

# FLORIDA CHILD ABUSE DEATH REVIEW

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**SECOND ANNUAL REPORT**

**DECEMBER 2001**



# FLORIDA CHILD ABUSE DEATH REVIEW TEAM



January 11, 2002

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The Honorable Jeb Bush  
Governor of Florida  
The Honorable John M. McKay  
President of the Florida Senate  
The Honorable Tom Feeney  
Speaker of the Florida House of Representatives  
The Capitol  
Tallahassee, FL 32399-0001

Dear Governor Bush, Mr. President, and Mr. Speaker:

In accordance with Chapter 383.402, Florida Statutes, as chairman of the State Child Abuse Death Review Team, I am submitting this annual report of child deaths due to abuse and neglect on behalf of the team for your review and information. This report includes information from the case reviews of the 30 children who died in 2000, and had at least one prior report of abuse or neglect filed with the Department of Children and Families. Additionally, it highlights major issues and trends for the 60 deaths reviewed over the two-year period since the inception of the Florida State Child Abuse Death Review Team.

During this second year, the State Child Abuse Death Review Team, in collaboration with local communities, continued to work diligently to develop local teams for the purpose of conducting child abuse and neglect death reviews. While we have accomplished a great deal, more work is required. In particular, more local child abuse death review teams need to be established or encouraged to be active.

I believe this report justifies the need for a continued review of child abuse deaths in Florida and for data-driven policymaking to prevent further avoidable child abuse and neglect deaths. There have been many challenges encountered and accomplishments made by the State Team and the Department of Children and Families. As our work progresses, I am optimistic that the end result will be a better understanding of the circumstances and contributing factors, supporting our ultimate goal of continuing the mission of working together to reduce preventable child abuse and neglect deaths.

Sincerely,

A handwritten signature in black ink that reads "Michael Bell".

Michael Bell, M.D., Chairman  
State Child Abuse Death Review Team

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**FLORIDA  
CHILD ABUSE DEATH REVIEW TEAM  
SECOND ANNUAL REPORT  
DECEMBER 2001**

**MISSION**

*To reduce preventable child abuse and neglect deaths*

Submitted to

The Honorable Jeb Bush, Governor, State of Florida  
The Honorable John M. McKay, President, Florida State Senate  
The Honorable Tom Feeney, Speaker, Florida State House of Representatives

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## DEDICATION

Thirty children who had prior involvement with child protection services died from abuse or neglect during 2000. This report is dedicated to these children.

<b>Profile Information</b>	<b>Date of Death</b>	<b>Cause of Death</b>	<b>Perpetrator or Caretaker Responsible</b>	<b>Number Prior Reports</b>
<i>2-month-old female</i>	<i>8/14/2000</i>	<i>Asphyxia from overlay</i>	<i>Mother's paramour</i>	<i>1</i>
<i>9-month-old male</i>	<i>4/8/2000</i>	<i>Blunt head trauma as a result of being forcefully thrown to asphalt road</i>	<i>Father</i>	<i>1</i>
<i>11-month-old female</i>	<i>11/29/2000</i>	<i>Shaken Infant Syndrome</i>	<i>Mother</i>	<i>1</i>
<i>11-month-old female</i>	<i>2/12/2000</i>	<i>Closed head injury due to blunt trauma</i>	<i>Mother and paramour*</i>	<i>1</i>
<i>18-month-old male</i>	<i>9/25/2000</i>	<i>Drowned in bathtub while unsupervised</i>	<i>Mother and father</i>	<i>3</i>
<i>19-month-old male</i>	<i>12/14/2000</i>	<i>Blunt force closed head trauma</i>	<i>Female relative</i>	<i>2</i>
<i>19-month-old female</i>	<i>3/11/2000</i>	<i>Multiple blunt impacts to head and torso with subdural hematoma and lacerations of lung and liver</i>	<i>Father</i>	<i>1</i>
<i>20-month-old female</i>	<i>12/20/2000</i>	<i>Drowned in swimming pool while unsupervised</i>	<i>Father</i>	<i>3</i>
<i>21-month-old male</i>	<i>12/18/2000</i>	<i>Closed head injury</i>	<i>Mother's paramour</i>	<i>1</i>
<i>22-month-old female</i>	<i>3/1/2000</i>	<i>Multiple sharp force injuries to the head and neck and blood loss caused by dog attack while unsupervised</i>	<i>Mother</i>	<i>1</i>
<i>22-month-old male</i>	<i>2/2/2000</i>	<i>Blunt impact to abdomen</i>	<i>Mother and paramour*</i>	<i>1</i>
<i>2-year-old male</i>	<i>5/3/2000</i>	<i>Drowned in family pool while unsupervised</i>	<i>Father</i>	<i>3</i>

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**DEDICATION (continued)**

<b>Profile Information</b>	<b>Date of Death</b>	<b>Cause of Death</b>	<b>Perpetrator or Caretaker Responsible</b>	<b>Number Prior Reports</b>
<i>2-year-old male</i>	<i>4/11/2000</i>	<i>Blunt trauma to head</i>	<i>Mother and paramour*</i>	<i>1</i>
<i>2-year-old male</i>	<i>5/7/2000</i>	<i>Multiple injuries to head and body</i>	<i>Mother's paramour</i>	<i>3</i>
<i>3-year-old male</i>	<i>2/8/2000</i>	<i>Drowned in family pool while unsupervised</i>	<i>Father</i>	<i>2</i>
<i>3-year-old male</i>	<i>4/17/2000</i>	<i>Drowned in apt pool while unsupervised</i>	<i>Grandfather</i>	<i>1</i>
<i>3-year-old female</i>	<i>5/31/2000</i>	<i>Drowned in retention pond while unsupervised</i>	<i>Aunt</i>	<i>1</i>
<i>3-year-old male</i>	<i>4/23/2000</i>	<i>Blunt force head trauma as a result of being struck by a vehicle while unsupervised</i>	<i>Mother</i>	<i>1</i>
<i>3-year-old male</i>	<i>1/24/2000</i>	<i>Multiple injuries to head and body from being struck by vehicle while unsupervised</i>	<i>Father</i>	<i>2</i>
<i>3-year-old male</i>	<i>3/4/2000</i>	<i>Drowned in apt pool while unsupervised</i>	<i>Father</i>	<i>1</i>
<i>4-year-old male</i>	<i>4/19/2000</i>	<i>Drowned in apt pool while unsupervised</i>	<i>Grandfather</i>	<i>1</i>
<i>4-year-old male</i>	<i>3/22/2000</i>	<i>Drowned in motel pool while unsupervised</i>	<i>Mother</i>	<i>1</i>
<i>4-year-old male</i>	<i>9/6/2000</i>	<i>Withholding of life sustaining medication, breathing treatments and supplements</i>	<i>Mother's paramour</i>	<i>1</i>
<i>6-year-old female</i>	<i>3/9/2000</i>	<i>Multiple blunt trauma to head and body</i>	<i>Mother</i>	<i>1</i>

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### DEDICATION (continued)

<b>Profile Information</b>	<b>Date of Death</b>	<b>Cause of Death</b>	<b>Perpetrator or Caretaker Responsible</b>	<b>Number Prior Reports</b>
<i>8-year-old male</i>	<i>6/26/2000</i>	<i>Massive internal hemorrhage and blunt force trauma to head and body/vehicle collision</i>	<i>Mother and paramour*</i>	<i>3</i>
<i>11-year-old female</i>	<i>5/27/2000</i>	<i>Compressional asphyxia</i>	<i>Father</i>	<i>1</i>
<i>12-year-old male</i>	<i>2/5/2000</i>	<i>Multiple injuries as a result of excessive restraint</i>	<i>Male employee of a residential facility</i>	<i>3</i>
<i>12-year-old male</i>	<i>10/13/2000</i>	<i>Multiple injuries as a result of beating</i>	<i>Father</i>	<i>4</i>
<i>13-year-old female</i>	<i>10/13/2000</i>	<i>Blunt trauma as a result of beating</i>	<i>Father</i>	<i>4</i>
<i>15-year-old female</i>	<i>11/17/2000</i>	<i>Gunshot to head</i>	<i>Step-father</i>	<i>2</i>

*\* Primary perpetrator*

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## EXECUTIVE SUMMARY

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

“The purpose of the reviews shall be to:

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

This second annual report includes information from the review of the 30 children who died in 2000. Additionally, it highlights major issues and trends for the 60 deaths reviewed over the two-year period since the inception of the Florida State Child Abuse Death Review Team. It is important for the reader to put the review of these child deaths in perspective. Because the population reviewed is limited in scope and representation of the total number of abuse and neglect deaths in Florida, the recommendations and comments made throughout this report are subject to those limitations when generalizations are made. There are clear patterns and trends noted for the state that are consistent with national data; however, because of the limited population there are variations, which are reflected in this report.

