CDR Report Form

National Fatality Review

Case Reporting System

Version 5.0

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

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

SAVING LIVES TOGETHER

Instructions:

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

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

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

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

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

HIPAA Reminder:

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

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

CASE NUMBER

_____/_____/_____/_____

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

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

☐ Child never left hospital following birth

Death Certificate Number:

Birth Certificate Number:

ME/Coroner Number:

Date Team Notified of Death:

A. CHILD INFORMATION

A1. CHILD INFORMATION (COMPLETE FOR ALL AGES)

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

2. Date of birth: ☐ U/K mm dd yyyy

3. Date of death: ☐ U/K mm dd yyyy

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

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

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

7. Sex: ○ Male ○ Female ○ U/K

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

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

10. Child's height at death: ☐ U/K
○ Feet/inches _____/_____
○ Cm _____

11. State of death:

12. County of death:

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

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

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

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

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

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

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

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

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

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

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

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

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

If through CPS:

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

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

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

A2. COMPLETE FOR CHILDREN OVER ONE YEAR OLD

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

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

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

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

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

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

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

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

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

A3. COMPLETE FOR ALL FETAL/INFANTS UNDER ONE YEAR

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

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

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

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

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

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

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

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

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

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

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

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

Respiratory
☐ Asthma
☐ Pulmonary embolism

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

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

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

STI (continued)
☐ Group B strep
☐ HIV/AIDS
☐ Other STI, specify:

Gynecologic
☐ Uterine/vaginal bleeding
☐ Chorioamnionitis
☐ Oligohydramnios
☐ Polyhydramnios
☐ Intrauterine growth restriction (IUGR)
☐ Premature rupture of membranes (PROM)
☐ Preterm premature rupture of membranes (PPROM)
☐ Incompetent cervix
Umbilical cord complications
☐ Prolapse
☐ Nuchal cord
☐ Other cord, specify:

Gynecologic (continued)
Placental problems
☐ Abruption
☐ Previa
☐ Other placental, specify:

Other Condition/Complication
☐ UTI
☐ Decreased fetal movement
☐ HELLP syndrome
☐ Maternal developmental delay
☐ Oral health/dental or gum infection
☐ Gastrointestinal
☐ Maternal genetic disorder
☐ Abnormal MSAFP
☐ Preterm labor
☐ Other, specify:

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

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

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

46. Was the infant born drug exposed? ○ Yes ○ No ○ U/K

47. Did the infant have neonatal abstinence syndrome (NAS)? ○ Yes ○ No ○ U/K

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

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

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

51. Did the infant have a NICU stay of more than one day? ○ Yes ○ No ○ U/K

If yes, for what reason(s)? Check all that apply:

☐ Prematurity	☐ Apnea	☐ Hypothermia	☐ Meconium aspiration
☐ Low birth weight	☐ Sepsis	☐ Jaundice	☐ Congenital anomalies
☐ Tachypnea	☐ Feeding difficulties	☐ Anemia	☐ Other, specify:
☐ Drug/alcohol exposure			☐ U/K

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

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

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

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

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

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

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

If yes, any breast milk at 3 months?	○ N/A	○ Yes ○ No	○ U/K
If yes, exclusively?		○ Yes ○ No	○ U/K
If yes, any breast milk at 6 months?	○ N/A	○ Yes ○ No	○ U/K
If yes, exclusively?		○ Yes ○ No	○ U/K

If ever, was infant receiving breast milk at time of death?
○ Yes ○ No ○ U/K

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

If the infant never left the hospital following birth, go to Section B.

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

☐ None	☐ Cyanosis
☐ Infection	☐ Seizures or convulsions
☐ Allergies	☐ Cardiac abnormalities
☐ Abnormal growth, weight gain/loss	☐ Other, specify:
☐ Apnea	☐ U/K

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

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

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

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

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

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

This space left intentionally blank.

B. BIOLOGICAL PARENT INFORMATION

○ No information available, go to Section C

1. Parents' race, check all that apply:

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

2. Parents' Hispanic or Latino origin?

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

3. Parents' age in years at death:

Female	Male	
_____	_____	# Years
☐	☐	U/K

4. Parents' employment status:

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

5. Parents' income:

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

6. Parents' education:

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

7. Parents speak and understand English?

Female	Male	
○	○	Yes
○	○	No
○	○	U/K

If no, language spoken:

8. Parents first generation immigrant?

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

9. Parents on active military duty?

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

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

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

11. Parents have substance abuse history?

Female	Male	
○	○	Yes
○	○	No
○	○	U/K

If yes, check all that apply:

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

12. Parents ever victim of child maltreatment?

Female	Male	
○	○	Yes
○	○	No
○	○	U/K

If yes, check all that apply:

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

13. Parents ever perpetrator of maltreatment?

Female	Male	
○	○	Yes
○	○	No
○	○	U/K

If yes, check all that apply:

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

14. Parents have disability or chronic illness?

Female	Male	
○	○	Yes
○	○	No
○	○	U/K

If yes, check all that apply:

