Child Abuse Death Review Committee

Working to eliminate preventable child abuse and neglect deaths in Florida

Annual Report

December 2017

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MISSION:

To eliminate preventable child abuse and neglect deaths

Submitted to:

The Honorable Rick Scott, Governor, State of Florida
The Honorable Joe Negron, President, Florida Senate
The Honorable Richard Corcoran, Speaker, Florida House of Representatives

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EXECUTIVE SUMMARY

Florida's Child Abuse Death Review Process

Section 383.402, Florida Statutes (FS), authorizes the State and Local Child Abuse Death Review (CADR) Committees and mandates guidelines for membership and duties. The Florida CADR system was established in Florida law in 1999. The program is administered by the Florida Department of Health (DOH) and utilizes Local CADR committees to conduct detailed reviews of the facts and circumstances surrounding child deaths reported to the Florida Abuse Hotline and accepted for investigation. The State CADR Committee collects and analyzes data from the local reviews and prepares an annual statistical report, which is submitted to the Governor, President of the Senate, and Speaker of the House of Representatives.

The purpose of the CADR process is to:

- Develop a community-based approach to address child abuse deaths and contributing factors;
- Achieve a greater understanding of the causes and contributing factors of deaths resulting from child abuse or neglect;
- Identify gaps, deficiencies, or problems in service delivery to children and families by public and private agencies that may be related to child abuse deaths;
- Develop data-driven recommendations for reducing child abuse and neglect deaths; and
- Implement such recommendations, to the extent possible.

Since the inception of the CADR system, changes in statutory requirements have gradually widened the scope of child fatality cases committees are expected to review. Currently, local committees conduct case reviews on all child fatalities reported to the Florida Abuse Hotline, including those investigated and found **verified** as child maltreatment, **not substantiated**, and those with **no indicators** of maltreatment. This expanded scope has allowed the state committee to review additional data sets that can be used to inform statewide and local prevention strategies aimed at reducing preventable child deaths in Florida.

2016 Data: Case Review Analyses

Throughout 2017, the death review system conducted case reviews on over 348 child fatalities that occurred in 2016. Analyses of 2016 case review data reveal that Florida's youngest children continue to be most vulnerable to child abuse and neglect fatalities. Regardless of verification status, **children under five had the highest risk for all forms of death**. Additional findings identify three primary preventable causes of child deaths, which remain consistent with findings from previous years.

- **Drowning** continues to be a primary cause of preventable death among children in Florida. Unsupervised access to pools, spas/tubs, and open bodies of water remains a potential threat to child safety.
- **Asphyxia,** often the result of unsafe sleep practices, claims the lives of younger children.
- **Trauma/wounds caused by a weapon,** primarily the use of firearms or bodily force (e.g., fists and feet) to inflict harm, also ranks in the top three causes of child deaths.

From Analysis to Action

Florida's child welfare system is continuously evolving to meet the needs of a diverse and dynamic population. Years of research showing consistent correlation between child maltreatment and poor health outcomes later in life bring child maltreatment to the forefront as a serious public health issue. As challenges continue to surface, the CADR system has renewed its focus on the need to move beyond data collection and to act on findings at both state and local levels. This trend is evident throughout the state as progressively

more local, circuit-based committees actively collaborate with community partners to develop and implement multi-sector strategies to further prevention initiatives. During the past year, all 20 local committees developed and implemented community-based action plans to employ a wide array of prevention strategies. Action plans are continuously informed by local child abuse death review data as well as other data sets. Public awareness campaigns, improvements in community-based systems of care, enhancements in staff training and programmatic policy, and many other impact-based activities continue to be shaped and informed by CADR findings and recommendations.

2017 Prevention Recommendations

The State CADR Committee developed this year's prevention recommendations based on input and participation from local committee members, an analysis of case review data findings, and a review of literature and the most current research on prevention strategies as outlined by our nation's foremost experts. Prevention recommendations were developed and organized using a multi-level social ecological model for change to identify strategies that will address all levels of our social ecology. Strategies geared toward individuals, families and their interpersonal social networks, communities, and society as a whole, seek to create sustainable change as they target the top three primary causes of child fatalities as defined by all data sources.

The following prevention recommendations for 2017 provide a high-level overview of strategies and approaches aimed at eliminating preventable child fatalities in Florida:

- ***Expand Efforts to Relay Timely Information to Parents Regarding the Safety of Children***

The committee recommends that communities consider providing timely messaging to parents regarding potential risks to children. For example, partnering with the business sector, such as pool supply and maintenance companies, may provide a venue to distribute additional water safety information during the purchase of pool or spa supplies. Waterfront communities are encouraged to post signage regarding potential water safety hazards. This could be further expanded by distribution of information by hotels and other locations where tourists may visit, such as turnpike rest areas and water parks. Messaging should consider language barriers and cultural differences which may apply to international tourists. The same concept applies to the prevention of asphyxia, by educating parents of infants on safe sleep practices. Breastfeeding education should incorporate instruction on safe sleep practices, and include information on over-the-counter and prescription medications that may pose a risk to an adult's alertness while breastfeeding.

- ***Expand Training of First Responders to Assess Risk to Children***

First responders play a key role in prevention efforts, as evidenced by several locally-based prevention strategies seeking to intervene during hazardous situations that place children at risk. First responders can assess for adequate supervision, substance misuse, and other factors that contribute to child death. Increased reporting by these professionals will allow for timely intervention. In those cases where a death has occurred, reporting such deaths and surrounding circumstances will aid efforts to further study and prevent the incidence of child death.

- ***Consider the Use of Social Media to Provide Timely Messaging and Support to Parents***

Parenting programs and awareness campaigns have begun to leverage social media as a powerful communication tool, especially among young parents. Expanding upon this platform, location services and targeted messaging could be used to alert parents to potential hazards in their environment. This potential targeted messaging should be further explored.

❖ *Leverage the Power of Shared Data*

Agencies such as DOH, the Department of Children and Families (DCF), community-based care agencies, and substance-abuse and mental health managing entities must capitalize on the vast amount of data collected on children, including aspects of child welfare involvement and health outcomes. Matching child death data with other data-rich systems such as Florida Safe Families Network (FSFN), Florida Community Health Resource Tool (FLCHARTS), and DOH vital statistics data could further inform prevention strategies.

Data findings could be expanded for further analysis to assess for racial disproportionality, health inequities and will increase understanding of how social determinants for health may play into the occurrence of preventable child death. Additional analysis can help determine if preventable deaths such as drowning are under-reported in certain areas. The sharing of data between agencies is crucial to this expanded effort.

The committee recommends that sufficient resources be provided to these agencies to sufficiently collect clean, accurate data, enabling the committee to further drill-down into specific maltreatments that lead to child death. While much of the CADR data and related prevention strategies target asphyxia and drowning, the dynamics behind inflicted trauma should be further explored. This knowledge will improve the ability to provide the appropriate support to families and caregivers and prevent violence within the home.

❖ *Continue to Encourage Collaborative Partnerships at both the State and Community Levels*

As demonstrated within this report, the well-being and protection of Florida's children is a shared responsibility, involving numerous agencies and professional services. Collective responses are necessary to fully meet the needs of at-risk children. A prime example of such efforts is a community-based approach provided by the National Drug-Endangered Children (DEC) Coalition. The National Alliance for Drug Endangered Children targets drug endangered children who are at risk of suffering physical or emotional harm as a result of illegal drug use, possession, manufacturing, cultivation, or distribution. This includes children whose caretaker's substance misuse interferes with the caretaker's ability to parent and provide a safe and nurturing environment. DEC provides training and support to communities seeking to protect these children via a multi-agency, multidisciplinary response to drug crises.

Another useful venue for state and local collaboration would be the continuation of joint meetings with State CADR Committee members and local chairpersons. The joint meetings provide opportunities to share ideas and best practices and troubleshoot concerns at both state and local levels.

At the local level, partnerships between agencies, councils, and task forces are a necessity. This would allow local groups to compare data, decide on key consistent prevention messaging, and develop collaborative community-based action plans to target the specific needs of their community. Local CADR committees should partner with community coalitions, their local Child Abuse Prevention and Permanency Task Force, local school systems, and community-based initiatives with similar goals.

❖ *Continue to Support the Integration of Behavioral Health Services into the Child Welfare System*

Substance use disorders, mental health disorders, and dynamics associated with intimate partner violence (IPV) can both independently and collectively impact parental capacity and child well-being while greatly increasing the risk of child harm. Readily accessible and appropriate interventions for families at risk dealing with these issues is a critical step toward ensuring a safe, stable, and nurturing environment for children. Community-based systems of care must take the necessary steps to ensure behavioral health services are comprehensively integrated into the service delivery system to sufficiently meet the needs of their client population. Scope of services should address all levels of need, including prevention, intervention, and

treatment services. The provision of ongoing support services helps to ensure families at risk have the resources needed to bolster resiliency and sustain stability.

- ***Continue to Support Programs that Enhance Parenting Skills***

Home visiting programs, such as Healthy Families Florida (HFF), serve families at risk and bolster those protective factors that offset the risk of child maltreatment and preventable child death. The services provided by such programs are wide in scope and timely address all potential causes of maltreatment death. Targeted prevention programs such as HFF ensure an efficient and strategic use of our state's resources. Continued expansion of Family Intensive Treatment Teams (FITT) is another example of a targeted response to prevent child maltreatment deaths.

The implementation of these comprehensive prevention strategies will provide the momentum needed to work toward our ultimate goal:

To eliminate preventable child deaths in Florida by better understanding the complexities of child maltreatment and leveraging this evidence-based knowledge to drive current and future prevention strategies.

SECTION ONE: BACKGROUND

PROGRAM DESCRIPTION

The Florida Child Abuse Death Review (CADR) System was established in Florida law in 1999. The program is administered by the Florida Department of Health (DOH) and utilizes local CADR committees to conduct detailed reviews of the facts and circumstances surrounding child deaths reported to the Florida Abuse Hotline and accepted for investigation. The State CADR Committee collects and analyzes data from the local reviews and prepares an annual statistical report, which is submitted to the Governor, President of the Senate and Speaker of the House of Representatives.

STATUTORY AUTHORITY

Section 383.402, FS, authorizes the state and local CADR committees and mandates guidelines for membership and duties. State and local committees were initially authorized to review only verified child abuse deaths with at least one prior report to the Florida Abuse Hotline. After several years, it was determined that the requirement for a prior report limited the committee's ability to review infant deaths, and in 2004, the Florida Legislature expanded reviews to include all verified child abuse or neglect deaths. The legislature expanded the scope of reviews even further in 2014, and currently the local and state committees review all child deaths reported to the Florida Abuse Hotline. Section 383.402, FS, is referenced in Appendix A.

PROGRAM PURPOSE

The purpose of the CADR process is to:

- Develop a community-based approach to address child abuse deaths and contributing factors;
- Achieve a greater understanding of the causes and contributing factors of deaths resulting from child abuse or neglect;
- Identify gaps, deficiencies, or problems in service delivery to children and families by public and private agencies that may be related to child abuse deaths;
- Develop data-driven recommendations for reducing child abuse and neglect deaths; and
- Implement such recommendations, to the extent possible.

STATE COMMITTEE

The State CADR Committee consists of seven agency representatives and twelve appointments from various disciplines related to the health and welfare of children and families. Members of the State CADR Committee are appointed for staggered two-year terms. All members are eligible for reappointment not to exceed three consecutive terms. The representative of DOH serves as the state committee coordinator.

In addition to DOH, the State CADR Committee is composed of representatives from the following departments, agencies, or organizations:

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

The State Surgeon General is also responsible for appointing the following members based on recommendations from the agencies listed. The State Surgeon General's selection of appointees ensures that the committee represents to the greatest possible extent, the regional, gender, and racial/ethnic diversity of the state.

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

For a listing of state committee members, see Appendix B.

The State CADR Committee is charged with oversight of the local committees through the establishment of local committee guidelines. Through analysis and discussion of statewide data, the State CADR Committee studies the adequacies of laws, rules, training, and services to determine what changes are needed to decrease the incidence of child abuse deaths, develop strategies, and recruit partners to implement these changes at both the state and local levels. Guidelines for the State CADR Committee are referenced in Appendix C.

LOCAL CHILD ABUSE DEATH REVIEW COMMITTEES

Local committees review all closed cases of alleged child abuse and neglect deaths reported to the Florida Abuse Hotline and present information relevant to these deaths to the State CADR Committee through the completion of the Case Report Form. Local committees comprise individuals from agencies within the community who share an interest in promoting, protecting, and improving the health and welfare of children.

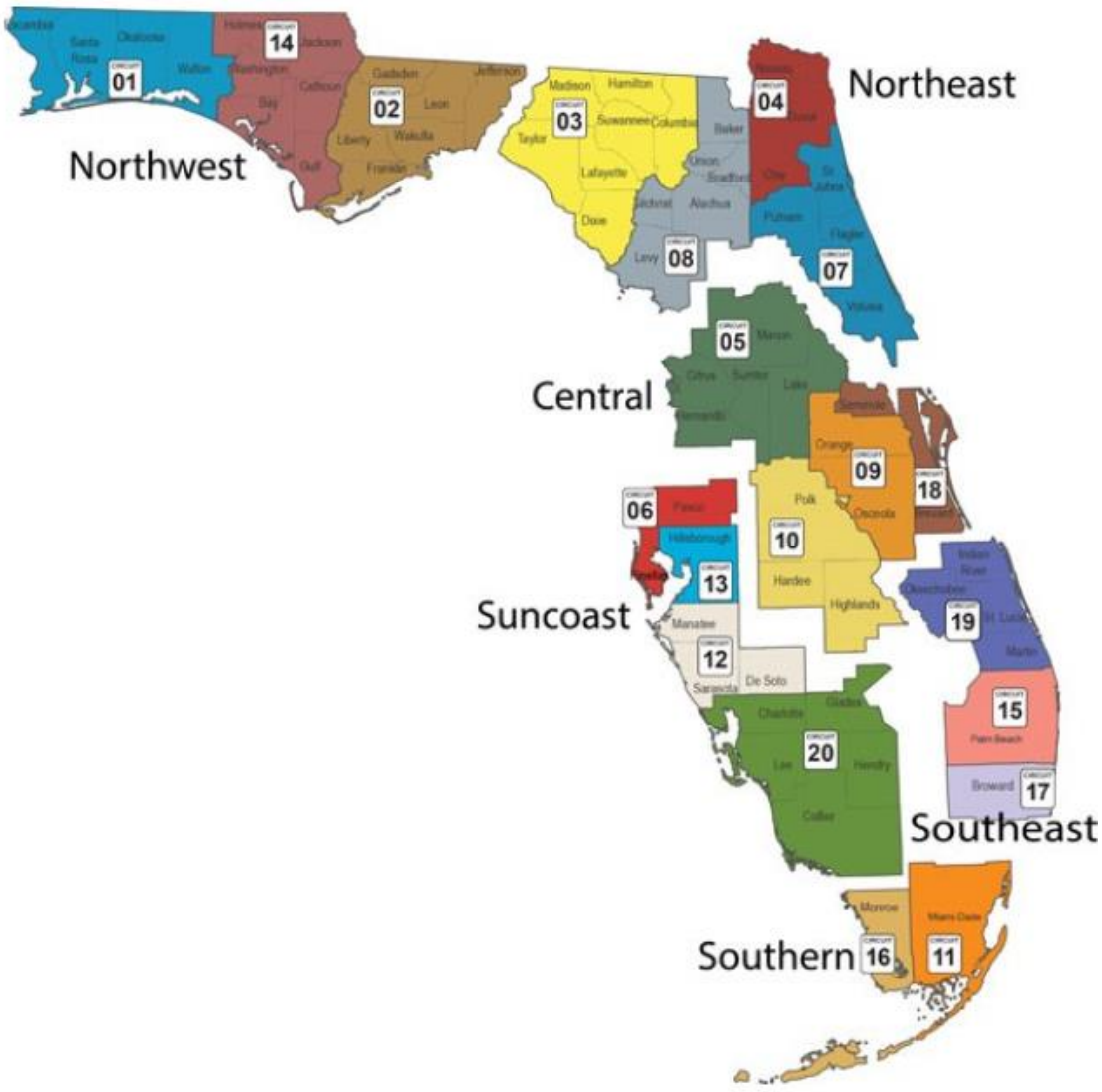
Membership of Local Committees

In January 2015, local committee boundaries were adjusted to realign with judicial circuits. County Health Officers are directed to appoint, convene, and support CADR committees. Every county has an appointed health officer, and one appointee is designated the lead CADR Health Officer for each circuit. At a minimum, representatives from the following organizations are appointed by CADR Health Officers:

- The state attorney's office
- The medical examiner's office
- The local Department of Children and Families child protective investigations unit
- Department of Health child protection team
- The community-based care lead agency
- State, county, or local law enforcement agencies
- The school district

- A mental health treatment provider
- A certified domestic violence center
- A substance abuse treatment provider
- Any other members who are listed in guidelines developed by the State CADR Committee

Map of Circuit-based Committees



Recent Developments

Over the past year, at the request of the State CADR Committee, local committees developed and submitted action plans designed to implement prevention strategies at the local level. While local committees have consistently submitted recommendations following case reviews, the implementation of such recommended strategies varied greatly amongst committees. By July 2017, 100 percent of local committees had developed and initiated implementation of written action plans. The action plans are informed by local case review data and help local committees make data driven decisions for local prevention initiatives. The action plans will continue to be utilized by local committees to clarify goals and strategies, identify specific tasks to be acted upon, and track completion of such tasks. DOH has developed a process to track and monitor local team activities as action plans are implemented, providing a statewide perspective of prevention activities aimed at eliminating child maltreatment deaths. Additional details regarding local committee action planning is included in section six of this report.

SECTION TWO: METHOD

CASE FILE TRANSFER

Following closure of a DCF investigation, a designated DCF Child Fatality Prevention Specialist reviews all pertinent information within the case file and completes a case review summary. The case file, along with the summary and supporting documentation, is then transferred to DOH. DOH archives the case and logs pertinent tracking information, then transfers all case information to the appropriate local committee chair. All file transfers are conducted using MoveIt, a secure file transfer protocol website. MoveIt provides the ability to track and safely deliver confidential case information. This process ensures accountability, protects the security of sensitive case information, and provides a reliable mechanism for tracking files as they move through the CADR system.

LOCAL COMMITTEE REVIEWS AND REPORTING PROCESS

For information detailing local CADR committee operating procedures, please see the *Guidelines for Local Committees* referenced in Appendix D. These local guidelines recommend best practices for conducting effective child fatality reviews and highlight the duties and responsibilities of the local CADR committees and members. The State CADR Committee has identified core data to be collected for each case and has provided detailed guidance on the content of case narratives.

Once the review is completed, case review data are entered into the Child Death Review Case Reporting System. Additional data sets, such as DCF's Florida Safe Families Network (FSFN) data, are used to validate the data sample and further inform the annual report and subsequent recommendations.

THE CADR CYCLE

Florida law directs state and local committees to identify gaps, deficiencies, or problems in the delivery of services to children and their families, and to recommend changes needed to better support the safe and healthy development of children. Local committees are encouraged to take a communitywide approach to address causes and contributing factors of deaths resulting from child maltreatment, and to implement identified strategies, to the extent possible.

Both state and local committees reinforce this goal – to move beyond data collection into collaborative action. During monthly circuit conference calls, training, and technical assistance, local committee members are encouraged to view the collective review process as a cycle, during which data are collected, analyzed and acted upon.

This recently adopted framework has enhanced state and local committee members' collective understanding of the need to build upon lessons learned, and supports our efforts to ensure the decision-making is based on applicable data.

SECTION THREE: DATA

Child maltreatment findings are rendered based on criteria outlined in DCF's policies and operating procedures. At the time of the local committee reviews of year 2016 cases, DCF's operating procedures (Child Maltreatment Index) classified the findings from investigations as follows:

- VERIFIED - This finding is used when a preponderance of the credible evidence results in a determination that the specific harm or threat of harm was the result of abuse, abandonment, or neglect.
- NOT SUBSTANTIATED - This finding is used when there is credible evidence, which does not meet the standard of being a preponderance, to support that the specific harm was the result of abuse, abandonment, or neglect.
- NO INDICATORS - This finding is used when there is no credible evidence to support the allegations of abuse, abandonment, or neglect.

Core data elements of case reviews are summarized in this report by child maltreatment verification status. In past years, the "not substantiated" and "no indicators" categories were collapsed into a "non-verified child maltreatment" death category for analyses. For this year's report, the state committee recommended stratification of select analyses using the original Child Maltreatment Index classification denoted above.

The State CADR Committee also recommended that statewide summary data include:

- Itemization of child fatalities across geographic regions
- Analyses related to the child's age, using one-year intervals through the age of five, followed by four-year or five-year groupings

Case Review Statistics

Case data analyzed for this report includes all information on closed cases reviewed with data entered into the National Center for the Review & Prevention of Child Deaths database by September 30, 2017. Cases that remain open to DCF for investigation (often due to law enforcement and/or judicial proceedings) are not available for review and are not included in the data sample. Table 1 details the distribution of 2016 child fatality cases reviewed (stratified by maltreatment verification status), those awaiting review, and those that were not available for review as of September 30, 2017, for each local CADR committee. Figure 1 provides a rank ordering of local committees (linked to judicial circuits) in terms of the number of 2016 child death cases that have or will be assigned for review. Finally, Figure 2, provides an aggregate summary of the case file status for all child deaths (N=459) reported to the Florida Child Abuse Hotline in 2016.

Table 1: Child Fatality Cases Reviewed and Case Review Status Across Local CADR Committees							
	Total Cases (Child deaths called into hotline)	Cases Not Available for Review (Open investigation/Case still being processed)	Closed Investigation (case available for review)	Review Completed	Verified Maltreatment Cases Reviewed	Not Substantiated Maltreatment Cases Reviewed	No Indicators Maltreatment Cases Reviewed
Circuit #1	28	9	19	18	2	5	11
Circuit #2	15	7	8	8	0	2	6
Circuit #3	6	0	6	6	2	0	4
Circuit #4	47	1	46	45	10	4	31
Circuit #5	30	5	25	24	2	5	17
Circuit #6	35	4	31	29	10	6	13
Circuit #7	15	0	15	15	3	0	12
Circuit #8	15	2	13	13	3	1	9
Circuit #9	36	2	34	34	6	7	21
Circuit #10	25	2	23	23	0	2	21
Circuit #11	33	14	19	11	4	4	3
Circuit #12	14	5	9	9	3	3	3
Circuit #13	30	7	23	20	1	2	17
Circuit #14	8	2	6	6	0	0	6
Circuit #15	24	4	20	20	4	5	11
Circuit #16	0	0	0	0	0	0	0
Circuit #17	32	3	29	22	7	9	6
Circuit #18	28	2	26	21	4	5	12
Circuit #19	10	1	9	3	1	0	2
Circuit #20	28	7	21	21	6	2	13
Totals	459	77	382	348	68	62	218

Figure 1: 2016 Child Death Cases Reported to the Hotline (N=459)

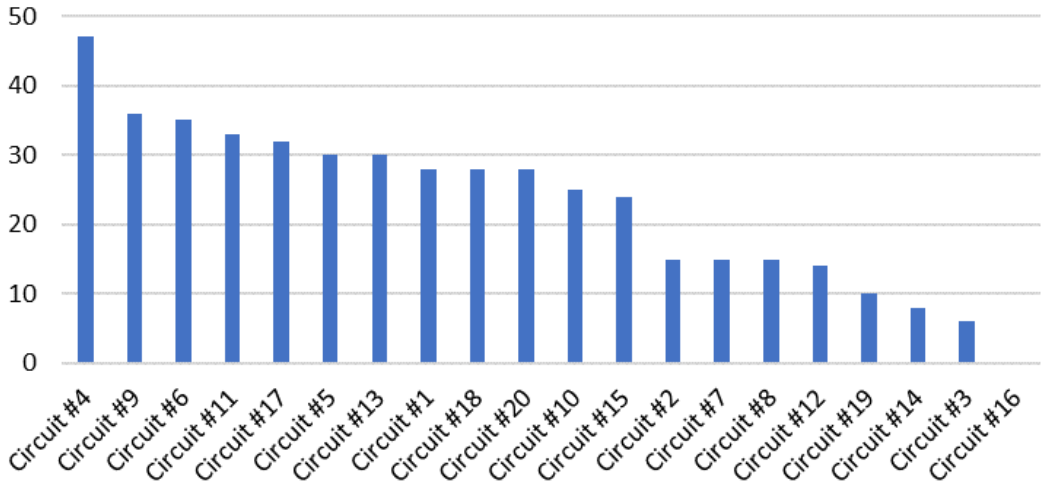
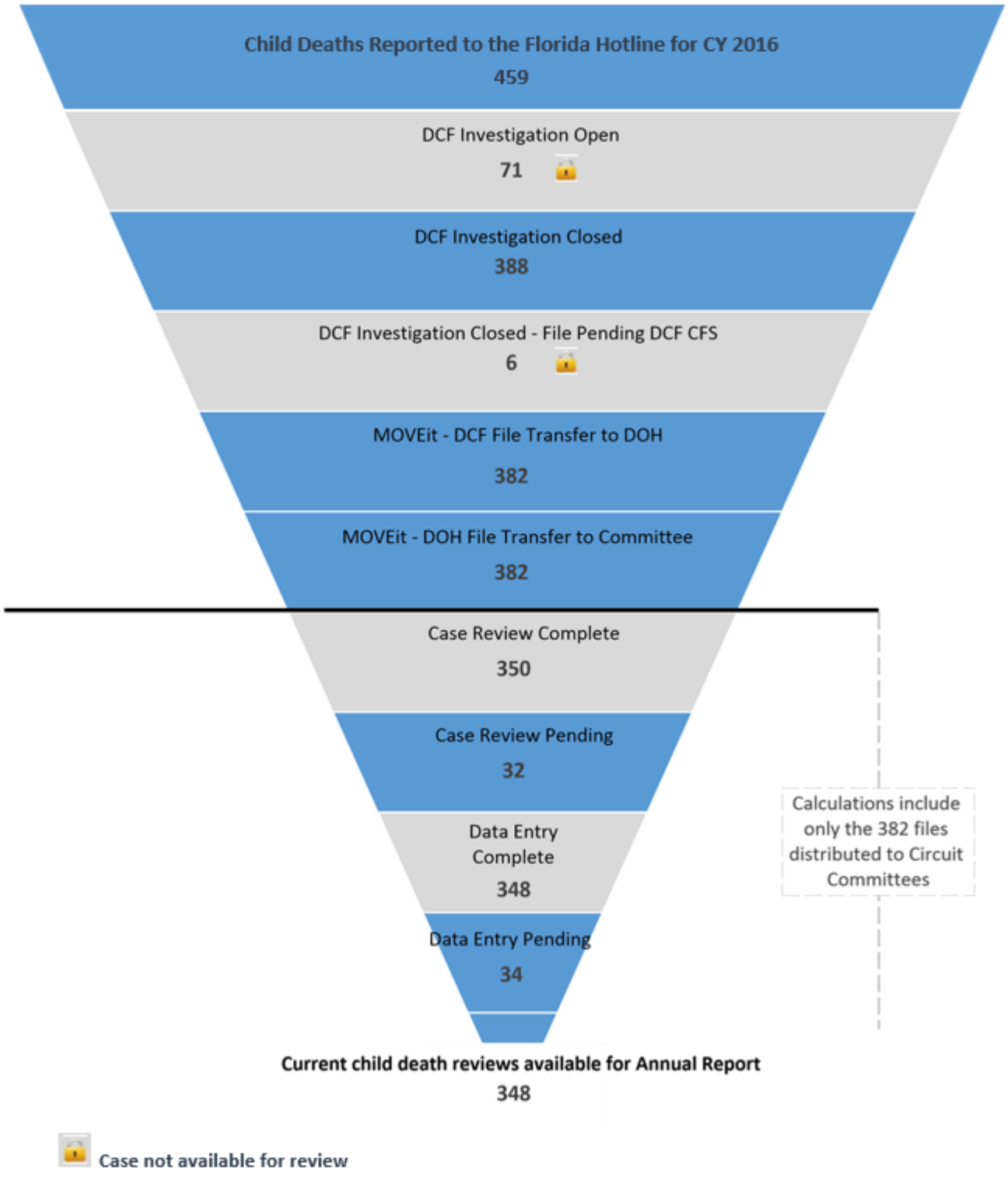


Figure 2: Case File Status All Child Deaths (459) reported to the Florida Hotline for CY 2016

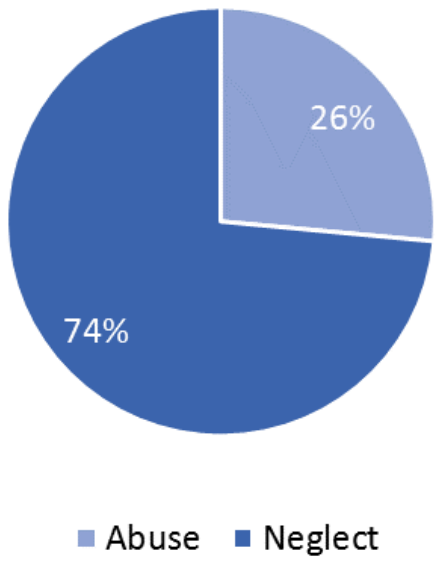


Summary Points:

As of September 30, 2017, 459 child fatalities for 2016 were called into DCF's Florida Abuse Hotline.

- 388 of these cases were closed by DCF.
- 77 cases were still open or recently closed for which case information was in the process of being assembled and prepared for review by local CADR committee.
- Of the 388 closed cases for which the information was available for review, 348 had local CADR committee reviews completed, with the remainder of cases (n=40) scheduled for review after September 30, 2017. Please note that this report applies to the 348 cases that local CADR committees completed. Findings are qualified by this fact and may change once all referenced child fatalities are reviewed. Consideration will be given in the future by the State CADR Committee toward supplemental analyses on 2016 fatalities when the remaining 111 child fatality cases are closed and reviewed by local committees.
- There were 11 local committees/circuits that had 25 or more child fatality cases called into the hotline in 2016. These include: Circuit 4 (n=47), Circuit 9 (n=36), Circuit 6 (n=35), Circuit 11 (n=33), Circuit 17 (n=32), Circuit 5 (n=30), Circuit 13 (n=30), Circuit 1 (n=28), Circuit 18 (n=28), Circuit 20 (n=28), and Circuit 10 (n=25).
- No cases were reported in Circuit 16 (Monroe County)
- Of the 68 verified maltreatment deaths reviewed, the majority, 50 (74%), were a result of neglect and 18 (26%) were a result of abuse (see Figure 3 below).

Figure 3: Distribution of Reviewed Verified Maltreatment Deaths by Abuse and Neglect (n=68)



CHILD DEATH TRENDS

In 2016, the all-cause death rate for children aged 0-17 was 52.5 deaths per 100,000 child population (Florida CHARTS, 2017). The reported 2016 verified child maltreatment death rate in Table 2 is 1.60 per 100,000 child population. This figure should be considered tentative and an underestimate as there are several cases (see Table 1) that were still open at DCF and not yet transferred to local CADR committees for which verification status has been determined. Further, the updated rate for 2015 child fatalities should be considered tentative for the same reason. With respect to 2015 deaths, as of September 30, 2017, there were still 20 child fatalities whose cases was still open at DCF, 3 recently closed cases (where case information had yet to be transferred) and 27 case reviews pending/planned by local CADR committees. Cases that remain open for an extended period are likely to involve the criminal justice system and be later classified as verified maltreatment cases. Subsequent analyses on these cases will be necessary after all cases have been closed and reviews completed by local committees. Table 2 shows the number and rates of all-cause and verified child maltreatment deaths among children in Florida from 2011-2016 where the child maltreatment death rate (between 2011 and 2014) has ranged from a low of 3.2 (per 100,000) in 2012 to a high of 3.58 (per 100,000) in 2014.

Table 2: Child Deaths: All Causes and Maltreatments Florida, 2011-2016

	Child Deaths All Causes	Child Death Rate per 100,000 Child Population	Verified Child Maltreatment Deaths	Child Maltreatment Death Rate per 100,000 Child Population
2011	2,191	54.7	136	3.40
2012	2,046	50.8	129	3.20
2013	2,105	51.7	137	3.37
2014	2,131	52	147	3.58
2015	2,249	54.4	98*	2.30
2016	2,217	52.5	68*	1.60

*The number of verified child maltreatment cases for 2015 and 2016 is not complete given the number of cases still open and not yet transferred to local CADR Committees OR not yet reviewed by local CADR Committees. Past year figures may have changed as cases were closed following the submission of past CADR reports. 2015 counts apply to 412 of 473 investigated child deaths. 2016 counts apply to 348 of 459 investigated child deaths.

CHILD DEATH INCIDENT INFORMATION

The following findings highlight information related to incident data associated with child fatalities, including an itemization of the location (by county) where the incident took place. Each child fatality review itemizes the official manner and primary cause of death, and if the death is ruled a homicide, whether the death is a result of child abuse or neglect. Some deaths classified by the Medical Examiner as accidental on death certificates will, upon investigation, be determined to be the result of neglect.

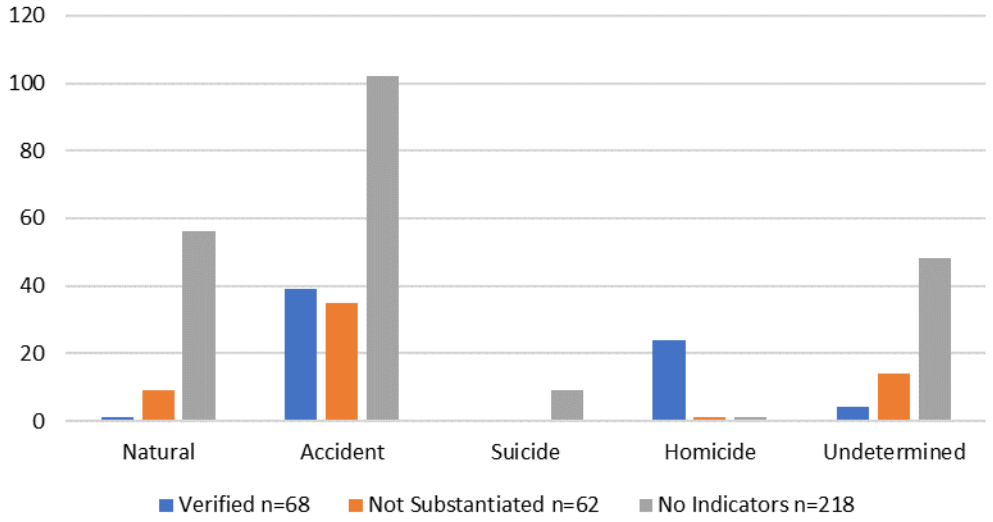
Official Manner of Death

Table 3 and Figure 4 denote the official manner of death obtained from death certificates for all child fatalities reviewed for this report. Of the 68 child fatalities verified to be the result of abuse and/or neglect, 39 (57.4%) were classified as accidents and 24 (35.3%) were classified as homicides. Among the 62 not-substantiated child maltreatment fatalities, the largest number of deaths 35 (56.5%) were classified as accidents followed by undetermined causes 14 (22.6%). Among the 218 no indicators deaths, the official manner of death was most likely classified as an accident 102 (46.8%) followed by natural 56 (25.7%) and undetermined 48 (22.0%) causes.

Table 3: Official Manner of Death (from death certificate) by Maltreatment Verification Status

Official Manner of Death	Child Maltreatment Death n=348		
	Verified n=68	Not Substantiated n=62	No Indicators n=218
Natural	1	9	56
Accident	39	35	102
Suicide	0	0	9
Homicide	24	1	1
Undetermined	4	14	48
Pending	0	1	2
Unknown	0	2	0

Figure 4: Official Manner of Death by Maltreatment Verification Status



Primary Cause of Death

Table 4 and Figure 5 denote the distribution of child fatality cases reviewed using the general classification of primary cause of death across child maltreatment verification status. Among the 68 child fatalities verified because of maltreatment, 66 (97.1%) resulted from an external injury and 2 (2.9%) due to a medical cause. Among the 62 not substantiated maltreatment fatalities, the majority 41 (66.1%) were the result of an external injury, 10 (16.1%) were determined to have a medical cause and 11 (17.7%) had undetermined or unknown cause of deaths. Among the 218 no indicators of maltreatment fatalities, the majority 118 (54.1%) were the result of an external injury, 52 (23.9%) were determined to have a medical cause, 36 (16.5%) were undetermined (if external injury or medical cause) and 12 (5.5%) had unknown cause of deaths.

Table 4: Primary Cause of Death by Maltreatment Verification Status			
Primary Cause of Death	Child Maltreatment Death n=348		
	Verified n=68	Not Substantiated n=62	No Indicators n=218
External Injury	66	41	118
Medical Cause	2	10	52
Undetermined If Injury or Medical	0	10	36
Unknown	0	1	12

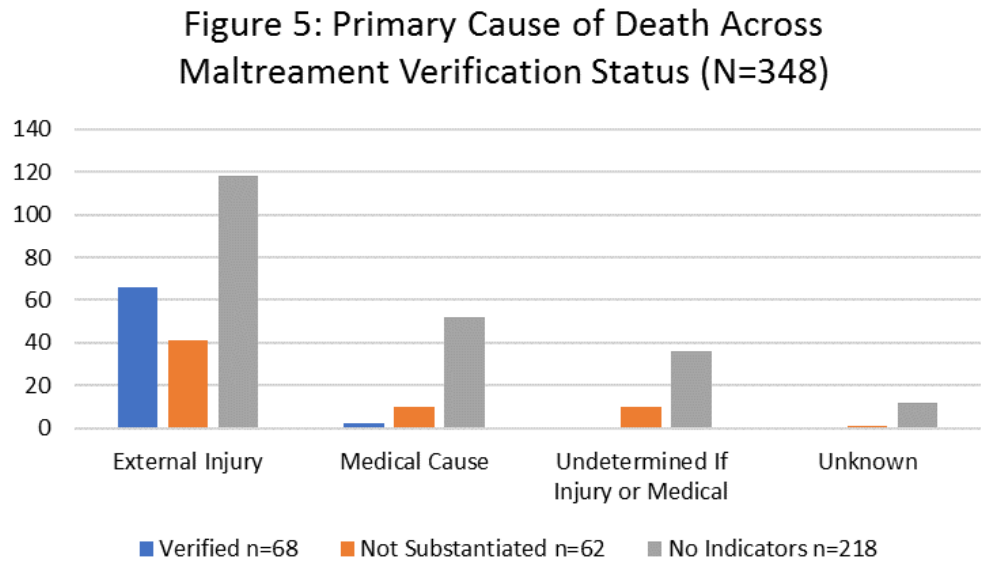


Table 5 and Figure 6 identify three specific primary causes of death (associated with external injuries) for maltreatment cases that account for 66.7% of known verified child maltreatment fatalities: deaths by drowning (33.3%), trauma/wounds caused by a weapon which may include fists, hands, or feet (21.2%) and asphyxia (12.1%). These are the primary cause of death categories throughout this report.

When the number of homicides (n=24) of children that were verified child maltreatment deaths are cross-referenced against primary cause of death categories, 13 (54.2%) resulted from weapons, 3 (12.5%) involved asphyxia, 1 (4.2%) involved drowning, 1 (4.2%) involved poisoning/overdose/intoxication and 6 (25.0%) were identified with “other” causes.

Table 5: Itemization of Specific Cause of Death for External Injuries by Child Maltreatment Verification Status

Specific External Injury Cause of Death	Child Maltreatment Death n=225		
	Verified n=66	Not Substantiated n=41	No Indicators n=118
Weapons	14	2	7
Asphyxia	8	22	66
Sleep-related	4	20	61
Not sleep-related	4	2	5
Drowning	22	8	33
Motor Vehicle	6	4	6
Poisoning, Overdose, Intoxication	8	1	2
Animal Bite/Attack	0	0	0
Fire, Burn, Electrocution	0	0	0
Exposure	2	0	0
Undetermined	0	3	2
Other	6	0	0
Fall/Crush	0	1	1
Unknown	0	0	1

Figure 6: Specific External Injury Cause of Death Across Maltreatment Verification Status (N=225)

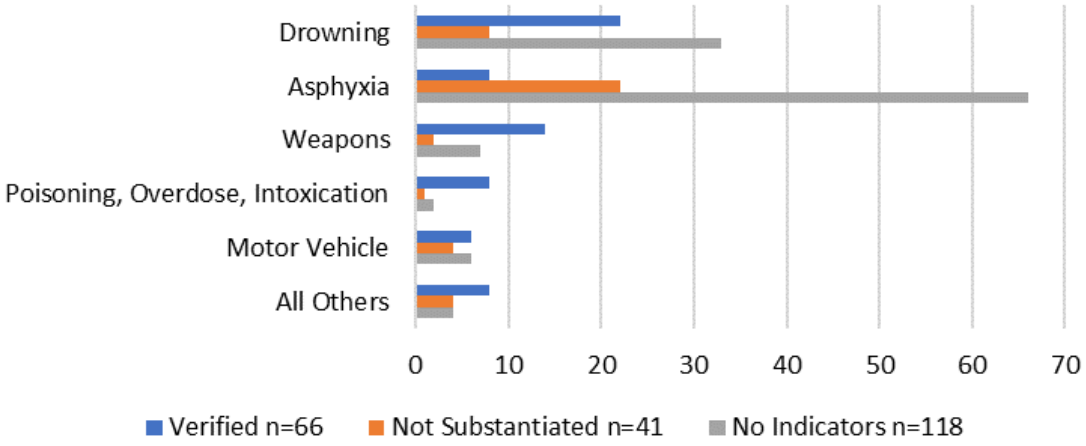


Table 6 displays counts of deaths resulting from medical causes. There were two verified maltreatment deaths due to medical neglect.

Table 6: Itemization of Specific Medical Cause of Death by Child Maltreatment Verification Status			
Specific Medical Cause of Death	Child Maltreatment Death (Medical Cause) n=62		
	Verified n=2	Not Substantiated n=10	No Indicators n=50
Cancer	0	0	1
Cardiovascular	0	0	2
Congenital Anomaly	0	2	7
HIV/AIDS	0	0	0
Influenza	0	0	0
Low Birth Weight	0	0	0
Malnutrition/Dehydration	0	1	0
Neurological/Seizure Disorder	0	0	4
Pneumonia	0	0	11
Prematurity	0	2	3
SIDS	0	1	1
Other Infection	0	0	6
Other Perinatal	0	1	0
Other Medical	2	2	12
Diabetes	0	0	1
Asthma	0	1	1
Undetermined	0	0	0
Unknown	0	0	1

Location of Child Deaths

Please note that in this report, the word “county” refers to the county where the incident took place, not necessarily the county where the death occurred or the county of a child’s residence. From a prevention standpoint, the use of the incident county provides more meaningful data regarding the death event. For the top three primary causes of death regardless of verification status:

- 52.4% (33 of 63) of all drownings occurred in eight counties: Broward, Duval, Hillsborough, Orange, Osceola, Polk, Sarasota, and Volusia.

- 56.3% (54 of 96) of all asphyxia deaths occurred in seven counties: Broward, Duval, Hillsborough, Miami-Dade, Palm Beach, Pinellas, and Polk. Duval county alone accounted for 17.7% (17 of 96) of all asphyxia deaths.

- The 23 weapons deaths occurred across 19 separate counties, although 4 weapons deaths were in Orange county (17.4%).

See Appendix G for additional information on location of child deaths.

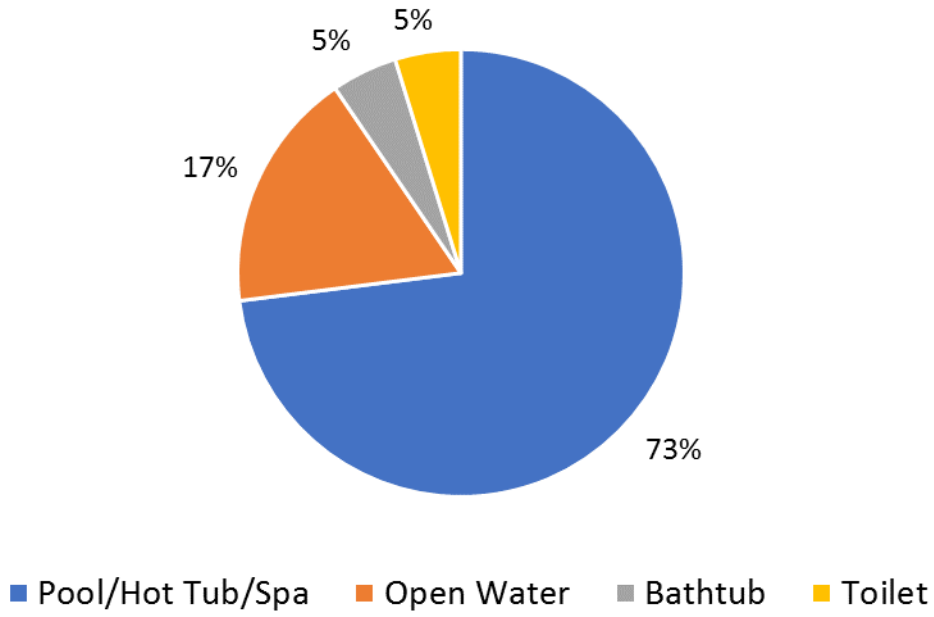
Drowning Death Incident Information

For drowning deaths, local committees collect information on specific details associated with each death, including location of deaths and whether a barrier was in place. Table 7 and Figure 7 identify details of the location of drowning deaths.

Table 7: Drowning Location by Child Maltreatment Verification Status

Drowning Location	Child Maltreatment Death n=63		
	Verified n=22	Not Sustantiated n=8	No Indicators n=33
Open Water	7	1	3
Pool/Hot Tub/Spa	13	6	27
Bathtub	2	1	0
Bucket	0	0	0
Well/Cistern/Septic	0	0	0
Toilet	0	0	3
Other	0	0	0

Figure 7: Drowning Location Across All Investigated Deaths (N=63)



Tables 8 details the barriers that were in place where the drowning took place. Barriers are physical structures (such as a door or a fence) that are intended to limit access to potentially hazardous bodies of water (such as a pool or spa). Note that the presence of a barrier does not necessarily mean that the barrier was in working order; the barrier could have been breached.

Table 8: Barriers in Place Where Drowning Took Place by Child Maltreatment Verification Status (Duplicate Counts if Multiple Barriers)

Barriers in Place	Child Maltreatment Death n=63		
	Verified n=22	Not Substantiated n=8	No Indicators n=33
None	8	1	7
Fence	6	2	6
Gate	6	2	7
Door	5	6	15
Alarm	1	0	3
Cover	0	0	0
Unknown	1	0	7

Among the 22 **verified** maltreatment drowning deaths:

- 19 (86.4%) of the children did not know how to swim, 16 (73.0%) of the drowning deaths occured under the age of 3 (Figure 12).
- 13 (59.1%) occurred in pools, hot tubs, or spas
- 8 (36.4%) drowning cases had no barriers (alarms, gates, etc.) to bodies of water
- Among deaths that occurred in pools, hot tubs, or spas, 3 of 13 (23.1%) had no barriers
- 13 (59.1%) of all verified drowning cases had barriers (some cases had more than 1 barrier)
- There were barriers in place for the 10 of 13 (76.9%) of the drowning deaths that took place in pools, hot tubs, or spas

Among the other 41 (combined) **not substantiated** and **no indicators** of maltreatment drowning deaths:

- 40 of the 41 cases had data on the child's ability to swim. Of these, 36 (87.8%) did not know how to swim
- 33 (80.5%) drowning cases occurred in pools, hot tubs, or spas
- 8 (19.5%) drowning cases had no barriers (alarms, gates, etc.) to bodies of water
- Among deaths that occurred in pools, hot tubs, or spas, only 5 of 33 (15.2%) had no barriers
- 26 (63.4%) cases had barriers in place (some cases had more than 1 barrier)
- There were barriers in place for 22 of 27 (81.5%) cases where barrier information was known of the drowning deaths that took place in pools, hot tubs, or spas

Where information was available, data elements were collected on the location of the child before drowning, activity of child before drowning, and drowning location. Among verified maltreatment deaths:

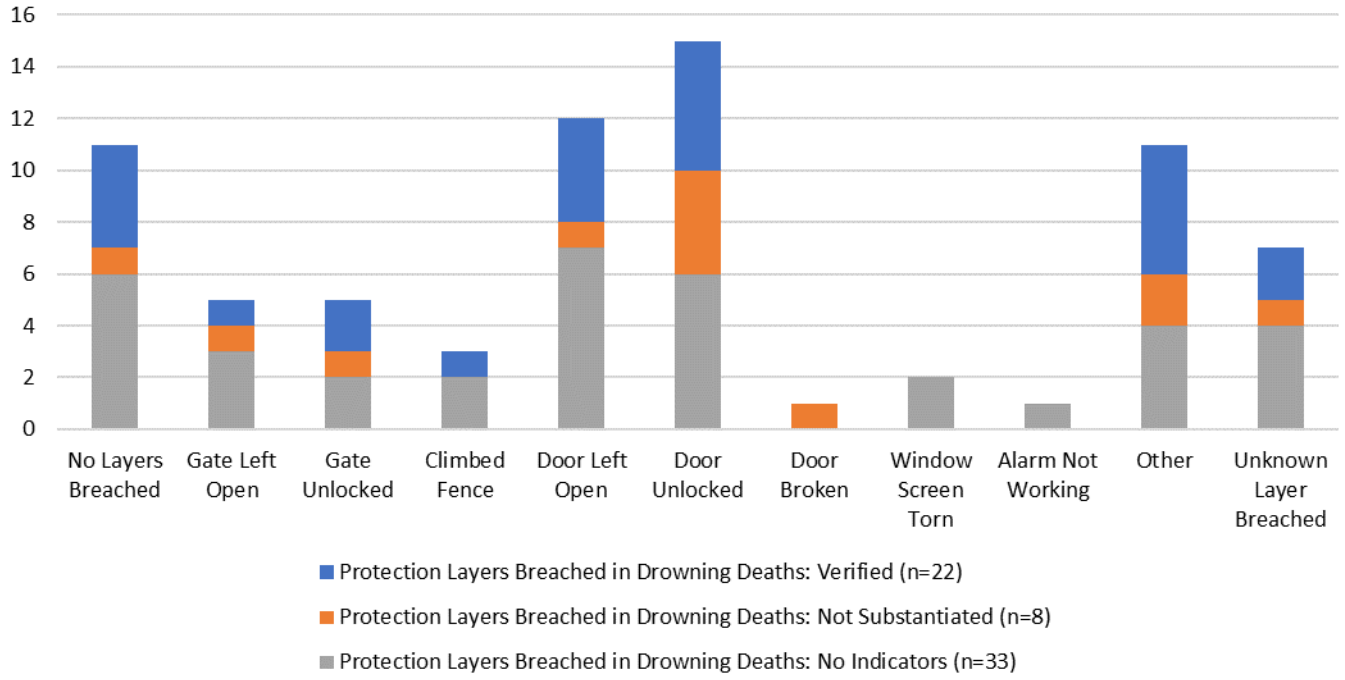
- 11 (50.0%) were in the home prior to drowning
- 6 (27.3%) were in the water prior to drowning

Most (19 of 22 or 86.4%) of the children whose death was verified as maltreatment and 36 of 41 (87.8%) of children whose drowning death was not substantiated or there were no indictors of maltreatment did not know how to swim. As for the activities children were engaged in prior to drowning, among verified maltreatment deaths, 12 of 22 (54.5%) of the children were playing, 4 of 22 (18.2%) were sleeping and the remaining 6 of 22 (27.3%) were swimming, bathing, engaged in an "other" activity and unknown before drowning. Among not substantiated and no indicator deaths (combined), 26 of 41 (63.4%) were playing prior to drowning. For additional detail, reference tables G-3, G-4, and Figure G-1 in Appendix G.

Since protective barriers were in place for most bodies of water (predominately pools, hot tubs, and spas) where children drowned, information was sought regarding the protective layers that were breached. Where data were available (see Figure 8), the most prevalent breach for verified maltreatment drowning deaths included doors being left unlocked (n=5), doors left open (n=4), and "other" breaches (n=5).

Among not substantiated and no indicator drowning deaths (combined), the most prevalent breach included unlocked doors (n=10), doors left open (n=8), "other" breaches (n=6), gate left open (n=4), and gates unlocked (n=3). With respect to "other" breaches, local CADR committees identified specific persons (typically adults and/or caretakers or neighbor) whose actions may have resulted in a barrier breach for the child.

Figure 8: Protection Layers Breached in Drowning Deaths (N=63)



For additional findings on these data elements, see Appendix G.

