DEATH REVIEW

ANNUAL REPORT
December 2011

This Annual Report is dedicated to the memory
of all the children who lost their lives due to abuse or neglect
in our state in 2010.
The information contained herein can be used
to help prevent any future harm
to our most vulnerable citizens.

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FLORIDA CHILD ABUSE DEATH REVIEW COMMITTEE

ANNUAL REPORT

DECEMBER 2011

Mission

"To Reduce Preventable Child Abuse and Neglect Deaths"

Submitted to:

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

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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.

EXECUTIVE SUMMARY

The Florida Child Abuse Death Review Committee, an independent committee, hereinafter referred to as the State Committee, was established by statute in s. *383.402 (1), F. S*., in 1999. It is the mandated responsibility of the State Committee, administered by the Florida Department of Health's Children's Medical Services (CMS) , to review cases of the children who died as a result of verified findings of child maltreatment. Additionally, the State Committee is required to submit an annual Child Abuse Death Review Report. The first report was submitted in September 2000 and annual reports have been submitted each year to the Governor and Legislature that included recommendations for changes in law, rules and policies that support the safe and healthy development of children and reduce preventable child abuse deaths. Some of these past recommendations have been implemented resulting in improvements in policy and practice, other recommendations remain but have not yet been implemented and some recommendations have been added as a result of this year's reviews. This 2011 Child Abuse Death Review Report, which represents the 12th annual report submitted to the Governor and Legislature, includes information on the 136 cases reviewed by the Committee this year. Annual and trend data is presented that examines how these children died, factors that contributed to the death caused by their caretakers and data-driven recommendations for preventing future child abuse and neglect deaths.

Sadly, 2,282 children under the age of 18 lost their lives in Florida during 2010. Of these, 1,306 were males, 973 were females and three were unknown. Of those children who died, 507 were reported to the Florida Abuse Hotline. There are cases that were called to the hotline in 2010 in which the death occurred in previous years. Of the child deaths reported to the hotline, and died in 2010, 155 were verified as child abuse or neglect. The State Committee received 136 during the review period (January – November 14, 2011). The cases verified and submitted to the Committee after the review period will be reviewed in 2012. The State Committee reviewed an additional eleven child deaths that occurred in the previous years, bringing the total number of child deaths reviewed by the State Committee to 147. Out of the 136 death cases of children who died in 2010 reviewed:

- 51 (37.5%) were from abuse
- 85 (62.5%) were neglect

Key Recommendations:

Continue and Enhance Statewide Public Awareness and Education Efforts - There is a need to continue and enhance researched-based statewide public awareness campaigns to educate the public on strategies and actions that work to prevent child abuse and neglect and child deaths from occurring.

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

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

- Phase II - expand the State's child abuse death review process to include the review of all child deaths.

Amend the statutory due date of the State Committee's annual report to March 31st – Amending the statute will allow the State Committee additional time to review reports closed during November and December and to conduct a more thorough review of the deaths.

Invest in Successful Prevention Programs to Prevent Child Abuse and Neglect - The 2012 Florida Legislature should maintain the 2011-12 funding level for Healthy Families Florida and other successful prevention programs that improve the health, safety and well-being of Florida's children to avoid the costly short-term and long-term consequences of child abuse and neglect.

There will be additional recommendations included this report that are more specific to the types of maltreatment deaths reviewed in 2011.

Purpose and History of the State Child Abuse Death Review Committee

The Florida Child Abuse Death Review Committee, an independent committee hereinafter referred to as the State Committee, was established by statute in s. *383.402 (1), F. S.*, in 1999. It is the mandated responsibility of the State Committee, administered by the Florida Department of Health's CMS, to review cases of the children who died as a result of verified findings of child maltreatment. Additionally, the State Committee is required to submit an annual Child Abuse Death Review Report. The first report was submitted in September 2000, and annual reports have been submitted each year to the Governor and Legislature that included recommendations for changes in law, rules and policies that support the safe and healthy development of children and reduce preventable child abuse deaths. Some of these past recommendations have been implemented resulting in improvements in policy and practice, other recommendations remain but have not yet been implemented and some recommendations have been added as a result of this year's reviews. There were 155 child deaths verified due to child abuse or neglect in 2010. This 2011 Child Abuse Death Review Report, which represents the 12th annual report submitted to the Governor and Legislature, includes information on the 136 cases reviewed by the Committee this year. Data is presented in this report that examines how these children died, factors that contributed to the death caused by their caretakers and data-driven recommendations for preventing future child abuse and neglect deaths.

A thorough review of child deaths allows the State Committee to:

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

Membership of the State Committee

The State Child Abuse Death Review Committee is composed of seven representatives of the following Florida 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

The representative of the Florida DOH, appointed by the State Surgeon General, also serves as the State Committee Coordinator.

The State Surgeon General is responsible for appointing an additional eleven members based on recommendations from the DOH and affiliated agencies and for ensuring that the Committee represents to the greatest possible extent, the regional, gender and ethnic diversity of the state:

- A board certified pediatrician
- A public health nurse
- A mental health professional who treats children or adolescents
- An employee of the Department of Children and 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 advocacy organization
- A social worker who has experience in working with victims and caretakers 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

Members of the State Child Abuse Death Review Committee are appointed for staggered two-year terms, and all are eligible for reappointment.

The names of the current members of the State Child Abuse Death Review Committee are in Appendix I.

STATE COMMITTEE ACCOMPLISHMENTS

- In the 2010 Annual Report, the State Committee identified unsafe sleep-related infant deaths as a priority issue. The recommendation was made by the State Committee that improvements in the investigation of child deaths and heightened public awareness and education should be implemented with the goal of preventing future infant suffocation deaths related to unsafe sleeping conditions. In 2011, the Florida Medical Examiners Commission (MEC) drafted changes to the sections pertaining to infant death investigation in Florida Administrative Code 11G, which governs the activities of Florida medical examiners. These changes, which were authored in collaboration with members of State Committee, reflect amendments to the Practice Guidelines for Florida Medical Examiners that were adopted in 2010 by the Florida Association of Medical Examiners (F.A.M.E.) and are designed to strengthen infant death investigations throughout the state. The Governor's Cabinet approved the MEC's request for rule promulgation on November 15, 2011.

- The State Committee has long recognized the difficulties inherent in elucidating the incidence, demographics and risk factors associated with unsafe sleep-related infant deaths in Florida. In 2010, members of the State Committee collaborated with the Florida DOH in a study supported by an MEC resolution to evaluate Florida death certificate terminology and coding pertaining to sudden unexpected infant deaths. All of Florida's medical examiner districts participated in providing data for this study, the results of which are currently being prepared for publication.

- In response to the recognized need to better evaluate the causative factors associated with sudden unexpected infant deaths in Florida, the MEC Annual Reports and Standards of Excellence Advisory Committee proposed changes to the Annual Workload Report that is prepared by each of Florida's medical examiner districts. The proposed changes will expand the classification of sudden unexpected infant deaths from simply Sudden Infant Death Syndrome (SIDS) to include infant suffocation deaths resulting from unsafe sleeping environments and bed-sharing. These changes, which were adopted at the November 17, 2011 meeting of the MEC and are supported by the State Committee, will facilitate the collection of data that will enable the State Committee to make data-driven recommendations for safe infant sleeping, with the goal of preventing unsafe sleep-related infant deaths in Florida.

- In collaboration with members of F.A.M.E, members of the State Committee have drafted a proposal for amendment of the Florida Statute that addresses infant deaths *(s. 383.3362, F.S., Sudden Infant Death Syndrome).* The proposed changes will broaden the depth of the statute, which currently only mentions SIDS, to include all sudden unexpected infant deaths (SUID). The goal is to foster training and education that will lead to improvements in the investigation of infant deaths in Florida and heightened public awareness, both of which are essential for the prevention of infant suffocation deaths related to unsafe sleeping conditions. These proposed changes, which are being sponsored by Senator Larcenia Bullard (Miami) as Senate Bill 322 and State

Representative Geraldine Thompson (Orlando) as House Bill 433, will be considered during the 2012 legislative session.

- The 2011 Florida Legislature maintained level funding for Healthy Families Florida at $18,114,329, recognizing the value of the program in preventing child abuse and neglect.

- Healthy Families continues to achieve positive outcomes. Ninety-eight percent of the children in the high risk families served by Healthy Families Florida are free from abuse and neglect. The program also improves family self-sufficiency, which promotes family stability. Seventy-three percent of participants that are unemployed at enrollment are employed when they leave the program.

- The Child Abuse Death Review Committee's 2010 findings show that a significant portion of verified child abuse and neglect cases result from interaction with other adults living in the home, most often a significant other of the participant that is not directly related to the child. Healthy Families Florida, in collaboration with the Child Abuse Death Review Committee and Florida Kiwanis developed and distributed an informative brochure entitled, "Who's Watching Your Child?" (Appendix II). The brochure encourages parents/caregivers to think carefully about whom they leave their child with and provides a safety checklist of items to cover with a caregiver prior to leaving the child in the caregiver's care.

- The Child Abuse Death Review Committee's findings show that the presence of domestic violence is a contributing risk factor in 34 percent of 174 perpetrator/caretakers responsible for the child death cases reviewed. The Florida Coalition Against Domestic Violence (FCADV) is partnering with Healthy Families Florida to develop, implement and evaluate a curriculum designed to prevent intimate partner violence. The curriculum will be used by Healthy Families home visitors to work with families to increase their knowledge and understanding of healthy relationships and empower them to make healthy decisions for themselves and their children.

- The Child Abuse Death Review Committee's findings show the presence of substance abuse in 64% of the 174 perpetrator/caretakers responsible for the child death cases reviewed. With guidance from the State Committee, Healthy Families revised the substance abuse training provided to the home visitors to incorporate the most recent research on this challenging issue which includes: updated statistics, neurobiology of addiction, the unique challenges of prescription drug abuse/dependence in Florida and the use of motivational interviewing to address substance abuse issues with the families served by the program.

