

## Child Death Review Case Reporting System

### Case Report - Version 3.0

#### Instructions:

This case report is a component of the web-based CDR Case Reporting System. It can be used alone as a paper instrument, but its full potential is reached when the data from this form is entered into the CDR Case Reporting System. This system is available to states from the National Center for the Review & Prevention of Child Deaths and requires a data use agreement for state and local data entry. System functions include data entry, case report, editing and printing, data download and standardized reports.

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

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

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

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

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

This edition is Version 3.0, effective October 2013. Additional paper forms can be ordered from the National Center at no charge. Users interested in participating in the web-based case reporting system for data entry and reporting should contact the National Center for the Review & Prevention of Child Deaths. This form was first developed in 2004 by a work group of over 26 persons, representing 18 states and the Maternal and Child Bureau of HRSA/HHS. Many of the Sudden and Unexpected Infant Deaths (SUID) variables were identified in consultation with national SUID experts, in partnership with the CDC Division of Reproductive Health.

Phone: 1-800-656-2434    Email: [info@childdeathreview.org](mailto:info@childdeathreview.org)    Website: [www.childdeathreview.org](http://www.childdeathreview.org)    Data entry website: <https://cdrdata.org>

Copyright: National Center for the Review & Prevention of Child Deaths, October 2013

The programming work to support the development of Version 3.0 was generously funded in-kind by Vantage Systems, Inc.