Asphyxia Death Incident Information

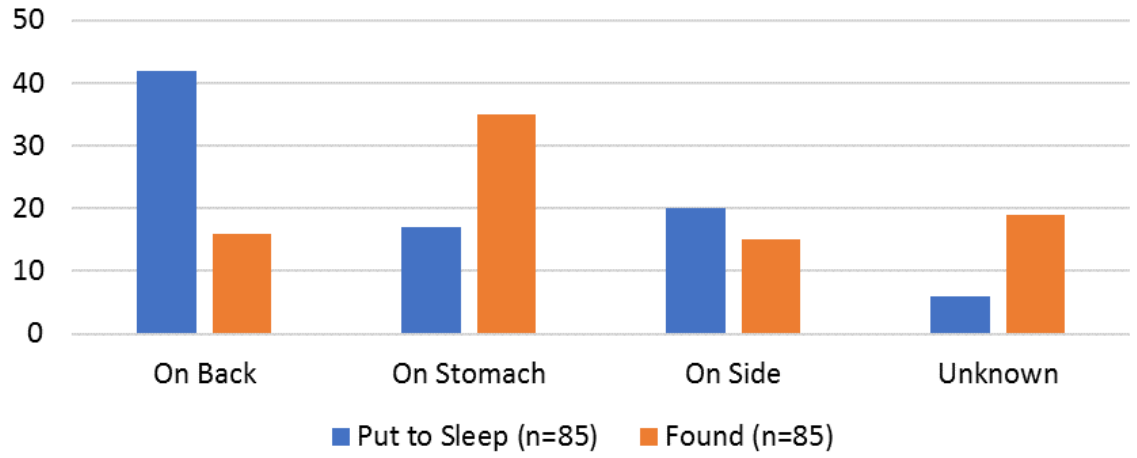
Asphyxia is the deprivation of oxygen that can be due to suffocation or strangulation. Among year 2016 CADR cases available for review, there were 96 deaths due to asphyxia. As noted in Table 5, 85 (88.5%) of these deaths (4 verified maltreatment deaths, 20 not substantiated, and 61 no indicators deaths) were classified as sleep-related. It is important to note that the cause of a sleep-related death may not be able to be determined after investigation. Therefore, it may be classified as a death from an unknown or undetermined cause.

When available, local CADR committees collect information on risk and protective factors that pertain to sleep-related deaths. For asphyxia deaths that were sleep-related, Table 9 (with Figure 9) and Table 10 (with Figure 10) provide overviews of some important factors of safe sleep placement and environments among reviewed cases.

Table 9 and Figure 9 provide information related to sleep placement position among cases that were classified as sleep-related asphyxia deaths: a child's usual sleep placement position, the sleep position a child was placed in before being found to be non-responsive or deceased, and the sleep position a child was in when found non-responsive or deceased. Please note that findings are presented on cases where data were reported (i.e. data were missing for one not substantiated death). The positions of sleep/sleep placement are: On Back, On Stomach, On Side, and Unknown.

Table 9: Sleep Positions Among Sleep-Related Asphyxia Deaths									
Position	Child Maltreatment Death n=85								
	Verified n=4			Not Substantiated n=20			No Indicators n=61		
	Usual n=4	Put to Sleep n=4	Found n=4	Usual n=20	Put to Sleep n=20	Found n=20	Usual n=61	Put to Sleep n=61	Found n=61
On Back	1	2	1	8	7	3	31	33	12
On Stomach	0	1	0	2	4	9	7	12	26
On Side	0	0	1	1	7	5	10	13	9
Unknown	3	1	2	9	2	3	13	3	14

Figure 9: Sleep Position Among Sleep Related Asphyxia Deaths (n=85)

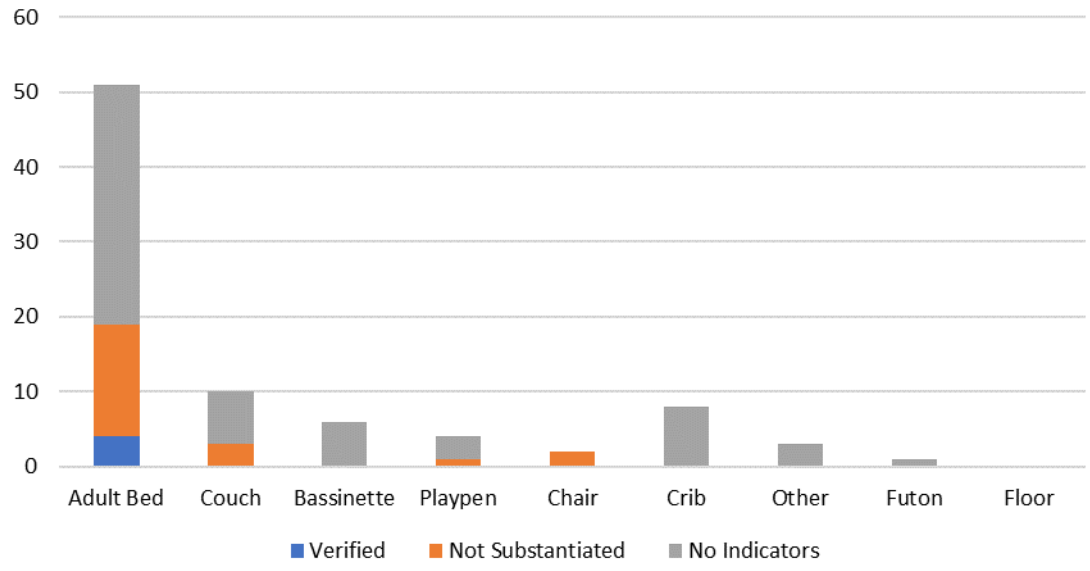


- On Back was the usual placement position for 42 of 85 (49.4%) of children who died from asphyxia.
- On Stomach was the most likely reported sleep position when the child was found non-responsive or deceased for 35 of 66 (53.0%) of child deaths where sleep position at time of death was known.

Table 10 and Figure 10 denote the incident sleep place for sleep-related asphyxia deaths. Here, 100% of verified maltreatment deaths, 75.0% of not substantiated, and 52.5% of no indicators for maltreatment occurred in an adult bed for all reviewed sleep-related asphyxia deaths. Together, 60% of all sleep-related asphyxia deaths took place in an adult bed. These statistics reinforce established concerns from extensive research regarding the risks of bed-sharing of adults with infants and toddlers.

Table 10: Incident Sleep Place for Sleep-Related Asphyxia Deaths			
Incident Sleep Place	Child Maltreatment Death n=85		
	Verified n=4	Not Substantiated n=20	No Indicators n=61
Adult Bed	4 (100%)	15 (75.0%)	32 (52.5%)
Couch	0 (0%)	3 (15.0%)	7 (11.5%)
Bassinette	0 (0%)	0 (0%)	6 (9.8%)
Playpen	0 (0%)	1 (5.0%)	3 (4.9%)
Chair	0 (0%)	1 (5.0%)	1 (1.6%)
Crib	0 (0%)	0 (0%)	8 (13.1%)
Other	0 (0%)	0 (0%)	3 (4.9%)
Futon	0 (0%)	0 (0%)	1 (1.6%)
Floor	0 (0%)	0 (0%)	0 (0%)

Figure 10: Incident Sleep Place for Sleep-Related Asphyxia Deaths (n=85)



Weapon Related Death Incident Information

The death review process collects a variety of information related to weapon-related deaths, including information related to the type of weapon, firearms used (if applicable), and the person handling the weapon related to the child fatality. Note that fatalities associated with weapons include a wide range of weapons from firearms to "body parts," such as fists, hands, or feet. This intentional bodily infliction of harm is captured in this

category and remains a primary concern. The reader should note that when the data sample was pulled, a number of cases were not yet available for review (71 cases were still open to DCF investigation). These cases remain open due to pending law enforcement investigation or judicial action and may be classified as weapon-related deaths. It is expected figures presented on weapons will increase when all 2016 deaths are reviewed. Table 11 (with Figure 11) and Table 12 present information regarding type of weapon and firearm associated with weapons-related deaths.

Among the **verified** maltreatment weapon deaths (n=14):

- 7 (50.0%) weapons used were firearms. Among these firearm deaths:
    - 6 of the firearms were handguns and 1 was a shotgun.
    - 6 of the owners (85.7%) of firearms used were owned by males.
- 5 (35.7%) weapons were "body parts" (indicating physical abuse).
- 2 (14.3%) weapons were sharp instruments.

Among the **not substantiated** and **no indicators** of maltreatment deaths combined (n=9):

- 6 (66.7%) weapons used were firearms
- 3 (33.3%) weapons were blunt instruments

For detailed information for this category, see Appendix G.

Table 11: Type of Weapon by Maltreatment Verification Status

Type of Weapon	Child Maltreatment Death n=23		
	Verified n=14	Not Substantiated n=2	No Indicators n=7
Firearm	7	0	6
Sharp Instrument	2	0	0
Blunt Instrument	0	2	1
Persons Body Part	5	0	0
Explosive	0	0	0
Rope	0	0	0
Biological	0	0	0
Other	0	0	0
Unknown	0	0	0

Figure 11: Type of Weapon
by Maltreatment Verification Status (N=23)

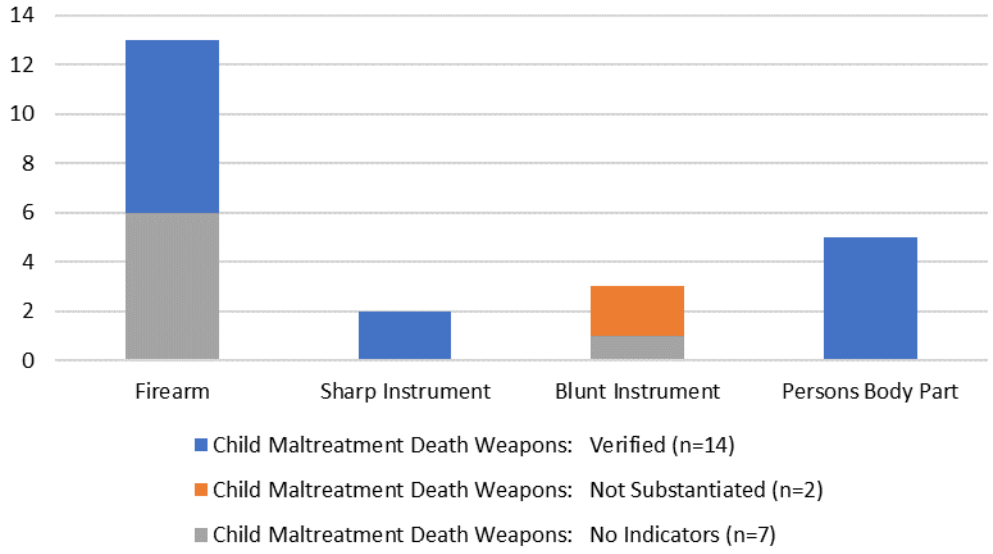


Table 12: Type of Firearm by Maltreatment Verification Status			
Type of Firearm	Child Maltreatment Death n=13		
	Verified n=7	Not Substantiated n=0	No Indicators n=6
Handgun	6	0	5
Shotgun	1	0	1
BB Gun	0	0	0
Hunting Rifle	0	0	0
Assault Rifle	0	0	0
Air Rifle	0	0	0
Sawed-Off Shotgun	0	0	0
Other	0	0	0
Unknown	0	0	0

CHILD CHARACTERISTICS

The following section highlights analyses associated with select child characteristics.

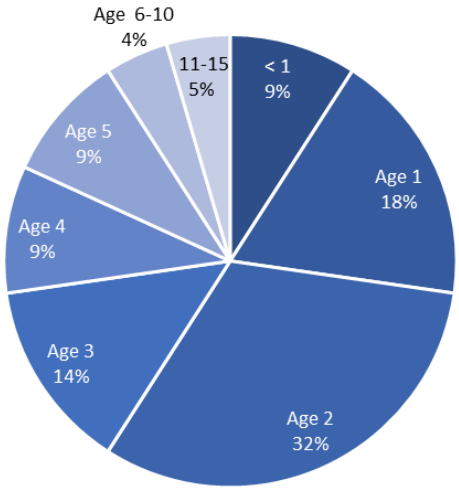
Age of Child

Regardless of verification status, children under age five had the highest risk for all forms of death. As shown in Table 13 and Figure 12, among drowning deaths, 73% of verified maltreatment deaths were children three

years of age and younger. 100% of not substantiated and 75% no indicators of maltreatment drowning deaths were three years of age and younger.

Table 13: Age of Children by Maltreatment Verification Status and Primary Cause of Death												
Age	Verified Child Maltreatment Death n=68				Not Substantiated Child Maltreatment Death n=51				No Indicators of Child Maltreatment Death n=170			
	Drowning n=22	Asphyxia n=8	Weapon n=14	Other n=24	Drowning n=8	Asphyxia n=22	Weapon n=2	Other n=19	Drowning n=33	Asphyxia n=66	Weapon n=7	Other n=64
< 1	2 (9%)	5 (63%)	3 (21%)	13 (54%)	1 (13%)	19 (86%)	0 (0%)	11 (58%)	2 (6%)	60 (91%)	0 (0%)	35 (55%)
1	4 (18%)	2 (25%)	3 (21%)	4 (17%)	2 (25%)	1 (5%)	0 (0%)	2 (11%)	8 (24%)	2 (3%)	1 (14%)	7 (11%)
2	7 (32%)	0 (0%)	1 (7%)	2 (9%)	4 (50%)	1 (5%)	2 (100%)	1 (5%)	10 (30%)	1 (2%)	0 (0%)	6 (9%)
3	3 (14%)	1 (13%)	2 (14%)	1 (4%)	1 (13%)	0 (0%)	0 (0%)	1 (5%)	5 (15%)	0 (0%)	0 (0%)	3 (5%)
4	2 (9%)	0 (0%)	2 (14%)	1 (4%)	0 (0%)	1 (5%)	0 (0%)	1 (5%)	2 (6%)	0 (0%)	0 (0%)	1 (2%)
5	2 (9%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	3 (5%)
6-10	1 (5%)	0 (0%)	1 (7%)	2 (8%)	0 (0%)	0 (0%)	0 (0%)	2 (11%)	5 (15%)	0 (0%)	0 (0%)	6 (9%)
11-15	1 (5%)	0 (0%)	1 (7%)	1 (4%)	0 (0%)	0 (0%)	0 (0%)	1 (5%)	1 (3%)	2 (3%)	5 (71%)	3 (5%)
16+	0%	0 (0%)	1 (7%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	1 (2%)	1 (14%)	0 (0%)

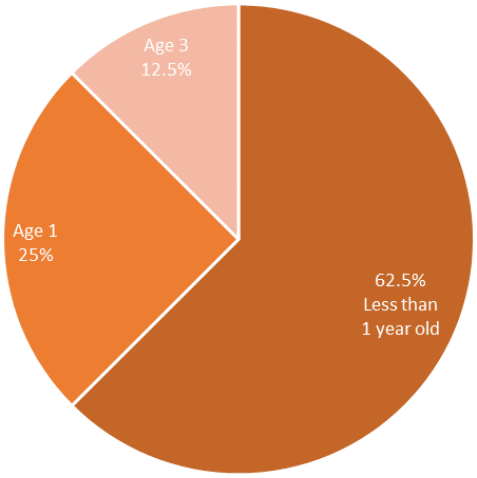
Figure 12: Verified Maltreatment Drowning Deaths by Age of Child (n=22)



As shown in Table 13 and Figure 13, the overwhelming majority of children dying from asphyxia were less than one year old:

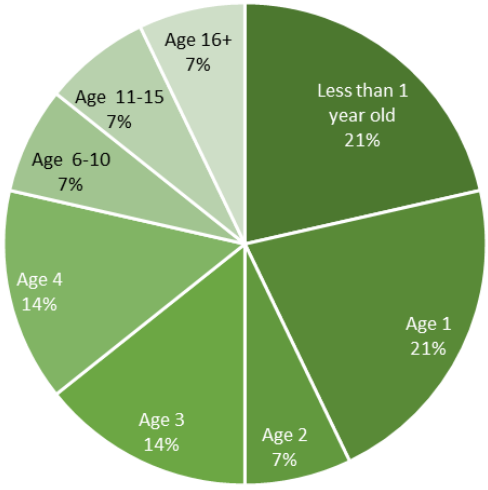
- 63% (n=5) of asphyxia deaths verified as child maltreatment involved children under the age of 1.
- 86% (n=19) of asphyxia deaths not substantiated as maltreatment involved children under the age of 1.
- 91% (n=60) of asphyxia deaths with no indicators of child maltreatment involved children under the age of 1.

Figure 13: Verified Maltreatment Asphyxia Deaths
by Age of Child (n=8)



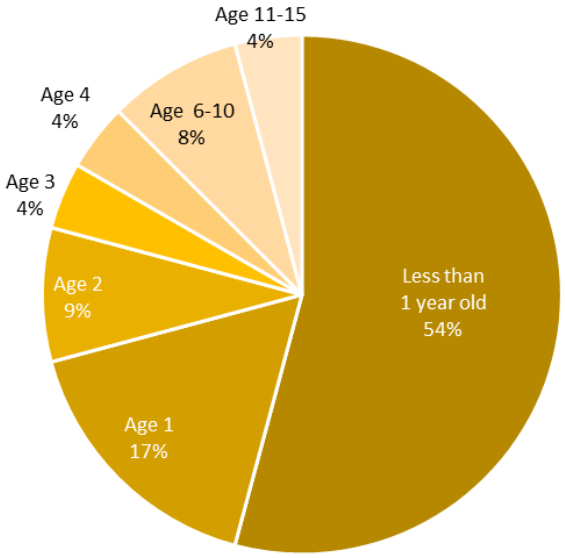
Although most children who died from a weapon (see Table 13 and Figure 14) were four years of age or younger (77.0% for verified maltreatment cases), 100% of (2 of 2) no indicators weapon deaths involved two-year-old children and 85.7% (6 of 7) of weapon deaths among no indicators of maltreatment involved children 11 and older.

Figure 14: Verified Maltreatment Weapon Deaths
by Age of Child (n=14)



As with asphyxia deaths, most child deaths (across child maltreatment verification statuses) attributed to "other" causes (most likely to be medical related events) were under the age of 1 (see Table 13 and Figure 15). Among verified "other" maltreatment deaths, 54% were under the age of 1 (71% age 1 and younger). Among not substantiated "other" deaths, 58% were under the age of 1 (69% age 1 and younger). Finally, among no indicator of maltreatment "other" deaths, 55% were under the age of 1 (66% age 1 and younger).

Figure 15: Verified Maltreatment Other Deaths by Age of Child (n=24)



Race of Child and Hispanic or Latino Origin

Child death case reviews result in the collection of data on race and ethnicity as they relate to child maltreatment fatalities. As seen in Table 14 (and Figures 16 and 17), black children are disproportionately represented in drowning deaths when compared to the general population (based on available data). Here, among all child deaths investigated, 31.9% of the children were identified as black and 65.6% were identified as white. This is consistent with national studies that show drowning rates to be significantly higher for black children in proportion to their representation within the general population.[1]

Ethnicity of the child could also be identified separate from race. Of all **verified** maltreatment fatalities, those children identified to be of **Hispanic or Latino** origin represented:

- 14% of drowning deaths
- 0% of asphyxia deaths
- 29% of weapon deaths
- 21% of other deaths

[1] Gilchrist J, Parker EM. Racial/ethnic disparities in fatal unintentional drowning among persons aged ≤29 years—United States, 1999–2010. MMWR 2014;63:421–6.

Table 14: Race and Ethnicity (Hispanic/Latino Origin) of Children by Primary Cause of Death and Maltreatment Verification Status												
Race	Verified Child Maltreatment Death n=68				Not Substantiated Child Maltreatment Death n=51				No Indicators Child Maltreatment Death n=170			
	Drowning n=22	Asphyxia n=8	Weapon n=14	Other n=24	Drowning n=8	Asphyxia n=22	Weapon n=2	Other n=19	Drowning n=33	Asphyxia n=66	Weapon n=7	Other n=64
Black	50%	38%	36%	4%	13%	50%	100%	42%	24%	38%	14%	25%
White	45%	63%	64%	96%	75%	50%	0%	58%	70%	61%	71%	72%
Other	5%	0%	0%	0%	13%	0%	0%	0%	6%	2%	14%	2%
Hispanic or Latino Origin												
Hispanic or Latino	14%	0%	29%	21%	25%	27%	0%	11%	27%	9%	0%	27%
Please note that column percentage totals may exceed 100% as children can be identified as bi- or multi-racial/ethnic.												

Figure 16: Race and Ethnicity of Child for Verified Maltreatment Deaths Across Primary Causes of Death (N=68)

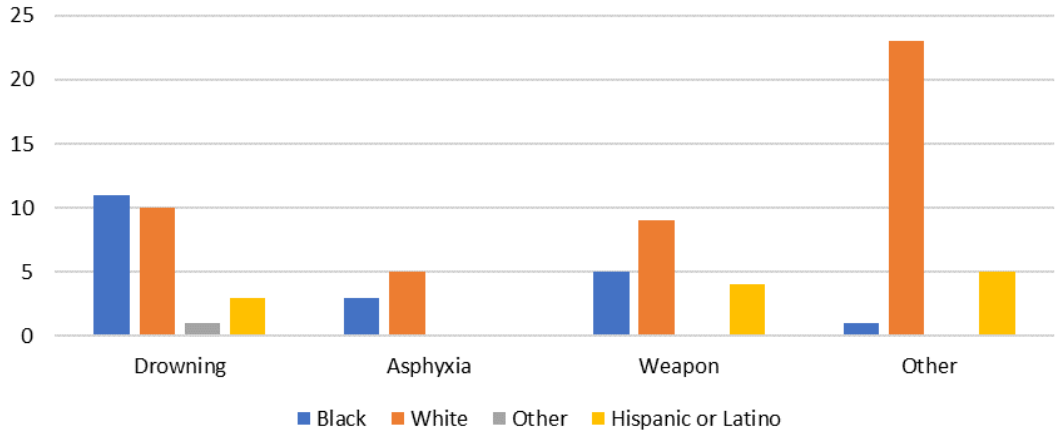
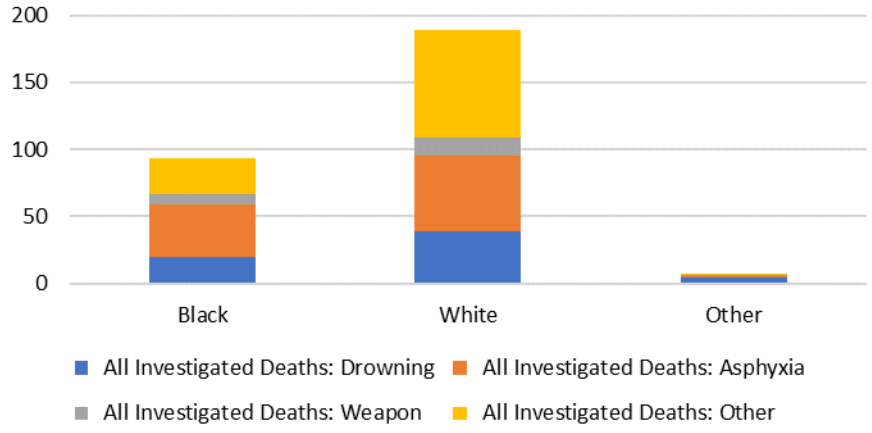


Figure 17: Race of Child Across All Investigated Deaths (n=289)



Sex of Child

Males (see Table 15 and Figures 18 through 21) were disproportionately represented among child fatalities across all primary causes of death (regardless of maltreatment verification status) except for weapons related deaths where most child victims were females.

Table 15: Sex of Children by Maltreatment Verification Status and Primary Cause of Death

Child Sex	Child Maltreatment Death n=289											
	Verified n=68				Not Substantiated n=51				No Indicators n=170			
	Drowning n=22	Asphyxia n=8	Weapon n=14	Other n=24	Drowning n=8	Asphyxia n=22	Weapon n=2	Other n=19	Drowning n=33*	Asphyxia n=66	Weapon n=7	Other n=64
Female	41%	38%	71%	38%	13%	41%	100%	37%	30%	42%	57%	39%
Male	59%	63%	29%	63%	88%	59%	0%	63%	67%	58%	43%	61%

* Although there were 33 no indicators drowning deaths, the sex of one child was not reported.

Figure 18: Sex of Child for All Investigated Drowning Deaths (N=62)

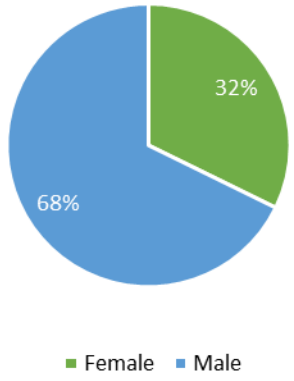


Figure 19: Sex of Child for All Investigated Asphyxia Deaths (N=96)

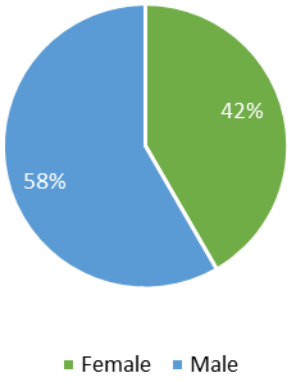


Figure 20: Sex of Child for All Investigated Weapon Deaths (N=23)

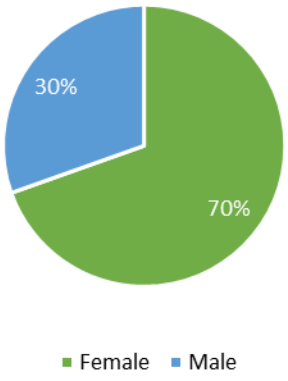
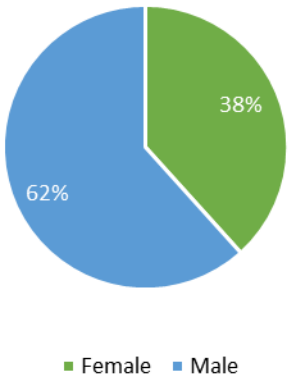


Figure 21: Sex of Child for All Investigated Other Deaths (N=107)



Type of Residence and New Residence

The overwhelming majority (83.6%) of all children who are the subject of this report resided in their parental home. In 4 verified, 5 not substantiated, and 19 no indicators of maltreatment deaths, children lived with non-parental relatives. In total, 3 resided in a relative foster home (1 in each verification status category) and 16 (4 verified, 3 not substantiated, and 9 no indicators) in "other" situations not classified by the case reporting form. These "other" situations included residence with a friend or neighbors (n=5), hotel/motel (n=4), babysitter/paramour's home (n=2), another legal guardian or godparent's home (n=2), a residential drug treatment program (n=1), a shed (n=1), and an illegal/unlicensed daycare facility (n=1). Statewide information on whether the child's residence was a new residence (occupied within the 30 days prior to the incident) was reportedly known for 268 cases for which only 35 (13%) of the residences were considered new residences. Among these 35 cases, 7 associated with verified maltreatment fatalities.

Is Child from Multiple Birth?

Data on multiple births apply only to those deaths for which the child was under the age of one year. Statewide, 13 cases (1 verified, 3 not substantiated, and 9 no indicators deaths) were identified to be from multiple births.

Child Problems in School?

This question was deemed not applicable for 312 children. Of these, 301 children were five years of age or younger and likely have yet to be enrolled in school. Among applicable children, six were identified as having a school problem which were identified as either academic (n=2), behavioral (n=4) and other (n=1).

Disability or Chronic Illness of Child

Statewide, 53 of 348 children (15.2%) were identified as having a disability or chronic illness (7 verified, 6 not substantiated, and 40 no indicators). Please note that information on this data element was unknown or missing for 42 children (12.1%). Among the 53 children identified to have a disability or chronic illness, where the type of disability or illness was classified*:

- 36 had physical disabilities
- 20 had cognitive/intellectual disabilities
- 4 had mental health disabilities
- 6 had sensory disabilities

* *Note: Some children had multiple disabilities.*

Child's Mental Health

Information was collected regarding whether a deceased child had been receiving "current" mental health services, if a child had received mental health services in the past, if a child was on medications for mental health issues/illnesses, and if there were issues that prevented a child from receiving mental health services. For the majority of cases reviewed, these inquiries were not applicable due to the age of the child. For the valid responses received, the following was identified:

- 9 children had received prior mental health services (2 were verified, 1 not substantiated, and 6 were no indicator cases)
- 7 children were currently receiving mental health services (2 were verified, 0 not substantiated, and 5 were no indicator cases)
- 5 children were identified as currently on medications for mental health issues (2 were verified, 0 not substantiated, and 3 were no indicator cases)
- No children were identified to have been prevented from receiving needed mental health services

Child's History of Substance Abuse

For most child fatalities reviewed (85.1%, 296 of 348), questions related to the child's history of substance use and abuse were deemed not applicable. Responses to child substance abuse questions were left blank for four cases and identified as unknown for two cases. Among the remaining 46 cases, there were three children (one affiliated with each verification status category) identified to have had a history of substance abuse.

Child's History as Victim of Child Maltreatment

Information related to the child's history of child maltreatment was solicited from two data sources. First, each local committee was asked to report on this history (within the National Child Death Review Reporting System) given their review of all case information. Second, efforts were made to gather data from the Florida Department of Children and Families data on the number of prior reports of child maltreatment for each child whose death was investigated and the subject of 2016 case reviews.

Past history of child maltreatment was known for 292 cases, and unknown or not reported for 56 cases. Among the 292 cases for which this history was reported, 68 children (23.3%) had a known history of child maltreatment. Of these 68 children with a known history of maltreatment:

- 42.6% (29 of 68) were classified as verified maltreatment deaths.
- 16.2% (11 of 68) were verified as not substantiated maltreatment deaths.
- 41.2% (28 of 68) were classified as no indicators of maltreatment deaths.

The distribution (using actual counts and percentage) of known past maltreatment incidents across maltreatment verification status and primary cause of death is shown in Appendix G.

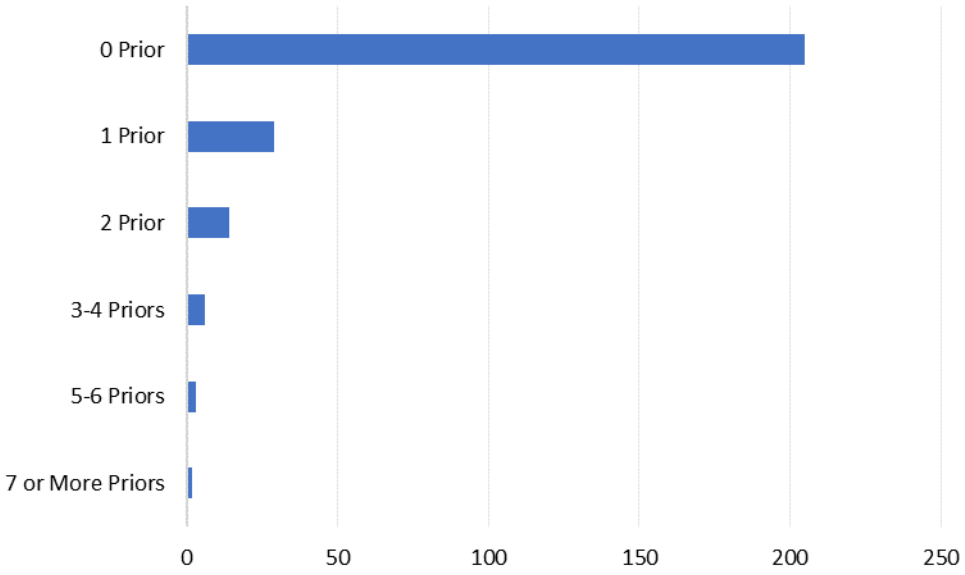
Table 16 and Figure 22 highlight the number and percentage of child deaths (across verification and primary cause of death categories) for which a prior DCF report of child maltreatment exists. The reader should note that the number of cases for which these data apply include those for which valid information (i.e. known history of prior maltreatment incident exists) could be matched with cases reviewed by local committees. ***Further, local committees can use information other than known priors investigated by the Florida Department of Children and Families (e.g. investigations in other states, unreported history made known following the child's death, etc.) in determining if there was a history of child maltreatment (reported above).*** Per DCF information, there were a total of 54 children (of those who are the subject of this report, not all 2016 deaths) for which there was a prior maltreatment incident investigated by DCF. Of these 54 children with priors:

- 40.7% (22 of 54) were classified as verified maltreatment deaths.
- 20.4% (11 of 54) were verified as not substantiated maltreatment deaths.
- 38.9% (21 of 54) were classified as no indicators of maltreatment death.

Among all known priors, the majority (53.7% or 29 of 54) had one known prior. A total of 14 (25.9%) had two known priors, six (11.1%) had three to four known priors, and five (9.3%) had five or more known priors.

Table 16: Number of Prior Reports on Child by Maltreatment Verification Status and Primary Cause of Death												
Prior Report	Verified Child Maltreatment Death n=60				Not Substantiated Child Maltreatment Death n=49				No Indicators Child Maltreatment Death n=150			
	Drowning n=20	Asphyxia n=6	Weapon n=14	Other n=20	Drowning n=7	Asphyxia n=21	Weapon n=2	Other n=19	Drowning n=25	Asphyxia n=60	Weapon n=7	Other n=58
Yes	40%	17%	50%	30%	29%	5%	50%	37%	12%	13%	29%	14%
No	60%	83%	50%	70%	71%	95%	50%	63%	88%	87%	71%	86%
Number of Reported Incidents	**If Yes, Verified Child Maltreatment Deaths (n=22)**				**If Yes, Not Substantiated as Child Maltreatment Deaths (n=11)**				**If Yes, No Indicators that Child Maltreatment Deaths (n=21)**			
	Drowning n=8	Asphyxia n=1	Weapon n=7	Other n=6	Drowning n=2	Asphyxia n=1	Weapon n=1	Other n=7	Drowning n=3	Asphyxia n=8	Weapon n=2	Other n=8
1	88%	100%	43%	33%	50%	0%	100%	43%	67%	75%	0%	38%
2	0%	0%	14%	50%	50%	100%	0%	29%	0%	0%	100%	50%
3	13%	0%	29%	0%	0%	0%	0%	0%	0%	0%	0%	0%
4	0%	0%	14%	0%	0%	0%	0%	0%	33%	0%	0%	13%
5	0%	0%	0%	17%	0%	0%	0%	0%	0%	0%	0%	0%
6	0%	0%	0%	0%	0%	0%	0%	29%	0%	0%	0%	0%
7	0%	0%	0%	0%	0%	0%	0%	0%	0%	13%	0%	0%
8	0%	0%	0%	0%	0%	0%	0%	0%	0%	13%	0%	0%

Figure 22: Total Number of Reported Incidents (n=259)



DCF Case Status at Time of Death and Past Placement History for Child and Siblings

Among the cases reviewed, there were 35 cases reported by the local committees with open child protective services cases at the time of the child death. Of these 35 cases, 10 (28.6%) of these child deaths were classified as verified maltreatment deaths, 8 (22.9%) were classified as not substantiated, and 17 (48.6%) were identified as no indicators of maltreatment deaths.

Among cases reviewed, there were 14 cases reported by the local committees placed outside the home at any time prior to the death (not necessarily at the time of the death). Of these 14 cases, 8 (57.1%) of these child deaths were classified as verified maltreatment deaths, 3 (21.4%) were classified as not substantiated, and 3 (21.4%) were identified as no indicators of maltreatment deaths.

Among cases reviewed, there were 40 cases reported by the local committees where siblings were placed outside of the home prior to the child's death. Of these 40 cases, 16 (40.0%) of these child deaths were classified as verified maltreatment deaths, 15 (37.5%) were classified as not substantiated, and 9 (22.5%) were identified as no indicators of maltreatment deaths.

CAREGIVER, SUPERVISOR, AND PERSON(S) RESPONSIBLE CHARACTERISTICS

During case reviews, information is collected on the child's caregivers, the supervisor of the child at the time of the incident leading to the child's death, and for verified child maltreatment deaths, the person(s) responsible for the child's death. **Caregivers** are identified as the child's "primary caregivers" regardless of their involvement in the child's death. Opportunities are provided for the local committees to collect information on up to two primary caregivers. The **supervisor** of the child is the person primarily responsible for monitoring the child at the time of the death incident. This person may or may not be one of the primary caregivers. Finally, for verified child maltreatment deaths, there is a classification of the **person(s) responsible** for action(s) that caused and/or contributed to the child's death. It is important to note that person(s) may be represented more than once and in various combinations across these three classifications.

Number of Caregivers Present

At least one primary caregiver was identified for all child fatality cases. See Appendix G, which summarizes the percentage of child fatality cases where one or two caregivers were identified.

Average Age of Caregivers, Supervisors, and Person(s) Responsible for Death

The average age of all caregivers, supervisors, and person(s) responsible across all primary causes of death ranges from a low of 15 years (for persons(s) responsible-caused for no indicators weapon related death) to a high of 50.0 years (for persons responsible-contributed for no indicators weapon related deaths) with the average age in the late twenties and early thirties for most other categories. See Appendix G for average ages of caregivers, supervisors, and person(s) responsible for child deaths.

Gender of Caregivers, Supervisors, and Person(s) Responsible for Death

Females were the majority caregivers for children across all categories of death and verification status categories except for no indicator weapon deaths where 57 percent of the caregivers were males. The majority supervisors of children for drowning, asphyxia, and other death cases were females. There was an equal distribution (50% each) of male and female supervisors in weapons related deaths for verified and no indicators of maltreatment deaths; however, males represented the majority (100% or 2 of 2) supervisors in weapon deaths not substantiated as maltreatment.

Note that the Case Report Form does not collect data on relationship or marital status, so head of household status is unknown. The state committee recommends adding this data element to the Case Report Form for Florida cases, if possible. By collecting these data, we will be better able to understand how marital status and household living situations may impact child maltreatment.

Substance Abuse History of Caregivers, Supervisors, and Person(s) Responsible for Child's Death

Local committees were asked to identify, using information available, whether any caregivers, supervisors, and/or person(s) responsible had an identified substance abuse history. Note that "history" of substance abuse does not necessarily indicate that the individual was using substances during the death incident.

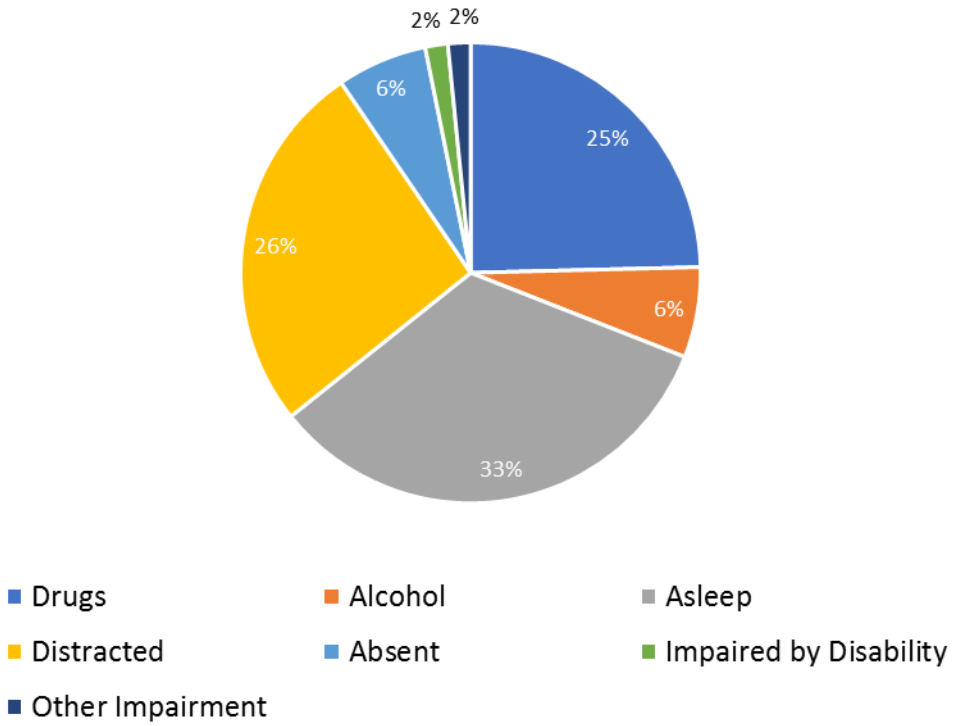
For verified child maltreatment cases:

- 36.0% of caregivers were known to have a substance abuse history
- 39.7% of supervisors were known to have a substance abuse history
- 51.5% of person(s) responsible were known to have a substance abuse history

Note that the above figures are conservative estimates based only on information that could be collected during the case review. The incidence is likely much higher. See Appendix G for detailed information related to substance abuse history of all caregivers, supervisors and person(s) responsible.

Information is collected regarding whether the supervisor of the child at the time of the death incident was impaired. Here, supervisor impairment was identified for 29.6 percent (103 of 348) cases, not identified for 46 percent (160 of 348), and unknown or missing for 24.4 percent (85 of 348) cases. Among the 103 cases where the supervisor was impaired, 30 were associated with verified maltreatment deaths, 19 with not substantiated, and 54 with no indicators of maltreatment deaths. Impairment can take several forms. Figure 23 provides a breakdown of the distribution of types of supervisor impairment across all investigated deaths. In total, 126 impairments were identified for 103 supervisors for which 33 percent of the impairments were associated with the supervisor being asleep, followed by being distracted (26%), and being under the influence of drugs (25%) and alcohol (6%).

Figure 23: Supervisor Impairment at Time of Death Incident
(n=126 Impairments for 103 Supervisors)



Mental Health History of Caregivers, Supervisors, and Person(s) Responsible for Child's Death

Collection of data regarding mental health history can be challenging for several reasons. There are likely differences in how this data element may be interpreted and collected by each committee (i.e., requiring a formal diagnosis versus collateral information). In addition, individuals with a past diagnosis of mental illness may be reluctant to share this information. Thus, mental health history is often under-reported, leading to case sample sizes that are too small to make valid conclusions. For example, among all caregivers (first and second) identified across all child fatality cases reviewed, information on the history of chronic illness (including mental health history) is unknown for 68 caregivers (denoted in tables). However, there were an additional 94 caregivers (9 first and 85 second) for which data (not reflected in tables) were missing on this question (i.e. data element). These figures highlight the need for better collection of information regarding mental health history of family members associated with a child fatality case.

When information was available, committees collected mental health history data across all investigated deaths. Of those cases where the presence of disability or chronic illness was identified, verified maltreatment deaths resulting from **drowning** show the following:

- 100% of caregivers were known to have a mental health history (5 out of 5 caregivers)
- 100% of supervisors were known to have a mental health history (3 out of 3 supervisors)
- 100% of person(s) responsible were known to have a mental health history (4 of 4 persons responsible)

Mental health histories were prevalent in asphyxia cases, particularly those verified as maltreatment. For verified maltreatment deaths resulting from **asphyxia** (of those cases where the presence of disability or chronic illness was identified):

- 100% of caregivers were known to have mental health history (4 of 4 caregivers)

- 100% of supervisors were known to have mental health history (2 of 2 caregivers)
- 100% of person(s) responsible were known to have mental health history (3 of 3 persons responsible)

For verified maltreatment deaths resulting from **weapons**:

- 80% of caregivers were known to have a mental health history (4 out of 5 caregivers)
- 67% of supervisors were known to have a mental health history (2 out of 3 supervisors)
- 100% of person(s) responsible were known to have a mental health history (2 out of 2)

As noted earlier, given the small number of those identified with mental health histories and the number of 2016 cases still to be reviewed, these findings should be considered tentative estimates.

Disability or Chronic Illness Occurrence of Caregivers, Supervisors, and Person(s) Responsible for Death

The Case Report Form collects information on the occurrence of disability or chronic illness among the categories identified above; however, note that the presence of such a disability or illness does not mean that the condition was related to the death incident. Most caregivers, supervisors, and person(s) responsible were noted not to have a disability at the time of a child's death. For more information on disability or chronic illness data element, see Appendix G.

Additional Characteristics of Caregivers, Supervisors, and Person(s) Responsible

Located in Appendix G is detailed information on the following:

- Employment of caregivers
- Education level of caregivers
- English spoken by caregivers, supervisors, and person(s) responsible
- Active military duty of caregivers, supervisors, and person(s) responsible
- Caregiver receipt of social services

Past History as Victim of Child Maltreatment among Caregivers, Supervisors, and Person(s) Responsible for Death

Local committees were asked to identify from available sources of information whether caregivers, supervisors, and person(s) responsible for the death of a child were past victims of child maltreatment. Local committees reported on 478 caregivers identified (up to two caregivers could be identified per case) for the 348 cases reviewed for which information on history as a victim of child maltreatment was available. History was unknown for 94 (19.7%) caregivers.

When past history as a victim of child maltreatment is examined for supervisors associated with verified maltreatment deaths:

- 33.9% (20 of 59) were past child victims of maltreatment
- 32.6% (14 of 43) of supervisors of not substantiated maltreatment had a past history as a victim of child maltreatment.
- 22.4% (34 of 152) of supervisors of no indicators maltreatment deaths had a past history as a victim of child maltreatment.

Among those persons responsible for the child's death, 31.3% (21 of 67) are known to be past child victims of maltreatment. See Appendix G for a breakdown of the proportion of caregivers, supervisors, and person(s) responsible with a history of maltreatment as children.

Past History as Perpetrator of Child Maltreatment among Caregivers, Supervisors, and Person(s) Responsible for Death

Local committees were asked to identify whether caregivers, supervisors, and person(s) responsible for a child's death have a history as a perpetrator of child maltreatment. For verified cases, the following had a history as a perpetrator: caregivers (47.2%), supervisors (52.5%) and person(s) responsible (50.7%).

Past History of Intimate Partner Violence (as Victim and Perpetrator) among Caregivers, Supervisors, and Person(s) Responsible

When available, local committees collected information about caregivers' history with intimate partner violence (IPV) as a victim and/or perpetrator. It is unclear whether the caregivers were victims or perpetrators near the time of the child's death or if caregiver history was determined by historical information gathered by local teams during case reviews. In total, 24 of 113 (21.2%) caregivers were known to be victims and 17 of 113 (15.0%) were known to be perpetrators of intimate violence among those affiliated with verified maltreatment deaths (Figure 24). With respect to caregivers in not substantiated maltreatment deaths, 22 of 102 (21.6%) were past victims and 20 of 102 (19.6%) were past perpetrators of intimate partner violence (Figure 24). In contrast, 40 of 308 (13.0%) and 27 of 308 (8.8%) caregivers in no indicators of maltreatment deaths have histories as victims and perpetrators (respectively) of intimate partner violence (Figure 24). Information regarding history of involvement with IPV (as victim and/or perpetrator) among persons responsible for

verified maltreatment deaths is unknown for approximately one quarter (25% for other deaths) to one third (32% and 38% for drowning and asphyxia deaths respectively). Findings presented in Table 17 and Figure 25 highlight that among verified maltreatment deaths, history as a perpetrator of intimate partner violence for the person responsible for the child's death ranged from a low of 0% for asphyxia deaths to a high of 36 percent for weapon deaths. History as a victim of intimate partner violence for the person responsible for the child's death ranged from a low of 14 percent for weapon deaths to a high of 50 percent for asphyxia deaths.

Figure 24: History of Intimate Partner Violence with All Caregivers by Maltreatment Verification Status (N=523)

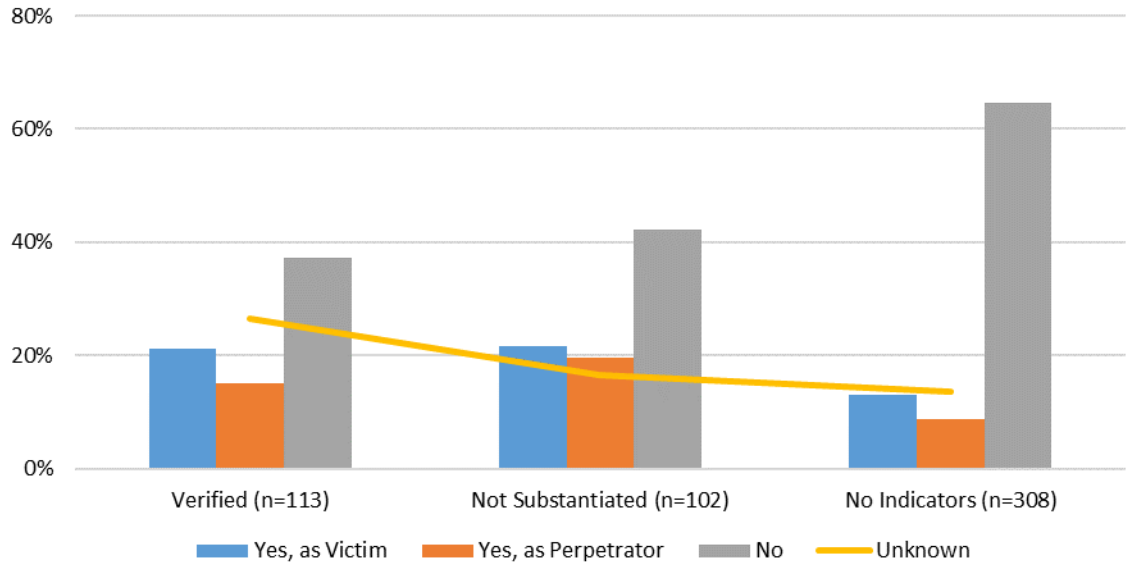
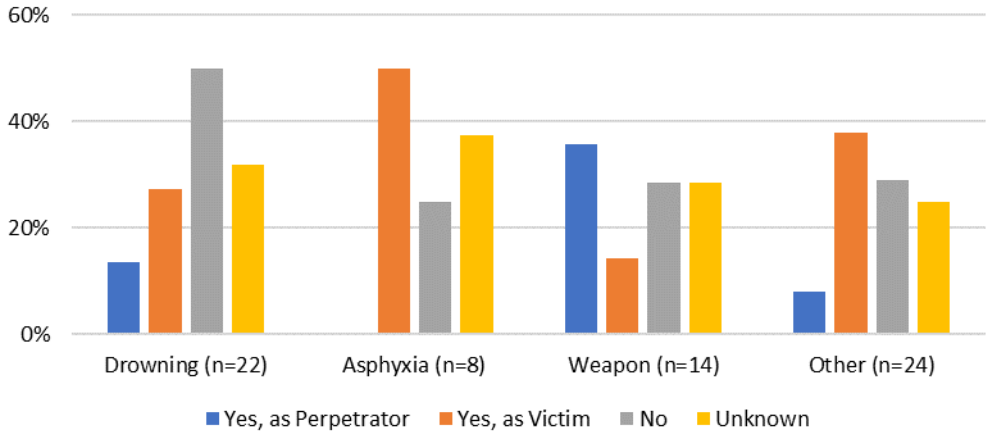


Table 17: Past History of Intimate Partner Violence for Person(s) Responsible for Verified Maltreatment Death				
History of Intimate Partner Violence: Person(s) Responsible for Child Death	Verified Child Maltreatment Death n=68			
	Drowning n=22	Asphyxia n=8	Weapon n=14	Other n=24
Yes, as Perpetrator	14%	0%	36%	8%
Yes, as Victim	27%	50%	14%	38%
No	50%	25%	29%	29%
Unknown	32%	38%	29%	25%
Data presented only on valid cases where information known to local CADR Committee. Percentage total can exceed 100% in cases where intimate partners are both victims and perpetrators.				

Figure 25: History of Intimate Partner Violence for Persons Responsible for Verified Maltreatment Death (N=68)



Appendix G provides more detailed information regarding the history of IPV (as victim and perpetrator) among caregivers, supervisors, and person(s) responsible.

National research suggests that exposure to IPV as a child, particularly for male children, is a risk factor for perpetrating violence on one's family members as an adult. However, many children who grow up in abusive homes will never abuse their family members and are often outspoken in their efforts to prevent such violence. It is recommended that supplemental analyses are conducted in future reports regarding the contextual factors in these cases to gain additional insight that will help to prevent such deaths in the future.

Past Criminal History of Caregivers, Supervisors, and Person(s) Responsible for Death

Among caregivers associated with verified maltreatment deaths, 38.0% (41 of 108) had committed a criminal offense in the past. Among those with a criminal history, those with drug offenses were represented from a low of 33% for caregivers associated with verified asphyxia deaths to a high of 75% of those caregivers associated with other deaths. The highest proportion of person(s) responsible (for verified maltreatment cases) with a criminal history were those affiliated with deaths caused by asphyxia (67%), weapons deaths (53%), other causes of deaths (29%), followed by drowning deaths (25%).

SECTION FOUR: FUTURE ANALYTIC PLANS

The overarching objective of epidemiological analyses is to connect findings and inform prevention and interventions for larger general populations, which, for State CADR Committee purposes, are children who are neglected and abused. The data analysis and subsequent assessments are utilized as evidence to direct prevention and intervention strategies for all children who are exposed to child safety risks. There are a variety of ways to conduct epidemiological studies; the following will outline the methods that were used to analyze CADR data.

Currently, data collected for the case reviews are comparable cross-sectional surveys, where information is gathered that is related to causes of death, events surrounding the death and characteristics of persons, time, and environments associated with deceased children. Some temporal (time sequence) and exposure outcome relationships can be explored with Florida CADR data, however, the data can be incomplete or may provide inconsistent information on other events, environments and circumstances that may have also influenced maltreatment outcomes and/or the risks of child death. In this report, findings of descriptive analyses of CADR data are used to compare and contrast with findings of other research about child maltreatment and deaths that result from child maltreatment.

In the past, the primary comparisons made within the CADR report have been between child fatalities verified versus non-verified to be a result of child maltreatment. The 2017 CADR report has separated the non-verified maltreatment status to include not substantiated and no indicators per the 2016 State CADR Committee recommendations and in keeping with investigatory finding classifications used by DCF (Child Maltreatment Index). Future comparisons will gauge and test factors that have a predictive influence on whether the child fatality is a result of maltreatment or not and (if not) distinguish factors that influence whether the fatality is not substantiated or shows no indicators of maltreatment. Identifying commonalities and differences across these three investigation finding categories can help refine the analysis of the magnitude of select risk factors upon child fatalities and, subsequently, improve targeted prevention initiatives. However, the conclusions from such analyses relate only to the population of cases called in to the Florida Abuse Hotline.

Other research/study designs may better inform prevention initiatives in the future. For example, using cohort study designs, children can be “followed” forward or back in time to obtain information on exposures and outcomes that occurred during a certain time-period. This type of study design permits a variety of exposures to be assessed and temporal sequence of risk/protective exposures and outcomes to be determined. An example of a desired cohort study design is a birth cohort analysis, where maternal, paternal, and infant factors before, during, and shortly after delivery of a child can be obtained; and outcomes can be compared between infants (children < 1-year old) who are not exposed to maltreatment or who are exposed to maltreatment. To obtain pertinent information on children after the first year of life, it will be important to link to data that can provide a true picture of events occurring in a child’s life beyond the first year (i.e. education; medical and mental health assessments and interventions; family socioeconomic status; neighborhood conditions).

