

## FLORIDA CHILD ABUSE DEATH REVIEW

Reviewing Committee: \_\_\_\_\_

Record Number \_\_\_\_\_

HSn Report # \_\_\_\_\_

<b>A. IDENTIFICATION INFORMATION</b>			
1. COUNTY OF RESIDENCE	2. COUNTY OF ILLNESS/INJURY	3. COUNTY OF DEATH	4. TYPE OF DEATH: (A or N)
5. CHILD'S LAST NAME	6. CHILD'S FIRST NAME/MI	7. DATE OF BIRTH (MM/DD/YYYY)	8. DATE OF DEATH (MM/DD/YYYY)
9. SEX a) <input type="checkbox"/> Male b) <input type="checkbox"/> Female	10. RACE a) <input type="checkbox"/> White    c) <input type="checkbox"/> Asian/Pacific Islander b) <input type="checkbox"/> Black    d) <input type="checkbox"/> American Indian/Alaskan Native		e) <input type="checkbox"/> Multi-racial f) <input type="checkbox"/> Unknown
12. MOTHER'S NAME (FIRST/MI/LAST)			13. MOTHER'S DOB (MM/DD/YYYY)
14. FATHER'S NAME (FIRST/MI/LAST)			15. FATHER'S DOB (MM/DD/YYYY)
16. CARETAKER'S NAME		17. RELATIONSHIP	18. CARETAKER'S DOB
19. CARETAKER'S NAME		20. RELATIONSHIP	21. CARETAKER'S DOB
11. ETHNICITY a) <input type="checkbox"/> Hispanic    c) <input type="checkbox"/> Other b) <input type="checkbox"/> Haitian    d) <input type="checkbox"/> Unknown			

**B. SOCIAL INFORMATION (Information provided by law enforcement and Department of Children and Families)**

1. Check all persons living in the residence of the child. Indicate their relationship by filling in the age, sex and race. Also indicate by a "Y" for Yes or "N" for No and "U" for Unknown if criminal record checks were completed on all appropriate household members. Indicate only one head of household by checking the appropriate box.

	AGE	SEX	RACE	FCIC/NCIC (History)
a) <input type="checkbox"/> Biological father	_____	_____	_____	_____
b) <input type="checkbox"/> Biological mother	_____	_____	_____	_____
c) <input type="checkbox"/> Grand father	_____	_____	_____	_____
d) <input type="checkbox"/> Grand mother	_____	_____	_____	_____
e) <input type="checkbox"/> Adoptive father	_____	_____	_____	_____
f) <input type="checkbox"/> Adoptive mother	_____	_____	_____	_____
g) <input type="checkbox"/> Step father	_____	_____	_____	_____
h) <input type="checkbox"/> Step mother	_____	_____	_____	_____
i) <input type="checkbox"/> Foster father	_____	_____	_____	_____
j) <input type="checkbox"/> Foster mother	_____	_____	_____	_____
k) <input type="checkbox"/> Uncle	_____	_____	_____	_____
l) <input type="checkbox"/> Aunt	_____	_____	_____	_____
m) <input type="checkbox"/> Parent's paramour	_____	_____	_____	_____
n) <input type="checkbox"/> Other relative	_____	_____	_____	_____
o) <input type="checkbox"/> Other relative	_____	_____	_____	_____
p) <input type="checkbox"/> Sibling	_____	_____	_____	_____
q) <input type="checkbox"/> Sibling	_____	_____	_____	_____
r) <input type="checkbox"/> Other non-relative	_____	_____	_____	_____
s) <input type="checkbox"/> More than two children	_____	_____	_____	_____

2. Current marital status of head of household?  
a)  Married    b)  Separated    c)  Divorced    d)  Widowed    e)  Never Married    f)  Unknown

3. Any other children in family deceased?    a)  Yes    b)  No    c)  Unknown  
If yes, Give name, age and cause of death  
Name \_\_\_\_\_    Age \_\_\_\_\_    Cause of death \_\_\_\_\_

4. Parent/caretaker has had more than one live-in paramour in the last two years?  
a)  Yes    b)  No    c)  Unknown    d)  N/A (no paramour)

5. Paramour is the primary caretaker of the children in the home?  
a)  Yes    b)  No    c)  Unknown    d)  N/A (no paramour)

6. Parent/caretaker allows the paramour to be primary disciplinarian?  
a)  Yes    b)  No    c)  Unknown    d)  N/A (no paramour)

7. Household income is provided by:  
a)  Parent(s)/caretaker    c)  Unknown    e)  Other (Specify) \_\_\_\_\_  
b)  Paramour    d)  Other household member    f)  Unknown

