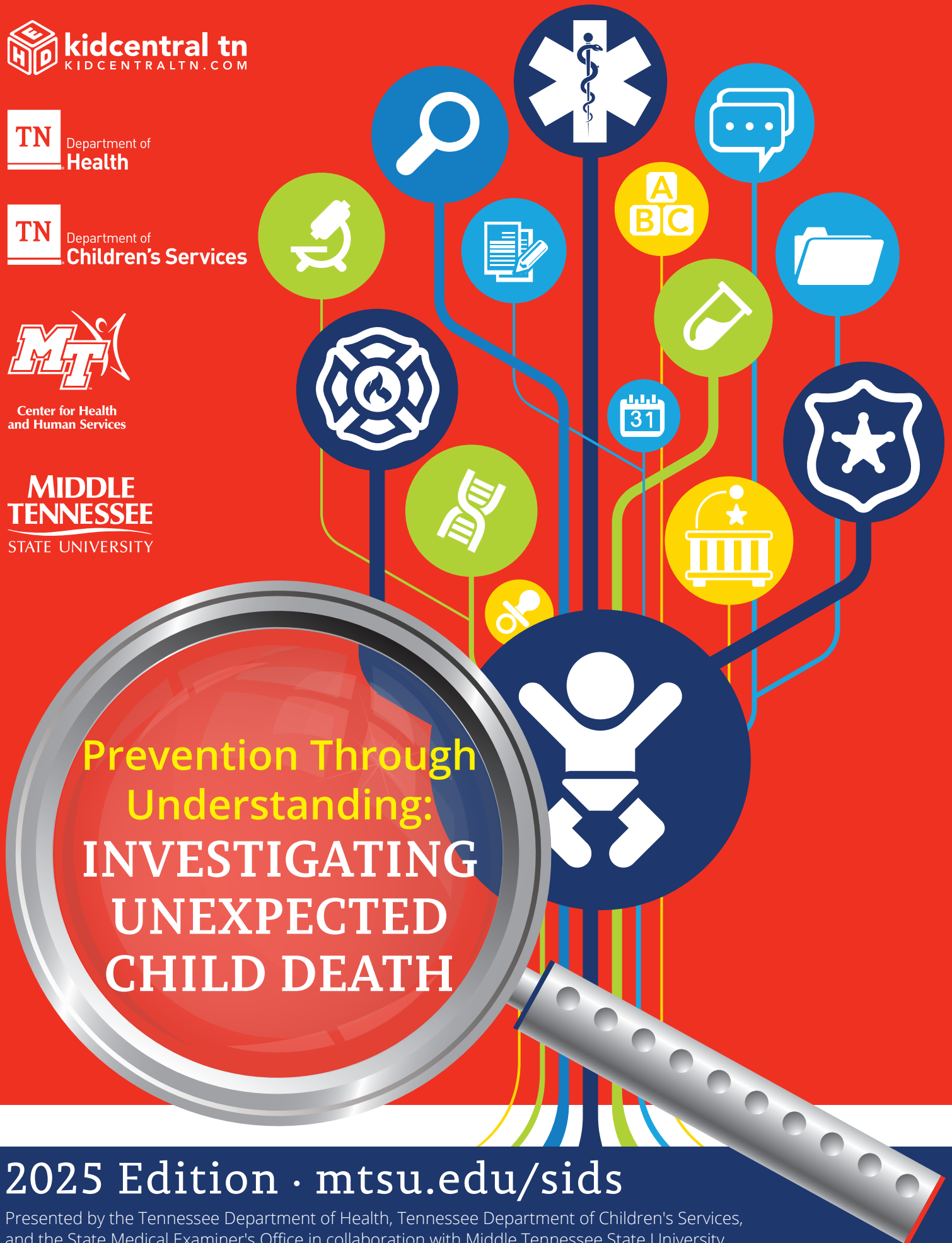




Prevention Through  
Understanding:  
**INVESTIGATING  
UNEXPECTED  
CHILD DEATH**

2025 Edition · [mtsu.edu/sids](https://mtsu.edu/sids)

Presented by the Tennessee Department of Health, Tennessee Department of Children's Services,  
and the State Medical Examiner's Office in collaboration with Middle Tennessee State University

# Prevention Through Understanding: **Investigating Unexpected Child Death**



In collaboration with

**Tennessee Medical Examiner's Office, Tennessee Department of Health  
Middle Tennessee State University, Center for Health and Human Services**

In partnership with

**Middle Tennessee State University, University College  
Tennessee Department of Children's Services**

2025 Edition





# Preface and Acknowledgments

The Sudden Unexplained Child Death Act, signed into law in May 2001 and amended in April 2002, states that all emergency medical technicians, firefighters, and law enforcement officers must receive training on the handling of cases of sudden, unexplained infant death as part of their basic and continuing training requirements (Tenn. Code Ann. § 68-1-1102, 2001 and supp. 2002). In June 2005, Tenn. Code Ann. § 68-1-1103 was signed into law, requiring an investigation into the sudden, unexplained death of **any child from birth through age 17**. The laws mandate that the Tennessee Departments of Health and Children's Services, in cooperation with the state's Medical Examiner's Office, develop the training program, rules, and minimum standards needed to comply with the law. Prevention Through Understanding: Investigating Unexpected Child Death is the result.

In addition to responding to the law, these materials may also be used to learn about Sudden Unexpected Infant Death (SUID) and Sudden Infant Death Syndrome (SIDS). Though there is a nuanced difference between these terms, as SUID includes all unexpected infant deaths including those that result from unsafe sleep environments, other deaths from unknown causes, and those resulting from SIDS, it should be noted that many use these terms somewhat interchangeably. SUID is the more correct term to use when describing sudden infant deaths that appear to be unexpected prior to investigation.

The welfare of Tennessee's children is important to all of us, and the death of even one child is a tragedy. By developing a more uniform approach to death investigation, we can more accurately determine the cause, manner, and circumstances of sudden, unexpected infant and child deaths. Prevention Through Understanding will provide emergency medical technicians, firefighters, and law enforcement personnel the information they need to respond appropriately and respectfully to one of the most professionally and personally challenging situations faced in death scene investigation.

On behalf of the Medical Examiner's Office and the Departments of Health and Children's Services, we wish to acknowledge those who gave their time, energy, and expertise to make this program possible. We thank the Center for Health and Human Services at Middle Tennessee State University for developing the training video and manuals and, through their partnership with MTSU's University College, for facilitating, implementing, and evaluating live and online training opportunities. We also thank the members of the Advisory Group for their invaluable assistance and all those associated with the making of the program's video presentation.

We hope these materials will be of interest and use to you as you perform the unique and difficult duties of your profession. We welcome your feedback and comments.

Please visit the Center for Health and Human Services website at [chhs.mtsu.edu](http://chhs.mtsu.edu) for links to training, trainer, and trainee resources, as well as to inquire about professional services offered to meet public health needs. For more information about the educational video and manual, contact the University College, Middle Tennessee State University, Attn: Prevention Through Understanding: Investigating Unexpected Child Death, MTSU Box 54, 1301 East Main Street, Murfreesboro, Tennessee 37132, 615-898-2177.

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# Tennessee Medical Examiner

The Office of the State Chief Medical Examiner (OSCME) was incorporated into the Tennessee Department of Health July 1, 2012, as a full-time position for the first time in the history of the state. Operating under the Department of Health, the goal is to create statewide consistency of high quality medicolegal death investigation and forensic autopsy services. The purpose is to serve our fellow citizens by protecting the public's health and safety, participating in the criminal justice system, and providing data for vital statistics.

Services provided by the Office of the State Chief Medical Examiner:

- Educating and training county medical examiners, county medical investigators, and law enforcement in death investigation.
- Consulting service to county medical examiners and other local and state departments in forensic pathology and medicolegal death investigation.
- Archiving county medical examiner and autopsy reports from throughout Tennessee.
- Supplying copies of autopsy reports and/or reports of investigation by county medical examiners to the public.
- Autopsy Report Request Form (PDF)
- Ensuring payments are made to pathologists for autopsies performed through the medical examiner program.
- "The Chief Medical Examiner shall have investigative authority for certain types of death that are in the interests of the state, including mass fatality incidents, for the identification, examination and disposition of victims' remains, and instances that represent a threat to the public health or safety, or both." TCA 38-7-103

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# Section I–Introduction

## Purpose

The purpose of this program is to help reduce the incidence of injury and death to infants and children by accurately identifying the cause and manner of death for those under 18 years of age. This will be accomplished by requiring that a death scene investigation be performed in all cases of sudden, unexpected infant and child death.

## Overview of the Law

According to the law, all emergency medical technicians (EMTs), professional firefighters, and law enforcement officers shall receive training on the handling of cases of sudden, unexplained child death—including being sensitive to the grief of family members—as part of their basic and/or continuing training requirements ([law.justia.com/codes/tennessee/title-68/health/chapter-1/part-11/section-68-1-1102](http://law.justia.com/codes/tennessee/title-68/health/chapter-1/part-11/section-68-1-1102)). Throughout this manual these professionals will also be described as “first responders.” In addition, the chief medical examiner for Tennessee shall develop and implement a program for training child death pathologists. For every sudden, unexplained death of a child under 1, the attending physician or coroner shall notify the county medical examiner, who will coordinate the death investigation. The county medical examiner shall also contact local law enforcement personnel to conduct the death scene investigation, according to the protocol developed by the chief medical examiner. The chief medical examiner’s protocol is presented to you through this in-service program.

## Why Target First Responders?

Like any other emergency situation, it is important to prepare for responding to a sudden infant or child death scene. This preparation should include an evaluation component to guide future performance. For example, if an infant death is due to Sudden Infant Death Syndrome (SIDS), it is important that first responders handle those tragedies with great care, giving families and care providers the empathy and support they deserve. Conversely, despite the presence of grieving parents and a lack of visible trauma, occasionally a child’s death can be the result of a criminal act or negligence. First responders have the difficult task of balancing the need for a thorough investigation with the concerns of the family and others involved in the event, recognizing that only a complete autopsy, medical history, and review of the death scene can determine the cause of an unexpected child death.

## What Is Included in This Curriculum?

*Prevention Through Understanding: Investigating Unexpected Child Death* provides an educational video presentation as well as written information for trainers and trainees. The program manual includes the following:

1. Program Objectives
2. Recommended Program Format
3. Materials Needed for Presenting the Program
4. A Section Focused on Teaching the Program
5. A Post-Assessment Questionnaire
6. In-Service Tracking and Evaluation Forms
7. Appendices and References

## Objectives of the In-Service Program

Upon completion of this program, **law enforcement personnel** should be able to conduct a child death scene investigation **using the Sudden Unexpected Infant/Child Death Investigation (SUIDI) form** developed by the Centers for Disease Control and Prevention and the Tennessee Medical Examiner. All first responder participants should be able to:

1. discuss the Tennessee law requiring (a) an investigation of all sudden unexplained child deaths in the state, and (b) training of current and future EMT, firefighter, and law enforcement personnel;
2. define Sudden Unexpected Infant Death, or SUID, and be able to describe what SUID is and what SUID is not;
3. define Sudden Infant Death Syndrome, or SIDS, and be able to describe what SIDS is and is not;
4. identify specific risk factors for sudden infant death;
5. describe the roles of EMTs, firefighters, and law enforcement personnel as witnesses and investigators at a scene and describe how to respond appropriately and obtain information as required by the state medical examiner;
6. identify the critical surroundings and environment when responding to a scene;
7. demonstrate sensitivity and a nonjudgmental approach to family members and caregivers;
8. describe the role of Child Protective Services (CPS) and its investigations relating to child abuse and neglect;
9. describe the importance of the Child Fatality Review (CFR) team; and
10. identify resources for grieving families and care providers and support for professionals.

## What to Consider While Watching the Video

While viewing the video, please be aware of the following:

1. the collaborative nature of the work of all first responders—EMTs, firefighters, and law enforcement—and the significant duties each professional has when responding to the scene of a nonresponsive child;
2. the importance of observing the surroundings and preserving the scene environment, understanding that law enforcement officers are typically responsible for investigating a child death scene while EMTs and firefighters are witnesses to the scene;
3. specific procedures and requirements for investigating a death scene, including interviewing techniques;
4. the roles and responsibilities of Child Protective Services (CPS) and Child Fatality Review (CFR) teams; and
5. the sensitivity and support shown to family members and care providers.

## Suggested In-Service Discussion Questions

1. discuss the Tennessee law requiring (a) an investigation of all sudden unexplained child deaths in the state, and (b) training of current and future EMT, firefighter, and law enforcement personnel;
2. define Sudden Unexpected Infant Death, or SUID, and be able to describe what SUID is and what SUID is not;
3. define Sudden Infant Death Syndrome, or SIDS, and be able to describe what SIDS is and is not;
4. identify specific risk factors for sudden infant death;
5. describe the roles of EMTs, firefighters, and law enforcement personnel as witnesses and investigators at a scene and describe how to respond appropriately and obtain information as required by the state medical examiner;
6. identify the critical surroundings and environment when responding to a scene;
7. demonstrate sensitivity and a nonjudgmental approach to family members and caregivers;
8. describe the role of Child Protective Services (CPS) and its investigations relating to child abuse and neglect;
9. describe the importance of the Child Fatality Review (CFR) team; and
10. identify resources for grieving families and care providers and support for professionals.

## SUID Online Training Courses

This course is also available in a self-guided format. It is designed for participants to take the course individually and completely online. There are no registration fees, but it is required for you to complete a registration process online and score 70% or more to receive credit for this training. Upon successful completion, a certificate will be mailed to the address you provided to verify your credit for completing the course.

To register, visit [www.sidstrainingtn.org](http://www.sidstrainingtn.org).

Available course:

1. **Prevention Through Understanding:  
Investigating Unexpected Infant Death**

Upon completion of this course, you will receive credit for the training requirements mandated by the State of Tennessee in response to the Sudden Unexplained Child Death Act.

2. **Sudden, Unexpected Infant Death Investigation:  
Guidelines for the Investigator**

The purpose of this course is to provide uniform guidelines for the death scene investigators to facilitate a properly documented and effective investigation.



Prevention  
Through  
Understanding:  
**Investigating  
Unexpected  
Child Death**

# Notes

# Section II - Core Concepts

## Understanding Infant Death Scene Investigation, SUID and SIDS, and Related

The Sudden Unexplained Child Death Act, signed into law in May 2001 and amended in April 2002, mandates that first responders receive training on handling cases of sudden, unexplained infant death as part of their basic and continuing training requirements. (See Tenn. Code Ann. § 68-1-11, 68-142, 68-3-5, 2001 and 68-1-1102, Supp., 2002.) In June 2005, Tenn. Code Ann. § 68-1-1103 was signed into law, requiring an investigation into the sudden unexplained death of **any child** from birth through age 17. The purpose of the law is to help reduce the incidence of injury and death to infants and children by accurately identifying the cause and manner of death. This is accomplished by requiring that a death investigation be performed in all cases of sudden, unexpected child death.

According to the law, all emergency medical technicians (EMTs), professional firefighters, and law enforcement officers should receive training on the handling of cases of sudden, unexplained child death—including being sensitive to the grief of family members—as part of their basic and continuing training requirements. (As of December 31, 2003, law enforcement officers were no longer required to receive this training as part of their continuing training requirements, but it is still part of their basic training. See Tenn. Code Ann. § 68-1-1102 (d), Supp., 2002, including compiler's notes). In addition, the chief medical examiner for Tennessee shall develop and implement a program for training child death pathologists.

For every sudden, unexplained death of a child under 18 years of age, the attending physician or coroner shall notify the county medical examiner, who will coordinate the death investigation. The county medical examiner will contact local law enforcement personnel to conduct the death scene investigation, according to the protocol developed by the chief medical examiner for the state. The law also permits the Tennessee Department of Health to reimburse county governments for autopsies performed in these investigations, **provided the Sudden Unexplained Infant/Child Death Investigation (SUIDI) form is used to complete the investigation.** The maximum allowable cost per autopsy is \$1,250. Appendix A provides a copy of the full text of the laws. Please see page 9 for a copy of the SUIDI form.

### Understanding Sudden Unexpected Infant Death

**Definition of Sudden Unexpected Infant Death (SUID)** — This is an umbrella phrase that describes all infant deaths that happen suddenly and unexpectedly. The manner and cause of death are not clear before an investigation is done. **An infant is defined as a child less than one year of age.**

**Definition of Sudden Infant Death Syndrome (SIDS)** — This refers to the sudden death of an infant that can't be explained after a thorough investigation is conducted. This includes a complete autopsy, examination of the death scene, and review of the medical history.

**Definition of Sleep-Related Death** — This refers to infant deaths caused by circumstances in the sleep environment such as pillows, blankets or stuffed animals in the crib, a baby sleeping on a surface other than a crib, or a baby sleeping with an adult.

### Facts About Sudden Unexpected Infant Death

Studies have shown that many sudden unexpected infant deaths are caused by an unsafe sleep environment. These deaths are preventable when parents and caregivers follow these safe sleep recommendations:

- always be placed on their backs to sleep
- sleep alone in a crib or bassinet, although it should be in the same room as an adult caregiver
- no bumper pads, blankets, stuffed animals, toys, or pets in their cribs
- sleep on a firm crib mattress with the mattress covered only by a fitted sheet
- a simple way to remember safe sleep recommendations are the AAP ABCs of Safe Sleep. Alone, on their Back, in a Crib.

## **SIDS in Tennessee Before and After the Back to Sleep Campaign**

The Back to Sleep campaign is named for its recommendation to place healthy babies on their backs to sleep. Placing babies on their backs to sleep reduces the risk of Sudden Infant Death Syndrome (SIDS). Originally recommended by the American Academy of Pediatrics in 1992, the Back to Sleep national public education campaign began in 1994. Since that time, there has been a dramatic decrease in SIDS cases nationwide.

The new national Safe to Sleep® campaign, formerly known as the Back to Sleep campaign, has helped educate millions of caregivers about ways to reduce the risk of SIDS and other sleep-related causes of infant death. The campaign builds on the successes of Back to Sleep to address SIDS and other sleep-related causes of infant death and to continue spreading safe sleep messages to members of all communities. These recommendations include sleeping alone and in a crib. Since the start of the campaign, SIDS rates in the United States have decreased by almost 50%, both overall and within various racial/ethnic groups.

Appendix B provides data on infant mortality, and sleep-related deaths in Tennessee from 2018-2022.

## **Understanding Child Protective Services (CPS) and Abuse and Neglect Cases**

According to the latest data, the Tennessee Department of Children's Services responded to 67,457 reports of child abuse and neglect in 2023. The Child Protective Services (CPS) division strives to protect children whose lives or health are seriously jeopardized because of abusive acts or negligence. The division also supports the preservation of families. According to Tennessee law, all persons (including doctors, mental health professionals, child care providers, dentists, family members, and friends) must report suspected cases of child abuse or neglect to either the Department of Children's Services, the juvenile court judge of jurisdiction, or the county sheriff. Failure to report a suspected case is a violation of the law. According to the latest data, the Tennessee Department of Children's Services conducted 70,718 investigations and assessments related to child abuse and neglect in the 2021-2022 period. These investigations are conducted to determine the condition of the children, to assess their safety, to evaluate their risk of any future harm, and to plan for their well-being.

Department practices risk-oriented case management and considers the following issues:

- investigating referrals of child abuse or neglect
- identifying the risks that contributed to the abuse or neglect
- delivering appropriate services to reduce risks
- evaluating the success of the intervention
- continuing services, if necessary
- closing the case or reuniting the child/children and family

Appendix C provides additional information on Child Protective Services including **24-hour contact information for reporting abuse and neglect.**

## **Understanding Child Fatality Review (CFR) Teams**

The Child Fatality Review and Prevention Act of 1995 established a statewide network of child fatality review teams. These multidiscipline, multiagency teams have been established in the 31 judicial districts in Tennessee to review all deaths of children 17 years of age or younger. The purpose of the Child Fatality Review teams is to promote an understanding of the causes of childhood deaths, identify deficiencies in the delivery of services to children and families, and make and carry out recommendations that will prevent future child deaths.

The state Child Fatality Review team reviews reports from local teams, analyzes statistics of the incidence and causes of child deaths, and makes recommendations to the governor and General Assembly to promote the safety and well-being of children.

Tennessee is part of a national movement to identify why children are dying and what preventive measures can be taken.

Law enforcement investigators who fill out the SUIDI form completely and accurately play an important role in helping the Medical Examiner's Office and Child Fatality Review teams confirm or determine the actual cause of a child's death.

Appendix C provides Child Fatality Review team information, a copy of the current CFR data collection form, and fatality review judicial districts.

## **How to Respond to an Unexpected Child Death Scene**

When responding to the scene of an unexpected infant or child death, it is important to maintain non judgmental, compassionate interaction with families and caregivers. If resources allow, it may be helpful to make an additional health care provider or professional available to support and assist the family in gathering items for the trip to the hospital. Calling on clergy or other community support persons for this may require that someone stay behind at the scene until additional resources arrive.

Key on-scene actions include:

1. observing the scene for the position of the child when first responders arrive;
2. noting on the baby the presence of any markings, color changes, or bleeding as well as the color and consistency of other body fluids;
3. recording the presence of any objects in close proximity that may have been involved in the scene;
4. noting the behavior of persons present; and
5. documenting all observations and interactions with the family or caregiver in a factual, objective manner, while keeping in mind that all written documentation may be collected as evidence in the investigation.

Some families may want to be in the room during resuscitation efforts. However, their presence can transform a focused, technical environment into a highly emotional one. Remember that the health care provider's first responsibility is to the child patient. Many elements need to be in place so that a family's presence during resuscitation does not jeopardize patient care, including.

1. available staff to stay with the family to explain and continually assess the family members' ability to withstand this additional trauma;
2. a controlled environment, relatively free of chaos; and
3. continued assessment of the appropriateness of the presence of family members and a willingness to remove them if the situation requires it (Minnesota Sudden Infant Death Center, 2003).

## **Compassionate Interaction**

Compassionate interaction is crucial in a death scene investigation. A parent or caregiver's immediate reaction to a child's death may be shock, denial, disbelief, or a sense of numbness or unreality. These are completely normal and cushion the impact of the loss until the parents are ready to face the devastating reality of their child's death. Although grief is a normal process and not an illness, often it is helpful for those who are grieving to share what they are feeling with someone outside the family. Doctors, social workers, and other counselors, nurses, and clergy can all be sympathetic. Demonstrating concern for the family/caregiver is helpful, but health care providers must be careful not to place the family/caregiver in a position of having to console the provider or first responder. Tears are acceptable as long as the provider is still able to function and does not seek comfort from the bereaved. Allow the family members to react in their own manner without trying to control their behavior. The grieving process is unique to each individual and to each culture. The variety of reactions should be respected as long as family members do not pose a danger to themselves or to others. Appendix B provides additional information on SUID and grief. Appendix D and the Bereavement Support Services booklet offer local and national support and information resources.

## Conducting an Infant or Child Death Scene Investigation

Child death investigation is different than many other types of investigations. It involves a combination of witness interviews, unique types of scene evidence, and medical evidence. A thorough investigation is a team effort. **All first responders have a duty to perform resuscitation efforts or seek medical help, secure the scene, identify potential witnesses, and determine what, if any, evidence needs to be preserved. Law enforcement personnel typically conduct the actual death scene investigation; other first responder professionals are witnesses to the scene.** It is important to remember that in most cases the death is due to natural or accidental causes. Parents will be in shock and may blame themselves for the death of their child. You are initially there to interview, not interrogate. Approach the scene with compassion and concern.

The Centers for Disease Control and Prevention's Infant Death Scene Investigation: Guidelines for the Scene Investigator publication included in this kit gives guidelines for conducting a reenactment scene with dolls. By ensuring photographic documentation of the infant at the scene, a permanent record of the body is created, and the infant's terminal position, appearance, and any external trauma is included in this documentation. As explained in the publication, when the infant's body has been moved, doll reenactments allow for the visualization and documentation of the discovered position as well as for the initial placed position. Please reference page 17 of the CDC publication for additional guidelines on doll reenactments.

## Completing and Submitting the SUIDI Form

Sudden Unexpected Infant Death Investigation (SUIDI) form is provided on the following pages. It was developed by the Centers for Disease Control and Prevention and is endorsed by the Tennessee Medical Examiner's Office. The SUIDI form should be used during the investigation of infant (under 1 year of age) deaths that are sudden, unexpected, and unexplained prior to investigation particularly the SUIDI Top 25.

Law enforcement personnel will conduct the investigation at the request of the county medical examiner. Law enforcement personnel assigned to the investigation will complete the SUIDI form and submit it to the county medical examiner; a copy shall be provided to the child death pathologist assigned to conduct the autopsy.

The SUIDI Top 25 is listed below. A copy of the complete SUIDI form begins on the following page. Guidelines titled "How to Use SUIDI Reporting Forms" appear after the form. These pages may be copied as needed. **For more information and for electronic versions of the SUIDI form and guide, please go to <https://www.cdc.gov/sudden-infant-death/index.html>.**

## SUIDI Top 25

Forensic pathologists consider the following information critical to the determination of the cause and manner of death with regard to the investigation of sudden, unexplained infant death. The following scene/case information should be collected and provided to the forensic pathologist BEFORE the performance of the forensic autopsy:

1. Case information
2. Evidence of asphyxia
3. Sharing sleep surfaces
4. Change in sleep conditions
5. Evidence of hyperthermia/hypothermia
6. Environmental scene hazards
7. Unsafe sleeping conditions
8. Diet or recent change in diet
9. Recent hospitalizations
10. Previous medical diagnosis
11. History of acute life threatening events
12. History of medical care - without diagnosis
13. Recent fall or other injury
14. History of religious, cultural, or ethnic remedies
15. COD due to natural causes - other than SIDS
16. Prior sibling deaths
17. Previous encounters with police or social service agencies
18. Request for tissue or organ donation
19. Objection to autopsy
20. Pre-terminal resuscitative treatment
21. Death due to trauma (injury), poisoning, or intoxication
22. Suspicious circumstances
23. Other alerts for pathologist's attention
24. Description of the circumstances surrounding the death
25. Pathologist contact information



# Sudden Unexpected Infant Death Investigation Reporting Form

For use during the investigation of infant (under 1 year of age) deaths that are sudden, unexpected, and unexplained prior to investigation.

## INFANT DEMOGRAPHICS

1. **Infant information.** Full name: \_\_\_\_\_ Date of birth: (mm/dd/yyyy) \_\_\_\_\_  
Age: \_\_\_\_\_ SS#: \_\_\_\_\_ Case number: \_\_\_\_\_  
Primary residence address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_
2. Race: ☐ White ☐ Black/African Am. ☐ Asian/Pacific Islander ☐ Am. Indian/Alaskan Native ☐ Hispanic/Latino ☐ Other
3. Sex: ☐ Male ☐ Female

## PREGNANCY HISTORY

1. **Birth mother information.** ☐ Unavailable Full name: \_\_\_\_\_  
Maiden name: \_\_\_\_\_ Date of birth: (mm/dd/yyyy) \_\_\_\_\_ SS#: \_\_\_\_\_  
Current address: \_\_\_\_\_  
☐ Same as infant's primary residence address above City: \_\_\_\_\_  
State: \_\_\_\_\_ Zip: \_\_\_\_\_ Email address: \_\_\_\_\_
2. How long has the birth mother been at this address? Years: \_\_\_\_\_ Months: \_\_\_\_\_ Days: \_\_\_\_\_
3. Previous address(es) (cities/counties/states) in the past 5 years:  
\_\_\_\_\_
4. Did the birth mother receive prenatal care? ☐ Yes ☐ No ☐ Unknown  
If yes: At how many weeks or months did prenatal care begin? \_\_\_\_\_ Weeks \_\_\_\_\_ Months  
How many prenatal care visits were completed? \_\_\_\_\_
5. Where did the birth mother receive prenatal care? Physician/Provider: \_\_\_\_\_  
Hospital or Clinic: \_\_\_\_\_ Phone: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_
6. Did the birth mother have any complications, medical conditions, or injuries during her pregnancy?  
(e.g., high blood pressure, bleeding, gestational diabetes, fall, or accident) ☐ Yes ☐ No ☐ Unknown  
If yes, describe:

CS310043



7. During her pregnancy, did the birth mother use any of the following?

| Substance                                  | Use                                                                              | Specify Type | Frequency |
|--------------------------------------------|----------------------------------------------------------------------------------|--------------|-----------|
| Over the counter medications               | <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown |              |           |
| Prescribed medications                     | <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown |              |           |
| Herbal remedies                            | <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown |              |           |
| Alcohol                                    | <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown |              |           |
| Illicit drugs (e.g., heroin)               | <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown |              |           |
| Tobacco (e.g., cigarettes or e-cigarettes) | <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown |              |           |
| Other                                      | <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown |              |           |

## INFANT HISTORY

1. Source of infant medical history information. (check all that apply)

- ☐ Doctor    ☐ Other health care provider    ☐ Medical record    ☐ Parent or primary caregiver    ☐ Other family member  
☐ Other, specify: \_\_\_\_\_

2. Were there any complications during delivery or at birth? (e.g., emergency C-section, or infant needed oxygen)

☐ Yes ☐ No ☐ Unknown    If yes, describe: \_\_\_\_\_

3. Did the infant have abnormal newborn screening results? ☐ Yes ☐ No ☐ Unknown

If yes, describe: \_\_\_\_\_

4. Infant's length at birth: \_\_\_\_\_ ☐ IN ☐ CM5. Infant's weight at birth: \_\_\_\_\_ ☐ LBS and OZ ☐ GM

6. Compared to the due date, when was the infant born?

☐ Early (before 37 weeks) ☐ Late (after 41 weeks) ☐ On time    How many weeks? \_\_\_\_\_ Infant's due date: (mm/dd/yyyy) \_\_\_\_\_

7. Was the infant a singleton or multiple birth? ☐ Singleton ☐ Twin ☐ Triplet ☐ Quadruplet or higher8. Was the infant born with Neonatal Abstinence Syndrome (NAS)? (NAS is a drug withdrawal syndrome in newborns exposed to substances, like opioids, before birth) ☐ Yes ☐ No ☐ Unknown

If yes, did the infant need pharmacologic treatment? ☐ Yes ☐ No ☐ Unknown

9. Fill out the contact information for the infant's regular pediatrician and birth hospital.

| Item                       | Regular Pediatrician | Birth Hospital      |
|----------------------------|----------------------|---------------------|
| Date                       | Of last visit: _____ | Of discharge: _____ |
| Name of hospital or clinic |                      |                     |
| Address                    |                      |                     |
| Phone number               |                      |                     |

10. Describe the two most recent times the infant was seen by a health care provider.

(include ER and clinic visits, hospital admissions, observational stays, regular pediatrician, and phone calls)

| Visit type         | 1 <sup>st</sup> most recent visit | 2 <sup>nd</sup> most recent visit |
|--------------------|-----------------------------------|-----------------------------------|
| Reason for visit   |                                   |                                   |
| Action taken       |                                   |                                   |
| Date               |                                   |                                   |
| Physician's name   |                                   |                                   |
| Hospital or clinic |                                   |                                   |
| Address            |                                   |                                   |
| Phone number       |                                   |                                   |

11. Did the infant have any of the following?

| Symptom                                                       | Within 72 hrs of incident                                                        |
|---------------------------------------------------------------|----------------------------------------------------------------------------------|
| Fever                                                         | <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown |
| Cough                                                         | <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown |
| Diarrhea                                                      | <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown |
| Excessive sweating                                            | <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown |
| Stool changes                                                 | <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown |
| Lethargy or sleeping more than usual                          | <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown |
| Difficulty breathing                                          | <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown |
| Fussiness or excessive crying                                 | <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown |
| Exposure to anyone who was sick (e.g., at home or at daycare) | <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown |
| Decrease in appetite                                          | <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown |
| Falls or injuries                                             | <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown |
| Other, specify: _____                                         | <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown |

| Symptom                                                          | Within 72 hrs of incident                                                        | At any time                                                                      |
|------------------------------------------------------------------|----------------------------------------------------------------------------------|----------------------------------------------------------------------------------|
| Allergies or allergic reactions (food, medication, or other)     | <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown | <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown |
| Abnormal growth, weight gain, or weight loss                     | <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown | <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown |
| Apnea (stopped breathing)                                        | <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown | <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown |
| Cyanosis (turned blue or gray)                                   | <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown | <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown |
| Seizures or convulsions                                          | <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown | <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown |
| Cardiac (heart) abnormalities                                    | <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown | <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown |
| Colic (frequent prolonged crying/chronic inconsolable fussiness) | <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown | <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown |
| Feeding issues (e.g., reflux)                                    | <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown | <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown |
| Vomiting                                                         | <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown | <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown |
| Choking                                                          | <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown | <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown |
| Other, specify: _____                                            | <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown | <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown |

If yes to any of the above, describe:



12. Infant exposed to second hand smoke? (*environmental tobacco smoke*) ☐ Yes ☐ No ☐ Unknown

If yes, how often? ☐ Frequently (*several times a week*) ☐ Occasionally (*several times a month*) ☐ Unknown

13. In the 72 hours before death, was the infant given any vaccinations or medications? (*include any home remedies, herbal medications, prescription medications, over-the-counter medications*)

| Vaccine or medication name | Dose last given | Date given (mm/dd/yy) | Approx. time given | Reasons given or comments |
|----------------------------|-----------------|-----------------------|--------------------|---------------------------|
|                            |                 |                       |                    |                           |
|                            |                 |                       |                    |                           |
|                            |                 |                       |                    |                           |

14. Was the infant last placed to sleep with a bottle? ☐ Yes ☐ No ☐ Unknown

If yes, was the bottle propped? (*object used to hold bottle while infant feeds*) ☐ Yes ☐ No ☐ Unknown

If yes: What object propped the bottle? \_\_\_\_\_

Could the infant hold the bottle? ☐ Yes ☐ No ☐ Unknown

15. Who was the last person to feed the infant? (*name and familial relationship to infant*)

16. Did the death occur during feeding? ☐ Breastfeeding ☐ Bottle-feeding ☐ Eating solids ☐ Not during feeding

17. Was the infant ever breastfed? ☐ Yes ☐ No ☐ Unknown If yes, for how many months? \_\_\_\_\_

18. What did the infant consume in the 24 hours prior to death?

| Consumed?                              | If yes, describe | If yes, newly introduced?                                                        | If yes, was this the last thing consumed prior to incident? | If last fed, indicate quantity | If last fed, indicate date and time? |
|----------------------------------------|------------------|----------------------------------------------------------------------------------|-------------------------------------------------------------|--------------------------------|--------------------------------------|
| <input type="checkbox"/> Breastmilk    |                  | <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown | <input type="radio"/> Yes <input type="radio"/> No          |                                |                                      |
| <input type="checkbox"/> Formula       |                  | <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown | <input type="radio"/> Yes <input type="radio"/> No          |                                |                                      |
| <input type="checkbox"/> Water         |                  | <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown | <input type="radio"/> Yes <input type="radio"/> No          |                                |                                      |
| <input type="checkbox"/> Other liquids |                  | <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown | <input type="radio"/> Yes <input type="radio"/> No          |                                |                                      |
| <input type="checkbox"/> Solids        |                  | <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown | <input type="radio"/> Yes <input type="radio"/> No          |                                |                                      |
| <input type="checkbox"/> Other         |                  | <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown | <input type="radio"/> Yes <input type="radio"/> No          |                                |                                      |

19. Among the infant's blood relatives (*siblings, parents, grandparents, aunts, uncles, or first cousins*) was there any...

Sudden or unexpected death before the age of 50? ☐ Yes ☐ No ☐ Unknown

Heart disease? (*e.g., cardiomyopathy, Marfan or Brugada syndrome, long or short QT syndrome, or catecholaminergic polymorphic ventricular tachycardia*)

☐ Yes ☐ No ☐ Unknown

If yes to either, describe: (*include relation to infant*) \_\_\_\_\_

INFANT HISTORY, *continued*

20. Did the infant have any birth defect(s)? ☐ Yes ☐ No ☐ Unknown

If yes, describe: \_\_\_\_\_

21. Was the infant able to roll over on his or her own? (check all that apply) ☐ Front to back ☐ Back to front

22. Indicate the infant's ability to lift or hold his or her head up. ☐ Unable ☐ 1 second ☐ 5 seconds ☐ ≥10 seconds ☐ Unknown

23. Was the infant meeting or not meeting growth and developmental milestones? (e.g., sitting up, crawling, rolling over, or feeding well. Include if the caregiver, supervisor, or medical professional had any concerns.)

24. Is there anything else that may have affected the infant that has not yet been documented? (e.g., exposed to fumes, infant unusually heavy, placed with positional support or wedge, or international travel)

INCIDENT SCENE INVESTIGATION

1. Incident scene (place infant found unresponsive or dead). Type of location? (e.g., primary residence, daycare, or grandmother's house)

\_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_

State: \_\_\_\_\_ Zip: \_\_\_\_\_

2. Was the infant in a new or different environment? (not part of the infant's normal routine) ☐ Yes ☐ No ☐ Unknown

If yes, describe: \_\_\_\_\_

3. Did the death occur at a daycare? ☐ Yes ☐ No ☐ Unknown

If yes: How many children younger than 18 years of age were under the care of the provider at the time of the incident?

(including their own children) \_\_\_\_\_

How many adults aged 18 years or older were supervising the child(ren)? \_\_\_\_\_

How long has the daycare been open for business? \_\_\_\_\_

Is the daycare licensed? ☐ Yes ☐ No ☐ Unknown

If yes: License number? \_\_\_\_\_ Licensing agency? \_\_\_\_\_

4. How many people live at the incident scene? **Children** (younger than 18 years) \_\_\_\_\_ **Adults** (18 years or older) \_\_\_\_\_

5. What kind of heating or cooling sources were being used at the incident scene? (e.g., A/C window unit, wood-burning fireplace, or open window)

\_\_\_\_\_

6. Was there a working carbon monoxide (CO) alarm at the incident scene? ☐ Yes ☐ No ☐ Unknown

7. Indicate the temperature of the room where the infant was found unresponsive, and the surrounding area. (fill in temperatures)

Thermostat setting: \_\_\_\_\_ Thermostat reading: \_\_\_\_\_ Incident room: \_\_\_\_\_ Outside: \_\_\_\_\_ Time of reading: \_\_\_\_\_

8. Which of these devices were operating in the room where the infant was found unresponsive? (check all that apply)

☐ Fan ☐ Apnea monitor ☐ Humidifier ☐ Vaporizer ☐ Air purifier ☐ None ☐ Unknown

☐ Other, specify: \_\_\_\_\_

9. What was the source of drinking water at the incident scene? (check all that apply)

☐ Public or municipal water ☐ Bottled water ☐ Well water ☐ Unknown

☐ Other, specify: \_\_\_\_\_

10. Which of the following were present at the incident scene? *(check all that apply)*

☐ Insects      ☐ Mold growth      ☐ Smokey smell      ☐ Pets      ☐ Dampness      ☐ Peeling paint      ☐ Visible standing water

☐ Presence of alcohol containers      ☐ Rodents or vermin      ☐ None

☐ Odors or fumes, describe: \_\_\_\_\_

☐ Presence of prescription drugs, describe: \_\_\_\_\_

☐ Presence of illicit drugs or drug paraphernalia, describe: \_\_\_\_\_

☐ Other, describe: \_\_\_\_\_

11. Describe the general appearance of incident scene. *(e.g., cleanliness, hazards, or overcrowding)*

12. Is there anything else that may have affected the infant that has not yet been documented? *(e.g., drug or alcohol use at scene, history of domestic violence, or child abuse or neglect)*

## INCIDENT CIRCUMSTANCES

1. Who was the usual caregiver(s)? *(name(s) and familial relationship to infant)* \_\_\_\_\_

2. Who was the caregiver(s) at the time of the incident? *(name(s) and familial relationship to infant)*

3. Who found the infant unresponsive? *(If caregiver is same as birth mother Skip question #3)*

Full name: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_

State: \_\_\_\_\_ Zip: \_\_\_\_\_ Date of birth: \_\_\_\_\_

Email address: \_\_\_\_\_ Phone number: \_\_\_\_\_

Work address: \_\_\_\_\_

Familial relationship to infant? *(e.g., birth mother, grandfather, or adoptive or foster parent)*

4. Describe what happened. *(include details about how the infant was found)*

5. Was there anything different about the infant in the last 24 hours?    ☐ Yes    ☐ No    ☐ Unknown

*If yes, describe:*

6. What was the temperature in the incident room?    ☐ Hot    ☐ Cold    ☐ Normal    ☐ Other

7. Was there a crib, bassinet, or portable crib at the place of incidence?    ☐ Yes    ☐ No    ☐ Unknown

*If yes, was it in good or usable condition? (e.g., not broken or not full of laundry)*    ☐ Yes    ☐ No    ☐ Unknown

*If no, explain:*

8. Where was the infant (P)laced before death, (L)ast known alive, (F)ound, and (U)sually placed? (*write P, L, F, or U, leave blank if none*)

Crib       Portable Crib       Waterbed       Stroller       Playpen/play area (*not portable crib*)  
 Bassinet       Sofa/couch       Swing       Futon       Bouncy chair  
 Bedside sleeper       Chair       Baby box       Floor       Rocking sleeper  
 Car seat       Unknown       Held in person's arms       In-bed sleeper

Other, specify: \_\_\_\_\_

Adult bed — *If yes, what type?*    ☐ Twin    ☐ Full    ☐ Queen    ☐ King    ☐ Unknown

☐ Other, specify: \_\_\_\_\_

9. Describe the condition and firmness of the surface where the infant was found.

\_\_\_\_\_

10. Was the infant wrapped or swaddled?    ☐ Yes    ☐ No    ☐ Unknown

*If yes: Describe the arm position.*    ☐ Arms free and out    ☐ Arms in    ☐ One arm in and one arm out

*Describe swaddle. (include blanket type and tightness)* \_\_\_\_\_

11. What was the infant wearing? (*e.g., t-shirt or disposable diaper*) \_\_\_\_\_

12. What was the infant's usual sleep position?    ☐ Sitting    ☐ Back    ☐ Stomach    ☐ Side    ☐ Unknown

13. Describe the circumstances of infant when last placed by caregiver, last known alive, and found.

|                                                                                                               | Placed | Last known alive | Found |
|---------------------------------------------------------------------------------------------------------------|--------|------------------|-------|
| Date                                                                                                          |        |                  |       |
| Time                                                                                                          |        |                  |       |
| Location ( <i>e.g., living room or bedroom</i> )                                                              |        |                  |       |
| Position ( <i>e.g., sitting, back, stomach, side, or unknown</i> )                                            |        |                  |       |
| Face position ( <i>e.g., down, up, left, right, or unknown</i> )                                              |        |                  |       |
| Neck position ( <i>e.g., hyperextended or head back, hyperextended or chin to chest, neutral, or turned</i> ) |        |                  |       |

14. Was the infant's airway obstructed by a person or object when found? (*includes obstruction of the mouth or nose, or compression of the neck or chest*)

☐ Unobstructed    ☐ Fully obstructed    ☐ Partially obstructed    ☐ Unknown

*If fully or partially, what was obstructed or compressed? (check all that apply)*    ☐ Nose    ☐ Mouth    ☐ Chest    ☐ Neck

15. Indicate the items present in the sleep environment and their positional relation to the infant when the infant was found.

| Item                                     | Present?                                                                         | If yes, position in relation to infant?                                                                            | If yes, did object obstruct the infant's mouth, nose, chest, or neck?            |
|------------------------------------------|----------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------|
| Adult(s) (18 years or older)             | <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown | <input type="radio"/> Over <input type="radio"/> Under <input type="radio"/> Next to <input type="radio"/> Unknown | <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown |
| Other child(ren) (younger than 18 years) | <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown | <input type="radio"/> Over <input type="radio"/> Under <input type="radio"/> Next to <input type="radio"/> Unknown | <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown |
| Animal(s)                                | <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown | <input type="radio"/> Over <input type="radio"/> Under <input type="radio"/> Next to <input type="radio"/> Unknown | <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown |
| Mattress                                 | <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown | <input type="radio"/> Over <input type="radio"/> Under <input type="radio"/> Next to <input type="radio"/> Unknown | <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown |
| Comforter, quilt or other                | <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown | <input type="radio"/> Over <input type="radio"/> Under <input type="radio"/> Next to <input type="radio"/> Unknown | <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown |
| Fitted sheet                             | <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown | <input type="radio"/> Over <input type="radio"/> Under <input type="radio"/> Next to <input type="radio"/> Unknown | <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown |
| Thin blanket                             | <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown | <input type="radio"/> Over <input type="radio"/> Under <input type="radio"/> Next to <input type="radio"/> Unknown | <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown |
| Pillow(s)                                | <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown | <input type="radio"/> Over <input type="radio"/> Under <input type="radio"/> Next to <input type="radio"/> Unknown | <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown |
| Cushion                                  | <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown | <input type="radio"/> Over <input type="radio"/> Under <input type="radio"/> Next to <input type="radio"/> Unknown | <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown |
| Nursing or u-shaped pillow               | <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown | <input type="radio"/> Over <input type="radio"/> Under <input type="radio"/> Next to <input type="radio"/> Unknown | <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown |
| Sleep positioner (wedge)                 | <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown | <input type="radio"/> Over <input type="radio"/> Under <input type="radio"/> Next to <input type="radio"/> Unknown | <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown |
| Bumper pads                              | <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown | <input type="radio"/> Over <input type="radio"/> Under <input type="radio"/> Next to <input type="radio"/> Unknown | <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown |
| Clothing (not on a person)               | <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown | <input type="radio"/> Over <input type="radio"/> Under <input type="radio"/> Next to <input type="radio"/> Unknown | <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown |
| Crib railing or side                     | <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown | <input type="radio"/> Over <input type="radio"/> Under <input type="radio"/> Next to <input type="radio"/> Unknown | <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown |
| Wall                                     | <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown | <input type="radio"/> Over <input type="radio"/> Under <input type="radio"/> Next to <input type="radio"/> Unknown | <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown |
| Toy(s)                                   | <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown | <input type="radio"/> Over <input type="radio"/> Under <input type="radio"/> Next to <input type="radio"/> Unknown | <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown |
| Other, specify: _____                    | <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown | <input type="radio"/> Over <input type="radio"/> Under <input type="radio"/> Next to <input type="radio"/> Unknown | <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown |

If yes to adult(s) or child(ren) sharing sleep surface with the infant, complete table below. ☐ NA

| Name of individual(s) sharing sleep surface with infant | Relationship to infant | Age | Height | Weight | Impaired by drugs or alcohol?                                                    | Fell asleep feeding infant?                                                      |
|---------------------------------------------------------|------------------------|-----|--------|--------|----------------------------------------------------------------------------------|----------------------------------------------------------------------------------|
|                                                         |                        |     |        |        | <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown | <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown |
|                                                         |                        |     |        |        | <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown | <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown |
|                                                         |                        |     |        |        | <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown | <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown |

If yes to impaired, describe: \_\_\_\_\_

16. Were there any secretions present at the scene? ☐ Yes ☐ No ☐ Unknown

If yes, describe: (include where they were found) \_\_\_\_\_

17. Was there evidence of wedging? (wedging is an obstruction of the nose or mouth, or compression of the neck or chest as a result of being stuck or trapped between inanimate objects) ☐ Yes ☐ No ☐ Unknown

If yes, describe: \_\_\_\_\_

18. Was there evidence of overlay? (overlay is an obstruction of the nose or mouth, or compression of the neck or chest as a result of a person rolling on top of or against an infant) ☐ Yes ☐ No ☐ Unknown

If yes, describe: \_\_\_\_\_

19. Was the infant breathing when found? ☐ Yes ☐ No ☐ Unknown

If no, did anyone witness the infant stop breathing? ☐ Yes ☐ No ☐ Unknown



20. Describe the infant's appearance when found. (*indicate all that apply*)

| Appearance                                                                               | Present?                                                                         | Describe and specify location |
|------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------|-------------------------------|
| Discoloration around face, nose, or mouth                                                | <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown |                               |
| Secretions or fluids ( <i>e.g., foam, froth, or urine</i> )                              | <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown |                               |
| Skin discoloration ( <i>e.g., livor mortis, pale areas, darkness, or color changes</i> ) | <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown |                               |
| Pressure marks ( <i>e.g., pale areas, or blanching</i> )                                 | <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown |                               |
| Rash or petechiae ( <i>e.g., small, red blood spots on skin, membrane, or eyes</i> )     | <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown |                               |
| Marks on body ( <i>e.g., scratches or bruises</i> )                                      | <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown |                               |
| Other: _____                                                                             | <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown |                               |

21. What did the infant feel like when found? (*check all that apply*)

☐ Sweaty ☐ Warm to touch ☐ Cool to touch ☐ Limp/flexible ☐ Rigid/stiff ☐ Unknown

☐ Other, specify: \_\_\_\_\_

22. Did EMS respond? ☐ Yes ☐ No ☐ Unknown

If yes, was the infant transported? ☐ Yes ☐ No ☐ Unknown

23. Was resuscitation attempted? ☐ Yes ☐ No ☐ Unknown

If yes: By whom? (*e.g., EMS, bystander, or parent*) \_\_\_\_\_

Date: (mm/dd/yyyy) \_\_\_\_\_

Time: \_\_\_\_\_

Type of compression? (*check all that apply*)

☐ Two finger ☐ One hand ☐ Two hands

Was rescue breathing done? ☐ Yes ☐ No ☐ Unknown

## The following questions refer to the caregiver(s) at the time of death.

## 24. Has the caregiver ever had a child under their care die suddenly and unexpectedly?

☐ Yes ☐ No ☐ Unknown

If yes, explain: (*include familial relationship of child and infant, and cause of death*) \_\_\_\_\_

## 25. Were the infant and caregiver in the same room at the time of the incident, but not sharing the same sleep surface?

