FLORIDA CHILD ABUSE DEATH REVIEW

FIFTH ANNUAL REPORT
DECEMBER 2004

State Child Abuse Death Review Team
4052 Bald Cypress Way, Bin A06
Tallahassee, Florida 32399
(850) 245-4200

FLORIDA CHILD ABUSE DEATH REVIEW TEAM

The Honorable Jeb Bush
Governor of Florida
The Honorable Tom Lee
President of the Florida Senate
The Honorable Allan Bense
Speaker of the Florida House of Representatives
The Capitol
Tallahassee, FL 32399-0001

Dear Governor Bush, President Lee, and Speaker Bense

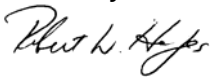
As chairman of the State Child Abuse Death Review Team, I am submitting this annual report of child abuse and neglect deaths in accordance with Chapter 383.402, Florida Statutes. This report summarizes information from the case reviews of the 35 children who died in 2003 that had at least one prior report of abuse or neglect filed with the Department of Children and Families. Additionally, it highlights major issues and trends for the 161 deaths reviewed over the five-year period since the inception of the State Child Abuse Death Review Team.

During this fifth year, the State Child Abuse Death Review Team, in collaboration with local communities, continued to work diligently to improve the review process, and train additional local teams on conducting child abuse and neglect death reviews. The State Child Abuse Death Review Team has established several local teams and continues to organize more through out the state.

However, the process of reviewing child abuse and neglect deaths has been complicated by the “Sunset” of Chapter 383.410 F.S., which provided confidentiality protections that enabled the Team to review all sensitive materials related to a child’s death. With that protection removed, the ability of the Team to carry out its statutory mandate has been significantly compromised. With the expansion of the Team’s responsibility to review all abuse and neglect deaths, it is imperative that we work in partnership to restore the confidentiality protection necessary for a thorough and unbiased review of all these cases.

As our work progresses, I am optimistic that the end result will be a better understanding of the circumstances and contributing factors of those deaths, which will support our ultimate goal of continuing the mission of working together to reduce preventable child abuse and neglect deaths.

Sincerely,



Robert W. Hodges, Chairman
State Child Abuse Death Review Team

FLORIDA
CHILD ABUSE DEATH REVIEW TEAM

FIFTH ANNUAL REPORT

DECEMBER 2004

MISSION

To reduce preventable child abuse and neglect deaths

Submitted to

The Honorable Jeb Bush, Governor, State of Florida
The Honorable Tom Lee, President, Florida State Senate
The Honorable Allan Bense, Speaker, Florida State House of Representatives

DEDICATION

The cases of 35 children who had prior involvement with child protection services and subsequently died from abuse or neglect during 2003 were presented to the Child Abuse Death Review Team for review. Two cases of children who died in 2002 were also reviewed in 2003. This report is dedicated to these children.

Profile Information	Date of Death	Cause of Death	Caretaker Responsible	Prior Reports
1-month-old female	*6/19/2003*	*Asphyxia/Co-sleeping*	*Mother*	*1*
1-month-old male	*7/18/2003*	*Blunt Force Head/Body Trauma/Shaken Baby*	*Father*	*1*
1-month-old male	*5/24/2003*	*Asphyxia/Co-Sleeping*	*Father*	*1*
1-month-old female	*4/4/2003*	*Blunt Force Head Trauma/Shaken Baby*	*Mother*	*1*
2-month-old female	*4/12/2003*	*Asphyxia/Co-Sleeping*	*Mother*	*1*
2-month-old male	*10/23/2003*	*Asphyxia/Co-sleeping*	*Father/Mother*	*1*
4-month-old male	*5/6/2003*	*Blunt Force Head Trauma/Shaken Baby*	*Father*	*2*
6-month-old male	*5/15/2003*	*Malnutrition*	*Father/Mother*	*2*
1-year- -old male	*7/26/2003*	*Drowning/pool*	*Father*	*2*
1-year-old male	*3/12/2003*	*Blunt Force Head Trauma Shaken Baby*	*Male Paramour*	*3*
1-year-old female	*3/1/2003*	*Head Trauma/Shaken Baby*	*Male Paramour*	*1*
1-year-old female	*3/26/2003*	*Drowning/pool*	*Mother*	*1*
1-year-oldfemale	*7/13/2002*	*Blunt Force Head Trauma*	*Male Paramour*	*1*
2-year-old male	*9/4/2003*	*Carbon Monoxide Poisoning/house fire*	*Sibling*	*1*
2-year-old male	*12/5/2003*	*Drowning/canal*	*Mother*	*2*

Profile Information	Date of Death	Cause of Death	Caretaker Responsible	Prior Reports
2-year-old female	*12/21/2002*	*Blunt Head Trauma/Shaken Baby*	*Father*	*2*
2-year-old female	*6/25/2003*	*Drowning/pond*	*Mother*	*2*
2-year-old male	*3/26/2003*	*Drowning/pool*	*Mother*	*1*
2-year-old female	*4/18/2003*	*Drowning/pool*	*Adopted Father*	*2*
2-year-old female	*2/4/2003*	*Blunt Force Head Trauma/vehicle*	*Aunt*	*1*
3-year-old male	*12/25/2003*	*Blunt Head Trauma/vehicle*	*Father*	*1*
3-year-old male	*6/11/2003*	*Hyperthermia/vehicle*	*Day Care Staff*	*1*
3-year-old male	*9/20/2003*	*Drowning/lake*	*Mother*	*1*
3-year-old male	*5/11/2003*	*Drowning/pool*	*Mother*	*11*
3-year-old male	*4/6/2003*	*Hyperthermia/vehicle*	*Mother*	*1*
3-year-old male	*1/19/2003*	*Blunt Force to Abdomen*	*Mother*	*4*
3-year old female	*1/3/2003*	*Blunt Head Trauma Shaken Baby*	*Mother*	*4*
4-year-old female	*4/8/2003*	*Drowning/pool*	*Aunt*	*1*
5-year-old female	*5/12/2003*	*Blunt Force Head and Body Trauma/vehicle*	*Mother*	*2*
5-year-old female	*3/24/2003*	*Poisoning/overdose*	*Adoptive Mother*	*1*
5-year-old male	*4/15/2003*	*Blunt Head Trauma*	*Father*	*4*

Profile Information	Date of Death	Cause of Death	Caretaker Responsible	Prior Reports
6-year old female	*12/25/2003*	*Blunt Trauma/vehicle*	*Father*	*1*
10-year old male	*5/15/2003*	*Drowning/pool*	*Foster Father*	*2*
11-year old female	*10/14/2003*	*Gunshot/homicide*	*Male paramour*	*1*
12 year old male	*10/14/2003*	*Gunshot/homicide*	*Male Paramour*	*1*
17 year old female	*11/27/03*	*Gunshot/accident*	*Sibling*	*11*
17 year old male	*6/9/2003*	*Peritonitis/Medical neglect*	*Other non-relative*	*1*

A simple child
That lightly draws its breath,
And feels its life in every limb
What should it know of death?

William Wordsworth (1770-1850)
We are Seven

TABLE OF CONTENTS

EXECUTIVE SUMMARY I

PURPOSE OF CHILD ABUSE DEATH REVIEWS 1

SUMMARY OF EARLY INITIATIVES 1

STATE CHILD ABUSE DEATH REVIEW TEAM 2

PROGRAM PURPOSE 2
SUMMARY OF FIRST FOUR YEARS 2
MEMBERSHIP OF THE STATE TEAM 3
ROLES AND RESPONSIBILITIES OF THE STATE TEAM 4

LOCAL CHILD ABUSE DEATH REVIEW TEAMS 5

MEMBERSHIP OF LOCAL DEATH REVIEW TEAMS 5
ROLES AND RESPONSIBILITIES OF LOCAL TEAMS 5
EXISTING AND PLANNED LOCAL TEAMS 7
Figure 1: Existing and Planned Local Teams as of 2004 7

CHILD ABUSE AND NEGLECT DATA 8

CHILD ABUSE DEATH REVIEW TEAM DEATHS 9

Figure 2: Location of Child Deaths 9
Figure 3: Number of Child Deaths by County/Year 10

CHILD ABUSE DEATH REVIEW DATA 11

NUMBER OF CHILD ABUSE AND NEGLECT DEATHS 11
Figure 4: Abuse & Neglect Deaths 11
CAUSE OF DEATH 12
Figure 5: Cause of Child's Death 12
AGE AT DEATH 13
Figure 6: Age at Death 14
RACE AND GENDER 15
Figure 7: Race and Gender of Child at Death 15
RELATIONSHIP OF CARETAKER RESPONSIBLE FOR ABUSE OR NEGLECT 16
Figure 8: Caretaker Responsible for Abuse or Neglect 16
Relationship to Child 16
AGE OF CARETAKER RESPONSIBLE FOR ABUSE OR NEGLECT 17
Figure 9: Age of Caretaker Responsible for Abuse or Neglect 17
CARETAKER RESPONSIBLE FOR ABUSE OR NEGLECT HISTORY 18
Figure 10: Family Risk Factors for Child Victims 20
TEAM CONCLUSIONS/ADEQUACY OF PRIOR INTERVENTIONS 21
TEAM CONCLUSIONS/ISSUES IDENTIFIED 22
CRIMINAL STATUS 24

STATUS OF 2003 REPORT RECOMMENDATIONS 25

CONCLUSIONS AND RECOMMENDATIONS 31

REFERENCES 36

ATTACHMENTS
State Child Abuse Review Team ..... Attachment I
Department of Children and Families Training Priorities ..... Attachment II

EXECUTIVE SUMMARY

In 1999, the Florida Legislature mandated that the Department of Health establish a statewide multidisciplinary, multi-agency child death review system, consisting of state and local review teams, to conduct reviews of the facts and circumstances surrounding child abuse and neglect deaths in which the Department of Children and Families, Florida Abuse Hotline accepted at least one prior report of abuse or neglect. Chapter 383.402 (1) Florida Statute, (FS) identifies the purpose of these child abuse death reviews as follows:

"The purpose of the reviews shall be to:

- Achieve a greater understanding of the causes and contributing factors of deaths resulting from child abuse or neglect.
- Whenever possible, develop a community-based approach to address child abuse deaths and contributing factors.
- Identify any gaps, deficiencies or problems in the delivery of services to children and their families by public and private agencies that may be related to deaths that are the result of
- child abuse.
- Make and implement recommendations for changes in law, rules, and policies, as well as develop practice standards that support the safe and healthy development of children and reduce preventable child abuse deaths."[1]

This fifth annual report includes information from the review of the 35 children who died in 2003. Additionally, it highlights major issues and trends for the 161 deaths reviewed over the five-year period since the inception of the Florida State Child Abuse Death Review Team. It is important for the reader to put the review of these child deaths in perspective. Because the population reviewed is limited in scope and representation of the total number of abuse and neglect deaths in Florida, the recommendations and comments made throughout this report are subject to those limitations when generalizations are made. There are clear patterns and trends noted for the state that are consistent with national data; however, because of the limited population there are variations, which are reflected in this report. Findings for this five-year period include the following:

- Neglect deaths occurred slightly higher at 52%, while abuse was at 48%.

- The majority of the abuse deaths involved direct attacks resulting in physical trauma. Of the 44 deaths caused by direct trauma, 21 of the children died from head trauma, 7 from abdominal trauma, and 16 from beatings and multiple traumas.

- Twelve children died from trauma resulting from shaking/impact.

- Drowning was the leading cause of neglect deaths with 37 child deaths for the five-year period.

- Thirteen of the children died from a fatal gunshot wound, and 9 were intentionally shot by an adult.

- Co-sleeping contributed to the deaths of 4 of the children under the age of 3 months.

- The National Child Abuse and Neglect Data System (NCANDS) reported an estimated 1,400 child fatalities in 2002. This translates to a rate of 1.98 children per 100,000 in the general population. "Research indicates very young children (ages 3 and younger) are the most frequent victims of child fatalities. NCANDS data for 2002 demonstrated children younger than 1 year accounted for 41 percent of the fatalities, while children younger than 4 years accounted for 76 percent of fatalities. This population of children is the most vulnerable for many reasons, including their dependency, small size and inability to defend themselves."[7]

  The Florida statistics are somewhat lower than the National statistics. One reason for this may have been that the review included only those deaths in which the victim had been the subject of a prior report to the Florida Abuse Hotline, and very young children, particularly infants, were less likely to have been reported to the abuse hotline than older children. It is likely that this data will be consistent with the national statistics next year when the reviews include all verified deaths. Figure 6 of the report provides a specific breakdown of age at death for these 160 children.

- The National Child Abuse and Neglect Data System report further states that national statistics for 2002 indicate 38% of child maltreatment fatalities were associated with neglect alone, 30% with abuse alone, and 29% were the result of multiple maltreatment types. The remaining 3% were due to either sexual or psychological maltreatment.

  The Florida statistics indicate that 52% of child deaths were associated with neglect and 48% with abuse. A comparison of Florida's data can not be made to the national statistics, as Florida does not capture the data on deaths by multiple maltreatment types.

- Of the 161 deaths, 94 (58%) were male and 67 (42%) were female. Ninety- three (58%) of the children were white, 63 (39%) percent were black, 1 (1%) was multi-racial, 1 (1%) was American Indian, and 3 (2%) were Asian Pacific. For those deaths that identified specific ethnicity, a total of 17 (25%) were identified as Hispanic and 6 (9%) were identified as Haitian.

- Fathers or male paramours were responsible in 83 (44%) of the deaths. Mothers were responsible in 68 (36%) of the deaths. Neglect was the primary cause of death in the majority of cases in which the mother was the only caretaker responsible. The majority of the deaths in which the father or male paramour was the sole caretaker responsible were caused by abuse.

- The identified caretaker responsible ranged in age from seventeen to seventy-nine, with 102 (54%) under the age of thirty years. Florida's data are inconsistent with national estimates, which report that caretakers responsible of maltreatment fatalities are generally younger than thirty years of age. This may be the result of the case criteria for this review as young parents with first time infants having no prior reports were not included.

- Ninety-two (57%) of the 161 cases had five or more risk factors present at the time of the child's death. Major risk factors for these children and the percent of deaths in which these factors were present included:

  - One or more children in the household were age four or younger (78% of deaths)

- A pattern of escalation or frequency of incidents of abuse or neglect (45% of deaths)
- Parent or caregiver unable to meet children's immediate needs (44% of deaths)
- Children in the home had limited community visibility (44% of deaths)
- Parent or caregiver's age, mental health, alcohol or substance abuse affected their ability to adequately care for child (42% of deaths)
- Parent or caregiver's criminal history presented a potential threat of harm to the child (33% of deaths)
- Pattern of escalating and/or continuing incidents of domestic violence (26% of deaths)
- Living conditions were physically hazardous to the health of the child (19% of deaths)
- Parent or caregiver were unable or unwilling to protect the child from abusive caregivers/paramours (23% of deaths)

Data for 2003 indicated that of the 35 deaths reviewed by the team, the causes and contributing factors included:

Abuse (13 deaths)

- The majority of the abuse deaths involved direct attacks resulting in physical trauma. Of the 6 trauma related deaths, 3 of the children died from head trauma and 3 from multiple traumas.
- 3 children died from shaking/impact.
- 2 children died with their father after he poured gasoline on the car and crashed it into a home
- 2 children died from a gunshot, homicide.