**C. CHILD ABUSE/NEGLECT (Information provided by Department of Children and Families)**

1. Were there abuse/neglect reports on any of the following prior to child's death?  
(Please indicate for all household members)

	YES	# OF REPORTS		NO	Not Applicable
		In State	Out of State		
a) Child	<input type="checkbox"/>	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
b) Sibling(s)	<input type="checkbox"/>	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
c) Parent	<input type="checkbox"/>	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
d) Caretaker	<input type="checkbox"/>	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
e) Paramour	<input type="checkbox"/>	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
f) Step parent	<input type="checkbox"/>	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>

2. Prior report on child at time of death? a) \_\_\_\_\_ (years) \_\_\_\_\_ (months) c)  N/A (no priors)

3. Prior reported maltreatment(s): (Check only one)

a)  Priors of abuse b)  Priors of neglect c)  Priors of abuse and neglect d)  N/A (no priors)

4. Was there an active child protection investigation report at time of death? a)  Yes b)  No c)  N/A (no priors)

5. Was child previously adjudicated dependent? a)  Yes b)  No c)  Unknown

6. Was child under supervision of the department at the time of or prior to death?

a)  Under supervision at time of death b)  Previously under supervision c)  Never under supervision d)  Unknown

7. Child previously/currently received mental health services. | a)  Yes | b)  No | c)  Unknown

8. Were child's siblings previously adjudicated dependent?

a)  Yes b)  No c)  Unknown d)  N/A (no siblings)

9. Were siblings under supervision of the department at the time of or prior to child's death?

a)  Under supervision at time of death c)  Never under supervision e)  N/A (no siblings)  
b)  Previously under supervision d)  Unknown

10. Deceased child was diagnosed as having one or more of the following which increased his or her vulnerability.

a)  Physical disability c)  Emotional disability e)  Other \_\_\_\_\_  
b)  Developmental disability or delay d)  Medical condition f)  Not applicable (No handicaps)

11. Child, prior to death, exhibited one or more of the following behaviors that may have been indicative of abuse or neglect:

a)  Enuretic and/or encopretic i)  Sexual abuse perpetrator  
b)  Physical harm to self j)  Expression of fear of caregiver(s) and/or others living in or frequenting the home  
c)  Use of drugs or alcohol k)  Excessive school absenteeism  
d)  Physical aggression and/or threats l)  Cruelty to animals  
e)  Fire setting m)  Other \_\_\_\_\_  
f)  Age-inappropriate sexual behavior and/or knowledge n)  No behaviors exhibited  
g)  Running away from home o)  Not applicable (child too young - <1)  
h)  Suicidal thoughts or threats p)  Unknown

12. One or more of the following risk factors prior to and at time of child's death:

	Yes	No	Unknown
a) One or more children in the home are age 4 or younger or nonverbal?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) Children have limited community visibility?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c) Other child(ren) in home exhibit behaviors that may be indicative of abuse or neglect?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d) Living conditions are physically hazardous to the health of the children?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e) Parent/caregiver is responsible for the death or serious injury of another child?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f) Parent/caregiver's criminal history presents a potential threat of harm to the child(ren)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g) Parent/caregiver or other subjects of report have been responsible for acts of animal cruelty?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h) Parent/caregiver describes or acts toward child(ren) in negative terms or has unrealistic expectations?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i) Parent/caregiver has made plausible threat that would result in serious physical harm to the child(ren)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
j) There is a pattern of escalating and/or continuing incidents of domestic violence?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
k) Parent/caregiver is unable or unwilling to protect the child(ren) from abusive caregivers/paramours?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
l) Parent/caregiver has not met or is unable to meet child(ren)s immediate needs for food/clothing/shelter/medical care or protection from harm?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
m) Parent/caregiver's age, mental health or substance/alcohol use affects ability to adequately care for child(ren)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
n) Pattern of escalating, and/or frequency of incidents of abuse or neglect, regardless of findings?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
o) Prior reports involving any of the household members, regardless of report findings?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

13. Other children in the home have been diagnosed as having one or more of the following which increases his or her vulnerability.

a)  Physical handicap c)  Emotional handicap e)  Other \_\_\_\_\_  
b)  Developmental handicap d)  Medical condition f)  Not applicable (no handicap/no siblings)  
g)  Unknown

**D. LAW ENFORCEMENT (Information provided by law enforcement and state attorney)**

1. Law enforcement has had prior involvement with the family? a)  Yes b)  No c)  Unknown
2. If yes, law enforcement involvement consisted of the following: (Check all that apply)
- a)  Call to the home regarding domestic violence c)  Calls to the home regarding neighbor disputes
- b)  Arrest of one or more household members d)  Other (specify) \_\_\_\_\_

