FLORIDA CHILD ABUSE DEATH REVIEW

ANNUAL REPORT
December 2007

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

December 21, 2007

The Honorable Charlie Crist
The Honorable Ken Pruitt
President of the Florida Senate
The Honorable Marco Rubio
Speaker of the Florida House of Representatives
The Capitol
Tallahassee, Florida 32399-0001

Dear Governor Crist, President Pruitt, and Speaker Rubio:

As Chairperson of the State Child Abuse Death Review Committee, I am submitting this annual report of child abuse in accordance with Chapter 383.402, Florida Statutes. This report summarizes information from reviews of 170 Florida children whose deaths were determined to be due to child abuse or neglect and were verified as such by the Department of Children and Families in 2006.

Fatal child abuse and neglect is a nationwide problem and continues to be an issue for Florida's children. As a State Committee, we are in our 3rd year of reviewing all verified child abuse deaths and believe that we are increasing awareness of child abuse and child abuse deaths, which is leading to better reporting to the Florida Abuse Hotline. Our work is critical and requires collaboration with you to make the recommendations of the State Committee a reality. The death of any child has a profound effect and any child abuse death is unacceptable.

Not all child abuse deaths are preventable, but with education, outreach, intervention programs, and family supports, we can work together towards our ultimate goal to reduce preventable child abuse and neglect deaths in Florida.

Sincerely,

Connie Shingledecker
Chairperson
State Child Abuse Death Review Committee

ACKNOWLEDGEMENTS

- First, the State Committee would like to recognize one of its own – Robert Hodges. Bob Hodges, representing the Florida Prosecuting Attorney's Association, has been a member of the State Committee since 2000 and served as Chairman from 2002-2006. Governor Charlie Crist recently appointed Bob as a Circuit Court Judge in the 5th Judicial Circuit. We honor Bob for his achievement, but more importantly for his friendship and contributions to the work of the State Committee, which grew under his guidance and leadership. His contributions to the Committee's work, quick wit, and keen legal mind will be missed. Congratulations Bob!

- The State Child Abuse Death Review Committee relies on the support and participation of many partners to accomplish its work. Without their commitment to our mission, the State Committee could not accomplish its statutory mandate. This year has been a formidable challenge due to the increase in the number of deaths reviewed and we couldn't have done it without the help of many friends at the State and Local level.

- As stated, the State Committee relies heavily on the work of the Local Child Abuse Death Review Committees, which work in tandem with the Department of Children and Families Child Abuse Death Coordinators. Without their close cooperation and commitment, the State Committee could not meet its responsibilities. In addition, representatives from the Florida Department of Health's Children's Medical Services Child Protection Teams chair many of the local committees. Their shining example of partnership, leadership, cooperation, and participation from all community participants makes this a process that benefits children by working together to reduce preventable child abuse deaths.

- The State Committee has worked very proactively to reach out to our community partners through training and increased awareness of the critical issues that are identified as a result of the child abuse death review process – a debt of gratitude is owed to many who help support this work through their commitment of time and resources. In particular, the State Committee would like to recognize the Florida Department of Law Enforcement and the Manatee County Sheriff's Department for their ongoing support of training for law enforcement representatives and others, through the work of Special Agent Terry Thomas and Major Connie Shingledecker.

- Finally, the State Committee would like to acknowledge the hard work and support from the staff of the Florida Department of Health Division of Prevention and Intervention in Children's Medical Services - Michelle Akins, Sue McLauchlin, Stephenie Gordy, and Chelsy McCarty - who work diligently with the State Committee to put this report together.

FLORIDA CHILD ABUSE DEATH REVIEW COMMITTEE

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DECEMBER 2007

Mission

"to reduce preventable child abuse and neglect deaths"

Submitted to:

The Honorable Charlie Crist, Governor of Florida
The Honorable Ken Pruitt, President, Florida Senate
The Honorable Marco Rubio, Speaker, Florida House of Representatives

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EXECUTIVE SUMMARY

The Florida Child Abuse Death Review Committee was established by statute in s. 383.402 (1), F. S., in 1999. The State Committee is supported administratively by the Florida Department of Health, Children's Medical Services Division of Prevention and Intervention, and utilizes state and locally developed multi-disciplinary teams to conduct detailed reviews of the facts and circumstances surrounding child abuse and neglect deaths in which a report of abuse or neglect was accepted by the Florida Abuse Hotline and verified as child abuse by the Department of Children and Families (DCF) or local Sheriff's Office protective investigators. The major purpose of the child abuse death review process is to develop and implement data-driven recommendations for reducing child abuse and neglect deaths.

In 2006, 171 children died as a result of abuse or neglect. This eighth annual report includes information from the review of 170 of the children who died in 2006 (Note: One death will be reviewed in 2007 due to it's unavailability to the Committee in time for inclusion in this report). The committee also reviewed four additional cases: two children who died in 2005, and two who died in 2004. The data from these cases has been updated into the respective years.

During 2005, an estimated 1,460 children died nationally from abuse and neglect at a rate of 1.96 deaths per 100,000 children, (Child Maltreatment, 2005). National data are not reported consistently across states and reflects different systems, state laws, definitions, practices and policies, including how the data are collected and reported. It is widely acknowledged that many child abuse and neglect deaths are underreported and/or misclassified. Scholars, professionals and officials around the nation agree that a system of comprehensive Child Death Review teams could make a difference. There are clear patterns and trends observed for the State that are consistent with national data; however, because of the limited population of deaths reviewed, there are variations, which are reflected in this report.

In 2006, there was a substantial increase in the number of Florida child abuse deaths from the previous year. Ninety-five were verified in 2005 and 171 in 2006. The State Committee believes that the increase may be attributed to more accurate reporting of child fatalities to the Florida Abuse Hotline. The State Committee, in conjunction with other agencies such as, the Florida Department of Law Enforcement, Florida Department of Health, Department of Children and Families, and Healthy Families Florida provided training throughout the State to increase awareness on mandated reporting in cases including, but not limited too: murder suicides; traffic crashes that resulted in a child's death where the caretaker was neglectful or impaired by substances; deaths that involved drugs (legal and illegal) and/or alcohol in the home where the caretaker was impaired; and drowning deaths, which were a result of children being inadequately supervised.

Based on the review of 170 Child Abuse Deaths in 2006, the State Child Abuse Death Review Committee has identified ten priority issues with recommendations. Other topic specific issues and recommendations can be found in the body of the report.

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

ISSUES AND RECOMMENDATIONS:

Issue 1: All child death review is needed to facilitate a complete understanding of why children die in Florida – Death certificates are an inadequate source for developing a comprehensive picture.

Recommendations: Implement all child death review or review all child deaths reported to the Florida abuse hotline.

A. Expand the child abuse death review process to include the review of all child deaths.

B. If all child death review cannot be accomplished, the Florida Legislature should expand the child abuse death review process to include the review of all child deaths reported to the Florida Abuse Hot Line.

Chapter 383.402 F.S. limits the review of child deaths to those that are verified as child abuse by the Department of Children and Family Services. In 2006, 2,756 children between the ages of birth up to the age of 18 died in Florida. Because the State Committee is only reviewing verified child abuse deaths, the larger picture of why children die is lost. The State Committee has seen inconsistencies in how child deaths are reported and recorded, which gives a false sense of understanding when the only source of information is the death certificate or medical examiner data. There is a national movement to establish all child death review in every state with a common data collection system that will allow information to be shared with agency partners in Florida and nationally. This effort will lead to quality prevention and early interventions that maximize community resources and reduce preventable child deaths.

The State Committee recommendations are limited to the review of verified child abuse deaths, and as a result these recommendations and our commentary on

trends is limited to that population and may not be generalized to the larger population of children who die in Florida. The benefits of implementing a comprehensive all child death review process would include more thorough child death investigations by law enforcement and medical examiners, enhanced interagency cooperation, improved allocation of limited resources, and consistency in the certification of the cause and manner of death, which would provide more accurate epidemiologic data as to risk factors that may play a role in the deaths of children in the State of Florida.

In 1995, the US Advisory Board on Child Abuse and Neglect recommended that all states review 100 percent of deaths for children ages 17 years and younger. A number of states have done so. A critical issue that must be addressed is the privacy of families who lose a child. No greater tragedy can befall a parent or family. The State Committee is respectful and committed to not intruding on a family's loss by further traumatizing them through an insensitive review process. It has been demonstrated by other death review processes around the country that these reviews can be accomplished in a respectful way that is protective of family rights to privacy.

Issue 2: Healthy Families Florida, a proven child abuse prevention program, is needed statewide to protect children from abuse and improve outcomes for families.

Recommendations: The Florida Legislature should fully fund Healthy Families Florida.

A. Continue to fund Healthy Families at the 2007-2008 level, which includes the $2.2 million in non-recurring funds for the expansion of Healthy Families into the remaining 14 of Florida's 67 counties.

B. Increase funding for Healthy Families Florida to sustain quality services by adjusting the base funding for workload and price level increase, unchanged since 2003-2004; enhance services by adding high-risk specialists to the core staffing; and expand services county-wide in the 21 counties that currently only provide services in targeted zip codes.

Healthy Families Florida is a nationally accredited, community-based, voluntary home visiting program proven to prevent child abuse and neglect. Trained family support workers educate parents on healthy child development and positive

parenting and provide information, guidance, and emotional and practical support to families in their homes. A five-year evaluation conducted by an independent third-party evaluator (cite) concluded that Healthy Families Florida has a significant impact on preventing child abuse and neglect in Florida's high-risk families before abuse ever begins:

- Healthy Families participants had 20 percent less child abuse and neglect than all families with children under five living in the targeted service area.

- Children whose families did not receive Healthy Families services were nearly four times more likely to suffer maltreatment before their second birthday than children in families who completed the program.

The goals of Healthy Families Florida are consistent with the goals of the Governor's Children and Youth Cabinet and the Office of Child Protection and Permanency. Healthy Families is also recognized by the U.S. Office of Juvenile Justice and Delinquency Prevention as an "effective" prevention program, demonstrating empirical findings using a sound conceptual framework and an evaluation design of high-quality."

Issue 3: Children continue to die from drowning at an alarming rate as a result of inadequate supervision.

Recommendations: There must be a comprehensive approach to preventing drowning of children, particularly those under the age of 5.

A. All risk assessments conducted by child protective investigators should include drowning risk factors when there are bodies of water or a pool on the premises or close by the home.

B. Law enforcement and medical professionals should report all child-drowning deaths to the Florida Abuse Hotline to allow neglect investigations to occur.

C. The Florida Abuse Hotline should accept reports from law enforcement or medical professionals on child deaths that occurred as a result of drowning.

D. Medical Professionals should report all child-drowning deaths where the death has been delayed due to resuscitation or medical intervention, to the Medical Examiner's office since these deaths resulted from a complication of the drowning and therefore, are not natural deaths.

E. Continue public awareness and education on drowning prevention especially targeted at the five and under age group.

Florida has the highest unintentional drowning rate in the nation for the 1 to 4 year old group with a rate of 8.38 per 100,000 populations in the US.

- Residential swimming pools are the location of nearly two thirds (64%) of the drowning deaths in Florida for the 0-4 age group (CDC WISQARS)[7].
- Florida had the 3rd highest overall unintentional drowning death rate of children in the US in the 5 years between1999-2003 (CDC WISQARS) and has the highest drowning death rate in the nation for children ages 1 to 4.
- In 2003, Florida surpassed California, the most populous state in the nation, in the number of children ages 1 to 4 who drowned.
- According to the Florida Department of Health, there were 95 children ages 0-6 who drowned in Florida in 2006.

Issue 4: Identification and awareness of common triggers for physical abuse is essential to the prevention of child abuse deaths caused by physical injury.

Recommendations: The Florida legislature should:

A. Provide ongoing funding for prevention education activities such as Coping with Crying and "Who's watching Your Child."

B. Support funding for training of investigators, providers, and any service agencies for the purpose of providing educational efforts focused on adult males between the ages of 20-30.

Crying, potty training and feeding are the most common triggers of physical abuse by the young, unskilled, or non-biological caregivers for children under the age of five. The Kimberlin West Act of 2002 requires that hospitals educate new parents on the dangers of shaking a baby.

Crying is the most common trigger for the violent shaking of a child. This Committee has also identified crying as a trigger in a majority of the abuse deaths

reviewed. In addition, the State Committee has seen common factors that are present in the deaths of these children in numerous cases.

These factors include young males between the ages of 20-30 who are unemployed and are often providing primary childcare while the biological mothers work. In addition, there are often histories of substance abuse, domestic violence or criminal history of aggressive or violent behavior. The fact that many of these males are unattached non-biological fathers contributes to their impatience and lack of parenting skills. Any partner in the child protection system should be aware of and sensitive to these risk factors when investigating an allegation of child abuse. Families with these risk factors and history of prior reports, irrespective of the findings, should be considered at the highest risk for child maltreatment.

Issue 5: Lack of understanding regarding the need for a safe sleeping environment continues to contribute to the tragic suffocation deaths of infants.

Recommendations: The State Child Abuse Death Review Committee believes that:

A. The Florida Legislature should provide funding for education and awareness on safe and unsafe sleep environment for child protective investigators, hospital staff medical personnel and parents with newborn children.

B. The Florida Department of Health should partner with the Florida Pediatric Society, Florida Hospital Association, Healthy Families Florida, Department of Children and Family Services, and Healthy Start to seek appropriate venues to provide educational materials and support to hospital staff, medical providers, child protective investigators, service providers and parents with newborn children.

There has been a nation-wide," Back to Sleep" campaign since 1992 to educate the public about the importance of placing children on their backs. (The National Institute of Child Health and Human Development, the Maternal and Child Health Bureau, the American Academy of Pediatrics, the SIDS Alliance, and the Association of SIDS and Infant Mortality Programs sponsor this campaign). Although this has reduced such deaths nearly in half, the State Committee continues to see an ongoing problem where parents make poor choices regarding the infants sleep environment such as co-sleeping with the infant or bedding that presents a risk to the infant. Other risks for infant suffocation when co-sleeping

include obesity, under the influence of alcohol or drugs and exhaustion. Many of these deaths have the potential to be classified as SIDS deaths instead of suffocation. The State committee adopted the recommendations regarding safe sleeping that the American Academy of Pediatrics released on November 5, 2005 (See Appendix VI).

Issue 6: There continues to be inconsistency in findings in child abuse death cases.

Recommendation: Consistent with DCF Administrative Code 65C-30.020(5)(f), DCF Death Review Coordinators, because of their expertise, experience and professional judgment, should review and have the authority to modify the findings in child death cases prior to the closure if they do not agree with the findings.

The State Committee found that there were inconsistencies, depending on the county where the Department of Children and Families reviewed the death, as to the percentages of child death reports closed with verified findings. The irregularities apparent in child death reports appears endemic to all child abuse reports, as certain counties repeatedly have lower rates of verified findings than would be expected to occur over time.

The State Committee understands that the Department of Children and Families has a comprehensively developed performance measure protocol that is used to gauge child protection functions and identify insufficiencies. The emphasis on favorable performance measures, however, may drive the verification rates for child abuse deaths. There is concern that child abuse deaths may be skewed due to miss-classification and underreporting, as stated earlier in this report. While it is commendable that many strides have been made in classifying more cases appropriately, as evidenced by the increase in verified child deaths, the State Committee believes that much work remains for the Department. It is known by the State Committee that cases classified as "some indicators" have been reassessed in the past and changed to "verified", which indicates the need for more careful analysis on classification outcomes. This issue will be a priority for the State Committee in 2008.

Issue 7: There are inadequate death scene investigations resulting in inconsistent certification of cause and manner of death by Medical Examiners in sudden infant death investigations.

Recommendations: The State Child Abuse Death Review Committee believes that:

A. The Medical Examiner's Commission should recommend that all M.E. districts adopt the Sudden Unexplained Infant Death Investigation (SUIDI) model.

B. All Florida Medical Examiner districts should participate in the National MDI (Medicolegal Death Investigation) Log registry (www.mdilog.net) for sudden unexplained infant deaths.

C. Law Enforcement agencies are urged to adopt and participate in the training of the Center for Disease Control's (CDC) initiative, Sudden Unexplained Infant Death Investigations, such training should include a drug testing component.

D. The Florida Department of Law Enforcement, through the Standards and Training Commission, should work with county sheriffs and local police chiefs to develop a standardized protocol for investigating child deaths or at a minimum adopt the CDC SUIDI protocol.

E. DCF should adopt and participate in establishing guidelines for investigating infant death possibly related to unsafe sleep practices, to include a drug-testing component.

F. DCF should provide all child protective investigators with a presumptive field drug testing kit for use in any alleged child abuse death.

Nationally, forensic pathologists consider the information on the Sudden Unexplained Infant Death Investigations (SUIDI) form critical to the determination of the cause and manner of death with regard to infant death investigation.

- The State Committee found that there is no comprehensive or consistent statewide training on child death investigations. Many cases lacked thorough crime scene investigation and documentation, drug testing was not requested or ordered in many cases even when drug paraphernalia was observed at the scene, and not all witnesses were interviewed.
- A recent initiative, SUIDI death investigation, through the Center's for Disease Control have encouraged all States to adopt a standardized approach to infant death scene investigation. Representatives from Florida participated in the initial training and have provided training through out the State of Florida when requested or when the opportunity presented by Medical Examiners and law enforcement agencies. The State Child Abuse Death Review Committee views this project as a high priority and is supportive of identifying resources to initiate a statewide approach to training and outreach.

