Child Abuse Death Review Committee

Working to eliminate preventable child abuse and neglect deaths in Florida

Annual Report

December 2022

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 2021.

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 Kathleen Passidomo, President, Florida Senate
The Honorable Paul Renner, 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. Section 383.402, Florida Statutes (F.S.), delineates CADR as 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.

2021 Data: Case Review Analysis

Throughout 2022, Local CADR Committees reviewed records related to 216 child fatalities which occurred in 2021. Analysis of the 2021 child fatality case review data revealed that regardless of Department of Children and Families (DCF) maltreatment classification, children under the age of five have the highest number of child deaths called into the Florida Abuse Hotline and continue to be at the greatest risk of preventable child death. The three leading causes of preventable child death in 2021, 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 34.3% of 2021 child fatalities reviewed by the CADR System. Of this total, infants four months of age and younger constitute 71.6% of all 2021 sleep-related fatalities. Infants placed to sleep on adult beds, couches, and other soft surfaces, as well as an infant sharing a sleep surface with another child and/or adult, are at significant risk of suffocation and sleep-related death.

- **Drowning** is the second leading cause of preventable child death, representing 33.8% of all child fatalities reviewed by the CADR System. Children four years of age and younger make up 86.3% of all 2021 drowning related fatalities reviewed by the CADR System. According to the American Academy of Pediatrics (2021), nearly 70% of child drowning occurs during unexpected, unsupervised access to bodies of water, which includes children younger than five who were not expected to be at or in a pool at the time of the drowning incident. Ineffective physical barriers and inadequate supervision continue to be primary contributing factors for drowning incidents in young children. Inadequate supervision can include caregivers who are present but distracted, as well as caregivers who are not within visible and audible range when a child is in or near water.

- **Inflicted Trauma** is the third most frequent cause of preventable child death, representing 5.1% of child fatalities reviewed by the CADR System. Children five years of age and younger represented 63.6% of these fatalities, whereas the remaining inflicted trauma incidents were found in children 11–15 years of age (18.2%) and 16 years of age or older (18.2%). 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 firearms and other weapons.

Child Characteristics

Children five years of age and younger account for 90.3% of preventable child death cases reviewed by the CADR System. The most vulnerable children are less than one year of age, representing 47.7% of cases reviewed. Children under the age of five, and to a greater extent, children under the age of one are in critical need of developmentally appropriate supervision, care, and support to ensure their safety.

Data Sample Limitation

Judicial circuits continue to experience a significant backlog of cases due to the temporary delay in court proceedings, impacting data made available for CADR, specifically cases of inflicted trauma and child homicide.

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 (complete details of these recommendations are in Section Seven):

- 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 in caregivers.
- Analyze efforts to improve data collection and assessment of factors contributing to preventable child fatalities which are currently underrepresented in CADR data.
- Continue to support the development and dissemination of messaging around appropriate supervision and barriers of protection as primary factors in drowning prevention, as well as establish age-appropriate expectations and swimming capabilities for young children, that are consistent with recommendations from the American Academy of Pediatrics (AAP).
- Effectively advocate for strengthened partnerships and collaborations between state agencies to ensure families are referred to evidence-based parent coaching and support programs.
- Advocate for statewide training of 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 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: 2022 CADR BACKGROUND

Program Description

The CADR Program is administered by the Department of Health (DOH) 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.

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 CADR 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.

The State CADR Committee consists of seven agency-specific representatives appointed by the heads of each respective agency and twelve representatives appointed by the State Surgeon General from various disciplines dedicated to the health and welfare of children and families. Members of the State CADR Committee (Appendix A) 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. Agencies appointing members to the State CADR Committee include:

- Department of Health
- Department of Legal Affairs
- Department of Children and Families
- Department of Law Enforcement
- Department of Education
- Florida Prosecuting Attorneys Association, Inc.

- Florida Medical Examiners Commission, whose representative must be a forensic pathologist

The State Surgeon General is also responsible for appointing the following members based on recommendations from DOH 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 DOH 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 CADR Committees

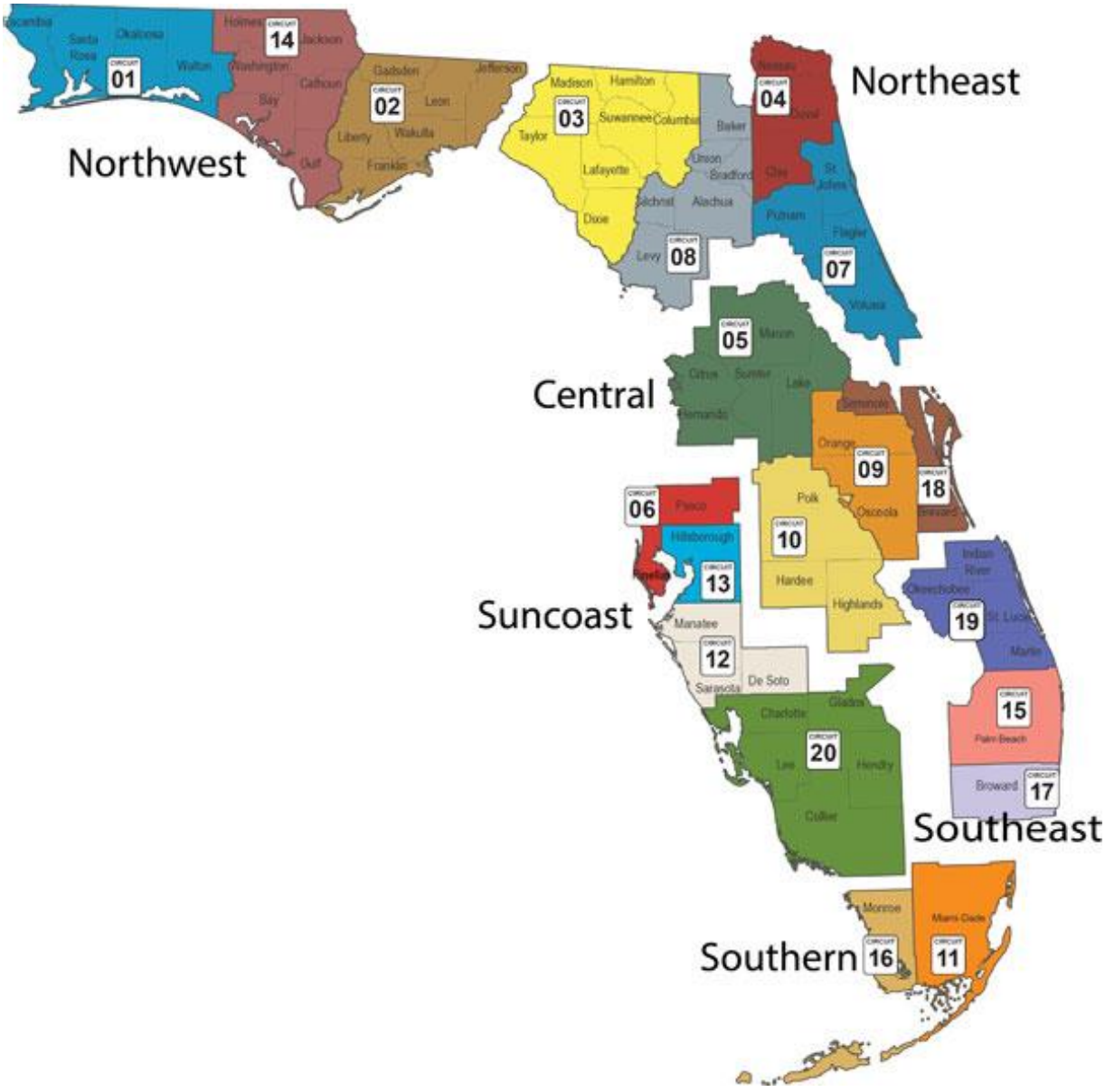
Local CADR Committees review all closed cases of alleged child abuse and neglect deaths reported to the Florida Abuse Hotline and present information relevant to these deaths to the State CADR Committee. Local CADR Committees, aligned with Florida's Judicial Circuits comprise individuals from agencies 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 A.

County Health Department (CHD) Directors 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
- DOH 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

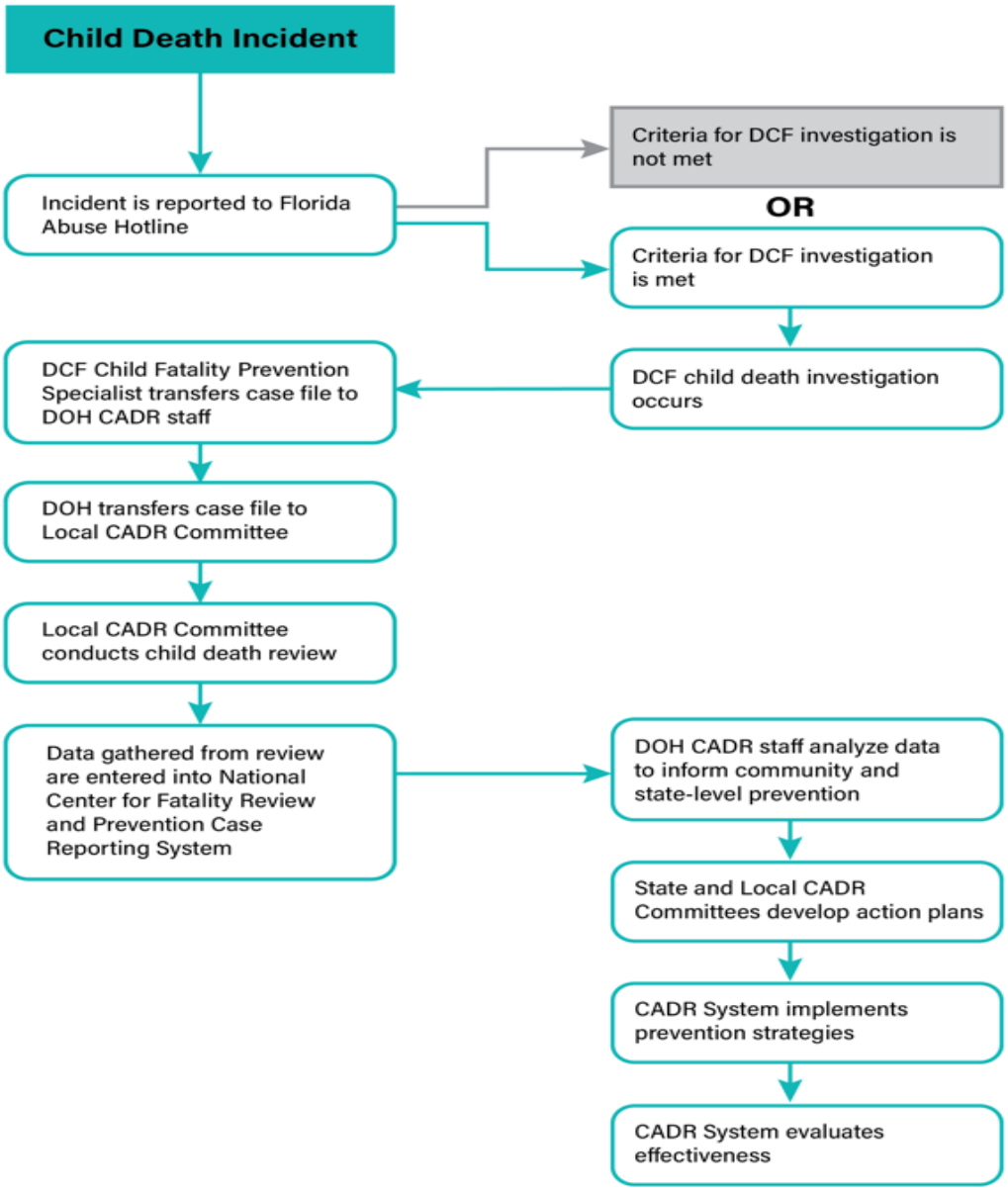
Map of Local CADR Committees

As a result of the close collaboration between DOH 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).



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 a collective understanding of the need to build upon lessons learned and further support efforts to ensure decision-making is based on applicable data.



SECTION THREE: DATA

Case Review Statistics

This report includes information on closed child fatality cases with suspected maltreatment, which were reviewed and entered into the National Center for Fatality Review and Prevention Case Reporting System (NFR-CRS, Appendix B) by this year's deadline, September 1, 2022. Cases that remain open to DCF for investigation are not available for review and thus are not included in this data sample. There were 216 child fatality review cases with complete data entry available for analysis by the data entry deadline, which are included in this report.

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.

It is important to note that the use of incident status for child maltreatment findings are concluded by DCF staff during the investigative process and are not indicative to case review findings made by CADR committees.

Throughout this section of the report, references are often made to unknown and missing data in certain graphs, charts, and tables. For the purpose of this section, unknown is used when the answer to a given question or equivalent data element in the NFR-CRS is not known, despite efforts to obtain information by the Local CADR Committee. Missing refers to data elements that were left blank when entering child fatality case data into the NFR-CRS.

Table 1 details the distribution of 2021 child fatality cases reviewed, cases awaiting review, and cases that were not available for review as of September 1, 2022.

Table 1: Child Fatality Cases Reviewed and Case Review Status Across Local CADR Committees				
Circuit	**Total Cases (Child deaths called into hotline)**	**Cases Not Available for Review (Open Investigation/Case in Processing)**	**Cases Available for Review**	**Cases Completed and Available for Annual Report**
Circuit #1a	15	3	12	10
Circuit #1b	6	1	5	5
Circuit #2	3	0	3	3
Circuit #3	8	3	5	0
Circuit #4	42	9	33	7
Circuit #5	25	0	25	25
Circuit #6	20	10	10	9
Circuit #7	17	7	10	2
Circuit #8	7	4	3	3
Circuit #9	53	0	53	50
Circuit #10	34	4	30	25
Circuit #11	27	10	17	5
Circuit #12a	5	0	5	5
Circuit #12b	9	4	5	5
Circuit #13	29	11	18	14
Circuit #14	18	5	13	2
Circuit #15	29	22	7	7
Circuit #16	0	0	0	0
Circuit #17	37	13	24	10
Circuit #18a	16	5	11	7
Circuit #18b	10	0	10	9
Circuit #19	16	7	9	9
Circuit #20	23	14	9	4
Totals	449	132	317	216

The distribution of child fatality cases reported to the Florida Abuse Hotline by Local CADR Circuit is shown in Figure 1, from greatest number of calls to least.

Figure 1: 2021 Child Death Cases Reported to the Hotline (n=449)

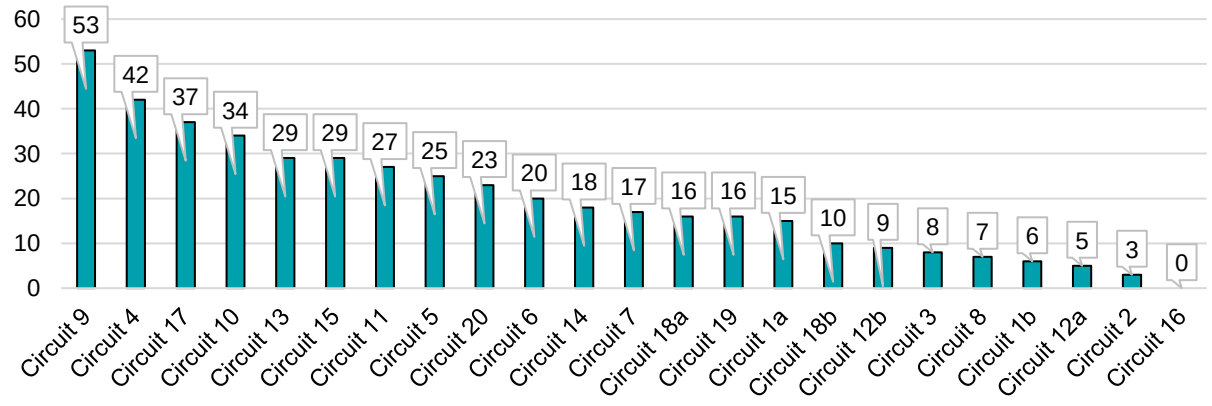
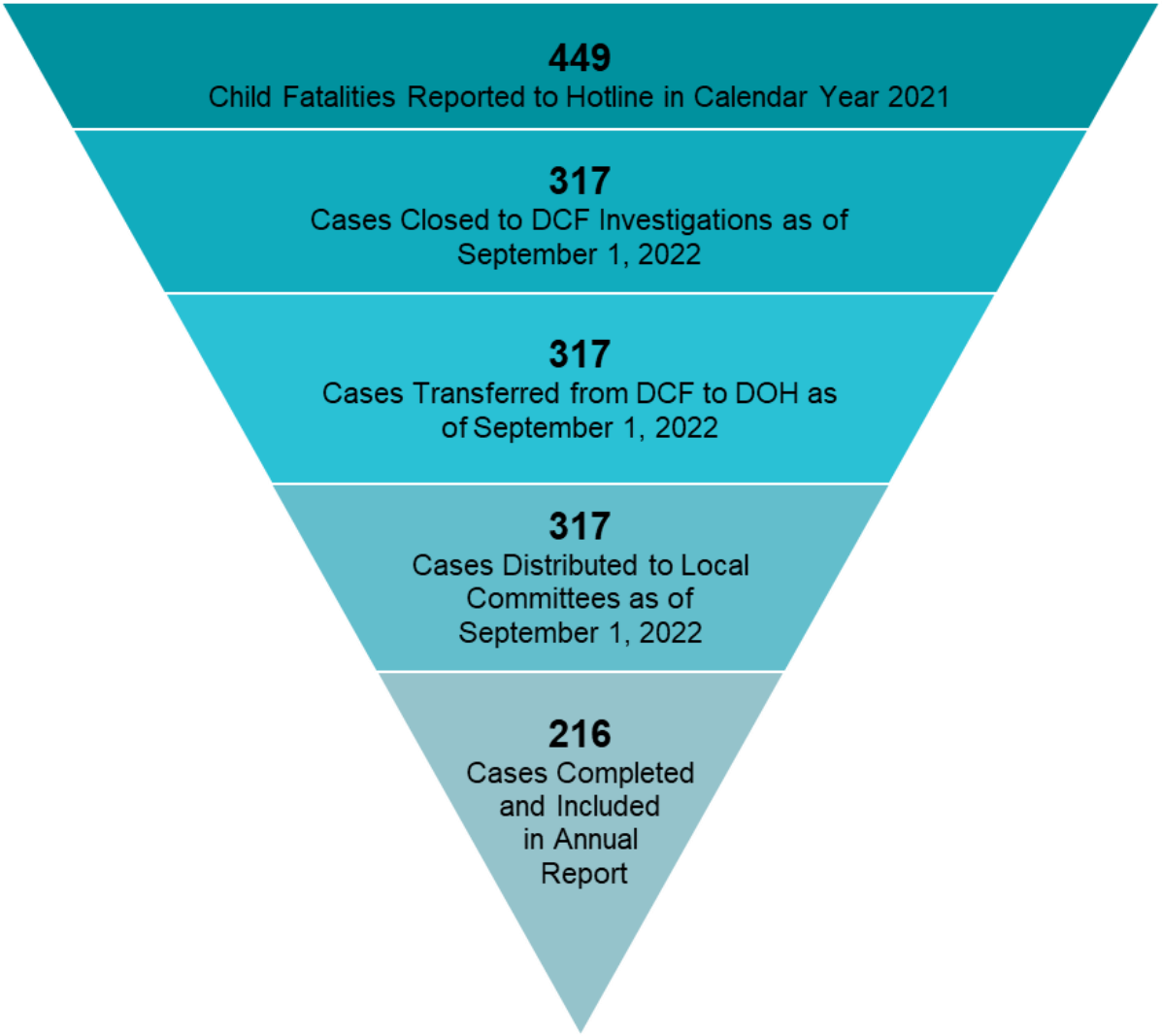


Figure 2 provides an aggregate summary of the case file status for all child fatalities (n=449) reported to the Florida Abuse Hotline in 2021, including the cases completed and analyzed in the 2022 Annual Report (n=216).