**E. DOMESTIC VIOLENCE (Information provided by law enforcement, Department of Children and Families and other agencies familiar with the family)**

1. There is a history of domestic violence in the home of the parent/caretaker? a)  Yes b)  No c)  Unknown
- If Yes, complete the following questions.
2. If yes, was there an increase in frequency prior to child's death? a)  Yes b)  No c)  Unknown
3. The incidents of domestic violence were: a)  documented b)  Undocumented c)  Other \_\_\_\_\_
4. If domestic violence history was documented was a safety plan developed as part of the agency/department's involvement with the family? a)  Yes b)  No c)  Unknown
5. Was the non-abusive parent involved in the development of the family safety plan? a)  Yes b)  No c)  Unknown
6. The children: ( Check all that apply)
- a)  Have witnessed the domestic violence (hearing/seeing) c)  Have been intentionally injured during domestic violence incidents
- b)  Have been injured during attempts to intervene.

**F. DEATH/AUTOPSY INFORMATION (Information provided by law enforcement and Medical Examiner)**

1. Place of injury/illness event that resulted in death?
- a)  Child's home e)  Parking lot i)  Other private property m)  Body of water
- b)  Other home f)  Street j)  Licensed child care facility n)  Work place
- c)  Hospital g)  Driveway k)  Unlicensed child care facility o)  Other \_\_\_\_\_
- d)  Highway h)  Wooded area l)  Child care residential facility
2. Date of injury/illness event? \_\_\_\_\_ (MM/DD/YYYY)  Unknown
3. Time of injury/illness event? \_\_\_\_\_ (hours/minutes)  AM  PM  Unknown
4. Date pronounced dead? \_\_\_\_\_ (MM/DD/YYYY)
5. Time pronounced dead? \_\_\_\_\_ (hours/minutes)  AM  PM  Unknown
6. Autopsy performed? a)  Yes b)  No c)  Unknown
7. Death scene investigation conducted by:
- a)  Law enforcement c)  Fire investigator e)  Other agency
- b)  Medical examiner d)  EMS f)  Not conducted
8. If an autopsy was performed, was there evidence of prior trauma?
- a)  Yes b)  No c)  Unknown d)  No autopsy
9. Primary cause of death? \_\_\_\_\_ ICD10 codes, if known \_\_\_\_\_
10. Secondary cause of death? \_\_\_\_\_ ICD10 codes, if known \_\_\_\_\_
11. Manner of death?
- a)  Natural \* b)  Accident c)  Homicide d)  Suicide e)  Undetermined f)  Pending
12. Was this a murder/suicide? | a)  Yes | b)  No |
13. If suicide, mark all that apply:
- a)  Prior Attempts c)  Prior mental health history e)  Suicide Unexpected (No indicators)
- b)  Suicide Ideation d)  Suicide unexpected

**G. SUPERVISION (Information provided by law enforcement and Department of Children and Families)**

1. Who was in charge of watching the child at the time of injury/illness event?

- |   |   |   |
|---|---|---|
| a) <input type="checkbox"/> Biological father | i) <input type="checkbox"/> Foster father         | p) <input type="checkbox"/> Licensed babysitter/child care worker   |
| b) <input type="checkbox"/> Biological mother | j) <input type="checkbox"/> Foster mother         | q) <input type="checkbox"/> Unlicensed babysitter/child care worker |
| c) <input type="checkbox"/> Grand father      | k) <input type="checkbox"/> Uncle                 | r) <input type="checkbox"/> Other non-relative: _____               |
| d) <input type="checkbox"/> Grand mother      | l) <input type="checkbox"/> Aunt                  | s) <input type="checkbox"/> Child, age: _____                       |
| e) <input type="checkbox"/> Adoptive father   | m) <input type="checkbox"/> Male paramour         | t) <input type="checkbox"/> Hospital staff                          |
| f) <input type="checkbox"/> Adoptive mother   | n) <input type="checkbox"/> Female paramour       | u) <input type="checkbox"/> No one in charge of watching            |
| g) <input type="checkbox"/> Step father       | o) <input type="checkbox"/> Other relative: _____ | v) <input type="checkbox"/> Due to child's age, no one in charge    |
| h) <input type="checkbox"/> Step mother       |   |   |

2. Was the child adequately supervised? a)  Yes b)  No c)  Unknown d)  Not applicable

If No:

- a) At the time of the injury/illness, did the person(s) in charge appear to be:
- |  |  |   |  |
|--|--|---|--|
| 1) <input type="checkbox"/> Intoxicated                  | 3) <input type="checkbox"/> Mentally ill/limited | 5) <input type="checkbox"/> Other _____ | 7) <input type="checkbox"/> Not impaired |
| 2) <input type="checkbox"/> Under the influence of drugs | 4) <input type="checkbox"/> Otherwise impaired   | 6) <input type="checkbox"/> Unknown     |  |
- b) Was the child in sight of the person in charge at the time of illness/injury event?
- |                                 |                                |                                     |
|---------------------------------|--------------------------------|-------------------------------------|
| 1) <input type="checkbox"/> Yes | 2) <input type="checkbox"/> No | 3) <input type="checkbox"/> Unknown |
|---------------------------------|--------------------------------|-------------------------------------|
- c) At the time of illness/injury was the person(s):
- |  |                                    |                                     |                                 |
|--|------------------------------------|-------------------------------------|---------------------------------|
| 1) <input type="checkbox"/> Distracted/preoccupied | 2) <input type="checkbox"/> Asleep | 3) <input type="checkbox"/> Unknown | 4) <input type="checkbox"/> N/A |
|--|------------------------------------|-------------------------------------|---------------------------------|
- d) Is the person(s) responsible for supervising other children? a)  Yes b)  No c)  Unknown

3. Was the injury/illness witnessed by anyone other than the person(s) responsible for supervision of the child?

- a)  Yes b)  No c)  Unknown

**H. PERPETRATOR INFORMATION (Complete questions 2-4 only if information from either law enforcement, state attorney or the Department of Children and Families identifies the perpetrator(s).)**

1. Has the perpetrator(s) been identified? a)  Yes b)  No c)  Unknown

2. Indicate relationship, race, sex and age of perpetrator(s) identified. (Use codes from Section A for race. Use codes "F" for female and "M" for male when identifying the sex of the perpetrator.)

	RACE	SEX	AGE
a) <input type="checkbox"/> Biological father	_____	_____	_____
b) <input type="checkbox"/> Biological mother	_____	_____	_____
c) <input type="checkbox"/> Grand father	_____	_____	_____
d) <input type="checkbox"/> Grandmother	_____	_____	_____
e) <input type="checkbox"/> Adoptive father	_____	_____	_____
f) <input type="checkbox"/> Adoptive mother	_____	_____	_____
g) <input type="checkbox"/> Step father	_____	_____	_____
h) <input type="checkbox"/> Step mother	_____	_____	_____
i) <input type="checkbox"/> foster father	_____	_____	_____
j) <input type="checkbox"/> Foster mother	_____	_____	_____
k) <input type="checkbox"/> Uncle	_____	_____	_____
l) <input type="checkbox"/> Aunt	_____	_____	_____
m) <input type="checkbox"/> Male paramour	_____	_____	_____
n) <input type="checkbox"/> Female paramour	_____	_____	_____
o) <input type="checkbox"/> Other relative	_____	_____	_____
p) <input type="checkbox"/> Sibling	_____	_____	_____
q) <input type="checkbox"/> Other non-relative	_____	_____	_____
r) <input type="checkbox"/> Babysitter/child care worker	_____	_____	_____
s) <input type="checkbox"/> Acquaintance/Friend	_____	_____	_____
t) <input type="checkbox"/> Stranger	_____	_____	_____
u) <input type="checkbox"/> Other child	_____	_____	_____

3. Please complete the following information for each identified perpetrator. Enter a Y (Yes) N (No) or U (Unknown)

	PRIMARY PERPETRATOR (1)- RESPONSIBLE FOR DEATH	PERPETRATOR (2) – JOINTLY OR INDIRECTLY RESPONSIBLE FOR DEATH
a) Mental health history	_____	_____
b) Perpetrator of domestic violence	_____	_____
c) Victim of domestic violence	_____	_____
d) Victim of child abuse/neglect	_____	_____
e) Prior perpetrator of child abuse/neglect	_____	_____
f) History of alcohol abuse	_____	_____
g) History of substance abuse	_____	_____
h) Criminal Record	_____	_____
i) Physically/Emotionally handicapped	_____	_____
j) Prior perpetrator of Shaken Baby	_____	_____

## H. PERPETRATOR INFORMATION (Continued)

### 4.. Status of criminal action concerning child's death:

- a)  investigation still pending    c)  Not prosecuted or nol prossed    e)  Convicted    g)  Unknown  
b)  No charges filed    d)  Charges filed, disposition pending    f)  Acquitted    h)  Incompetent to proceed  
i)  No, perp committed suicide

### 5. Perpetrator's criminal charge

- a)  Murder    c)  Child abuse    e)  Other (specify) \_\_\_\_\_  
b)  Manslaughter    d)  Negligence    f)  Unknown