- Abuse and neglect were equally distributed across the deaths included in this report.
- The majority of the abuse deaths involved direct attacks resulting in physical trauma. Of the 20 trauma related deaths, eight of the children died from head trauma, three from abdominal trauma, five from multiple traumas and four from trauma resulting from shaken infant impact. Two of the children who died from multiple traumas were siblings, and their deaths were the result of beatings perpetrated by their biological father. Another child died from blunt impact injuries to his head and chest, which he received in the care of his mother’s male paramour.
- Drowning, the leading cause of neglect deaths, was the second leading cause of all the child abuse deaths reviewed.
- Seven (12%) of the children died from a fatal gunshot wound. Six children were intentionally shot by an adult. Three were siblings and their deaths were the result of a murder–suicide perpetrated by their biological father. The remaining gunshot death was the result of neglect, an accidental shooting by another child while being inadequately supervised.

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- National statistics reported that the majority of children who suffered maltreatment related deaths in 1999 were young. The results of the 1999 Reports from the States to the National Child Abuse and Neglect Data System (NCANDS) indicated that 43% were under 12 months of age and 86% were younger than 6 years.<sup>3</sup> Results from this review indicated a lower percentage of children in these age groups, 12% of the children who died from abuse and neglect were under a year old and 72% of the children were younger than six years. One reason for this may have been that the review included only those deaths in which the victim had been the subject of a prior report to the Florida Abuse Hotline, and very young children, particularly infants, were less likely to have been reported to the abuse hotline than older children. Had the review included child victims whose older siblings or other household members had been the subject of a prior report, the number of deaths in this age range may have been higher. Figure 5 provides a specific breakdown of age at death for these 60 children.
  - Males represented 63% of the deaths and females represented 37%. Sixty-five (65%) percent of the children were white and 35% percent were black. For those deaths that identified specific ethnicity, a total of eleven (18%) were identified as Hispanic.
  - Fathers or male paramours were responsible in 36 (60%) of the deaths. Mothers were responsible in 24 (40%) of the deaths. Neglect was the primary cause of death in the majority of cases in which the mother was the only perpetrator. The majority of the deaths in which the father or male paramour was sole perpetrator were caused by abuse.
  - The identified perpetrators ranged in age from 17 to 58, with a median age of 36.4 years. This conflicts with national estimates, which report that perpetrators of maltreatment fatalities are generally younger than 30 years of age. This may be the result of the case criteria for this review as young parents with first time infants having no prior reports were not included.
  - Fifty-three (88%) of the 60 children had three or more risk factors present at the time of death. Major risk factors for these children and the percent of deaths in which these factors were present included:
    - One or more children in the household were age four or younger (75% of deaths)
    - A pattern of escalation or frequency of incidents of abuse or neglect (45% of deaths)
    - Parent or caregiver unable to meet children's immediate needs (45% of deaths)
    - Children in the home had limited community visibility (40% of deaths)
    - Parent or caregiver's age, mental health, alcohol or substance abuse affected their ability to adequately care for child (37% of deaths)
    - Parent or caregiver's criminal history presented a potential threat of harm to the child (30% of deaths)
    - Living conditions were physically hazardous to the health of the child (25% of deaths)
    - Parent or caregiver were unable or unwilling to protect the child from abusive caregivers/paramours (20% of deaths)

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After a careful analysis of the data, the state team offers the following recommendations to address issues identified during the review of the deaths of children:

1. The State Child Abuse Death Review Team should clarify the concept of preventability as it relates to child abuse deaths, and provide training and technical assistance to local teams so that determinations made by the local review teams will be accurate and consistent across the state.
2. The State Child Abuse Death Review Team should evaluate the state requirements related to pools and pool safety and make recommendations for additional safety requirements as indicated. The state team, in conjunction with the Department of Health and the Department of Children and Families should provide drowning prevention educational activities through the media and through training for staff and clients.
3. The Department of Children and Families should update their “Information Packet for Professionally Mandated Reporters” to include identifiable risk factors and indicators of abuse and neglect. Local DCF offices and Child Protection Teams should facilitate training for local professionals and other local support groups on recognizing and reporting child abuse and neglect. The Department of Children and Families should also resume their public service announcements regarding risk factors and reporting requirements to reach the general population.
4. The Department of Children and Families should develop operating procedures with strict guidelines for determining when petitions must be filed in lieu of voluntary services. These operating procedures should specify that voluntary cases require the same evidence collection and documentation as court cases, and establish mandatory time frames for case follow-up on all voluntary cases to ensure that more stringent action can be taken if necessary.
5. The Florida Department of Law Enforcement should provide training to local law enforcement agencies to ensure they recognize the crossover between domestic violence and child abuse, and the requirements for reporting domestic violence to the child abuse hotline when threatened harm to a child is suspected. Training on the relationship between domestic violence and child abuse and neglect should be provided statewide to all child protective staff and domestic violence service providers.
6. The Florida Legislature should expand the child abuse death review process to include the review of all deaths, or at a minimum to include all abuse or neglect deaths in which some indicators of the death maltreatment were found, and at least one prior abuse report was received involving the member of the victim’s immediate family or other household member.

## SUMMARY OF EARLY INITIATIVES

The death of a child is always difficult to accept. When a child dies from abuse or neglect it is especially tragic. Every child should not only have the right to grow up in a safe environment, but also have the expectation that they will thrive and flourish within that environment. Unfortunately, for many of Florida's children who died from abuse and neglect this was not the case.

Over the past 15 years, there have been several highly publicized child deaths from abuse or neglect involving children who had previously received child protection services from the Department of Children and Families. These deaths prompted professionals and other individuals interested in the protection of children to carefully review the specific circumstances surrounding each death and to evaluate management and systemic issues within the Department of Children and Families. This was done in an effort to determine why these children died despite the fact that child protection services had previously been involved with their families. Some of these death studies and initiatives included:

- 1985 HRS Task Force Subsequent to the Death of Corey Greer
- 1987 Protecting Florida's Children Task Force: A Blueprint for the Next Decade
- 1990 Child Welfare League of America Salary Study Subsequent to the Death of Bradley McGee
- 1991 Study Commission on Child Welfare (Barkett Commission)
- 1995 Governor's Panel on Child Protection Issues: A Review of the Lucas Ciambrone Case
- 1996 Task Force on Family Safety
- 1997 Governor's Child Abuse Task Force
- 1998 DCF Quality Assurance Review Subsequent to the Death of Kayla McKean
- 1999 District 7 Child Safety Strike Force

After careful review of these studies it became increasingly clear that each study identified a number of the same or similar problematic case-specific or systemic issues, including:

- Significant staff turnover rates among DCF staff
- High DCF caseloads
- Lack of a career ladder and competitive salaries within the discipline necessary to attract and retain qualified professionals
- Insufficient communication between DCF staff in different child protection programs and between DCF staff and staff from other agencies
- Lack of thoroughness in the child protective investigation process, including gathering complete family assessment information during the investigations
- Inadequate case planning for families receiving ongoing child protection services
- Inadequate training for DCF staff

## PURPOSE OF CHILD ABUSE DEATH REVIEWS

### Background

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

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

### Program Purpose

Chapter 383.402 (1) Florida Statute, (FS) identifies the purpose of the child abuse death reviews as follows:

“The purpose of the reviews shall be to:

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

#### **Mike \***

**Nine-month-old Mike died as a result of injuries he received when his father took him by the throat and slammed him into the asphalt street. The father was being questioned by Naval investigators regarding another matter when he became upset and picked up the child, threatened to hurt him and fled the house. While being chased by the authorities he stopped and slammed the child into the street. Mike was transported to the hospital where he subsequently died from blunt head trauma. There was an open FAHIS report of family violence threatens child at the time of the child’s death.**

**\*Alias**

## STATE CHILD ABUSE DEATH REVIEW TEAM

The State Child Abuse Death Review Team was established in statute to ensure oversight of the child abuse death review process.

### Membership of the State Team

The State Child Abuse Death Review Team consists of seven agency representatives and eleven appointments from various disciplines related to the health and welfare of children and families. Members of the State Child Abuse Death Review Team are appointed by the Secretary of Health for staggered two year terms. All members are eligible for reappointment. A representative of the Department of Health, appointed by the Secretary of Health, serves as the state committee coordinator.

