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CHILD ABUSE and NEGLECT DEATHS in FLORIDA

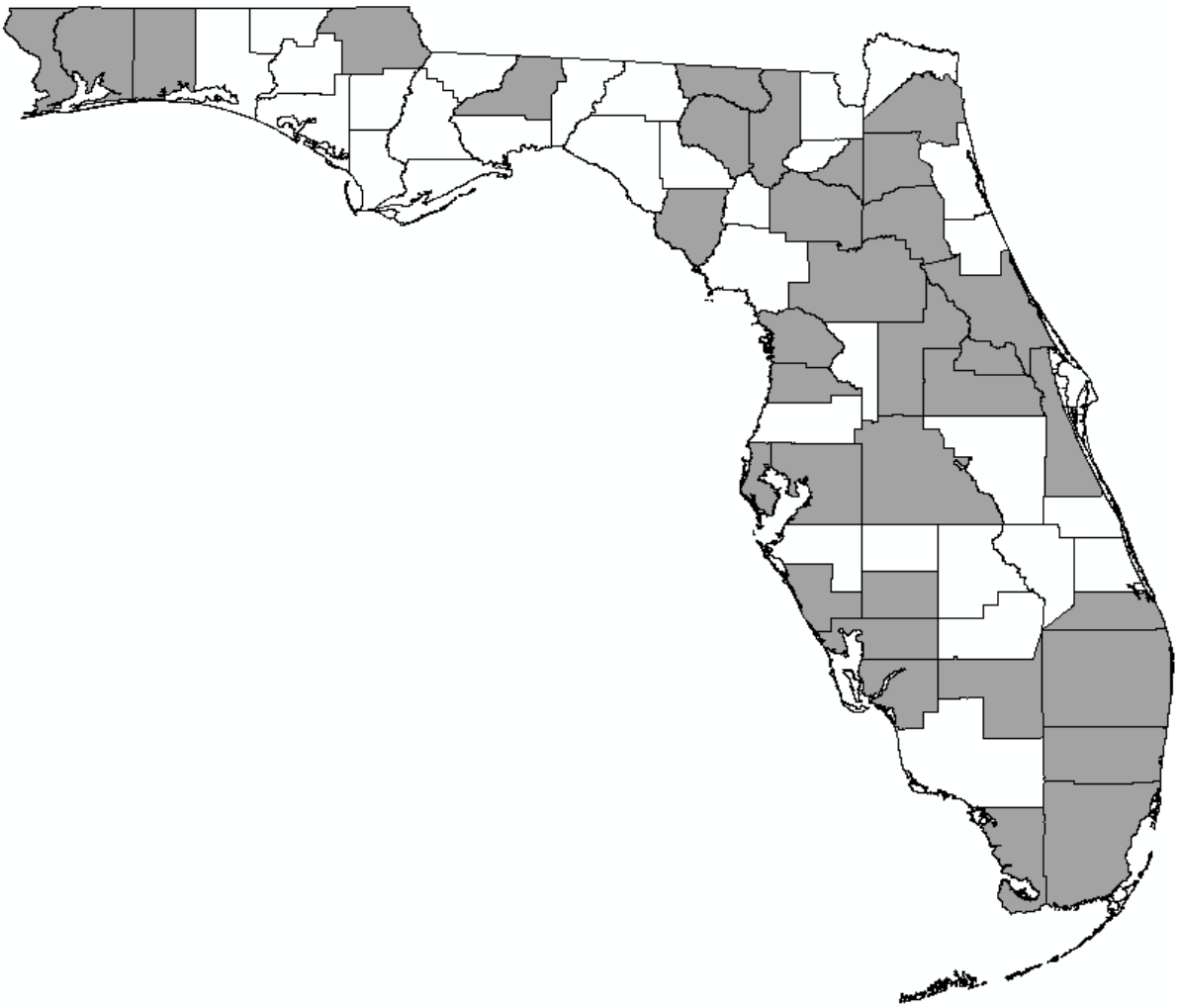
An Analysis of Children Who Died in 2011
and Key Prevention Recommendations
Submitted by the State Child Abuse Death Review Committee

