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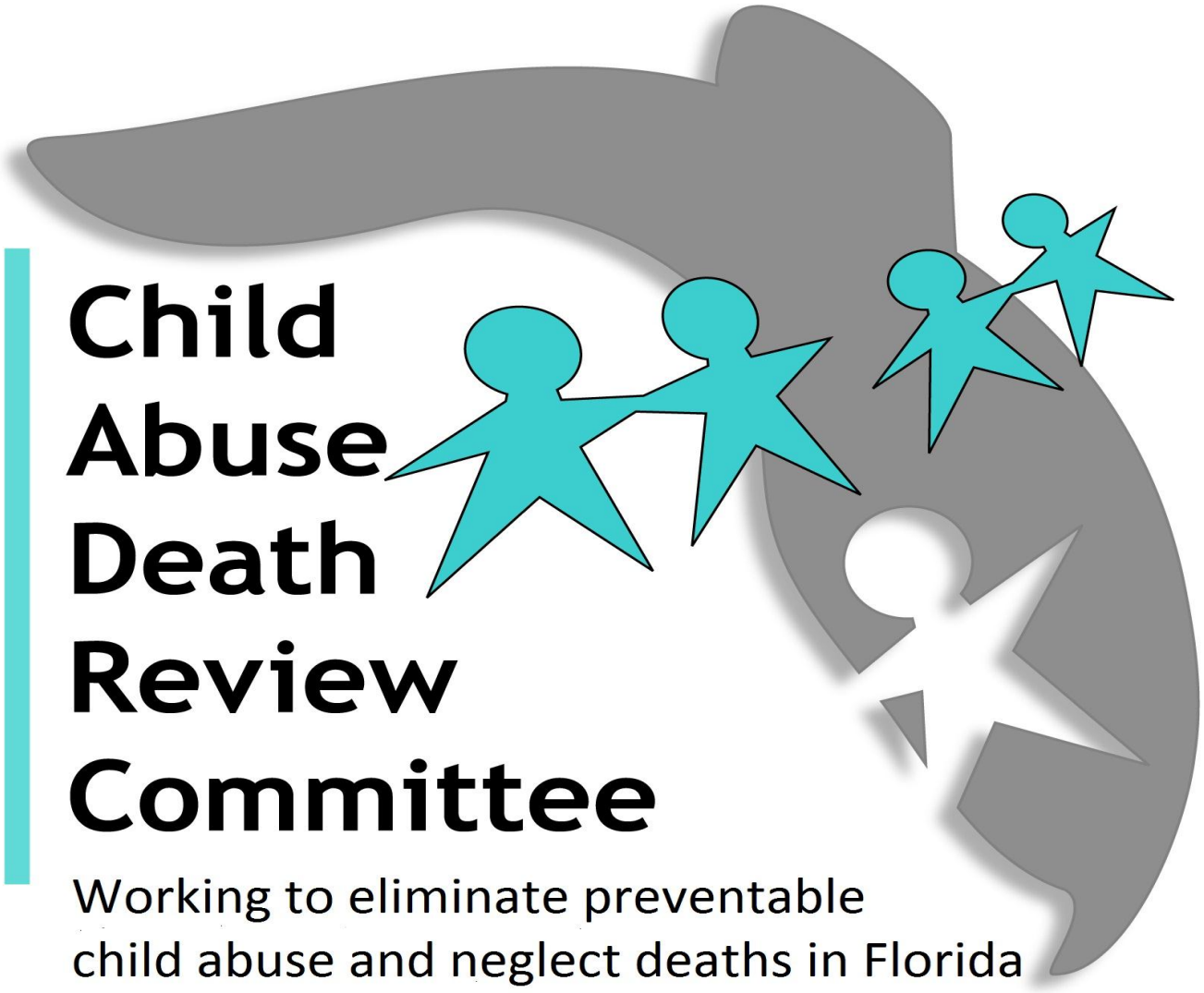


Child Abuse Death Review Committee

Working to eliminate preventable child abuse and neglect deaths in Florida

FLORIDA
CHILD ABUSE DEATH REVIEW COMMITTEE

ANNUAL REPORT

MISSION

To eliminate preventable child abuse and neglect deaths

Submitted to:

The Honorable Rick Scott, Governor, State of Florida
The Honorable Don Gaetz, President, Florida State Senate
The Honorable Will Weatherford, Speaker, Florida State House of Representatives

2014 State Child Abuse Death Review

TABLE OF CONTENTS

BACKGROUND

Program Description

The Florida Child Abuse Death Review Committee was established by statute in 1999. The program is administered by the Florida Department of Health and utilizes state and locally developed multidisciplinary committees to conduct detailed reviews of the facts and circumstances surrounding child deaths reported to the child abuse hotline and accepted for investigation.

