Child Abuse Death Review Committee

Working to eliminate preventable child abuse and neglect deaths in Florida

Annual Report

December 2016

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MISSION:

To eliminate preventable child abuse and neglect deaths

Submitted to:

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

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EXECUTIVE SUMMARY

Florida's Child Abuse Death Review Process

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

The purpose of the CADR process is to:

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

Since the inception of the CADR system, changes in statutory requirements have gradually widened the scope of child fatality cases committees are expected to review. Currently, local committees conduct case reviews on all child fatalities reported to the Florida Abuse Hotline, including those investigated and found **verified** as child maltreatment as well as those **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.

2015 Data: Case Review Analyses

Throughout 2016, the death review system conducted case reviews on over 349 child fatalities that occurred in 2015. Analyses of 2015 case review data reveal that Florida's youngest children continue to be most vulnerable to child abuse and neglect fatalities. Regardless of verification status, children under five had the highest risk for all forms of death. Additional findings identify three primary preventable causes of child deaths, which remain consistent with findings from previous years:

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

From Analysis to Action

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

multi-sector strategies to further prevention initiatives. Public awareness campaigns, improvements in community-based systems of care, enhancements in staff training and programmatic policy, and many other impact-based activities continue to be shaped and informed by CADR findings and recommendations.

Prevention Recommendations

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

The following prevention recommendations for 2016 provide a high-level overview of strategies and approaches aimed at eliminating preventable child fatalities in Florida:

- ***Enhance and Support the Integration of Behavioral Health Services into the Child Welfare System:*** Substance use disorders, mental health disorders, and dynamics associated with domestic violence have profoundly negative impacts on parental capacity and child well-being while greatly increasing the risk of child harm. Readily accessible and appropriate interventions for at-risk families dealing with these issues is a critical step toward ensuring a safe, stable, and nurturing environment for children. Behavioral health services in the child welfare system should include an assessment of trauma for children exposed to adverse child experiences (ACE) and appropriate trauma informed interventions to improve short and long-term health outcomes.

- ***Continue to Support Programs that Enhance Parenting Skills:*** Family support programs provide high-risk families with the necessary knowledge, resources, and support to bolster parental protective capacities, thereby increasing child safety. These supports lead to improved outcomes for families including reduction and prevention of child abuse and neglect, reduction in risk factors for abuse and neglect, improved parent-child interaction, increased family stability and self-sufficiency, and improved maternal and child health.

- ***Ensure Clear and Consistent Messaging among Agencies During Efforts to Increase Awareness:*** A wide array of agencies and organizations are actively involved in prevention messaging. While all stakeholders are striving toward similar goals, inconsistencies in messaging can and do occur. Consistency in messaging, particularly those communications designed to encourage prevention-oriented behaviors, eliminates confusion among caregivers and sends a stronger, more unified message to the general public. The consistency of Florida's prevention messaging is a priority at the state and local levels and requires active collaboration and communication between agencies to ensure alignment of content.

- ***Encourage Collaborative Partnerships at both the State and Community Levels:*** Interagency and community stakeholder partnerships must be established and maintained at both the state and local levels. Truly collaborative partnerships encourage the sharing of data and information by establishing reliable streams of communication between agencies and organizations. Active collaboration encourages the pooling of resources, reinforces the alignment of prevention planning, and ensures the consistency of collective prevention messaging informed by research literature, and state/federal agency.

- ***Explore the Value and Utility of Existing Prevention Activities Throughout Florida:*** The value and utility of current prevention initiatives and efforts should be fully explored. Strategies and approaches that show promise and appear to have positive impacts on prevention efforts should be considered for replication in other areas within the state. Resources including tools, templates, and promising practices should be shared among local committees to further attempt to reduce duplication of effort and encourage consistent messaging throughout the state.

- ***Support the Development of Toolkits to Assist in the Planning and Development of Prevention Activities:*** Various toolkits should be developed to help address specified hot topics, such as water safety awareness, safe sleep initiatives, bolstering protective factors to increase parental capacity, and tips and techniques for fostering community collaboration. These toolkits should be developed based on standards and recommendations acknowledged by research, professional literature, and/or existing state and federal agencies.

- ***Offer Training and Technical Assistance to Circuits Regarding How to Leverage Data to Inform and Improve Practice:*** Training and technical assistance should be offered to those circuits most interested in delving into their own localized data to further identify contributing factors specific to their community. This training should incorporate information on how to leverage available data tools, training on basic data analysis techniques, and instruction on action planning. All circuits and stakeholders should be provided with guidance regarding how to best leverage the findings of this report to develop sound and effective prevention techniques designed to meet the specific needs of their areas.

The implementation of these comprehensive prevention strategies will provide the momentum needed to work 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 CADR System was established in Florida law in 1999. The program is administered by DOH and utilizes local CADR committees to conduct detailed reviews of the facts and circumstances surrounding child deaths reported to the Florida Abuse Hotline and accepted for investigation. The State CADR Committee collects and analyzes data from the local reviews, and prepares an annual statistical report, which is submitted to the Governor, President of the Senate and Speaker of the House of Representatives.

STATUTORY AUTHORITY

Section 383.402, FS, authorizes the State and local CADR committees and mandates guidelines for membership and duties. The state committee was initially authorized to review only verified child abuse deaths with at least one prior report to the Florida Abuse Hotline. After several years, it was determined that the requirement for a prior report limited the committee's ability to review infant deaths, and in 2004 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 Florida Abuse Hotline. Section 383.402, FS, is referenced in Appendix A.

PROGRAM PURPOSE

The purpose of the CADR process is to:

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

STATE COMMITTEE

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

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

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

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

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

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

LOCAL CHILD ABUSE DEATH REVIEW COMMITTEES

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

Recent Systemic Changes

Local committees have successfully adapted to a number of system changes occurring this year. In January 2015, local committee boundaries were adjusted to realign with judicial circuits. During this transition:

- Several geographical regions were split in such a way that new committees had to completely rebuild membership;
- All local committee members throughout the state were appointed (or re-appointed) to ensure each committee met membership criteria outlined in statute; and
- A significant portion of appointed local committee members were new to the CADR system.

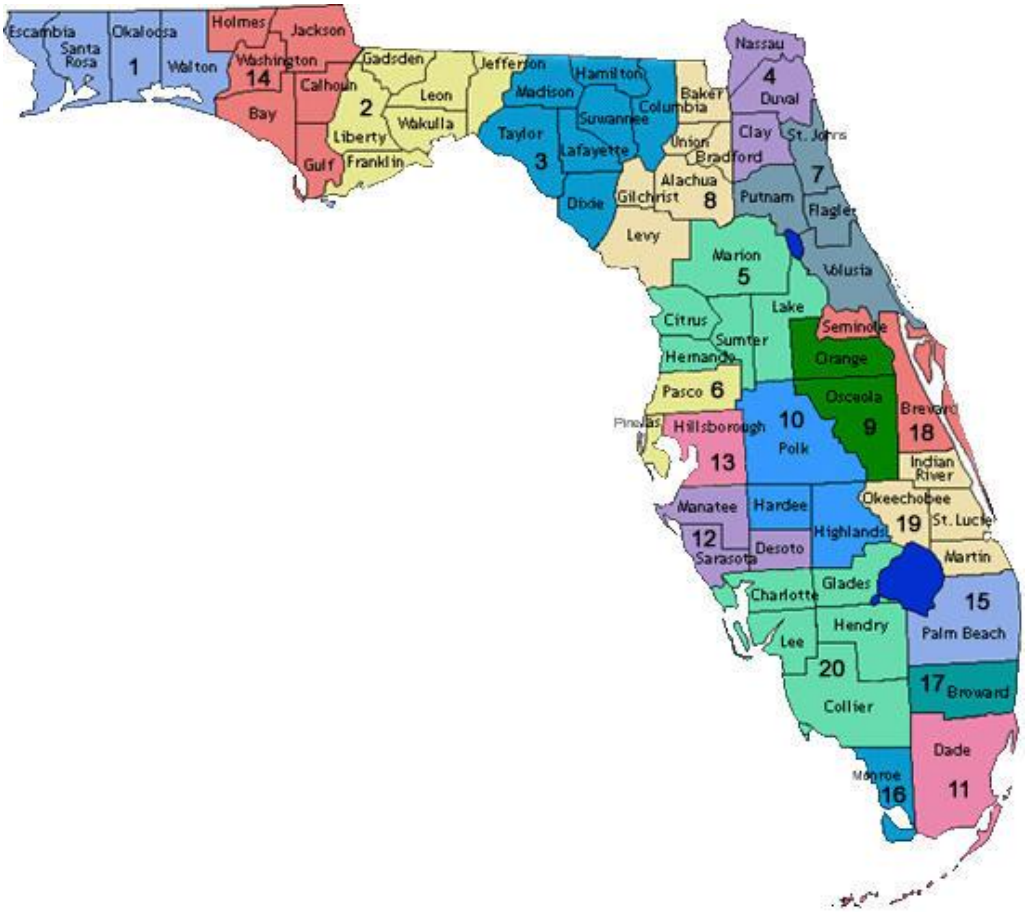
Recent changes in statute direct County Health Officers to appoint, convene, and support CADR committees. Every county has an appointed health officer, and one appointee is designated the lead CADR Health Officer for each circuit. This year brought about the full integration of health officer involvement in the CADR system. Their collective involvement has provided an extra layer of support to committees at the local level.

Membership of Local Committees

At a minimum, representatives from the following organizations are appointed by the CADR health officers:

- The state attorney's office
- The medical examiner's office
- The local Department of Children and Families child protective investigations unit
- Department of Health child protection team
- The community-based care lead agency
- State, county, or local law enforcement agencies
- The school district
- A mental health treatment provider
- A certified domestic violence center
- A substance abuse treatment provider
- Any other members that are listed in guidelines developed by the State CADR Committee

Map of Circuit-based Committees



Case Review Statistics

Case data analyzed for this report includes all information on cases reviewed with data entered into the National Center for the Review & Prevention of Child Deaths database by September 30, 2016. Table 1 details the distribution of 2015 child fatality cases reviewed (stratified by maltreatment verification status), those awaiting review, and those that were not available for review as of September 30, 2016 for each local CADR committee.

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

	Total Cases (Child deaths called into hotline)	Cases Not Available for Review (Open investigation/Case still being processed)	Closed Investigation (case available for review)	Review Completed	Verified Maltreatment Cases Reviewed	Non-Verified Maltreatment Cases Reviewed
Circuit #1	23	13	10	7	0	7
Circuit #2	10	4	6	5	1	4
Circuit #3	4	0	4	4	1	3
Circuit #4	43	0	43	42	9	33
Circuit #5	40	1	39	18	3	15
Circuit #6	37	2	35	35	8	27
Circuit #7	19	0	19	19	4	15
Circuit #8	6	0	6	6	1	5
Circuit #9	39	1	38	37	7	30
Circuit #10	40	1	39	36	4	32
Circuit #11	26	16	10	9	3	6
Circuit #12	19	9	10	10	3	7
Circuit #13	30	2	28	28	3	25
Circuit #14	12	9	3	0	0	0
Circuit #15	27	10	17	17	3	14
Circuit #16	0	0	0	0	0	0
Circuit #17	34	7	27	26	9	17
Circuit #18	25	1	24	24	10	14
Circuit #19	13	3	10	10	3	7
Circuit #20	27	7	20	16	7	9
Totals	474	86	388	349	79	270

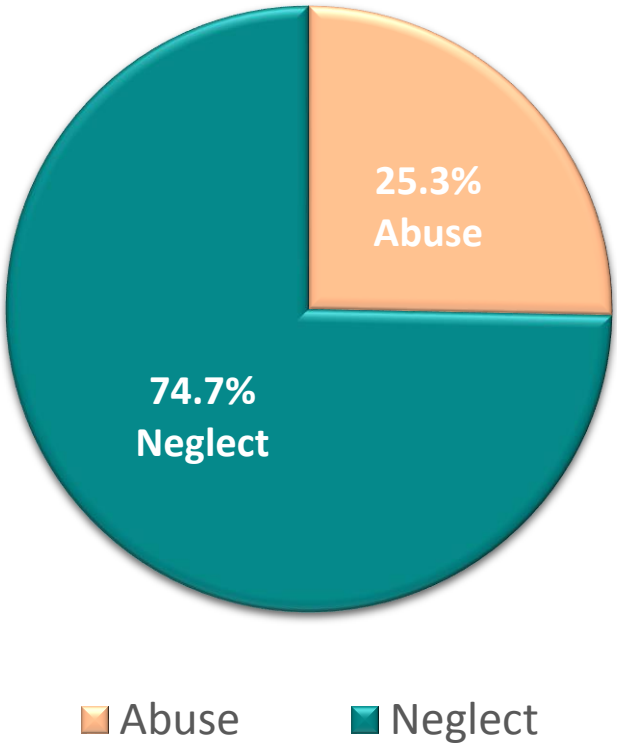
Summary Points:

- 474 child fatalities for 2015 were called into the Florida Abuse Hotline (Data as of 09/30/16)
  - 388 of these cases were closed by the Florida Department of Children and Families (DCF)
  - 86 cases were still open or recently closed for which case information was in the process of being assembled and prepared for review by local CADR committee.
- Of the 388 closed cases for which the information was available for review, 349 had local CADR committee reviews completed, with the remainder of cases (n=39) scheduled for review after September 30, 2016. Please note that this report applies to the 349 cases that local CADR committees completed. Findings are qualified by this fact and may change once all referenced child fatalities are reviewed. Consideration will be given in the future by the State CADR Committee toward

supplemental analyses on 2015 fatalities when the remaining 125 child fatality cases are closed and reviewed by local committees.

- Of the 79 verified maltreatment deaths reviewed, the majority, 59 (74.7%), were a result of neglect and 20 (25.3%) were a result of abuse (see Figure 1 below).

Figure 1: Distribution of Reviewed Verified Maltreatment Deaths by Abuse and Nelgect



SECTION TWO: METHOD

CASE FILE TRANSFER PROCESS IMPROVEMENTS

Significant improvements were made to the CADR case file transfer process during this calendar year. DOH central office staff, in partnership with DCF child fatality prevention staff, developed an improved system of transferring case file information using a secured, web-based site (MoveIt) as the point of transfer. Newly developed procedures streamline the transfer process as case information flows from DCF to DOH and is ultimately distributed to committee chairs. This newly established process improves accountability, ensures security of confidential case information, and provides a reliable mechanism for tracking files as they move through the CADR system. Increased collaboration is also evident during monthly CADR circuit calls, where participation has moved beyond committee chairs to also include CADR health officers, DCF staff, and other interested stakeholders. As a result, communication between all parties has greatly improved.

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 committees and members. The State CADR Committee has identified core data to be collected for each case, and has provided detailed guidance on the content of case narratives.

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, review data are entered into the Child Death Review Case Reporting System.

THE CADR CYCLE

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

Newly formed circuit-based committees brought about an opportunity to reinforce this goal – to move beyond data collection into collaborative action. During monthly circuit conference calls, training, and technical assistance, local committee members were encouraged to view the collective review process as a cycle, during which data are collected, analyzed and acted upon.

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

SECTION THREE: DATA

It is important for the reader to understand how abuse investigation findings are classified. At the time of the local committee reviews of year 2015 cases, DCF's operating procedures (Child Maltreatment Index) classified the findings from investigations as follows:

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

Core data elements of case reviews are summarized in this report by child maltreatment verification status. Since all cases were called into the Florida Abuse Hotline for investigation, all tabled data refer to cases as either "verified child maltreatment" death or a "non-verified child maltreatment" death. Non-verified child maltreatment death includes both "not substantiated" and "no indicators" findings.

The state committee also recommended that statewide summary data include:

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

CHILD DEATH TRENDS

In 2015, the all-cause death rate for children aged 0-17 was 54.4 deaths per 100,000 child population (Florida CHARTS, 2016). The reported 2015 verified child maltreatment death rate in Table 2 is 2.3 per 100,000 child population. This figure should be considered tentative and an underestimate as there are a number of cases (see Table 1) that were still open at DCF and not yet transferred to local CADR committees for which verification status has been determined. Table 2 shows the number and rates of all-cause and verified child maltreatment deaths among children in Florida from 2011-2015 where the child maltreatment death rate (between 2011 and 2014) has ranged from a low of 3.2 (per 100,000) in 2012 to a high of 3.58 (per 100,000) in 2014.

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

	Child Deaths All Causes	Child Death Rate per 100,000 Child Population	Verified Child Maltreatment Deaths	Child Maltreatment Death Rate per 100,000 Child Population
2011	2,191	54.7	136	3.40
2012	2,046	50.8	129	3.20
2013	2,105	51.7	137	3.37
2014	2,131	52	147	3.58
2015	2,249	54.4	95*	2.30*

* The number of verified child maltreatment cases for 2015 is not complete given the number of cases still open and not yet transferred to local CADR Committees for review. Past year figures may have changed as cases were closed following the submission of past CADR reports.

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 79 child fatalities verified to be the result of abuse and/or neglect, 48 (60.8%) were classified as accidents and 25 (31.6%) were classified as homicides. Among non-verified child maltreatment fatalities, the largest number of deaths (n=108 or 40.0%) were classified as accidents followed by natural causes (n=76 or 28.1%). There were 74 non-verified child maltreatment fatalities where the official manner of death was undetermined.

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

Official Manner of Death	Child Maltreatment Death	
	Verified n=79	Non-Verified n=270
Natural	3	76
Accident	48	108
Suicide	1	6
Homicide	25	2
Undetermined	2	74
Pending	0	0
Unknown	0	4

Table 4 identifies three specific primary causes of death for maltreatment cases that account for 74.7% of known verified child maltreatment fatalities: deaths by drowning (39.2%), trauma/wounds caused by a weapon (17.7%), and asphyxia (17.7%). These are the primary cause of death categories throughout this report.

When the number (n=25) of homicides of children that were verified child maltreatment deaths are cross-referenced against primary cause of death categories, 13 (52%) resulted from weapons, 4 involved asphyxia, 2 involved drowning, 1 involved fire/burns, 1 involved poisoning, 2 were identified with “other” causes. Information on manner of death was missing from the committee report on 2 homicide deaths. The 2 homicide deaths for non-verified child maltreatment cases reviewed involved weapons. In these 2 cases, the person responsible (i.e. that caused the death/homicide) was denoted as a sibling that was not a caregiver or supervisor. Subsequently, the homicide was not classified/verified as a maltreatment death.

Table 5 displays counts of deaths resulting from medical causes. There were 3 verified maltreatment deaths due to medical neglect.

