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Differences Between Male Perpetrators of Child Homicide

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**DIFFERENCES BETWEEN MALE PERPETRATORS
OF CHILD HOMICIDE**

by

Isabel Perez-Morina

A Dissertation Presented to the School of Psychology
of Nova Southeastern University
in Partial Fulfillment of the Requirements
for the Degree of Doctor of Philosophy

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DISSERTATION APPROVAL SHEET

This dissertation was submitted by Isabel Perez-Morina under the direction of the Chairperson of the dissertation committed listed below. It was submitted to the School of Psychology and approved in partial fulfillment of the requirements for the degree of Doctor of Philosophy in Clinical Psychology at Nova Southeastern University.

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TABLE OF CONTENTS

LIST OF TABLES	
LIST OF FIGURES	
ABSTRACT	
CHAPTER I: STATEMENT OF THE PROBLEM.....	
CHAPTER II: REVIEW OF THE LITERATURE	
Male Paramours	
Biological Fathers and Step-Fathers	
Child Homicide as Fatal Child Abuse	
Domestic Violence	
Age and Sex of Victim Child	
Hypotheses	
CHAPTER III: METHODS	
Subjects/Participants	
Procedures	
Measures	
Analyses	
CHAPTER IV: RESULTS	
CHAPTER V: DISCUSSION	
The Hypotheses	
Limitations of the Study	
Implications for Practice and Future Research	
Public Policy	
REFERENCES	
APPENDIX	
A. State of Florida Child Abuse Death Review Data Instrument	

LIST OF TABLES

Table 1. Comparison of Age between Male Perpetrators

Table 2. Comparison of Evidence of Prior Trauma

LIST OF FIGURES

Figure 1. Age of Child Victims Killed by Biological Fathers

Figure 2. Age of Child Victims Killed by Male Paramours

DIFFERENCES BETWEEN MALE PERPETRATORS OF CHILD HOMICIDE

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ABSTRACT

The scientific study of child abuse and infanticide is a relatively young practice in the field of medicine, psychiatry and psychology, and although the role of parents in child homicide has been studied, minimal research has focused on the role of the male paramour, or the child's mother's boyfriend, as the perpetrator of child homicides. This study aimed to examine the differences between male paramours and biological father who kill children and hypothesized that biological fathers or step-fathers are significantly more likely than the child's mother's male paramour to kill their children due to relationship factors between the perpetrator and the child's mother, specifically and for the purpose of this study in the context of domestic violence. Child homicides committed by male paramours, in comparison, are more likely to have resulted from factors that are individually or child-centered. Decedent children ages 0-17 that were killed at the hands of their biological father, male-stepfather, or biological mother's male paramours between the years 1999 through 2005 in Miami-Dade County were be studied. The age of the perpetrators and child victims killed by the two groups were compared using an independent samples t-test, with a significance level set at .05. The two groups of male

perpetrators were compared on prior domestic violence histories, prior criminal histories, evidence of prior trauma to the child, and perpetration of multiple homicide and post-incident suicide using a chi-square test, with a significance level set of .05.

Significant differences were found between the two groups. Specifically, paramours are significantly more likely to be younger than biological fathers and children killed by paramours are more likely to evidence prior trauma. Further, biological fathers are significantly more likely to have a history of domestic violence, as a perpetrator, engage in multiple killings, and commit suicide after perpetrating the child death. The study demonstrates the need for prevention resources to target the two groups differently, to be most effective in prevention. The study also demonstrates the need for more extensive research comparing differences child homicide versus child abuse and in those that perpetrate the two. Lastly, it should inform public policy and the law and how these are applied to cases of domestic violence and child welfare.

CHAPTER I

Statement of the Problem

The scientific study of child abuse and infanticide is a relatively young practice in the field of medicine, psychiatry and psychology. Kempe was among the first to record and study child abuse, leading to theory of “the battered child syndrome” (Helfer & Kempe, 1974). After 1974, child homicide statistics began to be collected and analyzed and specifically in the United States, demonstrated an upward trend and was found to be one of the leading manner of deaths to individuals under 18 (Browne & Lynch, 1995). Child homicide studies demonstrate that children are more likely to be killed in their home by a member of their family or co-inhabitant, than by anyone else (Browne & Lynch, 1995). Recent child fatality statistics continue to show that homicide is a leading manner of death in children, particularly infants (Bureau of Justice Statistics (BJS), 2006).

Because of the trend described above, several states began establishing teams that studied child deaths due to abuse and neglect more closely called Child Death Review Teams or Child Abuse Death Review Teams. The purpose of these teams is to collect data on risk factors that may play a role on these deaths, establish and study trends and gaps in service, and attempt to prevent child abuse deaths from happening in the future. Several states have implemented statutory changes authorizing state and local governments to establish multi -disciplinary committees to conduct detailed reviews of the facts and circumstances surrounding child abuse and neglect deaths (Florida Child Abuse Death Review, 2005).

The fatality review process includes the review of records, post-mortem, that include police reports, court documents and dockets, individual background checks, and medical examiner records. Although encouraged, surviving family members are not always interviewed, mostly due to lack of funding and lack of staff capacity and training. In most instances, these initiatives are not funded, and professionals and agencies that work with victimized families come together voluntarily to put together the puzzle that led up to the death(s). After a case is reviewed, the group reaches consensus to determine recommendations for prevention. A problem that has been identified with respect to this process is the lack of scientific data and study that guides the process, both on the state and local level. This again is mostly a result of lack of funding to support these initiatives, and at times, the lack of knowledge or involvement of institutions of higher learning in the review design and process. The study aims to contribute scientific data that will contribute to the enhancement and effectiveness of fatality review initiatives, in particular to child abuse death reviews, and to encourage more scientific research in this field. The trends observed through the collection and review of these cases formed the hypotheses outlined in this study.

CHAPTER II

Review of the Literature

Most research on child homicides has focused on parents who kill their children as a result of fatal child abuse. Research has found that biological parents are the leading perpetrators of child homicides, particularly of those children aged five or younger (BJS, 2003). Minimal research, however, has focused on the role of the male paramour, or the child's mother's boyfriend, as the perpetrator of child homicides. This group has often been confused either with step-fathers, or other male family acquaintances that commit child homicides. However, because more research is finding that male paramours pose a lethal risk to children, communities are designing public awareness campaigns to address this issue (Florida Child Abuse Death Review, 2005).

Alder and Polk (1996) made interesting arguments relating to the role of masculinity in the homicide of children. Their paper suggests that males perpetrate more violent crime than women in that males have a need to respond violently in order to maintain or regain their authority over the family. Although much of the argument posed is defended by research on child homicide perpetrated by males, Alder and Polk (1996) failed to empirically examine the topic proposed. Rather, they conducted an extensive case study on child homicides perpetrated by men, and reported results based on subjective measures of intent. Based on the limited empirical data presented, one must interpret Alder and Polk's (1996) findings cautiously. This is not to say that their theories are to be discounted, as Alder and Polk's (1996) study is one of few works attempting to reconcile gender differences in child homicide.

Male Paramours

Generally, in the child welfare field it is common knowledge that boyfriends, commonly referred to as paramours, pose a risk when left in the position to baby-sit their girlfriends' children. However, this general statement does not adequately address the issue. That is, are *all* boyfriends a danger to their girlfriends' offspring? At what point then does the issue cross over to common-law marriages or step-fathers? And should there be a distinction? Scientific research does not support the idea that all paramours pose a risk to the children in their care. Rather, there appears to be an overall social issue with respect to paramours who kill their girlfriends' children. Anecdotally, observation of the child abuse death review case studies suggest that these men are likely to be young, have criminal histories, engage in general violence (which may include domestic violence), have substance abuse issues, and have little or no education. Further, these men are often ill equipped with the resources necessary to care for these young children. That is, these men have little or no frustration tolerance, and have little to no attachment to the children they are caring for.

Margolin (1991) studied child maltreatment perpetrated by a non-parental caregiver. She cited research finding adolescent babysitters as common perpetrators of child physical abuse, child neglect, and child sexual abuse. Her research theorized that males are more prone to violence during the care of a child because they are less socialized to perform childcare duties. Moreover, the age of the caregiver also becomes a factor, as the younger caregiver's empathy and patience is less developed than the older caregiver. She also contended that the age and sex of the victim child also plays a role in the child maltreatment, hypothesizing that males under the age of three are more likely to

be physically abused by a non-parental caretaker. The findings of her study suggest that male adolescent babysitters that cared for the victim child in a home presented the greatest risk for child maltreatment, and children under the age of one were at highest risk (Margolin, 1991).