☐ Yes ☐ No ☐ Unknown ☐ N/A - sharing a sleep surface

26. Was the infant's caregiver using any of the following during the incident? (*indicate all that apply*)

| Substance                                                     | Caregiver used?                                                                  | Frequency |
|---------------------------------------------------------------|----------------------------------------------------------------------------------|-----------|
| Over the counter medications                                  | <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown |           |
| Prescription medications                                      | <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown |           |
| Opioids                                                       | <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown |           |
| Tobacco, specify: ( <i>e.g., cigarettes or e-cigarettes</i> ) | <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown |           |
| Alcohol                                                       | <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown |           |
| Herbal remedies                                               | <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown |           |
| Other, specify: _____                                         | <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown |           |

Was the infant's caregiver asked to consent to blood or urine for drug/alcohol testing? ☐ Yes ☐ No ☐ Unknown

If yes, what were the results? \_\_\_\_\_

## INVESTIGATION SUMMARY

### 1. Arrival dates and times.

| Person(s) involved | Hospital | Incident scene |
|--------------------|----------|----------------|
| Infant             |          | N/A            |
| Law enforcement    |          |                |
| Death investigator |          |                |

2. Agencies conducting an investigation? (check all that apply) ☐ Child protective services  
☐ Death investigator from medical examiner or coroner office ☐ Law enforcement, specify: \_\_\_\_\_  
☐ Other, specify: \_\_\_\_\_

3. Indicate when the form was completed. Date: (mm/dd/yyyy) \_\_\_\_\_ Time: \_\_\_\_\_

4. If more than one person was interviewed, does the information provided differ? ☐ Yes ☐ No ☐ N/A  
 If yes, detail any differences or inconsistencies of relevant information. (e.g., placed on sofa or last known alive on chair)

5. Indicate the task(s) performed. (check all that apply) ☐ Additional scene(s) (forms attached) conducted ☐ Photos or video taken  
☐ Materials collected or evidence logged ☐ Next of kin notified ☐ 911 tape obtained ☐ EMS run sheet or report obtained  
☐ Witness(es)/caregiver(s) interviewed

6. Was the family offered grief counseling services? ☐ Yes ☐ No ☐ Unknown

7. Was a doll scene reenactment performed? ☐ Yes ☐ No ☐ Unknown

If no, why? \_\_\_\_\_

If yes: How was it documented? (check all that apply) ☐ Photographed ☐ Videod ☐ Other, specify: \_\_\_\_\_

Where was it performed? ☐ Incident scene ☐ Hospital ☐ Other, specify: \_\_\_\_\_

Indicate when the doll reenactment was performed. Date performed: (mm/dd/yyyy) \_\_\_\_\_ Time performed: \_\_\_\_\_

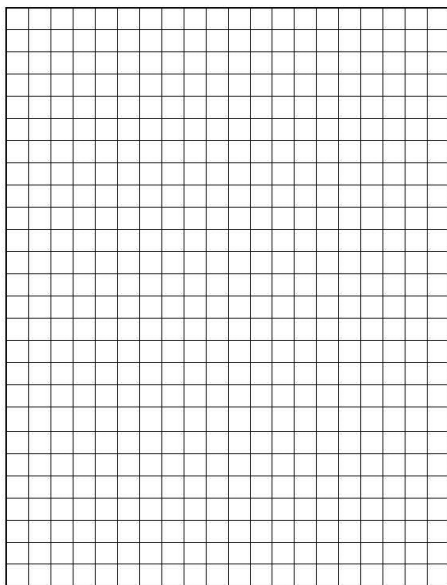
Were photos provided to the pathologist? ☐ Yes ☐ No ☐ Unknown

Do the scenarios given during the doll reenactment(s) match what was seen during the preliminary investigation?

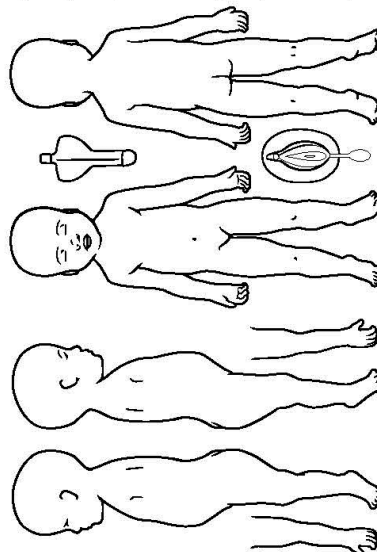
☐ Yes ☐ No ☐ N/A

## INVESTIGATION DIAGRAMS

### 1. Scene diagram (illustrate the infant's sleep environment)



### 2. Body diagram (note visible injuries, livor mortis, or rigor mortis)



### 3. Scene and doll reenactment photos (include with form)



## SUMMARY FOR PATHOLOGIST

1. Investigator information. Name: \_\_\_\_\_ Agency: \_\_\_\_\_  
 Phone: \_\_\_\_\_ Email address: \_\_\_\_\_
2. Indicate when the investigation took place. Date: *mm/dd/yyyy* \_\_\_\_\_ Time: \_\_\_\_\_
3. Indicate when the infant was pronounced dead. Date: *(mm/dd/yyyy)* \_\_\_\_\_ Time: \_\_\_\_\_
4. Indicate when it is estimated the infant died. Date: *(mm/dd/yyyy)* \_\_\_\_\_ Time: \_\_\_\_\_
5. Location of death: *(e.g., home or hospital)* \_\_\_\_\_
6. Data sources consulted to complete this form. *(check all that apply)* ☐ Infant medical records ☐ Birth records ☐ Prenatal records  
☐ Witness interview ☐ Photos/videos from caregivers demonstrating injuries, developmental milestone, or medical concerns  
☐ Other, specify: \_\_\_\_\_

7. Indicate whether preliminary investigation suggests any of the following. *(indicate all that apply)*

| Sleeping Environment                                                                                                                                       | Yes                   | No                    |
|------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------|-----------------------|
| Asphyxia <i>(e.g., evidence of overlying, wedging, choking, nose or mouth obstruction, re-breathing, neck or chest compression, or immersion in water)</i> | <input type="radio"/> | <input type="radio"/> |
| Sharing of sleep surface with adults, children, or pets                                                                                                    | <input type="radio"/> | <input type="radio"/> |
| Change in sleep condition <i>(e.g., unaccustomed stomach sleep position, location, or sleep surface)</i>                                                   | <input type="radio"/> | <input type="radio"/> |
| Hyperthermia or hypothermia <i>(e.g., excessive wrapping, blankets, clothing, or hot or cold environments)</i>                                             | <input type="radio"/> | <input type="radio"/> |
| Environmental hazards <i>(e.g., carbon monoxide, noxious gases, chemicals, drugs, or devices)</i>                                                          | <input type="radio"/> | <input type="radio"/> |
| Unsafe sleep condition <i>(e.g., non-supine, couch, adult bed, stuffed toys, pillows, or soft bedding)</i>                                                 | <input type="radio"/> | <input type="radio"/> |

| Infant History                                                                                                      | Yes                   | No                    |
|---------------------------------------------------------------------------------------------------------------------|-----------------------|-----------------------|
| Diet <i>(e.g., solids introduced)</i>                                                                               | <input type="radio"/> | <input type="radio"/> |
| Recent hospitalization                                                                                              | <input type="radio"/> | <input type="radio"/> |
| Previous medical diagnosis                                                                                          | <input type="radio"/> | <input type="radio"/> |
| History of acute life threatening events <i>(e.g., apnea, seizures, or difficulty breathing)</i>                    | <input type="radio"/> | <input type="radio"/> |
| History of medical care without diagnosis                                                                           | <input type="radio"/> | <input type="radio"/> |
| Recent fall or other injury                                                                                         | <input type="radio"/> | <input type="radio"/> |
| History of religious, cultural or alternative remedies                                                              | <input type="radio"/> | <input type="radio"/> |
| Cause of death due to natural causes other than SIDS <i>(e.g., birth defects or complications of preterm birth)</i> | <input type="radio"/> | <input type="radio"/> |

| Family Information                                                                                                                                                                                                                                                                                                              | Yes                   | No                    |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------|-----------------------|
| Prior sibling deaths                                                                                                                                                                                                                                                                                                            | <input type="radio"/> | <input type="radio"/> |
| Sudden or unexpected death before the age of 50 or heart disease <i>(e.g., cardiomyopathy, Marfan or Brugada syndrome, long or short QT syndrome, catecholaminergic polymorphic ventricular tachycardia)</i> among the infant's blood relatives <i>(e.g., siblings, parents, grandparents, aunts, uncles, or first cousins)</i> | <input type="radio"/> | <input type="radio"/> |
| Previous encounters with police or social service agencies                                                                                                                                                                                                                                                                      | <input type="radio"/> | <input type="radio"/> |
| Request for tissue or organ donation                                                                                                                                                                                                                                                                                            | <input type="radio"/> | <input type="radio"/> |
| Objection to autopsy                                                                                                                                                                                                                                                                                                            | <input type="radio"/> | <input type="radio"/> |

| Exam                                                  | Yes                   | No                    |
|-------------------------------------------------------|-----------------------|-----------------------|
| Preterminal resuscitative treatment                   | <input type="radio"/> | <input type="radio"/> |
| Signs of trauma or injury, poisoning, or intoxication | <input type="radio"/> | <input type="radio"/> |

| Other                                    | Yes                   | No                    |
|------------------------------------------|-----------------------|-----------------------|
| Suspicious circumstances                 | <input type="radio"/> | <input type="radio"/> |
| Other alerts for pathologist's attention | <input type="radio"/> | <input type="radio"/> |

*If yes to any of the above, explain in detail: (description of circumstances)*

8. Medical examiner or pathologist information.

Name: \_\_\_\_\_

Agency: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ Email address: \_\_\_\_\_

Visit <https://www.cdc.gov/sids/SUIDRF.htm> for Additional Investigative Scene Forms of Body Diagram, EMS Interview, Hospital Interview, Immunization Record, Infant Exposure History, Informant Contact, Law Enforcement Interview, Materials Collection Log, Non Professional Responder Interview, Parental Information, Primary Residence Investigation, and Scene Diagram.

# How to Use the Sudden Unexpected Infant Death Investigation Reporting Form

## Sudden Unexpected Infant Death Investigation (SUIDI) Reporting Form: A Guide for Investigators

The SUIDI Reporting Form is a guide for all investigators of infant deaths. The form is designed to facilitate the collection of information in a consistent and sensitive manner. [Training materials](#) on how to complete the form are available.

### Importance of the Reporting Form

- Contains key questions that medical examiners should ask before an autopsy is done.
- Guides investigators through the steps involved in an investigation.
- Improves classification of SIDS and other SUIDs by standardizing data collection.
- Produces information that researchers can use to recognize new health threats and risk factors for infant death so that future deaths can be prevented.

### Improvements in the SUIDI Reporting Form

- Changed the U from unexplained to unexpected at request of the National Association of Medical Examiners.
- Reduced redundancy and streamlined existing questions.
- Color coded sections for ease.
- Clarified with instructions and definitions.
- Reordered and retitled sections.
- Updated existing questions.
- Added questions.
- Revised [Supplemental form](#) for collecting information about contacts and evidence are available for jurisdictions to consider using if equivalents are not available.

### Filling out the SUIDI Reporting Form

This reporting form is designed as a questionnaire that can be read to the person being interviewed, or used to guide a more free flowing conversation. Questions can be answered by placing an "X" in the corresponding checkbox or filling in the blank provided. The 12-page form is divided into eight sections, described below.

### Infant Demographics

This section is filled out first by the person (e.g., coroner, death scene investigator, law enforcement, or medical examiner) investigating the circumstances of the infant death. Some terms to note:

- **SS#.** Social security number.
- **Case number.** Jurisdictional or office internal case number.
- **Primary residence.** Place where the infant lived at time of their death.

### Pregnancy History

This section is filled out by the person interviewing/consulting the biological mother, or someone who knows her and her history well (e.g., health care provider, medical record, or maternal grandmother).

### Infant History

This section is filled out by the person investigating the infant death. Additional information may be obtained from the infant's health care provider, medical record, or another caregiver.

### Incident Scene Investigation

This section is filled out by the person investigating the infant death.



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Control and Prevention

## Incident Circumstances

This section is filled out by the person interviewing the witness(es). This should be a careful documentation of the scene including documentation of the infant's airway when found. It includes:

- **Usual caregiver.** Person who took care of the infant more than 50% of the time.
- **Placed.** When the infant was originally put to sleep
- **Last known alive.** Where and when the infant was last observed to be alive (e.g., last time parent heard the infant cry).
- **Found.** When the infant was discovered to be not breathing or breathing but in distress.

## Investigation Summary

This section is filled out by the person doing the bulk of the investigation and summarizes everything done as part of the investigation.

## Investigation Diagrams

This section is filled out by the person investigating the infant death, and includes a scene diagram and a body diagram. It should supplement, and not be used instead of, the doll reenactment.

**The investigator should indicate the following on the scene diagram:**

- North direction.
- Windows and doors.
- Wall lengths and ceiling height.
- Location of furniture including infant's bed or sleep surface.
- Infant body location when found.
- Position of other persons or animals found near infant.
- Location of heating and cooling devices.
- Location of other objects in room.

**The investigator should indicate the following on the body diagram:**

- Discoloration around face, nose, or mouth.
- Secretions (drainage or discharge from anywhere on body).
- Skin discoloration (livor mortis).
- Pressure mark areas (pale areas, blanching).
- Rash or petechiae (small, red blood spots on skin, membranes or in eyes).
- Marks on body (scratches or bruises).
- Location of medical devices.
- Body temperature.

## Summary for Pathologist

This section is filled out by the person investigating the infant death. This section summarizes all the information collected during the witness interview and investigation of the incident or death scene. Some terms to note:

- **Asphyxia.** Condition of severely deficient supply of oxygen to the body that can rapidly lead to unconsciousness and death (e.g., compression of infant's chest and/or neck due to wedging or a person lying on the infant, or obstruction of the nose and/or mouth).
- **Hyperthermia.** Life-threatening condition where core body temperature is abnormally high (e.g., above 40°C [104°F]).
- **Hypothermia.** Life-threatening condition where core body temperature falls below 35°C (95°F).
- **Apnea.** Condition where an infant stops breathing for a short period of time. Can occur in the delivery room or any time afterwards.

# Section III–In-Service Forms

## Workshop Post-Assessment

Please answer the following questions after completing the workshop.

1. According to Tennessee law, which group or groups of first responders is/are required to receive training on cases of sudden, unexpected infant and child death?
  - a. EMS
  - b. Police
  - c. Firefighter
  - d. All of the above
2. Sudden infant death is the diagnosis given for the sudden death of an infant under one year of age that remains unexplained after a complete investigation. A complete investigation includes an examination of the death scene, an autopsy, and
  - a. A review of symptoms and illnesses the infant had before dying
  - b. A review of any other pertinent medical history
  - c. A Child Fatality Review team review
  - d. Answers a and b
3. Who is responsible for conducting the death scene investigation?
  - a. EMS, by request of the county medical examiner
  - b. Typically law enforcement, by request of the county medical examiner
  - c. The state medical examiner
  - d. None of the above
4. SIDS is the major cause of death in infants between
  - a. 2 months and 4 months of age
  - b. 1 month and 1 year of age
  - c. 1 month and 6 months of age
  - d. Newborn and 1 year of age
5. The Tennessee Department of Children's Services (DCS) Child Safety Division conducts investigations to
  - a. Determine the condition of a child
  - b. Evaluate the risk of any future harm
  - c. Plan for a child's well-being
  - d. All of the above
6. A diagnosis of exclusion means
  - a. No autopsy was performed for religious reasons
  - b. A cause of death could not be determined
  - c. After an autopsy, an examination of the death scene, and review of the clinical history, all causes of undiagnosed natural death are ruled out
  - d. After an autopsy and scene review, the medical examiner withheld the findings
7. The following are all risk factors for SUID except
  - a. Placing a baby to sleep on his/her stomach
  - b. Exposing a baby to smoke
  - c. Having a previous SUID death in the family
  - d. Placing a baby to sleep on a soft sleep surface
8. The following are all protective factors for SUID except
  - a. Breastfeeding
  - b. Co-sleeping
  - c. Sleeping alone on a firm mattress
  - d. Keeping temperature regulated so baby doesn't get overheated
9. Placing children on soft, collapsible bedding is dangerous because of which of the following?
  - a. This sleep position causes SIDS.
  - b. This sleep position decreases children's ability to keep their airways open.
  - c. This sleep position allows children to fall into sleep apnea.

10. The first responder's duties are to
  - a. Seek medical help
  - b. Secure the scene
  - c. Identify potential witnesses
  - d. Determine what, if any, evidence needs to be preserved
  - e. All of the above
11. Observing that a colleague's behavior has changed after an infant death scene call, you should first
  - a. Wait six months before intervening
  - b. Report your observations to the supervisor
  - c. Approach your colleague with your observations
  - d. Arrange for a post-traumatic stress debriefing intervention
12. The decision to not transport a child who has died is usually made by
  - a. The police on the scene
  - b. Medical direction
  - c. Standing orders
  - d. The coroner
  - e. The EMS health care providers
13. Identify which of the following are members of the local CFR teams.
  - a. Department of Health regional officer
  - b. Juvenile Court representative
  - c. Local law enforcement officer
  - d. All of the above
14. Identify which of the following statements may describe a grieving family member's behavior.
  - a. Strong feelings of guilt or anger
  - b. Unreasonable fears that they, or someone in their family, may be in danger
  - c. Being overprotective of surviving children and fearful about future children
  - d. All of the above
15. Taking time out during a SUID call to talk privately with your partner about the family's behavior is
  - a. Necessary for potential court action
  - b. Helpful to calm the situation
  - c. Detrimental to patient care
  - d. None of the above
16. What is the maximum allowable cost, reimbursed to county governments, for conducting autopsies on children who have died suddenly and without apparent explanation?
  - a. \$1,500 per autopsy
  - b. \$1,250 per autopsy
  - c. There is no maximum allowable cost for reimbursement.
  - d. The state does not reimburse for autopsies in any amount.
17. What is the SUIDI Top 25?
  - a. Critical information needed when investigating a sudden unexplained infant death, in order for forensic pathologists to determine the cause and manner of death
  - b. The most crucial 25 questions on the SUIDI form that must be filled out by an investigator
  - c. The top 25 reasons why a baby might die suddenly and unexpectedly
18. Where in your materials can you find the SUIDI form, instructions for filling out the form, and the SUIDI Top 25?
  - a. At the end of Section II in the manual
  - b. In the Appendix of the manual
  - c. In the Guidelines for the Scene Investigator booklet
  - d. Answers a and c



# Workshop Evaluation

Please complete this evaluation and turn it in to your instructor.

Providing this information will help improve future sessions.

Instructor Name \_\_\_\_\_

Date \_\_\_\_\_

Location/Building \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ County \_\_\_\_\_ Zip \_\_\_\_\_

Please answer the following questions.

1. Check your affiliation

☐ EMS      ☐ Firefighter      ☐ Law Enforcement      ☐ Other

2. How many hours a week do you work in a first responder role?

☐ 0–3 hours      ☐ 4–8 hours      ☐ 9–19 hours      ☐ 20–40 hours      ☐ 40+ hours

3. How knowledgeable were you about Sudden Infant Death Syndrome before this workshop?

☐ Not very      ☐ Somewhat      ☐ Fairly      ☐ Very

4. Before this workshop, how would you rate your comfort level when caring for pediatric patients?

☐ Anxious      ☐ Comfortable      ☐ Very comfortable

5. Before this workshop, how would you rate your comfort level when caring for families of pediatric patients?

☐ Anxious      ☐ Comfortable      ☐ Very comfortable

6. Has this workshop changed your attitude about responding to a sudden, unexpected infant or child death?

☐ Yes      ☐ No

Please describe: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

7. Do you have a family member or close friend who has suffered from a sudden unexplained child death?

☐ Yes      ☐ No

8. On a scale of 1 to 4, where 1 is Strongly Disagree, 2 is Disagree, 3 is Agree, and 4 is Strongly Agree, please circle your responses to the statements below.

- a) The objectives for this workshop were clearly presented. (1) (2) (3) (4)
- b) I have learned new ideas and/or skills. (1) (2) (3) (4)
- c) The video was easy to understand and held my interest. (1) (2) (3) (4)
- d) The manual was easy to follow and a good reference. (1) (2) (3) (4)
- e) I will use the SUIDI form and instructions if/when I have to investigate a sudden unexplained child death. (1) (2) (3) (4)
- f) Overall, I was favorably impressed with the workshop. (1) (2) (3) (4)

9. What aspect(s) of the workshop did you find most helpful?

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10. What aspect(s) of the workshop did you find least helpful?

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11. Can you think of ways in which we can improve this program in the future?

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Thank you for your input and consideration.

**Instructor: Contact hour certificates will be mailed to trainers upon receipt of tracking and evaluation forms.** Please send evaluation copies to Attn: Prevention Through Understanding, MTSU University College, MTSU Box 54, 1301 East Main Street, Murfreesboro, TN 37132, or fax to (615) 494-8777.

# Appendix A

## Rules of Tennessee Department of Health Maternal and Child Health

### CHAPTER 1200-15-03

#### INVESTIGATIONS OF SUDDEN, UNEXPLAINED INFANT AND CHILD DEATHS

##### TABLE OF CONTENTS

1200-15-03-.01 Purpose

1200-15-03-.02 Definitions

1200-15-03-.03 Standards for Investigations

1200-15-03-.04 Reimbursement of County Governments

##### **1200-15-03-.01 PURPOSE.**

The purpose of this chapter is to establish minimum standards for conducting and completing an investigation, including an autopsy if deemed necessary, into sudden, unexplained infant and child deaths.

**Authority:** T.C.A. §§ 68-1-1101, 68-1-1102, and 68-1-1103. **Administrative History:** Original rule filed May 11, 2010; effective October 29, 2010; however on October 28, 2010 the Department of Health withdrew the rules. Original rule filed January 24, 2012; effective June 30, 2012.

##### **1200-15-03-.02 DEFINITIONS.**

For purposes of this chapter,

- (1) "Autopsy" means the post mortuam examination of a deceased infant or child by a licensed pathologist to determine cause of death.
- (2) "Child" means a person who is at least one year of age and has not reached his or her eighteenth birthday.
- (3) "Department" means the Tennessee Department of Health.
- (4) "Infant" means a baby who was born alive and has not reached his or her first birthday.
- (5) "Sudden, unexplained infant or child death" means the unexpected death of an infant or a child with no known or apparent cause.

**Authority:** T.C.A. §§ 68-1-1101, 68-1-1102, and 68-1-1103. **Administrative History:** Original rule filed May 11, 2010; effective October 29, 2010; however on October 28, 2010 the Department of Health withdrew the rules. Original rule filed January 24, 2012; effective June 30, 2012.

##### **1200-15-03-.03 STANDARDS FOR INVESTIGATIONS.**

- (1) The standards for conducting and completing an investigation, including performance of an autopsy, into a sudden, unexplained infant death shall include the standards applicable to infants found in T.C.A. § 68-1-1102, and the standards authorized or required by Tennessee Code Annotated Title 38, Chapter 7. The same standards shall apply to sudden, unexplained child death.
- (2) In addition to the standards found in T.C.A. § 68-1-1102 and Title 38, Chapter 7, the standards for conducting and completing an investigation, including performance of an autopsy, into a sudden, unexplained infant or child death shall be those found in the most current version of the Centers for Disease Control and Prevention's publication, "Sudden, Unexplained Infant Death Investigation Reporting Form," for infants, and the Department's "Sudden, Unexplained Child Death Investigation Reporting Form," for children. The Department shall provide access to these publications upon request. The pathologist performing the autopsy shall complete the appropriate form.

**Authority:** T.C.A. §§ 68-1-1101, 68-1-1102, 68-1-1103, and 68-3-502. **Administrative History:** Original rule filed May 11, 2010; effective October 29, 2010; however on October 28, 2010 the Department of Health withdrew the rules. Original rule filed January 24, 2012; effective June 30, 2012.

##### **1200-15-03-.04 REIMBURSEMENT OF COUNTY GOVERNMENTS.**

The Department shall reimburse county governments for the cost of each autopsy performed for an investigation into a sudden, unexplained infant or child death that is carried out in accordance with the investigation standards in this chapter. The Department shall reimburse up to the maximum allowable of \$1,250.00 per autopsy, including travel costs. The Tennessee Department of Finance and Administration's Comprehensive Travel Regulations shall govern the reimbursement rate for travel costs.

**Authority:** T.C.A. §§ 68-1-1101, 68-1-1102, and 68-1-1103. **Administrative History:** Original rule filed May 11, 2010; effective October 29, 2010; however on October 28, 2010 the Department of Health withdrew the rules. Original rule filed January 24, 2012; effective June 30, 2012.

# Tenn. Code Ann. § 68-1-1101

Current through the 2024 Regular Session.

Tennessee Code Table of Contents PAW- ET TABLE OF CONTENTS

Title 68 Health, Safety and Environmental Protection

Health

Chapter 1 Department of Health

Part 11 Sudden,Unexplained Child Death Act

## 68-1-1101. Short title — Legislative findings — Definitions.

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**(a)** This part shall be known and may be cited as the “Sudden, Unexplained Child Death Act.”

**(b)** The legislature finds and declares that:

**(1)** Protection of the health and welfare of the children of this state is a goal of its people and the unexpected death of a child is an important public health concern that requires legislative action;

**(2)** The parents, guardians, and other persons legally responsible for the care of a child who dies unexpectedly have a need to know the cause of death;

**(3)** Collecting accurate data on the cause and manner of unexpected deaths will better enable the state to protect children from preventable deaths, and thus will help reduce the incidence of such deaths; and

**(4)** Identifying persons responsible for abuse or neglect resulting in unexpected death will better enable the state to protect other children who may be under the care of the same persons, and thus will help reduce the incidence of such deaths.

**(c)** As used in this part and in § 68-3-502, unless the context otherwise requires:

**(1)** “Certified child death pathologist” means a pathologist who is board certified or board eligible in forensic pathology, and who has received training in, and agrees to follow, the autopsy protocol, policies and guidelines for child death investigation, as prescribed by the chief medical examiner for the state of Tennessee;

**(2)** “Chief medical examiner” means the individual appointed pursuant to title 38, chapter 7; and

**(3)** “Sudden infant death syndrome” means the sudden death of an infant under one (1) year of age that remains unexplained after a thorough case investigation, including performance of a complete autopsy, examination of the death scene, and review of the clinical history.

### History

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Acts 2001, ch. 321, § 1.

# Tenn. Code Ann. § 68-1-1102

Current through the 2024 Regular Session.

Tennessee Code Table of Contents PAW- ET TABLE OF CONTENTS

Title 68 Health, Safety and Environmental Protection

Health

Chapter 1 Department of Health

Part 11 Sudden, Unexplained Child Death Act

## 68-1-1102. Purpose — Training — Notice and investigation — Autopsy.

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**(a)** The purpose of this part is to help reduce the incidence of injury and death to infants by accurately identifying the cause and manner of death of infants under one (1) year of age. This shall be accomplished by requiring that a death investigation be performed in all cases of all sudden, unexplained deaths of infants under one (1) year of age.

**(b)** The chief medical examiner shall develop and implement a program for training of child death pathologists. The protocol and policies shall be based on nationally recognized standards.

**(c)** All emergency medical technicians and professional firefighters shall receive training on the handling of cases of sudden, unexplained child death as a part of their basic and continuing training requirements. The training, which shall be developed jointly by the departments of health and children's services, shall include the importance of being sensitive to the grief of family members.

**(d)** All law enforcement officers shall receive training on the investigation and handling of cases of sudden, unexplained child death as part of their basic training requirements. The training, which shall be developed jointly by the departments of health and children's services, shall include the importance of being sensitive to the grief of family members and shall be consistent with the death scene investigation protocol approved by the chief medical examiner. Additionally, whenever changes occur in policies or procedures pertaining to sudden infant death syndrome investigations, the department of health shall promptly notify the various law enforcement associations within the state. Such changes shall then be communicated in a timely manner to the respective law enforcement agencies for dissemination to their enforcement personnel.

**(e)** In the case of every sudden, unexplained death of an infant under one (1) year of age, the attending physician or coroner shall notify the county medical examiner, who shall coordinate the death investigation.

**(f)** The county medical examiner shall inform the parent or parents or legal guardian of the child, if an autopsy is authorized.

**(g)** The county medical examiner shall ensure that the body is sent for autopsy to a child death pathologist as defined in this part. Parents or legal guardians who refuse to allow an autopsy based on the grounds of religious exemption shall personally file a petition for an emergency court hearing in the general sessions court for the county in which the death occurred.

**(h)** The county medical examiner shall contact the appropriate local law enforcement personnel to conduct a death scene investigation according to the protocol developed by the chief medical examiner. The investigation shall be initiated within twenty-four (24) hours of the time the local law enforcement personnel are contacted by the county medical examiner.

**(i)** The county medical examiner shall send a copy of the death scene investigation and the medical history of the child to the pathologist conducting the autopsy.

**(j)** A copy of the completed autopsy, medical history, and death scene investigation shall be forwarded to the chief medical examiner.

**(k)** The cause of death, as determined by the certified child death pathologist, may be reported to the parents or legal guardians of the child. A copy of the autopsy results, when available, may be furnished to the parent or parents or legal guardian of the child, upon request, within forty-eight (48) hours of the request, except where the cause of death may reasonably be attributed to child abuse or neglect, in the judgment of the certified child death pathologist.

**(l)** Sudden infant death syndrome shall not be listed as the cause of death of a child, unless the death involves an infant under one (1) year of age that remains unexplained after a thorough case investigation, including performance of a complete autopsy, examination of the death scene, and review of the child's clinical history.

**(m)** Any individual or entity providing information pertinent to the investigation and related autopsy in a suspected case of sudden, unexplained infant death syndrome shall not be civilly liable for breach of confidentiality concerning the release of the information.

## History

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Acts 2001, ch. 321, § 2; 2002, ch. 591, §§ 1, 2.



# Tenn. Code Ann. § 68-1-1103

Current through the 2024 Regular Session.

Tennessee Code Table of Contents PAW- ET TABLE OF CONTENTS

Title 68 Health, Safety and Environmental Protection

Health

Chapter 1 Department of Health

Part 11 Sudden,Unexplained Child Death Act

## 68-1-1103. Implementation.

In order to implement this part, the commissioner of health shall:

- (1)** Promulgate rules and regulations in accordance with the Uniform Administrative Procedures Act, compiled in title 4, chapter 5, as may be necessary to obtain in proper form all information relating to the occurrence of a sudden, unexplained child death that is relevant and appropriate for the establishment of a reliable statistical index of the incidence, distribution and characteristics of cases of sudden, unexplained child death;
- (2)** Promulgate rules and regulations in accordance with the Uniform Administrative Procedures Act that establish minimum standards for conducting and completing an investigation, including an autopsy if deemed necessary, into the sudden, unexplained death of any child from birth to age seventeen (17). Initial rules promulgated pursuant to this subdivision (2) are authorized to be promulgated as emergency rules, pursuant to § 4-5-208. In promulgating the rules, the commissioner may rely, in whole or in part, on any nationally recognized standards regarding such investigations. Compliance with the rules shall make county governments eligible for reimbursement, to the extent authorized by those rules, of the costs of any autopsy deemed necessary;
- (3)** Collect factual information from physicians, coroners, medical examiners, hospitals, and public health officials who have examined any child known or believed to have experienced sudden, unexplained death; provided, that no information shall be collected or solicited that reasonably could be expected to reveal the identity of the child;
- (4)** Make information collected pursuant to subdivision (3) available to physicians, coroners, medical examiners, hospitals, public health officials, and educational and institutional organizations conducting research as to the causes and incidence of sudden, unexplained child death;
- (5)** Cause appropriate counseling services to be established and maintained for families affected by the occurrence of sudden infant death syndrome;
- (6)** Conduct educational programs to inform the general public of any research findings that may lead to the possible means of prevention, early identification, and treatment of sudden infant death syndrome; and
- (7)** Develop educational literature to inform the general public of the risks and prevalence of sudden infant death syndrome and other infant sleep-related deaths that are sometimes mislabeled as sudden infant death syndrome, so that such information may lead to the possible means of prevention. The commissioner shall make the literature set out in this subdivision (7) available on the department of health's website.

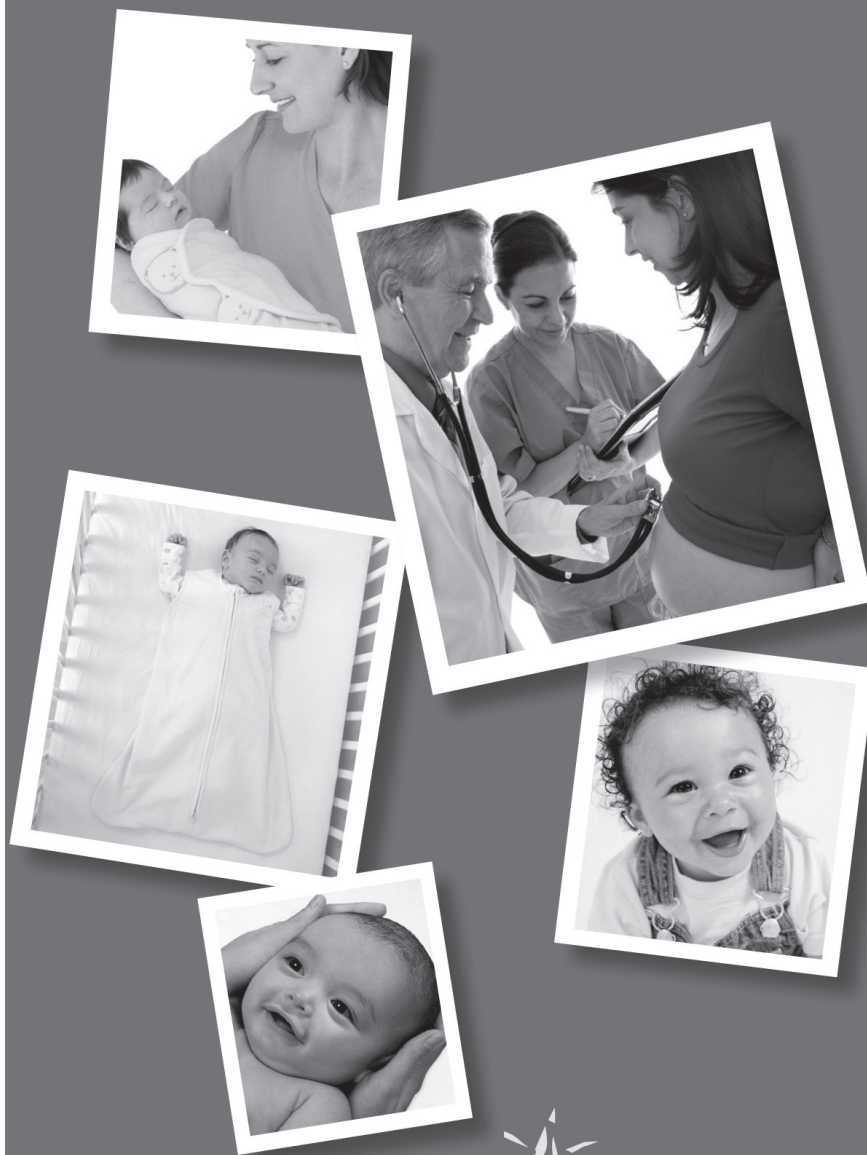
## History

Acts 2001, ch. 321, § 3; 2005, ch. 356, § 1; 2009, ch. 566, § 12; 2018, ch. 667, § 1.

## Appendix B Sudden Unexpected Infant Death

### Back Is Best For Baby's Sleep

and other tips to reduce the risk of SIDS  
and other sudden unexpected infant deaths (SUID)



  
**First  
Candle**

HELPING BABIES SURVIVE & THRIVE

1314 Bedford Avenue, Suite 210, Baltimore, Maryland 21208

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Sudden Infant Death Syndrome (SIDS) is the sudden, unexpected death of a baby younger than one year. SIDS is the leading cause of death for babies one month to one year of age and claims the lives of nearly 2,500 babies every year. In addition, there are up to 2,000 sudden unexpected infant deaths (SUID) caused by suffocation or accidents during sleep each year.

## What Is SIDS?

While SIDS affects families of all ethnic, social and economic backgrounds, we do know that African American and Native American babies are two to three times more likely to die from SIDS than Caucasian babies. Babies born too early or at a low birth rate are at increased risk, as are babies born to mothers who smoke during pregnancy and those who do not receive good prenatal care. Most SIDS deaths happen between two and four months of age, with 90 percent happening before six months of age.

While the exact cause of SIDS is not yet known, recent research has given us more information on what may cause these babies to die. Some babies are more likely to die than others because of a problem in their brainstems. We do not know which babies have this problem, but there are many things parents and caregivers can do to help protect their baby.

By following the important rules in this brochure, you will be giving your baby the best possible chance to reach not only his or her first birthday, but many happy birthdays beyond!



## What can I do to help reduce the risk of SIDS/SUID?

- Always put your baby to sleep on his or her back. *Side and tummy positions are not safe.*
- Use a firm mattress in a crib that meets current safety standards. For guidelines visit [www.jpma.org](http://www.jpma.org). *The mattress should fit snugly in the crib and be covered with only a tight-fitting crib sheet.*
- Never place your baby to sleep on any soft surface. *This includes adult beds, waterbeds, sofas, chairs, cushions, quilts and other soft surfaces.*
- Remove all soft, fluffy or loose bedding from your baby's sleep area. *This includes pillows, quilts, blankets, stuffed toys and other soft items.*
- Do not use soft or pillow-like bumper pads, wedges or positioners in your baby's sleep area. *These items do not help keep your baby safe and can be dangerous when your baby begins turning over and moving around the crib.*
- Use a wearable blanket or other type sleeper instead of loose blankets. *This will keep your baby warm and safe.*
- Room share with your baby, but don't bed share. Adult beds are not safe for sleeping babies. Feed and bond with your baby in bed, but when it's time to go to sleep, place your baby alongside your bed in his or her own separate space. *This will make breastfeeding easier and help reduce the risk of SIDS, suffocation and accidents during sleep.*
- Do not let your baby sleep in a car seat, infant carrier, bouncy seat, swing or other product. *Never leave your baby unattended while using these products. If your baby falls asleep, move him or her to a firm, flat surface as soon as possible.*
- Never fall asleep with your baby on a couch or armchair!





## What other things can I do to protect my baby?

- Good prenatal care is important. See a doctor as soon as you think you might be pregnant and keep all your appointments.
- If possible, feed your baby only breast milk for at least the first six months. Breastfeeding is important to your baby's overall health and well-being and can help protect your baby from illness and infection.
- Do not smoke while you are pregnant and do not allow anyone to smoke around your baby after he or she is born. Exposure to tobacco greatly increases the risk of SIDS and other illnesses.
- Do not drink alcohol or take drugs while you are pregnant.
- Take your baby for scheduled well-baby checkups. Make sure your baby receives his or her shots on time.

