Child Abuse Death Review Committee

Working to eliminate preventable child abuse and neglect deaths in Florida

Annual Report

December 2015

MISSION:

To eliminate preventable child abuse and neglect deaths

Submitted to:

The Honorable Rick Scott, Governor, State of Florida
The Honorable Andy Gardiner, President, Florida State Senate
The Honorable Steve Crisafulli, Speaker, Florida State House of Representatives

Table of Contents

Executive Summary 5

Section One: Background 8

Section Two: Method 12

Section Three: Data 12

Section Four: Future Analytic Plans 23

Section Five: Prevention Recommendations 24

Section Six: Conclusions and Next Steps 31

Appendices

Appendix A: Section 383.402, Florida Statutes

Appendix B: State and Local Committee Membership

Appendix C: Guidelines for the State Committee

Appendix D: Local Committee Guidelines

Appendix E: Case Report Form

Appendix F: Statewide Meeting – Summary of Feedback

Appendix G: Child Abuse Death Review Data

EXECUTIVE SUMMARY

Florida's Child Abuse Death Review Process

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

The purpose of the child abuse death review 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.

Following recent statutory changes, the state committee amended the criteria for reviews at both the state and local levels. This has been a year of transition as committees adjust to new processes that support a widened scope of case reviews which includes all child fatalities reported to Florida's Abuse Hotline. Throughout 2015, the death review system conducted case reviews on over 403 child fatalities that occurred in 2014. Cases reviewed included those fatalities investigated and **verified** as child maltreatment and those deaths that were **not verified** as maltreatment. This expanded scope has allowed the state committee to review additional data sets that can be used to inform statewide and local prevention strategies aimed at reducing child abuse and neglect deaths in Florida.

2014 Data: Case Review Analyses

Analyses of 2014 case review data reveal that Florida's youngest citizens are most vulnerable to child abuse and neglect. Regardless of verification status, children under five had the highest risk for all forms of death. Additional findings identify our three primary preventable causes of child deaths:

- **Drowning,** as in previous years, continues to be a primary cause of preventable death among children in Florida. Unsupervised access to pools, spas/tubs, and open bodies of water remains a potential threat to our most vulnerable citizens.
- **Asphyxia,** primarily as a result of unsafe sleep practices, claims the lives of our youngest. The overwhelming majority of children dying from asphyxia were less than one year old (88% of verified maltreatment deaths, 95% of non-verified deaths.)
- **Trauma/wounds caused by a weapon,** primarily the use of firearms or bodily force (e.g., fists and feet) to inflict harm, also ranks in the top three causes of child deaths.

Prevention Recommendations

The State Child Abuse Death Review Committee, with input and participation from local committee members, has reviewed and analyzed data findings to determine next steps for Florida's child maltreatment prevention initiatives. Prevention recommendations are built around our data findings, specifically the top three primary causes of child fatalities, as defined by all data sources. This framework provides a solid foundation for targeting and implementing prevention strategies at state and local levels specifically aimed at our most significant challenges.

DROWNING

- Public education awareness campaigns encouraging water safety practices continue to be a primary strategy to prevent drowning. State agencies must work together to provide uniform and consistent messaging for water safety practices.
- Educational activities should target those responsible for supervising children during water play or other activities that bring children in close proximity to any large or small bodies of water (i.e., parents, guardians, day care workers, other responsible adults). Recommended content for messaging water safety is included in the report.
- At the local, direct service level, a more individualized approach can be taken to provide solid messaging. Examples follow:
    - Information provided by obstetricians, pediatricians, family physicians and physician extenders
    - Review and discussion of such information by Healthy Start Care Coordinators and Healthy Families Florida's Family Support Workers
    - Brochures and pamphlets distributed at day care facilities and schools
    - Information provided at state parks, recreational areas, and other public-based bodies of water
- At the state or community level, officials should consider child safety when creating laws, rules, policies and procedures that could involve the potentially high-risk situations that place children in close proximity with bodies of water. The establishment of Water Safety Councils, especially in those areas most prone to water-based fatalities, could assist in the shaping of such law and policy.

ASPHYXIA

- Target safe sleep practice messaging to parents and caregivers who interact with children on a daily basis and are most likely responsible for their sleep environment. Focus on those populations that are high-risk.
- Staff providing services to high-risk populations should be well-trained in safe sleep practices.
- Messaging for safe sleep practices should consider and respect cultural beliefs and norms while still conveying best practice information. State agencies must work together to provide uniform and consistent messaging for water safety practices.
- Programs serving new or at-risk parents, such as Healthy Families Florida, Healthy Start and Women, Infant, and Children (WIC), play a key role in this effort. These programs should be supported and leveraged to the greatest extent possible.
- Obstetricians, pediatricians, family physicians and physician extenders should provide information on safe sleep practices to families served.

- At the population level, monitor the child products industry to maintain awareness of new products or devices that are marketed to target populations. Research safety on these products and inform the public accordingly.

TRAUMA/WOUNDS CAUSED BY A WEAPON

- At the state and community levels, focus on prevention programming and activities that build parental capacity by bolstering research-based protective factors, which have been linked to reduced rates of child abuse and neglect. State agencies must work together to infuse and reinforce research-based protective factors within their programs and systems.
- The majority of this prevention messaging should be targeted toward changing behaviors related to corporal punishment practices and other potential precursors to physical abuse.
- Educate parents on child development, specifically brain development and how physical and/or emotional trauma can derail cognitive and emotional development, leading to lifelong adverse consequences for children across their lifespan.
- Provide parents with instruction on evidence-based positive discipline parenting practices that reinforce appropriate behavior through a process of teaching as opposed to punishing.

MOTIVATING BEHAVIORAL CHANGE ACROSS ALL CATEGORIES

- Provide training on evidence-based Motivational Interviewing (MI) practices to direct-service staff working with high-risk target populations.
- Include front-line supervisors in training to develop coaching skills necessary to reinforce staff's emerging MI skills.

IMPROVEMENTS IN DATA AND PROCESSES

- Discuss and identify expansion of potential data sources for data elements that would allow the committee to "drill down" and more fully research identified risk factors. Develop and implement a plan to increase analytic capacity.
- Develop a dictionary of data terms for all committee members to refer to during data entry to provide clarity, consistency in reporting, and more accurate data collection.

Additional content within this 2015 Annual Report provides background information about Florida's child death review system and also includes specific information regarding the method and processes used for data collection. Detailed statistical analyses on various categories of data elements collected from case reviews are fully explored. Analyses delve deeply into factors associated with maltreatment, including child characteristics, perpetrator characteristics, family risk factors, and other established data sets. The state committee also outlines future plans for data analyses, as we continue to strive toward our ultimate goal:

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

SECTION ONE: BACKGROUND

PROGRAM DESCRIPTION

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

STATUTORY AUTHORITY

Section 383.402, Florida Statutes, authorizes the State and Local Child Abuse Death Review Committees and mandates guidelines for membership and duties. The state committee was initially authorized to review only verified child abuse deaths with at least one prior report to the Central Abuse Hotline. After several years, it was determined that the requirement for a prior report limited the committee's ability to review infant deaths, and in 2004 reviews were expanded to include all verified child abuse or neglect deaths. The legislature expanded the reviews even further in 2014, and currently the local and state committees review all child deaths reported to the Central Abuse Hotline. This is the first year that the state committee is reporting on the reviews of child deaths not verified as due to abuse or neglect in addition to child deaths that were verified as abuse or neglect. This will be a baseline year of data for the non-verified cases. Section 383.402, Florida Statutes, is referenced in Appendix A.

PROGRAM PURPOSE

The purpose of the child abuse death review 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 COMMITTEE

Membership of the State Committee

The State Child Abuse Death Review Committee consists of seven agency representatives and twelve appointments from various disciplines related to the health and welfare of children and families. Members of the State Child Abuse Death Review Committee are appointed by the State Surgeon General for staggered two (2) year terms. All members are eligible for reappointment not to exceed three consecutive terms. The representative of DOH serves as the state committee coordinator.

In addition to DOH, the State Child Abuse Death Review 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
- 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 agencies listed above; and for ensuring that the committee represents to the greatest possible extent, the regional, gender, and racial/ethnic diversity of the state.

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

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

State Committee's Activities

Following recent statutory changes, the state committee amended the criteria for reviews at both the state and local levels. During this transition year, the committee:

- Revised the State and Local Committee Guidelines: See Appendix C and D for the current Guidelines for the State and Local Committees
- Completed training initiatives and developed partnerships to offer web-based training
- Created the Local Committee Liaison and Annual Report Ad Hoc Committees
- Annotated and provided training on the National Center for the Review & Prevention of Child Deaths Case Report Form: See Appendix E
- Held a statewide meeting for state committee members and local committee chairpersons: See meeting summary in Appendix F

LOCAL CHILD ABUSE DEATH REVIEW COMMITTEES

Local committees have the primary responsibility for reviewing all child abuse and neglect deaths reported to the child abuse hotline and for presenting information relevant to these deaths to the State Child Abuse Death Review Committee through the completion of the Case Report Form.

Local committees comprise individuals from agencies within the community who share an interest in promoting, protecting, and improving the health and welfare of children.

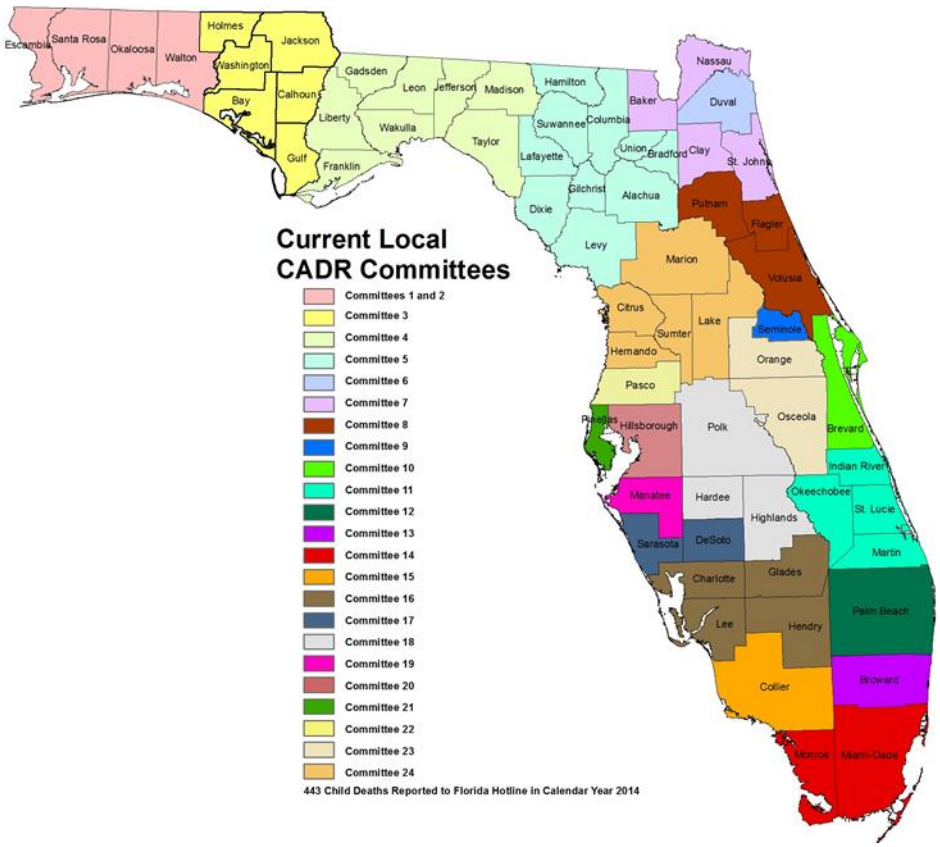
Membership of Local Committees

A county or multicounty child abuse death review committee shall be convened and supported by the county health departments. At a minimum, representatives from the following organizations are appointed by the county health officers.

- The state attorney's office
- The medical examiner's office
- The local Department of Children and Families child protective investigations unit
- DOH child protection team
- The community-based care lead agency
- State, county, or local law enforcement agencies
- The school district
- A mental health treatment provider
- A certified domestic violence center
- A substance abuse treatment provider

Any other members that are determined by guidelines developed by the State Child Abuse Death Review Committee

Map of Local Committees



Case Review Statistics

Case data analyzed for this report includes all information on cases reviewed and data entered into the National Center for the Review & Prevention of Child Deaths database by October 26, 2015. Table 1 details the distribution of 2014 child fatality cases reviewed (stratified by maltreatment verification status), those awaiting review, and those not yet available for review for each local CADR committee.

Table 1: Child Fatality Cases Reviewed and Case Review Status Across Local CADR Committees

Committee Number	Review Completed	Closed Investigation (case available for review)	Open/Closed Investigation (case not avail.)	Verified Maltreatment Cases Reviewed	Non-Verified Maltreatment Cases Reviewed
1 & 2	12	12	4	3	9
3	6	6	2	1	5
4	10	10	0	1	9
5	13	13	0	7	6
6	29	29	0	4	25
7	16	16	0	2	14
8	19	19	0	3	16
9	12	12	0	3	9
10	14	14	1	2	12
11	8	8	1	4	4
12	33	33	1	15	18
13	39	40	2	22	18
14	25	31	6	6	25
15	4	4	0	1	3
16	3	6	5	2	4
17	6	6	0	2	4
18	24	24	1	5	19
19	7	7	0	0	7
20	35	35	0	10	25
21	20	20	1	2	18
22	7	7	0	0	7
23	30	30	2	1	29
24	31	33	2	7	26
Totals	403	415	28	103	312

Summary Points:

- 443 child fatalities for 2014 were called into the child abuse hotline (Data as of 10/26/15)
  - 415 of these cases were closed by the Florida Department of Children and Families (DCF)
  - 28 cases were still open or recently closed for which case information was in the process of being assembled and processed for review by local CADR committee
- Of the 415 closed cases for which the information was available for review, 403 had local CADR Committee reviews completed, with the remainder of cases (n=12) scheduled for review after October 26, 2015. Please note that this report applies to the 403 cases that local CADR committees completed. Findings are qualified by this fact.

SECTION TWO: METHOD

CASE FILE TRANSFER AND REVIEW PROCESS

During this transition year, some local committees received cases directly from the DCF Regional Child Fatality Prevention Specialists, while other local committees requested cases from DOH central office staff. A uniform method of case transfers was developed and implemented to provide cases to the local committees.

LOCAL COMMITTEE REVIEWS AND REPORTING PROCESS

For information detailing local CADR committee operating procedures, please see the *Guidelines for Local Committees* denoted in Appendix D. These local guidelines recommend best practices for conducting effective child fatality reviews and highlight the duties and responsibilities of the local CADR committee and its members. The State CADR Committee has identified core data to be collected for each case, and has requested that all case narratives include the following:

- Interpretive summary
- What does the committee think happened? (brief case summary)
- Lessons learned
- Did the family have prevention services in the past?
- Was communication between intra-agencies sufficient?
- Any training issues identified?

Ideally, committee members reach consensus on the findings from the review and the wording of the final narrative. If consensus is not reached, it should be noted in the narrative summary. Once the review is completed, information and findings from the review are entered into the Child Death Review Case Reporting System.

SECTION THREE: DATA

It is important for the reader to understand how abuse investigation findings are classified. At the time of the local committee reviews of year 2014 cases, DCF's operating procedures (Child Maltreatment Index) classified the findings from investigations as follows:

(1) 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.

(2) 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.

(3) NO INDICATORS. This finding is used when there is no credible evidence to support the allegations of abuse, abandonment, or neglect.

Core data elements of case reviews are summarized in this report by child maltreatment verification status. Since all cases were referred to the child abuse hotline for investigation, all tabled data refers to cases as a "verified child maltreatment" death or a "non-verified child maltreatment" death. A non-verified child maltreatment death can mean there were no findings

of abuse and/or neglect or that there was not enough information to determine that the child's death was a result of abuse or neglect.

The statewide committee also recommended that statewide summary data include:

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

CHILD DEATH TRENDS

In 2014, the all-cause death rate for children aged 0-17 was 51.8 deaths per 100,000 child population (Florida CHARTS, 2015). The 2014 verified child maltreatment death rate was 2.6 per 100,000 child population, which represented 4.8% of Florida resident child deaths in 2014. Table 2 shows the number and rates of all-cause and verified child maltreatment deaths among children in Florida from 2011-2014.

Table 2: Child Deaths: All Causes and Maltreatments Florida, 2011-2014

	Child Deaths All Causes	Child Death Rate per 100,000 Child Population	Verified Child Maltreatment Deaths	Child Maltreatment Death Rate per 10,000 Child Population
2011	2,191	55	136	3.4
2012	2,046	51	127	3.2
2013	2,105	51,8	107	2.6
2014	2,131	52	103	2.5

CHILD DEATH INCIDENT INFORMATION

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

Table 3 denotes the official manner of death obtained from death certificates for all child fatalities reviewed for this report. Of the 103 child fatalities verified to be the result of abuse and/or neglect, a total of 56 (54.4%) and 35 (33.9%) were classified as accidents and homicides (respectively). Among non-verified child maltreatment fatalities the largest number of deaths (n=151 or 50.3%) were classified as accidents followed by natural causes (n=63 or 21%).

Table 3: Official Manner of Death (from death certificate) by Maltreatment Verification Status		
	Child Maltreatment Death	
Official Manner of Death	Verified n=103	Non-Verified n=300
Natural	3	63
Accident	56	151
Suicide	0	8
Homicide	35	17
Undetermined	9	60
Pending	0	0
Unknown	0	1

Table 4 identifies three specific primary causes of death for maltreatment cases that account for 73.8% of known verified child maltreatment fatalities: deaths by trauma/wounds caused by a weapon (29.3%), asphyxia (25.3%), and drowning (19.2%). These are the primary cause of death categories throughout this report.

Table 4: Itemization of Specific Cause of Death for External Injuries by Child Maltreatment Verification Status		
	Child Maltreatment Death	
Specific External Injury Cause of Death	Verified n=95	Non-Verified n=187
Weapons	29	15
Asphyxia	25	66
Sleep-related	18	52
Not sleep-related	7	14
Drowning	19	47
Motor Vehicle	6	15
Poisoning, Overdose, Intoxication	4	3
Animal Bite/Attack	3	1
Fire, Burn, Electrocution	2	6
Exposure	2	0
Undetermined	2	13
Other	2	15
Fall/Crush	1	5
Asthma	0	1
Unknown	0	0

Table 5: Itemization of Specific Medical Cause of Death by Child Maltreatment Verification Status		
	Child Maltreatment Death	
Specific Medical Cause of Death	Verified n=4	Non-Verified n=58
Cancer	0	0
Cardiovascular	0	7
Congenital Anomaly	1	4
HIV/AIDS	0	0
Influenza	0	1
Low Birth Weight	0	0
Malnutrition/ Dehydration	0	0
Neurological/Seizure Disorder	0	1
Pneumonia	0	13
Prematurity	1	3
SIDS	0	2
Other Infection	0	10
Other Perinatal	0	0
Other Medical	2	13
Undetermined	0	0
Unknown	0	2

Table 5 displays counts of deaths resulting from medical causes. There were four verified maltreatment deaths due to medical neglect.

Location of Child Deaths

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

- 68.2% of all drownings occurred in seven counties: Broward, Orange, Palm Beach, Polk, Hillsborough, Lake and Volusia
- 52.7% of all asphyxia deaths occurred in six counties: Broward, Hillsborough, Miami-Dade, Palm Beach, Hernando and Polk
- 34% of weapons deaths occurred in three counties: Gilchrist, Hillsborough and Palm Beach

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

Drowning Death Incident Information

For drowning deaths, local committees collect information on the details associated with the deaths. Tables 6 and 7 identify details of the location of drowning deaths and barriers in place.

Table 6: Drowning Location by Child Maltreatment Verification Status

	Child Maltreatment Death	
	Drowning n=66	
Drowning Location	Verified (n=19)	Non-Verified (n=47)
Open Water	1	12
Pool/Hot Tub/Spa	16	30
Bathtub	0	3
Bucket	0	0
Well/Cistern/Septic	0	1
Toilet	2	1
Other	0	0

Table 7: Barriers in Place Where Drowning Took Place by Child Maltreatment Verification Status (Duplicate Counts if Multiple Barriers)

	Child Maltreatment Death	
	Drowning n=66	
Barriers in Place	Verified (n=26)	Non-Verified (n=52)
None	4	9
Fence	7	12
Gate	4	5
Door	9	16
Alarm	0	0
Cover	0	0
Unknown	2	10

Among the 19 verified maltreatment drowning deaths:

- All 19 did not know how to swim
- 16 occurred in pools, hot tubs, or spas
- 4 drowning cases had no barriers (alarms, gates, etc.) to bodies of water

Among non-verified maltreatment drowning deaths:

- 30 occurred in pools, hot tubs, or spas
- 12 cases occurred in open water
- 9 cases had no barriers (alarms, gates, etc.) to bodies of water

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

Asphyxia Death Incident Information

Asphyxia is the deprivation of oxygen that can be due to suffocation or strangulation. Among year 2014 CADR cases, there were 91 deaths due to asphyxia. It is important to note that the

cause of a sleep-related death may not be able to be determined after investigation and, therefore, may be classified as Sudden Infant Death Syndrome (SIDS) or death from an unknown/undetermined cause.

When available, local CADR committees collect information on risk and protective factors that pertain to sleep-related deaths. For asphyxia deaths that were sleep-related, Tables 8 and 9 provide overviews of some important factors of safe sleep placement and environments among reviewed cases.

Table 8 provides information related to sleep placement position **among cases that were classified as sleep-related asphyxia deaths**: a child's usual sleep placement position, the sleep position a child was placed in **before** being found to be non-responsive or deceased, and the sleep position a child was in when found non-responsive or deceased. The positions of sleep/sleep placement are: On Back, On Stomach, On Side and Unknown.

Table 8: Sleep Positions Among Sleep-Related Asphyxia Deaths

Position	Verified n=19			Non-Verified n=64		
	Usual n=19	Put to Sleep n=19	Found n=19	Usual n=62	Put to Sleep n=62	Found n=61
On Back	5	4	2	19	25	13
On Stomach	3	7	7	13	22	27
On Side	3	3	2	1	5	8
Unknown	8	5	8	29	10	13

- On Back was the usual placement position for approximately 26% verified and 31% non-verified cases
- On Stomach or On Side was the reported sleep position before the child was found non-responsive or deceased in 53% verified (n=10) and 44% non-verified (n=27) cases
- On Stomach or On Side was the reported position for 47% of verified (9 of 19) and 57% of non-verified (35 of 61) cases when found non-responsive or deceased

CADR case review data indicates that a crib, bassinet or port-a-crib was present in the child's home at time of death for 56% of sleep-related asphyxia cases. However, as shown in Table 9, sleep-related asphyxia deaths occurred in an adult bed for 53% of all reviewed sleep-related asphyxia deaths.

Table 9: Incident Sleep Place for Sleep-Related Asphyxia Deaths

Incident Sleep Place	Verified n=19	Non-Verified n=64	Total n=83
Adult Bed	12 (63%)	32 (50%)	44 (53%)
Couch	3 (16%)	9 (14%)	12 (14%)
Crib	3 (16%)	8 (13%)	11 (13%)
Other	1 (5%)	6 (9%)	7 (8%)
Bassinette	0 (0%)	5 (8%)	5 (6%)
Futon	0 (0%)	0 (0%)	0 (0%)
Playpen	0 (0%)	4 (6%)	4 (5%)
Floor	0 (0%)	0 (0%)	0 (0%)
Total	19 (100%)	64 (100%)	83 (100%)

Case reviews collected information on bed-sharing and objects in the sleep environment. Nine persons (seven adults and two children) were found to have unintentionally obstructed airways of children who died from sleep-related asphyxia. Bedding (i.e., pillows, mattresses, comforters/quilts, sheets/thin blankets) was identified to have blocked a child's airway in 20 sleep-related asphyxia cases. See Appendix G for additional data on this topic.

Weapon Related Death Incident Information

The death review process collects a variety of information related to weapon-related deaths, including information related to the type of weapon, firearms used (if applicable), and the person handling the weapon related to the child fatality. Note that fatalities associated with weapons include a wide range of weapons from firearms to "body parts," indicating **physical abuse**. This intentional bodily infliction of harm is captured in this category and remains a primary concern.

Among the 28 **verified** maltreatment weapon deaths:

- 16 (57.1%) weapons used were firearms. Among these firearm deaths:
    - 13 (81.3%) of the firearms were handguns with the remaining three deaths associated with hunting rifles.
    - The vast majority of the owners (75%) of firearms used were owned by males.
- 9 (32.1%) were "body parts" (indicating physical abuse)
- 2 (7.1%) were sharp instruments

Among the **non-verified** maltreatment weapon deaths:

- 7 weapons used were firearms (46.7%)
- 6 weapons were a person's body part (40.0%)
- 1 weapon was a sharp instrument (6.7%)

For detailed information for this category, see Appendix G.

CHILD CHARACTERISTICS

The following section highlights analyses associated with select child characteristics.

Age of Child

Regardless of verification status, children under age five had the highest risk for all forms of death. As shown in Table 10, the overwhelming majority of children dying from asphyxia regardless of verification status were less than one year old with 88% and 95% of verified and non-verified maltreatment asphyxia deaths, respectively. Although the majority of children who died from a weapon were four years of age or younger (55% for verified and 53% for non-verified maltreatment deaths), 24% of verified and 27% of non-verified weapon deaths occurred with children aged 11-15 years.