Male paramours who kill their girlfriend's child may be compared to adolescent babysitters in several factors. Primarily, they can be compared in the purpose of their contact with the child, in that male paramours, unlike step-fathers, are likely to have limited exposure to the child, by means of the length of relationship to the child's mother. Further, they may reside elsewhere, and thus their attachment to the child may be quite limited. Mothers, however, may still ask their boyfriends to care for their children, particularly in cases where the mother maybe employed, but remains at a socio-economic disadvantage, and unable to afford outside daycare. It is here that male paramours differ theoretically from step-parents, and should be examined separately due to the innate differences in their relationship with the child.

Biological Fathers and Step-Fathers

The Bureau of Justice Statistics (2006) reported that most child homicides are perpetrated by parents and most are perpetrated by males. Yet most of the research to date has focused on child homicide perpetrated by mothers (Adinkrah, 2003). This is likely due to the research focusing on infanticide, and statistics showing that mothers are more likely than fathers to perpetrate this crime, the reasons for which are out of the scope of this study (Kunz & Bahr, 1996). More recently however, the study of men who kill their children has been receiving more attention.

Daly and Wilson (1988) proposed an evolutionary model to explain violence in families. The authors reported on differences between biological parents and stepparents who engage in child abuse. They noted that when looked at cross-nationally, these differences may reflect cultural attitudes and beliefs. However, the authors contended that there remains a large difference between biological parents and stepparents, in that stepparents often discriminate and spare their own biological children of the abuse perpetrated on the stepchildren in the same household (Daly & Wilson, 1988). Daly and Wilson (1988) argued that stepparents pose a higher lethal risk to children than do biological fathers. Their theory proposed that the risk is largely due to evolutionary theory and the belief that stepparents care less for children in which genetic relatedness is absent. More recent research, however, has found contradictions to Daly and Wilson's theory (Temrin, Buchmayer, Enquist, 2000). Temrin, et al. (2000) presented data that shows that children under the age of three are more likely to be killed by biological parents than stepparents. Additionally, although Daly & Wilson's theory may be true for child abuse in general, homicide data does not support the idea that stepparents represent perpetrators of child homicide above that of biological parents (Miami-Dade County Fatality Review Team Annual Report, in press). Further, the authors reported research supporting the notion that substitute parents represent a higher number of perpetrators of child homicide than biological parents, presuming similarities between stepparents and substitute parents (Temrin, et al., 2000).

Campion, Cravens, & Covan's research (1988) exclusively examined the characteristics of perpetrators, specifically men who committed filicide. The authors attempted to identify factors that led these fathers to kill their children, particularly the

psychological dynamics present in these men. The study makes three main conclusions. First, that most of the men were exposed to a traumatic event at some point in their development. These may include exposure to violence, child abuse, or loss of a parent (Campion, et al., 1983). Second, that most of the men had a psychological or neurological deficit which likely made them vulnerable to commit the homicidal act, and third, that most men lived in poverty or social isolation (Campion, et al., 1983). Inferences, however, must be made with caution as the participants in the study were selected from a psychiatric forensic setting, thus possibly resulting in an overrepresentation of psychiatric and neurological disorder in these men. Additionally, the findings relating to developmental stressors and social isolation may have been more of a factor of chronic mental illness rather than a characteristic of filicidal men.

In general, research on fathers who kill children merge biological fathers, common-law, and legal step-fathers into one group (Crittenden & Craig, 1990). However, there are notable differences between these groups. Specifically, the presence of psychiatric disorders appears to be more relevant in biological parents than in non biological caregivers (Stroud & Pritchard, 2001). Research on fathers who kill has postulated that fathers kill their children for several reasons (Adinkrah, 2003). Among these, is a belief held by the father that his children, in fact his entire family, are an extension of himself. In these cases, the family is viewed as a possession, and these men often may appear obsessed with their partner and children. In light of a disruption in the family, such as divorce, these men may become severely depressed and/or enraged. They are likely to be suicidal, and in believing that his family is part of him, his suicidal ideations easily transition into homicidal ideations. It is hypothesized then, that these

men are more likely than paramours to kill themselves after killing their children. In other cases, although nothing may be wrong with the domestic relationship, some other decompensatory issue, such as unemployment or other financial burden, depression, or medical illness, may be present, which then leads to the suicidal and homicidal ideations.

Child Homicide as Fatal Child Abuse

Browne & Lynch (1995) noted that there is a complex relationship between child homicide and child abuse. Homicides can be examined and clearly operationalized, however, child abuse is seen as a pattern of behaviors having subjective measurement. Gelles (1991) pointed out that little empirical data exists to support the causal relationship between the two acts. Rather, Gelles (1991) theorized that child homicide is a distinct behavior often in need of separate study. Still, many studies make substantial arguments relating child homicide as a form of severe child abuse, or chronic child maltreatment turned fatal. Creighton (1995) noted that documented fatal child abuse cases are too low. This might be because that the younger the child, the more likely the manner of death is classified as accidental (Browne & Lynch, 1995). Creighton (1995) also pointed out that many of these deaths are misclassified as caused by sudden infant death syndrome.

Crittenden and Craig's research (1990) identified several factors associated to fatal child risk, namely physical disabilities or prior records of child abuse and/or neglect. The literature generally supports the idea that child homicides are associated with prior child maltreatment (Fiala, R., & LaFree, G., 1988). Further, Fiala and LaFree's (1988) pioneering work on child homicide made a substantial argument for linking child abuse with child homicide, and presents a review of the literature on the subject. However, in

the study of child homicide, particularly in the study of filicide, researchers are limited in concluding that prior abuse was present, because such abuse may not have been reported.

In Fiala and Lafree's (1988) cross-national study, social variables relating to child homicide were examined. The findings suggest that economic stress in isolation is not a significant factor in the homicide of children, but rather, economic hardship in relation to the status of women offered a substantial explanation (Fiala & LaFree, 1988). For example, economic strain may force women to seek employment with poor compensation and subsequently increase tension in the home leading to child abuse. Therefore it is the interaction between the two variables that poses a risk, rather than the single variable of economic stress or the increase of women seeking employment and being out of the home. Gartner (1991), in another cross-national study, examined similar social variables such as low economic resources, poor social support systems, and family structure. He expanded his study to examine the relationship of these, with child homicide, and social service provisions. Their findings imply that government spending on social services is a mitigating factor, across nations, in variables affecting child homicides, though Briggs and Cutright (1994) found no evidence of such in their study. Although these studies offer compelling perspectives on the social variables that contribute to child homicides, the examination of vague social constructs across cultures may offer confounding variables that affect the measures being examined.

Domestic Violence

The review of the scientific literature overall showed a lack of research involving the co-morbidity of intimate partner homicide and intimate partner violence to the occurrence of child homicide deaths. Epidemiological studies, such as those conducted

by Lyman et al. (2003), failed to show a link between domestic violence and child homicides. This is thought to be due to the population of child victims selected for these studies, as child victims age six or younger. It is believed that upon the review of homicides perpetrated by fathers on children under age 18, more cases involving domestic violence and familicide would be identified.

Appel and Holden (1998) found through a review of empirical research considerable evidence that child physical abuse co-occurs in homes with intimate partner violence. University of Hawaii Center on the Family (2006) reported child abuse facts based on the National Committee to Prevent Child Abuse. They found that prior domestic violence was present in over 50% of these child abuse cases. Little empirical research, however, has studied the relationship between intimate partner homicide and child homicide. Research suggests that biological fathers and step-fathers are more likely than paramours to kill their children in the context of intimate partner violence.

Age and Sex of the Victim Child

Christoffel (1983) proposed a three type developmental model of homicides involving children; the homicide of infants, homicide due to fatal child abuse/neglect after infancy, and homicide in later childhood involving "social vulnerability". Homicide of infants, or infanticide, is defined as the murder of children under the age of one. This type of child homicide is the most common form of child killing (Browne & Lynch, 1995). Infanticide is theorized to be due to a lack of frustration tolerance by the parent, who then reacts violently to difficult infant behavior. These are thought to be acute violent episodes that end fatally, primarily due to the infant's biological nature. Fatal child abuse by contrast is thought to be due to parental or other adult caregiver's chronic

and excessive use of child maltreatment as a form of punishment. Lastly, homicide in later childhood or early adolescence can be compared to that of adult homicide, occurring based on social variables and at random (Christoffel, 1983).