- Enhancing education efforts on the prevention of child abuse and neglect continues to be a priority for the State Committee. Prevent Child Abuse Florida (PCA Florida), in partnership with the Department of Children and Families (DCF), provided agencies with a Community Resource Packet that contains an Advocate Resource Booklet, a Parent Resource Booklet and a poster promoting the toll-free Florida Parent Helpline: 1-800-FLA-LOVE. PCA Florida distributed a total of 22,854 Community Resource Packets in English and Spanish; and a total of 95,974 Parent Resource Booklets in English, Spanish and Creole throughout the state of Florida.

- The State Committee's findings show that unsafe sleep and drowning continue to be the most prevalent causes of child neglect fatalities among Florida's children under the age of five. PCA Florida, with funding provided from the DCF, disseminated 73,338 Safe Infant Sleep materials, brochures and tips sheets, and a total of 52,035 drowning prevention materials in English, Spanish and Creole were disseminated to corporate agencies and non-profit organizations throughout Florida.

- The State Committee participated in a joint meeting with the Florida Attorney General Statewide Domestic Violence Fatality Review Team. Both committees saw the need to make linkages between domestic violence and child death reviews. There was a wealth of information shared on how the two entities can utilize the recommendations and issues identified in case reviews to make supporting recommendations in our annual reports. There was a commitment by both to establish this as an annual meeting. The State Committee Chair, Co-chair and Medical Examiner were included as members of the Statewide Domestic Violence Fatality Review Team.

- The Florida's Children and Youth Cabinet established a Child Death Data Review Workgroup as an ad hoc committee and members from the State Committee have been included to assist in improving communication and collaboration across agencies regarding the investigation of child deaths and to recommend ways to improve the response to the investigation of deaths.

- Healthy Start has identified in their Child Abuse Prevention and Permanency Plan Implementation Report the importance of linking the local Fetal Infant Mortality Review committees with both the state and local committees and has identified individuals to participate in the reviews. This will be instrumental in the messaging and infusion of the Five Protective Factors into working with parents regarding mutual strategies to reduce child deaths.

- The State Committee has recognized that Substance Abuse is one of the leading risk factors present in both abuse and neglect deaths each year. For the past four years, the State Committee has recommended that law enforcement agencies and DCF should perform field drug testing of caregivers, when indicated, as part of their protocols for the investigation of unexpected deaths of infants and children. Several State Committee members provided training to both law enforcement and DCF protective investigators specific to identifying, documenting and collecting evidence related to substance abuse at a child death scene.

- Training provided by State Committee members has led to significant improvements in the investigations by both law enforcement and DCF protective investigators in many areas of the state. Although DCF has not adopted a statewide policy in regards to the use of field drug testing, many DCF regions use them when indicated. The State Committee recognizes the importance of continued training in this area and the need for agencies to adopt policies and procedures that will ensure continued training for future law enforcement officers, detectives and protective investigators.

- The State Committee established a collaborative working relationship with The National Center for the Review and Prevention of Child Deaths and received a letter of recognition and support from the Executive Director. (Appendix III).

- The State Committee sent letters to Congressional Representatives and Senators supporting the 2011 Protect Our Kids Act. This proposed bill will create a National Commission on Child Maltreatment Fatalities.

- The State Committee sent a letter in support of the Victims of Crime Act grant fund, which provides support to victim's families.

- The State Committee wrote a letter to the Similac Public Affairs Office expressing deep concern regarding the recent advertisement that illustrated a baby sleeping on its side, on a soft compressible surface covered with a blanket.

- The State Committee wrote a letter to the Health Resources and Services Administration (HRSA), Maternal and Child Heath Bureau, supporting their grant application to continue their work as the National Maternal and Child Health Center for Child Death Review.

Florida Data on Children: Birth through 17 Years

In Florida, the estimated population of children ages 0-17 was 4,123,708 in 2010. The following chart shows the number of children under the age of 18 in Florida and the number of all child deaths that occurred in Florida for a two year period. DCF Reports Received portion of the chart shows the number of reports that involved child deaths and how many of these child deaths had "no indicators", "not substantiated/some indication", or "verified findings" of child abuse or neglect. The State Committee is statutorily limited to the review of "verified" child death reports, which limits our understanding of why children are dying in Florida.

Florida Data on all Children Ages 0-17 years 2009 - 2010		
	2009	**2010**
Florida population for children ages 0 – 17 years	**4,150,374***	**4,123,708***
Number of child deaths regardless of residency	**2638**	**2282**
Number of Florida resident child deaths	**2586**	**2178**
DCF Reports Received & Abuse/Neglect Deaths		
Number of initial reports	**217,382****	**223,082****
Number of reports involving child deaths	**513**	**507**
Number of child death cases with no indicators	**196**	**199**
Number of child abuse deaths with some indicator findings/not substantiated	**96**	**107**
Number of verified child abuse deaths	**200**	**155**
Number of verified child abuse deaths reviewed by CADR***	**192**	**136**

*Florida Department of Health Vital Statistics
**DCF data report
***136 cases are from review period January-November 2011. Additional cases have been verified in 2011; however they will be addressed in next year's report.

National Center on Child Abuse Prevention Research 2009 - 2010		
	2009	**2010**
National estimate of child abuse and neglect deaths	**1770***	**1560***

*U.S. Department of Health and Human Services: Child Maltreatment 2009: Reports from the States National Center on Child Abuse Prevention Research.
**U.S. Department of Health and Human Services: Child Maltreatment 2010: Reports from the States National Center on Child Abuse Prevention Research.

The State Committee believes that the decrease in the number of neglect deaths reviewed may be due to the following reasons:

- Decrease in the population ages birth through 17
- Fewer child deaths in Florida
- Lack of thorough investigations using the Sudden Unexpected Infant Death Investigation (SUIDI) to include doll reenactments as recommended by the Centers for Disease Control (CDC)

Overview of Child Deaths Reviewed

During 2010, 2,282 children under the age of 18 lost their lives in Florida. Of these, 1,306 were males, 973 were females and three were unknown. Of those children who died, 507 were reported to the Florida Abuse Hotline. There are cases that were called to the hotline in 2010 in which the death occurred in previous years. Of the child deaths reported to the hotline, and died in 2010, 155 were verified as child abuse or neglect. The State Committee received 136 during the review period (January – November 14, 2011). The cases verified after the review period will be reviewed in 2012.

In 2010, there was a 23% decrease in the number of child abuse deaths in Florida; 155 compared to 200 children who died from verified child abuse or neglect in 2009. (Note there are open investigations for 2010 that are still pending that have potential for verification.) Over the past ten years however, these numbers have varied with no consistent trend emerging, either for Florida or nationally. Definitions and procedures may change within a state over time, as well as statutory requirements for reporting, as they have in Florida, resulting in data that is difficult to compare across years or states.

Additionally, the national data estimate used in this report is only one source of data and other experts and sources refute this national data. The Government Accountability Office (GAO) prepared a report to Congress (July 2011) and highlighted some of the inaccuracies in capturing the true number or circumstances of child fatalities from maltreatment. For more information see the report at http://gao.gov.

During 2011, the State Committee was able to review 136 of the child abuse deaths from 2010. The State Committee reviewed an additional eleven child deaths that occurred in the previous years, bringing the total number of child deaths reviewed by the State Committee in 2010 to 147. Neglect deaths, once again, are significantly higher than physical abuse deaths. While abuse deaths went up marginally from last year, neglect deaths have decreased from 140 in 2009 to 85 in 2010.

Abuse/Neglect

The State Committee reviewed 136 child abuse and neglect deaths that occurred in 2010.

- 51 (37.5%) were from abuse
- 85 (62.5%) were from neglect

Manner of Child 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, s. *406.11, F.S.*, specifies certain types of deaths and circumstances that fall under the jurisdiction of the District Medical Examiner. Such deaths include those due to trauma or accident, deaths occurring under suspicious or unusual circumstances and cases of sudden, unexplained deaths of individuals in apparent good health. Therefore, any death of a child in the state of Florida that is suspected to be related to accident, abuse or neglect, as well as the sudden death of a child who did not

have a previously diagnosed potentially terminal disease, is by statute to be investigated by the Medical Examiner's Office. For explanation go to definitions Appendix IV.

Note: In three cases the State Committee was unable to concur with the cause and/or manner of death as determined by the certifying medical examiner. It was not clear to the State Committee whether their questions pertaining to the medical examiners' conclusions were the result of additional information being available to the medical examiners and investigating law enforcement agencies that was not available to the State Committee.

The 136 child abuse and neglect deaths reviewed by the State Committee were classified as follows:

- 79 (58%) Accidental
- 49 (36%) Homicides
  - 41 (84%) were under 5 years of age
  - 22 (45%) were less than 1 year of age
- 4 (3%) Undetermined
- 3 (2%) Natural
- 1 (1%) Suicide

The following provides data on the demographic characteristics of the 136 verified child abuse and neglect deaths in 2010, as well as data on the perpetrator/caretaker/caretaker responsible for these deaths.

Age of Child

- 52 (38%) were <1
- 50 (37%) were 1-2
- 17 (13%) were 3-5
- 4 (3%) were 6-8
- 7 (5%) were 9-12
- 5 (4%) were 13-15
- 1 (.7%) was 16

There were 119 (88%) of the children age five and under.

According to the 2010 United States Department of Health and Human Services Child Maltreatment Report, 79.4% of children who were killed were younger than four years of age, 47.7% of child fatalities were younger than one year of age, 14% were one year of age, 11.6% were two years of age and 6.3% were three years of age.