Table 10: Age of Children by Maltreatment Verification Status and Primary Cause of Death								
Age	Verified Child Maltreatment Death				Non-Verified Child Maltreatment Death			
	Drowning n=19	Asphyxia n=25	Weapon n=29	Other n=30	Drowning n=47	Asphyxia n=66	Weapon n=15	Other n=172
< 1	5%	88%	3%	40%	2%	95%	13%	65%
1	11%	0%	21%	7%	19%	2%	20%	10%
2	26%	0%	14%	20%	38%	0%	7%	5%
3	21%	0%	10%	3%	6%	0%	13%	5%
4	5%	8%	7%	17%	15%	0%	0%	2%
5	16%	0%	3%	3%	2%	0%	0%	1%
6-10	16%	4%	10%	7%	11%	2%	7%	6%
11-15	0%	0%	24%	0%	2%	2%	27%	3%
16+	0%	0%	7%	3%	4%	0%	13%	2%

Race of Child and Hispanic or Latino Origin

Child death case reviews result in the collection of data on race and ethnicity as they relate to child maltreatment fatalities. As seen in Table 11, the majority of children within the review sample were identified as white or black.[1]

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

- 26% of drowning deaths
- 20% of asphyxia deaths
- 24% of weapon deaths
- 17% of other deaths

Table 11: Race and Ethnicity (Hispanic/Latino Origin) of Children by Primary Cause of Death and Maltreatment Verification Status								
Race	Verified Child Maltreatment Death				Non-Verified Child Maltreatment Death			
	Drowning n=19	Asphyxia n=25	Weapon n=29	Other n=30	Drowning n=47	Asphyxia n=66	Weapon n=15	Other n=172
Black	42%	44%	28%	53%	26%	41%	33%	44%
White	53%	56%	69%	47%	74%	59%	67%	56%
Other	5%	0%	3%	0%	0%	0%	0%	<1%
Hispanic or Latino Origin								
Hispanic or Latino	26%	20%	24%	17%	32%	23%	0%	13%

[1] A test of significance between two independent proportions (Z-Score) was done to determine if the observed proportion of drowning deaths that were white and black children for verified and non-verified maltreatment deaths differed significantly (at $p<.05$). The proportion of drowning deaths that were black (Z-Score=1.32, p=.18) and white (Z=-1.72, p=.09) did not differ significantly between verified and non-verified child maltreatment deaths.

Sex of Child

Males are disproportionately represented among child fatalities across all primary causes of death whether verified or not verified, as shown in Table 12.

Table 12: Sex of Children by Maltreatment Verification Status and Primary Cause of Death

Child Sex	Verified Child Maltreatment Death				Non-Verified Child Maltreatment Death			
	Drowning n=19	Asphyxia n=25	Weapon n=29	Other n=30	Drowning n=47	Asphyxia n=66	Weapon n=15	Other n=172
Female	26%	36%	48%	30%	43%	39%	40%	41%
Male	74%	64%	52%	70%	57%	61%	60%	59%

Type of Residence and New Residence

The overwhelming majority (85.6%) of all children who are the subject of this report (n=403) resided in their parental home. In eight verified and 23 non-verified cases, children lived with relatives. In total, four children resided in licensed foster homes (2 verified, 2 non-verified) and one (non-verified) in a licensed group home. Statewide information on whether the child's residence was a new residence (occupied within the 30 days prior to the incident) was reported on 380 cases for which only 42 (11%) of the residences were considered new residences. Among these 42 cases, 24 were associated with verified maltreatment fatalities.

Is Child From Multiple Birth?

Data on multiple births applies only to those deaths for which the child was under the age of one year. Statewide, only 11 cases, which were non-verified cases, were identified to be from multiple births. It should be noted that this data element was left blank for 190 cases.

Child Problems in School?

Given the age of children, this question was deemed not applicable for 328 children. Among applicable children, 16 were identified as having a school problem which were identified as either academic (n=3), truancy (n=1), suspensions (n=3), and behavioral (n=5).

Disability or Chronic Illness of Child

Statewide, 51 of 403 children were identified as having a disability or chronic illness; 287 children did not, and information on this characteristic was not known or missing for 65 children. Among the 51 children identified to have a disability or chronic illness where the type of disability or illness was classified (n=45), a total of 37, seven, and one had physical, mental, and sensory disabilities or illnesses respectively.

Child's Mental Health

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

- 15 children had received prior mental health services; 5 were verified and 10 were non-verified cases
- Eight children were identified as currently on medications for mental health issues; one of the eight was a verified maltreatment death
- Three children were identified to have been prevented from receiving needed mental health services; one of the three was a verified maltreatment death

Child's History of Substance Abuse

For the majority of child fatalities reviewed (81.1%), questions related to the child's history of substance use and abuse were deemed not applicable. Responses to child substance abuse questions were left blank for 14 cases and identified as unknown for five cases. Among the remaining cases, five cases identified one of the following substances: alcohol, cocaine, marijuana, methamphetamines, opiates, prescription drugs, and over-the-counter drugs.

Child's History as Victim of Child Maltreatment

Information related to the child's history of child maltreatment was known for 321 cases, and unknown or not reported for 82 cases. Among the 321 cases for which information regarding past history as a victim was reported by local committees, 95 children had a known history of child maltreatment. Of these 95 children with a known history of maltreatment, the majority (63 or 66.3%) were classified as non-verified. A total of 32 (33.7% of 95) children known to be a past victim of maltreatment had their deaths classified as a maltreatment death.

Prior to a review of 2014 child fatalities, the statewide and local CADRs have reviewed only those deaths deemed to have been the result of verified child maltreatment. Those cases "not substantiated" and with "no indicators" of abuse have been considered non-verified deaths, and analyses in this report have treated these data as such.

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

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

Among the cases reviewed, there were a total of 47 cases known and reported by the local committees to have been open child protective services cases at the time of the child death. Of these 47 cases, 16 (34%) of these child deaths were classified as verified maltreatment deaths and 31 (66%) were identified as non-verified deaths.

Among cases reviewed, there were a total of 26 cases known and reported by the local committees to have been placed outside the home prior to the death. Of these 26 cases, 11 (42.3%) of these child deaths were classified as verified maltreatment deaths and 15 (57.7%) were identified as non-verified deaths.

Among cases reviewed, there were a total of 46 cases known and reported by the local committees where siblings were placed outside of the home prior to the child's death. Of these 46 cases, 17 (36.9%) of these child deaths were classified as verified maltreatment deaths and 29 (63%) were identified as non-verified deaths.

CAREGIVER, SUPERVISOR, AND PERSON(S) RESPONSIBLE CHARACTERISTICS

During case reviews, information is collected on the child's caregivers, the supervisor of the child at the time of the incident leading to the child's death, and for verified child maltreatment

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

Number of Caregivers Present

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

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

The average age of all caregivers, supervisors, and person(s) responsible across all primary causes of death ranges from a low of 28.3 years (supervisors and all caregivers of non-verified maltreatment asphyxia deaths) to a high of 37.9 years (persons responsible for weapon deaths). See Appendix G for average ages of caregivers, supervisors, and person(s) responsible for child deaths.

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

The majority of caregivers and supervisors of children for drowning and asphyxia cases were females. Males were the majority of the supervisors in non-verified weapon cases, and were the majority of person(s) responsible in verified weapon cases.

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

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

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

For verified child maltreatment cases:

- 42% of caregivers are known to have a substance abuse history
- 40% of supervisors were known to have a substance abuse history
- 46% of person(s) responsible were known to have a substance abuse history

See Appendix G for detailed information related to substance abuse history of all caregivers, supervisors and person(s) responsible.

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

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

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

Located in Appendix G is detailed information on the following:

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

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

Local committees were asked to identify from available sources of information whether caregivers, supervisors, and person(s) responsible for the death of a child were past victims of child maltreatment. For approximately one-third of verified cases reviewed, past history as a victim of child maltreatment was unknown. Therefore, this data may not correctly estimate the true proportion of caregivers, supervisors and person(s) responsible with a history of maltreatment as children.

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

Local committees were asked to identify whether caregivers, supervisors, and person(s) responsible for a child's death have a past history as a perpetrator of child maltreatment. For verified cases, the following had a history as a perpetrator: caregivers (38%), supervisors (37%) and person(s) responsible (45%).

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

When available, local committees collected information about caregivers' history with intimate partner violence 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 they were labeled as victims or perpetrators because of historical information gathered by local teams, see Table 13. National research suggests that exposure to intimate partner violence as a child, particularly for male children, is a risk factor for perpetrating violence on one's family members as an adult. However, many children who grow up in abusive homes will never abuse their family members and are often outspoken in their efforts to prevent such violence. It is recommended that supplemental analyses are conducted in future reports regarding the contextual factors in these cases in order to gain additional insight that will help to prevent such deaths in the future.

Table 13: Past History of Intimate Partner Violence for Person(s) Responsible for Maltreatment Death (by Maltreatment Verification Status and Primary Cause of Death)				
History of Intimate Partner Violence: Person(s) Responsible	Verified Child Maltreatment Death (n=103)			
	Drowning n=19	Asphyxia n=25	Weapon n=29	Other n=30
Yes, as Perpetrator	2%	2%	25%	3%
Yes, as Victim	5%	3%	9%	3%
No	20%	12%	5%	3%
Unknown	6%	5%	27%	3%

The State Child Abuse Death Review Committee intends to collect additional information from local teams for future reports regarding contextual factors when intimate partner violence is present in child death cases.

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

Among caregivers associated with verified maltreatment deaths, 44.1% (78 of 177) had committed a criminal offense in the past. Among those with a criminal history, those with drug offenses were represented from a low of 25% for caregivers associated with verified asphyxia deaths to a high of 50% of those caregivers associated with drowning deaths. 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 deaths caused by weapons (67%), asphyxia deaths (58%), followed by other causes of deaths (41%) and drowning deaths (16%).

SECTION FOUR: FUTURE ANALYTIC PLANS

One overarching objective of epidemiological analyses is to connect findings of the CADR data to inform prevention and interventions for larger general populations which naturally, for our purposes, are children who are neglected and abused. However, analyses and assessments can also greatly inform prevention and interventions for all children who are exposed to child safety risks. There are a variety of ways to conduct epidemiological studies; the following will outline a few of the methods that will be used in forthcoming analytical works.

Currently, data collected for the case reviews is similar to cross sectional surveys where information is gathered that is related to causes of death events and characteristics associated with persons, time, and environments connected with the deceased children. Some temporal (time sequence) and exposure-outcome relationships can explored with Florida CADR data, but the data collected may not provide any or may provide inconsistent information on other events, environments and circumstances that may have also influenced maltreatment outcomes and/or the risks of child death. As has been done within this report, findings of descriptive analyses can be used to contrast and compare with findings of other reputable research about child maltreatment and deaths that result from child maltreatment.

The primary comparisons within this report have been between those child fatalities verified versus not verified to be a result of child maltreatment. Future comparisons can gauge and test factors that have a predictive influence on whether the child fatality is a result of maltreatment or

not. However, the conclusions from such tests relate only to the population of cases referred to the child abuse hotline.

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

The use of case control studies is also warranted for future CADR observational analyses. For the assessment of rare outcomes, case-control studies are deemed to be highly appropriate as these types of studies do not require the time, expense, and/or large number of events that are needed for most cohort analyses.

To inform a public health approach to child maltreatment deaths, connections between maltreatment outcomes and prevention/intervention initiatives, policies, and practices need to be assessed to determine evidence-based pathways that could lead to eliminating child maltreatment deaths. For future analyses of intervention and prevention impacts, studies could assess and compare outcomes of children participating in pilot programs, or when community-wide or statewide population interventions are implemented. Once again, data would be needed to provide the necessary information to make valid assessments on the impact of implemented preventions and interventions on child maltreatment outcomes.

SECTION FIVE: PREVENTION RECOMMENDATIONS

USING DATA TO DRIVE PREVENTION PRACTICES

The collection and subsequent analysis of child fatality data provides a solid foundation for targeting and implementing prevention strategies at state and local levels. Both qualitative and quantitative data assist in the identification of those categories of child deaths which are most paramount:

- Drowning
- Asphyxiation
- Trauma/Wounds Caused by a Weapon (including physical abuse)

The analysis of both verified and non-verified data sets allows Florida to utilize resources to target these issues in the most effective way possible, leading to a greater impact on the prevention of child maltreatment fatalities as a whole. Data sources for this year's report included case review data, narrative case summaries, and input from state and local committee members. The top three primary causes of child fatalities, as defined by all data sources, provide a meaningful framework for prevention recommendations.

DROWNING PREVENTION

As consistent with data from previous years, drowning continues to be a primary cause of preventable death among children in Florida. This issue has been highlighted in numerous previous reports and various recommendations have been made, many of which have been implemented at state and local levels. Widespread awareness campaigns, such as ***Waterproof FL***, continue to advocate for such measures as alarms for doors and pools as well as the designation of "water watchers." State agency collaboration on awareness campaigns is needed to provide a uniform and consistent message, as well as to disseminate information and resources to consumers and stakeholders. Still, access to bodies of water continues to be a potential threat to our most vulnerable citizens.

Consideration of quantitative data collected through the national database, coupled with qualitative data gathered from narrative summaries and committee members, provides insight into targeting the message, to whom the message should be sent, how the message should be shaped, and the best venues for delivery of drowning prevention messaging.

Targeting the Message: Audience

Public education awareness campaigns continue to be a primary strategy to prevent water-based tragedies. Educational activities should target those responsible for providing supervision to children during water play or other activities that bring children in close proximity to bodies of water (i.e., ponds, lakes, pools, tubs, toilets and even buckets of water.) Therefore, targeted messaging would be directed at audience populations such as parents, guardians, day care workers, and other caregivers responsible for supervising children near water.

Additional targeted audiences for drowning prevention messaging may include health care providers, first responders, school personnel and recreational providers. While the majority of drowning deaths occur in younger children, age-appropriate water safety should be taught directly to children of all ages, as even highly skilled swimmers can drown in dangerous water conditions.

Ideally, the need for vigilance would extend to all adults exposed to the combination of children and water, from those who occasionally visit the beach, to others living near holding ponds and rivers. While the message will provide the greatest impact when targeted to parents and caregivers, educating the general public as a whole would expand protective capacity to a population-based level and help ensure the ongoing safety of all children in Florida.

Crafting the Message: Content

An equally important consideration is content of the message. Several prevention strategies can easily be implemented at the individual parent/caregiver level, including the following:

- Establish as many barriers as possible between toddlers and young children and a backyard pool or spa. This may include patios, doors, fences, and gates.
- Use door and pool alarms, testing frequently to ensure proper functioning. Resist the temptation to disable alarms to avoid unintentional activation. Rather, take note of how often these "barriers" are breached and by whom.
- Maintain supervisory vigilance, even during seemingly low risk activities such as bathing or water play near shallow pools.

- Designate a “water-watcher” whose singular role is to provide constant observation of children in the water throughout each swimming event. This role should be transferred when necessary and should be assigned to a sober, responsible adult who agrees to avoid all other activity, such as using their phone, reading, or other distracting activities.
- Provide swimming lessons to children when developmentally appropriate; but keep in mind that swimming lessons and/or swimming ability is not a suitable replacement for supervision. An additional population-based strategy would be the offering of free or subsidized swimming lessons to children.
- Select child supervisors with utmost care; choose someone with water safety knowledge who understands child development and recognizes that a child’s curiosity, impulsivity, and limit-testing may be evident from birth throughout the teenage years.

Delivering the Message: Venue

While public awareness campaigns rely primarily on marketing intended to reach large groups of people (advertisements, bulletin boards, etc.), a more strategic approach can be taken by finding the points at which the path of our target populations intersect with entities or organizations that can provide solid messaging. Examples follow:

- Information provided by obstetricians and pediatricians
- Review and discussion of such information by Healthy Start Care Coordinators and Healthy Families Florida’s Family Support Workers
- Brochures and pamphlets distributed at day care facilities and schools
- Information provided at state parks, recreational areas, and other public-based bodies of water

Changes at the Population Level

When possible, state, county, and city officials should consider child safety when developing laws and policies involving the public’s exposure to bodies of water. The establishment of Water Safety Councils could assist in the shaping of such laws and policies. The Florida Child Abuse Prevention and Permanency Plan’s Circuit Taskforce members would be valuable partners in prevention efforts. An additional population-based strategy would be the offering of free or subsidized swimming lessons to children.

ASPHYXIA

Asphyxia, as coded on the Case Review Form, includes strangulation, suffocation, and other categories. One of the primary risks of asphyxia is unsafe sleep practices. The use of overly soft bedding, using too many blankets or other items in the crib, putting the baby to sleep on their stomach, and bed-sharing have contributed to a significant number of child deaths that may have been prevented by following safe sleep practices.

Confronting this issue does not come without its challenges. Asphyxia can be difficult to determine as the official cause of death, as data regarding surrounding circumstances of the death incident is more difficult to detect and gather. The nuances of cultural influences and potentially conflicting messages provided to parents by medical personnel increase the complexity of the issue. These contributing factors prompt additional questions about the beliefs and knowledge level of the caregiver responsible for the child during the fatal incident.

Targeting the Message: Audience

By targeting safe sleep messaging to parents and caregivers, we provide crucial information to those who interact directly with children on a regular basis and are most likely responsible for choosing and maintaining sleep environments. Another target audience for safe sleep messaging is daycare providers who have responsibility for children during naps and rest.

Conveying this information to certain populations of medical providers, particularly information about the risks of bed-sharing, has proven to be challenging in some cases. While data related to bed-sharing deaths has consistently identified significant risk, some medical and health care providers continue to advocate bed-sharing in an effort to encourage breastfeeding and bonding. Even well-intentioned relatives (i.e., grandmothers, aunts) may unduly encourage young parents to engage in unsafe sleep practices with infants and small children, while emphasizing they followed such practices with no negative outcomes.

Crafting the Safe Sleep Message

Data can be used to send a powerful message that highlights the risks inherent in unsafe sleep practices. Safe sleep practices should be presented as methods that have been highly researched, well-established, and unquestionably proven to reduce the risk of sleep-related fatalities. Note that Florida's state agencies should work together and with other influential stakeholders to provide uniform and consistent messaging.

The research and resulting data are clear on those factors that may contribute to sleep-related fatalities, as well as practices that promote positive outcomes, and the following can be confidently recommended when educating parents and caregivers:

- Use tight-fitting sheets and keep the sleeping area clear of objects. Avoid loose-fitting sheets, the overuse of blankets/bedding, decorative "bumpers," overly warm and/or large pajamas, and stuffed toys in the crib. These objects may pose a hazard to the baby during sleep.
- Put the baby to sleep on his or her back. Many parents observe babies sleep better when laying on their stomachs; however, the risk of compromised oxygen intake increases when sleeping in this position. Many new parents express concern that placing the baby on his or her back will cause the baby to aspirate if they vomit; these parents should be advised that the physiology of an infant's throat and tongue is such that any aspiration as a result of vomiting is highly unlikely.
- Ensure the baby's sleep area has a firm foundation. Do not put the baby to sleep on pillows, sofas, large cushions, or any foundation that is overly soft or may result in a fall. Soft surfaces can interfere with breathing as the baby rolls and re-positions during sleep.
- Do not share sleeping space with a baby. While breastfeeding/feeding and bonding are certainly good parenting practices, these should be conducted while the parent or caregiver is awake and aware. After rocking or breastfeeding, put the baby in his own bed *before* you fall asleep. The baby may fall asleep against a sleeping parent and become wedged in such a way that interferes with breathing.

- Reframe message to empower parents: Put the baby to sleep on his back, in temperature-appropriate attire, alone in a crib or other safe sleep space, use a well-fitted sheet and place no other objects in the baby's sleep space.

Delivering the Message: Venue

Messaging in any prevention campaign must be culturally sensitive, consistent, and realistic. To increase the receptivity of a well-delivered message, timing and circumstance must also be considered. Timing for safe sleep initiatives involves providing the information to expecting parents who will soon have an opportunity to put their newfound knowledge to good use.

Birthing hospitals and nurseries, OB/GYN offices, breastfeeding groups, and birthing classes are all ideal venues. Educating all families, particularly those considered high-risk (lacking in protective factors), bolsters the parent's knowledge of child safety and appropriate parenting practices. Home visiting programs such as Healthy Families Florida and Healthy Start are especially adept at providing this information to high-risk parents to increase their protective capacity. These programs also connect families to local and community-based organizations that may be able to provide concrete resources such as cribs or pack-n-plays to reinforce safe sleep practices. An additional strategy may involve partnering with faith-based organizations who engage target populations, as well as Circuit Taskforce members who are a part of the Florida Child Abuse Prevention and Permanency Plan.

Changes at the Population Level

As safe sleep research continues to solidify, gradual shifts are slowly taking place within industries that market products to parents. However, challenges still exist. Many infant products, including decorative bedding for cribs, continue to be marketed as highly luxurious and decorative, while posing significant risks to infants. Positioning and "protective" devices are often marketed without sufficient safety studies. State and federal regulations can provide minimal requirements, but these can be difficult to enforce. Thus, a combination of widespread awareness and targeted education continue to be our most effective means of informing the general public on this issue.

WEAPONS

Note that fatalities resulting from trauma/wounds caused by weapons include a wide range of weapons from firearms to "body parts;" therefore, preventing incidents within this category can be addressed in many ways depending on the nature of the incident. Physical abuse, the intentional infliction of bodily harm, continues to be a primary concern in this category.

Over the past ten years, extensive research on early brain development has provided a great deal of information regarding how adverse childhood experiences, including physical abuse, impacts brain functioning. Chronic exposure to this form of toxic stress has been shown to derail healthy development and can have lifelong effects on learning, behavior, and physical health.

Preventing physical abuse poses many challenges. This form of maltreatment may be associated with a number of contributing factors such as parental mental health status, substance abuse, and/or domestic violence in the home. Overzealous attempts to control one's child may result from a lack of knowledge about child development coupled with unrealistic expectations related to the child's behavior. Physical abuse can be cyclical from one generation

to the next, as parents or caregivers rely on tactics that their parents used to punish children for problem behavior.

Given the widespread scope of contributing factors, prevention must be geared toward resolving risk factors related to the abusive behaviors while "building in" or restoring any missing protective factors. The following sets of research-based protective factors are linked to a lower incidence of child abuse and neglect:

- Nurturing and attachment
- Knowledge of parenting and of child and youth development
- Parental resilience
- Social connections
- Concrete supports for parents
- Social and emotional competence of children

    - *Administration for Children & Families, U.S. Department of Health & Human Services*

Note that protective factors can be "built in" to at-risk families before abuse occurs. Child maltreatment prevention programs (such as Healthy Families Florida) work with families to enhance these protective factors and reduce risk. Additionally, state agencies can work together to infuse and reinforce protective factors within their programs and systems.

In summary, prevention strategies at both the state and local levels should be aimed at increasing protective capacities while addressing those factors that put families at risk. Parents and caregivers should be educated about the importance of nurturing and attachment as it relates to brain development. Increasing a parent's knowledge of child development will result in a parent who has more realistic expectations about their child's behavior. Encouraging the establishment of social connections and directing parents to appropriate resources also bolster protective capacity, thereby reducing the risk of child maltreatment.

The majority of all weapons deaths were by firearms. Given such, it is recommended that additional analyses on cases involving gun-related deaths is needed in the future to examine the correlates of these deaths with substance abuse, mental health, and intimate partner violence issues prior to developing targeted prevention strategies.

MOTIVATING BEHAVIORAL CHANGE ACROSS ALL CATEGORIES

Crafting and sending the right message, to the right audiences, at the right time and place is only a portion of the effort required to prevent child maltreatment fatalities. The most significant and difficult challenge faced in prevention initiatives involves the eliciting of motivation to change problematic behaviors in high-risk situations. We can provide excellent guidance and expert advice, but if the individual receiving this messaging is not motivated or does not want to change their approach, the message itself has little impact. Simple awareness is not enough.

Individuals learning new information on safe sleep practices or positive discipline techniques may have difficulty incorporating these types of changes into existing parenting practices. These changes require consistent effort and can prove to be difficult, as long-held beliefs and attitudes towards certain topics may result in resistance to new information. Our challenge is to assist in the behavioral change process.

Motivational Interviewing (MI) is an evidence-based, thoroughly researched skillset that involves the eliciting and reinforcement of a person's motivation toward behavioral change. It is a style of communication that can help gradually reshape unhealthy belief systems and inflexible attitudes that may prevent parents from making the necessary changes in approach to keep their kids safe. The use of MI techniques does not require a degree or certification. With appropriately structured training and some follow-up coaching, helping professionals, from paraprofessionals to medical doctors, can learn and integrate these skills into their day-to-day work with families.

Given the significant challenges faced by those working with families at the direct service level, and the evidence-based nature of this particular skillset, training in MI could be considered for those staff who work directly with our targeted high-risk populations. To ensure effective results, this training may also be explored for front-line supervisors, to equip them with the coaching skills needed to follow-up with staff as MI skills are integrated into day-to-day practice.

INCREASING CAPACITY FOR DATA-DRIVEN DECISION MAKING

Recommendations would not be complete without acknowledging the need to fill gaps in data that left us with unanswered questions. The compilation of case reviews, both verified and non-verified, have provided substantial insight into our most significant challenges, while suggesting a number of potential data points that could help us better understand our three biggest threats, drowning, asphyxia (unsafe sleep), and trauma/wounds caused by weapons (physical abuse). In addition to current data elements, the state committee will discuss and consider adjusting data collection requirements to allow for future analysis on the following:

- **Safe sleep** – How can we expand our data collection for this important issue? What data elements can we develop and implement to provide sufficient insight? How can we better assess belief systems, knowledge, and attitudes surrounding safe sleep practices?
- **Contextual factors surrounding substance abuse, mental health, and Intimate Partner Violence** (IPV) – What specifically can we learn about any existing correlations to death incidents? In what ways can we cross-reference data on these topics to further inform prevention? How can we tailor our efforts to provide best practice solutions to those who struggle with these issues?
- **Information regarding relationship/marital status and head of household status** – Due to overrepresentation of female headed households with children among these deaths, as well as the disproportionate number of IPV victims that are female, a bias may exist in the data towards victims as caregivers associated with the child deaths represented in this report. *(United States Department of Justice, http://www.bjs.gov/content/pub/pdf/fvv.pdf)*
- **Complications of substance use –** How can we better assess poly-substance use? What can we learn about the impact of co-occurring disorders on child maltreatment?
- **Services provided to families** – Were services appropriate? Were families assessed well enough to be referred to the appropriate service providers? For example, the need for substance abuse versus mental health services, the referral of IPV survivors to Domestic Violence shelters, etc.

Drilling down into these topics will help us find answers to these questions and will bolster our ability to develop more effective prevention strategies.

