111 Cases Reviewed for CY 2013 (55 Narratives, 21 Strategies)

Committee [redacted]

Narrative:

Mom was educated based on records obtained by the pediatrician on the dangers of co-sleeping and unsafe sleep positions. Furthermore, the mother has a cousin who had her child pass away in 2007 due to an unsafe sleep (co-sleeping) incident.

Strategies

Narrative:

According to the DCF Incident report: Mom reported that she put the now deceased infant in her crib around 0030. She woke up at 0700, did not check on the child, had coffee and fell asleep until 0930. She woke again, checked on the child, and found the child deceased in crib. An hour passed before she called 911. Mother enlisted assistance first from the neighbors across the street, then two friends. At 1029, 911 was called and PBC Fire Rescue, operating out of station 91 responded to the call at 1032. 1032 is listed as the time of death. There was an open investigation at the time of this child's death. There are many previous reports. All 4 of her other children have been removed, and placed for adoption.

Strategies

Narrative:

According to the SE Region CDR: The preponderance of evidence shows the twins were placed in an environment that could cause significant impairment. Based on the fact that the child had pneumonia and was still placed faced down on a soft pillow was a failure to provide the child proper care. Current recommendations by providers is to not place sibling children together in the same crib where rolling may increase the chance of suffocation or use soft pillows or blankets for props. This is considered to be an unsafe sleeping environment. According to the CPI, mother was advised on numerous occasions by her doctors of the dangers of placing her children in an unsafe sleep environment.

Strategies

Committee [redacted]

Narrative:

Premature infant born at 22 weeks gestation spent five months in hospital and discharged at 5th month. Parents declined medical inhome services and didn't comply with medical course of treatments as prescribed. They had also previously taken infant to ER and against medical advice left when asked to admit decedent as patient. Parents coslept with infant on regular basis. Infant at 7 months old was with cold and runny nose and father placed infant on his chest and went to sleep. Father admitted to smoking marijuana prior to retiring for the night. The medical opinion of ME was that asphyxia could not be ruled out in light of the cosleep event. Parents initially provided false information to first responders & LEO stating infant was in crib and found unresponsive. Parents refused to comply with CPS recommendations for drug testing. Parents denied family preservation service agency into home. Parent uncooperative. Perponderance of evidence that death was from omission and failure to provide infant safe sleep environment (ie: crib, and apnea machine) and opted for placing infant face down on father's chest to sleep when infant was congested.

Strategies

Narrative:

Parents had 14 year old daughter supervising the four year old at home while they shopped, a common occurrence on weekend. An adult uncle was at the residence but not asked to supervise. The parents called the daughter to remind her to feed the 4 year old and she acknowledged she had not checked on her sibling for 30 minutes. French door leading to pool patio was found open. Pool area checked, but murky water disallowed seeing into the water. After search was unsuccessful they uncle used a long stick to check the water and noted object, which was the decedent. The home was with no barriers and there was omission to secure doors or provide supervision. Pool patio area was commonly used for recreational purposes as noted by basketball hoop; bike, ball and baseball bat floating in pool, etc. outside.

Strategies

Narrative:

The mother, father and two children resided in the maternal grandparents residence. While the other adults were working the mom at home with the 9 month old and 2 year old left them unsupervised in the living room while she by admission was in bathroom 15 minutes. She had left the sliding glass door open leading to pool with only a slding screen door separating room from pool. The 2 year old known to play with screen door pushed it open. The decedent crawled outside and fell into pool. Mom returned to room & found screen door open & found her child in pool. She screamed and neighbors responded and did initiate CPR. Mom had marijuana out in kitchen & LEO found container of marijuana and other drug related items. Mom tested positive for marijuana when CPS had her tested. Prior CPS record noted the 2 year old was substance exposed at birth. CPS sought court sanctioned in-home protective supervision of the surviving child due to impending danger threats based on mother's diminished protective capacities linked to addiction issues. Drowning incident was preventable had parent not left the sliding glass door open and provided supervision.

Strategies

Narrative:

The couple resided in the paternal grandparents residence. The father traveled out of town often. Mom was advised to obtain and use crib. She elected to co-sleep. Despite initially providing false statements about the circumstances she did provide in her fourth account that she woke up to find infant beneath her and not breathing. She states she shook infant & infant began breathing, she then sought no EMS services. She reported infant vomited but scene investigation found no vomit. She drove to a distant hospital bypassing other more appropriate hospitals. Infant at admission to ER was noted with alert and normal vital signs. The history & circumstances shared by mom to hospital were false.While infant was with mom in hospital the condition deteriorated and infant transferred to an advanced hospital. The child was shortly placed on life-supports after arrival at second hospital. Child was declared dead four days later and organ were harvested. An anonymous call to hospital reported mom had harmed child to seek attention for herself. Hx involved multiple complaints by mom in prior medical sought appointment at pediatrician. Mother provided to hospital & LEO multiple statements and did eventually break down and admitting to having providing prior false statements. The autopsy ruled infant died from asphyxia. Time frame in mom's story had her finding infant under her not breating at 7 AM and not being taken to ER until 1030AM.

Strategies

Narrative:

The unmarried couple resided in the home of the father's great aunt. The home was occupied by 10 people. Dad remained out all night playing cards and by report smoking marijuana. Prior to his arrival home the mom who had coslept with infant got up and went to work leaving child awake in the home with a relative. When father arrived home in AM he took infant to bed with him. He slept briefly and then got up and left infant in the bed against a pillow and left the home. The bedroom door closed. He left by his account in the morning. He didn't check on child after his return after until family members asked where the infant. That infant was not reported to 911 until after 3 PM. The rigor mortis had passed into the body and it was evident the infant was dead for hours. There was clothing piled up against the bed in a plastic bag and this was leaning against the bed. It was determined that the child died of a result of asphyxia to suffocation by sleeping up against the plastic bag.

Strategies

Narrative:

Single parent with 1 month old infant residing in the residence of her adult sister. she opted to co-slep with infant although she had bassinet. She even had disassembled the bassinet and put it away. The parent had a babysitter the evening before as the parent went to a family gathering and didn't return until 3 AM. Parent fed infant and then retired to bed with infant at 5 AM. She did not awake until 1 PM to find infant unresponsive and blood had come from nose. She called 911 but elected to take infant to hospital by foot, since she lived approximately several city blocks. Police met parent at the ER room. Hospital attempted resucitate to no avail.

Strategies

Narrative:

Three month old infant reportedly was non-responsive and the mother left the residence and walked blocks to a convenience store. She left infant on couch and didn't wake the father. He woke and also noted infant not breathing and he too left the residence. Neither attempted CPR. Parametics arrived and had to wait for both parents to let them in. Inside the apartment was a three year old left with the deceased infant. Their statements were inconsistent as over 100 apartments in the complex existed and they could have knocked on doors to summon help versus walking to a store. The residence was filthy and the environment indicated the playpen was filled with items and unusable. The infant, sibling, and parents all would co-sleep. The infant per the report of parents was placed in a carseat and checked on 45 minutes later and found unresponsive. The father had a restraining order on him from NY and the mom was the protected party. LEO arrested dad for violating the restraining order. The family had no child-welfare history as reported by NY. The actions by FL to take the sibling into custody resulted in judge ordering the return of to parents and dismissal of court actions. Neither parent displayed any viewed external sadness or emotional distress. The infant's body was with notable evidence of neglect with skin lesions, dirty, etc.

Strategies

Narrative:

The mother left her child in the care of a close friend for babysitting regularly. The babysitter for the week leading up to the death had elected to use the bed for the infant's nap rather than the portable crib. The bed used was with pillows surrounding the infant and the reenactment with caregiver (babysitter) was that she placed infant on side with back against pillow and returned hours later to find the infant unresponsive face down in the soft bedding. The ME report clearly noted that the contributing cause was unsafe sleep environment.

Strategies

Expand babysitting courses to include safe sleep practices

Narrative:

Two adults brought home their premature infant who had stayed in the NCIU unit for 1 month and on the first night home they coslept with the infant. The two adults were obese and shared a twin bed per the ME & LEO reports. The father brought infant into the bed and placed infant on pillow. The ME determination was asphixia. The father had extensive criminal record and drug arrests, but both adults were non compliant with CPS efforts. No other children.

Strategies

Narrative:

Single parent with disabilities (legally blind & mental health) elected to cosleep with her infant. She awoke to find the infant wedged between the bed and the wall. Crib was within reach of the bed, but not used. Father of infant was a registered FL child sexual offender who stated he did not reside in home. Established that the cosleep events resulted in the death.