Table 4: Itemization of Specific Cause of Death for External Injuries by Child Maltreatment Verification Status		
Specific External Injury Cause of Death	Child Maltreatment Death	
	Verified n=72	Non-Verified n=135
Weapons	14	5
Asphyxia	14	66
Sleep-related	7	58
Not sleep-related	7	8
Drowning	31	42
Motor Vehicle	4	4
Poisoning, Overdose, Intoxication	3	2
Animal Bite/Attack	0	0
Fire, Burn, Electrocution	1	1
Exposure	1	1
Undetermined	0	4
Other	4	4
Fall/Crush	0	5
Asthma	0	0
Unknown	0	1

Table 5: Itemization of Specific Medical Cause of Death by Child Maltreatment Verification Status		
Specific Medical Cause of Death	Child Maltreatment Death	
	Verified n=2	Non-Verified n=68
Cancer	0	0
Cardiovascular	0	4
Congenital Anomaly	0	12
HIV/AIDS	0	0
Influenza	0	1
Low Birth Weight	0	0
Malnutrition	0	0
Dehydration	0	0
Neurological/Seizure Disorder	0	5
Pneumonia	1	8
Prematurity	1	9
SIDS	0	3
Other Infection	0	10
Other Perinatal	0	0
Other Medical	0	15
Undetermined	0	1
Unknown	0	0

Location of Child Deaths

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

- 50.7% of all drownings occurred in seven counties: Broward, Duval, Hillsborough, Lee, Orange, Polk, and Volusia.
- 57.5% of all asphyxia deaths occurred in seven counties: Brevard, Duval, Hillsborough, Orange, Pinellas, Polk, and Volusia.
- 78.94% of weapons deaths occurred in five counties: Duval, Orange, Pasco, Pinellas, Polk.

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

Drowning Location	Child Maltreatment Death	
	Drowning n=73	
	Verified (n=31)	Non-Verified (n=42)
Open Water	6	7
Pool/Hot Tub/Spa	19	32
Bathtub	5	1
Bucket	0	1
Well/Cistern/Septic	0	0
Toilet	1	1
Other	0	0

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

Barriers in Place	Child Maltreatment Death	
	Drowning n=73	
	Verified (n=31)	Non-Verified (n=42)
None	5	11
Fence	6	6
Gate	4	7
Door	15	16
Alarm	2	1
Cover	0	0
Unknown	1	6

Among the 31 verified maltreatment drowning deaths:

- 25 cases had data on the child's ability to swim, only 2 (8%) of the 25 children knew how to swim
- 19 (61.3%) occurred in pools, hot tubs, or spas
- 5 (16.1%) drowning cases had no barriers (alarms, gates, etc.) to bodies of water
- 25 (80.6%) cases had barriers in place (some cases had more than 1 barrier)

Among the 42 non-verified maltreatment drowning deaths:

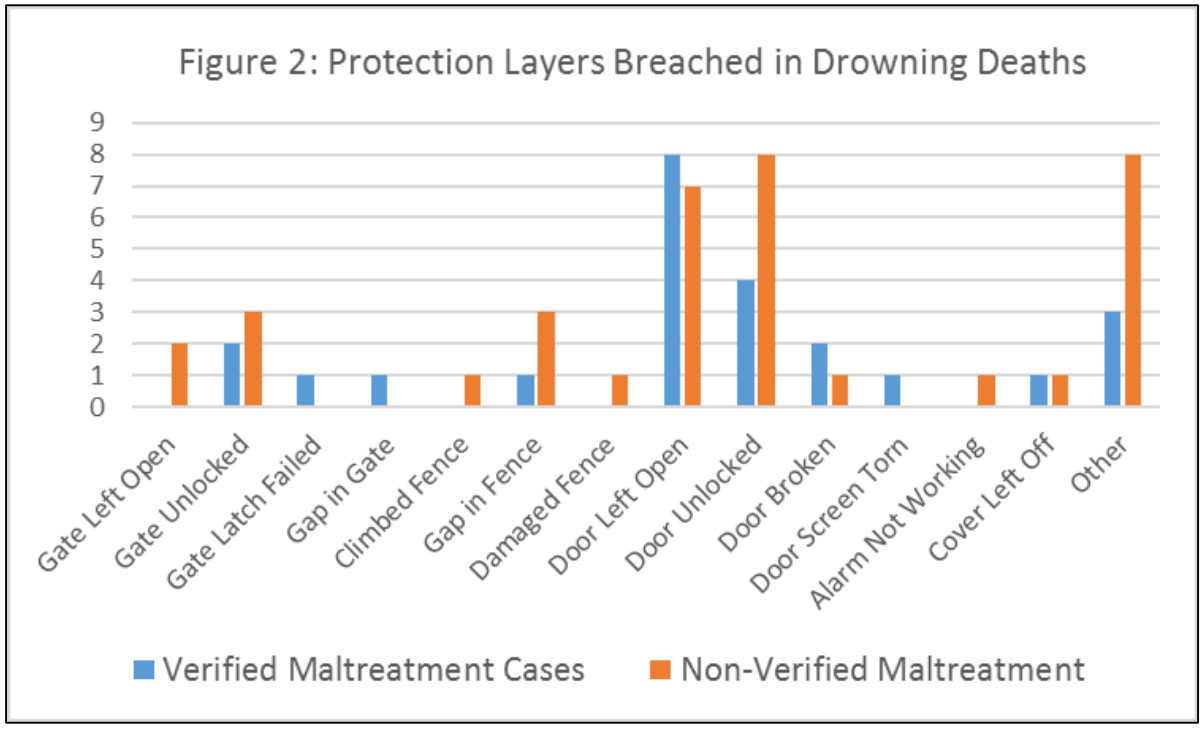
- 35 (or 100% of 35 cases with data on child's ability to swim) did not know how to swim
- 32 (76.2%) occurred in pools, hot tubs, or spas
- 7 (16.6%) cases occurred in open water
- 11 (26.2%) cases had no barriers (alarms, gates, etc.) to bodies of water

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

- 14 (45.2%) were located in the home prior to drowning
- 7 (22.6%) were in the water prior to drowning

All but two (93.5%) of the children whose death was verified as maltreatment and 100% of children whose death was not verified as maltreatment did not know how to swim. Among verified maltreatment deaths, 19 of 31 (61.3%) of the children were playing, four were sleeping and two were bathing before drowning. Among non-verified maltreatment deaths 33 of 42 (80.5%) were playing prior to drowning. For additional detail, reference tables G-4, G-5, and G-6 in Appendix G.

Since protective barriers were in place for the majority of bodies of water (predominately pools, hot tubs, and spas) where children drowned, information was sought regarding the protective layers that were breached. Where data were available (see Figure 2 below), the most prevalent breach for verified maltreatment drowning deaths included doors being left open (n=8), doors unlocked (n=4), and "other" breaches (n=3). Among non-verified maltreatment drowning deaths, the most prevalent breach included unlocked doors (n=8), "other" breaches (n=8), doors left open (n=7), gates unlocked (n=3), and gaps in fences (n=3). With respect to "other" breaches, local CADR committees identified specific persons (typically adults and/or caretakers) whose actions may have resulted in a barrier breach for the child.



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 2015 CADR cases thus far reviewed, there were 80 deaths due to asphyxia. As noted in Table 4, 68 of these deaths (8 among verified maltreatment deaths and 60 among non-verified maltreatment deaths) were classified as sleep related. It is important to note that the cause of a sleep-related death may not be able to be determined after investigation and, therefore, may be classified as Sudden Infant Death Syndrome (SIDS) or death from an unknown or undetermined cause.

When available, local CADR committees collect information on risk and protective factors that pertain to sleep-related deaths. For asphyxia deaths that were sleep-related, 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=8			Non-Verified n=60		
	Usual n=8	Put to Sleep n=8	Found n=8	Usual n=60	Put to Sleep n=60	Found n=60
On Back	4	4	1	29	27	11
On Stomach	0	1	4	10	18	29
On Side	0	1	2	3	5	12
Unknown	4	2	1	18	10	8

- On Back was the usual placement position for approximately 50% (4 of 8) verified and 48% (29 of 60) non-verified cases
- On Stomach or On Side was the reported sleep position when the child was found non-responsive or deceased in 75% verified (n=6) and 68% non-verified (n=41) cases

Table 9 denotes the incident sleep place for sleep-related asphyxia deaths. Here, 62.5% of verified maltreatment deaths and 60% of non-verified child maltreatment deaths occurred in an adult bed for all reviewed sleep-related asphyxia deaths. These statistics reinforce established concerns from extensive research regarding the risks of bed-sharing of adults with infants and toddlers.

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

Incident Sleep Place	Verified n=8	Non-Verified n=60	Total n=68
Adult Bed	5 (62.5%)	36 (60%)	41 (60%)
Couch	1 (12.5%)	6 (10%)	7 (10%)
Bassinette	0 (0%)	5 (8.3%)	5 (7.4%)
Playpen	0 (0%)	5 (8.3%)	5 (7.4%)
Chair	1 (12.5%)	2 (3.3%)	3 (4.4%)
Crib	0 (0%)	3 (5%)	3 (4.4%)
Other	0 (0%)	3 (5%)	3 (4.4%)
Futon	1 (12.5%)	0 (0%)	1 (1.5%)
Floor	0 (0%)	0 (0%)	0 (0%)
Total	8 (100%)	60 (100%)	68 (100%)

Case reviews collected information on bed-sharing and objects in the sleep environment. Twenty-two persons (17 adults and 5 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 53 sleep-related asphyxia cases. See Table G-7 in 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 **verified** maltreatment weapon deaths (n=14):

- 4 (28.6%) weapons used were firearms. Among these firearm deaths:
  - 2 of the firearms were handguns and 2 were assault rifles.
  - All of the owners (100%) of firearms used were owned by males.
- 4 (28.6%) weapons were "body parts" (indicating physical abuse).
- 2 weapons were blunt instruments and 1 was a sharp instrument.
- Of the remaining verified weapons deaths, 2 were listed as "other" and 1 was unknown.

Among the **non-verified** maltreatment weapon deaths (n=5):

- 4 weapons used were firearms (80.0%)
- 1 weapon was a sharp instrument (20.0%)

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 were less than one year old:

- 71% of asphyxia deaths verified as child maltreatment involved children under the age of 1.
- 91% of asphyxia deaths not verified as maltreatment involved children under the age of 1.

Although the majority of children who died from a weapon were four years of age or younger (71% for verified maltreatment cases), all weapon deaths among non-verified maltreatment deaths were with children 6 years of age and older.

Among drowning deaths, 64% of verified maltreatment deaths were children 3 years of age and younger, whereas 79% of non-verified drowning deaths were 3 years of age and younger.

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=31	Asphyxia n=14	Weapon n=14	Other n=16	Drowning n=42	Asphyxia n=66	Weapon n=5	Other n=94
< 1	6%	71%	29%	44%	7%	91%	0%	55%
1	29%	7%	21%	0%	45%	3%	0%	14%
2	16%	0%	14%	25%	17%	0%	0%	6%
3	13%	0%	0%	6%	10%	0%	0%	3%
4	13%	7%	7%	6%	10%	0%	0%	4%
5	10%	0%	0%	6%	0%	0%	0%	1%
6-10	10%	7%	14%	13%	12%	2%	20%	7%
11-15	0%	7%	14%	0%	0%	3%	60%	6%
16+	3%	0%	0%	0%	0%	2%	20%	2%

Figure 3a: Verified Maltreatment Drowning Deaths by Age of Child (n=31)

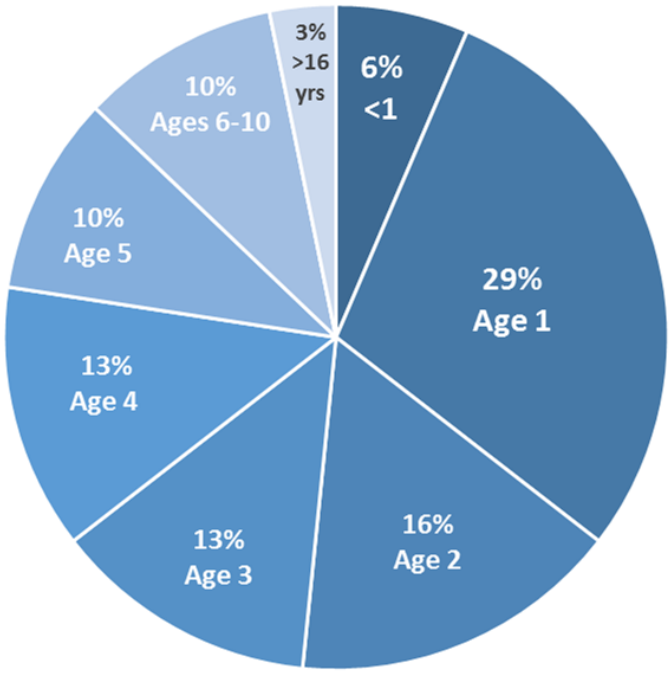


Figure 3b: Verified Maltreatment Asphyxia Deaths by Age of Child (n=14)

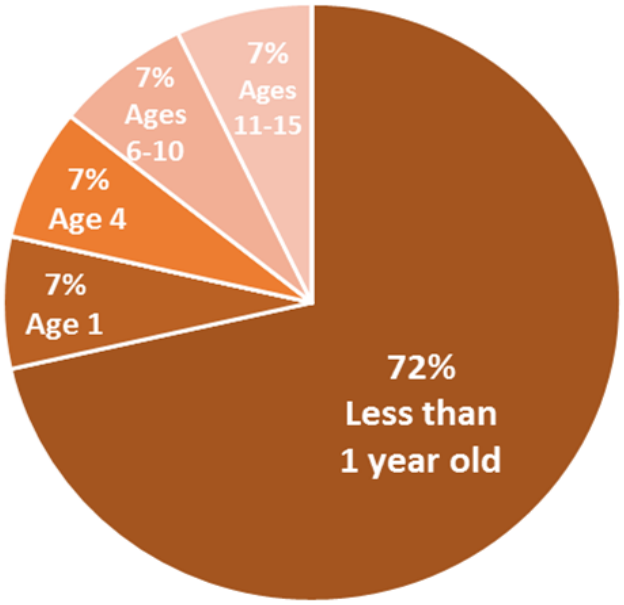
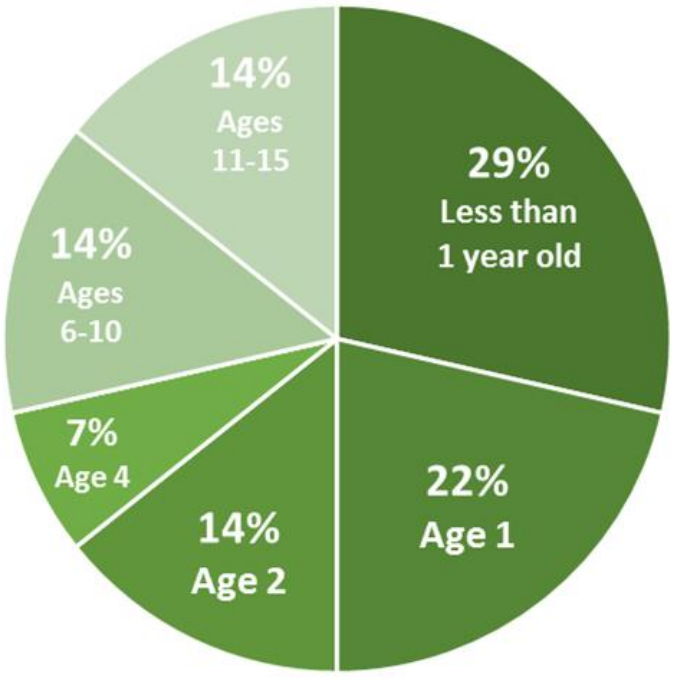


Figure 3c: Verified Maltreatment Weapon Deaths by Age of Child (n=14)



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.

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

- 26% of drowning deaths
- 20% of asphyxia deaths
- 21% of weapon deaths
- 13% 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=31	Asphyxia n=14	Weapon n=14	Other n=16	Drowning n=42	Asphyxia n=66	Weapon n=5	Other n=94
Black	39%	43%	36%	50%	33%	47%	40%	41%
White	55%	57%	57%	56%	57%	55%	60%	59%
Other	3%	0%	7%	0%	10%	0%	0%	<1%
Hispanic or Latino Origin								
Hispanic or Latino	26%	20%	21%	13%	5%	11%	0%	20%

Please note that column percentage totals may exceed 100% as children can be identified as bi- or multi-racial/ethnic.

Sex of Child

Males are disproportionately represented among child fatalities across all primary causes of death for non-verified child maltreatment deaths and for verified drowning and asphyxia maltreatment deaths, 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=31	Asphyxia n=14	Weapon n=14	Other n=16	Drowning n=42	Asphyxia n=66	Weapon n=5	Other n=94
Female	23%	43%	57%	56%	33%	39%	0%	39%
Male	77%	57%	43%	44%	67%	61%	100%	61%

Type of Residence and New Residence

The overwhelming majority (81.7%) of all children who are the subject of this report (n=349) resided in their parental home. In 6 verified and 25 non-verified cases, children lived with relatives. In total, 4 children resided in licensed foster homes (1 verified, 3 non-verified) and 6 resided in a relative foster home (4 verified, 2 non-verified). Statewide information on whether the child's residence was a new residence (occupied within the 30 days prior to the incident) was reportedly known for 262 cases for which only 37 (14.1%) of the residences were considered new residences. Among these 37 cases, 10 were associated with verified maltreatment fatalities.

Is Child From Multiple Birth?

Data on multiple births apply only to those deaths for which the child was under the age of one year. Statewide, only 13 cases (11 non-verified and 2 verified maltreatment cases) were identified to be from multiple births.

Child Problems in School?

Given the age of children, this question was deemed not applicable for 299 children. Among applicable children, 12 were identified as having a school problem which were identified as either academic (n=7), truancy (n=1), and behavioral (n=4).

Disability or Chronic Illness of Child

Statewide, 59 of 349 children (16.9%) were identified as having a disability or chronic illness (4 verified and 55 non-verified maltreatment deaths). Among the 59 children identified to have a disability or chronic illness, where the type of disability or illness was classified*:

- 40 had physical disabilities
- 8 had cognitive/intellectual disabilities
- 21 had sensory disabilities
- 7 had illnesses

** Note: Some children had multiple disabilities.*

Child's Mental Health

Information was collected regarding whether a deceased child had been receiving "current" mental health services, if a child had received mental health services in the past, if a child was on medications for mental health issues/illnesses, and if there were issues that prevented a child from receiving mental health services. For the majority of cases reviewed, these inquiries were not applicable due to the age of the child. For the valid responses received (17), the following was identified:

- 8 children had received prior mental health services (2 were verified and 6 were non-verified cases)
- 9 children were identified as currently on medications for mental health issues (2 of the 9 were verified maltreatment deaths)
- No children were identified to have been prevented from receiving needed mental health services

Child's History of Substance Abuse

For the majority of child fatalities reviewed (82.2%), 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 5 cases and identified as unknown for 4 cases. Among the remaining 53 cases, there were no children identified to have had a history of substance abuse.

