- The process for calculation of "prior"[4] allegations of abuse or neglect varies from region to region. One region examined "priors" history for only minors in the home while others reviewed "priors" information on all household members to include adults. Each regional DRC acknowledged keeping a separate spreadsheet regarding priors history that differed in the level of detail from the one maintained by the DCF State DRC to accommodate their needs at the regional level. Current policy[5] requires "Conducting or arranging for a Florida Abuse Hotline Information System (FAHIS) record check on all child deaths covered by this operating procedure to determine if there were any prior reports on the child or on any siblings, other children or adults in the home." But DRCs say they no longer have access to the automated "priors" history report.

- The process for distribution of final reports was not consistent. While all regional DRCs indicated a similar way of distributing final death review reports, the list of report recipients varied from region to region.

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[2] Per DCF operating procedure titled "CFOP 175-17 CHILD DEATH REVIEW PROCEDURES."

[3] A memo titled "Overview of DCF Internal Child Death Review Activities" sent by director of Office of Family Safety to regional directors on October 23, 2008.

[4] The term "priors" in this context relates to the number of calls accepted by the hotline, associated with allegations of abuse or neglect, and investigated by DCF.

[5] Extracted from CFOP 175-17 CHILD DEATH REVIEW PROCEDURES.

- The process for sharing recommendations and ideas regarding death prevention efforts is not identical from region to region. Moreover, lessons-learned are not gathered and distributed at the enterprise level. Some DRCs indicated sharing ideas and recommendations consistently with local management and others did not. One DRC indicated that the region "creates its own feedback loop."

- Interpretation of basic terminology used on child death data collection sheets also varied from coordinator to coordinator. All DRCs interviewed acknowledged a lack of consensus on what the fields on the DCF State DRC's spreadsheet meant or how the fields should be calculated. One DRC indicated that during a teleconference all regional DRCs were instructed to fix inconsistencies, but could not recall specific instructions on how to remedy the situation, nor recall being given a due date by which to do so.

- The CADR has made repeat recommendations in annual reports[6] on inconsistencies in how Child Protection Investigators (CPIs) request an appointment with a regional DRC to conduct a Death Review Staffing.[7] Regional DRCs also acknowledge inconsistencies in staffing particularly among newer staff. In addition, the Gabriel Myers Workgroup[8] also reported issues regarding the staffing process. Internal Audit has considered that the process for and frequency of staffing of local death review requires further in-depth evaluation.

- The quality of comprehensive reports varied greatly from region to region. Internal Audit's examination of a dozen final death review reports revealed that some reports included detailed narratives of events leading to the death of a child, but never answered the question "what could DCF do, if anything, to have prevented the death?" Other reports were clearer on how the activity of the Department impacted the family and did answer questions about level of agency response.

- The actual format of final death review reports varied from location to location. Some DRCs indicated that they were instructed to use a new report template in April 2009, but also admitted to not having yet done so.

- The level of interaction between regional DRCs and the DCF State DRC varied greatly from region to region. Some DRCs indicated speaking regularly with the DCF State DRC while others said the only interaction they had was while populating the child death data spreadsheet when an update was requested or during quarterly meetings.

- There is not a consensus on what data fields mean, thus data entry varies. For example, all DRCs interviewed agreed that the topic of listing all cases of drowning and co-sleeping[9] deaths as verified abuse and neglect was a "touchy subject" and admitted to handling such classification differently. In other words, the number of verified abuse and neglect cases collected by the DCF State DRC and reported to the CADR may be skewed because the term "verified" is subject to interpretation.

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[6] All reports produced by the CADR can be located at http://www.flcadr.org/. Several of the recommendations directed specifically at DCF are repeat recommendations.

[7] A meeting of professionals which at minimum include a CPI on the case, that CPI's supervisor and a regional DRC that convene to examine all relevant information in a death review. Often someone from the CADR and other experts such as medical experts or law enforcement representation join the staffing.

[8] Florida Department of Children and Families Secretary, George H. Sheldon, appointed the Gabriel Myers Work Group in April 2009 to analyze and make recommendations regarding Gabriel Myers, a 7-year-old in foster care who allegedly hanged himself on April 16, 2009 at the home of his foster parents in Margate, Florida.

[9] The term co-sleeping in this context refers to a child not sleeping alone, and most often (but not always) associated with one adult sleeping with a child or children.

Without consistency, meaningful comparisons cannot be made, benchmarking efforts geared toward identifying best practices are hindered, and prevention-oriented trend analysis will be difficult. The goal of a "standardized death review process with improved oversight and accountability for internal death reviews" is in sight, but yet to be fully realized.

Also, final assessments and recommendations should be compiled into a decision-making resource for global prevention of child death so meaningful trend analysis can be developed to enhance child safety.

We **recommend** Family Safety Central Office Management:

- Review current policy and refine guidance to provide:
  - Instruction on uniform handling of data.
  - Clear definitions of all terms used by the death review community.
  - Clear and standardized instruction on flow of information and work product distribution.
  - Clarification of death review staffing expectations and timeframes.
  - Examination of policy for outdated references and terminology, as well as ambiguous instruction.[10]
- Review operating procedures with similar titles for inconsistencies in region and Central Office level.[11]
- Clarify the DCF State Coordinator role in policy[12] to include enumerated responsibilities tied to measurable action items and deliverables.
- Expand the role of the DCF State Coordinator to include:
  - Identifying and documenting issues of inconsistency, noncompliance and training deficiencies of DRCs.
  - Taking swift action to create corrective action plans for identified deficiencies.
  - Submitting written recommendations on how to institutionalize best practices.
  - Requiring attendance at CADR meetings.
- Ensure staff receives appropriate supervision and training to understand and fulfill their functions.
- Create and maintain a plan for succession, recruitment, training and supervision practices to ensure that all staff recruited to, and working as DRCs, have sufficient experience, skills and training to appropriately assess cases.
- Design and deploy training based on identified needs related to final report writing. Consider creating an advisory regarding the completion of an "assessment and final

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[10] CFOP 175-17 for CHILD DEATH REVIEW PROCEDURES posted on the intranet is seven years old.