Strategies

Narrative:

Parents returned home in late evening and father placed infant prone in crib with blanket over child's body including partial face. The mother checked on infant at midnight and pulled blanket down to shoulders but left infant prone. Infant not checked on for 9 hours and found to be unresponsive. Infant was deemed by ME to have been with positional asphyxia that was based on matress and blanket affecting air passage. In the crib was a moon-shaped pillow and toys. The father in the morning upon discovering his unresponsive child did not call 911 immediately but ran to his parents residence nearby with infant in his arms. they were not home so he returned with the non-responsive infant to his home and he then called 911. The operator walked him through starting CPR which he did attempt until told to do so.

Strategies

Narrative:

A 17 year old male was killed in his family home by his father who also killed his wife using a crossbow bolt, then removing the bolt from the head on each of them to inflict the fatal injury. The father apparently distrought over business financial issues and immigration issues did premeditate the killing of his family. He did commit the homicides in the family home then drove across the state to a universtiy where his 21 year old son was attending classes and attempted to kill his son as well when he shot the same weapon at his adult son but only injured his adult son. He then traveled across the state to a hotel where he then committed suicide with sliting his throat. The decedent in this report was a good student, popular in school and had excelled in music and was in the school band. No prior criminal or child-welfare history existed with the family.

Strategies

Narrative:

Drug exposed infant removed by dependency court in another neighboring county and placed with relative caregiver. The relative caregiver had homestudy prior to placement which was denied by the reviewing investigator, however the court overruled and placed the infant with the relative. The relative elected to use her bed to cosleep with infant after the placement began. On the date of incident the caregiver had her bedding in the wash and elected to place infant on couch and then feed infant and also cosleep with the infant. The caregiver awoke at 9:30 AM and realized she was sleeping on top of infant forcing infant's face into the couch cushion. There was in-home case management associated with this infant when the incident occurred. The caregiver was provided information on safe sleep practices. It was recorded by the case manager that caregiver was using the bassinet even though she later stated she was not using it because it was too small.

Strategies

Narrative:

Parents and their three children traveled to relatives home in [redacted] County for a cookout and swimming party. Father was in pool and playing with his children in the water. The decedent could not swim. Father was watching TV from the pool and not carefully observing. The mother was in the pool and left the pool to sit outside poolside. Neighter parent aware of the child accessing the pool until the father observied the child at the bottom of the pool.

Strategies

Narrative:

The father in 2008 had co-slept with an infant that died in an asphyxication preventable death. The family was referred to court due to environmental issues. The reunification of children occurred and child protective services ended their involvement. The mother was at a MD appointment and the father at home with his adult sister watching the children. The infant was fussy and not taking formula. The infant spit up on the father. The father placed infant in bassinet with pacifer in month and in the bottom of bassinet was a blanket on top of mattress and then a pillow on top of blanket. The father put infant prone on stomach with pacifer on the pillow and then put the bassinet in a room under a AC vent. The aunt found the infant non-responsive. The medical examiner found broken ribs but could not rule that it was not caused or caused by the CPR of professionals. The judge in dependency family court felt this second infant death was suspicious. The father initially refused drug testing. He eventually was tested days later and was positive for THC and oxycodone and subsequently cocaine.

Strategies

When medical doctors from Child Protection Team and first responders (law enforcement, child protection, etc.) have information pertaining to neglect or abuse that pertains to the decedent's death; the medical examiner should be required to reference those opinions even if they conflict or expand on the medical examiner's opinion.When failures and/or omissions of caregivers cause death, the medical examiner should not reference that as accidental but should reference it as neglect according to criminal statute (FS 827).

Narrative:

After school had transported the special needs child home where the other family members where located the father took siblings to library and left the decedent in the home with his 14 year old, who was in her bedroom asleep. She denied being informed of her responsibility to supervise her sibling. Another sibling was given the role to inform the sister to watch the decedent while the father was in the vehicle. The siblings dispute what exchange of communication occurred. The father arrived back home a few minutes later and again left to go to work. The 12 year old sibling entered the home and asked where the decedent was at and the two younger brothers on a search found him in the pool. The sister ran outside and a local neighbor hearing her plight came to the home and pulled the decedent from the pool and the neighbor started to perform CPR.

Strategies

Narrative:

The decedent was identified during the course of a child protective investigation to be missing. The parents during initial and subsequent questioning by CPIS & law enforcement knowingly and willfully gave false and misleading information repeatedly concerning the infant's whereabouts. This resulted in the matter being escalated to a missing person investigation and the intentional false and misleading information given by the parents did impede the investigation. The missing infant was eventually found buried in the back yard of their former rental residence that the parents shared with the maternal grandmother and other extended family members. The family household was under a lease held by maternal grandmother and her paramour. The maternal grandmother of the decedent. That grandmother had four minor children still in her care ranging from ages 9 to 11. Additionally that grandmother permitted the decedent's mother and her children to live in the home. The residence also frequently had the grandmother's adult son who was the subject of frequent domestic violence within the residence when not incarcerated. Dependency court actions were sought in behalf of the grandmother's children in 2005 by CPIS with removal episodes and the court was involved with protective supervision through April 2007. The mom of the decedent in her past had gave birth to her first child at 17 with frequent calls continuing regarding the welfare of the infant and other children in the household. Legal consultation resulted in CPIS being denied approval for dependency action with the mother's 1st child in 2009 after a DV incident. In 2010 after continuing events in the household elevating BSO was able to have the dependency court case reheard in regards to the grandmother's minor children. The court denied the reopening of the dependency case at the first hearing. BSO referred the case for voluntary protective services with the local [redacted], soon after in 2010. Voluntary compliance was not successful with [redacted] In 2011 after additional reports concerning the children in the home the young mom accepted community-based family preservation services in the home through a local agency [redacted] Those services continued from February to April 2011. In May 2011 under a new report the CPI did photograph the decedent in the residence. This was the last noted visual observation noted by child welfare professionals. There were additional reports after that time regarding both the grandmother's children & the mother's children; however the deceased child was never noted in the home in the visits or discussions. In October 2012 law enforcement responding to a domestic were informed the decedent was taken by one parent from the other. Law enforcement in turn reported it to the state abuse hotline with the hotline declining to accept the report for investigation. During the initial interviews on this investigation the child's father told law enforcement that the child's mother told him, "You have to forgive me if you love me. Don't ask me about the whereabouts of the child. If you love me, you'll forgive me." The maternal grandmother and step-grandfather also were uncooperative in regards to the disappearance & death of the decedent. In dependency court after the events unfolded both grandparents who resided in the home did go on official record in dependency court that they wished to exercise their 5th amendment right to not answer questions that could self-incriminate them. After the decedent was not seen the grandmother ended her long term lease and moved into a different residence for her and her daughter family. The [redacted] Beach Police Department did after extensive efforts uncover the skeletal remains in the back yard of the family's previous residence in [redacted] located at [redacted]. The DNA test established the remains as the decedent who was an infant at the time of his death. The results indicated that the genetic data obtained from the parents as consistent with the unidentified human remains. The genetic data are approximately 31.2 trillion times more likely to be observed under the scenario that the unidentified remains originated from a biological child of the parents as opposed to the unidentified remains originating from an unrelated individual from any of the three major US population groups. Medical Examiner's report obtained determined that the cause of death was deemed as violence of undetermined means and the manner of death being homicide. Both parents were incarcerated, the mother on felony charge of the neglect of child resulting in bodily harm. This charge continues on in felony court at this time. The father's charges were the same, except additional charges of providing false information to LEO were added. The charges with the father were re-filed and are pending in the court. The specific homicide charge has not yet been filed on either. The dependency case met grounds for seeking termination of parental rights and is in trial phase. The surviving siblings remain in the custody of the Department without contact with the parents. Neither parent will provide statements as to what occurred with the death and burial of their son in their yard.

Strategies

Narrative:

The decedent along with a sibling was in the physical care of his paternal grandparents for three months due to the mother's incarceration. The grandfather and an aunt were home one late afternoon with relatives visiting. The had left both french doors in living room and a kitchen door ajar leading to a backyard patio. This patio had screen sections missing and the screen door had all screening missing. The toddler last seen in the home 15 minutes earlier was able to wander through the open doors through the patio to pool area due to no barriers in place. the aunt found the child floating on the surface of the in-ground pool. EMS arrived to find the grandfather attempting CPR on the hood of a vehicle in the front yard. The decedent was transported to a local hospital and placed on life supports. Three days later the child was medically declared deceased.