Issue 8: There is a need for multidisciplinary staffing where the family has had 3 or more prior reports of abuse and neglect irrespective of the previous finding.

Recommendations: Prior history must be taken into consideration by child protective investigators and child welfare legal representatives when assessing risk and making child safety decisions.

A. Multidisciplinary staffing needs to occur when there is a child under the age of five in the home and there have been three or more prior reports on the family, irrespective of the findings of the prior reports.

B. The Department of Children and Families should look into the process whereby Child Welfare Legal Services and child protective investigators review critical child safety decisions in determining what court action should be taken, and that the family's full history with the Department of Children and Families should be considered.

C. The Department should review, modify, and seek legislative change if necessary, to case closure timelines, to allow flexibility in keeping a case open when a family has three or more reports.

The State Committee reviewed 26 child abuse deaths where there were three or more prior reports to the Department of Children and Families and little to no services had been provided or the risk was overlooked; and it appeared that multidisciplinary staffings were not held.

The State Committee found that in the deaths where there were prior reports and Child Welfare Legal Services had determined that there was "insufficient evidence for court action", it often appeared as though that decision was made without taking the full family history into consideration.

In a recent review by the Quality Management Unit of Department of Children and Families services, it was determined that 70 percent of all child's deaths reported to the Florida Abuse Hotline had a family member who had prior involvement with the Department, which reinforces the need to consider prior history in making child safety decisions. Also, there is a need for identifying and expanding services and intervention for families in need to ensure that adequate resources are available to children and families when risk is identified. Additionally, rapid closure of cases by child protection investigators was identified as an issue in many deaths. When cases are closed without fully considering family history or past involvement with the community based care system, children are potentially placed at risk by continued exposure to identified risk factors without appropriate intervention by the system.

Issue 9: Substance abuse is a significant risk factor in many child abuse deaths.

Recommendations: Legislative change and training are required to address the issue of children exposed to illegal substances:

A. The Florida Legislature should initiate an interim project, in cooperation with the Florida Alliance for Drug Endangered Children and the Florida Pediatric Society's Committee on Child Abuse and Neglect to address the presence of illegal substances in the home as child abuse and amend Chapter 39 F. S., to address this issue.

B. The Office of Drug Control should coordinate mandatory training on substance abuse for partner agencies involved in the investigation and management of child abuse cases to include but not limited too, the Department of Children and Families, Florida Department of Health, Law Enforcement, Community Based Care Agencies, and the Judiciary.

C. The Office of Drug Control's curriculum should include recognition of increasing misuse of illegal, legal, and prescribed substances as a potential risk factor for child maltreatment by caretakers or access and exposure by child victims.

Chapter 39 Florida Statute does not currently recognize the presence of illegal substances in a child as harm.

- Children exposed to substance abuse by their caretaker may test positive by virtue of their exposure.
- Parental impairment due to the misuse of illegal substances should be recognized as risk to the child in their care.
- The use of legal and prescribed substances by the caretaker and/or child victim in a manner that is either unsupervised, inappropriate, or by careless accessibility should be recognized as a potential risk factor.

The State Committee has identified a pattern where investigative findings indicate that substance abuse by the parent or person responsible for the child was documented in prior reports or substances were discovered in the home at the time of the child's death. In addition to lack of follow through by investigators or law enforcement, for cases where the investigator convened a meeting with child welfare legal services, the substance abuse allegation does not appear to have been appropriately factored into the risk assessment. Subsequently, cases are either referred to Voluntary Services or no services. In addition, the State Committee recognizes that the Florida Appellate Courts have overturned the sheltering of children due to the lack of statutory authority in cases involving substance abuse as the nexus for sheltering child victims.

Issue 10: There is a need for judicial review when a child dies as a result of child abuse and the case was under the jurisdiction of the court.

Recommendation: The Florida Supreme Court or the Florida Legislature should establish an independent review process for judicial cases when a child dies from child abuse and was under the supervision of the court.

Since 1999, the State Committee has reviewed multiple deaths where dependency court was involved. Several of those deaths involved situations where the court either declined to follow the recommendations of the participating agencies, or when the case was brought before the court it declined to take any action on the recommendations of the supervising agency and the child was subsequently returned home and ultimately killed by a caretaker. One child death, for example, involved the community based care provider taking the mother before the dependency court on eight occasions for non-compliance with a court ordered case

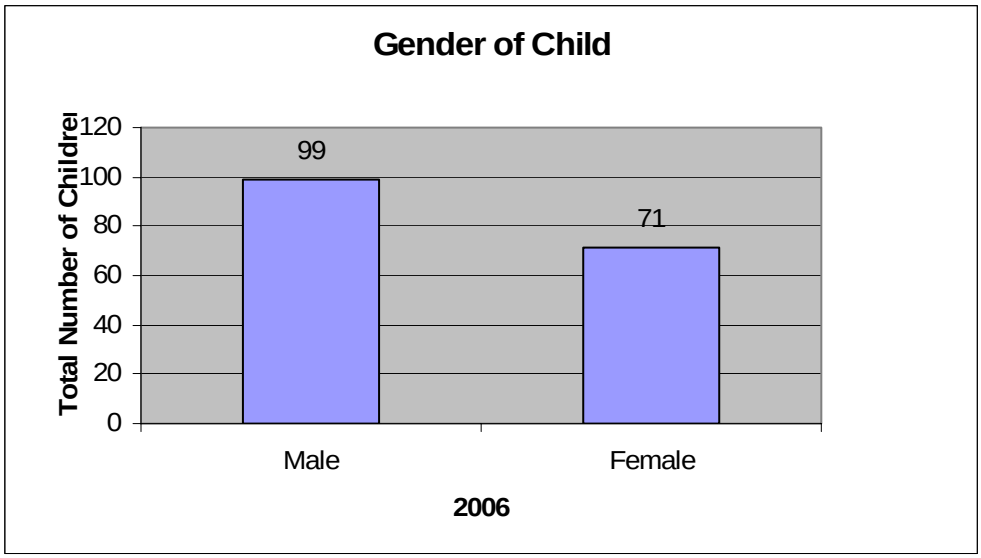
plan, yet the court declined to take any action or sanctions against the mother. While the State Committee is not making a direct nexus between the death of the child and lack of court action, it does believe that the judicial process should be reviewed in a manner similar to other child protection quality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

OVERVIEW

There were 170 infant/child deaths (under the age of 18) reviewed during 2006 that met the criteria for the State Child Abuse Death Review Committee. The following graphs show the total, gender-specific and race-specific child deaths for 2006.

Gender

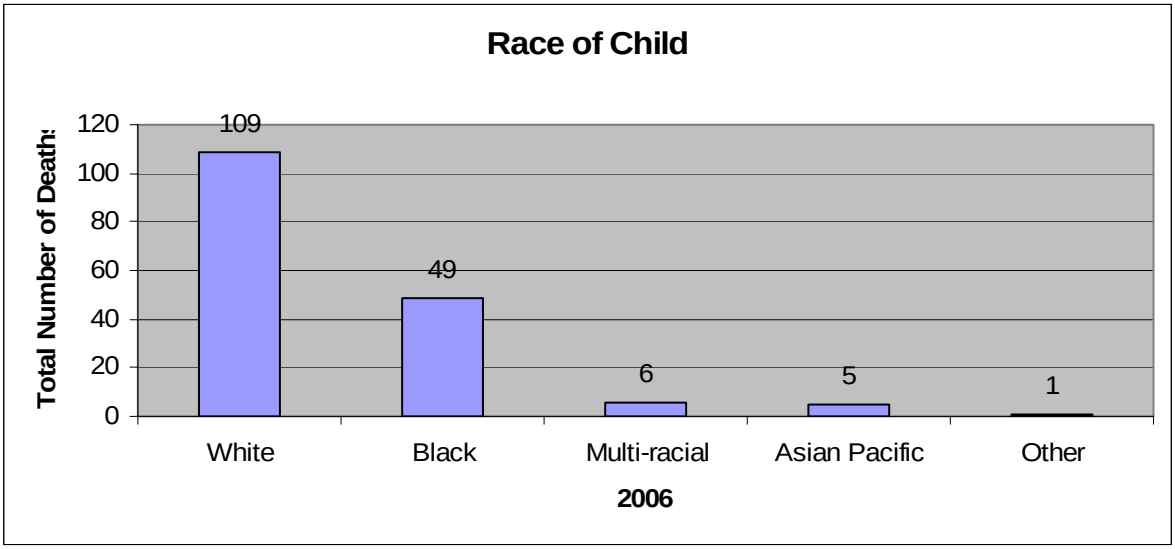
99 (58%) were male children
71 (42%) were female children



According to the US Department of Health and Human Services (DHHS), 2005, infant boys (younger than 1 year) had a fatality rate of 18 deaths per 100,000. Infant girls (younger than 1 year) had a fatality rate of 17 deaths per 100,000 girls.

Race of Child:

109 (64%) were white
49 (29%) were black
6 (4%) were multi-racial
5 (3%) were Asian
1 (1%) other



RISK FACTORS

Household risk factors include prior history of child abuse and neglect, child under age of 4, criminal history, parent's use of drugs and/or alcohol, parent's mental health and age, domestic violence and parent's inability to protect the child from harm. Investigators should be trained on the serious risk to children when there combinations of the risk factors.

Below are the totals for the risk factors for 2006.

Risk Factors in 2006 Child Abuse Deaths		
	2006	Percent
One or more children in the household age 4 or younger	141	**19%**
Prior reports involving any of the household members regardless of report findings	108	**15%**
Parent or caregiver is unable to meet child(rens) immediate needs	71	**10%**
Parents or caregiver's age, mental health, alcohol or substance abuse affects ability to parent	64	**9%**
A pattern or escalating and/or frequency of incidents of abuse or neglect	63	**9%**
Child(ren) in the home have limited community visibility	60	**8%**
Criminal history on any household member	58	**8%**
Parent or caregiver is unable or unwilling to protect the child(ren)	42	**6%**
Parent or caregiver has unrealistic expectations of child(ren)	37	**5%**
Conditions in the home are hazardous to child's health	37	**5%**
Domestic violence in the home	29	**4%**
Other child(ren) in home exhibit behaviors indicative of abuse or neglect	24	**3%**

CHILD ABUSE AND NEGLECT DATA

While the State Committee is very appreciative of the Legislative and Governor's support to expand the review authority to include all verified child abuse deaths, there are still limitations that remain. We are still reviewing subsets of larger populations of children who die and this limits the Committee's ability to fully meet the statutory charge of achieving a greater understanding of the causes and contributing factors of deaths resulting from child abuse, because not all deaths meeting that larger scope meet the criteria for review. The patterns and trends identified are subsequently limited to the population set reviewed and may or may not have generalizability to larger populations. The essential outcome is to be able to derive meaningful conclusions and provide concrete recommendations that can be implemented in hopes of preventing the death of additional children.

The following chart provides a better understanding of the current subset of the cases reviewed by The Child Abuse Death Review Committee and how it compares to the overall number of child deaths, as well as compared to the overall number of child abuse and neglect cases received in the state of Florida.

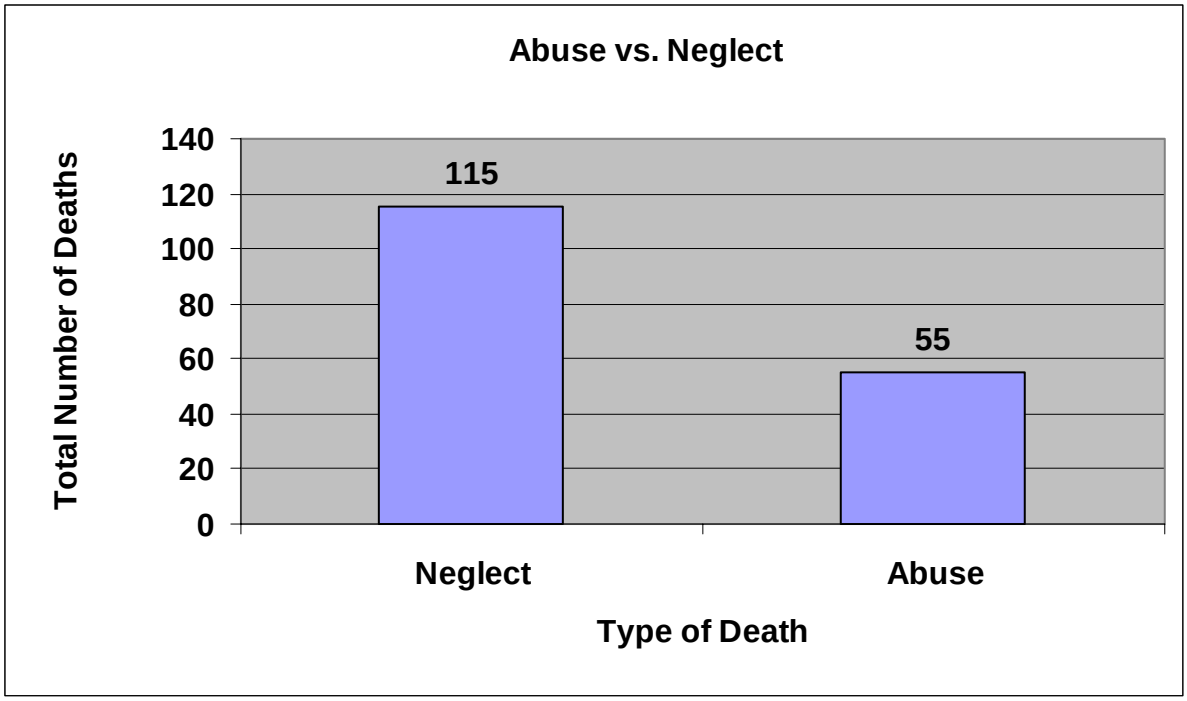
FLORIDA CHILD DEATHS - 2006	
Number of child deaths[5]	2,756
HSN REPORTS RECEIVED & ABUSE/NEGLECT DEATHS	
Number of initial reports	206,041
Number of reports involving child deaths	408
Number of child deaths with verified or some indicator findings	228
Number of verified child death reports	171
National estimate for 2004[3]	1,490

The 2004 and 2005 death cases were reviewed in 2006 however the data for 2004 and 2006 has been updated to reflect those 4 deaths.

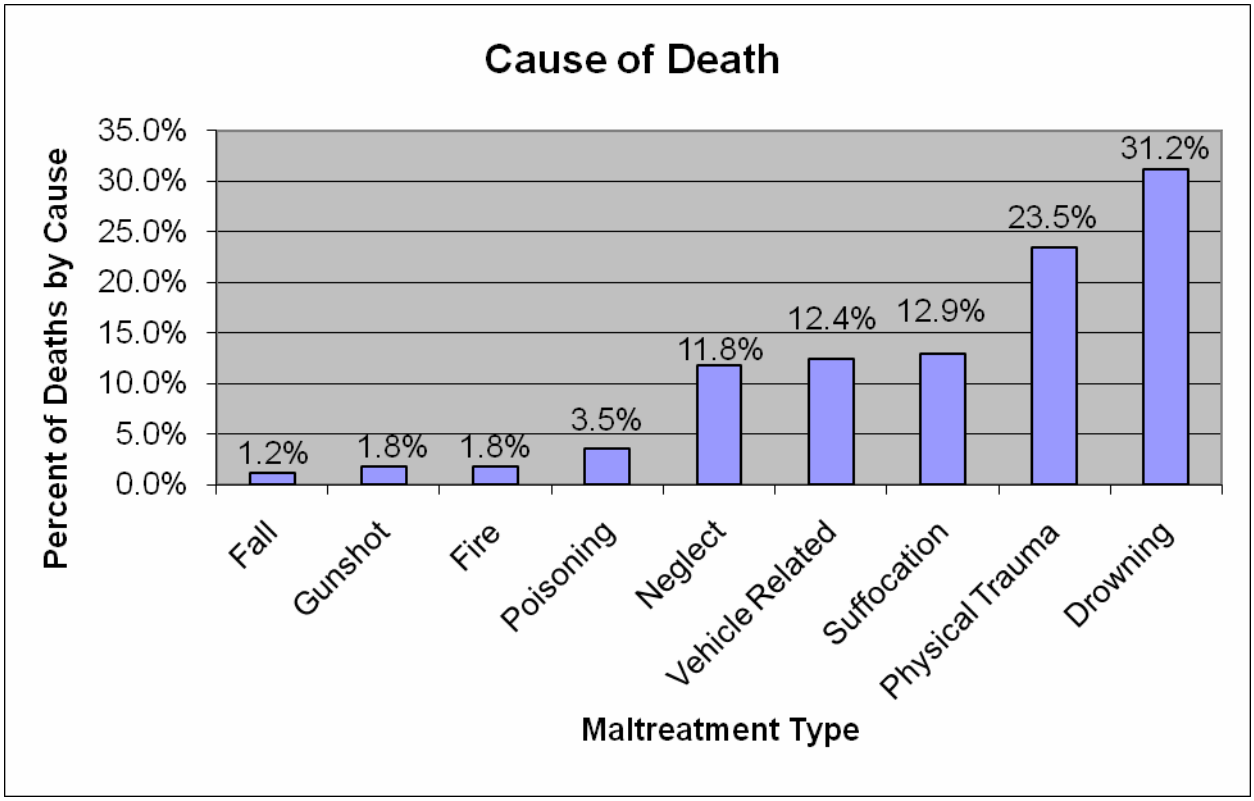
ABUSE/NEGLECT

In 2006 there were 170 child abuse deaths reviewed. Of those, 55 (32%) were from abuse and 115 (68%) were neglect.