Finally, the state committee also recommends the development of definitions for data terms used within the case review process. An established set of data-related definitions will:

- Provide clarity to local teams regarding each data element
- Ensure consistency in reporting
- Result in more accurate, meaningful data

SECTION SIX: CONCLUSIONS AND NEXT STEPS

In summary, prevention strategies at state and local levels should be aimed at issues clearly identified as our chief concerns: Drowning, Asphyxia (Unsafe Sleep), and Trauma/Wounds Caused by Weapons (primarily physical abuse).

To ensure successful outcomes we must strive to utilize evidence-based prevention programs and practices. Strategies should be aimed at increasing protective capacities (building in protective factors) while addressing those factors that put families at risk for poor outcomes.

Building in protective factors can be accomplished by:

- Infusing protective factors within state agency programs and systems
- Educating parents about the importance of nurturing and attachment as it relates to brain development
- Increasing parents' knowledge of child development to encourage realistic expectations about their child's behavior
- Encouraging the establishment of social connections for families
- Increasing each child's visibility within the community
- Directing parents to appropriate resources when concrete supports are needed
- Intervening early when there is any indication of problematic development

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

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

APPENDICES

ANNUAL REPORT

DECEMBER 2015

Child Abuse Death Review Committee

Working to eliminate preventable child abuse and neglect deaths in Florida

APPENDIX A:

Section 383.402, Florida Statutes

Section 383.402, Florida Statutes

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

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

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

(2) STATE CHILD ABUSE DEATH REVIEW COMMITTEE.—

(a) Membership.—

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

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

2. In addition, the State Surgeon General shall appoint the following members to the state committee, based on recommendations from the Department of Health and the agencies

listed in subparagraph 1., and ensuring that the committee represents the regional, gender, and ethnic diversity of the state to the greatest extent possible:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

To the extent possible, individuals from these organizations or entities who, in a professional capacity, dealt with a child whose death is verified as caused by abuse or neglect, or with the family of the child, shall attend any meetings where the child's case is reviewed. The members of a local committee shall be appointed to 2-year terms and may be reappointed. Members shall

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

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

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

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

a. Nonidentifying information from individual cases.

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

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

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

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

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

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

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

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

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

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

(5) ACCESS TO AND USE OF RECORDS.—

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

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

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

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

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

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

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

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

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

member, or other person who furnishes information, data, reports, or records to the state committee or a local committee is not liable for damages to any person and is not subject to any other civil, criminal, or administrative recourse. This [1]paragraph does not apply to any person who admits to committing a crime.

(6) DEPARTMENT OF HEALTH RESPONSIBILITIES.—

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

APPENDIX B:

State and Local Committee Membership

Florida Child Abuse Death Review State Committee Membership

Social Worker
Robin Perry, Ph.D., Chairperson

Department of Health
Patricia Ryder, MD, MPH

Department of Legal Affairs
Stephanie Bergen

Department of Children and Families
Jane E. Johnson

Department of Law Enforcement
Seth Montgomery

Department of Education
Trevis Killen
Iris Williams

Florida Prosecuting Attorneys Association
Thomas Bakkedahl

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

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

Public Health Nurse
Deborah Hogan, RN, MPH

Mental Health Professional
April Lott, LCSW

Department of Children and Families Supervisor
Lisa Mayrose

Medical Director, Child Protection Team
Mark Kesler, M.D.

Child Advocacy Organization
Jennifer Ohlsen, M.Ed.

Paraprofessional in patient resources, child abuse prevention program
Yomika S. McCalpine

Law Enforcement Officer
Captain David M. DeCarlo

Florida Coalition Against Domestic Violence
Ghia C. Kelly, MSW

Child Abuse Prevention Program
Zackary Gibson

Substance Abuse Professional
Linda Mann, LCSW, CAP

Florida Child Abuse Death Review
Local Committee Chairpersons

Committee 1 & 2
Kirsten Bucey

Committee 3
Monique Gorman

Committee 4
Evelyn Goslin, Ph.D.

Committee 5
Stephanie Cox

Committee 6, 7, 8
Vicki Whitfield

Committee 9
Denis Conus

Committee 10
Jeanie Raciti

Committee 11
Michelle Akins

Committee 12
Sharon Greene, MBA, CHES

Committee 13
Barbara Lesh

Committee 14
Lauren Lazarus Sabatino, Esq.

Committee 15
Jackie Stephens, MA

Committee 16
Francie Donnorummo

Committee 17
Laura McIntyre, M.A.

Committee 18
Dr. Stephen Nelson

Committee 19
Major Connie Shingledecker

Committee 20
Vacant - Chairperson

Committee 21
Karen Yatchum

Committee 22
Jon Wisenbaker

Committee 23
Laly Serraty

Committee 24
Edie Neal

APPENDIX C:

Guidelines for the State Committee

Guidelines for the State Committee

TABLE OF CONTENTS

CHAPTER I 1
PURPOSE OF CHILD ABUSE DEATH REVIEW COMMITTEES 1
1.1 Background and Description 1
1.2 Mission Statement 1
1.3 Operating Principle 1
1.4 Goal 1
1.5 Objectives 1
CHAPTER 2 2
STATE REVIEW COMMITTEE MEMBERSHIP AND DUTIES 2
2.1 Introduction 2
2.2 Statutory Membership 2
2.3 Term of Membership 2
2.4 Consultants 3
2.5 Election of State Chairperson 3
2.6 Reimbursement 3
2.7 Terminating State Committee Membership 3
2.8 State Review Committee Duties 3
CHAPTER 3 6
MAINTAINING AN EFFECTIVE COMMITTEE 6
3.1 Conducting an Effective Meeting 6
3.2 Focus on Prevention 6
CHAPTER 4 7
COMMITTEE OPERATING PROCEDURES 7
4.1 Obtaining Data from Local Committee Reviews 7
4.2 Record Keeping and Retention 7
4.3 Child Abuse Death Review Case Reporting System 7
CHAPTER 5 8
CONFIDENTIALITY AND ACCESS TO INFORMATION 8
5.1 Introduction 8
5.2 Confidentiality Statements 8
5.3 Protecting Family Privacy 9
5.4 Document Storage and Security 9
5.5 Media Relations and Public Records Request 9
CHAPTER 6 10
CHILD ABUSE DEATH REVIEW ANNUAL REPORT 10
6.1 Guidelines for Report 10

CHAPTER I

PURPOSE OF CHILD ABUSE DEATH REVIEW COMMITTEES

1.1 Background and Description

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

1.2 Mission Statement

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

1.3 Operating Principle

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

The state and local review committees shall work cooperatively.

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

1.4 Goal

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

1.5 Objectives

- Develop a system and protocol for uniform collection of child abuse and neglect death data statewide, utilizing existing data-collection systems to the greatest extent possible

- Identify needed changes in legislation, policy and practices, and expand efforts in child health and safety to prevent child abuse and neglect deaths

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

CHAPTER 2

STATE REVIEW COMMITTEE MEMBERSHIP AND DUTIES

2.1 Introduction

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

2.2 Statutory Membership

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

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

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

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

2.3 Term of Membership

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

Agency representatives who leave their agency during their term must notify the agency head, and the DOH Child Abuse Death Review Committee Coordinator. The agency appointment expires upon the effective date of the member's departure from the agency and the State Surgeon General will request that the agency appoint a new member.

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

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

2.4 Consultants

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

2.5 Election of State Chairperson

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

2.6 Reimbursement

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

2.7 Terminating State Committee Membership

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

2.8 State Review Committee Duties

Chairperson

- Chair Committee meetings
- Ensure that the Committee operates according to guidelines and protocols

- Ensure that all new Committee members and ad hoc members sign a confidentiality agreement

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

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

All Committee Members

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

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

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

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

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

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

- Educate the public regarding the incidence and causes of child abuse death, and the ways to prevent such deaths
- Provide continuing education for professionals who investigate, treat and prevent child abuse or neglect
- Recommend, when appropriate, the review of the death certificate of a child who is suspected to have died of abuse or neglect

CHAPTER 3

MAINTAINING AN EFFECTIVE COMMITTEE

3.1 Conducting an Effective Meeting

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

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

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

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

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

3.2 Focus on Prevention

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

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

CHAPTER 4

COMMITTEE OPERATING PROCEDURES

4.1 Obtaining Data from Local Committee Reviews

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

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

4.2 Record Keeping and Retention

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

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

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

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

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

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

4.3 Child Abuse Death Review Case Reporting System

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

CHAPTER 5

CONFIDENTIALITY AND ACCESS TO INFORMATION

5.1 Introduction

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

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

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

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

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

5.2 Confidentiality Statements

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

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

5.3 Protecting Family Privacy

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

5.4 Document Storage and Security

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

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

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

5.5 Media Relations and Public Records Request

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

CHAPTER 6

CHILD ABUSE DEATH REVIEW ANNUAL REPORT

6.1 Guidelines for Report

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

A) Background

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

B) Method

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

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

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

D) Conclusions

E) Prevention Recommendations

F) Summary

APPENDIX D:

Guidelines for Local Committees

Guidelines for Local Committees

July 2015

TABLE OF CONTENTS

CHAPTER I 1

PURPOSE OF CHILD ABUSE DEATH REVIEW COMMITTEES 1

1.1 Background and Description 1
1.2 Mission Statement 1
1.3 Operating Principle 1
1.4 Goal 1
1.5 Objectives 1

CHAPTER 2 2

LOCAL REVIEW COMMITTEE MEMBERSHIP AND DUTIES 2

2.1 Committee Membership 2
2.2 Term of Membership 3
2.3 Consultants 3
2.4 Ad Hoc Members 3
2.5 Local Review Committee Duties 3
2.6 Local Committee Members Responsibilities 3
2.7 Orientation and Training of Local Committee Members 4
2.8 Support and Technical Assistance for Local Committees 4

CHAPTER 3 5

MAINTAINING AN EFFECTIVE COMMITTEE 5

3.1 Conducting an Effective Meeting 5
3.2 Beginning the Meeting 5
3.3 Sharing Information 5
3.4 Community Education and Prevention 5

CHAPTER 4 7

COMMITTEE OPERATING PROCEDURES 7

4.1 Information Sharing 7
4.2 Committee Chairperson 7
4.3 Meeting Attendance 7
4.4 Obtaining Names for Committee Reviews 7
4.5 Record Keeping and Retention 8
4.6 Child Abuse Death Review Case Reporting System 8

CHAPTER 5 9

CONFIDENTIALITY AND ACCESS TO INFORMATION 9

5.1 Introduction 9
5.2 Confidentiality Statements 9
5.3 Protecting Family Privacy 9
5.4 Document Storage and Security 9
5.5 Media Relations and Public Records Request 10

Appendix A 11
Appendix B 15
Appendix C 17
Appendix D 18

CHAPTER I

PURPOSE OF CHILD ABUSE DEATH REVIEW COMMITTEES

1.1 Background and Description

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

1.2 Mission Statement

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

1.3 Operating Principle

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

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

1.4 Goal

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

1.5 Objectives

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

CHAPTER 2

LOCAL REVIEW COMMITTEE MEMBERSHIP AND DUTIES

2.1 Committee Membership

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

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

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

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

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

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

2.2 Term of Membership

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

2.3 Consultants

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

2.4 Ad Hoc Members

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

2.5 Local Review Committee Duties

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

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

2.6 Local Committee Member Responsibilities

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

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

- Explain the legal responsibilities or limitations of his or her profession

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

2.7 Orientation and Training of Local Committee Members

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

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

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

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

2.8 Support and Technical Assistance for Local Committees

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

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

CHAPTER 3

MAINTAINING AN EFFECTIVE COMMITTEE

3.1 Conducting an Effective Meeting

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

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

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

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

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

3.2 Beginning the Meeting

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

3.3 Sharing Information

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

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

3.4 Community Education and Prevention

The state and local Child Abuse Death Review Committees review and analyze information on the nature of child abuse deaths in Florida. The key to good prevention is leadership at the local level. Local committees identify trends in child abuse death statistics for their own communities, and develop and implement community education and prevention plans that are data-driven. Prevention efforts can range from simply changing one agency practice or policy or setting up more complex interventions for high-risk parents.

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

CHAPTER 4

COMMITTEE OPERATING PROCEDURES

4.1 Information Sharing

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

4.2 Committee Chairperson

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

Chairperson duties:

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

4.3 Meeting Attendance

Committee members must recognize the importance of regular attendance as a means of sharing the expertise and knowledge for which they were recruited. Attendance at meetings must be in person to ensure maximum participation in the death review process. For confidentiality reasons, phone conferencing is not acceptable. Local committees should develop a policy to address non-attendance of committee members.

4.4 Obtaining Names for Committee Reviews

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

4.5 Record Keeping and Retention

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

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

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

4.6 Child Abuse Death Review Case Reporting System

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

CHAPTER 5

CONFIDENTIALITY AND ACCESS TO INFORMATION

5.1 Introduction

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

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

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

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

5.2 Confidentiality Statements

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

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

5.3 Protecting Family Privacy

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

5.4 Document Storage and Security

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

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

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

5.5 Media Relations and Public Records Request

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

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

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

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

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

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

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

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

(2) STATE CHILD ABUSE DEATH REVIEW COMMITTEE.—

(a) Membership.—

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

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

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

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

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

2-year term, and the chairperson may appoint ad hoc committees as necessary to carry out the duties of the committee.
4. Members of the state committee shall serve without compensation but may receive reimbursement for per diem and travel expenses incurred in the performance of their duties as provided in s. 112.061 and to the extent that funds are available.
(b) Duties.—The State Child Abuse Death Review Committee shall:
1. Develop a system for collecting data from local committees on deaths that are reported to the central abuse hotline. The system must include a protocol for the uniform collection of data statewide, which must, at a minimum, use the National Child Death Review Case Reporting System administered by the National Center for the Review and Prevention of Child Deaths.
2. Provide training to cooperating agencies, individuals, and local child abuse death review committees on the use of the child abuse death data system.
3. Provide training to local child abuse death review committee members on the dynamics and impact of domestic violence, substance abuse, or mental health disorders when there is a co-occurrence of child abuse. Training must be provided by the Florida Coalition Against Domestic Violence, the Florida Alcohol and Drug Abuse Association, and the Florida Council for Community Mental Health in each entity's respective area of expertise.
4. Develop statewide uniform guidelines, standards, and protocols, including a protocol for standardized data collection and reporting, for local child abuse death review committees and provide training and technical assistance to local committees.
5. Develop statewide uniform guidelines for reviewing deaths that are the result of child abuse, including guidelines to be used by law enforcement agencies, prosecutors, medical examiners, health care practitioners, health care facilities, and social service agencies.
6. Study the adequacy of laws, rules, training, and services to determine what changes are needed to decrease the incidence of child abuse deaths and develop strategies and recruit partners to implement these changes.
7. Provide consultation on individual cases to local committees upon request.
8. Educate the public regarding the provisions of Chapter 99-168, Laws of Florida, the incidence and causes of child abuse death, and ways by which such deaths may be prevented.
9. Promote continuing education for professionals who investigate, treat, and prevent child abuse or neglect.
10. Recommend, when appropriate, the review of the death certificate of a child who died as a result of abuse or neglect.
(3) LOCAL CHILD ABUSE DEATH REVIEW COMMITTEES.—At the direction of the State Surgeon General, a county or multicounty child abuse death review committee shall be convened and supported by the county health department directors in accordance with the protocols established by the State Child Abuse Death Review Committee.
(a) Membership.—The local death review committees shall include, at a minimum, the following organizations' representatives, appointed by the county health department directors in consultation with those organizations:
1. The state attorney's office.
2. The medical examiner's office.
3. The local Department of Children and Families child protective investigations unit.
4. The Department of Health child protection team.
5. The community-based care lead agency.
6. State, county, or local law enforcement agencies.
7. The school district.
8. A mental health treatment provider.
9. A certified domestic violence center.
10. A substance abuse treatment provider.
11. Any other members that are determined by guidelines developed by the State Child Abuse Death Review Committee.

To the extent possible, individuals from these organizations or entities who, in a professional capacity, dealt with a child whose death is verified as caused by abuse or neglect, or with the family of the child, shall attend any meetings where the child's case is reviewed. The members of a local committee shall be appointed to 2-year terms and may be reappointed. Members shall serve without compensation but may

receive reimbursement for per diem and travel expenses incurred in the performance of their duties as provided in s. 112.061 and to the extent that funds are available.

(b) Duties.—Each local child abuse death review committee shall:
1. Assist the state committee in collecting data on deaths that are the result of child abuse, in accordance with the protocol established by the state committee. The local committee shall complete, to the fullest extent possible, the individual case report in the National Child Death Review Case Reporting System.
2. Submit written reports as required by the state committee. The reports must include:
a. Nonidentifying information from individual cases.
b. Identification of any problems with the data system uncovered through the review process and the committee's recommendations for system improvements and needed resources, training, and information dissemination, where gaps or deficiencies may exist.
c. All steps taken by the local committee and private and public agencies to implement necessary changes and improve the coordination of services and reviews.
3. Submit all records requested by the state committee at the conclusion of its review of a death resulting from child abuse.
4. Abide by the standards and protocols developed by the state committee.
5. On a case-by-case basis, request that the state committee review the data of a particular case.
(4) ANNUAL STATISTICAL REPORT.—The state committee shall prepare and submit a comprehensive statistical report by December 1 of each year to the Governor, the President of the Senate, and the Speaker of the House of Representatives which includes data, trends, analysis, findings, and recommendations for state and local action regarding deaths from child abuse. Data must be presented on an individual calendar year basis and in the context of a multiyear trend. At a minimum, the report must include:
(a) Descriptive statistics, including demographic information regarding victims and caregivers, and the causes and nature of deaths.
(b) A detailed statistical analysis of the incidence and causes of deaths.
(c) Specific issues identified within current policy, procedure, rule, or statute and recommendations to address those issues from both the state and local committees.
(d) Other recommendations to prevent deaths from child abuse based on an analysis of the data presented in the report.
(5) ACCESS TO AND USE OF RECORDS.—
(a) Notwithstanding any other law, the chairperson of the State Child Abuse Death Review Committee, or the chairperson of a local committee, shall be provided with access to any information or records that pertain to a child whose death is being reviewed by the committee and that are necessary for the committee to carry out its duties, including information or records that pertain to the child's family, as follows:
1. Patient records in the possession of a public or private provider of medical, dental, or mental health care, including, but not limited to, a facility licensed under Chapter 393, Chapter 394, or Chapter 395, or a health care practitioner as defined in s. 456.001. Providers may charge a fee for copies not to exceed 50 cents per page for paper records and $1 per fiche for microfiche records.
2. Information or records of any state agency or political subdivision which might assist a committee in reviewing a child's death, including, but not limited to, information or records of the Department of Children and Families, the Department of Health, the Department of Education, or the Department of Juvenile Justice.
(b) The State Child Abuse Death Review Committee or a local committee shall have access to all information of a law enforcement agency which is not the subject of an active investigation and which pertains to the review of the death of a child. A committee may not disclose any information that is not subject to public disclosure by the law enforcement agency, and active criminal intelligence information or criminal investigative information, as defined in s. 119.011(3), may not be made available for review or access under this section.
(c) The state committee and any local committee may share with each other any relevant information that pertains to the review of the death of a child.
(d) A member of the state committee or a local committee may not contact, interview, or obtain information by request or subpoena directly from a member of a deceased child's family as part of a committee's review of a child abuse death, except that if a committee member is also a public officer or state employee, that member may contact, interview, or obtain information from a member of the

deceased child's family, if necessary, as part of the committee's review. A member of the deceased child's family may voluntarily provide records or information to the state committee or a local committee.
(e) The chairperson of the State Child Abuse Death Review Committee may require the production of records by requesting a subpoena, through the Department of Legal Affairs, in any county of the state. Such subpoena is effective throughout the state and may be served by any sheriff. Failure to obey the subpoena is punishable as provided by law.
(f) This section does not authorize the members of the state committee or any local committee to have access to any grand jury proceedings.
(g) A person who has attended a meeting of the state committee or a local committee or who has otherwise participated in activities authorized by this section may not be permitted or required to testify in any civil, criminal, or administrative proceeding as to any records or information produced or presented to a committee during meetings or other activities authorized by this section. However, this [1]paragraph does not prevent any person who testifies before the committee or who is a member of the committee from testifying as to matters otherwise within his or her knowledge. An organization, institution, committee member, or other person who furnishes information, data, reports, or records to the state committee or a local committee is not liable for damages to any person and is not subject to any other civil, criminal, or administrative recourse. This [1]paragraph does not apply to any person who admits to committing a crime.
(6) DEPARTMENT OF HEALTH RESPONSIBILITIES.—
(a) The Department of Health shall administer the funds appropriated to operate the review committees and may apply for grants and accept donations.
(b) To the extent that funds are available, the Department of Health may hire staff or consultants to assist a review committee in performing its duties. Funds may also be used to reimburse reasonable expenses of the staff and consultants for the state committee and the local committees.
(c) For the purpose of carrying out the responsibilities assigned to the State Child Abuse Death Review Committee and the local review committees, the State Surgeon General may substitute an existing entity whose function and organization includes the function and organization of the committees established by this section.
(7) DEPARTMENT OF CHILDREN AND FAMILIES RESPONSIBILITIES.—Each regional managing director of the Department of Children and Families must appoint a child abuse death review coordinator for the region. The coordinator must have knowledge and expertise in the area of child abuse and neglect. The coordinator's general responsibilities include:
(a) Coordinating with the local child abuse death review committee.
(b) Ensuring the appropriate implementation of the child abuse death review process and all regional activities related to the review of child abuse deaths.
(c) Working with the committee to ensure that the reviews are thorough and that all issues are appropriately addressed.
(d) Maintaining a system of logging child abuse deaths covered by this procedure and tracking cases during the child abuse death review process.
(e) Conducting or arranging for a Florida Safe Families Network record check on all child abuse deaths covered by this procedure to determine whether there were any prior reports concerning the child or concerning any siblings, other children, or adults in the home.
(f) Coordinating child abuse death review activities, as needed, with individuals in the community and the Department of Health.
(g) Notifying the regional managing director, the Secretary of Children and Families, the Department of Health Deputy Secretary for Health and Deputy State Health Officer for Children's Medical Services, and the Department of Health Child Abuse Death Review Coordinator of all deaths meeting criteria for review as specified in this section within 1 working day after case closure.
(h) Ensuring that all critical issues identified by the local child abuse death review committee are brought to the attention of the regional managing director and the Secretary of Children and Families.
(i) Providing technical assistance to the local child abuse death review committee during the review of any child abuse death.
History.—s. 13, ch. 99-168; s. 11, ch. 2000-160; s. 8, ch. 2000-217; s. 13, ch. 2001-53; s. 14, ch. 2004-350; s. 41, ch. 2008-6; s. 69, ch. 2014-19; s. 21, ch. 2014-224; s. 4, ch. 2015-79.
[1]Note.—The word "paragraph" was substituted for the word "subsection" by the editors to conform to the redesignation of subsection (14) as paragraph (5)(g) by s. 4, ch. 2015-79.

Appendix B

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

383.412 Public records and public meetings exemptions.—

(1) For purposes of this section, the term “local committee” means a local child abuse death review committee or a panel or committee assembled by the State Child Abuse Death Review Committee or a local child abuse death review committee pursuant to s. 383.402.
(2)(a) Any information held by the State Child Abuse Death Review Committee or a local committee which reveals the identity of the surviving siblings of a deceased child whose death occurred as the result of a verified report of abuse or neglect is confidential and exempt from s. 119.07(1) and s. 24(a), Art. I of the State Constitution.
(b) Any information held by the State Child Abuse Death Review Committee or a local committee which reveals the identity of a deceased child whose death has been reported to the central abuse hotline but determined not to be the result of abuse or neglect, or the identity of the surviving siblings, family members, or others living in the home of such deceased child, is confidential and exempt from s. 119.07(1) and s. 24(a), Art. I of the State Constitution.
(c) Information made confidential or exempt from s. 119.07(1) and s. 24(a), Art. I of the State Constitution which is obtained by the State Child Abuse Death Review Committee or a local committee shall retain its confidential or exempt status.
(3)(a) Portions of meetings of the State Child Abuse Death Review Committee or a local committee at which information made confidential and exempt pursuant to subsection (2) is discussed are exempt from s. 286.011 and s. 24(b), Art. I of the State Constitution. The closed portion of a meeting must be recorded, and no portion of the closed meeting may be off the record. The recording shall be maintained by the State Child Abuse Death Review Committee or a local committee.
(b) The recording of a closed portion of a meeting is exempt from s. 119.07(1) and s. 24(a), Art. I of the State Constitution.
(4) The State Child Abuse Death Review Committee and local committees may share information made confidential and exempt by this section:
(a) With each other;
(b) With a governmental agency in furtherance of its duties; or
(c) With any person or entity authorized by the Department of Health to use such relevant information for bona fide research or statistical purposes. A person or entity who is authorized to obtain such relevant information for research or statistical purposes must enter into a privacy and security agreement with the Department of Health and comply with all laws and rules governing the use of such records and information for research or statistical purposes. Anything identifying the subjects of such relevant information must be treated as confidential by the person or entity and may not be released in any form.
(5) Any person who knowingly or willfully makes public or discloses to any unauthorized person any information made confidential and exempt under this section commits a misdemeanor of the first degree, punishable as provided in s. 775.082 or s. 775.083.
(6) This section is subject to the Open Government Sunset Review Act in accordance with s. 119.15, and shall stand repealed on October 2, 2020, unless reviewed and saved from repeal through reenactment by the Legislature.
History.—s. 1, ch. 2005-190; s. 95, ch. 2008-4; s. 1, ch. 2010-40; s. 1, ch. 2015-77.

Appendix D

Statement of Confidentiality

Name:

Date:

I understand the following:

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

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

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

_____

(Signature)

_____

(Agency)

APPENDIX E:

Case Report Form

The National Center for the REVIEW & PREVENTION OF CHILD DEATHS

Understanding How and Why Children Die & Taking Action to Prevent Child Deaths

Child Death Review Case Reporting System

Case Report - Version 4.0

Instructions:

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

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

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

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

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

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

This edition is Version 4.0, effective January 2015. Additional paper forms can be ordered from the National Center at no charge. Users interested in participating in the web-based case reporting system for data entry and reporting should contact the National Center for the Review & Prevention of Child Deaths. This latest version incorporates the Sudden and Unexpected Infant Death (SUID) Case Registry and the Sudden Death in the Young (SDY) Case Registry questions.