[11] For example, the operating procedure for INCIDENT REPORTING AND CLIENT RISK PREVENTION at the regional level (ROP 215-2) was nine pages longer and eight years more current than the operating procedure with the same title (CFOP 215-6) posted by Tallahassee headquarters on the intranet.

[12] Internal Audit is concerned that current CFOP 175-17 on CHILD DEATH REVIEW PROCEDURES is sometimes vague on what oversight is expected and thus may not elicit the level of coordination and activity expected of the DCF State DRC .

recommendations" section mandatory for each comprehensive report.

- Dedicate time and selected staff toward developing a definitions list to be incorporated into policy documents.
- If consensus cannot be obtained on terminology and other relevant items such as calculation of "priors" history, then team with Family Safety management, DCF State DRC and veteran regional DRCs to establish a decision endorsed by executive management and documented in policy.

DCF lacks a standardized system for collecting data on child deaths.

DRCs indicated they use multiple systems (spreadsheets and databases) containing child death data to do their jobs. For example, one DRC reported using two different spreadsheets, one Microsoft Access database, the web-based Incident Reporting database,[13] the FSFN database[14] and expected to add to the list the new *Child Death Review* database[15] that was put online September 16, 2009. The explanation for using multiple systems, manual and automated, varied from region to region and Internal Audit believes the reasons behind this practice should be further explored.

Staff responsible for the development of the new Child Death database and DRCs relayed to Internal Audit that the new database would not be connected to FSFN when it does go online. Internal Audit could not test the connection to FSFN because the system was not yet in use at the time of this audit, but believes this topic requires further review by General Counsel and Information Systems staff to determine if the lack of connection to FSFN violates any federal requirements.

Duplicative data entry and data tracking efforts diminish what time DRCs have to be productive every day. Redundant data entry is also a proven method for creating errors and confusion and leads to questionable data integrity.

We **recommend** Family Safety Central Office Management:

- Standardize the use of technologies in death review activities.
- Determine why child death data is collected in multiple systems by the DRCs and whether consolidation is possible.
- Evaluate if having a Child Death Review database that does not connect to FSFN is in compliance with federal requirements.
- Evaluate the Child Death Review to establish if the system:
  - Has all data fields required by DRCs.
  - Has appropriate required fields that cannot be bypassed.
  - Can produce a Limited final death review report with little manual manipulation.

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[13] The Lotus Notes Incident Reporting System is a tool for entering incidents concerning altercations, client deaths, client illnesses injuries, sexual batteries, suicide attempts, etc. as defined in DCF Operational Procedure No. 215-6.

[14] Florida Safe Families Network (FSFN) is a database that contains information on children from the time they enter the DCF system to the time they exit. It has also been referred to as the Statewide Automated Child Welfare information System (SACWIS) project.

[15] The Family Safety Program Office commissioned a database be developed starting in 2007, but the database was not online at the time this report was drafted.

- Can produce a Comprehensive final death review report with little manual manipulation.
- Can gauge timeliness of report submission.
- Can alert appropriate persons when reports are not sent timely.
- Can alert appropriate persons regarding timeliness of other death review activities such as staffing.
- Can provide meaningful trend analysis on what kills children in Florida and how their deaths can be prevented.

The process for extracting data for death review is inefficient and contributes to creating a backlog for DRCs.

Communication and coordination between the various entities involved in fatality investigations and reviews is essential to maximizing information sharing and avoiding duplication of efforts. Evaluation of departmental, community based care or other contracted services provided to the child or family prior to the child's death is a very critical component of a death review.[16] A good portion of the data needed for this communication and evaluation comes from interview notes found in FSFN.

However, DRCs revealed frustrations regarding reviewing case notes due to lack of detail or inability to interpret cryptic documentation in the notes. Some examples of issues identified by DRCs included:

- Sifting through caseworker and CPI observations that are based on emotion instead of revealing facts.
- Lack of relevant detail regarding condition of children's homes or health and well-being of the child.
- Cryptic and abbreviated entries that made interpretation difficult and sometimes even impossible.
- Some DRCs indicated that they no longer have access to a "priors report" previously available in FAHIS[17] that would shave days off their work process.
- DRCs expressed concern about being able to capture all pertinent details in cases, even when they felt their efforts exhibited due diligence, because of the free text nature of data fields in FSFN. Some DRCs say that days or even weeks of labor extracting data is added to their process.
- DRCs expressed concern over meeting deadlines when some of the delays in producing final reports were due to retrieving documents that they do not own, such as medical examinations and law enforcement reports.
- DRCs have access to many resources of data and historical knowledge. Coordinators can identify patterns in DCF activity with families that have both adverse and positive impacts on lives, but only if they spend more time evaluating data and less time struggling with extracting it.

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[16] Extracted from CFOP 175-17 CHILD DEATH REVIEW PROCEDURES.
[17] Florida Abuse Hotline Information System (FAHIS) formerly Florida Protective Services System (FPSS).

We **recommend** Family Safety Central Office Management:

- Research mandatory use of templates for investigative interviews such as the SUIDI[18] tool for deaths related to unsafe sleeping and other templates found on websites by organizations that specialize in evidence-based best practices for child death review.
- Identify barriers to the death review process created by poor case notes and inferior CPI interviews and create training and a template that will help standardize how notes and interviews are documented.
- Determine regional population cap ideals for each DRC to handle, and then determine if the current caseload for DRCs is reasonable.
- Determine the impact on the death review process of the following findings from the Gabriel Myers Workgroup:[19]
    - FSFN data are frequently incomplete and inaccurate.
    - FSFN has too many "free text" and "other" sections that complicate timely and effective use of the data system as an adequate monitoring device.

DCF could make better use of the information captured in DRC activities and final reports.

DRCs are aware of meaningful patterns. Such patterns and trends could be compiled into a comprehensive list of indicators of high risk or "red flags" that may enhance how DCF categorizes risk, segregates pertinent data, and boosts early prevention efforts by the agency. Internal Audit found evidence of workgroups at the circuit level[20] being created to identify "red flags," but believes an agency-wide approach is needed.