December 31, 2012

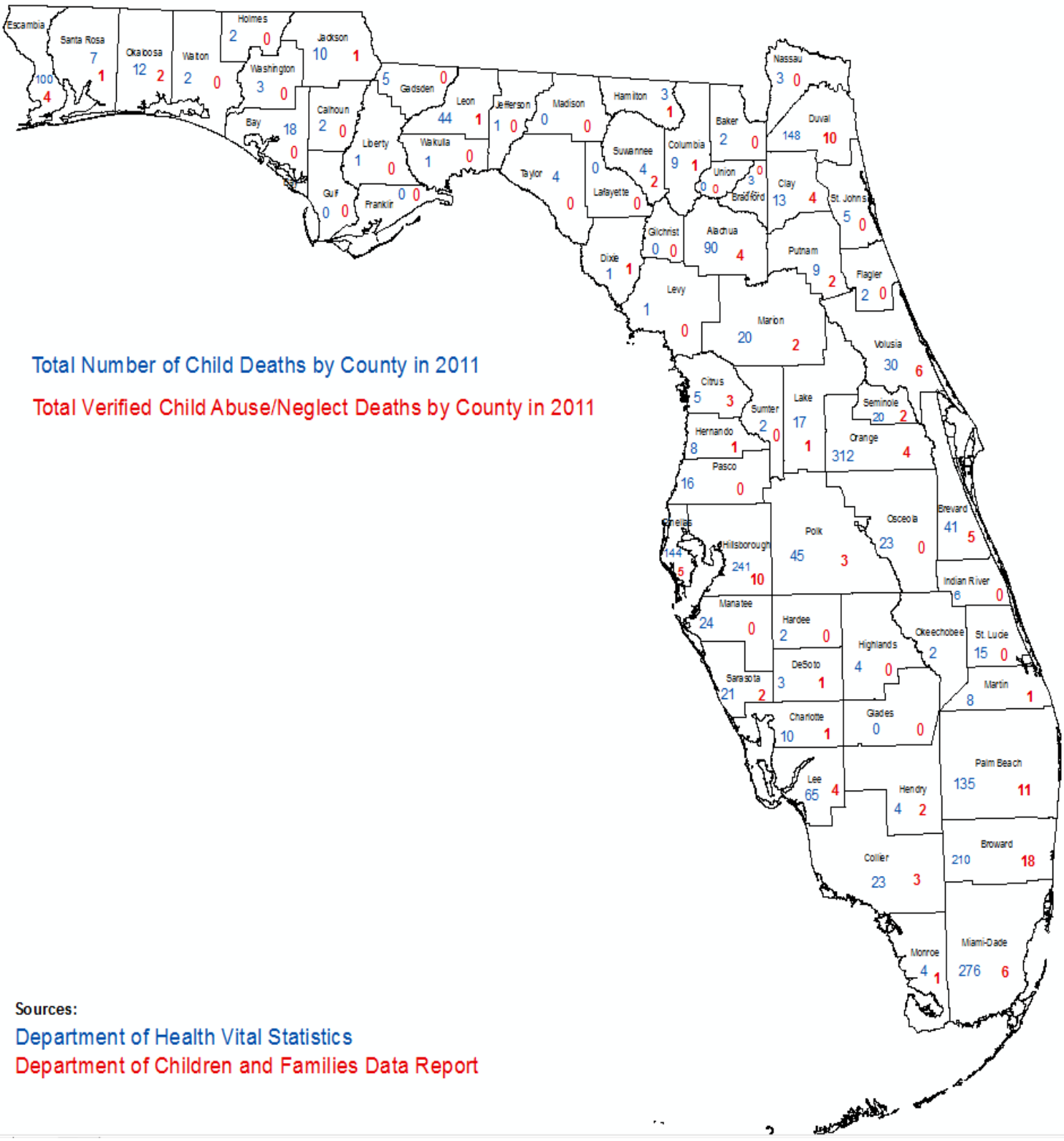
Presented by the Statewide Child Abuse Death Review Committee to:

Governor Rick Scott
Senate President Don Gaetz
Speaker of the House Will Weatherford

This map highlights counties where at least one child died with verified findings of abuse or neglect at the hands of parents or caregivers.