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

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

○	○	Yes
○	○	No
○	○	U/K

15. Parents have prior child deaths?

Female	Male	
○	○	Yes
○	○	No
○	○	U/K

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

Female	Male		Female	Male		Female	Male	
☐	☐	Child abuse # _____	☐	☐	Suicide # _____	☐	☐	Other # ____
☐	☐	Child neglect # _____	☐	☐	SIDS # _____			Other, specify:
☐	☐	Accident # _____	☐	☐	Undetermined cause # ____	☐	☐	U/K

16. Parents have history of intimate partner violence?

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

17. Parents have delinquent/criminal history?

Female	Male	
○	○	Yes
○	○	No
○	○	U/K

If yes, check all that apply:

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

C. PRIMARY CAREGIVER(S) INFORMATION

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

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

2. Caregiver(s) age in years:

One	Two	
_____	_____	# Years
☐	☐	U/K

3. Caregiver(s) sex:

One	Two	
○	○	Male
○	○	Female
○	○	U/K

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

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

5. Caregiver(s) Hispanic or Latino origin?

One	Two	
○	○	Yes
○	○	No
○	○	U/K

If yes, specify origin:

6. Caregiver(s) employment status:

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

7. Caregiver(s) income:

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

8. Caregiver(s) education:

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

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

One	Two	
○	○	Yes
○	○	No
○	○	U/K

If no, language spoken:

10. Caregiver(s) first generation immigrant?

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

11. Caregiver(s) on active military duty?

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

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

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

13. Caregiver(s) have substance abuse history?

One	Two	
○	○	Yes
○	○	No
○	○	U/K

If yes, check all that apply:

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

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

One	Two	
○	○	Yes
○	○	No
○	○	U/K

If yes, check all that apply:

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

15. Caregiver(s) ever perpetrator of maltreatment?

One	Two	
○	○	Yes
○	○	No
○	○	U/K

If yes, check all that apply:

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

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

One	Two	
○	○	Yes
○	○	No
○	○	U/K

If yes, check all that apply:

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

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

○	○	Yes
○	○	No
○	○	U/K

17. Caregiver(s) have prior child deaths?

One	Two	
○	○	Yes
○	○	No
○	○	U/K

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

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

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

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

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

One	Two	
○	○	Yes
○	○	No
○	○	U/K

If yes, check all that apply:

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

D. SUPERVISOR INFORMATION

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

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

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

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

4. Primary person responsible for supervision at the time of incident? Select only one:
   - ◯ Adoptive parent
   - ◯ Stepparent
   - ◯ Foster parent
   - ◯ Mother's partner
   - ◯ Father's partner
   - ◯ Grandparent
   - ◯ Sibling
   - ◯ Other relative
   - ◯ Friend
   - ◯ Acquaintance
   - ◯ Hospital staff, go to D15
   - ◯ Institutional staff, go to D15
   - ◯ Babysitter
   - ◯ Licensed child care worker
   - ◯ Other, specify:
   - ◯ U/K

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

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

7. Supervisor speaks and understands English?
   ◯ Yes ◯ No ◯ U/K
   If no, language spoken:

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

9. Supervisor has substance abuse history?
   ◯ Yes ◯ No ◯ U/K
   If yes, check all that apply:
   - ☐ Alcohol
   - ☐ Cocaine
   - ☐ Marijuana
   - ☐ Methamphetamine
   - ☐ Opiates
   - ☐ Prescription drugs
   - ☐ Over-the-counter
   - ☐ Other, specify:
   - ☐ U/K

10. Supervisor has history of child maltreatment?

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

If yes, check all that apply:

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

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

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

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

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

    Other, specify:
    - ☐ U/K

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

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

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

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

E. INCIDENT INFORMATION

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

1. Was the date of the incident the same as the date of death?
   - ◯ Yes, same as date of death
   - ◯ No, different than date of death. Enter date of incident: ____/____/____ mm / dd / yyyy
   - ◯ U/K

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

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

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

5. Incident state:

6. Incident county:

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

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

9. Was 911 or local emergency called? ○ N/A ○ Yes ○ No ○ U/K

10. Was resuscitation attempted? ○ N/A ○ Yes ○ No ○ U/K

If yes, by whom?
☐ EMS ☐ Parent/relative ☐ Other caretaker/babysitter ☐ Teacher/coach/athletic trainer ☐ Other acquaintance ☐ Health care professional, if death occurred in a hospital setting ☐ Stranger ☐ Other, specify:

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

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

11. At time of incident leading to death, had child used drugs or alcohol? ○ N/A ○ Yes ○ No ○ U/K
If yes, check all that apply:
☐ Alcohol ☐ Cocaine ☐ Marijuana ☐ Methamphetamine ☐ Opiate ☐ Prescription drugs ☐ Over-the-counter drugs ☐ Other, specify: ☐ U/K

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

13. Total number of deaths at incident event, including child:
_____ Children, ages 0-18 ○ U/K
_____ Adults

F. INVESTIGATION INFORMATION

1. Was a death investigation conducted? ○ Yes ○ No ○ U/K
If yes, check all that apply:
☐ Medical examiner ☐ Coroner ☐ ME investigator ☐ Coroner investigator ☐ Law enforcement ☐ Fire investigator ☐ EMS ☐ Child Protective Services ☐ Other, specify: ☐ U/K

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

13. What additional information would the team like to have known about the death scene investigation?

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

15. Did any investigation find evidence of prior abuse?

○ N/A ○ Yes ○ No ○ U/K

If yes, from what source?

