Child Abuse Death Review Committee

Working to eliminate preventable child abuse and neglect deaths in Florida

Annual Report

December 2021

CHILD ABUSE DEATH REVIEW MISSION:

To eliminate preventable child abuse and neglect deaths

This Annual Report is dedicated to the memory
of all the children who lost their lives in our state in 2020.

The information contained herein can be used
to help prevent any future harm
to our most vulnerable citizens.

Submitted to:

The Honorable Ron DeSantis, Governor, State of Florida
The Honorable Wilton Simpson, President, Florida Senate
The Honorable Chris Sprowls, Speaker, Florida House of Representatives

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EXECUTIVE SUMMARY

Florida's Child Abuse Death Review System

The Florida Child Abuse Death Review (CADR) System was established in Florida law in 1999. Per section 383.402, Florida Statutes (F.S.), CADR is a statewide multidisciplinary, multiagency, epidemiological child abuse death assessment and prevention system. State and Local CADR Committees are directed by statute to identify gaps, deficiencies, or problems in the delivery of services to children and their families, recommend changes needed to better support the safe and healthy development of children, and implement those changes to the extent possible. The essential goal of the CADR System is to eliminate preventable child fatalities in Florida by improving CADR members' collective understanding of the complexities of child maltreatment and leveraging data and evidence-based knowledge to support current and future prevention strategies. This statistical report is submitted annually to the Governor, President of the Florida Senate, and Speaker of the Florida House of Representatives.

2020 Data: Case Review Analysis

Throughout 2021, Local CADR Committees reviewed records related to 222 child fatalities which occurred in 2020. Analysis of the 2020 child fatality case review data revealed that regardless of maltreatment verification status, children under the age of five have the highest number of child deaths called into the Florida Abuse Hotline. The three leading causes of preventable child death in 2020, identified through CADR case reviews and subsequent analysis are listed below in order of greatest to least incidence.

- **Sleep-related Infant Death** is the leading cause of preventable child death in Florida and is often the result of unsafe sleep practices. Sleep-related infant deaths represent 35.1% of 2020 child fatalities reviewed by the CADR System. Children placed to sleep on adult beds, couches and other soft surfaces are at significant risk of suffocation. An infant sharing a sleep surface with another child or an adult also poses a risk for sleep-related death.
- **Drowning** is the second leading cause of preventable child death, representing 25.5% of all child fatalities reviewed by the CADR System. Children three years of age and younger make up 72.0% of all 2020 drowning related fatalities reviewed by the CADR System. According to the American Academy of Pediatrics, nearly 70% of child drowning occurs during non-swimming activities. Ineffective barriers of protection and failure to provide sufficient supervision to young children continue to be primary contributing factors.
- **Inflicted Trauma** is the third most frequent cause of preventable child death, representing 9.0% of child fatalities reviewed by the CADR System. Children under one year of age accounted for 26.7% of these fatalities. Inflicted trauma includes abuse to a child by way of bodily force, such as the use of hands, fists, and feet, or by the use of weapons and firearms.

Child Characteristics

Children 5 years old and under account for 83.8% of preventable child death cases reviewed by the CADR System. The most vulnerable children are less than 1 year of age, representing 51.8% of cases reviewed. Children under the age of 5, and to a greater extent, children under

the age of 1, are in critical need of developmentally appropriate supervision, care, and support to ensure their safety.

Prevention Recommendations:

The following prevention recommendations developed by the State CADR Committee provide an overview of strategies and approaches intended to address preventable child fatalities in Florida:

- Continue efforts to relay timely information to caregivers and community supports regarding the safety of children.

- Continue to develop strategies to ensure consistent and coordinated prevention-related messaging across local and state agencies, business and industry leaders, and other relevant private and public sector groups.

- Expand efforts to collect data related to co-occurring substance abuse and mental health disorders.

- Continue to explore efforts to collect data related to near fatalities in cases of near-fatal sleep-related asphyxia, near-drowning, and near-fatal incidents of inflicted trauma.

- Continue to support the development and dissemination of messaging around appropriate supervision and barriers of protection as primary factors in drowning prevention, in addition to establishing age-appropriate expectations related to young children and swimming capabilities consistent with recommendations of the American Academy of Pediatrics (AAP).

- Strongly support statewide drowning prevention programs and promote collaboration with the hospitality and tourism industry and all associated partners, in the development and dissemination of public messaging for water safety and drowning prevention.

- Effectively advocate for strengthened partnerships and collaborations between state agencies to ensure families are referred to evidence-based parent coaching and support programs.

- Train first responders on the consistent use of Sudden Unexpected Infant Death Investigation Reporting Forms (SUIDIRF) and doll reenactments by death scene investigators for all sleep-related infant deaths and explore opportunities to mandate statewide use of the form.

- Continue to support and encourage the development and evaluation of pilot projects and initiatives focused on local and regional community-based child fatality prevention.

- Explore collaborative partnerships with entities which may be currently examining child and adolescent suicide to better inform targeted prevention initiatives.

SECTION ONE: 2021 CADR BACKGROUND

Program Description

The program is administered by the Florida Department of Health (FDOH) and uses 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. A public health approach is applied as Local CADR Committees review the facts and circumstances surrounding child fatality cases with a reported suspicion of abuse or neglect. The State CADR Committee collects and analyzes data from the local reviews and prepares an annual statistical report.

Statutory Authority

Section 383.402, F.S. (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.
- Implement such recommendations, to the extent possible.

State Child Abuse Death Review Committee

The State CADR Committee is charged with oversight of the local committees. 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 Committee* are referenced in Appendix B.

The State CADR Committee consists of seven agency-specific representatives and twelve appointments from various disciplines related to the health and welfare of children and families. Members of the State CADR Committee (Appendix C) are appointed to staggered two-year terms. All members are eligible for reappointment, not to exceed three consecutive terms. The State CADR Committee elects a chairperson from among its members to serve a two-year term. A representative of FDOH, appointed by the State Surgeon General, serves as the committee coordinator. Additionally, the State CADR Committee includes representatives from the following departments, agencies, or organizations:

- Department of Legal Affairs
- Department of Children and Families (DCF)
- 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 FDOH and the agencies listed above. These appointees ensure that the committee represents, to the greatest extent possible, the regional, gender, and racial/ethnic diversity of the state. These appointees include:

- The FDOH Statewide Child Protection Team Medical Director.
- A public health nurse.
- A mental health professional who treats children or adolescents.
- An employee of DCF 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 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 from a Florida Domestic Violence organization.
- A representative from a private provider of programs on preventing child abuse and neglect.
- A substance abuse treatment professional.

Local Child Abuse Death Review Committees

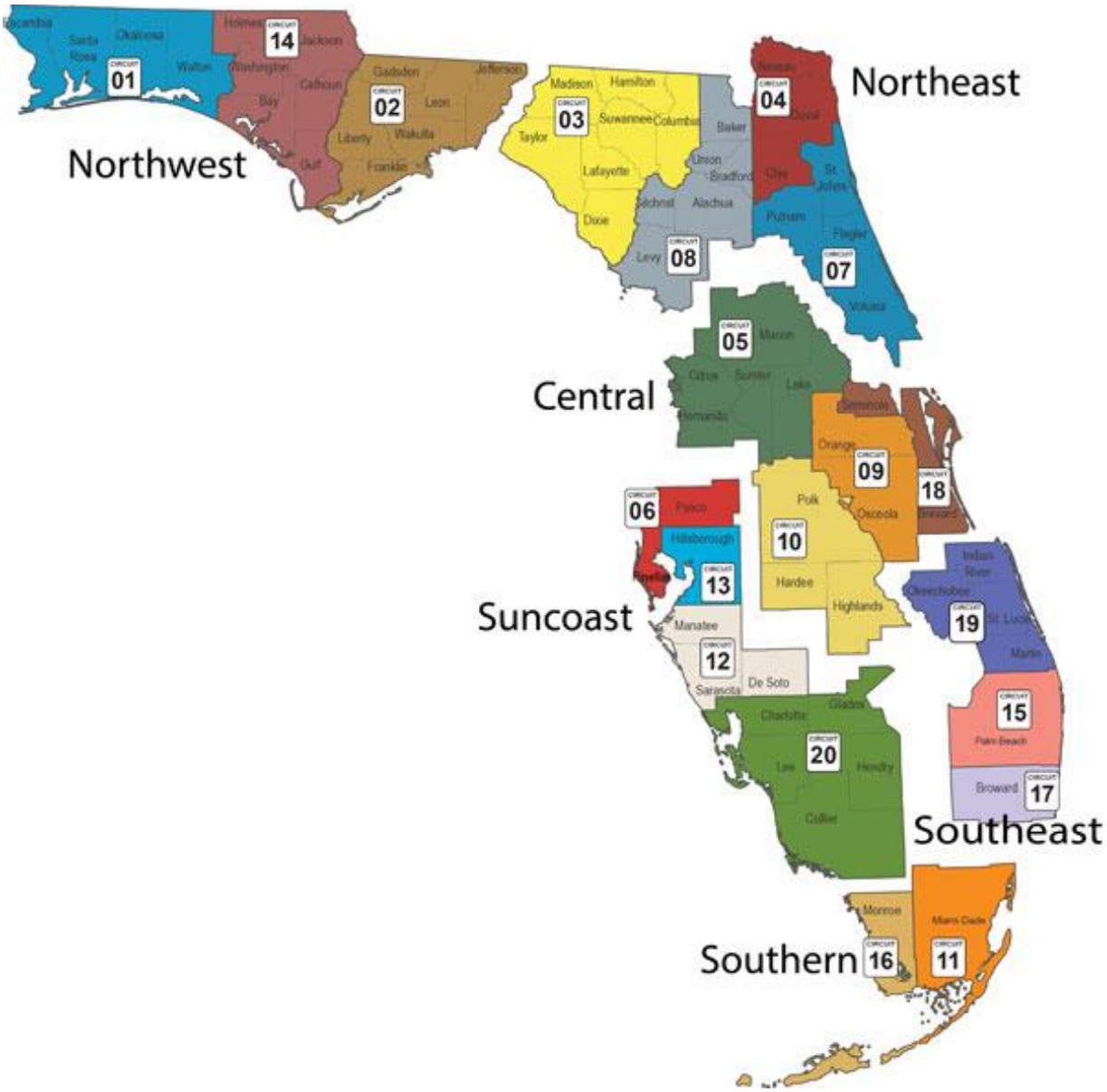
Local CADR Committees review all closed cases of alleged child abuse and neglect deaths reported to the Florida Abuse Hotline and present information relevant to these deaths to the State CADR Committee through the completion of a web-based case reporting form. Local CADR Committees, aligned with Florida's Judicial Circuits comprise individuals from agencies within the community who share an interest in promoting, protecting, and improving the health and welfare of children. Local CADR Committee membership can be found in Appendix C.

FDOH County Health Officers designated to serve Local CADR Committees (CADR Health Officers) appoint, convene, and support the committees. 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 DCF Child Protective Investigations Unit
- FDOH Child Protection Team
- The community-based care lead agency
- State, county, or local law enforcement agencies
- The school districts
- 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

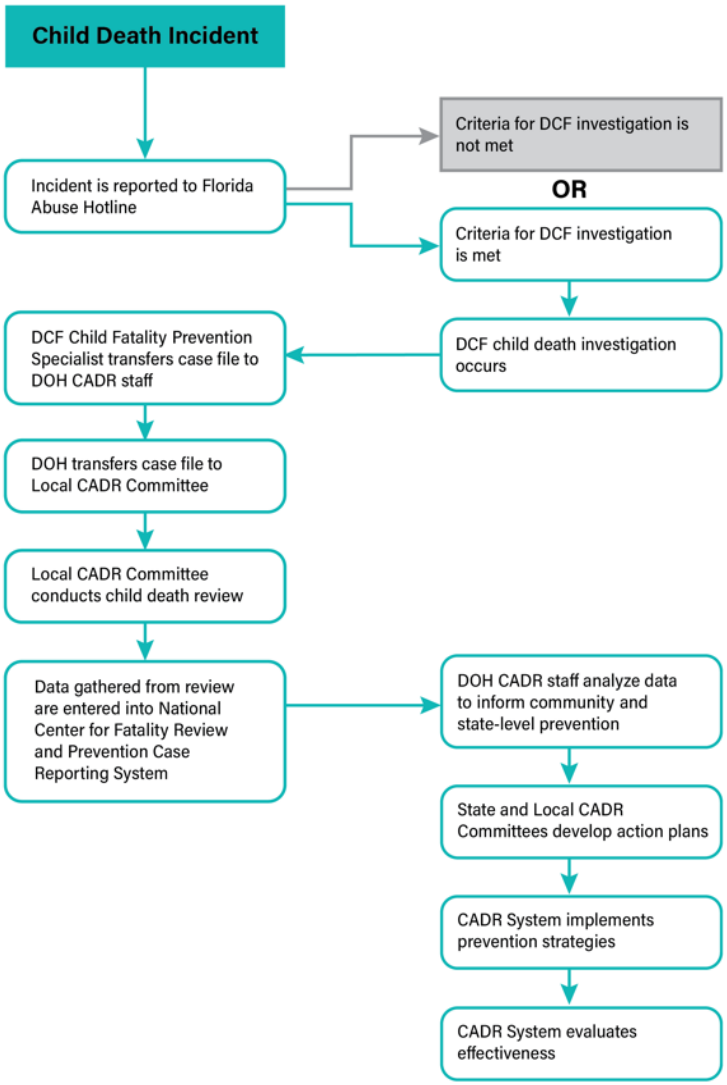
Map of Circuit-Based Committees

As a result of the close collaboration between FDOH and DCF within the CADR System, Local CADR Committees are in alignment with Florida's Judicial Circuits as well as the six DCF regions statewide (image below). Due to operational logistics, the Local CADR Committees located in Circuits 1, 12, and 18 each operate as two committees and the Local CADR Committees in Circuits 11 and 16 (Miami-Dade and Monroe counties) operate as a single committee; resulting in a total of 22 Local CADR Committees. The revised committees include: Escambia and Santa Rosa counties operating as Circuit 1A and Okaloosa and Walton counties operating as Circuit 1B; Manatee County operating as Circuit 12A and Sarasota and DeSoto operating as Circuit 12B; Brevard County operating as Circuit 18A and Seminole County operating as 18B.



CADR Process Flowchart

The CADR Process includes many steps from a child fatality incident through the implementation of state and community- level prevention initiatives. Local CADR Committees are encouraged to take a community-wide approach to address causes and contributing factors of deaths resulting from child maltreatment, and to implement identified strategies, to the extent possible. Local CADR Committees are further encouraged to look beyond the child welfare system when identifying and implementing prevention strategies. The flowchart below outlines the multiagency CADR process and demonstrates a framework which represents CADR Committee members' collective understanding of the need to build upon lessons learned and further support efforts to ensure decision-making is based on applicable data.



Local CADR Committee Best Practices

Local CADR Committee guidelines recommend best practices for conducting effective child fatality reviews and highlight the duties and responsibilities of Local CADR Committees. The State CADR Committee identifies core data elements to be collected for each case and provides detailed guidance on the content of case narratives. Once the Local CADR Committee's review is complete, data are entered into the National Center for Fatality Review and Prevention Case Reporting System (CFR-CRS). For information detailing Local CADR Committee operating procedures, please see the *Guidelines for Local CADR Committees* referenced in Appendix D.

SECTION THREE: DATA

Case Review Statistics

This report includes information on closed child fatality cases with suspected maltreatment which have been reviewed and entered into the National Center for Fatality Review and Prevention Case Reporting System (CFR-CRS, Appendix E) by September 1, 2021. Cases that remain open to DCF for investigation are not available for review and are not included in the data sample.

Under certain circumstances, case closure may be delayed due to pending investigations and criminal justice proceedings. To address case review backlog due to delays, Local CADR Committees dedicate the first quarter of each year to reviewing previous years' caseloads to contribute to overall trend analysis reporting. During the 2021 case review period, delays were extended due to the COVID-19 pandemic. Judicial circuits continue to experience a significant backlog of cases due to the temporary reduction in court proceedings, resulting in fewer cases available for CADR review.

Child maltreatment findings are based on the following criteria:

- 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.

References are often made to *Unknown* and *Missing* data in certain graphs, charts, and tables throughout this section of the report. For the purpose of this section, *Unknown* is used when knowledge of the data element in question is not known despite efforts to obtain information by the Local CADR Committee. *Missing* is used in reference to data elements that were left blank when entering child fatality case data into the CFR-CRS.

Table 1 details the distribution of 2020 child fatality cases reviewed (stratified by maltreatment verification status), cases awaiting review and cases that were not available for review as of September 1, 2021. Figure 1 demonstrates the distribution of child fatality cases assigned to each Local CADR Committee. Figure 2 provides an aggregate summary of the case file status for all child fatalities (445) reported to the Florida Abuse Hotline in 2020.

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 in Processing)	Cases Available for Review	Review Completed	Cases Completed and Available for Annual Report	Verified Maltreatment Cases Reviewed	Not Substantiated Maltreatment Cases Reviewed	No Indicators Maltreatment Cases Reviewed
Circuit #1a	16	0	16	11	11	1	2	8
Circuit #1b	8	1	7	5	5	3	0	2
Circuit #2	7	1	6	5	5	0	0	5
Circuit #3	8	6	2	0	0	0	0	0
Circuit #4	42	26	16	8	8	1	0	7
Circuit #5	42	2	40	40	38	8	9	21
Circuit #6	29	13	16	16	16	2	4	10
Circuit #7	15	8	7	2	2	0	2	0
Circuit #8	10	7	3	0	0	0	0	0
Circuit #9	38	1	37	37	37	8	5	24
Circuit #10	29	4	25	22	21	7	5	9
Circuit #11	29	7	22	10	9	1	7	1
Circuit #12a	9	0	9	9	9	1	3	5
Circuit #12b	4	1	3	0	0	0	0	0
Circuit #13	37	16	21	19	18	2	2	14
Circuit #14	9	5	4	3	3	1	0	2
Circuit #15	24	19	5	4	4	1	1	2
Circuit #16	0	0	0	0	0	2	2	3
Circuit #17	27	15	12	8	7	5	3	5
Circuit #18a	20	6	14	13	13	0	0	0
Circuit #18b	7	1	6	0	0	0	1	0
Circuit #19	6	4	2	1	1	6	1	8
Circuit #20	29	8	21	15	15	0	0	0
Totals	445	151	294	228	222	49	47	126

Figure 1: 2020 Child Death Cases Reported to the Hotline (N=445)

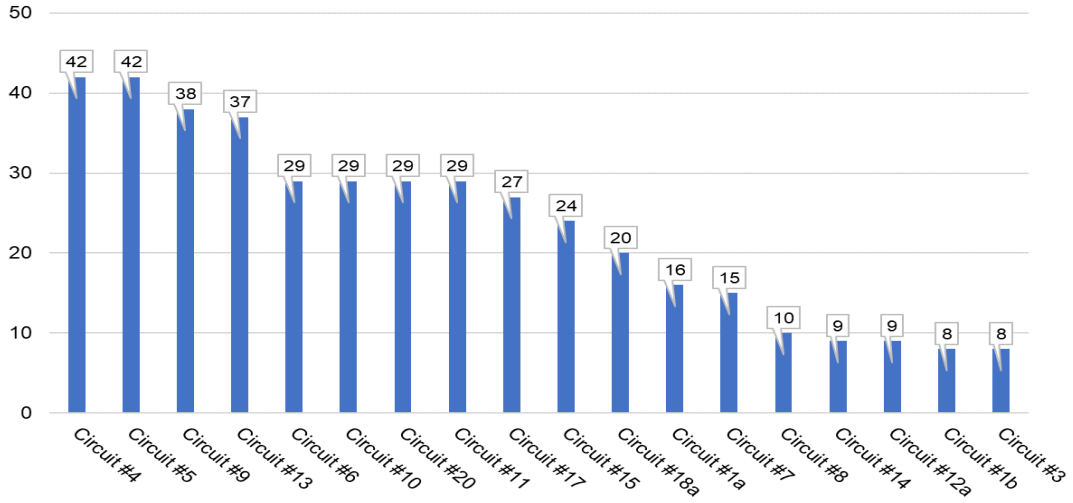
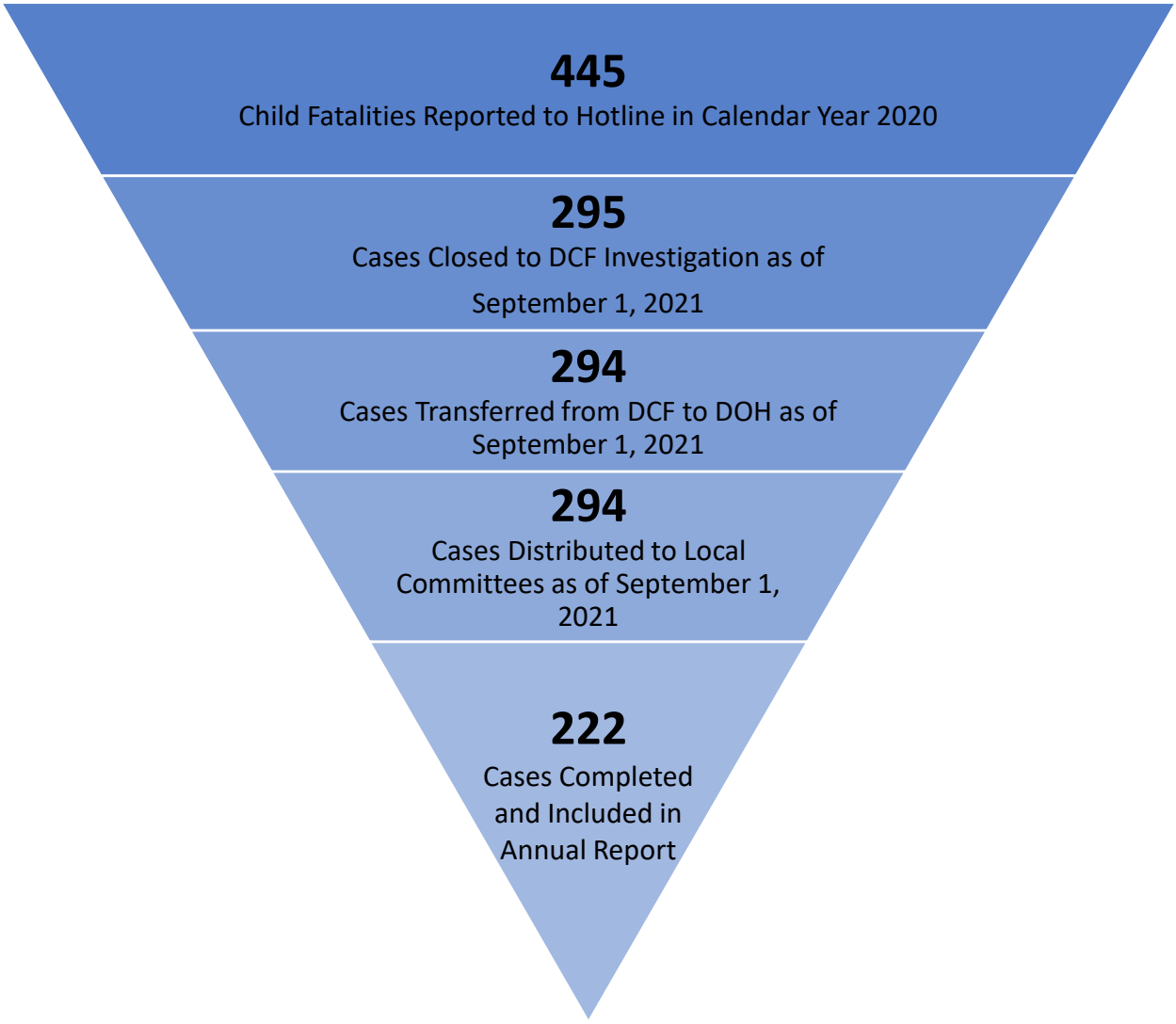


Figure 2: Case File Status of 2020 Child Deaths Reported to the Florida Abuse Hotline



*Per Table 1, child fatality reviews were completed for 228 cases. Of the 228 cases reviewed, data entry was completed for 222 by the September 1, 2021 deadline, resulting in six reviewed cases being unavailable for this report.

2020 Case Status Summary

As of September 1, 2021, 445 child fatalities were called into the Florida Abuse Hotline for 2020. Of these child death incidents:

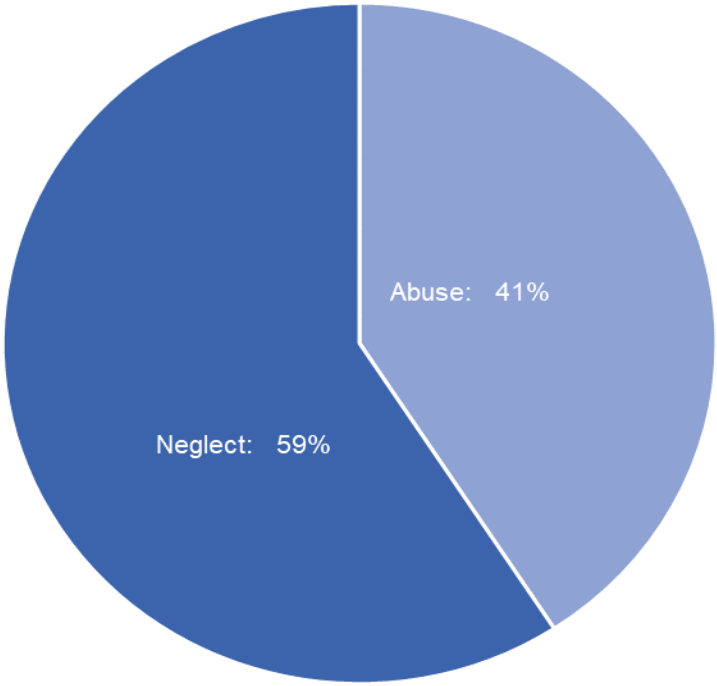
- 295 were closed by DCF.
  - Of these, 294 had information which was available for review and 222 reviews were completed. The remaining 72 cases are scheduled for review after September 1, 2021. Data included in this report apply only to the 222 reviewed cases. Findings may change once all child fatalities are reviewed.

- 150 were still open for investigation or recently closed, therefore case information was unavailable.
  - Consideration will be given toward supplemental analyses of the remaining 2020 fatalities (151) upon case closure and review.

- There were ten Local CADR Committees with 25 or more child fatality cases called into the hotline in 2020. These include: Circuit 4 (42), Circuit 5 (42), Circuit 6 (29), Circuit 9 (38), Circuit 10 (29), Circuit 11 (29), Circuit 13 (37), Circuit 15 (25), Circuit 17 (27), Circuit 20 (29).

- Of the 49 verified maltreatment deaths reviewed, 29 (59%) were the result of neglect, and 20 (41%) were the result of abuse (Figure 3).

Figure 3: Distribution of Reviewed Verified Maltreatment Deaths by Abuse and Neglect (n=49)



Child Death Trends

In 2020, the all-cause death rate for children aged 0-17 was 49.2 deaths per 100,000 child population (Florida CHARTS, 2021). The reported 2020 verified child maltreatment death rate in Table 2 is 1.45 per 100,000 child population. This rate is provisional, as there are several cases still open to investigation and unavailable for review. Child fatality cases with a higher propensity to be verified for abuse or neglect are likely to involve the criminal justice system as a result of the child's death and can require extended time for investigation. Table 2 shows the numbers and rates of all-causes of child death and verified child maltreatment deaths.

Table 2: Child Deaths: All Causes and Maltreatments, Florida, 2011-2020

	Resident Child Deaths All Causes	Resident Child Death Rate per 100,000 Population	Verified Child Maltreatment Deaths	Child Maltreatment Death Rate per 100,000 Population	Cases Pending (DCF)	Cases Pending (Local Review)
2011	2,191	54.2	136	3.37	-	-
2012	2,046	50.9	129	3.21	-	-
2013	2,105	52.5	137	3.41	-	-
2014	2,131	52.9	152	3.77	-	-
2015	2,249	55.4	123	3.03	-	-
2016	2,217	54.1	110*	2.69	1	7
2017	2,236	54.1	113*	2.73	4	7
2018	2,128	50.7	116*	2.77	17	23
2019	2,107	49.7	80*	1.89	61	87
2020	2,107**	49.2**	62*	1.45	152	218

*The numbers of verified child maltreatment cases for 2016, 2017, 2018, 2019, and 2020 are provisional, as some cases remain open and have not yet transferred to Local CADR Committees or have not yet been reviewed by Local CADR Committees. Past year figures may have changed as cases were closed following the submission of past CADR reports.
**2020 Vital Statistics death data are provisional and subject to change.

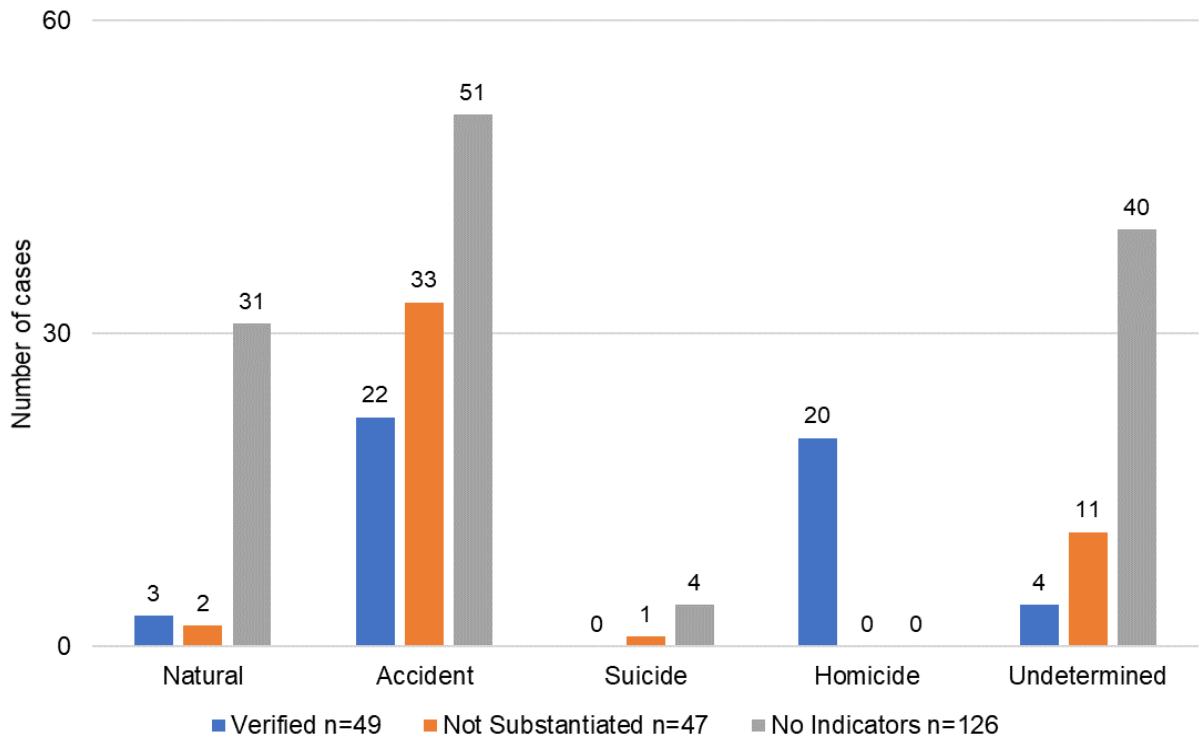
Official Manner of Death

Each child fatality review includes information regarding the official manner and primary cause of death, and if the death is a result of child abuse or neglect. Some deaths classified as accidental by the medical examiner (ME) have the potential, upon investigation, to be determined the result of abuse or neglect.

Figure 4 demonstrates the official manner of death as indicated on the death certificate for all child fatalities reviewed for this report. Of the 49 child fatalities verified to be the result of abuse and/or neglect, 22 (45.0%) were classified as accidents and 20 (41.0%) were classified as homicides. Among the 47 not-substantiated child deaths, the largest number of deaths (33 or 70.0%) were classified as accidents followed by undetermined causes (11 or 23.4%). Among the 126 no indicators child deaths, the official manner of death was most frequently classified as an

accident (51 or 40.5%), followed by undetermined (40 or 31.7%), and natural causes (31 or 24.6%). In determining manner of death, MEs are limited to a certain range of choices that do not include “neglect.” Subsequently, cases verified for neglect are often classified as accidental by the ME.

Figure 4: Manner of Death by Maltreatment Verification Status (n=222)



Primary Cause of Death

Figure 5 demonstrates the distribution of primary cause of death in all child fatality cases reviewed, stratified by child maltreatment verification status. Among the 49 verified maltreatment fatalities, 45 (91.8%) were the result of an external injury, 4 (8.2%) were due to a medical cause and 0 had an undetermined or unknown cause of death. Among the 47 not substantiated maltreatment fatalities, 35 (74.5%) were the result of an external injury, 2 (4.3%) were determined to have a medical cause, and 8 (17.0%) had undetermined, 2 (4.2%) were determined to have an unknown cause of death. Among the 126 no indicators deaths, 63 (50.0%) were the result of an external injury, 31 (24.6%) were determined to have a medical cause, 27 (21.4%) were undetermined, and 5 (4.0%) had unknown cause of death.

Figure 5: Primary Cause of Death Category by Maltreament Verification Status (N=222)

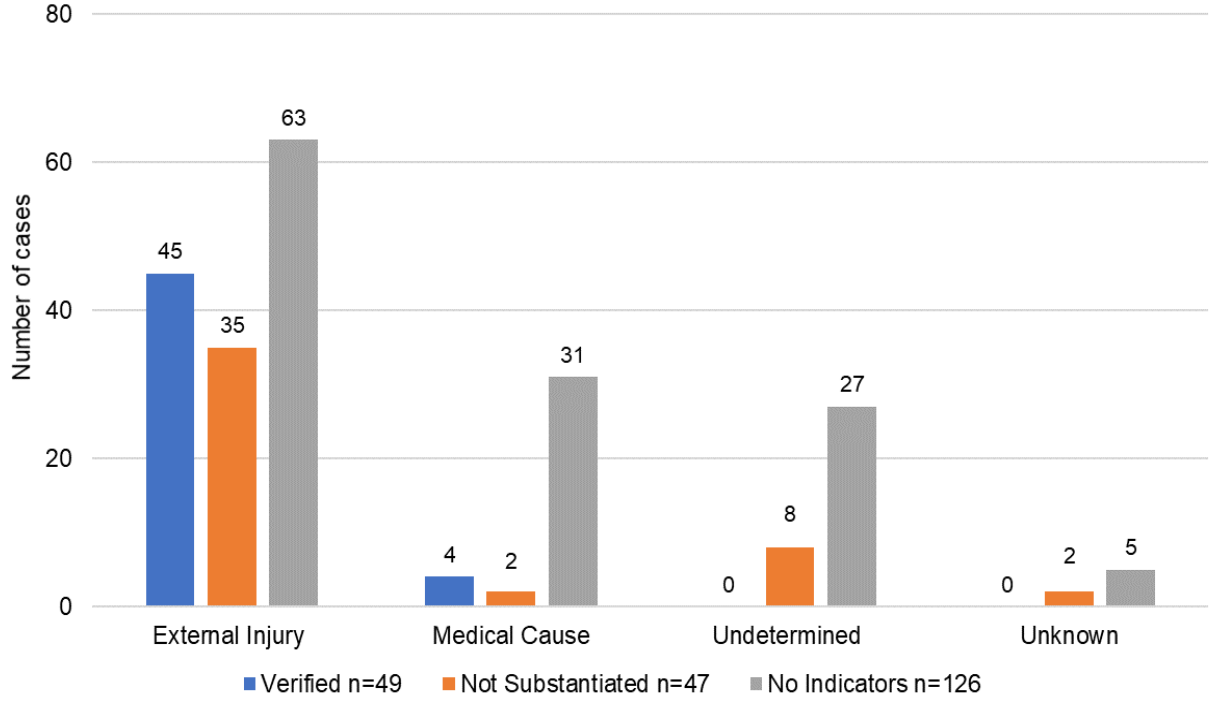
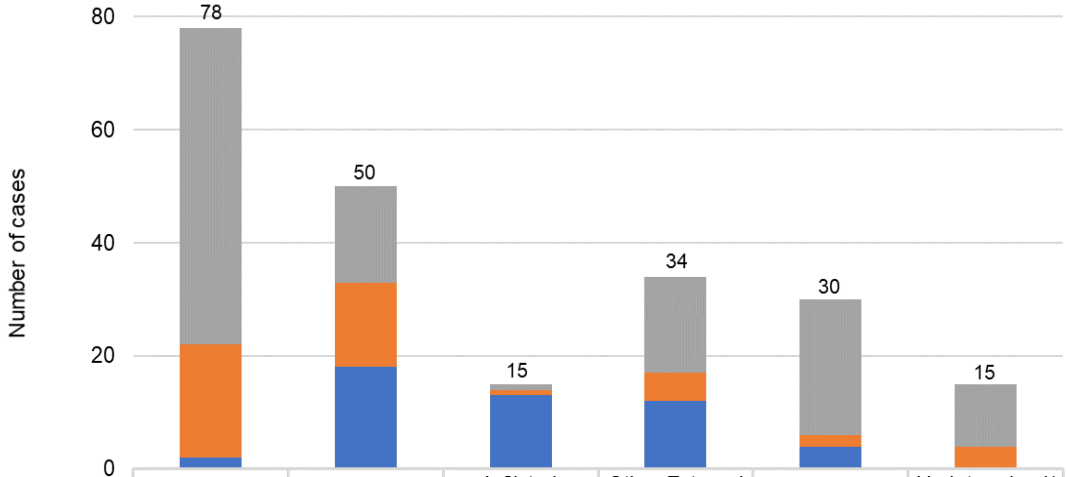


Figure 6 shows the distribution all cause of death categories stratified by maltreatment verification status. The reviewed cases have been categorized by three distinct causes: sleep-related (35.1%), drowning (22.5%), and inflicted trauma (6.8%). These comprise the leading cause of death categories which will be examined in detail throughout this report.