DCF is currently engaged in efforts that utilize predictive analytics tools and techniques with historical and cohort data from multiple sources (including DCF FSFN and DOH vital statistics data) whose results (when published) may be of assistance in furthering the interpretation of findings generated from the local CADR committee reviews of child fatality cases. The DCF study is complete and a final report is forthcoming. More importantly, the State CADR Committee has been made aware that DCF (as part of the above noted study) has developed an integrated database that includes (but is not limited to) a variety of historical data on all clients reported to and/or served by DCF, vital statistics, and other population data on Florida children and

families. The State CADR Committee plans to explore opportunities for partnering with DCF (if feasible and allowed by DCF and DOH policy/protocols and state law) to merge CADR data with population data for the purpose of implementing more advanced epidemiological modeling aimed at developing collaborative recommendations for prevention initiatives. Such a collaboration using resources within each agency reinforces, from a public health perspective, the value and necessity for interagency efforts and use of advanced analytics in preventing child abuse and neglect and child maltreatment fatalities.

Expanding on these concepts, an added in-depth analysis of statewide population statistics could assist in developing targeted action plans to groups of children shown to be at risk for maltreatment based on gender, race and age as compared to the total population. These analyses will be instrumental in determining whether specific demographics associated with child deaths are over or underrepresented as compared to statewide population totals in current statistical evaluations. In addition, conducting more localized and comparative analyses could be beneficial to local CADR committees and the communities they represent. Providing local CADR committees with statistical breakdowns of their districts, and allowing local committees to visualize the key causes of child maltreatment and death impacting their specific regions will enable the local committees to compare the significant complications impacting their local regions with statewide data. This information would result in increasingly tailored local action plans for each local CADR committee.

In addition to the analytical directions outlined above, the State CADR Committee has made the following recommendations for future analyses:

- Supplemental analyses (on select data elements) including, but not limited to, multi-year analysis on 2015 and 2016 fatalities when the remaining child fatality cases are closed and reviewed by local committees
- Consider adding relationship or marital status as a data element, so head of household status (among caregivers) is known and used in analyses to better understand how marital status and household living situations impact child maltreatment.
- Explore the availability of data from local committee reviews that can aid with supplemental analyses regarding the contextual factors associated with cases involving a history of intimate partner violence, mental health issues, substance abuse, and criminal activity (and interactions between and among any of these factors)
- Conduct more trend analyses on key factors associated with verified maltreatment deaths since the adoption of the Child Death Review Case Reporting System (through the National Center for the Review & Prevention of Child Deaths) for findings generated from child fatality death reviews by local committees.
- Conduct select trend analyses comparing data on key factors across investigatory finding classifications (that include not substantiated and no indicators of maltreatment deaths) since 2014 (when the scope of cases reviewed was expanded by statute).

To inform a public health approach to child maltreatment deaths, connections between maltreatment outcomes and prevention/intervention initiatives, policies, and practices need to be assessed to determine evidence-based pathways that could lead to eliminating child maltreatment deaths. Future analyses of intervention and prevention impact studies could assess and compare outcomes of children participating in pilot programs, or when community-wide or statewide population interventions are implemented. Population and longitudinal data—beyond that currently available to the State CADR Committee but potentially accessible through enhanced collaboration between DOH and DCF—would be needed to provide the necessary information to make valid assessments on the impact of implemented preventions and interventions on child maltreatment outcomes.

SECTION FIVE: CURRENT LANDSCAPE OF FLORIDA'S CHILD WELFARE SYSTEM

Florida's approach to the reduction of child fatalities has evolved over time. Through continuous analysis of data and timely reviews of the latest research, our child welfare system shifts, adapts, and continually seeks to improve our collective capacity to meet the ever-changing needs of a diverse population.

DCF: ENCOURAGING A PROACTIVE AND COLLABORATIVE APPROACH

The presence of substance use and mental health disorders within family systems are clearly contributing factors to child maltreatment. This is especially significant as Florida continues to battle a widespread opioid epidemic throughout the state. To address this ongoing challenge, DCF has led a statewide collaborative effort to improve the integration of behavioral health services within the child welfare system. This priority of effort seeks to improve the integration of critical substance abuse and mental health services within child welfare systems of care at the state and community level. Each DCF region within Florida has completed a self-assessment of their level of behavioral health integration based on a structured and scored rubric. Following this self-assessment process, each region was visited by a team of peers from neighboring regions to discuss and evaluate their status. This process provided an opportunity for peers to share insights, practices, and lessons learned as communities worked toward integrating these service delivery systems. The results of these activities led to the development of regional-level integration action plans, tailored to the individual needs of each community-level system of care. This work seeks to improve the processes and partnerships necessary to ensure that appropriate and timely mental health and substance abuse services are provided to those in need of such services.

Since 2015, DCF and community partners have taken an active role in investigating child deaths via the deployment of Critical Incident Rapid Response Teams (CIRRT). An immediate onsite investigation is required for all child deaths reported to DCF if the child or another child in his or her family was the subject of a verified report of suspected abuse or neglect during the previous 12 months. The Secretary of DCF may also direct an investigation for other cases involving serious injury to a child and those involving a child death fatality that occurred during an active investigation. The multiagency team is tasked with providing an immediate investigation to identify root causes and rapidly determine the need to change policies and practices related to child protection and child welfare. Each team consists of at least five professionals with expertise in child protection, child welfare, and organizational management. This initiative continues to provide ground-level insight, promoting positive change within the child welfare system.

DOH: IMPROVING PUBLIC HEALTH

DOH seeks to protect, promote and improve the health of all people in Florida through integrated state, county and community efforts. Given the unique and varied demographics of our population within Florida, public health practice continues to address health inequities and social determinants that impact health outcomes for all Floridians.

Healthy People 2020 states that social determinants of health as patterns of social engagement and sense of security and well-being are also affected by where people live. Resources that enhance quality of life can have a significant influence on population health outcomes. Examples of these resources include safe and affordable housing, access to education, public safety, availability of healthy foods, and local emergency/health services. The availability of these resources clearly nourish the research-based protective factors that serve to reduce the risk of child maltreatment: concrete supports for parents, parent education, social connections, resiliency, nurturing and attachment, among others. The study of social determinants

continues to direct our efforts to bolster protective factors and reduce child maltreatment by providing support to at-risk families.

Effective public health practice also demands that goals and progress are monitored on social and health indicators to assess community health. Our ability to “move the needle” on population-based outcomes and practices hinge on well-defined health outcomes and objectives. While preventive efforts can be more difficult to evaluate, child maltreatment prevention advocates must continue to find ways to measure our success so that resources can be strategically leveraged.

COLLABORATING PARTERSHIPS: UNDERSTANDING THE SCOPE OF THE CHILD WELFARE SYSTEM

Child maltreatment and preventable fatalities are issues that reach well beyond the scope of one or two agencies. Strategies to prevent child maltreatment must be implemented using a multi-level, multi-sector approach. Public health, social services, health care, education, justice, and even non-traditional partners such as businesses and service organizations need to work together to prevent child maltreatment and its consequences. This collaborative approach ensures consistency of messaging, encourages the pooling of resources, and reduces duplicative efforts.

A comprehensive approach that engages all levels of our social ecology (including societal culture) will positively impact community involvement, relationships among families, and individual behaviors. Effective prevention strategies should focus on modifying policies, practices, and societal norms to create safe, stable, nurturing relationships and environments. State and local CADR committees will continue to utilize research and practice recommendations of the Centers for Disease Control and Prevention (CDC) pertaining to child maltreatment and violence prevention.

SECTION SIX: IMPLEMENTATION OF PREVIOUS RECOMMENDATIONS

DRIVING DATA INTO ACTION

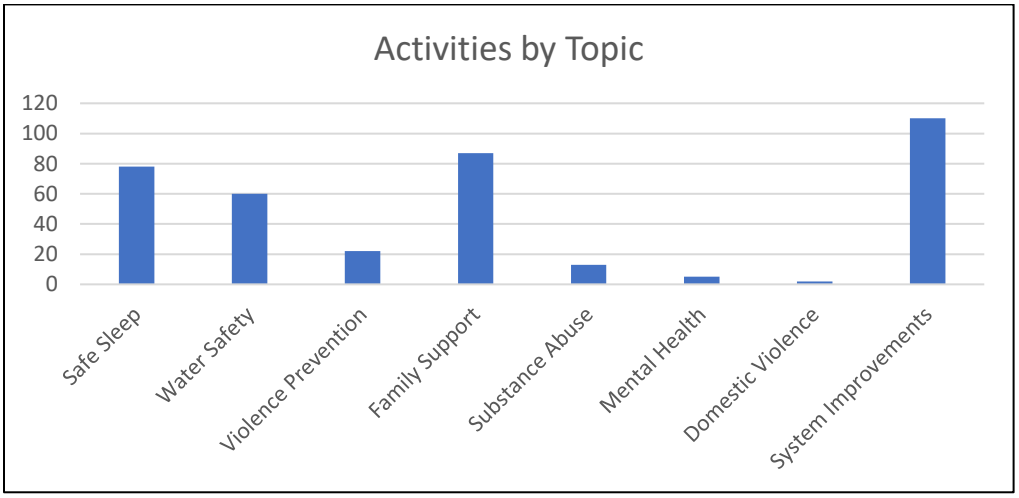
CADR data and corresponding recommendations continue to play a pivotal role in the shaping of prevention strategies at both state and local levels. Over the past year, local CADR committees used their community level data to develop action plans to enable them to act, when possible, on strategies aimed at prevention of child maltreatment. By July 2017, all 22 local CADR committees had prevention action plans in place comprising 194 activities.

PREVENTION ACTIVITIES AT THE LOCAL LEVEL

To better understand the scope and direction of community-based prevention activities throughout the state, DOH staff conducted a content analysis of CADR action plans created by local CADR committees. All 194 activities from local action plans were combined, sorted and coded based on the categories listed below:

- Safe Sleep – media campaigns, pack-n-plays, training, etc.
- Water Safety – media campaigns, swim lessons, watcher tags, pool/door alarms, etc.
- Violence Prevention – shaken baby/coping with crying, gun safety, positive discipline
- Family Support – parent education and support, bike safety, swim lessons, car seat installation, concrete goods
- Substance Abuse – drug treatment programs, facilitated access to treatment, partner education
- Mental Health – mental health treatment, facilitated access to treatment, partner education
- Domestic Violence (DV) – intimate partner violence prevention, access to DV advocates
- System Improvements – sustainable changes in processes or system, funding for position, etc.

The majority of topic-based prevention strategies targeted water safety and safe sleep, which is consistent with findings that drowning and asphyxia were top causes of death during last year's review of the data. Committees also demonstrated significant involvement in the provision of family supports and system improvements. These improvements often overlapped the specific targeting of safe sleep, water safety, and other areas known to be contributing factors to child death. System improvements and the provision of family support are often the venues by which we can address these contributing factors to child maltreatment. Many system improvements improved access to services by which the remaining topics could be addressed.



While these initial results are encouraging, potential opportunities for improvement are apparent. Prevention efforts aimed at violence prevention (prevention of inflicted trauma), substance use disorders, mental health, and domestic violence were lacking, despite evidence that these are often contributing factors to child maltreatment. Further analysis will serve to identify gaps in prevention strategies in circuits where these specific factors are significant enough to warrant additional attention. For a complete look at a content analysis of local CADR committee action planning, see Appendix F.

The remarkable leadership qualities that the local CADR chairpersons possess are constantly on display. These are individuals who have extremely demanding full-time careers, but commit countless hours of hard work to the prevention of child abuse and neglect deaths in Florida. These committed volunteers lead comprehensive child death review meetings, accurately complete data entry for each case they review, as well as recommend, plan, and implement prevention initiatives within their respective communities. In response to the 2016 recommendations to encourage collaborative partnerships and offer training to local committees, four highly regarded local chairpersons were selected by the State CADR Committee to serve as panelists for the 2017 Joint State and Local Child Abuse Death Review Meeting. The panelists included Connie Shingledecker, Karen Yatchum, Laly Serraty and Vicki Whitfield. These individuals were selected because of their experience, their proven ability to lead highly effective review meetings, and the innovations and prevention initiatives they are implementing at the local level. The panelists provided valuable information to meeting participants regarding three key objectives: operational and logistic processes, quality and consistency of specific review processes, and innovations and examples of prevention initiatives.

PREVENTION ACTIVITIES AT THE STATE LEVEL

CADR data findings and recommendations also significantly influence programmatic policies and processes at the state level. CADR findings help determine training needs for statewide staff, inform decisions regarding prioritization of effort, and assist in the development of policies to support and protect the well-being of Florida's children.

Over the past year, numerous statewide efforts have acted upon previous recommendations targeted to address preventable child deaths and identified contributing factors. Some examples follow:

- Safe Kids Florida Child Drowning Prevention efforts: WaterSmart drowning prevention campaign (www.WaterSmartFL.com)
- DOH continues to expand its Healthy Babies Florida initiative, which encourages Baby Friendly Hospitals and other efforts to reduce infant mortality throughout the state. Early Steps, a program designed to provide early intervention to children with developmental delays, is adding Neonatal Abstinence Syndrome (NAS) as an at-risk category.
- DCF's Substance Abuse and Mental Health (SAMH) Program partners with DOH and other agencies to prevent and reduce substance use disorders, a contributing factor to preventable child deaths. This partnership supports a website to educate public and health care providers including information on the effects of drug use during pregnancy.
- Home visiting programs, such as Healthy Families Florida (HFF), regularly provide information to clients regarding safe sleep, water safety, and coping with crying. In addition, HFF has received funding from DCF to implement and evaluate a dual-model behavioral health enhancement. This enhancement offers either in-home mental health counseling or behavioral health care navigation services to families who are experiencing domestic violence, substance abuse and mental health issues.

- Expansion of Family Intensive Treatment Teams (FITT): This unique program provides treatment and parent education to substance-involved families involved in the child welfare system and continues to be a model for child welfare and behavioral health integration.
- Recognizing that children in the foster care system often experience substandard life outcomes, the Florida Coalition Against Domestic Violence (FCADV), DCF, and the Office of the Attorney General (OAG) partnered to create a groundbreaking program designed to provide a coordinated community response for families experiencing the co-occurrence of domestic violence and child abuse by co-locating domestic violence advocates within child protection investigation units in all 67 counties. The co-located domestic violence advocates provide trauma-informed consultations with child welfare professionals around cases involving the co-occurrence of domestic violence and child abuse, utilizing trauma-informed practices to complete safety plans, case plans, and service provisions.

The above examples represent only a fraction of ongoing state efforts to reduce the incidence of child maltreatment and subsequent child death. Each State CADR Committee member, through the agencies they represent, serves as an advocate to seek positive change for this important cause.

SECTION SEVEN: 2017 PREVENTION RECOMMENDATIONS

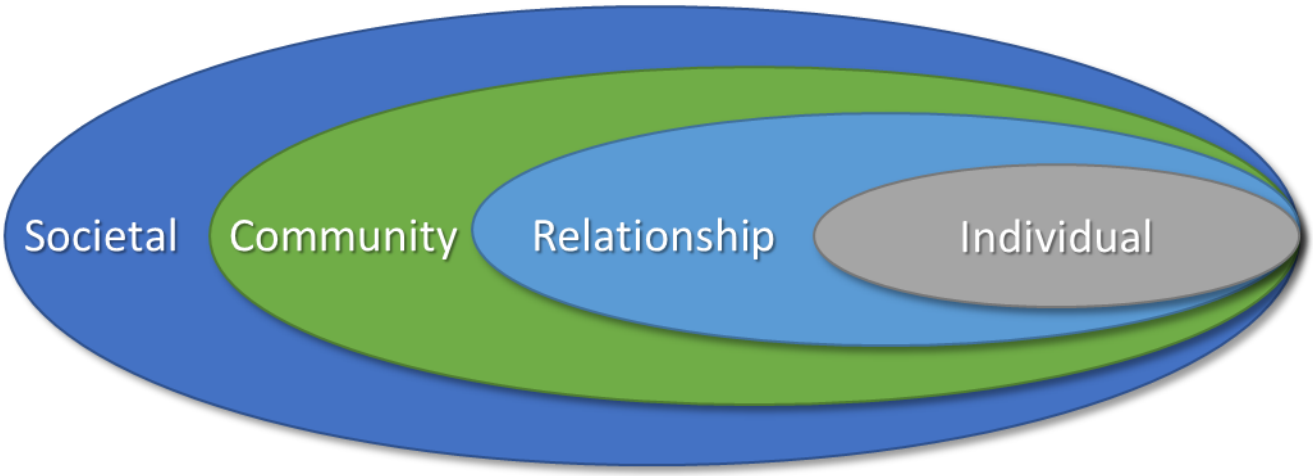
MOVING FORWARD: A SOCIAL ECOLOGICAL MODEL FOR CHANGE

As outlined in the Data Section (Section Three) of this report, the top three categories of preventable child fatalities in Florida continue a trend that has persisted over the last several years. These categories include child fatalities that occur as a result of:

- Asphyxiation
- Drowning
- Inflicted Trauma

The 2017 prevention recommendations are based on an analysis of Florida's CADR findings for 2016 cases reviewed to date, input provided by State and local CADR committees, and a review of literature and the most current research on prevention strategies as outlined by our nation's foremost experts. Research and literature contributing to this year's recommendations include the following:

As reflected within this report, successful strategies to prevent child maltreatment are best implemented using a highly collaborative, comprehensive, multi-level, and multi-sector approach. In order to adequately address each level of intervention, approaches to prevention can be organized using the following framework known as the Social Ecological Model for Change.



This four-level model, as presented by the CDC, serves as a framework for prevention and illustrates the various factors that interact, overlap, and ultimately impact our understanding of societal issues (such as interpersonal violence). The above graphic also reflects the need to act across multiple levels of the model to achieve sustainable change. Societal, community, relationship, and individual levels of social ecology must all be considered during the development of prevention strategies.

The following key prevention strategies and approaches recommended by the CDC cut across all levels of the social ecology model and engage a wide range of societal sectors in prevention efforts.

Strategy	Approaches	Lead Sectors
Strengthen economic supports to families	Strengthening household financial security Family-friendly work policies	• Government (Local, State, Federal) • Business/Labor
Change social norms to support parents and positive parenting	Public engagement and education campaigns Legislative approaches to reduce corporal punishment	• Public Health • Government (Local, State, Federal)
Provide quality care and education early in life	Preschool enrichment with family engagement Improved quality of child care through licensing and accreditation	• Social Services • Public Health • Business/Labor • Government (Local, State, Federal)
Enhance parenting skills to promote healthy child development	Early childhood home visitation Parenting skill and family relationship approaches	• Public Health • Social Services • Health Care
Intervene to lessen harms and prevent future risk	Enhanced primary care Behavioral parent training programs Treatment to lessen harms of abuse and neglect exposure Treatment to prevent problem behavior and later involvement in violence	• Public Health • Social Services • Health Care • Justice

** Table adapted from an expanded version outlined in Preventing Child Abuse and Neglect: A Technical Package for Policy, Norm, and Programmatic Activities, developed by the by the National Center for Injury Prevention and Control with the Centers for Disease Control (CDC)*

In response to a thorough review of the data presented in this year's report, the State CADR Committee also makes the following recommendations, all of which will serve to reduce the incidence of preventable child death by targeting drowning, unsafe sleep practices, inflicted trauma, and research-based contributing factors (i.e., substance use, mental health disorders, intimate partner violence) that increase the likelihood of such preventable deaths.

❖ *Expand Efforts to Relay Timely Information to Parents Regarding the Safety of Children*

The State CADR Committee recommends that communities consider providing timely messaging to parents regarding potential risks to children. For example, partnering with the business sector, such as pool supply and maintenance companies, may provide a venue to distribute additional water safety information during the purchase of pool or spa supplies. Waterfront communities are encouraged to post signage regarding potential water safety hazards. This could be further expanded by distribution of information by hotels and other locations where tourists may visit, such as turnpike rest areas and water parks. Messaging should consider language barriers and cultural differences which may apply to international tourists. The same concept applies

to the prevention of asphyxia, by educating parents of infants on safe sleep practices. Breastfeeding education should incorporate instruction on safe sleep practices, and include information on over-the-counter and prescription medications that may pose a risk to an adult's alertness while breastfeeding.

- ***Expand Training of First Responders to Assess Risk to Children***

First responders play a key role in prevention efforts, as evidenced by several locally-based prevention strategies seeking to intervene during hazardous situations that place children at risk. First responders can assess for adequate supervision, substance misuse, and other factors that contribute to child death. Increased reporting by these professionals will allow for timely intervention. In those cases where a death has occurred, reporting such deaths and surrounding circumstances will aid efforts to further study and prevent the incidence of child death.

- ***Consider the Use of Social Media to Provide Timely Messaging and Support to Parents***

Parenting programs and awareness campaigns have begun to leverage social media as a powerful communication tool, especially among young parents. Expanding upon this platform, location services and targeted messaging could be used to alert parents to potential hazards in their environment. This potential targeted messaging should be further explored.

- ***Leverage the Power of Shared Data***

Agencies such as DOH, DCF, community-based care agencies, and substance-abuse and mental health managing entities must capitalize on the vast amounts of data collected on children, including aspects of child welfare involvement and health outcomes. Matching child death data with other data-rich systems such as Florida Safe Families Network (FSFN), Florida Community Health Resource Tool (FLCHARTS), and DOH vital statistics data could further inform prevention strategies.

Data findings could be expanded for further analysis to assess for racial disproportionality, health inequities and will increase understanding of how social determinants for health may play into the occurrence of preventable child death. Additional analysis can help determine if preventable deaths such as drowning are under-reported in certain areas. The sharing of data between agencies is crucial to this expanded effort.

The committee recommends that sufficient resources be provided to these agencies to sufficiently collect clean, accurate data, enabling the committee to further drill-down into specific maltreatments that lead to child death. While much of the CADR data and related prevention strategies target asphyxia and drowning, the dynamics behind inflicted trauma should be further explored. This knowledge will improve the ability to provide the appropriate support to families and caregivers and prevent violence within the home.

- ***Continue to Encourage Collaborative Partnerships at both the State and Community Levels***

As demonstrated within this report, the well-being and protection of Florida's children is a shared responsibility, involving numerous agencies and professional services. Collective responses are necessary to fully meet the needs of at-risk children. A prime example of such efforts is a community-based approach provided by the National Drug-Endangered Children (DEC) Coalition. The National Alliance for Drug Endangered Children targets drug endangered children who are at risk of suffering physical or emotional harm as a result of illegal drug use, possession, manufacturing, cultivation, or distribution. This includes children whose caretaker's substance misuse interferes with the caretaker's ability to parent and provide a safe and nurturing environment. DEC provides training and support to communities seeking to protect these children via a multi-agency, multidisciplinary response to drug crises.

Another useful venue for state and local collaboration would be the continuation of joint meetings with State CADR Committee members and local CADR Committee chairpersons. The joint meetings provide opportunities to share ideas and best practices and troubleshoot concerns at both state and local levels.

At the local level, partnering with other agencies, councils, and task forces is a necessity. This would allow local groups to compare data, decide on key consistent prevention messaging, and develop collaborative community-based action plans to target the specific needs of their community. Local CADR committees should partner with community coalitions, their local Child Abuse Prevention and Permanency Task Force, local school systems, and community-based initiatives with similar goals.

- ***Continue to Support the Integration of Behavioral Health Services into the Child Welfare System***

Substance use disorders, mental health disorders, and dynamics associated with IPV can both independently and collectively impact parental capacity and child well-being while greatly increasing the risk of child harm. Readily accessible and appropriate interventions for families at risk dealing with these issues is a critical step toward ensuring a safe, stable, and nurturing environment for children. Community-based systems of care must take the necessary steps to ensure behavioral health services are comprehensively integrated into the service delivery system to sufficiently meet the needs of their client population. Scope of services should address all levels of need, including prevention, intervention, and treatment services. The provision of ongoing support services helps to ensure families at risk have the resources needed to bolster resiliency and sustain stability.

- ***Continue to Support Programs that Enhance Parenting Skills***

Home visiting programs, such as Healthy Families Florida (HFF), serve families at risk and bolster those protective factors that offset the risk of child maltreatment and preventable child death. The services provided by such programs are wide in scope and timely address all potential causes of maltreatment death. Targeted prevention programs such as HFF ensure an efficient and strategic use of our state's resources. Continued expansion of Family Intensive Treatment Teams (FITT) is another example of a targeted response to prevent child maltreatment deaths.

SECTION EIGHT: CONCLUSIONS AND NEXT STEPS

This study is not an undertaking for the faint of heart; numerous emotions are stirred when Florida's children die preventable deaths. Those who give their time and energy to this cause steadfastly pursue the issues at hand to better understand how the unnecessary pain and grief that accompanies the loss of children can be avoided, in hopes that needless tragedy can be prevented in the future. These deaths must speak in a way that paves the way for future progress, for improvements in systems that will support at-risk families and the challenges faced by the growing population. For this reason, putting this data into action is of paramount importance.

The prevention recommendations included in this report will help ensure successful outcomes. Evidence-based prevention programs and practices should be adopted, and new innovative practices should be evaluated. The State CADR Committee will continue to improve and expand upon appropriate and available data sets to further research child maltreatment in Florida, reaching beyond the mere collection of data to strategic action.

We must continue to improve and expand upon appropriate and available data sets to further research child maltreatment in Florida, as we strive to reach our ultimate goal:

To eliminate preventable child fatalities in Florida by better understanding the complexities of child maltreatment and leveraging this evidence-based knowledge to drive current and future prevention strategies.

APPENDICES

ANNUAL REPORT

DECEMBER 2017

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APPENDIX A:

Section 383.402, Florida Statutes

Section 383.402, Florida Statutes

383.402 Child abuse death review; State Child Abuse Death Review Committee; local child abuse death review committees.—

(1) INTENT.—It is the intent of the Legislature to establish a statewide multidisciplinary, multiagency, epidemiological child abuse death assessment and prevention system that consists of state and local review committees. The committees shall review the facts and circumstances of all deaths of children from birth to age 18 which occur in this state and are reported to the central abuse hotline of the Department of Children and Families. The state and local review committees shall work cooperatively. The primary function of the state review committee is to provide direction and leadership for the review system and to analyze data and recommendations from local review committees to identify issues and trends and to recommend statewide action. The primary function of the local review committees is to conduct individual case reviews of deaths, generate information, make recommendations, and implement improvements at the local level. The purpose of the state and local review system is to:

(a) Achieve a greater understanding of the causes and contributing factors of deaths resulting from child abuse.
(b) Whenever possible, develop a communitywide approach to address such causes and contributing factors.
(c) Identify any gaps, deficiencies, or problems in the delivery of services to children and their families by public and private agencies which may be related to deaths that are the result of child abuse.
(d) Recommend changes in law, rules, and policies at the state and local levels, as well as develop practice standards that support the safe and healthy development of children and reduce preventable child abuse deaths.
(e) Implement such recommendations, to the extent possible.

(2) STATE CHILD ABUSE DEATH REVIEW COMMITTEE.—

(a) Membership.—

1. The State Child Abuse Death Review Committee is established within the Department of Health and shall consist of a representative of the Department of Health, appointed by the State Surgeon General, who shall serve as the state committee coordinator. The head of each of the following agencies or organizations shall also appoint a representative to the state committee:

a. The Department of Legal Affairs.
b. The Department of Children and Families.
c. The Department of Law Enforcement.
d. The Department of Education.
e. The Florida Prosecuting Attorneys Association, Inc.
f. The Florida Medical Examiners Commission, whose representative must be a forensic pathologist.

2. In addition, the State Surgeon General shall appoint the following members to the state committee, based on recommendations from the Department of Health and the agencies listed in subparagraph 1., and ensuring that the committee represents the regional, gender, and ethnic diversity of the state to the greatest extent possible:

a. The Department of Health Statewide Child Protection Team Medical Director.
b. A public health nurse.
c. A mental health professional who treats children or adolescents.
d. An employee of the Department of Children and Families who supervises family services counselors and who has at least 5 years of experience in child protective investigations.
e. The medical director of a child protection team.
f. A member of a child advocacy organization.
g. A social worker who has experience in working with victims and perpetrators of child abuse.
h. A person trained as a paraprofessional in patient resources who is employed in a child abuse prevention program.
i. A law enforcement officer who has at least 5 years of experience in children's issues.
j. A representative of the Florida Coalition Against Domestic Violence.
k. A representative from a private provider of programs on preventing child abuse and neglect.
l. A substance abuse treatment professional.

3. The members of the state committee shall be appointed to staggered terms not to exceed 2 years each, as determined by the State Surgeon General. Members may be appointed to no more than three consecutive terms. The state committee shall elect a chairperson from among its members to serve for a 2-year term, and the chairperson may appoint ad hoc committees as necessary to carry out the duties of the committee.

4. Members of the state committee shall serve without compensation but may receive reimbursement for per diem and travel expenses incurred in the performance of their duties as provided in s. 112.061 and to the extent that funds are available.

(b) Duties.—The State Child Abuse Death Review Committee shall:

1. Develop a system for collecting data from local committees on deaths that are reported to the central abuse hotline. The system must include a protocol for the uniform collection of data statewide, which must, at a minimum, use the National Child Death Review Case Reporting System administered by the National Center for the Review and Prevention of Child Deaths.

2. Provide training to cooperating agencies, individuals, and local child abuse death review committees on the use of the child abuse death data system.

3. Provide training to local child abuse death review committee members on the dynamics and impact of domestic violence, substance abuse, or mental health disorders when there is a co-occurrence of child abuse. Training must be provided by the Florida Coalition Against

Domestic Violence, the Florida Alcohol and Drug Abuse Association, and the Florida Council for Community Mental Health in each entity's respective area of expertise.

4. Develop statewide uniform guidelines, standards, and protocols, including a protocol for standardized data collection and reporting, for local child abuse death review committees and provide training and technical assistance to local committees.

5. Develop statewide uniform guidelines for reviewing deaths that are the result of child abuse, including guidelines to be used by law enforcement agencies, prosecutors, medical examiners, health care practitioners, health care facilities, and social service agencies.

6. Study the adequacy of laws, rules, training, and services to determine what changes are needed to decrease the incidence of child abuse deaths and develop strategies and recruit partners to implement these changes.

7. Provide consultation on individual cases to local committees upon request.

8. Educate the public regarding the provisions of chapter 99-168, Laws of Florida, the incidence and causes of child abuse death, and ways by which such deaths may be prevented.

9. Promote continuing education for professionals who investigate, treat, and prevent child abuse or neglect.

10. Recommend, when appropriate, the review of the death certificate of a child who died as a result of abuse or neglect.

(3) LOCAL CHILD ABUSE DEATH REVIEW COMMITTEES.—At the direction of the State Surgeon General, a county or multicounty child abuse death review committee shall be convened and supported by the county health department directors in accordance with the protocols established by the State Child Abuse Death Review Committee.

(a) Membership.—The local death review committees shall include, at a minimum, the following organizations' representatives, appointed by the county health department directors in consultation with those organizations:

1. The state attorney's office.
2. The medical examiner's office.
3. The local Department of Children and Families child protective investigations unit.
4. The Department of Health child protection team.
5. The community-based care lead agency.
6. State, county, or local law enforcement agencies.
7. The school district.
8. A mental health treatment provider.
9. A certified domestic violence center.
10. A substance abuse treatment provider.
11. Any other members that are determined by guidelines developed by the State Child Abuse Death Review Committee.

To the extent possible, individuals from these organizations or entities who, in a professional capacity, dealt with a child whose death is verified as caused by abuse or neglect, or with the family of the child, shall attend any meetings where the child's case is reviewed. The members of a local committee shall be appointed to 2-year terms and may be reappointed. Members shall serve without compensation but may receive reimbursement for per diem and travel expenses incurred in the performance of their duties as provided in s. 112.061 and to the extent that funds are available.

(b) Duties.—Each local child abuse death review committee shall:

1. Assist the state committee in collecting data on deaths that are the result of child abuse, in accordance with the protocol established by the state committee. The local committee shall complete, to the fullest extent possible, the individual case report in the National Child Death Review Case Reporting System.

2. Submit written reports as required by the state committee. The reports must include:

a. Nonidentifying information from individual cases.

b. Identification of any problems with the data system uncovered through the review process and the committee's recommendations for system improvements and needed resources, training, and information dissemination, where gaps or deficiencies may exist.

c. All steps taken by the local committee and private and public agencies to implement necessary changes and improve the coordination of services and reviews.

3. Submit all records requested by the state committee at the conclusion of its review of a death resulting from child abuse.

4. Abide by the standards and protocols developed by the state committee.

5. On a case-by-case basis, request that the state committee review the data of a particular case.

(4) ANNUAL STATISTICAL REPORT.—The state committee shall prepare and submit a comprehensive statistical report by December 1 of each year to the Governor, the President of the Senate, and the Speaker of the House of Representatives which includes data, trends, analysis, findings, and recommendations for state and local action regarding deaths from child abuse. Data must be presented on an individual calendar year basis and in the context of a multiyear trend. At a minimum, the report must include:

(a) Descriptive statistics, including demographic information regarding victims and caregivers, and the causes and nature of deaths.

(b) A detailed statistical analysis of the incidence and causes of deaths.

(c) Specific issues identified within current policy, procedure, rule, or statute and recommendations to address those issues from both the state and local committees.

(d) Other recommendations to prevent deaths from child abuse based on an analysis of the data presented in the report.

(5) ACCESS TO AND USE OF RECORDS.—

(a) Notwithstanding any other law, the chairperson of the State Child Abuse Death Review Committee, or the chairperson of a local committee, shall be provided with access to any information or records that pertain to a child whose death is being reviewed by the committee and that are necessary for the committee to carry out its duties, including information or records that pertain to the child's family, as follows:

1. Patient records in the possession of a public or private provider of medical, dental, or mental health care, including, but not limited to, a facility licensed under chapter 393, chapter 394, or chapter 395, or a health care practitioner as defined in s. 456.001. Providers may charge a fee for copies not to exceed 50 cents per page for paper records and $1 per fiche for microfiche records.

2. Information or records of any state agency or political subdivision which might assist a committee in reviewing a child's death, including, but not limited to, information or records of the Department of Children and Families, the Department of Health, the Department of Education, or the Department of Juvenile Justice.

(b) The State Child Abuse Death Review Committee or a local committee shall have access to all information of a law enforcement agency which is not the subject of an active investigation and which pertains to the review of the death of a child. A committee may not disclose any information that is not subject to public disclosure by the law enforcement agency, and active criminal intelligence information or criminal investigative information, as defined in s. 119.011(3), may not be made available for review or access under this section.

(c) The state committee and any local committee may share with each other any relevant information that pertains to the review of the death of a child.

(d) A member of the state committee or a local committee may not contact, interview, or obtain information by request or subpoena directly from a member of a deceased child's family as part of a committee's review of a child abuse death, except that if a committee member is also a public officer or state employee, that member may contact, interview, or obtain information from a member of the deceased child's family, if necessary, as part of the committee's review. A member of the deceased child's family may voluntarily provide records or information to the state committee or a local committee.

(e) The chairperson of the State Child Abuse Death Review Committee may require the production of records by requesting a subpoena, through the Department of Legal Affairs, in any county of the state. Such subpoena is effective throughout the state and may be served by any sheriff. Failure to obey the subpoena is punishable as provided by law.

(f) This section does not authorize the members of the state committee or any local committee to have access to any grand jury proceedings.

(g) A person who has attended a meeting of the state committee or a local committee or who has otherwise participated in activities authorized by this section may not be permitted or required to testify in any civil, criminal, or administrative proceeding as to any records or information produced or presented to a committee during meetings or other activities authorized by this section. However, this [1]paragraph does not prevent any person who testifies before the committee or who is a member of the committee from testifying as to matters otherwise within his or her knowledge. An organization, institution, committee member, or other person who furnishes information, data, reports, or records to the state committee or a local committee is not liable for damages to any person and is not subject to any other civil, criminal, or administrative recourse. This [1]paragraph does not apply to any person who admits to committing a crime.

(6) DEPARTMENT OF HEALTH RESPONSIBILITIES.—

(a) The Department of Health shall administer the funds appropriated to operate the review committees and may apply for grants and accept donations.

(b) To the extent that funds are available, the Department of Health may hire staff or consultants to assist a review committee in performing its duties. Funds may also be used to reimburse reasonable expenses of the staff and consultants for the state committee and the local committees.

(c) For the purpose of carrying out the responsibilities assigned to the State Child Abuse Death Review Committee and the local review committees, the State Surgeon General may substitute an existing entity whose function and organization includes the function and organization of the committees established by this section.

(7) DEPARTMENT OF CHILDREN AND FAMILIES RESPONSIBILITIES.—Each regional managing director of the Department of Children and Families must appoint a child abuse death review coordinator for the region. The coordinator must have knowledge and expertise in the area of child abuse and neglect. The coordinator's general responsibilities include:

(a) Coordinating with the local child abuse death review committee.

(b) Ensuring the appropriate implementation of the child abuse death review process and all regional activities related to the review of child abuse deaths.

(c) Working with the committee to ensure that the reviews are thorough and that all issues are appropriately addressed.

(d) Maintaining a system of logging child abuse deaths covered by this procedure and tracking cases during the child abuse death review process.

(e) Conducting or arranging for a Florida Safe Families Network record check on all child abuse deaths covered by this procedure to determine whether there were any prior reports concerning the child or concerning any siblings, other children, or adults in the home.

(f) Coordinating child abuse death review activities, as needed, with individuals in the community and the Department of Health.

(g) Notifying the regional managing director, the Secretary of Children and Families, the Department of Health Deputy Secretary for Health and Deputy State Health Officer for Children's Medical Services, and the Department of Health Child Abuse Death Review Coordinator of all deaths meeting criteria for review as specified in this section within 1 working day after case closure.

(h) Ensuring that all critical issues identified by the local child abuse death review committee are brought to the attention of the regional managing director and the Secretary of Children and Families.

(i) Providing technical assistance to the local child abuse death review committee during the review of any child abuse death.

History.—s. 13, ch. 99-168; s. 11, ch. 2000-160; s. 8, ch. 2000-217; s. 13, ch. 2001-53; s. 14, ch. 2004-350; s. 41, ch. 2008-6; s. 69, ch. 2014-19; s. 21, ch. 2014-224; s. 4, ch. 2015-79.

[1]Note.—The word "paragraph" was substituted for the word "subsection" by the editors to conform to the redesignation of subsection (14) as paragraph (5)(g) by s. 4, ch. 2015-79.

APPENDIX B:

State and Local Committee Membership

Florida Child Abuse Death Review State Committee Membership

Social Worker
Robin Perry, Ph.D., Chairperson

Department of Health
Patricia Boswell, MPH

Department of Legal Affairs
Stephanie Bergen, JD

Department of Children and Families
Lesline Anglade-Dorleans, JD

Department of Law Enforcement
Seth Montgomery

Department of Education
Iris Williams, MSW

Florida Prosecuting Attorneys Association
Thomas Bakkedahl, JD

Florida Medical Examiners Commission
Anthony Jose Clark, M.D.

Child Protection Team Statewide Medical Director
Bruce McIntosh, M.D.

Public Health Nurse
Deborah Hogan, RN, MPH

Mental Health Professional
April Lott, LCSW

Department of Children and Families Supervisor
Pattie Medlock

Medical Director, Child Protection Team
Carol Sekhon, M.D.

Child Advocacy Organization
Jennifer Ohlsen, MS

Paraprofessional in patient resources, child abuse prevention program
Maria Lesvia Alaniz

Law Enforcement Officer
Deputy Jason Comans

Florida Coalition Against Domestic Violence
Brandy Carlson, MSW

Child Abuse Prevention Program
Zackary Gibson

Substance Abuse Professional
Linda Mann, LCSW, CAP

Florida Child Abuse Death Review
Local Committee Chairpersons

Committee 1
Karena Karshbaum
Pat Franklin

Committee 2
Holly Kirsch

Committee 3
Kim Loughe

Committee 4
Vicki Whitfield

Committee 5
Janine Hammett

Committee 6
Karen Yatchum

Committee 7
Vicki Whitfield

Committee 8
Stephanie Cox

Committee 9
Joy Chuba

Committee 10
Dr. Stephen Nelson

Committee 11
Lauren Lazarus-Sabatino

Committee 12
Connie Shingledecker
Laura McIntyre

Committee 13
Jane Murphy

Committee 14
Kelly Byrns-Davis
Stephanie Wood
Christi Bazemore

Committee 15
Sharon Greene

Committee 16
Lauren Lazarus-Sabatino

Committee 17
Barbara Lesh

Committee 18
Denise Conus
Jeanie Raciti

Committee 19
Miranda C. Hawker

Committee 20
Francine Donnorummo

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APPENDIX C:

Guidelines for the State Committee

Guidelines for the State Committee

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CHAPTER I
PURPOSE OF CHILD ABUSE DEATH REVIEW COMMITTEES

1.1 Background and Description

The Florida Child Abuse Death Review Committee was established by statute in s. 383.402, F.S., in 1999. The committee is established within the Department of Health, and utilizes state and local multi-disciplinary committees to review the facts and circumstances of all child deaths reported as suspected abuse or neglect and accepted by the Florida Abuse Hotline Information System within the Department of Children and Families (DCF). The major purpose of the committees is to make and implement data-driven recommendations for changes to law, rules and policies, as well as develop practice standards that support the safe and healthy development of children and reduce preventable deaths.

1.2 Mission Statement

Through systemic review and analysis of child deaths, identify and implement prevention strategies to eliminate child abuse and neglect deaths.

1.3 Operating Principle

A public health approach to child maltreatment is needed to address the range of conditions that place children at risk of harm. The circumstances involved in most child abuse and neglect deaths are multidimensional and require a data driven systemic review to identify successful prevention and intervention strategies.

The state and local review committees shall work cooperatively.

- The primary function of the state review committee is to provide direction and leadership for the review system and to analyze data and recommendations from local review committees
- To identify issues and trends and to recommend statewide action

1.4 Goal

The goal of Child Abuse Death Review Committee is to improve our understanding of the causes and contributing factors of deaths resulting from child abuse and neglect, to influence policies and programs to improve child health, safety and protection; and to eliminate preventable child deaths.

1.5 Objectives

- Develop a system and protocol for uniform collection of child abuse and neglect death data statewide, utilizing existing data-collection systems to the greatest extent possible
- Identify needed changes in legislation, policy and practices, and expand efforts in child health and safety to prevent child abuse and neglect deaths

- Improve communication and linkages among agencies and enhance coordination of efforts

CHAPTER 2
STATE REVIEW COMMITTEE MEMBERSHIP AND DUTIES

2.1 Introduction

This chapter describes the general standards for the State Child Abuse Death Review Committee membership, and outlines general duties and responsibilities of committee members.

2.2 Statutory Membership

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

- Department of Health - The Department of Health representative serves as the state committee coordinator.
- Department of Legal Affairs
- Department of Children and Families
- Department of Law Enforcement
- Department of Education
- Florida Prosecuting Attorneys Association
- Florida Medical Examiners Commission, whose representative must be a Forensic Pathologist

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

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

2.3 Term of Membership

The members of the state committee shall be appointed to staggered terms not to exceed 2 years each as determined by the State Surgeon General. Members may be appointed to no more than three consecutive terms. The state committee shall elect a chairperson from among its members to serve for a 2-year term, and the chairperson may appoint ad hoc committees as necessary to carry out the duties of the committee.
Agency representatives who leave their agency during their term must notify the agency head, and the DOH Child Abuse Death Review Committee Coordinator. The agency appointment expires upon the effective date of the member's departure from the agency and the State Surgeon General will request that the agency appoint a new member.

State Surgeon General appointees who resign from their current position must notify the DOH Child Abuse Death Review Committee Coordinator. At the discretion of the Surgeon General, they may remain on the state Committee provided they are still active in their appointed discipline and continue to be employed in the specific job category where indicated. All appointees who leave their employment and otherwise cease to be active in their designated discipline must notify the Chair of the State Committee and the DOH Death Review Committee Coordinator.

All replacements to the state Committee will serve the remainder of the term for the appointee they replace.

2.4 Consultants

The Department of Health may hire staff or consultants to assist the review committee in performing its duties. Consultants must be able to provide important information, experience, and expertise to the Committee. They may not use their participation on the Committee to discover, identify, acquire or use information for any purpose other than the stated purpose of conducting approved child abuse death review activities.

2.5 Election of State Chairperson

The chairperson of the State Child Abuse Death Review Committee is elected for a two (2) year term by a majority vote of the members of the State Child Abuse Death Review Committee. Members of the committee with investigatory responsibilities are not eligible to serve as chairperson. The State Child Abuse Death Review Committee Chairperson may appoint ad hoc committees as necessary to carry out the duties of the Committee.

2.6 Reimbursement

Members of the state Committee serve without compensation but are entitled to reimbursement for per diem and travel expenses incurred in the performance of their duties as provided in s. 112.061, F.S., and to the extent that funds are available. Consultants can be reimbursed reasonable expenses to the extent that funds are available. Requests for funding must be reviewed and approved by the Child Death Review Committee Coordinator.

2.7 Terminating State Committee Membership

A member or a consultant of the State Child Abuse Death Review Committee may resign at any time**.** A written resignation shall be submitted to the Child Death Review Committee Coordinator. Should action be required, a letter shall be addressed to the State Surgeon

General who will either make a new appointment or contact the agency head requesting the designation of a new representative.

2.8 State Review Committee Duties

Chairperson

- Chair Committee meetings
- Ensure that the Committee operates according to guidelines and protocols
- Ensure that all new Committee members and ad hoc members sign a confidentiality agreement

Department of Health Committee Coordinator/Department of Health, Death Review Coordinator for the State CADR or designee

- Send meeting notices to committee members
- Submit child abuse death review data to the State Committee for review and analysis
- Maintain current roster and bibliography of members, attendance records and minutes

All Committee Members

- Develop a system for collecting data from local committees on deaths that are reported to the central abuse hotline. The system must include a protocol for the uniform collection of data statewide, which must, at a minimum, use the National Child Death Review Case Reporting System administered by the National Center for the Review and Prevention of Child Deaths, deaths that are reported to the central abuse hotline
- Provide training to cooperating agencies, individuals and local child abuse death review committees on the use of the child abuse death data system
- ANNUAL STATISTICAL REPORT— prepare and submit a comprehensive statistical report by December 1 of each year to the Governor, the President of the Senate, and the Speaker of the House of Representatives which includes data, trends, analysis, findings, and recommendations for state and local action regarding deaths from child abuse. Data must be presented on an individual calendar year basis and in the context of a multiyear trend. At a minimum, the report must include:
  - (a) Descriptive statistics, including demographic information regarding victims and caregivers, and the causes and nature of deaths.
  - (b) A detailed statistical analysis of the incidence and causes of deaths.
  - (c) Specific issues identified within current policy, procedure, rule, or statute and recommendations to address those issues from both the state and local committees.
  - (d) Other recommendations to prevent deaths from child abuse based on an analysis of the data presented in the report.

- Encourage and assist in developing the local child abuse death review committees and provide consultation on individual cases to local committees upon request

- Develop guidelines, standards and protocols, including a protocol for data collection for local child abuse death review committees and provide training technical assistance to local committees upon request

- Provide training on the dynamics and impact of domestic violence, substance abuse or mental health disorders when there is a co-occurrence of child abuse. Training shall be provided by the Florida Coalition Against Domestic Violence, the Florida Alcohol and

Drug Abuse Association, and the Florida Council for Community Mental Health in each entity's respective area of expertise

- Develop guidelines for reviewing deaths that are the result of child abuse, including guidelines to be used by law enforcement agencies, prosecutors, medical examiners, health care practitioners, health care facilities and social service agencies

- Study the adequacy of laws, rules, training and services to determine what changes are needed to decrease the incidence of child abuse deaths and develop strategies and recruit partners to implement these changes

- Educate the public regarding the incidence and causes of child abuse death, and the ways to prevent such deaths

- Provide continuing education for professionals who investigate, treat and prevent child abuse or neglect

- Recommend, when appropriate, the review of the death certificate of a child who is suspected to have died of abuse or neglect

CHAPTER 3
MAINTAINING AN EFFECTIVE COMMITTEE

3.1 Conducting an Effective Meeting

The work of the Committee requires regular attendance and participation by all Committee members. Regularly scheduled meetings allow Committee members to make long-term plans and allow for better attendance. Members should become acquainted with protocol for data collection and analysis and come prepared to present their agencies' information and perspectives.

Each member agrees to keep meeting discussions and information regarding specific child abuse and neglect deaths confidential. Confidentiality is essential for each agency to fully participate in the meetings. Committee members are reminded of the following by the Chairperson.

- The review Committee is not an investigative body

- All participants agree to keep Committee discussions relating to specific child abuse deaths confidential

- Meeting minutes will not indicate any case specific information

- The purpose of the Committee is to improve services and agency practices by identifying issues and trends related to child abuse deaths and provide recommendations to address these issues and prevent other child deaths

Each professional brings to the review Committee a unique perspective, professional knowledge and expertise. Each member must acknowledge and respect the professional role of each participating agency.

This reference provides guidelines for the development, implementation, and management of the State Child Abuse Death Review Committee and will be reviewed bi-annually or more often if necessary. Revisions will be distributed to all committee members and posted to the Child Abuse Death Review website.

3.2 Focus on Prevention

The key to good prevention is implementation at the local level. Review Committee members can provide leadership by serving as catalysts for community action. Prevention efforts can range from simply changing one agency practice or policy or setting up more complex interventions for high-risk parents.

The State Committee should work with local committees and community programs involved in child death, safety and protection. Some communities have child safety coalitions, prevention coalitions or active citizen advocacy groups. Connect state and local Committee findings to ensure results. Assist these groups in accessing state and national resources in the prevention areas targeted by their communities.

CHAPTER 4
COMMITTEE OPERATING PROCEDURES

4.1 Obtaining Data from Local Committee Reviews

The Chairperson should work closely with the local committees and the state CADR Committee designee to ensure receipt of data from local committees.

Additionally, any meeting notes that directly relate to a specific child must also be secured and separate from general meeting notes.

4.2 Record Keeping and Retention

All records (e.g., completed data forms with attachments, copies of agency department files) must be maintained in a secure area.

All correspondence, public records requests, letters, and communications with the State Chairperson or other Committee members must be copied to Florida Department of Health Child Abuse Death Review Coordinator.

- Pursuant to State of Florida Department of State Record Retention Schedule #34 the State Child Abuse Death Review Committee shall retain a permanent copy of each annual report, either electronically or written.

- State of Florida Department of State Record Retention Schedule #35 addresses copies of documents received from third parties (e.g. individuals, entities, and government agencies) by the State and Local Child Abuse Death Review Committees pursuant to the review of child abuse deaths and for the preparation of the annual incidence and causes of death report required by Section 383.402, F.S. Record copies must be maintained for a period of one year from the date of publication of the annual report. Permission must be obtained from the Florida Department of Health State Child Abuse Death Review Coordinator prior to the destruction of any record

- Documents produced by the State or Local Child Abuse Death Review Committee (e.g., the data form, death summary report, or listing of records reviewed, etc.) must be maintained pursuant to State of Florida Department of State Record Retention Schedule GS1-S, item #338 for a period of five years. Permission must be obtained from the Florida Department of Health State Child Abuse Death Review Coordinator prior to the destruction of any record.

- Committee members must adhere to s. 286.011, F.S. (Florida's Government in the Sunshine Law), and can only communicate with one another about any committee business during a properly noticed meeting

4.3 Child Abuse Death Review Case Reporting System

The State Child Abuse Death Review Committee utilizes the national Child Death Review Case Reporting System to record and track data from child death reviews. The System Guide provides instructions for completing the data form. The Child Death Review Case Reporting System Case Report must be completed on all child abuse deaths reviewed. The committee coordinator should review the data form to ensure that all information is accurate and that the case review is complete.

CHAPTER 5
CONFIDENTIALITY AND ACCESS TO INFORMATION

5.1 Introduction

As provided in section 383.412, Florida Statutes., all information and records that are confidential or exempt under Florida's public records laws shall retain that status throughout the child abuse death review process, including, but not limited to the following:

- Information that reveals the identity of the siblings, surviving family members, or others living in home of a deceased child
- Any information held by the State Child Abuse Death Review Committee or a local committee which reveals the identity of a deceased child whose death has been reported to the central abuse hotline but determined not to be the result of abuse or neglect, or the identity of the surviving siblings, family members, or others living in the home of such deceased child.
- Portions of meetings of the state or local child death review committees at which confidential, exempt information is discussed
- Recordings of closed meetings

Pursuant to Section 383.412, Florida Statutes, , a person who violates the confidentiality provisions of this statute is guilty of a first degree misdemeanor. Violation of confidentiality provisions by committee members should be referred to the representative agency/organization for appropriate action,

Specific questions regarding confidentiality of child abuse death review information should be directed to the Department of Health, Child Abuse Death Review Committee Coordinator. The Coordinator will seek advice on the issue, as needed, from the Department of Health Office of General Counsel

The State Child Abuse Death Review Committee and local committees may share information made confidential and exempt by this section:
(a) With each other;
(b) With a governmental agency in furtherance of its duties; or
(c) With any person or entity authorized by the Department of Health to use such relevant information for bona fide research or statistical purposes. A person or entity who is authorized to obtain such relevant information for research or statistical purposes must enter into a privacy and security
agreement with the Department of Health and comply with all laws and rules governing the use of such records and information for research or statistical purposes. Anything identifying the subjects of such relevant information must be treated as confidential by the person or entity and may
not be released in any form

5.2 Confidentiality Statements

Any person who may have access to any information or records regarding review of a child abuse death is required to sign a statement of confidentiality. Persons who may have access to this information shall include state and local Committee chairpersons, state and local Committee members, administrative and support staff for the state and local Committees who open or handle mail, birth or death certificates, records, or any other components required in the preparation of a child abuse death review case.