Child's History as Victim of Child Maltreatment

Information related to the child's history of child maltreatment was known for 281 cases, and unknown or not reported for 68 cases. Among the 281 cases for which this history was reported, 72 children (26%) had a known history of child maltreatment. Of these 72 children with a known history of maltreatment:

- 66.6% were classified as non-verified.
- 33.3% were verified as maltreatment deaths.

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

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

Among the cases reviewed, there were 33 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 33 cases, 12 (36.4%) of these child deaths were classified as verified maltreatment deaths and 21 (63.6%) were identified as non-verified deaths.

Among cases reviewed, there were 27 cases known and reported by the local committees to have been placed outside the home at any time prior to the death (not necessarily at the time of the death). Of these 27 cases, 11 (40.7%) of these child deaths were classified as verified maltreatment deaths and 16 (59.3%) were identified as non-verified deaths. Among the 11 verified cases, seven had in the past been placed by DCF in relative care placements, one was in a group home, and three were reported to have been in out of home placements in the past that were not DCF placements. These last three placements appear to be out of home residences/placements for select child victims that were not the result of any Florida DCF protective orders/actions. For example, one youth who committed suicide had been in a substance abuse facility in the past; information on the specific reported placements of the remaining two verified cases is not known.

Among cases reviewed, there were 44 cases known and reported by the local committees where siblings were placed outside of the home prior to the child's death. Of these 44 cases, 13 (29.5%) of these child deaths were classified as verified maltreatment deaths and 31 (70.5%) were identified as non-verified deaths. Among the 13 verified maltreatment deaths, one case involved a sibling removal in 2005, and 6 cases involved siblings removed between 2009 and 2011. Three cases involved sibling removals between 2012 and 2013. For one case, the siblings were currently in a relative placement when one died; another case involved the removal of the siblings at the time of an incident that eventually led to a child's death months later. Finally, in one case, the siblings of a child were removed in the past from another parent/caregiver that was not the parent of the child that died.

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 27.0 years (for persons(s) responsible for verified weapon maltreatment deaths) to a high of 50.0 years (for persons responsible for non-verified weapon maltreatment deaths) with the average age in the late twenties and early thirties for most other categories. See Appendix G for average ages of caregivers, supervisors, and person(s) responsible for child deaths.

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

Females were the majority caregivers for children across all categories of death for verified and non-verified maltreatment deaths. The majority supervisors of children for drowning, asphyxia, and other death cases were females. Males were the majority of the supervisors in verified and 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 these data, we will be better able to understand how marital status and household living situations may impact child maltreatment.

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

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

For verified child maltreatment cases:

- 36% of caregivers were known to have a substance abuse history
- 38% of supervisors were known to have a substance abuse history
- 51% 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.

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

Collection of data regarding mental health history can be challenging for a number of reasons. There are likely differences in how this data element may be interpreted and collected by each committee (i.e., requiring a formal diagnosis vs. collateral information). In addition, individuals with a past diagnosis of mental illness may be reluctant to share this information. As a result, mental health history is often under-reported, leading to case sample sizes that are too small to make valid conclusions. For example, among all caregivers (first and second) identified across all child fatality cases reviewed, information on the history of chronic illness (including mental health history) is unknown for 95 caregivers (denoted in tables). However, there were an additional 101 caregivers (7 first and 94 second) for which data (not reflected in tables) were missing on this question (i.e. data element). These figures highlight the need for better collection of information regarding mental health history of family members associated with a child fatality case.

When information was available, committees collected mental health history data on both verified and non-verified maltreatment deaths. Of those cases where the presence of disability or chronic illness was identified, verified maltreatment deaths resulting from drowning show the following:

- 33% of caregivers were known to have a mental health history (2 out of 6 caregivers)
- 43% of person(s) responsible were known to have a mental health history (3 of 7 persons responsible)

Mental health histories were more prevalent in asphyxia cases, particularly those verified as maltreatment. For verified maltreatment deaths resulting from asphyxia (of those cases where the presence of disability or chronic illness was identified), 100% of caregivers (4 of 4), 100% of supervisors (3 of 3), and 100% of person(s) responsible (4 of 4) were known to have mental health issues.

For verified maltreatment deaths resulting from weapons:

- 25% of caregivers were known to have a mental health history (1 out of 4 caregivers)
- 100% of supervisors were known to have a mental health history (2 out of 2 supervisors)
- 25% of person(s) responsible were known to have a mental health history (1 out of 4)

As noted earlier, given the small number of those identified with mental health histories and the number of 2015 cases still to be reviewed, these findings should be considered tentative estimates.

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

The Case Report Form collects information on the occurrence of disability or chronic illness among the categories identified above, however, note that the presence of such a disability or illness does not mean that the condition was related to the death incident. The vast 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. Local committees reported on 480 caregivers identified (up to two caregivers could be identified per case) for the 349 cases reviewed for which information on past history as a victim of child maltreatment was unknown for 89 (18.5%) caregivers. See Appendix G for a breakdown of the proportion of caregivers, supervisors, and person(s) responsible with a history of maltreatment as children, where the majority of caregivers did not have a history as a victim.

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

Local committees were asked to identify whether caregivers, supervisors, and person(s) responsible for a child's death have a history as a perpetrator of child maltreatment. For verified cases, the following had a history as a perpetrator: caregivers (35%), supervisors (27%) and person(s) responsible (41%).

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.

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

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.

The State CADR 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, 37.2% (51 of 137) had committed a criminal offense in the past. Among those with a criminal history, those with drug offenses were represented from a low of 28% for caregivers associated with verified drowning deaths to a high of 59% of those caregivers associated with asphyxia deaths. The highest proportion of person(s) responsible (for verified maltreatment cases) with a criminal history were those affiliated with deaths caused by asphyxia (71%), other causes of deaths (44%), weapons deaths (38%), followed by drowning deaths (30%).

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, for the State Committee 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 is 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 are 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 be 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 non-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 called to the Florida Abuse Hotline.

Other research/study designs may better inform prevention initiatives in the future. For example, using cohort study designs, children can be "followed" forward or back in time to obtain information on exposures and outcomes that occurred during a 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). DCF is currently engaged in efforts that utilize predictive analytics tools and techniques with historical and cohort data from multiple sources (including DCF FSFN and DOH vital statistics data) whose results (when published) may be of assistance in furthering the interpretation of findings generated from the local CADR committee reviews of child fatality cases. Once the DCF study is complete, a review of the study's findings in concert with findings generated from CADR committee reviews may be warranted by the State CADR Committee as a means of developing collaborative recommendations for prevention initiatives.

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

- Supplemental analyses (on select data elements) including but not limited to multi-year analysis on 2015 fatalities when the remaining 125 child fatality cases are closed and reviewed by local committees.
- Examination of select differences in cases verified versus non-verified as child maltreatment for sleep-related asphyxia and drowning fatalities.

- Consider adding relationship or marital status as a data element, so head of household status (among caregivers) is known and used in analyses in an effort to better understand how marital status and household living situations may impact child maltreatment.
- Explore the availability of data from local committee reviews that can aid with supplemental analyses regarding the contextual factors associated with cases involving a history of intimate partner violence.

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, population data (beyond that available to the State CADR Committee) 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: THE CHANGING LANDSCAPE OF FLORIDA'S CHILD WELFARE SYSTEM

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

IMPROVING PRACTICE TO ENSURE CHILD SAFETY

DCF has adopted a practice model that combines a safety assessment and actuary risk assessment to better analyze the family condition and guide appropriate interventions. The practice requirements include: completing an immediate present danger assessment; developing safety plans upon the identification of a danger threat; collecting information in the Family Functioning Assessment (which includes six sections of collection around maltreatment, circumstances around maltreatment, adult functioning, child functioning, parenting, and parenting discipline); and assessing parental protective capacities to determine child safety and the need for service intervention. Assessment information is used to make the safety determination, as well as to determine risk of future maltreatment (using an actuarial tool). Note that both determinations guide the level of intervention. For example, if the child is determined unsafe, the family is provided formal case management services through the Community-Based Care Provider. If the family is determined safe but at high or very high risk for future maltreatment, the family must be referred for Family Support Services. The practice directs investigators to use subject matter experts and multidisciplinary teams to inform assessments and decisions. The model applies to upfront investigations, as well as ongoing services intervention, so the assessment is consistent and aligned throughout involvement with families.

In conjunction with the new practice model, DCF has taken significant steps to lead a statewide collaborative effort to support and enhance the integration of behavioral health services within the child welfare system. This initiative seeks to improve the integration of critical substance abuse and mental health services within child welfare systems of care at the community level. The Florida Framework for Child Welfare and Behavioral Health Integration outlines practice expectations and system components indicative of successful integration. Teams of community stakeholders have mobilized at regional and circuit levels to self-assess the level of integration within their own service delivery systems by using the framework. This important work will help improve the processes and partnerships necessary to ensure that appropriate and timely mental health and substance abuse services are provided to those in need of such services.

THE PUBLIC HEALTH PERSPECTIVE: A CALL TO ACTION

Child maltreatment is a serious public health problem. The Administration for Children and Families (ACF) estimates that approximately 700,000 children in the United States are victims of maltreatment each year; approximately 1,600 child deaths occur as a result of maltreatment. Recurring child maltreatment, whether or not it results in fatality, has far-reaching consequences and implications for society as a whole. Research has shown that an increased incidence of adverse childhood experiences strongly correlates with adverse health outcomes later in life. Increased exposure to such experiences not only increases the risk of subsequent substance abuse and mental health problems, but a host of chronic health issues as well, such as cancer, heart disease, diabetes, and chronic obstructive pulmonary disease. The Centers for Disease Control and Prevention (CDC) estimates that the total lifetime economic burden resulting from new cases of fatal and nonfatal child maltreatment in the United States is approximately $124 billion.

Child maltreatment and preventable fatalities are issues that reach well beyond the scope of one agency. Strategies to prevent child maltreatment must be implemented using a multi-level, multi-sector approach.

Public health, social services, health care, education, justice, and even non-traditional partners such as businesses and service organizations need to work together to prevent child maltreatment and its consequences. This collaborative approach ensures consistency of messaging, encourages the pooling of resources, and reduces duplicative efforts.

A comprehensive approach that engages all levels of our social ecology (including societal culture) will positively impact community involvement, relationships among families, and individual behaviors. Effective prevention strategies should focus on modifying policies, practices, and societal norms to create safe, stable, nurturing relationships and environments. The State CADR Committee has and will continue to utilize research and practice recommendations of the CDC pertaining to child maltreatment and violence prevention. Efforts to synthesize CDC recommendations with local prevention initiatives and resources will be a focus of coordinated efforts between the State CADR Committee and local CADR committees in the upcoming year.

THE COMMISSION TO ELIMINATE CHILD ABUSE AND NEGLECT FATALITIES

The Commission to Eliminate Child Abuse and Neglect Fatalities recently released a final report on developing a national strategy to eliminate child abuse and neglect fatalities. The State CADR Committee has begun review and discussion on the Commission's findings and their applicability for Florida. Focus has been on a series of recommendations targeting state and county governments. The State of Florida is engaged in many initiatives and has established efforts in keeping with many recommendations put forth by the Commission. Regardless, the State CADR Committee (as a collaborative partner with other state agencies and initiatives) will review how current and future efforts align with and can be responsive to recommendations put forth by the Commission for state agencies and counties.

SECTION SIX: IMPLEMENTATION OF PREVIOUS RECOMMENDATIONS

FROM ANALYSIS TO ACTION

The introduction of the CADR Cycle framework has prompted a renewed effort to ensure that data collection and analyses ultimately result in meaningful action. CADR data and corresponding recommendations continue to play a pivotal role in the shaping of prevention strategies at both state and local levels. From a CADR system perspective, the continuous evaluation of internal processes and ongoing assessment of the needs of stakeholders have resulted in a number of system improvements.

PREVENTION ACTIVITIES AT THE LOCAL LEVEL

Although local committees were newly formed this year to align with judicial circuits (see map, page 10), many carried the momentum of previously established community-based initiatives informed by previous years' CADR data and recommendations. Other local circuit-based committees engaged in new activities in response to patterns identified in 2015 case review data as they surfaced throughout the reporting period. In most circuits, local committees successfully leveraged previous CADR recommendations in a meaningful way.

Several local circuit-based committees have become especially adept at community collaboration, particularly in those areas where many agencies, boards, councils, and/or task forces may have similar or overlapping goals. These committees have successfully developed partnerships with other groups within their community, providing a workable venue for sharing information and resources, prioritizing efforts, and aligning prevention messaging to ensure consistency across groups.

Other local circuit-based committees have joined multiple community partners in prevention awareness campaigns and initiatives focused on water safety and/or safe sleep, based on past CADR data and recommendations. A number of these initiatives go beyond basic messaging to provide concrete supports and parent education to high-risk populations within their community.

As a result of committees' identification of potential gaps within local service delivery systems, several circuits took proactive measures to create processes that ensure appropriate mental health and substance abuse services are readily accessible for high priority, at-risk populations.

For detailed examples of local committee prevention activities, see Appendix F.

PREVENTION ACTIVITIES AT THE STATE LEVEL

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

DOH leverages CADR data, along with various other data sources, to address social determinants of health (behavioral, social, and environmental factors) that impact child development and health outcomes, with a specific focus on social determinants correlated with health inequities. This knowledge, in turn, informs statewide policy and practice. For example, the Florida Healthy Babies Initiative was launched this calendar year to address disparities in infant mortality. All Florida counties received funding to conduct data analysis on infant mortality and collaborate with multi-disciplinary community partners to create and implement action plans designed to address identified health disparities. As part of the new Healthy Moms and Babies program initiative, the Circle of Parents® program was initiated. Circle of Parents® provides a friendly, support

environment led by parents and other caregivers. It is a place where anyone in a parenting role can openly discuss the successes and challenges of raising children. Another project involves a contract with Florida A & M University to conduct focus groups statewide to evaluate the acceptance of the safe sleep concept as it relates to the use of "baby boxes." The box serves primarily as a safe, comfortable place for infants to sleep, similar to a bassinet. An ideal spot for the box is on a stable surface right next to the parents' bed. Some parents prefer keeping their box in the living room or dining area so that their baby can relax nearby while the parents are busy with chores, meals, and so on.

Several recommendations within the 2015 Annual CADR Report were operationalized by DCF, including the development and implementation of training on motivational interviewing, designed to enhance the supervisory skillsets of child protection investigator supervisors and case manager supervisors. The Office of Child Welfare recognized the need to incorporate motivational interviewing into the pre-service training that all direct service staff complete as part of the child welfare professional certification process; efforts to incorporate this material are currently underway. DCF also continues to maintain the Child Fatality Prevention Website – a publicly accessible website containing information on all child fatalities reported to the Florida Abuse Hotline alleged to be a result of abuse or neglect. The website serves as a portal for readily accessible child fatality data, which are sortable by county, child's age, causal factor, and prior DCF involvement. The website features seven years of historical data and can be used by local committees and other stakeholders to identify community-specific trends.

Prominent social service agencies with a statewide presence, such as the Ounce of Prevention Fund of Florida, incorporate CADR data and recommendations into trainings for home visitors and other staff working directly with families. CADR findings shape programmatic content to address potential hazards such as unsafe sleep practices. Findings also inform the strategic allocation of resources to ensure that prevention activities are aimed at those issues with the highest potential impact on child safety and well-being. CADR findings also inform the direction and content of statewide campaigns, such as the Prevent Child Abuse Florida campaign.

PROCESS IMPROVEMENTS WITHIN THE CADR SYSTEM

As the landscape of child welfare evolves over time, CADR processes adapt accordingly within Florida's dynamic multi-disciplinary system to collectively ensure the safety and well-being of children across the state. During this calendar year, several improvements have been made within the CADR system to streamline processes and increase the effectiveness of the fatality review process. Opportunities to improve are most often identified as a result of input from those actively working within the system, such as circuit committee chairs, CADR health officers, and DCF Child Fatality Prevention Specialists. Feedback and input from these key stakeholders resulted in improvements such as the new case file transfer process (described earlier in this report).

Upon the establishment of new circuit-based committees, needs assessment surveys were sent to key stakeholders to better determine the needs of committee chairs and CADR health officers and to identify potential barriers to meeting committee goals. The results of these surveys informed the provision of technical assistance to newly formed committees and training content presented during monthly circuit conference calls. The incorporation of web-based conferencing greatly improved participant engagement and the effectiveness of monthly calls, which now allow for the exchange of both audio and visual information. Expanding call participation to include additional stakeholders improved communication and encouraged collective problem solving among those with differing roles within the system.

SECTION SEVEN: 2016 PREVENTION RECOMMENDATIONS

MOVING FORWARD: A SOCIAL ECOLOGICAL MODEL FOR CHANGE

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

- Drowning
- Asphyxiation
- Inflicted Trauma (Weapons)

This year's prevention recommendations are based on an analysis of Florida's CADR findings for 2015 cases reviewed to date, input provided by State and local CADR committees, and a review of literature and the most current research on prevention strategies as outlined by our nation's foremost experts. Research and literature contributing to this year's recommendations include the following:

- *Preventing Child Abuse and Neglect: A Technical Package for Policy, Norm, and Programmatic Activities*, developed by the National Center for Injury Prevention and Control with the Centers for Disease Control (CDC)
- *Essentials for Childhood: Steps to Create Safe, Stable, Nurturing Relationships and Environments*, also developed by the CDC's National Center for Injury Prevention and Control
- *Within Our Reach: A National Strategy to Eliminate Child Abuse and Neglect Fatalities, Final Report, 2016,* developed by the Commission to Eliminate Child Abuse and Neglect Fatalities

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

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

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

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

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

In addition to the above strategies, the state committee makes the following state-specific recommendations, all of which will serve to further prevent the incidence of drowning, unsafe sleep practices, and inflicted trauma:

❖ ***Enhance and Support the Integration of Behavioral Health Services into the Child Welfare System***

Substance use disorders, mental health disorders, and dynamics associated with domestic violence result in profoundly negative impacts on parental capacity and child well-being while greatly increasing the risk of child harm. Readily accessible and appropriate interventions for at-risk families dealing with these issues is a critical step toward ensuring a safe, stable, and nurturing environment for children. Community-based systems of care must take the necessary steps to ensure behavioral health services are comprehensively integrated into the service delivery system to sufficiently meet the needs of their client population. Scope of services should address all levels of need, including prevention, intervention, and treatment services, as well as the provision of ongoing recovery supports to ensure struggling families have the resources needed to bolster resiliency and to attain sustained stability.

Traditional approaches to managing child maltreatment have focused, understandably, on treating its immediate short-term effects and preventing recurrences. Recent studies, however, have demonstrated that more comprehensive, trauma informed interventions are needed to prevent long-term effects extending into adulthood and causing serious morbidity and mortality.

