Florida Child Abuse Death Review

ANNUAL REPORT

DECEMBER 2024

CHILD ABUSE DEATH REVIEW MISSION:

To eliminate preventable child abuse and neglect deaths

This Annual Report is dedicated to the memory
of all the children who lost their lives in our state in 2023.

The information contained herein can be used
to help prevent future harm to Florida's children.

Submitted to:

The Honorable Ron DeSantis, Governor, State of Florida
The Honorable Ben Albritton, President, Florida Senate
The Honorable Daniel Perez, Speaker, Florida House of Representatives

Table Of Contents

EXECUTIVE SUMMARY

Florida's Child Abuse Death Review System

The Florida Child Abuse Death Review (CADR) System was established in Florida law in 1999. Section 383.402, Florida Statutes (F.S.), delineates CADR as a statewide multidisciplinary, multiagency, epidemiological child abuse death assessment, and prevention system. State and local CADR committees are directed by statute to identify gaps, deficiencies, or problems in the delivery of services to children and their families, recommend changes needed to better support the safe and healthy development of children, and implement those changes to the extent possible.

The goal of the CADR System is to work to eliminate preventable child fatalities in Florida by improving CADR members' collective understanding of the complexities of child maltreatment and leveraging data and evidence-based knowledge to support current and future prevention strategies. This statistical report is submitted annually to the Governor, President of the Florida Senate, and Speaker of the Florida House of Representatives.

2022 Data: Case Review Analysis

The State CADR committee opted to reexamine 2022 data to provide a more representative sample and comprehensive report. As of August 28, 2024, local CADR committees reviewed 435 child fatalities that occurred in 2022. Analysis of the case review data revealed that children under the age of 5 have the highest number of child deaths reported to the Florida Department of Children and Families' (DCF) Florida Abuse Hotline and continue to be at the greatest risk for preventable child death. The three leading causes of preventable child death in 2022 remain the same as the previous year's report and are listed below in order of greatest to least incidence.

1. **Sleep-Related Infant Death** is the leading cause of preventable child death in Florida and is often the result of unsafe sleep practices. Sleep-related deaths represent 42.3% of 2022 child fatalities reviewed by the CADR System. Infants 4 months of age and younger constitute 73.9% of all 2022 sleep-related fatalities. Infants placed to sleep on adult beds, couches, and other soft surfaces, as well as infants sharing a sleep surface with another child or adult, are at significant risk of suffocation and sleep-related death.
2. **Unintentional Drowning** is the second leading cause of preventable child death, representing 20.5% of all child fatalities reviewed by the CADR System. Children 5 years of age and younger make up 86.5% of all 2022 drowning-related fatalities reviewed by the CADR System. Ineffective physical barriers and inadequate supervision continue to be primary contributing factors to drowning incidents in young children. Inadequate supervision can include caregivers who are present but distracted and caregivers who are not within visible or audible range when a child is in or near water.
3. **Inflicted Trauma** is the third leading cause of preventable child death, representing 9.7% of child fatalities reviewed by the CADR System. Children 5 years of age and younger represented 47.6% of these fatalities, whereas the remaining inflicted trauma incidents were found in children 6-10 years of age (14.3%) and 11 years and older (38.1%). Inflicted trauma includes suicide and abuse to a child by bodily force, such as the use of hands, fists, and feet, or by the use of firearms and other weapons.

Comparison of 2023 and 2024 Annual Report

In the 2023 Annual Report, there were a total of 237 child fatalities reviewed from the 282 cases available (84.0%) and 472 total cases overall (50.2%) reported to the Florida Abuse Hotline in 2022.

As of August 28, 2024, there were 441 cases available for review, of which 435 were completed (98.6%), leading to an overall completion of 92.2% for 2022 cases. Below is a breakdown of percentage changes for the three leading causes of preventable child death, following the review of additional 2022 cases:

- Sleep-related deaths encompass 42.3% (186) of 2022 child fatalities reviewed, compared to 41.0% (96) in the previous year's report.
- Unintentional drowning deaths encompass 20.5% (89) of 2022 child fatalities reviewed, compared to 25.3% (60) in the previous year's report.
- Inflicted trauma deaths encompass 9.7% (42) of 2022 child fatalities reviewed, compared to 10.1% (24) in the previous year's report.

Prevention Recommendations

The following prevention recommendations developed by the State CADR Committee provide an overview of strategies and approaches intended to address preventable child fatalities in Florida (complete details of these recommendations are in Section Eight):

- Promote evidence-based drowning prevention strategies through the implementation and dissemination of statewide guidelines and best practices.
- Continue to promote and educate the public on the importance of safe sleep practices for infants through the ongoing implementation and evaluation of data-driven programs and initiatives.
- Continue to ensure all local CADR committees consistently report hazardous consumer products to the Consumer Product Safety Commission (CPSC), dating back to deaths occurring on or after January 1, 2021, in alignment with CPSC's reporting requirements.
- Continue to assess and adapt approaches to suicide prevention and postvention through community and state-level partnerships.
- Continue to develop and submit recommendations to the National Center for Fatality Review and Prevention (NCFRP) regarding potential changes to the National Fatality Review-Case Reporting System (NFR-CRS) to incorporate fields that would better contribute to a deeper understanding of child fatalities in Florida.
- Continue efforts to relay timely information to caregivers and community supports regarding the safety of children.

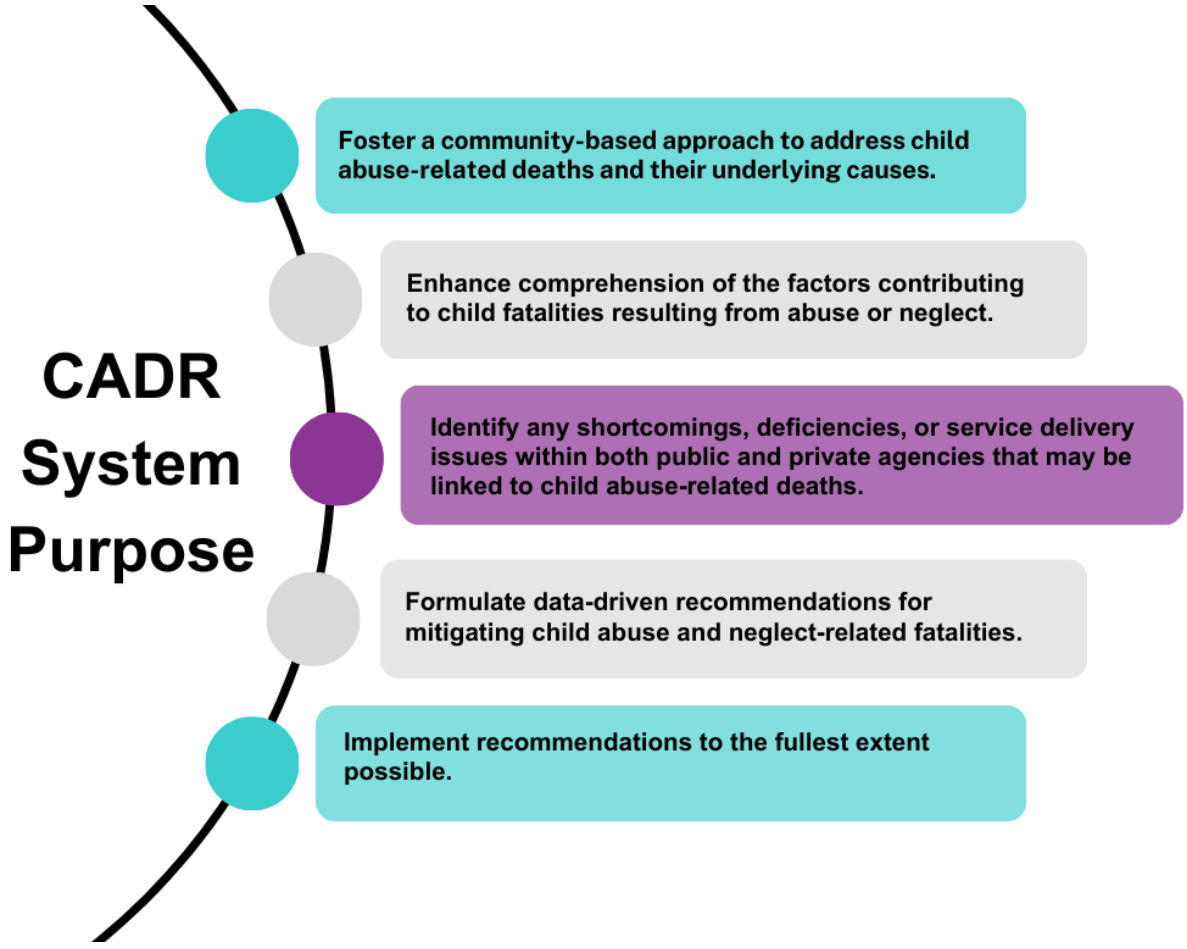
SECTION ONE: 2024 CADR BACKGROUND

System Description

The Florida Department of Health (Department), Division of Children's Medical Services, Bureau of Child Protection and Special Technologies, CADR Unit, administers this system, which utilizes local CADR committees to conduct comprehensive evaluations of the circumstances surrounding child fatalities reported to DCF's Florida Abuse Hotline and accepted for investigation. These committees employ a public health approach to examine child fatality cases with reported suspicions of abuse or neglect. Subsequently, the State CADR Committee aggregates and analyzes data from these local reviews to produce an annual statistical report.

Statutory Authority

The CADR System operates under the legal framework of section 383.402, F.S., as detailed in Appendix A.



State CADR Committee

The State CADR Committee oversees the activities of local CADR committees and engages in a comprehensive analysis of statewide data. This analysis informs evaluations of the adequacy of existing laws, rules, training programs, and services. Recommendations for necessary changes are developed to reduce the incidence of child abuse-related deaths. Strategies are devised, and partnerships are forged at both the state and local levels to implement these changes.

The State CADR Committee comprises seven agency-specific representatives appointed by the respective agency heads and 12 representatives appointed by the Department's State Surgeon General. These 12 members represent various disciplines dedicated to the well-being of children and families. Members of the State CADR Committee, as outlined in Appendix B, serve staggered two-year terms. Reappointment is permitted, but members may not exceed three consecutive terms. The committee selects a chairperson from among its members to serve a two-year term. The agencies responsible for appointing members to the State CADR Committee are:

- Florida Department of Health
- Florida Office of the Attorney General
- Florida Department of Children and Families
- Florida Department of Law Enforcement
- Florida Department of Education
- Florida Prosecuting Attorneys Association, Inc.
- Florida Medical Examiners Commission, with the requirement that the representative be a forensic pathologist

In addition to the above members, the State Surgeon General appoints the following individuals based on recommendations from the Department and the agencies listed above, ensuring varied representation:

- The Department's Statewide Child Protection Team Medical Director
- A public health nurse
- A mental health professional specializing in children or adolescents
- A DCF employee responsible for supervising family services counselors, with 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 experienced in working with child abuse victims and perpetrators
- A paraprofessional trained in patient resources employed in a child abuse prevention program
- A law enforcement officer with a minimum of five years of experience in children's issues

- A representative from a Florida Domestic Violence organization
- A representative from a private provider of programs addressing child abuse and neglect prevention
- A substance abuse treatment professional

Local CADR Committees

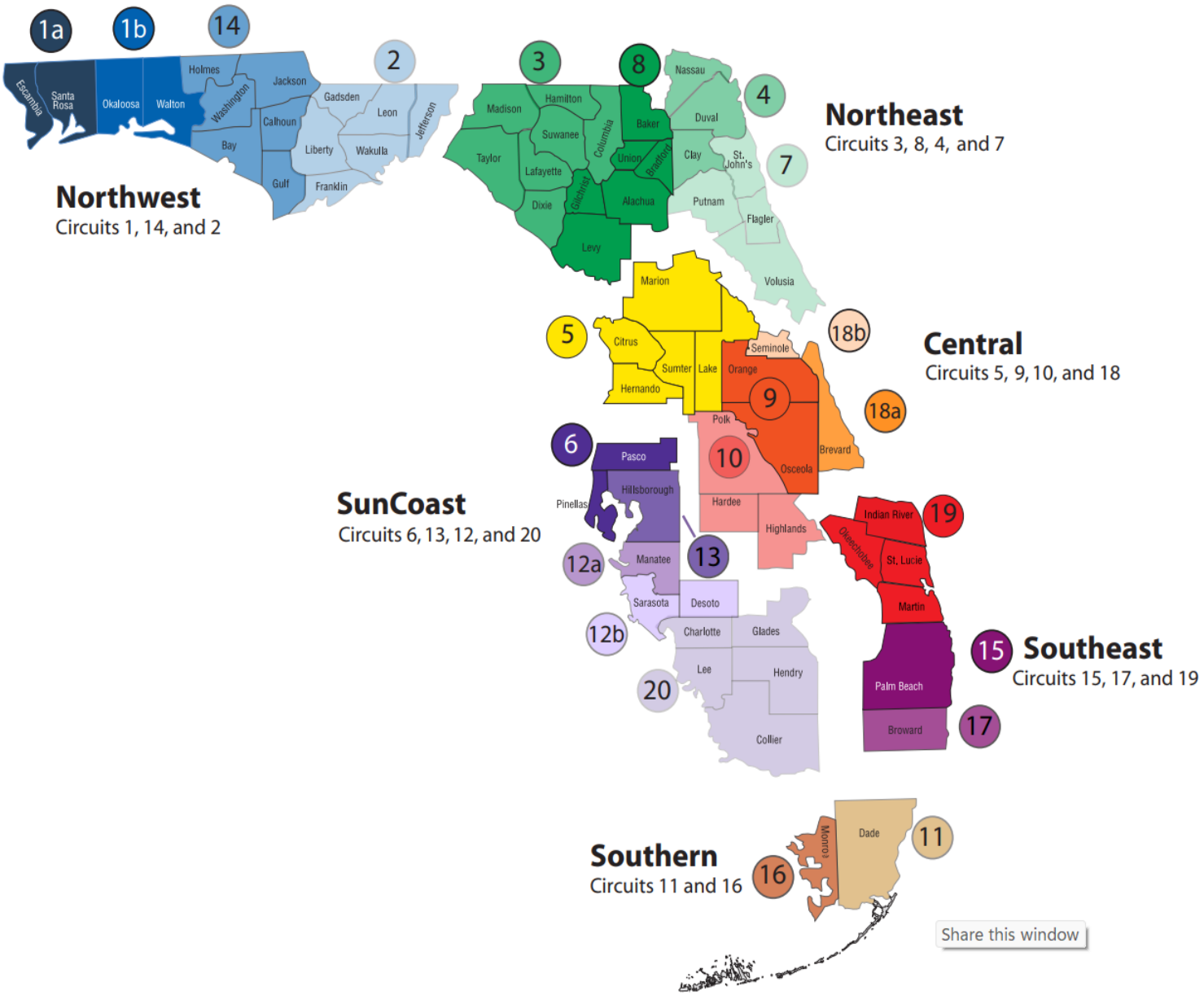
Local CADR committees are responsible for reviewing all closed cases involving alleged child abuse and neglect deaths reported to the DCF Florida Abuse Hotline, then present relevant information to the State CADR Committee. Comprising members from various community agencies within Florida's judicial circuits, local CADR committees share a common interest in promoting, safeguarding, and improving the well-being of children. Details about local CADR committee membership can also be found in Appendix B.