Child Deaths By County



Total Number of Child Deaths by County in 2011

Total Verified Child Abuse/Neglect Deaths by County in 2011

Sources:

Department of Health Vital Statistics

Department of Children and Families Data Report

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INTRODUCTION

During 2011, 2,241 children under the age of 18 lost their lives in Florida. Of these, 1,305 were male and 936 were female. Summary data from the Florida Department of Health (DOH) shows that of the 2,241 deaths, most were tragedies that involved medical, genetic or accidental histories leading to their shortened lives. Of those deaths, 474 were reported to the Florida Abuse Hotline and 130 deaths were verified by the Department of Children and Families (DCF) as being related to child abuse or neglect. The State Committee received 126 cases for review during the period of January through November 2012. The four cases verified after the review period will be reviewed in 2013.

In Florida during 2011, an average of two children died every week at the hands of an abuser.

The estimated population of children ages 0-17 in Florida was 3,999,132 in 2011. The following chart shows the number of children under the age of 18 in Florida and the number of cases classified as "substantiated/some indication" or "verified findings" of child abuse or neglect. The State Committee is statutorily limited to the review of "verified" child death reports, which limits our understanding of why children are dying in Florida. The numbers of all child deaths that occurred in Florida for the three-year period 2009-2011 are shown in the following table. The DCF Reports to Abuse Hotline portion of the chart below shows the number of reports to the Child Abuse Hotline that involved child deaths and how they were classified by DCF.

Department of Health Data on all Children Ages 0-17 years 2009 - 2011			
	2009	**2010**	**2011**
Florida population for children ages 0 – 17 years	**4,150,374**	**4,123,708**	**3,999,132**
Number of child deaths regardless of residency	**2,638**	**2,282**	**2,241**
Number of Florida resident child deaths	**2,586**	**2,178**	**2,586**
Department of Children and Families Data on Reports to the Abuse Hotline			
Number of reports to the Abuse Hotline	**217,382**	**223,082**	**186,579**
Number of reports involving child deaths	**513**	**507**	**474**
Number of child death cases closed with no indication of abuse or neglect	**196**	**199**	**218**
Number of child death cases closed with some indication of abuse or neglect	**96**	**107**	**101**
Number of child deaths verified due to abuse or neglect	**200**	**155**	**130**
Number of "**verified"** child abuse deaths provided to the Child Abuse Death Review Committee for review	**192**	**136**	**126**

About the Statewide Child Abuse Death Review Committee

The Child Abuse Death Review Committee (CADR) is statutorily required to carefully review children whose deaths have been investigated by the DCF and closed with a "verified" finding of child abuse or neglect. Established in 1999, an annual report is submitted to the Governor, the President of the Senate and the Speaker of the House of Representatives containing recommendations to reduce preventable child deaths. Included in the team composition are experts from the medical, social services and advocacy professions. The committee convenes throughout the year to examine the circumstances leading to child deaths. These meetings include a review of social services and other community interventions that interacted with the family at some point in time prior to the child's death. Local child abuse death review committees also conduct reviews of the verified deaths of children in their respective communities to develop prevention campaigns and prepare recommendations for improving local practices in child protection and support services to families. Further information regarding the State Child Abuse Death Review Committee and the current listing of local review committees can be found at www.flcadr.org.

When reviewing the cases with verified findings of death due to child abuse, the CADR attempts to determine whether the child's death was preventable based on the review of available records. The Committee categorizes each death as one of the following:

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

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

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

Not Preventable: No currently available medical, educational, social or technological resources could have prevented the death from occurring.

Based on the data collected and analyzed from the 126 child deaths reviewed in 2011, the committee has identified key recommendations for the Governor and the Florida Legislature to consider taking appropriate action in an effort to prevent future child abuse and neglect-related deaths.

KEY RECOMMENDATIONS

- **Florida lawmakers should amend the statutes governing the scope of responsibilities of the Statewide Child Abuse Death Review Committee to include all reported child fatalities accepted by the Abuse Hotline for an investigation.**

The Florida Governor's Children and Youth Cabinet analyzed the various entities reviewing child deaths in Florida and determined that expansion of the scope of the current State Child Abuse Death Review Committee to all suspicious child deaths investigated by the DCF would significantly improve prevention strategies at the local and statewide levels. Because current statute limits the team to verified child deaths, only one-third of DCF child death investigations are analyzed in a multidisciplinary review process. A legislatively established, comprehensive analysis of all child deaths investigated by DCF will dramatically impact the ability of the committee to identify and implement targeted prevention and education strategies for parents and caregivers of children.