Data entry website: https://cdrdata.org

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

! Core information for data gathering. Every effort should be made to provide the information for these fields (when applicable to manner of death).

 If Available

 Need to define

New Section added in form Version 4

CASE NUMBER

_____ /_____/_____/_____

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

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

Death Certificate Number:

Birth Certificate Number:

ME/Coroner Number:

Date CDRT Notified of Death:

A. CHILD INFORMATION

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

2. Date of birth: ☐ U/K
mm dd yyyy

3. Date of death: ☐ U/K
mm dd yyyy

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

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

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

7. Sex:
○ Male ○ Female ○ U/K

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

COMPLETE FOR ALL INFANTS UNDER ONE YEAR

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

B. PRIMARY CAREGIVER(S) INFORMATION

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

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

2. Caregiver(s) age in years:

One	Two	
_____	_____	# Years
☐	☐	U/K

3. Caregiver(s) sex:

One	Two	
○	○	Male
○	○	Female
○	○	U/K

4. Caregiver(s) employment status:

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

5. Caregiver(s) income:

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

6. Caregiver(s) education:

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

7. Do caregiver(s) speak English?

One	Two	
○	○	Yes
○	○	No
○	○	U/K

If no, language spoken:

8. Caregiver(s) on active military duty?

One	Two	
○	○	Yes
○	○	No
○	○	U/K

If yes, specify branch:

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

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

10. Caregiver(s) have substance abuse history?

One	Two	
○	○	Yes
○	○	No
○	○	U/K

If yes, check all that apply:

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

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

One	Two	
○	○	Yes
○	○	No
○	○	U/K

If yes, check all that apply:

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

12. Caregiver(s) ever perpetrator of maltreatment?

One	Two	
○	○	Yes
○	○	No
○	○	U/K

If yes, check all that apply:

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

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

One	Two	
○	○	Yes
○	○	No
○	○	U/K

If yes, check all that apply:

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

If mental illness, was caregiver receiving MH services?

○	○	Yes
○	○	No
○	○	U/K

14. Caregiver(s) have prior child deaths?

One	Two	
○	○	Yes
○	○	No
○	○	U/K

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

One	Two	
☐	☐	Child abuse # _____
☐	☐	Child neglect # _____
☐	☐	Accident # _____
☐	☐	Suicide # _____
☐	☐	SIDS # _____
☐	☐	Other # _____
		Other, specify:
☐	☐	U/K

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

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

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

One	Two	
○	○	Yes
○	○	No
○	○	U/K

If yes, check all that apply:

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

C. SUPERVISOR INFORMATION

1. Did child have supervision at time of incident leading to death?
○ Yes, answer 2-15
○ No, not needed given developmental age or circumstances, go to Sect. D
○ No, but needed, answer 3-15
○ Unable to determine, try to answer 3-15

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

3. Is person a primary caregiver as listed in previous section?
○ Yes, caregiver one, go to 15
○ Yes, caregiver two, go to 15
○ No

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

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

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

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

7. Does supervisor speak English? ○ Yes ○ No ○ U/K
If no, language spoken:

8. Supervisor on active military duty? ○ Yes ○ No ○ U/K
If yes, specify branch:

9. Supervisor has substance abuse history? ○ Yes ○ No ○ U/K

If yes, check all that apply:

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

10. Supervisor has history of child maltreatment?

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

If yes, check all that apply:

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

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

If yes, check all that apply:

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

If mental illness, was supervisor receiving MH services?
○ Yes
○ No
○ U/K

12. Supervisor has prior child deaths? ○ Yes ○ No ○ U/K

If yes, check all that apply:

☐	Child abuse # _____
☐	Child neglect # _____
☐	Accident #_____
☐	Suicide # _____
☐	SIDS # _____
☐	Other # _____
	Other, specify:
☐	U/K

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

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

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

D. INCIDENT INFORMATION

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

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

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

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

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

6. Incident state:
7. Incident county:
8. Death state:
9. Death county:

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

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

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

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

If yes, was a rhythm recorded?
◯ Yes ◯ No ◯ U/K
If yes, what was the rhythm? _____

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

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

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

E. INVESTIGATION INFORMATION

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

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

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

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

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

4. Were the following assessed either through the autopsy or through information collected prior to the autopsy:

Y	N	U/K	Abnormal?	
Imaging:				
◯	◯	◯	☐	X-ray - single
◯	◯	◯	☐	X-ray - multiple views
◯	◯	◯	☐	X-ray - complete skeletal series
◯	◯	◯	☐	CT scan
◯	◯	◯	☐	MRI
◯	◯	◯	☐	Photography of the brain
External Exam:				
◯	◯	◯	☐	Exam of general appearance
◯	◯	◯	☐	Head circumference
Gross Examination of:				
◯	◯	◯	☐	Body cavities
◯	◯	◯	☐	Brain
◯	◯	◯	☐	Endocrine organs
◯	◯	◯	☐	Gastrointestinal tract
◯	◯	◯	☐	Heart
◯	◯	◯	☐	Kidneys
◯	◯	◯	☐	Liver

Y	N	U/K	Abnormal?	
Gross Examination continued:				
◯	◯	◯	☐	Lungs
◯	◯	◯	☐	Neck structures
◯	◯	◯	☐	Pancreas
◯	◯	◯	☐	Spleen
◯	◯	◯	☐	Thymus
In situ exam with removal & dissection of:				
◯	◯	◯	☐	Brain
◯	◯	◯	☐	Endocrine organs
◯	◯	◯	☐	Gastrointestinal tract
◯	◯	◯	☐	Heart
◯	◯	◯	☐	Kidneys
◯	◯	◯	☐	Liver
◯	◯	◯	☐	Lungs
◯	◯	◯	☐	Neck structures
◯	◯	◯	☐	Pancreas
◯	◯	◯	☐	Spleen
◯	◯	◯	☐	Thymus

Y	N	U/K	Abnormal?	
Weights of the:				
◯	◯	◯	☐	Brain
◯	◯	◯	☐	Heart
◯	◯	◯	☐	Kidneys
◯	◯	◯	☐	Liver
◯	◯	◯	☐	Lungs
◯	◯	◯	☐	Neck structures
◯	◯	◯	☐	Pancreas
◯	◯	◯	☐	Spleen
◯	◯	◯	☐	Thymus

4. Continued: Were the following assessed either through the autopsy or through information collected prior to the autopsy:

Sampled tissue of:	Y	N	U/K	Abnormal?
Airway	○	○	○	☐
Bone or costochondral tissue	○	○	○	☐
Brain or meninges	○	○	○	☐
Endocrine organs	○	○	○	☐
Gastrointestinal tract	○	○	○	☐
Heart	○	○	○	☐
Kidneys	○	○	○	☐
Liver	○	○	○	☐
Lungs	○	○	○	☐
Neck structures	○	○	○	☐
Pancreas	○	○	○	☐
Spleen	○	○	○	☐
Thymus	○	○	○	☐

Microscopic/Histological exam of:	Y	N	U/K	Abnormal?
Airway	○	○	○	☐
Bone or costochondral tissue	○	○	○	☐
Brain or meninges	○	○	○	☐
Endocrine organs	○	○	○	☐
Gastrointestinal tract	○	○	○	☐
Heart	○	○	○	☐
Kidneys	○	○	○	☐
Liver	○	○	○	☐
Lungs	○	○	○	☐
Neck structures	○	○	○	☐
Pancreas	○	○	○	☐
Spleen	○	○	○	☐
Thymus	○	○	○	☐

Additional Testing:	Y	N	U/K	Abnormal?
Cultures for infectious disease	○	○	○	☐
Microbiology	○	○	○	☐
Postmortem metabolic screen	○	○	○	☐
Vitreous testing as an adjunct to other investigation results	○	○	○	☐
Genetic testing	○	○	○	☐

Toxicology:

○ ○ ○ ☐ Toxicology If yes, check all that apply:

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

5. 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

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

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

If no, describe the differences:

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

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

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

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

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

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

11. Did any investigation find evidence of prior abuse?

○ N/A ○ Yes ○ No ○ U/K

If yes, from what source?

Check all that apply:

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

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

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

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

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

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

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

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

F. OFFICIAL MANNER AND PRIMARY CAUSE OF DEATH

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

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

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

a.

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

b.

c.

d.

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

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

5. Official manner of death from the death certificate:

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

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

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

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

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

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

○ Undetermined if injury or medical cause, go to H1

○ U/K go to H1

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

1. MOTOR VEHICLE AND OTHER TRANSPORT

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

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

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

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

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

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

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

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

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

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

h. Total number of occupants in vehicles:

In child's vehicle, including child:

☐ N/A, child was not in a vehicle

Total number of occupants: _____ ☐ U/K

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

Total number of deaths: _____ ☐ U/K

Total number of teen deaths: _____ ☐ U/K

In other primary vehicle involved in incident:

☐ N/A, incident was a single vehicle crash

Total number of occupants: _____ ☐ U/K

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

Total number of deaths: _____ ☐ U/K

Total number of teen deaths: _____ ☐ U/K

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

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

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

2. 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

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

If yes, describe in narrative.

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

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

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

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

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

Other, specify:

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

q. Suspected arson?
○ Yes ○ No ○ U/K

r. For scald, was hot water heater set too high?
○ N/A
○ Yes, temp. setting: _____
○ No
○ U/K

s. For electrocution, what cause:
○ Electrical storm
○ Faulty wiring
○ Wire/product in water
○ Child playing with outlet
○ Other, specify:
○ U/K

t. Other, describe in detail:

3. DROWNING

a. Where was child last seen before drowning? Check all that apply:
☐ In water ☐ In yard
☐ On shore ☐ In bathroom
☐ On dock ☐ In house
☐ Poolside ☐ Other, specify:
☐ U/K

b. What was child last seen doing before drowning?
○ Playing ○ Tubing
○ Boating ○ Waterskiing
○ Swimming ○ Sleeping
○ Bathing ○ Other, specify:
○ Fishing
○ Surfing ○ U/K

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

d. Drowning location:
○ Open water, go to e ○ U/K, go to n
○ Pool, hot tub, spa, go to i
○ Bathtub, go to w
○ Bucket, go to x
○ Well/cistern/septic, go to n
○ Toilet, go to z
○ Other, specify and go to n

e. For open water, place:
○ Lake ○ Quarry
○ River ○ Gravel pit
○ Pond ○ Canal
○ Creek ○ U/K
○ Ocean

f. For open water, contributing environmental factors:
○ Weather ○ Drop off
○ Temperature ○ Rough waves
○ Current ○ Other, specify:
○ Riptide/ undertow ○ U/K

g. If boating, type of boat:
○ Sailboat ○ Commercial
○ Jet ski ○ Other, specify:
○ Motorboat
○ Canoe
○ Kayak ○ U/K
○ Raft

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

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

j. For pool, child found:
○ In the pool/hot tub/spa
○ On or under the cover
○ U/K

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

l. Length of time owners had pool/hot tub/spa:
○ N/A ○ >1yr
○ <6 months ○ U/K
○ 6m-1 yr

m. Flotation device used?
○ N/A
○ Yes
○ No
○ U/K

If yes, check all that apply:
☐ Coast Guard approved
☐ Jacket ☐ Cushion ☐ Lifesaving ring
If jacket:
Correct size? ○ Yes ○ No ○ U/K
Worn correctly? ○ Yes ○ No ○ U/K
☐ Not Coast Guard approved ☐ U/K
☐ Swim rings
☐ Inner tube
☐ Air mattress
☐ Other, specify:

n. What barriers/layers of protection existed to prevent access to water?
Check all that apply:
☐ None ☐ Alarm, go to r
☐ Fence, go to o ☐ Cover, go to s
☐ Gate, go to p ☐ U/K
☐ Door, go to q

o. Fence:
Describe type:
Fence height in ft _____
Fence surrounds water on:
○ Four sides ○ Two or less sides
○ Three sides
○ U/K

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

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

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

s. Type of cover:
○ Hard
○ Soft
○ U/K

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

If yes, rules violated?
○ Yes ○ No ○ U/K

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

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

If yes, who? Check all that apply:
☐ Parent ☐ Bystander
☐ Other child ☐ Other, specify:
☐ Lifeguard ☐ U/K

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

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

4. ASPHYXIA

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

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

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

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

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

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

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

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

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

5. WEAPON, INCLUDING PERSON'S BODY PART

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

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

c. Firearm licensed? ◯ Yes ◯ No ◯ U/K

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

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

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

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

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

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

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

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

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

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

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

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

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

p. Sex of person(s) handling weapon:

Fatal weapon:
- ◯ Male
- ◯ Female
- ◯ U/K

Other weapon:
- ◯ Male
- ◯ Female
- ◯ U/K

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

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

6. ANIMAL BITE OR ATTACK

a. Type of animal:

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

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

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

c. Did child provoke animal?

○ Yes ○ No ○ U/K

If yes, how?

d. Animal has history of biting or attacking?

○ Yes ○ No ○ U/K

7. FALL OR CRUSH

a. Type:

- ○ Fall, go to b
- ○ Crush, go to h

b. Height of fall:

___ feet ___ inches

☐ U/K

c. Child fell from:

- ○ Open window
  - Screen?
    - ○ Screen
    - ○ No screen
    - ○ U/K if screen
- ○ Natural elevation
- ○ Man-made elevation
- ○ Playground equipment
- ○ Tree
- ○ Stairs/steps
- ○ Furniture
- ○ Bed
- ○ Roof
- ○ Moving object, specify:
- ○ Bridge
- ○ Overpass
- ○ Balcony
- ○ Animal, specify:
- ○ Other, specify:
- ○ U/K

d. Surface child fell onto:

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

e. Barrier in place:

Check all that apply:

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

f. Child in a baby walker?

- ○ N/A
- ○ Yes
- ○ No
- ○ U/K

g. Was child pushed, dropped or thrown?

○ Yes ○ No ○ U/K

If yes, go to G5q

h. For crush, did child:

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

i. For crush, object causing crush:

- ○ Appliance
- ○ Television
- ○ Furniture
- ○ Walls
- ○ Playground equipment
- ○ Animal
- ○ Tree branch
- ○ Boulders/rocks
- ○ Dirt/sand
- ○ Person, go to G5q
- ○ Commercial equipment
- ○ Farm equipment
- ○ Other, specify:
- ○ U/K

8. POISONING, OVERDOSE OR ACUTE INTOXICATION

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

Prescription drug

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

Over-the-counter drug

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

Cleaning substances

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

Other substances

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

☐ U/K

b. Where was the substance stored?

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

c. Was the product in its original container?

○ N/A ○ No ○ Yes ○ U/K

d. Did container have a child safety cap?

○ N/A ○ No ○ Yes ○ U/K

e. If prescription, was it child's?

○ Yes ○ No ○ U/K

f. Was the incident the result of?

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

g. Was Poison Control called?

○ Yes ○ No ○ U/K

If yes, who called:

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

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

○ Yes ○ No ○ U/K

If yes, how many? ____

Functioning properly?

○ Yes ○ No ○ U/K

9. EXPOSURE

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

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

_____ Ambient temp, degrees F

c. Number of hours exposed:

_____

☐ U/K

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

10. MEDICAL CONDITION

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

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

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

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

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

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

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

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

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

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

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

11. OTHER KNOWN INJURY CAUSE

Specify cause, describe in detail:

H. OTHER CIRCUMSTANCES OF INCIDENT - ANSWER RELEVANT SECTIONS

1. SUDDEN AND UNEXPECTED DEATH IN THE YOUNG

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

b. Did the child have a history of any of the following acute conditions or symptoms within 72 hours prior to death? ☐ U/K for all

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

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

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

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

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

○ Yes ○ No ○ U/K If yes, describe:

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

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

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

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

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

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

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

Y	N	U/K	
			Deaths
○	○	○	Sudden unexpected death before age 50
			Heart Disease
○	○	○	Heart condition/heart attack or stroke before age 50
○	○	○	Aortic aneurysm or aortic rupture
○	○	○	Arrhythmia (fast or irregular heart rhythm)
○	○	○	Cardiomyopathy
○	○	○	Congenital heart disease
			Neurologic Disease
○	○	○	Epilepsy or convulsions/seizure
○	○	○	Other neurologic disease

Y	N	U/K	
			Symptoms
○	○	○	Febrile seizures
○	○	○	Unexplained fainting
			Other Diagnoses
○	○	○	Congenital deafness
○	○	○	Connective tissue disease
○	○	○	Mitochondrial disease
○	○	○	Muscle disorder or muscular dystrophy
○	○	○	Thrombophilia (clotting disorder)
○	○	○	Other diseases that are genetic or run in families, specify:

If sudden unexpected death before age 50, describe (for example, SIDS, drowning, relative who died in single and/or unexplained motor vehicle accident (driver of car):

g. Has any blood relative (siblings, parents, aunts, uncles, cousins, grandparents) had genetic testing?

○ Yes ○ No ○ U/K

If yes, describe what test and/or for what disease and results:

Was a gene mutation found?

○ Yes ○ No ○ U/K

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

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

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

j. Was the child compliant with their prescribed medications?
○ N/A ○ Yes ○ No ○ U/K
If not compliant, describe why and how often:

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

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

If yes to any items above, describe:

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

Stimuli	At incident Yes	At incident No	At incident U/K	Within 24 hrs of incident Yes	Within 24 hrs of incident No	Within 24 hrs of incident U/K
Physical activity	○	○	○	○	○	○
Sleep deprivation	○	○	○	○	○	○
Driving	○	○	○	○	○	○
Visual stimuli	○	○	○	○	○	○
Video game stimuli	○	○	○	○	○	○
Emotional stimuli	○	○	○	○	○	○
Auditory stimuli/startle	○	○	○	○	○	○
Physical trauma	○	○	○	○	○	○
Other, 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. Did the child ever have any of the following **uncharacteristic** symptoms during or within 24 hours after physical activity? Check all that apply:

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

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

n. 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 o through u: Answer if "Epilepsy/Seizure Disorder" is answered Yes in question e above (Diagnosed for a medical condition)

o. How old was the child when diagnosed with epilepsy/seizure disorder?
Age 0 (infant) through 20 years: _____
☐ U/K

p. What were the underlying cause(s) of the child's seizures? Check all that apply:

- ☐ Brain injury/trauma, specify:
- ☐ Brain tumor
- ☐ Cerebrovascular
- ☐ Central nervous system infection
- ☐ Degenerative process
- ☐ Developmental brain disorder
- ☐ Inborn error of metabolism
- ☐ Genetic/chromosomal
- ☐ Mesial temporal sclerosis
- ☐ Idiopathic or cryptogenic
- ☐ Other acute illness or injury other than epilepsy
- ☐ Other, specify:
- ☐ U/K

q. 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

r. Describe the child's epilepsy/seizures. Check all that apply:

- ☐ Last less than 30 minutes
- ☐ Last more than 30 minutes (status epilepticus)
- ☐ Occur in the presence of fever (febrile seizure)
- ☐ Occur in the absence of fever
- ☐ Occur when exposed to strobe lights, video game, or flickering light (reflex seizure)

s. How many seizures did the child have in the year preceding death?
○ 0/never ○ 1 ○ 2 ○ 3 ○ more than 3 ○ U/K

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

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

2. ANSWER THIS ONLY IF CHILD IS UNDER AGE FIVE: WAS DEATH RELATED TO SLEEPING OR THE SLEEP ENVIRONMENT? ○ Yes, go to H2a ○ No, go to H2s ○ U/K, go to H2s

a. Incident sleep place: !

- ○ Crib
  - If crib, type:
    - ○ Not portable
    - ○ Portable, e.g. pack-n-play
    - ○ Unknown crib type
- ○ Bassinette
- ○ Adult bed
- ○ Waterbed
- ○ Futon
- ○ Playpen/other play structure but not portable crib
- ○ Couch
- ○ Chair
- ○ Floor
- ○ Car seat
- ○ Stroller
- ○ Other, specify:
- ○ U/K

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

If futon,
○ Bed position ○ Couch position ○ U/K

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

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

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

f. Was there a crib, bassinette or port-a-crib in home for child? !
- ○ Yes ○ No ○ U/K

d. Usual sleep place:
- ○ Crib
  - If crib, type:
    - ○ Not portable
    - ○ Portable, e.g. pack-n-play
    - ○ Unknown crib type
- ○ Bassinette
- ○ Adult bed
- ○ Waterbed
- ○ Futon
- ○ Playpen/other play structure but not portable crib
- ○ Couch
- ○ Chair
- ○ Floor
- ○ Car seat
- ○ Stroller
- ○ Other, specify:
- ○ U/K

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

If futon, ○ Bed position ○ U/K ○ Couch position

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

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

i. Child wrapped or swaddled in blanket?
- ○ Yes ○ No ○ U/K

If yes, describe:

j. Child overheated? ○ Yes ○ No ○ U/K

If yes, outside temp ____ degrees F

Check all that apply:
- ☐ Room too hot, temp ____ degrees F
- ☐ Too much bedding
- ☐ Too much clothing

k. Child exposed to second hand smoke?
- ○ Yes ○ No ○ U/K

If yes, how often: ○ Frequently ○ U/K ○ Occasionally

l. Child face when found:
- ○ Down
- ○ Up
- ○ To left or right side
- ○ U/K

m. Child neck when found:
- ○ Hyperextended (head back)
- ○ Hypoextended (chin to chest)
- ○ Neutral
- ○ U/K

n. Child's airway was:
- ○ Unobstructed by person or object
- ○ Fully obstructed by person or object
- ○ Partially obstructed by person or object
- ○ U/K

If fully or partially obstructed, what was obstructed?
- ☐ Nose
- ☐ Mouth
- ☐ Chest compressed
- ☐ U/K

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

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

p. Caregiver/supervisor fell asleep while feeding child?
- ○ Yes ○ No ○ U/K

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

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

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

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

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

Select photo that most describes child placement and relevant objects. Size must be less than 6 mb and in .jpg or .gif format.

3. WAS DEATH A CONSEQUENCE OF A PROBLEM WITH A CONSUMER PRODUCT? ○ Yes ○ No, go to H4 ○ U/K, go to H4

a. Describe product and circumstances: !

b. Was product used properly?
- ○ Yes ○ No ○ U/K

c. Is a recall in place? !
- ○ Yes ○ No ○ U/K

d. Did product have safety label? !
- ○ Yes ○ No ○ U/K

e. Was Consumer Product Safety Commission (CPSC) notified? !
- ○ Yes ○ U/K
- ○ No, go to www.saferproducts.gov to report

4. DID DEATH OCCUR DURING COMMISSION OF ANOTHER CRIME? ◯ Yes ◯ No ◯ U/K

a. Type of crime, check all that apply:

! ☐ Robbery/burglary ☐ Other assault ☐ Arson ☐ Illegal border crossing ☐ U/K
☐ Interpersonal violence ☐ Gang conflict ☐ Prostitution ☐ Auto theft
☐ Sexual assault ☐ Drug trade ☐ Witness intimidation ☐ Other, specify:

I. ACTS OF OMISSION OR COMMISSION INCLUDING POOR SUPERVISION, CHILD ABUSE & NEGLECT, ASSAULTS, AND SUICIDE

TYPE OF ACT

1. Did any act(s) of omission or commission cause and/or contribute to the death?
◯ Yes
◯ No, go to Section J
◯ Probable
◯ U/K, go to Section J

If yes/probable, were the act(s) either or both? Check all that apply:
☐ The direct cause of death
☐ The contributing cause of death

2. What act(s) caused or contributed to the death? Check only one per column and describe in narrative.

Caused	Contributed	
◯	◯	Poor/absent supervision, go to 10
◯	◯	Child abuse, go to 3
◯	◯	Child neglect, go to 8
◯	◯	Other negligence, go to 9
◯	◯	Assault, not child abuse, go to 10
◯	◯	Religious/cultural practices, go to 10
◯	◯	Suicide, go to 27
◯	◯	Medical misadventure, specify and go to 11
◯	◯	Other, specify and go to 10
◯	◯	U/K, go to 10

3. Child abuse, type. Check all that apply and describe in narrative.
☐ Physical, go to 4
☐ Emotional, specify and go to 10
☐ Sexual, specify and go to 10
☐ U/K, go to 10

4. Type of physical abuse, check all that apply:
☐ Abusive head trauma, go to 5
☐ Chronic Battered Child Syndrome, go to 7
☐ Beating/kicking, go to 7
☐ Scalding or burning, go to 7
☐ Munchausen Syndrome by Proxy, go to 7
☐ Other, specify and go to 7
☐ U/K, go to 7

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

6. For abusive head trauma, was the child shaken?
◯ Yes ◯ No ◯ U/K
If yes, was there impact?
◯ Yes ◯ No ◯ U/K

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

8. Child neglect, check all that apply:
☐ Failure to protect from hazards, specify:
☐ Failure to provide necessities
☐ Food
☐ Shelter
☐ Other, specify:
☐ Failure to seek/follow treatment, specify:
☐ Emotional neglect, specify:
☐ Abandonment, specify:
☐ U/K

9. Other negligence:
◯ Vehicular
◯ Other, specify:
◯ U/K

10. Was act(s) of omission/commission:

Caused	Contributed	
◯	◯	Chronic with child
◯	◯	Pattern in family or with perpetrator
◯	◯	Isolated incident
◯	◯	U/K

PERSON(S) RESPONSIBLE

11. Is person the caregiver or supervisor in previous section? !

Caused	Contributed	
◯	◯	Yes, caregiver one, go to 24
◯	◯	Yes, caregiver two, go to 24
◯	◯	Yes, supervisor, go to 25
◯	◯	No

12. Primary person responsible for action(s) that caused and/or contributed to death: ! Select no more than one person for caused and one person for contributed.