County Health Department Directors, designated as CADR Health Officers, appoint, convene, and support these committees. At a minimum, representatives from the following organizations are appointed by CADR Health Officers:

- The State Attorney's Office
- The Medical Examiner's Office
- The local DCF Child Protective Investigations Unit
- The Department's Child Protection Team
- Community-based care lead agency
- State, county, or local law enforcement agencies
- School district
- A mental health treatment provider
- A certified domestic violence center
- A substance abuse treatment provider
- Any other members specified in guidelines developed by the State CADR Committee

Due to the strong partnership between the Department and DCF within the CADR System, local CADR committees are structured to align with both Florida's Judicial Circuits and the six DCF regions across the state, as illustrated below.*

Figure 1: Map of Local CADR Committees and DCF Regions



**Local CADR committees across Florida align with Judicial Circuits; however, Circuits 1, 12, and 18 each have two distinct local CADR committees.*

SECTION TWO: METHOD

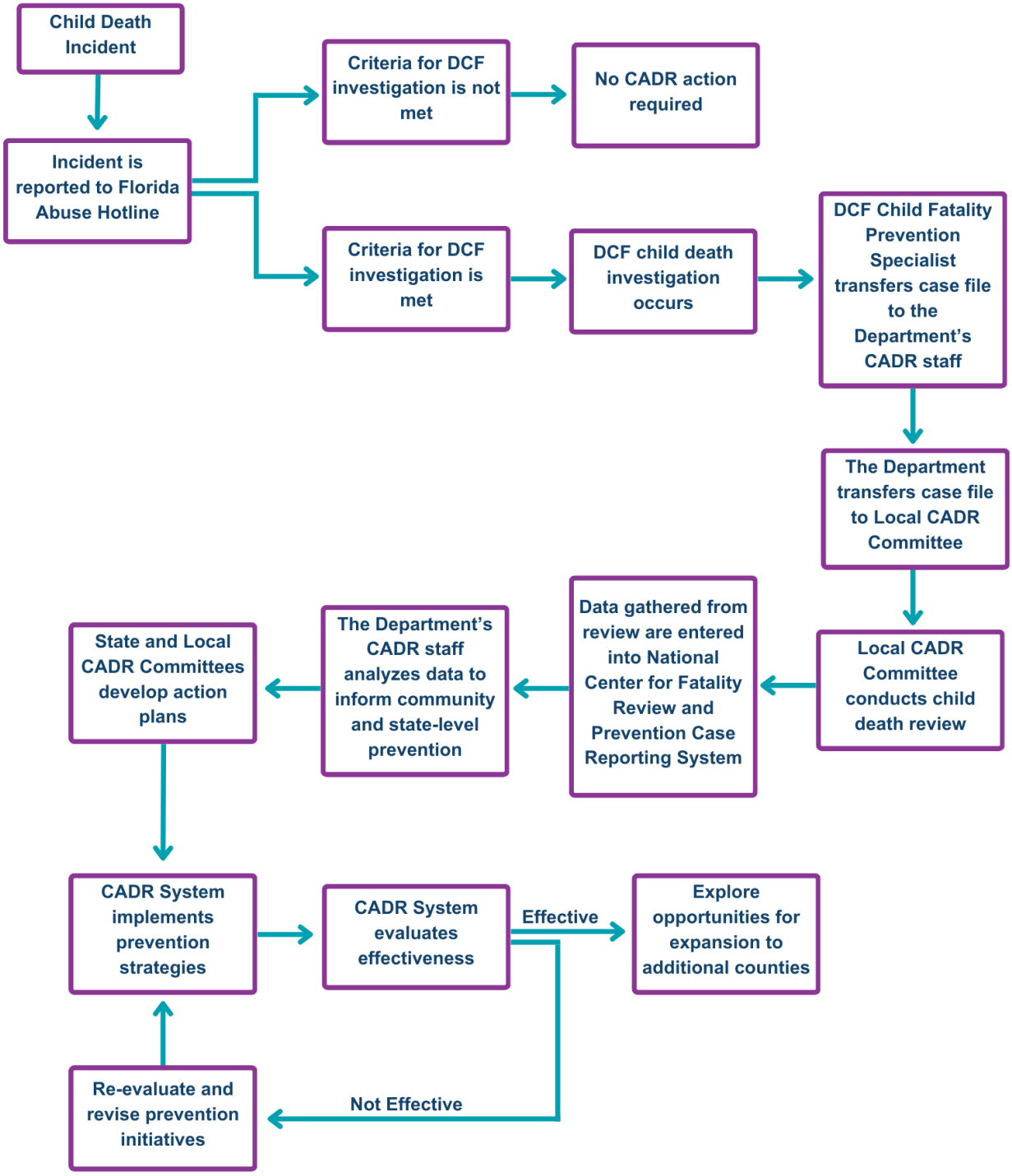
CADR Process Overview

The CADR process includes numerous essential steps, guiding CADR stakeholders from the initial child fatality incident through the execution of state and community-level prevention initiatives. Local CADR committees receive strong encouragement to adopt a holistic, community-wide approach in addressing the root causes and contributing factors behind child maltreatment-related deaths. Moreover, the committees are urged to proactively implement identified strategies to the fullest extent possible. It is crucial to acknowledge that local CADR committees explore solutions beyond the confines of the child welfare system when identifying and executing prevention strategies.

The flowchart presented in Figure 2 delineates the intricate, multiagency CADR process. This visual representation serves as a framework that embodies the collective commitment to building upon the insights gained and advancing the endeavors of CADR. The CADR System remains unwavering in ensuring that all decision-making is underpinned by relevant data, enabling informed and impactful choices.

The method and process in Florida aims to enhance child safety, deepen the understanding of child abuse and neglect, and drive systemic improvements to protect children and support families effectively.

Figure 2: Multiagency CADR Process



SECTION THREE: DATA

Case Review Statistics

This report includes information on closed child fatality cases with an element of suspected maltreatment, which were reviewed and entered into the NFR-CRS by August 28, 2024. There were 441 child fatality review cases available for analysis, of which 435 were completed and thus included in this report. Cases not included in this report consist of those that remain open to DCF for investigation, cases under investigation by the Florida State Attorney's Office, or cases where a local CADR committee was explicitly advised not to review until further notice.

Judicial circuits continue to experience a backlog of cases impacting data made available for CADR; specifically, cases of inflicted trauma and child homicide. To address case review delays, local CADR committees are responsible for developing a plan to complete the review of backlogged cases following the completion of the annual reporting year's cases.

Child maltreatment findings are based on the following criteria:

- Verified – A preponderance of the credible evidence results in a determination that the specific harm or threat of harm was the result of abuse, abandonment, or neglect.
- Not Substantiated – There is credible evidence, which does not meet the standard of being a preponderance, to support that the specific harm was the result of abuse, abandonment, or neglect.
- No Indicators – There is no credible evidence to support the allegations of abuse, abandonment, or neglect.

References are made to unknown and missing data in certain graphs, charts, and tables throughout this section of the report.

- Unknown – A value selected in the NFR-CRS when the answer to a given question is not known, despite efforts by the local CADR committee to obtain the information.

- Missing – Questions that were not answered when a child fatality case was entered into the NFR-CRS, result in a missing data value.

Child Death Trends

Counts and rates of all causes of child death derived from Vital Statistics and verified child maltreatment deaths from CADR are displayed in Table 1.

In 2022, the all-cause death rate for children aged 0-17 was 51.4 deaths per 100,000 child population (FL Health CHARTS, 2024). This rate has fluctuated annually over the last 12 years and does not indicate a particular trend or pattern. Every year, more than 2,000 Florida children die. Of these deaths, a proportion are reported to and investigated by DCF and reviewed by local CADR committees, and some are found to be maltreatment related. In 2022, 472 of the total child deaths in the state were investigated by DCF, with 83 of these investigated deaths determined to be verified maltreatment cases.

Table 1: Child Deaths: All Causes and Maltreatments, Florida, 2011-2022

Year	Resident Child Deaths All Causes	Resident Child Death Rate per 100,000 Population	Total Cases (Child Deaths Reported to Hotline)	Verified Child Maltreatment Deaths	Cases Pending (DCF)*	Cases Pending (Local Review)**
2011	2,191	54.2	428	136	-	-
2012	2,046	50.9	411	129	-	-
2013	2,105	52.5	436	137	-	-
2014	2,131	52.9	445	156	-	-
2015	2,249	55.4	473	123	-	-
2016	2,217	54.1	463	110	-	-
2017	2,236	54.1	462	113	-	-
2018	2,128	50.7	440	119	1	4
2019	2,107	49.7	398	91	3	14
2020	2,107	49.2	446	104	6	40
2021	2,227	51.6	450	66	27	68
2022	**2,272**	**51.4**	**472**	**83**	**28**	**9**

**Cases Pending (DCF) includes cases that are still open for investigation or recently closed.*
***Cases Pending (Local Review) includes cases available, but are not yet reviewed.*

2022 Case Status Summary

Table 2 details the distribution of 2022 child fatalities assigned to each local CADR committee, including child fatalities reported to the Florida Abuse Hotline, cases that were not available for review, cases awaiting review, and cases reviewed and analyzed as of August 28, 2024.

Table 2: Case Review Status of Child Deaths by Local CADR Committees				
Circuit	**Total Cases (Child Deaths Reported to Hotline)**	**Cases Not Available for Review (Open Investigation/ Case in Processing)**	**Cases Closed by DCF**	**Cases Completed and Available for Annual Report**
1a	11	0	11	11
1b	7	0	7	7
2	5	0	5	3
3	7	1	6	5
4	40	3	37	37
5	41	0	41	41
6	27	3	24	22
7	21	1	20	20
8	5	0	5	5
9	37	0	37	37
10	44	0	44	44
11	41	2	39	39
12a	8	0	8	8
12b	4	0	4	4
13	35	2	33	33
14	10	1	9	9
15	23	6	17	14
16	0	0	0	0
17	36	6	30	30
18a	20	0	20	20
18b	10	0	10	10
19	19	2	17	16
20	21	1	20	20
Total	**472**	**28**	**444**	**435**

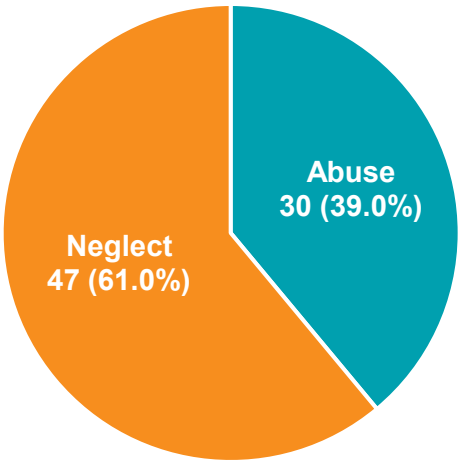
By the end of 2022, 472 child fatalities were reported to the Florida Abuse Hotline. Of these fatality cases:

- 444 cases were closed by DCF, in which 441 were available for review.
    - Of those available, 435 reviews were completed (98.6%).
    - The remaining cases available are scheduled for review after August 28, 2024.

- 28 cases were still open for DCF investigation, or were recently closed, therefore case information was unavailable for review by August 28, 2024. Findings may change once all available cases of child fatalities for 2022 are reviewed.

- Of the 77 verified maltreatment deaths reviewed, 47 (61.0%) were the result of neglect, and 30 (39.0%) were the result of abuse (Figure 3).

Figure 3: Verified Maltreatment Deaths by Type of Maltreatment (n=77)



Child Demographic Characteristics

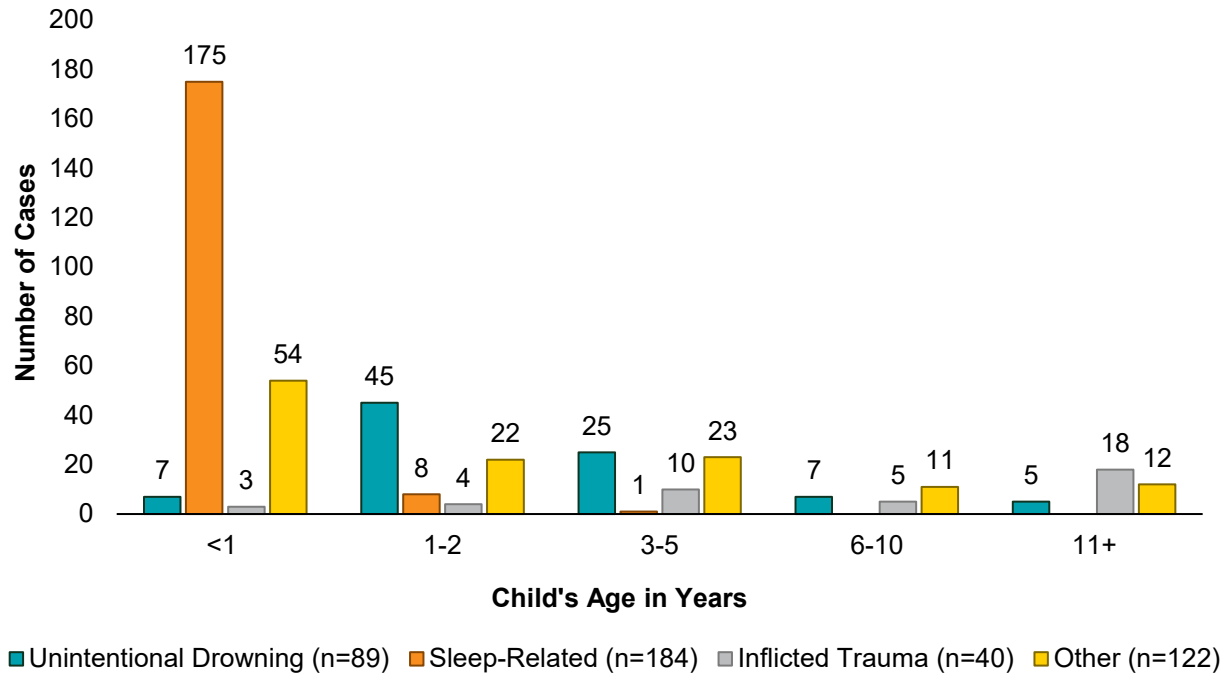
Child's Age

Children aged 5 and under comprised the majority of all fatalities, representing 377 of 435 (86.7%) cases.

As shown in Figure 4:

- Among unintentional drowning deaths, 77 of 89 (86.5%) were children 5 years of age and younger. Most of these deaths (67.4%) occurred in children between ages 1-3 years old.
- Among sleep-related deaths, 175 of 184 (95.1%) were children less than 1 year of age and most of these incidents (73.9%) occurred in infants 4 months old and younger.
- 54 of 122 (44.3%) child deaths attributed to other causes occurred in children younger than 1 year of age.

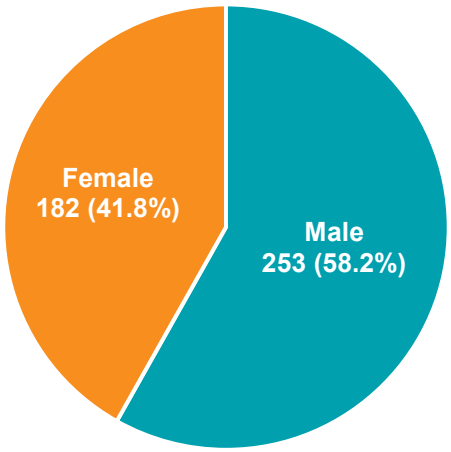
Figure 4: Age of Children by Primary Cause of Death (N=435)



Child's Sex

Figure 5 shows the distribution of sex in the 435 reviewed cases. Males were disproportionately represented among child fatalities, accounting for 58.2% of all reviewed cases.

