FLORIDA CHILD ABUSE DEATH REVIEW

ANNUAL REPORT
December 2008

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

December 24, 2008

The Honorable Charlie Crist
The Honorable Jeff Atwater
President of the Florida Senate
The Honorable Ray Sansom
Speaker of the Florida House of Representatives
The Capitol
Tallahassee, Florida 32399-0001

Dear Governor Crist, President Atwater, and Speaker Sansom:

Pursuant to Chapter 383.402 Florida Statues, I am submitting the State Child Abuse Death Review Committee's annual report, which summarizes 163 verified child abuse deaths from 2007 and 11 deaths from years preceding 2007. The State Committee has identified 8 issues that we are submitting to you for your consideration and action.

Issue # 1 All child death review - All child death review is a commitment to prevention. Identifying the causes of and developing strategies to reduce avoidable child deaths is the essence of prevention. An All Child Death Review process will place Florida on the path to provide a safe place for children to live, grow and become healthy contributing citizens. The All Child Death Review process will allow the Department of Health and other agencies to develop appropriate strategies to reduce the occurrence of child deaths from preventable situations.

Issue # 2 Healthy Families Prevention Funding - Research shows that the added stress low-income families face during economically depressed times causes child abuse and neglect to increase. The State Child Abuse Death Review Committee recognizes that the State of Florida is mired in an unprecedented fiscal crisis and that there are difficult decisions to be made regarding budget cuts. However, the prudent investment the Florida Legislature has made in the quality and proven prevention services that Healthy Families Florida has provided since its inception in 1998 should be continued, as addressing child abuse and neglect after the fact is far more costly in both human and budgetary terms.

Issue # 3 Safe Sleep- Sudden Infant Death Syndrome (SIDS) was defined in 1989 by the National Institute of Child Health and Human Development as "the sudden death of an infant less than one year of age which remains unexplained after a thorough case investigation including performance of a complete autopsy, examination of the death scene, and review of the clinical history." In subsequent years, however, it has been recognized that factors related to infant sleeping position and infant sleeping environments, including the prone sleeping position, bed sharing (co-sleeping, particularly with obese caregivers or those under the influence of drugs and/or alcohol or exhaustion) and soft bedding increase the risk of infant death from asphyxia due to suffocation or overlay.

Issue # 4 – Drowning - Florida loses enough children every year to fill four classrooms. It is alarming that the number of drowning deaths in Florida for children under age 5 is increasing each year. In the five years between 2001 and 2005, Florida had the 3rd highest overall unintentional drowning death rate in the nation and the highest unintentional drowning rate for the 0-4 year old group with a rate of 7.1 per 100,000 populations. In 2005, Florida lost more children ages 0-4 to drowning than any other state except California. In 2007, we lost 77 children.

Issue # 5 - Physical Abuse- Crying, toilet training and feeding are the most common triggers of physical abuse. In addition, the State Committee has seen common factors that are present in the deaths of these children in numerous cases. These factors include young males between the ages of 18-30 who are unemployed and often providing primary childcare while the biological mothers work. The fact that many of these males are unattached non-biological fathers contributes to their inability to cope and lack of parenting skills. In addition, there are often histories of substance abuse, domestic violence, animal abuse or criminal history of aggressive or violent behavior.

Issue # 6 - Substance Abuse - Substance abuse is one of the most common risk factors present in the death of a child from abuse or neglect. Yet, it is often overlooked and not given appropriate consideration in the risk assessment activities of child protection organizations that come into contact with children and their families. Approximately 50% to 80% of all child abuse and neglect cases substantiated by child protective services involve some degree of substance abuse by the child's parents. At least two-thirds of patients in drug abuse treatment centers say they were physically or sexually abused as children. At least half of the individuals arrested for major crimes including homicide, theft, and assault were under the influence of illicit drugs around the time of their arrest. Exposure to stress is one of the most powerful triggers of substance abuse in vulnerable individuals and of relapse in former addicts.

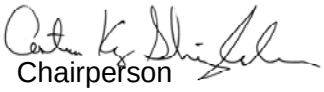
Issue #7 - Improved communication and consistency in investigations **-** Review of multi-agency records by the statewide child abuse death review team indicates that in many instances one particular entity involved in the investigation will note an evidentiary consideration (i.e., "parent admitted to using drugs the night before," etc.) which is not documented or assessed in the other agency's concurrent investigation.

Issue #8 – Better understanding of legal and court involvement in child abuse death cases - Since 1999, the State Committee has reviewed multiple deaths where dependency court was involved. Several of those deaths involved situations where the court either declined to follow

the recommendations of the participating agencies, or when the case was brought before the court it declined to take any action on the recommendations of the supervising agency and the child was subsequently returned home and ultimately killed by a caretaker. While the State Committee is not making a direct nexus between the death of the child and lack of court action, it does believe that the judicial process should be reviewed in a manner similar to other child protection quality improvement reviews.

As we continue our mission, we ask for your commitment and support to help us accomplish our critical goal to reduce preventable child abuse deaths in Florida. Our children are our most precious asset and we are obligated and dedicated to stopping needless child abuse deaths. Thank for consideration of our recommendations and we look forward to working in partnership with you to make these recommendations a reality.

Sincerely,



Chairperson
State Child Abuse Death Review Committee

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DEDICATION

The most tragic consequence of child abuse and neglect is a child's death.

The well being of a victim depends on the adults who are willing to take action.

As Albert Einstein advised us - "The world is a dangerous place to live not because of the people who are evil, but because of the people who don't do anything about it."

This report is dedicated to all children who have died as a result of abuse and neglect in the hope that we reach a time when no child will be victimized by abuse.

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FLORIDA CHILD ABUSE DEATH REVIEW COMMITTEE

ANNUAL REPORT

DECEMBER 2008

Mission

"To Reduce Preventable Child Abuse and Neglect Deaths"

Submitted to:

The Honorable Charlie Crist, Governor of Florida
The Honorable Jeff Atwater, President, Florida Senate
The Honorable Ray Sansom, Speaker, Florida House of Representatives

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RECOMMENDATIONS FOR 2008

Based on the review of 163 Child Abuse Deaths in 2007, the State Child Abuse Death Review Committee has identified eight priority issues with recommendations. Other topic specific issues and recommendations can be found in the body of the report.

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

ISSUES AND RECOMMENDATIONS:

Recommendations for 2008

Issue 1: An all child death review is needed to have a complete understanding of why children die in Florida.

Recommendation: Amend §383.402 (1), F. S to expand the State Child Abuse Death Review Committee's authority related to the review of child deaths in Florida.

- **Expand the child abuse death review process to include the review of all child deaths reported to the Florida Abuse Hotline for abuse, neglect or abandonment.**

- **Expand authority to provide for the voluntary review of all child deaths by local communities, within their resources, under the direction of the State Child Death Review Committee.**

One of Governor Charlie Crist's Healthcare priorities is a commitment to prevention. Identifying the causes of and developing strategies to reduce avoidable child deaths is the essence of prevention. An All Child Death Review process will place Florida on the path to provide a safe place for children to live, grow and become healthy contributing citizens. The All Child Death Review

process will allow the Department of Health and other agencies to develop appropriate strategies to reduce the occurrence of child deaths from preventable situations.

A priority for the Centers for Disease Control and Prevention (CDC) and the Healthy People 2010 is that a child fatality review team reviews 100% of deaths of children aged 17 years and younger that are due to external causes. Currently, 42 states authorize review of all child deaths in some manner, either mandated or permissive. By monitoring the occurrence of all childhood deaths and performing an appropriate review when deaths occur, child death review teams have a unique ability to gather the detailed information that is necessary for effective injury/disease prevention activities. The benefits of a comprehensive all child death review process include:

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

Many lives can be saved by identifying local factors related to mortality, heightening local awareness of these factors and mobilizing communities to enact changes needed to decrease the incidence of preventable child deaths. Florida lags behind 42 other States conducting child death review. In Florida, death certificates are the primary source of information and they do not provide a complete picture of why children die. Vital information that can better inform prevention efforts can be collected through a thorough record review.

The child death review process is a record review, focusing on critical areas such as sleeping related deaths, drowning, injury prevention, traffic crashes, poisoning, to name a few. Families are not interviewed as part of the death review process, unless it is a protocol already in place, such as Fetal Infant Mortality Review, where consent is obtained from the family for an interview. Otherwise, no family will be contacted as a result of this process. Of the 42 states conducting some

form of child death review, all have indicated that families are not impacted by these reviews.

In order to ensure the confidentiality of the parents and other surviving siblings, all records will be protected. All confidentiality protections currently cover the information sent to the State and Local Death Review Committees affording them the ability to protect information they receive, including their dialogue regarding the circumstances surrounding a child's death. Confidentiality ensures that family's feelings will be spared a public scrutiny as the Committee carries out its work and that no family be further traumatized as a result of this process; but that understanding how children die and how that might be prevented adds extra meaning to each child's death.

The proposed amendment to the current Florida law would authorize the State Child Abuse Death Review Committee to review all child deaths that were reported to the Florida Hotline and to review all other child deaths based on the availability of resources.

The amendment would also expand the membership of the State Child Abuse Death Review Committee in response to the broader scope of responsibility to include additional departmental/agency representatives and professional experts. Membership will be expanded to include the Department of Highway Safety, the Department of Health State Epidemiologist, The Office of Adoption and Child Protection, the Department of Juvenile Justice, a representative from the Florida Pediatric Society, a professional licensed in a mental health field who is knowledgeable concerning deaths of children, a social worker who is knowledgeable concerning deaths of children, a representative from the Florida Hospital Association, the Registrar for Vital Statistics, a perinatal expert, and a representative from the health insurance industry.

Issue 2: Healthy Families Florida is a critical program that is proven to prevent child abuse and neglect before it ever occurs.

Recommendation: The Florida Legislature should continue to fund Healthy Families at the 2008-2009 level.

Should additional revenue become available:

- **Expand services county-wide in the 22 counties that currently provide services in only targeted zip codes**
- **Increase funding to add high-risk specialists to the core staffing to better serve families experiencing domestic violence, mental health issues and substance abuse.**

Research shows that the added stress low-income families face during economically depressed times contributes to an increase in child abuse and neglect. The State Child Abuse Death Review Committee recognizes that the State of Florida is mired in an unprecedented fiscal crisis and that there are difficult decisions to be made regarding budget cuts. However, the prudent investment the Florida Legislature has made in the quality and proven prevention services that Healthy Families Florida has provided since its inception in 1998 should be continued, as addressing child abuse and neglect after the fact is far more costly in both human and budgetary terms.

Healthy Families Florida, the state's only nationally accredited, community-based, voluntary home visiting program is proven to prevent child abuse and neglect by keeping families together and working to ensure that children are raised in safe, stable and nurturing homes. Healthy Families services begin early, during pregnancy or shortly after the birth of a baby for parents who are voluntarily assessed as having risk factors that place their children at high risk for abuse and neglect. Trained family support workers visit the homes of their families and build trusting relationships, empowering families to recognize their strengths and build on those strengths to overcome factors that put them at risk of abuse and neglect. Family support workers educate parents on healthy child development and positive parenting, linking families to health and other family support services, and providing information, guidance, and emotional and practical support to families in their homes, Healthy Families prevents child abuse and neglect.

A rigorous, independent five-year evaluation concluded that Healthy Families Florida has a significant impact on preventing child abuse and neglect. The evaluation showed that children in families who completed the program or received long-term, intensive Healthy Families Florida services experienced **58 percent less child abuse and neglect** than did comparison groups with little or no services. Since the program's inception, Healthy Families Florida has consistently met or exceeded the child abuse and neglect participant outcome, the key measure of success -- **96 percent of children were free from abuse and neglect one year after the family completed the program.**

The goals of Healthy Families Florida are consistent with the goals of the Governor's Children and Youth Cabinet and the Office of Adoption and Child Protection.

Issue 3: Improvements in the investigation of child deaths and heightened public awareness and education are essential for the prevention of infant suffocation deaths related to unsafe sleeping conditions.

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

- **Law enforcement agencies, the Department of Children and Families (DCF) and Florida's medical examiner districts (through the Medical Examiners Commission) should adopt and participate in standardized guidelines and multidisciplinary approaches for the investigation of the unexpected deaths of infants and children. This should include adopting the Sudden Unexplained Infant Death Investigation (SUIDI) protocol, developed for and in conjunction with the Center for Disease Control and Prevention (CDC) (go to (http://www.cdc.gov/sids/SUIDHowtoUseForm.htm)**

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

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

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

- **Agencies and organizations that provide home visiting services should use or adapt the home safety checklist and prevention education topic sheets developed by Healthy Families Florida in partnership with the State Child Abuse Death Review Committee (see Best Practices section_).**

- **Provide infant safe sleep education for caregivers providing out of home care**

Sudden Infant Death Syndrome (SIDS) was defined in 1989 by the National Institute of Child Health and Human Development as "the sudden death of an infant under one year of age which remains unexplained after a thorough case investigation including performance of a complete autopsy, examination of the death scene, and review of the clinical history." In subsequent years, however, it has been recognized that factors related to infant sleeping position and infant sleeping environments, including the prone sleeping position, bed sharing (co-sleeping, particularly with those under the influence of drugs and/or alcohol, those that are obese or that are exhausted) and soft bedding increase the risk of infant death from asphyxia due to position or overlay.

Recognizing these risk factors, the American Academy of Pediatrics published a position paper in 2005 on the subject of safe infant sleeping conditions (see Appendix VI). Additionally, because of the realization that many deaths that formerly might have been classified as SIDS actually have specific, preventable causes, the term SUID (Sudden Unexplained Infant Death) has been designated to refer to all unexpected infant deaths,including those that are determined to be suffocation,SIDS, metabolic error, undetermined etc. Because the elucidation of these preventable causes requires the accurate determination of the cause and manner of death in such cases, and therefore a thorough investigation of the scene and circumstances, the CDC has launched a nationwide initiative to improve the quality of these infant death investigations.

Issue 4: Children continue to die from drowning at an alarming rate as a result of inadequate supervision.

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

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

- **Law enforcement and medical professionals should report all child-drowning deaths to the Florida Abuse Hotline therefore allowing investigations to occur to determine if the child's death is a result of neglect.**

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

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

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

The number of children Florida loses every year is enough to fill four classrooms. It is alarming that the number of drowning deaths in Florida for children under age 5 is increasing each year. In the five years between 2001 and 2005, Florida had the 3rd highest overall unintentional drowning death rate in the nation and the highest unintentional drowning rate for the 0-4 year old group with a rate of 7.1 per 100,000 populations. In 2005, Florida lost more children ages 0-4 to drowning than any other state except California (CDC WISQARS).

- During 2004 there were 63 child deaths related to drowning in Florida, 72 in 2005, 77 in 2006, which represents 14% and 7% increases respectively.
- In 2007, the number of drowning among Florida's children under age 5 was 77 .(Florida Vital Statistics)
- From 1999-2005, Florida lost more children to drowning than any other state.
- In 2006, most drowning of Florida children under five (60%) occurred from April through September.
- In 2006, males of all ages, especially those under five, were more likely to drown than females.
- Despite local ordinances and a state statute requiring safety features for backyard swimming pools, residential swimming pools are the location of 75 percent of the drowning deaths in Florida for children 0-4 (Florida Vital Statistics)

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

Adequate supervision is defined as an attentive person responsible for watching children and who is not under the influence of drugs or alcohol. The person must be proximate to the child (eyes on) to provide continuous supervision. According to caregivers, most child drowning victims were missing from sight for less than five minutes.

The Florida Abuse Hotline received 77 reports of child drowning deaths. However, the Child Death Review Committee reviewed only 45 of those deaths and did not

have the opportunity to review the deaths of all children who drowned due to inconsistencies in reporting of child drowning deaths by law enforcement, child protective investigators and other first responders. In addition, inconsistencies exist in the verification of neglect by the child protective investigators which contributed to less cases being reviewed by the State Committee. For example, Miami-Dade county ranks 2nd in the state for pool drowning, ages 0-6, and yet the State Committee did not receive any pool verified drowning deaths from that county for review.

In 2007, nearly 20 percent of childhood drowning cases reviewed occurred in bathtubs. The child was placed in the bathtub by the caregiver and then not supervised, creating the drowning opportunity. Therefore, bathtub cases should always be investigated as child neglect.

In its case reviews, the State Committee recognized a lack of thorough death scene investigation by responsible agencies, to include failing to consider drug testing when there is a history or suspicion of substance abuse by the caregiver at the time of the child's death. This results in missed opportunities to establish whether or not neglect has occurred as a result of the caregivers substance use.

Issue 5: There continues to be an alarming number of infant and toddler homicides that are attributed to common triggers and risk factors for physical abuse.

Recommendation: Anyone providing federal or state funded services, whether it be child protection investigations or case management, child care, home visiting or other services, should be aware of and sensitive to the common triggers and risk factors that contribute to child abuse.

- **The State Committee supports efforts by the Florida Pediatric Society and their partners to develop and implement a "Coping with Crying" program for hospitals and pediatricians.**
  - **"Coping with Crying" programs should emphasize approaches to male caregivers between the ages of 18 – 30.**
  - **Programs should also emphasize educating parents and caregivers on the importance of making informed, selective choices on "babysitters" for their children.**

- **Healthy Families Florida, Healthy Start, Early Steps and other early education and child care programs continue to provide caregivers with basic child development and behavior**

education designed to address the common risk factors and triggers for child physical abuse and neglect.

- **Training should be provided to Fire Rescue/EMS first responders and Fire Marshall Investigators on child injury and death investigations related to neglect by caregivers (i.e. drowning, infant suffocation, fire related, traffic crash related).**

- **Law Enforcement and DCF should consider drug testing when there is a history or suspicion of substance abuse by the caregiver at the time of the child's death**.

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

- **Fund training for law enforcement investigators and DCF Child Protective Investigators on physical child abuse investigations. Training should include:**

  - **Use of standardized Q & A (designed by FDLE) during investigations.**
  - **An emphasis on common risk factors and triggers pertaining to adult male caregivers between the ages of 18-30.**
  - **The dynamics of domestic violence and animal abuse occurring in the homes of child abuse and neglect cases.**

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

Crying, toilet training and feeding are the most common triggers of physical abuse. In addition, the State Committee has seen common factors that are present in the deaths of these children in numerous cases. These factors include young males between the ages of 18-30 who are unemployed and often providing primary childcare while the biological mothers work. The fact that many of these males are unattached non-biological fathers contributes to their inability to cope and lack of parenting skills. In addition, there are often histories of substance

abuse, domestic violence, animal abuse or criminal history of aggressive or violent behavior.

Issue 6: Substance abuse is a significant risk factor in many child abuse deaths.

Recommendation: Substance abuse is one of the most common risk factors present in child abuse or neglect deaths reviewed by the State Committee. Substance abuse should be given a higher priority in the risk assessment activities of child protection organizations that come into contact with children and their families.

- **Law Enforcement and Child Protective Investigators should develop a protocol to test for substance abuse of all caregivers when a child is a victim of drowning, motor vehicle crash, infant co-sleeping related death and any other child neglect death where substance abuse by the caregiver is suspected.**

- **Training should be provided to Fire Rescue/EMS first responders and Fire Marshall Investigators to recognize the signs of substance abuse by caregivers.**

- **Training should be provided to Law Enforcement and Narcotics Officers on mandatory reporting of child abuse when narcotic investigations indicate that children were present during drug related sales, manufacturing or use by a caregiver. Protocols for handling these reports should be established between law enforcement and the Department of Children and Families at the local level.**

- **The Office of Drug Control and Policy and the Department of Children and Families Substance Abuse and Family Safety program offices should establish an interdisciplinary workgroup to review the current pre-service child protection curriculum to make recommendations for specific training on the identification and assessment of substance abuse problems in families. The training should focus on how**

substance misuse contributes to or results in harm to infants and children whose caregivers use illicit substances, abuse alcohol, or allow children inappropriate to prescription drugs. In addition, training for Child Legal Services, in regards to these issues, should also be reviewed and revised, as needed.

Approximately 50% to 80% of all child abuse and neglect cases substantiated by child protective services involve some degree of substance abuse by the child's parents. At least two-thirds of patients in drug abuse treatment centers say they were physically or sexually abused as children. At least half of the individuals arrested for major crimes including homicide, theft, and assault were under the influence of illicit drugs around the time of their arrest. Exposure to stress is one of the most powerful triggers of substance abuse in vulnerable individuals and of relapse in former addicts (NIDA, 2008).

Substance abuse continues to be one of the highest risk factors for child fatality. Of concern is the lack of identification of substance abuse/use as a contributing factor in child abuse deaths because of lack of on-scene presumptive drug testing as part of the child protective or law enforcement investigation protocol. The State Committee continues to see a pattern where investigative findings indicate that substance abuse by the parent or person responsible for the child was documented in prior reports or substances were discovered in the home at the time of the child's death and no drug testing occurred. Substance abuse allegations or indicators do not appear to have been appropriately factored into the risk assessment. Frequently, cases are either referred to voluntary services or no services are offered. As acknowledged in last year's report, the State Committee recognizes that the Florida Appellate Courts have overturned the sheltering of children due to the lack of statutory authority in cases involving substance abuse as the nexus for sheltering child victims. However, this should not be the guiding factor when making determinations for child safety.

Issue 7: Communication between agencies and consistent evidence gathering protocol are crucial to the protection of children.

Recommendations: Improved consistency and communication among the various agencies involved in child abuse cases and child death cases.

- **A multidisciplinary staffing should be required when there is a change in the child's placement that differs from the**

recommendation made by the Child Protection Team and/or DCF. See Best Practice section for example

- **Improve the reporting and consistency in findings in child death cases.**
  - **Comparative data (by circuit) should be collected on both the reporting and verification rates of all alleged child deaths due to abuse or neglect.**
  - **Data analysis should include the potential under-reporting of maltreatment types, most noticeably drowning deaths due to inadequate supervision and unsafe sleep deaths.**
  - **The overall verification rate (i.e., ratio of confirmed child deaths to all alleged child deaths investigated) should also be analyzed to detect individual or unit bias in the handling of child death investigations.**
  - **Reporter type (i.e., professional vs. family member) should be reviewed to help identify patterns of reporting by maltreatment, and to assess for under-reporting by first responders.**

- **Provide cross training between disciplines to improve consistency in the collection and documentation regarding critical evidence at child death scenes.**

Consistency in reporting suspicious deaths is critical to determining the extent and causes of abuse and neglect related deaths. It is also essential to identifying strategies for future prevention of these deaths. During 2007, the statewide rate of alleged maltreatment deaths per 100,000 children was 10.6 (this represented all reported deaths regardless of findings). Of the six counties with the largest child population (Duval, Palm Beach, Orange, Hillsborough, Broward and Dade) the rate of alleged maltreatment deaths ranged from a high of 13.05 in Palm Beach County to a low of 6.69 in Dade County. Further analysis of the reported deaths statewide is necessary to determine whether low reporting trends exist; and if so, how best to address these.

In addition to consistency in reporting deaths due to alleged maltreatment, determination of accurate findings in investigations of maltreatment related fatalities is essential to promoting an understanding of the extent and causes of these deaths. In 2007, Duval, Palm Beach, Orange, Hillsborough, Broward and Dade Counties (those counties with the highest child population) “Verified” rates ranged from a high of 50% in Palm Beach to a low of 15 % in Dade County. Ongoing analysis of findings by circuit, county and unit should facilitate

identification of patterns and areas that would benefit from additional training and assist the Department in crafting training to address specific issues and needs. Communication and information-sharing between agencies involved in the investigation of child deaths must occur timely to ensure the safety of surviving siblings and promote preservation of evidence and accurate findings in child death investigations.

Issue 8: There is a need for judicial review when any child dies as a result of child abuse and the case was under the jurisdiction of the court.

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

- **The Department of Children and Families should notify the appropriate Circuit Judge when any child under jurisdiction of the court is alleged to have died as a result of abuse or neglect.**

- **The State Committee should facilitate with the State Court Administrators Office the development of a process to be implemented by the State Courts System that establishes a mechanism for judicial review of child abuse death cases that were under the jurisdiction of the courts.**

In all instances where a child dies while under the jurisdiction of dependency court, child protection or case management staff should timely notify the designated Judge of the child's death, so that the court can make an informed decision regarding the ongoing safety of surviving siblings.

Since 1999, the State Committee has reviewed multiple deaths where dependency court was involved. Several of those deaths involved situations where the court either declined to follow the recommendations of the participating agencies, or when the case was brought before the court it declined to take any action on the recommendations of the supervising agency and the child was subsequently returned home and ultimately killed by a caretaker. For example in one child death case, the court was allowing the father unsupervised visits, even though he had not been compliant with his case plan, he was to provide a drug test and not be positive. The court allowed him to have the visit even though he

had never taken a drug test. It was also learned that the narcotics had been buying drugs from this father at his home. .

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

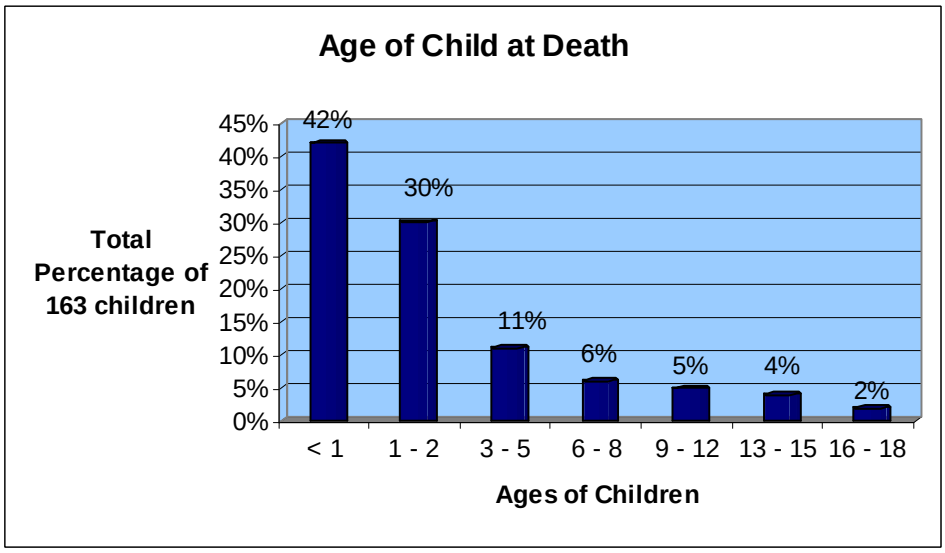
OVERVIEW OF ALL DEATHS

There were 163 infant/child deaths (under the age of 18) reviewed during 2007 that met the criteria for the State Child Abuse Death Review Committee. The following graphs show the total, age, gender-specific and race-specific child abuse deaths for Florida in 2007.