**COMPLETE FOR ALL INFANTS UNDER ONE YEAR**

34. Gestational age: <input type="checkbox"/> U/K _____ # weeks	35. Birth weight: <input type="checkbox"/> U/K <input type="radio"/> Grams/kilograms _____ <input type="radio"/> Pounds/ounces _____/_____	36. Multiple birth? <input type="radio"/> Yes, # _____ <input type="radio"/> No <input type="radio"/> U/K	37. Including the deceased infant, how many pregnancies did the birth mother have? # _____ <input type="checkbox"/> U/K	38. Including the deceased infant, how many live births did the birth mother have? # _____ <input type="checkbox"/> U/K																																																
39. Not including the deceased infant, number of children birth mother still has living? # _____ <input type="checkbox"/> U/K	40. Prenatal care provided during pregnancy of deceased infant? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K If yes, number of prenatal visits: # _____ <input type="checkbox"/> U/K    If yes, month of first prenatal visit? Specify 1-9 __ <input type="checkbox"/> U/K																																																			
41. During pregnancy, did mother (check all that apply): <table style="width:100%; border: none;"> <tr> <td style="width:35%; border: none;"> <table style="width:100%; border: none;"> <tr> <td><u>Yes</u> <u>No</u> <u>U/K</u></td> <td><input type="radio"/> <input type="radio"/> <input type="radio"/></td> <td>Have medical complications/infections?</td> </tr> <tr> <td><input type="radio"/> <input type="radio"/> <input type="radio"/></td> <td><input type="radio"/> <input type="radio"/> <input type="radio"/></td> <td>Experience intimate partner violence?</td> </tr> <tr> <td><input type="radio"/> <input type="radio"/> <input type="radio"/></td> <td><input type="radio"/> <input type="radio"/> <input type="radio"/></td> <td>Use illicit drugs?</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Infant born drug exposed?</td> </tr> <tr> <td><input type="radio"/> <input type="radio"/> <input type="radio"/></td> <td><input type="radio"/> <input type="radio"/> <input type="radio"/></td> <td>Misuse OTC or prescription drugs?</td> </tr> <tr> <td><input type="radio"/> <input type="radio"/> <input type="radio"/></td> <td><input type="radio"/> <input type="radio"/> <input type="radio"/></td> <td>Have heavy alcohol use?</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Infant born with fetal alcohol effects or syndrome?</td> </tr> </table> </td> <td colspan="2" style="width:65%; border: none;">                     If yes, medical complications/infections, check all that apply:  <table style="width:100%; border: none;"> <tr> <td><input type="checkbox"/> Acute/chronic lung disease</td> <td><input type="checkbox"/> Hemoglobinopathy</td> <td><input type="checkbox"/> Previous infant 4000+ grams</td> </tr> <tr> <td><input type="checkbox"/> Anemia</td> <td><input type="checkbox"/> High MSAFP</td> <td><input type="checkbox"/> Previous infant preterm/small for gestation</td> </tr> <tr> <td><input type="checkbox"/> Cardiac disease</td> <td><input type="checkbox"/> Hydramnios/oligohydramnios</td> <td><input type="checkbox"/> PROM</td> </tr> <tr> <td><input type="checkbox"/> Chorioamnionitis</td> <td><input type="checkbox"/> Incompetent cervix</td> <td><input type="checkbox"/> Renal disease</td> </tr> <tr> <td><input type="checkbox"/> Chronic hypertension</td> <td><input type="checkbox"/> Low MSAFP</td> <td><input type="checkbox"/> Rh sensitization</td> </tr> <tr> <td><input type="checkbox"/> Diabetes</td> <td><input type="checkbox"/> Other infectious disease</td> <td><input type="checkbox"/> Uterine bleeding</td> </tr> <tr> <td><input type="checkbox"/> Eclampsia</td> <td><input type="checkbox"/> Pregnancy-related hypertension</td> <td><input type="checkbox"/> Other, specify: _____</td> </tr> <tr> <td><input type="checkbox"/> Genital herpes</td> <td><input type="checkbox"/> Preterm labor</td> <td></td> </tr> </table> </td> </tr> </table>					<table style="width:100%; border: none;"> <tr> <td><u>Yes</u> <u>No</u> <u>U/K</u></td> <td><input type="radio"/> <input type="radio"/> <input type="radio"/></td> <td>Have medical complications/infections?</td> </tr> <tr> <td><input type="radio"/> <input type="radio"/> <input type="radio"/></td> <td><input type="radio"/> <input type="radio"/> <input type="radio"/></td> <td>Experience intimate partner violence?</td> </tr> <tr> <td><input type="radio"/> <input type="radio"/> <input type="radio"/></td> <td><input type="radio"/> <input type="radio"/> <input type="radio"/></td> <td>Use illicit drugs?</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Infant born drug exposed?</td> </tr> <tr> <td><input type="radio"/> <input type="radio"/> <input type="radio"/></td> <td><input type="radio"/> <input type="radio"/> <input type="radio"/></td> <td>Misuse OTC or prescription drugs?</td> </tr> <tr> <td><input type="radio"/> <input type="radio"/> <input type="radio"/></td> <td><input type="radio"/> <input type="radio"/> <input type="radio"/></td> <td>Have heavy alcohol use?</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Infant born with fetal alcohol effects or syndrome?</td> </tr> </table>	<u>Yes</u> <u>No</u> <u>U/K</u>	<input type="radio"/> <input type="radio"/> <input type="radio"/>	Have medical complications/infections?	<input type="radio"/> <input type="radio"/> <input type="radio"/>	<input type="radio"/> <input type="radio"/> <input type="radio"/>	Experience intimate partner violence?	<input type="radio"/> <input type="radio"/> <input type="radio"/>	<input type="radio"/> <input type="radio"/> <input type="radio"/>	Use illicit drugs?	<input type="checkbox"/>	<input type="checkbox"/>	Infant born drug exposed?	<input type="radio"/> <input type="radio"/> <input type="radio"/>	<input type="radio"/> <input type="radio"/> <input type="radio"/>	Misuse OTC or prescription drugs?	<input type="radio"/> <input type="radio"/> <input type="radio"/>	<input type="radio"/> <input type="radio"/> <input type="radio"/>	Have heavy alcohol use?	<input type="checkbox"/>	<input type="checkbox"/>	Infant born with fetal alcohol effects or syndrome?	If yes, medical complications/infections, check all that apply: <table style="width:100%; border: none;"> <tr> <td><input type="checkbox"/> Acute/chronic lung disease</td> <td><input type="checkbox"/> Hemoglobinopathy</td> <td><input type="checkbox"/> Previous infant 4000+ grams</td> </tr> <tr> <td><input type="checkbox"/> Anemia</td> <td><input type="checkbox"/> High MSAFP</td> <td><input type="checkbox"/> Previous infant preterm/small for gestation</td> </tr> <tr> <td><input type="checkbox"/> Cardiac disease</td> <td><input type="checkbox"/> Hydramnios/oligohydramnios</td> <td><input type="checkbox"/> PROM</td> </tr> <tr> <td><input type="checkbox"/> Chorioamnionitis</td> <td><input type="checkbox"/> Incompetent cervix</td> <td><input type="checkbox"/> Renal disease</td> </tr> <tr> <td><input type="checkbox"/> Chronic hypertension</td> <td><input type="checkbox"/> Low MSAFP</td> <td><input type="checkbox"/> Rh sensitization</td> </tr> <tr> <td><input type="checkbox"/> Diabetes</td> <td><input type="checkbox"/> Other infectious disease</td> <td><input type="checkbox"/> Uterine bleeding</td> </tr> <tr> <td><input type="checkbox"/> Eclampsia</td> <td><input type="checkbox"/> Pregnancy-related hypertension</td> <td><input type="checkbox"/> Other, specify: _____</td> </tr> <tr> <td><input type="checkbox"/> Genital herpes</td> <td><input type="checkbox"/> Preterm labor</td> <td></td> </tr> </table>		<input type="checkbox"/> Acute/chronic lung disease	<input type="checkbox"/> Hemoglobinopathy	<input type="checkbox"/> Previous infant 4000+ grams	<input type="checkbox"/> Anemia	<input type="checkbox"/> High MSAFP	<input type="checkbox"/> Previous infant preterm/small for gestation	<input type="checkbox"/> Cardiac disease	<input type="checkbox"/> Hydramnios/oligohydramnios	<input type="checkbox"/> PROM	<input type="checkbox"/> Chorioamnionitis	<input type="checkbox"/> Incompetent cervix	<input type="checkbox"/> Renal disease	<input type="checkbox"/> Chronic hypertension	<input type="checkbox"/> Low MSAFP	<input type="checkbox"/> Rh sensitization	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Other infectious disease	<input type="checkbox"/> Uterine bleeding	<input type="checkbox"/> Eclampsia	<input type="checkbox"/> Pregnancy-related hypertension	<input type="checkbox"/> Other, specify: _____	<input type="checkbox"/> Genital herpes	<input type="checkbox"/> Preterm labor	
<table style="width:100%; border: none;"> <tr> <td><u>Yes</u> <u>No</u> <u>U/K</u></td> <td><input type="radio"/> <input type="radio"/> <input type="radio"/></td> <td>Have medical complications/infections?</td> </tr> <tr> <td><input type="radio"/> <input type="radio"/> <input type="radio"/></td> <td><input type="radio"/> <input type="radio"/> <input type="radio"/></td> <td>Experience intimate partner violence?</td> </tr> <tr> <td><input type="radio"/> <input type="radio"/> <input type="radio"/></td> <td><input type="radio"/> <input type="radio"/> <input type="radio"/></td> <td>Use illicit drugs?</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Infant born drug exposed?</td> </tr> <tr> <td><input type="radio"/> <input type="radio"/> <input type="radio"/></td> <td><input type="radio"/> <input type="radio"/> <input type="radio"/></td> <td>Misuse OTC or prescription drugs?</td> </tr> <tr> <td><input type="radio"/> <input type="radio"/> <input type="radio"/></td> <td><input type="radio"/> <input type="radio"/> <input type="radio"/></td> <td>Have heavy alcohol use?</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Infant born with fetal alcohol effects or syndrome?</td> </tr> </table>	<u>Yes</u> <u>No</u> <u>U/K</u>	<input type="radio"/> <input type="radio"/> <input type="radio"/>	Have medical complications/infections?	<input type="radio"/> <input type="radio"/> <input type="radio"/>	<input type="radio"/> <input type="radio"/> <input type="radio"/>	Experience intimate partner violence?	<input type="radio"/> <input type="radio"/> <input type="radio"/>	<input type="radio"/> <input type="radio"/> <input type="radio"/>	Use illicit drugs?	<input type="checkbox"/>	<input type="checkbox"/>	Infant born drug exposed?	<input type="radio"/> <input type="radio"/> <input type="radio"/>	<input type="radio"/> <input type="radio"/> <input type="radio"/>	Misuse OTC or prescription drugs?	<input type="radio"/> <input type="radio"/> <input type="radio"/>	<input type="radio"/> <input type="radio"/> <input type="radio"/>	Have heavy alcohol use?	<input type="checkbox"/>	<input type="checkbox"/>	Infant born with fetal alcohol effects or syndrome?	If yes, medical complications/infections, check all that apply: <table style="width:100%; border: none;"> <tr> <td><input type="checkbox"/> Acute/chronic lung disease</td> <td><input type="checkbox"/> Hemoglobinopathy</td> <td><input type="checkbox"/> Previous infant 4000+ grams</td> </tr> <tr> <td><input type="checkbox"/> Anemia</td> <td><input type="checkbox"/> High MSAFP</td> <td><input type="checkbox"/> Previous infant preterm/small for gestation</td> </tr> <tr> <td><input type="checkbox"/> Cardiac disease</td> <td><input type="checkbox"/> Hydramnios/oligohydramnios</td> <td><input type="checkbox"/> PROM</td> </tr> <tr> <td><input type="checkbox"/> Chorioamnionitis</td> <td><input type="checkbox"/> Incompetent cervix</td> <td><input type="checkbox"/> Renal disease</td> </tr> <tr> <td><input type="checkbox"/> Chronic hypertension</td> <td><input type="checkbox"/> Low MSAFP</td> <td><input type="checkbox"/> Rh sensitization</td> </tr> <tr> <td><input type="checkbox"/> Diabetes</td> <td><input type="checkbox"/> Other infectious disease</td> <td><input type="checkbox"/> Uterine bleeding</td> </tr> <tr> <td><input type="checkbox"/> Eclampsia</td> <td><input type="checkbox"/> Pregnancy-related hypertension</td> <td><input type="checkbox"/> Other, specify: _____</td> </tr> <tr> <td><input type="checkbox"/> Genital herpes</td> <td><input type="checkbox"/> Preterm labor</td> <td></td> </tr> </table>		<input type="checkbox"/> Acute/chronic lung disease	<input type="checkbox"/> Hemoglobinopathy	<input type="checkbox"/> Previous infant 4000+ grams	<input type="checkbox"/> Anemia	<input type="checkbox"/> High MSAFP	<input type="checkbox"/> Previous infant preterm/small for gestation	<input type="checkbox"/> Cardiac disease	<input type="checkbox"/> Hydramnios/oligohydramnios	<input type="checkbox"/> PROM	<input type="checkbox"/> Chorioamnionitis	<input type="checkbox"/> Incompetent cervix	<input type="checkbox"/> Renal disease	<input type="checkbox"/> Chronic hypertension	<input type="checkbox"/> Low MSAFP	<input type="checkbox"/> Rh sensitization	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Other infectious disease	<input type="checkbox"/> Uterine bleeding	<input type="checkbox"/> Eclampsia	<input type="checkbox"/> Pregnancy-related hypertension	<input type="checkbox"/> Other, specify: _____	<input type="checkbox"/> Genital herpes	<input type="checkbox"/> Preterm labor						
<u>Yes</u> <u>No</u> <u>U/K</u>	<input type="radio"/> <input type="radio"/> <input type="radio"/>	Have medical complications/infections?																																																		
<input type="radio"/> <input type="radio"/> <input type="radio"/>	<input type="radio"/> <input type="radio"/> <input type="radio"/>	Experience intimate partner violence?																																																		
<input type="radio"/> <input type="radio"/> <input type="radio"/>	<input type="radio"/> <input type="radio"/> <input type="radio"/>	Use illicit drugs?																																																		
<input type="checkbox"/>	<input type="checkbox"/>	Infant born drug exposed?																																																		
<input type="radio"/> <input type="radio"/> <input type="radio"/>	<input type="radio"/> <input type="radio"/> <input type="radio"/>	Misuse OTC or prescription drugs?																																																		
<input type="radio"/> <input type="radio"/> <input type="radio"/>	<input type="radio"/> <input type="radio"/> <input type="radio"/>	Have heavy alcohol use?																																																		
<input type="checkbox"/>	<input type="checkbox"/>	Infant born with fetal alcohol effects or syndrome?																																																		
<input type="checkbox"/> Acute/chronic lung disease	<input type="checkbox"/> Hemoglobinopathy	<input type="checkbox"/> Previous infant 4000+ grams																																																		
<input type="checkbox"/> Anemia	<input type="checkbox"/> High MSAFP	<input type="checkbox"/> Previous infant preterm/small for gestation																																																		
<input type="checkbox"/> Cardiac disease	<input type="checkbox"/> Hydramnios/oligohydramnios	<input type="checkbox"/> PROM																																																		
<input type="checkbox"/> Chorioamnionitis	<input type="checkbox"/> Incompetent cervix	<input type="checkbox"/> Renal disease																																																		
<input type="checkbox"/> Chronic hypertension	<input type="checkbox"/> Low MSAFP	<input type="checkbox"/> Rh sensitization																																																		
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Other infectious disease	<input type="checkbox"/> Uterine bleeding																																																		
<input type="checkbox"/> Eclampsia	<input type="checkbox"/> Pregnancy-related hypertension	<input type="checkbox"/> Other, specify: _____																																																		
<input type="checkbox"/> Genital herpes	<input type="checkbox"/> Preterm labor																																																			
42. Were there access or compliance issues related to prenatal care? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K    If yes, check all that apply: <table style="width:100%; border: none;"> <tr> <td><input type="checkbox"/> Lack of money for care</td> <td><input type="checkbox"/> Cultural differences</td> <td><input type="checkbox"/> Multiple providers, not coordinated</td> <td><input type="checkbox"/> Unwilling to obtain care</td> </tr> <tr> <td><input type="checkbox"/> Limitations of health insurance coverage</td> <td><input type="checkbox"/> Religious objections to care</td> <td><input type="checkbox"/> Lack of child care</td> <td><input type="checkbox"/> Intimate partner would not allow care</td> </tr> <tr> <td><input type="checkbox"/> Multiple health insurance, not coordinated</td> <td><input type="checkbox"/> Language barriers</td> <td><input type="checkbox"/> Lack of family/social support</td> <td><input type="checkbox"/> Other, specify: _____</td> </tr> <tr> <td><input type="checkbox"/> Lack of transportation</td> <td><input type="checkbox"/> Referrals not made</td> <td><input type="checkbox"/> Services not available</td> <td><input type="checkbox"/> U/K</td> </tr> <tr> <td><input type="checkbox"/> No phone</td> <td><input type="checkbox"/> Specialist needed, not available</td> <td><input type="checkbox"/> Distrust of health care system</td> <td></td> </tr> </table>					<input type="checkbox"/> Lack of money for care	<input type="checkbox"/> Cultural differences	<input type="checkbox"/> Multiple providers, not coordinated	<input type="checkbox"/> Unwilling to obtain care	<input type="checkbox"/> Limitations of health insurance coverage	<input type="checkbox"/> Religious objections to care	<input type="checkbox"/> Lack of child care	<input type="checkbox"/> Intimate partner would not allow care	<input type="checkbox"/> Multiple health insurance, not coordinated	<input type="checkbox"/> Language barriers	<input type="checkbox"/> Lack of family/social support	<input type="checkbox"/> Other, specify: _____	<input type="checkbox"/> Lack of transportation	<input type="checkbox"/> Referrals not made	<input type="checkbox"/> Services not available	<input type="checkbox"/> U/K	<input type="checkbox"/> No phone	<input type="checkbox"/> Specialist needed, not available	<input type="checkbox"/> Distrust of health care system																													
<input type="checkbox"/> Lack of money for care	<input type="checkbox"/> Cultural differences	<input type="checkbox"/> Multiple providers, not coordinated	<input type="checkbox"/> Unwilling to obtain care																																																	
<input type="checkbox"/> Limitations of health insurance coverage	<input type="checkbox"/> Religious objections to care	<input type="checkbox"/> Lack of child care	<input type="checkbox"/> Intimate partner would not allow care																																																	
<input type="checkbox"/> Multiple health insurance, not coordinated	<input type="checkbox"/> Language barriers	<input type="checkbox"/> Lack of family/social support	<input type="checkbox"/> Other, specify: _____																																																	
<input type="checkbox"/> Lack of transportation	<input type="checkbox"/> Referrals not made	<input type="checkbox"/> Services not available	<input type="checkbox"/> U/K																																																	
<input type="checkbox"/> No phone	<input type="checkbox"/> Specialist needed, not available	<input type="checkbox"/> Distrust of health care system																																																		
43. Did mother smoke in the 3 months before pregnancy? <input type="radio"/> Yes    If yes, ___ Avg # cigarettes/day <input type="radio"/> No        (20 cigarettes in pack) <input type="radio"/> U/K <input type="checkbox"/> U/K quantity		44. Did mother smoke at any time during pregnancy? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K If yes, <table style="display: inline-table; border: none;"> <tr> <td style="text-align: center;">Trimester 1</td> <td style="text-align: center;">Trimester 2</td> <td style="text-align: center;">Trimester 3</td> </tr> <tr> <td style="text-align: center;">_____</td> <td style="text-align: center;">_____</td> <td style="text-align: center;">_____</td> </tr> <tr> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> </table> Avg # cigarettes/day (20 cigarettes in pack) <input type="checkbox"/> U/K quantity			Trimester 1	Trimester 2	Trimester 3	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																							
Trimester 1	Trimester 2	Trimester 3																																																		
_____	_____	_____																																																		
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																		
45. Infant ever breastfed? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K	46. Was mother injured during pregnancy? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K If yes, describe: _____	47. Did infant have abnormal metabolic newborn screening results? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K If yes, was abnormality a fatty acid oxidation error, such as MCAD? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K If yes, describe: _____    If other abnormalities, describe: _____																																																		
48. At any time prior to the infant's last 72 hours, did the infant have a history of (check all that apply): <input type="checkbox"/> Infection <input type="checkbox"/> Cyanosis <input type="checkbox"/> Allergies <input type="checkbox"/> Seizures or convulsions <input type="checkbox"/> Abnormal growth, weight gain/loss <input type="checkbox"/> Cardiac abnormalities <input type="checkbox"/> Apnea <input type="checkbox"/> Metabolic disorders <input type="checkbox"/> _____ <input type="checkbox"/> Other, specify: _____		49. In the 72 hours prior to death, did the infant have any of the following? Check all that apply: <input type="checkbox"/> Fever <input type="checkbox"/> Vomiting <input type="checkbox"/> Apnea <input type="checkbox"/> Excessive sweating <input type="checkbox"/> Choking <input type="checkbox"/> Cyanosis <input type="checkbox"/> Lethargy/sleeping more than usual <input type="checkbox"/> Diarrhea <input type="checkbox"/> Seizures or convulsions <input type="checkbox"/> Fussiness/excessive crying <input type="checkbox"/> Stool changes <input type="checkbox"/> Other, specify: _____ <input type="checkbox"/> Decrease in appetite <input type="checkbox"/> Difficulty breathing																																																		
50. In the 72 hours prior to death, was the infant injured? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K If yes, describe cause and injuries: _____	51. In the 72 hours prior to death, was the infant given any vaccines? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K If yes, list name(s) of vaccines: _____	52. In the 72 hours prior to death, was the infant given any medications or remedies? Include herbal, prescription and over-the-counter medications and home remedies. <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K If yes, list name and last dose given: _____	53. What did the infant have for his/her last meal? Check all that apply: <input type="checkbox"/> Breast milk <input type="checkbox"/> Other, specify: _____ <input type="checkbox"/> Formula, type: _____ <input type="checkbox"/> Baby food, type: _____ <input type="checkbox"/> Cereal, type: _____ <input type="checkbox"/> U/K																																																	