Figure 2: Case File Status of 2021 Child Deaths Reported to the Florida Abuse Hotline



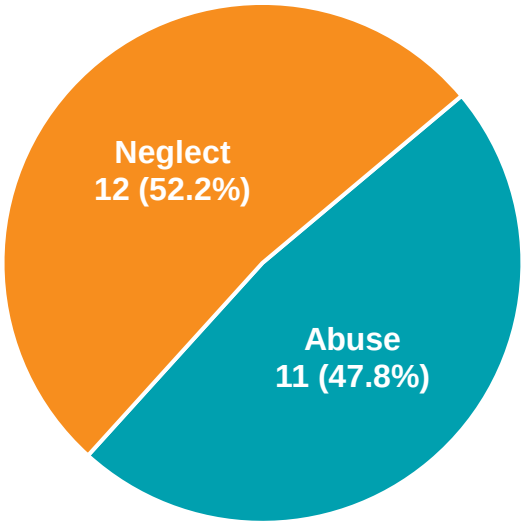
2021 Case Status Summary

As of September 1, 2022, 449 child fatalities were called into the Florida Abuse Hotline for 2021.

Of these child death incidents:

- 317 were closed by DCF.
    - Of these, 317 had information which was available for review and 216 reviews were completed by the Local CADR Committees. The remaining 101 cases are scheduled for review after September 1, 2022. Data included in this report apply only to the 216 reviewed cases. Findings may change once all child fatalities are reviewed.
- 132 were still open for investigation or recently closed, therefore case information was unavailable.
    - Consideration will be given toward supplemental analyses of the remaining 2021 fatalities (n=132) upon case closure and review.
- There were eight Local CADR Committees with 25 or more child fatality cases called into the hotline in 2021. These include Circuit 4 (n=42), Circuit 5 (n=25), Circuit 9 (n=53), Circuit 10 (n=34), Circuit 11 (n=27), Circuit 13 (n=29), Circuit 15 (n=29), and Circuit 17 (n=37).
- Of the 216 reviewed cases, 23 were classified as verified maltreatment deaths. The findings concluded that 12 (52.2%) were the result of neglect, and 11 (47.8%) were the result of abuse (Figure 3).

Figure 3: Distribution of Reviewed Verified Maltreatment Deaths by Abuse and Neglect (n=23)



Child Death Trends

Counts and rates of all causes of child death and verified child maltreatment deaths are displayed in Table 2. In 2021, the all-cause death rate for children aged 0-17 was 51.5 deaths per 100,000 child population (Florida CHARTS, 2022). The reported 2021 verified child maltreatment death rate in Table 2 is 0.53 per 100,000 child population. This rate is provisional, as there are several cases still open to investigation and unavailable for review. Changes in rates based on provisional data should be interpreted with caution.

Table 2: Child Deaths: All Causes and Maltreatments, Florida, 2011-2021

Year	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	156	3.77	-	-
2015	2,249	55.4	123	3.03	-	-
2016	2,217	54.1	110	2.69	0	6
2017	2,236	54.1	113	2.73	0	3
2018	2,128	50.7	116*	2.77*	5	5
2019	2,107	49.7	81*	1.89*	8	21
2020	2,107	49.2	80*	1.45*	19	61
2021	**2,221****	**51.5****	**23***	**0.53***	**132**	**101**

***The numbers of verified child maltreatment cases for 2018, 2019, 2020, and 2021 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.

****2021 Vital Statistics death data are provisional and subject to change.

Child Demographic Characteristics

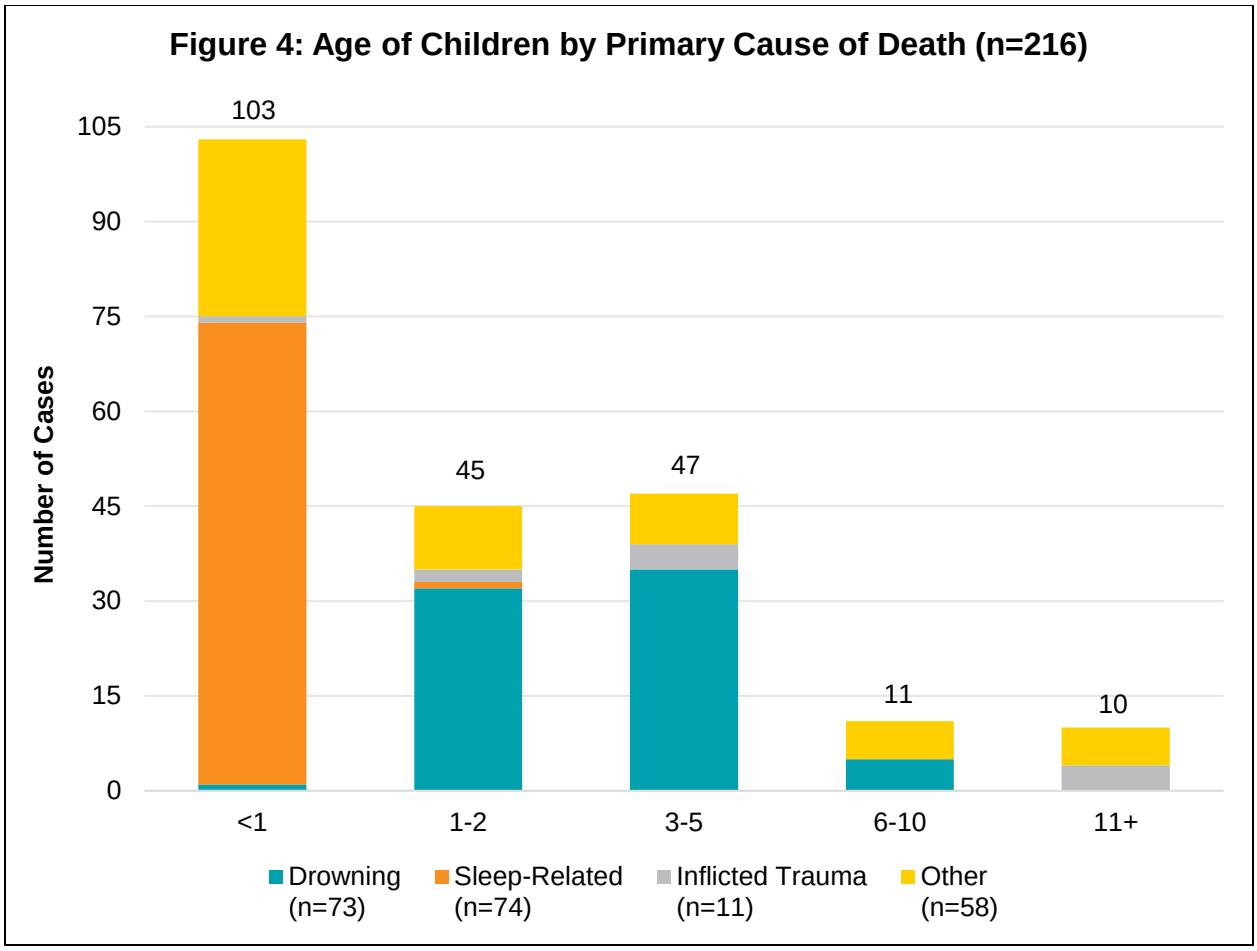
The following section summarizes information on select child demographic characteristics.

Age of Child

Regardless of maltreatment verification status, children five years of age and younger comprised the majority of fatalities, representing 195 of 216 (90.3%) cases.

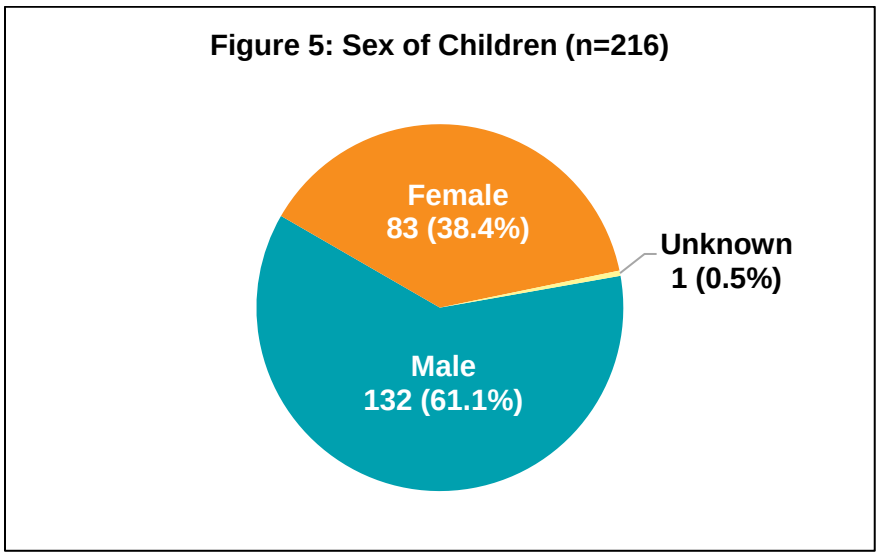
As shown in Figure 4:

- Among the 73 drowning deaths, 68 (93.2%) were children five years of age and younger. Most of these deaths occurred in children between ages 1 and 4 (84.9%).
- Among the 74 sleep-related deaths, 73 (98.6%) were children less than one year old, where 47 (63.5%) of the incidents involved infants 3 months and younger.
- 28 of 58 (48.3%) child deaths attributed to other causes were under the age of one.



Sex of Child

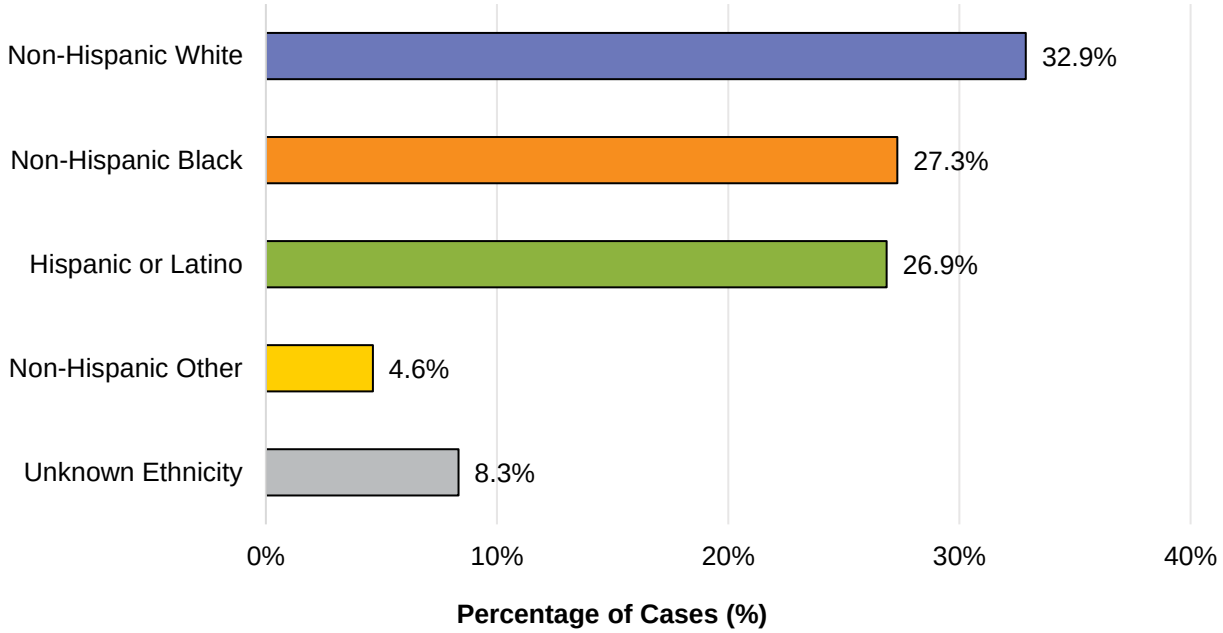
Figure 5 shows the distribution of sex for the 216 cases. Males were disproportionately represented among child fatalities. For unknown, the sex of the child could not be determined during the death investigation for one case due to the child's condition at the time of discovery.



Race and Ethnicity of Child

As displayed in Figure 6, 71 of 216 children (32.9%) were identified as non-Hispanic white, and 59 (27.3%) were identified as non-Hispanic black. Children who were identified as Hispanic or Latino, regardless of race, include 58 (26.9%) total cases, whereas 10 (4.6%) were identified as non-Hispanic other, and 18 (8.3%) were of unknown ethnicity.

Figure 6: Race and/or Ethnicity of Children (n=216)



Child Demographic Characteristics Data Summary

- ***47.7% of all child fatality incidents received by CADR were < 1 year old.***
- ***61.1% of all child fatality incidents received by CADR were classified as male.***
- ***32.9% of all child fatality incidents received by CADR were identified as non-Hispanic white, whereas 27.3% were identified as non-Hispanic black. Hispanic or Latino children, regardless of race, constituted 26.9% of all cases.***

Location of Child Deaths

County of the Death Incident

The incident county refers to the county where the incident that led to the death took place, which is not always the same as the child's residence county or the county where the child was declared deceased. The distribution of cases by incident county is shown in Table 3.

Table 3: County of Death Incident (n=216)

County	Leading Cause of Death Category				Total
	Drowning	Sleep-Related	Inflicted Trauma	Other	
Alachua	0	1	0	1	2
Bay	0	0	1	1	2
Brevard	2	2	2	1	7
Broward	4	3	1	2	10
Citrus	0	0	0	4	4
Clay	1	0	0	0	1
DeSoto	0	0	0	1	1
Duval	4	2	0	0	6
Escambia	2	4	0	1	7
Flagler	0	0	0	1	1
Hardee	1	0	0	0	1
Hernando	5	0	0	1	6
Highlands	1	0	0	1	2
Hillsborough	2	7	0	5	14
Indian River	0	2	0	0	2
Lake	1	1	2	1	5
Lee	1	2	0	1	4
Leon	1	2	0	0	3
Manatee	1	3	0	1	5
Marion	2	2	0	6	10
Martin	0	1	0	2	3
Miami-Dade	4	0	0	1	5
Okaloosa	0	3	0	1	4
Orange	7	15	1	7	30
Osceola	13	1	0	6	20
Palm Beach	0	3	1	3	7
Pasco	3	3	0	0	6
Pinellas	1	1	0	1	3
Polk	8	7	1	6	22
Santa Rosa	3	0	0	0	3
Sarasota	1	3	0	0	4
Seminole	3	4	1	1	9
St Johns	0	1	0	0	1
St Lucie	1	1	1	1	4
Union	0	0	0	1	1
Walton	1	0	0	0	1
Total	73	74	11	58	216

Of the top three primary cause of death categories, regardless of maltreatment verification status:

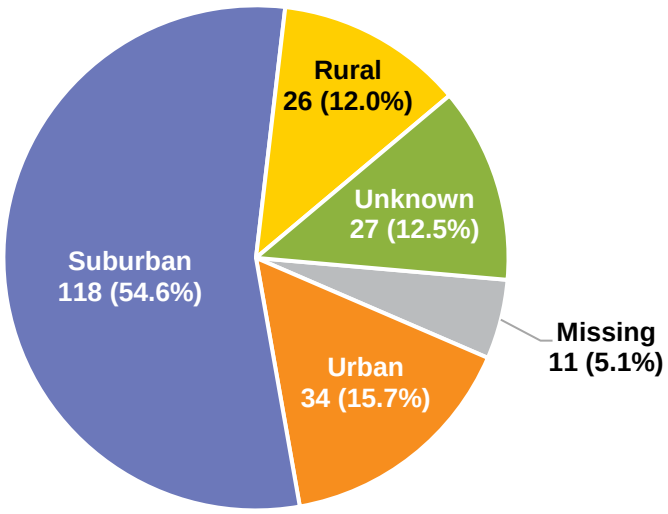
- 37 (50.0%) of all sleep-related deaths occurred in five counties: Orange, Hillsborough, Polk, Escambia, and Seminole. Orange County alone accounted for 15 (20.3%) of the sleep-related deaths.
- 33 (45.2%) of all drownings occurred in four counties: Osceola, Polk, Orange, and Hernando. Osceola County alone accounted for 13 (17.8%) of the drowning deaths.
- 11 deaths due to inflicted trauma occurred across nine counties: Brevard (n=2), Lake (n=2), Bay (n=1), Broward (n=1), Orange (n=1), Palm Beach (n=1), Polk (n=1), Seminole (n=1), St. Lucie (n=1).

Incident Area Type

Figure 7 displays the types of areas where child death incidents occurred. Of 216 cases, 118 (54.6%) took place in suburban areas. The remaining incidents included 34 (15.7%) that occurred in urban areas and 26 (12.4%) in rural; 27 (12.5%) and 11 (5.1%) were unknown and missing respectively.

Suburban is defined as a residential district located on the outskirts of a city. Urban is defined as a large city or densely populated area. A rural area is a community with low population densities and can include agricultural and recreational land.

Figure 7: Type of Area Where Incident Occured (n=216)



Official Manner of Death

Child fatality reviews document the official manner and cause of death, as well as the maltreatment verification finding that results from DCF investigation.

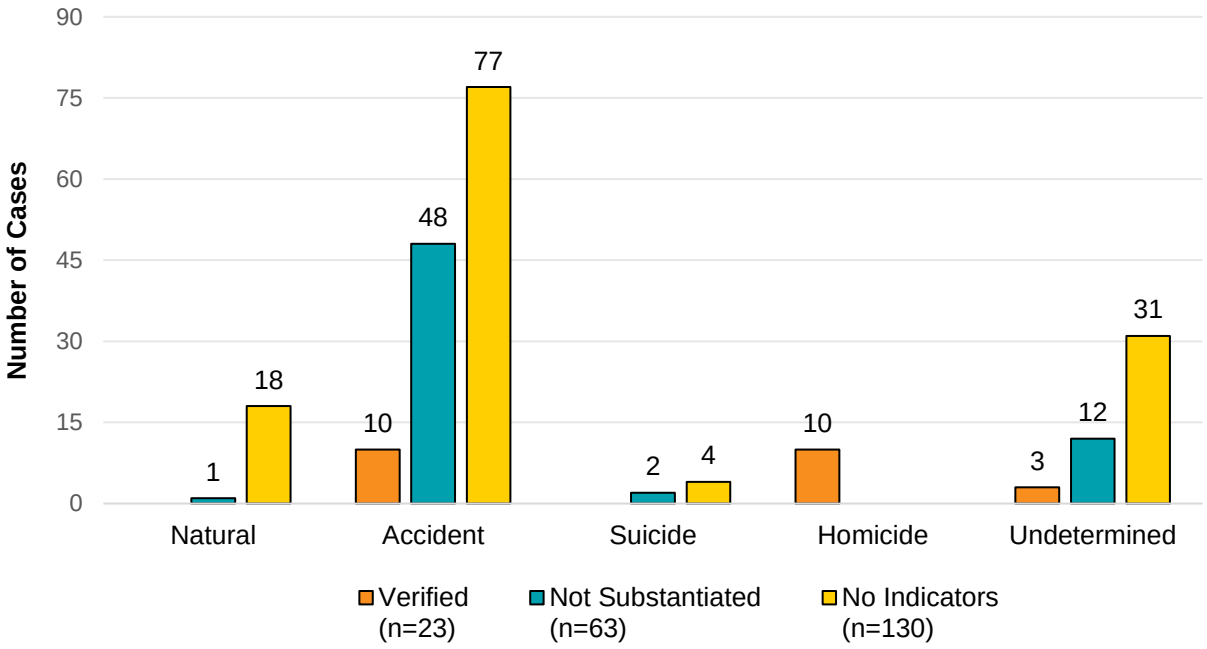
Figure 8 displays the official manner of death as indicated on the death certificate for all child fatalities reviewed for this report.