Adverse Childhood Experiences (ACEs) include physical, emotional and sexual abuse; physical and emotional neglect; exposure to domestic violence and substance abuse; loss of or abandonment by a parent; and parental mental health issues. Associations were found with poor academic achievement, poor work performance and health-related poor quality of life. Prevention and early, trauma-informed treatment of children with high ACE scores results in improved health outcomes across the lifespan and a reduction of healthcare costs.

Behavioral health services in the child welfare system should include an assessment of trauma for children exposed to ACEs and appropriate trauma informed interventions to improve short and long-term health outcomes.

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

Children develop within the context of the family; early experiences shape the brain during early childhood. Safe, stable, and nurturing relationships are essential for healthy child development. Evidence suggests that parent coaching and support programs are effective in increasing positive parenting practices, reducing child abuse and neglect, and increasing family stability. In Florida, voluntary in-home parent support programs supplement individual-level and relationship-level interventions by providing parent education, connecting families to needed resources in the community, and promoting the development of protective factors existing within the family and community. These supports lead to improved outcomes for families including reduction and prevention of child abuse and neglect, reduction in risk factors for abuse and neglect, improved parent-child interaction, increased family stability and self-sufficiency, and improved child and maternal health.

- ***Ensure Clear and Consistent Messaging among Agencies During Efforts to Increase Awareness***

Given the wide array of agencies and organizations involved in prevention messaging, it is not surprising that widespread messaging designed to encourage prevention-oriented behaviors may be susceptible to inconsistencies, especially if the conveyed messaging lacks the appropriate context to fully frame a more specific message. For example, a recent policy statement from the American Academy of Pediatrics (AAP) has consistently recommended safe infant sleep practices including supine sleeping, use of firm sleeping surface, room sharing without bed-sharing and avoiding soft bedding. The updated 2016 recommendations include these same risk-avoidance practices and maintain that infants should be placed wholly on their back for every sleeping episode by every caregiver until the child reaches one year of age. Caregivers are encouraged to limit or eliminate infant exposure to smoke, alcohol, and illicit drugs. The recommendations also promote protective practices including breastfeeding, routine immunization, and pacifier use during sleep.

The updated 2016 policy statement also recognizes caregiver fatigue as a risk factor for unsafe sleep related deaths. While underscoring the importance of a firm, separate sleep space for infants, the 2016 policy directs caregivers to return their baby to their own sleep space after calming or feeding in an adult bed. According to the policy statement, “Evidence suggests that it is less hazardous to fall asleep with the infant in the adult bed than on a sofa or armchair, should the parent fall asleep.” Recommendations include strong statements about how to safely calm or feed a baby in bed while tired, including keeping the adult bed free of pillows and bedding and moving baby to a separate sleep space as soon as possible. However, some media coverage of the updated recommendations has included headline statements such as “Stay on the Bed If You're Tired and Feeding Your Baby.” This can be confusing and may be misinterpreted to encourage bed-sharing.

The consistency of Florida’s safe sleep messaging is both a community- and state-level issue as collaboration and communication between agencies must occur so that consistent language can be crafted in a way to

avoid confusing caregivers about the safety of sharing a sleep surface with infants under the age of one. Care must be taken to ensure that all preventive measures outlined in the AAP recommendations are thoroughly and clearly presented to parents, especially if parents express fear that they may fall asleep while feeding their baby. If providers do share the recommendation to feed on an adult bed rather than a couch or armchair, care must be taken to ensure that parents understand how to make the adult bed as safe as possible and that moving the child to a separate sleep space must happen as soon as possible.

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

Challenges such as ensuring the consistency of messaging are far more manageable when well-connected interagency and community stakeholder partnerships are established and regularly maintained. Collaborative partnerships are a necessity for system success as they encourage the sharing of data and information by establishing reliable streams of communication between agencies and organizations. These partnerships address the state- and community-level factors that play into the success of collective prevention campaigns, a fact reinforced by recommendations put forth by the Commission to Eliminate Child Abuse and Neglect Fatalities. Collaborative partnerships also encourage the pooling of limited resources and serve to align prevention planning while reducing duplicative efforts.

❖ ***Explore the Value and Utility of Existing Prevention Activities Throughout Florida***

As demonstrated earlier in this report, many existing prevention activities are already underway in various circuits throughout Florida. The state committee recommends that the value and utility of such initiatives and efforts be fully explored. Strategies and approaches that show some level of promise and appear to have positive impacts on prevention efforts should be considered for replication in other areas within the state. Resources including tools, templates, and promising practices can be shared among local committees to further attempt to reduce duplication of effort and encourage consistent messaging throughout the state.

❖ ***Develop Toolkits to Assist in the Planning and Development of Prevention Activities***

As promising practices are identified, readily accessible toolkits should be developed to provide concrete resources, tools, templates, proven processes, and other information that may serve to further additional circuits' efforts to address identified concerns. Various toolkits could be developed to help address specified hot topics, such as Water Safety Awareness, Safe Sleep Initiatives, Bolstering Protective Factors to Increase Parental Capacity, and Tips and Techniques for Fostering Community Collaboration. These toolkits should be developed based on standards and recommendations acknowledged by research, professional literature, and/or existing state and federal agencies.

❖ ***Offer Training and Technical Assistance to Circuits Regarding How to Leverage Data to Inform and Improve Practice***

Training and related technical assistance should incorporate tips and techniques designed to result in the cleaner collection of data through the consistent use of agreed-upon interpretations of data elements. Technical assistance can incorporate information on how to leverage available data tools, such as the DCF Child Fatality Prevention Website, and training on basic data analysis techniques and action planning can be provided to those circuits most interested in delving into their own localized data. All circuits and stakeholders can be provided with guidance regarding how to best leverage the findings of this report to develop sound and effective prevention techniques designed to the meet the specific needs of their areas. This recommendation is, in part, in keeping with the following recommendations of the Commission to Eliminate Child Abuse and Neglect Fatalities:

- Enhance local systems' ability to share data to save children's lives and support research and practice
- Leverage opportunities across multiple systems to improve the identification of children and families at earliest signs of risk

SECTION EIGHT: CONCLUSIONS AND NEXT STEPS

In summary, child maltreatment is a critical public health issue with devastating consequences for society as a whole. Efforts to create positive, sustainable change will require a multi-sector approach that sufficiently addresses all levels of the social ecology model, from intervention at the individual level to influencing cultural and societal norms. Overarching prevention strategies at state and local levels can be tailored to address issues clearly identified as chief concerns. Drowning, asphyxia (unsafe sleep), and inflicted trauma continue to be the top three primary causes of preventable deaths in children, and will require well-coordinated efforts that incorporate consistent messaging to address these trends.

To ensure successful outcomes we must adopt evidence-based prevention programs and practices, as we further evaluate new and innovative practices that show promise. 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 beyond the mere collection of data, and ensure that meaningful analysis of the data ultimately leads to strategic action.

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

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

APPENDICES

ANNUAL REPORT

DECEMBER 2016

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APPENDIX A:

Section 383.402, Florida Statutes

Section 383.402, Florida Statutes

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

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

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

(2) STATE CHILD ABUSE DEATH REVIEW COMMITTEE.—

(a) Membership.—

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

a. The Department of Legal Affairs.
b. The Department of Children and Families.
c. The Department of Law Enforcement.

d. The Department of Education.
e. The Florida Prosecuting Attorneys Association, Inc.
f. The Florida Medical Examiners Commission, whose representative must be a forensic pathologist.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

8. A mental health treatment provider.
9. A certified domestic violence center.
10. A substance abuse treatment provider.
11. Any other members that are determined by guidelines developed by the State Child Abuse Death Review Committee.

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

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

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

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

a. Nonidentifying information from individual cases.

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

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

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

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

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

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

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

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

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

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

(5) ACCESS TO AND USE OF RECORDS.—

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

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

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

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

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

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

(e) The chairperson of the State Child Abuse Death Review Committee may require the production of records by requesting a subpoena, through the Department of Legal Affairs, in

any county of the state. Such subpoena is effective throughout the state and may be served by any sheriff. Failure to obey the subpoena is punishable as provided by law.

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

(g) A person who has attended a meeting of the state committee or a local committee or who has otherwise participated in activities authorized by this section may not be permitted or required to testify in any civil, criminal, or administrative proceeding as to any records or information produced or presented to a committee during meetings or other activities authorized by this section. However, this ¹paragraph 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 ¹paragraph does not apply to any person who admits to committing a crime.

(6) DEPARTMENT OF HEALTH RESPONSIBILITIES.—

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

APPENDIX B:

State and Local Committee Membership

Florida Child Abuse Death Review State Committee Membership

Social Worker
Robin Perry, Ph.D., Chairperson

Department of Health
Patricia Boswell, MPH

Department of Legal Affairs
Stephanie Bergen, JD

Department of Children and Families
Lesline Anglande-Dorleans, JD

Department of Law Enforcement
Seth Montgomery

Department of Education
Iris Williams, MSW

Florida Prosecuting Attorneys Association
Thomas Bakkedahl, JD

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

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

Public Health Nurse
Deborah Hogan, RN, MPH

Mental Health Professional
April Lott, LCSW

Department of Children and Families Supervisor
Pattie Medlock

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

Child Advocacy Organization
Jennifer Ohlsen, MS

Paraprofessional in patient resources, child abuse prevention program
Marie Alaniz

Law Enforcement Officer
Deputy Jason Comans

Florida Coalition Against Domestic Violence
Brandy Carlson, MSW

Child Abuse Prevention Program
Zackary Gibson

Substance Abuse Professional
Linda Mann, LCSW, CAP

Florida Child Abuse Death Review
Local Committee Chairpersons

Committee 1 & 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

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APPENDIX C:

Guidelines for the State Committee

Guidelines for the State Committee

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CHAPTER I

PURPOSE OF CHILD ABUSE DEATH REVIEW COMMITTEES

1.1 Background and Description

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

1.2 Mission Statement

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

1.3 Operating Principle

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

The state and local review committees shall work cooperatively.

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

1.4 Goal

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

1.5 Objectives

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

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

CHAPTER 2

STATE REVIEW COMMITTEE MEMBERSHIP AND DUTIES

2.1 Introduction

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

2.2 Statutory Membership

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

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

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

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

2.3 Term of Membership

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

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

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

2.4 Consultants

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

2.5 Election of State Chairperson

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

2.6 Reimbursement

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

2.7 Terminating State Committee Membership

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

2.8 State Review Committee Duties

Chairperson

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

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

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

All Committee Members

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

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

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

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

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

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

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

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

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

CHAPTER 3

MAINTAINING AN EFFECTIVE COMMITTEE

3.1 Conducting an Effective Meeting

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

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

- The review Committee is not an investigative body

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

- Meeting minutes will not indicate any case specific information

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

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

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

3.2 Focus on Prevention

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

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

CHAPTER 4

COMMITTEE OPERATING PROCEDURES

4.1 Obtaining Data from Local Committee Reviews

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

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

4.2 Record Keeping and Retention

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

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

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

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

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

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

4.3 Child Abuse Death Review Case Reporting System

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

CHAPTER 5

CONFIDENTIALITY AND ACCESS TO INFORMATION

5.1 Introduction

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

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

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

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

The State Child Abuse Death Review Committee and local committees may share information made confidential and exempt by this section:
(a) With each other;
(b) With a governmental agency in furtherance of its duties; or
(c) With any person or entity authorized by the Department of Health to use such relevant information for bona fide research or statistical purposes. A person or entity who is authorized to obtain such relevant information for research or statistical purposes must enter into a privacy and security
agreement with the Department of Health and comply with all laws and rules governing the use of such records and information for research or statistical purposes. Anything identifying the

subjects of such relevant information must be treated as confidential by the person or entity and may
not be released in any form

5.2 Confidentiality Statements

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

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

5.3 Protecting Family Privacy

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

5.4 Document Storage and Security

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

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

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

5.5 Media Relations and Public Records Request

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

CHAPTER 6

CHILD ABUSE DEATH REVIEW ANNUAL REPORT

6.1 Guidelines for Report

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

A) Background

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

B) Method

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

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

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

D) Conclusions

E) Prevention Recommendations

F) Summary

APPENDIX D:

Guidelines for Local Committees

Guidelines for Local Committees

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CHAPTER I

PURPOSE OF CHILD ABUSE DEATH REVIEW COMMITTEES

1.1 Background and Description

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

1.2 Mission Statement

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

1.3 Operating Principle

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

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

1.4 Goal

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

1.5 Objectives

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

CHAPTER 2

LOCAL REVIEW COMMITTEE MEMBERSHIP AND DUTIES

2.1 Committee Membership

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

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

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

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

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

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

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

2.2 Term of Membership

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

2.3 Consultants

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

2.4 Ad Hoc Members

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

2.5 Local Review Committee Duties

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

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

2.6 Local Committee Member Responsibilities

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

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

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

2.7 Orientation and Training of Local Committee Members

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

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

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

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

2.8 Support and Technical Assistance for Local Committees

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

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

CHAPTER 3

MAINTAINING AN EFFECTIVE COMMITTEE

3.1 Conducting an Effective Meeting

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

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

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

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

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

3.2 Beginning the Meeting

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

3.3 Sharing Information

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

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

3.4 Community Education and Prevention

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

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

CHAPTER 4

COMMITTEE OPERATING PROCEDURES

4.1 Information Sharing

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

4.2 Committee Chairperson

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

Chairperson duties:

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

- Maintain attendance records, current roster, and resumes or CVs detailing qualifications and experience of members.
- Ensure secure transfer of all records to new Chairperson upon transfer of duties.

4.3 Meeting Attendance

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

4.4 Obtaining Names for Committee Reviews

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

4.5 Record Keeping and Retention

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

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

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

4.6 Child Abuse Death Review Case Reporting System

The Child Abuse Death Review Committees utilize the national Child Death Review Case Reporting System to record and track data from child death reviews. The System Guide provides instructions for

completing the data form. The Child Death Review Case Reporting System Case Report must be completed on all child abuse deaths reviewed. The committee chair should review the data form to ensure that all information is accurate and that the case review is complete.

CHAPTER 5

CONFIDENTIALITY AND ACCESS TO INFORMATION

5.1 Introduction

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

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

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

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

5.2 Confidentiality Statements

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

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

5.3 Protecting Family Privacy

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

5.4 Document Storage and Security

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

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

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

5.5 Media Relations and Public Records Request

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

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

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

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

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

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

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

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

(2) STATE CHILD ABUSE DEATH REVIEW COMMITTEE.—

(a) Membership.—

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

a. The Department of Legal Affairs.

b. The Department of Children and Families.

c. The Department of Law Enforcement.

d. The Department of Education.

e. The Florida Prosecuting Attorneys Association, Inc.

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

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

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

b. A public health nurse.

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

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

e. The medical director of a child protection team.

f. A member of a child advocacy organization.

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

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

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

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

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

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

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

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

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

Appendix B

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

383.412 Public records and public meetings exemptions.—

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

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

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

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

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

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

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

(a) With each other;

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

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

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

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

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

Appendix D

STATEMENT OF CONFIDENTIALITY

Name:

Date:

I understand the following:

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

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

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

_____

(Signature)

_____

(Agency)

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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 ☐ Native Hawaiian
☐ Black ☐ Pacific Islander, specify:
☐ Asian, specify:
☐ American Indian, Tribe:
☐ Alaskan Native, Tribe:

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

7. Sex: ○ Male ○ Female ○ U/K

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

As Victim	As Perpetrator		As Victim	As Perpetrator
	○ N/A		☐	☐ Physical
○	○ Yes		☐	☐ Neglect
○	○ No		☐	☐ Sexual
○	○ U/K		☐	☐ Emotional/psychological
			☐	☐ U/K
○	○ Through CPS		_____	_____ # CPS referrals
○	○ Other sources		_____	_____ # Substantiations

If yes, how was history identified:

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

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

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

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

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

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

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

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

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

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

COMPLETE FOR ALL INFANTS UNDER ONE YEAR

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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	
○	○ Yes	
○	○ No	
○	○ U/K	
☐	☐	WIC
☐	☐	TANF
☐	☐	Medicaid
☐	☐	Food stamps
☐	☐	Other, specify:
☐	☐	U/K

If yes, check all that apply

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
- ○ Coroner
- ○ Hospital physician
- ○ Other physician
- ○ Mortician
- ○ Other, specify:
- ○ U/K

3. Autopsy performed? ○ Yes ○ No ○ U/K
If yes, conducted by:
- ○ Forensic pathologist
- ○ Pediatric pathologist
- ○ General pathologist
- ○ Unknown pathologist
- ○ Other physician
- ○ Other, specify:
- ○ 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
  - If passenger, relationship of driver to child:
    - ○ Front seat
    - ○ Back seat
    - ○ Truck bed
    - ○ Other, specify:
    - ○ U/K
    - ○ Biological parent
    - ○ Adoptive parent
    - ○ Stepparent
    - ○ Foster parent
    - ○ Mother's partner
    - ○ Father's partner
    - ○ Grandparent
    - ○ Sibling
    - ○ Other relative
    - ○ Friend
    - ○ Other, specify:
    - ○ U/K
- ○ On bicycle
- ○ Pedestrian
  - ○ Walking
  - ○ Boarding/blading
  - ○ Other, specify:
  - ○ U/K
- ○ 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					Has a graduated license
	○	○	<16 years				Has a full license
	○	○	16 to 18 years old				Has a full license that has been restricted
	○	○	19 to 21 years old				Has a suspended license
	○	○	22 to 29 years old				If recreational vehicle, has driver safety certificate
	○	○	30 to 65 years old				Other, specify:
	○	○	>65 years old				Was violating graduated licensing rules:
	○	○	U/K age				Nighttime driving curfew
☐	☐	☐	Responsible for causing incident				Passenger restrictions
☐	☐	☐	Was alcohol/drug impaired				Driving without required supervision
☐	☐	☐	Has no license				Other violations, specify:
☐	☐	☐	Has a learner's permit				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	○ Heating stove	○ Lightning	○ Other explosives
○ Cigarette lighter	○ Space heater	○ Oxygen tank	○ Appliance in water
○ Utility lighter	○ Furnace	○ Hot cooking water	○ Other, specify:
○ Cigarette or cigar	○ Power line	○ Hot bath water	
○ Candles	○ Electrical outlet	○ Other hot liquid, specify:	
○ Cooking stove	○ Electrical wiring	○ Fireworks	○ U/K

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

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

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

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

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

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

If yes, person's age _____

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

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

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

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

If yes, specify:

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

If yes, check all that apply:
☐ Locked door
☐ Window grate
☐ Locked window
☐ Blocked stairway
☐ Other, specify:
☐ U/K

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

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

If yes, describe in narrative.