## Pacifiers can greatly reduce the risk of SIDS!

New research shows that giving your baby a pacifier **every time you place him or her down to sleep** can greatly reduce the risk of SIDS. Follow these simple steps for safe, effective pacifier use:

- Offer your baby a pacifier at naptime and nighttime.
- If you are breastfeeding, wait one month before using a pacifier.
- Never use a pacifier to replace nursing or feeding.
- It is not necessary to put the pacifier back in your baby's mouth if it falls out – he or she will still be protected.
- Never attach a pacifier around your baby's neck or to clothing.
- Stop using a pacifier after one year when the risk of SIDS decreases.



## Educate everyone who takes care of your baby!

Let everyone who takes care of your baby know about these important rules. This includes grandparents, aunts, uncles, child care providers, friends, babysitters and **EVERYONE** who cares for your baby.



Make sure your baby has a safe place to sleep when visiting or traveling, too!

## Babies should always sleep on their backs!

One of the best things you can do to help reduce the risk of SIDS is to place your baby on his or her back to sleep, even for naps. Not everyone knows how important this is. When your mother and grandmother had babies, doctors told them to place babies on their stomachs for sleep. But research now shows that fewer babies will die of SIDS if they sleep on their backs. In fact, before the national *Back to Sleep* campaign, **3,500** more babies died from SIDS each year.

Placing your baby to sleep on his or her back is the only safe sleep position. Almost all babies will be comfortable sleeping on their back if placed that way from the time they are born. Let your doctor and nurse know that you want your baby placed only *Back to Sleep* in the hospital. Your doctor will let you know if there is a medical reason to use a different sleep position.

Some mothers and grandmothers worry that babies may choke on spit-up or vomit if they sleep on their backs. Doctors have **NOT** found this to be true. Millions of babies around the world sleep safely on their backs.

Many products are made to keep babies on their backs during sleep. But there is no proof that using these products will reduce the risk of SIDS. In fact, positioners and wedges can actually increase the risk of SIDS and accidental infant deaths when your baby starts moving around or rolling over during sleep.

## Make sure there is nothing soft, loose or fluffy in your baby's sleep area!

Research shows that soft bedding and other items placed in your baby's sleep area can increase the risk of SIDS and accidental suffocation. This includes blankets, quilts, pillows, soft or pillow-like bumper pads, stuffed animals and other soft items.



These items can block the flow of fresh air to your baby. Instead of fresh air, your baby will re-breathe his exhaled air, which doesn't have enough oxygen. This "re-breathing" may increase the risk of SIDS. Loose blankets and quilts can also cover your baby's head and cause suffocation.

## When your baby is awake, tummy time is important!

Place your baby on his or her stomach for "tummy time" when he or she is awake and being watched (supervised).



Tummy time while awake is good for your baby. It helps develop neck and shoulder muscles. It also helps prevent "flat spots" on the back of your baby's head. Flat spots are almost always temporary. They usually go away a few months after your baby begins to sit up or crawl.

There are other things you can do to help prevent flat spots:

- Alternate the direction in the crib where you place your baby to sleep.
- Alternate the arm you hold your baby in for feedings.
- Don't let your baby spend too much time in car seats, infant carriers, bouncers, swings and other similar items.



Remember, most babies are  
born healthy and most stay  
that way as they grow.

Don't let the fear of SIDS spoil your joy  
of having a new baby!



First Candle is the nation's leading nonprofit dedicated  
to promoting safe pregnancies and the survival of  
babies through the first years of life.

With programs of research, education and advocacy, we are  
working to ensure that every baby is given the best possible  
chance to survive and thrive. Until we reach that goal,  
we will continue to provide compassionate grief support  
to all those affected by the death of a baby.

For more information on other ways to help your baby  
survive and thrive, to access family support services  
or to make a donation, please call toll-free  
800.221.7437 or visit [www.firstcandle.org](http://www.firstcandle.org).



# NIH News: SIDS Infants Show Abnormalities in Brain Area Controlling Breathing

October 31, 2006

Prevention  
Through  
Understanding:  
Investigating  
Unexpected  
Child Death

Infants who die of sudden infant death syndrome have abnormalities in the brainstem, a part of the brain that helps control heart rate, breathing, blood pressure, temperature and arousal, report researchers funded by the National Institutes of Health. The finding is the strongest evidence to date suggesting that innate differences in a specific part of the brain may place some infants at increased risk for SIDS.

The abnormalities appeared to affect the brainstem's ability to use and recycle serotonin, a brain chemical which also is used in a number of other brain areas and plays a role in communications between brain cells. Serotonin is most well known for its role in regulating mood, but it also plays a role in regulating vital functions like breathing and blood pressure.

The study appears in the November 1 *Journal of the American Medical Association* and was conducted by researchers in the laboratory of Hannah Kinney, M.D., at Children's Hospital Boston and Harvard Medical School as well as other institutions.

"This finding lends credence to the view that SIDS risk may greatly increase when an underlying predisposition combines with an environmental risk—such as sleeping face down—at a developmentally sensitive time in early life," said Duane Alexander, M.D., Director of the NIH's National Institute of Child Health and Human Development.

SIDS is the sudden and unexpected death of an infant under 1 year of age, which cannot be explained after a complete autopsy, an investigation of the scene and circumstances of the death, and a review of the medical history of the infant and his or her family. Typically, the infant is found dead after having been put to sleep and shows no signs of having suffered.

In previous studies, researchers have hypothesized that abnormalities in the brainstem may make an infant susceptible to situations in which they re-breathe their own exhaled breath, depriving them of oxygen. This hypothesis holds that certain infants may not be able to detect high carbon dioxide or low oxygen levels during sleep, and do not wake up.

To conduct the current study, researchers examined tissue from the brainstems of 31 infants who died of SIDS and 10 infants who died of other causes. The tissue was provided by the office of the chief medical examiner in San Diego, California, and was collected from infants who died between 1997 and 2005.

The lower brainstem helps control such basic functions as breathing, heart rate, blood pressure, body temperature, and arousal. The researchers found that brainstems from SIDS infants contained more neurons (brain or nerve cells) that manufacture and use serotonin than did the brainstems of the control infants, explained the study's first author, David Paterson, PhD, a researcher at Children's Hospital in Boston.

Serotonin belongs to a class of molecules known as neurotransmitters, which serve to relay messages between neurons. Neurons release neurotransmitters, which fit into special sites, or receptors, on surrounding neurons, somewhat like a key fits into a lock. Once in place, the neurotransmitter either promotes or hinders electrical activity in the receiving neuron—next in line in a particular brain circuit—causing it to release its neurotransmitters, which either excite or inhibit still more neurons, and so on.

Although the brainstem tissue from the SIDS infants contained more serotonin-using neurons, these serotonin-using neurons appeared to contain fewer receptors for serotonin than did the brainstems of control infants. Dr. Paterson noted that there are at least 14 different subtypes of serotonin receptor. In their study, the researchers tested the infants' brainstem tissue for a serotonin receptor known as "subtype 1A."

Tissue from both the SIDS infants and the control infants contained roughly equal amounts of a key brain protein, serotonin transporter protein. This protein recycles serotonin, collecting the neurotransmitter from the surrounding spaces outside the neuron and transporting it back into the neuron so it can be used again. Dr. Paterson explained, however, that because the SIDS infants had

proportionately more serotonin-using neurons than did the control infants, they would also be expected to have more serotonin transporter protein. So even though they had equal amounts of serotonin transporter protein, the levels were nevertheless reduced—relative to the increased number of serotonin-using neurons—and, for this reason, unlikely to meet the needs of these cells.

Dr. Paterson added that from the observations in this study it was not possible to determine how much serotonin the infants' brainstems contained when the infants were alive. He noted, however, that the pattern of abnormalities—more serotonin neurons, an apparent reduction of serotonin 1A receptors, and insufficient serotonin transporter—suggested that the level of serotonin in the brainstems of SIDS infants was abnormal.

"Our hypothesis right now is that we're seeing a compensation mechanism," Dr. Paterson said. "If you have more serotonin neurons, it may be because you have less serotonin and more neurons are recruited to produce and use serotonin to correct this deficiency."

The researchers also found that male SIDS infants had fewer serotonin receptors than did either female SIDS infants or control infants. The finding may provide insight into why SIDS affects roughly twice as many males as females.

"These findings provide evidence that SIDS is not a mystery but a disorder that we can investigate with scientific methods, and some day, may be able to identify and treat," said Dr. Hannah Kinney, the senior author of the paper.

A large body of research has shown that placing an infant to sleep on his or her stomach greatly increases the risk of SIDS. The NICHD-sponsored Back to Sleep campaign urges parents and caregivers to place infants to sleep on their backs, to reduce SIDS risk. The campaign has reduced the number of SIDS deaths by about half since it began in 1994. The campaign also cautions against other practices that increase the risk of SIDS, such as soft bedding, smoking during pregnancy, and smoking around a baby after birth.

Despite the fact that the Back to Sleep campaign recommendations had been widely distributed by the time the study began, a large proportion of the SIDS cases in the study by Drs. Paterson, Kinney and their coworkers were correlated with known SIDS risk factors: 15 (48 percent) were found sleeping on their stomachs, 9 (29 percent) were found face down, and 7 (23 percent) were sharing a bed, at the time of death.

"The majority (65 percent) of the SIDS cases in this data set, however, were sleeping prone or on their side at the time of death, indicating the need for continued public health messages on safe sleeping practices, the study authors wrote."

### **To Learn More**

Information and free materials on ways parents and caregivers can reduce the risk of sudden infant death syndrome are available on the Safe to Sleep website at <https://safetosleep.nichd.nih.gov>.

Information about the search for ways to identify infants most at risk for SIDS is available in the article "Searching for Those at Greatest Risk for SIDS" at [https://www.nichd.nih.gov/newsroom/releases/sids\\_serotonin\\_backgrounder](https://www.nichd.nih.gov/newsroom/releases/sids_serotonin_backgrounder).

# Glossary of SUID-Related Terminology

**Apnea**—Transient cessation of breathing.

**Apnea of Prematurity**—Periodic breathing with respiratory pauses longer than 20 seconds in a premature infant of less than 37 weeks gestation; may be accompanied by changes in color or in muscle tone.

**Apparent Life Threatening Event (ALTE)**—An episode that is frightening to the observer and is characterized by some combination of apnea, color change, change in muscle tone, and choking or gagging, replacing the term “near-miss” SIDS.

**Arrhythmia**—Any variation from the normal rhythm of the heartbeat.

**Autopsy**—See Postmortem.

**Botulism**—An often fatal poisoning caused by the bacterium *Clostridium botulinum*. Infant deaths from botulism have been misdiagnosed as SIDS.

**Bradycardia**—Slowing of the heart rate. (See tachycardia.)

**Brainstem**—The base of the human brain, which lies just above the spinal cord and controls breathing and other involuntary activities.

**Cardio-Pulmonary Resuscitation (CPR)**—A procedure whereby a victim who is not breathing or has no pulse is massaged so that blood flow and oxygen exchange are maintained.

**Cause (of SIDS)**—A condition or event directly responsible for the death of an individual infant.

**Coroner**—An officer of the law who holds inquests in regard to violent, sudden, or unexplained deaths. (See medical examiner.)

**Co-Sleeping**—The practice of having an infant sleep in the same bed with its parents.

**Crib Death/Cot Death**—Synonyms for SIDS

**Diagnosis of Exclusion**—SIDS is known as a diagnosis of exclusion because it is reported as the cause of death only as a last resort, when all other causes have been eliminated from consideration.

**DPT Vaccine**—The vaccine, often given at about two months of age, to inoculate children against diphtheria, pertussis (whooping cough), and tetanus. Links between this vaccine and SIDS have not been supported by research findings.

**Forensic Medicine**—The application of medical knowledge to legal issues.

**Gastroesophageal Reflux**—An excessive or pathologic tendency toward the reverse flow of stomach contents into the esophagus and sometimes into the throat, from whence refluxed material can be inhaled into the lungs.

**Homeostatic Control Mechanisms**—Innate behaviors of an infant to automatically regulate body conditions such as temperature, oxygen, and carbon dioxide levels in the blood, or heart rate.

**Hypoxia**—The condition wherein too little oxygen reaches tissues and organs.

**International Classification of Diseases, 10th Revision (ICD-10)**—A guide for the classification of morbidity and mortality information for statistical purposes published by the World Health Organization.

**Medical Examiner**—A physician trained specifically in forensic medicine and pathology who conducts death investigations. (See coroner.)

**Metabolic Disorder**—An abnormality of a physical or chemical process underlying vital cellular or organ function.

## Investigating Unexpected Child Death

**Monitoring**—Using an apparatus to observe and/or record physical signs such as respiration, pulse, and blood pressure.

**Pathology**—1. The study of disease, its essential nature, cause, and development, and the structural and functional changes it produces. 2. A condition that might lead to sickness, disability, or death. No pathologies have been discovered that are strongly associated with subsequent SIDS deaths.

**Petechiae**—Pinpoint hemorrhages often found on the surfaces of organs or in the lining of the chest cavity. Petechiae are a characteristic finding in autopsies of SIDS victims.

**Postmortem**—An examination of the body after death, usually with such dissection as will expose the vital organs for determining the cause of death or the character and extent of changes produced by disease; an autopsy.

**Predisposition**—A latent susceptibility to disease that may be activated under certain conditions, such as by physiologic stresses.

**Prone (Sleep position)**—Sleeping on one's stomach. Evidence suggests that prone sleeping increases the risk of SIDS. (See supine.)

**Risk Factor**—A statistically derived rating of how much more common the factor under study is in the population suffering from the disease than in populations without the disease.

Risk factors for SIDS include

- prone sleeping,
- secondhand smoke,
- over- or under-dressing infants,
- male gender,
- age between 2 and 4 months,
- bottle-feeding, and
- subsequent SIDS sibling—a son or daughter born to parents after they have lost an infant to SIDS.

**Subsequent SIDS Sibling**—A son or daughter born to parents after they have lost an infant to SIDS.

**Sudden Infant Death Syndrome (SIDS)**—When an (often) apparently healthy baby suddenly dies, for no apparent reason. SIDS is defined as the death of an infant between the ages of one month and one year which remains unexplained after a thorough postmortem, investigation of the death scene, and review of the clinical history.

**Sudden Unexpected Infant Death (SUID)\***—The Centers for Disease Control and Prevention (CDC) defines this as the sudden and unexpected death of an infant under 1 year of age, where the cause of death is not immediately obvious before investigation. This category includes deaths from Sudden Infant Death Syndrome (SIDS), accidental suffocation in a sleeping environment, and other deaths from unknown causes.

**Supine (Sleep position)**—Sleeping on one's back. Evidence suggests that supine sleeping reduces the risk of SIDS. (See prone.)

**Surviving SIDS Sibling**—A son or daughter born to parents before they have lost an infant to SIDS.

**Syndrome**—A set of signs and symptoms that occur together often enough to constitute a specific condition or entity.

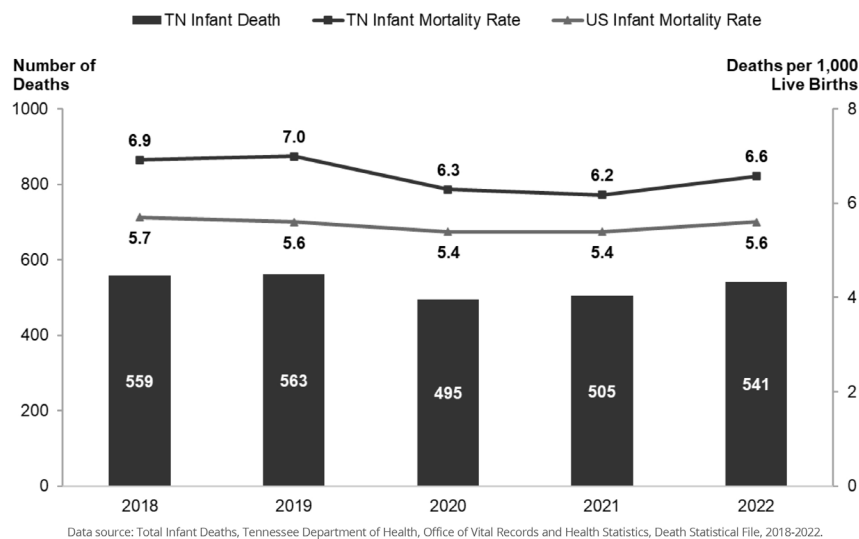
**Tachycardia**—A more rapid than normal heart rate. (See bradycardia.)

The terms Sudden Unexpected Infant Death (SUID) and Sudden Unexplained Infant Death (SUID) are often used interchangeably, but they have distinct meanings as noted in the definitions above. While both terms describe sudden infant deaths, Sudden Unexpected Infant Death is more inclusive, covering both explained and unexplained deaths, whereas Sudden Unexplained Infant Death specifically refers to cases where the cause remains unexplained after investigation. The CDC does not specifically define Sudden Unexplained Infant Death as a separate term from Sudden Unexpected Death.

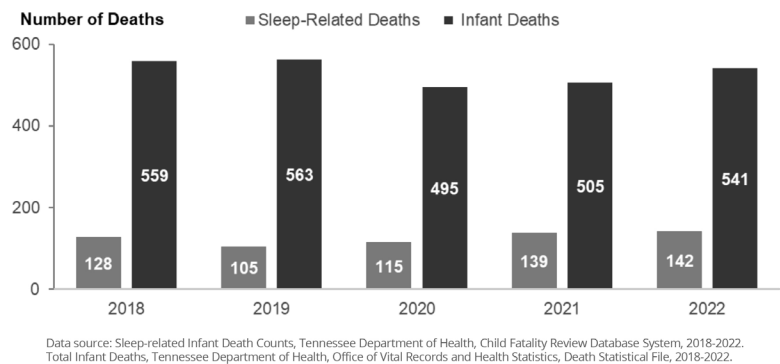
# SUID in Tennessee

Prevention  
Through  
Understanding:  
Investigating  
Unexpected  
Child Death

## Infant Mortality, Tennessee, 2018-2022



## Sleep-Related Infant Deaths, Tennessee, 2018-2022





## Contributing Factors in Sleep-Related Infant Deaths, Tennessee, 2021-2022

| Contributing Factors*                           | 2021 | 2022 |
|-------------------------------------------------|------|------|
| Infant found not sleeping in a crib or bassinet | 96   | 100  |
| Unsafe bedding or toys in sleeping area**       | 112  | 98   |
| Infant found sleeping with other people         | 79   | 73   |
| Infant found not sleeping on back               | 64   | 61   |
| Infant found sleeping with obese adult          | 29   | 14   |
| Drug-impaired adult sleeping with infant        | 6    | 3    |
| Alcohol-impaired adult sleeping with an infant  | 5    | 3    |
| Adult fell asleep while bottle feeding infant   | 4    | 3    |

\*Because more than one factor may have contributed to a single death, the total number across the contributing factors exceeds the number of sleep-related infant deaths for a given year. \*\*Includes comforter, blanket, pillow, bumper pads, toys, plastic bags, and other. Data source: Tennessee Department of Health, Child Fatality Review Database System, 2021-2022.

# Notes

# Appendix C

## Tennessee Services and Information

### Child Safety

The Department of Children's Services responds to over 37,000 reports of child abuse and neglect a year. Every day, more than 100 children are reported abused or neglected in Tennessee. The Child Protective Services division strives to protect children whose lives or health are seriously jeopardized because of abusive acts or negligence. This division also supports the preservation of families. The department practices risk-oriented case management in order to help protect children. These are some of the caseworker's major areas of responsibility:

- Investigating referrals of child abuse or neglect
- Identifying the risks that contributed to the abuse or neglect
- Delivering appropriate services to reduce risks
- Evaluating the success of the intervention
- Continuing services, if necessary
- Closing the case or reuniting the child/children and family

### What Is Child Abuse?

Child abuse and neglect occurs when a child is mistreated, resulting in injury or risk of harm. Abuse can be physical, verbal, emotional, or sexual.

**Physical abuse** is nonaccidental physical trauma or injury inflicted by a parent or caretaker on a child. It also includes a parent's or a caretaker's failure to protect a child from another person who perpetrated physical abuse on a child. In its most severe form, physical abuse is likely to cause great bodily harm or death.

**Physical neglect** is the failure to provide for a child's physical survival needs to the extent that there is harm or risk of harm to the child's health or safety. This may include, but is not limited to, abandonment, lack of supervision, life-endangering physical hygiene, lack of adequate nutrition that places the child below the normal growth curve, lack of shelter, lack of medical or dental care that results in health-threatening conditions, and the inability to meet basic clothing needs of a child. In its most severe form, physical neglect may result in great bodily harm or death.

**Sexual abuse** includes penetration or external touching of a child's intimate parts, oral sex with a child, indecent exposure or any other sexual act performed in a child's presence for sexual gratification, sexual use of a child for prostitution, and the manufacturing of child pornography. Child sexual abuse is also the willful failure of the parent or the child's caretaker to make a reasonable effort to stop child sexual abuse by another person.

**Emotional abuse** includes verbal assaults, ignoring and/or indifference to a child, or constant family conflict. If a child is degraded enough, the child will begin to live up to the image communicated by the abusing parent or caretaker.

Child abuse can happen anywhere—in poor, middle-class, or well-to-do homes or in rural or urban areas.

### Who Should Report Child Abuse?

Somewhere in your community there is a family who has a serious problem. The children in that family are being abused and neglected by their parents. According to

Tennessee law, all persons (including doctors, mental health professionals, child care providers, dentists, family members, and friends) must report suspected cases of child abuse or neglect. Failure to report child abuse or neglect is a violation of the law. [tn.gov/dcs/program-areas/child-safety/reporting/faqs](http://tn.gov/dcs/program-areas/child-safety/reporting/faqs)

**If you believe a child has been abused or neglected call (877) 237-0004 to report it.**

**Possible Indicators of Abuse and Neglect.**

- The child has repeated injuries that are not properly treated or adequately explained.
- The child begins acting in unusual ways, ranging from disruptive and aggressive to passive and withdrawn behavior.
- The child acts in the role of parent toward brothers and sisters or even toward parents.
- The child may have disturbed sleep (nightmares, bed-wetting, fear of sleeping alone, needing a nightlight).
- The child loses his/her appetite, overeats, or reports being hungry.
- There is a sudden drop in school grades or participation in activities.
- The child may act in stylized ways, such as sexual behavior that is not normal for his/her age group.
- The child may report abusive or neglectful acts.

The above signs indicate that something is wrong but do not necessarily point to abuse. However, if you notice these signs early, you may be able to prevent abuse or neglect.

**Parents who abuse or neglect their children may show some common characteristics:**

- Possible drug/alcohol history
- Disorganized home life
- May seem to be isolated from the community and have no close friends
- When asked about a child's injury, may offer conflicting reasons or no explanation at all
- May seem unwilling or unable to provide for a child's basic needs
- May not have age-appropriate expectations of their children
- May use harsh discipline that is not appropriate for a child's age or behavior
- Were abused or neglected as a child

Parents who abuse their children need help, but few are able to admit the problem and seek assistance. Long-term trends show that more than 93% of the perpetrators of child abuse and neglect in Tennessee were the parents or relatives of the victims. Staffs at schools, day cares, and institutions were perpetrators in only two percent of the investigations. Adolescents as well as adults can be perpetrators of abuse.

## **What Happens in an Investigation?**

The process of investigation can include talking with the alleged child victim (or observing a young, nonverbal child), parents, and/or the alleged perpetrator. CPS workers will gather pertinent medical and psychological information and will work with their counterparts in the medical, psychological, judicial, and law enforcement fields. The investigations can also include interviews of neighbors or friends who have knowledge of the child's situation. The emphasis remains on constantly evaluating the risk to the alleged child victim during the entire investigative process.

In reports involving severe child abuse, DCS will notify the local district attorney and law enforcement offices. These include reports that involve a child's death or serious injury or situations involving torture, malnutrition, and child sexual abuse. Furthermore,

Tennessee law requires local child protective investigation teams to review certain cases. The investigative team in each county includes representatives from DCS, the local district attorney general's office, juvenile court, law enforcement, and the mental health profession.

## **What Happens When I Call Central Intake?**

When a person notifies the Department of Children's Services regarding possible abuse or neglect of a child, Children's Services case managers determine how quickly to respond with an investigation. They must assess the referral information and focus on the present and future risks to the child. Considering the condition of the child and the risk of future maltreatment helps a case manager know how quickly to respond to an abuse or neglect referral and what priority to assign to that referral. DCS accepts reports of child maltreatment provided they meet the following three criteria:

- The report pertains to a child under the age of 18 years.
- The report alleges harm or imminent risk of harm to the child.
- The alleged perpetrator is a parent or caretaker; a relative or other person living in the home; an educator, volunteer, or employee of a recreational/organizational setting who is responsible for the child; any individual providing treatment, care, or supervision for the child.

DCS accepts all referrals involving sexual abuse of children under the age of 13 years, regardless of the previous relationship between the alleged victim and the alleged perpetrator. DCS does not investigate sexual abuse allegations of a child 13 to 18 years old by an alleged perpetrator who does not have a relationship with the child, as defined above, unless the child is in the department's custody. DCS may assist law enforcement or the district attorney's office in such cases.

Here is the information you'll be asked to provide if you call to report child abuse:

- Nature of the harm or specific incident(s) that precipitated the report
- Specific allegation(s), date(s) and descriptions(s) of the injuries or dangers
- Identities of alleged perpetrator(s) and their relationships to the victim
- Witnesses to the incident(s) and how to reach those witnesses
- Details of any physical evidence available
- Perpetrator's current access to the child
- Present condition of the child (alone, in need of medical attention, etc.)
- The location of the child and directions to get there
- Any statements from the child
- Parent's or perpetrator's explanation of the alleged child victim's condition or the incident
- Parent's current emotional, physical, or mental state, especially feelings about the child and reactions to the report
- How the reporter came to know the information and the reporter's thoughts about the likelihood of further harm to the child

The reporter's identity is confidential, but a name should be given so the department can follow up with the reporter, if necessary. The reporter is free from civil or criminal liability for reports of suspected child abuse or neglect made in good faith.

To report abuse or neglect, call 1-877-237-0004 or go to [www.tn.gov/dcs](http://www.tn.gov/dcs) and click on "How to Report Child Abuse."

Tennessee Department of Children's Services, Child Safety Division  
[tn.gov/dcs/program-areas/child-safety](http://tn.gov/dcs/program-areas/child-safety)

# Child Fatality Review (CFR) Teams

## Child Fatality Review Teams review deaths in order to:

- promote understanding of the causes of childhood deaths,
- identify deficiencies in the delivery of services to children and families by public agencies, and
- make and carry out recommendations that will prevent future childhood deaths.

## Members of the state team include the following:

- Department of Health commissioner (chair)
- Attorney general
- Department of Children's Services commissioner
- Tennessee Bureau of Investigation director
- Physician (nominated by Tennessee Medical Association)
- Physician credentialed in forensic pathology
- Department of Mental Health and Substance Abuse Services commissioner
- Judiciary member nominated by the Supreme Court chief justice
- Tennessee Commission on Children and Youth chair
- Department of Intellectual and Developmental Disabilities commissioner
- Two members of the Senate
- Two members of the House of Representatives
- One member representing a child abuse prevention organization
- Three parent representatives.

## Members of the local teams include the following:

- Department of Health regional health officer
- Department of Children's Services social services supervisor
- Medical examiner
- Prosecuting attorney appointed by the district attorney general
- Local law enforcement officer
- Mental health professional
- Pediatrician or family practice physician
- Emergency medical services provider or firefighter
- Juvenile court representative
- Representatives of other community agencies serving children



# Tennessee Child Fatality Review Districts

|                         |                                                                                                                                                                                                                                                                                                                                                                        |
|-------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Northeast</b>        | <b>Judicial District 1:</b> Carter, Johnson, Unicoi, and Washington Counties<br><b>Judicial District 3:</b> Greene, Hamblen, Hancock, and Hawkins Counties                                                                                                                                                                                                             |
| <b>Sullivan</b>         | <b>Judicial District 2:</b> Sullivan County                                                                                                                                                                                                                                                                                                                            |
| <b>East</b>             | <b>Judicial District 4:</b> Cocke, Grainger, Jefferson, and Sevier Counties<br><b>Judicial District 5:</b> Blount County<br><b>Judicial District 7:</b> Anderson County<br><b>Judicial District 8:</b> Campbell, Claiborne, Fentress, Scott, and Union Counties<br><b>Judicial District 9:</b> Loudon, Meigs, Morgan, and Roane Counties                               |
| <b>Knox</b>             | <b>Judicial District 6:</b> Knox County                                                                                                                                                                                                                                                                                                                                |
| <b>Southeast</b>        | <b>Judicial District 10:</b> Bradley, McMinn, Monroe, and Polk Counties<br><b>Judicial District 12:</b> Bledsoe, Franklin, Grundy, Marion, Rhea, and Sequatchie Counties                                                                                                                                                                                               |
| <b>Hamilton</b>         | <b>Judicial District 11:</b> Hamilton County                                                                                                                                                                                                                                                                                                                           |
| <b>Upper-Cumberland</b> | <b>Judicial District 13:</b> Clay, Cumberland, DeKalb, Overton, Pickett, Putnam, and White Counties<br><b>Judicial District 15:</b> Jackson, Macon, Smith, Trousdale, and Wilson Counties<br><b>Judicial District 31:</b> Van Buren and Warren Counties                                                                                                                |
| <b>South Central</b>    | <b>Judicial District 14:</b> Coffee County<br><b>Judicial District 17:</b> Bedford, Lincoln, Marshall, and Moore Counties<br><b>Judicial District 2101:</b> Hickman, Lewis, and Perry Counties<br><b>Judicial District 2201:</b> Giles, Lawrence, and Wayne Counties<br><b>Judicial District 2202:</b> Maury County                                                    |
| <b>Mid-Cumberland</b>   | <b>Judicial District 16:</b> Cannon, and Rutherford Counties<br><b>Judicial District 18:</b> Sumner County<br><b>Judicial District 1901:</b> Montgomery County<br><b>Judicial District 1902:</b> Robertson County<br><b>Judicial District 2102:</b> Williamson County<br><b>Judicial District 23:</b> Cheatham, Dickson, Houston, Humphreys, and Stewart Counties      |
| <b>Davidson</b>         | <b>Judicial District 20:</b> Davidson County                                                                                                                                                                                                                                                                                                                           |
| <b>West</b>             | <b>Judicial District 24:</b> Benton, Carroll, Decatur, Hardin, and Henry Counties<br><b>Judicial District 25:</b> Fayette, Hardeman, Lauderdale, McNairy, and Tipton Counties<br><b>Judicial District 27:</b> Obion and Weakley Counties<br><b>Judicial District 28:</b> Crockett, Gibson, and Haywood Counties<br><b>Judicial District 29:</b> Dyer and Lake Counties |
| <b>Madison</b>          | <b>Judicial District 26:</b> Chester, Henderson, and Madison Counties                                                                                                                                                                                                                                                                                                  |
| <b>Shelby</b>           | <b>Judicial District 30:</b> Shelby County                                                                                                                                                                                                                                                                                                                             |

Revised 12/14/2004

There is at least one local CFR team for each of the 31 judicial districts in Tennessee. Due to larger populations and caseloads, some judicial districts are broken up into two teams, resulting in 34 total local CFR teams covering the state.



State of Tennessee  
Department of Health  
**Sudden Unexplained Child Death Investigation Report**  
**For use in children aged 1 year and older**

**-Investigation Data-**

**Child's Information:**

|                                                                                                                                                                |          |             |                                                     |      |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------|----------|-------------|-----------------------------------------------------|------|
| Last Name:                                                                                                                                                     |          | First Name: |                                                     | M.   |
| Sex: <input type="checkbox"/> M <input type="checkbox"/> F                                                                                                     | DOB: / / | SS#:        | Case#:                                              |      |
| Race: <input type="checkbox"/> White <input type="checkbox"/> Black/African Am. <input type="checkbox"/> Asian/Pacific Islander <input type="checkbox"/> Other |          |             | Ethnicity: <input type="checkbox"/> Hispanic/Latino |      |
| Primary Address:                                                                                                                                               |          | City:       | St:                                                 | Zip: |
| Incident Address:                                                                                                                                              |          | City:       | St:                                                 | Zip: |

**Contact Information for Witness:**

|                                                                                                                                                                                                                                       |  |                |     |                    |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------|-----|--------------------|
| Relationship to the deceased: <input type="checkbox"/> Birth Mother <input type="checkbox"/> Birth Father <input type="checkbox"/> Grandmother <input type="checkbox"/> Adoptive or Foster Parents <input type="checkbox"/> Physician |  |                |     |                    |
| <input type="checkbox"/> Health Records <input type="checkbox"/> Other: _____                                                                                                                                                         |  |                |     |                    |
| Last Name:                                                                                                                                                                                                                            |  | First Name:    |     | M.                 |
| Home Address:                                                                                                                                                                                                                         |  | City:          | St: | Zip:               |
| Place of work:                                                                                                                                                                                                                        |  | City:          | St: | Zip:               |
| Phone (H): ( )                                                                                                                                                                                                                        |  | Phone (W): ( ) |     | Date of Birth: / / |

**-Witness Interview-**

|                                                                                                                                                            |  |                |               |                 |
|------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------|---------------|-----------------|
| 1. Tell me what happened:                                                                                                                                  |  |                |               |                 |
|                                                                                                                                                            |  |                |               |                 |
|                                                                                                                                                            |  |                |               |                 |
|                                                                                                                                                            |  |                |               |                 |
|                                                                                                                                                            |  |                |               |                 |
|                                                                                                                                                            |  |                |               |                 |
| 2. Did you notice anything unusual or different about the child in the last 24 hours? <input type="checkbox"/> No <input type="checkbox"/> Yes → Describe: |  |                |               |                 |
|                                                                                                                                                            |  |                |               |                 |
|                                                                                                                                                            |  |                |               |                 |
|                                                                                                                                                            |  |                |               |                 |
|                                                                                                                                                            |  |                |               |                 |
| 3. Did the child experience any falls or injury within the last 72 hours? <input type="checkbox"/> No <input type="checkbox"/> Yes → Describe:             |  |                |               |                 |
|                                                                                                                                                            |  |                |               |                 |
|                                                                                                                                                            |  |                |               |                 |
|                                                                                                                                                            |  |                |               |                 |
|                                                                                                                                                            |  |                |               |                 |
|                                                                                                                                                            |  |                |               |                 |
| 4. When was the child <b>LAST KNOWN ALIVE (LKA)</b> ?                                                                                                      |  | / /            | :             |                 |
|                                                                                                                                                            |  | Month Day Year | Military Time | Location (Room) |
| 5. When was the child <b>FOUND</b> ?                                                                                                                       |  | / /            | :             |                 |
|                                                                                                                                                            |  | Month Day Year | Military Time | Location (Room) |

|                                                                                                                                                                                                                              |                                                                                                                                            |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------|
| 6. Explain how you knew the child was still alive.                                                                                                                                                                           |                                                                                                                                            |
|                                                                                                                                                                                                                              |                                                                                                                                            |
|                                                                                                                                                                                                                              |                                                                                                                                            |
|                                                                                                                                                                                                                              |                                                                                                                                            |
| 7. Describe the child's appearance when found.                                                                                                                                                                               |                                                                                                                                            |
| Describe and specify location:                                                                                                                                                                                               |                                                                                                                                            |
| a) Discoloration around face/nose/mouth                                                                                                                                                                                      | <input type="checkbox"/> Unknown <input type="checkbox"/> No <input type="checkbox"/> Yes                                                  |
| b) Secretions (foam, froth)                                                                                                                                                                                                  | <input type="checkbox"/> Unknown <input type="checkbox"/> No <input type="checkbox"/> Yes                                                  |
| c) Skin discoloration (liver mortis)                                                                                                                                                                                         | <input type="checkbox"/> Unknown <input type="checkbox"/> No <input type="checkbox"/> Yes                                                  |
| d) Pressure marks (pale areas, blanching)                                                                                                                                                                                    | <input type="checkbox"/> Unknown <input type="checkbox"/> No <input type="checkbox"/> Yes                                                  |
| e) Rash or petechiae (small red blood spots on skin, membranes, or eyes)                                                                                                                                                     | <input type="checkbox"/> Unknown <input type="checkbox"/> No <input type="checkbox"/> Yes                                                  |
| f) Marks on body (scratches or bruises)                                                                                                                                                                                      | <input type="checkbox"/> Unknown <input type="checkbox"/> No <input type="checkbox"/> Yes                                                  |
| g) Other                                                                                                                                                                                                                     | <input type="checkbox"/> Unknown <input type="checkbox"/> No <input type="checkbox"/> Yes                                                  |
| 8. What did the child feel like when found? (Check all that apply)                                                                                                                                                           |                                                                                                                                            |
| <input type="checkbox"/> Sweaty <input type="checkbox"/> Limp, flexible <input type="checkbox"/> Warm to touch <input type="checkbox"/> Rigid, stiff <input type="checkbox"/> Cool to touch <input type="checkbox"/> Unknown |                                                                                                                                            |
| <input type="checkbox"/> Other, specify:                                                                                                                                                                                     |                                                                                                                                            |
| 9. Did anyone else other than EMS try to resuscitate the child?                                                                                                                                                              | <input type="checkbox"/> No    Who: _____    When:    /    /    :<br><input type="checkbox"/> Yes    Month    Day    Year    Military Time |
| 10. Please describe what was done as part of the resuscitation:                                                                                                                                                              |                                                                                                                                            |
|                                                                                                                                                                                                                              |                                                                                                                                            |
|                                                                                                                                                                                                                              |                                                                                                                                            |
|                                                                                                                                                                                                                              |                                                                                                                                            |
| 11. Has the parent/caregiver ever had a child die suddenly and unexpectedly? <input type="checkbox"/> No <input type="checkbox"/> Yes → Describe:                                                                            |                                                                                                                                            |
|                                                                                                                                                                                                                              |                                                                                                                                            |
|                                                                                                                                                                                                                              |                                                                                                                                            |
|                                                                                                                                                                                                                              |                                                                                                                                            |

### -Child Medical History-

|                                                                                                                                                                                                                                                        |                                                                                           |                                    |                                                                                           |                        |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------|------------------------------------|-------------------------------------------------------------------------------------------|------------------------|
| 1. Source of medical information:                                                                                                                                                                                                                      |                                                                                           |                                    |                                                                                           |                        |
| <input type="checkbox"/> Doctor <input type="checkbox"/> Other health care provider <input type="checkbox"/> Medical record <input type="checkbox"/> Parent/primary caregiver <input type="checkbox"/> Family <input type="checkbox"/> Other           |                                                                                           |                                    |                                                                                           |                        |
| 2. In the 72 hours prior to death, did the child have:                                                                                                                                                                                                 |                                                                                           |                                    |                                                                                           |                        |
| a) Fever                                                                                                                                                                                                                                               | <input type="checkbox"/> Unknown <input type="checkbox"/> No <input type="checkbox"/> Yes | h) Diarrhea                        | <input type="checkbox"/> Unknown <input type="checkbox"/> No <input type="checkbox"/> Yes |                        |
| b) Excessive sweating                                                                                                                                                                                                                                  | <input type="checkbox"/> Unknown <input type="checkbox"/> No <input type="checkbox"/> Yes | i) Stool changes                   | <input type="checkbox"/> Unknown <input type="checkbox"/> No <input type="checkbox"/> Yes |                        |
| c) Lethargy or sleeping more than usual                                                                                                                                                                                                                | <input type="checkbox"/> Unknown <input type="checkbox"/> No <input type="checkbox"/> Yes | j) Difficulty breathing            | <input type="checkbox"/> Unknown <input type="checkbox"/> No <input type="checkbox"/> Yes |                        |
| d) Fussiness or excessive crying                                                                                                                                                                                                                       | <input type="checkbox"/> Unknown <input type="checkbox"/> No <input type="checkbox"/> Yes | k) Apnea (stopped breathing)       | <input type="checkbox"/> Unknown <input type="checkbox"/> No <input type="checkbox"/> Yes |                        |
| e) Decrease in appetite                                                                                                                                                                                                                                | <input type="checkbox"/> Unknown <input type="checkbox"/> No <input type="checkbox"/> Yes | l) Cyanosis (turned blue/gray)     | <input type="checkbox"/> Unknown <input type="checkbox"/> No <input type="checkbox"/> Yes |                        |
| f) Vomiting                                                                                                                                                                                                                                            | <input type="checkbox"/> Unknown <input type="checkbox"/> No <input type="checkbox"/> Yes | m) Seizures or convulsions         | <input type="checkbox"/> Unknown <input type="checkbox"/> No <input type="checkbox"/> Yes |                        |
| g) Choking                                                                                                                                                                                                                                             | <input type="checkbox"/> Unknown <input type="checkbox"/> No <input type="checkbox"/> Yes | n) Other, specify:                 |                                                                                           |                        |
| 3. In the 72 hours prior to death, was the child injured or did s/he have any other condition(s) not mentioned? <input type="checkbox"/> No <input type="checkbox"/> Yes → Describe:                                                                   |                                                                                           |                                    |                                                                                           |                        |
|                                                                                                                                                                                                                                                        |                                                                                           |                                    |                                                                                           |                        |
|                                                                                                                                                                                                                                                        |                                                                                           |                                    |                                                                                           |                        |
|                                                                                                                                                                                                                                                        |                                                                                           |                                    |                                                                                           |                        |
| 4. In the 72 hours prior to death, was the child given any medications or vaccinations? <input type="checkbox"/> No <input type="checkbox"/> Yes → List Below:<br>(please include any home remedies, herbal medications, over-the-counter medications) |                                                                                           |                                    |                                                                                           |                        |
| Name of medication or vaccination                                                                                                                                                                                                                      | Dose last given                                                                           | Date given<br>Month    Day    Year | Approx. Time<br>Military Time                                                             | Reason given/comments: |
|                                                                                                                                                                                                                                                        |                                                                                           | /    /                             | :                                                                                         |                        |
|                                                                                                                                                                                                                                                        |                                                                                           | /    /                             | :                                                                                         |                        |
|                                                                                                                                                                                                                                                        |                                                                                           | /    /                             | :                                                                                         |                        |
|                                                                                                                                                                                                                                                        |                                                                                           | /    /                             | :                                                                                         |                        |

|                                                                                                                                                                                                                           |                                                                                                                                                                                |                                                                                                                                                                                 |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 5. At any time in the child's life, did s/he have a history of?                                                                                                                                                           |                                                                                                                                                                                | Describe                                                                                                                                                                        |
| a) Allergies (food, medication or other)                                                                                                                                                                                  | <input type="checkbox"/> Unknown <input type="checkbox"/> No <input type="checkbox"/> Yes →                                                                                    |                                                                                                                                                                                 |
| b) Abnormal growth or weight loss/gain                                                                                                                                                                                    | <input type="checkbox"/> Unknown <input type="checkbox"/> No <input type="checkbox"/> Yes →                                                                                    |                                                                                                                                                                                 |
| c) Apnea (stopped breathing)                                                                                                                                                                                              | <input type="checkbox"/> Unknown <input type="checkbox"/> No <input type="checkbox"/> Yes →                                                                                    |                                                                                                                                                                                 |
| d) Cyanosis (turned blue/gray)                                                                                                                                                                                            | <input type="checkbox"/> Unknown <input type="checkbox"/> No <input type="checkbox"/> Yes →                                                                                    |                                                                                                                                                                                 |
| e) Seizures or convulsions                                                                                                                                                                                                | <input type="checkbox"/> Unknown <input type="checkbox"/> No <input type="checkbox"/> Yes →                                                                                    |                                                                                                                                                                                 |
| f) Cardiac (heart) abnormalities                                                                                                                                                                                          | <input type="checkbox"/> Unknown <input type="checkbox"/> No <input type="checkbox"/> Yes →                                                                                    |                                                                                                                                                                                 |
| g) Other                                                                                                                                                                                                                  | <input type="checkbox"/> Unknown <input type="checkbox"/> No <input type="checkbox"/> Yes →                                                                                    |                                                                                                                                                                                 |
| 6. Did the child have any birth defects? <input type="checkbox"/> No <input type="checkbox"/> Yes → Describe:                                                                                                             |                                                                                                                                                                                |                                                                                                                                                                                 |
|                                                                                                                                                                                                                           |                                                                                                                                                                                |                                                                                                                                                                                 |
|                                                                                                                                                                                                                           |                                                                                                                                                                                |                                                                                                                                                                                 |
|                                                                                                                                                                                                                           |                                                                                                                                                                                |                                                                                                                                                                                 |
| 7. Describe the two most recent times that the child was seen by a physician or health care provider: (Include emergency department visits, clinic visits, hospital admissions, observational stays, and telephone calls) |                                                                                                                                                                                |                                                                                                                                                                                 |
| a) Date                                                                                                                                                                                                                   | <div style="text-align: center;">First most recent visit</div> <div style="text-align: center;">____/____/____</div> <div style="text-align: center;">Month   Day   Year</div> | <div style="text-align: center;">Second most recent visit</div> <div style="text-align: center;">____/____/____</div> <div style="text-align: center;">Month   Day   Year</div> |
| b) Reason for visit:                                                                                                                                                                                                      |                                                                                                                                                                                |                                                                                                                                                                                 |
| c) Action taken:                                                                                                                                                                                                          |                                                                                                                                                                                |                                                                                                                                                                                 |
| d) Physician's Name:                                                                                                                                                                                                      |                                                                                                                                                                                |                                                                                                                                                                                 |
| e) Hospital/Clinic:                                                                                                                                                                                                       |                                                                                                                                                                                |                                                                                                                                                                                 |
| f) Address:                                                                                                                                                                                                               |                                                                                                                                                                                |                                                                                                                                                                                 |
| g) City, Zip code:                                                                                                                                                                                                        |                                                                                                                                                                                |                                                                                                                                                                                 |
| f) Phone number:                                                                                                                                                                                                          | (   )   -                                                                                                                                                                      | (   )   -                                                                                                                                                                       |
| 8. Birth Hospital Name:                                                                                                                                                                                                   |                                                                                                                                                                                |                                                                                                                                                                                 |
| Street Address:                                                                                                                                                                                                           |                                                                                                                                                                                |                                                                                                                                                                                 |
| City:                                                                                                                                                                                                                     | State:                                                                                                                                                                         | Zip code:                                                                                                                                                                       |