- **The DOH central office, DCF, hospitals, the Florida Pediatric Society, county health departments, Healthy Families Florida, Healthy Start and similar resources should submit information to the Statewide Child Abuse Death Review Committee by September 30, 2013, describing present practices in teaching parents infant safe sleep.**

Children four months of age and younger die at alarming rates in our state. Investigations reveal that many of these children are sharing a sleeping surface with parents and/or siblings when they die. Despite the recommendation that all healthy infants be placed on their backs to sleep, many are dying after being placed face down in soft bedding. Others are found sleeping in a place other than a crib, such as a couch or adult bed, often shared with other children and/or adults. A review of the current practices and identification of limitations to the various avenues for teaching safe sleeping must be conducted.

Infant deaths due to unsafe sleep environments are preventable. Understanding the information that is being provided to parents and caregivers will assist in determining the inconsistencies, deficiencies and missed opportunities regarding infant safe sleep education. Under the current statute, the State Committee reviews only a handful of infant deaths related to unsafe infant sleeping environments. The ability to review a much broader group of cases will allow the State Committee to better elucidate risk factors associated with infant sleep-related deaths, including caregiver substance abuse, with the goal of the preventing such deaths in the future.

- **Targeted prevention campaigns specific to drowning in residential pools and bath tubs should be developed.**

An alarming number of pool drownings occur despite the recommendation of the installation of various security mechanisms. Eighty-four percent of these children easily wandered outdoors with free access to the pools and 11 percent were left unattended in bath tubs. Investigations reveal that many times sliding doors are left open, locks are not engaged and sensors or alarms are either turned off or not operable. These pool barriers represent the best intentions, but are rendered useless when neglected. Many investigations revealed that the caregivers were

distracted, by using the Internet or other computer related activity, and/or impaired by alcohol and/or drugs. Bath tubs are the second highest body of water to claim children by drowning and can occur with very little standing water. Infants and toddlers should never be left unattended in tubs.

- **To avoid the costly consequences of child abuse and neglect, the legislature should increase the funding level for Healthy Families Florida, a program proven to prevent child abuse and neglect and improve the health, safety and well-being of children in high-risk families.**

According to the DCF, in 2011-2012, 53,035 children were abused or neglected in Florida. More than 23,000 (44 percent) of these children were under the age of five. Too many of Florida's high-risk families and their children are without vital Healthy Families Florida services that build on families' strengths and help parents learn new skills to provide the safe, stable and nurturing experiences that children need to succeed in school and later in life. According to the Center on the Developing Child at Harvard University (2011), providing supportive, responsive relationships during early childhood builds resiliency and helps mitigate the costly consequences of early childhood adversities.

Healthy Families Florida, a, nationally accredited, evidence-based home visiting program, begins services early, during pregnancy or shortly after the birth of a child, before negative patterns of behavior develop that can have a detrimental impact on their child. Families who are experiencing stressful life situations that place their children at risk of abuse and neglect voluntarily participate in the program. In 2011-2012, Healthy Families served 8,475 high risk families and their 15,066 children.

A rigorous five-year independent evaluation by health consulting firm Williams, Stern and Associates and follow-up study conducted by Florida State University show that Healthy Families Florida prevents child abuse and neglect and achieves other positive outcomes. Since the independent evaluation, Healthy Families Florida continues to be successful in preventing child abuse and neglect. As of June 30, 2012:

- 97 percent of children were free from abuse and neglect during services.
- 98 percent of children were free from abuse and neglect within one year of program completion.
- 95 percent of children were free from abuse and neglect within three years of program completion.

Prevention programs that improve the health and well-being of children and families such as Healthy Start should continue to be funded.