- Of the 23 child deaths classified as verified maltreatment deaths, 10 (43.5%) were classified as accidents, 10 (43.5%) were classified as homicides, and 3 (13.0%) were classified as undetermined manner.

- Among the 63 not substantiated child deaths, 48 (76.2%) were classified as accidents, followed by 12 (19.0%) as undetermined causes.

- Among the 130 child deaths with no indicators of maltreatment, 77 (59.2%) were classified as accidents, followed by 31 (23.8%) classified as undetermined manner, and 18 (13.8%) classified as natural manner of death.

Figure 8: Manner of Death by Maltreatment Verification Status (n=216)



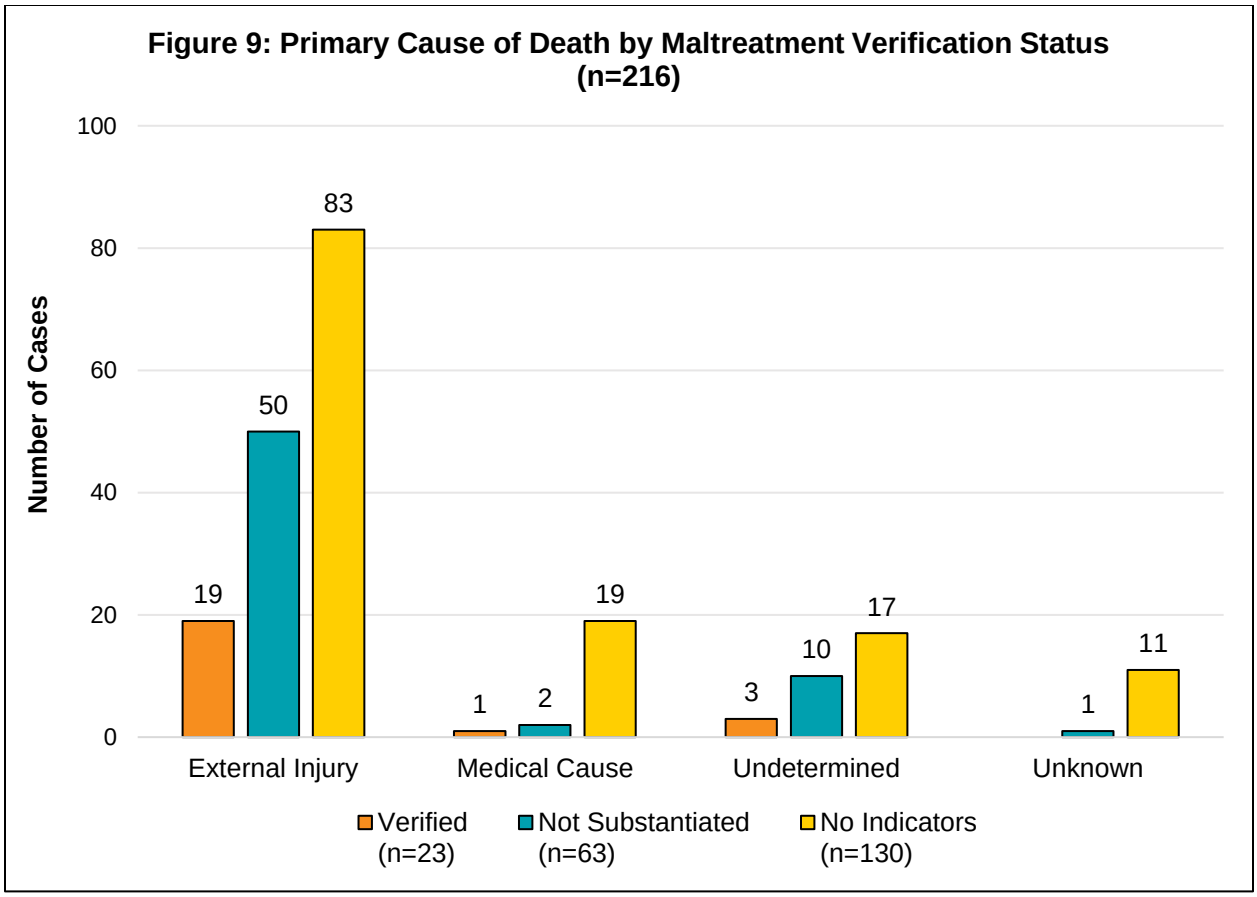
Primary Cause of Death

The distribution of primary cause of death in all child fatality cases reviewed, stratified by child maltreatment verification status, is displayed in Figure 9.

- Among the 23 verified maltreatment fatalities, 19 (82.6%) were the result of an external injury, 1 (4.3%) was due to a medical cause and 3 (13.0%) had an undetermined or unknown cause of death.

- Among the 63 not substantiated maltreatment fatalities, 50 (79.4%) were the result of an external injury, 2 (3.2%) were determined to have a medical cause, 10 (15.9%) were undetermined, and 1 (1.6%) was concluded to have an unknown cause of death.

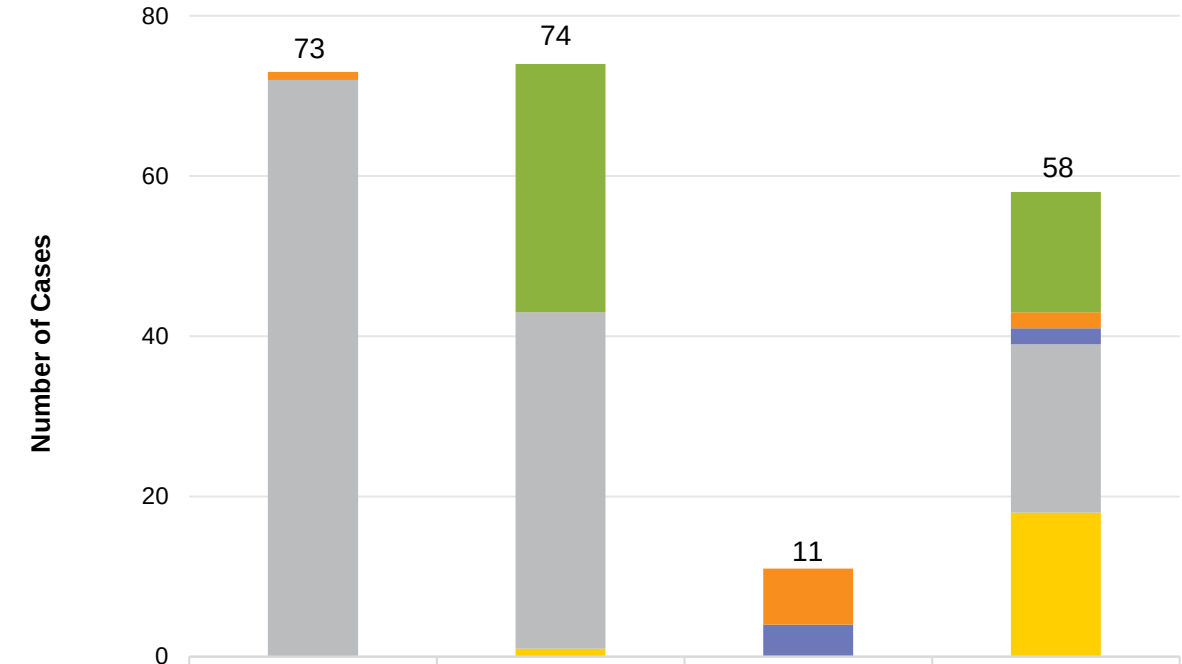
- Among the 130 no indicator deaths, 83 (63.8%) were the result of an external injury, 19 (14.6%) were the result of a medical cause, 17 (13.1%) were undetermined, and 11 (8.5%) had an unknown cause of death.



The distribution of leading cause of death by manner of death is displayed in Figure 10.

- Among the 73 drowning cases, 72 (98.6%) were accidental and 1 (1.4%) case was verified as a homicide.
- Among the 74 sleep-related cases, the manner of death was undetermined for 31 (41.9%) cases, whereas 42 (56.8%) were classified as accidental manner and 1 (1.4%) was due to natural manner.
- Homicidal manner accounted for 7 (63.6%) of the 11 inflicted trauma cases. In 4 (36.4%) of the 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 (31.0%), accidental (36.2%), or undetermined (25.9%). The remaining 4 cases in the other cause of death category comprised 2 (3.4%) homicides and 2 (3.4%) suicides as the official manner.

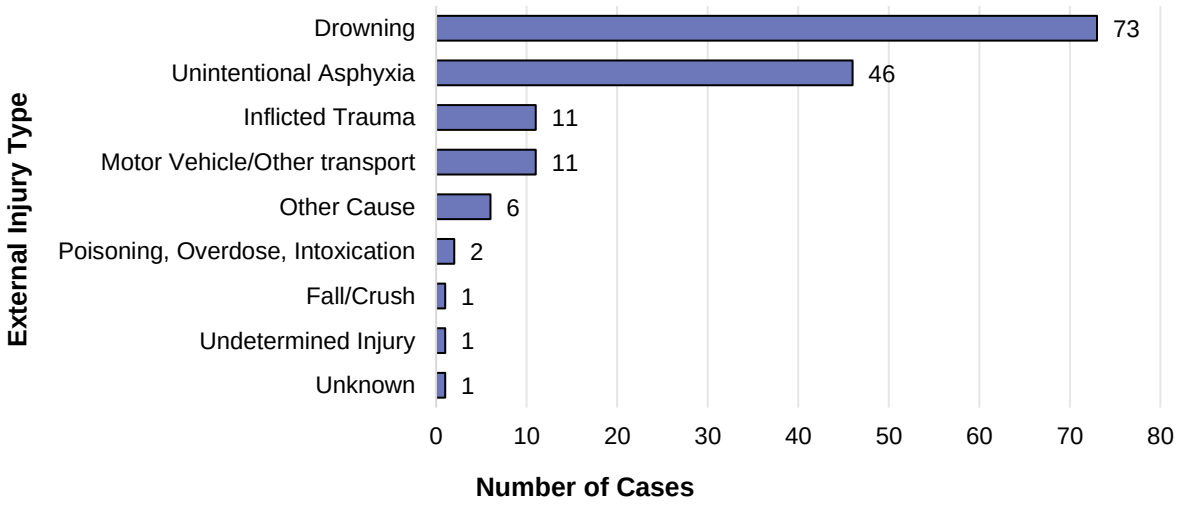
Figure 10: Manner of Death by Leading Cause of Death Category (n=216)



	Drowning (n=73)	Sleep-Related (n=74)	Inflicted Trauma (n=11)	Other (n=58)
Undetermined	0	31	0	15
Homicide	1	0	7	2
Suicide	0	0	4	2
Accident	72	42	0	21
Natural	0	1	0	18

Figure 11 displays specific causes of death resulting from external injury.

Figure 11: External Injury Cause of Death (n=152)



Tables 4 and 4.1 shows the specific types of injury causes for both homicide and suicide (n=16) manner of death, without cause of death stratification.

In 2021, there were 10 verified homicide deaths; in 7 of these cases, the cause of death was inflicted trauma by bodily force or weapon. In 1 verified maltreatment homicide case, the cause of death was drowning and in the remaining 2 cases, the external cause of death is reported as other cause for 1 case due to starvation/dehydration, and the other case was classified as undetermined if injury or medical cause.

Table 4: Homicide Breakdown (n=10)	
Injury Cause	Number of Cases
Drowning	1
Bodily Force or Weapon	7
Other cause	1
Undetermined	1

Table 4.1: Suicide Breakdown (n=6)	
Injury Cause	Number of Cases
Weapon	4
Other Injury Cause	2

Table 4 Homicide Incidents (n=10):

- In 5 cases, bodily force was used to inflict trauma.
- In 2 cases, firearms were used to inflict trauma.
- In 1 case of homicide death, the cause of death was drowning.

Table 4.1 Suicide Incidents (n=6):

- In 4 cases, firearms were used to self-inflict trauma.
- 2 cases were classified as other cause of injury, with both suicide incidents being due to self-inflicted hanging.

Table 5 displays specific primary causes of death resulting from a medical condition.

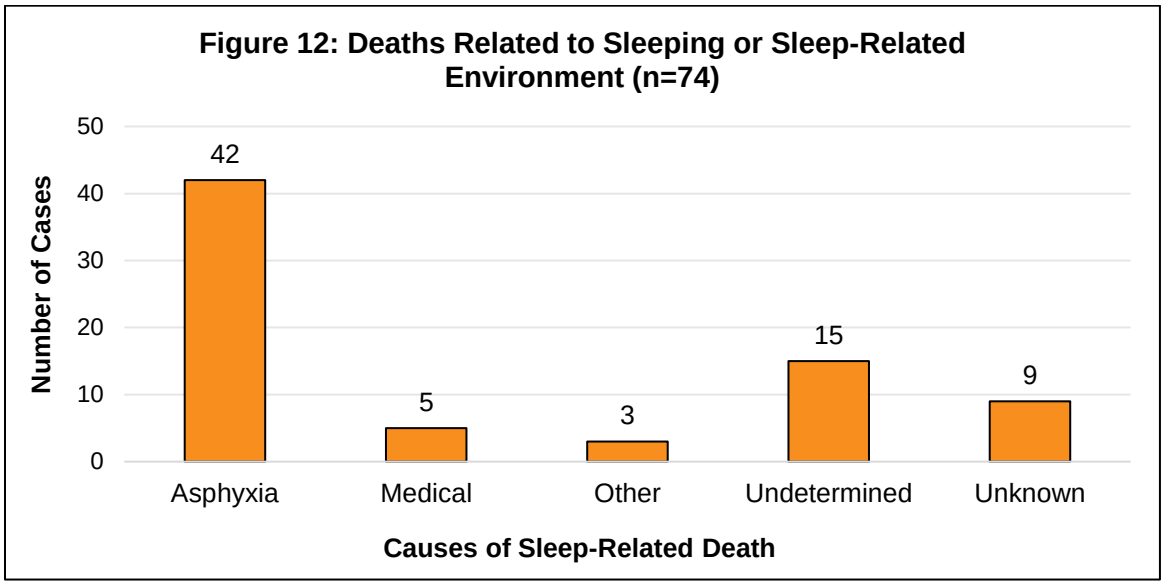
Table 5: Medical Cause of Death (n=22)	
Specific Medical Cause of Death	**Number of Cases**
Asthma/respiratory	1
Cardiovascular	1
Congenital Anomaly	1
Neurological/Seizure Disorder	1
Pneumonia	4
Sudden Infant Death Syndrome (SIDS)	4
Other Infection	4
Other Medical Condition	4
Undetermined Medical Cause	1
COVID-19	1

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. All sleep-related variables in this report pertain to children under five years of age.

Sleep-related deaths account for 74 (34.3%) of all 2021 CADR case entries, with 42 (56.8%) due to asphyxia, 5 (6.8%) due to medical cause, 3 (4.1%) due to other cause, 15 (20.3%) undetermined, and 9 (12.2%) unknown (Figure 12).

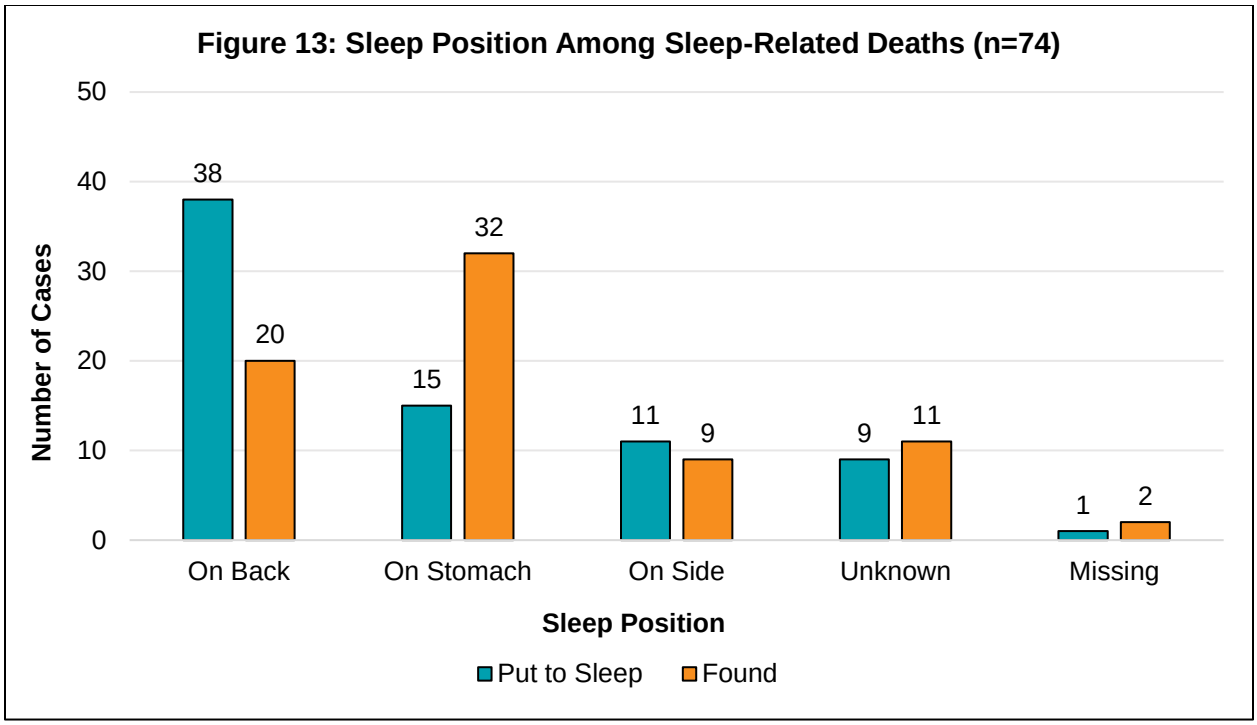
The cause of a sleep-related death can remain undetermined or unknown after investigation, therefore, may be classified as a death from an unknown or undetermined cause. Death scene investigations involving sleep-related incidents provide information regarding location and position in which the child was placed and found. These narratives can be used in conjunction with the medical examiner's (ME) findings to provide a more encompassing view of the incident.



When available, Local CADR Committees collect information on risks and protective factors pertaining to sleep-related deaths. Figures 13 through 15 and Table 6 provide an overview of critical factors regarding sleep placement, environments, and age distribution among the reviewed cases.

Figure 13 provides information related to sleep placement position among cases that were classified as sleep-related, including 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. Findings are only presented on cases where data were reported. Sleep position/sleep placement options are:

- On Back
- On Stomach
- On Side
- Unknown



- On Back was the usual reported placement position for 38 (51.4%) 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 32 (43.2%) child deaths where sleep position at the time of death was known.

Figure 14 shows the distribution of incident sleep place among sleep-related deaths, with 43 (58.1%) of all sleep-related deaths taking place in an adult bed.