Strategies

Narrative:

Married couple from [redacted] in process of relocating to [redacted]h Florida. The mother was staying with paternal relatives with her two year old. The father was not relocated to Florida at time of incident. the mother went to work and left the toddler in the care of an uncle. The uncle by admission knew the child could open and close the sliding glass doors. The home had safety locks at the top of the doors left unsecure and the regular locking latch left unlocked. The uncle was preoccupied in a bedroom for nearly 1/2 hour when the toddler accessed the unlocked sliding door and went onto patio where he subsequently was found floating unresponsive face down in the pool. Child died two days later in hospital from complications of the non-fatal drowning incident. The uncle did not know CPR.

Strategies

Narrative:

The mother of the decedent had an infant die in 2008 under very similar events which were substantiated by child welfare investigators. In this incident the mother and her boyfriend (decedent's father) did take the lining of a car seat with cushioning and placed infant into it (described as u shaped) and placed the infant between them. These are similar events from her other prior 2008 preventable infant death. There were multiple agency records of this mom since the death of the 1st child and the birth of this child being involved in drug related behaviors impacting the household of court ordered relative placement. The parents were extremely uncooperative and agency involvement without other children to protect was limited and minimal without jurisdiction to mandate their compliance to substance abuse evaluations.

Strategies

Narrative:

The infant's mother resided in a transitional shelter facility with her three children. She arrived back after midnight elected not to use a donated bassinet for her newborn as arranged by local agency that came with lessons on dangers of unsafe sleep & lessons on safe sleep practices. She arranged two twin beds together and placed her 1 ├é┬╜ year old in the twin bed and the infant face down in the middle of the two twin beds. The mom then` took three prescriptions and one over the counter medications [2 anti-depressants; 1 anti-seizure; 1 sleeping pill] all with side effects related to drowsiness. She admitted she was too tired to put the infant in bassinet. Her toddler woke her up the following morning at 9 AM and she felt her infant who was blue, cold, and unresponsive. She left the infant on bed & used payphone outside room. Dispatch inquired on her beginning CPR while awaiting first responders, but she told them she didn't have the infant with her. So she hung up got her infant & went to the shelter's lobby on the 1st floor. Staff called 911 again but neither mom nor shelter personnel started CPR. When paramedics arrived the infant was on the counter and no one had started CPR. LEO detective stated mother looked groggy when interviewed. Shelter staff stated the mom regularly felt sleepy & the psychiatrist when informed of their concerns had sought the mom to reduce the amount of medications she was taking. The [redacted] Protection Team medical consultation concluded positive for failure by the caregiver to provide the infant a safe sleep environment. This was same MD from CPT who had recently concluded in a prior investigation a month earlier that the infant was "positive for medical neglect" related to the mom missing medical appointments for the infant after his release from the NICU. The medical examiner's report deemed the cause of death as sudden unexpected infant death, manner undetermined, and the circumstance of death being the "decedent was found unresponsive, in bed, co-sleeping with family members."

Strategies

Narrative:

The toddler accessed the pool at the maternal great grandfather's residence where the couple and the two children were staying. They had come back to FL recently from Chicago and were staying with family until obtaining jobs & residency. The couple didn't supervise the toddler and allowed her to play on the pool patio while mom remained in the home and the father was occuppied fixing broken sliding glass doors on the pool patio. The mother from inside saw decedent in pool and ran out and jumped in. 911 was called but neither parent nor relative attempted CPR. The first responding LEO did initiate CPR prior to the EMS arriving.

Strategies

Narrative:

Six week old decedent died in circumstances related to unsafe sleep placement by obese mother and impairment of mother through usage of multiple prescription medications. The mother had history of child neglect incidents including prior report of sleeping with another infant (then 1 month old) that fell off bed and received injuries in 2009. During pregnancy the mother was homeless and recently after birth moved into her adult daughter's home and slept on couch. She had her other minor child sleeping on a second couch in same room. Parent had significant mental health issues related to schizoaffective disorder and history of non-compliance with mental health, and physical health providers. The decedent father also in the residence the date of the death was co-sleeping on another couch with the other minor child. The father had significant mental health problems too. Paranoid schizophrenic history led to mental health evaluations following intervention. The couch had pillows, blankets, cushions in addition the parent and decedent.

Strategies

Narrative:

The child was placed in the care of the relative through dependency court [redacted]. The child was very active to the point where she was being self abusive. The child intially shared room with her cousin who is also the same age as the decedent. The cousin was subsequently removed from the room and began sleeping in the room with her mother and younger sibling. The decedent was left in the room by herself. The lock was removed from the door to prevent the child from opening it. The caregiver, without the approval of the department allowed other individals to care for the child to include but not limited to administering medication. The caregiver deliberately kept the child from the community by not taking her to school, medical appointments, therapists who would have intervened in her nutritional and general neglected state. No primary care physician was identified for the child. According the the CPT report completed on 10/13, the characteristics of this case are describedin the definition of child torture. The caregiver gave believable explanations fro her injuries and deprived state by reporting that she was being bullied at school, and that she would bruise herself from climbing and jumping off furniture. The child was starved, malnurished, isolated and restrained/confined. The child physically had extensive old injuries and an open wounds that were as a result of those entrusted to provide care.

Strategies

Dependent children with disabilities and/or medically complex issues under the department's jurisdiction have enhanced family-centered services, supports & oversight by child-welfare case-management service providers and any state or local school and/or medical providers. With all agencies having enhanced collaboration for such services. [expansion of medical foster homes and medical foster care units]

Committee [redacted]

Narrative:

Mom was cleaning the home and doing laundry. She lost track of her daughter and could not see the pool area because there were clothes hanging out by the pool. After she realized that her daughter was missing, child was located in the pool. There were also toys in the bottom of the pool.

Strategies

media campaign with billboards by hospital and Safe Kids Coalition, door alarms provided at hospitals, EMS to talk to families with pools while on calls, drowning prevention pamphlets given at discharge from hospital, FIRE/EMS doing safety assessments of homes

Narrative:

Child suffered severe abuse by mother's paramour; responding officers seized a belt from where the child was deceased that matched a bruise on her face. The child's feet were also severely bruised. It was determined that this was not an isolated incident and a pattern of abuse existed.

Strategies

Work in conjunction with the DCF campaign "who is watching your children" and provide information at hosptitals, CPT and community events

Narrative:

5 females in the kitchen 10-15 adults in lanai by the pool 8 children in the pool Homeowner was treating pool for 2 weeks with chemicals because it was green Pool murky because cleaner was circulating from all the kids in the pool / could see bottom of pool the day before mother did not designate anyone to watch her child when she left to go to the store

Strategies

Educating parents on the dangers of pools and watching children

Committee [redacted]

Narrative:

The child was presented to the hospital with bruises all over. The child was pronounced dead. The mother stated that the child had a fever throughout the night. According to the autopsy, the child had old subdural hemorrages, contusions, and bite marks. The child also had a healing ulcer on the tongue and a torn uvula. The child's weight was below the 1 percentile. The second child in the home had similar injuries. CPT medical staff noted these to be consistent with physical abuse. The mother admitted that she saw the her paramour bite the child on the chest. The mother also saw the paramour inflicting injuries to the child; slamming the child's head and shaking the child on the night of the child's death. The paramour was arrested for first degree murder and the mother has bonded out for child neglect charges. The remaining children were sheltered and the mother's right are being terminated. There was marijuana found in the home. The children had a primary care physician that saw no injuries 3-6 months prior to the death. The mother and her paramour have a gang related history.

Strategies

Narrative:

The mother initially reported that her car broke down with the child in the back seat. She later indicated that the air conditioner was on in the car. Then the mother reported that she was actually in the car next to her own car. The mother left the child in the car for a couple of hours. The child died of heat stroke. The mother was arrested for aggravated manslaughter. The mother was in the parking lot of a hotel. The mother was having an affair with a correctional officer. He was also charged with neglect. The battery was dead in the mother's car when law enforcement arrived. There is no DCF history. Grief counseling was recommended, but declined by the father.

Strategies

Narrative:

The child's death was ruled a homicide - head trauma. The father changed his story numerous times. He stated that he put the child down to sleep. The father took a cap of niquil before going to bed. He later admited that he killed the child, though he did not know how. The father hit the baby's head on the dresser. The father has a criminal history that includes battery. There are numerous prior reports alleging domestic violence by the father. Charges are pending against the father for child abuse/manslaughter. The mother has support from the grandparents and she is going back to school. It is concerning that the mother was aware of the father's history of violence. It is also concerning that the father had taken a sleeping aid prior to the child's death.