Each child abuse and neglect death review Committee shall maintain a file with signed copies of the member's confidentiality statement. Other confidentiality statements must be obtained for non-Committee member participants, as needed, on a case-by-case basis. These should be maintained in the local Committee's file.

5.3 Protecting Family Privacy

A member or consultant of the State Child Abuse Death Review Committee shall not contact, interview, or obtain information by request or subpoena from a member of the deceased child's family. This does not apply to a member or consultant who makes such contact as part of his or her other official duties. Such member or consultant shall make no reference to his/her role or duties with the Child Abuse Death Review Committee.

5.4 Document Storage and Security

All information, records and documents for child abuse death review cases shall be stored in locked files. Persons who have access to the locked files or information contained therein shall be required to sign a confidentiality statement.

Copies of documents provided for Committee meetings shall not be taken from Committee meetings. At the conclusion of the Committee meeting, the copies shall be collected and destroyed.

Data about the circumstances surrounding the death of a child is entered into the Child Abuse Death Review Data System from the Child Abuse Death Review Data Form. This secure database is used to generate summary or management reports and statistical summaries or analyses.

5.5 Media Relations and Public Records Request

Public record requests or other media inquiries should be referred to the Florida Department of Health Child Abuse Death Review Committee Coordinator

CHAPTER 6
CHILD ABUSE DEATH REVIEW ANNUAL REPORT

6.1 Guidelines for Report

The State Child Abuse Death Review Committee is required to provide an annual report to the Governor, President of the Senate and Speaker of the House of Representatives by December 1st. The report will summarize information gathered by the local committees resulting from their review of specific cases meeting statutory review criteria. The report will contain the following sections.

A) Background

- Program Description
- Statutory Authority
- Program Purpose
- Membership of the State Committee
- Local Child Abuse Death Review Committees

B) Method

- Overview of Child Death Data
- Department of Health Data on all Children Ages 0 through 17 years

C) Findings-Trend Analysis Based on Three Years of Data

- Causes of Death (Abuse & Neglect)
- Age at Death
- Gender and Race
- Age and Relationship of Caregiver(s) Responsible
- Child and Family Risk Factors

D) Conclusions

E) Prevention Recommendations

F) Summary

APPENDIX D:

Guidelines for Local Committees

Guidelines for Local Committees

July 2015

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CHAPTER I

PURPOSE OF CHILD ABUSE DEATH REVIEW COMMITTEES

1.1 Background and Description

The Florida Child Abuse Death Review Committee (CADR) was established in 1999, in Section 383.402, *Florida Statutes* (appendix A). The committee is established within the Department of Health (DOH), and utilizes state and local multi-disciplinary committees to review the facts and circumstances of all child deaths reported as suspected abuse or neglect and accepted by the Florida Abuse Hotline Information System (FAHIS) within the Department of Children and Families (DCF). The major purpose of the committees is to recommend changes in law, rules and policies at the state and local levels, as well as develop practice standards that support the safe and healthy development of children and reduce preventable deaths.

1.2 Mission Statement

Through systematic review and analysis of child deaths, identify and implement prevention strategies to eliminate child abuse and neglect deaths.

1.3 Operating Principle

A public health approach to child maltreatment is needed to address the range of conditions that place children at risk of harm. The circumstances involved in most child abuse and neglect deaths are multidimensional and require a data driven systematic review to identify successful prevention and intervention strategies.

The state and local review committees shall work cooperatively. The primary function of the local review committees is to conduct individual case reviews of deaths, generate information, make recommendations, and implement improvements at the local level.

1.4 Goal

The goal of Child Abuse Death Review Committee is to improve our understanding of the causes and contributing factors of deaths resulting from child abuse and neglect, to influence policies and programs to improve child health, safety and protection, and to eliminate preventable child deaths.

1.5 Objectives

- Develop a system and protocol for uniform collection of child abuse and neglect death data statewide, utilizing existing data-collection systems to the greatest extent possible
- Identify needed changes in legislation, policy and practices, and expand efforts in child health and safety to prevent child abuse and neglect deaths
- Improve communication and linkages among agencies and enhance coordination of efforts

CHAPTER 2
LOCAL REVIEW COMMITTEE MEMBERSHIP AND DUTIES

2.1 Committee Membership

Local committees enable various disciplines to come together on a regular basis and combine their expertise to gain a better understanding of the causes and contributing factors of child abuse deaths in their jurisdictions.

The directors of county health departments or designee will convene and support a. county or multi-county review committees. The local death review committees shall include, at a minimum, the following organizations' representatives, appointed by the county health department directors in consultation with those organizations:

- State Attorney's Office
- County Health Department
- District Medical Examiner's Office
- Local Child Protective Investigations
- Local Child Protection Team
- The Community-based Care lead agency
- State, County, or Local Law Enforcement
- Local School District
- A mental health treatment provider
- A certified domestic violence center
- A substance abuse treatment provider

Other Committee members may include representatives of specific agencies from the community that provide services to children and families. Local child abuse death review core members should identify appropriate representatives from these agencies to participate on the committee. Suggested members include the following:

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

To the extent possible, individuals from these organizations or entities who, in a professional capacity, dealt with a child whose death is verified as caused by abuse or neglect, or with the family of the child shall attend any meetings where the child's case is reviewed. This participation can be of value in assisting the local committees in their critical appraisal of information that can aid in the evaluation of circumstances surrounding a death (not re-investigation of a case), identification of local trends and specific issues contributing to child abuse and neglect fatalities within their region, and the development of prevention recommendations in keeping with the mission of the Statewide Child Abuse Death Review Committee.

2.2 Term of Membership

Members of the Local Child Abuse Death Review Committee are appointed for two year terms and may be reappointed. Agency representatives who leave their agency during their term must notify the Chairperson of the local committee, who will notify the County Health Department representative. All replacements to the local committee are appointed for a new two year term.

2.3 Consultants

To the extent that funds are available, the Department of Health may hire staff or consultants to assist the review committee in performing its duties. Funds may also be used to reimburse reasonable expenses of the staff and consultants for the local committee. Consultants must be able to provide important information, experience, and expertise to the Committee. They may not use their participation on the Committee to discover, identify, acquire or use information for any purpose other than the stated purpose of conducting approved child abuse death review activities.

2.4 Ad Hoc Members

Committees may designate ad hoc members. They attend meetings only when they have been directly involved in a case scheduled for review or to provide information on committee related activities. They may be DCF child protective investigators or family services counselors involved in a specific case, law enforcement officers from a police agency that handled the case or a service provider or child advocate who worked with a family.

2.5 Local Review Committee Duties

The duties of the Local Child Abuse Death Review Committee are:

- Assist the state committee in collecting data on deaths that are reported to the child abuse hotline within the Department of Children and Families
- Collect data on applicable child deaths for the State Child Abuse Death Review Committee utilizing the National Child Death Review Case Reporting System
- Maintain a record of attendance, minutes and audio recording of the committee meetings
- Submit written reports to the state committee as directed and in keeping with the intent of the law as denoted in Appendix A. The reports must include:
- a. Nonidentifying information from individual cases.
- b. Identification of any problems with the data system uncovered through the review process and the committee's recommendations for system improvements and needed resources, training, and information dissemination, where gaps or deficiencies may exist.
- c. All steps taken by the local committee and private and public agencies to implement necessary changes and improve the coordination of services and reviews.

2.6 Local Committee Member Responsibilities

The role of local committee members can be flexible to meet the needs of particular communities. Each member should:

- Contribute information from his or her records, in accordance with Section 383.402, *Florida Statutes* (see Appendix A)
- Serve as a liaison to respective professional counterparts
- Provide definitions or professional terminology

- Interpret agency procedures and policies
- Explain the legal responsibilities or limitations of his or her profession

All committee members must have a clear understanding of their own and other professional and agency roles and responsibilities in their community's response to child abuse and neglect fatalities.

2.7 Orientation and Training of Local Committee Members

Orientation and ongoing training of review committees is required to maintain consistency in application of review methods, data review and collection activities. One of the primary goals of this training is to develop consistent, accurate, and thorough application of program standards, and to help ensure that meaningful information can be obtained for identification of prevention strategies for reduction of child abuse and neglect deaths.

Local committees will work in collaboration with the Department of Children and Families Child Fatality Prevention Specialist and the State Child Abuse Death Review Committee for planning and conducting these training activities, especially during the first several meetings of the local committee.

Orientation should include, at a minimum, review of the Child Abuse Death Review Guidelines with an emphasis on confidentiality of records and information, Section 286.011, *Florida Statutes (*Florida Sunshine Law; see Appendix B) and any other training required by Section 383.402, *Florida Statutes,* including:

- Provide training to cooperating agencies, individuals, and local child abuse death review committees on the use of the child abuse death data system.
- Provide training to local child abuse death review committee members on the dynamics and impact of domestic violence, substance abuse, or mental health disorders when there is a co-occurrence of child abuse.
- Develop guidelines for reviewing deaths that are the result of child abuse, including guidelines to be used by law enforcement agencies, prosecutors, medical examiners, health care practitioners, health care facilities, and social service agencies.
- Study the adequacy of laws, rules, training, and services to determine what changes are needed to decrease the incidence of child abuse deaths and develop strategies and recruit partners to implement these changes.

2.8 Support and Technical Assistance for Local Committees

The State Child Abuse Death Review Committee recognizes the importance of consistency and accuracy in the information provided by local child abuse death review Committees. Without this consistency, information collected about the reasons for child abuse and neglect deaths may not be reliable or accurate. To this end, the State Child Abuse Death Review Committee will provide training and technical assistance for local Committee members.

Local Committees may request technical assistance directly from the State Child Abuse Death Review Committee; requests should be directed to the State Committee Chairperson or the DOH State Child Abuse Death Review Coordinator.

CHAPTER 3
MAINTAINING AN EFFECTIVE COMMITTEE

3.1 Conducting an Effective Meeting

The work of the Committee requires regular attendance and participation by all committee members. Regularly scheduled meetings allow committee members to make long-term plans and allow for better attendance. Members should become acquainted with protocol for data collection and analysis and come prepared to present their agencies' information and perspectives.

Each member agrees to keep meeting discussions and information regarding specific child abuse and neglect deaths confidential. Confidentiality is essential for each agency to fully participate in the meetings. Committee members are reminded of the following by the Chairperson:

- The review Committee is not an investigative body
- All participants agree to keep Committee discussions relating to specific child abuse deaths confidential
- Meeting minutes will not indicate any case specific information
- The purpose of the Committee is to improve services and agency practices by identifying issues and trends related to child abuse deaths and provide recommendations to address these issues and prevent other child deaths

Each professional brings to the review Committee a unique perspective, professional knowledge and expertise. Each member must acknowledge and respect the professional role of each participating agency.

Committee members must adhere to Section 286.011, *Florida Statutes* (Florida's Government in the Sunshine Law; see Appendix B), and can only communicate with one another about any committee business during a properly noticed meeting.

3.2 Beginning the Meeting

Members and ad hoc members sign the Child Abuse Death Review Signature Sheet outlining confidentiality policies prior to the start of their participation in review meetings. A confidentiality agreement (see Appendix D) signed by committee members and required for other meeting attendees should be kept at each meeting by the Committee Coordinator.

3.3 Sharing Information

Reviews are conducted by discussing each child abuse death individually. It can be helpful to establish the order in which information will be presented. This will help the meetings and reviews to run more smoothly and make completing the data form easier. Each participant provides information from their agency's records. If any information is distributed, it must be collected before the end of the meeting.

Often committee members may be unable to share information due to confidentiality restrictions or lack of information. If there is insufficient information available at the time of the review, the Committee may postpone the review of that case until additional information is available.

3.4 Community Education and Prevention

The state and local Child Abuse Death Review Committees review and analyze information on the nature of child abuse deaths in Florida. The key to good prevention is leadership at the local level. Local committees identify trends in child abuse death statistics for their own communities, and develop and implement community education and prevention plans that are data-driven. Prevention efforts can range

from simply changing one agency practice or policy or setting up more complex interventions for high-risk parents.

Review committees should work with local community programs involved in child death, safety and protection. Some communities have child safety coalitions, prevention coalitions or active citizen advocacy groups. Connect review findings to these groups to ensure results. Also, assist these groups in accessing state and national resources in the prevention areas targeted by the community.

CHAPTER 4
COMMITTEE OPERATING PROCEDURES

4.1 Information Sharing

Background and current information from Committee members' records and other sources is necessary for case reviews. Committees can request information and records as needed to carry out their duties in accordance with state statutes. Such requests should be addressed to the "custodians of the records" or agency director and should include the review Committee authorizing statute, information regarding the Committee's operation and purpose, and a copy of the Committee's interagency agreement.

4.2 Committee Chairperson

A Committee chairperson should be selected biennially at the organizational meeting. The chairperson, who can be one of the committee members, serves at the discretion of the committee.

Chairperson duties:

- Call and chair committee meetings. Meetings should be held at least quarterly, or as often as needed to review cases and to discuss community prevention initiatives (quarterly meetings will be conducted even when there are no case files for review).
- Send meeting notices to committee members.
- Chairperson is to ensure that meetings are conducted according to Section 286.011, *Florida Statutes* (Florida's Government in the Sunshine Law).
- Work with DOH staff to obtain names and compile the summary sheet of child abuse deaths to be reviewed for distribution to committee members two weeks prior to each meeting.
- Obtain all records needed for the local reviews in accordance Section 383.402, *Florida Statutes.*
- Submit completed child abuse death review data forms with attached materials to the Department of Health, Death Review Coordinator for the State CADR or designee.
- Ensure that the Committee operates according to protocols as adapted by the Committee.
- Ensure that all new Committee members and ad hoc members sign a confidentiality agreement.
- Maintain attendance records, current roster, and resumes or CVs detailing qualifications and experience of members.
- Ensure secure transfer of all records to new Chairperson upon transfer of duties.

4.3 Meeting Attendance

Committee members must recognize the importance of regular attendance as a means of sharing the expertise and knowledge for which they were recruited. Attendance at meetings must be in person to

ensure maximum participation in the death review process. For confidentiality reasons, phone conferencing is not acceptable. Local committees should develop a policy to address non-attendance of committee members.

4.4 Obtaining Names for Committee Reviews

The Chairperson should work closely with the DCF Child Fatality Prevention Specialist to ensure notification of deaths that meet criteria for review.

4.5 Record Keeping and Retention

All records (e.g., completed data forms with attachments, copies of agency department files) must be maintained in a secure area within locked files and may not be destroyed without permission from the Department of Health Death Review Coordinator or designee.

All correspondence, public records requests, letters, and communications with the State Chairperson or other Committee members must be copied to Florida Department of Health Child Abuse Death Review Coordinator or designee.

- Pursuant to State of Florida Department of State Record Retention Schedule #34 the State Child Abuse Death Review Committee shall retain a permanent copy of each annual report, either electronically or written.
- State of Florida Department of State Record Retention Schedule #35 addresses copies of documents received from third parties (e.g. individuals, entities, and government agencies) by the State and Local Child Abuse Death Review Committees pursuant to the review of child abuse deaths and for the preparation of the annual incidence and causes of death report required by Section 383.402, *Florida Statutes*. Record copies must be maintained for a period of one year from the date of publication of the annual report. Permission must be obtained from the Florida Department of Health State Child Abuse Death Review Coordinator or designee prior to the destruction of any record.
- Documents produced by the State or Local Child Abuse Death Review Committee (e.g., the data form, death summary report, or listing of records reviewed, etc.) must be maintained pursuant to State of Florida Department of State Record Retention Schedule GS1-S, item #338 for a period of five years. Permission must be obtained from the Florida Department of Health State Child Abuse Death Review Coordinator or designee prior to the destruction of any record.
- Committee members must adhere to Section 286.011, *Florida Statutes* (Florida's Government in the Sunshine Law), and can only communicate with one another about any committee business during a properly noticed meeting.

4.6 Child Abuse Death Review Case Reporting System

The Child Abuse Death Review Committees utilize the national Child Death Review Case Reporting System to record and track data from child death reviews. The System Guide provides instructions for completing the data form. The Child Death Review Case Reporting System Case Report must be completed on all child abuse deaths reviewed. The committee chair should review the data form to ensure that all information is accurate and that the case review is complete.

CHAPTER 5
CONFIDENTIALITY AND ACCESS TO INFORMATION

5.1 Introduction

As provided in Section 383.412, *Florida Statutes* (Appendix C) all information and records that are confidential or exempt under Florida's public records laws shall retain that status throughout the child abuse death review process, including, but not limited to the following:

- Any Information that reveals the identity of the surviving siblings of a deceased child whose death occurred as the result of a verified report of abuse or neglect
- Any information that reveals the identity of a deceased child whose death has been reported to the central abuse hotline but determined not to be the result of abuse or neglect, or the identity of the surviving siblings, family members, or others living in the home of such deceased child
- Portions of meetings of the state or local child death review committees at which confidential, exempt information is discussed
- Recordings of closed meetings

Pursuant to Section 383.412, *Florida Statutes*, a person who violates the confidentiality provisions of this statute is guilty of a first degree misdemeanor. Violation of confidentiality provisions by committee members should be referred to the representative agency/organization for appropriate action.

Specific questions regarding confidentiality of child abuse death review information should be directed to the Department of Health, Child Abuse Death Review Committee Coordinator or designee. The Coordinator will seek advice on the issue, as needed, from the Department of Health, Office of the General Counsel.

5.2 Confidentiality Statements

Any person who may have access to any information or records regarding review of a child abuse death is required to sign a statement of confidentiality (Appendix D). Persons who may have access to this information shall include state and local committee chairpersons, state and local committee members, administrative and support staff for the state and local committees who open or handle mail, birth or death certificates, records, or any other components required in the preparation of a child abuse death review case.

Each child abuse and neglect death review Committee shall maintain a file with signed copies of the member's confidentiality statement. Other confidentiality statements must be obtained for non-committee member participants, as needed, on a case-by-case basis. These should be maintained in the local Committee's file.

5.3 Protecting Family Privacy

A member or consultant of the local review committee shall not contact, interview, or obtain information by request or subpoena from a member of the deceased child's family. This does not apply to a member or consultant who makes such contact as part of his or her other official duties. Such member or consultant shall make no reference to his/her role or duties with the Child Abuse Death Review Committee.

5.4 Document Storage and Security

All information, records and documents for child abuse death review cases must be maintained in a secure area within locked files. Persons who have access to the locked files or information contained therein shall be required to sign a confidentiality statement.

Copies of documents provided for Committee meetings shall not be taken from Committee meetings. At the conclusion of the Committee meeting, the copies provided to members for the review purposes shall be collected and destroyed.

Data about the circumstances surrounding the death of a child is entered into the Child Abuse Death Review Data System from the Child Abuse Death Review Data Form. This secure database is used to generate summary or management reports and statistical summaries or analyses.

5.5 Media Relations and Public Records Request

Public record requests or other media inquiries should be referred to the Florida Department of Health Child Abuse Death Review Committee Coordinator or designee.

383.402 Child abuse death review; State Child Abuse Death Review Committee; local child abuse death review committees.—

(1) INTENT.—It is the intent of the Legislature to establish a statewide multidisciplinary, multiagency, epidemiological child abuse death assessment and prevention system that consists of state and local review committees. The committees shall review the facts and circumstances of all deaths of children from birth to age 18 which occur in this state and are reported to the central abuse hotline of the Department of Children and Families. The state and local review committees shall work cooperatively. The primary function of the state review committee is to provide direction and leadership for the review system and to analyze data and recommendations from local review committees to identify issues and trends and to recommend statewide action. The primary function of the local review committees is to conduct individual case reviews of deaths, generate information, make recommendations, and implement improvements at the local level. The purpose of the state and local review system is to:

(a) Achieve a greater understanding of the causes and contributing factors of deaths resulting from child abuse.

(b) Whenever possible, develop a communitywide approach to address such causes and contributing factors.

(c) Identify any gaps, deficiencies, or problems in the delivery of services to children and their families by public and private agencies which may be related to deaths that are the result of child abuse.

(d) Recommend changes in law, rules, and policies at the state and local levels, as well as develop practice standards that support the safe and healthy development of children and reduce preventable child abuse deaths.

(e) Implement such recommendations, to the extent possible.

(2) STATE CHILD ABUSE DEATH REVIEW COMMITTEE.—

(a) Membership.—

1. The State Child Abuse Death Review Committee is established within the Department of Health and shall consist of a representative of the Department of Health, appointed by the State Surgeon General, who shall serve as the state committee coordinator. The head of each of the following agencies or organizations shall also appoint a representative to the state committee:

a. The Department of Legal Affairs.

b. The Department of Children and Families.

c. The Department of Law Enforcement.

d. The Department of Education.

e. The Florida Prosecuting Attorneys Association, Inc.

f. The Florida Medical Examiners Commission, whose representative must be a forensic pathologist.

2. In addition, the State Surgeon General shall appoint the following members to the state committee, based on recommendations from the Department of Health and the agencies listed in subparagraph 1., and ensuring that the committee represents the regional, gender, and ethnic diversity of the state to the greatest extent possible:

a. The Department of Health Statewide Child Protection Team Medical Director.

b. A public health nurse.

c. A mental health professional who treats children or adolescents.

d. An employee of the Department of Children and Families who supervises family services counselors and who has at least 5 years of experience in child protective investigations.

e. The medical director of a child protection team.

f. A member of a child advocacy organization.

g. A social worker who has experience in working with victims and perpetrators of child abuse.

h. A person trained as a paraprofessional in patient resources who is employed in a child abuse prevention program.

i. A law enforcement officer who has at least 5 years of experience in children’s issues.

j. A representative of the Florida Coalition Against Domestic Violence.
k. A representative from a private provider of programs on preventing child abuse and neglect.
l. A substance abuse treatment professional.
3. The members of the state committee shall be appointed to staggered terms not to exceed 2 years each, as determined by the State Surgeon General. Members may be appointed to no more than three consecutive terms. The state committee shall elect a chairperson from among its members to serve for a 2-year term, and the chairperson may appoint ad hoc committees as necessary to carry out the duties of the committee.
4. Members of the state committee shall serve without compensation but may receive reimbursement for per diem and travel expenses incurred in the performance of their duties as provided in s. 112.061 and to the extent that funds are available.
(b) Duties.—The State Child Abuse Death Review Committee shall:
1. Develop a system for collecting data from local committees on deaths that are reported to the central abuse hotline. The system must include a protocol for the uniform collection of data statewide, which must, at a minimum, use the National Child Death Review Case Reporting System administered by the National Center for the Review and Prevention of Child Deaths.
2. Provide training to cooperating agencies, individuals, and local child abuse death review committees on the use of the child abuse death data system.
3. Provide training to local child abuse death review committee members on the dynamics and impact of domestic violence, substance abuse, or mental health disorders when there is a co-occurrence of child abuse. Training must be provided by the Florida Coalition Against Domestic Violence, the Florida Alcohol and Drug Abuse Association, and the Florida Council for Community Mental Health in each entity's respective area of expertise.
4. Develop statewide uniform guidelines, standards, and protocols, including a protocol for standardized data collection and reporting, for local child abuse death review committees and provide training and technical assistance to local committees.
5. Develop statewide uniform guidelines for reviewing deaths that are the result of child abuse, including guidelines to be used by law enforcement agencies, prosecutors, medical examiners, health care practitioners, health care facilities, and social service agencies.
6. Study the adequacy of laws, rules, training, and services to determine what changes are needed to decrease the incidence of child abuse deaths and develop strategies and recruit partners to implement these changes.
7. Provide consultation on individual cases to local committees upon request.
8. Educate the public regarding the provisions of Chapter 99-168, Laws of Florida, the incidence and causes of child abuse death, and ways by which such deaths may be prevented.
9. Promote continuing education for professionals who investigate, treat, and prevent child abuse or neglect.
10. Recommend, when appropriate, the review of the death certificate of a child who died as a result of abuse or neglect.
(3) LOCAL CHILD ABUSE DEATH REVIEW COMMITTEES.—At the direction of the State Surgeon General, a county or multicounty child abuse death review committee shall be convened and supported by the county health department directors in accordance with the protocols established by the State Child Abuse Death Review Committee.
(a) Membership.—The local death review committees shall include, at a minimum, the following organizations' representatives, appointed by the county health department directors in consultation with those organizations:
1. The state attorney's office.
2. The medical examiner's office.
3. The local Department of Children and Families child protective investigations unit.
4. The Department of Health child protection team.
5. The community-based care lead agency.

6. State, county, or local law enforcement agencies.
7. The school district.
8. A mental health treatment provider.
9. A certified domestic violence center.
10. A substance abuse treatment provider.
11. Any other members that are determined by guidelines developed by the State Child Abuse Death Review Committee.

To the extent possible, individuals from these organizations or entities who, in a professional capacity, dealt with a child whose death is verified as caused by abuse or neglect, or with the family of the child, shall attend any meetings where the child's case is reviewed. The members of a local committee shall be appointed to 2-year terms and may be reappointed. Members shall serve without compensation but may receive reimbursement for per diem and travel expenses incurred in the performance of their duties as provided in s. 112.061 and to the extent that funds are available.

(b) Duties.—Each local child abuse death review committee shall:
1. Assist the state committee in collecting data on deaths that are the result of child abuse, in accordance with the protocol established by the state committee. The local committee shall complete, to the fullest extent possible, the individual case report in the National Child Death Review Case Reporting System.
2. Submit written reports as required by the state committee. The reports must include:
a. Nonidentifying information from individual cases.
b. Identification of any problems with the data system uncovered through the review process and the committee's recommendations for system improvements and needed resources, training, and information dissemination, where gaps or deficiencies may exist.
c. All steps taken by the local committee and private and public agencies to implement necessary changes and improve the coordination of services and reviews.
3. Submit all records requested by the state committee at the conclusion of its review of a death resulting from child abuse.
4. Abide by the standards and protocols developed by the state committee.
5. On a case-by-case basis, request that the state committee review the data of a particular case.
(4) ANNUAL STATISTICAL REPORT.—The state committee shall prepare and submit a comprehensive statistical report by December 1 of each year to the Governor, the President of the Senate, and the Speaker of the House of Representatives which includes data, trends, analysis, findings, and recommendations for state and local action regarding deaths from child abuse. Data must be presented on an individual calendar year basis and in the context of a multiyear trend. At a minimum, the report must include:
(a) Descriptive statistics, including demographic information regarding victims and caregivers, and the causes and nature of deaths.
(b) A detailed statistical analysis of the incidence and causes of deaths.
(c) Specific issues identified within current policy, procedure, rule, or statute and recommendations to address those issues from both the state and local committees.
(d) Other recommendations to prevent deaths from child abuse based on an analysis of the data presented in the report.
(5) ACCESS TO AND USE OF RECORDS.—
(a) Notwithstanding any other law, the chairperson of the State Child Abuse Death Review Committee, or the chairperson of a local committee, shall be provided with access to any information or records that pertain to a child whose death is being reviewed by the committee and that are necessary for the committee to carry out its duties, including information or records that pertain to the child's family, as follows:

1. Patient records in the possession of a public or private provider of medical, dental, or mental health care, including, but not limited to, a facility licensed under Chapter 393, Chapter 394, or Chapter 395, or a health care practitioner as defined in s. 456.001. Providers may charge a fee for copies not to exceed 50 cents per page for paper records and $1 per fiche for microfiche records.
2. Information or records of any state agency or political subdivision which might assist a committee in reviewing a child's death, including, but not limited to, information or records of the Department of Children and Families, the Department of Health, the Department of Education, or the Department of Juvenile Justice.
(b) The State Child Abuse Death Review Committee or a local committee shall have access to all information of a law enforcement agency which is not the subject of an active investigation and which pertains to the review of the death of a child. A committee may not disclose any information that is not subject to public disclosure by the law enforcement agency, and active criminal intelligence information or criminal investigative information, as defined in s. 119.011(3), may not be made available for review or access under this section.
(c) The state committee and any local committee may share with each other any relevant information that pertains to the review of the death of a child.
(d) A member of the state committee or a local committee may not contact, interview, or obtain information by request or subpoena directly from a member of a deceased child's family as part of a committee's review of a child abuse death, except that if a committee member is also a public officer or state employee, that member may contact, interview, or obtain information from a member of the deceased child's family, if necessary, as part of the committee's review. A member of the deceased child's family may voluntarily provide records or information to the state committee or a local committee.
(e) The chairperson of the State Child Abuse Death Review Committee may require the production of records by requesting a subpoena, through the Department of Legal Affairs, in any county of the state. Such subpoena is effective throughout the state and may be served by any sheriff. Failure to obey the subpoena is punishable as provided by law.
(f) This section does not authorize the members of the state committee or any local committee to have access to any grand jury proceedings.
(g) A person who has attended a meeting of the state committee or a local committee or who has otherwise participated in activities authorized by this section may not be permitted or required to testify in any civil, criminal, or administrative proceeding as to any records or information produced or presented to a committee during meetings or other activities authorized by this section. However, this [1]paragraph does not prevent any person who testifies before the committee or who is a member of the committee from testifying as to matters otherwise within his or her knowledge. An organization, institution, committee member, or other person who furnishes information, data, reports, or records to the state committee or a local committee is not liable for damages to any person and is not subject to any other civil, criminal, or administrative recourse. This [1]paragraph does not apply to any person who admits to committing a crime.
(6) DEPARTMENT OF HEALTH RESPONSIBILITIES.—
(a) The Department of Health shall administer the funds appropriated to operate the review committees and may apply for grants and accept donations.
(b) To the extent that funds are available, the Department of Health may hire staff or consultants to assist a review committee in performing its duties. Funds may also be used to reimburse reasonable expenses of the staff and consultants for the state committee and the local committees.
(c) For the purpose of carrying out the responsibilities assigned to the State Child Abuse Death Review Committee and the local review committees, the State Surgeon General may substitute an existing entity whose function and organization includes the function and organization of the committees established by this section.
(7) DEPARTMENT OF CHILDREN AND FAMILIES RESPONSIBILITIES.—Each regional managing director of the Department of Children and Families must appoint a child abuse death review coordinator for the region. The coordinator must have knowledge and expertise in the area of child abuse and neglect. The coordinator's general responsibilities include:

(a) Coordinating with the local child abuse death review committee.
(b) Ensuring the appropriate implementation of the child abuse death review process and all regional activities related to the review of child abuse deaths.
(c) Working with the committee to ensure that the reviews are thorough and that all issues are appropriately addressed.
(d) Maintaining a system of logging child abuse deaths covered by this procedure and tracking cases during the child abuse death review process.
(e) Conducting or arranging for a Florida Safe Families Network record check on all child abuse deaths covered by this procedure to determine whether there were any prior reports concerning the child or concerning any siblings, other children, or adults in the home.
(f) Coordinating child abuse death review activities, as needed, with individuals in the community and the Department of Health.
(g) Notifying the regional managing director, the Secretary of Children and Families, the Department of Health Deputy Secretary for Health and Deputy State Health Officer for Children's Medical Services, and the Department of Health Child Abuse Death Review Coordinator of all deaths meeting criteria for review as specified in this section within 1 working day after case closure.
(h) Ensuring that all critical issues identified by the local child abuse death review committee are brought to the attention of the regional managing director and the Secretary of Children and Families.
(i) Providing technical assistance to the local child abuse death review committee during the review of any child abuse death.
History.—s. 13, ch. 99-168; s. 11, ch. 2000-160; s. 8, ch. 2000-217; s. 13, ch. 2001-53; s. 14, ch. 2004-350; s. 41, ch. 2008-6; s. 69, ch. 2014-19; s. 21, ch. 2014-224; s. 4, ch. 2015-79.
[1]Note.—The word "paragraph" was substituted for the word "subsection" by the editors to conform to the redesignation of subsection (14) as paragraph (5)(g) by s. 4, ch. 2015-79.

Appendix B

286.011 Public meetings and records; public inspection; criminal and civil penalties —

(1) All meetings of any board or commission of any state agency or authority or of any agency or authority of any county, municipal corporation, or political subdivision, except as otherwise provided in the Constitution, including meetings with or attended by any person elected to such board or commission, but who has not yet taken office, at which official acts are to be taken are declared to be public meetings open to the public at all times, and no resolution, rule, or formal action shall be considered binding except as taken or made at such meeting. The board or commission must provide reasonable notice of all such meetings.

(2) The minutes of a meeting of any such board or commission of any such state agency or authority shall be promptly recorded, and such records shall be open to public inspection. The circuit courts of this state shall have jurisdiction to issue injunctions to enforce the purposes of this section upon application by any citizen of this state.

(3)(a) Any public officer who violates any provision of this section is guilty of a noncriminal infraction, punishable by fine not exceeding $500.

(b) Any person who is a member of a board or commission or of any state agency or authority of any county, municipal corporation, or political subdivision who knowingly violates the provisions of this section by attending a meeting not held in accordance with the provisions hereof is guilty of a misdemeanor of the second degree, punishable as provided in s. 775.082 or s. 775.083.

(c) Conduct which occurs outside the state which would constitute a knowing violation of this section is a misdemeanor of the second degree, punishable as provided in s. 775.082 or s. 775.083.

(4) Whenever an action has been filed against any board or commission of any state agency or authority or any agency or authority of any county, municipal corporation, or political subdivision to enforce the provisions of this section or to invalidate the actions of any such board, commission, agency, or authority, which action was taken in violation of this section, and the court determines that the defendant or defendants to such action acted in violation of this section, the court shall assess a reasonable attorney's fee against such agency, and may assess a reasonable attorney's fee against the individual filing such an action if the court finds it was filed in bad faith or was frivolous. Any fees so assessed may be assessed against the individual member or members of such board or commission; provided, that in any case where the board or commission seeks the advice of its attorney and such advice is followed, no such fees shall be assessed against the individual member or members of the board or commission. However, this subsection shall not apply to a state attorney or his or her duly authorized assistants or any officer charged with enforcing the provisions of this section.

(5) Whenever any board or commission of any state agency or authority or any agency or authority of any county, municipal corporation, or political subdivision appeals any court order which has found said board, commission, agency, or authority to have violated this section, and such order is affirmed, the court shall assess a reasonable attorney's fee for the appeal against such board, commission, agency, or authority. Any fees so assessed may be assessed against the individual member or members of such board or commission; provided, that in any case where the board or commission seeks the advice of its attorney and such advice is followed, no such fees shall be assessed against the individual member or members of the board or commission.

(6) All persons subject to subsection (1) are prohibited from holding meetings at any facility or location which discriminates on the basis of sex, age, race, creed, color, origin, or economic status or which operates in such a manner as to unreasonably restrict public access to such a facility.

(7) Whenever any member of any board or commission of any state agency or authority or any agency or authority of any county, municipal corporation, or political subdivision is charged with a violation of this section and is subsequently acquitted, the board or commission is authorized to reimburse said member for any portion of his or her reasonable attorney's fees.

(8) Notwithstanding the provisions of subsection (1), any board or commission of any state agency or authority or any agency or authority of any county, municipal corporation, or political subdivision, and the chief administrative or executive officer of the governmental entity, may meet in private with the entity's attorney to discuss pending litigation to which the entity is presently a party before a court or administrative agency, provided that the following conditions are met:

(a) The entity's attorney shall advise the entity at a public meeting that he or she desires advice concerning the litigation.

(b) The subject matter of the meeting shall be confined to settlement negotiations or strategy sessions related to litigation expenditures.

(c) The entire session shall be recorded by a certified court reporter. The reporter shall record the times of commencement and termination of the session, all discussion and proceedings, the names of all persons present at any time, and the names of all persons speaking. No portion of the session shall be off the record. The court reporter's notes shall be fully transcribed and filed with the entity's clerk within a reasonable time after the meeting.

(d) The entity shall give reasonable public notice of the time and date of the attorney-client session and the names of persons who will be attending the session. The session shall commence at an open meeting at which the persons chairing the meeting shall announce the commencement and estimated length of the attorney-client session and the names of the persons attending. At the conclusion of the attorney-client session, the meeting shall be reopened, and the person chairing the meeting shall announce the termination of the session.

(e) The transcript shall be made part of the public record upon conclusion of the litigation.

History.—s. 1, ch. 67-356; s. 159, ch. 71-136; s. 1, ch. 78-365; s. 6, ch. 85-301; s. 33, ch. 91-224; s. 1, ch. 93-232; s. 210, ch. 95-148; s. 1, ch. 95-353; s. 2, ch. 2012-25.

Appendix C - See Ch. 2015-77, Laws of Fla. @ www.leg.state.fl.us

383.412 Public records and public meetings exemptions.—

(1) For purposes of this section, the term “local committee” means a local child abuse death review committee or a panel or committee assembled by the State Child Abuse Death Review Committee or a local child abuse death review committee pursuant to s. 383.402.

(2)(a) Any information held by the State Child Abuse Death Review Committee or a local committee which reveals the identity of the surviving siblings of a deceased child whose death occurred as the result of a verified report of abuse or neglect is confidential and exempt from s. 119.07(1) and s. 24(a), Art. I of the State Constitution.

(b) Any information held by the State Child Abuse Death Review Committee or a local committee which reveals the identity of a deceased child whose death has been reported to the central abuse hotline but determined not to be the result of abuse or neglect, or the identity of the surviving siblings, family members, or others living in the home of such deceased child, is confidential and exempt from s. 119.07(1) and s. 24(a), Art. I of the State Constitution.

(c) Information made confidential or exempt from s. 119.07(1) and s. 24(a), Art. I of the State Constitution which is obtained by the State Child Abuse Death Review Committee or a local committee shall retain its confidential or exempt status.

(3)(a) Portions of meetings of the State Child Abuse Death Review Committee or a local committee at which information made confidential and exempt pursuant to subsection (2) is discussed are exempt from s. 286.011 and s. 24(b), Art. I of the State Constitution. The closed portion of a meeting must be recorded, and no portion of the closed meeting may be off the record. The recording shall be maintained by the State Child Abuse Death Review Committee or a local committee.

(b) The recording of a closed portion of a meeting is exempt from s. 119.07(1) and s. 24(a), Art. I of the State Constitution.

(4) The State Child Abuse Death Review Committee and local committees may share information made confidential and exempt by this section:

(a) With each other;

(b) With a governmental agency in furtherance of its duties; or

(c) With any person or entity authorized by the Department of Health to use such relevant information for bona fide research or statistical purposes. A person or entity who is authorized to obtain such relevant information for research or statistical purposes must enter into a privacy and security agreement with the Department of Health and comply with all laws and rules governing the use of such records and information for research or statistical purposes. Anything identifying the subjects of such relevant information must be treated as confidential by the person or entity and may not be released in any form.

(5) Any person who knowingly or willfully makes public or discloses to any unauthorized person any information made confidential and exempt under this section commits a misdemeanor of the first degree, punishable as provided in s. 775.082 or s. 775.083.

(6) This section is subject to the Open Government Sunset Review Act in accordance with s. 119.15, and shall stand repealed on October 2, 2020, unless reviewed and saved from repeal through reenactment by the Legislature.

History.—s. 1, ch. 2005-190; s. 95, ch. 2008-4; s. 1, ch. 2010-40; s. 1, ch. 2015-77.

Appendix D

Statement of Confidentiality

Name:

Date:

I understand the following:

The purpose of the Child Abuse Death Review Team is to conduct a full examination of the death incident.

No material will be taken from the meeting with case identifying information.

The confidentiality of the information and records is governed by applicable Florida law.

_____

(Signature)

_____

(Agency)

APPENDIX E:

Case Report Form

NATIONAL CFRP
Center for Fatality Review & Prevention

Saving Lives Together

Child Death Review Case Reporting System

Case Report - Version 4.1

Instructions:

This case report is used by Child Death Review (CDR) teams to enter data into the National CDR Case Reporting System. This system is available to states from the National Center for Fatality Review & Prevention and requires a data use agreement for state and local data entry. System functions include data entry, case report, editing and printing, data download and standardized reports.

The purpose of this form is to collect comprehensive information from multiple agencies participating in a child death review. The form documents demographics, the circumstances involved in the death, investigative actions, services provided or needed, key risk factors and actions recommended and/or taken by the CDR team to prevent other deaths.

While this data collection form is an important part of the child death review process, the form should not be the central focus of the review meeting. Experienced users have found that it works best to assign a person to record data while the team discussions are occurring. Persons should not attempt to answer every single question in a step-by-step manner as part of the team discussion. The form can be partially filled out before a meeting.

It is not expected that teams will have answers to all of the questions related to a death. However, over time teams begin to understand the importance of data collection and bring the necessary information to the meeting. They find that the percentage of unknowns and unanswered questions decreases as the team becomes more familiar with the form.

The form contains three types of questions: (1) Those that users should only select <u>one</u> response as represented by a circle; (2) Those in which users can select <u>multiple</u> responses as represented by a square; and (3) Those in which users enter text. This last type is indicated by the words 'specify' or 'describe'.

Most questions have a selection for unknown (U/K). A question should be marked 'unknown' if an attempt was made to find the answer but no clear or satisfactory response was obtained. A question should be left blank (unanswered) if no attempt was made to find the answer. 'N/A' stands for 'Not Applicable' and should be used if the question is not applicable.

This edition is Version 4.1, effective June 2016. Additional paper forms can be ordered from the National Center at no charge. Users interested in participating in the web-based case reporting system for data entry and reporting should contact the National Center for Fatality Review & Prevention. This latest version incorporates the Sudden and Unexpected Infant Death (SUID) Case Registry and the Sudden Death in the Young (SDY) Case Registry questions.

Data entry website: https://cdrdata.org

Phone: 1-800-656-2434 Email: info@childdeathreview.org Website: www.childdeathreview.org

CASE NUMBER

_____/_____/_____/_____
State / County or Team Number / Year of Review / Sequence of Review

Case Type: ○ Death ○ Near death/serious injury ○ Not born alive

Death Certificate Number:
Birth Certificate Number:
ME/Coroner Number:
Date CDRT Notified of Death:

A. CHILD INFORMATION

1. Child's name: First: Middle: Last: ☐ U/K

2. Date of birth: ☐ U/K mm dd yyyy

3. Date of death: ☐ U/K mm dd yyyy

4. Age: ○ Years ○ Months ○ Days ○ Hours ○ Minutes ○ U/K

5. Race, check all that apply: ☐ U/K
☐ White ☐ Native Hawaiian
☐ Black ☐ Pacific Islander, specify:
☐ Asian, specify:
☐ American Indian, Tribe:
☐ Alaskan Native, Tribe:

6. Hispanic or Latino origin? ○ Yes ○ No ○ U/K

7. Sex: ○ Male ○ Female ○ U/K

8. Residence address: ☐ U/K
Street: Apt.
City:
State: Zip: County:

9. Type of residence:
○ Parental home ○ Relative home ○ Jail/detention
○ Licensed group home ○ Living on own ○ Other, specify:
○ Licensed foster home ○ Shelter
○ Relative foster home ○ Homeless ○ U/K

10. New residence in past 30 days? ○ Yes ○ No ○ U/K

11. Residence overcrowded? ○ Yes ○ No ○ U/K

12. Child ever homeless? ○ Yes ○ No ○ U/K

13. Number of other children living with child: _____ ☐ U/K

14. Child's weight: ☐ U/K
○ Pounds/ounces _____/_____
○ Grams/kilograms _____

15. Child's height: ☐ U/K
○ Feet/inches _____/_____
○ Cm _____

16. Highest education level:
○ N/A ○ Drop out
○ None ○ HS graduate
○ Preschool ○ College
○ Grade K-8 ○ Other, specify:
○ Grade 9-12 ○ U/K
○ Home schooled, K-8
○ Home schooled, 9-12

17. Child's work status:
○ N/A
○ Employed
○ Full time
○ Part time
○ U/K
○ Not working
○ U/K

18. Did child have problems in school? ○ N/A ○ Yes ○ No ○ U/K
If yes, check all that apply:
☐ Academic ☐ Behavioral
☐ Truancy ☐ Expulsion
☐ Suspensions ☐ U/K
☐ Other, specify:

19. Child's health insurance, check all that apply:
☐ None
☐ Private
☐ Medicaid
☐ State plan
☐ Indian Health Service
☐ Other, specify:
☐ U/K

20. Child had disability or chronic illness? ○ Yes ○ No ○ U/K
If yes, check all that apply:
☐ Physical/orthopedic, specify:
☐ Mental health/substance abuse, specify:
☐ Cognitive/Intellectual, specify:
☐ Sensory, specify:
☐ U/K
If yes, was child receiving Children's Special Health Care Needs services?
○ Yes ○ No ○ U/K

21. Child's mental health (MH):
Child had received prior MH services? ○ N/A ○ Yes ○ No ○ U/K
Child was receiving MH services? ○ N/A ○ Yes ○ No ○ U/K
Child on medications for MH illness? ○ N/A ○ Yes ○ No ○ U/K
Issues prevented child from receiving MH services? ○ N/A ○ Yes ○ No ○ U/K
If yes, specify:

22. Child had history of substance abuse? ○ N/A ○ Yes ○ No ○ U/K
If yes, check all that apply:
☐ Alcohol ☐ Other, specify:
☐ Cocaine
☐ Marijuana ☐ U/K
☐ Methamphetamine
☐ Opiates
☐ Prescription drugs
☐ Over-the-counter drugs

23. Child had history of child maltreatment? If yes, check all that apply:

As Victim	As Perpetrator	As Victim	As Perpetrator
	○ N/A	☐	☐ Physical
○	○ Yes	☐	☐ Neglect
○	○ No	☐	☐ Sexual
○	○ U/K	☐	☐ Emotional/psychological
		☐	☐ U/K
If yes, how was history identified:			
○	○ Through CPS	____	____ # CPS referrals
○	○ Other sources	____	____ # Substantiations

24. Was there an open CPS case with child at time of death? ○ Yes ○ No ○ U/K

25. Was child ever placed outside of the home prior to the death? ○ Yes ○ No ○ U/K

26. Were any siblings placed outside of the home prior to this child's death? ○ N/A ○ Yes, #____ ○ No ○ U/K

27. Child had history of intimate partner violence? Check all that apply:
☐ N/A
☐ Yes, as victim
☐ Yes, as perpetrator
☐ No
☐ U/K

28. Child had delinquent or criminal history? ○ N/A ○ Yes ○ No ○ U/K
If yes, check all that apply:
☐ Assaults ☐ Other, specify:
☐ Robbery
☐ Drugs ☐ U/K

29. Child spent time in juvenile detention? ○ N/A ○ Yes ○ No ○ U/K

30. Child acutely ill during the two weeks before death? ○ Yes ○ No ○ U/K

31. Was any parent a first generation immigrant? ○ Yes ○ No ○ U/K
If yes, country of origin:

32. If child over age 12, what was child's gender identity?
○ Male
○ Female
○ U/K

33. If child over age 12, what was child's sexual orientation?
○ Heterosexual ○ Lesbian ○ Questioning
○ Gay ○ Bisexual ○ U/K

COMPLETE FOR ALL INFANTS UNDER ONE YEAR

34. Gestational age: ☐ U/K
_____ # weeks

35. Birth weight: ☐ U/K
○ Grams/kilograms _____
○ Pounds/ounces _____/_____

36. Multiple birth?
○ Yes, #_____
○ No ○ U/K

37. Including the deceased infant, how many pregnancies did the birth mother have? #____ ☐ U/K

38. Including the deceased infant, how many live births did the birth mother have? #____ ☐ U/K

39. Not including the deceased infant, number of children birth mother still has living? #_____ ☐ U/K

40. Prenatal care provided during pregnancy of deceased infant? ○ Yes ○ No ○ U/K
If yes, number of prenatal visits: #_____ ☐ U/K If yes, month of first prenatal visit: Specify 1-9 __ ☐ U/K

41. During pregnancy, did mother (check all that apply):

Yes	No	U/K	
○	○	○	Have medical complications/infections?
○	○	○	Experience intimate partner violence?
○	○	○	Use illicit drugs?
	☐		Infant born drug exposed?
☐	☐	☐	Misuse OTC or prescription drugs?
○	○	○	Have heavy alcohol use?
	☐		Infant born with fetal alcohol effects or syndrome?

If yes, medical complications/infections, check all that apply:

- ☐ Acute/chronic lung disease
- ☐ Anemia
- ☐ Cardiac disease
- ☐ Chorioamnionitis
- ☐ Chronic hypertension
- ☐ Diabetes
- ☐ Eclampsia
- ☐ Genital herpes
- ☐ Hemoglobinopathy
- ☐ High MSAFP
- ☐ Hydramnios/oligohydramnios
- ☐ Incompetent cervix
- ☐ Low MSAFP
- ☐ Other infectious disease
- ☐ Pregnancy-related hypertension
- ☐ Preterm labor
- ☐ Previous infant 4000+ grams
- ☐ Previous infant preterm/ small for gestation
- ☐ PROM
- ☐ Renal disease
- ☐ Rh sensitization
- ☐ Uterine bleeding
- ☐ Other, specify:

42. Were there access or compliance issues related to prenatal care? ○ Yes ○ No ○ U/K If yes, check all that apply:

- ☐ Lack of money for care
- ☐ Limitations of health insurance coverage
- ☐ Multiple health insurance, not coordinated
- ☐ Lack of transportation
- ☐ No phone
- ☐ Cultural differences
- ☐ Religious objections to care
- ☐ Language barriers
- ☐ Referrals not made
- ☐ Specialist needed, not available
- ☐ Multiple providers, not coordinated
- ☐ Lack of child care
- ☐ Lack of family/social support
- ☐ Services not available
- ☐ Distrust of health care system
- ☐ Unwilling to obtain care
- ☐ Intimate partner would not allow care
- ☐ Other, specify:
- ☐ U/K

43. Did mother smoke in the 3 months before pregnancy?
○ Yes
○ No
○ U/K
If yes, ____Avg # cigarettes/day (20 cigarettes in pack)
☐ U/K quantity

44. Did mother smoke at any time during pregnancy?
○ Yes ○ No ○ U/K

	Trimester 1	Trimester 2	Trimester 3	
If yes,	_____	_____	_____	Avg # cigarettes/day (20 cigarettes in pack)
	☐	☐	☐	U/K quantity

45. Infant ever breastfed? ○ Yes ○ No ○ U/K

46. Was mother injured during pregnancy? ○ Yes ○ No ○ U/K
If yes, describe:

47. Did infant have abnormal metabolic newborn screening results? ○ Yes ○ No ○ U/K
If yes, was abnormality a fatty acid oxidation error, such as MCAD? ○ Yes ○ No ○ U/K
If yes, describe: If other abnormalities, describe:

48. At any time prior to the infant's last 72 hours, did the infant have a history of (check all that apply):

- ☐ Infection
- ☐ Allergies
- ☐ Abnormal growth, weight gain/loss
- ☐ Apnea
- ☐ Cyanosis
- ☐ Seizures or convulsions
- ☐ Cardiac abnormalities
- ☐ Metabolic disorders
- ☐ Other, specify:

49. In the 72 hours prior to death, did the infant have any of the following? Check all that apply:

- ☐ Fever
- ☐ Excessive sweating
- ☐ Lethargy/sleeping more than usual
- ☐ Fussiness/excessive crying
- ☐ Decrease in appetite
- ☐ Vomiting
- ☐ Choking
- ☐ Diarrhea
- ☐ Stool changes
- ☐ Difficulty breathing
- ☐ Apnea
- ☐ Cyanosis
- ☐ Seizures or convulsions
- ☐ Other, specify:

50. In the 72 hours prior to death, was the infant injured? ○ Yes ○ No ☐ U/K
If yes, describe cause and injuries:

51. In the 72 hours prior to death, was the infant given any vaccines? ○ Yes ○ No ☐ U/K
If yes, list name(s) of vaccines:

52. In the 72 hours prior to death, was the infant given any medications or remedies? Include herbal, prescription and over-the-counter medications and home remedies. ○ Yes ☐ No ○ U/K
If yes, list name and last dose given:

53. What did the infant have for his/her last meal? Check all that apply:

- ☐ Breast milk
- ☐ Formula, type:
- ☐ Baby food, type:
- ☐ Cereal, type:
- ☐ Other, specify:
- ☐ U/K

B. PRIMARY CAREGIVER(S) INFORMATION

1. Primary caregiver(s): Select only one each in columns one and two.

One	Two	One	Two
○	Self, go to Section C	○	○ Grandparent
○	○ Biological parent	○	○ Sibling
○	○ Adoptive parent	○	○ Other relative
○	○ Stepparent	○	○ Friend
○	○ Foster parent	○	○ Institutional staff
○	○ Mother's partner	○	○ Other, specify:
○	○ Father's partner	○	○ U/K

2. Caregiver(s) age in years:

One	Two	
_____	_____	# Years
☐	☐	U/K

3. Caregiver(s) sex:

One	Two	
○	○	Male
○	○	Female
○	○	U/K

4. Caregiver(s) employment status:

One	Two	
○	○	Employed
○	○	Unemployed
○	○	On disability
○	○	Stay-at-home
○	○	Retired
○	○	U/K

5. Caregiver(s) income:

One	Two	
○	○	High
○	○	Medium
○	○	Low
○	○	U/K

6. Caregiver(s) education:

One	Two	
○	○	< High school
○	○	High school
○	○	College
○	○	Post graduate
○	○	U/K

7. Do caregiver(s) speak English?

One	Two	
○	○	Yes
○	○	No
○	○	U/K

If no, language spoken:

8. Caregiver(s) on active military duty?

One	Two	
○	○	Yes
○	○	No
○	○	U/K

If yes, specify branch:

9. Caregiver(s) receive social services in the past twelve months?

One	Two		One	Two	
○	○	Yes	☐	☐	WIC
○	○	No	☐	☐	TANF
○	○	U/K	☐	☐	Medicaid
		If yes, check all that apply	☐	☐	Food stamps
			☐	☐	Other, specify:
			☐	☐	U/K

10. Caregiver(s) have substance abuse history?

One Two

○ ○ Yes
○ ○ No
○ ○ U/K

If yes, check all that apply:

☐ ☐ Alcohol
☐ ☐ Cocaine
☐ ☐ Marijuana
☐ ☐ Methamphetamine
☐ ☐ Opiates
☐ ☐ Prescription drugs
☐ ☐ Over-the-counter
☐ ☐ Other, specify:
☐ ☐ U/K

11. Caregiver(s) ever victim of child maltreatment?

One Two

☐ ○ Yes
○ ○ No
○ ○ U/K

If yes, check all that apply:

☐ ☐ Physical
☐ ☐ Neglect
☐ ☐ Sexual
☐ ☐ Emotional/psychological
☐ ☐ U/K

____ _____# CPS referrals
____ _____# Substantiations

☐ ☐ Ever in foster care or adopted

12. Caregiver(s) ever perpetrator of maltreatment?

One Two

○ ○ Yes
○ ○ No
○ ○ U/K

If yes, check all that apply:

☐ ☐ Physical
☐ ☐ Neglect
☐ ☐ Sexual
☐ ☐ Emotional/psychological
☐ ☐ U/K

____ _____# CPS referrals
____ _____# Substantiations

☐ ☐ CPS prevention services
☐ ☐ Family preservation services
☐ ☐ Children ever removed

13. Caregiver(s) have disability or chronic illness?

One Two

☐ ○ Yes
○ ○ No
○ ○ U/K

If yes, check all that apply:

☐ ☐ Physical, specify:
☐ ☐ Mental, specify:
☐ ☐ Sensory, specify:
☐ ☐ U/K

If mental illness, was caregiver receiving MH services?