**B. PRIMARY CAREGIVER(S) INFORMATION**

1. Primary caregiver(s): Select only one each in columns one and two. <table style="width:100%; border: none;"> <tr> <td style="width:50%; border: none;"> <table style="width:100%; border: none;"> <tr> <td style="text-align: center;"><u>One</u></td> <td style="text-align: center;"><u>Two</u></td> </tr> <tr> <td><input type="radio"/> Self, go to Section C</td> <td><input type="radio"/> Grandparent</td> </tr> <tr> <td><input type="radio"/> Biological parent</td> <td><input type="radio"/> Sibling</td> </tr> <tr> <td><input type="radio"/> Adoptive parent</td> <td><input type="radio"/> Other relative</td> </tr> <tr> <td><input type="radio"/> Stepparent</td> <td><input type="radio"/> Friend</td> </tr> <tr> <td><input type="radio"/> Foster parent</td> <td><input type="radio"/> Institutional staff</td> </tr> <tr> <td><input type="radio"/> Mother's partner</td> <td><input type="radio"/> Other, specify: _____</td> </tr> <tr> <td><input type="radio"/> Father's partner</td> <td><input type="radio"/> U/K</td> </tr> </table> </td> <td style="width:50%; border: none;"> <table style="width:100%; border: none;"> <tr> <td style="text-align: center;"><u>One</u></td> <td style="text-align: center;"><u>Two</u></td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/></td> </tr> </table> </td> </tr> </table>	<table style="width:100%; border: none;"> <tr> <td style="text-align: center;"><u>One</u></td> <td style="text-align: center;"><u>Two</u></td> </tr> <tr> <td><input type="radio"/> Self, go to Section C</td> <td><input type="radio"/> Grandparent</td> </tr> <tr> <td><input type="radio"/> Biological parent</td> <td><input type="radio"/> Sibling</td> </tr> <tr> <td><input type="radio"/> Adoptive parent</td> <td><input type="radio"/> Other relative</td> </tr> <tr> <td><input type="radio"/> Stepparent</td> <td><input type="radio"/> Friend</td> </tr> <tr> <td><input type="radio"/> Foster parent</td> <td><input type="radio"/> Institutional staff</td> </tr> <tr> <td><input type="radio"/> Mother's partner</td> <td><input type="radio"/> Other, specify: _____</td> </tr> <tr> <td><input type="radio"/> Father's partner</td> <td><input type="radio"/> U/K</td> </tr> </table>	<u>One</u>	<u>Two</u>	<input type="radio"/> Self, go to Section C	<input type="radio"/> Grandparent	<input type="radio"/> Biological parent	<input type="radio"/> Sibling	<input type="radio"/> Adoptive parent	<input type="radio"/> Other relative	<input type="radio"/> Stepparent	<input type="radio"/> Friend	<input type="radio"/> Foster parent	<input type="radio"/> Institutional staff	<input type="radio"/> Mother's partner	<input type="radio"/> Other, specify: _____	<input type="radio"/> Father's partner	<input type="radio"/> U/K	<table style="width:100%; border: none;"> <tr> <td style="text-align: center;"><u>One</u></td> <td style="text-align: center;"><u>Two</u></td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/></td> </tr> </table>	<u>One</u>	<u>Two</u>	<input type="radio"/>	<input type="radio"/>	2. Caregiver(s) age in years: <table style="width:100%; border: none;"> <tr> <td style="text-align: center;"><u>One</u></td> <td style="text-align: center;"><u>Two</u></td> </tr> <tr> <td>_____</td> <td>_____ # Years</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/> U/K</td> </tr> </table>	<u>One</u>	<u>Two</u>	_____	_____ # Years	<input type="checkbox"/>	<input type="checkbox"/> U/K	4. Caregiver(s) employment status: <table style="width:100%; border: none;"> <tr> <td style="text-align: center;"><u>One</u></td> <td style="text-align: center;"><u>Two</u></td> </tr> <tr> <td><input type="radio"/> Employed</td> <td><input type="radio"/> Unemployed</td> </tr> <tr> <td><input type="radio"/> On disability</td> <td><input type="radio"/> Stay-at-home</td> </tr> <tr> <td><input type="radio"/> Retired</td> <td><input type="radio"/> U/K</td> </tr> </table>	<u>One</u>	<u>Two</u>	<input type="radio"/> Employed	<input type="radio"/> Unemployed	<input type="radio"/> On disability	<input type="radio"/> Stay-at-home	<input type="radio"/> Retired	<input type="radio"/> U/K	5. Caregiver(s) income: <table style="width:100%; border: none;"> <tr> <td style="text-align: center;"><u>One</u></td> <td style="text-align: center;"><u>Two</u></td> </tr> <tr> <td><input type="radio"/> High</td> <td><input type="radio"/> Medium</td> </tr> <tr> <td><input type="radio"/> Low</td> <td><input type="radio"/> U/K</td> </tr> </table>	<u>One</u>	<u>Two</u>	<input type="radio"/> High	<input type="radio"/> Medium	<input type="radio"/> Low	<input type="radio"/> U/K								
<table style="width:100%; border: none;"> <tr> <td style="text-align: center;"><u>One</u></td> <td style="text-align: center;"><u>Two</u></td> </tr> <tr> <td><input type="radio"/> Self, go to Section C</td> <td><input type="radio"/> Grandparent</td> </tr> <tr> <td><input type="radio"/> Biological parent</td> <td><input type="radio"/> Sibling</td> </tr> <tr> <td><input type="radio"/> Adoptive parent</td> <td><input type="radio"/> Other relative</td> </tr> <tr> <td><input type="radio"/> Stepparent</td> <td><input type="radio"/> Friend</td> </tr> <tr> <td><input type="radio"/> Foster parent</td> <td><input type="radio"/> Institutional staff</td> </tr> <tr> <td><input type="radio"/> Mother's partner</td> <td><input type="radio"/> Other, specify: _____</td> </tr> <tr> <td><input type="radio"/> Father's partner</td> <td><input type="radio"/> U/K</td> </tr> </table>	<u>One</u>	<u>Two</u>	<input type="radio"/> Self, go to Section C	<input type="radio"/> Grandparent	<input type="radio"/> Biological parent	<input type="radio"/> Sibling	<input type="radio"/> Adoptive parent	<input type="radio"/> Other relative	<input type="radio"/> Stepparent	<input type="radio"/> Friend	<input type="radio"/> Foster parent	<input type="radio"/> Institutional staff	<input type="radio"/> Mother's partner	<input type="radio"/> Other, specify: _____	<input type="radio"/> Father's partner	<input type="radio"/> U/K	<table style="width:100%; border: none;"> <tr> <td style="text-align: center;"><u>One</u></td> <td style="text-align: center;"><u>Two</u></td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/></td> </tr> </table>	<u>One</u>	<u>Two</u>	<input type="radio"/>	<input type="radio"/>																																
<u>One</u>	<u>Two</u>																																																				
<input type="radio"/> Self, go to Section C	<input type="radio"/> Grandparent																																																				
<input type="radio"/> Biological parent	<input type="radio"/> Sibling																																																				
<input type="radio"/> Adoptive parent	<input type="radio"/> Other relative																																																				
<input type="radio"/> Stepparent	<input type="radio"/> Friend																																																				
<input type="radio"/> Foster parent	<input type="radio"/> Institutional staff																																																				
<input type="radio"/> Mother's partner	<input type="radio"/> Other, specify: _____																																																				
<input type="radio"/> Father's partner	<input type="radio"/> U/K																																																				
<u>One</u>	<u>Two</u>																																																				
<input type="radio"/>	<input type="radio"/>																																																				
<u>One</u>	<u>Two</u>																																																				
_____	_____ # Years																																																				
<input type="checkbox"/>	<input type="checkbox"/> U/K																																																				
<u>One</u>	<u>Two</u>																																																				
<input type="radio"/> Employed	<input type="radio"/> Unemployed																																																				
<input type="radio"/> On disability	<input type="radio"/> Stay-at-home																																																				
<input type="radio"/> Retired	<input type="radio"/> U/K																																																				
<u>One</u>	<u>Two</u>																																																				
<input type="radio"/> High	<input type="radio"/> Medium																																																				
<input type="radio"/> Low	<input type="radio"/> U/K																																																				
6. Caregiver(s) education: <table style="width:100%; border: none;"> <tr> <td style="text-align: center;"><u>One</u></td> <td style="text-align: center;"><u>Two</u></td> </tr> <tr> <td><input type="radio"/> &lt; High school</td> <td><input type="radio"/> High school</td> </tr> <tr> <td><input type="radio"/> College</td> <td><input type="radio"/> Post graduate</td> </tr> <tr> <td><input type="radio"/> U/K</td> <td></td> </tr> </table>	<u>One</u>	<u>Two</u>	<input type="radio"/> < High school	<input type="radio"/> High school	<input type="radio"/> College	<input type="radio"/> Post graduate	<input type="radio"/> U/K		7. Do caregiver(s) speak English? <table style="width:100%; border: none;"> <tr> <td style="text-align: center;"><u>One</u></td> <td style="text-align: center;"><u>Two</u></td> </tr> <tr> <td><input type="radio"/> Yes</td> <td><input type="radio"/> No</td> </tr> <tr> <td><input type="radio"/> U/K</td> <td></td> </tr> </table> If no, language spoken: _____	<u>One</u>	<u>Two</u>	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> U/K		8. Caregiver(s) on active military duty? <table style="width:100%; border: none;"> <tr> <td style="text-align: center;"><u>One</u></td> <td style="text-align: center;"><u>Two</u></td> </tr> <tr> <td><input type="radio"/> Yes</td> <td><input type="radio"/> No</td> </tr> <tr> <td><input type="radio"/> U/K</td> <td></td> </tr> </table> If yes, specify branch: _____	<u>One</u>	<u>Two</u>	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> U/K		9. Caregiver(s) receive social services in the past twelve months? <table style="width:100%; border: none;"> <tr> <td style="text-align: center;"><u>One</u></td> <td style="text-align: center;"><u>Two</u></td> <td style="width:50%;"></td> <td style="text-align: center;"><u>One</u></td> <td style="text-align: center;"><u>Two</u></td> </tr> <tr> <td><input type="radio"/> Yes</td> <td><input type="radio"/> No</td> <td rowspan="6" style="border: none;">                     If yes, check all that apply:                 </td> <td><input type="checkbox"/></td> <td><input type="checkbox"/> WIC</td> </tr> <tr> <td><input type="radio"/> U/K</td> <td></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/> TANF</td> </tr> <tr> <td></td> <td></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/> Medicaid</td> </tr> <tr> <td></td> <td></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/> Food stamps</td> </tr> <tr> <td></td> <td></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/> Other, specify: _____</td> </tr> <tr> <td></td> <td></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/> U/K</td> </tr> </table>	<u>One</u>	<u>Two</u>		<u>One</u>	<u>Two</u>	<input type="radio"/> Yes	<input type="radio"/> No	If yes, check all that apply:	<input type="checkbox"/>	<input type="checkbox"/> WIC	<input type="radio"/> U/K		<input type="checkbox"/>	<input type="checkbox"/> TANF			<input type="checkbox"/>	<input type="checkbox"/> Medicaid			<input type="checkbox"/>	<input type="checkbox"/> Food stamps			<input type="checkbox"/>	<input type="checkbox"/> Other, specify: _____			<input type="checkbox"/>	<input type="checkbox"/> U/K
<u>One</u>	<u>Two</u>																																																				
<input type="radio"/> < High school	<input type="radio"/> High school																																																				
<input type="radio"/> College	<input type="radio"/> Post graduate																																																				
<input type="radio"/> U/K																																																					
<u>One</u>	<u>Two</u>																																																				
<input type="radio"/> Yes	<input type="radio"/> No																																																				
<input type="radio"/> U/K																																																					
<u>One</u>	<u>Two</u>																																																				
<input type="radio"/> Yes	<input type="radio"/> No																																																				
<input type="radio"/> U/K																																																					
<u>One</u>	<u>Two</u>		<u>One</u>	<u>Two</u>																																																	
<input type="radio"/> Yes	<input type="radio"/> No	If yes, check all that apply:	<input type="checkbox"/>	<input type="checkbox"/> WIC																																																	
<input type="radio"/> U/K			<input type="checkbox"/>	<input type="checkbox"/> TANF																																																	
			<input type="checkbox"/>	<input type="checkbox"/> Medicaid																																																	
			<input type="checkbox"/>	<input type="checkbox"/> Food stamps																																																	
			<input type="checkbox"/>	<input type="checkbox"/> Other, specify: _____																																																	
			<input type="checkbox"/>	<input type="checkbox"/> U/K																																																	