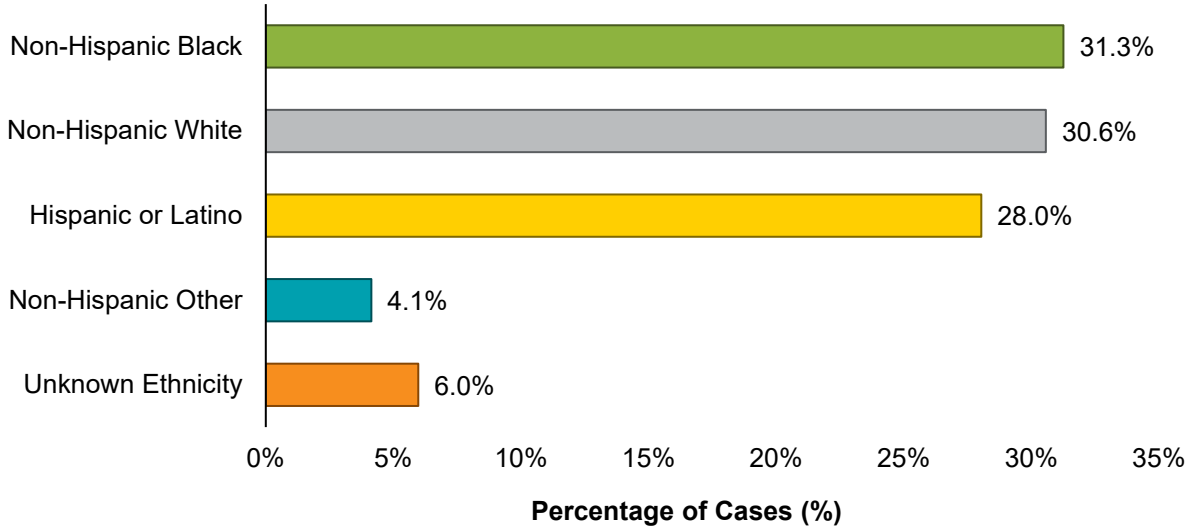
Figure 5: Child's Sex (N=435)



Race and Ethnicity of Child

As displayed in Figure 6, 136 of 435 (31.3%) children were non-Hispanic Black, and 133 (30.6%) were non-Hispanic White. Children of Hispanic or Latino ethnicity represent 122 (28.0%) total cases,18 (4.1%) were non-Hispanic other, and 26 (6.0%) were of unknown ethnicity. Non-Hispanic other can include Alaska Native, American Indian, Asian, Native Hawaiian, Pacific Islander, or multiple races.

Figure 6: Race and/or Ethnicity of Children (N=435)



Child Demographic Characteristics Data Summary

- 54.9% of all child fatality cases received by CADR involved children who were less than 1 year old.
- 58.2% of all child fatality cases received by CADR involved male children.
- 31.3% of all child fatality cases received by CADR were identified as non-Hispanic Black, whereas 30.6% were identified as non-Hispanic White. Children of Hispanic or Latino ethnicity, regardless of race, constituted 28.0% of all cases.

Location of Child Deaths

The incident county refers to the county where the incident that led to the death took place, which may be different from the child's residence county or the county where the child was declared deceased. The distribution of cases by incident county is shown in Table 3.

Table 3: County of Death Incident (N=435)					
Incident County (Circuit)*	Leading Causes of Death				Total
	Unintentional Drowning	Sleep-Related	Inflicted Trauma	Other	
Alachua (8)	0	0	2	0	2
Baker (8)	0	3	0	0	3
Bay (14)	0	3	1	1	5
Brevard (18a)	6	7	1	6	20
Broward (17)	7	11	2	10	30
Calhoun (14)	0	1	0	0	1
Charlotte (20)	0	1	0	1	2
Citrus (5)	1	4	0	1	5
Clay (4)	2	3	0	0	5
Collier (20)	1	0	0	1	2
Columbia	0	1	0	0	1
De Soto (12b)	1	1	0	0	2
Dixie (3)	0	1	0	0	1
Duval (4)	2	19	1	7	29
Escambia (1)	0	6	1	1	8
Flagler (7)	2	0	0	1	3
Gilchrist (8)	0	0	0	3	3
Hamilton (3)	0	1	0	0	1
Hardee (10)	0	2	0	1	3
Hernando (5)	1	2	2	2	7
Highlands (3)	2	2	1	1	6
Hillsborough (13)	7	14	4	9	34
Indian River (19)	1	1	1	0	3
Jackson (14)	0	1	0	0	1
Lake (5)	2	6	0	6	14
Lee (20)	4	4	1	7	16
Leon (2)	0	1	0	2	3
Madison (3)	0	1	0	0	1
Manatee (12a)	3	5	0	0	8
Marion (16)	4	5	2	2	13
Martin (19)	0	1	0	1	2
Miami-Dade (11)	7	6	6	20	39
Nassau (4)	0	1	0	0	1
Okaloosa (1b)	1	3	0	0	4
Okeechobee (19)	1	1	0	0	2
Orange (9)	6	10	4	5	25
Osceola (9)	8	1	2	1	12
Palm Beach (15)	5	6	0	3	14
Pasco (6)	0	5	2	3	10
Pinellas (6)	0	6	3	2	11
Polk (10)	3	18	2	12	35
Putnam (7)	3	1	0	1	5
Saint Johns (7)	0	1	1	2	4
Saint Lucie (19)	2	5	1	1	9
Santa Rosa (1a)	0	2	0	1	3
Sarasota (12b)	0	0	0	2	2
Seminole (18a)	5	3	2	0	10
Sumter (5)	0	0	0	1	1
Suwannee (3)	0	0	0	1	1
Volusia (7)	0	6	0	1	7
Walton (1b)	2	1	0	0	3
Washington (14)	0	1	0	1	2
Total	**89**	**184**	**42**	**120**	**435**

**Table 3 does not depict all 67 Florida counties, as it only comprises reviewed cases available for this annual report. Thus, counties with cases that have not been closed or reviewed are excluded.*

Of the top three primary cause of death categories:

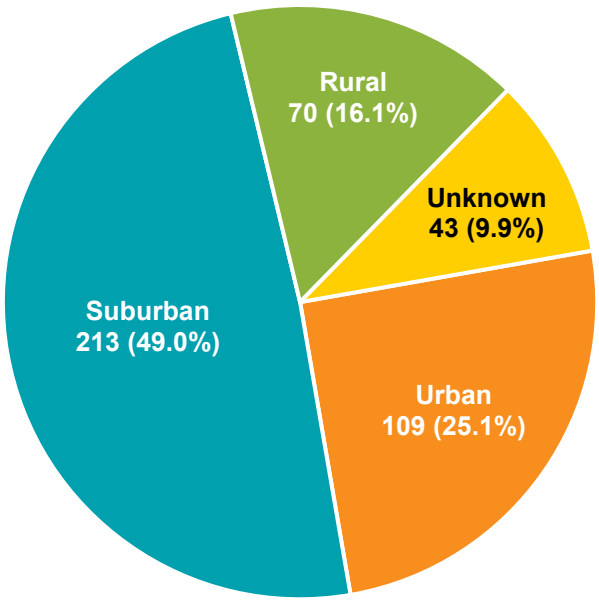
- 79 of 184 (42.9%) of all sleep-related deaths occurred in six counties: Duval (19), Polk (18), Hillsborough (14), Broward (11), Orange (10), and Brevard (7). Duval County accounted for 10.3% of these cases.
- 41 of 89 (46.1%) of unintentional drowning deaths occurred in six counties: Osceola (8), Hillsborough (7), Broward (7), Miami-Dade (7) Orange (6), and Brevard (6). Osceola County accounted for 9.0% of these cases.
- The 42 deaths due to inflicted trauma occurred across 21 counties: Miami-Dade (6), Hillsborough (4), Orange (4), Pinellas (3), Osceola (2), Broward (2), Seminole (2), Marion (2), Polk (2), Hernando (2), Pasco (2), Alachua (2), Brevard (1), Lee (1), Duval (1), Saint Lucie (1), Highlands (1), Indian River (1), Escambia (1), Bay (1), and Saint Johns (1).

Incident Area Type

Figure 7 displays the type of area where child death incidents occurred. Of the 435 cases reviewed, 213 (49.0%) took place in suburban areas. The remaining incidents included 109 (25.1%) that occurred in urban areas and 70 (16.1%) in rural areas.

Suburban is defined as a residential district located on the outskirts of a city. Urban is defined as a large city or densely populated area. A rural area is a community with low population densities and can include agricultural and recreational land.

Figure 7: Type of Area where Incident Occured (N=435)



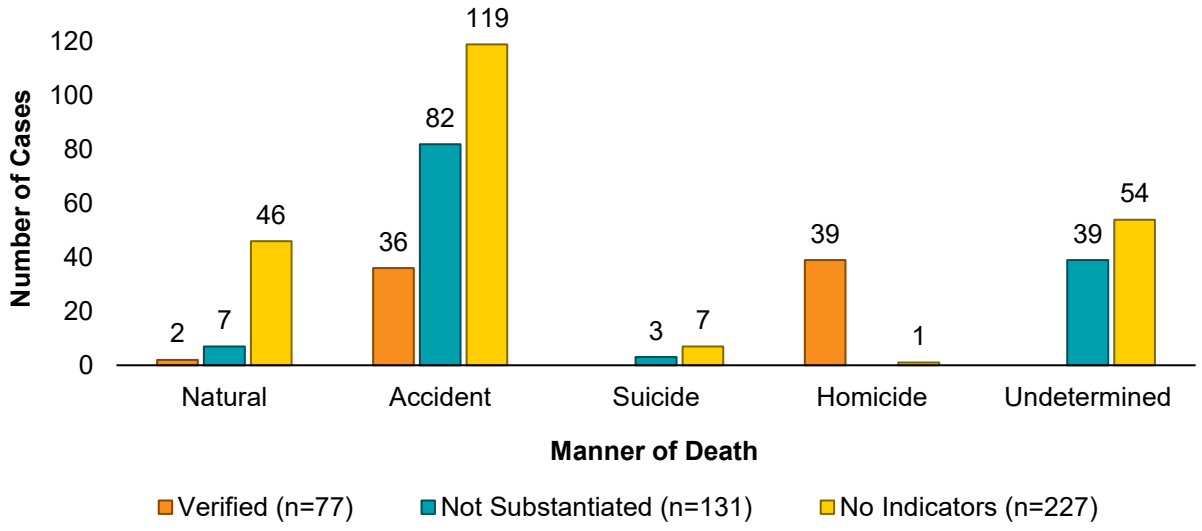
Official Manner of Death

Child fatality reviews document the official manner and cause of death as recorded on the child's death certificate, as well as the maltreatment verification finding that results from DCF investigation.

Figure 8 displays the official manner of death for all child fatalities reviewed in this report.

- Of the 77 verified maltreatment deaths, 36 (46.8%) were classified as accidents, 39 (50.6%) were homicidal manner, and 2 (2.6%) were natural manner.
- Out of 131 not substantiated deaths, 82 (62.6%) were classified as accidents, 39 (29.8%) were undetermined manner, seven (5.3%) were natural manner, and three (2.3%) were suicidal manner.
- Of the 227 deaths with no indicators of maltreatment, 119 (52.4%) were classified as accidents, 54 (23.8%) were undetermined manner, and 46 (20.3%) were natural manner.

Figure 8: Manner of Death by Maltreatment Verification Status (N=435)

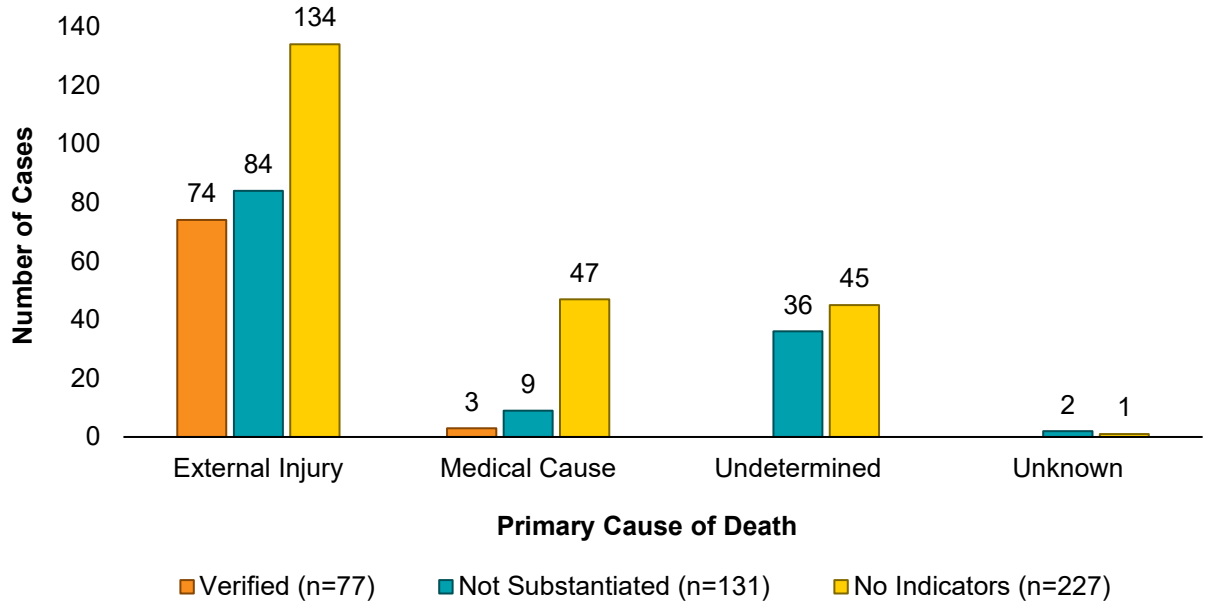


Primary Cause of Death

The distribution of primary cause of death by maltreatment verification status is displayed in Figure 9.

- Among the 77 verified maltreatment fatalities, 74 (96.1%) were the result of an external injury, and three (3.9%) were due to a medical cause of death.
- Among the 131 maltreatment fatalities that were not substantiated, 84 (64.1%) were the result of an external injury, 36 (27.5%) had an undetermined cause, nine (6.9%) were determined to have a medical cause, and two (1.5%) had an unknown cause of death.
- Among the 227 deaths with no indicators, 134 (59.0%) were the result of an external injury, 47 (20.7%) were the result of a medical cause, 45 (19.8%) were undetermined, and one (0.4%) had an unknown cause of death.

Figure 9: Primary Cause of Death by Maltreatment Verification Status (N=435)



The distribution of leading cause of death by manner of death is displayed in Figure 10.

- Unintentional drownings accounted for 89 of the 435 reviewed cases.
- Among the 184 sleep-related death cases, the manner of death was accidental in 108 cases (58.7%), whereas 61 deaths (33.2%) were classified as undetermined, 13 (7.1%) were due to a natural manner of death and two (1.1%) were homicidal manner.
- Homicidal manner accounted for 30 (75.0%) of the 40 inflicted trauma cases. The remaining ten cases of inflicted trauma include suicide (20.0%), accidental (5.0%) and undetermined (5.0%) manner.
- The other cause of death category comprises deaths caused by other external injuries (not sleep-related, drowning, or inflicted trauma), medical conditions, and undetermined and unknown causes. Most of these cases were identified as having a natural manner of death (34.4%), followed by accidental (31.1%), and undetermined (24.6%). The remaining four cases in this category include two homicides and two suicides.