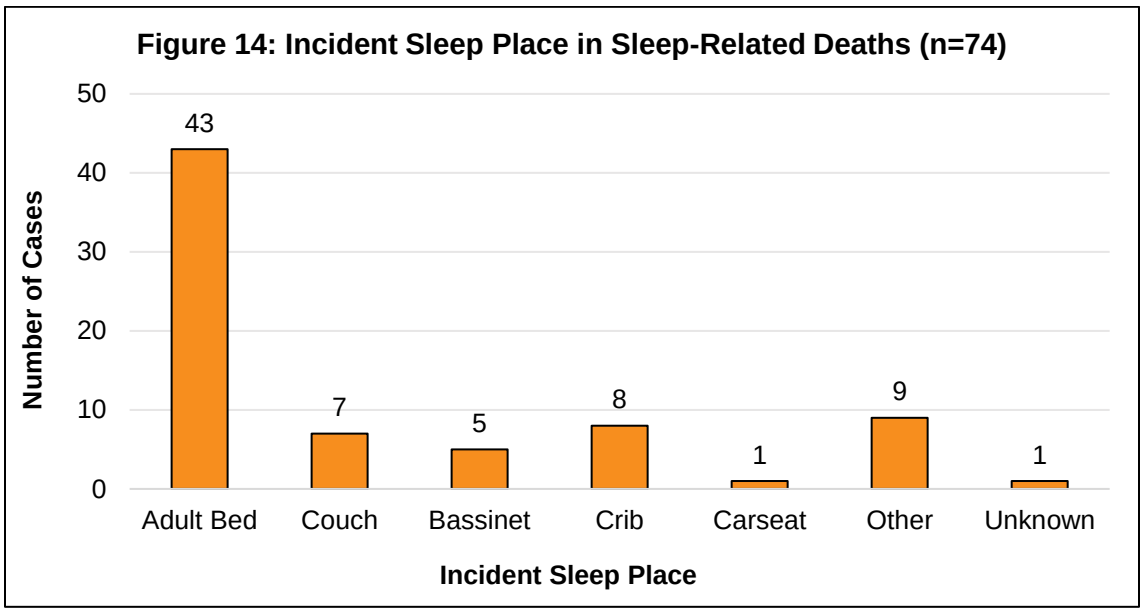
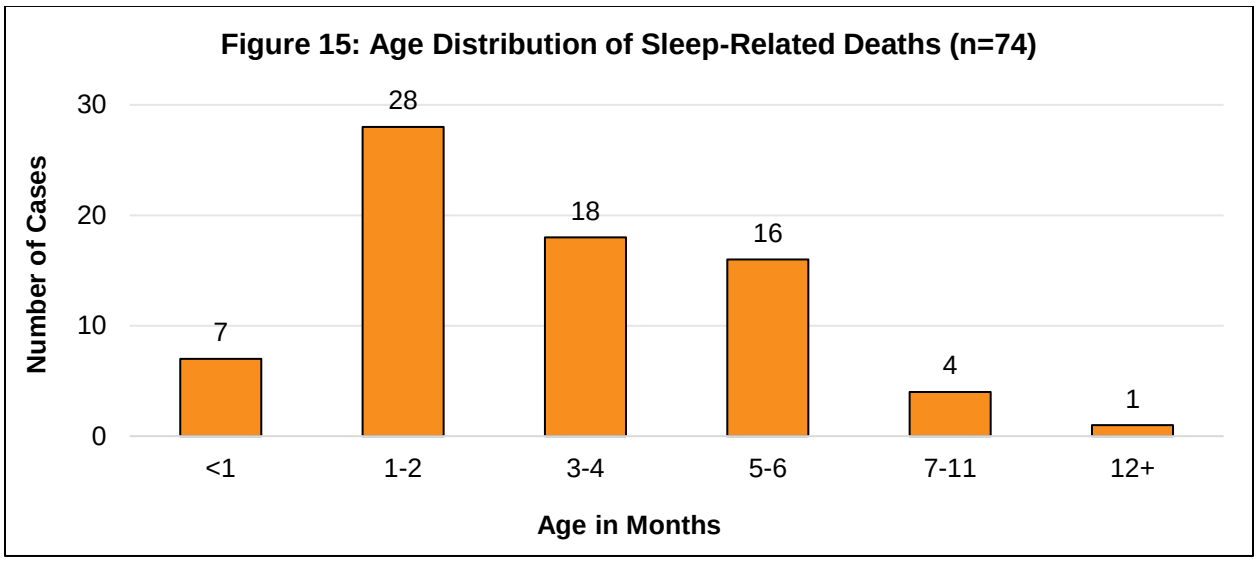


Table 6 provides counts of specific objects (including persons) that were reported in a child's sleep environment, in which some may have contributed to a child's airway obstruction among the 74 reviewed sleep-related cases. More than one object may have been present in the sleep environment; thus, column totals exceed the number of children in some of the reported incidents. In 36 cases, an adult was present in the sleep environment, and in 14 cases, another child or multiple children were present in the sleep environment.

Table 6: Objects in Sleep Environment Among Sleep-Related Deaths (n=74)

Object(s) Present in Sleep Environment	Count	Percentage (%)
Pillow/Cushion	49	66.2%
Mattress	46	62.2%
Adult	36	48.6%
Comforter, Quilt, or Other	33	44.6%
Fitted Sheet	33	44.6%
Thin Blanket/Flat Sheet	32	43.2%
Child(ren)	14	18.9%
Clothing	10	13.5%
Other	9	12.2%
Toy(s)	7	9.5%
Nursing or U-shaped Pillow	7	9.5%
Bottle	2	2.7%
Crib Railing/Side	2	2.7%
Wall	2	2.7%
Animal(s)	1	1.4%

Figure 15 provides the age breakdown of children who died as a result of a sleep-related death incident. Of the 74 sleep-related death incidents in 2021, 35 (47.3%) involved infants 2 months of age and younger, while 18 (24.3%) involved infants between 3 and 4 months of age, and 16 (21.6%) involved infants that were between 5 and 6 months of age.



Information analyzed as part of the 2021 child fatality review indicate the following:

Death scene investigations for sleep-related incidents at the place of the incident were completed for 72 (97.3%) of the reviewed cases. Of the 72 cases, 25 (33.8%) death scene recreations with a doll were conducted, where the findings were shared with Local CADR Review Committees in 13 of the 25 (52.0%) cases.

Sleep-related Data Summary

- ***58.1% of all sleep-related deaths took place in an adult bed.***
- ***Children between 0 and 3 months of age made up 63.5% of all 2021 sleep-related fatalities. When including infants up to 4 months of age, this percentage increases to 71.6%.***
- ***59.5% of all sleep-related deaths involved male children.***
- ***51.4% of children were placed on their back to sleep and 43.2% were found on their stomach.***
- ***48.6% of the 74 sleep-related deaths had another adult in the bed, whereas 18.9% had another child or children in the bed at the time of incident.***

Drowning Death Incident Information

For drowning 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 or not a barrier was in place.

Table 7 displays the location of drowning deaths, with a pool, hot tub, or spa represented in 61 (83.6%) of the total drowning incidents. The majority (98.6%) of drowning incidents were classified as accidental manner, regardless of the drowning location, and one homicide incident (1.4%) occurred in a pool at the home.

Table 7: Drowning Location by Manner of Death (n=73)

Drowning Location	Manner of Death		Total
	Accident	Homicide	
Open Water/Pond	9	0	9
Pool/Hot Tub/Spa	60	1	61
Bathtub	2	0	2
Other	1	0	1
Total	72	1	73

Figure 16 shows the location where children were last seen before drowning. Children were most likely to be last seen in their house (61.6%) or in a yard (16.4%) prior to drowning.

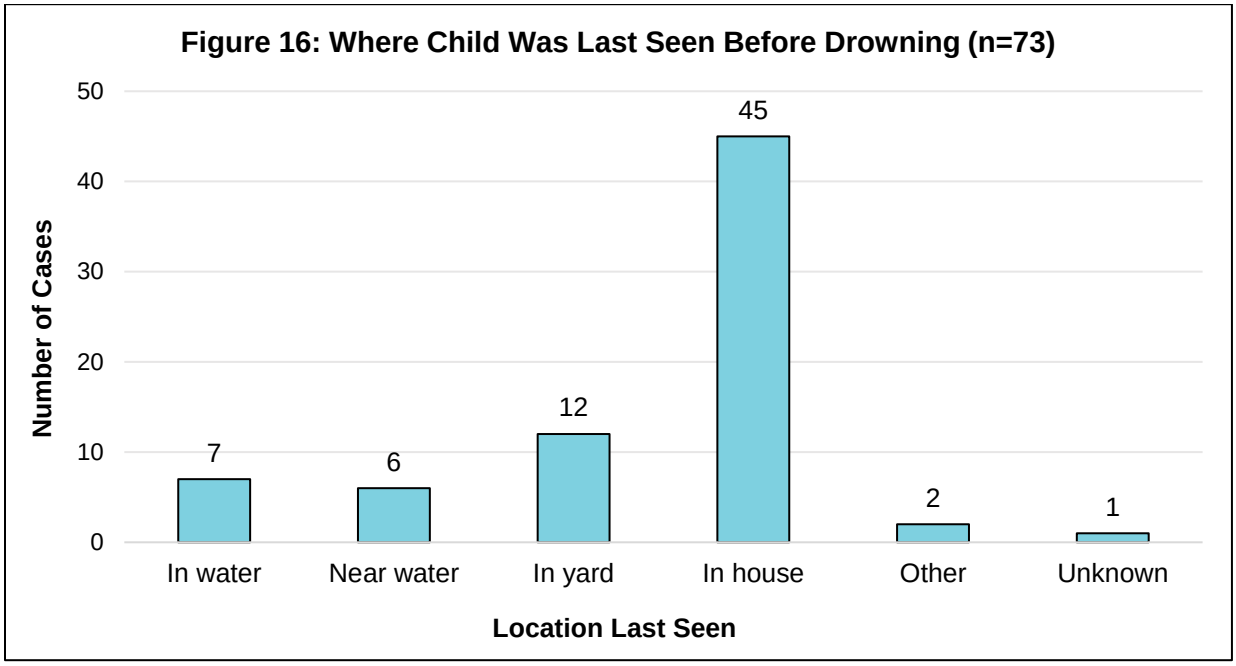
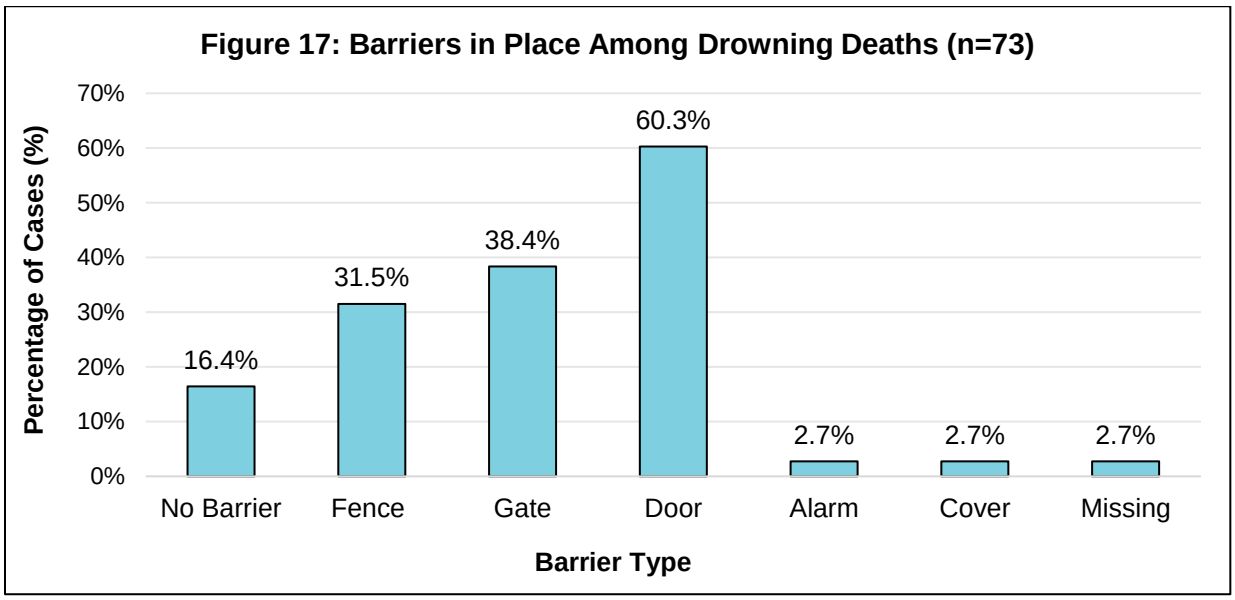


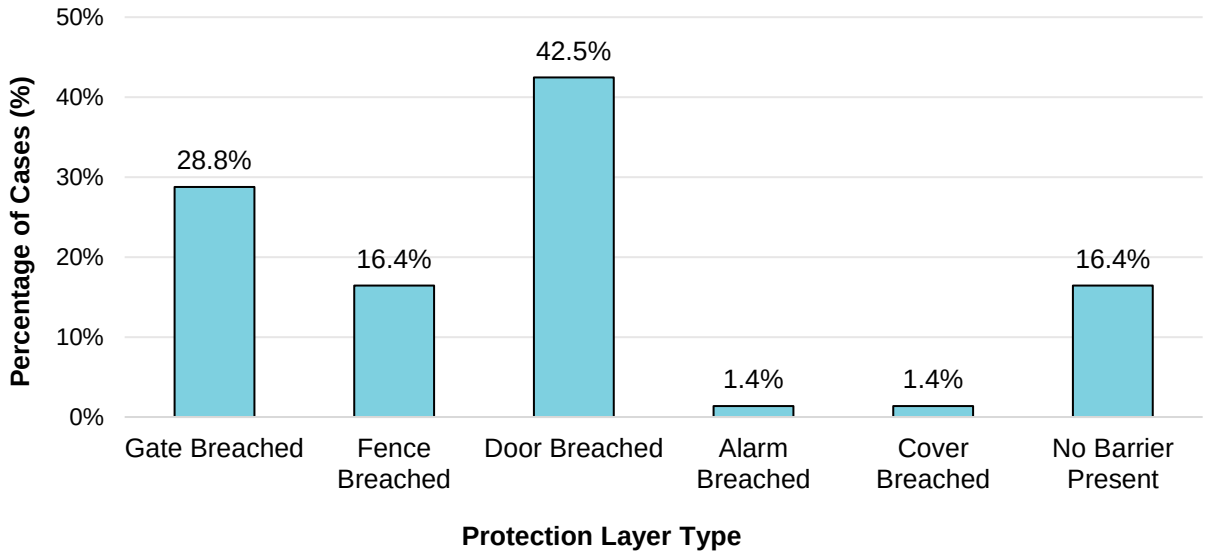
Figure 17 details physical barriers and other protection layers that were in place at the time of drowning incident. Barriers are physical structures, such as a door or a fence, that are intended to limit access to potentially hazardous bodies of water. More than one barrier can be present in individual drowning cases.



In the majority of drownings (80.8%), there was at least one physical barrier in place at the time of the incident. In 12 drowning cases (16.4%), there were no layers of protection indicated to prevent access to water. The most common physical barriers in place among the 73 drownings were doors (60.3%) and gates (38.4%), as seen in Figure 17.

Figure 18 details physical barriers and other protection layers that were breached. A breached barrier is defined as opened, broken, or not functioning. Therefore, the presence of a barrier does not imply that the barrier is always effective in preventing a child from accessing a water source and may also not be applicable in water sources such as an open beach. More than one barrier can be breached in individual drowning cases.

Figure 18: Protection Layers Breached in Drowning Deaths (n=73)



In Figure 18, the most prevalent barrier breached in drowning incidents were doors (42.5%) and gates (28.8%), followed by fences (16.4%).

Drowning Data Summary

- ***Drowning deaths occurring in a Pool/Hot tub/Spa account for 83.6% of all 2021 drowning fatalities.***
- ***Children 3 years of age and younger make up 64.4% of all 2021 drowning fatalities. This percentage increases to 86.3% when including children 4 years of age and younger.***
- ***60 children (82.19%) did not know how to swim at the time of the incident.****
- ***67.1% of all 2021 drowning related fatalities involved male children.***
- ***61.6% of children were located within the home prior to the drowning incident.***
- ***Of all protection layers that were present in reviewed drowning cases, 38.9% were identified as being a door.***
- ***Doors and gates accounted for over half (66.7%) of all protection layers that were breached prior to drowning incidents.***

This statement reflects all child drownings reviewed by CADR, of which 86.3% were under the age of five. Children in this age range are not expected to have the developmental capacity to be reliable swimmers.

Inflicted Trauma Death Incident Information

The intentional infliction of bodily harm is captured in this category and remains a leading cause of preventable child death. Information collected on cases involving bodily force or weapon-related deaths include the type of weapon used and manner of death. Weapon types include firearms, bodily force, or body parts, such as fists, hands or feet, and any other items that can be used to inflict bodily harm. At the time the data were analyzed for this report, several cases were not yet available for review and thus not fully representative of severity of inflicted trauma incidence. 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 that figures presented on weapons or bodily force will increase when all 2021 deaths are reviewed.

Figure 19 displays bodily force or type of weapons used in inflicted trauma cases. Among the 11 reviewed inflicted trauma deaths including both homicide and suicide cases:

- 6 (54.5%) cases used firearms (handguns) as weapons to inflict trauma.
- 3 (27.3%) cases involved bodily force/body parts to inflict trauma.
- 2 (18.2%) cases indicated unknown weapon type or bodily force.