Here is a very short list of examples conveyed to Internal Audit of patterns coordinators felt required further examination:

- At-risk homes that also have adults with history of child abuse may need to be automatically listed as high-risk. No DRC interviewed could identify any infant death that resulted from violence that could not be attributed to any perpetrator who had not also been a victim of child abuse themselves.
- Women who are victims of domestic violence are potential child abusers, but are often overlooked as perpetrators.
- DCF may want to research the possibility of mandatory drug testing in some cases. Deaths connected in some way to substance abuse occurred in families with known substance abuse history, but potential perpetrators were not asked to take drug tests.[21]

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[18] Information on the Sudden Unexplained Infant Death Investigation (SUIDI) protocol, developed for and in conjunction with the Center for Disease Control and Prevention (CDC) can be found at http://www.cdc.gov/sids/SUIDHowtoUseForm.htm.

[19] All findings from the Gabriel Myers Workgroup described earlier in footnote 9 are posted with all information and reports regarding the Gabriel Myers case, including what was presented to the Work Group, on the DCF Web site.

[20] Circuit 15 developed "red flags" workgroup and create a checklist which can be found on the DCF intranet.

[21] Concerns regarding inconsistent drug testing were expressed by DRCs and viewed as a result of emotional investigators feeling sympathy for families hesitant to question grieving caregivers or sometimes a distrust in the quality of the urine kits used for testing for substance abuse.

- High numbers of "priors" are often found in families with "generational dysfunction" history known already to the agency, but are sometimes categorized as "low risk."

- Homes with more than two children per adult and containing an adult with impaired ability to provide care for children tend to have more problems than others. This can be further exacerbated if one or more of the children in the home also has complex needs that no caregiver in the home is trained to deal with.

- DCF showed patterns of inconsistent approaches to deploying and maintaining services in the home of high-risk families that later encountered tragedy.

- The majority of deaths on the CADR 2008 Annual Report were for children under the age of two. Many of these children were listed as low-risk based on the fact that they had little to no "priors" history. It is not typical of this age group to have "priors" history.

- Data reflects that paramours are an issue for child safety because they are frequently young males, whose mobility and ability to intimidate household members makes them difficult to track. Their existence is often denied or unconfirmed until a child dies.

We **recommend** Family Safety Central Office Management:

- Develop an agency-wide comprehensive list of "red flags" and prioritize this list; priority should be based on both severity of overall risk and response required.

- Create a vehicle (possibly web-based) for:
  - Collecting final assessments and recommendations found in death review reports for distribution across the entire agency.
  - Documenting patterns revealed in DRC reports and distribute lessons-learned globally.
- Consider returning to a more detailed maltreatment matrix[22] so DRCs can more easily clarify their findings with more detailed categorization of causes of death.

- Consider creating a different strategy for creating family safety plans for families with children under the age of two with minimal or no "priors" history.

Multidisciplinary participation from communities may contribute to improved death review recommendations, training and public education.

During an August training session,[23] DRCs, Child Protection Team staff and law enforcement staff indicated that partnering with more than just required staff for death reviews and related death review activities helped DRCs make better recommendations, led to enhanced training of CPIs and also gave DRCs a clearer understanding of events surrounding a child's death.

We **recommend** Family Safety Central Office Management:

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[22] The allegation matrix (CFOP175-28) is a tool used by the Abuse Hotline to screen calls and determine if possible abuse; neglect or abandonment has occurred and should be investigated. The maltreatment matrix is a sister matrix used by DRCs to categorize the type of abuse and maltreatment inflicted on victims. The old maltreatment matrix was more extensive and detailed. DRCs say it was easier to clarify the events surrounding a death with more granularity and choices.

[23] Training hosted by DOH in Tampa, August 19, 2009.

- Consider creating a team to explore the benefits of partnering regularly with other agency resources and community partners to create improved training for DCF staff and for creating informational advisories to communities. Some ideas offered by DRCs and others include partnerships with:
    - Florida Highway Patrol to identify trends related to traffic fatalities.
    - Florida Wildlife Commission and Florida Recreation and Parks regarding deaths resulting from recreational activities.
    - Judges on communication related to judicial review that impact outcomes of families negatively.
    - Medical specialists regarding specific medical issues such as appropriate medications, approved treatments, signs of health problems that may be indicators of abuse or neglect as well as helping staff review evidence not readily understood.
    - Emergency Medical Services (EMS) staff regarding what might be missed at EMS scenes.
    - Fire departments regarding evidence missed at fire scenes, such as substance abuse indicators.
    - Persons that aged out of the DCF system and foster parents regarding issues unique to foster care.
    - Vendors of bedding and pool supplies regarding public education.
    - School guidance counselors that can survey classes to find out new issues impacting our children.
    - Medical examiners and coroners on training about the difference terminology makes on child death review.
    - Hotels regarding educating vacationers on pool safety or suspicious behavior occurring at hotels.
    - Anyone else in our Florida communities that can offer guidance on current agency prevention methods and best practices for death review.

CONCLUSION

The collaborative and multidisciplinary nature of the death review process unites the experience and data from a wealth of resources including caseworkers, CPI's, law enforcement, Department of Health staff and others. The depth of this information affords the Department an opportunity to better understand how and why children die and to use that understanding to take swift and decisive action to prevent future deaths. As Secretary Sheldon said in his 2008 Strategic Initiative "We also have to go further. We cannot wait until a child or an adult is hurt. We need to focus on preventing harm. We need to dig into root causes and work to solve them. We need to look at root causes of bad outcomes in cases we manage. Whenever a child dies, we need to be aggressive about learning and disseminating every lesson we can to prevent another tragedy."

A DRC's final report often has information that could enhance public education and change tragic outcomes. That information should not get buried in scattered databases or in a local

memo. A death review process that does not consistently update a global list of identified risk factors to child safety and that does not regularly produce evidence-based best global practices in injury-prevention falls short of reaching Family Safety goals.

MANAGEMENT RESPONSE

In accordance with s. 20.055(5)(d), F.S., Management's response to the preliminary and tentative audit findings is included as an attachment to this report.