In 1991, the Florida Legislature gave statutory authority for the Florida Healthy Start Program. There are 31 Healthy Start coalitions and two county health departments that provide Healthy Start, which together cover all of Florida's 67 counties. Between January 1, 2011, and December 31, 2011, there were 212,703 births in Florida. Of the 212,703 births, 194,007 infants were screened for Healthy Start and 82,094 infants received Healthy Start services. The Healthy Start program assists pregnant women, women who are between pregnancies, and women, infants, and children (WIC) up to age three obtain the health care and social support needed to reduce the risks for poor maternal and child health outcomes including the prevention of child abuse. An important role of Healthy Start is increasing access to early, risk-appropriate

care for children up to age three. Healthy Start also provides education (i.e. safe sleep environment), care coordination, referral and follow-up to infants and children to ensure they receive the care they need. Healthy Start, a program that promotes the health, safety and well-being of children, should continue to participate on the Child Abuse Death Review Committee at both the state and local levels.

- **Local DCF offices and subcontracted Community-Based Care (CBC) agencies should develop formal partnerships and referral processes with local certified domestic violence centers to enhance the safety of families experiencing domestic violence.**

Domestic violence was noted in 14 of the 38 physical abuse child death cases reviewed by the State Committee. In order to increase family safety in cases involving domestic violence, existing promising programs such as the Florida Coalition Against Domestic Violence Child Protective Investigators (CPI) Initiative should be replicated in areas where it does not currently exist. This project is being implemented in ten counties in Florida to bridge the gap between child welfare and domestic violence service providers to enhance family safety, create permanency for children and hold domestic violence perpetrators accountable for their actions. Partnerships between child welfare agencies and certified domestic violence centers are critical for two reasons:

1. Domestic violence advocates' early involvement in cases can reduce risk to children by providing immediate resource and referral information and safety planning with domestic violence survivors and their children. Domestic violence advocates work from an empowerment-based philosophy, therefore they are skilled at identifying family strengths. Advocates' expertise in this area assists survivors/non-offending parents to increase protective factors already existing in the home.

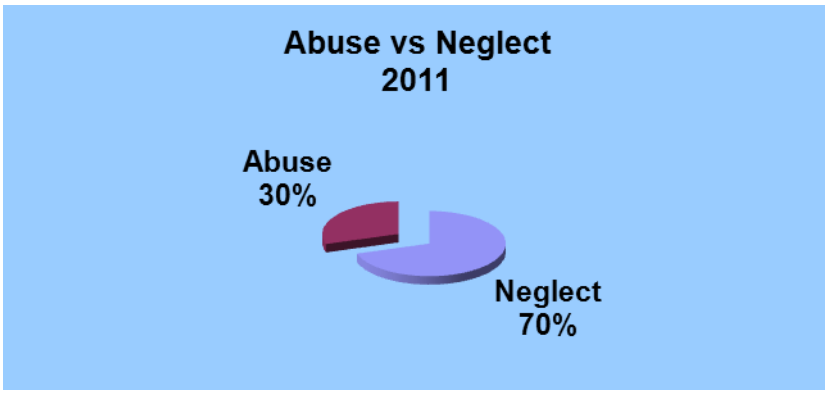
2. Domestic violence advocates can also assist CPI's and case managers in clearly identifying batterers' patterns of coercive control while garnering a greater understanding of the impact of the batterer's behaviors on the children.

WHAT WE KNOW ABOUT CHILD ABUSE AND NEGLECT DEATHS IN FLORIDA

The pages that follow present a more detailed look at the 126 verified abuse and neglect-related child deaths that were reviewed by the State Committee.

In 2011, 63 percent of the 126 child deaths reviewed were male victims and 37 percent were female. Fifty-nine percent of the children who died were white and 41 percent were black. **Eighty-three percent of the children were under the age of five.**

The chart below shows that of the 126 child deaths, 31 (30 percent) died from abuse and 87 (70 percent) died from neglect.