Statutory Authority

Section 383.402, Florida Statutes

Program Purpose

The purpose of the child abuse death review process is to:

- Develop a community-based approach to address child abuse deaths and contributing factors.
- Achieve a greater understanding of the causes and contributing factors of deaths resulting from child abuse or neglect.
- Identify gaps, deficiencies or problems in service delivery to children and families by public and private agencies that may be related to child abuse deaths.
- Develop and implement data-driven recommendations for reducing child abuse and neglect deaths.

Membership of the State Committee

The State Child Abuse Death Review Committee consists of seven agency representatives and eleven appointments from various disciplines related to the health and welfare of children and families. Members of the State Child Abuse Death Review Committee are appointed for staggered two (2) year terms. All members are eligible for reappointment. A representative of the Department of Health, appointed by the Secretary of Health, serves as the State Committee coordinator.

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

- Department of Legal Affairs
- Department of Children and Families
- Department of Law Enforcement
- Department of Education
- Florida Prosecuting Attorneys Association

- Florida Medical Examiners Commission, whose representative must be a forensic pathologist

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

- The Statewide Medical Director for Child Protection
- A public health nurse
- A mental health professional who treats children or adolescents
- An employee of the Department of Children and Families (DCF) 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 perpetrators 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

Local Child Abuse Death Review Committees

Local review committees are the cornerstone of the child abuse death review process. These committees have the primary responsibility for reviewing all child abuse and neglect deaths reported to the child abuse hotline and for presenting information relevant to these deaths to the State Child Abuse Death Review Committee. Local committees either are comprised of individuals from the community who have some responsibility when a child dies from abuse or neglect or share an interest in improving the health and welfare of children. A map identifying the location of each local committee is available online at www.flcadr.com.

ELIMINATION OF CHILD DEATHS DUE TO ABUSE AND NEGLECT

The circumstances involved in most child abuse and neglect deaths are multidimensional and require a data driven multi-system review to identify successful prevention and intervention strategies. Careful analysis of the causes and contributing factors across years of data will produce recommendations for changes in law, policy and practice that will promote a true public health approach to the prevention of child maltreatment, and the reduction of preventable child deaths due to abuse and neglect.

METHOD

This report is based on data obtained from:

- Department of Children and Families records reviewed related to investigation, ongoing case work activity, supervision, risk assessment, treatment and safety planning
- Department of Children and Families Internal Fatality Review Reports
- Child Protection Team records
- Law enforcement reports and documents from the Medical Examiner
- Analysis of three years of Florida data from the National Child Death Review Case Reporting System
- Literature review on the topics of child maltreatment, risk and safety assessment, pediatric best practices, and injury and fatality prevention
- *Review of Child Fatalities Reported to the Florida Department of Children and Families*, Casey Family Programs, October 2013
- Recommendations from both the state and local committees

OVERVIEW OF CHILD DEATH DATA

In Florida, the estimated 2013 population of children aged 0-17 was 4.06 million. Of these children, approximately 1.09 million children were under five years old and 211,231 children were less than one year old.

In 2013, the all-cause death rate for children aged 0-17 was 51.8 deaths per 100,000 child population (Florida Community Health Assessment Resource Tool Set Department of Health [Florida CHARTS], 2014). The 2013 verified child maltreatment death rate was 2.6 per 100,000 child population, which represented 5% of the Florida resident child deaths in 2013.

The following table provides a summary of the number and rates of all-cause and verified child maltreatment deaths among children in Florida for 2011, 2012 and 2013.

Child Deaths: All-Causes and Maltreatments Florida, 2011- 2013

Year	Child Deaths (All Causes)	Child Death Rate per 100,000 Child Population	Child Maltreatment Deaths (Verified)	Child Maltreatment Death Rate (Verified)per 100,000 Child Population
2011	2,191	54.8	136	3.4
2012	2,046	50.8	127	3.2
2013	2,105	51.8	107	2.6

The above table is based on data available as of August 28, 2014. Population estimates used to calculate annual death rates were obtained from Florida CHARTS at http://www.floridacharts.com/FLQUERY/Population/PopulationRpt.aspx)

FINDINGS: TREND ANALYSIS BASED ON THREE YEARS OF DATA

The Florida Department of Health entered into a data agreement with the National Center for the Review and Prevention of Child Deaths and began utilizing its Child Death Review Case Reporting System beginning with the reviews of 2011 child deaths. The following data summaries, graphs, and charts in this report are based on reviews of the Florida child abuse and neglect deaths that occurred from 2011 through 2013.

Causes of Death

Abuse and neglect are two broad categories of child deaths comprised from many specific manners of child maltreatment.