○ ○ Yes
○ ○ No
○ ○ U/K

14. Caregiver(s) have prior child deaths?

One Two

○ ○ Yes
○ ○ No
○ ○ U/K

If yes, cause(s): Check all that apply:

One Two

☐ ☐ Child abuse #_____
☐ ☐ Child neglect #_____
☐ ☐ Accident #_____
☐ ☐ Suicide #_____
☐ ☐ SIDS #_____
☐ ☐ Other #_____

Other, specify:

☐ ☐ U/K

15. Caregiver(s) have history of intimate partner violence?

One Two

☐ ☐ Yes, as victim
☐ ☐ Yes, as perpetrator
☐ ☐ No
☐ ☐ U/K

16. Caregiver(s) have delinquent/criminal history?

One Two

○ ○ Yes
○ ○ No
○ ○ U/K

If yes, check all that apply:

☐ ☐ Assaults
☐ ☐ Robbery
☐ ☐ Drugs
☐ ☐ Other, specify:
☐ ☐ U/K

C. SUPERVISOR INFORMATION

1. Did child have supervision at time of incident leading to death?

○ Yes, answer 2-15
○ No, not needed given developmental age or circumstances, go to Sect. D
○ No, but needed, answer 3-15
○ Unable to determine, try to answer 3-15

2. How long before incident did supervisor last see child? Select one:

○ Child in sight of supervisor
○ Minutes _____ ○ Days _____
○ Hours _____ ○ U/K

3. Is person a primary caregiver as listed in previous section?

○ Yes, caregiver one, go to 15
○ Yes, caregiver two, go to 15
○ No

4. Primary person responsible for supervision? Select only one:

○ Biological parent ○ Foster parent ○ Grandparent ○ Friend ○ Institutional staff, go to 15 ○ Other, specify:
○ Adoptive parent ○ Mother's partner ○ Sibling ○ Acquaintance ○ Babysitter
○ Stepparent ○ Father's partner ○ Other relative ○ Hospital staff, go to 15 ○ Licensed child care worker ○ U/K

5. Supervisor's age in years:

_____ ☐ U/K

6. Supervisor's sex:

○ Male ○ Female ○ U/K

7. Does supervisor speak English?

○ Yes ○ No ○ U/K

If no, language spoken:

8. Supervisor on active military duty?

○ Yes ☐ No ○ U/K

If yes, specify branch:

9. Supervisor has substance abuse history?

○ Yes ○ No ○ U/K

If yes, check all that apply:

☐ Alcohol
☐ Cocaine
☐ Marijuana
☐ Methamphetamine
☐ Opiates
☐ Prescription drugs
☐ Over-the-counter
☐ Other, specify:

☐ U/K

10. Supervisor has history of child maltreatment?

As Victim As Perpetrator

○ ○ Yes
○ ○ No
○ ○ U/K

If yes, check all that apply:

☐ ☐ Physical
☐ ☐ Neglect
☐ ☐ Sexual
☐ ☐ Emotional/psychological
☐ ☐ U/K

____ _____# CPS referrals
____ _____# Substantiations

☐ Ever in foster care/adopted
☐ CPS prevention services
☐ Family preservation services
☐ Children ever removed

11. Supervisor has disability or chronic illness?

○ Yes ○ No ○ U/K

If yes, check all that apply:

☐ Physical, specify:
☐ Mental, specify:
☐ Sensory, specify:
☐ U/K

If mental illness, was supervisor receiving MH services?

○ Yes
○ No
○ U/K

12. Supervisor has prior child deaths?

○ Yes ○ No ○ U/K

If yes, check all that apply:

☐ Child abuse #_____
☐ Child neglect #_____
☐ Accident #_____
☐ Suicide #_____
☐ SIDS #_____
☐ Other #_____

Other, specify:

☐ U/K

13. Supervisor has history of intimate partner violence?
- ☐ Yes, as victim
- ☐ Yes, as perpetrator
- ☐ No
- ☐ U/K

14. Supervisor has delinquent or criminal history?
- ○ Yes ○ No ○ U/K

If yes, check all that apply:
- ☐ Assaults ☐ Drugs ☐ U/K
- ☐ Robbery ☐ Other, specify:

15. At time of incident was supervisor impaired? ○ Yes ○ No ○ U/K

If yes, check all that apply:
- ☐ Drug impaired, specify:
- ☐ Alcohol impaired
- ☐ Asleep
- ☐ Distracted
- ☐ Absent
- ☐ Impaired by illness, specify:
- ☐ Impaired by disability, specify:
- ☐ Other, specify:

D. INCIDENT INFORMATION

1. Date of incident event:
- ○ Same as date of death
- ○ If different than date of death: ___/___/___ (mm/dd/yyyy)
- ○ U/K

2. Approximate time of day that incident occurred?
- Hour, specify 1-12____
- ○ AM ○ PM ○ U/K

3. Interval between incident and death: ☐ U/K
- ☐ Minutes ____ ☐ Weeks ____
- ☐ Hours ____ ☐ Months ____
- ☐ Days ____ ☐ Years ____

4. Place of incident, check all that apply:
- ☐ Child's home
- ☐ Relative's home
- ☐ Friend's home
- ☐ Licensed foster care home
- ☐ Relative foster care home
- ☐ Licensed group home
- ☐ Licensed child care center
- ☐ Licensed child care home
- ☐ Unlicensed child care home
- ☐ Farm/ranch
- ☐ School
- ☐ Place of work
- ☐ Indian reservation/ trust lands
- ☐ Military installation
- ☐ Jail/detention facility
- ☐ Sidewalk
- ☐ Roadway
- ☐ Driveway
- ☐ Other parking area
- ☐ State or county park
- ☐ Sports area
- ☐ Other recreation area
- ☐ Hospital
- ☐ Other, specify:
- ☐ U/K

5. Type of area:
- ○ Urban
- ○ Suburban
- ○ Rural
- ○ Frontier
- ○ U/K

6. Incident state:

7. Incident county:

8. Death state:

9. Death county:

10. Was the incident witnessed? ○ Yes ○ No ○ UK

If yes, by whom?
- ☐ Parent/relative
- ☐ Other caretaker/babysitter
- ☐ Teacher/coach/athletic trainer
- ☐ Other acquaintance
- ☐ Health care professional, if death occurred in a hospital setting
- ☐ Stranger
- ☐ Other, specify:

11. Was 911 or local emergency called?
- ○ N/A ○ Yes ○ No ○ U/K

12. Was resuscitation attempted? ○ N/A ○ Yes ○ No ○ U/K

If yes, by whom?
- ☐ EMS
- ☐ Parent/relative
- ☐ Other caretaker/babysitter
- ☐ Teacher/coach/athletic trainer
- ☐ Other acquaintance
- ☐ Health care professional, if death occurred in a hospital setting
- ☐ Stranger
- ☐ Other, specify:

If yes, type of resuscitation:
- ☐ CPR
- ☐ Automated External Defibrillator (AED)
  - If no AED, was AED available/accessible? ○ Yes ○ No ○ U/K
  - If AED, was shock administered? ○ Yes ○ No ○ U/K
  - If yes, how many shocks were administered? ____
- ☐ Rescue medications, specify type:
- ☐ Other, specify:

If yes, was a rhythm recorded? ○ Yes ○ No ○ U/K

If yes, what was the rhythm? ____

13. At time of incident leading to death, had child used drugs or alcohol? ○ N/A ○ Yes ○ No ○ U/K

14. Child's activity at time of incident, check all that apply:
- ☐ Sleeping ☐ Working ☐ Driving/vehicle occupant ☐ U/K
- ☐ Playing ☐ Eating ☐ Other, specify:

15. Total number of deaths at incident event:
- ____ Children, ages 0-18 ○ U/K
- ____ Adults

E. INVESTIGATION INFORMATION

1. Death referred to:
- ○ Medical examiner
- ○ Coroner
- ○ Not referred
- ○ U/K

2. Person declaring official cause and manner of death:
- ○ Medical examiner ○ Mortician
- ○ Coroner ○ Other, specify:
- ○ Hospital physician
- ○ Other physician ○ U/K

3. Autopsy performed? ○ Yes ○ No ○ U/K

If yes, conducted by:
- ○ Forensic pathologist ○ Other physician
- ○ Pediatric pathologist ○ Other, specify:
- ○ General pathologist
- ○ Unknown pathologist ○ U/K

If no, why not (e.g. parent or caregiver objected)?

If yes, was a specialist consulted during autopsy (cardiac, neurology, etc.)? ○ Yes ○ No ○ U/K If yes, specify specialist:

4. Were the following assessed either through the autopsy or through information collected prior to the autopsy? Please list any abnormalities/significant findings in E8.

	Yes	No	U/K
Imaging:			
X-ray - single	○	○	○
X-ray - multiple views	○	○	○
X-ray - complete skeletal series	○	○	○
Other imaging, specify (includes MRI, CT scan, photos of the brain, etc):	○	○	○
External Exam:			
Exam of general appearance	○	○	○
Head circumference	○	○	○
Other Autopsy Proceedures:			
Was a gross examination of organs done?	○	○	○
Were weights of any organs taken?	○	○	○

5. Were any of these additional tests performed at or prior to the autopsy? Please list any abnormalities/significant findings in E8.

	Yes	No	U/K
Cultures for infectious disease	○	○	○
Microscopic/histologic exam	○	○	○
Postmortem metabolic screen	○	○	○
Vitreous testing	○	○	○
Genetic testing	○	○	○

6. Was any toxicology testing performed?

○ Yes ○ No ○ U/K If yes, check all that apply:

☐ Negative ☐ Opiates ☐ Too high Rx drug, specify:
☐ Alcohol ☐ Marijuana ☐ Too high OTC drug, specify:
☐ Cocaine ☐ Methamphetamine ☐ Other, specify:
☐ U/K

7. Was the child's medical history reviewed as part of the autopsy? ○ Yes ○ No ○ U/K

If yes, did this include:

Review of the newborn metabolic screen results? ○ Yes ○ No ○ U/K ○ Not Performed

Review of neonatal CCHD screen results? ○ Yes ○ No ○ U/K ○ Not Performed

8. Describe any abnormalities checked in E4 or E5 or other significant findings noted in the autopsy:

9. Was there agreement between the cause of death listed on the pathology report and on the death certificate? ○ N/A ○ Yes ○ No ○ U/K

If no, describe the differences:

10. Was a death scene investigation performed? ○ Yes ○ No ○ U/K

If yes, which of the following death scene investigation components were completed?

Yes	No	U/K		If yes, shared with CDR team?
○	○	○	CDC's SUIDI Reporting Form or jurisdictional equivalent	○ Yes ○ No
○	○	○	Narrative description of circumstances	○ Yes ○ No
○	○	○	Scene photos	○ Yes ○ No
○	○	○	Scene recreation with doll	○ Yes ○ No
○	○	○	Scene recreation without doll	○ Yes ○ No
○	○	○	Witness interviews	○ Yes ○ No

11. Agencies that conducted a scene investigation, check all that apply:

☐ Medical examiner
☐ Coroner
☐ ME investigator
☐ Coroner investigator
☐ Law enforcement
☐ Fire investigator
☐ EMS
☐ Child Protective Services
☐ Other, specify:

☐ U/K

12. Was a CPS record check conducted as a result of death? ○ Yes ○ No ○ U/K

13. Did any investigation find evidence of prior abuse?

○ N/A ○ Yes ○ No ○ U/K

If yes, from what source?

Check all that apply:

☐ From x-rays ☐ U/K
☐ From autopsy
☐ From CPS review
☐ From law enforcement

14. CPS action taken because of death? ○ N/A ○ Yes ○ No ○ U/K

If yes, highest level of action taken because of death:

○ Report screened out and not investigated
○ Unsubstantiated
○ Inconclusive
○ Substantiated

If yes, services or actions resulting, check all that apply:

☐ Voluntary services offered
☐ Voluntary services provided
☐ Court-ordered services provided
☐ Voluntary out of home placement
☐ Court-ordered out of home placement
☐ Children removed
☐ Parental rights terminated
☐ U/K

15. If death occurred in licensed setting (see D4), indicate action taken:

○ No action
○ License suspended
○ License revoked
○ Investigation ongoing
○ Other, specify:
○ U/K

F. OFFICIAL MANNER AND PRIMARY CAUSE OF DEATH

1. Enter the cause of death code (ICD-10) assigned to this case by Vital Records using a capital letter and corresponding number (e.g., W75 or V94.4) and include up to one decimal place if applicable: _____ ☐ U/K

2. Enter the following information exactly as written on the death certificate: ☐ U/K

Immediate cause (final disease or condition resulting in death):

a.

Sequentially list any conditions leading to immediate cause of death. In other words, list underlying disease or injury that initiated events resulting in death:

b.

c.

d.

3. Enter other significant conditions contributing to death but not the underlying cause(s) listed in F2 exactly as written on the death certificate: ☐ U/K

4. If injury, describe how injury occurred exactly as written on the death certificate: ☐ U/K

5. Official manner of death from the death certificate:

- ○ Natural
- ○ Accident
- ○ Suicide
- ○ Homicide
- ○ Undetermined
- ○ Pending
- ○ U/K

If Homicide: Yes
Child abuse? ☐
Child neglect? ☐
Complete Section I, Acts of Omission or Commission

If Suicide: Complete Section I, Acts of Omission or Commission

6. Primary cause of death: Choose only 1 of the 4 major categories, then a specific cause. For pending, choose most likely cause.

○ From an injury (external cause). Select one and answer F4:
- ○ Motor vehicle and other transport, go to G1
- ○ Fire, burn, or electrocution, go to G2
- ○ Drowning, go to G3
- ○ Asphyxia, go to G4
- ○ Weapon, including body part, go to G5
- ○ Animal bite or attack, go to G6
- ○ Fall or crush, go to G7
- ○ Poisoning, overdose or acute intoxication, go to G8
- ○ Exposure, go to G9
- ○ Undetermined, go to H1
- ○ Other cause, go to G11
- ○ U/K, go to H1

○ From a medical cause. Select one:
- ○ Asthma, go to G10
- ○ Cancer, specify and go to G10
- ○ Cardiovascular, specify and go to G10
- ○ Congenital anomaly, specify and go to G10
- ○ Diabetes, go to G10
- ○ HIV/AIDS, go to G10
- ○ Influenza, go to G10
- ○ Low birth weight, go to G10
- ○ Malnutrition/dehydration, go to G10
- ○ Neurological/seizure disorder, go to G10
- ○ Pneumonia, specify and go to G10
- ○ Prematurity, go to G10
- ○ SIDS, go to G10
- ○ Other infection, specify and go to G10
- ○ Other perinatal condition, specify and go to G10
- ○ Other medical condition, specify and go to G10
- ○ Undetermined, go to G10
- ○ U/K, go to G10

○ Undetermined if injury or medical cause, go to H1

○ U/K go to H1

G. DETAILED INFORMATION BY *CAUSE* OF DEATH: CHOOSE ONE SECTION ONLY, THAT IS SAME AS THE CAUSE SELECTED ABOVE

1. MOTOR VEHICLE AND OTHER TRANSPORT

a. Vehicles involved in incident:
Total number of vehicles: _____

Child's	Other primary vehicle	
○	○	None
○	○	Car
○	○	Van
○	○	Sport utility vehicle
○	○	Truck
○	○	Semi/tractor trailer
○	○	RV
○	○	School bus
○	○	Other bus
○	○	Motorcycle
○	○	Tractor
○	○	Other farm vehicle
○	○	All terrain vehicle
○	○	Snowmobile
○	○	Bicycle
○	○	Train
○	○	Subway
○	○	Trolley
○	○	Other, specify:
○	○	U/K

b. Position of child:
- ○ Driver
- ○ Passenger
  - ○ Front seat
  - ○ Back seat
  - ○ Truck bed
  - ○ Other, specify:
  - ○ U/K
- ○ On bicycle
- ○ Pedestrian
  - ○ Walking
  - ○ Boarding/blading
  - ○ Other, specify:
  - ○ U/K
- ○ U/K

If passenger, relationship of driver to child:
- ○ Biological parent
- ○ Adoptive parent
- ○ Stepparent
- ○ Foster parent
- ○ Mother's partner
- ○ Father's partner
- ○ Grandparent
- ○ Sibling
- ○ Other relative
- ○ Friend
- ○ Other, specify:
- ○ U/K

c. Causes of incident, check all that apply:
- ☐ Speeding over limit
- ☐ Unsafe speed for conditions
- ☐ Recklessness
- ☐ Ran stop sign or red light
- ☐ Driver distraction
- ☐ Driver inexperience
- ☐ Mechanical failure
- ☐ Poor tires
- ☐ Poor weather
- ☐ Poor visibility
- ☐ Drugs or alcohol use
- ☐ Fatigue/sleeping
- ☐ Medical event, specify:
- ☐ Back/front over
- ☐ Flipover
- ☐ Poor sight line
- ☐ Car changing lanes
- ☐ Road hazard
- ☐ Animal in road
- ☐ Cell phone use while driving
- ☐ Racing, not authorized
- ☐ Other driver error, specify:
- ☐ Other, specify:
- ☐ U/K

d. Collision type:
- ○ Child *not* in/on a vehicle, but struck by vehicle
- ○ Child in/on a vehicle, struck by other vehicle
- ○ Child in/on a vehicle that struck other vehicle
- ○ Child in/on a vehicle that struck person/object
- ○ Other event, specify:
- ○ U/K

e. Driving conditions, check all that apply:
- ☐ Normal
- ☐ Loose gravel
- ☐ Muddy
- ☐ Ice/snow
- ☐ Fog
- ☐ Wet
- ☐ Construction zone
- ☐ Inadequate lighting
- ☐ Other, specify:
- ☐ U/K

f. Location of incident, check all that apply:
- ☐ City street
- ☐ Residential street
- ☐ Rural road
- ☐ Highway
- ☐ Intersection
- ☐ Shoulder
- ☐ Sidewalk
- ☐ Driveway
- ☐ Parking area
- ☐ Off road
- ☐ RR xing/tracks
- ☐ Other, specify:
- ☐ U/K

g. Drivers involved in incident, check all that apply:

Child as driver	Child's driver	Driver of other primary vehicle		Child as driver	Child's driver	Driver of other primary vehicle	
	Age of Driver	Age of Driver					
	○	○	<16 years	☐	☐	☐	Has a graduated license
	○	○	16 to 18 years old	☐	☐	☐	Has a full license
	○	○	19 to 21 years old	☐	☐	☐	Has a full license that has been restricted
	○	○	22 to 29 years old	☐	☐	☐	Has a suspended license
	○	○	30 to 65 years old	☐	☐	☐	If recreational vehicle, has driver safety certificate
	○	○	>65 years old	☐	☐	☐	Other, specify:
	○	○	U/K age	☐	☐	☐	Was violating graduated licensing rules:
☐	☐	☐	Responsible for causing incident	☐	☐	☐	Nighttime driving curfew
☐	☐	☐	Was alcohol/drug impaired	☐	☐	☐	Passenger restrictions
☐	☐	☐	Has no license	☐	☐	☐	Driving without required supervision
☐	☐	☐	Has a learner's permit	☐	☐	☐	Other violations, specify:
				☐	☐	☐	U/K

h. Total number of occupants in vehicles:

In child's vehicle, including child:		In other primary vehicle involved in incident:	
☐ N/A, child was not in a vehicle		☐ N/A, incident was a single vehicle crash	
Total number of occupants: _____	☐ U/K	Total number of occupants: _____	☐ U/K
Number of teens, ages 14-21: _____	☐ U/K	Number of teens, ages 14-21: _____	☐ U/K
Total number of deaths: _____	☐ U/K	Total number of deaths: _____	☐ U/K
Total number of teen deaths: _____	☐ U/K	Total number of teen deaths: _____	☐ U/K

i. Protective measures for child, Select one option per row:

	Not Needed	Needed, none present	Present, used correctly	Present, used incorrectly	Present, not used	U/K
Airbag	○	○	○	○	○	○
Lap belt	○	○	○	○	○	○
Shoulder belt	○	○	○	○	○	○
Child seat*	○	○	○	○	○	○
Belt positioning booster seat	○	○	○	○	○	○
Helmet	○	○	○	○	○	○
Other, specify:	○	○	○	○	○	○

*If child seat, type:
○ Rear facing
○ Front facing
○ U/K

2. FIRE, BURN, OR ELECTROCUTION

a. Ignition, heat or electrocution source:

○ Matches	○ Heating stove	○ Lightning	○ Other explosives
○ Cigarette lighter	○ Space heater	○ Oxygen tank	○ Appliance in water
○ Utility lighter	○ Furnace	○ Hot cooking water	○ Other, specify:
○ Cigarette or cigar	○ Power line	○ Hot bath water	
○ Candles	○ Electrical outlet	○ Other hot liquid, specify:	
○ Cooking stove	○ Electrical wiring	○ Fireworks	○ U/K

b. Type of incident:
○ Fire, go to c
○ Scald, go to r
○ Other burn, go to t
○ Electrocution, go to s
○ Other, specify and go to t
○ U/K, go to t

c. For fire, child died from:
○ Burns
○ Smoke inhalation
○ Other, specify:
○ U/K

d. Material first ignited:
○ Upholstery
○ Mattress
○ Christmas tree
○ Clothing
○ Curtain
○ Other, specify:
○ U/K

e. Type of building on fire:
○ N/A
○ Single home
○ Duplex
○ Apartment
○ Trailer/mobile home
○ Other, specify:
○ U/K

f. Building's primary construction material:
○ Wood
○ Steel
○ Brick/stone
○ Aluminum
○ Other, specify:
○ U/K

g. Fire started by a person?
○ Yes ○ No ○ U/K
If yes, person's age _____
Does person have a history of setting fires?
○ Yes ○ No ○ U/K

h. Did anyone attempt to put out fire?
○ Yes ○ No ○ U/K

i. Did escape or rescue efforts worsen fire?
○ Yes ○ No ○ U/K

j. Did any factors delay fire department arrival?
○ Yes ○ No ○ U/K
If yes, specify:

k. Were barriers preventing safe exit?
○ Yes ○ No ○ U/K
If yes, check all that apply:
☐ Locked door
☐ Window grate
☐ Locked window
☐ Blocked stairway
☐ Other, specify:
☐ U/K

l. Was building a rental property?
○ Yes ○ No ○ U/K

m. Were building/rental codes violated?
○ Yes ○ No ○ U/K
If yes, describe in narrative.

n. Were proper working fire extinguishers present?
○ Yes ○ No ○ U/K

o. Was sprinkler system present?
○ Yes ○ No ○ U/K
If yes, was it working?
○ Yes ○ No ○ U/K

p. Were smoke detectors present? ○ Yes ○ No ○ U/K

If yes, what type?	If yes, functioning properly?	If not functioning properly, reason: Missing batteries	Other	U/K
☐ Removable batteries	○ Yes ○ No ○ U/K	☐	☐	☐
☐ Non-removable batteries	○ Yes ○ No ○ U/K		☐	☐
☐ Hardwired	○ Yes ○ No ○ U/K	☐	☐	☐
☐ U/K	○ Yes ○ No ○ U/K	☐	☐	☐

Other, specify:

If yes, was there an adequate number present? ○ Yes ○ No ○ U/K

q. Suspected arson?	r. For scald, was hot water heater set too high?	s. For electrocution, what cause:	t. Other, describe in detail:
○ Yes ○ No ○ U/K	○ N/A ○ Yes, temp. setting: _____ ○ No ○ U/K	○ Electrical storm ○ Faulty wiring ○ Wire/product in water ○ Child playing with outlet ○ Other, specify: ○ U/K	

3. DROWNING

a. Where was child last seen before drowning? Check all that apply:	b. What was child last seen doing before drowning?	c. Was child forcibly submerged?	d. Drowning location:
☐ In water ☐ In yard ☐ On shore ☐ In bathroom ☐ On dock ☐ In house ☐ Poolside ☐ Other, specify: ☐ U/K	○ Playing ○ Tubing ○ Boating ○ Waterskiing ○ Swimming ○ Sleeping ○ Bathing ○ Other, specify: ○ Fishing ○ Surfing ○ U/K	○ Yes ○ No ○ U/K	○ Open water, go to e ○ U/K, go to n ○ Pool, hot tub, spa, go to i ○ Bathtub, go to w ○ Bucket, go to x ○ Well/cistern/septic, go to n ○ Toilet, go to z ○ Other, specify and go to n

e. For open water, place:	f. For open water, contributing environmental factors:	g. If boating, type of boat:	h. For boating, was the child piloting boat?
○ Lake ○ Quarry ○ River ○ Gravel pit ○ Pond ○ Canal ○ Creek ○ U/K ○ Ocean	○ Weather ○ Drop off ○ Temperature ○ Rough waves ○ Current ○ Other, specify: ○ Riptide/ undertow ○ U/K	○ Sailboat ○ Commercial ○ Jet ski ○ Other, specify: ○ Motorboat ○ Canoe ○ Kayak ○ U/K ○ Raft	○ Yes ○ No ○ U/K

i. For pool, type of pool:	j. For pool, child found:	k. For pool, ownership is:	l. Length of time owners had pool/hot tub/spa:
○ Above ground ○ In-ground ○ Hot tub, spa ○ Wading ○ U/K	○ In the pool/hot tub/spa ○ On or under the cover ○ U/K	○ Private ○ Public ○ U/K	○ N/A ○ >1yr ○ <6 months ○ U/K ○ 6m-1 yr

m. Flotation device used?	n. What barriers/layers of protection existed to prevent access to water?
○ N/A ○ Yes ○ No ○ U/K If yes, check all that apply: ☐ Coast Guard approved ☐ Not Coast Guard approved ☐ U/K ☐ Jacket ☐ Cushion ☐ Lifesaving ring If jacket: Correct size? ○ Yes ○ No ○ U/K Worn correctly? ○ Yes ○ No ○ U/K ☐ Swim rings ☐ Inner tube ☐ Air mattress ☐ Other, specify:	Check all that apply: ☐ None ☐ Alarm, go to r ☐ Fence, go to o ☐ Cover, go to s ☐ Gate, go to p ☐ U/K ☐ Door, go to q

o. Fence:	p. Gate, check all that apply:	q. Door, check all that apply:	r. Alarm, check all that apply:	s. Type of cover:
Describe type: Fence height in ft _____ Fence surrounds water on: ○ Four sides ○ Two or ○ Three sides less sides ○ U/K	☐ Has self-closing latch ☐ Has lock ☐ Is a double gate ☐ Opens to water ☐ U/K	☐ Patio door ☐ Opens to water ☐ Screen door ☐ Barrier between door and water ☐ Steel door ☐ Self-closing ☐ U/K ☐ Has lock	☐ Door ☐ Window ☐ Pool ☐ Laser ☐ U/K	○ Hard ○ Soft ○ U/K

t. Local ordinance(s) regulating access to water?	u. How were layers of protection breached? Check all that apply:			
○ Yes ○ No ○ U/K If yes, rules violated? ○ Yes ○ No ○ U/K	☐ No layers breached ☐ Gate left open ☐ Gate unlocked ☐ Gate latch failed ☐ Gap in gate ☐ Climbed fence	☐ Gap in fence ☐ Damaged fence ☐ Fence too short ☐ Door left open ☐ Door unlocked ☐ Door broken	☐ Door screen torn ☐ Door self-closer failed ☐ Window left open ☐ Window screen torn ☐ Alarm not working ☐ Alarm not answered	☐ Cover left off ☐ Cover not locked ☐ Other, specify: ☐ U/K

v. Child able to swim?	w. For bathtub, child in a bathing aid?	x. Warning sign or label posted?	y. Lifeguard present?
○ N/A ○ No ○ Yes ○ U/K	○ Yes ○ No ○ U/K If yes, specify type:	○ N/A ○ No ○ Yes ○ U/K	○ N/A ○ No ○ Yes ○ U/K

z. Rescue attempt made?	aa. Did rescuer(s) also drown?	bb. Appropriate rescue equipment present?
○ N/A ○ Yes ○ No ○ U/K If yes, who? Check all that apply: ☐ Parent ☐ Bystander ☐ Other child ☐ Other, specify: ☐ Lifeguard ☐ U/K	○ N/A ○ No ○ Yes ○ U/K If yes, number of rescuers that drowned: _____	○ N/A ○ No ○ Yes ○ U/K

4. ASPHYXIA

a. Type of event:
- Suffocation, go to b
- Strangulation, go to c
- Choking, go to d
- Other, specify and go to e
- U/K, go to e

b. If suffocation/asphyxia, action causing event:
- Sleep-related (e.g. bedding, overlay, wedged)
- Covered in or fell into object, but not sleep-related
  - Plastic bag
  - Dirt/sand
  - Other, specify:
  - U/K
- Confined in tight space
  - Refrigerator/freezer
  - Toy chest
  - Automobile
    - Trunk
    - Other, specify:
    - U/K
  - Other, specify:
  - U/K
- Swaddled in tight blanket, but not sleep-related
- Wedged into tight space, but not sleep-related
- Asphyxia by gas, go to G8h
- Other, specify:
- U/K

c. If strangulation, object causing event:
- Clothing
- Blind cord
- Car seat
- Stroller
- High chair
- Belt
- Rope/string
- Leash
- Electrical cord
- Person, go to G5q
- Automobile power window or sunroof
- Other, specify:
- U/K

d. If choking, object causing choking:
- Food, specify:
- Toy, specify:
- Balloon
- Other, specify:
- U/K

e. Was asphyxia an autoerotic event?
- Yes
- No
- U/K

f. Was child participating in 'choking game' or 'pass out game'?
- Yes
- No
- U/K

g. History of seizures?
- Yes
- No
- U/K
- If yes, #_____
- If yes, witnessed? Yes / No / U/K

h. History of apnea?
- Yes
- No
- U/K
- If yes, #_____
- If yes, witnessed? Yes / No / U/K

i. Was Heimlich Maneuver attempted?
- Yes
- No
- U/K

5. WEAPON, INCLUDING PERSON'S BODY PART

a. Type of weapon:
- Firearm, go to b
- Sharp instrument, go to j
- Blunt instrument, go to k
- Person's body part, go to l
- Explosive, go to m
- Rope, go to m
- Pipe, go to m
- Biological, go to m
- Other, specify and go to m
- U/K, go to m

b. For firearms, type:
- Handgun
- Shotgun
- BB gun
- Hunting rifle
- Assault rifle
- Air rifle
- Sawed off shotgun
- Other, specify:
- U/K

c. Firearm licensed?
- Yes
- No
- U/K

d. Firearm safety features, check all that apply:
- Trigger lock
- Personalization device
- External safety/drop safety
- Loaded chamber indicator
- Magazine disconnect
- Minimum trigger pull
- Other, specify:
- U/K

e. Where was firearm stored?
- Not stored
- Locked cabinet
- Unlocked cabinet
- Glove compartment
- Under mattress/pillow
- Other, specify:
- U/K

f. Firearm stored with ammunition?
- Yes
- No
- U/K

g. Firearm stored loaded?
- Yes
- No
- U/K

h. Owner of fatal firearm:
- U/K, weapon stolen
- U/K, weapon found
- Self
- Biological parent
- Adoptive parent
- Stepparent
- Foster parent
- Mother's partner
- Father's partner
- Grandparent
- Sibling
- Spouse
- Other relative
- Friend
- Acquaintance
- Child's boyfriend or girlfriend
- Classmate
- Co-worker
- Institutional staff
- Neighbor
- Rival gang member
- Stranger
- Law enforcement
- Other, specify:
- U/K

i. Sex of fatal firearm owner:
- Male
- Female
- U/K

j. Type of sharp object:
- Kitchen knife
- Switchblade
- Pocketknife
- Razor
- Hunting knife
- Scissors
- Other, specify:
- U/K

k. Type of blunt object:
- Bat
- Club
- Stick
- Hammer
- Rock
- Household item
- Other, specify:
- U/K

l. What did person's body part do? Check all that apply:
- Beat, kick or punch
- Drop
- Push
- Bite
- Shake
- Strangle
- Throw
- Drown
- Burn
- Other, specify:
- U/K

m. Did person using weapon have history of weapon-related offenses?
- Yes
- No
- U/K

n. Does anyone in child's family have a history of weapon offenses or die of weapons-related causes?
- Yes, describe circumstances:
- No
- U/K

o. Persons handling weapons at time of incident, check all that apply:

Fatal and/or Other weapon		Fatal and/or Other weapon	
☐	☐ Self	☐	☐ Friend
☐	☐ Biological parent	☐	☐ Acquaintance
☐	☐ Adoptive parent	☐	☐ Child's boyfriend or girlfriend
☐	☐ Stepparent	☐	☐ Classmate
☐	☐ Foster parent	☐	☐ Co-worker
☐	☐ Mother's partner	☐	☐ Institutional staff
☐	☐ Father's partner	☐	☐ Neighbor
☐	☐ Grandparent	☐	☐ Rival gang member
☐	☐ Sibling	☐	☐ Stranger
☐	☐ Spouse	☐	☐ Law enforcement officer
☐	☐ Other relative	☐	☐ Other, specify:
		☐	☐ U/K

p. Sex of person(s) handling weapon:

Fatal weapon:
- Male
- Female
- U/K

Other weapon:
- Male
- Female
- U/K

g. Use of weapon at time, check all that apply:

- ☐ Self injury
- ☐ Commission of crime
- ☐ Drive-by shooting
- ☐ Random violence
- ☐ Child was a bystander
- ☐ Argument
- ☐ Jealousy
- ☐ Intimate partner violence
- ☐ Hate crime
- ☐ Bullying
- ☐ Hunting
- ☐ Target shooting
- ☐ Playing with weapon
- ☐ Weapon mistaken for toy
- ☐ Showing gun to others
- ☐ Russian roulette
- ☐ Gang-related activity
- ☐ Self-defense
- ☐ Cleaning weapon
- ☐ Loading weapon
- ☐ Intervener assisting crime victim (Good Samaritan)
- ☐ Other, specify:
- ☐ U/K

6. ANIMAL BITE OR ATTACK

a. Type of animal:

- ○ Domesticated dog
- ○ Domesticated cat
- ○ Snake
- ○ Wild mammal, specify:
- ○ Insect
- ○ Other, specify:
- ○ U/K

b. Animal access to child, check all that apply:

- ☐ Animal on leash
- ☐ Animal caged or inside fence
  - ○ Child reached in
  - ○ Child entered animal area
  - ○ U/K
- ☐ Animal escaped from cage or leash
- ☐ Animal not caged or leashed
- ☐ U/K

c. Did child provoke animal?

○ Yes ○ No ○ U/K

If yes, how?

d. Animal has history of biting or attacking?

○ Yes ○ No ○ U/K

7. FALL OR CRUSH

a. Type:

- ☐ Fall, go to b
- ○ Crush, go to h

b. Height of fall:

_____ feet

_____ inches

☐ U/K

c. Child fell from:

○ Open window

Screen?
- ○ Screen
- ○ No screen
- ○ U/K if screen

- ○ Natural elevation
- ○ Man-made elevation
- ○ Playground equipment
- ○ Tree
- ○ Stairs/steps
- ○ Furniture
- ○ Bed
- ○ Roof
- ○ Moving object, specify:
- ○ Bridge
- ○ Overpass
- ○ Balcony
- ○ Animal, specify:
- ○ Other, specify:
- ○ U/K

d. Surface child fell onto:

- ○ Cement/concrete
- ○ Grass
- ○ Gravel
- ○ Wood floor
- ○ Carpeted floor
- ○ Linoleum/vinyl
- ○ Marble/tile
- ○ Other, specify:
- ○ U/K

e. Barrier in place:

Check all that apply:

- ☐ None
- ☐ Screen
- ☐ Other window guard
- ☐ Fence
- ☐ Railing
- ☐ Stairway
- ☐ Gate
- ☐ Other, specify:
- ☐ U/K

f. Child in a baby walker?

- ○ N/A
- ○ Yes
- ○ No
- ○ U/K

g. Was child pushed, dropped or thrown?

○ Yes ○ No ○ U/K

If yes, go to GSq

h. For crush, did child:

- ○ Climb up on object
- ○ Pull object down
- ○ Hide behind object
- ○ Go behind object
- ○ Fall out of object
- ○ Other, specify:
- ○ U/K

i. For crush, object causing crush:

- ○ Appliance
- ○ Television
- ○ Furniture
- ○ Walls
- ○ Playground equipment
- ○ Animal
- ○ Tree branch
- ○ Boulders/rocks
- ○ Dirt/sand
- ○ Person, go to GSq
- ○ Commercial equipment
- ○ Farm equipment
- ○ Other, specify:
- ○ U/K

8. POISONING, OVERDOSE OR ACUTE INTOXICATION

a. Type of substance involved, check all that apply:

☐ U/K

Prescription drug
- ☐ Antidepressant
- ☐ Blood pressure medication
- ☐ Pain killer (opiate)
- ☐ Pain killer (non-opiate)
- ☐ Methadone
- ☐ Cardiac medication
- ☐ Other, specify:

Over-the-counter drug
- ☐ Diet pills
- ☐ Stimulants
- ☐ Cough medicine
- ☐ Pain medication
- ☐ Children's vitamins
- ☐ Iron supplement
- ☐ Other vitamins
- ☐ Other, specify:
- ☐ Cosmetics/personal care products

Cleaning substances
- ☐ Bleach
- ☐ Drain cleaner
- ☐ Alkaline-based cleaner
- ☐ Solvent
- ☐ Other, specify:

Other substances
- ☐ Plants
- ☐ Alcohol
- ☐ Street drugs
- ☐ Pesticide
- ☐ Antifreeze
- ☐ Other chemical
- ☐ Herbal remedy
- ☐ Carbon monoxide, go to f
- ☐ Other fume/gas/vapor
- ☐ Other, specify:

b. Where was the substance stored?

- ○ Open area
- ○ Open cabinet
- ○ Closed cabinet, unlocked
- ○ Closed cabinet, locked
- ○ Other, specify:
- ☐ U/K

c. Was the product in its original container?

○ N/A ○ No
○ Yes ○ U/K

d. Did container have a child safety cap?

○ N/A ○ No
○ Yes ○ U/K

e. If prescription, was it child's?

○ Yes ○ No ○ U/K

f. Was the incident the result of?

- ○ Accidental overdose
- ○ Medical treatment mishap
- ○ Adverse effect, but not overdose
- ○ Deliberate poisoning
- ○ Acute intoxication
- ○ Other, specify:
- ○ U/K

g. Was Poison Control called?

○ Yes ○ No ○ U/K

If yes, who called:

- ○ Child
- ○ Parent
- ○ Other caregiver
- ○ First responder
- ○ Medical person
- ○ Other, specify:
- ○ U/K

h. For CO poisoning, was a CO detector present?

○ Yes ○ No ○ U/K

If yes, how many?

_____

Functioning properly?

○ Yes ○ No ○ U/K

9. EXPOSURE

a. Circumstances, check all that apply:
- ☐ Abandonment
- ☐ Left in car
- ☐ Left in room
- ☐ Submerged in water
- ☐ Injured outdoors
- ☐ Lost outdoors
- ☐ Illegal border crossing
- ☐ Other, specify:
- ☐ U/K

b. Condition of exposure:
- ○ Hyperthermia
- ○ Hypothermia
- ○ U/K

_____ Ambient temp, degrees F

c. Number of hours exposed:

_____

☐ U/K

d. Was child wearing appropriate clothing?
- ○ Yes
- ○ No
- ○ U/K

10. MEDICAL CONDITION

a. How long did the child have the medical condition?
- ○ In utero
- ○ Since birth
- ○ Hours
- ○ Days
- ○ Weeks
- ○ Months
- ○ Years
- ○ U/K

b. Was death expected as a result of the medical condition?
- ○ N/A not previously diagnosed
- ○ Yes ☐ But at a later date
- ○ No
- ○ U/K

c. Was child receiving health care for the medical condition?
- ○ Yes ○ No ○ U/K

If yes, within 48 hours of the death?
- ○ Yes ○ No ○ U/K

d. Were the prescribed care plans appropriate for the medical condition?
- ○ N/A
- ○ Yes
- ○ No, specify:
- ○ U/K

e. Was child/family compliant with the prescribed care plans?
- ○ N/A
- ○ Yes
- ○ No
- ○ U/K

If no, what wasn't compliant? Check all that apply.
- ☐ Appointments
- ☐ Medications, specify:
- ☐ Medical equipment use, specify:
- ☐ Therapies, specify:
- ☐ Other, specify:
- ☐ U/K

f. Was child up to date with American Academy of Pediatrics immunization schedule?
- ○ N/A
- ○ Yes
- ○ No, specify:
- ○ U/K

g. Was the medical condition associated with an outbreak?
- ○ Yes, specify:
- ○ No
- ○ U/K

h. Was environmental tobacco exposure a contributing factor in death?
- ○ Yes
- ○ No
- ○ U/K

i. Were there access or compliance issues related to the death? ○ Yes ○ No ○ U/K If yes, check all that apply:
- ☐ Lack of money for care
- ☐ Limitations of health insurance coverage
- ☐ Multiple health insurance, not coordinated
- ☐ Lack of transportation
- ☐ No phone
- ☐ Cultural differences
- ☐ Religious objections to care
- ☐ Language barriers
- ☐ Referrals not made
- ☐ Specialist needed, not available
- ☐ Multiple providers, not coordinated
- ☐ Lack of child care
- ☐ Lack of family or social support
- ☐ Services not available
- ☐ Caregiver distrust of health care system
- ☐ Caregiver unskilled in providing care
- ☐ Caregiver unwilling to provide care
- ☐ Caregiver's partner would not allow care
- ☐ Other, specify:
- ☐ U/K

11. OTHER KNOWN INJURY CAUSE

Specify cause, describe in detail:

H. OTHER CIRCUMSTANCES OF INCIDENT - ANSWER RELEVANT SECTIONS

1. SUDDEN AND UNEXPECTED DEATH IN THE YOUNG

a. Was this death a homicide, suicide, overdose, injury with the external cause as the only and obvious cause of death or a death which was expected within 6 months due to terminal illness? ○ Yes ○ No ○ U/K If yes, go to Section H2

b. Did the child have a history of any of the following acute conditions or symptoms within 72 hours prior to death?

☐ U/K for all

Symptom	Present w/in 72 hours of death: Yes	No	U/K
Cardiac			
Chest pain	○	○	○
Dizziness/lightheadedness	○	○	○
Fainting	○	○	○
Palpitations	○	○	○
Neurologic			
Concussion	○	○	○
Confusion	○	○	○
Convulsions/seizure	○	○	○
Headache	○	○	○
Head injury	○	○	○
Psychiatric symptoms	○	○	○
Paralysis (acute)	○	○	○
Respiratory			
Asthma	○	○	○
Pneumonia	○	○	○
Difficulty breathing	○	○	○

Symptom	Present w/in 72 hours of death: Yes	No	U/K
Other Acute Symptoms			
Fever	○	○	○
Heat exhaustion/heat stroke	○	○	○
Muscle aches/cramping	○	○	○
Slurred speech	○	○	○
Vomiting	○	○	○
Other, specify:	○		

c. At any time more than 72 hours preceding death did the child have a personal history of any of the following chronic conditions or symptoms? ☐ U/K for all

Symptom	Present more than 72 hours of death: Yes	No	U/K
Cardiac			
Chest pain	○	○	○
Dizziness/lightheadedness	○	○	○
Fainting	○	○	○
Palpitations	○	○	○
Neurologic			
Concussion	○	○	○
Confusion	○	○	○
Convulsions/seizure	○	○	○
Headache	○	○	○
Head injury	○	○	○
Respiratory			
Difficulty breathing	○	○	○
Other			
Slurred speech	○	○	○
Other, specify:	○		

d. Did the child have any prior serious injuries (e.g. near drowning, car accident, brain injury)?

○ Yes ○ No ○ U/K If yes, describe:

e. Had the child ever been diagnosed by a medical professional for the following? ☐ U/K for all

Condition	Diagnosed Yes	No	U/K
Blood disease			
Sickle cell disease	○	○	○
Sickle cell trait	○	○	○
Thrombophilia (clotting disorder)	○	○	○
Cardiac			
Abnormal electrocardiogram (EKG or ECG)	○	○	○
Aneurysm or aortic dilatation	○	○	○
Arrhythmia/arrhythmia syndrome	○	○	○
Cardiomyopathy	○	○	○
Commotio cordis	○	○	○
Congenital heart disease	○	○	○
Coronary artery abnormality	○	○	○
Coronary artery disease (atherosclerosis)	○	○	○
Endocarditis	○	○	○
Heart failure	○	○	○
Heart murmur	○	○	○
High cholesterol	○	○	○
Hypertension	○	○	○
Myocarditis (heart infection)	○	○	○
Pulmonary hypertension	○	○	○
Sudden cardiac arrest	○	○	○
Neurologic			
Anoxic brain injury	○	○	○
Traumatic brain injury/ head injury/concussion	○	○	○
Brain tumor	○	○	○
Brain aneurysm	○	○	○
Brain hemorrhage	○	○	○
Developmental brain disorder	○	○	○

Condition	Diagnosed Yes	No	U/K
Neurologic (cont)			
Epilepsy/seizure disorder	○	○	○
Febrile seizure	○	○	○
Mesial temporal sclerosis	○	○	○
Neurodegenerative disease	○	○	○
Stroke/mini stroke/ TIA-Transient Ischemic Attack	○	○	○
Central nervous system infection (meningitis or encephalitis)	○	○	○
Respiratory			
Apnea	○	○	○
Asthma	○	○	○
Pulmonary embolism	○	○	○
Pulmonary hemorrhage	○	○	○
Respiratory arrest	○	○	○
Other			
Connective tissue disease	○	○	○
Diabetes	○	○	○
Endocrine disorder, other: thyroid, adrenal, pituitary	○	○	○
Hearing problems or deafness	○	○	○
Kidney disease	○	○	○
Mental illness/psychiatric disease	○	○	○
Metabolic disease	○	○	○
Muscle disorder or muscular dystrophy	○	○	○
Oncologic disease treated by chemotherapy or radiation	○	○	○
Prematurity	○	○	○
Congenital disorder/ genetic syndrome	○	○	○
Other, specify:	○		

If a more specific diagnosis is known, provide any additional information:

If any cardiac conditions above are selected, what cardiac treatments did the child have? Check all that apply: ☐ None

☐ Cardiac ablation
☐ Cardiac device placement (implanted cardioverter defibrillator (ICD) or pacemaker or Ventricular Assist Device (VAD))
☐ Heart surgery
☐ Interventional cardiac catheterization
☐ Heart transplant
☐ Other, specify:
☐ U/K

f. Did the child have any blood relatives (brothers, sisters, parents, aunts, uncles, cousins, grandparents or other more distant relatives) with the following diseases, conditions or symptoms? ☐ U/K for all

Y	N	U/K	Deaths
○	○	○	Sudden unexpected death before age 50
			Heart Disease
○	○	○	Heart condition/heart attack or stroke before age 50
○	○	○	Aortic aneurysm or aortic rupture
○	○	○	Arrhythmia (fast or irregular heart rhythm)
○	○	○	Cardiomyopathy
○	○	○	Congenital heart disease
			Neurologic Disease
○	○	○	Epilepsy or convulsions/seizure
○	○	○	Other neurologic disease

Y	N	U/K	Symptoms
○	○	○	Febrile seizures
○	○	○	Unexplained fainting
			Other Diagnoses
○	○	○	Congenital deafness
○	○	○	Connective tissue disease
○	○	○	Mitochondrial disease
○	○	○	Muscle disorder or muscular dystrophy
○	○	○	Thrombophilia (clotting disorder)
○			Other diseases that are genetic or run in families, specify:

If sudden unexpected death before age 50, describe (for example, SIDS, drowning, relative who died in single and/or unexplained motor vehicle accident (driver of car)):

g. Has any blood relative (siblings, parents, aunts, uncles, cousins, grandparents) had genetic testing?

○ Yes ○ No ○ U/K

If yes, describe what test and/or for what disease and results:

Was a gene mutation found?

