Transcript of New Resources to Facilitate Local Child Fatality Prevention Efforts Training Video

Secretary Mike Carroll, Secretary, Florida Department of Children and Families:

Good Morning, It's good to be with you this morning, thanks for tuning into this and learning more about our child fatality website.

Preventing Child Fatalities in Florida is really my number one priority and has been since I became Interim Secretary. I feel very strongly that the folks we deal with at the department, we sometimes deal with families with some very complex long standing issues, the work isn't easy, the level of uncertainty sometimes in making decisions regarding that family can be challenging, but nonetheless sometimes when we walk through a front door of a home, it's sometimes that child's last best chance at being safe, being healthy, being developmentally on track, being educationally on track, and so we've got to do better. And we've made it a priority within our department, for all those families we touch and have contact with to reduce the number of child fatalities that we have in those homes. I think to do that we need to be very clear with folks in terms if what information we have and what is actually causing a lot of the child fatalities that we deal with. I think in looking at the data it tells an even bigger story. Although the department deals with many of the families who experience a child fatality, most families did not have contact with the department. I think when you dig into the data around child fatalities, most folks are kind of surprised; it was certainly an eye opening thing for me. In the region, what my former position, Suncoast region director, we did have an issue we needed to look into, so we've tracked this information for a long time. And one thing that was striking to me was that we had involvement with 1 in 4 children who were the victim of a child fatality in our area and was called into the hotline. We had prior involvement with a 3rd of the families, and so clearly, with that number, it tells you that we have to do a better job within the department of the families we touch. In light of the tragedy that unfolded in Bell two weeks ago, I'm absolutely even more committed to making sure that we do better for the families that we interact with, but I think if that's our only focus, I think we've missed the boat. Because if 1 in 4 children who experience a child fatality were known to the department, that means 3 in 4 were not. If about a 3rd of the families were known to the department prior to the child fatality that means 2 out of 3 were not known to the department. And when you look at the root causes of the child deaths or the demographics around the family and some of the issues they were struggling with, regardless of whether they had involvement with the department or not, many of the issues impacting that family are similar. When we began to dig into the child death data, one of the things that jumped off the page to me personally was inflicted child deaths, which is something we normally would associate with the department, for inflicted child deaths a high number of those cases did have involvement with the department, I think it was 50% of inflicted child deaths did have some type of involvement, but those are not the leading cause of death for children in Florida, and in fact over time, those deaths have been trending down not only in Florida, but nationally. Where we have a bigger issue in the state of Florida is deaths associated with drowning and deaths associated with what I would term unsafe sleep. In terms of drowning, I understand that in the state we live in, the weather we have, our proximity to water, we're much more prone to somebody accidentally drowning.

A lot of the drownings we see though also involve some sort of marginal supervision and oversight that we've got to get our arms around.

On Unsafe sleep, some of our child deaths, the second leading cause of child deaths for us at the department… In the region I managed prior to becoming the interim secretary, unsafe sleep was the number one cause of child death. And it ranged the whole gamut…some involved co-sleep, some involved unsafe situations, where we were putting kids in unsafe sleep environments, whether it's on the couch with pillows, an unsafe crib, we were putting kids to bed with siblings. In many of the cases, the child fatalities were not intentional, they were not intended, and in almost every one of them, if you look at child drowning or unsafe sleep, in almost every one of them, while I don't think they were intentional, most were inherently preventable. And I think that as a community is what we need to get our arms around is really reducing all child deaths. And so what we created the child fatality website for – a couple of reasons:

One, we wanted to end the talk around transparency; this state should be the most open state in terms of how we look at child deaths and how we look, across agencies and communities, at child death data; we should all be involved I think in the mission of reducing child fatalities over time and keeping kids safer. And I think a first step toward that through the creation of this website, was not only to report on deaths as they occur in our community, but we made it a priority of ours, we had a goal to get 5 years plus current year data, so 6 years' worth, of data on child deaths in Florida that were reported through the hotline. We met that goal, we have 5 years' worth of data up; so every child death that was reported through the hotline, and we averaged around 450 child deaths a year, every child death that was reported through the hotline in the last 6 months, is now on the website. We provide some demographic information, and then we also provide a report that provides some of the specifics around that child death; that report is redacted for confidentiality reasons, but it provides folks a glimpse into the circumstances around the case. By the end of this fiscal year, we hope to have the past 10 years' worth of child data up, and I hope in doing so, we put to bed this whole question of transparency. Florida needs to be the most transparent state around child death. We've also worked hard with our partners at Health to begin to understand, and make sure that our numbers mesh. Not all child deaths are reported to the hotline, and that's appropriate, quite frankly. We have lots of deaths where child abuse and neglect is not suspected as a root cause of that child death. And we're going to do more work in the coming year to make sure we fully understand any differences or anomalies, between the numbers that our partners at health may have and we have here through our hotline.