As defined by Section 39.01, Florida Statutes:

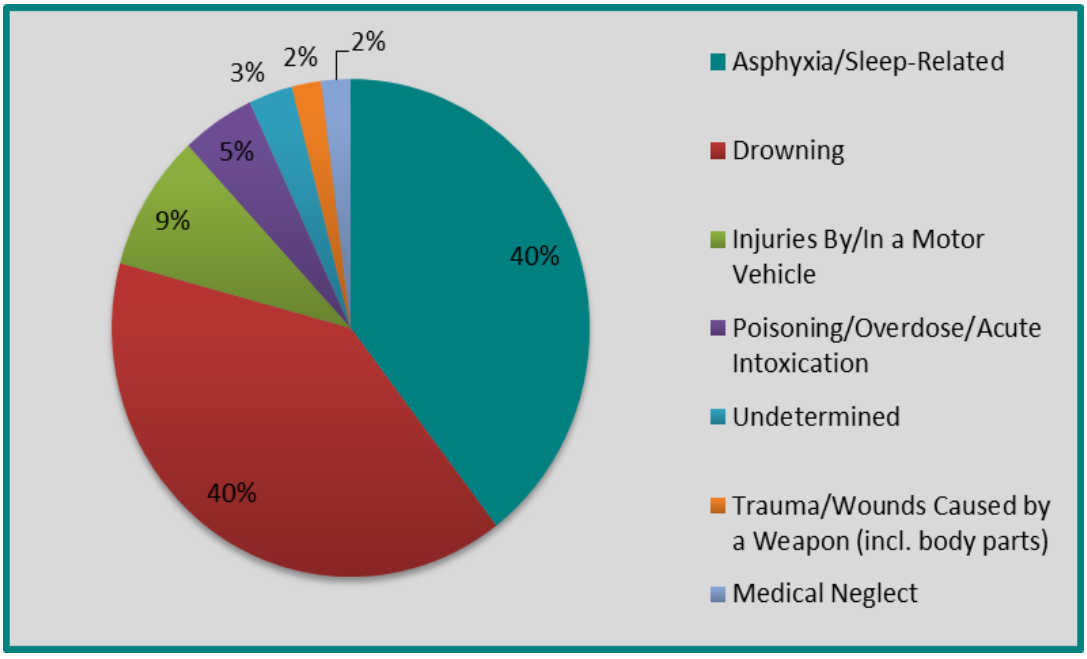
> *"Neglect" occurs when a child is deprived of, or is allowed to be deprived of, necessary food, clothing, shelter, or medical treatment or a child is permitted to live in an environment when such deprivation or environment causes the child's physical, mental, or emotional health to be significantly impaired or to be in danger of being significantly impaired.*

The neglect category consistently represents a majority of Florida's verified child maltreatment deaths during the 2011-2013 period. The proportion of Florida child maltreatment deaths that are due to neglect is similar to the U.S proportion. In 2012, neglect was reported to be a primary component in 70% of U.S. child maltreatment deaths (Children's Bureau, 2013). [Note: The U.S. neglect and abuse percentages are reported as categories; national data reports classify child maltreatment deaths as due to abuse alone, neglect alone, or a combination of both abuse and neglect (Children's Bureau, 2013).]

The following table and graph displays the primary causes of child neglect deaths in Florida for 2011, 2012, and 2013. During the 2011-2013 period, the primary causes of death among child neglect deaths were asphyxia/suffocation, which includes asphyxia/suffocation in bed or other sleep-related environment, and drowning. In 2013, the ranks of these two causes tied at 40% each to represent the causes of over half (80%) of the child neglect deaths. While the proportions of most causes of neglect deaths stayed relatively consistent during the 2011-2013 period, there was a significant increase in the proportion of neglect deaths due to asphyxia/suffocation in bed or other sleep-related environment from Year 2012 to Year 2013.

Primary Causes of Child Neglect Deaths: Florida, 2011-2013						
	2011		2012		2013	
	Counts	Percent	Counts	Percent	Counts	Percent
Drowning	33	36%	37	49%	26	40%
Asphyxia/Sleep-Related	30	33%	19	25%	26	40%
Injuries By/In a Motor Vehicle	9	10%	8	11%	6	9%
Poisoning/Overdose/Acute Intoxication	4	4%	3	4%	3	5%
Undetermined	0	0%	0	0%	2	3%
Medical Neglect	8	9%	2	3%	1	2%
Trauma/Wounds Caused by a Weapon (incl. body parts)	5	5%	3	4%	1	2%
Fall/Crush	1	1%	1	1%	0	0%
Fire/Burn/Electrocution	0	0%	2	3%	0	0%
Exposure	2	2%	0	0%	0	0%
Animal Bite/Attack	0	0%	1	1%	0	0%

Child Neglect Deaths by Primary Causes of Death: Florida, 2013



As defined by Section 39.01, Florida Statutes:

"Abuse" means any willful act or threatened act that results in any physical, mental, or sexual abuse, 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. Corporal discipline of a child by a parent or legal custodian for disciplinary purposes does not in itself constitute abuse when it does not result in harm to the child.