Caused	Contributed		Caused	Contributed		Caused	Contributed	
◯	◯	Self, go to 24	◯	◯	Grandparent	◯	◯	Medical provider
◯	◯	Biological parent	◯	◯	Sibling	◯	◯	Institutional staff
◯	◯	Adoptive parent	◯	◯	Other relative	◯	◯	Babysitter
◯	◯	Stepparent	◯	◯	Friend	◯	◯	Licensed child care worker
◯	◯	Foster parent	◯	◯	Acquaintance			
◯	◯	Mother's partner	◯	◯	Child's boyfriend or girlfriend	◯	◯	Other, specify:
◯	◯	Father's partner	◯	◯	Stranger	◯	◯	U/K

13. Person's age in years: !

Caused	Contributed	
____	____	# Years
☐	☐	U/K

14. Person's sex: !

Caused	Contributed	
◯	◯	Male
◯	◯	Female
◯	◯	U/K

15. Does person speak English? !

Caused	Contributed	
◯	◯	Yes
◯	◯	No
◯	◯	U/K

If no, language spoken:

16. Person on active military duty? !

Caused	Contributed	
◯	◯	Yes
◯	◯	No
◯	◯	U/K

If yes, specify branch:

17. Person have history of substance abuse?

Caused / Contributed: Yes / No / U/K

If yes, check all that apply:

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

18. Person have history of child maltreatment as victim?

Caused / Contributed: Yes / No / U/K

If yes, check all that apply:

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

19. Person have history of child maltreatment as a perpetrator?

Caused / Contributed: Yes / No / U/K

If yes, check all that apply:

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

20. Person have disability or chronic illness?

Caused / Contributed: Yes / No / U/K

If yes, check all that apply:

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

If mental illness, was person receiving MH services?

Yes / No / U/K

21. Person have prior child deaths?

Caused / Contributed: Yes / No / U/K

If yes, check all that apply:

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

Other, specify:

- U/K

22. Person have history of intimate partner violence?

Caused / Contributed:

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

23. Person have delinquent/criminal history?

Caused / Contributed: Yes / No / U/K

If yes, check all that apply:

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

24. At time of incident was person impaired?

Caused: Yes / No / U/K

Contributed: Yes / No / U/K

If yes, check all that apply:

- Drug impaired
- Alcohol impaired
- Asleep
- Distracted
- Absent
- Impaired by illness, specify:
- Impaired by disability, specify:
- Other, specify:

25. Does person have, check all that apply:

- Prior history of similar acts
- Prior arrests
- Prior convictions

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

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

FOR SUICIDE

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

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

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

- None known
- Family discord
- Parents' divorce/separation
- Argument with parents/caregivers
- Argument with boyfriend/girlfriend
- Breakup with boyfriend/girlfriend
- Argument with other friends
- Rumor mongering
- Suicide by friend or relative
- Other death of friend or relative
- Bullying as victim
- Bullying as perpetrator
- School failure
- Move/new school
- Other serious school problems
- Pregnancy
- Physical abuse/assault
- Rape/sexual abuse
- Problems with the law
- Drugs/alcohol
- Sexual orientation
- Religious/cultural issues
- Job problems
- Money problems
- Gambling problems
- Involvement in cult activities
- Involvement in computer or video games
- Involvement with the Internet, specify:
- Other, specify:
- U/K

J. SERVICES TO FAMILY AND COMMUNITY AS A RESULT OF DEATH

1. Services: Select one option per row:	Provided after death	Offered but refused	Offered but U/K if used	Should be offered	Needed but not available	U/K	CDR review led to referral
Bereavement counseling	○	○	○	○	○	○	☐
Debriefing for professionals	○	○	○	○	○	○	☐
Economic support	○	○	○	○	○	○	☐
Funeral arrangements	○	○	○	○	○	○	☐
Emergency shelter	○	○	○	○	○	○	☐
Mental health services	○	○	○	○	○	○	☐
Foster care	○	○	○	○	○	○	☐
Health services	○	○	○	○	○	○	☐
Legal services	○	○	○	○	○	○	☐
Genetic counseling	○	○	○	○	○	○	☐
Other, specify:	○	○	○	○	○	○	☐

K. PREVENTION INITIATIVES RESULTING FROM THE REVIEW

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

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

2. What specific recommendations and/or initiatives resulted from the review? Check all that apply: ○ No recommendations made, go to Section L

		Current Action Stage			Type of Action		Level of Action		
		Recommendation	Planning	Implementation	Short term	Long term	Local	State	National
Education	Media campaign	○	○	○	☐	☐	☐	☐	☐
	School program	○	○	○	☐	☐	☐	☐	☐
	Community safety project	○	○	○	☐	☐	☐	☐	☐
	Provider education	○	○	○	☐	☐	☐	☐	☐
	Parent education	○	○	○	☐	☐	☐	☐	☐
	Public forum	○	○	○	☐	☐	☐	☐	☐
	Other education	○	○	○	☐	☐	☐	☐	☐
Agency	New policy(ies)	○	○	○	☐	☐	☐	☐	☐
	Revised policy(ies)	○	○	○	☐	☐	☐	☐	☐
	New program	○	○	○	☐	☐	☐	☐	☐
	New services	○	○	○	☐	☐	☐	☐	☐
	Expanded services	○	○	○	☐	☐	☐	☐	☐
Law	New law/ordinance	○	○	○	☐	☐	☐	☐	☐
	Amended law/ordinance	○	○	○	☐	☐	☐	☐	☐
	Enforcement of law/ordinance	○	○	○	☐	☐	☐	☐	☐
Environment	Modify a consumer product	○	○	○	☐	☐	☐	☐	☐
	Recall a consumer product	○	○	○	☐	☐	☐	☐	☐
	Modify a public space	○	○	○	☐	☐	☐	☐	☐
	Modify a private space(s)	○	○	○	☐	☐	☐	☐	☐
	Other, specify:	○	○	○	☐	☐	☐	☐	☐

Briefly describe the initiatives:

3. Who took responsibility for championing the prevention initiatives? Check all that apply: !

☐ N/A, no strategies	☐ Mental health	☐ Law enforcement	☐ Advocacy organization	☐ Other, specify:
☐ No one	☐ Schools	☐ Medical examiner	☐ Local community group	
☐ Health department	☐ Hospital	☐ Coroner	☐ New coalition/task force	
☐ Social services	☐ Other health care providers	☐ Elected official	☐ Youth group	☐ U/K

L. THE REVIEW MEETING PROCESS

1. Date of first CDR meeting: !

2. Number of CDR meetings for this case: ! _____

3. Is CDR complete? ! ○ N/A ○ Yes ○ No

4. Agencies at CDR meeting, check all that apply: !

☐ Medical examiner/coroner	☐ CPS	☐ Other health care	☐ Mental health	☐ Military
☐ Law enforcement	☐ Other social services	☐ Fire	☐ Substance abuse	☐ Others, list:
☐ Prosecutor/district attorney	☐ Physician	☐ EMS	☐ Court	
☐ Public health	☐ Hospital	☐ Education	☐ Child advocate	

5. Were the following data sources available at the CDR meeting?

Check all that apply:

- ☐ CDC's SUIDI Reporting Form
- ☐ Jurisdictional equivalent of the CDC SUIDI Reporting Form
- ☐ Birth certificate - full form
- ☐ Death certificate
- ☐ Child's medical records or clinical history, including vaccinations
- ☐ Biological mother's obstetric and prenatal information
- ☐ Newborn screening results
- ☐ Law enforcement records
- ☐ Social service records
- ☐ Child protection agency records
- ☐ EMS run sheet
- ☐ Hospital records
- ☐ Autopsy/pathology reports
- ☐ Mental health records
- ☐ School records
- ☐ Substance abuse treatment records

6. Factors that prevented an effective CDR meeting, check all that apply:

- ☐ Confidentiality issues among members prevented full exchange of information
- ☐ HIPAA regulations prevented access to or exchange of information
- ☐ Inadequate investigation precluded having enough information for review
- ☐ Team members did not bring adequate information to the meeting
- ☐ Necessary team members were absent
- ☐ Meeting was held too soon after death
- ☐ Meeting was held too long after death
- ☐ Records or information were needed from another locality in-state
- ☐ Records or information were needed from another state
- ☐ Team disagreement on circumstances
- ☐ Other factors, specify:

7. CDR meeting outcomes, check all that apply:

- ☐ Review led to additional investigation
- ☐ Team disagreed with official manner of death. What did team believe manner should be?
- ☐ Team disagreed with official cause of death. What did team believe cause should be?
- ☐ Because of the review, the official cause or manner of death was changed
- ☐ Review led to the delivery of services
- ☐ Review led to changes in agency policies or practices
- ☐ Review led to prevention initiatives being implemented
  - ☐ Local ☐ State ☐ National

8. Describe the factor(s) that directly contributed to this death:

9. Which of the factors that directly contributed to this death are modifiable?

10. List any recommendations to prevent deaths from similar causes or circumstances in the future:

11. What additional information would the team like to know about the death scene investigation?

12. What additional information would the team like to know about the autopsy?

M. SUID AND SDY CASE REGISTRY

1. Is this an SDY or SUID case? ○ Yes ○ No If no, go to Section N

2. Did this case go to Advance Review for the SDY Case Registry?
○ N/A ○ Yes ○ No
If yes, date of first Advance Review meeting:

3. Notes from Advance Review meeting:

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

5. Was a specimen sent to the SDY Case Registry bio-repository?
○ Yes ○ No ○ N/A ○ U/K

6. Did the family consent to the SDY Case Registry?
○ Yes ○ No ○ N/A ○ U/K

7. Categorization for SDY Case Registry (choose only one):

- ○ Excluded from SDY Case Registry
- ○ No autopsy or death scene investigation
- ○ Incomplete case information
- ○ Explained cardiac
- ○ Explained neurological
- ○ Explained infant suffocation (under age 1)
- ○ Explained other
- ○ Unexplained, possible cardiac
- ○ Unexplained, possible cardiac and SUDEP
- ○ Unexplained, SUDEP
- ○ Unexplained infant death (under age 1)
- ○ Unexplained child death (age 1 and over)

8. 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:

N. NARRATIVE

Use this space to provide more detail on the circumstances of the death and to describe any other relevant information.
DO NOT INCLUDE IDENTIFIERS IN THE NARRATIVE such as names, addresses, and specific service providers. Consider the following questions: What was the child doing? Where did it happen? How did it happen? What went wrong? What was the quality of supervision? What was the injury cause of death?

!

Standard template for narratives should be used as follows:

Interpretive Summary

What does the committee think happened? - brief case summary (tell us the story)

Lessons learned

Did the family have prevention services in the past?

Was communication between intra-agencies sufficient?

Any training issues identified?

O. 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 National Center for the REVIEW & PREVENTION OF CHILD DEATHS

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Data Entry: https://cdrdata.org
www.childdeathreview.org
For help, email: info@childdeathreview.org
1-800-656-2434

APPENDIX F:

Statewide Meeting Summary

State and Local Child Abuse Death Review (CADR) Meeting
September 8, 2015
Meeting Summary and Participant Feedback

Introductions and Opening Remarks

Cassandra G. Pasley, BSN, JD, Director of Children's Medical Services, opened the meeting and welcomed participants.

Robin Perry, Ph.D., Chairman of the State CADR Committee, presented on the following:

- Components of a public health approach to preventing child fatalities
- Statutory directives and recent legislative changes

Child Fatality Reviews: Developing a Model for Florida

As a platform for discussion, a panel of four experienced chairs/members of local child abuse death review committees shared their thoughts and experiences associated with conducting child fatality reviews. Panelists Lauren Villalba, Connie Shingledecker, Laly Serraty and Evelyn Goslin provided valuable information to participants and discussion unfolded in response to three questions:

1. What are the key elements for conducting an effective meeting?
2. How should conflict or differences of opinion between members be addressed?
3. What changes in process and resources are needed to enhance the quality and effectiveness of local reviews?

An aggregate summary of select points made by panelists in response to each question follows:

1. **What are the key elements for conducting an effective meeting?**
    - Time
        - Importance of being notified of the child death case within a reasonable time frame
        - Reviewing the child death case in an appropriate time frame based on the length and severity of the case
        - Coordinate with everyone with sufficient time to attend
    - Leadership and Engagement
        - CADR committees are multidisciplinary, and require strong leadership and engagement
        - Consistent member attendance is crucial, and participation from various agencies/experts is required
        - Record collection and agency cooperation is necessary to obtain all appropriate information needed for reviews

- Invite the child protective investigator and law enforcement professionals directly involved in investigating the fatality to come to the meeting to answer questions and participate in the discussion
- Effectively facilitate so that everyone participates and the meeting progresses in a positive way
- Have a clear goal of what you want to accomplish and what is expected. This is clearly conveyed when members join, but always reiterate this in subtle ways. For example, if no recommendations are suggested remind them of the prevention focus

- Culture
  - Have protocols that encourage the sharing of information. For example, explain chronology, ask the State Attorney's Office to share their involvement and decisions regarding prosecution, the Police Department to recap, and the Child Protective Investigator from either the Department of Children and Families or Sheriff's Office to fill the committee in on the children involved in the case and family. Ask for contributions directly if needed, as this emphasizes their value to the review and committee
  - Emphasize confidentiality so that people are open to sharing, and not afraid of repercussions of sharing confidential information
  - Practice constant cultural sensitivity to the family's perspective. If you don't understand the family's perspective, you are not going to effectively help with appropriate identification of system gaps and meaningful recommendations. Understanding disparities across groups in the community is important
  - After each meeting, send personalized thank you e-mails
- Focus
  - Engage in meaningful dialogue
  - Analyze community so you can properly address issues
  - Collect and analyze data
  - Focus on the issues and how to improve without placing blame
  - Open communication and dialogue is necessary, as well as having case specific information available for the case review
- Outcome
  - People want to see that you are making a contribution in these reviews. Three good ways of doing this:
    1) Reports that can be dispersed throughout the community
    2) Findings on the various measures
    3) Realistic recommendations that can be implemented and measured
- Logistics and Administrative Tasks
  - Use Attachment V from data form to keep track of documents received and reviewed
  - Use Attachment VI "Information Sheet" to log from the documents details that will be asked on the data form

2. How should conflict or differences of opinion between members be addressed?

- Chair/Committee leader needs to mediate

- Difference of opinion is okay
- Agree to disagree if consensus is not possible
  - Make a finding stating that there was a disagreement between team members. (As a result, the committee was unable to discuss issues relating to _____but unanimously agree that the death could have been prevented by _____.)
  - The committee was unable to come to a collective determination of _____, yet agree to _____.)
- Conflict or differences of opinion should be addressed via open dialogue, in a respectful manner, between the members. If necessary, the program office should be contacted to address any conflicts or differences which were not able to be resolved

- The questioning technique
  - Ask questions until the committee understands what the difficulties, issues, and other viewpoints are among members
  - Stay neutral
- Committee members' roles need to be clear. What is their role within their agency and what information and insights do they have with respect to a particular case?
  - Example: Committee members may become upset with others if they do not understand each other's functions
    - Example: Department of Children and Families vs. State Attorney's Office vs. Law Enforcement
    - Terminology/definitions: Department of Children and Families vs. State Attorney's Office definition of neglect
    - Usually differences in opinion are caused by one party having information the other does not have or has not reviewed. The best approach is to focus on obtaining and sharing additional information and continue respectful discussion

3. What changes in process and resources are needed to enhance the quality and effectiveness of local reviews?

- Child death cases need to be closed out in a timelier manner
- Reduce the amount of data required for entry on the national form or streamline process; provide added supports for data entry
- Continue assistance with data entry or funding to provide for a local data entry support person to assist with the printing of all case documents and data entry
- Have a contact person to relay local recommendations that have statewide implications and would need statewide implementation
- Funding for the implementation of local and statewide recommendations
- Law enforcement "comprehensive report" need to accompany the Department of Children and Families investigative report at the same time the case is delivered to the respective CADR committee

- Medical Examiner's "final autopsy report" should be mandated to be sent to each CADR committee at the time they are finalized. Extensive section on case form requires specific autopsy information

Following the panel presentation, participants worked in break-out groups to expand upon these ideas and brainstorm their own responses to the same three questions:

1. What are the key elements for conducting an effective meeting?
2. How should conflict or differences of opinion between members be addressed?
3. What changes in process and resources are needed to enhance the quality and effectiveness of local reviews?

Break-out groups then reported findings to the large group. A lot of detailed information was collected and many responses were similar across the groups. To summarize responses, group feedback for each question was organized into similar themes. Themed responses for each question are outlined below:

1. What are the key elements for conducting an effective meeting?

Theme: Organization

- Set regularly scheduled meeting times for the year
  - Send meeting reminder via email
- Advanced planning and preparation prior to meeting
  - Complete agenda one week before meeting and have a clear purpose/mission statement
  - Have case summaries available before the meeting
- Orientation (resource packet) for new members and outline expectations
- Meeting framework consistency
- Maintain focus on purpose of committee

Theme: Time

- Ability to adjust timeframe depending on case
- Anticipate time needed for each case and schedule accordingly
- Start and end on time; stay on task
- Improve timeliness of case review

Theme: Have key members present and engaged/Build Committee rapport

- Open communication among members and between chairperson and members
- Respect for professional expertise
- Value each other's time
- Outline committee responsibilities and roles
- Confidentiality

Theme: Need for complete and detailed case information

- Allow members to provide additional information pertinent to the case
- Effective checklist of documents

Other:

- Location with accessible parking
- Video and teleconference capability
- Support for local CADR from state

2. How should conflict or differences of opinion between members be addressed?

Theme: Focus on purpose of committee and have clear definitions

- Chair to maintain focus of the group
- Have a copy of child maltreatment index available to review definition of neglect
- Clear iteration of statutes across all circuits
- Have ground rules for meetings

Theme: Vote if no consensus

- Important to have a group consensus
- Core group membership votes

Theme: Show mutual respect and understanding of differing views

- Be open minded
- Be mindful of different roles of various members
- Agree to disagree

Theme: Review the facts and facilitate discussion

- Open discussion
- Document differences in opinion, reasons, and concerns
- Give equal time for all opinions
- Allow the option to seek additional information and postpone review if necessary

3. What changes in process and resources are needed to enhance the quality and effectiveness of local reviews?

Theme: Data Quality and Access

- Electronic receipt vs. Fed Ex of case documents
- All data files sent from a common source
- Timely receipt and review of cases
- Receive complete file of information (all documents on check list) prior to review
- How to process files and policies documented for data encryption
- Fix online reporting system so priority data elements can be identified

Theme: Additional support and resources

- Clerical and administrative support to committees, especially with case load increase
- Funding
- Annual meeting of state and local committees
- Continued assistance from Department of Health program office with data entry
- Medical Examiner training on child deaths

Theme: Partnership

- Engage community providers
- Work on developing/maintaining good working relationships between agency partners (Medical Examiner, law enforcement)
- Liaison between agencies
- Look at other reviews (Fetal Infant Mortality Review, Domestic Violence) for areas of possible collaboration to decrease duplication
- Engage circuit task force

Theme: Information and Results Dissemination

- Identify responsible person to share recommendations with other committees
- Regional roll-ups of individual committee recommendations
- Send consistent messages from all providers of big issues
- Develop methods to effectively share information
- PowerPoint presentation on statewide CADR recommendations to be shared at local level

Theme: Clear and Consistent Process

- More guidance from state-level and defined expectations of local committees
- Seamless handoff to new chairs and provide orientation
- One page guidance for format of case presentation, discussion, review and recommendations
- Listserv for questions and answers on policies and procedures

Policy, Processes, and Protocols

Dr. Perry reported on available resources and provided information on upcoming changes, including the following topics:

- Guidelines for Local Committees
- Alignment with Judicial Circuits
- Protocols for File Case Management and Data Input

Local Prevention Initiatives

Break-out groups were again utilized to brainstorm responses to questions regarding potential contributing factors, prevention initiatives, and accomplishments.

The following is an itemization of select factor/data elements that the 10 working groups of meeting participants itemized for consideration as possible contributing factors associated with preventable child abuse and neglect. Those data elements/factors that are **bolded** were mentioned by multiple working groups.

Location of Child Death at Time of Death

Child Characteristics:

- **Age of child at death (especially if under five)**
- Is child from multiple birth

- Presence of developmental delays and special needs (including preexisting medical conditions)
- **Child has limited visibility in the community**

Caregiver and/or Perpetrator Risk Factors/Data:

- **Age of responsible caregiver/perpetrator (especially if teen or young parent/caregiver)**
- **Developmental delays, cognitive impairment (education deficit/level) of caregiver**
- Impulse control
- **Marital/relationship status (including if single parent)**
- **Relationship of perpetrator/caregiver to child (including legal/illegal guardian, boyfriend, biological versus non-biological, unqualified caregiver, etc.)**
- Education level of parent/caregivers
- **Prior involvement with child welfare (including as a victim; previous abuse history as victim and/or perpetrator)**
- **Substance abuse history (including itemization of substances: alcohol, type of drugs, prescription misuse, etc.)**
- **Domestic/family violence history**
- **Mental health history**
- Criminal history
- **Co-sleeping practices and beliefs**

Family Risk Factors (apart from caregiver and perpetrator factors):

- **Presence of young children (under five) and siblings in the household**
- **Prior involvement with child welfare/prior abuse and/or neglect history**
- Prior animal cruelty concerns/instances
- **Substance abuse history (entire family)**
- Lack of access to substance abuse services
- Lack of access to health care services
- **Poor parenting skills/parental limitations in ability to adequately parent (limited discipline options, poor/inadequate supervision practices, etc.)**
- Limited water safety knowledge of parents (limited water safety education opportunities in community
- Limited co-sleeping knowledge of parents (limited education opportunities in community)
- **Access of family to affordable and adequate childcare**
- **Economic/environmental hardship (poverty, unstable housing, unsafe housing, financial stressors, limited financial stability over time, etc.)**
- Hazardous conditions in the home (unsafe physical environment; presence and/or misuse of unsafe products)
- **Utilization and adequacy of prior services/interventions to child and family (by the Department of Children and Families, Healthy Start, mental health services, etc.)**
- **Child(ren) in the home have limited community visibility**
- Criminal history (violence and drug-related offences) on any household member

- **Cultural beliefs/practices/norms (especially with respect to sleeping with infants, discipline, etc.)**
- **Lack of family supports and resources (support systems and community response to families in need)**
- Presence of guns in the home

Additional brainstorming was conducted to answer questions regarding prevention of child maltreatment. The following is an outline of responses to questions related to child abuse prevention initiatives.

1. What should prevention initiatives target?

Education

- Educate Specific Groups
    - Parents/caregivers
    - Healthcare providers
    - First responders (e.g., recognizing signs of abuse/neglect)
    - High schools
    - At-risk populations
    - Children
- Education Topics
    - Sex education
    - Reproductive life planning
    - Parenting practices
    - Developmental changes/stages in children
    - Healthy families and relationships
    - Safety and prevention
- Messaging & Outreach
    - Public service announcements
    - Social media
    - Through influential partners
- Recipients
    - Group-specific (i.e., populations-at-risk, abuse/violence victims, persons w/ child welfare contact)
- Message Content
    - Culturally appropriate and sensitive
    - Consistent (especially across agencies)
    - Realistic
- Safety and Prevention Efforts/Topics
    - Safe sleep
    - Drowning
    - Gun safety
    - Dangers of leaving children in hot cars
- Mental/Behavioral Health Topics (some are non-specific)
    - Substance abuse
    - Prescription abuse
    - Impact of mental health on parenting

        - Mental health providers
        - Mental health of child victims
        - Behavior change
        - Breaking the cycle of abuse
    - Resources
        - Community outreach
        - Community support
        - Increase community responsibility and reporting
        - Safe housing
        - Babysitting programs
        - Education and work programs
        - Support for family and caretakers
        - Universal/comprehensive care (available for everyone and started early)
        - Increase opportunities for safe child care
        - Faith communities be more inclusive of diversity
        - Neighborhood resources
    - Macro Level
        - Industry changes
            - Automobile industry to include alarms in cars so kids aren't left in hot cars
            - Baby supply industry
            - Business impact
        - Legislation changes
        - Economic stability
        - Department of Children and Families
            - Case enforcement
            - Full investigation of children placed outside the home

2. How should prevention initiatives be monitored and their effectiveness gauged?

- Components of Prevention Initiative Monitoring
    - Data & measures
        - Data characteristics
            - Accurate
            - Available
        - Development of standard definitions of outcomes and measures
        - Data levels
            - Zip Code
            - County
            - Community
            - State
        - Methods & analysis
            - Data collection
                - Surveys
                - Focus groups
                - Community feedback
        - Analysis

        - Monitoring data trends (i.e., continuous over time)
        - Point-in-time comparisons
        - Root cause analysis
        - Heat maps

    - Data usage
        - Inform tasks forces
        - Development of action plans
        - State score cards
        - Resource justification
        - Monitor compliance
        - Program evaluations
        - Implementation of evidence-based programs
- Gauge of Effectiveness
    - Desired Outcomes of prevention Initiatives
        - Decreased calls to the Central Abuse Hotline
        - Decreased mortality due to neglect and abuse
        - Improvements in Social Determinants of Health
            - Decreased need for social service programs
            - Increase in employment rates
            - Improvement in graduation rates
        - Expansion of Prevention Programs
            - Increased access to programs
            - Increased support of programs

3. What past and current prevention initiatives and accomplishments exist in your locality?

1. Safe Sleep
    - Campaigns (Back2Sleep, Cribs for Kids)
    - Education materials – development and provision
    - Provision of sleepwear and furniture (i.e., pack ‘n plays, onesies)
    - Education/training of parents, caregivers, hospitals
    - Center for Disease Control Sudden Unexpected Infant Death Investigation training
    - Safe sleep coordinators
2. Water and Pool Safety
    - Provision of door and pool alarms
    - Water safety council
    - Education
    - Choose child supervision
    - Designating “pool watchers”
    - Swimming lessons
    - Drowning prevention coordinators
3. Training/Materials to Child Caregivers/Supervisors

- Who's Watching Your Child?
- Hot car
- Shaken Baby Syndrome Prevention
- How to soothe a crying infant/child
- Car seat installation training
- Bike helmet use education
- Fetal Alcohol Syndrome

4. Community Level
   - Family Resource Centers
   - Family Justice Centers
   - Mental Health Center
   - Healthy Start
   - Child Advocacy Center
5. Institution Level
   - Health education in schools
   - Baby friendly hospitals
   - Policy, law, or ordinance development/changes
6. Others
   - Research
   - Build partnerships
   - Develop resource guides
   - Media

Meeting Summary and Next Steps

Dr. Perry acknowledged participants and staff for their dedication and hard work. Primary points were summarized and next steps were identified, including:

- Finalize data input to allow for analysis of data
- Begin crafting annual report

APPENDIX G:

Child Abuse Death Review Data

CHILD DEATH INCIDENT INFORMATION

Location of Child Deaths

Tables G-1 and G-2 provide information related to the number of child fatalities that occurred in each county in Florida. Please note that the county refers to the county where the incident took place, not necessarily the county where the death occurred (although they may be the same county). By way of explanation, there are occasions where the incident causing a child's death may happen in one county; however, the child's death (for example, because he/she was transported to a medical facility in another county) may be documented in another county. From a prevention standpoint, for this report, any county reference refers to the county where the incident contributing to the death (i.e., "death county") took place. Table G-1 highlights every child death across individual counties stratified by maltreatment verification status and primary cause of death (i.e., drowning, asphyxia, weapon, and other). Table G-2 aggregates information denoted in Table G-1 for all primary causes of death for each county. No information in a table cell in either Table G-1 or Table G-2 indicates a zero count for that county category.