Age of Child

- 68 (42%) children were <1
- 49 (30%) children were 1-2
- 18 (11%) children were 3-5
- 9 (6%) children were 6-8
- 8 (5%) children were 9-12
- 7 (4%) children were 13-15
- 4 (2%) children were 16-17

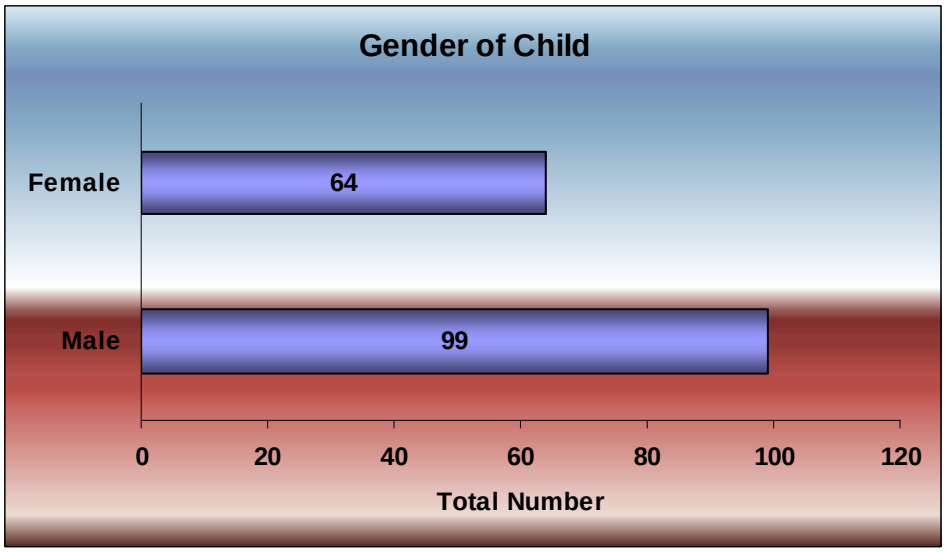
135 (83%) of the children were 5 and under



According to the US Department of Health and Human Services[3] (DHHS), Child Maltreatment 2006, more than three-quarters (78%) who were killed were younger than 4 years of age, 11.9% were 4-7 years of age.

Gender of Child

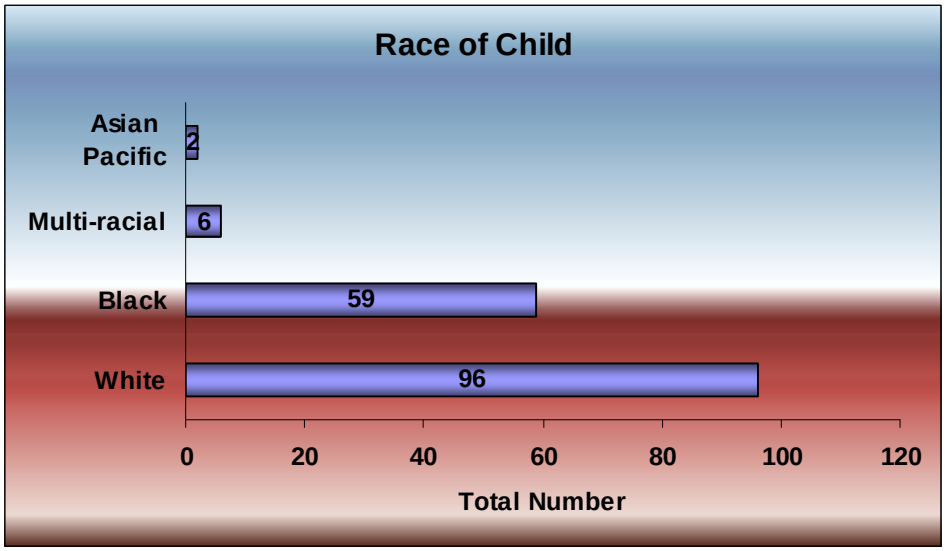
- 99 (61%) were male children
- 64 (39%) were female children



According to the US Department of Health and Human Services[3] (DHHS), Child Maltreatment 2006, infant boys (younger than 1 year) had a fatality rate of 18.5 deaths per 100,000 boys of the same age. Infant girls (younger than 1 year) had a fatality rate of 14.7 deaths per 100,000 girls of the same age.

Race of Child

- 96 (59%) were white
- 59 (36%) were black
- 6 (4%) were multi-racial
- 2 (1%) were Asian



According to the US Department of Health and Human Services[3] (DHHS), Child Maltreatment 2006, nearly one-half (43%) off all fatalities were White children. More than one-quarter were African-American and nearly one-fifth (17%) were Hispanic children. Children of other race categories collectively accounted for 10.7 percent of fatalities.

CHILD ABUSE AND NEGLECT DATA

The State Committee's review of death cases only includes verified child abuse deaths, which are a subset of the larger population of children who die. This limits the Committee's ability to fully meet the statutory charge of achieving a greater understanding of the causes and contributing factors of deaths resulting from child abuse. As a result, the patterns and trends identified are subsequently limited to the population set reviewed and may or may not have generalizability to larger populations. The essential outcome is to be able to derive meaningful conclusions and provide concrete recommendations that can be implemented in hopes of preventing the death of additional children.

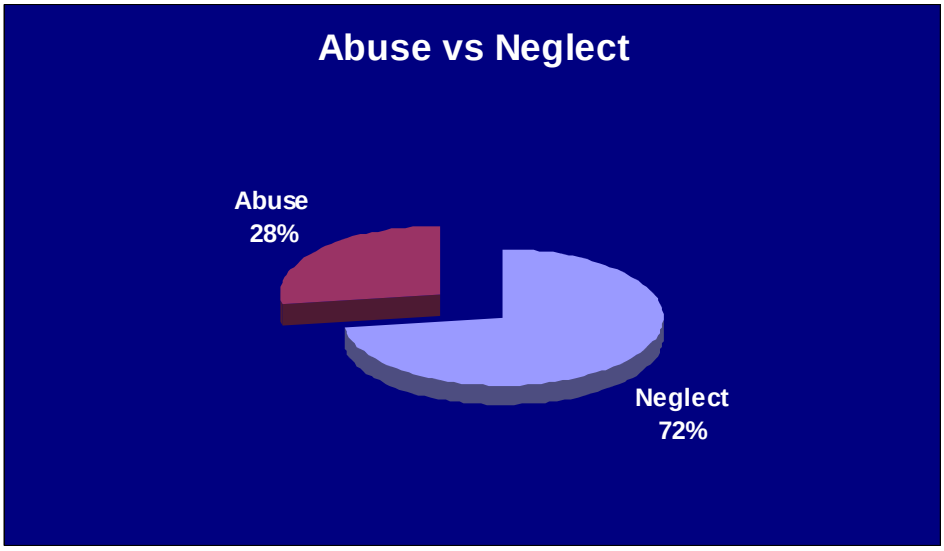
The following chart shows the number of all child deaths that occurred in Florida as wells as a breakdown of the number of reports called into the Florida Hotline, how many of these reports involved child abuse deaths, which deaths had some indicator findings, and which had verified findings. The verified child death reports are the reports reviewed by the State Committee. The number of verified deaths compared to all child deaths and those deaths due to abuse and neglect provides a better understanding of the limited number of child abuse death cases that are reviewed by The State Child Abuse Death Review Committee.

FLORIDA CHILD DEATHS - 2007	
Number of child deaths[5]	2718
DCF REPORTS RECEIVED & ABUSE/NEGLECT DEATHS[4]	
Number of initial reports	166,599
Number of reports involving child deaths	473
Number of child abuse death's with some indicator findings	97
Number of verified child abuse death reports	166*
National estimate for 2006[3]	1,530

* Three cases from 2007 will be reviewed next year due to pending criminal investigations.

ABUSE/NEGLECT

In 2007, there were 163 child abuse and neglect deaths reviewed. Of those, 45 (28%) were from abuse and 118 (72%) were neglect.

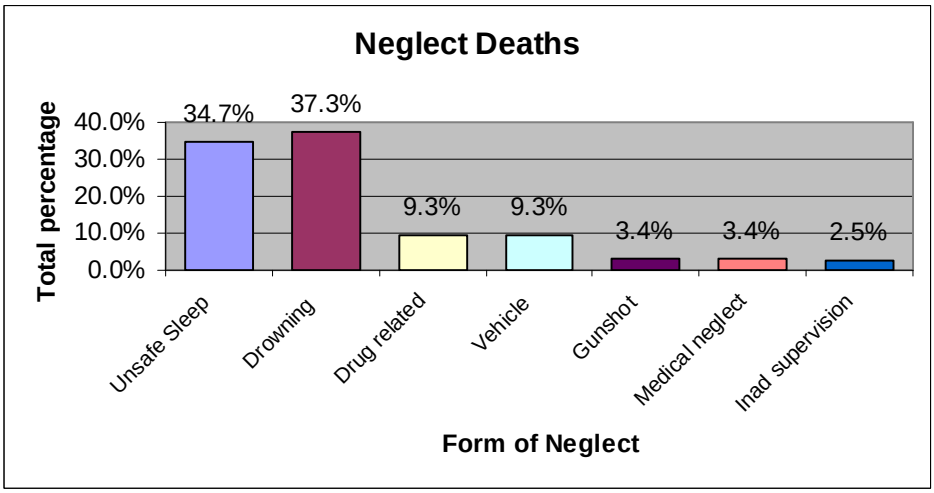


Research indicates that child fatalities are under reported. Studies in Colorado and North Carolina have estimated that as many as 50 to 60 percent of child deaths resulting from abuse or neglect are not recorded as such (Crume, DiGuiseppi, Byers, Sirotnak & Garrett, 2002: Herman-Giddens et al., 1999)[8] A recent study funded by the Centers for Disease Control and Prevention, have suggested that more accurate counts of maltreatment deaths are obtained by linking multiple reporting sources, including death certificates, crime reports, child protection services reports and child death review records(Mercy, Baker & Frazier, 2006)[9]

In cases of fatal neglect, the child's death is not a result of anything the caregiver did, but rather the result of a caregiver's failure to act. The neglect may be chronic (e.g., extended malnourishment) or acute (e.g., an infant who drowns because she is left unsupervised in the bathtub). NCANDS (National Child Abuse and Neglect Data System)[3] show that in 2006, 41.1% of child maltreatment fatalities were associated with neglect alone. Neglect has been the leading cause of child abuse deaths in Florida over the past seven years. Below is a graph of years 2004-2007. Neglect covers a broad section of maltreatments and may have no outward signs, so is often missed.

Child Neglect deaths are often over looked and coded as “just a tragic accident” by law enforcement and Child Protective Investigators, feeling that the family has suffered enough. With emotions clouding the investigator’s judgment and ability to look for facts and contributing factors of neglect, they close the case accidental. There is a lack of training to both law enforcement officers as well as Protective Investigators on child death investigations. There is no standardization in these investigations; allowing for inconsistencies in information collected by law enforcement and inconsistencies in child death verification by DCF.

The graph below shows the 118 child deaths reviewed caused by a type of neglect



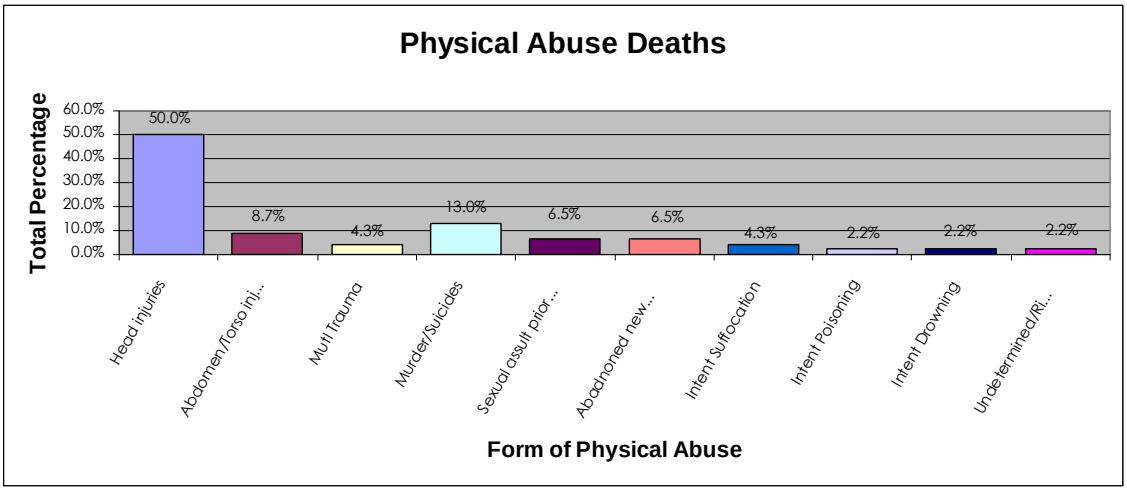
Physical abuse is often the most easily spotted form of abuse. It may be any form of hitting, shaking, burning, pinching, biting, choking, throwing, beating, and other action that causes physical injury, leaves marks, or produce significant physical pain. No one single triggering event has been identified that explains the occurrence of all cases of physical abuse.

Angleo Giardion and Elieen Girardino[10], PHD have suggested that there are circumstances that may give rise to the occurrence of a child's injury via physically abusive actions have been organized into a typology having the following 5 subtypes: (1) caregiver's angry and uncontrolled disciplinary response to actual or perceived misconduct of the child; (2) caregiver's psychological impairment, which causes resentment and rejection of the child by the caregiver and a perception of the child as different and provocative; (3)

child left in care of a baby-sitter who is abusive; (4) caregiver's use of substances that disinhibit behavior; and (5) caregiver's entanglement in a domestic violence situation.

Specific factors that may place the child at higher risk for physical maltreatment include prematurity, poor bonding with caregiver, medical fragility, various special needs (attention deficit hyperactivity disorder), and the child being perceived as different (physical, developmental, and/or behavioral/emotional abnormalities) or difficult, based on temperament .

The graph below shows the 45 child deaths reviewed caused by a type of physical abuse.

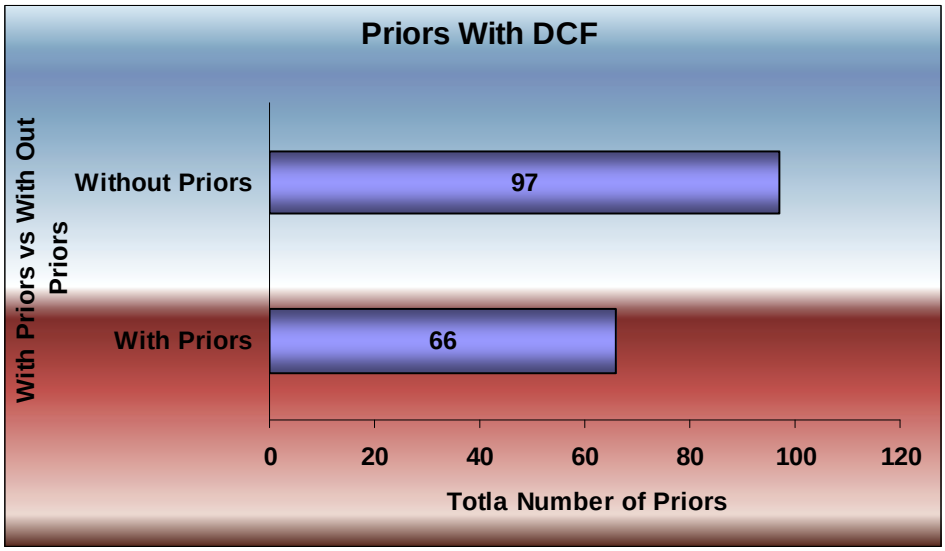


PRIOR INVOLVEMENT WITH THE DEPARTMENT OF CHILDREN AND FAMILIES

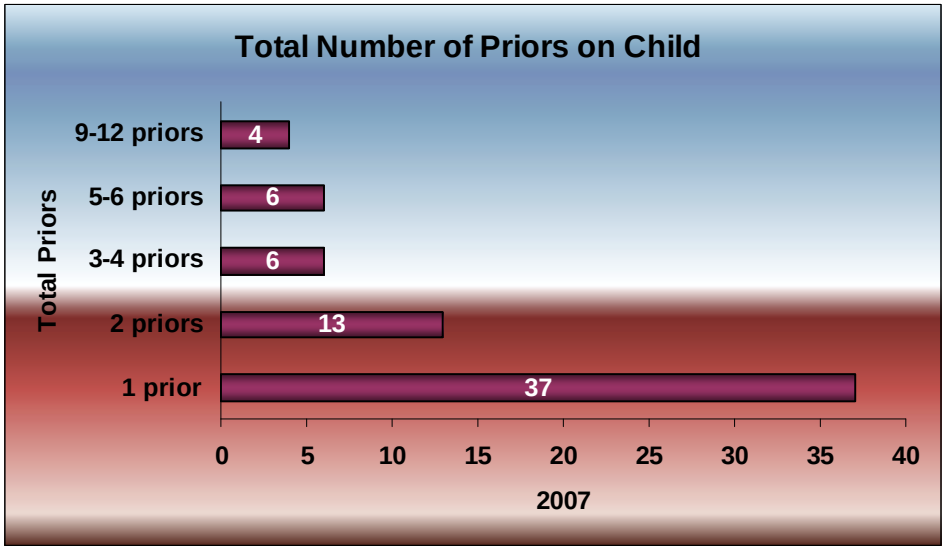
According to the US Department of Health and Human Services[3], children who had been abused or neglected and whose families had received family preservation services in the past five years accounted for 13.7 percent of child fatalities. Nearly 2 percent (2.3%) of the children who died had previously been in foster care and were reunited with their families in the past five years.

One of the best predictors of future behavior is past behavior. The following graphs demonstrate a number of deaths with priors and without priors as well as the number of priors on each child who died.
There were 66(46%) cases in 2007 where the child had prior involvement with the Department of Children and Families.

97(54%) did not have prior involvement with the Department of Children and Families.



The graph below depicts the number child abused death cases that had one or more prior reports.



Elizabeth*
Co-sleeping

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The mother, age 24, and father, age 32, put the Elizabeth, 4 months old, in their adult bed with them. When they woke up, Elizabeth was not breathing. Their home was noted to have hazards and filthy. Drug tests were requested 3 days after the death and the mother tested positive for benzodiazepine, and the father tested positive for benzodiazepine and marijuana. There was an open DCF investigation regarding drug use as well as physical abuse. The parents have criminal and drug histories.

There are a significant number of cases where the family or caretakers had been involved with the Department of Children and Families prior to the child's death, which is shown in the chart below. (Note some of the priors are from other States) Often the history of the parents is overlooked and opportunities to provide services are missed. Many of these young parents were neglected as children and parent as they were parented, allowing the cycle of abuse and neglect to continue.

The graph below shows the number of prior reports on household members of the deceased child with the Department of Children and Families prior to the child's death. (Household member: parent, grandparent, sibling, paramour, or other person living in the home).

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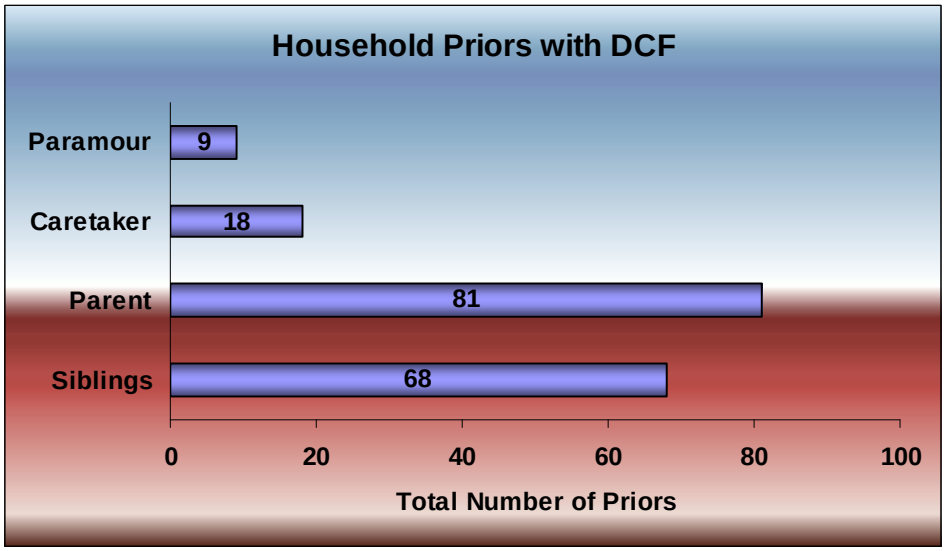

Household Priors with DCF
Paramour
9
Caretaker
18
Parent
81
Siblings
68
0
20
40
60
80
100
Total Number of Priors

PREVENTABILITY

Preventable deaths

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

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

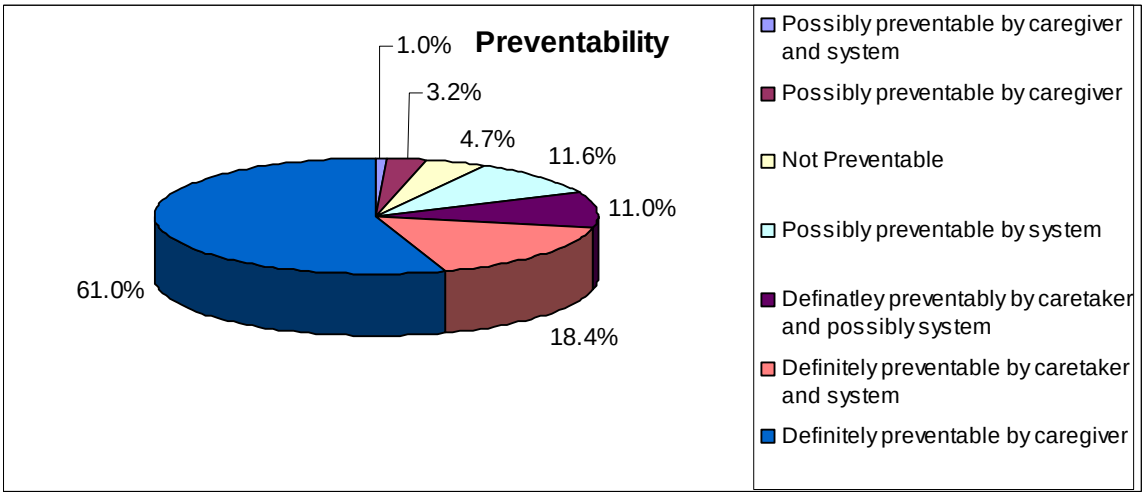
Deaths resulting from homicidal violence are classified as "not preventable" unless the information provided clearly demonstrates that actions taken by the community or and individual other than the perpetrator could definitely have prevented the death or could possibly have prevented the death

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

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

Of the abuse deaths reviewed:

- 90 (61.0%) were definitely preventable by caretaker
- 30 (18.4%) were definitely preventable by caretaker and system
- 18 (11.0%) were definitely preventable by caretaker and possibly system
- 14 (3.2%) were possibly preventable by caretaker
- 5 (1.0%) were possibly preventable by caretaker and system
- 3 (11.6%) were possibly preventable by system
- 3 (4.7%) were not preventable


Preventability
1.0%
3.2%
4.7%
11.6%
11.0%
61.0%
18.4%
Possibly preventable by caregiver and system
Possibly preventable by caregiver
Not Preventable
Possibly preventable by system
Definatley preventably by caretaker and possibly system
Definitely preventable by caretaker and system
Definitely preventable by caregiver

PERPETRATOR INFORMATION

The State Committee has seen common factors in numerous cases that seem to be contributing factors in the death of children. Frequently, the perpetrator is a young adult in his or her mid-20's without a high school diploma, living at or below the poverty level, depressed and who may have experienced violence first-hand. Fathers and other male caregivers were responsible for the majority of the physical abuse fatalities. These factors include young males between the ages of 18-30 who are unemployed and are often providing primary child care while the biological mothers work. The fact that many of these males are unattached non-biological fathers contributes to their impatience and lack of parenting skills. In addition, many male caregivers had histories of substance abuse, domestic violence, criminal history of aggressive or violent behavior or history of involvement in the child protection system.

Female perpetrators were generally responsible for the majority of the neglect fatalities. However there were many instances where mother's also failed to protect their child from the male perpetrator of the physical child abuse fatality. Many of the mothers were aware of the abuse occurring yet left their child in the care of abuser. In addition, many of the female caregivers had histories of substance abuse, domestic violence, criminal history and history of involvement in the child protection system.

Any partner in the child protection system should be aware of and sensitive to these male and female related risk factors when investigating an allegation of child abuse. Families with these risk factors, irrespective of the findings, should be considered at the highest risk for child maltreatment, in many of the deaths, the State Committee found more than one person to be responsible for the child's death, whether they committed the act intentionally or failed to protect the child.

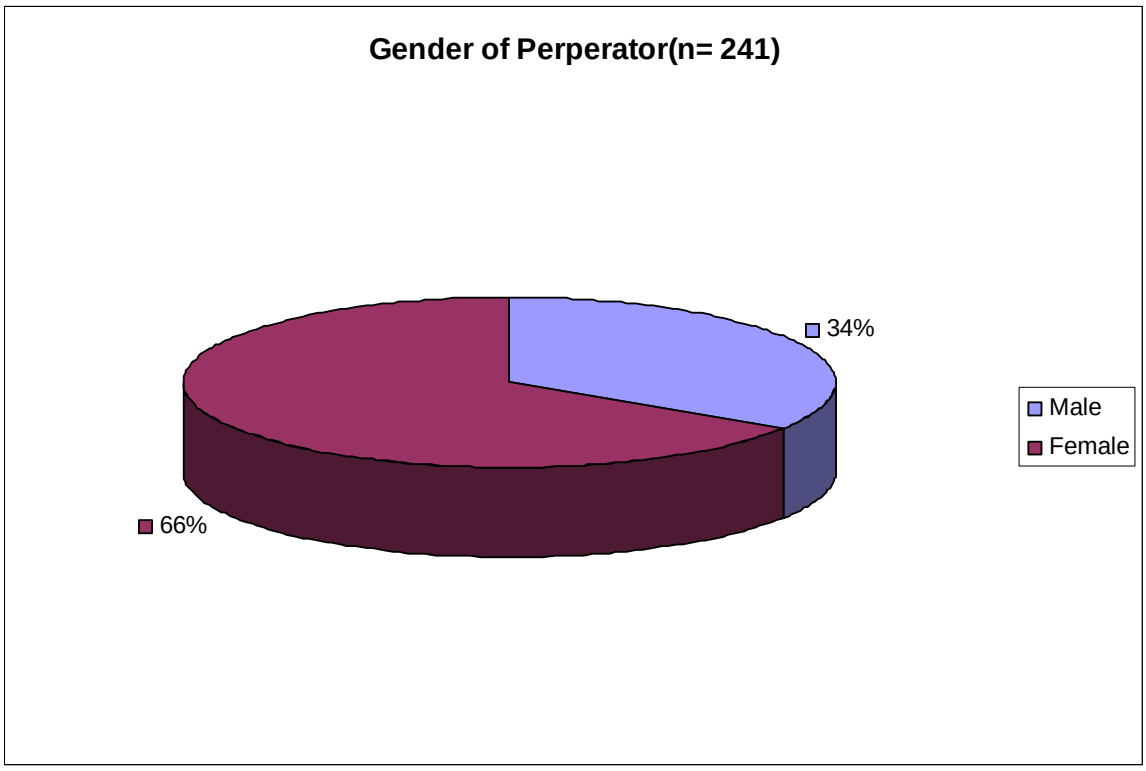
The total perpetrators responsible for the 163 child deaths were 241.