In cases of fatal neglect, the child's death results not from anything the caregiver does, but from a caregiver's failure to act. The neglect may be chronic (e.g., extended malnourishment) or acute (e.g., an infant who drowns because she is left unsupervised in the bathtub). NCANDS (National Child Abuse and Neglect Data System) show more than 60% of nearly one million children reported suffered neglect and nearly one-third of the 1,500 related deaths were a result of neglect. Neglect has been the leading cause of child abuse deaths over the last five years. Neglect covers a broad section of maltreatments and may have no outward signs, so is often missed. Neglect is the leading cause of child death especially children under the age of 5. The second leading cause of Florida child abuse deaths is physical abuse.



68% of children whose deaths were reviewed, died from neglect and 32% died as a result of physical abuse. The graph below shows the cause of death by maltreatment type.



PRIOR INVOLVEMENT WITH THE DEPARTMENT OF CHILDREN AND FAMILY SERVICES

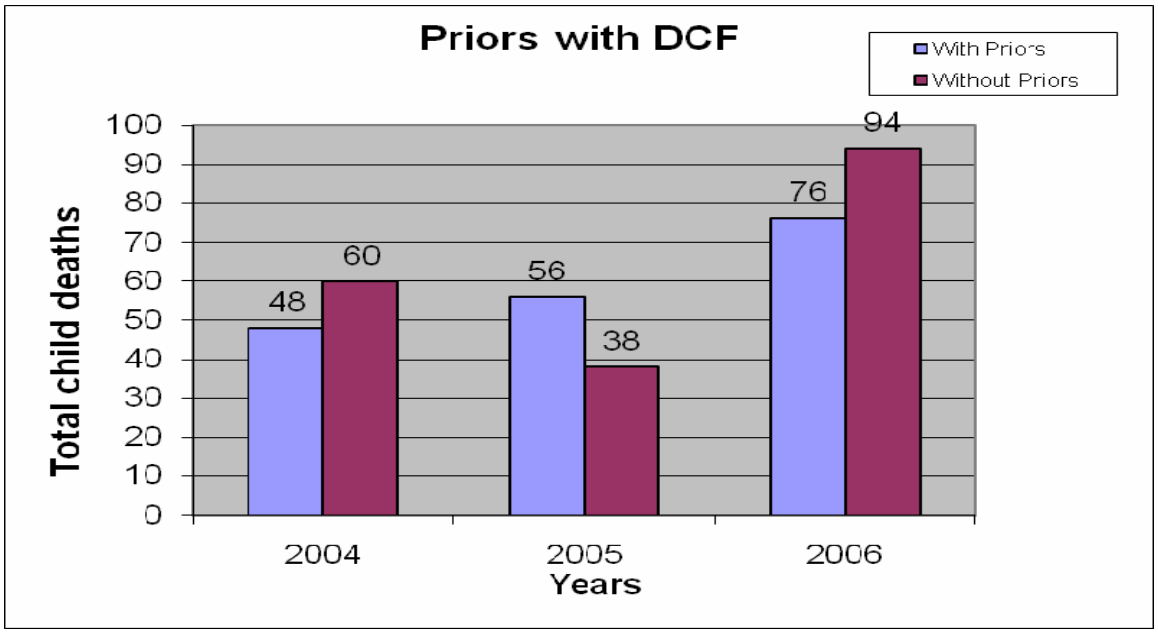
According to the US Department of Health and Human Services, children whose families had received family preservation services in the past five years accounted for 11.7 percent of child fatalities. Nearly 3 percent (2.7%) of the children who died had previously been in foster care and were reunited with their families in the past five years.

The following graphs demonstrate a number of deaths with priors or no priors and the number of priors on each child who died. The increase reflected from 2005 to 2006 may be due to the statutory review of all verified cases combined with the training and work the State Committee has done to educate professionals and the general public on mandatory reporting and improved consistency in verification of findings by child protective investigators.

There were 76(45%) cases in 2006 where the child had prior involvement with the Department of Children and Families.

Ninety-one cases (56%) did not have any prior involvement with the Department of Children and Families.

The graph below shows the number of child abuse death cases that had prior reports on that deceased child with the Department of Children and Families prior to the child's death.



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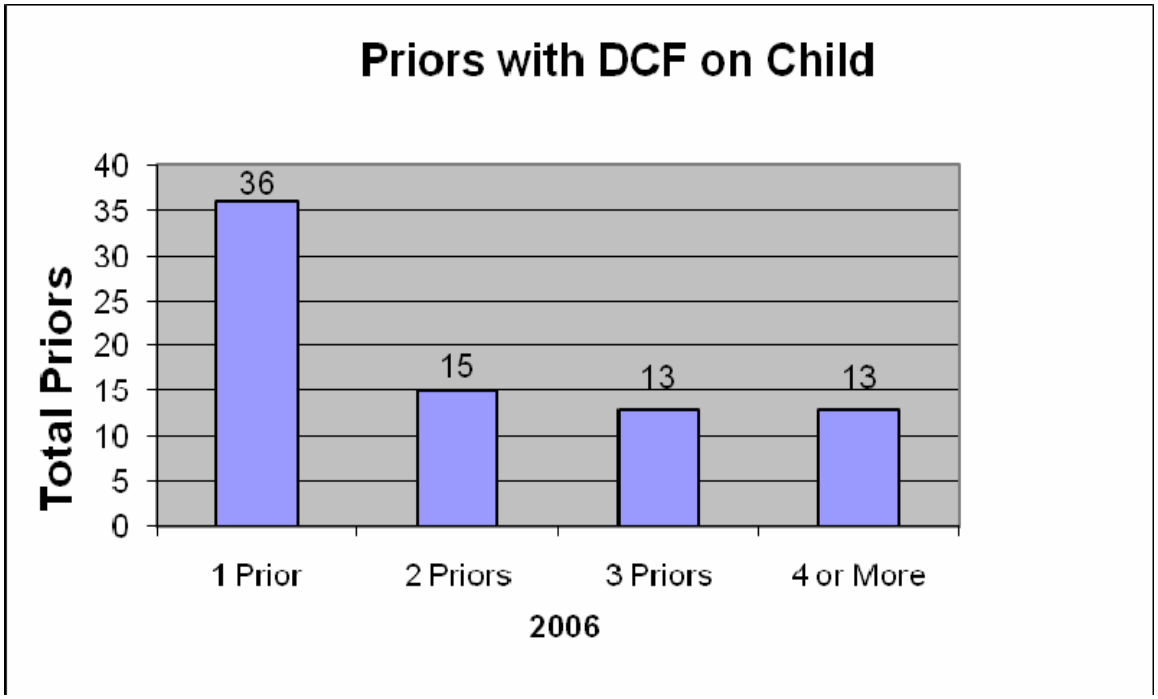


PREVENTABILITY

Preventable deaths

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

Definitely preventable by caretaker or system or both: The information provided demonstrates clearly that steps or actions could have been taken that would have prevented the death from occurring.

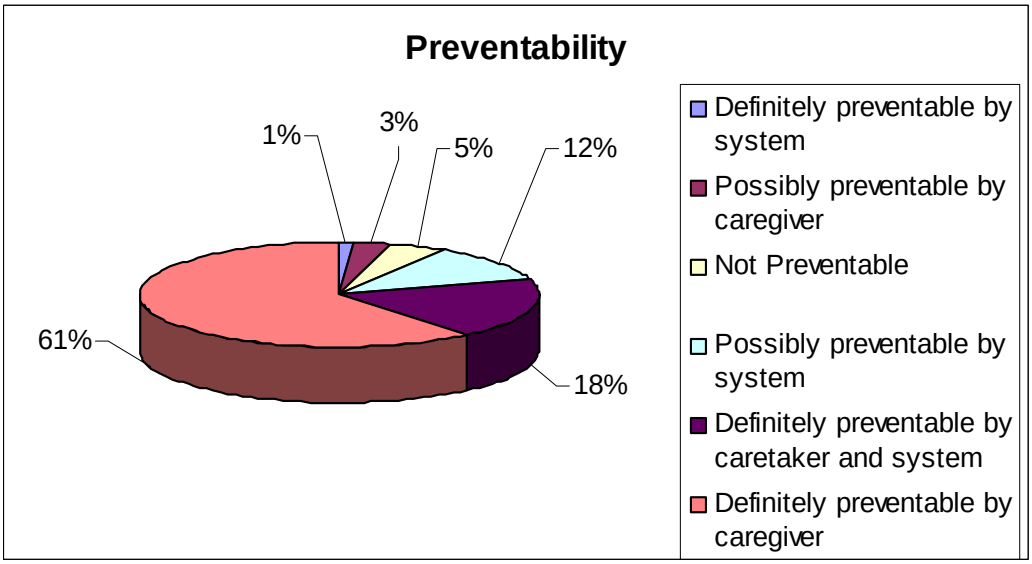
Possibly preventable by caretaker or system or both: There is insufficient information to determine if the death was preventable.

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

Of the abuse deaths reviewed:

61% were definitely preventable by caretaker
18% were definitely preventable by caretaker and system
12% were possibly preventable by system
5% were not preventable
3% were possibly preventable by caretaker
1% was definitely preventable by system

(Note some cases have more than one finding)

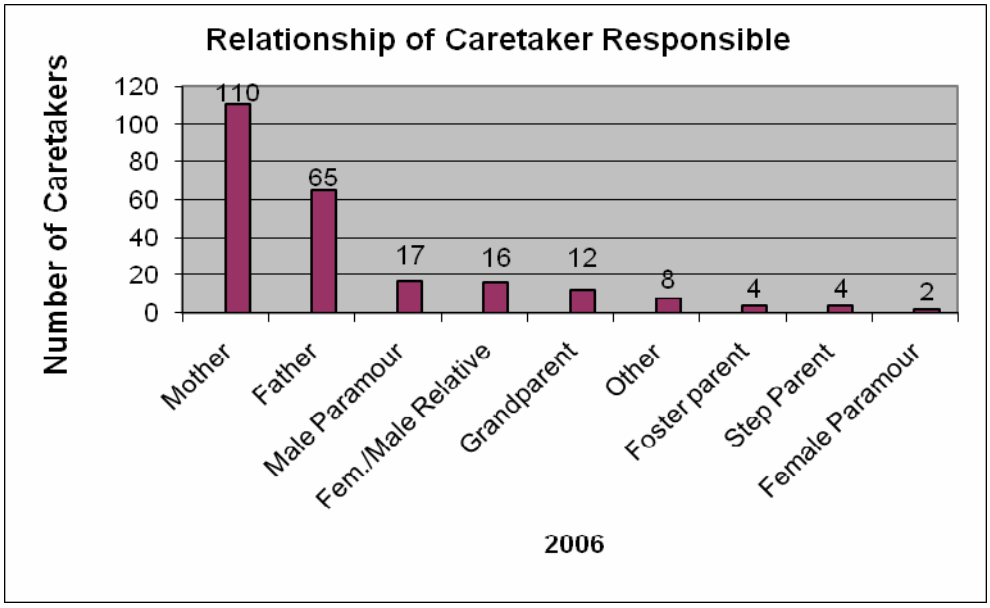


PERPETRATOR INFORMATION

The State Committee has seen common factors in numerous cases that seem to be contributing factors in the death of children. These factors include young males between the ages of 20-30 who are unemployed and are often providing primary child care while the biological mothers work. In addition, there are often histories of substance abuse, domestic violence or criminal history of aggressive or violent behavior. The fact that many of these males are unattached non-biological fathers contributes to their impatience and lack of parenting skills. Any partner in the child protection system should be aware of and sensitive to these risk factors when investigating an allegation of child abuse. Families with these risk factors and history of prior reports, irrespective of the findings, should be considered at the highest risk for child maltreatment. In many of the deaths, the Committee found more than one person to be responsible, whether they committed the act intentionally or failed to protect the child. The total perpetrators responsible for the 170 deaths are 238.

Relationship of Caregivers to Child

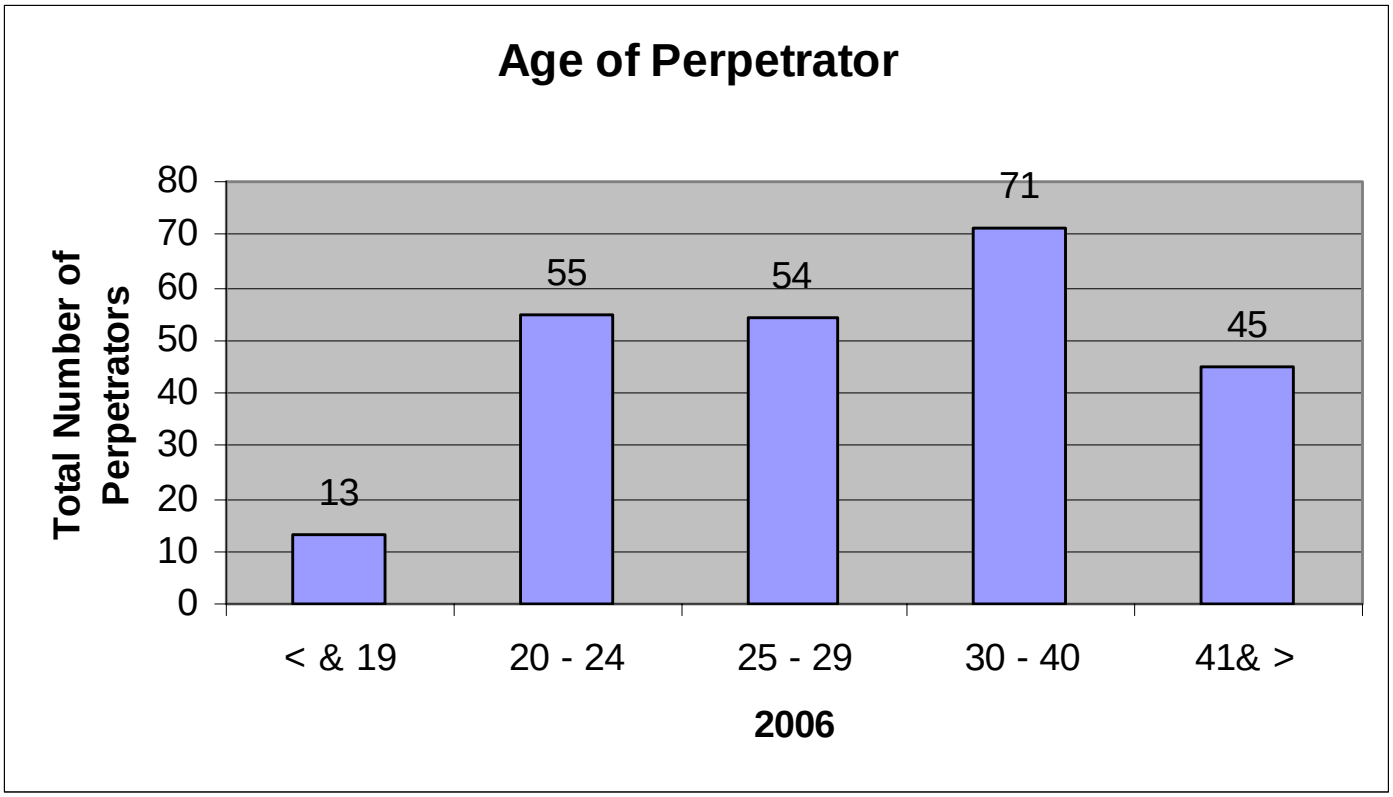
52% Mother
31% Father
8% Male Paramour
8% Female/Male Relative
6% Grandparent
3% Other
2% Foster parent
2% Step-parent
1% Female Paramour



Age of Perpetrator/Caregiver

Frequently the perpetrator is a young adult in his or her mid-20's without a high school diploma, living at or below the poverty level, depressed and who may experience violence first-hand. Fathers and other male caregivers cause most fatalities from physical abuse. Female perpetrators, who were generally biological mothers, were typically younger than male perpetrators, who were mostly biological fathers. Women also comprised a larger percentage of all perpetrators than men: 58 percent compared to 42 percent. (National Clearinghouse on Child Abuse and Neglect Information, 2005).[3] However, in some cases, this may be because women are most often responsible or assumed to be responsible for the children's care.