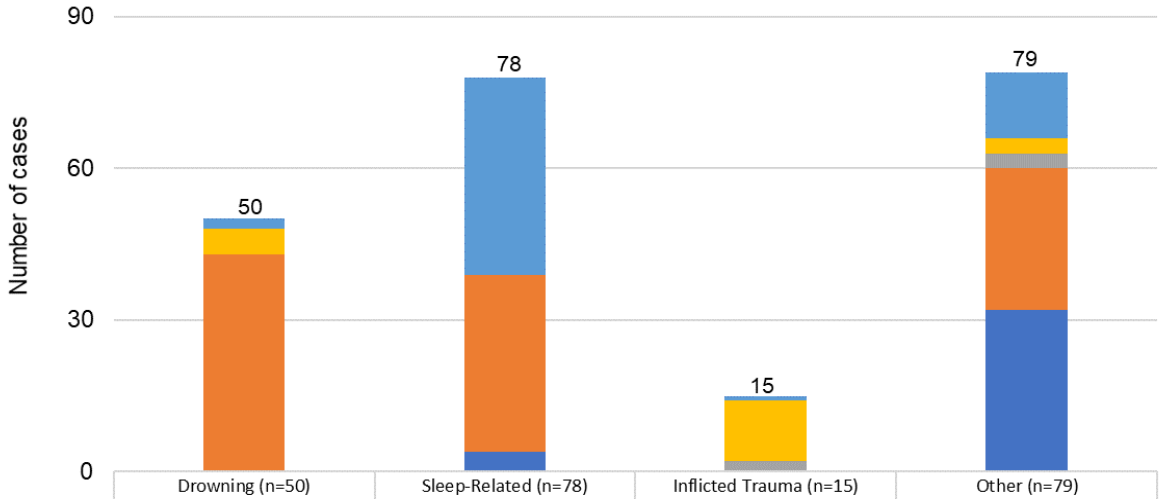
Figure 6: All Cause of Death Categories by Maltreatment Verification Status (n=222)



	Sleep-Related	Drowning	Inflicted Trauma	Other External Injury	Medical	Undetermined/ Unknown
No Indicators (n=126)	56	17	1	17	24	11
Not Substantiated (n=47)	20	15	1	5	2	4
Verified (n=49)	2	18	13	12	4	0

The distribution of leading cause of death by manner of death is displayed in Figure 6.1. Among drowning cases, the majority (86%) were accidental; 5 drowning cases were verified homicide deaths, and the remaining 2 were undetermined. The manner of death was undetermined in half (50%) of sleep-related cases; accidental and natural manner of death accounted for, respectively, 45% and 5% of the other half of sleep-related cases. Homicidal manner accounted for the majority (80%) of inflicted trauma cases; in 2 inflicted trauma cases the manner of death was suicide. The remaining "other" cause of death category comprises deaths caused by other external injuries (not sleep-related, drowning or inflicted trauma), medical conditions, and undetermined and unknown causes. In the majority of cases included in this category, manner of death was natural (41%) or accidental (35%).

Figure 6.1: Manner of Death by Leading Cause of Death Category (n=222)



	Drowning (n=50)	Sleep-Related (n=78)	Inflicted Trauma (n=15)	Other (n=79)
Undetermined	2	39	1	13
Homicide	5	0	12	3
Suicide	0	0	2	3
Accident	43	35	0	28
Natural	0	4	0	32

Table 3 displays specific primary causes of death resulting from an external injury.

Table 3: External Injury Cause of Death by Child Maltreatment Verification Status			
External Injury Cause of Death	Child Maltreatment Status n=143		
	Verified n=45	Not Substantiated n=35	No Indicators n=63
Motor Vehicle	5	3	4
Fire	1	0	2
Drowning	18	15	17
Unintentional Asphyxia	1	15	31
Assault	13	1	1
Poisoning, Overdose, Intoxication	1	1	1
Undetermined Injury	0	0	1
Other Cause	6	0	5
Unknown	0	0	1

Table 4 displays specific primary causes of death resulting from a medical condition.

Table 4: Medical Cause of Death by Child Maltreatment Verification Status			
Specific Medical Cause of Death	Child Maltreatment Death n=37		
	Verified n=4	Not Substantiated n=2	No Indicators n=31
Asthma	0	0	2
Cardiovascular	0	0	2
Congenital Anomaly	0	1	2
Neurological/Seizure	1	0	1
Pneumonia	0	0	5
Prematurity	2	0	2
SIDS	0	0	5
Other Infection	1	1	5
Other Medical Condition	0	0	6
COVID-19	0	0	1

Location of Child Deaths

In this report, the word county refers to where the incident took place, not necessarily the county where the death occurred or the county of a child's residence. Use of the incident county provides more meaningful data regarding the death event. Additional information on the location of child death is available in Appendix F. Of the top three primary causes of death regardless of verification status:

- 36 of 78 (46.2%) of all sleep-related deaths occurred in five counties: Orange, Hillsborough, Polk, Duval, and Manatee. Orange County alone accounted for 11 of 78 (14.1%) of all sleep-related deaths.
- 19 of 50 (38.0%) of all drownings occurred in five counties: Orange, Hillsborough, Marion, Brevard, and Broward.
- 15 deaths due to inflicted trauma occurred across seven counties, with nearly half of these deaths (46.7%) occurring in Polk (n=4) and Orange (n=3).

Sleep-Related Death Incident Information

Incidents related to sleeping or the sleep environment remain the primary cause of child deaths reviewed by Local CADR Committees. Sleep-related deaths account for 78 of 222 (35.1%) of all 2020 CADR cases available for review, with 2 verified maltreatment deaths, 20 not substantiated, and 56 deaths determined to have no indicators of abuse or neglect (Table 5). The cause of a sleep-related death may not be able to be determined after investigation, therefore, may be classified as a death from an unknown or undetermined cause.
Death scene investigations involving sleep-related incidents provide information regarding location and position in which the child was placed and found. These narratives can be used in conjunction with ME findings to provide a more encompassing view of the incident.

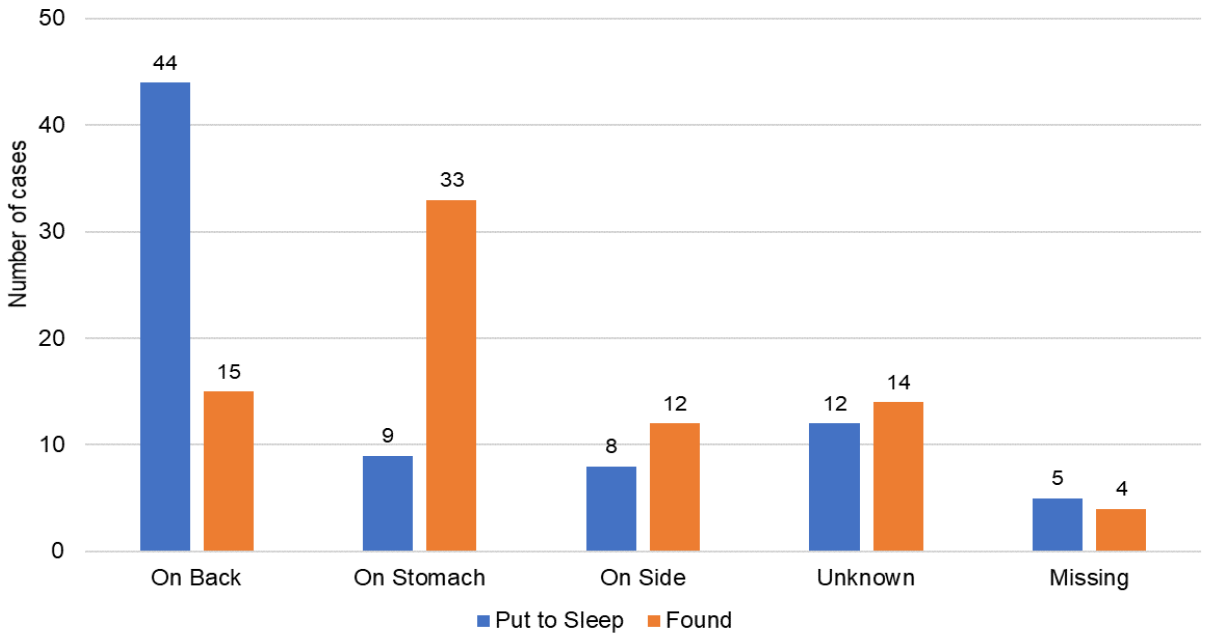
Table 5: Death Related to Sleeping or Sleep-related Environment

Cause of Sleep-Related Death	Child Maltreatment Status n=78		
	Verified (n=2)	Not Substantiated (n=20)	No Indicators (n=56)
Asphyxia	1	14	26
Medical	0	0	7
Other	1	0	2
Undetermined	0	5	17
Unknown	0	1	4

When available, Local CADR Committees collect information on risks and protective factors pertaining to sleep-related deaths. Figures 7 through 9 and Table 6 provide overviews of critical factors regarding sleep placement, environments, and age among reviewed cases.

Figure 7 provides information related to sleep placement position among cases that were classified as sleep-related: a child's usual sleep placement position, the sleep position in which a child was placed prior to death, and the sleep position in which a child was found non-responsive or deceased. Please note that findings are only presented on cases where data were reported. Sleep position/sleep placement options are: On Back, On Stomach, On Side, and Unknown.

Figure 7: Sleep Position Among Sleep Related Deaths (n=78)



- On Back was the usual reported placement position for 44 of 78 (56.4%) of children who died from sleep-related incidents.
- On Stomach was the most frequently reported sleep position when the child was found non-responsive or deceased, accounting for 33 of 78 (42.3%) child deaths where sleep position at time of death was known.

Figure 8 show the distribution of incident sleep place among sleep-related deaths. The majority (57.7%) of all sleep-related deaths took place in an adult bed.

Figure 8: Incident Sleep Place in Sleep-Related Deaths (n=78)

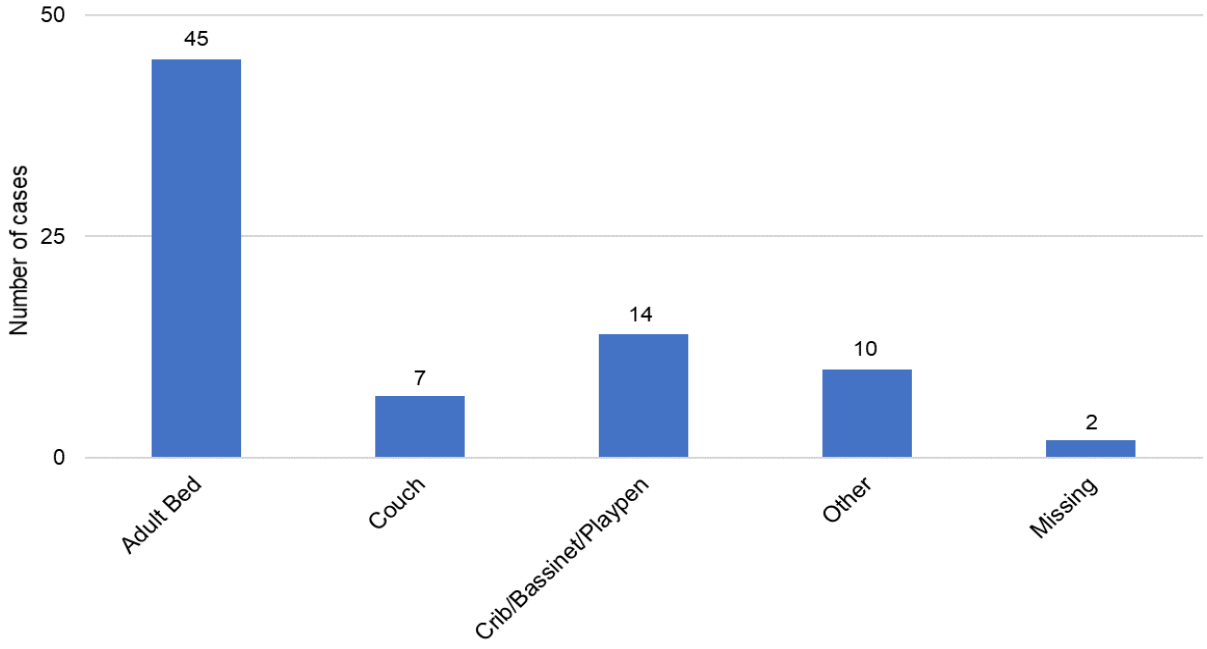
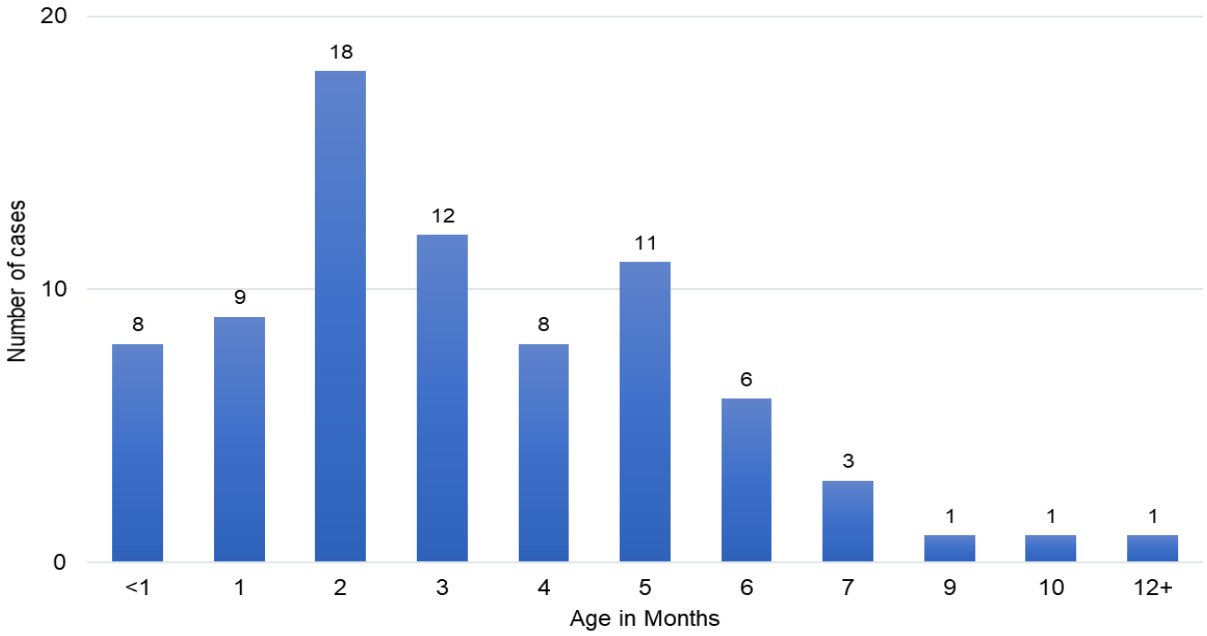


Figure 9 provides the age breakdown of the child during a sleep-related death incident. In 2020, of the 78 sleep-related death incidents, 47 (60.3%) involved children 3 months of age and younger, while 17 (21.8%) occurred at one month of age or less.

Figure 9: Age Distribution of Sleep-Related Deaths (n=78)



Information analyzed as part of the 2020 child fatality review indicate the following:

12 caregivers/supervisors fell asleep while feeding

- 2 of 12 (16.7%) were bottle feeding
- 9 of 12 (75.0%) were breastfeeding

Death scene investigations for sleep-related incidents at the place of the incident were completed for 63 of 78 (80.8%) reported cases. Of the 78 cases, 24 (30.8%) death scene doll reenactments were conducted; information from 16 (55.2%) were shared with Local CADR Committees.

Sleep-related Data Summary

- ***57.7% of all sleep-related deaths took place in an adult bed.***
- ***Children between 0 and 3 months of age made up 60.3% of all 2020 sleep-related fatalities.***
- ***59.8% of all sleep-related deaths involved male children.***
- ***56.4% of children were placed on their back prior to the sleep event and 42.3% were found non-responsive on their stomach.***

Drowning Death Incident Information

For drowning related child death cases, Local CADR Committees collect detailed information on the circumstances and environmental factors associated with each death, including the location of the incident and whether a barrier was in place. Figure 10 displays the location of drowning deaths with a pool, hot tub, or spa represented in 36 of 50 (72.0%) of total drowning incidents. The majority (86%) of drowning incidents were classified as accidental manner, regardless of the drowning location; three of five homicide drownings occurred in open bodies of water, one occurred in a bathtub and one in another location.

Figure 10: Drowning Location by Manner of Death (n=50)

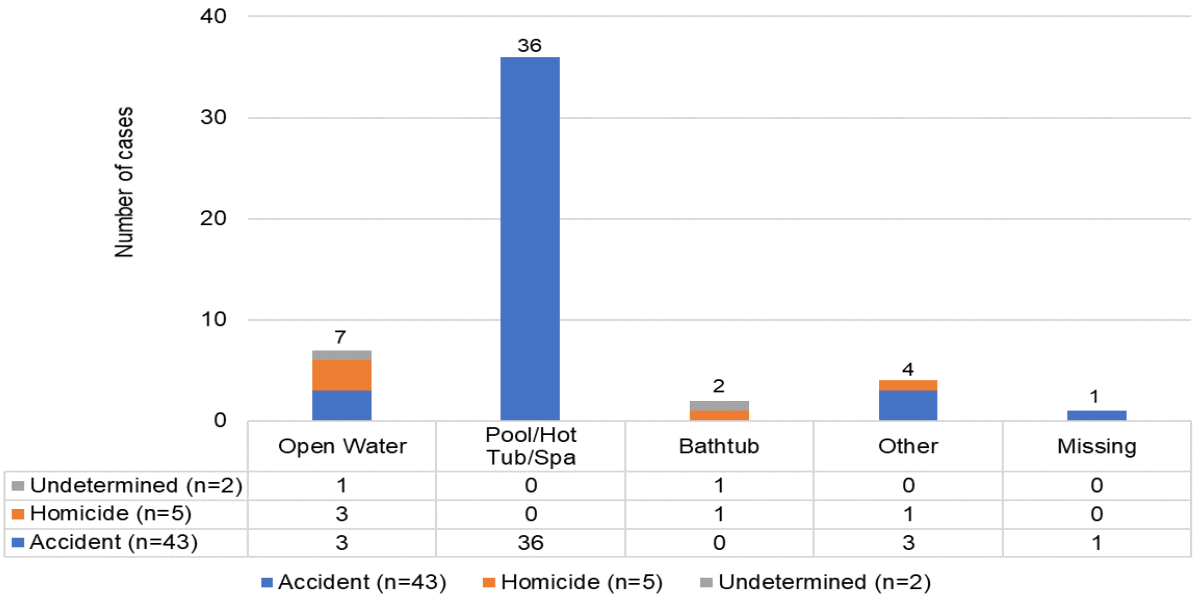
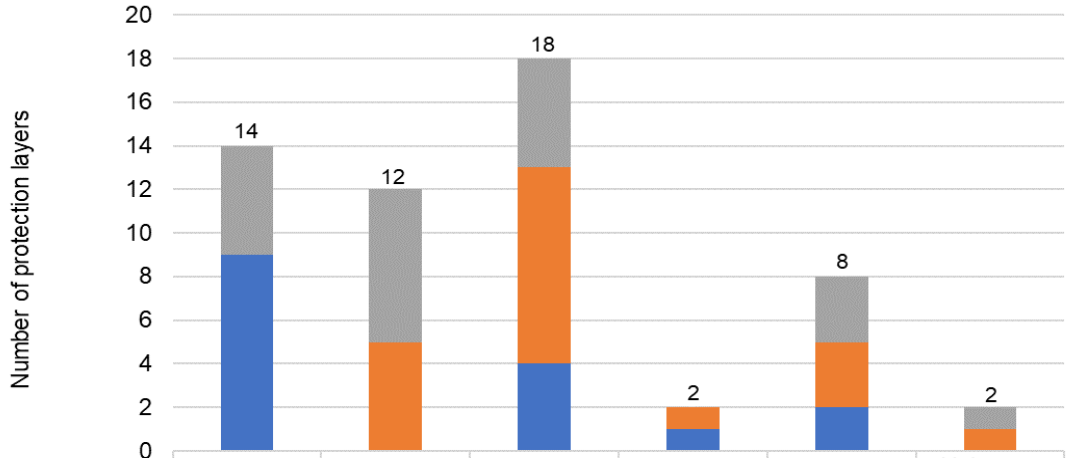


Table 7 and Figure 11 detail, respectively, barriers and other protection layers that were in place at the time of drowning incidents and those which were breached. Barriers are physical structures, such as a door or a fence, that are intended to limit access to potentially hazardous bodies of water. Note that the presence of a barrier does not indicate effectiveness of the barrier.

Table 7: Barriers in Place Among Drowning Fatalities (Duplicate Counts if Multiple Barriers)			
Barriers in Place	Child Maltreatment Status n=50		
	Verified n=18	Not Substantiated n=15	No Indicators n=17
None	10	0	6
Fence	0	3	2
Gate	1	6	6
Door	3	11	7
Alarm	1	1	3
Cover	0	1	0
Unknown	0	1	0

In approximately half (52.0%) of drowning deaths, there was at least one physical barrier in place at the time of the incident. In 16 of 50 drowning cases, there were no layers of protection indicated to prevent access to water. The most common physical barriers in place among drownings were doors (42.0%) and gates (26.0%) (Table 7).

Figure 11: Protection Layers Breached in Drowning Deaths (n=50)*



	No Layers Breached	Gate Breached	Door Breached	Alarm Breached	Other Layer Breach	Unknown Layer Breached
No Indicators (n=17)	5	7	5	0	3	1
Not Substantiated (n=15)	0	5	9	1	3	1
Verified (n=18)	9	0	4	1	2	0

Verified (n=18) Not Substantiated (n=15) No Indicators (n=17)

*As more than one barrier could be indicated for individual cases, the number of barriers breached exceeds the number of total drowning cases.

In over half (55.6%) of verified maltreatment drowning deaths, no layers of protection were breached; of note, 5 of these verified maltreatment-related drownings were homicides. Overall, the most prevalent barriers breached in drowning cases were doors (32.1%) and gates (21.4%) (Figure 11). For additional detail, reference tables F-3, F-4 and Figure F-1 in Appendix F.

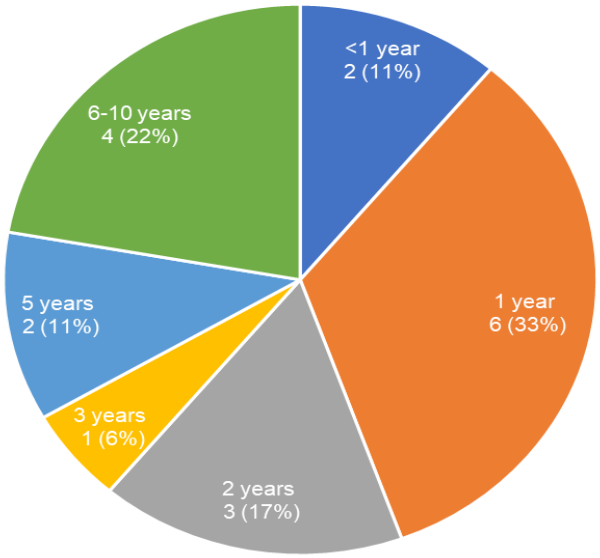
Of 18 verified maltreatment drowning deaths:

- 12 (66.7%) occurred at the age of 3 or under (Figure 12).
- 9 (50.0%) of the children did not know how to swim.
- 8 (44.4%) occurred in pools, hot tubs, or spas.
- 10 (55.6%) had no barriers to bodies of water.

Of 32 not substantiated or no indicators drowning deaths:

- 26 (81.3%) children were not able to swim.
- 28 (87.5%) occurred in pools, hot tubs, or spas.
- 6 (18.8%) had no barriers to bodies of water.

Figure 12: Verified Maltreatment Drowning Deaths by Age (n=18)



Drowning Data Summary

- ***Drowning deaths occurring in a Pool/Hot tub/Spa account for 72.0% of all 2020 drowning related fatalities.***
- ***Children 3 years of age and younger make up 72.0% of all 2020 drowning related fatalities.***
- ***68.0% of all 2020 drowning related fatalities involved male children.***
- ***50.0% of children were located within the home prior to the drowning incident with 48.0% described as playing before the drowning event took place.***
- ***Of all protection layers that were present in reviewed drowning cases, 33.9% were identified as being a door.***
- ***Doors and gates accounted for over half (53.6%) of all protection layers that were breached prior to drowning incidents.***

Inflicted Trauma Death Incident Information

The intentional bodily infliction of harm is captured in this category and remains a leading cause of preventable child death. Information is assessed regarding weapon-related deaths, including the type of weapon used and the person handling the weapon. The weapons category includes firearms, body parts such as fists, hands or feet and any other items that can be used as weapons. At the time data were analyzed for this report, several cases were not yet available for review (61 cases were still open to investigation). Many of 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 2020 deaths are reviewed. Figure 13 displays the types of weapons used in inflicted trauma cases by maltreatment verification status.

Among the verified maltreatment inflicted trauma deaths (13):

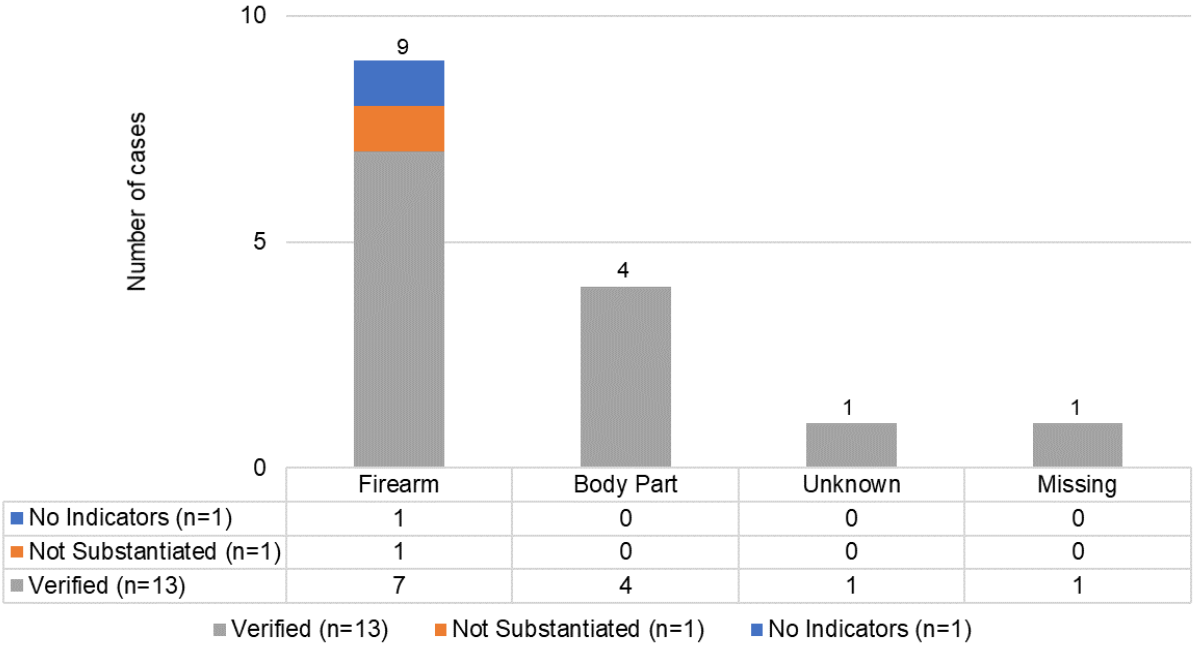
- 7 (53.9%) weapons used were firearms:
  - 4 of 7 firearms (57.1%) were handguns.
  - 3 of 4 (75.0%) firearm owners were male.
- 4 (30.8%) weapons were body parts.

Among the not substantiated and no indicators of maltreatment deaths combined (2):

- 2 (100.0%) weapons used were firearms.

For additional information regarding inflicted trauma-related deaths, see Appendix F.

Figure 13: Type of Weapon
by Maltreatment Verification Status
Among Inflicted Trauma Deaths (N=15)



	Firearm	Body Part	Unknown	Missing
No Indicators (n=1)	1	0	0	0
Not Substantiated (n=1)	1	0	0	0
Verified (n=13)	7	4	1	1

Table 9 shows the specific types of firearms used in deaths resulting from firearms.

Table 9: Type of Firearm by Maltreatment Verification Status			
Type of Firearm	Child Maltreatment Death n=9		
	Verified n=7	Not Substantiated n=1	No Indicators n=1
Handgun	4	1	1
Other	1	0	0
Unknown	1	0	0
Missing	1	0	0

In 2020, there were 20 verified homicide deaths; in 12 of these cases, the cause of death was inflicted trauma, or assault. In 5 of 20 (25.0%) verified maltreatment homicide cases, the cause of death was drowning and in the remaining 3 cases, the external cause of death is reported as another type of injury.

Table 10: Homicide Breakdown	
Homicide (Verfied Maltreatment n=20)	
Inflicted Trauma	12
Drowning	5
Other Injury Cause	3

Inflicted Trauma Data Summary

- ***60.0% of verified maltreatment homicides were the result of inflicted trauma.***
- ***53.9% of weapons utilized in cases of inflicted trauma death were firearms.***
- ***57.1% of firearms used in cases of inflicted trauma death were handguns.***
- ***30.8% of weapons utilized in cases of inflicted trauma death were body parts.***

Child Characteristics

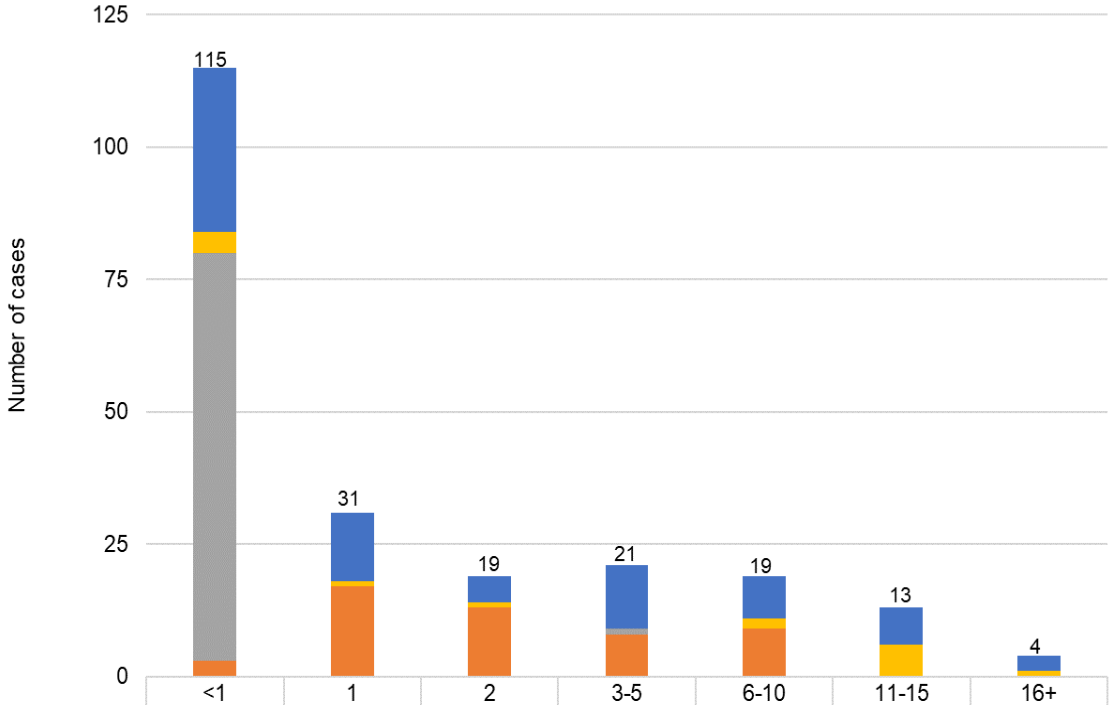
The following section highlights analyses associated with select child characteristics.

Age of Child

Regardless of verification status, children under age five had the highest risk for all forms of death with 186 of 222 (83.8%) of reported cases. As shown in Figure 14:

- Among drowning deaths 36 of 50 (72%) were children three years of age and younger.
- Among sleep-related deaths 77 of 78 (98.7%) were children less than one-year-old and most of the incidents, 47 of 78 (60.3%), were 3 months and younger.
- 31 of 79 (39.2%) child deaths attributed to “other” causes were under the age of one.

Figure 14: Age of Children by Primary Cause of Death (n=222)

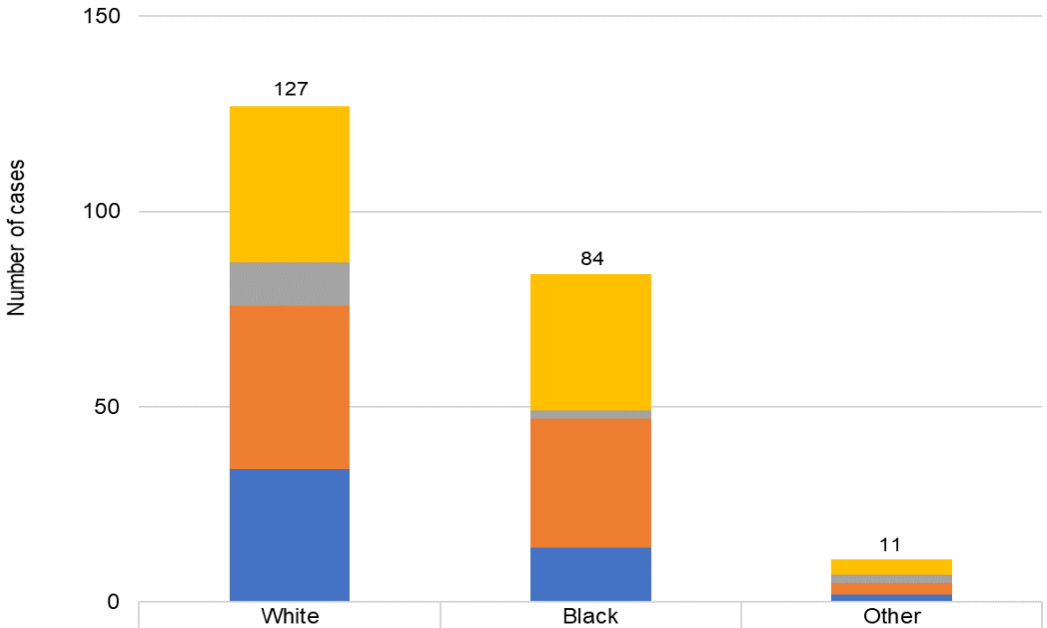


	<1	1	2	3-5	6-10	11-15	16+
Other (n=79)	31	13	5	12	8	7	3
Inflicted Trauma (n=15)	4	1	1	0	2	6	1
Sleep-Related (n=78)	77	0	0	1	0	0	0
Drowning (n=50)	3	17	13	8	9	0	0

Race of Child and Hispanic or Latino Origin

Child death case reviews result in the collection of data on race and ethnicity as related to child fatalities. As seen in Figure 15, 84 of 222 (37.8%) children were identified as black and 127 (57.2%) were identified as white.

Figure 15: Race of Children by Leading Cause of Death (n=222)

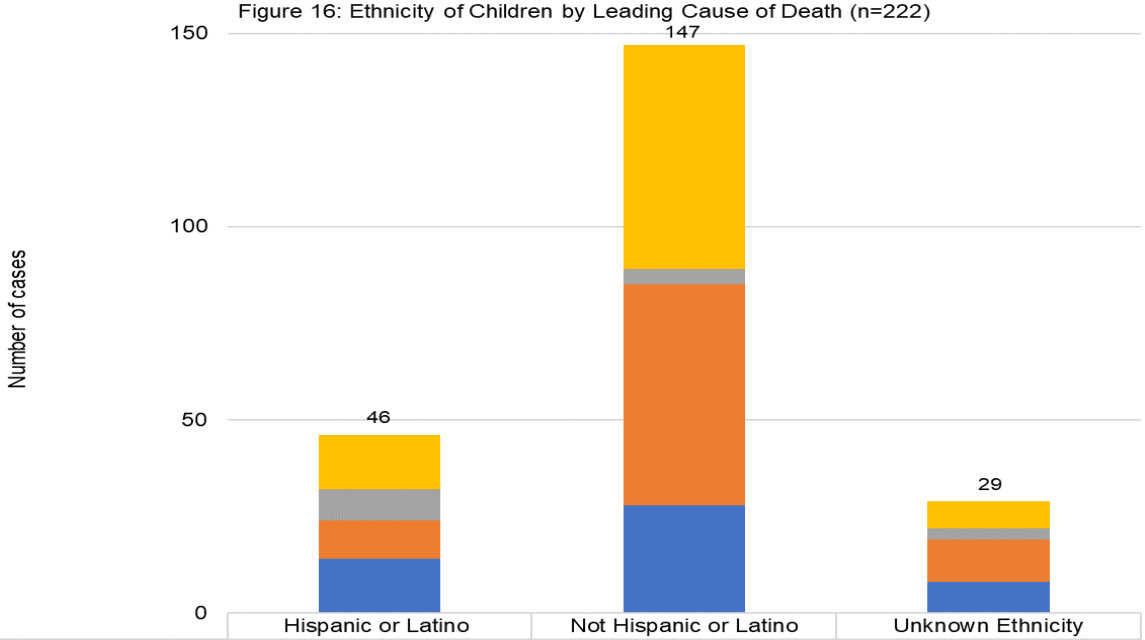


	White	Black	Other
Other n=79	40	35	4
Inflicted Trauma n=15	11	2	2
Sleep-related n=78	42	33	3
Drowning n=50	34	14	2

Figure 16 displays the breakdown of ethnicity across cases. Of all verified maltreatment fatalities, children identified as Hispanic or Latino represented:

- 28.0% of drowning deaths.
- 12.8% of asphyxia deaths.
- 53.3% of weapon deaths.
- 17.7% of other deaths.