Figure 19: Bodily Force or Weapon Type Among Inflicted Trauma Deaths (n=11)

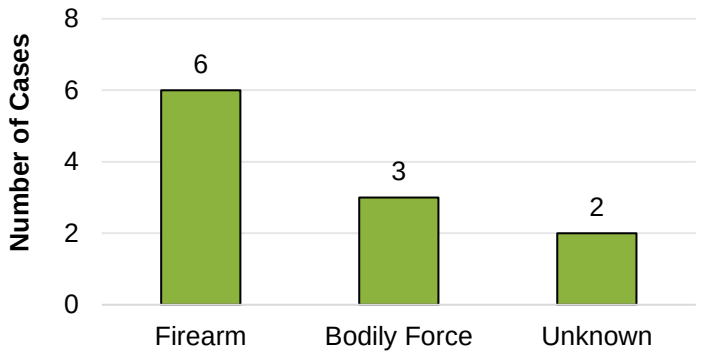


Table 8: Inflicted Trauma Cases by Manner of Death (n=11)

Manner	Number of Cases	Percent (%)
Homicide	7	63.6%
Suicide	4	36.4%

Table 8 displays the breakdown of inflicted trauma cases by manner of death. Among these deaths, homicides comprised 7 (63.6%) total cases, and 2 of those cases involved firearms, while 3 were due to bodily force, and in 2 cases the weapon type was unknown. Suicides comprised 4 (36.4%) of the cases, and all 4 suicide deaths involved firearms. Additional information regarding these homicide and suicide incidents is referenced in Tables 4 and 4.1

Inflicted Trauma Data Summary

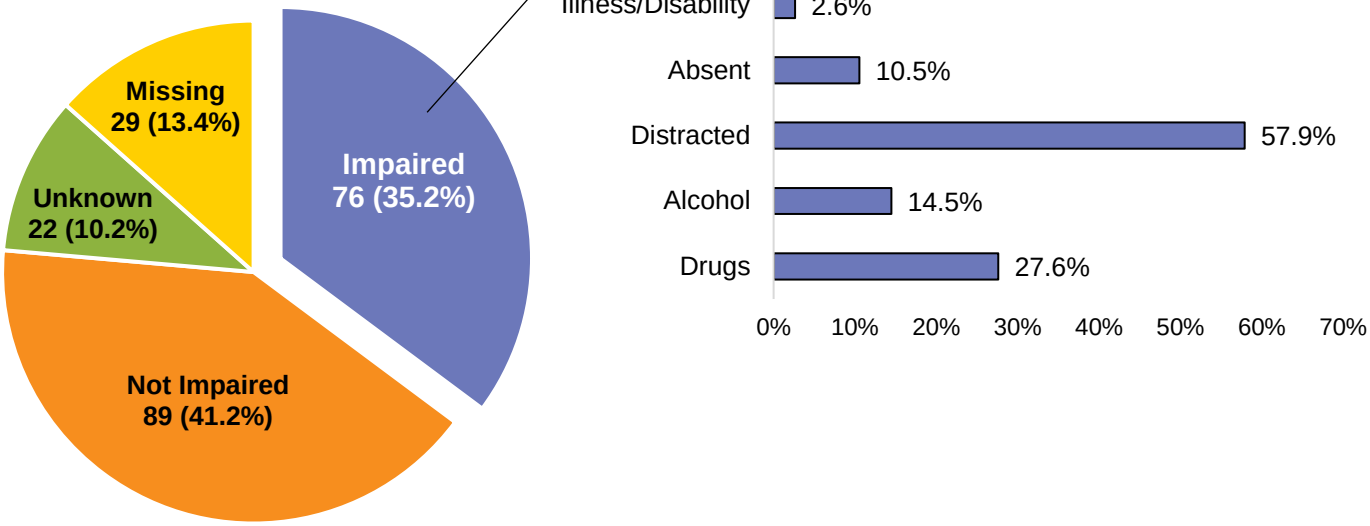
- ***70.0% of verified maltreatment homicides were the result of inflicted trauma.***
- ***54.5% of weapons utilized in cases of inflicted trauma death were firearms (handguns).***
- ***In the 6 cases where a firearm was used, 2 were homicide incidents and 4 were suicide incidents.***
- ***27.3% of inflicted trauma cases involved body parts or bodily force.***

Supervisor Impairment

Information is collected regarding whether the supervisor of the child at the time of the death incident was impaired. Figure 20 provides the distribution of impairment type among cases where a supervisor was impaired. More than one type of impairment can be present for a single supervisor at the time of incident.

Supervisors were found to be impaired in 76 (35.2%) cases and not impaired in 89 (41.2%) cases, whereas impairment status was unknown or missing in 51 (23.6%) cases. The most common type of impairment among supervisors was found to be distraction (57.9%), followed by drugs (27.6%) and alcohol (14.5%).

Figure 20: Supervisor Impairment at Time of Incident (n=216)



Supervisor Types of Impairment Data Summary

At the time of the incident:

- ***76 of 216 supervisors (35.2%) were impaired.***
- ***Most supervisors who were indicated to be impaired (57.9%) were found to be distracted.***
- ***27.6% supervisors found to be impaired indicated influence of drugs.***
- ***14.5% supervisors found to be impaired indicated influence of alcohol.***

Limitations

There are several important limitations to consider when interpreting the data in this report. First, the report only includes cases which have been reviewed and have completed data entry into the NFR-CRS. The degree to which the data are representative of all child death cases reported to and investigated by DCF each year is highly dependent on the proportion of total cases that have complete data entry and are available for analysis at the time of data extraction for the report. In the 2022 CADR Annual Report, less than half (48%) of total 2021 cases were completed in the NFR-CRS.

A second limitation to these data is the occurrence of missing and/or unknown values. Missing data values generally occur when a question in the NFR-CRS is left unanswered, resulting in variables without observations. This is similar but distinct from unknown data values, which result from questions in the NFR-CRS that allow for a response of unknown as a valid observation when information from case file review is insufficient to make a definitive selection. Both missing and unknown data values reflect a lack of information, and both may introduce bias into the results of analysis, as certain types of cases or subgroups in the data may become underrepresented.

Finally, small sample size is a considerable limitation for several analyses in this report. While the overall sample of cases (n=216) is not problematically small from a statistical perspective, this sample is broken down into smaller subgroups throughout the report that are then further stratified by variables of interest. Increasingly smaller subgroups in the data can result in estimates (percentages, rates, etc.) that are highly unstable and may not be suitable for making comparisons and drawing conclusions about statistical relationships. Estimates that are calculated with a numerator less than 5 or with a denominator less than 20 should be interpreted with caution and should not be used to infer statistical associations.

SECTION FOUR: SUPPLEMENTAL ANALYTIC REPORTS

The 2022 CADR Annual Report presents the results of systematic analysis of child fatality review cases in Florida which is critically important for the future development and implementation of strategic initiatives around child death prevention. Detailed analysis of these data coupled with a critical appraisal of past and current prevention initiatives will be instrumental in evaluating and distinguishing the effectiveness of select prevention strategies.

In-depth Supplemental Analysis of Florida's CADR Database (2014-2022)

The Division of Children's Medical Services' (CMS) Epidemiology Unit, in partnership with the CADR Program team and State and Local CADR Committees, will continue to actively perform focused analyses on continuing or emerging issues in child deaths observed in the CADR database. Reports and other data products used to disseminate the results of these analyses will be structured to provide in-depth breakdowns of child deaths relating to safe sleep practices, water safety, inflicted trauma, and other related topics. Analytic projects will also be guided by questions and feedback generated from ongoing data analysis and CADR stakeholders. These focused reports will also aim to explore, where feasible, data elements that are underreported such as child/adolescent suicide, mental health, and substance abuse. The focused reports will be designed with the intent on empowering child fatality prevention stakeholders with data-driven evidence to shape program and policy efforts at the local, state, and potentially national levels.

Finalized Focused Reports for the 2022 Reporting Year:

Comparing asphyxia and unexplained causes of death: a retrospective cohort analysis of sleep-related infant death cases from a state child fatality review program.

Megan Macdonald, Daniel Thompson, Robin Perry, Robert Brooks

ABSTRACT

Objectives: To examine the characteristics and circumstances of infants who died while sleeping or in a sleep environment and compare deaths classified as either unintentional asphyxia or an unexplained cause.

Design: A retrospective cohort study.

Setting: Data were extracted from the National Fatality Review Case Reporting System and Florida Vital Statistics databases.

Participants: Data on 778 sleep-related infant deaths occurring from 2014 to 2018 in Florida were analyzed.

Primary outcome measure: Cause of death classification as unintentional asphyxia or unexplained.

Results: Overall, 36% (n=276) of sleep-related infant deaths in this study sample were classified as resulting from an unexplained cause compared with unintentional asphyxia. Most infants were reported to be in an adult bed (60%; n=464) and sharing a sleep surface with a person or animal (60%; n=468); less than half (44%; n=343) were reportedly placed to sleep on their back. After controlling for the influence of other independent variables, female sex

(adjusted risk ratio: 1.36; 95% CI 1.06 to 1.74) and fully obstructed airway condition (adjusted risk ratio: 0.30; 95% CI 0.18 to 0.50) were associated with an unexplained cause of death.

Conclusions: The results of this analysis indicate that sleep environment hazards remain prevalent among infants who die suddenly and unexpectedly, regardless of the cause of death determination. While significant differences were observed for some factors, in many others the distributions of both demographic and incident characteristics were similar between unexplained deaths and those resulting from asphyxia. The results of this study support growing evidence that unsafe sleep environments contribute to all forms of sudden unexpected infant death, underscoring the need for standardizing cause of death determination practices and promoting consistent, high-quality forensic investigations to accurately explain, monitor, and prevent these deaths.

This study was published in the British Medical Journal (BMJ) Open, and the full-text article can be accessed at the following link: https://bmjopen.bmj.com/content/12/9/e059745.long.

Proposed Focused Reports for the 2023 Reporting Year:

- Inflicted Trauma
    - A comprehensive multi-year analysis of child deaths resulting from inflicted physical trauma with a body part or weapon will be produced within the first quarter of 2023. This report will provide enhanced analysis of inflicted trauma cases to examine cause and manner of death, child and caregiver/supervisor information and history, weapon type, incident characteristics, and other relevant factors. The multi-year structure of the data for this report will overcome some of the limitations of reporting the same data elements on an annual basis, such as small sample size and incomplete case review or data entry on a significant proportion of total cases. A retrospective examination of case closure and review timelines for inflicted trauma cases will also be conducted on complete data years to estimate delays in timely case entry into the NFR-CRS database.
- Caregiver History in Verified Maltreatment Cases
    - A thorough analysis of caregiver background will be performed on cases of verified child maltreatment death. The data sample for this analysis will include verified abuse and neglect deaths of all causes and manners. The report will examine a variety of data elements that capture important information about caregivers of children in Florida who die from abuse or neglect, including basic demographic characteristics, social-economic factors, mental health and substance abuse history, past history of maltreatment as perpetrator or victim, past criminal history, and other relevant factors.
- Trends in Case Investigation, Review and Data Entry Processes
    - At the time of data extraction for the current year's annual report, less than half of total cases for the year had complete data entry in the NRF-CRS. The continually decreasing number of cases available for the annual report each year highlights a significant issue for the integrity of annual CADR reports, as the data in the report will become less representative of the total cases for the year as the proportion of cases with complete data decreases. This supplemental analysis will examine trends in the proportions of cases at the time of annual reporting that:
        - Have been closed by DCF.
        - Are available for local CADR committees to review.
        - Have completed reviews.

        - Have competed case data entry in the NFR-CRS.
    - The data and trends to be analyzed in this report are intended to help inform State and Local CADR Committee members of irregularities among case review status and completion from year to year that hinder analysis of the data, as well as to improve efforts for consistent timely completion of case review and data entry for each year's Annual Report. Sequentially, the increased accessibility of cases reviewed and availability for each year's Annual Report would aid in providing a more representative sample of preventable child deaths and more accurately informing the efforts of both State and Local CADR Committees and other stakeholders in child fatality prevention.
    - In order to improve the quality of the data in future reports, it is important to develop an action plan that would help mitigate the decreasing availability of reviewed cases which is currently impacting the ability to perform more accurate and representative analyses of child fatalities.

Emphasis on data access and collaboration

A primary focus of the State CADR Committee is to continue enhancing data infrastructure with an emphasis on accessibility. Permitting state and local CADR stakeholders to guide data-driven prevention strategies will require significant efforts on understanding the current state of the data. Upon request, CADR staff performs queries regarding individual circuit level data with advanced comparisons to statewide CADR data as well as vital statistics information.
While the CADR Annual Report currently contains a robust collection of variables reflecting the causes and contributing factors of child deaths called into the Florida Abuse Hotline, the NFR-CRS is an expansive database that contains additional elements allowing for further data analyses. CADR staff welcomes any questions or data queries regarding elements that are found within the reporting form, but not represented in the CADR Annual Report. These questions can be instrumental in detecting data elements that are underreported and identifying specific local and regional trends associated with child deaths. A strong data-driven relationship between state and local CADR stakeholders is imperative to the implementation of prevention initiatives.

SECTION FIVE: 2022 CADR SUMMIT

Bringing together CADR leadership, members, and partners face-to-face for the first time in two years, the 2022 CADR Annual Summit provided valuable opportunities for new members and partners to connect and network with established and experienced CADR leaders and staff.

The theme of the 2022 CADR Annual Summit, Bridging the Gap, engaged stakeholders in developing a deeper understanding of how critical factors, such as health equity, community engagement, committee accountability, and prevention recommendations can contribute to the overarching goal of CADR, to eliminate preventable child death in Florida.

Lesline Anglade-Dorleans, JD, introduced the Family Navigator Program, newly implemented by DCF, demonstrating innovative approaches to community engagement and child maltreatment prevention.

Heather Dykstra, epidemiologist with the National Center for Fatality Review and Prevention, provided a valuable examination of CADR data quality, introduced new data tools, and highlighted advancement in data collection and analysis.

Megan Macdonald, epidemiologist with DOH Division of CMS, provided a presentation, The Impact of Data Quality on Child Death Review Analysis, which gave an in-depth overview of critical components of data quality including consistency, accuracy, completeness, and timeliness, presenting each component with examples and visuals for added clarity.

Stacey Hoaglund, Executive Director of Autism Society of Florida, contributed a presentation, Key Steps to Altering the Serious Drowning Statistic of Children with Autism, providing a valuable opportunity to examine specific prevention needs to effectively address families of children with autism.

Dr. Randell Alexander, Professor and Chief for the Division of Child Protection and Forensic Pediatrics at the University of Florida, College of Medicine-Jacksonville, introduced a child abuse prevention initiative, No Hit Zones, during a presentation provided at the Summit. Attendees learned about opportunities to designate No Hit Zones in their communities and were provided guidance and programmatic support for implementing this exciting initiative.

Ret. Major and current State CADR Chairperson, Connie Shingledecker, provided a presentation on Sudden Unexpected Infant Death Investigation Reporting Form (SUIDI-RF) Utilization, Completion, and Impact on Data Collection and Analysis. During the presentation, materials used during SUIDI trainings were made available for participants to examine.

A panel discussion examined how health equity presents in the child fatality review setting and ways to increase health equity in the work of CADR and stakeholder organizations. Panelists contributing to this discussion included Sasha Mintz, Abby Collier, Stacey Hoaglund, and Dr. Randell Alexander. Panelists discussed the under-representation of children with disabilities in drowning prevention efforts, how health equity is addressed in data collection and case review process, as well as many socio-economic factors contributing to health disparities affecting children and families.

The 2022 CADR Annual Summit presentations are available to be viewed and shared at www.FLCADR.com.

SECTION SIX: IMPLEMENTATION OF 2021 PREVENTION RECOMMENDATIONS

CADR 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 2021 Prevention Recommendations developed by the State CADR Committee.

The Circuit 10 Local CADR Committee displayed safe sleep billboards in four locations throughout Polk County from April through July 2022. To promote health equity, Circuit 10 also hosted a Melanin Families Matter virtual panel titled Hope During a Health Decline. Panelists included the Polk County Health Officer as well as other clinical service providers in the community. Topics impacting infant mortality including premature birth, low birthweight, birth defects, safe sleep practices, and breastfeeding were discussed. March 2022 was proclaimed Melanin Families Matter Month by City of Winter Haven, City of Lakeland, and Polk County Board of County Commissioners.

Circuit 15 Local CADR Committee partnered with community providers including BRIDGES, Healthy Mothers, Healthy Babies and Women's Health Initiative Programs to jointly host a baby shower, Bows and Bowties. The focus on this event was to build parent and community capacity in ten geographic areas within the Palm Beach County area, with a specific focus on areas demonstrating disparities in early childhood outcomes.

Many Local CADR Committees throughout the state partner with DOH and community providers to host monthly baby shower events providing new and expectant parents with baby items, educational materials, newborn care information, and resources to promote newborn safety with a focus on safe sleep education.

Circuit 12 Local CADR Committee worked collaboratively with the Manatee County Sheriff's Office to promote safe sleep education in the community by displaying posters at convenience stores and gas pump toppers in both English and Spanish. Additionally, they promoted safe sleep by submitting informative articles for publication in the NEXTGEN Family Magazine and the Bradenton Herald. This committee also partnered with the Manatee County Teen Parenting Program, providing presentations about infant safe sleep, and promoting physical abuse prevention through the Who Is Watching Your Child campaign.

In 2022, Circuit 12 Local CADR Committee, continued efforts in collaboration with the Manatee County Sheriff's Office providing education to recovery pod inmates at the Manatee County Jail, addressing a variety of child abuse and neglect prevention topics including substance exposed newborns, safe sleep, Who Is Watching Your Child, Period of Purple Crying, and the dangers of shaken baby or abusive head trauma.

Local CADR Committees continued efforts in drowning prevention outreach by promoting the Keep Kids Safe From Drowning project developed by the State CADR Committee in 2020. This effort was coordinated 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.

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 posters, door hangers, Water Watcher tags, and lanyards in both English and Spanish.

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. This effort includes the distribution of door alarms to families along with guidance for how to utilize this layer of prevention most effectively. 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.

As a result of increased child drowning fatalities in 2021, DOH collaborated with the University of South Florida (USF) to assess existing drowning prevention materials and conduct formative research to inform a multi-layered social marketing campaign to prevent child drowning. During the initial phase of this ongoing collaborative effort with USF, drowning prevention messaging developed by the State CADR Committee was displayed in Orlando International Airport to inform travelers within the airport of the need for vigilant supervision and water safety as well as interview travelers regarding current behaviors and thoughts around water safety. This effort addresses the ongoing and increasing issue of fatal child drownings among non-Florida residents.

Circuit 13 Local CADR Committee collaborated with community partners, Crisis Center of Tampa Baby to promote suicide prevention initiatives including utilization of 211, a 24-hour resource which provides care coordination and crisis intervention to those seeking assistance. Additionally, this committee worked with the Children’s Board of Hillsborough County to promote the Be Smart gun safety campaign.

These initiatives demonstrate the ongoing efforts of the State CADR Committee and Local CADR Committees to utilize CADR data to inform, develop, and implement effective prevention initiatives addressing the contributing factors of preventable child death.

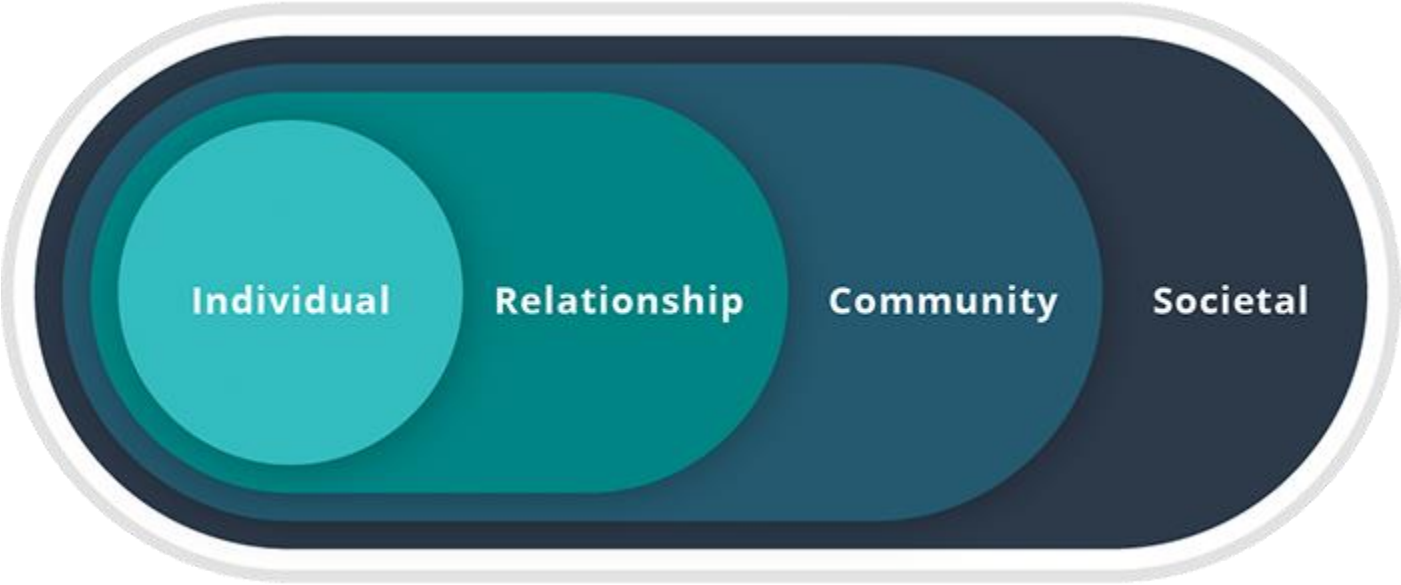
SECTION SEVEN: PREVENTION RECOMMENDATIONS

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 2022 State CADR Committee prevention recommendations are based on an analysis of CADR findings for the 2021 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 Centers for Disease Control and Prevention (CDC), demonstrates how behaviors are formed based on characteristics of individuals, relationships, communities, and societal factors. To develop effective prevention strategies, it is necessary to address each level of the model, and most effective to act across multiple levels at the same time, as one level influences another. This approach can contribute to more sustainable prevention over time and achieve a greater impact.