### 6. Perpetrator's criminal conviction:

- a)  Murder    c)  Child abuse    e)  Other (specify) \_\_\_\_\_  
b)  Manslaughter    d)  Negligence

## I. INFANT DEATHS (Complete for deaths of <1 year of age) (Information provided by medical providers)

1. Child regularly exposed to tobacco smoke?    |  Yes    |  No    |  Unknown
2. Drug use during pregnancy?    |  Yes    |  No    |  Unknown
3. Alcohol use during pregnancy?    |  Yes    |  No    |  Unknown
4. Age at death  
a)  0-48 hours after birth    b)  3 – 28 days    c)  29 days - 6 months    d)  7 months – 1 year
5. Gestation age at birth?  
a)  < 25 weeks    b)  26-30 weeks    c)  31-37 weeks    d)  > 37 weeks    e)  Unknown
6. Birth weight in grams (approx. lbs./oz)  
a)  <750 (<1 lb. 10 oz)    c)  1500 – 2499 (3 lbs. 6 oz – 5 lbs. 5 oz)    e)  Unknown  
b)  750 – 1499 (1 lb. 10 oz - 3 lbs. 5 oz)    d)  >2500 (>5 lbs. 6 oz)
7. Multiple births? (Number of times mother has given birth)    a)  Yes    b)  No
8. Total number of prenatal visits  
a)  None    b)  1-3    c)  4-6    d)  7-10    e)  Unknown
9. First prenatal visit occurred during?  
a)  First trimester    b)  Second trimester    c)  Third trimester    d)  Unknown
10. Medical complications during pregnancy?    a)  Yes    b)  No    c)  Unknown
11. Type of complications:  
a)  Diabetes    d)  Trauma  
b)  Hypertension    e)  Infection  
c)  Anemia    f)  Other \_\_\_\_\_

**J. CIRCUMSTANCES OF DEATH (Information provided by law enforcement and Medical Examiner's Office)**

Check the appropriate circumstance below, then locate and complete the corresponding subsection.

- Inadequate Care/Neglect
- Child Left In Car
- Vehicle Crash Related Death
- Drowning
- Firearm
- Suffocation/Strangulation

- Fall/Injury
- Poisoning/Overdose
- Fire/Burn
- Inflicted Injury

**INADEQUATE CARE OR NEGLECT (Mark all that apply)**

- 1)  Apparent lack of supervision
- 2)  Apparent lack of medical care
- 3)  Munchausen's Syndrome by Proxy
- 4)  Failure to thrive (non-organic)
- 5)  Malnutrition
- 6)  Dehydration
- 7)  Oral water intoxication
- 8)  Delayed medical care
- 9)  Inadequate medical attention
- 10)  Out-of-hospital birth
- 11)  Failure to Protect
- 12)  Other

**CHILD LEFT IN VEHICLE**

Please check all that apply

- 1) Incident was a)  Intentional b)  Unintentional
- 2) Child got in vehicle on own
- 3) Child left in vehicle
- 4) Vehicle was:  
a) Locked  b) Unlocked
- 5) Length of time child left in vehicle before being discovered? \_\_\_\_\_ (hours) \_\_\_\_\_ (minutes)
- 6) Was parent/caretaker typically responsible for transporting child? a)  Yes b)  No

**VEHICLE CRASH RELATED DEATH**

- 1. Vehicle Crash was: a)  Intentional b)  Unintentional
- 2. Incident occurred where? a)  On road b)  In driveway c)  In parking lot
- 3. Position of child?  
a)  Operator c)  Front seat passenger e)  Bicyclist g)  Unknown  
b)  Pedestrian d)  Back seat passenger f)  Other
- 4. Vehicle in which child was occupant?  
a)  Car d)  Bicycle g)  Semi-Tractor trailer j)  Not applicable  
b)  Truck/RV/Van e)  Riding Mower h)  Farm tractor  
c)  Motorcycle f)  All terrain vehicle i)  Other
- 5. Vehicle in which child was not occupant  
a)  Car d)  Bicycle g)  Semi-Tractor trailer j)  Not Applicable  
b)  Truck/RV/Van e)  Riding mower h)  Farm tractor  
c)  Motorcycle f)  All terrain vehicle i)  Other
- 6. Condition of road?  
a)  Normal b)  Loose gravel c)  Wet d)  Other \_\_\_\_\_ e)  Unknown
- 7. Restraint used?  
a)  Present, not used c)  Used correctly e)  Unknown  
b)  None in vehicle d)  Used incorrectly f)  Not applicable
- 8. Helmet used?  
a)  Helmet worn b)  Helmet not worn c)  Not applicable
- 9. Alcohol and/or other drug used?  
a)  Child impaired c)  Driver of other vehicle impaired e)  Unknown  
b)  Driver of child's vehicle impaired d)  Not applicable
- 10. Primary cause of accident?  
a)  Speeding c)  Weather conditions e)  Unknown f)  Impaired driver  
b)  Mechanical failure d)  Driver error g)  Other \_\_\_\_\_ h)  Road rage