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

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

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

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

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

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## Roles and Responsibilities of the State Team

The duties of the state team are to:

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

Three subcommittees of the state team were appointed to address these issues. The membership of the following subcommittees is included as an attachment to this report:

- Protocol and guidelines committee
- Training committee
- Case review committee.

## LOCAL CHILD ABUSE DEATH REVIEW TEAMS

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

### Membership of Local Death Review Teams

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

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

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

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

### Roles and Responsibilities of Local Teams

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

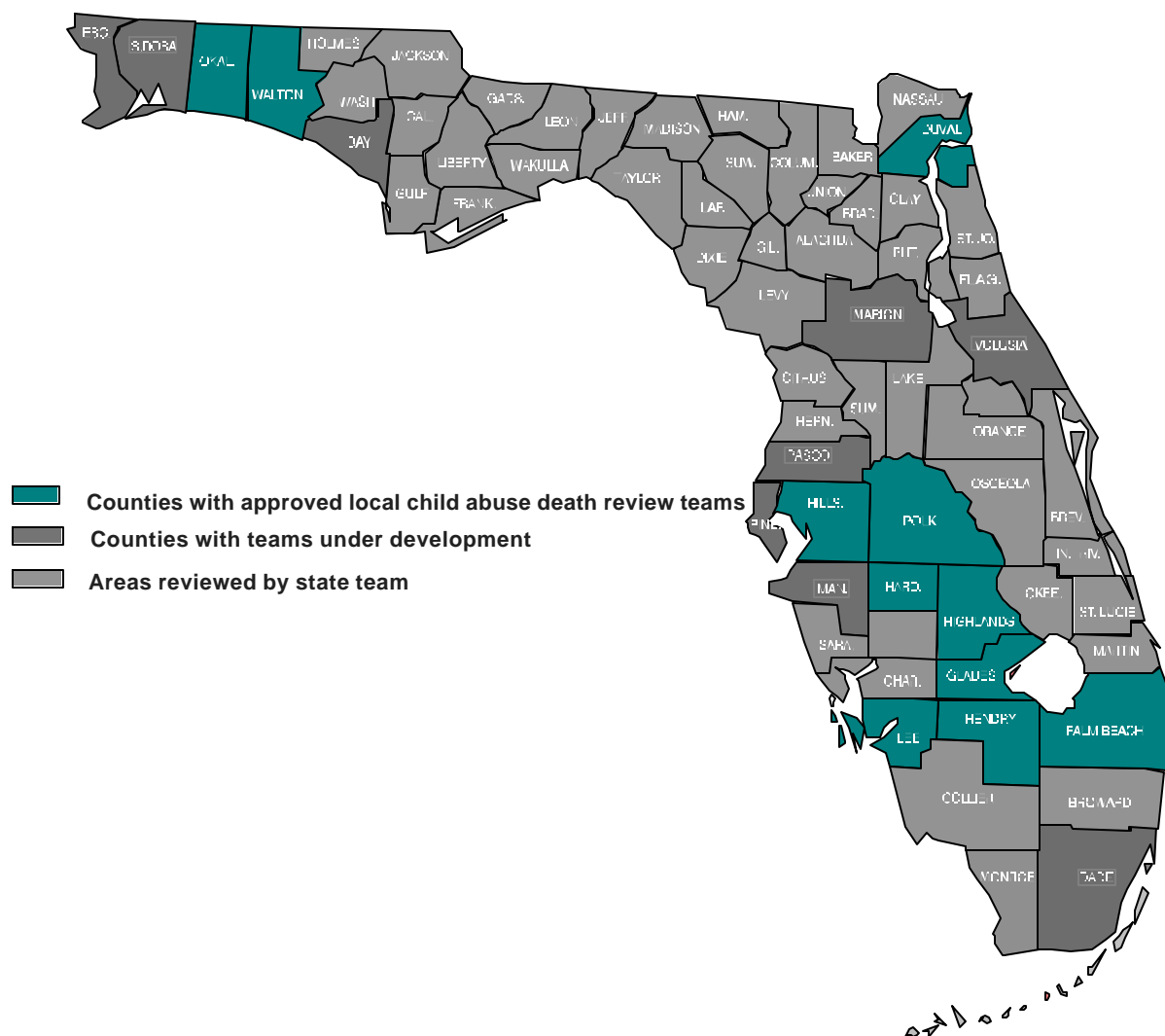
- Review all deaths resulting from child abuse and neglect with at least one report of abuse or neglect accepted by the central abuse hotline within the Department of Children and Family Services. Assist the state team in collecting data on applicable child abuse deaths.
- Submit written reports to the state team as directed. The reports are to include information on individual cases, and steps taken by the local team to implement necessary changes and improve the coordination of services and investigations.
- Submit all records requested by the State Child Abuse Death Review Team at the conclusion of its review of a death resulting from child abuse or neglect.

- Abide by standards and protocols established by the State Child Abuse Death Review Team in the conduct of child abuse death reviews.
- On a case-by-case basis, request that the State Child Abuse Death Review Team review the data of a particular case.

## Existing and Planned Local Teams

Training and technical assistance to local areas has resulted in the establishment of six local teams covering eleven counties. Figure 1 shows those counties with existing local death review teams and those areas where teams are in various stages of development.

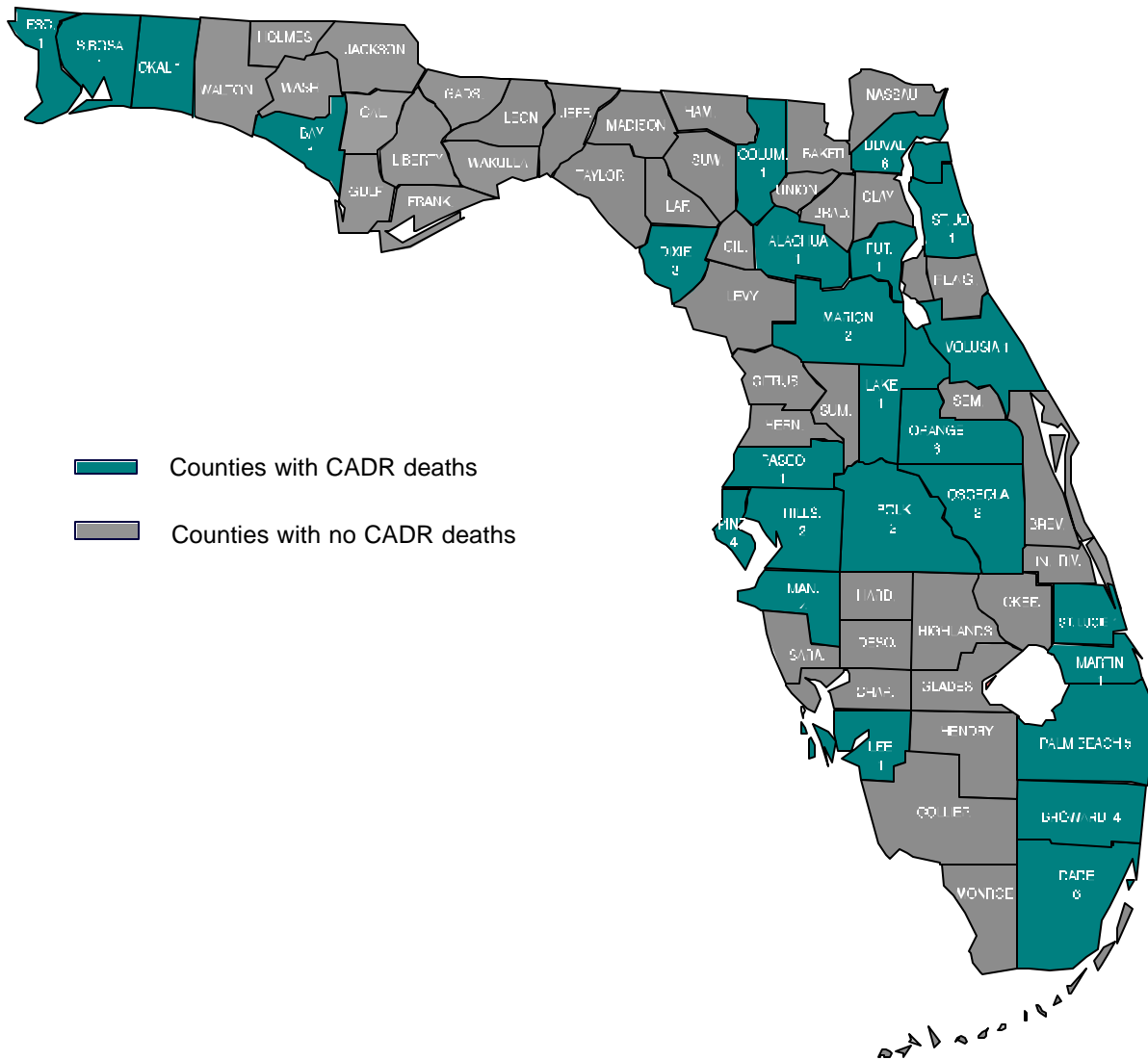
**Figure 1: Existing and Planned Local Teams**



# CHILD ABUSE AND NEGLECT DEATH DATA

The following map, statistical reports, graphs and charts are based on a review of the child abuse and neglect deaths that occurred in 1999 and 2000. Sixty (60) child deaths met the criteria for review by the State Child Abuse Death Review Team. Figure 2 below indicates the counties in which the deaths occurred and includes the number of deaths per county.