This audit was conducted in accordance with the *International Standards for the Professional Practice of Internal Auditing,* published by the Institute of Internal Auditors. The audit was conducted by Shandy Strivelli under the supervision of Jerry Chesnutt, Director of Auditing, (850) 488-8722.

This report is available on our website: http://www.dcf.state.fl.us/admin/io/pubs_ia.shtml

State of Florida
Department of Children and Families

Charlie Crist
Governor

George H. Sheldon
Interim Secretary

DATE: October 15, 2009

TO: Sheryl G. Steckler, Inspector General

THROUGH: Peter Digre, Assistant Secretary for Operations
David L. Fairbanks, Assistant Secretary for Programs

FROM: Alan Abramowitz, State Director, Office of Family Safety

SUBJECT: Draft Report: Evaluation of Child Death Review Process

Thank you for the opportunity to review the draft Evaluation of the Child Death Review Process. This report has identified gaps that must be addressed to ensure Florida's child death review process is meaningful. In response to the report, we are taking action to improve the process. We hope the response below is helpful as you move forward with release of the final report.

1. Issues related to statute, rule, and policy for the death review environment.

   The Family Safety Program Office is currently taking the following actions related to law, rule, and policy:

   - Revising CFOP 175-17 Child Death Review Procedures to ensure roles, responsibilities and terminology are updated, comprehensive and reflect current policy. Revisions in the operating procedure will also address the internal death review staffing process to ensure consistent application between the Child Protective Investigators and the Region Death Review Coordinator.
   - Reviewing Florida Administrative Rule 65C-30.021, as well as a review of Chapter 383.402, F.S. and revising as necessary.
   - Reviewing CFOP 215-6 Incident Reporting and Client Risk Prevention and revising as necessary. This review will include representatives from Children's Legal Services and the Office of General Counsel.

2. Issues related to training and personnel.

   - We agree with the finding related to the quality of some of the comprehensive reports. We will continue to work with the regional death review coordinators to improve the quality and consistency of reports. We currently provide training that addresses this and other issues at every quarterly death review coordinator's meeting.

- Although the Family Safety Program Office and the State Death Review Coordinator have no supervisory authority over the regional coordinators, we will begin to hold monthly conference calls with the regional death review coordinators. These calls will provide another forum to address inconsistencies, etc.
- The Family Safety Program Office will develop a training plan that addresses recruitment and training so that regional death review coordinators have the skills needed for the position.
- The position description of the State Death Review Coordinator is currently under review and will be revised to be more measurable and action oriented.
- The Family Safety Program Office and Operations will work with the regional directors to identify efficiencies that will impact the inequities in caseload sizes of death review coordinators.

3. Issues related to standardized data collection and inefficiencies of extracting data for death reviews.
   - The Child Death Review (CDR) database became operational September 16, 2009 and the regional death review coordinators have entered all death reports received as of September 1st.
   - The existing databases will continue to be used for tracking the 2009 deaths received January through August 2009. Due to the workload issues it is not practical to shift the entire 2009 calendar year of reported child deaths to the new database.
   - The web based database will be the only database in use effective September 2009. This should resolve duplication of effort and many of the data collecting problems. The State Death Review Coordinator will monitor the system for the next several months to determine where changes or enhancements are needed.
   - Regional directors will be advised through a joint memorandum issued by both the Family Safety Program Office, the Assistant Secretary for Programs and Assistant Secretary for Operations that previously developed report templates must be used.
   - The long range goal is for the death review database to interface with the Florida Safe Families Network (FSFN) and a change order will be submitted.
   - Florida Safe Families Network (FSFN) was developed with representation and input by subject matter experts in child protective investigations as well child welfare and is the Department's case file of record. We recognize that adequate documentation and results of interviews, particularly related to unexpected deaths of infants, is oftentimes lacking in depth and critical analysis. The 2008 Annual Child Abuse Death Review (CADR) Report also recommended standardized guidelines and documentation through use of the Sudden Unexplained Infant Death Investigation (SUIDI) protocol.

- We would reiterate the Department's response (to the 2008 CADR Report) of ensuring availability of training opportunities, through webcasts and other sources, to child protective investigators, child welfare and other appropriate staff. To encourage more thorough documentation, the Assistant Secretary for Operations will address these concerns during his Regional Rounds visits.

4. Issues related to data analysis and other activities that could be used for prevention activities.

- The Department has recently partnered with Hornby Zeller Associates to assist with the critical redesign of the allegation matrix. Additionally, plans are underway to convene a workgroup whose task will be to develop guidelines for investigative findings of alleged child deaths related to co-sleeping, unsafe sleep and drowning incidents. Participants in this workgroup will be representative of child protective investigations, regional death review coordinators, Children's Legal Services, Child Protection Team staff and the Department of Health State and local Child Abuse Death Review (CADR) teams. The workgroup is expected to complete their assignment to coincide with the completion, by December 31, 2009, of the Hornby Zeller Associates project.

- The new web based data system will provide the Department the opportunity to conduct better data analysis. On-going analysis will become a performance measure for the statewide death review coordinator.

- The mandatory use of the statewide Red Flag Protocol, initially put in place in 2004, was rescinded in June 2009 with the provision that Department staff shall continue to ensure that all child and parental risk and safety factors are thoroughly reviewed and considered in the process of decision-making throughout the life of the case. With the July 2007 implementation of the Florida Safe Families Network (FSFN), an automated child safety assessment with supervisory review and second party review capabilities was incorporated. The safety assessment included the risk factors identified in the Red Flag Protocol. Regions and individual circuits continue to use the Red Flag Protocol as a tool to ensure comprehensive child safety assessments.

- In 2008, the Department implemented the enhanced supervisory guidance for child protective investigators. This mentoring and modeling process guides dialogue between the investigator and the supervisor and is designed to improve staff skills, develop critical thinking and ensure risk and core safety processes are adequately addressed. Additionally, in its response to the 2008 Annual Child Abuse Death Review Report prepared by the State Child Abuse Death Review committee, the Department addressed the need to educate child protective investigation and child welfare staff on risk factors and child safety concerns related to domestic violence and substance abuse.

- Documentation and thoroughness of child protective investigations remains a concern and will be addressed by the Assistant Secretary for Operations during his Regional Rounds visits. Additionally, the Department's Quality Assurance program and regional quality assurance staff will continue to review practice through semi-annual reviews of child protective investigations units.