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

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

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

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

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

Other, specify:

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

q. Suspected arson?
○ 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 ☐ Not Coast Guard approved ☐ U/K
☐ Jacket ☐ Cushion ☐ Lifesaving ring
If jacket:
Correct size? ○ Yes ○ No ○ U/K
Worn correctly? ○ Yes ○ No ○ U/K
☐ Swim rings
☐ Inner tube
☐ Air mattress
☐ Other, specify:

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

o. Fence:
Describe type:
Fence height in ft ____
Fence surrounds water on:
○ Four sides ○ Two or less sides
○ Three 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 ☐ Gap in fence ☐ Door screen torn ☐ Cover left off
☐ Gate left open ☐ Damaged fence ☐ Door self-closer failed ☐ Cover not locked
☐ Gate unlocked ☐ Fence too short ☐ Window left open ☐ Other, specify:
☐ Gate latch failed ☐ Door left open ☐ Window screen torn
☐ Gap in gate ☐ Door unlocked ☐ Alarm not working
☐ Climbed fence ☐ Door broken ☐ Alarm not answered ☐ U/K

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

w. For bathtub, child in a bathing aid?
○ 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
- ○ Child's boyfriend or girlfriend
- ○ Classmate
- ○ Co-worker
- ○ Institutional staff
- ○ Neighbor
- ○ Rival gang member
- ○ Stranger
- ○ Law enforcement
- ○ Other, specify:
- ○ U/K

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

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

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

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

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

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

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

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

p. Sex of person(s) handling weapon:

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

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

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

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

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

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

○ Yes ○ No ○ U/K If yes, describe:

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

Condition	Diagnosed 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	No	U/K	Within 24 hrs of incident Yes	No	U/K
Physical activity	○	○	○	○	○	○
Sleep deprivation	○	○	○	○	○	○
Driving	○	○	○	○	○	○
Visual stimuli	○	○	○	○	○	○
Video game stimuli	○	○	○	○	○	○
Emotional stimuli	○	○	○	○	○	○
Auditory stimuli/startle	○	○	○	○	○	○
Physical trauma	○	○	○	○	○	○
Other, specify:	○			○		

If yes to physical activity, describe type of activity:
At incident Within 24 hours of incident

Other specify:
At incident Within 24 hours of incident

m. 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
- Couch position
- U/K

g. Child in a new or different environment than usual?
- Yes
- No
- U/K

If yes, specify:

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

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

If yes, describe:

j. Child overheated?
- Yes
- No
- U/K

If yes, outside temp ____ degrees F

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

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

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

l. Child 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
- Breast
- U/K

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

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

If yes, check all that apply:
- With adult(s):
  - #_____ #U/K
  - Adult obese: Yes / No / U/K
- 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:

Caused / Contributed:

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

25. Does person have, check all that apply:

Caused / Contributed:

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

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

Caused / Contributed:

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

FOR SUICIDE

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

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

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

- None known
- Family discord
- Parents' divorce/separation
- Argument with parents/caregivers
- Argument with boyfriend/girlfriend
- Breakup with boyfriend/girlfriend
- Argument with other friends
- Rumor mongering
- Suicide by friend or relative
- Other death of friend or relative
- Bullying as victim
- Bullying as perpetrator
- School failure
- Move/new school
- Other serious school problems
- Pregnancy
- Physical abuse/assault
- Rape/sexual abuse
- Problems with the law
- Drugs/alcohol
- Sexual orientation
- Religious/cultural issues
- Job problems
- Money problems
- Gambling problems
- Involvement in cult activities
- Involvement in computer or video games
- Involvement with the Internet, specify:
- Other, specify:
- U/K

J. SERVICES TO FAMILY AND COMMUNITY AS A RESULT OF DEATH

1. Services: Select one option per row:	Provided after death	Offered but refused	Offered but 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:

Prevention Activities Informed by CADR Data

Examples of Prevention Activities Informed by CADR Data at the Local Level

(as submitted by circuits and state committee members)

Circuit	Counties	Target Area(s)	Brief Summary of Activities	Reference Docs *(if provided)*
Circuit 3	Madison, Taylor, Columbia, Suwannee, Dixie, Lafayette, Hamilton	Community Collaboration	Circuit 3 was newly formed this year; a completely new team was developed to adapt to judicial realignment. The newly formed committee is made up of 7 rural counties with similar demographics. This allowed for focused discussion regarding concerns specific to rural counties. Topics that surfaced during case reviews prompted each agency to share what they are doing in response to the topic. For example, two cases reviewed included co-sleeping deaths; each agency discussed their current practices/policies to inform parents about the risks of co-sleeping.	n/a
Circuit 6	Pinellas, Pasco	Community Collaboration Water Safety Safe Sleep	The Local CADR Local CADR committee reports trends and prevention strategies to our Preventable Death Committee. We work together as a community to ensure we are sharing information on water safety, swimming lessons, speaking opportunities, strategies etc. Please see the attached one-page outline of our committee.	Warning Signs Campaign Update *(Word document)*
Circuit 7	St. Johns	Community Collaboration Substance Abuse Health Equity	As a result of the Circuit 7 CADR reviews, St Johns County has, or is in the process of, implementing the following activities: • Due to a heightened awareness of multiple community agency involvement yet limited communication and/or coordination between agencies, re: shared high risk families, we are in the initial planning phase of developing a multiagency 'rapid response' team approach for infants and children in identified heightened or imminent risk. • Due to heightened awareness of maternal substance abuse as an increasing factor in infant and child deaths, a Neonatal Abstinence Workgroup has been established within the St Johns County Infant Mortality Task Force. • A Health Equity framework, using social determinants of health, has been adopted for which assessments, services, programs etc. are developed and/or refined.	n/a
Circuit 9	Orange, Osceola	Safe Sleep Water Safety Community Collaboration	The data from the local team is used to inform practice and focus resources on priority issues. For instance, the local CADR action committee pulled and reviewed causes of death and manners and used it to focus on the top two initiatives which were safe sleep and water safety. The committee also reviewed common factors to the deaths, such as prior DCF reports, ages, etc. and the zip codes experiencing the highest number of deaths. This provides the framework to focus interventions to those populations at highest risk. The local circuit data is presented to the Children's Cabinets in both Orange and Osceola counties in the form of a scorecard related to the 5 Year Child Abuse Prevention circuit plan and Children's Cabinet	n/a

Examples of Prevention Activities Informed by CADR Data at the Local Level

(as submitted by circuits and state committee members)

Circuit	Counties	Target Area(s)	Brief Summary of Activities	Reference Docs *(if provided)*
			members are asked to focus in on supporting the focus areas for prevention. The data also guides local initiatives, such as the Osceola Safe Families Task Force, Healthy Babies Initiatives and other local groups and safe sleep practice education is being infused into many family support programs.	
Circuit 12	Manatee	Safe Sleep	The Florida Department of Health in Manatee County, along with community partners, has utilized the data from the CADR to create a Safe Sleep campaign for parents. The campaign partners are The Healthy Start Coalition of Manatee County, the Manatee Sheriff's Office, and Manatee Education Television (METV). The Safe Sleep campaign was created in 2005 as a result of a review of infant and child deaths in Manatee County. The emphasis on parent education about safe sleep practices along with the provision of Moses Baskets to families in need is one factor that may have contributed to the decrease in the Manatee County infant mortality rate from 2007 to 2014. Parent education and support are provided in English and Spanish utilizing pamphlets and an educational DVD created in partnership with METV. Parent education focuses on creating a safe sleep environment, avoidance of co-sleeping, and proper clothing and position for the infant. The campaign also provides Moses Baskets to parents who do not have a safe sleep environment for their newborn infant. The baskets are created in partnership with the Healthy Start Coalition of Manatee County and the Manatee Sheriff's Office. DOH-Manatee and community partners continue to innovate to provide safe sleep education. Displays of a safe sleep environment, including a Moses basket along with parent education materials, are currently planned for two DOH-Manatee clinic sites.	CADR Data Review and Impact: Manatee County *(Word document)*
Circuit 12	Sarasota	Safe Sleep Water Safety	One of the efforts in Sarasota that was a direct result of the CADR team meeting in 2014 is the Safe Sleep Sarasota initiative. I'm including a link to the Healthy Start website that has a summary and goals of this initiative listed out, along with the power point that is used when training community partners. We also developed a safe sleep pledge that the parents are signing (following a brief training) at the discharge brunch when parents are getting ready to go home with their newborns. I've attached a copy of one I have, but it likely has been updated since. The Safe Sleep summary includes our community efforts for the last fiscal year. Since our last meeting which included 2 child drownings, we are now including training curriculum related to mandated reporting. Representative Gonzalez, one of	Link to Safe Sleep Sarasota Initiative *(Web link)* Safe Sleep Training (*PowerPoint)* Safe Sleep Pledge *(Word document)*

Examples of Prevention Activities Informed by CADR Data at the Local Level

(as submitted by circuits and state committee members)

Circuit	Counties	Target Area(s)	Brief Summary of Activities	Reference Docs *(if provided)*
			our newest members, attended the last CADR meeting and was VERY interested in championing the bill to direct funding for all of the YMCA's in the state to be able to provide free swim lessons in an effort to help prevent child drownings. This bill died last year and he felt it was important to bring it back again.	Safe Sleep Summary *(Word document)*
Circuit 14	Gulf, Franklin, Washington, Bay, Calhoun, Holmes, Jackson	Child Passenger Safety Parenting Support Community Collaboration	Child Passenger Safety Awareness Campaigns: • The Gulf County Tobacco Prevention Partnership and Healthy Start Program hosted an event in order to promote the safety of children in vehicles. Held at North Florida Child Development in Port St. Joe, 15 families signed up for Car Seat Installment Checks, provided by a Healthy Start Certified Specialist. Additionally, Gulf County Tobacco Prevention Program Coordinator shared educational information about the dangers of secondhand smoke in vehicles with parents and caregivers. • DOH- Franklin Healthy Start Program hosted a Car Seat Safety Inspection event in October 2016 to promote the safety of children in vehicles. These events were held in partnership with community agencies such as North Florida Child Development, Franklin County Sheriff's Office and Weems' Emergency Medical Services. Circle of Parents: • As part of the new Healthy Moms and Babies program initiative, there were five Circle of Parents ® Meetings were held in Gulf County. Circle of Parents® provides a friendly, supportive environment led by parents and other caregivers. It's a place where anyone in a parenting role can openly discuss the successes and challenges of raising children. There were 45 parent participants. Collaboration with local councils and committees *(Mental Health / Substance Abuse)*: • The Gulf County Community Health Improvement Partners formed a Mental Health/Substance Abuse subcommittee based on the need to link individuals and families to these services. Partners include mental health and substance abuse providers, faith-based organizations, police, schools, Healthy Start, and the Bureau of Alcohol, Tobacco and Firearms. Recently, the first Mental	n/a

Examples of Prevention Activities Informed by CADR Data at the Local Level

(as submitted by circuits and state committee members)

Circuit	Counties	Target Area(s)	Brief Summary of Activities	Reference Docs *(if provided)*
			Health/Substance Abuse resource guide for Gulf and Franklin residents was created and distributed throughout communities.	
Circuit 15	Palm Beach	Water Safety Safe Sleep Mental Health & Substance Abuse Fire Safety Community Collaboration	• The Drowning Prevention Coalition (DPC) provided water safety education programming to 562 summer camp children during the month of July and up until the beginning of school. Since the start of the 2016/2017 school year, the DPC has provided water safety presentations to all children at three elementary schools (1,806 students). In addition, another 1,197 students benefited from land-based programming via pre-school, health class, physical education, and fine arts. Ultimately, 40,631 people were educated about the importance of water safety during a total of 70 different activities and presentations. • Partnerships promoting community education are numerous. They range from providing literature at resource fairs; speaking at community forums; or providing portable cribs to families. These efforts cover a variety of topics that include drowning prevention; safe sleep; gang avoidance education; drug and alcohol misuse by underage youth; leaving children in hot cars; proper nutrition and exercise; proper parenting techniques; and anti-violence campaigns. • Hanley Center Foundation partners with Friends of Foster Children to provide Youth Mental Health First Aid twice a year. This enables foster parents 8 hours of mental health/suicide prevention training. In the past 2 years we have served nearly 100 parents with this program. • As a result of Palm Beach County Fire Rescue's involvement with CADR we continue to promote Child Safety in schools, Homeowners Associations, Scout, Libraries, etc. covering the 8 major causes of death and injury to children. We at PBCFR partner with the Palm Beach County Drowning Prevention Coalition, Safe Kids Palm Beach County, Children's Home Society, Palm Beach County Health Department and the list goes on so that we can make Palm Beach County a safer place for our children. PCBFR also has a 30-minute television program on Channel 20 where we have done programming on issues currently happening in the County. The January segment will cover Safe Sleeping which we know is an issue for CADR; CADR team members that are SMEs on this topic will be involved in the segment. • Southeast Florida Behavioral Health Network is highly involved with integrating behavioral health services and child welfare. For the past 3 years we have been collaborating with Child Net and Devereux CBC's and began subcontracting with several of our providers to operate a hotline/call center for	Drowning Prevention Coalition of WPB *(Word document)* Prevention Partnerships *(Word document)* PBCFR Email *(full text)* SE Florida Behavioral Network Email *(full text)*

Examples of Prevention Activities Informed by CADR Data at the Local Level

(as submitted by circuits and state committee members)

Circuit	Counties	Target Area(s)	Brief Summary of Activities	Reference Docs *(if provided)*
			Child Protective Investigators to call and get parents needing substance abuse assessments and services immediate appointments. We also contract with a provider for a FIT Team, (Family Intensive Treatment) Team. The team provides behavioral health services to families involved in child welfare system to prevent further abuse and/or neglect and get families the help they need and back on track.	
Circuit 19	Indian River	Safe Sleep	In Indian River we are looking at starting a baby box initiative with healthy start.	
Circuit 20	Collier, Lee, Charlotte, Hendry, Glades	Community Collaboration Process Improvements	Collier, Lee, Charlotte and Hendry/Glades have been reorganized into what is now Circuit 20. The last part of 2015 and the first part of 2016 have been spent mostly in reorganization work, finishing up 2015 cases and setting the new system into place. A recent addition of a dedicated clerical support is hopefully going to expedite completed case submissions and allow the chair and members of the group to focus on more of the evaluative purpose of the Circuit Group rather than spending time on process issues.	
NE Region (DCF)		Community Collaboration	The Northeast Region uses findings from the statewide CADR and our local CADR Teams. We are very involved in our local teams and have used information for many years to guide our prevention work as well as our quality investigative/case management/and provider work. Examples follow: 1. Creation of our Circuit Child Fatality Prevention Consortiums 2. Safety Initiative NER: 3 years ago we initiated the Safety Campaign in NER to equip our Child Protection and Case Management staff with safety items so they can, on site, provide them to families accompanied by a mini training on safety. 3. We use findings and recommendation to drive quality work in areas such as how the Investigators partner with CPT; with medical providers to get information and participate in cross training and staffings; how we utilize Multi-Disciplinary Teams and when; prevention work while in homes; etc. 4. CADR findings drive community discussions; media interactions; and action teams. We share data sheets showing exactly by County what is happening and at what frequency so they are aware. This has shown some impact in areas such as in our Substance Abuse provider agencies where they have incorporated home safety questions. 5. Data: We use monthly data on all child fatalities to drive discussions.	CADR Findings NE region DCF *(Word document, full text)*

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 and includes those cases for which the primary cause of death was undetermined or unknown (most likely associated with non-verified child maltreatment deaths). 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 four counties that account for approximately 40% of the verified child maltreatment deaths (across all categories) in Florida thus far reviewed. These include Broward (n=9), Duval (n=9), Brevard (n=7), and Pinellas (n=7, includes 1 case whose cause of death was "undetermined"). Verified child maltreatment deaths happened in 23 additional counties throughout Florida for a total of 27 or 40.3% of Florida's 67 counties. When primary cause of death among verified maltreatment cases are examined, 45.2% (14 of 31) of all drowning deaths took place in only three counties. These include Broward (n=6), Duval (n=4), and Lee (n=4). The remaining verified maltreatment drowning deaths were located in thirteen additional counties. Verified maltreatment deaths involving asphyxia were located in ten counties where the most were represented in Brevard (n=3) and Pinellas (n=3). The remaining eight asphyxia deaths are found across eight additional counties (one in each county). The 14 verified maltreatment deaths by weapons are found across nine different counties in Florida with the greatest number occurring in Duval (n=4).

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					0	Alachua		1		1	2
Baker					0	Baker					0
Bay					0	Bay					0
Bradford					0	Bradford					0
Brevard	1	3	1	2	7	Brevard		2		3	5
Broward	6	1		2	9	Broward	1	1		9	11
Calhoun					0	Calhoun					0
Charlotte					0	Charlotte	2				2
Citrus					0	Citrus	3	1			4
Clay					0	Clay	1	2		2	5
Collier					0	Collier	1				1
Columbia			1		1	Columbia				3	3
DeSoto					0	DeSoto					0
Dixie					0	Dixie					0
Duval	4		4	1	9	Duval		12	2	11	25
Escambia					0	Escambia	1	1		2	4
Flagler					0	Flagler					0
Franklin					0	Franklin					0
Gadsden					0	Gadsden					0
Gilchrist				1	1	Gilchrist					0
Glades					0	Glades					0
Gulf					0	Gulf					0
Hamilton					0	Hamilton					0
Hardee					0	Hardee					0
Hendry	2				2	Hendry					0
Hernando					0	Hernando	1	2			3
Highlands					0	Highlands	1	1		1	3
Hillsborough			1	2	3	Hillsborough	4	5		9	18
Holmes					0	Holmes					0
Indian River	1				1	Indian River		1			1
Jackson					0	Jackson					0
Jefferson					0	Jefferson					0
Lafayette					0	Lafayette					0
Lake	1		1		2	Lake	2	2			4
Lee	4	1			5	Lee	1	1		1	3
Leon				1	1	Leon		2		2	4
Levy					0	Levy					0
Liberty					0	Liberty					0
Madison					0	Madison					0
Manatee	1				1	Manatee		1		2	3
Marion					0	Marion	1				1
Martin	1				1	Martin		1		2	3
Miami-Dade		1		2	3	Miami-Dade	1			5	6
Monroe					0	Monroe					0
Nassua					0	Nassua		1			1
Okaloosa					0	Okaloosa					0
Okeechobee					0	Okeechobee					0
Orange	2	1	2	1	6	Orange	4	3		5	12
Osceola	1				1	Osceola	2			1	3
Palm Beach	1			1	2	Palm Beach	1	3		8	12
Pasco			1		1	Pasco	2	2	2	3	9
Pinellas		3	2	1	6	Pinellas	1	5		5	11
Polk	1		1	1	3	Polk	6	8	1	11	26
Putnam		1			1	Putnam	1	1			2
St Johns		1			1	St Johns		1		1	2
St Lucie	1	1			2	St Lucie		1			1
Santa Rosa					0	Santa Rosa	1				1
Sarasota	2				2	Sarasota				1	1
Seminole				1	1	Seminole	1	1		1	3
Sumter		1			1	Sumter	1			1	2
Suwanee					0	Suwanee					0
Taylor					0	Taylor					0
Union					0	Union					0
Volusia	2				2	Volusia	2	4		3	9
Wakulla					0	Wakulla					0
Walton					0	Walton				1	1
Washington					0	Washington					0
Total	31	14	14	16	75	Total	42	66	5	94	207

The above figures do not include child deaths for which the cause of death was listed as undetermined, unknown, or missing. Most of these were non-verified maltreatment deaths; however there were two verified maltreament deaths (1 in Pinellas and 1 in Seminole) whose cause of death was undetermined.