Gender of Child

- 92 (70%) were male children
- 44 (30%) were female children

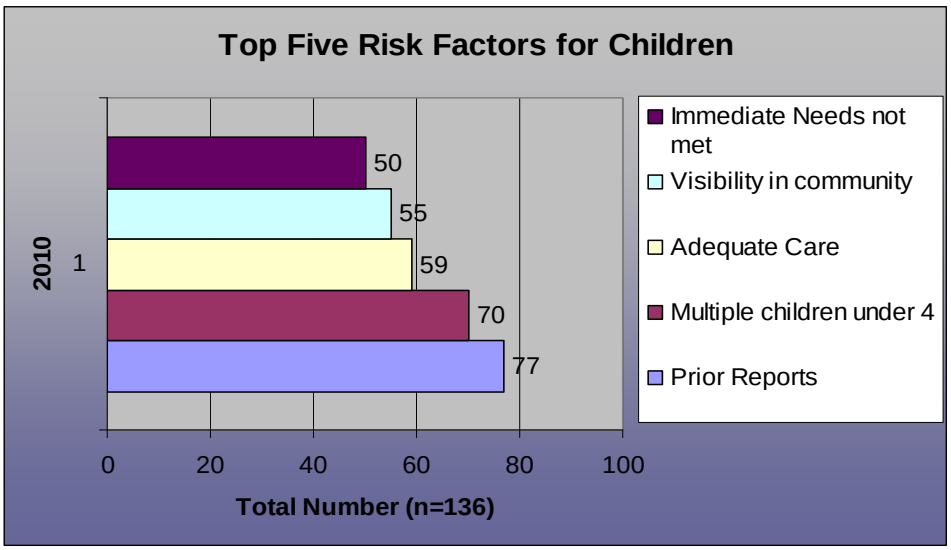
According to the 2010 United States Department of Health and Human Services Child Maltreatment Report, boys had a fatality rate of 2.51 per 100,000 and girls had a fatality rate of 1.73 per 100,000.

Race/Ethnicity of Child

- 62 (46%) were White
- 39 (29%) were Black
- 11 (8%) were Hispanic
- 10 (7%) were Multi-racial
- 9 (7%) were Haitian
- 3 (2%) were Asian Pacific
- 2 (1%) were Middle Eastern

According to the 2010 United States Department of Health and Human Services Child Maltreatment Report, of the children maltreated, 43.6% were white, 28.1% were African-American and 16.6% were Hispanic. Children of American Indian or Alaska Native, Asian and Pacific Islander racial categories collectively accounted for 1.7% of child fatalities. Fewer than five percent (4.4%) were of two or more racial types and more than five percent (5.5%) were of an unknown race.

Top Five Child Risk Factors



Perpetrator/Caretaker Characteristics

The total number of identifiable perpetrator/caretakers responsible for the 136 child deaths was 174 (more than one perpetrator can be responsible for a death.) Two of the 136 deaths involved an unknown perpetrator/caretaker(s).

Age of Perpetrator/Caretaker

- 10 (6%) were under the age of 19
- 41 (24%) were 20-24
- 47 (27%) were 25-29
- 41 (24%) were 30-40
- 35 (20%) were > 41

The majority of the perpetrator/caretakers (56%) were under the age of 30.

Gender of Perpetrator/Caretaker

- 94 (54%) were females
- 80 (46%) were males

Race of Perpetrator/Caretaker

- 107 (62%) were White
- 62 (36%) were Black
- 5 (3%) were Other

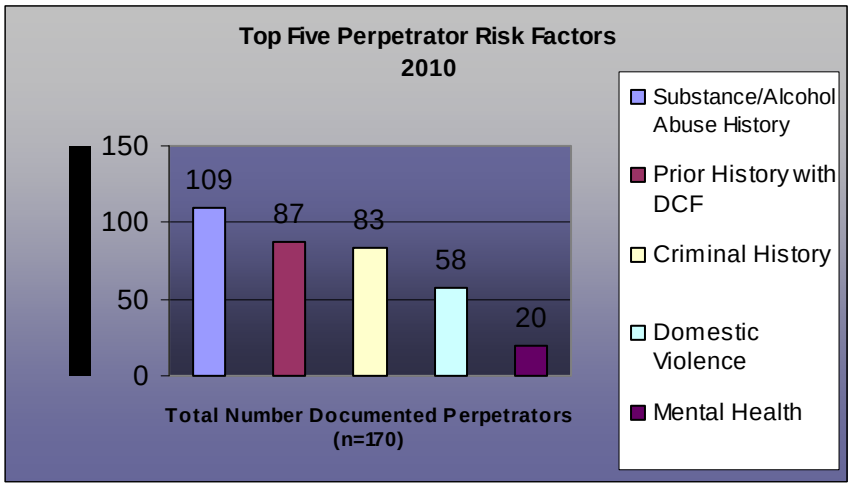
Relationship of Perpetrator/Caretaker to Child

- 76 (44%) were Mothers/Stepmothers
- 60 (34%) were Fathers/Stepfathers
- 12 (7%) were Other Relatives**
- 8 (5%) were Other non-relatives
- 5 (3%) were Day care workers
  - Four were licensed facilities
  - One was an unlicensed home day care
- 3 (2%) were Male and Female Paramours
- 1 (0.5%) was a Foster Mother

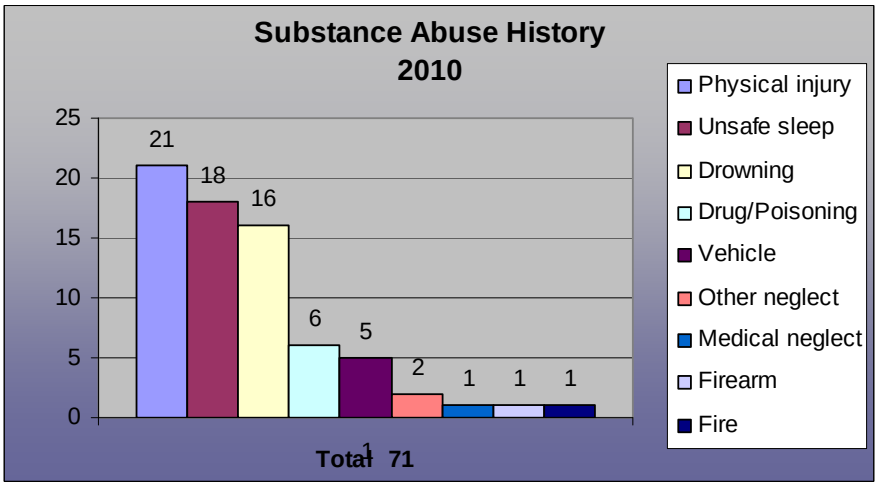
***Other relatives included grandparents, aunts, great grandparents, and other relatives.*

Top Five Perpetrator/Caretaker Risk Factors

There were 174 identified perpetrator/caretakers: however, documentation as to the risk factors was either missing or unknown on four, thus the chart below reflects the 170 perpetrator/caretakers documented.



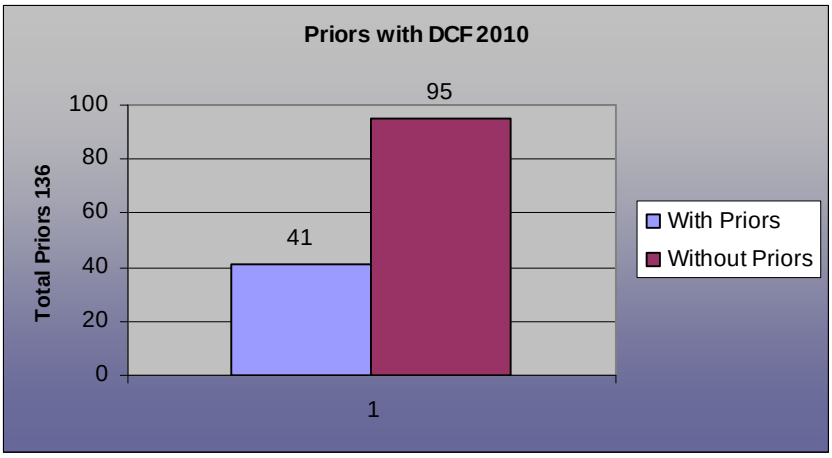
The graph below shows the substance abuse history identified by the State Committee from the 136 cases by the types of maltreatment deaths.

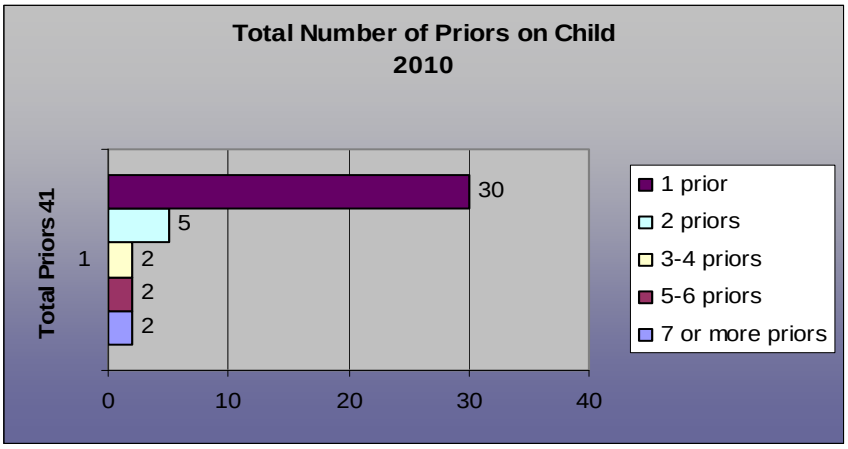


Prior Abuse or Neglect History

- In 95 (70%) of the 2010 child death cases reviewed, the child did not have any prior involvement with DCF.
- In 41 (30%) of the 2010 child death cases reviewed, the child had prior involvement with DCF.

The following graphs demonstrate the 136 child deaths reviewed that had prior involvement with DCF and those child deaths reviewed that did not have any prior involvement with DCF.





- There were nine cases where Community Based Care was providing services at the time of child's death.

- There were six cases involving an open investigation with DCF at the time of the child's death.