Figure 16: Ethnicity of Children by Leading Cause of Death (n=222)

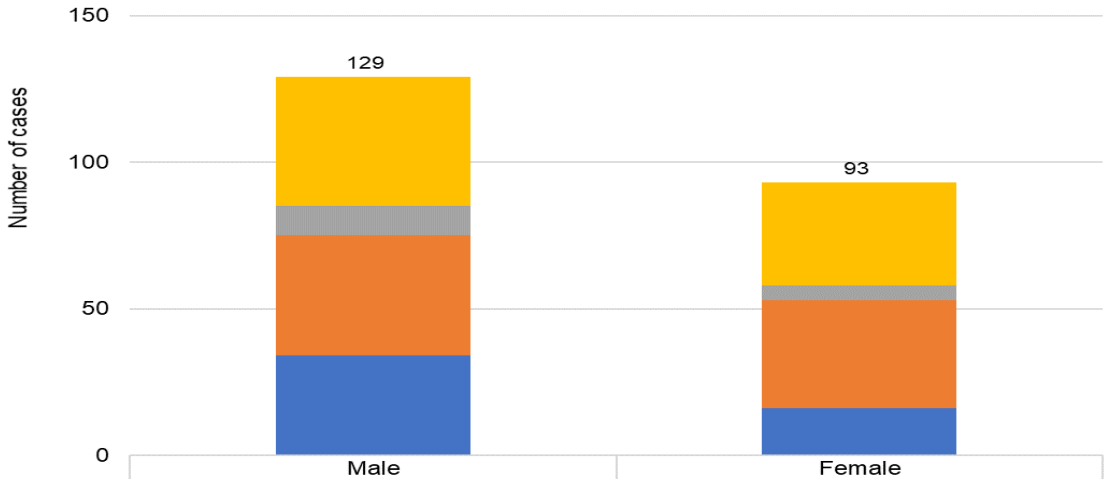


	Hispanic or Latino	Not Hispanic or Latino	Unknown Ethnicity
Other (n=79)	14	58	7
Inflicted Trauma (n=15)	8	4	3
Sleep-Related (n=78)	10	57	11
Drowning (n=50)	14	28	8

Sex of Child

Figure 17 shows the distribution of sex across cases by leading cause of death category. Males were disproportionately represented among child fatalities across all causes of death.

Figure 17: Sex of Children by Leading Cause of Death (n=222)



	Male	Female
Other n=79	44	35
Inflicted Trauma n=15	10	5
Sleep-related n=78	41	37
Drowning n=50	34	16

Child's History as Victim of Child Maltreatment

Child maltreatment history as a victim was known for 175 of 222 cases (78.8%), and unknown or missing for 40 (21.2%) cases. Among the 175 cases for which this history was reported, 37 (16.7%) children had a known history of maltreatment as a victim. Of cases where the child had a known history of maltreatment as a victim:

- 11 (29.7%) were verified.
- 7 (18.9%) were not substantiated.
- 19 (51.4%) were no indicators.

The distribution of known past maltreatment incidents across maltreatment verification status and primary cause of death is shown in Appendix F.

Child Characteristics Data Summary

- ***52.4% of all child fatality incidents received by CADR were < 1 year old.***
- ***58.1% of all child fatality incidents received by CADR were classified as male.***
- ***40.9% of all child fatality incidents received by CADR were identified as black.***

Caregiver and Supervisor Characteristics

During case reviews, information is collected on the child's caregivers and the supervisor of the child at the time of the incident leading to 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 CADR 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.

Substance Abuse History of Caregivers and Supervisors

Local CADR Committees assessed caregiver and supervisor substance abuse history. History of substance abuse does not necessarily indicate that the individual was using substances during the death incident.

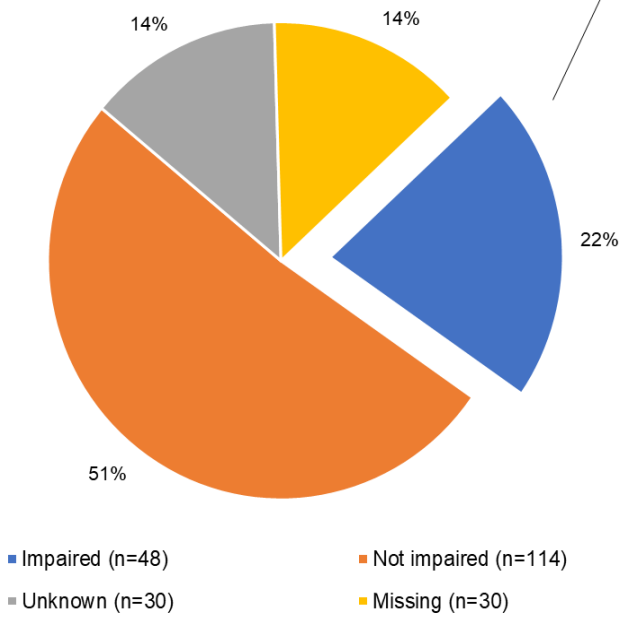
For verified child maltreatment cases:

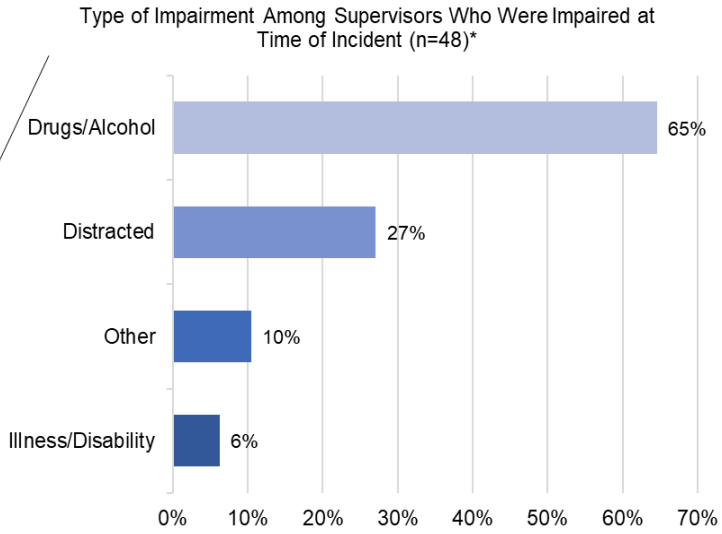
- 53.9% of caregivers were known to have a substance abuse history.
- 56.3% of supervisors were known to have a substance abuse history.

Appendix F includes detailed information related to substance abuse history of all caregivers and supervisors.

Information is collected regarding whether the supervisor of the child at the time of the death incident was impaired. Supervisors were found to be impaired in 48 of 222 (21.6%) cases, not impaired in 114 of 222 (51.4%) and unknown or missing for 60 of 222 (27.0%) cases. Among cases where the supervisor was impaired, 15 were verified, 12 were not substantiated, and 21 had no indicators. Figure 18 provides a breakdown of the distribution of types of supervisor impairment across all investigated deaths; more than one type of impairment can be present for a single supervisor.

Figure 18: Supervisor Impairment at Time of Incident (n=222)





**More than one type of impairment can be selected for a single supervisor*

Mental Health History of Caregivers and Supervisors

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 can be under-reported, leading to case sample sizes that are too small to reach valid conclusions. For example, among all caregivers identified across all child fatality cases reviewed, information on disability or chronic illness (including mental health /substance use) is unknown for 38 caregivers. However, there were an additional 65 caregivers for which data were missing. These figures highlight the need for better collection of information regarding mental health history of family members associated with a child fatality case.

Disability or Chronic Illness Occurrence of Caregivers and Supervisors

The National Fatality Review Case Reporting System collects information on the occurrence of disability or chronic illness among caregivers and supervisors. The presence of such a disability or illness does not mean that the condition was related to the death incident. For more information on disability or chronic illness data element, see Appendix F.

Additional Characteristics of Caregivers and Supervisors

Appendix F includes detailed information on the following:

- Employment of caregivers
- Education level of caregivers
- Language spoken by caregivers and supervisors
- Caregiver receipt of social services

History as Victim of Child Maltreatment among Caregivers and Supervisors

Local CADR Committees collect information regarding caregiver and supervisor history as a victim of child maltreatment. Local CADR Committees reported this maltreatment history for 359 caregivers identified (up to two caregivers could be identified per case) for the 222 cases reviewed of which historical information was available.

When history as a victim of child maltreatment is examined for all caregivers associated with maltreatment deaths:

- 14 of 78 (17.9%) caregivers of verified maltreatment cases had a history as a victim of child maltreatment.
- 25 of 80 (31.3%) caregivers of not substantiated maltreatment had a history as a victim of child maltreatment.
- 45 of 201 (22.4%) caregivers of no indicators maltreatment deaths had a history as a victim of child maltreatment.

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

- 6 of 49 (12.2%) supervisors of verified maltreatment had a history as a victim of child maltreatment.
- 15 of 47 (31.9%) supervisors of not substantiated maltreatment had a history as a victim of child maltreatment.
- 26 of 126 (20.6%) supervisors of no indicators maltreatment deaths had a history as a victim of child maltreatment.

History as Perpetrator of Child Maltreatment among Caregivers and Supervisors

Local CADR Committees identified caregivers and supervisors who have a prior history as a perpetrator of child maltreatment. When history as a perpetrator of child maltreatment is examined for all caregivers associated with maltreatment deaths:

- 23 of 81 (28.4%) caregivers of verified maltreatment had a history as a perpetrator of child maltreatment.
- 24 of 80 (30.0%) caregivers of not substantiated maltreatment had a history as a perpetrator of child maltreatment.
- 54 of 210 (25.7%) caregivers of no indicators maltreatment deaths had a history as a perpetrator of child maltreatment.

When history as a perpetrator of child maltreatment is examined for supervisors associated with maltreatment deaths:

- 13 of 49 (26.5%) supervisors of verified maltreatment had a history as a perpetrator of child maltreatment.
- 12 of 47 (25.5%) supervisors of not substantiated maltreatment had a history as a perpetrator of child maltreatment.
- 28 of 126 (22.2%) supervisors of no indicators maltreatment deaths had a history as a perpetrator of child maltreatment.

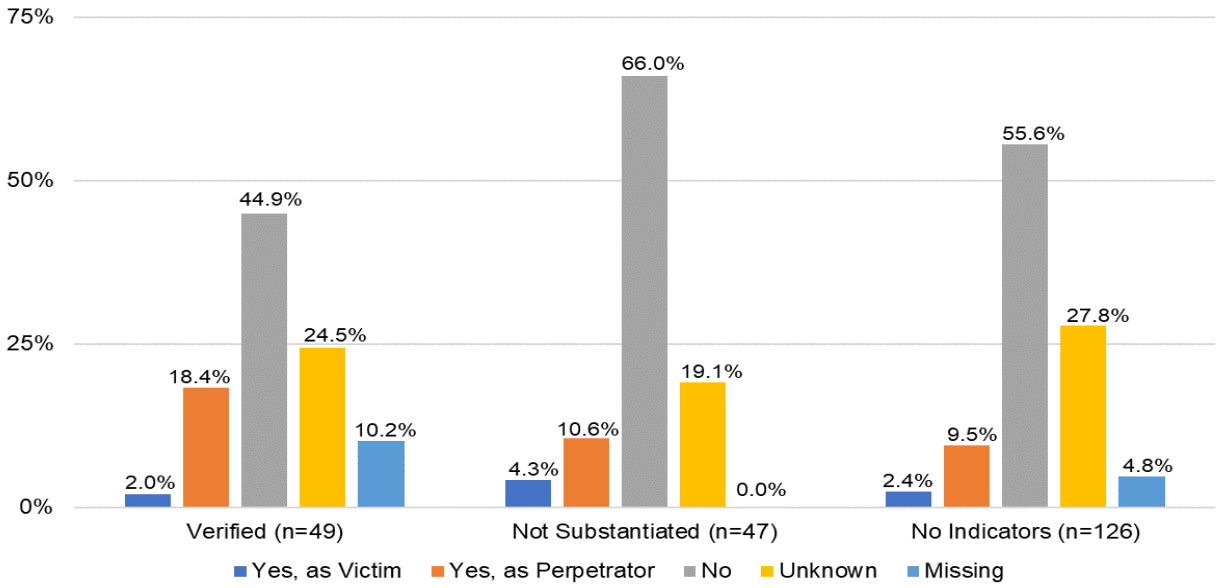
History of Intimate Partner Violence (as Victim and Perpetrator) among Caregivers and Supervisors

When available, Local CADR Committees collected information about caregivers' history with intimate partner violence (IPV) as a victim (survivor)[1] 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, in 1 of 49 (2.0%) cases of verified maltreatment death, at least one caregiver was known to be a victim and 9 of 49 (18.4%) were known to be perpetrators of intimate partner violence (Figure 18). With respect to caregivers in not substantiated maltreatment deaths, in 5 of 47 (4.3%) cases, at least one caregiver was a past victim and 5 of 47 (10.6%) were past perpetrators of intimate partner violence (Figure 18). Finally, with respect to caregivers in no

[1] *Victim* used in this context, holds legal meaning necessary within the criminal justice system. S*urvivor* can be used as a term of empowerment to convey that a person has started the healing process and may have gained a sense of peace in their life. More information regarding the use of victim versus survivor can be found at: Victim or Survivor: Terminology from Investigation Through Prosecution (sakitta.org)

indicator deaths, in 3 of 126 (2.4%) cases, there was at least one caregiver with a history as a past victim of intimate partner violence and in 12 of 126 (9.5%) cases, a caregiver was a past perpetrator of intimate partner violence (Figure 19).

Figure 19: History of Intimate Partner Violence Among Caregivers by Maltreatment Verification Status (N=222)



When available, Local CADR Committees collected information about supervisors' history with intimate partner violence (IPV) as a victim and/or perpetrator. It is unclear whether the supervisors were victims or perpetrators near the time of the child's death or if supervisor history was determined by historical information gathered by local teams during case reviews. In total, 8 of 49 (16.3%) supervisors were known to be victims and 10 of 49 (20.4%) were known to be perpetrators of intimate partner violence among those affiliated with verified maltreatment deaths. With respect to supervisors in not substantiated maltreatment deaths, 7 of 47 (14.9%) were past victims and 4 of 47 (8.5%) were past perpetrators of intimate partner violence. Finally, with respect to supervisors in no indicator deaths,12 of 126 (9.5%) were past victims of intimate partner violence and 11 of 126 (8.7%) were past perpetrators of intimate partner violence. Appendix F provides more detailed information regarding the history of IPV (as victim and perpetrator) among caregivers and supervisors.

Past Criminal History of Caregivers and Supervisors

Among caregivers associated with verified maltreatment deaths, 28 of 85 (32.9%) committed a criminal offense in the past with the most common offenses identified as: drugs representing 16 of 28 (57.1%) and "other criminal act" representing 14 of 28 (50.0%).

Among supervisors associated with verified maltreatment deaths, 13 of 49 (26.5%) committed a criminal offense in the past with the most common offenses identified as: assault, representing 11 of 13 (84.6%), drugs, representing 6 of 13 (46.2%) and other, representing 6 of 13 (46.2%).

Caregiver and Supervisor Data Summary

- ***Relating to verified maltreatment, 37.2% of caregivers and 34.7% of supervisors reported having a substance abuse history.***
- ***Relating to verified maltreatment, 32.9% of caregivers and 26.5% of supervisors reported having a criminal past.***
- ***21.6% of supervisors were impaired at the time of the death incident; in 65% of these cases, the impairment was caused by drugs or alcohol.***

SECTION FOUR: 2021 CADR SUMMIT

The CADR Annual Summit brings together Local and State CADR stakeholders to provide informative and engaging learning opportunities and enhance CADR Committee efforts in eliminating preventable child death. The 2021 CADR Summit occurred over the course of two half-days, July 15-16, 2021, using the virtual platform GoToWebinar. State and Local CADR stakeholders completed an interest survey to identify topics that would best serve the needs and interests of their communities. The survey results indicated a strong interest in demonstrating methods for using CADR data to develop effective prevention initiatives, prompting the theme: Data-to-Action.

Facilitating the 2021 CADR Annual Summit posed new challenges as the event was moved to a virtual platform for the first time. While there were limitations, the participation and contributions of outstanding presenters and panelists allowed the 2021 CADR Annual Summit to reach intended goals, providing a valuable experience for all attendees.

The presentation provided by Abby Collier and Susanna Joy of the National Center for Fatality Review and Prevention, *Shifting From Recommendations to Findings: Using Brain Science*, guided attendees in the examination of current protocols, exploration of opportunities to enhance case review practices and provided critical resources for moving the work of CADR Committees from data collection and analysis to effective prevention activities in communities across the state. The introduction and training on the Socio-Economic Model Matrix provided CADR members a structured tool to rely upon to incorporate further consideration of social determinants of health and continue to build health equity into the case review process and development of community prevention.

Recent Increases in Suicide Among Children and Adolescents in Florida, presented by Megan Macdonald of the Florida Department of Health, provided a meaningful response to the interest of many Local and State CADR members who are actively seeking to learn more about how suicide is impacting Florida's youth and to assess ways that the CADR process can contribute to the development of effective prevention initiatives.

Amanda Regis of the Florida Department of Children and Families provided the presentation, *Suicide Prevention,* which offered a comprehensive overview of suicide risk factors and prevention opportunities and provided invaluable resources with the 2021 CADR Summit attendees.

The presentations regarding suicide prevention support the State CADR Committee's interest in addressing high-level recommendations, such as exploring collaborative partnerships with entities who may be currently examining child and adolescent suicide to better inform targeted prevention initiatives.

State CADR Committee member and President and CEO of Directions for Living, April Lott, provided the presentation, *Impact of Trauma on Family Functioning and Child Wellbeing.* This presentation provided an opportunity for summit attendees to glean from the expertise of Ms. Lott as it relates to child trauma, Adverse Childhood Experiences (ACEs), and resilience, addressing many critical areas pertinent to the work of CADR.

The presentation provided by Ken DeCerchio of the National Center on Substance Abuse and Child Welfare titled *Impact of Substance Abuse on Children and Families* provided a

comprehensive overview of a highly impactful topic, including Florida-specific data. The focus on strengthening families and increasing the use of alternative familial supports highlighted the continuous need for collaboration and coordination across multiple service systems including CADR Committees and stakeholders. The resources provided in this presentation will continue to be utilized in training and further educating members of the CADR community across the state.

In line with previous CADR Annual Summits, a Local Prevention Panel was hosted to provide an opportunity for Local CADR Committees to highlight community level prevention efforts. The Local Prevention Panel serves as a valuable opportunity for summit attendees to engage with other Local CADR Committee leaders and learn how to most effectively implement prevention strategies at the local community level.

Local Prevention Panelist, Vicki Whitfield, provided an in-depth overview of the development and implementation of the highly effective safe sleep initiative, Sleep Baby Safely. Ms. Whitfield demonstrated how to build community support and create opportunities for expansion of the program to include additional funding and continuation of efforts.

As a Local Prevention Panelist, Rebecca Albert provided an informative presentation on an innovative approach to increasing awareness regarding the impact of trauma on children and effective ways to reduce the impact of trauma. Ms. Albert demonstrated how strong community relationships with partners and pediatricians allow for a broader reaching assessment of ACEs and an opportunity to better meet the needs of children.

Local Prevention Specialists Taylor Freeman and Cassie McGovern from Local CADR Committees in Circuits 10 and 17, respectively shared professional expertise for building strong community relationships as a critically valuable element for implementing multi-faceted drowning prevention initiatives and outreach efforts, highlighting strategies for educating hard-to-reach populations.

The 2021 CADR Annual Summit presentations were recorded and are available to be viewed and shared at www.FLCADR.com. Biographies for each presenter and panelist can be found in Appendix G.

The Impacts of the COVID-19 Pandemic on Children and Families

Reports of increased incidents of severe child abuse and neglect in Florida during the COVID-19 pandemic is complicated by a demonstrated decrease of reported cases of child abuse and neglect, as children's interactions with professionals and teachers were limited, primarily by the closure of schools, followed by some families opting for virtual learning after schools re-opened.[2]

The COVID-19 pandemic has resulted in an increase in risk factors associated with social determinants of health including income and employment instability, food insecurity, access to health care, and heightened stress which is indicated to have led to a rise in child abuse and neglect.[3] The Centers for Disease Control and Prevention (CDC) reports, "During the COVID-19 pandemic, the total number of emergency department visits related to child abuse and neglect decreased, but the percentage of such visits resulting in hospitalization increased, compared with 2019."[4] Some Florida hospitals have reported a similar increase in severe child abuse injuries, resulting in prolonged hospitalizations.[5] This information suggests, "the COVID-19 pandemic response has affected health care–seeking patterns for child abuse and neglect, raising concerns that victims might not have received care and that severity of injuries remained stable or worsened. Implementation of strategies to prevent child abuse and neglect is important, particularly during public health emergencies."[2]

Additionally, Florida systems of child and family well-being have been significantly impacted due to the COVID-19 pandemic, requiring multiple changes in protocols as teachers, doctors, and other professionals navigate reporting suspected abuse and neglect with limited in-person interaction. Innovative approaches to service delivery in systems of child and family well-being such as applying virtual alternatives to services including child-parent visits, court appearances, and home-based parenting programs have been implemented to ensure the safety and well-being of children despite challenges posed by the pandemic. This change in service delivery has inadvertently increased access to services for some families and may be recognized as an effective means for providing services to families moving forward.

The CDC states "Child abuse is preventable; implementation of strategies including strengthening household economic supports and creating family-friendly work policies can reduce stress during difficult times and increase children's opportunities to thrive in safe, stable, and nurturing relationships and environments." (CDC Morbidity and Mortality Weekly Report, December 11, 2020). The encompassing impact of the COVID-19 pandemic demonstrates a critical importance to rely upon protective factors such as these to eliminate preventable child death.

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[2] United States Government Accountability Office (GAO), CHILD WELFARE Pandemic Posed Challenges, but also Created Opportunities for Agencies to Enhance Future Operations (July 2021)
[3] Rosenthal C.M. & Thompson L.A., Child Abuse Awareness Month During the Coronavirus Disease 2019 Pandemic, *JAMA Pediatr.* (2020)
[4] Swedo E, Idaikkadar N, Leemis R, et al. Trends in U.S. Emergency Department Visits Related to Suspected or Confirmed Child Abuse and Neglect Among Children and Adolescents Aged <18 Years Before and During the COVID-19 Pandemic — United States, January 2019–September 2020. MMWR Morb Mortal Wkly Rep (2020)
[5] Lee Health, COVID-19 Fallout: More Severe Child Abuse Injuries During Pandemic. COVID-19 Fallout: More Severe Child Abuse Injuries During Pandemic | Lee Health (2020)

As of April 2021, the NCFRP began collecting data regarding the direct and indirect impacts of COVID-19 on child fatality incidents. Local CADR Committees have been instructed to complete this section for all child fatalities occurring after March 1, 2020. The State CADR Committee is committed to tracking these data to further assess and better understand the effects of public health emergencies on children and families to inform future prevention efforts.

Adverse Childhood Experiences (ACEs)

There has been extensive research on the impact of ACEs including child abuse and neglect as well as other life stressors on the immediate and later-in-life health and well-being of individuals. One finding of the original ACEs Study demonstrated that persons with four or more exposures to ACEs had a four-to-twelve-fold increased risk for alcohol and substance abuse, depression, and suicide attempts (Felitti, et al., 1998). Other studies have corroborated these findings, collectively reinforcing the necessity and value in minimizing the exposure to and mitigating the influence of ACEs on children, youth, and families.[6] ACEs are prevalent across all aspects of society. The CDC reports that 61% of adults have experienced at least one ACE, with 16% experiencing four or more types of ACEs. Females and numerous minority groups have disproportionately higher risk for experiencing four or more ACEs (CDC, 2019a; CDC, 2019b). The Annie E. Casey Foundation, Kids Count Survey demonstrates rates of children living in Florida who have an ACEs score of two or higher based on having specific measurable adverse childhood experiences. According to this survey, in 2016-2017, 25% of children in Florida had an ACEs score of two or more, while in 2018-2019 (the last published data), 18% of children in the state were identified to have an ACEs score of two or more.

Prevention efforts focused on reducing child maltreatment, child fatalities, and the risk of child and adolescent suicide can benefit from a focus on ACEs and associated initiatives at reducing life stressors, strengthening families, enhancing life skills, and building individual and community resilience with effective social, environmental, and economic supports (CDC, 2019a; CDC, 2019b; Center for the Developing Child, 2021; Ellis, W.R. & Dietz, W.H., 2017; National Conference of State Legislatures, 2018). Through valuable partnerships and multi-disciplinary, trauma-informed care, communities can effectively address and treat childhood trauma, mitigate the adverse influences of ACEs, potentially reduce incidences of suicide, and increase overall wellness for children and families in Florida. Integrated systemic collaboration reinforces a community-based, public-health perspective which can enhance community resilience through direct and indirect efforts focused on ACEs and community environments (Ellis & Dietz, W.H., 2017).

Co-Occurring Disorders

Co-occurring disorders, involving both mental health and substance abuse have a continued prevalence throughout Florida and a significant impact on the well-being of children. Substance Abuse and Mental Health Services Administration (SAMHSA) identifies a significant correlation between persons dually diagnosed with substance abuse and mental health disorders, including Post-Traumatic Stress Disorder (PTSD) and a variety of depressive and anxiety related disorders. Current literature based upon the ACEs Study demonstrates that children with caregivers experiencing co-occurring mental health and substance abuse disorders are at a

[6] For more information regarding the impact of ACEs and associated prevention recommendations, please see: Felitti V.J., et al. (1998); Bartlett, J.D. & Sacks, V. (2019); Centers for Disease Control and Prevention (2019a); Centers for Disease Control and Prevention (2019b); Center for the Developing Child (2021); Ellis, W.R. & Dietz, W.H. (2017); National Conference of State Legislatures (2018); Sege, R., et al. (2017); Sege, R. D., & Browne, C. H. (2017).

greater risk of a variety of stressors including exposure to domestic violence,[7] increased risk of poverty, and may be at an increased risk of child abuse and neglect. Local CADR Committees work together with providers in their communities who are addressing co-occurring substance abuse and mental health in the home, providing critical data, and education regarding the needs of this population.

Drowning

Drowning has consistently been the second leading cause of preventable child death in Florida for the past six years. From 2019 to 2021 (provisional), DCF documented a 21.5% increase in child fatalities due to drowning. The Central Florida region has experienced the largest increase in these incidents, specifically Orange and Osceola counties. Between January 1, 2021 and September 29, 2021, there have been 17 fatal child drowning incidents occurring in Orange and Osceola counties. Of the 17 drowning incidents, 9 occurred at vacation rental properties located in Osceola County. This increase of child drowning fatalities occurring in Florida, further indicates a need to increase water safety and drowning prevention messaging, particularly to families and caregivers visiting the state. The State CADR Committee, along with drowning prevention experts throughout the state, are working to address fatal child drownings in Florida with special attention given to tourists and non-Florida residents staying at vacation rental properties.

Child and Adolescent Suicide Fatalities

Most recent FDOH data identify suicide as the eighth leading cause of death in Florida in 2019, recognizing death by suicide as a serious public health issue. In 2020, there were 91 child suicides in Florida, according to Florida Health Community Health Assessment Resource Tool Set (FLHealthCHARTS).[8] Of the 91 child suicide incidents, 7 were called into the Florida Abuse Hotline on the suspicion of alleged abuse or neglect and subsequently forwarded to Local CADR Committees for review. The State CADR Committee identifies the need for a more comprehensive assessment of the contributing factors of child suicide deaths.

State and Local CADR Committees work to thoroughly understand and effectively address these critical issues facing Florida's children and families through continued collaboration with various state agencies and organizations.

[7] Exposure to domestic violence can include hearing, witnessing and/or intervening when one caregiver chooses to harm the protective caregiver as a means of gaining power and control.
[8] At the time of this report, 2020 and 2021 data in FLHealthCHARTS are provisional.

SECTION SIX: IMPLEMENTATION OF 2020 PREVENTION RECOMMENDATIONS

Local and State CADR Committees collect and analyze data from case reviews. These data are utilized to inform the development and implementation of prevention initiatives at the local level, to eliminate child fatalities as a result of abuse and neglect. The initiatives outlined below provide an example of efforts made in response to the 2020 Prevention Recommendations developed by the State CADR Committee.

Safe Sleep Education Efforts

Local CADR Safe Sleep Outreach

In 2021, the Local CADR Committee in Circuit 12B (Sarasota and DeSoto counties) implemented a number of initiatives to address the primary leading causes of preventable child fatalities with a focus on factors affecting families in the local area and with a strategy of engaging with local providers and stakeholders to enhance prevention efforts.

Safe sleep kits containing a pack n' play with bassinet, crib sheet with safe sleep messaging, pacifier, and safe sleep educational materials were provided to all DCF Child Protection Investigators, Child Welfare Case Managers, and Healthy Start Coalition Care Coordinators for distribution to families along with face-to-face education. The Local CADR Committee partnered with Sarasota Memorial Hospital to support efforts to provide safe sleep education to every new parent during discharge from the hospital and to encourage parents to sign a pledge, committing to safe sleep practices. A safe sleep public service announcement was developed and aired locally to further share safe sleep messaging throughout the community.

The Local CADR Committee in Circuit 12B participated in numerous local events to raise awareness about infant safe sleep including the Sarasota Community Baby Shower, North Port Community Baby Shower and Preschool Expo. Education and safe baby kits were shared at the Children First Early Head Start Program which included safe sleep and drowning prevention information. Additionally, trainings regarding safe sleep education, DCFs *Who's Really Watching Your Child?* campaign, and the impact of substance abuse during pregnancy were provided to persons incarcerated at the Sarasota County Jail.

The Local CADR Committee in Circuit 12B has made these efforts in alignment with a number of the recommendations developed by the State CADR, including relaying timely information to caregivers regarding the safety of children, developing strategies to ensure consistent messaging across multiple agencies, increasing drowning prevention messaging, and supporting programs that enhance parenting skills. The work of the Local CADR Committee in Circuit 12B is a demonstration of how CADR committees utilize data collected through the case review process to inform prevention activities that are relevant and effective within the local community.

In 2021, the Local CADR Committee in Circuit 13 (Hillsborough County) implemented a safe sleep messaging campaign to raise awareness regarding the dangers of unsafe sleep practices. Local CADR Committee members participated in the development of a public service announcement which aired on various platforms throughout the Tampa Bay area. Nine Spanish language billboards were displayed in targeted areas of Hillsborough County which promoted

the ABCs of safe sleep. The Committee worked throughout the year to provide training addressing the three primary causes of preventable child death to partners, providers, and directly to families. The training focused on choosing a safe caregiver, preventing inflicted trauma, and promoting safe sleep practices. The Local CADR Committee worked to provide this training to 750 professionals throughout the community. As a result, Safe Baby education was provided to over 16,000 families and over 1,400 families completed the Safe Baby Parent Survey with 91% of parents indicating alignment with placing a baby to sleep on their back.

In addition to providing critical safe sleep messaging to the local community, the Local CADR Committee in Circuit 13 also worked to ensure that other professionals and stakeholders received important information regarding mental health issues affecting families and caregivers and received information regarding the use of Mental Health First-Aid. Community resources and access points for care were shared with professionals to support continuity of care throughout the local community. These efforts are in alignment with the State CADR Committee's recommendations to relaying timely information to caregivers regarding the safety of children, developing strategies to ensure consistent prevention-related messaging across multiple agencies, and supporting programs that enhance parenting skills.

Sleep Baby Safely, Duval County

In January 2020, the Local CADR Committee in Circuit 4 (Duval, Nassau, Clay counties) initiated Sleep Baby Safely, partnering with nine area birthing hospitals to provide infant safe sleep education and materials to the parents of each baby born in the facility. Participating hospitals originally included: Ascension St. Vincent's Riverside, Baptist Medical Center Jacksonville, Baptist Medical Center Beaches, Baptist Medical Center South, Memorial Hospital, Naval Hospital Jacksonville, St. Vincent's Medical Center Southside, UF Health Jacksonville, and UF Health North. Safe sleep education was provided by labor and delivery nurses, Neonatal Intensive Care Unit (NICU) nurses and lactation specialists at each hospital. Prior to the implementation of Sleep Baby Safely, a review of data available during the planning phase illustrated an average of 2.08 sleep-related deaths per month over a three-year period (2016-2018) in Duval County. Since the program was implemented, the Local CADR Committee in Circuit 4 reported a total of eight confirmed sleep-related infant death incidents during the first twelve months, resulting in a decrease of 1.41 sleep-related infant deaths per month. This decrease demonstrates the potential efficacy of Sleep Baby Safely.

Sleep Baby Safely continues to evolve to best serve the Northeast Florida community. One significant change includes a reduction in participating hospitals, as the three Baptist Medical Centers have developed their own safe sleep initiative resulting in six remaining birthing hospitals participating in the Sleep Baby Safely program including: Ascension St. Vincent's Riverside, Memorial Hospital, Naval Hospital Jacksonville, St. Vincent's Medical Center Southside, UF Health Jacksonville, and UF Health North. Another notable change includes plans to expand the initiative to hospitals and medical providers in surrounding counties including Clay, St. Johns, Flagler, Volusia, and Nassau counties. Furthermore, the Local CADR Committee in Circuit 4 plans to provide the safe sleep education included in the Sleep Baby Safely program beyond birthing hospitals to include: pediatric offices, family practitioner offices, local health departments, WIC and immunization clinics, especially in areas of Baker and Putnam counties where there is no immediate access to birthing hospitals.

The Sleep Baby Safely initiative has been well-received and supported; however, there have been challenges, particularly maintaining consistent volunteer involvement, securing funding, and storage space for tangible materials and printed items. The COVID-19 pandemic has also resulted in new challenges in bringing together volunteers in-person for preparing materials for delivery to hospitals.

These efforts are in alignment with the State CADR Committee's recommendations including: relaying timely information to caregivers regarding the safety of children; developing strategies to ensure consistent prevention-related messaging across multiple agencies and providers; supporting programs that enhance parenting skills; supporting and encouraging the development and evaluation of pilot projects and initiatives focused on local and regional community-based child fatality prevention.

Sudden Unexpected Infant Death Investigation (SUIDI) Training

In 2021, State CADR Committee Chairperson, Ret. Major Connie Shingledecker facilitated SUIDI trainings designed for professionals in the use of the Sudden Unexpected Infant Death Investigation Reporting Form (SUIDIRF) and doll reenactments during a death scene investigation. Attendees included law enforcement personnel and medical examiners, who are responsible for conducting the death scene investigation, but also included other professionals, such as crime scene technicians, victim advocates, DCF personnel, and others who interact with the death scene investigation or intercept the findings of the death scene investigation. Attendees were trained in the following objectives:

- Understanding different types of SUID and differentiate SUID deaths from deaths due to physical abuse and neglect.
- Describing normal infant development and applying knowledge to infant death scene findings.
- Conducting a comprehensive infant death scene investigation using the SUIDIRF.
- Describing appropriate interviewing techniques.
- Understanding how use and misuse of certain products may play a role in infant death cases and the importance of documentation.

The effort to provide training to professionals conducting infant death scene investigations is aligned with the State CADR Committee's recommendation to encourage the consistent use of SUIDIRF and doll reenactments by death scene investigators for all sleep-related infant death investigations. Consistent use of the SUIDIRF contributes to more comprehensive data collection and analysis to further inform an understanding of the factors contributing to sleep-related infant death. Ret. Major Shingledecker continues efforts to provide this training to professionals throughout the state.

Drowning Prevention Efforts

Keep Kids Safe From Drowning Initiative

A targeted drowning prevention effort developed by the State CADR Committee, Keep Kids Safe From Drowning, was implemented by Local CADR Committees in the eight Florida counties demonstrating the highest incidence of child drowning over the past three years including: Broward, Polk, Orange, Hillsborough, Palm Beach, Duval, Volusia, and Miami-Dade counties.

The Keep Kids Safe From Drowning prevention pilot program targets both swim-time and non-swim time related drownings with the overall objective of reducing or eliminating preventable child drowning. In this effort, Local CADR Committee members partner with local service providers including pediatricians, day care centers and pre-schools, home visiting programs, community centers, apartment complexes, local school boards, county health departments and others to collectively distribute 4,500 posters, 50,000 door hangers and 55,000 Water Watcher tags and lanyards in both English and Spanish language.

Through partnership with home-visiting programs, including Healthy Start, Healthy Families, and DCF, this initiative promotes face-to-face education regarding child drowning incidents which occur when children exit the home undetected. Local CADR Committees have taken the lead in identifying local partners for distributing drowning prevention materials and ensuring consistent messaging reaches communities. This effort intends to increase awareness and heighten supervision of young children who might unknowingly breach barriers, such as doors and windows, to outside bodies of water.

Drowning Prevention Public Media Campaign

The FDOH, Division of Children's Medical Services (CMS) and Division of Community Health Promotion partnered with Florida Public Media to develop public service announcements (PSA) featuring swim-time and non-swim-time drowning prevention messaging to be aired on Public Broadcasting Service (PBS) Kids television channel and National Public Radio (NPR).

Drowning Prevention, Orlando International Airport

Drowning prevention messaging developed by the State CADR Committee will be prominently displayed in Orlando International Airport to inform tourists of the need for vigilant supervision and water safety. This effort addresses the ongoing and increasing issue of fatal child drownings among non-Florida residents.

These efforts are in alignment with the State CADR Committee's recommendations including: relaying timely information to caregivers regarding the safety of children and to increase messaging around appropriate supervision and barriers of protection as primary factors in drowning prevention, in addition to establishing age appropriate expectations related to young children and swimming capabilities consistent with recommendations of the AAP.

General Prevention Efforts

Florida Prevention Advisory Council (FPAC)

FPAC was developed to make recommendations to Prevent Child Abuse, Florida (PCAFL), related to strategic planning and implementation, advocacy, training, evaluation, and funding of PCAFL's programming. The mission of FPAC is to prevent all forms of child abuse and neglect through community partnerships, education, collaboration, and advocacy. FPAC intends to address these issues by working with diverse partners to increase the public's understanding, ownership, and investment in child abuse prevention programs and services as well as advocate for resources needed to prevent child abuse and neglect, promote child well-being, and strengthen families. Employees of the CADR Unit staff serve on FPAC to help promote this mission, strengthen relationships with key stakeholders and ensure cohesive communication and collaboration with partners in other agencies and organizations as each entity aims to contribute to the development of effective, sustainable child abuse and neglect prevention activities.