### -Incident Scene Investigation-

|                                                                                                                                                                                |                                                  |                                                          |                                             |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------|----------------------------------------------------------|---------------------------------------------|
| 1. Where did the incident or death occur?                                                                                                                                      |                                                  |                                                          |                                             |
|                                                                                                                                                                                |                                                  |                                                          |                                             |
| 2. Was this the primary residence? <input type="checkbox"/> No <input type="checkbox"/> Yes                                                                                    |                                                  |                                                          |                                             |
| 3. Is the site of the incident or death scene a daycare or other childcare setting? <input type="checkbox"/> Yes <input type="checkbox"/> No → Skip to question <b>8</b> below |                                                  |                                                          |                                             |
| 4. How many children were under the care of the provider at the time of the incident or death? _____ (Under 18 years old)                                                      |                                                  |                                                          |                                             |
| 5. How many adults were supervising the child(ren)? _____ (18 years or older)                                                                                                  |                                                  |                                                          |                                             |
| 6. What is the license number and licensing agency for the daycare?                                                                                                            |                                                  |                                                          |                                             |
| License Number:                                                                                                                                                                |                                                  | Agency:                                                  |                                             |
| 7. How long has the daycare been open for business?                                                                                                                            |                                                  |                                                          |                                             |
| 8. How many people live at the site of the incident or death scene?                                                                                                            |                                                  |                                                          |                                             |
| Number of adults (18 years or older):                                                                                                                                          |                                                  | Number of children (under 18 years old):                 |                                             |
| 9. Which of the following heating or cooling sources were being used? (Check all that apply)                                                                                   |                                                  |                                                          |                                             |
| <input type="checkbox"/> Central air                                                                                                                                           | <input type="checkbox"/> Window fan              | <input type="checkbox"/> Electric (radiant) ceiling heat | <input type="checkbox"/> Open window(s)     |
| <input type="checkbox"/> A/C window unit                                                                                                                                       | <input type="checkbox"/> Gas furnace or boiler   | <input type="checkbox"/> Wood burning fireplace          | <input type="checkbox"/> Wood burning stove |
| <input type="checkbox"/> Ceiling fan                                                                                                                                           | <input type="checkbox"/> Electric space heater   | <input type="checkbox"/> Coal burning furnace            | <input type="checkbox"/> Unknown            |
| <input type="checkbox"/> Floor/table fan                                                                                                                                       | <input type="checkbox"/> Electric baseboard heat | <input type="checkbox"/> Kerosene space heater           |                                             |
| <input type="checkbox"/> Other, specify:                                                                                                                                       |                                                  |                                                          |                                             |
| 10. Describe the general appearance of the incident scene: (ex. Cleanliness, hazards, overcrowding, etc.)                                                                      |                                                  |                                                          |                                             |
|                                                                                                                                                                                |                                                  |                                                          |                                             |
|                                                                                                                                                                                |                                                  |                                                          |                                             |
|                                                                                                                                                                                |                                                  |                                                          |                                             |

### -Investigation Summary-

1. Are there any factors, circumstances, or environmental concerns about the incident scene investigation that may have impacted the child that have not yet been identified?

|  |
|--|
|  |
|  |
|  |

2. Arrival times:

|                           |   |               |               |   |               |                    |   |               |
|---------------------------|---|---------------|---------------|---|---------------|--------------------|---|---------------|
| Law enforcement at scene: | : |               | DSI at scene: | : |               | Child at hospital: | : |               |
|                           |   | Military time |               |   | Military time |                    |   | Military time |

### -Investigator's Notes-

Indicate the task(s) performed:

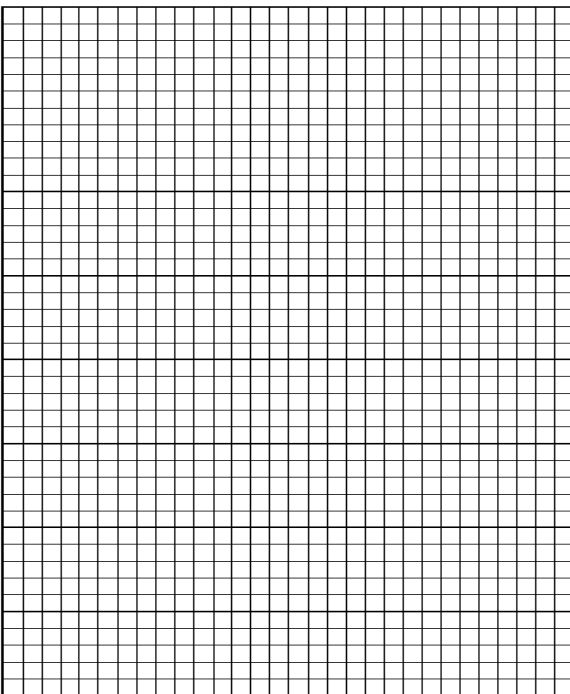
|                                                                    |                                                             |                                                          |
|--------------------------------------------------------------------|-------------------------------------------------------------|----------------------------------------------------------|
| <input type="checkbox"/> Additional scenes(s)? (Forms attached)    | <input type="checkbox"/> Doll reenactment/scene re-creation | <input type="checkbox"/> Photos or video taken and noted |
| <input type="checkbox"/> Materials collected/evidence logged       | <input type="checkbox"/> Referral for counseling            | <input type="checkbox"/> EMS run sheet/report            |
| <input type="checkbox"/> Notify next of kin or verify notification | <input type="checkbox"/> 911 tape                           |                                                          |
| <input type="checkbox"/> Other (explain)                           |                                                             |                                                          |

If more than one person was interviewed, does the information differ? ☐ No ☐ Yes → Detail any differences, inconsistencies of relevant information: (ex. Placed on sofa, last known alive on chair)

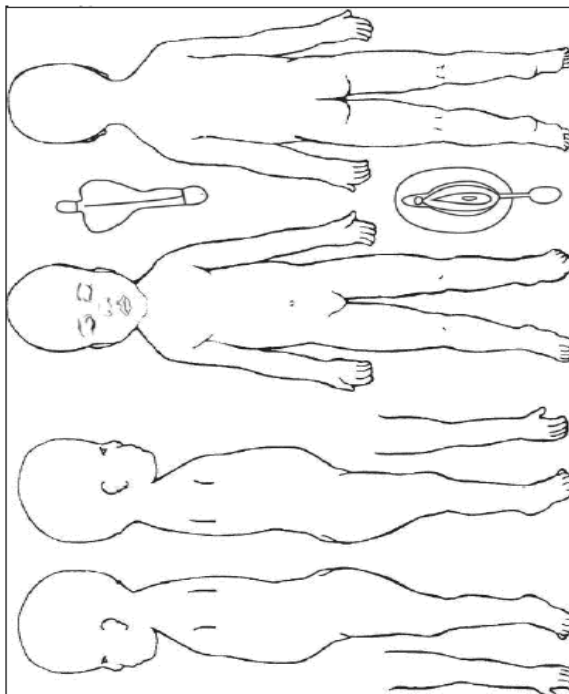
|  |
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|  |

### -Investigation Diagrams-

Scene Diagram:



Body Diagram:



Lead Death Investigator or Designee:

|            |        |       |
|------------|--------|-------|
| Signature: | Title: | Date: |
| Signature: | Title: | Date: |

### -Summary for Pathologist-

|                      |                                                                                                                                                                |  |                                                                                                           |  |               |                            |                               |    |                              |       |
|----------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------|--|---------------|----------------------------|-------------------------------|----|------------------------------|-------|
| Case Information     | <b>Investigator Information:</b>                                                                                                                               |  |                                                                                                           |  |               |                            |                               |    |                              |       |
|                      | Name:                                                                                                                                                          |  |                                                                                                           |  |               | Agency:                    |                               |    | Phone:                       |       |
|                      | Investigated:                                                                                                                                                  |  | / /                                                                                                       |  | :             |                            | Pronounced dead:              |    | / / :                        |       |
|                      |                                                                                                                                                                |  | Month Day Year                                                                                            |  | Military Time |                            |                               |    | Month Day Year Military Time |       |
|                      |                                                                                                                                                                |  |                                                                                                           |  |               |                            |                               |    |                              |       |
| Case Information     | <b>Child Information:</b>                                                                                                                                      |  |                                                                                                           |  |               |                            |                               |    |                              |       |
|                      | Last Name:                                                                                                                                                     |  |                                                                                                           |  | First:        |                            |                               | M. |                              | Case# |
|                      | Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female                                                                                             |  | Date of Birth: / /                                                                                        |  |               |                            | Age: _____ Years _____ Months |    |                              |       |
|                      | Race: <input type="checkbox"/> White <input type="checkbox"/> Black/African Am. <input type="checkbox"/> Asian/Pacific Islander <input type="checkbox"/> Other |  |                                                                                                           |  |               |                            |                               |    |                              |       |
|                      | Ethnicity: <input type="checkbox"/> Hispanic/Latino                                                                                                            |  |                                                                                                           |  |               |                            |                               |    |                              |       |
| Sleeping Environment | <b>1. Indicate whether preliminary investigation suggests any of the following:</b>                                                                            |  |                                                                                                           |  |               |                            |                               |    |                              |       |
|                      | <input type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                       |  | Asphyxia (ex. Wedging, choking, nose/mouth obstruction, neck compression, immersion in water)             |  |               |                            |                               |    |                              |       |
|                      | <input type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                       |  | Hyperthermia/Hypothermia (ex. Hot or cold environments)                                                   |  |               |                            |                               |    |                              |       |
|                      | <input type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                       |  | Environmental hazards (ex. Carbon monoxide, noxious gases, chemicals, drugs, devices)                     |  |               |                            |                               |    |                              |       |
|                      |                                                                                                                                                                |  |                                                                                                           |  |               |                            |                               |    |                              |       |
| Child History        | <input type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                       |  | Recent hospitalization                                                                                    |  |               |                            |                               |    |                              |       |
|                      | <input type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                       |  | Previous medical diagnosis                                                                                |  |               |                            |                               |    |                              |       |
|                      | <input type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                       |  | History of acute life-threatening events (ex. Apnea, seizures, difficulty breathing)                      |  |               |                            |                               |    |                              |       |
|                      | <input type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                       |  | History of medical care without diagnosis                                                                 |  |               |                            |                               |    |                              |       |
|                      | <input type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                       |  | Recent fall or other injury                                                                               |  |               |                            |                               |    |                              |       |
| Family Info          | <input type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                       |  | Cause of death due to natural causes other than SIDS (ex. Birth defects, complications of pre-term birth) |  |               |                            |                               |    |                              |       |
|                      | <input type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                       |  | Prior sibling deaths                                                                                      |  |               |                            |                               |    |                              |       |
|                      | <input type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                       |  | Previous encounters with police or social service agencies                                                |  |               |                            |                               |    |                              |       |
|                      | <input type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                       |  | Request for tissue or organ donation                                                                      |  |               |                            |                               |    |                              |       |
|                      | <input type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                       |  | Objection to autopsy                                                                                      |  |               |                            |                               |    |                              |       |
| Exam                 | <input type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                       |  | Pre-terminal resuscitative treatment                                                                      |  |               |                            |                               |    |                              |       |
|                      | <input type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                       |  | Death due to trauma (injury), poisoning, or intoxication                                                  |  |               |                            |                               |    |                              |       |
| Investigator Insight | <b>Any "Yes" answers should be explained and detailed. Brief description of circumstances:</b>                                                                 |  |                                                                                                           |  |               |                            |                               |    |                              |       |
|                      |                                                                                                                                                                |  |                                                                                                           |  |               |                            |                               |    |                              |       |
|                      |                                                                                                                                                                |  |                                                                                                           |  |               |                            |                               |    |                              |       |
|                      |                                                                                                                                                                |  |                                                                                                           |  |               |                            |                               |    |                              |       |
|                      |                                                                                                                                                                |  |                                                                                                           |  |               |                            |                               |    |                              |       |
|                      |                                                                                                                                                                |  |                                                                                                           |  |               |                            |                               |    |                              |       |
|                      |                                                                                                                                                                |  |                                                                                                           |  |               |                            |                               |    |                              |       |
|                      |                                                                                                                                                                |  |                                                                                                           |  |               |                            |                               |    |                              |       |
|                      |                                                                                                                                                                |  |                                                                                                           |  |               |                            |                               |    |                              |       |
|                      |                                                                                                                                                                |  |                                                                                                           |  |               |                            |                               |    |                              |       |
| Pathologist          | <b>2. Pathologist Information:</b>                                                                                                                             |  |                                                                                                           |  |               |                            |                               |    |                              |       |
|                      | Name:                                                                                                                                                          |  |                                                                                                           |  |               | Agency:                    |                               |    |                              |       |
|                      | Phone: (     ) -     -     -                                                                                                                                   |  |                                                                                                           |  |               | Fax: (     ) -     -     - |                               |    |                              |       |





Saving Lives Together

# CDR REPORT FORM

*Version 6.1*

## National Fatality Review Case Reporting System

Data Entry Website: [data.ncfrp.org](http://data.ncfrp.org)

Phone: 800-656-2434

Email: [info@ncfrp.org](mailto:info@ncfrp.org)

[ncfrp.org](http://ncfrp.org)



[@nationalcfrp](https://twitter.com/nationalcfrp)



# SAVING LIVES TOGETHER

## Instructions:

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

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

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

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

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

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

## Reminder:

Enter identifiable information (**names, dates, addresses, counties**) into the NFR-CRS if your state/local policy allows. Follow your state laws in regards to reporting psychological, substance abuse and HIV/AIDS status. Please check with your fatality review coordinator if you are unsure. For other text fields, such as the **Narrative section or any "specify" or "describe" fields**, do not include specific names, dates of birth, dates of death, references to specific counties, practitioners, or facility names in these text fields. Examples: "Evans County EMS" should be "EMS"; "Evans County Children's Hospital" should be "the children's hospital." **Why this reminder?** Text fields may be shared with approved researchers as noted in the Data Use Agreement in your state or jurisdiction. Therefore, entering identified data into those fields would compromise your responsibility under HIPAA.

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

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| CASE NUMBER                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                                                                                                                                             |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| _____ / _____ / _____ / _____<br>State / County or Team Number / Year of Review / Sequence of Review                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                             | Case Type: <input type="radio"/> Death<br><input type="radio"/> Near death/serious injury<br><input type="radio"/> Not born alive (fetal/stillborn)<br><input type="checkbox"/> Child never left hospital following birth                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | Death Certificate Number:<br>Birth Certificate Number:<br>ME/Coroner Number:<br>Date Team Notified of Death:                                                                                                                |
| A. CHILD INFORMATION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                                                                                                                                             |
| A1. CHILD INFORMATION (COMPLETE FOR ALL AGES) <span style="float: right; font-size: small;">A + symbol means that the question is skipped for fetal deaths.</span>                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                                                                                                                                             |
| 1. Child's name:    First: _____    Middle: _____    Last: _____ <input type="checkbox"/> U/K                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                                                                                                                                             |
| 2. Date of birth: <input type="checkbox"/> U/K<br>_____ / _____ / _____<br>mm    dd    yyyy                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | 3. Date of death: <input type="checkbox"/> U/K<br>_____ / _____ / _____<br>mm    dd    yyyy | 5. Race, check all that apply:<br><input type="checkbox"/> Alaska Native, Tribe: _____ <input type="checkbox"/> Native Hawaiian<br><input type="checkbox"/> Pacific Islander, specify: _____<br><input type="checkbox"/> American Indian, Tribe: _____ <input type="checkbox"/> White<br><input type="checkbox"/> Asian, specify: _____ <input type="checkbox"/> U/K<br><input type="checkbox"/> Black                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | 6. Hispanic or Latino/a origin?<br><input type="radio"/> Yes<br><input type="radio"/> No<br><input type="radio"/> U/K<br>7. Sex:<br><input type="radio"/> Male<br><input type="radio"/> Female<br><input type="radio"/> U/K |
| 4. Age*: <input type="radio"/> Years <input type="radio"/> Hours<br><input type="radio"/> Months <input type="radio"/> Minutes<br><input type="radio"/> Days <input type="radio"/> U/K                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                             | 8. Residence address: <input type="checkbox"/> U/K<br>Street: _____ Apt. _____<br>City: _____<br>State: _____ Zip: _____ County: _____                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                                                                                                                                             |
| 9. Child's weight at death*: <input type="checkbox"/> U/K<br><input type="radio"/> Pounds/ounces _____<br><input type="radio"/> Grams/kilograms _____                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                             | 10. Child's height at death*: <input type="checkbox"/> U/K<br><input type="radio"/> Feet/inches _____<br><input type="radio"/> Cm _____                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                                                                                                                                             |
| 11. State of death: _____                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                             | 12. County of death: _____                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                             |
| 13. Child had disability or chronic illness*?<br><input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K<br>If yes, check all that apply:<br><input type="checkbox"/> Physical/orthopedic, specify:<br><input type="checkbox"/> Mental health/substance abuse, specify:<br><input type="checkbox"/> Cognitive/intellectual, specify:<br><input type="checkbox"/> Sensory, specify:<br><input type="checkbox"/> U/K<br>If yes, was child receiving Children's Special Health Care Needs services? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K |                                                                                             | 14. Were any siblings placed outside of the home prior to this child's death?<br><input type="radio"/> N/A <input type="radio"/> Yes, # _____ <input type="radio"/> No <input type="radio"/> U/K<br>15. Child's health insurance, check all that apply*:<br><input type="checkbox"/> None <input type="checkbox"/> Medicaid <input type="checkbox"/> Indian Health Service <input type="checkbox"/> U/K<br><input type="checkbox"/> Private <input type="checkbox"/> State plan <input type="checkbox"/> Other, specify:<br>16. Was the child up to date with the Centers for Disease Control and Prevention (CDC) immunization schedule*?<br><input type="radio"/> NA <input type="radio"/> Yes <input type="radio"/> No, specify: _____ <input type="radio"/> U/K<br>17. Household income:<br><input type="radio"/> High <input type="radio"/> Medium <input type="radio"/> Low <input type="radio"/> U/K |                                                                                                                                                                                                                             |
| If the child never left the hospital following birth, go to A2.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                                                                                                                                             |
| 18. Type of residence:<br><input checked="" type="radio"/> Parental home <input type="radio"/> Relative home <input type="radio"/> Jail/detention<br><input type="radio"/> Licensed group home <input type="radio"/> Living on own <input type="radio"/> Other, specify:<br><input type="radio"/> Licensed foster home <input type="radio"/> Shelter<br><input type="radio"/> Relative foster home <input type="radio"/> Homeless <input type="radio"/> U/K                                                                                                                                        |                                                                                             | 19. New residence in past 30 days?<br><input type="radio"/> Yes<br><input type="radio"/> No<br><input type="radio"/> U/K                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                                                                                                                             |
| 20. Residence overcrowded?<br><input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                             | 21. Child ever homeless?<br><input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                                                                                                                             |
| 22. Number of other children living with child:<br>_____ <input type="checkbox"/> U/K                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                             | 23. Child had history of child maltreatment as victim?<br><input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K<br>If yes, check all that apply:<br><input type="checkbox"/> Physical<br><input type="checkbox"/> Neglect<br><input type="checkbox"/> Sexual<br><input type="checkbox"/> Emotional/psychological<br><input type="checkbox"/> U/K<br>If yes, how was history identified:<br><input type="radio"/> Through CPS<br><input type="radio"/> Other sources<br>If through CPS:<br>_____ # CPS referrals<br>_____ # Substantiations                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                                                                                                             |
| 24. Was there an open CPS case with child at time of death?<br><input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                             | 25. Was child ever placed outside of the home prior to the death? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                                                                                                             |
| 26. How many months prior to death did child last have contact with a health care provider? _____                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                             | 27. Child's highest education level:<br><input type="radio"/> N/A <input type="radio"/> Home schooled, 9-12<br><input type="radio"/> None <input type="radio"/> Drop out<br><input type="radio"/> Preschool <input type="radio"/> HS graduate/GED<br><input type="radio"/> Grade K-8 <input type="radio"/> College<br><input type="radio"/> Grade 9-12 <input type="radio"/> U/K<br><input type="radio"/> Home schooled, K-8                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                                                                                                             |
| A2. COMPLETE FOR CHILDREN OVER ONE YEAR OLD                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                                                                                                                                             |
| 28. Child's work status:<br><input type="radio"/> N/A<br><input type="radio"/> Employed<br><input type="radio"/> Not working<br><input type="radio"/> U/K                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                             | 29. Did child have problems in school?<br><input type="radio"/> N/A <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K<br>If yes, check all that apply:<br><input type="checkbox"/> Academic <input type="checkbox"/> Expulsion<br><input type="checkbox"/> Truancy <input type="checkbox"/> Other, specify:<br><input type="checkbox"/> Suspensions<br><input type="checkbox"/> Behavioral <input type="checkbox"/> U/K                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                                                                                                                                             |
| 30. Child had history of intimate partner violence?<br>Check all that apply:<br><input type="checkbox"/> N/A<br><input type="checkbox"/> Yes, as victim<br><input type="checkbox"/> Yes, as perpetrator<br><input type="checkbox"/> No<br><input type="checkbox"/> U/K                                                                                                                                                                                                                                                                                                                             |                                                                                             | 31. Child's highest education level:<br><input type="radio"/> N/A <input type="radio"/> Home schooled, 9-12<br><input type="radio"/> None <input type="radio"/> Drop out<br><input type="radio"/> Preschool <input type="radio"/> HS graduate/GED<br><input type="radio"/> Grade K-8 <input type="radio"/> College<br><input type="radio"/> Grade 9-12 <input type="radio"/> U/K<br><input type="radio"/> Home schooled, K-8                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                                                                                                             |

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        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| <p>31. Child had received prior mental health services? <br/> <input type="radio"/> N/A <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K<br/>         If yes, check all that apply:<br/> <input type="checkbox"/> Outpatient<br/> <input type="checkbox"/> Day treatment/partial hospitalization<br/> <input type="checkbox"/> Residential</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | <p>33. Child on medications for mental health illness? <br/> <input type="radio"/> N/A <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | <p>35. Child was hospitalized for mental health care within the previous 12 months? <br/> <input type="radio"/> N/A <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K<br/>         If yes, did the child have a follow-up mental health appointment within 30 days of discharge from the hospital? <br/> <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K</p>                                                                                                                                                                                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| <p>32. Child was receiving mental health services? <br/> <input type="radio"/> N/A <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K<br/>         If yes, check all that apply:<br/> <input type="checkbox"/> Outpatient <input type="checkbox"/> Residential<br/> <input type="checkbox"/> Day treatment/partial hospitalization</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | <p>34. Child had emergency department visit for mental health care within the previous 12 months? <br/> <input type="radio"/> N/A <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K<br/>         If yes, did the child have a follow-up mental health appointment within 30 days of emergency department visit? <br/> <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K</p>                                                                                                                                                                                                         | <p>36. Issues prevented child from receiving mental health services? <br/> <input type="radio"/> N/A <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K<br/>         If yes, specify:</p>                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| <p>37. Child had history of substance use or abuse? <br/> <input type="radio"/> N/A <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K<br/>         If yes, check all that apply:<br/> <input type="checkbox"/> Alcohol <input type="checkbox"/> Prescription drugs, specify:<br/> <input type="checkbox"/> Cocaine <input type="checkbox"/> Over-the-counter drugs, specify:<br/> <input type="checkbox"/> Marijuana <input type="checkbox"/> Tobacco/nicotine, specify type:<br/> <input type="checkbox"/> Methamphetamine <input type="checkbox"/> Other, specify:<br/> <input type="checkbox"/> Opioids <input type="checkbox"/> U/K<br/>         If yes, did the child receive treatment? <br/> <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K<br/>         If yes, type? Check all that apply:<br/> <input type="checkbox"/> Outpatient <input type="checkbox"/> Day treatment/partial hospital<br/> <input type="checkbox"/> Inpatient/detox <input type="checkbox"/> Residential<br/>         If yes, age at first use: _____ <input type="checkbox"/> U/K</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | <p>38. Child had delinquent or criminal history? <br/> <input type="radio"/> N/A <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K<br/>         If yes, check all that apply:<br/> <input type="checkbox"/> Assault <input type="checkbox"/> Weapon<br/> <input type="checkbox"/> Robbery/theft offense<br/> <input type="checkbox"/> Drugs/alcohol <input type="checkbox"/> Other, specify:<br/> <input type="checkbox"/> Misbehavior <input type="checkbox"/> U/K<br/>         (truancy, destruction of property, trespassing)</p>                                                                           | <p>41. What was child's gender identity?<br/> <input type="radio"/> No identity expressed<br/> <input type="radio"/> Male, not transgender<br/> <input type="radio"/> Female, not transgender<br/> <input type="radio"/> Transgender male<br/> <input type="radio"/> Transgender female<br/> <input type="radio"/> Non-binary<br/> <input type="radio"/> Other, specify:<br/> <input type="radio"/> U/K</p>                                                                                                                                                                                                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| <p>39. Child spent time in juvenile detention? <br/> <input type="radio"/> N/A <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | <p>40. Child acutely ill in the two weeks before death? <br/> <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | <p>42. What was child's sexual orientation?<br/> <input type="radio"/> No orientation expressed<br/> <input type="radio"/> Straight/heterosexual <input type="radio"/> Questioning<br/> <input type="radio"/> Gay/lesbian <input type="radio"/> Other, specify:<br/> <input type="radio"/> Bisexual <input type="radio"/> U/K</p>                                                                                                                                                                                                                                                                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| <p><b>A3. COMPLETE FOR ALL FETAL/INFANTS UNDER ONE YEAR</b> A + symbol means that the question is skipped for fetal deaths.</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    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| <p>43. Was this case reviewed by both a Fetal/Infant Mortality Review (FIMR) and Child Death Review (CDR/CFR) team? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            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| <p>44. Gestational age: <br/> <input type="checkbox"/> U/K<br/>         _____ # weeks</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | <p>45. Birth weight: <input type="checkbox"/> U/K<br/> <input type="radio"/> Grams/kilograms _____<br/> <input type="radio"/> Pounds/ounces _____</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | <p>46. Multiple gestation pregnancy?<br/> <input type="radio"/> Yes, # of fetuses _____<br/> <input type="radio"/> No <input type="radio"/> U/K</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| <p>47. Including the deceased infant, how many pregnancies did the childbearing parent have? # _____ <input type="checkbox"/> U/K</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           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| <p>48. Including the deceased infant, how many live births did the childbearing parent have? # _____ <input type="checkbox"/> U/K</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | <p>49. Not including the deceased infant, number of children childbearing parent still has living? <br/>         # _____ <input type="checkbox"/> U/K</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| <p>50. Prenatal care provided during pregnancy of deceased infant? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K<br/>         If yes, number of prenatal visits kept: # _____ <input type="checkbox"/> U/K<br/>         If yes, what month of pregnancy for first prenatal visit kept. Specify 1-9: _____ <input type="checkbox"/> U/K</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      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| <p>51. Were there access or barrier issues related to prenatal care? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K If yes, check all that apply:<br/> <input type="checkbox"/> Lack of money for care <input type="checkbox"/> Couldn't get provider to take as patient <input type="checkbox"/> Services not available <input type="checkbox"/> Other, specify:<br/> <input type="checkbox"/> Limitations of health insurance coverage <input type="checkbox"/> Multiple providers, not coordinated <input type="checkbox"/> Distrust of health care system<br/> <input type="checkbox"/> Lack of transportation <input type="checkbox"/> Couldn't get an earlier appointment <input type="checkbox"/> Unwilling to obtain care <input type="checkbox"/> U/K<br/> <input type="checkbox"/> Cultural differences <input type="checkbox"/> Lack of child care <input type="checkbox"/> Didn't know where to go<br/> <input type="checkbox"/> Language barriers <input type="checkbox"/> Lack of family/social support <input type="checkbox"/> Didn't think they were pregnant</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     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| <p>52. During pregnancy, did the childbearing parent have any medical conditions/complications? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K If yes, check all that apply:</p> <table style="width:100%; border: none;"> <tr> <td style="vertical-align: top;"> <p><u>Cardiovascular</u></p> <input type="checkbox"/> Hypertension - gestational<br/> <input type="checkbox"/> Hypertension - chronic<br/> <input type="checkbox"/> Pre-eclampsia<br/> <input type="checkbox"/> Eclampsia<br/> <input type="checkbox"/> Clotting disorder <p><u>Hematologic</u></p> <input type="checkbox"/> Sickle cell disease<br/> <input type="checkbox"/> Anemia (iron deficiency) <p><u>Respiratory</u></p> <input type="checkbox"/> Asthma <p><u>Endocrine/Metabolic</u></p> <input type="checkbox"/> Diabetes, type 1 chronic<br/> <input type="checkbox"/> Diabetes, type 2 chronic<br/> <input type="checkbox"/> Diabetes, gestational<br/> <input type="checkbox"/> Thyroid<br/> <input type="checkbox"/> Polycystic ovarian disease </td> <td style="vertical-align: top;"> <p><u>Neurologic/Psychiatric</u></p> <input type="checkbox"/> Addiction disorder<br/> <input type="checkbox"/> Depression<br/> <input type="checkbox"/> Anxiety disorder<br/> <input type="checkbox"/> Seizure disorder <p><u>Sexually Transmitted Infection (STI)</u></p> <input type="checkbox"/> Bacterial vaginosis (BV)<br/> <input type="checkbox"/> Chlamydia<br/> <input type="checkbox"/> Gonorrhea<br/> <input type="checkbox"/> Herpes<br/> <input type="checkbox"/> HPV<br/> <input type="checkbox"/> Syphilis<br/> <input type="checkbox"/> Group B strep<br/> <input type="checkbox"/> HIV/AIDS<br/> <input type="checkbox"/> Other STI, specify: </td> <td style="vertical-align: top;"> <p><u>Gynecologic</u></p> <input type="checkbox"/> Uterine/vaginal bleeding<br/> <input type="checkbox"/> Chorioamnionitis<br/> <input type="checkbox"/> Oligohydramnios<br/> <input type="checkbox"/> Polyhydramnios<br/> <input type="checkbox"/> Intrauterine growth restriction (IUGR)<br/> <input type="checkbox"/> Premature rupture of membranes (PROM)<br/> <input type="checkbox"/> Preterm premature rupture of membranes (PPROM)<br/> <input type="checkbox"/> Cervical Insufficiency <p><u>Umbilical cord complications</u></p> <input type="checkbox"/> Prolapse<br/> <input type="checkbox"/> Nuchal cord<br/> <input type="checkbox"/> Other cord, specify: </td> <td style="vertical-align: top;"> <p><u>Gynecologic (continued)</u></p> <p><u>Placental problems</u></p> <input type="checkbox"/> Abruptio<br/> <input type="checkbox"/> Previa<br/> <input type="checkbox"/> Other placental, specify: <p><u>Other Condition/Complication</u></p> <input type="checkbox"/> UTI<br/> <input type="checkbox"/> Decreased fetal movement<br/> <input type="checkbox"/> HELLP syndrome<br/> <input type="checkbox"/> CBP developmental delay<br/> <input type="checkbox"/> Oral health/dental or gum infection<br/> <input type="checkbox"/> Gastrointestinal<br/> <input type="checkbox"/> CBP genetic disorder<br/> <input type="checkbox"/> Abnormal MSAFP<br/> <input type="checkbox"/> Preterm labor<br/> <input type="checkbox"/> Obesity<br/> <input type="checkbox"/> Other, specify: </td> </tr> </table> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | <p><u>Cardiovascular</u></p> <input type="checkbox"/> Hypertension - gestational<br><input type="checkbox"/> Hypertension - chronic<br><input type="checkbox"/> Pre-eclampsia<br><input type="checkbox"/> Eclampsia<br><input type="checkbox"/> Clotting disorder <p><u>Hematologic</u></p> <input type="checkbox"/> Sickle cell disease<br><input type="checkbox"/> Anemia (iron deficiency) <p><u>Respiratory</u></p> <input type="checkbox"/> Asthma <p><u>Endocrine/Metabolic</u></p> <input type="checkbox"/> Diabetes, type 1 chronic<br><input type="checkbox"/> Diabetes, type 2 chronic<br><input type="checkbox"/> Diabetes, gestational<br><input type="checkbox"/> Thyroid<br><input type="checkbox"/> Polycystic ovarian disease                    | <p><u>Neurologic/Psychiatric</u></p> <input type="checkbox"/> Addiction disorder<br><input type="checkbox"/> Depression<br><input type="checkbox"/> Anxiety disorder<br><input type="checkbox"/> Seizure disorder <p><u>Sexually Transmitted Infection (STI)</u></p> <input type="checkbox"/> Bacterial vaginosis (BV)<br><input type="checkbox"/> Chlamydia<br><input type="checkbox"/> Gonorrhea<br><input type="checkbox"/> Herpes<br><input type="checkbox"/> HPV<br><input type="checkbox"/> Syphilis<br><input type="checkbox"/> Group B strep<br><input type="checkbox"/> HIV/AIDS<br><input type="checkbox"/> Other STI, specify: | <p><u>Gynecologic</u></p> <input type="checkbox"/> Uterine/vaginal bleeding<br><input type="checkbox"/> Chorioamnionitis<br><input type="checkbox"/> Oligohydramnios<br><input type="checkbox"/> Polyhydramnios<br><input type="checkbox"/> Intrauterine growth restriction (IUGR)<br><input type="checkbox"/> Premature rupture of membranes (PROM)<br><input type="checkbox"/> Preterm premature rupture of membranes (PPROM)<br><input type="checkbox"/> Cervical Insufficiency <p><u>Umbilical cord complications</u></p> <input type="checkbox"/> Prolapse<br><input type="checkbox"/> Nuchal cord<br><input type="checkbox"/> Other cord, specify: | <p><u>Gynecologic (continued)</u></p> <p><u>Placental problems</u></p> <input type="checkbox"/> Abruptio<br><input type="checkbox"/> Previa<br><input type="checkbox"/> Other placental, specify: <p><u>Other Condition/Complication</u></p> <input type="checkbox"/> UTI<br><input type="checkbox"/> Decreased fetal movement<br><input type="checkbox"/> HELLP syndrome<br><input type="checkbox"/> CBP developmental delay<br><input type="checkbox"/> Oral health/dental or gum infection<br><input type="checkbox"/> Gastrointestinal<br><input type="checkbox"/> CBP genetic disorder<br><input type="checkbox"/> Abnormal MSAFP<br><input type="checkbox"/> Preterm labor<br><input type="checkbox"/> Obesity<br><input type="checkbox"/> Other, specify: |
| <p><u>Cardiovascular</u></p> <input type="checkbox"/> Hypertension - gestational<br><input type="checkbox"/> Hypertension - chronic<br><input type="checkbox"/> Pre-eclampsia<br><input type="checkbox"/> Eclampsia<br><input type="checkbox"/> Clotting disorder <p><u>Hematologic</u></p> <input type="checkbox"/> Sickle cell disease<br><input type="checkbox"/> Anemia (iron deficiency) <p><u>Respiratory</u></p> <input type="checkbox"/> Asthma <p><u>Endocrine/Metabolic</u></p> <input type="checkbox"/> Diabetes, type 1 chronic<br><input type="checkbox"/> Diabetes, type 2 chronic<br><input type="checkbox"/> Diabetes, gestational<br><input type="checkbox"/> Thyroid<br><input type="checkbox"/> Polycystic ovarian disease                                                                                                                                                                                                                                                                                          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Oligohydramnios<br><input type="checkbox"/> Polyhydramnios<br><input type="checkbox"/> Intrauterine growth restriction (IUGR)<br><input type="checkbox"/> Premature rupture of membranes (PROM)<br><input type="checkbox"/> Preterm premature rupture of membranes (PPROM)<br><input type="checkbox"/> Cervical Insufficiency <p><u>Umbilical cord complications</u></p> <input type="checkbox"/> Prolapse<br><input type="checkbox"/> Nuchal cord<br><input type="checkbox"/> Other cord, specify: | <p><u>Gynecologic (continued)</u></p> <p><u>Placental problems</u></p> <input type="checkbox"/> Abruptio<br><input type="checkbox"/> Previa<br><input type="checkbox"/> Other placental, specify: <p><u>Other Condition/Complication</u></p> <input type="checkbox"/> UTI<br><input type="checkbox"/> Decreased fetal movement<br><input type="checkbox"/> HELLP syndrome<br><input type="checkbox"/> CBP developmental delay<br><input type="checkbox"/> Oral health/dental or gum infection<br><input type="checkbox"/> Gastrointestinal<br><input type="checkbox"/> CBP genetic disorder<br><input type="checkbox"/> Abnormal MSAFP<br><input type="checkbox"/> Preterm labor<br><input type="checkbox"/> Obesity<br><input type="checkbox"/> Other, specify: |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                                     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| 53. Did the childbearing parent experience any medical complications in previous pregnancies?<br><input type="radio"/> N/A <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K <input type="checkbox"/> Previous preterm birth <input type="checkbox"/> Previous small for gestational age<br>If yes, check all that apply: <input type="checkbox"/> Previous low birth weight birth <input type="checkbox"/> Previous large for gestational age (greater than 4000 grams)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                                                                                                                                                                                                                               |
| 54. Did the childbearing parent use any medications, drugs or other substances during pregnancy?<br><input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K If yes, check all that apply:<br><div style="display: flex; flex-wrap: wrap;"> <div style="width: 50%;"> <input type="checkbox"/> Over-the-counter meds    <input type="checkbox"/> Anti-epileptic<br/> <input type="checkbox"/> Allergy medications      <input type="checkbox"/> Anti-hypertensives<br/> <input type="checkbox"/> Antibiotics                  <input type="checkbox"/> Anti-hypothyroidism<br/> <input type="checkbox"/> Anti-depressants/anti-anxiety/anti-psychotics    <input type="checkbox"/> Arthritis medications<br/> <input type="checkbox"/> Diabetes medications      <input type="checkbox"/> Asthma medications </div> <div style="width: 50%;"> <input type="checkbox"/> Nausea/vomiting medications      <input type="checkbox"/> Cocaine<br/> <input type="checkbox"/> Cholesterol medications              <input type="checkbox"/> Heroin<br/> <input type="checkbox"/> Meds to treat preterm labor            <input type="checkbox"/> Marijuana<br/> <input type="checkbox"/> Meds used during delivery            <input type="checkbox"/> Methamphetamine<br/> <input type="checkbox"/> Progesterone/P17                        <input type="checkbox"/> Alcohol<br/> <input type="checkbox"/> If alcohol, infant born with fetal effects or syndrome? </div> <div style="width: 50%;"> <input type="checkbox"/> Meds to treat drug addiction<br/> <input type="checkbox"/> Opioids<br/> <input type="checkbox"/> Other pain meds<br/> <input type="checkbox"/> Other, specify:<br/> <input type="checkbox"/> U/K </div> </div> If any item is checked, please indicate the generic or brand name of the medications or drugs: |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                                                                                                                                                                                                                               |
| 55. Was the infant/fetus delivered drug expos <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | 56. Did the infant have neonatal abstinence syndrome (NAS)*? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                                                                                               |
| 57. Level of birth hospital:<br><input type="radio"/> 1<br><input type="radio"/> 2<br><input type="radio"/> 3<br><input type="radio"/> 4<br><input type="radio"/> Freestanding birth center<br><input type="radio"/> Home birth<br><input type="radio"/> Other, specify:<br><input type="radio"/> U/K                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | 58. At discharge from the birth hospital, was a case manager assigned to the childbearing parent?<br><input type="radio"/> N/A, childbearing parent did not go to a birth hospital <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                                                                                                                                                                                                                               |
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| 61. Did the childbearing parent smoke in the 3 months before pregnancy?<br><input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K<br>If yes, Avg # cigarettes/day (20 cigarettes in pack)<br><input type="checkbox"/> U/K quantity                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | 62. Did the childbearing parent smoke at any time during pregnancy?<br><input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K<br>If yes, Avg # cigarettes/day (20 cigarettes in pack)<br><input type="checkbox"/> U/K quantity                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                                                                                                                                                                                                                               |
| 63. Did the childbearing parent use e-cigarettes or other electronic nicotine products at any time during pregnancy? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K<br>If yes, on average how often? <input type="radio"/> More than once a day <input type="radio"/> Once a day <input type="radio"/> 2-6 days a week <input type="radio"/> 1 day a week or less <input type="radio"/> U/K                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                                                                                                                                                                                                                               |
| 64. Was the childbearing parent injured during pregnancy?<br><input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K If yes, describe:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | 65. Did the childbearing parent have postpartum depression?<br><input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                                                                                                                                                                                               |
| If this was a fetal death, go to Section B.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                                                                                                                                                                                                                               |
| 66. Infant ever breastfed? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K<br>If yes, any breast milk at 3 months? <input type="radio"/> N/A <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K<br>If yes, exclusively? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K<br>If yes, any breast milk at 6 months? <input type="radio"/> N/A <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K<br>If yes, exclusively? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K<br>If ever, was infant receiving breast milk at time of death? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | 67. Did infant have abnormal metabolic newborn screening results?<br><input type="radio"/> N/A <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K<br>If yes, describe any abnormality such as a fatty acid oxidation error:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                                                                                                                                                                                                                               |
| If the infant never left the hospital following birth, go to Section B.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                                                                                                                                                                                                                               |
| 68. At any time prior to the infant's last 72 hours, did the infant have a history of (check all that apply):<br><div style="display: flex; flex-wrap: wrap;"> <div style="width: 50%;"> <input type="checkbox"/> None<br/> <input type="checkbox"/> Infection<br/> <input type="checkbox"/> Allergies<br/> <input type="checkbox"/> Abnormal growth, weight gain/loss<br/> <input type="checkbox"/> Apnea </div> <div style="width: 50%;"> <input type="checkbox"/> Cyanosis<br/> <input type="checkbox"/> Seizures or convulsions<br/> <input type="checkbox"/> Cardiac abnormalities<br/> <input type="checkbox"/> Other, specify:<br/> <input type="checkbox"/> U/K </div> </div>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | 69. In the 72 hours prior to death, did the infant have any of the following?<br>Check all that apply:<br><div style="display: flex; flex-wrap: wrap;"> <div style="width: 50%;"> <input type="checkbox"/> None<br/> <input type="checkbox"/> Fever<br/> <input type="checkbox"/> Excessive sweating<br/> <input type="checkbox"/> Lethargy/sleeping more than usual<br/> <input type="checkbox"/> Fussiness/excessive crying </div> <div style="width: 50%;"> <input type="checkbox"/> Decrease in appetite<br/> <input type="checkbox"/> Vomiting<br/> <input type="checkbox"/> Choking<br/> <input type="checkbox"/> Diarrhea<br/> <input type="checkbox"/> Stool changes </div> <div style="width: 50%;"> <input type="checkbox"/> Difficulty breathing<br/> <input type="checkbox"/> Apnea<br/> <input type="checkbox"/> Cyanosis<br/> <input type="checkbox"/> Seizures or convulsions<br/> <input type="checkbox"/> Other, specify:<br/> <input type="checkbox"/> U/K </div> </div> |                                                                                                                                                                                                                                                                                                               |
| 70. In the 72 hours prior to death, was the infant injured?<br><input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K<br>If yes, describe cause and injuries:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | 71. In the 72 hours prior to death, was the infant given any vaccines?<br><input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K<br>If yes, list name(s) of vaccines:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | 72. In the 72 hours prior to death, was the infant given any medications or remedies? Include herbal, prescription, over-the-counter medications and home remedies.<br><input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K<br>If yes, list name and last dose given:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | 73. What did the infant have for his/her last meal?<br>Check all that apply:<br><input type="checkbox"/> Breast milk<br><input type="checkbox"/> Formula<br><input type="checkbox"/> Baby food<br><input type="checkbox"/> Cereal<br><input type="checkbox"/> Other, specify:<br><input type="checkbox"/> U/K |