Check all that apply:

☐ X-rays ☐ U/K

☐ Autopsy

☐ CPS review

☐ Law enforcement

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

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

○ Report screened out and not investigated

○ Unsubstantiated

○ Inconclusive

○ Substantiated

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

☐ Voluntary services offered

☐ Voluntary services provided

☐ Court-ordered services provided

☐ Voluntary out of home placement

☐ Court-ordered out of home placement

☐ Children removed

☐ Parental rights terminated

☐ U/K

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

○ No action

○ License suspended

○ License revoked

○ Investigation ongoing

○ Other, specify:

○ U/K

G. OFFICIAL MANNER AND PRIMARY CAUSE OF DEATH

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

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

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

a.

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

b.

c.

d.

3. Enter other significant conditions contributing to death but not the underlying cause(s) listed in G2 exactly as written on the death certificate: ☐ U/K

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

5. Official manner of death from the death certificate:

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

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

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

○ Motor vehicle and other transport, go to H1
○ Fire, burn, or electrocution, go to H2
○ Drowning, go to H3
○ Unintentional asphyxia, go to H4
○ Assault, weapon or person's body part, go to H5
○ Fall or crush, go to H6
○ Poisoning, overdose or acute intoxication, go to H7
○ Undetermined injury, go to I1
○ Other cause, go to H9
○ U/K, go to I1

○ From a medical cause. Select one:

○ Asthma/respiratory, specify and go to H8
○ Cancer, specify and go to H8
○ Cardiovascular, specify and go to H8
○ Congenital anomaly, specify and go to H8
○ Diabetes, go to H8
○ HIV/AIDS, go to H8
○ Influenza, go to H8
○ Low birth weight, go to H8
○ Malnutrition/dehydration, go to H8
○ Neurological/seizure disorder, go to H8
○ Pneumonia, specify and go to H8
○ Prematurity, go to H8
○ SIDS, go to H8
○ Other infection, specify and go to H8
○ Other perinatal condition, specify and go to H8
○ Other medical condition, specify and go to H8
○ Undetermined medical cause, go to H8
○ U/K, go to H8

○ Undetermined if injury or medical cause, go to I1

○ U/K go to I1

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

H1. MOTOR VEHICLE AND OTHER TRANSPORT

a. Vehicles involved in incident:

Total number of vehicles: _____

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

b. Position of child:

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

If passenger, relationship of driver to child:

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

c. Causes of incident, check all that apply:

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

d. Collision type:

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

e. Driving conditions, check all that apply:

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

f. Location of incident, check all that apply:

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

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

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

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

h. Total number of occupants in vehicles:

In child's vehicle, including child:

☐ N/A, child was not in a vehicle

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

In other primary vehicle involved in incident:

☐ N/A, incident was a single vehicle crash

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

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

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

*If child seat, type:

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

H2. FIRE, BURN, OR ELECTROCUTION

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

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

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

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

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

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

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

If yes, person's age _____

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

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

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

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

If yes, specify:

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

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

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

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

If yes, describe in narrative.

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

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

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

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

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

Other, specify:

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

q. Suspected arson? ○ Yes ○ No ○ U/K

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

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

t. Other, describe in detail:

H3. DROWNING

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

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

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

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

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

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

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

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

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

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

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

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

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

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

n. What barriers/layers of protection existed to prevent access to water?

Check all that apply:
- ☐ None
- ☐ Fence, go to o
- ☐ Gate, go to p
- ☐ Door, go to q
- ☐ Alarm, go to r
- ☐ Cover, go to s
- ☐ U/K

o. Fence:

Describe type:

Fence height in ft _____

Fence surrounds water on:
- ○ Four sides
- ○ Three sides
- ○ Two or less sides
- ○ U/K

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

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

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

s. Type of cover:
- ○ Hard
- ○ Soft
- ○ U/K

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

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

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

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

w. For bathtub, child in a bathing aid?
- ○ Yes ○ No ○ U/K

If yes, specify type:

x. Warning sign or label posted?
- ○ N/A ○ No
- ○ Yes ○ U/K

y. Lifeguard present?
- ○ N/A ○ No
- ○ Yes ○ U/K

z. Rescue attempt made?
- ○ N/A
- ○ Yes
- ○ No
- ○ U/K

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

aa. Did rescuer(s) also drown?
- ○ N/A ○ No
- ○ Yes ○ U/K

If yes, number of rescuers that drowned: _____

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

H4. UNINTENTIONAL ASPHYXIA

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

b. If suffocation/asphyxia, action causing event:
- ○ Sleep-related (e.g. bedding, overlay, wedged)
- ○ Covered in or fell into object, but not sleep-related
  - ○ Plastic bag
  - ○ Dirt/sand
  - ○ Other, specify:
  - ○ U/K
- ○ Confined in tight space
  - ○ Refrigerator/freezer
  - ○ Toy chest
  - ○ Automobile
    - ○ Trunk
    - ○ Other, specify:
    - ○ U/K
  - ○ Other, specify:
  - ○ U/K
- ○ Swaddled in tight blanket, but not sleep-related
- ○ Wedged into tight space, but not sleep-related, specify:
- ○ Asphyxia by gas, go to H7g
- ○ Other, specify:
- ○ U/K

c. If strangulation, object causing event:
- ○ Clothing
- ○ Blind cord
- ○ Car seat
- ○ Stroller
- ○ High chair
- ○ Belt
- ○ Rope/string
- ○ Leash
- ○ Electrical cord
- ○ Person, go to H5q
- ○ Automobile power window or sunroof
- ○ Other, specify:
- ○ U/K