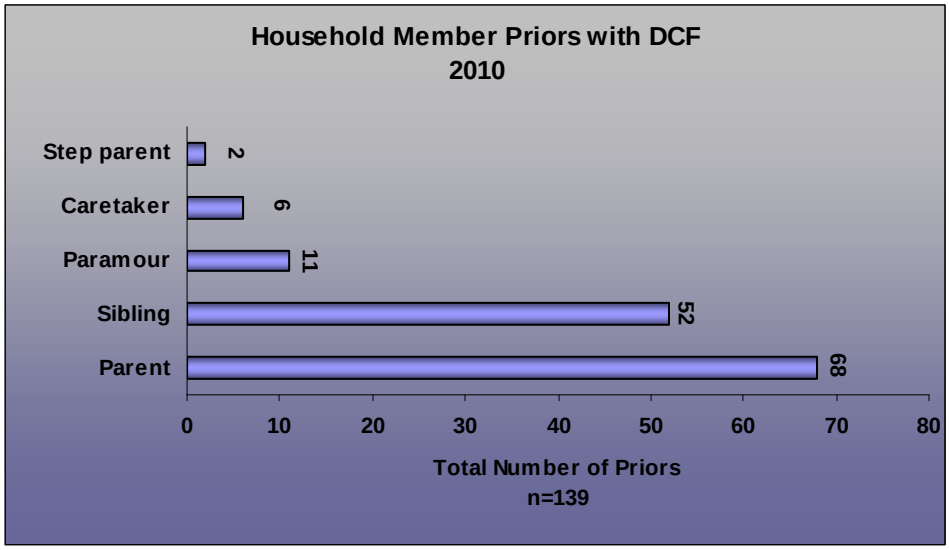
- There was one case in which a report was made to the hotline prior to the child's death and the call was screened out (did not meet the criteria for acceptance by the hotline.)

- There was one case in which there was a prior DCF investigation on a sibling of the deceased child. However, at the time of the investigation the child protective investigator failed to identify the deceased child as a household member.

Prior Abuse or Neglect History on Household Members

Research suggests that about one-third of all individuals who are maltreated as children will abuse or neglect their children, further contributing to the intergenerational cycle of abuse.

The graph below depicts the individual members residing in the deceased child's household that had priors with DCF. **Note:** Some of the priors are from other states.



PREVENTABILITY

Preventable Deaths

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

Definitely preventable by caretaker or system or both

The information provided demonstrates clearly that steps or actions could have been taken that would have prevented the death from occurring. A system can be agencies such as DOH, DCF, Community Based Care, Healthy Families, Healthy Start, Law Enforcement, the Judicial system, or relatives, 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 an individual other than the perpetrator/caretaker 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.

- 76 (56%) were definitely preventable by caretaker
- 19 (14%) were definitely preventable by caretaker and system
- 17 (13%) were not preventable
- 8 (6%) were definitely preventable by caretaker and possibly system
- 8 (6%) were possibly preventable by caretaker
- 6 (4%) were definitely preventable by system
- 2 (1%) were undetermined

NEGLECT MALTREAMENT DEATHS

According to section 39.01(44), *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."

Neglect covers a broad spectrum of maltreatments and has been the leading cause of child deaths reviewed by the State Committee. The Committee breaks down the neglect deaths into categories such as drowning, unsafe sleep-related and others in order to identify trends and issues in order to target prevention efforts. Neglect may have no outward signs, so is often missed. Child neglect deaths are often overlooked and coded as "just a tragic accident" by law enforcement, first responders and child protective investigators, feeling that the family has suffered enough. There is a lack of training for both law enforcement officers, as well as protective investigators, in recognizing neglect as a cause or contributing factor in a child's death. 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 Committee has noted that substance abuse leads to more instances of child neglect deaths than physical abuse deaths. Adults who are impaired, or preoccupied with chasing their next "high", are less likely to attend to the needs of their children, and spend their often-limited resources on drugs or alcohol. In numerous cases reviewed by the State Committee, there was a lack of thorough death scene investigation by responsible agencies. Investigators failed to explore or ask for drug testing when there was a family history of substance abuse, drug paraphernalia at the scene, or suspicion of drug abuse at the time of the child's death. This resulted in missed opportunities to determine if the child's death was due to neglect, related to the caregivers substance use or abuse.

Eighty-five (62.5%) child deaths were from neglect, the following are the specific maltreatments related to those deaths.

- 42 (49%) Drowning
- 21 (25%) Unsafe sleep
- 9 (11%) Vehicle
- 6 (7%) Drug toxicity deaths
- 3 (4%) Other neglect deaths
- 2 (2%) Medical neglect
- 1 (1%) Firearm
- 1 (1%) Fire

DROWNING

In 2010, the number of drowning deaths in Florida among children less than five years old increased from the year before, following a 15% decrease from 2007-2009. The DCF hotline received 91 cases of child death drowning during 2010. Forty-two were verified for abuse/neglect and submitted to the state committee for review. Between 2004 and 2008, 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 6.3 per 100,000 population. The top five counties statewide for unintentional pool drowning deaths among ages 0-4 for 2009-2010 were as follows:

Hillsborough - 10
Broward - 9
Orange - 8
Pinellas - 7
Miami-Dade - 6

The State Committee did not have the opportunity to review the deaths of all children who drowned in Florida. Inconsistencies in reporting of child drowning deaths by law enforcement and medical personnel, and inconsistencies in the verification of drowning deaths related to neglect by the Department of Children and Families or sheriff's department child protective investigators, contributed to the cases not meeting the statutory requirements for review by the State Committee.

There were a total of 42 drowning deaths. Inadequate supervision was found in all drowning deaths.

- 29 (69%) were in pools
- 10 (24%) were in other bodies of water
- 3 (7%) were in bathtubs

Risk Factors

- 18 had criminal history
- 16 had substance abuse history
- 14 had prior history
- 12 had domestic violence history

CHILD CHARACTERISTICS

Age of Children

- 5 (12%) were between ages 0-12 months
- 9 (21%) were between ages 13 months to 23 months
- 23 (55%) were between ages 2 to 3 years
- 5 (12%) were between ages 4 to 6 years

Gender of Children

- 30 (71%) were males
- 12 (29%) were females

Race/Ethnicity of Children

- 21 (50%) were White
- 8 (19%) were Black
- 8 (19%) were Haitian
- 2 (5%) were Multi-racial
- 2 (5%) were Middle Eastern
- 1 (2%) was Asian

PERPETRATOR/CARETAKER CHARACTERISTICS

Fifty-one perpetrators/caretakers were identified in the drowning deaths

Age of Perpetrator/Caretaker

- 25 (49%) were between the ages of 18-29 years
- 12 (24%) were between the ages of 30-38 years
- 9 (18%) were between ages of 40-48 years
- 5 (10%) were between ages of 53-72 years

Gender of Perpetrator/Caretaker

- 27 (53%) were females
- 24 (47%) were males

Relationship of Perpetrator/Caretaker to Child

- 22 (43%) were fathers/stepfathers
- 21 (41%) were mothers
- 5 (10%) were grandparents
- 2 (4%) were non-relatives
- 1 (2%) was an aunt

Recommendations:

- Implement a systemic approach to prevent drowning of children in Florida, with a focus on those less than five years of age.

- Increase 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.

- Conduct a risk assessment of drowning risk factors by Child Protective Investigators when there is a pool on the premises or bodies of water close to the home.

- Enhance reporting by law enforcement and medical professionals of all child-drowning deaths to the Florida Abuse Hotline, thereby allowing investigations to occur to determine if the child's death was the result of neglect.

- Allow the Florida Abuse Hotline to accept all reports from law enforcement or medical professionals on child deaths that occurred as a result of drowning.

- Enhance reporting by medical professionals of 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.

- Establish a "testing protocol" for law enforcement and DCF to follow for alcohol/substance abuse that determines whether illicit drug use, prescription drug abuse or alcohol consumption was a contributing factor to inadequate supervision in the drowning death.

- Initiate Legislative action to amend s. 515.27, F.S., mandating that whenever a building permit is issued for remodeling of an existing pool, spa or hot tub, it shall meet and maintain at least one of the requirements relating to pool safety features.

- Initiate Legislative action to amend s. 515.27, F.S., requiring that whenever a residential property that has a swimming pool, spa or hot tub is sold or ownership is transferred, the pool, spa or hot tub shall meet and maintain at least one of the requirements relating to pool safety features in s. 515.27, F.S.

SLEEP ENVIRONMENT RELATED DEATHS

Issues of unsafe sleep practices have been recognized as a major priority by the State Committee and by many of Florida's state agencies and organizations. The State Committee, along with several of its members, supported the DOH's review/analysis of Florida's Sudden Unexpected Infant Deaths (SUID). The purpose of this review/analysis was to measure the impact of SUID in Florida, to assess the quality of SUID investigations at the local level and to estimate the impact of unsafe sleep practices on SUID. In addition, several of the State Committee members actively participated in the review/analysis along with their other job-related duties. Committee member involvement included being primary reviewers as well as serving on the advisory committee. The findings from the review/analysis are forthcoming and will be critical to both the State Committee and the DOH in advancing their efforts to identify, improve surveillance of, and reduce SUID and sleep-related deaths: which are responsible for 200 to 300 infant deaths each year in Florida.

There were 21 unsafe sleep-related child deaths

- 14 (67%) were co-sleeping related
- 7 (33%) were due to unsafe sleep environments

Overall Risk Factors

- 18 had substance abuse history
- 18 had criminal history
- 18 had prior history
- 9 had domestic violence history

CHILD CHARACTERISTICS

Age of Children

- 15 (71%) were between 0 and 3 months
- 4 (19%) were between 3 and 6 months
- 2 (10%) were between 6 and 9 months

Gender of Children

- 15 (71%) were males
- 6 (29%) were females

Race/Ethnicity of Children

- 12 (57%) were White
- 4 (19%) were Hispanic
- 3 (14%) were Black
- 2 (10%) were Multi-racial

PERPETRATOR/CARETAKER CHARACTERISTICS

Twenty-eight perpetrator/caretakers were identified in the 21 infant sleep-related deaths.