CADR participation on FPAC is in alignment with the State CADR Committee's recommendations including: relaying timely information to caregivers regarding the safety of children, developing strategies to ensure consistent prevention-related messaging across multiple agencies and providers, supporting programs that enhance parenting skills, supporting and encouraging the development and evaluation of pilot projects and initiatives focused on local and regional community-based child fatality prevention.

2021 CADR Annual Summit

The State CADR Committee hosted the 2021 CADR Annual Summit on July 15-16, 2021. The two-day summit was hosted on a virtual platform, permitting attendees from around the state to participate. Local and national experts in numerous fields related to the work of CADR provided valuable presentations, ensuring that attendees experienced an informative, educational, and engaging training opportunity.

The Summit's 110 attendees included State and Local CADR Committee members, county health department representatives, and other CADR stakeholders. The State CADR Committee designed the 2021 CADR Annual Summit with this audience in mind, around the theme, Data-to-Action. Presentation topics of the 2021 CADR Annual Summit included:

- Developing data-informed prevention initiatives at the community level.
- Utilizing a new tool for prevention initiative development and design.
- Co-occurring disorders and their impact on child and family well-being.
- Suicide among Florida's youth.

The CADR Annual Summit also included a Local Prevention Panel, highlighting the current prevention work developed and implemented by Local CADR Committees around the state. The Local Prevention Panel provided an opportunity for summit attendees to engage with and learn directly from Local CADR leaders who are effectively implementing prevention strategies at the community level. For more information regarding the 2021 CADR Annual Summit, please refer back to Section Four of this report.

Hosting the 2021 CADR Annual Summit is in alignment with the State CADR Committee's recommendations including: developing strategies to ensure consistent prevention-related messaging across multiple agencies and providers, expanding efforts to collect data related to co-occurring substance abuse and mental health disorders, exploring the expansion of the CADR statute language to permit Local CADR Committees the ability to review child and adolescent suicides to better inform targeted prevention initiatives, supporting and encouraging the development and evaluation of pilot projects and initiatives focused on local and regional community-based child fatality prevention.

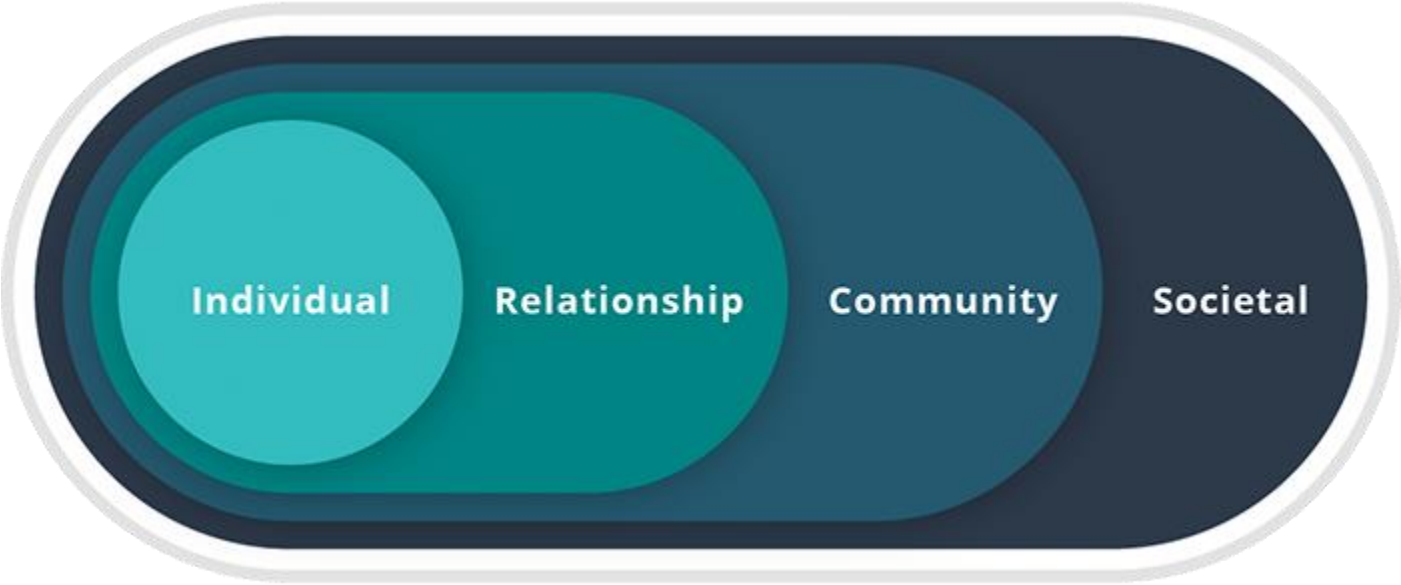
SECTION SEVEN: PREVENTION RECOMMENDATIONS

Moving Forward: A Social Ecological Model for Change

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:

- Sleep-Related Infant Death.
- Drowning.
- Inflicted Trauma.

The 2021 State CADR Committee prevention recommendations are based on an analysis of CADR findings for the 2020 child fatality cases reviewed, as well as input provided by community and state partners, and a review of current child welfare literature. To effectively address each level of intervention, approaches to prevention have been organized using the following framework known as the Social-Ecological Model for Change.



The four-level Social-Ecological Model for Change is utilized to demonstrate the multifaceted and interactive aspects of personal and environmental factors that determine behavior, impact behavioral change, and help inform risk-prevention strategies. This model, as presented by the CDC, demonstrates how behaviors are formed based on characteristics of individuals, relationships, communities, and the broader society. The framework suggests, in order to develop effective prevention strategies, it is necessary to address each level of the model.

The 2021 Prevention Recommendations developed by the State CADR Committee are as follows:

- **Continue efforts to relay timely information to caregivers and community supports regarding the safety of children.**

  The State CADR Committee recommends that communities continue providing timely messaging to parents regarding potential risks to children related to the leading causes of preventable child deaths, including sleep-related infant death, drowning, and inflicted trauma. Bolstering efforts to educate parents and families on the risks associated with the leading causes of preventable child death must remain a priority for the citizens of Florida. The State CADR Committee encourages collaboration among community supports, such as family resource centers, faith-based communities, and culturally specific entities. The influence of these types of community organizations could vastly improve the perceived reliability of information provided, thus increasing the overall reach of the messaging and the likelihood of parents and caregivers acting upon the potentially lifesaving information.

  Providers who engage with caregivers in their home environment, such as DCF and Healthy Families Florida, assess for potential risks in the home, provide education and support, link parents to resources and evaluate caregiver and child well-being. Partnership with these programs is an important link to ensuring key messaging reaches caregivers in a timely manner.

  There is a continued need for effective engagement of expectant mothers, partners, and grandparents; especially as it relates to maternal health, safe sleep practices, and the adverse effects of maternal substance misuse on the fetus and on the newborn. Additionally, the State CADR Committee supports the consistent use of maternal depression screening tools at well-child pediatric appointments and a coordinated response to address any needs identified as a result of the screening. The State CADR Committee recommends the use of home safety checklists which are designed to help identify hazardous conditions within the home that could pose a risk to children.

- **Continue to develop strategies to ensure consistent and coordinated prevention-related messaging across local and state agencies, business and industry leaders, and other relevant private and public sector groups.**

  Building upon existing efforts, the State CADR Committee recommends the continued development of a formal plan for widespread collaboration focused on prevention messaging consistent with recommendations of the American Academy of Pediatrics (AAP) regarding safe sleep practices and drowning prevention. Strategies may include:

  - Collaborating with stakeholders during quarterly meetings.
  - Using research as a foundation for information and messaging priorities.
  - Using a positive messaging approach.
  - Ensuring coordinated statewide messaging.
  - Exploring resources available to support messaging outreach.
  - Developing an online centralized statewide clearinghouse of prevention resources to be available to providers, families, and the general public.
  - Creating prevention tool kits.

- Expanding partner networks to include chambers of commerce, school boards, hospitals, law enforcement, Healthy Start Coalitions, Children's Services Councils, other community resources, and relevant local parties.
- Further leveraging social media for sharing prevention-related information.
- Collaborating with public health programs at state universities to strengthen social marketing strategies.

- **Expand efforts to collect data related to co-occurring substance abuse and mental health disorders.**

  Substance abuse and mental health disorders continue to be identified as risk factors associated with verified maltreatment deaths of children. Enhanced efforts are needed to identify opportunities to engage with community partners who are addressing co-occurring disorders in caregivers. Further efforts are needed to explore evidence-based prevention initiatives that can be utilized in communities where these issues are more prominent. The State CADR Committee recommends that consideration be given to existing guides, such as the Strategic Prevention Framework of the Substance Abuse and Mental Health Services Administration (SAMHSA)[9] as well as outcomes of the Florida Perinatal Quality Collaborative relating to co-occurring disorders in caregivers, in data collection efforts and in the development and implementation of collaborative community-based prevention initiatives.

- **Continue to explore efforts to collect data related to near fatalities in cases of near-fatal sleep-related asphyxia, near-drowning, and near-fatal incidents of inflicted trauma.**

  Near-fatal incidents are not identified as a legislative focus of Local CADR Committee reviews; however, the CADR system has concluded that information obtained in the review of near-fatal sleep-related asphyxia incidents, near-drowning incidents, and near-fatal incidents of inflicted trauma would contribute to a deeper understanding of the circumstances surrounding these leading causes of preventable child death in Florida. Data collection and analysis would provide critical information to better inform effective prevention strategies. Efforts should be made to explore the means and mechanisms by which data could be collected and analyzed. CMS epidemiologists have identified emergency department and hospital discharge records from the Florida Agency for Health Care Administration (AHCA) as a potential data source for monitoring near-fatal drowning incidents and plan to explore these resources with focused analysis projects in the near future.

- **Continue to support the development and dissemination of messaging around appropriate supervision and barriers of protection as primary factors in drowning prevention, in addition to establishing age-appropriate expectations related to young children and swimming capabilities consistent with recommendations of the American Academy of Pediatrics (AAP).**

[9] Substance Abuse and Mental Health Services Administration (2019). *A Guide to SAMHSA's Strategic Prevention Framework.* Rockville, MD: Center for Substance Abuse Prevention, Substance Abuse and Mental Health Services Administration. Available at: https://www.samhsa.gov/sites/default/files/20190620-samhsa-strategic-prevention-framework-guide.pdf

Inadequate supervision and breached barriers to pools and other bodies of water continue to be the primary factors associated with child drowning deaths. Caregivers require continued education and messaging regarding layers of protection and supervision as the most effective means of drowning prevention related to home swimming pools and nearby ponds. The recommended use of touch-supervision of children in the water entails that a caregiver or supervisor is always within reach of a child in or near the water. Further concerns are raised regarding caregiver expectations associated with the swimming capability of children under the age of 5 and the potential risk such expectations may have for drowning. The State CADR Committee supports the recommendations of the AAP regarding age appropriate expectations related to young children and swimming capabilities.

The State CADR Committee endorses the following AAP recommendations and encourages statewide integration of the recommendations as a part of a comprehensive drowning prevention strategy.

- The AAP does not recommend infant swim lessons but does recommend that children ages 1 through 4 may be ready to learn water-survival skills, including how to float and get to an exit.
- The AAP encourages parents to look for learning opportunities that expand a child's experience beyond learning specific strokes, but instead focus on broader water-survival competency skills.
- Outreach efforts should include working with swim lesson organizations to provide education regarding the AAP recommendations, with encouragement to offer water-survival skills training to children under age 5.
- Efforts should be made to provide education to parents and caregivers regarding avoiding the development of a false sense of security about young children's swimming ability.

- **Strongly support statewide drowning prevention programs and promote collaboration with the hospitality and tourism industry and all associated partners, in the development and dissemination of public messaging for water safety and drowning prevention.**

The State CADR Committee recommends the ongoing support of statewide drowning prevention programs such as WaterSmartFL and collaboration with the hospitality and tourism industry in the development and dissemination of public water safety and drowning prevention messaging. Florida welcomes millions of tourists each year. While tourists travel to and within Florida to enjoy the warm weather, sandy beaches, and kid-friendly attractions, the unfortunate reality is that some tourists leave the state with a drowning-related tragedy.

To effectively prevent these tragic drowning deaths, the State CADR Committee strongly encourages efforts be taken to display water safety and drowning prevention information to tourists upon arrival and while vacationing in Florida. Critical locations for water safety and drowning prevention information to be displayed include airport baggage claim areas, interstate rest areas and information centers, hotel and resort lobbies, guest rooms, elevators, and corridors. The State CADR Committee also identifies the need to address child drowning incidents occurring at vacation rental properties which are often rented through services such as

Airbnb, VRBO, and HomeAway. Some actionable steps that can be taken by the vacation rental services to help prevent drownings include: adding water safety and drowning prevention language to reservation pages, requiring owners to provide complimentary Water Watcher tags to renters, and direct owners to display water safety and drowning prevention messaging (e.g. door hangers, posters, etc.) throughout the home for all rental properties with direct access to water.

The State CADR Committee is dedicated to collaborating with hospitality and tourism agencies and organizations in Florida, such as Visit Florida, Florida Hospitality Industry Association, Florida Restaurant and Lodging Association, and any other relevant parties interested in collaborating to prevent child drownings.

- **Effectively advocate for strengthened partnerships and collaborations between state agencies to ensure families are referred to evidence-based parent coaching and support programs.**

  Florida's Family First Prevention Plan,[10] submitted for review and approval on September 30, 2021 states:

  "The Family First Prevention Services Act (FFPSA) was signed into law on February 9, 2018, as part of Public Law (P.L.) 115-123 and has several provisions to enhance support for families to help children remain at home, reduce the unnecessary use of congregate care, and build the capacity of communities to support children and families. (Child Welfare Capacity Building Collaborative, n.d.) FFPSA provides an opportunity for Florida to deepen its commitment to prevention by further activating available resources to holistically serve children and families utilizing an integrative model."

  Under FFPSA, federal Title IV-E funds can be drawn down to support prevention services for at-risk families. Passage of this legislation provides the opportunity for Florida to prioritize partnerships, operations, and system improvements to ensure access to evidence-based programs for at-risk families. The State CADR Committee strongly recommends state agencies (FDOH, DCF, AHCA) strengthen partnerships and collaborations to ensure that families are referred to evidence-based parent coaching and support programs, such as Motivational Interviewing, Healthy Families Florida, and Homebuilders. These are programs with a large body of research supporting their effectiveness in reducing child maltreatment, trauma, and ACEs. In-home prevention services, especially those which engage families prenatally, enhance parent-child relationships and build parenting capacity. Importantly, home visiting programs serve families with children in age groups with the highest removal and preventable death rates. The most recent home visiting needs assessment, conducted by the FDOH and the Florida Maternal, Infant and Early Childhood Home Visiting (MIECHV) Initiative identified a significant gap in service availability and the number of families who need services. State agencies should lead coordinated efforts to develop operating procedures that streamline referral of families through a no wrong door approach, thereby increasing access to evidence-based home visiting for Florida families.

[10] To view Florida's Family First Prevention Plan, please visit: https://cdn.ymaws.com/flchildren.org/resource/resmgr/dcf_resources/florida_s_5_year_family_firs.pdf

- **Train first responders on the consistent use of Sudden Unexpected Infant Death Investigation Reporting Forms (SUIDIRF) and doll reenactments by death scene investigators for all sleep-related infant deaths and explore opportunities to mandate statewide use of the form.**

  The State CADR Committee continues to recommend the consistent use of the CDC's Sudden Unexpected Infant Death Investigation (SUIDIRF) model, which includes completion of the SUIDIRF and doll reenactments. The use of doll reenactments at the scene of a child fatality incident has the potential to provide a more thorough understanding of the circumstances surrounding a child's death, especially in sleep-related deaths. The findings from the SUIDI are used to inform the ME in the development of official cause of death findings. Training of the use of this model should be provided to all law enforcement agencies, MEs and ME Investigators who respond to the unexpected deaths of infants or children. The State CADR Committee will research the current utilization of the CDC SUIDI model among Florida law enforcement agencies and ME offices to identify potential barriers and assess the need for additional training and support to ensure consistent utilization of the CDC SUIDI model.

- **Continue to support and encourage the development and evaluation of pilot projects and initiatives focused on local and regional community-based child fatality prevention.**

  The State CADR Committee has acknowledged and identified several innovative and best practice prevention strategies developed and implemented in local communities (please refer back to Section Six). There is value in encouraging community prevention initiatives to target trends and risks which may be unique to specific communities. Local communities with identified trends associated with preventable child fatalities are ideal for piloting innovative and promising prevention initiatives. Process, outcome, and impact evaluations of these initiatives will help to expand the knowledge base and provide a foundation for more rigorous studies and potential expansion of prevention practices that have demonstrated efficacy.

- **Explore collaborative partnerships with entities which may be currently examining child and adolescent suicide to better inform targeted prevention initiatives.**

  Although seldom reported to the Florida Abuse Hotline, child and adolescent suicides in Florida remain a concern of the Florida CADR System. The State CADR Committee will collaborate with the Florida Suicide Prevention Coordinating Council and any other public health, mental health, substance abuse prevention, and child welfare agencies, organizations, or other relevant parties interested in working together to prevent child and adolescent suicide.

The most tragic consequence of child abuse and neglect is the death of a child.

The well-being of our children depends on individuals and communities that are willing to take action.

APPENDICES

ANNUAL REPORT

DECEMBER 2021

APPENDIX A:

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 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 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; s. 42, ch. 2016-10; s. 55, ch. 2019-3.

APPENDIX B:

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 FDOH 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 FDOH 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 FDOH 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 C:

State and Local Committee Membership

FLORIDA CHILD ABUSE DEATH REVIEW

State Committee Membership

Social Worker
Robin Perry, PhD

Department of Health
Patricia Boswell, MPH

Department of Legal Affairs
Vacant

Department of Children and Families
Stephanie Weis

Department of Law Enforcement
Jeremy Gordon, Inspector

Department of Education
Teresa Masterson, MEd, BSN, RN

Florida Prosecuting Attorneys Association
Thomas Bakkedahl, State Attorney

Florida Medical Examiners Commission
Shanedelle Norford, MD, MS

Child Protection Team Statewide Medical Director
Carol M. Lilly, MD, MPH

Public Health Nurse
Deborah Hogan, RN, MPH

Mental Health Professional
April Lott, LCSW

Department of Children and Families Supervisor
Holly Cummings

Medical Director, Child Protection Team
Cameron Rosenthal, MD, FAAP

Child Advocacy Organization
Jennifer Ohlsen, MS

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

Law Enforcement Officer
Ret. Major Connie Shingledecker, Chairperson

Florida Domestic Violence Advocate
Cynthia Rubenstein, MS, LMHC

Child Abuse Prevention Program
Rebecca Albert, MSW

Substance Abuse Professional
Erica Floyd Thomas

Department of Health Staff
Patricia Armstrong, LCSW - Bureau Chief, Child Protection and Special Technologies
Joshua G. Thomas - CADR Unit Director
Renee Senn - CADR Program Analyst
Brenna Radigan - CADR Prevention Specialist
Erica Puckett (she/her) - CADR Project Coordinator

Department of Children and Families Staff
Lisa Rivera, MSW - Statewide Child Fatality Prevention Manager
Leslie Chytka, MSW - Sr. Management Analyst II, CIRRT Unit – Special Projects

Florida Child Abuse Death Review Local Committee Leadership

Committee 1A
Claire Kirchharr, MPH, CPH
Kirsten Bucey
Sandra Park-O'Hara, APRN

Committee 1B
Jennifer Clark
Cheryl Canipe
Elizabeth Smith, BSN, RN

Committee 2
Holly Kirsch, LD, RDN
Claudia Blackburn, MPH, RN, CPM

Committee 3
Cheriese Brown, BS, CWCM
Mr. Kerry Waldron, MPA

Committee 4
Vicki Whitfield
Funmi Borisade, RN, MSM, MPH, MSN
Heather Huffman, MS, RDN, LD/N, IBCLC

Committee 5
Janine Hammett, RN
Robin Napier, MS

Committee 6
Rebecca Albert, MSW
Rebecca Wilkinson-Shields
Ray Hensley
Mike Napier, MS

Committee 7
Vicki Whitfield
Dawn Allicock, MD

Committee 8
Stephanie Cox
Nikki Meadow
Natalie McKellips, JD
Amie Johns, MPH

Committee 9
Ilvia Ortiz-Paez
Brianne Bell
Anne Johnson, BSN, MN
Raul Pino, MD
Vianca McCluskey, MPH

Committee 10
David Acevedo
Taylor Freeman
Stephen Nelson, MD
Joy Jackson, MD

Committee 11
Lauren Lazarus-Sabatino, Esq. CCE
Lauren Villalba-Cruz, MPA
Yoselin Garcia, MPH
Yesenia Villalta, APRN, DNP, MSN

Committee 12A
Maj. Connie Shingledecker
Katie Powers, RN, IBCLC
Jennifer Bencie, MD

Committee 12B
Laura McIntyre, MA
Catherine Duff
Jennifer Bencie, MD

Committee 13
Jane Murphy, MPA
Melissa Iturraspe, MS, RHIA
Douglas Holt, MD, FACP

Committee 14
Kelly Byrns-Davis
Stephanie Wood
Christi Bazemore
Sandon Speedling, MHS, CPM, CPH

Committee 15
Merlene Ramnon, PhD, MPH, MSN, RN
Maricor Wall
Alina Alonso, MD

Committee 16
Lauren Lazarus-Sabatino, Esq., CCE
Lauren Villalba, MPA
Mary Vanden Brook
Bob Eadie, JD

Committee 17
Samantha Silver, BA, CAP, CRPS-A
Casey Woolley
Paula Thaqi, MD, MPH

Committee 18A
Jeanie Raciti, LCSW
Maria Stahl, DNP, RN

Committee 18A
Jennifer Grant
Lindsey A. Bayer, MS, F-ABMDI
Donna Walsh, MPA, BSN, RN

Committee 19
Carol Ann Wegener-Vitani, RN, BS
Caroline Vinyard, LMHC, MBA

Committee 20
Francine Donnorummo, JD
Sally Kreuscher
Stephenie Vick, MS, BSN, RN

APPENDIX D:

Guidelines for Local Committees

Guidelines for Local Committees

December 2018

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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 (FDOH), 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 FDOH 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. At least one regular monthly meeting (e.g., every 1st Friday of each month) will be scheduled. Regularly scheduled monthly meetings can be cancelled if there are no cases to review. At least quarterly meetings must be held to discuss community prevention initiatives (even when there are no case files for review). Case reviews should be scheduled for review within 30 days of receipt of a case file.

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 FDOH 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 and/or enter data collected from the case review/CDR Report Form into the National Fatality Review Case Reporting System within 15 calendar days of the fatality review.

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 Child Death Review (CDR) Report Form within the National Fatality Review Case Reporting System to record and track data from child death reviews. The System Guide provides instructions for completing the data form. The CDR Report Form must be completed on all child abuse deaths reviewed. The committee chair should review the data form to ensure that all information is accurate, that the case review is complete, and ensure that data entry takes place within 15 calendar days of the fatality case review.

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.

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 REPORTING FORM VERSION 5.1

CDR Report Form

National Fatality Review

Case Reporting System

Version 5.1

Data entry website: https://data.ncfrp.org

1-800-656-2434 info@ncfrp.org www.ncfrp.org

SAVING LIVES TOGETHER

Instructions:

This case report is used by Child Death Review (CDR) teams to enter data into the National Fatality Review Case Reporting System (NFR-CRS). The NFR-CRS is available to states and local sites from the National Center for Fatality Review & Prevention (NCFRP) and requires a data use agreement for data entry. The purpose is to collect comprehensive information from multiple agencies participating in a review. The NFR-CRS 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 team to prevent other deaths.

While this data collection form is an important part of the CDR process, it 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.

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. The percentage of cases marked "unknown" and unanswered questions decreases as the team becomes more familiar with the form. **The NFR-CRS Data Dictionary is available**. It contains definitions for each data element and should be referred to when the team is unsure how to answer a question. Use of the data dictionary helps teams improve consistency of data entry.

The form contains three types of questions: (1) select one response as represented by a circle; (2) select multiple responses as represented by a square; and (3) free text responses. This last type is indicated by the words "specify" or "describe."

Many teams ask what is the difference between leaving a question blank and selecting the response "unknown." 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 does not apply.

Reminder:

Enter identifiable information (**names, dates, addresses, counties**) into the NFR-CRS if your state/local policy allows. Follow your state laws in regards to reporting psychological, substance abuse and HIV/AIDS status. Please check with your fatality review coordinator if you are unsure. For other text fields, such as the **Narrative section or any "specify" or "describe" fields**, do not include specific names, dates of birth, dates of death, references to specific counties, practitioners, or facility names in these text fields. Examples: "Evans County EMS" should be "EMS"; "Evans County Children's Hospital" should be "the children's hospital." **Why this reminder?** Text fields may be shared with approved researchers as noted in the Data Use Agreement in your state or jurisdiction. Therefore, entering identified data into those fields would compromise your responsibility under HIPAA.

Additional paper forms can be ordered from the NCFRP at no charge. Users interested in participating in the NFR-CRS for data entry and reporting should contact the NCFRP. This version includes the Sudden and Unexpected Infant Death (SUID) Case Registry and the Sudden Death in the Young (SDY) Case Registry questions.

CASE NUMBER

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

Case Type: ○ Death ○ Near death/serious injury ○ Not born alive (fetal/stillborn)

☐ Child never left hospital following birth

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

A. CHILD INFORMATION

A1. CHILD INFORMATION (COMPLETE FOR ALL AGES)

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:
☐ Alaska 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. Child's weight at death: ☐ U/K
○ Pounds/ounces ____/____
○ Grams/kilograms _____

10. Child's height at death: ☐ U/K
○ Feet/inches ____/____
○ Cm _____

11. State of death:

12. County of death:

13. 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

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

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

16. Was the child up to date with the Centers for Disease Control and Prevention (CDC) immunization schedule?
○ NA ○ Yes ○ No, specify: ○ U/K

If the child never left the hospital following birth, go to A2.

17. 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

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

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

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

21. Number of other children living with child: ____ ☐ U/K

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

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 ○ Other sources

If through CPS:

As Victim	As Perpetrator	
____	____	# CPS referrals
____	____	# Substantiations

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

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

25. How many months prior to death did child last have contact with a health care provider? ___

A2. COMPLETE FOR CHILDREN OVER ONE YEAR OLD

26. Child's highest education level:
○ N/A ○ Drop out
○ None ○ HS graduate/GED
○ Preschool ○ College
○ Grade K-8 ○ Other, specify:
○ Grade 9-12 ○ U/K
○ Home schooled, K-8
○ Home schooled, 9-12

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

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

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

30. Child had received prior mental health services?
○ N/A ○ Yes ○ No ○ U/K
If yes, check all that apply:
☐ Outpatient
☐ Day treatment/partial hospitalization
☐ Residential

31. Child was receiving mental health services?
○ N/A ○ Yes ○ No ○ U/K
If yes, check all that apply:
☐ Outpatient
☐ Day treatment/partial hospitalization
☐ Residential

32. Child on medications for mental health illness?
○ N/A ○ Yes ○ No ○ U/K

33. Child had emergency department visit for mental health care within the previous 12 months?
○ N/A ○ Yes ○ No ○ U/K
If yes, did the child have a follow-up mental health appointment within 30 days of emergency department visit?
○ Yes ○ No ○ U/K

34. Child was hospitalized for mental health care within the previous 12 months?
○ N/A ○ Yes ○ No ○ U/K
If yes, did the child have a follow-up MH appointment within 30 days of discharge from the hospital?
○ Yes ○ No ○ U/K

35. Issues prevented child from receiving mental health services?
○ N/A ○ Yes ○ No ○ U/K
If yes, specify:

36. Child had history of substance use or abuse?
○ N/A ○ Yes ○ No ○ U/K
If yes, check all that apply:
☐ Alcohol ☐ Prescription drugs, specify:
☐ Cocaine ☐ Over-the-counter drugs, specify:
☐ Marijuana ☐ Tobacco/nicotine, specify type:
☐ Methamphetamine ☐ Other, specify:
☐ Opioids ☐ U/K
If yes, did the child receive treatment?
○ Ye ○ No ○ U/K
If yes, type? Check all that apply:
☐ Outpatient ☐ Day treatment/partial hospitalization
☐ Inpatient/detox ☐ Residential

37. 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

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

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

40. What was child's gender identity?
○ No identity expressed ○ Non-binary
○ Male, not transgender ○ Other, specify:
○ Female, not transgender
○ Transgender male ○ U/K
○ Transgender female

41. What was child's sexual orientation?
○ No orientation expressed ○ Other, specify:
○ Straight/heterosexual
○ Gay/lesbian ○ U/K
○ Bisexual
○ Questioning

A3. COMPLETE FOR ALL FETAL/INFANTS UNDER ONE YEAR

42. Was this case reviewed by both a Fetal/Infant Mortality Review (FIMR) and Child Death Review (CDR/CFR) team? ○ Yes ○ No ○ U/K

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

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

45. Multiple gestation?
○ Yes, # _____
○ No ○ U/K

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

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

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

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

50. 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
☐ Lack of transportation
☐ No phone
☐ Cultural differences
☐ Language barriers
☐ Couldn't get provider to take as patient
☐ Multiple providers, not coordinated
☐ Couldn't get an earlier appointment
☐ Lack of child care
☐ Lack of family/social support
☐ Services not available
☐ Distrust of health care system
☐ Unwilling to obtain care
☐ Didn't know where to go
☐ Didn't think she was pregnant
☐ Other, specify:
☐ U/K

51. During pregnancy, did mother have any medical conditions/complications? ○ Yes ○ No ○ U/K If yes, check all that apply:

Cardiovascular
☐ Hypertension - gestational
☐ Hypertension - chronic
☐ Pre-eclampsia
☐ Eclampsia
☐ Clotting disorder

Hematologic
☐ Folic acid deficiency
☐ Sickle cell disease
☐ Anemia (iron deficiency)

Respiratory
☐ Asthma
☐ Pulmonary embolism

Endocrine/Metabolic
☐ Diabetes, type 1 chronic
☐ Diabetes, type 2 chronic
☐ Diabetes, gestational
☐ Thyroid
☐ Polycystic ovarian disease

Neurologic/Psychiatric
☐ Addiction disorder
☐ Eating disorder
☐ Depression
☐ Anxiety disorder
☐ Seizure disorder

Sexually Transmitted Infection (STI)
☐ Bacterial vaginosis (BV)
☐ Chlamydia
☐ Gonorrhea
☐ Herpes
☐ HPV
☐ Syphilis
☐ Group B strep
☐ HIV/AIDS
☐ Other STI, specify:

Gynecologic
☐ Uterine/vaginal bleeding
☐ Chorioamnionitis
☐ Oligohydramnios
☐ Polyhydramnios

Gynecologic (continued)
☐ Intrauterine growth restriction (IUGR)
☐ Premature rupture of membranes (PROM)
☐ Preterm premature rupture of membranes (PPROM)
☐ Incompetent cervix

Umbilical cord complications
☐ Prolapse
☐ Nuchal cord
☐ Other cord, specify:

Placental problems
☐ Abruption
☐ Previa
☐ Other placental, specify:

51. Mother's medical conditions (continued) ☐ Other Condition/Complication

☐ UTI ☐ HELLP syndrome ☐ Oral health/dental or gum infection ☐ Maternal genetic disorder ☐ Preterm labor

☐ Decreased fetal movement ☐ Maternal developmental delay ☐ Gastrointestinal ☐ Abnormal MSAFP ☐ Other, specify:

52. Did the mother experience any medical complications in previous pregnancies? ○ N/A ○ Yes ○ No ○ U/K If yes, check all that apply:

☐ Previous preterm birth ☐ Previous small for gestational age

☐ Previous low birth weight birth ☐ Previous large for gestational age (greater than 4000 grams)

53. Did the mother use any medications, drugs or other substances during pregnancy? ○ Yes ○ No ○ U/K If yes, check all that apply:

☐ Over-the-counter meds ☐ Anti-epileptic ☐ Nausea/vomiting medications ☐ Cocaine ☐ Meds to treat drug addiction

☐ Allergy medications ☐ Anti-hypertensives ☐ Cholesterol medications ☐ Heroin ☐ Opioids

☐ Antibiotics ☐ Anti-hypothyroidism ☐ Sleeping pills ☐ Marijuana ☐ Other pain meds

☐ Anti-flu/antivirals ☐ Arthritis medications ☐ Meds to treat preterm labor ☐ Methamphetamine ☐ Other, specify:

☐ Anti-depressants/anti-anxiety/anti-psychotics ☐ Diabetes medications ☐ Meds used during delivery ☐ Alcohol ☐ U/K

☐ Asthma medications ☐ Progesterone/P17 ☐ If alcohol, infant born with fetal effects or syndrome?

If any item is checked, please indicate the generic or brand name of the medications or drugs:

54. Was the infant born drug exposed? ○ Yes ○ No ○ U/K

55. Did the infant have neonatal abstinence syndrome (NAS)? ○ Yes ○ No ○ U/K

56. Level of birth hospital:

○ 1
○ 2
○ 3
○ Free-standing birth center
○ Home birth
○ Other, specify:
○ U/K

57. At discharge from the birth hospital, was a case manager assigned to the mother?

○ N/A, mother did not go to a birth hospital ○ Yes ○ No ○ U/K

58. Did the mother attend a postpartum visit? ○ Yes ○ No ○ U/K

59. Did the infant have a NICU stay of more than one day? ○ Yes ○ No ○ U/K

If yes, for what reason(s)? Check all that apply:

☐ Prematurity ☐ Apnea ☐ Hypothermia ☐ Meconium aspiration

☐ Low birth weight ☐ Sepsis ☐ Jaundice ☐ Congenital anomalies

☐ Tachypnea ☐ Feeding difficulties ☐ Anemia ☐ Other, specify:

☐ Drug/alcohol exposure ☐ U/K

60. Did mother smoke in the 3 months before pregnancy?

○ Yes If yes, ___ Avg # cigarettes/day (20 cigarettes in pack)

○ No

○ U/K ☐ U/K quantity

61. Did the 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

62. Did the mother use e-cigarettes or other electronic nicotine products at any time during pregnancy? ○ Yes ○ No ○ U/K

If yes, on average how often? ○ More than once a day ○ Once a day ○ 2-6 days a week ○ 1 day a week or less ○ U/K

63. Was mother injured during pregnancy?

○ Yes ○ No ○ U/K If yes, describe:

64. Did the mother have postpartum depression?

○ Yes ○ No ○ U/K

If this was a fetal death, go to Section B.

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

If yes, any breast milk at 3 months? ○ N/A ○ Yes ○ No ○ U/K

If yes, exclusively? ○ Yes ○ No ○ U/K

If yes, any breast milk at 6 months? ○ N/A ○ Yes ○ No ○ U/K

If yes, exclusively? ○ Yes ○ No ○ U/K

If ever, was infant receiving breast milk at time of death?

○ Yes ○ No ○ U/K

66. Did infant have abnormal metabolic newborn screening results?

○ N/A ○ Yes ○ No ○ U/K

If yes, describe any abnormality such as a fatty acid oxidation error:

If the infant never left the hospital following birth, go to Section B.

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

☐ None ☐ Cyanosis

☐ Infection ☐ Seizures or convulsions

☐ Allergies ☐ Cardiac abnormalities

☐ Abnormal growth, weight gain/loss ☐ Other, specify:

☐ Apnea ☐ U/K

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

☐ None ☐ Vomiting ☐ Cyanosis

☐ Fever ☐ Choking ☐ Seizures or convulsions

☐ Excessive sweating ☐ Diarrhea ☐ Other, specify:

☐ Lethargy/sleeping more than usual ☐ Stool changes

☐ Fussiness/excessive crying ☐ Difficulty breathing ☐ U/K

☐ Decrease in appetite ☐ Apnea

69. In the 72 hours prior to death, was the infant injured?

○ Yes ○ No ○ U/K

If yes, describe cause and injuries:

70. In the 72 hours prior to death, was the infant given any vaccines?

○ Yes ○ No ○ U/K

If yes, list name(s) of vaccines:

71. In the 72 hours prior to death, was the infant given any medications or remedies? Include herbal, prescription, over-the-counter medications and home remedies.

○ Yes ○ No ○ U/K

If yes, list name and last dose given:

72. 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. BIOLOGICAL PARENT INFORMATION

○ No information available, go to Section C

1. Parents alive on date of child's death? Even if parent(s) are deceased at time of child's death, please fill out the remaining questions.

	Yes	No	U/K
Female	○	○	○
Male	○	○	○

2. Parents' race, check all that apply:

Female	Male		Female	Male	
☐	☐	White	☐	☐	Native Hawaiian
☐	☐	Black	☐	☐	Pacific Islander, specify:
☐	☐	Asian, specify:			
☐	☐	American Indian, Tribe:	☐	☐	U/K
☐	☐	Alaska Native, Tribe:			

3. Parents' Hispanic or Latino origin?

Female	Male	
○	○	Yes, specify origin:
○	○	No
○	○	U/K

4. Parents' age in years at time of child's death:

Female	Male	
____	____	# Years
☐	☐	U/K

5. Parents' employment status:

Female	Male	
○	○	Employed
○	○	Unemployed
○	○	On disability
○	○	Stay-at-home
○	○	Retired
○	○	U/K

6. Parents' income:

Female	Male	
○	○	High
○	○	Medium
○	○	Low
○	○	U/K

7. Parents' education:

Female	Male	
○	○	< High school
○	○	High school/ GED
○	○	College
○	○	Post graduate
○	○	U/K

8. Parents speak and understand English?

Female	Male	
○	○	Yes
○	○	No
○	○	U/K

If no, language spoken:

9. Parents first generation immigrant?

Female	Male	
○	○	Yes, country of origin:
○	○	No
○	○	U/K

10. Parents on active military duty?

Female	Male	
○	○	Yes, specify branch:
○	○	No
○	○	U/K

11. Parents receive social services in the past twelve months?

Female	Male	
○	○	Ye If yes, check all that apply below:
○	○	No
○	○	U/K

Female	Male		Female	Male	
☐	☐	WIC	☐	☐	Section 8/housing
☐	☐	Home visiting, specify:	☐	☐	Social Security Disability Insurance (SSI/SSDI)
☐	☐	TANF	☐	☐	Other, specify:
☐	☐	Medicaid			
☐	☐	Food stamps/ SNAP/EBT	☐	☐	U/K

12. Parents have substance abuse history?

Female	Male	
○	○	Yes
○	○	No
○	○	U/K

If yes, check all that apply:

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

13. Parents ever victim of child maltreatment?

Female	Male	
○	○	Yes
○	○	No
○	○	U/K

If yes, check all that apply:

Female	Male	
☐	☐	Physical
☐	☐	Neglect
☐	☐	Sexual
☐	☐	Emotional/psychological
☐	☐	U/K
____	____	# CPS referrals
____	____	# Substantiations
☐	☐	Ever in foster care or adopted

14. Parents ever perpetrator of maltreatment?

Female	Male	
○	○	Yes
○	○	No
○	○	U/K

If yes, check all that apply:

Female	Male	
☐	☐	Physical
☐	☐	Neglect
☐	☐	Sexual
☐	☐	Emotional/psychological
☐	☐	U/K
____	____	# CPS referrals
____	____	# Substantiations
☐	☐	CPS prevention services
☐	☐	Family preservation services
☐	☐	Children ever removed

15. Parents have disability or chronic illness?

Female	Male	
○	○	Yes
○	○	No
○	○	U/K

If yes, check all that apply:

Female	Male	
☐	☐	Physical/orthopedic, specify:
☐	☐	Mental health/substance abuse, specify:
☐	☐	Cognitive/intellectual, specify:
☐	☐	Sensory, specify:
☐	☐	U/K

If mental health/substance abuse, was parent receiving mental health services?