Crittenden and Craig (1990) adopted Christoffel's (1983) developmental model, though amending the theory to look at neonates separate from infants, and grouping older infants to the population of early childhood. Crittenden and Craig (1990) pointed out, that in relative terms, research on child homicide is minimal, mostly due to the complexity of this issue as a three-dimensional problem rather than as a result of a single cause. Their study was instrumental in recognizing multiple variables, noting age in relationship to cultural status, and role and developmental factors relating to a child's physical vulnerability, that contribute to child homicide. This supports research identifying how individual and situational factors interact in an effort to establish an epidemiological approach to prevention (Crittenden & Craig, 1990).

Statistics regarding the sex of victims of child homicide is less clear. The Bureau of Justice Statistics (2005) reported no observable differences between the number of males and females that are killed by their parents, Christoffel (1983) found that child homicide victims tend to be males across all age groups. Bureau of Justice Statistics (2006) also showed that most homicide victim children under the age of five are most likely males that are killed by male perpetrators. Kunz and Bahr (1996) studied profiles of victims and perpetrators, and found with respect to sex that the chances of being killed by a parent during the first week of life was the same for males and females, but found an increase in male victims of parent-child homicides after the first week of life.

Christoffel's (1983) purpose in studying developmental trends in child homicide was to design developmentally appropriate prevention efforts to address the issue. The focus of her study purposely neglected to examine the perpetrators' attitude and intent in carrying out these crimes. This author contends, however, that by examining these issues jointly systems of prevention can be better designed.

In their study, Crittenden and Craig (1990) used age of the child victim as the independent variable, and examined these against the relationship between the child and the perpetrator, other risk factors associated with the act, and the cause of death (i.e., gunshot wound, stabbing, blunt trauma, etc.). The study supported Christoffel's (1983) theory that the child's age is a risk factor, but integrated other variables to find that the developmental trend differed based on the relationship of the victim to the perpetrator (Crittenden & Craig, 1990).

Statistics and research provide overwhelming evidence on the consistency of methods used to perpetrate child homicide, and findings indicate a relationship between the method used and the age of the child. Kunz and Bahr (1996) found that among very young children the predominant causes of death were blunt trauma, suffocation, and drowning, while for older children stabbing and gunshot wounds were the major causes of deaths identified. Cavanagh, Dobash, and Dobash (2005) did research on men who kill children, examining both extra-familial and intra-familial child homicides. Their study cited research which indicates that intra-familial child killings in general are more likely than extra-familial child killings to be committed through the use of blunt instruments. Research suggesting that older children killed, irrespective of relationship to

the perpetrator, show that these were more likely to be committed through the use of firearms (Cavanagh, et al., 2005).

Cavanagh et al's. (2005) research was unique to prior research in that it included not only the review of homicide case records, but involved the extensive interview of perpetrators of child homicides that were confined as a result of their crime. Cavanagh et al. (2005) found that perpetrators noted that a trigger to the killing was poor tolerance to the child's crying. It was theorized that these males viewed the role of caregiver as a mother's responsibility, and not an expectation that should be put upon the father figure. Although this provides a more objective measure of triggers and social variables increasing risk of child homicide, it is important to note that perpetrators who commit suicide after the homicide of their children, is neglected. This population is thought to require a separate explanation when perpetrators do not commit suicide after the killing of their children. In fact, research by Friedman, Hrouda, Holden, Noffsinger, & Resnick (2005) indicate differences between those who kill their children versus those who kill their children and then themselves, noting that perpetrators who also commit suicide frequently have mental health history and show prior signs of depression. It is in this population that the study of psychiatric history and prior use of child abuse by perpetrators becomes most relevant.

Hypotheses

Based on the above-noted research the general hypothesis of this research is that biological fathers and male paramours have significant differences with respect to the reasons for which they perpetrate child deaths. That is, biological fathers or step-fathers are significantly more likely than the child's mother's male paramour to kill their

children due to relationship factors between the perpetrator and the child's mother, while child homicides committed by male paramours in comparison are more likely to have resulted in factors that are individual or child-centered.

Specifically, the following measurable hypotheses have been formulated to demonstrate significant differences between the two groups:

1. Male paramours who perpetrator child homicides are likely to be significantly younger in age than biological fathers that commit such crimes.
2. Male paramours are more likely than biological fathers to have engaged in prior criminal behavior.
3. Male paramours are more likely than biological fathers to have engaged in prior child maltreatment.
4. Male paramours are significantly more likely to kill children under the age of 3, while biological fathers show more variability with respect to the age of the child victim.
5. Biological fathers or step-fathers are significantly more likely than the male paramours to commit suicide after the fatal act.
6. Biological fathers are more likely to have been perpetrators of domestic violence.
7. Biological fathers are more likely to engage in multiple killings than are male paramours.

CHAPTER III

Methods

Subjects/Participants

Decedent children ages 0-17 that were killed at the hands of their biological father, male-stepfather, or biological mother's male paramours between the years 1999 through early 2008 in large urban area will be studied. Only intentional deaths, i.e. homicides, were studied. The total sample size was 25. The perpetrators of these child deaths will be examined as to their age, prior criminal history, including documented domestic violence history, race, employment status, and method used to commit the homicidal act. The commission of suicide by the perpetrator will also be a factor examined.

Procedures

Under the Florida Sunshine Law, records involving closed homicide crimes are open for public review (F.S. 286.011). However, in Florida, fatality review teams are exempt from Sunshine requirements and have the ability to obtain confidential records pertaining to the review of domestic violence homicides (F.S. 741.3165). Under this law, confidential data collected by the review team must remain confidential and reported to the public in aggregate form. For the purposes of this study, aggregate data will be collected from the Miami-Dade County Domestic Violence Review Team's records for the years and variables discussed above.

Measures

The Florida Child Abuse Death Review Data Instrument (Appendix A) was used to obtain data elements for this study. Specifically, redacted instruments, previously

reviewed and finalized by the review team were obtained, with permission, and we analyzed for specific data elements to support the hypothesis proposed. Elements extracted from this form were the demographics of the perpetrators and children, documentation of multiple homicide and/or suicide as part of the homicide incident, cause and manner of death to the child, prior documented domestic violence history and perpetrator criminal history in general, and medical examiner post-mortem evidence of prior physical child trauma.

Analyses

In order to determine whether significant differences were evident between male paramours and biological fathers, the age of the perpetrators and child victims killed by the two groups were compared using an independent samples t-test, with a significance level set at .05. The two groups of male perpetrators were compared on prior domestic violence histories, prior criminal histories, evidence of prior trauma to the child, and perpetration of multiple homicide and post-incident suicide using a chi-square test, with a significance level set of .05. Descriptive statistics were also obtained to demonstrate the difference of the age of the child victim between the two groups.

CHAPTER IV

Results

There was a significant effect for perpetrator age, $t(23)=3.567, p<.01$, with male paramours younger than biological fathers. Table 1. shows the results of the comparison between male paramours and biological fathers with respective to age.

	Perpetrator	N	Mean	Std. Deviation	Std. Error Mean
Age	Biological Father	13	42.23	16.654	4.619
	Paramour	12	24.08	5.931	1.712

Table 1. Comparison of age between male perpetrators

Results did not demonstrate a significant difference between male paramours and biological fathers as it relates to the victim child's age, $t(23)=1.077, p>.05$. Figure 1 and Figure 2 demonstrate the distribution of victim child ages for both groups. Figure 2 shows the presence of an outlier. When removed, significant differences were found, $t(22)=2.146, p<.05$.