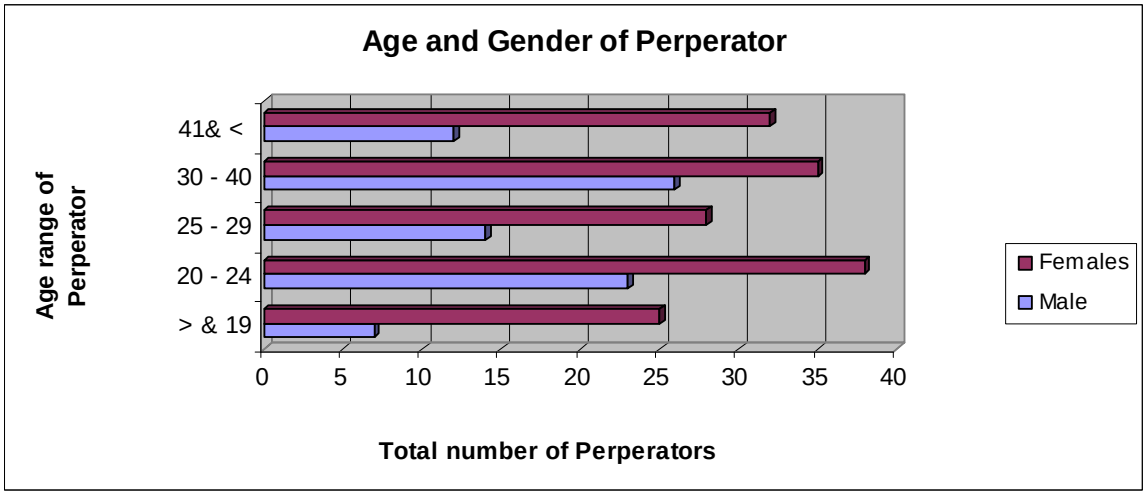
Note: more than one perpetrator may be identified in a case

Gender of Perpetrator/ Caregiver

Of the 241 perpetrators identified

- 158 (66%) were females
- 82 (34%) were males



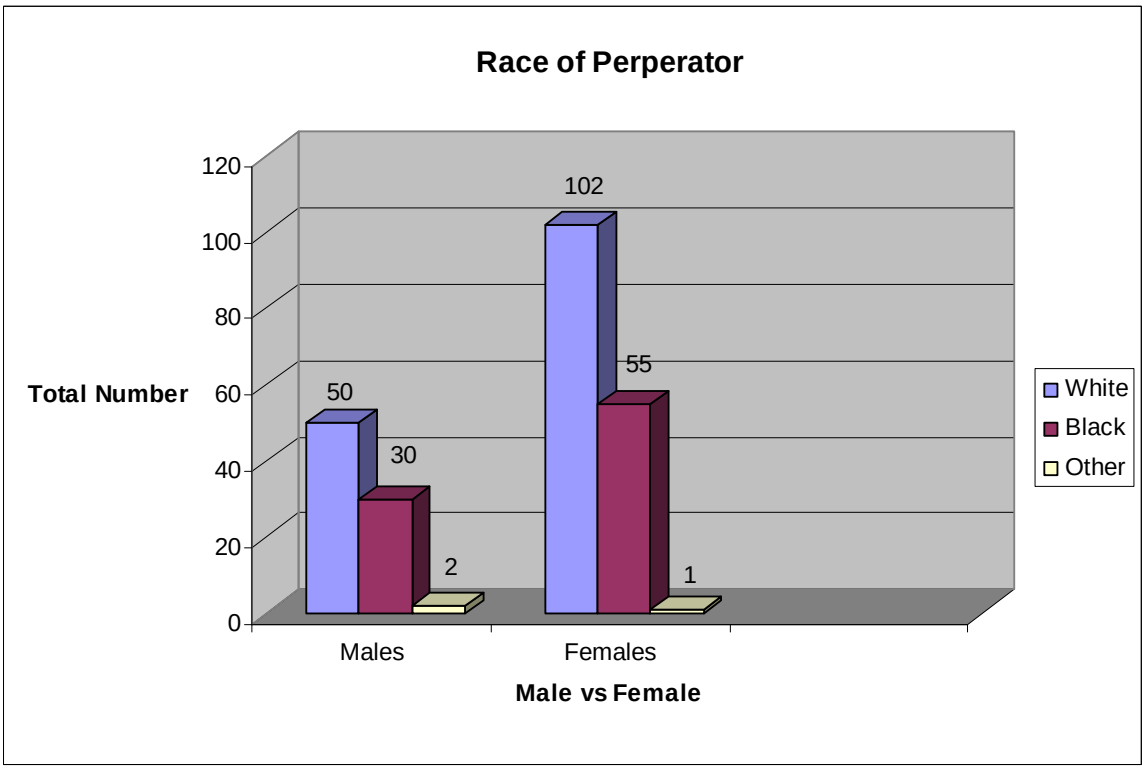


The State CADRT noted a significant increase in grandmothers as perpetrators responsible for numerous child drowning and co-sleeping/suffocation related child neglect deaths. Therefore explaining the unusually high number of females represented in the 30 and higher age categories shown above.

Race of Perpetrator

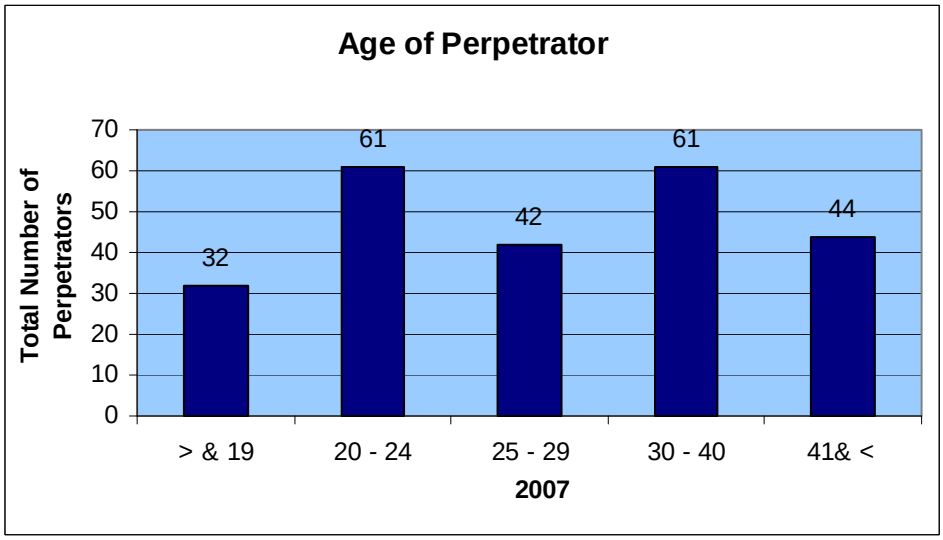
- 152 (63%) perpetrators were white
- 85 (35%) perpetrators were black
- 3 (1%) perpetrators were other

The graph below shows the breakdown of race by gender.



Age of Perpetrator

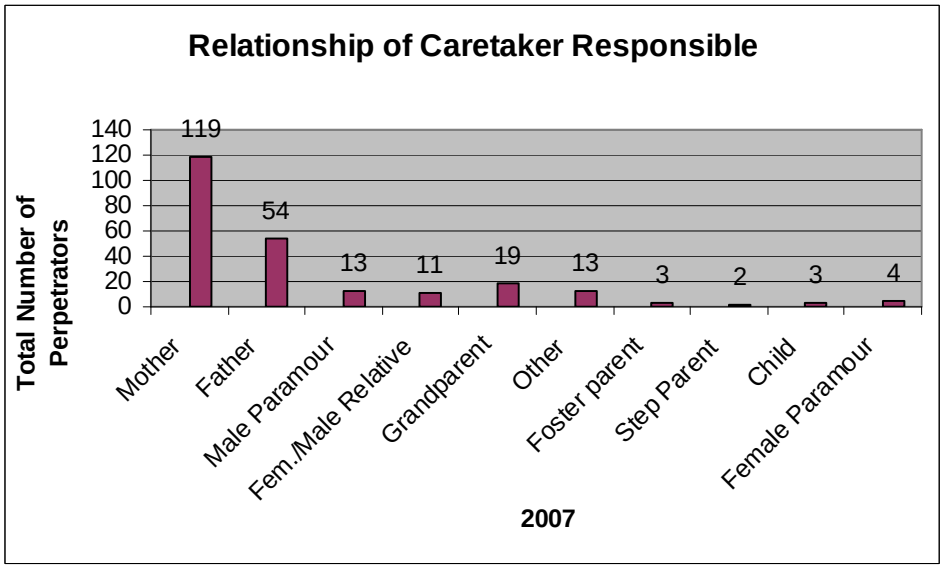
- 32 (13.3%) were under the age of 19
- 61 (25.4%) were 20-24
- 42 (17.5%) were 25-29
- 61 (24.4%) were 30-40
- 44 (18.7%) were > 41



Their relationship to the deceased child is shown below.

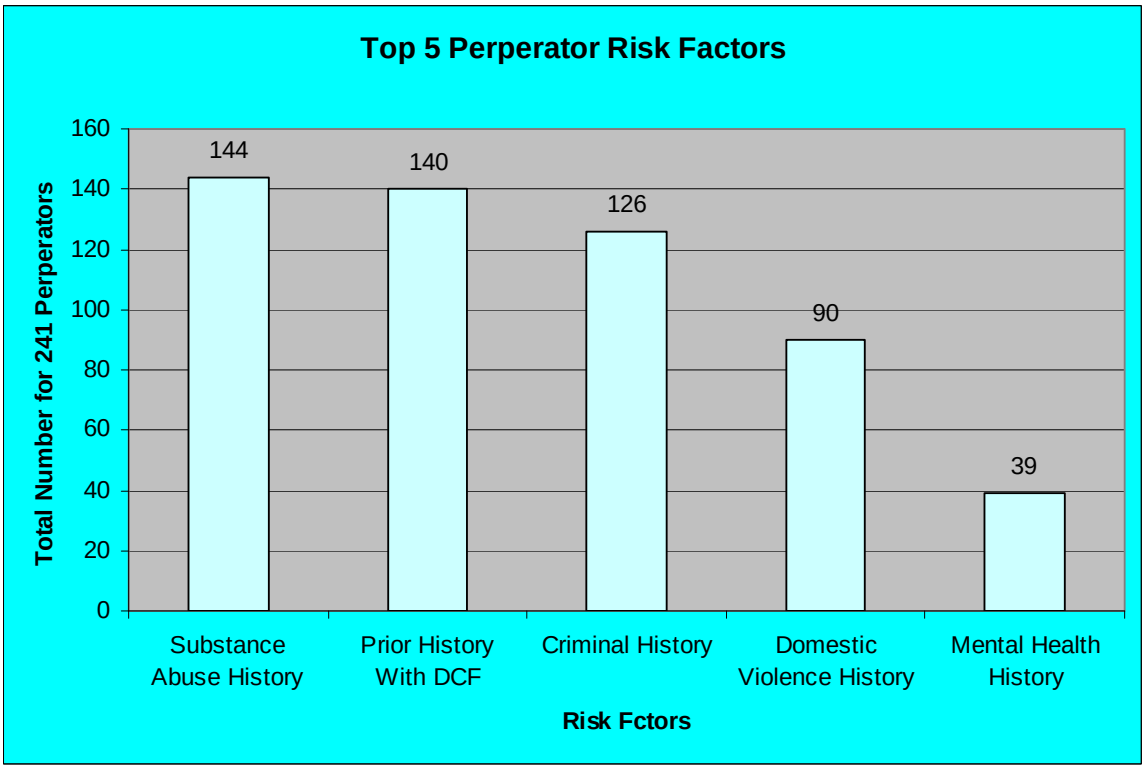
Relationship of Caregivers to Child

- 119 (49%) Mother
- 54 (22%) Father
- 19 (8%) Grandparent
- 13 (5%) Male Paramour
- 11 (5%) Female/Male Relative
- 13 (5%) Other
- 4 (2%) Female Paramour
- 3 (1%) Child
- 3 (1%) Foster parent
- 2 (1%) Step-parent


Relationship of Caretaker Responsible
Total Number of Perpetrators
140
120
100
80
60
40
20
0
119
54
13
11
19
13
3
2
3
4
Mother
Father
Male Paramour
Fem./Male Relative
Grandparent
Other
Foster parent
Step Parent
Child
Female Paramour
2007

PERPETRATOR/CAREGIVER RISK FACTORS

The total perpetrators responsible for the 163 child deaths were 241. There may be more than one perpetrator identified in a case. The State Committee identified the most significant perpetrator risk factors as, substance abuse history, DCF history, criminal history, domestic violence history and mental health history. The graph below shows risk factors for 241 perpetrators in the 163 child abuse death cases.



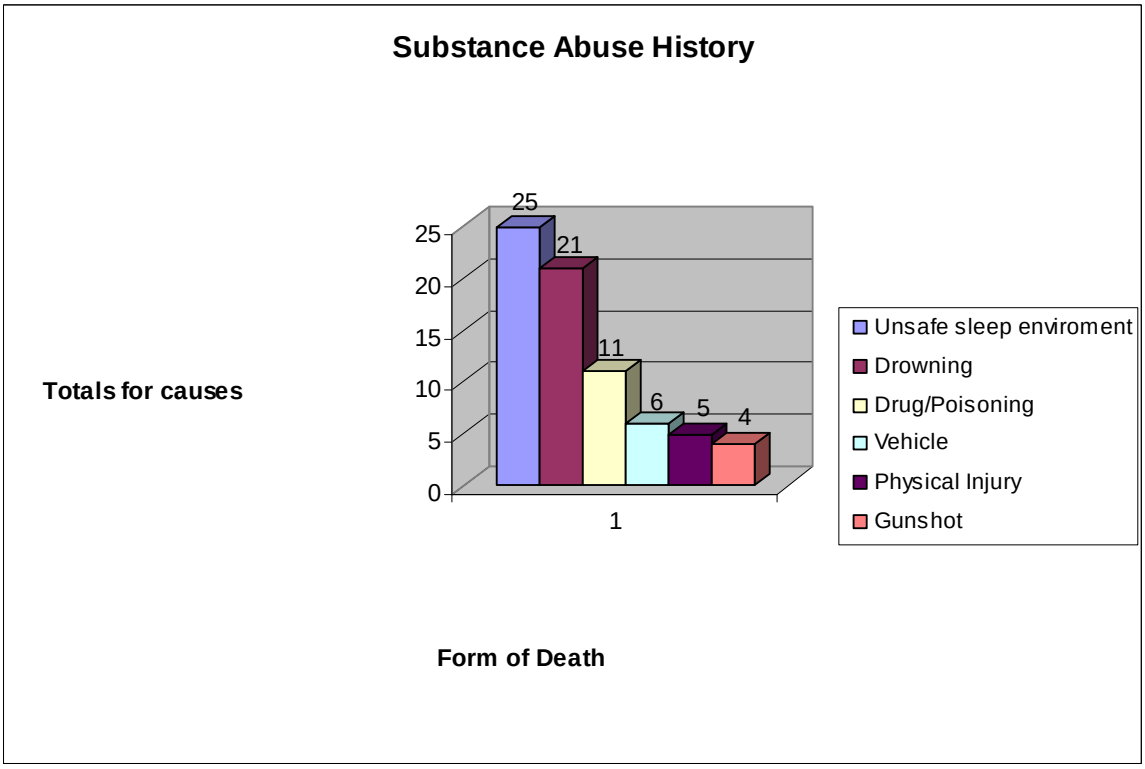
SUBSTANCE ABUSE

Substance abuse continues to be one of the highest risk factors for child fatality. Parents or caregivers who abuse drugs or alcohol suffer from impaired ability to care for their children. Of concern is the lack of identification of substance abuse/use as a contributing factor in child abuse deaths because of lack of on-scene presumptive drug testing as part of the child protective or law enforcement investigation protocol. Further there should be training that includes the

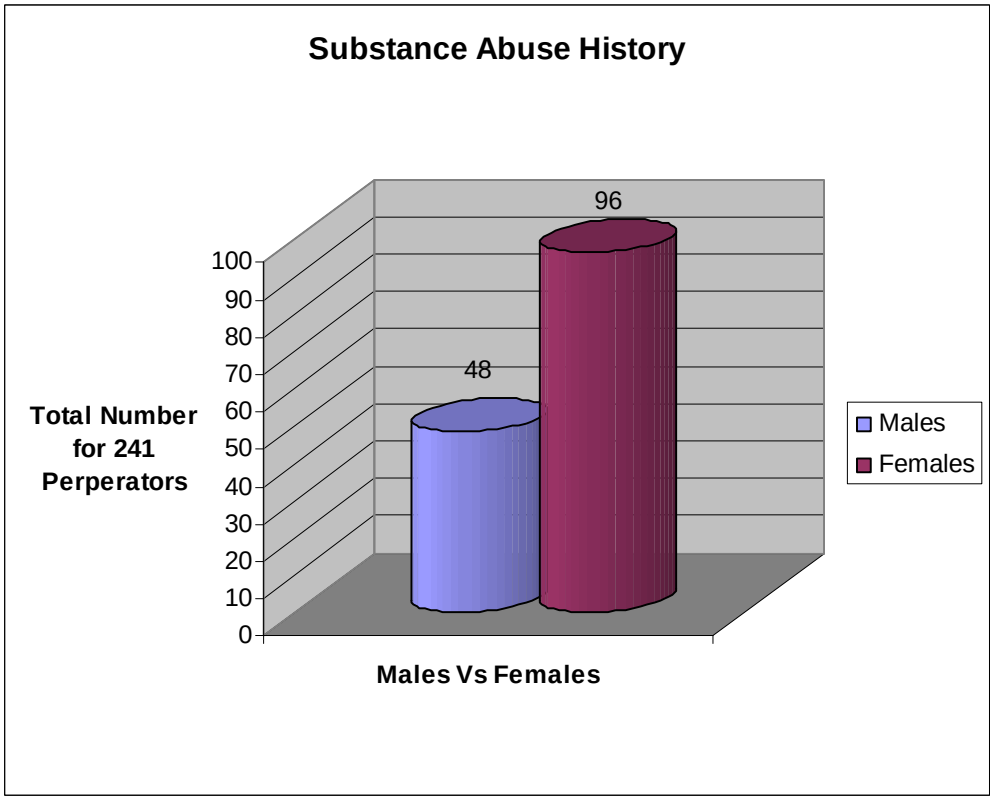
identification and assessment of substance abuse not only when the allegations include substance abuse, but in all abuse and neglect cases as part of the safety and risk assessment. The training should include specific tools and strategies to identify the "nexus of harm" in each case; and to recognize when substance abuse intervention and treatment is necessary to reduce the risk of further abuse or neglect.

The State Committee continues to see a pattern where investigative findings indicate that substance abuse by the parent or person responsible for the child was documented in prior reports or substances were discovered in the home at the time of the child's death and no drug testing occurred. Substance abuse allegations or indicators do not appear to have been appropriately factored into the risk assessment. Subsequently, cases are either referred to voluntary services or no services are offered. As acknowledged in last year's report, the State Committee recognizes that the Florida Appellate Courts have overturned the sheltering of children due to the lack of statutory authority in cases involving substance abuse as the nexus for sheltering child victims. However, this should not be the guiding factor when making determinations for child safety.

The graph below shows the substance abuse history identified by the State Committee by the causes of deaths.



The State Committee identified the substance abuse history by gender of the perpetrator shown below in the graph. There were more females that had substance abuse history than males. Females are more responsible for the majority of the neglect cases.



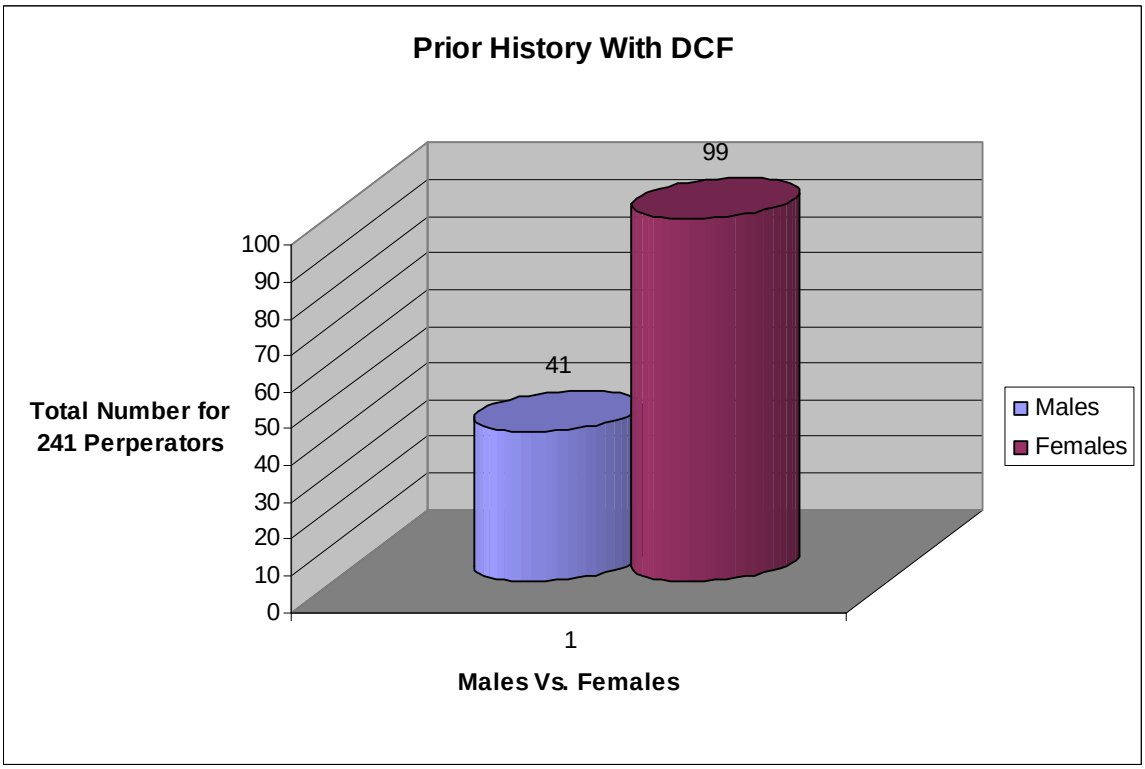
***Sarah**
Pool drowning

The Grandmother, who had legal custody, allowed the Sarah's mother to take her outside by the pool. Sarah, who was 8 months old, was in her walker. The mother, who was supposed to be supervising Sarah, "fell asleep" while smoking a cigarette. Sarah fell into the pool in her walker and drowned. The mother had a long history of substance abuse and criminal history. No criminal charges were filed and no drug tests were requested.

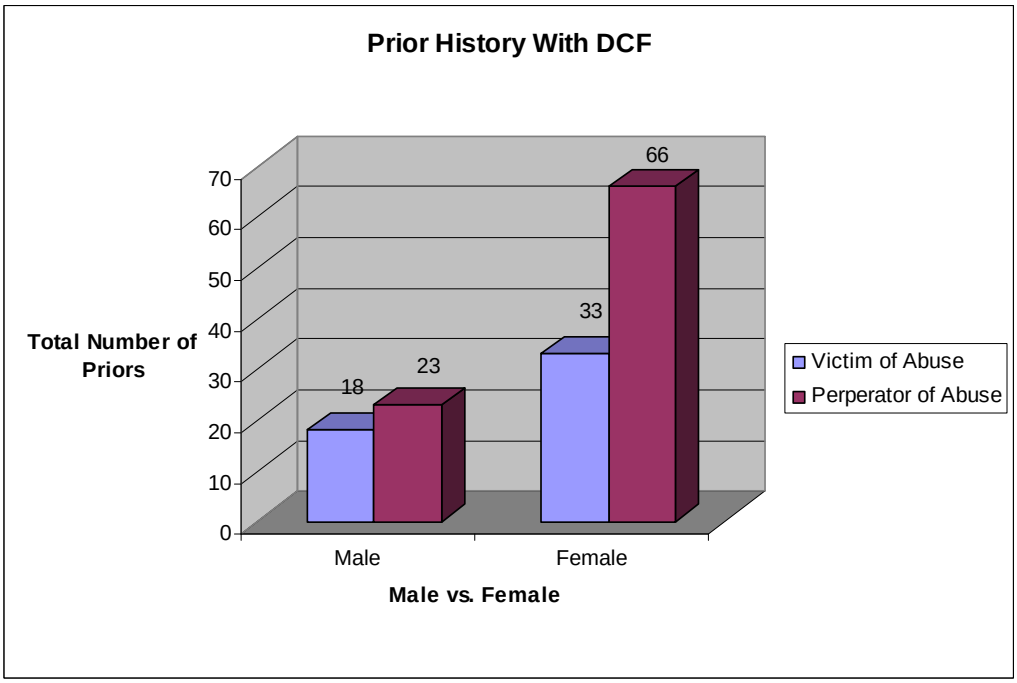
DCF HISTORY

Caretakers who abuse or neglect their children are most often acting upon beliefs and experiences from their own childhood. Many of the caretakers were victims of child abuse and neglect. Research suggests that about one-third of all individuals who are maltreated as children will subject their children to maltreatment, further contributing to the cycle of abuse. The Committee often finds that this risk factor is not considered, thus missing opportunities to intervene with appropriate services.

The graph shown below represents the Prior History with DCF.

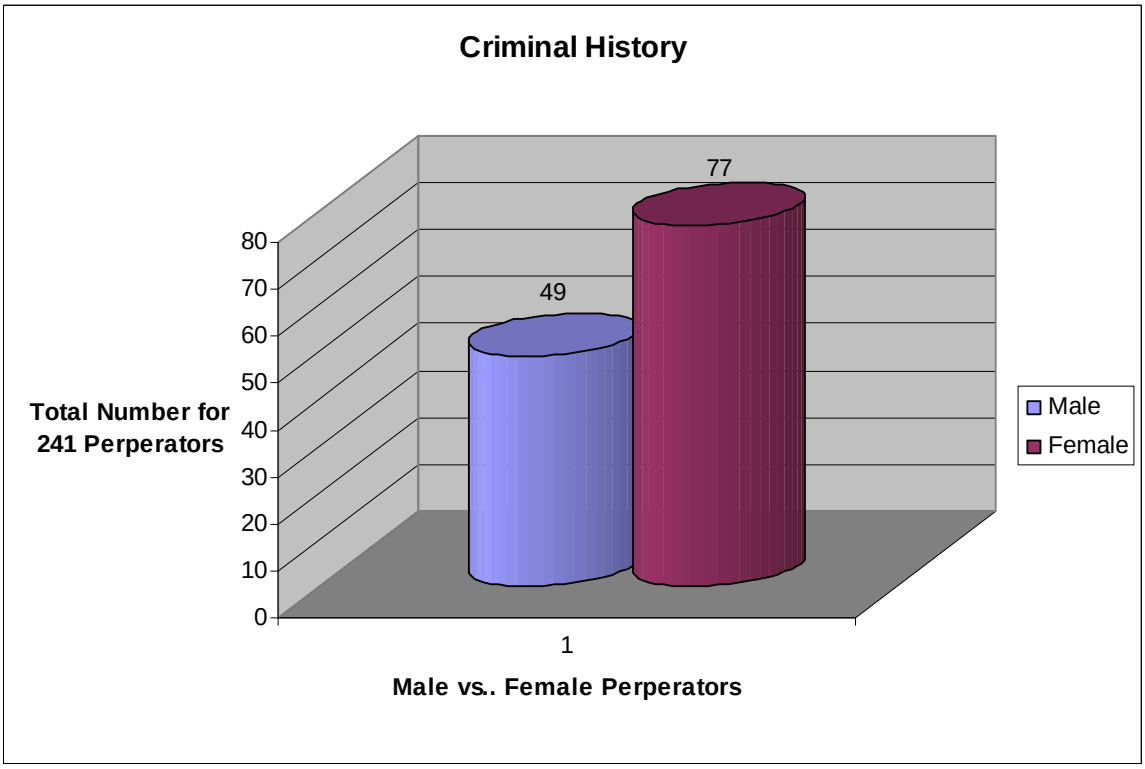


The graph below represents the type of history the perpetrators had with DCF (whether they were a perpetrator or victim of abuse/neglect).



