Child Abuse Death Review Committee

Working to eliminate preventable child abuse and neglect deaths in Florida

ANNUAL REPORT

DECEMBER 2019

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 2018.

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 Bill Galvano, President, Florida Senate
The Honorable Jose R. Oliva, Speaker, Florida House of Representatives

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EXECUTIVE SUMMARY

Florida's Child Abuse Death Review System

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

2018 Data: Case Review Analysis

Throughout 2019, Local CADR Committees reviewed the records related to 325 child fatalities which occurred in 2018. Analysis of the 2018 case review data reveal that regardless of maltreatment verification status, children under the age of five have the highest number of child deaths called to the Florida Abuse Hotline. The three leading causes of child death in 2018 CADR cases are:

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 40.3% of all preventable child fatalities called into the Florida Abuse Hotline. Children placed to sleep on adult beds, couches and other soft surfaces are at significant risk of suffocation. An infant sharing a sleep surface with another child or an adult also poses a risk for sleep-related death.

Drowning is the second leading cause of preventable child death, representing 21.8% of all preventable child death cases. Drowning primarily affects children under the age of five. According to the American Academy of Pediatrics, nearly 70% of child drowning occurs during non-swimming activities. Ineffective barriers of protection and failure to provide sufficient supervision to young children continue to be primary contributing factors.

Inflicted Trauma is the third most frequent cause of preventable child death, representing 8.3% of child fatalities called into the hotline. Inflicted trauma includes abuse to a child by way of bodily force, such as the use of fists, hands and feet or by the use of weapons and firearms.

Child Characteristics

Of cases reviewed by Local CADR Committees, children under the age of five account for 86.8% of preventable child death. The most vulnerable children are less than one year of age, representing 58.2% of cases reviewed. Children under the age of five, and to a greater extent,

children under the age of one, are in need of developmentally appropriate supervision, care and support to ensure their safety.

Prevention Recommendations

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

- Continue efforts to relay timely information to caregivers regarding the safety of children.
- Develop strategies to ensure consistent and coordinated prevention-related messaging across local and state agencies.
- Expand efforts to collect data related to co-occurring substance abuse and mental health disorders.
- Explore efforts to collect data related to near fatalities in cases of near-drowning, near-fatal incidents of inflicted trauma and near-fatal sleep-related asphyxia.
- Increase messaging around appropriate supervision and barriers of protection as primary factors in drowning prevention, in addition to establishing age appropriate expectations related to young children and swimming capabilities consistent with recommendations of the American Academy of Pediatrics.
- Continue to support programs and practices that enhance parenting skills and coordinate services provided to expectant mothers and partners.
- Encourage the consistent use of Sudden Unexpected Infant Death Reporting Forms and doll reenactments by death scene investigators for all sleep-related infant death investigations.
- Continue to support and encourage the development and evaluation of pilot projects and initiatives focused on local and regional community-based child fatality prevention.

SECTION ONE: BACKGROUND

PROGRAM DESCRIPTION

The Florida Child Abuse Death Review (CADR) System was established in Florida law in 1999. The program is administered by the Florida Department of Health (DOH) and utilizes Local CADR Committees to conduct detailed reviews of the facts and circumstances surrounding child deaths reported to the Florida Abuse Hotline and accepted for investigation. A public health approach is applied as Local CADR Committees review the facts and circumstances surrounding child fatality cases reported to the Florida Abuse Hotline on the suspicion of abuse or neglect. The State CADR Committee collects and analyzes data from the local reviews and prepares an annual statistical report, which is submitted to the Governor, President of the Senate and Speaker of the House of Representatives.

STATUTORY AUTHORITY

Section 383.402, Florida Statutes (Appendix A)

PROGRAM PURPOSE

The purpose of the CADR process is to:

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

STATE CHILD ABUSE DEATH REVIEW COMMITTEE

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

The State CADR Committee consists of seven agency-specific representatives and twelve appointments from various disciplines related to the health and welfare of children and families. Members of the State CADR Committee (Appendix C) are appointed to staggered two-year terms. All members are eligible for reappointment not to exceed three consecutive terms. The State CADR Committee elects a chairperson from among its members to serve a two-year term.

A representative of DOH, appointed by the State Surgeon General, serves as the committee coordinator.

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

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

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

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

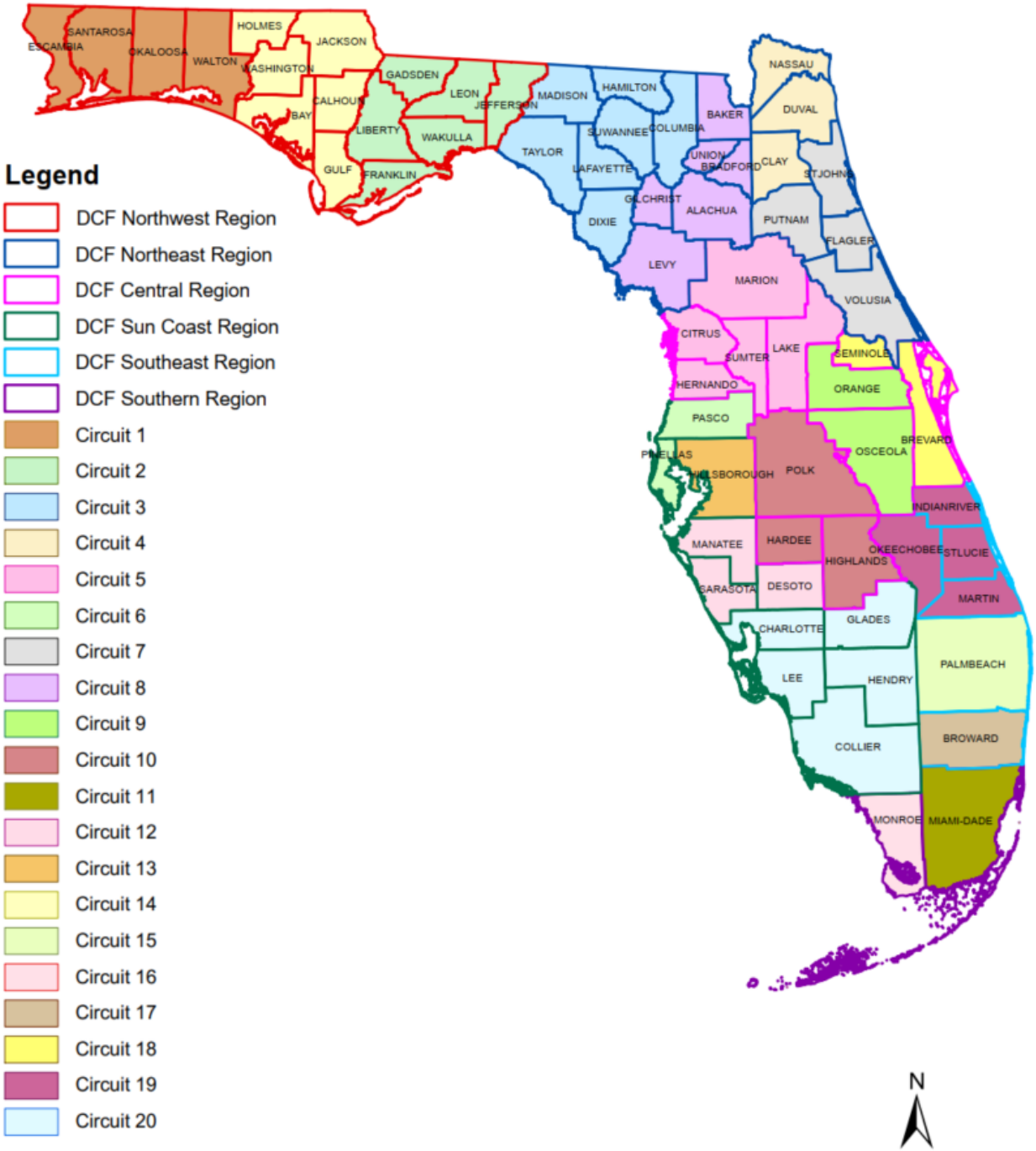
LOCAL CHILD ABUSE DEATH REVIEW COMMITTEES

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

County Health Officers appoint, convene and support Local CADR 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 Department of Children and Families child protective investigations unit
- Department of Health Child Protection Team
- The community-based care lead agency
- State, county or local law enforcement agencies
- The school districts
- A mental health treatment provider
- A certified domestic violence center
- A substance abuse treatment provider
- Any other members who are listed in guidelines developed by the State CADR Committee

Map of Circuit-based Committees



SECTION TWO: METHOD

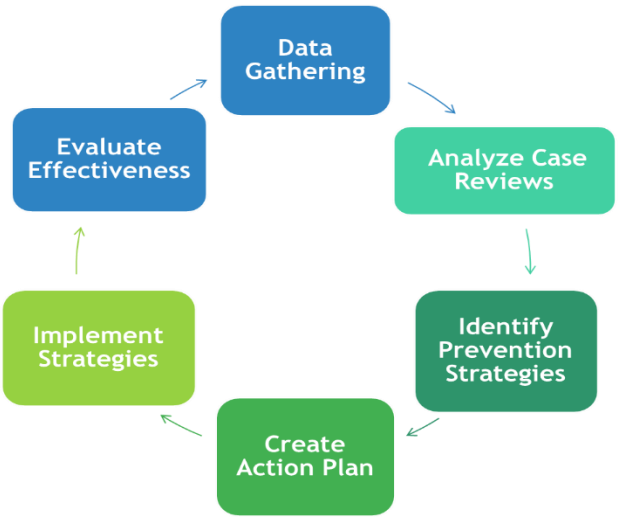
CASE FILE TRANSFER

Following the closure of a DCF investigation, a regional DCF Child Fatality Prevention Specialist reviews all pertinent information within the case file and completes a case review summary. The case file, along with the summary and supporting documentation, is then transferred to the CADR Unit at DOH. The CADR Unit archives the case file and logs pertinent tracking information into an internal database, then transfers all case information to the appropriate local committee chair. All file transfers are conducted using a secure file transfer website, providing the ability to track and safely deliver confidential case information.

LOCAL COMMITTEE REVIEWS AND REPORTING PROCESS

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

THE CADR CYCLE



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

SECTION THREE: DATA

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.

CASE REVIEW STATISTICS

This report includes information on closed child fatality cases which have been reviewed and entered into the National Center for Review and Prevention Case Reporting System (Appendix E) by October 15, 2019. Cases that remain open to DCF for investigation (often due to law enforcement and/or judicial proceedings) are not available for review and are not included in the data sample. Table 1 details the distribution of 2018 child fatality cases reviewed (stratified by maltreatment verification status), cases awaiting review and cases that were not available for review as of October 15, 2019. Figure 1 demonstrates the distribution of child fatality cases assigned to each Local CADR Committee. Figure 2 provides an aggregate summary of the case file status for all child fatalities (438) reported to the Florida Abuse Hotline in 2018.

Table 1: Child Fatality Cases Reviewed and Case Review Status Across Local CADR Committees							
	Total Cases (Child deaths called into hotline)	Cases Not Available for Review (Open Investigation/Case in Processing)	Cases Available for Review	Review Completed	Verified Maltreatment Cases Reviewed	Not Substantiated Maltreatment Cases Reviewed	No Indicators Maltreatment Cases Reviewed
Circuit #1a	13	2	11	11	0	0	11
Circuit #1b	8	0	8	8	0	1	7
Circuit #2	11	0	11	11	1	1	9
Circuit #3	5	0	5	4	1	2	1
Circuit #4	52	1	51	47	10	12	25
Circuit #5	29	11	18	17	4	2	14
Circuit #6	21	3	18	18	4	1	12
Circuit #7	17	4	13	9	1	7	1
Circuit #8	9	1	8	4	1	1	2
Circuit #9	30	1	29	29	7	3	19
Circuit #10	33	1	32	32	11	2	19
Circuit #11	38	6	32	17	4	6	6
Circuit #12a	8	0	8	7	2	0	4
Circuit #12b	10	3	7	7	1	2	4
Circuit #13	39	9	30	29	7	5	17
Circuit #14	7	3	4	3	2	0	1
Circuit #15	24	3	21	11	5	1	5
Circuit #16	1	1	0	0	0	0	0
Circuit #17	30	5	25	23	12	8	3
Circuit #18a	10	0	10	10	3	1	6
Circuit #18b	13	3	10	8	1	0	7
Circuit #19	12	1	11	8	3	2	3
Circuit #20	18	2	16	12	3	1	8
Totals	438	60	378	325	83	58	184

Figure 1: 2018 Child Death Cases Reported to the Hotline (N=438)

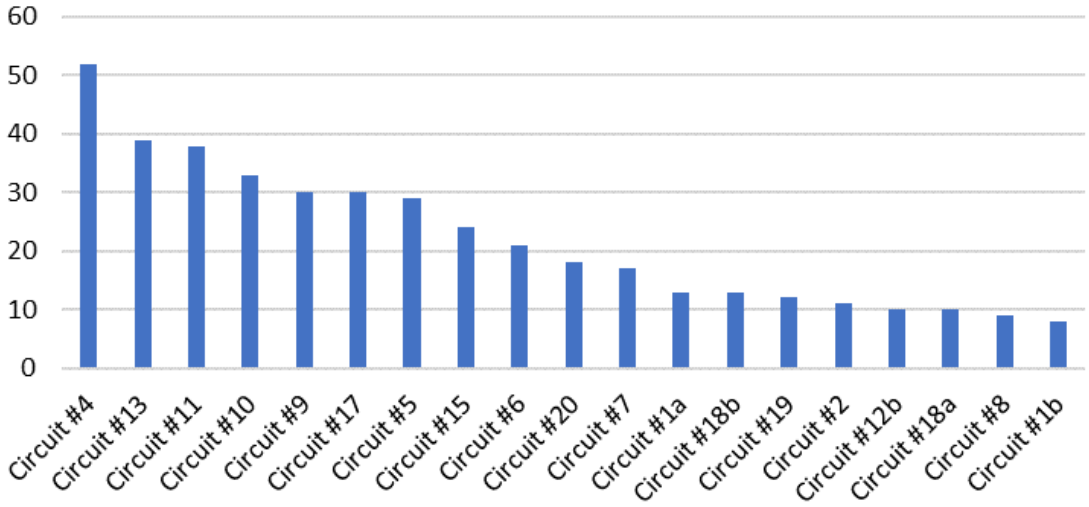
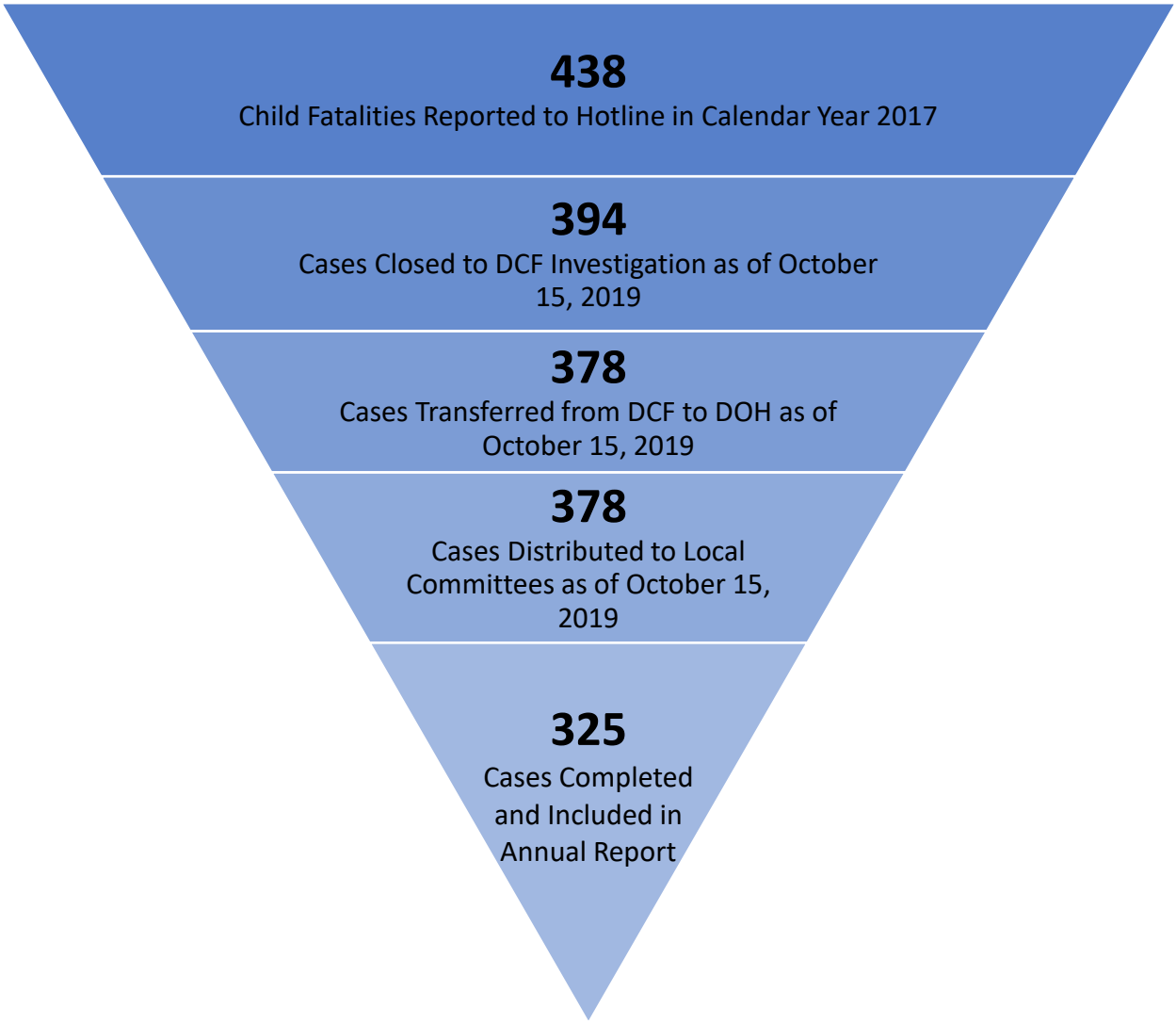


Figure 2: Case File Status of 2018 Child Deaths Reported to the Florida Abuse Hotline



SUMMARY POINTS:

As of October 15, 2019, 438 child fatalities for 2018 were called into the Florida Abuse Hotline. Of these child death incidents:

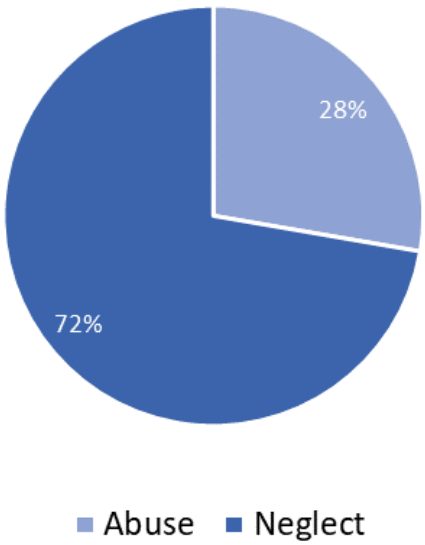
- 394 were closed by DCF
- 44 were still open or recently closed, therefore case information was unavailable

- Of the 394 closed cases for which the information was available for review, 325 reviews were completed, with the remainder of cases (69) scheduled for review after October 15, 2019. Please note that this report applies only to the 325 cases reviewed. Findings are qualified by this fact and may change once all referenced child fatalities are reviewed. Consideration will be given toward supplemental analyses of the remaining 2018 fatalities (113) upon case closure and review.

- There were seven Local CADR Committees with 25 or more child fatality cases called into the hotline in 2018. These include: Circuit 4 (52), Circuit 13 (39), Circuit 11 (38), Circuit 10 (33), Circuit 9 (30), Circuit 17 (30), Circuit 5 (29).

- Of the 83 verified maltreatment deaths reviewed, 60 (72.2%) were the result of neglect, and 23 (27.7%) were the result of abuse (Figure 3).

Figure 3: Distribution of Reviewed Verified Maltreatment Deaths by Abuse and Neglect (n=83)



CHILD DEATH TRENDS

In 2018, the all-cause death rate for children aged 0-17 was 50.7 deaths per 100,000 child population (Florida CHARTS, 2019). The reported 2018 verified child maltreatment death rate in Table 2 is 1.98 per 100,000 child population. This rate is inconclusive, as there are several cases still open to investigation and unavailable for review. Child fatality cases with a higher propensity to be verified for abuse or neglect are likely to involve the criminal justice system as a result of the child's death and can require extended time for investigation. Table 2 shows the numbers and rates of all-causes of child death and verified child maltreatment deaths.

Table 2: Child Deaths: All Causes and Maltreatments Florida, 2011-2018

	Child Deaths All Causes	Child Death Rate per 100,000 Child Population	Verified Child Maltreatment Deaths	Child Maltreatment Death Rate per 100,000 Child Population	Cases Pending (DCF)	Cases Pending (Local Review)
2011	2,191	54.3	136	3.37	-	-
2012	2,046	50.9	129	3.21	-	-
2013	2,105	52.5	137	3.42	-	-
2014	2,131	52.9	152	3.77	0	3
2015	2,249	55.4	121*	2.98	1	3
2016	2,217	54.2	105*	2.56	4	9
2017	2,236	54.1	103*	2.49	6	12
2018	2,128	50.7	83*	1.98	44	113

*The number of verified child maltreatment cases for 2015, 2016, 2017 and 2018 is not complete given the number of cases still open and not yet transferred to local CADR Committees OR not yet reviewed by local CADR Committees. Past year figures may have changed as cases were closed following the submission of past CADR reports. 2015 counts apply to 469 of 473 investigated child deaths. 2016 counts apply to 448 of 459 investigated child deaths. 2017 counts apply to 434 of 460 investigated child deaths. 2018 counts apply to 325 of 438 investigated child deaths.

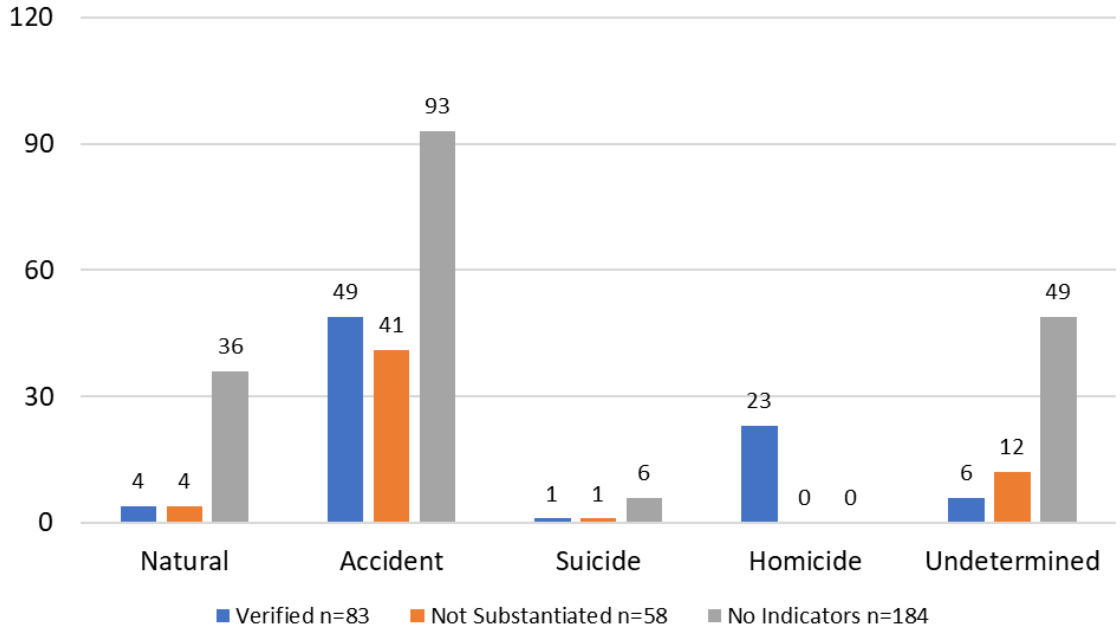
OFFICIAL MANNER OF DEATH

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

Figure 4 demonstrates the official manner of death as indicated on the death certificate for all child fatalities reviewed for this report. Of the 83 child fatalities verified to be the result of abuse and/or neglect, 49 (59.0%) were classified as accidents and 23 (27.7%) were classified as homicides. Among the 58 not-substantiated child deaths, the largest number of deaths (41 or 70.1%) were classified as accidents followed by undetermined causes (12 or 20.1%). Among the 184 no indicators child deaths, the official manner of death was most frequently classified as an accident (93 or 50.5%), followed by undetermined (49 or 26.6%) and natural causes (36 or

19.6%). In determining manner of death, Medical Examiners (ME) are limited to a certain range of choices that do not include “neglect.” Subsequently, cases verified for neglect are often classified as accidental by Medical Examiners.

Figure 4: Official Manner of Death by Maltreatment Verification Status (n=325)



PRIMARY CAUSE OF DEATH

Figure 5 demonstrates the distribution of child fatality cases reviewed by the primary cause of death, across child maltreatment verification status. Among the 83 verified maltreatment fatalities, 73 (88.0%) were the result of an external injury, 3 (3.6%) were due to a medical cause and 7 (8.4%) had an undetermined or unknown cause of death. Among the 58 not substantiated maltreatment fatalities, 45 (77.6%) were the result of an external injury, 3 (5.2%) were determined to have a medical cause and 10 (5.8%) had undetermined or unknown cause of death. Among the 184 no indicators deaths, 112 (60.9%) were the result of an external injury, 32 (17.4%) were determined to have a medical cause, 37 (20.1%) were undetermined and 3 (1.6%) had unknown cause of death.

Figure 5: Primary Cause of Death Across Maltreament Verification Status (N=325)

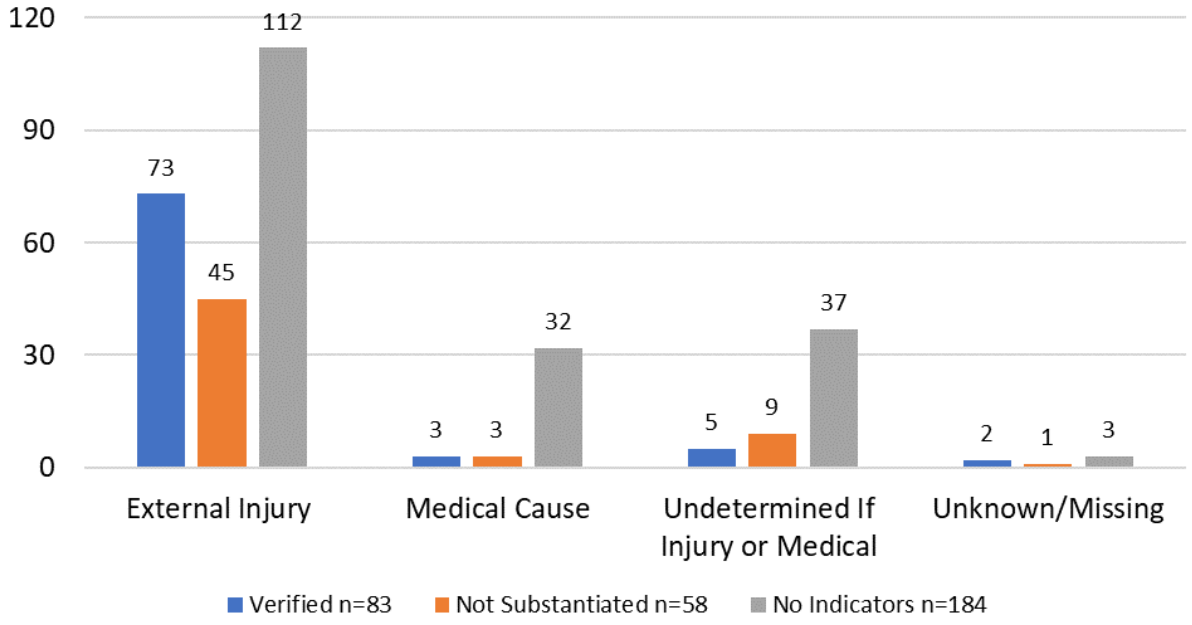


Figure 6 and Table 3 distinguish three prevalent primary causes of death associated with external injuries. They account for 76.1% of verified maltreatment fatalities: sleep-related (40.3%), drowning (21.8%) and inflicted trauma (8.3%). These are the primary cause of death categories throughout this report.

Of the 23 verified child fatality incidents due to homicide, 20 (86.9%) resulted from inflicted trauma, 1 (4.3%) involved fire, burn, or electrocution, 1 (4.3%) involved drowning and 1 (4.3%) was identified as “other cause.”

Figure 6: Cause of Death Across Maltreatment Verification Status (N=325)

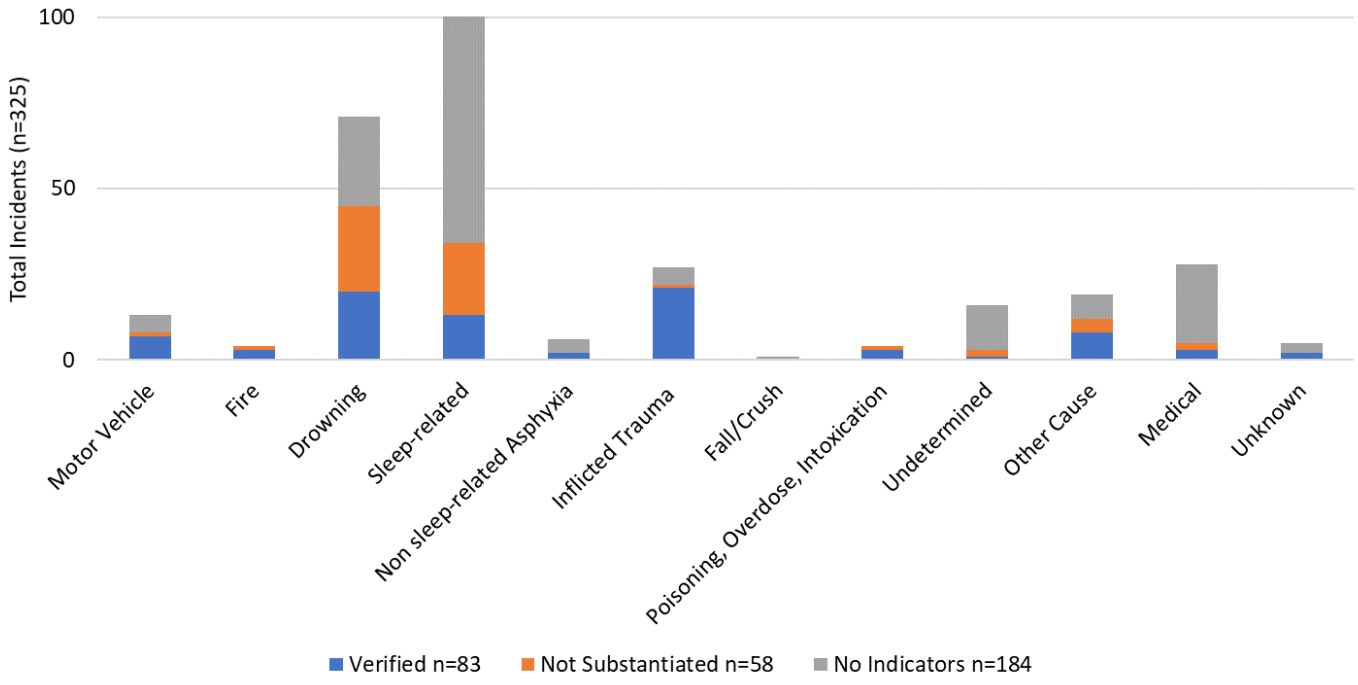


Table 3: Itemization of Cause of Death by Child Maltreatment Verification Status			
	Child Maltreatment Death		
Cause of Death	Verified n=83	Not Substantiated n=58	No Indicators n=184
Motor Vehicle	7	1	5
Fire	3	1	0
Drowning	20	25	26
Sleep-related	13	21	97
Non sleep-related Asphyxia	2	0	4
Inflicted Trauma	21	1	5
Fall/Crush	0	0	1
Poisoning, Overdose, Intoxication	3	1	0
Undetermined	1	2	13
Other Cause	8	4	7
Medical	3	2	23
Unknown	2	0	3

Table 4 displays primary cause of death resulting from a medical cause.

Table 4: Itemization of Specific Medical Cause of Death by Child Maltreatment Verification Status			
Specific Medical Cause of Death	Child Maltreatment Death (Medical Cause) n=38		
	Verified n=3	Not Substantiated n=3	No Indicators n=32
Cancer	0	0	1
Cardiovascular	0	0	4
Congenital Anomaly	0	0	3
HIV/AIDS	0	0	0
Influenza	1	0	1
Low Birth Weight	0	0	0
Malnutrition/Dehydration	0	0	0
Neurological/Seizure Disorder	0	0	2
Pneumonia	0	1	7
Prematurity	2	1	1
SIDS	0	0	3
Other Infection	0	0	2
Other Perinatal	0	0	0
Other Medical	0	1	5
Diabetes	0	0	0
Asthma	0	0	2
Undetermined	0	0	1
Unknown/Missing	0	0	0

LOCATION OF CHILD DEATHS

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

- 68 of 131 (51.9%) of all sleep-related deaths occurred in five counties: Broward, Duval, Hillsborough, Orange and Polk. Duval County alone accounted for 24 of 131 (18.3%) of all sleep-related deaths
- 34 of 71 (47.9%) of all drownings occurred in five counties: Broward, Duval, Hillsborough, Pasco and Volusia

- 27 deaths due to inflicted trauma occurred across 15 counties, with 4 occurring in Orange County (14.8%)

SLEEP-RELATED DEATH INCIDENT INFORMATION

Incidents related to sleeping or the sleep environment remain the primary cause of child deaths reviewed by Local CADR Committees. Sleep-related deaths account for 131 of 325 (40.3%) of all 2018 CADR cases available for review, with 13 verified maltreatment deaths, 21 not substantiated and 97 deaths determined to have no indicators of abuse or neglect (Table 5). The cause of a sleep-related death may not be able to be determined after investigation, therefore, may be classified as a death from an unknown or undetermined cause.

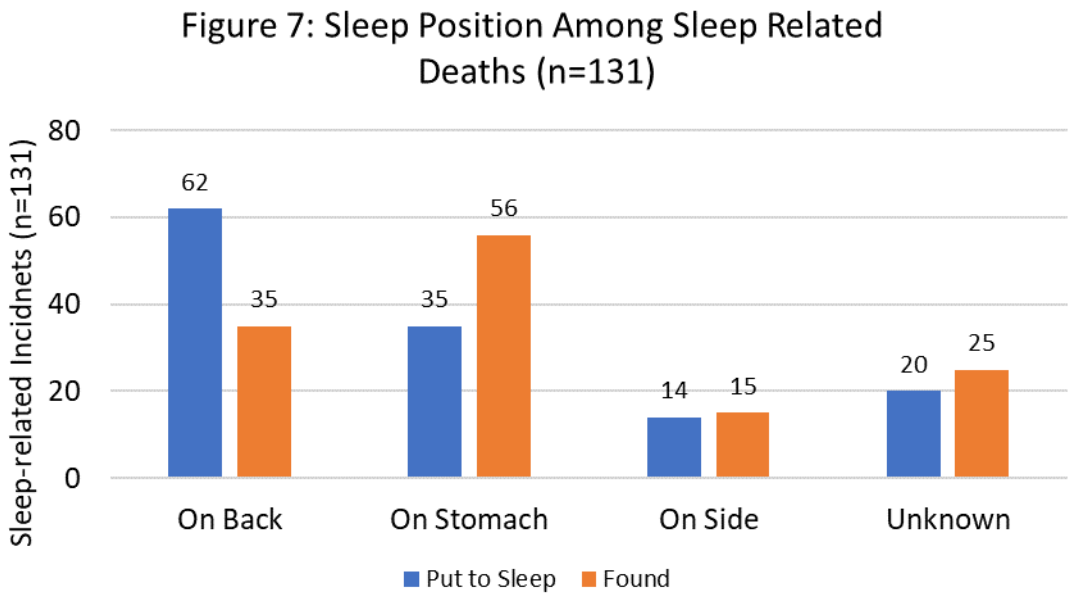
Death scene investigations involving sleep-related incidents provide information regarding location and position in which the child was placed and found. These narratives can be used in conjunction with ME findings to provide a more encompassing view of the incident.

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

Death due to Sleeping or Sleep-environment	Child Maltreatment Death n=131		
	Verified (n=13)	Not Substantiated (n=21)	No Indicators (n=97)
Asphyxia	9	12	61
Medical	0	1	9
Undetermined	4	7	27
Unknown	0	1	0

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

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



- On Back was the usual reported placement position for 62 of 131 (47.3%) of children who died from asphyxia.
- On Stomach was the most frequently reported sleep position when the child was found non-responsive or deceased, accounting for 56 of 131 (42.7%) child deaths where sleep position at time of death was known.