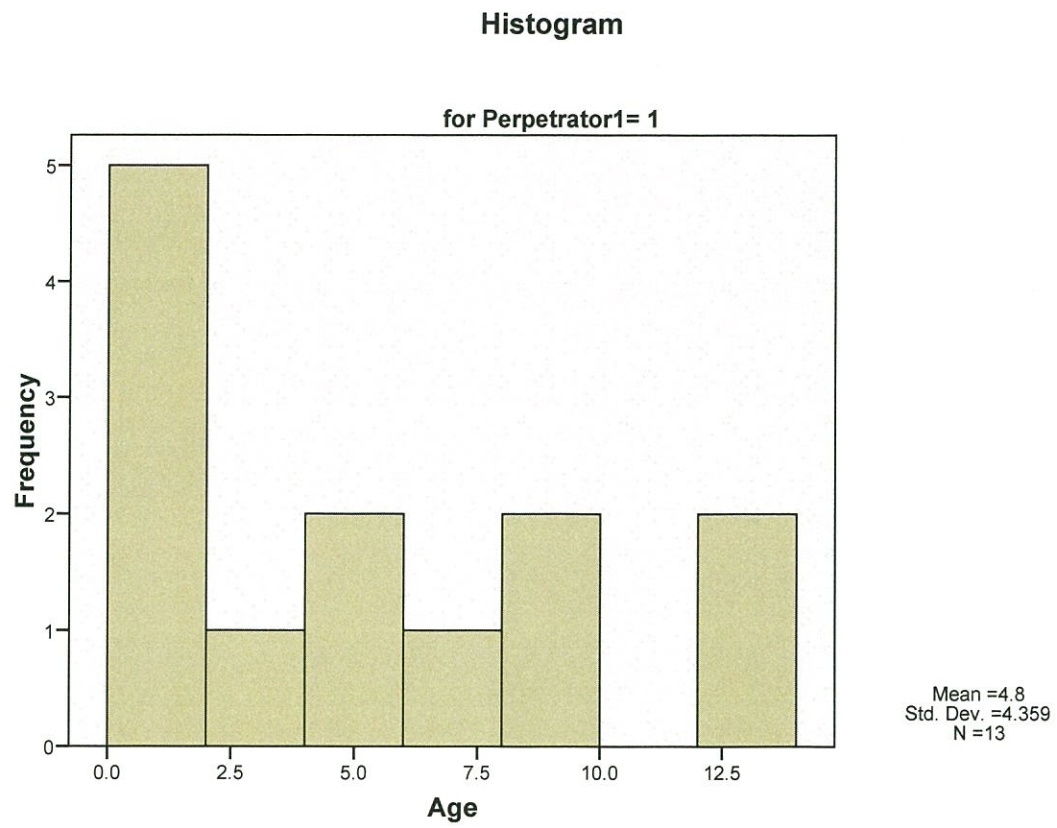


Figure 1. Age of child victims killed by biological fathers

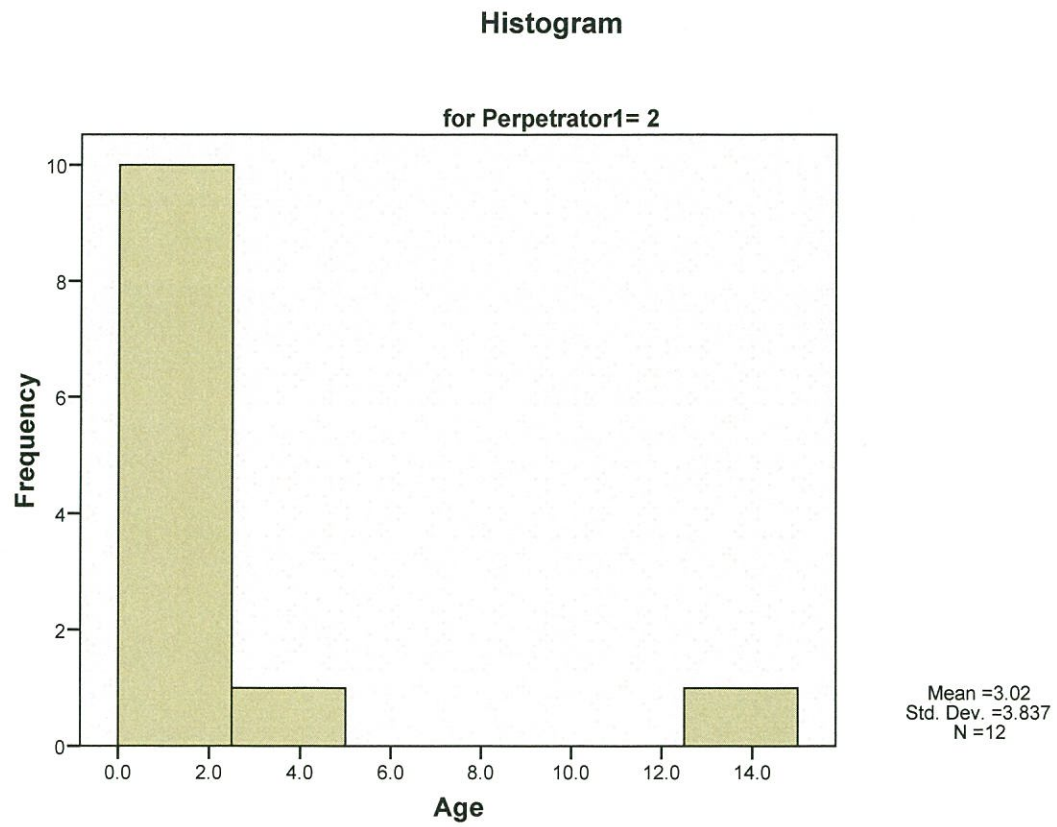


Figure 2. Age of child victims killed by male paramours

The percentage of perpetrators that committed suicide after the child homicide incident did differ between the two groups, $\chi^2(1, N=25)=5.940, p<.05.$, with biological fathers committing suicide in 58% of the cases, compared to 8% of male paramours. perpetrators committing suicide. Additionally, the percentage of perpetrators that committed multiple homicides (killing child and another family member) also differed between the two groups, $\chi^2(1, N=25)=7.667, p<.01,$ with biological fathers killing additional family members in 62% of all cases studied, compared to only 8% in male paramours.

Demonstrating a reverse trend, the percentage of deaths with evidence of prior physical trauma to the child did differ between the two group, $\chi^2(2, N=25)=9.324, p<.01,$ with children killed by male paramours almost 4 times more likely to evidence prior trauma than those killed by their biological fathers (see Table 2.).

		Perpetrator		Total
		Fathers	Paramours	
Prior Trauma	Yes	2	7	9
	No	11	3	14
	Unknown	0	2	2
Total		13	12	25
Percentage with trauma		15%	58%	

Table 2. Comparison of evidence of prior child trauma

There was no difference noted relating to the cause of the child's death when comparing the two groups, $\chi^2(2, N=25)=1.852, p>.05.$ Although no significant effect was found between the cause of the child's death and the age of the child, $t(22)=-1.864, p>.05,$ the average age of children killed by blunt trauma was 3.167 (SD=3.8029) and the average age of children killed by gunshot was 6.667 (SD=4.5461).

The groups did not differ with respect to the presence of prior criminal history, $\chi^2(2, N=25)=1.140, p>.05$. However, the groups did differ with respect to the percentage of subjects with a history of being a perpetrator of domestic violence, $\chi^2(2, N=25)=8.574, p<.05$, with biological fathers being twice as likely to have a documented history of domestic violence compared to that of male paramours.

CHAPTER V

Discussion

The Hypotheses

The overall analysis demonstrates that there are significant differences between male perpetrators of child homicide. The hypothesis that male paramours who perpetrator child homicides were more likely to be younger in age than biological fathers that commit such crimes was validated. This suggests that given the younger age of male paramours who kill children, their level of maturity, parenting skills, and general tolerance may be factors contributing to the deaths of the children in their care. Additionally, the analysis demonstrates that children killed by male paramours are significantly more likely to have evidence of prior physical trauma. This implies that these children have a higher incidence of prior child maltreatment and physical abuse. The findings also suggest that fathers who kill their children, in comparison, may not engage child abuse prior to the homicide. Further, although findings did not demonstrate significant differences between the two groups when comparing the average age of the child victim, the trend clearly shows that male paramours generally kill younger children, or children under the age of 3. When further analyzing these results the presence of an outlier was identified. This case was examined showed that the one child, age 15 was killed by her common-law father. That is, the perpetrator in this instance was the live-in partner of the child's mother for several years. Additionally, the case study demonstrates that the perpetrator has been previously arrested for domestic violence against the child's mother, that the perpetrator also killed the child's mother in this instance, that the child was killed while attempting to intervene in her mother's death, and that the perpetrator

committed suicide after the event. This study shows that the presence of these factors is more likely to be associated with biological fathers. Further, in the analysis of these factors, this case accounted for the only suicide perpetrated by a non-biological father, the only case where a non-biological father killed more than one victim, and 1 of 2 cases where prior child physical abuse was not evident. Given these findings, when removed from analysis significant differences with respect to the child's age was seen between the two groups, where overwhelmingly, paramours were more likely to kill young children compared to fathers who had more variability with respect to the child's age (Figure 1, 2).

These analyses lend support to the claim that male paramours engage in the killing of children in their care due to their own lack of tolerance and poor coping skills. They appear to be placed in babysitting roles of very young children, who require high levels of tolerance and coping. Anecdotally, the case studies reveal that many of these men have been in the home for less than 6 months, and have not had an opportunity to develop an emotional attachment to the children left in their care. Additionally, these case studies reveal that many times, mothers leave these children in the care of an unemployed boyfriend, while they go to work and have little access to daycare.