The 2022 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 to provide 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 critical messaging and the likelihood of parents and caregivers utilizing information obtained to make informed decisions regarding the safety and wellbeing of children.

  Partnerships with home-visiting providers, such as DCF and Healthy Families Florida, who have the unique opportunity to engage with families inside their homes, assessing for potential risks and providing specific education and support to caregivers, are an important link to ensuring key messaging reaches caregivers in a timely and applicable 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 and expanding partner networks.
  - Using research as a foundation for information and messaging priorities.
  - Coordinating statewide efforts to utilize standardized prevention tool kits promoting consistent messaging.
  - Support utilization of social media content for sharing prevention-related information.

- **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)[1] 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.

- **Analyze efforts to improve data collection and assessment of factors contributing to preventable child fatalities which are currently underrepresented in CADR data.**

  The current CADR data collection tool presents opportunities for examining circumstances not currently captured therein through the addition of state-specific data collection elements. Incorporating Florida-specific questions to the data collection tool will allow additional analysis of data not currently examined during the CADR process, including, but not limited to, incidents of hot-car and intimate partner violence-related child fatalities.

  Inflicted trauma and child homicides are largely underrepresented in the CADR Annual Report. These cases often require lengthy criminal investigation and court proceedings resulting in a delay of these cases being available for inclusion in the report sample. To address this issue, the State CADR Committee recommends conducting multi-year trend analysis to further examine facts and circumstances of inflicted trauma and child homicides.

  With this recommendation, the State CADR Committee demonstrates its commitment to effectively and consistently address gaps in the data collection process and promote the continued development of community-level prevention initiatives based on comprehensive data.

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

[1] 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

CADR data demonstrate that drowning deaths among young children ages one to five years, most frequently occur during non-swim-time activities. Inadequate supervision and breached barriers to pools and other bodies of water continue to be the primary factors associated with child drowning deaths. Inadequate supervision can include caregivers who are present but distracted (e.g. using a cell phone, reading, conversing, or otherwise not maintaining visual contact with a child in the water), as well as caregivers who are not within visible and audible range when a child is in or near water. 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 five and the potential risk such expectations may have for drowning. The State CADR Committee endorses AAP recommendations and encourages statewide integration of the recommendations as a part of a comprehensive drowning prevention strategy.

The State CADR Committee supports the implementation of Keep Kids Safe From Drowning pilot project in the eight leading counties demonstrating the highest rates of child drowning incidents. The messaging incorporated in Keep Kids Safe From Drowning is in alignment with AAP recommendations as well as Florida CADR data which demonstrates the primary factors associated with swim-time and non-swim-time drowning, specifically for young children ages five and under.

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

  Under Florida's Family First Prevention Services Act (FFPSA),[2] DCF has worked with community and child welfare stakeholders to identify available evidence-based services with the goal of leveraging and expanding service arrays to meet the needs of children and families. Family First Transition Act provides funding to support training in the following evidence-based programs to support capacity building in communities statewide: Homebuilders, Motivational Interviewing, Multisystemic Therapy, and Parent-Child Interaction Therapy.

  Under FFPSA, federal Title IV-E funds can be drawn down to support prevention services for families who are at-risk. The State CADR Committee strongly recommends state agencies (DOH, DCF, Agency for Health Care Administration) strengthen partnerships and collaborations to ensure that families are referred to evidence-based parent coaching and support programs. The most recent home visiting needs assessment, conducted by the DOH 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.

[2] 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

Additionally, the State CADR Committee supports programs, such as the DCF Family Navigation Program, which enhances the collaboration of community service providers and resources made available to caregivers in an effort to provide the right service or resource at the right time, to prevent child abuse and neglect.

- **Advocate for statewide training of 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 supports the implementation of the SUIDI Advocacy Project to be implemented by Local CADR Committees statewide. The SUIDI Advocacy Project will provide support and resources to promote SUIDI training opportunities and consistent completion of the SUIDIRF and doll reenactments.

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

  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.

  Two promising pilot projects include Keep Kids Safe From Drowning and Sleep Baby Safely.

  CADR data demonstrate drowning as the second leading cause of preventable child death over the last five years, as reported to the Florida Abuse Hotline and the leading cause of injury death among children ages one to four. The Keep Kids Safe From Drowning prevention pilot project was implemented in April 2021 throughout eight Florida counties demonstrating the highest incidence of child drowning over the past three years. These counties include Broward, Polk, Orange, Hillsborough, Palm Beach, Duval, Volusia, and Miami-Dade. The State CADR Committee supports the continuation and expansion of this program and its mission to partner with local service providers in the distribution of Keep Kids Safe From Drowning prevention materials including posters, flyers, door clings, water watcher tags and lanyards, and to include the distribution of home door alarms for caregivers residing at, or near, a pool, canal, retention pond or other bodies of water. The Keep Kids Safe From Drowning prevention pilot program addresses both swim-time and non-swim-time related drownings and highlights the primary factors contributing to drowning among young children with the overall objective of reducing or eliminating child drowning.

The State CADR Committee supports the continuation and expansion of the Sleep Baby Safely pilot project, initially developed and implemented in Pinellas County and replicated in Duval County, demonstrating promising indicators of efficacy in reducing sleep-related infant death. This pilot project will be implemented in the eight counties demonstrating the highest number of sleep-related infant deaths over the past three years including Broward, Duval, Miami-Dade, Hillsborough, Orange, Palm Beach, Pinellas, and Polk. In addition, the State CADR Committee supports the replication of this pilot program in Columbia County, providing a first opportunity to implement this comprehensive safe sleep project in a rural area of the state. The Sleep Baby Safely project provides face-to-face safe sleep education and information, increasing caregivers' knowledge regarding actionable steps to reducing the risk of sleep-related infant death. The clear messaging utilized in this project is replicated in printed materials and on imprinted baby-related items including a Welcome Baby Bag, This Side Up onesie, Sleep Baby Safe and Snug Board Book, ABCs of Safe Sleep imprinted nightlight, outlet plug covers, and sleep sack. The Sleep Baby Safely project provides this information and Welcome Baby Bag to every new parent in the county where it is implemented, providing a comprehensive and widespread approach to safe sleep education.

The State CADR Committee is committed to ongoing assessment and support of Local CADR prevention initiatives developed in response to community needs as demonstrated through CADR data analysis.

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

  Child and adolescent suicides in Florida remain a grave concern of the State and Local CADR Committees. 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 2022

Appendix A: State and Local Committee Membership

Appendix B: Case Reporting Form Version 6.0

Child Abuse Death Review Committee

Working to eliminate preventable child abuse and neglect deaths in Florida

APPENDIX A:

State and Local Committee Membership

Florida Child Abuse Death Review State Committee Membership

Social Worker
Vicki Whitfield, BSW

Department of Health
Carol Ann Wegner-Vitani, BS, RN

Department of Legal Affairs
Richard Mantei

Department of Children and Families
Stephanie Weis

Department of Law Enforcement
Jeremy Gordon, Special Agent Supervisor

Department of Education
Vacant

Florida Prosecuting Attorneys Association
Dawn Buff, Assistant State Attorney

Florida Medical Examiners Commission
Shanedelle Norford, MD, MS

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

Public Health Nurse
Merlene Ramnon, PhD, MPH, MSN, RN

Mental Health Professional
Rachel Smith, MSW

Department of Children and Families Supervisor
Vacant

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

Child Advocacy Organization
Rebecca Albert, MSW

Paraprofessional in Patient Resources, Child Abuse Prevention Program
Maria Lesvia Alaniz

Law Enforcement Officer
Ret. Major Connie Shingledecker, Chairperson

Department of Children and Families Office of Domestic Violence
Cynthia Rubenstein, MS, LMHC

Child Abuse Prevention Program
Rebekkah Sheetz, MSW

Substance Abuse Professional
Silvia Quintana, LMHC, CAP

Florida Child Abuse Death Review Local Committee Leadership

Committee 1A
Claire Kirchharr, MPH, CPH
Kirsten Bucey
R. Matthew Dobson, MS

Committee 1B
Solange Arnett
Cheryl Canipe
Elizabeth Smith, BSN, RN

Committee 2
Holly Kirsch, LD, RD

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
Shane Lockwood, MPH, BSPH

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

Committee 9
Ilvia Ortiz-Paez
Brianne Bell
Anne Johnson, BSN, MN
Robert Karch, MD, MPH, FAAP
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
Carla McGill
Jennifer Bencie, MD, MSA

Committee 12B
Laura Carson, MA
Catherine Duff
Jennifer Bencie, MD, MSA

Committee 13
Barbara Marcelli
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
Caroline Vinyard, LMHC, MBA
Carol Ann Wegener-Vitani, RN, BS

Committee 20
Francine Donnorummo, JD
Julie Noble, MMSM, CPST
Lisa Adamczyk, DNP, RN, APRN, NEA-BC
Kim Kossler, MPH, RN, CPH

APPENDIX B:

CASE REPORTING FORM VERSION 6.0

NATIONAL CFRP
Center for Fatality Review & Prevention

Saving Lives Together

CDR REPORT FORM

Version 6.0

National Fatality Review Case Reporting System

Data Entry Website: data.ncfrp.org
Phone: 800-656-2434
Email: info@ncfrp.org
ncfrp.org
@nationalcfrp

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** as a PDF in the Help menu or as individual help icons in the online data entry system. 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.

Throughout the form, a plus sign (+) beside a question indicates that the question is skipped for fetal deaths.

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)

A * symbol means that the question is skipped for fetal deaths.

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

6. Hispanic or Latino/a 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/A ○ Yes, # ____ ○ No ○ U/K

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

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

17. Household income:
○ High ○ Medium ○ Low ○ U/K

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

18. 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

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

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

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

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

23. Child had history of child maltreatment as victim? ○ Yes ○ No ○ U/K
If yes, check all that apply:
☐ Physical
☐ Neglect
☐ Sexual
☐ Emotional/psychological
☐ U/K
If yes, how was history identified:
○ Through CPS
○ Other sources
If through CPS:
____ # CPS referrals
____ # Substantiations

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

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

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

A2. COMPLETE FOR CHILDREN OVER ONE YEAR OLD

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

28. Child's work status:
○ N/A
○ Employed
○ Not working
○ U/K

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

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

31. 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

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

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

34. 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

35. 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 mental health appointment within 30 days of discharge from the hospital?
○ Yes ○ No ○ U/K

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

37. 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?
○ Yes ○ No ○ U/K
If yes, type? Check all that apply:
☐ Outpatient ☐ Day treatment/partial hospital
☐ Inpatient/detox ☐ Residential
If yes, age at first use: _____ ☐ U/K

38. Child had delinquent or criminal history?
○ N/A ○ Yes ○ No ○ U/K
If yes, check all that apply:
☐ Assault ☐ Weapon offense
☐ Robbery/theft
☐ Drugs/alcohol ☐ Other, specify:
☐ Misbehavior ☐ U/K (truancy, destruction of property, trespassing)

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

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

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

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

A3. COMPLETE FOR ALL FETAL/INFANTS UNDER ONE YEAR

A + symbol means that the question is skipped for fetal deaths.

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

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

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

46. Multiple gestation pregnancy?
○ Yes, # of fetuses _____
○ No ○ U/K

47. Including the deceased infant, how many pregnancies did the childbearing parent have? # ___ ☐ U/K

48. Including the deceased infant, how many live births did the childbearing parent have? # _____ ☐ U/K

49. Not including the deceased infant, number of children childbearing parent still has living?
_____ ☐ U/K

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

51. Were there access or barrier 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
☐ 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 they were pregnant
☐ Other, specify:
☐ U/K

52. During pregnancy, did the childbearing parent 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
☐ Sickle cell disease
☐ Anemia (iron deficiency)

Respiratory
☐ Asthma

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

Neurologic/Psychiatric
☐ Addiction 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
☐ Intrauterine growth restriction (IUGR)
☐ Premature rupture of membranes (PROM)
☐ Preterm premature rupture of membranes (PPROM)
☐ Cervical insufficiency

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

Gynecologic (continued)

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

Other Condition/Complication
☐ UTI
☐ Decreased fetal movement
☐ HELLP syndrome
☐ CBP developmental delay
☐ Oral health/dental or gum infection
☐ Gastrointestinal
☐ CBP genetic disorder
☐ Abnormal MSAFP
☐ Preterm labor
☐ Obesity
☐ Other, specify:

53. Did the childbearing parent experience any medical complications in previous pregnancies?

○ N/A ○ Yes ○ No ○ U/K

If yes, check all that apply: ☐ Previous preterm birth ☐ Previous low birth weight birth ☐ Previous small for gestational age ☐ Previous large for gestational age (greater than 4000 grams)

54. Did the childbearing parent 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	☐ Meds to treat preterm labor	☐ Marijuana	☐ Other pain meds
☐ Anti-depressants/ anti-anxiety/ anti-psychotics	☐ Arthritis medications	☐ Meds used during delivery	☐ Methamphetamine	☐ Other, specify:
	☐ Diabetes medications	☐ Progesterone/P17	☐ Alcohol	☐ U/K
	☐ Asthma medications		☐ 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:

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

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

57. Level of birth hospital:

○ 1
○ 2
○ 3
○ 4
○ Freestanding birth center
○ Home birth
○ Other, specify:
○ U/K

58. At discharge from the birth hospital, was a case manager assigned to the childbearing parent?

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

59. Did the childbearing parent have contact with their care provider within the first 3 weeks postpartum?

○ Yes ○ No ○ U/K

60. 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

61. Did the childbearing parent smoke in the 3 months before pregnancy?

○ Yes ○ No ○ U/K

If yes, ___ Avg # cigarettes/day (20 cigarettes in pack) ☐ U/K quantity

62. Did the childbearing parent smoke at any time during pregnancy?

○ Yes ○ No ○ U/K

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

63. Did the childbearing parent 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

64. Was the childbearing parent injured during pregnancy?

○ Yes ○ No ○ U/K If yes, describe:

65. Did the childbearing parent have postpartum depression?

○ Yes ○ No ○ U/K

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

66. 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

67. 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.

68. 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	

69. In the 72 hours prior to death, did the infant have any of the following?

Check all that apply:

☐ None	☐ Decrease in appetite	☐ Difficulty breathing
☐ Fever	☐ Vomiting	☐ Apnea
☐ Excessive sweating	☐ Choking	☐ Cyanosis
☐ Lethargy/sleeping more than usual	☐ Diarrhea	☐ Seizures or convulsions
	☐ Stool changes	☐ Other, specify:
☐ Fussiness/excessive crying		☐ U/K

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

○ Yes ○ No ○ U/K

If yes, describe cause and injuries:

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

○ Yes ○ No ○ U/K

If yes, list name(s) of vaccines:

72. 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:

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

☐ Breast milk
☐ Formula
☐ Baby food
☐ Cereal
☐ 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.

Childbearing Biological Parent (CBP) alive: ○ Yes ○ No ○ U/K

Non-Childbearing Biological Parent (Non-CBP) alive: ○ Yes ○ No ○ U/K

2. Parents' race, check all that apply:

CBP	Non-CBP	
☐	☐	Alaska Native, Tribe:
☐	☐	American Indian, Tribe:
☐	☐	Asian, specify:
☐	☐	Black
☐	☐	Native Hawaiian
☐	☐	Pacific Islander, specify:
☐	☐	White
☐	☐	U/K

3. Parents' Hispanic or Latino/a origin?

CBP	Non-CBP	
○	○	Yes, specify origin:
○	○	No
○	○	U/K

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

CBP	Non-CBP	
____	____	# Years
☐	☐	U/K

5. Parents' employment status:

CBP	Non-CBP	
○	○	Employed
○	○	Unemployed
○	○	On disability
○	○	Stay-at-home
○	○	Retired
○	○	U/K

6. Parents' education:

CBP	Non-CBP	
○	○	< High school
○	○	High school/GED
○	○	College
○	○	Post graduate
○	○	U/K

7. Parents speak and understand English?

CBP	Non-CBP	
○	○	Yes
○	○	No
○	○	U/K

If no, language spoken:

8. Parents first generation immigrant?

CBP	Non-CBP	
○	○	Yes, country of origin:
○	○	No
○	○	U/K

9. Parents on active military duty?

CBP	Non-CBP	
○	○	Yes, specify branch:
○	○	No
○	○	U/K

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

CBP	Non-CBP				
○	○	Yes	If yes, check all that apply below:		
○	○	No			
○	○	U/K			
☐	☐	WIC	☐	☐	Section 8/housing
☐	☐	Home visiting, specify:	☐	☐	Social Security Disability Insurance (SSI/SSDI)
☐	☐	TANF			
☐	☐	Medicaid	☐	☐	Other, specify:
☐	☐	Food stamps/SNAP/EBT	☐	☐	U/K

11. Parents have substance abuse history?

CBP	Non-CBP	
○	○	Yes
○	○	No
○	○	U/K

12. Parents ever victim of child maltreatment?

CBP	Non-CBP	
○	○	Yes
○	○	No
○	○	U/K

13. Parents ever perpetrator of maltreatment?

CBP	Non-CBP	
○	○	Yes
○	○	No
○	○	U/K

14. Parents have disability or chronic illness?

CBP	Non-CBP	
○	○	Yes
○	○	No
○	○	U/K

15. Parents have prior child deaths?

CBP	Non-CBP	
○	○	Yes
○	○	No
○	○	U/K

16. Parents have history of intimate partner violence?

CBP	Non-CBP	
☐	☐	Yes, as victim
☐	☐	Yes, as perpetrator
☐	☐	No
☐	☐	U/K

17. Parents have delinquent/criminal history?

CBP	Non-CBP	
○	○	Yes
○	○	No
○	○	U/K

C. PRIMARY CAREGIVER(S) INFORMATION

If fetal death, skip to Section D.