Figure 8 and Table 6 demonstrate incident sleep place for sleep-related deaths. Here, 60.0% of verified maltreatment deaths, 50.0% of not substantiated, and 59.8% of no indicators for maltreatment occurred in an adult bed for all reviewed sleep-related deaths. Together, 58.8% of all sleep-related deaths took place in an adult bed.

Figure 8: Incident Sleep Place for Sleep-Related (n=131)

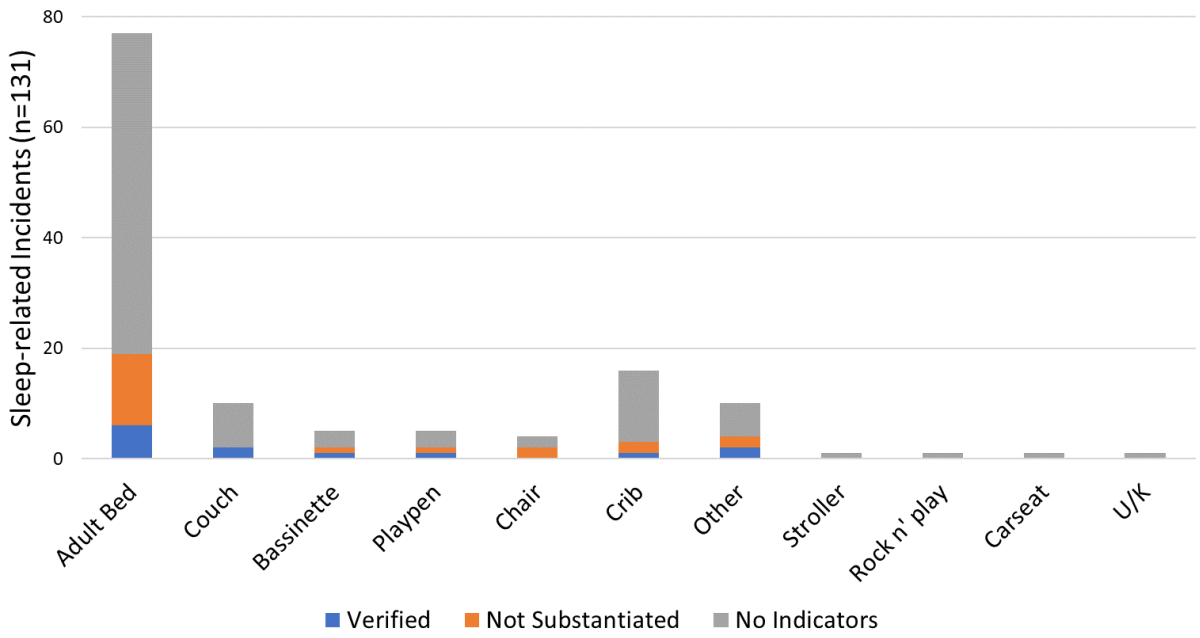
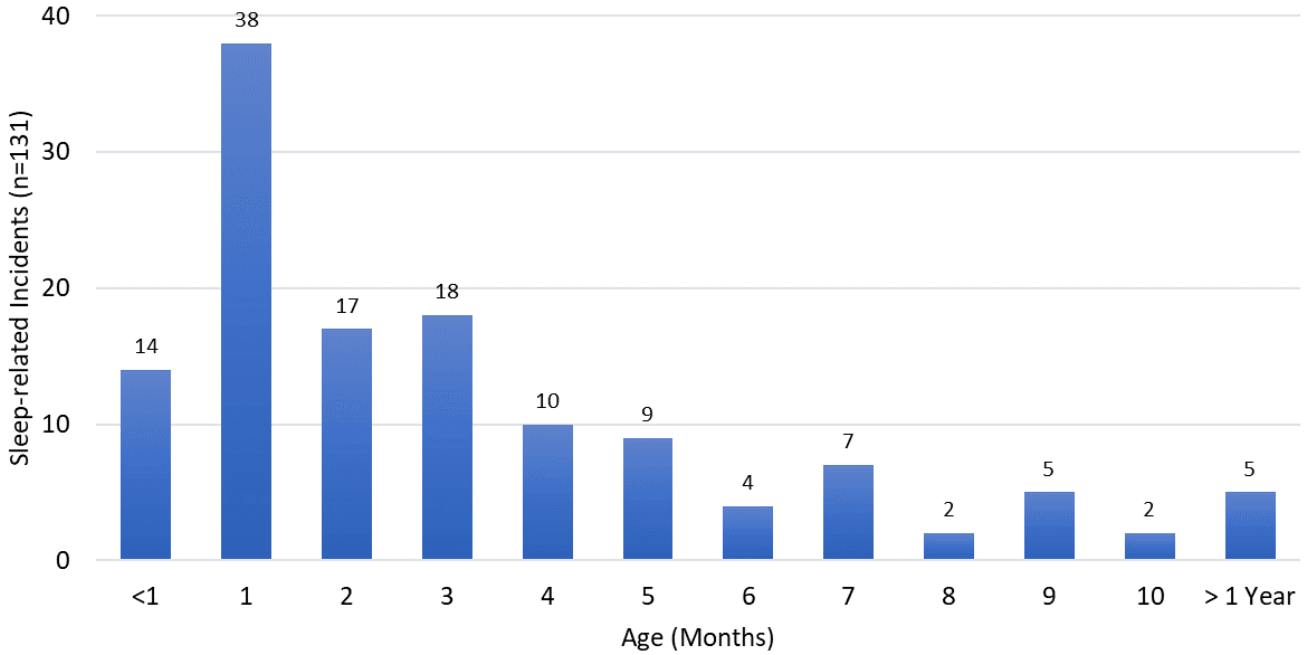


Table 6: Incident Sleep Place for Sleep-Related Deaths			
Incident Sleep Place	Child Maltreatment Death n=131		
	Verified n=13	Not Substantiated n=21	No Indicators n=97
Adult Bed	6	13	58
Couch	2	0	8
Bassinette	1	1	3
Playpen	1	1	3
Chair	0	2	2
Crib	1	2	13
Other	2	2	6
Stroller	0	0	1
Rock n' play	0	0	1
Carseat	0	0	1
Unknown/Missing	0	0	1

Figure 9 provides the age breakdown of the child during a sleep-related death incident. In 2018, of the 131 sleep-related death incidents, 87 (66.4%) involved children 3 months of age and younger, while 38 (29%) occurred at one month of age.

Figure 9: Age breakdown of sleep-related Deaths



Information analyzed as part of the 2018 child fatality review indicate the following:

- 10 caregivers/supervisors fell asleep while feeding
  - 4 of 10 (40.0%) bottle feeding
  - 6 of 10 (60.0%) breastfeeding

Death scene investigations for sleep-related incidents were completed for 123 of 131 (93.9%) reported cases. Of the 123 cases, 37 (30.1%) death scene doll-reenactments were conducted. Of the 37 doll-reenactments conducted, information from 17 (45.9%) were shared with Local CADR Committees.

Sleep-related Data Summary

- ***58.8% of all sleep-related deaths took place in an adult bed***
- ***Children between 0 and 3 months of age made up 66.4% of all 2018 sleep-related fatalities***
- ***58.8% of all sleep-related deaths involved male children***
- ***47.3% of children were placed on their back prior to the sleep event and 42.7% were found non-responsive on their stomach***

DROWNING DEATH INCIDENT INFORMATION

For drowning related child death cases, Local CADR Committees collect specific information on the details associated with each death including location of the incident and whether a barrier was in place. Figure 10 demonstrates details of the location of drowning deaths with pool/hot tub/spa represented in 44 of 71 (62.0%) of total drowning incidents.

Figure 10: Drowning Location by Child Maltreatment Verification Status n=71

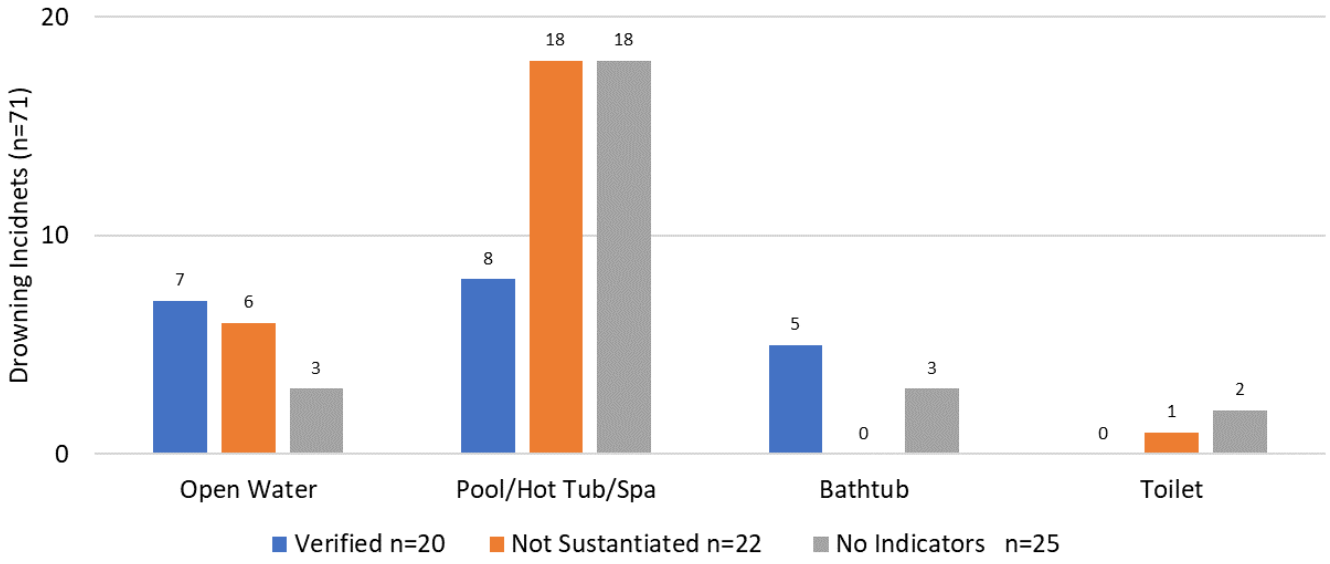


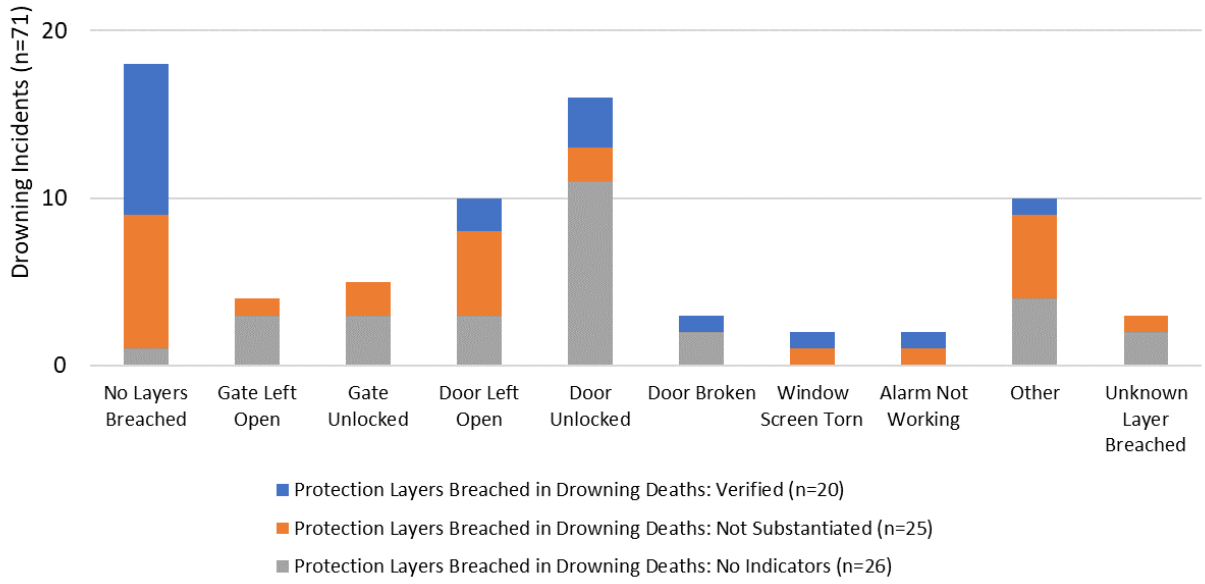
Table 7 details the type of barrier(s) that were in place. Barriers are physical structures such as a door or a fence that are intended to limit access to potentially hazardous bodies of water. Note that the presence of a barrier does not indicate effectiveness of the barrier.

Table 7: Barriers in Place Where Drowning Took Place by Child Maltreatment Verification Status (Duplicate Counts if Multiple Barriers)			
Barriers in Place	Child Maltreatment Death n=71		
	Verified n=20	Not Substantiated n=25	No Indicators n=26
None	6	8	4
Fence	3	8	5
Gate	2	7	6
Door	4	11	13
Alarm	1	2	2
Cover	0	0	0
Unknown/Missing	1	1	1

Since protective barriers were in place for most bodies of water (predominately pools, hot tubs, and spas) where children drowned, information was reviewed regarding the protective layers that were breached. Where data were available, the most prevalent breach for verified maltreatment drowning deaths included doors being left unlocked (3) and doors left open (2), as seen in Figure 11.

Among not substantiated and no indicator drowning deaths, the most prevalent breaches included unlocked door (13), door left open (8), gate left open (4), and “other” breach (9). For additional detail, reference tables F-3, F-4 and Figure F-1 in Appendix F.

Figure 11: Protection Layers Breached in Drowning Deaths (N=71)



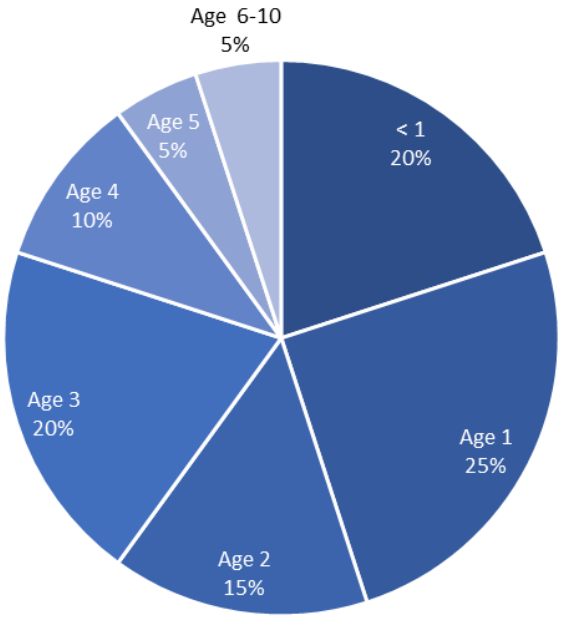
Of 20 verified drowning deaths

- 16 (80.0%) occurred at the age of 3 or under (Figure 12)
- 15 (75.0%) of the children did not know how to swim
- 8 (40.0%) occurred in pools, hot tubs, or spas
- 6 (30.0%) had no barriers to bodies of water

Of 51 not substantiated or no indicators drowning deaths:

- 42 (82.4%) children were not able to swim
- 36 (83.0%) drowning death locations occurred in pools, hot tubs, or spas
- 12 (23.5%) drowning death locations had no barriers to bodies of water

Figure 12: Verified Maltreatment Drowning Deaths by Age of Child (n=20)



Drowning Data Summary

- ***Drowning deaths occurring in a Pool/Hot tub/Spa account for 62.0% of all 2018 drowning related fatalities***
- ***Children 3 years of age and younger make up 74.6% of all 2018 drowning related fatalities***
- ***66.2% of all 2018 drowning related fatalities involved male children***
- ***40.8% of children were located within the home prior to the drowning incident with 63.4% described as playing before the drowning event took place***
- ***39.4% of barriers designed to prevent a child from entering a location where a potential drowning hazard can be located were identified as being a door***
- ***40.8% of barriers breached during the drowning incident were recognized as "Door Left Open", "Door Unlocked" and "Door Broken"***

INFLICTED TRAUMA DEATH INCIDENT INFORMATION

The intentional bodily infliction of harm is captured in this category and remains a leading cause of preventable child death. Information is assessed regarding weapon-related deaths, including the type of weapon used and the person handling the weapon. The "weapons" category includes firearms, body parts such as fists, hands or feet and any other items that can be used as weapons. At the time data were analyzed for this report, several cases were not yet available for review (44 cases were still open to investigation). Many of these cases remain open due to pending law enforcement investigation or judicial action and may be classified as weapon-related deaths. It is expected figures presented on weapons will increase when all 2018 deaths are reviewed. Table 8 (with Figure 13) demonstrates the type of weapons used across maltreatment verification status. Table 9 presents information specific to firearms used in weapons-related deaths.

Among the verified maltreatment weapon deaths (21):

- 10 (47.6%) weapons used were firearms:
  - 9 of 10 firearms (90.0%) were handguns
  - 5 of 10 (50.0%) firearm owners were male
- 7 (33.3%) weapons were body parts (indicating physical abuse)
- 2 (9.5%) weapons were sharp instruments
- 1 (4.8%) weapons were blunt instruments
- 1 (4.8%) was classified as other

Among the not substantiated and no indicators of maltreatment deaths combined (6):

- 6 (100.0%) weapons used were firearms

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

Table 8: Type of Weapon by Maltreatment Verification Status

Type of Weapon	Child Maltreatment Death		
	Weapons:		
	Verified (n=21)	Not Substantiated (n=1)	No Indicators (n=5)
Firearm	10	1	5
Sharp Instrument	2	0	0
Blunt Instrument	1	0	0
Persons Body Part	7	0	0
Other	1	0	0

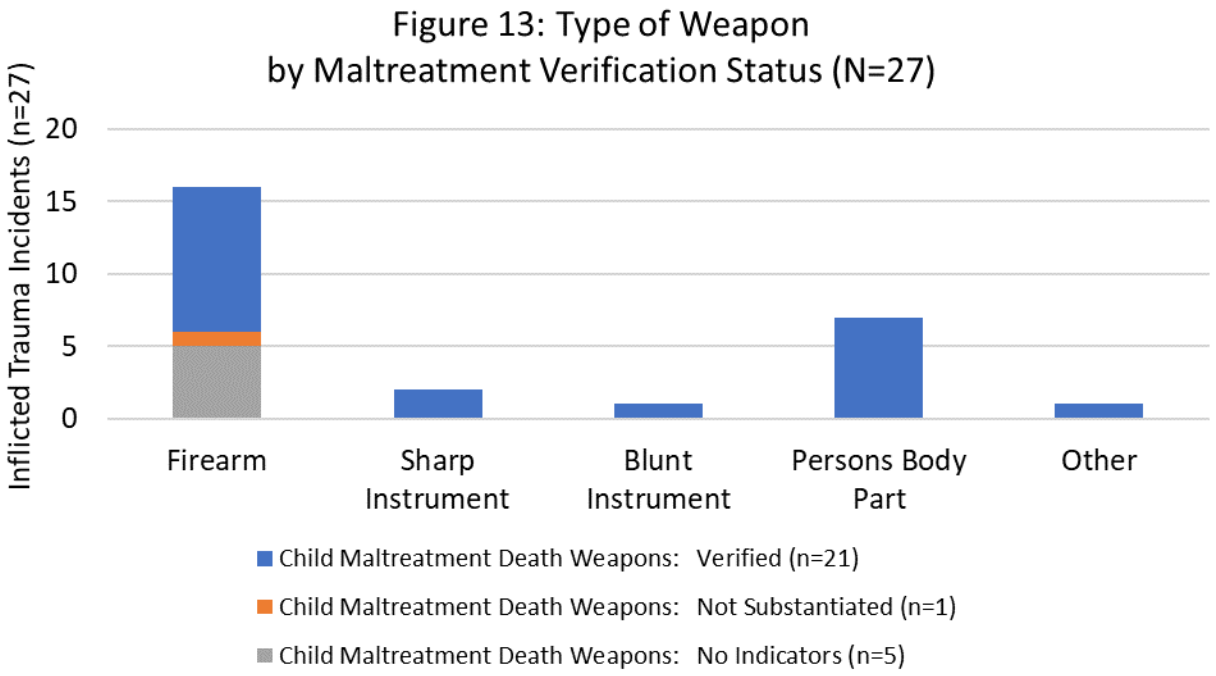


Table 9: Type of Firearm by Maltreatment Verification Status			
Type of Firearm	Child Maltreatment Death n=16		
	Verified n=10	Not Substantiated n=1	No Indicators n=5
Handgun	9	0	5
Shotgun	0	1	0
BB Gun	0	0	0
Hunting Rifle	0	0	0
Assault Rifle	0	0	0
Air Rifle	1	0	0
Sawed-Off Shotgun	0	0	0
Other	0	0	0
Unknown/Missing	0	0	0

Table 10 data reveal 20 of 23 (87.0%) verified homicides were the cause of inflicted trauma. However, there were 3 of 23 (13.0%) verified maltreatment homicide cases in which the external cause of death is reported as something other than inflicted trauma.

Table 10: Homicide Breakdown	
Homicide (Verfied Maltreatment n=23)	
Inflicted Trauma	20
Fire	1
Drowning	1
Other Cause	1

Inflicted Trauma Data Summary

- ***87.0% of homicides were the result of inflicted trauma***
- ***59.3% of weapons utilized during death incidents were firearms***
- ***87.5% of weapons identified as a firearm were handguns***
- ***25.9% of weapons utilized during death incidents were body parts***

CHILD CHARACTERISTICS

The following section highlights analyses associated with select child characteristics.

Age of Child

Regardless of verification status, children under age five had the highest risk for all forms of death with 282 of 325 (86.8%) of reported cases. As shown in Table 11 and Figure 14:

- Among drowning deaths 53 of 71 (74.6%) were children three years of age and younger
- Among sleep-related deaths 126 of 131 (96.2%) were children less than one-year-old and most of the incidents, 87 of 131 (66.4%), were 3 months and younger
- Most children who died from a weapon related causes were between 6 and 15 years of age with 16 of 27 (55.6%) of cases representing this group
- 62 of 96 (64.6%) child deaths attributed to “other” causes were under the age of one

Figure 14: Age of Children by Primary Cause of Death (n=325)

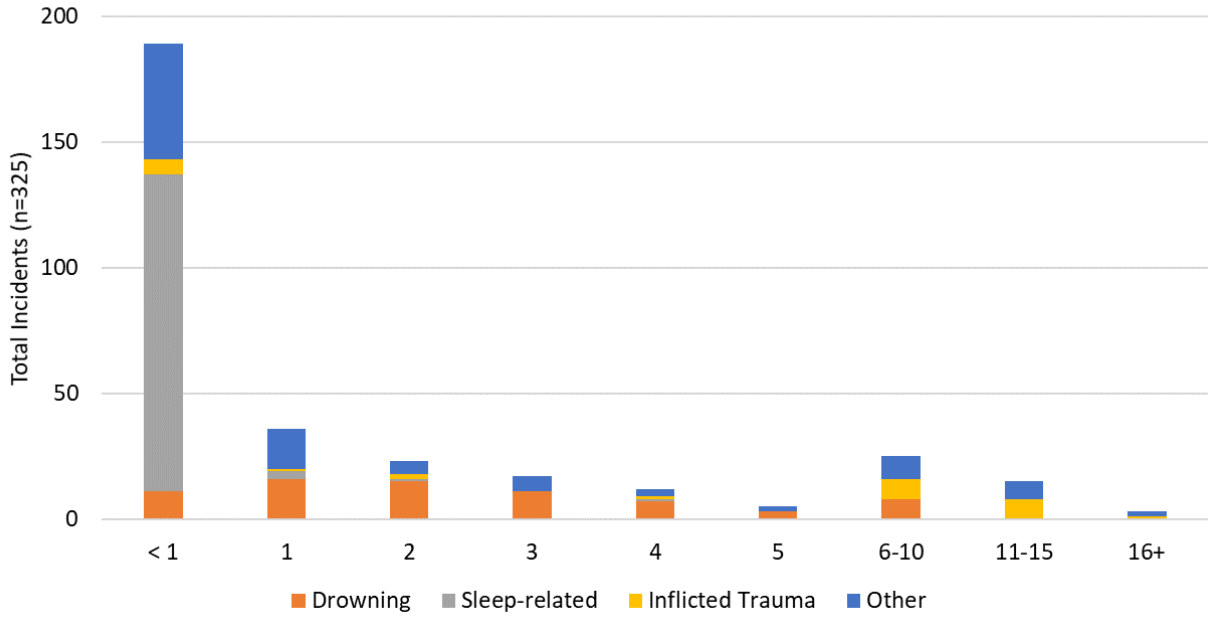


Table 11: Age of Children by Primary Cause of Death				
Age	Verified Child Maltreatment Death			
	Drowning n=71	Sleep-related n=131	Inflicted Trauma n=27	Other n=96
< 1	11	126	6	46
1	16	3	1	16
2	15	1	2	5
3	11	0	0	6
4	7	1	1	3
5	3	0	0	2
6-10	8	0	8	9
11-15	0	0	8	7
16+	0	0	1	2

RACE OF CHILD AND HISPANIC OR LATINO ORIGIN

Child death case reviews result in the collection of data on race and ethnicity as related to child fatalities. As seen in Table 12 and Figure 15, 125 of 325 (38.5%) children were identified as black and 187 (57.5%) were identified as white.

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

- 15.0% of drowning deaths
- 9.1% of asphyxia deaths
- 21.7% of weapon deaths
- 12.0% of other deaths

Figure 15: Race of Children by Primary Cause of Death (n=325)

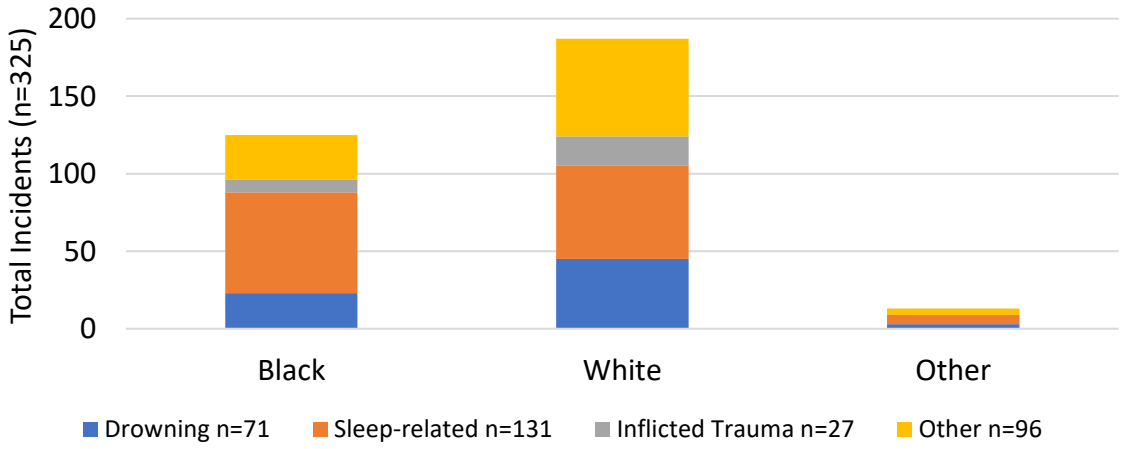


Table 12: Race and Ethnicity (Hispanic/Latino Origin) of Children by Primary Cause of Death				
Race	Drowning n=71	Sleep-related n=131	Inflicted Trauma n=27	Other n=96
Black	23	65	8	29
White	45	60	19	63
Other	3	6	0	4
Hispanic or Latino Origin				
Hispanic or Latino	19	26	8	23
Please note that column totals may exceed 100% as children can be identified as bi- or multi-racial/ethnic.				

SEX OF CHILD

Males were disproportionately represented among child fatalities across all primary causes of death (see Table 13 and Figure 16).

Figure 16: Gender of Children Primary Cause of Death (n=325)

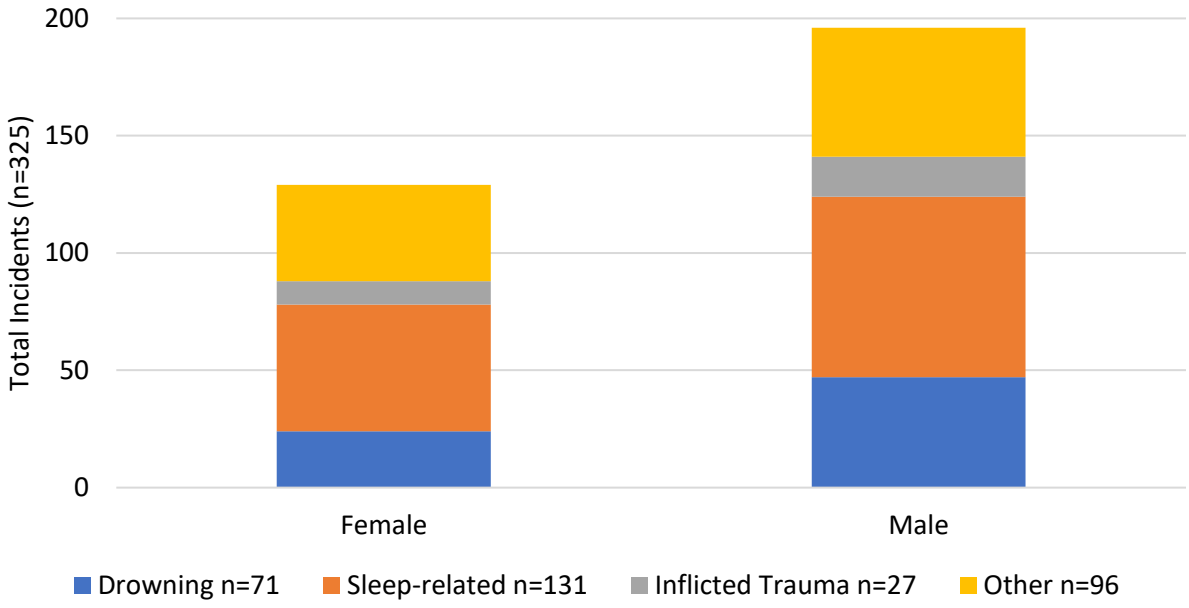


Table 13: Gender of Children by Primary Cause of Death				
Gender	Drowning n=71	Sleep-related n=131	Inflicted Trauma n=27	Other n=96
Female	24	54	10	41
Male	47	77	17	55

Child's History as Victim of Child Maltreatment

Information related to the child's history of child maltreatment was solicited from two data sources. Local CADR Committees reported on the child's history based upon a review of case information.

Child maltreatment history was known for 257 of 325 cases (79.1%), and unknown or not reported for 68 (21%) cases. Among the 257 cases for which this history was reported, 47 (18.3%) children had a known history of child maltreatment. Of these 47 children with a known history of maltreatment:

- 21 (44.7%) were verified
- 7 (14.9%) were not substantiated
- 19 (40.4%) were no indicators

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

Child Characteristics Data Summary
• ***58.2% of all child fatality incidents reported to the DCF hotline were < 1-year-old*** • ***60.3% of all child fatality incidents reported to the DCF hotline were classified as male*** • ***38.5% of all child fatality incidents reported to the DCF hotline were identified as black***

CAREGIVER AND SUPERVISOR CHARACTERISTICS

During case reviews, information is collected on the child's caregivers and the supervisor of the child at the time of the incident leading to the child's death. Caregivers are identified as the child's "primary caregivers" regardless of their involvement in the child's death. Opportunities are provided for the Local CADR Committees to collect information on up to two primary caregivers. The supervisor of the child is the person primarily responsible for monitoring the child at the time of the death incident. This person may or may not be one of the primary caregivers.

Substance Abuse History of Caregivers and Supervisors

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

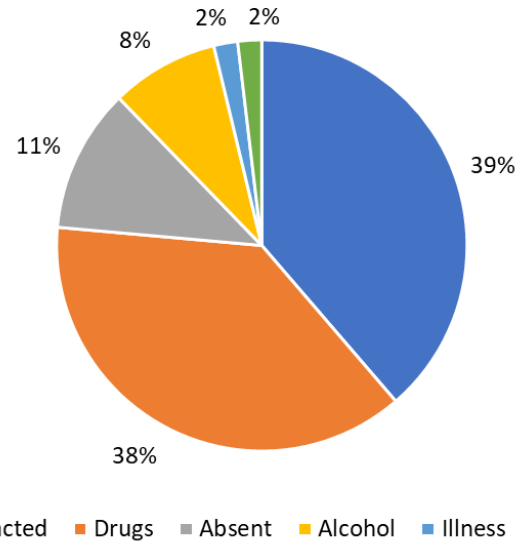
For verified child maltreatment cases:

- 33.7% of caregivers were known to have a substance abuse history
- 38.6% of supervisors were known to have a substance abuse history

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

Information is collected regarding whether the supervisor of the child at the time of the death incident was impaired. Supervisor impairment was identified for 86 of 325 (26.5%) cases, not identified for 145 of 325 (44.6%) and unknown or missing for 94 of 325 (28.9%) cases. Among the 86 cases where the supervisor was impaired, 28 were verified, 24 were not substantiated and 34 had no indicators. Figure 17 provides a breakdown of the distribution of types of supervisor impairment across all investigated deaths; supervisors can be identified to have more than one impairment.

Figure 17: Supervisor Impairment at Time of Death Incident
(n=106 Impairments for 86 Supervisors)



Mental Health History of Caregivers and Supervisors

Collection of data regarding mental health history can be challenging for several reasons. There are likely differences in how this data element may be interpreted and collected by each committee (i.e., requiring a formal diagnosis versus collateral information). In addition, individuals with a past diagnosis of mental illness may be reluctant to share this information. Thus, mental health history can be under-reported, leading to case sample sizes that are too small to reach valid conclusions. For example, among all caregivers identified across all child fatality cases reviewed, information on the history of chronic illness (including mental health history) is unknown for 80 caregivers. However, there were an additional 114 caregivers for which data were missing on this question. These figures highlight the need for better collection of information regarding mental health history of family members associated with a child fatality case.

Disability or Chronic Illness Occurrence of Caregivers and Supervisors

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

Additional Characteristics of Caregivers and Supervisors

Appendix F includes detailed information on the following:

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

History as Victim of Child Maltreatment among Caregivers and Supervisors

Local CADR Committees collect information regarding caregiver and supervisor history as a victim of child maltreatment. Local CADR Committees reported on 566 caregivers identified (up to two caregivers could be identified per case) for the 325 cases reviewed of which historical information was available.

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

- 27 of 135 (20.0%) caregivers of verified maltreatment had a history as a victim of child maltreatment.
- 28 of 104 (26.9%) caregivers of not substantiated maltreatment had a history as a victim of child maltreatment.
- 66 of 327 (20.2%) caregivers of no indicators maltreatment deaths had a history as a victim of child maltreatment.

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

- 16 of 83 (19.3%) supervisors of verified maltreatment had a history as a victim of child maltreatment.
- 14 of 58 (24.1%) supervisors of not substantiated maltreatment had a history as a victim of child maltreatment.
  39 of 184 (21.2%) supervisors of no indicators maltreatment deaths had a history as a victim of child maltreatment.

History as Perpetrator of Child Maltreatment among Caregivers and Supervisors

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

- 46 of 135 (34.1%) caregivers of verified maltreatment had a history as a perpetrator of child maltreatment.
- 19 of 104 (18.1%) caregivers of not substantiated maltreatment had a history as a perpetrator of child maltreatment.
- 76 of 327 (23.2%) caregivers of no indicators maltreatment deaths had a history as a perpetrator of child maltreatment.