NEGLECT: THE LEADING FACTOR UNDERLYING CHILD DEATHS

Neglect covers a broad spectrum of maltreatments, has been the leading cause of child deaths reviewed by the State Committee over the past decade and was the leading cause of child deaths in 2011. Listed below is the categorization and number of children who died due to neglect:

- 32 Drowning
- 30 Unsafe sleep
- 10 Motor vehicle-related
- 7 Medical neglect
- 5 Drug toxicity deaths
- 4 Firearm-related

Drowning: The leading cause of neglect-related deaths of children

The moment a child is submerged in water, the clock starts ticking for his/her survivability. Last year in Florida, according to the Agency for Health Care Administration Hospital and Emergency Department Discharge Data, there were 337 non-fatal emergency department visits. Of these non-fatal hospitalizations, 186 were children ages birth to four years, and the result of a near drowning. Depending upon the timing of a rescue, a child can fully recover. Child drownings plague every state in the country. Additionally, the head of an infant or toddler is disproportionately large and heavy, representing approximately 20 percent of the total body

weight, making them top-heavy and unable to escape when headfirst in a toilet or bucket. Florida leads the nation in pool drownings for children ages one to four years. In 2011, 26 (84 percent) of the child drownings reviewed by the State Committee were in residential pools, with bathtub drownings being second.

> ***Grandma's two and four-year-old granddaughters are visiting for the weekend. Frequent visitors to the home, the four year old had on two prior occasions fallen into the pool from her bicycle and had to be rescued. On a Saturday afternoon, the grandmother advises the child that she has to check on the two year old sibling and warns the four year old to stay away from the pool. The four-year-old proceeds to circle the pool on her bike and fatally plunges to her death while grandmother was reportedly in the home for only minutes.***

It is interesting to note that in a number of the child drownings investigated, a family member revealed that an incident of falling into the pool occurred prior to the drowning fatality. Despite past warnings of a child's great attraction to water and the potential for a tragedy, parental or caregiver behavior is not always modified to ensure the constant supervision of a child around pools or other bodies of water. Another common theme is the family home equipped with a variety of safety measures that are not in active use or are non-functioning. Alarms may be disengaged due to their "annoying" sounds. Sliding doors may be closed and not locked, rendering them easily opened by toddlers who are naturally infatuated with water. Children with disabilities, especially autism, are at a greater risk of wandering episodes and adults must be vigilant in providing continuous supervision. Parents and caregivers greatly underestimate how "safe" it is to leave a child unsupervised for moments while tending to other children or allowing for distractions such as phone calls or computers and doing household chores. Too often it has been noted that caregivers are under the influence of alcohol and or drugs when a child drowns. Trend data on drowning can be found at www.flcadr.org.

> ***A 34-year-old mother places her three children, ages four, two and 11 months, together in a tub with the shower water turned on lightly. Various accounts are offered as to whether the tub stopper is left to drain or to capture the water. The mother states that she leaves "momentarily" to fetch towels and, upon her return, finds her 11-month-old floating face down in 10 inches of water. Speculation occurs as to whether the two-year-old engaged the tub stopper or increased the water flow while the mother stepped out of the bathroom.***

The State Committee review revealed that in 23 of the 32 child drowning fatalities in 2011, the child had entered the pool unattended or without the knowledge of their parent or caregiver. The absence of appropriate supervision was a clearly a factor in these deaths. There were also issues noted with several of the pool barriers, such as how they were used or not being used at all. All but two of the 32 children who drowned were under the age of five and 23 of the 32 were white.

The majority (21) of the caregivers responsible were mothers, followed by 10 fathers. Twenty-six of those identified as the responsible caregiver were between the ages of 20 and 39. In 14 of the cases there was history of drug and/or alcohol abuse by the responsible caregiver.

The best way to prevent the drowning of young children is to restrict a child's access to water through multiple barriers. When a child does have access to water, constant supervision by a responsible adult is imperative. Drowning is often a silent death. A child can slip under water without attracting attention through loud splashing or cries for help, while a parent or caregiver is

talking on a cellular phone, using the bathroom or otherwise not actively supervising. Targeted awareness campaigns, such as those articulated in the key recommendation section (pg.3), can greatly impact public understanding.

Unsafe Sleep: The second leading cause of neglect-related deaths

Unsafe sleep practices jeopardize too many infant lives. While co-sleeping with an infant can have deep cultural roots in some families, for others it can be simply the lack of a separate safe sleep surface. It is more likely that these co-sleeping deaths involve parents or caregivers who have a pattern of behavior surrounding co-sleeping practices.