CRIMINAL HISTORY

The best predictor of future behavior is past behavior. It is important that investigators look for and take into consideration criminal history of the caretakers as a risk factor, especially when the history involves violent behavior and drug related offences. The graph below shows the total number of perpetrators by gender that had prior criminal history. Out of 241 perpetrators, 140 (58%) had a criminal history.



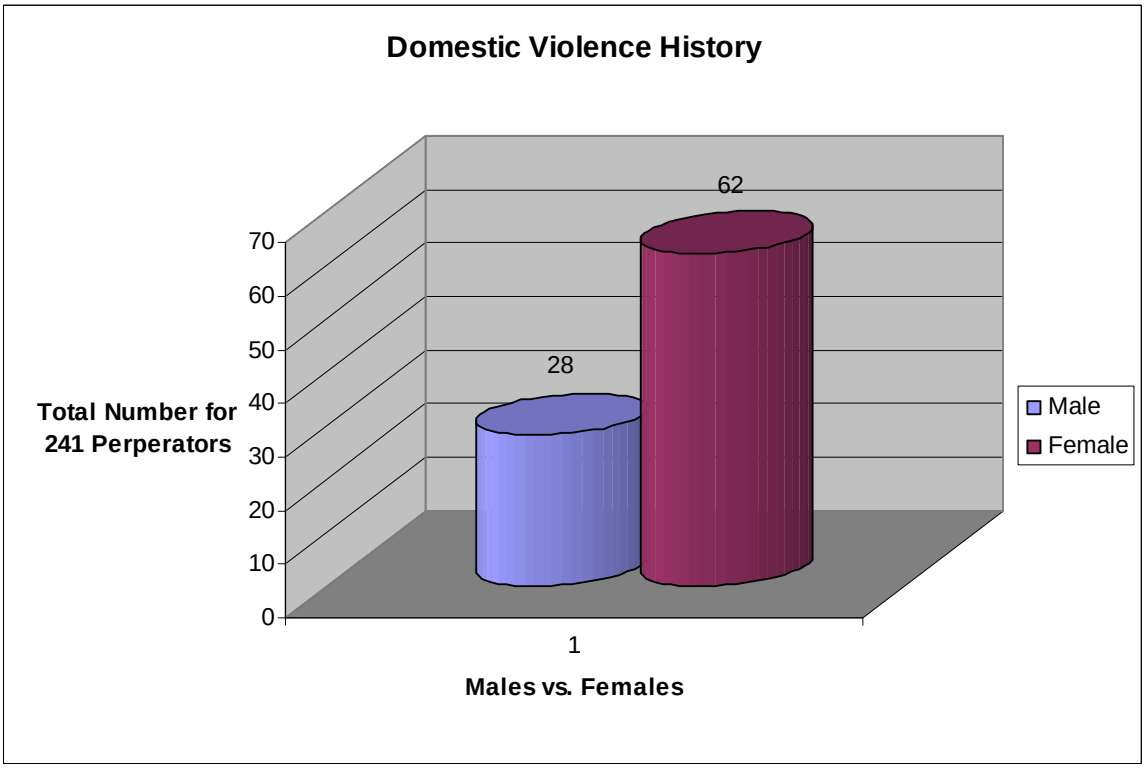
DOMESTIC VIOLENCE

Child abuse and domestic violence are closely related -- 30% to 60% of domestic violence perpetrators also abuse children in the household[11]. Therefore, to reduce child abuse deaths at the hands of domestic violence perpetrators, it is critical that victims of domestic violence be encouraged to seek out the safety planning assistance of their local domestic violence center -- keeping domestic violence victims safe can keep their children safe.

Increased public awareness regarding the importance of reporting domestic violence or threats of violence is important in preventing future homicides, including child abuse fatalities, by providing an opportunity to intervene. Furthermore, it is important that the practice of screening for domestic violence whenever there is a DCF referral, regardless of the nature of the referral.

Florida Department of Law Enforcement reported that Domestic Violence accounted for 164 (15%) of the state's 1129 homicides in 2006. Children accounted for 19% of the victims.

Of 241 perpetrators identified in 163 cases reviewed by the State Committee, domestic violence history occurred in 37% percent.

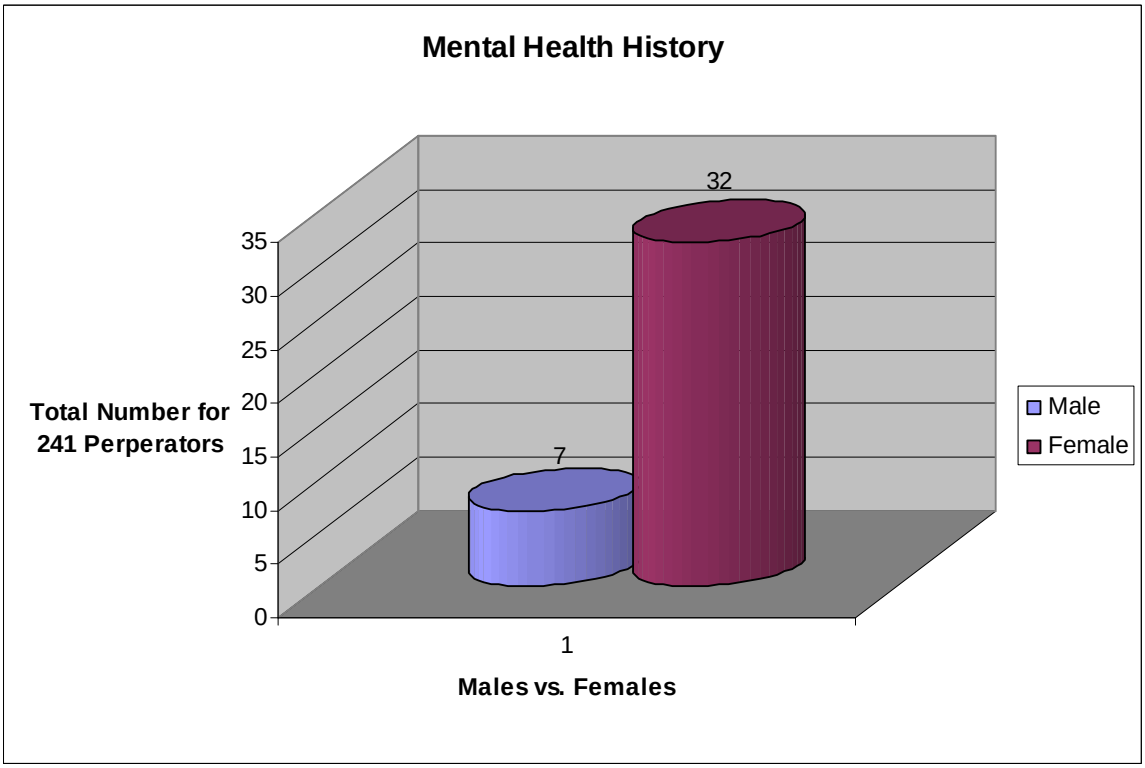


The graph below shows domestic violence history as a victim or perpetrator by gender.

MENTAL HEALTH

Mental Health records are critical sources of information when assessing child safety and essential to the review process when a child has died from abuse or neglect. The State Committee recognizes the need for confidentiality and the reluctance of many providers to release information to child abuse death review committees. However, often there is essential information that helps to better understand the dynamics and circumstances related to the death of a child. The State Committee recognizes that not all persons with mental health conditions put their children at risk, but there are times when individuals are non-compliant with treatment and uncooperative with family members that children may be placed at higher risk. Child Protection workers should be knowledgeable about mental health conditions and ensure that mental health history is considered as a factor in child abuse investigations.

The graph below shows the total number of perpetrators with mental health history identified by the State Committee.

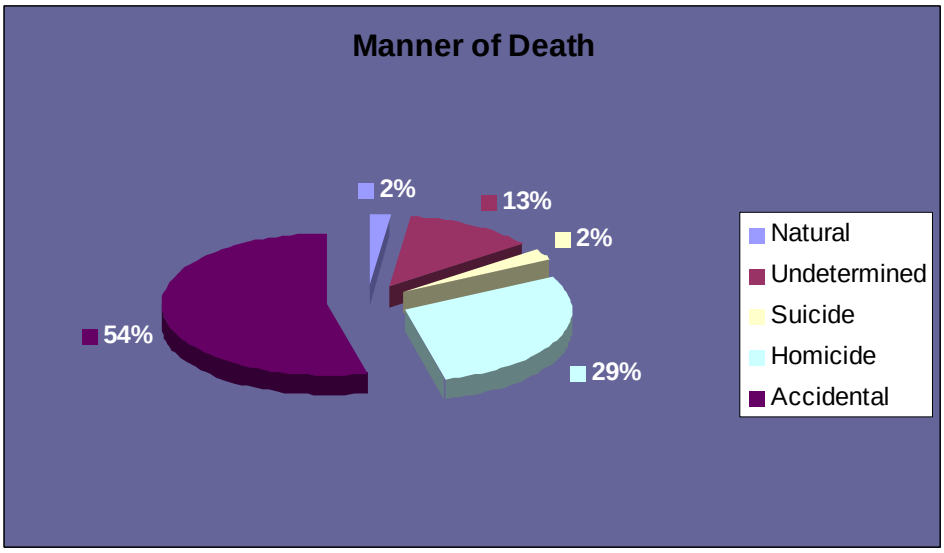

Mental Health History
Total Number for 241 Perperators
35
30
25
20
15
10
5
0
32
7
1
Males vs. Females
Male
Female

MANNER OF DEATH

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

The State Committee reviewed 163 child abuse deaths, which were classified as follows:

- 88 (54%) Accidental
- 47 (29%) Homicides
  - 39 (83%) were 4 and under
- 21 (13%) Undetermined
- 3 (2%) Natural
- 4 (2%) Suicide



SLEEPING ENVIRONMENT-RELATED DEATHS

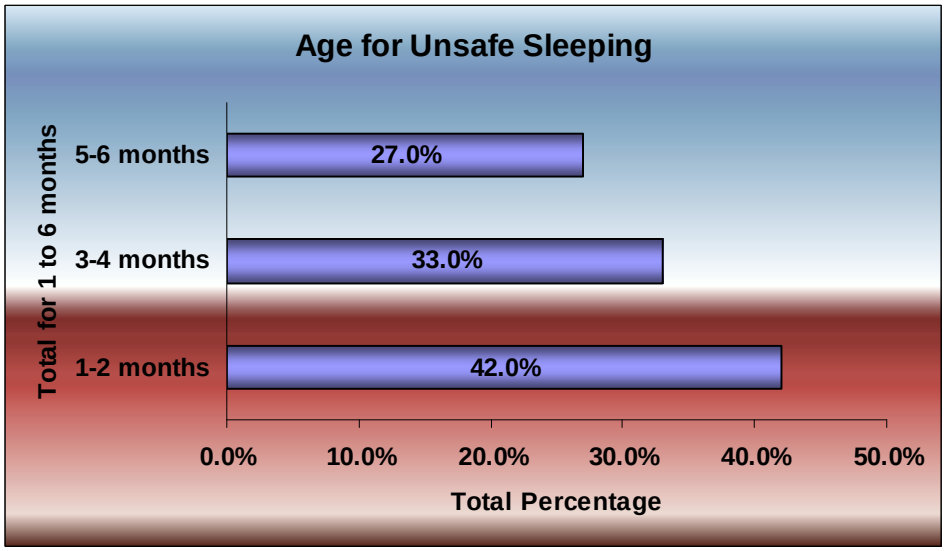
Infant deaths are tragic, but must be investigated. Nothing is more difficult on a family than dealing with the death of their child. It is understandable that the medical professionals, law enforcement agencies and child protection agencies would tread gently when dealing with the death of an infant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

Having a safe sleep environment can be a matter of life and death for an infant. Unsafe sleep environments include a sleep surface not designed for an infant, (i.e. couch, sofa, adult bed, chair), excessive bedding, toys or decorative bumper guards, sleeping with head or face covered, or sharing a sleep surface with multiple persons or with a person who is overly tired, obese, or under the influence drugs or alcohol. The State Committee has seen out of home placements made where the sleeping arrangement has not been addressed and unfortunately children have died as a result of the unsafe sleeping practices. In Manatee County they have established a Placement Notice that the caregivers sign, see Recommended Practices Section.

The State Committee has identified this issue as an on going problem over the past seven years. The Scripps Howard report showed inconsistencies across the country in how these deaths are investigated. Thus the need for training and/or education for parents, hospitals, nurses, medical examiners, pediatricians and law enforcement officers investigating these types of deaths is essential. The Center for Disease Control has provided the Sudden Unexplained Infant Death Investigation training (SUIDI) to every State in the country. The CDC has encouraged every State to adopt the SUIDI as a standardized approach to infant death scene investigation by all Medical Examiner Districts as well as law enforcement agencies. The State Child Abuse Death Review Committee views this project as a high priority and is supportive of identifying resources to initiate a statewide approach to training and outreach.

Key Findings

- 38 children died as a result of suffocation due to an unsafe sleep environment
  - Ages ranged from 1 month to 2 years
- 33 were 6 months and younger
  - 1-2 months
  - 3-4 months
  - 5-6 months



Gender of Child

- 26 were males
- 11 were females

Race of Child

- 19 were white
- 15 were African American
- 1 was Hispanic
- 1 multi racial

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Location of infant sleeping related suffocation deaths:

Cribs are the safest sleep environment for a child, of the 38 cases reviewed,19 of the cases had cribs in the home that were not being used,3 of the cases had cribs that were broken,11 of the cases had no crib at all and in 5 of the cases there was no documentation related to a crib.

- 26 were attributed to co-sleeping/overlay
  - 21 were co-sleeping in beds
  - 3 were co-sleeping on sofas
  - 1 was co-sleeping on a futon
  - 1 was co-sleeping on an air mattress

- 12 were placed in un-safe sleep safe environments

- 5 children were placed in either a crib or bassinet with pillows, blankets, or other unsafe items
  - 2 of the cribs were broken and unsafe
- 4 children were placed on adult beds with pillows surrounding
- 2 children rolled off and suffocated on items on the floor
- 2 children were left in car seats for extended period of time
- 1 child was placed in a bean bag chair with pillows and blankets

Perpetrators involved in these sleep related suffocation deaths:

- 17 (55%) caregivers were between ages of 17-29
- 9 deaths were attributed to both parents
- 7 deaths were attributed to mothers
- 6 deaths were attributed to relatives
  - 5 were grandmothers
  - 1 was a relative placement
- 4 from sharing a sleep environment with parents and sibling(s)
- 1 death was attributable to fathers

Risk Factors attributed to infant sleep related suffocation deaths:

- Substance abuse histories were noted in 25 of the 38 (66%) sleep related cases
  - 7 drug tests were requested by DCF after the death
  - 5 drug tests were requested by DCF and administered days later
  - 3 drug tests were requested by DCF days after the death but were refused
  - 10 of the cases had no drug test requested by DCF
- Obesity of the adult was a factor in 2 of the co-sleeping cases
- Inadequate supervision was a factor in 3 of the suffocation deaths
  - Bottle propping was noted in 2 of the cases
    - 2 infants aspirated on their formula after they were left unsupervised, ages 2 months and 3 months
    - One 2 month old was put in crib at day care and had not been checked on for a long period of time. The cause of death was undetermined due to inconsistency in statements by staff

Martha*
Co-sleeping

The parents, ages 22 and 24, were sleeping on an air mattress with their children, ages 6 and 1. The air mattress was partially inflated. Due to financial difficulties, the family was living with relatives. The father went to check on the children and found the children wrapped around each other. He discovered that the baby was face down and partially under the 6 yr old. During this investigation, it was learned that the family had a one-month old child die in 2004 from SIDS. The family was sleeping on the same air mattress when that baby's death occurred.

PHYSICAL INJURY

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…"

Intentional physical injury has components that the state committee found noteworthy to separate into three categories: Physical injury, Murder/suicide, and Abandoned newborns. In this section we will review these three categories and provide perpetrator risk factors discovered by the State Committee during the review of the child's death.

Children living in households with unrelated adults are nearly 50 times as likely to die of inflicted injuries as children living with two biological parents, according to a study of Missouri abuse reports published in the journal of the American Academy of Pediatric in 2005[12]. Lack of a relationship or attachment to the child can cause a non-relative to become frustrated and irritated when there is a perceived problem with the child. Many unrelated males have little to no experience in parenting, yet they are often trusted to care for the child while the mother works. Some non-abusing mothers chose not to intervene in abusive situations for a myriad of reasons, some unknown, and allow the abuse to continue with no intervention. Children should be raised by caretakers that create an environment that is nurturing and that allows them to learn and thrive as they grow. Abusive caretaker behavior does just the opposite and often creates long lasting emotional and physical scars that many children to carry into adulthood.

The State Committee has found that a majority of the mothers are not held accountable or charged criminally.

Head injury is the leading cause of death among children who have been physically abused. Many of the children who died from head trauma also suffered multiple injuries to other areas of their bodies.

Key Findings

- 45 children died as a result of abusive injury
- 18 (40%) of the cases had prior DCF involvement
- 19 of the children had healing injuries(fractures, bruises, burns)

- **Age of Child**

- 39 (87%) of the children were 4 and younger
- 24(53%) of the children were under the age of one

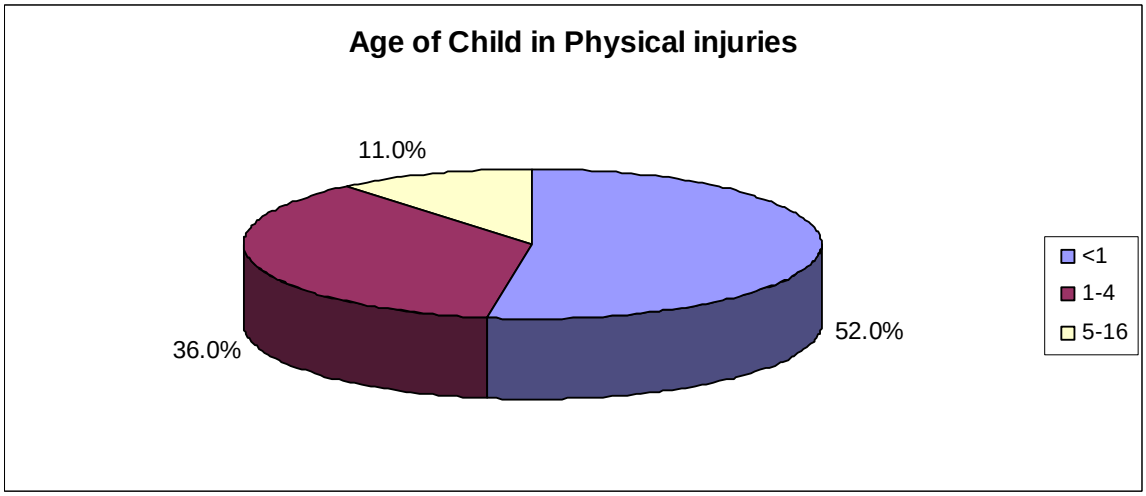
- **Gender of Child**

- 21 (47%) were males
- 24 (53%) were females

- **Race of Child**

- 21(47%) were white
- 6 (35%) were black
- 7 (15%) were Hispanic
- 1 (2%) was multi racial

The graph below shows the age of the child at the time of injury



Jill*
Asphyxia

The motel manager found Jill, age, 2, underneath her father in a motel room. Her father was found nude from the waist down, with only a t-shirt and socks on. His abdomen was completely covering child's mouth and nose. It was determined he died from a heart attack possibly the result of cocaine ingestion - he tested positive – and appeared to have fallen on top of the child during a possible attempted sexual act. Jill had bite marks on her arms and chest, contusions of eyes and laceration of the lip. Most of her teeth were decayed.

Of the 45 children that died as a result of abusive injury:

28 died from physical injury

- 23 died as a result of head trauma
- 4 died as a result of abdominal/torso trauma
- 1 died as a result of multiple trauma

- 6 died as a result of a murder-suicide
  - 4 children were intentionally shot
  - 1 child was stabbed/cut by a sharp object
  - 1 child was intentional poisoned by carbon monoxide
- 3 deaths involved sexual assaults prior to death
- 2 were by asphyxia and one by a head injury
- 3 children were abandoned newborns
- 2 children were intentionally suffocated
- 1 child was undetermined and child had healing rib fractures
- 1 child was intentionally poisoned by morphine intoxication
- 1 child was intentionally drown in a pool

***Adam**
Abusive head trauma

Adam endured abuse at the hands of his 24 year-old father the whole 10 weeks of his life, while his 19 year old mother stood by and watched. The parents had been dating only 14 months. The father put a washcloth in child's mouth, secured it by putting tape over it and then put child in car seat in a closet. The child had broken ribs and a bruise on his head. The mother stated the father grew frustrated with the crying and learned he could stop the crying by pushing on child's abdomen. There was undocumented history of domestic violence with the parents. The parents have a long criminal history that includes drug related offenses. The mother was a victim of prolonged abuse and neglect as a child. After the death, the parents took the baby's car seat back to Wal-Mart for a refund. The father was charged with first-degree murder.

Murder/Suicide

Murder/suicide deaths involve cases where the child was intentionally murdered by their parent. The parent then took their own life or attempted too, hence the term murder/suicide. Although not necessarily predictors, domestic violence or mental health issues such as depression, schizophrenia, bi-polar disorder etc, were present in many cases.

The committee found that often in these types of deaths, the case files did not contain mental health records of the perpetrator, even though family members identified that there was past or on-going history of mental health concerns.

A domestic violence case should be considered “high risk” whenever a parent has threatened to harm their children regardless of whether the non-offending parent obtained an injunction for protection. In cases where the Department of Children and Families are involved, DCF should be vigilant in monitoring the parties’ behavior and court actions to ensure an injunction is not violated or dissolved without follow up safety planning on behalf of the victim and child(ren).

Key Findings

Of the 45 physical abuse deaths,

- 6 children died as a result of a murder/suicide by the parent
    - 4 children were killed by gunfire
    - 1 child was stabbed by a sharp object
    - 1 child was killed by carbon monoxide poisoning

Perpetrator related factors

- 3 children were killed by their mothers
- 3 children (2 were siblings) were killed by their fathers

Murder/suicide Perpetrator risk factors

- 4 had mental health concerns, including depression
- One had history of domestic violence and child custody concerns

***Phillip**
Murder suicide

A relative found the 2 yr old child covered in blood after being stabbed to death by his mother, age 24. She said she was trying to kill the demons that she believed lived in the child. The mother was also bleeding from self-inflicted wounds and told EMS not to save her. The mother had been diagnosed with schizophrenia in 2004 after a suicide attempt. The mother had been receiving mental health treatment for years but it was unknown if she was taking her medication. A co-worker noted that the mother believed someone watching her. The mother was charged murder, however was found incompetent and hospitalized.

Abandoned newborn

Neonaticide, the killing of a baby in the first 24 hours of life, generates strong public reaction. Hundreds of newborns likely die undiscovered every year after being

abandoned by their mothers in trash dumpsters, unoccupied dwellings, alleys etc. Many deaths are unreported to the child abuse hotline, but statewide training has resulted in notable improvement in reporting and verification.

According to Nick Silverio, founder of Safe Haven for newborns in Florida, their records for 2007 show that there were a total of: 4 abandoned newborns, 3 were found deceased and one was alive. They report that the incident of abandoned babies is less and less each year as more babies are being left at a fire station or Hospital, as allowed by the "Safe Haven Program," authorized by Florida State Statute:383.50[14].

Key Findings

The State Committee reviewed three death cases where the mothers abandoned newborns immediately after birth.

- One was thrown in the trash and taken to waste facility, the child was never located
- One was thrown in the garbage at her home
- One was thrown down the hotel trash bin on the 7th floor
- There is a need to continue providing continuing education on the "Safe Haven Law"
- Training is needed for law enforcement and child protective investigators to ensure reporting of these types of deaths to the Florida Abuse Hotline

Perpetrator related factors

- All were biological mothers
- All three hid and denied the pregnancy to family and friends
- Two of the mothers were white and one was Hispanic
- Ages were 18, 23 and 24
- All three were charged with murder
  - One was sentenced to 13 years prison
  - Two are pending judicial action

Baby Marsha*
Abandoned Baby

Baby Marsha was thrown a hotel trash shoot on the 7th floor by her 18 year-old mother. The family was vacationing in Florida. The parents were not aware she was pregnant. Fearing no support from her family, she hid the pregnancy by wearing loose fit clothing. The mother admitted she heard the baby cry prior to wrapping the baby in a towel. The mother was charged with first-degree murder.