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
○	○	Childbearing parent, go to Section D	○	○	Parent's partner	○	○	Friend
○	○	Non-childbearing biological parent, go to Section D	○	○	Grandparent	○	○	Institutional staff
			○	○	Sibling	○	○	Other, specify:
○	○	Adoptive parent						
○	○	Stepparent				○	○	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	
☐	☐	Alaska Native, Tribe:	☐	☐	Pacific Islander, specify:
☐	☐	American Indian, Tribe:			
☐	☐	Asian, specify:	☐	☐	White
☐	☐	Black	☐	☐	U/K
☐	☐	Native Hawaiian			

5. Caregiver(s) Hispanic or Latino/a 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) education:

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

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

One	Two	
○	○	Yes
○	○	No
○	○	U/K

If no, language spoken:

9. Caregiver(s) first generation immigrant?

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

10. Caregiver(s) on active military duty?

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

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

One	Two	
○	○	Yes
○	○	No
○	○	U/K

If yes, check all services that apply:

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

12. Caregiver(s) have substance abuse history?

One	Two	
○	○	Yes
○	○	No
○	○	U/K

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

One	Two	
○	○	Yes
○	○	No
○	○	U/K

14. Caregiver(s) ever perpetrator of maltreatment?

One	Two	
○	○	Yes
○	○	No
○	○	U/K

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

One	Two	
○	○	Yes
○	○	No
○	○	U/K

16. Caregiver(s) have prior child deaths?

One	Two	
○	○	Yes
○	○	No
○	○	U/K

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

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

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

One	Two	
○	○	Yes
○	○	No
○	○	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, childbearing parent, go to D15
   - ○ Yes, non-childbearing biological parent, 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	○ Sibling	○ Institutional staff, go to D15
○ Stepparent	○ Other relative	○ Babysitter
○ Foster parent	○ Friend	○ Licensed child care worker
○ Parent's partner	○ Acquaintance	○ Other, specify:
○ Grandparent	○ Hospital staff, go to D15	○ U/K

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

10. Supervisor has history of child maltreatment?

As Victim	As Perpetrator	
○	○	Yes
○	○	No
○	○	U/K

11. Supervisor has disability or chronic illness? ○ Yes ○ No ○ U/K

12. Supervisor has prior child deaths? ○ Yes ○ No ○ 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

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

Answer only E7 if the child never left the hospital following birth

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

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
   - ☐ Other caretaker/babysitter
   - ☐ Teacher/coach/athletic trainer
   - ☐ Other acquaintance
   - ☐ Health care professional, if death occurred in a hospital setting
   - ☐ Stranger
   - ☐ Other, specify:

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

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

    If yes, type of resuscitation:
    - ☐ CPR
    - ☐ Automated External Defibrillator (AED)
      - If no AED, was AED available/accessible? ○ Yes ○ No ○ U/K
      - If AED, was shock administered? ○ Yes ○ No ○ U/K
        - If yes, how many shocks were administered?_____
    - ☐ Rescue medications, including naloxone, 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?
    ○ N/A ○ Yes ○ No ○ U/K
    If yes, check all that apply:
    - ☐ Alcohol
    - ☐ Cocaine
    - ☐ Marijuana
    - ☐ Methamphetamine
    - ☐ Opioids
    - ☐ Prescription drugs
    - ☐ Over-the-counter drugs
    - ☐ Other, specify:
    - ☐ U/K

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
    - ____ Adults
    - ☐ U/K

F. INVESTIGATION INFORMATION

A + symbol means that the question is skipped for fetal deaths.

1. Was a death investigation conducted+? ○ Yes ○ No ○ U/K
   If yes, check all that apply:
   - ☐ Medical examiner
   - ☐ Coroner
   - ☐ ME investigator
   - ☐ Coroner investigator
   - ☐ Law enforcement
   - ☐ Fire investigator
   - ☐ EMS
   - ☐ Child Protective Services
   - ☐ Other, specify:
   - ☐ 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*:
O Medical examiner O Not referred
O Coroner O U/K

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

5. Autopsy performed? O Yes O No O U/K
If yes, conducted by: O Forensic pathologist O Unknown type pathologist
O Pediatric pathologist O Other physician
O General pathologist O Other, specify:
O U/K
If yes, was a specialist consulted during autopsy (cardiac, neurology, etc.)?
O Yes O No O 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	O	O	O
X-ray - multiple views	O	O	O
X-ray - complete skeletal series	O	O	O
Other imaging, specify (includes MRI, CT scan, photos of the brain, etc):	O	O	O
External Exam:			
Exam of general appearance	O	O	O
Head circumference	O	O	O
Other Autopsy Procedures:			
Gross examination of organs done?	O	O	O
Were weights of any organs taken?	O	O	O

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	O	O	O
Microscopic/histologic exam	O	O	O
Postmortem metabolic screen	O	O	O
Vitreous testing	O	O	O
Genetic testing	O	O	O

8. Was any toxicology testing performed on the child? O Yes O No O U/K
If yes, what were the results? Check all that apply: ☐ Negative ☐ Cocaine ☐ Methamphetamine ☐ Too high Rx drug, specify: ☐ Other, specify:
☐ Alcohol ☐ Marijuana ☐ Opioids ☐ Too high OTC drug, specify: ☐ U/K

9. Was the child's medical history reviewed as part of the autopsy*? O Yes O No O U/K
If yes, did this include: Review of the newborn metabolic screen results? O Yes O No O U/K O Not performed
Review of neonatal CCHD screen results? O Yes O No O U/K O 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*? O N/A O Yes O No O U/K
If no, describe the differences:

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

14. Did the child ever have any injuries that were suspicious of child abuse*? O Yes O No O U/K
If yes, what injuries were found?
☐ Skin injury ☐ Broken bones ☐ Abdominal injury
☐ Mouth injury ☐ Head injury ☐ U/K
☐ Burns

15. Did any investigation find evidence of prior abuse*? O N/A O Yes O No O U/K
If yes, from what source?
☐ From x-rays ☐ From law enforcement
☐ From autopsy ☐ U/K
☐ From CPS review

16. CPS action taken because of death*? O N/A O Yes O No O U/K
If yes, highest level of action taken because of death:
O Report screened out and not investigated
O Unsubstantiated
O Inconclusive
O Substantiated
If yes, what services or actions resulted? Check all that apply:
☐ Voluntary services offered ☐ Court-ordered out of home placement
☐ Voluntary services provided ☐ Children removed
☐ Court-ordered services provided ☐ Parental rights terminated
☐ Voluntary out of home placement ☐ U/K

17. If death occurred in licensed setting (see E3), indicate action taken*:
O No action
O License suspended
O License revoked
O Investigation ongoing
O Other, specify:
O 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 1 of the 4 major categories, then a specific cause. For pending, choose most likely cause.

○ From an external cause of injury. Select one:

- ○ Motor vehicle and other transport, go to H1
- ○ Fire, burn, or electrocution, go to H2
- ○ Drowning, go to H3
- ○ Asphyxia, go to H4
- ○ Bodily force or weapon, 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 and go to H8:

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

○ 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/bus/school bus
○	○	Motorcycle
○	○	Tractor/farm vehicle
○	○	All terrain vehicle
○	○	Snowmobile
○	○	Bicycle
○	○	Train/subway/trolley
○	○	Other, specify:
○	○	U/K

	N/A	Autonomous? Yes	No	U/K
Child's vehicle	○	○	○	○
Other vehicle	○	○	○	○

b. Position of child:

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

If passenger, relationship of driver to child:

- ○ Biological parent
- ○ Adoptive parent
- ○ Stepparent
- ○ Foster parent
- ○ Parent's partner
- ○ Grandparent
- ○ Sibling
- ○ Other relative
- ○ Friend
- ○ Other, specify:
- ○ U/K

If bicycle, boarding/blading or other, was the child riding something electric?

○ Yes ○ No ○ U/K

c. Did any of the following contribute to the incident? Check all that apply:

- ☐ None listed below
- ☐ Speeding over limit
- ☐ Unsafe speed for conditions
- ☐ Recklessness
- ☐ Carelessness
- ☐ Racing, not authorized
- ☐ Drug use
- ☐ Alcohol use
- ☐ Vehicle ran over child
- ☐ Vehicle flipped over
- ☐ Poor weather
- ☐ Poor visibility
- ☐ Poor sight line
- ☐ Road hazard
- ☐ Car changing lanes
- ☐ Driver inexperience
- ☐ Electronic use e.g., cell phone, smart watch,in-car navigation
- ☐ Driver distraction
- ☐ Ran stop sign or red light
- ☐ Other driver error, specify:
- ☐ Other, specify:
- ☐ U/K

d. Location of incident, check all that apply:

- ☐ City street
- ☐ Residential street
- ☐ Rural road
- ☐ Highway
- ☐ Intersection
- ☐ Driveway
- ☐ Parking area
- ☐ Off road
- ☐ RR xing/tracks
- ☐ Other, specify:
- ☐ U/K

e. Did driving conditions factor into this incident?

○ Yes ○ No ○ U/K

If yes, check all that apply:

- ☐ Loose gravel
- ☐ Ice/snow
- ☐ Wet
- ☐ Inadequate lighting
- ☐ Other, specify:
- ☐ U/K

f. Incident type:
- ○ Child *not* in/on a vehicle, but struck by vehicle
- ○ Child in/on a vehicle, struck by the other vehicle
- ○ Child in/on a vehicle that struck the other vehicle
- ○ Child in/on a vehicle that struck person/ object/ran off the road
- ○ Other event, specify:
- ○ U/K

g. Driver who was responsible for the incident. Vehicles include motorized vehicles (cars, SUVs, motorbikes, etc) but also bicycles, skates, scooters, and other wheeled conveyances, whether motorized or not.
- ○ Child was responsible as driver of vehicle, including single vehicle incidents
- ○ Driver of child's vehicle was responsible, including single vehicle incidents
- ○ Driver of the other vehicle was responsible, including child as pedestrian hit by vehicle
- ○ Multiple drivers were responsible, go to j
- ○ Unable to determine driver responsible, go to j
- ○ Other, specify:
- ○ U/K

h. Age and license type of driver responsible for incident, check all that apply:

Age of Driver (if not child)
- ○ <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

License type/violation:
- ☐ Has no license
- ☐ Has a learner's permit
- ☐ Has a graduated license
- ☐ Has a full license
- ☐ Has a full license that has been restricted
- ☐ Has a suspended license
- ☐ Was violating graduated licensing rules
- ☐ Other, specify:
- ☐ U/K

i. Total number of occupants in vehicle responsible for incident:
- ☐ N/A

Total number of occupants: _____ ☐ U/K

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

j. Was a restraint or safety measure used by the child?
○ Yes ○ No ○ U/K

If yes, select the restraint or safety measures used:
- ☐ Lap/shoulder belt
- ☐ Child seat
- ☐ Belt positioning booster seat
- ☐ Helmet
- ☐ U/K

If yes, describe:

H2. FIRE, BURN, OR ELECTROCUTION

a. Ignition, heat or electrocution source:
- ○ Matches
- ○ Cigarette lighter
- ○ Cigarette or cigar
- ○ Candles
- ○ Cooking stove
- ○ Heating stove
- ○ Space heater
- ○ Power line
- ○ Electrical outlet
- ○ Electrical wiring
- ○ Lightning
- ○ Hot bath water
- ○ Other, specify:
- ○ U/K

b. Type of incident:
- ○ Fire, go to c
- ○ Scald, go to I1
- ○ Electrocution, go to o
- ○ U/K, go to I1

c. Type of building on fire:
- ○ N/A
- ○ Single home
- ○ Row home/townhouse
- ○ Multi-unit (duplex, apartment, condo)
- ○ Trailer/mobile home
- ○ Other, specify:
- ○ U/K

d. Fire started by a person?
○ Yes ○ No ○ U/K

If yes, person's age:

If yes, did the person have a history of starting fires?
○ Yes ○ No ○ U/K

If yes, suspected arson?
○ Yes ○ No ○ U/K

e. Did any factors delay fire department arrival?
○ Yes ○ No ○ U/K

If yes, specify:

f. Were barriers preventing safe exit?
○ Yes ○ No ○ U/K

If yes, check all that apply:
- ☐ Locked/blocked door
- ☐ Window security bars
- ☐ Locked/blocked window
- ☐ Blocked stairway
- ☐ Trapped above first floor
- ☐ Smoke/fire
- ☐ Household items/ hoarding
- ☐ Other, specify:
- ☐ U/K

g. Was the child found in the same location as where the fire started?
○ Yes ○ No ○ U/K

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

i. Were building/rental codes violated?
○ Yes ○ No ○ U/K

If yes, describe in narrative.

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

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

l. Was fire sprinkler system required?
○ Yes ○ No ○ U/K

m. Were smoke alarms present?
○ Yes ○ No ○ U/K

Were they functioning properly?
○ Yes ○ No ○ U/K

n. Did the child or family (check all that apply):
- ☐ None listed below
- ☐ Have a fire escape plan
- ☐ Practice a home fire drill
- ☐ Have two or more possible exits from the location as where the child was found
- ☐ Attempt to put out the fire
- ☐ U/K

o. For electrocution, what cause:
- ○ Lightning/electrical storm
- ○ Faulty wiring
- ○ Contact with power line
- ○ Wire/product in water
- ○ Child playing with outlet
- ○ Other, specify:
- ○ U/K

H3. DRUWNING

a. Where was child last seen before drowning? Select one.
- ○ In water
- ○ Near water
- ○ In yard
- ○ In bathroom/tub
- ○ In house
- ○ In car
- ○ Other, specify:
- ○ U/K

b. Drowning location:
- ○ Open water/pond, go to c
- ○ Pool, hot tub, spa, go to f
- ○ Bathtub, go to i1
- ○ Other, specify and go to h
- ○ U/K, go to h

c. For open water, place:
- ○ Lake ○ Ocean
- ○ River ○ Quarry or gravel pit
- ○ Pond ○ Canal/drainage ditch
- ○ Creek ○ U/K

d. Was child boating?
○ Yes ○ No ○ U/K

e. Select all contributing environmental factors. Check all that apply.
- ☐ None ☐ Dropoff
- ☐ Weather ☐ Rough waves
- ☐ Temperature ☐ Flash flood
- ☐ Current ☐ Water clarity
- ☐ Riptide/undertow ☐ U/K

f. For pool, type of pool:
- ○ Above-ground
- ○ In-ground ○ Hot tub, spa
- ○ Wading ○ U/K

g. For pool, ownership is:
- ○ Private
- ○ Public
- ○ U/K

h. Flotation device used at time of the incident?
- ○ N/A ○ No
- ○ Yes, specify: ○ U/K

i. Did the child depend on a life jacket, swim vest or swim aid while in or around water?
○ N/A ○ No
○ Yes ○ U/K

j. Did barriers/layers of protection exist to prevent access to water? ○Yes ○No ○U/K

If yes, check all that apply:

☐ Fence
Was it breached? ○Yes ○No ○U/K
If yes, check all that apply:
- ☐ Climbed fence
- ☐ Gap in fence
- ☐ Damaged fence
- ☐ Fence too short

Fence surrounds water on:
- ○Four sides
- ○Three sides
- ○Two or one side
- ○U/K

☐ Gate
Was it breached? ○ Yes ○ No ○ U/K
If yes, check all that apply:
- ☐ Gate left open
- ☐ Gate unlocked
- ☐ Gate latch failed
- ☐ Gap in gate

☐ Door
Was it breached? ○Yes ○No ○U/K
If yes, check all that apply:
- ☐ Door left open
- ☐ Door unlocked
- ☐ Door broken
- ☐ Door screen torn
- ☐ Door self-closer failed

☐ Alarm
Was it breached? ○ Yes ○ No ○ U/K
If yes, check all that apply:
- ☐ Alarm not working
- ☐ Alarm not answered

☐ Cover
Was it breached? ○Yes ○No ○ U/K
If yes, check all that apply:
- ☐ Cover left off
- ☐ Cover not locked

k. Local ordinance(s) regulating access to water? ○Yes ○No ○U/K

If yes, rules violated? ○Yes ○No ○U/K

l. Select all of the child's water safety skills (without assistance or flotation device):
- ☐ None of these
- ☐ Float on their back independently
- ☐ Step or jump into water over their head
- ☐ Tread water for 1 minute
- ☐ Find a safe exit from the water
- ☐ Control breathing
- ☐ Return to surface
- ☐ Swim 25 yards
- ☐ Exit the water
- ☐ Had swimming lessons
- ☐ U/K

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

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

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

p. Rescue attempt made? ○N/A ○Yes ○No ○U/K

If yes, who? Check all that apply:
- ☐ Parent/relative
- ☐ Other child
- ☐ Lifeguard
- ☐ Other adult
- ☐ EMS/first responder
- ☐ Bystander
- ☐ Other, specify:
- ☐ U/K

If yes, did rescuer(s) also drown?
- ○ Yes
- ○ No
- ○ U/K

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

If yes, was it used? ○Yes ○No ○U/K

If no, describe:

H4. ASPHYXIA

a. Type of event:
- ○ Sleep-related, go to i1
- ○ Not sleep-related, go to b
- ○ U/K, go to b

b. If not sleep-related, was the event:
- ○ Suffocation, go to c
- ○ Strangulation, go to d
- ○ Choking, go to e
- ○ Other, go to i1

c. If suffocation, was the child:
- ○ Covered in or fell into object
- ○ Confined in tight space
- ○ Wedged into tight space, specify:
- ○ Other, specify:

d. If strangulation, object causing event:
- ○ Clothing ○ Electrical cord
- ○ Blind cord ○ Person, go to H5i
- ○ Car seat ○ Automobile power window or sunroof
- ○ Belt ○ Other, specify:
- ○ Rope/string
- ○ Leash ○ U/K

e. If choking, object causing choking:
- ○ Food, specify:
- ○ Toy, specify:
- ○ Vomit/gastric contents
- ○ Other, specify:
- ○ U/K

f. If choking, was Heimlich Maneuver attempted?
○Yes ○No ○U/K

H5. BODILY FORCE OR WEAPON

a. Was the death a result of a weapon?
- ○ Yes, go to b
- ○ No, death due to bodily force, go to l
- ○ U/K, go to b

b. Type of weapon:
- ○ Firearm, go to c
- ○ Knife or sharp instrument, go to l
- ○ Rope, go to l
- ○ Other, specify and go to l
- ○ U/K, go to l

c. For firearms, type:
- ○ Handgun
- ○ Shotgun
- ○ Rifle, specify:
- ○ 3D gun
- ○ Other, specify:
- ○ U/K

d. Was the firearm considered a smart firearm, e.g., uses a fingerprint lock, RFID watch?
- ○ Yes
- ○ No
- ○ U/K

e. Was firearm kept loaded?
- ○ Yes
- ○ No
- ○ U/K

If no, was the ammunition stored locked?
- ○ Yes
- ○ No
- ○ U/K

f. Was the firearm kept locked?
- ○ Yes
- ○ No
- ○ U/K

g. Did the shooter of the firearm have permission to use the firearm at the time of incident?
○ Yes ○ No ○ U/K

h. Did the caregiver or supervisor know a firearm was present at the time of incident?
○ Yes ○ No ○ U/K

i. Was the person handling the firearm the owner? ○ Yes ○ No ○ U/K

j. Owner of fatal firearm:
- ○ Caregiver
- ○ Other family member
- ○ Child's significant other
- ○ Friend/acquaintance
- ○ Stranger
- ○ Other, specify:
- ○ U/K

k. Was the firearm stolen?
- ○ Yes
- ○ No
- ○ U/K

l. Use of weapon at time, check all that apply:
- ☐ Self injury
- ☐ Commission of crime
- ☐ Drug dealing/trading
- ☐ Drive-by shooting
- ☐ Random violence
- ☐ Child abuse
- ☐ Child was a bystander
- ☐ Argument
- ☐ Jealousy
- ☐ Intimate partner violence
- ☐ Hate crime
- ☐ Bullying
- ☐ Hunting
- ☐ Target shooting
- ☐ Playing with weapon
- ☐ Showing gun to others
- ☐ Russian roulette
- ☐ Gang-related activity
- ☐ Self-defense
- ☐ Cleaning weapon
- ☐ Loading weapon
- ☐ Other, specify:
- ☐ U/K

m. Type of bodily force used. Check all that apply:
- ☐ Beat, kick or punch
- ☐ Bite
- ☐ Throw
- ☐ Other, specify:
- ☐ Drop
- ☐ Shake
- ☐ Drown
- ☐ Push
- ☐ Strangle/choke
- ☐ Burn
- ☐ U/K

H6. FALL OR CRUSH

a. Type:
- ○ Fall, go to b
- ○ Crush, go to g

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 H5l

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 H5l
- ○ 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, storage, and route of administration of substance: ☐ U/K