Female	Male	
○	○	Yes
○	○	No
○	○	U/K

16. Parents have prior child deaths?

Female	Male	
○	○	Yes
○	○	No
○	○	U/K

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

Female	Male		Female	Male		Female	Male	
☐	☐	Child abuse # ____	☐	☐	Suicide # ____	☐	☐	Other # ____
☐	☐	Child neglect # ____	☐	☐	SIDS # ____			Other, specify:
☐	☐	Accident # ____	☐	☐	Undetermined cause # ____	☐	☐	U/K

17. Parents have history of intimate partner violence?

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

18. Parents have delinquent/criminal history?

Female	Male	
○	○	Yes
○	○	No
○	○	U/K

If yes, check all that apply:

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

C. PRIMARY CAREGIVER(S) INFORMATION

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

One	Two		One	Two		One	Two	
○		Self, go to Section D	○	○	Foster parent	○	○	Other relative
○	○	Biological mother, go to Section D	○	○	Mother's partner	○	○	Friend
○	○	Biological father, go to Section D	○	○	Father's partner	○	○	Institutional staff
○	○	Adoptive parent	○	○	Grandparent	○	○	Other, specify:
○	○	Stepparent	○	○	Sibling			
						○	○	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) race, check all that apply:

One	Two		One	Two	
☐	☐	White	☐	☐	Native Hawaiian
☐	☐	Black	☐	☐	Pacific Islander, specify:
☐	☐	Asian, specify:			
☐	☐	American Indian, Tribe:	☐	☐	U/K
☐	☐	Alaska Native, Tribe:			

5. Caregiver(s) Hispanic or Latino origin?

One	Two	
○	○	Yes
○	○	No
○	○	U/K

If yes, specify origin:

6. Caregiver(s) employment status:

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

7. Caregiver(s) income:

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

8. Caregiver(s) education:

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

9. Do caregiver(s) speak and understand English?

One	Two	
○	○	Yes
○	○	No
○	○	U/K

If no, language spoken:

10. Caregiver(s) first generation immigrant?

One	Two	
○	○	Yes, country of origin:
○	○	No
○	○	U/K

11. Caregiver(s) on active military duty?

One	Two	
○	○	Yes, specify branch:
○	○	No
○	○	U/K

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

One	Two	
○	○	Ye If yes, check all that apply below:
○	○	No
○	○	U/K

One	Two		One	Two	
☐	☐	WIC	☐	☐	Food stamps/SNAP/EBT
☐	☐	Home visiting	☐	☐	Section 8/housing
		specify:	☐	☐	Soc Sec Disability (SSI/SSDI)
☐	☐	TANF	☐	☐	Other, specify:
☐	☐	Medicaid	☐	☐	U/K

13. Caregiver(s) have substance abuse history?

One	Two	
○	○	Yes
○	○	No
○	○	U/K

If yes, check all that apply:

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

14. 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

15. 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

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

One	Two	
○	○	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 mental health/substance abuse, was caregiver receiving MH services?

○	○	Yes
○	○	No
○	○	U/K

17. 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 # ____
☐	☐	Undetermined cause # ____
☐	☐	Other # ____
		Other, specify:
☐	☐	U/K

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

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

19. 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

D. SUPERVISOR INFORMATION

Answer this section only if the child ever left the hospital following birth

1. Did child have supervision at time of incident leading to death?
   - ○ Yes, answer D2-16
   - ○ No, not needed given developmental age or circumstances, go to Sec. E
   - ○ No, but needed, answer D3-16
   - ○ Unable to determine, try to answer D3-16

2. How long before incident did supervisor last see child?
   Select one:
   - ○ Child in sight of supervisor
   - ○ Minutes ____ ○ Days ____
   - ○ Hours ____ ○ U/K

3. Is supervisor listed in a previous section?
   - ○ Yes, biological mother, go to D15
   - ○ Yes, biological father, go to D15
   - ○ Yes, caregiver one, go to D15
   - ○ Yes, caregiver two, go to D15
   - ○ No

4. Primary person responsible for supervision at the time of incident? Select only one:
   - ○ Adoptive parent ○ Grandparent ○ Institutional staff, go to D15
   - ○ Stepparent ○ Sibling ○ Babysitter
   - ○ Foster parent ○ Other relative ○ Licensed child care worker
   - ○ Mother's partner ○ Friend ○ Other, specify:
   - ○ Father's partner ○ Acquaintance ○ U/K
   - ○ Hospital staff, go to D15

5. Supervisor's age in years: _____ ☐ U/K

6. Supervisor's sex: ○ Male ○ Female ○ U/K

7. Supervisor speaks and understands 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
   - ☐ Opioids
   - ☐ 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/orthopedic, specify:
    - ☐ Mental health/substance abuse specify:
    - ☐ Cognitive/intellectual, specify:
    - ☐ Sensory, specify:
    - ☐ U/K

    If mental health/substance abuse, was supervisor receiving mental health 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 # _____
    - ☐ Undetermined cause # _____
    - ☐ 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:
    - ☐ Assault
    - ☐ Robbery
    - ☐ Drugs
    - ☐ Other, specify:
    - ☐ U/K

15. At the time of the incident, was the supervisor asleep? ○ Yes ○ No ○ U/K
    If yes, select the most appropriate description of the supervisor's sleeping period at incident:
    - ○ Night time sleep
    - ○ Day time nap, describe:
    - ○ Day time sleep (for example, supervisor is night shift worker), describe:
    - ○ Other, describe:

16. At time of incident was supervisor impaired? ○ Yes ○ No ○ U/K
    If yes, check all that apply:
    - ☐ Drug impaired, specify:
    - ☐ Alcohol impaired
    - ☐ Distracted
    - ☐ Absent
    - ☐ Impaired by illness, specify:
    - ☐ Impaired by disability, specify:
    - ☐ Other, specify:

E. INCIDENT INFORMATION

1. Was the date of the incident the same as the date of death?
   - ○ Yes, same as date of death
   - ○ No, different than date of death. Enter date of incident: ____/____/____ mm / dd / yyyy
   - ○ U/K

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

3. Place of incident, check all that apply:

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

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

5. Incident state: | 6. Incident county:

7. Was the death attributed (either directly or indirectly) to an extreme weather event, emergency medical situation, natural disaster or mass shooting?
○ Yes ○ No ○ U/K If yes, specify the type of event (e.g., tornado, heat wave, flood, medical crisis, etc.) and general circumstances surrounding the death:
If yes, specify the name of the event if applicable (e.g., Paradise Wild Fire, Hurricane Irma, COVID-19, etc.):

8. Was the incident witnessed? ○ Yes ○ No ○ UK
If yes, by whom?
☐ Parent/relative ☐ Health care professional, if death occurred in a hospital setting
☐ Other caretaker/babysitter
☐ Teacher/coach/athletic trainer ☐ Stranger
☐ Other acquaintance ☐ Other, specify:

9. Was 911 or local emergency called?
○ N/ ○ Yes
○ No ○ U/K

10. Was resuscitation attempted? ○ N/A ○ Yes ○ No ○ U/K
If yes, by whom?
☐ EMS ☐ Stranger
☐ Parent/relative ☐ Other, specify:
☐ Other caretaker/babysitter
☐ Teacher/coach/athletic trainer
☐ Other acquaintance
☐ Health care professional, if death occurred in a hospital setting

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?
_____

11. At time of incident leading to death, had child used drugs or alcohol? If yes, check all that apply:
○ N/A ○ Yes ○ No ○ U/K
☐ Alcohol ☐ Opioids ☐ U/K
☐ Cocaine ☐ Prescription drugs
☐ Marijuana ☐ Over-the-counter drugs
☐ Methamphetamine ☐ Other, specify:

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

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

F. INVESTIGATION INFORMATION

1. Was a death investigation conducted? ○ Yes ○ No ○ U/K
If yes, check all that apply:
☐ Medical examiner ☐ ME investigator ☐ Law enforcement ☐ EMS ☐ Other, specify:
☐ Coroner ☐ Coroner investigator ☐ Fire investigator ☐ Child Protective Services ☐ U/K

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

Yes	No	U/K		If yes, shared with review 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

If yes, was a death scene investigation conducted at the place of incident? ○ Yes ○ No ○ U/K

2. What additional information would the team like to have known about the death scene investigation?

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

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

5. Autopsy performed? ○ Yes ○ No ○ U/K
If yes, conducted by: ○ Forensic pathologist ○ Unknown type pathologist
○ Pediatric pathologist ○ Other physician
○ General pathologist ○ Other, specify:
○ U/K

If yes, was a specialist consulted during autopsy (cardiac, neurology, etc.)?
○ Yes ○ No ○ U/K If yes, specify specialist:
If no, why not (e.g. parent or caregiver objected)?

6. Were the following assessed either through the autopsy or through information collected prior to the autopsy? Please list any abnormalities/significant findings in F10.

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):

Yes	No	U/K	External Exam:
○	○	○	Exam of general appearance
○	○	○	Head circumference
			Other Autopsy Procedures:
○	○	○	Was a gross examination of organs done?
○	○	○	Were weights of any organs taken?

7. Were any of these additional tests performed at or prior to the autopsy? Please list any abnormalities/significant findings in F10.

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

8. Was any toxicology testing performed? ○ Yes ○ No ○ U/K

If yes, what were the results? Check all that apply: ☐ Negative ☐ Alcohol ☐ Cocaine ☐ Marijuana ☐ Methamphetamine ☐ Opioids ☐ Too high Rx drug, specify: ☐ Too high OTC drug, specify: ☐ Other, specify: ☐ U/K

9. 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

10. Describe any abnormalities or other significant findings noted in the autopsy:

11. What additional information would the team like to have known about the autopsy?

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

If no, describe the differences:

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

14. Did any investigation find evidence of prior abuse? ○ N/A ○ Yes ○ No ○ U/K

If yes, from what source? Check all that apply:

☐ X-rays ☐ U/K
☐ Autopsy
☐ CPS review
☐ Law enforcement

15. 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, what services or actions resulted? 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

16. If death occurred in licensed setting (see E3), indicate action taken:

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

G. 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 G2 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 manner of death was not Natural or Suicide, check this box if it is possible that the child intended to hurt him/herself. If checked, complete the Suicide Section (I6) to note other risk factors in the child's life.

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 G4:

○ Motor vehicle and other transport, go to H1
○ Fire, burn, or electrocution, go to H2
○ Drowning, go to H3
○ Unintentional asphyxia, go to H4
○ Assault, weapon or person's body part, go to H5
○ Fall or crush, go to H6
○ Poisoning, overdose or acute intoxication, go to H7
○ Undetermined injury, go to I1
○ Other cause, go to H9
○ U/K, go to I1

○ From a medical cause. Select one:

○ Asthma/respiratory, specify and go to H8
○ Cancer, specify and go to H8
○ Cardiovascular, specify and go to H8
○ Congenital anomaly, specify and go to H8
○ COVID-19, go to H8
○ Diabetes, go to H8
○ HIV/AIDS, go to H8
○ Influenza, go to H8
○ Low birth weight, go to H8
○ Malnutrition/dehydration, go to H8
○ Neurological/seizure disorder, go to H8
○ Pneumonia, specify and go to H8
○ Prematurity, go to H8
○ SIDS, go to H8
○ Other infection, specify and go to H8
○ Other perinatal condition, specify and go to H8
○ Other medical condition, specify and go to H8
○ Undetermined medical cause, go to H8
○ U/K, go to H8

○ Undetermined if injury or medical cause, go to I1

○ U/K go to I1

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

H1. 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 — If passenger, relationship of driver to child:
  - ○ 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	
	Age of Driver	Age of Driver	
	○	○	<16 years
	○	○	16 to 18 years old
	○	○	19 to 21 years old
	○	○	22 to 29 years old
	○	○	30 to 65 years old
	○	○	>65 years old
	○	○	U/K age
☐	☐	☐	Responsible for causing incident
☐	☐	☐	Was alcohol/drug impaired
☐	☐	☐	Has no license
☐	☐	☐	Has a learner's permit

Child as driver	Child's driver	Driver of other primary vehicle	
☐	☐	☐	Has a graduated license
☐	☐	☐	Has a full license
☐	☐	☐	Has a full license that has been restricted
☐	☐	☐	Has a suspended license
☐	☐	☐	If recreational vehicle, has driver safety certificate
☐	☐	☐	Other, specify:
☐	☐	☐	Was violating graduated licensing rules:
☐	☐	☐	Nighttime driving curfew
☐	☐	☐	Passenger restrictions
☐	☐	☐	Driving without required supervision
☐	☐	☐	Other violations, specify:
☐	☐	☐	U/K

h. Total number of occupants in vehicles:

In child's vehicle, including child:

☐ N/A, child was not in a vehicle

- Total number of occupants: _____ ☐ U/K
- Number of teens, ages 14-21 _____ ☐ U/K
- Total number of deaths: _____ ☐ U/K
- Total number of teen deaths: _____ ☐ U/K

In other primary vehicle involved in incident:

☐ N/A, incident was a single vehicle crash

- Total number of occupants: _____ ☐ U/K
- Number of teens, ages 14-21 _____ ☐ U/K
- Total number of 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

H2. FIRE, BURN, OR ELECTROCUTION

a. Ignition, heat or electrocution source:

- ○ Matches
- ○ Cigarette lighter
- ○ Utility lighter
- ○ Cigarette or cigar
- ○ Candles
- ○ Cooking stove
- ○ Heating stove
- ○ Space heater
- ○ Furnace
- ○ Power line
- ○ Electrical outlet
- ○ Electrical wiring
- ○ Lightning
- ○ Oxygen tank
- ○ Hot cooking water
- ○ Hot bath water
- ○ Other hot liquid, specify:
- ○ Fireworks
- ○ Other explosives
- ○ Appliance in water
- ○ Other, specify:
- ○ 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? ○ Ye ○ 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? ○ Ye ○ No ○ U/K

o. Was sprinkler system present? ○ Yes ○ No ○ U/K

If yes, was it working? ○ Yes ○ No ○ U/K

p. Were smoke alarms 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? ○ Yes ○ No ○ U/K

r. For scald, was hot water heater set too high?

- ○ N/A
- ○ Yes, temp. setting: ___
- ○ No
- ○ U/K

s. For electrocution, what cause:

- ○ Electrical storm
- ○ Faulty wiring
- ○ Wire/product in water
- ○ Child playing with outlet
- ○ Other, specify:
- ○ U/K

t. Other, describe in detail:

H3. DROWNING

a. Where was child last seen before drowning? Check all that apply:

- ☐ In water
- ☐ On shore
- ☐ On dock
- ☐ Poolside
- ☐ In yard
- ☐ In bathroom
- ☐ In house
- ☐ Other, specify:
- ☐ U/K

b. What was child last seen doing before drowning?

- ○ Playing
- ○ Boating
- ○ Swimming
- ○ Bathing
- ○ Fishing
- ○ Surfing
- ○ Tubing
- ○ Waterskiing
- ○ Sleeping
- ○ Other, specify:
- ○ U/K

c. Was child forcibly submerged? ○ Ye ○ No ○ U/K

d. Drowning location:

- ○ 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:

- ○ Lake
- ○ River
- ○ Pond
- ○ Creek
- ○ Ocean
- ○ Quarry
- ○ Gravel pit
- ○ Canal
- ○ U/K

f. For open water, contributing environmental factors:

- ○ Weather
- ○ Temperatur
- ○ Current
- ○ Riptide/ undertow
- ○ Drop off
- ○ Rough waves
- ○ Other, specify:
- ○ U/K

g. If boating, type of boat:

- ○ Sailboat
- ○ Jet ski
- ○ Motorboat
- ○ Canoe
- ○ Kayak
- ○ Raft
- ○ Commercial
- ○ Other, specify:
- ○ U/K

h. For boating, was the child piloting boat? ○ Ye ○ No ○ U/K

i. For pool, type of pool:

- ○ Above ground
- ○ In-ground
- ○ Wading
- ○ Hot tub, spa
- ○ U/K

j. For pool, child found:

- ○ In the pool/hot tub/spa
- ○ On or under the cover
- ○ U/K

k. For pool, ownership is:

- ○ Private
- ○ Public
- ○ U/K

l. Length of time owners had pool/hot tub/spa:

- ○ N/A
- ○ <6 months
- ○ 6m-1 yr
- ○ >1yr
- ○ U/K

m. Flotation device used?
○ 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:

n. What barriers/layers of protection existed to prevent access to water?
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:
Describe type:
Fence height in ft ____
Fence surrounds water on:
○ Four sides ○ Two or less sides
○ Three side
○ U/K

p. Gate, check all that apply:
☐ Has self-closing latch
☐ Has lock
☐ Is a double gate
☐ Opens to water
☐ U/K

q. Door, check all that apply:
☐ Patio door ☐ Opens to water
☐ Screen door ☐ Barrier between door and water
☐ Steel door
☐ Self-closing ☐ U/K
☐ Has lock

r. Alarm, check all that apply:
☐ Door
☐ Window
☐ Pool
☐ Laser
☐ U/K

s. Type of cover:
○ Hard
○ Soft
○ U/K

t. Local ordinance(s) regulating access to water?
○ Yes ○ No ○ U/K
If yes, rules violated?
○ Yes ○ No ○ U/K

u. How were layers of protection breached? Check all that apply:
☐ No layers breached ☐ Gap in fence ☐ Door screen torn ☐ Cover left off
☐ Gate left open ☐ Damaged fence ☐ Door self-closer failed ☐ Cover not locked
☐ Gate unlocked ☐ Fence too short ☐ Window left open ☐ Other, specify:
☐ Gate latch failed ☐ Door left open ☐ Window screen torn
☐ Gap in gate ☐ Door unlocked ☐ Alarm not working
☐ Climbed fence ☐ Door broken ☐ Alarm not answered ☐ U/K

v. Child able to swim?
○ N/A ○ No
○ Yes ○ U/K

w. For bathtub, child in a bathing aid?
○ Ye ○ N ○ U/K
If yes, specify type:

x. Warning sign or label posted?
○ N/A ○ No
○ Yes ○ U/K

y. Lifeguard present?
○ N/A ○ No
○ Yes ○ U/K

z. Rescue attempt made?
○ N/A ○ Yes ○ No ○ U/K
If yes, who? Check all that apply:
☐ Parent ☐ Bystander
☐ Other child ☐ Other, specify:
☐ Lifeguard ☐ U/K

aa. Did rescuer(s) also drown?
○ N/A ○ No
○ Yes ○ U/K
If yes, number of rescuers that drowned: _____

bb. Appropriate rescue equipment present?
○ N/A ○ No
○ Yes ○ U/K

H4. UNINTENTIONAL 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, specify:
◯ Asphyxia by gas, go to H7g
◯ Other, specify:
◯ U/K

c. If strangulation, object causing event:
○ Clothing ○ Leash
○ Blind cord ○ Electrical cord
○ Car seat ○ Person, go to H5q
○ Stroller ○ Automobile power window or sunroof
○ High chair
○ Belt ○ Other, specify:
○ Rope/string ○ U/K

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

e. Was asphyxia an autoerotic event?
○ N/ ○ Ye ○ No ○ U/K

f. Was child participating in 'choking game' or 'pass out game'?
○ N/ ○ Ye ○ No ○ U/K

g. History of seizures?
○ Ye ○ No ○ U/K If yes, #____
If yes, witnessed? ○ Yes ○ No ○ U/K

h. History of apnea?
○ Ye ○ No ○ U/K If yes, #____
If yes, witnessed? ○ Yes ○ No ○ U/K

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

H5. ASSAULT, WEAPON OR 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
- ☐ Magazine disconnect
- ☐ Personalization device
- ☐ Minimum trigger pull
- ☐ External safety/drop safety
- ☐ Other, specify:
- ☐ Loaded chamber indicator
- ☐ U/K

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

q. Use of weapon at time, check all that apply:
- ☐ Self injury
- ☐ Commission of crime
- ☐ Drug dealing/trading
- ☐ 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

H6. 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. Was child pushed, dropped or thrown?
○ Yes ○ No ○ U/K
If yes, go to H5q

g. 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

h. For crush, object causing crush:
- ○ Appliance
- ○ Television
- ○ Furniture
- ○ Walls
- ○ Playground equipment
- ○ Animal
- ○ Tree branch
- ○ Boulders/rocks
- ○ Dirt/sand
- ○ Person, go to H5q
- ○ Commercial equipment
- ○ Farm equipment
- ○ Other, specify:
- ○ U/K

H7. POISONING, OVERDOSE OR ACUTE INTOXICATION

a. Type of substance involved, check all that apply and note source of substance: ☐ U/K

Source codes: 1 = Bought from dealer or stranger (Prescription or illicit only); 2 = Bought from friend or relative; 3 = From friend or relative for free; 4 = Took from friend or relative without asking; 5 = Own prescription (Prescription only); 6 = Bought from store/pharmacy (OTC or other substances only); 7 = Other; 9 = U/K

Prescription drug/source
- ☐__ Antidepressant
- ☐__ Pain medication (opioids)
- ☐__ Pain medication (non-opioids)
- ☐__ Methadone
- ☐__ Other Rx, specify:

If prescription, was it child's? ○ Yes ○ No ○ U/K

Over-the-counter drug/source
- ☐__ Pain medication
- ☐__ Cold medicine
- ☐__ Other OTC, specify:

Illicit drugs/source
- ☐__ Pain medication (opioids)
- ☐__ Pain medication (non-opioids)
- ☐__ Methadone
- ☐__ Cocaine
- ☐__ Heroin
- ☐__ Other illicit drug, specify:

Other substances/source
- ☐__ Alcohol
- ☐__ Carbon monoxide, go to e
- ☐__ 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. Was the incident the result of?
- ○ Accidental overdose
- ○ Medical treatment mishap
- ○ Adverse effect, but not overdose
- ○ Deliberate poisoning
- ○ Acute intoxication
- ○ Other, specify:
- ○ U/K

f. Was Poison Control called?
○ Yes ○ No ○ U/K
If yes, who called:
- ○ Child
- ○ Parent
- ○ Other caregiver
- ○ First responder
- ○ Medical person
- ○ Other, specify:
- ○ U/K

g. For CO poisoning, was a CO alarm present?
○ Yes ○ No ○ U/K
If yes, how many? _____
Functioning properly?
○ Yes ○ No ○ U/K

H8. 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 the medical condition associated with an outbreak?
○ Yes, specify: ○ No ○ U/K

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

h. 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
- ☐ Lack of transportation
- ☐ No phone
- ☐ Cultural differences
- ☐ Language barriers
- ☐ Couldn't get provider to take as patient
- ☐ Multiple providers, not coordinated
- ☐ Couldn't get an earlier appointment
- ☐ Lack of child care
- ☐ Lack of family/social support
- ☐ Services not available
- ☐ Caregiver distrust of health care system
- ☐ Caregiver unskilled in providing care
- ☐ Caregiver unwilling to provide care
- ☐ Didn't know where to go
- ☐ Mother didn't think she was pregnant
- ☐ Other, specify:
- ☐ U/K

i. Was death caused by a medical misadventure?
○ Yes ○ No ○ U/K

H9. OTHER KNOWN INJURY CAUSE

Specify cause, describe in detail:

I. OTHER CIRCUMSTANCES OF INCIDENT - ANSWER RELEVANT SECTIONS

I1. SUDDEN AND UNEXPECTED DEATH IN THE YOUNG (SDY)

This section displays online based on your state's settings.

Section I1: OMB No. 0920-1092, Exp. Date: 4/30/2022

a. Was this death:

- ○ A homicide?
- ○ A suicide?
- ○ An overdose?
- ○ A result of an external cause that was the obvious and only reason for the fatal injury?
- ○ Expected within 6 months due to terminal illness?

If any of these apply, go to Section I2, THIS IS NOT AN SDY CASE.

- ○ None of the above, go to I1b THIS IS AN SDY CASE
- ○ U/K, go to I1b

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			Other Acute Symptom	Present w/in 72 hours of death		
	Yes	No	U/K		Yes	No	U/K
Cardiac							
Chest pain	○	○	○	Fever	○	○	○
Dizziness/lightheadedness	○	○	○	Heat exhaustion/heat stroke	○	○	○
Fainting	○	○	○	Muscle aches/cramping	○	○	○
Palpitations	○	○	○	Slurred speech	○	○	○
Neurologic				Vomiting	○	○	○
Concussion	○	○	○	Other, specify:	○		
Confusion	○	○	○				
Convulsions/seizure	○	○	○				
Headache	○	○	○				
Head injury	○	○	○				
Psychiatric symptoms	○	○	○				
Paralysis (acute)	○	○	○				
Respiratory							
Asthma	○	○	○				
Pneumonia	○	○	○				
Difficulty breathing	○	○	○				

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			Condition	Diagnosed			Condition	Diagnosed		
	Yes	No	U/K		Yes	No	U/K		Yes	No	U/K
Blood disease				**Neurologic**				**Other**			
Sickle cell disease	○	○	○	Anoxic brain injury	○	○	○	Connective tissue disease	○	○	○
Sickle cell trait	○	○	○	Traumatic brain injury/ head injury/concussion	○	○	○	Diabetes	○	○	○
Thrombophilia (clotting disorder)	○	○	○					Endocrine disorder, other: thyroid, adrenal, pituitary	○	○	○
Cardiac				Brain tumor	○	○	○				
Abnormal electrocardiogram (EKG or ECG)	○	○	○	Brain aneurysm	○	○	○	Hearing problems or deafness	○	○	○
				Brain hemorrhage	○	○	○	Kidney disease	○	○	○
Aneurysm or aortic dilatation	○	○	○	Developmental brain disorder	○	○	○	Mental illness/psychiatric disease	○	○	○
Arrhythmia/arrhythmia syndrome	○	○	○	Epilepsy/seizure disorder	○	○	○	Metabolic disease	○	○	○
Cardiomyopathy	○	○	○	Febrile seizure	○	○	○	Muscle disorder or muscular dystrophy	○	○	○
Commotio cordis	○	○	○	Mesial temporal sclerosis	○	○	○				
Congenital heart disease	○	○	○	Neurodegenerative disease	○	○	○	Oncologic disease treated by chemotherapy or radiation	○	○	○
Coronary artery abnormality	○	○	○	Stroke/mini stroke/ TIA-Transient Ischemic Attack	○	○	○				
Coronary artery disease (atherosclerosis)	○	○	○					Prematurity	○	○	○
				Central nervous system infection (meningitis or encephalitis)	○	○	○	Congenital disorder/ genetic syndrome	○	○	○
Endocarditis	○	○	○								
Heart failure	○	○	○	**Respiratory**				Other, specify:	○		
Heart murmur	○	○	○	Apnea	○	○	○				
High cholesterol	○	○	○	Asthma	○	○	○				
Hypertension	○	○	○	Pulmonary embolism	○	○	○				
Myocarditis (heart infection)	○	○	○	Pulmonary hemorrhage	○	○	○				
Pulmonary hypertension	○	○	○	Respiratory arrest	○	○	○				
Sudden cardiac arrest	○	○	○								

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 ☐ Heart surgery ☐ Heart transplant
☐ Cardiac device placement (Implanted cardioverter defibrillator (ICD) or pacemaker or Ventricular Assist Device (VAD)) ☐ Interventional cardiac catheterization ☐ 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/	Deaths
○	○	○	Sudden unexpected death before age 50

If yes, describe the type of event, which relative, and relative's age at death (for example, brother at age 30 who died in an unexplained motor vehicle accident (driver of car)):

			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:

g. Has any blood relative (siblings, parents, aunts, uncles, cousins, grandparents) had genetic testing? ○ Yes ○ No ○ U/K

If yes, describe the test/gene tested, reason for testing, family member tested, 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 ☐ Supplements
☐ Recent/short term prescriptions ☐ Tobacco
☐ Energy drinks ☐ Alcohol
☐ Caffeine ☐ Illegal drugs
☐ Performance enhancers ☐ Legalized marijuana
☐ Diet assisting medications ☐ 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	No	U/K	Within 24 hrs of Incident Yes	No	U/K
Physical activity	○	○	○	○	○	○
Sleep deprivation	○	○	○	○	○	○
Driving	○	○	○	○	○	○
Visual stimuli	○	○	○	○	○	○
Video game stimuli	○	○	○	○	○	○
Emotional stimuli	○	○	○	○	○	○
Auditory stimuli/startle	○	○	○	○	○	○
Physical trauma	○	○	○	○	○	○
Other, specify:	○			○		

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 ○ U/K

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 ☐ Headache
☐ Confusion ☐ Palpitations
☐ Convulsions/seizure ☐ Shortness of breath/difficulty breathing
☐ Dizziness/lightheadedness ☐ Other, specify:
☐ Fainting ☐ U/K

If yes to any item, describe type of physical activity and extent of symptoms:

o. For 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 exposure to strobe lights, video game, or flickering light (reflex seizure)
☐ U/K

s. Describe the child's epilepsy/seizures (not including the seizure at time of death). 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 ○ 2 ○ More than 3
○ 1 ○ 3 ○ U/K

u. Did treatment for seizures include anti-epileptic drugs?
○ Yes ○ No ○ U/K
If yes, how many different types of anti-epileptic drugs did the child take?
○ 1 ○ 4 ○ More than 6
○ 2 ○ 5 ○ U/K
○ 3 ○ 6

v. Was night surveillance used?
○ Yes ○ No ○ U/K

I2. ANSWER THIS ONLY IF CHILD IS UNDER AGE FIVE: WAS DEATH RELATED TO SLEEPING OR THE SLEEP ENVIRONMENT? ○ Yes, go to i2a ○ No, go to i2s ○ U/K, go to i2a

a. Incident sleep place:
○ Crib
If crib, type:
○ Not portable
○ Portable, e.g. Pack 'n Play
○ Unknown crib type
○ Bassinet
○ Bed side sleeper
○ Baby box
○ Adult bed
○ Waterbed
○ Futon
○ Playpen/other play structure, not a portable crib
○ Couch
○ Chair
○ Floor
○ Car seat
○ Rock 'n Play
○ Stroller
○ Swing
○ Bouncy chair
○ 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
If car seat, was car seat secured in seat of car?
○ Yes ○ No ○ 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 any type of crib, Pack 'n Play, bassinet, bed side sleeper or baby box 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
○ Bassinet
○ Bed side sleeper
○ Baby box
○ Adult bed
○ Waterbed
○ Futon
○ Playpen/other play structure, not a portable crib
○ Couch
○ Chair
○ Floor
○ Car seat
○ Rock 'n Play
○ Stroller
○ Swing
○ Bouncy chair
○ 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, describe why:

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 ○ U/K
○ Occasionally

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 when found (includes nose, mouth, neck and/or chest):
○ 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
☐ Neck compressed
☐ Chest compressed
☐ U/K
If fully or partially obstructed, describe obstruction in detail:

o. Objects in child's sleep environment and relation to airway obstruction:

Objects:	Present? Ye	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	UK
Adult(s)	○	○	○	☐	☐	☐	☐	☐	○	○	○
Other child(ren)	○	○	○	☐	☐	☐	☐	☐	○	○	○
Animal(s)	○	○	○	☐	☐	☐	☐	☐	○	○	○
Mattress	○	○	○	☐	☐	☐	☐	☐	○	○	○
Comforter, quilt, or other	○	○	○	☐	☐	☐	☐	☐	○	○	○
Fitted sheet	○	○	○	☐	☐	☐	☐	☐	○	○	○
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:											
_____	○			☐	☐	☐	☐	☐	○	○	○
_____	○			☐	☐	☐	☐	☐	○	○	○

→ If adult(s) obstructed airway, describe relationship of adult to child (for example, biological mother):

p. Was there a reliable, non-conflicting witness account of how the child was found? ○ Yes ○ No ○ U/K

q. Caregiver/supervisor fell asleep while feeding child?
○ Yes ○ No ○ U/K
If yes, type of feeding: ○ Bottle ○ Breast ○ U/K

r. Child sleeping in the same room as caregiver/supervisor at time of death?
○ Yes ○ No ○ U/K

s. Child sleeping on same surface with person(s) or animal(s)?
○ Yes ○ No ○ U/K

If yes, reasons stated for sleeping on same surface, check all that apply:
- ☐ To feed
- ☐ To soothe
- ☐ Usual sleep pattern
- ☐ No infant bed available
- ☐ Home/living space overcrowded
- ☐ Other, specify:
- ☐ U/K

If yes, check all that apply:
- ☐ With adult(s): # _____ ☐ # U/K
  Adult obese: ○ Yes ○ No ○ U/K
- ☐ With other children: # _____ ☐ # U/K Children's ages: _____
- ☐ With animal(s): # _____ ☐ # U/K Type(s) of animal: _____

t. Is there a scene re-creation photo available for upload? ○ Yes ○ No If yes, upload here. Only one photo allowed.
Select photo that demonstrates position and location of child's body and airway (nose, mouth, neck, and chest). Size must be less than 6 mb and in .jpg or .gif format.