Intentional Physical Injury Perpetrator Risk Factors:

36 deaths were attributed to intentional physical injury:

- 5 (14%) had drugs as a significant contributing factor for the perpetrator

Male Perpetrator related factors

- 31 (86%) were caused by male perpetrators
  - 11 deaths were caused by a male paramour
  - 13 deaths were caused by the biological father
  - 2 deaths were caused by male children
  - 2 deaths were caused by non-related persons
  - 3 perpetrators were not identified by law enforcement, however the father was the last known person with the child
- 21 (68%) of the male perpetrators had criminal history
- 19 (61%) of the male perpetrators had a domestic violence history
- 17 (55%) of the male perpetrators were between the ages of 18-30

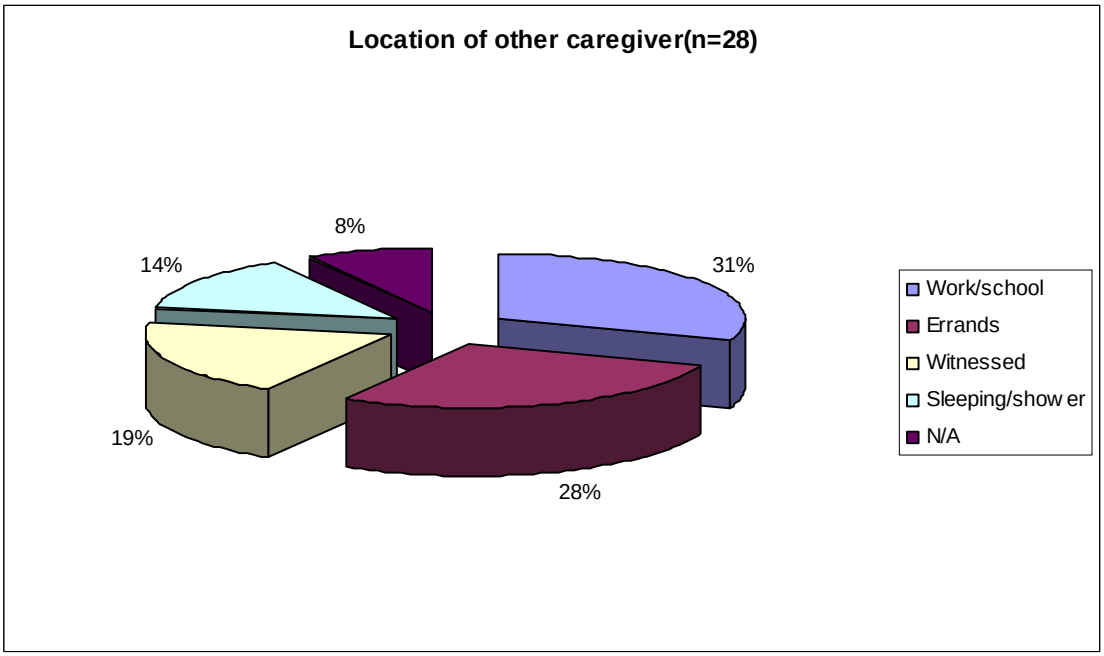
Female Perpetrator related factors

- 5 (14%) were caused by female perpetrators
  - 1 deaths were caused by a female paramour
  - 2 deaths were caused by biological mothers
  - 2 deaths were caused by non-relative

- 4 (80%) were between the ages of 18-30

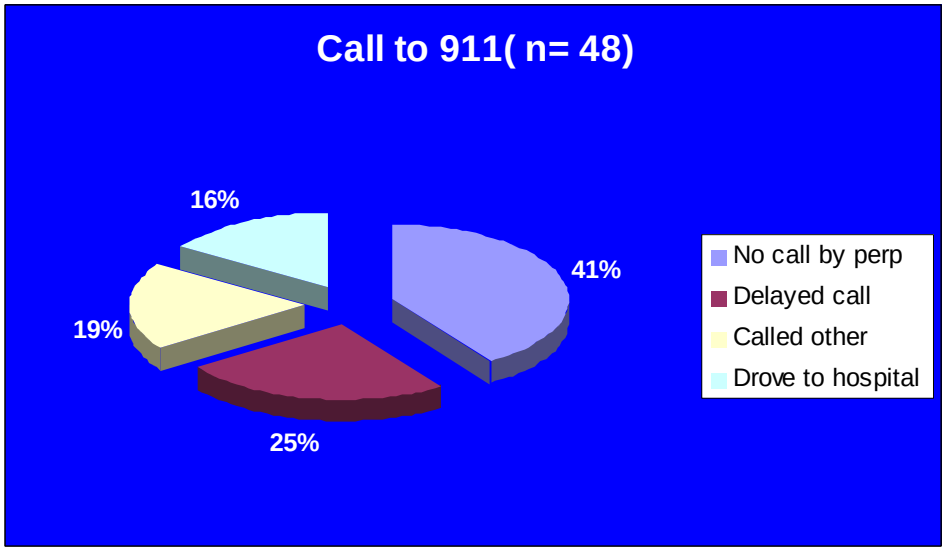
Female perpetrators

- 28 (78%) of the mothers, who were not the perpetrator, failed to protect their children
  - "failed to protect" is defined as being aware that abuse was occurring but failing to take any action to prevent it
  - 10 of the mothers were at work leaving male perpetrator as the caretaker
  - 11 of the mothers protect were ages 20-29
  - 8 of the mothers were between the ages of 16-19
  - 5 of the mothers were ages 30-49
  - 6 of the mothers were criminally charged



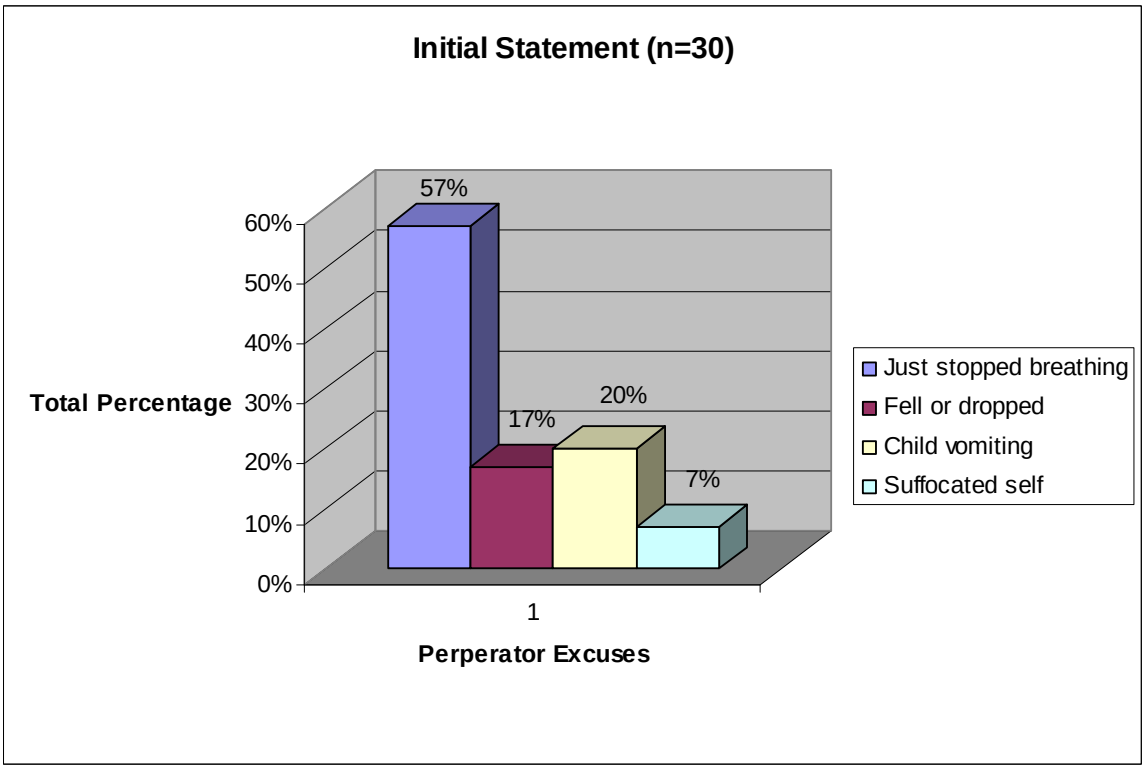
The Committee examined perpetrator responses in the physical injury deaths:

- 14 failed to call 911 and the majority waited until the mother arrived home at which time she called emergency services
- 14 caregivers intentionally delayed calling 911
- 14 called someone else before calling 911
- 6 drove the injured child to hospital instead of calling 911


Call to 911(n= 48)
16%
41%
19%
25%
No call by perp
Delayed call
Called other
Drove to hospital

Perpetrator statements:

- 17 gave an initial statement that the child "just" stopped breathing and/or was unresponsive
- 5 gave statements that the child fell or was dropped
- 6 gave initial statements that the child was vomiting or had medical issue
- 2 gave initial statements that the child was suffocated by a blanket



Melonie*
Asphyxia and sexual assault

Melonie, 14 years old, was with her mother at a friend's house. The mother left with a male friend, leaving her daughter with her friends, a husband and wife. Everyone was drinking, including Melonie. The adults she was left with had a fight and the wife left the home. The male then raped, assaulted and strangled Melonie. He took her body and buried it in the yard, claming she had run away. The mother did not report her daughter missing right away and initially gave false statements to law enforcement. He was charged with first-degree murder and sexual assault and has been sentenced to life in prison. The mother had criminal history of contributing to minor. She was not charged as to the death of her child. There were 4 prior reports to DCF on Melonie.

DROWNING

The Florida Abuse Hotline received 77 reports of child drowning deaths, but only 45 cases were verified. Therefore the State Committee was only able to review the 45 verified deaths. This is a significant drop from the 52 reviewed in 2006, given the fact that child-drowning deaths did not decrease for the state in 2007.

It is alarming that the number of drowning deaths in Florida for children under age 5 is increasing each year. In the five years between 2001 and 2005, Florida had the 3rd highest overall unintentional drowning death rate in the nation and the highest unintentional drowning rate for the 0-4 year old group with a rate of 7.1 per 100,000 populations. In 2005, Florida lost more children ages 0-4 to drowning than any other state except California.(CDC WISQARS)[7] Florida loses enough children every year to fill four classrooms. The Florida Abuse Hotline received 79 reports of child drowning deaths. However, the Child Death Review Team reviewed only 45 of those deaths.

- During 2004, there were 63 deaths, 72 in 2005, and 77 in 2006, which represents 14% and 7% increases respectively.
- In 2007, the number of drowning among Florida's residents under age 5 was 77 children lost.(Florida Vital Statistics)
- From 1999-2005, Florida lost more children to drowning than any other state.
- In 2006, most drowning of Florida children under five (60%) occurred from April through September.
- In 2006, males of all ages, especially those under five, were more likely to drown than females.
- Despite local ordinances and a state statute requiring safety features for backyard swimming pools, residential swimming pools are the location of 75 percent of the drowning deaths in Florida for the 0-4 age group (Florida Vital Statistics)

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

Adequate supervision is defined as an attentive person responsible for watching children and who is not under the influence of drugs or alcohol. The person must always be proximate to the child (eyes on) to provide continuous supervision. According to caregivers, most child drowning victims were missing from sight for less than five minutes.

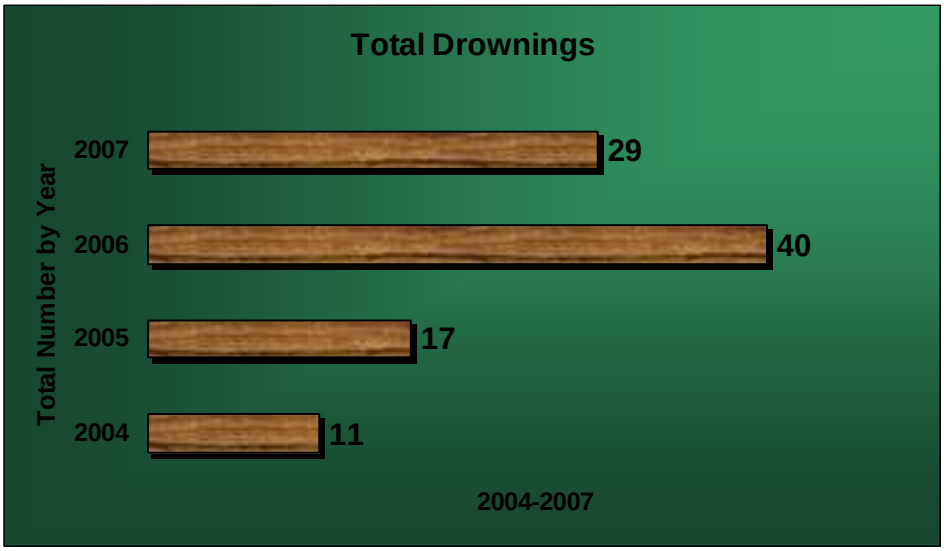
The State Committee believes that it did not have the opportunity to review the deaths of all children who drowned due to inconsistencies in reporting of child drowning deaths by law enforcement and other first responders. In addition, inconsistencies in the verification of neglect by the Department of Children and Families or Sheriff's Department child protective investigators contributed to the lack of reporting. For example, Miami-Dade county ranks 2nd in the state for pool drowning, ages 0-6, and yet the State Committee did not review any pool drowning deaths from that county.

More than 10 percent of childhood drowning occurs in bathtubs. The only way to prevent these deaths is continuous supervision. These cases should always be considered child neglect due to the fact that the caregiver created the danger by placing the child in the bathtub and then left the child unsupervised to drown. The State Committee reviewed eight bathtub-drowning cases this year. According to Florida Vital Statistics, there were actually12 bathtub-drowning incidences for 2007.

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

The American Academy of Pediatrics Policy Statement on Prevention of Drowning in Infants, Children, and Adolescents recommends that children are generally not developmentally ready for formal swimming lessons until after their fourth birthday. However, because some children develop skills more quickly than others, not all children will be ready to learn to swim at exactly the same age. For example, children with motor or cognitive disabilities may not be developmentally ready for swimming lessons until a later age. Ultimately, the decision of when to start a child in swimming lessons must be individualized. Parents should be reminded that swimming lessons will not provide "drown proofing" for children of any age.

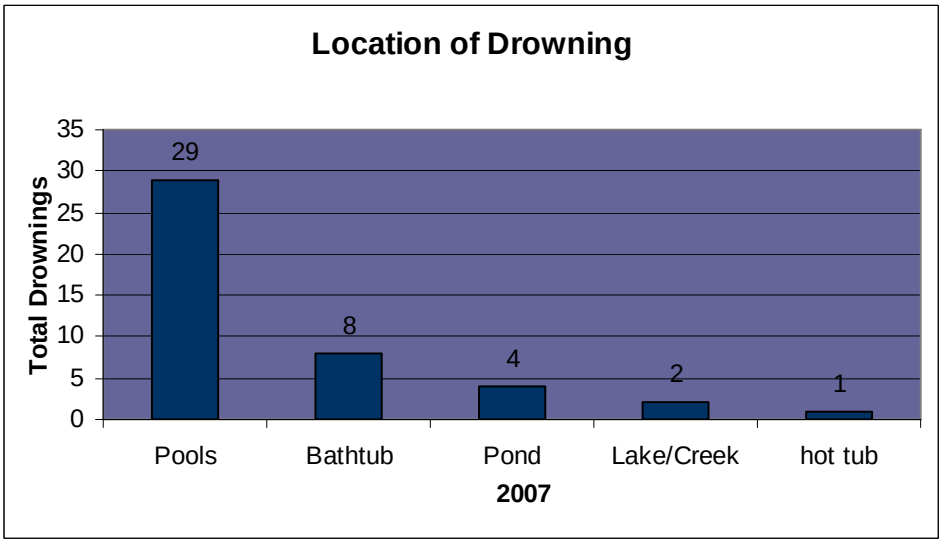
The graph below shows by year the total number of drowning deaths reviewed by the State Committee.



Key Findings

- 44 drowning cases were reviewed
  - 30 (82%) children were 5 and under

Inadequate supervision was found in all drowning deaths



- 8 (18%) children drowned in a bathtub
- The age range was from 3 months to 11 years
  - 6 children were males and 2 children were females
  - 2 of the older children had known seizure disorders
  - 4 children were left unsupervised with other siblings in the tub

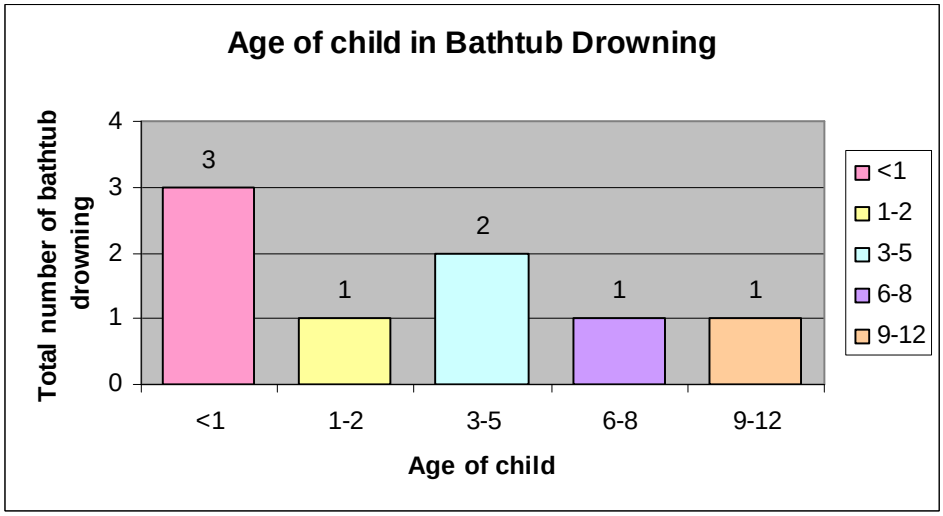
Perpetrator related Factors

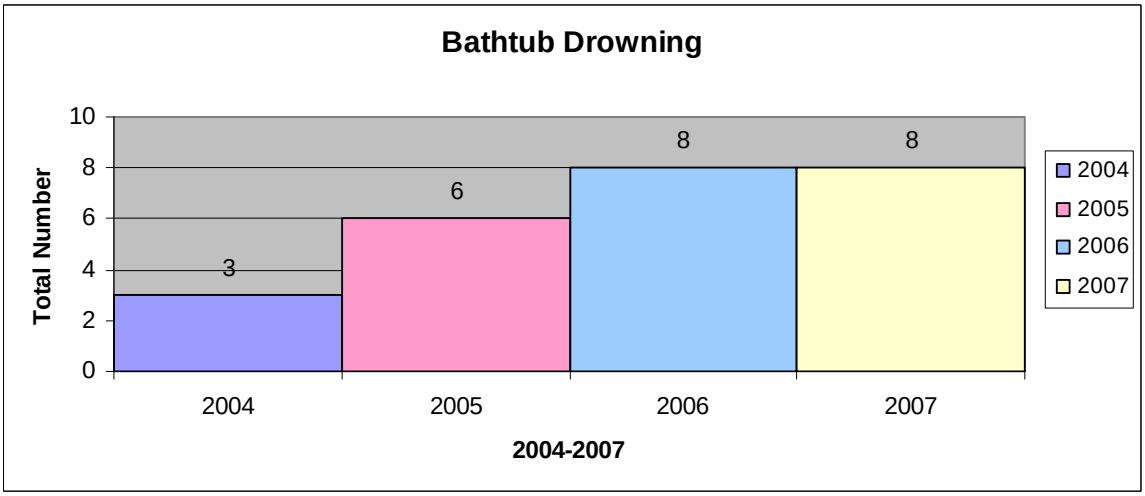
- 6 Mothers were responsible
- 1 father was responsible
- 1 Aunt was responsible
- 1 mother left a 13 yr old to watch child, but the 13 yr old left to use a computer and left the child unsupervised

Bathtub drowning perpetrator risk factors

- Drugs were a factor in 3 of the cases

The graph below shows the number of bathtub drowning that the State Committee has reviewed from 200-2007.

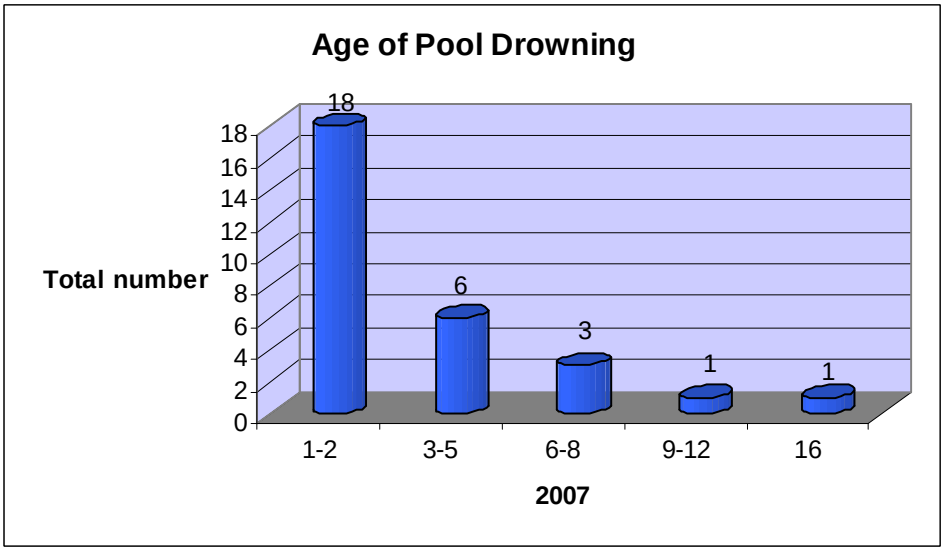




- 29 (66%) children drowned in a swimming pool
- 19 children were males and 10 children were females
- 24 (83%) were 5 and younger
  - 18 children were between the ages of 1 and 2
  - 6 children were between the ages of 3-5

***Jeremy**
Bathtub drowning

Jeremy, 3 years old, had been placed in a foster home with a sibling. The 28 year-old foster other stated she went to use other bathroom leaving the 3 and 1 yr old alone in the tub. When she returned, she found the 1 yr old on top of 3 yr. The statement given by the foster mother's biological child was that her mother was in the living room watching TV. There was a prior case on this foster mom for leaving foster children to be supervised by her child, who was 11 years old. The foster mother did not know CPR.



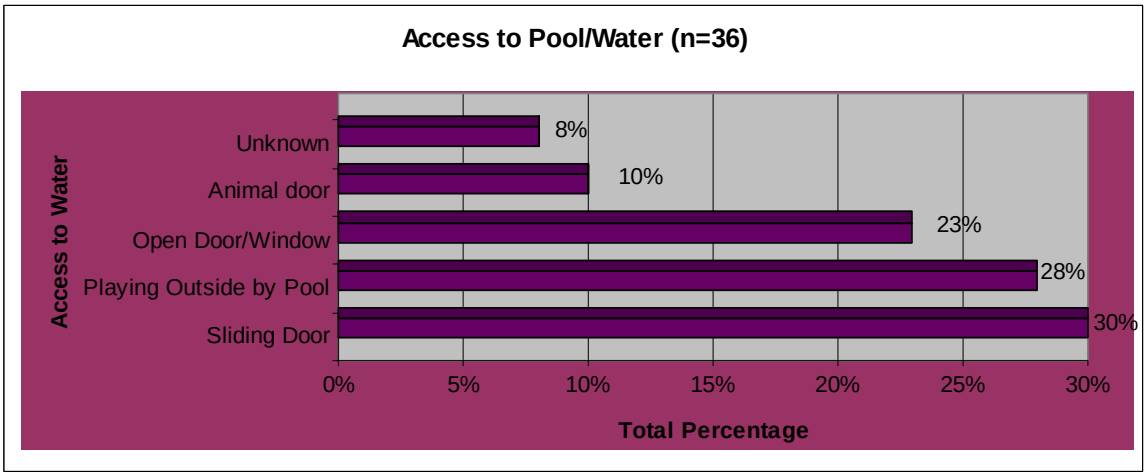
All were supposed to be supervised by either parents or a relative with the exception of one who was being supervised by a babysitter.

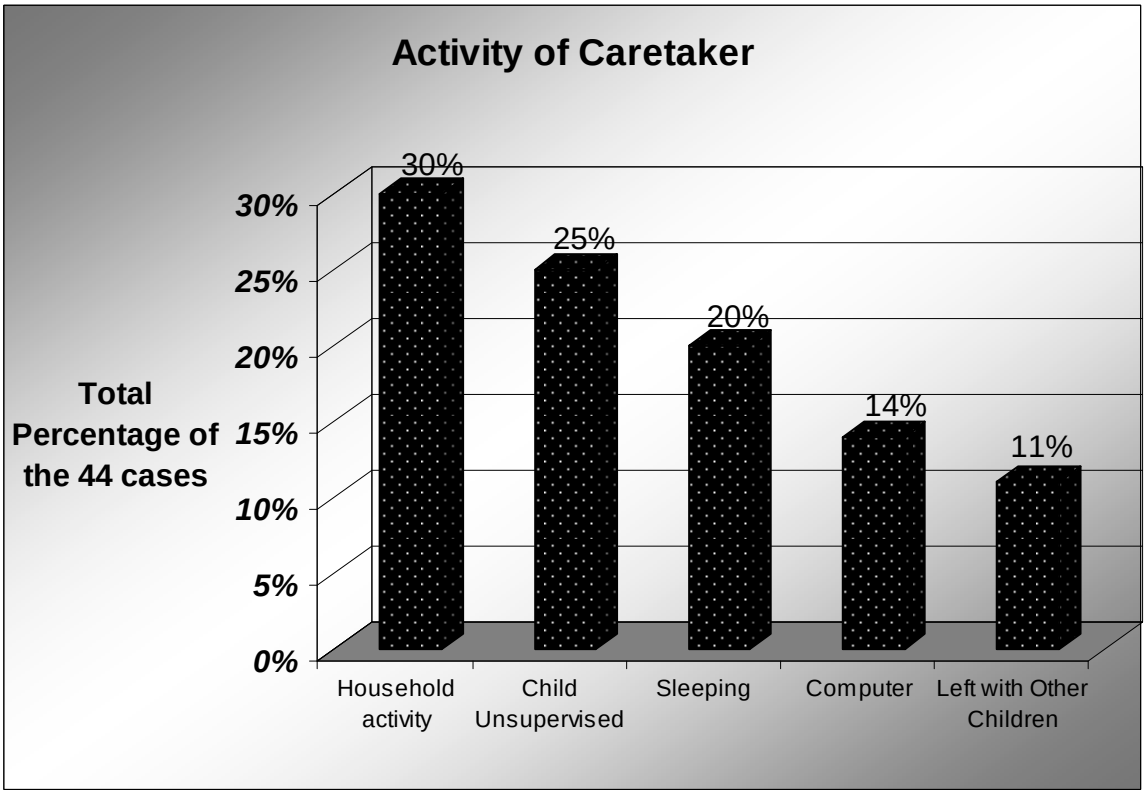
- 4 children drowned in a pond
- 1 child drowned in a creek
- 1 child drown in a lake
- 1 child drown in a Jacuzzi hot tub

Drowning Perpetrator risk factors

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

The Committee found trends in how the child gained access to the pool as well as the activity of the caretaker at the time of the incident, as show in the graphs below. The sliding door or the door that leads directly to the pool is the mostly likely way children access the water and subsequently die.





***Jacqueline**
Pool drowning

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Jacqueline's father, age 37, went to work but would call the mother to make sure she was awake. The mother ran an early morning paper route. Mom stated she allowed her Jacqueline, 4 years old, to go outside to play while she was on the computer and while doing so Mom fell asleep. The mother estimated that she had been asleep 30 minutes. Jacqueline was found in the neighbor's swimming pool. The mother had past history of drug use, however no drug testing was requested. A neighbor had observed Jacqueline unsupervised on other occasions.

DRUG/POISONING RELATED DEATHS

Poisoning refers to the type of poisoning agent that resulted in the child's death. This can be anything from over the counter medicines to cleaning agents commonly found in the home. Prescription drug overdoses caused 1,720 deaths in 2006, up about 40% from three years earlier. People in their 40s were the most likely to die from prescription drugs, followed by those in their 20s and 30s. Teens were the fastest-growing group. Approximately 50% to 80% of all child abuse and neglect cases substantiated by child protective services involve some degree of substance abuse by the child's parents. The State Committee has seen an increase in these deaths. In 2007 there were 10 children who died as a result of drug/poisoning compared to 6 in 2006.

Key Findings

- 10 children from 8 months to 17 years died as a result of drug toxicity
  - 4 children were 2 and younger
  - 6 children were ages 12-17 years
- 3 children died from Multi drug toxicity
- 2 children died from methadone toxicity
- 2 children died from Acute oxycodone Toxicity
- 2 siblings died from Carbon Monoxcide poisoning
- 1 child died from Acute Heroin toxicity
- There is a need for a standardized on-scene presumptive drug testing as part of the child protective or law enforcement investigation protocol.