In comparison, the analysis shows that biological fathers are significantly more likely to have engaged in prior domestic violence, are significantly more likely to kill multiple victims, are significantly more likely to commit suicide after the event. This supports the theory that fathers generally kill in the context of the relationship to the mother or family unit in general. In one case, the father killed his children, ages 12 and 13, while they were home alone. The father called the mother, who was working and

stated that he was on his way to the home to kill their children because she had left him. The mother had secured a restraining order against the father and her address was presumably not available. However, the Perpetrator later admitted that he had followed the children home from school. When he arrived at the home, his son let him in and he proceeded to bludgeon his daughter with a lead pipe while in her sleep. The son attempted to fight him off, as several defensive wounds were discovered, but the father later overpowered him and killed the child in the same manner. The police and mother arrived shortly thereafter, and after his arrest the perpetrator committed suicide by hanging himself with his shoestrings while in jail. Other cases involving domestic violence are similar and in most cases the children are killed not because of their behavior or age, but plainly because they are part of the family unit.

Other cases where fathers kill their children involve mental illness such as the case of an out of town doctor who killed his two young children by throwing them out of a balcony hotel window, and then jumping himself. There was no evidence of prior domestic violence, however, there was evidence of family difficulties and many noted that the perpetrator had been evidencing bizarre behavior in the days just preceding the fatal incident. When reviewing the cases, a common factor among fathers seems to be that there is a perceived threat to the family unit, whether it be through the father's own individual's health, mental or physical, or through separation.

The hypothesis that was not validated was the paramours are more likely to engage in prior criminal behavior than are biological fathers. The analysis did not demonstrate this trend. One reason could be because the study did not control for domestic violence arrests. That is, fathers were more likely to engage in prior

documented domestic abuse, which includes arrests for domestic violence. However, they may not engage in general or habitual crime otherwise. Future analysis should focus on controlling for domestic violence when comparing criminal history. This may help to scientifically examine individual characteristics in paramours that may contribute to these deaths.

Limitations of the Study

A clear limitation to this study is the small sample size involved in analysis. This is due primarily to the fact that child homicides are generally a rare event. Additionally, the sample involves subject from only one large urban area that may not be representative of other populations or jurisdictions.

Implications for Practice and Future Research

The main purpose of this research is to contribute to the limited knowledge base on child homicides and to the differences between perpetrators of child homicides in general. Additionally, the study demonstrated the need to utilize scientific methodology when engaging in the fatality review process. Specifically, that obtaining objective data on child deaths should be encouraged, and that conducting scientific analysis of the data should be utilized to provide informative and effective prevention strategies and recommendations for practice changes.

This research demonstrates the need for prevention strategies and campaigns to target groups differently. Specifically, because batterers may not engage in child abuse, many victims of domestic violence generally do not perceive the danger that batterers pose on their children. Yet, a primary reason for victims to seek safety is to protect their children. The findings of this research imply that batterers are in fact a lethal threat to

their children, particularly upon separation. The author finds it necessary to state, however, that although this research should be used to help victims obtain safety and prevent child deaths, that the use of this research to remove children from the care of the non-offending parent for failure to protect is not warranted. That is, the goal should be to increase victim awareness and prevention of domestic violence in general.

With the growing body of scientific research demonstrating the effects of domestic violence on children, it would also be interested to compare prior incidents of exposure of domestic violence on children by fathers who engage in child homicides versus those who engage in domestic violence in general. This may compound the argument that batterers who engage in physical violence in the presence of children should be arrested for domestic violence and child abuse.

Future research should also compare perpetrators of child deaths with respect to criminal history, while controlling for domestic violence. This will allow for the analysis of trends between the two group with respect to general violent or general criminal behavior and how these factors either do or do not play a role in the child death incident. Additionally, research comparing mothers and father who kill their children is encouraged.

Lastly, this research implies that single mothers with young children are in need of more resources to provide childcare. Unfortunately, at present government funding threatens the livelihood of the already scarce resources for the provision of childcare to young mothers. Trends in child deaths should be continually examined to determine whether these funding cuts and lack of community resources results in an increase of child deaths, particularly by paramours, in the next coming years.

Public Policy

This research should be used to inform public policy practice and law. Specifically, the fatality review process should be informed by research and psychology. Information should be used not only to provide recommendations that have scientific backing, but also to enhance the design of the data collection instrument and systematically collect objective information that can be used to further research. Examples of this would be to include factors such as immigration status or the length of time residing in the United States, and unemployment. Additionally, the results showing that cause of death is not a significant factor that differentiates these deaths suggests the need to categorize child deaths according to the dynamics found, such as domestic violence, mental health, or fatal child abuse.

As stated above, this research should also help guide funding that can be effective in preventing child deaths. Although the process itself is regulated through statutory mandate, and in many states the review findings are exempt from public release of confidential information, the process is still constrained by HIPPA requirements demanding patient privacy, and as such, confidential, but relevant, information on mental health is not available. These make it necessary for information of this nature to be collected through the interview of surviving family members and with proper consents and releases. However, a limitation of the child death process and subsequent research is that the process itself is generally an unfunded initiative. As such, resources do not exist to gather information on undocumented domestic violence, history of child abuse of parents, and history of mental illness.

Lastly, the information provided in this study should be used to guide the family court system, the dependency system, and the field of domestic violence. Findings suggest the need for these systems to work together so that factors are clearly identified and children are kept safe, while also accounting for the safety of victims and accountability of batterers. As stated earlier the goal should not be to remove children from the care of the non-offending parent, or to punish non-offending parents by labeling them as evidencing “parental alienation syndrome”, but rather to understand the complex dynamics involved to informed custody, protection, and justice.

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APPENDIX A

State of Florida Child Abuse Death Review Data Instrument

C. CHILD ABUSE/NEGLECT (Information provided by Department of Children and Families)

1. Were there abuse/neglect reports on any of the following prior to child's death?
(Please indicate for all household members)

	YES	# OF REPORTS		NO	Not Applicable
		In State	Out of State		
a) Child	<input type="checkbox"/>	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
b) Sibling(s)	<input type="checkbox"/>	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
c) Parent	<input type="checkbox"/>	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
d) Caretaker	<input type="checkbox"/>	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
e) Paramour	<input type="checkbox"/>	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
f) Step parent	<input type="checkbox"/>	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>

2. Prior report on child at time of death? a) XXXX (years) XXXXX (months) c) N/A (no priors)

3. Prior reported maltreatment(s): (Check only one)

a) Priors of abuse b) Priors of neglect c) Priors of abuse and neglect d) N/A (no priors)

4. Was there an active child protection investigation report at time of death? a) Yes b) No c) N/A (no priors)

5. Was child previously adjudicated dependent? a) Yes b) No c) Unknown

6. Was child under supervision of the department at the time of or prior to death?

a) Under supervision at time of death b) Previously under supervision c) Never under supervision d) Unknown

7. Child previously/currently received mental health services. | a) Yes | b) No | c) Unknown

8. Were child's siblings previously adjudicated dependent?

a) Yes b) No c) Unknown d) N/A (no siblings)

9. Were siblings under supervision of the department at the time of or prior to child's death?

a) Under supervision at time of death b) Previously under supervision c) Never under supervision e) N/A (no siblings)
d) Unknown

10. Deceased child was diagnosed as having one or more of the following which increased his or her vulnerability.

a) Physical disability b) Developmental disability or delay c) Emotional disability d) Medical condition e) Other _____ f) Not applicable (No handicaps)

11. Child, prior to death, exhibited one or more of the following behaviors that may have been indicative of abuse or neglect:

a) Enuretic and/or encopretic b) Physical harm to self c) Use of drugs or alcohol d) Physical aggression and/or threats e) Fire setting f) Age-inappropriate sexual behavior and/or knowledge g) Running away from home h) Suicidal thoughts or threats i) Sexual abuse perpetrator j) Expression of fear of caregiver(s) and/or others living in or frequenting the home k) Excessive school absenteeism l) Cruelty to animals m) Other _____ n) No behaviors exhibited o) Not applicable (child too young - <1) p) Unknown