**Figure 2: Location of Child Deaths (1999/2000)**

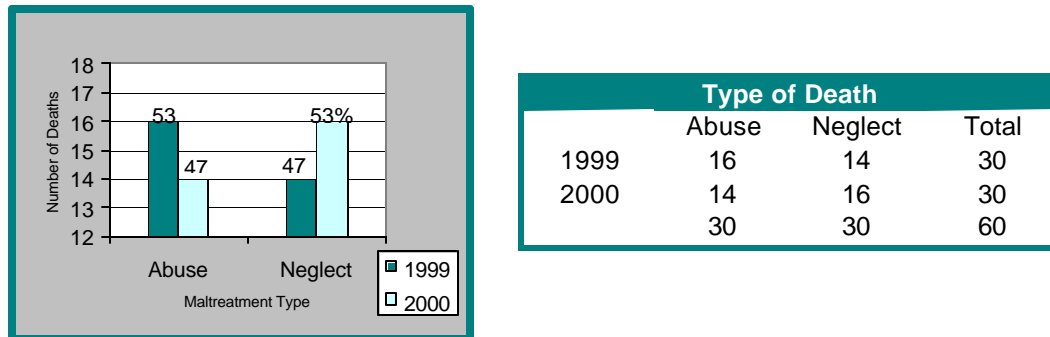


Local law enforcement agencies are currently responsible for protective investigations in Manatee, Pinellas, Broward, Pasco and Seminole counties. The Department of Children and Families is responsible for protective investigations in the remaining counties.

## Number of Child Abuse and Neglect Deaths

For the deaths included in this report, abuse and neglect were equally distributed over the two-year period, as shown in Figure 3.

**Figure 3: Abuse & Neglect Deaths**



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”<sup>2</sup> Neglect maltreatments were the primary cause of death in 30 of the 60 child deaths that met the statutory criteria for review in 1999 and 2000. A high percentage of these deaths may be due to the population included in this study. Since the child deaths that were reviewed involved children who had previously been the subject of a report to the abuse hotline, the prior report may have served to substantiate the death maltreatment by revealing a pattern of failure to provide reasonable care or supervision.

Physical abuse maltreatments were the primary cause of death in 30 of the 60 child deaths that met the statutory criteria for review in 1999 and 2000. Physical abuse is the most visible form of child abuse and is defined as “..any act which results in non-accidental trauma or physical injury. Inflicted physical injury most often represents unreasonable, severe corporal punishment or unjustifiable punishment. This usually happens when a frustrated parent strikes, shakes or throws a child.”<sup>4</sup>

### **Ricky and Johnny\***

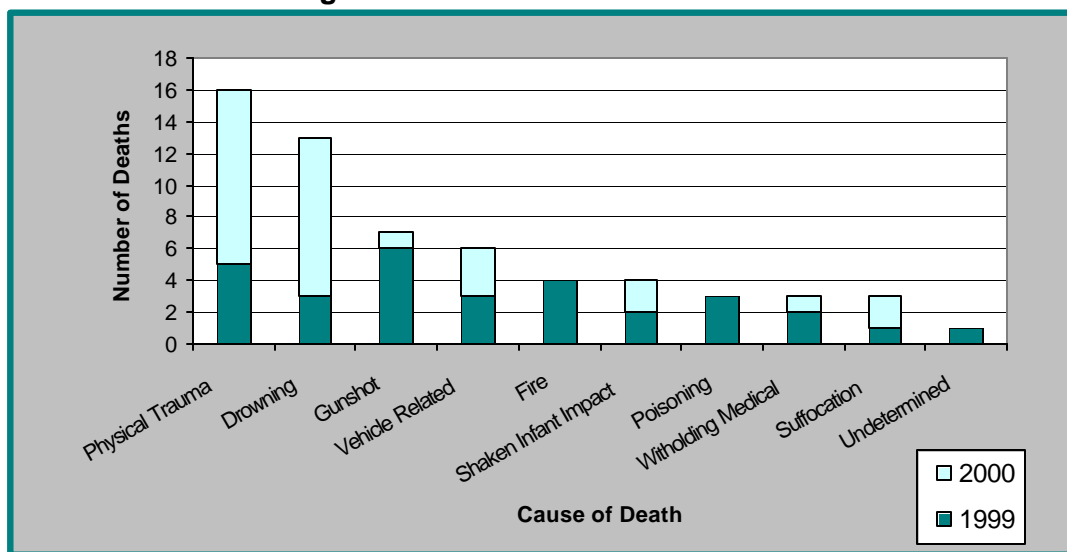
**Four-year-old Ricky and his three-year-old brother Johnny drowned in an apartment pool while under the supervision of their grandfather. Their mother had left the children in the grandfather’s care while she went to the doctor. Once she returned home, she went to her room, never checking with the grandfather or the children. The grandfather thought the children had gone inside. Neither adult checked again on the children until they noticed the fire trucks and ambulances. A prior report of physical abuse had been closed with no findings for abuse and some indicator findings for family violence threatens child.**

**\*Alias**

## Cause of Death

Abuse and neglect are broad categories of child endangerment, each including multiple specific maltreatments. The review team analyzed the specific maltreatment breakdown within the abuse and neglect categories. The number of deaths by maltreatment is included in Figure 4.

**Figure 4: Cause of Child's Death**



Cause of Child's Death				
	1999	2000	Total	%
Physical Trauma	5	11	16	27%
Drowning	3	10	13	22%
Gunshot	6	1	7	12%
Vehicle Related	3	3	6	10%
Fire	4	0	4	6%
Shaken Infant Impact	2	2	4	6%
Poisoning	3	0	3	5%
Withholding Medical Treatment	2	1	3	5%
Suffocation	1	2	3	5%
Undetermined	1	0	1	2%
Total	30	30	60	100%

In the majority of neglect deaths reviewed during 1999 and 2000, inadequate supervision of the children resulted in death from drowning, asphyxiation or house fire. There were at least three additional deaths in which children died from illness or medication toxicity secondary to medical neglect by their caregivers.

The majority of the abuse deaths involved direct attacks resulting in physical trauma. Of the 20 trauma related deaths, eight of the children died from head trauma, three from abdominal trauma, five from multiple traumas and four from trauma resulting from shaken infant impact. Two of the children who died from multiple traumas were siblings, and their deaths were the

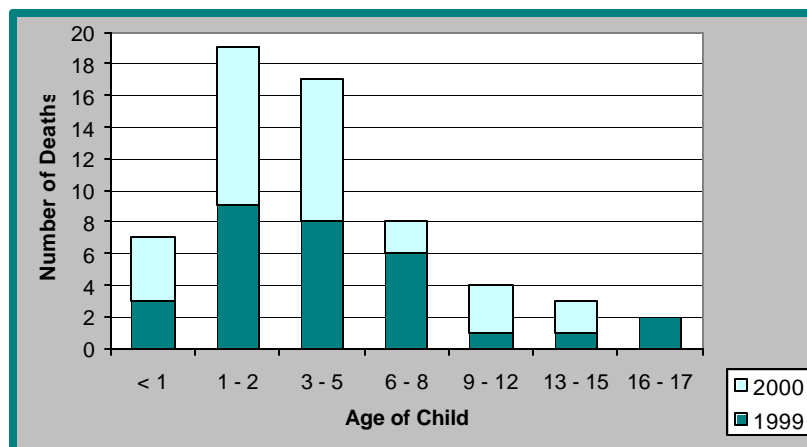
result of beatings perpetrated by their biological father. Another child died from blunt impact injuries to his head and chest, which he received in the care of his mother's male paramour.