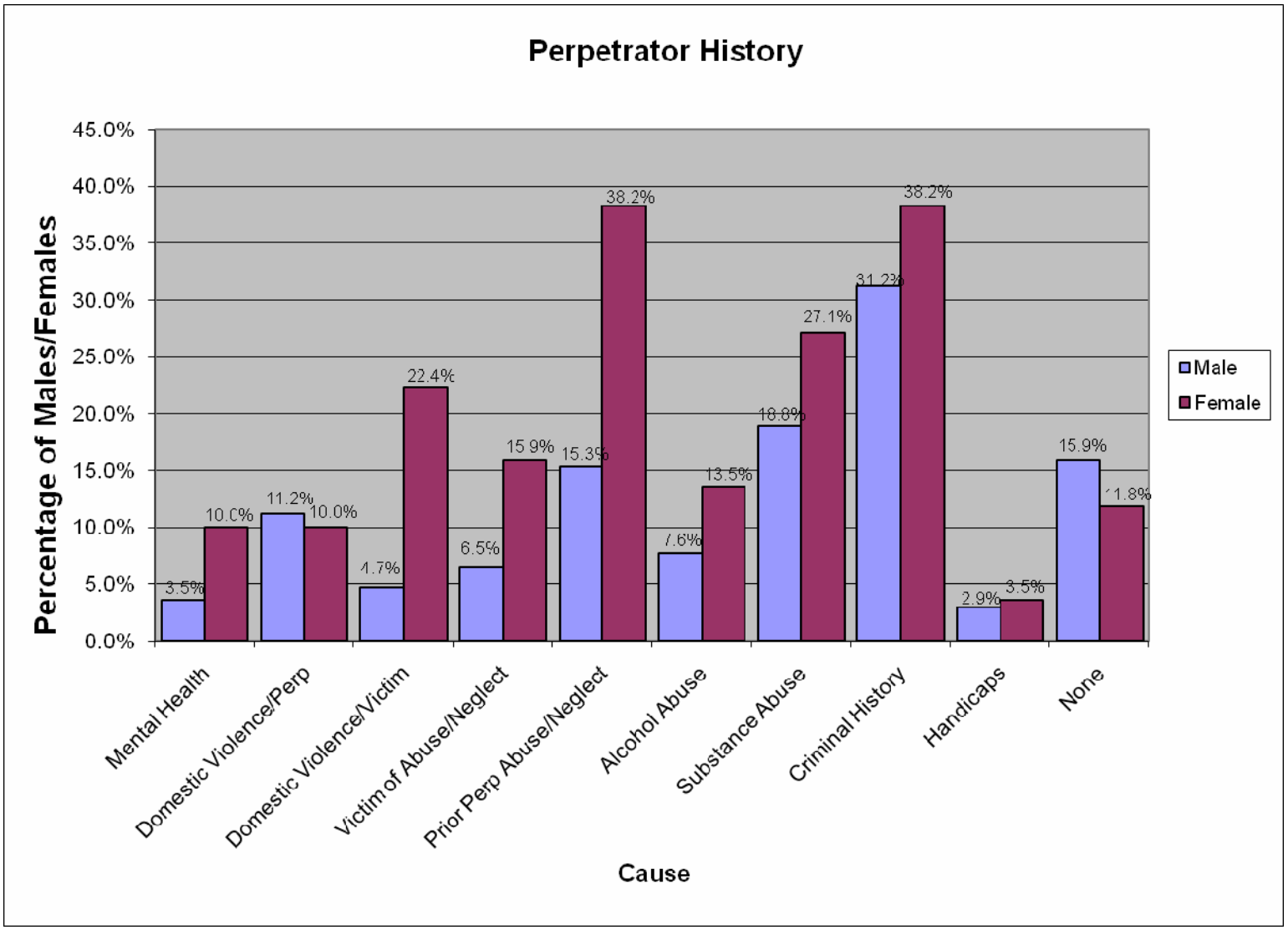
- 6% were under the age of 19
- 23% were 20-24
- 23% were 25-29
- 30% were 30-40
- 18% were > 41



Risk Factors of Perpetrator/Caregiver

- 69% had Criminal History
- 54% had previously been a Perpetrator Abuse/Neglect
- 46% had a history of Substance Abuse
- 27% had been a victim of Domestic Violence
- 22% had been a Victim of Abuse/Neglect
- 21% had a history of Alcohol Abuse
- 21% were perpetrators of Domestic Violence
- 14 % had a history of Mental Illness
- 7% had Handicaps

The following graph shows the break down of perpetrator information by males and females as well as the total.



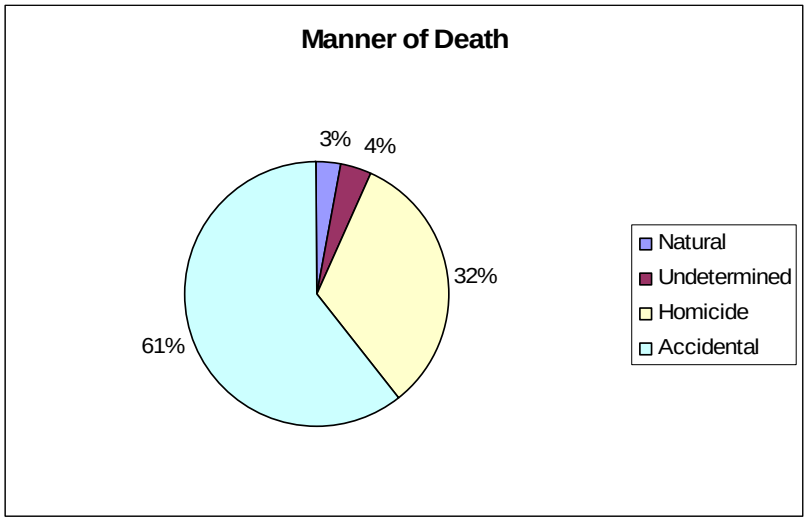
MANNER OF DEATH

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

During its review of the verified abuse and/or neglect related child deaths in Florida in 2006, the State Committee raised questions pertaining to the certification of the manner of death as stated on the death certificate in 5 child death cases, based on the limited materials available for review by the Committee.

The State Committee reviewed 170 child abuse deaths, which were classified as follows:

- 55 homicides
  - 76 percent were 4 and under
- 103 accidental
- 7 undetermined
- 5 natural



THE WELL BEING IF A VICTIM DEPENDS ON THE ADULTS WHO ARE WILLING TO TAKE ACTION.

DROWNING

Profile Information	Date of Death	Cause of Death	Caregiver Responsible	Age
Jesse	6/4/06	Drowning/tub	Mother	10 month
Brianna	8/14/06	Drowning/tub	Mother and other relative	11 month
Alexus	6/2/06	Drowning/tub	Mother	11 month
Taylor	4/8/06	Drowning/tub	Aunt	13 month
Ryan	6/14/06	Drowning/tub	Babysitter	13 month
Cameron	9/27/06	Drowning/tub	Male paramour	18 month
Arieyana	2/7/06	Drowning/tub	Female paramour and mother	3 year
Jondalynn	5/25/06	Drowning/tub	Mother	4 year
Angelica	1/24/06	Drowning/pool	Mother	9 month
Christine	6/10/06	Drowning/pool	Mother	13 month
Caleb	5/12/06	Drowning/pool	Father and mother	17 month
Dainian	11/8/06	Drowning/pool	Father	18 month
Ashley	10/31/06	Drowning/pool	Mother and Grandmother	19 month
Jaylyn	4/5/06	Drowning/pool	Grandmother	19 month
Dillon	10/3/06	Drowning/pool	Father and mother	19 month
Breonna	12/13/06	Drowning/pool	Mother and other relative	19 month
Nickaro	5/18/06	Drowning/pool	Babysitter	20 month
Katera	1/28/06	Drowning/pool	Father	22 month
Landen	6/17/06	Drowning/pool	Mother	23 month
Jasper	5/31/06	Drowning/pool	Mother and aunt	23 month

Profile Information	Date of Death	Cause of Death	Caregiver Responsible	Age
Joel	3/23/06	Drowning/pool	Uncle	2 year
David	4/20/06	Drowning/pool	Father and mother	2 year
William	4/17/06	Drowning/pool	Father and mother	2 year
Gabrielle	3/7/06	Drowning/pool	Father and mother	2 year
Carlos	8/16/06	Drowning/pool	Mother	2 year
Raiden	6/19/06	Drowning/pool	Father and mother	2 year
Genaro	12/10/06	Drowning/pool	Father and mother	2 year
Anthony	5/27/06	Drowning/pool	Father and mother	2 year
Kody	12/28/06	Drowning/pool	Father	2 year
Nicolas	9/8/06	Drowning/pool	Father and mother	2 year
Gabrielle	6/12/06	Drowning/pool	Father	2 year
Devin	8/5/06	Drowning/pool	Father and mother	2 year
Lacy	3/22/06	Drowning/pool	Mother	2 year
Isaiah	6/23/06	Drowning/pool	Mother	2 year
Ethan	10/22/06	Drowning/pool	Mother and male paramour	2 year
Jillian	10/28/06	Drowning/pool	Mother	3 year
Gracie	3/8/06	Drowning/pool	Grandmother	3 year
Harmony	5/27/06	Drowning/pool	Mother	3 year
Alyssa	1/5/06	Drowning/pool	Father and mother	3 year
Robin	12/9/06	Drowning/pool	Father and aunt	3 year

Profile Information	Date of Death	Cause of Death	Caregiver Responsible	Age
Isaiah	6/23/06	Drowning/pool	Mother	2 year
Ethan	10/22/06	Drowning/pool	Mother and male paramour	2 year
Jillian	10/28/06	Drowning/pool	Mother	3 year
Gracie	3/8/06	Drowning/pool	Grandmother	3 year
Harmony	5/27/06	Drowning/pool	Mother	3 year
Alyssa	1/5/06	Drowning/pool	Father and mother	3 year
Robin	12/9/06	Drowning/pool	Father and aunt	3 year
James	10/3/06	Drowning/pool	Other relative	3 year
Timothy	2/24/06	Drowning/pool	Aunt	3 year
Nicole	5/17/06	Drowning/pool	Mother and Acquaintance	4 year
Aaron	4/18/06	Drowning/pool	Father and mother	4 year
Anthony	5/21/06	Drowning/pool	Mother	4year
Kaysha	6/10/06	Drowning/pool	Acquaintance	5 year
Luis	6/9/06	Drowning/pool	Mother	5 year
Quintavia	5/22/06	Drowning/pool	Other relative and aunt	6 year
Gabriella	3/7/06	Drowning/pond	Mother	23 month
Josh	5/9/06	Drowning/pond	Mother	3 year
Labian	6/17/06	Drowning/pond	Grandmother	5 year
Jared	2/23/06	Drowning/canal	Mother	8 year

DROWNING

In Florida in 2006, the leading cause in child abuse deaths was drowning, the silent killer.

Florida had the 3rd highest overall unintentional drowning death rate of children in the US in the 5 years between 1999-2003 (CDC WISQARS)[7]. In 2003, Florida surpassed California, the most populous state in the nation, in the number of children ages 1 to 4 who drowned. Florida overwhelmingly has the highest unintentional drowning rate in the nation for the 1 to 4 year old group with a rate of 8.38 per 1000,000 populations in the US.

Residential swimming pools are the location of 64% or nearly two thirds of the drowning deaths in Florida for the 0-4 age group (CDC WISQARS).

Despite local ordinances and a state statute requiring safety features for backyard swimming pools enough children drowned in Florida in 2004 to fill four preschool classrooms.

It is alarming that the number of drowning deaths in Florida for children under age 5 is increasing each year. From 2004 to 2005, there was a 17 percent increase in children ages 1 to 4 that drowned. During 2005 in Florida, there were 75 unintentional drowning deaths of children under age 5, compared to 64 in 2004. According to Florida Department of Health, there were 95 children ages 0-6 that drowned in Florida in 2006

Pool drowning involving children happens quickly and silently. Adequate supervision is defined as being provided by an attentive functional person who is not under the influence of drugs or alcohol. The person must be proximate to the child (eyes on) and provide continuous supervision. According to caregivers, most child drowning victims were missing from sight for less than 5 minutes.

The State Committee believes that it did not have the opportunity to review the deaths of all children who drowned due to inconsistencies in reporting of child drowning deaths by law enforcement and other first responders. In addition, inconsistencies in the verification of neglect by the Department of Children and Families Services or Sheriff's Department child protective investigators contributed to the lack of reporting. For example, Miami-Dade county ranks 2nd in the state for pool drowning, ages 0-4, and yet the State Committee did not review any drowning deaths from that county.

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

More than 10% of childhood drowning occurs in bathtubs. The only prevention is supervision and these should always be looked at as neglect. The Committee reviewed 8 cases this year where the caretaker left the child unsupervised in a tub, which resulted in the death.

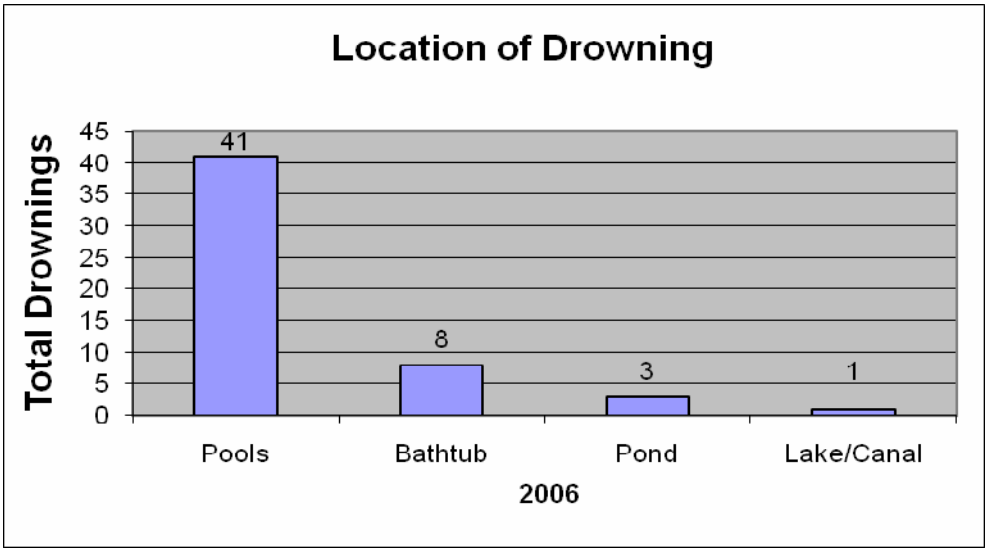
In cases reviewed by the Committee often there is a lack of thorough death scene investigation by responsible agencies, including not exploring or asking for drug testing when there is a family history of substance abuse of suspicion at the time of the child's death. This results in missed opportunities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

Key Findings

- 52 drowning cases were reviewed
  - 85% were 5 and under
  - Inadequate supervision was found in all drowning deaths
- 8 children drowned in a bathtub
  - The age range was from 10 months to 4 years
  - 4 were males and four females
  - Mother's were responsible for 4, paramours 2, 1 baby sitter and 1 relative
- 40 children drowned in a swimming pool (75%)
  - 24 were males and 16 were females
  - 27 were between the ages of 9 months and 2
  - 12 were between the ages of 3-5
  - 90% were 5 and younger

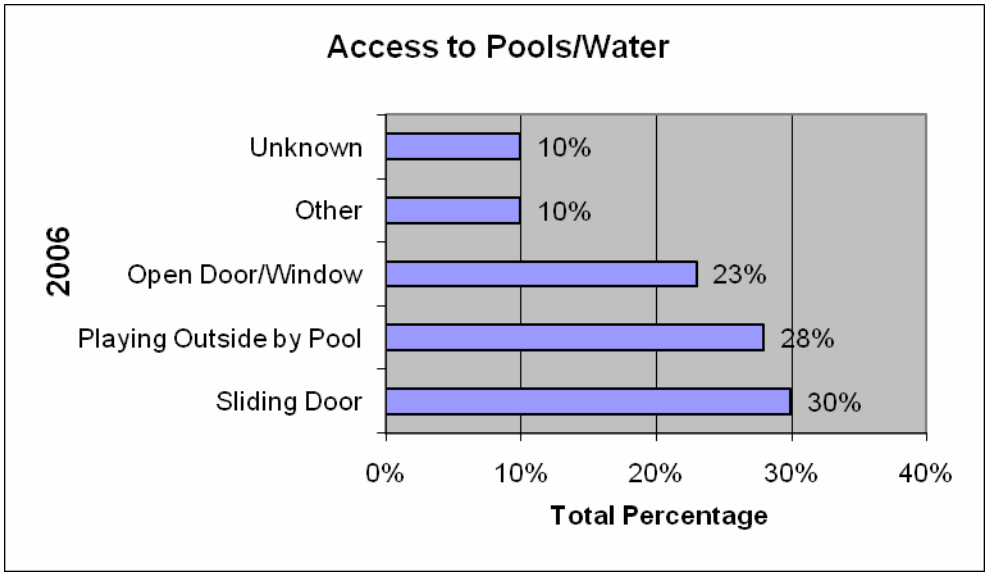
All were supposed to be supervised by either parents or a relative with the exception of one who was being supervised by a babysitter.

- 3 children drowned in a pond
- 1 child drowned in a canal



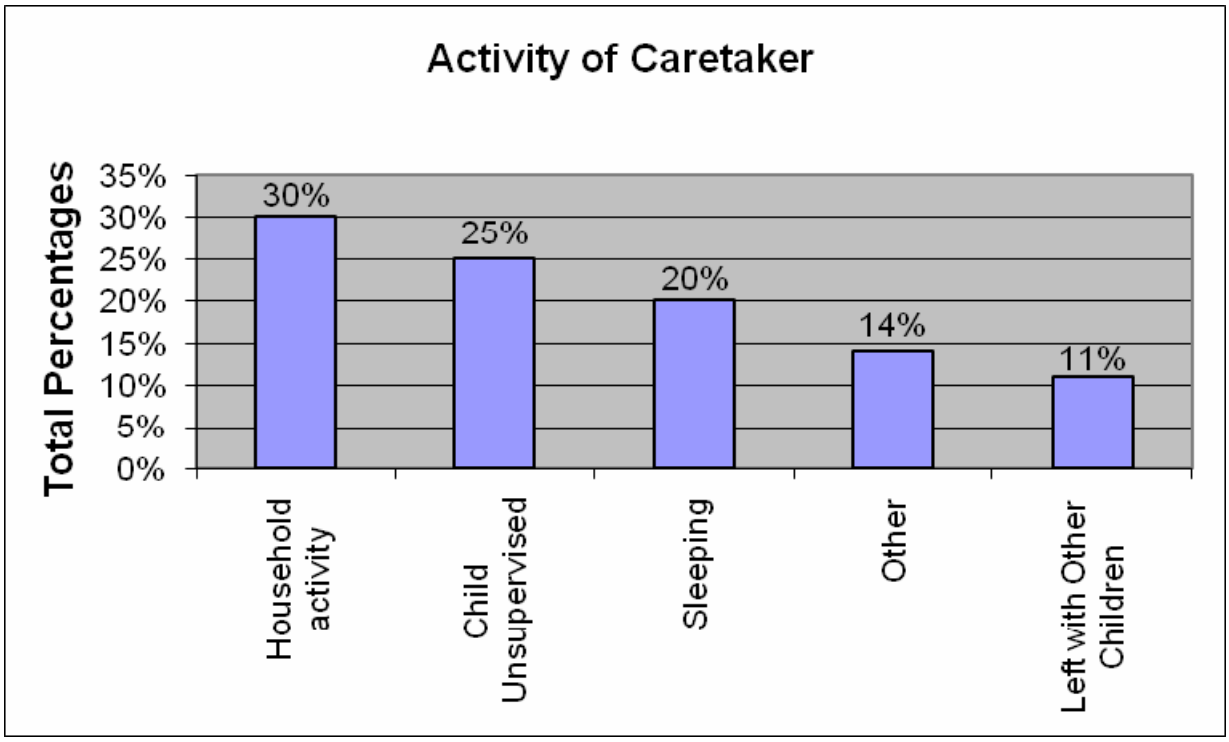
- 19 of the caretakers had a history of Substance abuse
- The caretaker was asked to submit to a drug test in 3 of the 19 cases

The Committee found trends in the access to the pool as well as the activity of the caretaker at the time of the incident, as show in the graphs below.