○ Yes ○ No ○ U/K

h. In the 72 hours prior to death was the child taking any prescribed medication(s)?
○ Yes ○ No ○ U/K
If yes, describe:

i. Within 2 weeks prior to death had the child:

	N/A	Yes	No	U/K
Taken extra doses of prescribed medications	○	○	○	○
Missed doses of prescribed medications	○	○	○	○
Changed prescribed medications, describe:	○	○	○	○

j. Was the child compliant with their prescribed medications?
○ N/A ○ Yes ○ No ○ U/K
If not compliant, describe why and how often:

k. Was the child taking any of the following substance(s) within 24 hours of death?
Check all that apply:
- ☐ Over the counter medicine
- ☐ Recent/short term prescriptions
- ☐ Energy drinks
- ☐ Caffeine
- ☐ Performance enhancers
- ☐ Diet assisting medications
- ☐ Supplements
- ☐ Tobacco
- ☐ Alcohol
- ☐ Illegal drugs
- ☐ Legalized marijuana
- ☐ Other, specify:
- ☐ U/K

If yes to any items above, describe:

l. Did the child experience any of the following stimuli at time of incident or within 24 hours of the incident? ☐ U/K for all at time of incident ☐ U/K for all within 24 hours of incident

Stimuli	At Incident Yes	At Incident No	At Incident U/K	Within 24 hrs of Incident Yes	Within 24 hrs of Incident No	Within 24 hrs of Incident U/K
Physical activity	○	○	○	○	○	○
Sleep deprivation	○	○	○	○	○	○
Driving	○	○	○	○	○	○
Visual stimuli	○	○	○	○	○	○
Video game stimuli	○	○	○	○	○	○
Emotional stimuli	○	○	○	○	○	○
Auditory stimuli/startle	○	○	○	○	○	○
Physical trauma	○	○	○	○	○	○
Other	○			○		

If yes to physical activity, describe type of activity:
At incident / Within 24 hours of incident

Other specify:
At incident / Within 24 hours of incident

m. Was the child an athlete? ○ N/A ○ Yes ○ No ○ U/K
If yes, type of sport: ○ Competitive ○ Recreational ○ Unknown
If competitive, did the child participate in the 6 months prior to death? ○ Yes ○ No ○ U/K

n. Did the child ever have any of the following **uncharacteristic** symptoms during or within 24 hours after physical activity? Check all that apply:
- ☐ Chest pain
- ☐ Confusion
- ☐ Convulsions/seizure
- ☐ Dizziness/lightheadedness
- ☐ Fainting
- ☐ Headache
- ☐ Palpitations
- ☐ Shortness of breath/difficulty breathing
- ☐ Other, specify:
- ☐ U/K

If yes to any item, describe type of physical activity and extent of symptoms:

o. If child age 12 or older, did the child receive a pre-participation exam for a sport?
○ N/A ○ Yes ○ No ○ U/K
If yes:
Was it done within a year prior to death? ○ Yes ○ No ○ U/K
Did the exam lead to restrictions for sports or otherwise? ○ Yes ○ No ○ U/K
If yes, specify restrictions:

Questions p through v: Answer if "Epilepsy/Seizure Disorder" is answered Yes in question e above (Diagnosed for a medical condition)

p. How old was the child when diagnosed with epilepsy/seizure disorder?
Age 0 (infant) through 20 years: _____
☐ U/K

q. What were the underlying cause(s) of the child's seizures? Check all that apply:
- ☐ Brain injury/trauma, specify:
- ☐ Brain tumor
- ☐ Cerebrovascular
- ☐ Central nervous system infection
- ☐ Degenerative process
- ☐ Developmental brain disorder
- ☐ Inborn error of metabolism
- ☐ Genetic/chromosomal
- ☐ Mesial temporal sclerosis
- ☐ Idiopathic or cryptogenic
- ☐ Other acute illness or injury other than epilepsy
- ☐ Other, specify:
- ☐ U/K

r. What type(s) of seizures did the child have? Check all that apply:
- ☐ Non-convulsive
- ☐ Convulsive (grand mal seizure or generalized tonic-clonic seizure)
- ☐ Occur when exposed to strobe lights, video game, or flickering light (reflex seizure)
- ☐ U/K

s. Describe the child's epilepsy/seizures. Check all that apply:
- ☐ Last less than 30 minutes
- ☐ Last more than 30 minutes (status epilepticus)
- ☐ Occur in the presence of fever (febrile seizure)
- ☐ Occur in the absence of fever
- ☐ Occur when exposed to strobe lights, video game, or flickering light (reflex seizure)

t. How many seizures did the child have in the year preceding death?
○ 0/never ○ 1 ○ 2 ○ 3 ○ More than 3 ○ U/K

u. Did treatment for seizures include anti-epileptic drugs?
○ Yes ○ No ○ U/K
If yes, how many different types of anti-epilepsy drugs (AED) did the child take?
○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ More than 6 ○ U/K

v. Was night surveillance used?
○ Yes ○ No ○ U/K

2. ANSWER THIS ONLY IF CHILD IS UNDER AGE FIVE: WAS DEATH RELATED TO SLEEPING OR THE SLEEP ENVIRONMENT? ○ Yes, go to H2a ○ No, go to H2s ○ U/K, go to H2s

a. Incident sleep place:
- ○ Crib
  - If crib, type:
    - ○ Not portable
    - ○ Portable, e.g. pack-n-play
    - ○ Unknown crib type
- ○ Bassinette
- ○ Adult bed
- ○ Waterbed
- ○ Futon
- ○ Playpen/other play structure but not portable crib
- ○ Couch
- ○ Chair
- ○ Floor
- ○ Car seat
- ○ Stroller
- ○ Other, specify:
- ○ U/K

If adult bed, what type?
○ Twin ○ Full ○ Queen ○ King ○ Other, specify: ○ U/K

If futon,
○ Bed position ○ Couch position ○ U/K

b. Child put to sleep:
- On back
- On stomach
- On side
- U/K

c. Child found:
- On back
- On stomach
- On side
- U/K

e. Usual sleep position:
- On back
- On stomach
- On side
- U/K

f. Was there a crib, bassinette or port-a-crib in home for child?
- Yes
- No
- U/K

d. Usual sleep place:
- Crib
  - If crib, type:
    - Not portable
    - Portable, e.g. pack-n-play
    - Unknown crib type
- Bassinette
- Adult bed
- Waterbed
- Futon
- Playpen/other play structure but not portable crib
- Couch
- Chair
- Floor
- Car seat
- Stroller
- Other, specify:
- U/K

If adult bed, what type?
- Twin
- Full
- Queen
- King
- Other, specify:
- U/K

If futon,
- Bed position
- Couch position
- U/K

g. Child in a new or different environment than usual?
- Yes
- No
- U/K

If yes, specify:

h. Child last placed to sleep with a pacifier?
- Yes
- No
- U/K

i. Child wrapped or swaddled in blanket?
- Yes
- No
- U/K

If yes, describe:

j. Child overheated?
- Yes
- No
- U/K

If yes, outside temp ____ degrees F

Check all that apply:
- Room too hot, temp ____ degrees F
- Too much bedding
- Too much clothing

k. Child exposed to second hand smoke?
- Yes
- No
- U/K

If yes, how often:
- Frequently
- Occasionally
- U/K

l. Child's face when found:
- Down
- Up
- To left or right side
- U/K

m. Child's neck when found:
- Hyperextended (head back)
- Hypoextended (chin to chest)
- Neutral
- Turned
- U/K

n. Child's airway:
- Unobstructed by person or object
- Fully obstructed by person or object
- Partially obstructed by person or object
- U/K

If fully or partially obstructed, what was obstructed?
- Nose
- Mouth
- Chest compressed
- U/K

o. Objects in child's sleep environment in relation to airway obstruction:

Objects:	Present? Yes	No	U/K	If present, describe position of object: On top of child	Under child	Next to child	Tangled around child	U/K	If present, did object obstruct airway? Yes	No	U/K
Adult(s)	○	○	○	☐	☐	☐	☐	☐	○	○	○
Other child(ren)	○	○	○	☐	☐	☐	☐	☐	○	○	○
Animal(s)	○	○	○	☐	☐	☐	☐	☐	○	○	○
Mattress	○	○	○	☐	☐	☐	☐	☐	○	○	○
Comforter, quilt, or other	○	○	○	☐	☐	☐	☐	☐	○	○	○
Thin blanket/flat sheet	○	○	○	☐	☐	☐	☐	☐	○	○	○
Pillow(s)	○	○	○	☐	☐	☐	☐	☐	○	○	○
Cushion	○	○	○	☐	☐	☐	☐	☐	○	○	○
Boppy or U shaped pillow	○	○	○	☐	☐	☐	☐	☐	○	○	○
Sleep positioner (wedge)	○	○	○	☐	☐	☐	☐	☐	○	○	○
Bumper pads	○	○	○	☐	☐	☐	☐	☐	○	○	○
Clothing	○	○	○	☐	☐	☐	☐	☐	○	○	○
Crib railing/side	○	○	○	☐	☐	☐	☐	☐	○	○	○
Wall	○	○	○	☐	☐	☐	☐	☐	○	○	○
Toy(s)	○	○	○	☐	☐	☐	☐	☐	○	○	○
Other(s), specify:											
_____	○			☐	☐	☐	☐	☐	○	○	○
_____	○			☐	☐	☐	☐	☐	○	○	○

p. Caregiver/supervisor fell asleep while feeding child?
- Yes
- No
- U/K

If yes, type of feeding:
- Bottle
- Breast
- U/K

q. Child sleeping in the same room as caregiver/supervisor at time of death?
- Yes
- No
- U/K

r. Child sleeping on same surface with person(s) or animal(s)?
- Yes
- No
- U/K

If yes, check all that apply:
- ☐ With adult(s):
  - #_____ #U/K
  - Adult obese: ○ Yes ○ U/K ○ No
- ☐ With other children:
  - #_____ #U/K
  - Children's ages: _____
- ☐ With animal(s):
  - #_____ #U/K
  - Type(s) of animal: _____
- ☐ U/K

s. Is there a scene re-creation photo available for upload? ○ Yes ○ No If yes, upload here. Only one photo allowed.

Select photo that most describes child placement and relevant objects. Size must be less than 6 mb and in .jpg or .gif format.

3. WAS DEATH A CONSEQUENCE OF A PROBLEM WITH A CONSUMER PRODUCT? ○ Yes ○ No, go to H4 ○ U/K, go to H4

a. Describe product and circumstances:

b. Was product used properly?
- Yes
- No
- U/K

c. Is a recall in place?
- Yes
- No
- U/K

d. Did product have safety label?
- Yes
- No
- U/K

e. Was Consumer Product Safety Commission (CPSC) notified?
- Yes
- U/K
- No, go to www.saferproducts.gov to report

4. DID DEATH OCCUR DURING COMMISSION OF ANOTHER CRIME? ○ Yes ○ No ○ U/K

a. Type of crime, check all that apply:

☐ Robbery/burglary ☐ Other assault ☐ Arson ☐ Illegal border crossing ☐ U/K
☐ Interpersonal violence ☐ Gang conflict ☐ Prostitution ☐ Auto theft
☐ Sexual assault ☐ Drug trade ☐ Witness intimidation ☐ Other, specify:

I. ACTS OF OMISSION OR COMMISSION INCLUDING POOR SUPERVISION, CHILD ABUSE & NEGLECT, ASSAULTS, AND SUICIDE

TYPE OF ACT

1. Did any act(s) of omission or commission cause and/or contribute to the death?
○ Yes
○ No, go to Section J
○ Probable
○ U/K, go to Section J

If yes/probable, were the act(s) either or both? Check all that apply:
☐ The direct cause of death
☐ The contributing cause of death

2. What act(s) caused or contributed to the death? Check only one per column and describe in narrative.

Caused	Contributed	
○	○	Poor/absent supervision, go to 10
○	○	Child abuse, go to 3
○	○	Child neglect, go to 8
○	○	Other negligence, go to 9
○	○	Assault, not child abuse, go to 10
○	○	Religious/cultural practices, go to 10
○	○	Suicide, go to 27
○	○	Medical misadventure, specify and go to 11
○	○	Other, specify and go to 10
○	○	U/K, go to 10

3. Child abuse, type. Check all that apply and describe in narrative.
☐ Physical, go to 4
☐ Emotional, specify and go to 10
☐ Sexual, specify and go to 10
☐ U/K, go to 10

4. Type of physical abuse, check all that apply:
☐ Abusive head trauma, go to 5
☐ Chronic Battered Child Syndrome, go to 7
☐ Beating/kicking, go to 7
☐ Scalding or burning, go to 7
☐ Munchausen Syndrome by Proxy, go to 7
☐ Other, specify and go to 7
☐ U/K, go to 7

5. For abusive head trauma, were there retinal hemorrhages?
○ Yes ○ No ○ U/K

6. For abusive head trauma, was the child shaken?
○ Yes ○ No ○ U/K
If yes, was there impact?
○ Yes ○ No ○ U/K

7. Events(s) triggering physical abuse, check all that apply:
☐ None
☐ Crying
☐ Toilet training
☐ Disobedience
☐ Feeding problems
☐ Domestic argument
☐ Other, specify:
☐ U/K

8. Child neglect, check all that apply:
☐ Failure to protect from hazards, specify:
☐ Failure to provide necessities
☐ Food
☐ Shelter
☐ Other, specify:
☐ Failure to seek/follow treatment, specify:
☐ Emotional neglect, specify:
☐ Abandonment, specify:
☐ U/K

9. Other negligence:
○ Vehicular
○ Other, specify:
○ U/K

10. Was act(s) of omission/commission:

Caused	Contributed	
○	○	Chronic with child
○	○	Pattern in family or with perpetrator
○	○	Isolated incident
○	○	U/K

PERSON(S) RESPONSIBLE

11. Is person the caregiver or supervisor in previous section?

Caused	Contributed	
○	○	Yes, caregiver one, go to 24
○	○	Yes, caregiver two, go to 24
○	○	Yes, supervisor, go to 25
○	○	No

12. Primary person responsible for action(s) that caused and/or contributed to death: Select no more than one person for caused and one person for contributed.

Caused	Contributed		Caused	Contributed		Caused	Contributed	
○	○	Self, go to 24	○	○	Grandparent	○	○	Medical provider
○	○	Biological parent	○	○	Sibling	○	○	Institutional staff
○	○	Adoptive parent	○	○	Other relative	○	○	Babysitter
○	○	Stepparent	○	○	Friend	○	○	Licensed child care worker
○	○	Foster parent	○	○	Acquaintance			
○	○	Mother's partner	○	○	Child's boyfriend or girlfriend	○	○	Other, specify:
○	○	Father's partner	○	○	Stranger	○	○	U/K

13. Person's age in years:

Caused	Contributed	
____	____	# Years
☐	☐	U/K

14. Person's sex:

Caused	Contributed	
○	○	Male
○	○	Female
○	○	U/K

15. Does person speak English?

Caused	Contributed	
○	○	Yes
○	○	No
○	○	U/K

If no, language spoken:

16. Person on active military duty?

Caused	Contributed	
○	○	Yes
○	○	No
○	○	U/K

If yes, specify branch:

17. Person have history of substance abuse?

Caused / Contributed
- Yes
- No
- U/K

If yes, check all that apply:
- Alcohol
- Cocaine
- Marijuana
- Methamphetamine
- Opiates
- Prescription drugs
- Over-the-counter
- Other, specify:
- U/K

18. Person have history of child maltreatment as victim?

Caused / Contributed
- Yes
- No
- U/K

If yes, check all that apply:
- Physical
- Neglect
- Sexual
- Emotional/ psychological
- U/K
- ____ ____ # CPS referrals
- ____ ____ # Substantiations
- Ever in foster care or adopted

19. Person have history of child maltreatment as a perpetrator?

Caused / Contributed
- Yes
- No
- U/K

If yes, check all that apply:
- Physical
- Neglect
- Sexual
- Emotional/psychological
- U/K
- ____ ____ # CPS referrals
- ____ ____ # Substantiations
- CPS prevention services
- Family preservation services
- Children ever removed

20. Person have disability or chronic illness?

Caused / Contributed
- Yes
- No
- U/K

If yes, check all that apply:
- Physical, specify:
- Mental, specify:
- Sensory, specify:
- U/K

If mental illness, was person receiving MH services?
- Yes
- No
- U/K

21. Person have prior child deaths?

Caused / Contributed
- Yes
- No
- U/K

If yes, check all that apply:

Caused / Contributed
- Child abuse #_____
- Child neglect #_____
- Accident #_____
- Suicide #_____
- SIDS #_____
- Other #_____

Other, specify:
- U/K

22. Person have history of intimate partner violence?

Caused / Contributed
- Yes, as victim
- Yes, as perpetrator
- No
- U/K

23. Person have delinquent/criminal history?

Caused / Contributed
- Yes
- No
- U/K

If yes, check all that apply:
- Assaults
- Robbery
- Drugs
- Other, specify:
- U/K

24. At time of incident was person impaired?

Caused: Yes No U/K — Contributed: Yes No U/K

If yes, check all that apply:

Caused / Contributed
- Drug impaired
- Alcohol impaired
- Asleep
- Distracted
- Absent
- Impaired by illness, specify:
- Impaired by disability, specify:
- Other, specify:

25. Does person have, check all that apply:

Caused / Contributed
- Prior history of similar acts
- Prior arrests
- Prior convictions

26. Legal outcomes in this death, check all that apply:

Caused / Contributed
- No charges filed
- Charges pending
- Charges filed, specify:
- Charges dismissed
- Confession
- Plead, specify:
- Not guilty verdict
- Guilty verdict, specify:
- Tort charges, specify:
- U/K

FOR SUICIDE

27. For suicide, select yes, no or u/k for each question. Describe answers in narrative.

Yes	No	U/K		Yes	No	U/K	
○	○	○	A note was left	○	○	○	Child had a history of self mutilation
○	○	○	Child talked about suicide	○	○	○	There is a family history of suicide
○	○	○	Prior suicide threats were made	○	○	○	Suicide was part of a murder-suicide
○	○	○	Prior attempts were made	○	○	○	Suicide was part of a suicide pact
○	○	○	Suicide was completely unexpected	○	○	○	Suicide was part of a suicide cluster
○	○	○	Child had a history of running away				

28. For suicide, was there a history of acute or cumulative personal crises that may have contributed to the child's despondency? Check all that apply:
- None known
- Family discord
- Parents' divorce/separation
- Argument with parents/caregivers
- Argument with boyfriend/girlfriend
- Breakup with boyfriend/girlfriend
- Argument with other friends
- Rumor mongering
- Suicide by friend or relative
- Other death of friend or relative
- Bullying as victim
- Bullying as perpetrator
- School failure
- Move/new school
- Other serious school problems
- Pregnancy
- Physical abuse/assault
- Rape/sexual abuse
- Problems with the law
- Drugs/alcohol
- Sexual orientation
- Religious/cultural issues
- Job problems
- Money problems
- Gambling problems
- Involvement in cult activities
- Involvement in computer or video games
- Involvement with the Internet, specify:
- Other, specify:
- U/K

J. SERVICES TO FAMILY AND COMMUNITY AS A RESULT OF DEATH

1. Services: Select one option per row:	Provided after death	Offered but refused	Offered but UIK if used	Should be offered	Needed but not available	UIK	CDR review led to referral
Bereavement counseling	○	○	○	○	○	○	□
Debriefing for professionals	○	○	○	○	○	○	□
Economic support	○	○	○	○	○	○	□
Funeral arrangements	○	○	○	○	○	○	□
Emergency shelter	○	○	○	○	○	○	□
Mental health services	○	○	○	○	○	○	□
Foster care	○	○	○	○	○	○	□
Health services	○	○	○	○	○	○	□
Legal services	○	○	○	○	○	○	□
Genetic counseling	○	○	○	○	○	○	□
Other, specify:	○	○	○	○	○	○	□

K. PREVENTION INITIATIVES RESULTING FROM THE REVIEW

○ Mark this case to edit/add prevention actions at a later date

1. Could the death have been prevented? ○ Yes, probably ○ No, probably not ○ Team could not determine

2. What specific recommendations and/or initiatives resulted from the review? Check all that apply: ○ No recommendations made, go to Section L

		Current Action Stage			Type of Action		Level of Action		
		Recommendation	Planning	Implementation	Short term	Long term	Local	State	National
Education	Media campaign	○	○	○	□	□	□	□	□
	School program	○	○	○	□	□	□	□	□
	Community safety project	○	○	○	□	□	□	□	□
	Provider education	○	○	○	□	□	□	□	□
	Parent education	○	○	○	□	□	□	□	□
	Public forum	○	○	○	□	□	□	□	□
	Other education	○	○	○	□	□	□	□	□
Agency	New policy(ies)	○	○	○	□	□	□	□	□
	Revised policy(ies)	○	○	○	□	□	□	□	□
	New program	○	○	○	□	□	□	□	□
	New services	○	○	○	□	□	□	□	□
	Expanded services	○	○	○	□	□	□	□	□
Law	New law/ordinance	○	○	○	□	□	□	□	□
	Amended law/ordinance	○	○	○	□	□	□	□	□
	Enforcement of law/ordinance	○	○	○	□	□	□	□	□
Environment	Modify a consumer product	○	○	○	□	□	□	□	□
	Recall a consumer product	○	○	○	□	□	□	□	□
	Modify a public space	○	○	○	□	□	□	□	□
	Modify a private space(s)	○	○	○	□	□	□	□	□
	Other, specify:	○	○	○	□	□	□	□	□

Briefly describe the initiatives:

3. Who took responsibility for championing the prevention initiatives? Check all that apply:

- □ N/A, no strategies
- □ No one
- □ Health department
- □ Social services
- □ Mental health
- □ Schools
- □ Hospital
- □ Other health care providers
- □ Law enforcement
- □ Medical examiner
- □ Coroner
- □ Elected official
- □ Advocacy organization
- □ Local community group
- □ New coalition/task force
- □ Youth group
- □ Other, specify:
- □ UIK

L. THE REVIEW MEETING PROCESS

1. Date of first CDR meeting:

2. Number of CDR meetings for this case: _____

3. Is CDR complete? ○ N/A ○ Yes ○ No

4. Agencies at CDR meeting, check all that apply:

- □ Medical examiner/coroner
- □ Law enforcement
- □ Prosecutor/district attorney
- □ Public health
- □ CPS
- □ Other social services
- □ Physician
- □ Hospital
- □ Other health care
- □ Fire
- □ EMS
- □ Education
- □ Mental health
- □ Substance abuse
- □ Court
- □ Child advocate
- □ Military
- □ Others, list:

5. Were the following data sources available at the CDR meeting?

Check all that apply:

- ☐ CDC's SUIDI Reporting Form
- ☐ Jurisdictional equivalent of the CDC SUIDI Reporting Form
- ☐ Birth certificate - full form
- ☐ Death certificate
- ☐ Child's medical records or clinical history, including vaccinations
- ☐ Biological mother's obstetric and prenatal information
- ☐ Newborn screening results
- ☐ Law enforcement records
- ☐ Social service records
- ☐ Child protection agency records
- ☐ EMS run sheet
- ☐ Hospital records
- ☐ Autopsy/pathology reports
- ☐ Mental health records
- ☐ School records
- ☐ Substance abuse treatment records

6. Factors that prevented an effective CDR meeting, check all that apply:

- ☐ Confidentiality issues among members prevented full exchange of information
- ☐ HIPAA regulations prevented access to or exchange of information
- ☐ Inadequate investigation precluded having enough information for review
- ☐ Team members did not bring adequate information to the meeting
- ☐ Necessary team members were absent
- ☐ Meeting was held too soon after death
- ☐ Meeting was held too long after death
- ☐ Records or information were needed from another locality in-state
- ☐ Records or information were needed from another state
- ☐ Team disagreement on circumstances
- ☐ Other factors, specify:

7. CDR meeting outcomes, check all that apply:

- ☐ Review led to additional investigation
- ☐ Team disagreed with official manner of death. What did team believe manner should be?
- ☐ Team disagreed with official cause of death. What did team believe cause should be?
- ☐ Because of the review, the official cause or manner of death was changed
- ☐ Review led to the delivery of services
- ☐ Review led to changes in agency policies or practices
- ☐ Review led to prevention initiatives being implemented ☐ Local ☐ State ☐ National

8. Describe the factor(s) that directly contributed to this death:

9. Which of the factors that directly contributed to this death are modifiable?

10. List any recommendations to prevent deaths from similar causes or circumstances in the future:

11. What additional information would the team like to know about the death scene investigation?

12. What additional information would the team like to know about the autopsy?

M. SUID AND SDY CASE REGISTRY

Section M: OMB No. 0920-1092, Exp. Date: 12/31/2018

Public reporting burden of this collection of information is estimated to average 10 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to: CDC/ATSDR Reports Clearance Officer; 1600 Clifton Road NE, MS D-74, Atlanta, Georgia 30333; ATTN: PRA (0920-1092)

1. Is this an SDY or SUID case? ○ Yes ○ No — If no, go to Section N

2. Did this case go to Advanced Review for the SDY Case Registry? ○ N/A ○ Yes ○ No

If yes, date of first Advanced Review meeting:

3. Notes from Advanced Review meeting, including case details that helped determine SDY categorization and any ways to improve the review:

4. Did the Advanced Review team believe the autopsy was comprehensive? ○ Yes ○ No ○ U/K

5. If autopsy performed, did the ME/coroner/pathologist use the SDY Autopsy Guidance or Summary? ○ N/A ○ Yes ○ No ○ U/K

6. Was a specimen sent to the SDY Case Registry bio-repository? ○ N/A ○ Yes ○ No ○ U/K

7. Did the family consent to have DNA saved as part of the SDY Case Registry? ○ N/A ○ Yes ○ No ○ U/K

If no, why not?
- ○ Consent was not attempted
- ○ Consent was attempted but follow up was unsuccessful
- ○ Consent was attempted but family declined
- ○ Other, specify:

8. Categorization for SDY Case Registry (choose only one):

- ○ Excluded from SDY Case Registry
- ○ Incomplete case information
- ○ Explained cardiac
- ○ Explained neurological
- ○ Explained infant suffocation (under age 1)
- ○ Explained other
- ○ Unexplained, possible cardiac
- ○ Unexplained, possible cardiac and SUDEP
- ○ Unexplained, SUDEP
- ○ Unexplained infant death/SUID (under age 1)
- ○ Unexplained child death (age 1 and over)

9. Categorization for SUID Case Registry (choose only one):

- ○ Excluded (other explained causes, not suffocation)
- ○ Unexplained: No autopsy or death scene investigation
- ○ Unexplained: Incomplete case information
- ○ Unexplained: No unsafe sleep factors
- ○ Unexplained: Unsafe sleep factors
- ○ Unexplained: Possible suffocation with unsafe sleep factors
- ○ Explained: Suffocation with unsafe sleep factors

If possible suffocation or explained suffocation, select the primary mechanism(s) leading to the death, check all that apply:

- ☐ Soft bedding
- ☐ Wedging
- ☐ Overlay
- ☐ Other, specify:

10. Check the box below when a SUID case is complete and ready for inclusion in the SUID data analyses. This box should be checked if a completed case is awaiting SDY Advanced Review or not going to SDY Advanced Review.

SUID Case Registry Data Entry Complete ☐

N. NARRATIVE

Use this space to provide more detail on the circumstances of the death and to describe any other relevant information.
DO NOT INCLUDE IDENTIFIERS IN THE NARRATIVE such as names, addresses, and specific service providers. Consider the following questions: What was the child doing? Where did it happen? How did it happen? What went wrong? What was the quality of supervision? What was the injury cause of death?

O. FORM COMPLETED BY:

PERSON:	EMAIL:
TITLE:	DATE COMPLETED:
AGENCY:	DATA ENTRY COMPLETED FOR THIS CASE? ☐
PHONE:	For State Program Use Only: DATA QUALITY ASSURANCE COMPLETED BY STATE ☐

NATIONAL CFRP
Center for Fatality Review & Prevention

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from the Maternal and Child Health Bureau (Title V, Social Security Act),
Health Resources and Services Administration, Department of Health and Human Services
and with additional funding from the US Centers for Disease Control and Prevention, Division of Reproductive Health

Data Entry: https://cdrdata.org
www.childdeathreview.org
For help, email: info@childdeathreview.org
1-800-656-2434

APPENDIX F:

Local Committee Action Planning: Content Analysis Summary

BACKGROUND:

Over the past year, local committees have been directed to develop action plans to enable them to act, when possible, on strategies aimed at prevention of child maltreatment. By July 2017, all 22 local committees had action plans in place.

CURRENT FORMAT OF ACTION PLANS:

The action plan template distributed to circuits was organized to correspond with prevention data entry in the National Database and featured five sections:

- EDUCATION (ex: media campaign, school program, community safety project, provider education, parent education, public forum, and other education)
- AGENCY (ex: new policies, new programs, new services and expanded services)
- LAW (ex: new law/ordinance, amended law/ordinance, enforcement of law/ordinance)
- ENVIRONMENT (ex: modify a consumer product, recall a consumer product, modify public space, modify private space)

METHOD:

Activities from all action plans were combined into a master spreadsheet. Activities were then sorted and tabulated based on the categories listed above. In an effort to gain more insight into the scope of prevention efforts aimed at our most significant challenges, each activity was coded (based on available content) based on the topic addressed.* Topic areas included:

- Safe Sleep – media campaigns, pack-n-plays, training, etc.
- Water Safety – media campaigns, swim lessons, watcher tags, pool/door alarms, etc.
- Violence Prevention – shaken baby/coping with crying, gun safety, positive discipline
- Family Support – parent education and support, bike safety, swim lessons, car seat installation, concrete goods
- Substance Abuse – drug treatment programs, facilitated access to treatment, partner education
- Mental Health – mental health treatment, facilitated access to treatment, partner education
- Domestic Violence – intimate partner violence prevention, access to DV advocates
- System Improvements – sustainable changes in processes or system, funding for position, etc.

Activities were not restricted to one code. Numerous activities addressed more than one topic, therefore, certain activities were coded under multiple areas.

FINDINGS:

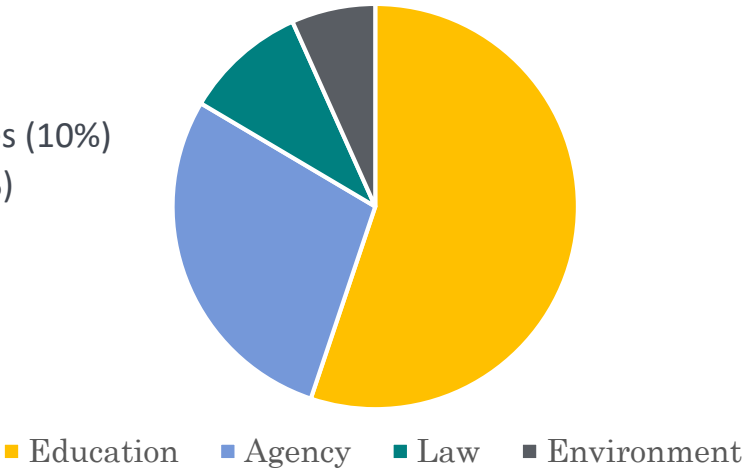
A combined total of **194** activities were included in local level action planning. Some general observations follow:

- The quality of action plans varied. Many were thoughtfully planned and included viable prevention strategies.
- Based on the entities/persons responsible for each activity, most action plans showed significant collaboration between community partners and shared initiatives.
- Activities varied greatly, ranging from recommendations to prevention strategies to system improvements.

Breakdown by Action Plan Category

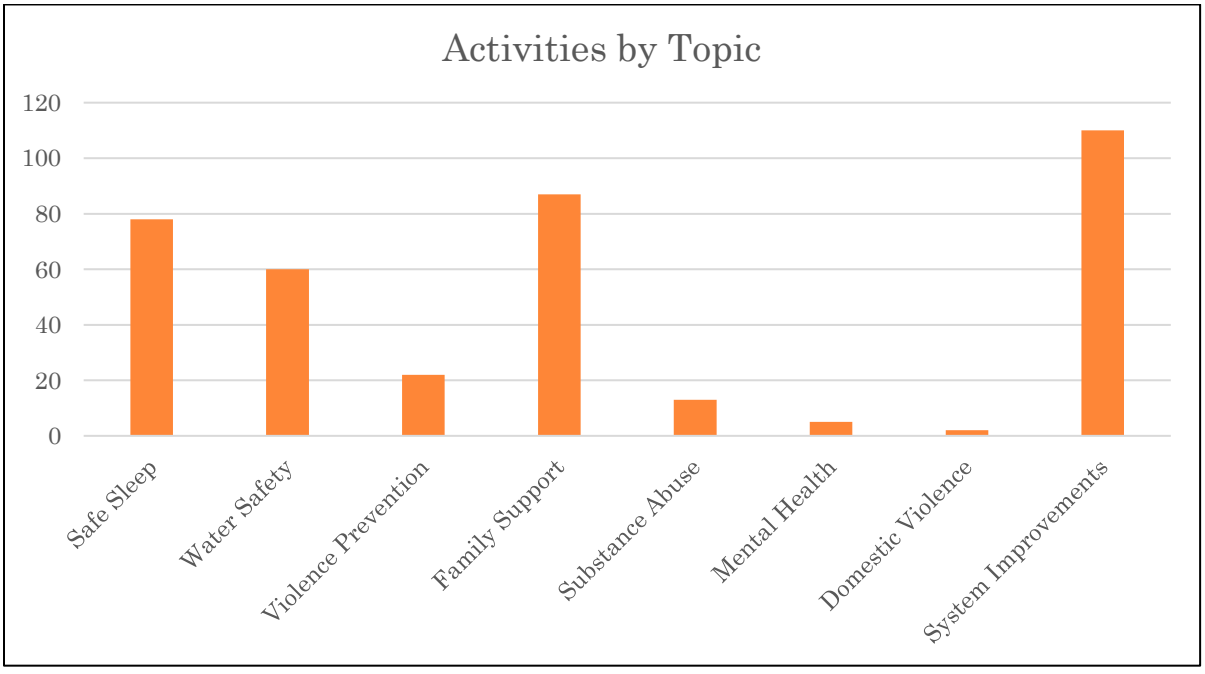
Activities were categorized based on the sections listed above. The breakdown in these categories was as follows:

- EDUCATION – 107 activities (55%)
- AGENCY – 55 activities (28%)
- LAW ENFORCEMENT – 19 activities (10%)
- ENVIRONMENT – 13 activities (7%)



Breakdown by Topic Area:

In addition to the above categories, activities were further coded and sorted by identified prevention topic areas. "System improvements" was the most commonly addressed topic with 110 activities aimed at improving systems or processes (57% of total activities).



A complete cross-walk showing both categories and topics follows:

TOPIC	# of Education Activities	# of Agency Activities	# of Law Activities	# of Enviroment Activities	TOTALS:	% of Total Activities
Safe Sleep	50	21	2	5	78	40%
Water Safety	36	15	7	2	60	31%
Violence Prevention	15	3	4	0	22	11%
Family Support	50	29	3	5	87	45%
Substance Abuse	5	5	3	0	13	7%
Mental Health	2	3	0	0	5	3%
Domestic Violence	1	1	0	0	2	1%
System Improvements	40	40	19	11	110	57%

FUTURE CONSIDERATIONS:

- Further analysis could be completed by breaking down certain topics, especially Family Support and System Improvements, as these topics cover a wide range of activities.
- Feedback from local committees regarding the template of the action plan and its utility would be informative as we consider improving the format to capture categories of information that are most relevant.
- Local committees would benefit from training and guidance in the development and implementation of action planning. This could be accomplished through our monthly call with local CADR chairs and stakeholders.
- Central office CADR liaisons assigned to specific regions can help monitor the progress of action plans at the local level via monthly calls with each chair.

APPENDIX G:

Additional Child Abuse Death Review Data

CHILD DEATH INCIDENT INFORMATION

Location of Child Deaths

Tables G-1 and G-2 provide information related to the number of child fatalities that occurred in each county in Florida. Please note that the county refers to the county where the incident took place, not necessarily the county where the death occurred (although they may be the same). By way of explanation, there are occasions where the incident causing a child's death may happen in one county; however, the child's death (for example, because he/she was transported to a medical facility in another county) may be documented in another county. From a prevention standpoint, for this report, any county reference refers to the county where the incident contributing to the death (i.e., "death county") took place. Table G-1 highlights every child death across individual counties stratified by maltreatment verification status and primary cause of death (i.e., drowning, asphyxia, weapon, and other). Table G-2 aggregates information denoted in Table G-1 for all primary causes of death for each county. No information in a table cell in either Table G-1 or Table G-2 indicates a zero count for that county category.

When information from Table G-1 is examined, there are six counties that account for almost half 31 of 68 (45.6%) of the verified child maltreatment deaths (across all primary causes of death) in Florida. These include Broward (n=7), Duval (n=5), Orange (n=5), Pinellas (n=6), Miami-Dade (n=4), and Pasco (n=4). Verified child maltreatment deaths happened in 24 additional counties throughout Florida for a total of 37 of 67 (54.4%) of Florida's counties.

When primary cause of death among verified maltreatment cases are examined, all drowning deaths (thus far reviewed) took place in thirteen counties (n=22) with 7 of 22 (31.8%) taken place in two counties (Broward and Duval). Among verified maltreatment deaths involving asphyxia, all took place in five counties; namely, Broward (n=3), Pasco (n=2), Okeechobee (n=1), Palm Beach (n=1), and Seminole (n=1). The 14 verified maltreatment deaths by weapons are found across 11 different counties in Florida with the greatest number occurring in Orange county (n=3).

When the total number of child fatalities (regardless of verification status and primary cause of death) investigated for each county is examined (see Table G-2), there are 12 counties with more than ten investigated deaths that collectively account for 217 of 348 (62.4%) of all fatalities. These include: Duval (n=34), Orange (n=23), Broward (n=22), Polk (n=22), Hillsborough (n=20), Pinellas (n=20), Palm Beach (n=20), Brevard (n=12), Alachua (n=12), Miami-Dade (n=11), Osceola (n=11), and Escambia (n=10).

Table G-1: Distribution of Maltreatment Finding Status Across Florida Counties by Primary Cause of Death

County	Verified for Maltreatment n=68				Not Substantiated as Maltreatment n=62				No Indicators of Maltreatment n=218				Total
	Drowning	Asphyxia	Weapon	Other	Drowning	Asphyxia	Weapon	Other	Drowning	Asphyxia	Weapon	Other	
Alachua	1			1				1	1			2	6
Baker													0
Bay									1	2			3
Bradford				1									1
Brevard	1				1			1			1	2	6
Broward	3	3	1			4		1				1	13
Calhoun													0
Charlotte									1	1			2
Citrus					1					1	1	1	4
Clay			1	1	1				1	1		2	7
Collier				1					2	2		4	9
Columbia				1						3		1	5
DeSoto								1					1
Dixie													0
Duval	4			1			1	2	1	17		5	31
Escambia			1			2				1		2	6
Flagler									1	1			2
Franklin													0
Gadsden						1							1
Gilchrist													0
Glades	1												1
Gulf													0
Hamilton				1									1
Hardee													0
Hendry				1					1				2
Hernando								1		1			2
Highlands											1		1
Hillsborough				1		2			3	3		6	15
Holmes													0
Indian River													0
Jackson												1	1
Jefferson													0
Lafayette													0
Lake					1				1	3		1	6
Lee			2	1		2			1				6
Leon								1	1	1		1	4
Levy													0
Liberty													0
Madison													0
Manatee			1		1	1				1			4
Marion				2		1	1			3		1	8
Martin													0
Miami-Dade	1		1	2		4				1		2	11
Monroe													0
Nassua	1			2						1			4
Okaloosa								1	1			4	6
Okeechobee		1										2	3
Orange	1		3	1	1			3	3		1	5	18
Osceola				1	1			1	4			2	9
Palm Beach	2	1	1			2		3	1	4		5	19
Pasco	2	2							1		1	2	8
Pinellas	1			5		3		1		4		2	16
Polk					1			1	5	6		7	20
Putnam											1		1
St Johns										2		1	3
St Lucie													0
Santa Rosa				1						1			2
Sarasota	2								1		1		4
Seminole		1	2					1	1	1		1	7
Sumter										2			2
Suwanee													0
Taylor													0
Union													0
Volusia	2		1						1	3		1	8
Wakulla													0
Walton													0
Washington													0
Total	22	8	14	24	8	22	2	19	33	66	7	64	289

The above figures do not include child deaths for which the cause of death was listed as undetermined, unknown, or missing. There were a total of 59 deaths whose cause of death was undetermined or not known for which 12 of these deaths were classifed as Not Sustantiated for Child Maltreatment and 47 were found to have No Indicators for Child Maltreatment.

Table G-2: Distribution of All Child Death Cases Reviewed Across Florida Counties by Primary Cause of Death

County	Primary Cause of Death					
	Drowning (N=63)	Asphyxia (N=96)	Weapon (N=23)	Other (N=107)	Undetermined/ Unknown (N=59)	Total (N=348)
Alachua	2			4	6	12
Baker						0
Bay	1	2				3
Bradford				1		1
Brevard	2		1	3	6	12
Broward	3	7	1	2	9	22
Calhoun					1	1
Charlotte	1	1				2
Citrus	1	1	1	1		4
Clay	2	1	1	3		7
Collier	2	2		5		9
Columbia		3		2		5
DeSoto				1		1
Dixie						0
Duval	5	17	1	8	3	34
Escambia		3	1	2	4	10
Flagler	1	1				2
Franklin						0
Gadsden		1			1	2
Gilchrist						0
Glades	1					1
Gulf						0
Hamilton				1		1
Hardee						0
Hendry	1			1		2
Hernando		1		1		2
Highlands			1			1
Hillsborough	3	5		7	5	20
Holmes						0
Indian River						0
Jackson				1	1	2
Jefferson						0
Lafayette						0
Lake	2	3		1	1	7
Lee	1	2	2	1	1	7
Leon	1	1		2	2	6
Levy						0
Liberty						0
Madison						0
Manatee	1	2	1			4
Marion		4	1	3		8
Martin						0
Miami-Dade	1	5	1	4		11
Monroe						0
Nassau	1	1		2		4
Okaloosa	1			5		6
Okeechobee		1		2		3
Orange	5		4	9	5	23
Osceola	5			4	2	11
Palm Beach	3	7	1	8	1	20
Pasco	3	2	1	2	1	9
Pinellas	1	7		8	4	20
Polk	6	6		8	2	22
Putnam			1			1
Saint Johns		2		1		3
St Lucie						0
Santa Rosa		1		1		2
Sarasota	3		1			4
Seminole	1	2	2	2	2	9
Sumter		2			1	3
Suwanee						0
Taylor						0
Union						0
Volusia	3	3	1	1	1	9
Wakulla						0
Walton						0
Washington						0
	63	96	23	107	59	348

Drowning Death Incident Information

Where information was available, Tables G-3 and G-4 with Figure G-1 represent findings on the location and activity of child before drowning. As findings suggest in Table G-3, children (regardless of verification status) were most likely to be last documented in their house 32 of 63 (50.8%) or in the water (18 of 63 or 28.6%) of deaths investigated prior to drowning. The majority 38 of 63 (60.3%) of all children (across all verification status categories) were playing before drowning; there were 8 of 63 (12.7%) children that were sleeping prior to drowning.

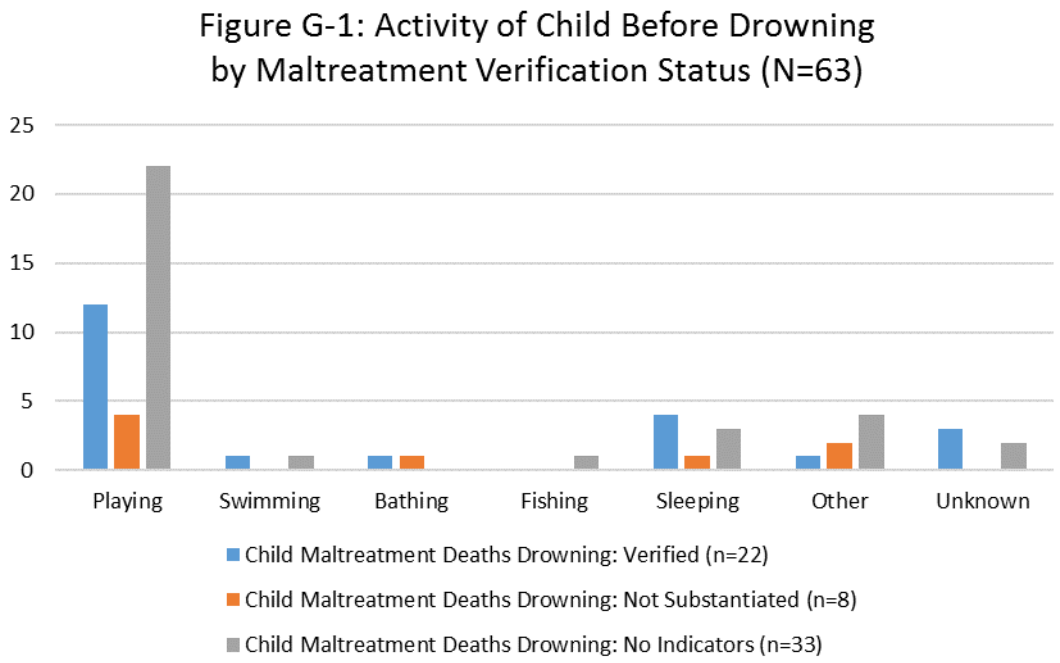
Table G-3: Location of Child Before Drowning by Child Maltreatment Verification Status

Location of Child Before Drowning	Child Maltreatment Deaths Drowning n=63		
	Verified (n=22)	Not Substantiated (n=8)	No Indicators (n=33)
In Water	6	2	10
On Shore	0	0	0
On Dock	0	0	0
Pool Side	1	0	4
In Yard	2	0	5
In Bathroom	2	1	0
In House	11	6	15
Other	0	0	1
Unknown	0	0	0

Aggregate totals across locations may exceed total number of cases as multiple locations were reported for select cases.

Table G-4: Activity of Child Before Drowning by Child Maltreatment Verification Status

Activity Before Drowning	Child Maltreatment Deaths Drowning n=63		
	Verified (n=22)	Not Substantiated (n=8)	No Indicators (n=33)
Playing	12	4	22
Boating	0	0	0
Swimming	1	0	1
Bathing	1	1	0
Fishing	0	0	1
Surfing	0	0	0
Tubing	0	0	0
Water Skiing	0	0	0
Sleeping	4	1	3
Other	1	2	4
Unknown	3	0	2



Sleep-Related Asphyxia Death Incident Information

Table G-5 provides a listing and associated counts of specific objects (including persons) that were reported in a child's sleep environment and for objects identified to have blocked/obstructed a child's airway among the reviewed sleep-related asphyxia cases (N=85) regardless of verification status. Please note that there may be more than one identified object present in the sleeping environment as well as more than one object(s) blocking the child's airway contributing to death. There was a total of 97 objects blocking the airways of the 85 children that died from sleep-related asphyxia. Among these objects, 68 of 97 (70.1%) objects were associated with bedding-related objects (i.e., pillows, mattresses, comforters/quilts, sheets/thin blankets, bumper pads, etc.). A total of 17 of 63 (27.0%) adults reportedly blocked the airways of children that died; however, 51 adults were sleeping/present with the child at the time of the death incident.

Table G-5: Objects in Sleep Environment Among Sleep-Related Asphyxia Deaths (N=85)		
	Objects Present in Sleeping Environment	Objects Obstructing Child's Airway
Adult(s)	51	17
Other Children	11	1
Animal(s)	0	0
Mattress	53	19
Comforter	35	13
Thin blanket/flat sheet	43	14
Pillow(s)	46	17
Cushion	9	3
Boppy or U-Shaped Pillow	4	2
Sleep Positioner	2	0
Bumper Pads	2	1
Clothing	7	3
Crib Railing/Side	5	1
Wall	3	0
Toy(s)	6	2
Other	12	2
The above data apply to sleep-related deaths if the child was under the age of five. Column totals may exceed number of children as multiple objects could be present or a source of obstruction.		

Weapon-Related Death Incident Information

Tables G-6 through G-8 summarize information related to the sex of the firearm owner (in firearm deaths only), and the sex and relationship of the person handling the weapon related to the child fatality at the time of the incident. The clear majority of the owners 11 of 13 (84.6%) of firearms used in the fatality were owned by males. When all weapons used in verified maltreatment deaths are considered, 20 of 29 (69.0%) were males who handled the weapon that was used in the child's fatality.

As highlighted in Table G-8 and Figure G-3 and G-4 the biological parent was most likely (8 of 14 or 57.1%) to be the person handling the weapon at the time of death, followed by the mother's partner (n=2) and the child's sibling (n=2). In 5 of the 7 (71.4%) no indicators of maltreatment deaths, the child who died was handling the fatal weapon at the time of death incident.

Table G-6: Sex of Fatal Firearm Owner by Maltreatment Verification Status			
Sex of Fatal Firearm Owner	Child Maltreament Death Firearm Deaths n=13		
	Verified (n= 7)	Not Substantiated (n=0)	No Indicators (n=6)
Male	6	0	5
Female	1	0	1
Unknown	0	0	0

Table G-7: Sex of Person Handling Weapon by Maltreatment Verification Status			
Sex of Person Handling Weapon	Child Maltreatment Death n=23		
	Verified (n=14)	Not Substantiated (n=2)	No Indicators (n= 7)
Male	10	2	4
Female	4	0	3
Unknown	0	0	0
Missing	0	0	0

Figure G-2: Sex of Person Handing Weapon by Maltreatment Verification Status (N=23)

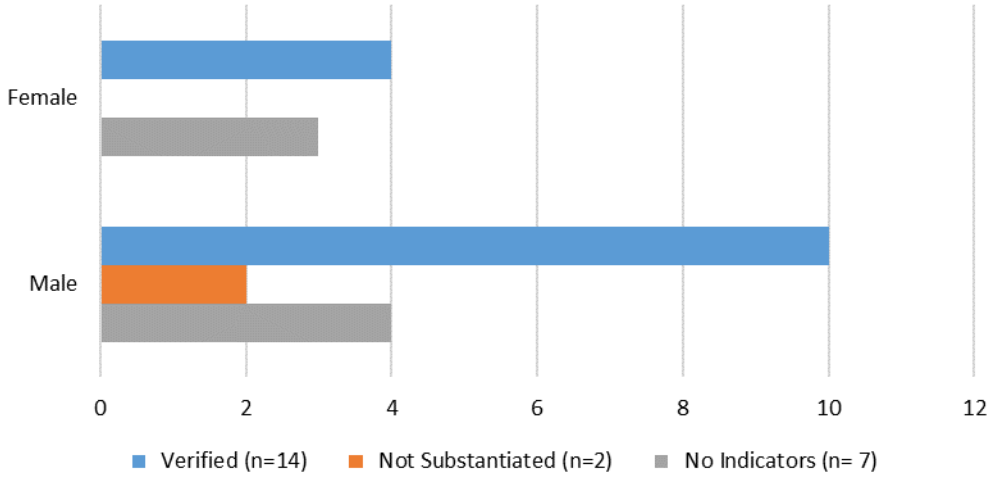


Table G-8: Person Handling Fatal Weapon at Time of Death Incident by Maltreatment Verification Status			
Person Handling Fatal Weapon	Child Maltreatment Death (n=23)		
	Verified (n=14)	Not Substantiated (n=2)	No Indicators (n= 7)
Self/Child	1	0	5
Biological Parent	8	0	0
Adoptive Parent	0	0	0
Stepparent	0	0	0
Foster parent	0	0	0
Mother's Partner	2	1	0
Father's Partner	0	0	0
Grandparent	0	0	0
Sibling	2	0	1
Other relative	0	1	0
Other Non-relative	1	0	1

Figure G-3: Person Handling Fatal Weapon at Time of Death (N=23)

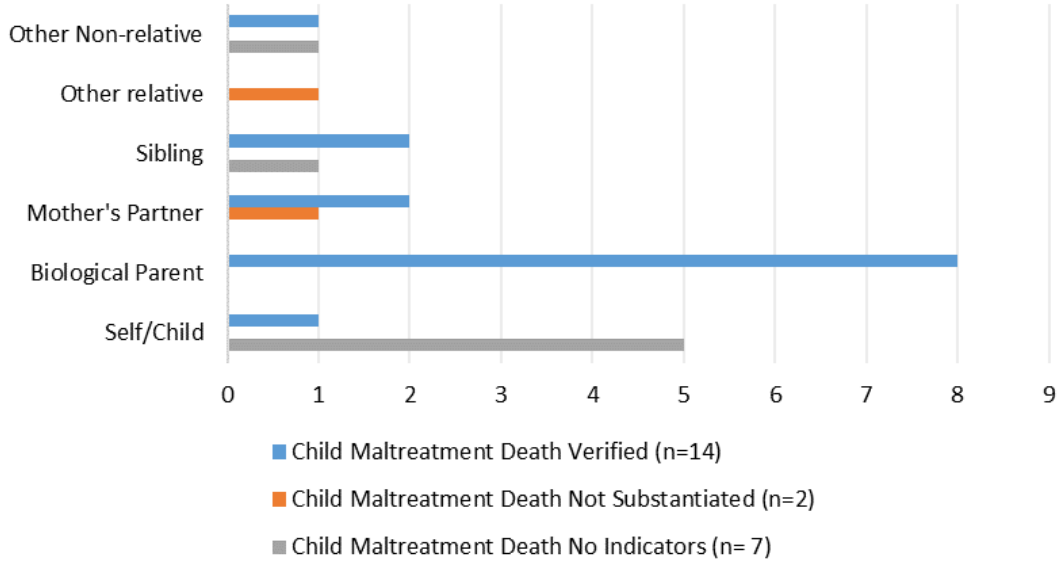
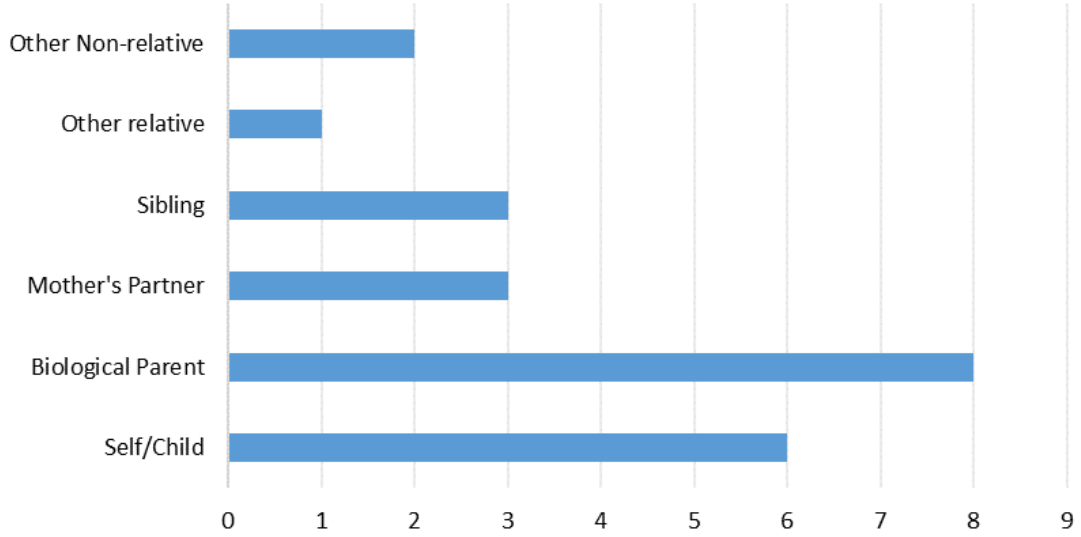


Figure G-4: Person Handling Fatal Weapon at Time of Fatal Death Incident Across All Investigated Cases (N=23)



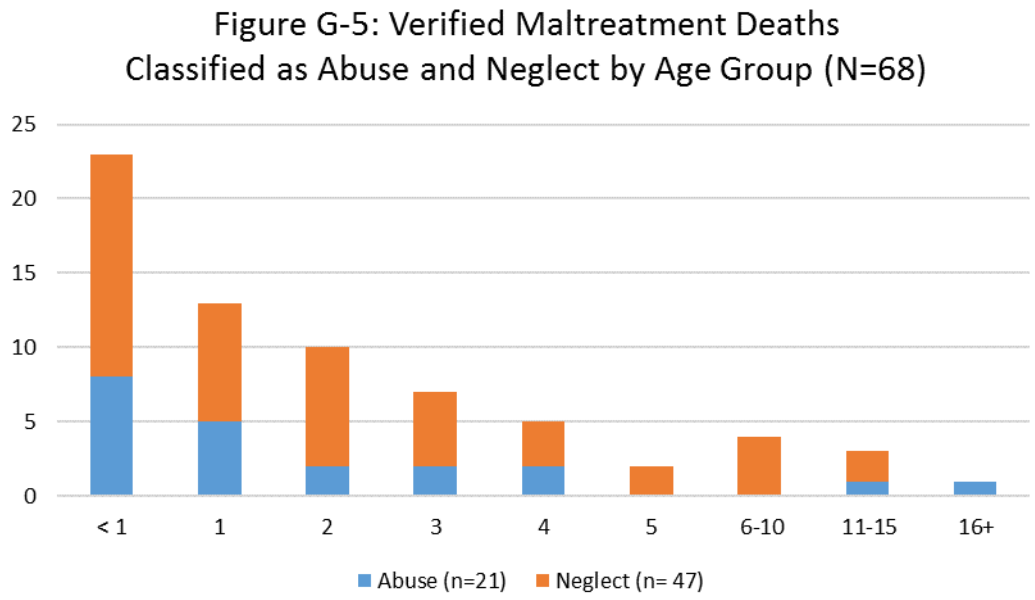
CHILD CHARACTERISTICS

Age of Child

Table G-9 provides a count of children by age group for which their death was verified as maltreatment by primary cause of death. Table G-10 and Figure G-5 itemize the number of children by age group whose death was classified as abuse or neglect.