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

e. Was asphyxia an autoerotic event?
- ○ N/A ○ Yes ○ No ○ U/K

f. Was child participating in 'choking game' or 'pass out game'?
- ○ N/A ○ Yes ○ No ○ U/K

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

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

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

H5. ASSAULT, WEAPON OR PERSON'S BODY PART

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

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

c. Firearm licensed?
○ Yes ○ No ○ U/K

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

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

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

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

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

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

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

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

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

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

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

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

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

p. Sex of person(s) handling weapon:

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

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

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

H6. FALL OR CRUSH

a. Type:
- ○ Fall, go to b
- ○ Crush, go to h

b. Height of fall:
_____ feet
_____ inches
☐ U/K

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

d. Surface child fell onto:
- ○ Cement/concrete
- ○ Grass
- ○ Gravel
- ○ Wood floor
- ○ Carpeted floor
- ○ Linoleum/vinyl
- ○ Marble/tile
- ○ Other, specify:
- ○ U/K

e. Barrier in place:
Check all that apply:
- ☐ None
- ☐ Screen
- ☐ Other window guard
- ☐ Fence
- ☐ Railing
- ☐ Stairway
- ☐ Gate
- ☐ Other, specify:
- ☐ U/K

f. Child in a baby walker?
- ○ N/A
- ○ Yes
- ○ No
- ○ U/K

g. Was child pushed, dropped or thrown?
○ Yes ○ No ○ U/K
If yes, go to H5q

h. For crush, did child:
- ○ Climb up on object
- ○ Pull object down
- ○ Hide behind object
- ○ Go behind object
- ○ Fall out of object
- ○ Other, specify:
- ○ U/K

i. For crush, object causing crush:
- ○ Appliance
- ○ Television
- ○ Furniture
- ○ Walls
- ○ Playground equipment
- ○ Animal
- ○ Tree branch
- ○ Boulders/rocks
- ○ Dirt/sand
- ○ Person, go to H5q
- ○ Commercial equipment
- ○ Farm equipment
- ○ Other, specify:
- ○ U/K

H7. POISONING, OVERDOSE OR ACUTE INTOXICATION

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

Prescription drug
- ☐ Antidepressant
- ☐ Pain medication (opiate)
- ☐ Pain medication (non-opiate)
- ☐ Methadone
- ☐ Other Rx, specify:

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

Over-the-counter drug
- ☐ Pain medication
- ☐ Cold medicine
- ☐ Other OTC, specify:

Illicit drugs
- ☐ Pain medication (opiate)
- ☐ Pain medication (non-opiate)
- ☐ Methadone
- ☐ Cocaine
- ☐ Heroin
- ☐ Other illicit drug, specify:

Other substances
- ☐ Alcohol
- ☐ Carbon monoxide, go to e
- ☐ Other fume/gas/vapor
- ☐ Other, specify:

b. Where was the substance stored?
- ○ Open area
- ○ Open cabinet
- ○ Closed cabinet, unlocked
- ○ Closed cabinet, locked
- ○ Other, specify:
- ○ U/K

c. Was the product in its original container?
○ N/A ○ No
○ Yes ○ U/K

d. Did container have a child safety cap?
○ N/A ○ No
○ Yes ○ U/K

e. Was the incident the result of?
- ○ Accidental overdose
- ○ Medical treatment mishap
- ○ Adverse effect, but not overdose
- ○ Deliberate poisoning
- ○ Acute intoxication
- ○ Other, specify:
- ○ U/K

f. Was Poison Control called?
○ Yes ○ No ○ U/K
If yes, who called:
- ○ Child
- ○ Parent
- ○ Other caregiver
- ○ First responder
- ○ Medical person
- ○ Other, specify:
- ○ U/K

g. For CO poisoning, was a CO detector present?
○ Yes ○ No ○ U/K
If yes, how many? _____
Functioning properly?
○ Yes ○ No ○ U/K

H8. MEDICAL CONDITION

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

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

c. Was child receiving health care for the medical condition?
○ Yes ○ No ○ U/K
If yes, within 48 hours of the death?
○ Yes ○ No ○ U/K

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

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

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

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

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

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

i. Was death caused by a medical misadventure?
- ○ Yes
- ○ No
- ○ U/K

H9. OTHER KNOWN INJURY CAUSE

Specify cause, describe in detail:

I. OTHER CIRCUMSTANCES OF INCIDENT - ANSWER RELEVANT SECTIONS

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

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

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

a. Was this death:

- ○ A homicide?
- ○ A suicide?
- ○ An overdose?
- ○ A result of an external cause that was the obvious and only reason for the fatal injury?
- ○ Expected within 6 months due to terminal illness?

If any of these apply, go to Section I2, THIS IS NOT AN SDY CASE.