Age of Perpetrator/Caretaker

- 18 (64%) were between 19-25
- 4 (14%) were between 26-30
- 4 (14%) were between 31-35
- 1 (4%) was 36 years
- 1 (4%) was 46 years

Gender of Perpetrator/Caretaker

- 19 (68%) were females
- 9 (32%) were males

Relationship of Perpetrator/Caretaker to Child

- 18 (64%) were mothers
- 9 (32%) were fathers
- 1 (4%) was a foster mother

Recommendations:

- Law enforcement agencies, DCF and Florida's medical examiner districts (through the Medical Examiners Commission) should 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 Centers for Disease Control and Prevention. http://www.cdc.gov/sids/SUIDHowtoUseForm.htm

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

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

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

- Agencies and organizations that provide home visiting services should use the home safety checklist and prevention education topic sheets developed by Healthy Families Florida in partnership with the State Committee. For more information contact Healthy Families Florida at www.healthyfamiliesfla.org.

- The DCF should provide infant safe sleep education for caregivers providing out of home care.

VEHICLE RELATED DEATHS

Vehicle crashes are the most under-reported child neglect deaths. Although there was no Florida data on children who die in vehicle crashes in which the driver was impaired, according to the National Highway Traffic Safety Administration (NHTSA) report, in 2009 (the most recent data), a total of 1,314 children age 14 and younger were killed in motor vehicle traffic crashes. Of those 1,314 fatalities, 181 (14%) occurred in alcohol-impaired driving crashes. Out of those 181 deaths, 92 (51%) were occupants of a vehicle with a driver who had a blood-alcohol (BAC) level of .08 or higher. For further information on the report see http://www.nhtsa.gov.

These vehicle-related child deaths are often viewed as a traffic fatality and not as a child neglect death. There is a lack of training for law enforcement officers on mandatory reporting of child neglect deaths that occur when the parent/caregiver is driving under the influence of alcohol.

There were six children in Florida that died as a result of being left in a vehicle. Of those, four were verified during the review period. Florida is second in the nation for these types of child deaths.

Nine children died from vehicle-related deaths

- 4 (44%) were left in vehicles
- 4 (44%) were either driven or backed over
- 1 (11%) was killed in a vehicle crash

Overall Risk Factors

- 5 had substance abuse history
- 3 had prior history
- 3 had domestic violence history
- 3 had criminal history

CHILD CHARACTERISTICS

Age of Children

- 1 (11%) was 4 months
- 5 (56%) were between the ages of 1-2
- 2 (22%) were between the ages of 3-4
- 1 (11%) was 8 years old

Gender of Children

- 5 (56%) were males
- 4 (44%) were females

Race/Ethnicity of Children

- 5 (56%) were Black
- 2 (22%) were White
- 1 (11%) was Asian
- 1 (11%) was Hispanic

PERPETRATOR/CARETAKER CHARACTERISTICS

Ten perpetrator/caretakers were indentified in the vehicle-related deaths.

Age of Perpetrator/Caretaker

- 5 (50%) were between the ages of 20-25
- 2 (20%) were between the ages of 30-35
- 3 (30%) were between the ages of 35-40

Gender of Perpetrator/Caretaker

- 8 (80%) were females
- 2 (20%) were males

Relationship of Perpetrator/Caretaker to Child

- 6 (60%) were mothers
- 2 (20%) were fathers
- 1 (10%) was a day care employee
- 1 (10%) was an aunt

Recommendations:

- The Florida Highway Safety and Motor Vehicles Traffic Crash Statistics Report should collect data that mirrors NHTSA data as it relates to traffic crashes when children are killed as a result of an impaired driver.

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

- The Department of Children and Families should establish maltreatment guidelines and craft statewide training on vehicle-related child deaths to provide consistency in investigation and child maltreatment findings.

- The Local Child Abuse Death Review Committees should include the Florida Highway Patrol to participate in local child abuse death reviews.

- Campaigns should focus on,"Families do not let Families Drive Drunk."

- Florida Legislature should pass a "booster seat belt law" that meets National Highway Safety recommendations which states: any driver of a motor vehicle when transporting a child under the age of eight years who is between forty inches and fifty-seven inches in height and weighing less than eighty pounds, operated on the roadways, streets, and highways of this state, shall have the child properly secured in a child booster seat.

- Promote public awareness campaigns such as the ones by Safe Kids USA (www.safekids.org) "Never leave your child alone **Beat the Heat, Check the Backseat."**

DRUG TOXICITY RELATED DEATHS

About seven million people abuse prescription drugs, including painkillers, according to the 2010 National Survey on Drug Use and Health. Centers for Disease Control and Prevention (CDC) deaths in Florida attributed to prescription overdose increased by 84.2 % from 2003 to 2009. Data from the Florida MEC highlight a continuing and disturbing trend in prescription misuse and abuse. The State Committee has recognized that substance abuse is one of the leading risk factors present in both abuse and neglect deaths each year. For the past four years, the State Committee has recommended that 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.

Six children died as a result of drug toxicity

- 4 (67%) were teen drug overdose deaths
- 1 (17%) was a premature drug exposed new born
- 1 (17%) was an accidental drug overdose due to inadequate supervision

Overall Risk Factors

- 6 had substance abuse history
- 5 had prior history with DCF
- 4 had criminal history
- 3 had domestic violence history

CHILD CHARACTERISTICS

Age of Children

- 4 (67%) were between ages 13-17 years
- 1 (17%) was 2 years old
- 1 (17%) was 4 hours old

Gender of Children

- 4 (67%) were females
- 2 (33%) were males

Race/Ethnicity of Children

- 3 (50%) were White
- 3 (50%) were Black

PERPETRATOR/CARETAKER CHARACTERISTICS

There were nine perpetrator/caretakers identified in the drug toxicity related deaths.

Age of Perpetrator/Caretaker

- 2 (22%) were between 20-25
- 2 (22%) were between 25-30
- 2 (22%) were between 35-40
- 3 (33%) were between 41-46

Race of Perpetrator/Caretaker

- 6 (67%) were White
- 3 (33%) were Black

Gender of Perpetrator/Caretaker

- 7 (78%) were females
- 2 (22%) were males

Relationship of Perpetrator/Caretaker to Child

- 5 (56%) were mothers
- 2 (22%) were other non-relatives
- 1 (11%) was a father
- 1 (11%) was a grandmother

Five cases of prescription medications were noted to be of concern.

Recommendations:

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

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

- Enhance or develop new risk assessment instruments to focus more directly on substance abuse indicators in these families. Upon identification of a problem, investigative protocols should be developed to prioritize engaging these parents in treatment.

- Develop and implement a “testing protocol” for drugs and alcohol for use by law enforcement and child protective investigators. This protocol should have specific guidelines for use in all child deaths where substance abuse is indicated; when a child is a victim of drowning, motor vehicle crash, infant co-sleeping related death and other child neglect deaths.

- Provide training to Fire Rescue/EMS first responders and Fire Marshall Investigators to recognize the signs of substance abuse by caregivers.

- Provide training to law enforcement and narcotics officers on mandatory reporting of child abuse when narcotics 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 Department of Children and Families Substance Abuse and Family Safety program offices should develop a standardized protocol for screening, assessment, linkage and retention of substance abusing parents in substance abuse treatment. Essential elements should include required attendance at recovery/support groups, use of family intervention or substance abuse specialists, drug testing and use of peer recovery specialists.

- The DCF should develop and provide training to Child Protective Investigators that focuses 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.

- Training for Child Legal Services, in regards to these issues, should also be reviewed and revised, as needed.

OTHER NEGLECT RELATED DEATHS

Three children died and the contributory factor was inadequate supervision.

- 2 (67%) died from dog mauling
- 1 (33%) died from inhaling a balloon

Overall Risk Factors

- 2 had substance abuse history
- 2 had prior abuse history
- 1 had criminal history

CHILD CHARACTERISTICS

Age of Children

- 1 (33%) was 7 days
- 1 (33%) was 2 years
- 1 (33%) was 3 years

Gender of Children

- 2 (67%) were males
- 1 (33%) was female

Race/ Ethnicity of Children

- 2 (67%) were White
- 1 (33%) was Black

PERPETRATOR/CARETAKER CHARACTERISTICS

Four perpetrator/caretakers were identified in the other neglect related deaths.

Age of Perpetrator/Caretaker

- 2 (50%) were between 30-33 years
- 1 (25%) was 47 years
- 1 (25%) was 16 years

Race of Perpetrator/Caretaker

- 2 (50%) were White
- 2 (50%) were Black

Gender of Perpetrator/Caretaker

- 3 (75%) were females
- 1 (25%) was male

Relationship of Perpetrator/Caretaker to Child

- 3 (75%) were mothers
- 1 (25%) was a father

MEDICAL NEGLECT RELATED DEATHS

Medical neglect is the refusal or failure on the part of the person responsible for the child's care to seek, obtain, and/or maintain services for necessary medical, dental, or mental health care, or withholding medically indicated treatment from disabled infants with life-threatening conditions. Medical neglect means that even minimal health care is not being obtained for a child. This lack of health care can lead to serious harm and even death.

Two children died from medical neglect

- 1 died from ketoacidosis due to type 1 diabetes
- 1 died from hanging

Overall Risk Factors

- 2 had prior abuse history
- 1 had substance abuse history

- 1 had criminal history
- 1 had domestic violence history

CHILD CHARACTERISTICS

Age of Children

- 1 was 11 years
- 1 was 12 years

Gender of Children

- Both children were females

Race/ Ethnicity of Children

- 1 was White
- 1 was Black

PERPETRATOR/CARETAKER CHARACTERISTICS

Three perpetrator/caretakers were identified in the medical neglect related deaths.

Age of Perpetrator/Caretaker

- 1 (33%) was 40 years
- 1 (33%) was 36 years
- 1 (33%) was of unknown age

Race of Perpetrator/Caretaker

- 2 (67%) were White
- 1 (33%) was Black

Gender Perpetrator/Caretaker

- All three were female

Relationship of the Perpetrator/Caretaker

- 2 were mothers
- 1 was a grandmother

Recommendation:

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

FIREARM RELATED DEATHS

Florida's Child Access Prevention Law is one of only three such state 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 U.S. households have a firearm. 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.