Neglect (22 deaths)

- 9 children accidentally drowned. Seven drowned in swimming pools, 1 in a canal and 1 in a pond. Inadequate supervision by the caretaker responsible contributed to these deaths.
- 1 child died in a vehicle related accident, the child was run over by a mail truck. Inadequate supervision contributed to the death.
- 2 children died due to hyperthermia. One child was left in a van by child care staff and the other climbed into a rental car at the home while an aunt was babysitting. Inadequate supervision contributed to these deaths.
- 1 child residing in a detention died due to medical neglect by facility staff.
- 1 child was accidentally shot by her sibling and died from the gunshot wound.
- 4 children died while co-sleeping with their parent(s)
- 1 child was starved to death
- 1 child died from carbon monoxide poisoning due to a house fire started by a sibling
- 1 child died from intentional poisoning/ overdose by the adoptive parent.

ISSUES AND RECOMMENDATIONS

The State Child Abuse Death Review Team has evolved over the past five years. In the initial years, the team built a foundation for the child abuse death review process at the state level, and began to develop local teams. This early work focused on a multidisciplinary

approach to child abuse and neglect deaths, with the goal of achieving a better understanding of the causes and contributing factors and recommendations for better approaches to prevention. Once the foundation was laid, the focus expanded to the further development of local teams, multidisciplinary protocols, data gathering and analysis, and the development and implementation of recommendations.

It remains important for the reader to put the overall analysis of these child deaths in perspective. In addition to the limitations in the information used to analyze individual cases, the population reviewed is limited in scope and representation of the total number of abuse and neglect deaths in Florida. Therefore, although there are some clear patterns reflective of national trends, the specifics may vary.

The Child Abuse Death Review Team identified both case specific and overall systemic issues in the child protection system. After a careful analysis of the data, the state team presents the following recommendations to address critical issues identified during their reviews.

ISSUE 1: CONFIDENTIALITY

In 1999, the Florida Legislature established the State Child Abuse Death Review Committee pursuant to Chapter 383.402 F.S. and a companion section Chapter 383.410 F.S., which provided confidentiality protections that enabled the Team to carry out its work. The intent of this legislation requires the State Team to review and investigate the circumstances surrounding the death of a child from verified child abuse or neglect, where there was one prior report to the Department of Children and Families. In 2004, the Legislature expanded the team's mandate to reviewing all child abuse or child neglect deaths regardless of whether there was a prior report to the Department.

During the 2004 legislative session, the confidentiality section came up for Sunset Review. The Florida Senate unanimously passed Senate Bill 462 which ensured the retention of this confidentiality section. Regrettably, in the House, a similar Committee Bill (PCB 04-02) was held up in the State Administration Committee for unknown reasons. Thus, the bill was not heard by the Administration Committee or given the opportunity to be voted upon by the full House of Representatives. Senate Bill 462 subsequently died in House messages.

As a result of this action, Chapter 383.410 F.S. was "sunset" on October 2, 2004. Without the confidentiality section, the State Committee cannot view important aspects of child abuse or neglect deaths. Consequently, the loss of the confidentiality section has significantly impeded the State Committee's ability to carry out its statutory function.

Action Needed/Recommendation: It is imperative that the Florida Legislature work in partnership with the Governor's office to restore the confidentiality protection necessary for a through and unbiased review of all these cases.

ISSUE 2: DROWNING DEATHS

The Child Abuse Death Review Team identified drowning as a major concern. Florida is a peninsula saturated by lakes, rivers, retention ponds, and swimming pools. Additionally, most homes have bathtubs that pose drowning risk to children who are inadequately supervised. The Vital Statistics data for 2003 shows that 381 deaths ages 0-85, were related to drowning 99 of those were between the ages of 0-10. Ten of the 35 cases reviewed by the State Child Abuse Death Review Team were related to drowning.

Action Needed/Recommendation: It is essential that preventative measures be taken to decrease the number of children drowning in Florida. These measures would include, at a minimum:

- Emphasis on drowning risk factors in all risk assessments, which the Department of Children and Families has begun to implement in their training curriculum.
- Continue public awareness and education on drowning prevention especially targeted at the under five age group.

ISSUE 3: TRAINING NEEDS

Enhancing knowledge and skills of professional and paraprofessionals who work in the discipline of child abuse and neglect is essential. Training needs include recognizing signs and symptoms of child abuse and neglect, risk assessment, and mandatory reporting requirements.

Action Needed/Recommendation:

Law Enforcement should be required to immediately report to the Hotline when a child is injured or dies due to being improperly or not restrained in motor vehicle crashes. It is only through the reporting mechanism that a true picture of this behavior's repercussions can be studied and prevented. The team also strongly encourages the enforcement of child automobile restraint laws.

Training should be provided to law enforcement officers on indicators of child abuse and neglect, including the requirements for mandatory reporting. They should fully understand the implications of risk and the need for reporting cases involving drug offenses, and cases of domestic violence where children are involved.

The team recommends that law enforcement training on child abuse and neglect, as well as domestic violence, occurs at the academy level and local agency level. It is recommended that the Standards and Training Commission require specific time frames and curriculum.

<u>Department of Children and Families Staff</u>
The team continues to recommend that child protective investigators receive training on critical decision-making. This training should include actual case scenarios whose lessons learned could be applied in the field. Domestic violence is another area in which additional training is needed. It is further recommended that Child Welfare Legal Services (CWLS) and child protective investigators review the process for child safety decision-making; and that CWLS attorneys receive training on the risk to children in domestic violence situations, as well as strategies for court intervention.

Based on recent reviews of both death and non death cases, the Department of Children and Families has identified a need for additional training for Protective Investigators to enhance core pre-service training. Protective Investigators need training in recognizing the signs of physical abuse, i.e., inflicted vs. accidental trauma. They also need specialized training in investigative interview techniques, especially, but not limited to, sexual abuse cases. Discussions on this subject have been initiated with the Florida Department of Health's Statewide Child Protection Team Medical Director and a plan for development of training is under way.

Judiciary

The team recommends that the judiciary receive training in domestic violence issues and the concurrent risk to children.

School Personnel

The team recommends that all school personnel receive training on child abuse and neglect. Training should include recognizing the signs and symptoms of abuse and neglect, mandatory reporting and the child protective investigative process. The Department of Education has, in collaboration with many professional agencies, developed a guide to child abuse and neglect mandated reporting, "Child Abuse Source Book for Florida School Personnel: A Prevention and Intervention Tool". This resource has been sent to all school districts throughout the state, and can be located on their website at http://www.firn.edu/doe/commhome/pdf/chiabuse.pdf.

ISSUE 4: FACILITATION OF COMMUNICATION

With the increased number of agencies involved in the child protection system, communication regarding the status and transfer of cases is problematic. Case planning can be difficult without valuable input and information from the various caseworkers involved with a family and can result in gaps in services that leave children at risk.

Action Needed/Recommendation: The team continues to recommend that the Department of Children and Families and its community based care providers review and, if necessary, revise their policies and procedures regarding their interagency communication, including a review of policies regarding the closure of cases in which in-home services are being provided. The team recommends that the Department of Children and Families also consider Child Protection Team recommendations prior to case closure.

ISSUE 5: SUBSIDIZED CHILD CARE

Families with children at increased risk of abuse and neglect have an ever-increasing need for adequate, affordable childcare. Parents, regrettably, often leave their children inadequately supervised due to the lack of appropriate, available caretakers.

Action Needed/Recommendation:

The team recommends that at risk children be prioritized for subsidized childcare. There should be legislative language to prioritize the at risk children. There needs to be additional funding to meet the needs of the working poor, whose children are at risk of abuse and neglect, with priority given to children who are exposed to domestic violence in their home, children of substance abusers in rehabilitation facilities, and families with a large number of children. The Team also supports quality universal pre-k for all four year olds as recommended by the State Pre-K Advisory Council.

ISSUE 6: VOLUNTARY PLACEMENTS

The State Team recognized a deficiency in the process of voluntary placement by Department of Children and Families staff. In some cases, where children are determined to be at risk with their caregivers/parents, these parents are allowed to arrange voluntary placement with relatives and or non-relatives without any court involvement. Often there is no follow up on the cases if the family chooses not to continue with the voluntary case plan. There is also inconsistency as to what cases are appropriate for voluntary supervision.

Action needed/Recommendation
The Department of Children and Families needs to address these deficiencies by either a written policy or a quality assurance procedure to ensure a reduction of risk, and the safety of these children.

ISSUE 7: CO-SLEEPING/UNSAFE ENVIROMENT

The State Team identified a significant risk of infant death related to unsafe sleeping environments. Infants were placed in unsafe positions, beds, bedding, or were co-sleeping with adults or children, that caused their death due to suffocation. In Florida, according to Vital Statistics, there were 53 deaths attributed to suffocation or strangulation. This year, Florida's Child Abuse Death Review team reviewed 4 cases of co-sleeping deaths involving children 2 months of age or younger. National statistics point to the need for training and/or education for parents, hospitals, pediatricians, law enforcement and Medical Examiners investigating these types of deaths.

Action Needed/Recommendations:

The need for training of first responders/law enforcement officers, DCF, Medical Examiners and any person/agency handling these cases need to document specific details of the sleeping environment to include infants initial position, and position found in at time of death, bed or surface infant was place on, bedding on or near infant, other persons co-sleeping with the infant, and potential substance abuse by the caretaker/parent.

Continue community awareness efforts on safe sleeping and the risk and dangers of co-sleeping. Hospitals, pediatricians, and home visiting programs should address with parents the risks associated with co-sleeping.

Home visitors in Healthy Families Florida and other home visiting programs continue to educate parents on the risks associated with co-sleeping and safe sleeping as a part of their home visiting curriculum.

8 ISSUE: CHILD ABUSE AND NEGLECT PREVENTION EFFORTS

The State Team recognizes that an effort must be made to educate professionals working in the child protection system to enable them to better understand and investigate child abuse and

neglect. However, it is equally important to be proactive and advocate for prevention initiatives, which ultimately lead to a reduction of child abuse and neglect.

Action Needed/Recommendations:
Recognizing that the ultimate solution to the problems of child abuse and neglect is prevention, the Department of Children and Families has begun several new initiatives for FY 2004-2005. Through a contract with TEAM Florida, the Department will participate in the development of a statewide Child Abuse Prevention Task Force. Mandated by Chapter 39, Florida Statutes, this Task Force will provide assistance and oversight to the development and implementation of statewide and local child abuse prevention efforts.

Additionally, through an appropriation by the legislature in 2004, the Department will contract for a statewide display of roadside billboards dedicated to the message that a baby should never be shaken. This campaign will be modeled after a similar successful one conducted in 2003 in the Suncoast Region.

The Florida Legislature is encouraged to provide funding to supplement the Federal Child Abuse and Neglect Prevention Funds that the state currently receives.

The State Team encourages the Florida Pediatric Society and the Florida Medical Examiners Commission to develop and issue position papers on the prevention of Shaken Baby Syndrome and deaths resulting from unsafe co-sleeping.

PURPOSE OF CHILD ABUSE DEATH REVIEWS

Every child death is tragic, however when a child dies from abuse or neglect, especially if that death could have been prevented, it is seemingly incomprehensible. According to the Office of Vital Statistics in Florida 3,376 children died in 2003. To better understand how and why these children die requires in-depth review of the causes and circumstances surrounding these deaths. To prevent further deaths requires a multidisciplinary approach designed to improve service delivery and linkage among the various disciplines, agencies and community partners that work with children and their families on both local and statewide levels.

Summary of Early Initiatives

While many agencies may have been involved with a child who dies as a result of abuse or neglect, the Department of Children and Families because of its' statutory mandate to investigate abuse and neglect, is most often the focus of inquiries or reviews into such deaths. Over the past 15 years, there have been at least ten such reviews of child deaths by independent panels, task forces, and Grand Juries. Five of these reviews were conducted in response to the death of a specific child, all of whom had some contact with Department prior to their deaths. The reviews that focused on specific children also focused primarily on acts or omissions by the Department and found similar, ongoing systemic issues that were thought to have contributed to the ultimate death of the children involved.

The reviews also noted concerns with other agencies or individuals involved with the deceased child. Changes in statute and internal policies within those agencies who participate in the child protection system were often initiated as a result of these reviews. All of these reviews, and their findings and recommendations can be viewed on the Internet at the following address: http://www.state.fl.us/cf_web/news/cwtfsummary.pdf

The Department of Children and Families began tracking and analyzing child abuse and neglect deaths in 1988. Using an elaborate database to identify cases needing review, quality assurance staff and the 14 district and regional child abuse death review coordinators now analyze every report made to the Abuse Hotline that alleges that a child's death was due to abuse or neglect. The results of these reviews are published annually, and information learned through this process has helped in the development of policies and procedures, as well as investigative tools such as the department's Initial Child Safety Assessment. The data in the Department of Children and Families internal death review database are used by the state Child Abuse Death Review team to identify cases for review.

STATE CHILD ABUSE DEATH REVIEW TEAM

The Florida Legislature and the Department of Children and Families has developed a number of initiatives and programs to address the issues identified as a result of previous reviews of child abuse and neglect deaths. However, after the tragic death of a six year old who was brutally murdered by her father in 1998, it became clear that these efforts fell short of their intended goal, which was to reduce child abuse and neglect deaths.

As a result of this death, and the deaths of other children due to abuse and neglect, the 1999 Florida Legislature authorized the development of independent, multidisciplinary statewide and local child abuse death review teams to review child abuse and neglect deaths in which the Florida Abuse Hotline had accepted at least one prior report of abuse or neglect. The intent of the legislature was to facilitate a better understanding of these deaths and to develop enhanced strategies for preventing future deaths by developing a multidisciplinary panel of individuals at the state and local level who had expertise in the fields directly impacting the health and welfare of children and families.[1]

Program Purpose

The State Child Abuse Death Review Team was established in statute to provide an independent objective review of child abuse and neglect deaths.. Chapter 383.402 (1) Florida Statute, (FS) identifies the purpose of the child abuse death reviews as follows:

"The purpose of the reviews shall be to:

- Achieve a greater understanding of the causes and contributing factors of deaths resulting from child abuse or neglect.
- Whenever possible, develop a community-based approach to address child abuse deaths and contributing factors.
- Identify any gaps, deficiencies or problems in the delivery of services to children and their families by public and private agencies, which may be related to deaths that are the result of child abuse.
- Make and implement recommendations for changes in law, rules, and policies, as well as develop practice standards that support the safe and healthy development of children and reduce preventable child abuse deaths."[1]

Summary of First Four Years

Until recently, the Child Abuse Death Review Team had limited jurisdiction. It was empowered to review child deaths only when the death resulted from a verified abuse or neglect maltreatment and when the deceased child had previously been referred to the Department of Children and Families child abuse hotline. Over the past five years, the deaths reviewed by the Child Abuse Death Review team represent approximately one-third of the total number of child maltreatment deaths verified in each of those years.

During the past five years, the Child Abuse Death Review Team concluded that the deaths were preventable in approximately 80 % of the cases reviewed. In those cases, the team found that the deaths could have been prevented if appropriate action had been taken either by staff

responsible for protective investigations, other state agencies, private service providers, parents, relatives, neighbors or other individuals involved with the child. The team found that some of the deaths, although due to abuse or neglect, were not preventable by anyone other than the identified caretaker responsible.