Figure 10: Manner of Death by Leading Cause of Death Category (N=435)

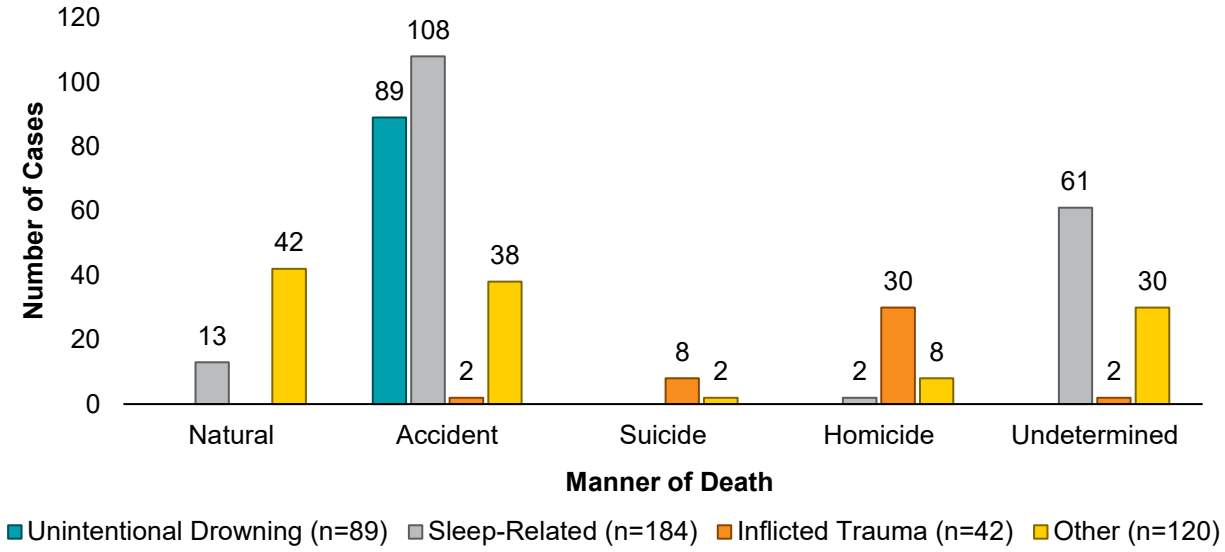
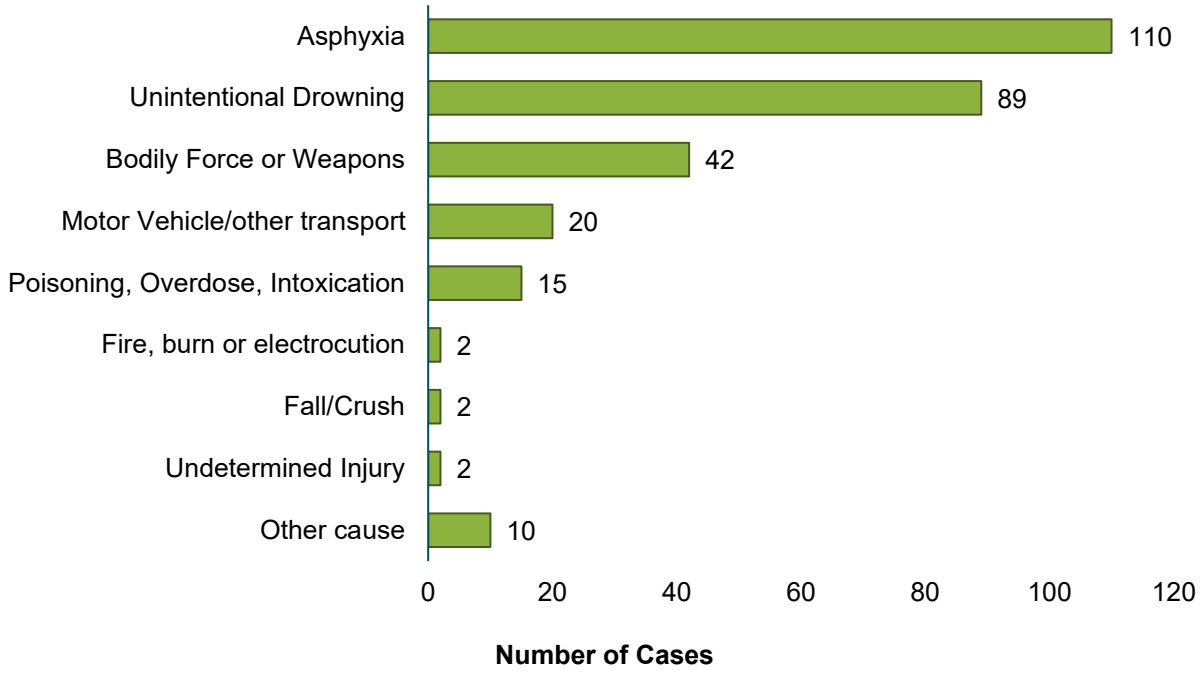


Figure 11 displays specific primary causes of death resulting from an external injury.

Figure 11: External Injury Causes of Death (n=292)



Tables 4 and 5 show the specific injury causes of death among homicide and suicide cases.

In 2022, there were 40 homicide deaths. In 30 of these cases, the cause of death was inflicted trauma through bodily force or the use of a weapon. There were 16 homicides that involved the use of a firearm as a weapon and one case involved a knife. In 13 cases, the use of bodily force was involved. In the remaining eight cases, the external cause of death was reported as poisoning, overdose, or acute strangulation (4); drowning (3); asphyxia (1); and other cause (2) due to hyperthermia from a hot car death and because of malnutrition/dehydration (Table 4).

Of the 10 suicide incidents, eight cases used firearms; one case involved fire, burn, or electrocution; and one case involved poisoning, overdose, or intoxication (Table 5).

Table 4: Cause of Death Among Homicide Cases (n=40)

Injury Cause	Number of Cases
Weapon	17
Bodily force	13
Poisoning, overdose, or acute intoxication	4
Drowning	3
Asphyxia	1
Other	2

Table 5: Cause of Death Among Suicide Cases (n=10)

Injury Cause	Number of Cases
Weapon	8
Fire, burn, or electrocution	1
Poisoning, overdose, intoxication	1

Table 6 displays specific primary causes of death resulting from a medical condition.

Table 6: Medical Cause of Death (n=59)

Specific Medical Cause of Death	Number of Cases
Asthma/respiratory	3
Cardiovascular	4
Congenital Anomaly	3
COVID-19	5
Diabetes	2
Influenza	1
Malnutrition/Dehydration	1
Neurological/Seizure Disorder	1
Pneumonia	17
Prematurity	5
SIDS	1
Other Infection	7
Other Perinatal Condition	2
Other Medical Condition	6
Undetermined Medical Cause	1

Sleep-Related Deaths

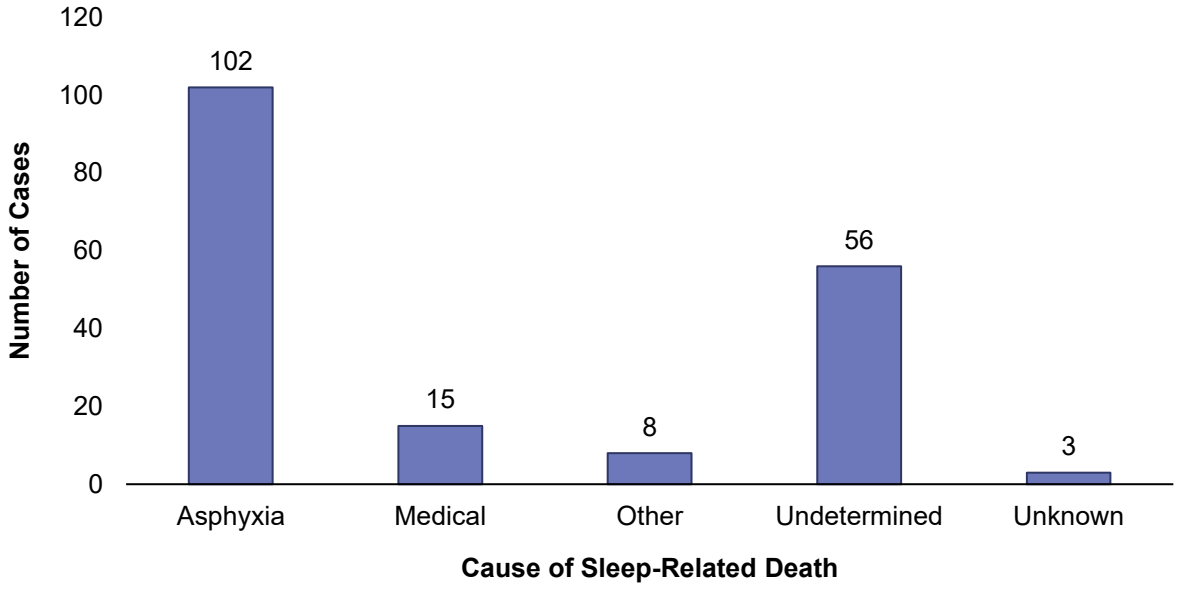
Sleep-related deaths remain the primary category of child deaths reviewed by local CADR committees. All sleep-related information in this report pertains to children under 5 years of age. Of the 184 sleep-related incidents, 175 (95.1%) occurred in infants under 1 year of age.

Sleep-related deaths account for 184 (42.3%) of all 2022 CADR case entries, with 102 (55.4%) due to asphyxia, 15 (8.2%) due to medical cause, eight (4.3%) due to other cause, 56 (30.4%) undetermined, and three (1.6%) unknown (Figure 12).

In sleep-related deaths, determining a clear cause of death is often challenging for medical examiners. Death scene investigations for sleep-related incidents at the place of the incident were completed for 182 of 184 (98.9%) reported cases. Of the 182 cases with a completed death scene investigation, 62 (34.1%) included doll reenactments and the findings were shared with local CADR committees in 25 of the 62 (40.3%) cases.

As a result, some of these deaths may be classified as unknown or undetermined, even after an investigation or autopsy. Death scene investigations involving sleep-related incidents provide valuable information regarding sleep environment risk factors, such as sleeping location and position in which the child was placed to sleep. These narratives can be used in conjunction with autopsy results to provide a more comprehensive view of the incident.

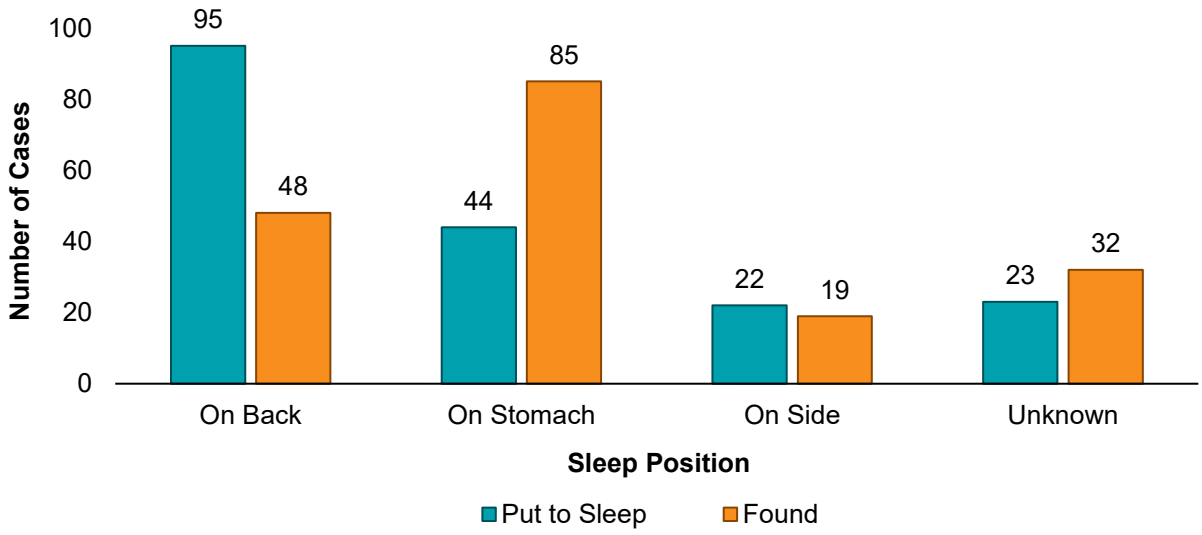
Figure 12: Sleep-Related Deaths by Cause (n=184)



Local CADR committees collect information on the details of the child's sleep environment. Figures 13 through 15 and Table 7 provide an overview of important factors in sleep-related death cases.

Figure 13 details sleep position among cases that were classified as sleep-related, including how the child was placed to sleep and their sleep position when found deceased.

Figure 13: Sleep Position Among Sleep-Related Deaths (n=184)



- In 95 (51.6%) of the 184 sleep-related cases, the child was placed to sleep on their back.
- On the stomach was the most frequently reported sleep position when the child was found non-responsive or deceased, accounting for 85 (46.2%) child deaths where sleep position at the time of death was known.

Figure 14 shows the distribution of sleep location among cases that were classified as sleep related. Of all sleep-related deaths, 121 (65.8%) took place in an adult bed.

Figure 14: Incident Sleep Location in Sleep-Related Deaths (n=184)

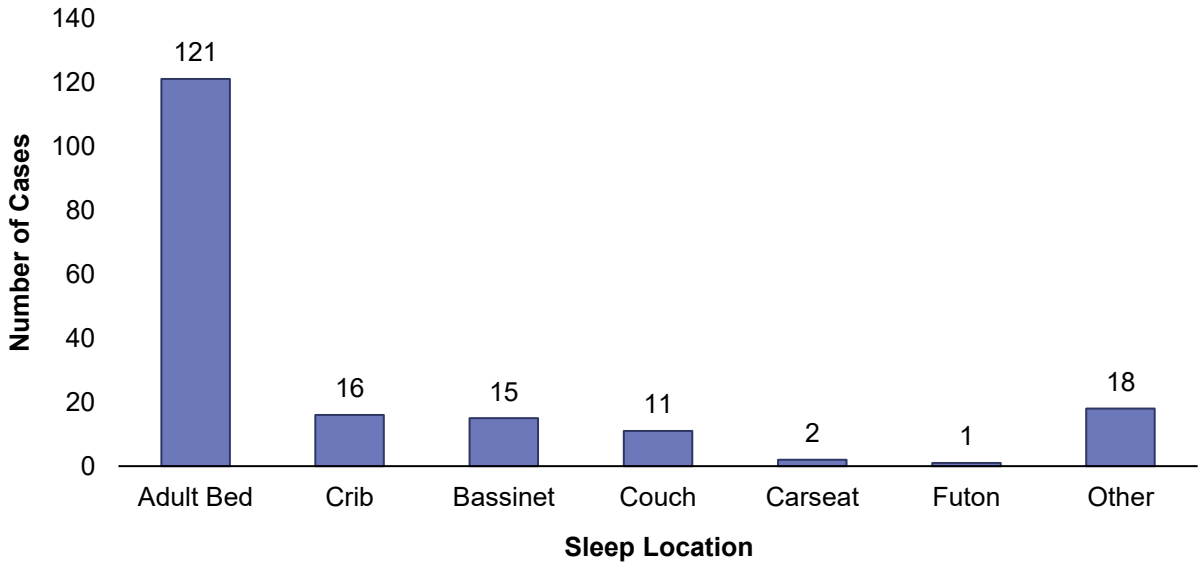


Table 7 provides counts of specific objects (including persons) that were found in a child's sleep environment, in sleep-related death cases. More than one object may have been present in the sleep environment. In 112 (60.9%) cases, an adult was present in the sleep environment, and in 41 (22.3%) cases, one or more children were present in the sleep environment.