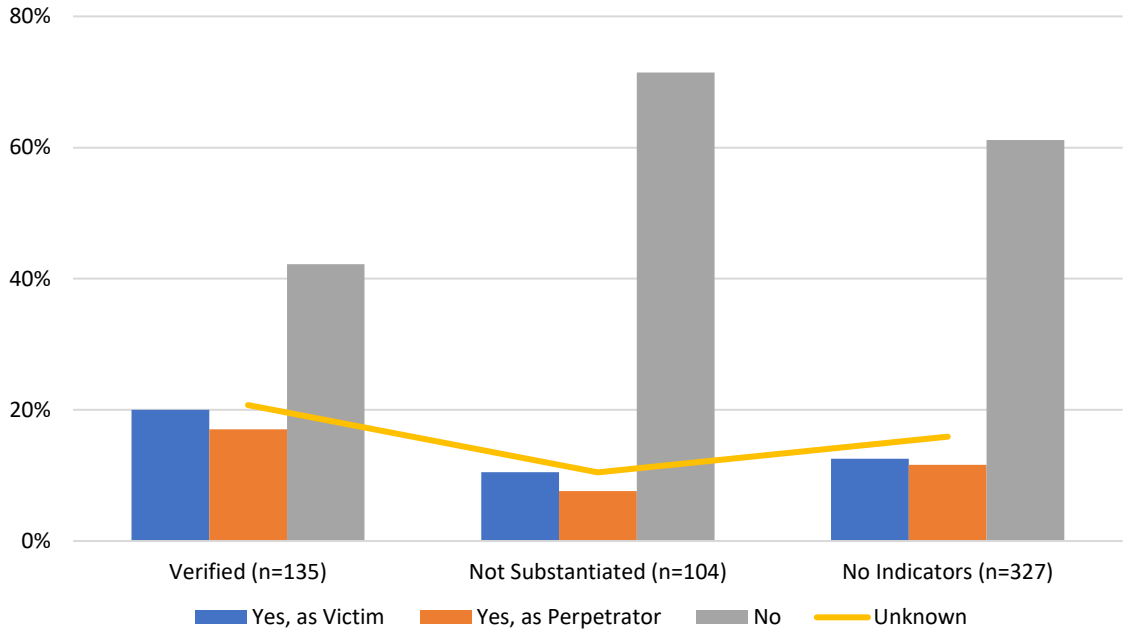
When history as a perpetrator of child maltreatment is examined for supervisors associated with maltreatment deaths:

- 21 of 83 (25.3%) supervisors of verified maltreatment had a history as a perpetrator of child maltreatment.
- 7 of 58 (12.1%) supervisors of not substantiated maltreatment had a history as a perpetrator of child maltreatment.
- 39 of 184 (21.2%) supervisors of no indicators maltreatment deaths had a history as a perpetrator of child maltreatment.

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

When available, Local CADR Committees collected information about caregivers' history with intimate partner violence (IPV) as a victim and/or perpetrator. It is unclear whether the caregivers were victims or perpetrators near the time of the child's death or if caregiver history was determined by historical information gathered by local teams during case reviews. In total, 27 of 135 (20.0%) of caregivers were known to be victims and 23 of 135 (17.0%) were known to be perpetrators of intimate partner violence among those affiliated with verified maltreatment deaths (Figure 18). With respect to caregivers in not substantiated maltreatment deaths, 11 of 104 (10.6%) were past victims and 8 of 104 (7.7%) were past perpetrators of intimate partner violence (Figure 18). Finally, with respect to caregivers in no indicator deaths, 41 of 327 (12.5%) were past victims of intimate partner violence and 38 of 327 (11.6%) were past perpetrators of intimate partner violence (Figure 18).

Figure 18: History of Intimate Partner Violence with All Caregivers by Maltreatment Verification Status (N=566)



When available, Local CADR Committees collected information about supervisors' history with intimate partner violence (IPV) as a victim and/or perpetrator. It is unclear whether the supervisors were victims or perpetrators near the time of the child's death or if supervisor history

was determined by historical information gathered by local teams during case reviews. In total, 16 of 83 (19.3%) of supervisors were known to be victims and 12 of 83 (14.5%) were known to be perpetrators of intimate partner violence among those affiliated with verified maltreatment deaths. With respect to supervisors in not substantiated maltreatment deaths, 4 of 58 (6.9%) were past victims and 2 of 58 (3.4%) were past perpetrators of intimate partner violence. Finally, with respect to supervisors in no indicator deaths, 24 of 184 (13.0%) were past victims of intimate partner violence and 16 of 184 (8.7%) were past perpetrators of intimate partner violence. Appendix F provides more detailed information regarding the history of IPV (as victim and perpetrator) among caregivers and supervisors.

Past Criminal History of Caregivers and Supervisors

Among caregivers associated with verified maltreatment deaths, 49 of 135 (36.3%) committed a criminal offense in the past with the most common offenses identified as: “other criminal act” representing 30 of 49 (61.2%), “assault” representing 22 of 49 (44.9%) and “drug offense” representing 12 of 49 (40.8%).

Among supervisors associated with verified maltreatment deaths, 29 of 83 (34.9%) committed a criminal offense in the past with the most common offenses identified as: “other criminal act” representing 18 of 29 (62.1%), “assault” representing 13 of 29 (44.8%) and “drug offense” representing 12 of 29 (41.4%).

Caregiver and Supervisor Data Summary

- ***Relating to verified maltreatment, 33.7% of caregivers and 38.6% of supervisors reported having a substance abuse history***
- ***Relating to verified maltreatment, 36.3% of caregivers and 34.9% of supervisors reported having a criminal past***
- ***39.0% of supervisors were reported their impairment status as “distracted” during the death incident***

SECTION FOUR: FUTURE ANALYTIC PLANS

The 2019 CADR Annual Report represents Florida's fifth year reporting through the National Fatality Review Case Reporting System. This compilation of data signifies a milestone in which trend analysis of child deaths in Florida can have a significant impact on the future development and implementation of prevention strategies. In-depth trend analyses of child death investigations coupled with a critical appraisal of past and current prevention initiatives will be instrumental in evaluating the effectiveness of prevention strategies. Listed below are strategies intended to bolster local and state CADR stakeholders' collaborative efforts through the utilization of data tools and planned future analyses.

Emphasis on data access and collaboration

- **Engaging Stakeholders** - The primary focus of the State CADR Committee will continue to be enhancing data infrastructure with an emphasis on data access. CADR support staff will perform queries regarding circuit-level data with advanced comparisons to statewide CADR data and vital statistics information. Data quality assurance will be performed quarterly. Any data elements captured in the National Fatality Review Case Reporting Form can be analyzed to support Local CADR Committee queries. These queries 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 local and state CADR stakeholders is imperative to improving future prevention strategies.

- **Business Intelligence and Analytics** - Implementation of data portals and dashboards through the statistical analysis software will provide Local CADR Committees access to all information pertaining to child fatalities while permitting control over the data elements. Complete access, dynamic capacity and the geographical location of incidents to the ZIP code level will allow CADR data to further support Local CADR Committees and stakeholders.

- **Data Webinars** – Business intelligence software can assist in providing access, analysis and presentation of robust databases. However, the prospect of utilizing data portals and dashboards can be daunting. CADR support staff will provide web-based training on CADR data, navigation of CADR dashboards and how to maximize the value and utility of available data to enhance collaboration with stakeholders.

In-depth supplemental analysis of Florida's CADR database (2015-2019 Reporting Years)

- **Trend Analysis** - A consistent annual reporting system allows for thorough analysis of multiple years of information for the purpose of identifying local and statewide child fatality trends and contributing factors. These trend-analyses will afford stakeholders at the local and state level an exclusive opportunity to gauge the success of prevention strategies, evaluate the benefit-cost ratio associated with these initiatives and share program successes and failures with other local municipalities.

- **Statewide population statistics** - An in-depth analysis of statewide population data will offer an exclusive look at groups of children who are disproportionately at risk for maltreatment and specific fatality incidents based on gender, race, age and other factors as compared to the total population. These analyses on integrated data (from multiple sources) will be instrumental in determining whether specific demographics or social determinants associated with child fatalities are over or under-represented as compared to local and statewide populations. As a result, this will allow local committees to create more tailored action plans to underrepresented at-risk children.

- **Focused Report** - CADR support staff will continue to actively perform focused analysis on continuing or emerging trends in child deaths observed in the National Fatality Review Case Reporting System. These analyses will be structured to provide in-depth breakdowns of child deaths relating to safe sleep practices, water safety and inflicted trauma; and be responsive to questions generated from continued analyses, State and Local CADR Committees and local and statewide community stakeholders. These focused reports will also highlight data elements that are underreported, such as mental health and substance abuse. Current CADR data demonstrate a potential correlation between caregiver substance use or abuse and child fatality incidents. However, there is a significant amount of information unknown and underreported regarding caregiver substance use and abuse, demonstrating a required need to enhance data collection opportunities and methods. Enhanced data collection and focused analyses can contribute to a more thorough understanding of how substances such as marijuana, alcohol, over-the-counter medications and other substances impact child safety.

SECTION FIVE: CURRENT ISSUES AFFECTING FLORIDA'S CHILDREN AND FAMILIES

The climate of child welfare in Florida continues to evolve with numerous issues adversely affecting the well-being of children and families including the opioid crisis, suicide and co-occurring substance abuse and mental health disorders. While data collected during child-death investigations is valuable, information regarding substance abuse and mental health is primarily self-reported and data regarding this contributing factor is not consistently available. By studying literature and research regarding current social issues facing Florida families, State and Local CADR Committees can apply a more in-depth and thorough understanding to local prevention efforts.

The opioid crisis continues to have a severe impact on the welfare of Florida's children including an increase in the number of children born addicted to opioids. On May 3, 2017, the Governor of the State of Florida signed Executive Order Number 17-146 declaring a public health emergency due to the state's opioid epidemic. Since the implementation of the E-FORCSE® Prescription Drug Monitoring Program in 2011, the state has seen a dramatic decrease in deaths associated with prescribed opioids, while seeing a continual increase in deaths associated with the use of heroin, morphine, fentanyl, and illicitly manufactured fentanyl analogs instead of Oxycodone, as reported in the 2018 State Epidemiological Outcomes Workgroup Annual Report. CADR continues to work to develop effective prevention strategies in partnership with agencies including DCF, Agency for Health Care Administration, Florida Department of Law Enforcement and others to collaboratively address this critical issue facing Florida's families.

Co-occurring disorders, involving both mental health issues and substance abuse have a continued prevalence throughout Florida and a significant impact on the well-being of children in our state. Substance Abuse and Mental Health Services Administration (SAMHSA) reports almost all persons struggling with substance abuse are also dually diagnosed with mental health disorders including Post-Traumatic Stress disorder (PTSD) and a variety of depressive and anxiety related disorders. Current literature based upon the Adverse Childhood Experiences Study (ACEs) demonstrates that children with caregivers suffering from mental health and substance abuse disorders are more likely to experience a variety of stressors including exposure to domestic violence, increased risk of poverty and at an increased risk of child abuse and neglect. Local CADR Committees work together with resources in their communities who are addressing co-occurring substance abuse and mental health in the home, providing critical data and education regarding the needs of this population.

In 2017, the Centers for Disease Control and Prevention (CDC) identified suicide as the eighth leading cause of death in the state of Florida, identifying death by suicide as a serious public health issue. In 2018, there were 76 child suicides according to Florida Health CHARTS; 8 of which were called into the Florida Abuse Hotline on the suspicion of alleged abuse or neglect and subsequently reviewed by Local CADR Committees. The ACEs Study indicates that a primary contributing factor to suicide is the prevalence of adverse childhood experiences, particularly in early childhood. An increased exposure to adverse childhood experiences has a

strong relationship to suicide attempts in childhood, adolescence and adulthood. The Annie E. Casey Foundation, Kids Count Survey, demonstrates that 25% of children living in Florida have an ACEs score of two or higher based on having specific measurable adverse childhood experiences. Through valuable partnership and multi-disciplinary, trauma-informed care; communities can effectively address and treat childhood trauma, effectively reducing incidence of suicide and increasing overall wellness for children and families in Florida.

State and Local CADR Committees work to thoroughly understand and effectively address these critical issues facing Florida's children and families through continued partnerships with a variety of agencies and organizations.

SECTION SIX: IMPLEMENTATION OF PREVIOUS RECOMMENDATIONS

Each year the State CADR Committee develops data-driven recommendations for preventing child fatalities in Florida. In 2018, State and Local CADR Committees engaged in various events, initiatives, and outreach opportunities in response to the following recommendations:

- Expand efforts to relay timely information to parents regarding the safety of children
- Encourage participation in existing child maltreatment trainings for first responders
- Use social media to provide timely messaging and support to parents
- Leverage the power of shared data
- Continue to encourage collaborative partnerships at the state and community levels
- Continue to support the integration of behavioral health services into the Child Welfare System
- Continue to support programs that enhance parenting skills

2019 Annual Child Abuse Death Review Summit

The 2019 Annual Child Abuse Death Review Summit provided stakeholders an opportunity to interact and share innovative best practices and prevention strategies, as well as enhance knowledge of data quality and current child welfare investigative processes. With a theme focusing on the Six Protective Factors Promoting Child Wellbeing, attendees gained a deeper understanding of the critical importance of each factor:

- Resilience
- Concrete Support
- Social Connections
- Nurturing and Attachment
- Social and Emotional Competence
- Parent Knowledge and Education

Local CADR Committee members shared promising initiatives implemented in their communities with summit attendees, inspiring other committees to adopt similar initiatives.

Sleep Baby Safely

One promising initiative that was introduced at the CADR Summit, presented by the Circuit 6 Local CADR Committee, was the Sleep Baby Safely initiative. This presentation was well received by all stakeholders in attendance and is viewed as a model for other committees to follow. To address the high incidence of unsafe sleep related death occurring in Duval County, the Circuit 4 Local CADR Committee is implementing the Sleep Baby Safely initiative and aims to provide education and Sleep Baby Safely initiative materials to neonatal hospital staff, pediatrician office staff, first responders and others in the community who have contact with parents of newborns. Sleep Baby Safely utilizes a universal safe sleep message and provides valuable products to help strengthen the new parent's engagement in ensuring that their baby sleeps safely "every night and every nap."

Through this initiative, community partners receive training to provide one-on-one education to new parents, reinforcing safe sleep messaging and allowing an opportunity for parents to ask questions and further deepen their understanding of how to best care for their new baby. Starting January 2020, each new parent in Duval County will receive a Welcome Baby Bag filled with items printed with safe-sleep messaging which all promote safe-sleep practices. Included in the Welcome Baby Bag is a board book, *Sleep Baby Safe and Snug*. This book tells the story of parents putting their baby to sleep safely, reinforcing the need for consistent safe sleep. This initiative has been implemented in Pinellas County with great response and demonstrated success.

Safe Sleep Outreach

The Division of Children's Medical Services, Bureau of Child Protection and Special Technologies aims to provide community education to new parents in Florida, with a goal of reducing infant mortality. This educational project includes working in partnership with Local CADR Committee members, child protection community leaders, first responders and community birthing hospitals to provide new parents with individual, face-to-face education, local resource information and an educational book, *Sleep Baby Safe and Snug*, to help further promote their alignment with current infant-care recommendations. *Sleep Baby Safe and Snug* has been successfully utilized in many communities around the country as a tool to help reduce infant mortality. The book meets the essential needs of the state, as the infant-care information provided is aligned with the American Academy of Pediatrics and the Florida Department of Health's recommendations for safe sleep.

During the next 12 months, community education will be provided in areas with a demonstrated need based on 2016-2018 infant mortality data with the goal of expanding efforts to other parts of the state in the future.

Data analysis indicates that the following counties in Florida have some of the highest rates of infant death associated with unsafe sleep environments; Duval, Leon, Bay, Columbia, Gadsden and Alachua. Between 2016-2018, each of these counties demonstrated rates of unsafe sleep related infant death which is higher than the state average.

To best understand the impact of these initiatives, each parent will be asked to participate in an online survey to collect information regarding how their perceptions and infant sleep practices may have changed based on this educational outreach. Information collected from this survey will be used to further inform future initiatives.

Healthy Families Florida has continued to use *Sleep Baby Safe and Snug*, providing this book to all families at the first meeting, assessing the family's level of risk, and providing on-going education regarding infant safe-sleep practices with families before and after a baby is born.

Safe Sleep PSA

In a collaborative effort to address infant sleep related death in Florida, CADR collaborated with DOH Communications Office, the Florida Department of Children and Families, the Ounce of Prevention Fund of Florida and Prevention Child Abuse Florida to create a public service announcement to raise awareness of safe sleep practices. The public service announcement, which was shared across multiple social media platforms, is a readily available resource for caregivers and community partners.

Manatee County Prevention Outreach Efforts:

Circuit 12 CADR developed and implemented an educational outreach program, “Healthy Pregnancy and Child Safety Training,” designed to provide valuable information to Recovery Pod Inmates at the Manatee County Jail. This program provides two hours of training and education to male and female inmates covering topics including the impact of substance use and abuse during pregnancy and substance exposed newborns. Additionally, this program educates inmates on general child maltreatment, prevention of sleep-related infant death, and child death due to inflicted trauma. Resources of family support programs were shared along with pregnancy prevention options. Throughout the duration of this program, approximately 95 male and 60 female inmates participated.

Additional efforts led by the Circuit 12 CADR Committee included a Guardian Ad Litem Training on Child Maltreatment Prevention; a Child Protection Investigator (CPI) Training on Substance Exposed Newborns and “How to Recognize Verbal and Nonverbal Cues of Deception”; and a training for Detectives, Law Enforcement Officers, CPIs, Crime Scene Technicians, Assistant State Attorneys and Victim Advocates on Conducting a Sudden Unexpected Infant Death Investigation.

Trauma-Informed Care Initiative

Handle With Care aims to promote school and community partnerships that help children succeed in school by reducing secondary incidents of trauma. This early intervention effort is a trauma-informed care approach to help children heal and thrive. Manatee County was the first to initiate Handle With Care in Florida in April 2018, with the support of Local CADR Committee members. Since that time, Sarasota and Desoto Counties have also implemented this initiative, making Handle With Care available across the judicial circuit. The State CADR Committee has continued its support of this trauma-informed care initiative by participating in stakeholder meetings in an effort to expand this initiative statewide.

Drowning Prevention Initiatives

Through the continued efforts of DOH’s Violence and Injury Prevention program, WaterSmart Florida has provided water safety education and materials to children and families throughout the state to enhance water safety knowledge. WaterSmart Florida consistently promotes the use of layers of protection including supervision, barriers and emergency preparedness as key drowning prevention methods.

Local CADR Committees around the state regularly host and participate in community events which provide valuable opportunities to provide education and water-safety related materials to the public including:

- Outreach to pool supply companies to provide water safety educational materials for new customers.
- Distribution of water-safety educational materials to families engaged in local social services.
- Participation in community events, providing water-safety education to the public.
- Use of social media campaign to further advance public awareness of drowning prevention.

Injury Prevention

State CADR Committee member, Dr. Bruce McIntosh, developed and implemented a comprehensive Home Safety Checklist (Appendix G) for use by DCF home visiting programs. The use of this tool assists providers and caregivers with identifying potential dangers in the home and preventing future injuries and deaths. The Home Safety Checklist assesses the prevention of various injuries or death associated with unsafe-sleep environment, drowning, falling, burning, choking, poisoning, suffocating, and automobile safety. Additionally, this tool assists providers with assessing for a caregiver's knowledge of circumstances relating to injury prevention.

Innovative Data Sharing

Through the implementation of innovative data dissemination techniques, community child-welfare stakeholders are provided with visual tools to identify and address gaps, deficiencies or inadequacies in the availability or delivery of services to children and families within communities. The heat maps provided to local committee stakeholders offer a visual representation of child death incident locations down to the ZIP code level, allowing for targeted prevention initiatives to be implemented. The interactive dashboards allow stakeholders to select any data variables preferred as they work to develop data-driven community-wide prevention initiatives. The effort of developing integrated databases that reliably identify local, regional and state child fatality trends and factors should prioritize identifying racial disproportionality and health inequities to further develop an understanding of how social determinants of health impact the occurrence of preventable child death.

The Governor's Office of Adoption and Child Protection (OACP) has utilized monthly statewide webinars to highlight health, safety, education and employment topics to increase awareness and promote action within local communities. OACP has utilized the CADR Annual Report to specifically focus on the primary causes of preventable child death and shared the CADR heat maps to encourage greater collaboration among stakeholders at the local level. This can enable more targeted efforts to provide community education and referrals to state programs and providers. OACP has also worked with state partners to propose language to be included in the Governor's proclamations on Water Safety and Safe Sleep (Appendix H) to further support the efforts of the State and Local CADR Committees.

Coordinated Prevention Messaging

This year a subcommittee met several times to discuss creating uniform messaging across agencies. The Ounce of Prevention Fund of Florida (The Ounce) is a leader of statewide child abuse prevention campaigns including abuse prevention, water safety, safe sleep, look before you lock and coping with crying. The Ounce works with state agencies, including DOH, DCF, Florida Department of Juvenile Justice and the Governor's Office on prevention messaging. Regular prevention meetings are held to ensure that all agencies are coordinating messages with evidence-based methods and recommendations informed by the American Academy of Pediatrics (AAP), CADR and other reliable sources.

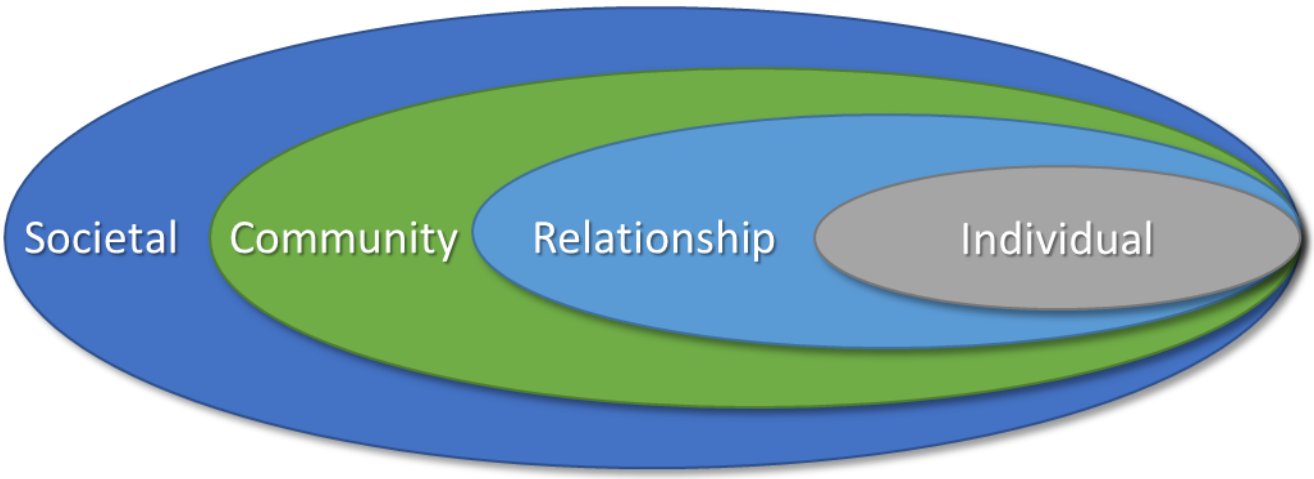
SECTION SEVEN: PREVENTION RECOMMENDATIONS

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 2019 State CADR Committee prevention recommendations are based on an analysis of Florida's CADR findings for 2018 cases reviewed, as well as input provided by State and Local CADR Committees, partners and a review of current child welfare literature. In order to adequately address each level of intervention, approaches to prevention have been organized using the following framework known as the Social-Ecological Model for Change.



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

❖ **Continue efforts to relay timely information to caregivers regarding the safety of children**

The State CADR Committee recommends that communities continue providing timely messaging to parents regarding potential risks to children related to the leading causes of preventable child deaths, including sleep-related infant death, drowning and inflicted harm. 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.

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

❖ **Develop strategies to ensure consistent and coordinated prevention-related messaging across local and state agencies**

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

- Collaborating with stakeholders during quarterly meetings
- Using research as a foundation for information and messaging priorities
- Using a positive messaging approach
- Ensuring coordinated statewide messaging
- Exploring resources available to support messaging outreach
- Assessing for the need of an online centralized clearinghouse of prevention resources to be available to providers, families and the general public
- Creating prevention tool kits
- Expanding partner networks to include local stakeholders, chambers of commerce, school boards, hospitals, law enforcement, and other community resources
- Further leveraging social media 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.

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

Although near-fatal deaths are not identified as a legislative focus for CADR Committee reviews, the State CADR Committee and Chairpersons of Local CADR Committees have identified that information obtained in the review of near-drowning incidents, near-fatal incidents of inflicted

trauma, and near-fatal sleep-related asphyxia would all contribute to a deeper understanding of the circumstances surrounding these leading causes of preventable child death in Florida. Data collection and analysis would provide critical information to better inform effective prevention strategies. Efforts should be made to explore the means and mechanisms by which data could be collected and analyzed.

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

  Inadequate supervision and breached barriers to pools and other bodies of water continue to be associated with child drowning deaths. Caregivers require continued education and messaging regarding layers of protection and supervision that are the most effective means of drowning prevention and the recommended use of touch-supervision of children in the water. Touch-supervision entails that a caregiver or supervisor is within reach of a child in the water at all times. 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 supports the recommendations of the AAP regarding age appropriate expectations related to young children and swimming capabilities. The State CADR Committee encourages the integration of these recommendations as a part of a comprehensive drowning prevention strategy.

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

- **Continue to support programs and practices that enhance parenting skills and coordinate services provided to expectant mothers and partners**

  Various practices, ranging from community education through evidence-based programs are implemented by entities such as: Florida's Women, Infant and Children (WIC) program, Circle of Parents support groups, Healthy Start, Healthy Families Florida, Prevent Child Abuse Florida and Florida's Maternal, Infant and Early Childhood Home Visiting (MIECHV) program, to serve families by building protective factors that can reduce the risk of preventable child death.

  There is a continued need for effective engagement of expectant mothers and partners; especially as it relates to maternal health, safe sleep practices, and the adverse effects of maternal substance use and abuse 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 for a coordinated response to any identified need. The State CADR Committee recommends the use of home safety checklists which are designed to help parents and child welfare professionals identify hazardous conditions within the home that could pose a risk to children. Healthy Families Florida's home safety checklist comprises questions for

a Family Support Worker to ask the parent/caregiver during a home visit when a child reaches developmental milestones or when a family moves to a new home.

- **Encourage the consistent use of Sudden Unexpected Infant Death Reporting Forms and doll reenactments by death scene investigators for all sleep-related infant deaths**

  The State CADR Committee recommends the use of the CDC's Sudden Unexpected Infant Death Investigation (SUIDI) model, including the SUIDI Reporting Form and doll reenactments. The use of doll reenactments has the potential to aid in a more thorough understanding of the circumstances surrounding a child's death (especially sleep-related deaths). Training of the use of this model should be provided to all law enforcement agencies, Medical Examiners and Medical Examiner Investigators who respond to the unexpected deaths of infants or children.

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

  The State CADR Committee has acknowledged and identified several innovative and best practice prevention strategies developed and implemented in local communities (see Section Six); especially pertaining to sleep-related deaths of children. In keeping with a community-based care model for child welfare and a public health perspective, there is value in encouraging community prevention initiatives that target unique trends and risks associated with these communities. Local communities with identified trends associated with preventable child fatalities are ideal venues to pilot new, innovative and promising prevention initiatives. The evaluation of these initiatives can help expand the knowledge base and provide a foundation for more rigorous study and potential expansion of prevention practices that have demonstrated efficacy.

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 2019

APPENDIX A:

Section 383.402, Florida Statutes

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

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

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

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

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

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

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

(2) STATE CHILD ABUSE DEATH REVIEW COMMITTEE.—

(a) *Membership.—*

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

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

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

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

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

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

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

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

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

3. Provide training to local child abuse death review committee members on the dynamics and impact of domestic violence, substance abuse, or mental health disorders when there is a co-occurrence of child abuse. Training must be provided by the Florida Coalition Against Domestic Violence, the Florida Alcohol and Drug Abuse Association, and the Florida Council for Community Mental Health in each entity's respective area of expertise.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

a. Nonidentifying information from individual cases.

b. Identification of any problems with the data system uncovered through the review process and the committee's recommendations for system improvements and needed resources, training, and information dissemination, where gaps or deficiencies may exist.
c. All steps taken by the local committee and private and public agencies to implement necessary changes and improve the coordination of services and reviews.

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

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

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

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

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

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

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

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

(5) ACCESS TO AND USE OF RECORDS.—

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

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

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

(b) The State Child Abuse Death Review Committee or a local committee shall have access to all information of a law enforcement agency which is not the subject of an active investigation

and which pertains to the review of the death of a child. A committee may not disclose any information that is not subject to public disclosure by the law enforcement agency, and active criminal intelligence information or criminal investigative information, as defined in s. 119.011(3), may not be made available for review or access under this section.

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

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

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

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

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

(6) DEPARTMENT OF HEALTH RESPONSIBILITIES.—

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

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

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

(7) DEPARTMENT OF CHILDREN AND FAMILIES RESPONSIBILITIES.—Each regional managing director of the Department of Children and Families must appoint a child abuse death

review coordinator for the region. The coordinator must have knowledge and expertise in the area of child abuse and neglect. The coordinator's general responsibilities include:

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

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

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

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

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

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

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

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

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

History.—s. 13, ch. 99-168; s. 11, ch. 2000-160; s. 8, ch. 2000-217; s. 13, ch. 2001-53; s. 14, ch. 2004-350; s. 41, ch. 2008-6; s. 69, ch. 2014-19; s. 21, ch. 2014-224; s. 4, ch. 2015-79; s. 42, ch. 2016-10; s. 55, ch. 2019-3.

APPENDIX B:

Guidelines for the State Committee

Guidelines for the State Committee

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CHAPTER I

PURPOSE OF CHILD ABUSE DEATH REVIEW COMMITTEES

1.1 Background and Description

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

1.2 Mission Statement

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

1.3 Operating Principle

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

The state and local review committees shall work cooperatively.

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

1.4 Goal

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

1.5 Objectives

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

CHAPTER 2

STATE REVIEW COMMITTEE MEMBERSHIP AND DUTIES

2.1 Introduction

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

2.2 Statutory Membership

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

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

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

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

2.3 Term of Membership

The members of the state committee shall be appointed to staggered terms not to exceed 2 years each as determined by the State Surgeon General. Members may be appointed to no more than three consecutive terms. The state committee shall elect a chairperson from among its members

to serve for a 2-year term, and the chairperson may appoint ad hoc committees as necessary to carry out the duties of the committee.
Agency representatives who leave their agency during their term must notify the agency head, and the DOH Child Abuse Death Review Committee Coordinator. The agency appointment expires upon the effective date of the member's departure from the agency and the State Surgeon General will request that the agency appoint a new member.

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

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

2.4 Consultants

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

2.5 Election of State Chairperson

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

2.6 Reimbursement

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

2.7 Terminating State Committee Membership

A member or a consultant of the State Child Abuse Death Review Committee may resign at any time**.** A written resignation shall be submitted to the Child Death Review Committee Coordinator. Should action be required, a letter shall be addressed to the State Surgeon General who will either make a new appointment or contact the agency head requesting the designation of a new representative.

2.8 State Review Committee Duties

Chairperson

- Chair Committee meetings

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

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

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

All Committee Members

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

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

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

- Provide training on the dynamics and impact of domestic violence, substance abuse or mental health disorders when there is a co-occurrence of child abuse. Training shall be provided by the Florida Coalition Against Domestic Violence, the Florida Alcohol and Drug Abuse Association, and the Florida Council for Community Mental Health in each entity's respective area of expertise

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

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

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

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

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

CHAPTER 3

MAINTAINING AN EFFECTIVE COMMITTEE

3.1 Conducting an Effective Meeting

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

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

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

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

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

3.2 Focus on Prevention

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

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

CHAPTER 4

COMMITTEE OPERATING PROCEDURES

4.1 Obtaining Data from Local Committee Reviews

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

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

4.2 Record Keeping and Retention

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

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

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

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

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

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

4.3 Child Abuse Death Review Case Reporting System

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

CHAPTER 5

CONFIDENTIALITY AND ACCESS TO INFORMATION

5.1 Introduction

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

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

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

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

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

5.2 Confidentiality Statements

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

mail, birth or death certificates, records, or any other components required in the preparation of a child abuse death review case.

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

5.3 Protecting Family Privacy

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

5.4 Document Storage and Security

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

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

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

5.5 Media Relations and Public Records Request

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

CHAPTER 6

CHILD ABUSE DEATH REVIEW ANNUAL REPORT

6.1 Guidelines for Report

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

A) Background

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

B) Method

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

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

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

D) Conclusions

E) Prevention Recommendations

F) Summary

APPENDIX C:

State and Local Committee Membership

Florida Child Abuse Death Review State Committee Membership

Social Worker
Robin Perry, PhD, Chairperson

Department of Health
Patricia Boswell, MPH

Department of Legal Affairs
Stephanie Bergen, JD

Department of Children and Families
Courtney Stanford

Department of Law Enforcement
Jeremy Gordon, Inspector

Department of Education
Iris Williams, MSW

Florida Prosecuting Attorneys Association
Thomas Bakkedahl, JD

Florida Medical Examiners Commission
Anthony Jose Clark, MD

Child Protection Team Statewide Medical Director
Bruce McIntosh, MD

Public Health Nurse
Deborah Hogan, RN, MPH

Mental Health Professional
April Lott, LCSW

Department of Children and Families Supervisor
Erika Summerfield

Medical Director, Child Protection Team
Vacant

Child Advocacy Organization
Jennifer Ohlsen, MS

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

Law Enforcement Officer
Ret. Major Connie Shingledecker

Florida Coalition Against Domestic Violence
Brandy Carlson, MSW

Child Abuse Prevention Program
Zackary Gibson

Substance Abuse Professional
Linda Mann, LCSW, CAP

Florida Child Abuse Death Review Local Committee Leadership

Committee 1
Claire Kirchharr, MPH, CPH
Kirsten Bucey
Ashlee Turner
Sandra Park-O'Hara, ARNP

Jennifer Clark
Christine Syfrett, RN, MPH
Karen Chapman, MD, MPH

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

Committee 3
Cheriese Brown
Mr. Kerry Waldron, MPA

Committee 4
Vicki Whitfield
Funmi Borisade, RN, MSM, MPH, MSN
Kelli Wells, MD

Committee 5
Janine Hammett,
Robin Napier

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

Committee 7
Vicki Whitfield
Dawn Allicock, MD

Committee 8
Stephanie Cox
Barbara Locke, RN, BSN, MPH

Committee 9
Joy Chuba, MSW
Brianne Bell
Anne Johnson, BSN, MN
Vianca McCluskey, MPH
Dr. Raul Pino

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

Committee 11
Lauren Lazarus-Sabatino, Esq. CCE
Lauren Villalba, MPA
Keya Brandon, Ed.D
Vanessa Villamil, MPH
Yesenia Villalta, APRN, DNP, MSN

Committee 12
Ret. Maj. Connie Shingledecker
Katie Powers
Jennifer Bencie, MD

Laura McIntyre, MA
Catherine Duff
Jennifer Bencie, MD

Committee 13
Jane Murphy, MPA
Alice Horton, RN, FCCM
Melissa Iturraspe, MS, RHIA
Douglas Holt, MD, FACP

Committee 14
Kelly Byrns-Davis
Stephanie Wood
Christi Bazemore
Barbara Altidort, MPH
Pamela Boobyer, RN
Karen Johnson, MSN, APRN

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

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

Committee 17
Barbara Lesh, MPA
Trisha Dowell, LCSW
Paula Thaqi, MD, MPH

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

Odies Grant, MS
Lindsey A. Bayer, MS, F-ABMDI
Donna Walsh, MPA, BSN, RN

Committee 19
Miranda C. Hawker, MPH

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

APPENDIX D:

Guidelines for Local Committees

Guidelines for Local Committees

Rev. October 2018

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CHAPTER I

PURPOSE OF CHILD ABUSE DEATH REVIEW COMMITTEES

1.1 Background and Description

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

1.2 Mission Statement

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

1.3 Operating Principle

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

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

1.4 Goal

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

1.5 Objectives

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

CHAPTER 2

LOCAL REVIEW COMMITTEE MEMBERSHIP AND DUTIES

2.1 Committee Membership

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

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

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

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

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

To the extent possible, individuals from these organizations or entities who, in a professional capacity, dealt with a child whose death is verified as caused by abuse or neglect, or with the family of the child shall attend any meetings where the child's case is reviewed. This participation can be of value in assisting the local committees in their critical appraisal of information that can aid in the evaluation of circumstances surrounding a death (not re-investigation of a case), identification of local trends and

specific issues contributing to child abuse and neglect fatalities within their region, and the development of prevention recommendations in keeping with the mission of the Statewide Child Abuse Death Review Committee.

2.2 Term of Membership

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

2.3 Consultants

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

2.4 Ad Hoc Members

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

2.5 Local Review Committee Duties

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

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

2.6 Local Committee Member Responsibilities

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

- Contribute information from his or her records, in accordance with Section 383.402, *Florida Statutes* (see Appendix A)
- Serve as a liaison to respective professional counterparts
- Provide definitions or professional terminology
- Interpret agency procedures and policies
- Explain the legal responsibilities or limitations of his or her profession

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

2.7 Orientation and Training of Local Committee Members

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

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

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

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

2.8 Support and Technical Assistance for Local Committees

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

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

CHAPTER 3

MAINTAINING AN EFFECTIVE COMMITTEE

3.1 Conducting an Effective Meeting

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

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

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

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

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

3.2 Beginning the Meeting

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

3.3 Sharing Information

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

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

3.4 Community Education and Prevention

The state and local Child Abuse Death Review Committees review and analyze information on the nature of child abuse deaths in Florida. The key to good prevention is leadership at the local level. Local committees identify trends in child abuse death statistics for their own communities, and develop and implement

community education and prevention plans that are data-driven. Prevention efforts can range from simply changing one agency practice or policy or setting up more complex interventions for high-risk parents.