Strategies

Narrative:

The child died by drowning. The child was also found to be underweight; though there were no other injuries noted. The child drowned in a pool at the home of the mother's friend. The mother reported that she had taken the child upstairs with her; however, the children stated that the mother left the three children at the pool while the mother was in the residence, with no visual line of sight of the children. The mother tested positive for marijuana and there was marijuana found in the home. The mother was charged with aggrevated man slaughter, though the trial is currently pending. There was concern that the man who owned the home was possibly a pimp. He had a warrant for his arrest. The mother has a criminal history including prostitution. At the home, there were only mattresses and alcohol in the rooms. There are further concerns that the biological father knew about the mother's prostitution and allowed the children to remain in her care.

Strategies

Reduce substance abuse around children campaign. Choosing appropriate caregivers campaign. Educate school staff on identifying malnutrition. Pool Safety Campaign.

Narrative:

The child died of a self-inflicted, accidental gunshot wound to the head. The father owned the gun and he possessed a permit. The mother was under the influence of marijuana at the time of the child's death. The mother also tested positive for marijuana during her pregnancy. The mother was looking through the car and placed the holstered gun on the car seat. The child was able to pull the trigger after the gun had fallen out of the holster. The mother was charged wtih 3rd degree culpable negligence. Additional narcotics were found in the home. The family was referred to grief counseling.

Strategies

Gun Safety Education and Substance Abuse Education.

Committee [redacted]

Narrative:

Mother went to the PAR clinic at 8:00 in the morning, took her 155mg dose of Methadone, but was also abusing and illegally taking Benzodiazipines (which she tested positive for in a preumptive test provided at the death scene). She came home, and fed the baby, then fell asleep with the baby in an adult bed. She overlayed the baby while passed out/asleep and then awoke around 10:45 am to find the infant deceased. There was blood on the mother's bra from compression/overlay of the baby's mouth and nose.

Strategies

PAR drug treatment Program and Child Protective Services of [redacted] County Sheriff's Office developed a local program as a result of three infant deaths in Manatee County related to moms that were in the PAR Methodone Treatment Program and abusing other illicit drugs.

Narrative:

The mother has a significant substance abuse history that resulted in a previous child being removed. She has continued to abuse drugs that are prescribed and that are obtained illgegally. She, the father, the decedent and an infant were all living in a motel efficiency unit. The father was allegedly taking a shower when the incident occurred and the mother was allegedly cooking in the kitchenette with the door closed to keep the toddler out. This left the toddler and infant unspervised for a period of time that she decribes to be 5 minutes. When she went into the bedroom she saw the toddler lying on the bed unconcious, struggling to breath and believed the victim was choking on Tylenol pills that she may have left loose on the bed. Her infant son was born at 30 weeks gestation and she tested positive for benzodiazapines, tricyclic antidepressants, PCP, Methadone, and admitted to taking up to 35 Tylemol PM pills to help her sleep. She left the hospital AMA. This infant was removed as a result of this verified death.

Strategies

PAR drug treatment Program and Child Protective Services of [redacted] County Sheriff's Office developed a local program as a result of three infant deaths and one toddler death in Manatee County related to moms that were in the PAR Methodone Treatment Program and abusing other illicit drugs.

Narrative:

The father, mother and their 4 children had come from out of town to attend a funeral. The father was riding in a relatives car with his three sons, ages 3, 4, and 5. They stopped at a relatives house where the three boys were to be babysat by a 16 year old cousin. They were running late and the father failed to ensure that all of his sons exited the car and entered the house. The three year old victim was left in the back seat when his brothers exited and closed the car doors. The child locks were not on, and it was normal for the victim to wait for someone to take him out of a car. The car he was in was not a car he was familiar with. The babysitter assumed that the victim had gone to the funeral with his parents and did not go looking for him. The father tested positive for cocaine and said that he had used cocaine a few days prior to the incident.

Strategies

Media campaign to bring about awareness to the public. Product safety in vehicles to focus on door handles that would allow young children to operate them and install sensors and alarms that would alert if a child was left in a vehicle.

Committee [redacted]

Narrative:

ON 1/31/13 the child drowned while at the home of her grandparents. The child had wandered over to the landscaping, subsequently fell in and drowned. At the time of the incident there was a party and the were approximately 15-20 people in the home. The grandmother to the backyard and found the child floating in the pond. The child was retrieved from the water and 9-1-1 was called.

Strategies

Water safety program through [redacted] Hospital was available and the campaigns presently in place will continue to provide literature and training on water safety, including ponds, pools, and other bodies of water

Narrative:

7 month old child found face down in tub after being left unattended by his 22 year old mother. She reported that she step away for 5-10 minutes, but it is important to remember that she gave several accounts for her absence, including passing out for 2 minutes and awakening to find the child. IN another account a Verizon Employee indicates that he was speaking with the mother for 15-20 minutes in her doorway and could hear the child playing in the bath, but after a while could no longer hear the child, but mother did not seem concerned so he thought someone else was with the child.

Strategies

Narrative:

On 9/29/13 the maternal grandfather, who had care and custody of the child for the day, he took the child to a friend's home to watch football. After an indeterminate period of time, the child, who was believed to be playing with children of the grandfather's friend in the yard, was determined to be missing. A search was initiated and the child was found drowned and deceased at the bottom of a dirty swimming pool in the yard of the home.

Strategies

Narrative:

On 12/13/13, according to the perpetrator-grandmother, the child was taking a bath unsupervised. When the grandmother checked on her, the child appeared to be having a seizure. The grandmother jumped in the bathtub and started performing CPR on the child. The seizure would not stop so the grandmother called 911. The child was taken to the hospital where she was pronounced dead. The child has bruising "all over her body" (back, arms, legs, and head). The bruises on her back appear fresh and could possibly be from the CPR. She has "old cuts and new contusions" on her head. She also has old and new contusions and bumping on her legs, back, chest, and arms. The grandmother is paralyzed and wheelchair bound; however, she was able to get herself in the bathtub to try and rescue the child.

Strategies

Committee [redacted]

Narrative:

Child Abuse Death Review Team Summary Report Team: [redacted] Date of Review: [redacted] DOD: 04/13/13 This case is in reference to a then 15 month old black female who was born in South Korea to her parents, who subsequently lived apart. The child ├óГé¼Гäós mother lived in the Philippines and her father lived in Florida. The child was living with her mother out of the U.S. until 03/13/13 when the child ├óГé¼Гäós father brought her to the U.S so the child could access benefits. The child ├óГé¼Гäós father was a medic in the army and had VA benefits. The mother remained in the Philippines when the child was brought the U.S. to live with her father and paternal grandmother, minor paternal uncle and a minor cousin at their home in [redacted]. Shortly after arriving here, the baby experienced a chronic fever and she was brought to the ER at [redacted] 3/31/13 where she was treated for a UTI. At the time of that visit, the child was noted to have injuries including bruising to the forehead and cheek and a burn on her foot. The family was questioned but the injuries were unexplained. The child was reportedly feverish for a few weeks but was ├óГé¼┼ôback to her normal self ├óГé¼ by 04/09. The child typically stayed home with her father while the minor children attended school and his mother went to work. On the morning of 04/11/13, the paternal grandmother brought the child to the father and advised him to give the child pedialite and some food and then she left for work. That was the last time the child was known to be responsive. The father reported the baby was tired and fell asleep after vomiting pedialite that morning. The father tried to wake the child around noon and called 911 when he noticed her breathing change. The father reported he was giving the child rescue breaths, however, EMS documented there was no evidence of this when they responded to the scene. EMS noted bruising to the child ├óГé¼Гäós face that appeared to be fingerprint brushing around her mouth. EMS provided CPR and transported the child to the hospital where she survived for two days before being declared brain dead. . The child ├óГé¼Гäós father admitted he had urges to see how the child would react to being hurt. He admitted to burning the child on the foot with a cigar, pushing her down repeatedly causing her to hit her head and researching on the internet ways to do things to cause reaction but not leaving injury. He explained one example of pouring copious amounts of water on her face to simulate drowning. The child ├óГé¼Гäós father reported he was not very close to the baby and he admitted he hid this child from his ex-wife, with whom he has two children, because had had hoped to reconcile with her. The child ├óГé¼Гäós mother in the Philippines produced photos for law enforcement noting that none of the injuries seen while the baby was here in the U.S. were present when the mother had her in the Philippines. Cause of Death/Autopsy Findings: [redacted] performed the autopsy on the child and the manner of death was determined to be homicide and the cause was blunt force head trauma. Based on the information availble to the team, the team was in agreement with this finding. In addition to the fatal injuries, evidence of prior maltreatment was also detected during the autopsy. The child had a suspected bite mark as well, but not confirmed by forensic odontologist. Law Enforcement/Criminal Investigation: [redacted] Police Department arrested the suspect who was with the baby at the time of symptom onset. Charges were filed and the case is pending disposition. There have been two competency hearings and one more is scheduled for February 2014. Assessment: The team determined that this death was entirely preventable by the caretaker(s). The father was the caregiver at the time of the incident. Of additional concern was the pattern of abuse perpetrated by the father and the lack of detection by ER staff and family members, all of whom noticed prior injuries on this child. Recommendations: Based on this review, the team made the following recommendation: ├óГÇö Public education efforts should be targeted to ER staff and reporting guidelines emphasized. Child Protection Team of [redacted] Hospital is carrying out this training. Child Abuse Death Review Report Completed By: [redacted] Child Abuse Death Review