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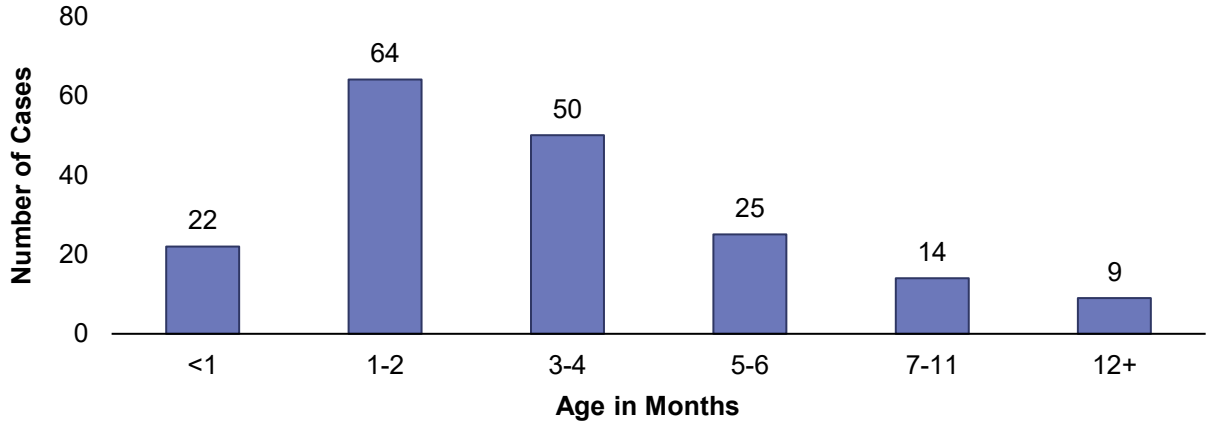
Table 7: Objects in the Sleep Environment (n=184)		
Object(s) Present in Sleeping Environment	**Cases**	**Percentage (%)***
Mattress	127	69.0%
Pillow or Cushion	118	64.1%
Adult	112	60.9%
Comforter, quilt or other	85	46.2%
Thin blanket/flat sheet	82	44.6%
Fitted sheet	76	41.3%
Child(ren)	41	22.3%
Bottle	19	10.3%
Nursing or U-shaped pillow	18	9.8%
Clothing	17	9.2%
Wall	16	8.7%
Toy(s)	9	4.9%
Animal(s)	5	2.7%
Crib railing/side	5	2.7%
Bumper pads	3	1.6%
Sleep Positioner	2	1.1%
Other	23	12.5%

**Percentage reflects the proportion of cases out of the total number of sleep-related deaths for each row item in the table.*

Figure 15 provides the age distribution of sleep-related deaths. Of the 184 sleep-related death incidents in 2022, 86 (46.7%) involved infants 2 months of age and younger, while 50 (27.2%) involved infants between 3 and 4 months of age, and 25 (13.6%) involved infants who were between 5 and 6 months of age.

Figure 15: Age Distribution of Sleep-Related Deaths (n=184)



Key Points of 2022 Sleep-Related Data
• 65.8% of all sleep-related deaths took place in an adult bed. • 73.9% of all sleep-related deaths were children less than 5 months old. • 57.6% of all sleep-related deaths involved male children. • 51.6% of children were placed on their back to sleep and 46.2% were found on their stomach. • 60.9% of the 184 sleep-related deaths had another adult in the bed, whereas 22.3% had another child or children in the bed at the time of incident.

Unintentional Drowning Death Incident Information

Local CADR committees collect detailed information on the circumstances and environmental factors associated with child drowning fatalities, including the location of the incident and whether a barrier was in place to prevent access to a water source.

Table 8 displays the location of unintentional drowning deaths. Pools, hot tubs, or spas accounted for the majority of total drowning incidents (64.0%), followed by open water or ponds (24.7%), and bathtubs (10.1%).

Table 8: Drowning Location (n=89)

Drowning Location	Number of Cases	Percent (%)
Pool, hot tub, spa	57	64.0%
Open water/pond	22	24.7%
Bathtub	9	10.1%
Other	1	1.1%

Figure 16 shows the location where children were last seen before drowning. Children were most likely to be last seen in the house (38.2%) or in water (24.7%) prior to drowning.

Figure 16: Where Child Was Last Seen Before Drowning (n=89)

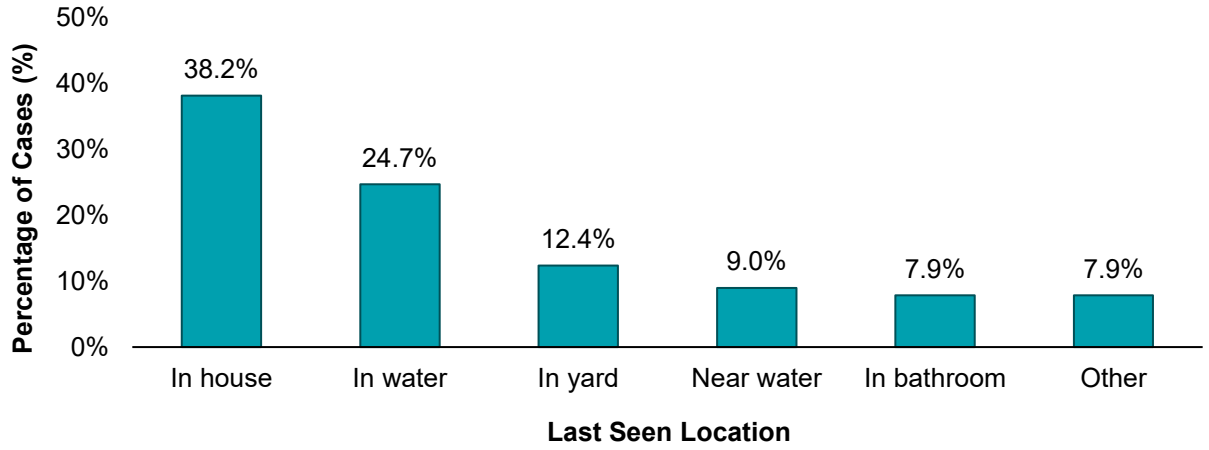
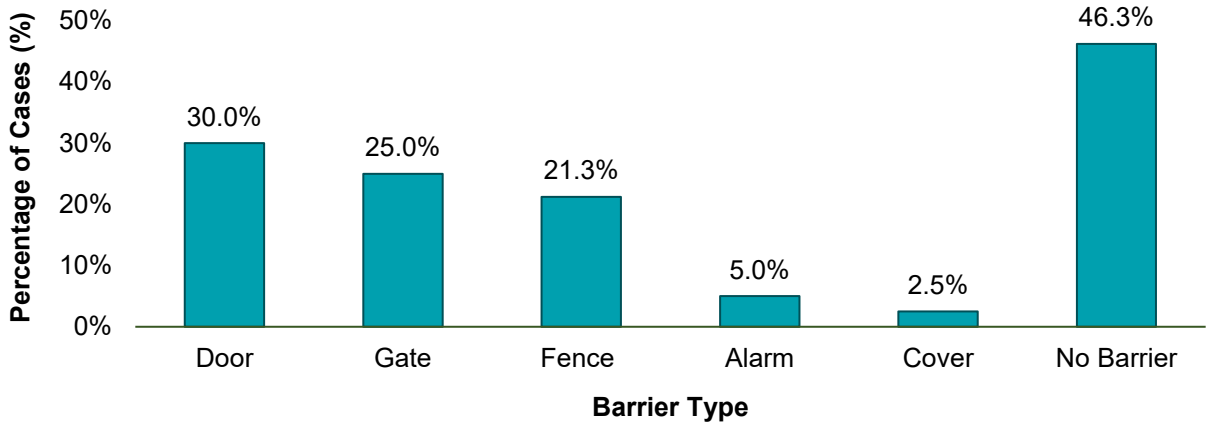


Figure 17 details the physical barriers and other protection layers that were in place at the time of the unintentional drowning incident. Barriers are physical structures, such as a door or a fence, that help limit access to potentially hazardous bodies of water. More than one barrier type can be present in individual drowning cases. Incidents involving bathtubs are excluded.

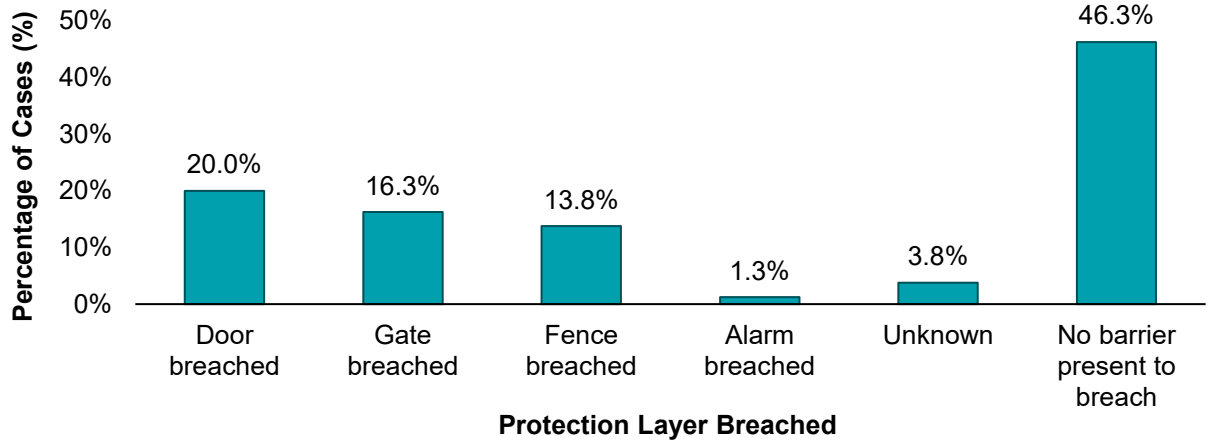
Figure 17: Barriers in Place Among Unintentional Drowning Deaths (n=80)



In 50.0% of unintentional drownings, at least one physical barrier was present at the time of the incident. The most common physical barriers in place among the 80 drownings were doors (30.0%) and gates (25.0%).

Figure 18 details physical barriers and other protection layers that were breached. A breached barrier is defined as opened, broken, or not functioning. Therefore, the presence of a barrier does not imply that the barrier is always effective in preventing a child from accessing a water source and may also not be applicable in certain water sources, such as an open beach.

Figure 18: Protection Layers Breached Among Unintentional Drowning Deaths (n=80)



The most prevalent barriers breached were doors (20.0%), gates (16.3%), and fences (13.8%). However, there were no layers of protection indicated to prevent access to water in 37 (46.3%) of the unintentional drowning cases.

Unintentional Drowning Data Summary
• Drowning deaths occurring in a pool, hot tub, or spa account for 64.0% of all 2022 drowning fatalities. • Children 3 years of age and younger make up 75.3% of all 2022 drowning fatalities. This percentage increases to 78.7% when including children 4 years of age and younger. • 60.0% of children did not know how to swim at the time of the incident. • 64.0% of all 2022 drowning-related fatalities involved male children. • 38.2% of children were last seen in the home prior to the drowning incident. • Of all protection layers that were present among reviewed drowning cases, 30.0% were identified as being a door. • 46.3% of cases had no barrier in place. • Doors and gates accounted for 36.3% of all protection layers breached prior to drowning incidents.

Inflicted Trauma Death Incident Information

The intentional infliction of physical harm using bodily force or other weapons remains a leading cause of preventable child death. Inflicted trauma deaths can include both homicide and suicide deaths. Weapon types include firearms, bodily force, or body parts, such as fists, hands, or feet, and any other items that can be used to inflict bodily harm. At the time data were analyzed for this report, several cases were not yet available for review. Many of these cases remain open due to pending law enforcement investigations or judicial action and may be classified as weapon-related deaths. It is expected that figures presented on weapons or bodily force will increase when all 2022 deaths are reviewed.

Figure 19 displays the type of force used in inflicted trauma cases. Among the 42 inflicted trauma deaths, 28 (66.7%) involved the use of firearms, 13 (31.0%) involved the use of body parts or bodily force, and one (2.4%) used a knife or sharp instrument.

The manner of death in inflicted trauma cases is displayed in Table 9. Among these deaths, homicides comprised 30 of 42 (71.4%) total cases, and 16 of those cases involved firearms, while 13 were due to bodily force. Suicides comprised eight (19.0%) of the inflicted trauma cases, which all involved firearms. Additional information regarding all reviewed homicide and suicide deaths are referenced in Tables 4 and 5.

Figure 19: Mechanism of Injury Among Inflicted Trauma Cases (n=42)

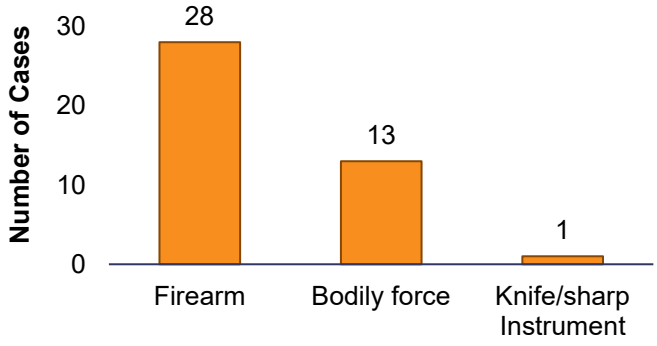


Table 9: Inflicted Trauma Cases by Manner of Death (n=42)

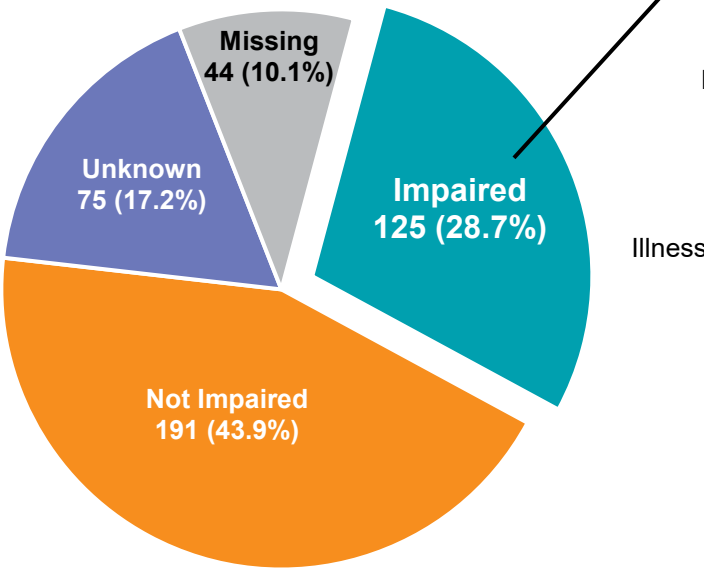
Manner	Number of Cases	Percent (%)
Homicide	30	71.4%
Suicide	8	19.0%
Accident	2	4.8%
Undetermined	2	4.8%

Inflicted Trauma Data Summary
• 75.0% of the 40 homicide incidents were the result of inflicted trauma. • 66.7% of the 42 inflicted trauma deaths involved the use of firearms. • In cases where a firearm was used, 16 out of 28 were homicide incidents, followed by eight suicides, two accidents, and two undetermined. • 31.0% of the 42 inflicted trauma deaths involved the use of body parts or bodily force. • Children 5 and under comprised 47.6% of inflicted trauma deaths, followed by children 11 and older (38.1%), and children ages 6-10 (14.3%). • Use of firearms was the primary mechanism of injury for children over 6 years old.