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

CHAPTER 4

COMMITTEE OPERATING PROCEDURES

4.1 Information Sharing

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

4.2 Committee Chairperson

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

Chairperson duties:

- Call and chair committee meetings. At least one regular monthly meeting (e.g., every 1st Friday of each month) will be scheduled. Regularly scheduled monthly meetings can be cancelled if there are no cases to review. At least quarterly meetings must be held to discuss community prevention initiatives (even when there are no case files for review). Case reviews should be scheduled for review within 30 days of receipt of a case file.
- Send meeting notices to committee members.
- Chairperson is to ensure that meetings are conducted according to Section 286.011, *Florida Statutes* (Florida's Government in the Sunshine Law).
- Work with DOH staff to obtain names and compile the summary sheet of child abuse deaths to be reviewed for distribution to committee members two weeks prior to each meeting.
- Obtain all records needed for the local reviews in accordance Section 383.402, *Florida Statutes.*
- Submit completed child abuse death review data forms with attached materials to the Department of Health, Death Review Coordinator for the State CADR or designee and/or enter data collected from the case review/CDR Report Form into the National Fatality Review Case Reporting System within 15 calendar days of the fatality review.
- Ensure that the Committee operates according to protocols as adapted by the Committee.
- Ensure that all new Committee members and ad hoc members sign a confidentiality agreement.
- Maintain attendance records, current roster, and resumes or CVs detailing qualifications and experience of members.
- Ensure secure transfer of all records to new Chairperson upon transfer of duties.

4.3 Meeting Attendance

Committee members must recognize the importance of regular attendance as a means of sharing the expertise and knowledge for which they were recruited. Attendance at meetings must be in person to ensure maximum participation in the death review process. For confidentiality reasons, phone

conferencing is not acceptable. Local committees should develop a policy to address non-attendance of committee members.

4.4 Obtaining Names for Committee Reviews

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

4.5 Record Keeping and Retention

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

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

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

4.6 Child Abuse Death Review Case Reporting System

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

CHAPTER 5

CONFIDENTIALITY AND ACCESS TO INFORMATION

5.1 Introduction

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

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

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

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

5.2 Confidentiality Statements

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

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

5.3 Protecting Family Privacy

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

5.4 Document Storage and Security

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

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

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

5.5 Media Relations and Public Records Request

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

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

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

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

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

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

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

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

(2) STATE CHILD ABUSE DEATH REVIEW COMMITTEE.—

(a) Membership.—

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

a. The Department of Legal Affairs.

b. The Department of Children and Families.

c. The Department of Law Enforcement.

d. The Department of Education.

e. The Florida Prosecuting Attorneys Association, Inc.

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

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

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

b. A public health nurse.

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

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

e. The medical director of a child protection team.

f. A member of a child advocacy organization.

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

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

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

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

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

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

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

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

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

Appendix B

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

383.412 Public records and public meetings exemptions.—

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

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

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

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

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

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

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

(a) With each other;

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

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

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

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

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

Appendix D

STATEMENT OF CONFIDENTIALITY

Name:

Date:

I understand the following:

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

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

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

_____

(Signature)

_____

(Agency)

APPENDIX E:

CASE REPORTING FORM VERSION 5.0

NATIONAL CFRP
Center for Fatality Review & Prevention

CDR Report Form

National Fatality Review

Case Reporting System

Version 5.0

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

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

SAVING LIVES TOGETHER

Instructions:

This case report is used by Child Death Review (CDR) teams to enter data into the National Fatality Review Case Reporting System (NFR-CRS). The NFR-CRS is available to states and local sites from the National Center for Fatality Review & Prevention (NCFRP) and requires a data use agreement for data entry. The purpose is to collect comprehensive information from multiple agencies participating in a review. The NFR-CRS documents demographics, the circumstances involved in the death, investigative actions, services provided or needed, key risk factors and actions recommended and/or taken by the team to prevent other deaths.

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

It is not expected that teams will have answers to all of the questions related to a death. However, over time teams begin to understand the importance of data collection and bring the necessary information to the meeting. The percentage of cases marked "unknown" and unanswered questions decreases as the team becomes more familiar with the form. **The NFR-CRS Data Dictionary is available**. It contains definitions for each data element and should be referred to when the team is unsure how to answer a question. Use of the data dictionary helps teams improve consistency of data entry.

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

Many teams ask what is the difference between leaving a question blank and selecting the response "unknown." A question should be marked "unknown" if an attempt was made to find the answer but no clear or satisfactory response was obtained. A question should be left blank (unanswered) if no attempt was made to find the answer. "N/A" stands for "not applicable" and should be used if the question does not apply.

HIPAA 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 our Data Use Agreements. Therefore, entering identified data into those fields would compromise your responsibility under HIPAA.

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

CASE NUMBER

_____/_____/_____/_____

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

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

☐ Child never left hospital following birth

Death Certificate Number:

Birth Certificate Number:

ME/Coroner Number:

Date Team Notified of Death:

A. CHILD INFORMATION

A1. CHILD INFORMATION (COMPLETE FOR ALL AGES)

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

2. Date of birth: ☐ U/K
mm dd yyyy

3. Date of death: ☐ U/K
mm dd yyyy

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

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

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

7. Sex: ○ Male ○ Female ○ U/K

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

9. 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

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

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

16. Was the child up to date with Academy of Pediatrics Immunization Schedule?
○ NA ○ Yes ○ No, specify: ○ U/K

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

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

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

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

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

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

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

As Victim	As Perpetrator		
	○ N/A	☐	☐ Physical
○	○ Yes	☐	☐ Neglect
○	○ No	☐	☐ Sexual
○	○ U/K	☐	☐ Emotional/ psychological
		☐	☐ U/K

If yes, how was history identified:
○ ○ Through CPS
○ ○ Other sources

If through CPS:

As Victim	As Perpetrator	
_____	_____	# CPS referrals
_____	_____	# Substantiations

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

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

A2. COMPLETE FOR CHILDREN OVER ONE YEAR OLD

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

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

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

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

29. Child's mental health (MH):

Child had received prior MH services?
○ N/A ○ Yes ○ No ○ U/K

Child was receiving MH services?
○ N/A ○ Yes ○ No ○ U/K

Child on medications for MH illness?
○ N/A ○ Yes ○ No ○ U/K

Issues prevented child from receiving MH services?
○ N/A ○ Yes ○ No ○ U/K

If yes, specify:

30. Child had history of substance abuse?
○ N/A ○ Yes ○ No ○ U/K

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

31. Child had delinquent or criminal history?
○ N/A ○ Yes ○ No ○ U/K

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

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

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

A3. COMPLETE FOR ALL FETAL/INFANTS UNDER ONE YEAR

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

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

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

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

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

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

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

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

42. Were there access or compliance issues related to prenatal care? ○ Yes ○ No ○ U/K If yes, check all that apply:
☐ Lack of money for care
☐ Limitations of health insurance coverage
☐ Lack of transportation
☐ No phone
☐ Cultural differences
☐ Language barriers
☐ Couldn't get provider to take as patient
☐ Multiple providers, not coordinated
☐ Couldn't get an earlier appointment
☐ Lack of child care
☐ Lack of family/social support
☐ Services not available
☐ Distrust of health care system
☐ Unwilling to obtain care
☐ Didn't know where to go
☐ Didn't think she was pregnant
☐ Other, specify:
☐ U/K

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

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

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

Respiratory
☐ Asthma
☐ Pulmonary embolism

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

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

Sexually Transmitted Infection (STI)
☐ Bacterial vaginosis (BV)
☐ Chlamydia
☐ Gonorrhea
☐ Herpes
☐ HPV
☐ Syphilis

STI (continued)
☐ 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)
☐ Incompetent cervix
☐ 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
☐ Maternal developmental delay
☐ Oral health/dental or gum infection
☐ Gastrointestinal
☐ Maternal genetic disorder
☐ Abnormal MSAFP
☐ Preterm labor
☐ Other, specify:

44. Did the mother experience any medical complications in previous pregnancies? ○ N/A ○ Yes ○ No ○ U/K If yes, check all that apply:
☐ Previous preterm birth
☐ Previous low birth weight birth
☐ Previous small for gestational age
☐ Previous large for gestational age (greater than 4000 grams)

45. Did the mother use any medications, drugs or other substances during pregnancy? ○ Yes ○ No ○ U/K If yes, check all that apply:
☐ Over-the-counter meds
☐ Allergy medications
☐ Antibiotics
☐ Anti-flu/antivirals
☐ Anti-depressants/anti-anxiety/anti-psychotics
☐ Anti-epileptic
☐ Anti-hypertensives
☐ Anti-hypothyroidism
☐ Arthritis medications
☐ Diabetes medications
☐ Asthma medications
☐ Nausea/vomiting medications
☐ Cholesterol medications
☐ Sleeping pills
☐ Meds to treat preterm labor
☐ Meds used during delivery
☐ Progesterone/P17
☐ Cocaine
☐ Heroin
☐ Marijuana
☐ Methamphetamine
☐ Alcohol
☐ If alcohol, infant born with fetal effects or syndrome?
☐ Meds to treat drug addiction
☐ Opiates
☐ Other pain meds
☐ Other, specify:
☐ U/K

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

48. Level of birth hospital:
- ○ 1°
- ○ 2°
- ○ 3°
- ○ Free-standing birth hospital
- ○ Home birth
- ○ Other, specify:
- ○ U/K

49. At discharge from the birth hospital, was a case manager assigned to the mother?
○ N/A, mother did not go to a birth hospital ○ Yes ○ No ○ U/K

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

51. 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

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

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

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

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

55. Did the mother have postpartum depression?
○ Yes ○ No ○ U/K

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

56. 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

57. Did infant have abnormal metabolic newborn screening results?
○ 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.

58. 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

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

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

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

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

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

63. What did the infant have for his/her last meal? Check all that apply:
- ☐ Breast milk
- ☐ Formula, type:
- ☐ Baby food, type:
- ☐ Cereal, type:
- ☐ Other, specify:
- ☐ U/K

This space left intentionally blank.

B. BIOLOGICAL PARENT INFORMATION

○ No information available, go to Section C

1. Parents' race, check all that apply:

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

2. Parents' Hispanic or Latino origin?

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

3. Parents' age in years at death:

Female	Male	
____	____	# Years
☐	☐	U/K

4. Parents' employment status:

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

5. Parents' income:

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

6. Parents' education:

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

7. Parents speak and understand English?

Female	Male	
○	○	Yes
○	○	No
○	○	U/K

If no, language spoken:

8. Parents first generation immigrant?

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

9. Parents on active military duty?

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

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

Female	Male		Female	Male	
○	○	Yes			
○	○	No	☐	☐	WIC
○	○	U/K	☐	☐	Home visiting, specify:
			☐	☐	all TANF
			☐	☐	apply:Medicaid
			☐	☐	
			☐	☐	Food stamps/SNAP/EBT
			☐	☐	Other, specify:
					U/K

If yes, check that

11. Parents have substance abuse history?

Female	Male	
○	○	Yes
○	○	No
○	○	U/K

If yes, check all that apply:

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

12. Parents ever victim of child maltreatment?

Female	Male	
○	○	Yes
○	○	No
○	○	U/K

If yes, check all that apply:

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

13. Parents ever perpetrator of maltreatment?

Female	Male	
○	○	Yes
○	○	No
○	○	U/K

If yes, check all that apply:

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

14. Parents have disability or chronic illness?

Female	Male	
○	○	Yes
○	○	No
○	○	U/K

If yes, check all that apply:

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

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

○	○	Yes
○	○	No
○	○	U/K

15. Parents have prior child deaths?

Female	Male		If yes, cause(s): Check all that apply:	Female	Male		Female	Male
○	○	Yes						
○	○	NoChild abuse #	☐ ☐ _____Suicide # _____Other #	☐	☐	____	☐	☐
○	○	U/KChild neglect #	☐ ☐ _____SIDS # _____Other,	☐	☐	specify:		
			☐ ☐ Accident # _____Undetermined	☐	☐	cause # ____U/K	☐	☐

16. Parents have history of intimate partner violence?

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

17. Parents have delinquent/criminal history? If yes, check all that apply:

Female	Male		Female	Male	
○	○	Yes	☐	☐	Assaults
○	○	No	☐	☐	Robbery
○	○	U/K	☐	☐	Drugs
			☐	☐	Other, specify:
			☐	☐	U/K

C. PRIMARY CAREGIVER(S) INFORMATION

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

One	Two		One	Two		One	Two	
○		Self, go to Section D	○	○	Foster parent	○	○	Other relative
○	○	Biological mother, go to Section DMother's	○	○	partnerFriend	○	○	
○	○	Biological father, go to Section DFather's	○	○	partnerInstitutional staff	○	○	
○	○	Adoptive parent	○	○	Grandparent	○	○	Other, specify:
○	○	Stepparent	○	○	Sibling			
						○	○	U/K

2. Caregiver(s) age in years:

One	Two	
		# Years
☐	☐	U/K

3. Caregiver(s) sex:

One	Two	
○	○	Male
○	○	Female
○	○	U/K

4. Caregiver(s) race, check all that apply:

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

5. Caregiver(s) Hispanic or Latino origin?

One	Two	
○	○	Yes
○	○	No
○	○	U/K

If yes, specify origin:

6. Caregiver(s) employment status:

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

7. Caregiver(s) income:

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

8. Caregiver(s) education:

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

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

One	Two	
○	○	Yes
○	○	No
○	○	U/K

If no, language spoken:

10. Caregiver(s) first generation immigrant?

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

11. Caregiver(s) on active military duty?

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

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

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

13. Caregiver(s) have substance abuse history?

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

15. Caregiver(s) ever perpetrator of maltreatment?

One	Two	

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

One	Two	

One Two

○ ○ Yes
○ ○ No
○ ○ U/K

If yes, check all that apply:

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

One Two

○ ○ Yes
○ ○ No
○ ○ U/K

If yes, check all that apply:

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

_____ _____ # CPS referrals

_____ _____ # Substantiations

☐ ☐ Ever in foster care or adopted

○ ○ Yes
○ ○ No
○ ○ U/K

If yes, check all that apply:

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

_____ _____ # CPS referrals

_____ _____ # Substantiations

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

○ ○ Yes
○ ○ No
○ ○ U/K

If yes, check all that apply:

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

If mental health/substance abuse, was caregiver receiving MH services?

○ ○ Yes
○ ○ No
○ ○ U/K

17. Caregiver(s) have prior Child abuse #____

Check all that apply: child

One Two

○ ○
○ ○
○ ○

If yes, cause(s): deaths?

One Two

☐ ☐
☐ ☐ neglect Yes # Child
☐ ☐ # No Accident
☐ ☐ U/K Suicide #
☐ ☐ SIDS #
☐ ☐ _____
☐ ☐
☐ ☐ Undetermined cause # _____
Other # _____
Other, specify:
☐ ☐ U/K

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

One Two

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

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

One Two

○ ○ Yes
○ ○ No
○ ○ U/K

If yes, check all that apply:

☐ ☐ Assaults
☐ ☐ Robbery
☐ ☐ Drugs
☐ ☐ Other, specify:

☐ ☐ U/K

D. SUPERVISOR INFORMATION

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

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

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

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

4. Primary person responsible for supervision at the time of incident? Select only one:
   - ◯ Adoptive parent
   - ◯ Stepparent
   - ◯ Foster parent
   - ◯ Mother's partner
   - ◯ Father's partner
   - ◯ Grandparent
   - ◯ Sibling
   - ◯ Other relative
   - ◯ Friend
   - ◯ Acquaintance
   - ◯ Hospital staff, go to D15
   - ◯ Institutional staff, go to D15
   - ◯ Babysitter
   - ◯ Licensed child care worker
   - ◯ Other, specify:
   - ◯ 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
   If yes, check all that apply:
   - ☐ Alcohol
   - ☐ Cocaine
   - ☐ Marijuana
   - ☐ Methamphetamine
   - ☐ Opiates
   - ☐ Prescription drugs
   - ☐ Over-the-counter
   - ☐ Other, specify:
   - ☐ U/K

10. Supervisor has history of child maltreatment?

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

If yes, check all that apply:

☐	☐ Physical
☐	☐ Neglect
☐	☐ Sexual
☐	☐ Emotional/psychological
☐	☐ U/K
_____	_____# CPS referrals
_____	_____# Substantiations
☐	Ever in foster care/adopted
	☐ CPS prevention services
	☐ Family preservation services
	☐ Children ever removed

11. Supervisor has disability or chronic illness?
    ◯ Yes ◯ No ◯ U/K
    If yes, check all that apply:
    - ☐ Physical/orthopedic, specify:
    - ☐ Mental health/substance abuse, specify:
    - ☐ Cognitive/intellectual, specify:
    - ☐ Sensory, specify:
    - ☐ U/K

    If mental health/substance abuse, was supervisor receiving MH services?
    - ◯ Yes
    - ◯ No
    - ◯ U/K

12. Supervisor has prior child deaths?
    ◯ Yes ◯ No ◯ U/K
    If yes, check all that apply:
    - ☐ Child abuse # _____
    - ☐ Child neglect # _____
    - ☐ Accident #_____
    - ☐ Suicide # _____
    - ☐ SIDS # _____
    - ☐ Undetermined cause # _____
    - ☐ Other # _____

    Other, specify:
    - ☐ U/K

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

14. Supervisor has delinquent or criminal history?
    ◯ Yes ◯ No ◯ U/K
    If yes, check all that apply:
    - ☐ Assault
    - ☐ Robbery
    - ☐ Drugs
    - ☐ Other, specify:
    - ☐ U/K

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

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

E. INCIDENT INFORMATION

Answer this section only if the child ever 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
   - ☐ Place of work
   - ☐ Indian reservation/ trust lands
   - ☐ Military installation
   - ☐ Jail/detention facility
   - ☐ Sidewalk
   - ☐ Roadway
   - ☐ Driveway
   - ☐ Other parking area
   - ☐ State or county park
   - ☐ Sports area
   - ☐ Other recreation area
   - ☐ Hospital
   - ☐ Other, specify:
   - ☐ U/K

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

5. Incident state:

6. Incident county:

7. Did the death occur due to a natural disaster or mass fatality? ○ Yes ○ No ○ U/K
If yes, describe:

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, 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 ☐ Opiate ☐ 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 ○ U/K
_____ Adults

F. INVESTIGATION INFORMATION

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

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

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

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

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

5. Were the following assessed either through the autopsy or through information collected prior to the autopsy? Please list any abnormalities/significant findings in F9.

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

6. Were any of these additional tests performed at or prior to the autopsy? Please list any abnormalities/significant findings in F9.

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

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

8. Was the child's medical history reviewed as part of the autopsy? ○ Yes ○ No ○ U/K
If yes, did this include:
Review of the newborn metabolic screen results? ○ Yes ○ No ○ U/K ○ Not performed
Review of neonatal CCHD screen results? ○ Yes ○ No ○ U/K ○ Not performed

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

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

11. Was there agreement between the cause of death listed on the pathology report and on the death certificate? ○ N/A ○ Yes ○ No ○ U/K
If no, describe the differences:

12. Was a death scene investigation conducted at the place of the incident? ○ Yes ○ No ○ U/K
If yes, which of the following death scene 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

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

15. Did any investigation find evidence of prior abuse?

○ N/A ○ Yes ○ No ○ U/K If yes, from what source? Check all that apply:

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

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

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

○ Report screened out and not investigated
○ Unsubstantiated
○ Inconclusive
○ Substantiated U/K

If yes, what services or actions resulted? Check all that apply:

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

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

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

G. OFFICIAL MANNER AND PRIMARY CAUSE OF DEATH

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

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

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

Sequentially list any conditions leading to immediate cause of death. In other word ist 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

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

◯ From an injury (external cause). Select one answer G4:

- ◯ Asthma/respiratory, specify
- ◯ Motor vehicle and other transport, go to
- ◯ Fire, burn, or electrocution, go to
- ◯ Drowning, go to H3
- ◯ Congenital anomaly,
- ◯ Unintentional asphyxia, go to H4
- ◯ Diabetes, go
- ◯ Assault, weapon or person's body part, go to
- ◯ Fall or crush, go to H6
- ◯ Influenza, go to H8
- ◯ Poisoning, overdose or acute intoxication,Low
- ◯ go to H7
- ◯ Malnutrition/dehydration, go to H8
- ◯ Undetermined injury, go to
- ◯ Other cause, go to H9
- ◯ Pneumonia, specify and
- ◯ U/K, go to I1
- ◯ Prematurity, go to H8

◯ and From a medical cause. Select one:

- ◯ and go to H8
- ◯ H1Cancer, specify and go to H8
- ◯ H2Cardiovascular, specify and go to H8
- ◯ specify and go to H8
- ◯ to H8
- ◯ H5HIV/AIDS, go to H8
- ◯
- ◯ birth weight, go to H8
- ◯
- ◯ I1Neurological/seizure disorder, go to H8
- ◯ go to H8
- ◯
- ◯
- ◯ SIDS, go to H8
- ◯ Other infection, specify and go to H8
- ◯ Other perinatal condition, specify and go to H8
- ◯ Other medical condition, specify and go to H8
- ◯ Undetermined medical cause, go to H8
- ◯ U/K, go to H8

◯ Undetermined if injury or medical cause, go to I1

◯ U/K go to I1

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

H1. MOTOR VEHICLE AND OTHER TRANSPORT

a. Vehicles involved in incident:

Total number of vehicles: _____

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

b. Position of child:

- ○ Driver
- ○ Passenger — If passenger, relationship of driver to child:
  - ○ Front seat
  - ○ Back seat
  - ○ Truck bed
  - ○ Other, specify:
  - ○ U/K
- ○ On bicycle
- ○ Pedestrian
  - ○ Walking
  - ○ Boarding/blading
  - ○ Other, specify:
  - ○ U/K
- ○ U/K

If passenger, relationship of driver to child:

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

c. Causes of incident, check all that apply:

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

d. Collision type:

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

e. Driving conditions, check all that apply:

- ☐ Normal
- ☐ Loose gravel
- ☐ Muddy
- ☐ Ice/snow
- ☐ Fog
- ☐ Wet
- ☐ Construction zone
- ☐ Inadequate lighting
- ☐ Other, specify:
- ☐ U/K

f. Location of incident, check all that apply:

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

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

Child as driver	Child's driver	Driver of other primary vehicle	
	Age of Driver	Age of Driver	
	○	○	<16 years
	○	○	16 to 18 years old
	○	○	19 to 21 years old
	○	○	22 to 29 years old
	○	○	30 to 65 years old
	○	○	>65 years old
	○	○	U/K age
☐	☐	☐	Responsible for causing incident
☐	☐	☐	Was alcohol/drug impaired
☐	☐	☐	Has no license
☐	☐	☐	Has a learner's permit

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

h. Total number of occupants in vehicles:

In child's vehicle, including child:

☐ N/A, child was not in a vehicle

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

In other primary vehicle involved in incident:

☐ N/A, incident was a single vehicle crash

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

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

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

*If child seat, type:

- ○ Rear facing
- ○ Front facing
- ○ U/K

H2. FIRE, BURN, OR ELECTROCUTION

a. Ignition, heat or electrocution source:

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

b. Type of incident:

- ○ Fire, go to c
- ○ Scald, go to r
- ○ Other burn, go to t
- ○ Electrocution, go to s
- ○ Other, specify and go to t
- ○ U/K, go to t

c. For fire, child died from:

- ○ Burns
- ○ Smoke inhalation
- ○ Other, specify:
- ○ U/K

d. Material first ignited:

- ○ Upholstery
- ○ Mattress
- ○ Christmas tree
- ○ Clothing
- ○ Curtain
- ○ Other, specify:
- ○ U/K

e. Type of building on fire:

- ○ N/A
- ○ Single home
- ○ Duplex
- ○ Apartment
- ○ Trailer/mobile home
- ○ Other, specify:
- ○ U/K

f. Building's primary construction material:

- ○ Wood
- ○ Steel
- ○ Brick/stone
- ○ Aluminum
- ○ Other, specify:
- ○ U/K

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

If yes, person's age _____

Does person have a history of setting fires? ○ Yes ○ No ○ U/K

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

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

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

If yes, specify:

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

If yes, check all that apply:

- ☐ Locked door
- ☐ Window grate
- ☐ Locked window
- ☐ Blocked stairway
- ☐ Other, specify:
- ☐ U/K

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

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

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

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

If yes, describe in narrative.

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

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

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

Other, specify: _____

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

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

H3. DROWNING

a. Where was child last seen before drowning? Check all that apply:	b. What was child last seen doing before drowning?	c. Was child forcibly submerged?	d. Drowning location:
☐ In ☐ waterIn yard ☐ On ☐ shoreIn ☐ ☐ bathroom ☐ On ☐ dockIn house ☐ PoolsideOther, specify: U/K	○ ○ PlayingTubing ○ Boating ○ Waterskiing ○ ○ SwimmingSleeping ○ ○ BathingOther, ○ specify: ○ Fishing ○ SurfingU/K	○ Yes ○ No ○ U/K	○ Open water, go to e ○ U/K, go to n ○ Pool, hot tub, spa, go to i ○ Bathtub, go to w ○ Bucket, go to x ○ Well/cistern/septic, go to n ○ Toilet, go to z ○ Other, specify and go to n

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

i. For pool, type of pool:	j. For pool, child found:	k. For pool, ownership is:	l. Length of time owners had pool/hot tub/spa:
○ Above ground ○ In-ground Hot ○ tub, spa ○ ○ Wading U/K	○ In the pool/hot tub/spa ○ On or under the cover ○ U/K	○ Private ○ Public ○ U/K	○ ○ N/A1yr ○ <6 months U/K ○ ○ 6m-1 yr

m. Flotation device used?	n. What barriers/layers of protection existed to prevent access to water? Check all that apply:
○ ○ ○ ○ ☐ N/A ☐ Yes ☐ ☐ Cushion ☐ Lifesaving ring U/K If Correct ○ Yes ○ No ○ U/K Worn correctly?Other, specify: ○ Yes ○ No ○ U/K If yes, check all that apply: ☐ Coast Guard approved Not Coast ☐ U/K ☐ NoJacketSwim rings ☐ jacket:Inner tube ☐ size?Air mattress ☐	☐ NoneAlarm, go to ☐ r ☐ Fence, go to ☐ oCover, go to s ☐ Gate, go to pU/K ☐ ☐ Door, go to q

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

t. Local ordinance(s) regulating access to water?

○ Yes ○ No ○ U/K

If yes, rules violated?

○ Yes ○ No ○ U/K

u. How were layers of protection breached? Check all that apply:

☐ No layers breached ☐ Gate left ☐ locked Gate

☐ Gap in fence ☐ openDamaged ☐ unlockedFence too

☐ Door screen torn ☐ fenceDoor self-closer ☐ shortWindow left openOther,

☐ Cover left off ☐ failedCover not ☐ specify:

☐ Gate latch failed ☐ Gap in gateDoor ☐ Climbed fence

☐ Door left open ☐ unlockedAlarm not ☐ Door broken

☐ Window screen torn ☐ working ☐ Alarm not answered U/K ☐

v. Child able to swim?

○ N/A ○ No ○ Yes ○ U/K

w. For bathtub, child in a bathing aid?

○ Yes ○ No ○ U/K

If yes, specify type:

x. Warning sign or label posted?

○ N/A ○ No ○ Yes ○ U/K

y. Lifeguard present?

○ N/A ○ No ○ Yes ○ U/K

z. Rescue attempt made?

○ ○ ○ ○ N/A ☐ ☐ NoOther ☐

If yes, who? Check all that apply:

☐ YesParentBystander ☐ childOther, specify: ☐ U/KLifeguardU/K

aa. Did rescuer(s) also drown?

○ N/ANo ○ ○ YesU/K ○

If yes, number of rescuers that drowned: _____

bb. Appropriate rescue equipment present?

○ N/A No ○ ○ YesU/K ○

H4. UNINTENTIONAL ASPHYXIA

a. Type of event:

○ Suffocation, go to b
○ Strangulation, go to c
○ Choking, go to d
○ Other, specify and go to e
○ U/K, go to e

b. If suffocation/asphyxia, action causing event:

○ Sleep-related (e.g. bedding, overlay, wedged)
○ Covered in or fell into object, but not sleep-related
○ Plastic bag
○ Dirt/sand Automobile Asphyxia by gas, go to H7g
○ ○ ○ U/K
U/K
Other, specify:

○ Confined in tight space
○ Refrigerator/freezer
○ Toy chest
○ Other, specify:Trunk
○ ○ ○ Other, specify: U/K
○ U/K

○ Swaddled in tight blanket, but not sleep-related
○ Wedged into tight space, but not sleep-related, specify:
○ Other, specify:
○ ○ ○

c. If strangulation, object causing event:

○ Clothing ○ Blind ○ Car
○ Leash ○ cordElectrical cord ○ seatPerson, go to H5q
○ Stroller ○ High chair ○
○ Automobile power window or sunroof
Belt ○ Other, specify:
○ Rope/string ○ U/K

d. If choking, object causing choking:

○ Food, specify:
○ Toy, specify:
○ Balloon
○ Other, specify:
○ U/K

e. Was asphyxia an autoerotic event?

○ N/A ○ Yes ○ No ○ U/K

f. Was child participating in 'choking game' or 'pass out game'?

○ N/A ○ Yes ○ No ○ U/K

g. History of seizures?

○ Yes ○ No ○ U/K If yes, #_____

If yes, witnessed? ○ Yes ○ No ○ U/K

h. History of apnea?

○ Yes ○ No ○ U/K If yes, #_____

If yes, witnessed? ○ Yes ○ No ○ U/K

i. Was Heimlich Maneuver attempted?

○ Yes ○ No ○ U/K

H5. ASSAULT, WEAPON OR PERSON'S BODY PART

a. Type of weapon:

○ Firearm, go to b
○ Sharp instrument, go to j

b. For firearms, type:

○ Handgun
○ Shotgun

c. Firearm licensed?

○ Yes ○ No ○ U/K

d. Firearm safety features, check all that apply:

☐ Trigger lock ☐ Magazine disconnect
☐ Personalization device ☐ Minimum trigger pull

○ Blunt instrument, go to k ○ Person's body part, go to l ○ Explosive, go to m ○ Rope, go to m ○ Pipe, go to m ○ Biological, go to m ○ Other, specify and go to m ○ U/K, go to m	○ BB gun ○ Hunting rifle ○ Assault rifle ○ Air rifle ○ Sawed off shotgun ○ Other, specify: ○ U/K		☐ External safety/drop safety ☐ Other, specify: ☐ Loaded chamber indicator ☐ U/K
		e. Where was firearm stored? ○ Not stored ○ Under mattress/pillow ○ Locked cabinet ○ Other, specify: ○ Unlocked cabinet ○ Glove compartment ○ U/K	f. Firearm stored with ammunition? ○ Yes ○ No ○ U/K g. Firearm stored loaded? ○ Yes ○ No ○ U/K

h. Owner of fatal firearm:			i. Sex of fatal firearm owner:	j. Type of sharp object:	k. Type of blunt object:
○ U/K, weapon stolen	○ Grandparent	○ Co-worker	○ Male	○ Kitchen knife	○ Bat
○ U/K, weapon found	○ Sibling	○ Institutional staff	○ Female	○ Switchblade	○ Club
○ Self	○ Spouse	○ Neighbor	○ U/K	○ Pocketknife	○ Stick
○ Biological parent	○ Other relative	○ Rival gang member		○ Razor	○ Hammer
○ Adoptive parent	○ Friend	○ Stranger		○ Hunting knife	○ Rock
○ Stepparent	○ Acquaintance	○ Law enforcement		○ Scissors	○ Household item
○ Foster parent	○ Child's boyfriend or girlfriend	○ Other, specify:		○ Other, specify:	○ Other, specify:
○ Mother's partner ○ Father's partner	○ Classmate	○ U/K		○ U/K	○ U/K

l. What did person's body part do? Check all that apply:	m. Did person using weapon have history of weapon-related offenses?	o. Persons handling weapons at time of incident, check all that apply:	p. Sex of person(s) handling weapon:
☐ Beat, kick or punch ☐ Drop ☐ Push ☐ Bite ☐ Shake ☐ Strangle/choke ☐ Throw ☐ Drown ☐ Burn ☐ Other, specify: ☐ U/K	○ Yes ○ No ○ U/K n. Does anyone in child's family have a history of weapon offenses or die of weapons-related causes? ○ Yes, describe circumstances: ○ No ○ U/K	Fatal and/or Other weapon ☐ ☐ SelfFriend ☐ ☐ Biological ☐ ☐ Adoptive ☐ ☐ girlfriend ☐ ☐ Foster parentCo- ☐ ☐ Mother's ☐ ☐ Father's ☐ ☐ member ☐ ☐ SiblingStranger ☐ ☐ Spouse Law enforcement officer Fatal and/or Other weapon ☐ ☐ parentAcquaintance ☐ ☐ parentChild's boyfriend or ☐ ☐ StepparentClassmate ☐ ☐ worker ☐ ☐ partnerInstitutional staff ☐ ☐ partnerNeighbor ☐ ☐ GrandparentRival gang ☐ ☐ Other relativeOther, specify: ☐ ☐ U/K	Fatal weapon: ○ Male ○ Female ○ U/K Other weapon: ○ Male ○ Female ○ U/K

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

☐ Self injury ☐ Child was a victim (Good Samaritan) ☐ bystander ☐ Bullying ☐ Showing ☐ gun to others ☐ Loading weapon ☐ ☐

☐ Commission of ☐ crime ☐ Argument ☐ Hunting ☐ Russian ☐ roulette ☐ Intervener assisting ☐ crime Drug

☐ ☐ ☐ ☐ dealing/trading ☐ Jealousy ☐ Target ☐ shooting ☐ Gang-related

☐ activity ☐ ☐ Drive-by ☐ shooting ☐ Intimate partner ☐ violence ☐ Playing with ☐ weapon ☐ Self-defense ☐ Other,

☐ specify: ☐ ☐ ☐ ☐ ☐

☐ Random violence ☐ Hate crime ☐ Weapon mistaken for toy ☐ Cleaning weapon ☐ U/K

H6. FALL OR CRUSH

a. Type:

○ Fall, go to b

○ Crush, go to h

b. Height of fall:

_____ feet

_____ inches

☐ U/K

c. Child fell from:

○ Open window ○ Natural elevation ○ Stairs/steps ○ Moving object, specify: ○ Animal, specify:

○ Screen ○ Man-made elevation ○ Furniture ○ Bridge ○ Other, specify:

Screen? ○ No ○ screen ○ Playground ○ equipment ○ Bed ○ Overpass

○ U/K if ○ screen ○ Tree ○ Roof Balcony ○ U/K

d. Surface child fell onto:

○ Cement/concrete

○ Grass

○ Gravel

○ Wood floor

○ Carpeted floor

○ Linoleum/vinyl

○ Marble/tile

○ Other, specify:

○ U/K

e. Barrier in place:

Check all that apply:

☐ None

☐ Screen

☐ Other window guard

☐ Fence

☐ Railing

☐ Stairway

☐ Gate

☐ Other, specify:

☐ U/K

f. Child in a baby walker?

○ N/A

○ Yes

○ No

○ U/K

g. Was child pushed, dropped or thrown?

○ Yes ○ No ○ U/K

If yes, go to H5q

h. For crush, did child:

○ Climb up on object

○ Pull object down

○ Hide behind object

○ Go behind object

○ Fall out of object

○ Other, specify:

○ U/K

i. For crush, object causing crush:

○ Appliance ○ Dirt/sand

○ Television ○ Person, go to H5q

○ Furniture ○ Commercial equipment

○ Walls ○ Farm equipment

○ Playground ○ equipment ○ Other, specify:

○ Animal

○ Tree branch ○ U/K

○ Boulders/rocks

H7. POISONING, OVERDOSE OR ACUTE INTOXICATION

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

Prescription drug	Over-the-counter drug	Illicit drugs	Other substances
☐ Antidepressant	☐ Pain medication	☐	☐
☐ Pain medication (opiate)	☐ Cold medication (opiate)	☐ Alcohol	☐
☐ Pain medication (non-opiate)	☐ Other OTC, specify:	☐ Carbon monoxide, go to e	☐
☐ Methadone	☐ Cocaine	☐ Other, specify:	☐
☐ Other Rx, specify:	☐ Heroin	☐	
		☐	
		☐	

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

b. Where was the substance stored?