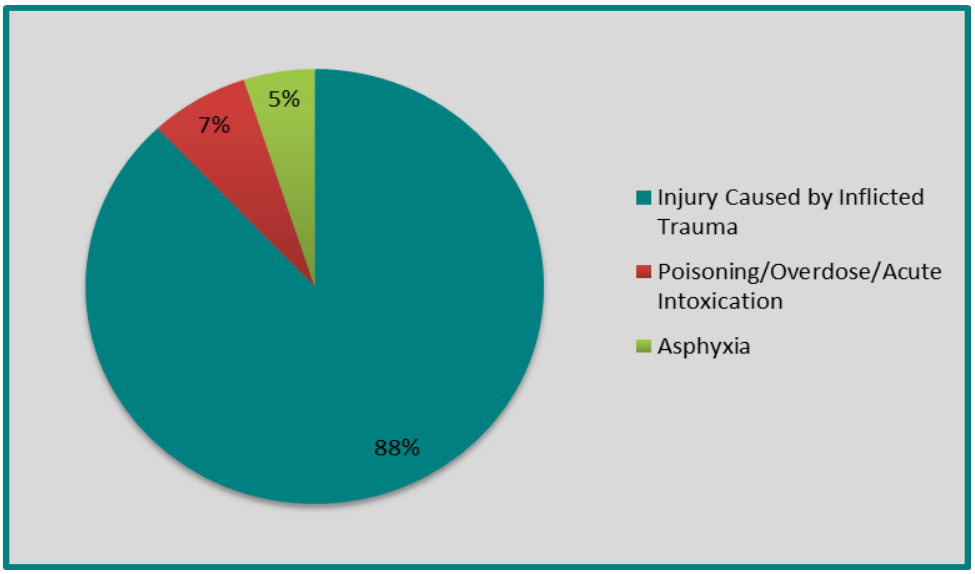
Child maltreatment deaths due to abuse represented slightly over one-third of all child maltreatment deaths between 2011 and 2013. National reports state that for 2011 and 2012, abuse was a primary component in 48% and 44% of U.S. child maltreatment deaths respectively (Children's Bureau, 2012, 2013). [Note: The Children Bureau's Child Maltreatment reports classify child maltreatment deaths as due to abuse alone, neglect alone, or a combination of both abuse and neglect (Children's Bureau, 2012, 2013).]

In Florida, the primary cause of child abuse deaths is injury inflicted by trauma. In 2013, injuries caused by inflicted trauma represent 88% of the child abuse deaths in Florida.

Primary Causes of Child Abuse Deaths: Florida, 2011-2013

	2011		2012		2013	
	Count	Percent	Count	Percent	Count	Percent
Injury Caused by Inflicted Trauma	41	93%	39	76%	37	88%
Poisoning/Overdose/Acute Intoxication	2	5%	2	4%	3	7%
Asphyxia	1	2%	3	6%	2	5%
Drowning	0	0%	4	8%	0	0%
Abandoned Newborn	0	0%	1	2%	0	0%
Fire/Burn/Electrocution	0	0%	1	2%	0	0%
Injuries by or in Motor Vehicles	0	0%	1	2%	0	0%

Child Abuse Deaths by Primary Cause of Death: Florida, 2013



Age at Death

Children less than 1 year old have higher rates of child maltreatment compared to older children (Centers for Disease Control and Prevention [CDC], 2014a). Children less than 4 years old are more likely to experience "severe injury and death" from child abuse than older children (CDC, 2014b).