In the past four reports the Child Abuse Death Review Team made recommendations, to agencies responsible for protective investigations, and to other state and community agencies providing a variety of services to families. Many of these recommendations focused on improvement of training and/or changes in policies and practices, such as the necessity to implement a training program to increase the level of understanding of the co-existence of child maltreatment and domestic violence. Some of these recommendations have been adopted and implemented, while others have not been implemented and continue to be emphasized in the annual recommendations. The team also made recommendations pertaining to its own operations and scope of jurisdiction. A summary of all prior recommendations is available by contacting the chair. The State Team recommended to the Legislature that the death review process should include all verified cases of child abuse and neglect so that it would enhance their ability to have a better understanding of the causes and contributing factors to enable them to make effective and preventive recommendations. This recommendation was accomplished in July 2004.

Membership of the State Team

The State Child Abuse Death Review Team 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 Team 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 Child Abuse Death Review Coordinator.

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

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

In addition, the Secretary of the Department of Health is responsible for appointing the following members based on recommendations from the Department of Health and affiliated agencies, and for ensuring that the 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 Families who supervises family services counselors and who has at least five years of experience in child protective investigations
- A medical director of a child protection team
- A member of a child advocacy organization
- A social worker who has experience in working with victims and caretaker 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

The names of the current members of the State Child Abuse Death Review Team are included in Attachment 1.

Roles and Responsibilities of the State Team

The duties of the state team are to:

- Develop a standard protocol for the uniform collection of data that uses existing and tested data collection systems to the greatest extent possible.
- Provide training to cooperating agencies, individuals and local child abuse death review teams on the use of the child abuse death data protocol.
- Prepare an annual statistical report on the incidence and causes of death resulting from child abuse in the state during the prior calendar year to submit to the Governor, the President of the Senate, and the Speaker of the House of Representatives by December 31 of each year. The report must include recommendations for state and local action, including specific policy, procedural, regulatory, or statutory changes, and any other recommended preventative action.
- Encourage and assist in developing local child abuse death review teams and providing consultation on individual cases to local teams, upon request.
- Develop guidelines, standards and protocols, including a protocol for data collection for local child abuse death review teams, and provide training and technical assistance to local teams.
- Develop guidelines for reviewing child abuse deaths, including guidelines to be used by law enforcement agencies, prosecutors, medical examiners, health care practitioners, health care facilities and social service agencies.
- Study the adequacy of laws, rules, training and services to determine what changes are needed to decrease the incidence of child abuse deaths and develop strategies and recruit partners to implement these changes.
- Educate the public regarding the incidence and causes of child abuse death, and the ways to prevent such deaths.
- Provide continuing education for professionals who investigate, treat and prevent child abuse or neglect.
- Recommend, when appropriate, the review of the death certificate of a child who is suspected to have died of abuse or neglect.

LOCAL CHILD ABUSE DEATH REVIEW TEAMS

Local child abuse death review teams are an integral part of the death review process. These multidisciplinary teams have the primary responsibility for conducting the initial child abuse and neglect death reviews and forwarding their findings to the state team for review and inclusion in the annual report.

Membership of Local Death Review Teams

Local child abuse death review teams are comprised of individuals from the community who either have some responsibility when a child dies from abuse or neglect or share an interest in improving the health and welfare of children. Local child abuse death review teams should include, at a minimum, representatives from the following departments, agencies, or associations:

- District Medical Examiner's Office
- Child Protection Team
- County Health Department
- Department of Children and Families
- State Attorney's Office
- Local Law Enforcement Agency
- School District Office

The chairperson of the local team may also appoint the following members to the local team as necessary:

- A board-certified pediatrician or family practice physician
- A public health nurse
- A mental health professional who treats children or adolescents
- A member of a child advocacy organization
- A social worker who has experience in working with victims and caretaker responsible of child abuse
- A person trained as a paraprofessional in patient resources who is employed in a child abuse prevention program
- A representative of the Florida Coalition Against Domestic Violence
- A representative from a private provider of programs on preventing child abuse and neglect

Roles and Responsibilities of Local Teams

The duties of the local child abuse death review team are to:

- Review all deaths resulting from child abuse and neglect with at least one report of abuse or neglect accepted by the Florida central abuse hotline
- Collect data on applicable child abuse deaths for The State Child Abuse Death Review Team.

- Submit written reports to the state team as directed. The reports are to include information on individual cases, and steps taken by the local team to implement necessary changes and improve the coordination of services and investigations.
- Submit all records requested by The State Child Abuse Death Review Team at the conclusion of its review of a death resulting from child abuse or neglect.
- Abide by standards and protocols established by The State Child Abuse Death Review Team in the conduct of child abuse death reviews.
- Designate a team chairperson who oversees the activities of the local team and calls meetings of the team when necessary.
- Designate a member of the local team, if there is not a state team member on the local team, to liaison to the state team for the purpose of ensuring consistency in review protocols, to present case information when requested, and to request as needed on a case-by-case basis, that the state team reviews the data of a particular case.

Melissa*

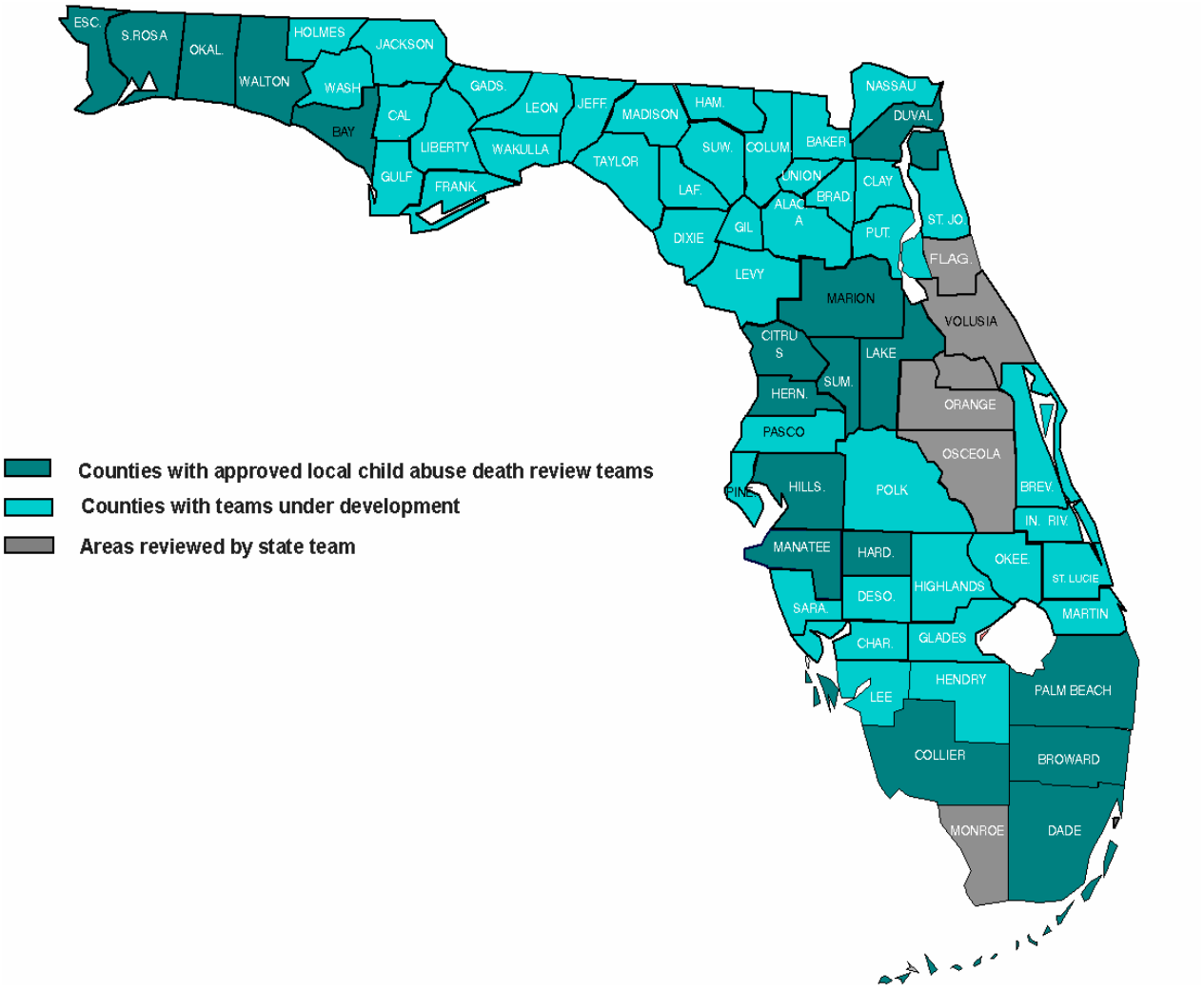
Three year old Melissa drowned in the family pool. Her adoptive mother had gone shopping, leaving Melissa in the care of her adoptive father. He stated he had been playing cards on the patio when he noticed she was missing. The pool door was not locked, and opened easily.

****Alias***

Existing and Planned Local Teams

The State Team recognized the need to establish additional local teams in order to meet the new statutory change which expanded the criteria for case reviews. Recruitment efforts were a primary focus for the State Team this year. This effort has resulted in 11 teams in various stages of development around the State. There has been a set back in getting some of the teams activated due to the loss of confidentiality Figure 1 identifies counties with existing local death review teams and those areas where teams are in various stages of development. State team members have attended community meetings and death review meetings, providing information and technical assistance to both existing and emerging local teams. Figure 1 shows those counties with existing local death review teams and those areas where teams are in various stages of development.

Figure 1: Existing and Planned Local Teams as of 2004



CHILD ABUSE AND NEGLECT DATA

Due to the past limitations of the team's statutory jurisdiction, the child abuse and neglect deaths reviewed by the state and local teams included only verified child abuse and neglect deaths in which the Department of Children and Families Child Abuse Hotline received at least one prior report. The Child Abuse Death Review Team, in its previous reports, identified this as a limitation in its 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. This smaller sample also limits the team's ability to identify patterns and trends and derive meaningful conclusions from them.

In order to overcome some of the limitations discussed above, the team's annual report compiles and aggregates the data from the deaths reviewed by the team over the past five years, resulting in an analysis of a larger sample of cases.

The following chart provides a better understanding of the current subset of the cases reviewed by The Child Abuse Death Review Team, 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. The data source for this chart is the Department of Health vital statistics, the Florida Abuse Hotline Information System (FAHIS), and the Department of Children and Families HomeSafenet Information System and Quality Assurance Child Death database.

ALL CHILD DEATHS - 2003	
Number of child deaths	3,376
FAHIS REPORTS RECEIVED & ABUSE/NEGLECT DEATHS	
Number of Initial Reports	145,649
Number of reports involving child deaths	275
Number of child death reports with verified or some indicator findings	158
Number of verified child death reports	95
Number of verified child death reports with at least one prior report, presented to the Child Abuse Death Review Team for review (to date)	35*

*Two additional death reports are pending review by the Child Abuse Death Review Team
Two 2002 death cases were reviewed in 2003; however the data for 2002 has been updated to reflect those 2 deaths

CHILD ABUSE DEATH REVIEW TEAM DEATHS

The following map, statistical reports, graphs and charts are based on a review of the child abuse and neglect deaths that occurred from 1999 through 2003. One hundred and sixty-one (161) child deaths met the criteria for review by the State Child Abuse Death Review Team. Figures 2 and 3 below indicate the counties in which the deaths occurred, and the number of deaths per county by year.

Figure 2: Location of Child Deaths (1999-2003)

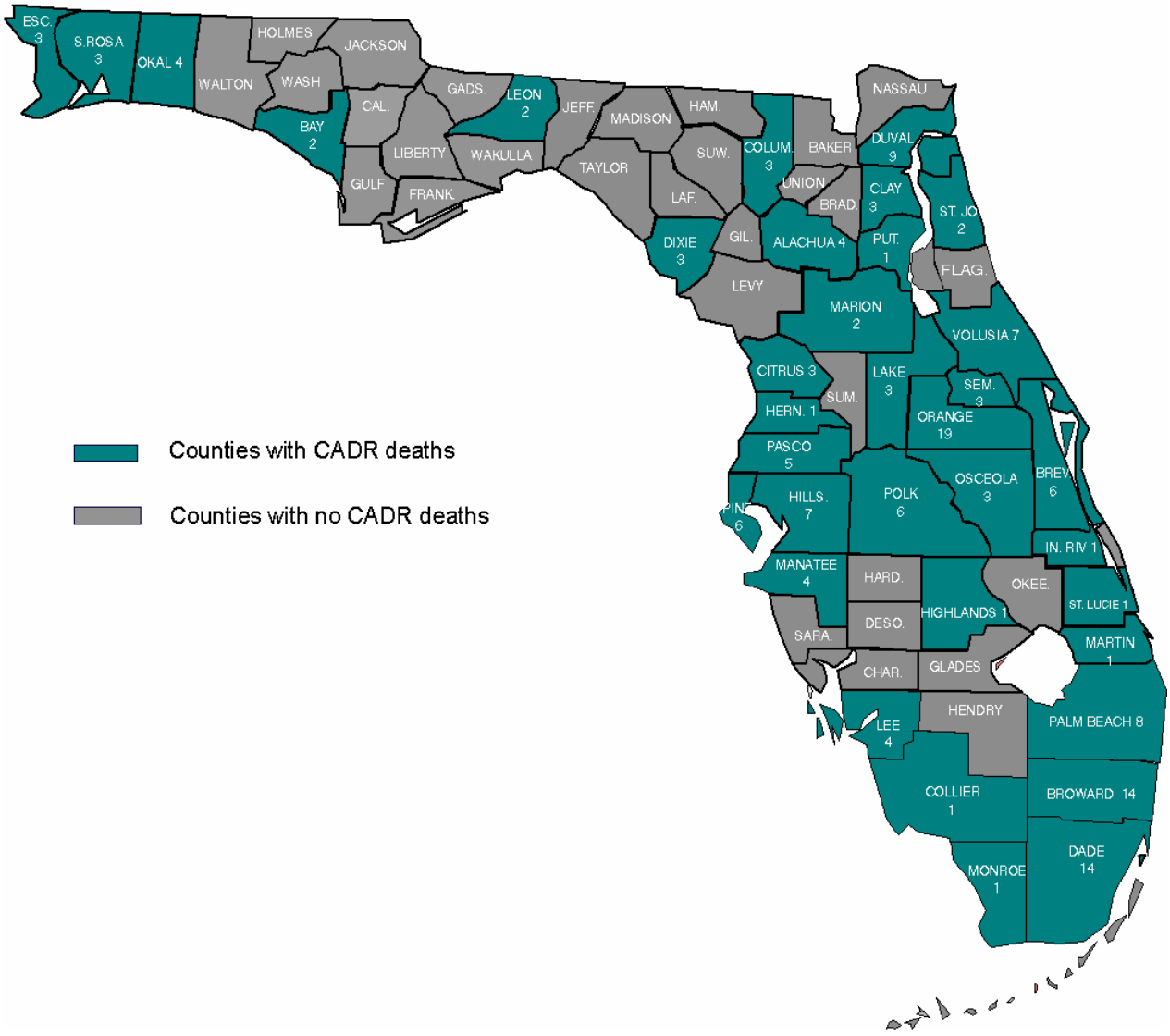


Figure 3: Number of Child Deaths by County/Year (1999 – 2003)

Number of Deaths by County													
County	Year					Total # of Deaths	County	Year					Total # of Deaths
	1999	2000	2001	2002	2003			1999	2000	2001	2002	2003	
Alachua	1	-	1	1	1	4	Leon	-	-	1	1	-	2
Bay	1	-	1	-	-	2	*Manatee	-	4	-	-	-	4
Brevard	-	-	-	1	5	6	Marion	-	2	-	-	-	2
*Broward	2	2	7	1	2	14	Martin	-	1	-	-	-	1
Citrus	-	-	1	1	1	3	Monroe					1	1
Clay	-	1	-	1	1	3	*Okaloosa	-	1	1	1	1	4
*Collier	-	-	-	1	-	1	Orange	4	2	3	2	8	19
Columbia	-	1	-	1	1	3	Osceola	2	-	-	-	1	3
*Dade	3	3	-	5	3	14	*Palm Beach	4	-	1	2	1	8
Dixie	3	-	-	-		3	Pasco	1	-	1	3	-	5
*Duval	3	2	3	-	1	9	Pinellas	1	3	1	-	1	6
*Escambia	-	1	-	2		3	*Polk	-	2	-	1	3	6
Hernando	-	-	-	-	2	2	Putnam	-	1	-	-	-	1
Highlands	-	-	-	1	-	1	*Santa Rosa	-	1	-	2	-	3
*Hillsborough	-	2	4	1	-	7	Seminole	-	-	-	2	1	3
Indian River	-	-	-	1	-	1	St. John	1	-	1	-	-	2
Lake	1	-	2	-	-	3	St. Lucie	1	-	-	-	-	1
*Lee	1	-	3	-	-	4	Volusia	1	-	4	1	1	7
* = Counties with local CADR teams													

Steven and Mike*

Six year old Steven and three year old Mike died in their father's car after he poured gasoline over them, set them afire, and crashed into their maternal grandmother's home. The father and both children died.