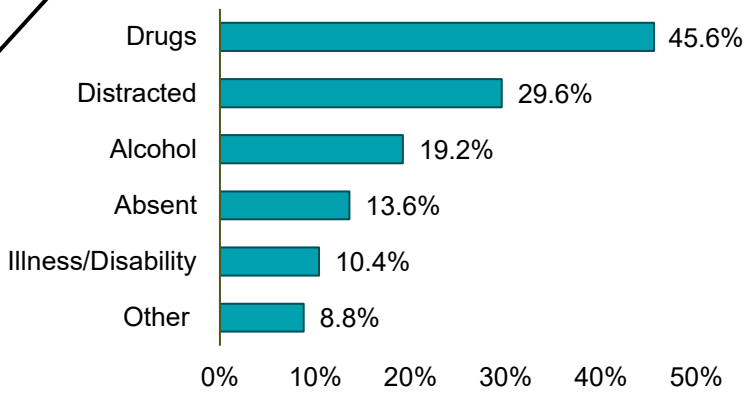
Supervisor Impairment

Information is collected regarding whether the person responsible for supervising the child at the time of the death incident was impaired. Supervisors were found to be impaired in 125 (28.7%) cases and not impaired in 191 (43.9%) cases; impairment status was unknown or missing in 119 (27.3%) cases. Among supervisors who were impaired, the causes of impairment are shown in Figure 20. More than one type of impairment can be present at the time of the incident.

Figure 20: Supervisor Impairment at Time of Incident (N=435)



Type of Impairment Among Impaired Supervisors at Time of Incident (n=125)



**More than one type of impairment can be selected for a single supervisor.*

Supervisor Types of Impairment Data Summary
• At the time of incident: 125 out of 435 supervisors (28.7%) were impaired. • Most supervisors who were indicated to be impaired were either under the influence of drugs (45.6%) and/or distracted (29.6%). • 19.2% of supervisors were found to be under the influence of alcohol. • 13.2% of supervisors were found to be absent.

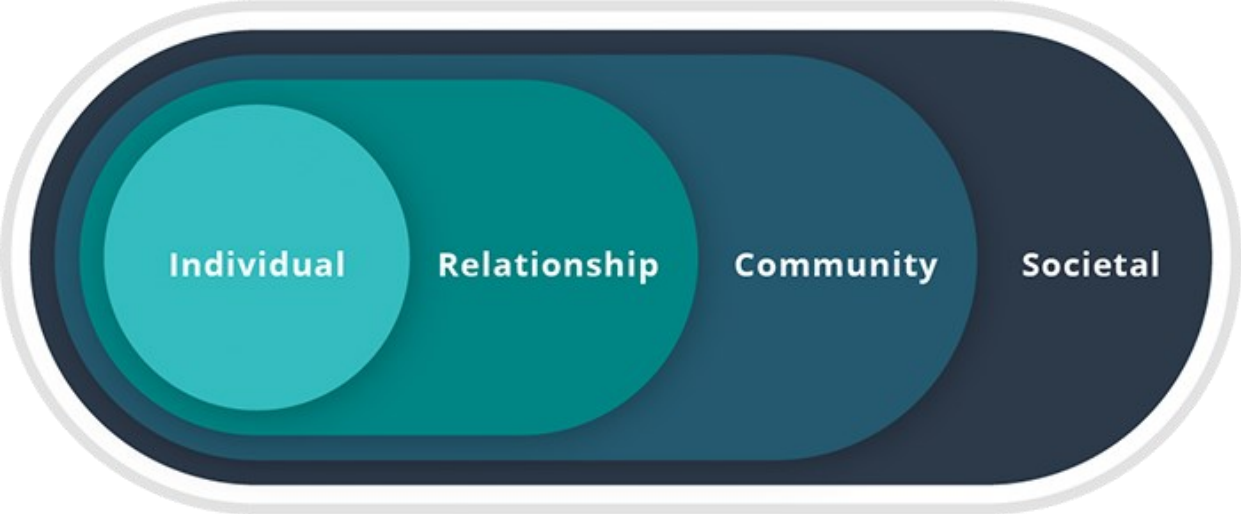
SECTION FOUR: 2024 PREVENTION RECOMMENDATIONS

Moving Forward: A Social Ecological Model for Change

The 2024 State CADR Committee prevention recommendations are based on a secondary analysis of CADR findings for the 2022 child fatality cases reviewed, as well as input provided by community and state partners, and a review of current child welfare literature. The top three categories of preventable child fatalities in Florida remain unchanged over the last several years. These categories include child fatalities that occur as a result of:

- Sleep-Related Infant Death
- Drowning
- Inflicted Trauma

To effectively address various intervention levels, prevention strategies are structured under the comprehensive framework known as the Social-Ecological Model for Change, as seen below.



This model, comprising four levels, serves to illustrate the intricate interplay between personal and environmental factors influencing behavior and guiding behavioral change. This model delineates how individual traits, relationships, community dynamics, and societal factors shape behavior. Addressing all these levels is crucial in devising potent prevention methods. Acting simultaneously across multiple levels is most impactful, given the interconnected nature of these influences. By adopting this holistic approach, interventions become more enduring, fostering sustainable prevention efforts, and maximizing their overall effectiveness.

The 2024 Prevention Recommendations developed by the State CADR Committee are as follows:

Promote evidence-based drowning prevention strategies through the implementation and dissemination of statewide guidelines and best practices.

Recognizing the critical role of evidence-based strategies in drowning prevention, the State CADR Committee strongly emphasizes the promotion of drowning prevention awareness and education through data-driven initiatives and collaborative efforts. These efforts are supported by initiatives such as Keep Kids Safe From Drowning (see Appendix C) and the Florida Department of Health's WaterSmartFL campaign, which provides practical guidance and resources on water safety.

Key evidence-based strategies promoted through these initiatives include:

- Regular evaluation of children's drowning risk based on age, environmental factors, and underlying medical conditions.
- Implementation of multiple layers of protection, including barriers such as pool fencing, self-closing gates, and alarms to prevent unsupervised access to water.
- Close, constant, and capable adult supervision, with an emphasis on designated "Water Watchers" who remain focused and free from distractions.
- Promotion of water safety education, including formal swim lessons to teach floating, treading, and basic swimming skills.
- Encouraging consistent use of properly fitted, Coast Guard-approved life jackets for children and adults in appropriate water settings.

The WaterSmartFL campaign reinforces these strategies by highlighting layers of protection such as barriers, supervision, and preparedness, including CPR training and emergency response planning. Resources like downloadable Water Watcher tags and checklists for pool barriers provide practical tools for families to enhance water safety.

By aligning messaging with evidence-based practices and leveraging the collective impact of initiatives such as Keep Kids Safe From Drowning and WaterSmartFL, the State CADR Committee remains committed to reducing child drowning fatalities. Through continued collaboration, education, and outreach, we can equip parents, caregivers, and communities with the tools needed to create safer water environments and prevent these tragic incidents.

Continue to promote and educate the public on the importance of safe sleep practices for infants through the ongoing implementation and evaluation of data-driven programs and initiatives.

Sleep-related infant deaths remain a pressing concern despite ongoing efforts to prevent these tragedies. The 2022 CADR data analysis reveals that of the 435 total deaths reviewed by local CADR committees, 184 (42.3%) were sleep-related deaths. Among these, 121 (65.8%) occurred in an adult bed, and in 112 (60.9%) of these cases, an adult was reported to be sharing the bed with the infant. These findings highlight a compelling need for continued safe sleep education for parents and caregivers, along with enhanced dissemination of educational resources.

The State CADR Committee is addressing this critical issue through initiatives such as Sleep Baby Safely, in collaboration with the Juvenile Welfare Board of Pinellas County. This initiative provides targeted education and resources to caregivers, emphasizing safe sleep practices. Additionally, the Healthy Start Coalition's programs complement these efforts by supporting families with tailored guidance and resources to promote safe sleep environments for infants.

Recognizing the importance of addressing the factors contributing to sleep-related infant deaths, the State CADR Committee emphasizes the ongoing promotion and public education regarding safe sleep practices. Through the implementation and evaluation of data-driven programs and initiatives, the committee seeks to increase awareness and understanding among caregivers and the broader community to reduce these preventable deaths.

Key elements of current safe sleep education efforts include:

- Using consistent terminology, such as Sudden Unexpected Infant Death (SUID), to ensure clarity in messaging and accurate classification of infant deaths.
- Reinforcing the importance of placing infants on their backs, alone, and on non-inclined sleep surfaces, for every sleep. This guidance aims to address common misconceptions about choking risks and emphasizes the dangers of inclined sleep surfaces, which can compromise an infant's breathing and increase the risk of suffocation.

These focused efforts underscore the need for consistent, evidence-based education that is clear and accessible to all caregivers, ensuring that infants are provided with the safest possible sleep environment.

Continue to ensure all local CADR committees consistently report hazardous consumer products to the CPSC, dating back to deaths occurring on or after January 1, 2021, in alignment with CPSC's reporting requirements.

Child fatalities resulting from hazardous consumer products represent a serious and preventable public health concern. In many instances, such products pose hidden dangers to children, and these tragedies can occur without warning. Pillows, toys, nursery items, and household goods can pose risks if they are used improperly, defective, or mislabeled. CADR committees have a pivotal role in identifying, investigating, and preventing child deaths associated with such products.

Reporting hazardous consumer products to the CPSC is proactive and intended to prevent future tragedies by increasing awareness of product misuse. Systematic identification and reporting contribute to holding manufacturers accountable, prompting recalls, and improving effectiveness of product warning labels and safety standards. It is vital that local law enforcement agencies are in communication with local CADR committees to coordinate proper documentation and procedures to provide necessary information to make reports.

Continue to assess and adapt approaches to suicide prevention and postvention through community and state-level partnerships.

Child and adolescent deaths by suicide remain a critical public health concern in Florida, requiring ongoing attention and adaptation of prevention and postvention strategies. Building on last year's efforts, the State CADR Committee continues to prioritize partnerships with local agencies, mental health organizations, and schools to enhance targeted prevention efforts. In 2023, the State CADR Committee's Child Death by Suicide Case Review Feasibility Ad Hoc Committee revealed that CADR remains the only entity conducting case-by-case reviews of child and adolescent suicides. This year, the State CADR Committee recommends sustained collaboration at both the community and state levels to address the complex factors contributing to youth deaths by suicide.

According to FL Health CHARTS, there was a 22% increase in the number of deaths by suicide among children aged 10-17 between 2014-2022. This concerning increase reinforces the need for comprehensive case reviews to understand and mitigate risks such as bullying, mental health challenges, and access to lethal means.

The State CADR Committee's focus this year is on fostering community and state-level collaboration. By integrating mental health services with prevention efforts, the goal is to provide timely support to at-risk youth and implement data-driven, evidence-based interventions. These ongoing efforts reflect a commitment to reducing child and adolescent suicides, protecting the well-being of Florida's young population, and working toward a future where such tragedies are preventable.

Continue to develop and submit recommendations to the NCFRP regarding potential changes to the NFR-CRS to incorporate fields that would better contribute to a deeper understanding of child fatalities in Florida.

The NCFRP encourages the submission of recommended changes to the existing NFR-CRS for all states, as well as the development of questions to display solely on the form of the requesting state. The State CADR Committee recognizes state-level form customization as an effective means to collect additional data for further analysis surrounding causes and contributing factors of child fatalities relevant to Florida families.

Continue efforts to relay timely information to caregivers and community supports regarding the safety of children.

The State CADR Committee emphasizes the importance of ongoing efforts to promptly disseminate critical child safety information to caregivers and community support networks. To safeguard children from preventable deaths related to factors, such as sleep-related infant death, drowning, and inflicted trauma, it is imperative that Florida's communities maintain a proactive stance in educating parents and families about these risks. The following aims to empower caregivers with the knowledge and resources needed to ensure the safety and well-being of children across Florida.

1. **Pilot Projects and Initiatives:** The State CADR Committee is dedicated to supporting the development and thorough evaluation of pilot programs aimed at reducing child fatalities in high-risk communities. By focusing on local trends, these initiatives allow for trial and refinement of prevention strategies that address specific community needs. Ongoing assessments of these projects help to identify successful approaches that can be expanded statewide, ensuring that evidence-based practices are implemented effectively to protect children across Florida.

2. **Community Collaboration:** The State CADR Committee encourages strong collaboration among community resources, such as family resource centers, faith-based groups, and organizations rooted in community identity. Leveraging their influence can significantly enhance the credibility of safety information, expanding its reach and increasing the likelihood of parents and caregivers utilizing this knowledge to make informed decisions about child safety.

3. **Partnerships with Evidence-Based Home-Visiting Providers:** Evidence-based home-visiting programs offered by agencies, such as DCF, Maternal and Child Health home-visiting programs, and Healthy Families Florida, provide a unique opportunity to engage with families in their homes. These providers can assess

potential risks and offer tailored education and support to caregivers, ensuring that vital safety messages are provided promptly and effectively.

4. **Engagement of Expectant Mothers and Caregivers:** There is a persistent need for engaging expectant mothers, partners, grandparents, and other caregivers in discussions about maternal health, safe sleep practices, and the adverse effects of maternal substance misuse on both the fetus and newborn. Education and support programs, such as the Period of PURPLE Crying program and Florida's Association of Healthy Start Coalitions' programs, address these topics comprehensively. Additionally, the State CADR Committee acknowledges the heightened need to promote doula and midwife services for expectant mothers who may have various concerns regarding hospitals and birthing centers.

5. **Communication with Medical Professionals:** Improved communication with health care professionals in birthing hospitals, and in pediatric, obstetric, and gynecology offices is vital. Consistent messaging aligned with evidence-based recommendations should be reinforced to ensure parents receive up-to-date guidance that is age and developmentally appropriate.

6. **Maternal Depression Screening:** Implementing maternal depression screening tools during well-child pediatric appointments can help identify potential concerns. A coordinated response should be in place to address any needs that are identified.

7. **Home Safety Checklists:** Utilizing home safety checklists designed to identify potentially hazardous conditions that pose risks to children is recommended. These checklists can serve as practical tools to enhance child safety within the home environment.

8. **Insights from CADR Annual Summits:** The Annual CADR Summit serves as a cornerstone for State and Local CADR Committee members to explore innovative prevention strategies, foster collaboration, and strengthen their understanding of data-driven solutions to reduce child fatalities. Each summit offers a platform to share emerging trends, discuss challenges, and identify actionable approaches to enhance child safety initiatives. Attendees gain valuable insights into fostering multidisciplinary partnerships, forming sustainable prevention efforts, and utilizing data effectively to drive decision-making. These opportunities equip committee members with the tools and knowledge to refine local strategies and strengthen statewide efforts in child fatality prevention.

Section Five: Conclusions and Next Steps

The findings of this report highlight significant public health concerns. Addressing these concerns requires careful consideration of system improvements to support vulnerable families and the challenges faced by the growing population. The protection of Florida's children should remain a top priority for all Floridians. Creating lasting change by positively influencing society will necessitate a broad, collaborative, multi-sector approach that covers all aspects of the Social Ecological Model for Change. Furthermore, these tragic deaths should inspire action, based on the data and recommendations presented in this report to ensure a safe future for Florida's children.