Seven (12%) of the children died from a fatal gunshot wound. Six children were intentionally shot by an adult. Three were siblings and their deaths were the result of a murder–suicide perpetrated by their biological father. The remaining gunshot death was the result of neglect, an accidental shooting by another child while being inadequately supervised.

### Age at Death

National statistics reported that the majority of children who suffered maltreatment related deaths in 1999 were young. The results of the 1999 Reports from the States to the National Child Abuse and Neglect Data System (NCANDS) indicated that 43% were under 12 months of age and 86% were younger than 6 years.<sup>3</sup> Results from this review indicated a lower percentage of children in these age groups, 12% of the children who died from abuse and neglect were under a year old and 72% of the children were younger than six years. One reason for this may have been that the review included only those deaths in which the victim had been the subject of a prior report to the Florida Abuse Hotline, and very young children, particularly infants, were less likely to have been reported to the abuse hotline than older children. Had the review included child victims whose older siblings or other household members had been the subject of a prior report, the number of deaths in this age range may have been higher. Figure 5 provides a specific breakdown of age at death for these 60 children.

**Figure 5: Age at Death**

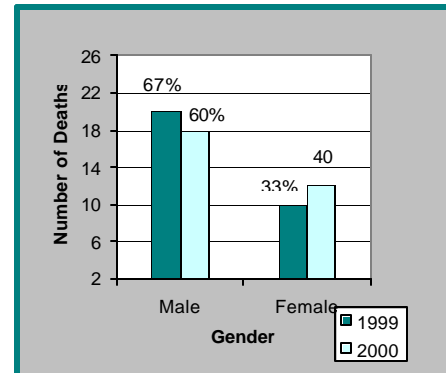
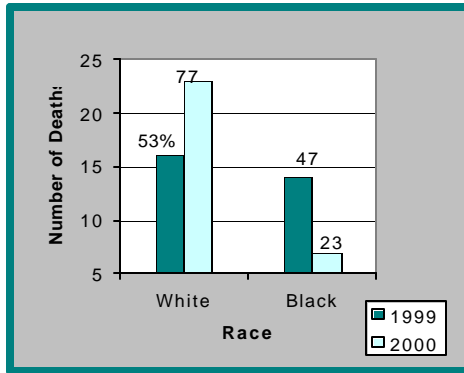


Age of Child at Death				
	1999	2000	Total	%
< 1	3	4	7	12%
1 - 2	9	10	19	32%
3 - 5	8	9	17	28%
6 - 8	6	2	8	13%
9 - 12	1	3	4	7%
13 - 15	1	2	3	5%
16 - 17	2	0	2	3%
Total	30	30	60	100%

## Race and Gender

Males represented 63% and females 37% of the 60 deaths. Sixty five percent (65%) of the children were white and 35% percent were black. For those deaths that identified specific ethnicity, a total of eleven (18%) were identified as Hispanic.

**Figure 6: Race and Gender of Child at Death**



Race of Children			
	White	Black	Total
1999	16	14	30
2000	23	7	30
Total	39	21	60
%	65%	35%	100%

Gender of Children			
	Male	Female	Total
1999	20	10	30
2000	18	12	30
Total	38	22	60
%	63%	37%	100%

### Rosa\*

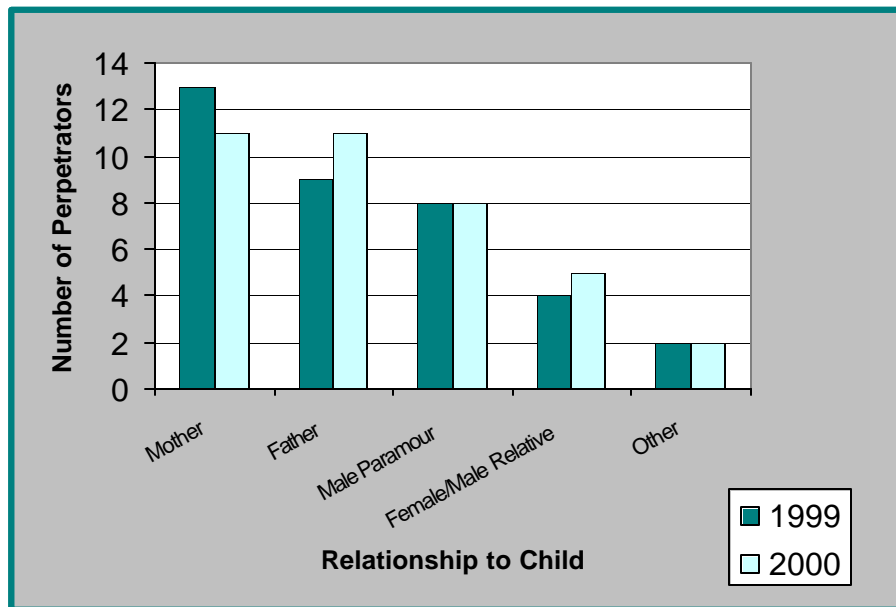
Twenty-month-old Rosa died after her father struck her repeatedly and then left her and her sibling home alone until the next morning when the mother returned home from work. The mother went to bed and was awakened an hour later by the sibling. She went to wake Rosa and found her unresponsive. The mother had allowed the father back in the home despite a prior verified report of physical abuse concerning the older sibling who had two broken legs by the same perpetrator. The child was removed from the mother's custody and the mother completed a case plan prior to the sibling being returned. Additionally, the mother was ordered to not allow the father back in the home. The mother admitted that she had allowed the father back in the home and allowed him to be a caretaker of the children in her absence. Rosa died from multiple blunt impacts to head and torso with subdural hematoma and lacerations of lung and liver.

\*Alias

## Relationship of Perpetrator

Seventy-three (73) perpetrators were identified in the 60 deaths. This included 14 deaths in which more than one person was responsible. Mothers were involved in or responsible for 24 (33%) of the 60 deaths reviewed, while fathers and male paramours were responsible for 36 (43%) of the deaths. The majority of the deaths in which the mother was the sole perpetrator were caused by neglect. The majority of the deaths in which the father or male paramour was the sole perpetrator were caused by abuse. A breakdown of the number of deaths by perpetrator is shown in Figure 7.

**Figure 7: Relationship of Perpetrator to Child**

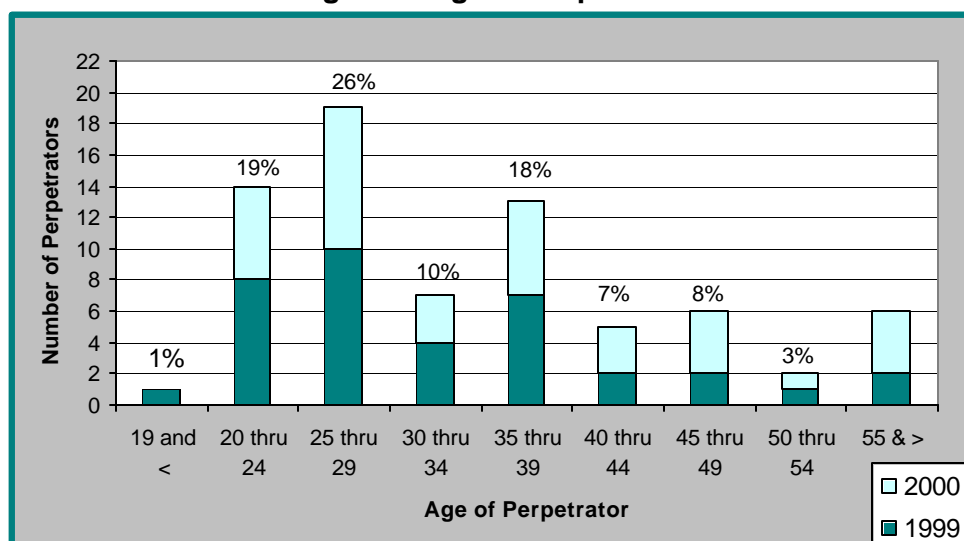


Relationship of Perpetrator			
	1999	2000	Total
Mother	13	11	24
Father	9	11	20
Male Paramour	8	8	16
Female/Male Relative	4	5	9
Other	2	2	4
<b>Total</b>	<b>36</b>	<b>37</b>	<b>73</b>

## Age of Perpetrators

The perpetrators of the 60 deaths ranged in age from 17 to 58, with a median age of 36.4 years. This conflicts with national estimates, which report that perpetrators of maltreatment fatalities are generally young. "In 1998 nearly two thirds (62%) of the persons responsible for child abuse and neglect deaths nationally were younger than 30 years of age..."<sup>5</sup> Figure 8 shows a breakdown, by category, of the age of the perpetrators for these deaths.