## DROWNING

1. Drowning was: a)  Intentional | b)  Unintentional
2. Place of drowning?  
a)  Lake, river, pond, creek, ocean c)  Swimming pool e)  Bucket g)  Other  
b)  Bathtub d)  Well/Cistern f)  Wading pool h)  Unknown
3. Activity at time of drowning?  
a)  Boating c)  Swimming e)  Other \_\_\_\_\_  
b)  Playing at water's edge d)  Playing in water f)  Unknown
4. Was child wearing a floatation device? a)  Yes b)  No c)  Not applicable
5. Did child enter area of water unattended? a)  Yes b)  No c)  Unknown d)  Not applicable
6. Did parent/caregiver know CPR? a)  Yes b)  No c)  Unknown d)  Not applicable
7. Was safety equipment available in area? a)  Yes b)  No c)  Unknown
8. If drowning occurred in pool:
- |                         | Yes                      | No                       | Unknown                  | Not Applicable           |
|-------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| a. Was the pool fenced? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Was lock secure?     | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Was yard fenced?     | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Was lock secure?     | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
9. Could child swim? a)  Yes b)  No c)  Unknown d)  Not applicable
10. Was child under the influence of alcohol or drugs? a)  Yes b)  No c)  Unknown

## FIREARM

1. Shooting was: a)  Intentional b)  Unintentional
2. Person handling the firearm?  
a)  Child b)  Family member c)  Acquaintance d)  Stranger e)  Unknown
3. Type of firearm?  
a)  Handgun b)  Rifle c)  Shotgun d)  Other e)  Unknown
4. Age of person handling firearm? a)  \_\_\_\_\_ (Indicate age) b)  Unknown
5. Source of firearm  
a)  Parent b)  Other relative c)  Acquaintance d)  Stranger e)  Unknown
6. Storage location of firearm prior to injury?  
a)  Secured b)  Unsecured c)  Unknown
7. Use of firearm at time of injury?  
a)  Shooting at other person d)  Target shooting g)  Playing  
b)  Shooting at self e)  Loading firearm h)  Other  
c)  Cleaning firearm f)  Hunting i)  Unknown

## SUFFOCATION/STRANGULATION/ASPHYXIATION

1. Incident was: a)  Intentional b)  Unintentional
2. Cause of suffocation/strangulation/asphyxiation?  
a)  Other person overlay or rolling over child g)  Small object or toy in mouth  
b)  Wedging h)  Hanging  
c)  Food i)  Trapped in confined space  
d)  Other person's hand j)  Other  
e)  Object covering child's mouth/nose k)  Unknown  
f)  Object exerting pressure on victim's neck/chest
3. Location of child when discovered?  
a)  In crib/bed c)  Being held e)  On floor  (DEACTIVATE)  
b)  On couch/chair d)  In infant car seat f)  Other (Specify) \_\_\_\_\_ h)  Playpen
4. Child sleeping: a)  Alone b)  With adult/caregiver c)  with another child d)  Unknown
5. If bedding was involved:
- |  | Yes                      | No                       | Unknown                  |
|--|--------------------------|--------------------------|--------------------------|
| a) Was the design of the bed hazardous?  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| b) Was the child placed on soft bedding? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| c) Was there improper use of bedding?    | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

6. Position of child at discovery

- a)  On stomach, face down
- b)  On stomach, face to side
- c)  On stomach, face position unknown
- d)  On back
- e)  On side
- f)  Unknown

7. If known, normal sleeping position

- a)  On back
- b)  On Stomach
- c)  On Side
- d)  Varies
- e)  Unknown

8. Item in contact with child:

- a)  Sheet
- b)  Blanket/Comforter
- c)  Bumper guard
- d)  Plastic item
- e)  Other \_\_\_\_\_ (Indicate)

FALL INJURY

1. Fall was: a)  Intentional b)  Unintentional
2. Fall was from?  
 a)  Open window      c)  Natural elevation      e)  Man made elevation      g)  Unknown  
 b)  Furniture      d)  Stairs or steps      f)  Other (Specify) \_\_\_\_\_
3. Height of fall?      a)  # of feet \_\_\_\_\_      b)  Unknown
4. Landing surface composition/hardness?      a)  Carpet      b)  Concrete      c)  Ground      d)  Other
5. Was child in baby walker?      a)  Yes      b)  No      c)  Not applicable
6. Was child thrown or pushed down?      a)  Yes      b)  No      c)  Unknown