- ○ None of the above, go to I1b THIS IS AN SDY CASE
- ○ Unknown, go to I1b

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

☐ U/K for all

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

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

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

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

○ Yes ○ No ○ U/K If yes, describe:

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

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

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

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

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

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

Y	N	U/K	Deaths
○	○	○	Sudden unexpected death before age 50

Heart Disease

○	○	○	Heart condition/heart attack or stroke before age 50
○	○	○	Aortic aneurysm or aortic rupture
○	○	○	Arrhythmia (fast or irregular heart rhythm)
○	○	○	Cardiomyopathy
○	○	○	Congenital heart disease

Neurologic Disease

○	○	○	Epilepsy or convulsions/seizure
○	○	○	Other neurologic disease

Y	N	U/K	Symptoms
○	○	○	Febrile seizures
○	○	○	Unexplained fainting

Other Diagnoses

○	○	○	Congenital deafness
○	○	○	Connective tissue disease
○	○	○	Mitochondrial disease
○	○	○	Muscle disorder or muscular dystrophy
○	○	○	Thrombophilia (clotting disorder)
○			Other diseases that are genetic or run in families, specify:

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

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

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

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

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

If yes, describe:

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

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

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

If not compliant, describe why and how often:

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

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

If yes to any items above, describe:

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

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

If yes to physical activity, describe type of activity:

At incident Within 24 hours of incident

Other specify:

At incident Within 24 hours of incident

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

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

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

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

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

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? ○ N/A ○ Yes ○ No ○ U/K

If yes:

Was it done within a year prior to death? ○ Yes ○ No ○ U/K

Did the exam lead to restrictions for sports or otherwise? ○ Yes ○ No ○ U/K

If yes, specify restrictions:

Questions p through v: Answer if "Epilepsy/Seizure Disorder" is answered Yes in question e above (Diagnosed for a medical condition)

p. How old was the child when diagnosed with epilepsy/seizure disorder?

Age 0 (infant) through 20 years: _____

☐ U/K

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

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

r. What type(s) of seizures did the child have? Check all that apply:

☐ Non-convulsive
☐ Convulsive (grand mal seizure or generalized tonic-clonic seizure)
☐ Occur when exposure to strobe lights, video game, or flickering light (reflex seizure)
☐ U/K

s. Describe the child's epilepsy/seizures (not including the seizure at time of death). Check all that apply:

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

t. How many seizures did the child have in the year preceding death?

○ 0/never ○ 2 ○ More than 3
○ 1 ○ 3 ○ U/K

u. Did treatment for seizures include anti-epileptic drugs?

○ Yes ○ No ○ U/K

If yes, how many different types of anti-epileptic drugs did the child take?

○ 1 ○ 4 ○ More than 6
○ 2 ○ 5 ○ U/K
○ 3 ○ 6

v. Was night surveillance used?

○ Yes ○ No ○ U/K

I2. ANSWER THIS ONLY IF CHILD IS UNDER AGE FIVE: WAS DEATH RELATED TO SLEEPING OR THE SLEEP ENVIRONMENT? ○ Yes, go to I2a ○ No, go to I2s ○ U/K, go to I2a

a. Incident sleep place:

○ Crib
  If crib, type:
  ○ Not portable
  ○ Portable, e.g. Pack 'n Play
  ○ Unknown crib type
○ Bassinet
○ Bed side sleeper
○ Baby box
○ Adult bed
○ Waterbed
○ Futon
○ Playpen/other play structure, not a portable crib
○ Couch
○ Chair
○ Floor
○ Car seat
○ Rock 'n Play
○ Stroller
○ Swing
○ Bouncy chair
○ Other, specify:
○ U/K

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

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

If car seat, was car seat secured in seat of car?
○ Yes ○ No ○ U/K

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

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

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

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

d. Usual sleep place:

○ Crib
  If crib, type:
  ○ Not portable
  ○ Portable, e.g. Pack 'n Play
  ○ Unknown crib type
○ Bassinet
○ Bed side sleeper
○ Baby box
○ Adult bed
○ Waterbed
○ Futon
○ Playpen/other play structure, not a portable crib
○ Couch
○ Chair
○ Floor
○ Car seat
○ Rock 'n Play
○ Stroller
○ Swing
○ Bouncy chair
○ Other, specify:
○ U/K

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

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

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

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

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

j. Child overheated? ○ Yes ○ No ○ U/K
If yes, outside temp ____ degrees F
Check all that apply:
☐ Room too hot, temp ____ degrees F
☐ Too much bedding
☐ Too much clothing

k. Child exposed to second hand smoke?
○ Yes ○ No ○ U/K
If yes, how often: ○ Frequently ○ Occasionally ○ U/K

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

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

n. Child's airway (includes nose, mouth, neck and/or chest):
○ Unobstructed by person or object
○ Fully obstructed by person or object
○ Partially obstructed by person or object
○ U/K

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

If fully or partially obstructed, describe obstruction in detail:

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

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

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

p. Caregiver/supervisor fell asleep while feeding child?
○ Yes ○ No ○ U/K
If yes, type of feeding: ○ Bottle ○ Breast ○ U/K

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

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

If yes, reasons stated for sleeping on same surface, check all that apply:
☐ To feed
☐ To soothe
☐ Usual sleep pattern
☐ No infant bed available
☐ Home/living space overcrowded
☐ Other, specify:
☐ U/K

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

s. Is there a scene re-creation photo available for upload? ○ Yes ○ No If yes, upload here. Only one photo allowed.
Select photo that demonstrates position and location of child's body and airway (nose, mouth, neck, and chest). Size must be less than 6 mb and in .jpg or .gif format.