Table G-9: Age of Children with Verified Maltreatment by Primary Cause of Death and if Death Classified as Abuse or Neglect								
Age	Verified Child Maltreatment Death n=68							
	Drowning n=22		Asphyxia n=8		Weapon n=14		Other n=24	
	Abuse	Neglect	Abuse	Neglect	Abuse	Neglect	Abuse	Neglect
< 1	0	2	1	4	2	1	5	8
1	0	4	1	1	3	0	1	3
2	1	6	0	0	1	0	0	2
3	0	3	1	0	1	1	0	1
4	0	2	0	0	1	1	1	0
5	0	2	0	0	0	0	0	0
6-10	0	1	0	0	0	1	0	2
11-15	0	1	0	0	1	0	0	1
16+	0	0	0	0	1	0	0	0
There were no cases classified as abuse or neglect for cases where the cause of death was classified as undetermined or unknown.								

Table G-10: Age of Children with Verified Maltreatment Death Classified as Abuse or Neglect		
Age	Verified Child Maltreatment Death n=68	
	Abuse n=21	Neglect n=47
< 1	8	15
1	5	8
2	2	8
3	2	5
4	2	3
5	0	2
6-10	0	4
11-15	1	2
16+	1	0

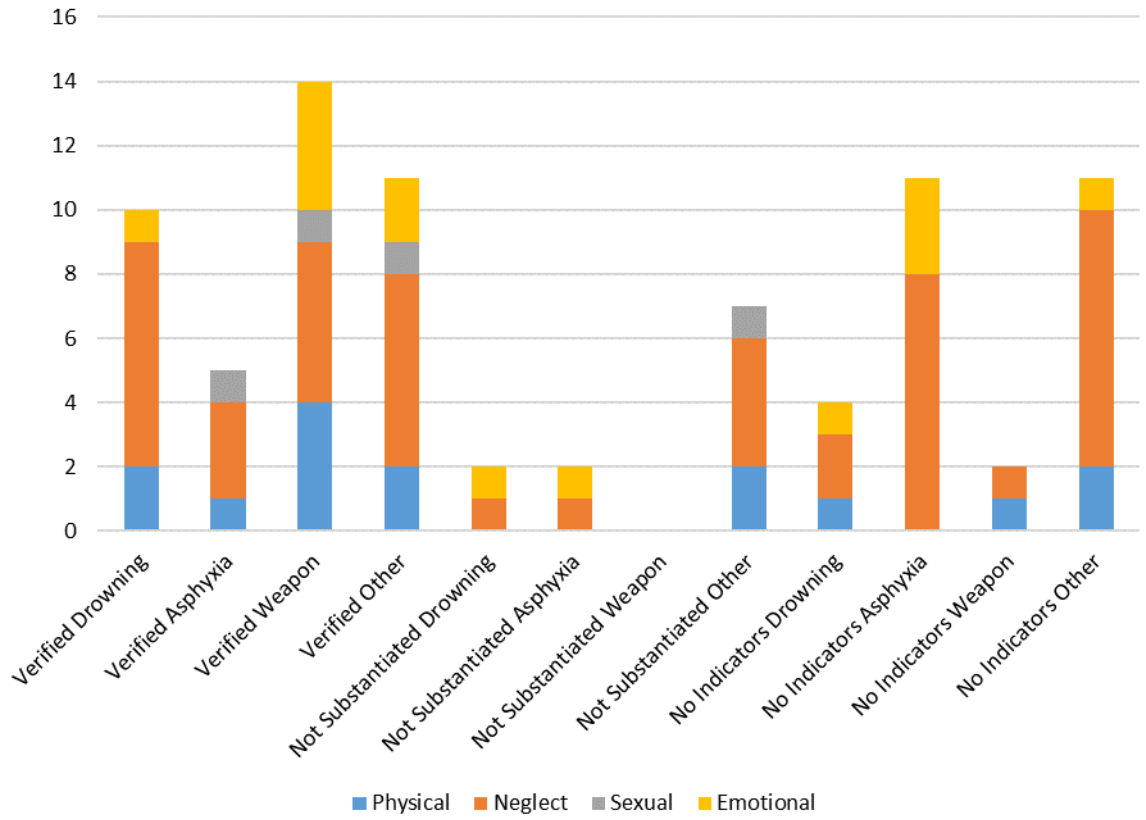


Child's History as Victim of Maltreatment

If known and applicable, the distribution of past maltreatment incidents across maltreatment verification status and primary cause of death are denoted in Table G-11 and Figure 6. Please note that for each child identified as a past victim of maltreatment, there may be multiple past maltreatment incidents and/or multiple forms of maltreatment during a single incident.

Table G-11: Child's History as a Victim of Maltreatment for Child Fatality Cases												
Type of Past Maltreatment	Child Maltreatment Death											
	Verified Child n=68				Not Substantiated n=51				No Indicators n=170			
	Drowning n=22	**Asphyxia n=8**	**Weapon n=14**	**Other n=24**	**Drowning n=8**	**Asphyxia n=22**	**Weapon n=2**	**Other n=19**	**Drowning n=33**	**Asphyxia n=66**	**Weapon n=7**	**Other n=64**
Physical	9.1%	12.5%	28.6%	8.3%	0.0%	0.0%	0.0%	10.5%	3.0%	0.0%	14.3%	3.1%
Neglect	31.8%	37.5%	35.7%	25.0%	12.5%	4.5%	0.0%	21.1%	6.1%	12.1%	14.3%	12.5%
Sexual	0.0%	12.5%	7.1%	4.2%	0.0%	0.0%	0.0%	5.3%	0.0%	0.0%	0.0%	0.0%
Emotional	4.5%	0.0%	28.6%	8.3%	12.5%	4.5%	0.0%	0.0%	3.0%	4.5%	0.0%	1.6%

Figure G-6: Child's History as Victim of Maltreatment by Type of Past Maltreatment and Verification Status (n=79)



CAREGIVER, SUPERVISOR, AND PERSON(S) RESPONSIBLE CHARACTERISTICS

Table G-12 summarizes the percentage of child fatality cases where one or two caregivers were identified. At least one primary caregiver was identified for all child fatality cases. Among verified maltreatment deaths, between 41.67% (other deaths) and 92.86% (weapon deaths) of the children had a second caregiver present in the home. Most of the not substantiated and no indicators of maltreatment deaths had a second caregiver present in the home.

Table G-12: Percentage of Cases with One and Two Caregivers Identified as Present by Child Maltreatment Verification Status and Primary Cause of Death

Caregiver Present	Child Maltreatment Death											
	Verified n=68				Not Substantiated n=51				No Indicators n=170			
	Drowning n=22	Asphyxia n=8	Weapon n=14	Other n=24	Drowning n=8	Asphyxia n=22	Weapon n=2	Other n=19	Drowning n=33	Asphyxia n=66	Weapon n=7	Other n=64
One	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
Two	68.18%	62.50%	92.86%	41.67%	87.50%	95.45%	100.00%	68.42%	90.91%	75.76%	100.00%	70.31%

Relationship to Child of Caregivers, Supervisors, and Person(s) Responsible for Death

Tables G-13 through G-15 and Figure G-7 demonstrate that the most likely caregiver(s) present across all causes of death were the biological parents of the child. Of the 507 caregivers identified for the 348 children, 433 (85.4%) were the child's biological parents, followed by 26 (5.1%) grandparents.

Among verified child maltreatment deaths, the proportion of aggregate caregivers who are biological parents was 73% for drowning deaths, 92% for asphyxia deaths, 78% for weapons deaths (grandparents were other caregivers in weapons deaths), and 88% for other deaths. These proportions are approximately paralleled for not substantiated and no indicators for maltreatment deaths.

Table G-13: Relationship to Child of All Identified Caregivers (Aggregate) by Maltreatment Verification Status and Primary Cause of Death

Caregiver Relationship To Child (All Caregivers)	Child Maltreatment Death											
	Verified n=111				Not Substantiated n=94				No Indicators n=302			
	Drowning n=37	Asphyxia n=13	Weapon n=27	Other n=34	Drowning n=15	Asphyxia n=43	Weapon n=4	Other n=32	Drowning n=63	Asphyxia n=116	Weapon n=14	Other n=109
Self	0%	0%	4%	0%	0%	0%	0%	0%	0%	0%	0%	0%
Biological Parent	73%	92%	78%	88%	73%	91%	25%	81%	84%	91%	71%	90%
Adoptive Parent	0%	0%	0%	0%	0%	0%	0%	0%	3%	0%	0%	2%
Step-Parent	0%	8%	0%	0%	0%	0%	0%	0%	0%	2%	21%	1%
Foster Parent	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
Mother's Partner	5%	0%	7%	3%	7%	5%	25%	0%	0%	1%	0%	2%
Father's Partner	0%	0%	0%	3%	0%	0%	0%	0%	0%	0%	0%	0%
Grandparent	14%	0%	11%	3%	7%	5%	25%	13%	5%	3%	0%	3%
Sibling	3%	0%	0%	0%	0%	0%	0%	0%	0%	0%	7%	0%
Other Relative	3%	0%	0%	3%	13%	0%	25%	0%	3%	1%	0%	1%
Friend	3%	0%	0%	0%	0%	0%	0%	3%	0%	0%	0%	0%
Institutional Staff	0%	0%	0%	0%	0%	0%	0%	0%	0%	1%	0%	1%
Other	0%	0%	0%	0%	0%	0%	0%	3%	3%	3%	0%	1%
Unknown	0%	0%	0%	0%	0%	0%	0%	0%	2%	0%	0%	0%

Figure G-7: Caregiver (Aggregate) Relationship to Child by Child Maltreatment Verification Status (N=507)

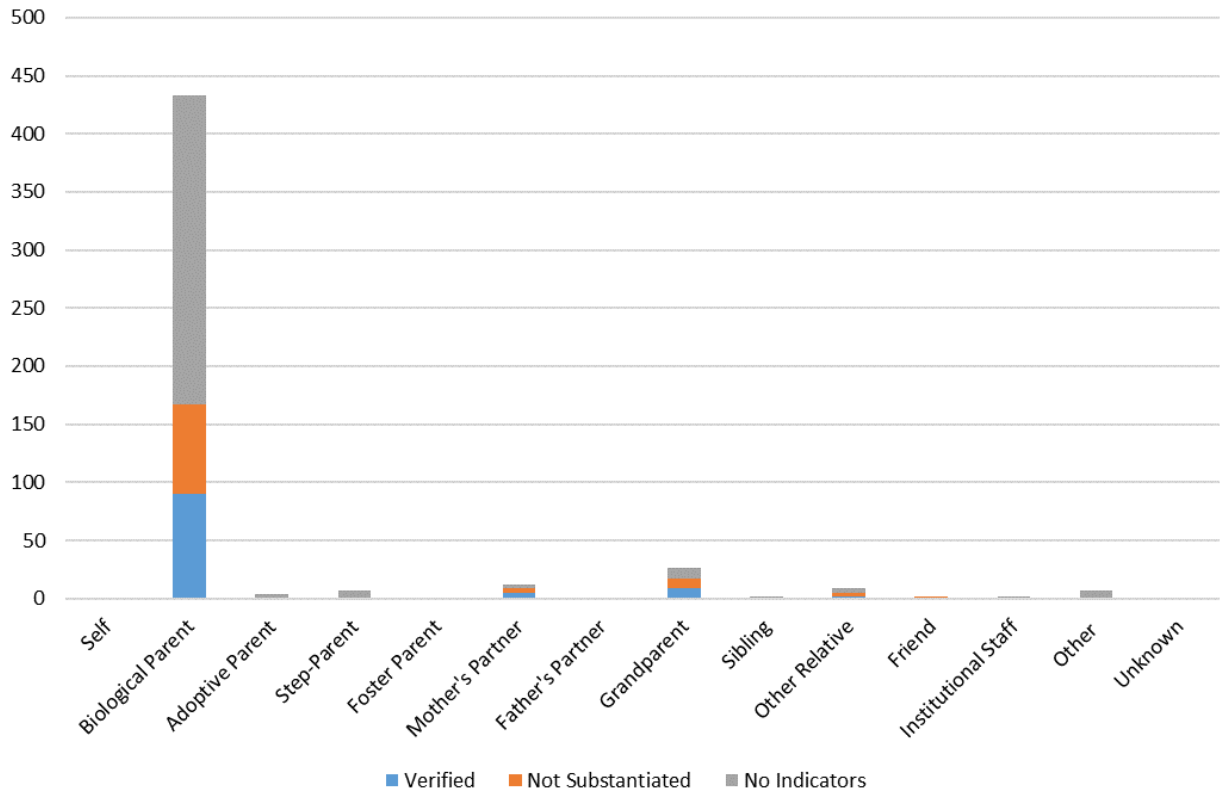


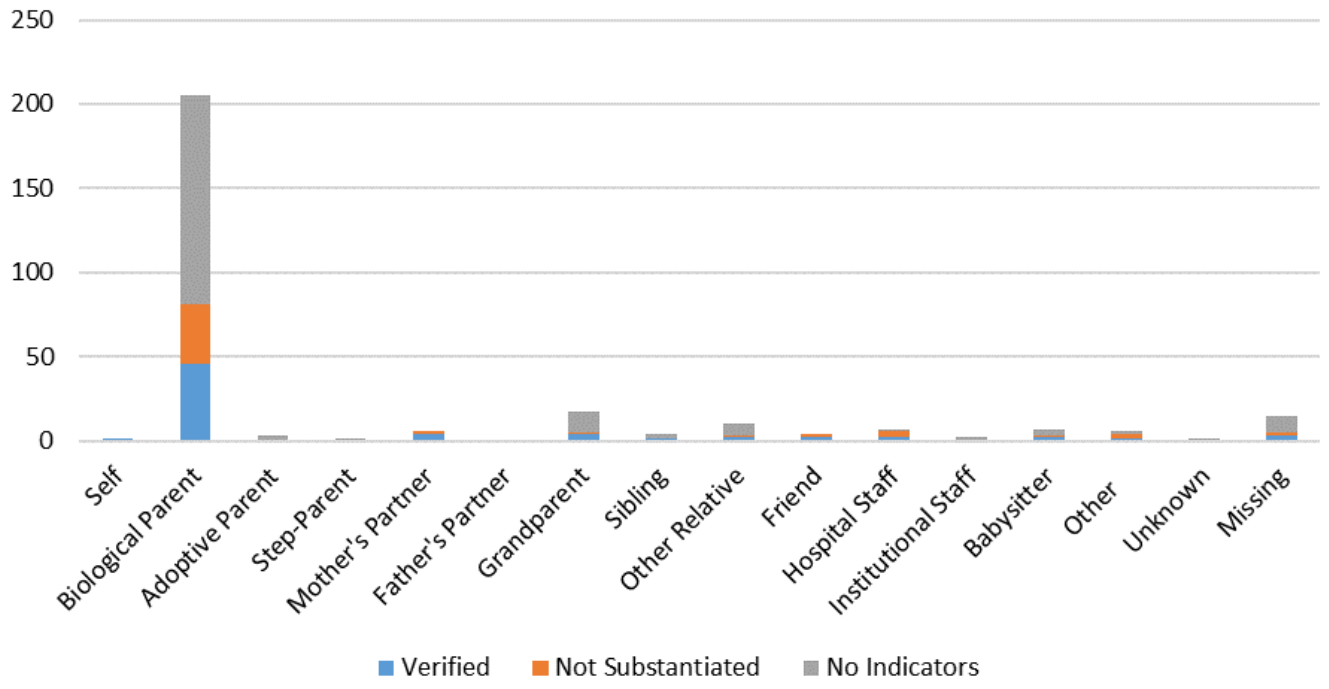
Table G-14: Relationship to Child of Primary (First) Caregiver Identified by Maltreatment Verification Status and Primary Cause of Death												
Caregiver Relationship To Child (Caregiver 1 Only)	Child Maltreatment Death											
	Verified n=68				Not Substantiated n=51				No Indicators n=170			
	Drowning n=22	Asphyxia n=8	Weapon n=14	Other n=24	Drowning n=8	Asphyxia n=22	Weapon n=2	Other n=19	Drowning n=33	Asphyxia n=66	Weapon n=7	Other n=64
Self	0%	0%	7%	0%	0%	0%	0%	0%	0%	0%	0%	0%
Biological Parent	82%	100%	79%	85%	67%	100%	50%	94%	91%	97%	86%	97%
Adoptive Parent	0%	0%	0%	0%	0%	0%	0%	0%	3%	0%	0%	3%
Step-Parent	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
Foster Parent	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
Mother's Partner	0%	0%	0%	0%	11%	0%	0%	0%	0%	0%	0%	0%
Father's Partner	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
Grandparent	14%	0%	14%	4%	0%	0%	50%	6%	6%	0%	0%	2%
Sibling	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	14%	0%
Other Relative	5%	0%	0%	0%	11%	0%	0%	0%	3%	2%	0%	0%
Friend	0%	0%	0%	0%	0%	0%	0%	6%	0%	0%	0%	0%
Institutional Staff	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
Other	0%	0%	0%	0%	0%	0%	0%	6%	0%	2%	0%	0%
Unknown	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%

Table G-15: Relationship to Child of Second Caregiver Identified by Maltreatment Verification Status and Primary Cause of Death												
Caregiver Relationship To Child (Caregiver 2 only)	Child Maltreatment Death											
	Verified n=43				Not Substantiated n=43				No Indicators n=132			
	Drowning n=15	Asphyxia n=5	Weapon n=13	Other n=10	Drowning n=7	Asphyxia n=21	Weapon n=2	Other n=13	Drowning n=30	Asphyxia n=50	Weapon n=7	Other n=45
Self	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
Biological Parent	60%	80%	77%	70%	71%	81%	0%	77%	80%	82%	57%	82%
Adoptive Parent	0%	0%	0%	0%	0%	0%	0%	0%	3%	0%	0%	0%
Step-Parent	0%	20%	0%	0%	0%	0%	0%	0%	0%	4%	43%	2%
Foster Parent	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
Mother's Partner	13%	0%	15%	10%	0%	10%	50%	0%	0%	2%	0%	4%
Father's Partner	0%	0%	0%	10%	0%	0%	0%	0%	0%	0%	0%	0%
Grandparent	13%	0%	8%	0%	14%	10%	0%	23%	3%	6%	0%	4%
Sibling	7%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
Other Relative	0%	0%	0%	10%	14%	0%	50%	0%	3%	0%	0%	2%
Friend	7%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
Institutional Staff	0%	0%	0%	0%	0%	0%	0%	0%	0%	2%	0%	2%
Other	0%	0%	0%	0%	0%	0%	0%	0%	7%	4%	0%	2%
Unknown	0%	0%	0%	0%	0%	0%	0%	0%	3%	0%	0%	0%

Table G-16 and Figure G-8 focus on the relationship of the supervisor of the child at the time of the incident leading to the child's death. Here, some parallels exist with data associated with caregivers (see Table G-13). Among verified maltreatment deaths, the percentage of supervisors (across primary causes of death) who were biological parents ranges from 55% (for drowning deaths) to 100% (for asphyxia deaths); a large majority for each cause of death. Among verified maltreatment weapon deaths, 14% of the supervisors were the mother's partner with an additional 14% being a grandparent. Among verified maltreatment drownings, 9% were the child's grandparent, 5% a babysitter, and another 15% being the mother's partner, sibling and other relative (combined).

Table G-16: Relationship to Child of Supervisor by Maltreatment Verification Status and Primary Cause of Death												
Supervisor Relationship to Child	Child Maltreatment Death											
	Verified n=68				Not Substantiated n=51				No Indicators n=170			
	Drowning n=22	Asphyxia n=8	Weapon n=14	Other n=24	Drowning n=8	Asphyxia n=22	Weapon n=2	Other n=19	Drowning n=33	Asphyxia n=66	Weapon n=7	Other n=64
Self	0%	0%	7%	0%	0%	0%	0%	0%	0%	0%	0%	0%
Biological Parent	55%	100%	64%	71%	63%	91%	0%	53%	61%	83%	14%	75%
Adoptive Parent	0%	0%	0%	0%	0%	0%	0%	0%	3%	0%	0%	3%
Step-Parent	0%	0%	0%	0%	0%	0%	0%	0%	0%	2%	0%	0%
Foster Parent	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
Mother's Partner	5%	0%	14%	4%	13%	0%	50%	0%	0%	0%	0%	0%
Father's Partner	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
Grandparent	9%	0%	14%	0%	0%	5%	0%	0%	15%	5%	0%	6%
Sibling	5%	0%	0%	0%	0%	0%	0%	0%	6%	0%	14%	0%
Other Relative	5%	0%	0%	4%	13%	0%	0%	0%	3%	3%	0%	6%
Friend	9%	0%	0%	0%	0%	0%	0%	11%	0%	0%	0%	0%
Acquaintance	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
Hospital Staff	0%	0%	0%	8%	0%	0%	0%	21%	0%	0%	0%	2%
Institutional Staff	0%	0%	0%	0%	0%	0%	0%	0%	0%	2%	0%	2%
Babysitter	5%	0%	0%	4%	13%	0%	0%	0%	0%	0%	0%	6%
Licensed Child Care Worker	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
Other	5%	0%	0%	0%	0%	0%	50%	11%	3%	2%	0%	0%
Unknown	5%	0%	0%	8%	0%	5%	0%	5%	9%	5%	71%	0%

Figure G-8: Supervisor Relationship to Child by Maltreatment Verification Status (N=289)



For verified child maltreatment deaths, Tables G-17 through G-19 (and Figure G-9) present information on the relationship to the child of the person(s) deemed responsible for the child's death. Collectively, biological parents represented those person(s) who were responsible for 67% of drowning, 100% of asphyxia, 69% of weapon, and 83% of other causes deaths. For weapon deaths, 13% of all person(s) responsible and 14% of persons directly causing a child's death were the mother's partner.

Table G-17: Relationship to Child of All Person(s) Responsible for Maltreatment Death (aggregate) by Primary Cause of Death				
All Person(s) Responsible Relationship To Child	Verified Child Maltreatment Death n=73			
	Drowning n=24	Asphyxia n=9	Weapon n=16	Other n=24
Self	0%	0%	6%	0%
Biological Parent	67%	100%	69%	83%
Adoptive Parent	0%	0%	0%	0%
Step-Parent	0%	0%	0%	0%
Foster Parent	0%	0%	0%	0%
Mother's Partner	0%	0%	13%	4%
Father's Partner	0%	0%	0%	0%
Grandparent	8%	0%	6%	0%
Sibling	0%	0%	6%	0%
Other Relative	4%	0%	0%	4%
Friend	13%	0%	0%	4%
Acquaintance	0%	0%	0%	0%
Child's Boyfriend/ Girlfriend	0%	0%	0%	0%
Stranger	0%	0%	0%	0%
Medical Staff	0%	0%	0%	0%
Institutional Staff	0%	0%	0%	0%
Babysitter	4%	0%	0%	4%
Licensed Child Care Worker	0%	0%	0%	0%
Other	4%	0%	0%	0%
Totals	24	9	16	24
The Column Total (on which percentages are based) reflect the total number of individuals identified as causal and contributing influences on child's death.				

Figure G-9: Persons Responsible (Caused and Contributed) to Verified Maltreatment Death (N=73)

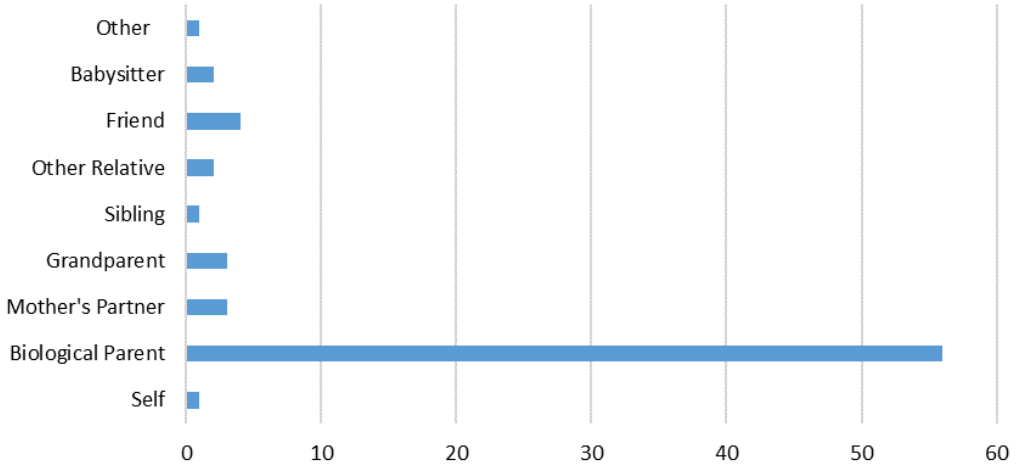


Table G-18: Relationship to Child of Person who Caused Verified Maltreatment Death by Primary Casue of Death				
Person Responsible - Caused Relationship To Child	Verified Child Maltreatment Death n=68			
	Drowning n=22	Asphyxia n=8	Weapon n=14	Other n=24
Self	0%	0%	7%	0%
Biological Parent	23%	75%	64%	42%
Adoptive Parent	0%	0%	0%	0%
Step-Parent	0%	0%	0%	0%
Foster Parent	0%	0%	0%	0%
Mother's Partner	0%	0%	14%	4%
Father's Partner	0%	0%	0%	0%
Grandparent	0%	0%	0%	0%
Sibling	0%	0%	7%	0%
Other Relative	0%	0%	0%	4%
Friend	9%	0%	0%	4%
Acquaintance	0%	0%	0%	0%
Child's Boyfriend/ Girlfriend	0%	0%	0%	0%
Stranger	0%	0%	0%	0%
Medical Staff	0%	0%	0%	0%
Institutional Staff	0%	0%	0%	0%
Babysitter	0%	0%	0%	4%
Licensed Child Care Worker	0%	0%	0%	0%
Other	0%	0%	0%	0%
Percentages relate to the total number of cases associated with each primary cause of death. Columns may not total 100% due to unknown or missing data on item.				

Table G-19: Relationship to Child of Person who Contributed to Verified Maltreatment Death by Primary Cause of Death				
Person Responsible - Contributed Relationship To Child	Verified Child Maltreatment Death n=68			
	Drowning n=22	Asphyxia n=8	Weapon n=14	Other n=24
Self	0%	0%	0%	0%
Biological Parent	50%	38%	14%	42%
Adoptive Parent	0%	0%	0%	0%
Step-Parent	0%	0%	0%	0%
Foster Parent	0%	0%	0%	0%
Mother's Partner	0%	0%	0%	0%
Father's Partner	0%	0%	0%	0%
Grandparent	9%	0%	7%	0%
Sibling	0%	0%	0%	0%
Other Relative	5%	0%	0%	0%
Friend	5%	0%	0%	0%
Acquaintance	0%	0%	0%	0%
Child's Boyfriend/ Girlfriend	0%	0%	0%	0%
Stranger	0%	0%	0%	0%
Medical Staff	0%	0%	0%	0%
Institutional Staff	0%	0%	0%	0%
Babysitter	5%	0%	0%	0%
Licensed Child Care Worker	0%	0%	0%	0%
Other	5%	0%	0%	0%
Percentages relate to the total number of cases associated with each primary cause of death. Columns may not total 100% due to unknown or missing data on item.				

Average Age of Caregivers, Supervisors and Person(s) Responsible

Table G-20 provides the average ages of caregivers, supervisors, and person(s) responsible for child deaths.

Table G-20: Average Ages of Caregivers, Supervisors, and Person(s) Responsible for Child Fatality by Child Maltreatment Verification Status												
Average Age (years)	Child Maltreatment Death											
	Verified n=68				Not Substantiated n=51				No Indicators n=170			
	Drowning n=22	Asphyxia n=8	Weapon n=14	Other n=24	Drowning n=8	Asphyxia n=22	Weapon n=2	Other n=19	Drowning n=33	Asphyxia n=66	Weapon n=7	Other n=64
Caregiver1	32.2	30.5	32.4	31.1	31.3	26.4	43.0	33.5	30.8	26.8	36.4	29.0
Caregiver2	35.7	33.5	30.4	26.5	39.0	32.9	27.0	39.9	33.9	30.5	43.4	32.5
All Caregivers	34.0	32.0	31.4	28.8	35.1	29.6	35.0	36.7	32.4	28.7	39.9	30.8
Supervisors	34.0	30.5	31.9	29.9	34.4	31.0	15.5	32.4	33.8	27.5	32.5	32.4
Person Responsible - Caused	29.6	31.7	26.8	30.2	36.6	31.8	21.0	31.3	26.0	29.5	15.0	28.0
Person Responsible - Contributed	34.1	32.3	33.3	33.6	32.6	27.9	65.0	25.8	34.8	27.1	50.0	29.5
All Person(s) Responsible	31.8	32.0	30.1	31.9	34.6	29.8	43.0	28.6	30.4	28.3	32.5	28.8

Gender of Caregivers, Supervisors and Person(s) Responsible for Death

Observation of information summarized in Table G-21 reveals that most caregivers for children (across all primary cause of death categories) were female. Among verified maltreatment deaths, between 59% (for weapon deaths) and 71% (for other deaths) of caregivers were female. Among supervisors of verified child maltreatment deaths, 50% of weapon cases, 77% of drowning cases, and 100% asphyxia cases were females (Table G-22). Among person(s) responsible (either caused or contributed to) the child's death among verified maltreatment deaths, most drowning deaths (52%) and asphyxia deaths (50%), followed by other deaths (35%) were women (Table G-23 and Figure G-10). However, the person(s) responsible for most weapon deaths (36%) were male.

Table G-21: Gender of All Identified Caregivers (Aggregate) by Maltreatment Verification Status and Primary Cause of Death

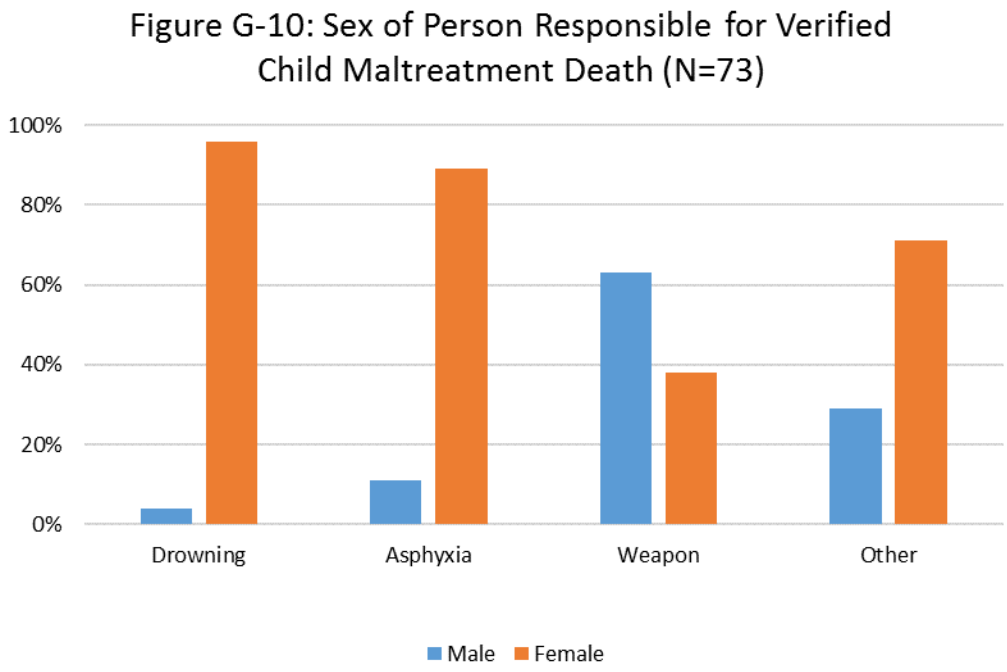
Caregiver Gender	Child Maltreatment Death											
	Verified n=115				Not Substantiated n=93				No Indicators n=297			
	Drowning n=37	Asphyxia n=13	Weapon n=27	Other n=34	Drowning n=15	Asphyxia n=43	Weapon n=4	Other n=32	Drowning n=62	Asphyxia n=115	Weapon n=14	Other n=109
Male	32%	38%	41%	29%	40%	44%	25%	28%	37%	39%	57%	39%
Female	68%	62%	59%	71%	60%	56%	75%	69%	63%	61%	43%	61%
Unknown	0%	0%	0%	0%	0%	0%	0%	3%	0%	0%	0%	0%

Table G-22: Gender of Supervisors by Maltreatment Verification Status and Primary Cause of Death

Supervisor Gender	Child Maltreatment Death											
	Verified n=62				Not Substantiated n=45				No Indicators n=158			
	Drowning n=20	Asphyxia n=8	Weapon n=14	Other n=20	Drowning n=8	Asphyxia n=21	Weapon n=2	Other n=14	Drowning n=30	Asphyxia n=63	Weapon n=2	Other n=63
Male	15%	0%	50%	27%	33%	38%	100%	25%	17%	22%	50%	13%
Female	85%	100%	50%	64%	56%	62%	0%	92%	86%	78%	50%	87%
Unknown	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%

Table G-23: Gender of All Identified Person(s) Responsible for Verified Maltreatment Death

All Person(s) Responsible	Verified Child Maltreatment Death n=73			
	Drowning n=24	Asphyxia n=9	Weapon n=16	Other n=24
Male	4%	11%	63%	29%
Female	96%	89%	38%	71%
Unknown	0%	0%	0%	0%



Substance Abuse History of Caregivers, Supervisors and Person(s) Responsible for Child's Death

Tables G-24 through G-26 (with accompanying Figures G-11 through G-14) summarize information related to substance abuse history of all caregivers, supervisors and person(s) responsible. Findings from Table G-24 reveal that among the caregivers of children whose deaths were verified as child maltreatment, 49 of 101 (48.5%) are known to have a substance abuse history. This rate mirrors the percentage of caregivers with a substance abuse history among not substantiated maltreatment deaths (44 of 90 or 48.8%); both of which are significantly larger than the 28.7% of caregivers associated with no indicators of maltreatment deaths (84 of 293 or 28.7%).[2] This suggests that the likelihood of a substance abuse history among caregivers of verified and not substantiated maltreatment deaths are similar.

[2] A series of tests of significance between two independent proportions (Z-Scores) were done to determine if the observed total proportion of caregivers with a substance abuse history for verified, not substantiated, and no indicators for maltreatment cases differed significantly (at $p<.05$, two-tailed test). The observed proportion differences between verified and no indicators (Z-Score=3.64, $p<.01$) and not substantiated and no indicators for maltreatment (Z-Score=3.56, $p<.01$) deaths were statistically significant.

Table G-24: Substance Abuse History of All Identified Caregivers of Children by Maltreatment Verification Status and Primary Cause of Death												
Substance Abuse History	Child Maltreatment Death											
	Verified n=101				Not Substantiated n=90				No Indicators n=293			
	Drowning n=35	Asphyxia n=12	Weapon n=24	Other n=30	Drowning n=15	Asphyxia n=42	Weapon n=4	Other n=29	Drowning n=61	Asphyxia n=110	Weapon n=14	Other n=108
Yes	31%	58%	42%	70%	13%	64%	25%	48%	13%	42%	21%	25%
No	57%	25%	29%	27%	87%	31%	25%	28%	70%	49%	64%	56%
Unknown	11%	17%	29%	3%	0%	5%	50%	24%	16%	9%	14%	19%
Type of Substance	**If Yes, Verified Child Maltreatment (n= 50)**				**If Yes, Not Substantiated as Child Maltreatment (n=44)**				**If Yes, No Indicators that Child Maltreatment (n=83)**			
	Drowning n=11	Asphyxia n=7	Weapon n=10	Other n=21	Drowning n=2	Asphyxia n=27	Weapon n=1	Other n=14	Drowning n=8	Asphyxia n=46	Weapon n=3	Other n=27
Alcohol	45%	43%	20%	29%	50%	33%	0%	29%	38%	22%	67%	44%
Cocaine	27%	29%	30%	48%	0%	22%	100%	50%	13%	17%	0%	0%
Marijuana	64%	71%	70%	71%	100%	89%	100%	100%	88%	76%	100%	81%
Methamphetamine	18%	29%	0%	14%	0%	7%	0%	7%	0%	11%	0%	4%
Opiates	18%	0%	0%	38%	0%	15%	0%	29%	0%	4%	33%	0%
Prescription	18%	0%	30%	10%	50%	11%	0%	29%	0%	13%	0%	4%
Over-the-Counter Drugs	0%	0%	0%	5%	0%	0%	0%	0%	0%	0%	0%	0%
Other	9%	14%	20%	14%	50%	4%	0%	43%	13%	4%	0%	11%
Unknown	0%	0%	20%	5%	0%	0%	0%	0%	0%	2%	0%	4%

Figure G-11: Substance Abuse History of All Caregivers by Maltreatment Verification Status (N=484)

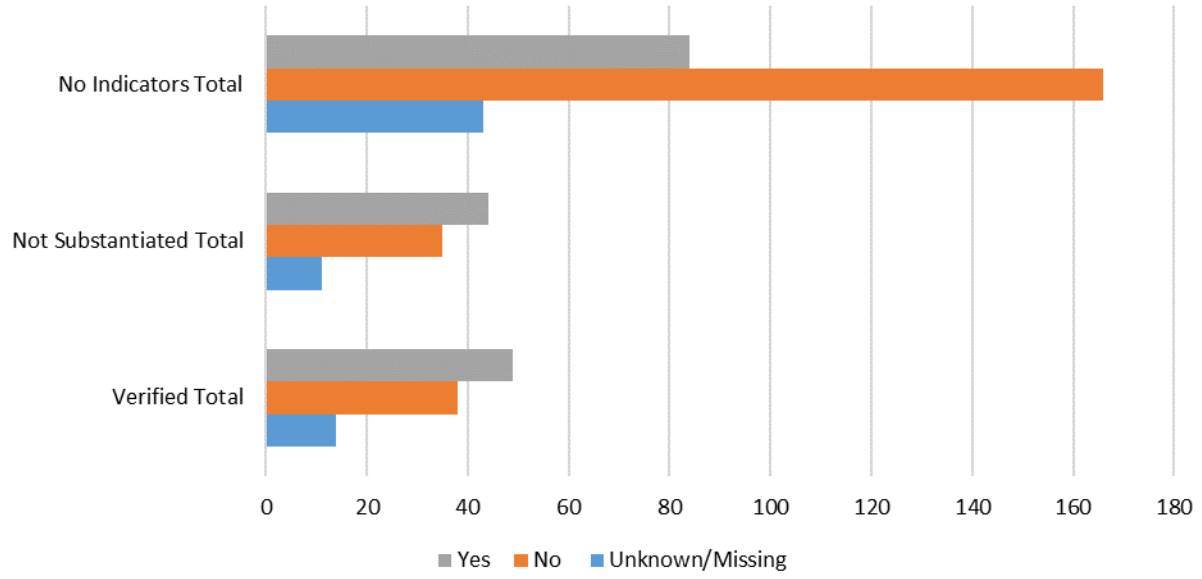
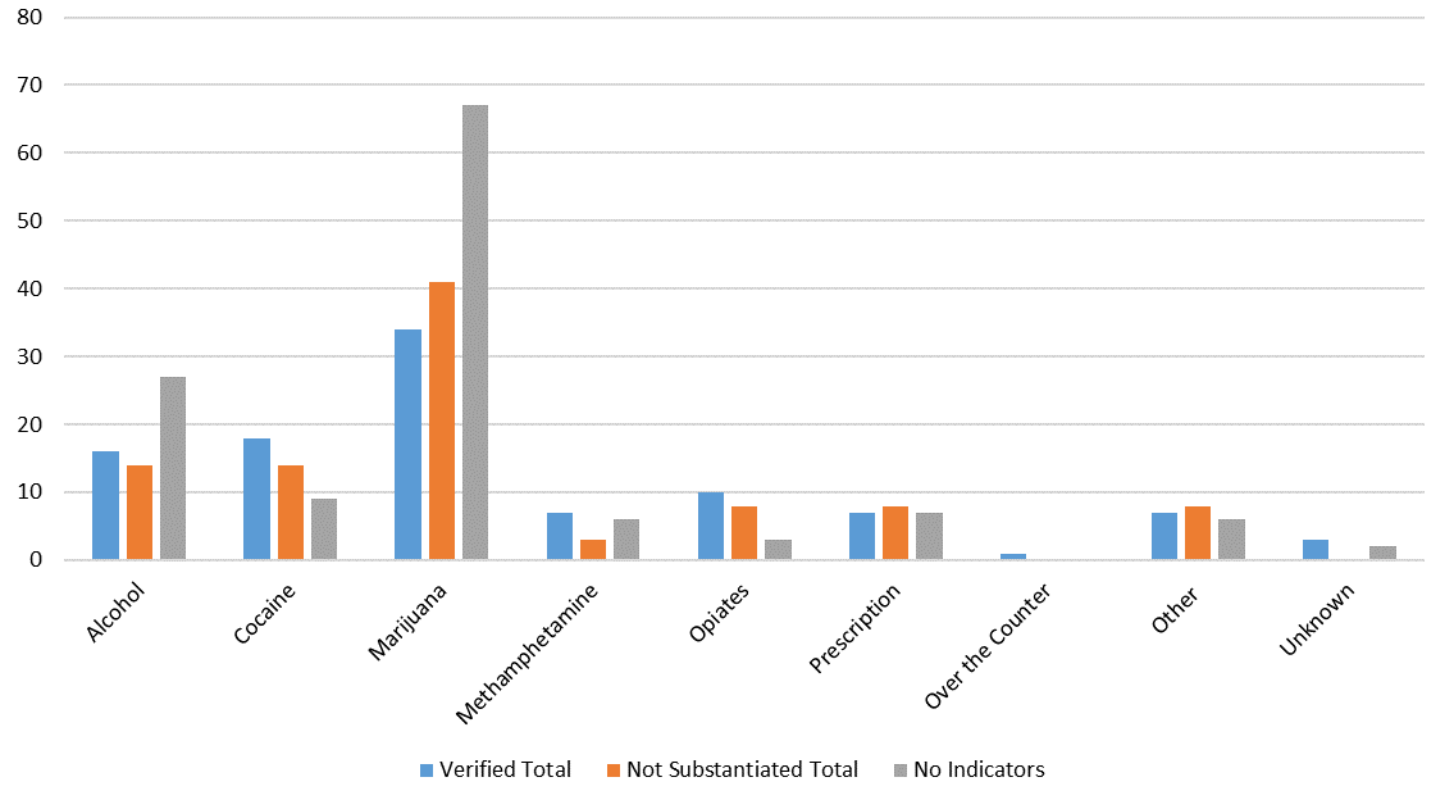


Figure G-12: Type of Substance Used by All Caregivers (with Substance Abuse History) by Maltreatment Verification Status (N=177)



When types of substances are examined (see Table G-24 and Figure G-11) for those with a substance abuse history, most of all caregivers of children whose deaths were verified as maltreatment had a history of marijuana use (from a low of 64% for drowning causes to high of 71% for other deaths). Similarly, high percentages of caregiver use of marijuana are observed for all primary causes of death for not substantiated and no indicators of maltreatment deaths; from a low of 76% for no indicator asphyxia to a high of 100% for not substantiated weapons and other deaths, as well as, no indicator weapons deaths. When the substance abuse history of supervisors of children at the time of the child's death is examined (see Table G-25), 27 of 58 (46.6%), 24 of 43 (55.8%) and 40 of 154 (26.0%) of supervisors in verified, not substantiated, and no indicators of maltreatment deaths (respectively) were known to have a substance abuse history.[3] This suggests that the likelihood of a substance abuse history among supervisors at the time of verified and not substantiated maltreatment deaths are similar.

[3] A series of tests of significance between independent proportions (Z-Score) were done to determine if the observed total proportion of supervisors with a substance abuse history for verified, not substantiated, and no indicators for maltreatment cases differed significantly (at $p<.05$, two-tailed test). The observed proportion differences between verified and no indicators (Z-Score=2.87, $p=.011$) and not substantiated and no indicators for maltreatment (Z-Score=3.69, $p<.01$) deaths were statistically significant.

Table G-25: Substance Abuse History of Supervisors of Children at Time of Death by Maltreatment Verification Status and Primary Cause of Death												
Drug Abuse Supervisor	Child Maltreatment Death											
	Verified n=58				Not Substantiated n=43				No Indicators n=154			
	Drowning n=21	Asphyxia n=7	Weapon n=12	Other n=18	Drowning n=8	Asphyxia n=20	Weapon n=2	Other n=13	Drowning n=30	Asphyxia n=60	Weapon n=2	Other n=62
Yes	33%	57%	42%	61%	38%	70%	50%	46%	13%	40%	50%	18%
No	62%	29%	25%	39%	63%	30%	50%	31%	73%	52%	50%	60%
Unknown	5%	14%	33%	0%	0%	0%	0%	23%	13%	8%	0%	23%
Type of Substance	**If Yes, Verified Child Maltreatment (n=27)**				**If Yes, Not Substantiated as Child Maltreatment (n=24)**				**If Yes, No Indicators that Child Maltreatment (n=40)**			
	Drowning n=7	Asphyxia n=4	Weapon n=5	Other n=11	Drowning n=3	Asphyxia n=14	Weapon n=1	Other n=6	Drowning n=4	Asphyxia n=24	Weapon n=1	Other n=11
Alcohol	29%	50%	20%	45%	33%	29%	0%	17%	25%	29%	0%	36%
Cocaine	14%	25%	40%	55%	0%	14%	100%	0%	0%	21%	0%	0%
Marijuana	71%	75%	80%	64%	67%	86%	100%	83%	100%	83%	100%	91%
Methamphetamine	29%	25%	0%	18%	0%	7%	0%	0%	0%	13%	0%	0%
Opiates	43%	0%	0%	27%	0%	7%	0%	17%	0%	8%	0%	0%
Prescription	29%	0%	20%	9%	33%	14%	0%	33%	0%	13%	0%	9%
Over-the-Counter Drugs	0%	0%	0%	9%	0%	0%	0%	0%	0%	0%	0%	0%
Other	14%	25%	20%	9%	67%	0%	0%	67%	0%	4%	0%	9%
Unknown	0%	0%	20%	9%	0%	0%	0%	17%	0%	0%	0%	0%

When types of substances are examined, the clear majority of all supervisors of children whose death was verified as maltreatment used marijuana (from a low of 64% for other deaths to high of 80% for weapon deaths). As with caregivers, similarly high percentages of supervisor use of marijuana are observed for all primary causes of death for not substantiated and no indicators of maltreatment deaths; from a low of 67% for not substantiated drowning deaths to a high of 100% for not substantiated weapons deaths, as well as, no indicator drowning and weapons deaths. A note is made of other substances supervisors of verified maltreatment deaths used. Among those supervisors with a substance abuse history, 43% of supervisors associated with drowning deaths used opiates and 29% reportedly had substance abuse issues associated with alcohol and prescription drugs. 50% of supervisors associated with asphyxia deaths had substance abuse issues with alcohol; 40% of supervisors associated with weapons deaths had substance abuse issues with cocaine; and, supervisors of other verified deaths (with a substance abuse history) used alcohol (45%), cocaine (55%), and opiates (27%).

Table G-26 summarizes information related to substance abuse history of all person(s) deemed responsible (caused and contributed) for the child's death. Findings from Table G-26 and Figures G13 and G-14 reveal that among the person(s) responsible for the child's death whose death was verified as child maltreatment, 35 of 68 (51.5%) are known to have a substance abuse history. Substance abuse was identified to be present among 63% of those person(s) responsible for asphyxia deaths, 47% of weapon deaths, 68% of "other" causes of death, and 35% of drowning deaths verified as maltreatment. When types of substances are examined, the clear majority of those responsible for the child's death verified as maltreatment used marijuana from a low of 60% for asphyxia deaths to high of 88% of drowning deaths. The majority (60%) of all person(s) responsible for a child's death whose death was classified as other primary cause had an identified history of cocaine use. In addition, alcohol (33%) and opiate (40%) use was evident with persons responsible for other verified maltreatment deaths. Further, the majority (60%) of all person(s) responsible for a child's death whose death was classified as asphyxia had an identified history of alcohol abuse. In at least one quarter of the drowning deaths, the person(s) responsible for the death also abused alcohol (38%), methamphetamines (38%), opiates (50%), and prescription drugs (25%).

Table G-26: Substance Abuse History of All Person(s) Responsible for Child's Death by Maltreatment Verification Status and Primary Cause of Death				
All Person(s) Responsible	Verified Child Maltreatment Death n=68			
	Drowning n=23	Asphyxia n=8	Weapon n=15	Other n=22
Yes	8	5	7	15
No	14	2	4	7
Unknown	1	1	4	0
Type of Substance	**If Yes, Verified Child Maltreatment Deaths (n=35)**			
	Drowning n=8	Asphyxia n=5	Weapon n=7	Other n=15
Alcohol	3	3	1	5
Cocaine	1	1	3	9
Marijuana	7	3	6	10
Methamphetamine	3	2	0	3
Opiates	4	0	0	6
Prescription	2	0	3	2
Over-the-Counter Drugs	0	0	0	1
Other	1	1	2	4
Unknown	0	0	1	0

Figure G-13: Substance Abuse History of All Persons Responsible for Verified Maltreatment Deaths by Primary Cause of Death (n=68)

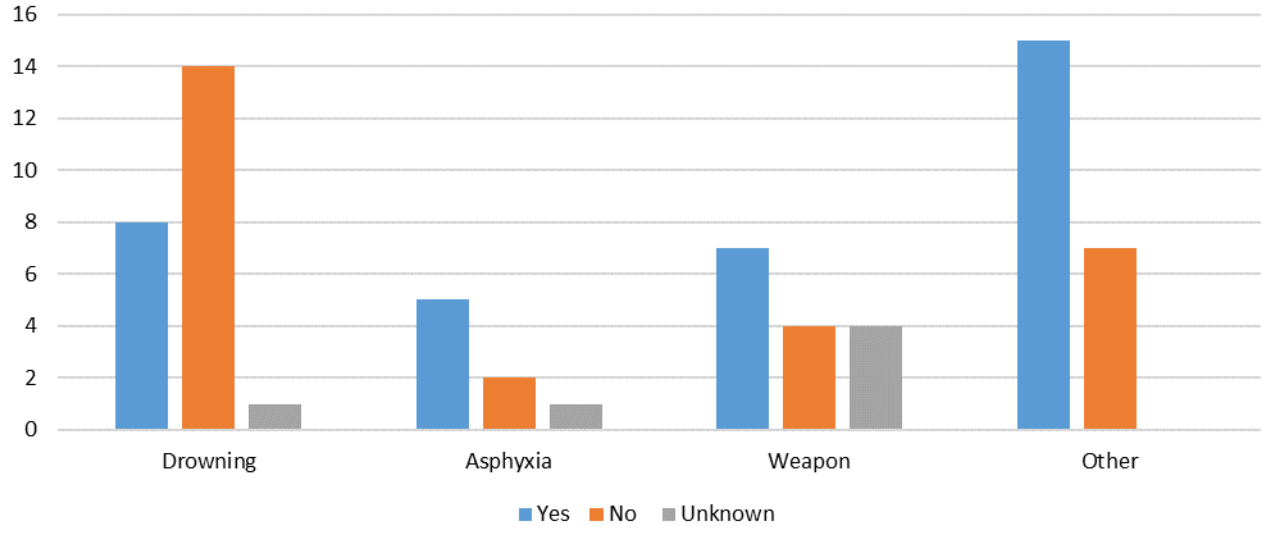
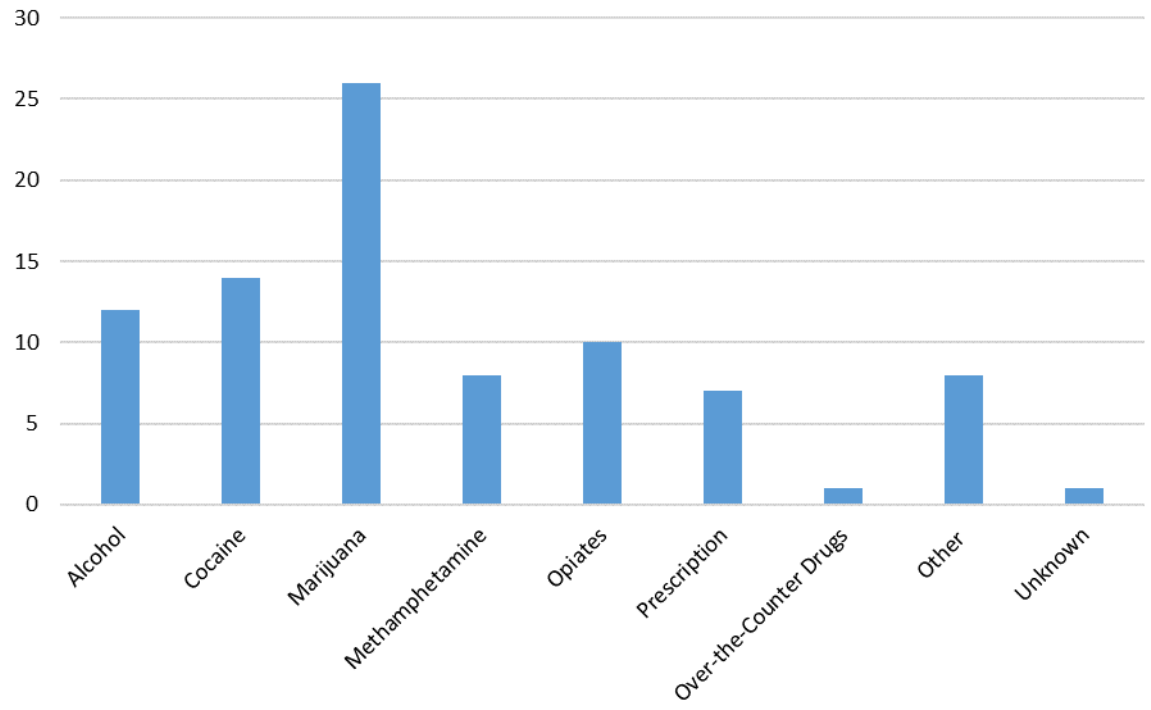


Figure G-14: Type of Substance Used by All Persons Responsible for Verified Maltreatment Death with Substance Abuse History (n=35)



Disability or Chronic Illness Occurrence among Caregivers, Supervisors and Person(s) Responsible for Death

Tables G-27 through G-29 highlight the distribution of caregivers, supervisors and person(s) responsible known to have an identified disability or chronic illness. Among all caregivers in deaths verified to have resulted from maltreatment, 21 of 105 (20.0%) were known to have an identified disability or chronic illness of which the predominant disability was associated with mental illness; from low of 4 of 5 (80.0%) caregivers associated with verified weapon deaths to a high of 100% of caregivers associated with drowning (5 of 5) and asphyxia (4 of 4) deaths. The percentage of caregivers of verified maltreatment deaths with an identified disability or chronic illness mirrors the observed rate of caregivers among not substantiated maltreatment deaths (17 of 88 or 19.3%); both of which are significantly larger than the 9.3% of caregivers associated with no indicators of maltreatment deaths (27 of 291).[4]

[4] A series of tests of significance between independent proportions (Z-Scores) were done to determine if the observed total proportion of caregivers with a disability or chronic illness for verified, not substantiated, and no indicators for maltreatment cases differed significantly (at $p<.05$, two-tailed test). The observed proportion differences between verified and no indicators (Z-Score=2.89, $p<.01$) and not substantiated and no indicators for maltreatment (Z-Score=2.58, $p<.01$) deaths were statistically significant.