5. Recommendations related to multidisciplinary participation.

- We concur that engaging with community partners to address child death reviews and develop prevention initiatives is beneficial and contributes to the overall effectiveness of the Department's child death review process. To that end, the Department will encourage child protective investigations staff, child welfare staff and death review coordinators to continue building and enhancing collaborative relationships with community partners to make a positive impact on the lives of Florida's children and their families.

Again, thank you for the opportunity to review the draft report. Please contact Alan Abramowitz at (850) 566-5670, Eleese Davis at (850) 921-5897 or Pat Bedland at (850) 922-2298 if you have questions or need additional information.

Appendix X

Resolution

RESOLUTION

WHEREAS, "The Medical Examiners Act", Florida Statutes Chapter 406, created the Medical Examiners Commission by its legislative enactment in 1970; and

WHEREAS, the Medical Examiners Commission plays a vital role in support of Florida's criminal justice system, in service to the families of the deceased by determining both the cause and the manner of death, and by protecting the public health of the citizens of Florida; and

WHEREAS, the Florida Child Abuse Death Review Committee was established by Statute in 1999; and

WHEREAS, there were 166,599 reports made to the Department of Children and Families Child Abuse Hotline, of which 473 involved child deaths; and

WHEREAS, the Florida Child Abuse Death Review Committee was only able to investigate 166 verified abuse related child deaths due to statutory constraints; and

WHEREAS, the Florida Child Abuse Death Review Committee develops data-based recommendations to prevent child abuse related deaths, encourages community solutions to preventing future deaths, and makes statutory or statewide recommendations for the prevention of child deaths;

NOW THEREFORE, be it resolved that the Medical Examiners Commission, on behalf of the Florida Department of Law Enforcement, Florida's medical-legal community, and the citizens of our State, supports expanding the role of the Florida Child Abuse Death Review Committee to include reviewing all child deaths related to abuse cases called into the Department of Children and Families Child Abuse Hotline.

PASSED AND RECORDED, in the official minutes of the Medical Examiners Commission meeting on this Wednesday, the 12th day of August, 2009, in Sarasota, Sarasota County, Florida.

Medical Examiners Commission Chairman
Bruce A. Hyma, M.D., *District 11 Medical Examiner*

Russell S. Vega, M.D., District 12 Medical Examiner

Robert J. Krauss, J.D., *Bureau Chief, Asst. Atty. General*

Hon. Grady C. Judd, Jr., *Sheriff, Polk County*

Jun C Thomas, *Licensed Funeral Director*

Ken Jones, *Deputy State Registrar, Dept. of Health*

Hon. James S. Purdy, *Public Defender, 7th Circuit*

Appendix XI

Letter

FLORIDA CHILD ABUSE
DEATH REVIEW COMMITTEE

April 6, 2009

Ms. Electra Theodorides-Bustle
Executive Director
Department of Highway Safety and Motor Vehicles
2900 Apalachee Parkway, MS 01
Tallahassee, FL 32399

Dear Ms. Theodorides- Bustle:

Thank you for the immediate action you took to address the issue of mandatory training on reporting child abuse/neglect pertaining to vehicle related injuries, death or neglect of children. Also, we would like to recognize the outstanding work of Lieutenant Kristina D. Quenneville, Troop Training Coordinator with Troop C – Headquarters. She coordinated and scheduled the training with our Committee members to ensure that every Trooper in her area was able to attend. Her commitment, diligence and efforts to assist our Committee are notable and deserving of recognition.

Our primary goal of the State Committee is to reduce preventable child abuse deaths in Florida. We believe it is critical for communities and agencies to unite and work together to educate the public on important children's issues, including traffic related incidents that could be preventable. We have already seen an improvement of reporting of these incidents to the Florida Abuse Hotline and we commend your efforts for making that possible.

Thank you for increasing awareness and taking action to help prevent needless deaths of children. The State Committee offers a special thanks to Lieutenant Quenneville for going the extra mile to help us get the message out. Keep up the outstanding work and accept our heartfelt thanks for all that you do.

Sincerely,

Connie Shingledecker
Chairperson
State Child Abuse Death Review Coordinator

4052 Bald Cypress Way • BIN A06 • Tallahassee, FL 32399-1700

Appendix XII

State of Florida
Department of Children and Families

Charlie Crist
Governor

George H. Sheldon
Secretary

June 10, 2009

Dr. Haney -
Thanks for your support.

RECEIVED JUN 11 2009

Michael L. Haney, Ph.D., N.C.C., L.M.H.C.
Child Abuse Death Review Coordinator
Division Director
Prevention and Interventions
Children's Medical Services
4052 Bald Cypress Way, BIN A06
Tallahassee, FL 32399

Dear Dr. Haney:

I wish to designate the state Child Abuse Death Review Committee (CADR) as one of Florida's citizen review panels, in support of the requirements of the Child Abuse Prevention and Treatment Act (CAPTA). By so designating Child Abuse Death Review Committee, we are in part providing national recognition of the important role the Committee plays in shaping Florida's system. The structure and functions of the state CADR are truly reflective of the national intent to have citizen input and review of child welfare as required by CAPTA.

In brief, CAPTA requires states to establish citizen review panels. These panels must be a diverse group of volunteers with knowledge of the child protection system. Panels evaluate the extent to which the state child protection agency is effectively discharging child protection responsibilities, provide for public outreach, and make recommendations on improving the child protection system. Each panel must prepare an annual report, such as the Committee already does. I am confident that the state CADR will be an effective CAPTA designee.

I look forward to continued collaboration, and as always appreciate your commitment and effort. Feel free to contact me or Sallie Bond, Supervisor of Interagency Management, at (850) 922-0419, or through electronic mail at Sallie_Bond@dcf.state.fl.us.