I3. WAS DEATH A CONSEQUENCE OF A PROBLEM WITH A CONSUMER PRODUCT? ○ Yes ○ No, go to I4 ○ U/K, go to I4

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
- ○ No, go to www.saferproducts.gov to report
- ○ U/K

I4. DID DEATH OCCUR DURING COMMISSION OF ANOTHER CRIME? ○ Yes ○ No, go to I5 ○ U/K, go to I5

a. Type of crime, check all that apply:
- ☐ Robbery/burglary
- ☐ Interpersonal violence
- ☐ Sexual assault
- ☐ Other assault
- ☐ Gang conflict
- ☐ Drug trade
- ☐ Arson
- ☐ Prostitution
- ☐ Witness intimidation
- ☐ Illegal border crossing
- ☐ Auto theft
- ☐ Other, specify:
- ☐ U/K

I5. CHILD ABUSE, NEGLECT, POOR SUPERVISION AND EXPOSURE TO HAZARDS

a. Did child abuse, neglect, poor or absent supervision or exposure to hazards cause or contribute to the child's death?
- ○ Yes/probable
- ○ No, go to next section
- ○ U/K, go to next section

If yes/probable, choose primary reason:
- ○ Child abuse, go to I5b
- ○ Child neglect, go to I5f
- ○ Poor/absent supervision, go to I5h
- ○ Exposure to hazards, go to I5g

b. Type of child abuse, check all that apply:
- ☐ Abusive head trauma, go to I5c
- ☐ Chronic Battered Child Syndrome, go to I5e
- ☐ Beating/kicking, go to I5e
- ☐ Scalding or burning, go to I5e
- ☐ Munchausen Syndrome by Proxy, go to I5e
- ☐ Sexual assault, go to I5h
- ☐ Other, specify and go to I5h
- ☐ U/K, go to I5e

c. For abusive head trauma, were there retinal hemorrhages?
○ Yes ○ No ○ U/K

d. For abusive head trauma, was the child shaken?
○ Yes ○ No ○ U/K

If yes, was there impact?
○ Yes ○ No ○ U/K

e. Events(s) triggering child abuse, check all that apply:
- ☐ None
- ☐ Crying
- ☐ Toilet training
- ☐ Disobedience
- ☐ Feeding problems
- ☐ Domestic argument
- ☐ Other, specify:
- ☐ U/K

f. Child neglect, check all that apply:
- ☐ Failure to provide necessities
  - ☐ Food
  - ☐ Shelter
  - ☐ Other, specify:
- ☐ Failure to provide supervision
- ☐ Emotional neglect, specify:
- ☐ Abandonment, specify:
- ☐ Failure to seek/follow treatment, specify:

If yes, was this due to religious or cultural practices?
○ Yes ○ No ○ U/K

☐ Exposure to hazards:
Do not include child's own behavior.
- ○ Hazard(s) in sleep environment (including sleep position and surface sharing)
- ○ Fire hazard
- ○ Unsecured medication/poison
- ○ Firearm hazard
- ○ Water hazard
- ○ Motor vehicle hazard
- ○ Other hazard, specify:

g. Exposure to hazards:
Do not include child's own behavior.
- ○ Hazard(s) in sleep environment (including sleep position and surface sharing)
- ○ Fire hazard
- ○ Unsecured medication/poison
- ○ Firearm hazard
- ○ Water hazard
- ○ Motor vehicle hazard
- ○ Maternal substance use during pregnancy
- ○ Other hazard, specify:

h. Was poverty a factor?
○ Yes ○ No ○ U/K

If yes, explain in Narrative

I6. SUICIDE

a. Child's history. Check all that have ever applied:
- ☐ None listed below
- ☐ Involved in sports
- ☐ Involved in activities (not sports)
- ☐ Viewed, posted or interacted on social media
  If yes, specify platform(s):
- ☐ History of running away
- ☐ History of fearfulness, withdrawal or anxiety
- ☐ History of explosive anger, yelling or disobeying
- ☐ History of head injury
  If yes, when was the last head injury? _____
- ☐ Death of a peer, friend or family member
  If yes, specify relationship to child: _____
  When did death occur: _____
  Was death a suicide? ○ Yes ○ No ○ U/K

b. Was the child ever diagnosed with any of the following? Check all that apply.
- ☐ None listed below
- ☐ Anxiety spectrum disorder
- ☐ Depressive spectrum disorder
- ☐ Bipolar spectrum disorder
- ☐ Disruptive, impulse control or conduct disorder
- ☐ Eating disorder
- ☐ Substance-related or addictive disorders
- ☐ Other, specify:
- ☐ U/K

c. Check all suicidal behaviors/attempts that ever applied:
- ☐ None listed below
- ☐ Interrupted attempt #__
- ☐ Preparatory behavior #__
- ☐ Non-fatal attempt #__
- ☐ Aborted attempt #__
- ☐ U/K

d. Did the child ever communicate any suicidal thoughts, actions or intent?
○ Yes ○ No ○ U/K
If yes, with whom? _____

e. Was there evidence the death was planned or premeditated?
○ Yes ○ No ○ U/K

f. Did the death occur under circumstances where it would likely be observed and intervened by others?
○ Yes ○ No ○ U/K

g. Did the child ever have a history of non-suicidal self-harm, such as cutting or burning oneself?
○ Yes ○ No ○ U/K
If yes ☐ Reported to others ☐ Other, specify:
☐ Noted on autopsy

h. Warning signs (https://youthsuicidewarningsigns.org) w/in 30 days of death. Check all that apply:
- ☐ None listed below
- ☐ Talked about or made plans for suicide
- ☐ Expressed hopelessness about the future
- ☐ Displayed severe/overwhelming emotional pain or distress
- ☐ Expressed perceived burden on others
- ☐ Showed worrisome behavioral cues or marked changes in behavior
- ☐ U/K

i. Child experienced a known crisis within 30 days of the death?
○ Yes ○ No ○ U/K
If yes, explain:

j. Suicide was part of: Check all that apply.
- ☐ None listed below
- ☐ A cluster
- ☐ A contagion, copy-cat or imitation
- ☐ A suicide pact
- ☐ A murder-suicide

I7. LIFE STRESSORS

Please indicate all stressors that were present for this child around the time of death.

a. Life stressors - Social/economic
- ☐ None listed below
- ☐ Racism
- ☐ Discrimination
- ☐ Poverty
- ☐ Neighborhood discord
- ☐ Job problems
- ☐ Money problems
- ☐ Food insecurity
- ☐ Housing instability
- ☐ Witnessed violence
- ☐ Pregnancy
- ☐ Pregnancy scare

b. Life stressors - Relationships (age 5 and over)
- ☐ None listed below
- ☐ Family discord
- ☐ Argument with parents/caregivers
- ☐ Parents' divorce/separation
- ☐ Parents' incarceration
- ☐ Argument with significant other
- ☐ Breakup with significant other
- ☐ Social discord
- ☐ Argument with friends
- ☐ Bullying as a victim
- ☐ Bullying as a perpetrator
- ☐ Cyberbullying as a victim
- ☐ Cyberbullying as a perpetrator
- ☐ Peer violence as a victim
- ☐ Peer violence as a perpetrator
- ☐ Isolation
- ☐ Stress due to sexual orientation
- ☐ Stress due to gender identity

c. Life stressors - School (age 5 and over)
- ☐ None listed below
- ☐ School failure
- ☐ Pressure to succeed
- ☐ Extracurricular activities
- ☐ New school
- ☐ Other school problems

d. Life stressors - Technology (age 5+)

Stress/negative consequences due to:

- ☐ None listed below
- ☐ Electronic gaming
- ☐ Texting
- ☐ Restriction of technology
- ☐ Social media

e. Life stressors - Transitions (age 5 and over)

- ☐ None listed below
- ☐ Release from hospital
- ☐ Transition from any level of mental health care to another (e.g. inpatien to outpatient, inpatient to residential outpatient to inpatient, etc.)
- ☐ Release from juvenile justice facility
- ☐ End of school year/school break
- ☐ Transition to/from child welfare system
- ☐ Release from immigrant detention center

f. Life stressors - Trauma (age 5 and over)

- ☐ None listed below
- ☐ Rape/sexual assault
- ☐ Previous abuse (emotional/physical)
- ☐ Family/domestic violence

g. Life stressors - Describe any other life stressors: (age 5 and over)

I8. COVID-19-RELATED DEATHS

a. For the 12 months before the child's death, did the family experience any disruptions or significant changes to the following? Check all that apply:

- ☐ None listed below
- ☐ School
- ☐ Daycare
- ☐ Employment
- ☐ Social services (such as unemployment assistance, TANF, WIC)
- ☐ Living environment
- ☐ Medical care
- ☐ Mental health or substance use/abuse care
- ☐ Home-based services (non-child welfare)
- ☐ Child welfare services
- ☐ Legal proceedings within criminal, civil, or family courts
- ☐ Other
- ☐ U/K

If any disruptions or significant changes, describe:

b. For the 12 months before the child's death, did the child's family live in an area with an official stay at home order?

○ Yes ○ No ○ U/K

If yes, was the stay at home order in place at the time of the child's death?

○ Yes ○ No ○ U/K

c. Was the child exposed to COVID-19 within 14 days of death?

○ Yes ○ No ○ U/K

If yes, describe:

d. Select the one option that best describes the impact of COVID-19 on this child's death:

- ○ COVID-19 was the immediate or underlying cause of death
- ○ COVID-19 was diagnosed at autopsy or the child was suspected to have COVID-19
- ○ COVID-19 indirectly contributed to the death but was not the immediate or underlying cause of death
- ○ The birthing parent contracted COVID-19 during pregnancy
- ○ Other, specify:
- ○ COVID-19 had no impact on this child's death
- ○ U/K

e. Did COVID-19 impact the team's ability to conduct this fatality review?

○ Yes ○ No ○ U/K

If yes, check all that apply:

- ☐ Unable to obtain records
- ☐ Team members unable to attend review
- ☐ Remote reviews negatively impacted review process
- ☐ Team leaders redirected to COVID-19 response

J. PERSON RESPONSIBLE (OTHER THAN DECEDENT)

1. Did a person or persons other than the child do something or fail to do something that caused or contributed to the death?

- ○ Yes/probable
- ○ No, go to Section K
- ○ U/K, go to Section K

2. What act(s)? Enter information for the first person under "One" and if there is a second person, use column "Two." Describe acts in narrative.

One	Two		One	Two	
○	○	Child abuse	○	○	Exposure to hazards
○	○	Child neglect	○	○	Assault, not child abuse
○	○	Poor/absent supervision	○	○	Other, specify:
			○	○	U/K

3. Did the team have information about the person(s)?

One	Two	
○	○	Yes
○	○	No, go to Section K

4. Is person listed in a previous section?

One	Two	
○	○	Yes, biological mother, go to J17
○	○	Yes, biological father, go to J17
○	○	Yes, caregiver one, go to J17
○	○	Yes, caregiver two, go to J17
○	○	Yes, supervisor, go to J19
○	○	No

5. Primary person(s) responsible for action(s): Select one for each person responsible.

One	Two		One	Two		One	Two	
○	○	Adoptive parent	○	○	Grandparent	○	○	Medical provider
○	○	Stepparent	○	○	Sibling	○	○	Institutional staff
○	○	Foster parent	○	○	Other relative	○	○	Babysitter
○	○	Mother's partner	○	○	Friend	○	○	Licensed child care worker
○	○	Father's partner	○	○	Acquaintance	○	○	Other, specify:
			○	○	Child's boyfriend or girlfriend	○	○	U/K
			○	○	Stranger			

6. Person's age in years:

One	Two	
____	____	# Years
☐	☐	U/K

7. Person's sex:

One	Two	
○	○	Male
○	○	Female
○	○	U/K

8. Person speaks and understands English?

One	Two	
○	○	Yes
○	○	No
○	○	U/K

If no, language spoken:

9. Person on active military duty?

One	Two	
○	○	Yes
○	○	No
○	○	U/K

If yes, specify branch:

J. PERSON RESPONSIBLE (OTHER THAN DECEDENT) (Continued)

10. Person(s) have history of substance abuse?

One Two
- ○ ○ Yes
- ○ ○ No
- ○ ○ U/K

If yes, check all that apply:
- ☐ ☐ Alcohol
- ☐ ☐ Cocaine
- ☐ ☐ Marijuana
- ☐ ☐ Methamphetamine
- ☐ ☐ Opioids
- ☐ ☐ Prescription drugs
- ☐ ☐ Over-the-counter
- ☐ ☐ Other, specify:
- ☐ ☐ U/K

11. Person(s) have history of child maltreatment as victim?

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. Person(s) have history of child maltreatment as a perpetrator?

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. Person(s) have disability or chronic illness?

One Two
- ○ ○ 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 mental health/substance abuse, was person receiving mental health services?
- ○ ○ Yes
- ○ ○ No
- ○ ○ U/K

14. Person(s) have prior child deaths?

One Two
- ○ ○ Yes
- ○ ○ No
- ○ ○ U/K

If yes, check all that apply:
- ☐ ☐ Child abuse # _____
- ☐ ☐ Child neglect # _____
- ☐ ☐ Accident # _____
- ☐ ☐ Suicide # _____
- ☐ ☐ SIDS # _____
- ☐ ☐ Undetermined cause # ____
- ☐ ☐ Other # _____
- Other, specify:
- ☐ ☐ U/K

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

One Two
- ☐ ☐ Yes, as victim
- ☐ ☐ Yes, as perpetrator
- ☐ ☐ No
- ☐ ☐ U/K

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

One Two
- ○ ○ Yes
- ○ ○ No
- ○ ○ U/K

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

17. At the time of the incident, was the person asleep?

One Two
- ○ ○ Yes
- ○ ○ No
- ○ ○ U/K

If yes, select the most appropriate description of the person's sleeping period at incident:

On Two
- ○ ○ Night time sleep
- ○ ○ Day time nap, describe:
- ○ ○ Day time sleep (for example, person is night shift worker), describe:
- ○ ○ Other, describe:

18. At time of incident was person impaired?

One
○ Ye ○ No ○ U/K

Two
○ Ye ○ N ○ U/K

If yes, check all that apply:

One Two
- ☐ ☐ Drug impaired, specify:
- ☐ ☐ Alcohol impaired
- ☐ ☐ Distracted
- ☐ ☐ Absent

Or Two
- ☐ ☐ Impaired by illness, specify:
- ☐ ☐ Impaired by disability, specify:
- ☐ ☐ Other, specify:

19. Person(s) have, check all that apply:

One Two
- ☐ ☐ Prior history of similar acts
- ☐ ☐ Prior arrests
- ☐ ☐ Prior convictions

20. Legal outcomes in this death, check all that apply:

One Two
- ☐ ☐ No charges filed
- ☐ ☐ Charges pending
- ☐ ☐ Charges filed, specify:
- ☐ ☐ Charges dismissed
- ☐ ☐ Confession
- ☐ ☐ Plead, specify:
- ☐ ☐ Not guilty verdict
- ☐ ☐ Guilty verdict, specify:
- ☐ ☐ Tort charges, specify:
- ☐ ☐ U/K

K. SERVICES TO FAMILY AND COMMUNITY AS A RESULT OF THE DEATH

1. Were new or revised services recommended or implemented as a result of the death? ○ Yes ○ No ○ U/K

If yes, select one option per row:

	Referred for service before review	Review led to referral	Referral needed, not available	N/A	U/K
Bereavement counseling	○	○	○	○	○
Debriefing for professionals	○	○	○	○	○
Economic support	○	○	○	○	○
Funeral arrangements	○	○	○	○	○
Emergency shelter	○	○	○	○	○
Mental health services	○	○	○	○	○
Foster care	○	○	○	○	○
Health services	○	○	○	○	○
Legal services	○	○	○	○	○
Genetic counseling	○	○	○	○	○
Home visiting	○	○	○	○	○
Substance abuse	○	○	○	○	○
Other, specify:	○	○	○	○	○

L. FINDINGS IDENTIFIED DURING THE REVIEW

○ **Mark this case to edit/add findings at a later date**

1. Describe any significant challenges faced by the child, the family, the systems with which they interacted, or the response to the incident. These could be related to demographics, overt or inadvertent actions, the way systems functioned, or other environmental characteristics. (See Data Dictionary for examples.)

2. Describe any notable positive elements in this case. They could be demographic, behavioral, or environmental characteristics that may have promoted resiliency in the child or family, the systems with which they interreacted or the response to the incident. (See Data Dictionary for examples).

3. List any recommendations and/or initiatives that could be implemented to prevent deaths from similar causes or circumstances in the future:

4. Were new or revised agency services, policies or practices recommended or implemented as a result of the review? ○ Yes ○ No ○ U/K

If yes, select all that apply and describe:

☐ Child welfare	Describe:	☐ Education	Describe:
☐ Law enforcement	Describe:	☐ Mental health	Describe:
☐ Public health	Describe:	☐ EMS	Describe:
☐ Coroner/medical examiner	Describe:	☐ Substance abuse	Describe:
☐ Courts	Describe:	☐ Other, specify:	Describe:
☐ Health care systems	Describe:		

5. Could the death have been prevented? ○ Yes, probably ○ No, probably not ○ Team could not determine

M. THE REVIEW MEETING PROCESS

1. Date of first review meeting:

2. Number of review meetings for this case: _____

3. Is review complete? ○ N/A ○ Yes ○ No

4. Agencies and individuals at review meeting, check all that apply:

- ☐ Medical examiner/coroner/pathologist
- ☐ Death investigator
- ☐ Law enforcement
- ☐ Prosecutor/district attorney
- ☐ Public health
- ☐ HMO/managed care
- ☐ CPS
- ☐ Other social services
- ☐ Physician
- ☐ Nurse
- ☐ Hospital
- ☐ Other health care
- ☐ Fire
- ☐ EMS
- ☐ Faith based organization
- ☐ Education
- ☐ Mental health
- ☐ Substance abuse
- ☐ Indian Health Services/ Tribal Health
- ☐ Home visiting
- ☐ Healthy Start
- ☐ Court
- ☐ Child advocate
- ☐ Military
- ☐ Domestic violence
- ☐ Others, list:

5. Were the following data sources available at the review 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
- ☐ Home visiting
- ☐ Mental health records
- ☐ School records
- ☐ Substance abuse treatment records

6. Did any of the following factors reduce meeting effectiveness, check all that apply:

- ☐ None
- ☐ 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. Review 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

N. SUID AND SDY CASE REGISTRY

This section displays online based on your state's settings.

Section N: OMB No. 0920-1092, Exp. Date: 4/30/2022

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 O

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 (include case details that helped determine SDY categorization and any ways to improve the review) or reason why case did not go to Advanced Review:

4. Professionals at the Advanced Review meeting, check all that apply:

- ☐ Cardiologist
- ☐ CDR representative
- ☐ Coroner
- ☐ Death investigator
- ☐ Epileptologist
- ☐ Forensic pathologist/medical examiner
- ☐ Geneticist or genetic counselor
- ☐ Mental health professional
- ☐ Neonatologist
- ☐ Pediatrician
- ☐ Public health representative
- ☐ Others, specify:

5. Did the Advanced Review team believe the autopsy was comprehensive? ○ Yes ○ No ○ U/K

6. If autopsy performed, did the ME/coroner/pathologist use the SDY Autopsy Guidance or Summary?
   ○ N/A ○ Yes ○ No ○ U/K

7. Was a specimen saved for the SDY Case Registry?
○ N/A ○ Yes ○ No ○ U/K

8. Was a specimen sent to the SDY Case Registry biorepository?
○ N/A ○ Yes ○ No ○ U/K

9. 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:

10. Categorization for SDY Case Registry (choose only one):
○ Excluded from SDY Case Registry
○ Incomplete case information
○ Explained cardiac, specify:
○ Explained neurological, specify:
○ Explained infant suffocation (under age 1)
○ Explained other, specify:
○ Unexplained, possible cardiac
○ Unexplained, possible cardiac and SUDEP
○ Unexplained, SUDEP
○ Unexplained death

11. 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:

O. NARRATIVE

O1. 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, dates, 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? The Narrative is included in de-identified downloads, and per MPHI/NCFRP's data use agreement with your state, HIPAA identifying information should not be recorded in this field.

P. FORM COMPLETED BY:

Person:
Title:
Agency:
Phone:
Email:
Date completed:
Data entry completed for this case? ☐

For State Program Use Only:
Data quality assurance completed by state? ☐

NATIONAL CFRP
Center for Fatality Review & Prevention

The development of this report tool was supported, in part, by Grant No. UG7MC28482 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://data.ncfrp.org

www.ncfrp.org info@ncfrp.org 1-800-656-2434 Facebook and Twitter: NationalCFRP

APPENDIX F:

ADDITIONAL CHILD ABUSE DEATH REVIEW DATA

ADDITIONAL CHILD ABUSE DEATH REVIEW DATA

TABLE OF CONTENTS

CHILD DEATH INCIDENT INFORMATION

Location of Child Deaths

Tables F-1 and F-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 F-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 F-2 aggregates information denoted in Table F-1 for all primary causes of death for each county. No information in a table cell in either Table F-1 or Table F-2 indicates a zero count for that county category.

When information from Table F-1 is examined, there are six counties that account for more than half (26 of 49 or 53.1%) of the verified child maltreatment deaths (across all primary causes of death) in Florida. These include Polk (n=6), Brevard (n=5), Orange (n=5), Citrus (n=4), Lee (n=3) and Osceola (n=3)

When primary cause of death among verified maltreatment cases are examined, all drowning deaths (thus far reviewed) took place in 16 different counties (n=18). There were two counties that had verified maltreatment deaths involving sleep-related incidents: Citrus (n=1) and Hillsborough (n=1). The 13 verified maltreatment deaths by inflicted trauma are found across seven different counties in Florida with the greatest number occurring in Polk 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 F-2), there are eight counties with ten or more investigated deaths that collectively account for 132 of 222 (59.5%) of all fatalities. These include Orange (n=27), Polk (n=20), Pinellas (n=20), Hillsborough (n=18), Brevard (n=13), Pasco (n=13), Marion (n=11), Osceola (n=10).

Table F-1: Distribution of Cases by County, Maltreatment Verification Status and Leading Cause of Death													
County	Verified for Maltreatment n=49				Not Substantiated as Maltreatment n=47				No Indicators of Maltreatment n=126				Total
	Drowning	Sleep-related	Inflicted Trauma	Other	Drowning	Sleep-related	Inflicted Trauma	Other	Drowning	Sleep-related	Inflicted Trauma	Other	
Alachua													
Baker													
Bay													
Bradford													
Brevard	1		2	2	1	1		1	1	3		1	13
Broward	1		1		1	1		0	1	1		1	7
Calhoun													
Charlotte	1								1			2	4
Citrus		1	2	1				1				4	9
Clay													
Collier	1												1
Columbia													
DeSoto													
Dixie													
Duval										5		2	7
Escambia				1	1			1	2	4			9
Flagler													
Franklin													
Gadsden													
Gilchrist													
Glades													
Gulf													
Hamilton													
Hardee													
Hendry				1								1	2
Hernando			2		2	1				1		1	7
Highlands	1												1
Hillsborough	1	1			1	1			2	7		5	18
Holmes	1												1
Indian River						1							1
Jackson										1		1	2
Jefferson													
Lafayette													
Lake	1							1	2	1		1	6
Lee	2			1	1							4	8
Leon										3		1	4
Levy													
Liberty													
Madison													
Manatee	1				1	2			1	3		1	9
Marion	1				2			1	1	3		3	11
Martin													
Miami-Dade	1					4		3				1	9
Monroe													
Nassau	1												1
Okaloosa			1	1									2
Okeechobee													
Orange	2		2	1	2	2	1		1	9		7	27
Osceola				3					3	2		2	10
Palm Beach	1				1					1		1	4
Pasco	1					1		1		1		5	9
Pinellas				1		2			1			3	7
Polk			3	3	2	1		2		5	1	3	20
Putnam						1							1
St Johns						1							1
St Lucie													
Santa Rosa										2			2
Sarasota													
Seminole													
Sumter						1			1	2		1	5
Suwanee													
Taylor													
Union													
Volusia													
Wakulla										1			1
Walton				1						1		1	3
Washington													
Total	18	2	13	16	15	20	1	11	17	56	1	52	222

Table F-2: Distribution of All Child Death Cases Reviewed Across Florida Counties by Leading Cause of Death Category					
County	Leading Causes of Death				
	Drowning (N=50)	Sleep-related (N=78)	Inflicted Trauma (N=15)	Other (N=79)	Total (N=222)
Alachua					
Baker					
Bay					
Bradford					
Brevard	3	4	2	4	13
Broward	3	2	1	1	7
Calhoun					
Charlotte	2			2	4
Citrus		1	2	6	9
Clay					
Collier	1				1
Columbia					
DeSoto					
Dixie					
Duval		5		2	7
Escambia	3	4		2	9
Flagler					
Franklin					
Gadsden					
Gilchrist					
Glades					
Gulf					
Hamilton					
Hardee					
Hendry				2	2
Hernando	2	2	2	1	7
Highlands	1				1
Hillsborough	4	9		5	18
Holmes	1				1
Indian River		1			1
Jackson		1		1	2
Jefferson					
Lafayette					
Lake	3	1		2	6
Lee	3			5	8
Leon		3		1	4
Levy					
Liberty					
Madison					
Manatee	3	5		1	9
Marion	4	3		4	11
Martin					
Miami-Dade	1	4		4	9
Monroe					
Nassau	1				1
Okaloosa			1	1	2
Okeechobee					
Orange	5	11	3	8	27
Osceola	3	2		5	10
Palm Beach	2	1		1	4
Pasco	1	2		6	9
Pinellas	1	2		4	7
Polk	2	6	4	8	20
Putnam		1			1
St Johns		1			1
St Lucie					
Santa Rosa		2			2
Sarasota					
Seminole					
Sumter	1	3		1	5
Suwanee					
Taylor					
Union					
Volusia					
Wakulla		1			1
Walton		1		2	3
Washington					
Total	50	78	15	79	222

Drowning Death Incident Information

Where information was available, Tables F-3 and F-4 with Figure F-1 represent findings on the location and activity of child before drowning. As findings suggest in Table F-3, children (regardless of verification status) were most likely to be last documented in their house (50.0%) or in the water (18.0%) prior to drowning. Regardless of maltreatment verification status, in 48.0% of cases, children were playing before drowning.

Table F-3: Location of Child Before Drowning by Child Maltreatment Verification Status

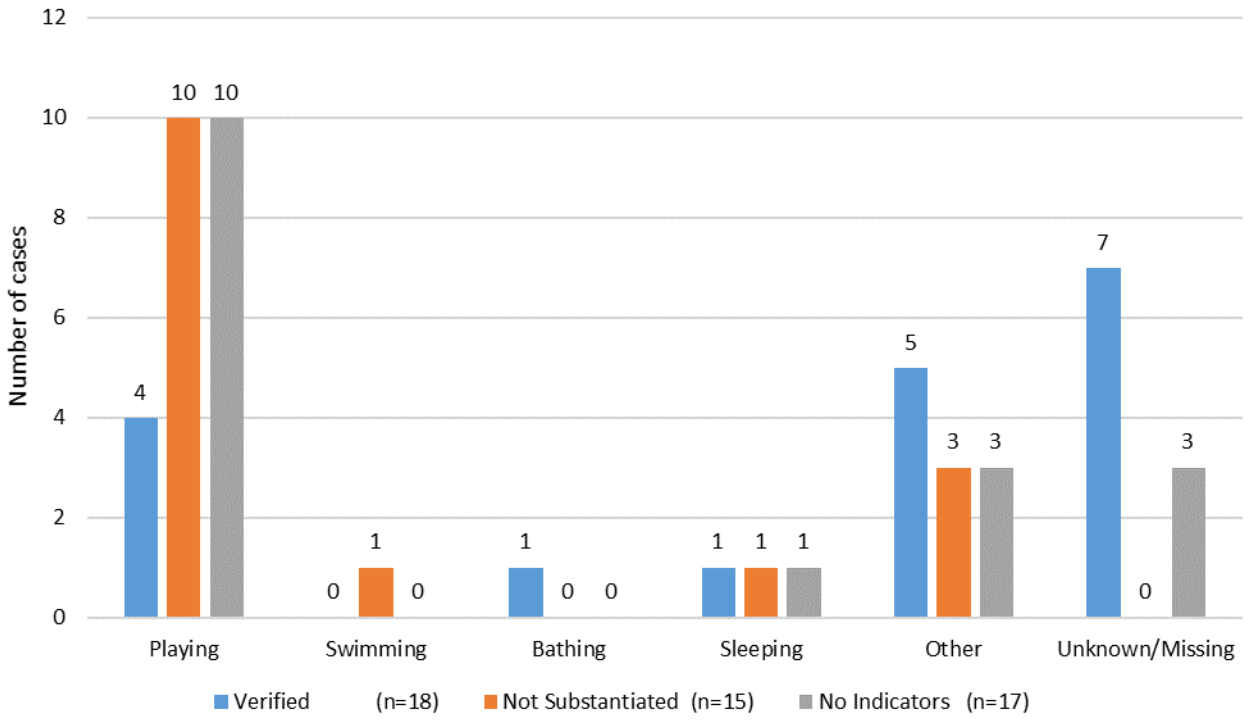
Location of Child Before Drowning	Child Drowning Deaths by Maltreatment Verification Status n=50		
	Verified (n=18)	Not Substantiated (n=15)	No Indicators (n=17)
In Water	3	3	3
On Shore	0	0	0
On Dock	0	0	0
Pool Side	1	0	2
In Yard	2	1	1
In Bathroom	2	0	0
In House	4	11	10
Other	6	0	2
Unknown	1	0	0

Aggregate totals across locations may exceed total number of cases as multiple locations were reported for select cases.

Table F-4: Activity of Child Before Drowning by Maltreatment Verification Status

Activity Before Drowning	Child Drowning Deaths by Maltreatment Verification Status (n=50)		
	Verified (n=18)	Not Substantiated (n=15)	No Indicators (n=17)
Playing	4	10	10
Swimming	0	1	0
Bathing	1	0	0
Sleeping	1	1	1
Other	5	3	3
Unknown/Missing	7	0	3

Figure F-1: Activity of Child Before Drowning
by Maltreatment Verification Status (N=50)



Sleep-Related Asphyxia Death Incident Information

Table F-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 cases (n=78) 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 blocking the child's airway contributing to death. Sleep-related deaths can include children up to age four. There was a total of 33 objects blocking the airways of the 78 children that died from sleep-related causes. Among these objects, 28.2% objects were bedding-related objects (i.e., pillows, mattresses, comforters/quilts, sheets/thin blankets, bumper pads, etc.). In 10.3% cases, the child's airway was blocked by an adult; in 44 cases, an adult was present in the sleeping environment at the time of the death incident.

Table F-5: Objects in Sleep Environment Among Sleep-Related Deaths (N=78)		
	Objects Present in Sleeping Environment	Objects Obstructing Child's Airway
Adult(s)	44	8
Other Children	15	0
Animal(s)	0	0
Mattress	50	5
Comforter	25	6
Sheet	28	1
Blanket	28	4
Pillow(s)	34	3
Cushion	2	1
Boppy or U-Shaped Pillow	4	2
Sleep Positioner	0	0
Bumper Pads	2	0
Clothing	8	0
Crib Railing/Side	3	1
Wall	4	1
Toy(s)	2	0
Other	8	1
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.		

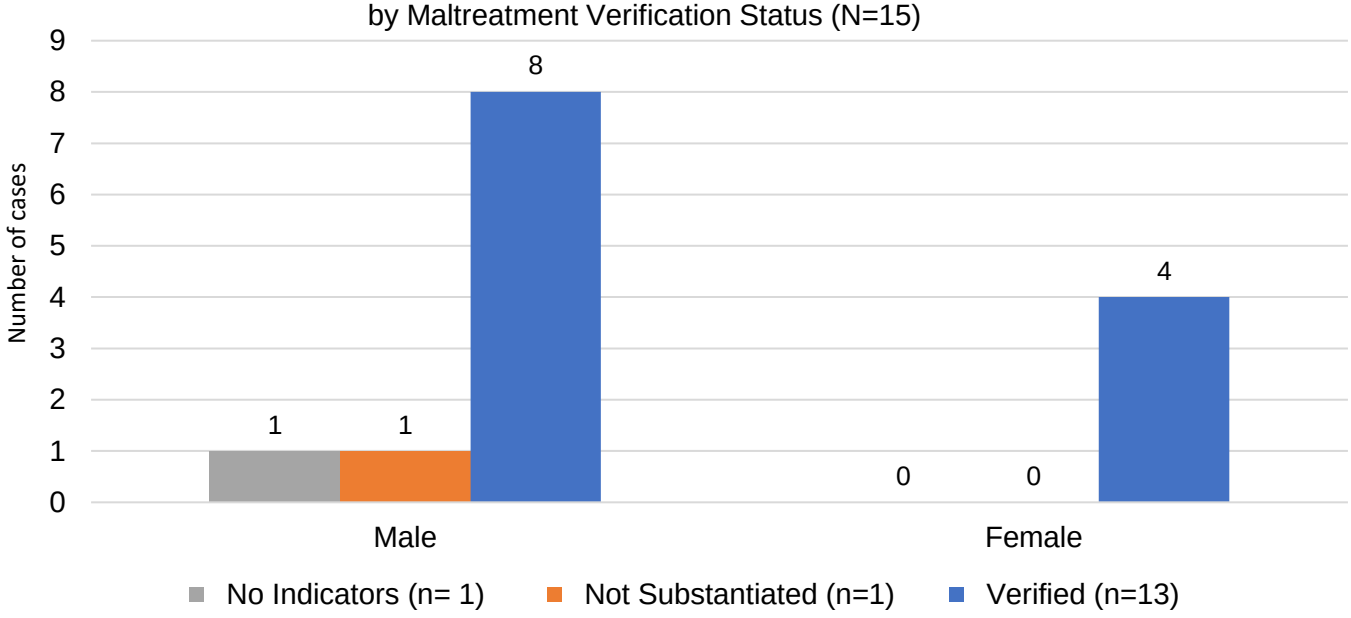
Body Part/Weapon-Related Death Incident Information

Tables F-6 through F-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. Most of the owners of firearms used in the fatality were owned by males (78.8%). When all weapons used in verified maltreatment deaths are considered, 67.7% were males who handled the weapon that was used in the child's fatality.

Table F-6: Sex of Fatal Firearm Owner by Maltreatment Verification Status			
Sex of Fatal Firearm Owner	Child Firearm Deaths by Maltreatment Verification Status (n=9)		
	Verified (n= 7)	Not Substantiated (n=1)	No Indicators (n=1)
Male	6	0	1
Female	1	1	0
Unknown/Missing	0	0	0

Table F-7: Sex of Person Handling Weapon by Maltreatment Verification Status			
Sex of Person Handling Weapon	Child Weapon Deaths by Maltreatment Verification Status (n=15)		
	Verified (n=13)	Not Substantiated (n=1)	No Indicators (n= 1)
Male	8	1	1
Female	4	0	0
Unknown/Missing	1	0	0

Figure F-2: Sex of Person Handling Weapon by Maltreatment Verification Status (N=15)



As highlighted in Table F-8 and Figure F-3 and F-4 the biological parent was the person handling the weapon at the time of death in 60.0% of cases.

Table F-8: Person Handling Fatal Weapon at Time of Death Incident by Maltreatment Verification Status			
Person Handling Fatal Weapon	Child Weapon Deaths by Maltreatment Verification Status (n=15)		
	Verified (n=13)	Not Substantiated (n=1)	No Indicators (n= 1)
Self/Child	0	1	1
Biological Parent	9	0	0
Adoptive Parent	0	0	0
Stepparent	0	0	0
Foster parent	0	0	0
Mother's Partner	1	0	0
Father's Partner	0	0	0
Grandparent	0	0	0
Friend	0	0	0
Neighbor	0	0	0
Other relative	1	0	0
Other Non-relative	1	0	0
Unknown/Missing	2	0	0

Figure F-3: Person Handling Fatal Weapon at Time of Death (N=15)

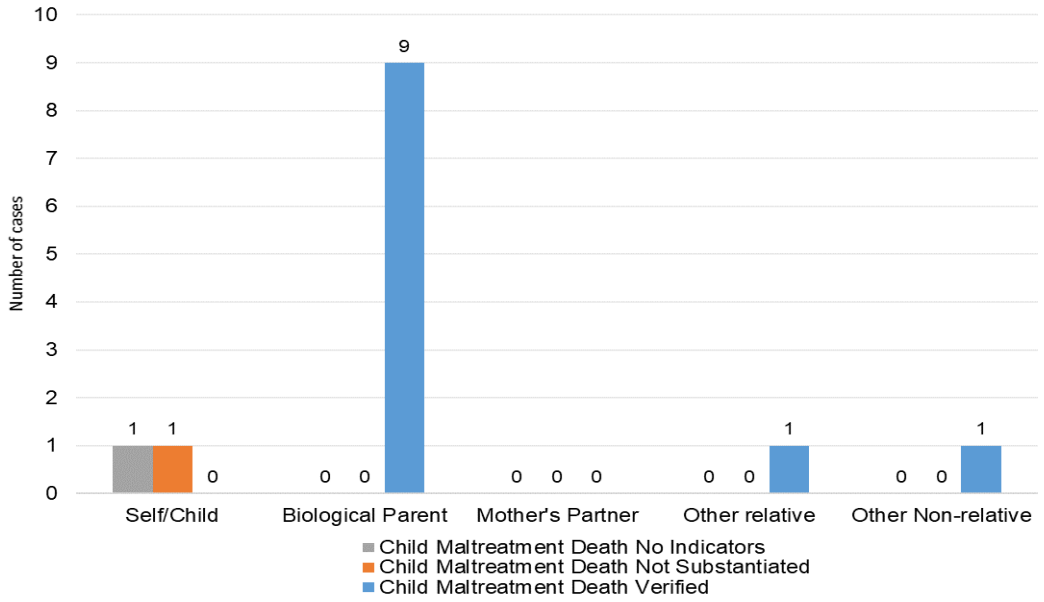
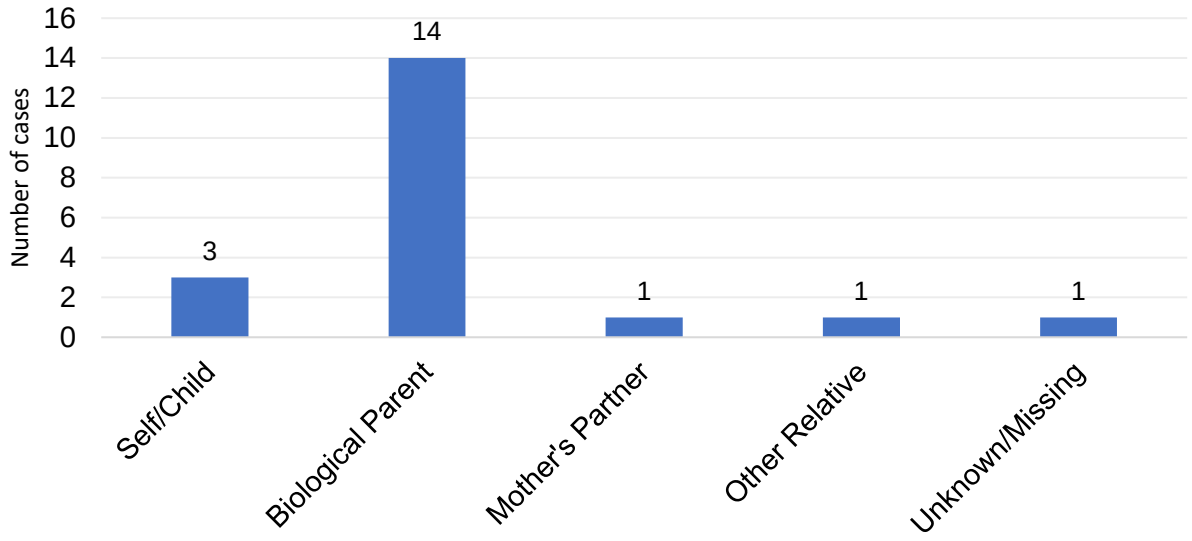


Figure F-4: Person Handling Fatal Weapon at Time of Fatal Death Incident Across All Investigated Cases (N=15)



CHILD CHARACTERISTICS

Age of Child

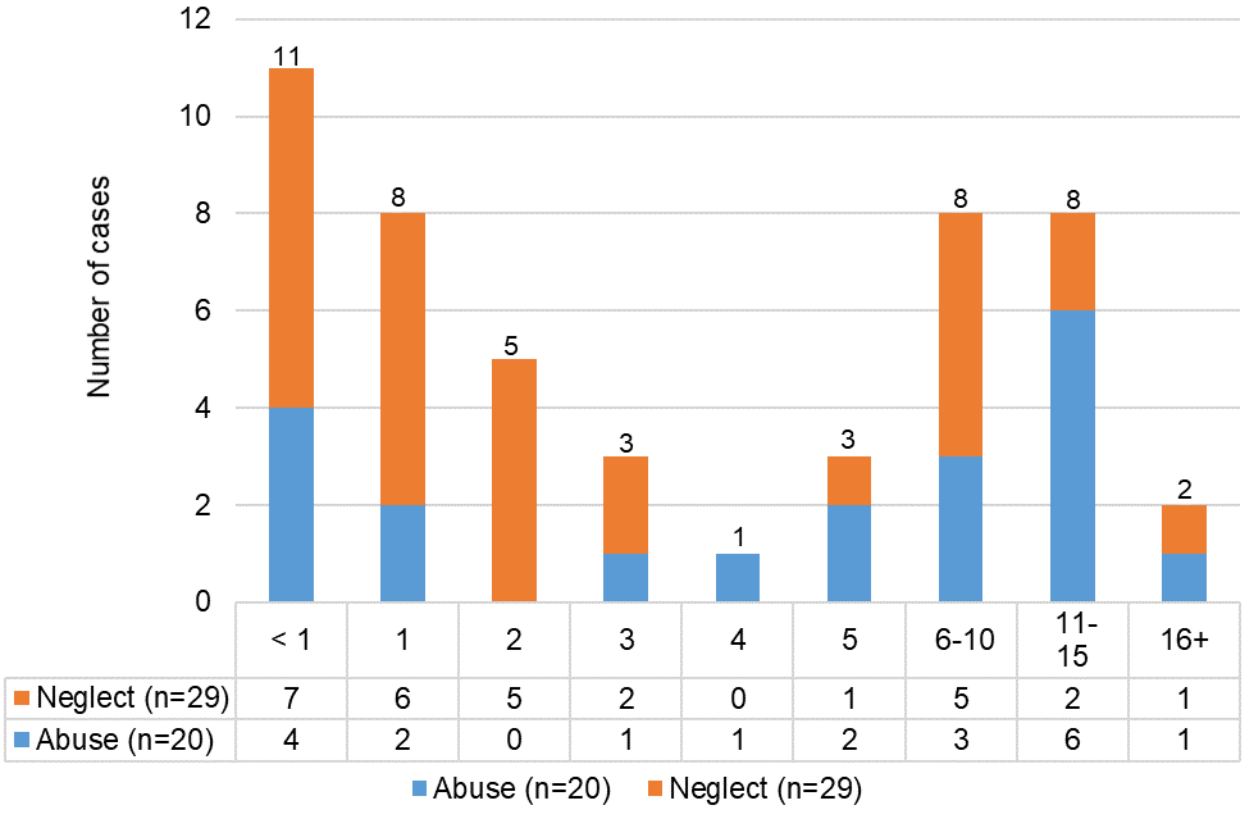
Table F-9 provides a count of children by age group for which their death was verified as maltreatment by primary cause of death. Table F-10 and Figure F-5 itemize the number of children by age group whose death was classified as abuse or neglect.