POISONING/OVERDOSE

1. Poisoning/Overdose was:      a)  Intentional      b)  Unintentional
1. Type of poisoning?  
 a)  Prescription medicine      d)  Illegal drug      g)  Food product  
 b)  Over-the-counter medicine      e)  Alcohol      h)  Other  
 c)  Chemical      f)  Carbon monoxide or other gas inhalation
2. Location of poisoning agent?  
 a)  In closed, secured area      b)  In closed, unsecured area      c)  In open area
3. Was substance in safety packaging?  
 a)  Yes      b)  No      c)  Unknown      d)  Not applicable
4. Poison contained in:  
 a)  Pill bottle      b)  Commercial package      c)  Formula bottle      D)  Other (Specify)

FIRE/BURN

1. Fire was:      a)  Intentional      b)  Unintentional
2. If fire, the source?  
 a)  Matches      c)  Cigarette      e)  Explosives      g)  Space heater      i)  Other  
 b)  Lighter      d)  Combustible      f)  Fireworks      h)  Faulty wiring      j)  Unknown
3. Smoke alarm present?      a)  Yes      b)  No      c)  Unknown      d)  Not applicable
4. Smoke alarm in working order?      a)  Yes      b)  No      c)  Unknown      d)  Not applicable
5. Fire started by?  
 a)  Deceased Child      c)  Other (Specify) \_\_\_\_\_      e)  Unknown  
 b)  Sibling      d)  No one
6. Activity of person starting fire?  
 a)  Playing      c)  Cooking      e)  Other \_\_\_\_\_      g)  Not applicable  
 b)  Smoking      d)  Suspected arson      f)  Unknown
7. Construction of fire site?  
 a)  Wood frame      c)  Metal      e)  Other  
 b)  Brick/stone      d)  Trailer      f)  Not applicable
8. Multiple fire injuries or deaths?      a)  Yes      b)  No
9. For structure fire, where was child found?  
 a)  Hiding      b)  In bed      c)  Stairway      d)  Close to exit      e)  Other

10. Did child know of a fire escape plan? a)  Yes b)  No c)  Unknown d)  Not applicable
11. If burned, the source?  
 a)  Hot water c)  Appliance e)  Cigarettes g)  Unknown  
 b)  Heater d)  Chemical f)  Other

### INFLECTED INJURY

1. Inflicted Injury was: a)  Intentional b)  Unintentional
2. Type of Injury  
 a)  Beating Deactivate d)  Multiple trauma g)  Excess heat Impact k)  Shaken baby  
 b)  Head Trauma e)  Stabbing h)  Hypothermia  
 c)  Trauma to torso/abdomen f)  Scalding/hot object i)  Object fell on child  
 j)  Other \_\_\_\_\_
3. Prior history of Shaken Baby (Victim) a)  Yes b)  No c)  Unknown
4. Suspected Triggers  
 a)  Crying d)  Feeding difficulty g)  Unknown  
 b)  Toilet Training e)  Medical triggers (illness, shots, disability)  
 c)  Disobedience f)  Other Specify \_\_\_\_\_
5. Manner of injury?  
 a)  Cut/stabbed c)  Thrown e)  Other \_\_\_\_\_  
 b)  Struck d)  Crushed f)  Unknown
6. Injury inflicted with?  
 a)  Sharp object (e.g. knife, scissors) c)  Hands/feet e)  Unknown  
 b)  Blunt object e.g. hammer, bat d)  Other