Table G-27: Presence of Disability or Chronic Illness for All Caregivers by Maltreatment Verification Status and Primary Cause of Death												
Disability All Caregivers	Child Maltreatment Death											
	Verified n=105				Not Substantiated n=88				No Indicators n=291			
	Drowning n=37	Asphyxia n=13	Weapon n=25	Other n=30	Drowning n=15	Asphyxia n=39	Weapon n=4	Other n=30	Drowning n=61	Asphyxia n=112	Weapon n=14	Other n=104
Yes	14%	31%	20%	23%	7%	18%	0%	30%	7%	10%	7%	11%
No	68%	54%	68%	70%	87%	77%	50%	43%	67%	79%	93%	78%
Unknown	19%	15%	12%	7%	7%	5%	50%	27%	26%	12%	0%	12%
Type of Disability	**If Yes, Verified Child Maltreatment (n=21)**				**If Yes, Not Substantiated as Child Maltreatment (n=17)**				**If Yes, No Indicators that Child Maltreatment (n=27)**			
	Drowning n=5	Asphyxia n=4	Weapon n=5	Other n=7	Drowning n=1	Asphyxia n=7	Weapon n=0	Other n=9	Drowning n=4	Asphyxia n=11	Weapon n=1	Other n=11
Physical	0%	0%	40%	29%	0%	14%	0%	44%	50%	27%	100%	27%
Mental	100%	100%	80%	100%	100%	57%	0%	56%	75%	73%	0%	73%
Sensory	0%	0%	0%	0%	0%	14%	0%	0%	0%	0%	0%	9%
Unknown	0%	0%	0%	0%	0%	14%	0%	0%	0%	0%	0%	0%

When findings from Table G-28 are examined, 12 of 59 (20.3%) supervisors of children whose death was verified to result from maltreatment were identified as having a disability or chronic illness. This rate was similar to that observed with supervisors of not substantiated maltreatment deaths (10 of 42 or 23.8%) which was a statistically higher rate than the 18 of 153 (11.8%) of supervisors whose child related deaths showed no indicators of maltreatment.[5]

Table G-28: Presence of Disability or Chronic Illness for Supervisors by Maltreatment Verification Status and Primary Cause of Death												
Disability or Chronic Illness?	Child Maltreatment Death											
	Verified n=59				Not Substantiated n=42				No Indicators n=153			
	Drowning n=21	Asphyxia n=8	Weapon n=13	Other n=17	Drowning n=8	Asphyxia n=19	Weapon n=2	Other n=13	Drowning n=30	Asphyxia n=61	Weapon n=2	Other n=60
Yes	14%	25%	23%	24%	25%	26%	0%	23%	10%	13%	0%	12%
No	81%	63%	62%	71%	75%	68%	100%	46%	63%	77%	100%	77%
Unknown	5%	13%	15%	6%	0%	5%	0%	31%	27%	10%	0%	12%
Type of Disability	**If Yes, Verified Child Maltreatment (n=12)**				**If Yes, Not Substantiated as Child Maltreatment (n=10)**				**If Yes, No Indicators that Child Maltreatment (n=18)**			
	Drowning n=3	Asphyxia n=2	Weapon n=3	Other n=4	Drowning n=2	Asphyxia n=5	Weapon n=0	Other n=3	Drowning n=3	Asphyxia n=8	Weapon n=0	Other n=7
Physical	0%	0%	33%	25%	0%	20%	0%	33%	100%	25%	0%	29%
Mental	100%	100%	67%	100%	100%	60%	0%	67%	33%	75%	0%	71%
Sensory	0%	0%	0%	0%	0%	20%	0%	0%	0%	0%	0%	14%
Unknown	100%	100%	100%	100%	100%	100%	0%	100%	100%	100%	0%	100%

Table G-29 summarizes information related to the presence of a disability or chronic illness history of all person(s) deemed responsible (caused and contributed) for the child's death. Among person(s) responsible for a child's death, 14 of 69 (20.3%) were identified to have a disability or chronic illness. Again, where chronic disability or illness was

[5] A test of significance between two independent proportions (Z-Score) was done to determine if the observed total proportion of supervisors with an identified disability or chronic illness for verified and no indicators of maltreatment deaths differed significantly (Z-Score=1.61, NS p=0.11, two-tailed test). The observed proportion differences between not substantiated and no indicator child maltreatment deaths WAS statistically significant (Z-Score=1.97, p=.031).

present, the prevalence of mental health issues was prominent; identified for 100% of all persons responsible across all primary causes of death.

Table G-29: Presence of Disability or Chronic Illness for Person(s) Responsible for Verified Maltreatment Death by Maltreatment Verification Status and Primary Cause of Death				
Disability or Chronic Illness?	Verified Child Maltreatment Death n=69			
	Drowning n=24	Asphyxia n=9	Weapon n=15	Other n=21
Yes	17%	33%	13%	24%
No	75%	56%	73%	67%
Unknown	8%	11%	13%	10%
Type of Disability	**If Yes, Person(s) Responsible Verified Child Maltreatment (n=14)**			
	Drowning n=4	Asphyxia n=3	Weapon n=2	Other n=5
Physical	0%	0%	0%	40%
Mental	100%	100%	100%	100%
Sensory	0%	0%	0%	0%
Unknown	0%	0%	0%	0%

Employment Status of Caregivers

Employment status was examined for all identified caregivers. Tables G-30 through G-32 provide information on the distribution of the caregiver employment status. Table G-30 aggregates all caregivers (whether identified as the first or second primary caregiver), whereas Tables G-31 and G-32 breakdown the distribution of caregiver employment status as the first or second listed primary caregiver.

Table G-30: Employment Status of All Identified Caregivers by Maltreatment Verification Status and Primary Cause of Death												
Employment All Caregivers	Child Maltreatment Death											
	Verified n=107				Not Substantiated n=90				No Indicators n=299			
	Drowning n=37	Asphyxia n=13	Weapon n=23	Other n=34	Drowning n=15	Asphyxia n=41	Weapon n=4	Other n=30	Drowning n=62	Asphyxia n=115	Weapon n=14	Other n=108
Employed	51%	31%	48%	53%	67%	44%	25%	27%	55%	60%	79%	56%
Unemployed	32%	54%	30%	41%	7%	37%	75%	47%	16%	20%	7%	24%
On Disability	3%	0%	0%	0%	0%	2%	0%	10%	2%	2%	0%	3%
Stay-at-Home Caregiver	5%	0%	17%	3%	27%	5%	0%	3%	16%	10%	0%	10%
Retired	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
Unknown	8%	15%	4%	3%	0%	12%	0%	13%	11%	8%	14%	6%

Table G-31: Employment Status of Primary (First) Caregiver Identified by Maltreatment Verification Status and Primary Cause of Death												
Employment (Caregiver 1)	Child Maltreatment Death											
	Verified n=65				Not Substantiated n=49				No Indicators n=168			
	Drowning n=22	Asphyxia n=8	Weapon n=11	Other n=24	Drowning n=8	Asphyxia n=21	Weapon n=2	Other n=18	Drowning n=33	Asphyxia n=65	Weapon n=7	Other n=63
Employed	41%	38%	45%	38%	63%	24%	50%	22%	36%	45%	71%	43%
Unemployed	41%	63%	18%	54%	0%	52%	50%	56%	18%	29%	14%	32%
On Disability	0%	0%	0%	0%	0%	0%	0%	11%	0%	3%	0%	3%
Stay-at-Home Caregiver	9%	0%	36%	4%	38%	10%	0%	0%	30%	17%	0%	17%
Retired	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
Unknown	9%	0%	0%	4%	0%	14%	0%	11%	15%	6%	14%	5%

Table G-32: Employment Status of Second Caregiver Identified by Maltreatment Verification Status and Primary Cause of Death												
Employment (Caregiver2)	Child Maltreatment Death											
	Verified n=42				Not Substantiated n=41				No Indicators n=131			
	Drowning n=15	Asphyxia n=5	Weapon n=12	Other n=10	Drowning n=7	Asphyxia n=20	Weapon n=2	Other n=12	Drowning n=29	Asphyxia n=50	Weapon n=7	Other n=45
Employed	67%	20%	50%	90%	71%	65%	0%	33%	76%	80%	86%	76%
Unemployed	20%	40%	42%	10%	14%	20%	100%	33%	14%	8%	0%	13%
On Disability	7%	0%	0%	0%	0%	5%	0%	8%	3%	0%	0%	2%
Stay-at-Home Caregiver	0%	0%	0%	0%	14%	0%	0%	8%	0%	2%	0%	0%
Retired	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
Unknown	7%	40%	8%	0%	0%	10%	0%	17%	7%	10%	14%	9%

Education Level of Caregivers

Information on the education level of the caregivers was either unknown or not available for many, if not all, of the caregivers across maltreatment verification and primary cause of death categories (Table G-33). Where caregiver education level was documented, high school or less than high school education was the most frequently reported. Given these findings, it is suggested that continued efforts be made in future reviews to explore data sources that can provide this information so that more representative conclusions can be made.

Table G-33: Education Level of All Identified Caregivers by Maltreatment Verification Status and Primary Cause of Death												
Education - All Caregivers	Child Maltreatment Death											
	Verified n=103				Not Substantiated n=89				No Indicators n=288			
	Drowning n=37	Asphyxia n=13	Weapon n=23	Other n=30	Drowning n=15	Asphyxia n=41	Weapon n=4	Other n=29	Drowning n=60	Asphyxia n=112	Weapon n=14	Other n=102
Less than High School	22%	23%	9%	20%	13%	20%	50%	21%	8%	21%	14%	18%
High School	27%	15%	17%	37%	33%	49%	0%	21%	18%	37%	29%	30%
College	19%	0%	22%	10%	7%	2%	0%	3%	27%	8%	7%	13%
Post Graduate	0%	0%	0%	0%	0%	0%	0%	0%	0%	1%	0%	0%
Unknown	32%	62%	52%	33%	47%	29%	50%	55%	47%	33%	50%	39%

English Spoken by Caregivers, Supervisors, and Person(s) Responsible for Death

As can be observed from information detailed in Tables G-34 through G-36, most caregivers, supervisors, and person(s) responsible for deaths speak English.

Table G-34: English Speaking by All Identified Caregivers by Maltreatment Verification Status and Primary Cause of Death												
Can Caregiver Speak English- All Caregivers	Child Maltreatment Death											
	Verified n=110				Not Substantiated n=91				No Indicators n=293			
	Drowning n=37	Asphyxia n=13	Weapon n=26	Other n=34	Drowning n=14	Asphyxia n=41	Weapon n=4	Other n=32	Drowning n=58	Asphyxia n=113	Weapon n=14	Other n=108
Yes	100%	85%	100%	94%	79%	95%	100%	97%	90%	96%	100%	81%
No	0%	0%	0%	0%	21%	0%	0%	0%	5%	2%	0%	12%
Unknown	0%	15%	0%	6%	0%	5%	0%	3%	5%	2%	0%	7%

Table G-35: English Speaking Ability All Identified Supervisors by Maltreatment Verification Status and Primary Cause of Death												
Can Supervisor Speak English	Child Maltreatment Death											
	Verified n=62				Not Substantiated n=43				No Indicators n=155			
	Drowning n=21	Asphyxia n=8	Weapon n=13	Other n=20	Drowning n=7	Asphyxia n=20	Weapon n=2	Other n=14	Drowning n=29	Asphyxia n=62	Weapon n=2	Other n=62
Yes	100%	88%	100%	95%	71%	95%	100%	100%	93%	95%	100%	82%
No	0%	0%	0%	0%	29%	0%	0%	0%	3%	3%	0%	13%
Unknown	0%	13%	0%	5%	0%	5%	0%	0%	3%	2%	0%	5%

Table G-36: English Speaking Ability All Identified Person(s) Responsible for Verified Maltreatment Death by Primary Cause of Death				
All Person(s) Responsible English	Verified Child Maltreatment Death n=72			
	Drowning n=24	Asphyxia n=9	Weapon n=15	Other n=24
Yes	100%	89%	100%	96%
No	0%	0%	0%	0%
Unknown	0%	11%	0%	4%

Active Duty Military Status of Caregivers, Supervisors and Person(s) Responsible for Death

One of the core data elements the statewide committee requested to be reported on by the local committees was whether any caregivers, supervisors, and person(s) responsible for the death of a child were on active duty military. Among all caregivers, there was only one caregiver (identified as the second caregiver) who was on active duty military where the child fatality was classified as no indicators for maltreatment drowning death. Among supervisors of children at the time of the death and persons responsible for a child's death, no person was identified as someone on active duty military.

Caregiver Receipt of Social Services in the Past Twelve Months

Local committees were asked to identify from available sources of information the extent to which caregivers had received social services in the twelve months prior to the child's death. Examination of this information is not meant to stigmatize anyone receiving social services. Rather, it can be a potential indicator of environmental stressors and may help identify possible venues for outreach involving future prevention initiatives. Table G-37 summarizes information related to social services received among all caregivers (aggregate) identified and reported on for this data element. Please note (as with all measures of combined/aggregate caregivers) that the number of caregivers denoted in Table G-37 exceeds the number of child fatalities as many children had two identified caregivers. Table G-37 first identifies the number of caregivers (associated with verified maltreatment deaths and non-verified) that received social services and then further identifies the specific type of support services received. Please note that with respect to the type of support received, the column percentages (which relate to the total caregivers associated with each primary cause of death) may exceed 100% as caregivers may receive more than one type of service/support over the course of twelve months.

Table G-37: Receipt of Social Services by All Identified Caregivers of Children by Maltreatment Verification Status and Primary Cause of Death

Receipt of Social Services	Child Maltreatment Death											
	Verified n=100				Not Substantiated n=85				No Indicators n=274			
	Drowning n=34	Asphyxia n=13	Weapon n=23	Other n=30	Drowning n=14	Asphyxia n=38	Weapon n=4	Other n=29	Drowning n=56	Asphyxia n=102	Weapon n=14	Other n=102
Yes	29%	46%	22%	37%	21%	39%	50%	41%	13%	41%	7%	33%
No	35%	15%	26%	10%	7%	24%	50%	17%	43%	28%	29%	32%
Unknown	35%	38%	52%	53%	71%	37%	0%	41%	45%	30%	64%	34%
Type of Support	**If Yes, Verified Child Maltreatment (n=32)**				**If Yes, Not Substantiated as Child Maltreatment (n=32)**				**If Yes, No Indicators that Child Maltreatment (n=84)**			
	Drowning n=10	Asphyxia n=6	Weapon n=5	Other n=11	Drowning n=3	Asphyxia n=15	Weapon n=2	Other n=12	Drowning n=7	Asphyxia n=42	Weapon n=1	Other n=34
WIC	30%	33%	60%	36%	67%	47%	100%	42%	14%	83%	0%	47%
TANF	10%	17%	40%	18%	0%	7%	0%	8%	0%	21%	0%	6%
Medicaid	80%	100%	100%	64%	100%	53%	0%	58%	71%	76%	0%	76%
Food Stamps	60%	50%	60%	91%	67%	73%	50%	58%	71%	43%	0%	35%
Other	20%	0%	20%	18%	0%	20%	0%	8%	0%	12%	0%	12%
Unknown	10%	0%	0%	0%	0%	0%	0%	8%	0%	0%	100%	3%

It is important to note that there were several caregivers across each primary cause of death for which receipt status of social services could not be identified (see first listed "unknown" row category in Table G-37). Regardless, findings from Table G-37 reveal that among the caregivers of children whose death was verified as child maltreatment, 32 of 100 (32.0%) are known to have received some form of social service support in the twelve months prior to the child's death. This rate was not significantly higher than the 32 of 85 (37.6%) of caregivers of children whose death was not substantiated and the 84 of 274 (30.7%) whose death showed no indicators of child maltreatment.

When types of services received are examined across primary cause of the child's death, the majority of caregivers (that received some type of support) of children whose deaths were verified as maltreatment received Medicaid (from a low of 64% for "other" causes to high of 100% for weapon and asphyxia deaths).

Past History as Victim of Child Maltreatment among Caregivers, Supervisors and Person(s) Responsible

Local committees were asked to identify from available sources of information whether caregivers, supervisors, and person(s) responsible for the death of a child were past victims of child maltreatment. Collectively, it was known that 28 of 103 (27.2%) of caregivers (Table G-38) of children of verified maltreatment deaths were past child victims of maltreatment. This figure may underestimate the true proportion of caregivers with a history of maltreatment as a child victim as this status was unknown for 24 of 100 (23.3%) of the total number of caregivers for children where the child's death was verified as maltreatment. The greatest proportion of caregivers (across cause of death categories) for which this history is unknown is for those children who died by asphyxia (31%), followed by those children who died from weapon related causes (28%).

There were no statistically significant differences in the percentage of caregivers associated with verified (27.2% or 28 of 103), not substantiated 21 of 87 (24.1%), and no indicator 61 of 288 (21.2%) maltreatment deaths in terms of their past history as a victim of child maltreatment. When past history as a victim of child maltreatment is examined for supervisors (Table G-39) associated with verified maltreatment deaths, it was known that 20 of 59 (33.9%) were past child victims of maltreatment, whereas 14 of 43 (32.6%) and 34 of 152 (22.4%) of supervisors of not substantiated and no indicators of maltreatment deaths had a past history as a victim of child maltreatment. Among those persons responsible for the child's death (Table G-40), 21 of 67 (31.3%) are known to be past child victims of maltreatment.

Table G-38: Past History as Victim of Child Maltreatment for All Caregivers by Maltreatment Verification Status and Primary Cause of Death

Cargiver Past Victim of Child Maltreatment	Child Maltreatment Death											
	Verified n=103				Not Substantiated n=87				No Indicators n=288			
	Drowning n=34	Asphyxia n=13	Weapon n=25	Other n=31	Drowning n=14	Asphyxia n=40	Weapon n=4	Other n=29	Drowning n=60	Asphyxia n=112	Weapon n=13	Other n=103
Yes	21%	23%	32%	32%	21%	28%	25%	21%	15%	31%	8%	16%
No	56%	46%	40%	52%	79%	60%	25%	52%	50%	61%	85%	61%
Unknown	24%	31%	28%	16%	0%	13%	50%	28%	35%	8%	8%	23%
Type of Maltreatment	**If Yes, Verified Child Maltreatment (n=28)**				**If Yes, Not Substantiated as Child Maltreatment (n=21)**				**If Yes, No Indicators that Child Maltreatment (n=61)**			
	Drowning n=7	Asphyxia n=3	Weapon n=8	Other n=10	Drowning n=3	Asphyxia n=11	Weapon n=1	Other n=6	Drowning n=9	Asphyxia n=33	Weapon n=1	Other n=15
Physical	43%	67%	38%	50%	50%	36%	0%	33%	0%	36%	100%	53%
Neglect	43%	67%	50%	50%	0%	55%	100%	50%	33%	52%	100%	40%
Sexual	43%	33%	38%	70%	25%	36%	0%	17%	33%	42%	0%	27%
Emotional/ Psychological	14%	67%	25%	30%	50%	9%	0%	33%	0%	27%	0%	27%
Unknown	0%	0%	0%	0%	0%	0%	0%	0%	22%	12%	0%	7%

Table G-39: Past History as Victim of Child Maltreatment for Supervisors by Maltreatment Verification Status and Primary Cause of Death												
Cargiver Past Victim of Child Maltreatment	Child Maltreatment Death											
	Verified n=59				Not Substantiated n=43				No Indicators n=152			
	Drowning n=19	Asphyxia n=8	Weapon n=13	Other n=19	Drowning n=8	Asphyxia n=20	Weapon n=2	Other n=13	Drowning n=30	Asphyxia n=60	Weapon n=2	Other n=60
Yes	32%	38%	38%	32%	38%	35%	50%	8%	20%	35%	50%	13%
No	58%	50%	31%	47%	50%	55%	50%	62%	43%	57%	50%	62%
Unknown	11%	13%	31%	21%	13%	10%	0%	31%	37%	8%	0%	25%
Type of Maltreatment	**If Yes, Verified Child Maltreatment Deaths (n=20)**				**If Yes, Not Substantiated as Child Maltreatment Deaths (n=14)**				**If Yes, No Indicators that Child Maltreatment Deaths (n=34)**			
	Drowning n=6	Asphyxia n=3	Weapon n=5	Other n=6	Drowning n=3	Asphyxia n=7	Weapon n=1	Other n=1	Drowning n=6	Asphyxia n=21	Weapon n=1	Other n=8
Physical	50%	67%	20%	67%	67%	43%	0%	0%	0%	33%	100%	50%
Neglect	50%	67%	20%	50%	0%	43%	100%	0%	50%	38%	100%	13%
Sexual	33%	33%	60%	83%	33%	43%	0%	0%	50%	38%	0%	38%
Emotional/ Psychological	17%	67%	0%	50%	67%	14%	0%	0%	0%	19%	0%	13%
Unknown	0%	0%	0%	0%	0%	0%	0%	0%	0%	10%	0%	13%

Table G-40: Past History as Victim of Child Maltreatment for Persons Responsible for Verified Maltreatment Death by Maltreatment Verification Status and Primary Cause of Death				
All Persons Responsible as Past Victim of Child Maltreatment	Verified Child Maltreatment Death n=67			
	Drowning n=21	Asphyxia n=9	Weapon n=15	Other n=22
Yes	33%	33%	40%	23%
No	57%	44%	40%	59%
Unknown	10%	22%	20%	18%
Type of Maltreatment	**If Yes, Persons Responsible Verified Child Maltreatment Death (n=21)**			
	Drowning n=7	Asphyxia n=3	Weapon n=6	Other n=5
Physical	43%	67%	50%	20%
Neglect	43%	67%	50%	40%
Sexual	43%	33%	33%	100%
Emotional/ Psychological	14%	67%	33%	40%
Unknown	0%	0%	0%	0%

Past History as Perpetrator of Child Maltreatment among Caregivers, Supervisors, and Person(s) Responsible for Death

Local committees were asked to identify from available sources and reports whether caregivers, supervisors, and person(s) responsible for a child's death have a past history as a perpetrator of child maltreatment. When the aggregate of caregivers is examined (Table G-41), 48 of 104 (46.2%) of caregivers of children whose death was verified to result from child maltreatment were identified as past perpetrators of child maltreatment. This rate is not significantly higher than the 33 of 85 (38.8%) of caregivers of not substantiated child maltreatment deaths with a perpetrator past. However, the percentage of caregivers of no indicator child maltreatment deaths with a perpetrator past (62 of 293 or 21.2%) is significantly lower than the rates observed with the other two maltreatment verification categories.[6]

Among identified verified maltreatment cases, the type of maltreatment the perpetrator inflicted on children in the past was most likely to be neglect, from a low of 38% of caregivers associated with weapons deaths to a high of 92% of caregivers associated with other deaths. Neglect was the most prevalent form of maltreatment observed among those caregivers with a perpetrator history associated with not substantiated and no indicator of maltreatment deaths.

Table G-41: Past History as Perpetrator of Child Maltreatment for All Caregivers by Maltreatment Verification Status and Primary Cause of Death

Caregiver Has History as Perpetrator	Child Maltreatment Death											
	Verified n=104				Not Substantiated n=85				No Indicators n=293			
	Drowning n=37	Asphyxia n=13	Weapon n=24	Other n=30	Drowning n=15	Asphyxia n=39	Weapon n=4	Other n=27	Drowning n=59	Asphyxia n=112	Weapon n=14	Other n=108
Yes	41%	54%	54%	43%	33%	26%	25%	63%	10%	23%	7%	27%
No	46%	46%	46%	47%	60%	67%	50%	30%	76%	74%	86%	60%
Unknown	14%	0%	0%	10%	7%	8%	25%	7%	14%	3%	7%	13%
Type of Maltreatment	**If Yes, Verified Child Maltreatment (n=48)**				**If Yes, Not Substantiated as Child Maltreatment (n=33)**				**If Yes, No Indicators that Child Maltreatment (n=62)**			
	Drowning n=15	Asphyxia n=7	Weapon n=13	Other n=13	Drowning n=5	Asphyxia n=10	Weapon n=1	Other n=17	Drowning n=6	Asphyxia n=26	Weapon n=1	Other n=29
Physical	27%	29%	31%	23%	40%	20%	0%	24%	83%	27%	100%	41%
Neglect	87%	86%	38%	92%	60%	70%	11%	71%	67%	77%	100%	76%
Sexual	7%	14%	0%	0%	0%	10%	0%	0%	0%	8%	0%	0%
Emotional/ Psychological	7%	29%	38%	15%	40%	10%	0%	12%	17%	31%	0%	10%
Unknown	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	3%

When the past history of supervisors as a perpetrator is examined (see Table G-42), 30 of 59 (50.8%) of supervisors of children whose death was verified to result from child maltreatment were identified as past perpetrators of child maltreatment (with neglect being most prominent). This observed rate is not significantly higher than the 18 of 42 (42.9%) of supervisors of not substantiated child maltreatment deaths with a perpetrator past. However, the percentage of supervisors of no indicator child maltreatment deaths with a perpetrator past (36 of 156 or 23.0%) is significantly lower than the rates observed with the other two maltreatment verification categories.[7]

[6] A series of tests of significance between independent proportions (Z-Scores) were done to determine if the observed total proportion of caregivers with a history as a perpetrator for verified, not substantiated, and no indicators for maltreatment cases differed significantly (at $p<.05$, two-tailed test). The observed proportion differences between verified and no indicators (Z-Score=4.89, $p<.01$) and not substantiated and no indicators for maltreatment (Z-Score=3.31, $p<.01$) deaths were statistically significant.

[7] A series of tests of significance between independent proportions (Z-Scores) were done to determine if the observed total proportion of supervisors with a history as a perpetrator for verified, not substantiated, and no indicators for maltreatment cases differed significantly (at $p<.05$, two-tailed test). The observed proportion

Table G-42: Past History as Perpetrator of Child Maltreatment for Supervisors by Maltreatment Verification Status and Primary Cause of Death												
Supervisor Has History as Perpetrator	Child Maltreatment Death											
	Verified n=59				Not Substantiated n=42				No Indicators n=156			
	Drowning n=21	Asphyxia n=8	Weapon n=12	Other n=18	Drowning n=7	Asphyxia n=20	Weapon n=2	Other n=13	Drowning n=29	Asphyxia n=62	Weapon n=2	Other n=63
Yes	43%	63%	50%	50%	38%	40%	0%	64%	11%	26%	0%	27%
No	48%	38%	50%	30%	38%	55%	100%	36%	71%	71%	100%	57%
Unknown	10%	0%	0%	10%	13%	5%	0%	18%	21%	3%	0%	16%
Type of Maltreatment	**If Yes, Verified Child Maltreatment (n=30)**				**If Yes, Not Substantiated as Child Maltreatment (n=18)**				**If Yes, No Indicators that Child Maltreatment (n=36)**			
	Drowning n=9	Asphyxia n=5	Weapon n=6	Other n=10	Drowning n=3	Asphyxia n=8	Weapon n=0	Other n=7	Drowning n=3	Asphyxia n=16	Weapon n=0	Other n=17
Physical	33%	40%	33%	30%	33%	25%	0%	0%	100%	31%	0%	35%
Neglect	78%	100%	17%	90%	67%	63%	0%	71%	33%	88%	0%	71%
Sexual	0%	0%	0%	0%	0%	13%	0%	0%	0%	13%	0%	0%
Emotional/ Psychological	22%	20%	33%	20%	33%	0%	0%	14%	0%	25%	0%	12%
Unknown	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	6%

Table G-43 summarizes information related to the history of child maltreatment for all persons deemed responsible (caused and contributed) for the verified maltreatment death of the child. Findings from Table G-43 reveal that among persons responsible for a child's death 35 of 69 (50.7%) were identified to have a history as a perpetrator of child maltreatment. Among these 35 individuals, 11 were affiliated with drowning deaths, 11 were affiliated with other deaths, 8 with weapon deaths, and 5 with asphyxia deaths. Again, across all causes of death, the type of maltreatment inflicted on children in the past was principally neglect, although physical and emotional abuse was also evident with 38% of perpetrators of verified weapon deaths.

Table G-43: Past History as Perpetrator of Child Maltreatment for Persons Responsible for Verified Maltreatment Death by Maltreatment Verification Status and Primary Cause of Death				
Person(s) Responsible Have History as Perpetrator	Verified Child Maltreatment Death n=69			
	Drowning n=24	Asphyxia n=9	Weapon n=14	Other n=22
Yes	46%	56%	57%	50%
No	50%	44%	43%	36%
Unknown	4%	0%	0%	14%
Type of Maltreatment	**If Yes, Persons Responsible Verified Child Maltreatment Death (n=35)**			
	Drowning n=11	Asphyxia n=5	Weapon n=8	Other n=11
Physical	36%	40%	38%	18%
Neglect	82%	100%	38%	100%
Sexual	0%	0%	0%	0%
Emotional/ Psychological	9%	20%	38%	36%
Unknown	0%	0%	0%	0%

differences between verified and no indicators (Z-Score=3.93, $p<.01$) and not substantiated and no indicators for maltreatment (Z-Score=2.55, $p<.05$) deaths were statistically significant.

History of Intimate Partner Violence (as Victim and Perpetrator) among Caregivers and Supervisors

Table G-44 highlights the distribution of caregivers' history with intimate partner violence as a victim and/or perpetrator. In total, 24 of 113 (21.2%) of caregivers were known to be victims and 17 of 113 (15.0%) were known to be perpetrators of intimate violence among those affiliated with verified maltreatment deaths. With respect to caregivers in not substantiated maltreatment deaths, 22 of 102 (21.6%) were past victims and 20 of 102 (19.6%) were past perpetrators of intimate partner violence. In contrast, 40 of 308 (13.0%) and 27 of 308 (8.8%) of caregivers in no indicators of maltreatment deaths have histories as victims and perpetrators (respectively) of intimate partner violence. Statistical tests suggest that the proportion of caregivers known to be victims of intimate violence among verified child maltreatment deaths (21.2%) and not substantiated (21.6%) maltreatment deaths were significantly higher than the 13.0% of caregivers associated with no indicators of maltreatment deaths. Similar differences were observed among groups as such related to the percentage of caregivers with a history as a perpetrator.[8]

Table G-44: History of Intimate Partner Violence with Caregivers by Maltreatment Verification Status and Primary Cause of Death

History of Intimate Partner Violence	Child Maltreatment Death											
	Verified n=113				Not Substantiated n=102				No Indicators n=308			
	Drowning n=40	Asphyxia n=13	Weapon n=27	Other n=33	Drowning n=15	Asphyxia n=49	Weapon n=4	Other n=34	Drowning n=63	Asphyxia n=119	Weapon n=14	Other n=112
Yes, as Victim	15%	31%	26%	21%	7%	22%	25%	26%	5%	12%	14%	19%
Yes, as Perpetrator	13%	15%	22%	12%	7%	24%	0%	21%	2%	8%	7%	14%
No	48%	31%	22%	39%	80%	39%	50%	29%	73%	68%	71%	55%
Unknown	25%	23%	30%	27%	7%	14%	25%	24%	21%	13%	7%	12%

[8] A series of tests of significance between independent proportions (Z-Scores) were done to determine if the observed total proportion of caregivers with a history as a perpetrator of IPV for verified, not substantiated, and no indicators for maltreatment cases differed significantly (at $p<.05$, two-tailed test). The observed proportion differences between verified and no indicators (Z-Score=2.09, $p<.05$) and not substantiated and no indicators for maltreatment (Z-Score=2.10, $p<.05$) deaths were statistically significant.

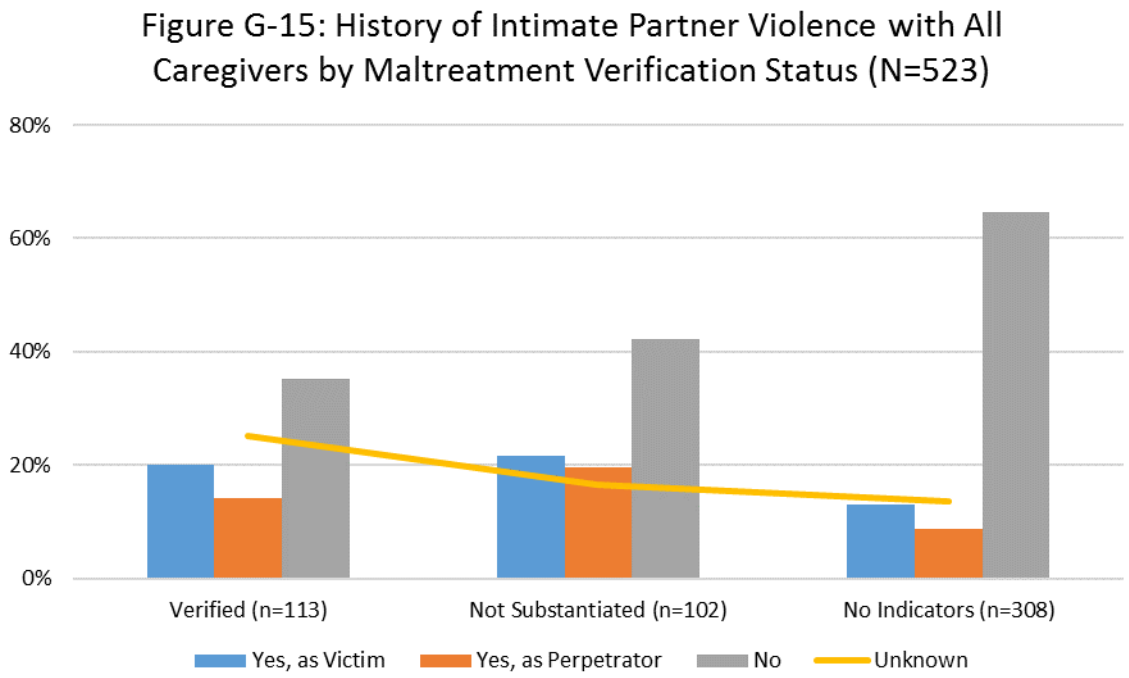


Table G-45 highlights the distribution of supervisors' history with intimate partner violence as a victim and/or perpetrator.

Table G-45: History of Intimate Partner Violence with Supervisors by Maltreatment Verification Status and Primary Cause of Death												
History of Intimate Partner Violence	Child Maltreatment Death											
	Verified n=68				Not Substantiated n=49				No Indicators n=161			
	Drowning n=24	Asphyxia n=8	Weapon n=15	Other n=21	Drowning n=8	Asphyxia n=24	Weapon n=2	Other n=15	Drowning n=30	Asphyxia n=64	Weapon n=2	Other n=65
Yes, as Victim	13%	50%	7%	33%	0%	25%	0%	27%	7%	17%	50%	22%
Yes, as Perpetrator	21%	0%	40%	10%	13%	25%	0%	7%	0%	3%	0%	6%
No	46%	25%	27%	38%	75%	38%	100%	40%	63%	67%	50%	57%
Unknown	21%	25%	27%	19%	13%	13%	0%	27%	30%	13%	0%	15%

Past Criminal History of Caregivers, Supervisors, and Person(s) Responsible for Death

When the criminal history of caregivers is examined (Table G-46), 41 of 108 (38.0%), 38 of 90 (42.2%), and 81 of 300 (27.0%) of caregivers associated with verified, not substantiated, and no indicators child maltreatment deaths (respectively) have a past criminal history.[9] When primary cause of maltreatment deaths is observed, the highest proportion of caregivers for verified maltreatment cases with a criminal past were those affiliated with asphyxia deaths (69%), followed by weapon deaths (42%). The types of offenses (for verified cases) that caregivers committed vary in proportional representation across primary cause of death. Among those with a criminal history, those with drug offenses were represented from a low of 33% for caregivers associated with verified asphyxia deaths to a high of 75%

[9] A series of tests of significance between independent proportions (Z-Scores) were done to determine if the observed total proportion of caregivers with a criminal history for verified, not substantiated, and no indicators for maltreatment cases differed significantly (at $p<.05$, two-tailed test). The observed proportion differences between verified and no indicators (Z-Score=2.13, $p<.05$) and not substantiated and no indicators for maltreatment (Z-Score=2.75, $p<.05$) deaths were statistically significant.

of those caregivers associated with other deaths. Please note that the column totals for the type of offense for across each category of primary cause of death may exceed 100% as individual caregivers may have more than one past criminal offense.

Table G-46: Past Criminal History of Caregivers by Maltreatment Verification Status and Primary Cause of Death												
Criminal History of Caregivers	Child Maltreatment Death											
	Verified n=108				Not Substantiated n=90				No Indicators n=300			
	Drowning n=37	Asphyxia n=13	Weapon n=24	Other n=34	Drowning n=15	Asphyxia n=42	Weapon n=4	Other n=29	Drowning n=62	Asphyxia n=116	Weapon n=14	Other n=108
Yes	27%	69%	42%	35%	27%	52%	25%	38%	18%	34%	7%	27%
No	57%	23%	46%	50%	67%	38%	25%	41%	73%	59%	93%	63%
Unknown	16%	8%	13%	15%	7%	10%	50%	21%	10%	7%	0%	10%
Type of Offense	**If Yes, Verified Child Maltreatment (n=41)**				**If Yes, Not Substantiated as Child Maltreatment (n=38)**				**If Yes, No Indicators that Child Maltreatment (n=81)**			
	Drowning n=10	Asphyxia n=9	Weapon n=10	Other n=12	Drowning n=4	Asphyxia n=22	Weapon n=1	Other n=11	Drowning n=11	Asphyxia n=40	Weapon n=1	Other n=29
Assaults	30%	22%	40%	33%	75%	41%	0%	18%	9%	15%	0%	38%
Robbery	20%	33%	30%	17%	25%	18%	0%	9%	9%	8%	0%	10%
Drugs	70%	33%	60%	75%	50%	50%	100%	55%	27%	48%	100%	52%
Other	50%	78%	90%	75%	75%	59%	0%	36%	45%	63%	100%	59%
Unknown	0%	0%	0%	8%	0%	0%	0%	18%	9%	3%	0%	3%

Figure G-16: Criminal Background History of All Caregivers (N=498)

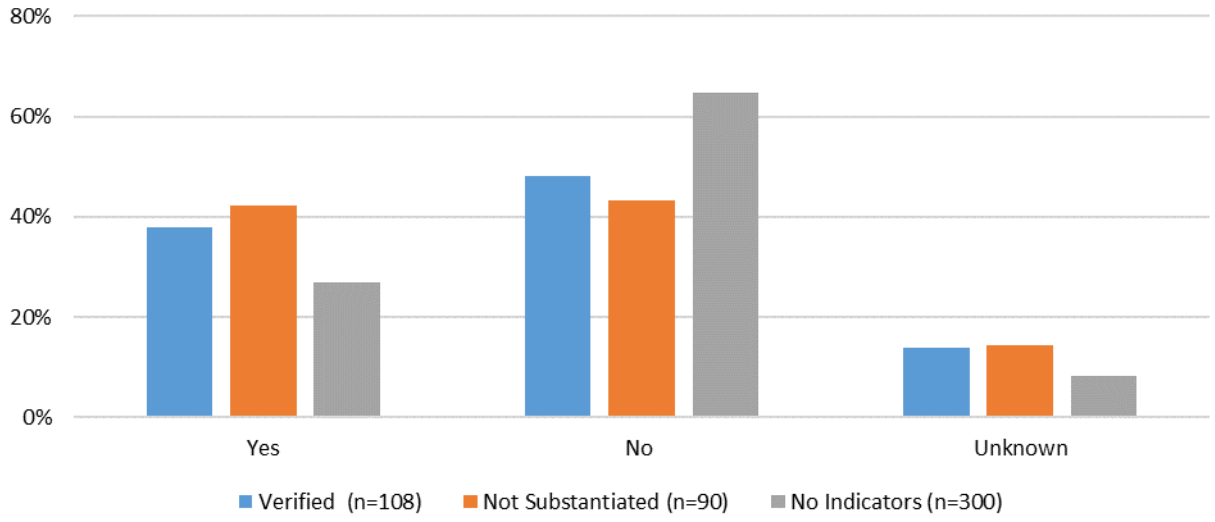
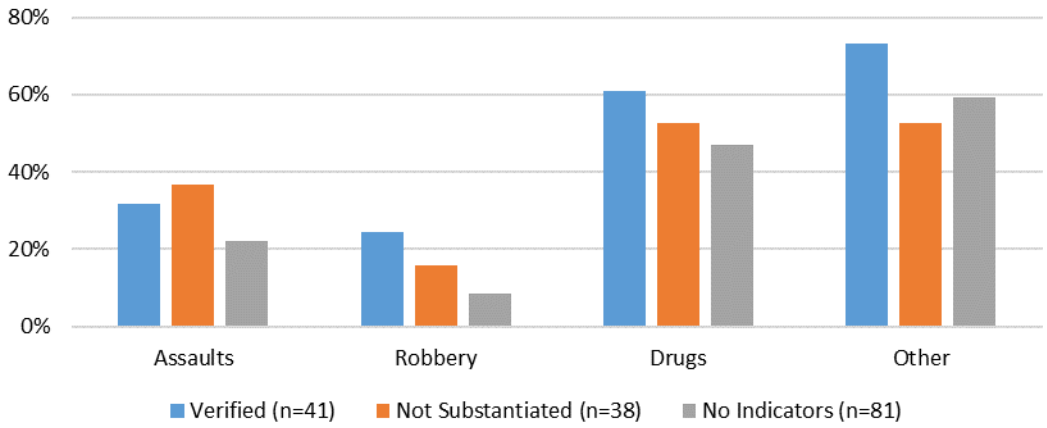


Figure G-17: Offense Type for Those Caregivers With Criminal Background (N=160)



When the criminal history of supervisors is examined (See Table G-47), 22 of 60 (36.7%), 19 of 44 (43.2%), and 37 of 157 (23.6%) of supervisors associated with verified, not substantiated, and no indicators child maltreatment deaths (respectively) have a past criminal history. Only the observed difference in percentage of supervisors with a criminal history for not substantiated and no indicators of maltreatment deaths were statistically significant.[10] When primary cause of maltreatment deaths is observed, the highest proportion of supervisors for verified maltreatment cases with a criminal past were those affiliated with asphyxia deaths (63%) and weapons (58%). The types of offenses (for verified cases) that supervisors committed vary in proportional representation across primary cause of death. Among those with a criminal history, those with drug offenses were represented from a low of 20% for supervisors associated with verified asphyxia to a high of 67% of those supervisors associated with other deaths. Please note that the column totals for the type of offense for each category of primary cause of death may exceed 100% as individual caregivers may have more than one past criminal offense.

[10] A test of significance between two independent proportions (Z-Score) determined that observed proportion differences of supervisors with a criminal history between not substantiated and no indicators of maltreatment deaths WAS statistically significant (Z-Score=2.57, p<.01).

Table G-47: Past Criminal History Associated with Supervisors by Maltreatment Verification Status and Primary Cause of Death												
Criminal History of Supervisors	Child Maltreatment Death											
	Verified n=60				Not Substantiated n=44				No Indicators n=157			
	Drowning n=20	Asphyxia n=8	Weapon n=12	Other n=20	Drowning n=8	Asphyxia n=21	Weapon n=2	Other n=13	Drowning n=30	Asphyxia n=63	Weapon n=2	Other n=62
Yes	20%	63%	58%	30%	38%	48%	50%	38%	23%	30%	0%	18%
No	70%	38%	33%	60%	63%	38%	50%	38%	67%	63%	100%	68%
Unknown	10%	0%	8%	10%	0%	14%	0%	23%	10%	6%	0%	15%
Type of Offense	**If Yes, Verified Child Maltreatment (n=22)**				**If Yes, Not Substantiated as Child Maltreatment (n=19)**				**If Yes, No Indicators that Child Maltreatment (n=37)**			
	Drowning n=4	Asphyxia n=5	Weapon n=7	Other n=6	Drowning n=3	Asphyxia n=10	Weapon n=1	Other n=5	Drowning n=7	Asphyxia n=19	Weapon n=0	Other n=11
Assaults	100%	0%	57%	17%	67%	40%	0%	20%	14%	16%	0%	27%
Robbery	25%	20%	43%	0%	33%	10%	0%	0%	14%	11%	0%	0%
Drugs	50%	20%	57%	67%	67%	40%	100%	20%	14%	53%	0%	45%
Other	50%	80%	86%	50%	67%	70%	0%	40%	57%	63%	0%	73%
Unknown	0%	0%	0%	17%	0%	0%	0%	20%	0%	0%	0%	0%

When the criminal history of person(s) responsible for maltreatment is examined (See Table G-48), 27 of 72 (38%) of person(s) responsible associated with verified child maltreatment deaths have a past criminal history. Focusing primarily on the cause of maltreatment deaths, the highest proportion of person(s) responsible for verified maltreatment cases with a criminal past were those affiliated with asphyxia deaths (67%), followed by weapons (53%), other (29%) and drowning (25%). Among those with a criminal history, those with drug offenses were represented from a low of 33% for person(s) associated with verified asphyxia to a high of 100% of those person(s) associated with other deaths. Drug offenses (67%) and offenses classified as “other” (74%) signify the largest percentage of offenses used to classify all person(s) responsible for verified child maltreatment (Figure G-19). However, please note that the “other” category may include duplicate counts of offenses that are already represented within the existing categories (ie Assaults, robbery, drugs, etc.) which may be attributed to respondent error. Also, the column totals for the type of offense for each category of primary cause of death may exceed 100% as individual person(s) responsible may have more than one past criminal offense.

Table G-48: Past Criminal History Associated with All Persons Responsible by Maltreatment Verification Status and Primary Cause of Death				
Criminal History All Persons Responsible	Verified Child Maltreatment Death n=72			
	Drowning n=24	Asphyxia n=9	Weapon n=15	Other n=24
Yes	25%	67%	53%	29%
No	67%	33%	40%	54%
Unknown	8%	0%	7%	17%
Type of Criminal History	**If Yes, Persons Responsible Verified Child Maltreatment Death (n=27)**			
	Drowning n=6	Asphyxia n=6	Weapon n=8	Other n=7
Assaults	50%	0%	38%	29%
Robbery	33%	33%	38%	0%
Drugs	50%	33%	75%	100%
Other	50%	83%	100%	57%
Unknown	0%	0%	0%	0%

Figure G-18: Percentage of Persons Responsible for Verified Maltreatment Deaths (Primary Cause) With Criminal Backgrounds (N=72)

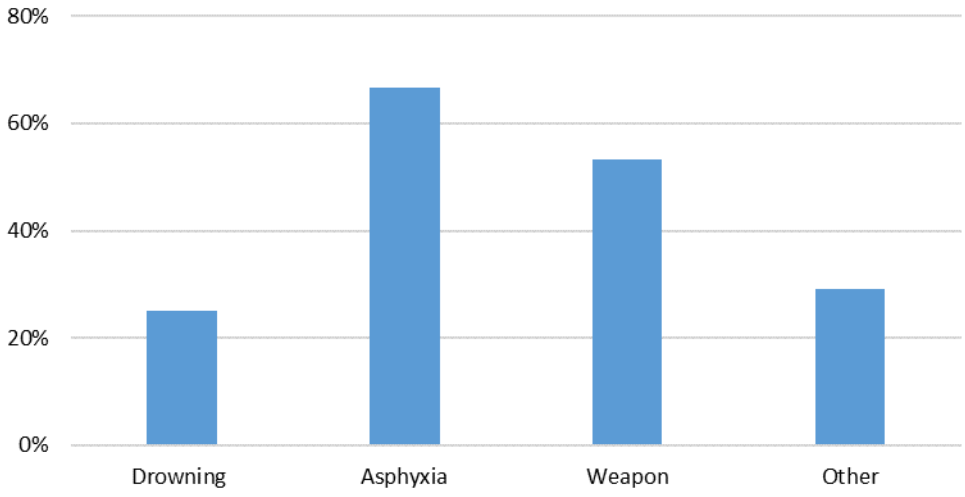
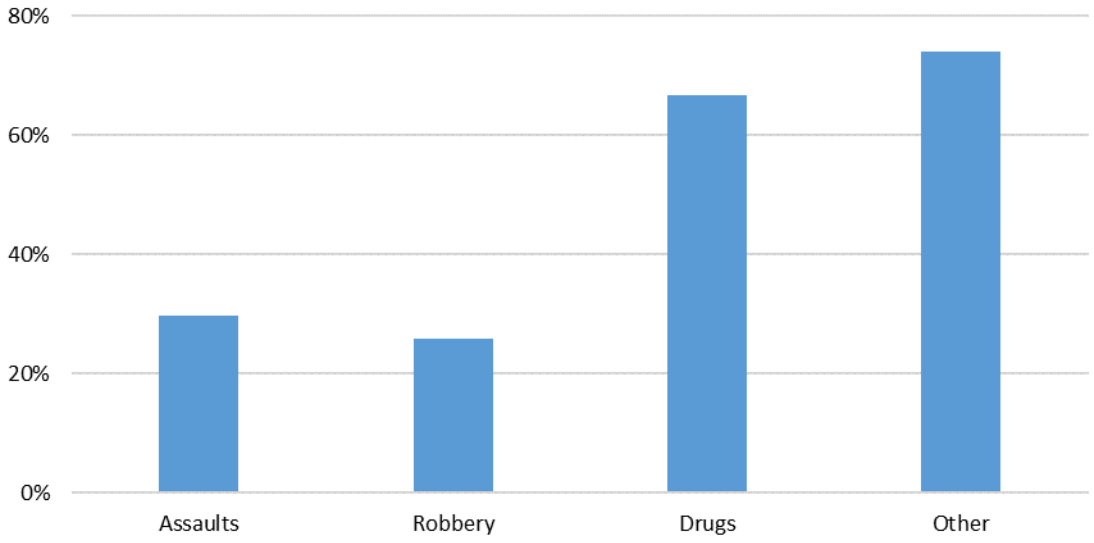


Figure G-19: Offense Type of Those Responsible for Verified Maltreatment Death with Criminal Background (N=27)



Past Child Death Associated with Caregivers, Supervisors, and Person(s) Responsible for Death

Table G-49: Past Child Death Associated with Caregivers by Maltreatment Verification Status and Primary Cause of Death												
Past Child Death with Caregiver	Child Maltreatment Death											
	Verified n=106				Not substantiated n=87				No Indicators n=293			
	Drowning n=37	Asphyxia n=13	Weapon n=24	Other n=32	Drowning n=14	Asphyxia n=40	Weapon n=3	Other n=30	Drowning n=61	Asphyxia n=114	Weapon n=13	Other n=105
Yes	0%	0%	4%	13%	0%	13%	0%	17%	5%	4%	0%	2%
No	100%	100%	88%	81%	93%	88%	100%	70%	70%	93%	100%	86%
Unknown	0%	0%	8%	6%	7%	0%	0%	13%	25%	4%	0%	12%

Table G-50: Past Child Death Associated with Supervisors by Maltreatment Verification Status and Primary Cause of Death												
Past Child Death with Supervisor	Child Maltreatment Death											
	Verified n=60				Not Substantiated n=41				No Indicators n=156			
	Drowning n=21	Asphyxia n=8	Weapon n=12	Other n=19	Drowning n=8	Asphyxia n=19	Weapon n=1	Other n=13	Drowning n=30	Asphyxia n=62	Weapon n=2	Other n=62
Yes	0%	0%	8%	11%	0%	11%	0%	15%	7%	5%	0%	2%
No	100%	100%	83%	84%	100%	89%	100%	54%	77%	95%	100%	82%
Unknown	0%	0%	8%	5%	0%	0%	0%	31%	17%	0%	0%	16%

Table G-51: Past Child Death Associated with Persons Responsible for Verified Maltreatment Death by Maltreatment Verification Status and Primary Cause of Death				
Past Child Death with Persons Responsible	Verified Child Maltreatment Death n=70			
	Drowning n=24	Asphyxia n=9	Weapon n=14	Other n=23
Yes	0%	0%	7%	4%
No	100%	100%	86%	87%
Unknown	0%	0%	7%	9%