Penny

The mother was sharing a home with another single mother of two children, ages 4 and 7. The mother put her 4 year old, who is autistic and described as mentally delayed, and Penny (an 11 month old) in the bath tub and left to fold laundry and clean the kitchen. Penny's mother was outside smoking a cigarette with a friend. The 7 year old checked on the children and found the Penny under water. Both families had priors, one of which involved inadequate supervision allegations.
* alias



***David**
Pool drowning

The Grandparents had a gathering at their home. They all left the pool area to go eat. After a period of time the adults realized that no one knew where David was. Initially when they looked in to the pool they did not see the child, as the pool was complete dark, green with algae and full of brown sand on the bottom. The mother was asked to take a drug test but she refused. The mother did admit that the adults had been drinking. The mother has a history of substance abuse and a criminal history to include child abuse charges and drugs offences. Law enforcement submitted charges to the State attorney, but it was declined. This is the 2nd drowning in this home, the year prior a 4 yr old grandson drown while visiting from Ohio. * alias

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THE WELL BEING OF A VICTIM DEPENDS ON THE ADULTS WHO ARE WILLING TO TAKE ACTION.

PHYSICAL INJURY

Profile Information	Date of Death	Cause of Death	Caregiver Responsible	Age
Ali	11/26/06	Burns	Father	1 year
Jaquez	1/6/06	Burns	Mother and Grandmother	3 years
Solycia	10/10/06	Blunt trauma to head	Father	2 months
Leanne	3/20/06	Closed head injury	Father	2 months
Lilyann	11/4/06	Blunt Impact to head	Male paramour	2 months
Shatavia	12/7/06	Blunt head trauma	Mother	2 months
Dallas	4/27/06	Blunt head injury	Male paramour	4 months
Adrian	2/10/06	Choking/baby wipes in throat	Father	4 months
Elijah	2/19/06	Blunt force injuries(head)	Male paramour	4 months
Emanuel	9/1/06	Blunt trauma(head)	Father	5 months
Robert	1/28/06	Closed head injury	Father	5 months
Destiny	2/12/06	Blunt head injury	Babysitter	6 months
Rachel	5/12/06	Stab wounds of chest	Mother	9 months
Sheldon	11/3/06	Blunt force trauma to head	Male paramour	12 months
Jasmine	9/21/06	Blunt Multiple trauma	Male paramour	13 months
Xavion	1/20/06	Blunt head trauma	Male paramour	14 months
Charles Jr.	4/27/06	Drowning/thrown in canal	Father	14 months
Jakiera	9/22/06	Blunt impact of head	Male paramour	16 months
Serenity	11/10/06	Multiple blunt injuries /sexual assault	Father	16 months
William	8/29/06	Closed head injury	Male paramour	16 months

Profile Information	Date of Death	Cause of Death	Caregiver Responsible	Age
Joncarlos	5/15/06	Blunt head trauma/sexual assault	Male paramour	17 months
Dakari	5/16/06	Blunt trauma to head	Male paramour	21 months
Cameron	1/11/06	Blunt head injury	Male paramour	22 months
Noeris	2/12/06	Blunt impact to head	Male paramour	2 years
Abigail	5/5/06	Blunt head trauma	Male paramour	2 years
Amara	10/13/06	Blunt force to head	Babysitter	2 years
Heather	8/16/06	Blunt head injury/sexual assault	Male paramour	2 years
John	5/18/06	Blunt impact to head	Father	2 years
Jordan	6/21/06	Blunt head injury	Male paramour	2 years
Kyler	6/24/06	Abusive head trauma	Godfather	3 years
Alexander	12/3/06	Sharp force of neck	Mother	3 years
Edward	11/15/06	Abusive head injury	Male paramour	3 years
Jelani	7/2/06	Closed head injury	Male paramour	4 years
Cheyene	12/20/06	Blunt force head trauma	Female paramour	4 years
Coreyon	2/16/06	Multiple trauma	Father	5 years
Roman	1/31/06	Closed head injury	Mother	6 years
Marcel	1/1/06	Blunt head trauma	Father	7 years
Dean	7/28/06	Blunt force head injury	Father	7 years
Michelle	2/23/06	Traumatic asphyxiation/sexual assault	Male paramour	13 years

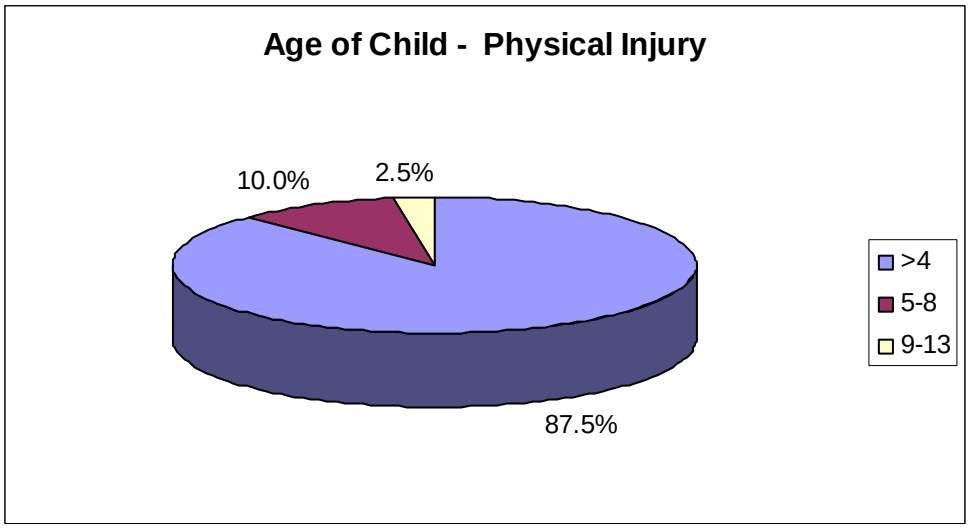
PHYSICAL INJURY

Children living in households with unrelated adults are nearly 50 times as likely to die of inflicted injuries as children living with two biological parents, according to a study of Missouri abuse reports published in the journal of the American Academy of Pediatric in 2005. Lack of a relationship or attachment to the child can cause a non-relative to become frustrated and irritated when there is a perceived problem with the child. Many unrelated males have little to no experience in parenting, yet they are often trusted to care for the child while the mother works. Some non-abusing mothers chose not to intervene in abusive situations for a myriad of reasons, some unknown, and allowed the abuse to continue with no intervention. The committee has found that a majority of the mothers were not held accountable or charged criminally.

Head injury is the leading cause of death among children who have been abused. Although a significant number of the deaths primary cause is head trauma many also have suffered multiple injuries. This has been the second leading cause among Florida child abuse deaths for the last three years.

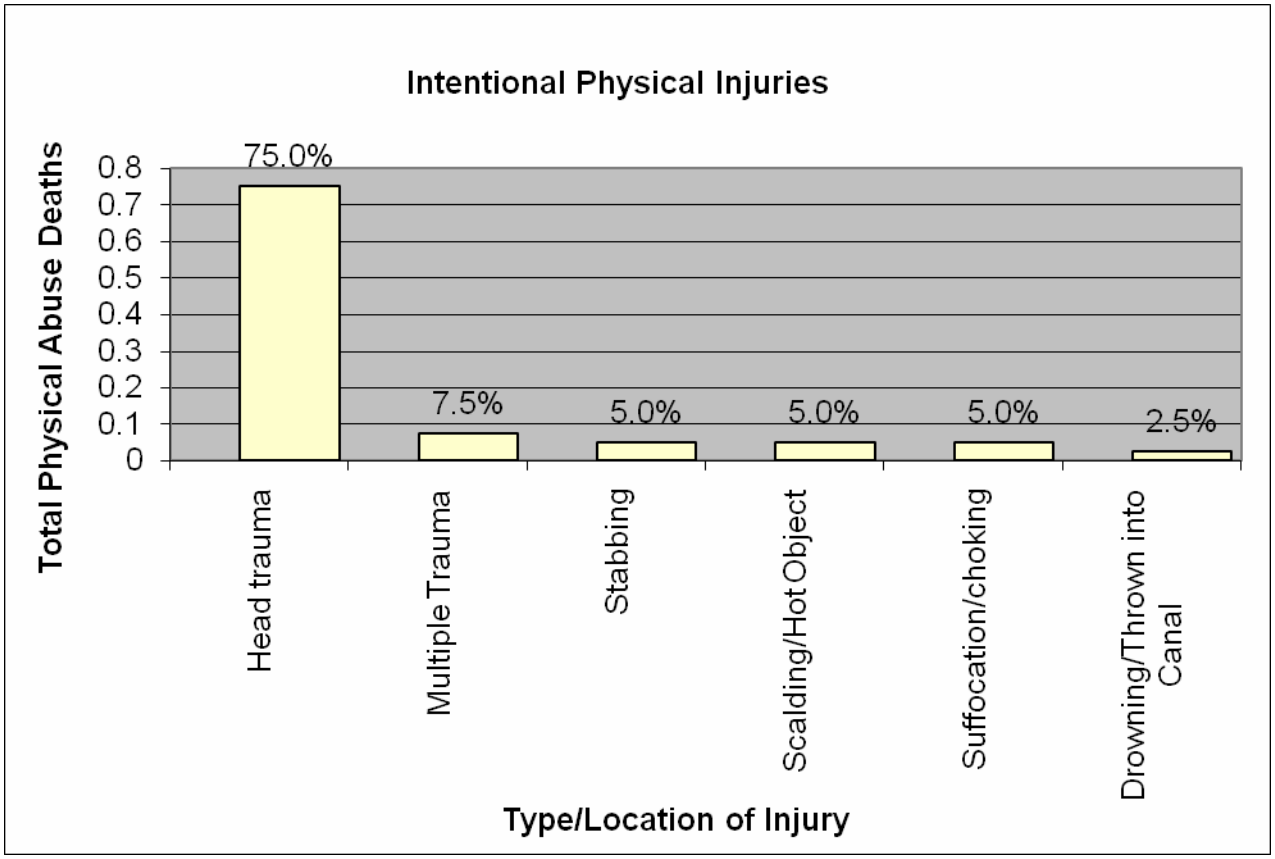
Key Findings

- 40 children died as a result of abusive injury
  - 35 were 4 and younger
  - 24 children were under the age of one
  - 24 were males, 16 were females
  - 4 deaths involved sexual assaults prior to the death



The graph below shows the location and type of physical injury.

- 30 died as a result of head trauma
- 3 died as a result of multiple trauma
- 2 died from intentional burns
- 2 died from being intentionally suffocated
- 2 died from being stabbed/cut by sharp objects
- 1 died from being thrown into a canal after abusing him



Wallace*
Abusive head trauma

The 2 1/2 month old baby was left in the care of his 22 yr old father. The Father called 911 and said his son was not breathing. The father later confessed and charged with murder and was convicted. He stated that Wallace was crying and out of frustration he threw him against the railing of the crib. He also admitted to shaking Wallace numerous times when he cried. The mother, age 19, had seen the father shake Wallace and because of her knowledge of the abuse, she was arrested. * alias

Perpetrator information:

- 31 were male perpetrators
    - 18 deaths were caused by a male paramour
    - 13 deaths were caused by the biological father
- 28 of the perpetrators had criminal history
- 19 of the 31 male perpetrators were their 20's
- 15 of the male perpetrators were white
- 11 of the male perpetrators were African American
- 2 of the male perpetrators were Hispanic
- 2 deaths siblings were **accused** of causing the injury
- 1 of the male perpetrators was Asian
- 1 was a Godfather

Female perpetrators:

- In 28 of the 40 deaths, the mothers failed to protect the children
- 19 of the mothers who failed to protect were working and the male perpetrator was the caretaker
- 14 of the mothers who failed to protect were in their 20's
- 6 of the mothers who failed to protect were 19 and younger
- 4 of the mothers who failed to protect were criminally charged
- 1 perpetrator was female paramour
- 3 perpetrators were biological mothers
    - all female perpetrators were in their 30's
- 2 perpetrators were babysitters (1 male - 1 female)

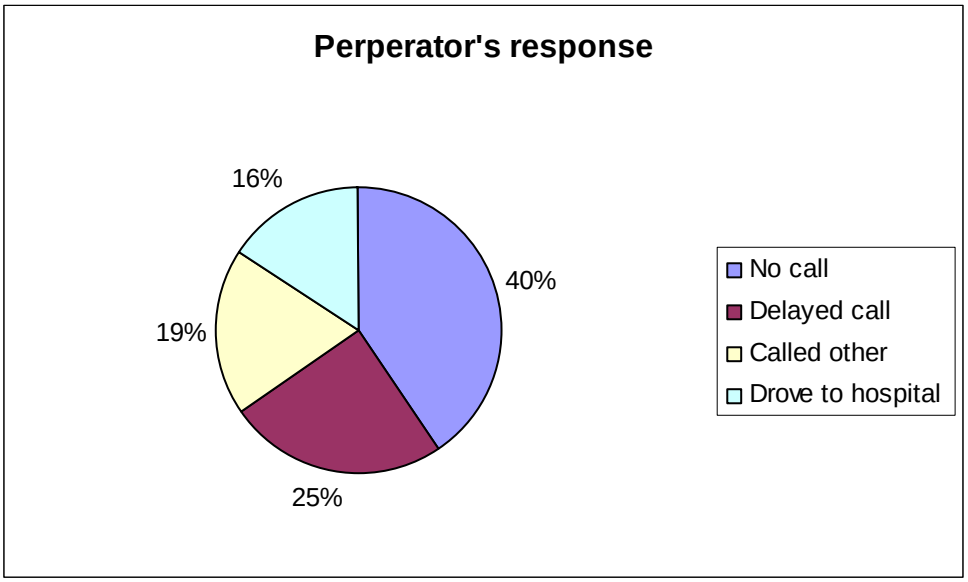
*

Melinda*
Blunt Head Trauma and sexual assault

The mother's paramour stated that Melinda (2 yr. old) fell off the couch. She had been sexually assaulted and beaten. The paramour is 20 years old and mom 18 years old. The mother had been dating her paramour for 6 months. The paramour did not work and when the mother worked she left Melinda in his care. The mother's relatives reported seeing missing hair, bruises on her back and buttocks, but did not reported it to the hotline. The paramour was charged with first degree murder - death penalty. * alias

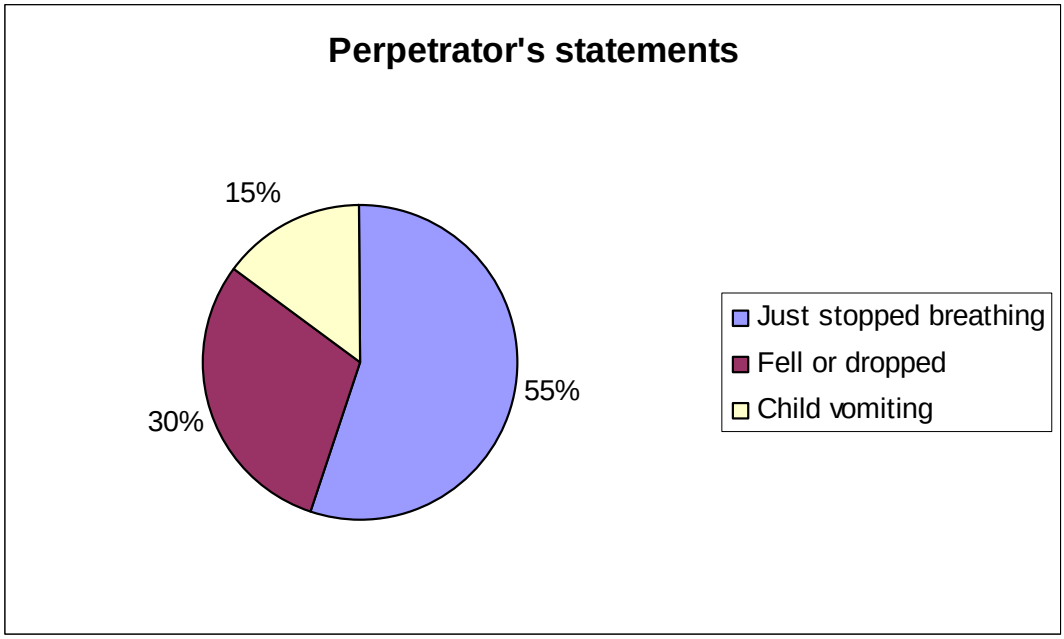
The Committee examined perpetrator responses in the physical injury deaths:

- 13 failed to call 911 and the majority waited until the mother arrived home at which time she called emergency services
- 8 Caregivers delayed calling 911
- 6 called someone else before calling 911
- 5 drove the injured child to hospital



Perpetrator statements:

- 18 gave an initial statement that the child "just" stopped breathing and/or was unresponsive
- 10 gave statements that the child fell or was dropped
- 5 gave initial statements that the child was vomiting



Stephanie*
Burns

Stephanie, a 4-month-old child, was in the care of her 27 yr old father while the mother, age 20, was at work. She was brought to the hospital with burns over 80% of her body. The father said he was giving her a shower and left her alone to get some toys. The father's story did not match the extent of Stephanie's burns. Six months prior, Stephanie had been taken to the hospital with a broken tibia, which the parents could not explain. . Both parents have criminal history. The Father was charged with manslaughter. * alias

THE WELL BEING OF A VICTIM DEPENDS ON THE ADULTS WHO ARE WILLING TO TAKE ACTION.