In addition to implementing data-driven prevention strategies, Floridians must actively seek out opportunities for early intervention. Every day, law enforcement officers, health care professionals, school system personnel, and others are presented with opportunities to provide potentially life-saving information to families with children long before child welfare services are involved.

The State CADR Committee strongly encourages readers of this report to act upon the prevention recommendations, as these are key to achieving positive outcomes for children. It is crucial to embrace evidence-based prevention programs and practices while also exploring innovative approaches. To eliminate preventable child fatalities in Florida and gain a deeper understanding of the complexities surrounding child maltreatment fatalities, Florida's state and local CADR committees will continue to use evidence-based knowledge and available data to shape current and future prevention strategies.

The only way to break the cycle of child abuse is through education, awareness, and intervention.

APPENDICES

ANNUAL REPORT

DECEMBER 2024

Florida
Child Abuse
Death Review

APPENDIX A

Section 383.402, Florida Statutes

ANNUAL REPORT

DECEMBER 2024

Florida
Child Abuse
Death Review

383.402 Child abuse death review; State Child Abuse Death Review Committee; local child abuse death review committees.—

(1) INTENT.—It is the intent of the Legislature to establish a statewide multidisciplinary, multiagency, epidemiological child abuse death assessment and prevention system that consists of state and local review committees. The committees shall review the facts and circumstances of all deaths of children from birth to age 18 which occur in this state and are reported to the central abuse hotline of the Department of Children and Families. The state and local review committees shall work cooperatively. The primary function of the state review committee is to provide direction and leadership for the review system and to analyze data and recommendations from local review committees to identify issues and trends and to recommend statewide action. The primary function of the local review committees is to conduct individual case reviews of deaths, generate information, make recommendations, and implement improvements at the local level. The purpose of the state and local review system is to:

(a) Achieve a greater understanding of the causes and contributing factors of deaths resulting from child abuse.

(b) Whenever possible, develop a communitywide approach to address such causes and contributing factors.

(c) Identify any gaps, deficiencies, or problems in the delivery of services to children and their families by public and private agencies which may be related to deaths that are the result of child abuse.

(d) Recommend changes in law, rules, and policies at the state and local levels, as well as develop practice standards that support the safe and healthy development of children and reduce preventable child abuse deaths.

(e) Implement such recommendations, to the extent possible.

(2) STATE CHILD ABUSE DEATH REVIEW COMMITTEE.—

(a) *Membership.*—

1. The State Child Abuse Death Review Committee is established within the Department of Health and shall consist of a representative of the Department of Health, appointed by the State Surgeon General, who shall serve as the state

committee coordinator. The head of each of the following agencies or organizations shall also appoint a representative to the state committee:

a. The Department of Legal Affairs.

b. The Department of Children and Families.

c. The Department of Law Enforcement.

d. The Department of Education.

e. The Florida Prosecuting Attorneys Association, Inc.

f. The Florida Medical Examiners Commission, whose representative must be a forensic pathologist.

2. In addition, the State Surgeon General shall appoint the following members to the state committee, based on recommendations from the Department of Health and the agencies listed in subparagraph 1., and ensuring that the committee represents the regional, gender, and ethnic diversity of the state to the greatest extent possible:

a. The Department of Health Statewide Child Protection Team Medical Director.

b. A public health nurse.

c. A mental health professional who treats children or adolescents.

d. An employee of the Department of Children and Families who supervises family services counselors and who has at least 5 years of experience in child protective investigations.

e. The medical director of a Child Protection Team.

f. A member of a child advocacy organization.

g. A social worker who has experience in working with victims and perpetrators of child abuse.

h. A person trained as a paraprofessional in patient resources who is employed in a child abuse prevention program.

i. A law enforcement officer who has at least 5 years of experience in children's issues.

j. A representative of a domestic violence advocacy group.

k. A representative from a private provider of programs on preventing child abuse and neglect.

l. A substance abuse treatment professional.

3. The members of the state committee shall be appointed to staggered terms not to exceed 2 years each, as determined by the State Surgeon General. Members may be appointed to no more than three consecutive terms. The state committee shall elect a chairperson from among its members to serve for a 2-year term, and the chairperson may appoint ad hoc committees as necessary to carry out the duties of the committee.

4. Members of the state committee shall serve without compensation but may receive reimbursement for per diem and travel expenses incurred in the performance of their duties as provided in s. 112.061 and to the extent that funds are available.

(b) *Duties.*—The State Child Abuse Death Review Committee shall:

1. Develop a system for collecting data from local committees on deaths that are reported to the central abuse hotline. The system must include a protocol for the uniform collection of data statewide, which must, at a minimum, use the National Child Death Review Case Reporting System administered by the National Center for the Review and Prevention of Child Deaths.

2. Provide training to cooperating agencies, individuals, and local child abuse death review committees on the use of the child abuse death data system.

3. Provide training to local child abuse death review committee members on the dynamics and impact of domestic violence, substance abuse, or mental health disorders when there is a co-occurrence of child abuse. Training must be provided by the Department of Children and Families, the Florida Alcohol and Drug Abuse Association, and the Florida Council for Community Mental Health in each entity's respective area of expertise.

4. Develop statewide uniform guidelines, standards, and protocols, including a protocol for standardized data collection and reporting, for local child abuse death review committees and provide training and technical assistance to local committees.

5. Develop statewide uniform guidelines for reviewing deaths that are the result of child abuse, including guidelines to be used by law enforcement agencies, prosecutors, medical examiners, health care practitioners, health care facilities, and social service agencies.

6. Study the adequacy of laws, rules, training, and services to determine what changes are needed to decrease the incidence of child abuse deaths and develop strategies and recruit partners to implement these changes.

7. Provide consultation on individual cases to local committees upon request.

8. Educate the public regarding the provisions of chapter 99-168, Laws of Florida, the incidence and causes of child abuse death, and ways by which such deaths may be prevented.

9. Promote continuing education for professionals who investigate, treat, and prevent child abuse or neglect.

10. Recommend, when appropriate, the review of the death certificate of a child who died as a result of abuse or neglect.

(3) LOCAL CHILD ABUSE DEATH REVIEW COMMITTEES.—At the direction of the State Surgeon General, a county or multicounty child abuse death review committee shall be convened and supported by the county health department directors in accordance with the protocols established by the State Child Abuse Death Review Committee.

(a) *Membership.*—The local death review committees shall include, at a minimum, the following organizations' representatives, appointed by the county health department directors in consultation with those organizations:

1. The state attorney's office.

2. The medical examiner's office.

3. The local Department of Children and Families child protective investigations unit.

4. The Department of Health Child Protection Team.

5. The community-based care lead agency.

6. State, county, or local law enforcement agencies.

7. The school district.

8. A mental health treatment provider.

9. A certified domestic violence center.

10. A substance abuse treatment provider.

11. Any other members that are determined by guidelines developed by the State Child Abuse Death Review Committee.

To the extent possible, individuals from these organizations or entities who, in a professional capacity, dealt with a child whose death is verified as caused by abuse or neglect, or with the family of the child, shall attend any meetings where the child's case is reviewed. The members of a local committee shall be appointed to 2-year terms and may be reappointed. Members shall serve without compensation but may receive

reimbursement for per diem and travel expenses incurred in the performance of their duties as provided in s. 112.061 and to the extent that funds are available.

(b) *Duties.*—Each local child abuse death review committee shall:

1. Assist the state committee in collecting data on deaths that are the result of child abuse, in accordance with the protocol established by the state committee. The local committee shall complete, to the fullest extent possible, the individual case report in the National Child Death Review Case Reporting System.

2. Submit written reports as required by the state committee. The reports must include:

a. Nonidentifying information from individual cases.

b. Identification of any problems with the data system uncovered through the review process and the committee's recommendations for system improvements and needed resources, training, and information dissemination, where gaps or deficiencies may exist.

c. All steps taken by the local committee and private and public agencies to implement necessary changes and improve the coordination of services and reviews.

3. Submit all records requested by the state committee at the conclusion of its review of a death resulting from child abuse.

4. Abide by the standards and protocols developed by the state committee.

5. On a case-by-case basis, request that the state committee review the data of a particular case.

(4) ANNUAL STATISTICAL REPORT.—The state committee shall prepare and submit a comprehensive statistical report by December 1 of each year to the Governor, the President of the Senate, and the Speaker of the House of Representatives which includes data, trends, analysis, findings, and recommendations for state and local action regarding deaths from child abuse. Data must be presented on an individual calendar year basis and in the context of a multiyear trend. At a minimum, the report must include:

(a) Descriptive statistics, including demographic information regarding victims and caregivers, and the causes and nature of deaths.

(b) A detailed statistical analysis of the incidence and causes of deaths.

(c) Specific issues identified within current policy, procedure, rule, or statute and recommendations to address those issues from both the state and local committees.

(d) Other recommendations to prevent deaths from child abuse based on an analysis of the data presented in the report.

(5) ACCESS TO AND USE OF RECORDS.—

(a) Notwithstanding any other law, the chairperson of the State Child Abuse Death Review Committee, or the chairperson of a local committee, shall be provided with access to any information or records that pertain to a child whose death is being reviewed by the committee and that are necessary for the committee to carry out its duties, including information or records that pertain to the child's family, as follows:

1. Patient records in the possession of a public or private provider of medical, dental, or mental health care, including, but not limited to, a facility licensed under chapter 393, chapter 394, or chapter 395, or a health care practitioner as defined in s. 456.001. Providers may charge a fee for copies not to exceed 50 cents per page for paper records and $1 per fiche for microfiche records.

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

(b) The State Child Abuse Death Review Committee or a local committee shall have access to all information of a law enforcement agency which is not the subject of an active investigation and which pertains to the review of the death of a child. A committee may not disclose any information that is not subject to public disclosure by the law enforcement agency, and active criminal intelligence information or criminal investigative information, as defined in s. 119.011(3), may not be made available for review or access under this section.

(c) The state committee and any local committee may share with each other any relevant information that pertains to the review of the death of a child.

(d) A member of the state committee or a local committee may not contact, interview, or obtain information by request or subpoena directly from a member of a deceased child's family as part of a committee's review of a child abuse death, except that if a committee member is also a public officer or state employee, that member may contact, interview, or obtain information from a member of the deceased child's family, if necessary, as part of the committee's review. A member of the deceased child's family may voluntarily provide records or information to the state committee or a local committee.

(e) The chairperson of the State Child Abuse Death Review Committee may require the production of records by requesting a subpoena, through the Department of Legal

Affairs, in any county of the state. Such subpoena is effective throughout the state and may be served by any sheriff. Failure to obey the subpoena is punishable as provided by law.

(f) This section does not authorize the members of the state committee or any local committee to have access to any grand jury proceedings.

(g) A person who has attended a meeting of the state committee or a local committee or who has otherwise participated in activities authorized by this section may not be permitted or required to testify in any civil, criminal, or administrative proceeding as to any records or information produced or presented to a committee during meetings or other activities authorized by this section. However, this paragraph does not prevent any person who testifies before the committee or who is a member of the committee from testifying as to matters otherwise within his or her knowledge. An organization, institution, committee member, or other person who furnishes information, data, reports, or records to the state committee or a local committee is not liable for damages to any person and is not subject to any other civil, criminal, or administrative recourse. This paragraph does not apply to any person who admits to committing a crime.

(6) DEPARTMENT OF HEALTH RESPONSIBILITIES.—

(a) The Department of Health shall administer the funds appropriated to operate the review committees and may apply for grants and accept donations.

(b) To the extent that funds are available, the Department of Health may hire staff or consultants to assist a review committee in performing its duties. Funds may also be used to reimburse reasonable expenses of the staff and consultants for the state committee and the local committees.

(c) For the purpose of carrying out the responsibilities assigned to the State Child Abuse Death Review Committee and the local review committees, the State Surgeon General may substitute an existing entity whose function and organization includes the function and organization of the committees established by this section.

(7) DEPARTMENT OF CHILDREN AND FAMILIES RESPONSIBILITIES.—Each regional managing director of the Department of Children and Families must appoint a child abuse death review coordinator for the region. The coordinator must have knowledge and expertise in the area of child abuse and neglect. The coordinator’s general responsibilities include:

(a) Coordinating with the local child abuse death review committee.

(b) Ensuring the appropriate implementation of the child abuse death review process and all regional activities related to the review of child abuse deaths.

(c) Working with the committee to ensure that the reviews are thorough and that all issues are appropriately addressed.

(d) Maintaining a system of logging child abuse deaths covered by this procedure and tracking cases during the child abuse death review process.

(e) Conducting or arranging for a Florida Safe Families Network record check on all child abuse deaths covered by this procedure to determine whether there were any prior reports concerning the child or concerning any siblings, other children, or adults in the home.

(f) Coordinating child abuse death review activities, as needed, with individuals in the community and the Department of Health.

(g) Notifying the regional managing director, the Secretary of Children and Families, the Department of Health Deputy Secretary for Health and Deputy State Health Officer for Children's Medical Services, and the Department of Health Child Abuse Death Review Coordinator of all deaths meeting criteria for review as specified in this section within 1 working day after case closure.

(h) Ensuring that all critical issues identified by the local child abuse death review committee are brought to the attention of the regional managing director and the Secretary of Children and Families.

(i) Providing technical assistance to the local child abuse death review committee during the review of any child abuse death.

History.—s. 13, ch. 99-168; s. 11, ch. 2000-160; s. 8, ch. 2000-217; s. 13, ch. 2001-53; s. 14, ch. 2004-350; s. 41, ch. 2008-6; s. 69, ch. 2014-19; s. 21, ch. 2014-224; s. 4, ch. 2015-79; s. 42, ch. 2016-10; s. 55, ch. 2019-3; s. 10, ch. 2020-6.