Alias

CHILD ABUSE DEATH REVIEW DATA

In the following sections, data are presented from the findings of the local and state child abuse death review teams over the past four years. Graphs depict the four-year aggregate data, and are accompanied by charts that provide the breakdown of the data by year of death. National data is included when available; however, differences in review processes, policies, state laws, and child abuse and neglect definitions affect the ability to compare state and national data and presents challenges in trend analysis.

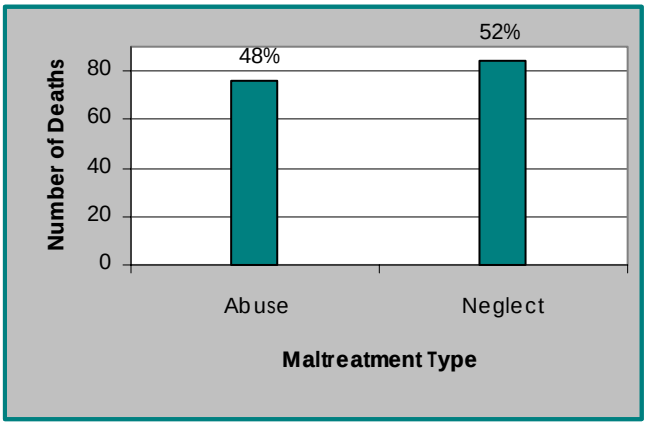
Number of Child Abuse and Neglect Deaths

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…"[2]

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"[2]

A high representation of neglect deaths in Florida's child abuse death reviews may be due to the population included in this study. Since the child deaths that were reviewed involved children who had previously been the subject of a report to the abuse hotline, the prior report may have served to substantiate the death maltreatment by revealing a pattern of failure to provide reasonable care or supervision. The number of deaths by category for the aggregate four-year period is shown in Figure 4.

Figure 4: Abuse & Neglect Deaths (1999-2003)



	Type of Death		
	Abuse	Neglect	Total
1999	16	14	30
2000	14	16	30
2001	19	16	35
2002	15	16	31
2003	13	22	35
Total	77	84	161

Aggregate data indicates that the deaths were equally caused by abuse and neglect for the first four years. For each of those annual periods, the difference between deaths due to abuse and those due to neglect varied from 55% to 45%, with the major cause of death alternating

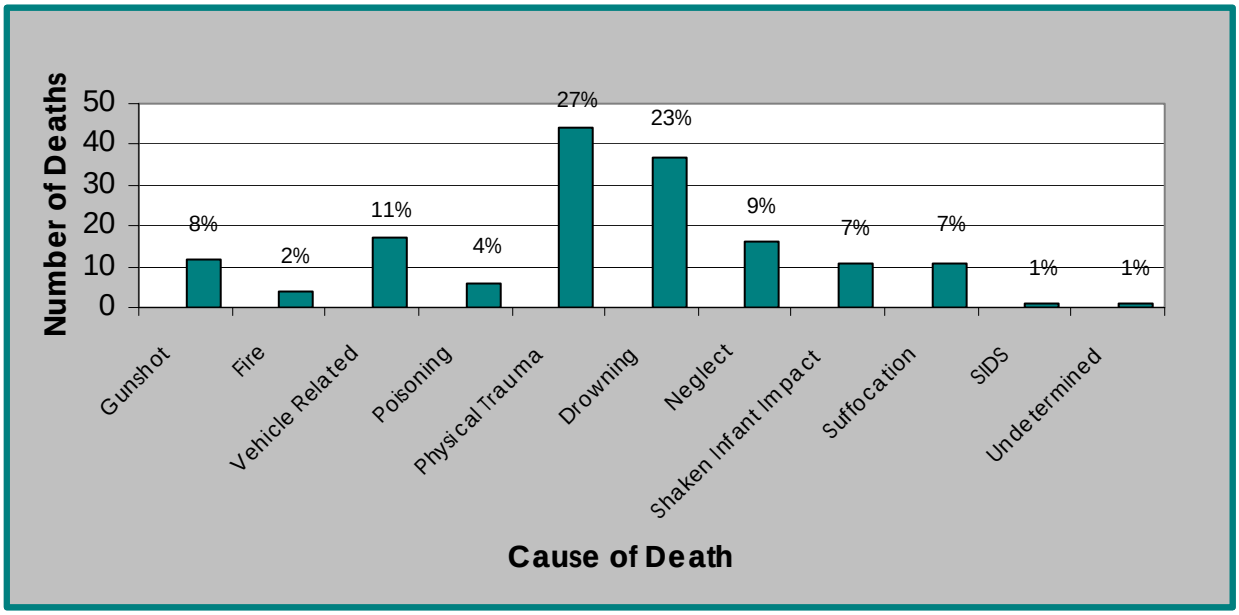
annually. However, neglect maltreatment (63%) was significantly larger than abuse (37%) for the 2003 deaths.

The NACANDS data for 2002 indicates more than 38 percent of child maltreatment fatalities were associated with neglect alone, 30 percent with abuse alone, and 29 percent were the result of multiple maltreatment types. The remaining 3 percent were due to either sexual or psychological maltreatment.

Cause of Death

Abuse and neglect are broad categories of child endangerment, each including multiple specific maltreatments. The review team analyzed the specific maltreatment breakdown within the abuse and neglect categories. The number of deaths by maltreatment is included in Figure 5.

Figure 5: Cause of Child's Death (1999-2003)



Cause of Child's Death							
	1999	2000	2001	2002	2003	Total	%
Gunshot	6	1	2	1	3	13	8%
Fire	4	0	0	0	0	4	2%
Vehicle Related	3	3	5	3	3	17	11%
Poisoning	3	0	0	2	1	6	4%
Physical Trauma	5	11	15	7	6	44	27%
Drowning	3	10	4	10	10	37	23%
Neglect	2	1	4	3	5	15	9%
Shaken Infant Impact	2	2	1	4	3	12	7%
Suffocation	1	2	4	1	3	11	7%
SIDS	0	0	0	0	1	1	1%
Undetermined	1	0	0	0	0	1	1%
	30	30	35	31	35	161	100%

Aggregate data includes the following trends:

- The leading cause of deaths (27%) was physical trauma.
- The second leading cause of deaths (23%) was drowning, some due to abuse and some due to neglect.
- The majority of the neglect deaths reviewed for the five-year period were attributed to inadequate supervision, resulting in deaths from drowning, asphyxiation, house fire, or accidental gunshot wounds.
- There were at least 10 additional deaths in which children died from illness or medication toxicity, both medical neglect and lack of supervision contributed to these deaths.
- Gunshot wounds were the cause of 13 deaths. This cause of death peaked in 1999, and declined in subsequent years.

Data for 2003 indicated that of the 35 deaths reviewed by the team, the causes and contributing factors included:

Abuse (13 deaths)

- The majority of the abuse deaths involved direct attacks resulting in physical trauma. Of the 6 trauma related deaths, 3 children died from head trauma and 3 from multiple traumas.
- 3 children died from shaking/impact.
- 2 children died with their father after he poured gasoline on the car and crashed it into a home
- 2 children died from a gunshot, homicide.

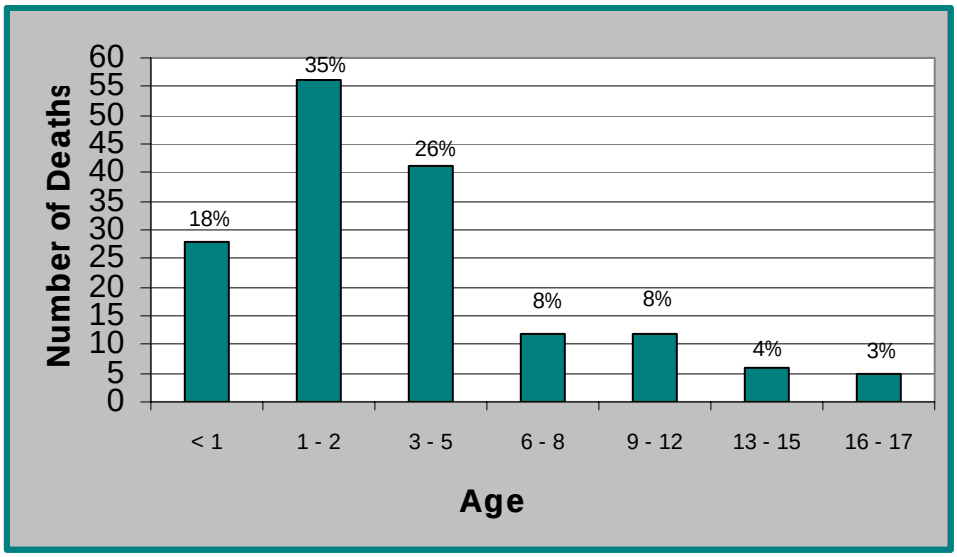
Neglect (22 deaths)

- 9 children accidentally drowned. Seven drowned in swimming pools, 1 in a canal and 1 in a pond. Inadequate supervision by the caretaker responsible contributed to these deaths.
- 1 child died in a vehicle related accident, the child was run over by a mail truck. Inadequate supervision contributed to the death.
- 2 children died due to hyperthermia. One child was left by day care staff in a van and the other climbed into a rental car at the home while an aunt was babysitting. Inadequate supervision contributed to these deaths.
- 1 child residing in a detention died due to medical neglect by facility staff.
- 1 child was accidentally shot by her sibling and died from the gunshot wound.
- 4 children died while co-sleeping with their parent(s)
- 1 child was starved to death
- 1 child died from carbon monoxide poisoning in a house fire set by a sibling
- 1 child died from intentional poisoning/ overdose by the adoptive parent.

Age at Death

Age is a factor in the analysis of risk due to abuse or neglect. Florida statute identifies children under the age of six as being at greater risk by requiring professional medical evaluation on any child under this age with alleged injuries. Figure 6 provides a specific breakdown of age at death for these 161 children.

Figure 6: Age at Death
(1999-2003)



Age of Child at Death						
	1999	2000	2001	2002	2003	Total
< 1	3	4	6	7	8	28
1 - 2	9	10	16	11	11	57
3 - 5	8	9	7	7	10	41
6 - 8	6	2	0	3	1	12
9 - 12	1	3	3	2	3	12
13 - 15	1	2	2	1	0	6
16 - 17	2	0	1	0	2	5
	30	30	35	31	35	161

Reviews by The Child Abuse Death Review Team in Florida for the 1999 through 2003 five-year period indicate that, of the children who died, 126 (78%) were under the age of six, 98 (60%) were between the ages of one and five, and 28 (17%) were under the age of one year.

Of the child deaths reviewed for 2003, 29 (18%) were under the age of six, 21 (14%) were between the ages of one and five, and 8 (23%) were under the age of one year.

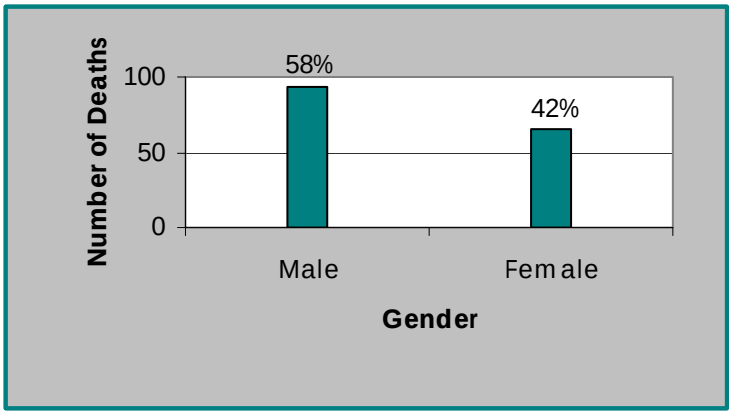
National research indicates very young children (ages 3 and younger) are the most frequent victims of child Fatalities. NACANDS data for 2002 indicated children younger than 1 year accounted for 41 percent of fatalities, while children younger than 4 years accounted for 76 percent of the fatalities. This population of children is the most vulnerable for many reasons, including their dependency, small size and inability to defend themselves.

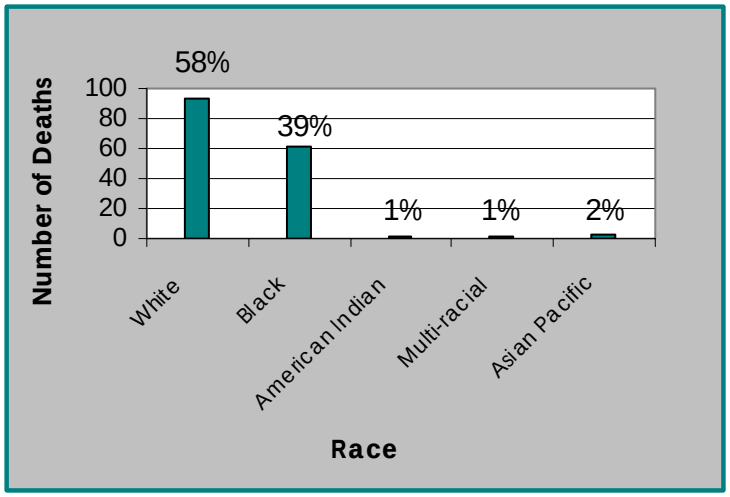
The number of deaths involving children under the age of one reviewed by Florida's child abuse death review team is significantly lower than the national average. This may be related to the statutory requirement of a prior report on the victim to the child abuse hotline, because children under one year are less likely to have been previously reported.

Race and Gender

For the 161 deaths reviewed during the four-year period, 94 (58%) were male, and 67 (42%) were female. For these deaths 93 (58%) of the children were white, 63 (39%) percent were black, 1 (1%) was multi-racial, 1 (1%) was American Indian and 3 (2%) were Asian Pacific. When a specific ethnicity was identified, a total of 17 (25%) were identified as Hispanic and 6 (9%) were identified as Haitian. Figure 7 provides the aggregate data and breakdown by year for these factors.