○ Open area

○ Open cabinet

○ Closed cabinet, unlocked

○ Closed cabinet, locked

○ Other, specify:

c. Was the product in its original container?

○ N/A ○ No

○ Yes ○ U/K

d. Did container have a child

e. Was the incident the result of?

○ Accidental overdose

○ Medical treatment mishap

○ Adverse effect, but not overdose

○ Deliberate poisoning

○ Acute intoxication

f. Was Poison Control called?

○ Yes ○ No ○ U/K

If yes, who called:

○ Child

○ Parent

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

○ Yes ○ No ○ U/K

If yes, how many?

○ U/K	safety cap? ○ N/A ○ No ○ Yes ○ U/K	○ Other, specify: ○ U/K	○ Other caregiver ○ First responder ○ Medical person ○ Other, specify: ○ U/K	_____ Functioning properly? ○ Yes ○ No ○ U/K

H8. MEDICAL CONDITION

a. How long did the child have the medical condition?	b. Was death expected as a result of the medical condition?	c. Was child receiving health care for the medical condition?	d. Were the prescribed care plans appropriate for the medical condition?
○ In utero ○ Weeks ○ Since birth ○ Months ○ Hours ○ Years ○ Days ○ U/K	○ N/A, not previously diagnosed ○ Yes ☐ But at a later date ○ No ○ U/K	○ Yes ○ No ○ U/K If yes, within 48 hours of the death? ○ Yes ○ No ○ U/K	○ N/A ○ Yes ○ No, specify: ○ U/K

e. Was child/family compliant with the prescribed care plans?

○ N/A ○ Yes ○ No ○ U/K

If no, what wasn't compliant? Check all that apply.

☐ Appointments ☐ Therapies, specify:
☐ Medications, specify: ☐ Other, specify:
☐ Medical equipment use, specify:
☐

f. Was the medical condition associated with an outbreak?

○ Yes, specify:
○ No
○ U/K

g. Was environmental tobacco exposure a contributing factor in death?

○ Yes
○ No
○ U/K

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

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

i. Was death caused by a medical misadventure?

○ Yes
○ No
○ U/K

H9. OTHER KNOWN INJURY CAUSE

Specify cause, describe in detail:

I. OTHER CIRCUMSTANCES OF INCIDENT - ANSWER RELEVANT SECTIONS

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

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

Section I1: OMB No. 0920-1092, Exp. Date: 12/31/2018

Public reporting burden of this collection of information is estimated to average 10 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to: CDC/ATSDR Reports Clearance Officer; 1600 Clifton Road NE, MS D-74, Atlanta, Georgia 30333; ATTN: PRA (0920-1092)

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
- ○ Unknown, go to I1b

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

☐ U/K for all

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

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

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

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

○ Yes ○ No ○ U/K If yes, describe:

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

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

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

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

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

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

Y	N	U/K	Deaths
○	○	○	Sudden unexpected death before age 50
			Heart Disease
○	○	○	Heart condition/heart attack or stroke before age 50
○	○	○	Aortic aneurysm or aortic rupture
○	○	○	Arrhythmia (fast or irregular heart rhythm)
○	○	○	Cardiomyopathy
○	○	○	Congenital heart disease
			Neurologic Disease
○	○	○	Mitochondrial disease
○	○	○	Muscle disorder or muscular dystrophy
○	○	○	Thrombophilia (clotting disorder)
○	○	○	diseases that are genetic or run in families
○	○	○	Other neurologic disease

Y	N	U/K	Symptoms
○	○	○	Febrile seizures
○	○	○	Unexplained fainting
			Other Diagnoses
○	○	○	Congenital deafness
○	○	○	Connective tissue disease
○	○	○	
○	○	○	
○	○	○	Epilepsy or convulsions/seizure
○			Other, specify:

If sudden unexpected death before age 50, describe the type of event, which relative, and relative's age at death (for example, brother at age 30 who died in an unexplained motor vehicle accident (driver of car)):

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

If yes, describe the test/gene tested, reason for testing, family member tested, and results:

Was a gene mutation found?
○ Yes ○ No ○ U/K

h. In the 72 hours prior to death was the child taking any prescribed medication(s)?
○ Yes ○ No ○ U/K

If yes, describe:

i. Within 2 weeks prior to death had the child:

	N/A	Yes	No	U/K
Taken extra doses of prescribed medications	○	○	○	○
Missed doses of prescribed medications	○	○	○	○
Changed prescribed medications, describe:	○	○	○	○

j. Was the child compliant with their prescribed medications?
○ N/A ○ Yes ○ No ○ U/K

If not compliant, describe why and how often:

k. Was the child taking any of the following substance(s) within 24 hours of death?
Check all that apply:

☐ Over-the-counter medicine ☐ Supplements ☐ Recent/short term
☐ prescriptions ☐ Tobacco ☐
☐ Energy drinks ☐ Alcohol ☐
☐ Caffeine ☐ Illegal drugs
☐ Performance enhancers ☐ Legalized marijuana
☐ Diet assisting medications Other, specify: ☐ ☐ U/K

If yes to any items above, describe:

l. Did the child experience any of the following stimuli at time of incident or within 24 hours o the incident? U/K for all at time of incident

	At incident	Within 24 hrs of incident

☐ U/K for all within 24 hours of incident

Stimuli	Yes	No	U/K	Yes	No	U/K
Physical activity	○	○	○	○	○	○
Sleep deprivation	○	○	○	○	○	○
Driving	○	○	○	○	○	○
Visual stimuli	○	○	○	○	○	○
Video game stimuli	○	○	○	○	○	○
Emotional stimuli	○	○	○	○	○	○
Auditory stimuli/startle	○	○	○	○	○	○
Physical trauma Other, specify:	○	○	○	○	○	○
	○			○		

If yes to physical activity, describe type of activity:

At incident Within 24 hours of incident

Other specify:

At incident Within 24 hours of incident

m. Was the child an athlete? ○ N/A ○ Yes ○ No ○ U/K

If yes, type of sport: ○ Competitive ○ Recreational ○ U/K

If competitive, did the child participate in the 6 ıonths prior to death? ○ Yes ○ No ○ U/K

n. Did the child ever have any of the following **uncharacteristic** symptoms during or within 24 hours after physical activity? Check all that apply:

- ☐ Chest pain
- ☐ Confusion
- ☐ Convulsions/seizure
- ☐ Dizziness/lightheadedness
- ☐ Fainting
- ☐ Headache
- ☐ Palpitations
- ☐ Shortness of breath/difficulty breathing
- ☐ Other, specify:
- ☐ U/K activity and extent of ;ymptoms:

If yes to any item, describe type of physical

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:Genetic/chromosomal

Brain tumorMesial temporal sclerosis

CerebrovascularIdiopathic or cryptogenic

Central nervous system Other acute illness or injury infection other than epilepsy

Degenerative process Other, specify:

Developmental brain disorder U/K

Inborn error of metabolism

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 antiepileptic 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:

Yes, go to I2a No, go to I2sU/K, go to I2a **WAS DEATH RELATED TO SLEEPING OR ○ THE ○ SLEEP ○ ENVIRONMENT?**

a. Incident sleep place:

Crib
If crib, type:WaterbedRock 'n
Not portableFutonStrollerFullCouch
Portable, e.g. Pack 'n
Baby boxFloorU/K
PlayTwinBed position
position
PlayPlaypen/other play
Unknown crib typestructure, not a portable cribBouncy chairKingIf car seat, was car seat
BassinetCouchOther, specify:Other, specify:secured in seat of car?
Bed side sleeperChairU/K
Adult bedCar seatIf adult bed, what type? If futon,
SwingQueenU/K
Yes No U/K

b. Child put to sleep:
On back
On stomach
On side
U/K

c. Child found:
On back
On stomach
On side
U/K

e. Usual sleep position:
On back
On stomach
On side
U/K

f. Was there any type of crib, Pack 'n Play, bassinet, bed side sleeper or baby box in home for child?
Yes No U/K

d. Usual sleep place:

Crib
If crib, type:Adult bedCar seat
Not portableWaterbedRock 'n Play
Portable, e.g. Pack 'n
Unknown crib typePlaypen/other
Bassinetstructure, not a portable
Bed side sleeperCouchOther, specify:
Baby boxFloor
PlayFutonStroller
playSwing
cribBouncy chair
ChairU/K

If adult bed, what type?
Twin King
Full Other, specify:
Queen U/K

If futon,
Bed position
Couch position
U/K

g. Child in a new or different environment than usual?
Yes No U/K
If yes, describe why:

h. Child last placed to sleep with a pacifier?
Yes No U/K

i. Child wrapped or swaddled in blanket?
Yes No U/K
If yes, describe:

j. Child overheated? Yes No U/K
If yes, outside temp ____ degrees FCheckallthatapplyRoomtoohot,temp ___degreesF
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 (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?
NoseChest compressed
MouthU/K
Neck compressed

If fully or partially obstructed, describe obstruction in detail:

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

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

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

p. Caregiver/supervisor fell asleep while feeding child?

○ Yes ○ No ○ U/K

If yes, type of feeding: ○ Bottle ○ Breast ○ U/K

q. Child sleeping in the same room as caregiver/supervisor at time of death?

○ Yes ○ No ○ U/K

r. Child sleeping on same surface with person(s) or animal(s)?

○ Yes ○ No ○ U/K

If yes, reasons stated for sleeping on all that apply:

☐ With adult(s): # _____
☐ To feed
☐ Adult obese: U/K
☐ To soothe
☐ With other children: # _____
☐ Usual sleep pattern
☐ With animal(s): #
☐ No infant bed available
☐ Home/living space overcrowded
☐ Other, specify:
☐ U/K

If yes, check all that apply: same surface, check

☐ ☐ # U/K
○ Yes ○ No ○
☐ Children's ages: _____ ☐ # U/K
☐ _____ Type of animal ☐ # U/K

s. Is there a scene re-creation photo available for upload? ○ Yes ○ No If yes, upload here. Only one photo allowed.

Select photo that 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
◯ Yes ◯ No ◯ U/K	◯ Yes ◯ No ◯ U/K	◯ Yes ◯ No ◯ U/K	◯ 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

☐ Exposure to hazards:

Do not include child's own behavior.

◯ Hazard(s) in sleep environment (including sleep position and co-sleeping)
◯ 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 co-sleeping)
◯ Fire hazard
◯ Unsecured medication/poison
◯ Firearm hazard
◯ Water hazard
◯ Motor vehicle hazard
◯ Maternal substance use during pregnancy

h. Was poverty a factor?

◯ Yes ◯ No ◯ U/K

If yes, explain in Narrative

cultural practices?

○ Yes ○ No ○ U/K

○ Other hazard, specify:

I6. SUICIDE

a. For suicide, select yes, no or u/k for each question. Describe answers in narrative.

Yes	No	U/K		Yes	No	U/K	
○	○	○	A note was leftChild had a history of self mutilation	○	○	○	
○	○	○	Child talked about suicideThere is a family history of suicide	○	○	○	
○	○	○	Prior suicide threats were madeSuicide was part of a murder-	○	○	○	suicide
○	○	○	Prior attempts were madeSuicide was part of a suicide pact	○	○	○	
○	○	○	Suicide was completely unexpectedSuicide was part of a suicide	○	○	○	cluster
○	○	○	Child had a history of running away				

b. For suicide, was there a history of acute or cumulative personal crises that may have contributed to the child's despondency? Check all that apply:

☐ None knownRumor mongeringPregnancyInvolvement in computer

☐ Family discordSuicide by friend or relativePhysical abuse/assault or video games

☐ Parents' divorce/separationOther death of friend or relativeRape/sexual abuse Involvement with the Internet, Argument with parents/caregiversBullying

☐ as victimProblems with the law specify:

☐ Argument with boyfriend/girlfriendBullying as perpetratorDrugs/alcoholOther, specify:

☐ Breakup with boyfriend/girlfriendSchool failureSexual orientation/gender identityU/K

☐ Argument with other friendsMove/new schoolJob problems

☐ Emotional neglect/abuseOther serious school problemsMoney problems

J. PERSON RESPONSIBLE (OTHER THAN DECEDENT)

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

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

2. What act(s)?

Check only one per column and describe in narrative.

One	Two		One	Two	
○	○	Child abuse	○	○	Exposure to hazards
○	○	Child neglect	○	○	Assault, not child abuse
○	○	Poor/absentOther,specify: supervisionU/K	○	○	
			○	○	

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

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

4. Is person listed in a previous section?

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

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

One	Two		One	Two		One	Two	
○	○	Adoptive	○	○	parentGrandparentMedical	○	○	provider
○	○	StepparentSibling	○	○	Institutional staff	○	○	
○	○	Foster parentOther	○	○	relative Babysitter	○	○	
○	○	Mother's	○	○	partnerFriendLicensed child	○	○	care
○	○	Father's	○	○	partnerAcquaintance worker			
			○	○	Child's boyfriend or	○	○	girlfriendOther, specify:
			○	○	StrangerU/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

If yes, check all that apply:

☐ ☐ Alcohol

☐ ☐ Cocaine

☐ ☐ Marijuana

☐ ☐ Methamphetamine

☐ ☐ Opiates

☐ ☐ Prescription drugs

☐ ☐ Over-the-counter

☐ ☐ Other, specify:

☐ ☐ U/K

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

One Two

○ ○ Yes

○ ○ No

○ ○ U/K

If yes, check all that apply:

☐ ☐ Physical

☐ ☐ Neglect

☐ ☐ Sexual

☐ ☐ Emotional/ psychological

☐ ☐ U/K

_____ _____ # CPS referrals

_____ _____ # Substantiations

☐ ☐ Ever in foster care or adopted

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

One Two

○ ○ Yes

○ ○ No

○ ○ U/K

If yes, check all that apply:

☐ ☐ Physical

☐ ☐ Neglect

☐ ☐ Sexual

☐ ☐ Emotional/psychological

☐ ☐ U/K

_____ _____ # CPS referrals

_____ _____ # Substantiations

☐ ☐ CPS prevention services

☐ ☐ Family preservation services

☐ ☐ Children ever removed

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

One Two

○ ○ Yes

○ ○ No

○ ○ U/K

If yes, check all that apply:

☐ ☐ Physical/orthopedic, specify:

☐ ☐ Mental health/substance abuse, specify:

☐ ☐ Cognitive/intellectual, specify:

☐ ☐ Sensory, specify:

☐ ☐ U/K

If mental health/substance abuse, was person receiving MH services?

○ ○ Yes

○ ○ No

○ ○ U/K

14. Person(s) have prior child deaths?

One Two

○ ○ Yes

○ ○ No

○ ○ U/K

If yes, check all that apply:

One Two

☐ ☐ Child abuse # _____

☐ ☐ Child neglect # _____

☐ ☐ Accident # _____

☐ ☐ Suicide # _____

☐ ☐ SIDS # _____

☐ ☐ Undetermined cause # ____

☐ ☐ Other # _____

Other, specify:

☐ ☐ U/K

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

One Two

☐ ☐ Yes, as victim

☐ ☐ Yes, as perpetrator

☐ ☐ No

☐ ☐ U/K

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

One Two

○ ○ Yes

○ ○ No

○ ○ U/K

If yes, check all that apply:

☐ ☐ Assaults

☐ ☐ Robbery

☐ ☐ Drugs

☐ ☐ Other, specify:

☐ ☐ U/K

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

One Two

○ ○ Yes

○ ○ No

○ ○ U/K

If yes, select the most appropriate Night time sleep description of the person's sleeping Day time nap, describe:

period at incident:Day time sleep (for example, person is night shift worker), describe:

Other, describe:

One Two

○ ○

○ ○

○ ○

○ ○

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. PREVENTION INITIATIVES RESULTING FROM THE REVIEW

◯ Mark this case to edit/add prevention actions at a later date

1. 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:
☐	Law enforcement	Describe:
☐	Public health	Describe:
☐	Coroner/medical examiner	Describe:
☐	Courts	Describe:
☐	Health care systems	Describe:
☐	Education	Describe:
☐	Mental health	Describe:
☐	EMS	Describe:
☐	Substance abuse	Describe:
☐	Other, specify:	Describe:

2. Describe the risk factors in the death that the team feels need to be addressed:

3. What recommendations and/or initiatives resulted from the review? Check all that apply:

◯ No recommendations and/or initiatives made, go to L7

		Current Action Stage		Level of Action		
		Recommendation	Implementation	Local	State	National
Education	Media campaign	◯	◯	☐	☐	☐
	School program	◯	◯	☐	☐	☐
	Community safety project	◯	◯	☐	☐	☐
	Provider education	◯	◯	☐	☐	☐
	Parent education	◯	◯	☐	☐	☐
	Public forum	◯	◯	☐	☐	☐
	Other education	◯	◯	☐	☐	☐
Law	New law/ordinance	◯	◯	☐	☐	☐
	Amended law/ordinance	◯	◯	☐	☐	☐
	Enforcement of law/ordinance	◯	◯	☐	☐	☐
Environment	Modify a consumer product	◯	◯	☐	☐	☐
	Recall a consumer product	◯	◯	☐	☐	☐
	Modify a public space	◯	◯	☐	☐	☐
	Modify a private space(s)	◯	◯	☐	☐	☐
	Other, specify:	◯	◯	☐	☐	☐

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

5. Briefly describe recommendations and/or initiatives that will be or have been implemented as a result of the death:

6. Who was given the recommendation(s) and or/initiative(s) to implement? Check all that apply:

☐ N/A, no strategies	☐ Social services	☐ Other health care providers	☐ Elected official	☐ Youth group
☐ No one	☐ Mental health	☐ Law enforcement	☐ Advocacy organization	☐ Other, specify:
☐ Community Action Team	☐ Schools	☐ Medical examiner	☐ Local community group	
☐ Health department	☐ Hospital	☐ Coroner	☐ New coalition/task force	☐ U/K

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

5. Were the following data sources available at the review meeting?

Check all that apply:

- ☐ CDC's SUIDI Reporting Form
- ☐ Jurisdictional equivalent of the CDC SUIDI Reporting Form
- ☐ Birth certificate - full form
- ☐ Death certificate
- ☐ Child's medical records or clinical history, including vaccinations
- ☐ Biological mother's obstetric and prenatal information
- ☐ Newborn screening results
- ☐ Law enforcement records
- ☐ Social service records
- ☐ Child protection agency records
- ☐ EMS run sheet
- ☐ Hospital records
- ☐ Autopsy/pathology reports
- ☐ Home visiting
- ☐ Mental health records
- ☐ School records
- ☐ Substance abuse treatment records

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

- ☐ None
- ☐ Confidentiality issues among members prevented full exchange of information
- ☐ HIPAA regulations prevented access to or exchange of information
- ☐ Inadequate investigation precluded having enough information for review
- ☐ Team members did not bring adequate information to the meeting
- ☐ Necessary team members were absent
- ☐ Meeting was held too soon after death
- ☐ Meeting was held too long after death
- ☐ Records or information were needed from another locality in-state
- ☐ Records or information were needed from another state
- ☐ Team disagreement on circumstances
- ☐ Other factors, specify:

7. Review meeting outcomes, check all that apply:

- ☐ Review led to additional investigation
- ☐ Team disagreed with official manner of death. What did team believe manner should be?
- ☐ Team disagreed with official cause of death. What did team believe cause should be?
- ☐ Because of the review, the official cause or manner of death was changed
- ☐ Review led to the delivery of services
- ☐ Review led to changes in agency policies or practices
- ☐ Review led to prevention initiatives being implemented ☐ Local ☐ State ☐ National

N. SUID AND SDY CASE REGISTRY

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

Section N: OMB No. 0920-1092, Exp. Date: 12/31/2018

Public reporting burden of this collection of information is estimated to average 10 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to: CDC/ATSDR Reports Clearance Officer; 1600 Clifton Road NE, MS D-74, Atlanta, Georgia 30333; ATTN: PRA (0920-1092)

1. Is this an SDY or SUID case? ○ Yes ○ No If no, go to Section 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, including case details that helped determine SDY categorization and any ways to improve the review:

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

☐ Cardiologist	☐ Death investigator	☐ Geneticist or genetic counselor	☐ Pediatrician
☐ CDR representative	☐ Epileptologist	☐ Mental health professional	☐ 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 sent to the SDY Case Registry biorepository?

○ N/A ○ Yes ○ No ○ U/K

8. 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:

9. Categorization for SDY Case Registry (choose only one):

○ Excluded from SDY Case Registry

○ Explained

○ Incomplete case information

○ Explained infant

○ Explained cardiac (under age 1)

○ Unexplained, possible cardiac

○ Unexplained child death (age 1 and over)

○ neurological

○ Explained other, specify:

○ suffocation

○ Unexplained, possible cardiac

○ Unexplained and SUDEP

○ Unexplained, SUDEP

○ infant death/SUID (under age 1)

10. 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:

11. Check the box below when a SUID case is complete and ready for inclusion in the SUID data analyses. This box should be checked if a completed case is awaiting SDY Advanced Review or not going to SDY Advanced Review.

☐ SUID Case Registry Data Entry Complete

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

APPENDIX F:

ADDITIONAL CHILD ABUSE DEATH REVIEW DATA

CHILD DEATH INCIDENT INFORMATION

Location of Child Deaths

Tables F-1 and F-2 provide information related to the number of child fatalities that occurred in each county in Florida. Please note that the county refers to the county where the incident took place, not necessarily the county where the death occurred (although they may be the same). By way of explanation, there are occasions where the incident causing a child's death may happen in one county; however, the child's death (for example, because he/she was transported to a medical facility in another county) may be documented in another county. From a prevention standpoint, for this report, any county reference refers to the county where the incident contributing to the death (i.e., "death county") took place. Table F-1 highlights every child death across individual counties stratified by maltreatment verification status and primary cause of death (i.e., drowning, asphyxia, weapon, and other). Table F-2 aggregates information denoted in Table F-1 for all primary causes of death for each county. No information in a table cell in either Table F-1 or Table F-2 indicates a zero count for that county category.

When information from Table F-1 is examined, there are five counties that account for more than half (43 of 83 or 51.8%) of the verified child maltreatment deaths (across all primary causes of death) in Florida. These include Broward (n=12), Duval (n=9), Polk (n=9), Hillsborough (n=7) and Orange (n=6). Additionally, verified child maltreatment deaths happened in counties throughout Florida for a total of 40 of 83 (48.2%) of Florida's counties.

When primary cause of death among verified maltreatment cases are examined, all drowning deaths (thus far reviewed) took place in 13 counties (n=20) with 8 of 20 (40.0%) taken place in two counties (Broward and Miami-Dade). Among verified maltreatment deaths involving sleep-related incidents, all took place in seven counties; namely, Broward (n=5), Bay (n=1), Duval (n=2), Indian River (n=1), Lee (n=1), Palm Beach (n=2), and St. Lucie (n=1). The 21 verified maltreatment deaths by weapons are found across 12 different counties in Florida with the greatest number occurring in Orange county (n=4).

When the total number of child fatalities (regardless of verification status and primary cause of death) investigated for each county is examined (see Table F-2), there are 8 counties with more than ten investigated deaths that collectively account for 183 of 325 (56.3%) of all fatalities. These include: Duval (n=42), Orange (n=24), Hillsborough (n=29), Broward (n=23), Polk (n=28), Brevard (n=10), Palm Beach (n=11) and Miami-Dade (n=16).

Table F-1: Distribution of Maltreatment Finding Status Across Florida Counties by Primary Cause of Death

County	Verified for Maltreatment n=83				Not Substantiated as Maltreatment n=58				No Indicators of Maltreatment n=184				Total
	Drowning	Sleep-related	Inflicted Trauma	Other Undetermined Unknown	Drowning	Sleep-related	Inflicted Trauma	Other Undetermined Unknown	Drowning	Asphyxia	Body Part/ Weapon	Other Undetermined Unknown	
Alachua	0	0	1	0	0	0	0	0	0	1	1	0	3
Baker	0	0	0	0	0	0	0	0	0	2	0	0	2
Bay	0	1	0	0	0	0	0	0	0	0	0	0	1
Bradford													0
Brevard	1	0	2	0	0	0	0	1	0	4	1	1	10
Broward	5	5	0	2	1	5	0	2	1	0	1	1	23
Calhoun													0
Charlotte	0	0	0	0	0	1	0	0	0	0	0	0	1
Citrus	0	0	0	1	0	0	0	0	0	0	0	2	3
Clay	0	0	0	0	1	1	0	0	0	0	0	0	2
Collier	0	0	0	0	0	0	0	0	0	0	0	1	1
Columbia	0	0	0	0	0	2	0	0	0	1	0	0	3
DeSoto													0
Dixie	0	0	1	0	0	0	0	0	0	0	0	0	1
Duval	1	2	2	4	6	3	0	1	0	19	0	4	42
Escambia	0	0	0	0	0	0	0	0	1	5	0	1	7
Flagler	0	0	0	0	1	0	0	0	0	1	0	0	2
Franklin													0
Gadsden	0	0	0	0	0	0	0	0	0	0	0	1	1
Gilchrist													0
Glades													0
Gulf													0
Hamilton													0
Hardee													0
Hendry													0
Hernando	0	0	0	1	0	1	0	0	0	0	0	0	2
Highlands	0	0	1	1	0	0	0	0	1	1	0	0	4
Hillsborough	2	0	3	2	3	2	0	0	4	10	0	3	29
Holmes													0
Indian River	0	1	0	0	0	1	0	0	1	0	0	0	3
Jackson	0	0	1	0	0	0	0	0	0	0	0	1	2
Jefferson	1	0	0	0	0	0	0	0	0	1	0	0	2
Lafayette													0
Lake	0	0	0	0	0	0	0	0	0	0	0	5	5
Lee	0	1	1	1	0	0	0	0	0	2	0	5	10
Leon	0	0	0	0	0	0	0	1	1	1	0	4	7
Levy	0	0	0	0	1	0	0	0	0	0	0	0	1
Liberty													0
Madison													0
Manatee	0	0	1	1	0	0	0	0	1	0	1	2	6
Marion	0	0	0	2	1	0	0	0	0	4	0	2	9
Martin													0
Miami-Dade	3	0	0	1	1	4	0	1	0	2	0	4	16
Monroe													0
Nassau	1	0	0	0	0	0	0	0	0	0	0	0	1
Okaloosa	0	0	0	0	0	0	0	1	0	6	0	0	7
Okeechobee	1	0	0	0	0	0	0	0	0	0	1	0	2
Orange	0	0	4	2	1	0	0	1	0	14	0	2	24
Osceola	1	0	0	0	0	0	1	0	1	2	0	0	5
Palm Beach	1	2	0	2	1	0	0	0	1	1	0	3	11
Pasco	1	0	0	0	1	0	0	0	4	1	0	2	9
Pinellas	0	0	1	2	0	0	0	0	1	3	0	1	8
Polk	0	0	3	6	0	0	0	2	4	8	0	5	28
Putnam	1	0	0	0	0	0	0	0	0	0	0	0	1
St Johns													0
St Lucie	0	1	0	0	1	0	0	0	0	1	0	0	3
Santa Rosa	0	0	0	0	0	0	0	0	2	1	0	1	4
Sarasota	1	0	0	0	1	1	0	0	2	1	0	1	7
Seminole	0	0	0	1	0	0	0	0	0	3	0	4	8
Sumter	0	0	0	0	0	0	0	0	0	1	0	0	1
Suwanee													0
Taylor													0
Union													0
Volusia	0	0	0	0	5	0	0	1	0	0	0	0	6
Wakulla	0	0	0	0	0	0	0	0	0	1	0	0	1
Walton	0	0	0	0	0	0	0	0	1	0	0	0	1
Washington													0
Total	20	13	21	29	25	21	1	11	26	97	5	56	325

Table F-2: Distribution of All Child Death Cases Reviewed Across Florida Counties by Primary Cause of Death					
County	Primary Cause of Death				
	Drowning (N=71)	Sleep-related (N=131)	Inflicted Trauma (N=27)	Other/Undetermined/ Unknown (N=96)	Total (N=325)
Alachua		1	2		3
Baker		2			2
Bay		1			1
Bradford					0
Brevard	1	4	3	2	10
Broward	7	10	1	5	23
Calhoun					0
Charlotte		1			1
Citrus					0
Clay	1	1		3	5
Collier		0		1	1
Columbia		3			3
DeSoto					0
Dixie			1		1
Duval	7	24	2	9	42
Escambia	1	5		1	7
Flagler	1	1			2
Franklin					0
Gadsden				1	1
Gilchrist					0
Glades					0
Gulf					0
Hamilton					0
Hardee					0
Hendry					0
Hernando		1		1	2
Highlands	1	1	1	1	4
Hillsborough	9	12	3	5	29
Holmes					0
Indian River	1	2			3
Jackson			1	1	2
Jefferson	1	1			2
Lafayette					0
Lake				5	5
Lee		3	1	6	10
Leon	1	1		5	7
Levy	1				1
Liberty					0
Madison					0
Manatee	1		2	3	6
Marion	1	4		4	9
Martin	0				0
Miami-Dade	4	6		6	16
Monroe					0
Nassau	1				1
Okaloosa		6		1	7
Okeechobee	1		1		2
Orange	1	14	4	5	24
Osceola	2	2	1		5
Palm Beach	3	3		5	11
Pasco	6	1		2	9
Pinellas	1	3	1	3	8
Polk	4	8	3	13	28
Putnam	1				1
St Johns					0
St Lucie	1	2			3
Santa Rosa	2	1		1	4
Sarasota	4	2		1	7
Seminole		3		5	8
Sumter		1			1
Suwanee					0
Taylor					0
Union					0
Volusia	5			1	6
Wakulla		1			1
Walton	1				1
Washington					0
Total	71	131	27	96	325

Drowning Death Incident Information

Where information was available, Tables F-3 and F-4 with Figure F-1 represent findings on the location and activity of child before drowning. As findings suggest in Table F-3, children (regardless of verification status) were most likely to be last documented in their house 29 of 71 (40.8%) or in the water 21 of 71 (29.6%) of deaths investigated prior to drowning. The majority 45 of 71 (63.4%) of all children (across all verification status categories) were playing before drowning; there were 12 of 71 (16.9%) children that were do other activities prior to drowning.

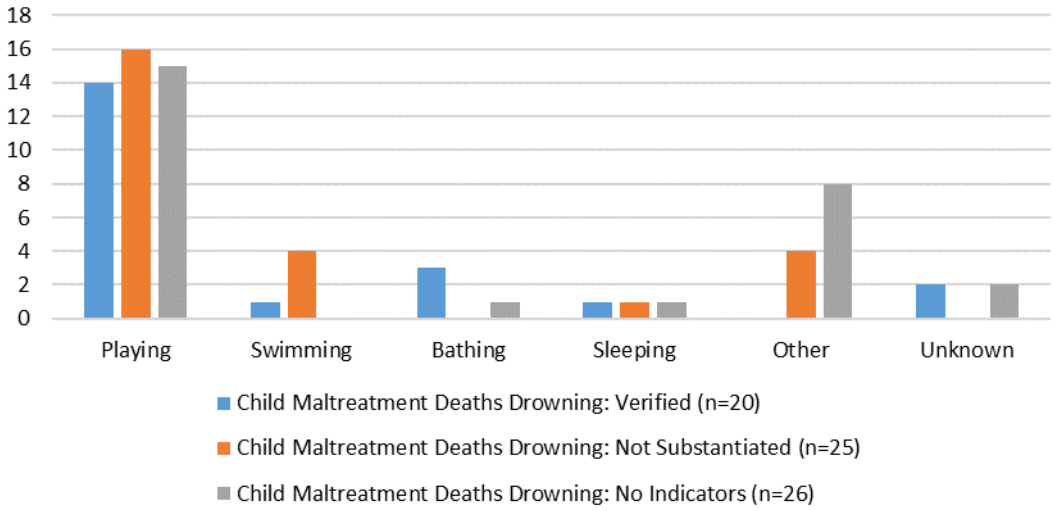
Table F-3: Location of Child Before Drowning by Child Maltreatment Verification Status

Location of Child Before Drowning	Child Maltreatment Deaths Drowning n=67		
	Verified (n=20)	Not Substantiated (n=25)	No Indicators (n=26)
In Water	8	6	7
On Shore	0	1	0
On Dock	0	0	0
Pool Side	1	2	1
In Yard	0	3	4
In Bathroom	4	0	3
In House	5	11	13
Other	2	4	1
Unknown/Missing	1	0	1

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

Table F-4: Activity of Child Before Drowning by Child Maltreatment Verification Status			
Activity Before Drowning	Child Maltreatment Deaths Drowning n=71		
	Verified (n=20)	Not Substantiated (n=25)	No Indicators (n=26)
Playing	14	16	15
Boating	0	0	0
Swimming	1	4	0
Bathing	3	0	1
Fishing	0	0	0
Surfing	0	0	0
Tubing	0	0	0
Water Skiing	0	0	0
Sleeping	1	1	1
Other	0	4	8
Unknown/Missing	1	0	1

Figure F-1: Activity of Child Before Drowning by Maltreatment Verification Status (N=71)



Sleep-Related Asphyxia Death Incident Information

Table F-5 provides a listing and associated counts of specific objects (including persons) that were reported in a child's sleep environment and for objects identified to have blocked/obstructed a child's airway among the reviewed sleep-related cases (N=131) regardless of verification status. Please note that there may be more than one identified object present in the sleeping environment as well as more than one object(s) blocking the child's airway contributing to death. Also, the data applies to sleep-related deaths pertaining to children under the age of five. There was a total of 103 objects blocking the airways of the 131 children that died from sleep-related causes. Among these objects, 91 of 103 (88.3%) objects were associated with bedding-related objects (i.e., pillows, mattresses, comforters/quilts, sheets/thin blankets, bumper pads, etc.). A total of 22 of 77 (28.6%) adults reportedly blocked the airways of children that died; however, 77 adults were sleeping/present with the child at the time of the death incident.

Table F-5: Objects in Sleep Environment Among Sleep-Related Deaths (N=131)

	Objects Present in Sleeping Environment	Objects Obstructing Child's Airway
Adult(s)	77	22
Other Children	19	5
Animal(s)	1	0
Mattress	76	12
Comforter	51	14
Sheet	50	7
Blanket	57	15
Pillow(s)	65	16
Cushion	9	3
Boppy or U-Shaped Pillow	6	2
Sleep Positioner	0	0
Bumper Pads	1	0
Clothing	16	1
Crib Railing/Side	4	0
Wall	9	2
Toy(s)	9	0
Other	14	4

The above data apply to sleep-related deaths if the child was under the age of five. Column totals may exceed number of children as multiple objects could be present or a source of obstruction.

Body Part/Weapon-Related Death Incident Information

Tables F-6 through F-8 summarize information related to the sex of the firearm owner (in firearm deaths only), and the sex and relationship of the person handling the weapon related to the child fatality at the time of the incident. Most of the owners (9 of 15 or 60.0%) of firearms used in the fatality were owned by males. When all weapons used in verified maltreatment deaths are considered, 15 of 23 (65.2%) were males who handled the weapon that was used in the child's fatality.

As highlighted in Table F-8 and Figure F-3 and F-4 the biological parent was most likely 9 of 21 (42.9%) to be the person handling the weapon at the time of death, followed by the mother's partner (n=6) and the child's friend (n=2). In 1 of the 1 (100.0%) no indicators of maltreatment deaths, the child who died was handling the fatal weapon at the time of death incident.