12. One or more of the following risk factors prior to and at time of child's death:

	Yes	No	Unknown
a) One or more children in the home are age 4 or younger or nonverbal?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) Children have limited community visibility?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c) Other child(ren) in home exhibit behaviors that may be indicative of abuse or neglect?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d) Living conditions are physically hazardous to the health of the children?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e) Parent/caregiver is responsible for the death or serious injury of another child?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f) Parent/caregiver's criminal history presents a potential threat of harm to the child(ren)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g) Parent/caregiver or other subjects of report have been responsible for acts of animal cruelty?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h) Parent/caregiver describes or acts toward child(ren) in negative terms or has unrealistic expectations?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i) Parent/caregiver has made plausible threat that would result in serious physical harm to the child(ren)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
j) There is a pattern of escalating and/or continuing incidents of domestic violence?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
k) Parent/caregiver is unable or unwilling to protect the child(ren) from abusive caregivers/paramours?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
l) Parent/caregiver has not met or is unable to meet child(ren)s immediate needs for food/clothing/shelter/medical care or protection from harm?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
m) Parent/caregiver's age, mental health or substance/alcohol use affects ability to adequately care for child(ren)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
n) Pattern of escalating, and/or frequency of incidents of abuse or neglect, regardless of findings?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
o) Prior reports involving any of the household members, regardless of report findings?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

13. Other children in the home have been diagnosed as having one or more of the following which increases his or her vulnerability.

a) Physical handicap b) Developmental handicap c) Emotional handicap d) Medical condition e) Other _____ f) Not applicable (no handicap/no siblings) g) Unknown

D. LAW ENFORCEMENT (Information provided by law enforcement and state attorney)

1. Law enforcement has had prior involvement with the family? a) Yes b) No c) Unknown
2. If yes, law enforcement involvement consisted of the following: (Check all that apply)
- a) Call to the home regarding domestic violence c) Calls to the home regarding neighbor disputes
- b) Arrest of one or more household members d) Other (specify) _____

E. DOMESTIC VIOLENCE (Information provided by law enforcement, Department of Children and Families and other agencies familiar with the family)

1. There is a history of domestic violence in the home of the parent/caretaker? a) Yes b) No c) Unknown
- If Yes, complete the following questions.
2. If yes, was there an increase in frequency prior to child's death? a) Yes b) No c) Unknown
3. The incidents of domestic violence were: a) documented b) Undocumented c) Other _____
4. If domestic violence history was documented was a safety plan developed as part of the agency/department's involvement with the family? a) Yes b) No c) Unknown
5. Was the non-abusive parent involved in the development of the family safety plan? a) Yes b) No c) Unknown
6. The children: (Check all that apply)
- a) Have witnessed the domestic violence (hearing/seeing) c) Have been intentionally injured during domestic violence incidents
- b) Have been injured during attempts to intervene.

F. DEATH/AUTOPSY INFORMATION (Information provided by law enforcement and Medical Examiner)

1. Place of injury/illness event that resulted in death? XXXXXXXXXXXXXXX
- a) Child's home e) Parking lot i) Other private property m) Body of water
- b) Other home f) Street j) Licensed child care facility n) Work place
- c) Hospital g) Driveway k) Unlicensed child care facility o) Other _____
- d) Highway h) Wooded area l) Child care residential facility
2. Date of injury/illness event? XXXXXXXXXXXX (MM/DD/YYYY) Unknown
3. Time of injury/illness event? XXXXXXXXXX (hours/minutes) AM PM Unknown
4. Date pronounced dead? XXXXXXXXXXXX (MM/DD/YYYY)
5. Time pronounced dead? XXXXXXXXXX (hours/minutes) AM PM Unknown
6. Autopsy performed? a) Yes b) No c) Unknown
7. Death scene investigation conducted by:
- a) Law enforcement c) Fire investigator e) Other agency
- b) Medical examiner d) EMS f) Not conducted
8. If an autopsy was performed, was there evidence of prior trauma?
- a) Yes b) No c) Unknown d) No autopsy
9. Primary cause of death? _____ ICD10 codes, if known _____
10. Secondary cause of death? _____ ICD10 codes, if known _____
11. Manner of death?
- a) Natural * b) Accident c) Homicide d) Suicide e) Undetermined f) Pending
12. Was this a murder/suicide? | a) Yes | b) No |
13. If suicide, mark all that apply:
- a) Prior Attempts c) Prior mental health history e) Suicide Unexpected (No indicators)
- b) Suicide Ideation d) Suicide unexpected

G. SUPERVISION (Information provided by law enforcement and Department of Children and Families)

1. Who was in charge of watching the child at the time of injury/illness event?

- | | | |
|---|---|---|
| a) <input type="checkbox"/> Biological father | i) <input type="checkbox"/> Foster father | p) <input type="checkbox"/> Licensed babysitter/child care worker |
| b) <input type="checkbox"/> Biological mother | j) <input type="checkbox"/> Foster mother | q) <input type="checkbox"/> Unlicensed babysitter/child care worker |
| c) <input type="checkbox"/> Grand father | k) <input type="checkbox"/> Uncle | r) <input type="checkbox"/> Other non-relative: _____ |
| d) <input type="checkbox"/> Grand mother | l) <input type="checkbox"/> Aunt | s) <input type="checkbox"/> Child, age: _____ |
| e) <input type="checkbox"/> Adoptive father | m) <input type="checkbox"/> Male paramour | t) <input type="checkbox"/> Hospital staff |
| f) <input type="checkbox"/> Adoptive mother | n) <input type="checkbox"/> Female paramour | u) <input type="checkbox"/> No one in charge of watching |
| g) <input type="checkbox"/> Step father | o) <input type="checkbox"/> Other relative: _____ | v) <input type="checkbox"/> Due to child's age, no one in charge |
| h) <input type="checkbox"/> Step mother | | |

2. Was the child adequately supervised? a) Yes b) No c) Unknown d) Not applicable

If No:

- a) At the time of the injury/illness, did the person(s) in charge appear to be:
- | | | | |
|--|--|---|--|
| 1) <input type="checkbox"/> Intoxicated | 3) <input type="checkbox"/> Mentally ill/limited | 5) <input type="checkbox"/> Other _____ | 7) <input type="checkbox"/> Not impaired |
| 2) <input type="checkbox"/> Under the influence of drugs | 4) <input type="checkbox"/> Otherwise impaired | 6) <input type="checkbox"/> Unknown | |
- b) Was the child in sight of the person in charge at the time of illness/injury event?
- | | | |
|---------------------------------|--------------------------------|-------------------------------------|
| 1) <input type="checkbox"/> Yes | 2) <input type="checkbox"/> No | 3) <input type="checkbox"/> Unknown |
|---------------------------------|--------------------------------|-------------------------------------|
- c) At the time of illness/injury was the person(s):
- | | | | |
|--|------------------------------------|-------------------------------------|---------------------------------|
| 1) <input type="checkbox"/> Distracted/preoccupied | 2) <input type="checkbox"/> Asleep | 3) <input type="checkbox"/> Unknown | 4) <input type="checkbox"/> N/A |
|--|------------------------------------|-------------------------------------|---------------------------------|
- d) Is the person(s) responsible for supervising other children? a) Yes b) No c) Unknown

3. Was the injury/illness witnessed by anyone other than the person(s) responsible for supervision of the child?

- a) Yes b) No c) Unknown

H. PERPETRATOR INFORMATION (Complete questions 2-4 only if information from either law enforcement, state attorney or the Department of Children and Families identifies the perpetrator(s).)

1. Has the perpetrator(s) been identified? a) Yes b) No c) Unknown

2. Indicate relationship, race, sex and age of perpetrator(s) identified. (Use codes from Section A for race. Use codes "F" for female and "M" for male when identifying the sex of the perpetrator.)