Figure 7: Race and Gender of Child at Death (1999-2003)





Gender of Children			
	Male	Female	Total
1999	20	10	30
2000	18	12	30
2001	19	16	35
2002	18	13	31
2003	19	16	35
Total	94	67	161
%	58%	42%	100%

Race of Children						
	White	Black	American Indian	Multi-racial	Asian Pacific	Total
1999	16	14	0	0	0	30
2000	23	7	0	0	0	30
2001	17	17	1	0	0	35
2002	19	10	0	1	1	31
2003	18	15	0	0	2	35
Total	93	63	1	1	3	161
%	58%	39%	1%	1%	2%	100%

Raymond*

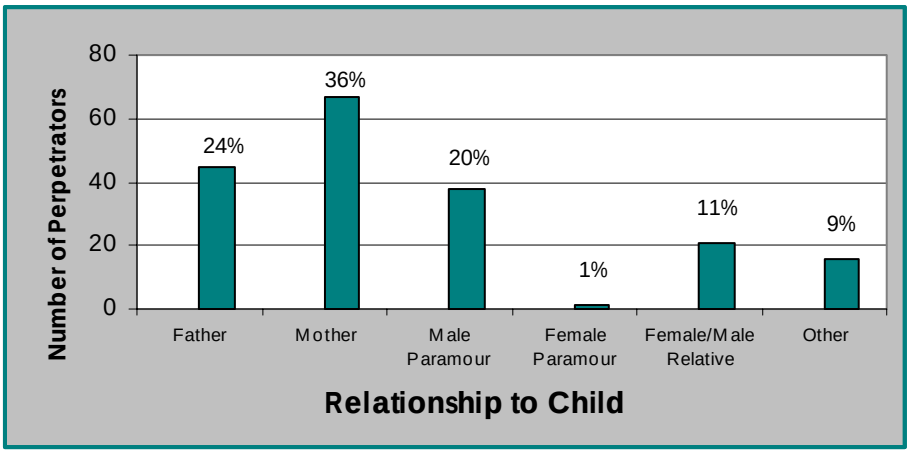
Three year old Raymond died from hyperthermia. He and four other children were transported to a child care center in a van driven by the owner's daughter. Two hours later, Raymond's sibling noticed he was missing and a search ensued. The center's owner found Raymond in the van.

****Alias***

Relationship of Caretaker Responsible for Abuse or Neglect

Child protection professionals have identified the relationship of caretakers as one of the factors to consider when evaluating risk. Children in the care of their parent's paramours are generally considered at higher risk. A breakdown of the number of deaths by caretaker responsible is shown in Figure 8.

Figure 8: Caretaker Responsible for Abuse or Neglect
Relationship to Child
(1999-2003)



Relationship of Caretaker Responsible to Child							
	1999	2000	2001	2002	2003	Total	%
Father	9	11	9	7	9	45	24%
Mother	13	11	15	14	15	68	36%
Male Paramour	9	8	10	6	5	38	20%
Female Paramour	0	0	0	1	0	1	1%
Female/Male Relative	5	6	4	2	4	21	11%
Other	1	1	5	2	7	16	8%
	37	37	43	32	40	189	100%

For the 161 deaths reviewed during the five-year period, 189 perpetrators/caretakers responsible were identified. Mothers were involved in or responsible for 68 (36%) of the 161 deaths reviewed, fathers for 45 (24%) of the deaths, and male paramours for 38 (20%) of the deaths and female paramour 1 (1%). The majority of the deaths in which the mother was the sole caretaker responsible were caused by neglect. The majority of the deaths in which the father or male paramour was the sole caretaker responsible were caused by abuse.

For the deaths reviewed in 2003, mothers were involved in or responsible for 15 (42%), fathers for 9 (26%) of the deaths, and male paramours for 5 (14%) of the deaths. This does not significantly differ from the aggregate data.

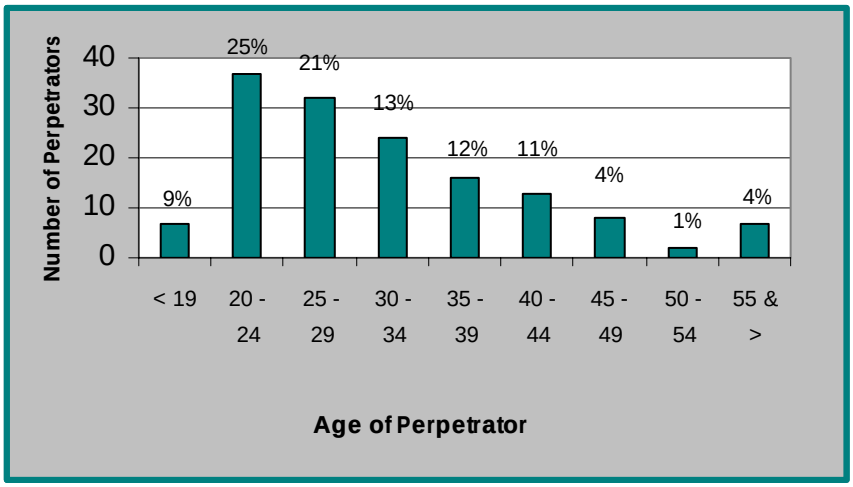
Age of Caretaker Responsible for Abuse or Neglect

Data for the five-year period (161 deaths) indicated that the 189 perpetrators/caretakers responsible ranged in age from 17 to 79, with 86 (53%) under the age of 30 years.

For the year 2003, the 40 perpetrators/caretakers responsible of the 35 deaths ranged in age from 19 to 44, with 24 (60%) under the age of 30 years.

Florida's 2003 and aggregate data varies slightly higher than national reports that indicate the perpetrators/caretakers responsible of maltreatment fatalities are generally young. "In 1998 nearly two thirds (62%) of the persons responsible for child abuse and neglect deaths nationally were younger than 30 years of age…."[5] This factor may also be affected by the narrow criteria for Florida's reviews. Very young children who died due to abuse or neglect, but did not meet the criteria for review because they had no prior reports, may also have had a higher percentage of young parents who were the caretaker responsible. Figure 9 shows the age, by category, of the caretaker responsible for these deaths.

Figure 9: Age of Caretaker Responsible for Abuse or Neglect (1999 – 2003)



Age of Perpetrator							
	1999	2000	2001	2002	2003	Total	%
19 and <	1	0	5	1	9	16	9%
20 thru 24	8	6	10	14	9	47	25%
25 thru 29	10	9	9	4	7	39	21%
30 thru 34	4	3	14	4	0	25	13%
35 thru 39	7	6	2	1	7	23	12%
40 thru 44	2	3	2	6	8	21	11%
45 thru 49	2	4	1	1	0	8	4%
50 thru 54	1	1	0	0	0	2	1%
55 & >	2	4	0	1	0	7	4%
Total	37	36	43	32	40	188	100%

Caretaker Responsible for Abuse or Neglect History

Specific data regarding caretaker responsible history of domestic violence, alcohol and substance abuse, and criminal activity was gathered over the five-year period. Based on the information gathered:

- 88 (55%) of the perpetrators/caretakers responsible had criminal records.
- 53 (33%) of the perpetrators/caretakers responsible had a history of substance abuse.
- 34 (21%) of the perpetrators/caretakers responsible had a history of alcohol abuse.

Domestic violence is often a factor in child abuse deaths. This type of abuse can begin with the battering of a spouse, then spread to include other household members, including children. A review of the caretaker responsible history for the aggregate period indicated that:

- 60 (37%) of the perpetrators/caretakers responsible were also perpetrators of domestic violence.
- 41 (25%) of the perpetrators/caretakers responsible were also victims of domestic violence.

According to the National Clearinghouse on Child Abuse and Neglect, child physical abuse deaths are the most baffling. But some answers are being provided by new research and analysis of data emerging from Child Death Review Teams, for example, states such as Colorado and Oregon have identified specific "triggers" that occur just before many fatal parental assaults on infants and young children. They include the following:

- An infant's inconsolable crying
- Feeding difficulties
- A toddler's failed toilet training
- Exaggerated parental perceptions of acts of "disobedience"

The purpose of the protective investigation, triggered by a call to the child abuse hotline, is to gather information from a variety of sources to evaluate the safety of the child and determine if removal is necessary to protect the child from further harm. Information gathered should be used to assess the safety of the child and will include:

Justin*

Two year old Justin drowned in a canal. His mother stated she couldn't find him when she awakened at 9 AM. The doors to the home were not locked and there was no secure gate.

Alias

- A history of criminal conduct
- Whether law enforcement should take the lead, or be involved in the investigation
- If maltreatment has occurred
- The likelihood that the problem will continue or escalate
- Immediate measures necessary to ensure child safety, including the need for removal and placement
- Whether follow up visits or protective supervision is necessary
- Intervention strategies needed if the child remains in the home

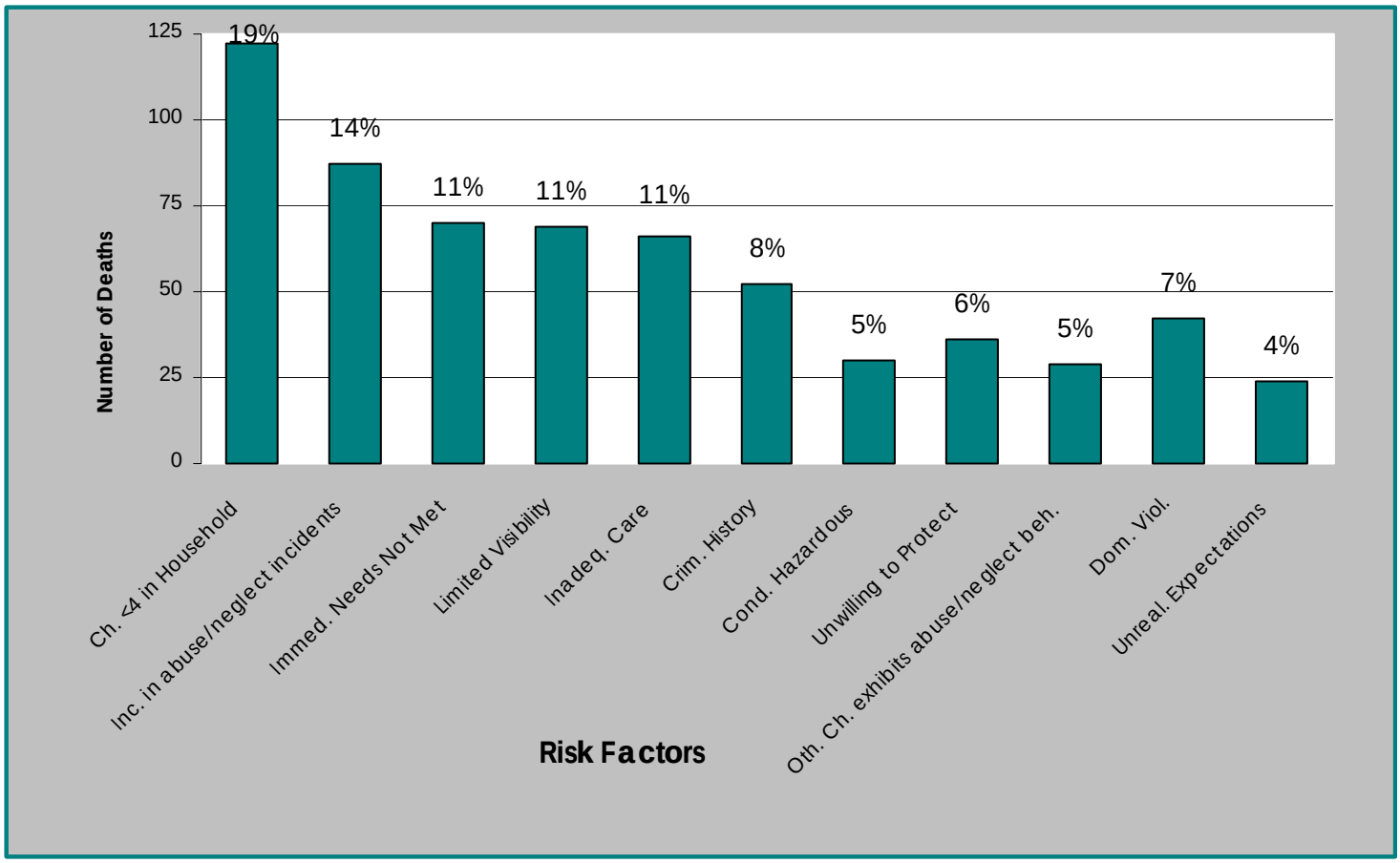
All cases meeting the criteria for this review involved a prior report of abuse or neglect. Other specific risk factors identified during the review process included:

- Child in the home under the age of four years (78%)
- Patterns of escalating and/or increased frequency of incidents of abuse or neglect (45%)
- Children with limited community visibility (43%)
- Parent/Caretaker has not met or is unable to meet immediate needs for food/clothing/shelter/medical care, or protect from harm (43%)
- Parental limitations in ability to adequately parent due to age, mental capacity or substance abuse (42%)
- Criminal history of caretaker responsible or other adult in the home (33%)

Fifty-seven (57%) of the 161 children had five or more family risk factors present at the time of death. Of the children who died in 2003, 18 children (51%) had five or more family risk factors. Figure 10 shows the major family risk factors identified for the deaths reviewed by the Florida Child Abuse Death Review Team.

Figure 10 shows the major family risk factors identified for the deaths reviewed.

Figure 10: Family Risk Factors for Child Victims (1999-2003)



Risk Factors in 2003 Child Abuse Deaths						
	1999	2000	2001	2002	2003	Total
One or more children in the household age 4 or younger	20	25	29	24	25	123
A pattern or escalating and/or frequency of incidents of abuse or neglect	13	14	19	12	29	87
Parent or caregiver is unable to meet child(rens) immediate needs	12	14	15	14	15	70
Child(ren) in the home have limited community visibility	12	12	16	15	14	69
Parents or caregiver's age, mental health, alcohol or substance abuse affects ability to pare	10	12	19	11	14	66
Criminal history on any household member	6	12	13	7	14	52
Conditions in the home are hazardous to child's health	8	7	6	7	2	30
Parent or caregiver is unable or unw illing to protect the child(ren)	4	8	10	9	5	36
Other child(ren) in home exhibit behaviors indicative of abuse or neglect	6	6	4	8	5	29
Domestic violence in the home	5	6	14	6	11	42
Parent or caregiver has unrealistic expectations of child(ren)	2	8	6	5	3	24

Team Conclusions/Adequacy of Prior Interventions

Review teams were asked to identify the interventions and services provided prior to the child's death, to identify needed improvement in these services. In determining adequacy, the team looked at whether the services provided addressed the needs of the family at the time of the service provision.

For the 35 child deaths in 2003, in addition to the prior investigations, 29 victims received a total of 35 direct services from either the Department of Children and Families, or community service providers, including but not limited to substance abuse treatment, mental health treatment, parenting classes or domestic violence intervention classes. Of the services provided to these victims or their families:

- 56% were found to have been adequate
- 29% were found to have been inadequate
- 15% were of unknown adequacy (some of which were unanswered, perhaps due to a lack of information)

The breakdown of services by agency/organization is as follows:

- Department of Children and Families in 22 cases
  Found to have been adequate in 11cases (50%) and inadequate in 6 cases (27%)
- Department of Health in 5 cases
  Found to have been adequate in 4 cases (80%) and inadequate in 1 case (20%)
- Child Protection Teams in 7 cases
  Found to have been adequate in 5 cases (71%) and inadequate in 2 cases (29%)
- Department of Juvenile Justice in 3 cases
  Found to have been adequate in 1 case (33%) and inadequate in 2 cases (67%)
- Mental Health Agencies in 3 cases
  Found to be adequate in 1 case (33%) and inadequate in 2 cases (67%)
- Other Service Providers in 8 cases
  Found to be adequate in 5 cases (63%) and inadequate in 1 case (13%)

In 7 (20%) of these 35 provisions of services, reviewers were unable to determine the adequacy based on the information made available to the team for review. Information in the files provided, both from the service providers and the case managers, was at the time either missing or incomplete.