In Florida many law enforcement agencies and medical examiner offices have included *doll re-enactments* as part of their infant death investigation protocol. The *doll re-enactment* has been extremely beneficial in assisting in the identification of infant deaths from suffocation in unsafe sleep environments. It is part of a standardized guideline and multidisciplinary approach in Sudden Unexplained Infant Death Investigation (SUIDI) http://www.cdc.gov/sids/suidabout.htm developed for and in conjunction with the Centers for Disease Control and Prevention.

Many of the child protective investigations, regarding infant deaths due to suffocation while co-sleeping, have revealed that a parent or caretaker was under the influence of drugs and/or alcohol during the co-sleeping episode. In some cases this has led to findings of criminal culpability and prosecution of the impaired parent or caretaker. Trend data on unsafe sleep can be found at www.flcadr.org.

> ***A 28-year-old single mother, living with her parents and on a waiting list for substance abuse treatment, takes her eight-week-old son to spend the night with friends. She falls asleep on a couch cradling her child in her arms after breast-feeding and awakens 12 hours later to find, to her horror, her infant wedged between cushions, stiff and blue.***

Campaigns warning of the dangers of unsafe infant sleep have been significant in recent years. Most maternity wards ensure that new parents are instructed on the proper sleeping arrangements for their newborn. Many mothers admit that they have been instructed on safe sleep practices. Local communities organize the provision and distribution of new bedding to parents who cannot afford to purchase cribs for their infants. Voluntary prevention programs such as Healthy Families Florida and Healthy Start include consultation and instruction to new parents in their homes on how to prepare a child for sleep. Child protective investigations reveal documentation that suitable sleeping cribs were in the homes of some infants who died while co-sleeping. Case records often include verification that a parent acknowledged their understanding of unsafe sleep practices.

> ***The young parents of a nine-week-old infant and a two-year-old toddler prepare their children for bed at 8 pm. After a feeding, the infant is placed on a pillow in the middle of a queen-sized bed and the father and two year old join him in sleep. Sleeping together in one bed is the family ritual, although, on this night, the mother sleeps in a separate room. She arises at 6 am and finds her infant stiff, face down in the pillow next to the father where he had been placed to sleep. While the father tests negative for any drugs, the mother admits to smoking marijuana the previous night.***

Many communities have effectively saturated the avenues available to provide education on safe sleep practices, yet far too many parents who wake to find their non-cribbed infant wedged between cushions or under pillows acknowledge that they were instructed on how to put their infant safely to sleep for the night. This recommendation stresses the critical importance of understanding the difficulties inherent in implementing campaigns against co-sleeping.

In 2011, 27 of the 30 unsafe sleep related deaths resulted from the child sleeping with others. Twenty-one of the victims of unsafe sleep were males and 24 of the victims were between the ages of three weeks to three months of age. Twenty-two of the adults responsible were mothers and 13 were fathers. Twenty-five of the adults were between the ages of 16 and 29. Most noteworthy was that in 21 of the cases one or more of the adults had a substance abuse history.

PHYSICAL ABUSE: INTENTIONAL VIOLENCE TO CHILDREN

The post-mortem examination of a child who dies as a result of intentional physical violence often reveals past patterns of abusive behavior on the part of a parent or caregiver. Healing rib fractures, bruised organs and signs of neurological distress are common findings that tell the story of a child who suffered for days, weeks or even months before the fatal event. The following breaks down the circumstances and numbers related to those deaths:

- 18 died as a result of abusive head trauma
- 6 died as a result of blunt abdominal trauma
- 4 died from multiple traumatic injuries
- 4 died as a result of intentional gunshot wounds
- 2 died of intentional poisoning
- 2 died from undetermined causes
- 1 died from homicidal violence of unspecified type
- 1 died from suffocation

Thirty-eight of the 126 child death reviews indicated that physical abuse caused or contributed to the death. Head injuries and internal abdominal injuries are the most frequent cause of child physical abuse death. In 22 cases of intentional physical abuse, the cause of death was abusive head trauma or multiple traumatic injuries including abusive head trauma. Twenty of the physical abuse cases had evidence of prior trauma. Violent actions against children often hold common themes, with crying as the trigger.