Perpetrator related factors

- 2 were non-relatives and both were 42 years
- 8 were mothers, ages from 20-52
- 4 were fathers, ages 38-46, one step-father

Drug/poison Perpetrator risk factors

- 6 had previous reports with DCF involving drug allegations
- 10 cases had evidence of drug use – either by admission, history, or drugs noted at the crime scene
- Of those 10 cases, drug testing was done on two

Benny*
Poisoning

The mother, age 20, woke up with Benny, one year old, next to her and realized that he was unresponsive. The Medical examiner ruled the cause of death to be from an acute heroin overdose. The Medical Examiner stated the toxicity was extremely high. There were no drug tests requested on the mother. The mother had a criminal history of battery. No charges have been filed and the perpetrator remains unknown.

PREMATURE AND DRUG EXPOSED NEWBORNS

According to a 2005 Study by National Center on Addiction and Substance Abuse, 4.0% of pregnant women ages15-44 reported illicit drug use. .In a 2003 study by the Center for Disease Control and Prevention, nearly three percent of pregnant women use illegal drugs including marijuana, cocaine, Ecstasy and other amphetamines, and heroin. The use of illegal drugs during pregnancy, as well as the inappropriate use of prescription medications may pose serious risks for both the pregnant woman and her unborn child. Possible risks to the fetus include premature birth as well as developmental delays and adverse health effects later in life. This is an emerging issue that merits further study. The magnitude of the problem in the state of Florida has not yet been defined. There are several obstacles inherent in attempts to collect epidemiologic data related to drug abuse during pregnancy and possible adverse effects on the developing child. Most notably, there is inconsistency among the medical examiner districts as to whether jurisdiction should be assumed in cases of intrauterine deaths and deaths in the neonatal period when maternal substance abuse are suspected. Additionally, there is no consensus among medical examiners as to the certification of the cause and manner of death in these cases.

Key Findings

There are definite needs for:

- The Florida legislature to form a special project committee to explore the impact of substance abuse in the home, as well as maternal substance abuse and its impact on the unborn child
- Providing training to hospitals and emergency personnel on mandatory child abuse reporting
- Providing statutory authority to hospitals to test mothers and babies for substances when there is suspected drug use.

Perpetrator Information

- Mom was 25 years old

Premature and Drug Exposed Newborn Perpetrator risk factors

- Mom tested positive for cocaine at birth
- Mom had a long history of substance abuse
- Mom denied she was pregnant
- Mom had previous children removed due to her drug use.
- Only one case was verified for substance exposure
    - Child less than a day old

***Julia**
Substance Exposed

The child was born at 27 weeks gestation. The 25 year-old mother and Julia tested positive for cocaine at the time of delivery. The mother has a history of drug use and her other 2 children had been removed from her because of her substance abuse. She did not seek prenatal care with Julia's pregnancy. She had criminal history related to drug charges and had an outstanding warrant at the time of Julia's birth. The mother was a victim of abuse as a child, and her mother was also a known drug user.

VEHICLE-RELATED DEATHS

Hyperthermia, in its advanced state referred to as heat stroke or sunstroke, is an acute condition, which occurs when the body produces or absorbs more heat than it can dissipate. It is usually caused by prolonged exposure to high temperatures. The heat-regulating mechanisms of the body eventually become overwhelmed and unable to effectively deal with the heat, causing the body temperature to climb uncontrollably. Hyperthermia is a medical emergency, which requires immediate treatment

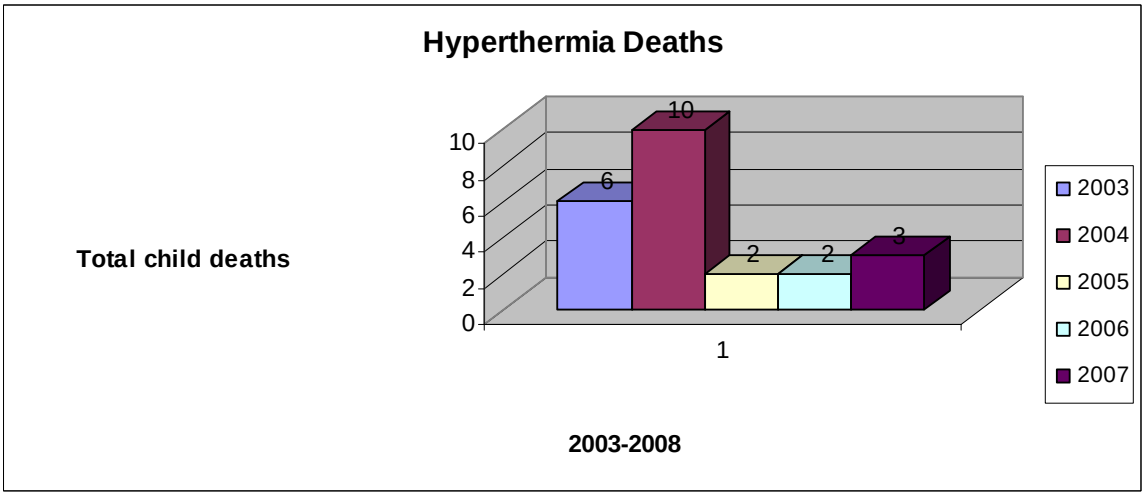
Twenty-Five children died in Florida from 2003 to 2008 as a result of being left in vehicles. Public awareness campaigns such as the ones by Safe Kids USA (www.safekids.org) “Never leave you child alone” have helped in reducing deaths. Media attention and the prosecution of individuals who have left children unattended in vehicles have occurred. These efforts must continue to ensure that no young child is left alone in a vehicle for any period of time.

In 2007, there were three deaths; however, the State Committee was only able to review two of the deaths.

Key Findings

- One child was two years of age and was left in a vehicle
  - Mom was not the one who usually took the child to daycare and forgot to remove the child from the car
- One child got into an unlocked vehicle at the house
  - Parents assumed siblings were watching the child

The graph below shows the total number of children from 2003-2007 that died from hyperthermia, whose deaths were reviewed by the State Committee



***Maggie**
Hyperthermia-Vehicle

The mother, age 39, drove her children to school and had her 2 year-old child in the back seat to take to daycare prior to going to work. She then went straight to her job, forgetting the child in the backseat of the car for approximately 4 hours. She died. The father was the one who routinely took the child but he was out of town. Law enforcement requested charges be filed against the mother, however the State Attorney's Office declined.

VEHICLE CRASHES

The CDC Child injury Report: Patterns of Unintentional Injuries among 0-19 Year Olds in the United States-2006[7], states that injuries due to transportation were the leading cause of death for children. However this is one type of child deaths that is often not reported to the Florida Abuse Hotline.

The State Committee made a recommendation in 2005 that training should be given to Florida Highway Patrol (FHP) Officers on the mandatory reporting of child abuse. Many crashes with serious injury or death of children were due to negligent behavior of the driver/caregiver and were not being reported to the Florida Abuse Hotline. This still continues to be an issue. The Committee has written letters to FHP addressing the requirement for mandatory reporting as well as offering to provide training. FHP has also been encouraged to participate in local committee reviews.

Key Findings

- There should be continuing education for law enforcement on reporting these deaths to the Florida Abuse Hotline
- The Local Child Abuse Death Review Committees should continue to invite Florida Highway Patrol to participate in local child abuse death reviews
- Media Campaigns should focus on " Families do not let Family Members Drive Drunk," including ads showing intoxicated caretakers driving vehicles with children in the car
- 6 children died in moving vehicle crashes
    - 1 child fell out of the back of a truck
    - 1 child was sitting on mothers lap

***Samson**
Vehicle accident

Mother,26 was driving her son to the hospital emergency room because he was complaining of ear pain. In route, she lost control of her car and hit a concrete wall, throwing the child from the vehicle, as he was not wearing seat belt nor in a booster seat. The mother was driving 35 miles over speed limit. The parents admitted they had been out partying and had consumed several drinks, as well as the mother admitted to taking 4 Xanax tablets. The father was passed out at the time of the incident. After the father arrived at the hospital, he was caught stealing a prescription pad. The parents have criminal history to include DUI's. and other violent charges. There was a prior that also involved substance abuse allegations. The Department of Children and Families removed the siblings, however the Court ordered their return.

Perpetrator factors

- All crashes were caused by mothers
- Age of mothers ranged from 24-34
- 7 mothers were charged criminally
- 2 fathers knew the mother was under the influence and allowed the mother to drive

Vehicle Perpetrator risk factors

- 3 mothers did not put their children in seat belts
- 4 mothers were under the influence of drugs/alcohol
- 6 mothers had substance abuse history
- 5 mothers had prior history with DCF
-

Drove/ Backed over

- 3 children died as a result of being run or backed over
    - One was one year and the other was 5 years

Perpetrator factors

- 1 was a school bus driver
- 1 was a female paramour
- 1 was a relative

GUNSHOT RELATED DEATHS

Florida's Child Access Prevention Law is one of only three such laws allowing felony prosecution of violators and this appears to have significantly reduced unintentional firearm deaths of children. Recent surveys indicate that 33 to 40 percent of US households have a gun in them. Caregivers, family members, or others must remember that firearms must be secured, preferably with gunlocks to ensure that they cannot be accidentally discharged. Florida law already requires individuals to ensure that firearms are secured and kept in locations away from children. The State Committee reviewed the cases of 4 children who died as a result of gunshot wounds in 2007.

Key Findings

- The Florida Pediatric Society and the State Child Abuse Death Review Committee should work together to
  - promote gun safety, including counsel to parents about risks associated with keeping guns in the home, including how to store guns safely
  - educate parents about risk associated with not securing guns when their children have issues of depression and substance abuse
- 4 children died as a result of gunshot wounds
  - 2 were the result of suicides (self inflicted)
  - 2 were the result of accidental shootings
- 2 children were white males and 2 children were African American males
- 2 children were 16 years old, 1 was 14 years old and 1was 12 years old

Perpetrator Factors

- 2 cases involved suicides by male teenagers
- 1 case child was shot by a 12 year old male cousin
- 1 case child was shot by 15 year old male friend

Gunshot perpetrator risk factors

- Two of the children had mental health issues
- Three of the children had a history of substance misuse
- Caretakers in all four cases had a history of substance abuse
- All four cases had prior history with DCF
- In all cases, the guns were not stored safely in the homes

***Terrance**
Gun/Suicide

Terrance, 16 year old, and had a history of depression and substance abuse. His mother, age 49, was aware of his history. The mother had reported that he had tried to commit suicide in 2007 with pills. There were two prior abuse reports, which were related to underage drinking. The mother was referred for services; however she did not follow through seek any treatment. The child had friends over and one brought a gun, which the child used to kill himself. A 16 year old friend was subsequently charged.

OTHER NEGLECT RELATED DEATHS

Medical Neglect

Key Findings

- 4 children died as a result of medical neglect
  - 1 child who was 1 month old died from complications of congenital anomalies
  - 1 child who was 5 months old died from Dehydration and Nutritional Deprivation
  - 1 child who was13 years old died from San Joaquin Valley Fever
  - 1 child who was 14 years old died from Seizure disorder, malnourishment and dehydration and acute bronchopneumonia

Perpetrator Facts

- All were from mothers failing to get medical attention

Joshua*
Medical neglect

Joshua, 14 years of age, had Ring 18 chromosome disorder and a multitude of other medical problems. His mother, age 37, had 5 other children. Joshua had previously been removed in another state for medical neglect. The mother moved to Florida and advised the court she had services in place in Florida. The child was placed back with the mother, however there was no verification that any services were actually in place. The mother had the child sleeping in a crib in a closet in the home. The child had been by a doctor in the previous State and weighed 30 lbs. However at his death, 2 months later, he weighed 18 lbs. The toxicity reports reflect that he was not given his medication. The mother has drug and criminal history. There are possible criminal charges pending against the mother for Joshua's death.

Hanging

- 1 child, age 13, died playing the "choking game" and hung himself with a belt

Fire

- 1 child, age, 3 years, died as a result of smoke inhalation

Inadequate Supervision

- 1 child died from aspiration from choking on popcorn when left unsupervised

Drew*
Fire

Drew, age 3, and his sibling were placed with the Grandparents due to neglect by the parents. The Grandmother was in the pool with the sibling and the Grandfather had taken Drew to the living room. The Grandfather left to attend a class and left Drew unsupervised. The Grandmother stated she checked on the child 20 min later and saw smoke in the home. She was unable to find Drew. The Fire Marshall determined that the fire started in the living room as a result of lighters igniting a fire in the hallway where Drew was found. There were no smoke detectors in home.

LOCAL COMMITTEE ACCOMPLISHMENTS AND ACHIEVEMENTS FOR 2008

The Local Florida Committee's take seriously the charge to understand why children are dying and based on their local child abuse death reviews they are able to focus on reducing risk to children and work to minimize preventable child abuse deaths. They are able to gather and create a picture of the child's death. The members of the local Committee's volunteer countless hours and are dedicated individuals who care about children and want to find ways to make life a safer place for children. The local Chairs were asked to spotlight activities and accomplishments they have had through out the year. The prevention efforts, best practices and training reflected from the Chair's below show the importance of having local communities review child abuse deaths. The communities are developing prevention efforts to reduce the number of child abuse deaths in Florida. Below are responses that some of the Committee's wrote:

Bay, Calhoun, Gulf, Holmes, Jackson and Washington Counties- Committee 3 :

As you know we are brand new team which has enabled us to build good relationships with our committee members. Our medical examiner has been notifying us when he suspects abuse or neglect and now has a practice of having our CPT Medical Director to the autopsy. The DCF Investigator and local law enforcement agencies have both been great with supplying information to us: photos, documentation, etc. to assist us in preparing for our local committee reviews.

Monique Gorman, Chair

Indian River, Martin, Okeechobee and St. Lucie Counties- Committee 11 :

The Circuit 19 Local Death Review Committee has reviewed a number of cases over the past few years. The majority of the cases reviewed involved two primary causes of death:

1. Sleep-overs/Roll-overs/Bottle-propping (asphyxiation)
2. Drowning

As a result of the local reviews, a number of initiatives have been started to prevent future deaths or reduce the number of deaths by these two leading causes. The following are some examples of these initiatives:

"DO NOT PROP" Campaign – Bottles propped up on thick blankets and placed in an infant's mouth can lead to suffocation. Local inquiries found that teaching parents, especially young parents, about the dangers of bottle propping when placing them to sleep in a crib is not common in many of the programs serving at risk families. A local initiative

has been established to work with programs such as Healthy Start, Healthy Families, etc., to incorporate this into their programs. Additionally correspondence has been sent to major manufacturers of baby bottles to discuss the possibility of inscribing "DO NOT PROP" directly on the bottles themselves.

Safe Sleeping Initiative – The local team has developed a pilot program in St. Lucie County between St. Lucie County Fire Rescue and the Department of Children and Families (DCF) to get cribs to needy families. The pilot program allows emergency medical professionals and paramedics to contact DCF when they respond to a call and identify that an infant does not have a crib or safe sleeping arrangements. DCF will work with local service agencies to obtain a crib and provide it to the family at no charge.

Drowning Prevention – The local team discussed opportunities on expanding the outreach efforts of current drowning prevention initiatives already established. One example is having emergency medical professionals and paramedics responding to homes with pools distribute lanyards that discuss drowning prevention created by the Health Department. Other examples include incorporating swimming lessons marketing into child care centers via the Early Learning Coalitions and having more thorough assessments of pools/bodies of water when children are legally placed with relatives through the dependency process.

Chad Collins, Chair

Duval County- Committee 7:

The Duval Committee has initiated the following initiatives.

- *Public Education*: messages utilizing campaigns on local bus transportation, Public Service Announcements, and professional health worker trainings; topics include drowning prevention, home safety, safe sleep ,parent education etc.
- *Safe Sleep Partnership*: a community network to advocate, teach and share policy and practice with the goal to prevent sleep related deaths
- *Special local Studies:* Maternal and Child Health Graduate Student Internship Program - The leading Causes of Adolescent (15-19) Deaths: Analysis from 1996-2006 and Jacksonville Community Council's efforts to examine Infant Mortality and report to the community with recommendations and actions.

Carol Synkewecz, Chair

Brevard County- Committee 10:

Our local United Way has undertaken a community wide effort to increase awareness of child abuse/neglect issues. Using the 2007 CY Statewide Child Abuse Death Review Report they have included co-sleeping and water safety among other areas of emphasis. Their efforts have been central to the present UW Campaign, e.g. their locally produced DVD speaks to issues of child abuse/neglect and literature provided to their local company representatives speaks to numbers of children served (in different capacities) through pay day dollar contributions, etc.

The Brevard County Department of Health has increased emphasis on water safety. DCF has PIs briefing caregivers re water safety when they visit homes with pools and briefs caregivers re co-sleeping in those homes with infants.

Future/Continued Efforts:

We have made recommendations and will continue to make recommendations regarding mandating DCF to include all CPT reporting in their reports prior to closing.

We have made and will continue to address the timeliness of LE reports in conjunction with child deaths. You may recall one case in which the child died over a year prior and the LE report still had not been completed. It was suggested that the Attorney Generals Office formulate a "reasonable", yet mandated period in which LE reports must be prepared.

It must continue to be recognized and emphasized that these child deaths, as a result of abuse/neglect, are not anomalies. It is indeed a rare circumstance that a child death due to abuse/neglect is not preceded by a history of drugs/alcohol, family violence, and/or otherwise involved with DCF and/or LE. PIs and LE must be trained not to concentrate on only the situation at hand, but rather embrace the notion that whenever they "touch" a family, they too become a player in the history of that family; if they are "touching" the family for the first time, they are (at least partially) "creating the history."

Chuck Beiehl, Co-Chair

Alachua, Bradford, Columbia, Dixie, Gilchrist, Hamilton, Lafayette, Levy, Putman, Suwannee and Union Counties- Committee 5:

This has been a productive year and we have a great team. I was most impressed when at our last meeting one of our team members volunteered to coordinate with a local hospital to improve Healthy Families screenings. I believe we have improved understanding and cooperation among participating agencies. And it is simply beneficial to know someone to contact within another agency. At some point I recommend we have a resource list of team participants with titles, functions and phone numbers.

DCF has implemented Death Review Training for CPI supervisors and new CPI hires and established CPIs. This has occurred multiple times in the Region.
As the law enforcement member of the local Committee, I have used the data from the State Child Abuse Death Review Annual report they disseminate to prove several different points in presentations, relating to abuse and neglect numbers, DV involved etc.
Detective. T Elliott

As for our continued efforts with St Francis House (SFH)—we are well into our second month of “Family Night” at the shelter. Each Tuesday evening a community agency goes to SFH with a snack for the children and to provide the families with resource information. For example, on my family night—there were 2 expectant mothers there and a Mom with her new 7 week-old daughter. The UF College of Nursing Professor and students were conducting a childbirth class while I was working with our 7 week old mom on safe sleep

conditions for the baby. The mother and infant were in need of many items which I was able to coordinate with other partner agencies in our area. We are also working on a fundraising campaign to purchase playground equipment at the shelter. Due to budget cuts, the SW that was on site at SFH is gone. This has left the families with no case manager. The UF Nursing Staff that has been ongoing at SFH and our new Family Nights is filling in as case manager. A new, nice but inexperienced, case manager has been hired and we are now coordinating with her.

Our most recent infant death occurred at a housing project in the area. We found out that the housing project hired an SW to work there and help coordinate referrals and resources to the families. I have made contact with her and have invited her to our prevention taskforce in Alachua County.

MicheleScavone-Stone, Chair

Escambia and Santa Rosa Counties- Committee 1:

In Escambia County we have combined our CADR recommendations that are preventative in nature with the "Chapter 39 Local Planning Team" for the Governors initiative "Adoption Promotion and Prevention of Abuse, Abandonment and Neglect". The CADR chair now is the co-chair to the prevention workgroup that was developed for the Circuit.

Also we have begun a Co-sleeping/Safe Sleeping task force for the circuit. This utilized community members from the non-profit community, law enforcement, judicial, hospital and local medical as well as the Medical Examiner. We have three initiatives we are working on:

1. Public Education (PSA's ect)
2. Education of initial responders as to investigation and possible prosecution of "overlays"
3. Reviewing of Curriculum provided to new parents at the different newborn nurseries and birthing centers.

Phyllis Gonzales, Chair

Collier County- Committee 15:

We haven't really initiated any new projects or activities, but I think it is great that we finally have the understanding and participation of our team members. We have included information on safe sleeping in our parenting curriculums and have expanded our parenting classes' community wide. Also, we have included a prevention person from the Southwest Florida Children's Hospital on our review team. I think that is a great addition going forward.

Jackie Stevens, Chair

Franklin, Gadsden, Jefferson, Leon, Liberty, Madison, Taylor and Wakulla Counties- Committee 21:

We are brand new and have only reviewed for a little over a year. I think our greatest accomplishment has been collecting a wide assortment of people interested in being involved and committing to participate. We will be working more on coming up with prevention projects in the future.

Evie Goslin, Chair

Citrus, Hernando, Lake, Marion and Sumter Counties-Committee 24:

1. Citrus County Sheriff's Office has implemented a policy where all child deaths have to be called in to the hotline regardless of the circumstances
2. Multi-disciplinary staffings are held in Citrus, Hernando, Marion, and Lake Counties on child death cases, and have hopes of working this same procedure in Sumter County
3. All agencies have gotten better in reporting child deaths to the hotline including counties that in the past had not reported child deaths.
4. PSA's have been implemented in Marion County concerning child drownings, co-sleeping, and children being left in vehicles.
5. Training has been provided for our team and local agencies regarding the death review team; we are in the process of setting up training, hopefully for some time after the first of the year.
6. The Medical Examiner's Office, DCF, and law enforcement have started to work together on child death cases as a team and have established a protocol.
7. We are attempting to get the Community Based Care's more involved in the death reviews and have them attend the meetings. One of the issues we are working on with the Community Based Care's is for them to provide all the information they have a death case to DCF in a timely manner per Chapter 39 F.S.
8. Another identified issue we recognized is the lack of reporting by local agencies and Community Based Care's on suicide attempts of juveniles to the hot line and this was due to two child death reviews were cases of juveniles committing suicides and the possible prevention efforts that were missed.

Edie O'Neal

Manatee County- Committee 19:

In Manatee County we are continuing our efforts in the following areas:

1. Training for law enforcement, Child Protective Investigators, Fire Rescue and EMS first responders, Social Service providers and medical professionals on infant suffocation due to unsafe sleep environment and Sudden Unexplained Infant Death Investigation.
2. A Teen Driver Training program offered by the Manatee County Sheriff's Office for teen drivers to reduce the incident of death related to auto accidents.
3. Drowning prevention education through a partnership with the Kiwanis Club of Bradenton; a mail out to all pool owners explaining the need for closer supervision of children in homes with swimming pools.
4. For the last three years providing public education and awareness at the Children's Summit that educated thousands of families on toddler drowning prevention and infant unsafe sleep environments that can lead to suffocation.

Connie Shingledecker, Chair

TRAINING

Every year the State Committee has made a recommendation for training in a variety of aspects of child abuse and neglect and particularly child death investigations. The Committee has the opportunity to review child abuse deaths that occur all over the State of Florida. It is important that the lessons learned from the many cases reviewed are learned locally so that the child's death serves as a valuable tool to improve child protection and law enforcement procedures and practices. The Committee believes that a national standard with a high level of multi-agency involvement and information gathering is the way to effectively establish how and why a child died and what can be done to prevent the next child death.

The State Committee therefore took the responsibility to make training a top priority, specifically the Sudden Unexplained Infant Death Investigation (SUIDI) training. The Centers for Disease Control conducted 5 SUIDI "Train the Trainer" academies throughout the United States from 2006 to 2008. They trained 5 people from every state from varying disciplines involved in infant death investigations. Those individuals were charged with teaching the SUIDI training to others responsible for infant death investigations in their respective states. The State Committee was fortunate to have two members sent to this training in September of 2006, Major Connie Shingledecker and Dr. Barbara Wolf. Throughout the last two of years they have trained thousands.

The State Committee has also provided training on investigating physical abuse, neglect deaths, mandatory reports of child deaths, and how opportunities for making good risk assessments can help in the protection of children. These trainings have contributed to increased reports to the hotline. For example deaths related to murder/suicides and abandoned newborns are now being called in to the hotline. The documentation of crime scenes, request or information of drug history and the request for drug testing has been noted in the case files. Training is still needed for Protective Investigators and their Supervisors, to stress taking all the factors into consideration in order to make better and consistent classification on child death cases across the state.

The following organizations have received trainings from the State Committee:

Healthy Start-Pinellas County–
Seminole Kids House-
DCF/CBC –Panama City-
Ft. Myers – DCF/CBC

Monroe County
CAC Daytona Beach
USF – Polk County
Police Academy – Leon County
FDLE – Jacksonville
Child Abuse Prevention Conf. Largo
Fl Coalition Against DV – Orlando
DCF and Law Enforcement- Leesburg
Prosecutors- Orlando
CAC- Orlando
Pathologists- Denver
Law Enforcement- Houston Tx
Law Enforcement – Spartanburg, SC
DCF and CPT Rapid Response-Palm Beach
Hillsborough Community Alliance- Tampa
CPT/CAC/DCF/LEO- Brevard Conference
Florida School Resource Officers- Bonita Springs
Dependency Court Improvement Conference- Orlando
Prevention Conference- Orlando
Drowning Prevention Conference-Tampa
CAC Gainesville Conference- Gainesville

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RECOMMENDED PRACTICES

1. **Manatee Sheriff's Office Child Protection Placement Notice**
2. **Manatee County Sheriff's Office Drug Screen Testing Policy**
3. **Healthy Families Florida home safety check lists and Safe sleep tips**
4. **Protocol for Immediate Staffings-4th Judicial Circuit**
5. **Brevard County Protocol For Drug Endangered Children(DEC)**
6. **DCF Marion County Child Death Investigation Protocol**

MANATEE COUNTY SHERIFF'S OFFICE

Child Protection Placement Notice

I _____ understand that the Child Protection Division of the Manatee County Sheriff's Office recognizes that it is unsafe for infants to sleep with adults or other children, to sleep in adult beds, on couches or other such surfaces. I will not allow _____, who has been placed in my custody, to sleep with adults or other children, and will only use a crib/bassinet.

We recommend that infants be placed to sleep on their back in a crib, or in a bassinet if under 4 months of age. Any other sleep environment used is not approved by this agency.

Yo _____ entiendo que la Unidad de Protection a Ninos del Manatee County Sheriff's Office reconoce que no es seguro para un bebe dormir junto con adultos o otros ninos, tampoco que duerma en camas para adultos, en sofas o alguna otra superficie similar. No permitire que _____ quien esta ahora bajo mi custodia, duerma con otros adultos u otros ninos. Usare una cuna o cuna portatil.

Recomendamos que los bebes sean acostados en su espalda en una cuna, o en una cuna portatil si el bebe es menor de 4 meses de edad. Cualquier otro ambiente o condiciones para dormir no es aprovado por esta agencia.

_____ _____
Signature/Firma Date/Fecha

_____ _____
Witnessed By/testigo ID#

Case#_____

MANATEE COUNTY SHERIFF'S OFFICE
CHILD PROTECTIVE INVESTIGATION DIVISION
Drug Screen Testing Policy

I. PURPOSE

The purpose of this Operating Procedure is to establish criteria and procedures for administering drug screening tests on individuals who are the subjects of an open child protection investigation.