| B. BIOLOGICAL PARENT INFORMATION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |   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                                                                                                                                                                                                                                                                           |  | ● No information available, go to Section C                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            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| 1. Parents alive on date of child's death? Even if parent(s) are deceased at time of child's death, please fill out the remaining questions.<br><u>Childbearing Biological Parent (CBP) alive:</u> <span style="margin-left: 20px;"><input type="radio"/> Yes</span> <span style="margin-left: 20px;"><input type="radio"/> No</span> <span style="margin-left: 20px;"><input type="radio"/> U/K</span><br><u>Non-Childbearing Biological Parent (Non-CBP) alive:</u> <span style="margin-left: 20px;"><input type="radio"/> Yes</span> <span style="margin-left: 20px;"><input type="radio"/> No</span> <span style="margin-left: 20px;"><input type="radio"/> U/K</span>                                                                                                                                                                                                                                                                                                                                                           |  |                                           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| 2. Parents' race, check all that apply:<br><div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> <u>CBP</u>   <u>Non-CBP</u><br/> <input type="checkbox"/> <input type="checkbox"/> Alaska Native, Tribe:<br/> <input type="checkbox"/> <input type="checkbox"/> American Indian, Tribe:<br/> <input type="checkbox"/> <input type="checkbox"/> Asian, specify:<br/> <input type="checkbox"/> <input type="checkbox"/> Black<br/> <input type="checkbox"/> <input type="checkbox"/> Native Hawaiian<br/> <input type="checkbox"/> <input type="checkbox"/> Pacific Islander, specify:<br/> <input type="checkbox"/> <input type="checkbox"/> White<br/> <input type="checkbox"/> <input type="checkbox"/> U/K               </div> <div style="width: 45%;"> <u>CBP</u>   <u>Non-CBP</u><br/> <input type="radio"/> <input type="radio"/> Yes, specify origin:<br/> <input type="radio"/> <input type="radio"/> No<br/> <input type="radio"/> <input type="radio"/> U/K               </div> </div> |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | 3. Parents' Hispanic or Latino/a origin?<br><u>CBP</u> <u>Non-CBP</u><br><input type="radio"/> <input type="radio"/> Yes, specify origin:<br><input type="radio"/> <input type="radio"/> No<br><input type="radio"/> <input type="radio"/> U/K                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                              | 5. Parents' employment status:<br><div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> <u>CBP</u>   <u>Non-CBP</u><br/> <input type="radio"/> <input type="radio"/> Employed<br/> <input type="radio"/> <input type="radio"/> Unemployed<br/> <input type="radio"/> <input type="radio"/> On disability<br/> <input type="radio"/> <input type="radio"/> Stay-at-home<br/> <input type="radio"/> <input type="radio"/> Retired<br/> <input type="radio"/> <input type="radio"/> U/K               </div> <div style="width: 45%;"> <input type="radio"/> <input type="radio"/> U/K               </div> </div> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 6. Parents' education:<br><div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> <u>CBP</u>   <u>Non-CBP</u><br/> <input type="radio"/> <input type="radio"/> &lt; High school<br/> <input type="radio"/> <input type="radio"/> High school/GED<br/> <input type="radio"/> <input type="radio"/> College<br/> <input type="radio"/> <input type="radio"/> Post graduate<br/> <input type="radio"/> <input type="radio"/> U/K               </div> <div style="width: 45%;"> <input type="radio"/> <input type="radio"/> U/K               </div> </div> |  |                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |  |
| 7. Parents speak and understand English?<br><div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> <u>CBP</u>   <u>Non-CBP</u><br/> <input type="radio"/> <input type="radio"/> Yes<br/> <input type="radio"/> <input type="radio"/> No<br/> <input type="radio"/> <input type="radio"/> U/K<br/>           If no, language spoken:               </div> <div style="width: 45%;"> <u>CBP</u>   <u>Non-CBP</u><br/> <input type="radio"/> <input type="radio"/> Yes, country of origin:<br/> <input type="radio"/> <input type="radio"/> No<br/> <input type="radio"/> <input type="radio"/> U/K               </div> </div>                                                                                                                                                                                                                                                                                                                                                                         |  | 8. Parents first generation immigrant?<br><div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> <u>CBP</u>   <u>Non-CBP</u><br/> <input type="radio"/> <input type="radio"/> Yes, specify branch:<br/> <input type="radio"/> <input type="radio"/> No<br/> <input type="radio"/> <input type="radio"/> U/K               </div> <div style="width: 45%;"> <input type="radio"/> <input type="radio"/> U/K               </div> </div> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | 10. Parents receive social services in the past twelve months?<br><div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> <u>CBP</u>   <u>Non-CBP</u><br/> <input type="radio"/> <input type="radio"/> Yes   If yes, check all that apply below:<br/> <input type="radio"/> <input type="radio"/> No<br/> <input type="radio"/> <input type="radio"/> U/K<br/> <u>CBP</u>   <u>Non-CBP</u><br/> <input type="checkbox"/> <input type="checkbox"/> WIC<br/> <input type="checkbox"/> <input type="checkbox"/> Home visiting, specify:<br/> <input type="checkbox"/> <input type="checkbox"/> TANF<br/> <input type="checkbox"/> <input type="checkbox"/> Medicaid<br/> <input type="checkbox"/> <input type="checkbox"/> Food stamps/SNAP/EBT               </div> <div style="width: 45%;"> <u>CBP</u>   <u>Non-CBP</u><br/> <input type="checkbox"/> <input type="checkbox"/> Section 8/housing<br/> <input type="checkbox"/> <input type="checkbox"/> Social Security Disability Insurance (SSI/SSDI)<br/> <input type="checkbox"/> <input type="checkbox"/> Other, specify:<br/> <input type="checkbox"/> <input type="checkbox"/> U/K               </div> </div> |                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |  |
| 11. Parents have substance abuse history?<br><div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> <u>CBP</u>   <u>Non-CBP</u><br/> <input type="radio"/> <input type="radio"/> Yes<br/> <input type="radio"/> <input type="radio"/> No<br/> <input type="radio"/> <input type="radio"/> U/K               </div> <div style="width: 45%;"> <input type="radio"/> <input type="radio"/> U/K               </div> </div>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | 12. Parents ever victim of child maltreatment?<br><div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> <u>CBP</u>   <u>Non-CBP</u><br/> <input type="radio"/> <input type="radio"/> Yes<br/> <input type="radio"/> <input type="radio"/> No<br/> <input type="radio"/> <input type="radio"/> U/K               </div> <div style="width: 45%;"> <input type="radio"/> <input type="radio"/> U/K               </div> </div>                                                                                                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | 13. Parents ever perpetrator of maltreatment?<br><div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> <u>CBP</u>   <u>Non-CBP</u><br/> <input type="radio"/> <input type="radio"/> Yes<br/> <input type="radio"/> <input type="radio"/> No<br/> <input type="radio"/> <input type="radio"/> U/K               </div> <div style="width: 45%;"> <input type="radio"/> <input type="radio"/> U/K               </div> </div> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | 14. Parents have disability or chronic illness?<br><div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> <u>CBP</u>   <u>Non-CBP</u><br/> <input type="radio"/> <input type="radio"/> Yes<br/> <input type="radio"/> <input type="radio"/> No<br/> <input type="radio"/> <input type="radio"/> U/K               </div> <div style="width: 45%;"> <input type="radio"/> <input type="radio"/> U/K               </div> </div> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |  |
| 15. Parents have prior child deaths?<br><div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> <u>CBP</u>   <u>Non-CBP</u><br/> <input type="radio"/> <input type="radio"/> Yes<br/> <input type="radio"/> <input type="radio"/> No<br/> <input type="radio"/> <input type="radio"/> U/K               </div> <div style="width: 45%;"> <input type="radio"/> <input type="radio"/> U/K               </div> </div>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | 16. Parents have history of intimate partner violence?<br><div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> <u>CBP</u>   <u>Non-CBP</u><br/> <input type="checkbox"/> <input type="checkbox"/> Yes, as victim<br/> <input type="checkbox"/> <input type="checkbox"/> Yes, as perpetrator<br/> <input type="checkbox"/> <input type="checkbox"/> No<br/> <input type="checkbox"/> <input type="checkbox"/> U/K               </div> <div style="width: 45%;"> <input type="checkbox"/> <input type="checkbox"/> U/K               </div> </div> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | 17. Parents have delinquent/criminal history?<br><div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> <u>CBP</u>   <u>Non-CBP</u><br/> <input type="radio"/> <input type="radio"/> Yes<br/> <input type="radio"/> <input type="radio"/> No<br/> <input type="radio"/> <input type="radio"/> U/K               </div> <div style="width: 45%;"> <input type="radio"/> <input type="radio"/> U/K               </div> </div>   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |  |
| C. PRIMARY CAREGIVER(S) INFORMATION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |   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                                                                                                                                                                                                                                                                           |  | If fetal death, skip to Section D.                                                                                                                                                                                                                       |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |  |
| 1. Primary caregiver(s): Select only one each in columns one and two.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |   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| <div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> <u>One</u>   <u>Two</u><br/> <input type="radio"/> Self, go to Section D<br/> <input type="radio"/> Childbearing parent, go to Section D<br/> <input type="radio"/> Non-childbearing biological parent, go to Section D<br/> <input type="radio"/> Adoptive parent<br/> <input type="radio"/> Stepparent               </div> <div style="width: 45%;"> <u>One</u>   <u>Two</u><br/> <input type="radio"/> Foster parent<br/> <input type="radio"/> Parent's partner<br/> <input type="radio"/> Grandparent<br/> <input type="radio"/> Sibling               </div> </div>                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | <div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> <u>One</u>   <u>Two</u><br/> <input type="radio"/> Other relative<br/> <input type="radio"/> Friend<br/> <input type="radio"/> Institutional staff<br/> <input type="radio"/> Other, specify:<br/> <input type="radio"/> U/K               </div> <div style="width: 45%;"> <input type="radio"/> U/K               </div> </div>                                                                                                                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                              | 2. Caregiver(s) age in years:<br><div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> <u>One</u>   <u>Two</u><br/> <input type="radio"/> <input type="radio"/> # Years<br/> <input type="checkbox"/> <input type="checkbox"/> U/K               </div> <div style="width: 45%;"> <input type="checkbox"/> <input type="checkbox"/> U/K               </div> </div>                                                                                                                                                                                                                                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |  |
| 4. Caregiver(s) race, check all that apply:<br><div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> <u>One</u>   <u>Two</u><br/> <input type="checkbox"/> <input type="checkbox"/> Alaska Native, Tribe:<br/> <input type="checkbox"/> <input type="checkbox"/> American Indian, Tribe:<br/> <input type="checkbox"/> <input type="checkbox"/> Asian, specify:<br/> <input type="checkbox"/> <input type="checkbox"/> Black<br/> <input type="checkbox"/> <input type="checkbox"/> Native Hawaiian               </div> <div style="width: 45%;"> <u>One</u>   <u>Two</u><br/> <input type="checkbox"/> <input type="checkbox"/> Pacific Islander, specify:<br/> <input type="checkbox"/> <input type="checkbox"/> White<br/> <input type="checkbox"/> <input type="checkbox"/> U/K               </div> </div>                                                                                                                                                                                    |  |   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Caregiver(s) Hispanic or Latino/a origin?<br><u>One</u> <u>Two</u><br><input type="radio"/> <input type="radio"/> Yes<br><input type="radio"/> <input type="radio"/> No<br><input type="radio"/> <input type="radio"/> U/K<br>If yes, specify origin: |  | 6. Caregiver(s) employment status:<br><div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> <u>One</u>   <u>Two</u><br/> <input type="radio"/> <input type="radio"/> Employed<br/> <input type="radio"/> <input type="radio"/> Unemployed<br/> <input type="radio"/> <input type="radio"/> On disability<br/> <input type="radio"/> <input type="radio"/> Stay-at-home<br/> <input type="radio"/> <input type="radio"/> Retired<br/> <input type="radio"/> <input type="radio"/> U/K               </div> <div style="width: 45%;"> <input type="radio"/> <input type="radio"/> U/K               </div> </div> |  |  |

INCIDENT CIRCUMSTANCES, *continued*

8. Where was the infant (P)laced before death, (L)ast known alive, (F)ound, and (U)sually placed? (*write P, L, F, or U, leave blank if none*)

☐ Crib      ☐ Portable Crib      ☐ Waterbed      ☐ Stroller      ☐ Playpen/play area (*not portable crib*)  
☐ Bassinet      ☐ Sofa/couch      ☐ Swing      ☐ Futon      ☐ Bouncy chair  
☐ Bedside sleeper      ☐ Chair      ☐ Baby box      ☐ Floor      ☐ Rocking sleeper  
☐ Car seat      ☐ Unknown      ☐ Held in person's arms      ☐ In-bed sleeper

☐ Other, specify: \_\_\_\_\_

☐ Adult bed — *If yes, what type?*    ☐ Twin    ☐ Full    ☐ Queen    ☐ King    ☐ Unknown

☐ Other, specify: \_\_\_\_\_

9. Describe the condition and firmness of the surface where the infant was found.

\_\_\_\_\_

10. Was the infant wrapped or swaddled?    ☐ Yes    ☐ No    ☐ Unknown

*If yes:* Describe the arm position.    ☐ Arms free and out    ☐ Arms in    ☐ One arm in and one arm out

Describe swaddle. (*include blanket type and tightness*) \_\_\_\_\_

11. What was the infant wearing? (*e.g., t-shirt or disposable diaper*) \_\_\_\_\_

12. What was the infant's usual sleep position?    ☐ Sitting    ☐ Back    ☐ Stomach    ☐ Side    ☐ Unknown

13. Describe the circumstances of infant when last placed by caregiver, last known alive, and found.

|                                                                                                               | Placed | Last known alive | Found |
|---------------------------------------------------------------------------------------------------------------|--------|------------------|-------|
| Date                                                                                                          |        |                  |       |
| Time                                                                                                          |        |                  |       |
| Location ( <i>e.g., living room or bedroom</i> )                                                              |        |                  |       |
| Position ( <i>e.g., sitting, back, stomach, side, or unknown</i> )                                            |        |                  |       |
| Face position ( <i>e.g., down, up, left, right, or unknown</i> )                                              |        |                  |       |
| Neck position ( <i>e.g., hyperextended or head back, hyperextended or chin to chest, neutral, or turned</i> ) |        |                  |       |

14. Was the infant's airway obstructed by a person or object when found? (*includes obstruction of the mouth or nose, or compression of the neck or chest*)

☐ Unobstructed    ☐ Fully obstructed    ☐ Partially obstructed    ☐ Unknown

*If fully or partially, what was obstructed or compressed? (check all that apply)*    ☐ Nose    ☐ Mouth    ☐ Chest    ☐ Neck



| E. INCIDENT INFORMATION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     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| <p>1. Was the date of the incident the same as the date of death?</p> <p><input type="radio"/> Yes, same as date of death</p> <p><input type="radio"/> No, different than date of death. Enter date of incident:     /     /     </p> <p style="text-align: center;">mm / dd / yyyy</p> <p><input type="radio"/> U/K</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | <p>2. Approximate time of day that incident occurred?</p> <p style="text-align: right;"><input type="radio"/> AM</p> <p>Hour, specify 1-12: _____ <input type="radio"/> PM</p> <p style="text-align: right;"><input type="radio"/> U/K</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                                                                                                                                                                                                          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        |                       |                       |                            |                       |                       |                       |                               |                       |                       |                       |                    |
| <p>3. Place of incident, check all that apply:</p> <table style="width: 100%; border: none;"> <tr> <td><input type="checkbox"/> Child's home</td> <td><input type="checkbox"/> Licensed child care center</td> <td><input type="checkbox"/> Military installation</td> <td><input type="checkbox"/> State or county park, other recreation area</td> </tr> <tr> <td><input type="checkbox"/> Relative's home</td> <td><input type="checkbox"/> Licensed child care home</td> <td><input type="checkbox"/> Jail/detention facility</td> <td><input type="checkbox"/> Hospital</td> </tr> <tr> <td><input type="checkbox"/> Friend's home</td> <td><input type="checkbox"/> Unlicensed child care home</td> <td><input type="checkbox"/> Sidewalk</td> <td><input type="checkbox"/> Other, specify: _____</td> </tr> <tr> <td><input type="checkbox"/> Licensed foster care home</td> <td><input type="checkbox"/> Farm/ranch</td> <td><input type="checkbox"/> Roadway</td> <td><input type="checkbox"/> U/K</td> </tr> <tr> <td><input type="checkbox"/> Relative foster care home</td> <td><input type="checkbox"/> School</td> <td><input type="checkbox"/> Driveway</td> <td></td> </tr> <tr> <td><input type="checkbox"/> Licensed group home</td> <td><input type="checkbox"/> Indian reservation/trust lands</td> <td><input type="checkbox"/> Other parking area</td> <td></td> </tr> </table>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           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Unlicensed child care home | <input type="checkbox"/> Sidewalk                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | <input type="checkbox"/> Other, specify: _____ | <input type="checkbox"/> Licensed foster care home | <input type="checkbox"/> Farm/ranch                                                                                                                                                                                                                                             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| <input type="checkbox"/> Child's home                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  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| <input type="checkbox"/> Relative's home                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               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| <input type="checkbox"/> Friend's home                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 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| <input type="checkbox"/> Licensed foster care home                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     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| <input type="checkbox"/> Relative foster care home                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     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| <input type="checkbox"/> Licensed group home                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           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                    |                       |                    |
| <p>4. Type of area:     <input type="radio"/> Urban     <input type="radio"/> Suburban     <input type="radio"/> Rural     <input type="radio"/> Frontier     <input type="radio"/> U/K</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    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| <p>5. Incident state: _____ 6. Incident county: _____</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               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           |                    |
| <p>7. Was the death attributed (either directly or indirectly) to an extreme weather event, emergency medical situation, natural disaster or mass shooting?</p> <p style="text-align: center;"><input type="radio"/> Yes   <input type="radio"/> No   <input type="radio"/> U/K</p> <p style="text-align: center;">If yes, specify the type of event (e.g., tornado, heat wave, flood, medical crisis, etc.) and general circumstances surrounding the death:</p> <p style="text-align: center;">If yes, specify the name of the event if applicable (e.g., Paradise Wild Fire, Hurricane Irma, COVID-19, etc.):</p>                                                                                                                                                                                                                                                                                                                                                                                                                           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Was the incident witnessed?</p> <p style="text-align: center;"><input type="radio"/> Yes   <input type="radio"/> No   <input type="radio"/> UK</p> <p style="text-align: center;">If yes, by whom?</p> <p><input type="checkbox"/> EMS</p> <p><input type="checkbox"/> Parent/relative</p> <p><input type="checkbox"/> Other caretaker/babysitter</p> <p><input type="checkbox"/> Teacher/coach/athletic trainer</p> <p><input type="checkbox"/> Other acquaintance</p> <p><input type="checkbox"/> Health care professional, if death occurred in a hospital setting</p> <p><input type="checkbox"/> Stranger</p> <p><input type="checkbox"/> Other, specify: _____</p> </td> <td style="width: 33%; vertical-align: top;"> <p><input type="checkbox"/> Parent/relative</p> <p><input type="checkbox"/> Other caretaker/babysitter</p> <p><input type="checkbox"/> Teacher/coach/athletic trainer</p> <p><input type="checkbox"/> Other acquaintance</p> <p><input type="checkbox"/> Health care professional, if death occurred in a hospital setting</p> <p><input type="checkbox"/> Stranger</p> <p><input type="checkbox"/> Other, specify: _____</p> </td> <td style="width: 33%; vertical-align: top;"> <p>9. Was 911 or local emergency called?</p> <p style="text-align: center;"><input type="radio"/> N/A           <input type="radio"/> Yes</p> <p style="text-align: center;"><input type="radio"/> No             <input type="radio"/> U/K</p> </td> </tr> </table>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                                                                                                                                                                                                                | <p>8. 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Child's activity at time of incident, check all that apply:</p> <p><input type="checkbox"/> Sleeping   <input type="checkbox"/> Working   <input type="checkbox"/> Driving/vehicle occupant   <input type="checkbox"/> U/K</p> <p><input type="checkbox"/> Playing   <input type="checkbox"/> Eating   <input type="checkbox"/> Other, specify: _____</p> <p>13. 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| <input type="checkbox"/> Cocaine                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       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| <input type="checkbox"/> Marijuana                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     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| <input type="checkbox"/> Methamphetamine                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               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| F. INVESTIGATION INFORMATION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                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                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | A + symbol means that the question is skipped for fetal deaths.                                                                                                                                                                                                                                |                                                                                                                                                                                                                       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| <p>1. Was a death investigation conducted*? <input type="radio"/> Yes   <input type="radio"/> No   <input type="radio"/> U/K</p> <p style="text-align: center;">If yes, check all that apply:</p> <table style="width: 100%; border: none;"> <tr> <td><input type="checkbox"/> Medical examiner</td> <td><input type="checkbox"/> ME investigator</td> <td><input type="checkbox"/> Law enforcement</td> <td><input type="checkbox"/> EMS</td> <td><input type="checkbox"/> Other, specify: _____</td> </tr> <tr> <td><input type="checkbox"/> Coroner</td> <td><input type="checkbox"/> Coroner investigator</td> <td><input type="checkbox"/> Fire investigator</td> <td><input type="checkbox"/> Child Protective Services</td> <td><input type="checkbox"/> U/K</td> </tr> </table> <p style="text-align: center;">If yes, which of the following death investigation components were completed?</p> <table style="width: 100%; border: none;"> <tr> <td style="text-align: center;"><u>Yes</u></td> <td style="text-align: center;"><u>No</u></td> <td style="text-align: center;"><u>U/K</u></td> <td></td> </tr> <tr> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/></td> <td>CDC's SUIDI Reporting Form or jurisdictional equivalent</td> </tr> <tr> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/></td> <td>Narrative description of circumstances</td> </tr> <tr> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/></td> <td>Scene photos</td> </tr> <tr> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/></td> <td>Scene recreation with doll</td> </tr> <tr> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/></td> <td>Scene recreation without doll</td> </tr> <tr> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/></td> <td>Witness interviews</td> </tr> </table> <p style="text-align: center;">If yes, was a death scene investigation conducted at the place of incident?     <input type="radio"/> Yes   <input type="radio"/> No   <input type="radio"/> U/K</p> <p style="text-align: center;">If yes, shared with review team?     <input type="radio"/> Yes   <input type="radio"/> No</p> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                                                                                                                                                                                                                | <input type="checkbox"/> Medical examiner                                                                                                                                                           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type="checkbox"/> U/K                        | <u>Yes</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | <u>No</u>                                      | <u>U/K</u>                                         |                                                                                                                                                                                                                                                               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| <u>Yes</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             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| <p>2. What additional information would the team like to have known about the death scene investigation*?</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  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| <p>5. Official manner of death from the death certificate:</p> <p> <input type="radio"/> Natural<br/> <input type="radio"/> Accident<br/> <input type="radio"/> Suicide<br/> <input type="radio"/> Homicide<br/> <input type="radio"/> Undetermined<br/> <input type="radio"/> Pending<br/> <input type="radio"/> U/K         </p> <p><input type="checkbox"/> If manner of death was not Natural or Suicide, check this box if it is possible that the child intended to hurt him/herself. If checked, complete the Suicide Section (16) to note other risk factors in the child's life.</p> | <p>6. Primary cause of death: Choose 1 of the 4 major categories, then a specific cause. For pending, choose most likely cause.</p> <p><input type="radio"/> <u>From an external cause of injury. Select one:</u></p> <table style="width: 100%;"> <tr> <td><input type="radio"/> Motor vehicle and other transport, go to H1</td> <td><input type="radio"/> Fall or crush, go to H6</td> </tr> <tr> <td><input type="radio"/> Fire, burn, or electrocution, go to H2</td> <td><input type="radio"/> Poisoning, overdose or acute intoxication, go to H7</td> </tr> <tr> <td><input type="radio"/> Drowning, go to H3</td> <td><input type="radio"/> Undetermined injury, go to I1</td> </tr> <tr> <td><input type="radio"/> Asphyxia, go to H4</td> <td><input type="radio"/> Other cause, go to H9</td> </tr> <tr> <td><input type="radio"/> Bodily force or weapon, go to H5</td> <td><input type="radio"/> U/K, go to I1</td> </tr> </table> <hr/> <p><input type="radio"/> <u>From a medical cause. Select one and go to H8:</u></p> <table style="width: 100%;"> <tr> <td><input type="radio"/> Asthma/respiratory, specify:</td> <td><input type="radio"/> Neurological/seizure disorder</td> </tr> <tr> <td><input type="radio"/> Cancer, specify:</td> <td><input type="radio"/> Pneumonia, specify:</td> </tr> <tr> <td><input type="radio"/> Cardiovascular, specify:</td> <td><input type="radio"/> Prematurity</td> </tr> <tr> <td><input type="radio"/> Congenital anomaly, specify:</td> <td><input type="radio"/> SIDS</td> </tr> <tr> <td><input type="radio"/> COVID-19</td> <td><input type="radio"/> Other infection, specify:</td> </tr> <tr> <td><input type="radio"/> Diabetes</td> <td><input type="radio"/> Other perinatal condition, specify:</td> </tr> <tr> <td><input type="radio"/> HIV/AIDS</td> <td><input type="radio"/> Other medical condition, specify:</td> </tr> <tr> <td><input type="radio"/> Influenza</td> <td><input type="radio"/> Undetermined medical cause</td> </tr> <tr> <td><input type="radio"/> Low birth weight</td> <td><input type="radio"/> U/K</td> </tr> <tr> <td><input type="radio"/> Malnutrition/dehydration</td> <td></td> </tr> </table> <hr/> <p><input type="radio"/> <u>Undetermined if injury or medical cause, go to I1</u></p> <p><input type="radio"/> <u>U/K, go to I1</u></p> | <input type="radio"/> Motor vehicle and other transport, go to H1 | <input type="radio"/> Fall or crush, go to H6 | <input type="radio"/> Fire, burn, or electrocution, go to H2 | <input type="radio"/> Poisoning, overdose or acute intoxication, go to H7 | <input type="radio"/> Drowning, go to H3 | <input type="radio"/> Undetermined injury, go to I1 | <input type="radio"/> Asphyxia, go to H4 | <input type="radio"/> Other cause, go to H9 | <input type="radio"/> Bodily force or weapon, go to H5 | <input type="radio"/> U/K, go to I1 | <input type="radio"/> Asthma/respiratory, specify: | <input type="radio"/> Neurological/seizure disorder | <input type="radio"/> Cancer, specify: | <input type="radio"/> Pneumonia, specify: | <input type="radio"/> Cardiovascular, specify: | <input type="radio"/> Prematurity | <input type="radio"/> Congenital anomaly, specify: | <input type="radio"/> SIDS | <input type="radio"/> COVID-19 | <input type="radio"/> Other infection, specify: | <input type="radio"/> Diabetes | <input type="radio"/> Other perinatal condition, specify: | <input type="radio"/> HIV/AIDS | <input type="radio"/> Other medical condition, specify: | <input type="radio"/> Influenza | <input type="radio"/> Undetermined medical cause | <input type="radio"/> Low birth weight | <input type="radio"/> U/K | <input type="radio"/> Malnutrition/dehydration |  |
| <input type="radio"/> Motor vehicle and other transport, go to H1                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | <input type="radio"/> Fall or crush, go to H6                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                   |                                               |                                                              |                                                                           |                                          |                                                     |                                          |                                             |                                                        |                                     |                                                    |                                                     |                                        |                                           |                                                |                                   |                                                    |                            |                                |                                                 |                                |                                                           |                                |                                                         |                                 |                                                  |                                        |                           |                                                |  |
| <input type="radio"/> Fire, burn, or electrocution, go to H2                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | <input type="radio"/> Poisoning, overdose or acute intoxication, go to H7                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                   |                                               |                                                              |                                                                           |                                          |                                                     |                                          |                                             |                                                        |                                     |                                                    |                                                     |                                        |                                           |                                                |                                   |                                                    |                            |                                |                                                 |                                |                                                           |                                |                                                         |                                 |                                                  |                                        |                           |                                                |  |
| <input type="radio"/> Drowning, go to H3                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | <input type="radio"/> Undetermined injury, go to I1                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                   |                                               |                                                              |                                                                           |                                          |                                                     |                                          |                                             |                                                        |                                     |                                                    |                                                     |                                        |                                           |                                                |                                   |                                                    |                            |                                |                                                 |                                |                                                           |                                |                                                         |                                 |                                                  |                                        |                           |                                                |  |
| <input type="radio"/> Asphyxia, go to H4                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | <input type="radio"/> Other cause, go to H9                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                   |                                               |                                                              |                                                                           |                                          |                                                     |                                          |                                             |                                                        |                                     |                                                    |                                                     |                                        |                                           |                                                |                                   |                                                    |                            |                                |                                                 |                                |                                                           |                                |                                                         |                                 |                                                  |                                        |                           |                                                |  |
| <input type="radio"/> Bodily force or weapon, go to H5                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | <input type="radio"/> U/K, go to I1                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                   |                                               |                                                              |                                                                           |                                          |                                                     |                                          |                                             |                                                        |                                     |                                                    |                                                     |                                        |                                           |                                                |                                   |                                                    |                            |                                |                                                 |                                |                                                           |                                |                                                         |                                 |                                                  |                                        |                           |                                                |  |
| <input type="radio"/> Asthma/respiratory, specify:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | <input type="radio"/> Neurological/seizure disorder                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                   |                                               |                                                              |                                                                           |                                          |                                                     |                                          |                                             |                                                        |                                     |                                                    |                                                     |                                        |                                           |                                                |                                   |                                                    |                            |                                |                                                 |                                |                                                           |                                |                                                         |                                 |                                                  |                                        |                           |                                                |  |
| <input type="radio"/> Cancer, specify:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | <input type="radio"/> Pneumonia, specify:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                   |                                               |                                                              |                                                                           |                                          |                                                     |                                          |                                             |                                                        |                                     |                                                    |                                                     |                                        |                                           |                                                |                                   |                                                    |                            |                                |                                                 |                                |                                                           |                                |                                                         |                                 |                                                  |                                        |                           |                                                |  |
| <input type="radio"/> Cardiovascular, specify:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | <input type="radio"/> Prematurity                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                   |                                               |                                                              |                                                                           |                                          |                                                     |                                          |                                             |                                                        |                                     |                                                    |                                                     |                                        |                                           |                                                |                                   |                                                    |                            |                                |                                                 |                                |                                                           |                                |                                                         |                                 |                                                  |                                        |                           |                                                |  |
| <input type="radio"/> Congenital anomaly, specify:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | <input type="radio"/> SIDS                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                   |                                               |                                                              |                                                                           |                                          |                                                     |                                          |                                             |                                                        |                                     |                                                    |                                                     |                                        |                                           |                                                |                                   |                                                    |                            |                                |                                                 |                                |                                                           |                                |                                                         |                                 |                                                  |                                        |                           |                                                |  |
| <input type="radio"/> COVID-19                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | <input type="radio"/> Other infection, specify:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                   |                                               |                                                              |                                                                           |                                          |                                                     |                                          |                                             |                                                        |                                     |                                                    |                                                     |                                        |                                           |                                                |                                   |                                                    |                            |                                |                                                 |                                |                                                           |                                |                                                         |                                 |                                                  |                                        |                           |                                                |  |
| <input type="radio"/> Diabetes                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | <input type="radio"/> Other perinatal condition, specify:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                   |                                               |                                                              |                                                                           |                                          |                                                     |                                          |                                             |                                                        |                                     |                                                    |                                                     |                                        |                                           |                                                |                                   |                                                    |                            |                                |                                                 |                                |                                                           |                                |                                                         |                                 |                                                  |                                        |                           |                                                |  |
| <input type="radio"/> HIV/AIDS                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | <input type="radio"/> Other medical condition, specify:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                   |                                               |                                                              |                                                                           |                                          |                                                     |                                          |                                             |                                                        |                                     |                                                    |                                                     |                                        |                                           |                                                |                                   |                                                    |                            |                                |                                                 |                                |                                                           |                                |                                                         |                                 |                                                  |                                        |                           |                                                |  |
| <input type="radio"/> Influenza                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | <input type="radio"/> Undetermined medical cause                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                   |                                               |                                                              |                                                                           |                                          |                                                     |                                          |                                             |                                                        |                                     |                                                    |                                                     |                                        |                                           |                                                |                                   |                                                    |                            |                                |                                                 |                                |                                                           |                                |                                                         |                                 |                                                  |                                        |                           |                                                |  |
| <input type="radio"/> Low birth weight                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | <input type="radio"/> U/K                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                   |                                               |                                                              |                                                                           |                                          |                                                     |                                          |                                             |                                                        |                                     |                                                    |                                                     |                                        |                                           |                                                |                                   |                                                    |                            |                                |                                                 |                                |                                                           |                                |                                                         |                                 |                                                  |                                        |                           |                                                |  |
| <input type="radio"/> Malnutrition/dehydration                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                   |                                               |                                                              |                                                                           |                                          |                                                     |                                          |                                             |                                                        |                                     |                                                    |                                                     |                                        |                                           |                                                |                                   |                                                    |                            |                                |                                                 |                                |                                                           |                                |                                                         |                                 |                                                  |                                        |                           |                                                |  |