**Figure 8: Age of Perpetrator**



Age of Perpetrator				
	1999	2000	Total	%
19 and <	1	0	1	1%
20 thru 24	8	6	14	19%
25 thru 29	10	9	19	26%
30 thru 34	4	3	7	10%
35 thru 39	7	6	13	18%
40 thru 44	2	3	5	7%
45 thru 49	2	4	6	8%
50 thru 54	1	1	2	3%
55 & >	2	4	6	8%
<b>Total</b>	<b>37</b>	<b>36</b>	<b>73</b>	<b>100%</b>

Forty-six percent (46%) of the perpetrators in these 60 deaths were less than 30 years of age. Again, the discrepancy between these data and data from national studies may be the result of reviewing only those deaths in which there was a prior report on the victim.

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## Family Risk Factors

According to national research, "...the children most vulnerable to serious or fatal abuse and neglect are those whose parents or other caregivers are ill-equipped to care for them, who live in social isolation and poverty, and who are virtually invisible to the larger community. They tend to live in environments that have few supports for parents (and) they may not know their neighbors well enough to ask for help."<sup>6</sup>

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

- The likelihood that the problem will continue or escalate
- Is there a history of criminal conduct
- Whether law enforcement should take the lead, or be involved in the investigation
- Whether follow up visits needed
- The child's need protective supervision
- Intervention strategies needed if the child remains in the home

Pre-existing risk indicators are examined to determine if the need for intervention was identified by either the protective investigator or law enforcement. In every case reviewed, one or more risk factors were clearly identified, which should have triggered a greater degree of scrutiny and more intensive intervention. Specific risk factors included:

- Multiple prior reports
- Presence of child under the age of five years
- Prior reports of domestic violence, perpetrator history of violence, pattern of abusive relationships, or pattern of escalating violence
- Parental limitations in ability to adequately parent due to age, mental capacity or substance abuse
- Criminal history of caretaker or other adult in the home
- Hazardous conditions in the home
- Behavioral indicators of abuse

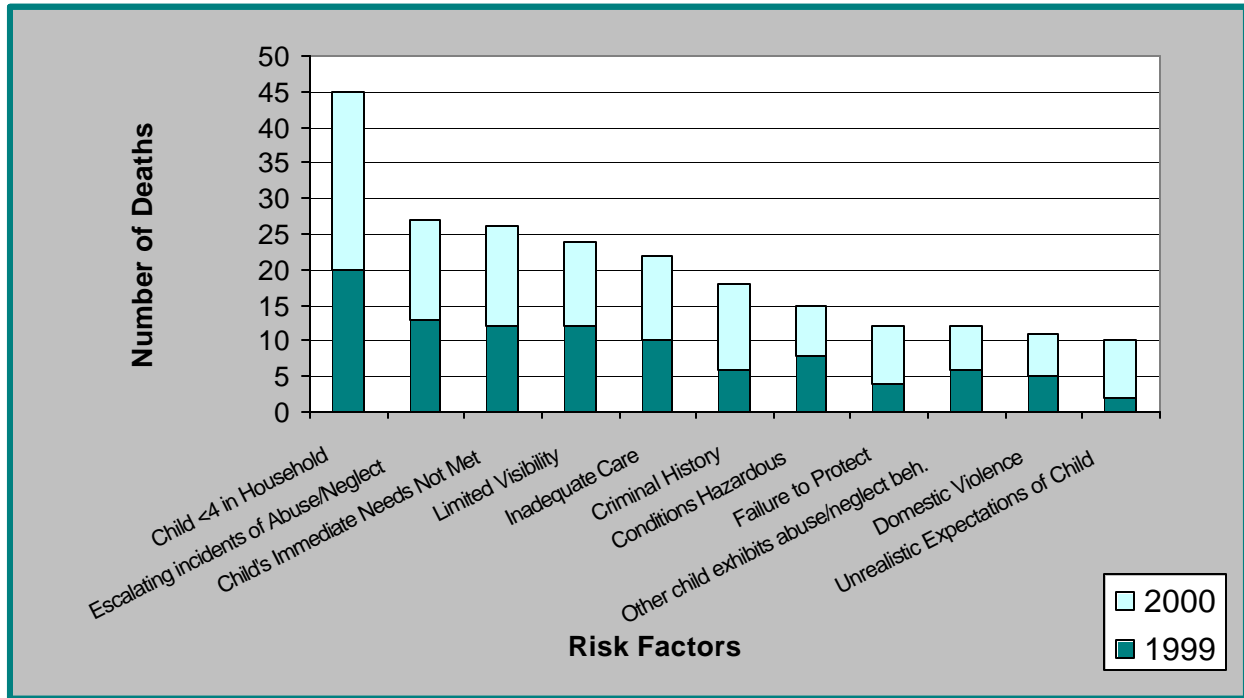
### **Sally**

**Fifteen-year-old Sally was shot and killed, along with her mother, by her stepfather who then turned the gun on himself and committed suicide. This was witnessed by a younger sibling. The parents were arguing prior to the incident and both children attempted to intervene. Mother and girls were packing to leave when the two were killed. Two prior reports involved this family. The first alleged physical abuse and conditions hazardous to health and was closed with no indicator findings. The second report alleged threat with deadly weapon and other mental injury and was closed with no indicator findings. There was documented domestic violence in the home and the stepfather was on probation for a previous incident. No services were involved with this family. The younger sibling is living with her natural father.**

**\*Alias**

Fifty-three (88%) of the 60 children had three or more family risk factors present at the time of death. Due to the statutory criteria for review of child abuse deaths, all of the children included in this study had been the victim of a prior report to the Florida Abuse Hotline. Figure 9 shows the additional major family risk factors for these children.

**Figure 9: Family Risk Factors for Child Victims**



Risk Factors in 1999/2000 Child Abuse Deaths		
	Total	%
One or more children in the household age four or younger	45	75%
A pattern or escalating and/or frequency of incidents of abuse or neglect	27	45%
Parent or caregiver is unable to meet child's immediate needs	27	45%
Child in the home has limited community visibility	24	40%
Parents or caregiver's age, mental health, or substance abuse affects ability to parent	22	37%
Criminal history on any household member	18	30%
Conditions in the home are hazardous to child's health	15	25%
Parent or caregiver is unable or unwilling to protect the child	12	20%
Other child in home exhibit behaviors indicative of abuse or neglect	12	20%
Domestic violence in the home	11	18%
Parent or caregiver has unrealistic expectations of child	10	17%

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## Adequacy of Prior Interventions

Review teams were asked to determine the adequacy of services provided prior to the child's death. In addition to the Department of Children and Families, services were provided by the Department of Health (19 cases), Child Protection Teams (20 cases), Juvenile Justice (three cases) and mental health agencies (three cases).

The team identified issues specific to protective investigations in 27 (45%) of the cases reviewed. Deficiencies in investigations included:

- Failure to identify cases with significant risk factors for immediate supervisory review to ensure appropriate actions are taken to address immediate child safety
- Failure to investigate out of state information (for criminal checks and other state abuse report history)
- Poor coordination and communication between law enforcement and the Department of Children and Families staff and between child protective investigators and child protection teams

In 48 of the 60 child deaths, the victims either received direct services from the Department of Children and Families or were referred for community services by DCF staff prior to their death. The State Child Abuse Death Review Team determined that the previous services provided by the Department of Children and Families were adequate in 20 (42%) of these cases and inadequate in 10 (21%) of the cases. In 18 (37%) of the cases, reviewers were unable to determine the appropriateness or adequacy of prior services based on the information made available to the team for review. In cases where prior services by the Department of Children and Families were found to be inappropriate or inadequate, gaps or deficiencies identified included:

- Referrals for inappropriate or inadequate services when risk factors indicated a need for more intensive intervention
- Overuse of informal referrals, and lack of follow-up in voluntary services to assess case progress and ongoing child safety

The Child Abuse Death Review Team's additional findings included:

- A lack of updated operating procedures for Department of Children and Families internal death reviews, and lack of a rigorous internal death review process
- Insufficient priority placed on internal death reviews by the Department of Children and Families

Because the Children and Families district child abuse death review coordinator's responsibilities include providing necessary information to the state and local teams, these factors contributed to the high percentage of cases in which the adequacy of prior services could not be determined.