Table F-6: Sex of Fatal Firearm Owner by Maltreatment Verification Status			
Sex of Fatal Firearm Owner	Child Maltreament Death Firearm Deaths n=16		
	Verified (n= 10)	Not Substantiated (n=1)	No Indicators (n=5)
Male	5	1	4
Female	1	0	1
Unknown/Missing	4	0	0

Table F-7: Sex of Person Handling Weapon by Maltreatment Verification Status			
Sex of Person Handling Weapon	Child Maltreatment Death n=27		
	Verified (n=21)	Not Substantiated (n=1)	No Indicators (n= 5)
Male	16	1	4
Female	5	0	1
Unknown/Missing	0	0	0

Figure F-2: Sex of Person Handling Weapon by Maltreatment Verification Status (N=27)

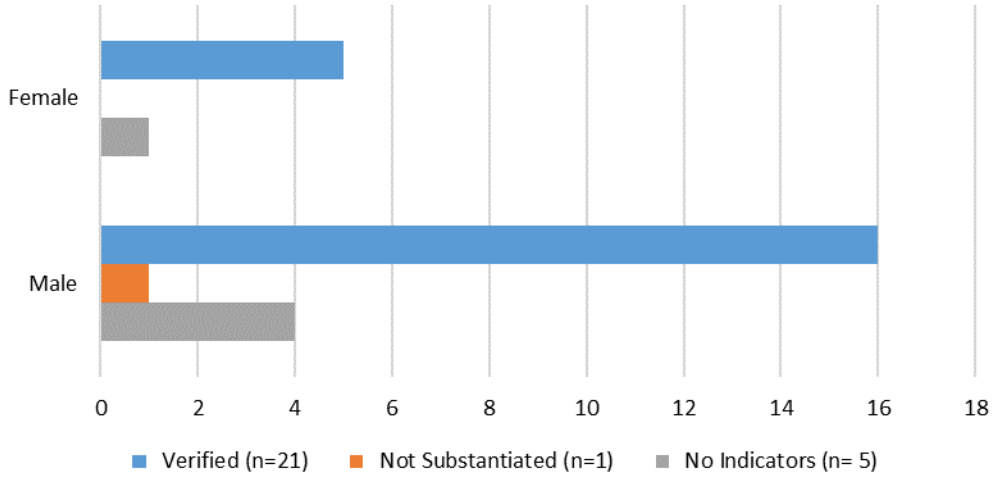


Table F-8: Person Handling Fatal Weapon at Time of Death Incident			
Person Handling Fatal Weapon	Child Maltreatment Death (n=27)		
	Verified (n=21)	Not Substantiated (n=1)	No Indicators (n= 5)
Self/Child	1	1	1
Biological Parent	9	0	0
Adoptive Parent	0	0	0
Stepparent	1	0	0
Foster parent	0	0	0
Mother's Partner	6	0	0
Father's Partner	0	0	0
Grandparent	1	0	0
Friend	2	0	0
Neighbor	1	0	0
Other relative	0	0	0
Other Non-relative	1	0	0
Unknown/Missing	0	0	0

Figure F-3: Person Handling Fatal Weapon at Time of Death (N=27)

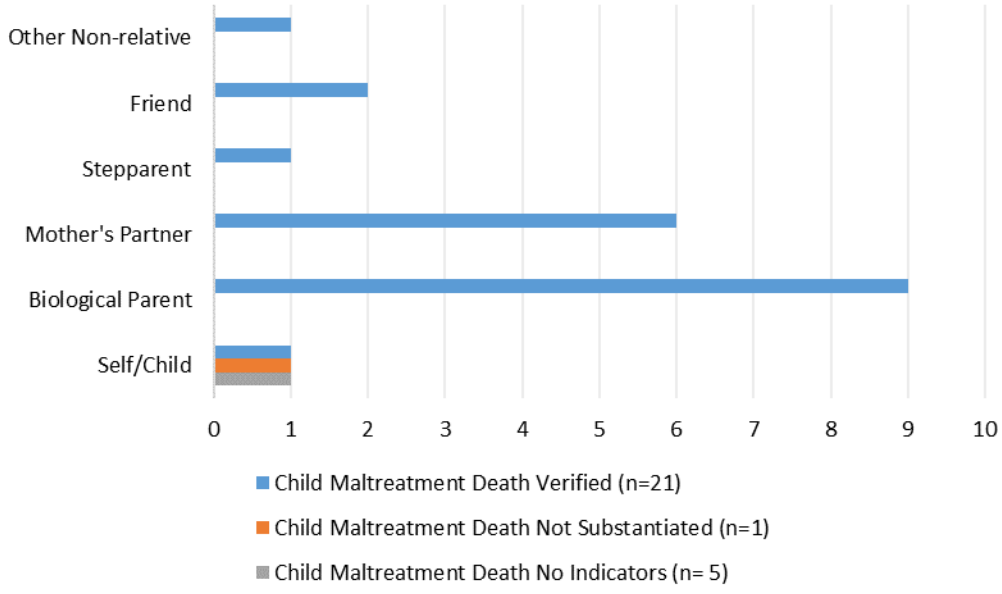
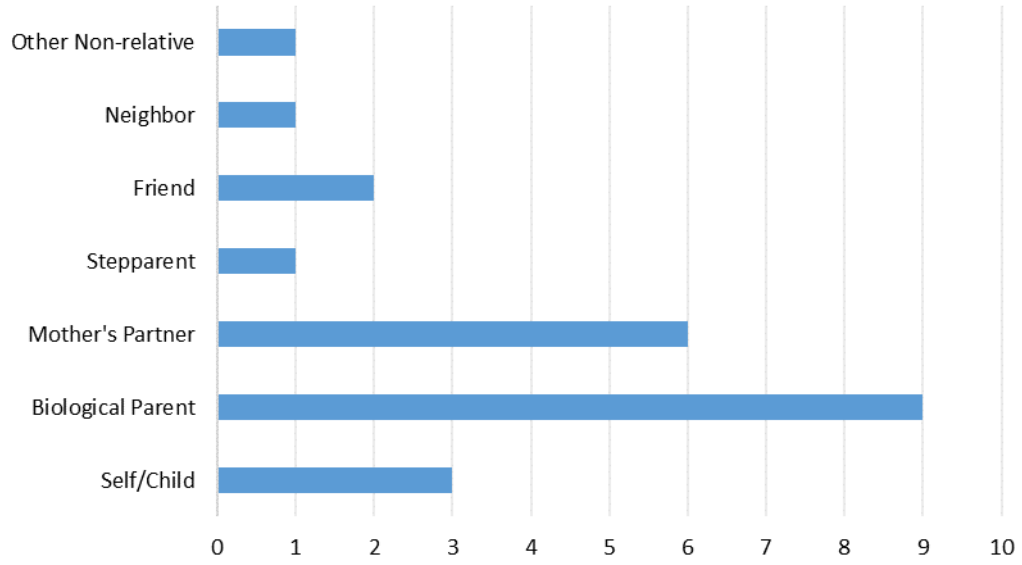


Figure F-4: Person Handling Fatal Weapon at Time of Fatal Death Incident Across All Investigated Cases (N=27)



CHILD CHARACTERISTICS

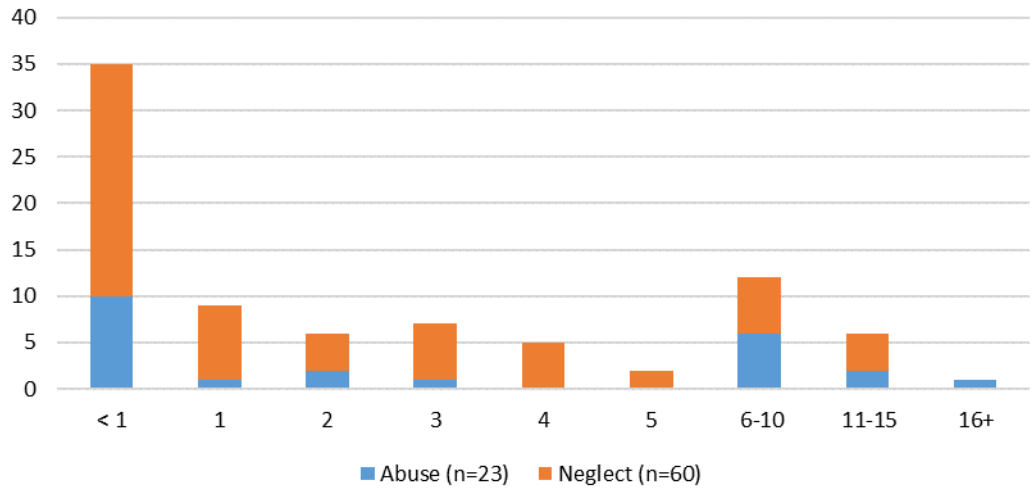
Age of Child

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

Table F-9: Age of Children with Verified Maltreatment by Primary Cause of Death and if Death Classified as Abuse or Neglect								
Age	Verified Child Maltreatment Death n=83							
	Drowning n=20		Sleep-related n=13		Inflicted Trauma n=21		Other Undetermined Unknown n=29	
	Abuse	Neglect	Abuse	Neglect	Abuse	Neglect	Abuse	Neglect
< 1	1	3	1	12	6	0	2	10
1	0	5	0	0	1	0	0	3
2	0	3	0	0	2	0	0	1
3	0	4	0	0	0	0	1	2
4	0	2	0	0	0	1	0	2
5	0	1	0	0	0	0	0	1
6-10	0	1	0	0	6	2	0	3
11-15	0	0	0	0	2	0	0	4
16+	0	0	0	0	1	0	0	0

Table F-10: Age of Children with Verified Maltreatment Death Classified as Abuse or Neglect		
Age	Verified Child Maltreatment Death n=83	
	Abuse n=23	Neglect n=60
< 1	10	25
1	1	8
2	2	4
3	1	6
4	0	5
5	0	2
6-10	6	6
11-15	2	4
16+	1	0

Figure F-5: Verified Maltreatment Deaths
Classified as Abuse or Neglect by Age Group (N=83)



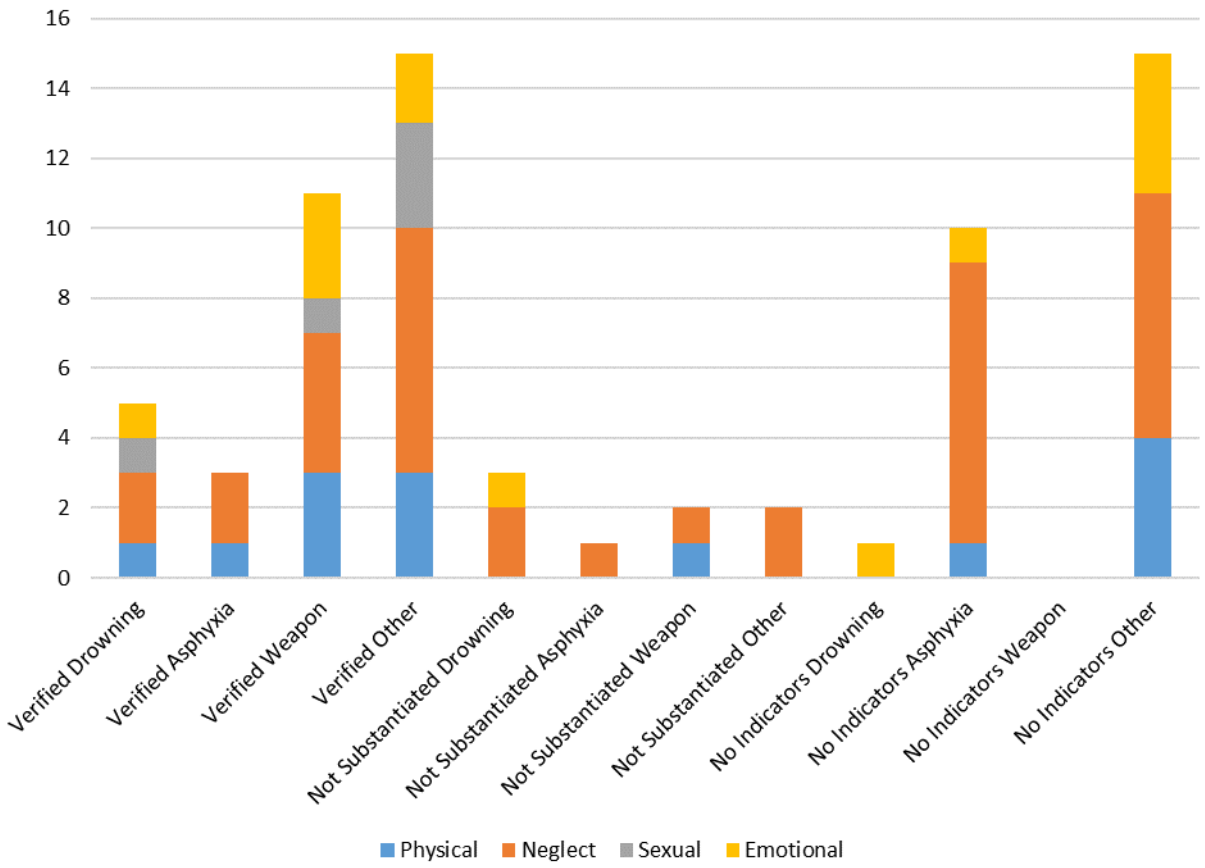
Child's History as Victim of Maltreatment

If known and applicable, the distribution of past maltreatment incidents across maltreatment verification status and primary cause of death are denoted in Table F-11 and Figure 6. Please note that for each child identified as a past victim of maltreatment, there may be multiple past maltreatment incidents and/or multiple forms of maltreatment during a single incident.

Table F-11: Child's History as a Victim of Maltreatment for Child Fatality Cases

Type of Past Maltreatment	Child Maltreatment Death											
	Verified n=83				Not Substantiated n=58				No Indicators n=184			
	Drowning n=20	Sleep-related n=13	Inflicted Trauma n=21	Other Undetermined Unknown n=29	Drowning n=25	Sleep-related n=21	Inflicted Trauma n=1	Other Undetermined Unknown n=11	Drowning n=26	Sleep-related n=97	Inflicted Trauma n=5	Other Undetermined Unknown n=56
Physical	5.0%	7.7%	14.3%	10.3%	0.0%	0.0%	100.0%	0.0%	0.0%	1.0%	0.0%	7.1%
Neglect	10.0%	15.4%	19.0%	24.1%	8.0%	4.8%	100.0%	18.2%	0.0%	8.2%	0.0%	12.5%
Sexual	5.0%	0.0%	4.8%	10.3%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Emotional	5.0%	0.0%	14.3%	6.9%	4.0%	0.0%	0.0%	0.0%	3.8%	1.0%	0.0%	7.1%

Figure F-6: Child's History as Victim of Maltreatment (n=101)



CAREGIVER AND SUPERVISOR CHARACTERISTICS

Table F-12 summarizes the percentage of child fatality cases where one or two caregivers were identified. At least one primary caregiver was identified for all child fatality cases. Among verified maltreatment deaths, between 58.6% (other deaths) and 85.7% (weapon deaths) of the children had a second caregiver present in the home. Most of the not substantiated and no indicators of maltreatment deaths had a second caregiver present in the home.

Table F-12: Percentage of Cases with One and Two Caregivers Identified as Present by Child Maltreatment Verification Status and Primary Cause of Death

Caregiver Present	Child Maltreatment Death											
	Verified n=83				Not Substantiated n=58				No Indicators n=184			
	Drowning n=20	Sleep-related n=13	Inflicted Trauma n=21	Other Undetermined Unknown n=29	Drowning n=25	Sleep-related n=21	Inflicted Trauma n=1	Other Undetermined Unknown n=11	Drowning n=26	Sleep-related n=97	Inflicted Trauma n=5	Other Undetermined Unknown n=56
One	95.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Two	60.0%	46.2%	85.7%	58.6%	80.0%	85.7%	0.0%	72.7%	80.8%	77.3%	100.0%	45.7%

Relationship to Child of Caregivers and Supervisors

Tables F-13 through F-15 and Figure F-7 demonstrate that the most likely caregiver(s) present across all causes of death were the biological parents of the child. Of the 564 caregivers identified for the 325 children, 476 (84.4%) were the child's biological parents, followed by 23 (4.1%) fathers partner.

Among verified child maltreatment deaths, the proportion of aggregate caregivers who are biological parents was 87.5% for drowning deaths, 84.2% for sleep-related deaths, 66.7% for inflicted trauma deaths and 78.6% for other deaths. These proportions are approximately paralleled for not substantiated and no indicators for maltreatment deaths.

Table F-13: Relationship to Child of All Identified Caregivers (Aggregate) by Maltreatment Verification Status and Primary Cause of Death

Caregiver Relationship To Child (All Caregivers)	Child Maltreatment Death											
	Verified n=132				Not Substantiated n=105				No Indicators n=327			
	Drowning n=32	Sleep-related n=19	Inflicted Trauma n=39	Other Undetermined Unknown n=42	Drowning n=45	Sleep-related n=39	Inflicted Trauma n=2	Other Undetermined Unknown n=19	Drowning n=47	Sleep-related n=172	Inflicted Trauma n=10	Other Undetermined Unknown n=98
Biological Parent	87.5%	84.2%	66.7%	78.6%	82.2%	94.9%	50.0%	89.5%	85.1%	89.0%	100.0%	79.6%
Other	12.5%	15.8%	33.3%	21.4%	17.8%	5.1%	50.0%	10.5%	14.9%	11.0%	0.0%	20.4%

Figure F-7: Caregiver (Aggregate) Relationship to Child by Child Maltreatment Verification Status (N=564)

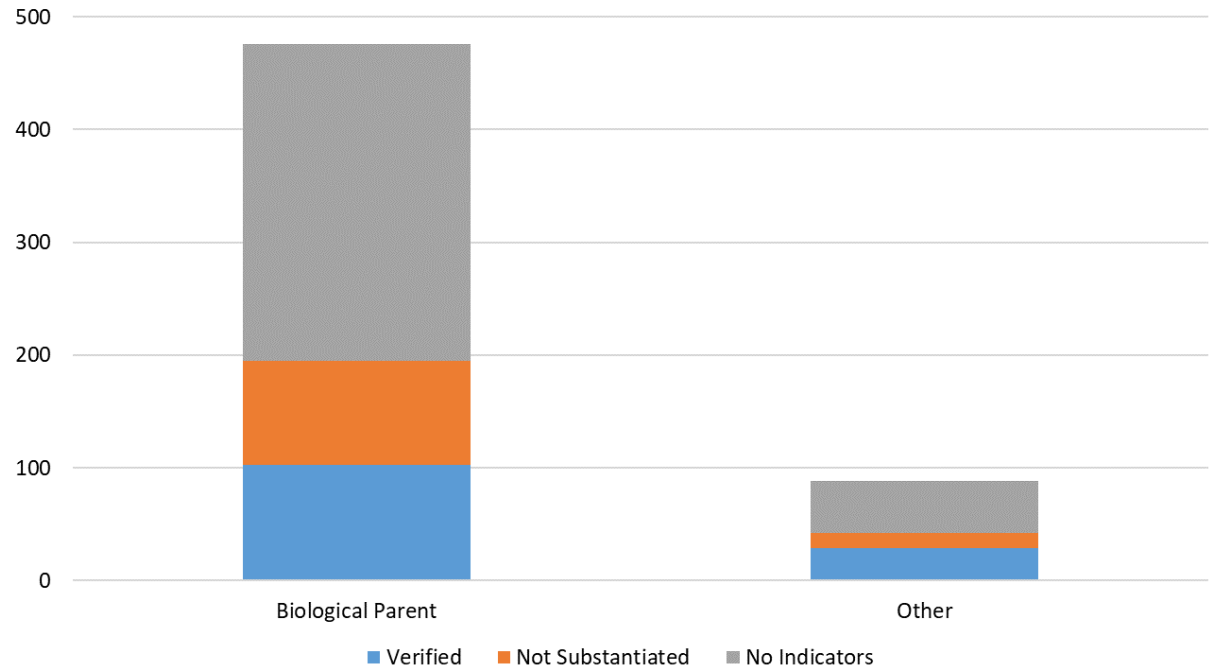


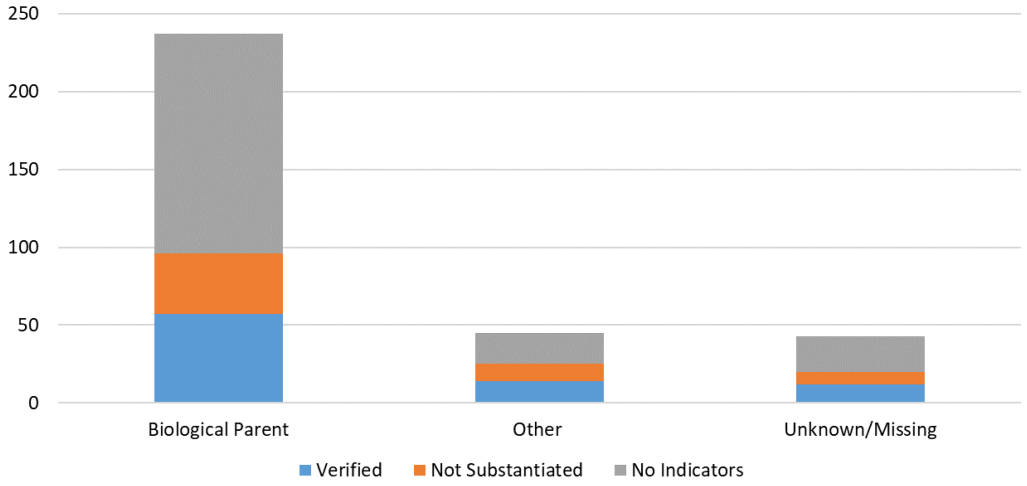
Table F-14: Relationship to Child of Primary (First) Caregiver Identified by Maltreatment Verification Status and Primary Cause of Death												
Caregiver Relationship To Child (Caregiver 1 Only)	Child Maltreatment Death											
	Verified n=83				Not Substantiated n=58				No Indicators n=184			
	Drowning n=20	Sleep-related n=13	Inflicted Trauma n=21	Other Undetermined Unknown n=29	Drowning n=25	Sleep-related n=21	Inflicted Trauma n=1	Other Undetermined Unknown n=11	Drowning n=26	Sleep-related n=97	Inflicted Trauma n=5	Other Undetermined Unknown n=56
Biological Parent	85.0%	92.3%	90.5%	89.7%	84.0%	95.2%	100.0%	100.0%	92.3%	96.9%	100.0%	85.7%
Other	15.0%	7.7%	9.5%	10.3%	16.0%	4.8%	0.0%	0.0%	7.7%	3.1%	0.0%	14.3%

Table F-15: Relationship to Child of Second Caregiver Identified by Maltreatment Verification Status and Primary Cause of Death												
Caregiver Relationship To Child (Caregiver 2 only)	Child Maltreatment Death											
	Verified n=49				Not Substantiated n=47				No Indicators n=143			
	Drowning n=12	Sleep-related n=6	Inflicted Trauma n=18	Other Undetermined Unknown n=13	Drowning n=20	Sleep-related n=18	Inflicted Trauma n=1	Other Undetermined Unknown n=8	Drowning n=21	Sleep-related n=75	Inflicted Trauma n=5	Other Undetermined Unknown n=42
Biological Parent	91.7%	66.7%	38.9%	53.8%	80.0%	94.4%	0.0%	75.0%	76.2%	78.7%	100.0%	71.4%
Other	8.3%	33.3%	61.1%	46.2%	20.0%	5.6%	100.0%	25.0%	23.8%	21.3%	0.0%	28.6%

Table F-16 and Figure F-8 focus on the relationship of the supervisor of the child at the time of the incident leading to the child's death. Here, some parallels exist with data associated with caregivers (see Table F-13). Among verified maltreatment deaths, the percentage of supervisors (across primary causes of death) who were biological parents ranges from 58.6% (for other deaths) to 76.9% (for sleep-related deaths); a large majority for each cause of death. Among verified maltreatment weapon deaths, 9.5% of the supervisors were the grandparent. Among verified maltreatment drownings, 70.0% were the child's biological parent, 10.0% grandparent and another 5.0% being unknown.

Table F-16: Relationship to Child of Supervisor by Maltreatment Verification Status and Primary Cause of Death												
Supervisor Relationship to Child	Child Maltreatment Death											
	Verified n=83				Not Substantiated n=58				No Indicators n=184			
	Drowning n=20	Sleep-related n=13	Inflicted Trauma n=21	Other Undetermined Unknown n=29	Drowning n=25	Sleep-related n=21	Inflicted Trauma n=1	Other Undetermined Unknown n=11	Drowning n=26	Sleep-related n=97	Inflicted Trauma n=5	Other Undetermined Unknown n=56
Biological Parent	70.0%	76.9%	76.2%	58.6%	72.0%	76.2%	0.0%	45.5%	73.1%	85.6%	0.0%	69.6%
Other	20.0%	23.1%	23.8%	6.9%	24.0%	14.3%	0.0%	18.2%	15.4%	5.2%	0.0%	19.6%
Unknown/Missing	10.0%	0.0%	0.0%	34.5%	4.0%	9.5%	100.0%	36.4%	11.5%	9.3%	100.0%	10.7%

Figure F-8: Supervisor Relationship to Child by Maltreatment Verification Status (N=325)



Average Age of Caregivers and Supervisors

Table F-17 provides the average ages of caregivers and supervisors.

Table F-17: Average Ages of Caregivers & Supervisors for Child Fatality by Child Maltreatment Verification Status												
Average Age (years)	Verified n=83				Not Substantiated n=58				No Indicators n=184			
	Drowning n=20	Sleep-related n=13	Inflicted Trauma n=21	Other Undetermined Unknown n=29	Drowning n=25	Sleep-related n=21	Inflicted Trauma n=1	Other Undetermined Unknown n=11	Drowning n=26	Sleep-related n=97	Inflicted Trauma n=5	Other Undetermined Unknown n=56
Caregiver1	32.0	29.0	33.0	30.0	32.0	25.0	33.0	27.0	33.0	26.0	42.0	29.0
Caregiver2	30.0	37.0	36.0	34.0	33.0	26.0	26.0	32.0	38.0	33.0	49.0	36.0
All Caregivers	31.0	33.0	34.5	32.0	32.5	25.5	29.5	29.5	35.5	29.5	45.5	32.5
Supervisors	30.0	30.0	32.0	30.0	32.0	28.0	0.0	38.0	32.0	26.0	0.0	31.0

Gender of Caregivers and Supervisors

Observation of information summarized in Table F-18 reveals that most caregivers for children (across all primary cause of death categories) were female. Among verified maltreatment deaths, between 50.0% (for other deaths) and 50.0% (for drowning deaths) of caregivers were female. Among supervisors of verified child maltreatment deaths, 70.0% of drowning cases, 61.9.0% of weapon cases and 76.9.0% sleep-related cases were females (Table G-19).

Table F-18: Gender of All Identified Caregivers (Aggregate) by Maltreatment Verification Status and Primary Cause of Death												
Caregiver Gender	Child Maltreatment Death											
	Verified n=166				Not Substantiated n=116				No Indicators n=368			
	Drowning n=40	Sleep-related n=26	Inflicted Trauma n=42	Other Undetermined Unknown n=58	Drowning n=50	Sleep-related n=42	Inflicted Trauma n=2	Other Undetermined Unknown n=22	Drowning n=52	Sleep-related n=194	Inflicted Trauma n=10	Other Undetermined Unknown n=112
Male	27.5%	19.2%	40.5%	22.4%	40.0%	40.5%	50.0%	31.8%	38.5%	35.1%	50.0%	34.8%
Female	50.0%	53.8%	52.4%	50.0%	50.0%	52.4%	50.0%	54.5%	51.9%	53.6%	50.0%	52.7%
Unknown/Missing	22.5%	26.9%	7.1%	27.6%	10.0%	7.1%	0.0%	13.6%	9.6%	11.3%	0.0%	12.5%

Table F-19: Gender of Supervisors by Maltreatment Verification Status and Primary Cause of Death												
Supervisor Gender	Child Maltreatment Death											
	Verified n=83				Not Substantiated n=58				No Indicators n=184			
	Drowning n=20	Sleep-related n=13	Inflicted Trauma n=21	Other Undetermined Unknown n=29	Drowning n=25	Sleep-related n=21	Inflicted Trauma n=1	Other Undetermined Unknown n=11	Drowning n=26	Sleep-related n=97	Inflicted Trauma n=5	Other Undetermined Unknown n=56
Male	20.0%	23.1%	38.1%	17.2%	24.0%	33.3%	0.0%	9.1%	34.6%	24.7%	0.0%	16.1%
Female	70.0%	76.9%	61.9%	48.3%	72.0%	57.1%	0.0%	54.5%	53.8%	66.0%	0.0%	71.4%
Unknown/Missing	10.0%	0.0%	0.0%	34.5%	4.0%	9.5%	100.0%	36.4%	11.5%	9.3%	100.0%	12.5%

Substance Abuse History of Caregivers and Supervisors

Tables F-20 through F-21 (with accompanying Figures F-9 through F-12) summarize information related to substance abuse history of all caregivers, supervisors and person(s) responsible. Findings from Table F-20 reveal that among the caregivers of children whose deaths were verified as child maltreatment, 56 of 166 (33.7%) are known to have a substance abuse history. This rate mirrors the percentage of caregivers with a substance abuse history among not substantiated maltreatment deaths (37 of 116 or 31.9%); both of which are larger than the 26.9% of caregivers associated with no indicators of maltreatment deaths (99 of 368). However, the significance of the difference is not statistically greater. [1]

[1] A series of tests of significance between two independent proportions (Z-Scores) were done to determine if the observed total proportion of caregivers with a substance abuse history for verified, not substantiated, and no indicators for maltreatment cases differed significantly (at $p<.05$, two-tailed test). The observed proportion differences between verified and no indicators (Z-Score=1.6101, $p>.05$) and not substantiated and no indicators for maltreatment (Z-Score=1.0435, $p>.05$) deaths were not statistically significant.

Table F-20: Substance Abuse History of All Identified Caregivers of Children by Maltreatment Verification Status and Primary Cause of Death												
Substance Abuse History	Child Maltreatment Death											
	Verified n=166				Not Substantiated n=116				No Indicators n=368			
	Drowning n=40	Sleep-related n=26	Inflicted Trauma n=42	Other Undetermined Unknown n=58	Drowning n=50	Sleep-related n=42	Inflicted Trauma n=2	Other Undetermined Unknown n=22	Drowning n=52	Sleep-related n=194	Inflicted Trauma n=10	Other Undetermined Unknown n=112
Yes	20.0%	38.5%	42.9%	34.5%	22.0%	40.5%	0.0%	40.9%	13.5%	33.5%	0.0%	24.1%
No	47.5%	15.4%	23.8%	22.4%	62.0%	50.0%	50.0%	45.5%	67.3%	38.1%	80.0%	45.5%
Unknown/Missing	32.5%	46.2%	33.3%	43.1%	16.0%	9.5%	50.0%	13.6%	19.2%	28.4%	20.0%	30.4%
Type of Substance	**If Yes, Verified Child Maltreatment (n= 56)**				**If Yes, Not Substantiated as Child Maltreatment (n=37)**				**If Yes, No Indicators that Child Maltreatment (n=99)**			
	Drowning n=8	Sleep-related n=10	Inflicted Trauma n=18	Other Undetermined Unknown n=20	Drowning n=11	Sleep-related n=17	Inflicted Trauma n=0	Other Undetermined Unknown n=9	Drowning n=7	Sleep-related n=65	Inflicted Trauma n=0	Other Undetermined Unknown n=27
Alcohol	12.5%	20.0%	22.2%	25.0%	9.1%	5.9%	0.0%	11.1%	0.0%	13.8%	0.0%	11.1%
Cocaine	12.5%	20.0%	11.1%	45.0%	0.0%	0.0%	0.0%	33.3%	28.6%	10.8%	0.0%	11.1%
Marijuana	87.5%	90.0%	77.8%	45.0%	63.6%	82.4%	0.0%	88.9%	85.7%	76.9%	0.0%	74.1%
Methamphetamine	0.0%	10.0%	0.0%	35.0%	0.0%	17.6%	0.0%	0.0%	0.0%	4.6%	0.0%	22.2%
Opiates	25.0%	30.0%	16.7%	30.0%	0.0%	11.8%	0.0%	11.1%	0.0%	7.7%	0.0%	14.8%
Prescription	12.5%	20.0%	5.6%	20.0%	0.0%	0.0%	0.0%	11.1%	0.0%	9.2%	0.0%	18.5%
Over-the-Counter Drugs	50.0%	40.0%	33.3%	55.0%	45.5%	35.3%	0.0%	66.7%	57.1%	50.8%	0.0%	51.9%
Other	75.0%	70.0%	44.4%	75.0%	36.4%	52.9%	0.0%	55.6%	57.1%	70.8%	0.0%	59.3%
Unknown/Missing	0.0%	0.0%	0.0%	10.0%	27.3%	0.0%	0.0%	11.1%	0.0%	3.1%	0.0%	7.4%

Figure F-9: Substance Abuse History of All Caregivers by Maltreatment Verification Status (N=650)

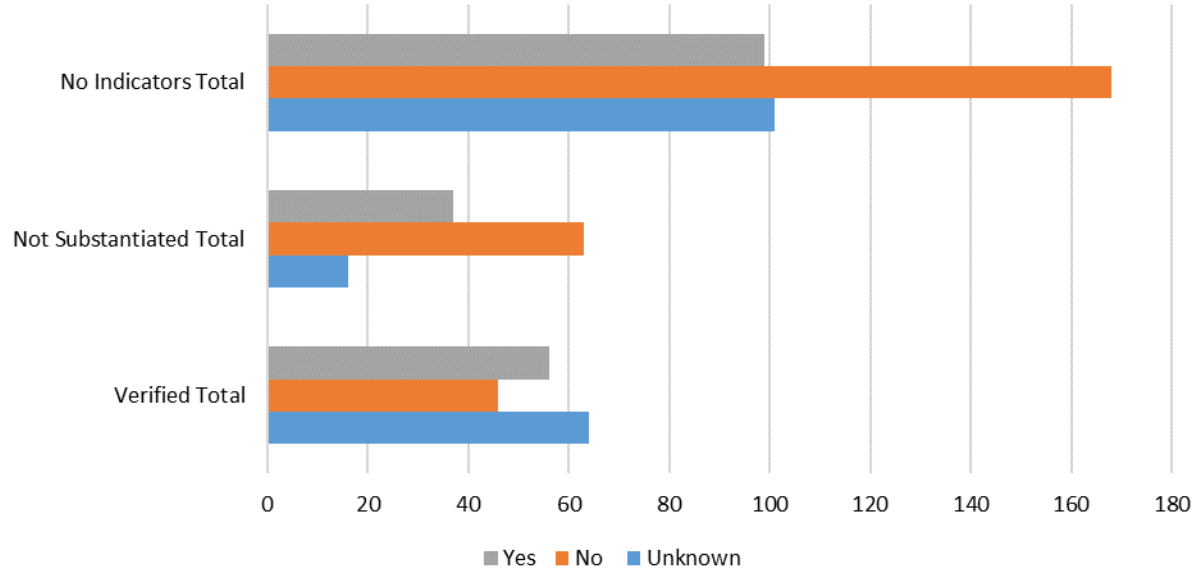
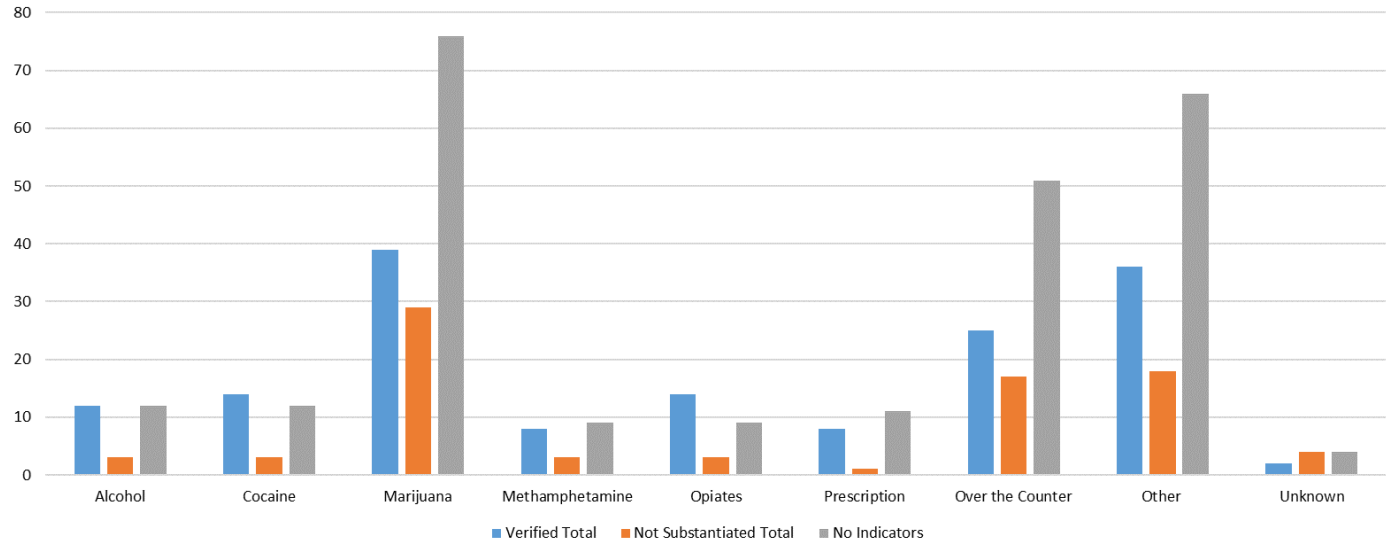


Figure F-10: Type of Substance Used by All Caregivers (with Substance Abuse History) by Maltreatment Verification Status (N=192)



When types of substances are examined (see Table F-20 and Figure F-10) for those with a substance abuse history, most of all caregivers of children whose deaths were verified as maltreatment had a history of marijuana use (from a low of 45.0% for other causes to high of 90.0% for sleep-related deaths). Similarly, high percentages of caregiver use of marijuana are observed for all primary causes of death for not substantiated and no indicators of maltreatment deaths; from a low of 0.0% for not substantiated weapons deaths to a high of 88.9% for not substantiated other deaths. When the substance abuse history of supervisors of children at the time of the child's death is examined (see Table F-21), 32 of 83 (38.6%), 19 of 58 (32.8%) and 59 of 184 (70.2%) of supervisors in verified, not substantiated, and no indicators of maltreatment deaths (respectively) were known to have a substance abuse history.