Team Conclusions/Issues Identified

In analyzing the data available for the 35 deaths reviewed for 2003, the state and local teams identified issues in the following areas, some of which had been identified by the Department of Children and Families internal death review teams and were taken directly from their reports:

- Protective investigations, which included the following concerns:

  - Standards are needed regarding collateral contact requirements, such as determining needed contacts based on the complexity of the case, making appropriate contact with law enforcement, and requiring multi-disciplinary staffings for children who are substance exposed or who have special health care needs.
  - Standards for investigation are needed for cases involving domestic violence, and domestic violence safety assessments are needed.
  - Protective investigators need quick and reliable access to all criminal history information, and should obtain and include essential law enforcement information to assess child safety.
  - Protective investigators should follow policy to ensure reports are referred to the Child Protection Team, and should review all recommendations of the team prior to case closure.
  - Removal or other intense intervention should be carefully considered in cases with numerous priors.
  - Cases involving numerous priors, domestic violence, substance abuse and mental health issues, or other high risk factors should be staffed with the dependency attorney. Multi-disciplinary staffings should be held when the attorney determines additional evidence is needed for legal sufficiency to file a dependency petition.
  - The Department of Children and Families should develop a procedure and written policy to assure the safety and risk to children are not compromised where voluntary placement and or supervision is made.
  - Requests for psychological evaluations and other professional assessments should be case specific and the recommendations stemming from these assessments should be incorporated into the case plan when appropriate.
  - Supervisory case review should be timely.

Local law enforcement agencies are currently responsible for protective investigations in Manatee, Pinellas, Broward, Pasco and Seminole counties. The Department of Children and Families is responsible for protective investigations in the remaining counties.

- Law enforcement, which included the following concerns:

  - Reporting issues, i.e. lack of training on reporting and failure to report child abuse or neglect to the child abuse hotline by Florida Highway Patrol officers, narcotic offers and homicide investigators
  - Need for training on suicide prevention and lethality assessment.
  - Need for increased enforcement of vehicle child restraints, and need for increased reporting child neglect hotline for unrestrained minor involved in traffic violations and accidents.
  - Lack of referral for criminal prosecution.

- Provision of Services, which included the following concerns:

- Lack of cooperation in voluntary cases should prompt updated risk assessment and legal staffing to determine necessary action.
- Improvement is needed in communication within and between agencies regarding service provision and case closure.

- Department Policies/Practices, which included the following concerns:

  - Child Protection Teams should develop policy regarding medical evaluation to ensure that client history and social assessment information is available to medical staff and included in the assessment determination.
  - Department of Health service providers, including but not limited to Healthy Start, should require initial and ongoing training on recognizing and reporting child abuse and neglect for staff working with children.
  - Medical Examiners failure to complete cause of death and/or date of injury.
  - Medical Examiners commission should collect the data for sleeping infant deaths or circumstances of the death state wide.

Degree of Preventability

The sample reviewed was limited to deaths resulting from physical abuse or neglect in which at least one prior report to the abuse hotline on the victim had been received. Therefore, all of these children had received some level of intervention from either the Department of Children and Families or local law enforcement agency responsible for protective investigations. Additionally, because of the investigations, many of these children had been referred for other community services provided by the Department of Health, Child Protection Teams, or other community based care providers.

Based on the information provided, the team determined whether the child's death was preventable, by either a caregiver, or the "system", which could include the child protection system or other various service agencies involved with the family. To determine a death was definitely preventable, the information provided had to demonstrate clearly that steps or actions could have been taken, either by the various agencies previously involved with the family, the non-offending caretaker responsible for the child, or by family members or other individuals who may have had knowledge of the abuse or neglect, that could have prevented the death from occurring. In this instance, predictability is a strong factor in evaluating preventability. It is important to look, not only at what actions may have prevented the incident leading to the death, but to also determine whether a reasonable person should have anticipated the need for such action.

Stacy*

Two month old Stacy died from suffocation. She had slept with her mother and father in their bed, although there was a crib in the home. The father stated that everything was fine when he awakened at 6 AM to go to work. When mother awakened later, she noticed that Stacy was unresponsive.

**** Alias***

The State Child Abuse Death Review Team assessed preventability, by both the caregiver and the system in 35 of deaths reviewed and concluded that:

- 30 (81%) were definitely preventable by a caretaker not responsible for the death
- 10 (27%) were definitely preventable by the system
- 1 (5%) were possibly preventable by a caretaker not responsible for the death
- 2 (3%) were possibly preventable by the system
- 2 (5%) were not preventable

Of the cases determined to be definitely preventable, 12 were found to have been preventable by both the caregiver and the system (32%).

Criminal Status

As part of the process of gathering data on child abuse deaths, the state team began to track these cases through the criminal justice system. Criminal prosecution of the caretaker responsible charged does not always occur quickly, some cases take several years to reach disposition. The Department of Children and Families Quality Assurance Unit currently tracks criminal history information in their death database. Based on this information, and information gathered from the other sources, The State Child Abuse Death Review Team has collected the following highlights:

- In 55 of the 161 cases there was either no charges filed or the case was nol-prossed
  - 3 of the caretakers responsible committed suicide at the time of the child's death
  - 1 caretaker responsible was found incompetent

- 86 were criminally charged, of those
  - 51 were charged with murder
  - 16 were charged with manslaughter
  - 19 were charged with negligence or other charges

Criminal cases have been completed on 19 of the individuals charged and resulted in:

- 5 convictions of murder
- 5 convictions of manslaughter
- 9 convictions of child abuse, negligence or other charges

Note: Overlap exists in the criminal data because some individuals were charged and convicted for multiple offenses.

The State Child Abuse Death Review Team voted not to complete a detailed analysis of criminal convictions due to the limited data available; however the state team will continue to track this information for future analysis.

Status of 2003 Report Recommendations

ISSUE 1: NOT ALL VERIFIED CHILD DEATHS REVIEWED

In the past the Child Abuse Death Review Team identified a significant problem in the scope of the deaths reviewed. Currently, verified child deaths are only reviewed if the child had a prior abuse or neglect report with the Department of Children and Families, thereby excluding many child victims. If all verified child abuse and neglect deaths were reviewed, the teams would have a better understanding of causes and contributing factors, thereby enhancing their ability to make effective preventive recommendations.

Recommendation/Action Taken: The State Child Abuse Death Review Team made the recommendation to the Florida Legislature that the child abuse and neglect death review process should be expanded to include all verified cases of child abuse and neglect. The Legislature expanded the role of the State Team to review all verified deaths effective 7/1/2004.

ISSUE 2: DROWNING DEATHS

The Child Abuse Death Review Team identified drowning as a major concern. Florida is a peninsula saturated by lakes, rivers, retention ponds, and swimming pools. Additionally, most homes have bathtubs that pose drowning risk to children who are inadequately supervised. Figures for 2002 indicated that at least 78 children died as a result of verified abuse or neglect, and of those 78 children, 14 died as a result of drowning, representing 21% of all verified child abuse and neglect deaths in the state.

Recommendation/Action Taken: It is essential that preventative measures be taken to decrease the number of children drowning in Florida. These measures would include, at a minimum:

- Emphasis on drowning risk factors in all risk assessments, which the Department has begun to implement this in their training curriculum.
- Continue public awareness and education on drowning prevention especially targeted at the under five age group.

Healthy Families Florida and Healthy Start programs now have check lists that are filled out at home visits which address pool and any water safety issues. The State Team, the Department of Health and the Ounce of Prevention collaborated to produce public service announcements through out the state of Florida.
Currently, Department of Children and Families requires that all foster parents who have a swimming pool attached to their home take an approved water safety course and provide assurances that their pool is fenced. New Rules that will go into effect in 2005 will require all foster parents licensed by the department to take the water safety course, regardless of whether they have a pool. Emphasis on water safety and drowning prevention will be added to a revised core curriculum under development for all new Protective Investigators and counselors.

ISSUE 3: CASE SPECIFICITY/CASE PLANS

Individualized and specific case plans were identified as a priority need by the Child Abuse Death Review Team. It was discovered that often, psychological evaluations and reports were not case specific, and case plans did not require follow-up on the psychological evaluation recommendations.

Recommendation/Action Taken:
The Department of Children and Families is revising the core training for Protective Investigators, counselors and Supervisors and is expected to be completely revised and implemented by July 1, 2005. The contract with the Professional Development Center for training all Department of Children and Families staff has ended and interim contracts with several state Universities are in place. The new core training will address the issue of case plans tailored for each individual child and family. (See Attachment II)

ISSUE 4: TRAINING NEEDS

Additional training is needed for various professional and paraprofessional positions. Training needs include recognizing signs and symptoms of child abuse and neglect, risk assessment, and mandatory reporting requirements.

Training is an on-going need for various professional and paraprofessional positions. Training needs include recognizing signs and symptoms of child abuse and neglect, risk assessment, and mandatory reporting requirements.

Recommendation/Action Taken:

- Law Enforcement

The team recommended that law enforcement and 911 operators receive additional training in suicide prevention and intervention, and recognition of risk factors by means of lethality assessments. Because telephone 911 operators and law enforcement officers are usually the first people exposed to potentially lethal situations they need to be highly trained to recognize these risk factors and take appropriate action.

Law enforcement should also be required to immediately report to the Hotline when a child is injured or dies due to being improperly or not restrained in motor vehicle crashes. It is only through the reporting mechanism that a true picture of this behavior's repercussions can be studied and prevented. The team also strongly encourages the enforcement of child automobile restraint laws.

Training should be provided to law enforcement officers on indicators of child abuse and neglect, including mandatory reporting. They should fully understand the implications of risk and the need for reporting in cases of drug offenses, and cases of domestic violence where children are involved.
The team recommended that the law enforcement training on child abuse and neglect, as well as domestic violence, take place at the academy level and at local agency level. It is recommended that the Standards and Training Commission require specific time frames and curriculum.

Status

Training for Homicide investigators was scheduled however due to the hurricane damage had to be cancelled. It will be rescheduled for the spring and Florida Department of Law Enforcement (FDLE) jointly with the QA coordinator the State Child Abuse Death Review Team will train on the mandatory reporting of child deaths and the impact of Child Abuse Death Review Teams.

FDLE has provided ten trainings to 1,400 participants, to include the Department of Children and Families LEO, School resource officers, Psychological Associates, Child Protection Teams, Guardian Ad Litem's and Community Based Care providers. These trainings will continue through out the state to law enforcement officers on child abuse and neglect including the impact of domestic violence to children.
Training on Sudden Infant Death during Sleep was provided to 52 participants to include law enforcement officers, child protection and victim advocates by the State Team representative for law enforcement.

- Department of Children and Families Staff

The team recommended that child protective investigators receive training on critical decision-making. This training should include actual case scenarios whose lessons learned could be applied in the field. Domestic violence is another area in which additional training is needed. It is further recommended that Child Welfare Legal Services (CWLS) and child protective investigators review the process for child safety decision-making; and that CWLS attorneys receive training on the risk to children in domestic violence situations, as well as strategies for court intervention.

Status

The Department of Children and Families is in the process of revising the core training for Protective Investigators and counselors that is expected to be implemented by July 1, 2005. The contract with the Professional Development Center for training all the DEPARTMENT OF CHILDREN AND FAMILIES staff has ended and interim contract with several Universities are in place. The new training curriculum will include expanded training for Child Welfare Legal Service attorneys. This will support consistency between case planning and legal representation.(See Attachment II)

- Judiciary

The team recommended that the judiciary receive training in domestic violence issues and the concurrent risk to children.

Status

The State Team needs to pursue partnerships with Universities, Collages and other professional agencies to develop training for the Judiciary pertinent to child deaths.

- School Personnel

The team recommended that all school personnel receive training on child abuse and neglect. Training should include recognizing the signs and symptoms of abuse and neglect, mandatory reporting and the child protective investigative process.

Status

The team recommends that all school personnel receive training on child abuse and neglect. Training should include recognizing the signs and symptoms of abuse and neglect, mandatory reporting and the child protective investigative process. The Department of Education has in collaboration with many professional agencies developed a guide to child abuse and neglect mandated reporting, "Child Abuse Source Book for Florida School Personnel: A Prevention and Intervention Tool". This has been sent to all school districts through out the state. The web site is http://www.firn.edu/doe/commhome/pdf/chiabuse.pdf.

ISSUE 5: FACILITATION OF COMMUNICATION

With the increased number of agencies involved in the child protection system, communication regarding the status and transfer of cases is problematic. Case planning can be difficult without valuable input and information from the various caseworkers involved with a family and result in gaps in services that leave children at risk.

The team recommended that the Department of Children and Families and its community based care providers review and if necessary, revise their policies and procedures regarding their interagency communication, including a review of policies regarding the closure of cases in which in-home services are being provided. The team recommends that the Department of Children and Families also consider Child Protection Team recommendations prior to case closure.

Recommendation/Action Taken:
The Department of Children and Families has put into the new core training segments addressing communication between their staff and service providers, including the Child Protection Teams.

The Department of Children and Families has committed to re-establishing the practice of regular meetings with Department of Health to discuss ongoing issues. The first such meeting was scheduled for early December 2004 and staff will meet no less frequently than quarterly.

The Department of Health has initiated new processes for the Child Protection Teams to get critical information back to the Department of Children and Families in a timely manner.

ISSUE 6: ACCESSIBILITY OF CRIMINAL HISTORY

Although the Department of Children and Families has some access to criminal information, improvement is needed in the speed and accuracy of this information.

The team recommended that the Department of Children and Families be granted access to all criminal histories, both local and national, in an expedient and consistent manner statewide.

This may require stronger language in working agreements between the Department and law enforcement. It is further recommended that specialized Criminal Intelligence Analysts (CIA's) be utilized for this function statewide, to insure greater reliability on the completeness and accuracy of the criminal history information.

Recommendation/Action Taken:
The Department of Children and Families was granted National Crime Information Center (NCIC) access for limited purposes for which there is an emergency placement of children taken into custody with a relative or non-relative. .

The Department of Children and Families has hired and currently employs Crime Intelligence Analysts to conduct criminal and abuse history background checks on subjects of an abuse investigation. These positions were allocated to every district in the state. The majority of these positions are attached to the Protective Investigations units. A small number have also been transferred over to local community based care organizations. Incumbents are trained to run background checks through the Florida Crime Information Center, local law enforcement, the Juvenile Justice Information System, HomeSafenet, direct queries to other states and, in times of placement of a child other than with a parent, the National Crime Information Center.

ISSUE 7: SUBSIDIZED CHILD CARE

Families with children at increased risk of abuse and neglect have an ever-increasing need for adequate, affordable childcare. Parents with multiple daily living needs often leave their children inadequately supervised due to the lack of appropriate, available caretakers.