UNSAFE SLEEP ENVIRONMENT

Profile Information	Date of Death	Cause of Death	Caregiver Responsible	Age
Kaitlin	1/24/06	Co-sleeping	**Foster mother**	2 days
Christian	2/9/06	Co-sleeping	Mother	2 weeks
Irre	10/20/06	Overlay	parents	1 month
Alan Jesus	11/12/06	Co-sleeping	Mother	1 month
Arianna	7/13/06	Overlay on couch	Mother	1 month
Dasani	6/21/06	Co-sleeping with sibling	Foster mother	1 month
Kendale	3/21/06	Unsafe sleeping/couch	Mother	1 month
Joshua	8/24/06	Co-sleeping	Father	2 month
Karma	12/8/06	Unsafe sleeping/in a car seat on adult bed	Mother	2 month
Briannah	7/6/06	Co-sleeping	Parents	2 month
Austin	6/15/06	Co-sleeping	Parents	2 month
John Paul	9/5/06	Unsafe sleep/ in a bouncy seat	Father	3 month
Marquil	9/11/06	Co-sleeping	Mother	3 month
Cameron	1/6/06	Co-sleeping in car	Parents	4 month
Derion	4/8/06	Co-sleeping	Father	4 month
Jonathan	10/16/06	Co-sleeping	Mother	4 month
Rylee	10/23/06	Unsafe sleeping/hole in bassinet	Parents	5 month
Rachelle	8/13/06	Co-sleeping with sibling	Parents and aunt	5 month
Johnna	6/20/06	Unsafe sleep/changing table	Mother	6 month
Charleston	1/28/06	Unsafe sleep/wedged between bed and nightstand	Grandmother	6 month
Destiney	2/2/06	Unsafe sleep/wedged in waterbed	Mother	6 month
Alex	11/1/06	Overlay in adult bed	Mother	8 month

SLEEPING ENVIRONMENT-RELATED DEATHS

Infant deaths are tragic, but must be investigated. Nothing is more difficult on a family than dealing with the death of their child. It is understandable that the medical professionals, law enforcement agencies and child protection agencies would tread gently when dealing with the death of an infant who dies unexplained.

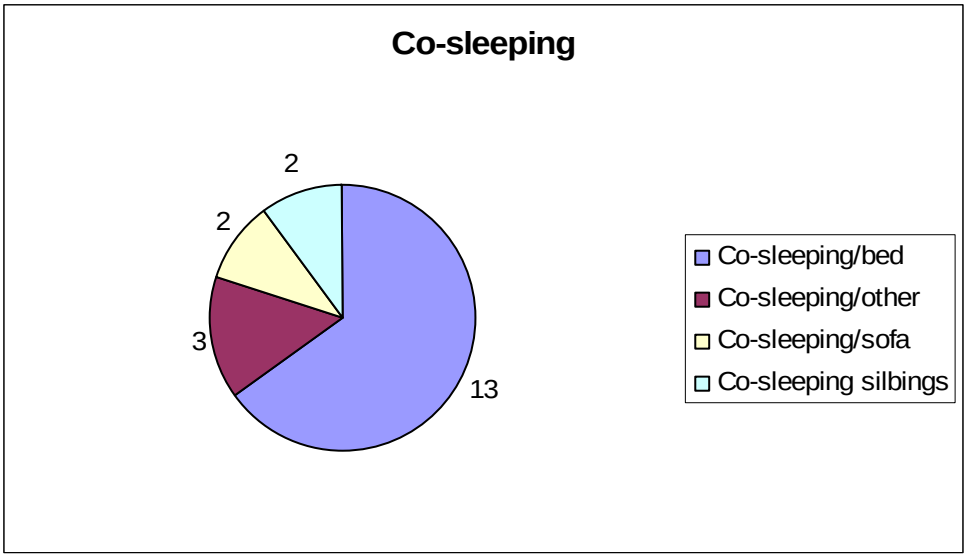
Having a safe sleep environment can be a matter of life and death for an infant. Unsafe sleep environments include a sleep surface not designed for an infant, (i.e. couch, sofa, adult bed, chair), excessive bedding, toys or decorative bumper guards, sleeping with head or face covered, or sharing a sleep surface with multiple persons or with a person who is overly tired, obese, or under the influence drugs or alcohol.

The State Committee has identified this issue as an on going problem over the past seven years. The Scripps Howard report showed there are areas where it is too differential in how these deaths are investigated, thus the need for training and/or education for parents, hospitals, medical examiners, pediatricians and law enforcement investigating these types of deaths are essential. The Center for Disease Control has encouraged all States to adopt a standardized approach to infant death scene investigation by all Medical Examiner Districts as well as law enforcement agencies. The State Child Abuse Death Review Committee views this project as a high priority and is supportive of identifying resources to initiate a statewide approach to training and outreach.

Key Findings

- 22 children died as a result of an unsafe sleep environment- related death
  - Ages ranged from 16 days to 10 months
- 22 caregivers were in their 20's
- 22 were white, 6 were African American and one Hispanic
- 21 were 6 months and younger
- 20 were attributed to co-sleeping/overlay
- 16 deaths were attributable to mothers
- 13 were co-sleeping in beds
- 11 children were two months and younger
- 10 deaths were attributable to fathers
- 3 were by relatives
- 3 were co-sleeping in unsafe environments
- 2 were co-sleeping in sofas
- 2 were by foster mothers
  - The foster mothers were in their 30's
- 2 from sharing a sleep environment with a sibling

- 1 child died sleeping in a bouncy seat
- 1 child died sleeping in a faulty bassinet
- Obesity of the adult was a factor in 2 of the co-sleeping cases
- There were substance abuse histories in 13 of the cases; however, substance abuse testing was requested in only 5 deaths



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Martha*
Co-sleeping

The 23-year-old mother placed Martha (her 9 month old) in the bed with her at 1 pm. When she awoke she found the child unresponsive. The mother admitted to consuming alcohol and using cocaine the night prior to death. Law enforcement found large amounts of alcohol and cocaine in the room. The father admitted to abusing cocaine and was aware when he went to work that he saw the cocaine on the mother's lips. No charges were filed.

* alias

GUNSHOT RELATED DEATHS

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

Key Findings

- 2 children died as a result of gunshot wounds
- 1 child was shot by a 9 yr old sibling
- 1 child shot himself accidentally
- Both accidental cases were found to have inadequate supervision of the children and the guns were left out where the children had access
- In one of the cases the caregiver had a prior criminal history

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

***Terrance**
Gun

The mother went to wash clothes at the laundry mat across the street. She left 3 of her children home unsupervised. One of the children, age, 8, climbed onto a chair and got a 22 revolver off the china cabinet and shot his sister in the head. The mother was charged with culpable negligence and received 5 yrs probation.*alias

MURDER/SUICIDE

The committee found that in several of the cases the mental health records were never obtained even though family members identified there was past or on going history of mental health concerns.

A case should be considered "high risk" whenever a caregiver has threatened to harm children regardless of whether the non-offending caregiver obtains an injunction for protection. The Department of Children and Families should remain vigilant in monitoring the parties' behavior and court actions to ensure that the injunction is not violated or dissolved.

Key Findings

There were 8 children who died as a result of murder/suicides:

- 7 male children were killed by fathers
- 1 female child was killed by their mother
- 3 of the perpetrators were in their 40's and one was 24 years old
- 2 perpetrators killed the mothers also
- 3 perpetrators had no previous history with DCF
- The mechanisms used were carbon monoxide, strangulation, gunshot, sword, and thrown off a hotel balcony

***George**
Murder suicide

The stepfather called 911 and stated he had strangled his wife and son and told the dispatcher where the bodies could be located. When law enforcement arrived, they found the stepfather hanging from a tree. He left a confession to the murders and admitted he had been using crack cocaine. There had been several call outs to law enforcement on the family. There were priors with DCF involving domestic violence and substance abuse. The cases were closed no indicators, *alias

THE WELL BEING OF A VICTIM DEPENDS ON THE ADULTS WHO ARE WILLING TO TAKE ACTION.

VEHICLE RELATED DEATHS

Profile Information	Date of Death	Cause of Death	Caregiver Responsible	Age
Justice	06/27/06	Vehicle crash	Mother	7 months
Seanna	4/29/06	Left in vehicle	Male paramour	14 months
Harold	8/10/06	Left in vehicle	Mother	21 months
Carolyn	8/25/06	Left in vehicle	Mother	23 months
Envy	12/20/06	Hit by ice cream truck	Parents	16 months
Dakwon	6/25/06	Hit by a vehicle	Parents	20 months
Anthony	2/16/06	Vehicle crash	Foster Parents	20 months
Thomaris	1/12/06	Suffocation/head caught in window	Father	2 years
Hunter	4/12/06	Vehicle crash	Mother	2 years
Ruben	12/20/06	Vehicle crash	Parents	2 years
Cristofer	1/29/06	Hit by a vehicle	Parents	2 years
Shkya	6/21/06	Hit by a vehicle	Grandmother	2 years
Heaven	1/25/06	Vehicle crash	Parents	3 years
Eliscia	6/27/06	Vehicle crash	Mother	7 years
Booker	6/27/06	Vehicle crash	Mother	8 years
Miranda	1/25/06	Vehicle crash	Aunt and Uncle	10 years
Mallory	12/27/06	Vehicle crash	Parents	10 years
Johnny	1/25/06	Vehicle crash	Parents	13 years
Ashley	1/25/06	Vehicle crash	Aunt and Uncle	14 years
Cynthia	1/25/06	Vehicle crash	Parents	15 years
Elizabeth	1/25/06	Vehicle crash	Parents	15 years

VEHICLE-RELATED DEATHS

Eighteen children died in Florida from 2004 to 2007 as a result of being left in vehicles. Public awareness campaigns, media attention and the prosecution of individuals who have left leave children unattended in vehicles have occurred. These efforts must continue to ensure that no young child is left alone in a vehicle for any period of time.

Key Findings

- 3 children died as a result of being left in vehicles
  - All were under 2 years
  - 2 were left by mothers and one by a father
    - All three forgot the child was in the backseat
  - 1 was due to the mother being under the influence of drugs
  - 1 child died as a result of his head being trapped in the window while the father was asleep in the car
  - All caretakers were in their 20's
  - All caretakers were charged with manslaughter or negligence

***Rachel**
Vehicle accident

The parents of a 16 month old allowed her to go to an ice cream truck alone. The driver of the truck didn't see Rachel by his front tire when leaving the area. It was determined that the driver was not impaired, however the parents, ages 22 and 26, were in their vehicle smoking marijuana at the time Rachel was run over by the ice cream truck.

* alias

VEHICLE CRASHES

The State Committee made a recommendation in 2005 that training should be given to Florida Highway Patrol Officers on the mandatory reporting of child abuse. Many crashes were not being reported to the Florida Abuse Hotline. The FHP has been very responsive and receptive to education of its officers on the reporting requirements set forth in Chapter 39 F.S. The State Committee commends them for their timely and enthusiastic response to the issue.

Key Findings

- 12 children died in moving vehicle crashes
  - 7 children died in one car crash
  - 3 children died in another car crash
  - 2 children died in single car crashes
- 1 driver was a 15 yr old driving illegally
- 2 drivers were under the influence of alcohol and/or drugs
  - Both were parents driving the vehicles
  - Both had priors with DCF relating to substance/alcohol abuse
- 4 children died as a result of being backed over or run over by vehicles
  - All were 2 years and younger
  - Inadequate supervision was the factor in all 4 deaths

Recommendations:

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

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

***Harry**
Vehicle accident

When the mother arrived at the day care center to pick up her children, the worker could smell alcohol, but did not call 911. Calls were made to 911 regarding the mothers erratic driving but, before law enforcement could locate the vehicle, the mother lost control and crashed. The mother and Harry were thrown from the vehicle. The mother's blood alcohol lever was .178. She was charged with DUI manslaughter. There was an open dependency case. The mother had admitted to her caseworker that she would mix alcohol and her prescriptions. The mother had criminal history to include alcohol related offenses.. * alias

THE WELL BEING OF A VICTIM DEPENDS ON THE ADULTS WHO ARE WILLING TO TAKE ACTION.

ABANDONED BABIES

Profile Information	Date of Death	Cause of Death	Caregiver Responsible	Age
Gabrielle	2/23/06	Left in cupboard wrapped in a towel	Mother	0 Day
Elizabeth	9/11/06	Left in a trash can	Mother	0 Day
Joshua	9/8/06	Left in a closet	Mother	0 Day
Alyssa	5/9/06	Found in alley	Mother	0 Day
Baby Grace	11/21/06	Found in recycling facility	Unknown Mother	0 Day
Justin	6/20/06	Delivery in toilet	Mother	1 Day
Baby Boy	7/17/06	Delivery in toilet	Mother	2 Days

ABANDONED BABIES

Neonaticide, the killing of a baby in the first 24 hours of life, generates strong public reaction. Hundreds of newborns likely die undiscovered every year after being abandoned by their mothers in trash dumpsters, unoccupied dwellings, alleys etc. Many deaths are unreported to the child abuse hotline, but statewide training has resulted in notable improvement in reporting and verification.

Key Findings

- 7 children died as a result of the mother abandoning them after birth
  - 2 were left in toilets
  - 1 at a recycling plant
  - 1 in a trash can at work
  - 1 in an alley
  - 2 were wrapped and left in a dresser/cupboard
- 6 mothers were criminally charged, one remains unidentified
- 5 of the 7 mothers had substance abuse history and/or tested positive at birth
- 5 mothers denied knowledge of their pregnancy
- 4 mothers were in their 20's and two were in their 40's

Recommendations:

A. Continued training for law enforcement and Department of Children and Families staff on mandatory reporting of these types of deaths.

B. Drug testing of the mother, when possible, is needed immediately after the discovery of the child.

C. Provide continuing education on the Safe Haven Law.

Baby Carol*
Abandoned Baby

Baby Carol was found at a recycling facility for rubble and concrete materials. Her umbilical cord was still attached. The medical examiner found that there was evidence of breathing after birth. The identity of the mother is unknown and law enforcement is still investigating.
* alias

THE WELL BEING OF A VICTIM DEPENDS ON THE ADULTS WHO ARE WILLING TO TAKE ACTION.

PREMATURE AND DRUG EXPOSED

Profile Information	Date of Death	Cause of Death	Caregiver Responsible	Age
Emmanuel	**11/22/06**	**Premature due to mothers Cocaine use**	**Mother**	**12 day**
Noah	**1/15/06**	**Cardiac arrest and maternal drug use(cocaine)**	Mother	4 months

PREMATURE AND DRUG EXPOSED NEWBORNS

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

Key Findings

- 2 deaths were reviewed of newborns who were born prematurely and had cocaine in their system
- Many more newborns in Florida would have been found to have cocaine or other illegal drugs in their system had they been tested and the results reported as abuse
- The mothers were in their 30's
- Both had prior abuse reports that related to substance abuse

Recommendations:

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

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

***Eric**
Substance Exposed

The child was born at 27 weeks gestation. The 38-year-old mother and Eric tested positive for cocaine at the time of delivery. She has a history of drug use and her other 9 children had been removed for her substance abuse. The father also admitted to abusing cocaine. The parents refused treatment. *alias

THE WELL BEING OF A VICTIM DEPENDS ON THE ADULTS WHO ARE WILLING TO TAKE ACTION.

OTHER TYPES OF DEATHS

Profile Information	Date of Death	Cause of Death	Caregiver Responsible	Age
Naomi	5/3/06	Hanging/bungee cord	Parents	4 years
Timberland	11/26/06	Gunshot wound/self inflicted	Father	2 years
Taishay	2/25/06	Gunshot wound/sibling	Mother	5 years
Riley	11/7/06	Closed head injury/fell out of 2nd story window	Mother	19 months
James	7/2/06	Blunt head trauma/fell while being held	Father	2 years
Jasmine	9/8/06	Chronic malnutrition	Mother	13 months
Rejoined	9/10/06	Medical neglect/untreated Bronchial Asthma	Parents	10 years
Benjamine	1/27/06	Carbon monoxide/house fire	Grandmother	11 months
Heaven	1/27/06	Carbon monoxide/house fire	Grandmother	2 years
Shelsie	5/15/06	Carbon monoxide/house fire	Mother	3 years
Yaquan	2/17/06	Wedged behind a dresser	Mother	17 months
Kenia	12/18/06	Suffocation/oven door fell on child	Mother	18 months

THE WELL BEING OF A VICTIM DEPENDS ON THE ADULTS WHO ARE WILLING TO TAKE ACTION.