When information from Table G-1 is examined, there are three counties that account for almost half the verified child maltreatment deaths (across all categories) in Florida. These include Broward (n=22 or 21.4%), Palm Beach (n=15 or 14.6%), and Hillsborough (n=10 or 9.7%). Verified child maltreatment deaths happened in 29 additional counties throughout Florida for a total of 32 or 47.7% of Florida's 67 counties. When primary cause of death among verified maltreatment cases are examined, 57.9% (11 of 19) of all drowning deaths took place in only two counties. These include Broward (n=6) and Palm Beach (n=5). The remaining verified maltreatment drowning deaths were located in five additional counties, including Hillsborough (n=2), Okeechobee (n=2), Polk (n=2), St. Johns (n=1), and Walton (n=1). Among verified maltreatment deaths involving asphyxia, Broward (n=7) and Palm Beach (n=5) account for 48% of all deaths. The remaining thirteen asphyxia deaths are found across eleven additional counties. The 29 verified maltreatment deaths by weapons are found across 15 different counties in Florida with the greatest number occurring in Gilchrist (n=6), Palm Beach (n=4) and Hillsborough (n=3) counties.

Table G-1 : Distribution of Verified and Non-verified Child Maltreament Deaths Across Florida Counties by Primary Cause of Death

County	Verified for Maltreatment					County	Non- Verified for Maltreatment				
	Drowning	Asphyxia	Weapon	Other	Total		Drowning	Asphyxia	Weapon	Other	Total
Alachua				1	1	Alachua				2	2
Baker						Baker					
Bay				1	1	Bay	1	2		1	4
Bradford						Bradford					
Brevard		1		1	2	Brevard	1	3		8	12
Broward	6	7	1	8	22	Broward	3	3		10	16
Calhoun						Calhoun		1			1
Charlotte		1			1	Charlotte					
Citrus			1	1	2	Citrus		3			3
Clay				1	1	Clay			2	3	5
Collier				1	1	Collier	2			1	3
Columbia						Columbia					
DeSoto						DeSoto					
Dixie						Dixie				1	1
Duval		1	2	1	4	Duval	2	2	2	21	27
Escambia			1	1	2	Escambia		1	1	2	4
Flagler						Flagler				1	1
Franklin						Franklin				1	1
Gadsden						Gadsden					
Gilchrist			6		6	Gilchrist					
Glades						Glades					
Gulf						Gulf					
Hamilton						Hamilton					
Hardee						Hardee					
Hendry						Hendry					
Hernando		1			1	Hernando		4		1	5
Highlands						Highlands		1		3	4
Hillsborough	2	3	3	2	10	Hillsborough	3	7	2	13	25
Holmes						Holmes					
Indian River						Indian River				1	1
Jackson						Jackson					
Jefferson				1	1	Jefferson					
Lafayette						Lafayette					
Lake				1	1	Lake	4	2		3	9
Lee		1			1	Lee				1	1
Leon						Leon		2	2	3	7
Levy						Levy				1	1
Liberty						Liberty					
Madison						Madison				1	1
Manatee						Manatee	1	3		3	7
Marion		1	2		3	Marion	1	2		3	6
Martin						Martin		1	1		2
Miami- Dade		1	2	2	5	Miami- Dade	1	8		10	19
Monroe				1	1	Monroe				1	1
Nassua						Nassua	1				1
Okaloosa						Okaloosa	1			2	3
Okeechobee	2				2	Okeechobee					
Orange			1		1	Orange	9	1	2	10	22
Osceola						Osceola	3		1	5	9
Palm Beach	5	5	4	1	15	Palm Beach	3	4		11	18
Pasco						Pasco	1	4		2	7
Pinellas		1	1		2	Pinellas		2	1	14	17
Polk	2	1		2	5	Polk	4	4		7	15
Putnam				1	1	Putnam				2	2
St Johns	1				1	St Johns	1			6	7
St Lucie		1	1		2	St Lucie				1	1
Santa Rosa						Santa Rosa		1		1	2
Sarasota				2	2	Sarasota				4	4
Seminole			1	1	2	Seminole		1	1	5	7
Sumter						Sumter		1			1
Suwanee			1		1	Suwanee	1			1	2
Taylor						Taylor					
Union						Union					
Volusia			2		2	Volusia	4	3		6	13
Wakulla						Wakulla					
Walton	1				1	Walton					
Washington						Washington					
Total	19	25	29	30	103	Total	47	66	15	172	300

Table G-2: Distribution of All Child Maltreament Deaths Across Florida Counties by Primary Cause of Death

County	Total				
	Drowning	Asphyxia	Weapon	Other	Total
Alachua				3	3
Baker					
Bay	1	2		2	5
Bradford					
Brevard	1	4		9	14
Broward	9	10	1	18	38
Calhoun		1			1
Charlotte		1			1
Citrus		3	1	1	5
Clay			2	4	6
Collier	2			2	4
Columbia					
DeSoto					
Dixie				1	1
Duval	2	3	4	22	31
Escambia		1	2	3	6
Flagler				1	1
Franklin				1	1
Gadsden					
Gilchrist			6		6
Glades					
Gulf					
Hamilton					
Hardee					
Hendry					
Hernando		5		1	6
Highlands		1		3	4
Hillsborough	5	10	5	15	35
Holmes					
Indian River				1	1
Jackson					
Jefferson				1	1
Lafayette					
Lake	4	2		4	10
Lee		1		1	2
Leon		2	2	3	7
Levy				1	1
Liberty					
Madison				1	1
Manatee	1	3		3	7
Marion	1	3	2	3	9
Martin		1	1		2
Miami-Dade	1	9	2	12	24
Monroe				2	2
Nassua	1				1
Okaloosa	1			2	3
Okeechobee	2				2
Orange	9	1	3	10	23
Osceola	3		1	5	9
Palm Beach	8	9	4	12	33
Pasco	1	4		2	7
Pinellas		3	2	14	19
Polk	6	5		9	20
Putnam				3	3
St Johns	2			6	8
St Lucie		1	1	1	3
Santa Rosa		1		1	2
Sarasota				6	6
Seminole		1	2	6	9
Sumter		1			1
Suwanee	1		1	1	3
Taylor					
Union					
Volusia	4	3	2	6	15
Wakulla					
Walton	1				1
Washington					
Total	66	91	44	202	403

Primary Cause of Death

Table G-3 denotes the distribution of child fatality cases reviewed using the general classification of primary cause of death for those cases verified/non-verified to be the result of child maltreatment. Among the 103 child fatalities verified as a result of maltreatment, 95 (92.2%) resulted from an external injury, 4 (3.9%) due to a medical cause, and 4 (3.9%) were undetermined. Among those child fatalities non-verified to be the result of abuse and neglect (n=300), a total of 187 (62.3%) were the result of an external injury, 58 (19.3%) were determined to have a medical cause, and 55 (18.3%) had undetermined or unknown cause of deaths.

Table G-3: Primary Cause of Death by Maltreatment Verification Status		
Primary Cause of Death	Verified n=103	Non-Verified n=300
External Injury	95	187
Medical Cause	4	58
Undetermined If Injury or Medical	4	33
Unknown	0	22

Drowning Death Incident Information

Where information was available, Tables G-4, G-5 and G-6 present findings on the location of the child before drowning, activity of child before drowning and drowning location. A total of 13 (of 19, 68.4%) of the children were playing, two were sleeping and one child was swimming before drowning (see Table G-5). Prior to drowning, a total of 8 (42.1%) were located in the home and 6 (31.6%) were in the water. All (100%) of the children whose death was verified as maltreatment and 92% of children whose death was not verified as maltreatment did not know how to swim.

Table G-4: Location of Child Before Drowning by Child Maltreatment Verification Status		
Location of Child Before Drowning	Child Maltreatment Deaths Drowning n=66	
	Verified (n=19)	Non-Verified (n=50)
In Water	6	13
On Shore	0	2
On Dock	0	0
Pool Side	1	4
In Yard	1	1
In Bathroom	0	2
In House	8	21
Other	3	4
Unknown	0	3

Table G-5: Activity of Child Before Drowning by Child Maltreatment Verification Status		
	Child Maltreatment Death Drowning n=66	
Activity Before Drowning	Verified (n=19)	Non-Verified (n=47)
Playing	13	25
Boating	0	0
Swimming	1	2
Bathing	0	3
Fishing	0	0
Surfing	0	0
Tubing	0	0
Water Skiing	0	0
Sleeping	2	1
Other	2	10
Unknown	1	6

Table G-6 : Drowning Location by Child Maltreatment Verification Status		
	Child Maltreatment Death Drowning n=66	
Drowning Location	Verified (n=19)	Non-Verified (n=47)
Open Water	1	12
Pool/Hot Tub/Spa	16	30
Bathtub	0	3
Bucket	0	0
Well/Cistern/Septic	0	1
Toilet	2	1
Other	0	0

Sleep-Related Asphyxia Death Incident Information

Table G-7 provides a listing and associated counts of specific objects (including persons) that were reported in a child's sleep environment and for objects identified to have blocked/obstructed a child's airway among the reviewed sleep-related asphyxia cases. The other persons (34 adults, 19 other children) were reported to be in the child's sleep environment among sleep-related asphyxia cases. Five persons (3 adults and 2 children) were reported to have unintentionally obstructed airways of children who died from sleep-related asphyxia. Bedding (i.e., pillows, mattresses, comforters/quilts, sheets/thin blankets) was identified to have blocked a child's airway in 16 sleep-related asphyxia cases.

Table G-7: Objects in Sleep Environment Among Sleep-Related Asphyxia Deaths

	Objects Present in Sleep Environment	Objects Obstructing Child's Airway
Adult(s)	34	3
Other Children	19	2
Animal(s)	0	0
Mattress	33	5
Comforter	20	2
Thin blanket/flat sheet	33	1
Pillow(s)	33	8
Cushion	9	2
Boppy or U-Shaped Pillow	6	2
Sleep Positioner	0	0
Bumper Pads	3	1
Clothing	4	0
Crib Railing/Side	2	1
Wall	2	1
Toy(s)	4	0
Other	7	5

Weapon-Related Death Incident Information

Tables G-8 through G-11 summarize information related to the type of weapon, type of firearm, and the sex of the firearm owner, and sex of person handling the weapon related to the child fatality. For **verified** maltreatment weapon deaths, 16 (57.1%) of weapons used were firearms, 9 (32.1%) were body parts, and 2 (7.1%) were sharp instruments. Among the 16 firearm deaths, 13 (81.3%) of the firearms were handguns with the remaining three deaths associated with hunting rifles. The vast majority of the owners 12 of 16 (75%) of firearms used in the fatality were owned by males. When all weapons used in verified maltreatment deaths are considered, 18 of 29 (62.1%) were males who handled the weapon that was used in the child's fatality.

Among **non-verified** weapon deaths, 7 (46.7%) of weapons used were firearms, 6 (40%) were a person's body part, and 1 (6.7%) was a sharp instrument. Among the 7 firearm deaths, 4 (57.1%) of the firearms were handguns, two of the firearm were shotgun and one was an unknown firearm type. All of the owners (100%) of firearms used in the fatality were owned by males. For 11 of 15 (73.3%) of verified weapon cases, males handled the weapon used in the child's fatality.

Table G-8: Type of Weapon by Maltreatment Verification Status

Type of Weapon	Child Maltreatment Death Weapons n=44	
	Verified (n=28)	Non-Verified (n=15)
Firearm	16	7
Sharp Instrument	2	1
Blunt Instrument	0	0
Persons Body Part	9	6
Explosive	0	0
Rope	0	0
Pipe	0	0
Biological	0	0
Other	1	0
Unknown	0	1

Table G-9: Type of Firearm by Maltreatment Verification Status

Firearms	Child Maltreatment Death Weapon Type n=23	
	Verified (n=16)	Non-Verified (n=7)
Handgun	13	4
Shotgun	0	2
BB Gun	0	0
Hunting Rifle	3	0
Assault Rifle	0	0
Air Rifle	0	0
Sawed-Off Shotgun	0	0
Other	0	0
Unknown	0	1

Table G-10: Sex of Fatal Firearm Owner by Maltreatment Verification Status		
Sex of Fatal Firearm Owner	Child Maltreatment Death Weapon Type n=23	
	Verified (n=16)	Non-Verified (n=7)
Male	12	7
Female	4	0
Unknown	0	0

Table G-11: Sex of Person Handling Weapon by Maltreatment Verification Status		
Sex of Person Handling Weapon	Child Maltreatment Death Weapon Type n=44	
	Verified (n=29)	Non-Verified (n=15)
Male	18	11
Female	9	4
Unknown	0	0
Left Blank	2	0

CHILD CHARACTERISTICS

Age of Child

Table G-12 provides a count of children by age group for which their death was verified as maltreatment by primary cause of death.

Table G-12: Age of Children with Verified Maltreatment by Primary Cause of Death and if Death Classified as Abuse or Neglect

Age	Verified Child Maltreatment Death							
	Drowning n=19		Asphyxia n=25		Weapon n=29		Other n=30	
	Abuse	Neglect	Abuse	Neglect	Abuse	Neglect	Abuse	Neglect
< 1	0	1	1	21	1	0	3	9
1	0	2	0	0	6	0	1	1
2	0	5	0	0	3	1	3	3
3	0	4	0	0	2	1	0	1
4	0	1	1	1	2	0	0	5
5	0	3	0	0	1	0	0	1
6-10	0	3	1	0	3	0	0	2
11-15	0	0	0	0	6	1	0	0
16+	0	0	0	0	2	0	0	1

Child's History of Victim of Maltreatment

If known and applicable, the distribution (using counts) of past maltreatment incidents across maltreatment verification status and primary cause of death are denoted in G-13. 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 inflicted on the child at one time. There were 110 past maltreatment incidents reported for the 95 children who died, of which 69 (62.7%) were associated with non-verified child maltreatment deaths.

Table G-13: Child's History as a Victim of Maltreatment for Child Fatality Cases

Type of Past Maltreatment	Verified Child Maltreatment Death				Non-Verified Child Maltreatment Death			
	Drowning	**Asphyxia**	**Weapon**	**Other**	**Drowning**	**Asphyxia**	**Weapon**	**Other**
Physical	0	1	10	2	3	0	2	9
Neglect	2	3	11	9	3	5	3	34
Sexual	0	0	0	0	1	0	0	2
Emotional	0	0	2	1	0	0	1	6

CAREGIVER, SUPERVISOR, AND PERSON(S) RESPONSIBLE CHARACTERISTICS

Table G-14 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 with the exception of one non-verified child maltreatment death classified as "other". Among verified maltreatment deaths, between 68% (asphyxia deaths) and 79.3% (weapon deaths) of the children had a second caregiver present in the home. Among non-verified deaths, 100% of weapon cases had a second caregiver present in the home.

Table G-14: Percentage of Cases with One and Two Caregivers Identified as Present by Child Maltreatment Verification Status and Primary Cause of Death

Caregiver Present	Verified Child Maltreatment Death				Non-Verified Child Maltreatment Death			
	Drowning n=19	Asphyxia n=25	Weapon n=29	Other n=30	Drowning n=47	Asphyxia n=66	Weapon n=15	Other n=172
One	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	99.4%
Two	73.7%	68.0%	79.3%	73.3%	80.9%	78.8%	100.0%	77.3%

Relationship to Child of Caregivers, Supervisors, and Person(s) Responsible for Death

Tables G-15 through G-17 suggest the majority of all caregivers present across all causes of death were the biological parents of the child. However, the proportion of caregivers who are biological parents for weapons related deaths appears to be substantially less than the proportions observed for the other three causes of death categories for both verified and non-verified cases.

Among verified child maltreatment deaths, the proportion of aggregate caregivers who are biological parents was 88% for drowning deaths, 90% for other deaths, and 93% for asphyxia deaths. These proportions are paralleled for non-verified deaths where the proportion of aggregate caregivers who are biological parents was 91% for drowning deaths, 85% for other deaths, and 89% for asphyxia deaths. However, when weapon deaths are examined, 67% of caregivers for verified maltreatment deaths were identified as biological parents. There was a greater likelihood among verified maltreatment deaths for weapon deaths to have a "mother's partner" (13%) or a grandparent (15%) as a primary caregiver.

These findings are reinforced when examining the distributions of caregiver relationship to child is observed for the second, not first identified caregiver. Among verified child maltreatment weapon deaths, the biological parent was identified as the second caregiver 39% of the time. Further, the mother's partner was identified as the second caregiver (where applicable) 30% of the time, along with the child's grandparent (30%). Grandparents were also identified as the second primary caregiver for 14% of the verified child maltreatment drownings and 11% of the verified child maltreatment asphyxia deaths.

Table G-15 Relationship to Child of All Identified Caregivers (aggregate) by Maltreatment Verification Status and Primary Cause of Death								
Caregiver Relationship To Child (All Caregivers)	Verified Child Maltreatment Death				Non-Verified Child Maltreatment Death			
	Drowning n=33	Asphyxia n=43	Weapon n=52	Other n=52	Drowning n=85	Asphyxia n=118	Weapon n=30	Other n=171
Self	0%	0%	0%	0%	0%	0%	0%	0%
Biological Parent	88%	93%	67%	90%	91%	89%	73%	85%
Adoptive Parent	0%	0%	0%	0%	1%	0%	0%	0%
Step-Parent	3%	0%	0%	0%	1%	1%	7%	1%
Foster Parent	0%	0%	2%	2%	0%	0%	0%	2%
Mother's Partner	0%	0%	13%	4%	2%	1%	7%	2%
Father's Partner	0%	0%	2%	0%	0%	1%	3%	0%
Grandparent	9%	5%	15%	2%	4%	5%	7%	5%
Sibling	0%	0%	0%	0%	0%	0%	0%	1%
Other Relative	0%	0%	0%	2%	0%	2%	0%	1%
Friend	0%	0%	0%	0%	1%	1%	3%	1%
Institutional Staff	0%	0%	0%	0%	0%	0%	0%	1%
Other	0%	0%	0%	0%	0%	1%	0%	2%
Unknown	0%	2%	0%	0%	0%	0%	0%	0%

Table G-16: Relationship to Child of Primary (First) Caregiver Identified by Maltreatment Verification Status and Primary Cause of Death								
Caregiver Relationship To Child (Caregiver 1 only)	Verified Child Maltreatment Death				Non-Verified Child Maltreatment Death			
	Drowning n=19	Asphyxia n=25	Weapon n=29	Other n=30	Drowning n=47	Asphyxia n=66	Weapon n=15	Other n=172
Self	0%	0%	0%	0%	0%	0%	0%	1%
Biological Parent	95%	100%	90%	93%	98%	98%	93%	91%
Adoptive Parent	0%	0%	0%	0%	2%	0%	0%	0%
Step-Parent	0%	0%	0%	0%	0%	0%	0%	0%
Foster Parent	0%	0%	3%	3%	0%	0%	0%	2%
Mother's Partner	0%	0%	0%	3%	0%	0%	0%	0%
Father's Partner	0%	0%	3%	0%	0%	0%	0%	0%
Grandparent	5%	0%	3%	0%	0%	0%	7%	4%
Sibling	0%	0%	0%	0%	0%	0%	0%	0%
Other Relative	0%	0%	0%	0%	0%	2%	0%	1%
Friend	0%	0%	0%	0%	0%	0%	0%	1%
Institutional Staff	0%	0%	0%	0%	0%	0%	0%	1%
Other	0%	0%	0%	0%	0%	0%	0%	1%
Unknown	0%	0%	0%	0%	0%	0%	0%	0%

Table G-17: Relationship to Child of Second Caregiver Identified by Maltreatment Verification Status and Primary Cause of Death								
Caregiver Relationship To Child (Caregiver 2 only)	Verified Child Maltreatment Death				Non-Verified Child Maltreatment Death			
	Drowning n=14	Asphyxia n=18	Weapon n=23	Other n=22	Drowning n=38	Asphyxia n=52	Weapon n=15	Other n=133
Self	0%	0%	0%	0%	0%	0%	0%	0%
Biological Parent	79%	83%	39%	86%	82%	77%	53%	77%
Adoptive Parent	0%	0%	0%	0%	0%	0%	0%	0%
Step-Parent	7%	0%	0%	0%	3%	2%	13%	3%
Foster Parent	0%	0%	0%	0%	0%	0%	0%	2%
Mother's Partner	0%	0%	30%	5%	5%	2%	13%	5%
Father's Partner	0%	0%	0%	0%	0%	2%	7%	0%
Grandparent	14%	11%	30%	5%	8%	12%	7%	5%
Sibling	0%	0%	0%	0%	0%	0%	0%	2%
Other Relative	0%	0%	0%	5%	0%	2%	0%	2%
Friend	0%	0%	0%	0%	3%	2%	7%	1%
Institutional Staff	0%	0%	0%	0%	0%	0%	0%	0%
Other	0%	0%	0%	0%	0%	2%	0%	3%
Unknown	0%	6%	0%	0%	0%	0%	0%	1%

Table G-18 focuses on the relationship of the supervisor of the child at the time of the incident leading to the child's death. Here, some parallels exist with data associated with caregivers (see Table G-15) with some noted exceptions. Among verified maltreatment deaths, the percentage of supervisors (across primary causes of death) who were biological parents ranges from 67% (for weapon deaths) to 79% (for other deaths); a large majority for each cause of death. Among verified maltreatment weapon deaths, 22% of the supervisors were the mother's partner, with an additional 4% being the father's partner, and 4% being a grandparent. Among verified maltreatment drownings, 11% were the child's grandparent, 5% a babysitter, and another 5% an "other" relative. Although a large proportion of supervisors associated with asphyxia deaths were biological parents (72%), 8% were identified as babysitters, 8% as friends, 4% as grandparents, 4% as "other" relatives, and 4% as licensed child care workers.

Table G-18: Relationship to Child of Supervisor by Maltreatment Verification Status and Primary Cause of Death								
Supervisor Relationship To Child	Verified Child Maltreatment Death				Non-Verified Child Maltreatment Death			
	Drowning n=19	Asphyxia n=25	Weapon n=27	Other n=29	Drowning n=41	Asphyxia n=60	Weapon n=9	Other n=156
Biological Parent	74%	72%	67%	79%	78%	85%	44%	76%
Adoptive Parent	0%	0%	0%	0%	0%	0%	0%	0%
Step-Parent	0%	0%	0%	0%	0%	2%	11%	1%
Foster Parent	0%	0%	4%	0%	0%	0%	0%	2%
Mother's Partner	0%	0%	22%	7%	0%	0%	22%	3%
Father's Partner	0%	0%	4%	0%	0%	0%	0%	0%
Grandparent	11%	4%	4%	3%	10%	7%	11%	8%
Sibling	0%	0%	0%	3%	2%	2%	0%	1%
Other Relative	5%	4%	0%	3%	5%	2%	0%	2%
Friend	0%	8%	0%	0%	5%	2%	11%	1%
Acquaintance	0%	0%	0%	0%	0%	0%	0%	1%
Hospital Staff	0%	0%	0%	0%	0%	0%	0%	1%
Institutional Staff	0%	0%	0%	0%	0%	0%	0%	1%
Babysitter	5%	8%	0%	3%	0%	0%	0%	3%
Licensed Child Care Worker	0%	4%	0%	0%	0%	0%	0%	0%
Other	5%	0%	0%	0%	0%	2%	0%	3%
Unknown	0%	0%	0%	0%	0%	0%	0%	0%

For verified child maltreatment deaths, Tables G-19 through G-21 present information on the relationship to the child of the person (or persons) deemed responsible for the child's death. Collectively, biological parents represented those who were person(s) responsible for 68% of drowning, 83% of asphyxia, 54% of weapon, and 91% of other causes deaths. For weapon deaths, 18% of all person(s) responsible and 24% of persons directly causing a child's death were the mother's partner. For weapon death cases, 21% listed a child's grandparent as a person responsible with 10% of cases those who directly caused were the child's grandparents. However, it is important to note that one case involved a grandparent who was deemed the person responsible in the weapon deaths of six children, which accounted for a large proportion in this category.