### K. STATE OR LOCAL TEAM CONCLUSIONS

1. Date of meeting: \_\_\_\_\_ (MM/DD/YYYY)
2. Members participating:  
 a)  Medical examiner d)  Public health/physician g)  DJJ staff  
 b)  State attorney e)  DCF staff h)  Community providers  
 c)  Law enforcement f)  DOH staff i)  Other members
3. Agency/Community Services Review: Prior community services a)  Yes b)  No (go to question 4)
- | Agency/Department Name              | Services Provided        | Services Refused         | Service Provision Appears Adequate Yes | No                       | Unknown                  |
|-------------------------------------|--------------------------|--------------------------|--|--------------------------|--------------------------|
| Department of Health                | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>               | <input type="checkbox"/> | <input type="checkbox"/> |
| Department of Children and Families | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>               | <input type="checkbox"/> | <input type="checkbox"/> |
| Child Protection Team               | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>               | <input type="checkbox"/> | <input type="checkbox"/> |
| Department of Juvenile Justice      | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>               | <input type="checkbox"/> | <input type="checkbox"/> |
| Mental Health Agency                | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>               | <input type="checkbox"/> | <input type="checkbox"/> |
| Community Based Care                | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>               | <input type="checkbox"/> | <input type="checkbox"/> |
| _____                               | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>               | <input type="checkbox"/> | <input type="checkbox"/> |
| _____                               | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>               | <input type="checkbox"/> | <input type="checkbox"/> |
| _____                               | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>               | <input type="checkbox"/> | <input type="checkbox"/> |
4. Did team review lead to a recommendation of additional investigation activities? If Yes, which department?  
 a)  Yes, DCF b)  Yes, law enforcement c)  Yes, both d)  No
5. After review and consideration the team determined the manner of death for child was:  
 a)  Natural b)  Accidental c)  Homicide d)  Suicide e)  Undetermined
6. Does the team agree with the conclusion that this is an abuse/neglect death?  
 a)  Yes b)  No c)  Unknown d)  N/A (Not Abuse/Neglect Death)
7. Does the team agree with the information on the death certificate? a)  Yes b)  No (specify in Comment Section)
8. As a result of the team review issues were identified in the following area: (check all that apply and provide brief comment)
- a)  Protective investigation \_\_\_\_\_
  - b)  Criminal investigation \_\_\_\_\_
  - c)  Provision of services \_\_\_\_\_
  - d)  Availability of resources in the community \_\_\_\_\_
  - e)  Department/agency policies and practice \_\_\_\_\_

- f)  Local ordinance \_\_\_\_\_
- g)  State statute \_\_\_\_\_
- h)  None \_\_\_\_\_
- i)  Community Based Care \_\_\_\_\_

9. All appropriate information was made available to the team? a)  Yes b)  No (Specify)

10. Did the team encounter any problems while reviewing this child's death?  
 a)  Yes (Specify) \_\_\_\_\_ b)  No

**L. PREVENTION**

A preventable death is one in which with retrospective analysis it is determined that reasonable intervention could have prevented the death. The identification of risk factors/issues that will help in preventing similar child deaths can be accomplished through the systematic, multi-disciplinary, multi-agency and multi-modality review of child abuse and neglect deaths in Florida.

1. To what degree was this death believed to be preventable?  
 a)  Not at all                      b)  Possibly                      c)  Definitely
2. Possibly Preventable By:                      a) Caretaker:  System  Both                      b)  N/A (Not Applicable)
3. Definitely Preventable By:                      | a) Caretaker:  System  Both                      b)  N/A (Not Applicable)
4. Primary risk factors involved in the child's death? (Mark all that apply)  
 a)  Medical                      c)  Economic                      e)  Environmental                      g)  Drugs or alcohol  
 b)  Social                      d)  Behavioral                      f)  Product safety                      h)  Other
5. Could the caregiver have taken action to reduce the risk?  
 a)  Yes                      b)  No                      c)  Unknown
6. What prevention activities have been proposed as a result of this death? (A specific recommendation must be made for each area checked)  
 a)  Changes in legislation or law                      g)  Consumer product safety action  
 b)  Changes in local ordinance                      h)  News services  
 c)  Community safety project                      i)  Changes in agency/department practice  
 d)  Public forums                      j)  Other programs or activities (specify) \_\_\_\_\_  
 e)  Educational activities in school                      k)  None  
 f)  Educational activities in the media

**SPECIFIC RECOMMENDATIONS TO ADDRESS ITEMS IDENTIFIED IN #4:**

- 
- 
- 

**ADDITIONAL COMMENTS: (If additional space is needed use additional sheets of paper)**



**CHILD ABUSE DEATH REVIEW CHECKLIST**  
(Attach to the front of the data form)

<b>Name:</b>	
<b>Date of Birth:</b>	<b>Date of Death:</b>
<b>Date reviewed by State or local team:</b>	

Please check the following to ensure all materials have been obtained and attached to the child death data form for this child abuse death review:

1.  All applicable sections of form completed
2.  Death certificate
3.  Birth certificate
4.  Medical examiner autopsy report
5.  Law enforcement report/copies of all criminal histories
6.  Fire department reports/EMS reports
7.  Medical/hospital records
8.  Agency/Department Involvement Summary sheet
9.  DCF District Child Death Review Report
10.  HSn Reports– current & priors
11.  DCF - Initial Assessment of Child Safety
12.  Child Protection Team
13.  Community Based Care
14.  Child Welfare Legal Documents
15.  Mental Health/Substance Abuse/Domestic Violence Information
16.  Other (specify) \_\_\_\_\_

Child Abuse Death Report completed by:

_____	_____
Print Name	Signature
Address _____	
Phone _____	

(Please ensure that you sign your name and provide a phone number, so that should a question arise, you can be contacted.)