Table G-2: Distribution of All Child Maltreatment Deaths Across Florida Counties by Primary Cause of Death

County	Primary Cause of Death						
	Drowning	Asphyxia	Weapon	Other	Undetermined	Unknown	Total
Alachua	0	1	0	1	2	0	4
Baker	0	0	0	0	0	0	0
Bay	0	0	0	0	0	0	0
Bradford	0	0	0	0	0	0	0
Brevard	1	5	1	5	0	1	13
Broward	7	2	0	11	5	2	27
Calhoun	0	0	0	0	0	0	0
Charlotte	2	0	0	0	0	1	3
Citrus	3	1	0	0	0	0	4
Clay	1	2	0	2	0	0	5
Collier	1	0	0	0	0	0	1
Columbia	0	0	1	3	1	0	5
DeSoto	0	0	0	0	0	1	1
Dixie	0	0	0	0	0	0	0
Duval	4	12	6	12	2	0	36
Escambia	1	1	0	2	0	0	4
Flagler	0	0	0	0	0	0	0
Franklin	0	0	0	0	0	0	0
Gadsden	0	0	0	0	0	0	0
Gilchrist	0	0	0	1	0	0	1
Glades	0	0	0	0	0	0	0
Gulf	0	0	0	0	0	0	0
Hamilton	0	0	0	0	0	0	0
Hardee	0	0	0	0	0	0	0
Hendry	2	0	0	0	0	0	2
Hernando	1	2	0	0	0	0	3
Highlands	1	1	0	1	0	0	3
Hillsborough	4	5	1	11	5	2	28
Holmes	0	0	0	0	0	0	0
Indian River	1	1	0	0	1	0	3
Jackson	0	0	0	0	0	0	0
Jefferson	0	0	0	0	0	0	0
Lafayette	0	0	0	0	0	0	0
Lake	3	2	1	0	1	0	7
Lee	5	2	0	1	0	0	8
Leon	0	2	0	3	0	0	5
Levy	0	0	0	0	1	0	1
Liberty	0	0	0	0	0	0	0
Madison	0	0	0	0	0	0	0
Manatee	1	1	0	2	1	0	5
Marion	1	0	0	0	0	0	1
Martin	1	1	0	2	1	0	5
Miami-Dade	1	1	0	7	0	0	9
Monroe	0	0	0	0	0	0	0
Nassua	0	1	0	0	0	0	1
Okaloosa	0	0	0	0	0	0	0
Okeechobee	0	0	0	0	0	0	0
Orange	6	4	2	6	9	3	30
Osceola	3	0	0	1	3	1	8
Palm Beach	2	3	0	9	1	0	15
Pasco	2	2	3	3	0	0	10
Pinellas	1	8	2	6	6	0	23
Polk	7	8	2	12	2	0	31
Putnam	1	2	0	0	0	0	3
St Johns	0	2	0	1	1	0	4
St Lucie	1	2	0	0	0	0	3
Santa Rosa	1	0	0	0	0	0	1
Sarasota	2	0	0	1	1	0	4
Seminole	1	1	0	2	3	1	8
Sumter	1	1	0	1	0	0	3
Suwanee	0	0	0	0	0	0	0
Taylor	0	0	0	0	0	0	0
Union	0	0	0	0	0	0	0
Volusia	4	4	0	3	1	1	13
Wakulla	0	0	0	0	0	0	0
Walton	0	0	0	1	1	0	2
Washington	0	0	0	0	0	0	0
Total	73	80	19	110	48	13	343

Information on primary cause of death was missing for six cases where the death incident took place in the following counties: Orange (1), Palm Beach (1), Pasco (2), Polk (1), Seminole (1)

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 79 child fatalities verified as a result of maltreatment, 73 (92.4%) resulted from an external injury, 3 (3.7%) due to a medical cause, and 2 (2.5%) were undetermined. These proportions paralleled distributions observed among 2014 cases reported on in 2015. Among those child fatalities non-verified to be the result of abuse and neglect (n=270), a total of 135 (50.0%) were the result of an external injury, 72 (26.7%) were determined to have a medical cause, and 46 (17.0%) had undetermined or unknown cause of deaths.

Table G-3: Primary Cause of Death by Maltreatment Verification Status

Primary Cause of Death	Verified n=79	Non-Verified n=270
External Injury	73	135
Medical Cause	3	72
Undetermined If Injury or Medical	2	46
Unknown or Missing	1	17

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. Among verified maltreatment deaths, a total of 19 (of 31, 61.3%) of the children were playing, four were sleeping and two were bathing before drowning (see Table G-5). Among non-verified maltreatment deaths 80.5% (n=33 of 42) were playing prior to drowning. Among verified maltreatment deaths, prior to drowning, a total of 14 (45.2%) were located in the home and 7 (22.6%) were in the water. All but two (93.5%) of the children whose death was verified as maltreatment and 100% 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=73	
	Verified (n=31)	Non-Verified (n=42)
In Water	7	6
On Shore	0	0
On Dock	0	0
Pool Side	3	5
In Yard	3	12
In Bathroom	6	1
In House	14	18
Other	2	4
Unknown	0	0
Aggregate totals across locations may exceed total number of cases as multiple locations were reported for select cases.		

Table G-5: Activity of Child Before Drowning by Child Maltreatment Verification Status		
Activity Before Drowning	Child Maltreatment Death Drowning n=73	
	Verified (n=31)	Non-Verified (n=42)
Playing	19	33
Boating	0	0
Swimming	1	1
Bathing	2	1
Fishing	0	0
Surfing	0	0
Tubing	0	0
Water Skiing	0	0
Sleeping	4	2
Other	2	2
Unknown	3	3

Table G-6 : Drowning Location by Child Maltreatment Verification Status		
Drowning Location	Child Maltreatment Death Drowning n=73	
	Verified (n=31)	Non-Verified (n=42)
Open Water	6	7
Pool/Hot Tub/Spa	19	32
Bathtub	5	1
Bucket	0	1
Well/Cistern/Septic	0	0
Toilet	1	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 (62 adults, 16 other children) were reported to be in the child's sleep environment among sleep-related asphyxia cases. Twenty-three persons (17 adults and 5 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 53 sleep-related asphyxia cases.

Table G-7: Objects in Sleep Environment Among Sleep-Related Asphyxia Deaths		
	Objects Present in Sleeping Environment	Objects Obstructing Child's Airway
Adult(s)	62	17
Other Children	16	5
Animal(s)	0	0
Mattress	59	13
Comforter	30	12
Thin blanket/flat	44	10
Pillow(s)	52	13
Cushion	8	3
Boppy or U-Shaped Pillow	4	2
Sleep Positioner	2	0
Bumper Pads	1	1
Clothing	4	0
Crib Railing/Side	4	2
Wall	2	0
Toy(s)	2	0
Other	12	7
The above data apply to sleep-related deaths if the child was under the age of five.		

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. Please note, in contrast to the past year's reports, the number of weapon-related deaths reported on for 2015 is likely to increase as the remaining child death reviews (n=125) are completed following the closure of criminal and DCF investigations/services for select 2015 child deaths. For **verified** maltreatment weapon deaths, 4 (28.6%) of weapons used were firearms, 4 (28.6%) were body parts, and 2 (7.1%) were blunt instruments. Among the four firearm deaths, two involved handguns and two involved assault rifles. All of the owners of firearms used in the fatality (for verified maltreatment deaths) were owned by males. When all weapons used in verified maltreatment deaths are considered,12 of 14 (85.7%) were males who handled the weapon that was used in the child's fatality.

Among **non-verified** weapon deaths, 4 (80.0%) of weapons used were firearms, and 1 (20.0%) was a sharp instrument. Among the 4 firearm deaths, all of the firearms were handguns. The owners of firearms used in the fatality were equally likely to be owned by males and females. For 5 of 5 (100%) 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=19	
	Verified (n=14)	Non-Verified (n=5)
Firearm	4	4
Sharp Instrument	1	1
Blunt Instrument	2	0
Persons Body Part	4	0
Explosive	0	0
Rope	0	0
Pipe	0	0
Biological	0	0
Other	2	0
Unknown	1	0

Table G-9: Type of Firearm by Maltreatment Verification Status

Firearms	Firearm Deaths (n=8) Weapon Type	
	Verified (n=4)	Non-Verified (n=4)
Handgun	2	4
Shotgun	0	0
BB Gun	0	0
Hunting Rifle	0	0
Assault Rifle	2	0
Air Rifle	0	0
Sawed-Off Shotgun	0	0
Other	0	0
Unknown	0	0

Table G-10: Sex of Fatal Firearm Owner by Maltreatment Verification Status		
Sex of Fatal Firearm Owner	Firearm Deaths (n=8)	
	Verified (n=4)	Firearm Deaths (n=4)
Male	4	2
Female	0	2
Unknown	0	0

Table G-11: Sex of Person Handling Weapon by Maltreatment Verification Status		
Sex of Person Handling Weapon	Child Maltreatment Death (n=19)	
	Verified (n=14)	Non-Verified (n=5)
Male	12	5
Female	1	0
Unknown	0	0
Missing	1	0

CHILD CHARACTERISTICS

Age of Child

Table G-12a provides a count of children by age group for which their death was verified as maltreatment by primary cause of death. Table G-12b provides a count of children by age group for which their death was verified as maltreatment and whether the death was classified as abuse or neglect (regardless of primary cause of death). As noted in Table G-12b, 65% (13 of 20) of all abuse deaths and 64.4% (38 of 59) of all neglect deaths happened to children two years of age and younger.

Table G-12a: 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=31		Asphyxia n=14		Weapon n=14		Other n=16	
	Abuse	Neglect	Abuse	Neglect	Abuse	Neglect	Abuse	Neglect
< 1	0	2	1	9	4	0	2	5
1	0	9	0	1	3	0	0	0
2	0	5	0	0	1	1	1	3
3	0	4	0	0	0	0	0	1
4	0	4	0	1	1	0	0	1
5	0	3	0	0	0	0	0	1
6-10	1	2	1	0	2	0	0	2
11-15	0	0	0	1	2	0	0	0
16+	0	1	0	0	0	0	0	0
The above data does not include: two verified maltreatment deaths (children <1) classified as neglect where the cause of death was undetermined; one verified abuse death (child <1) with a missing primary cause of death; and, one verified neglect death (1 year old) with a missing primary cause of death.								

Table G-12b: Age of Children with Verified Maltreatment Death Classified as Abuse or Neglect		
Age	Verified Child Maltreatment Death	
	Verified Child Maltreatment n=79	
	Abuse (n=20)	Neglect (n=59)
< 1	8	18
1	3	11
2	2	9
3	0	5
4	1	6
5	0	4
6-10	4	4
11-15	2	1
16+	0	1

Child's History of Victim of Maltreatment

If known and applicable, the distribution of past maltreatment incidents across maltreatment verification status and primary cause of death are denoted in 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 75 past maltreatment identifications for the 227 children who died, of which 64% (n=48) were associated with and 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**
	n=27	**n=11**	**n=12**	**n=13**	**n=31**	**n=48**	**n=5**	**n=80**
Physical	7.4%	9.1%	16.7%	0.0%	6.5%	2.1%	40.0%	1.3%
Neglect	40.7%	18.2%	25.0%	23.1%	22.6%	10.4%	40.0%	16.3%
Sexual	0.0%	0.0%	8.3%	0.0%	0.0%	0.0%	20.0%	0.0%
Emotional	3.7%	0.0%	0.0%	0.0%	3.2%	0.0%	40.0%	2.5%

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. Among verified maltreatment deaths, between 62.5% ("other" deaths) and 100% (asphyxia deaths) of the children had a second caregiver present in the home. Among non-verified deaths, between 20.0% (weapon deaths) and 83.3% (asphyxia deaths) of the children 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=31	Asphyxia n=14	Weapon n=14	Other n=16	Drowning n=42	Asphyxia n=66	Weapon n=5	Other n=94
One	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
Two	83.87%	100.00%	92.86%	62.50%	73.81%	83.33%	20.00%	71.28%

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. Among verified child maltreatment deaths, the proportion of aggregate caregivers who are biological parents ranged from a low of 70% for weapon deaths to a high of 93% for asphyxia deaths. These proportions are generally paralleled for non-verified deaths where the proportion of aggregate caregivers who are biological parents ranged from a low of 82% for drowning deaths to a high of 90% for asphyxia deaths.

These findings are reinforced when examining the distributions of caregiver relationship to child is observed for the first identified caregiver. When the primary relationship of the second caregiver is examined (see Table G-17), only a minority of caregivers in weapons deaths were biological parents with 23% being a step-parent and 23% identified as the mother's partner. Statistical tests of significance of the differences in relationship proportions should be conducted once a larger representative population of 2015 fatality cases has been reviewed.

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=57	Asphyxia n=28	Weapon n=27	Other n=26	Drowning n=73	Asphyxia n=121	Weapon n=6	Other n=161
Self	0%	0%	0%	0%	0%	0%	0%	0%
Biological Parent	75%	93%	70%	81%	82%	90%	83%	85%
Adoptive Parent	4%	0%	0%	0%	0%	2%	17%	0%
Step-Parent	5%	4%	11%	0%	1%	1%	0%	1%
Foster Parent	0%	0%	0%	0%	0%	0%	0%	2%
Mother's Partner	2%	4%	11%	4%	1%	2%	0%	1%
Father's Partner	0%	0%	0%	0%	1%	0%	0%	0%
Grandparent	9%	0%	7%	12%	11%	4%	0%	1%
Sibling	0%	0%	0%	0%	0%	1%	0%	1%
Other Relative	0%	0%	0%	4%	3%	1%	0%	2%
Friend	0%	0%	0%	0%	0%	0%	0%	1%
Institutional Staff	4%	0%	0%	0%	0%	0%	0%	2%
Other	2%	0%	0%	0%	0%	0%	0%	4%
Unknown	0%	0%	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=31	Asphyxia n=14	Weapon n=14	Other n=16	Drowning n=42	Asphyxia n=66	Weapon n=5	Other n=94
Self	0%	0%	0%	0%	0%	0%	0%	0%
Biological Parent	87%	100%	93%	81%	93%	97%	80%	87%
Adoptive Parent	3%	0%	0%	0%	0%	2%	20%	0%
Step-Parent	0%	0%	0%	0%	0%	0%	0%	0%
Foster Parent	0%	0%	0%	0%	0%	0%	0%	2%
Mother's Partner	0%	0%	0%	0%	0%	0%	0%	0%
Father's Partner	0%	0%	0%	0%	0%	0%	0%	0%
Grandparent	3%	0%	7%	13%	7%	2%	0%	1%
Sibling	0%	0%	0%	0%	0%	0%	0%	0%
Other Relative	0%	0%	0%	6%	0%	0%	0%	1%
Friend	0%	0%	0%	0%	0%	0%	0%	1%
Institutional Staff	3%	0%	0%	0%	0%	0%	0%	2%
Other	0%	0%	0%	0%	0%	0%	0%	5%
Unknown	3%	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=26	Asphyxia n=14	Weapon n=13	Other n=10	Drowning n=31	Asphyxia n=55	Weapon n=1	Other n=67
Self	0%	0%	0%	0%	0%	0%	0%	0%
Biological Parent	62%	86%	46%	80%	68%	82%	100%	82%
Adoptive Parent	4%	0%	0%	0%	0%	2%	0%	0%
Step-Parent	12%	7%	23%	0%	3%	2%	0%	3%
Foster Parent	0%	0%	0%	0%	0%	0%	0%	1%
Mother's Partner	4%	7%	23%	10%	3%	4%	0%	3%
Father's Partner	0%	0%	0%	0%	3%	0%	0%	0%
Grandparent	15%	0%	8%	10%	16%	7%	0%	1%
Sibling	0%	0%	0%	0%	0%	2%	0%	1%
Other Relative	0%	0%	0%	0%	6%	2%	0%	4%
Friend	0%	0%	0%	0%	0%	0%	0%	0%
Institutional Staff	4%	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-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 exceptions. Among verified maltreatment deaths, the percentage of supervisors (across primary causes of death) who were biological parents ranges from 54% (for "other" deaths) to 83% (for asphyxia deaths); a majority for each cause of death. Among verified maltreatment weapon deaths, 15% of the supervisors were the mother's partner, with an additional 8% being a stepparent, and 8% being a grandparent. Among verified maltreatment drownings, 17% were the child's grandparent and another 7% involved an "other" relative. Although a large proportion of supervisors associated with asphyxia deaths were biological parents (83%), 8% were identified as friends, and another 8% as institutional staff.

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=29	Asphyxia n=12	Weapon n=13	Other n=13	Drowning n=36	Asphyxia n=50	Weapon n=4	Other n=81
Biological Parent	55%	83%	69%	54%	75%	90%	25%	68%
Adoptive Parent	3%	0%	0%	0%	0%	0%	25%	0%
Step-Parent	3%	0%	8%	0%	0%	0%	0%	0%
Foster Parent	0%	0%	0%	0%	0%	0%	0%	1%
Mother's Partner	0%	0%	15%	8%	0%	0%	0%	0%
Father's Partner	0%	0%	0%	0%	0%	0%	0%	0%
Grandparent	17%	0%	8%	15%	14%	2%	0%	5%
Sibling	3%	0%	0%	8%	3%	0%	50%	1%
Other Relative	7%	0%	0%	8%	8%	2%	0%	4%
Friend	3%	8%	0%	0%	0%	0%	0%	2%
Acquaintance	0%	0%	0%	0%	0%	0%	0%	0%
Hospital Staff	0%	0%	0%	8%	0%	0%	0%	6%
Institutional Staff	3%	8%	0%	0%	0%	0%	0%	4%
Babysitter	0%	0%	0%	0%	0%	6%	0%	1%
Licensed Child Care Worker	0%	0%	0%	0%	0%	0%	0%	1%
Other	3%	0%	0%	0%	0%	0%	0%	6%
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 64% of drowning, 86% of asphyxia, 57% of weapon, and 72% of other causes deaths. For weapon deaths, 14% of all person(s) responsible and 17% of persons directly causing a child's death were the mother's partner. For weapon death cases, an additional 14% listed a child's stepparent as a person responsible with 8% of cases those who directly caused a weapon's death as a stepparent.