The most serious child abuse occurs in the privacy of the home and seldom in the view of other family members or witnesses. This type of child death is arguably the most difficult to understand due to the violent and unexplained nature of these deaths. Because of the lack of eyewitnesses, these are often very difficult cases to investigate and to prosecute. The investigation frequently depends on the medical interpretation of the child's injuries, the establishment of a timeline and possibly a confession. Whether biologically related to the victim or not, most often the abuser is a unemployed male, with a history of criminal activity, who is in his late 20's or early 30's. Perpetrator profiles can be found on www.flcadr.org.

> **A call is placed to 911 by a frantic mother who comes home from work to find her two-year-old son unconscious on the floor of the living room. When paramedics arrive, the mother's boyfriend states that the child had tumbled from a flight of stairs in the house, was given a pain reliever, and fell asleep watching television. The boy dies en-route to the hospital. The autopsy reveals acute trauma to the**

liver and kidneys, a healing femur fracture and other signs of injuries in various stages of healing. After several versions of the last hours of the child's life, the paramour confesses to beating the child to death.

Understanding the behaviors of a parent or caregiver at a critical moment is difficult. Great strides have been made in the law enforcement and medical examiner professions to include a *re-enactment* of the events leading to the death of a child with the caregivers. This essential investigative activity provides the opportunity to learn the precise description of the physical setting and circumstances leading up to the fatality and allows parents and caregivers to be challenged on their version of events to lead to the truth. This re-enactment can be shared with a medical expert to determine if the injury is consistent with the story provided by the caregiver. When injuries are not consistent with the information provided, law enforcement is able to confront the caregiver and, in many instances, obtain a confession of the abuse inflicted on the deceased child.

An 11-month-old boy is strapped in his car seat by his father, who is being driven to his place of work by his father-in-law. The father-in-law, grandfather to the boy, notices that his grandson has acted increasingly drowsy during the car ride, leading up to the time that the father is dropped off at his place of employment. The grandfather drives his grandson home and finds the child's lifeless body as he is unbuckled from his car seat. Upon questioning, the father of the child eventually confesses to having shaken and caused his fatal traumatic brain injury.

In 2011, 30 of the children who died from inflicted injuries were four years of age or younger. Of those, 13 were infants under one year of age. The majority of the children (20) were males and 20 were white.

According to the U.S. Department of Health & Human Services Administration for Children and Families Administration on Children, Youth and Families Children's Bureau report: Child Maltreatment 2011, 78.3 percent of child fatalities were caused by one or more parents. Perpetrators without a parental relationship to the child accounted for 13.4 percent of fatalities. In 2011, Florida parents accounted for 86 percent of the fatalities and abusers without a parental relationship to the child, which included mother's boyfriends, accounted for 31 percent of the fatalities. In several of the cases, neighbors, friends, family and mothers were aware of bruises, unexplained injuries and broken bones caused by the abuser yet failed to report the abuse. Florida law, sometimes called the toughest in the nation for reporting child abuse, now will make it a third degree felony for failure to report child abuse to DCF. A report is not an accusation. It is a statement for authorities to evaluate and investigate. Reporting abuse or neglect can protect a child and get help for a family—it may even save a child's life. Mothers in 11 of the cases reviewed were aware of the abuse and had failed to take action to protect their child. In many instances, the abuser was alone with the child while the mother was at work. Biological mothers were the abusers in seven of the child deaths.

CONCLUSION

The State Child Abuse Death Review Committee is legislatively mandated to review the deaths of children when there is a Department of Children and Families investigation that results in a verified finding of child abuse or neglect. Because the scope of our review is specific only to *verified* findings, a full understanding of child deaths reported to the Abuse Hotline cannot be achieved.

The Florida Department of Health, designated by the legislature to provide staffing support for the State and Local Committees, is considering statutory changes to broaden the scope of the review to all child deaths investigated by DCF. This will significantly improve the State Committee's ability to craft strategic prevention and education strategies through a broader understanding of these tragedies. We can learn from each child death. The DCF investigative classification of "verified," "not substantiated" or "no findings" should not be the barrier to a more fully informed statewide community gaining understanding on how we can work together to prevent the deaths of children in Florida.