Table F-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=49							
	Drowning n=18		Sleep-related n=2		Inflicted Trauma n=13		Other n=16	
	Abuse	Neglect	Abuse	Neglect	Abuse	Neglect	Abuse	Neglect
< 1	0	2	0	2	4	0	0	3
1	1	5	0	0	1	0	0	1
2	0	3	0	0	0	1	0	1
3	0	1	0	0	0	0	1	1
4	2	0	0	0	0	0	1	0
5	2	2	0	0	0	0	0	1
6-10	2	2	0	0	1	1	0	2
11-15	0	0	0	0	4	0	2	2
16+	0	0	0	0	1	0	0	1

Table F-10: Age of Children with Verified Maltreatment Death Classified as Abuse or Neglect		
Age	Verified Child Maltreatment Death n=49	
	Abuse n=20	Neglect n=29
< 1	4	7
1	2	6
2	0	5
3	1	2
4	1	0
5	2	1
6-10	3	5
11-15	6	2
16+	1	1

Figure F-5: Verified Maltreatment Deaths Classified as Abuse or Neglect by Age Group (N=49)



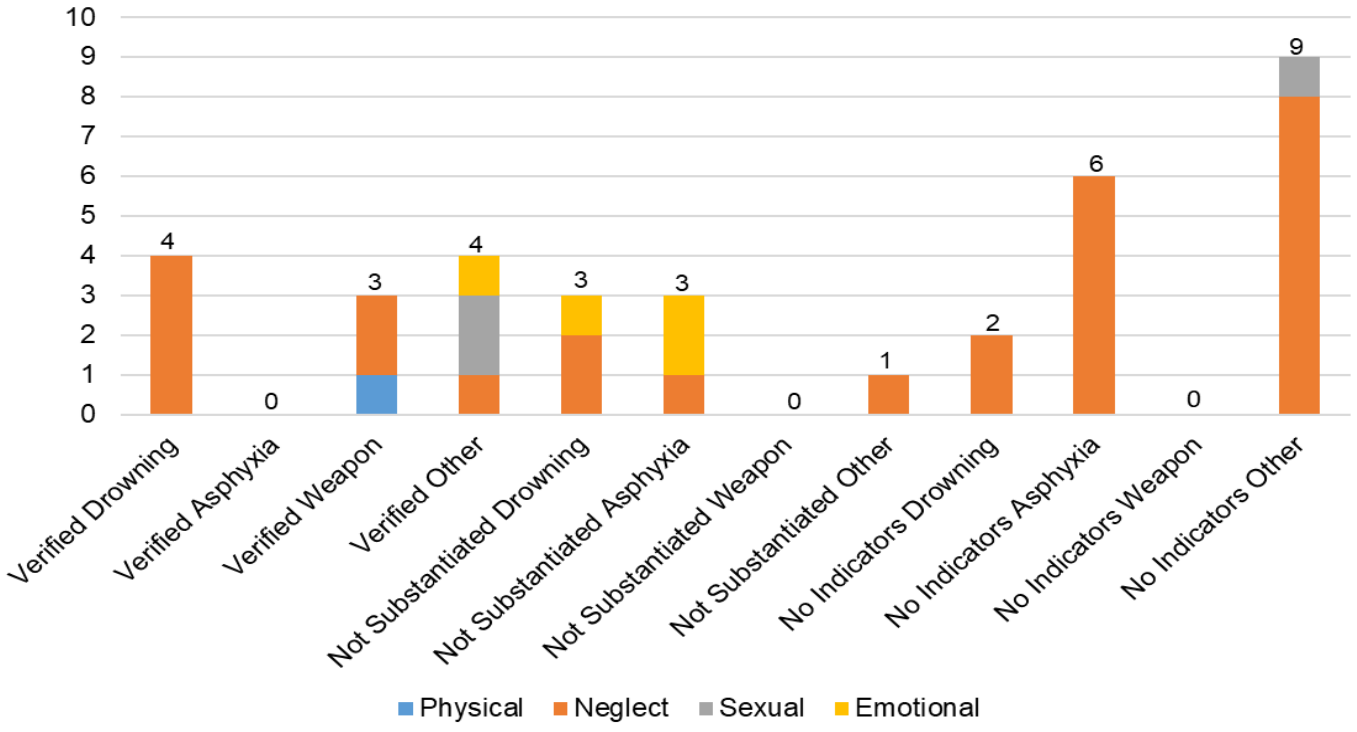
Child's History as Victim of Maltreatment

If known and applicable, the distribution of past maltreatment incidents across maltreatment verification status and primary cause of death are denoted in Table F-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 F-11: Child's History as a Victim of Maltreatment for Child Fatality Cases

Type of Past Maltreatment	Child Maltreatment Status											
	Verified n=49				Not Substantiated n=47				No Indicators n=126			
	Drowning n=18	Sleep-related n=2	Inflicted Trauma n=13	Other n=16	Drowning n=15	Sleep-related n=20	Inflicted Trauma n=1	Other n=11	Drowning n=17	Sleep-related n=56	Inflicted Trauma n=1	Other n=52
Physical	0	0	1	0	0	0	0	0	0	0	0	0
Neglect	4	0	2	1	2	1	0	1	2	6	0	8
Sexual	0	0	0	2	0	0	0	0	0	0	0	1
Emotional	0	0	0	1	1	2	0	0	0	0	0	0

Figure F-6: Child's History as Victim of Maltreatment (n=222)



CAREGIVER AND SUPERVISOR CHARACTERISTICS

Table F-12 summarizes the number 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, 83.7% of the children had a second caregiver present in the home. In cases where the maltreatment was determined to either be not substantiated or no indicators there was a second caregiver present in the home 75.7% of the time.

Table F-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=49				Not Substantiated n=47				No Indicators n=126			
	Drowning n=18	Sleep-related n=2	Inflicted Trauma n=13	Other n=16	Drowning n=15	Sleep-related n=20	Inflicted Trauma n=1	Other n=11	Drowning n=17	Sleep-related n=56	Inflicted Trauma n=1	Other n=52
One	18	2	13	16	15	20	1	11	17	56	1	52
Two	16	2	12	11	11	17	1	5	15	40	1	41

Relationship to Child of Caregivers and Supervisors

Tables F-13 through F-15 and Figure F-7 demonstrate that the most likely caregiver(s) present across all causes of death were the biological parents of the child. Of the 393 caregivers identified for the 222 children, 83.5% were the child's biological parents.

Among verified child maltreatment deaths, the proportion of all caregivers who are biological parents was 88.2% for drowning deaths, 100.0% for sleep-related deaths, 84.0% for inflicted trauma deaths and 85.2% for other deaths.

Table F-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=49				Not Substantiated n=47				No Indicators n=126			
	Drowning n=18	Sleep-related n=2	Inflicted Trauma n=13	Other n=16	Drowning n=15	Sleep-related n=20	Inflicted Trauma n=1	Other n=11	Drowning n=17	Sleep-related n=56	Inflicted Trauma n=1	Other n=52
Biological Parent	30	4	21	23	20	32	1	14	23	84	2	74
Other	4	0	3	4	6	5	1	2	8	10	0	18
Unknown	0	0	1	0	0	0	0	0	1	1	0	1

Figure F-7: Caregiver (Aggregate) Relationship to Child by Child Maltreatment Verification Status (N=393)

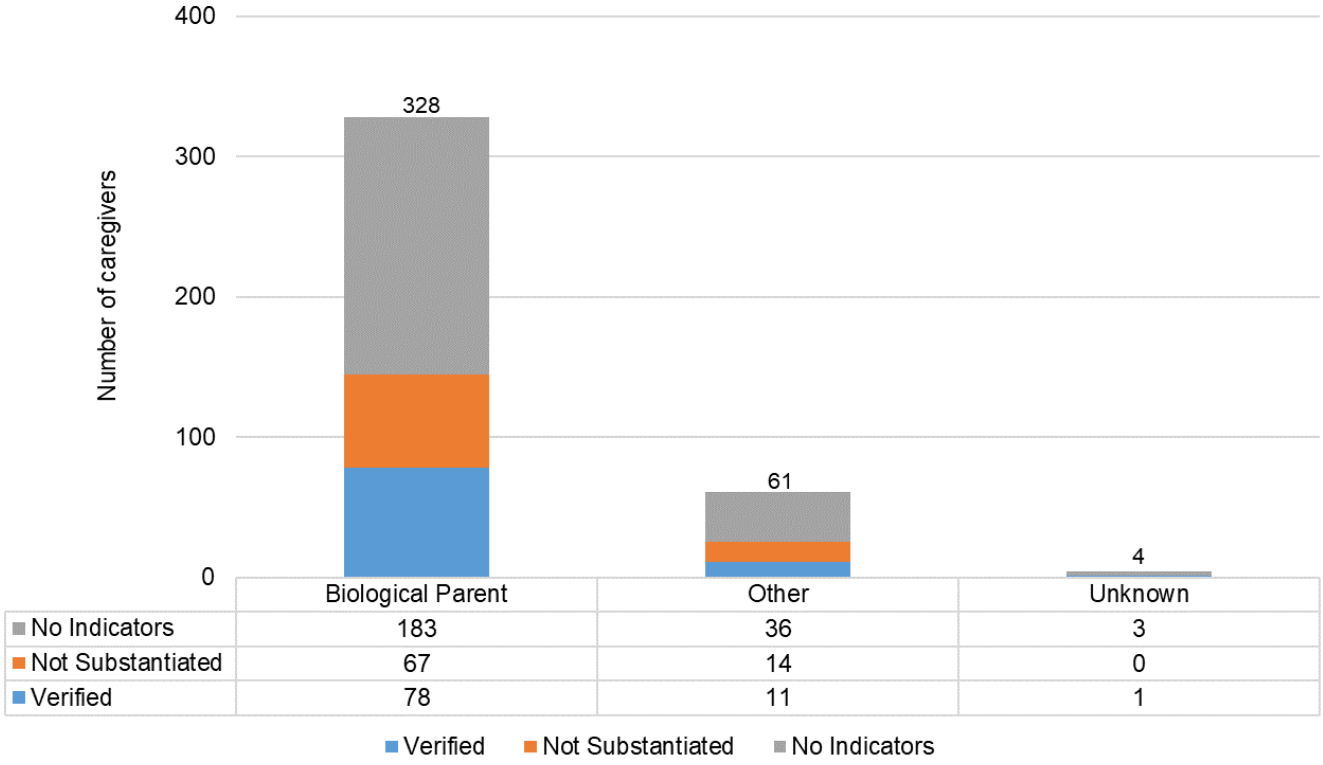


Table F-14: Relationship to Child of Primary (First) Caregiver Identified by Maltreatment Verification Status and Primary Cause of Death												
Caregiver Relationship To Child (Caregiver 1 Only)	Child Maltreatment Death											
	Verified n=49				Not Substantiated n=47				No Indicators n=126			
	Drowning n=18	Sleep-related n=2	Inflicted Trauma n=13	Other n=16	Drowning n=15	Sleep-related n=20	Inflicted Trauma n=1	Other n=11	Drowning n=17	Sleep-related n=56	Inflicted Trauma n=1	Other n=52
Biological Parent	15	2	13	15	12	19	1	10	15	52	1	47
Other	3	0	0	1	3	1	0	1	2	3	0	5

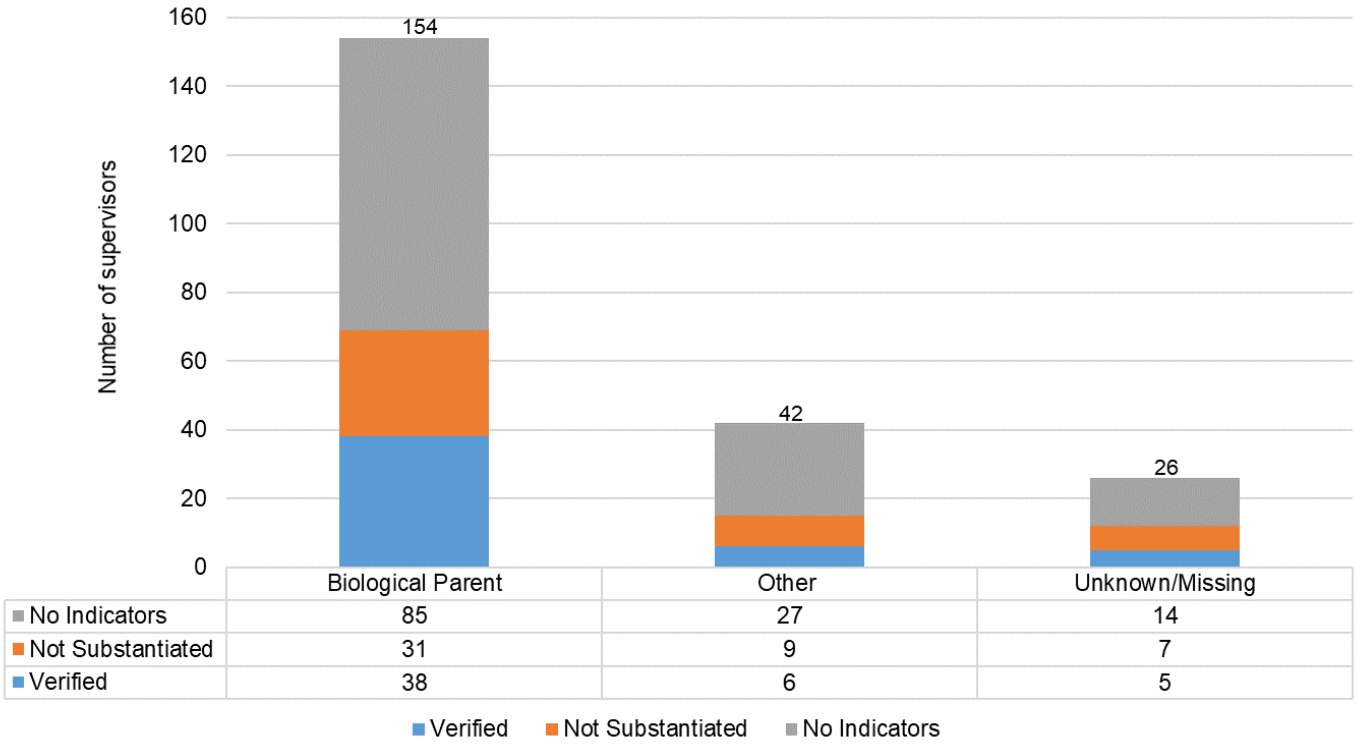
Table F-15: Relationship to Child of Second Caregiver Identified by Maltreatment Verification Status and Primary Cause of Death												
Caregiver Relationship To Child (Caregiver 2 only)	Child Maltreatment Death											
	Verified n=49				Not Substantiated n=47				No Indicators n=126			
	Drowning n=18	Sleep-related n=2	Inflicted Trauma n=13	Other n=16	Drowning n=15	Sleep-related n=20	Inflicted Trauma n=1	Other n=11	Drowning n=17	Sleep-related n=56	Inflicted Trauma n=1	Other n=52
Biological Parent	15	2	8	8	8	13	0	4	8	32	1	27
Other	1	0	3	3	3	4	1	1	6	7	0	13

Table F-16 and Figure F-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 F-13). Among verified maltreatment deaths, in 77.6% of cases, the child's supervisor was a biological parent. Among verified maltreatment inflicted trauma deaths, 92.3% of the supervisors were biological parents. Among verified maltreatment drownings, 83.3% of supervisors were the child's biological parent.

Table F-16: Relationship to Child of All Identified Supervisors by Maltreatment Verification Status and Primary Cause of Death

Supervisor Relationship to Child	Child Maltreatment Death											
	Verified n=49				Not Substantiated n=47				No Indicators n=126			
	Drowning n=18	Sleep-related n=2	Inflicted Trauma n=13	Other n=16	Drowning n=15	Sleep-related n=20	Inflicted Trauma n=1	Other n=11	Drowning n=17	Sleep-related n=56	Inflicted Trauma n=1	Other n=52
Biological Parent	15	2	12	9	9	15	0	7	9	43	0	33
Other	3	0	0	3	5	2	0	2	7	8	0	12
Missing	0	0	1	4	1	3	1	2	1	5	1	7

Figure F-8: Supervisor Relationship to Child by Maltreatment Verification Status (N=222)



Average Age of Caregivers and Supervisors

Table F-17: Average Ages of Caregivers and Supervisors in Child Fatality Cases by Maltreatment Verification Status												
Average Age (years)	Verified n=49				Not Substantiated n=47				No Indicators n=126			
	Drowning n=18	Sleep-related n=2	Inflicted Trauma n=13	Other n=16	Drowning n=15	Sleep-related n=20	Inflicted Trauma n=1	Other n=11	Drowning n=17	Sleep-related n=56	Inflicted Trauma n=1	Other n=52
Caregiver 1	32.8	29.0	33.1	33.8	34.3	26.9	*	28.2	31.9	27.5	47.0	30.5
Caregiver 2	35.8	26.5	36.6	36.1	36.8	30.3	*	31.0	40.5	31.7	40.0	33.5
Supervisor	36.4	29.0	33.5	34.4	37.1	28.0	*	31.6	32.7	30.5	*	33.6

*Age value was missing for this variable.

Gender of Caregivers and Supervisors

Observation of information summarized in Table F-18 reveals that most caregivers for children (across all primary cause of death categories) were female. Among verified maltreatment deaths, 53.1% of all caregivers were female. Among supervisors of verified child maltreatment deaths, 55.1% of supervisors were females (Table F-19).

Table F-18: Gender of All Identified Caregivers (Aggregate) by Maltreatment Verification Status and Leading Cause of Death Category												
Caregiver Gender	Maltreatment Verification Status											
	Verified n=98				Not Substantiated n=94				No Indicators n=252			
	Drowning n=36	Sleep-related n=4	Inflicted Trauma n=26	Other n=32	Drowning n=30	Sleep-related n=40	Inflicted Trauma n=2	Other n=22	Drowning n=34	Sleep-related n=112	Inflicted Trauma n=2	Other n=104
Male	15	2	10	10	10	16	1	5	11	38	1	33
Female	19	2	14	17	16	21	1	11	21	56	1	59
Unknown/Missing	2	0	2	5	4	3	0	6	2	18	0	12

Table F-19: Gender of Supervisors by Maltreatment Verification Status and Leading Cause of Death Category												
Supervisor Gender	Maltreatment Verification Status											
	Verified n=49				Not Substantiated n=47				No Indicators n=126			
	Drowning n=18	Sleep-related n=2	Inflicted Trauma n=13	Other n=16	Drowning n=15	Sleep-related n=20	Inflicted Trauma n=1	Other n=11	Drowning n=17	Sleep-related n=56	Inflicted Trauma n=1	Other Undetermined Unknown n=52
Male	5	1	6	5	3	6	0	3	2	12	0	8
Female	13	1	6	7	11	11	0	6	14	39	0	37
Missing	0	0	1	4	1	3	1	2	1	5	1	7

Substance Abuse History of Caregivers and Supervisors

Tables F-20 through F-21 (with accompanying Figures F-9 through F-12) summarize information related to substance abuse history of all caregivers, supervisors, and person(s) responsible. Findings from Table F-20 reveal that among the caregivers of children whose deaths were verified as child maltreatment, 32 of 98 (32.7%) are known to have a substance abuse history. The percentage of caregivers with a substance abuse history was highest among not substantiated cases (38.3%) compared with caregivers in verified maltreatment cases (32.7%) and cases with no indicators of maltreatment (29.0%).

Regardless of maltreatment verification status, the majority of caregivers with a substance abuse history (n=141), 67.4% had a history of marijuana use, 20.6% had abused alcohol and 17.0% had used cocaine (Table F-20 and Figure F-9,10).

When the substance abuse history of supervisors of children at the time of the incident is examined (see Table F-21), 34.7%, 42.6% and 31.0% of supervisors in verified, not substantiated, and no indicators of maltreatment deaths, respectively, were known to have a substance abuse history.

Table F-20: Substance Abuse History of All Identified Caregivers of Children by Maltreatment Verification Status and Leading Cause of Death Category												
Substance Abuse History	Maltreatment Verification Status											
	Verified n=98				Not Substantiated n=94				No Indicators n=252			
	Drowning n=36	Sleep-related n=4	Inflicted Trauma n=26	Other n=32	Drowning n=30	Sleep-related n=40	Inflicted Trauma n=2	Other n=22	Drowning n=34	Sleep-related n=112	Inflicted Trauma n=2	Other n=104
Yes	10	4	10	8	5	25	0	6	3	38	0	32
No	14	0	6	10	17	11	0	9	21	39	2	43
Unknown/Missing	12	0	10	14	8	4	2	7	10	35	0	29
Type of Substance	**If Yes, Verified Child Maltreatment (n= 32)**				**If Yes, Not Substantiated as Child Maltreatment (n=36)**				**If Yes, No Indicators that Child Maltreatment (n=73)**			
	Drowning n=10	Sleep-related n=4	Inflicted Trauma n=10	Other n=8	Drowning n=5	Sleep-related n=25	Inflicted Trauma n=0	Other n=6	Drowning n=32	Sleep-related n=38	Inflicted Trauma n=0	Other n=32
Alcohol	2	1	2	2	1	5	0	3	1	7	0	5
Cocaine	1	0	1	2	0	3	0	3	1	6	0	7
Marijuana	5	2	6	3	3	20	0	5	3	26	0	22
Methamphetamine	3	0	0	3	0	3	0	1	0	4	0	2
Opiates	2	0	2	2	0	6	0	1	0	4	0	3
Prescription	2	0	3	1	1	3	0	1	0	3	0	4
Over-the-Counter Drugs	0	0	0	0	0	0	0	0	0	0	0	0
Other	0	0	0	3	0	2	0	2	1	0	0	6
Unknown	2	0	0	0	0	0	0	0	0	3	0	0

Figure F-9: Substance Abuse History of All Caregivers by Maltreatment Verification Status (N=444)

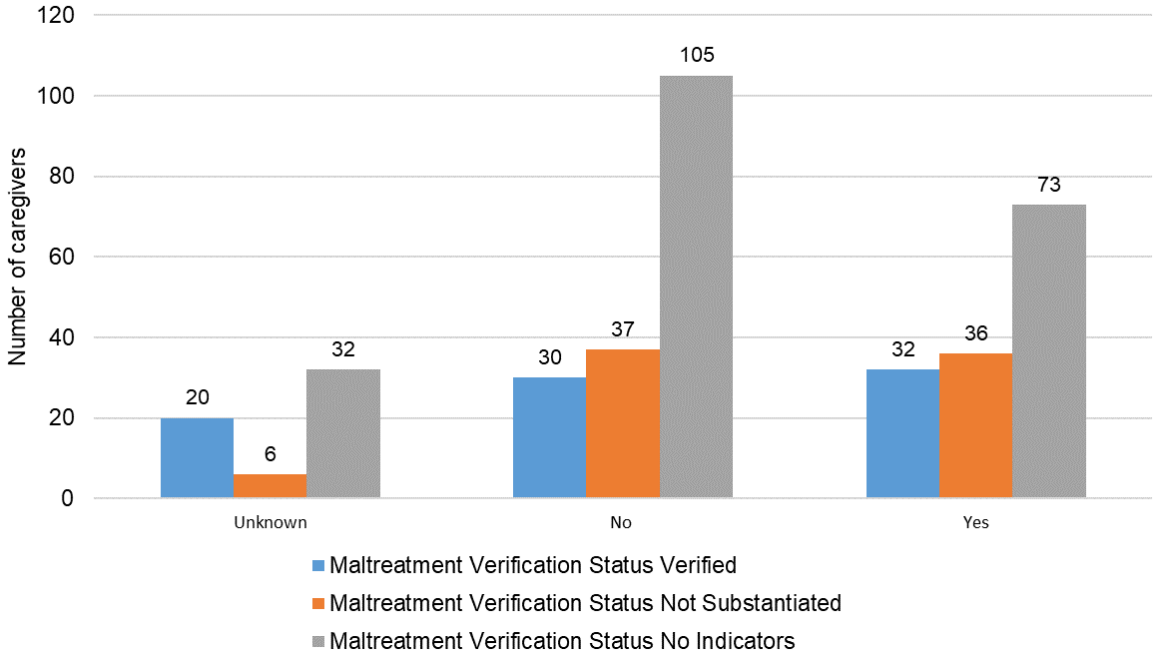


Figure F-10: Type of Substance Used by All Caregivers with a Substance Abuse History by Maltreatment Verification Status (N=141)

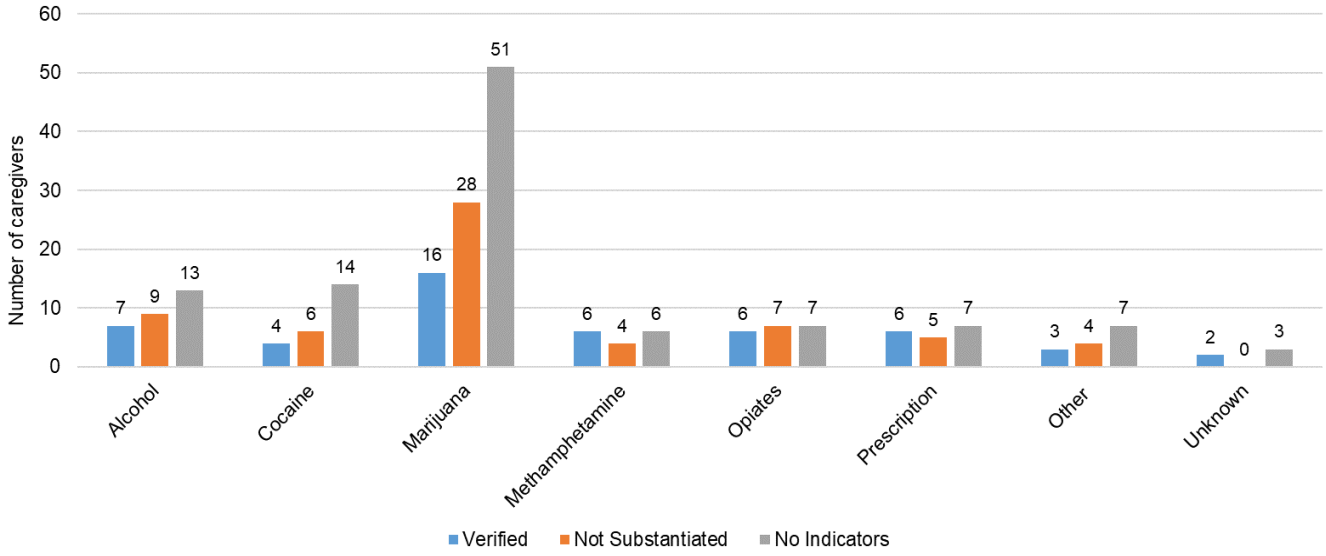


Table F-21: Substance Abuse History of Supervisors of Children at Time of Death by Maltreatment Verification Status and Leading Cause of Death Category												
Drug Abuse Supervisor	Maltreatment Verification Status											
	Verified n=49				Not Substantiated n=47				No Indicators n=126			
	Drowning n=18	Sleep-related n=2	Inflicted Trauma n=13	Other n=16	Drowning n=15	Sleep-related n=20	Inflicted Trauma n=1	Other n=11	Drowning n=17	Sleep-related n=56	Inflicted Trauma n=1	Other n=52
Yes	7	2	5	3	4	13	0	3	1	24	0	14
No	8	0	2	5	9	4	0	5	12	21	0	23
Unknown/Missing	3	0	6	8	2	3	1	3	4	11	1	15
Type of Substance	**If Yes, Verified Child Maltreatment (n=17)**				**If Yes, Not Substantiated as Child Maltreatment (n=20)**				**If Yes, No Indicators that Child Maltreatment (n=39)**			
	Drowning n=7	Sleep-related n=2	Inflicted Trauma n=5	Other n=3	Drowning n=4	Sleep-related n=13	Inflicted Trauma n=0	Other n=3	Drowning n=1	Sleep-related n=24	Inflicted Trauma n=0	Other n=14
Alcohol	2	1	1	1	1	3	0	1	0	5	0	2
Cocaine	10	0	0	1	0	3	0	1	0	6	0	3
Marijuana	4	1	4	0	2	10	0	3	1	18	0	11
Methamphetamine	4	0	0	0	0	1	0	0	0	3	0	1
Opiates	1	0	1	1	0	2	0	1	0	2	0	1
Prescription	2	0	2	0	1	2	0	1	0	2	0	4
Over-the-Counter Drugs	0	0	0	0	0	0	0	0	0	0	0	0
Other	0	0	0	0	0	0	0	0	0	0	0	0
Unknown	1	0	0	0	0	0	0	0	0	1	0	0

Disability or Chronic Illness Occurrence among Caregivers and Supervisors

Tables F-22 through F-23 highlight the distribution of caregivers and supervisors known to have an identified disability or chronic illness. Among all caregivers in verified maltreatment cases, 8.2% had a disability or chronic illness of which the predominant disability was associated with mental illness.

Table F-22: Presence of Disability or Chronic Illness for All Caregivers by Maltreatment Verification Status and Leading Cause of Death Category												
Disability All Caregivers	Maltreatment Verification Status											
	Verified n=98				Not Substantiated n=94				No Indicators n=252			
	Drowning n=36	Sleep-related n=4	Inflicted Trauma n=26	Other n=32	Drowning n=30	Sleep-related n=40	Inflicted Trauma n=2	Other n=22	Drowning n=34	Sleep-related n=112	Inflicted Trauma n=2	Other n=104
Yes	5	0	4	2	3	8	0	6	2	11	0	11
No	21	4	11	14	16	28	2	10	17	64	2	66
Unknown/Missing	10	0	11	16	11	4	0	6	15	37	0	27
Type of Disability	**If Yes, Verified Child Maltreatment (n=22)**				**If Yes, Not Substantiated as Child Maltreatment (n=10)**				**If Yes, No Indicators that Child Maltreatment (n=41)**			
	Drowning n=5	Sleep-related n=0	Inflicted Trauma n=4	Other n=27	Drowning n=3	Sleep-related n=8	Inflicted Trauma n=0	Other n=6	Drowning n=2	Sleep-related n=11	Inflicted Trauma n=0	Other n=11
Physical	2	0	0	0	1	0	0	1	0	6	0	2
Mental	4	0	2	2	3	7	0	5	1	4	0	6
Cognitive	0	0	0	0	1	0	0	0	0	1	0	0
Sensory	0	0	0	0	0	0	0	0	0	0	0	1
Unknown	0	0	0	0	0	0	0	0	0	0	0	0

When findings from Table F-23 are examined, 8.1% supervisors of children whose death was verified to result from maltreatment were identified as having a disability or chronic illness. This rate was like that observed with supervisors of not substantiated maltreatment deaths 21.3% and no indicators 14.3% of supervisors whose child related deaths showed no indicators of maltreatment.

Table F-23: Presence of Disability or Chronic Illness for Supervisors by Maltreatment Verification Status and Leading Cause of Death Category												
Disability or Chronic Illness	Maltreatment Verification Status											
	Verified n=49				Not Substantiated n=47				No Indicators n=126			
	Drowning n=18	Sleep-related n=2	Inflicted Trauma n=13	Other n=16	Drowning n=15	Sleep-related n=20	Inflicted Trauma n=1	Other n=11	Drowning n=17	Sleep-related n=56	Inflicted Trauma n=1	Other n=52
Yes	3	0	1	0	2	5	0	3	0	9	0	9
No	11	2	4	7	7	12	0	6	9	33	0	28
Unknown/Missing	4	0	8	9	6	3	1	2	8	14	1	15
Type of Disability	**If Yes, Verified Child Maltreatment (n=4)**				**If Yes, Not Substantiated as Child Maltreatment (n=10)**				**If Yes, No Indicators that Child Maltreatment (n=18)**			
	Drowning n=3	Sleep-related n=0	Inflicted Trauma n=1	Other n=0	Drowning n=2	Sleep-related n=5	Inflicted Trauma n=0	Other n=3	Drowning n=0	Sleep-related n=9	Inflicted Trauma n=0	Other n=9
Physical	1	0	0	0	1	0	0	0	0	4	0	5
Mental	2	0	1	0	2	5	0	2	0	4	0	4
Cognitive	0	0	0	0	0	0	0	0	0	1	0	0
Sensory	0	0	0	0	0	0	0	0	0	0	0	1
Unknown	0	0	0	0	0	0	0	1	0	0	0	0

Employment Status of Caregivers

Employment status was examined for all identified caregivers. Tables F-24 through F-26 provide information on the distribution of the caregiver employment status. Table F-24 aggregates all caregivers (whether identified as the first or second primary caregiver), whereas Tables F-25 and F-26 breakdown the distribution of caregiver employment status as the first or second listed primary caregiver.

Table F-24: Employment Status of All Identified Caregivers by Maltreatment Verification Status and Leading Cause of Death Category												
Employment All Caregivers	Maltreatment Verification Status											
	Verified n=98				Not Substantiated n=94				No Indicators n=252			
	Drowning n=36	Sleep-related n=4	Inflicted Trauma n=26	Other n=32	Drowning n=30	Sleep-related n=40	Inflicted Trauma n=2	Other n=22	Drowning n=34	Sleep-related n=112	Inflicted Trauma n=2	Other n=104
Employed	15	1	12	14	10	17	2	5	13	49	1	42
Unemployed	7	3	3	4	0	11	0	7	7	23	0	15
On Disability	0	0	0	0	1	0	0	0	1	0	0	5
Stay-at-Home	7	0	4	1	3	3	0	1	2	7	1	10
Retired	1	0	0	0	2	0	0	1	1	0	0	0
Unknown/Missing	6	0	7	13	14	9	0	8	10	33	0	32

Table F-25: Employment Status of Primary Caregiver Identified by Maltreatment Verification Status and Primary Cause of Death												
Employment (Caregiver 1)	Maltreatment Verification Status											
	Verified n=49				Not Substantiated n=47				No Indicators n=126			
	Drowning n=18	Sleep-related n=2	Inflicted Trauma n=13	Other n=16	Drowning n=15	Sleep-related n=20	Inflicted Trauma n=1	Other n=11	Drowning n=17	Sleep-related n=56	Inflicted Trauma n=1	Other n=52
Employed	4	0	4	7	4	9	1	2	6	24	1	22
Unemployed	5	2	3	2	0	6	0	6	5	18	0	12
On Disability	0	0	0	0	1	0	0	0	0	0	0	1
Stay-at-Home	7	0	3	1	3	3	0	1	2	7	0	8
Retired	0	0	0	0	1	0	0	1	0	0	0	0
Unknown/Missing	2	0	3	6	6	2	0	1	4	7	0	9

Table F-26: Employment Status of Second Caregiver Identified by Maltreatment Verification Status and Primary Cause of Death												
Employment (Caregiver2)	Maltreatment Verification Status											
	Verified n=49				Not Substantiated n=47				No Indicators n=126			
	Drowning n=18	Sleep-related n=2	Inflicted Trauma n=13	Other n=16	Drowning n=15	Sleep-related n=20	Inflicted Trauma n=1	Other n=11	Drowning n=17	Sleep-related n=56	Inflicted Trauma n=1	Other n=52
Employed	11	1	8	7	6	8	1	3	7	25	0	20
Unemployed	2	1	0	2	0	5	0	1	2	5	0	3
On Disability	0	0	0	0	0	0	0	0	1	0	0	4
Stay-at-Home Caregiver	0	0	1	0	0	0	0	0	0	0	1	2
Retired	1	0	0	0	1	0	0	0	1	0	0	0
Unknown/Missing	4	0	4	7	8	7	0	7	6	26	0	23

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 F-27). 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 F-27: Education Level of All Identified Caregivers by Maltreatment Verification Status and Primary Cause of Death												
Education - All Caregivers	Maltreatment Verification Status											
	Verified n=98				Not Substantiated n=94				No Indicators n=252			
	Drowning n=36	Sleep-related n=4	Inflicted Trauma n=26	Other n=32	Drowning n=30	Sleep-related n=40	Inflicted Trauma n=2	Other n=22	Drowning n=34	Sleep-related n=112	Inflicted Trauma n=2	Other n=104
Less than High School	2	0	0	0	2	4	0	4	2	19	0	4
High School	6	0	9	7	7	16	0	7	7	32	1	17
College	6	0	2	4	1	3	1	1	2	11	0	16
Post Graduate	1	0	0	0	0	0	0	0	3	1	1	4
Unknown/Missing	21	4	15	21	20	17	1	10	20	49	0	63

English Spoken by Caregivers and Supervisors

As can be observed from information detailed in Tables F-28 through F-29, most caregivers and supervisors speak English.