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

**H1. MOTOR VEHICLE AND OTHER TRANSPORT**

| <p>a. Vehicles involved in incident:</p> <p>Total number of vehicles: _____</p> <table style="width: 100%;"> <thead> <tr> <th style="text-align: left;"><u>Child's</u></th> <th style="text-align: left;"><u>Other primary vehicle</u></th> </tr> </thead> <tbody> <tr><td><input type="radio"/></td><td><input type="radio"/> None</td></tr> <tr><td><input type="radio"/></td><td><input type="radio"/> Car</td></tr> <tr><td><input type="radio"/></td><td><input type="radio"/> Van</td></tr> <tr><td><input type="radio"/></td><td><input type="radio"/> Sport utility vehicle</td></tr> <tr><td><input type="radio"/></td><td><input type="radio"/> Truck</td></tr> <tr><td><input type="radio"/></td><td><input type="radio"/> Semi/tractor trailer</td></tr> <tr><td><input type="radio"/></td><td><input type="radio"/> RV/bus/school bus</td></tr> <tr><td><input type="radio"/></td><td><input type="radio"/> Motorcycle</td></tr> <tr><td><input type="radio"/></td><td><input type="radio"/> Tractor/farm vehicle</td></tr> <tr><td><input type="radio"/></td><td><input type="radio"/> All terrain vehicle</td></tr> <tr><td><input type="radio"/></td><td><input type="radio"/> Snowmobile</td></tr> <tr><td><input type="radio"/></td><td><input type="radio"/> Bicycle</td></tr> <tr><td><input type="radio"/></td><td><input type="radio"/> Train/subway/trolley</td></tr> <tr><td><input type="radio"/></td><td><input type="radio"/> Other, specify:</td></tr> <tr><td><input type="radio"/></td><td><input type="radio"/> U/K</td></tr> </tbody> </table><br><table style="width: 100%;"> <thead> <tr> <th></th> <th style="text-align: center;"><u>Autonomous?</u></th> </tr> <tr> <th></th> <th style="text-align: center;">N/A    Yes    No    U/K</th> </tr> </thead> <tbody> <tr> <td>Child's vehicle</td> <td style="text-align: center;"><input type="radio"/>    <input type="radio"/>    <input type="radio"/>    <input type="radio"/></td> </tr> <tr> <td>Other vehicle</td> <td style="text-align: center;"><input type="radio"/>    <input type="radio"/>    <input type="radio"/>    <input type="radio"/></td> </tr> </tbody> </table> | <u>Child's</u>                                                                           | <u>Other primary vehicle</u>             | <input type="radio"/>                        | <input type="radio"/> None           | <input type="radio"/>                                | <input type="radio"/> Car                   | <input type="radio"/>                 | <input type="radio"/> Van                    | <input type="radio"/>                 | <input type="radio"/> Sport utility vehicle                                              | <input type="radio"/>                           | <input type="radio"/> Truck                 | <input type="radio"/>             | <input type="radio"/> Semi/tractor trailer          | <input type="radio"/>                | <input type="radio"/> RV/bus/school bus               | <input type="radio"/>                           | <input type="radio"/> Motorcycle         | <input type="radio"/>                         | <input type="radio"/> Tractor/farm vehicle | <input type="radio"/>                 | <input type="radio"/> All terrain vehicle | <input type="radio"/>                    | <input type="radio"/> Snowmobile | <input type="radio"/>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | <input type="radio"/> Bicycle        | <input type="radio"/>                       | <input type="radio"/> Train/subway/trolley | <input type="radio"/>            | <input type="radio"/> Other, specify: | <input type="radio"/>             | <input type="radio"/> U/K             |                                   | <u>Autonomous?</u>                      |                                          | N/A    Yes    No    U/K      | Child's vehicle                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> | Other vehicle                     | <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> | <p>b. Position of child:</p> <p><input type="radio"/> Driver</p> <p><input type="radio"/> Passenger      If passenger, relationship of driver to child:</p> <table style="width: 100%;"> <tr> <td><input type="radio"/> Front seat</td> <td><input type="radio"/> Biological parent</td> </tr> <tr> <td><input type="radio"/> Back seat</td> <td><input type="radio"/> Adoptive parent</td> </tr> <tr> <td><input type="radio"/> Truck bed</td> <td><input type="radio"/> Stepparent</td> </tr> <tr> <td><input type="radio"/> Other, specify:</td> <td><input type="radio"/> Foster parent</td> </tr> <tr> <td><input type="radio"/> U/K</td> <td><input type="radio"/> Parent's partner</td> </tr> <tr> <td><input type="radio"/> On bicycle</td> <td><input type="radio"/> Grandparent</td> </tr> <tr> <td><input type="radio"/> Pedestrian</td> <td><input type="radio"/> Sibling</td> </tr> <tr> <td><input type="radio"/> Walking</td> <td><input type="radio"/> Other relative</td> </tr> <tr> <td><input type="radio"/> Boarding/blading</td> <td><input type="radio"/> Friend</td> </tr> <tr> <td><input type="radio"/> Other, specify:</td> <td><input type="radio"/> Other, specify:</td> </tr> <tr> <td><input type="radio"/> U/K</td> <td><input type="radio"/> U/K</td> </tr> </table> <p><input type="radio"/> U/K</p> <p>If bicycle, boarding/blading or other, was the child riding something electric?<br/> <input type="radio"/> Yes    <input type="radio"/> No    <input type="radio"/> U/K</p> | <input type="radio"/> Front seat         | <input type="radio"/> Biological parent | <input type="radio"/> Back seat | <input type="radio"/> Adoptive parent | <input type="radio"/> Truck bed | <input type="radio"/> Stepparent | <input type="radio"/> Other, specify: | <input type="radio"/> Foster parent | <input type="radio"/> U/K | <input type="radio"/> Parent's partner | <input type="radio"/> On bicycle | <input type="radio"/> Grandparent | <input type="radio"/> Pedestrian | <input type="radio"/> Sibling | <input type="radio"/> Walking | <input type="radio"/> Other relative | <input type="radio"/> Boarding/blading | <input type="radio"/> Friend | <input type="radio"/> Other, specify: | <input type="radio"/> Other, specify: | <input type="radio"/> U/K | <input type="radio"/> U/K |
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| <u>Child's</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | <u>Other primary vehicle</u>                                                             |                                          |                                              |                                      |                                                      |                                             |                                       |                                              |                                       |                                                                                          |                                                 |                                             |                                   |                                                     |                                      |                                                       |                                                 |                                       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| <input type="radio"/> Back seat                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        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| <input type="radio"/> Truck bed                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        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| <input type="radio"/> Other, specify:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  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| <input type="radio"/> U/K                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              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| <input type="radio"/> On bicycle                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | <input type="radio"/> Grandparent                                                        |                                          |                                              |                                      |                                                      |                                             |                                       |                                              |                                       |                                                                                          |                                                 |                                             |                                   |                                                     |                                      |                                                       |                                                 |                                       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| <input type="radio"/> Pedestrian                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       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| <input type="radio"/> Walking                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          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| <input type="radio"/> Boarding/blading                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 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| <input type="radio"/> U/K                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              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| <p>c. Did any of the following contribute to the incident? Check all that apply:</p> <table style="width: 100%;"> <tr> <td><input type="checkbox"/> None listed below</td> <td><input type="checkbox"/> Poor sight line</td> </tr> <tr> <td><input type="checkbox"/> Speeding over limit</td> <td><input type="checkbox"/> Road hazard</td> </tr> <tr> <td><input type="checkbox"/> Unsafe speed for conditions</td> <td><input type="checkbox"/> Car changing lanes</td> </tr> <tr> <td><input type="checkbox"/> Recklessness</td> <td><input type="checkbox"/> Driver inexperience</td> </tr> <tr> <td><input type="checkbox"/> Carelessness</td> <td><input type="checkbox"/> Electronic use e.g., cell phone, smart watch, in-car navigation</td> </tr> <tr> <td><input type="checkbox"/> Racing, not authorized</td> <td><input type="checkbox"/> Driver distraction</td> </tr> <tr> <td><input type="checkbox"/> Drug use</td> <td><input type="checkbox"/> Ran stop sign or red light</td> </tr> <tr> <td><input type="checkbox"/> Alcohol use</td> <td><input type="checkbox"/> Other driver error, specify:</td> </tr> <tr> <td><input type="checkbox"/> Vehicle ran over child</td> <td><input type="checkbox"/> Other, specify:</td> </tr> <tr> <td><input type="checkbox"/> Vehicle flipped over</td> <td><input type="checkbox"/> U/K</td> </tr> <tr> <td><input type="checkbox"/> Poor weather</td> <td></td> </tr> <tr> <td><input type="checkbox"/> Poor visibility</td> <td></td> </tr> </table>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | <input type="checkbox"/> None listed below                                               | <input type="checkbox"/> Poor sight line | <input type="checkbox"/> Speeding over limit | <input type="checkbox"/> Road hazard | <input type="checkbox"/> Unsafe speed for conditions | <input type="checkbox"/> Car changing lanes | <input type="checkbox"/> Recklessness | <input type="checkbox"/> Driver inexperience | <input type="checkbox"/> Carelessness | <input type="checkbox"/> Electronic use e.g., cell phone, smart watch, in-car navigation | <input type="checkbox"/> Racing, not authorized | <input type="checkbox"/> Driver distraction | <input type="checkbox"/> Drug use | <input type="checkbox"/> Ran stop sign or red light | <input type="checkbox"/> Alcohol use | <input type="checkbox"/> Other driver error, specify: | <input type="checkbox"/> Vehicle ran over child | <input type="checkbox"/> Other, specify: | <input type="checkbox"/> Vehicle flipped over | <input type="checkbox"/> U/K               | <input type="checkbox"/> Poor weather |                                           | <input type="checkbox"/> Poor visibility |                                  | <p>d. Location of incident, check all that apply:</p> <table style="width: 100%;"> <tr><td><input type="checkbox"/> City street</td></tr> <tr><td><input type="checkbox"/> Residential street</td></tr> <tr><td><input type="checkbox"/> Rural road</td></tr> <tr><td><input type="checkbox"/> Highway</td></tr> <tr><td><input type="checkbox"/> Intersection</td></tr> <tr><td><input type="checkbox"/> Driveway</td></tr> <tr><td><input type="checkbox"/> Parking area</td></tr> <tr><td><input type="checkbox"/> Off road</td></tr> <tr><td><input type="checkbox"/> RR xing/tracks</td></tr> <tr><td><input type="checkbox"/> Other, specify:</td></tr> <tr><td><input type="checkbox"/> U/K</td></tr> </table> | <input type="checkbox"/> City street | <input type="checkbox"/> Residential street | <input type="checkbox"/> Rural road        | <input type="checkbox"/> Highway | <input type="checkbox"/> Intersection | <input type="checkbox"/> Driveway | <input type="checkbox"/> Parking area | <input type="checkbox"/> Off road | <input type="checkbox"/> RR xing/tracks | <input type="checkbox"/> Other, specify: | <input type="checkbox"/> U/K | <p>e. Did driving conditions factor into this incident?</p> <p><input type="radio"/> Yes    <input type="radio"/> No    <input type="radio"/> U/K</p> <p>If yes, check all that apply:</p> <table style="width: 100%;"> <tr><td><input type="checkbox"/> Loose gravel</td></tr> <tr><td><input type="checkbox"/> Ice/snow</td></tr> <tr><td><input type="checkbox"/> Wet</td></tr> <tr><td><input type="checkbox"/> Inadequate lighting</td></tr> <tr><td><input type="checkbox"/> Other, specify:</td></tr> <tr><td><input type="checkbox"/> U/K</td></tr> </table> | <input type="checkbox"/> Loose gravel                                                   | <input type="checkbox"/> Ice/snow | <input type="checkbox"/> Wet                                                            | <input type="checkbox"/> Inadequate lighting                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | <input type="checkbox"/> Other, specify: | <input type="checkbox"/> U/K            |                                 |                                       |                                 |                                  |                                       |                                     |                           |                                        |                                  |                                   |                                  |                               |                               |                                      |                                        |                              |                                       |                                       |                           |                           |
| <input type="checkbox"/> None listed below                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | <input type="checkbox"/> Poor sight line                                                 |                                          |                                              |                                      |                                                      |                                             |                                       |                                              |                                       |                                                                                          |                                                 |                                             |                                   |                                                     |                                      |                                                       |                                                 |                                       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| <input type="checkbox"/> Speeding over limit                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | <input type="checkbox"/> Road hazard                                                     |                                          |                                              |                                      |                                                      |                                             |                                       |                                              |                                       |                                                                                          |                                                 |                                             |                                   |                                                     |                                      |                                                       |                                                 |                                       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| <input type="checkbox"/> Unsafe speed for conditions                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | <input type="checkbox"/> Car changing lanes                                              |                                          |                                              |                                      |                                                      |                                             |                                       |                                              |                                       |                                                                                          |                                                 |                                             |                                   |                                                     |                                      |                                                       |                                                 |                                       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| <input type="checkbox"/> Recklessness                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | <input type="checkbox"/> Driver inexperience                                             |                                          |                                              |                                      |                                                      |                                             |                                       |                                              |                                       |                                                                                          |                                                 |                                             |                                   |                                                     |                                      |                                                       |                                                 |                                       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| <input type="checkbox"/> Carelessness                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | <input type="checkbox"/> Electronic use e.g., cell phone, smart watch, in-car navigation |                                          |                                              |                                      |                                                      |                                             |                                       |                                              |                                       |                                                                                          |                                                 |                                             |                                   |                                                     |                                      |                                                       |                                                 |                                       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| <input type="checkbox"/> Racing, not authorized                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        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| <input type="checkbox"/> Drug use                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | <input type="checkbox"/> Ran stop sign or red light                                      |                                          |                                              |                                      |                                                      |                                             |                                       |                                              |                                       |                                                                                          |                                                 |                                             |                                   |                                                     |                                      |                                                       |                                                 |                                       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| <input type="checkbox"/> Alcohol use                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   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| <input type="checkbox"/> Vehicle ran over child                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        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| <input type="checkbox"/> Vehicle flipped over                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          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| <input type="checkbox"/> Poor weather                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  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| <input type="checkbox"/> Poor visibility                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               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| <input type="checkbox"/> City street                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   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| <input type="checkbox"/> Residential street                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            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| <input type="checkbox"/> Rural road                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    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| <input type="checkbox"/> Highway                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       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| <input type="checkbox"/> Intersection                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  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| <input type="checkbox"/> Driveway                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      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| <input type="checkbox"/> Parking area                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  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| <input type="checkbox"/> Off road                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      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| <input type="checkbox"/> RR xing/tracks                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                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| <input type="checkbox"/> Other, specify:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               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| <input type="checkbox"/> U/K                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           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| <input type="checkbox"/> Loose gravel                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  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| <input type="checkbox"/> Ice/snow                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      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| <input type="checkbox"/> Wet                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           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| <input type="checkbox"/> Inadequate lighting                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           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| <input type="checkbox"/> Other, specify:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               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| <input type="checkbox"/> U/K                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           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| <p>f. Incident type:</p> <p><input type="radio"/> Child <i>not</i> in/on a vehicle, but struck by vehicle</p> <p><input type="radio"/> Child in/on a vehicle, struck by the other vehicle</p> <p><input type="radio"/> Child in/on a vehicle that struck the other vehicle</p> <p><input type="radio"/> Child in/on a vehicle that struck person/object/ran off the road</p> <p><input type="radio"/> Other event, specify:</p> <p><input type="radio"/> U/K</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | <p>g. Driver who was responsible for the incident. Vehicles include motorized vehicles (cars, SUVs, motorbikes, etc) but also bicycles, skates, scooters, and other wheeled conveyances, whether motorized or not.</p> <p><input type="radio"/> Child was responsible as driver of vehicle, including single vehicle incidents</p> <p><input type="radio"/> Driver of child's vehicle was responsible, including single vehicle incidents</p> <p><input type="radio"/> Driver of the other vehicle was responsible, including child as pedestrian hit by vehicle</p> <p><input type="radio"/> Multiple drivers were responsible, go to j</p> <p><input type="radio"/> Unable to determine driver responsible, go to j</p> <p><input type="radio"/> Other, specify:</p> <p><input type="radio"/> U/K</p> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
| <p>h. Age and license type of driver responsible for incident, check all that apply:</p> <div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> <p>Age of Driver (if not child)</p> <p><input type="radio"/> &lt;16 years</p> <p><input type="radio"/> 16 to 18 years old</p> <p><input type="radio"/> 19 to 21 years old</p> <p><input type="radio"/> 22 to 29 years old</p> <p><input type="radio"/> 30 to 65 years old</p> <p><input type="radio"/> &gt;65 years old</p> <p><input type="radio"/> U/K</p> </div> <div style="width: 45%;"> <p>License type/violation:</p> <p><input type="checkbox"/> Has no license</p> <p><input type="checkbox"/> Has a learner's permit</p> <p><input type="checkbox"/> Has a graduated license</p> <p><input type="checkbox"/> Has a full license</p> <p><input type="checkbox"/> Has a full license that has been restricted</p> <p><input type="checkbox"/> Has a suspended license</p> <p><input type="checkbox"/> Was violating graduated licensing rules</p> <p><input type="checkbox"/> Other, specify:</p> <p><input type="checkbox"/> U/K</p> </div> </div> | <p>i. Total number of occupants in vehicle responsible for incident:</p> <p><input type="checkbox"/> N/A</p> <p>Total number of occupants: _____ <input type="checkbox"/> U/K</p> <p>Number of teens, ages 14-21: _____ <input type="checkbox"/> U/K</p> <p>j. Was a restraint or safety measure used by the child?</p> <p><input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K</p> <p>If yes, select the restraint or safety measures used:</p> <p><input type="checkbox"/> Lap/shoulder belt</p> <p><input type="checkbox"/> Child seat</p> <p><input type="checkbox"/> Belt positioning booster seat</p> <p><input type="checkbox"/> Helmet</p> <p><input type="checkbox"/> U/K</p> <p>If yes, describe:</p>                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
| <p><b>H2. FIRE, BURN, OR ELECTROCUTION</b></p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
| <p>a. Ignition, heat or electrocution source:</p> <p><input type="radio"/> Matches <input type="radio"/> Heating stove <input type="radio"/> Lightning</p> <p><input type="radio"/> Cigarette lighter <input type="radio"/> Space heater <input type="radio"/> Hot bath water</p> <p><input type="radio"/> Cigarette or cigar <input type="radio"/> Power line <input type="radio"/> Other, specify:</p> <p><input type="radio"/> Candles <input type="radio"/> Electrical outlet <input type="radio"/> U/K</p> <p><input type="radio"/> Cooking stove <input type="radio"/> Electrical wiring</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | <p>b. Type of incident:</p> <p><input type="radio"/> Fire, go to c</p> <p><input type="radio"/> Scald, go to I1</p> <p><input type="radio"/> Electrocution, go to o</p> <p><input type="radio"/> U/K, go to I1</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | <p>c. Type of building on fire:</p> <p><input type="radio"/> N/A <input type="radio"/> Trailer/mobile home</p> <p><input type="radio"/> Single home</p> <p><input type="radio"/> Row home/townhouse</p> <p><input type="radio"/> Multi-unit (duplex, apartment, condo)</p> <p><input type="radio"/> Other, specify:</p> <p><input type="radio"/> U/K</p>                                                                                                                                                                                                                                                     |
| <p>d. Fire started by a person?</p> <p><input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K</p> <p>If yes, person's age:</p> <p>If yes, did the person have a history of starting fires?</p> <p><input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K</p> <p>If yes, suspected arson?</p> <p><input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | <p>e. Did any factors delay fire department arrival?</p> <p><input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K</p> <p>If yes, specify:</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | <p>f. Were barriers preventing safe exit?</p> <p><input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K</p> <p>If yes, check all that apply:</p> <p><input type="checkbox"/> Locked/blocked door <input type="checkbox"/> Smoke/fire</p> <p><input type="checkbox"/> Window security bars <input type="checkbox"/> Household items/hoarding</p> <p><input type="checkbox"/> Locked/blocked window</p> <p><input type="checkbox"/> Blocked stairway <input type="checkbox"/> Other, specify:</p> <p><input type="checkbox"/> Trapped above first floor <input type="checkbox"/> U/K</p> |
| <p>g. Was the child found in the same location as where the fire started?</p> <p><input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | <p>h. Was building a rental property?</p> <p><input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | <p>i. Were building/rental codes violated?</p> <p><input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K</p> <p>If yes, describe in narrative.</p>                                                                                                                                                                                                                                                                                                                                                                                                                                     |
| <p>j. Were proper working fire extinguishers present?</p> <p><input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | <p>k. Was fire sprinkler system present?</p> <p><input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | <p>l. Was fire sprinkler system required?</p> <p><input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
| <p>m. Were smoke alarms present?</p> <p><input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K</p> <p>Were they functioning properly?</p> <p><input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | <p>n. Did the child or family (check all that apply):</p> <div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> <p><input type="checkbox"/> None listed below</p> <p><input type="checkbox"/> Have a fire escape plan</p> <p><input type="checkbox"/> Practice a home fire drill</p> </div> <div style="width: 45%;"> <p><input type="checkbox"/> Have two or more possible exits from the location as where the child was found</p> <p><input type="checkbox"/> Attempt to put out the fire</p> <p><input type="checkbox"/> U/K</p> </div> </div>                                                                                                                                                                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
| <p>o. For electrocution, what cause:</p> <p><input type="radio"/> Lightning/electrical storm <input type="radio"/> Wire/product in water <input type="radio"/> U/K</p> <p><input type="radio"/> Faulty wiring <input type="radio"/> Child playing with outlet</p> <p><input type="radio"/> Contact with power line <input type="radio"/> Other, specify:</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |

| H3. DROWNING                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 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| <p>a. Where was child last seen before drowning? Select one.</p> <p><input type="radio"/> In water</p> <p><input type="radio"/> Near water</p> <p><input type="radio"/> In yard</p> <p><input type="radio"/> In bathroom/tub</p> <p><input type="radio"/> In house</p> <p><input type="radio"/> In car</p> <p><input type="radio"/> Other, specify:</p> <p><input type="radio"/> U/K</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                                                                                                                                                                  | <p>b. Drowning location:</p> <p><input type="radio"/> Open water/pond, go to c</p> <p><input type="radio"/> Pool, hot tub, spa, go to f</p> <p><input type="radio"/> Bathtub, go to i1</p> <p><input type="radio"/> Other, specify and go to h</p> <p><input type="radio"/> U/K, go to h</p>                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                                                                                                             |                                                                                                                                                                                                                                                                                        |
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For open water, place:</p> <p><input type="radio"/> Lake <input type="radio"/> Ocean</p> <p><input type="radio"/> River <input type="radio"/> Quarry or gravel pit</p> <p><input type="radio"/> Pond <input type="radio"/> Canal/drainage ditch</p> <p><input type="radio"/> Creek <input type="radio"/> U/K</p>                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                                                                                                                                                                                                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                                                                                                             |                                                                                                                                                                                                                                                                                        |
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Was child boating?</p> <p><input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                                                                                                                                                                                                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                                                                                                             |                                                                                                                                                                                                                                                                                        |
| <p>e. Select all contributing environmental factors. Check all that apply.</p> <p><input type="checkbox"/> None <input type="checkbox"/> Dropoff</p> <p><input type="checkbox"/> Weather <input type="checkbox"/> Rough waves</p> <p><input type="checkbox"/> Temperature <input type="checkbox"/> Flash flood</p> <p><input type="checkbox"/> Current <input type="checkbox"/> Water clarity</p> <p><input type="checkbox"/> Riptide/undertow <input type="checkbox"/> U/K</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               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| <p>f. For pool, type of pool:</p> <p><input type="radio"/> Above-ground</p> <p><input type="radio"/> In-ground <input type="radio"/> Hot tub, spa</p> <p><input type="radio"/> Wading <input type="radio"/> U/K</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                                                                                                                                                                                                                                                                                                  | <p>g. For pool, ownership is:</p> <p><input type="radio"/> Private</p> <p><input type="radio"/> Public</p> <p><input type="radio"/> U/K</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                                                                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                                                                                                             |                                                                                                                                                                                                                                                                                        |
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Flotation device used at time of the incident?</p> <p><input type="radio"/> N/A <input type="radio"/> No</p> <p><input type="radio"/> Yes, specify: <input type="radio"/> U/K</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                                                                                                                                                                                                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                                                                                                             |                                                                                                                                                                                                                                                                                        |
| <p>i. Did the child depend on a life jacket, swim vest or swim aid while in or around water?</p> <p><input type="radio"/> N/A <input type="radio"/> No</p> <p><input type="radio"/> Yes <input type="radio"/> U/K</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          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| <p>j. Did barriers/layers of protection exist to prevent access to water? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K</p> <p>If yes, check all that apply:</p> <table border="0"> <tr> <td> <p><input type="checkbox"/> Fence</p> <p>Was it breached?</p> <p><input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K</p> <p>If yes, check all that apply:</p> <p><input type="checkbox"/> Climbed fence</p> <p><input type="checkbox"/> Gap in fence</p> <p><input type="checkbox"/> Damaged fence</p> <p><input type="checkbox"/> Fence too short</p> <p>Fence surrounds water on:</p> <p><input type="radio"/> Four sides</p> <p><input type="radio"/> Three sides</p> <p><input type="radio"/> Two or one side</p> <p><input type="radio"/> U/K</p> </td> <td> <p><input type="checkbox"/> Gate</p> <p>Was it breached?</p> <p><input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K</p> <p>If yes, check all that apply:</p> <p><input type="checkbox"/> Gate left open</p> <p><input type="checkbox"/> Gate unlocked</p> <p><input type="checkbox"/> Gate latch failed</p> <p><input type="checkbox"/> Gap in gate</p> </td> <td> <p><input type="checkbox"/> Door</p> <p>Was it breached?</p> <p><input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K</p> <p>If yes, check all that apply:</p> <p><input type="checkbox"/> Door left open</p> <p><input type="checkbox"/> Door unlocked</p> <p><input type="checkbox"/> Door broken</p> <p><input type="checkbox"/> Door screen torn</p> <p><input type="checkbox"/> Door self-closer failed</p> </td> <td> <p><input type="checkbox"/> Alarm</p> <p>Was it breached?</p> <p><input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K</p> <p>If yes, check all that apply:</p> <p><input type="checkbox"/> Alarm not working</p> <p><input type="checkbox"/> Alarm not answered</p> </td> <td> <p><input type="checkbox"/> Cover</p> <p>Was it breached?</p> <p><input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K</p> <p>If yes, check all that apply:</p> <p><input type="checkbox"/> Cover left off</p> <p><input type="checkbox"/> Cover not locked</p> </td> </tr> </table> |                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                                                                                                                                                                             | <p><input type="checkbox"/> Fence</p> <p>Was it breached?</p> <p><input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K</p> <p>If yes, check all that apply:</p> <p><input type="checkbox"/> Climbed fence</p> <p><input type="checkbox"/> Gap in fence</p> <p><input type="checkbox"/> Damaged fence</p> <p><input type="checkbox"/> Fence too short</p> <p>Fence surrounds water on:</p> <p><input type="radio"/> Four sides</p> <p><input type="radio"/> Three sides</p> <p><input type="radio"/> Two or one side</p> <p><input type="radio"/> U/K</p> | <p><input type="checkbox"/> Gate</p> <p>Was it breached?</p> <p><input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K</p> <p>If yes, check all that apply:</p> <p><input type="checkbox"/> Gate left open</p> <p><input type="checkbox"/> Gate unlocked</p> <p><input type="checkbox"/> Gate latch failed</p> <p><input type="checkbox"/> Gap in gate</p> | <p><input type="checkbox"/> Door</p> <p>Was it breached?</p> <p><input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K</p> <p>If yes, check all that apply:</p> <p><input type="checkbox"/> Door left open</p> <p><input type="checkbox"/> Door unlocked</p> <p><input type="checkbox"/> Door broken</p> <p><input type="checkbox"/> Door screen torn</p> <p><input type="checkbox"/> Door self-closer failed</p> | <p><input type="checkbox"/> Alarm</p> <p>Was it breached?</p> <p><input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K</p> <p>If yes, check all that apply:</p> <p><input type="checkbox"/> Alarm not working</p> <p><input type="checkbox"/> Alarm not answered</p> | <p><input type="checkbox"/> Cover</p> <p>Was it breached?</p> <p><input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K</p> <p>If yes, check all that apply:</p> <p><input type="checkbox"/> Cover left off</p> <p><input type="checkbox"/> Cover not locked</p> |
| <p><input type="checkbox"/> Fence</p> <p>Was it breached?</p> <p><input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K</p> <p>If yes, check all that apply:</p> <p><input type="checkbox"/> Climbed fence</p> <p><input type="checkbox"/> Gap in fence</p> <p><input type="checkbox"/> Damaged fence</p> <p><input type="checkbox"/> Fence too short</p> <p>Fence surrounds water on:</p> <p><input type="radio"/> Four sides</p> <p><input type="radio"/> Three sides</p> <p><input type="radio"/> Two or one side</p> <p><input type="radio"/> U/K</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                        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                                                                                                                                                                                                                                                                   | <p><input type="checkbox"/> Alarm</p> <p>Was it breached?</p> <p><input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K</p> <p>If yes, check all that apply:</p> <p><input type="checkbox"/> Alarm not working</p> <p><input type="checkbox"/> Alarm not answered</p> | <p><input type="checkbox"/> Cover</p> <p>Was it breached?</p> <p><input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K</p> <p>If yes, check all that apply:</p> <p><input type="checkbox"/> Cover left off</p> <p><input type="checkbox"/> Cover not locked</p>                                                                                                                                                                                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| <p>k. Local ordinance(s) regulating access to water?</p> <p><input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K</p> <p>If yes, rules violated?</p> <p><input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                                                                                                                                                                                                                                                                  | <p>l. Select all of the child's water safety skills (without assistance or flotation device):</p> <p><input type="checkbox"/> None of these</p> <p><input type="checkbox"/> Float on their back independently</p> <p><input type="checkbox"/> Step or jump into water over their head</p> <p><input type="checkbox"/> Tread water for 1 minute</p> <p><input type="checkbox"/> Find a safe exit from the water</p> <p><input type="checkbox"/> Control breathing</p> <p><input type="checkbox"/> Return to surface</p> <p><input type="checkbox"/> Swim 25 yards</p> <p><input type="checkbox"/> Exit the water</p> <p><input type="checkbox"/> Had swimming lessons</p> <p><input type="checkbox"/> U/K</p> |                                                                                                                                                                                                                                                                                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                                                                                                             |                                                                                                                                                                                                                                                                                        |
| <p>m. Child able to swim?</p> <p><input type="radio"/> N/A <input type="radio"/> No</p> <p><input type="radio"/> Yes <input type="radio"/> U/K</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                                                                                                                                                                                                                                                                                                  | <p>n. Warning sign or label posted?</p> <p><input type="radio"/> N/A <input type="radio"/> No</p> <p><input type="radio"/> Yes <input type="radio"/> U/K</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                                                                                                             |                                                                                                                                                                                                                                                                                        |
| <p>o. Lifeguard present?</p> <p><input type="radio"/> N/A</p> <p><input type="radio"/> Yes</p> <p><input type="radio"/> No</p> <p><input type="radio"/> U/K</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                                                                                                                                                                                                                                                                  | <p>p. Rescue attempt made? <input type="radio"/> N/A <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K</p> <p>If yes, who? Check all that apply:</p> <p><input type="checkbox"/> Parent/relative</p> <p><input type="checkbox"/> EMS/first responder</p> <p><input type="checkbox"/> Other child</p> <p><input type="checkbox"/> Bystander</p> <p><input type="checkbox"/> Lifeguard</p> <p><input type="checkbox"/> Other, specify:</p> <p><input type="checkbox"/> Other adult</p> <p><input type="checkbox"/> U/K</p> <p>If yes, did rescuer(s) also drown?</p> <p><input type="radio"/> Yes</p> <p><input type="radio"/> No</p> <p><input type="radio"/> U/K</p>              |                                                                                                                                                                                                                                                                                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                                                                                                             |                                                                                                                                                                                                                                                                                        |
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Appropriate rescue equipment present?</p> <p><input type="radio"/> N/A <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K</p> <p>If yes, was it used?</p> <p><input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K</p> <p>If no, describe:</p>                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                                                                                                                                                                                                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                                                                                                             |                                                                                                                                                                                                                                                                                        |
| H4. ASPHYXIA                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 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| <p>a. Type of event:</p> <p><input type="radio"/> Sleep-related, go to i1</p> <p><input type="radio"/> Not sleep-related, go to b</p> <p><input type="radio"/> U/K, go to b</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                                                                                                                                                                                                                                                                  | <p>b. If not sleep-related, was the event:</p> <p><input type="radio"/> Suffocation, go to c</p> <p><input type="radio"/> Strangulation, go to d</p> <p><input type="radio"/> Choking, go to e</p> <p><input type="radio"/> Other, go to i1</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                                                                                                                                                                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                                                                                                             |                                                                                                                                                                                                                                                                                        |
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If suffocation, was the child:</p> <p><input type="radio"/> Covered in or fell into object</p> <p><input type="radio"/> Confined in tight space</p> <p><input type="radio"/> Wedged into tight space, specify:</p> <p><input type="radio"/> Other, specify:</p>                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                                                                                                                                                                                                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                                                                                                             |                                                                                                                                                                                                                                                                                        |
| <p>d. If strangulation, object causing event:</p> <p><input type="radio"/> Clothing <input type="radio"/> Electrical cord</p> <p><input type="radio"/> Blind cord <input type="radio"/> Person, go to H5I</p> <p><input type="radio"/> Car seat <input type="radio"/> Automobile power window or sunroof</p> <p><input type="radio"/> Belt <input type="radio"/> Other, specify:</p> <p><input type="radio"/> Rope/string</p> <p><input type="radio"/> Leash <input type="radio"/> U/K</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                                                                                                                                                                                                                                                                  | <p>e. If choking, object causing choking:</p> <p><input type="radio"/> Food, specify:</p> <p><input type="radio"/> Toy, specify:</p> <p><input type="radio"/> Vomit/gastric contents</p> <p><input type="radio"/> Other, specify:</p> <p><input type="radio"/> U/K</p>                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                                                                                                                                                                                                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                                                                                                             |                                                                                                                                                                                                                                                                                        |
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If choking, was Heimlich Maneuver attempted?</p> <p><input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                                                                                                                                                                                                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                                                                                                             |                                                                                                                                                                                                                                                                                        |



**H5. BODILY FORCE OR WEAPON**

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| a. Was the death a result of a weapon?<br><input type="radio"/> Yes, go to b<br><input type="radio"/> No, death due to bodily force, go to l<br><input type="radio"/> U/K, go to b                                                                                                                                                                                                                                                                                                                                                                                                 | b. Type of weapon:<br><input type="radio"/> Firearm, go to c<br><input type="radio"/> Knife or sharp instrument, go to l<br><input type="radio"/> Rope, go to l<br><input type="radio"/> Other, specify and go to l<br><input type="radio"/> U/K, go to l                                                                                                                                                                                            | c. For firearms, type:<br><input type="radio"/> Handgun<br><input type="radio"/> Shotgun<br><input type="radio"/> Rifle, specify:<br><input type="radio"/> 3D gun<br><input type="radio"/> Other, specify:<br><input type="radio"/> U/K | d. Was the firearm considered a smart firearm, e.g., uses a fingerprint lock, RFID watch?<br><input type="radio"/> Yes<br><input type="radio"/> No<br><input type="radio"/> U/K                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | e. Was firearm kept loaded?<br><input type="radio"/> Yes<br><input type="radio"/> No<br><input type="radio"/> U/K<br><br>If no, was the ammunition stored locked?<br><input type="radio"/> Yes<br><input type="radio"/> No<br><input type="radio"/> U/K |                                              |                               |                                |                                          |                               |                                |                                |  |                               |                                         |                               |                              |
| f. Was the firearm kept locked?<br><input type="radio"/> Yes<br><input type="radio"/> No<br><input type="radio"/> U/K                                                                                                                                                                                                                                                                                                                                                                                                                                                              | i. Was the person handling the firearm the owner? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K<br>j. Owner of fatal firearm:<br><input type="radio"/> Caregiver<br><input type="radio"/> Other family member<br><input type="radio"/> Child's significant other<br><input type="radio"/> Friend/acquaintance<br><input type="radio"/> Stranger<br><input type="radio"/> Other, specify:<br><input type="radio"/> U/K |                                                                                                                                                                                                                                         | l. Use of weapon at time, check all that apply:<br><input type="checkbox"/> Self injury<br><input type="checkbox"/> Commission of crime<br><input type="checkbox"/> Drug dealing/trading<br><input type="checkbox"/> Drive-by shooting<br><input type="checkbox"/> Random violence<br><input type="checkbox"/> Child abuse<br><input type="checkbox"/> Child was a bystander<br><input type="checkbox"/> Argument<br><input type="checkbox"/> Jealousy<br><input type="checkbox"/> Intimate partner violence<br><input type="checkbox"/> Hate crime<br><input type="checkbox"/> Bullying<br><br><input type="checkbox"/> Hunting<br><input type="checkbox"/> Target shooting<br><input type="checkbox"/> Playing with weapon<br><input type="checkbox"/> Showing gun to others<br><input type="checkbox"/> Russian roulette<br><input type="checkbox"/> Gang-related activity<br><input type="checkbox"/> Self-defense<br><input type="checkbox"/> Cleaning weapon<br><input type="checkbox"/> Loading weapon<br><input type="checkbox"/> Other, specify:<br><br><input type="checkbox"/> U/K |                                                                                                                                                                                                                                                         |                                              |                               |                                |                                          |                               |                                |                                |  |                               |                                         |                               |                              |
| g. Did the shooter of the firearm have permission to use the firearm at the time of incident?<br><input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K                                                                                                                                                                                                                                                                                                                                                                                                      | h. Did the caregiver or supervisor know a firearm was present at the time of incident?<br><input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K                                                                                                                                                                                                                                                                               |                                                                                                                                                                                                                                         | k. Was the firearm stolen?<br><input type="radio"/> Yes<br><input type="radio"/> No<br><input type="radio"/> U/K                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                                                                                                                                         |                                              |                               |                                |                                          |                               |                                |                                |  |                               |                                         |                               |                              |
| m. Type of bodily force used. Check all that apply:<br><table><tr><td><input type="checkbox"/> Beat, kick or punch</td><td><input type="checkbox"/> Bite</td><td><input type="checkbox"/> Throw</td><td><input type="checkbox"/> Other, specify:</td></tr><tr><td><input type="checkbox"/> Drop</td><td><input type="checkbox"/> Shake</td><td><input type="checkbox"/> Drown</td><td></td></tr><tr><td><input type="checkbox"/> Push</td><td><input type="checkbox"/> Strangle/choke</td><td><input type="checkbox"/> Burn</td><td><input type="checkbox"/> U/K</td></tr></table> |                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                                                                                                                                                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                                                                                                                                                                         | <input type="checkbox"/> Beat, kick or punch | <input type="checkbox"/> Bite | <input type="checkbox"/> Throw | <input type="checkbox"/> Other, specify: | <input type="checkbox"/> Drop | <input type="checkbox"/> Shake | <input type="checkbox"/> Drown |  | <input type="checkbox"/> Push | <input type="checkbox"/> Strangle/choke | <input type="checkbox"/> Burn | <input type="checkbox"/> U/K |
| <input type="checkbox"/> Beat, kick or punch                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | <input type="checkbox"/> Bite                                                                                                                                                                                                                                                                                                                                                                                                                        | <input type="checkbox"/> Throw                                                                                                                                                                                                          | <input type="checkbox"/> Other, specify:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                                                                                                                                                                         |                                              |                               |                                |                                          |                               |                                |                                |  |                               |                                         |                               |                              |
| <input type="checkbox"/> Drop                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | <input type="checkbox"/> Shake                                                                                                                                                                                                                                                                                                                                                                                                                       | <input type="checkbox"/> Drown                                                                                                                                                                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                                                                                                                                                                         |                                              |                               |                                |                                          |                               |                                |                                |  |                               |                                         |                               |                              |
| <input type="checkbox"/> Push                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | <input type="checkbox"/> Strangle/choke                                                                                                                                                                                                                                                                                                                                                                                                              | <input type="checkbox"/> Burn                                                                                                                                                                                                           | <input type="checkbox"/> U/K                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                                         |                                              |                               |                                |                                          |                               |                                |                                |  |                               |                                         |                               |                              |

**H6. FALL OR CRUSH**

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| a. Type:<br><input type="radio"/> Fall, go to b<br><input checked="" type="radio"/> Crush, go to g                                                                                                                                                                                                                                                                         | b. Height of fall:<br>_____ feet<br>_____ inches<br><br><input type="checkbox"/> U/K                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | c. Child fell from:<br><table><tr><td><input type="radio"/> Open window</td><td><input type="radio"/> Natural elevation</td><td><input type="radio"/> Stairs/steps</td><td><input type="radio"/> Moving object, specify:</td><td><input type="radio"/> Animal, specify:</td></tr><tr><td><input type="radio"/> Screen</td><td><input type="radio"/> Man-made elevation</td><td><input type="radio"/> Furniture</td><td><input type="radio"/> Bridge</td><td><input type="radio"/> Other, specify:</td></tr><tr><td><input type="radio"/> No screen</td><td><input type="radio"/> Playground equipment</td><td><input type="radio"/> Bed</td><td><input type="radio"/> Overpass</td><td></td></tr><tr><td><input type="radio"/> U/K if screen</td><td><input type="radio"/> Tree</td><td><input type="radio"/> Roof</td><td><input type="radio"/> Balcony</td><td><input type="radio"/> U/K</td></tr></table> |                                               |                                        |                                 | <input type="radio"/> Open window | <input type="radio"/> Natural elevation     | <input type="radio"/> Stairs/steps       | <input type="radio"/> Moving object, specify: | <input type="radio"/> Animal, specify: | <input type="radio"/> Screen     | <input type="radio"/> Man-made elevation | <input type="radio"/> Furniture                                                                                                                                                                                                                                                                                            | <input type="radio"/> Bridge                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | <input type="radio"/> Other, specify: | <input type="radio"/> No screen | <input type="radio"/> Playground equipment | <input type="radio"/> Bed        | <input type="radio"/> Overpass  |                                 | <input type="radio"/> U/K if screen     | <input type="radio"/> Tree  | <input type="radio"/> Roof                 | <input type="radio"/> Balcony              | <input type="radio"/> U/K            |                              |                                       |                                   |                           |
| <input type="radio"/> Open window                                                                                                                                                                                                                                                                                                                                          | <input type="radio"/> Natural elevation                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | <input type="radio"/> Stairs/steps                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | <input type="radio"/> Moving object, specify: | <input type="radio"/> Animal, specify: |                                 |                                   |                                             |                                          |                                               |                                        |                                  |                                          |                                                                                                                                                                                                                                                                                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                       |                                 |                                            |                                  |                                 |                                 |                                         |                             |                                            |                                            |                                      |                              |                                       |                                   |                           |
| <input type="radio"/> Screen                                                                                                                                                                                                                                                                                                                                               | <input type="radio"/> Man-made elevation                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | <input type="radio"/> Furniture                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | <input type="radio"/> Bridge                  | <input type="radio"/> Other, specify:  |                                 |                                   |                                             |                                          |                                               |                                        |                                  |                                          |                                                                                                                                                                                                                                                                                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                       |                                 |                                            |                                  |                                 |                                 |                                         |                             |                                            |                                            |                                      |                              |                                       |                                   |                           |
| <input type="radio"/> No screen                                                                                                                                                                                                                                                                                                                                            | <input type="radio"/> Playground equipment                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | <input type="radio"/> Bed                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | <input type="radio"/> Overpass                |                                        |                                 |                                   |                                             |                                          |                                               |                                        |                                  |                                          |                                                                                                                                                                                                                                                                                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                       |                                 |                                            |                                  |                                 |                                 |                                         |                             |                                            |                                            |                                      |                              |                                       |                                   |                           |
| <input type="radio"/> U/K if screen                                                                                                                                                                                                                                                                                                                                        | <input type="radio"/> Tree                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | <input type="radio"/> Roof                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | <input type="radio"/> Balcony                 | <input type="radio"/> U/K              |                                 |                                   |                                             |                                          |                                               |                                        |                                  |                                          |                                                                                                                                                                                                                                                                                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                       |                                 |                                            |                                  |                                 |                                 |                                         |                             |                                            |                                            |                                      |                              |                                       |                                   |                           |
| d. Surface child fell onto:<br><input type="radio"/> Cement/concrete<br><input type="radio"/> Grass<br><input type="radio"/> Gravel<br><input type="radio"/> Wood floor<br><input type="radio"/> Carpeted floor<br><br><input type="radio"/> Linoleum/vinyl<br><input type="radio"/> Marble/tile<br><input type="radio"/> Other, specify:<br><br><input type="radio"/> U/K | e. Barrier in place, check all that apply:.<br><table><tr><td><input type="checkbox"/> None</td><td><input type="checkbox"/> Stairway</td></tr><tr><td><input type="checkbox"/> Screen</td><td><input type="checkbox"/> Gate</td></tr><tr><td><input type="checkbox"/> Other window guard</td><td><input type="checkbox"/> Other, specify:</td></tr><tr><td><input type="checkbox"/> Fence</td><td><input type="checkbox"/> U/K</td></tr><tr><td><input type="checkbox"/> Railing</td><td></td></tr></table><br>f. Was child pushed, dropped or thrown?<br><input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K<br>If yes, go to H5l |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | <input type="checkbox"/> None                 | <input type="checkbox"/> Stairway      | <input type="checkbox"/> Screen | <input type="checkbox"/> Gate     | <input type="checkbox"/> Other window guard | <input type="checkbox"/> Other, specify: | <input type="checkbox"/> Fence                | <input type="checkbox"/> U/K           | <input type="checkbox"/> Railing |                                          | g. For crush, did child:<br><input type="radio"/> Climb up on object<br><input type="radio"/> Pull object down<br><input type="radio"/> Hide behind object<br><input type="radio"/> Go behind object<br><input type="radio"/> Fall out of object<br><input type="radio"/> Other, specify:<br><br><input type="radio"/> U/K | h. For crush, object causing crush:<br><table><tr><td><input type="radio"/> Appliance</td><td><input type="radio"/> Boulders/rocks</td></tr><tr><td><input type="radio"/> Television</td><td><input type="radio"/> Dirt/sand</td></tr><tr><td><input type="radio"/> Furniture</td><td><input type="radio"/> Person, go to H5l</td></tr><tr><td><input type="radio"/> Walls</td><td><input type="radio"/> Commercial equipment</td></tr><tr><td><input type="radio"/> Playground equipment</td><td><input type="radio"/> Farm equipment</td></tr><tr><td><input type="radio"/> Animal</td><td><input type="radio"/> Other, specify:</td></tr><tr><td><input type="radio"/> Tree branch</td><td><input type="radio"/> U/K</td></tr></table> |                                       | <input type="radio"/> Appliance | <input type="radio"/> Boulders/rocks       | <input type="radio"/> Television | <input type="radio"/> Dirt/sand | <input type="radio"/> Furniture | <input type="radio"/> Person, go to H5l | <input type="radio"/> Walls | <input type="radio"/> Commercial equipment | <input type="radio"/> Playground equipment | <input type="radio"/> Farm equipment | <input type="radio"/> Animal | <input type="radio"/> Other, specify: | <input type="radio"/> Tree branch | <input type="radio"/> U/K |
| <input type="checkbox"/> None                                                                                                                                                                                                                                                                                                                                              | <input type="checkbox"/> Stairway                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                               |                                        |                                 |                                   |                                             |                                          |                                               |                                        |                                  |                                          |                                                                                                                                                                                                                                                                                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                       |                                 |                                            |                                  |                                 |                                 |                                         |                             |                                            |                                            |                                      |                              |                                       |                                   |                           |
| <input type="checkbox"/> Screen                                                                                                                                                                                                                                                                                                                                            | <input type="checkbox"/> Gate                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                               |                                        |                                 |                                   |                                             |                                          |                                               |                                        |                                  |                                          |                                                                                                                                                                                                                                                                                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                       |                                 |                                            |                                  |                                 |                                 |                                         |                             |                                            |                                            |                                      |                              |                                       |                                   |                           |
| <input type="checkbox"/> Other window guard                                                                                                                                                                                                                                                                                                                                | <input type="checkbox"/> Other, specify:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                               |                                        |                                 |                                   |                                             |                                          |                                               |                                        |                                  |                                          |                                                                                                                                                                                                                                                                                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                       |                                 |                                            |                                  |                                 |                                 |                                         |                             |                                            |                                            |                                      |                              |                                       |                                   |                           |
| <input type="checkbox"/> Fence                                                                                                                                                                                                                                                                                                                                             | <input type="checkbox"/> U/K                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                               |                                        |                                 |                                   |                                             |                                          |                                               |                                        |                                  |                                          |                                                                                                                                                                                                                                                                                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                       |                                 |                                            |                                  |                                 |                                 |                                         |                             |                                            |                                            |                                      |                              |                                       |                                   |                           |
| <input type="checkbox"/> Railing                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                               |                                        |                                 |                                   |                                             |                                          |                                               |                                        |                                  |                                          |                                                                                                                                                                                                                                                                                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                       |                                 |                                            |                                  |                                 |                                 |                                         |                             |                                            |                                            |                                      |                              |                                       |                                   |                           |
| <input type="radio"/> Appliance                                                                                                                                                                                                                                                                                                                                            | <input type="radio"/> Boulders/rocks                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                               |                                        |                                 |                                   |                                             |                                          |                                               |                                        |                                  |                                          |                                                                                                                                                                                                                                                                                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                       |                                 |                                            |                                  |                                 |                                 |                                         |                             |                                            |                                            |                                      |                              |                                       |                                   |                           |
| <input type="radio"/> Television                                                                                                                                                                                                                                                                                                                                           | <input type="radio"/> Dirt/sand                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                               |                                        |                                 |                                   |                                             |                                          |                                               |                                        |                                  |                                          |                                                                                                                                                                                                                                                                                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                       |                                 |                                            |                                  |                                 |                                 |                                         |                             |                                            |                                            |                                      |                              |                                       |                                   |                           |
| <input type="radio"/> Furniture                                                                                                                                                                                                                                                                                                                                            | <input type="radio"/> Person, go to H5l                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                               |                                        |                                 |                                   |                                             |                                          |                                               |                                        |                                  |                                          |                                                                                                                                                                                                                                                                                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                       |                                 |                                            |                                  |                                 |                                 |                                         |                             |                                            |                                            |                                      |                              |                                       |                                   |                           |
| <input type="radio"/> Walls                                                                                                                                                                                                                                                                                                                                                | <input type="radio"/> Commercial equipment                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                               |                                        |                                 |                                   |                                             |                                          |                                               |                                        |                                  |                                          |                                                                                                                                                                                                                                                                                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                       |                                 |                                            |                                  |                                 |                                 |                                         |                             |                                            |                                            |                                      |                              |                                       |                                   |                           |
| <input type="radio"/> Playground equipment                                                                                                                                                                                                                                                                                                                                 | <input type="radio"/> Farm equipment                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                               |                                        |                                 |                                   |                                             |                                          |                                               |                                        |                                  |                                          |                                                                                                                                                                                                                                                                                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                       |                                 |                                            |                                  |                                 |                                 |                                         |                             |                                            |                                            |                                      |                              |                                       |                                   |                           |
| <input type="radio"/> Animal                                                                                                                                                                                                                                                                                                                                               | <input type="radio"/> Other, specify:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                               |                                        |                                 |                                   |                                             |                                          |                                               |                                        |                                  |                                          |                                                                                                                                                                                                                                                                                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                       |                                 |                                            |                                  |                                 |                                 |                                         |                             |                                            |                                            |                                      |                              |                                       |                                   |                           |
| <input type="radio"/> Tree branch                                                                                                                                                                                                                                                                                                                                          | <input type="radio"/> U/K                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                               |                                        |                                 |                                   |                                             |                                          |                                               |                                        |                                  |                                          |                                                                                                                                                                                                                                                                                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                       |                                 |                                            |                                  |                                 |                                 |                                         |                             |                                            |                                            |                                      |                              |                                       |                                   |                           |

| H7. POISONING, OVERDOSE OR ACUTE INTOXICATION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                |                                                                                                                                                                                                                                                           |                                                                                                                                                       |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                              |                       |  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------|-----------------------|--|
| a. Type of substance involved, check all that apply and note source, storage, and route of administration of substance: <span style="float: right;"><input type="checkbox"/> U/K</span>                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                |                                                                                                                                                                                                                                                           |                                                                                                                                                       |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                              |                       |  |
| <b>Source of Substance</b><br>1 = Bought from dealer or stranger (Prescription or illicit only)<br>2 = Bought from friend or relative<br>3 = From friend or relative for free<br>4 = Took from friend or relative without asking                                                                                                                                                                                                                                                                                                                                                                                                                                  |  | 5 = Own prescription (Prescription only)<br>6 = Bought from store/pharmacy (OTC or other substances only)<br>7 = Other<br>9 = U/K                                              |                                                                                                                                                                                                                                                           | <b>Stored in locked cabinet?</b><br>Yes<br>No<br>U/K                                                                                                  |  | <b>How substance was taken</b><br>1 = In utero<br>2 = Orally<br>3 = Nasally<br>4 = Intravenously<br>5 = Through skin<br>9 = U/K                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                              |                       |  |
| <b>Prescription drug</b><br><input type="checkbox"/> Antidepressant/antianxiety<br><input type="checkbox"/> Anticonvulsant<br><input type="checkbox"/> Antipsychotic<br><input type="checkbox"/> Benzodiazepines<br><input type="checkbox"/> Medications for substance use disorder (e.g. Methadone, buprenorphine, naltrexone)<br><input type="checkbox"/> Non-opioid pain medication<br><input type="checkbox"/> Opioid pain medication (including fentanyl)<br><input type="checkbox"/> Stimulants<br><input type="checkbox"/> Other Rx, specify:<br>Was it child's prescription? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K |  |                                                                                                                                                                                | <b>Source</b><br>Y N U                                                                                                                                                                                                                                    |                                                                                                                                                       |  | <b>Stored</b><br>Y N U                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                              | <b>Taken</b><br>Y N U |  |
| <b>Over-the-counter drug</b><br><input type="checkbox"/> Antihistamine<br><input type="checkbox"/> Cold medicine<br><input type="checkbox"/> Pain medication<br><input type="checkbox"/> Other OTC, specify:                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                                                | <b>Source</b><br>Y N U                                                                                                                                                                                                                                    |                                                                                                                                                       |  | <b>Stored</b><br>Y N U                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                              | <b>Taken</b><br>Y N U |  |
| <b>Illicit drugs</b><br><input type="checkbox"/> Cocaine<br><input type="checkbox"/> Heroin<br><input type="checkbox"/> Illicitly manufactured fentanyl/fentanyl analogs<br><input type="checkbox"/> Marijuana/THC<br><input type="checkbox"/> Methamphetamine<br><input type="checkbox"/> Other, specify:                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                | <b>Source</b><br>Y N U                                                                                                                                                                                                                                    |                                                                                                                                                       |  | <b>Stored</b><br>Y N U                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                              | <b>Taken</b><br>Y N U |  |
| <b>Other substances</b><br><input type="checkbox"/> Alcohol<br><input type="checkbox"/> Battery<br><input type="checkbox"/> Carbon monoxide<br><input type="checkbox"/> Other fume/gas/vapor<br><input type="checkbox"/> Other, specify:                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                | <b>Source</b><br>Y N U                                                                                                                                                                                                                                    |                                                                                                                                                       |  | <b>Stored</b><br>Y N U                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                              | <b>Taken</b><br>Y N U |  |
| b. Was the incident the result of?<br><input type="radio"/> Accidental overdose/acute intoxication<br><input type="radio"/> Medical treatment mishap<br><input type="radio"/> Deliberate poisoning<br><input type="radio"/> Other, specify:<br><input type="radio"/> U/K                                                                                                                                                                                                                                                                                                                                                                                          |  | c. Did the child have a prescription for a controlled substance within the previous 24 months?<br><input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K |                                                                                                                                                                                                                                                           | d. Did child have a non-fatal overdose within the previous 12 months?<br><input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K |  | e. Was Poison Control contacted?<br><input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K                                                                                                                                                                                                                                                                                                                                                        |  | f. For CO poisoning, was a CO alarm present?<br><input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K |                       |  |
| H8. MEDICAL CONDITION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                |                                                                                                                                                                                                                                                           |                                                                                                                                                       |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                              |                       |  |
| This section is skipped for fetal deaths <sup>†</sup>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                |                                                                                                                                                                                                                                                           |                                                                                                                                                       |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                              |                       |  |
| a. How long did the child have the medical condition?<br><input type="radio"/> In utero<br><input type="radio"/> Since birth<br><input type="radio"/> < 1 day<br><input type="radio"/> 1-6 days<br><input type="radio"/> 7-30 Days<br><input type="radio"/> 1-11 months<br><input type="radio"/> >= 1 year<br><input type="radio"/> U/K                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                | b. Was the death expected as a result of the medical condition?<br><input type="checkbox"/> N/A, not previously diagnosed<br><input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K<br><input type="checkbox"/> But at a later date |                                                                                                                                                       |  | c. Was child receiving health care for the medical condition?<br><input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K<br>If yes, within 48 hours of the death?<br><input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K<br>If yes, was the care plan appropriate for the medical condition?<br><input type="radio"/> N/A <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K<br>If no, specify: |  |                                                                                                                              |                       |  |
| d. Did the family experience barriers that prohibited following the care plan?<br><input type="radio"/> N/A<br><input type="radio"/> Yes<br><input type="radio"/> No<br><input type="radio"/> U/K<br>If yes, what treatment components were not completed? Check all that apply.                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                |                                                                                                                                                                                                                                                           |                                                                                                                                                       |  | e. In the week prior to the death, did the child experience any changes to medical care?<br><input type="radio"/> Yes, describe:<br><input type="radio"/> No<br><input type="radio"/> U/K                                                                                                                                                                                                                                                                               |  |                                                                                                                              |                       |  |
| f. Was the medical condition associated with an outbreak?<br><input type="radio"/> Yes, specify:<br><input type="radio"/> No<br><input type="radio"/> U/K<br>If yes, was the child vaccinated?<br><input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                |                                                                                                                                                                                                                                                           |                                                                                                                                                       |  | g. Was the death potentially caused by a medical error?<br><input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                              |                       |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                                                |                                                                                                                                                                                                                                                           |                                                                                                                                                       |  | h. Was the medical condition that caused the death a result of a complication or side effect of a previous illness, injury, condition, or medical treatment?<br><input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K                                                                                                                                                                                                                            |  |                                                                                                                              |                       |  |
| H9. OTHER KNOWN INJURY CAUSE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                                                |                                                                                                                                                                                                                                                           |                                                                                                                                                       |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                              |                       |  |
| Specify cause, describe in detail:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                |                                                                                                                                                                                                                                                           |                                                                                                                                                       |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                              |                       |  |



**I. OTHER CIRCUMSTANCES OF INCIDENT - ANSWER RELEVANT SECTIONS****11. SUDDEN AND UNEXPECTED DEATH IN THE YOUNG (SDY)**

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

Section 11: OMB No. 0920-1092, Exp. Date: 9/30/2025

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

- a. Was this death:
- ☐ A homicide?
  - ☐ A suicide?
  - ☐ An overdose?
  - ☐ A result of an external cause that was the obvious and only reason for the fatal injury?
  - ☐ Expected within 6 months due to terminal illness?
  - ☐ None of the above, go to 11b THIS IS AN SDY CASE
  - ☐ U/K, go to 11b
- If any of these apply, go to Section 12, THIS IS NOT AN SDY CASE.