<p>10. Caregiver(s) have substance abuse history?</p> <p><u>One</u>    <u>Two</u></p> <p><input type="radio"/>    <input type="radio"/> Yes</p> <p><input type="radio"/>    <input type="radio"/> No</p> <p><input type="radio"/>    <input type="radio"/> U/K</p> <p>If yes, check all that apply:</p> <p><input type="checkbox"/>    <input type="checkbox"/> Alcohol</p> <p><input type="checkbox"/>    <input type="checkbox"/> Cocaine</p> <p><input type="checkbox"/>    <input type="checkbox"/> Marijuana</p> <p><input type="checkbox"/>    <input type="checkbox"/> Methamphetamine</p> <p><input type="checkbox"/>    <input type="checkbox"/> Opiates</p> <p><input type="checkbox"/>    <input type="checkbox"/> Prescription drugs</p> <p><input type="checkbox"/>    <input type="checkbox"/> Over-the-counter</p> <p><input type="checkbox"/>    <input type="checkbox"/> Other, specify:</p> <p><input type="checkbox"/>    <input type="checkbox"/> U/K</p>	<p>11. Caregiver(s) ever victim of child maltreatment?</p> <p><u>One</u>    <u>Two</u></p> <p><input type="radio"/>    <input type="radio"/> Yes</p> <p><input type="radio"/>    <input type="radio"/> No</p> <p><input type="radio"/>    <input type="radio"/> U/K</p> <p>If yes, check all that apply:</p> <p><input type="checkbox"/>    <input type="checkbox"/> Physical</p> <p><input type="checkbox"/>    <input type="checkbox"/> Neglect</p> <p><input type="checkbox"/>    <input type="checkbox"/> Sexual</p> <p><input type="checkbox"/>    <input type="checkbox"/> Emotional/psychological</p> <p><input type="checkbox"/>    <input type="checkbox"/> U/K</p> <p>_____ # CPS referrals</p> <p>_____ # Substantiations</p> <p><input type="checkbox"/>    <input type="checkbox"/> Ever in foster care or adopted</p>	<p>12. Caregiver(s) ever perpetrator of maltreatment?</p> <p><u>One</u>    <u>Two</u></p> <p><input type="radio"/>    <input type="radio"/> Yes</p> <p><input type="radio"/>    <input type="radio"/> No</p> <p><input type="radio"/>    <input type="radio"/> U/K</p> <p>If yes, check all that apply:</p> <p><input type="checkbox"/>    <input type="checkbox"/> Physical</p> <p><input type="checkbox"/>    <input type="checkbox"/> Neglect</p> <p><input type="checkbox"/>    <input type="checkbox"/> Sexual</p> <p><input type="checkbox"/>    <input type="checkbox"/> Emotional/psychological</p> <p><input type="checkbox"/>    <input type="checkbox"/> U/K</p> <p>_____ # CPS referrals</p> <p>_____ # Substantiations</p> <p><input type="checkbox"/>    <input type="checkbox"/> CPS prevention services</p> <p><input type="checkbox"/>    <input type="checkbox"/> Family preservation services</p> <p><input type="checkbox"/>    <input type="checkbox"/> Children ever removed</p>	<p>13. Caregiver(s) have disability or chronic illness?</p> <p><u>One</u>    <u>Two</u></p> <p><input type="radio"/>    <input type="radio"/> Yes</p> <p><input type="radio"/>    <input type="radio"/> No</p> <p><input type="radio"/>    <input type="radio"/> U/K</p> <p>If yes, check all that apply:</p> <p><input type="checkbox"/>    <input type="checkbox"/> Physical, specify:</p> <p><input type="checkbox"/>    <input type="checkbox"/> Mental, specify:</p> <p><input type="checkbox"/>    <input type="checkbox"/> Sensory, specify:</p> <p><input type="checkbox"/>    <input type="checkbox"/> U/K</p> <p>If mental illness, was caregiver receiving MH services?</p> <p><input type="radio"/>    <input type="radio"/> Yes</p> <p><input type="radio"/>    <input type="radio"/> No</p> <p><input type="radio"/>    <input type="radio"/> U/K</p>
---	---	--	---

<p>14. Caregiver(s) have prior child deaths?</p> <p><u>One</u>    <u>Two</u></p> <p><input type="radio"/>    <input type="radio"/> Yes</p> <p><input type="radio"/>    <input type="radio"/> No</p> <p><input type="radio"/>    <input type="radio"/> U/K</p>	<p>If yes, cause(s): Check all that apply:</p> <p><u>One</u>    <u>Two</u></p> <p><input type="checkbox"/>    <input type="checkbox"/> Child abuse # _____</p> <p><input type="checkbox"/>    <input type="checkbox"/> Child neglect # _____</p> <p><input type="checkbox"/>    <input type="checkbox"/> Accident # _____</p> <p><input type="checkbox"/>    <input type="checkbox"/> Suicide # _____</p> <p><input type="checkbox"/>    <input type="checkbox"/> SIDS # _____</p> <p><input type="checkbox"/>    <input type="checkbox"/> Other # _____</p> <p>Other, specify:</p> <p><input type="checkbox"/>    <input type="checkbox"/> U/K</p>	<p>15. Caregiver(s) have history of intimate partner violence?</p> <p><u>One</u>    <u>Two</u></p> <p><input type="checkbox"/>    <input type="checkbox"/> Yes, as victim</p> <p><input type="checkbox"/>    <input type="checkbox"/> Yes, as perpetrator</p> <p><input type="checkbox"/>    <input type="checkbox"/> No</p> <p><input type="checkbox"/>    <input type="checkbox"/> U/K</p>	<p>16. Caregiver(s) have delinquent/criminal history?</p> <p><u>One</u>    <u>Two</u></p> <p><input type="radio"/>    <input type="radio"/> Yes</p> <p><input type="radio"/>    <input type="radio"/> No</p> <p><input type="radio"/>    <input type="radio"/> U/K</p> <p>If yes, check all that apply:</p> <p><input type="checkbox"/>    <input type="checkbox"/> Assaults</p> <p><input type="checkbox"/>    <input type="checkbox"/> Robbery</p> <p><input type="checkbox"/>    <input type="checkbox"/> Drugs</p> <p><input type="checkbox"/>    <input type="checkbox"/> Other, specify:</p> <p><input type="checkbox"/>    <input type="checkbox"/> U/K</p>
---	---	--	--