I3. WAS DEATH A CONSEQUENCE OF A PROBLEM WITH A CONSUMER PRODUCT? ○ Yes ○ No, go to I4 ○ U/K, go to I4

a. Describe product and circumstances:

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

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

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

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

I4. DID DEATH OCCUR DURING COMMISSION OF ANOTHER CRIME? ○ Yes ○ No, go to I5 ○ U/K, go to I5

a. Type of crime, check all that apply:
☐ Robbery/burglary ☐ Other assault ☐ Arson ☐ Illegal border crossing ☐ U/K
☐ Interpersonal violence ☐ Gang conflict ☐ Prostitution ☐ Auto theft
☐ Sexual assault ☐ Drug trade ☐ Witness intimidation ☐ Other, specify:

I5. CHILD ABUSE, NEGLECT, POOR SUPERVISION AND EXPOSURE TO HAZARDS

a. Did child abuse, neglect, poor or absent supervision or exposure to hazards cause or contribute to the child's death?

- ◯ Yes/probable
- ◯ No, go to next section
- ◯ U/K, go to next section

If yes/probable, choose primary reason:

- ◯ Child abuse, go to I5b
- ◯ Child neglect, go to I5f
- ◯ Poor/absent supervision, go to I5h
- ◯ Exposure to hazards, go to I5g

b. Type of child abuse, check all that apply:

- ☐ Abusive head trauma, go to I5c
- ☐ Chronic Battered Child Syndrome, go to I5e
- ☐ Beating/kicking, go to I5e
- ☐ Scalding or burning, go to I5e
- ☐ Munchausen Syndrome by Proxy, go to I5e
- ☐ Sexual assault, go to I5h
- ☐ Other, specify and go to I5h
- ☐ U/K, go to I5e

c. For abusive head trauma, were there retinal hemorrhages?

◯ Yes ◯ No ◯ U/K

d. For abusive head trauma, was the child shaken?

◯ Yes ◯ No ◯ U/K

If yes, was there impact?

◯ Yes ◯ No ◯ U/K

e. Events(s) triggering child abuse, check all that apply:

- ☐ None
- ☐ Crying
- ☐ Toilet training
- ☐ Disobedience
- ☐ Feeding problems
- ☐ Domestic argument
- ☐ Other, specify:
- ☐ U/K

f. Child neglect, check all that apply:

- ☐ Failure to provide necessities
  - ☐ Food
  - ☐ Shelter
  - ☐ Other, specify:
- ☐ Failure to provide supervision
- ☐ Emotional neglect, specify:
- ☐ Abandonment, specify:
- ☐ Failure to seek/follow treatment, specify:

If yes, was this due to religious or cultural practices?

◯ Yes ◯ No ◯ U/K

☐ Exposure to hazards:

Do not include child's own behavior.

- ◯ Hazard(s) in sleep environment (including sleep position and bed sharing)
- ◯ Fire hazard
- ◯ Unsecured medication/poison
- ◯ Firearm hazard
- ◯ Water hazard
- ◯ Motor vehicle hazard
- ◯ Other hazard, specify:

g. Exposure to hazards:

Do not include child's own behavior.

- ◯ Hazard(s) in sleep environment (including sleep position and bed sharing)
- ◯ Fire hazard
- ◯ Unsecured medication/poison
- ◯ Firearm hazard
- ◯ Water hazard
- ◯ Motor vehicle hazard
- ◯ Maternal substance use during pregnancy
- ◯ Other hazard, specify:

h. Was poverty a factor?

◯ Yes ◯ No ◯ U/K

If yes, explain in Narrative

I6. SUICIDE

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

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

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

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

J. PERSON RESPONSIBLE (OTHER THAN DECEDENT)

1. Did a person or persons other than the child do something or fail to do something that caused or contributed to the death?
   - ○ Yes/probable
   - ○ No, go to Section K
   - ○ U/K, go to Section K

2. What act(s)?
   Check only one per column and describe in narrative.

One	Two		One	Two	
○	○	Child abuse	○	○	Exposure to hazards
○	○	Child neglect	○	○	Assault, not child abuse
○	○	Poor/absent supervision	○	○	Other, specify:
			○	○	U/K

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

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

4. Is person listed in a previous section?

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

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

One	Two		One	Two		One	Two	
○	○	Adoptive parent	○	○	Grandparent	○	○	Medical provider
○	○	Stepparent	○	○	Sibling	○	○	Institutional staff
○	○	Foster parent	○	○	Other relative	○	○	Babysitter
○	○	Mother's partner	○	○	Friend	○	○	Licensed child care worker
○	○	Father's partner	○	○	Acquaintance	○	○	Other, specify:
			○	○	Child's boyfriend or girlfriend	○	○	U/K
			○	○	Stranger			

6. Person's age in years:

One	Two	
_____	_____	# Years
☐	☐	U/K

7. Person's sex:

One	Two	
○	○	Male
○	○	Female
○	○	U/K

8. Person speaks and understands English?

One	Two	
○	○	Yes
○	○	No
○	○	U/K

If no, language spoken:

9. Person on active military duty?

One	Two	
○	○	Yes
○	○	No
○	○	U/K

If yes, specify branch:

10. Person(s) have history of substance abuse?

One	Two	
○	○	Yes
○	○	No
○	○	U/K

If yes, check all that apply:

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

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

One	Two	
○	○	Yes
○	○	No
○	○	U/K

If yes, check all that apply:

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

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

One	Two	
○	○	Yes
○	○	No
○	○	U/K

If yes, check all that apply:

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

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

One	Two	
○	○	Yes
○	○	No
○	○	U/K

If yes, check all that apply:

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

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

One	Two	
○	○	Yes
○	○	No
○	○	U/K

14. Person(s) have prior child deaths?

One	Two	
○	○	Yes
○	○	No
○	○	U/K

If yes, check all that apply:

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

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

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

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

One	Two	
○	○	Yes
○	○	No
○	○	U/K

If yes, check all that apply:

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

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

One	Two	
○	○	Yes
○	○	No
○	○	U/K

If yes, select the most appropriate description of the person's sleeping period at incident:

One	Two	
○	○	Night time sleep
○	○	Day time nap, describe:
○	○	Day time sleep (for example, person is night shift worker), describe:
○	○	Other, describe:

18. At time of incident was person impaired?

One: ◯ Yes ◯ No ◯ U/K Two: ◯ Yes ◯ No ◯ U/K

If yes, check all that apply:

One	Two		One	Two	
☐	☐	Drug impaired, specify:	☐	☐	Impaired by illness, specify:
☐	☐	Alcohol impaired	☐	☐	Impaired by disability, specify:
☐	☐	Distracted	☐	☐	Other, specify:
☐	☐	Absent			

19. Person(s) have, check all that apply:

One	Two	
☐	☐	Prior history of similar acts
☐	☐	Prior arrests
☐	☐	Prior convictions

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

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

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

1. Were new or revised services recommended or implemented as a result of the death? ◯ Yes ◯ No ◯ U/K

If yes, select one option per row:

	Referred for service before review	Review led to referral	Referral needed, not available	N/A	U/K
Bereavement counseling	◯	◯	◯	◯	◯
Debriefing for professionals	◯	◯	◯	◯	◯
Economic support	◯	◯	◯	◯	◯
Funeral arrangements	◯	◯	◯	◯	◯
Emergency shelter	◯	◯	◯	◯	◯
Mental health services	◯	◯	◯	◯	◯
Foster care	◯	◯	◯	◯	◯
Health services	◯	◯	◯	◯	◯
Legal services	◯	◯	◯	◯	◯
Genetic counseling	◯	◯	◯	◯	◯
Home visiting	◯	◯	◯	◯	◯
Substance abuse	◯	◯	◯	◯	◯
Other, specify:	◯	◯	◯	◯	◯

L. PREVENTION INITIATIVES RESULTING FROM THE REVIEW

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

1. Were new or revised agency services, policies or practices recommended or implemented as a result of the review?

◯ Yes ◯ No ◯ U/K

If yes, select all that apply and describe:

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

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

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

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

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

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

5. Briefly describe recommendations and/or initiatives that will be or have been implemented as a result of the death:

6. Who was given the recommendation(s) and or/initiative(s) to implement? Check all that apply:

☐ N/A, no strategies	☐ Social services	☐ Other health care providers	☐ Elected official	☐ Youth group
☐ No one	☐ Mental health	☐ Law enforcement	☐ Advocacy organization	☐ Other, specify:
☐ Community Action Team	☐ Schools	☐ Medical examiner	☐ Local community group	
☐ Health department	☐ Hospital	☐ Coroner	☐ New coalition/task force	☐ U/K

7. Could the death have been prevented? ○ Yes, probably ○ No, probably not ○ Team could not determine

M. THE REVIEW MEETING PROCESS

1. Date of first review meeting:

2. Number of review meetings for this case: _____

3. Is review complete? ○ N/A ○ Yes ○ No

4. Agencies and individuals at review meeting, check all that apply:

☐ Medical examiner/coroner	☐ CPS	☐ Other health care	☐ Mental health	☐ Child advocate
☐ Law enforcement	☐ Other social services	☐ Fire	☐ Substance abuse	☐ Military
☐ Prosecutor/district attorney	☐ Physician	☐ EMS	☐ Home visiting	☐ Domestic violence
☐ Public health	☐ Nurse	☐ Faith based organization	☐ Healthy Start	☐ Others, list:
☐ HMO/managed care	☐ Hospital	☐ Education	☐ Court	

5. Were the following data sources available at the review meeting?
Check all that apply:

- ☐ CDC's SUIDI Reporting Form
- ☐ Jurisdictional equivalent of the CDC SUIDI Reporting Form
- ☐ Birth certificate - full form
- ☐ Death certificate
- ☐ Child's medical records or clinical history, including vaccinations
- ☐ Biological mother's obstetric and prenatal information
- ☐ Newborn screening results
- ☐ Law enforcement records
- ☐ Social service records
- ☐ Child protection agency records
- ☐ EMS run sheet
- ☐ Hospital records
- ☐ Autopsy/pathology reports
- ☐ Home visiting
- ☐ Mental health records
- ☐ School records
- ☐ Substance abuse treatment records