One child died from a gunshot wound to the head

Overall Risk Factors

- 1 had substance abuse history
- 1 had prior history

CHILD CHARACTERISTICS

Age of Child

- was 2 years

Gender of Child

- was male

Race/ Ethnicity of Child

- was White

PERPETRATOR/CARETAKER CHARACTERISTICS

One caretaker was responsible for the firearm related death.

Age of Perpetrator/Caretaker

- was 57 years

Race of Perpetrator/Caretaker

- was White

Gender of Perpetrator/Caretaker

- was female

Relationship of Perpetrator/Caretaker to Child

- was a great grandmother

Recommendations:

- Follow the American Academy of Pediatrics recommendations that pediatricians counsel parents about risks associated with keeping firearms in the home and how to store them safely when they are in the environment of children.

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

FIRE RELATED DEATHS

The high cost of home heating fuels and utilities has caused many Americans to search for alternate sources of home heating. The use of wood burning stoves is growing and space heaters are selling rapidly, or coming out of storage. Fireplaces are burning wood and man-made logs. All of these methods of heating may be acceptable, but can present a danger to children. Parents/caregivers must remain diligent in supervising their children around fire related hazards to prevent possible injury or death. Children playing with fire cause injuries and deaths each year. Preschoolers and kindergartners often start these fires, usually by playing with matches and lighters, and are the most likely to die in fires.

One child died of complications from a thermal burn

Overall Risk Factors

- 1 had substance abuse history
- 1 had prior history
- 1 had criminal history

CHILD CHARACTERISTICS

Age of Child

- was seven months

Gender of Child

- was male

Race/Ethnicity of Child

- was Black

PERPETRATOR/CARETAKER CHARACTERISTICS

One perpetrator was responsible for this thermal burn death.

Age of Perpetrator/Caretaker

- was 37 years

Race of Perpetrator/Caretaker

- was black

Gender of Perpetrator/Caretaker

- was male

Relationship of Perpetrator/Caretaker

- was a father

Recommendations:

- Continuing education should be provided to fire marshals on reporting fire related child deaths to the Florida Abuse Hotline.

- On-scene presumptive drug testing should be standardized as part of the child protective or law enforcement investigation protocol in fire related child deaths.

- The Local Child Abuse Death Review Committees should have local fire marshals or law enforcement agencies that investigate fire related deaths participate in local child abuse death reviews when appropriate.

PHYSICAL ABUSE MALTREATMENT DEATHS

Physical abuse is the most visible form of child abuse. Abuse is defined in s. 39.01(2), F.S., 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…"

This section will provide an analysis of the child deaths from three categories of physical abuse: intentional injury, murder/suicides and out-of-hospital births. Perpetrator/caretaker risk factors discovered by the State Committee during the death reviews are also presented.

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

There were a total of 51 (37.5%) children who died as a result of physical abuse.

- 40 (78%) died as a result of intentional injury
  - 20 had evidence of prior trauma
- 9 (18%) died as a result of a murder/suicide
  - 4 killed by the stepfather were siblings
  - 2 killed by the father were siblings
- 2 (4%) died as a result of newborn abandoned babies

Overall Risk Factors

- 36 had criminal history
- 24 had domestic violence history
- 23 had substance abuse history
- 29 had prior history

CHILD CHARACTERISTICS

Age of Children

- 24 (47%) were <1
- 13 (25%) were ages 1-2
- 5 (10%) were ages 3-4
- 4 (8%) were ages 6-10
- 5 (10%) were ages 11-15

There were 42 (82%) children that were under the age of five.

Gender of Children

- 34 (67%) were males
- 17 (33%) were females

Race/Ethnicity of Children

- 20 (39%) were White
- 17 (33%) were Black
- 6 (12%) were Hispanic
- 6 (12%) were Multi-racial
- 1 (2%) was Haitian
- 1 (2%) was Asian

PERPETRATOR/CARETAKER CHARACTERISTICS

A total of 67 perpetrator/caretakers were identified in the physical abuse related deaths and two child deaths had unidentified perpetrator/caretaker(s).

- 3 also killed the mothers
- 2 also attempted to kill the mothers

Age of Perpetrator/Caretaker

- 38 (57%) were between the ages of 18-29
- 17 (25%) were between the ages of 30-40
- 10 (15%) were between the ages of 41-52
- 2 (3%) were between the ages of 67-72 years

Gender of Perpetrator/Caretaker

- 39 (58%) were males
- 28 (42%) were females

Relationship of Perpetrator/Caretaker to Child

- 24 (36%) were fathers/stepfathers
- 23 (34%) were mothers/stepmothers
- 12 (18%) were male /female paramours
- 4 (6%) were other non-relatives
- 2 (3%) were other relatives
- 2 (3%) were day care providers
  - 1 was a licensed provider
  - 1 was an unlicensed home care provider

Intentional Physical Injury Perpetrator/Caretaker Characteristics

This does not include the murder/suicides or the abandoned newborns.

Of the 40 deaths attributed to intentional physical injury:

Age of Male Perpetrator/Caretaker

- 19 (68%) were between ages 19-29
- 7 (25%) were between ages of 30-40
- 2 (7%) were between ages 43-45 years

Relationship of Male Perpetrator/Caretaker to Child

- 11 (39%) were male paramours
- 11 (39%) were fathers
- 3 (11%) were other non-relatives
- 2 (7%) were stepfathers
- 1 (4%) was a grandfather

Age of Female Perpetrator/Caretaker

- 5 (63%) were between ages 18-29
- 2 (25%) were between ages 30-40
- 1 (13%) was 52 years

Relationship of Female Perpetrator/Caretaker to Child

- 4 (50%) were mothers
- 1 (13%) was a licensed day care worker
- 1 (13%) was an unlicensed home care provider
- 1 (13%) was a female paramour
- 1 (13%) was an other non-relative

Non-offending Caregiver/Parent

Is defined as a parent or caregiver who was residing in the household but was not aware of the abuse.

Secondary Perpetrator/Caretaker

Is defined as caregivers who were residing in the household or who were aware of injuries and who negligently failed to protect a child in his or her care from inflicted physical, mental, or sexual injury caused by the acts of others. The characteristics of the secondary perpetrator/caretakers are identified below.

Age of Secondary Perpetrator/Caretaker

- 9 (60%) were between the ages of 19-29
- 5 (33%) were between the ages of 30-40
- 1 (7%) was 67 years

Gender of Secondary Perpetrator/Caretaker

- 13 (87%) were females
- 2 (13%) were males

Relationship of Secondary Perpetrator/Caretaker to Child

- 12 (80%) were mothers
- 2 (13%) were fathers
- 1 (7%) was a grandmother

Recommendations:

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

- Agencies that come in contact with families should continue to distribute the "Who is Watching Your Child" brochure.

- Support efforts by the Florida Pediatric Society and their partners to develop and implement a "Coping with Crying" program for hospitals and pediatricians.

- "Coping with Crying" programs should emphasize approaches to educate male caregivers between the ages of 18–30.

- Programs should emphasize educating parents and caregivers on the importance of making informed, selective choices on "babysitters" for their children.

- Any agency investigating child abuse should make it a priority to document and collect information as to a parent's ability or inability to place their children in center-based child care as the state committee often observes that in physical abuse deaths, children were often with inappropriate caretakers.

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

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

- Fund training for law enforcement investigators and the Department of Children and Families Child Protective Investigators on physical child abuse investigations. Training should include:
  - Use of standardized Q & A (designed by Florida Department of Law Enforcement) during investigations.
  - An emphasis on common risk factors and triggers pertaining to adult male caregivers between the ages of 18-30.
  - The dynamics of substance abuse, domestic violence and animal abuse and how they relate to maltreatment and risk in child abuse and neglect cases.

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

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

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

- DCF should continue their efforts to improve consistency in verifying findings in child neglect death cases related to drowning and unsafe sleep. Comparative data (by circuit) should be collected on maltreatment allegations and verification rates of all child deaths reported to the child abuse hotline.

- The overall verification rate (i.e., ratio of confirmed child deaths to all alleged child deaths investigated) should also be analyzed to detect individual or unit bias in the handling of child death investigations.

Child Deaths Reviewed from Previous Years

As indicated earlier in the report, there were 11 child death cases reviewed by the State Committee in 2011 that occurred in years 2005-2009. The following data reflect the data related to these cases.

Types of maltreatment and years death occurred

- 2 physical injury deaths occurred in 2009
  Bringing the total in that year to 54
- 1 physical injury occurred in 2008
  Bringing the total in that year to 63
- 2 medical neglect deaths occurred in 2009
  Bringing the total in that year to 4
- 2 unsafe sleep related deaths occurred in 2009
  Bringing the total in that year to 44
- 1 other neglect related death occurred in 2009-(hanging)
  Bringing the total that occurred in that year to 6
- 1 bathtub drowning occurred in 2007
  Bringing the total that occurred in that year to 9
- 1 vehicle related death occurred in 2005
  Bringing the total that occurred in that year to 8

CHILD CHARACTERISTICS

Age of Children

- 2 were between 2 months and 6 months
- 5 were between 19 months and 4 years
- 2 were between 7 and 8 years
- 2 were between 13 and 16 years

Gender of Children

- 8 were males
- 3 were females

Race/Ethnicity of Children

- 7 were White
- 2 were Multi-racial
- 1 was Black
- 1 was Hispanic

Causes of Child Death

- 4 died from blunt trauma to the head, chest trunk and extremities
    - 1 in 2008 was a result of chronic pneumonia which is sequel of severe blunt head trauma-severe shaking
- 2 died as a result of hanging
- 1 died from positional/compressional asphyxia due to co-sleeping
- 1 died from complications of Idiopathic Seizure disorder
- 1 died from complications of respiratory tract infection
- 1 was ruled as undetermined

Manner of Child Death

- 3 were ruled a homicide
- 3 were ruled an accident
- 2 were ruled undetermined
- 1 was ruled a suicide
- 1 was ruled as natural

PERPETRATOR/CARETAKER CHARACTERISTICS

There were 15 perpetrator/caretakers identified. There was an additional death with an unidentified perpetrator/caretaker.