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=33	Asphyxia n=14	Weapon n=21	Other n=18
Self	0%	0%	0%	0%
Biological Parent	64%	86%	57%	72%
Adoptive Parent	3%	0%	0%	0%
Step-Parent	3%	0%	14%	0%
Foster Parent	0%	0%	0%	0%
Mother's Partner	0%	0%	14%	6%
Father's Partner	0%	0%	0%	6%
Grandparent	18%	0%	5%	11%
Sibling	0%	0%	0%	0%
Other Relative	6%	0%	5%	6%
Friend	3%	7%	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	3%	7%	5%	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 - Who Caused Relationship To Child	Verified Child Maltreatment Death			
	Drowning n=6	Asphyxia n=8	Weapon n=12	Other n=13
Self	0%	0%	0%	0%
Biological Parent	83%	88%	58%	77%
Adoptive Parent	0%	0%	0%	0%
Step-Parent	0%	0%	8%	0%
Foster Parent	0%	0%	0%	0%
Mother's Partner	0%	0%	17%	8%
Father's Partner	0%	0%	0%	8%
Grandparent	0%	0%	0%	0%
Sibling	0%	0%	0%	0%
Other Relative	0%	0%	8%	8%
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	17%	13%	8%	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=27	Asphyxia n=6	Weapon n=9	Other n=5
Self	0%	0%	0%	0%
Biological Parent	59%	83%	56%	60%
Adoptive Parent	4%	0%	0%	0%
Step-Parent	4%	0%	22%	0%
Foster Parent	0%	0%	0%	0%
Mother's Partner	0%	0%	11%	0%
Father's Partner	0%	0%	0%	0%
Grandparent	22%	0%	11%	40%
Sibling	0%	0%	0%	0%
Other Relative	7%	0%	0%	0%
Friend	4%	17%	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%	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	33.0	28.1	28.1	34.9	32.0	28.2	49.8	31.8
Caregiver2	37.2	31.3	29.9	29.9	40.1	31.8	50.0	33.7
All Caregivers	34.9	29.7	29.0	33.0	35.4	29.8	49.8	32.6
Supervisors	36.8	30.8	28.8	34.8	33.4	28.6	39.0	32.2
Person Responsible - Caused	36.3	26.3	27.0	33.2	NA	NA	NA	NA
Person Responsible - Contributed	37.8	33.7	29.3	38.8	NA	NA	NA	NA
All Person(s) Responsible	37.5	29.4	28.0	34.7	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 52% (for weapon deaths) and 69% (for other deaths) of caregivers were female. Among supervisors of verified child maltreatment deaths, 73% of asphyxia cases, 75% of other deaths, and 86% drowning cases were females (Table G-24). The exception to this gender trend was found with verified and non-verified deaths involving weapons. Here, 69% and 75% of the supervisors associated with v3erified and non-verified maltreatment deaths (respectively) 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 (88%) and other deaths (78%), and the majority of asphyxia deaths (64%) were women (Table G-25). However, the person(s) responsible for the majority of weapon deaths (71%) 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=57	Asphyxia n=28	Weapon n=27	Other n=26	Drowning n=73	Asphyxia n=120	Weapon n=6	Other n=161
Male	37%	46%	48%	31%	41%	40%	33%	37%
Female	63%	54%	52%	69%	59%	60%	67%	62%
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=29	Asphyxia n=11	Weapon n=13	Other n=12	Drowning n=36	Asphyxia n=50	Weapon n=4	Other n=74
Male	14%	27%	69%	25%	33%	22%	75%	23%
Female	86%	73%	31%	75%	67%	78%	25%	77%
Unknown	0%	0%	0%	0%	0%	0%	0%	0%

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=33	Asphyxia n=14	Weapon n=21	Other n=18
Male	12%	36%	71%	22%
Female	88%	64%	29%	78%
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, 56 of 142 (39.4%) are known to have a substance abuse history. A total of 121 of 349 (35%) of caregivers of children whose death was not verified to result from child maltreatment.

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=142)				Non-Verified Child Maltreatment Death (n=349)			
Substance Abuse History	Drowning n=55	Asphyxia n=28	Weapon n=23	Other n=26	Drowning n=72	Asphyxia n=118	Weapon n=6	Other n=153
Yes	33%	68%	22%	54%	18%	49%	0%	33%
No	55%	21%	48%	42%	56%	44%	67%	56%
Unknown	13%	11%	30%	4%	26%	7%	33%	12%
	If Yes, Verified Child Maltreatment Deaths (n=56)				**If Yes, Non-Verified Child Maltreatment Death (n=121)**			
Type of Substance	Drowning n=18	Asphyxia n=19	Weapon n=5	Other n=14	Drowning n=13	Asphyxia n=58	Weapon n=0	Other n=50
Alcohol	44%	74%	0%	36%	23%	14%	0%	14%
Cocaine	22%	16%	20%	21%	15%	26%	0%	24%
Marijuana	44%	47%	40%	64%	85%	84%	0%	74%
Methamphetamine	17%	0%	0%	7%	0%	7%	0%	4%
Opiates	33%	16%	20%	21%	15%	14%	0%	24%
Prescription	56%	26%	20%	7%	0%	10%	0%	12%
Over-the-Counter Drugs	0%	0%	0%	0%	0%	0%	0%	2%
Other	22%	11%	0%	29%	23%	12%	0%	22%
Unknown	17%	0%	20%	0%	0%	2%	0%	2%

When types of substances are examined among caregivers with a substance abuse history, among verified drowning maltreatment deaths the substances most prevalent included prescription drugs (56%), alcohol (44%), and marijuana (44%). In addition, one third (33%) of caregivers were found to have a history of opiate abuse. Alcohol abuse (74%) followed by marijuana (47%) and prescription drug abuse (26%) were most represented with verified asphyxia maltreatment deaths. Further, the majority (64%) of caregivers associated with other verified maltreatment deaths had a history with marijuana use. Among non-verified maltreatment deaths, marijuana use by caregivers was identified with an overwhelming majority of deaths with respect to drowning (85%), asphyxia (84%), and other (74%) deaths.

When the substance abuse history of supervisors of children at the time of the child's death is examined (see Table G-27), 49% (n=31 of 63) and 34% (n=53 of 158) of supervisors in verified and non-verified deaths (respectively) were known to have a substance abuse history.[1] Again, given that there are 125 2015 child fatality cases that are still open and/or require local committee review, the above percentages should be considered estimates of the prevalence of substance abuse histories among supervisors involved in child fatalities.

[1] 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 statistically significant (Z-Score=2.165, p=.03).

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=63)				Non-Verified Child Maltreatment Death (n=158)			
	Drowning n=28	Asphyxia n=11	Weapon n=12	Other n=12	Drowning n=35	Asphyxia n=49	Weapon n=4	Other n=70
Yes	43%	82%	25%	58%	29%	45%	0%	30%
No	50%	18%	58%	33%	57%	51%	100%	60%
Unknown	7%	0%	17%	8%	14%	4%	0%	10%
	If Yes, Verified Child Maltreatment Deaths (n=31)				**If Yes, Non-Verified Child Maltreatment Death (n=53)**			
Type of Substance	Drowning n=12	Asphyxia n=9	Weapon n=3	Other n=7	Drowning n=10	Asphyxia n=22	Weapon n=0	Other n=21
Alcohol	42%	56%	0%	43%	20%	18%	0%	14%
Cocaine	17%	22%	33%	29%	20%	18%	0%	14%
Marijuana	50%	56%	33%	71%	80%	86%	0%	67%
Methamphetamine	25%	0%	0%	14%	0%	14%	0%	0%
Opiates	33%	22%	0%	14%	20%	14%	0%	24%
Prescription	58%	44%	0%	14%	0%	9%	0%	14%
Over-the-Counter Drugs	0%	0%	0%	0%	0%	0%	0%	0%
Other	17%	22%	0%	43%	20%	14%	0%	24%
Unknown	0%	0%	33%	0%	0%	5%	0%	0%

When types of substances are examined (for those with a substance abuse history), the results parallel many of the observations made with caregivers. Among verified drowning maltreatment deaths, the substances most prevalent included prescription drugs (58%), marijuana (50%), and alcohol (42%). In addition, one third (33%) of caregivers were found to have a history of opiate abuse. Alcohol (56%) and marijuana (56%) followed by prescription drug abuse (44%) were most represented with verified asphyxia maltreatment deaths. Further, the majority (71%) of caregivers associated with other verified maltreatment deaths had a history with marijuana use. Among non-verified maltreatment deaths, marijuana use by caregivers was identified with an overwhelming majority of deaths with respect to drowning (80%), asphyxia (86%), and other (67%) deaths.

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, 51.0% (42 of 82) are known to have a substance abuse history. Substance abuse was identified to be present among 79% of those person(s) responsible for asphyxia deaths, 41% of drowning deaths, 67% of "other" causes of death, and 33% of weapons deaths. Please note that the substance abuse history of 28% of those persons responsible for weapons-related deaths was not known. When types of substances are examined, the majority (or near majority) of those responsible for the child's death verified as maltreatment used marijuana from a low of 46% for drowning deaths to high of 67% of "other" causes of death. Alcohol abuse was prevalent for the majority of persons responsible for asphyxia (55%) and "other" (50%) verified child maltreatment deaths. Further, the majority (62%) of all person(s) responsible for a child's drowning death had an identified history of prescription drug abuse.

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) Responsible	Verified Child Maltreatment Death (n=82)			
	Drowning n=32	Asphyxia n=14	Weapon n=18	Other n=18
Yes	41%	79%	33%	67%
No	50%	21%	39%	28%
Unknown	9%	0%	28%	6%
	If Yes, Verified Child Maltreatment Deaths (n=42)			
Type of Substance	Drowning n=13	Asphyxia n=11	Weapon n=6	Other n=12
Alcohol	31%	55%	0%	50%
Cocaine	15%	27%	17%	33%
Marijuana	46%	55%	50%	67%
Methamphetamine	23%	0%	0%	8%
Opiates	38%	27%	0%	17%
Prescription	62%	45%	0%	17%
Over-the-Counter Drugs	0%	0%	0%	0%
Other	23%	27%	17%	42%
Unknown	0%	0%	17%	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, 12% (16 of 134) were known to have an identified disability or chronic illness of which 6 (or 37.5%) were associated with drowning deaths (Table G-29). Among all caregivers associated with non-verified maltreatment deaths, 9% (30 of 348) were known to have an identified disability or chronic illness.[2]

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=134)				Non-Verified Child Maltreatment Death (n=348)			
	Drowning n=56	Asphyxia n=27	Weapon n=27	Other n=24	Drowning n=70	Asphyxia n=120	Weapon n=6	Other n=152
Yes	11%	15%	15%	8%	9%	8%	33%	9%
No	75%	85%	63%	92%	63%	80%	33%	78%
Unknown	14%	0%	22%	0%	29%	13%	33%	14%
	If Yes, Verified Child Maltreatment Deaths (n=16)				**If Yes, Non-Verified Child Maltreatment Death (n=30)**			
Type of Disability	Drowning n=6	Asphyxia n=4	Weapon n=4	Other n=2	Drowning n=6	Asphyxia n=9	Weapon n=2	Other n=13
Physical	67%	0%	100%	0%	50%	56%	100%	23%
Mental	33%	100%	25%	100%	33%	56%	0%	85%
Sensory	0%	0%	25%	0%	17%	0%	0%	0%
Unknown	0%	0%	0%	0%	0%	11%	0%	0%

When findings from Table G-30 are examined, 13 of 64 (20.0%) supervisors of children whose death was verified to result from maltreatment were identified as having a disability or chronic illness and was statistically significantly higher than the 14 of 158 (9.0%) of supervisors of children whose deaths were not classified as maltreatment.[3] For both verified and non-verified maltreatment deaths, physical disabilities among supervisors were prevalent in the majority of drowning and weapons deaths, whereas mental disabilities were more prevalent in asphyxia and (for verified cases) and asphyxia and "other" deaths for non-verified cases. However, as noted earlier, given the small number of supervisors identified with disabilities and the number of 2015 cases still to be reviewed, these findings should be considered tentative estimates.

[2] 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 NOT statistically significant (Z-Score=1.11, p=.267).

[3] 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=2.37, p=.019).

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=64)				Non-Verified Child Maltreatment Death (n=158)			
	Drowning n=29	Asphyxia n=11	Weapon n=13	Other n=11	Drowning n=35	Asphyxia n=50	Weapon n=4	Other n=69
Yes	21%	27%	15%	18%	9%	10%	25%	7%
No	66%	73%	62%	82%	77%	88%	75%	83%
Unknown	14%	0%	23%	0%	14%	2%	0%	10%
	If Yes, Verified Child Maltreatment Deaths (n= 13)				If Yes, Non-Verified Child Maltreatment Death (n=14)			
Type of Disability	Drowning n=6	Asphyxia n=3	Weapon n=2	Other n=2	Drowning n=3	Asphyxia n=5	Weapon n=1	Other n=5
Physical	67%	0%	100%	0%	67%	20%	100%	20%
Mental	0%	100%	100%	0%	33%	80%	0%	80%
Sensory	0%	0%	0%	50%	0%	0%	0%	0%
Unknown	0%	0%	0%	0%	0%	20%	0%	0%

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.

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? (n=85)	Verified Child Maltreatment Death			
	Drowning n=33	Asphyxia n=14	Weapon n=21	Other n=17
Yes	21%	29%	19%	18%
No	67%	71%	57%	82%
Unknown	12%	0%	24%	0%
	If Yes, Person(s) Responsible Verified Child Maltreatment Deaths (n=18)			
Type of Disability	Drowning n=7	Asphyxia n=4	Weapon n=4	Other n=3
Physical	57%	0%	75%	33%
Mental	43%	100%	25%	100%
Sensory	0%	0%	25%	0%
Unknown	86%	75%	75%	67%

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=57	Asphyxia n=28	Weapon n=27	Other n=24	Drowning n=72	Asphyxia n=121	Weapon n=6	Other n=159
Employed	61%	57%	41%	54%	54%	46%	83%	47%
Unemployed	23%	21%	26%	21%	10%	21%	17%	22%
On Disability	2%	0%	7%	4%	0%	2%	0%	1%
Stay-at-Home Caregiver	5%	11%	15%	4%	13%	8%	0%	8%
Retired	0%	0%	0%	4%	6%	1%	0%	0%
Unknown	9%	11%	11%	13%	18%	21%	0%	23%

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=31	Asphyxia n=14	Weapon n=14	Other n=15	Drowning n=42	Asphyxia n=66	Weapon n=5	Other n=92
Employed	52%	21%	50%	47%	50%	39%	80%	37%
Unemployed	32%	36%	21%	20%	10%	24%	20%	32%
On Disability	0%	0%	0%	7%	0%	3%	0%	0%
Stay-at-Home Caregiver	10%	21%	21%	7%	19%	14%	0%	14%
Retired	0%	0%	0%	7%	2%	0%	0%	0%
Unknown	6%	21%	7%	13%	19%	20%	0%	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=26	Asphyxia n=14	Weapon n=13	Other n=9	Drowning n=30	Asphyxia n=55	Weapon n=1	Other n=67
Employed	73%	93%	31%	67%	60%	55%	100%	60%
Unemployed	12%	7%	31%	22%	10%	18%	0%	9%
On Disability	4%	0%	15%	0%	0%	0%	0%	1%
Stay-at-Home Caregiver	0%	0%	8%	0%	3%	2%	0%	0%
Retired	0%	0%	0%	0%	10%	2%	0%	0%
Unknown	12%	0%	15%	11%	17%	24%	0%	30%

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. This observation parallels observations noted in the 2015 report (on 2014 cases). 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=57	Asphyxia n=28	Weapon n=25	Other n=26	Drowning n=72	Asphyxia n=121	Weapon n=6	Other n=159
Less than High School	19%	21%	8%	27%	11%	18%	0%	12%
High School	23%	7%	32%	8%	17%	32%	33%	26%
College	5%	0%	12%	15%	13%	13%	17%	13%
Post Graduate	2%	0%	0%	0%	0%	0%	0%	3%
Unknown	51%	71%	48%	50%	60%	36%	50%	47%

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 vast 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=56	Asphyxia n=28	Weapon n=27	Other n=26	Drowning n=72	Asphyxia n=114	Weapon n=6	Other n=158
Yes	84%	93%	81%	100%	99%	98%	100%	92%
No	16%	4%	7%	0%	1%	0%	0%	5%
Unknown	0%	4%	11%	0%	0%	2%	0%	3%

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=28	Asphyxia n=11	Weapon n=13	Other n=12	Drowning n=36	Asphyxia n=47	Weapon n=4	Other n=73
Yes	82%	91%	77%	100%	97%	100%	100%	93%
No	14%	9%	8%	0%	3%	0%	0%	5%
Unknown	4%	0%	15%	0%	0%	0%	0%	1%

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=32	Asphyxia n=14	Weapon n=21	Other n=18
Yes	81%	93%	90%	100%
No	19%	7%	5%	0%
Unknown	0%	0%	5%	0%

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 were nine caregivers (three verified and six non-verified) who were on active duty military for which six were identified as the second caregiver. Of the three verified maltreatment deaths, two were weapons deaths and one was asphyxia.

Among supervisors of children at the time of the death, there was one identified person on active duty military for an asphyxia death verified as child maltreatment. Further, there were two supervisors of non-verified asphyxia deaths that were on active duty military. When information related to person(s) responsible for a maltreatment fatality is examined,

three individuals were identified as being on active duty military for two verified weapons and one verified asphyxia deaths.

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=137)				Non-Verified Child Maltreatment Death (n=347)			
Receipt of Social Services	Drowning n=57	Asphyxia n=27	Weapon n=27	Other n=26	Drowning n=71	Asphyxia n=117	Weapon n=6	Other n=153
Yes	21%	44%	33%	38%	17%	36%	17%	28%
No	42%	15%	26%	0%	37%	20%	50%	22%
Unknown	37%	41%	41%	62%	46%	44%	33%	50%
	If Yes, Verified Child Maltreatment Deaths (n= 43)				**If Yes, Non-Verified Child Maltreatment Death (n=98)**			
Type of Support	Drowning n=12	Asphyxia n=12	Weapon n=9	Other n=10	Drowning n=12	Asphyxia n=42	Weapon n=1	Other n=43
WIC	17%	58%	44%	20%	8%	67%	0%	28%
TANF	42%	17%	0%	20%	0%	7%	100%	12%
Medicaid	92%	75%	67%	90%	67%	81%	100%	81%
Food Stamps	75%	50%	78%	40%	42%	60%	100%	51%
Other	17%	8%	11%	20%	33%	12%	0%	16%
Unknown	0%	0%	0%	10%	0%	0%	0%	0%

It is important to note that there were a significant 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). Thus, the findings presented on these data elements should be considered conservative estimates. Regardless, findings from Table G-39 reveal that among the caregivers of children whose death was verified as child maltreatment, 31% (43 of 137) are known to have received some form of social service support in the twelve months prior to the child's death. This rate approximated the 28.2% (98 of 347) of caregivers of children whose death was not verified to result from child maltreatment. 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 67% for weapons deaths to high of 92% for drowning deaths). The majority of all caregivers of children whose death

was not verified as resulting from maltreatment also received Medicaid (from a low of 67% for drowning deaths to a high of 100% for the one weapon death).