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

**Symptom** **Present w/in 72 hours of death**

**Cardiac** **Yes** **No** **U/K**

Chest pain ☐ ☐ ☐

Dizziness/lightheadedness ☐ ☐ ☐

Fainting ☐ ☐ ☐

Palpitations ☐ ☐ ☐

**Neurologic**

Concussion ☐ ☐ ☐

Confusion ☐ ☐ ☐

Convulsions/seizure ☐ ☐ ☐

Headache ☐ ☐ ☐

Head injury ☐ ☐ ☐

**Respiratory**

Asthma ☐ ☐ ☐

Pneumonia ☐ ☐ ☐

Difficulty breathing ☐ ☐ ☐

**Other Acute Symptoms**

Fever ☐ ☐ ☐

Muscle aches/cramping ☐ ☐ ☐

Vomiting ☐ ☐ ☐

Other, specify: ☐

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

**Symptom** **Present more than 72 hours of death**

**Cardiac** **Yes** **No** **U/K**

Chest pain ☐ ☐ ☐

Dizziness/lightheadedness ☐ ☐ ☐

Fainting ☐ ☐ ☐

Palpitations ☐ ☐ ☐

**Neurologic**

Concussion ☐ ☐ ☐

Confusion ☐ ☐ ☐

Convulsions/seizure ☐ ☐ ☐

Head injury ☐ ☐ ☐

**Respiratory**

Difficulty breathing ☐ ☐ ☐

**Other**

Other, specify: ☐

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

☐ Yes ☐ No ☐ U/K

If yes, describe:

- e. Had the child in the past ever been diagnosed by a medical professional for the following?

| Condition                         | Diagnosed                                                         | Condition                     | Diagnosed                                                         | Condition                     | Diagnosed                                                         |
|-----------------------------------|-------------------------------------------------------------------|-------------------------------|-------------------------------------------------------------------|-------------------------------|-------------------------------------------------------------------|
| <b>Blood disease</b>              | <b>Y N U</b>                                                      | <b>Cardiac (continued)</b>    | <b>Y N U</b>                                                      | <b>Neurologic (continued)</b> | <b>Y N U</b>                                                      |
| Sickle cell disease               | <input type="radio"/> <input type="radio"/> <input type="radio"/> | High cholesterol              | <input type="radio"/> <input type="radio"/> <input type="radio"/> | Neurodegenerative disease     | <input type="radio"/> <input type="radio"/> <input type="radio"/> |
| Sickle cell trait                 | <input type="radio"/> <input type="radio"/> <input type="radio"/> | Hypertension                  | <input type="radio"/> <input type="radio"/> <input type="radio"/> | Stroke/mini stroke/           | <input type="radio"/> <input type="radio"/> <input type="radio"/> |
| Thrombophilia (clotting disorder) | <input type="radio"/> <input type="radio"/> <input type="radio"/> | Myocarditis (heart infection) | <input type="radio"/> <input type="radio"/> <input type="radio"/> | TIA-Transient Ischemic        |                                                                   |
| <b>Cardiac</b>                    | <b>Y N U</b>                                                      | Pulmonary hypertension        | <input type="radio"/> <input type="radio"/> <input type="radio"/> | Attack                        |                                                                   |
| Abnormal electrocardiogram        | <input type="radio"/> <input type="radio"/> <input type="radio"/> | Sudden cardiac arrest         | <input type="radio"/> <input type="radio"/> <input type="radio"/> | Central nervous system        | <input type="radio"/> <input type="radio"/> <input type="radio"/> |
| (EKG or ECG)                      |                                                                   | <b>Neurologic</b>             | <b>Y N U</b>                                                      | infection (meningitis         |                                                                   |
| Aneurysm or aortic dilatation     | <input type="radio"/> <input type="radio"/> <input type="radio"/> | Anoxic brain Injury           | <input type="radio"/> <input type="radio"/> <input type="radio"/> | or encephalitis)              |                                                                   |
| Arrhythmia/arrhythmia syndrome    | <input type="radio"/> <input type="radio"/> <input type="radio"/> | Traumatic brain injury/       | <input type="radio"/> <input type="radio"/> <input type="radio"/> | <b>Respiratory</b>            | <b>Y N U</b>                                                      |
| Cardiomyopathy                    | <input type="radio"/> <input type="radio"/> <input type="radio"/> | head injury/concussion        |                                                                   | Apnea                         | <input type="radio"/> <input type="radio"/> <input type="radio"/> |
| Congenital heart disease          | <input type="radio"/> <input type="radio"/> <input type="radio"/> | Brain tumor                   | <input type="radio"/> <input type="radio"/> <input type="radio"/> | Asthma                        | <input type="radio"/> <input type="radio"/> <input type="radio"/> |
| Coronary artery abnormality       | <input type="radio"/> <input type="radio"/> <input type="radio"/> | Brain hemorrhage              | <input type="radio"/> <input type="radio"/> <input type="radio"/> | Pulmonary embolism            | <input type="radio"/> <input type="radio"/> <input type="radio"/> |
| Endocarditis                      | <input type="radio"/> <input type="radio"/> <input type="radio"/> | Developmental brain disorder  | <input type="radio"/> <input type="radio"/> <input type="radio"/> | Pulmonary hemorrhage          | <input type="radio"/> <input type="radio"/> <input type="radio"/> |
| Heart failure                     | <input type="radio"/> <input type="radio"/> <input type="radio"/> | Epilepsy/seizure disorder     | <input type="radio"/> <input type="radio"/> <input type="radio"/> | Respiratory arrest            | <input type="radio"/> <input type="radio"/> <input type="radio"/> |
| Heart murmur                      | <input type="radio"/> <input type="radio"/> <input type="radio"/> | Febrile seizure               | <input type="radio"/> <input type="radio"/> <input type="radio"/> |                               |                                                                   |

| Condition (continued)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | Diagnosed             |                       |                       | Diagnosed                             |                       |                       | Diagnosed             |                                                        |                       |                       |                       |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------|-----------------------|-----------------------|---------------------------------------|-----------------------|-----------------------|-----------------------|--------------------------------------------------------|-----------------------|-----------------------|-----------------------|
| Other                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | Y                     | N                     | U                     | Y                                     | N                     | U                     | Y                     | N                                                      | U                     |                       |                       |
| Connective tissue disease                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | Kidney disease                        | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | Oncologic disease treated by chemotherapy or radiation | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Diabetes                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | Mental illness/psychiatric disease    | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | Prematurity                                            | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Endocrine disorder, other:<br>thyroid, adrenal, pituitary                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | Metabolic disease                     | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | Congenital disorder/genetic syndrome                   | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Hearing problems or deafness                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | Muscle disorder or muscular dystrophy | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | Other, specify:                                        | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| <p>If a more specific diagnosis is known, provide any additional information:</p> <hr/> <p>If any cardiac conditions above are selected, what cardiac treatments did the child have? Check all that apply:</p> <div style="display: flex; justify-content: space-between;"> <div> <input type="checkbox"/> Cardiac ablation<br/> <input type="checkbox"/> Cardiac device placement<br/>           (implanted cardioverter defibrillator (ICD) or pacemaker or Ventricular Assist Device (VAD))         </div> <div> <input type="checkbox"/> Heart surgery<br/> <input type="checkbox"/> Interventional cardiac catheterization         </div> <div> <input type="checkbox"/> None<br/> <input type="checkbox"/> Heart transplant<br/> <input type="checkbox"/> Other, specify:<br/> <input type="checkbox"/> U/K         </div> </div> |                       |                       |                       |                                       |                       |                       |                       |                                                        |                       |                       |                       |

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <p>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?</p> <p><u>Y</u> <u>N</u> <u>U</u>     <b>Deaths</b></p> <p><input type="radio"/> <input type="radio"/> <input type="radio"/> Sudden unexpected death before age 50</p> <p>If yes, the type of event, which relative, and relative's age at death (for example, brother at age 30 who died in an unexplained motor vehicle accident (driver of car)):</p> <div style="display: flex; justify-content: space-between;"> <div> <p><b>Heart Disease</b></p> <p><input type="radio"/> <input type="radio"/> <input type="radio"/> Heart condition/heart attack or stroke before age 50</p> <p>If yes, describe:</p> <p><input type="radio"/> <input type="radio"/> <input type="radio"/> Aortic aneurysm or aortic rupture</p> <p><input type="radio"/> <input type="radio"/> <input type="radio"/> Arrhythmia (fast or irregular heart rhythm)</p> <p><input type="radio"/> <input type="radio"/> <input type="radio"/> Cardiomyopathy</p> <p><input type="radio"/> <input type="radio"/> <input type="radio"/> Congenital heart disease</p> <p><b>Neurologic Disease</b></p> <p><input type="radio"/> <input type="radio"/> <input type="radio"/> Epilepsy or convulsions/seizure</p> <p><input type="radio"/> <input type="radio"/> <input type="radio"/> Other neurologic disease</p> </div> <div> <p><u>Y</u> <u>N</u> <u>U</u>     <b>Symptoms</b></p> <p><input type="radio"/> <input type="radio"/> <input type="radio"/> Febrile seizures</p> <p><input type="radio"/> <input type="radio"/> <input type="radio"/> Unexplained fainting</p> <p><b>Other Diagnoses</b></p> <p><input type="radio"/> <input type="radio"/> <input type="radio"/> Congenital deafness</p> <p><input type="radio"/> <input type="radio"/> <input type="radio"/> Connective tissue disease</p> <p><input type="radio"/> <input type="radio"/> <input type="radio"/> Mitochondrial disease</p> <p><input type="radio"/> <input type="radio"/> <input type="radio"/> Muscle disorder or muscular dystrophy</p> <p><input type="radio"/> <input type="radio"/> <input type="radio"/> Thrombophilia (clotting disorder)</p> <p><input type="radio"/> <input type="radio"/> <input type="radio"/> Other diseases that are genetic or run in families, specify:</p> </div> </div> | <p>g. Has any blood relative (siblings, parents, aunts, uncles, cousins, grandparents) had genetic testing?</p> <p><input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K</p> <p>If yes, describe the test/gene tested, reason for testing, family member tested, and results:</p> <p>Was a gene mutation found?</p> <p><input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K</p> |
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| <p>h. In the 72 hours prior to death was the child taking any prescribed medication(s)?     <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K</p> <p>If yes, describe:</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | <p>k. Was the child taking any of the following substance(s) within 24 hours of death? Check all that apply:</p> <div style="display: flex; justify-content: space-between;"> <div> <input type="checkbox"/> Over-the-counter medicine<br/> <input type="checkbox"/> Energy drinks<br/> <input type="checkbox"/> Caffeine<br/> <input type="checkbox"/> Performance enhancers<br/> <input type="checkbox"/> Supplements<br/> <input type="checkbox"/> Tobacco         </div> <div> <input type="checkbox"/> Alcohol<br/> <input type="checkbox"/> Illegal drugs<br/> <input type="checkbox"/> Legalized marijuana<br/> <input type="checkbox"/> Other, specify:<br/> <input type="checkbox"/> U/K         </div> </div> <p>If yes to any items above, describe:</p> |                       |                       |                       |     |                                             |                       |                       |                       |                       |                                        |                       |                       |                       |                       |                                           |                       |                       |                       |                       |                                                                                                                                                                                                                                         |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------|-----------------------|-----------------------|-----|---------------------------------------------|-----------------------|-----------------------|-----------------------|-----------------------|----------------------------------------|-----------------------|-----------------------|-----------------------|-----------------------|-------------------------------------------|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <p>i. Within 2 weeks prior to death had the child:</p> <table style="width: 100%;"> <thead> <tr> <th></th> <th>N/A</th> <th>Yes</th> <th>No</th> <th>U/K</th> </tr> </thead> <tbody> <tr> <td>Taken extra doses of prescribed medications</td> <td><input type="radio"/></td> <td><input type="radio"/></td> <td><input type="radio"/></td> <td><input type="radio"/></td> </tr> <tr> <td>Missed doses of prescribed medications</td> <td><input type="radio"/></td> <td><input type="radio"/></td> <td><input type="radio"/></td> <td><input type="radio"/></td> </tr> <tr> <td>Changed prescribed medications, describe:</td> <td><input type="radio"/></td> <td><input type="radio"/></td> <td><input type="radio"/></td> <td><input type="radio"/></td> </tr> </tbody> </table> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | N/A                   | Yes                   | No                    | U/K | Taken extra doses of prescribed medications | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | Missed doses of prescribed medications | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | Changed prescribed medications, describe: | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <p>j. Was the child compliant with their prescribed medications?</p> <p><input type="radio"/> N/A <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K</p> <p>If not compliant, describe why and how often:</p> |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | N/A                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | Yes                   | No                    | U/K                   |     |                                             |                       |                       |                       |                       |                                        |                       |                       |                       |                       |                                           |                       |                       |                       |                       |                                                                                                                                                                                                                                         |
| Taken extra doses of prescribed medications                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | <input type="radio"/>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |     |                                             |                       |                       |                       |                       |                                        |                       |                       |                       |                       |                                           |                       |                       |                       |                       |                                                                                                                                                                                                                                         |
| Missed doses of prescribed medications                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | <input type="radio"/>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |     |                                             |                       |                       |                       |                       |                                        |                       |                       |                       |                       |                                           |                       |                       |                       |                       |                                                                                                                                                                                                                                         |
| Changed prescribed medications, describe:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | <input type="radio"/>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |     |                                             |                       |                       |                       |                       |                                        |                       |                       |                       |                       |                                           |                       |                       |                       |                       |                                                                                                                                                                                                                                         |

| <p>l. Did the child experience any of the following stimuli at time of incident or within 24 hours of the incident?</p> |                       |                       |                       |                           |                       |                       |                                                                                                                                                                                                                   |  |  |
|-------------------------------------------------------------------------------------------------------------------------|-----------------------|-----------------------|-----------------------|---------------------------|-----------------------|-----------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--|
| Stimuli                                                                                                                 | At incident           |                       |                       | Within 24 hrs of incident |                       |                       |                                                                                                                                                                                                                   |  |  |
|                                                                                                                         | Yes                   | No                    | U/K                   | Yes                       | No                    | U/K                   |                                                                                                                                                                                                                   |  |  |
| Physical activity                                                                                                       | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/>     | <input type="radio"/> | <input type="radio"/> | If yes to physical activity, describe type of activity:<br>At incident                      Within 24 hours of incident<br><br><br>Other specify:<br>At incident                      Within 24 hours of incident |  |  |
| Sleep deprivation                                                                                                       | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/>     | <input type="radio"/> | <input type="radio"/> |                                                                                                                                                                                                                   |  |  |
| Driving                                                                                                                 | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/>     | <input type="radio"/> | <input type="radio"/> |                                                                                                                                                                                                                   |  |  |
| Visual/video game stimuli                                                                                               | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/>     | <input type="radio"/> | <input type="radio"/> |                                                                                                                                                                                                                   |  |  |
| Emotional stimuli                                                                                                       | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/>     | <input type="radio"/> | <input type="radio"/> |                                                                                                                                                                                                                   |  |  |
| Auditory stimuli/startle                                                                                                | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/>     | <input type="radio"/> | <input type="radio"/> |                                                                                                                                                                                                                   |  |  |
| Physical trauma                                                                                                         | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/>     | <input type="radio"/> | <input type="radio"/> |                                                                                                                                                                                                                   |  |  |
| Other, specify:                                                                                                         | <input type="radio"/> |                       |                       | <input type="radio"/>     |                       |                       |                                                                                                                                                                                                                   |  |  |

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| m. Was the child an athlete? <input type="radio"/> N/A <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K<br>If yes, type of sport: <input type="radio"/> Competitive <input type="radio"/> Recreational <input type="radio"/> U/K<br>If competitive, did the child participate in the 6 months prior to death? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |
| n. Did the child ever have any of the following <b>uncharacteristic</b> symptoms during or within 24 hours after physical activity? Check all that apply:<br><div style="display: flex; flex-wrap: wrap;"> <div style="width: 50%;"> <input type="checkbox"/> Chest pain<br/> <input type="checkbox"/> Convulsions/seizure<br/> <input type="checkbox"/> Dizziness/lightheadedness<br/> <input type="checkbox"/> Fainting         </div> <div style="width: 50%;"> <input type="checkbox"/> Palpitations<br/> <input type="checkbox"/> Shortness of breath/difficulty breathing<br/> <input type="checkbox"/> Other, specify:<br/> <input type="checkbox"/> U/K         </div> </div> If yes to any item, describe type of physical activity and extent of symptoms:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  | o. For child age 12 or older, did the child receive a pre-participation exam for a sport? <input type="radio"/> N/A <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K<br>If yes:<br>Was it done within a year prior to death? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K<br>Did the exam lead to restrictions for sports or otherwise?<br><input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K<br>If yes, specify restrictions: |  |
| <b>Questions p through v: Answer if "Epilepsy/Seizure Disorder" is answered Yes in question e above (Diagnosed for a medical condition)</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |
| p. How old was the child when diagnosed with epilepsy/seizure disorder?<br>Age 0 (infant) through 20 years: _____<br><input type="checkbox"/> U/K                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  | r. What type(s) of seizures did the child have? Check all that apply:<br><input type="checkbox"/> Non-convulsive<br><input type="checkbox"/> Convulsive (grand mal seizure or generalized tonic-clonic seizure)<br><input type="checkbox"/> Occur when exposure to strobe lights, video game, or flickering light (reflex seizure)<br><input type="checkbox"/> U/K                                                                                                                                                   |  |
| q. What were the underlying cause(s) of the child's seizures? Check all that apply:<br><div style="display: flex; flex-wrap: wrap;"> <div style="width: 50%;"> <input type="checkbox"/> Brain injury/trauma, specify:<br/> <input type="checkbox"/> Brain tumor<br/> <input type="checkbox"/> Cerebrovascular<br/> <input type="checkbox"/> Central nervous system infection<br/> <input type="checkbox"/> Developmental brain disorder<br/> <input type="checkbox"/> Genetic/chromosomal<br/> <input type="checkbox"/> Idiopathic or cryptogenic         </div> <div style="width: 50%;"> <input type="checkbox"/> Other acute illness or injury other than epilepsy<br/> <input type="checkbox"/> Other, specify:<br/> <input type="checkbox"/> U/K         </div> </div>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  | s. Describe the child's epilepsy/seizures (not including the seizure at time of death). Check all that apply:<br><input type="checkbox"/> Last less than 30 minutes<br><input type="checkbox"/> Last more than 30 minutes (status epilepticus)<br><input type="checkbox"/> Occur in the presence of fever (febrile seizure)<br><input type="checkbox"/> Occur in the absence of fever<br><input type="checkbox"/> Occur when exposed to strobe lights, video game, or flickering light (reflex seizure)              |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  | t. How many seizures did the child have in the year preceding death?<br><input type="radio"/> 0/never <input type="radio"/> 2 <input type="radio"/> More than 3<br><input type="radio"/> 1 <input type="radio"/> 3 <input type="radio"/> U/K                                                                                                                                                                                                                                                                         |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  | u. Did treatment for seizures include anti-epileptic drugs?<br><input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K<br>If yes, how many different types of anti-epileptic drugs did the child take?<br><input type="radio"/> 1 <input type="radio"/> 4 <input type="radio"/> More than 6<br><input type="radio"/> 2 <input type="radio"/> 5 <input type="radio"/> U/K<br><input type="radio"/> 3 <input type="radio"/> 6                                                                     |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  | v. Was night surveillance used?<br><input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K                                                                                                                                                                                                                                                                                                                                                                                                      |  |
| <b>12. ANSWER THIS ONLY IF CHILD IS UNDER AGE FIVE: WAS DEATH RELATED TO SLEEPING OR THE SLEEP ENVIRONMENT?</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |
| <div style="display: flex; justify-content: space-between;"> <span><input type="radio"/> Yes, go to I2a</span> <span><input type="radio"/> No, go to I2t</span> <span><input type="radio"/> U/K, go to I2a</span> </div>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |
| a. Incident sleep place:<br><div style="display: flex; flex-wrap: wrap;"> <div style="width: 33%;"> <input type="radio"/> Crib<br/>         If crib, type:<br/> <input type="radio"/> Not portable<br/> <input type="radio"/> Portable<br/> <input type="radio"/> Unknown crib type<br/> <input type="radio"/> Bassinet<br/> <input type="radio"/> Bed side sleeper<br/> <input type="radio"/> Baby box         </div> <div style="width: 33%;"> <input type="radio"/> Adult bed<br/> <input type="radio"/> Waterbed<br/> <input type="radio"/> Futon<br/> <input type="radio"/> Couch<br/> <input type="radio"/> Chair<br/> <input type="radio"/> Floor<br/> <input type="radio"/> Car seat         </div> <div style="width: 33%;"> <input type="radio"/> Rocking-inclined sleeper<br/> <input type="radio"/> Stroller<br/> <input type="radio"/> Swing<br/> <input type="radio"/> Bouncy chair<br/> <input type="radio"/> Other, specify:<br/> <input type="radio"/> U/K         </div> </div> <div style="display: flex; justify-content: space-between; margin-top: 10px;"> <div style="width: 33%;">         If adult bed, what type?<br/> <input type="radio"/> Twin<br/> <input type="radio"/> Full<br/> <input type="radio"/> Queen<br/> <input type="radio"/> King<br/> <input type="radio"/> Other, specify:<br/> <input type="radio"/> U/K         </div> <div style="width: 33%;">         If car seat, was car seat secured in seat of car?<br/> <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K         </div> </div> |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |
| b. Child put to sleep:<br><input type="radio"/> On back<br><input type="radio"/> On stomach<br><input type="radio"/> On side<br><input type="radio"/> U/K                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  | c. Child found:<br><input type="radio"/> On back<br><input type="radio"/> On stomach<br><input type="radio"/> On side<br><input type="radio"/> U/K                                                                                                                                                                                                                                                                                                                                                                   |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  | e. Usual sleep position:<br><input type="radio"/> On back<br><input type="radio"/> On stomach<br><input type="radio"/> On side<br><input type="radio"/> U/K                                                                                                                                                                                                                                                                                                                                                          |  |
| f. Was there any type of crib, portable crib or bassinet in home for child?<br><input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |
| d. Usual sleep place:<br><div style="display: flex; flex-wrap: wrap;"> <div style="width: 33%;"> <input type="radio"/> Crib<br/>         If crib, type:<br/> <input type="radio"/> Not portable<br/> <input type="radio"/> Portable<br/> <input type="radio"/> Unknown crib type<br/> <input type="radio"/> Bassinet<br/> <input type="radio"/> Bed side sleeper<br/> <input type="radio"/> Baby box         </div> <div style="width: 33%;"> <input type="radio"/> Adult bed<br/> <input type="radio"/> Waterbed<br/> <input type="radio"/> Futon<br/> <input type="radio"/> Couch<br/> <input type="radio"/> Chair<br/> <input type="radio"/> Floor<br/> <input type="radio"/> Car seat         </div> <div style="width: 33%;"> <input type="radio"/> Rocking-inclined sleeper<br/> <input type="radio"/> Stroller<br/> <input type="radio"/> Swing<br/> <input type="radio"/> Bouncy chair<br/> <input type="radio"/> Other, specify:<br/> <input type="radio"/> U/K         </div> </div> <div style="display: flex; justify-content: space-between; margin-top: 10px;"> <div style="width: 33%;">         If adult bed, what type?<br/> <input type="radio"/> Twin<br/> <input type="radio"/> Full<br/> <input type="radio"/> Queen<br/> <input type="radio"/> King<br/> <input type="radio"/> Other, specify:<br/> <input type="radio"/> U/K         </div> <div style="width: 33%;"> <input type="radio"/> King<br/> <input type="radio"/> Other, specify:<br/> <input type="radio"/> U/K         </div> </div>                                           |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |
| g. Child in a new or different environment than usual?<br><input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K<br>If yes, describe why:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  | h. Child last placed to sleep with a pacifier?<br><input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K                                                                                                                                                                                                                                                                                                                                                                                       |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  | i. Child wrapped or swaddled in blanket when last placed?<br><input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K<br>If yes, describe:                                                                                                                                                                                                                                                                                                                                                       |  |







|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                             |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <p>i. Warning signs (<a href="https://youthsuicidewarningsigns.org">https://youthsuicidewarningsigns.org</a>) w/in 30 days of death:</p> <p>Check all that apply:</p> <div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> <input type="checkbox"/> None listed below<br/> <input type="checkbox"/> Talked about or made plans for suicide<br/> <input type="checkbox"/> Expressed hopelessness about the future<br/> <input type="checkbox"/> Displayed severe/overwhelming emotional pain or distress         </div> <div style="width: 45%;"> <input type="checkbox"/> Expressed perceived burden on others<br/> <input type="checkbox"/> Showed worrisome behavioral cues or marked changes in behavior<br/> <input type="checkbox"/> U/K         </div> </div>                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | <p>j. Child experienced a known crisis within 30 days of the death?</p> <p style="text-align: center;"><input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K</p> <p>If yes, explain:</p>                                                                                                                                                                                             |
| <p>k. Suicide was part of:</p> <div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> <input type="checkbox"/> None listed below<br/> <input type="checkbox"/> A cluster         </div> <div style="width: 45%;"> <input type="checkbox"/> A contagion, copy-cat or imitation<br/> <input type="checkbox"/> A suicide pact         </div> </div>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | <p><input type="checkbox"/> A murder-suicide</p>                                                                                                                                                                                                                                                                                                                                                            |
| <p><b>17. LIFE STRESSORS</b> Please indicate all stressors that were present for this child and family around the time of death.</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                                                                                                                                                                                                                                                                                                                             |
| <p>a. Life stressors - Social/economic</p> <div style="display: flex; flex-wrap: wrap;"> <div style="width: 25%;"> <input type="checkbox"/> None listed below<br/> <input type="checkbox"/> Racism<br/> <input type="checkbox"/> Discrimination<br/> <input type="checkbox"/> Poverty         </div> <div style="width: 25%;"> <input type="checkbox"/> Neighborhood discord<br/> <input type="checkbox"/> Job problems<br/> <input type="checkbox"/> Money problems<br/> <input type="checkbox"/> Food insecurity         </div> <div style="width: 25%;"> <input type="checkbox"/> No phone<br/> <input type="checkbox"/> Housing instability<br/> <input type="checkbox"/> Witnessed violence<br/> <input type="checkbox"/> Tobacco exposure         </div> <div style="width: 25%;"> <input type="checkbox"/> Lack of transportation<br/> <input type="checkbox"/> Cultural differences<br/> <input type="checkbox"/> Language barriers         </div> <div style="width: 25%;"> <input type="checkbox"/> Lack of child care<br/> <input type="checkbox"/> Pregnancy<br/> <input type="checkbox"/> Pregnancy scare         </div> </div>                                                                                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                             |
| <p>b. Life stressors - Medical</p> <div style="display: flex; flex-wrap: wrap;"> <div style="width: 25%;"> <input type="checkbox"/> None listed below<br/> <input type="checkbox"/> Lack of family or social support for care<br/> <input type="checkbox"/> Caregiver distrust of health care system         </div> <div style="width: 25%;"> <input type="checkbox"/> Caregiver unskilled in providing care<br/> <input type="checkbox"/> Lack of money for care<br/> <input type="checkbox"/> Services not available         </div> <div style="width: 25%;"> <input type="checkbox"/> Multiple providers, not coordinated<br/> <input type="checkbox"/> Limitations of health insurance<br/> <input type="checkbox"/> Provider bias         </div> <div style="width: 25%;"> <input type="checkbox"/> Felt dismissed by provider<br/> <input type="checkbox"/> Lack of provider-family compatibility         </div> </div>                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                             |
| <p>c. Life Stressors- Relationships</p> <div style="display: flex; flex-wrap: wrap;"> <div style="width: 25%;"> <input type="checkbox"/> None listed below<br/> <input type="checkbox"/> Family discord<br/> <input type="checkbox"/> Argument w/ parents/caregivers<br/> <input type="checkbox"/> Parents' divorce/separation         </div> <div style="width: 25%;"> <input type="checkbox"/> Parents' incarceration<br/> <input type="checkbox"/> Breakup<br/> <input type="checkbox"/> Argument with significant other<br/> <input type="checkbox"/> Social discord         </div> <div style="width: 25%;"> <input type="checkbox"/> Argument with friends<br/> <input type="checkbox"/> Isolation<br/> <input type="checkbox"/> Bullying as victim<br/> <input type="checkbox"/> Bullying as perpetrator         </div> <div style="width: 25%;"> <input type="checkbox"/> Cyberbullying as victim<br/> <input type="checkbox"/> Cyberbullying as a perpetrator<br/> <input type="checkbox"/> Peer violence as a victim<br/> <input type="checkbox"/> Peer violence as a perpetrator         </div> <div style="width: 25%;"> <input type="checkbox"/> Stress due to gender identity<br/> <input type="checkbox"/> Stress due to sexual orientation         </div> </div> |                                                                                                                                                                                                                                                                                                                                                                                                             |
| <p>d. Life stressors - School (age 5 and over)</p> <div style="display: flex; flex-wrap: wrap;"> <div style="width: 50%;"> <input type="checkbox"/> None listed below<br/> <input type="checkbox"/> School failure<br/> <input type="checkbox"/> Pressure to succeed         </div> <div style="width: 50%;"> <input type="checkbox"/> Extracurricular activities<br/> <input type="checkbox"/> New school<br/> <input type="checkbox"/> Other school problems         </div> </div>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | <p>e. Technology (age 5 and over)</p> <div style="display: flex; flex-wrap: wrap;"> <div style="width: 50%;"> <input type="checkbox"/> None listed below<br/> <input type="checkbox"/> Electronic gaming<br/> <input type="checkbox"/> Texting         </div> <div style="width: 50%;"> <input type="checkbox"/> Restriction of technology<br/> <input type="checkbox"/> Social media         </div> </div> |
| <p>f. Life stressors - Transitions (age 5 and over)</p> <div style="display: flex; flex-wrap: wrap;"> <div style="width: 50%;"> <input type="checkbox"/> None listed below<br/> <input type="checkbox"/> Release from hospital<br/> <input type="checkbox"/> Transition from any level of mental health care to another (e.g. inpatient to outpatient, inpatient to residential, etc.)         </div> <div style="width: 50%;"> <input type="checkbox"/> Release from juvenile justice facility<br/> <input type="checkbox"/> End of school year/school break<br/> <input type="checkbox"/> Transition to/from child welfare system<br/> <input type="checkbox"/> Release from immigrant detention center         </div> </div>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | <p>g. Life stressors - Trauma (age 5 and over)</p> <div style="display: flex; flex-wrap: wrap;"> <div style="width: 50%;"> <input type="checkbox"/> None listed below<br/> <input type="checkbox"/> Rape/sexual assault<br/> <input type="checkbox"/> Previous abuse (emotional/physical)         </div> <div style="width: 50%;"> <input type="checkbox"/> Family/domestic violence         </div> </div>  |
| <p>h. Life stressors - Describe any other life stressors:</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                             |
| <p><b>18. DEATHS DURING THE COVID-19 PANDEMIC (complete for all ages)</b></p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                             |
| <p>a. For the 12 months before the child's death, did the family experience any disruptions or significant changes to the following? Check all that apply:</p> <div style="display: flex; flex-wrap: wrap;"> <div style="width: 45%;"> <input type="checkbox"/> None listed below<br/> <input type="checkbox"/> School<br/> <input type="checkbox"/> Daycare<br/> <input type="checkbox"/> Employment<br/> <input type="checkbox"/> Social services (like unemployment assistance, TANF, WIC)<br/> <input type="checkbox"/> Living environment<br/> <input type="checkbox"/> Medical care         </div> <div style="width: 45%;"> <input type="checkbox"/> Mental health or substance use/abuse care<br/> <input type="checkbox"/> Home-based services (non-child welfare)<br/> <input type="checkbox"/> Child welfare services<br/> <input type="checkbox"/> Legal proceedings within criminal, civil, or family courts<br/> <input type="checkbox"/> Other, specify:<br/> <input type="checkbox"/> U/K         </div> </div>                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                             |
| <p>b. For the 12 months before the child's death, did the child's family live in an area with an official stay at home order? <span style="float: right;"><input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K</span></p> <p>If yes, was the stay at home order in place at the time of the child's death? <span style="float: right;"><input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K</span></p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                                                                                                                                                                                                                                                                                             |
| <p>c. Was the child exposed to COVID-19 within 14 days of death? <span style="float: right;"><input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K</span> If yes, describe:</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                                                                                                                                                                                                                                                                                             |
| <p>d. Did the child have medical evidence of a significant inflammatory syndrome (including for example, fever, laboratory evidence of inflammation, and involvement of two or more organs) requiring hospitalization in the week before death? <span style="float: right;"><input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K</span></p> <p>If yes, was the child diagnosed with MIS-C? <span style="float: right;"><input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K</span></p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                                                                                                                                                                                                                                                                                             |
| <p>e. Was the child eligible to receive a COVID-19 vaccination? <span style="float: right;"><input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K</span></p> <p>If eligible, did they receive their first dose? <span style="float: right;"><input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K</span> If yes, approx. number of weeks before death: ____</p> <p>If eligible and received their first dose, which option best represents their vaccination status? <span style="float: right;"><input type="radio"/> Partially vaccinated <input type="radio"/> Fully vaccinated <input type="radio"/> U/K</span></p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                                                                                                                                                                                                                                                                                                                             |
| <p>f. For infants or fetal deaths only, did the childbearing parent receive their COVID-19 vaccination? <span style="float: right;"><input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K</span></p> <p>If yes, when did they receive their first dose?</p> <div style="display: flex; flex-wrap: wrap;"> <div style="width: 50%;"> <input type="radio"/> Before pregnancy<br/> <input type="radio"/> 1st trimester<br/> <input type="radio"/> 2nd trimester         </div> <div style="width: 50%;"> <input type="radio"/> 3rd trimester<br/> <input type="radio"/> After delivery<br/> <input type="radio"/> U/K         </div> </div> <p>If yes, which option best represents their vaccination status? <span style="float: right;"><input type="radio"/> Partially vaccinated <input type="radio"/> Fully vaccinated <input type="radio"/> U/K</span></p>                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                                                                                                                                                                                                                                                                                                                             |