Strategies

Provider education on reporting injuries for ER staff which is underway at Florida Hospital.

Narrative:

Incident Surrounding Death: On October 10, 2013, the Department of Children and Families responded to a report alleging the six-year-old victim died under suspicious circumstances at his mother's home in [redacted] The child died of acute oxycodone toxicity. The six-year-old child had a history of severe asthma and Down Syndrome. There were three surviving siblings residing in the home at that time and they were ages 5, 8 and 9 respectively. Another adult sibling who was previously removed from her mother's care resided in the [redacted] area and an older child had previously been placed with his biological father due to prior department judicial intervention. On the day of October 10, 2013, various histories were provided but the decedent child was reported to have fallen asleep unexpectedly early in the evening with his head hitting the floor. The child was later found unresponsive and "sweaty" by his 8 and 9 year old sisters who reported the child's condition to their mother. The children's mother subsequently called 911 and the child was unresponsive en route to [redacted] Hospital South, where he was pronounced dead at 10:21pm on October 10, 2013. One of the children in the home reported that the deceased child had previously eaten his mother's medication as he thought they were candy. The mother reported she had the medication in a pill bottle under her pillow where she slept. It was documented that a pill bottle was found within reach of the children in the residence. The mother's bed and pillow were relayed to be in the common living room on the floor, where all the children had access. The autopsy of the deceased child revealed findings of significant concentrations of oxycodone in the peripheral blood. Department of Children and Families' records revealed a pattern of prior abuse dating back to 1997. The children's mother was the identified alleged perpetrator in 20 reports alleging maltreatments of inadequate supervision, abandonment, neglect, environmental hazards, failure to protect against sexual abuse and emotional abuse. One of the mother's now adult children was removed from the home due to abandonment. In 2008, the decedent and his minor siblings were sheltered and placed in foster care due to inadequate supervision. The children's mother completed her case plan and the four children were reunited with their mother in March 2012. After reunification two abuse reports were made to the hotline for alleged inadequate supervision. One report alleged that the children were left unattended in the mother's vehicle; that case was closed with no indicators of abuse or neglect. The other report was alleging concners that the mother did not care about the deceased child when he was ill and that case was coded inadequate supervision and it was closed with no indicators despite a collateral contact expressing concerns over neglect. It should be noted that in September 2012, the post reunification supervision was closed out to the court with the children in the care of their mother. Cause of Death/Autopsy Findings: [redacted], performed the autopsy on the child and concluded the cause of death was acute oxycodone toxicity. The manner of death was classified as accidental. The team was in agreement with the findings of the autopsy report. Law Enforcement/Criminal Investigation: The [redacted] County Sheriff's Office conducted an investigation of the child's death and no charges have been filed as a result of the investigation. Assessment: The team determined this death to have been entirely preventable by the caretaker as the matter of death was due to neglect. Comments/Conclusions: The team concluded that this case demonstrated a pattern of parental neglect and apparently ineffective prior interventions. Two children under the ages of 7 were both developmentally delayed and it was unclear if specialized services were in place. Following the removal and subsequent reunification of these children, continued concerns were reported for neglect as evidenced by two DCF reports being called in after reunification. Below recommendations made by the review team include considering changes in local policies as well as department policies. It should be noted that as a result of this review, specific follow up related to the prior dependency case services and law enforcement case decision will be reexamined by the respective agency representatives. Recommendations: Based on this review, the team made the following recommendations: [redacted] with CBCCFL will review prior case file while children were in care to determine services provision and conduct a QA review. Sgt. [redacted] will follow up with the State Attorney's Office for review of filing decision. [redacted] (Child Protection Team) will work on the engagement of CMS when a child with a medical disability is involved with child welfare. [redacted] (Dept. of Children and Families) will explore the possibility of flagging high risk cases on the initial CSA report-to alert CPI and others of recent reunification, or other circumstances needing to be factored in to the initial safety assessment upon commencement of case. This system will also be used to alert CPT upon the review of abuse reports to help with medical triage and follow up to ensure referral and appropriate consultation. Consideration for longer term supervision for children post reunification and for heightened concern when reports of abuse/neglect are made regarding children with a prior removal history, factoring in social and emotional competence of child and medical needs. Child Abuse Death Review Report completed by: [redacted] Child Abuse Death Review Co-Chair

Strategies

Based on this review, the team made the following recommendations: [redacted] with CBCCFL will review prior case

file while children were in care to determine services provision and conduct a QA review. Sgt. [redacted] will follow up with the State Attorney's Office for review of filing decision. [redacted] (Child Protection Team) will work on the engagement of CMS when a child with a medical disability is involved with child welfare. [redacted] (Dept. of Children and Families) will explore the possibility of flagging high risk cases on the initial CSA report-to alert CPI and others of recent reunification, or other circumstances needing to be factored in to the initial safety assessment upon commencement of case. This system will also be used to alert CPT upon the review of abuse reports to help with medical triage and follow up to ensure referral and appropriate consultation.

Narrative:

The child and his twin sibling died as a result of a homicide. On 11/14/13, the children's parents were allegedly involved in an argument, which culminated with the children's mother being shot in the head. Initially, it was alleged that the children's mother shot herself in the head. However, upon further questioning of the father by law enforcement, it was determined that the children's father shot the children's mother in the head. It should be noted that the mother was 8 months pregnant with twin boys at the time of this incident. When EMS arrived, the mother was found slumped in a chair in the living room of the home. It should be noted that the mother had not received any CPT prior to the arrival of EMS. The mother was unresponsive and was not breathing. Resuscitation efforts were initiated and the mother was intubated. Upon arrival at the hospital, the mother underwent an emergency cesarean section, where twin K expired within minutes following his birth. Twin J survived for seven days; however, life support was discontinued due to the extent of Twin J's medical condition, which included Hypoxic ischemic encephalopathy; hemorrhagic disease; respiratory failure in newborn. Medical complications noted were the result of lack of oxygen for the children while in utero. The children's mother was expired as she was unable to be resuscitated while at the hospital. The father did not provide a statement to the protective investigator as he would not engage or speak as to the incident. The father was arrested and was charged with three counts of first degree murder with a fire arm. Family History: the children's parents had been married for two years and had recently been honorably discharged from the Navy. The family reported that the father had been working in security, but the family was having some struggles financially. The parents had been living with the mother's parents, upon leaving the Navy in July 2013. The family reports that the parents had arguments but it was never violent. The family denied witnessing any domestic violence in the marriage and noted that the mother did not appear afraid of the father. However, it was reported by the children's maternal grandmother, that sometimes the father had difficulty calming down after an argument with the mother. Both parents were reportedly excited about the pregnancy as the mother had three prior miscarriages. The father attended all of the pre-natal appointments. The maternal grandmother denied that the parents had a history of substance abuse or mental health issues. The maternal grandmother also denied that the mother had ever been suicidal.