In addition to the receipt of Medicaid, among known cases where social service support was received and where maltreatment was verified, the majority of caregivers of children who drowned (75%) and the majority of caregivers of children who died from asphyxia (50%) and weapons deaths (78%) received food stamps.

It is important to note that for year 2015, 49% of mothers who delivered infants participated in WIC and approximately 48.8% deliveries were funded by Medicaid (Florida CHARTS, 2016). Therefore, 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% (26 of 132) 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 25 (or 18.9%) 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 "other" causes (32%), followed by those children who died from asphyxia (29%).

Among the caregivers of children whose death was not a verified maltreatment death, 22% (76 of 348) were identified to have been a past victim of child maltreatment.

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 27% (17 of 63) were past child victims of maltreatment. Among the supervisors of children whose death was not a verified maltreatment death, 22% (35 of 159) are known to have a history of maltreatment as a child victim.

Among those persons responsible for the child's death (Table G-42), 25% (21 of 83) are known to be past child victims of maltreatment.

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=132)				Non-Verified Child Maltreatment Death (n=348)			
Caregiver Past Victim of Child Maltreatment	Drowning n=55	Asphyxia n=28	Weapon n=27	Other n=22	Drowning n=71	Asphyxia n=116	Weapon n=6	Other n=155
Yes	9%	29%	22%	32%	21%	24%	0%	21%
No	76%	50%	52%	50%	65%	59%	67%	57%
Unknown	15%	21%	26%	18%	14%	16%	33%	21%
	If Yes, Verified Child Maltreatment Deaths (n= 26)				If Yes, Non-Verified Child Maltreatment Death (n=76)			
Type of Maltreatment	Drowning n=5	Asphyxia n=8	Weapon n=6	Other n=7	Drowning n=15	Asphyxia n=28	Weapon n=0	Other n=33
Physical	20%	63%	100%	71%	53%	36%	0%	48%
Neglect	60%	63%	17%	57%	60%	68%	0%	36%
Sexual	40%	38%	17%	43%	33%	11%	0%	30%
Emotional/ Psychological	0%	25%	17%	0%	7%	25%	0%	15%
Unknown	20%	0%	17%	0%	7%	0%	0%	15%

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=63)				Non-Verified Child Maltreatment Death (n=159)			
Supervisor Past Victim of Child Maltreatment	Drowning n=28	Asphyxia n=11	Weapon n=13	Other n=11	Drowning n=34	Asphyxia n=49	Weapon n=4	Other n=72
Yes	11%	36%	38%	45%	29%	27%	0%	17%
No	71%	64%	46%	36%	59%	57%	100%	63%
Unknown	18%	0%	15%	18%	12%	16%	0%	21%
	If Yes, Verified Child Maltreatment Deaths (n=17)				If Yes, Non-Verified Child Maltreatment Death (n=35)			
Type of Maltreatment	Drowning n=3	Asphyxia n=4	Weapon n=5	Other n=5	Drowning n=10	Asphyxia n=13	Weapon n=0	Other n=12
Physical	33%	75%	100%	60%	60%	31%	0%	75%
Neglect	33%	50%	60%	20%	60%	69%	0%	33%
Sexual	0%	50%	0%	80%	40%	15%	0%	33%
Emotional/ Psychological	0%	0%	20%	0%	0%	31%	0%	8%
Unknown	0%	25%	0%	20%	10%	0%	0%	0%

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			
All Persons Responsible as Past Victim of Child Maltreatment (n=83)	Drowning n=32	Asphyxia n=14	Weapon n=21	Other n=16
Yes	6%	43%	29%	44%
No	78%	43%	52%	44%
Unknown	16%	14%	19%	13%
	If Yes, Persons Responsible Verified Child Maltreatment Death (n=21)			
Type of Maltreatment	Drowning n=2	Asphyxia n=14	Weapon n=21	Other n=16
Physical	0%	36%	29%	31%
Neglect	0%	36%	10%	25%
Sexual	1%	14%	0%	19%
Emotional/ Psychological	50%	21%	0%	6%
Unknown	100%	29%	24%	38%

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), 35% (47 of 134) 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 (apart from weapons deaths) to be neglect, from a low of 83% of caregivers associated with drowning deaths to a high of 100% of caregivers associated with asphyxia deaths.

When the aggregate of caregivers associated with non-verified deaths is examined, 34.9% (81 of 232) 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 77% of caregivers associated with asphyxia deaths to a high of 100% of caregivers associated with weapons 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=134)				Non-Verified Child Maltreatment Death (n=232)			
Caregiver Has History as Perpetrator	Drowning n=56	Asphyxia n=28	Weapon n=27	Other n=23	Drowning n=71	Asphyxia n=120	Weapon n=6	Other n=158
Yes	41%	32%	22%	39%	21%	25%	17%	22%
No	54%	64%	59%	57%	73%	68%	83%	67%
Unknown	5%	4%	19%	4%	6%	7%	0%	11%
	If Yes, Verified Child Maltreatment Deaths (n= 47)				If Yes, Non-Verified Child Maltreatment Death (n=81)			
Type of Maltreatment	Drowning n=23	Asphyxia n=9	Weapon n=6	Other n=9	Drowning n=15	Asphyxia n=30	Weapon n=1	Other n=35
Physical	26%	44%	33%	33%	40%	33%	100%	34%
Neglect	83%	100%	17%	89%	80%	77%	100%	86%
Sexual	0%	22%	0%	11%	13%	10%	0%	3%
Emotional/ Psychological	4%	22%	0%	0%	13%	13%	100%	17%
Unknown	9%	0%	0%	0%	0%	0%	0%	6%

When the past history as a perpetrator of supervisors is examined (see Table G-44), 31.7% (20 of 63) 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 (excluding weapons related deaths) to be neglect, from a low of 70% (7 of 10) for supervisors associated with drowning deaths to a high of 100% (4 of 4) for supervisors associated with asphyxia and "other" deaths.

When the aggregate of supervisors associated with non-verified deaths is examined, 24.4% (39 of 160) were identified as past perpetrators of child maltreatment[4]. 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 78% (7 of 9) of caregivers associated with drowning deaths to a high of 100% (1 of 1) of supervisors associated with weapons deaths.

[4] 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=1.12, p=.263).

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=63)				Non-Verified Child Maltreatment Death (n=160)			
Supervisor Has History as Perpetrator	Drowning n=28	Asphyxia n=11	Weapon n=13	Other n=11	Drowning n=34	Asphyxia n=50	Weapon n=4	Other n=72
Yes	36%	36%	15%	36%	26%	26%	25%	22%
No	57%	64%	69%	55%	68%	70%	75%	67%
Unknown	7%	0%	15%	9%	6%	4%	0%	11%
	If Yes, Verified Child Maltreatment Deaths (n=20)				If Yes, Non-Verified Child Maltreatment Death (n=39)			
Type of Maltreatment	Drowning n=10	Asphyxia n=4	Weapon n=2	Other n=4	Drowning n=9	Asphyxia n=13	Weapon n=1	Other n=16
Physical	0%	50%	50%	0%	22%	23%	100%	44%
Neglect	70%	100%	0%	100%	78%	85%	100%	94%
Sexual	0%	25%	0%	25%	0%	8%	0%	0%
Emotional/ Psychological	10%	25%	0%	0%	11%	15%	100%	6%
Unknown	10%	0%	0%	0%	0%	0%	0%	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 40.5% (34 of 84) were identified to have a past history as a perpetrator of child maltreatment. Among these 34 individuals, 15 (44%) were affiliated with drowning deaths 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 (50%) of perpetrators who were responsible for asphyxia 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			
Persons Responsible Have History as Perpetrator	Drowning n=32	Asphyxia n=14	Weapon n=21	Other n=17
Yes	47%	43%	24%	47%
No	47%	50%	57%	47%
Unknown	6%	7%	19%	6%
	If Yes, Persons Responsible Verified Child Maltreatment Death (n=34)			
Type of Maltreatment	Drowning n=15	Asphyxia n=6	Weapon n=5	Other n=8
Physical	33%	50%	40%	25%
Neglect	80%	83%	0%	100%
Sexual	0%	33%	0%	13%
Emotional/ Psychological	7%	33%	0%	0%
Unknown	7%	0%	0%	0%

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, 29 caregivers (21.6% of 134) were known to be victims and 20 (14.9% of 134) 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 (38%) and perpetrators (25%) were verified maltreatment "other" deaths. Among non-verified deaths, a total of 42 caregivers (11.8% of 357) were known to be victims and 37 (10.4% of 357) 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 is significantly higher than the percentage 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.[5]

[5] 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=2.77, p=.0056). The same test was conducted for those with a history as a perpetrator of intimate violence. Observed proportions were NOT statistically significant (Z-score =1.41, p=.16)

Table G-46: History of Intimate Partner Violence with Caregivers by Maltreatment Verification Status and Primary Cause of Death								
	Verified Child Maltreatment Death (n=134)				Non-Verified Child Maltreatment Death (n=357)			
History of Intimate Partner Violence	Drowning n=55	Asphyxia n=28	Weapon n=27	Other n=24	Drowning n=73	Asphyxia n=119	Weapon n=6	Other n=159
Yes, as Victim	13%	29%	19%	38%	7%	15%	0%	12%
Yes, as Perpetrator	7%	25%	11%	25%	5%	16%	0%	9%
No	62%	29%	33%	38%	59%	58%	50%	64%
Unknown	20%	25%	37%	8%	32%	15%	50%	19%

Table G-47 highlights the distribution of supervisors' history with intimate partner violence as a victim and/or perpetrator. In total, 12 caregivers (18.8% of 64) were known to be victims and 7 (10.9% of 64) 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 (27%) was among asphyxia deaths. Among non-verified deaths, a total of 20 of 163 supervisors (12.3%) were known to be victims and 19 of 163 (11.7%) 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=64)				Non-Verified Child Maltreatment Death (n=163)			
History of Intimate Partner Violence	Drowning n=28	Asphyxia n=11	Weapon n=13	Other n=12	Drowning n=36	Asphyxia n=50	Weapon n=4	Other n=73
Yes, as Victim	14%	27%	15%	25%	11%	16%	0%	11%
Yes, as Perpetrator	7%	9%	8%	25%	3%	20%	0%	11%
No	57%	36%	38%	58%	61%	58%	75%	67%
Unknown	25%	27%	38%	0%	28%	12%	25%	16%

Table G-48: 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=75)			
	Drowning n=31	Asphyxia n=14	Weapon n=14	Other n=16
Yes, as Perpetrator	6%	14%	21%	25%
Yes, as Victim	16%	14%	21%	31%
No	55%	43%	36%	44%
Unknown	19%	14%	21%	0%

When the history of intimate partner violence is examined for persons responsible for a child's death is examined, among verified maltreatment deaths, information on this data element is unknown for 19%, 14%, and 21% of those responsible for drowning, asphyxia, and weapons respectively. Those with a history as a victim of intimate partner violence ranged from a low of 14% for those responsible for asphyxia deaths to a high of 31% for those responsible for "other" deaths. Those with a history as a perpetrator of intimate partner violence ranged from a low of 6% for those responsible for drowning deaths to a high of 25% for those responsible for "other" deaths.

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, 51 of 137 (37.21%) had committed a criminal offense in the past. This rate is contrasted against 118 of 359 (32.9%) of caregivers of children whose death was not verified as child maltreatment. When primary cause of maltreatment deaths is observed, the highest proportion of caregivers for verified maltreatment cases with a criminal past were those affiliated asphyxia deaths (59%), followed by other causes of deaths (42%), weapons deaths (30%), and drowning deaths (28%). 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 38% for caregivers associated with weapons deaths to a high of 63% of verified asphyxia deaths. The modal type of offenses for caregivers for weapons (100%), drowning (88%), asphyxia (63%), and other causes of death (82%) 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.

When the criminal history of supervisors is examined (See Table G-49), among supervisors associated with verified maltreatment deaths, 26 of 64 (40.6%) had committed a criminal offense in the past. This rate is significantly higher when contrasted against 47 of 164 (28.7%) of supervisors of children whose death was not verified as child maltreatment.[6] When primary cause of maltreatment deaths is observed, the highest proportion of supervisors for verified maltreatment cases with a criminal past were those affiliated with asphyxia deaths (60%) followed by weapons

[6] 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 NOT statistically significant (Z-Score=1.30, p=.194).

deaths (38%). 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 40% for supervisors associated with verified weapons deaths to a high of 75% of those supervisors associated with "other" deaths. The modal type of offenses for supervisors for drowning (71%), weapons (100%), and other causes of death (100%) 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: History of Intimate Partner Violence Known Within Case (as Victim and/or Perpetrator) For Caregivers, Supervisors, and Person(s) Responsible for Death by Maltreatment Verification Status and Primary Cause of Death

	Verified Child Maltreatment Death				Non-Verified Child Maltreatment Death			
	Drowning n=31	Asphyxia n=14	Weapon n=14	Other n=16	Drowning n=42	Asphyxia n=66	Weapon n=5	Other n=94
IPV History Exists	23%	64%	36%	56%	12%	33%	0%	21%

Table G-50: Past Criminal History of Caregivers by Maltreatment Verification Status and Primary Cause of Death

	Verified Child Maltreatment Death (n=137)				Non-Verified Child Maltreatment Death (n=359)			
Criminal History of Caregivers	Drowning n=57	Asphyxia n=27	Weapon n=27	Other n=26	Drowning n=73	Asphyxia n=121	Weapon n=6	Other n=159
Yes	28%	59%	30%	42%	16%	45%	17%	31%
No	58%	26%	52%	50%	67%	45%	83%	57%
Unknown	14%	15%	19%	8%	16%	10%	0%	11%
	If Yes, Verified Child Maltreatment Deaths (n=51)				If Yes, Non-Verified Child Maltreatment Death (n=118)			
Type of Offense	Drowning n=16	Asphyxia n=16	Weapon n=8	Other n=11	Drowning n=12	Asphyxia n=55	Weapon n=1	Other n=50
Assaults	25%	38%	25%	45%	17%	31%	0%	28%
Robbery	6%	19%	25%	27%	25%	15%	0%	26%
Drugs	63%	56%	38%	55%	50%	64%	0%	30%
Other	88%	63%	100%	82%	67%	62%	100%	76%
Unknown	0%	0%	0%	0%	0%	0%	0%	0%

Past Child Death Associated with Caregivers, Supervisors, and Person(s) Responsible for Death

Tables G-51 identifies past child deaths linked to one caregiver associated with a verified drowning death and three caregivers (two first and one second) associated with non-verified asphyxia deaths. When the supervisors of children are examined (see Table G-52), past child deaths are linked to one associated with a verified drowning death and one supervisor associated with non-verified asphyxia deaths. Among those responsible for verified maltreatment deaths (Table G-53), two associated with drowning deaths were linked to past child deaths.

Table G-51: Past Criminal History Associated with Supervisors by Maltreatment Verification Status and Primary Cause of Death								
	Verified Child Maltreatment Death (n=64)				Non-Verified Child Maltreatment Death (n=164)			
Criminal History of Supervisors	Drowning n=29	Asphyxia n=10	Weapon n=13	Other n=12	Drowning n=36	Asphyxia n=50	Weapon n=4	Other n=74
Yes	24%	60%	38%	33%	17%	48%	0%	23%
No	66%	40%	54%	58%	69%	46%	100%	66%
Unknown	10%	0%	8%	8%	14%	6%	0%	11%
	If Yes, Supervisor of Verified Maltreatment Death (n=26)				If Yes, Supervisors of Non-Verified Child Maltreatment Death (n=47)			
Type of Offense	Drowning n=7	Asphyxia n=10	Weapon n=5	Other n=4	Drowning n=6	Asphyxia n=24	Weapon n=0	Other n=17
Assaults	43%	0%	20%	25%	33%	29%	0%	35%
Robbery	0%	10%	40%	25%	33%	4%	0%	24%
Drugs	43%	60%	40%	75%	67%	58%	0%	18%
Other	71%	50%	100%	100%	67%	71%	0%	76%
Unknown	0%	0%	0%	0%	0%	0%	0%	0%

Table G-52: Past Criminal History Associated with All Persons Responsible by Maltreatment Verification Status and Primary Cause of Death				
Criminal History All Persons Responsible (n=86)	Verified Child Maltreatment Death			
	Drowning n=33	Asphyxia n=14	Weapon n=21	Other n=18
Yes	30%	71%	38%	44%
No	55%	29%	48%	50%
Unknown	15%	0%	14%	6%
	If Yes, Persons Responsible Verified Child Maltreatment Death (n=36)			
Type of Criminal History	Drowning n=10	Asphyxia n=10	Weapon n=8	Other n=8
Assaults	30%	20%	25%	25%
Robbery	0%	20%	38%	38%
Drugs	60%	80%	25%	63%
Other	80%	70%	100%	75%
Unknown	0%	0%	0%	0%

Table G-53: Past Child Death Associated with Caregivers by Maltreatment Verification Status and Primary Cause of Death								
	Verified Child Maltreatment Death (n=135)				Non-Verified Child Maltreatment Death (n=355)			
Past Child Death with Caregiver	Drowning n=57	Asphyxia n=28	Weapon n=26	Other n=24	Drowning n=70	Asphyxia n=119	Weapon n=6	Other n=160
Yes	2%	0%	0%	0%	0%	3%	0%	3%
No	96%	100%	88%	100%	89%	97%	100%	91%
Unknown	2%	0%	12%	0%	11%	1%	0%	7%

Table G-54: Past Child Death Associated with Supervisors by Maltreatment Verification Status and Primary Cause of Death								
	Verified Child Maltreatment Death (n=64)				Non-Verified Child Maltreatment Death (n=162)			
Past Child Death with	Drowning n=29	Asphyxia n=11	Weapon n=13	Other n=11	Drowning n=34	Asphyxia n=50	Weapon n=4	Other n=74
Yes	3%	0%	0%	0%	0%	2%	0%	5%
No	90%	100%	85%	100%	91%	96%	100%	86%
Unknown	7%	0%	15%	0%	9%	2%	0%	8%

Table G-55: Past Child Death Associated with Persons Responsible for Verified Maltreatment Death by Maltreatment Verification Status and Primary Cause of Death				
	Verified Child Maltreatment Death			
Past Child Death with Persons Responsible (n=85)	Drowning n=33	Asphyxia n=14	Weapon n=21	Other n=17
Yes	6%	0%	0%	0%
No	88%	100%	86%	100%
Unknown	6%	0%	14%	0%