II. DISCUSSION

The welfare of a child is often endangered due to a caretaker's excessive use of alcohol or the use of other drugs. Child protection investigators must have a means of obtaining an effective assessment of an investigative subject's abuse of drugs if they are to make accurate evaluations and recommendations to the courts regarding the welfare of children in the care of those individuals. Therefore, the Manatee County Sheriff's Office Child Protection Investigation Division has established a method for obtaining such information involving on-site testing of urine samples obtained from the investigative subjects.

III. PROCEDURES

A. Basis for Administering a Presumptive Drug Test.

1. A presumptive drug test shall be administered by a CPS to those subjects of a child protection investigation who are in a caregiver or supervisory position of a child, and whom the CPS has reasonable grounds to believe that the individual has been or is using drugs illegally, and that such use could adversely affect the care of the child. Information sources, provided they establish reasonable grounds, may include, but are not limited to:

> a. Allegations of illegal drug use in the original report, or from other individuals interviewed during the investigation.
> b. Observations within the investigative subject's residence that lead the CPS to believe that illegal drug use or the excessive use of alcohol is taking place; i.e., odor of burned marijuana, burned marijuana cigarette butts or other drugs observed in the home, large number of empty beer cans, etc.

2. A presumptive drug test shall be given in every case involving the death of a child, as well as any case involving known or suspected great bodily harm to a child when the death or harm could have been the result of the caregiver being impaired. A presumptive drug test shall be given to any caregiver or person who may have been in a supervisory position to the child at the time of the death or great bodily harm.

B. Administering a Presumptive Drug Test

Once a CPS is able to establish the reasonable grounds to justify requiring a presumptive drug test from the subject of an investigation, the following procedures are to be followed.

1. The CPS will obtain the drug test from the CPID Analysts. The analyst in charge of the inventory log will log the case number and the test ID number on the log. The analyst will then give the CPS however many tests are needed for the case.

2. Complete the Presumptive Drug Test Form. Advise the subject that a presumptive drug test is being offered to him/her. Read the introductory paragraph completely to the subject, making sure that the person understands the nature and use of the document that is being executed.

3. Have the subject check the appropriate box indicating whether or not he/she will submit a urine sample at that time. If the subject wishes to write additional comments explaining why he/she will not submit a urine sample, he/she may do so in the appropriate location on the form.

4. When a subject states that he or she is currently taking prescription drugs that have been medically prescribed for that person, have the individual indicate such in the "Comments" section of the form. The reverse side may be used if additional writing space is needed.

5. The subject must also check the appropriate box indicating whether or not he/she knows or has reason to believe that blood may be present in his/her urine. The individual must then sign the Presumptive Drug Test Form in the appropriate location. If the subject refuses to sign the form, write, "REFUSED TO SIGN," on the subject's signature line.

6. If the subject admits to recent drug use, record such on the form and in the case file. You may still want to test the subject, as they may not admit to all the substances in their system.

7. If the subject claims to be drug-free and agrees to submit a urine sample for the presumptive drug test, proceed with the following steps.

a. Ensure the expiration date (EXP) on the foil pouch containing the urine test cup has not passed.

b. Open the sealed foil pouch and inspect the test cup to make sure the label is still intact.

c. Inspect the restroom to ensure the subject will be alone. The subject must wash his/her hands thoroughly while being observed by the CPS.

d. Show the subject the minimum level of urine required as indicated on the side of the test cup. Tell the subject to recap the test cup before exiting the restroom.

e. Wait outside the restroom and put on protective latex gloves.

f. When the subject exits the restroom, take the cup from him/her and immediately record the urine temperature on the Presumptive Drug Test Form. Any temperatures below 90.5º Fahrenheit must be considered adulterated.

g. The label, which reveals the drug test strips, should be peeled after waiting a full five minutes before completing a final reading. Any double lines, including a faint line is supposed to be assumed as a negative reading. Interpret the results and record them on the Presumptive Drug Test Form.

h. Once the test has been read and the Presumptive Drug Test Form has been completed, the subject should dispose of the urine in the toilet in the restroom and flush the toilet, provided that the CPS is confident that having the subject do so will be non-confrontational and safe. Other-wise, the CPS should dispose of the urine.

(1) It should be noted that according to the United States Center for Disease Control (CDC), urine is not classified as a body fluid that could reasonably transmit blood borne pathogens unless there is blood visibly present or the subject has a medical condition that would lead to blood in the urine.

(2) However, CPID members should take reasonable precautions when disposing of the urine sample so as to avoid contact with it. Care should be exercised to avoid any "splash-back" of the urine when pouring it out.

(3) The test cup should be resealed and returned to the foil pouch. The protective latex gloves may then be removed. They must not be reused. The CPI shall dispose of the gloves and the foil pouch containing the test container in an appropriate trash container at a location other than the subject's residence, taking care to ensure that the subject will not be able to retrieve it.

C. Results of a Presumptive Drug Test

1. Once a presumptive drug test has been completed and the results recorded, the CPS may inform the subject of the test results, provided he/she believes that doing so will not result in an antagonistic confrontation with the subject. An alternative to personal notification of the test results is telephonic notification by the CPI or supervisor.

2. If the test result indicates a positive or adulterated test, the CPS shall attempt to get an explanation from the subject for such results. The subject's explanation, as well as any admissions or denials, shall be included in the case file.

3. If the test result indicates a positive or adulterated test, and there are extenuating circumstances that would indicate that the potential for violence or other irrational behavior directed toward the CPS exists if the test results are disclosed immediately, the CPSI may choose to wait until another time to disclose the results.

4. The CPS shall explain to the subject that a presumptive drug test is not absolutely conclusive, but that a positive or adulterated result may result in an order from the court for a more controlled and scientific test.

5. If a presumptive drug test gives a positive result for the presence of drugs, and the subject claims that the reading was caused by a prescription drug that has been medically prescribed for the subject, instruct the person to write that information in the "Comments" section of the form.

6. If the presumptive drug test is either positive or indicates an adulterated result, or the subject refused to submit a urine sample for testing, document such in the case file and place the original Presumptive Drug Test Form in the case file. The Office of the Attorney General attorney should be notified as soon as practical and a copy of the form should be routed to that attorney.

7. Upon returning to the CPID office, the results of the drug test will be given to the analyst who is in charge of the inventory log. The following information will need to be recorded on the log: test results, what type of drug, allegations, relationship to the child.

D. Disputing the Results

1. If the test kit reveals a positive result, and the Subject disputes the result. Advise the Subject that they may submit another sample at a lab of their own choosing, at their own expense.

2. The Sheriff's Office will only incur the cost of a lab-verified drug test when approved by Director/Lieutenant or above on a case by case basis.

E. Miscellaneous Provisions

1. The only persons authorized to administer a presumptive drug test are those members of the Manatee County Sheriff's Office Child Protection Investigation Division who have been trained on the use and interpretation of the presumptive drug test kit that is currently in use by the Division.

2. CPID members are not to store presumptive drug test kits in their assigned vehicles, as the high temperatures reached in a closed vehicle will affect the reliability and shelf life of the test kit. The CPS shall sign a drug test kit out from the appropriate staff member prior to going to meet with the investigative subject.

E. Submission to a Certified Laboratory

In the rare instance where a urine sample must be submitted to a certified laboratory, the CPS must use the appropriate laboratory form and the packaging provided by the lab. The entire test kit, to include the urine must be sent to the appropriate lab.

1. A seal for the test cup's lid is attached to the form as a peel-away label. It must be removed and placed over the lid. Ensure the bar code number on the seal matches the "Specimen ID Number" on the laboratory form.

2. Complete the laboratory form. Both the subject who submitted the urine sample and the CPI must sign the form.

3. Attach a copy of the Presumptive Drug/Alcohol Test form, if appropriate.

4. Mail the sample via the provided mailer as soon as possible.

Manatee County Sheriff's Office Child Protective Investigations Field Drug Testing Log

Case Number	Date of Test	Subject Tested Name-Last/First	Subject D.O.B.	Relation to A/V	Test Kit Number	Allegations	Results Pos / Neg Findings (See Key)	
08-	/ /		/ /				+ —	
08-	/ /		/ /				+ —	
08-	/ /		/ /				+ —	
08-	/ /		/ /				+ —	
08-	/ /		/ /				+ —	
08-	/ /		/ /				+ —	

Positive Results Totals

AMP	BAR	BZD	COC	THC	MTD	mAMP	OPI	PCP	MDMA

Key: AMP (amphetamine) BAR (barbiturate) BZD (benzodiazepine) COC (cocaine) THC (marijuana) MTD (methadone) mAMP (methamphetamine) OPI (opiate) PCP (Phencyclidine) MDMA (methylenedioxymethamphetamine

Safe Infant Sleeping

(Tool used by home vistors)

Questions:

What can you tell me about the safest way for a baby to sleep? Where does your baby sleep at night? Where does your baby sleep for naps?

Facts:

- Babies are safest when sleeping on their backs on a firm mattress in a crib that meets current safety standards.
- Each year in the United States, more than 4,500 infants die suddenly of no obvious cause. These deaths are called Sudden Unexpected Infant Deaths or SUIDs.
- Suffocation and strangulation in bed is the leading cause of injury-related death for infants under age 1.
- Infant deaths due to suffocation, strangulation and Sudden Infant Death Syndrome (SIDS) are highest among infants 1 to 3 months of age.
- The risk for suffocation among infants who sleep in adult beds is **40 times higher** than the risk for suffocation in cribs.
- Babies laid down to sleep without a pacifier in their mouth are more than twice as likely to die of SIDS.
- Soft bedding or lying on or next to an adult or child can lead to suffocation. This could also cause overheating which increases the risk of SIDS.
- The risk of SIDS is 3 times higher for mothers who smoke while pregnant and 2-3 times higher for babies living in smokers' households. After pregnancy, the risk rises depending on the number of smokers in the household and the number of cigarettes smoked by each person.
- The SIDS rate has been declining significantly since the early 1990s. However, Centers for Disease Control (CDC) research has found that the decline in SIDS since 1999 can be explained by increases in other SUID rates (e.g., deaths attributed to someone rolling over on top of the infant, suffocation and wedging).
- Babies that are placed on their stomachs to sleep when they are used to sleeping on their backs are 18 times more likely to die of SIDS.
- Bottle propping (such as using a pillow or something else to “prop” a bottle for feeding) or allowing a baby to bottle-feed alone can causing choking or suffocation.

Tips:

- Babies should never sleep with an adult or another child.
- Babies should sleep alone, on their back, on a firm, flat surface.
- The safest place a baby can sleep is in a crib, bassinet, Pack ‘n’ Play or cradle located in the same room as the caregiver.
- Cover the mattress with a tightly fitted sheet that tucks well under the mattress pad.
- Babies should never sleep in an adult bed, on a couch, pillow, chair, bean bag, air mattress, waterbed or any other piece of furniture not made for babies.
- Do not put anything in the baby’s bed. Pillows, quilts, comforters, sheepskin, stuffed animals, bumper pads and other soft products are not safe for sleeping babies. Use a sleeper or sleep sack, instead of a blanket.
- Always take off a bib before the baby goes to sleep.

- Babies should sleep on their backs during naps and at night until age 1, unless the baby's doctor says another position is better.
- Babies learn to sleep in the position they are placed from birth. It is important for the baby to start sleeping on their back. This may be hard at first, but parents should not give up. Babies will learn to sleep on their backs!
- Parents should talk about safe sleeping with everyone that takes care of their baby.
- Babies should always sleep in an area with no smoke.
- Offer a pacifier until the baby is one-year-old using the following steps:
  - The pacifier should be used when placing the baby down to sleep and should not be put back in the baby's mouth after the baby falls asleep.
  - If the baby does not want the pacifier, do not force it.
  - If breastfeeding, do not use a pacifier until the baby is one-month-old.
- Hold the baby when feeding, since propping a bottle up can cause the baby to choke and possibly die.

References:

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http://www.aap.org/healthtopics/Sleep.cfm
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Centers for Disease Control and Prevention
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Scheers, Rutherford, and Kemp. (2003) "Where Should Infants Sleep? A Comparison of Risk for Suffocation of Infants Sleeping in Cribs, Adult Beds, and Other Sleeping Locations." *Pediatrics*. Vol. 112.4; pp. 883-889.
http://pediatrics.aappublications.org/content/vol112/issue4/index.shtml

Safe Infant Sleeping

(discussed and left with parents and caregivers)

Tips:

- Babies should never sleep with an adult or another child.
- Babies should sleep alone, on their back, on a firm, flat surface.
- The safest place a baby can sleep is in a crib, bassinet, Pack 'n' Play or cradle located in the same room as the caregiver.
- Cover the mattress with a tightly fitted sheet that tucks well under the mattress pad.
- Babies should never sleep in an adult bed, on a couch, pillow, chair, bean bag, air mattress, waterbed or any other piece of furniture not made for babies.
- Do not put anything in the baby's bed. Pillows, quilts, comforters, sheepskin, stuffed animals, bumper pads and other soft products are not safe for sleeping babies. Use a sleeper or sleep sack, instead of a blanket.
- Always take off a bib before the baby goes to sleep.
- Babies should sleep on their backs during naps and at night until age 1, unless the baby's doctor says another position is better.
- Babies learn to sleep in the position they are placed from birth. It is important for the baby to start sleeping on their back. This may be hard at first, but parents should not give up. Babies will learn to sleep on their backs!
- Parents should talk about safe sleeping with everyone that takes care of their baby.
- Babies should always sleep in an area with no smoke.
- Offer a pacifier until the baby is one-year-old using the following steps:

- The pacifier should be used when placing the baby down to sleep and should not be put back in the baby's mouth after the baby falls asleep.
- If the baby does not want the pacifier, do not force it.
- If breastfeeding, do not use a pacifier until the baby is one-month-old.

- Hold the baby when feeding, since propping a bottle up can cause the baby to choke and possibly die.

References:

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http://pediatrics.aappublications.org/content/vol112/issue4/index.shtml

Additional Resources:

The Back to Sleep Information Line: **1-800-505-CRIB**
Florida SIDS Alliance: **1-800-SIDSFLA**
Florida Tobacco Quit-For-Life Line: **1-877-U-CAN NOW**

Home Safety Checklist (home visitor and parents/caregivers walk through house together to conduct this home safety check)

Parent's Name: _____ Date: _____

Please check the appropriate interval:

_____ Initial: Within first three months of services
_____ 4-6 months-old: Getting ready for crawling
_____ 9 to 12-months-old: Increased mobility
_____ 24-months-old
_____ Annually, after 24-months-old
_____ New Home

Circle the appropriate answers, based on your observations.

Home Safety – ***Ask the parent(s) if they would like to walk around their home with you to assess the safety of the home (bathroom, kitchen, bedroom, etc.) by answering the questions below.***				
1.	Yes	No		Are electrical cords intact and away from the reach of children?
2.	Yes	No		Are electrical appliances away from a filled tub, sink or running water?
3.	Yes	No		Are painted surfaces (including walls and furniture) free from chalking, flaking and peeling, which could indicate the presence of lead-based paint?
4.	Yes	No		Are all exterior doors, including pet doors if applicable, childproofed (latches, high locks or alarms, etc.)?
5.	Yes	No		Are all stairways and floor space for walking clear from obstruction and in a non-slippery condition?
6.	Yes	No	N/A	Is there railing protecting all stairways and elevated landings (top and bottom of stairs)?
7.	Yes	No	N/A	If there are railing slats greater than 2 and 3/8 inches apart, are they covered with a piece of wood or hard plastic?
8.	Yes	No		Is there a safe place for the child to sleep?
9.	Yes	No	N/A	If there is a crib, are the gaps between the slats on the crib 2 and 3/8 inches or less?
10.	Yes	No	N/A	If there is a child under 1 year of age, is the sleeping area free of soft bedding (including bumper pads), pillows, blankets and stuffed animals?
11.	Yes	No	N/A	If there is a crib, does the crib sheet and mattress fit tightly to avoid entrapment and suffocation?
12.	Yes	No	N/A	Are all houseplants out of the reach of children?
13.	Yes	No	N/A	Are all ashtrays out of the reach of children?
14.	Yes	No	N/A	Are emergency numbers readily accessible? (See list of phone numbers)
15.	Yes	No		Are knives and other sharp objects out of the reach of children or in a childproofed drawer?
16.	Yes	No		Are plastic bags out of the reach of children?
17.	Yes	No		Are sharp edges and corners covered (i.e., fireplace, tables, etc.)?
18.	Yes	No		Are there safety plugs in all unused electrical outlets?
19.	Yes	No	N/A	Are hair dryers and curling irons out of the reach of children?
20.	Yes	No	N/A	Are the iron and ironing board out of the reach of children?
21.	Yes	No		Are all chemicals and cleaning supplies stored in original containers? (Some examples of dangerous products include paint thinner, antifreeze, gasoline, turpentine, bleach, insect spray, fertilizer, poison.)
22.	Yes	No		Are all chemicals and cleaning supplies stored out of the reach of children or

				in a childproofed cabinet?
23.	Yes	No		Are all vitamins, over-the-counter and prescription medication stored out of the reach of children or in a childproofed drawer/cabinet?
24.	Yes	No	N/A	Are all alcoholic beverages stored out of the reach of children or in a childproofed cabinet?
25.	Yes	No	N/A	Are cosmetics stored out of the reach of children or in a childproofed drawer/cabinet?
26.	Yes	No	N/A	Are curtain and blind cords kept out of the reach of children?
27.	Yes	No	N/A	If residence is not on the ground floor, is furniture that a child could climb on away from windows, or are there window guards installed?
Guns/Weapons Safety - ***If applicable, verify the location and method of storage.***				
28.	Yes	No	N/A	Are all guns and ammunition stored/locked out of sight and reach of children?
29.	Yes	No	N/A	Are guns and ammunition stored separately?
Fire Safety - ***Ask the parent(s) to show you the smoke alarm(s) and unrestricted exits.***				
30.	Yes	No		Are smoke alarm(s) in working order and located on every floor?
31.	Yes	No	N/A	Are space heaters in good repair and are they at least 4 feet from clothing, curtains/drapes or any flammable material?
32.	Yes	No		Are there two unrestricted exits (windows or doors) that can be used in case of fire?
Water Safety - ***If applicable, ask the parent(s) to show you all areas with water (pool, hot tub, retention pond and/or fountain). Measurements are based on current Florida Building Code 424.2.17.***				
33.	Yes	No	N/A	If there is an in-ground pool, is there at least a 4-foot barrier with gaps of no more than 4 inches?
34.	Yes	No	N/A	If there is an in-ground pool, is there two inches or less between the ground and the bottom of the pool barrier?
35.	Yes	No	N/A	If there is a door from the house that leads into an area with water, is there an exit alarm or a lock located at least 54 inches above the floor?
36.	Yes	No	N/A	If there is a barrier around the pool, are large objects outside of the barrier (such as tables, chairs or ladders) far enough away from the barrier to prevent children from using them to climb over the barrier and into the pool area?
37.	Yes	No	N/A	If there is a gate into the area with water, is there a latch on the gate that closes automatically? Is the latch located on the side with the water? Is the latch located at least 54 inches above the bottom of the gate?
38.	Yes	No	N/A	If there is a window that is accessible to the area with water, is there an exit alarm and/or is the base of the window at least 48 inches from the interior floor (can be 42 inches if there is a cabinet beneath a screened or protected pass-through window)?
39.	Yes	No	N/A	Are toys and objects that may attract children kept out of the water when not in use?
40.	Yes	No	N/A	Are there life saving devices near the pool such as a hook, pole or flotation device?
41.	Yes	No	N/A	Are pool chemicals kept away from heat sources and out of the reach of children?
42.	Yes	No		Is the property free from containers of water or other fluid left uncovered or accessible to a child (i.e., inflatable “kiddie pool”, buckets, etc.)?

Safety concerns resolved:

_____

_____

_____

_____

_____
_____

Plans for follow-up:
_____
_____
_____
_____
_____
_____
_____
_____

Parent's Signature:
_____

Protocol for Immediate Staffings
4th Judicial Circuit
Clay, Duval, & Nassau Counties
December 12, 2008

Agency Representatives
Department of Children & Families
First Coast Child Protection Team
Family Support Services
Community Based Care Agencies (Daniel & Jewish Family Services in attendance)
Guardian Ad Litem
Children's Medical Services

Agencies listed above (and additional attendance by Children's Legal Services) is paramount to the success of following child abuse victims & their families through the investigative and services process in order to ensure child safety. These agencies are the "Core Agencies." Attending representatives from each agency must include the following or designee:

DCF	Operations Manager, Program Administrator, Supervisor, & Protective Investigator
CPT	Team Coordinator, Asst. Team Coordinator, Case Coordinator, Dr. Vallely (Team Psychologist) and Medical Provider (when appropriate)
FSS	Supervisor
CBC	Individual Agencies' supervisors and assigned family counselor
GAL	Assigned GAL & Supervisor or Director
CMS	Assigned Nurse &/or Social Worker (If involved)
CLS	Assigned CLS and Managing Attorney

Staffings will be scheduled as soon as possible for the following:

- Upon request of any agency involved with the family/child during the life of the case when significant concerns arise
- When Egregious Abuse or Critical Injuries have occurred
- When a child death has occurred and additional services are needed
- When the investigative recommendation by DCF or CPT is either expedited TPR or TPR
- When original investigative recommendations by DCF or CPT are changed resulting in less restrictive case plans/goal development and implementation or reunification of the family

Staffings will be conducted at the UF First Coast Child Protection Team Offices located at 4539 Beach Blvd., Jacksonville, FL 32207.

Please notify UF CPT of your request for reserving the conference room. Invitations will be faxed to all agency representatives involved with the family. Every effort should be taken to attend these staffings.

This protocol was developed by the following agency representatives on December 3 & 12, 2008 and will be implemented immediately by the community agencies, reflected by signatures that follow.

_____ _____

Department of Children & Families (Date) Children's Legal Services
(Date)

_____ _____

UF First Coast Child Protection Team (Date) Family Support Services
(Date)

Community Based Care Agencies

_____ _____

Children's Medical Services (Date) Guardian Ad Litem
(Date)

Brevard County Protocol for Drug Endangered Children (DEC)

1. **Joint Investigation**
   It is recommended that Drug Endangered Children (DEC) investigations be worked jointly by the Department of Children and Families (DCF), the appropriate law enforcement (LE) agency having criminal jurisdiction, the appropriate emergency medical agency (Emergency Medical Services (EMS) and Fire Department), and follow-up treatment agencies. All agencies will share information, and respond in a coordinated, collaborative effort throughout the investigative process.

   a. Known/suspected Clandestine Drug Laboratory

   1. **When DCF receives the initial DEC report,** they will notify the appropriate law enforcement agency and provide them with all known information. Information should include all prior DCF reports on members of the household. Law enforcement should request a call history of the current address and any available criminal intelligence, and share all information with the responding DCF investigator. LE should notify EMS or the Fire Department to be available to respond to any emergency situation that may arise.

   2. **When law enforcement receives the initial DEC report,** they will notify the Abuse Registry/Hotline and request an immediate DCF response. This call may be expedited by calling the dedicated law enforcement line 1-866-LEABUSE. Law enforcement should request a call history of the current address, coordinate with their Narcotics Unit (if available) for any prior narcotics intelligence, and share all pertinent information with the DCF investigator. The DCF investigator should provide law enforcement with all current and previous DCF report information on members of the household. (Law enforcement should make initial contact at the residence, ensuring safety and security of the law enforcement operation)

   3. **If possible** and prior to making initial contact, the law enforcement and DCF representatives should develop an investigative plan based on all available information. Once it is determined a DEC situation exists, law enforcement will notify and coordinate with EMS and the Fire Department. When appropriate and without compromising the criminal investigation, EMS and Fire Department personnel should be ready to immediately respond to the site of drug activity. This is important because of the hazardous nature of these drug sites which may endanger investigators, perpetrators or victims.

   b. Unknown Clandestine Drug Site Discovered on Unrelated Complaint

1. **DCF Discovery -** If children are present, children should be taken to a safe environment outside the home if possible. Law enforcement should be notified immediately and the home should not be re-entered.
2. **Law enforcement Discovery -** all individuals should be immediately removed from the home and the crime scene should be secured. The appropriate narcotics unit, medical personnel, and the DCF Abuse Hotline should be notified, requesting an immediate response from DCF Investigations.

2. **Immediate procedures at the scene of clandestine drug sites or when chemicals or paraphernalia are present.**
   It is recommended that when children are found at the scene, or are known to have been present at the scene of a suspected or working clandestine drug site that the following steps are taken for their safety and protection, as well as the safety and protection of responding investigative/medical personnel:

   a. All investigative/medical personnel responding at the scene of a clandestine drug site should follow their agency safety procedures when dealing with or coming in contact with hazardous materials (HAZMAT).

   b. All persons inside the home should be immediately removed. Law enforcement should take the lead in removing occupants from the home, ensuring their safety while preserving the integrity of the crime scene.

   c. Appropriate emergency personnel (EMS and Fire Department) should be notified by law enforcement and respond to the scene. Emergency personnel may be needed to respond to chemical hazards, explosions or fires caused by the hazardous nature of drug sites. They also may be needed to respond to medical emergencies of victims, perpetrators or investigators.

   d. Law enforcement should immediately notify their Narcotics Unit. If the responding law enforcement agency does not have an internal Narcotics Unit, then they should notify the appropriate law enforcement agency for assistance.

3. **DCF Investigation (On-Scene)**

   a. Children located at the scene, or known to have been present at the scene of a clandestine drug site should be placed in protective custody by DCF.

   b. To minimize contamination, no personal items should be removed from the scene. If cleared medically by EMS at the scene, DCF will transport the children to the designated fire station for decontamination to include a shower and change of clothes. Every precaution should be taken to minimize exposure to contaminated materials. Disposable seat covers should be utilized for transport of the children and their clothing should be bagged for decontamination following removal. DCF and Fire Department personnel should coordinate their activities for

decontaminating children. Whenever possible, a witness should be present during this process.

c. Children, if age appropriate, should be interviewed regarding their home situation and any information they may have regarding the drug lab. Relevant information should be provided to the appropriate LE agency. DCF will help the child understand why he is being separated from his parents and ensure ongoing services will be provided to the child and his parents. Forensic interviews should be conducted on all verbal children. This may be performed by LE or CPT. The need for forensic interviews will be determined in collaboration with LE, CPT, and DCF, subsequent to the field interview conducted by LE and/or DCF. Forensic interviews should be conducted at the Children's Advocacy Center (CAC) or similar facility.

d. The child's medical history should be obtained from the caregiver at the scene if possible. CPT should be contacted to arrange for forensic medical evaluation.

e. Parents and other caregivers should be interviewed regarding relatives and social history at the time the children are removed. DCF will need to obtain information for the removal packet, Health Insurance Portability and Accountability Act (HIPAA) , Temporary Assistance for Needy Families (TANF), etc. Any other interviews with the parents or caregivers should be coordinated with the involved law enforcement agency.

f. Copies of photographs, evidence sheets and law enforcement reports should be obtained in order to ensure that dependency action can be documented for judicial purposes.