Table F-28: English Speaking by All Identified Caregivers by Maltreatment Verification Status and Primary Cause of Death

Can Caregiver Speak English- All Caregivers	Maltreatment Verification Status											
	Verified n=98				Not Substantiated n=94				No Indicators n=252			
	Drowning n=36	Sleep-related n=4	Inflicted Trauma n=26	Other n=32	Drowning n=30	Sleep-related n=40	Inflicted Trauma n=2	Other n=22	Drowning n=34	Sleep-related n=112	Inflicted Trauma n=2	Other n=104
Yes	31	4	22	25	23	32	2	12	30	82	1	80
No	2	0	2	0	2	1	0	4	2	3	1	5
Unknown/Missing	3	0	2	7	5	7	0	6	2	27	0	19

Table F-29: English Speaking Ability All Identified Supervisors by Maltreatment Verification Status and Primary Cause of Death

Can Supervisor Speak English	Maltreatment Verification Status											
	Verified n=49				Not Substantiated n=47				No Indicators n=126			
	Drowning n=18	Sleep-related n=2	Inflicted Trauma n=13	Other n=16	Drowning n=15	Sleep-related n=20	Inflicted Trauma n=1	Other n=11	Drowning n=17	Sleep-related n=56	Inflicted Trauma n=1	Other n=52
Yes	17	2	11	11	13	15	0	7	14	48	0	40
No	0	0	1	0	1	1	0	2	0	1	0	2
Unknown/Missing	1	0	1	5	1	4	1	2	3	7	1	10

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 F-30 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 F-30 exceeds the number of child fatalities as many children had two identified caregivers. Table F-30 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 F-30: Receipt of Social Services by All Identified Caregivers of Children by Maltreatment Verification Status and Primary Cause of Death												
Receipt of Social Services	Maltreatment Verification Status											
	Verified n=98				Not Substantiated n=94				No Indicators n=252			
	Drowning n=36	Sleep-related n=4	Inflicted Trauma n=26	Other n=32	Drowning n=30	Sleep-related n=40	Inflicted Trauma n=2	Other n=22	Drowning n=34	Sleep-related n=112	Inflicted Trauma n=2	Other n=104
Yes	6	2	4	5	1	12	0	9	7	31	0	15
No	8	0	7	5	7	14	2	5	13	15	2	31
Unknown	22	2	15	22	22	14	0	8	14	66	0	58
Type of Support	**If Yes, Verified Child Maltreatment (n=17)**				**If Yes, Not Substantiated as Child Maltreatment (n=22)**				**If Yes, No Indicators that Child Maltreatment (n=53)**			
	Drowning n=6	Sleep-related n=2	Inflicted Trauma n=4	Other n=5	Drowning n=1	Sleep-related n=12	Inflicted Trauma n=0	Other n=9	Drowning n=7	Sleep-related n=31	Inflicted Trauma n=0	Other n=15
WIC	5	0	3	1	0	6	0	5	2	16	0	6
TANF	0	0	0	0	0	1	0	0	0	4	0	1
Medicaid	3	0	4	5	1	8	0	8	4	25	0	10
Food Stamps	3	0	2	1	0	7	0	1	3	10	0	5
Other	0	0	0	0	0	0	0	1	1	2	0	1
Unknown	0	0	0	0	0	0	0	0	0	0	0	1

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 F-30). Regardless, findings from Table F-30 reveal that among the caregivers of children whose death was verified as child maltreatment, 17.3% are known to have received some form of social service support in the twelve months prior to the child’s death. In comparison, 23.4% caregivers of children whose death was not substantiated and the 21.0% whose death showed no indicators of child maltreatment.

When types of services received are examined across all cause of death categories, most caregivers in verified maltreatment cases, who received some type of support, 70.6% received Medicaid.

History as Victim of Child Maltreatment among Caregivers and Supervisors

Local committees were asked to identify from available sources of information whether caregivers, supervisors responsible for the death of a child were past victims of child maltreatment. Collectively, it was known that 14.3% of caregivers (Table F-31) 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 or missing for 46.0% of the total number of caregivers for children where the child’s death was verified as maltreatment. For 57.4% of all caregivers in all cases, the history of social services received is unknown

Among caregivers in cases of verified maltreatment death, 14.3% had a history as a victim of child maltreatment, compared with 26.6% of not substantiated cases and 17.9% of cases with no indicators of maltreatment.

Table F-31: 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	Maltreatment Verification Status											
	Verified n=98				Not Substantiated n=94				No Indicators n=252			
	Drowning n=36	Sleep-related n=4	Inflicted Trauma n=26	Other n=32	Drowning n=30	Sleep-related n=40	Inflicted Trauma n=2	Other n=22	Drowning n=34	Sleep-related n=112	Inflicted Trauma n=2	Other n=104
Yes	4	2	7	1	4	16	0	5	3	24	0	18
No	15	2	9	13	18	14	1	9	17	36	2	43
Unknown/Missing	17	0	10	18	8	10	1	8	14	52	0	43
Type of Maltreatment	**If Yes, Verified Child Maltreatment (n=14)**				**If Yes, Not Substantiated as Child Maltreatment (n=25)**				**If Yes, No Indicators that Child Maltreatment (n=45)**			
	Drowning n=4	Sleep-related n=2	Inflicted Trauma n=7	Other n=1	Drowning n=4	Sleep-related n=16	Inflicted Trauma n=0	Other n=5	Drowning n=34	Sleep-related n=24	Inflicted Trauma n=0	Other n=18
Physical	2	1	1	1	1	6	0	3	1	12	0	6
Neglect	1	1	5	0	4	12	0	3	2	14	0	10
Sexual	1	0	0	0	0	3	0	1	2	4	0	4
Emotional/ Psychological	0	0	1	0	0	4	0	0	0	5	0	2
Unknown	1	0	0	0	0	1	0	1	0	2	0	2

When history as a victim of child maltreatment is examined for supervisors (Table F-32) associated with verified maltreatment deaths, it was known that 6 of 49 (12.2%) were past child victims of maltreatment, whereas 15 of 47 (31.9%) and 26 of 126 (20.6%) of supervisors of not substantiated and no indicators of maltreatment deaths had a history as a victim of child maltreatment.

Table F-32: Past History as Victim of Child Maltreatment for Supervisors by Maltreatment Verification Status and Primary Cause of Death												
Cargiver Past Victim of Child Maltreatment	Maltreatment Verification Status											
	Verified n=49				Not Substantiated n=47				No Indicators n=126			
	Drowning n=18	Sleep-related n=2	Inflicted Trauma n=13	Other n=16	Drowning n=15	Sleep-related n=20	Inflicted Trauma n=1	Other n=11	Drowning n=17	Sleep-related n=56	Inflicted Trauma n=1	Other n=52
Yes	2	1	3	0	2	10	0	3	2	16	0	8
No	7	1	4	7	8	6	0	6	10	20	0	22
Unknown/Missing	9	0	6	9	5	4	1	2	5	20	1	22
Type of Maltreatment	**If Yes, Verified Child Maltreatment (n=6)**				**If Yes, Not Substantiated as Child Maltreatment (n=15)**				**If Yes, No Indicators that Child Maltreatment (n=26)**			
	Drowning n=2	Sleep-related n=1	Inflicted Trauma n=3	Other n=0	Drowning n=2	Sleep-related n=10	Inflicted Trauma n=0	Other n=3	Drowning n=2	Sleep-related n=16	Inflicted Trauma n=0	Other n=8
Physical	1	1	0	0	1	6	0	2	0	7	0	3
Neglect	0	1	3	0	2	7	0	2	1	9	0	5
Sexual	1	0	0	0	0	3	0	1	1	2	0	1
Emotional/ Psychological	0	0	0	0	0	3	0	0	0	3	0	0
Unknown	0	0	0	0	0	1	0	0	0	2	0	0

Table F-33: Past History as Perpetrator of Child Maltreatment for All Caregivers by Maltreatment Verification Status and Primary Cause of Death												
Caregiver Has History as Perpetrator	Maltreatment Verification Status											
	Verified n=98				Not Substantiated n=94				No Indicators n=252			
	Drowning n=36	Sleep-related n=4	Inflicted Trauma n=26	Other n=32	Drowning n=30	Sleep-related n=40	Inflicted Trauma n=2	Other n=22	Drowning n=34	Sleep-related n=112	Inflicted Trauma n=2	Other n=104
Yes	7	0	8	8	4	15	0	5	7	24	0	23
No	25	4	7	16	18	21	2	10	18	55	2	60
Unknown/Missing	4	0	11	8	8	4	0	7	9	33	0	21
Type of Maltreatment	**If Yes, Verified Child Maltreatment (n=23)**				**If Yes, Not Substantiated as Child Maltreatment (n=24)**				**If Yes, No Indicators that Child Maltreatment (n=54)**			
	Drowning n=7	Sleep-related n=0	Inflicted Trauma n=8	Other n=8	Drowning n=4	Sleep-related n=15	Inflicted Trauma n=0	Other n=5	Drowning n=7	Sleep-related n=24	Inflicted Trauma n=0	Other n=23
Physical	1	0	3	1	0	2	0	1	4	4	0	11
Neglect	5	0	5	5	3	13	0	5	4	21	0	15
Sexual	0	0	0	1	0	3	0	0	1	0	0	0
Emotional/ Psychological	0	0	2	2	1	3	0	0	1	2	0	2
Unknown	0	0	0	0	0	0	0	0	0	0	0	0

History as Perpetrator of Child Maltreatment among Caregivers and Supervisors

Local committees were asked to identify from available sources and reports whether caregivers and supervisors for a child's death have a history as a perpetrator of child maltreatment. When the aggregate of caregivers is examined (Table F-33), 23.5% of caregivers in verified maltreatment cases were identified as past perpetrators of child maltreatment. By comparison, 25.5% of caregivers in not substantiated child maltreatment deaths and 21.4% caregivers in cases with no indicators of maltreatment had been past perpetrators of maltreatment.

Among caregivers who had themselves been victims of child maltreatment in the past, the most prevalent type of maltreatment among them was neglect at 61.9%.

When the history of supervisors as a perpetrator is examined (see Table F-34), 26.5% of supervisors in verified maltreatment cases were past perpetrators of child maltreatment, compared with 25.5% of supervisors in not substantiated cases and 22.2% of supervisors in cases with no indicators of maltreatment. Neglect was the most prominent form of past maltreatment among supervisors who had been perpetrators.

Table F-34: Past History as Perpetrator of Child Maltreatment for Supervisors by Maltreatment Verification Status and Primary Cause of Death												
Supervisor Has History as Perpetrator	Maltreatment Verification Status											
	Verified n=49				Not Substantiated n=47				No Indicators n=126			
	Drowning n=18	Sleep-related n=2	Inflicted Trauma n=13	Other n=16	Drowning n=15	Sleep-related n=20	Inflicted Trauma n=1	Other n=11	Drowning n=17	Sleep-related n=56	Inflicted Trauma n=1	Other n=52
Yes	4	0	5	4	4	6	0	2	2	14	0	12
No	12	2	3	7	8	11	0	7	10	28	0	28
Unknown/Missing	2	0	5	5	3	3	1	2	5	14	1	12
Type of Maltreatment	**If Yes, Verified Child Maltreatment (n=13)**				**If Yes, Not Substantiated as Child Maltreatment (n=12)**				**If Yes, No Indicators that Child Maltreatment (n=28)**			
	Drowning n=4	Sleep-related n=0	Inflicted Trauma n=5	Other n=4	Drowning n=4	Sleep-related n=6	Inflicted Trauma n=0	Other n=2	Drowning n=2	Sleep-related n=14	Inflicted Trauma n=0	Other n=12
Physical	1	0	2	0	0	1	0	1	1	4	0	4
Neglect	3	0	3	2	4	6	0	2	1	12	0	7
Sexual	0	0	0	1	0	2	0	0	0	0	0	1
Emotional/ Psychological	0	0	1	1	0	1	0	0	0	2	0	0
Unknown	0	0	0	0	0	0	0	0	0	0	0	0

History of Intimate Partner Violence (as Victim and Perpetrator) among Caregivers and Supervisors

Table F-35 highlights the distribution of caregivers' history with intimate partner violence as a victim and/or perpetrator. In total, 17.3% of caregivers were known to be victims and 15.3% were known to be perpetrators of intimate violence among those affiliated with verified maltreatment deaths. With respect to caregivers in not substantiated maltreatment deaths, 11.7% were past victims and 11.7% were past perpetrators of intimate partner violence. In contrast, 8.3% and 10.0% of caregivers in no indicators of maltreatment deaths have histories as victims and perpetrators (respectively) of intimate partner violence.

Table F-35: History of Intimate Partner Violence with Caregivers by Maltreatment Verification Status and Primary Cause of Death

History of Intimate Partner Violence	Maltreatment Verification Status											
	Verified n=98				Not Substantiated n=94				No Indicators n=252			
	Drowning n=36	Sleep-related n=4	Inflicted Trauma n=26	Other n=32	Drowning n=30	Sleep-related n=40	Inflicted Trauma n=2	Other n=22	Drowning n=34	Sleep-related n=112	Inflicted Trauma n=2	Other n=104
Yes, as Victim	4	0	8	5	1	7	1	2	4	8	0	9
Yes, as Perpetrator	4	0	7	4	1	8	0	2	4	9	0	12
No	16	4	8	12	19	22	1	9	14	48	2	59
Unknown/Missing	12	0	3	11	9	3	0	9	12	47	0	24

Figure F-11: History of Intimate Partner Violence with All Caregivers by Maltreatment Verification Status (N=444)

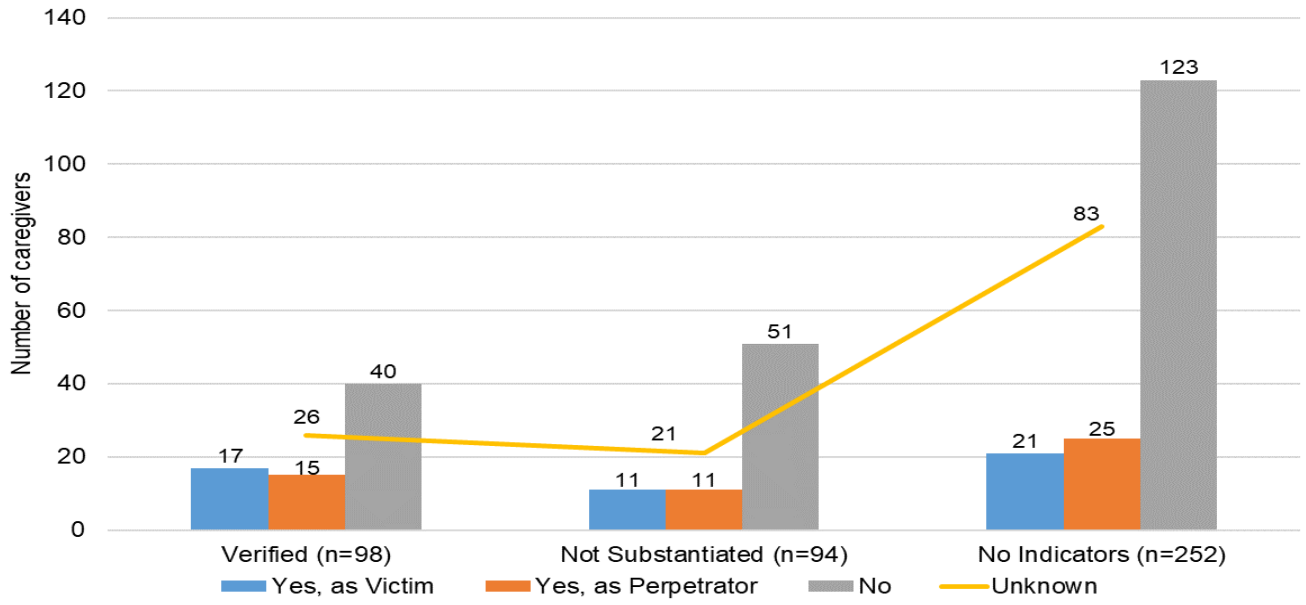


Table F-36 highlights the distribution of supervisors' history with intimate partner violence as a victim and/or perpetrator.

Table F-36: History of Intimate Partner Violence with Supervisors by Maltreatment Verification Status and Primary Cause of Death												
History of Intimate Partner Violence	Maltreatment Verification Status											
	Verified n=49				Not Substantiated n=47				No Indicators n=126			
	Drowning n=18	Sleep-related n=2	Inflicted Trauma n=13	Other n=16	Drowning n=15	Sleep-related n=20	Inflicted Trauma n=1	Other n=11	Drowning n=17	Sleep-related n=56	Inflicted Trauma n=1	Other n=52
Yes, as Victim	2	0	3	3	1	5	0	1	2	4	0	6
Yes, as Perpetrator	3	0	6	1	0	3	0	1	0	6	0	5
No	9	2	3	5	11	10	0	5	9	27	0	29
Unknown/Missing	4	0	2	7	3	2	1	9	6	19	1	12

Past Criminal History of Caregivers & Supervisors

When the criminal history of caregivers is examined (Table F-37), 28.6%, 35.1% and 20.6% of caregivers associated with verified, not substantiated, and no indicators child maltreatment deaths (respectively) have a past criminal history. Among all caregivers with a criminal history, the most common types of offense were assault (51.3%), drugs (46.9%) and other offenses (52.2%). 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 F-37: Past Criminal History of Caregivers by Maltreatment Verification Status and Primary Cause of Death												
Criminal History of Caregivers	Other											
	Verified n=98				Not Substantiated n=94				No Indicators n=252			
	Drowning n=36	Sleep-related n=4	Inflicted Trauma n=26	Other n=32	Drowning n=30	Sleep-related n=40	Inflicted Trauma n=2	Other n=22	Drowning n=34	Sleep-related n=112	Inflicted Trauma n=2	Other n=104
Yes	9	1	9	9	6	21	0	6	6	25	0	21
No	20	1	13	17	19	11	2	10	20	61	2	57
Unknown/Missing	7	2	4	6	5	8	0	6	8	26	0	26
Type of Offense	**If Yes, Verified Child Maltreatment (n=28)**				**If Yes, Not Substantiated as Child Maltreatment (n=33)**				**If Yes, No Indicators that Child Maltreatment (n=52)**			
	Drowning n=9	Sleep-related n=1	Inflicted Trauma n=9	Other n=9	Drowning n=6	Sleep-related n=21	Inflicted Trauma n=0	Other n=6	Drowning n=6	Sleep-related n=25	Inflicted Trauma n=0	Other n=21
Assaults	6	0	6	4	1	10	0	3	2	13	0	13
Robbery	2	1	0	1	1	3	0	0	2	10	0	7
Drugs	4	1	2	5	4	10	0	2	3	10	0	12
Other	3	1	5	5	3	13	0	4	4	11	0	10
Unknown/Missing	1	0	0	1	0	0	0	0	0	0	0	0

Figure F-12: Criminal Background History
of All Caregivers (N=444)

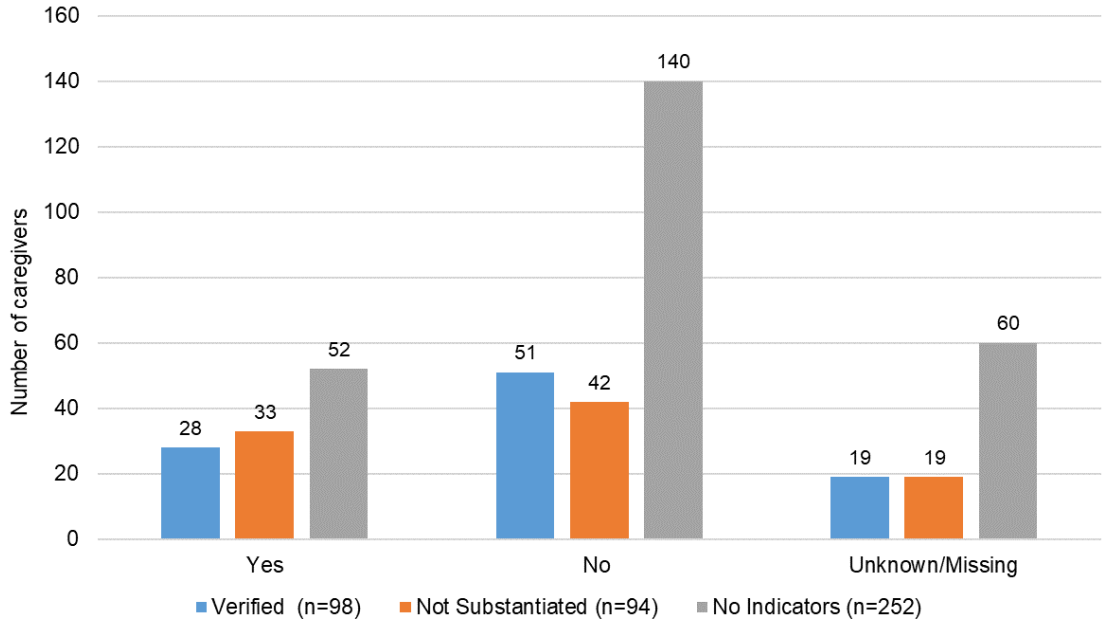
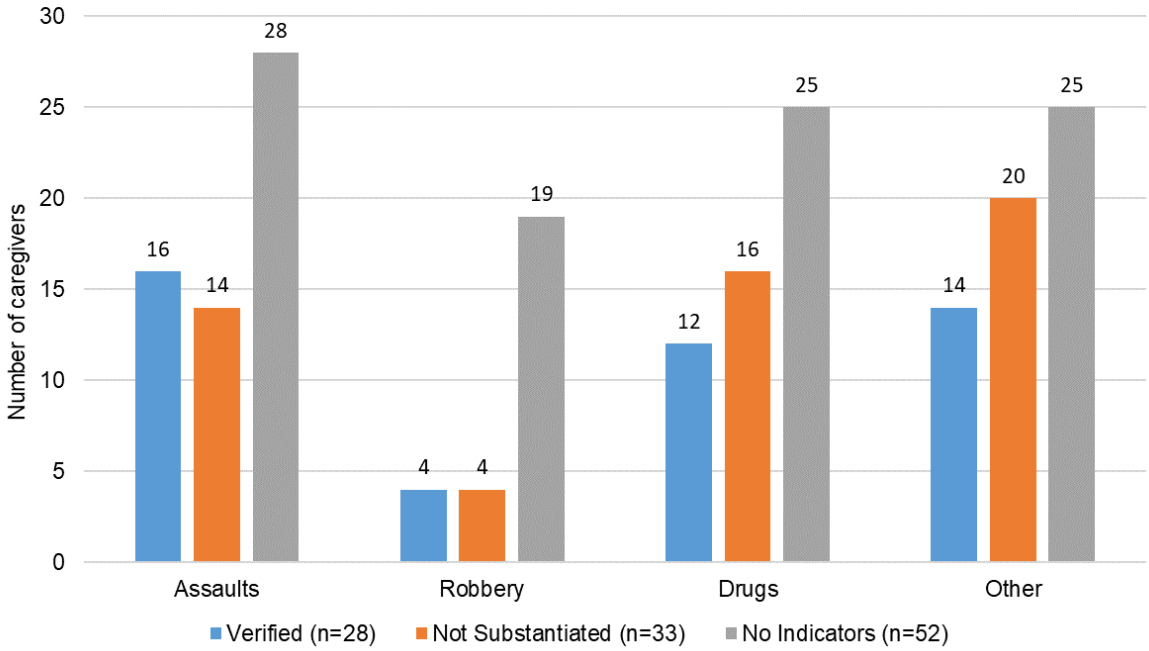


Figure F-13: Offense Type for Those Caregivers
With Criminal Background (N=113)



When the criminal history of supervisors is examined (See Table F-38), 26.5%, 36.2% and 22.2% of supervisors associated with verified, not substantiated, and no indicators child maltreatment deaths (respectively) have a past criminal history. Among supervisors with a criminal history, the most common types of offense were assault (53.4%), drugs (46.5%) and other offenses (50.0%). 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.

Table F-38: Past Criminal History Associated with Supervisors by Maltreatment Verification Status and Primary Cause of Death												
Criminal History of Supervisors	Maltreatment Verification Status											
	Verified n=49				Not Substantiated n=47				No Indicators n=126			
	Drowning n=18	Sleep-related n=2	Inflicted Trauma n=13	Other n=16	Drowning n=15	Sleep-related n=20	Inflicted Trauma n=1	Other n=11	Drowning n=17	Sleep-related n=56	Inflicted Trauma n=1	Other n=52
Yes	5	0	4	4	2	11	0	4	4	16	0	8
No	10	1	7	8	11	4	0	5	10	31	0	30
Unknown/Missing	3	1	2	4	2	5	1	2	3	9	1	14
Type of Offense	**If Yes, Verified Child Maltreatment (n=13)**				**If Yes, Not Substantiated as Child Maltreatment (n=17)**				**If Yes, No Indicators that Child Maltreatment (n=28)**			
	Drowning n=5	Sleep-related n=0	Inflicted Trauma n=4	Other n=4	Drowning n=2	Sleep-related n=11	Inflicted Trauma n=0	Other n=4	Drowning n=4	Sleep-related n=16	Inflicted Trauma n=0	Other n=8
Assaults	5	0	4	2	0	4	0	3	0	8	0	5
Robbery	2	0	0	0	0	1	0	0	1	5	0	3
Drugs	3	0	1	2	2	6	0	1	2	6	0	4
Other	1	0	2	3	1	7	0	3	2	6	0	4
Unknown/Missing	0	0	0	0	0	0	0	0	0	0	0	0

Past Child Death Associated with Caregivers and Supervisors

Table F-39 highlights the distribution of caregivers with past child death events. In total, 1 caregiver out of 98 all 98 caregivers in verified maltreatment deaths was known to have a past child death. With respect to caregivers in not substantiated maltreatment deaths, 2 of 94 were identified as having a past child death event. Lastly, 3 of 252 caregivers in no indicators of maltreatment deaths have histories with child death events.

Table F-40 highlights the distribution of supervisors with past child death events. No supervisors in verified maltreatment deaths were known to have a past child death. With respect to supervisors in not substantiated maltreatment deaths, 2 of 47 were identified as having any association with a past child death event. Lastly, 2 of 146 of supervisors in no indicators of maltreatment deaths have histories with child death events.

Table F-39: Past Child Death Associated with Caregivers by Maltreatment Verification Status and Primary Cause of Death												
Past Child Death with Caregiver	Maltreatment Verification Status											
	Verified n=98				Not Substantiated n=94				No Indicators n=252			
	Drowning n=36	Sleep-related n=4	Inflicted Trauma n=26	Other n=32	Drowning n=30	Sleep-related n=40	Inflicted Trauma n=2	Other n=22	Drowning n=34	Sleep-related n=112	Inflicted Trauma n=2	Other n=104
Yes	1	0	0	0	0	2	0	0	0	1	0	2
No	31	4	19	23	12	19	1	11	28	84	2	80
Unknown/Missing	4	0	7	9	18	19	1	11	6	27	0	22

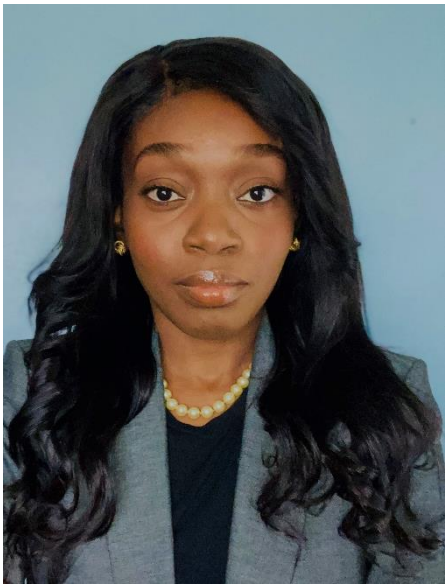
Table F-40: Past Child Death Associated with Supervisors by Maltreatment Verification Status and Primary Cause of Death												
Past Child Death with Supervisor	Maltreatment Verification Status											
	Verified n=49				Not Substantiated n=47				No Indicators n=126			
	Drowning n=18	Sleep-related n=2	Inflicted Trauma n=13	Other n=16	Drowning n=15	Sleep-related n=20	Inflicted Trauma n=1	Other n=11	Drowning n=17	Sleep-related n=56	Inflicted Trauma n=1	Other n=52
Yes	0	0	0	0	0	2	0	0	0	0	0	2
No	16	2	9	10	11	15	0	9	15	46	0	37
Unknown/Missing	2	0	4	6	4	3	1	2	2	10	1	13

APPENDIX G:

CADR SUMMIT PRESENTER BIOGRAPHIES

Abby Collier, MS

Abby Collier is the Director at the National Center for Fatality Review and Prevention (National Center), a program of the Michigan Public Health Institute. In this role, Ms. Collier leads the National Center in providing technical assistance and support to local and state child death review (CDR) and fetal infant mortality review (FIMR) programs throughout the United States. One of her focus areas is building collaboration between CDR and FIMR. Ms. Collier provides training on a variety of topics including improving death scene investigations, best practices for CDR/FIMR reviews, self-care and vicarious trauma, writing prevention recommendations, implementing evidence-based recommendations, advocacy, and engaging partners.



Amanda Regis, MSW (she/her/hers)

Amanda Regis joined the Department of Children and Families, Office of Substance Abuse and Mental Health, Statewide Office for Suicide Prevention as the Suicide Prevention Specialist in February 2021. In her current role, Ms. Regis monitors the activities of the Florida Suicide Prevention Interagency Action Plan, serves as Chair of the Suicide Prevention Coordinating Council's Special Populations Committee, and provides data analysis and conducts research regarding suicide prevention including evidence best practices.

Prior to joining DCF, Ms. Regis worked with local behavioral health agencies in Tampa, FL providing services to individuals with serious mental illness and those with dual diagnoses. During her time in Tampa, FL, Ms. Regis collaborated with various behavioral health stakeholders including public defenders, law enforcement, and community agencies.

Ms. Regis graduated with a Bachelor of Arts in Psychology and a Bachelor of Arts in Spanish from the University of South Florida. In 2020, Ms. Regis graduated with a Master of Social Work degree, with a concentration in Adult Mental Health and Wellness from the University of Southern California.

April Lott, LCSW

April Lott, LCSW is a fourteen-year employee of Directions for Living and serves as the President & Chief Executive Officer. Ms. Lott is a Licensed Clinical Social Worker (LCSW) with more than three decades of experience in understanding co-occurring substance use disorders, mental health disorders, trauma and domestic violence. Prior to joining Directions for Living, Ms. Lott served in a variety of service and leadership roles within the human services industry, including serving as the CEO of a large not-for-profit residential program for abused and neglected children, serving as the principal for five alternative education schools, working as a protective investigator and probation officer, and operating a private practice. Ms. Lott serves on the Statewide Florida Child Abuse Death Review Committee and the Statewide Florida Critical Incident Rapid Response Team. Additionally, Ms. Lott is the Co-chair of the Pinellas County Continuum of Care for the Homeless and the Chair of the Continuum of Care for the Homeless Provider's Council, and the Chair of the Pinellas County Crisis Intervention Team Collaborative. Ms. Lott is a certified trainer in Mental Health First Aid for adults, youth and first responders. Ms. Lott currently manages more than 20 Mental Health First Aid instructors and is committed to developing a small army of every-day people who can recognize the signs and symptoms of a mental health condition and connect people to the resources they need.

Ms. Lott received her master's degree and bachelor's degree in Social Work from Florida State University. Ms. Lott is the recipient of the 1989 Joann Gorman Award for her outstanding clinical work with children impacted by trauma, the 2008 National Alliance on Mental Illness IRIS award winner for her cooperation and commitment to provide support and services to people with mental illness in recovery, the 2010 Pinellas County Sheriff's Office Community Leadership Award, and the 2017 National Alliance on Mental Illness Leadership Award.

Cassie McGovern

Cassie McGovern is the Founder of the McGovern Foundation, aimed at raising awareness regarding drowning prevention and organ donation. She has served as the Drowning Prevention Program Supervisor with the Florida Department of Health in Broward for the past seven years. Ms. McGovern has also chaired the Broward County Drowning Prevention Task Force for the past seven years, leading all drowning prevention initiatives for the county. During her time with the Department of Health, she was part of Circuit 17 CADR committee, holding the Chair and Co-Chair position over the past four years.

Ms. McGovern and her team created innovative initiatives to help educate our community on the risk factors related to drowning prevention. Ms. McGovern brings a unique perspective, being a mother of a drowning victim.

Ms. McGovern's daughter, Edna Mae, passed away to a drowning in the family's backyard fenced pool. Since her daughters passing, Ms. McGovern has been relentless with her efforts to educate the community.

Ken DeCerchio

Ken DeCerchio currently serves as the program director of the In-Depth Technical Assistance Program of the Substance Abuse and Mental Health Services Administration's (SAMHSA) National Center on Substance Abuse and Child Welfare, and the Deputy Project Director of the National Quality Improvement Center for Collaborative Community Court Teams, funded by the Children's Bureau in the Administration on Children, Youth and Families.

Prior to joining the Center for Children and Family Futures, Mr. DeCerchio served as the Assistant Secretary for Substance Abuse and Mental Health with the Florida Department of Children and Families from 2005 to 2007, and as the state Substance Abuse Director from 1995-2005. Mr. DeCerchio has served on Florida's Drug Policy Advisory Council and Supreme Court Task Force on Treatment-Based Drug Courts, and SAMHSA's Center for Substance Abuse Treatment National Advisory Council. In 2005, Mr. DeCerchio received the National Association of State Alcohol and Drug Abuse Directors' Service Award for his leadership and support in the substance abuse prevention and treatment field, and in 2007, Mr. DeCerchio received the Florida Alcohol and Drug Abuse Association´s Lifetime Achievement Award for his contributions to prevention and treatment services in Florida. Mr. DeCerchio has been a volunteer Guardian Ad Litem for children in foster care since October 2008.

Megan Macdonald, MPH

Megan Macdonald is an epidemiologist with the State Systems Development Initiative (SSDI) team at the Florida Department of Health, Division of Children's Medical Services. Ms. Macdonald has been involved in public health research and practice for over 10 years and specializes in maternal and child health epidemiology. She works closely with Florida's CADR Program to provide data analysis and epidemiologic consultation to support the program's statewide efforts to prevent child fatalities. Before joining CMS, Ms. Macdonald served as an epidemiologist in both Maternal and Child Health and Chronic Disease Prevention areas at the Florida Department of Health.

Rebecca Albert, MSW

Rebecca Albert is the Strategic Initiatives Manager at the Juvenile Welfare Board of Pinellas County. In this role, she is responsible for overseeing the integration of behavioral health and support services into pediatric practices, a county-wide initiative focused on increasing access to mental health services and enhancing care coordination for children and their families. Ms. Albert serves as Chair for the Child Abuse Death Review (CADR) Team for Pinellas and Pasco Counties (Circuit 6), utilizing data to inform, improve, and execute prevention efforts. Recently, she was appointed to the State CADR Committee in the role of Member of a Child Advocacy Organization. Ms. Albert has evaluated federal and state grants to include 21st Century Community Learning Centers and local prevention programming relevant to behavioral health, school-based health clinics, and parenting education.

Ms. Albert earned both a Bachelor of Science in Business Administration and a Bachelor of Arts in Psychology. In 2012, she graduated from the University of South Florida with a master's degree in Social Work.

Susanna Joy, MA (she/her/hers)

Susanna Joy provides training, programmatic support, and technical assistance to fetal, infant, and child death review teams through the National Center for Fatality Review and Prevention. Prior to joining the National Center, she coordinated a network of Fetal and Infant Mortality Review (FIMR) teams in the state of Michigan on behalf of the Michigan Department of Health and Human Services (MDHHS). She also coordinated a statewide infant bereavement support program and Michigan's safe infant surrender program on behalf of MDHHS.

An enthusiastic maternal and child health (MCH) public health practitioner, Ms. Joy worked in MCH epidemiology as a program evaluator and on the CDC-funded Michigan Pregnancy Risk Assessment Monitoring System (PRAMS) study after completing her graduate program in health and risk communication from Michigan State University. Ms. Joy has been with the National Center since 2017, and she enjoys supporting the important work of prevention-focused fatality review teams across the country.

In her free time, she enjoys being outdoors with her active family of five, hiking, kayaking, and loudly cheering at youth soccer games, volleyball matches, and track meets.

Taylor Freeman

Taylor Freeman works as a Public Health Planning Manager for the Florida Department of Health in Polk County. She oversees the injury prevention, infant mortality, and health equity initiatives for the along with the implementation of the Community Health Improvement Plan. She is also the Accreditation Coordinator and helps maintain the department's accreditation status.

Ms. Freeman completed her bachelor's degree in Health Sciences at the University of South Florida.

Ms. Freeman is currently the Co-Chair of the Coalition on Injury Prevention (CIP), Chair of Safe Kids Polk, Vice Chair of Safe Kids Suncoast, and the Chair of the Drowning Prevention Team in collaboration with CIP. Ms. Freeman is a member of several other community groups including the Child Abuse Death Review Team and Heartland for Children's Local Task Force.

Vicki Whitfield

Vicki Whitfield started her social work career in Alabama in 1986 as a child abuse/neglect investigator for the State Child Welfare Agency until 2003. She then moved to Florida and started with the First Coast Child Protection Team in 2003 as a Case Coordinator before being promoted to Assistant Team Coordinator. Ms. Whitfield served as Assistant Team Coordinator from 2004 to 2015. Ms. Whitfield currently serves as the Program Coordinator for the University of Florida, First Coast Child Advocacy Center/Child Protection Team and as the Chairperson of the Local Child Abuse Death Review Committees in Circuits 4, 7, and Baker County.

Ms. Whitfield is a member of the American Professional Society on the Abuse of Children (APSAC), National Association of Social Workers (NASW), National Child Advocacy Center (NCAC), National Alliance for Drug Endangered Children (NADEC), and is a Designated Victim Service Practitioner. She also serves as a member of numerous task force groups, interagency teams, and advisory boards in the Northeast Region of Florida.