**C. SUPERVISOR INFORMATION**

<p>1. Did child have supervision at time of incident leading to death?</p> <p><input type="radio"/> Yes, answer 2-15</p> <p><input type="radio"/> No, not needed given developmental age or circumstances, go to Sect. D</p> <p><input type="radio"/> No, but needed, answer 3-15</p> <p><input type="radio"/> Unable to determine, try to answer 3-15</p>	<p>2. How long before incident did supervisor last see child? Select one:</p> <p><input type="radio"/> Child in sight of supervisor</p> <p><input type="radio"/> Minutes _____    <input type="radio"/> Days _____</p> <p><input type="radio"/> Hours _____    <input type="radio"/> U/K</p>	<p>3. Is person a primary caregiver as listed in previous section?</p> <p><input type="radio"/> Yes, caregiver one, go to 15</p> <p><input type="radio"/> Yes, caregiver two, go to 15</p> <p><input type="radio"/> No</p>
--	--	--

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

Biological parent     Foster parent     Grandparent     Friend     Institutional staff, go to 15     Other, specify:

Adoptive parent     Mother's partner     Sibling     Acquaintance     Babysitter

Stepparent     Father's partner     Other relative     Hospital staff, go to 15     Licensed child care worker     U/K

<p>5. Supervisor's age in years:</p> <p>_____    <input type="checkbox"/> U/K</p>	<p>6. Supervisor's sex:</p> <p><input type="radio"/> Male    <input type="radio"/> Female    <input type="radio"/> U/K</p>	<p>7. Does supervisor speak English?</p> <p><input type="radio"/> Yes    <input type="radio"/> No    <input type="radio"/> U/K</p> <p>If no, language spoken:</p>	<p>8. Supervisor on active military duty?</p> <p><input type="radio"/> Yes    <input type="radio"/> No    <input type="radio"/> U/K</p> <p>If yes, specify branch:</p>
---	--	---	--

<p>9. Supervisor has substance abuse history?</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"/> Alcohol</p> <p><input type="checkbox"/> Cocaine</p> <p><input type="checkbox"/> Marijuana</p> <p><input type="checkbox"/> Methamphetamine</p> <p><input type="checkbox"/> Opiates</p> <p><input type="checkbox"/> Prescription drugs</p> <p><input type="checkbox"/> Over-the-counter</p> <p><input type="checkbox"/> Other, specify:</p> <p><input type="checkbox"/> U/K</p>	<p>10. Supervisor has history of child maltreatment?</p> <p><u>As Victim</u>    <u>As Perpetrator</u></p> <p><input type="radio"/>    <input type="radio"/> Yes</p> <p><input type="radio"/>    <input type="radio"/> No</p> <p><input type="radio"/>    <input type="radio"/> U/K</p> <p>If yes, check all that apply:</p> <p><input type="checkbox"/>    <input type="checkbox"/> Physical</p> <p><input type="checkbox"/>    <input type="checkbox"/> Neglect</p> <p><input type="checkbox"/>    <input type="checkbox"/> Sexual</p> <p><input type="checkbox"/>    <input type="checkbox"/> Emotional/psychological</p> <p><input type="checkbox"/>    <input type="checkbox"/> U/K</p> <p>_____ # CPS referrals</p> <p>_____ # Substantiations</p> <p><input type="checkbox"/>    <input type="checkbox"/> Ever in foster care/adopted</p> <p><input type="checkbox"/> CPS prevention services</p> <p><input type="checkbox"/> Family preservation services</p> <p><input type="checkbox"/> Children ever removed</p>	<p>11. Supervisor has disability or chronic illness?</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"/> Physical, specify:</p> <p><input type="checkbox"/> Mental, specify:</p> <p><input type="checkbox"/> Sensory, specify:</p> <p><input type="checkbox"/> U/K</p> <p>If mental illness, was supervisor receiving MH services?</p> <p><input type="radio"/> Yes</p> <p><input type="radio"/> No</p> <p><input type="radio"/> U/K</p>	<p>12. Supervisor has prior child deaths?</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"/> Child abuse # _____</p> <p><input type="checkbox"/> Child neglect # _____</p> <p><input type="checkbox"/> Accident # _____</p> <p><input type="checkbox"/> Suicide # _____</p> <p><input type="checkbox"/> SIDS # _____</p> <p><input type="checkbox"/> Other # _____</p> <p>Other, specify:</p> <p><input type="checkbox"/> U/K</p>
--	--	---	---

13. Supervisor has history of intimate partner violence? <input type="checkbox"/> Yes, as victim <input type="checkbox"/> Yes, as perpetrator <input type="checkbox"/> No <input type="checkbox"/> U/K	14. Supervisor has delinquent or criminal history? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> U/K If yes, check all that apply: <input type="checkbox"/> Assaults <input type="checkbox"/> Drugs <input type="checkbox"/> U/K <input type="checkbox"/> Robbery <input type="checkbox"/> Other, specify:	15. At time of incident was supervisor impaired? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K If yes, check all that apply: <input type="checkbox"/> Drug impaired <input type="checkbox"/> Absent <input type="checkbox"/> Alcohol impaired <input type="checkbox"/> Impaired by illness, specify: <input type="checkbox"/> Asleep <input type="checkbox"/> Impaired by disability, specify: <input type="checkbox"/> Distracted <input type="checkbox"/> Other, specify:
--	--	---

**D. INCIDENT INFORMATION**

1. Date of incident event: <input type="radio"/> Same as date of death <input type="radio"/> If different than date of death: ____/____/____ <input type="radio"/> U/K <small>(mm/dd/yyyy)</small>	2. Approximate time of day that incident occurred? <input type="radio"/> AM <input type="radio"/> PM <input type="radio"/> U/K	3. Interval between incident and death: <input type="checkbox"/> U/K <input type="checkbox"/> Minutes ____ <input type="checkbox"/> Weeks ____ <input type="checkbox"/> Hours ____ <input type="checkbox"/> Months ____ <input type="checkbox"/> Days ____ <input type="checkbox"/> Years ____		
4. Place of incident, check all that apply: <input type="checkbox"/> Child's home <input type="checkbox"/> Licensed group home <input type="checkbox"/> School <input type="checkbox"/> Sidewalk <input type="checkbox"/> Sports area <input type="checkbox"/> Relative's home <input type="checkbox"/> Licensed child care center <input type="checkbox"/> Place of work <input type="checkbox"/> Roadway <input type="checkbox"/> Other recreation area <input type="checkbox"/> Friend's home <input type="checkbox"/> Licensed child care home <input type="checkbox"/> Indian reservation <input type="checkbox"/> Driveway <input type="checkbox"/> Hospital <input type="checkbox"/> Licensed foster care home <input type="checkbox"/> Unlicensed child care home <input type="checkbox"/> Military installation <input type="checkbox"/> Other parking area <input type="checkbox"/> Other, specify: <input type="checkbox"/> Relative foster care home <input type="checkbox"/> Farm <input type="checkbox"/> Jail/detention facility <input type="checkbox"/> State or county park <input type="checkbox"/> U/K			5. Type of area: <input type="radio"/> Urban <input type="radio"/> Suburban <input type="radio"/> Rural <input type="radio"/> Frontier <input type="radio"/> U/K	
6. Incident state: _____	7. Incident county: _____	8. Was 911 or local emergency called? <input type="radio"/> N/A <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K	9. CPR performed before EMS arrived? <input type="radio"/> N/A <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K	10. At time of incident leading to death, had child used drugs or alcohol? <input type="radio"/> N/A <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K
11. EMS to scene? <input type="radio"/> N/A <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K	12. Child's activity at time of incident, check all that apply: <input type="checkbox"/> Sleeping <input type="checkbox"/> Working <input type="checkbox"/> Driving/vehicle occupant <input type="checkbox"/> U/K <input type="checkbox"/> Playing <input type="checkbox"/> Eating <input type="checkbox"/> Other, specify:		13. Total number of deaths at incident event: ____ Children, ages 0-18 <input type="radio"/> U/K ____ Adults	