Source of Substance		Stored in locked cabinet?	How substance was taken
1 = Bought from dealer or stranger (Prescription or illicit only)	5 = Own prescription (Prescription only)	Yes	1 = In utero
2 = Bought from friend or relative	6 = Bought from store/pharmacy (OTC or other substances only)	No	2 = Orally
3 = From friend or relative for free	7 = Other	U/K	3 = Nasally
4 = Took from friend or relative without asking	9 = U/K		4 = Intravenously
			5 = Through skin
			9 = U/K

Prescription drug	Source	Stored	Taken
☐ Antidepressant/antianxiety		Y N U	
☐ Anticonvulsant		Y N U	
☐ Antipsychotic		Y N U	
☐ Benzodiazepines		Y N U	
☐ Medications for substance use disorder (e.g. Methadone, buprenorphine, naltrexone)		Y N U	
☐ Non-opioid pain medication		Y N U	
☐ Opioid pain medication (including fentanyl)		Y N U	
☐ Stimulants		Y N U	
☐ Other Rx, specify:		Y N U	
Was it child's prescription? ○ Yes ○ No ○ U/K			

Over-the-counter drug	Source	Stored	Taken
☐ Antihistamine		Y N U	
☐ Cold medicine		Y N U	
☐ Pain medication		Y N U	
☐ Other OTC, specify:		Y N U	

Illicit drugs	Source	Stored	Taken
☐ Cocaine		Y N U	
☐ Heroin		Y N U	
☐ Illicitly manufactured fentanyl/fentanyl analogs		Y N U	
☐ Marijuana/THC		Y N U	
☐ Methamphetamine		Y N U	
☐ Other, specify:		Y N U	

Other substances	Source	Stored	Taken
☐ Alcohol		Y N U	
☐ Battery		Y N U	
☐ Carbon monoxide		Y N U	
☐ Other fume/gas/vapor		Y N U	
☐ Other, specify:		Y N U	

b. Was the incident the result of?
- ○ Accidental overdose/acute intoxication
- ○ Medical treatment mishap
- ○ Deliberate poisoning
- ○ Other, specify:
- ○ U/K

c. Did the child have a prescription for a controlled substance within the previous 24 months?
○ Yes ○ No ○ U/K

d. Did child have a non-fatal overdose within the previous 12 months?
- ○ Yes
- ○ No
- ○ U/K

e. Was Poison Control contacted?
- ○ Yes
- ○ No
- ○ U/K

f. For CO poisoning, was a CO alarm present?
- ○ Yes
- ○ No
- ○ U/K

H8. MEDICAL CONDITION

This section is skipped for fetal deaths*

a. How long did the child have the medical condition?
- ○ In utero
- ○ Since birth
- ○ < 1 day
- ○ 1-6 days
- ○ 7-30 Days
- ○ 1-11 months
- ○ >= 1 year
- ○ U/K

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

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

If yes, was the care plan appropriate for the medical condition?
○ N/A ○ Yes ○ No ○ U/K

If no, specify:

d. Did the family experience barriers that prohibited following the care plan?
- ○ N/A
- ○ Yes
- ○ No
- ○ U/K

If yes, what treatment components were not completed? Check all that apply.
- ☐ Appointments
- ☐ Medications, specify:
- ☐ Medical equipment use, specify:
- ☐ Therapies, specify:
- ☐ Other, specify:
- ☐ U/K

e. In the week prior to the death, did the child experience any changes to medical care?
- ○ Yes, describe:
- ○ No
- ○ U/K

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

If yes, was the child vaccinated?
○ Yes ○ No ○ U/K

g. Was the death potentially caused by a medical error?
○ Yes ○ No ○ U/K

h. Was the medical condition that caused the death a result of a complication or side effect of a previous illness, injury, condition, or medical treatment?
○ 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.

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?

Symptom	Present w/in 72 hours of death		
Cardiac	Yes	No	U/K
Chest pain	○	○	○
Dizziness/lightheadedness	○	○	○
Fainting	○	○	○
Palpitations	○	○	○
Neurologic			
Concussion	○	○	○
Confusion	○	○	○
Convulsions/seizure	○	○	○
Headache	○	○	○
Head injury	○	○	○
Respiratory			
Asthma	○	○	○
Pneumonia	○	○	○
Difficulty breathing	○	○	○
Other Acute Symptoms			
Fever	○	○	○
Muscle aches/cramping	○	○	○
Vomiting	○	○	○
Other, specify:	○		

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

Symptom	Present more than 72 hours of death		
Cardiac	Yes	No	U/K
Chest pain	○	○	○
Dizziness/lightheadedness	○	○	○
Fainting	○	○	○
Palpitations	○	○	○
Neurologic			
Concussion	○	○	○
Confusion	○	○	○
Convulsions/seizure	○	○	○
Head injury	○	○	○
Respiratory			
Difficulty breathing	○	○	○
Other			
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 in the past ever been diagnosed by a medical professional for the following?

Condition	Diagnosed		
Blood disease	Y	N	U
Sickle cell disease	○	○	○
Sickle cell trait	○	○	○
Thrombophilia (clotting disorder)	○	○	○
Cardiac	Y	N	U
Abnormal electrocardiogram (EKG or ECG)	○	○	○
Aneurysm or aortic dilatation	○	○	○
Arrhythmia/arrhythmia syndrome	○	○	○
Cardiomyopathy	○	○	○
Congenital heart disease	○	○	○
Coronary artery abnormality	○	○	○
Endocarditis	○	○	○
Heart failure	○	○	○
Heart murmur	○	○	○

Condition	Diagnosed		
Cardiac (continued)	Y	N	U
High cholesterol	○	○	○
Hypertension	○	○	○
Myocarditis (heart infection)	○	○	○
Pulmonary hypertension	○	○	○
Sudden cardiac arrest	○	○	○
Neurologic	Y	N	U
Anoxic brain injury	○	○	○
Traumatic brain injury/ head injury/concussion	○	○	○
Brain tumor	○	○	○
Brain hemorrhage	○	○	○
Developmental brain disorder	○	○	○
Epilepsy/seizure disorder	○	○	○
Febrile seizure	○	○	○

Condition	Diagnosed		
Neurologic (continued)	Y	N	U
Neurodegenerative disease	○	○	○
Stroke/mini stroke/ TIA-Transient Ischemic Attack	○	○	○
Central nervous system infection (meningitis or encephalitis)	○	○	○
Respiratory	Y	N	U
Apnea	○	○	○
Asthma	○	○	○
Pulmonary embolism	○	○	○
Pulmonary hemorrhage	○	○	○
Respiratory arrest	○	○	○

Condition (continued)	Diagnosed Y	N	U		Diagnosed Y	N	U		Diagnosed Y	N	U
Other											
Connective tissue disease	○	○	○	Kidney disease	○	○	○	Oncologic disease treated by chemotherapy or radiation	○	○	○
Diabetes	○	○	○	Mental illness/psychiatric disease	○	○	○	Prematurity	○	○	○
Endocrine disorder, other: thyroid, adrenal, pituitary	○	○	○	Metabolic disease	○	○	○	Congenital disorder/ genetic syndrome	○	○	○
Hearing problems or deafness	○	○	○	Muscle disorder or muscular dystrophy	○	○	○	Other, specify:	○	○	○

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

If any cardiac conditions above are selected, what cardiac treatments did the child have? Check all that apply:

☐ None

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

f. Did the child have any blood relatives (brothers, sisters, parents, aunts, uncles, cousins, grandparents or other more distant relatives) with the following diseases, conditions or symptoms?

Y	N	U	Deaths
○	○	○	Sudden unexpected death before age 50

If yes, 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

If yes, describe:

○	○	○	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	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
☐ Energy drinks
☐ Caffeine
☐ Performance enhancers
☐ Supplements
☐ Tobacco
☐ Alcohol
☐ Illegal drugs
☐ Legalized marijuana
☐ Other, specify:
☐ U/K

If yes to any items above, describe:

l. Did the child experience any of the following stimuli at time of incident or within 24 hours of the incident?

Stimuli	At incident Yes	No	U/K	Within 24 hrs of incident Yes	No	U/K
Physical activity	○	○	○	○	○	○
Sleep deprivation	○	○	○	○	○	○
Driving	○	○	○	○	○	○
Visual/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
- ☐ Convulsions/seizure
- ☐ Dizziness/lightheadedness
- ☐ Fainting
- ☐ Palpitations
- ☐ Shortness of breath/difficulty breathing
- ☐ Other, specify:
- ☐ U/K

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

o. 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
- ☐ Developmental brain disorder
- ☐ Genetic/chromosomal
- ☐ 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 ○ 1 ○ 2 ○ 3 ○ More than 3 ○ U/K

u. Did treatment for seizures include anti-epileptic drugs?

○ Yes ○ No ○ U/K

If yes, how many different types of anti-epileptic drugs did the child take?

○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ More than 6 ○ U/K

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 I2t ○ U/K, go to I2a

a. Incident sleep place:

- ○ Crib
  - If crib, type:
    - ○ Not portable
    - ○ Portable
    - ○ Unknown crib type
- ○ Bassinet
- ○ Bed side sleeper
- ○ Baby box
- ○ Adult bed
- ○ Waterbed
- ○ Futon
- ○ Couch
- ○ Chair
- ○ Floor
- ○ Car seat
- ○ Rocking-inclined sleeper
- ○ Stroller
- ○ Swing
- ○ Bouncy chair
- ○ Other, specify:
- ○ U/K

If adult bed, what type?

○ Twin ○ Full ○ Queen ○ King ○ Other, specify: ○ 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, portable crib or bassinet in home for child?

○ Yes ○ No ○ U/K

d. Usual sleep place:

- ○ Crib
  - If crib, type:
    - ○ Not portable
    - ○ Portable
    - ○ Unknown crib type
- ○ Bassinet
- ○ Bed side sleeper
- ○ Baby box
- ○ Adult bed
- ○ Waterbed
- ○ Futon
- ○ Couch
- ○ Chair
- ○ Floor
- ○ Car seat
- ○ Rocking-inclined sleeper
- ○ Stroller
- ○ Swing
- ○ Bouncy chair
- ○ Other, specify:
- ○ U/K

If adult bed, what type?

○ Twin ○ Full ○ Queen ○ King ○ Other, specify: ○ 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 when last placed?

○ Yes ○ No ○ U/K

If yes, describe:

j. Child overheated? ○ Yes ○ No ○ U/K

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 ☐ Chest compressed
☐ Mouth ☐ U/K
☐ Neck compressed

If fully or partially obstructed, describe obstruction in detail:

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

Objects:	Present? Yes	No	U/K	If **present**, describe position of object: On top of child	Under child	Next to child	Tangled around child	U/K	If **present**, did object obstruct airway? Yes	No	UK
Adult(s)	○	○	○	☐	☐	☐	☐	☐	○	○	○
Other child(ren)	○	○	○	☐	☐	☐	☐	☐	○	○	○
Animal(s)	○	○	○	☐	☐	☐	☐	☐	○	○	○
Mattress	○	○	○	☐	☐	☐	☐	☐	○	○	○
Comforter, quilt, or other	○	○	○	☐	☐	☐	☐	☐	○	○	○
Fitted sheet	○	○	○	☐	☐	☐	☐	☐	○	○	○
Thin blanket/flat sheet	○	○	○	☐	☐	☐	☐	☐	○	○	○
Pillow(s)	○	○	○	☐	☐	☐	☐	☐	○	○	○
Cushion	○	○	○	☐	☐	☐	☐	☐	○	○	○
Nursing or U shaped pillow	○	○	○	☐	☐	☐	☐	☐	○	○	○
Sleep positioner (wedge)	○	○	○	☐	☐	☐	☐	☐	○	○	○
Bumper pads	○	○	○	☐	☐	☐	☐	☐	○	○	○
Clothing	○	○	○	☐	☐	☐	☐	☐	○	○	○
Bottle	○	○	○	☐	☐	☐	☐	☐	○	○	○
Wearable monitor	○	○	○	☐	☐	☐	☐	☐	○	○	○
Crib railing/side	○	○	○	☐	☐	☐	☐	☐	○	○	○
Wall	○	○	○	☐	☐	☐	☐	☐	○	○	○
Toy(s)	○	○	○	☐	☐	☐	☐	☐	○	○	○
Other(s), specify:											
_____	○			☐	☐	☐	☐	☐	○	○	○
_____	○			☐	☐	☐	☐	☐	○	○	○

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

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: _____
☐ U/K

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?	c. Is a recall in place?	d. Did product have safety label?	e. Was Consumer Product Safety Commission (CPSC) notified?
○ Yes ○ No ○ U/K	○ Yes ○ No ○ U/K	○ Yes ○ No ○ U/K	○ 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 ☐ Other assault ☐ Arson ☐ Illegal border crossing ☐ U/K
☐ Interpersonal violence ☐ Gang conflict ☐ Prostitution ☐ Auto theft
☐ Sexual assault ☐ Drug trade ☐ Witness intimidation ☐ Other, specify:

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
○ Childbearing parent 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. Did child have a suicide safety plan (a document that helps individuals when experiencing thoughts of suicide to help them avoid intense suicidal crisis)?
○ Yes ○ No ○ U/K

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

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

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

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

h. 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 ☐ Noted on autopsy ☐ Other, specify:

i. 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

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

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

I7. LIFE STRESSORS

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

a. Life stressors - Social/economic

- ☐ None listed below
- ☐ Racism
- ☐ Discrimination
- ☐ Poverty
- ☐ Neighborhood discord
- ☐ Job problems
- ☐ Money problems
- ☐ Food insecurity
- ☐ No phone
- ☐ Housing instability
- ☐ Witnessed violence
- ☐ Tobacco exposure
- ☐ Lack of transportation
- ☐ Cultural differences
- ☐ Language barriers
- ☐ Lack of child care
- ☐ Pregnancy
- ☐ Pregnancy scare

b. Life stressors - Medical

- ☐ None listed below
- ☐ Lack of family or social support for care
- ☐ Caregiver distrust of health care system
- ☐ Caregiver unskilled in providing care
- ☐ Lack of money for care
- ☐ Services not available
- ☐ Multiple providers, not coordinated
- ☐ Limitations of health insurance
- ☐ Provider bias
- ☐ Felt dismissed by provider
- ☐ Lack of provider-family compatibility

c. Life Stressors- Relationships

- ☐ None listed below
- ☐ Family discord
- ☐ Argument w/ parents/caregivers
- ☐ Parents' divorce/separation
- ☐ Parents' incarceration
- ☐ Breakup
- ☐ Argument with significant other
- ☐ Social discord
- ☐ Argument with friends
- ☐ Isolation
- ☐ Bullying as victim
- ☐ Bullying as perpetrator
- ☐ Cyberbullying as victim
- ☐ Cyberbullying as a perpetrator
- ☐ Peer violence as a victim
- ☐ Peer violence as a perpetrator
- ☐ Stress due to gender identity
- ☐ Stress due to sexual orientation

d. Life stressors - School (age 5 and over)

- ☐ None listed below
- ☐ School failure
- ☐ Pressure to succeed
- ☐ Extracurricular activities
- ☐ New school
- ☐ Other school problems

e. Technology (age 5 and over)

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

f. 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. inpatient to outpatient, inpatient to residential, etc.)
- ☐ Release from juvenile justice facility
- ☐ End of school year/school break
- ☐ Transition to/from child welfare system
- ☐ Release from immigrant detention center

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

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

h. Life stressors - Describe any other life stressors:

I8. DEATHS DURING THE COVID-19 PANDEMIC (complete for all ages)

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 (like 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, specify:
- ☐ U/K

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. Did the child have medical evidence of a significant inflammatory syndrome (including for example, fever, laboratory evidence of inflammation, and involvement of two or more organs) requiring hospitalization in the week before death? ○Yes ○No ○U/K
If yes, was the child diagnosed with MIS-C? ○Yes ○No ○U/K

e. Was the child eligible to receive a COVID-19 vaccination? ○Yes ○No ○U/K
If eligible, did they receive their first dose? ○Yes ○No ○U/K If yes, approx. number of weeks before death: ____
If eligible and received their first dose, which option best represents their vaccination status? ○Partially vaccinated ○Fully vaccinated ○U/K

f. For infants or fetal deaths only, did the childbearing parent receive their COVID-19 vaccination? ○Yes ○No ○U/K
If yes, when did they receive their first dose?
○ Before pregnancy ○ 3rd trimester
○ 1st trimester ○ After delivery
○ 2nd trimester ○ U/K
If yes, which option best represents their vaccination status? ○ Partially vaccinated ○ Fully vaccinated ○ U/K

g. 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 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 childbearing parent contracted COVID-19, specify:
  - ○ Before pregnancy
  - ○ 1st trimester
  - ○ 2nd trimester
  - ○ 3rd trimester
  - ○ After delivery
  - ○ U/K
- ○ Other, specify:
- ○ COVID-19 had no impact on this child's death
- ○ U/K

h. 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)

This section is skipped for fetal deaths*

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 K
   - ○ U/K, go to 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 K

4. Is person listed in a previous section?

One	Two	
○	○	Yes, childbearing parent, go to J17
○	○	Yes, non-childbearing biological parent, 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	○	○	Sibling	○	○	Medical provider
○	○	Stepparent	○	○	Other relative	○	○	Institutional staff
○	○	Foster parent	○	○	Friend	○	○	Babysitter
○	○	Parent's partner	○	○	Acquaintance	○	○	Licensed child care worker
○	○	Grandparent	○	○	Child's boyfriend or girlfriend	○	○	Other, specify:
			○	○	Stranger	○	○	U/K

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:

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

One	Two	
○	○	Yes
○	○	No
○	○	U/K

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

One	Two	
○	○	Yes
○	○	No
○	○	U/K

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

One	Two	
○	○	Yes
○	○	No
○	○	U/K

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

One	Two	
○	○	Yes
○	○	No
○	○	U/K

14. Person(s) have prior child deaths?

One	Two	
○	○	Yes
○	○	No
○	○	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

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:

One	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	Two
○Yes ○No ○U/K	○Yes ○No ○U/K

If yes, check all that apply:

One	Two		One	Two	
☐	☐	Drug impaired, specify:	☐	☐	Impaired by illness, specify:
☐	☐	Alcohol impaired	☐	☐	Impaired by disability, specify:
☐	☐	Distracted	☐	☐	Other, specify:
☐	☐	Absent			

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

5. Were the following data sources available at the review meeting?
Check all that apply:

Vital statistics
- ☐ Birth certificate - full form
- ☐ Death certificate

Health records
- ☐ Child's medical records or clinical history, including vaccination
- ☐ Hospital records
- ☐ Childbearing parent's obstetric and prenatal information
- ☐ Newborn screening results
- ☐ Mental health records
- ☐ Substance abuse treatment records

Investigation records
- ☐ Autopsy/pathology reports
- ☐ CDC's SUIDI Reporting Form
- ☐ Jurisdictional equivalent of the CDC SUIDI Reporting Form
- ☐ Law enforcement records
- ☐ Social service records
- ☐ Child protection agency records
- ☐ EMS run sheet

Other
- ☐ Home visiting
- ☐ School 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:
- ☐ 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

N. SUID AND SDY CASE REGISTRY

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

Section N: OMB No. 0920-1092, Exp. Date: 5/31/2022
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	☐ Death investigator	☐ Geneticist or genetic counselor	☐ Pediatrician
☐ CDR representative	☐ Epileptologist	☐ Neurologist	☐ Public health representative
☐ Coroner	☐ Forensic pathologist/medical examiner	☐ Neonatologist	☐ 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
○ Unexplained, 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? ☐

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