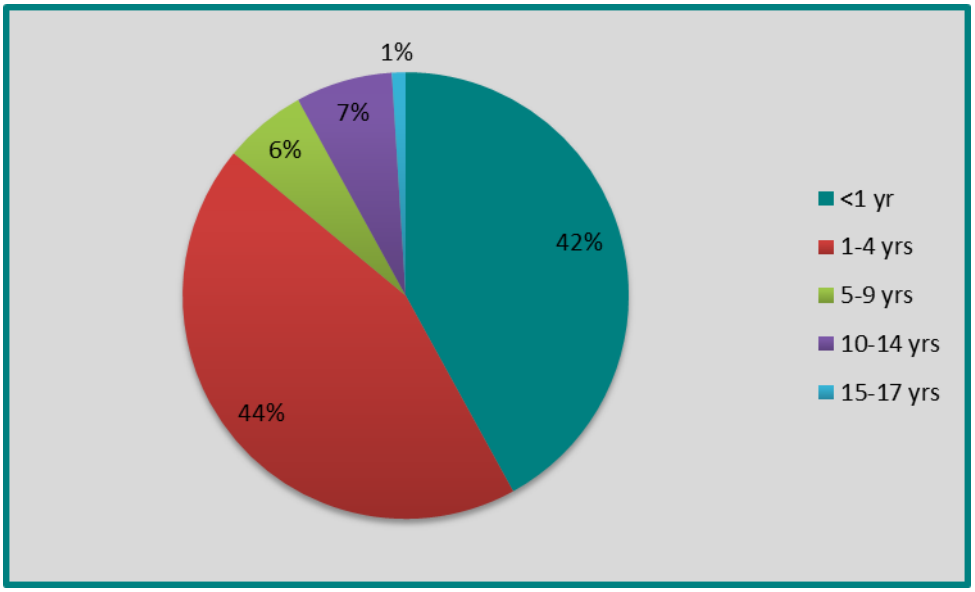
In 2012, children less than 1 year old accounted for 44% of maltreatment deaths among U.S. children (Children's Bureau, 2013). Between 2011 and 2013, maltreatment deaths of children less than 1 year old represented approximately 40% of the child maltreatment deaths among Florida children. During this same period, children less than one year old had higher age-specific rates of maltreatment deaths compared to children aged 1-17 years old. The death rates for children less than 1 year old were nearly four times higher than the death rate for children aged 1-4 years old, which had the second highest rates among children.

Child Maltreatment Deaths by Age Group: Florida, 2011 -2013

	2011		2012		2013	
	Count	Death Rate per 100,000	Count	Death Rate per 100,000	Count	Death Rate per 100,000
< 1	54	24.2	51	24.4	45	21.3
1 – 4	58	6.9	49	5.6	47	5.3
5 – 9	7	0.6	16	1.5	6	0.5
10–14	15	1.3	7	0.6	8	0.7
15 - 17	2	0.3	4	0.6	1	0.1

Note: Population estimates used to calculate age-specific death rates were obtained from Florida CHARTS at http://www.floridacharts.com/FLQUERY/Population/PopulationRpt.aspx.

Distribution of Child Maltreatment Deaths by Age Group: Florida, 2013



Child Gender and Race

For the Florida child maltreatment deaths that occurred during the 2011-2013 period, the majority of the deaths involved male children. During that time, male children in Florida had higher rates of child maltreatment deaths compared to Florida female children as displayed in the following table. This mirrors the higher rates of child maltreatment deaths for males seen in national statistics (Children's Bureau, 2013).

Child Maltreatment Deaths by Child Gender: Florida, 2011 -2013

	2011		2012		2013	
	Count	Death Rate per 100,000*	Count	Death Rate per 100,000*	Count	Death Rate per 100,000*
Females	54	2.8	49	2.5	44	2.2
Males	82	4.0	78	3.8	63	3.0

Note: Population estimates used to calculate gender-specific death rates were obtained from Florida CHARTS at http://www.floridacharts.com/FLQUERY/Population/PopulationRpt.aspx.

Between 2011 and 2013, the majority of the children who died from maltreatment in Florida were white, followed by black children, and children classified as other (i.e., multi-race, American Indian, Asian). However, during this period, black children had the highest rate of child maltreatment deaths per 100,000 compared to white and other race children. This is similar to racial disparities in maltreatment deaths between black and white children that are seen at the national level. For example, the 2012 U.S. mortality rate for non-Hispanic black

children was 4.7 per 100,000 child population compared to 1.6 deaths per 100,000 per child population among non-Hispanic White children (Children's Bureau, 2013).

It is important to note that this Florida data set is incomplete as it does not include specific breakdowns in either race or ethnicity, or consider other mitigating factors. Processes to collect this data for future reports will be assessed.

Age and Relationship of Caregiver(s) Responsible

As defined by Section 39.01, Florida Statutes, "Caregiver" means the parent, legal custodian, permanent guardian, adult household member, or other person responsible for a child's welfare. "Other person responsible for a child's welfare" includes the child's legal guardian or foster parent; an employee of any school, public or private child day care center, residential home, institution, facility, or agency; a law enforcement officer employed in any facility, service, or program for children that is operated or contracted by the Department of Juvenile Justice; or any other person legally responsible for the child's welfare in a residential setting; and also includes an adult sitter or relative entrusted with a child's care.

Persons who were primarily responsible for the welfare of the children at the time of the maltreatment resulting in death, hereafter known as "Caregivers Responsible", may have been classified as such due to direct (e.g., abuse) or indirect actions (e.g., failure to seek medical treatment for a child or failure to protect from harmful acts or environments).

As displayed in the following table, the majority of the caregivers responsible for children who died from child maltreatment between 2011 and 2013 were between the ages of 25 and 34 years old. The 18-24 years old age group was the second largest during the same period.