Table F-21: Substance Abuse History of Supervisors of Children at Time of Death by Maltreatment Verification Status and Primary Cause of Death												
Drug Abuse Supervisor	Child Maltreatment Death											
	Verified n=83				Not Substantiated n=58				No Indicators n=184			
	Drowning n=20	Sleep-related n=13	Inflicted Trauma n=21	Other Undetermined Unknown n=29	Drowning n=25	Sleep-related n=21	Inflicted Trauma n=1	Other Undetermined Unknown n=11	Drowning n=26	Sleep-related n=97	Inflicted Trauma n=5	Other Undetermined Unknown n=56
Yes	30.0%	53.8%	42.9%	34.5%	28.0%	47.6%	0.0%	18.2%	15.4%	41.2%	0.0%	26.8%
No	50.0%	30.8%	23.8%	24.1%	64.0%	38.1%	0.0%	36.4%	65.4%	37.1%	0.0%	48.2%
Unknown/Missing	20.0%	15.4%	33.3%	41.4%	8.0%	14.3%	100.0%	45.5%	19.2%	21.6%	100.0%	25.0%
Type of Substance	**If Yes, Verified Child Maltreatment (n=32)**				**If Yes, Not Substantiated as Child Maltreatment (n=19)**				**If Yes, No Indicators that Child Maltreatment (n=59)**			
	Drowning n=6	Sleep-related n=7	Inflicted Trauma n=9	Other Undetermined Unknown n=10	Drowning n=7	Sleep-related n=10	Inflicted Trauma n=0	Other Undetermined Unknown n=2	Drowning n=4	Sleep-related n=40	Inflicted Trauma n=0	Other Undetermined Unknown n=15
Alcohol	16.7%	28.6%	22.2%	20.0%	0.0%	0.0%	0.0%	50.0%	0.0%	7.5%	0.0%	13.3%
Cocaine	16.7%	14.3%	11.1%	30.0%	0.0%	0.0%	0.0%	0.0%	25.0%	12.5%	0.0%	6.7%
Marijuana	83.3%	85.7%	77.8%	60.0%	71.4%	80.0%	0.0%	100.0%	75.0%	70.0%	0.0%	66.7%
Methamphetamine	0.0%	14.3%	0.0%	40.0%	0.0%	10.0%	0.0%	0.0%	0.0%	5.0%	0.0%	26.7%
Opiates	0.0%	28.6%	11.1%	30.0%	0.0%	10.0%	0.0%	0.0%	0.0%	7.5%	0.0%	13.3%
Prescription	16.7%	28.6%	11.1%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	10.0%	0.0%	13.3%
Over-the-Counter Drugs	83.3%	71.4%	88.9%	70.0%	100.0%	90.0%	0.0%	100.0%	100.0%	80.0%	0.0%	86.7%
Other	100.0%	100.0%	100.0%	90.0%	71.4%	100.0%	0.0%	100.0%	100.0%	95.0%	0.0%	93.3%
Unknown/Missing	0.0%	0.0%	0.0%	0.0%	0.0%	10.0%	0.0%	100.0%	0.0%	2.5%	0.0%	0.0%

When types of substances are examined, most of all supervisors of children whose death was verified as maltreatment used marijuana (from a low of 60.0% for other deaths to high of 85.7% for sleep-related deaths). As with caregivers, similarly high percentages of supervisor use of marijuana are observed for all primary causes of death for not substantiated and no indicators of maltreatment deaths; from a low of 0.0% for not substantiated weapons deaths to a high of 100% for not substantiated other deaths. A note is made of other substances supervisors of verified maltreatment deaths used. Among those supervisors with a substance abuse history, 100.0% of supervisors associated with drowning deaths used other and 16.7% reportedly had substance abuse issues associated with alcohol. 28.6% of supervisors associated with sleep-related deaths had substance abuse issues with cocaine; 11.1% of supervisors associated with weapons deaths had substance abuse issues with cocaine; and, supervisors of other verified deaths (with a substance abuse history) used alcohol (20.0%), cocaine (30.0%), and opiates (30.0%).

Disability or Chronic Illness Occurrence among Caregivers and Supervisors

Tables F-22 through F-23 highlight the distribution of caregivers and supervisors known to have an identified disability or chronic illness. Among all caregivers in deaths verified to have resulted from maltreatment, 22 of 166 (13.3%) were known to have an identified disability or chronic illness of which the predominant disability was associated with mental illness. Caregivers identified with mental illness ranged from a low of 2 of 9 (22.2%) associated with verified weapon deaths to a high of 100.0% of caregivers associated with sleep-related (1 of 1). The percentage of caregivers of verified maltreatment deaths with an identified disability or chronic illness mirrors the observed rate of caregivers among not substantiated maltreatment deaths (10 of 116 or 8.6%); 11.1% of caregivers associated with no indicators of maltreatment deaths (41 of 368).

Table F-22: Presence of Disability or Chronic Illness for All Caregivers by Maltreatment Verification Status and Primary Cause of Death												
Disability All Caregivers	Child Maltreatment Death											
	Verified n=166				Not Substantiated n=116				No Indicators n=368			
	Drowning n=40	Sleep-related n=26	Inflicted Trauma n=42	Other Undetermined Unknown n=58	Drowning n=50	Sleep-related n=42	Inflicted Trauma n=2	Other Undetermined Unknown n=22	Drowning n=52	Sleep-related n=194	Inflicted Trauma n=10	Other Undetermined Unknown n=112
Yes	10.0%	3.8%	21.4%	13.8%	6.0%	11.9%	0.0%	9.1%	17.3%	11.9%	20.0%	6.3%
No	57.5%	46.2%	50.0%	41.4%	78.0%	69.0%	100.0%	54.5%	67.3%	63.9%	20.0%	63.4%
Unknown/Missing	32.5%	50.0%	28.6%	44.8%	16.0%	19.0%	0.0%	36.4%	15.4%	24.2%	60.0%	30.4%
Type of Disability	**If Yes, Verified Child Maltreatment (n=22)**				**If Yes, Not Substantiated as Child Maltreatment (n=10)**				**If Yes, No Indicators that Child Maltreatment (n=41)**			
	Drowning n=4	Sleep-related n=1	Inflicted Trauma n=9	Other Undetermined Unknown n=8	Drowning n=3	Sleep-related n=5	Inflicted Trauma n=0	Other Undetermined Unknown n=2	Drowning n=9	Sleep-related n=23	Inflicted Trauma n=2	Other Undetermined Unknown n=7
Physical	50.0%	0.0%	77.8%	25.0%	66.7%	20.0%	0.0%	0.0%	44.4%	30.4%	0.0%	71.4%
Mental	50.0%	100.0%	22.2%	87.5%	33.3%	40.0%	0.0%	100.0%	88.9%	65.2%	100.0%	28.6%
Sensory	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Unknown/Missing	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%

When findings from Table F-23 are examined, 15 of 83 (18.1%) supervisors of children whose death was verified to result from maltreatment were identified as having a disability or chronic illness. This rate was like that observed with supervisors of not substantiated maltreatment deaths (7 of 58 or 12.1%) and no indicators 28 of 184 (15.2%) of supervisors whose child related deaths showed no indicators of maltreatment.

Table F-23: Presence of Disability or Chronic Illness for Supervisors by Maltreatment Verification Status and Primary Cause of Death												
Disability or Chronic Illness	Child Maltreatment Death											
	Verified n=83				Not Substantiated n=58				No Indicators n=184			
	Drowning n=20	Sleep-related n=13	Inflicted Trauma n=21	Other Undetermined Unknown n=29	Drowning n=25	Sleep-related n=21	Inflicted Trauma n=1	Other Undetermined Unknown n=11	Drowning n=26	Sleep-related n=97	Inflicted Trauma n=5	Other Undetermined Unknown n=56
Yes	15.0%	15.4%	19.0%	20.7%	12.0%	14.3%	0.0%	9.1%	23.1%	16.5%	0.0%	10.7%
No	65.0%	61.5%	61.9%	41.4%	84.0%	61.9%	0.0%	45.5%	61.5%	63.9%	0.0%	67.9%
Unknown/Missing	20.0%	23.1%	19.0%	37.9%	4.0%	23.8%	100.0%	45.5%	15.4%	19.6%	100.0%	21.4%
Type of Disability	**If Yes, Verified Child Maltreatment (n=15)**				**If Yes, Not Substantiated as Child Maltreatment (n=7)**				**If Yes, No Indicators that Child Maltreatment (n=28)**			
	Drowning n=3	Sleep-related n=2	Inflicted Trauma n=4	Other Undetermined Unknown n=6	Drowning n=3	Sleep-related n=3	Inflicted Trauma n=0	Other Undetermined Unknown n=1	Drowning n=6	Sleep-related n=16	Inflicted Trauma n=0	Other Undetermined Unknown n=6
Physical	66.7%	0.0%	75.0%	16.7%	66.7%	33.3%	0.0%	0.0%	50.0%	18.8%	0.0%	66.7%
Mental	33.3%	50.0%	25.0%	100.0%	33.3%	66.7%	0.0%	100.0%	83.3%	81.3%	0.0%	16.7%
Sensory	0.0%	50.0%	0.0%	0.0%	0.0%	33.3%	0.0%	0.0%	0.0%	6.3%	0.0%	16.7%
Unknown/Missing	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%

Employment Status of Caregivers

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

Table F-24: Employment Status of All Identified Caregivers by Maltreatment Verification Status and Primary Cause of Death

Employment All Caregivers	Child Maltreatment Death											
	Verified n=166				Not Substantiated n=116				No Indicators n=368			
	Drowning n=40	Sleep-related n=26	Inflicted Trauma n=42	Other Undetermined Unknown n=58	Drowning n=50	Sleep-related n=42	Inflicted Trauma n=2	Other Undetermined Unknown n=22	Drowning n=52	Sleep-related n=194	Inflicted Trauma n=10	Other Undetermined Unknown n=112
Employed	57.5%	42.3%	47.6%	32.8%	54.0%	50.0%	50.0%	50.0%	57.7%	44.3%	70.0%	43.8%
Unemployed	7.5%	19.2%	21.4%	24.1%	2.0%	21.4%	50.0%	27.3%	3.8%	21.1%	0.0%	17.0%
On Disability	0.0%	0.0%	2.4%	1.7%	0.0%	4.8%	0.0%	0.0%	0.0%	1.5%	0.0%	0.9%
Stay-at-Home Caregiver	7.5%	0.0%	2.4%	3.4%	16.0%	4.8%	0.0%	4.5%	15.4%	9.8%	10.0%	11.6%
Retired	0.0%	0.0%	0.0%	0.0%	2.0%	0.0%	0.0%	0.0%	0.0%	0.5%	0.0%	0.0%
Unknown/Missing	27.5%	38.5%	26.2%	37.9%	26.0%	19.0%	0.0%	18.2%	23.1%	22.7%	20.0%	26.8%

Table F-25: Employment Status of Primary (First) Caregiver Identified by Maltreatment Verification Status and Primary Cause of Death

Employment (Caregiver 1)	Child Maltreatment Death											
	Verified n=83				Not Substantiated n=58				No Indicators n=184			
	Drowning n=20	Sleep-related n=13	Inflicted Trauma n=21	Other Undetermined Unknown n=29	Drowning n=25	Sleep-related n=21	Inflicted Trauma n=1	Other Undetermined Unknown n=11	Drowning n=26	Sleep-related n=97	Inflicted Trauma n=5	Other Undetermined Unknown n=56
Employed	70.0%	53.8%	42.9%	37.9%	36.0%	52.4%	100.0%	27.3%	50.0%	42.3%	60.0%	44.6%
Unemployed	10.0%	38.5%	19.0%	44.8%	4.0%	23.8%	0.0%	54.5%	7.7%	30.9%	0.0%	21.4%
On Disability	0.0%	0.0%	4.8%	0.0%	0.0%	4.8%	0.0%	0.0%	0.0%	1.0%	0.0%	0.0%
Stay-at-Home Caregiver	10.0%	0.0%	4.8%	6.9%	32.0%	9.5%	0.0%	9.1%	19.2%	18.6%	20.0%	19.6%
Retired	0.0%	0.0%	0.0%	0.0%	4.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Unknown/Missing	10.0%	7.7%	28.6%	10.3%	24.0%	9.5%	0.0%	9.1%	23.1%	7.2%	20.0%	14.3%

Table F-26: Employment Status of Second Caregiver Identified by Maltreatment Verification Status and Primary Cause of Death

Employment (Caregiver2)	Child Maltreatment Death											
	Verified n=83				Not Substantiated n=58				No Indicators n=184			
	Drowning n=20	Sleep-related n=13	Inflicted Trauma n=21	Other Undetermined Unknown n=29	Drowning n=25	Sleep-related n=21	Inflicted Trauma n=1	Other Undetermined Unknown n=11	Drowning n=26	Sleep-related n=97	Inflicted Trauma n=5	Other Undetermined Unknown n=56
Employed	45.0%	30.8%	52.4%	27.6%	72.0%	47.6%	0.0%	72.7%	65.4%	46.4%	80.0%	42.9%
Unemployed	5.0%	0.0%	23.8%	3.4%	0.0%	19.0%	100.0%	0.0%	0.0%	11.3%	0.0%	12.5%
On Disability	0.0%	0.0%	0.0%	3.4%	0.0%	4.8%	0.0%	0.0%	0.0%	2.1%	0.0%	1.8%
Stay-at-Home Caregiver	5.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	11.5%	1.0%	0.0%	3.6%
Retired	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	1.0%	0.0%	0.0%
Unknown/Missing	45.0%	69.2%	23.8%	65.5%	28.0%	28.6%	0.0%	27.3%	23.1%	38.1%	20.0%	39.3%

Education Level of Caregivers

Information on the education level of the caregivers was either unknown or not available for many, if not all, of the caregivers across maltreatment verification and primary cause of death categories (Table F-27). Where caregiver education level was documented, high school or less than high school education was the most frequently reported. Given these findings, it is suggested that continued efforts be made in future reviews to explore data sources that can provide this information so that more representative conclusions can be made.

Table F-27: Education Level of All Identified Caregivers by Maltreatment Verification Status and Primary Cause of Death

Education - All Caregivers	Child Maltreatment Death											
	Verified n=166				Not Substantiated n=116				No Indicators n=368			
	Drowning n=40	Sleep-related n=26	Inflicted Trauma n=42	Other Undetermined Unknown n=58	Drowning n=50	Sleep-related n=42	Inflicted Trauma n=2	Other Undetermined Unknown n=22	Drowning n=52	Sleep-related n=194	Inflicted Trauma n=10	Other Undetermined Unknown n=112
Less than High School	7.5%	11.5%	4.8%	19.0%	6.0%	26.2%	0.0%	4.5%	7.7%	11.9%	0.0%	9.8%
High School	27.5%	34.6%	38.1%	12.1%	30.0%	31.0%	100.0%	50.0%	28.8%	37.6%	0.0%	28.6%
College	17.5%	11.5%	4.8%	6.9%	14.0%	4.8%	0.0%	9.1%	21.2%	8.8%	20.0%	8.9%
Post Graduate	5.0%	0.0%	2.4%	1.7%	2.0%	0.0%	0.0%	0.0%	0.0%	2.1%	0.0%	1.8%
Unknown/Missing	42.5%	42.3%	50.0%	60.3%	48.0%	38.1%	0.0%	36.4%	42.3%	39.7%	80.0%	50.9%

English Spoken by Caregivers and Supervisors

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

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

Can Caregiver Speak English- All Caregivers	Child Maltreatment Death											
	Verified n=166				Not Substantiated n=116				No Indicators n=368			
	Drowning n=40	Sleep-related n=26	Inflicted Trauma n=42	Other Undetermined Unknown n=58	Drowning n=50	Sleep-related n=42	Inflicted Trauma n=2	Other Undetermined Unknown n=22	Drowning n=52	Sleep-related n=194	Inflicted Trauma n=10	Other Undetermined Unknown n=112
Yes	67.5%	73.1%	88.1%	60.3%	84.0%	92.9%	100.0%	86.4%	73.1%	87.6%	80.0%	76.8%
No	2.5%	0.0%	4.8%	6.9%	6.0%	0.0%	0.0%	0.0%	7.7%	1.0%	0.0%	2.7%
Unknown/Missing	30.0%	26.9%	7.1%	32.8%	10.0%	7.1%	0.0%	13.6%	19.2%	11.3%	20.0%	20.5%

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

Can Supervisor Speak English	Child Maltreatment Death											
	Verified n=83				Not Substantiated n=58				No Indicators n=184			
	Drowning n=20	Sleep-related n=13	Inflicted Trauma n=21	Other Undetermined Unknown n=29	Drowning n=25	Sleep-related n=21	Inflicted Trauma n=1	Other Undetermined Unknown n=11	Drowning n=26	Sleep-related n=97	Inflicted Trauma n=5	Other Undetermined Unknown n=56
Yes	80.0%	100.0%	90.5%	51.7%	88.0%	85.7%	0.0%	54.5%	76.9%	89.7%	0.0%	80.4%
No	0.0%	0.0%	4.8%	6.9%	8.0%	0.0%	0.0%	9.1%	7.7%	1.0%	0.0%	1.8%
Unknown/Missing	20.0%	0.0%	4.8%	41.4%	4.0%	14.3%	100.0%	36.4%	15.4%	9.3%	100.0%	17.9%

Caregiver Receipt of Social Services in the Past Twelve Months

Local committees were asked to identify from available sources of information the extent to which caregivers had received social services in the twelve months prior to the child's death. Examination of this information is not meant to stigmatize anyone receiving social services. Rather, it can be a potential indicator of environmental stressors and may help identify possible venues for outreach involving future prevention initiatives. Table F-30 summarizes information related to social services received among all caregivers (aggregate) identified and reported on for this data element. Please note (as with all measures of combined/aggregate caregivers) that the number of caregivers denoted in Table F-30 exceeds the number of child fatalities as many children had two identified caregivers. Table F-30 first identifies the number of caregivers (associated with verified maltreatment deaths and non-verified) that received social services and then further identifies the specific type of support services received. Please note that with respect to the type of support received, the column percentages (which relate to the total caregivers associated with each primary cause of death) may exceed 100% as caregivers may receive more than one type of service/support over the course of twelve months.

It is important to note that there were several caregivers across each primary cause of death for which receipt status of social services could not be identified (see first listed "unknown" row category in Table F-30). Regardless, findings from Table F-30 reveal that among the caregivers of children whose death was verified as child maltreatment, 28 of 166 (16.9%) are known to have received some form of social service support in the twelve months prior to the child's death. This rate was not significantly higher than the 22 of 116 (19.0%) of caregivers of children whose death was not substantiated and the 109 of 368 (29.6%) whose death showed no indicators of child maltreatment.

Table F-30: Receipt of Social Services by All Identified Caregivers of Children by Maltreatment Verification Status and Primary Cause of Death

Receipt of Social Services	Child Maltreatment Death											
	Verified n=166				Not Substantiated n=116				No Indicators n=368			
	Drowning n=40	Sleep-related n=26	Inflicted Trauma n=42	Other Undetermined Unknown n=58	Drowning n=50	Sleep-related n=42	Inflicted Trauma n=2	Other Undetermined Unknown n=22	Drowning n=52	Sleep-related n=194	Inflicted Trauma n=10	Other Undetermined Unknown n=112
Yes	12.5%	19.2%	19.0%	17.2%	10.0%	26.2%	0.0%	27.3%	15.4%	34.5%	0.0%	30.4%
No	30.0%	30.8%	16.7%	24.1%	60.0%	21.4%	0.0%	36.4%	28.8%	18.6%	80.0%	18.8%
Unknown	57.5%	50.0%	64.3%	58.6%	30.0%	52.4%	100.0%	36.4%	55.8%	46.9%	20.0%	50.9%
Type of Support	**If Yes, Verified Child Maltreatment (n=28)**				**If Yes, Not Substantiated as Child Maltreatment (n=22)**				**If Yes, No Indicators that Child Maltreatment (n=109)**			
	Drowning n=5	Sleep-related n=5	Inflicted Trauma n=8	Other Undetermined Unknown n=10	Drowning n=50	Sleep-related n=11	Inflicted Trauma n=0	Other Undetermined Unknown n=6	Drowning n=8	Sleep-related n=67	Inflicted Trauma n=0	Other Undetermined Unknown n=34
WIC	40.0%	80.0%	37.5%	20.0%	60.0%	81.8%	0.0%	66.7%	37.5%	59.7%	0.0%	50.0%
TANF	0.0%	0.0%	25.0%	10.0%	60.0%	9.1%	0.0%	16.7%	25.0%	20.9%	0.0%	17.6%
Medicaid	60.0%	60.0%	62.5%	90.0%	40.0%	90.9%	0.0%	50.0%	50.0%	83.6%	0.0%	61.8%
Food Stamps	40.0%	60.0%	62.5%	60.0%	0.0%	45.5%	0.0%	33.3%	62.5%	44.8%	0.0%	52.9%
Other	20.0%	0.0%	25.0%	10.0%	40.0%	9.1%	0.0%	0.0%	37.5%	14.9%	0.0%	17.6%
Unknown	0.0%	0.0%	37.5%	0.0%	0.0%	9.1%	0.0%	0.0%	0.0%	0.0%	0.0%	2.9%

When types of services received are examined across primary cause of the child's death, most caregivers (that received some type of support) of children whose deaths were verified as maltreatment received Medicaid (from a low of 0.0% for inflicted trauma causes to high of 90.0% for other deaths).

History as Victim of Child Maltreatment among Caregivers and Supervisors

Local committees were asked to identify from available sources of information whether caregivers, supervisors responsible for the death of a child were past victims of child maltreatment. Collectively, it was known that 27 of 166 (16.3%) of caregivers (Table F-31) of children of verified maltreatment deaths were past child victims of maltreatment. This figure may underestimate the true proportion of caregivers with a history of maltreatment as a child victim as this status was unknown or missing for 68 of 166 (41.0%) of the total number of caregivers for children where the child's death was verified as maltreatment. The greatest proportion of caregivers (across cause of death categories) for which this history is unknown for those children who died by sleep-related (38.1%).

There were no statistically significant differences in the percentage of caregivers associated with verified (16.3% or 27 of 166), not substantiated 28 of 116 (24.1%) and no indicator 66 of 368 (17.9%) maltreatment deaths in terms of their history as a victim of child maltreatment. When history as a victim of child maltreatment is examined for supervisors (Table F-32) associated with verified maltreatment deaths, it was known that 16 of 83 (19.3%) were past child victims of maltreatment, whereas 14 of 58 (24.1%) and 39 of 184 (21.26%) of supervisors of not substantiated and no indicators of maltreatment deaths had a history as a victim of child maltreatment.

Table F-31: Past History as Victim of Child Maltreatment for All Caregivers by Maltreatment Verification Status and Primary Cause of Death												
Cargiver Past Victim of Child Maltreatment	Child Maltreatment Death											
	Verified n=166				Not Substantiated n=116				No Indicators n=368			
	Drowning n=40	Sleep-related n=26	Inflicted Trauma n=42	Other Undetermined Unknown n=58	Drowning n=50	Sleep-related n=42	Inflicted Trauma n=2	Other Undetermined Unknown n=22	Drowning n=52	Sleep-related n=194	Inflicted Trauma n=10	Other Undetermined Unknown n=112
Yes	17.5%	11.5%	16.7%	17.2%	8.0%	38.1%	0.0%	36.4%	7.7%	21.6%	10.0%	17.0%
No	42.5%	46.2%	54.8%	32.8%	62.0%	52.4%	50.0%	45.5%	55.8%	37.1%	40.0%	39.3%
Unknown/Missing	40.0%	42.3%	28.6%	50.0%	30.0%	9.5%	50.0%	18.2%	36.5%	41.2%	50.0%	43.8%
Type of Maltreatment	**If Yes, Verified Child Maltreatment (n=27)**				**If Yes, Not Substantiated as Child Maltreatment (n=28)**				**If Yes, No Indicators that Child Maltreatment (n=66)**			
	Drowning n=7	Sleep-related n=3	Inflicted Trauma n=7	Other Undetermined Unknown n=10	Drowning n=4	Sleep-related n=16	Inflicted Trauma n=0	Other Undetermined Unknown n=8	Drowning n=4	Sleep-related n=42	Inflicted Trauma n=1	Other Undetermined Unknown n=19
Physical	42.9%	33.3%	28.6%	60.0%	50.0%	43.8%	0.0%	12.5%	25.0%	45.2%	0.0%	15.8%
Neglect	57.1%	100.0%	57.1%	70.0%	100.0%	93.8%	0.0%	62.5%	0.0%	50.0%	0.0%	52.6%
Sexual	14.3%	0.0%	28.6%	30.0%	25.0%	25.0%	0.0%	25.0%	0.0%	14.3%	0.0%	31.6%
Emotional/ Psychological	0.0%	0.0%	28.6%	40.0%	0.0%	6.3%	0.0%	12.5%	25.0%	14.3%	100.0%	5.3%
Unknown/Missing	0.0%	0.0%	14.3%	0.0%	0.0%	0.0%	0.0%	12.5%	25.0%	7.1%	0.0%	21.1%

Table F-32: Past History as Victim of Child Maltreatment for Supervisors by Maltreatment Verification Status and Primary Cause of Death												
Cargiver Past Victim of Child Maltreatment	Child Maltreatment Death											
	Verified n=83				Not Substantiated n=58				No Indicators n=184			
	Drowning n=20	Sleep-related n=13	Inflicted Trauma n=21	Other Undetermined Unknown n=29	Drowning n=25	Sleep-related n=21	Inflicted Trauma n=1	Other Undetermined Unknown n=11	Drowning n=26	Sleep-related n=97	Inflicted Trauma n=5	Other Undetermined Unknown n=56
Yes	25.0%	23.1%	14.3%	17.2%	16.0%	42.9%	0.0%	9.1%	11.5%	26.8%	0.0%	17.9%
No	45.0%	53.8%	61.9%	31.0%	64.0%	42.9%	0.0%	45.5%	50.0%	40.2%	0.0%	44.6%
Unknown/Missing	30.0%	23.1%	23.8%	51.7%	20.0%	14.3%	100.0%	45.5%	38.5%	33.0%	100.0%	37.5%
Type of Maltreatment	**If Yes, Verified Child Maltreatment (n=16)**				**If Yes, Not Substantiated as Child Maltreatment (n=14)**				**If Yes, No Indicators that Child Maltreatment (n=39)**			
	Drowning n=5	Sleep-related n=3	Inflicted Trauma n=3	Other Undetermined Unknown n=5	Drowning n=4	Sleep-related n=9	Inflicted Trauma n=0	Other Undetermined Unknown n=1	Drowning n=3	Sleep-related n=26	Inflicted Trauma n=0	Other Undetermined Unknown n=10
Physical	40.0%	66.7%	33.3%	80.0%	25.0%	55.6%	0.0%	0.0%	33.3%	50.0%	0.0%	10.0%
Neglect	60.0%	66.7%	33.3%	40.0%	100.0%	88.9%	0.0%	0.0%	0.0%	57.7%	0.0%	60.0%
Sexual	20.0%	0.0%	33.3%	40.0%	25.0%	44.4%	0.0%	100.0%	0.0%	7.7%	0.0%	20.0%
Emotional/ Psychological	0.0%	0.0%	0.0%	40.0%	0.0%	11.1%	0.0%	0.0%	33.3%	15.4%	0.0%	0.0%
Unknown/Missing	0.0%	0.0%	0.0%	20.0%	0.0%	0.0%	0.0%	0.0%	33.3%	3.8%	0.0%	20.0%

History as Perpetrator of Child Maltreatment among Caregivers and Supervisors

Local committees were asked to identify from available sources and reports whether caregivers, supervisors, and person(s) responsible for a child's death have a history as a perpetrator of child maltreatment. When the aggregate of caregivers is examined (Table F-33), 46 of 166 (27.7%) of caregivers of children whose death was verified to result from child maltreatment were identified as past perpetrators of child maltreatment. This rate is not significantly higher than the 19 of 116 (16.4%) of caregivers of not substantiated child maltreatment deaths with a perpetrator past. However, the percentage of caregivers of no indicator child maltreatment deaths with a perpetrator past (76 of 368 or 20.7%) is not significantly lower than the rates observed with the other two maltreatment verification categories.[2]

Among identified verified maltreatment cases, the type of maltreatment the perpetrator inflicted on children in the past was most likely to be neglect, from a low of 54.5% of caregivers associated with inflicted trauma deaths to a high of 100.0% of caregivers associated with drowning deaths. Neglect was the most prevalent form of maltreatment observed among those caregivers with a perpetrator history associated with not substantiated and no indicator of maltreatment deaths.

[2] A series of tests of significance between independent proportions (Z-Scores) were done to determine if the observed total proportion of caregivers with a history as a perpetrator for verified, not substantiated, and no indicators for maltreatment cases differed significantly (at $p<.05$, two-tailed test). The observed proportion differences between verified and no indicators (Z-Score=1.7982, $p>.05$) was not statistically significant.

Table F-33: Past History as Perpetrator of Child Maltreatment for All Caregivers by Maltreatment Verification Status and Primary Cause of Death												
Caregiver Has History as Perpetrator	Child Maltreatment Death											
	Verified n=166				Not Substantiated n=116				No Indicators n=368			
	Drowning n=40	Sleep-related n=26	Inflicted Trauma n=42	Other Undetermined Unknown n=58	Drowning n=50	Sleep-related n=42	Inflicted Trauma n=2	Other Undetermined Unknown n=22	Drowning n=52	Sleep-related n=194	Inflicted Trauma n=10	Other Undetermined Unknown n=112
Yes	10.0%	23.1%	33.3%	37.9%	10.0%	16.7%	0.0%	31.8%	11.5%	24.2%	20.0%	18.8%
No	55.0%	38.5%	40.5%	29.3%	74.0%	73.8%	100.0%	50.0%	71.2%	51.0%	60.0%	52.7%
Unknown/Missing	35.0%	38.5%	26.2%	32.8%	16.0%	9.5%	0.0%	18.2%	17.3%	24.7%	20.0%	28.6%
Type of Maltreatment	**If Yes, Verified Child Maltreatment (n=46)**				**If Yes, Not Substantiated as Child Maltreatment (n=19)**				**If Yes, No Indicators that Child Maltreatment (n=76)**			
	Drowning n=4	Sleep-related n=6	Inflicted Trauma n=14	Other Undetermined Unknown n=22	Drowning n=5	Sleep-related n=7	Inflicted Trauma n=0	Other Undetermined Unknown n=7	Drowning n=6	Sleep-related n=47	Inflicted Trauma n=2	Other Undetermined Unknown n=21
Physical	25.0%	33.3%	50.0%	45.5%	40.0%	28.6%	0.0%	28.6%	33.3%	44.7%	100.0%	42.9%
Neglect	100.0%	83.3%	71.4%	54.5%	80.0%	85.7%	0.0%	100.0%	33.3%	59.6%	0.0%	66.7%
Sexual	25.0%	0.0%	0.0%	13.6%	0.0%	0.0%	0.0%	0.0%	16.7%	12.8%	0.0%	0.0%
Emotional/ Psychological	25.0%	0.0%	57.1%	13.6%	20.0%	0.0%	0.0%	14.3%	50.0%	19.1%	0.0%	14.3%
Unknown/Missing	0.0%	0.0%	0.0%	4.5%	0.0%	0.0%	0.0%	0.0%	0.0%	4.3%	0.0%	4.8%

When the history of supervisors as a perpetrator is examined (see Table F-34), 21 of 83 (25.3%) of supervisors of children whose death was verified to result from child maltreatment were identified as past perpetrators of child maltreatment (with neglect being most prominent). This observed rate is not significantly higher than the 7 of 58 (12.1%) of supervisors of not substantiated child maltreatment deaths with a perpetrator past. However, the percentage of supervisors of no indicator child maltreatment deaths with a perpetrator past (39 of 184 or 21.2%) is not significantly lower than the rates observed with the other two maltreatment verification categories.[3]

[3] A series of tests of significance between independent proportions (Z-Scores) were done to determine if the observed total proportion of supervisors with a history as a perpetrator for verified, not substantiated, and no indicators for maltreatment cases differed significantly (at $p<.05$, two-tailed test). The observed proportion differences between verified and no indicators (Z-Score=.7439, $p>.05$) and not substantiated and no indicators for maltreatment (Z-Score=-1.5447, $p>.05$) deaths were not statistically significant.

Table F-34: Past History as Perpetrator of Child Maltreatment for Supervisors by Maltreatment Verification Status and Primary Cause of Death												
Supervisor Has History as Perpetrator	Child Maltreatment Death											
	Verified n=83				Not Substantiated n=58				No Indicators n=184			
	Drowning n=20	Sleep-related n=13	Inflicted Trauma n=21	Other Undetermined Unknown n=29	Drowning n=25	Sleep-related n=21	Inflicted Trauma n=1	Other Undetermined Unknown n=11	Drowning n=26	Sleep-related n=97	Inflicted Trauma n=5	Other Undetermined Unknown n=56
Yes	10.0%	30.8%	23.8%	34.5%	4.0%	23.8%	0.0%	9.1%	15.4%	26.8%	0.0%	16.1%
No	65.0%	53.8%	52.4%	27.6%	84.0%	66.7%	0.0%	36.4%	69.2%	51.5%	0.0%	60.7%
Unknown/Missing	25.0%	15.4%	23.8%	37.9%	12.0%	9.5%	100.0%	54.5%	15.4%	21.6%	100.0%	23.2%
Type of Maltreatment	**If Yes, Verified Child Maltreatment (n=21)**				**If Yes, Not Substantiated as Child Maltreatment (n=7)**				**If Yes, No Indicators that Child Maltreatment (n=39)**			
	Drowning n=2	Sleep-related n=4	Inflicted Trauma n=5	Other Undetermined Unknown n=10	Drowning n=1	Sleep-related n=5	Inflicted Trauma n=0	Other Undetermined Unknown n=1	Drowning n=4	Sleep-related n=26	Inflicted Trauma n=0	Other Undetermined Unknown n=9
Physical	50.0%	25.0%	80.0%	30.0%	0.0%	40.0%	0.0%	0.0%	25.0%	38.5%	0.0%	33.3%
Neglect	100.0%	100.0%	60.0%	70.0%	100.0%	100.0%	0.0%	100.0%	25.0%	76.9%	0.0%	77.8%
Sexual	50.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	25.0%	11.5%	0.0%	0.0%
Emotional/ Psychological	50.0%	0.0%	60.0%	0.0%	0.0%	0.0%	0.0%	0.0%	50.0%	19.2%	0.0%	11.1%
Unknown/Missing	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	100.0%	0.0%	0.0%	0.0%	11.1%

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

Table F-35 highlights the distribution of caregivers' history with intimate partner violence as a victim and/or perpetrator. In total, 27 of 139 (19.4%) of caregivers were known to be victims and 23 of 139 (16.5%) were known to be perpetrators of intimate violence among those affiliated with verified maltreatment deaths. With respect to caregivers in not substantiated maltreatment deaths, 11 of 139 (7.9%) were past victims and 8 of 139 (5.8%) were past perpetrators of intimate partner violence. In contrast, 41 of 393 (10.4%) and 38 of 393 (9.6%) of caregivers in no indicators of maltreatment deaths have histories as victims and perpetrators (respectively) of intimate partner violence.