But I think more importantly what we hope this website will do, is, I believe that if we're really going to get our arms around child fatalities, it's just not a thing that the department can do themselves. If we only touch 1 in 4 of the children or only 1 in 3 of the families, it has to be a broader act, we have to protect all kids, and I don't think it's something state government in general can do by themselves. I think it has to be a community by community intervention strategy, and really community by community building a culture of safety and awareness around some of the issues that drive child fatalities. We've tried in the past to have Public Service Announcements at a statewide level that talk about water safety that talk about safe sleep and other issues, particularly for us at the department, knowing who's watching your child because in many cases it's not the parent that ends up inflicting

injury to the child that results in death, it's often a paramour; we have to make sure we understand who is watching our child. And so we've done those public service announcements in the past. I met a young reporter the other day, I don't think he was much older than my daughter, and he asked me a question and I thought it was a great question. He said he's been around a number of years, and he's seen these public service announcements over the years. And why is it that we put so much effort into seemingly education and public service announcements around water safety for instance, yet we don't seem to be making any traction in terms of lowering the number of child deaths. Good question, right? And I believe the answer to that is that we haven't gotten the message out at the right level. We at a statewide level, or we at a level where we're doing PSAs, yes it's helpful and it begins to provide the information and it begins to really construct a sandbox that we have to be playing in, but if we're going to have an impact on this, we have to get into communities, into neighborhoods where folks can talk about this in ways that as state government we can't. We have to get in, communicate with partners in nontraditional ways where folks have a lot of credibility. When I grew up, and I'm dating myself now, but you know I used to go swimming at the city pool back in Boston, used to live in the projects, and I think it was a wives' tale, but everybody knew that if you ate you couldn't go in the water for an hour because you were going to get cramps and you may drown. Now I don't even know if that's true, in fact I've subsequently talked to a physician who said it's not true, but everybody believed it to be true. If you had lunch, you couldn't go in the pool for an hour. We need to begin to create some of those same wives' tales around water safety, around unsafe sleep, and we have to be doing it neighborhood by neighborhood.

One of the things we hope to accomplish with the child fatality website is, not only does it provide data on the child fatalities that we have received through the hotline, but it does it community by community, because if you're going to involve communities in this, yes they need to know statewide data, but what they really need to know is "what's going on in my community?", and when you look at it some of the differences are striking. In some areas you have a pronounced issue with child drownings, in other areas, child drownings is relatively minimal and you have a pronounced issue with unsafe sleep related child deaths. The community needs to have that information and data, and they need to be able to use it in a way that all of our community partners, the traditional folks, that most of you folks on the phone, that we can begin to work together and understand those families that might be at a high risk of this happening. But all those nontraditional partners that touch these same families in much different ways and at times quite frankly, have much more credibility than we do - we have to get this information into their hands in a way that it can be used to begin to reduce child fatalities and create a culture of safety, community by community, and I hope this is a start to it.

One of the things that I would ask us statewide, and this is for the partners who work with at risk families, when we did a profile and we dug into the child deaths that we have had over the last five years, the profile was striking. Most of the kids that we lose are 3 years old or younger; in fact it's over 80 percent, I think right now it's about 79%, but some years it was as high as 88%. Clearly, it's our youngest kids that are most vulnerable. And typically for us it's usually also in families that have other issues that drive, quite frankly, the level of parenting capacity in the home. So for us when you looked at the profile it was a child that was 3 and under, it was parents who had a substance abuse or mental

health issue, it was a parent who had chronic involvement with the child welfare system or the legal system, and when you combined all of those things together, it wasn't that they had one adverse child experience, it was they had multiple. And that's not rocket science for most folks… but for us, we've tried to change our practice internally particularly around the families we serve to focus on the highest to high risk families. And those are those families, that have children that are 3 or under, that may be experiencing substance abuse or a have mental health issue, that do have a prior experience with the department, many times it involves a younger parent. For us it was parents 26 or under; that's not always true. The tragedy in Bell, the mom was 28, although the father in the case was younger. We have a profile, and I would hope we begin to use that profile, not just within the department, because we don't touch all the families that meet this profile. That's what jumped off the page to me as well…was when we looked at the child death cases that we did not have involvement with, many of them also met the profile. And I know many of these families work with agencies beyond the department even if they don't have involvement with us, and so I think we need to work together to understand and to really calibrate and tailor our services across state agencies and across community providers to make sure that we have a higher level of triage as it relates to these families. But the more we can engage our local communities in this fight, the better off we'll be. The good news is, we have placed such an emphasis on this, that, and I knock on wood, if the trend holds this year, it looks like child deaths will significantly lower than we've experienced in a long time, certainly lower than the data we have on the prior 6 years.