APPENDIX B

State and Local Committee Membership

ANNUAL REPORT

DECEMBER 2024

Florida
Child Abuse
Death Review

Florida Child Abuse Death Review State Committee Membership

Child Abuse Prevention Program
Rebekkah Sheetz, MSW

Child Advocacy Organization
Rebecca Albert, MSW

Department of Children and Families
David Martine

Department of Children and Families Office of Domestic Violence
Morgan Macholeth, BA

Department of Children and Families Supervisor
Halee Smith, BA, MS

Department of Education
Karla Bass, BSN, RN

Department of Health
Sandon Speedling, MHS, CPM, CPH

Department of Law Enforcement
Jeremy Gordon, Special Agent Supervisor

Florida Medical Examiners Commission
Russell Vega, MD

Florida Office of the Attorney General
Richard Mantei

Florida Prosecuting Attorneys Association
Dawn M. Buff

Law Enforcement Officer
Ret. Major Connie Shingledecker, Chairperson

Medical Director, Child Protection Team
Cameron Rosenthal, MD, FAAP

Mental Health Professional
Rachel Smith, MSW

Statewide Medical Director, Child Protection Team
Carol Lilly, MD, MPH

Paraprofessional in Patient Resources, Child Abuse Prevention Program
Tracy Murrell

Public Health Nurse
Merlene Ramnon, PhD, MPH, MSN, RN

Social Worker
Vicki Whitfield, BSW

Substance Abuse Professional
Silvia Quintana, LMHC, CAP

Florida Child Abuse Death Review
Local Committee Leadership

Committee 1A
Claire Kirchharr, MPH, CPH
Ashlee Turner, MPH
R. Matthew Dobson, MS

Committee 1B
Solange Arnett
Cheryl Canipe
Elizabeth Smith, BSN, RN

Committee 2
Dawn McGriff, BSW, MS
Brandy Knight, MPH

Committee 3
Angela Moore
Kerry Waldron, MPA

Committee 4
Jessica Winberry
Betsy Boyce
Heather Huffman, MS, RDN, LD/N, IBCLC

Committee 5
Janine Hammett, RN
Jaclyn Kanaar

Committee 6
Rebecca Albert, MSW
Nicholas Benedetto
Trang Chitakone, MPH
Ulyee Choe, DO

Committee 7
Robyn Jernigan
Tina Merritt
Shane Lockwood, MPH, BSPH

Committee 8
Nikki Meadow
Natalie McKellips, JD
Amie Oody, MPH

Committee 9
Ilvia Ortiz-Paez
Brianne Bell
Stacey Georges
Robert Karch, MD, MPH, FAAP
Vianca McCluskey, MPH

Committee 10
Sarah Pitts
Taylor Freeman
Stephen Nelson, MD
Yesenia Villalta, APRN, DNP, MSN

Committee 11
Lauren Lazarus-Sabatino, Esq. CCE
Lauren Villalba-Cruz, MPA
Yoselin Garcia, MPH
Yesenia Villalta, APRN, DNP, MSN

Committee 12A
Maj. Connie Shingledecker
Carla McGill
Jennifer Bencie, MD, MSA

Committee 12B
Laura Carson, MA
Catherine Duff
Jennifer Bencie, MD, MSA

Committee 13
Barbara Macelli
Carry Simons, RN
Paola Galarza
Douglas Holt, MD, FACP

Committee 14
Kelly Byrns-Davis
Stephanie Wood
Christi Bazemore
Stephanie Cash, MSW
Sandon Speedling, MHS, CPM, CPH

Committee 15
Merlene Ramnon, PhD, MPH, MSN, RN
Maricor Wall
Alina Alonso, MD

Committee 16
Lauren Lazarus-Sabatino, Esq., CCE
Lauren Villalba, MPA
Carla Fry, PhD

Committee 17
Casey Woolley, LCSW
L'Mara Thomas, BA
Paula Thaqi, MD, MPH

Committee 18A
Jeanie Raciti, LCSW
Maria Stahl, DNP, RN

Committee 18B
Christine Cornell
Lindsey A. Bayer, MS, F-ABMDI
Ethan Johnson

Committee 19
Miranda Swanson
Jennifer Furtwangler

Committee 20
Francine Donnorummo
Julie Noble
Danelle Rodriguez
Kim Kossler

APPENDIX C

Implementation of 2023 Prevention Recommendations

ANNUAL REPORT

DECEMBER 2024

Florida
Child Abuse
Death Review

IMPLEMENTATION OF 2023 PREVENTION RECOMMENDATIONS

CADR data are utilized to inform the development and implementation of prevention initiatives at the local level to eliminate child fatalities as a result of abuse and neglect. The initiatives outlined below provide an example of efforts made in response to the 2023 prevention recommendations developed by the State CADR Committee.

State CADR Committee Prevention Initiatives

In 2024, the State CADR Committee continued the development, evaluation, and expansion of several promising prevention initiatives to address infant safe sleep and drowning prevention. In 2022, the State CADR Committee supported the initial implementation of Sleep Baby Safely, a safe sleep education initiative, in eight Florida counties with the highest rates of sleep-related infant deaths between 2017 and 2021: Broward, Miami-Dade, Duval, Hillsborough, Orange, Polk, Palm Beach, and Pinellas. Collaborating with local safe sleep champions and the Juvenile Welfare Board of Pinellas County, the initiative's originators, along with partners in Duval County—the first Department-sponsored pilot site—the CADR Unit successfully procured and distributed Welcome Baby Bags, filled with essential newborn materials imprinted with safe sleep messaging. These bags are provided to all parents of newborns in these designated counties, following face-to-face education on safe sleep practices. In 2023, the State CADR Committee, in partnership with the CADR Unit, expanded Sleep Baby Safely to an additional nine counties with high rates of sleep-related infant deaths: Bay, Escambia, Jackson, Leon, Marion, Putnam, Sarasota, Sumter, and Wakulla. Through responsible financial management and strategic reallocation of existing resources, Sleep Baby Safely reached 65 of Florida's 67 counties with a one-time distribution of Welcome Baby Bags available to all counties in 2024.

In addition to the Sleep Baby Safely expansion, the State CADR Committee also expanded the Keep Kids Safe From Drowning initiative. Through this initiative, drowning prevention awareness and education is primarily spread through the dissemination of printed materials at the community-level, including: cinch-style backpacks imprinted with the words *Keep Kids Safe From Drowning*, as well as window clings, vinyl stickers, and magnets for parents to place directly on points of access to swimming pools. Originally, this initiative was implemented in eight Florida counties with the highest counts of child fatalities by drowning (Broward, Miami-Dade, Duval, Hillsborough, Orange, Palm Beach, Polk, Volusia.) Through discussions with drowning prevention champions in the participating counties, the State CADR

Committee further assessed areas for improvement regarding this initiative. This resulted in tailoring materials and distribution efforts to the needs of the community, and exploring options for expanding these efforts to marginalized communities. As a result, in 2024, the State CADR Committee, in partnership with the CADR Unit, expanded this initiative into eight additional counties with the highest rates of child fatalities by drowning (Bay, Charlotte, Hernando, Marion, Osceola, Putnam, Saint Lucie, and Santa Rosa) and all Keep Kids Safe From Drowning materials are currently available in English, Spanish, and Haitian Creole.

The State CADR Committee introduced the Sudden Unexpected Infant Death Investigation (SUIDI) Initiative in 2023, supplying each Florida county with two SUIDI Kits. These kits serve as a significant resource for law enforcement and medical examiner investigators, enhancing the accuracy of cause of death determinations in sleep-related infant death cases. To support this initiative, State CADR Chairperson, Retired Major Connie Shingledecker, conducted SUIDI trainings to four circuits in Florida in 2023. The SUIDI trainings, alongside the initial distribution of SUIDI kits, generated significant interest and momentum around the SUIDI model. As a result, Retired Major Connie Shingledecker continued providing SUIDI trainings in 2024 and an additional three SUIDI kits were procured and will be distributed to each Florida county by the end of the calendar year.

SUIDI kits include materials used by death scene investigators to conduct a proper investigation. Materials include: 5.11® Tactical Bag, an orange 8lb SUIDI doll, a pocket rod measuring device, an infrared digital thermometer, a 21-inch lifelike newborn baby doll, laminated placards labeled: placed, found, pet, and sibling for photographic purposes, Infant Death Investigation: Guidelines for the Scene Investigator, and additional resources for investigators and instructors.

Local CADR Committee Prevention Initiatives

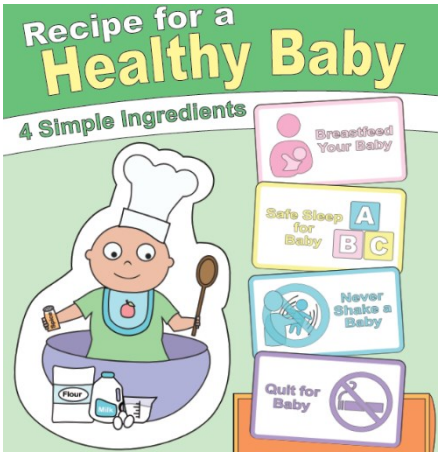
To effectively address sleep-related infant deaths in Florida and demonstrate an ongoing commitment to promoting safe sleep practices for infants and reduce the risk of sleep-related infant deaths, the following Local CADR Committees have taken significant actions. Safe sleep initiatives highlighted below addressed the following 2023 Prevention Recommendations developed by the State CADR Committee:

- Promote guidelines regarding safe sleep practices for infants.
- Ensure all local CADR committees and other entities reviewing child fatalities consistently report hazardous consumer products to the U.S. Consumer Product Safety Commission (CPSC), dating back to deaths occurring on or after January 1, 2021.
- Reevaluate Florida's child and adolescent suicide review model.

- Develop and submit recommendations to the National Center for Fatality Review and Prevention (NCFRP) regarding potential changes to the National Fatality Review-Case Reporting System (NFR-CRS) to incorporate fields that would better contribute to a deeper understanding of child fatalities in Florida.
- Continue efforts to relay timely information to caregivers and community supports regarding the safety of children.
- Continue to support and encourage the development and evaluation of pilot projects and initiatives focused on community-based child fatality prevention.

Circuit 1B:

Florida Healthy Baby Initiative (FHBI): FHBI is a statewide initiative designed to positively impact the disparities in infant mortality. Circuit 1B CADR members, in collaboration with Healthy Start Coalition of Okaloosa and Walton Counties, provided Healthy Start participants with a *Recipe for a Healthy Baby (*R4HB*)* presentation. Participants receive materials imprinted with the R4HB (Breastfeed Your Baby, Safe Sleep for Baby, Never Shake a Baby, and Quit for Baby). The Florida Healthy Babies Community Action Planning Team provides informational sessions, including demonstrations displaying the potential effects of shaking an infant, smoking cessation classes, lactation support, and much more.



- **Paramedicine Program**: Okaloosa County's EMS Community Paramedicine Program provides mobile non-emergency health services that include scheduled home visits, education, and access to other health; reducing the need for ambulance use costly emergency room visits. The program engages with families of drowning victims to educate them on water safety and drowning prevention.

Circuit 9:

- **Door Alarm Installation:** Circuit 9 CADR local committee leadership partnered with Orange County Fire Rescue to provide free door alarm installation for Orange County residences that have at least one entry point to a body of water.
- **Partnership with Local Lodging:** Circuit 9 DCF and the Local CADR Committee collaborated to educate Orange County lodging companies on safe sleep practices, with the goal of distributing basinets to guests checking in with infants.

Circuit 10:

- **Safe Kids Day:** Safe Kids Day was held April 6, 2024, in Polk County. The event was hosted by Lakeland Regional Health in collaboration with Safe Kids Florida Suncoast, the Florida Department of Health in Polk, Lakeland Police Department, and Lakeland Fire and Rescue. Safe Kids Day is a free, family-friendly event that focuses on injury

prevention, child safety, and lifesaving practices. Swim Lesson Facilities: DOH-Polk, in collaboration with the Coalition on Injury Prevention of Polk County and Johns Hopkins Children's Hospital, compiled and published a list of swim lesson facilities disseminated throughout the community. The list includes swim lesson locations, as well as details on the lesson type, cost, and specifies if facility memberships are required to participate.

- **DCF Water Safety Training:** Circuit 10 Local Committee Chair, Taylor Freeman facilitates in-service water safety training for DCF case managers and CPI's. The first trainings occurred on January 5th with nine attendees and the second on March 28th with 13 attendees.
- **Drowning Public Service Announcement (PSA):** Circuit 10's Local CADR Committee participated and shared a PSA recording in partnership with the Polk County Fire Rescue regarding water safety and drowning prevention practices; The PSA was disseminated among multiple social media platforms.
- **Door Alarm Distribution:** Circuit 10 has actively distributed door alarms to the community along with water safety information at the following events: 200 at the Watermelon Festival, 41 at the Children's Resource Center End of Year Luau, 79 at the Early Learning Coalition Family Fun Day, and 17 at Paul A. Diggs Neighborhood Association meeting. Water Safety Education was also provided to children ages 3-5 at Kids, Inc. VPK.
- **Safe Kids Day:** Polk County hosted a water safety table at the Safe Kids Day 2024 event. Approximately 350 families attended the event. A few families received Pack n Plays, children received helmet fittings, water watcher tags, and a list of organization that provide free swim lessons.

Circuit 11:

- **Zero Funding Drownings Miami-Dade:** Zero Funding Drownings Miami-Dade, supported by public and private funding, will launch in the Fall of 2024.This collaborative effort involves The Children's Trust, Miami-Dade County, Miami-Dade County Public Schools, the American Red Cross - South Florida Region, The Miami Foundation, United Way Miami, Edu Foundation, and the Templeton Family Foundation. The program[1] aims to prevent childhood drownings by offering free swim lessons for four- and five-year-olds, water safety education for families, and a community wide water safety campaign. Swim lessons will be provided during the school day using American Red Cross certified curriculum at public and private swim safety locations.

Circuit 12A:

- **Safe Sleep Awareness**: In May 2024, Healthy Start of Manatee County provided a Safe Sleep Awareness Event where attendees were provided safe sleep education, prevention materials and opportunities to connect with other community resources.

Circuit 13:

[1] CBS News Coverage Miami-Dade County swim program
https://www.cbsnews.com/miami/news/miami-takes-aim-at-drowning-stats-with-county-swim-program/

- **Safe Baby Program Community Outreach and Education Safe Sleep Messages:** The Tampa Bay Times published Hurricane Awareness ads in both English and Spanish, reminding parents to practice safe sleep habits for infants during evacuations caused by natural disasters.
- **Morning Blend Interview:** Hillsborough County's Safe Sleep Champion, Lisa Colen, joined Allison Godlove on Tampa Bay's Morning Blend show to provide safe sleep practices and spread awareness on commonly used unsafe infant products. The interview can be found here[2].

Circuit 15:

- **Community Baby Shower**: In April 2024, Circuit 15 CADR committee members participated a community baby shower held by St Mary's Medical Center and Palm Beach Children's Hospital. The event aimed to increase awareness of available services for all families, regardless of insurance or economic status. It also highlighted the importance of prenatal care and educated attendees on the ABCs of safe sleep.
- **Doula Program:** DOH-Palm Beach, Community Health Promotion and Education Division developed a Community Health Forum on the Doula Program. The forum provides participants valuable insight into childbirth, postpartum care, tips on pain management, and infant care including breastfeeding and safe sleep practices.

Circuit 17:

- **Life Jacket Loaner Project:** The Life Vest Loaner Program was launched, in partnership with the CADR Unit and Safe Kids Broward County, to build two life vest kiosks at public beaches. Each kiosk holds 20 vests in various sizes, available at no cost to beachgoers. The program ensures that all individuals, regardless of economic status, have access to life vests, helping to reducing water-related injuries and deaths.

Circuit 18A:

- **Sleep Baby Safely**: During the months of April and May, DOH-Seminole distributed over 150 Sleep Baby Safely bags with plans to distribute more bags to the Seminole county WIC offices, area pediatric offices and daycares.
- **Child Safety Presentation**: In June 2024, DOH-Seminole gave a presentation to high school students at Antioch Missionary Church in Oviedo, Florida. The presentation emphasized the importance of keeping younger siblings safe, covering topics such as safe sleep practices, drowning prevention, child abuse awareness, and the dangers of secondhand and thirdhand smoke.

[2] https://www.abcactionnews.com/morning-blend/keep-your-sleeping-infant-safe-tips-parents-need-to-know

- **Cradle Seminole**: DOH-Seminole's Cradle Seminole: Every Baby, Every Day is a nurse home visiting program designed to enhance access to maternal and infant care. Registered Nurses provide personalized, evidence-based care, which includes comprehensive health education, addressing social and economic factors, and monitoring infant growth and development up to two years of age. Parents receive in-person safe sleep education and additional support tailored to their needs.
- **Joy Baby Shower:** In May 2024, Circuit 18A CADR committee members participated in the Joy Baby Shower, a community outreach event, centered on the dissemination of materials and resources to expecting parents and caregivers in Sanford, FL.
- **Welcome Baby Bag and Door Alarm Distribution:** In April, DOH-Seminole partnered with Healthy Start Coalition to provide 150 Welcome Baby Bags and 200 door alarms for distribution to their clients, hospital, and birthing centers. This includes but not limited to:
    - 110 Welcome Baby Bags to DOH-Seminole, and
    - 100 door alarms to the Family Wraparound Services with the Seminole county Sheriff's Office.