6. Did any of the following factors reduce meeting effectiveness, check all that apply:

- ☐ None
- ☐ Confidentiality issues among members prevented full exchange of information
- ☐ HIPAA regulations prevented access to or exchange of information
- ☐ Inadequate investigation precluded having enough information for review
- ☐ Team members did not bring adequate information to the meeting
- ☐ Necessary team members were absent
- ☐ Meeting was held too soon after death
- ☐ Meeting was held too long after death
- ☐ Records or information were needed from another locality in-state
- ☐ Records or information were needed from another state
- ☐ Team disagreement on circumstances
- ☐ Other factors, specify:

7. Review meeting outcomes, check all that apply:

- ☐ Review led to additional investigation
- ☐ Team disagreed with official manner of death. What did team believe manner should be?
- ☐ Team disagreed with official cause of death. What did team believe cause should be?
- ☐ Because of the review, the official cause or manner of death was changed
- ☐ Review led to the delivery of services
- ☐ Review led to changes in agency policies or practices
- ☐ Review led to prevention initiatives being implemented ☐ Local ☐ State ☐ National

N. SUID AND SDY CASE REGISTRY

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

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

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

1. Is this an SDY or SUID case? ○ Yes ○ No If no, go to Section O

2. Did this case go to Advanced Review for the SDY Case Registry?
○ N/A ○ Yes ○ No
If yes, date of first Advanced Review meeting:

3. Notes from Advanced Review meeting, including case details that helped determine SDY categorization and any ways to improve the review:

4. Professionals at the Advanced Review meeting, check all that apply:

☐ Cardiologist	☐ Death investigator	☐ Geneticist or genetic counselor	☐ Pediatrician
☐ CDR representative	☐ Epileptologist	☐ Mental health professional	☐ Public health representative
☐ Coroner	☐ Forensic pathologist/medical examiner	☐ Neonatologist	☐ Others, specify:

5. Did the Advanced Review team believe the autopsy was comprehensive? ○ Yes ○ No ○ U/K

6. If autopsy performed, did the ME/coroner/pathologist use the SDY Autopsy Guidance or Summary?
○ N/A ○ Yes ○ No ○ U/K

7. Was a specimen sent to the SDY Case Registry biorepository?

○ N/A ○ Yes ○ No ○ U/K

8. Did the family consent to have DNA saved as part of the SDY Case Registry?

○ N/A ○ Yes ○ No ○ U/K

If no, why not?
- ○ Consent was not attempted
- ○ Consent was attempted but follow up was unsuccessful
- ○ Consent was attempted but family declined
- ○ Other, specify:

9. Categorization for SDY Case Registry (choose only one):

- ○ Excluded from SDY Case Registry
- ○ Incomplete case information
- ○ Explained cardiac
- ○ Explained neurological
- ○ Explained infant suffocation (under age 1)
- ○ Explained other, specify:
- ○ Unexplained, possible cardiac
- ○ Unexplained, possible cardiac and SUDEP
- ○ Unexplained, SUDEP
- ○ Unexplained infant death/SUID (under age 1)
- ○ Unexplained child death (age 1 and over)

10. Categorization for SUID Case Registry (choose only one):

- ○ Excluded (other explained causes, not suffocation)
- ○ Unexplained: No autopsy or death scene investigation
- ○ Unexplained: Incomplete case information
- ○ Unexplained: No unsafe sleep factors
- ○ Unexplained: Unsafe sleep factors
- ○ Unexplained: Possible suffocation with unsafe sleep factors
- ○ Explained: Suffocation with unsafe sleep factors

If possible suffocation or explained suffocation, select the primary mechanism(s) leading to the death, check all that apply:

- ☐ Soft bedding
- ☐ Wedging
- ☐ Overlay
- ☐ Other, specify:

11. Check the box below when a SUID case is complete and ready for inclusion in the SUID data analyses. This box should be checked if a completed case is awaiting SDY Advanced Review or not going to SDY Advanced Review.

☐ SUID Case Registry Data Entry Complete

O. NARRATIVE

O1. NARRATIVE

Use this space to provide more detail on the circumstances of the death and to describe any other relevant information.
DO NOT INCLUDE IDENTIFIERS IN THE NARRATIVE such as names, dates, addresses, and specific service providers. Consider the following questions: What was the child doing? Where did it happen? How did it happen? What went wrong? What was the quality of supervision? What was the injury cause of death? The Narrative is included in de-identified downloads, and per MPHI/NCFRP's data use agreement with your state, HIPAA identifying information should not be recorded in this field.

P. FORM COMPLETED BY:

Person:

Title:

Agency:

Phone:

Email:

Date completed:

Data entry completed for this case? ☐

For State Program Use Only:

Data quality assurance completed by state? ☐

The development of this report tool was supported, in part, by Grant No. UG7MC28482 from the Maternal and Child Health Bureau (Title V, Social Security Act), Health Resources and Services Administration, Department of Health and Human Services and with additional funding from the US Centers for Disease Control and Prevention, Division of Reproductive Health

Data Entry: https://data.ncfrp.org

www.ncfrp.org info@ncfrp.org 1-800-656-2434 Facebook and Twitter: NationalCFRP