**E. INVESTIGATION INFORMATION**

1. Death referred to: <input type="radio"/> Medical examiner <input type="radio"/> Coroner <input type="radio"/> Not referred <input type="radio"/> U/K	2. Person declaring official cause and manner of death: <input type="radio"/> Medical examiner <input type="radio"/> Mortician <input type="radio"/> Coroner <input type="radio"/> Other, specify: <input type="radio"/> Hospital physician <input type="radio"/> Other physician <input type="radio"/> U/K	3. Autopsy performed? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K If yes, conducted by: <input type="radio"/> Forensic pathologist <input type="radio"/> Other physician <input type="radio"/> Pediatric pathologist <input type="radio"/> Other, specify: <input type="radio"/> General pathologist <input type="radio"/> Unknown pathologist <input type="radio"/> U/K If no, because parents or caregivers objected? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K																																													
4. For <b>infants</b> , if autopsy performed, were the following assessed in the autopsy? <table style="width:100%; border-collapse: collapse;"> <thead> <tr> <th style="text-align: left;"><u>Yes</u> <u>No</u> <u>U/K</u></th> <th style="text-align: left;"><u>Yes</u> <u>No</u> <u>U/K</u></th> <th style="text-align: left;"><u>Yes</u> <u>No</u> <u>U/K</u></th> </tr> </thead> <tbody> <tr> <td><input type="radio"/> <input type="radio"/> <input type="radio"/> Exam of general appearance and development</td> <td><input type="radio"/> <input type="radio"/> <input type="radio"/> Microscopic exam of:</td> <td><input type="radio"/> <input type="radio"/> <input type="radio"/> Weights of the:</td> </tr> <tr> <td><input type="radio"/> <input type="radio"/> <input type="radio"/> Metabolic screening</td> <td><input type="radio"/> <input type="radio"/> <input type="radio"/> Brain and meninges</td> <td><input type="radio"/> <input type="radio"/> <input type="radio"/> Brain</td> </tr> <tr> <td><input type="radio"/> <input type="radio"/> <input type="radio"/> Genetic testing</td> <td><input type="radio"/> <input type="radio"/> <input type="radio"/> Heart</td> <td><input type="radio"/> <input type="radio"/> <input type="radio"/> Heart</td> </tr> <tr> <td><input type="radio"/> <input type="radio"/> <input type="radio"/> Routine toxicology for ethanol, sedatives, and/or stimulants</td> <td><input type="radio"/> <input type="radio"/> <input type="radio"/> Lung</td> <td><input type="radio"/> <input type="radio"/> <input type="radio"/> Lungs</td> </tr> <tr> <td><input type="radio"/> <input type="radio"/> <input type="radio"/> Toxicology for <i>suspected</i> drugs if investigation suggests exposure</td> <td><input type="radio"/> <input type="radio"/> <input type="radio"/> Airways</td> <td><input type="radio"/> <input type="radio"/> <input type="radio"/> Liver</td> </tr> <tr> <td><input type="radio"/> <input type="radio"/> <input type="radio"/> Vitreous testing as an adjunct to other investigation results</td> <td><input type="radio"/> <input type="radio"/> <input type="radio"/> Liver</td> <td><input type="radio"/> <input type="radio"/> <input type="radio"/> Kidneys</td> </tr> <tr> <td><input type="radio"/> <input type="radio"/> <input type="radio"/> Radiograph-single</td> <td><input type="radio"/> <input type="radio"/> <input type="radio"/> Sampled tissue of:</td> <td><input type="radio"/> <input type="radio"/> <input type="radio"/> Thymus</td> </tr> <tr> <td><input type="radio"/> <input type="radio"/> <input type="radio"/> Radiograph-complete skeletal series</td> <td><input type="radio"/> <input type="radio"/> <input type="radio"/> Kidney</td> <td><input type="radio"/> <input type="radio"/> <input type="radio"/> Spleen</td> </tr> <tr> <td><input type="radio"/> <input type="radio"/> <input type="radio"/> CAT scan</td> <td><input type="radio"/> <input type="radio"/> <input type="radio"/> Spleen</td> <td></td> </tr> <tr> <td><input type="radio"/> <input type="radio"/> <input type="radio"/> Microbiology</td> <td><input type="radio"/> <input type="radio"/> <input type="radio"/> Thymus</td> <td></td> </tr> <tr> <td><input type="radio"/> <input type="radio"/> <input type="radio"/> In situ exam with removal &amp; dissection of:</td> <td><input type="radio"/> <input type="radio"/> <input type="radio"/> Bone or costochondral tissue</td> <td></td> </tr> <tr> <td><input type="radio"/> <input type="radio"/> <input type="radio"/> Brain</td> <td><input type="radio"/> <input type="radio"/> <input type="radio"/> Endocrine organs</td> <td></td> </tr> <tr> <td><input type="radio"/> <input type="radio"/> <input type="radio"/> Neck structures</td> <td><input type="radio"/> <input type="radio"/> <input type="radio"/> Sections of gastrointestinal tract</td> <td></td> </tr> <tr> <td><input type="radio"/> <input type="radio"/> <input type="radio"/> Thoracoabdominal organs</td> <td></td> <td></td> </tr> </tbody> </table>			<u>Yes</u> <u>No</u> <u>U/K</u>	<u>Yes</u> <u>No</u> <u>U/K</u>	<u>Yes</u> <u>No</u> <u>U/K</u>	<input type="radio"/> <input type="radio"/> <input type="radio"/> Exam of general appearance and development	<input type="radio"/> <input type="radio"/> <input type="radio"/> Microscopic exam of:	<input type="radio"/> <input type="radio"/> <input type="radio"/> Weights of the:	<input type="radio"/> <input type="radio"/> <input type="radio"/> Metabolic screening	<input type="radio"/> <input type="radio"/> <input type="radio"/> Brain and meninges	<input type="radio"/> <input type="radio"/> <input type="radio"/> Brain	<input type="radio"/> <input type="radio"/> <input type="radio"/> Genetic testing	<input type="radio"/> <input type="radio"/> <input type="radio"/> Heart	<input type="radio"/> <input type="radio"/> <input type="radio"/> Heart	<input type="radio"/> <input type="radio"/> <input type="radio"/> Routine toxicology for ethanol, sedatives, and/or stimulants	<input type="radio"/> <input type="radio"/> <input type="radio"/> Lung	<input type="radio"/> <input type="radio"/> <input type="radio"/> Lungs	<input type="radio"/> <input type="radio"/> <input type="radio"/> Toxicology for <i>suspected</i> drugs if investigation suggests exposure	<input type="radio"/> <input type="radio"/> <input type="radio"/> Airways	<input type="radio"/> <input type="radio"/> <input type="radio"/> Liver	<input type="radio"/> <input type="radio"/> <input type="radio"/> Vitreous testing as an adjunct to other investigation results	<input type="radio"/> <input type="radio"/> <input type="radio"/> Liver	<input type="radio"/> <input type="radio"/> <input type="radio"/> Kidneys	<input type="radio"/> <input type="radio"/> <input type="radio"/> Radiograph-single	<input type="radio"/> <input type="radio"/> <input type="radio"/> Sampled tissue of:	<input type="radio"/> <input type="radio"/> <input type="radio"/> Thymus	<input type="radio"/> <input type="radio"/> <input type="radio"/> Radiograph-complete skeletal series	<input type="radio"/> <input type="radio"/> <input type="radio"/> Kidney	<input type="radio"/> <input type="radio"/> <input type="radio"/> Spleen	<input type="radio"/> <input type="radio"/> <input type="radio"/> CAT scan	<input type="radio"/> <input type="radio"/> <input type="radio"/> Spleen		<input type="radio"/> <input type="radio"/> <input type="radio"/> Microbiology	<input type="radio"/> <input type="radio"/> <input type="radio"/> Thymus		<input type="radio"/> <input type="radio"/> <input type="radio"/> In situ exam with removal & dissection of:	<input type="radio"/> <input type="radio"/> <input type="radio"/> Bone or costochondral tissue		<input type="radio"/> <input type="radio"/> <input type="radio"/> Brain	<input type="radio"/> <input type="radio"/> <input type="radio"/> Endocrine organs		<input type="radio"/> <input type="radio"/> <input type="radio"/> Neck structures	<input type="radio"/> <input type="radio"/> <input type="radio"/> Sections of gastrointestinal tract		<input type="radio"/> <input type="radio"/> <input type="radio"/> Thoracoabdominal organs		
<u>Yes</u> <u>No</u> <u>U/K</u>	<u>Yes</u> <u>No</u> <u>U/K</u>	<u>Yes</u> <u>No</u> <u>U/K</u>																																													
<input type="radio"/> <input type="radio"/> <input type="radio"/> Exam of general appearance and development	<input type="radio"/> <input type="radio"/> <input type="radio"/> Microscopic exam of:	<input type="radio"/> <input type="radio"/> <input type="radio"/> Weights of the:																																													
<input type="radio"/> <input type="radio"/> <input type="radio"/> Metabolic screening	<input type="radio"/> <input type="radio"/> <input type="radio"/> Brain and meninges	<input type="radio"/> <input type="radio"/> <input type="radio"/> Brain																																													
<input type="radio"/> <input type="radio"/> <input type="radio"/> Genetic testing	<input type="radio"/> <input type="radio"/> <input type="radio"/> Heart	<input type="radio"/> <input type="radio"/> <input type="radio"/> Heart																																													
<input type="radio"/> <input type="radio"/> <input type="radio"/> Routine toxicology for ethanol, sedatives, and/or stimulants	<input type="radio"/> <input type="radio"/> <input type="radio"/> Lung	<input type="radio"/> <input type="radio"/> <input type="radio"/> Lungs																																													
<input type="radio"/> <input type="radio"/> <input type="radio"/> Toxicology for <i>suspected</i> drugs if investigation suggests exposure	<input type="radio"/> <input type="radio"/> <input type="radio"/> Airways	<input type="radio"/> <input type="radio"/> <input type="radio"/> Liver																																													
<input type="radio"/> <input type="radio"/> <input type="radio"/> Vitreous testing as an adjunct to other investigation results	<input type="radio"/> <input type="radio"/> <input type="radio"/> Liver	<input type="radio"/> <input type="radio"/> <input type="radio"/> Kidneys																																													
<input type="radio"/> <input type="radio"/> <input type="radio"/> Radiograph-single	<input type="radio"/> <input type="radio"/> <input type="radio"/> Sampled tissue of:	<input type="radio"/> <input type="radio"/> <input type="radio"/> Thymus																																													
<input type="radio"/> <input type="radio"/> <input type="radio"/> Radiograph-complete skeletal series	<input type="radio"/> <input type="radio"/> <input type="radio"/> Kidney	<input type="radio"/> <input type="radio"/> <input type="radio"/> Spleen																																													
<input type="radio"/> <input type="radio"/> <input type="radio"/> CAT scan	<input type="radio"/> <input type="radio"/> <input type="radio"/> Spleen																																														
<input type="radio"/> <input type="radio"/> <input type="radio"/> Microbiology	<input type="radio"/> <input type="radio"/> <input type="radio"/> Thymus																																														
<input type="radio"/> <input type="radio"/> <input type="radio"/> In situ exam with removal & dissection of:	<input type="radio"/> <input type="radio"/> <input type="radio"/> Bone or costochondral tissue																																														
<input type="radio"/> <input type="radio"/> <input type="radio"/> Brain	<input type="radio"/> <input type="radio"/> <input type="radio"/> Endocrine organs																																														
<input type="radio"/> <input type="radio"/> <input type="radio"/> Neck structures	<input type="radio"/> <input type="radio"/> <input type="radio"/> Sections of gastrointestinal tract																																														
<input type="radio"/> <input type="radio"/> <input type="radio"/> Thoracoabdominal organs																																															
5. Toxicology screen? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K If yes, check all that apply: <input type="checkbox"/> Negative <input type="checkbox"/> Cocaine <input type="checkbox"/> Methamphetamine <input type="checkbox"/> Too high prescription drug, specify: <input type="checkbox"/> Other, specify: <input type="checkbox"/> Alcohol <input type="checkbox"/> Marijuana <input type="checkbox"/> Opiates <input type="checkbox"/> Too high over-the-counter drug, specify: <input type="checkbox"/> U/K																																															
6. For <b>infants</b> , histology conducted? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K If yes, were there abnormal tissue samples? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K If abnormal, describe:																																															
7. For <b>infants</b> , microbiology conducted? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K If yes, were there abnormal results? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K If abnormal, check all that apply: <input type="checkbox"/> Bacteria, specify: <input type="checkbox"/> Other, specify: <input type="checkbox"/> Virus, specify: <input type="checkbox"/> Fungi, specify: <input type="checkbox"/> U/K		8. For <b>infants</b> , other pathology conducted? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K If yes, were there abnormal results? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K If abnormal, describe:																																													
9. For <b>infants</b> , blood chemistry conducted? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K If yes, were there abnormal results? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K If abnormal, describe:																																															