Table F-35: History of Intimate Partner Violence with Caregivers by Maltreatment Verification Status and Primary Cause of Death												
History of Intimate Partner Violence	Child Maltreatment Death											
	Verified n=139				Not Substantiated n=139				No Indicators n=393			
	Drowning n=31	Sleep-related n=18	Inflicted Trauma n=43	Other Undetermined Unknown n=47	Drowning n=43	Sleep-related n=61	Inflicted Trauma n=3	Other Undetermined Unknown n=32	Drowning n=57	Sleep-related n=187	Inflicted Trauma n=17	Other Undetermined Unknown n=132
Yes, as Victim	12.9%	27.8%	20.9%	19.1%	7.0%	6.6%	0.0%	12.5%	3.5%	17.6%	0.0%	4.5%
Yes, as Perpetrator	12.9%	5.6%	18.6%	21.3%	2.3%	6.6%	33.3%	6.3%	3.5%	15.5%	0.0%	5.3%
No	64.5%	38.9%	37.2%	29.8%	81.4%	50.8%	33.3%	25.0%	63.2%	48.1%	58.8%	48.5%
Unknown/Missing	9.7%	27.8%	23.3%	29.8%	9.3%	36.1%	33.3%	56.3%	29.8%	18.7%	41.2%	41.7%

Figure F-11: History of Intimate Partner Violence with All Caregivers by Maltreatment Verification Status (N=523)

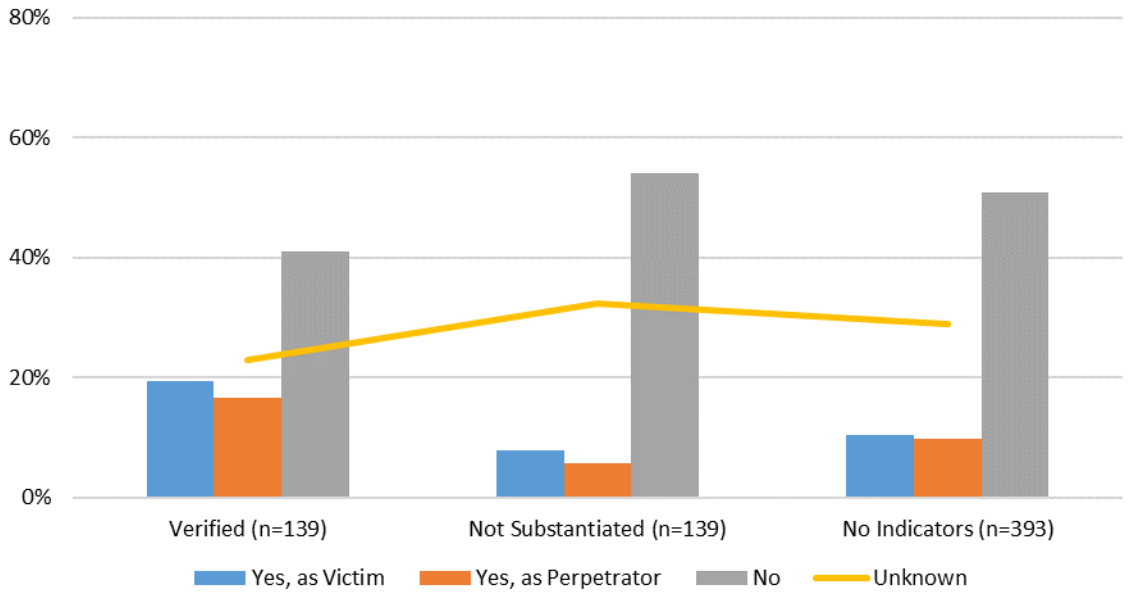


Table F-36 highlights the distribution of supervisors' history with intimate partner violence as a victim and/or perpetrator.

Table F-36: History of Intimate Partner Violence with Supervisors by Maltreatment Verification Status and Primary Cause of Death

History of Intimate Partner Violence	Child Maltreatment Death											
	Verified n=83				Not Substantiated n=58				No Indicators n=184			
	Drowning n=20	Sleep-related n=13	Inflicted Trauma n=21	Other Undetermined Unknown n=29	Drowning n=25	Sleep-related n=21	Inflicted Trauma n=1	Other Undetermined Unknown n=11	Drowning n=26	Sleep-related n=97	Inflicted Trauma n=5	Other Undetermined Unknown n=56
Yes, as Victim	15.0%	38.5%	19.0%	13.8%	0.0%	14.3%	0.0%	9.1%	3.8%	19.6%	0.0%	7.1%
Yes, as Perpetrator	10.0%	0.0%	19.0%	20.7%	0.0%	4.8%	0.0%	9.1%	3.8%	12.4%	0.0%	5.4%
No	50.0%	30.8%	42.9%	13.8%	90.9%	71.4%	0.0%	36.4%	73.1%	48.5%	0.0%	55.4%
Unknown/Missing	25.0%	30.8%	19.0%	51.7%	22.7%	9.5%	100.0%	45.5%	19.2%	19.6%	100.0%	32.1%

Past Criminal History of Caregivers & Supervisors

When the criminal history of caregivers is examined (Table F-37), 49 of 166 (29.5%), 31 of 116 (26.7%) and 95 of 368 (25.8%) of caregivers associated with verified, not substantiated, and no indicators child maltreatment deaths (respectively) have a past criminal history.[4] When primary

[4] A series of tests of significance between independent proportions (Z-Scores) were done to determine if the observed total proportion of caregivers with a criminal history for verified, not substantiated, and no indicators for maltreatment cases differed significantly (at p<.05, two-tailed test). The observed proportion differences between verified and no indicators (Z-Score=0.8924, p>.05) and not substantiated and no indicators for maltreatment (Z-Score=0.1945, p>.05) deaths were not statistically significant.

cause of maltreatment deaths is observed, the highest proportion of caregivers for verified maltreatment cases with a criminal past were those affiliated with inflicted trauma deaths (35.7%), followed by sleep-related deaths (30.8%). The types of offenses (for verified cases) that caregivers committed vary in proportional representation across primary cause of death. Among those with a criminal history, those with drug offenses were represented from a low of 22.2% for caregivers associated with verified drowning deaths to a high of 52.9% of those caregivers associated with other deaths. Please note that the column totals for the type of offense for across each category of primary cause of death may exceed 100% as individual caregivers may have more than one past criminal offense.

Table F-37: Past Criminal History of Caregivers by Maltreatment Verification Status and Primary Cause of Death

Criminal History of Caregivers	Child Maltreatment Death											
	Verified n=166				Not Substantiated n=116				No Indicators n=368			
	Drowning n=40	Sleep-related n=26	Inflicted Trauma n=42	Other Undetermined Unknown n=58	Drowning n=50	Sleep-related n=42	Inflicted Trauma n=2	Other Undetermined Unknown n=22	Drowning n=52	Sleep-related n=194	Inflicted Trauma n=10	Other Undetermined Unknown n=112
Yes	22.5%	30.8%	35.7%	29.3%	12.0%	35.7%	50.0%	40.9%	17.3%	29.9%	20.0%	23.2%
No	37.5%	34.6%	40.5%	32.8%	74.0%	54.8%	50.0%	40.9%	67.3%	51.5%	80.0%	51.8%
Unknown/Missing	40.0%	34.6%	23.8%	37.9%	14.0%	9.5%	0.0%	18.2%	15.4%	18.6%	0.0%	25.0%
Type of Offense	**If Yes, Verified Child Maltreatment (n=49)**				**If Yes, Not Substantiated as Child Maltreatment (n=31)**				**If Yes, No Indicators that Child Maltreatment (n=95)**			
	Drowning n=9	Sleep-related n=8	Inflicted Trauma n=15	Other Undetermined Unknown n=17	Drowning n=6	Sleep-related n=15	Inflicted Trauma n=1	Other Undetermined Unknown n=9	Drowning n=9	Sleep-related n=58	Inflicted Trauma n=2	Other Undetermined Unknown n=26
Assaults	22.2%	25.0%	53.3%	58.8%	16.7%	20.0%	0.0%	44.4%	33.3%	34.5%	50.0%	42.3%
Robbery	11.1%	0.0%	13.3%	17.6%	0.0%	13.3%	0.0%	33.3%	22.2%	10.3%	0.0%	30.8%
Drugs	22.2%	50.0%	33.3%	52.9%	33.3%	33.3%	0.0%	11.1%	44.4%	34.5%	50.0%	34.6%
Other	55.6%	62.5%	80.0%	47.1%	83.3%	73.3%	100.0%	88.9%	77.8%	63.8%	50.0%	65.4%
Unknown/Missing	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%

Figure F-12: Criminal Background History of All Caregivers (N=650)

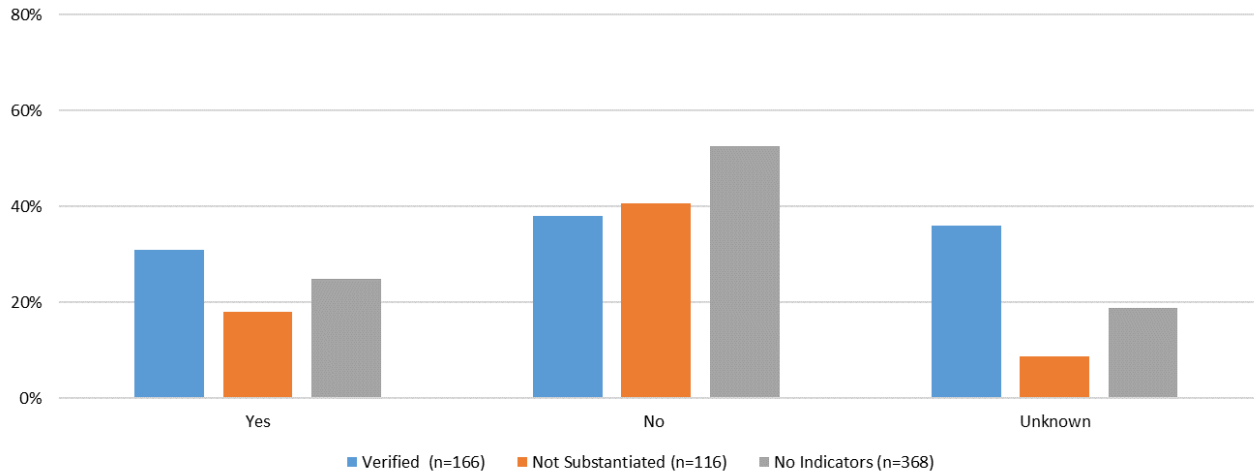
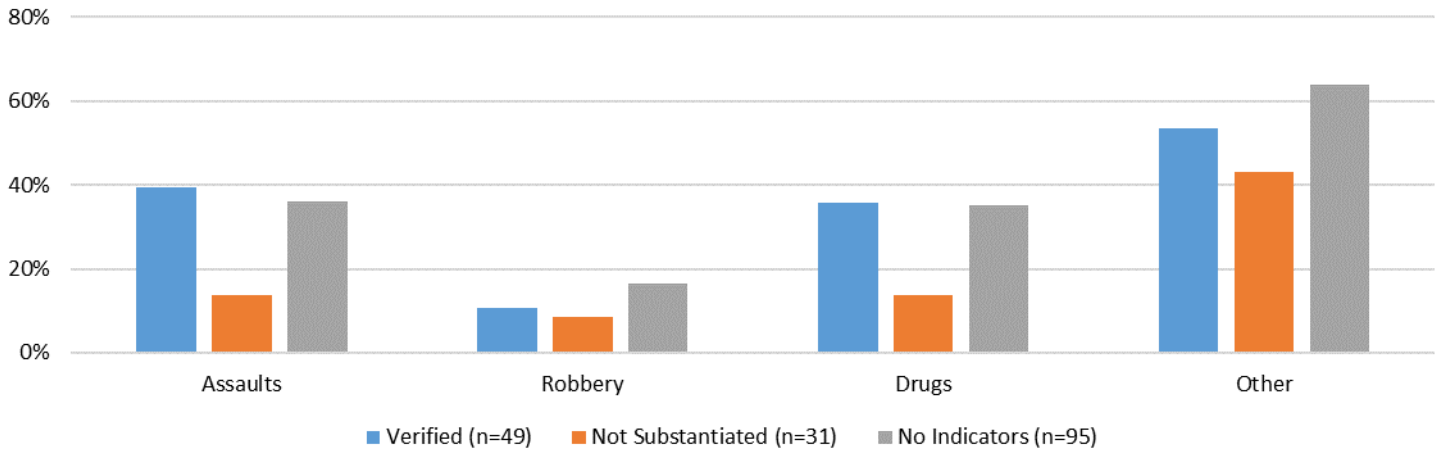


Figure F-13: Offense Type for Those Caregivers With Criminal Background (N=175)



When the criminal history of supervisors is examined (See Table F-38), 29 of 83 (34.9%), 10 of 58 (5.8%) and 47 of 184 (25.5%) of supervisors associated with verified, not substantiated, and no indicators child maltreatment deaths (respectively) have a past criminal history. Only the observed difference in percentage of supervisors with a criminal history for not substantiated and no indicators of maltreatment deaths were not statistically significant.[5] When primary cause of maltreatment deaths is observed, the highest proportion of supervisors for verified maltreatment cases with a criminal past were those affiliated with sleep-related deaths (46.2%). The types of offenses (for verified cases) that supervisors committed vary in proportional representation across primary cause of death. Among those with a criminal history, those with drug offenses were represented from a low of 28.6% for supervisors associated with verified inflicted trauma to a high of 66.7% of those supervisors associated with sleep-related deaths. Please note that the column totals for the type of offense for each category of primary cause of death may exceed 100% as individual caregivers may have more than one past criminal offense.

[5] A series of tests of significance between independent proportions (Z-Scores) were done to determine if the observed total proportion of caregivers with a criminal history for verified, not substantiated, and no indicators for maltreatment cases differed significantly (at $p<.05$, two-tailed test). The observed proportion differences between verified and no indicators (Z-Score=1.5748, $p>.05$) and not substantiated and no indicators for maltreatment (Z-Score=-1.2993, $p>.05$) deaths were statistically significant.

Table F-38: Past Criminal History Associated with Supervisors by Maltreatment Verification Status and Primary Cause of Death												
Criminal History of Supervisors	Child Maltreatment Death											
	Verified n=83				Not Substantiated n=58				No Indicators n=184			
	Drowning n=20	Sleep-related n=13	Inflicted Trauma n=21	Other Undetermined Unknown n=29	Drowning n=25	Sleep-related n=21	Inflicted Trauma n=1	Other Undetermined Unknown n=11	Drowning n=26	Sleep-related n=97	Inflicted Trauma n=5	Other Undetermined Unknown n=56
Yes	30.0%	46.2%	33.3%	34.5%	12.0%	28.6%	0.0%	9.1%	15.4%	29.9%	0.0%	25.0%
No	40.0%	46.2%	42.9%	31.0%	80.0%	57.1%	0.0%	45.5%	69.2%	56.7%	0.0%	51.8%
Unknown/Missing	30.0%	7.7%	23.8%	34.5%	8.0%	14.3%	100.0%	45.5%	15.4%	13.4%	100.0%	23.2%
Type of Offense	**If Yes, Verified Child Maltreatment (n=29)**				**If Yes, Not Substantiated as Child Maltreatment (n=10)**				**If Yes, No Indicators that Child Maltreatment (n=47)**			
	Drowning n=6	Sleep-related n=6	Inflicted Trauma n=7	Other Undetermined Unknown n=10	Drowning n=3	Sleep-related n=6	Inflicted Trauma n=0	Other Undetermined Unknown n=1	Drowning n=4	Sleep-related n=29	Inflicted Trauma n=0	Other Undetermined Unknown n=14
Assaults	33.3%	33.3%	42.9%	60.0%	33.3%	16.7%	0.0%	0.0%	50.0%	37.9%	0.0%	42.9%
Robbery	16.7%	0.0%	28.6%	30.0%	0.0%	0.0%	0.0%	100.0%	25.0%	3.4%	0.0%	21.4%
Drugs	33.3%	66.7%	28.6%	40.0%	66.7%	33.3%	0.0%	0.0%	50.0%	31.0%	0.0%	21.4%
Other	66.7%	50.0%	71.4%	60.0%	66.7%	66.7%	0.0%	100.0%	75.0%	75.9%	0.0%	71.4%
Unknown/Missing	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%

Past Child Death Associated with Caregivers and Supervisors

Table F-39 highlights the distribution of caregivers with past child death events. In total, 3 of 166 (1.8%) caregivers in association with verified maltreatment deaths were known to have a past child death. With respect to caregivers in not substantiated maltreatment deaths, 3 of 116 (2.5%) were identified as having a past child death event. Lastly, 5 of 368 (1.4%) of caregivers in no indicators of maltreatment deaths have histories with child death events.

Table F-40 highlights the distribution of supervisors with past child death events. In total, 1 of 83 (1.2%) supervisors in association with verified maltreatment deaths were known to have a past child death. With respect to supervisors in not substantiated maltreatment deaths, 2 of 58 (3.4%) were identified as having any association with a past child death event. Lastly, 3 of 184 (1.6%) of supervisors in no indicators of maltreatment deaths have histories with child death events.

Table F-39: Past Child Death Associated with Caregivers by Maltreatment Verification Status and Primary Cause of Death												
Past Child Death with Caregiver	Child Maltreatment Death											
	Verified n=166				Not Substantiated n=116				No Indicators n=368			
	Drowning n=40	Sleep-related n=26	Inflicted Trauma n=42	Other Undetermined Unknown n=58	Drowning n=50	Sleep-related n=42	Inflicted Trauma n=2	Other Undetermined Unknown n=22	Drowning n=52	Sleep-related n=194	Inflicted Trauma n=10	Other Undetermined Unknown n=112
Yes	0.0%	3.8%	0.0%	3.4%	0.0%	2.4%	0.0%	9.1%	3.8%	1.5%	0.0%	0.0%
No	72.5%	53.8%	83.3%	58.6%	86.0%	90.5%	100.0%	72.7%	75.0%	79.9%	80.0%	67.9%
Unknown/Missing	27.5%	42.3%	16.7%	37.9%	14.0%	7.1%	0.0%	18.2%	21.2%	18.6%	20.0%	32.1%

Table F-40: Past Child Death Associated with Supervisors by Maltreatment Verification Status and Primary Cause of Death												
Past Child Death with Supervisor	Child Maltreatment Death											
	Verified n=83				Not Substantiated n=58				No Indicators n=184			
	Drowning n=20	Sleep-related n=13	Inflicted Trauma n=21	Other Undetermined Unknown n=29	Drowning n=25	Sleep-related n=21	Inflicted Trauma n=1	Other Undetermined Unknown n=11	Drowning n=26	Sleep-related n=97	Inflicted Trauma n=5	Other Undetermined Unknown n=56
Yes	0.0%	7.7%	0.0%	0.0%	0.0%	0.0%	0.0%	18.2%	3.8%	2.1%	0.0%	0.0%
No	85.0%	76.9%	90.5%	62.1%	104.5%	90.5%	0.0%	45.5%	73.1%	83.5%	0.0%	73.2%
Unknown/Missing	15.0%	15.4%	9.5%	37.9%	9.1%	9.5%	100.0%	36.4%	23.1%	14.4%	100.0%	26.8%

APPENDIX G:

DCF HOME SAFETY CHECKLIST

Child Protection Team Home Safety Check List

Pre-School Children 2-6 Years Old

Although much child protection work focuses on the problem of abuse, unintentional injuries resulting from negligent care actually cause twice as many infant and child deaths each year. Negligent supervision of children and hazardous conditions in the home also cause numerous non-fatal injuries. Many parents are unaware of the dangers to children present in the home. You can help them to identify these dangers and prevent future injuries and deaths.

Drowning Prevention: *Drowning is the leading cause of preventable death in children in Florida.* In 2017 in Florida, 67 children died as a result of negligent supervision around water, inadequate locks and gates to keep them in the home, or inadequate barriers around water.

☐	If there is a body of water of any type (pool, retention pond, river, lake or ocean), there are fences and gates with secure locks separating the living areas from the water.	It is difficult to keep active children in sight every moment. There must be effective barriers to keep them away from water when the parent is busy cooking or in the bathroom.
☐	If there is a body of water of any type, the parent expresses an understanding that doors to the outdoors and barrier gates must be kept closed and latched.	Doors, gates and latches do no good if they are not secured. In Florida in 2017, 32 children between 2-6 years of age drowned after getting out of the home undetected. Caretakers were often sleeping or distracted.
☐	The parent expresses an understanding that at any gathering near water where children are present, an adult not using alcohol or drugs must be responsible specifically for watching the children.	Children often drown while adults are nearby but distracted by party activities. In Florida in 2017, 43 children drowned while not being supervised outdoors.
☐	The parent expresses an understanding that it would be desirable for the child to take swimming lessons.	Children who know how to swim less likely to drown – but they still need to be watched carefully!

Burn Prevention: Pre-school children are curious about adult activities like cooking, smoking and fire-starting. They like to imitate adults in doing these things and may get burned.

☐	The home has smoke alarms with working batteries to provide early warning of fire.	When homes catch fire, infants and children often die in back bedrooms while adults are driven out by flames and smoke.
☐	Matches and cigarette lighters are safely Stored where the child cannot get them.	Children will play with matches and lighters if given a chance.

☐	The parent expresses an understanding that flat irons and curling irons should always be put away immediately after use.	Many children are burned by hot irons left on the floor or bed or that they pull down off an ironing board.
☐	The parent expresses and understanding that a playpen can be used to keep the child from being burned while meals are being prepared.	Children may be burned when they pull pots from the stove or touch open oven doors.
☐	There are plugs in all accessible electrical outlets.	Children like to put wet fingers and metal objects in outlets.

Poisoning Prevention: Children may eat or drink anything they can get their hands on. In this age group, medications belonging to parents and grandparents are a special danger.

☐	Kitchen, bathroom and other cabinets all have child-proof latches on them.	Insecticides, drain cleaners and other Things stored in these locations can cause severe injuries.
☐	All medications, both prescription and over-the-counter, are kept in their child-proof containers.	Many medications look like candy. Toddlers will eat them if they can get them.
☐	The parent has access to the Florida Poison Control Center phone number, 1-800-222-1222. (Provide a copy.)	Parents should have this on hand just in case the child gets into something despite precautions.

Automobile Safety: After age 2 years, children can ride in forward-facing car safety seats. As they outgrow seats, appropriate new restraints must be used.

☐	Parent has a car safety seat appropriate for the child's age and weight and knows how to use it. (Check limits printed on on seat.)	Improperly restrained children in improperly installed car seats are not protected.
☐	Parent expresses an understanding that the child must be restrained in the car every time he or she travels.	You can never predict when a car accident will happen. It is never safe to let a child be unrestrained.
☐	If the child is too big for a car safety seat, a belt-positioning booster seat is used.	Car seat belts should go over child's lap or pelvis and chest, not over the tummy, face or neck.

Child Protection Team Home Safety Check List

Infants 6 – 12 Months Old

Although much child protection work focuses on the problem of abuse, unintentional injuries resulting from negligent care actually cause twice as many infant and child deaths each year. Negligent supervision of children and hazardous conditions in the home also cause numerous non-fatal injuries. Many parents are unaware of the dangers to children present in the home. You can help them to identify these dangers and prevent future injuries and deaths.

Safe Sleep: *Unsafe sleep conditions are the most common cause of preventable death in infants less than 12 months old.* Bed-sharing with adults and sleeping in places not intended for safe sleep are common causes of death in infants in this age group. In 2015, 140 infants, 21 of them 6-12 months of age, died as a result of the unsafe sleeping arrangements described below.

	Observation	**Rationale**
☐	Crib, Bassinet or Playpen: In good repair. free of toys, blankets, bumper pads, stuffed animals and away from hanging window cords. Mattress fits snugly against rails.	Cribs, bassinets and playpens are the safest places for infants to sleep. Any object in the sleeping area is a suffocation or strangulation hazard.
☐	Parent expresses an understanding of the importance of the infant sleeping in a crib, bassinet or playpen and not in bed with an adult.	Parents sleeping with their babies often suffocate them as they sleep. In Florida in 2017, there were 93 bed-sharing deaths. Of these, 14 were 6-12 months old.
☐	Parent expresses an understanding of the importance of the infant sleeping in a crib, bassinet or playpen and not on a sofa, couch or chair.	Babies sleeping on couches, futons and chairs often get their faces wedged in places where they suffocate. In Florida in 2017, 3 infants 6-12 months old died in this manner.

Fall Prevention: Infants in this age group are very mobile. Not only can they roll over, but most will be crawling and some will be cruising or walking before they are a year old.

☐	Parent expresses an understanding of the importance of never leaving the infant on any raised surface from which he or she could fall.	There is no maybe: Infants in this age range will fall and get hurt if they are left on beds and couches.
☐	Parent has barrier gates on steps or stairs to prevent falls.	Infants in this age range can start crawling up or down stairs and can fall, hurting themselves.
☐	Parent is not putting the infant in an infant walker.	Infants in walkers suffer more falls and injuries. They are also slower learning to walk. Stationary infant play stations are safer.

Drowning Prevention: Because they are starting to move around and cannot recognize danger, infants in this age range will drown if given a chance to get into water.

☐	Parent expresses an understanding that the infant should never be left in a bath either alone or with another child.	In Florida in 2017, 3 infants 6-12 months old drowned when they were left unsupervised in bathtubs.
☐	Parent expresses an understanding that buckets of water are a drowning danger for children in this age group.	Infants who can crawl will sometimes pull up on the side of a bucket of water and fall in head first.
☐	If there is a swimming pool of any kind on the property, there are doors or gates with secure locks and latches on them separating the living areas from the water.	Smart, mobile infants will find a way to get to water very quickly when a parent's back is turned.

Poisoning Prevention: Infants learn about the world by tasting it. They may eat or drink anything they can get their hands on.

☐	Kitchen, bathroom and other cabinets all have child-proof latches on them.	Insecticides, drain cleaners and other things stored in these locations can cause severe injuries or death.
☐	All medications, both prescription and over-the-counter, are kept in their child-proof containers.	Many medications look like candy. Infants will eat them if they can get them.

Choking Prevention: Infants in this age range are moving around the house. They will put anything they find in their mouths. They may choke to death.

☐	The floor and furniture are free of small objects that would fit in the infant's mouth, including older children's small toys.	Small objects choke children. In Florida in 2017, six children died from choking. Of these six children, 2 were 6-12 months old.

Burn Prevention: Many infants suffer burns from hot liquids, hot objects and cigarettes handled carelessly around them. Adults and children alike may die in home fires, often from smoke inhalation.

☐	Parent expresses an understanding that He/she should not smoke or drink hot or tea while holding the infant.	Babies wave their arms and kick their legs and may cause spills or come in contact with hot things.
☐	The home has smoke alarms with working batteries to provide early warning of fire.	When homes catch fire, infants and children often die in back bedrooms while adults are driven out by flames and smoke.

Automobile Safety: Many serious injuries and fatal accidents to infants and children occur when the car or truck they are riding in is involved in a collision. Some infants approaching a year of age may be outgrowing their infant car seats.

☐	Parent has a car seat and knows how to install it and the baby correctly.	Improperly restrained infants in improperly installed car seats are not protected.
☐	Parent expresses an understanding that the infant must be restrained in the car every time he or she travels.	You can never predict when a car accident will happen. It is never Safe to carry an infant in one's arms or otherwise unrestrained in a car.

Child Protection Team Home Safety Check List

Toddlers 12 – 24 Months Old

Although much child protection work focuses on the problem of abuse, unintentional injuries resulting from negligent care actually cause twice as many infant and child deaths each year. Negligent supervision of children and hazardous conditions in the home also cause numerous non-fatal injuries. Many parents are unaware of the dangers to children present in the home. You can help them to identify these dangers and prevent future injuries and deaths.

Drowning Prevention: *Drowning is the leading cause of preventable death in children in Florida.* In 2017 in Florida 67 children died as a result of negligent supervision around water, inadequate locks and gates to keep them in the home, or inadequate barriers around water. Of the 67 children reported, 3 were between 12-24 months of age. Active toddlers will find a way to get into water if not protected.

☐	Parent expresses an understanding that buckets of water are a drowning danger for children in this age group.	Toddlers will sometimes fall head first into half-filled buckets of water and drown.
☐	Parent expresses an understanding that the child should never be left in a bath tub either alone or with another child.	In Florida in 2017, 3 infants drowned when they were left unsupervised in bath tubs.
☐	If there is a body of water of any type nearby, the parent expresses an understanding that doors to the outdoors and barrier gates must be kept closed and latched.	Doors, gates and latches do no good if they are not secured. Older toddlers may learn to open latches, they can reach, so additional higher latches may be needed. In Florida in 2017, 40 children drowned after getting out of the home undetected. Caretakers were usually sleeping or distracted.
☐	If there is a body of water of any type, the parent expresses an understanding that when the child is outdoors there must be constant eyes-on supervision of the child.	Children can drown in minutes if they are not watched constantly around water when outdoors. In Florida in 2017, 43 children drowned while not being supervised outdoors. Of these, 14 children were between 12-24 month of age
☐	If there is a body of water of any type (pool, retention pond, river, lake or ocean), there are fences and gates with secure locks separating the living areas from the water.	It is difficult to keep active toddlers in sight every moment. There must be effective barriers to keep them away from water when the parent is busy cooking or in the bathroom.

Choking Prevention: Toddlers are constantly on the move and will put anything they find in their mouths. They may choke to death. They do not have a full set of chewing teeth and can choke on some foods and candies.

☐	The floor and furniture are free of small objects that would fit in the child's mouth, including older children's small toys.	Small objects choke children. A good rule of thumb is that if something will fit through a toilet paper roll it is too small for a toddler to play with.
☐	The parent expresses an understanding that foods given to the child must be cut up in small pieces or soft enough that the child can safely swallow them without chewing.	Chunks of hot dog, whole grapes and hard candies are common causes of choking deaths in small children.

Burn Prevention: Toddlers exploring their environments are especially likely to be burned by hot objects left where they can touch them.

☐	The parent expresses an understanding that flat irons and curling irons should always be put away immediately after use.	Many toddlers are burned by hot irons left on the floor or bed or that they pull down off an ironing board.
☐	The parent expresses an understanding that a playpen can be used to keep the child from being burned while meals are being prepared.	Toddlers may be burned when they pull pots from the stove or touch open oven doors.
☐	There are plugs in all accessible electrical outlets.	Toddlers like to put wet fingers and metal objects into outlets.
☐	The home has smoke alarms with working batteries to provide early warning of fire.	When homes catch fire, infants and children often die in back bedrooms while adults are driven out by flames and smoke.

Poisoning Prevention: Toddlers explore the world by tasting it. They may eat or drink anything they can get their hands on.

☐	Kitchen, bathroom and other cabinets all have child-proof latches on them.	Insecticides, drain cleaners and other Things stored in these locations can cause severe injuries.
☐	All medications, both prescription and over-the-counter, are kept in their child-proof containers.	Many medications look like candy. Toddlers will eat them if they can get them.
☐	The parent has access to the Florida Poison Control Center phone number, 1-800-222-1222. (Provide a copy.)	Parents should have this on hand just in case the child gets into something despite precautions.

Fall Prevention: Toddlers are very mobile and like to climb.

☐	Parent has barrier gates on steps or stairs to prevent falls.	Toddlers typically like to crawl up and down stairs and may fall.

Automobile Safety: The American Academy of Pediatrics now recommends that for maximum protection toddlers stay in rear-facing car safety seats until they are 2 years old or reach the maximum height and weight of their seat.

☐	Parent has a car seat and knows how to install it and the child correctly.	Improperly restrained toddlers in improperly installed car seats are not protected.
☐	Parent expresses an understanding that the infant must be restrained in the car every time he or she travels.	You can never predict when a car accident will happen. It is never safe to carry an infant in one's arms or otherwise unrestrained in a car.
☐	Parent expresses an understanding that the child should ride facing backwards until he or she is 2 years old or gets too big for their car seat.	This position provides more support for the head and neck in the event of a collision.
☐	The child does not exceed the maximum height and weight limits printed on the seat.	A car seat cannot provide good protection for a child who is too big for it.

State of Florida
Department of Children and Families

Ron DeSantis
Governor

Chad Poppell
Secretary

Child Protection Team Home Safety Checklist

Infants Less Than 6 Months Old

Although much child protection work focuses on the problem of abuse, unintentional injuries resulting from negligent care actually cause twice as many infant and child deaths each year. Negligent supervision of children and hazardous conditions in the home also cause numerous non-fatal injuries. Many parents are unaware of the dangers to children present in the home. You can help them to identify these dangers and prevent future injuries and deaths.

Safe Sleep: *Unsafe sleep conditions are the most common cause of preventable death in infants less than 6 months old.* Bed-sharing with adults, sleeping on the stomach and sleeping in places not intended for safe sleep are all common causes of death in infants. In 2017, 119 infants less than 6 months old died as a result of the unsafe sleeping arrangements described below.

	Observation	**Rationale**
☐	Crib, Bassinet or Playpen: In good repair. free of toys, blankets, bumper pads, stuffed animals and away from hanging window cords. Mattress fits snugly against rails.	Cribs, bassinets and playpens are the safest places for infants to sleep. Any object in the sleeping area is a suffocation or strangulation hazard.
☐	Parent expresses an understanding of the importance of placing the infant down to sleep on his/her back.	Infants who sleep on their stomachs are more likely to die in their sleep of Sudden Infant Death Syndrome (SIDS).
☐	Parent expresses an understanding of the importance of the infant sleeping in a crib, bassinet or playpen and not in bed or elsewhere with an adult or older child.	Parents sleeping with their babies often suffocate them as they sleep. In Florida in 2017, 77 infants less than 6 months old died from bed-sharing. Sleeping in the same room is good, but not the same bed.
☐	Parent expresses an understanding of the importance of the infant sleeping in a crib, bassinet or playpen and not on a sofa, couch or chair.	Babies sleeping on couches, futons and chairs often get their faces wedged in places where they suffocate. This happened to 11 babies less than 6 months old in Florida in 2017.

Fall Prevention: Although household falls rarely cause death, they cause many bumps, bruises, broken bones and even skull fractures. Many parents first find that their baby has learned to roll over when he or she is hurt falling off of a bed, couch or changing table.

☐	Parent expresses an understanding of the and importance of never leaving the infant on any raised surface from which he or she could fall.	Even young infants can scoot squirm and can fall from beds, couches and changing tables.

Burn Prevention: Many infants suffer burns from hot liquids, hot objects and cigarettes handled carelessly around them.

☐	Parent expresses an understanding that he/she should not smoke or drink hot coffee or tea while holding the infant.	Babies wave their arms and kick their legs and may cause spills or come in contact with hot things.
☐	Parent expresses an understanding that the hot water heater should be set to a temperature no higher than 120 degrees.	If the hot water heater is set at a hotter temperature, scald burns can happen in seconds. Parent, friend or landlord can adjust.

Automobile Safety: Many serious injuries and fatal accidents to infants and children occur when the car or truck they are riding in is involved in a collision.

☐	Parent has a car seat and knows how to install it and the baby correctly.	Improperly restrained infants in improperly installed car seats are not protected.
☐	Parent expresses an understanding that the infant must be restrained in the car every time he or she travels.	You can never predict when a car accident will happen. It is never safe to carry an infant in one's arms or otherwise unrestrained in a car.

APPENDIX H:

GOVERNOR PROCLAMATIONS

RON DESANTIS
GOVERNOR

SAFE SLEEP AWARENESS MONTH IN FLORIDA

WHEREAS, Florida is committed to helping our families and youth reach their full potential and lead healthy lives; and

WHEREAS, the Centers for Disease Control and Prevention's research indicates that there are approximately 3,500 sleep-related deaths among babies every year; and

WHEREAS, since suffocation is the leading cause of unintentional injury-related death for infants in Florida under the age of one, safe sleeping environments are critical; and

WHEREAS, unexpected infant deaths can be prevented by implementing safe sleep practices, including placing the baby alone on his or her back in a crib in the parent's room for the first year of life; and

WHEREAS, additional safety tips include using a firm sleeping surface with only a fitted sheet, removing all soft objects, and prohibiting smoking around babies;

NOW, THEREFORE, I, Ron DeSantis, Governor of the State of Florida, do hereby extend my support to all observing October 2019 as *Safe Sleep Awareness Month in Florida*.

IN WITNESS WHEREOF, I have hereunto set my hand and caused the Great Seal of the State of Florida to be affixed at Tallahassee, the Capital, this 1st day of October, in the year two thousand nineteen.

Governor

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RON DESANTIS
GOVERNOR

WATER SAFETY MONTH IN FLORIDA

WHEREAS, Floridians recognize the vital role that swimming and aquatic-related activities play in good physical and mental health and the enhancement of the quality of life; and

WHEREAS, efforts to educate the public about water safety prevent drownings and recreational water-related injuries; and

WHEREAS, there are many contributions made by the recreational water industry in developing safe swimming facilities, aquatic programs, home pools and spas; and

WHEREAS, Floridians understand the vital importance of communicating water safety rules and programs to families and individuals of all ages, whether they are owners of private pools, users of public swimming facilities, or visitors to waterparks.

NOW, THEREFORE, I, Ron DeSantis, Governor of the State of Florida, do hereby extend greetings and best wishes to all observing May 2019 as *Water Safety Month in Florida*.

IN WITNESS WHEREOF, I have hereunto set my hand and caused the Great Seal of the State of Florida to be affixed at Tallahassee, the Capital, this 1st day of May, in the year two thousand nineteen.

Governor

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