There were no services found to be inadequate for any other service providers identified. Services provided by the Department of Health were found to be adequate in 10 (53%) of the cases. Reviewers were unable to determine the appropriateness or adequacy of Department of

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Health services in 9 (47%) of the cases. Services provided Child Protection Teams were found to be adequate in 18 (90%) of the cases and could not be determined in 2 (10%) of the cases.

### **Degree of Preventability**

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

Based on the information provided, the team determined whether the child's death was preventable. To determine a death was definitely preventable, the information provided had to demonstrate clearly that steps or actions could have been taken, either by the various agencies previously involved with the family, the caretaker responsible for the child, or by family members or other individuals who may have had knowledge of the abuse or neglect, that would have prevented the death from occurring. For instance, the review of these deaths looked at the protective investigation process to try and ascertain if anything could have been done differently during the front-end safety assessment, or subsequent service referrals and interventions to prevent the death of the child.

The State Child Abuse Death Review Team assessed preventability in 58 of the 60 cases reviewed and concluded that 48 (82.8%) of the 60 deaths were definitely preventable, eight (13.8%) were possibly preventable and two (3.4%) were considered not preventable.

It is important to note that many risk factors are associated with the increased likelihood that a child will be injured or killed by a parent or caretaker. While research suggests that the best predictor of future behavior is past behavior, there is no way to know for certain which child will be harmed and which will not. Making this judgment, often with limited information, is the challenge for all who work in the discipline of child protection.

An additional factor that the state team will monitor during the coming year is the relationship between the maltreatments alleged in the prior reports and those maltreatments alleged at the time of the child's death to see if any pertinent information can be gleaned to further inform our knowledge and understanding of risk factors present in those cases where children are killed.

#### **Marie and Juan\***

**Thirteen-year-old Marie and her 12-year old brother were repeatedly stabbed about the head and killed by their father, who then injured himself with the same weapon but survived. The father had gone to the mother's home while she was at work and gained entrance. When the mother could not reach the children by phone she returned to the home and, upon seeing the father's car, called the police. The father was charged with two counts of first-degree murder. At the time of the children's death the mother had a restraining order on the father due to repeated incidences of domestic violence and his threats. There were several prior reports regarding domestic violence in the home and the father had previously served time in jail for domestic violence.**

**\*Alias**

## STATE TEAM ACCOMPLISHMENTS AND PROGRESS

During the first two years, the State Child Abuse Death Review Team worked diligently to develop a foundation for the child abuse death review process at both state and local levels. The first year brought both challenges and insight in the efforts to develop a multidisciplinary approach to review these deaths, achieve a better understanding of why these children died and create better approaches for preventing future deaths. The challenges of the second year focused on the development of local teams and the establishment of protocols for receiving the necessary information for review from the various agencies involved in child death investigations.

### Accomplishments During Year 2001

- Distributed and implemented policy and procedure guidelines for the Florida Child Abuse Death Review process at both the state and local level.
- Enhanced the data collection instrument and instructional guide, collected data on child abuse deaths, and analyzed data collected over the two year period to identify specific factors and trends in child abuse and neglect deaths.
- Continued to facilitate the development of local review teams.
- Provided information on local child death review teams to all county health departments and responded to requests from communities interested in establishing local teams.
- Provided training and technical assistance to local areas resulting in the establishment of six local teams receiving official designation and nine local teams in various stages of development.
- Reviewed the 30 child abuse and neglect deaths that occurred in calendar year 2000 that met the statutory criteria for review. Deaths occurring in areas without local teams were reviewed by the State Child Abuse Death Review Team.
- Developed curricula for multidisciplinary training in the co-occurrence of domestic violence and child maltreatment, and death investigations to be presented during 2002.

### Future Goals

- Establish additional local death review teams to enable a local response to child abuse deaths in every area of the state, with emphasis on geographic areas of priority identified through death reviews.
- Work with existing local death review teams to accomplish the review of applicable calendar year 2001 child abuse deaths.
- Provide additional training materials for agencies, individuals and local child abuse death review committees.
- Assist local teams in the development of protocols for review of child abuse deaths to be used by law enforcement agencies, prosecutors, medical examiners, health care professionals, health care facilities and social service agencies.
- Continue to enhance the Child Abuse Death Review (CADR) web site that provides a general description of the program, the CADR Guidelines, the state team directory, the 1999 annual report, and the CADR brochure. Additional information to be provided will include a power point presentation on the Florida CADR process and the 2000 annual report.

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- Formalize communication between the child abuse death review team and agencies providing child protection investigation and services concerning follow-up to the findings and recommendations to assist in the development and implementation of resolutions.
  - To expand the cases to be reviewed to include all maltreatment deaths and ultimately all child deaths.

### Sam\*

Twenty-month-old Sam died from blunt impact to the abdomen while he was in the care of the mother's paramour. He also had blunt impact injuries to his head and chest and fractures of the left radius and left ulna. A total of 32 bite marks were noted on his extremities, chest and back. The bite marks were determined to have been caused by the mother, not a sibling. The paramour was arrested and charged with 2<sup>nd</sup> degree murder and the mother was charged with aggravated child abuse. It was determined at the child death review that had the mother and paramour sought immediate medical attention once they were aware of the child's condition, there would have been a high likelihood of preventing Sam's death. Sam was born with a chromosome abnormality and was developmentally delayed. He was followed through the CMS clinic, along with an older sibling who had medical problems. The mother was not consistent in keeping all the medical appointments. There was an open prior report of physical abuse alleging that Sam was seen with a bruise on his face and cheek. It was reported that the mother's paramour had been holding Sam when he slipped and the bruises were caused by the paramour grabbing Sam so he would not fall. There was a delay in completing contact with the family due to initially incomplete information on where to locate the family. When Sam was finally seen, no bruises were noted then, nor at the CPT medical exam. After the child's death the mother reported that domestic violence had occurred in the home and she was afraid of the paramour. The surviving siblings were removed from the home and procedures for termination of parental rights were initiated.

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## STATUS OF 1999 ANNUAL REPORT RECOMMENDATIONS

**Recommendation 1: The Department of Children and Families should coordinate and, if necessary, realign resources on the state and local level in an effort to maximize the time and attention provided to the child death review process and to ensure the quality and timeliness of child death reviews.**

According to the Department of Children and Families (DCF), district death review coordinators have other major job responsibilities, including managing contracts and serving as the district policy specialist for one or more child protection programs. While the Office of Family Safety fully agrees with the importance of the death review process, and supports the statewide and local efforts by DCF and other agencies in this process, they identify the issue as one of lacking resources within their department. Based on this, the recommendation has not been implemented at this time. The Department of Children and Families has indicated they would welcome any assistance the Statewide Child Abuse Death Review Team may be able to supply to address this issue. The State Team encourages the Department of Children and Families to include in their annual legislative budget request sufficient resources to support their child abuse death review progress.

**Recommendation 2: The Department of Children and Families should revise departmental operating procedures to address the quality and timeliness of the district death review report, to require local multidisciplinary staffings for all child abuse deaths with prior DCF involvement and to better define the roles and responsibilities of the state and local death review coordinators.**

According to the Department of Children and Families, the existing Child Death Operating Procedure (CFOP 175-17) has undergone extensive revision, and will be released for review and comment by district staff and community partners the week of October 15, 2001. It is not clear at the writing of this report whether this has been accomplished.

The revised procedure includes time frames for completion of the district death report and specific roles and responsibilities for the state and district death review coordinators. The procedure also addresses the responsibility of the Department of Children and Families to support the death review process established by Chapter 383.404, Florida Statute. Because of confidentiality issues, DCF will not be able to initiate or lead multidisciplinary staffings for child abuse deaths. DCF staff will, however, provide information gathered during the department's internal review process to local child death review teams and/or the state CADR team. Additionally, the Children's Justice Act Task Force has committed to offer financial support to efforts to recruit and develop community death review teams.

**Recommendation 3: The State Child Abuse Death Review Team, in collaboration with the Department of Health and the Department of Children and Families, should consider the facilitation, development and training of local death review teams a priority for calendar years 2000-2001.**

As indicated on the map of existing and planned local teams, the efforts of the State Child Abuse Death Review Team to recruit and train local review teams resulted in six local teams covering eleven counties. An additional eight counties have local teams in various stages of

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development. The state team's case review subcommittee has been successful in reviewing the deaths in areas without local teams and including their findings in the child death database. The recruitment of local teams continues however, to remain a priority. A guide for local teams was finalized and distributed, and the state child abuse death review team has provided on site training and technical assistance to developing local teams.