Caregiver Responsible for Child at Time of Incident by Age Group: Florida, 2011-2013

	2011		2012		2013	
	Count	Percent	Count	Percent	Count	Percent
< 18	7	4%	2	1%	2	2%
18 – 24	55	31%	48	31%	42	32%
25 – 34	76	42%	68	44%	61	46%
35 – 39	10	6%	16	10%	9	7%
40 – 44	13	7%	7	5%	5	4%
45 – 49	4	2%	5	3%	7	5%
50 – 59	10	6%	4	3%	5	4%
> 60	5	3%	3	2%	1	1%

The following table displays types of relationships between the caregiver responsible and the child maltreatment victims who died between 2011 and 2013. For Florida child maltreatment deaths in this period, the primary caregivers responsible were the biological parents. In 2013, the biological parents represented nearly 75% of the caregivers responsible for children who

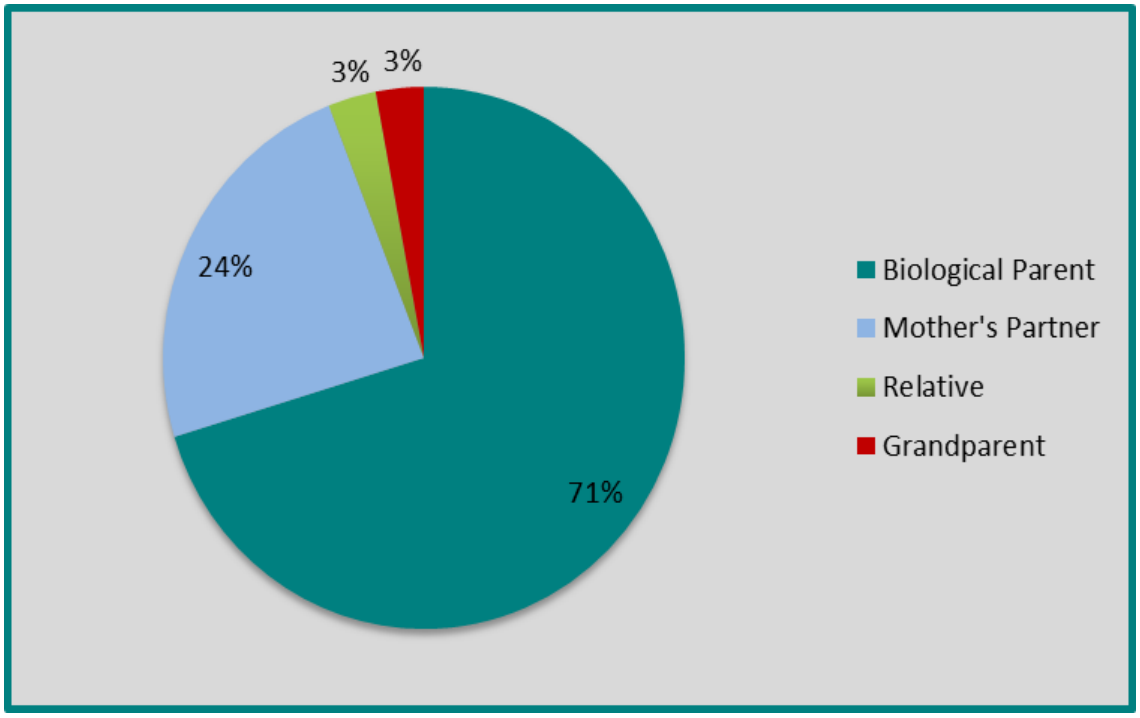
died from maltreatment. A national report states that in 2012, 80% of child maltreatment deaths in the U.S. involved the biological parent (Children's Bureau, 2013).

Between 2011 and 2013, the second most frequent category for caregivers responsible was the mother's partner.