4. **Law Enforcement Investigation (On-Scene)**

a. Photographs should be taken if children are present or if evidence exists that children resided at the location. Photographs should include:

1. Location of the incident.
2. Interior living conditions of the home.
3. Children's ability to access drugs, chemicals, drug paraphernalia and by-products. Measurements of furniture height should be taken into consideration based on the age and developmental stages of the children.
4. Play area/yard where the children may have been exposed.
5. Children's bedroom or sleeping area, including evidence of attempts to reduce exposure to chemical residue such as blocked air vents, etc.
6. Conditions of the bathroom(s).
7. Food supply in kitchen cabinets, pantry, refrigerator or freezer.
8. Proximity of food to chemicals, paraphernalia, fire and chemical hazards, and where discovered.
9. Drug lab components, associated chemicals, paraphernalia, fire and chemical hazards, and locations discovered.

10. All evidence collected by law enforcement personnel.
11. Physical condition of the children and all other occupants of the residence.
12. Indication of any fires caused as a result of the clandestine production of drugs within the residence.
13. All injection sites or other methods of intake of the drug.

b. Law Enforcement personnel will be responsible for the collection and preservation of all evidence according to Drug Enforcement Agency (DEA) and Florida Department of Law Enforcement evidence collection protocol.

c. Law Enforcement personnel will document and attempt to identify all chemicals located at the residence and provide the information to DCF and medical personnel. If large quantities of chemicals are present in the form of 55-gallon drums or 5-gallon buckets, the Department of Environmental Protection (DEP), Division of Law Enforcement should be notified via the state warning point (1-800-320-0519). An on-call agent supervisor will contact the reporting officer or agent to discuss the potential environmental impact.

d. Law Enforcement will conduct criminal interviews with individuals present (suspects, witnesses and children):

    1. Field interviews of the children may be performed by LE and/or DCF.
    2. Forensic interviews with children should be conducted at a Children's Advocacy Center (CAC) or similar type facility. They will be conducted by either CPT or LE. (Refer to attached interview guidelines.)
    3. Videotaped interviews of the children should be conducted whenever possible, utilizing age appropriate methods.
    4. Interviews with parents and witnesses should include targeted questions which address their knowledge of the dangers to children, admissions that children were near lab hazards, or disregard for the danger posed to children, the kinds of chemicals used in production, number of times manufactured, and frequency of occurrences in the presence of the children.

e. Reports/Documentation:

    1. All occupants in the home (full-time and part-time residents) should be identified and included in the report.
    2. Agency reports regarding drug exposure (manufacture, sale and /or possession) should be documented.
    3. A listing of all chemicals discovered at the site should be immediately reported and provided to DCF for their dependency action.
    4. Upon discovery and verification of a drug lab at a residence, it is strongly recommended that law enforcement notify the following agencies:

        a. Health Department (community safety)
        b. Property Owner (responsible for HAZMAT clean-up)
        c. Property Appraisal Office (require disclosure to future residents)

f. The Drug Enforcement Agency will be responsible for the coordination of the removal of the chemicals and by-products at the drug site.

5. Medical Assessment of Children Removed from Locations in which Methamphetamine Manufacture is Suspected

a. Initial medical assessment will be provided by emergency medical services (EMS) at the scene. Children should be evaluated at the emergency department where a urine drug screen should be collected to identify any level of exposure.
b. If significant problems are identified, EMS should transport child to the hospital emergency department.
c. If no emergency problems are noted or EMS is not on the scene, DCF will transport child to the designated Fire Department for decontamination as soon as possible. Entire body and hair should be washed with soap and water and the child should be dressed in clean clothes.
d. Subsequent to the decontamination, DCF will transport the child to the emergency department for evaluation and collection of urine drug screen. DCF should proceed with placement after children have been decontaminated and medically cleared in the emergency department.
e. Disposable seat covers should be used by DCF personnel if child is transported before decontamination.
f. All DEC children should be referred to CPT. Determination will then be made as to the appropriate CPT services to be utilized. CPT will provide necessary services depending on the circumstances of each case. This could include medical examination (if there are additional allegations of abuse and neglect), medical consultation, and/or forensic interview.
g. All children should be seen by their primary care provider within 72 hours after placement as with all children in DCF custody.
h. CPT will provide information regarding drug endangered children to the physician who will be providing primary care for the child including:

    1. Consideration of laboratory evaluation including chemistry panel and complete blood count
    2. Need for developmental evaluation
    3. Need for referral to dentist
    4. Need for mental health services

6. Child Protection Team (CPT)

a. The role of the CPT is to assist in child abuse investigations.
b. All drug endangered children should be referred to CPT.
c. CPT will provide necessary services depending on the circumstances of each case. This may include medical examination (if there are additional allegations of abuse and/or neglect), medical consultation, and/or forensic interview.

d. CPT will provide follow-up case management to include referral to Early Steps or Child Find for developmental services and referral for mental health services.
e. CPT will provide information regarding the drug-endangered child to the physician who will be providing primary care for the child.
f. CPT will arrange multidisciplinary staffings as necessary.

7. Fire Department/EMS

a. Fire rescue personnel are an essential part of the response to drug sites because of the hazardous nature of these sites resulting from the presence of volatile chemicals and the potential for fire and explosions. They are also vital first responders to provide emergency medical care to investigators, victims or perpetrators.
b. Emergency Medical Services personnel will provide initial medical evaluation of children found at drug sites. They will transport children to an emergency department for treatment when indicated.
c. They will provide support to law enforcement agencies and DCF representatives at the site in any way possible based on the capabilities of units, equipment, and personnel currently on the scene of the incident.
d. Fire Department personnel will provide decontamination support to children removed from drug sites at designated fire stations.
e. Fire Department and EMS reports, including identification of responding personnel, should be made available by appropriate request and forwarded to the requesting agency.

8. Safety Procedures

We are facing an unprecedented epidemic of clandestine drug sites in the United States. Seizures of drug sites continue to rise putting police and first responders at risks for a variety of hazards. First responders and children residing in the home are at risk for exposures to the chemical hazards, fire, explosion, and safety hazards inherent with clandestine manufacturing of methamphetamines. Responding investigative, and medical personnel should follow their agency safety procedures and corresponding OSHA requirements.

9. Team Coordination /Review

There are several agencies and organizations that participate in the DEC protocol. First responders to an investigation scene include law enforcement, DCF investigators, EMS personnel, Fire Department personnel, and HAZMAT teams. It is essential that all agencies work together, share information, and respond in a coordinated, collaborative effort. In general, law enforcement should take the lead role at the scene. Law enforcement should be responsible for securing the scene and conducting the criminal investigation. Whenever children are found at the scene or are suspected of exposure to toxic chemicals, DCF should be notified and children should be taken into protective custody. EMS should perform a field medical assessment and if required, transport them to nearest medical facility. HAZMAT teams should be responsible for removal of toxic waste.

10. Training

As part of this protocol, it is planned that a formal Brevard County Protocol for Drug Endangered children training program will be formulated. Presenters of this training program will be comprised of Law Enforcement, Department of Children and Families, the Child Protection Team, and Emergency Services/Fire Department personnel. It is anticipated that once the training program has been finalized it will be presented to family provider agencies such as (but not limited to) Community Based Care staff, law enforcement personnel, Department of Children and Families personnel, in home service providers, etc.

To: All DCF staff in the Marion County Service Center

From: Kimberly Grabert, Program Administrator

Date: December 31, 2008

Re: MARION COUNTY DEATH INVESTIGATION PROTOCOL

Effective January 1, 2007, the following protocol is in place for all staff at the Marion County Service Center.

Notification

Upon receipt of a death case, the Child Protective Investigator will immediately notice their Supervisor who will in turn immediately notice the Program Administrator. The Program Administrator will send notification to the Circuit Operations Manager, the Circuit Administrator, the Public Information Office and the Death Review Coordinator.

The Investigative Supervisor will ensure that incident and media reports are sent out within 5 hours of the commencement of the death investigation. It will be copied to the Program Administrator, the Operations Manager, the Circuit Administrator, the Public Information Officer, and the Death Review Coordinator.

Initial Contact with the Family

The Child Protective Investigator will use the Sudden Unexplained Infant Death (SUID) tool for victim children 24 months and younger. The SUID form will apply for the deceased child.

In any child death, the Child Protective Investigator will provide a drug screen to all parents and/or caregivers of the child immediately upon initial contact.

The Child Protective Investigator will obtain a timeline of caregivers for the deceased child for a period of 72 hours prior to the child's death.

The Child Protective Investigator has the right to request that their Supervisor meet the Investigator at the scene to assist with the initial contact. If the Supervisor is unable to respond, the Child Protective Investigator should contact the Program Administrator who will respond to the scene.

Follow up

The Child Protective Investigator and Supervisor will staff the case with the Program Administrator within 24 hours of receipt of case to identify current status, risk/safety issues and identify follow up tasks.

If there are any additional siblings in the home, a CPT referral will be made within 24 hours of commencement of the case. An exception or consult will not be considered appropriate and, depending on the maltreatment allegations and age/verbal skills, the siblings should be referred for a medical examination and/or forensic interview.

By day 5 of the case, the file will be copied and forwarded with all current notes, pictures, drug screen results, priors, and FDLE to the Medical Examiners Office. Redact all confidential information (SSN and Reporter).

By day 30, CPIS will request an appointment with the Death Review Coordinator to conduct a Death Review Staffing. The case must be submitted and reviewed for disposition prior to the request for an appointment. The Investigator is to copy the file and send to the Death Review Coordinator. This staffing is to be completed by day 45.

If the final autopsy is not received until after the report is closed, the original report will be placed in the case file with copies going to Program Administrator and the Death Review Coordinator. If there is any information that conflicts with the original findings of case, it should be staffed with the Child Protective Investigator, Supervisor, Program Administrator and (by phone) the Death Review Coordinator.

The Program Administrator is to maintain a log of death cases for ongoing analysis.

STATE COMMITTEE GOALS AND ACCOMPLISHMENTS FOR 2008

Goals:

- Continue to train professionals on child death investigations and in particular following the recommendations from the Center for Disease Control. The Center for Disease Control has encouraged all States to adopt a standardized approach to infant death scene investigation by all Medical Examiner Districts as well as law enforcement agencies. The State Child Abuse Death Review Committee views this project as a high priority and is supportive of identifying resources to initiate a statewide approach to training and outreach.

- Increase verified child abuse death reporting compliance to 99% for the 2008 deaths from the Department of Children and Families.

- The Quality Assurance Coordinator for the State Committee and the Quality Assurance Specialist for DCF Family Safety Program Office provide co training to all the DCF death review coordinators and to Protective Investigators through out the state.

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

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

- Provide training at the Dependency Court Improvement Summit on issues related to child fatalities identified by the State Training Committee.

Accomplishments:

- The State Committee made the recommendation that DCF should review, modify and seek legislative change to allow flexibility in keeping a case open when there is a death of a child in order to obtain the Medical Examiners report in order to classify the maltreatments accurately. This legislation was approved July 1, 2008 and now modifies the requirement to exclude reports involving missing children, child deaths, and criminal investigations. F.S. 39.301(16)

- Major Connie Shingledecker, Chairperson, presented research on using doll reenactments as a tool in child death investigation to the Florida Police Chief's Association and as a result they issued Resolution 2008-5, Supporting the State Child Abuse Death Review Committee's findings, and recommended using the doll reenactments as a tool. See Appendix VII

- The State Committee helped Healthy Families Florida revise the infant safe sleep materials which are included in the Recommended Practice Section of the report.

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

- The State Committee invited the Chairperson from each local Committee to a joint meeting with the Department of Children and Families Child Death Review Coordinators and Family and Safety Staff to address the process of reviews and to standardize them statewide.

- Reviewed 163 of the 166 child abuse death cases that met the criteria for review.

- Continue to educate and promote the use of the FDLE child investigation visor guide, which is available on the CADR website www.flcadr.org.

REFERENCES

1. Section 383.402, *Florida Statute*s

2. Section 39.01, *Florida Statutes*

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

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

5. Department of Health Vital Statistics Annual Report 2006

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

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

8. Crume, DiGuiseppi, Byers, Sirotnak & Garrett, 2002: Herman-Giddens et al., 1999)

9. (Mercy, Baker & Frazier, 2006)

10. Angelo P Giardino, MD, PhD, Clinical Associate Professor, Department of Pediatrics, Baylor College of Medicine; Medical Director, Texas Children's Health Plan, Inc
Eileen R Giardino, PhD, RN, MSN, FNP-BC, ANP-BC, Associate Professor of Nursing, Department of Acute and Continuing Care, University of Texas Health Sciences Center Houston School of Nursing,

11. [1]Tjaden, Patricia & Thoennes, Nancy. National Institute of Justice and the Centers of Disease Control and Prevention, “Extent, Nature and Consequences of Intimate Partner Violence: Findings from the National Violence Against Women Survey,” (2000).

12. Edelson, J.L. (1999). “The Overlap Between Child Maltreatment and Woman Battering.” *Violence Against Women*. 5:134-154.

13. American Academy of Pediatric in 2005

14. *Florida Statute*:383.50.

15. *Florida Statute* 406.11

Appendix I

Purpose of Child Abuse Death Review Committee

Program Background and Description

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

Mission Statement

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

Goal

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

Achieving Objectives

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

Membership of the State Committee

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

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

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

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

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

Appendix II

Membership of the Local Committee

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

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

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

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

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

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

Ad Hoc Members

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

Appendix III

American Academy of Pediatrics Prevention of Drowning

Organizational Principles to Guide and Define the Child Health Care System and/or Improve the Health of All Children
Committee on Injury, Violence, and Poison Prevention

Prevention of Drowning in Infants, Children, and Adolescents

RECOMMENDATIONS

Pediatricians should alert parents to the dangers that water presents at different ages and in different situations.

For Newborn Infants and Children Through 4 Years of Age

1. Parents and caregivers need to be advised that they should never—even for a moment—leave children alone or in the care of another young child while in bathtubs, pools, spas, or wading pools or near irrigation ditches or other open standing water. They should also be reminded that infant bath seats or supporting rings are not a substitute for adult supervision.[11] They should remove all water from containers, such as pails and 5-gallon buckets, immediately after use. To prevent drowning in toilets, young children should not be left alone in the bathroom, and unsupervised access to the bathroom should be prevented.

2. Whenever infants and toddlers are in or around water, be it at their own home, the home of a neighbor, a party, or elsewhere, a supervising adult should be within an arm's length providing "touch supervision." The attention of the supervising adult should be focused on the child, and the adult should not be engaged in other distracting activities, such as talking on the telephone, socializing, or tending to household chores. 3. If a home has a residential swimming pool, it should be surrounded by a fence that prevents direct access to the pool from the house. Rigid, motorized pool covers, pool alarms, and other protective devices, which may offer some protection if used appropriately and consistently, are not a substitute for 4-sided fencing.

4. Children are generally not developmentally ready for formal swimming lessons until after their fourth birthday. However, because some children develop skills more quickly than others, not all children will be ready to learn to swim at exactly the same age. For example, children with motor or cognitive disabilities may not be developmentally ready for swimming lessons until a later age. Ultimately, the decision of when to start a child in swimming lessons must be individualized. Parents should be reminded that swimming lessons will not provide "drown proofing" for children of any age.

5. Parents, caregivers, and pool owners should learn CPR and keep a telephone and equipment approved by the US Coast Guard (eg, life preservers, life jackets, shepherd's crook) at poolside.

6. Parents should be cautioned not to use air-filled swimming aids (such as water wings) in place of personal floatation devices (life preservers).

7. Parents should be certain that all people who will be caring for their child or children understand the need for constant supervision of children when in or around water. If children are in out of-home child care, parents should inquire about exposure to water and water-related activities at the provider site, such as presence of a swimming pool at the home or visits to off-site pools. Recommendations for child-staff ratios while children are wading or swimming are available and vary with the age of the child and by jurisdiction. Some states include in their licensing requirements staffing ratios for water activities. Parents should be aware of the ratios at their child's site of care. National recommendations are available in *Caring for Our Children: National Health and Safety Performance Standards for Out-of-Home Child Care Programs*.[12]

8. Pediatricians are encouraged to identify familieswho have residential swimming pools and then schedule periodic counseling beginning in the perinatal period to ensure that parents remain aware of the risk of drowning and near-drowning. Families (and extended families and others visited by children) should be advised to install an isolation fence (also referred to as a 4-sided fence) that

prevents direct access to the pool from the house. The fence should be at least 4 feet high (or greater if required by local ordinance). The fence should also be climb-resistant. For example, chain-link fences are easily scaled by young children, whereas ornamental iron bar fences are more difficult to climb.[13] The distance between the bottom of the fence and the ground should be less than 4 inches. The distance between vertical members of the fence also should be less than 4 inches. The gate is the single most important component of the fence. It should be self-latching and self-closing, should open away from the pool, and should be checked often to ensure good working order. Detailed guidelines for safety barriers for home pools are available online from the Consumer Product Safety Commission.[14] Families can also be advised to consider supplemental pool alarms and rigid pool covers as additional layers of protection; however, neither alarms nor pool covers are a substitute for adequate fencing. (Importantly, some types of pool covers, such as solar covers, should not be used as a means of protection, as detailed in the accompanying technical report.[8])

Appendix IV

Child Abuse Deaths by County

The following map, statistical reports, graphs and charts are based on a review of the child abuse and neglect deaths that occurred from 2004-2007. Below indicate the counties in which the deaths occurred and the number of deaths per county by year. This year the Committee reviewed 11 deaths that occurred in previous years. There data has been updated and the numbers are reflected in the chart below. This is a significant increase and it is due largely to better reporting as well as during the course of investigations they discover that the family has had a previous death and it was unreported to the hotline.

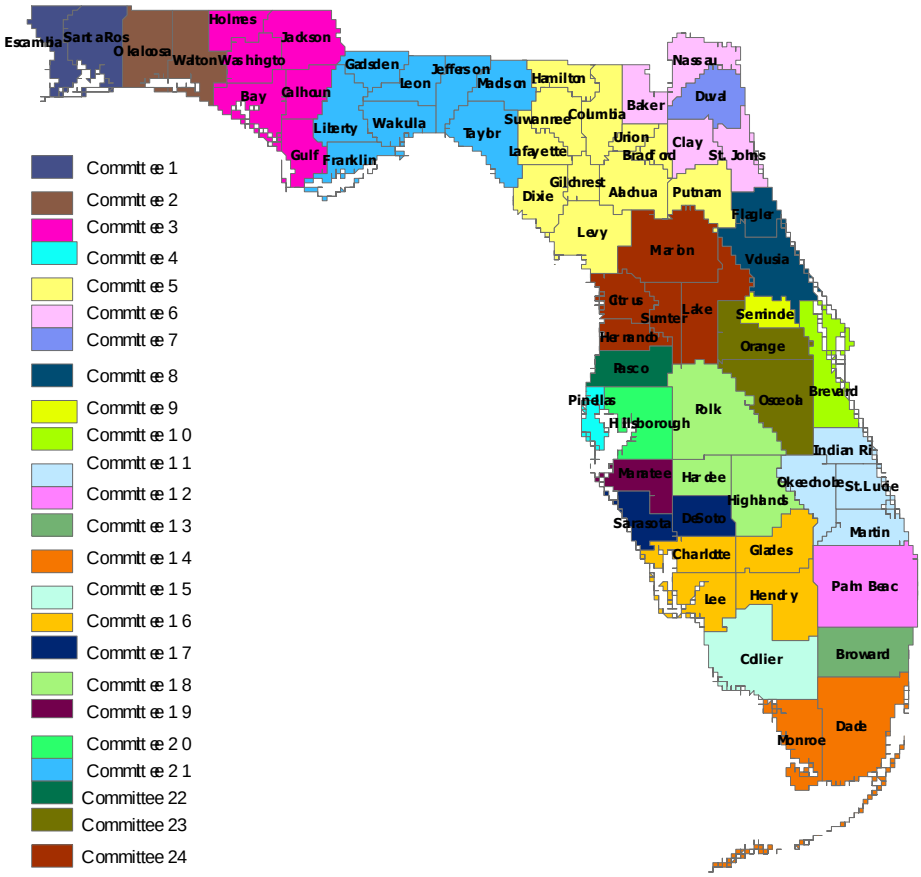
Number of Deaths by County												
County	Year				Total # of Deaths	County	Year				Total # of Deaths	
	2004	**2005**	**2006**	**2007**	**Total # of Deaths**		**2004**	**2005**	**2006**	**2007**	Total # of Deaths	
Alachua	1	3	2	2	8	Madison	0	0	0	2	2	
Baker	1	1	1	1	4	Manatee	1	0	4	1	6	
Bay	0	1	0	1	2	Marion	4	6	7	7	24	
Bradford	0	1	1	0	2	Monroe	0	0	1	0	1	
Brevard	7	5	11	8	31	Martin	0	0	2	0	2	
Broward	13	9	14	11	47	Okaloosa	0	0	2	2	4	
Charlotte	2	0	2	0	4	Okeechobee	0	0	1	1	2	
Citrus	4	0	1	2	7	Orange	5	9	9	10	33	
Clay	1	0	0	2	3	Osceola	1	1	3	4	9	
Collier	0	0	3	2	5	Palm Beach	6	6	14	18	44	
Columbia	0	0	1	0	1	Pasco	2	0	4	8	14	
Dade	14	5	11	7	37	Pinellas	2	5	6	6	19	
Duval	16	9	12	8	45	Polk	7	8	16	16	47	
Escambia	1	0	4	2	7	Putman	0	0	3	0	3	
Flagler	0	0	1	0	1	Santa Rosa	2	2	3	1	8	
Gadsden	0	1	0	1	2	Sarasota	1	1	1	4	7	
Glades	1	0	0	0	1	Seminole	3	2	4	3	12	
Hernando	1	2	3	0	6	St. John	2	1	0	1	4	
Highlands	0	0	1	6	7							
Hillsborough	2	6	9	8	25	St. Lucie	0	0	1	3	4	
Holmes	2	0	0	1	3	Sumter	0	2	1	1	4	
Indian River	3	0	0	2	5	Suwannee	1	0	0	1	2	
Jackson	1	4	1	0	6	Union	0	1	7	2	8	
Lafayette	0	0	1	0	1	Volusia	1	2	1	4	8	
Lake	0	0	1	4	5	Walton	0	2	1	0	3	
Lee	5	4	4	3	16	Wakulla	0	0	0	0	1	
Leon	2	0	0	1	3	Washington	0	0	1	0	1	

Appendix V

Local Child Abuse Death Review Committees

- One of the goals of the State Committee for 2007 was establishing local child abuse death review committees statewide, which was accomplished in November 2007.
- Local Committees did an excellent job reviewing the increased number of child abuse death cases.
- They did so in a timely manner and made valuable recommendations for the State Committee to consider.
- The members are dedicated, passionate professionals who have volunteered timeless hours in an effort to prevent future child abuse deaths in their communities.
- The local Committee's have been able to make local prevention efforts and changes that have been identified by the case reviews, see below initiatives from some of the local committee Chairs.

Local Child Abuse Death Review Committees



Appendix VI

American Pediatrics Policy Statement

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

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

Appendix VII

Letter to Florida Police Chiefs Association

Florida Police Chiefs Association

Quality Law Enforcement for the Sunshine State

Resolution 2008-5, Supports the State Child Abuse Death Review Committee's Findings and Recommendations on Using Doll Re-enactments as a tool in child death investigations.

WHEREAS, the State Child Abuse Death Review Committee presented compelling research on using doll re enactments as a tool in child death investigations.

WHEREAS, thorough investigative findings have revealed many cases that were classified as Sudden Infant Death Syndrome, were actually deaths as a result of suffocation due to unsafe sleep practices.

WHEREAS, the FPCA supports this initiative, urging members of Law Enforcement involved in child death investigations to include doll re-enactments as part of their investigation.

WHEREAS, the Center for Disease Control and Prevention is sponsoring the SUIDI, or Sudden Unexplained Infant Death Investigation. This new initiative is designed to promote a more thorough investigation of sudden and unexpected infant death cases throughout the country with the goal of identifying risk factors involved in certain types of infant deaths and using knowledge of these risk factors to prevent many future infant deaths.

WHEREAS, the SUIDI initiative stresses the use of doll re-enactments as valuable tools in an investigation. By recreating the position and sleeping environment in which the infant was placed to sleep and the position in which the infant was found, the doll re-enactment in many cases provides law enforcement and the pathologist with a much better understanding of the role that the sleeping environment played in the death.

WHEREAS, the FPCA supports the CDC SUIDI initiative stressing the necessity of a multidisciplinary approach to these investigations, with collaboration between law enforcement, the medical examiner's office, Department of Children and Families and treating physicians.

THEREFORE BE IT RESOLVED, having considered a formal request by Major Connie Shingledecker, Chairperson for the State Child Abuse Death Review Committee, the Florida Police Chiefs Association officially supports the findings and recommendations of the State Child Abuse Death Review Committee in regards to the use of doll re-enactments in child death investigations.

PASSED AND ADOPTED this 13th day of January, 2008 in St. Augustine, Florida at a duly constituted meeting of the Board of Directors of the Florida Police Chiefs Association.

Tallahassee Headquarters: 924 North Gadsden Street, Tallahassee, FL 32303 • **Mailing Address:** P.O. Box 14038, Tallahassee, FL 32317-4038
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DEFINITIONS

❖ Cases that meet the criteria for review

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

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

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

❖ Cause of Death

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

❖ Manner of Death

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

❖ Preventable death.

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

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

Deaths resulting from homicidal violence are classified as "not preventable" unless the information provided clearly demonstrates that actions taken by the community or and individual other than the perpetrator could definitely have prevented the death or could possibly have prevented the death

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

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

❖ Physical Abuse

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

❖ Neglect

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

❖ Harm

F.S.39.01

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

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

1. Willful acts that produce the following specific injuries:

a. Sprains, dislocations, or cartilage damage.

b. Bone or skull fractures.

c. Brain or spinal cord damage.

d. Intracranial hemorrhage or injury to other internal organs.

e. Asphyxiation, suffocation, or drowning.

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

g. Burns or scalding.

h. Cuts, lacerations, punctures, or bites.

i. Permanent or temporary disfigurement.

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

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

2. Purposely giving a child poison, alcohol, drugs, or other substances that substantially affect the child's behavior, motor coordination, or judgment or that results in sickness or internal injury. For the purposes of this subparagraph, the term "drugs" means prescription drugs not prescribed for the child or not administered as prescribed, and controlled substances as outlined in Schedule I or Schedule II of s. 893.03.

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

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

a. Sprains, dislocations, or cartilage damage.

b. Bone or skull fractures.

c. Brain or spinal cord damage.

d. Intracranial hemorrhage or injury to other internal organs.

e. Asphyxiation, suffocation, or drowning.

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

g. Burns or scalding.

h. Cuts, lacerations, punctures, or bites.

i. Permanent or temporary disfigurement.

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

k. Significant bruises or welts.

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

1. Solicit for or engage in prostitution; or

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

❖ System

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

❖ Caregiver

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

❖ Adequate Supervision

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

❖ Sudden Infant Death

"the sudden death of an infant under one year of age which remains unexplained after a thorough case investigation including performance of a complete autopsy, examination of the death scene, and review of the clinical history. By definition SIDS can be diagnosed ONLY after a thorough examination of the death scene, a review of the clinical history, and performance of an autopsy fail to find an explanation for the death.

A SIDS diagnosis should NOT be assigned if the infant was found in the prone position and/or sleeping in an unsafe sleep environment.

❖ Sudden Unexplained Infant Death

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

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Division Director, Children's Medical Services
Representing: Florida Department of Health

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