**Recommendation 4: The Department of Children and Families should continue to implement the District 7 Child Safety Strike Force recommendations.**

According to the Department of Children and Families, District 7 has a staff person responsible for coordinating and tracking the implementation of the Strike Force recommendations. They have fully implemented a majority of the recommendations and are continuing to work on the remainder.

Implementation of the statewide recommendations has been ongoing. Efforts already addressed include completion of an investigative response operating procedure, development of a desk reference that includes all statutes, administrative codes and operating procedures relevant to child protection programs and the development and signing of an interagency agreement between DCF and the Florida Coalition Against Domestic Violence. A staff person in the Family Safety Quality Assurance office has been given the assignment of coordinating and tracking implementation of all of the Strike Force recommendations. District and central office participation in this process was discussed in a recent statewide video-teleconference between Family Safety administration and DCF District Program Administrators.

**Recommendation 5: The Department of Health should propose a legislative amendment revising the due date of the annual report from September 30 to December 31.**

Legislative change was passed and implemented.

**Recommendation 6: During the next year, the State Child Abuse Death Review Team should coordinate with local death review teams and relevant professional organizations to develop guidelines to ensure the thoroughness and integrity of child death investigations.**

The Child Abuse Death Review Team training subcommittee has gathered examples of guidelines for child death investigations from various agencies across the state. They have begun the task of analyzing the examples to incorporate them into one document. Once completed, the document will be shared with the statewide team for approval, and plans to distribute the document and train child death investigators will proceed.

**Recommendation 7: The Florida Department of Law Enforcement, in collaboration with the Department of Children and Families, the Medical Examiners Association and the Child Protection Teams, should develop and facilitate training specific to child abuse death investigations.**

Members of the child abuse death review team representing the above agencies met with the Florida Prosecuting Attorney's Association and other community representatives to develop curriculum for a series of three-day workshop/conferences on a team approach to investigating and prosecuting domestic violence and child abuse, including child abuse death investigations. Topics include basic domestic violence education, domestic violence and child maltreatment,

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the role of the mental health professional in investigations and prosecution, refuting claims of accidental death or injury, language development of children, forensic vs. treatment interviews, offender interviews, strategies for successful prosecution, the team approach to child protection, and child death review. A schedule and specific outline for the curriculum have been developed, however the group has suspended further planning due to budgetary limitations. Current plans are to combine with existing scheduled conferences appropriate for presentations on child abuse deaths and death investigations.

**Recommendation 8: The Florida Legislature should expand the Child Abuse Death Review Process to include the review of all child deaths.**

No legislation has been introduced.

## CONCLUSIONS AND RECOMMENDATIONS

The State Child Abuse Death Review Team reviewed all of the 1999 cases in the absence of local teams. During this second year, with local child abuse death review teams still in the process of development, local teams reviewed only three cases. To review the deaths that occurred in CY 2000, the State Child Abuse Death Review Team appointed a case review subcommittee, meeting the membership requirements of local teams, to undertake the responsibility for reviewing the remaining child deaths that fit the criteria for review mandated in Florida Statutes that were not reviewed by local teams.

Since the publication of the first annual report, the state child abuse death review team and staff from the Department of Health have worked diligently to develop protocols with the Department of Children and Families for receiving information resulting from their internal death reviews to assist the case review subcommittee. The quality and quantity of information received from district Children and Families death review coordinators varies significantly across the state. Some districts currently do not produce a written internal death review report on all child abuse deaths. Although data from the review of several of the deaths were limited, team members were able to identify some trends based on the case reviews.

It is important for the reader to put the review of these child deaths in perspective. Because the population reviewed is limited in scope and representation of the total number of abuse and neglect deaths in Florida, the recommendations and comments made throughout this report are subject to those limitations when generalizations are made. There are clear patterns and trends noted for the state that are consistent with national data; however, because of the limited population there are variations, which are reflected in this report. The issues and recommendations below stem from the review of these deaths:

**Issue 1:** Local teams and other local reviewers lack consistency in their approach to the review and identification of preventable deaths and prevention strategies.

**Recommendation:** The State Child Abuse Death Review Team should clarify the concept of preventability as it relates to child abuse deaths, and provide training and technical assistance to local teams so that determinations made by the local review teams will be accurate and consistent across the state.

**Issue 2:** Drowning occurs most frequently in swimming pools. Among the most significant risk factors are: inadequate supervision of young children, children's inability to swim, alcohol or other substance misuse by supervising caregivers, inadequate pool fencing, and easy access to unsupervised areas.

**Recommendation:** The State Child Abuse Death Review Team should evaluate the state requirements related to pools and pool safety and make recommendations for additional safety requirements as indicated. The state team, in conjunction with the Department of Health and the Department of Children and Families, should provide drowning prevention educational activities through the media and through training for staff and clients.

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**Issue 3:** During the course of child death investigations, it is not uncommon for relatives, school officials, neighbors, or other witnesses to disclose information known prior to the current report that constituted a reason to suspect abuse or neglect that should have been reported to the child abuse hotline. Prevention steps may have been available if early identification of risk had occurred.

**Recommendation:** The Department of Children and Families should update their “Information Packet for Professionally Mandated Reporters” to include identifiable risk factors and indicators of abuse and neglect. Local DCF offices and Child Protection Teams should facilitate training for local professionals and other local support groups on recognizing and reporting child abuse and neglect. The Department of Children and Families should also resume their public service announcements regarding risk factors and reporting requirements to reach the general population.

**Issue 4:** Stricter guidelines are needed for determining case plans involving serious or repeat cases of abuse and neglect. Informal referrals are often made during case closure with no follow up, and voluntary services are sometimes offered in lieu of court action with no follow up provided to assess continued or increased risk.

**Recommendation:** The Department of Children and Families should develop operating procedures with strict guidelines for determining when petitions must be filed in lieu of voluntary services. These operating procedures should specify that voluntary cases require the same evidence collection and documentation as court cases, and establish mandatory time frames for case follow-up on all voluntary cases to ensure that more stringent action can be taken if necessary.

**Issue 5:** Domestic violence posing risk of harm to children often goes unreported to the child abuse hotline. These cases frequently do not come to the attention of child protection staff until a child has already been directly harmed as a result of the violence. When child protection staff are called to investigate cases involving domestic violence, they frequently do not have adequate knowledge of domestic violence to assess the risk to the child and non-offending caretaker and make appropriate services referrals.

**Recommendation:** The Florida Department of Law Enforcement, in conjunction with the Florida Coalition Against Domestic Violence, should provide training to local law enforcement agencies to ensure they recognize the crossover between domestic violence and child abuse, and the requirements for reporting domestic violence to the child abuse hotline when threatened harm to a child is suspected. Training on the relationship between domestic violence and child abuse and neglect should be provided statewide to all child protective staff and domestic violence service providers.

**Issue 6:** The criteria for the cases reviewed should be expanded. Because the reviews are limited to only those children with a verified death maltreatment and at least one prior report, many deaths are not reviewed that would assist the team in their overall assessment of the causes and contributing factors to all abuse and neglect deaths. Including additional deaths would afford the team to draw conclusions based on a larger sample.

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**Recommendation: The Florida Legislature should expand the child abuse death review process to include the review of all deaths, or at a minimum to include all abuse or neglect deaths in which some indicators of the death maltreatment were found, and at least one prior abuse report was received involving the member of the victim's immediate family or other household member.**

The State Child Abuse Death Review Team is cognizant that some of these recommendations can be accomplished with existing resources; however, where there is an expansion or increased focus on an activity, the Legislature is encouraged to allocate adequate resources to those parties responsible for the completion of these critical tasks.

## REFERENCES

1. Section 383.402, Florida Statutes
2. Section 39.01, Florida Statutes
3. U.S. Department of Health and Human Services: Child Maltreatment 1999: Reports from the States to the National Child Abuse and Neglect Data System.
4. Florida Department of Children and Families: Child Abuse and Neglect Deaths: Calendar Year 1998.
5. The National Center on Child Abuse Prevention Research: Current Trends in Child Abuse Reporting and Fatalities: The Results of the 1998 Annual Fifty State Survey.
6. National Exchange Club Foundation, Abuse Publication, 2000.

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