POISONING

Profile Information	Date of Death	Cause of Death	Caregiver Responsible	Age
Kadena	3/6/06	Overdosed with children's benadryl and infants motrin and covered face with blanket	Father	2 months
Emmanuel	4/20/06	Acute fentanyl intoxication	Mother	17 months
Marily	9/23/06	Poisoning/chemical put in soda can	Parents	3 years
Johathan	7/26/06	Fentanyl Intoxication	Grandmother	4 years
Louis	3/17/06	Overdose	Mother and Step-Father	15 years
Heather	11/28/06	Overdose/ Multiple drug intoxication	Mother and Aunt	16 years

Poisoning/overdose

Poisoning refers to the type of poisoning agent that resulted in the child's death. This can be anything from over the counter medicines to cleaning agents commonly found in the home.

Key Findings

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- 2 children died from Fentynal medication
  - One was applied intentionally to the child
  - One licked the mothers lollipop morphine which was left out in the open
- 2 children, ages 15 and 16, died from drug overdoses
  - The adults were aware of their drug use
  - The prescriptions belonged to the adults and left unsecured
- 1 child was overdosed on child cold medicine
- 1 child died from a poisoning agent left in a coke bottle

Lance*
Poisoning

The father had put a chemical in a Pepsi bottle, which was a solvent that he used at his place of work, and left it in his car. The children were outside playing and Lance got into his car and drank from the Pepsi bottle ingesting the solvent.

*alias

Medical Neglect

- 2 children died as a result of medical neglect
  - 1 died from asthma, when the parents failed to seek treatment
  - 1 died from malnutrition

Hanging

- -1 child died on a swing set as a result of hanging from a bungee cord

Falls

- 1 died from a fall from a second story open window
- 1 died when the father fell on top on the child

Fire

- 3 children died as a result of carbon monoxide due to fires in their homes
  - Inadequate supervision was a factor in all 3 deaths

Suffocation

According to the Consumer Product Safety Commission, an average of 22 deaths and 3,000 injuries occur annually when TV stands, dressers, furniture and ranges tip over and crush young children. These deaths have increased by nearly 50 percent between 2005 and 2006. Parents need to be aware of unstable furniture that is not secured to a wall especially when they have toddlers.

Key findings

- 1 child died climbing on an oven door causing the oven to fall on the child and asphyxiate him
- 1 child died when a dresser fell on the child
- Inadequate supervision was a factor in both the deaths

Donte*
Suffocation/unsafe furniture

Mom had ordered furniture and after the delivery she and her girlfriend went shopping leaving a four, two, and one yr old home alone. They were gone several hours; when they returned, they found Donte (the 1 yr old) with his neck lodged between the dresser and a drawer. The child tried to climb in/on the furniture that had a label that stated cheap and not sturdy. She was charged with 3rd degree murder and received a 4-year prison sentence. * alias

RECOMMENDATIONS FOR 2007

Based on the review of 170 Child Abuse Deaths in 2006, the State Child Abuse Death Review Committee has identified ten priority issues with recommendations. Other topic specific issues and recommendations can be found in the body of the report.

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

ISSUES AND RECOMMENDATIONS:

Issue 1: All child death review is needed to facilitate a complete understanding of why children die in Florida – Death certificates are an inadequate source for developing a comprehensive picture.

Recommendations: Implement all child death review or review all child deaths reported to the Florida abuse hotline.

A. Expand the child abuse death review process to include the review of all child deaths.

B. If all child death review cannot be accomplished, the Florida Legislature should expand the child abuse death review process to include the review of all child deaths reported to the Florida Abuse Hot Line.

Chapter 383.402 F.S. limits the review of child deaths to those that are verified as child abuse by the Department of Children and Family Services. In 2006, 2,756 children between the ages of birth up to the age of 18 died in Florida. Because the State Committee is only reviewing verified child abuse deaths, the larger picture of why children die is lost. The State Committee has seen inconsistencies in how child deaths are reported and recorded, which gives a false sense of understanding when the only source of information is the death certificate or medical examiner data. There is a national movement to establish all child death review in every state with a common data collection system that will allow information to be shared with agency partners in Florida and nationally. This effort will lead to quality prevention and

early interventions that maximize community resources and reduce preventable child deaths.
The State Committee recommendations are limited to the review of verified child abuse deaths, and as a result these recommendations and our commentary on trends is limited to that population and may not be generalized to the larger population of children who die in Florida. The benefits of implementing a comprehensive all child death review process would include more thorough child death investigations by law enforcement and medical examiners, enhanced interagency cooperation, improved allocation of limited resources, and consistency in the certification of the cause and manner of death, which would provide more accurate epidemiologic data as to risk factors that may play a role in the deaths of children in the State of Florida.

In 1995, the US Advisory Board on Child Abuse and Neglect recommended that all states review 100 percent of deaths for children ages 17 years and younger. A number of states have done so. A critical issue that must be addressed is the privacy of families who lose a child. No greater tragedy can befall a parent or family. The State Committee is respectful and committed to not intruding on a family's loss by further traumatizing them through an insensitive review process. It has been demonstrated by other death review processes around the country that these reviews can be accomplished in a respectful way that is protective of family rights to privacy.

Issue 2: Healthy Families Florida, a proven child abuse prevention program, is needed statewide to protect children from abuse and improve outcomes for families.

Recommendations: The Florida Legislature should fully fund Healthy Families Florida.

A. Continue to fund Healthy Families at the 2007-2008 level, which includes the $2.2 million in non-recurring funds for the expansion of Healthy Families into the remaining 14 of Florida's 67 counties.

B. Increase funding for Healthy Families Florida to sustain quality services by adjusting the base funding for workload and price level increase, unchanged since 2003-2004; enhance services by adding high-risk specialists to the core staffing; and expand services county-wide in the 21 counties that currently only provide services in targeted zip codes.

Healthy Families Florida is a nationally accredited, community-based, voluntary home visiting program proven to prevent child abuse and neglect. Trained family support workers educate parents on healthy child development and positive parenting and provide information, guidance, and emotional and practical support to families in their homes. A five-year evaluation conducted by an independent third-party evaluator (cite) concluded that Healthy Families Florida has a significant impact on preventing child abuse and neglect in Florida's high-risk families before abuse ever begins:

- Healthy Families participants had 20 percent less child abuse and neglect than all families with children under five living in the targeted service area.

- Children whose families did not receive Healthy Families services were nearly four times more likely to suffer maltreatment before their second birthday than children in families who completed the program.

The goals of Healthy Families Florida are consistent with the goals of the Governor's Children and Youth Cabinet and the Office of Child Protection and Permanency. Healthy Families is also recognized by the U.S. Office of Juvenile Justice and Delinquency Prevention as an "effective" prevention program, demonstrating empirical findings using a sound conceptual framework and an evaluation design of high-quality."

Issue 3: Children continue to die from drowning at an alarming rate as a result of inadequate supervision.

Recommendations: There must be a comprehensive approach to preventing drowning of children, particularly those under the age of 5.

A. All risk assessments conducted by child protective investigators should include drowning risk factors when there are bodies of water or a pool on the premises or close by the home.

B. Law enforcement and medical professionals should report all child-drowning deaths to the Florida Abuse Hotline to allow neglect investigations to occur.

C. The Florida Abuse Hotline should accept reports from law enforcement or medical professionals on child deaths that occurred as a result of drowning.

D. Medical Professionals should report all child-drowning deaths where the death has been delayed due to resuscitation or medical intervention, to the Medical Examiner's office since these deaths resulted from a complication of the drowning and therefore, are not natural deaths.

E. Continue public awareness and education on drowning prevention especially targeted at the five and under age group.

Florida has the highest unintentional drowning rate in the nation for the 1 to 4 year old group with a rate of 8.38 per 100,000 populations in the US.

- Residential swimming pools are the location of nearly two thirds (64%) of the drowning deaths in Florida for the 0-4 age group (CDC WISQARS)[7].
- Florida had the 3rd highest overall unintentional drowning death rate of children in the US in the 5 years between1999-2003 (CDC WISQARS) and has the highest drowning death rate in the nation for children ages 1 to 4.
- In 2003, Florida surpassed California, the most populous state in the nation, in the number of children ages 1 to 4 who drowned.
- According to the Florida Department of Health, there were 95 children ages 0-6 who drowned in Florida in 2006.

Issue 4: Identification and awareness of common triggers for physical abuse is essential to the prevention of child abuse deaths caused by physical injury.

Recommendations: The Florida legislature should:

A. Provide ongoing funding for prevention education activities such as Coping with Crying and "Who's watching Your Child."

B. Support funding for training of investigators, providers, and any service agencies for the purpose of providing educational efforts focused on adult males between the ages of 20-30.

Crying, potty training and feeding are the most common triggers of physical abuse by the young, unskilled, or non-biological caregivers for children under the age of

five. The Kimberlin West Act of 2002 requires that hospitals educate new parents on the dangers of shaking a baby.

Crying is the most common trigger for the violent shaking of a child. This Committee has also identified crying as a trigger in a majority of the abuse deaths reviewed. In addition, the State Committee has seen common factors that are present in the deaths of these children in numerous cases.

These factors include young males between the ages of 20-30 who are unemployed and are often providing primary childcare while the biological mothers work. In addition, there are often histories of substance abuse, domestic violence or criminal history of aggressive or violent behavior. The fact that many of these males are unattached non-biological fathers contributes to their impatience and lack of parenting skills. Any partner in the child protection system should be aware of and sensitive to these risk factors when investigating an allegation of child abuse. Families with these risk factors and history of prior reports, irrespective of the findings, should be considered at the highest risk for child maltreatment.

Issue 5: Lack of understanding regarding the need for a safe sleeping environment continues to contribute to the tragic suffocation deaths of infants.

Recommendations: The State Child Abuse Death Review Committee believes that:

A. The Florida Legislature should provide funding for education and awareness on safe and unsafe sleep environment for child protective investigators, hospital staff medical personnel and parents with newborn children.

B. The Florida Department of Health should partner with the Florida Pediatric Society, Florida Hospital Association, Healthy Families Florida, Department of Children and Family Services, and Healthy Start to seek appropriate venues to provide educational materials and support to hospital staff, medical providers, child protective investigators, service providers and parents with newborn children.

There has been a nation-wide," Back to Sleep" campaign since 1992 to educate the public about the importance of placing children on their backs. (The National Institute of Child Health and Human Development, the Maternal and Child Health Bureau, the American Academy of Pediatrics, the SIDS Alliance, and the

Association of SIDS and Infant Mortality Programs sponsor this campaign). Although this has reduced such deaths nearly in half, the State Committee continues to see an ongoing problem where parents make poor choices regarding the infants sleep environment such as co-sleeping with the infant or bedding that presents a risk to the infant. Other risks for infant suffocation when co-sleeping include obesity, under the influence of alcohol or drugs and exhaustion. Many of these deaths have the potential to be classified as SIDS deaths instead of suffocation. The State committee adopted the recommendations regarding safe sleeping that the American Academy of Pediatrics released on November 5, 2005 (See Appendix VI).

Issue 6: There continues to be inconsistency in findings in child abuse death cases.

Recommendation: Consistent with DCF Administrative Code 65C-30.020(5)(f), DCF Death Review Coordinators, because of their expertise, experience and professional judgment, should review and have the authority to modify the findings in child death cases prior to the closure if they do not agree with the findings.

The State Committee found that there were inconsistencies, depending on the county where the Department of Children and Families reviewed the death, as to the percentages of child death reports closed with verified findings. The irregularities apparent in child death reports appears endemic to all child abuse reports, as certain counties repeatedly have lower rates of verified findings than would be expected to occur over time.

The State Committee understands that the Department of Children and Families has a comprehensively developed performance measure protocol that is used to gauge child protection functions and identify insufficiencies. The emphasis on favorable performance measures, however, may drive the verification rates for child abuse deaths. There is concern that child abuse deaths may be skewed due to miss-classification and underreporting, as stated earlier in this report. While it is commendable that many strides have been made in classifying more cases appropriately, as evidenced by the increase in verified child deaths, the State Committee believes that much work remains for the Department. It is known by the State Committee that cases classified as "some indicators" have been reassessed in the past and changed to "verified", which indicates the need for more careful analysis on classification outcomes. This issue will be a priority for the State Committee in 2008.

Issue 7: There are inadequate death scene investigations resulting in inconsistent certification of cause and manner of death by Medical Examiners in sudden infant death investigations.

Recommendations: The State Child Abuse Death Review Committee believes that:

A. The Medical Examiner's Commission should recommend that all M.E. districts adopt the Sudden Unexplained Infant Death Investigation (SUIDI) model.

B. All Florida Medical Examiner districts should participate in the National MDI (Medicolegal Death Investigation) Log registry (www.mdilog.net) for sudden unexplained infant deaths.

C. Law Enforcement agencies are urged to adopt and participate in the training of the Center for Disease Control's (CDC) initiative, Sudden Unexplained Infant Death Investigations, such training should include a drug testing component.

D. The Florida Department of Law Enforcement, through the Standards and Training Commission, should work with county sheriffs and local police chiefs to develop a standardized protocol for investigating child deaths or at a minimum adopt the CDC SUIDI protocol.

E. DCF should adopt and participate in establishing guidelines for investigating infant death possibly related to unsafe sleep practices, to include a drug-testing component.

F. DCF should provide all child protective investigators with a presumptive field drug testing kit for use in any alleged child abuse death.

Nationally, forensic pathologists consider the information on the Sudden Unexplained Infant Death Investigations (SUIDI) form critical to the determination of the cause and manner of death with regard to infant death investigation.

- The State Committee found that there is no comprehensive or consistent statewide training on child death investigations. Many cases lacked thorough crime scene investigation and documentation, drug testing was not requested or ordered in many cases even when drug paraphernalia was observed at the scene, and not all witnesses were interviewed.
- A recent initiative, SUIDI death investigation, through the Center's for Disease Control have encouraged all States to adopt a standardized approach to infant death scene investigation. Representatives from Florida participated in the initial training and have provided training through out the State of Florida when requested or when the opportunity presented by Medical Examiners and law enforcement agencies. The State Child Abuse Death Review Committee views this project as a high priority and is supportive of identifying resources to initiate a statewide approach to training and outreach.

Issue 8: There is a need for multidisciplinary staffing where the family has had 3 or more prior reports of abuse and neglect irrespective of the previous finding.

Recommendations: Prior history must be taken into consideration by child protective investigators and child welfare legal representatives when assessing risk and making child safety decisions.

A. Multidisciplinary staffing needs to occur when there is a child under the age of five in the home and there have been three or more prior reports on the family, irrespective of the findings of the prior reports.

B. The Department of Children and Families should look into the process whereby Child Welfare Legal Services and child protective investigators review critical child safety decisions in determining what court action should be taken, and that the family's full history with the Department of Children and Families should be considered.

C. The Department should review, modify, and seek legislative change if necessary, to case closure timelines, to allow flexibility in keeping a case open when a family has three or more reports.

The State Committee reviewed 26 child abuse deaths where there were three or more prior reports to the Department of Children and Families and little to no services had been provided or the risk was overlooked; and it appeared that multidisciplinary staffings were not held.

The State Committee found that in the deaths where there were prior reports and Child Welfare Legal Services had determined that there was "insufficient evidence for court action", it often appeared as though that decision was made without taking the full family history into consideration.

In a recent review by the Quality Management Unit of Department of Children and Families services, it was determined that 70 percent of all child's deaths reported to the Florida Abuse Hotline had a family member who had prior involvement with the Department, which reinforces the need to consider prior history in making child safety decisions. Also, there is a need for identifying and expanding services and intervention for families in need to ensure that adequate resources are available to children and families when risk is identified. Additionally, rapid closure of cases by child protection investigators was identified as an issue in many deaths. When cases are closed without fully considering family history or past involvement with the community based care system, children are potentially placed at risk by continued exposure to identified risk factors without appropriate intervention by the system.

Issue 9: Substance abuse is a significant risk factor in many child abuse deaths.

Recommendations: Legislative change and training are required to address the issue of children exposed to illegal substances:

A. The Florida Legislature should initiate an interim project, in cooperation with the Florida Alliance for Drug Endangered Children and the Florida Pediatric Society's Committee on Child Abuse and Neglect to address the presence of illegal substances in the home as child abuse and amend Chapter 39 F. S., to address this issue.

B. The Office of Drug Control should coordinate mandatory training on substance abuse for partner agencies involved in the investigation and management of child abuse cases to include but not limited too, the Department of Children and Families, Florida Department of Health, Law Enforcement, Community Based Care Agencies, and the Judiciary.

C. The Office of Drug Control's curriculum should include recognition of increasing misuse of illegal, legal, and prescribed substances as a potential risk factor for child maltreatment by caretakers or access and exposure by child victims.

Chapter 39 Florida Statute does not currently recognize the presence of illegal substances in a child as harm.

- Children exposed to substance abuse by their caretaker may test positive by virtue of their exposure.
- Parental impairment due to the misuse of illegal substances should be recognized as risk to the child in their care.
- The use of legal and prescribed substances by the caretaker and/or child victim in a manner that is either unsupervised, inappropriate, or by careless accessibility should be recognized as a potential risk factor.