Recommendation/Action Taken:
The team recommended that at risk children be prioritized for subsidized childcare. There should be legislative language to prioritize the at risk children. There needs to be additional funding to meet the needs of the working poor who are at risk of abuse and neglect with priority given to children who are exposed to domestic violence in their home, substance abusers in rehab facilities, and families with a large number of children. The Team also supports quality universal pre-k for all four year olds as recommended by the State Pre-K Advisory Council.

The Department is currently able to access subsidized care for some of the children they serve: however they are not given priority status for this resource. Child care slots are limited due to the state wide demand and waiting list for such care. During the past year, central office staff from the office of Child Welfare/Community Base Care has worked with the staff from the Child Care Program Office to insure that we maintain the maximum number available of these slots.

ISSUE 8 PROTECTIVE INVESTIGATIONS STAFF RETENTION

Due to the increasing turnover rate in protective investigations, legislation was recently passed to appoint a Protective Investigator Retention Workgroup, to address the issues surrounding turnover and to make recommendations for alternative responses to investigations, staff recruitment and training, and staff retention. The workgroup's report is due to the legislature by the end of the calendar year.

Recommendation/Action Taken: The team recommended that the legislature and the Department of Children and Families support and implement the recommendations of the Protective Investigator Retention Workgroup.

In 2003, the legislatively mandated Protective Investigator Retention Workgroup delivered a final report. Among the recommendations included in that report were a redesign of the Child Welfare Certification Training and incentives to keep Protective Investigators on the job such as payment of vehicle insurance, assistance with repayment of college loans, and a leadership program to train nominated individuals for future administrative positions. All of these recommendations have subsequently been initiated. Current data indicates statewide turnover among PI staff is in decline.

Eddie*

Ten year old Eddie drowned in a foster family home pool. He had multiple handicaps and required close supervision. He was sitting on a sofa by the pool, watching television. The foster mother went to check on another child in the home and, when she returned, she found Eddie floating in the pool.

****Alias***

CONCLUSIONS AND RECOMMENDATIONS

The State Child Abuse Death Review Team has evolved over the past five years. In the initial years, the team built a foundation for the child abuse death review process at the state level, and began to recruit local teams. This early work focused on developing a multidisciplinary approach to this specific population of child abuse and deaths, to achieve a better understanding of the causes and contributing factors and recommend better approaches to prevention. Once the foundation was built, the focus expanded to the further development of local teams, multidisciplinary protocols, data gathering and analysis, and the development and implementation of recommendations.

It remains important for the reader to put the overall analysis of these child deaths in perspective. In addition to the limitations in the information used to analyze individual cases, the population reviewed is limited in scope and representation of the total number of abuse and neglect deaths in Florida. Therefore, although there are some clear patterns reflective of national trends, the specifics may vary.

The Child Abuse Death Review Team identified both case specific and overall systemic issues in the child protection system. After a careful analysis of the data, the state team presents the following recommendations to address critical issues identified during their reviews.

ISSUE 1: CONFIDENTIALITY

In 1999, the Florida Legislature established the State Child Abuse Death Review Committee pursuant to Chapter 383.402 F.S. and a companion section Chapter 383.410 F.S., which provided confidentiality protections that enabled the Team to carry out its work. The intent of this legislation requires the State Team to review and investigate the circumstances surrounding the death of a child from verified child abuse or neglect, where there was one prior report to the Department of Children and Families. In 2004, the Legislature expanded the team's mandate to reviewing all child abuse or child neglect deaths regardless of whether there was a prior report to the Department.

During the 2004 legislative session, the confidentiality section came up for Sunset Review. The Florida Senate unanimously passed Senate Bill 462 which ensured the retention of this confidentiality section. Regrettably, in the House, a similar Committee Bill (PCB 04-02) was held up in the State Administration Committee for unknown reasons. Thus, the bill was not heard by the Administration Committee or given the opportunity to be voted upon by the full House of Representatives. Senate Bill 462 subsequently died in House messages.

As a result of this action, Chapter 383.410 F.S. was "sunset" on October 2, 2004. Without the confidentiality section, the State Committee cannot view important aspects of child abuse or neglect deaths. Consequently, the loss of the confidentiality section has significantly impeded the State Committee's ability to carry out its statutory function.

Action Needed/Recommendation: It is imperative that the Florida Legislature work in partnership with the Governor's office to restore the confidentiality protection necessary for a through and unbiased review of all these cases.

ISSUE 2: DROWNING DEATHS

The Child Abuse Death Review Team identified drowning as a major concern. Florida is a peninsula saturated by lakes, rivers, retention ponds, and swimming pools. Additionally, most homes have bathtubs that pose drowning risk to children who are inadequately supervised. The Vital Statistics data for 2003 shows that 381 deaths ages 0-85, were related to drowning 99 of those were between the ages of 0-10. Out of the 35 cases reviewed by the State Death Review Team, 10 were related to drowning.

Action Needed/Recommendation: It is essential that preventative measures be taken to decrease the number of children drowning in Florida. These measures would include, at a minimum:

- Emphasis on drowning risk factors in all risk assessments, which the Department has begun to implement this in their training curriculum.
- Continue public awareness and education on drowning prevention especially targeted at the under five age group.

ISSUE 3: TRAINING NEEDS

Enhancing knowledge and skills of professional and paraprofessionals who work in the discipline of child abuse and neglect is essential. Training needs include recognizing signs and symptoms of child abuse and neglect, risk assessment, and mandatory reporting requirements.

Action Needed/Recommendation:

Law enforcement should be required to immediately report to the Hotline when a child is injured or dies due to being improperly or not restrained in motor vehicle crashes. It is only through the reporting mechanism that a true picture of this behavior's repercussions can be studied and prevented. The team also strongly encourages the enforcement of child automobile restraint laws.

Training should be provided to law enforcement officers on indicators of child abuse and neglect, including the requirements for mandatory reporting. They should fully understand the implications of risk and the need for reporting cases involving drug offenses, and cases of domestic violence where children are involved.

The team recommends that law enforcement training on child abuse and neglect, as well as domestic violence, occurs at the academy level and at local agency level. It is recommended that the Standards and Training Commission require specific time frames and curriculum.

<u>Department of Children and Families Staff</u>

The team continues to recommend that child protective investigators receive training on critical decision- making. This training should include actual case scenarios whose lessons learned could be applied in the field. Domestic violence is another area in which additional training is needed. It is further recommended that Child Welfare Legal Services (CWLS) and child protective investigators review the process for child safety decision-making; and that CWLS attorneys receive training on the risk to children in domestic violence situations, as well as strategies for court intervention.

Based on recent reviews of both death and non death cases, the Department of Children and Families has identified a need for additional training for Protective Investigators in addition to the core pre-service training. Protective Investigators need training in recognizing the signs of physical abuse, i.e., inflicted vs. accidental trauma. They also need specialized training in investigative interview techniques, especially, but not limited to, sexual abuse cases. Discussions on this subject have been initiated with the Florida Department of Health's Statewide Child Protection Team Medical Director and a plan for development of training is under way.

Judiciary

The team recommends that the judiciary receive training in domestic violence issues and the concurrent risk to children.

School Personnel

The team recommends that all school personnel receive training on child abuse and neglect. Training should include recognizing the signs and symptoms of abuse and neglect, mandatory reporting and the child protective investigative process. The Department of Education has, in collaboration with many professional agencies, developed a guide to child abuse and neglect mandated reporting, "Child Abuse Source Book for Florida School Personnel: A Prevention and Intervention Tool". This resource has been sent to all school districts throughout the state, and can be located on their website http://www.firn.edu/doe/commhome/pdf/chiabuse.pdf.

ISSUE 4: FACILITATION OF COMMUNICATION

With the increased number of agencies involved in the child protection system, communication regarding the status and transfer of cases is problematic. Case planning can be difficult without valuable input and information from the various caseworkers involved with a family and result in gaps in services that leave children at risk.

Action Needed/Recommendation: The team continues to recommend that the Department of Children and Families and its community based care providers review and, if necessary, revise their policies and procedures regarding their interagency communication, including a review of policies regarding the closure of cases in which in-home services are being provided. The team recommends that the Department of Children and Families also consider Child Protection Team recommendations prior to case closure.

ISSUE 5: SUBSIDIZED CHILD CARE

Families with children at increased risk of abuse and neglect have an ever-increasing need for adequate, affordable childcare. Parents, regrettably, often leave their children inadequately supervised due to the lack of appropriate, available caretakers.

Action Needed/Recommendation:

The team recommends that at risk children be prioritized for subsidized childcare. There should be legislative language to prioritize the at risk children. There needs to be additional funding to meet the needs of the working poor who are at risk of abuse and neglect with priority given to children who are exposed to domestic violence in their home, substance abusers in rehabilitation facilities, and families with a large number of children. The Team also supports

quality universal pre-k for all four year olds as recommended by the State Pre-K Advisory Council.

ISSUE 6: VOLUNTARY PLACEMENTS

The State Team recognized a deficiency in the process of voluntary placement by Department of Children and Families staff. In some cases, children are determined to be at risk with their caregivers/parents and these parents are allowed to arrange voluntary placement with relatives and or non-relatives without any court involvement. There is no follow up on the cases if the family chooses not to continue with the voluntary case plan. There is also inconsistency as to what cases are appropriate for voluntary supervision.

Action needed/Recommendation
The Department of Children and Families needs to address these deficiencies by either a written policy or a quality assurance procedure, to ensure a reduction of risk and the safety of these children.

ISSUE 7: CO-SLEEPING/UNSAFE ENVIROMENT

The State Team identified a significant risk of infant death related to unsafe sleeping environments. Infants were placed in unsafe positions, beds, bedding, or were co-sleeping with adults or children that caused their death due to suffocation. In Florida, according to Vital Statistics, there were 53 deaths attributed to suffocation or strangulation. This year, Florida's Child Abuse Death Review team reviewed 4 cases of co-sleeping deaths involving children 2 months of age or younger. National statistics point to the need for training and/or education for parents, hospitals, pediatricians, law enforcement and Medical Examiners investigating these types of deaths.

Action Needed/Recommendations:

The need for training of first responders/law enforcement officers, DCF, Medical Examiners and any person/agency handling these cases need to document specific details of the sleeping environment to include infants initial position, and position found in at time of death, bed or surface infant was place on, bedding on or near infant, other persons co-sleeping with the infant, and potential substance abuse by the caretaker/parent.

Continue community awareness efforts on safe sleeping and the risk and dangers of sleeping with their child. The hospitals, pediatricians, and home visiting programs should address with the parents the risks associated with the co-sleeping.

Home visitors in Healthy Families Florida continue to educate parents on the risks associated with co-sleeping and safe sleeping as a part of their home visiting curriculum.

8 ISSUE: CHILD ABUSE AND NEGLECT PREVENTION EFFORTS

The State Team recognizes that an effort must be made to educate professionals working in the child protection system to enable them to better understand and investigate child abuse and neglect. However, it is equally important to be proactive and advocate for prevention initiatives, which ultimately lead to a reduction of child abuse and neglect.

Action Needed/Recommendations:
Recognizing that the ultimate solution to the problems of child abuse and neglect is prevention, the Department of Children and Families has begun several new initiatives for FY 2004-2005. Through a contract with TEAM Florida, the Department will participate in the development of a statewide Child Abuse Prevention Task Force. Mandated by Chapter 39, Florida Statutes, this Task Force will provide assistance and oversight to the development and implementation of statewide and local child abuse prevention efforts.

Additionally, through an appropriation by the legislature in 2004, the Department will contract for a statewide display of roadside billboards dedicated to the message that a baby should never be shaken. This campaign will be modeled after a similar successful one conducted in 2003 in the Suncoast Region.

The Florida Legislature is encouraged to provide funding to supplement the Federal Child Abuse and Neglect Prevention Funds that the State currently receives.

The State Team encourages the Florida Pediatric Society and the Florida Medical Examiners Commission to develop and issue position papers on the prevention of Shaken Baby Syndrome and deaths resulting from unsafe co-sleeping.

REFERENCES

1. Section 383.402, Florida Statutes

2. Section 39.01, Florida Statutes

3. U.S. Department of Health and Human Services: Child Maltreatment 2000: Reports from the States National Center on Child Abuse Prevention Research.

4. Florida Department of Children and Families: Child Abuse and Neglect Deaths: Calendar Year 2002.

5. National Center on Child Abuse Prevention Research: The 2000 Fifty State Survey: Current Calendar Year 2002.

6. National Clearinghouse on Child Abuse and Neglect Information: Child Abuse and Neglect Fatalities Statistics and Interventions: Publication 2004

7. National Clearinghouse on Child Abuse and Neglect Information: Frequently Asked Questions About Child Fatalities, Published 2004

8. Department of Health Vital Statistics Annual Report 2003

STATE CHILD ABUSE REVIEW TEAM

Robert W. Hodges, J.D., Chairperson
Assistant State Attorney, 5th Circuit
Representing: Florida Prosecuting Attorney's Association

Michael L. Haney, Ph.D., N.C.C., L.M.H.C
State Child Abuse Death Review Coordinator
Division Director, Children's Medical Services
Representing: Department of Health

Tom Wheeler
Office of the Attorney General
Representing: Department of Legal Affairs

Beth Englander
Director, Child Welfare and Community Based Care Program
Representing: Department of Children and Families

Terry Thomas
Special Agent, FDLE
Representing: Florida Department of Law Enforcement

Michele Polland
Educational Policy Analyst
Representing: Department of Education

Wanda G. Philyor
Healthy Families Temple Terrace
Representing: Paraprofessional

Judith Cobb, R.N., M.S.P.H.
Palm Beach County Health Department
Representing: Public Health Nurse

Stephanie B. Wellon
Children's Home Society of Palatka
Representing: Child Abuse Prevention Program

Barbara Wolf, M.D.
District 21 Medical Examiner
Representing: Florida Medical Examiners Commission

Bethany Mohr, MD
Statewide Medical Director
Child Protection Team
Representing: Board-Certified Pediatricians

Lorretta E. Glass, M.A., L.M.F.T.
Director of Foster Parent Support Services
Representing: Mental Health Professionals

Janice Thomas
Department of Children and Families
Representing: Family Services Supervisors

Randy Alexander, MD
Child Protection Team State Medical Director
Representing: Child Protection Team Medical Directors

Carol M. McNally
Healthy Families Florida Executive Director
Representing: Child Advocacy Organizations

Major Connie Shingledecker
Commander – Manatee County
Representing: Law Enforcement

Jayne Johnson, M.S.W., L.C.S.W.
Child Protection Training Coordinator
Representing: Social Worker Experienced in Field of Child Abuse

Radonda Dobbins
Child Welfare Specialist
Representing: Domestic Violence Programs

STAFF

Peggy Scheuermann, M.Ed.
Staff Director
Children's Medical Services/Department of Health

Michelle Akins
QA Coordinator State Child Abuse Death Team
Child Protection Unit/Children's Medical Services
Department of Health

Jim Spencer
Family Safety Child Death Review Coordinator
Department of Children and Families

Mia Filmore
Staff Assistant
Child Protection Unit/Children's Medical Services
Department of Health

Stephenie Gordy
Staff Assistant
Child Protection Unit/Children's Medical Services
Department of Health