Sincerely,

Alan F. Abramowitz
State Director,
Office of Family Safety

cc: Connie Shingledecker, Chairperson, State Child Abuse Death Review Committee

Appendix XIII

AMERICAN ACADEMY OF PEDIATRICS

Committee on Injury and Poison Prevention

All-Terrain Vehicle Injury Prevention: Two-, Three-, and Four-Wheeled Unlicensed Motor Vehicles

ABSTRACT. Since 1987, the American Academy of Pediatrics (AAP) has had a policy about the use of motorized cycles and all-terrain vehicles (ATVs) by children. The purpose of this policy statement is to update and strengthen previous policy. This statement describes the various kinds of motorized cycles and ATVs and outlines the epidemiologic characteristics of deaths and injuries related to their use by children in light of the 1987 consent decrees entered into by the US Consumer Product Safety Commission and the manufacturers of ATVs. Recommendations are made for public, patient, and parent education by pediatricians; equipment modifications; the use of safety equipment; and the development and improvement of safer off-road trails and responsive emergency medical systems. In addition, the AAP strengthens its recommendation for passage of legislation in all states prohibiting the use of 2- and 4-wheeled off-road vehicles by children younger than 16 years, as well as a ban on the sale of new and used 3-wheeled ATVs, with a recall of all used 3-wheeled ATVs.

ABBREVIATIONS. CPSC, US Consumer Product Safety Commission; ATV, all-terrain vehicle; AAP, American Academy of Pediatrics.

TWO-WHEELED VEHICLES

Miniature motorcycles intended for off-road use by children and adolescents have enjoyed wide popularity since the 1960s. However, manufacture of these vehicles is not regulated by federal motor vehicle safety standards. Neither the rider nor the vehicle is required to be licensed. Some of these cycles are small enough to be operated by children as young as 4 years, and many have been sold for use by school-aged children.[1]

Minibikes, the smallest and most primitive of the 2-wheelers, are motorized bicycle-style frames that weigh <45 kg and are powered by engines operating at <4 horsepower. The more sophisticated and higher-powered *minicycles* are constructed with suspension systems and transmissions that resemble miniature motorcycles. *Trailbikes* or *trailcycles* are larger than minicycles and have power and design characteristics that make them suitable for rough terrain. They are generally only approved for off-road use. *Mopeds* are bicycles with small, unenclosed assist motors and top speeds of about 30 mph. They are intended for street use but, in many states, neither the mopeds nor their drivers must be licensed.[2] Two-wheeled vehicles generally have a short and relatively unstable wheelbase, small tires, slow acceleration, borderline brakes, and poor visibility in traffic (both of the cycle and by the cycle operator).[2,3] *Motorcycles* are also 2-wheeled cycles, but require licenses in all states; these vehicles are not specifically discussed in this statement.

About 40 000 injuries related to 2-wheeled motorized off-road cycles were treated in emergency departments each year, 1994 through 1996.[4] Of the injuries, 26% were sustained by children younger than 15 years. From 1990 through the first quarter of 1995, the US Consumer Product Safety Commission (CPSC) collected at least 50 reports of deaths related to minibike and trailcycle use. All but 1 of the victims were male, and 42% were 16 years of age or younger.[5]

Injury typically results from loss of control of the cycle after striking rocks, bumps, or holes, or from illegal on-road use. Mopeds are more often involved in collisions with other vehicles, presumably because they are legally used on-road, and frequently in urban areas.[2] Shoulder, knee, and leg injuries account for more than one third of emergency department visits for moped-related injuries. Head injuries account for about half of the deaths.[5] Laryngotracheal trauma may result from driving across open fields into poorly visible wire fences. Thermal burns occur when engines are not enclosed, which is usual for mopeds.[6] Deaths are more likely to be associated with racing or jumping.[5]

THREE- AND FOUR-WHEELED VEHICLES

All-terrain vehicles (ATVs) are motorized cycles, with 3 or 4 balloon-style tires, designed for off-road use on a variety of terrains. Although ATVs give the appearance of stability, the 3-wheeled design is especially unstable on hard surfaces. The ATV stability is further compromised by a high center of gravity, a poor or absent suspension system, and no rear-wheel differential. The danger is magnified because these vehicles can attain substantial speeds (30–50 mph).[7]

Most injuries associated with ATVs occur when the driver loses control, the vehicle rolls over, the driver or passenger is thrown off, or there is a collision with a fixed object.[8] Studies in Alaska and Missouri have identified a number of risk factors for injury, including rider inexperience, intoxication with alcohol, excessive speed, and lack of helmet use.[9,10] The recognition of the significant hazards associated with ATV use led to a federal investigation

PEDIATRICS (ISSN 0031 4005).

and the acceptance of consent decrees by the ATV manufacturers in early 1988.[11] Under the decrees, the industry agreed to cease production and sale of new 3-wheeled ATVs (but not to recall old ones), to implement a rider-safety training program nationally, and to develop a voluntary standard to make ATVs safer. Warnings and age recommendations were included on the vehicle and in advertising. ATVs with engines >70 mL could be used only by children 12 years and older; "adult-sized" engines (those >90 mL) were not to be used by children or adolescents under 16 years.[11] Although the decrees did not prohibit the sale of the ATVs with engines <70 mL, which previously had been promoted for children younger than 12 years, none have been manufactured since 1986. After acceptance of the decrees, problems have occurred with some dealers not communicating the age restrictions to consumers, although pressure and enforcement by the CPSC have improved the situation. Nevertheless, children under 12 years still represent 15% of the deaths related to ATVs.[12-14] It is probable that the most effective outcome of the 1988 consent decrees was the attendant publicity that led up to the decrees and the educational campaigns that occurred after them. The consent decrees expired in 1998. At that time, participating manufacturers agreed to an ATV Action Plan in which they agreed not to market or sell 3-wheeled ATVs, not market or sell adult-size ATVs to or for use by children younger than 16, promote training, and conduct safety education campaigns.[15]