	RACE	SEX	AGE
a) <input type="checkbox"/> Biological father	_____	_____	_____
b) <input type="checkbox"/> Biological mother	_____	_____	_____
c) <input type="checkbox"/> Grand father	_____	_____	_____
d) <input type="checkbox"/> Grandmother	_____	_____	_____
e) <input type="checkbox"/> Adoptive father	_____	_____	_____
f) <input type="checkbox"/> Adoptive mother	_____	_____	_____
g) <input type="checkbox"/> Step father	_____	_____	_____
h) <input type="checkbox"/> Step mother	_____	_____	_____
i) <input type="checkbox"/> foster father	_____	_____	_____
j) <input type="checkbox"/> Foster mother	_____	_____	_____
k) <input type="checkbox"/> Uncle	_____	_____	_____
l) <input type="checkbox"/> Aunt	_____	_____	_____
m) <input type="checkbox"/> Male paramour	_____	_____	_____
n) <input type="checkbox"/> Female paramour	_____	_____	_____
o) <input type="checkbox"/> Other relative	_____	_____	_____
p) <input type="checkbox"/> Sibling	_____	_____	_____
q) <input type="checkbox"/> Other non-relative	_____	_____	_____
r) <input type="checkbox"/> Babysitter/child care worker	_____	_____	_____
s) <input type="checkbox"/> Acquaintance/Friend	_____	_____	_____
t) <input type="checkbox"/> Stranger	_____	_____	_____
u) <input type="checkbox"/> Other child	_____	_____	_____

3. Please complete the following information for each identified perpetrator. Enter a Y (Yes) N (No) or U (Unknown)

	PRIMARY PERPETRATOR (1)- RESPONSIBLE FOR DEATH	PERPETRATOR (2) - JOINTLY OR INDIRECTLY RESPONSIBLE FOR DEATH
a) Mental health history	_____	_____
b) Perpetrator of domestic violence	_____	_____
c) Victim of domestic violence	_____	_____
d) Victim of child abuse/neglect	_____	_____
e) Prior perpetrator of child abuse/neglect	_____	_____
f) History of alcohol abuse	_____	_____
g) History of substance abuse	_____	_____
h) Criminal Record	_____	_____
i) Physically/Emotionally handicapped	_____	_____
j) Prior perpetrator of Shaken Baby	_____	_____

H. PERPETRATOR INFORMATION (Continued)

4.. Status of criminal action concerning child's death: XXXXXXXXXXXXXXXXXXXX

- a) investigation still pending
- b) No charges filed
- c) Not prosecuted or nol prossed
- d) Charges filed, disposition pending
- e) Convicted
- f) Acquitted
- g) Unknown
- h) Incompetent to proceed
- i) No, perp committed suicide

5. Perpetrator's criminal charge XXXXXXXXXXXXXXXXXXXX

- a) Murder
- b) Manslaughter
- c) Child abuse
- d) Negligence
- e) Other (specify) _____
- f) Unknown

6. Perpetrator's criminal conviction: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

- a) Murder
- b) Manslaughter
- c) Child abuse
- d) Negligence
- e) Other (specify) _____

I. INFANT DEATHS (Complete for deaths of <1 year of age) (Information provided by medical providers)

XXXXXXXXXXXX SECTION WILL BE RETRACTEDXXXXXXXXXXXXXXXXXXXX

- 1. Child regularly exposed to tobacco smoke? | Yes | No | Unknown
- 2. Drug use during pregnancy? | Yes | No | Unknown
- 3. Alcohol use during pregnancy? | Yes | No | Unknown
- 4. Age at death
 - a) 0-48 hours after birth
 - b) 3 – 28 days
 - c) 29 days - 6 months
 - d) 7 months – 1 year
- 5. Gestation age at birth?
 - a) < 25 weeks
 - b) 26-30 weeks
 - c) 31-37 weeks
 - d) > 37 weeks
 - e) Unknown
- 6. Birth weight in grams (approx. lbs./oz)
 - a) <750 (<1 lb. 10 oz)
 - b) 750 – 1499 (1 lb. 10 oz - 3 lbs. 5 oz)
 - c) 1500 – 2499 (3 lbs. 6 oz – 5 lbs. 5 oz)
 - d) >2500 (>5 lbs. 6 oz)
 - e) Unknown
- 7. Multiple births? (Number of times mother has given birth) a) Yes b) No
- 8. Total number of prenatal visits
 - a) None
 - b) 1-3
 - c) 4-6
 - d) 7-10
 - e) Unknown
- 9. First prenatal visit occurred during?
 - a) First trimester
 - b) Second trimester
 - c) Third trimester
 - d) Unknown
- 10. Medical complications during pregnancy? a) Yes b) No c) Unknown
- 11. Type of complications:
 - a) Diabetes
 - b) Hypertension
 - c) Anemia
 - d) Trauma
 - e) Infection
 - f) Other _____

J. CIRCUMSTANCES OF DEATH (Information provided by law enforcement and Medical Examiner's Office)

Check the appropriate circumstance below, then locate and complete the corresponding subsection.

- | | |
|--|---|
| <input type="checkbox"/> Inadequate Care/Neglect | <input type="checkbox"/> Fall/Injury |
| <input type="checkbox"/> Child Left In Car | <input type="checkbox"/> Poisoning/Overdose |
| <input type="checkbox"/> Vehicle Crash Related Death | <input type="checkbox"/> Fire/Burn |
| <input type="checkbox"/> Drowning | <input type="checkbox"/> Inflicted Injury |
| <input type="checkbox"/> Firearm | |
| <input type="checkbox"/> Suffocation/Strangulation | |

INADEQUATE CARE OR NEGLECT (Mark all that apply)

- | | | |
|---|--|--|
| 1) <input type="checkbox"/> Apparent lack of supervision | 6) <input type="checkbox"/> Dehydration | 10) <input type="checkbox"/> Out-of-hospital birth |
| 2) <input type="checkbox"/> Apparent lack of medical care | 7) <input type="checkbox"/> Oral water intoxication | 11) <input type="checkbox"/> Failure to Protect |
| 3) <input type="checkbox"/> Munchausen's Syndrome by Proxy | 8) <input type="checkbox"/> Delayed medical care | 12) <input type="checkbox"/> Other |
| 4) <input type="checkbox"/> Failure to thrive (non-organic) | 9) <input type="checkbox"/> Inadequate medical attention | |
| 5) <input type="checkbox"/> Malnutrition | | |

CHILD LEFT IN VEHICLE

Please check all that apply

- 1) Incident was a) Intentional b) Unintentional
- 2) Child got in vehicle on own
- 3) Child left in vehicle
- 4) Vehicle was:
a) Locked b) Unlocked
- 5) Length of time child left in vehicle before being discovered? _____ (hours) _____ (minutes)
- 6) Was parent/caretaker typically responsible for transporting child? a) Yes b) No

VEHICLE CRASH RELATED DEATH

1. Vehicle Crash was: a) Intentional b) Unintentional
2. Incident occurred where?
a) On road b) In driveway c) In parking lot
3. Position of child?
a) Operator c) Front seat passenger e) Bicyclist g) Unknown
b) Pedestrian d) Back seat passenger f) Other
4. Vehicle in which child was occupant?
a) Car d) Bicycle g) Semi-Tractor trailer j) Not applicable
b) Truck/RV/Van e) Riding Mower h) Farm tractor
c) Motorcycle f) All terrain vehicle i) Other
5. Vehicle in which child was not occupant
a) Car d) Bicycle g) Semi-Tractor trailer j) Not Applicable
b) Truck/RV/Van e) Riding mower h) Farm tractor
c) Motorcycle f) All terrain vehicle i) Other
6. Condition of road?
a) Normal b) Loose gravel c) Wet d) Other _____ e) Unknown
7. Restraint used?
a) Present, not used c) Used correctly e) Unknown
b) None in vehicle d) Used incorrectly f) Not applicable
8. Helmet used?
a) Helmet worn b) Helmet not worn c) Not applicable
9. Alcohol and/or other drug used?
a) Child impaired c) Driver of other vehicle impaired e) Unknown
b) Driver of child's vehicle impaired d) Not applicable
10. Primary cause of accident?
a) Speeding c) Weather conditions e) Unknown f) Impaired driver
b) Mechanical failure d) Driver error g) Other _____ h) Road rage

DROWNING

1. Drowning was: a) Intentional b) Unintentional
2. Place of drowning?
a) Lake, river, pond, creek, ocean c) Swimming pool e) Bucket g) Other
b) Bathtub d) Well/Cistern f) Wading pool h) Unknown
3. Activity at time of drowning?
a) Boating c) Swimming e) Other _____
b) Playing at water's edge d) Playing in water f) Unknown
4. Was child wearing a floatation device? a) Yes b) No c) Not applicable
5. Did child enter area of water unattended? a) Yes b) No c) Unknown d) Not applicable
6. Did parent/caregiver know CPR? a) Yes b) No c) Unknown d) Not applicable
7. Was safety equipment available in area? a) Yes b) No c) Unknown
8. If drowning occurred in pool:
- | | Yes | No | Unknown | Not Applicable |
|-------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| a. Was the pool fenced? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Was lock secure? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Was yard fenced? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Was lock secure? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
9. Could child swim? a) Yes b) No c) Unknown d) Not applicable
10. Was child under the influence of alcohol or drugs? a) Yes b) No c) Unknown