Strategies

Narrative:

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Strategies

Narrative:

Five year old had been experiencing behavioral problems at school, which resulted in the child being suspended from school. Child was suspended from school for not following directions, hitting another student, kicking a teacher and refusing to return to class. As a result of the child's behavior, the father went to the school to pick him up, went to the mother's house to pick up clothes and then they returned to the father's home. It should be noted that at the father's home, reside the father, his one year old son, and his paramour, who is not the child victim's mother. The child victim visited the father's home during the weekend. It should be noted that the school initially contacted the mother; however, she did not have transportation and was unable to pick up the child victim. The mother contacted the father to pick up the child and told the father to handle the child. It should be noted that the child victim's mother reported that the child had no marks or bruises, when he left for school on the morning of the incident. While at the father's home, the father indicated that he disciplined the child victim by physically disciplining the child victim, hitting him on the buttocks, and then making the child stand in a corner and do squats and push ups. The father reported that the child victim began to complain of pain to his feet and of being hot; therefore, the father sent the child victim to bathe. The father reported that after the child bathed, began getting dressed, became dizzy and fell. The father indicated that the child was breathing at that time. The father indicated that he slapped the child victim on his face in an effort to awake the child victim. The father indicated that he rocked the child victim and also picked up the child victim and shook him, in attempts to awaken the child victim. The child victim did not respond. The father then contacted a neighbor who came over. The neighbor observed the child victim laying on the floor, face down, turned the child victim over, and began CPR. The neighbor instructed the father to call 911. The child victim was pronounced dead at the scene. An autopsy was completed, which found the child to have multiple injuries to include contusions, lacerations, trauma to his pancreas, liver, spleen, adrenal gland, and kidneys, fractures, as well as multiple other internal and external trauma. The child victim was found to have died from internal injuries due to multiple blunt force trauma. The manner of death was found to be homicide. The father has been arrested and charged with first degree murder. During the autopsy, the child victim was observed with over 200 external injuries, with only his head and lower extremities spared. The child victim also had internal injuries. The medical examiner indicated that the child victim died from a combination of all of his injuries; however, had the child received timely medical attention, he probably would have survived. Of note is that child victim had linear marks to his neck, which were very visible. They did not go all the way around his neck. The child's school teacher provided a statement to law enforcement in which she indicated that that the child victim did not have any marks or bruises when the child left the school with the father. It should be noted that the father has an extensive criminal history, dating back to the year 2000, to include charges related to traffic offenses, contempt of court, domestic violence, violation of probation, aggravated assault, possession of cannabis and cocaine, as well as lewd and lascivious assault on a child under the age of 12. As a result of the social services investigation, the one year old child that was residing in the home with the father and his mother, was sheltered by social services and placed in the sole custody of the child's mother, with the father to have no contact with the child. It should be noted that a forensic interview was completed with the child's victim's maternal half sibling, who reported previously seeing the victim with marks on his neck, from being hit with an extension cord as well as bruises to his upper thighs. The child reported that her mother, grandmother and cousins had previously seen the child victim with bruising to his body. The child reported that the child victim's father used drugs and he knew this because she observed him smoking drugs when she went to drop off the child victim at his father's home with her mother. It should be noted that there are no prior DCF investigations noting concerns for physical abuse of the child victim. Per a statement provided by the child's mother, the child victim was afraid of the father. The family had DCF prior history. There is one report involving the child victim, his mother and siblings, in 2013 which was closed with no indicators of inadequate supervision. During this investigation, a body check of the child victim revealed some scratches to his legs and no other marks or bruises. There was one DCF prior from 1995, involving the child victim's mother's sibling, due to allegations of medical neglect, which was closed with some indicators. There were 4 prior DCF investigations involved the father of the child victim and his oldest child and the child's mother. Maltreatment themes included special conditions and family violence threatens child. In 2006, the father and the mother of his oldest child were referred for voluntary protective supervision. The mother was cooperative and the father refused. The 2006 investigation was closed with some indicators of family violence threatens child. The father's paramour gave birth to a child in July of this year. She declined services from Healthy Start. Of note, all of the mothers, have declined services from Healthy Start, when offered at time of birth. Referral packet for grief counseling was provided to family. It is unknown if the family pursued this service. Discussion held regarding the marks to the child's neck, and the other injuries that child victim was observed to have in the past, which were never reported to DCF or law enforcement. Failure to protect of child by mother was not addressed in the DCF investigation. DCF has agreed to explore options in regards to failure to protect concerns.

Strategies

It was recommended that an educational campaign be initiated letting people know that everyone is responsible to report child abuse. This would be a statewise initiative. [redacted] with DCF has indicated that DCF with follow up on this initiative.

Narrative:

Child Abuse Death Review Team Summary Report Incident Surrounding Death: The subject was a ten year old female who resided in [redacted] County with her parents where the family rented a single family home. The family had resided at the home as renters for the five years leading up to the child's death. According to reports reviewed, the landlord had been trying to work with the family when they became behind on their rent starting in September 2013. It was alleged the father had lost his job sometime around September 2013. The owner of the leased home resided out of state, but sent a local property manager to the residence. The manager did not get a response at the door when she went to the home on 11/30/13; however, she posted an eviction notice on the front door. On 12/07/13, the leasing agent returned to the home and noticed the eviction notice still on the front door. At that time, the agent noticed a foul odor coming from the garage and called law enforcement to assist in checking on the family. When law enforcement entered the home, they found the family's three bodies in the garage sitting in lawn chairs with their SUV, which had been left on and a lawnmower with the throttle open and no gas remaining. The door to the garage was found closed with towels sealing the bottom opening gap. Once the bodies were discovered, homicide detectives were called to the scene. The case was determined to be a murder related to the minor child and suicide for the child's parents. History: No history about the specific incident is known due to all witnesses deceased. The timeline during which the death occurred was determined to be between 11/13/13 and 12/07/13 based on evidence found at the scene to include electronic devices showing last use on 11/13/13 and old newspapers in the driveway. The family did have on prior from 2011 which was verified for physical injury, after the father reportedly disciplined the child with a belt and left bruises. No services were provided as a result of the investigation. However, the family did pull the child out of school following that report and home-schooled her. Collaterals reported no concerns about the family. The landlord did believe the father had recently lost his job resulting in financial strain. According to the reports the home answering machine had numerous calls from bill collectors when the residence was entered on 12/07/13. Cause of Death/Autopsy Findings: [redacted], performed the autopsy on the child and the manner of death was determined to be homicide. The child's cause of death was from asphyxiation. Law Enforcement/Criminal Investigation: No charges were filed as a result of this incident as the parents are deceased as this was a murder suicide. Comments: The family was of Brazilian descent and it is unknown what, if any cultural influences, contributed to the deaths. Recommendations: Based on this review, the team did not identify any prevention activities, but did note that job placement support immediately following job loss might have been of help. Child Abuse Death Review Report completed by: [redacted] Child Abuse Death Review

Strategies

Narrative:

The child was a two year old child, who was diagnosed with mitochondrial disease. The child had limited mobility and his vision was also compromised. In April 2013, the Department of Children and Families received a report with concerns for medical neglect as to the child victim. The case was referred to the Child Protection Team and the case was verified for medical neglect as the mother had missed seveval appointments for the child and failed to provide the child his medication as prescribed. The Department of Children and Families also verified their investigation. At the time of case closure, the family had relocated to [redacted] County, Florida, where the father resided. In addition, the child was being followed by Children's Medical Services (CMS). A safety plan was implemented with CMS for DCF to be contacted if the parents did not follow appointments or referrals. In addition, the parents were provided with a community referral packet. The investigations was closed on 5/26/13. On 5/31/13, DCF received an abuse report with allegations that the child victim had drowned. The mother reported that she had left the child in the bathtub, starpped into a special seat, with the water running because the child liked to play with the water with his feet. The bathroom is located on the second floor. The mother indicated that she left the child unattended for three to four minutes while she went downstairs; however, the scene does not appear to support this information. There was water falling through the ceiling of the first floor, resulting from the bahttub overflowing with water. The counter tops in the kitchen were observed with water on them. the mother reported that she had been cooking and had let the dogs out of the cage and then had to chase the dogs back into their cage. The mother returned to the bathroom to find the child submerged in the water, as the seat had turned over. The mother reported that she immediately began CPR. The parents were drug tested and tested positive for opiates. Both parents with chronic medical parents. the mother has hepatitis and liver cancer, for which she was not being treated. The mother admitted to taking the father's percocet. As a result of the death investigation, the child victim's two siblings were removed from the care of their parents and placed in foster care. The mother was arrested and charged with aggravated manslaughter in August 2013. Currently, the child's siblings remain in foster care. It is unknown to the review team if the parents are complying with the terms of their case plan and/or if they have pursued grief counseling that was offered.

Strategies

If CPT recommends SMU services for a case and DCF determines that it is not appropriate or declines to pursue this recommendation, there will be a conversation between DCF and CPT to discuss this recommendation.