And I think that's a good thing, but I don't think our work is done until we end all preventable child deaths. And I think as a community we need to come together and say just that. I live in the Tampa Bay area…well the Tampa Bay area ought to have a child goal, zero preventable child deaths. And it's not one state agency that can do that, the school system can't do it alone, our partners at health can't do this alone, but if we work together and we engage the community we have a chance to do it, and we can move in that direction. And I hope that's what this website does, is provide us at least with a common platform that we can begin those efforts with.

I do want to…Lisa Rivera is our statewide child fatality prevention leader, and she works with all of our communities. She was also intimately involved in the development and ongoing maintenance of the website, and I'd like her to walk you through it. Because I think you will find that the depth and breadth of information, how it's broken up by community, some of the trends it provides you, and it even right now provides a link to some of the prevention strategies. We would like to localize that, right now it's linked to mostly statewide efforts, but we would really like to get it to a point where even those local prevention strategies that are in place are linked so that it becomes a one stop, one shop place for folks to really look at what is going on in the community around preventing child fatalities.

Lisa Rivera, MSW, Statewide Child Fatality Prevention Specialist:

Ok here…when you go to http://myflfamilies.com/childfatality, or if you're on myflfamilies.com, there's a banner at the top that will eventually roll around and you can click on the child fatality link, and it will take you right to this very first page. This is our home page, and it kind of gives you a little bit of details

and explanation of what the site is about, but I want to bring your attention to the first graph that you see, which is light red or pink as some people call it and green. And basically this is from 2009-2013 and this is real data that shows you the green is basically the number of reports that had been received during that entire year, and the red parameters are those that were verified as the result of abuse or neglect. And that trending line as the years are added in is going to continue to move on. Underneath that graph, you have 3 selections. You have statewide data, which we're probably going to go to in just a second, local data, which we're also going to visit, and then what Secretary Carroll was just referring to is a prevention tab so we can click on that link also and look at prevention measures that have been initiated within the state. But I want to kind of go to…and this is very user friendly, this was developed for the general public in mind because this information needs to go out to our general public and not just agency partners that are well educated with computers and computer savvy and how programs run. Actually you can pull this up on smart phones so people that are doing home visits that don't necessarily have a traveling laptop, if you have a smart phone that has google chrome on it, you can pull the site up right there and kind of educate the families while you're on site, to kind of see what's going on when we're talking about drowning measures and unsafe sleep and really see the numbers we're talking about.

So I clicked on the statewide data, and the first thing that comes up , we're in the year 2014, and to date, as of the last update, there were 332 deaths, and as Secretary Carroll referenced with those numbers, 80% of them are for children 3 years and under. And as we go through the site, if you go through and play around, it's very interactive and very easy to use, you can kind of start to see even the age break downs. Generally our <1 are going to fall into the unsafe sleep categories in most instances and your 1-3 are usually going to represent your drownings, oftentimes we'll have a couple of older kids, but that's usually the parameters and the breakdowns. To make it again, more user -friendly and so the public can understand, there's different causal factors, not necessarily cause and manners of death because medical examiners use different definitions throughout the state. But the biggest ones, and we collapsed some of them in different categories, but the broad spectrum is, first one you see is drowning. Second is unsafe sleep, and that includes your co-sleeping deaths, deaths of children that occur when they're placed to sleep on the couch or where they're placed to sleep with excessive bedding. They could be placed to sleep in their crib, in an appropriate setting, but they're on a pillow and on their stomach, and the autopsy comes back that it was an asphyxiated related death, so that would be considered unsafe sleep. Accidental Trauma, those are the children that are hit by a car, mauled by a dog, accidentally shot by a gun if they were playing with it and not a suicide, those kinds of things. Inflicted Trauma is self-explanatory. It's that...it's purposefully done to a child and results in a death. Because this is live data, we have a huge area, it's grey on my screen, under investigation, that means that the cases are under investigation and we don't have a definitive cause or manner of death. And that will always...it's always going to be moving because once we find out it's going to enter into one of these other causal factors so that grey area will decrease as the year goes by. We have natural causes, then we have SIDS/SUID, which is Sudden Unexplained Infant Death or Sudden Infant Death Syndrome, and then Other, we have grouped that – it includes overdoses, suicides, children left in cars, because we don't have an astronomically high number of deaths to each warrant their own category or we're going to fill up the page for each individual scenario.