COMMITTEES

TRAINING COMMITTEE

Terry Thomas, Chairperson
Radonda Dobbins
Connie Shingledecker
Michael L. Haney

PROTOCOL AND GUIDELINES COMMITTEE

Michael Haney, Chairperson
Randy Alexander, MD
Robert Hodges

REPORT COMMITTEE

Robert Hodges, Chairperson
Connie Shingledecker
Terry Thomas

DCF TRAINING PRIORITES			
FOCUS: CERTIFICATION, CLINICAL SUPERVISION, STAFF RETENTION			
Action Steps and Lead	**Benchmarks**	**Date of Achievement**	
		Projected	**Actual**
1.b. Identify and provide Quality Case Management curriculum to program office subject matter experts to ensure that family engagement, assessment, on-going assessment and family-centered practice content is correct. Lead: Child Welfare Training Unit	The Quality Case Management curriculum is updated and provides staff with the ability to develop skills related to family engagement, assessment, on-gong assessment and family-center practice. A revision report will document completion of this action step.	12/1/01	
Lead: CW-CBC Program Office	i. Subject Matter Experts identified and work time appropriated for task.		
Lead: Child Welfare Training Unit	ii. Curricula identified, copied and provided to program office staff to review.		
Lead: Child Welfare Training Unit and CW-CBC Program Office	iii. Comments are reviewed in a face-to-face meeting of subject matter expert(s) and curriculum developer(s) to finalize revisions.		
Lead: Child Welfare Training Unit	iv. Revisions are completed and a new curriculum is provided to vendors for implementation.	12/1/04	
2. Develop and deliver emergent-need Training, using video-teleconferencing capabilities to provide supervisors with the skills to improve their clinical supervision skills. Lead: Child Welfare Training Unit and CW-CMC Program Office	A selection of emergent-needs training topics will be identified by the CW-CBC Program Office management Team and a series mandatory, semi-monthly video-teleconference training sessions will be held with supervisors. These trainings will use department cases to teach key concepts.	10/21/04 12/2004 2/2005	

DCF TRAINING PRIORITES			
FOCUS: CERTIFICATION, CLINICAL SUPERVISION, STAFF RETENTION			
Action Steps and Lead	**Benchmarks**	**Date of Achievement**	
		Projected	**Actual**
Lead: Child Welfare Training Unit and CW-CBC Program Office	i. The CW-CBC Program Office identifies three video-teleconference suitable emergent-needs training topics.	10/15/04	
Lead: Child Welfare Training Unit	ii. Delivery parameters and instructional strategies are finalized/training dates are set.	10/15/04	
2. a. Deliver emergent needs training on the department's High Risk Protocol. Lead: Child Welfare Training Unit	Emergent needs training is provided to supervisors, giving them the skills and knowledge necessary to provide clinical supervision to their staff	10/21/04	
Lead: Child Welfare Training Unit and CW-CBC Program Office	i. Identify trainer(s), field facilitators, and curriculum developer(s).		
Lead: Child Welfare Training Unit	ii. Develop and disseminate course announcement materials.		
Lead: Child Welfare Training Unit and CW-CBC Program Office	iii. Identify learning objectives and training goals.		
Lead: CW-CBC Program Office	v. Identify case records for training delivery.		
Lead: Child Welfare Training Unit	v. Develop curriculum materials.		
Lead: Child Welfare Training Unit	vi. Prepare trainer(s) to deliver curriculum.		
Lead: Child Welfare Training Unit	vii. Prepare facilitators at each site to facilitate discussion during curriculum delivery.		

DCF TRAINING PRIORITES			
FOCUS: CERTIFICATION, CLINICAL SUPERVISION, STAFF RETENTION			
Action Steps and Lead	**Benchmarks**	**Date of Achievement**	
		Projected	**Actual**
Lead: Child Welfare Training Unit and CW-CBC Program Office	viii. Deliver Training.	12/21/04	
Lead: Child Welfare Training Unit	ix. Review training evaluation results.		
Lead: Child Welfare Training Unit and CW-CBC Program Office	x. Incorporate participant comments into next emergent-need training delivery.		
2. b. Deliver emergent needs training on topic TBD. Lead: Child Welfare Training Unit	Emergent needs training is provided to supervisors, giving them the skills and knowledge necessary to provide clinical supervision to their staff.	12/2004	
Lead: Child Welfare Training Unit and CW-CBC Program Office	i. Identify trainer(s), field facilitators, and curriculum developer(s).		
Lead: Child Welfare Training Unit	ii. Develop and disseminate course announcement materials		
Lead: Child Welfare Training Unit and CW-CBC Program Office	iii. Identify learning objectives and training goals.		
Lead: CW-CBC Program Office	iv. Identify case records for training delivery.		
Lead: Child Welfare Training Unit	v. Develop curriculum materials.		
Lead: Child Welfare Training Unit	vi. Prepare trainer(s) to deliver curriculum.		

DCF TRAINING PRIORITES			
FOCUS: CERTIFICATION, CLINICAL SUPERVISION, STAFF RETENTION			
Action Steps and Lead	**Benchmarks**	**Date of Achievement**	
		Projected	**Actual**
Lead: Child Welfare Training Unit	vii. Prepare facilitators at each site to facilitate discussion during curriculum delivery.		
Lead: Child Welfare Training Unit and CW-CBC Program office	viii. Deliver training	12/2004	
Lead: Child Welfare Training Unit	ix. Review training evaluation results.		
Lead: Child Welfare Training and CW-CBC Program Office	x. Incorporate participant comments into next emergent-need training delivery.		
2. c. Deliver emergent needs training on topic TBD.	Emergent needs training to provided to supervisors, giving them the skills and knowledge necessary to provide clinical supervision to their staff.	2/2005	
Lead: Child Welfare Training Unit and CW-CBC Program Office	i. Identify trainer(s), field facilitators, and curriculum developer(s)		
Lead: Child Welfare Training Unit	ii. Develop and disseminate course announcement materials.		
Lead: Child Welfare Training Unit and CW-CBC Program Office	iii. Identify learning objectives and training goals.		
Lead: CW-CBC Program Office	iv. Identify case records for training delivery.		
Lead: Child Welfare Training Unit	v. Develop curriculum materials.		

DCF TRAINING PRIORITES			
FOCUS: CERTIFICATION, CLINICAL SUPERVISION, STAFF RETENTION			
Action Steps and Lead	**Benchmarks**	**Date of Achievement**	
		Projected	**Actual**
Lead: Child Welfare Training Unit	Prepare trainer(s) to deliver curriculum		
Lead: Child Welfare Training Unit	vii. Preparer facilitators at each site t facilitate discussion during curriculum delivery		
Lead: Child Welfare Training Unit and CW-CBC Program Office	viii. Deliver training.	2/2005	
Lead: Child Welfare Training Unit	ix. Review training evaluation results.		
Lead: Child Welfare Training Unit and CW-CBC Program Office	x. Incorporate participant comments into next emergent-need training delivery.		
3. Develop and deliver emergent-need training to provide supervisors with the skills to improve their clinical supervision skills. Lead: Child Welfare Training Unit and CW CBC Program Office	A selection of emergent-needs training topics will be identified by the CW-CBC Program Office Management Team and mandatory training will be held with appropriate child welfare staff. The department will train supervisors, specialist and other program managers to delivery these emergent-need training sessions. This will increase transfer of learning and build training capacity within the agency.	12/2004	
Lead: Child Welfare Training Unit and CW-CBC Program Office	i. The CW-CBC Program Office identifies critical emergent-needs training topics	10/15/04	
Lead: Child Welfare Training Unit	ii. Delivery parameters and instructional strategies are finalized/training dates are set.	10/15/04	

DCF TRAINING PRIORITES			
FOCUS: CERTIFICATION, CLINICAL SUPERVISION, STAFF RETENTION			
Action Steps and Lead	**Benchmarks**	**Date of Achievement**	
		Projected	**Actual**
3.a. Deliver emergent needs training on the department's Family Engagement and Assessment. Lead: Child Welfare Training Unit	Family Engagement and Assessment curriculum is delivered to all child welfare supervisors during the December 2004 Supervisors Conference, hosted by the department. This session is mandatory for all attendees.	12/2004	
Lead: Child Welfare Training Unit and CW-CBC Program Office	i. Identify trainer(s) and curriculum developer(s).		
Lead: Child Welfare Training Unit and CW-CBC Program Office	ii. Identify learning objectives and training goals.		
Lead: Child Welfare Training Unit and CW-CBC Program Office	iii. Develop curriculum materials.		
Lead: Child Welfare Training Unit and CW-CBC Program Office	iv. Deliver training.	12/2004	
	v. Review training evaluation results.		
Lead: Child Welfare Training Unit and CW-CBC Program Office	vi. Incorporate participant comments into next emergent-need training delivery.		
3.b. Deliver emergent needs training on investigations and post-adoption services. Lead: Child Welfare Training Unit and CW-CBC Program Office	The department will identify protective investigations and adoption specialists or equivalent positions to participate in a train-the-trainer and deliver cross-training to PI and adoption staff on responding to allegations of maltreatment regarding families engaged in post-adoption services.	2/2005	

DCF TRAINING PRIORITES			
FOCUS: CERTIFICATION, CLINICAL SUPERVISION, STAFF RETENTION			
Action Steps and Lead	**Benchmarks**	**Date of Achievement**	
		Projected	**Actual**
Lead: Child Welfare Training Unit	i. Schedule Train-the Trainer session with national provider.		
Lead: CW-CBC Program Office	ii. Identify protective investigations and adoption specialists or equivalent staff to serve as trainers		
Lead: Child Welfare Training Unit	iii. Conduct Train-the-Trainer session	1/2005	
Lead: Child Welfare Training Unit	iv. Develop and disseminate course announcement materials.		
Lead: CW-CBC Program Office	v. Deliver training.	2/2005	
Lead: Child Welfare Training Unit and CW-CBC Program Office	vi. Review training evaluation results.		
Lead: Child Welfare Training Unit and CW-CBC Program Office	vii. Incorporate participant comments into next emergent-need training delivery.		
Lead: CW-CBC Program Office	viii. Revise performance standards to require on-going delivery of this training curriculum to new staff.		
4. Develop and implement Knowledge Management strategies to provide staff with just-in-time access to critical policy and practice information. Lead: Child Welfare Training Unit and CW-CBC Program Office	Host a child welfare web-site to implement and disseminate knowledge management strategies		
4.a. Develop a CW-CBC web-page to implement and disseminate Knowledge Management strategies. Lead: Child Welfare Training Unit	This web-site will be the central repository for all child welfare policy and procedure documents, job-aides, link to professional resources, links to the on-line child welfare training and certification learning center, SkillNet: as well as other informational or performance improvement materials		

DCF TRAINING PRIORITES			
FOCUS: CERTIFICATION, CLINICAL SUPERVISION, STAFF RETENTION			
Action Steps and Lead	**Benchmarks**	**Date of Achievement**	
		Projected	**Actual**
Lead: Child Welfare Training Unit and CW-CBC Program Office	i. Establish a Child Welfare Knowledge Management committee to provide guidance and oversight to the development and maintenance of the CW-CBC web-page.		
Lead: Child Welfare Training Unit and CW-CBC Program Office	ii. Identify pages and sub-pages of information to be accessed on the web-page.		
Lead: CW-CBC Program Office	iii. Identify those information that can be easily accessed and included on the web-page		
Lead: Child Welfare Training Unit	iv. Launch a basic web page, including the information identified in task 4.a.iii.	11/15/04	
Lead: Child Welfare Training Unit	v. Develop a project plan to continue the development and maintenance of the web-page		
4.b. Develop and produce a monthly Child Welfare Performance Improvement Newsletter	A monthly Performance Improvement Newsletter is published, which serves as a resource for the Child Welfare and Community Based Care Program Office to communicate with the field.		
Lead: Child Welfare Training Unit and CW-CBC Program Office	i. Finalize newsletter format and contributors.	10/15/04	
Lead: Child Welfare Training Unit	ii.. Write, proof, and circulate newsletter for approval.		
Lead: Child Welfare Training Unit	iii. Publish newsletter in PDF format on DCF web-page.		
Lead: Child Welfare Training Unit	iv. Develop project plans for on-going monthly newsletter development.		
Lead: Child Welfare Training Unit	v. Implement newsletter project plans.		
5. Expand Child Welfare Legal Services(CWLS) training programs and requirements. Lead: Child Welfare Training Unit, Office of the General Counsel, and the CW-CBC Program Office	A uniform training plan is established for CWLS support staff, paralegals, attorney, senior attorneys and managing attorneys.	12/2004 and on-going	
Lead: Office of the General Counsel	i. Establish a CWLS Education Committee	10/2004	

DCF TRAINING PRIORITES			
FOCUS: CERTIFICATION, CLINICAL SUPERVISION, STAFF RETENTION			
Action Steps and Lead	**Benchmarks**	**Date of Achievement**	
		Projected	**Actual**
Lead: Child Welfare Training Unit	ii. Identify specific budget allocation to support CWLS education/training	10/2204	
Lead: Child Welfare Training Unit and Office of the General Counsel	iii. Conduct a training needs assessment to identify training needs of CWLS support staff, paralegals, attorney, senior attorneys and managing attorneys.	11/2004	
Lead: Child Welfare Training Unit and Office of the General Counsel	iv. Analyze training needs assessment results and develop training plans for CWLS support staff, paralegals, attorney, senior attorneys and managing attorneys.	12/2004	
Lead: Child Welfare Training Unit and Office of the General Counsel	v. Identify a minimum of one training activity to respond to the most pressing training need of each of the following CWLS staff groups: support staff, paralegals, attorneys, senior attorneys, and managing attorneys.	1/2005	
Lead: Child Welfare Training Unit	vi. Procure and provide training activities identified in action step 5.v.	3/2005	
6. Plan and host the 8th Annual Dependency Court Improvement Summit Lead: Child Welfare Training Unit, CW-CBC Program Office and the Office of the State Court Administrator	An educational event is provided that brings together judicial, state, community, law enforcement and other child welfare professionals for cross-training and networking opportunities. Two local break-out sessions are focused on developing local strategies for improving performance on PIP measures.	11/2004 and on going	
7. Realign training staff and requirements to reflect department's new administrative structure. Lead: CW-CBC Program Office, Office of the Secretary	A child welfare training unit that is aligned with the organizational structure of the department's Child Welfare and Community Based Care Program Office.	11/2005	
	i. Restructure the reporting relationship so that the Child Welfare Training Unit administrator reports to the director of the Child Welfare and Community-Based Care Program Office.	7/2004	

DCF TRAINING PRIORITES			
FOCUS: CERTIFICATION, CLINICAL SUPERVISION, STAFF RETENTION			
Action Steps and Lead	**Benchmarks**	**Date of Achievement**	
		Projected	**Actual**
	ii. Restructure the Child Welfare Training Unit staff and performance specifications to reflect the needs of the new reporting structure.	11/2005	
8. Revise grant agreements and contract language to require contracted child welfare staff to meet department training requirements. Lead: CW-CBC Program Office, Office o the Secretary	Grants and contracts include language requiring contracted child welfare staff to meet certain training and certification requirements established by the department.	11/2005	
	i. Revise grant language to require Sheriff Offices conducting Protective Investigations to (1) meet department mandated training requirements and (2) ensure that the department has a current roster of child welfare staff for monitoring purposes.	7/2004	
	ii.. Execute revised Sheriff Office grants		
	i. Revise Community-Based Care Lead Agency contract language to require CBC's and their contracted providers to (1) meet department mandated training requirements, (2) ensure that the department has a current roster of child welfare staff for monitoring purposes and (3) develop an annual training plan for any foster parent, in-services and advanced training funds provided to the Lead Agency.		
	ii. Execute revised Community-Based Care Lead Agency contract language		