Age of Perpetrator/Caretaker

- 4 were between ages 20-25 years
- 4 were between ages 26-30 years
- 7 were between ages 31-48 years

Gender of Perpetrator/Caretaker

- 8 were males
- 7 were females

Relationship of Perpetrator/Caretaker to Children

- 6 were mothers
- 6 were fathers/step-fathers
- 3 were foster parents
- 1 was a male paramour

KEY RECOMMENDATIONS FOR 2011

Continue and Enhance Statewide Public Awareness and Education Efforts – There is a need to continue and enhance research-based statewide public awareness campaigns to educate the public on strategies and actions that work to prevent child abuse and neglect and child deaths from occurring.

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

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

Public awareness efforts for the prevention of child abuse and neglect in Florida have shifted from placing a heavy emphasis on recognizing and reporting child abuse and neglect to promoting a better understanding of child development and safety, positive parenting practices and community action.

The State Committee recognizes the benefits a statewide infrastructure can have in communicating a consistent message: reinforcing healthy behaviors and preventing child deaths. Through Prevent Child Abuse Florida, the *Pinwheels for Prevention* campaign is delivered throughout the state during Child Abuse Prevention Month, which is in April every year. This campaign provides statewide distribution of community resource packets, broadcast of television and radio public service announcements (PSAs) in English, radio PSAs in Spanish, and coordination of community involvement and advertisement of community events based on a central statewide theme. The campaign promotes the prevention of child abuse and neglect through an increased understanding of child development, positive parenting practices and community action. It also emphasizes efforts to change the way our state and nation think about prevention by focusing on healthy child development and protective factors that keep families strong.

The campaign was expanded to include updated prevention information in the **Parent Resource Guide** and production of a new series of **Public Service Announcements.** The Parent Resource Guide was updated to provide families with a comprehensive section on child development including: age appropriate physical, emotional, cognitive and social development; activities that promote nurturing and attachment, safety tips and when to be concerned if your child has not reached certain milestones. Other sections that were added include: tips just for dads, tips for developmentally delayed children and a home safety

checklist developed by Healthy Families Florida. A new series of Public Service Announcements, featuring Dwight Howard, were scripted and produced in collaboration with Prevent Child Abuse America and Ron Sachs Communications. The Florida Chapter continues to receive remarkable feedback on the series and other State Chapters have begun airing them in their respective states.

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

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

- Phase II - expand the State's child abuse death review process to include the review of all child deaths.

Identifying the causes of and developing strategies to reduce avoidable child deaths is the essence of prevention. Regrettably, the State of Florida has not made much progress in accomplishing this goal. Since 1999, the State Committee has been articulating a need to better understand why children in our state die. The State Committee acknowledges there are individuals concerned that this process would be intrusive; however, that is not the case. Families will not be contacted or interviewed as result of this proposed legislative change. Of the states conducting some form of child death review, all have indicated that families are not impacted by these reviews. The child death review process is a review of records and reports, focusing on critical areas which include infant sleep-related deaths, drowning, suicides, traffic crashes and poisoning.

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

As stated in last year's annual report, a priority for the CDC and the Healthy People 2010 report is that a child fatality review team reviews 100 percent of deaths of children aged 17 years and younger that are due to external causes. By monitoring the occurrence of all childhood deaths and performing an appropriate review when deaths occur, child death review teams have a unique ability to gather the detailed information that is necessary for effective injury/disease prevention activities. The benefits of a comprehensive all child death review process includes:

- A more thorough child death investigation by law enforcement and medical examiners

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

Finally, it is essential to protect the confidentiality of the parents and other surviving siblings, and any other protected records. Currently, *Florida Statutes* provide confidentiality for all protected records received by the State or Local Committees. Confidentiality ensures that a family's feelings will be spared public scrutiny as the State Committee carries out its work and that no family be further traumatized as a result of this process. To understand why one child dies may save the lives of countless others. Expanding child death reviews is one of the key prevention strategies in Florida's Five-Year Child Abuse Prevention and Permanency Plan.

Amend the statutory due date of the State Committee's annual report to March 31st - Amending the statute will allow the State Committee additional time to review reports closed during November and December and to conduct a more thorough review of the deaths.

Invest in Successful Prevention Programs to Prevent Child Abuse and Neglect - The 2012 Florida Legislature should maintain the 2011-12 funding level for Healthy Families Florida and other successful prevention programs that improve the health, safety and well-being of Florida's children to avoid the costly short-term and long-term consequences of child abuse and neglect.

Research shows there are certain factors that place children at increased risk for abuse and neglect, which can be mitigated through effective prevention programs that build protective factors in vulnerable families. One proven approach to preventing child abuse and neglect is home visiting. High quality home visiting programs like Healthy Families Florida are proven to not only prevent child abuse and neglect, but also promote healthy child development, increase family stability and self-sufficiency and contribute to our state's long-term economic prosperity. According to the Rand Corporation, the return on investment for these programs can be as great as $5.70 for each dollar invested. These gains are realized through cost savings from health care, remedial education, foster care and juvenile delinquency.

The State Committee recognizes that the Florida Legislature is once again faced with difficult budget decisions. With scarce resources, it is even more critical that the Governor and Legislature prioritize funding for programs and services that show consistent positive

results and yield the greatest possible return for the future economic prosperity of Florida and its citizens.

Priority should be given to prevention programs that:

- *Intervene early* - The key to preventing abuse is intervening early, ideally during pregnancy or shortly after the birth of a baby, *before* negative parenting patterns develop that will have a detrimental impact on their child. Research shows that 90% of brain development occurs in the first five years of life, the period when most abuse and neglect occurs. In order to stimulate healthy brain development, there needs to be a positive parent-child relationship and healthy environment for a child to grow and develop to his or her full potential. When a child is maltreated, the brain architecture is affected, leading to learning and behavioral problems. Children are more likely to experience traumatic injuries, be placed in foster care, require special education and eventually commit juvenile crime, costing Florida taxpayers over $64,000 a year per abused child.

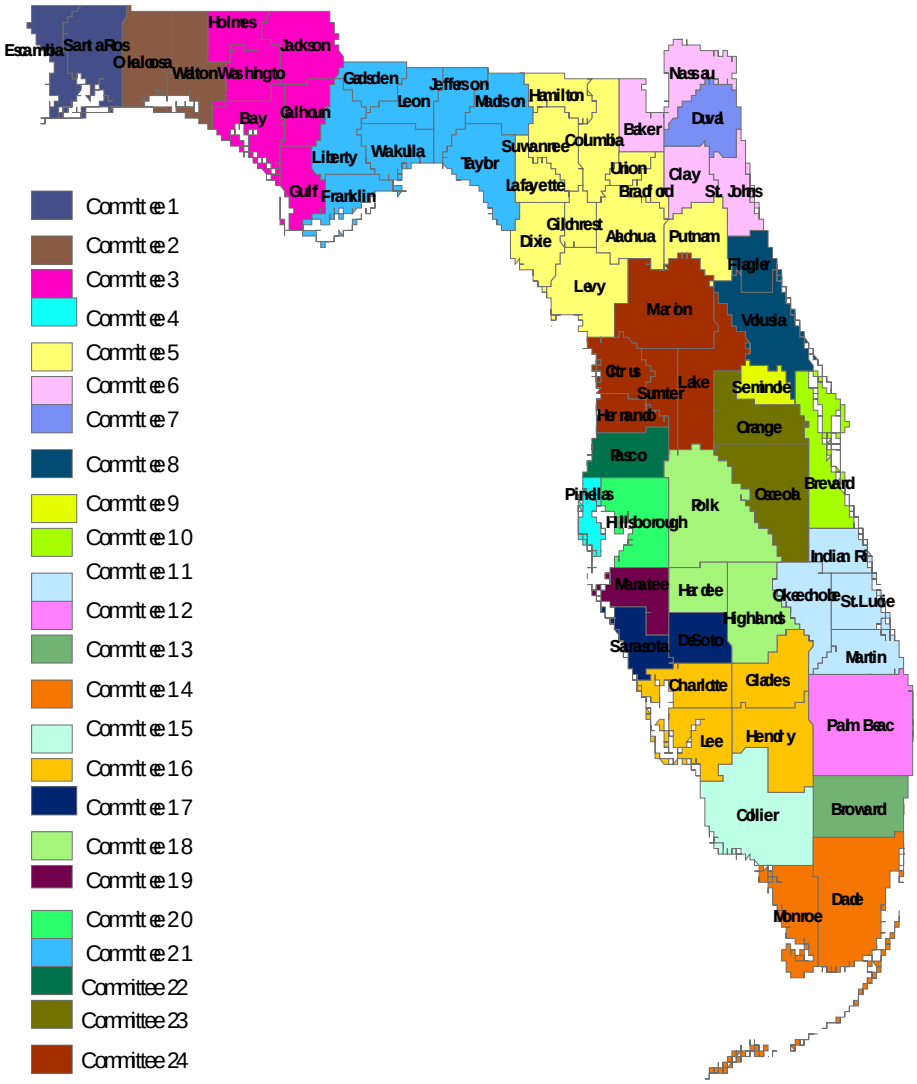
- *Provide services to the most vulnerable families* - The cause of child abuse and neglect is not one isolated factor. Decades of research confirm that the presence of a combination of personal and societal factors place a child at high risk for abuse and neglect. These factors include but are not limited to social isolation, substance abuse, family violence, mental health related issues, family history of abuse, inadequate income and limited knowledge of parenting skills. While all families could benefit from prevention programs, high quality programs that focus services to the *most vulnerable* families see the greatest impact in the prevention of child abuse and neglect.

- *Demonstrate effectiveness* - There are many good programs that promote healthy child development and increase protective factors in families. The key is to invest in those that are implemented well and can show positive results. One example of a prevention program that has demonstrated effectiveness since its inception is Healthy Families Florida.