So once we understand that, and again, we're in 2014 right now, I just kind of want to run down here and reference again the numbers and statistics Secretary Carroll referenced. Thus far in 2014, of the deaths that have been received at the hotline, 5% have had a verified prior report within the past 12 months, which is a very small number; 94% did not have any verified prior involvement. Then we have the priors with the deceased child, and it breaks out there…this changes every year, this is live data. As you scroll down a little bit further, this is where you can kind of start to play and see what's going on with regards to age parameters, the year you want to look at, the causal factors, whether there have been verified priors within 12 months of death, whether or not the death itself was verified. So I just want to show you – We have minimum age range, you can adjust this to show an age gap, so let's do 2. We're going to start the minimum age at 2, the maximum age range, we'll do 5, just to do that 3 year gap right there. And we'll do "all causes" for now, and we'll do "view statewide results". Now what's going to happen, it shows you in ages 2-5, half of them are the result of drowning, although we have some that are still under investigation, but as you scroll down, not only are you going to get the same graph depictions about the verified prior within 12 months, if there was any involvement with the deceased child or the family in general, but you're going to get a little narrative about what's happened in the deaths. So we might not have reports if it's still under investigation viewable yet, but you're going to have the information. So this first one, which happened on January 1st, the narrative says the "3 yr old drowned in the family swimming pool after getting out of the house undetected. The parents were asleep at the time, and the father had believed that he locked the French doors leading out to the pool area where no safety barrier was observed". So that's just a general description of the circumstances surrounding the death.

The case right below it, there's another description regarding a 2 year old who was found at the bottom of the swimming pool. But you'll notice here in blue it says "view report". Now what you're going to have access to is a child fatality summary, or they used to be called death reviews – as the years go by you'll see them titled differently. But all you have to do is click on that link, and you're - again what Secretary Carroll referenced, is the fatality summary, the death report that was written on that specific case, and depending on the maltreatment findings, is going to be the level of redaction there, because we do have to abide by confidentiality within the state, but it kind of gives you a little overall synopsis. I'm just going to scroll down – And you'll see a difference between – this report was not verified for abuse or neglect, and you'll see a difference between one that is and one that isn't.

So again, it will trend you all the way down, you just got to keep scrolling, and you'll see every single death that meets that parameter throughout the state. This is age again, 2-5, these are the parameters, it will tell you whether or not the report was verified and if there's a report that's been completed.

What I'd like to do is, I want to show you folks something interesting. Again when you go on these search screens, you just need to back back out to start your searches over. I want to show you a new parameter that was just uploaded onto the site, which is extremely exciting. I want to talk about drownings, and there's going to be a trend analysis here. So what we're going to do is we're going to select a causal factor, now this is where we can differentiate, and we're going to do drownings only. We're going to do…we'll just do 2013 because we're going to get some information there and then we'll do view statewide results. So this is the statewide information for the year 2013, there are 79 cases in

which children drowned, and again the represented age when we talked about drownings, ages 1-3, is highly represented. The same parameters exist here where you have the circumstances surrounding the death, usually brief statement, but most of these are completed so you'll see a link to view the reports on every one.

To do statewide trend, this is the new feature that's on the website, this is statewide information right here, so from 2009-2013, this is what our drowning deaths look like, it's irregardless of findings. And between 2010 and 2011, and this is going to become important because I want to show some specific counties, there was a little bit of a dip here. And so those are the kind of trend analysis that we want to start paying attention to in our communities – what happened here to cause a little dip?

As we go back in, we're going to do some local data now. We're going back to the first screen, I just backed out twice, and we're going to hit local data. And that's going to bring you to the state of Florida. This is where we can do those – really look at indicators within our communities, and I'm going to do the same thing, I'm going to do drowinings, and I'm just going to choose 2013, and I'm going to go to Orange county because they tend to have a lot of drowning deaths in Orange. Again, well in 2013 they only had 9, but what I want to show you with Orange County, is when you hit their view trend, again, this is only Orange County, but we went from a number in 2010, to a significant drop in 2011, and then it's going up a little bit more.