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| <p>g. Select the one option that best describes the impact of COVID-19 on this child's death:</p> <p><input type="radio"/> COVID-19 was the immediate or underlying cause of death</p> <p><input type="radio"/> COVID-19 was diagnosed at autopsy or child was suspected to have COVID-19</p> <p><input type="radio"/> COVID-19 indirectly contributed to the death but was not the immediate or underlying cause of death</p> <p><input type="radio"/> The childbearing parent contracted COVID-19, specify:</p> <div style="display: flex; justify-content: space-between;"> <div> <input type="radio"/> Before pregnancy<br/> <input type="radio"/> 1st trimester<br/> <input type="radio"/> 2nd trimester         </div> <div> <input type="radio"/> 3rd trimester<br/> <input type="radio"/> After delivery<br/> <input type="radio"/> U/K         </div> </div> <p><input type="radio"/> Other, specify:</p> <p><input type="radio"/> COVID-19 had no impact on this child's death</p> <p><input type="radio"/> U/K</p> | <p>h. Did COVID-19 impact the team's ability to conduct this fatality review?</p> <p><input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K</p> <p>If yes, check all that apply:</p> <p><input type="checkbox"/> Unable to obtain records</p> <p><input type="checkbox"/> Team members unable to attend review</p> <p><input type="checkbox"/> Remote reviews negatively impacted review process</p> <p><input type="checkbox"/> Team leaders redirected to COVID-19 response</p> |
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| J. PERSON RESPONSIBLE (OTHER THAN DECEDENT)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | This section is skipped for fetal deaths*        |                                                           |                                   |                                                                          |                                     |                                                                                                                                                                                                                                                                                                                                                                                                                               |                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                            |                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                           |                                                                                     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| <p>1. Did a person or persons other than the child do something or fail to do something that caused or contributed to the death?</p> <p><input type="radio"/> Yes/probable</p> <p><input type="radio"/> No, go to K</p> <p><input type="radio"/> U/K, go to K</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | <p>2. What act(s)? Enter information for the first person under "One" and if there is a second person, use column "Two." Describe acts in narrative.</p> <table style="width: 100%; border-collapse: collapse;"> <tr> <th style="text-align: left; border-bottom: 1px solid black;">One</th> <th style="text-align: left; border-bottom: 1px solid black;">Two</th> </tr> <tr> <td><input type="radio"/> Child abuse</td> <td><input type="radio"/> Exposure to hazards</td> </tr> <tr> <td><input type="radio"/> Child neglect</td> <td><input type="radio"/> Assault, not child abuse</td> </tr> <tr> <td><input type="radio"/> Poor/absent supervision</td> <td><input type="radio"/> Other, specify:</td> </tr> <tr> <td></td> <td><input type="radio"/> U/K</td> </tr> </table> | One                                              | Two                                                       | <input type="radio"/> Child abuse | <input type="radio"/> Exposure to hazards                                | <input type="radio"/> Child neglect | <input type="radio"/> Assault, not child abuse                                                                                                                                                                                                                                                                                                                                                                                | <input type="radio"/> Poor/absent supervision | <input type="radio"/> Other, specify:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                            | <input type="radio"/> U/K                        | <p>3. Did the team have information about the person(s)?</p> <table style="width: 100%; border-collapse: collapse;"> <tr> <th style="text-align: left; border-bottom: 1px solid black;">One</th> <th style="text-align: left; border-bottom: 1px solid black;">Two</th> </tr> <tr> <td><input type="radio"/> Yes</td> <td><input type="radio"/> Yes</td> </tr> <tr> <td><input type="radio"/> No, go to K</td> <td><input type="radio"/> No, go to K</td> </tr> </table> | One                       | Two                                                                                                 | <input type="radio"/> Yes                                                                                                                                                                                                                                                                                                                                                                                                         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| <p>4. Is person listed in a previous section?</p> <table style="width: 100%; border-collapse: collapse;"> <tr> <th style="text-align: left; border-bottom: 1px solid black;">One</th> <th style="text-align: left; border-bottom: 1px solid black;">Two</th> </tr> <tr> <td><input type="radio"/> Yes, childbearing parent, go to J17</td> <td></td> </tr> <tr> <td><input type="radio"/> Yes, non-childbearing biological parent, go to J17</td> <td></td> </tr> <tr> <td><input type="radio"/> Yes, caregiver one, go to J17</td> <td></td> </tr> <tr> <td><input type="radio"/> Yes, caregiver two, go to J17</td> <td></td> </tr> <tr> <td><input type="radio"/> Yes, supervisor, go to J19</td> <td></td> </tr> <tr> <td><input type="radio"/> No</td> <td></td> </tr> </table>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | One                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | Two                                              | <input type="radio"/> Yes, childbearing parent, go to J17 |                                   | <input type="radio"/> Yes, non-childbearing biological parent, go to J17 |                                     | <input type="radio"/> Yes, caregiver one, go to J17                                                                                                                                                                                                                                                                                                                                                                           |                                               | <input type="radio"/> Yes, caregiver two, go to J17                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                            | <input type="radio"/> Yes, supervisor, go to J19 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | <input type="radio"/> No  |                                                                                                     | <p>5. Primary person(s) responsible for action(s): Select one for each person responsible.</p> <table style="width: 100%; border-collapse: collapse;"> <tr> <th style="text-align: left; border-bottom: 1px solid black;">One</th> <th style="text-align: left; border-bottom: 1px solid black;">Two</th> <th style="text-align: left; border-bottom: 1px solid black;">One</th> <th style="text-align: left; border-bottom: 1px solid black;">Two</th> <th style="text-align: left; border-bottom: 1px solid black;">One</th> <th style="text-align: left; border-bottom: 1px solid black;">Two</th> </tr> <tr> <td><input type="radio"/> Adoptive parent</td> <td><input type="radio"/> Sibling</td> <td><input type="radio"/> Medical provider</td> <td></td> <td></td> <td></td> </tr> <tr> <td><input type="radio"/> Stepparent</td> <td><input type="radio"/> Other relative</td> <td><input type="radio"/> Institutional staff</td> <td></td> <td></td> <td></td> </tr> <tr> <td><input type="radio"/> Foster parent</td> <td><input type="radio"/> Friend</td> <td><input type="radio"/> Babysitter</td> <td></td> <td></td> <td></td> </tr> <tr> <td><input type="radio"/> Parent's partner</td> <td><input type="radio"/> Acquaintance</td> <td><input type="radio"/> Licensed child care worker</td> <td></td> <td></td> <td></td> </tr> <tr> <td><input type="radio"/> Grandparent</td> <td><input type="radio"/> Child's boyfriend or girlfriend</td> <td><input type="radio"/> Other, specify:</td> <td></td> <td></td> <td></td> </tr> <tr> <td></td> <td><input type="radio"/> Stranger</td> <td><input type="radio"/> U/K</td> <td></td> <td></td> <td></td> </tr> </table> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | One                               | Two                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | One                       | Two                                                                                                                                                                                                                                                                                                                                                                                                                                                     | One                       | Two                                                                                         | <input type="radio"/> Adoptive parent | <input type="radio"/> Sibling          | <input type="radio"/> Medical provider                                                                                                                                                                                                                                                                                                                                                                                                                                    |     |                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                           | <input type="radio"/> Stepparent | <input type="radio"/> Other relative | <input type="radio"/> Institutional staff |                           |  |                           | <input type="radio"/> Foster parent | <input type="radio"/> Friend | <input type="radio"/> Babysitter |  |  |  | <input type="radio"/> Parent's partner | <input type="radio"/> Acquaintance | <input type="radio"/> Licensed child care worker |  |  |  | <input type="radio"/> Grandparent | <input type="radio"/> Child's boyfriend or girlfriend | <input type="radio"/> Other, specify: |  |  |  |  | <input type="radio"/> Stranger | <input type="radio"/> U/K |  |  |  |
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| <input type="radio"/> Yes, caregiver two, go to J17                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    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| <input type="radio"/> Yes, supervisor, go to J19                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       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| <p>6. Person's age in years:</p> <table style="width: 100%; border-collapse: collapse;"> <tr> <th style="text-align: left; border-bottom: 1px solid black;">One</th> <th style="text-align: left; border-bottom: 1px solid black;">Two</th> </tr> <tr> <td>_____</td> <td>_____ # Years</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/> U/K</td> </tr> </table>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | One                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | Two                                              | _____                                                     | _____ # Years                     | <input type="checkbox"/>                                                 | <input type="checkbox"/> U/K        | <p>7. 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Person speaks and understands English?</p> <table style="width: 100%; border-collapse: collapse;"> <tr> <th style="text-align: left; border-bottom: 1px solid black;">One</th> <th style="text-align: left; border-bottom: 1px solid black;">Two</th> </tr> <tr> <td><input type="radio"/> Yes</td> <td></td> </tr> <tr> <td><input type="radio"/> No</td> <td></td> </tr> <tr> <td><input type="radio"/> U/K</td> <td></td> </tr> </table> <p>If no, language spoken:</p> | One                               | Two                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | <input type="radio"/> Yes |                                                                                                                                                                                                                                                                                                                                                                                                                                                         | <input type="radio"/> No  |                                                                                             | <input type="radio"/> U/K             |                                        | <p>9. Person on active military duty?</p> <table style="width: 100%; border-collapse: collapse;"> <tr> <th style="text-align: left; border-bottom: 1px solid black;">One</th> <th style="text-align: left; border-bottom: 1px solid black;">Two</th> </tr> <tr> <td><input type="radio"/> Yes</td> <td></td> </tr> <tr> <td><input type="radio"/> No</td> <td></td> </tr> <tr> <td><input type="radio"/> U/K</td> <td></td> </tr> </table> <p>If yes, specify branch:</p> | One | Two                                                                                                                                                                                                                                                                                                                                                                                                                                                       | <input type="radio"/> Yes |                                  | <input type="radio"/> No             |                                           | <input type="radio"/> U/K |  |                           |                                     |                              |                                  |  |  |  |                                        |                                    |                                                  |  |  |  |                                   |                                                       |                                       |  |  |  |  |                                |                           |  |  |  |
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| <p>10. Person(s) have history of substance abuse?</p> <table style="width: 100%; border-collapse: collapse;"> <tr> <th style="text-align: left; border-bottom: 1px solid black;">One</th> <th style="text-align: left; border-bottom: 1px solid black;">Two</th> </tr> <tr> <td><input type="radio"/> Yes</td> <td></td> </tr> <tr> <td><input type="radio"/> No</td> <td></td> </tr> <tr> <td><input type="radio"/> U/K</td> <td></td> </tr> </table>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | One                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | Two                                              | <input type="radio"/> Yes                                 |                                   | <input type="radio"/> No                                                 |                                     | <input type="radio"/> U/K                                                                                                                                                                                                                                                                                                                                                                                                     |                                               | <p>11. Person(s) have history of child maltreatment as victim?</p> <table style="width: 100%; border-collapse: collapse;"> <tr> <th style="text-align: left; border-bottom: 1px solid black;">One</th> <th style="text-align: left; border-bottom: 1px solid black;">Two</th> </tr> <tr> <td><input type="radio"/> Yes</td> <td></td> </tr> <tr> <td><input type="radio"/> No</td> <td></td> </tr> <tr> <td><input type="radio"/> U/K</td> <td></td> </tr> </table>                                                                                             | One                        | Two                                              | <input type="radio"/> Yes                                                                                                                                                                                                                                                                                                                                                                                                                                                |                           | <input type="radio"/> No                                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | <input type="radio"/> U/K                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                   | <p>12. Person(s) have history of child maltreatment as a perpetrator?</p> <table style="width: 100%; border-collapse: collapse;"> <tr> <th style="text-align: left; border-bottom: 1px solid black;">One</th> <th style="text-align: left; border-bottom: 1px solid black;">Two</th> </tr> <tr> <td><input type="radio"/> Yes</td> <td></td> </tr> <tr> <td><input type="radio"/> No</td> <td></td> </tr> <tr> <td><input type="radio"/> U/K</td> <td></td> </tr> </table> | One                       | Two                                                                                                                                                                                                                                                                                                                                                                                                                                                     | <input type="radio"/> Yes |                                                                                             | <input type="radio"/> No              |                                        | <input type="radio"/> U/K                                                                                                                                                                                                                                                                                                                                                                                                                                                 |     | <p>13. Person(s) have disability or chronic illness?</p> <table style="width: 100%; border-collapse: collapse;"> <tr> <th style="text-align: left; border-bottom: 1px solid black;">One</th> <th style="text-align: left; border-bottom: 1px solid black;">Two</th> </tr> <tr> <td><input type="radio"/> Yes</td> <td></td> </tr> <tr> <td><input type="radio"/> No</td> <td></td> </tr> <tr> <td><input type="radio"/> U/K</td> <td></td> </tr> </table> | One                       | Two                              | <input type="radio"/> Yes            |                                           | <input type="radio"/> No  |  | <input type="radio"/> U/K |                                     |                              |                                  |  |  |  |                                        |                                    |                                                  |  |  |  |                                   |                                                       |                                       |  |  |  |  |                                |                           |  |  |  |
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| <p>14. Person(s) have prior child deaths?</p> <table style="width: 100%; border-collapse: collapse;"> <tr> <th style="text-align: left; border-bottom: 1px solid black;">One</th> <th style="text-align: left; border-bottom: 1px solid black;">Two</th> </tr> <tr> <td><input type="radio"/> Yes</td> <td></td> </tr> <tr> <td><input type="radio"/> No</td> <td></td> </tr> <tr> <td><input type="radio"/> U/K</td> <td></td> </tr> </table>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | One                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | Two                                              | <input type="radio"/> Yes                                 |                                   | <input type="radio"/> No                                                 |                                     | <input type="radio"/> U/K                                                                                                                                                                                                                                                                                                                                                                                                     |                                               | <p>15. Person(s) have history of intimate partner violence?</p> <table style="width: 100%; border-collapse: collapse;"> <tr> <th style="text-align: left; border-bottom: 1px solid black;">One</th> <th style="text-align: left; border-bottom: 1px solid black;">Two</th> </tr> <tr> <td><input type="checkbox"/> Yes, as victim</td> <td></td> </tr> <tr> <td><input type="checkbox"/> Yes, as perpetrator</td> <td></td> </tr> <tr> <td><input type="checkbox"/> No</td> <td></td> </tr> <tr> <td><input type="checkbox"/> U/K</td> <td></td> </tr> </table> | One                        | Two                                              | <input type="checkbox"/> Yes, as victim                                                                                                                                                                                                                                                                                                                                                                                                                                  |                           | <input type="checkbox"/> Yes, as perpetrator                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                   | <input type="checkbox"/> U/K                                                                                                                                                                                                                                                                                                                                                                                                                                               |                           | <p>16. Person(s) have delinquent/criminal history?</p> <table style="width: 100%; border-collapse: collapse;"> <tr> <th style="text-align: left; border-bottom: 1px solid black;">One</th> <th style="text-align: left; border-bottom: 1px solid black;">Two</th> </tr> <tr> <td><input type="radio"/> Yes</td> <td></td> </tr> <tr> <td><input type="radio"/> No</td> <td></td> </tr> <tr> <td><input type="radio"/> U/K</td> <td></td> </tr> </table> | One                       | Two                                                                                         | <input type="radio"/> Yes             |                                        | <input type="radio"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                  |     | <input type="radio"/> U/K                                                                                                                                                                                                                                                                                                                                                                                                                                 |                           |                                  |                                      |                                           |                           |  |                           |                                     |                              |                                  |  |  |  |                                        |                                    |                                                  |  |  |  |                                   |                                                       |                                       |  |  |  |  |                                |                           |  |  |  |
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| <p>17. At the time of the incident, was the person asleep?</p> <table style="width: 100%; border-collapse: collapse;"> <tr> <th style="text-align: left; border-bottom: 1px solid black;">One</th> <th style="text-align: left; border-bottom: 1px solid black;">Two</th> <th></th> </tr> <tr> <td><input type="radio"/> Yes</td> <td><input type="radio"/> Yes</td> <td rowspan="4" style="font-size: 3em; vertical-align: middle; padding: 0 10px;">}</td> </tr> <tr> <td><input type="radio"/> No</td> <td><input type="radio"/> No</td> </tr> <tr> <td><input type="radio"/> U/K</td> <td><input type="radio"/> U/K</td> </tr> <tr> <td colspan="2"> <p>If yes, select the most appropriate description of the person's sleeping period at incident:</p> </td> </tr> </table> <table style="width: 100%; border-collapse: collapse; margin-top: 5px;"> <tr> <th style="text-align: left; border-bottom: 1px solid black;">One</th> <th style="text-align: left; border-bottom: 1px solid black;">Two</th> </tr> <tr> <td><input 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| <p>If yes, select the most appropriate description of the person's sleeping period at incident:</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    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| <input type="radio"/> Night time sleep                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 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| <input type="radio"/> Day time nap, describe:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          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| <input type="radio"/> Day time sleep (for example, person is night shift worker), describe:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            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| <input type="radio"/> Other, describe:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 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| <p>18. At time of incident was person impaired?</p> <p><u>One</u>      <u>Two</u></p> <p><input type="radio"/> Yes   <input type="radio"/> No   <input type="radio"/> U/K      <input type="radio"/> Yes   <input type="radio"/> No   <input type="radio"/> U/K</p> <p>If yes, check all that apply:</p> <table style="width: 100%;"> <tr> <td style="width: 50%;"><u>One</u>      <u>Two</u></td> <td style="width: 50%;"><u>One</u>      <u>Two</u></td> </tr> <tr> <td><input type="checkbox"/> <input type="checkbox"/> Drug impaired, specify:</td> <td><input type="checkbox"/> <input type="checkbox"/> Impaired by illness, specify:</td> </tr> <tr> <td><input type="checkbox"/> <input type="checkbox"/> Alcohol impaired</td> <td><input type="checkbox"/> <input type="checkbox"/> Impaired by disability, specify:</td> </tr> <tr> <td><input type="checkbox"/> <input type="checkbox"/> Distracted</td> <td><input type="checkbox"/> <input type="checkbox"/> Absent</td> </tr> <tr> <td></td> <td><input type="checkbox"/> <input type="checkbox"/> Other, specify:</td> </tr> </table> | <u>One</u> <u>Two</u>                                                              | <u>One</u> <u>Two</u> | <input type="checkbox"/> <input type="checkbox"/> Drug impaired, specify: | <input type="checkbox"/> <input type="checkbox"/> Impaired by illness, specify: | <input type="checkbox"/> <input type="checkbox"/> Alcohol impaired | <input type="checkbox"/> <input type="checkbox"/> Impaired by disability, specify: | <input type="checkbox"/> <input type="checkbox"/> Distracted | <input type="checkbox"/> <input type="checkbox"/> Absent |  | <input type="checkbox"/> <input type="checkbox"/> Other, specify: | <p>19. Person(s) have, check all that apply:</p> <p><u>One</u>      <u>Two</u></p> <p><input type="checkbox"/> <input type="checkbox"/> Prior history of similar acts</p> <p><input type="checkbox"/> <input type="checkbox"/> Prior arrests</p> <p><input type="checkbox"/> <input type="checkbox"/> Prior convictions</p> | <p>20. Legal outcomes in this death, check all that apply:</p> <p><u>One</u>      <u>Two</u></p> <p><input type="checkbox"/> <input type="checkbox"/> No charges filed</p> <p><input type="checkbox"/> <input type="checkbox"/> Charges pending</p> <p><input type="checkbox"/> <input type="checkbox"/> Charges filed, specify:</p> <p><input type="checkbox"/> <input type="checkbox"/> Charges dismissed</p> <p><input type="checkbox"/> <input type="checkbox"/> Confession</p> <p><input type="checkbox"/> <input type="checkbox"/> Plead, specify:</p> <p><input type="checkbox"/> <input type="checkbox"/> Not guilty verdict</p> <p><input type="checkbox"/> <input type="checkbox"/> Guilty verdict, specify:</p> <p><input type="checkbox"/> <input type="checkbox"/> Tort charges, specify:</p> <p><input type="checkbox"/> <input type="checkbox"/> U/K</p> |
| <u>One</u> <u>Two</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | <u>One</u> <u>Two</u>                                                              |                       |                                                                           |                                                                                 |                                                                    |                                                                                    |                                                              |                                                          |  |                                                                   |                                                                                                                                                                                                                                                                                                                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| <input type="checkbox"/> <input type="checkbox"/> Drug impaired, specify:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | <input type="checkbox"/> <input type="checkbox"/> Impaired by illness, specify:    |                       |                                                                           |                                                                                 |                                                                    |                                                                                    |                                                              |                                                          |  |                                                                   |                                                                                                                                                                                                                                                                                                                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| <input type="checkbox"/> <input type="checkbox"/> Alcohol impaired                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | <input type="checkbox"/> <input type="checkbox"/> Impaired by disability, specify: |                       |                                                                           |                                                                                 |                                                                    |                                                                                    |                                                              |                                                          |  |                                                                   |                                                                                                                                                                                                                                                                                                                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| <input type="checkbox"/> <input type="checkbox"/> Distracted                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | <input type="checkbox"/> <input type="checkbox"/> Absent                           |                       |                                                                           |                                                                                 |                                                                    |                                                                                    |                                                              |                                                          |  |                                                                   |                                                                                                                                                                                                                                                                                                                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | <input type="checkbox"/> <input type="checkbox"/> Other, specify:                  |                       |                                                                           |                                                                                 |                                                                    |                                                                                    |                                                              |                                                          |  |                                                                   |                                                                                                                                                                                                                                                                                                                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |

K. SERVICES TO FAMILY AND COMMUNITY AS A RESULT OF THE DEATH

|                                                                                                                                                                   |                       |                       |                       |                       |                       |  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|--|
| 1. Were new or revised services recommended or implemented as a result of the death? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K |                       |                       |                       |                       |                       |  |
| If yes, select one option per row:                                                                                                                                | Referred for service  | Review led to         | Referral needed,      |                       |                       |  |
|                                                                                                                                                                   | <u>before review</u>  | <u>referral</u>       | <u>not available</u>  | <u>N/A</u>            | <u>U/K</u>            |  |
| Bereavement counseling                                                                                                                                            | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |  |
| Debriefing for professionals                                                                                                                                      | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |  |
| Economic support                                                                                                                                                  | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |  |
| Funeral arrangements                                                                                                                                              | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |  |
| Emergency shelter                                                                                                                                                 | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |  |
| Mental health services                                                                                                                                            | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |  |
| Foster care                                                                                                                                                       | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |  |
| Health services                                                                                                                                                   | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |  |
| Legal services                                                                                                                                                    | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |  |
| Genetic counseling                                                                                                                                                | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |  |
| Home visiting                                                                                                                                                     | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |  |
| Substance abuse                                                                                                                                                   | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |  |
| Other, specify:                                                                                                                                                   | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |  |

L. FINDINGS IDENTIFIED DURING THE REVIEW ☒ Mark this case to edit/add findings at a later date

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                         |                                                   |                                                         |                                                       |                                                       |                                             |                                                                  |                                                         |                                                |                                                         |                                                             |  |
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| 1. Describe any significant challenges faced by the child, the family, the systems with which they interacted, or the response to the incident. These could be related to demographics, overt or inadvertent actions, the way systems functioned, or other environmental characteristics. (See Data Dictionary for examples.)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                         |                                                   |                                                         |                                                       |                                                       |                                             |                                                                  |                                                         |                                                |                                                         |                                                             |  |
| 2. Describe any notable positive elements in this case. They could be demographic, behavioral, or environmental characteristics that may have promoted resiliency in the child or family, the systems with which they interacted or the response to the incident. (See Data Dictionary for examples.)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                         |                                                   |                                                         |                                                       |                                                       |                                             |                                                                  |                                                         |                                                |                                                         |                                                             |  |
| 3. List any recommendations and/or initiatives that could be implemented to prevent deaths from similar causes or circumstances in the future:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                         |                                                   |                                                         |                                                       |                                                       |                                             |                                                                  |                                                         |                                                |                                                         |                                                             |  |
| <p>4. Were new or revised agency services, policies or practices recommended or implemented as a result of the review? <input type="radio"/> Yes   <input type="radio"/> No   <input type="radio"/> U/K</p> <p>If yes, select all that apply and describe:</p> <table style="width: 100%;"> <tr> <td style="width: 50%;"><input type="checkbox"/> Child welfare      Describe:</td> <td style="width: 50%;"><input type="checkbox"/> Education      Describe:</td> </tr> <tr> <td><input type="checkbox"/> Law enforcement      Describe:</td> <td><input type="checkbox"/> Mental health      Describe:</td> </tr> <tr> <td><input type="checkbox"/> Public health      Describe:</td> <td><input type="checkbox"/> EMS      Describe:</td> </tr> <tr> <td><input type="checkbox"/> Coroner/medical examiner      Describe:</td> <td><input type="checkbox"/> Substance abuse      Describe:</td> </tr> <tr> <td><input type="checkbox"/> Courts      Describe:</td> <td><input type="checkbox"/> Other, specify:      Describe:</td> </tr> <tr> <td><input type="checkbox"/> Health care systems      Describe:</td> <td></td> </tr> </table> | <input type="checkbox"/> Child welfare      Describe:   | <input type="checkbox"/> Education      Describe: | <input type="checkbox"/> Law enforcement      Describe: | <input type="checkbox"/> Mental health      Describe: | <input type="checkbox"/> Public health      Describe: | <input type="checkbox"/> EMS      Describe: | <input type="checkbox"/> Coroner/medical examiner      Describe: | <input type="checkbox"/> Substance abuse      Describe: | <input type="checkbox"/> Courts      Describe: | <input type="checkbox"/> Other, specify:      Describe: | <input type="checkbox"/> Health care systems      Describe: |  |
| <input type="checkbox"/> Child welfare      Describe:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | <input type="checkbox"/> Education      Describe:       |                                                   |                                                         |                                                       |                                                       |                                             |                                                                  |                                                         |                                                |                                                         |                                                             |  |
| <input type="checkbox"/> Law enforcement      Describe:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | <input type="checkbox"/> Mental health      Describe:   |                                                   |                                                         |                                                       |                                                       |                                             |                                                                  |                                                         |                                                |                                                         |                                                             |  |
| <input type="checkbox"/> Public health      Describe:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | <input type="checkbox"/> EMS      Describe:             |                                                   |                                                         |                                                       |                                                       |                                             |                                                                  |                                                         |                                                |                                                         |                                                             |  |
| <input type="checkbox"/> Coroner/medical examiner      Describe:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | <input type="checkbox"/> Substance abuse      Describe: |                                                   |                                                         |                                                       |                                                       |                                             |                                                                  |                                                         |                                                |                                                         |                                                             |  |
| <input type="checkbox"/> Courts      Describe:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | <input type="checkbox"/> Other, specify:      Describe: |                                                   |                                                         |                                                       |                                                       |                                             |                                                                  |                                                         |                                                |                                                         |                                                             |  |
| <input type="checkbox"/> Health care systems      Describe:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                         |                                                   |                                                         |                                                       |                                                       |                                             |                                                                  |                                                         |                                                |                                                         |                                                             |  |
| 5. Could the death have been prevented? <input type="radio"/> Yes, probably <input type="radio"/> No, probably not <input type="radio"/> Team could not determine                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                         |                                                   |                                                         |                                                       |                                                       |                                             |                                                                  |                                                         |                                                |                                                         |                                                             |  |

| M. THE REVIEW MEETING PROCESS                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                     |                                                                |                                              |                                                          |                                                                |                                             |                                             |                                                |                                                       |                                        |                                                                |                                          |                                                 |                                                   |                                        |                                              |                                                       |                                |                                    |                                |  |                                        |                                   |                                        |                                         |  |                                           |                                            |                                          |  |  |
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| 1. Date of first review meeting: _____                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | 2. Number of review meetings for this case: _____                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | 3. Is review complete? <input type="radio"/> N/A <input type="radio"/> Yes <input type="radio"/> No |                                                                |                                              |                                                          |                                                                |                                             |                                             |                                                |                                                       |                                        |                                                                |                                          |                                                 |                                                   |                                        |                                              |                                                       |                                |                                    |                                |  |                                        |                                   |                                        |                                         |  |                                           |                                            |                                          |  |  |
| 4. Agencies and individuals at review meeting, check all that apply: <table style="width: 100%; border: none;"> <tr> <td><input type="checkbox"/> Medical examiner/coroner/pathologist</td> <td><input type="checkbox"/> CPS</td> <td><input type="checkbox"/> Fire</td> <td><input type="checkbox"/> Indian Health Services/ Tribal Health</td> <td><input type="checkbox"/> Military</td> </tr> <tr> <td><input type="checkbox"/> Death investigator</td> <td><input type="checkbox"/> Other social services</td> <td><input type="checkbox"/> EMS</td> <td><input type="checkbox"/> Home visiting</td> <td><input type="checkbox"/> Domestic violence</td> </tr> <tr> <td><input type="checkbox"/> Law enforcement</td> <td><input type="checkbox"/> Physician</td> <td><input type="checkbox"/> Faith based organization</td> <td><input type="checkbox"/> Healthy Start</td> <td><input type="checkbox"/> Others, list: _____</td> </tr> <tr> <td><input type="checkbox"/> Prosecutor/district attorney</td> <td><input type="checkbox"/> Nurse</td> <td><input type="checkbox"/> Education</td> <td><input type="checkbox"/> Court</td> <td></td> </tr> <tr> <td><input type="checkbox"/> Public health</td> <td><input type="checkbox"/> Hospital</td> <td><input type="checkbox"/> Mental health</td> <td><input type="checkbox"/> Child advocate</td> <td></td> </tr> <tr> <td><input type="checkbox"/> HMO/managed care</td> <td><input type="checkbox"/> Other health care</td> <td><input type="checkbox"/> Substance abuse</td> <td></td> <td></td> </tr> </table> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                     | <input type="checkbox"/> Medical examiner/coroner/pathologist  | <input type="checkbox"/> CPS                 | <input type="checkbox"/> Fire                            | <input type="checkbox"/> Indian Health Services/ Tribal Health | <input type="checkbox"/> Military           | <input type="checkbox"/> Death investigator | <input type="checkbox"/> Other social services | <input type="checkbox"/> EMS                          | <input type="checkbox"/> Home visiting | <input type="checkbox"/> Domestic violence                     | <input type="checkbox"/> Law enforcement | <input type="checkbox"/> Physician              | <input type="checkbox"/> Faith based organization | <input type="checkbox"/> Healthy Start | <input type="checkbox"/> Others, list: _____ | <input type="checkbox"/> Prosecutor/district attorney | <input type="checkbox"/> Nurse | <input type="checkbox"/> Education | <input type="checkbox"/> Court |  | <input type="checkbox"/> Public health | <input type="checkbox"/> Hospital | <input type="checkbox"/> Mental health | <input type="checkbox"/> Child advocate |  | <input type="checkbox"/> HMO/managed care | <input type="checkbox"/> Other health care | <input type="checkbox"/> Substance abuse |  |  |
| <input type="checkbox"/> Medical examiner/coroner/pathologist                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | <input type="checkbox"/> CPS                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | <input type="checkbox"/> Fire                                                                       | <input type="checkbox"/> Indian Health Services/ Tribal Health | <input type="checkbox"/> Military            |                                                          |                                                                |                                             |                                             |                                                |                                                       |                                        |                                                                |                                          |                                                 |                                                   |                                        |                                              |                                                       |                                |                                    |                                |  |                                        |                                   |                                        |                                         |  |                                           |                                            |                                          |  |  |
| <input type="checkbox"/> Death investigator                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | <input type="checkbox"/> Other social services                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | <input type="checkbox"/> EMS                                                                        | <input type="checkbox"/> Home visiting                         | <input type="checkbox"/> Domestic violence   |                                                          |                                                                |                                             |                                             |                                                |                                                       |                                        |                                                                |                                          |                                                 |                                                   |                                        |                                              |                                                       |                                |                                    |                                |  |                                        |                                   |                                        |                                         |  |                                           |                                            |                                          |  |  |
| <input type="checkbox"/> Law enforcement                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | <input type="checkbox"/> Physician                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | <input type="checkbox"/> Faith based organization                                                   | <input type="checkbox"/> Healthy Start                         | <input type="checkbox"/> Others, list: _____ |                                                          |                                                                |                                             |                                             |                                                |                                                       |                                        |                                                                |                                          |                                                 |                                                   |                                        |                                              |                                                       |                                |                                    |                                |  |                                        |                                   |                                        |                                         |  |                                           |                                            |                                          |  |  |
| <input type="checkbox"/> Prosecutor/district attorney                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | <input type="checkbox"/> Nurse                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | <input type="checkbox"/> Education                                                                  | <input type="checkbox"/> Court                                 |                                              |                                                          |                                                                |                                             |                                             |                                                |                                                       |                                        |                                                                |                                          |                                                 |                                                   |                                        |                                              |                                                       |                                |                                    |                                |  |                                        |                                   |                                        |                                         |  |                                           |                                            |                                          |  |  |
| <input type="checkbox"/> Public health                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | <input type="checkbox"/> Hospital                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | <input type="checkbox"/> Mental health                                                              | <input type="checkbox"/> Child advocate                        |                                              |                                                          |                                                                |                                             |                                             |                                                |                                                       |                                        |                                                                |                                          |                                                 |                                                   |                                        |                                              |                                                       |                                |                                    |                                |  |                                        |                                   |                                        |                                         |  |                                           |                                            |                                          |  |  |
| <input type="checkbox"/> HMO/managed care                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | <input type="checkbox"/> Other health care                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | <input type="checkbox"/> Substance abuse                                                            |                                                                |                                              |                                                          |                                                                |                                             |                                             |                                                |                                                       |                                        |                                                                |                                          |                                                 |                                                   |                                        |                                              |                                                       |                                |                                    |                                |  |                                        |                                   |                                        |                                         |  |                                           |                                            |                                          |  |  |
| 5. Were the following data sources available at the review meeting?<br>Check all that apply:<br><b>Vital statistics</b><br><input type="checkbox"/> Birth certificate - full form<br><input type="checkbox"/> Death certificate<br><b>Health records</b><br><input type="checkbox"/> Child's medical records or clinical history, including vaccinations<br><input type="checkbox"/> Hospital records<br><input type="checkbox"/> Childbearing parent's obstetric and prenatal information<br><input type="checkbox"/> Newborn screening results<br><input type="checkbox"/> Mental health records<br><input type="checkbox"/> Substance abuse treatment records<br><b>Investigation records</b><br><input type="checkbox"/> Autopsy/pathology reports<br><input type="checkbox"/> CDC's SUIDI Reporting Form<br><input type="checkbox"/> Jurisdictional equivalent of the CDC SUIDI Reporting Form<br><input type="checkbox"/> Law enforcement records<br><input type="checkbox"/> Social service records<br><input type="checkbox"/> Child protection agency records<br><input type="checkbox"/> EMS run sheet<br><b>Other</b><br><input type="checkbox"/> Home visiting<br><input type="checkbox"/> School records                                                                                                                                                                                                                                                                                                                                                           | 6. Did any of the following factors reduce meeting effectiveness, check all that apply:<br><input type="checkbox"/> None<br><input type="checkbox"/> Confidentiality issues among members prevented full exchange of information<br><input type="checkbox"/> HIPAA regulations prevented access to or exchange of information<br><input type="checkbox"/> Inadequate investigation precluded having enough information for review<br><input type="checkbox"/> Team members did not bring adequate information to the meeting<br><input type="checkbox"/> Necessary team members were absent<br><input type="checkbox"/> Meeting was held too soon after death<br><input type="checkbox"/> Meeting was held too long after death<br><input type="checkbox"/> Records or information were needed from another locality in-state<br><input type="checkbox"/> Records or information were needed from another state<br><input type="checkbox"/> Team disagreement on circumstances<br><input type="checkbox"/> Other factors, specify: _____ |                                                                                                     |                                                                |                                              |                                                          |                                                                |                                             |                                             |                                                |                                                       |                                        |                                                                |                                          |                                                 |                                                   |                                        |                                              |                                                       |                                |                                    |                                |  |                                        |                                   |                                        |                                         |  |                                           |                                            |                                          |  |  |
| 7. Review meeting outcomes, check all that apply:<br><input type="checkbox"/> Team disagreed with official manner of death. What did team believe manner should be?<br><input type="checkbox"/> Team disagreed with official cause of death. What did team believe cause should be?<br><input type="checkbox"/> Because of the review, the official cause or manner of death was changed                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                     |                                                                |                                              |                                                          |                                                                |                                             |                                             |                                                |                                                       |                                        |                                                                |                                          |                                                 |                                                   |                                        |                                              |                                                       |                                |                                    |                                |  |                                        |                                   |                                        |                                         |  |                                           |                                            |                                          |  |  |
| N. SUID AND SDY CASE REGISTRY                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                     |                                                                |                                              |                                                          |                                                                |                                             |                                             |                                                |                                                       |                                        |                                                                |                                          |                                                 |                                                   |                                        |                                              |                                                       |                                |                                    |                                |  |                                        |                                   |                                        |                                         |  |                                           |                                            |                                          |  |  |
| Section N: OMB No. 0920-1092, Exp. Date: 9/30/2025<br>Public reporting burden of this collection of information is estimated to average 10 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to: CDC/ATSDR Reports Clearance Officer; 1600 Clifton Road NE, MS D-74, Atlanta, Georgia 30333; ATTN: PRA (0920-1092)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                     |                                                                |                                              |                                                          |                                                                |                                             |                                             |                                                |                                                       |                                        |                                                                |                                          |                                                 |                                                   |                                        |                                              |                                                       |                                |                                    |                                |  |                                        |                                   |                                        |                                         |  |                                           |                                            |                                          |  |  |
| 1. Is this an SDY or SUID case? <input type="radio"/> Yes <input type="radio"/> No    If no, go to Section O                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                     |                                                                |                                              |                                                          |                                                                |                                             |                                             |                                                |                                                       |                                        |                                                                |                                          |                                                 |                                                   |                                        |                                              |                                                       |                                |                                    |                                |  |                                        |                                   |                                        |                                         |  |                                           |                                            |                                          |  |  |
| 2. Did this case go to Advanced Review for the SDY Case Registry?<br><input type="radio"/> N/A <input type="radio"/> Yes <input type="radio"/> No<br>If yes, date of first Advanced Review meeting: _____                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | 3. Notes from Advanced Review meeting (include case details that helped determine SDY categorization and any ways to improve the review) or reason why case did not go to Advanced Review: _____                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                     |                                                                |                                              |                                                          |                                                                |                                             |                                             |                                                |                                                       |                                        |                                                                |                                          |                                                 |                                                   |                                        |                                              |                                                       |                                |                                    |                                |  |                                        |                                   |                                        |                                         |  |                                           |                                            |                                          |  |  |
| 4. Professionals at the Advanced Review meeting, check all that apply: <table style="width: 100%; border: none;"> <tr> <td><input type="checkbox"/> Cardiologist</td> <td><input type="checkbox"/> Death investigator</td> <td><input type="checkbox"/> Geneticist or genetic counselor</td> <td><input type="checkbox"/> Pediatrician</td> </tr> <tr> <td><input type="checkbox"/> CDR representative</td> <td><input type="checkbox"/> Epileptologist</td> <td><input type="checkbox"/> Neurologist</td> <td><input type="checkbox"/> Public health representative</td> </tr> <tr> <td><input type="checkbox"/> Coroner</td> <td><input type="checkbox"/> Forensic pathologist/medical examiner</td> <td><input type="checkbox"/> Neonatologist</td> <td><input type="checkbox"/> Others, specify: _____</td> </tr> </table>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                     | <input type="checkbox"/> Cardiologist                          | <input type="checkbox"/> Death investigator  | <input type="checkbox"/> Geneticist or genetic counselor | <input type="checkbox"/> Pediatrician                          | <input type="checkbox"/> CDR representative | <input type="checkbox"/> Epileptologist     | <input type="checkbox"/> Neurologist           | <input type="checkbox"/> Public health representative | <input type="checkbox"/> Coroner       | <input type="checkbox"/> Forensic pathologist/medical examiner | <input type="checkbox"/> Neonatologist   | <input type="checkbox"/> Others, specify: _____ |                                                   |                                        |                                              |                                                       |                                |                                    |                                |  |                                        |                                   |                                        |                                         |  |                                           |                                            |                                          |  |  |
| <input type="checkbox"/> Cardiologist                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | <input type="checkbox"/> Death investigator                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | <input type="checkbox"/> Geneticist or genetic counselor                                            | <input type="checkbox"/> Pediatrician                          |                                              |                                                          |                                                                |                                             |                                             |                                                |                                                       |                                        |                                                                |                                          |                                                 |                                                   |                                        |                                              |                                                       |                                |                                    |                                |  |                                        |                                   |                                        |                                         |  |                                           |                                            |                                          |  |  |
| <input type="checkbox"/> CDR representative                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | <input type="checkbox"/> Epileptologist                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | <input type="checkbox"/> Neurologist                                                                | <input type="checkbox"/> Public health representative          |                                              |                                                          |                                                                |                                             |                                             |                                                |                                                       |                                        |                                                                |                                          |                                                 |                                                   |                                        |                                              |                                                       |                                |                                    |                                |  |                                        |                                   |                                        |                                         |  |                                           |                                            |                                          |  |  |
| <input type="checkbox"/> Coroner                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | <input type="checkbox"/> Forensic pathologist/medical examiner                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | <input type="checkbox"/> Neonatologist                                                              | <input type="checkbox"/> Others, specify: _____                |                                              |                                                          |                                                                |                                             |                                             |                                                |                                                       |                                        |                                                                |                                          |                                                 |                                                   |                                        |                                              |                                                       |                                |                                    |                                |  |                                        |                                   |                                        |                                         |  |                                           |                                            |                                          |  |  |
| 5. Did the Advanced Review team believe the autopsy was comprehensive? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | 6. If autopsy performed, did the ME/coroner/pathologist use the SDY Autopsy Guidance or Summary? <input type="radio"/> N/A <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                     |                                                                |                                              |                                                          |                                                                |                                             |                                             |                                                |                                                       |                                        |                                                                |                                          |                                                 |                                                   |                                        |                                              |                                                       |                                |                                    |                                |  |                                        |                                   |                                        |                                         |  |                                           |                                            |                                          |  |  |

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|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <p>7. Was a specimen saved for the SDY Case Registry?<br/> <input type="radio"/> N/A   <input type="radio"/> Yes   <input type="radio"/> No   <input type="radio"/> U/K</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | <p>9. Did the family consent to have DNA saved as part of the SDY Case Registry?<br/> <input type="radio"/> N/A   <input type="radio"/> Yes   <input type="radio"/> No   <input type="radio"/> U/K</p> <p>If no, why not? <input type="radio"/> Consent was not attempted<br/> <input type="radio"/> Consent was attempted but follow up was unsuccessful<br/> <input type="radio"/> Consent was attempted but family declined<br/> <input type="radio"/> Other, specify:</p> |
| <p>8. Was a specimen sent to the SDY Case Registry biorepository?<br/> <input type="radio"/> N/A   <input type="radio"/> Yes   <input type="radio"/> No   <input type="radio"/> U/K</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| <p>10. Categorization for SDY Case Registry (choose only one):</p> <div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> <input type="radio"/> Excluded from SDY Case Registry   <input type="radio"/> Explained neurological, specify:<br/> <input type="radio"/> Unexplained, incomplete case information   <input type="radio"/> Explained infant suffocation<br/> <input type="radio"/> Explained cardiac, specify: (under age 1) </div> <div style="width: 45%;"> <input type="radio"/> Explained other, specify:   <input type="radio"/> Unexplained, SUDEP<br/> <input type="radio"/> Unexplained, possible cardiac   <input type="radio"/> Unexplained death<br/> <input type="radio"/> Unexplained, possible cardiac and SUDEP </div> </div>                                                                                                                                                                                                                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| <p>11. Categorization for SUID Case Registry (choose only one):</p> <div style="display: flex;"> <div style="width: 50%;"> <input type="radio"/> Excluded (other explained causes, not suffocation)<br/> <input type="radio"/> Unexplained: No autopsy or death scene investigation<br/> <input type="radio"/> Unexplained: Incomplete case information<br/> <input type="radio"/> Unexplained: No unsafe sleep factors<br/> <input type="radio"/> Unexplained: Unsafe sleep factors<br/> <input type="radio"/> Unexplained: Possible suffocation with unsafe sleep factors<br/> <input type="radio"/> Explained: Suffocation with unsafe sleep factors </div> <div style="width: 50%; border-left: 1px solid black; padding-left: 10px;"> <p>If possible suffocation or explained suffocation, select the primary mechanism(s) leading to the death, check all that apply:</p> <input type="checkbox"/> Soft bedding<br/> <input type="checkbox"/> Wedging<br/> <input type="checkbox"/> Overlay<br/> <input type="checkbox"/> Other, specify: </div> </div> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| <b>O. NARRATIVE</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| <b>O1. NARRATIVE</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| <p><b>Use this space to provide more detail on the circumstances of the death and to describe any other relevant information. DO NOT INCLUDE IDENTIFIERS IN THE NARRATIVE such as names, dates, addresses, and specific service providers.</b> Consider the following questions: What was the child doing? Where did it happen? How did it happen? What went wrong? What was the quality of supervision? What was the injury cause of death? The Narrative is included in de-identified downloads, and per MPHI/NCFRP's data use agreement with your state, HIPAA identifying information should not be recorded in this field.</p> <div style="height: 150px; border: 1px solid #ccc; margin-top: 10px;"></div>                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| <b>P. FORM COMPLETED BY:</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| <p>Person:<br/>Title:<br/>Agency:<br/>Phone:</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | <p>Email:<br/>Date completed:<br/>Data entry completed for this case? <input type="checkbox"/></p> <div style="border: 1px solid #ccc; background-color: #f0f0f0; padding: 5px; margin-top: 5px;"> <p><b>For State Program Use Only:</b><br/> Data quality assurance completed by state? <input type="checkbox"/></p> </div>                                                                                                                                                  |
|  <p><b>NATIONAL CFRP</b><br/> Center for Fatality Review &amp; Prevention</p> <p>The development of this report tool was supported, in part, by Grant No. UG7MC28482 from the Maternal and Child Health Bureau (Title V, Social Security Act), Health Resources and Services Administration, Department of Health and Human Services and with additional funding from the US Centers for Disease Control and Prevention, Division of Reproductive Health</p> <p>Data Entry: <a href="https://data.ncfrp.org">https://data.ncfrp.org</a></p> <p><a href="http://www.ncfrp.org">www.ncfrp.org</a>   <a href="mailto:info@ncfrp.org">info@ncfrp.org</a>   1-800-656-2434   Facebook and Twitter: NationalCFRP</p>                                                                                                                                                                                                                                                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |

# Appendix D

## Grief Support Resources

**For information on local support groups throughout Tennessee, refer to the accompanying booklet, Bereavement Support Services in Tennessee. Examples of national resources are listed below.**

### **Bereaved Parents of the USA (BPUSA)**

[bereavedparentsusa.org/](http://bereavedparentsusa.org/) find-a-chapter Offers resources and national and local chapters for support for those who have lost children, siblings, or grandchildren.

### **The Compassionate Friends**

[compassionatefriends.org](http://compassionatefriends.org)

**Johnson City, TN**.....423-677-6431

**Knoxville, TN** .....865-687-2117

**Murfreesboro, TN** .....615-896-4343

**Nashville, TN**.....615-356-4823

**Tullahoma, TN** .....931-962-0458

**Sevierville, TN**.....865-902-2040

### **Compassionate Friends, National Office**

P.O. Box 3696 Oak Brook, IL 60523

For a chapter near you, contact toll-free at 877-969-0010, or for self-help support go to [compassionatfriends.org](http://compassionatfriends.org) to find a group near you.

### **First Candle Grief Line**

800-221-7437

Provides compassionate immediate grief counseling to anyone who has experienced loss by death of a baby.

### **MISS Foundation (Mothers in Sympathy and Support)**

[missfoundation.org](http://missfoundation.org) Genmitsu Kahn, Program Assistant

[info@missfoundation.org](mailto:info@missfoundation.org) P.O. Box 9195 Austin, TX 787 66602-279-6477

Call or check the website to see if in-person support groups are available in your area.

National Pregnancy Share National Share provides online support for pregnancy and infant loss.

Visit [nationalshare.org](http://nationalshare.org) for more information.

### **Star Legacy Foundation**

[starlegacyfoundation.org](http://starlegacyfoundation.org)

### **Family bereavement support after the death of an infant**

952-715-7731, ext. 2

### **Tennessee SIDS Alliance**

373 Woodcrest Dr., Kingsport, TN 37663

Kimberly Collette, President, [sidstn@cs.co](mailto:sidstn@cs.co)

## Training

### **Prevention Through Understanding**

Tennessee Department of Health and Middle Tennessee State University

[sidstrainingtn.org](http://sidstrainingtn.org)

<https://chhs.mtsu.edu/publications/>

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# Notes



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