Table G-19: Relationship to Child of All Person(s)s Responsible for Maltreatment Death (aggregate) by Primary Cause of Death				
All Person(s)s Responsible Relationship To Child	Verified Child Maltreatment Death			
	Drowning n=19	Asphyxia n=23	Weapon n=28	Other n=23
Self	0%	0%	0%	0%
Biological Parent	68%	83%	54%	91%
Adoptive Parent	0%	0%	0%	0%
Step-Parent	0%	0%	0%	0%
Foster Parent	0%	0%	4%	0%
Mother's Partner	0%	0%	18%	4%
Father's Partner	0%	0%	4%	0%
Grandparent	11%	0%	21%	0%
Sibling	0%	0%	0%	0%
Other Relative	5%	0%	0%	4%
Friend	5%	4%	0%	0%
Acquaintance	0%	0%	0%	0%
Child's Boyfriend/ Girlfriend	0%	0%	0%	0%
Stranger	0%	0%	0%	0%
Medical Staff	0%	0%	0%	0%
Institutional Staff	0%	0%	0%	0%
Babysitter	5%	4%	0%	0%
Licensed Child Care Worker	0%	4%	0%	0%
Other	5%	4%	0%	0%
Unknown	0%	0%	0%	0%

Table G-20: Relationship to Child of Person who Caused Verified Maltreatment Death by Primary Cause of Death				
Person Responsible - Caused Relationship To Child	Verified Child Maltreatment Death			
	Drowning n=1	Asphyxia n=7	Weapon n=21	Other n=8
Self	0%	0%	0%	0%
Biological Parent	100%	86%	62%	75%
Adoptive Parent	0%	0%	0%	0%
Step-Parent	0%	0%	0%	0%
Foster Parent	0%	0%	5%	0%
Mother's Partner	0%	0%	24%	13%
Father's Partner	0%	0%	0%	0%
Grandparent	0%	0%	10%	0%
Sibling	0%	0%	0%	0%
Other Relative	0%	0%	0%	13%
Friend	0%	0%	0%	0%
Acquaintance	0%	0%	0%	0%
Child's Boyfriend/ Girlfriend	0%	0%	0%	0%
Stranger	0%	0%	0%	0%
Medical Staff	0%	0%	0%	0%
Institutional Staff	0%	0%	0%	0%
Babysitter	0%	0%	0%	0%
Licensed Child Care Worker	0%	0%	0%	0%
Other	0%	14%	0%	0%
Unknown	0%	0%	0%	0%

Table G-21: Relationship to Child of Person who Contributed to Verified Maltreatment Death by Primary Cause of Death				
Person Responsible - Contributed Relationship To Child	Verified Child Maltreatment Death			
	Drowning n=18	Asphyxia n=16	Weapon n=7	Other n=15
Self	0%	0%	0%	0%
Biological Parent	67%	81%	29%	100%
Adoptive Parent	0%	0%	0%	0%
Step-Parent	0%	0%	0%	0%
Foster Parent	0%	0%	0%	0%
Mother's Partner	0%	0%	0%	0%
Father's Partner	0%	0%	14%	0%
Grandparent	11%	0%	57%	0%
Sibling	0%	0%	0%	0%
Other Relative	6%	0%	0%	0%
Friend	6%	6%	0%	0%
Acquaintance	0%	0%	0%	0%
Child's Boyfriend/ Girlfriend	0%	0%	0%	0%
Stranger	0%	0%	0%	0%
Medical Staff	0%	0%	0%	0%
Institutional Staff	0%	0%	0%	0%
Babysitter	6%	6%	0%	0%
Licensed Child Care Worker	0%	6%	0%	0%
Other	6%	0%	0%	0%
Unknown	0%	0%	0%	0%

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

Table G-22 provides the average ages of caregivers, supervisors, and person(s) responsible for child deaths.

Table G-22: Average Ages of Caregivers, Supervisors, and Person(s) Responsible for Child Fatality by Child Maltreatment Verification Status

Average Age (years)	Verified Child Maltreatment Death				Non-Verified Child Maltreatment Death			
	Drowning	Asphyxia	Weapon	Other	Drowning	Asphyxia	Weapon	Other
Caregiver1	29.4	26.5	33.7	31.2	32.3	26.3	32.3	30.0
Caregiver2	36.0	31.8	40.4	32.7	35.0	30.7	30.9	31.8
All Caregivers	32.2	28.7	36.7	31.8	33.5	28.2	31.6	30.8
Supervisors	31.7	30.8	33.6	30.9	34.1	28.2	28.3	31
Person Responsible - Caused	28.0	27.9	37.0	30.9	NA	NA	NA	NA
Person Responsible - Contributed	32.2	30.1	40.1	32.5	NA	NA	NA	NA
All Person(s) Responsible	32.0	29.5	37.9	32.0	NA	NA	NA	NA

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

Observation of information summarized in Table G-23 reveals that the majority of caregivers for children (across all primary cause of death categories) were female. Among verified maltreatment deaths, between 58% (for weapon deaths) and 64% (for drowning deaths) of caregivers were female. Among supervisors of verified child maltreatment deaths, 56% of weapon cases, 64% of asphyxia cases, and 89% drowning cases were females (Table G-24). The exception to this gender trend was found with non-verified deaths involving weapons. Here, 6 of 9 (67%) of the supervisors were males. Among person(s) responsible (either caused or contributed to) the child's death among verified maltreatment deaths, a large majority of drowning deaths (93%) and majority of asphyxia deaths (62%) were women (Table G-25). However, the person(s) responsible for a majority of weapon deaths (63%) and other causes of death (57%) were male.

Table G-23: Gender of All Identified Caregivers (aggregate) by Maltreatment Verification Status and Primary Cause of Death								
Caregiver Gender	Verified Child Maltreatment Death				Non-Verified Child Maltreatment Death			
	Drowning n=33	Asphyxia n=43	Weapon n=52	Other n=52	Drowning n=85	Asphyxia n=117	Weapon n=30	Other n=302
Male	36%	37%	42%	40%	44%	38%	47%	42%
Female	64%	63%	58%	60%	56%	62%	53%	57%
Unknown	0%	0%	0%	0%	0%	0%	0%	1%

Table G-24: Gender of Supervisors by Maltreatment Verification Status and Primary Cause of Death								
Supervisor Gender	Verified Child Maltreatment Death				Non-Verified Child Maltreatment Death			
	Drowning n=19	Asphyxia n=25	Weapon n=27	Other n=29	Drowning n=41	Asphyxia n=60	Weapon n=9	Other n=153
Male	11%	36%	44%	38%	41%	27%	67%	34%
Female	89%	64%	56%	62%	59%	73%	33%	65%
Unknown	0%	0%	0%	0%	0%	0%	0%	1%

Table G-25: Gender of All Identified Person(s) Responsible for Verified Maltreatment Death by Primary Cause of Death				
All Person(s) Responsible	Verified Child Maltreatment Death			
	Drowning n=15	Asphyxia n=26	Weapon n=48	Other n=30
Male	7%	38%	63%	57%
Female	93%	62%	38%	43%
Unknown	0%	0%	0%	0%

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

Tables G-26 through G-28 summarize information related to substance abuse history of all caregivers, supervisors and person(s) responsible.

Findings from Table G-26 reveal that among the caregivers of children whose deaths were verified as child maltreatment, 74 of 178 (41.6%) are known to have a substance abuse history. This proportion is statistically significantly higher than the 152 of 503 (30.2%) of caregivers of children whose death was not verified to result from child maltreatment.[1]

Table G-26: Substance Abuse History of All Identified Caregivers of Children by Maltreatment Verification Status and Primary Cause of Death

	Verified Child Maltreatment Death (n=178)				Non-Verified (n=503) Child Maltreatment Death			
Substance Abuse History	Drowning n=31	Asphyxia n=43	Weapon n=52	Other n=52	Drowning n=81	Asphyxia n=102	Weapon n=29	Other n=291
Yes	19%	51%	58%	31%	10%	40%	31%	32%
No	65%	26%	13%	44%	68%	47%	38%	47%
Unknown	10%	12%	13%	13%	22%	13%	31%	21%
	If Yes, Verified Child Maltreatment Deaths (n=74)				**If Yes, Non-Verified Child Maltreatment Death (n=152)**			
Type of Substance	Drowning n=6	Asphyxia n=22	Weapon n=30	Other n=16	Drowning n=8	Asphyxia n=41	Weapon n=9	Other n=94
Alcohol	0%	23%	17%	25%	63%	24%	44%	30%
Cocaine	0%	14%	17%	56%	13%	7%	33%	22%
Marijuana	83%	91%	73%	69%	13%	71%	56%	66%
Methamphetamine	17%	0%	3%	13%	0%	2%	22%	3%
Opiates	0%	14%	0%	6%	13%	7%	0%	9%
Prescription	0%	18%	3%	38%	0%	15%	33%	19%
Over-the-Counter Drugs	0%	0%	0%	13%	0%	0%	0%	0%
Other	0%	14%	40%	13%	13%	10%	11%	6%
Unknown	0%	0%	7%	0%	13%	7%	11%	9%

When types of substances are examined, the majority of all caregivers of children whose deaths were verified as maltreatment had a history of marijuana use (from a low of 69% for "other" causes to high of 91% for asphyxia deaths). For asphyxia (71%), weapons (56%), and "other" primary causes of death (66%), the majority of all caregivers of children whose deaths were not verified as resulting from maltreatment also had a history of marijuana use. In addition to the use of marijuana, among known cases with substance abuse information, the majority (56%) of caregivers of children who died from "other"

[1] A test of significance between two independent proportions (Z-Score) was done to determine if the observed total proportion of caregivers with a substance abuse history for verified and non-verified cases differed significantly (at $p<.05$, two-tailed test). The observed proportion differences between verified and non-verified child maltreatment deaths was statistically significant (Z-Score-2.77, $p<.01$).

causes used cocaine. Further, in approximately one quarter of the asphyxia deaths (23%) and "other" causes of deaths, there was a primary caregiver with a history of alcohol abuse.

When the substance abuse history of supervisors of children at the time of the child's death is examined (see Table G-27), 40% (n=39 of 98) and 33% (n=82 of 250) of supervisors in verified and non-verified deaths (respectively) were known to have a substance abuse history.[2] Again, given that there are notable numbers of supervisors for which substance abuse history was not known (from a low of 11% of drowning deaths to a high of 37% of weapon deaths among verified cases) the above percentages should be considered conservative estimates of the prevalence of substance abuse histories among supervisors involved in child fatalities.

Table G-27: Substance Abuse History of Supervisors of Children at Time of Death by Maltreatment Verification Status and Primary Cause of Death

Drug Abuse Supervisor	Verified Child Maltreatment Death (n=98)				Non-Verified Child Maltreatment Death (n=250)			
	Drowning n=18	Asphyxia n=24	Weapon n=27	Other n=29	Drowning n=39	Asphyxia n=53	Weapon n=8	Other n=150
Yes	11%	63%	48%	31%	13%	43%	50%	33%
No	78%	17%	15%	41%	67%	45%	25%	46%
Unknown	11%	21%	37%	28%	21%	11%	25%	21%
	If Yes, Verified Child Maltreatment Deaths (n=39)				**If Yes, Non-Verified Child Maltreatment Death (n=82)**			
Type of Substance	Drowning n=2	Asphyxia n=15	Weapon n=13	Other n=9	Drowning n=5	Asphyxia n=23	Weapon n=4	Other n=50
Alcohol	0%	40%	8%	33%	60%	26%	25%	30%
Cocaine	0%	33%	23%	56%	20%	9%	25%	22%
Marijuana	50%	87%	85%	78%	20%	65%	75%	72%
Methamphetamine	50%	0%	8%	11%	0%	4%	25%	4%
Opiates	0%	13%	0%	11%	20%	9%	0%	8%
Prescription	0%	13%	0%	44%	20%	9%	0%	20%
Over-the-Counter Drugs	0%	0%	0%	11%	0%	0%	0%	0%
Other	0%	13%	46%	11%	0%	9%	0%	4%
Unknown	0%	0%	0%	0%	0%	13%	25%	4%

When types of substances are examined, the vast majority of all supervisors of children whose death was verified as maltreatment used marijuana (from a low of 50% for drowning deaths to high of 87% for asphyxia deaths). The majority of all supervisors of children whose death was not verified as resulting from maltreatment also used marijuana when such applied (as it did for caregivers) to deaths by asphyxia (65%), weapons (75%), and "other" primary causes of death (72%). In addition to the use of marijuana, among known cases with substance abuse information, the majority (56%) of supervisors of children (for

[2] A test of significance between two independent proportions (Z-Score) was done to determine if the observed total proportion of supervisors with a substance abuse history for verified and non-verified deaths differed significantly (at $p<.05$, two-tailed test). The observed proportion differences between verified and non-verified child maltreatment deaths was NOT statistically significant (Z-Score=1.23, p=.22).

verified maltreatment deaths) who died from “other” causes used cocaine and 33% had a history of alcohol abuse. Further, in asphyxia deaths, 33% and 40% of the supervisors had a history of cocaine and alcohol abuse (respectively).

Table G-28 summarizes information related to substance abuse history of all person(s) deemed responsible (caused and contributed) for the child’s death. Findings from Table G-28 reveal that among the person(s) responsible for the child’s death whose death was verified as child maltreatment, 46.4% (45 of 97) are known to have a substance abuse history. Substance abuse was identified to be present among 70% of those person(s) responsible for asphyxia deaths, 52% of weapon deaths, 46% of “other” causes of death, and 11% of drowning deaths verified as maltreatment. When types of substances are examined, the vast majority of those responsible for the child’s death verified as maltreatment used marijuana from a low of 50% (one of two) for drowning deaths to high of 94% (15 of 16) of asphyxia deaths. The majority (58%) of all person(s) responsible for a child’s death whose death was classified as an “other” primary cause had an identified history of cocaine use. Further, the majority 10 of 15 (67%) of all person(s) responsible for a child’s death whose death was classified as a weapon death had an identified history of opiate abuse. In at least one quarter of the asphyxia deaths, the person(s) responsible for the death also abused alcohol (25%) and opiates (38%).

Table G-28: Substance Abuse History of All Person(s) Responsible for Child's Death by Maltreatment Verification Status and Primary Cause of Death

All Person(s)s Responsible	Verified Child Maltreatment Death (n=97)			
	Drowning n=19	Asphyxia n=23	Weapon n=29	Other n=26
Yes	11%	70%	52%	46%
No	79%	17%	7%	31%
Unknown	11%	13%	41%	23%
	If Yes, Verified Child Maltreatment Deaths (n=45)			
Type of Substance	Drowning n=2	Asphyxia n=16	Weapon n=15	Other n=12
Alcohol	0%	25%	13%	33%
Cocaine	0%	19%	20%	58%
Marijuana	50%	94%	73%	75%
Methamphetamine	50%	0%	0%	8%
Opiates	0%	38%	67%	25%
Prescription	0%	13%	0%	42%
Over-the-Counter Drugs	0%	0%	0%	8%
Other	0%	19%	40%	25%
Unknown	0%	0%	13%	0%

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

Tables G-29 through G-31 highlight the distribution of caregivers, supervisors and person(s) responsible known to have an identified disability or chronic illness.

Among all caregivers in deaths verified to have resulted from maltreatment, 14% (25 of 179) were known to have an identified disability or chronic illness of which 16 (or 64%) were associated with weapon deaths (Table G-29). Of these 16 caregivers in weapon deaths, 13 were identified as having a physical disability/chronic illness and 3 having a mental disability or illness. The 14% of caregivers with a known disability or chronic illness was significantly higher than the 8% (38 of 497) of caregivers in deaths not verified to have resulted from maltreatment.[3] Among the other causes death, 27 of the 38 caregivers (71%) with known disability.

Table G-29: Presence of Disability or Chronic Illness for All Caregivers by Maltreatment Verification Status and Primary Cause of Death

Disability All Caregivers	Verified Child Maltreatment Death (n=179)				Non-Verified Child Maltreatment Death (n=497)			
	Drowning n=33	Asphyxia n=42	Weapon n=52	Other n=52	Drowning n=75	Asphyxia n=102	Weapon n=30	Other n=290
Yes	0%	10%	31%	10%	7%	5%	3%	9%
No	70%	62%	38%	69%	65%	80%	77%	72%
Unknown	30%	29%	31%	21%	28%	15%	20%	19%
	If Yes, Verified Child Maltreatment Deaths (n=25)				**If Yes, Non-Verified Child Maltreatment Death (n=38)**			
Type of Disability	Drowning n=0	Asphyxia n=4	Weapon n=16	Other n=5	Drowning n=5	Asphyxia n=5	Weapon n=1	Other n=27
Physical	0%	0%	81%	60%	80%	60%	0%	19%
Mental	0%	100%	56%	20%	20%	80%	100%	70%
Sensory	0%	0%	0%	0%	0%	0%	0%	0%
Unknown	0%	0%	0%	20%	0%	0%	0%	7%

When findings from Table G-30 are examined, 15 of 101 (14.8%) supervisors of children whose death was verified to result from maltreatment were identified as having a disability or chronic illness and was statistically higher than the 22 of 277 (7.9%) of supervisors of children whose deaths were not classified as maltreatment.[4] Whereas the majority of verified maltreatment deaths where a supervisor had an illness or disability were due to weapons, 8 of 15 (53.3%). The majority of non-verified deaths where a supervisor had an illness or disability were due to "other" causes of deaths (17 of 22 or 77.3%).

[3] A test of significance between two independent proportions (Z-Score) was done to determine if the observed total proportion of caregivers with an identified disability or chronic illness for verified and non-verified deaths differed significantly (at $p<.05$, two-tailed test). The observed proportion differences between verified and non-verified child maltreatment deaths WAS statistically significant (Z-Score=2.49, p=.013).

[4] A test of significance between two independent proportions (Z-Score) was done to determine if the observed total proportion of supervisors with an identified disability or chronic illness for verified and non-verified deaths differed significantly (at $p<.05$, two-tailed test). The observed proportion differences between verified and non-verified child maltreatment deaths WAS statistically significant (Z-Score=2.00, p=.046).

Table G-30: Presence of Disability or Chronic Illness for Supervisors by Maltreatment Verification Status and Primary Cause of Death								
Disability or Chronic Illness?	Verified Child Maltreatment Death (n=101)				Non-Verified Child Maltreatment Death (n=277)			
	Drowning n=19	Asphyxia n=24	Weapon n=29	Other n=29	Drowning n=40	Asphyxia n=59	Weapon n=15	Other n=163
Yes	0%	13%	31%	20%	2%	7%	7%	10%
No	68%	57%	41%	57%	73%	81%	73%	68%
Unknown	32%	30%	28%	23%	24%	12%	20%	22%
	If Yes, Verified Child Maltreatment Deaths (n= 15)				If Yes, Non-Verified Child Maltreatment Death (n=22)			
Type of Disability	Drowning n=0	Asphyxia n=3	Weapon n=8	Other n=4	Drowning n=1	Asphyxia n=4	Weapon n=0	Other n=17
Physical	0%	0%	88%	75%	100%	50%	0%	24%
Mental	0%	100%	13%	50%	0%	100%	0%	65%
Sensory	0%	0%	0%	0%	0%	0%	0%	6%
Unknown	0%	0%	0%	25%	100%	0%	0%	6%

Table G-31 summarizes information related to the presence of a disability or chronic illness history of all person(s) deemed responsible (caused and contributed) for the child's death. Among person(s) responsible for a child's death, 15 of 97 (15.5%) were identified to have a disability or chronic illness. Nine of these 15 individuals were responsible for weapons deaths for which all of them were identified as having a mental illness or disability and six were identified as having a physical disability or chronic illness.

Table G-31: Presence of Disability or Chronic Illness for Person(s) Responsible for Verified Maltreatment Death by Maltreatment Verification Status and Primary Cause of Death				
Disability or Chronic Illness?	Verified Child Maltreatment Death (n=97)			
	Drowning n=19	Asphyxia n=23	Weapon n=29	Other n=26
Yes	0%	9%	31%	15%
No	70%	64%	41%	65%
Unknown	30%	27%	28%	19%
	If Yes, Person(s) Responsible Verified Child Maltreatment Deaths (n=15)			
Type of Disability	Drowning n=0	Asphyxia n=2	Weapon n=9	Other n=4
Physical	0%	0%	67%	50%
Mental	0%	100%	100%	0%
Sensory	0%	0%	0%	0%
Unknown	0%	0%	0%	50%

Employment Status of Caregivers

Employment status was examined for all identified caregivers. Tables G-32 through G-34 provide information on the distribution of the caregiver employment status. Table G-32 aggregates all caregivers (whether identified as the first or second primary caregiver), whereas Tables G-33 and G-34 breakdown the distribution of caregiver employment status as the first or second listed primary caregiver.

Table G-32: Employment Status of All Identified Caregivers by Maltreatment Verification Status and Primary Cause of Death

Employment - All Caregivers	Verified Child Maltreatment Death				Non-Verified Child Maltreatment Death			
	Drowning n=33	Asphyxia n=42	Weapon n=52	Other n=50	Drowning n=81	Asphyxia n=108	Weapon n=30	Other n=298
Employed	61%	38%	23%	48%	58%	45%	53%	45%
Unemployed	18%	38%	42%	24%	14%	27%	20%	26%
On Disability	0%	2%	0%	4%	0%	1%	0%	3%
Stay-at-Home Caregiver	3%	2%	0%	6%	6%	8%	0%	7%
Retired	3%	0%	4%	0%	0%	1%	0%	0%
Unknown	15%	19%	31%	18%	22%	18%	27%	20%

Table G-33: Employment Status of Primary (First) Caregiver Identified by Maltreatment Verification Status and Primary Cause of Death

Employment - Caregiver1	Verified Child Maltreatment Death				Non-Verified Child Maltreatment Death			
	Drowning n=19	Asphyxia n=25	Weapon n=29	Other n=30	Drowning n=47	Asphyxia n=62	Weapon n=15	Other n=168
Employed	53%	25%	24%	40%	64%	44%	60%	42%
Unemployed	26%	42%	45%	30%	18%	29%	20%	27%
On Disability	0%	4%	0%	3%	0%	2%	0%	3%
Stay-at-Home Caregiver	5%	4%	0%	10%	2%	11%	0%	11%
Retired	0%	0%	7%	0%	0%	0%	0%	0%
Unknown	16%	25%	24%	17%	16%	15%	20%	17%

Table G-34: Employment Status of Second Caregiver Identified by Maltreatment Verification Status and Primary Cause of Death								
Employment - Caregiver2	Verified Child Maltreatment Death				Non-Verified Child Maltreatment Death			
	Drowning n=14	Asphyxia n=18	Weapon n=23	Other n=20	Drowning n=37	Asphyxia n=46	Weapon n=15	Other n=130
Employed	53%	25%	24%	40%	64%	44%	60%	42%
Unemployed	26%	42%	45%	30%	18%	29%	20%	27%
On Disability	0%	4%	0%	3%	0%	2%	0%	3%
Stay-at-Home Caregiver	5%	4%	0%	10%	2%	11%	0%	11%
Retired	0%	0%	7%	0%	0%	0%	0%	0%
Unknown	16%	25%	24%	17%	16%	15%	20%	17%

Education Level of Caregivers

Information on the education level of the caregivers was either unknown or not available for the majority of caregivers across maltreatment verification and primary cause of death categories (Table G-35). 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 efforts be made in future reviews to explore data sources that can provide this information so that more representative conclusions can be made.

Table G-35: Education Level of All Identified Caregivers by Maltreatment Verification Status and Primary Cause of Death								
Education - All Caregivers	Verified Child Maltreatment Death				Non-Verified Child Maltreatment Death			
	Drowning n=31	Asphyxia n=44	Weapon n=49	Other n=51	Drowning n=82	Asphyxia n=109	Weapon n=30	Other n=279
Less than High School	13%	16%	20%	14%	7%	10%	17%	16%
High School	29%	23%	4%	20%	15%	23%	20%	20%
College	6%	5%	10%	14%	10%	3%	0%	4%
Post Graduate	0%	0%	0%	0%	1%	0%	0%	0%
Unknown	52%	57%	65%	53%	67%	64%	63%	59%

English Spoken by Caregivers, Supervisors, and Person(s) Responsible for Death

As can be observed from information detailed in Tables G-36 through G-38, the majority of all caregivers, supervisors, and person(s) responsible for deaths could speak English.

Table G-36: English Speaking by All Identified Caregivers by Maltreatment Verification Status and Primary Cause of Death

Can Caregiver Speak English- All Caregivers	Verified Child Maltreatment Death				Non-Verified Child Maltreatment Death			
	Drowning n=33	Asphyxia n=42	Weapon n=51	Other n=51	Drowning n=84	Asphyxia n=115	Weapon n=27	Other n=293
Yes	91%	100%	96%	98%	88%	97%	100%	95%
No	6%	0%	4%	0%	11%	3%	0%	3%
Unknown	3%	0%	0%	2%	1%	0%	0%	2%

Table G-37: English Speaking Ability All Identified Supervisors by Maltreatment Verification Status and Primary Cause of Death

Can Supervisor Speak English	Verified Child Maltreatment Death				Non-Verified Child Maltreatment Death			
	Drowning n=19	Asphyxia n=24	Weapon n=26	Other n=29	Drowning n=41	Asphyxia n=59	Weapon n=7	Other n=150
Yes	89%	96%	96%	97%	90%	97%	100%	93%
No	5%	0%	4%	0%	10%	3%	0%	4%
Unknown	5%	4%	0%	3%	0%	0%	0%	3%

Table G-38: English Speaking Ability All Identified Person(s) Responsible for Verified Maltreatment Death by Primary Cause of Death

All Persons Responsible English	Verified Child Maltreatment Death			
	Drowning n=21	Asphyxia n=28	Weapon n=32	Other n=28
Yes	81%	100%	100%	93%
No	5%	0%	0%	0%
Unknown	14%	0%	0%	7%

Active Duty Military Status of Caregivers, Supervisors and Person(s) Responsible for Death

One of the core data elements the statewide committee requested to be reported on by the local committees was whether any caregivers, supervisors, and person(s) responsible for the death of a child were on active duty military. Among all caregivers, there was only one caregiver (identified as the second caregiver) who was on active duty military where the child fatality was classified as a verified maltreatment death due to drowning. When fatalities not verified as maltreatment are examined, there were two caregivers (both identified as the second caregiver) who were on active duty military. These deaths were related to "other" primary causes of death.

Among supervisors of children at the time of the death, there were no identified persons on active duty military for any fatality verified as child maltreatment; and, one supervisor who was on active duty military for a fatality that was not verified as a child maltreatment fatality (classified as an "other" primary cause of death). When information related to person(s) responsible for a maltreatment fatality is examined, no person was identified as someone on active duty military.