The State Committee has identified a pattern where investigative findings indicate that substance abuse by the parent or person responsible for the child was documented in prior reports or substances were discovered in the home at the time of the child's death. In addition to lack of follow through by investigators or law enforcement, for cases where the investigator convened a meeting with child welfare legal services, the substance abuse allegation does not appear to have been appropriately factored into the risk assessment. Subsequently, cases are either referred to Voluntary Services or no services. In addition, the State Committee recognizes that the Florida Appellate Courts have overturned shelters due to the lack of statutory authority in cases involving substance abuse as the nexus for sheltering child victims.

Issue 10: There is a need for judicial review when a child dies as a result of child abuse and the case was under the jurisdiction of the court.

Recommendation: The Florida Supreme Court or the Florida Legislature should establish an independent review process for judicial cases when a child dies from child abuse and was under the supervision of the court.

Since 1999, the State Committee has reviewed multiple deaths where dependency court was involved. Several of those deaths involved situations where the court either declined to follow the recommendations of the participating agencies, or when the case was brought before the court it declined to take any action on the recommendations of the supervising agency and the child was subsequently returned home and ultimately killed by a caretaker. One child death, for example,

involved the community based care provider taking the mother before the dependency court on eight occasions for non-compliance with a court ordered case plan, yet the court declined to take any action or sanctions against the mother. While the State Committee is not making a direct nexus between the death of the child and lack of court action, it does believe that the judicial process should be reviewed in a manner similar to other child protection quality improvement reviews. Understanding the thinking and decision-making process of the court would be extremely valuable. The lessons learned from such reviews could contribute significantly to an educational initiative for dependency court judges, which would inform their decision making process leading to better outcomes for children.

REFERENCES

1. Section 383.402, *Florida Statute*s

2. Section 39.01, *Florida Statutes*

3. U.S. Department of Health and Human Services: Child Maltreatment 2005: Reports from the States National Center on Child Abuse Prevention Research.

4. Florida Department of Children and Family Services: Child Abuse and Neglect Deaths: Calendar Year 2006.

5. Department of Health Vital Statistics Annual Report 2006

6. American Academy of Pediatrics: Policy Statement, The Changing Concept of Sudden Infant Death Syndrome: Diagnostic Coding Shifts, Controversies Regarding the Sleeping Environment, and New Variable to Consider in Reducing Risk. Pediatrics Vol. 116 No. 5, November 2005

7. 1999-2003, Centers for Disease Control - Web-based Injury Statistics Query and Reporting System (CDC WISQARS)

Appendix I

Purpose of Child Abuse Death Review Committee

Program Background and Description

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

Mission Statement

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

Goal

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

Achieving Objectives

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

Membership of the State Committee

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

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

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

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

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

Appendix II

Membership of the Local Committee

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

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

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

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

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

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

Ad Hoc Members

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

Appendix III

Goals and Accomplishments for 2007

Goals:

Continue to train professionals on child death investigations as well as prevention efforts

Increase verified child abuse death reporting compliance to 99% for the 2007 deaths from the Department of Children and Families.

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

Accomplishments:

Training was provided to over 1,251 in 2006 and it is well over 2,000 that were trained by State Committee members in 2007. The training topics were on child death investigations to include the CDC model on Sudden Unexplained Infant Death Investigations, key findings from the State Committee, and mandatory reporting of child abuse deaths, risk factors, issues relating to consistency in verifying child abuse deaths by the Department of Children and Families and prevention strategies.
Professionals included, Law Enforcement, Department of Children and Families, Community Based Care, Child Protection Teams, Federal Probation, Child Advocacy Centers, local child death review committees, Healthy Families and Healthy Start, Medical Examiners' Commission, Florida Highway Patrol, Military personnel and others.

The State Committee has and will continue to provided education and support to the Florida Highway Patrol regarding mandatory reporting on cases where children are killed or seriously injured as a result of the caregivers being under the influence or driving in a reckless manor.

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

The State Committee sanctioned the last local child abuse committee, making Florida a state that has a local committee covering every county.

Reviewed 170 of the 171 child abuse death cases that met the criteria for review.

Adopted the FDLE child investigation visor guide, which is available on the CADR website www.flcadr.org.

Appendix IV

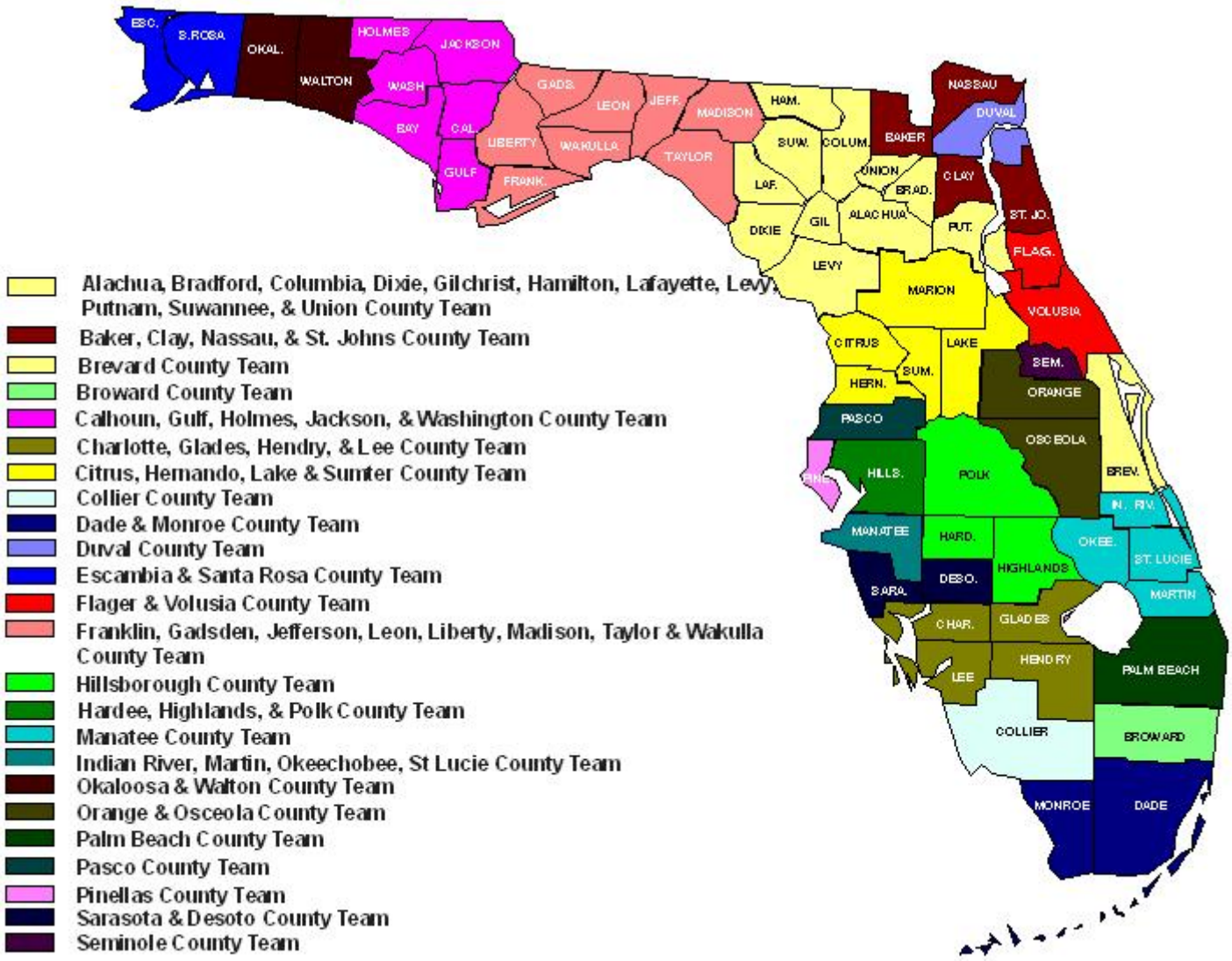
Child Abuse Deaths by County

The following map, statistical reports, graphs and charts are based on a review of the child abuse and neglect deaths that occurred from 2004-2006. Below indicate the counties in which the deaths occurred and the number of deaths per county by year.

Number of Deaths by County										
County	Year			Total # of Deaths	County	Year			Total # of Deaths	
	2004	2005	2006	Total # of Deaths		2004	2005	2006	Total # of Deaths	
Alachua	1	3	2	6	Leon	2	0	0	2	
Baker	1	1	1	3	*Manatee	1	0	4	4	
*Bay	0	1	0	1	*Marion	4	6	6	16	
Bradford	0	1	1	2	Monroe	0	0	1	1	
*Brevard	7	5	11	23	Martin	0	0	2	2	
*Broward	13	9	14	36	Okaloosa	0	0	2	2	
Charlotte	2	0	2	4	Okeechobee	0	0	1	1	
*Citrus	4	0	1	5	*Orange	5	9	9	23	
*Clay	1	0	0	1	*Osceola	1	1	3	5	
Collier	0	0	1	1	*Palm Beach	6	6	14	26	
Columbia	0	0	1	1	*Pasco	2	0	4	6	
*Dade	14	5	11	30	*Pinellas	2	5	6	13	
*Duval	16	9	12	37	*Polk	7	8	16	31	
*Escambia	1	0	4	5	Putman	0	0	3	3	
Flagler	0	0	1	1	*Santa Rosa	2	2	3	7	
Gadsden	0	1	0	1	*Sarasota	1	1	1	3	
Glades	1	0	0	1	*Seminole	3	2	4	9	
*Hernando	1	2	2	5	*St. John	2	1	0	3	
*Hillsborough	2	6	9	17	St. Lucie	0	0	1	1	
Holmes	2	0	0	2	Sumter	0	2	1	3	
*Indian River	2	0	0	2	Suwannee	1	0	0	1	
Jackson	1	1	1	3	Union	0	1	7	8	
Lafayette	0	0	1	1	*Volusia	1	2	1	4	
Lake	0	0	1	1	Walton	0	2	1	3	
*Lee	5	4	4	13	Washington	0	0	1	1	

Appendix V

Local Child Abuse Death Review Committees



- One of the goals of the State Committee for 2007 was establishing local child abuse death review committees statewide, which was accomplished in November 2007.
- Local Committees did an excellent job reviewing the increased number of child abuse death cases.
- They did so in a timely manner and made valuable recommendations for the State Committee to consider.
- The members are dedicated, passionate professionals who have volunteered timeless hours in an effort to prevent future child abuse deaths in their communities.

Appendix VI

American Pediatrics Policy Statement

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

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

DEFINITIONS

❖ Cases that meet the criteria for review

In accordance with s. 383.401, F.S., the Committee must conduct detailed reviews of the facts and circumstances surrounding child abuse and neglect deaths in which the Florida Abuse hotline within the Department of Children and Families accepted a report of abuse or neglect and verified it.

Verified= When a preponderance of the creditable evidence results in a determination that the specific injury, harm, or threatened harm was the result of abuse or neglect.

Some Indication= When there is credible evidence, which does not meet the standard of being a preponderance, to support that the specific injury, harm, or threatened harm was the result of abuse or neglect. (Pat will look at)

❖ Cause of Death

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

❖ Manner of Death

This is one of the five general categories (Accident, Homicide, Suicide, Undetermined and Natural) that are found on the death certificate.

❖ Preventable death.

Based on the information provided, the Committee shall determine whether the child's death was preventable.

Definitely preventable: The information provided demonstrates clearly that steps or actions could have been taken that would have prevented the death from occurring.

Possibly preventable: There is insufficient information to determine if the death was preventable.

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

❖ Physical Abuse

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

❖ Neglect

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

❖ Harm

F.S.39.01

(31) "Harm" to a child's health or welfare can occur when any person:

(a) Inflicts or allows to be inflicted upon the child physical, mental, or emotional injury. In determining whether harm has occurred, the following factors must be considered in evaluating any physical, mental, or emotional injury to a child: the age of the child; any prior history of injuries to the child; the location of the injury on the body of the child; the multiplicity of the injury; and the type of trauma inflicted. Such injury includes, but is not limited to:

1. Willful acts that produce the following specific injuries:

a. Sprains, dislocations, or cartilage damage.

b. Bone or skull fractures.

c. Brain or spinal cord damage.

d. Intracranial hemorrhage or injury to other internal organs.

e. Asphyxiation, suffocation, or drowning.

f. Injury resulting from the use of a deadly weapon.

g. Burns or scalding.

h. Cuts, lacerations, punctures, or bites.

i. Permanent or temporary disfigurement.

j. Permanent or temporary loss or impairment of a body part or function.

As used in this subparagraph, the term "willful" refers to the intent to perform an action, not to the intent to achieve a result or to cause an injury.

2. Purposely giving a child poison, alcohol, drugs, or other substances that substantially affect the child's behavior, motor coordination, or judgment or that results in sickness or internal injury. For the purposes of this subparagraph, the

term "drugs" means prescription drugs not prescribed for the child or not administered as prescribed, and controlled substances as outlined in Schedule I or Schedule II of s. 893.03.

3. Leaving a child without adult supervision or arrangement appropriate for the child's age or mental or physical condition, so that the child is unable to care for the child's own needs or another's basic needs or is unable to exercise good judgment in responding to any kind of physical or emotional crisis.

4. Inappropriate or excessively harsh disciplinary action that is likely to result in physical injury, mental injury as defined in this section, or emotional injury. The significance of any injury must be evaluated in light of the following factors: the age of the child; any prior history of injuries to the child; the location of the injury on the body of the child; the multiplicity of the injury; and the type of trauma inflicted. Corporal discipline may be considered excessive or abusive when it results in any of the following or other similar injuries:

a. Sprains, dislocations, or cartilage damage.

b. Bone or skull fractures.

c. Brain or spinal cord damage.

d. Intracranial hemorrhage or injury to other internal organs.

e. Asphyxiation, suffocation, or drowning.

f. Injury resulting from the use of a deadly weapon.

g. Burns or scalding.

h. Cuts, lacerations, punctures, or bites.

i. Permanent or temporary disfigurement.

j. Permanent or temporary loss or impairment of a body part or function.

k. Significant bruises or welts.

(a) Commits, or allows to be committed, sexual battery, as defined in chapter 794, or lewd or lascivious acts, as defined in chapter 800, against the child.
(b) Allows, encourages, or forces the sexual exploitation of a child, which includes allowing, encouraging, or forcing a child to:

1. Solicit for or engage in prostitution; or

2. Engage in a sexual performance, as defined by chapter 827.

(c) Exploits a child, or allows a child to be exploited, as provided in s. 450.151.

(d) Abandons the child. Within the context of the definition of "harm," the term "abandons the child" means that the parent or legal custodian of a child or, in the absence of a parent or legal custodian, the person responsible for the child's welfare, while being able, makes no provision for the child's support and makes no effort to communicate with the child, which situation is sufficient to evince a willful rejection of parental obligation. If the efforts of the parent or legal custodian or person primarily responsible for the child's welfare to support and communicate with the child are only marginal efforts that do not evince a settled purpose to assume all parental duties, the child may be determined to have been abandoned. The term "abandoned" does not include an abandoned newborn infant as described in s. 383.50.

(e) Neglects the child. Within the context of the definition of "harm," the term "neglects the child" means that the parent or other person responsible for the child's welfare fails to supply the child with adequate food, clothing, shelter, or health care, although financially able to do so or although offered financial or other means to do so. However, a parent or legal custodian who, by reason of the legitimate practice of religious beliefs, does not provide specified medical treatment for a child may not be considered abusive or neglectful for that reason alone, but such an exception does not:

1. Eliminate the requirement that such a case be reported to the department;

2. Prevent the department from investigating such a case; or

3. Preclude a court from ordering, when the health of the child requires it, the provision of medical services by a physician, as defined in this section, or treatment by a duly accredited practitioner who relies solely on spiritual means for healing in accordance with the tenets and practices of a well-recognized church or religious organization.

(f) Exposes a child to a controlled substance or alcohol. Exposure to a controlled substance or alcohol is established by:

1. Use by the mother of a controlled substance or alcohol during pregnancy when the child, at birth, is demonstrably adversely affected by such usage; or

2. Continued chronic and severe use of a controlled substance or alcohol by a parent when the child is demonstrably adversely affected by such usage.

As used in this paragraph, the term "controlled substance" means prescription drugs not prescribed for the parent or not administered as prescribed and controlled substances as outlined in Schedule I or Schedule II of s. 893.03.

(g) Uses mechanical devices, unreasonable restraints, or extended periods of isolation to control a child.

(h) Engages in violent behavior that demonstrates a wanton disregard for the presence of a child and could reasonably result in serious injury to the child.

(i) Negligently fails to protect a child in his or her care from inflicted physical, mental, or sexual injury caused by the acts of another.

(j) Has allowed a child's sibling to die as a result of abuse, abandonment, or neglect.

(k) Makes the child unavailable for the purpose of impeding or avoiding a protective investigation unless the court determines that the parent, legal custodian, or caregiver was fleeing from a situation involving domestic violence.

❖ System

The organization of agencies, associations and other entities that is responsible for the oversight and implementation of services, resources and laws designed to protect children who are reported to the Florida Abuse Hotline System. (Judiciary, Law Enforcement, etc.)

❖ Caregiver

Means the parent, legal custodian, permanent guardian, adult household member or other person responsible for a child's welfare, which included foster parent, and employee of any private school, public or private child day care center, residential home, institution, facility, or agency, or any other person legally responsible for the child's welfare in a residential setting: and also includes an adult sitter or adult relative entrusted with a child's care F.S. 39.01 (10) and (46)

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