The approximately 2.4 million ATVs still in use are associated with significant morbidity and mortality. Almost 2800 deaths have been attributed to ATVs (about 200 to 300 annually) since 1985.[14] The risk of death, approximately .8 to 1.0 per 10 000 ATVs, has remained fairly steady since 1987. Annual emergency department visits for treatment of ATV-related injuries reached a peak of 108 000 in 1986 and declined after that to the present level of about 54 500.[14] Children younger than 16 years account for 47% of the injuries in 1997 and >36% of the deaths since 1985.[15] Head injuries account for most of the deaths, which usually are instantaneous.[12] Serious nonfatal injuries include head and spinal trauma, abdominal injuries, and multiple trauma.[4] Abrasions, lacerations, and clavicle and extremity fractures are common and less serious.[4,13] Some studies have suggested that children suffer more severe injuries. The severity of injury is the same for 3- and 4-wheeled ATVs.[10,13,16] Currently, 4-wheeled vehicles account for 75% of the injuries, largely because of changes in the manufacture and sales of 3-wheeled ATVs after the 1988 consent decree, although many 3-wheeled ATVs remain in use. More injuries occur when ATVs are used for recreation than when they are used for nonrecreational purposes, for example, as farm vehicles.[4]

It is clear that deaths and injuries began to decline in 1986, possibly as an effect of the publicity before the consent decrees on the driving behavior of ATV users. A decline in sales, as well as diminished use by children, occurred after the decrees, but well before the ban on 3-wheelers and design changes to make "safer" vehicles could have had a great effect.

RECOMMENDATIONS

The American Academy of Pediatrics (AAP) now updates its earlier recommendations[10,17] to decrease death and injury related to the use of all 2-, 3-, and 4-wheeled ATVs:

1. Education, public and individual patient and parent, about the hazards of all ATVs should continue. (Besides benefiting the riders, it may increase public demand for greater regulation; eg, helmet laws and limitation on use by children.)
2. During anticipatory guidance, families should be asked, either by direct questioning or intake survey, about the kinds of recreational activities in which they engage. Just as those who have a swimming pool merit special counseling, so do families who engage in off-road vehicle use. The following points should be emphasized:
   - Off-road vehicles are particularly dangerous for children younger than 16 years who may have immature judgment and motor skills.[10] Children who are not licensed to drive a car should not be allowed to operate off-road vehicles.
   - Injuries frequently occur to passengers, therefore riding double should not be permitted.
   - All riders should wear helmets, eye protection, and protective reflective clothing. Appropriate helmets are those designed for motorcycle (not bicycle) use, and should include safety visors/face shields for eye protection.
   - Parents should never permit the street use of off-road vehicles, and nighttime riding should not be allowed.
   - Flags, reflectors, and lights should be used to make vehicles more visible.
   - Drivers of recreational vehicles should not drive after drinking alcohol. Parents should set an example for their children in this regard.
   - Young drivers should be discouraged from on-road riding of any 2-wheeled motorized cycle, even when they are able to be licensed to do so, because they are inherently more dangerous than passenger cars.
3. Although the consent decrees required some equipment modifications to make ATVs safer, further changes have been suggested. They include the following:
   - Install seat belts on 4-wheeled ATVs and require that the vehicles also have a roll bar to prevent the driver from being crushed by the weight of the vehicle in the event of a rollover.
   - Headlights that automatically turn on when the engine is started should be routinely installed on all ATVs to improve visibility by other vehicles.
   - Speed governors (devices that limit maximum speed) should be installed on ATVs used by inexperienced operators.
   - Efforts should be made to design ATVs so that they cannot carry passengers.
   - Engine covers on small 2-wheeled vehicles, such as mopeds and minibikes, could reduce

burn injuries resulting from body contact with the engine and exhaust system. A sturdy leg guard could avoid injuries from sideswiping solid objects or being pinned to the ground.

All of these proposed modifications should be thoroughly evaluated before use and monitored after introduction.

4. Laws should be passed in all states requiring motorcycle-style helmets for off-road use as well as for on-road use. Motorcycle helmet laws have been proven to increase helmet use, and helmet use has been proven to reduce death and serious head injuries.[16,18]
5. Many injuries are caused by various disruptions in the driving surface such as, bumps and holes. Developing and maintaining trails for the use of off-road vehicles may help reduce injury rates.
6. Prehospital care networks and emergency services should be improved in rural areas, which may minimize the effects of injuries and reduce deaths.[11]
7. The AAP recommends a ban on the sale of all 3-wheeled ATVs, new and used, and a recall with a refund for present owners of the 3-wheeled models.
8. Laws should prohibit the use of ATVs, on- or off-road, by children and adolescents younger than 16 years. An automobile driver's license, and preferably some additional certification in ATV use, should be required to operate an ATV. The safe use of ATVs requires the same or greater skill, judgment, and experience as needed to operate an automobile.
9. ATVs should not be used after sunset or before sunrise, and carrying passengers should not be allowed. These provisions should be included in legislation.
10. Pediatricians should advocate for the passage of the AAP's model bill[19] that:
    - prohibits the use of ATVs, on- or off-road, by children and adolescents younger than 16 years;
    - requires an automobile drivers' license, and preferably some additional certification in ATV use;
    - prohibits the use of ATVs on public streets and highways;
    - prohibits passengers from riding on ATVs;
    - prohibits operating an ATV under the influence of alcohol; and
    - prohibits the use of ATVs between sundown and sunrise.

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DEFINITIONS

❖ Cases that meet the criteria for review

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

Verified= When a preponderance of the creditable evidence results in a determination that the specific injury, harm, or threatened harm was the result of abuse or neglect.

Some Indication= When there is credible evidence, which does not meet the standard of being a preponderance, to support that the specific injury, harm, or threatened harm was the result of abuse or neglect. (Pat will look at)

❖ Cause of Death

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

❖ Manner of Death

This is one of the five general categories (Accident, Homicide, Suicide, Undetermined and Natural) that are found on the death certificate.

❖ Preventable death.

Based on the information provided, the Committee shall determine whether the child's death was preventable.

Definitely preventable: The information provided demonstrates clearly that steps or actions could have been taken that would have prevented the death from occurring.

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

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

Not Preventable: No current amount of medical, educational, social or technological resources could prevent the death from occurring.