<p>10. X-rays taken? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K          If yes, were there abnormal results?  <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K If abnormal, describe:</p>	<p>11. Describe any significant findings not addressed above:</p>																																																				
<p>12. Was there agreement between the cause of death listed on the pathology report and on the death certificate? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K          If no, describe the differences:</p>																																																					
<p>13. Was a death scene investigation performed? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K          If yes, which of the following death scene investigation components were completed?</p> <table style="width:100%; border-collapse: collapse;"> <thead> <tr> <th style="text-align: left;">Yes</th> <th style="text-align: left;">No</th> <th style="text-align: left;">U/K</th> <th></th> <th style="text-align: left;">Yes</th> <th style="text-align: left;">No</th> </tr> </thead> <tbody> <tr> <td><input type="radio"/></td> <td><input type="radio"/></td> <td><input type="radio"/></td> <td>CDC's SUIDI Reporting Form or jurisdictional equivalent</td> <td><input type="radio"/></td> <td><input type="radio"/></td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/></td> <td><input type="radio"/></td> <td>Narrative description of circumstances</td> <td><input type="radio"/></td> <td><input type="radio"/></td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/></td> <td><input type="radio"/></td> <td>Scene photos</td> <td><input type="radio"/></td> <td><input type="radio"/></td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/></td> <td><input type="radio"/></td> <td>Scene recreation with doll</td> <td><input type="radio"/></td> <td><input type="radio"/></td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/></td> <td><input type="radio"/></td> <td>Scene recreation without doll</td> <td><input type="radio"/></td> <td><input type="radio"/></td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/></td> <td><input type="radio"/></td> <td>Witness interviews</td> <td><input type="radio"/></td> <td><input type="radio"/></td> </tr> </tbody> </table>	Yes	No	U/K		Yes	No	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	CDC's SUIDI Reporting Form or jurisdictional equivalent	<input type="radio"/>	Narrative description of circumstances	<input type="radio"/>	Scene photos	<input type="radio"/>	Scene recreation with doll	<input type="radio"/>	Scene recreation without doll	<input type="radio"/>	Witness interviews	<input type="radio"/>	<input type="radio"/>	<p>14. Agencies that conducted a scene investigation, check all that apply:</p> <table style="width:100%; border-collapse: collapse;"> <tr> <td><input type="checkbox"/> Medical examiner</td> <td><input type="checkbox"/> Fire investigator</td> </tr> <tr> <td><input type="checkbox"/> Coroner</td> <td><input type="checkbox"/> EMS</td> </tr> <tr> <td><input type="checkbox"/> ME investigator</td> <td><input type="checkbox"/> Child Protective Services</td> </tr> <tr> <td><input type="checkbox"/> Coroner investigator</td> <td><input type="checkbox"/> Other, specify:</td> </tr> <tr> <td><input type="checkbox"/> Law enforcement</td> <td><input type="checkbox"/> U/K</td> </tr> </table>	<input type="checkbox"/> Medical examiner	<input type="checkbox"/> Fire investigator	<input type="checkbox"/> Coroner	<input type="checkbox"/> EMS	<input type="checkbox"/> ME investigator	<input type="checkbox"/> Child Protective Services	<input type="checkbox"/> Coroner investigator	<input type="checkbox"/> Other, specify:	<input type="checkbox"/> Law enforcement	<input type="checkbox"/> U/K																				
Yes	No	U/K		Yes	No																																																
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	CDC's SUIDI Reporting Form or jurisdictional equivalent	<input type="radio"/>	<input type="radio"/>																																																
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Narrative description of circumstances	<input type="radio"/>	<input type="radio"/>																																																
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Scene photos	<input type="radio"/>	<input type="radio"/>																																																
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Scene recreation with doll	<input type="radio"/>	<input type="radio"/>																																																
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Scene recreation without doll	<input type="radio"/>	<input type="radio"/>																																																
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Witness interviews	<input type="radio"/>	<input type="radio"/>																																																
<input type="checkbox"/> Medical examiner	<input type="checkbox"/> Fire investigator																																																				
<input type="checkbox"/> Coroner	<input type="checkbox"/> EMS																																																				
<input type="checkbox"/> ME investigator	<input type="checkbox"/> Child Protective Services																																																				
<input type="checkbox"/> Coroner investigator	<input type="checkbox"/> Other, specify:																																																				
<input type="checkbox"/> Law enforcement	<input type="checkbox"/> U/K																																																				
<p>15. Was a CPS record check conducted as a result of death? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K</p>																																																					
<p>16. Did any investigation find evidence of prior abuse?  <input type="radio"/> N/A <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K          If yes, from what source?          Check all that apply:  <input type="checkbox"/> From x-rays <input type="checkbox"/> U/K  <input type="checkbox"/> From autopsy  <input type="checkbox"/> From CPS review  <input type="checkbox"/> From law enforcement</p>	<p>17. CPS action taken because of death? <input type="radio"/> N/A <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K          If yes, highest level of action taken because of death:  <input type="radio"/> Report screened out and not investigated  <input type="radio"/> Unsubstantiated  <input type="radio"/> Inconclusive  <input type="radio"/> Substantiated</p> <p>If yes, services or actions resulting, check all that apply:  <input type="checkbox"/> Voluntary services offered  <input type="checkbox"/> Voluntary services provided  <input type="checkbox"/> Court ordered services provided  <input type="checkbox"/> Voluntary out of home placement  <input type="checkbox"/> Court ordered out of home placement  <input type="checkbox"/> Children removed  <input type="checkbox"/> Parental rights terminated  <input type="checkbox"/> U/K</p>	<p>18. If death occurred in licensed setting (see D4), indicate action taken:  <input type="radio"/> No action  <input type="radio"/> License suspended  <input type="radio"/> License revoked  <input type="radio"/> Investigation ongoing  <input type="radio"/> Other, specify:  <input type="radio"/> U/K</p>																																																			
<b>F. OFFICIAL MANNER AND PRIMARY CAUSE OF DEATH</b>																																																					
<p>1. Official manner of death from the death certificate:  <input type="radio"/> Natural  <input type="radio"/> Accident  <input type="radio"/> Suicide  <input type="radio"/> Homicide  <input type="radio"/> Undetermined  <input type="radio"/> Pending  <input type="radio"/> U/K</p>	<p>2. Primary cause of death: Choose only 1 of the 4 major categories, then a specific cause. For pending, choose most likely cause.</p> <table style="width:100%; border-collapse: collapse;"> <tr> <td style="width:33%; vertical-align: top;"> <input type="radio"/> <u>From an injury (external cause). Select one &amp; answer F5:</u>  <input type="radio"/> Motor vehicle and other transport, go to G1  <input type="radio"/> Fire, burn, or electrocution, go to G2  <input type="radio"/> Drowning, go to G3  <input type="radio"/> Asphyxia, go to G4  <input type="radio"/> Weapon, including body part, go to G6  <input type="radio"/> Animal bite or attack, go to G7  <input type="radio"/> Fall or crush, go to G8  <input type="radio"/> Poisoning, overdose or acute intoxication, go to G9  <input type="radio"/> Exposure, go to G10  <input type="radio"/> Undetermined. If under age one, go to G5 &amp; G12              If over age one, go to G12  <input type="radio"/> Other cause, go to G12  <input type="radio"/> U/K, go to G12         </td> <td style="width:33%; vertical-align: top;"> <input type="radio"/> <u>From a medical cause. Select one:</u>  <input type="radio"/> Asthma, go to G11  <input type="radio"/> Cancer, specify and go to G11  <input type="radio"/> Cardiovascular, specify and go to G11  <input type="radio"/> Congenital anomaly, specify and go to G11  <input type="radio"/> HIV/AIDS, go to G11  <input type="radio"/> Influenza, go to G11  <input type="radio"/> Low birth weight, go to G11  <input type="radio"/> Malnutrition/dehydration, go to G11  <input type="radio"/> Neurological/seizure disorder, go to G11  <input type="radio"/> Pneumonia, specify and go to G11  <input type="radio"/> Prematurity, go to G11  <input type="radio"/> SIDS, go to G5  <input type="radio"/> Other infection, specify and go to G11  <input type="radio"/> Other perinatal condition, specify &amp; go to G11  <input type="radio"/> Other medical condition, specify &amp; go to G11  <input type="radio"/> Undetermined. If under age one, go to G5 &amp; G11. If over age one, go to G11.  <input type="radio"/> U/K. If under age one, go to G5 &amp; G11. If over age one, go to G11.         </td> <td style="width:33%; vertical-align: top;"> <input type="radio"/> <u>Undetermined if injury or medical cause. go to G12. go to G12.</u>  <input type="radio"/> <u>Undetermined if injury or medical cause. go to G12. go to G12.</u>  <input type="radio"/> <u>If under age one, go to G5 &amp; G12.</u> </td> </tr> </table>		<input type="radio"/> <u>From an injury (external cause). Select one &amp; answer F5:</u> <input type="radio"/> Motor vehicle and other transport, go to G1 <input type="radio"/> Fire, burn, or electrocution, go to G2 <input type="radio"/> Drowning, go to G3 <input type="radio"/> Asphyxia, go to G4 <input type="radio"/> Weapon, including body part, go to G6 <input type="radio"/> Animal bite or attack, go to G7 <input type="radio"/> Fall or crush, go to G8 <input type="radio"/> Poisoning, overdose or acute intoxication, go to G9 <input type="radio"/> Exposure, go to G10 <input type="radio"/> Undetermined. If under age one, go to G5 & G12 If over age one, go to G12 <input type="radio"/> Other cause, go to G12 <input type="radio"/> U/K, go to G12	<input type="radio"/> <u>From a medical cause. Select one:</u> <input type="radio"/> Asthma, go to G11 <input type="radio"/> Cancer, specify and go to G11 <input type="radio"/> Cardiovascular, specify and go to G11 <input type="radio"/> Congenital anomaly, specify and go to G11 <input type="radio"/> HIV/AIDS, go to G11 <input type="radio"/> Influenza, go to G11 <input type="radio"/> Low birth weight, go to G11 <input type="radio"/> Malnutrition/dehydration, go to G11 <input type="radio"/> Neurological/seizure disorder, go to G11 <input type="radio"/> Pneumonia, specify and go to G11 <input type="radio"/> Prematurity, go to G11 <input type="radio"/> SIDS, go to G5 <input type="radio"/> Other infection, specify and go to G11 <input type="radio"/> Other perinatal condition, specify & go to G11 <input type="radio"/> Other medical condition, specify & go to G11 <input type="radio"/> Undetermined. If under age one, go to G5 & G11. If over age one, go to G11. <input type="radio"/> U/K. If under age one, go to G5 & G11. If over age one, go to G11.	<input type="radio"/> <u>Undetermined if injury or medical cause. go to G12. go to G12.</u> <input type="radio"/> <u>Undetermined if injury or medical cause. go to G12. go to G12.</u> <input type="radio"/> <u>If under age one, go to G5 &amp; G12.</u>																																																
<input type="radio"/> <u>From an injury (external cause). Select one &amp; answer F5:</u> <input type="radio"/> Motor vehicle and other transport, go to G1 <input type="radio"/> Fire, burn, or electrocution, go to G2 <input type="radio"/> Drowning, go to G3 <input type="radio"/> Asphyxia, go to G4 <input type="radio"/> Weapon, including body part, go to G6 <input type="radio"/> Animal bite or attack, go to G7 <input type="radio"/> Fall or crush, go to G8 <input type="radio"/> Poisoning, overdose or acute intoxication, go to G9 <input type="radio"/> Exposure, go to G10 <input type="radio"/> Undetermined. If under age one, go to G5 & G12 If over age one, go to G12 <input type="radio"/> Other cause, go to G12 <input type="radio"/> U/K, go to G12	<input type="radio"/> <u>From a medical cause. Select one:</u> <input type="radio"/> Asthma, go to G11 <input type="radio"/> Cancer, specify and go to G11 <input type="radio"/> Cardiovascular, specify and go to G11 <input type="radio"/> Congenital anomaly, specify and go to G11 <input type="radio"/> HIV/AIDS, go to G11 <input type="radio"/> Influenza, go to G11 <input type="radio"/> Low birth weight, go to G11 <input type="radio"/> Malnutrition/dehydration, go to G11 <input type="radio"/> Neurological/seizure disorder, go to G11 <input type="radio"/> Pneumonia, specify and go to G11 <input type="radio"/> Prematurity, go to G11 <input type="radio"/> SIDS, go to G5 <input type="radio"/> Other infection, specify and go to G11 <input type="radio"/> Other perinatal condition, specify & go to G11 <input type="radio"/> Other medical condition, specify & go to G11 <input type="radio"/> Undetermined. If under age one, go to G5 & G11. If over age one, go to G11. <input type="radio"/> U/K. If under age one, go to G5 & G11. If over age one, go to G11.	<input type="radio"/> <u>Undetermined if injury or medical cause. go to G12. go to G12.</u> <input type="radio"/> <u>Undetermined if injury or medical cause. go to G12. go to G12.</u> <input type="radio"/> <u>If under age one, go to G5 &amp; G12.</u>																																																			
<p>3. Enter the following information exactly as written on the death certificate:</p> <p>Immediate Cause (final disease or condition resulting in death):</p> <p>a.</p> <p>Sequentially list any conditions leading to immediate cause of death. In other words, list underlying disease or injury that initiated events resulting in death:</p> <p>b.</p> <p>c.</p> <p>d.</p>																																																					
<p>4. Enter other significant conditions contributing to death but not an underlying cause(s) listed in F3 exactly as written on the death certificate:</p>																																																					
<p>5. If external cause in F2, describe how injury occurred exactly as written on the death certificate:</p>																																																					