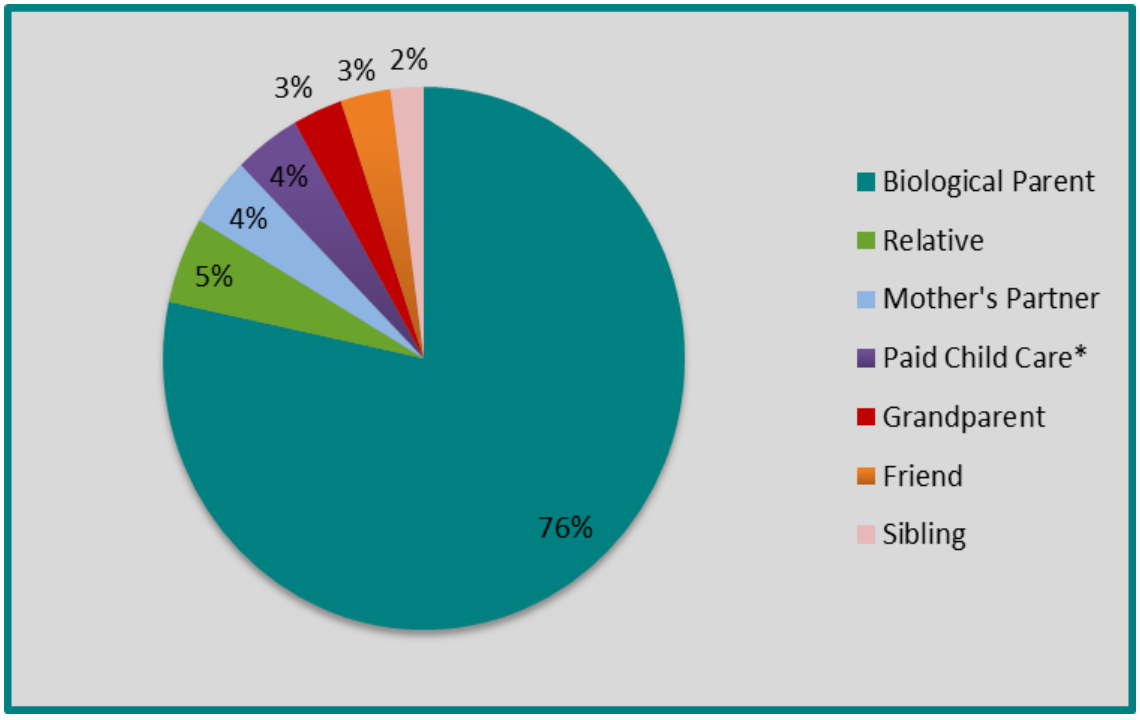
Relationship of Caregiver to Child at Time of Death: Florida, 2011-2013 (* see note below table)						
	2011		2012		2013	
	Count	Percent	Count	Percent	Count	Percent
Biological Parent	123	68%	114	75%	99	74%
Mother's Partner	18	10%	12	8%	13	10%
Other Relative	9	5%	3	2%	6	5%
Grandparent	7	4%	6	4%	4	3%
Friend	4	2%	4	3%	3	2%
Sibling	4	2%	0	0%	2	2%
Institutional Staff	0	0%	2	1%	2	2%
Foster Parent	2	1%	1	1%	1	1%
Father's Partner	2	1%	0	0%	1	1%
Licensed Childcare Worker	3	2%	1	1%	1	1%
Babysitter	3	2%	3	2%	1	1%
Adoptive Parent	2	1%	1	1%	0	0%
Step Parent	1	1%	4	3%	0	0%
Other	2	1%	2	1%	0	0%

*Note: Data includes counts and percentages for caregivers responsible who are designated to have caused or contributed to a child's death due to abuse and neglect. A caregiver responsible can be classified as causing and contributing to a child's death. A caregiver responsible may be also be counted more than once if designated to responsible for multiple deaths (e.g., more than one child in a family).

Relationship of Caregiver to Child for Abuse; 2013



Relationship of Caregiver to Child for Neglect; 2013



* Note: The Paid Child Care category includes licensed childcare workers, institutional staff and babysitters.

Child and Family Risk Factors

In the publication, *New Directions in Child Abuse and Neglect Research* (Institute of Medicine and National Research Council, 2014), the following risk factors were associated with child maltreatment:

- Becoming a parent at a young age
- Poor parenting skills
- Domestic violence
- Substance abuse
- Mental health problems/disorders
- Children with medical, behavioral, and developmental problems
- Income near or below the poverty level
- Social isolation
- Complex and changeable family structures

The presence of multiple and interacting factors can impact a parent's ability to be a nurturing caregiver, putting a child at greater risk for abuse and neglect.

PREVENTION RECOMMENDATIONS

- Partner agencies involved in child safety should continue to support public awareness and education initiatives targeted at prevention campaigns specific to drowning in residential pools and bath tubs and examine other prevention strategies.

- Partner agencies involved in child safety should continue to support public awareness and education initiatives targeted at promoting safe sleep practices.

- The State Child Abuse Death Review Committee, in conjunction with program experts, should perform a critical appraisal/review of the type and level (including an examination of curricula) of domestic violence and substance abuse training (whether academy, pre-service, in-service) provided to law enforcement and child welfare personnel throughout Florida.

- Local DCF offices, contracted, and sub-contracted case management providers, should develop formal partnerships and referral processes with local certified domestic violence centers to enhance the safety of families experiencing domestic violence and establish Memoranda of Understanding (MOUs) with those agencies including law enforcement agencies, state attorney's offices, courts and local probation offices to increase the level of perpetrator accountability.