❖ Physical Abuse

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…"

❖ Neglect

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"

❖ Harm

F.S.39.01

(31) "Harm" to a child's health or welfare can occur when any person:

(a) Inflicts or allows to be inflicted upon the child physical, mental, or emotional injury. In determining whether harm has occurred, the following factors must be considered in evaluating any physical, mental, or emotional injury to a child: the age of the child; any prior history of injuries to the child; the location of the injury on the body of the child; the multiplicity of the injury; and the type of trauma inflicted. Such injury includes, but is not limited to:

1. Willful acts that produce the following specific injuries:

a. Sprains, dislocations, or cartilage damage.

b. Bone or skull fractures.

c. Brain or spinal cord damage.

d. Intracranial hemorrhage or injury to other internal organs.

e. Asphyxiation, suffocation, or drowning.

f. Injury resulting from the use of a deadly weapon.

g. Burns or scalding.

h. Cuts, lacerations, punctures, or bites.

i. Permanent or temporary disfigurement.

j. Permanent or temporary loss or impairment of a body part or function.

As used in this subparagraph, the term "willful" refers to the intent to perform an action, not to the intent to achieve a result or to cause an injury.

2. Purposely giving a child poison, alcohol, drugs, or other substances that substantially affect the child's behavior, motor coordination, or judgment or that results in sickness or internal injury. For the purposes of this subparagraph, the term "drugs" means prescription drugs not prescribed for the child or not administered as prescribed, and controlled substances as outlined in Schedule I or Schedule II of s. 893.03.

3. Leaving a child without adult supervision or arrangement appropriate for the child's age or mental or physical condition, so that the child is unable to care for the child's own needs or another's basic needs or is unable to exercise good judgment in responding to any kind of physical or emotional crisis.

4. Inappropriate or excessively harsh disciplinary action that is likely to result in physical injury, mental injury as defined in this section, or emotional injury. The significance of any injury must be evaluated in light of the following factors: the age of the child; any prior history of injuries to the child; the location of the injury on the body of the child; the multiplicity of the injury; and the type of trauma inflicted. Corporal discipline may be considered excessive or abusive when it results in any of the following or other similar injuries:

a. Sprains, dislocations, or cartilage damage.

b. Bone or skull fractures.

c. Brain or spinal cord damage.

d. Intracranial hemorrhage or injury to other internal organs.

e. Asphyxiation, suffocation, or drowning.

f. Injury resulting from the use of a deadly weapon.

g. Burns or scalding.

h. Cuts, lacerations, punctures, or bites.

i. Permanent or temporary disfigurement.

j. Permanent or temporary loss or impairment of a body part or function.

k. Significant bruises or welts.

(a) Commits, or allows to be committed, sexual battery, as defined in chapter 794, or lewd or lascivious acts, as defined in chapter 800, against the child.
(b) Allows, encourages, or forces the sexual exploitation of a child, which includes allowing, encouraging, or forcing a child to:

1. Solicit for or engage in prostitution; or

2. Engage in a sexual performance, as defined by chapter 827.

(c) Exploits a child, or allows a child to be exploited, as provided in s. 450.151.

(d) Abandons the child. Within the context of the definition of "harm," the term "abandons the child" means that the parent or legal custodian of a child or, in the absence of a parent or legal custodian, the person responsible for the child's welfare, while being able, makes no provision for the child's support and makes no effort to communicate with the child, which situation is sufficient to evince a willful rejection of parental obligation. If the efforts of the parent or legal custodian or person primarily responsible for the child's welfare to support and communicate with the child are only marginal efforts that do not evince a settled purpose to assume all parental duties, the child may be determined to have been abandoned. The term "abandoned" does not include an abandoned newborn infant as described in s. 383.50.

(e) Neglects the child. Within the context of the definition of "harm," the term "neglects the child" means that the parent or other person responsible for the child's welfare fails to supply the child with adequate food, clothing, shelter, or health care, although financially able to do so or although offered financial or other means to do so. However, a parent or legal custodian who, by reason of the legitimate practice of religious beliefs, does not provide specified medical treatment for a child may not be considered abusive or neglectful for that reason alone, but such an exception does not:

1. Eliminate the requirement that such a case be reported to the department;

2. Prevent the department from investigating such a case; or

3. Preclude a court from ordering, when the health of the child requires it, the provision of medical services by a physician, as defined in this section, or treatment by a duly accredited practitioner who relies solely on spiritual means for healing in accordance with the tenets and practices of a well-recognized church or religious organization.

(f) Exposes a child to a controlled substance or alcohol. Exposure to a controlled substance or alcohol is established by:

1. Use by the mother of a controlled substance or alcohol during pregnancy when the child, at birth, is demonstrably adversely affected by such usage; or

2. Continued chronic and severe use of a controlled substance or alcohol by a parent when the child is demonstrably adversely affected by such usage.

As used in this paragraph, the term "controlled substance" means prescription drugs not prescribed for the parent or not administered as prescribed and controlled substances as outlined in Schedule I or Schedule II of s. 893.03.

(g) Uses mechanical devices, unreasonable restraints, or extended periods of isolation to control a child.

(h) Engages in violent behavior that demonstrates a wanton disregard for the presence of a child and could reasonably result in serious injury to the child.

(i) Negligently fails to protect a child in his or her care from inflicted physical, mental, or sexual injury caused by the acts of another.

(j) Has allowed a child's sibling to die as a result of abuse, abandonment, or neglect.

(k) Makes the child unavailable for the purpose of impeding or avoiding a protective investigation unless the court determines that the parent, legal custodian, or caregiver was fleeing from a situation involving domestic violence.

❖ System

The organization of agencies, associations and other entities that is responsible for the oversight and implementation of services, resources and laws designed to protect children who are reported to the Florida Abuse Hotline System. (Judiciary, Law Enforcement, etc.)

❖ Caregiver

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

Adequate Supervision

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

Sudden Infant Death

"the sudden death of an infant under one year of age which remains unexplained after a thorough case investigation including performance of a complete autopsy, examination of the death scene, and review of the clinical history. By definition SIDS can be diagnosed ONLY after a thorough examination of the death scene, a review of the clinical history, and performance of an autopsy fail to find an explanation for the death.

A SIDS diagnosis should NOT be assigned if the infant was found in the prone position and/or sleeping in an unsafe sleep environment.

Sudden Unexplained Infant Death

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

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Representing: Law Enforcement

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