Caregiver Receipt of Social Services in the Past Twelve Months

Local committees were asked to identify from available sources of information the extent to which caregivers had received social services in the twelve months prior to the child's death. Examination of this information is not meant to stigmatize anyone receiving social services. Rather, it can be a potential indicator of environmental stresses and may help identify possible venues for outreach involving future prevention initiatives. Table G-39 summarizes information related to social services receipt among all caregivers (aggregate) identified and reported on for this data element. Please note (as with all measures of combined/aggregate caregivers) that the number of caregivers denoted in Table G-39 exceeds the number of child fatalities as the majority of children had two identified caregivers. Table G-39 first identifies the number of caregivers (associated with verified maltreatment deaths and non-verified) that received social services and then further identifies the specific type of support services received. Please note that with respect to the type of support received, the column percentages (which relate to the total caregivers associated with each primary cause of death) may exceed 100% as caregivers may receive more than one type of service/support over the course of twelve months.

Table G-39: Receipt of Social Services by All Identified Caregivers of Children by Maltreatment Verification Status and Primary Cause of Death								
	Verified Child Maltreatment Death (n=176)				Non-Verified (n=499) Child Maltreatment Death			
Receipt of Social Services	Drowning n=32	Asphyxia n=42	Weapon n=52	Other n=50	Drowning n=75	Asphyxia n=108	Weapon n=30	Other n=286
Yes	25%	40%	48%	34%	15%	23%	7%	33%
No	38%	14%	17%	20%	32%	18%	43%	21%
Unknown	38%	45%	35%	46%	53%	59%	50%	45%
	If Yes, Verified Child Maltreatment Deaths (n= 67)				**If Yes, Non-Verified Child Maltreatment Death (n=133)**			
Type of Support	Drowning n=8	Asphyxia n=17	Weapon n=25	Other n=17	Drowning n=11	Asphyxia n=25	Weapon n=2	Other n=95
WIC	50%	65%	44%	47%	36%	64%	100%	65%
TANF	13%	6%	28%	12%	0%	4%	0%	12%
Medicaid	75%	88%	92%	71%	73%	60%	50%	64%
Food Stamps	13%	59%	56%	35%	36%	52%	100%	53%
Other	13%	12%	24%	24%	0%	20%	0%	16%
Unknown	0%	0%	20%	0%	9%	0%	0%	2%

It is important to note that there were a number of caregivers across each primary cause of death for which receipt status of social services could not be identified (see first listed "unknown" row category in Table G-39). Regardless, findings from Table G-39 reveal that among the caregivers of children whose death was verified as child maltreatment, 38% (67 of 176) are known to have received some form of social service support in the twelve months prior to the child's death. This rate was significantly higher than the 26.7% (133 of 499) of caregivers of children whose death was not verified to result from child maltreatment.[5] When types of services received is examined across primary cause of the child's death, the vast majority of all caregivers of children whose death was verified as maltreatment received Medicaid (from a low of 71% for "other" causes to high of 92% for weapon deaths). The majority of all caregivers of children whose death was not verified as resulting from maltreatment also received Medicaid (from a low of 50% for weapon deaths to a high of 73% for drowning deaths).

In addition to the receipt of Medicaid, among known cases where social service support was received and where maltreatment was verified, half of caregivers of children who drowned (50%) and the majority of caregivers of children who died from asphyxia (65%) received WIC. The majority of caregivers of children who died from asphyxia (59%) and weapons (56%) received food stamps.

It is important to note that for year 2014, approximately 50% of mothers who delivered infants participated in WIC and approximately 49.7% deliveries were funded by Medicaid (Florida CHARTS, 2015). Therefore,

[5] A test of significance between two independent proportions (Z-Score) was done to determine if the observed total proportion of caregivers receiving social services for verified and non-verified deaths differed significantly (at $p<.05$, two-tailed test). The observed proportions difference was statistically significant (Z-Score = 2.85, $p<.01$) between verified and non-verified child maltreatment deaths.

this data series may be reflective of similar social service receipt occurrences that exist in the general population.

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

Local committees were asked to identify from available sources of information whether caregivers, supervisors, and person(s) responsible for the death of a child were past victims of child maltreatment. Collectively, it was known that 21.6% (38 of 176) of caregivers (Table G-40) of children of verified maltreatment deaths were past child victims of maltreatment. This figure may underestimate the true proportion of caregivers with a history of maltreatment as a child victim as this status was unknown for 59 (or 33.5%) of the total number of caregivers for children where the child's death was verified as maltreatment. The greatest proportion of caregivers (across cause of death categories) for which this history is unknown is for those children who died by weapon (44%), followed by those children who died from "other" causes (37%).

Among the caregivers of children whose death was not a verified maltreatment death, 19.3% (116 of 600) were identified to have been a past victim of child maltreatment.[6]

When past history as a victim of child maltreatment is examined for supervisors (Table G-41) associated with verified maltreatment deaths, it was known that 25.8% (25 of 97) were past child victims of maltreatment. Among the supervisors of children whose death was not a verified maltreatment death, 26.9% (65 of 242) are known to have a history of maltreatment as a child victim.

Among those persons responsible for the child's death (Table G-42), 22.5% (23 of 102) are known to be past child victims of maltreatment.

[6] A test of significance between two independent proportions (Z-Score) was done to determine if the observed total proportion of caregivers with a past history as a victim of child maltreatment for verified and non-verified deaths differed significantly (at $p<.05$, two-tailed test). The observed proportion differences between verified and non-verified child maltreatment deaths was NOT statistically significant (Z-Score=0.66, $p=.51$).

Table G-40: Past History as Victim of Child Maltreatment for All Caregivers by Maltreatment Verification Status and Primary Cause of Death								
	Verified Child Maltreatment Death (n=176)				Non-Verified Child Maltreatment Death (n=600)			
Caregiver Past Victim of Child Maltreatment	Drowning n=32	Asphyxia n=41	Weapon n=52	Other n=51	Drowning n=94	Asphyxia n=132	Weapon n=30	Other n=344
Yes	19%	27%	25%	16%	11%	23%	27%	20%
No	69%	41%	31%	47%	49%	34%	37%	42%
Unknown	13%	32%	44%	37%	27%	17%	30%	20%
	If Yes, Verified Child Maltreatment Deaths (n= 38)				If Yes, Non-Verified Child Maltreatment Death (n=116)			
Type of Maltreatment	Drowning n=6	Asphyxia n=11	Weapon n=13	Other n=8	Drowning n=10	Asphyxia n=30	Weapon n=8	Other n=68
Physical	17%	55%	23%	63%	50%	37%	25%	46%
Neglect	83%	91%	31%	50%	50%	53%	50%	62%
Sexual	50%	27%	15%	38%	10%	23%	25%	24%
Emotional/ Psychological	33%	36%	0%	25%	20%	7%	0%	15%
Unknown	0%	0%	23%	0%	10%	13%	13%	10%

Table G-41: Past History as Victim of Child Maltreatment for Supervisors by Maltreatment Verification Status and Primary Cause of Death								
	Verified Child Maltreatment Death (n=97)				Non-Verified Child Maltreatment Death (n=242)			
Caregiver Past Victim of Child Maltreatment	Drowning n=18	Asphyxia n=23	Weapon n=27	Other n=29	Drowning n=40	Asphyxia n=53	Weapon n=9	Other n=140
Yes	22%	26%	37%	17%	10%	40%	33%	26%
No	61%	39%	33%	48%	63%	40%	33%	51%
Unknown	17%	35%	30%	34%	28%	21%	33%	23%
	If Yes, Verified Child Maltreatment Deaths (n=25)				If Yes, Non-Verified Child Maltreatment Death (n=65)			
Type of Maltreatment	Drowning n=4	Asphyxia n=6	Weapon n=10	Other n=5	Drowning n=4	Asphyxia n=21	Weapon n=3	Other n=37
Physical	0%	67%	20%	100%	25%	43%	33%	46%
Neglect	100%	83%	40%	60%	25%	52%	0%	62%
Sexual	75%	17%	20%	40%	0%	24%	0%	32%
Emotional/ Psychological	25%	17%	0%	40%	0%	10%	0%	19%
Unknown	0%	0%	30%	0%	50%	5%	67%	5%

Table G-42: Past History as Victim of Child Maltreatment for Persons Responsible for Verified Maltreatment Death by Maltreatment Verification Status and Primary Cause of Death				
	Verified Child Maltreatment Death (n=102)			
All Persons Responsible as Past Victim of Child Maltreatment	Drowning n=19	Asphyxia n=23	Weapon n=33	Other n=27
Yes	21%	22%	24%	22%
No	58%	39%	30%	44%
Unknown	21%	39%	45%	33%
	If Yes, Persons Responsible Verified Child Maltreatment Death (n=23)			
Type of Maltreatment	Drowning n=4	Asphyxia n=5	Weapon n=8	Other n=6
Physical	0%	60%	0%	67%
Neglect	100%	100%	25%	67%
Sexual	75%	20%	25%	50%
Emotional/ Psychological	25%	20%	0%	33%
Unknown	0%	0%	13%	0%

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

Local committees were asked to identify from available sources and reports whether caregivers, supervisors, and person(s) responsible for a child's death have a past history as a perpetrator of child maltreatment. When the aggregate of caregivers is examined (Table G-43), 38% (66 of 176) of caregivers of children whose death was verified to result from child maltreatment were identified as past perpetrators of child maltreatment. Among identified cases, the type of maltreatment the perpetrator inflicted on children in the past was most likely to be neglect, from a low of 60% of caregivers associated with weapons deaths to a high of 90% of caregivers associated with asphyxia deaths. However, for weapons related deaths, 60% of the caregivers were perpetrators of neglect and physical abuse of children in the past.

When the aggregate of caregivers associated with non-verified deaths is examined, 31% (156 of 503) were identified as past perpetrators of child maltreatment. Among identified cases, the type of maltreatment the perpetrator inflicted on children in the past was most likely to be neglect, from a low of 44% of caregivers associated with weapons deaths to a high of 75% of caregivers associated with other deaths.

Table G-43: Past History as Perpetrator of Child Maltreatment for All Caregivers by Maltreatment Verification Status and Primary Cause of Death								
	Verified Child Maltreatment Death (n=176)				Non-Verified Child Maltreatment Death (n=503)			
Caregiver Has History as Perpetrator	Drowning n=33	Asphyxia n=40	Weapon n=52	Other n=51	Drowning n=80	Asphyxia n=104	Weapon n=28	Other n=291
Yes	12%	25%	58%	43%	16%	26%	32%	37%
No	79%	70%	27%	47%	78%	63%	54%	57%
Unknown	3%	0%	10%	6%	3%	7%	11%	3%
	If Yes, Verified Child Maltreatment Deaths (n= 66)				If Yes, Non-Verified Child Maltreatment Death (n=156)			
Type of Maltreatment	Drowning n=4	Asphyxia n=10	Weapon n=30	Other n=22	Drowning n=13	Asphyxia n=27	Weapon n=9	Other n=107
Physical	25%	10%	60%	36%	31%	19%	44%	41%
Neglect	75%	90%	60%	64%	69%	70%	44%	75%
Sexual	0%	0%	3%	0%	0%	0%	11%	4%
Emotional/ Psychological	0%	0%	13%	9%	23%	7%	0%	17%
Unknown	0%	0%	3%	5%	8%	0%	11%	1%

When the past history as a perpetrator of supervisors is examined (see Table G-44), 37% (36 of 97) of supervisors of children whose death was verified to result from child maltreatment were identified as past perpetrators of child maltreatment. Among identified cases, the type of maltreatment the perpetrator inflicted on children in the past was most likely to be neglect, from a low of 63% (10 of 16) for supervisors associated with weapons deaths to a high of 75% (3 of 4) for supervisors associated with drowning deaths. However, for weapons related deaths, 69% (11 of 16) of the supervisors were additionally perpetrators of physical abuse of children in the past.

When the aggregate of supervisors associated with non-verified deaths is examined, 34% (84 of 249) were identified as past perpetrators of child maltreatment[7]. Of these 84 perpetrators, a total of 60 (71%) were supervisors of children with other causes of death. Among identified cases, the type of maltreatment the perpetrator inflicted on children in the past was most likely to be neglect (for all causes of death except weapon deaths) from a low of 67% (10 of 15) of caregivers associated with asphyxia deaths to a high of 73% (44 of 60) of supervisors associated with other deaths**.**

[7] A test of significance between two independent proportions (Z-Score) was done to determine if the observed total proportion of supervisors with a past history as a perpetrator of child maltreatment for verified and non-verified deaths differed significantly (at p<.05, two-tailed test). The observed proportion differences between verified and non-verified child maltreatment deaths was NOT statistically significant (Z-Score=0.593, p=.56).

Table G-44: Past History as Perpetrator of Child Maltreatment for Supervisors by Maltreatment Verification Status and Primary Cause of Death								
	Verified Child Maltreatment Death (n=97)				Non-Verified Child Maltreatment Death (n=249)			
Supervisor Has History as Perpetrator	Drowning n=18	Asphyxia n=23	Weapon n=27	Other n=29	Drowning n=39	Asphyxia n=55	Weapon n=9	Other n=146
Yes	22%	13%	59%	45%	18%	27%	22%	41%
No	67%	70%	22%	48%	72%	64%	56%	52%
Unknown	11%	17%	19%	7%	10%	9%	22%	7%
	If Yes, Verified Child Maltreatment Deaths (n=36)				If Yes, Non-Verified Child Maltreatment Death (n=84)			
Type of Maltreatment	Drowning n=4	Asphyxia n=3	Weapon n=16	Other n=13	Drowning n=7	Asphyxia n=15	Weapon n=2	Other n=60
Physical	25%	0%	69%	31%	43%	27%	0%	45%
Neglect	75%	67%	63%	69%	71%	67%	0%	73%
Sexual	0%	0%	6%	0%	0%	0%	0%	3%
Emotional/ Psychological	0%	0%	13%	8%	43%	7%	0%	17%
Unknown	0%	0%	0%	0%	0%	0%	50%	0%

Table G-45 summarizes information related to the past history of child maltreatment for all persons deemed responsible (caused and contributed) for the child's verified maltreatment death. Findings from Table G-45 reveal that among persons responsible for a child's death 45% (43 of 95) were identified to have a past history as a perpetrator of child maltreatment. Among these 43 individuals, 18 (42%) were affiliated with weapons deaths and 17 (40%) were affiliated with "other" causes of death. Again across all causes of death, the type of maltreatment inflicted on children in the past was principally neglect, although physical abuse was also evident with the majority (61%) of perpetrators who were responsible for weapon deaths.

Table G-45: Past History as Perpetrator of Child Maltreatment for Persons Responsible for Verified Maltreatment Death by Maltreatment Verification Status and Primary Cause of Death				
	Verified Child Maltreatment Death (n=95)			
Supervisor Has History as Perpetrator	Drowning n=19	Asphyxia n=21	Weapon n=29	Other n=26
Yes	16%	24%	62%	65%
No	68%	71%	17%	31%
Unknown	16%	5%	21%	4%
	If Yes, Persons Responsible Verified Child Maltreatment Death (n=43)			
Type of Maltreatment	Drowning n=3	Asphyxia n=5	Weapon n=18	Other n=17
Physical	0%	20%	61%	29%
Neglect	67%	80%	61%	65%
Sexual	0%	0%	6%	0%
Emotional/ Psychological	0%	0%	11%	12%
Unknown	0%	0%	6%	6%

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

Table G-46 highlights the distribution of caregivers' history with intimate partner violence as a victim and/or perpetrator. In total, 37 caregivers (18% of 206) were known to be victims and 27 (13.1% of 206) were known to be perpetrators of intimate violence among those affiliated with verified maltreatment deaths. The primary cause of death with the greatest proportion of caregivers as victims (22%) and perpetrators (21%) were verified maltreatment weapon deaths. Among non-verified deaths, a total of 73 caregivers (12.2% of 600) were known to be victims and 65 (10.8% of 600) were known to be perpetrators of intimate violence among those affiliated with verified maltreatment deaths. Statistical tests suggest that the proportion of caregivers known to be victims of intimate violence among verified child maltreatment deaths (18%) was significantly higher than the 12.2% of caregivers associated with non-verified child maltreatment deaths. However, there was no statistical significance in the proportions of caregivers who were past perpetrators of intimate violence.[8]

[8] A test of significance between two independent proportions (Z-Score) was done to determine if the observed total proportion of caregivers with a history as a victim of intimate for verified and non-verified deaths differed significantly (at $p<.05$, two-tailed test). The observed proportion differences between verified and non-verified child maltreatment deaths WAS statistically significant (Z-Score=2.09, p=.037). The same test was conducted for those with a history as a perpetrator of intimate violence. Observed proportions were NOT statistically significant (Z-score =0.98, p=.37)

Table G-46: History of Intimate Partner Violence with Caregivers by Maltreatment Verification Status and Primary Cause of Death								
	Verified Child Maltreatment Death (N=206)				Non-Verified Child Maltreatment Death (n=600)			
History of Intimate Partner Violence	Drowning n=38	Asphyxia n=50	Weapon n=58	Other n=60	Drowning n=94	Asphyxia n=132	Weapon n=30	Other n=344
Yes, as Victim	13%	14%	22%	20%	6%	12%	20%	13%
Yes, as Perpetrator	8%	4%	21%	17%	4%	12%	13%	12%
No	55%	44%	7%	23%	55%	41%	40%	40%
Unknown	13%	18%	40%	27%	19%	17%	27%	22%

Table G-47 highlights the distribution of supervisors' history with intimate partner violence as a victim and/or perpetrator. In total, 23 caregivers (22.3% of 103) were known to be victims and 14 (13.6% of 103) were known to be perpetrators of intimate violence among those affiliated with verified maltreatment deaths. The primary cause of death with the greatest proportion of supervisors as victims (34%) and perpetrators (21%) were verified maltreatment weapons deaths. Among non-verified deaths, a total of 40 of 300 supervisors (13.3%) were known to be victims and 27 of 300 (9%) were known to be perpetrators of intimate violence among those affiliated with verified maltreatment deaths.

Table G-47: History of Intimate Partner Violence with Supervisors by Maltreatment Verification Status and Primary Cause of Death								
	Verified Child Maltreatment Death (n=103)				Non-Verified Child Maltreatment Death (n=300)			
History of Intimate Partner Violence	Drowning n=19	Asphyxia n=25	Weapon n=29	Other n=30	Drowning n=47	Asphyxia n=66	Weapon n=15	Other n=172
Yes, as Victim	16%	12%	34%	23%	6%	14%	13%	15%
Yes, as Perpetrator	11%	4%	21%	17%	2%	12%	13%	9%
No	63%	40%	7%	23%	57%	42%	27%	40%
Unknown	16%	32%	31%	30%	17%	18%	7%	24%

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

When the criminal history of caregivers is examined (Table G-48), among caregivers associated with verified maltreatment deaths, 78 of 177 (44.1%) had committed a criminal offense in the past. This rate was significantly higher when contrasted against 154 of 506 (30.4%) of caregivers of children whose death was not verified as child maltreatment.[9] When primary cause of maltreatment deaths is observed, the highest proportion of caregivers for verified maltreatment cases with a criminal past were those affiliated with weapons deaths (57%), asphyxia deaths (49%), followed by other causes of deaths (40%) and drowning deaths (24%). 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 25% for caregivers associated with verified asphyxia deaths to a high of 50% of those caregivers associated with drowning deaths. The modal type of offenses for caregivers for drowning (50%), asphyxia (75%), and other causes of death (81%) were offenses "other" than assault, robbery and drugs. Please note that the column totals for the type of offense for across each category of primary cause of death may exceed 100% as individual caregivers may have more than one past criminal offense.

Table G-48: Past Criminal History of Caregivers
by Maltreatment Verification Status and Primary Cause of Death

	Verified Child Maltreatment Death (n=177)				Non-Verified Child Maltreatment Death (n=506)			
Criminal History of Caregivers	Drowning n=33	Asphyxia n=41	Weapon n=51	Other n=52	Drowning n=80	Asphyxia n=103	Weapon n=30	Other n=293
Yes	24%	49%	57%	40%	21%	31%	20%	34%
No	67%	44%	33%	38%	71%	52%	60%	53%
Unknown	9%	7%	10%	21%	8%	17%	20%	13%
	If Yes, Verified Child Maltreatment Deaths (n=78)				If Yes, Non-Verified Child Maltreatment Death (n=154)			
Type of Offense	Drowning n=8	Asphyxia n=20	Weapon n=29	Other n=21	Drowning n=17	Asphyxia n=32	Weapon n=6	Other n=99
Assaults	25%	20%	14%	24%	6%	28%	33%	33%
Robbery	0%	20%	0%	14%	0%	6%	17%	12%
Drugs	50%	25%	41%	48%	29%	34%	50%	37%
Other	50%	75%	34%	81%	88%	69%	83%	71%
Unknown	0%	0%	24%	5%	0%	3%	0%	1%

When the criminal history of supervisors is examined (See Table G-49), among supervisors associated with verified maltreatment deaths, 47 of 99 (47.5%) had committed a criminal offense in the past. This rate is significantly higher when contrasted against 83 of 250 (33.2%) of supervisors of children whose death

[9] A test of significance between two independent proportions (Z-Score) was done to determine if the observed total proportion of caregivers with a past criminal history for verified and non-verified deaths differed significantly (at p<.05, two-tailed test). The observed proportion differences between verified and non-verified child maltreatment deaths WAS statistically significant (Z-Score=3.29, p<.01).

was not verified as child maltreatment.[10] When primary cause of maltreatment deaths is observed, the highest proportion of supervisors for verified maltreatment cases with a criminal past were those affiliated with weapons deaths (67%), asphyxia deaths (58%), followed by other causes of deaths (41%) and drowning deaths (16%). 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 33% for supervisors associated with verified asphyxia and other deaths to a high of 56% of those supervisors associated with weapon deaths. The modal type of offenses for supervisors for drowning (67%), asphyxia (57%), and other causes of death (83%) were offenses "other" than assault, robbery, and drugs. Please note that the column totals for the type of offense for each category of primary cause of death may exceed 100% as individual caregivers may have more than one past criminal offense.

Table G-49: Past Criminal History Associated with Supervisors by Maltreatment Verification Status and Primary Cause of Death								
	Verified Child Maltreatment Death (n=99)				Non-Verified Child Maltreatment Death (n=250)			
Criminal History of Supervisors	Drowning n=19	Asphyxia n=24	Weapon n=27	Other n=29	Drowning n=39	Asphyxia n=54	Weapon n=9	Other n=148
Yes	16%	58%	67%	41%	23%	37%	33%	34%
No	74%	29%	26%	38%	67%	50%	44%	52%
Unknown	11%	13%	7%	21%	10%	13%	22%	14%
	If Yes, Supervisor of Verified Maltreatment Death (n=47)				If Yes, Supervisors of Non-Verified Child Maltreatment Death (n=83)			
Type of Offense	Drowning n=3	Asphyxia n=14	Weapon n=18	Other n=12	Drowning n=9	Asphyxia n=20	Weapon n=3	Other n=51
Assaults	33%	14%	11%	17%	0%	30%	33%	31%
Robbery	0%	21%	0%	17%	0%	10%	0%	8%
Drugs	33%	43%	56%	33%	56%	35%	100%	35%
Other	67%	57%	44%	83%	78%	70%	33%	69%
Unknown	0%	0%	0%	8%	0%	5%	0%	2%

[10] A test of significance between two independent proportions (Z-Score) was done to determine if the observed total proportion of supervisors with a past criminal history for verified and non-verified deaths differed significantly (at $p<.05$, two-tailed test). The observed proportion differences between verified and non-verified child maltreatment deaths WAS statistically significant (Z-Score=2.49, p=.012).

Table G-50: Past Criminal History Associated with All Persons Responsible by Maltreatment Verification Status and Primary Cause of Death				
Criminal History All Persons Responsible	Verified Child Maltreatment Death (n=98)			
	Drowning n=20	Asphyxia n=23	Weapon n=29	Other n=26
Yes	10%	65%	62%	58%
No	75%	30%	31%	31%
Unknown	15%	4%	7%	12%
	If Yes, Persons Responsible Verified Child Maltreatment Death (n=50)			
Type of Criminal History	Drowning n=2	Asphyxia n=15	Weapon n=18	Other n=15
Assaults	50%	20%	11%	27%
Robbery	0%	7%	0%	20%
Drugs	50%	40%	17%	40%
Other	50%	60%	44%	87%
Unknown	0%	0%	39%	7%

Past Child Death Associated with Caregivers, Supervisors, and Person(s) Responsible for Death

Table G-51: Past Child Death Associated with Caregivers by Maltreatment Verification Status and Primary Cause of Death								
	Verified Child Maltreatment Death (n=178)				Non-Verified Child Maltreatment Death (n=503)			
Past Child Death with Caregiver	Drowning n=33	Asphyxia n=41	Weapon n=52	Other n=52	Drowning n=80	Asphyxia n=104	Weapon n=30	Other n=289
Yes	0%	2%	13%	2%	0%	2%	0%	2%
No	97%	93%	79%	90%	99%	93%	100%	91%
Unknown	3%	5%	8%	8%	1%	5%	0%	7%

Table G-52: Past Child Death Associated with Supervisors by Maltreatment Verification Status and Primary Cause of Death								
	Verified Child Maltreatment Death (n=98)				Non-Verified Child Maltreatment Death (n=246)			
Past Child Death with Supervisor	Drowning n=19	Asphyxia n=23	Weapon n=27	Other n=29	Drowning n=39	Asphyxia n=54	Weapon n=8	Other n=145
Yes	0%	4%	4%	3%	0%	4%	0%	0%
No	95%	83%	89%	90%	97%	93%	100%	92%
Unknown	5%	13%	7%	7%	3%	4%	0%	8%

Table G-53: Past Child Death Associated with Persons Responsible for Verified Maltreatment Death by Maltreatment Verification Status and Primary Cause of Death				
	Verified Child Maltreatment Death (n=96)			
Past Child Death with Persons Responsible	Drowning n=20	Asphyxia n=21	Weapon n=29	Other n=26
Yes	0%	5%	24%	4%
No	90%	86%	69%	92%
Unknown	10%	10%	7%	4%