Narrative:

Four year old child found unresponsive in a community resort swimming pool and subsequently died. Four year old child and her older sister, mother and mother's paramour came to Florida, from Alabama on vacation. In addition, to the four year old and her family, the mother's best friend, her paramour and her children were visiting as well. The family had arrived to the resort and the four year old and her sister remained with their mother's best friend and the best friends paramour. The children were taken to the pool. There were 8 children at the pool, including the four year old victim, while the mother's best friend and her paramour were to watch the children. The four year old child's mother indicated she did not know the children were being taken to the swimming pool and noted that her children do not know how to swim. While in the pool, the children were not being supervised. Child was last seen in the hot tub. However, according to video of the pool area of the resort, the child victim was observed unsupervised in the pool area, along with other children. The mother's best friend was in the pool area, however, not always observed watching the children. THe best friend's paramour was in the pool area, tending to his two children, only. Video of the incident show the child go from the hot tub to the pool. Attempt to get a "noodle" from the pool, which is a long flotation type decide, and fall into the water. Child is observed struggling in the water and eventually goes under water. In the meantime, no one appears to notice child fall into the pool or going under water. According to video of the incident, the mother's best friend's paramour, appear to look in the direction of where the child victim was, on several occasions, and also uses the "noodle" to prod at something in the water. Yet, at no moment were any efforts made by the paramour to ascertain who or what was in the water. Or notify anyone. On four different occasions, the best friend's paramour was observed looking in the direction of the child victim. A child in the group notifies the adults that the child victim is in the water and the mother's best friend proceeds to jump into the water and pull the child out. While resucitation efforts are started, the paramour of the best friend is observed walking around, not participating in resucitation efforts. He tells his girlfriend to take the other children to the room. According to video of the scene, he appeared calm and was observing others attempting to save the child's life. EMS subsequently arrived nad took over resucitation efforts and took child to the hospital; however, she subsequently died. The mother's best friend's paramour was arrested and charged wtih child neglect. the charges have since been dropped by the State Attorney's Office. The families have since returned to Alabama. Social services in Alabama was notified and a wellbeing check was completed and referrals made for grief counseling. child. A recommendation resulting from this death review is to provide local hotels with water watcher tags, in an effort to educate and help visiting family's develop a system to supervise their children while in a swimming pool setting. This is an initiative that the [redacted] Task force will be working on.

Strategies

Narrative:

Child Abuse Death Review Team Summary Report Team: [redacted] Date of Review: 01/24/14 DOD: 02/14/13 This case is in reference to a then 2 month old black male born to his parents who resided in [redacted] This baby was the mother ├óГé¼Гäós 6th child and the father ├óГé¼Гäós only child. The child ├óГé¼Гäós mother has an extensive history with DCF and has had 4 of her children adopted out after being removed from her care due to abuse and neglect. The baby ├óГé¼Гäós mother was incarcerated for trafficking heroin on 02/1/13, leaving the father the sole caretaker of the baby while the baby ├óГé¼╥£s older half-sibling went to stay with a family fried. On 02/13/13, the baby was alone in the home with his father and reportedly would not stop crying. The father reacted by throwing the baby on the bed, twisting his neck and then carrying him into the living room throwing him on the floor and stepping on his head. The father then called 911 and confessed to abusing the baby. The baby died on 02/14/13. Cause of Death/Autopsy Findings: [redacted], performed the autopsy on the child and the manner of death was determined to be homicide and the cause was blunt force head trauma. Based on the information availble to the team, the team was in agreement with this finding. The baby also sustained posterior rib fractures during the abuse incident. It should be noted that the ME observed patterned marks consistent with the father ├óГé¼Гäós shoe imprint on the child ├óГé¼Гäós face. Law Enforcement/Criminal Investigation: [redacted] Police Department arrested the suspect who was with the baby at the time of symptom onset. Charges were filed and the case is pending disposition. Assessment: The team determined that this death was entirely preventable by the caretaker(s). The father was the caregiver at the time of the incident. Recommendations: Based on this review, the team made the following recommendation: ├óГé¼┬ó Parental support and education related to coping with crying ├óГé¼┬ó State support with funding of the above initiatives ├óГé¼┬ó Consideration to change policies for those receiving state fund to ensure they are connected with child rearing education and support Child Abuse Death Review Report Completed By: [redacted]

Strategies

A media campaign targeting coping with crying was recommended. Also, a local group of Pediatricians were working to implement ongoing education on this topic and need state support and funding to unroll this initiative. The Team also suggests that those individuals who received benefits from the state should be required to participate in parent training, education or other early childhood services.

Committee [redacted]

Narrative:

The child's death is the result of cosleeping with the father who was under the influence of substances to include: methamphetamine, marijuana and benzodiazapines. The father and mother both have a history of drug abuse and it was common practice in the family to cosleep with the children. This child routinely slept with an adult and his 4 yr old sibling in a twin bed.

Strategies

Department of Corrections Felony Probation Officers will begin providing education to families with new borns. * Law enforcement investigators should request a blood test from any caregiver with whom they have reason to believe used alcohol, illegal drugs, or prescription medication over the prescribed dosage, while caring for the deceased infant. The State Attorney's Office believes acquiring a blood test will aid in the prosecution of rollover cases as they are able to show what substance(s) were used and to what degree. In the case of a rollover death, all agree there is no intent to kill, however, neglect is present, and especially for those caregivers who were under the influence when they rolled over on their child. * The [redacted] Judicial Circuit continues to recommend children who die as a result of compressional asphyxia (rollover death), whose caregivers were under the influence of substances, whether it is drugs, alcohol or a combination of the two, that those caregivers be held accountable for the negligence, charged and prosecuted. * New Born Staffings are being implemented at the onset of a pregnancy in all cases where the expected mother currently has dependent children. These staffings will be held every six weeks throughout the mother's pregnancy and are designed to formulate a plan of action for the newborn. * Children's Legal Services will take into account the current dependency action, on existing cases, when a newborn enters the family. The legal department has the presumption to file for dependency of the newborn child. Each case will be reviewed thoroughly for the appropriate action to be taken. * In cases where the pregnant mother has other dependent children, Child Protective Investigators and Case Managers are notifying local hospital personnel of the pregnancy and the expected due date. This increases the likelihood that DCF and BBCBC will be notified of the birth immediately and can carry out their formulated plan of action. * Child Protective Investigators and Case Managers in the [redacted] Judicial Circuit should ensure they are discussing safe sleeping habits with each person responsible for providing care for a newborn. Also, it is imperative that these discussion include how to ensure a safe sleep environment if the family will be staying away from home overnight. * Child Protective Investigators will continue to request urinalysis from the caregiver(s) responsible for the child at the time of their death. * Should the responsible caregiver be on probation, Child Protective Investigators, Law Enforcement Investigators, and BBCBC Case Managers should contact the probation officer immediately as the probation officers can assist in drug and alcohol testing and are not required to have a court order/warrant to conduct such testing. * Child Protective Investigators, Child Protection Team Case Coordinators, and BBCBC Case Managers should all take a more active role in ensuring families with newborns have appropriate sleeping environments for their newborns to include cribs, bassinets and, or port a cribs (pack-n-plays).

Narrative:

Additional Pertinent Information Gathered At Review: EMS Director, [redacted] provided a summary of EMS involvement in this case. He advised they received a call to [redacted] for a multiple shooting incident. EMS arrived on scene and encountered a 10 year old male being carried to their ambulance unit. First responders found two penetrating wounds, one in front and one in the back of (10 yr old male child)'s head. Fire Rescue and Sheriff's Office first responders were on the scene along with EMS. EMS went through the necessary resuscitation procedures and started at 11:12pm on way to hospital. There were nine minutes from the time they received the call to when they left the scene in route to the hospital. On the way to the hospital (10 yr old male child) had a pulse. They arrived at Bay Medical Center and turned (10 yr old male child) over to hospital staff. There were no other apparent injuries noted by EMS. The only wound noted was the penetrating wound to the head. No one from EMS noted that they spoke with family members. EMS was able to quicly pronounce the father dead on scene. [redacted] udicial Circuit Medical Director, [redacted], spoke next. He advised there were two decedents in this event. He completed an autopsy on both. (10 yr old male child) appeared to be a healthy ten year old male. He was shot, in the head, at intermediate range (intermediate range is considered a couple of inches up to two feet). From his exam he believes that the shot was closer to a few inches than feet away. The bullet perforated through the skull. [redacted] had a pulse when first responders arrived and was transported to the hospital where he was pronounced dead at 1:42am. From the scene investigation it was clear that (10 yr old male child) was shot while lying in his parents' bed. He was face down when shot. The father was clearly the shooter in the event as he had gun powder on his hands. The father also had a gunshot wound to the head. He shot himself in the front of the head. The father was pronounced dead on scene. Toxicology was completed on both (10 yr old male child) and his father. The father had a good bit of alcohol in his system. His blood alcohol level was .23. With further testing [redacted] believes his blood alcohol was actually closer to a .11. Small amount of Xanax and Tramadol were also found in the father's system which suggests he was taking prescribed medication regularly. He did have lower lumbar and hip issues and was most likely suffering from chronic pain. [redacted] County Sheriff's Office (BCSO) Sgt [redacted] explained that when BCSO arrived, Sister, (10 yr old male child)'s 18 year old sister, and mother, *** *** were home. Through their investigation they learned that Father was angry with Mother for going out with friends after work. She is employed at Captain [redacted] s Restaurant. She and a few friends went to [redacted] to have drinks when they got off of work that evening. Sister and (10 yr old male child) were home with Father. Sister also had a friend at the home with her. The incident occurred fairly late at night. Sister told authorities that (10 yr old male child) asked her to come and watch videos with him. When she went to her parents' room to look for him, Father told Sister, through his closed bedroom door, that he was outside. Sister went to look for (10 yr old male child) and heard a loud noise. She returned inside and again spoke to Father. Again he spoke to her through a closed door. He told her (10 yr old male child) ran outside when the loud noise occurred. Sister again went outside to look for him. This is when she heard a second loud noise. She returned inside and was unable to open her parents' bedroom door. She called her mother to notify her that something was wrong. Sister had overheard her mother and Father on the phone prior to the loud noises taking place. She heard Father saying "It's all your fault." When Mother arrived home she managed to get her bedroom door open. Father had placed a dresser in front of the bedroom door. She opened the door and discovered both (10 yr old male child) and Father. When first responders arrived (10 yr old male child) was being brought to the front door by his mother and sister. Further investigation revealed that Father was Baker Acted in March 2013 by BCSO. Mother called 911 following an argument with her husband where he threatened to commit suicide. He threatened to use a gun a shoot himself. Mother told law enforcement at that time that her husband had two guns, but that she was only able to locate and secure one of them. Father was taken to [redacted] Hospital where he was hospitalized for 72 hours and released to Mother. Sgt [redacted] reported that gun Father used during the event was a 9mm gun. It is unknown where he kept the gun or ammunition or if the gun was routinely secured by the father. The entire family is believed to have been present in the home at the time of Mr. [redacted] Baker Act. (10 yr old male child) gave a statement to law enforcement confirming he heard his father threaten to take his own life. There were no prior 911 calls to this home and no documented history of domestic violence through the BCSO. The mother was absolutely beside herself following the incident. BCSO Family Advocate Chevina Jackson assisted the family with funeral arrangements, relocation assistance and grief counseling. [redacted], DCF OPA, advised that there is no prior abuse report history for this family in the state of Florida. The OPA assigned to this case in 2013 was [redacted]. From reviewing the case file it is apparent that OPA [redacted] chose not to complete a full investigation on this case as there were no surviving siblings under the age of 18. They did pull criminal records checks and each of the three adults in the home were clear of an arrest record. They also requested child protective service history through the state of Alabama where the family had previously resided. No prior history was provided by Alabama. The family was offered grief counseling through Life Management Center. The mother was not pleased with LMC's services and was then provided information about grief counseling through Hospice.

It was unknown by DCF if the mother ever followed through with contacting Hospice. Life Management Center Supervisor, [redacted] noted that Father was referred to Life Management Center following his Baker Act, but there is no record that he ever followed through with the referral for services. Salvation Army Domestic Violence Specialist [redacted] addressed the group last. She was not able to find any record of any member of the ***'s family having ever received services. However, she has a very close friend who is employed at [redacted] with Mother. The information should be considered hearsay as it was received second hand. She was told that the mother had no idea that an event like this was coming. She thought she had a good relationship with her husband. She admitted they had communication issues at times, but denied a history of domestic violence. The mother knew the father was mad at her the night of the incident because she had gone out with friends. He believed that she was cheating on him. Mother believes that Father killed (10 yr old male child) because he knew just how much (10 yr old male child) meant to Mother and just how much she loved him. She believes he wanted to hurt her badly and knew that harming (10 yr old male child) was the way to do it. Ms. [redacted] believes that Sister was most likely spared because she was 18 years old and almost out of the home. There was some discussion by the group regarding Sister not being Father's biological child. This information was not able to be confirmed during the review. The review concluded with the formulation of the case's conclusion and recommendations. Conclusions: It is the conclusion of this team that the death of (10 yr old male child) *** was a result of abuse and that the Medical Examiner's cause and manner of death findings were appropriate. (10 yr old male child) died as a result of a gunshot wound to his head. (10 yr old male child) was shot by his father, in his home, while lying in his father's bed. (10 yr old male child)'s activity was unknown at the time of his death. After *** *** shot (10 yr old male child), he shot himself in the head and was pronounced dead on the scene. It was learned during the review that the father was Baker Acted three months prior to the incident for suicidal ideations. The father was under the influence of substances at the time of his Baker Act and at the time of the murder/suicide. It is the opinion of this team that the father's mental health and use of substances were contributing factors in (10 yr old male child)'s death. The father had been diagnosed with Depression and ADHD but failed to follow up with the referral for mental health services. Although there were no written documentation of domestic violence incidents between the mother and father (via 911 calls, LE reports, or DV services provided), it is believed that there was at minimum a history of verbal violence , despite the mother's denial, based on the information collected during the investigation. The relationship issues and history of domestic violence were also contributing factors in this case.

Strategies

Committee [redacted]

Narrative:

Re Child: No medical records found so not in contact with MD, but appeared to be very healthy and well cared for. Not in pre school or day care so no community visibility and no opportunity for professionals to note problems mother may be having and intervene or support. Re Mother: Abandoned at age 3 by mother with serious mental health issues, adopted by grandparents. Father (adopt) recently had stroke and in rehab facility, and mother (adopt) with severe cancer and subsequently deceased. Nobody knew identity of child's bio father. Boyfriend disabled (legally blind) with criminal history of battery, burglary and criminal mischief, the latter directed toward the suicidal mother, which raised probability of domestic violence between them. Mother hospitalized on Baker Act as teenager, and demonstrated depression in suicide attempt several months prior and suicidal threats and comments within past month. Friend who found her after suicide attempt and boyfriend did not report this or apparently push mother to obtain therapeutic intervention. Mother arrested for DUI two months before event, and attended DUI traffic school month prior, anticipating court date shortly. Financial stressors associated with this. Family did not know about this.

Strategies

Narrative:

The 20 year old mother claimed she left the child unattended in the tub for only 5 minutes. Lae enforcement on scene reported a neighbor as saying "It was just a matter of time" before something like this happened as mom habitually left child unattended in home for up to 30 minutes at a time. But neighbors were not interviewed specifically about this and information obtained long afterwards suggested mom had actually left the home and was in another trailer at the time of the incident. The 23 year old father was on felony probation for producing marijuana. At the time of the incident there was found in the home synthetic marijuana. Both parents tested negative for marijuana on UA's, but synthetic would not show up. Given the psychologically addicting properties of synthetic, and the problematic behaviors that can reportedly occur (including psychosis), a more thorough exploration of parental substance use would have been helpful. The mother was pregnant at the time of the fatality and subsequently gave birth to a child 8 months later. That child is now 8 months old and entering the high risk age (8-24 months) for bathtub drowning because parents assume since the child can sit and stand he/she can get out of the water. There is immediate concern for the safety of this child in the home.

Strategies

1. Invite EMS and law enforecement from rural counties to a meeting about child deaths and have FDLE, ME and CADR educate them re investigating child fatalities. 2. Contact the county health office to ask for follow up with this family and possibly getting Healthy Start involved with family's new baby. 3. Work with [redacted] County School Board to provide a presentation to parent/teacher association regarding safety issues with young children, specifically drowning and safe sleeping.

Committee [redacted]

Narrative:

Strategies

The Committee agreed that having a representative from DOH and code enforcement attend the beginning of our next meeting would be beneficial as there were many unanswered questions about other pools in this condition that pose a danger to children.

Narrative:

Strategies

Gun Safety training program for the housing project and nearby community resource center