I want to show you the same thing with Hillsborough County, another big county that we have. Again, choose drowning, and we're going to choose Hillsborough County, and we're going to view their trend over the years. Again, from 2010 – 2011, there was a drop. So we see 2 drops in 2 significant counties, which was Hillsborough and Orange, and I even did this with Duvall and there was a little bit of a drop. And because there was a drop significant statewide, in the community what we should be asking is what happened between 2010 and 2011 to cause that drop and there probably was a big push regarding either eyes on children or somebody had mentioned that might have been the year that door locks were furnished to everybody, and if you look when you go down and you read the narrative reports on drowning deaths, most of these children that drowned are not drowning because they're left unattended at a pool, they're drowning when they get out of the home undetected. So maybe the door lock prevention was a great strategy that worked, but whatever it was between 2010 and 2011, maybe we need to revisit that,

The other causal factor that we take a look at is unsafe sleep, and… I'm going to back this up actually, and do unsafe sleep data on a statewide. There's a little phenomenon that's going on here, for us to be educated especially when we go into the homes and we try to talk about unsafe sleep practices, and we want to make sure that we're reporting accurate trends and analysis of that. So if we go to statewide results for unsafe sleep, at this point, this is for 2014, this number is probably going to rise because most of our under investigation have to do with unsafe sleep parameters, but throughout the state, it's really not been a huge drop except in 2010. There was a decrease in unsafe sleep deaths that warranted some attention. Immediately my thought went to I wonder if we were diagnosing something different that year?". And my next step was, when I went into the statewide data, I wanted to see what SIDS deaths looked like because we do have the correlation, it's either a SIDS death or it's an unsafe sleep death. So

when we looked at that statewide, and we viewed that trend, guess what went up in 2010? The SIDS diagnosis. So sometimes we can even play around on this, on our own data, and it can be a wealth of information just to see the way we're classifying things. Now as SIDS deaths have been decreasing as the final diagnoses on medical examiner reports, remember the trend analysis on unsafe sleep was actually increasing, so we're seeing more thorough autopsies or more consideration of sleep environment when the investigation is even being conducted by the medical examiner.

But I encourage everyone to go on and play you know with it, it's very user friendly, you can do any parameter you want, you can view statewide results, you can view county by county - it's very very user friendly. It came in handy when none of our laptops were working the other day, and all of our smartphones were, and we all could still get on and look at the website.

Secretary Mike Carroll, Secretary, Florida Department of Children and Families:

And this isn't the end all be all. In fact we're still working furiously to get some of our prior data history up, but as you begin to experiment online with the website, if you have any ideas or any suggestions for improving the website or information you'd like to see included, please let us know. Because we're very open to that. We want this to be as user friendly, and we want the information to be as helpful as possible to our all of our partners and to local communities. So if you have suggestions or questions in terms of why something is not included, let us know because we can make those adjustments. Our work this year was primarily around the construct of the original website and getting all of the prior history in place and loaded into the system. One of the things you'll see, and one of the things we did at least around how we handle child fatalities internally, is we had to do a lot of work to standardize our approach and I don't think many years that we were using this data in a way that we were learning from it, actively learning and actively making changes to how we did things. I don't think we can function as an agency without looking at this level of data, learning from this data, and then using this data to inform our practice within the department. And I certainly don't think that you can do that in the community in relation to what your child fatality prevention strategies are. So I think it's been a helpful exercise for us. You will see, and I think Lisa alluded to this, when you begin to – particularly when we lay in the data from 10 years ago – you're going to see a decidedly different format on the Child Fatality Report, you'll see inconsistencies between Child Fatality Reports from one area to the other. I told my staff, in doing this we're not going to go back and fix what was done 10 years ago, put it up there, it speaks to the inconsistency if you will of the system that was in place at the time, but hopefully this effort will internally get us to a much better place in terms of our ability to evaluate our involvement with a family when we have a child fatality, and that be shared in a much more consistent way, but I also hope it is going to lead to a much more unified approach across agencies and within communities on how we actually put prevention strategies in place to really reduce child fatalities for all children, not just those kids that the department has involvement with. But I'm certainly open to questions – if you do have any questions, please let us know, and you can write me directly, my contact information is fairly easy to find - or Lisa Rivera, she really is our point person on all this, and we would be very happy to hear your feedback because we've already used the feedback we've gotten from other stakeholders to actually make changes to the website up til now. So thank you.