FIREARM

1. Shooting was: a) Intentional b) Unintentional
2. Person handling the firearm?
a) Child b) Family member c) Acquaintance d) Stranger e) Unknown
3. Type of firearm?
a) Handgun b) Rifle c) Shotgun d) Other e) Unknown
4. Age of person handling firearm? a) _____ (Indicate age) b) Unknown
5. Source of firearm
a) Parent b) Other relative c) Acquaintance d) Stranger e) Unknown
6. Storage location of firearm prior to injury?
a) Secured b) Unsecured c) Unknown
7. Use of firearm at time of injury?
a) Shooting at other person d) Target shooting g) Playing
b) Shooting at self e) Loading firearm h) Other
c) Cleaning firearm f) Hunting i) Unknown

SUFFOCATION/STRANGULATION/ASPHYXIATION

1. Incident was: a) Intentional b) Unintentional
2. Cause of suffocation/strangulation/asphyxiation?
a) Other person overlay or rolling over child g) Small object or toy in mouth
b) Wedging h) Hanging
c) Food i) Trapped in confined space
d) Other person's hand j) Other
e) Object covering child's mouth/nose k) Unknown
f) Object exerting pressure on victim's neck/chest
3. Location of child when discovered?
a) In crib/bed c) Being held e) On floor (DEACTIVATE)
b) On couch/chair d) In infant car seat f) Other (Specify) _____ h) Playpen
4. Child sleeping: a) Alone b) With adult/caregiver c) with another child d) Unknown
5. If bedding was involved:
- | | Yes | No | Unknown |
|---|--------------------------|--------------------------|--------------------------|
| a) Was the design of the bed hazardous? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

- b) Was the child placed on soft bedding
- c) Was there improper use of bedding?

6. Position of child at discovery

- a) On stomach, face down c) On stomach, face position unknown e) On side
- b) On stomach, face to side d) On back f) Unknown

7. If known, normal sleeping position

- a) On back d) Varies
- b) On Stomach e) Unknown
- c) On Side

8. Item in contact with child:

- a) Sheet d) Plastic item
- b) Blanket/Comforter e) Other _____ (Indicate)
- c) Bumper guard

FALL INJURY

1. Fall was: a) Intentional b) Unintentional
2. Fall was from?
a) Open window c) Natural elevation e) Man made elevation g) Unknown
b) Furniture d) Stairs or steps f) Other (Specify) _____
3. Height of fall? a) # of feet _____ b) Unknown
4. Landing surface composition/hardness? a) Carpet b) Concrete c) Ground d) Other
5. Was child in baby walker? a) Yes b) No c) Not applicable
6. Was child thrown or pushed down? a) Yes b) No c) Unknown

POISONING/OVERDOSE

1. Poisoning/Overdose was: a) Intentional b) Unintentional
1. Type of poisoning?
a) Prescription medicine d) Illegal drug g) Food product
b) Over-the-counter medicine e) Alcohol h) Other
c) Chemical f) Carbon monoxide or other gas inhalation
2. Location of poisoning agent?
a) In closed, secured area b) In closed, unsecured area c) In open area
3. Was substance in safety packaging?
a) Yes b) No c) Unknown d) Not applicable
4. Poison contained in:
a) Pill bottle b) Commercial package c) Formula bottle D) Other (Specify)

FIRE/BURN

1. Fire was: a) Intentional b) Unintentional
2. If fire, the source?
a) Matches c) Cigarette e) Explosives g) Space heater i) Other
b) Lighter d) Combustible f) Fireworks h) Faulty wiring j) Unknown
3. Smoke alarm present? a) Yes b) No c) Unknown d) Not applicable
4. Smoke alarm in working order? a) Yes b) No c) Unknown d) Not applicable
5. Fire started by?
a) Deceased Child c) Other (Specify) _____ e) Unknown
b) Sibling d) No one
6. Activity of person starting fire?
a) Playing c) Cooking e) Other _____ g) Not applicable
b) Smoking d) Suspected arson f) Unknown
7. Construction of fire site?
a) Wood frame c) Metal e) Other
b) Brick/stone d) Trailer f) Not applicable
8. Multiple fire injuries or deaths? a) Yes b) No

9. For structure fire, where was child found?

- a) Hiding b) In bed c) Stairway d) Close to exit e) Other

10. Did child know of a fire escape plan?

- a) Yes b) No c) Unknown d) Not applicable

11. If burned, the source?

- a) Hot water b) Heater c) Appliance d) Chemical e) Cigarettes f) Other g) Unknown

INFLECTED INJURY

1. Inflicted Injury was:

- a) Intentional b) Unintentional

2. Type of Injury

- a) Beating Deactivate b) Head Trauma c) Trauma to torso/abdomen d) Multiple trauma e) Stabbing f) Scalding/hot object g) Excess heat Impact h) Hypothermia i) Object fell on child j) Other _____ k) Shaken baby

3. Suspected Triggers

- a) Crying b) Toilet Training c) Disobedience d) Feeding difficulty e) Medical triggers (illness, shots, disability) f) Other Specify _____ g) Unknown

4. Manner of injury?

- a) Cut/stabbed b) Struck c) Thrown d) Crushed e) Other _____ f) Unknown

5. Injury inflicted with?

- a) Sharp object (e.g. knife, scissors) b) Blunt object e.g. hammer, bat c) Hands/feet d) Other e) Unknown

K. STATE OR LOCAL TEAM CONCLUSIONS

1. Date of meeting: XXXXXXXXXXXXXXXXXXXX (MM/DD/YYYY)

2. Members participating: XXXXXXXXXXXXXXXXXXXX

- a) Medical examiner b) State attorney c) Law enforcement d) Public health/physician e) DCF staff f) DOH staff g) DJJ staff h) Community providers i) Other members

3. Prior history of Shaken Baby (Victim)

- a) Yes b) No c) Unknown

3. Agency/Community Services Review:

XXXXXXXXXXXXXXXXXXXX Prior community services a) Yes b) No (go to question 4)

Agency/Department Name	Services Provided	Services Refused	Service Provision Appears Adequate
			Yes No Unknown
Department of Health	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Department of Children and Families	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Child Protection Team	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Department of Juvenile Justice	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Mental Health Agency	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Community Based Care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

4. Did team review lead to a recommendation of additional investigation activities? If Yes, which department?

- a) Yes, DCF b) Yes, law enforcement c) Yes, both d) No

5. After review and consideration the team determined the manner of death for child was:

- a) Natural b) Accidental c) Homicide d) Suicide e) Undetermined

6. Does the team agree with the conclusion that this is an abuse/neglect death?

- a) Yes b) No c) Unknown d) N/A (Not Abuse/Neglect Death)

7. Does the team agree with the information on the death certificate?

- a) Yes b) No (specify in Comment Section)

8. As a result of the team review issues were identified in the following area: (check all that apply and provide brief comment)

- a) Protective investigation _____
- b) Criminal investigation _____
- c) Provision of services _____
- d) Availability of resources in the community _____
- e) Department/agency policies and practice _____
- f) Local ordinance _____
- g) State statute _____
- h) None _____
- i) Community Based Care _____

9. All appropriate information was made available to the team? a) Yes b) No (Specify)

10. Did the team encounter any problems while reviewing this child's death?

- a) Yes (Specify) _____
- b) No

L. PREVENTION

A preventable death is one in which with retrospective analysis it is determined that reasonable intervention could have prevented the death. The identification of risk factors/issues that will help in preventing similar child deaths can be accomplished through the systematic, multi-disciplinary, multi-agency and multi-modality review of child abuse and neglect deaths in Florida.

1. To what degree was this death believed to be preventable?

- a) Not at all
- b) Possibly
- c) Definitely

2. Possibly Preventable By:

- a) Caretaker: System Both
- b) N/A (Not Applicable)

3. Definitely Preventable By:

- a) Caretaker: System Both
- b) N/A (Not Applicable)

4. Primary risk factors involved in the child's death? (Mark all that apply)

- a) Medical
- b) Social
- c) Economic
- d) Behavioral
- e) Environmental
- f) Product safety
- g) Drugs or alcohol
- h) Other

5. Could the caregiver have taken action to reduce the risk?

- a) Yes
- b) No
- c) Unknown

6. What prevention activities have been proposed as a result of this death? (A specific recommendation must be made for each area checked)

- a) Changes in legislation or law
- b) Changes in local ordinance
- c) Community safety project
- d) Public forums
- e) Educational activities in school
- f) Educational activities in the media
- g) Consumer product safety action
- h) News services
- i) Changes in agency/department practice
- j) Other programs or activities (specify) _____
- k) None