- The 2015 Florida Legislature should consider the continued investment in prevention programs that have been proven to be successful in improving the health, safety and well-being of Florida's children.

- The quality of the final work product produced by the State Child Abuse Death Review Committee is largely dependent upon the individual case reviews conducted at the local committee level. To ensure a comprehensive and thorough review, the local committee must have the active, candid and critical participation of all parties involved in every aspect of the child's death investigation. Some local committees have reported an unwillingness of crucial stakeholders to participate and a lack of candor or critical analysis by others involved in the review process. It has been reported that this is due in large part to the audio recording requirement as contained in Section 383.412(3) (a), Florida Statutes 2014. The recording requirements of the statute may adversely affect the quality and quantity of information generated during the case review process. Therefore, the State Committee believes that in order to fully comply with its statutory mandate to "achieve a greater understanding of the causes and contributing factors of deaths resulting from child abuse" the legislature should consider repealing the recording provision of Section 383.412(3) (a), Florida Statutes.

- The Child Abuse Death Review Committee should develop a multi-year plan related to the top 3 causes of child abuse and neglect deaths with short and long term goals. The committee should determine applicable data elements needed from local teams, and provide ongoing analysis to establish a foundational framework for prevention.

IN SUMMARY

Historically, the State Child Abuse Death Review Committee was legislatively mandated to review the deaths of children when the Department of Children and Families investigation resulted in verified findings of child abuse or neglect. The scope of this report is consistent with that mandate.

During the 2014 legislative session, the review criteria were expanded to include all cases of child death reported to the Department of Children and Families Abuse Hotline. Going forward, the State Committee will analyze the data provided by the local committees with a focus on multi-year trends. This will improve the State Committee's ability to craft strategic prevention and education strategies to eliminate preventable child deaths.

References

Administration for Children and Families, Children's Bureau. (2012). Child Maltreatment 2011. Washington DC: U.S. Department of Health and Human Services available at http://www.acf.hhs.gov/programs/cb/resource/child-maltreatment-2011.

Administration for Children and Families, Children's Bureau. (2013). Child Maltreatment 2012. Washington DC: U.S. Department of Health and Human Services available at http://www.acf.hhs.gov/programs/cb/resource/child-maltreatment-2012.

Centers for Disease Control and Prevention. (2014a). Child Maltreatment: Facts at a Glance. Available at http://www.cdc.gov/violenceprevention/pdf/childmaltreatment-facts-at-a-glance.pdf

Centers for Disease Control and Prevention. (2014b). Understanding Child Maltreatment – Fact Sheet. Available at http://www.cdc.gov/violenceprevention/pdf/cm-factsheet-a.pdf.

Child Trends. (2013). Infant, Child, and Teen Mortality: Indicators on Children and Youth. Available at: www.childtrendsdatabank.org.

Florida Department of Health. (2014). Florida Community Resource Tool Set. Available at http://www.floridacharts.com/charts/default.aspx

Gumbs, G.R., Keenan, H. T., Sevick, C.J., Conlin, A.S., Lloyd, D.W., Runyan, D.K., Ryan, M.A. & Smith, T.C. (2013). Infant abusive head trauma in a military cohort. Pediatrics, 132: 668-676.

Institute of Medicine and National Research Council. (2014). New directions in child abuse and neglect research. A.C. Petersen, J. Joseph, & M. Feit (Eds.). Washington, DC: The National Academies Press.

Sedlak, A.J., Mettenburg, J., Basena, M., Petta, I., McPherson, K., Greene, A., and Li, S. (2010). *Fourth National Incidence Study of Child Abuse and Neglect (NIS–4): Report to Congress.* Washington, DC: U.S. Department of Health and Human Services, Administration for Children and Families.

Stith, S.M., Liu, T., Davies, L.C., Boykin, E.L., Alder, M. C., Harris, J., Som, A., McPherson, M. & Dees, J.E.M.E.G. (2009). Risk factors in child maltreatment: A meta-analytic review of the literature. Aggression and Violent Behavior, 14: 13-39.

Wu, S.S., Ma, C., Carter, R.L., Ariet, M., Feaver, E. A., Resnick, M.B. & Roth, J. (2004). Risk factors for infant maltreatment: A population-based study. Child Abuse & Neglect, 1253-1264.

Appendix

Definitions

❖ **Cases That Meet the Criteria for Review**

In accordance with *section 383.401, Florida Statutes*, 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.

- Verified: a preponderance of credible evidence exists to determine that the specific harm or threat of harm was a result of abuse, abandonment or neglect
- Not Substantiated: there is credible evidence, but it does not meet the standard of being a “preponderance” to support the harm or threat of harm
- No Indicators: no credible evidence to support a finding

❖ **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. 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.

❖ **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 *sections 39.01 (10) and (46), Florida Statutes.*