LOCAL CHILD ABUSE DEATH REVIEW COMMITTEES

The State Committee relies heavily on the work of the Local Child Abuse Death Review Committees as well as the support and participation of many partners to accomplish its work. Without their commitment to our mission, the State Committee could not accomplish its statutory mandate and it would be impossible to meet its responsibilities. The Local Committee Chairs, many of whom are representatives from the Florida Department of Health's Children's Medical Services Child Protection Teams, local law enforcement officers and other dedicated professionals, are shining examples of partnership, leadership, dedication and cooperation. Participation from all community representatives makes this a process that benefits children by working together to reduce preventable child abuse deaths. These local committee members are all dedicated and passionate professionals who have volunteered countless hours in an effort to prevent future child abuse deaths in their communities.

Local Child Abuse Death Review Committees



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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 2004-2010 that were verified by DCF. Below indicate the counties in which the deaths occurred and the number of deaths per county by year.

Number of Deaths by County																	
County	Year							Total # of Deaths	County	Year							Total # of Deaths
	2004	2005	2006	2007	2008	2009	2010			2004	2005	2006	2007	2008	2009	2010	
Alachua	1	3	2	2	1	2	0	**11**	Lake	0	0	1	4	7	3	4	**19**
Baker	1	1	1	1	1	2	0	**7**	Lee	5	4	4	4	8	2	8	**35**
Bay	0	1	0	1	3	3	2	**10**	Leon	2	0	0	1	1	0	2	**6**
Bradford	0	2	1	0	0	0	0	**3**	Levy	0	0	0	0	1	1	0	**2**
Brevard	7	5	11	8	10	8	4	**53**	Liberty	0	0	0	0	0	0	0	**0**
Broward	13	9	14	11	26	23	17	**113**	Madison	0	0	0	2	1	0		**3**
Calhoun	0	0	0	0	0	0	0	**0**	Manatee	1	0	4	1	5	7	2	**20**
Charlotte	2	0	2	0	0	1	0	**5**	Marion	4	6	7	7	12	7	2	**45**
Citrus	4	0	1	2	6	3	2	**18**	Monroe	0	0	1	0	0	1	0	**2**
Clay	1	0	0	2	0	4	1	**8**	Martin	0	0	2	0	0	1	0	**3**
Collier	0	0	3	2	1	9	1	**16**	Nassau	0	0	0	0	3	0	1	**4**
Columbia	0	0	1	0	0	2	1	**4**	Okaloosa	0	0	2	2	0	2	1	**7**
Dade	14	5	11	6	11	6	9	**62**	Okeechobee	0	0	1	1	1	1	1	**5**
Dixie	0	0	0	0	1	0	0	**1**	Orange	5	10	9	10	13	5	9	**61**
Desota	0	0	0	0	1	0	0	**1**	Osceola	1	1	3	4	1	4	2	**16**
Duval	16	9	12	8	10	19	7	**81**	Palm Beach	6	6	14	18	9	10	14	**77**
Escambia	1	0	4	2	0	4	1	**12**	Pasco	2	0	4	8	2	3	3	**22**
Flagler	0	0	1	0	0	0	0	**1**	Pinellas	2	5	6	7	7	5	6	**38**
Franklin	0	0	0	0	0	1	0	**1**	Polk	7	8	17	16	14	14	5	**81**
Gadsden	0	1	0	1	1	0	0	**3**	Putman	0	0	3	0	1	2	1	**7**
Glades	1	0	0	0	0	0	0	**1**	Santa Rosa	2	2	3	1	1	1	1	**11**
Gilchrest	0	0	0	0	0	1	1	**2**	Sarasota	1	1	1	4	5	4	3	**19**
Gulf	0	0	0	0	0	0	0	**0**	Seminole	3	2	4	3	3	4	1	**20**
Hamilton	0	0	0	0	0	0	0	**0**	St. John	2	1	0	1	1	1	1	**7**
Hardee	0	0	0	0	1	1	1	**3**	St. Lucie	0	0	1	3	7	0	0	**11**
Hendry	0	0	0	0	0	0	1	**1**	Sumter	0	2	1	1	1	1	0	**6**
Hernando	1	2	3	0	4	5	1	**16**	Suwannee	1	0	0	1	2	1	1	**6**
Highlands	0	0	0	6	1	2	1	**10**	Taylor	0	0	0	0	0	0	0	**0**
Hillsborough	2	6	9	8	12	13	15	**65**	Union	0	1	7	2	0	0	0	**10**
Holmes	2	0	0	1	0	0	0	**3**	Volusia	1	2	1	4	4	4	2	**18**
Indian River	3	0	0	2	1	2	1	**9**	Walton	0	2	1	0	1	2	0	**6**
Jackson	1	4	1	0	0	1	0	**7**	Wakulla	0	0	0	1	0	1	0	**2**
Jefferson	0	0	0	0	1	1	0	**2**	Washington	0	0	1	0	0	0	0	**1**
Lafayette	0	0	1	0	0	0	0	**1**		45	53	98	106	111	87	70	
	70	48	78	63	92	113	66		total	115	101	176	169	203	200	136	

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Appendix I

STATE CHILD ABUSE REVIEW COMMITTEE

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Representing: Law Enforcement

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Regina Walsh
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Vacant
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Representing: Florida Medical Examiner's Commission

Stephenie Gordy
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Appendix II

"Who's Watching Your Child" Brochure

What Your Partner/Babysitter Needs to Know When Caring for Your Child

Coping with Crying

- ☑ What works best to help your baby stop crying. Show your partner/babysitter how to soothe your baby before you leave.
- ☑ Put the baby in a safe place and call right away, if your baby will not stop crying.
- ☑ What your child likes to do and what toys he likes to play with. Show your partner/babysitter how you and your baby like to play together.

Safe Sleep

- ☑ Your baby always sleeps alone and should never sleep with an adult or another child.
- ☑ Your baby always sleeps on their back in a crib/ bassinet/Pack 'n Play® and should never be put to sleep on a couch, chair, waterbed or any other kind of soft bedding.

Water Safety

- ☑ Always watch your child while in the bathtub, at the swimming pool, near any bodies of water or other things filled with water.

Discipline

- ☑ Never spank, yell, throw things, shake or hit your child.

Diapering/Toileting

- ☑ How to toilet or diaper your child. Let them know it is ok if your child has an accident.
- ☑ Have clean clothes and diapers on hand.

Eating

- ☑ How much your child usually eats and that it is okay if your child does not eat everything.
- ☑ That food messes are okay!

Resources

For more parenting tips and information on local resources, call the Parent HelpLine at 1-800-FLA-LOVE, (1-800-352-5683). Calls are free and confidential.

For free, confidential information and services on domestic violence, call the Domestic Violence hotline at 1-800-500-1119.

To report suspected child abuse and neglect, call the Child Abuse and Neglect hotline at 1-800-962-2873.

Local Resources:

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Kiwanis Florida District

Who's Watching Your Child?

The person you choose to watch your child is one of your most important decisions.

Did you know?

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

You could be making a deadly mistake.

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

Does your partner/babysitter:

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

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

What You Can Do

In case of an emergency and before you leave home:

- Leave your cell phone number and other emergency numbers.
- Let your partner/babysitter know it is okay to call you for help. Check in several times while you are away.

When you get home:

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

Teach your child:

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

Appendix III

The National Center for the
REVIEW & PREVENTION
OF CHILD DEATHS

1115 Massachusetts Ave NW
Washington, DC 20005

2455 Woodlake Circle
Okemos, MI 48864

Phone: (800) 656-2434
Fax: (517) 324-7365

Dear Chairperson Shingledecker:

The citizens of Florida should be proud of the work of the State Child Abuse Death Review Committee. The members of the Committee have dedicated their time and effort to review the deaths of Florida children known to the Department of Social Services and substantiated as dying from abuse or neglect. Our National Center for the Review and Prevention of Child Deaths applauds the high quality of your reviews and this report, which demonstrates a commitment to prevent future deaths of Florida's most vulnerable children.

We especially support your recommendation to amend Florida Statute Section 383.402(1) to expand the scope of your authority to allow you to review all child deaths. Currently, Florida is the only state in the nation to narrowly limit the scope of child death reviews to only deaths already substantiated as child abuse and neglect. If this recommendation is adopted by your policy makers, Florida will join with every other state in the U.S. in following the national standard for child death review. This standard encourages the review of at least all preventable deaths to children under the age of 18. It parallels the 2020 U.S. Healthy People Objectives related to child death review that include:

> Injury and Violence Prevention Objective 4: Increase the number of states and the District of Columbia where 90% of deaths of children aged 17 years and under that are due to external causes (accidents, homicides and suicides) are reviewed by a child fatality review team; and
>
> Injury and Violence Prevention Objective 5: Increase the number of states and District of Columbia where 90% of sudden and unexpected deaths to infants are reviewed by a child fatality reviewed team.

By expanding the scope of your reviews, your State Child Abuse Death Review Committee will be able to continue its excellent work in reviewing known abuse and neglect cases. A number of published studies have demonstrated that the Committee will also be more likely to identify other deaths in which abuse or neglect were factors leading to the deaths. This will improve opportunities to better protect children at risk and obtain justice for the deceased children. Expanding Florida's reviews to other causes such as motor vehicle accidents and drowning, will also create greater opportunities for Florida to take actions to keep all children safe and healthy.

We urge Florida policy makers to adopt this important recommendation and become the 50th state in the nation reviewing preventable child deaths. Congratulations on your report and your efforts to *Keep Kids Alive.*

Sincerely,

Theresa Covington, MPH
Executive Director

Appendix IV

Definitions

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

No Indicators - When there is no credible evidence to support the allegations of abuse, abandonment or neglect**.**

Not Substantiated - When there is credible evidence, which does not meet the standard of being a preponderance, to support that specific harm was the result of abuse, neglect or abandonment. (This used to be called Some Indicators**).**

Verified - When a preponderance of the credible evidence results in a determination that the specific harm or threat of harm was the result of abuse, neglect or abandonment.

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

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

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

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

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

❖ **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/caretaker 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 Section *39.01 (2), F.S.* 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), F.S.*, "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**

According to Section *39.01(31),F.S*. "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), F.S.*

❖ **Adequate Supervision**

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

❖ **Sudden Infant Death (SIDS)**

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

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

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