## 2. FIRE, BURN, OR ELECTROCUTION

<p>a. Ignition, heat or electrocution source:</p> <input type="radio"/> Matches <input type="radio"/> Heating stove <input type="radio"/> Lightning <input type="radio"/> Other explosives <input type="radio"/> Cigarette lighter <input type="radio"/> Space heater <input type="radio"/> Oxygen tank <input type="radio"/> Appliance in water <input type="radio"/> Utility lighter <input type="radio"/> Furnace <input type="radio"/> Hot cooking water <input type="radio"/> Other, specify: <input type="radio"/> Cigarette or cigar <input type="radio"/> Power line <input type="radio"/> Hot bath water <input type="radio"/> Candles <input type="radio"/> Electrical outlet <input type="radio"/> Other hot liquid, specify: <input type="radio"/> Cooking stove <input type="radio"/> Electrical wiring <input type="radio"/> Fireworks <input type="radio"/> U/K				<p>b. Type of incident:</p> <input type="radio"/> Fire, go to c <input type="radio"/> Scald, go to r <input type="radio"/> Other burn, go to t <input type="radio"/> Electrocution, go to s <input type="radio"/> Other, specify and go to t <input type="radio"/> U/K, go to t		<p>c. For fire, child died from:</p> <input type="radio"/> Burns <input type="radio"/> Smoke inhalation <input type="radio"/> Other, specify: <input type="radio"/> U/K																
<p>d. Material first ignited:</p> <input type="radio"/> Upholstery <input type="radio"/> Mattress <input type="radio"/> Christmas tree <input type="radio"/> Clothing <input type="radio"/> Curtain <input type="radio"/> Other, specify: <input type="radio"/> U/K		<p>e. Type of building on fire:</p> <input type="radio"/> N/A <input type="radio"/> Single home <input type="radio"/> Duplex <input type="radio"/> Apartment <input type="radio"/> Trailer/mobile home <input type="radio"/> Other, specify: <input type="radio"/> U/K		<p>f. Building's primary construction material:</p> <input type="radio"/> Wood <input type="radio"/> Steel <input type="radio"/> Brick/stone <input type="radio"/> Aluminum <input type="radio"/> Other, specify: <input type="radio"/> U/K		<p>g. Fire started by a person?</p> <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K If yes, person's age _____ Does person have a history of setting fires? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K		<p>h. Did anyone attempt to put out fire?</p> <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K <p>i. Did escape or rescue efforts worsen fire?</p> <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K <p>j. Did any factors delay fire department arrival?</p> <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K If yes, specify:														
<p>k. Were barriers preventing safe exit?</p> <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K If yes, check all that apply: <input type="checkbox"/> Locked door <input type="checkbox"/> Window grate <input type="checkbox"/> Locked window <input type="checkbox"/> Blocked stairway <input type="checkbox"/> Other, specify: <input type="checkbox"/> U/K		<p>l. Was building a rental property?</p> <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K <p>o. Was sprinkler system present?</p> <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K If yes, was it working? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K		<p>m. Were building/rental codes violated?</p> <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K If yes, describe in narrative.		<p>n. Were proper working fire extinguishers present?</p> <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K <p>p. Were smoke detectors present?   <input type="radio"/> Yes   <input type="radio"/> No   <input type="radio"/> U/K</p> <table style="width:100%; border-collapse: collapse;"> <tr> <td style="width:33%; vertical-align: top;">           If yes, what type?  <input type="checkbox"/> Removable batteries  <input type="checkbox"/> Non-removable batteries  <input type="checkbox"/> Hardwired  <input type="checkbox"/> U/K         </td> <td style="width:33%; vertical-align: top;">           If yes, functioning properly?  <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  <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         </td> <td style="width:33%; vertical-align: top;">           If not functioning properly, reason:  <table style="width:100%; border-collapse: collapse;"> <tr> <td style="width:33%;">Missing batteries</td> <td style="width:33%;">Other</td> <td style="width:33%;">U/K</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> </table>           Other, specify: _____            If yes, was there an adequate number present?   <input type="radio"/> Yes   <input type="radio"/> No   <input type="radio"/> U/K         </td> </tr> </table>		If yes, what type? <input type="checkbox"/> Removable batteries <input type="checkbox"/> Non-removable batteries <input type="checkbox"/> Hardwired <input type="checkbox"/> U/K	If yes, functioning properly? <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 <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	If not functioning properly, reason: <table style="width:100%; border-collapse: collapse;"> <tr> <td style="width:33%;">Missing batteries</td> <td style="width:33%;">Other</td> <td style="width:33%;">U/K</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> </table> Other, specify: _____ If yes, was there an adequate number present? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K	Missing batteries	Other	U/K	<input type="checkbox"/>								
If yes, what type? <input type="checkbox"/> Removable batteries <input type="checkbox"/> Non-removable batteries <input type="checkbox"/> Hardwired <input type="checkbox"/> U/K	If yes, functioning properly? <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 <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	If not functioning properly, reason: <table style="width:100%; border-collapse: collapse;"> <tr> <td style="width:33%;">Missing batteries</td> <td style="width:33%;">Other</td> <td style="width:33%;">U/K</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> </table> Other, specify: _____ If yes, was there an adequate number present? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K	Missing batteries	Other	U/K	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>								
Missing batteries	Other	U/K																				
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																				
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																				
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																				
<p>q. Suspected arson?</p> <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K		<p>r. For scald, was hot water heater set too high?</p> <input type="radio"/> N/A <input type="radio"/> Yes, temp. setting: _____ <input type="radio"/> No <input type="radio"/> U/K		<p>s. For electrocution, what cause:</p> <input type="radio"/> Electrical storm <input type="radio"/> Faulty wiring <input type="radio"/> Wire/product in water <input type="radio"/> Child playing with outlet <input type="radio"/> Other, specify: <input type="radio"/> U/K		<p>t. Other, describe in detail:</p>																

## 3. DROWNING

<p>a. Where was child last seen before drowning? Check all that apply:</p> <input type="checkbox"/> In water <input type="checkbox"/> In yard <input type="checkbox"/> On shore <input type="checkbox"/> In bathroom <input type="checkbox"/> On dock <input type="checkbox"/> In house <input type="checkbox"/> Poolside <input type="checkbox"/> Other, specify: <input type="checkbox"/> U/K		<p>b. What was child last seen doing before drowning?</p> <input type="radio"/> Playing <input type="radio"/> Tubing <input type="radio"/> Boating <input type="radio"/> Waterskiing <input type="radio"/> Swimming <input type="radio"/> Sleeping <input type="radio"/> Bathing <input type="radio"/> Other, specify: <input type="radio"/> Fishing <input type="radio"/> Surfing <input type="radio"/> U/K		<p>c. Was child forcibly submerged?</p> <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K		<p>d. Drowning location:</p> <input type="radio"/> Open water, go to e <input type="radio"/> U/K, go to n <input type="radio"/> Pool, hot tub, spa, go to i <input type="radio"/> Bathtub, go to w <input type="radio"/> Bucket, go to x <input type="radio"/> Well/cistern/septic, go to n <input type="radio"/> Toilet, go to z <input type="radio"/> Other, specify and go to n	
<p>e. For open water, place:</p> <input type="radio"/> Lake <input type="radio"/> Quarry <input type="radio"/> River <input type="radio"/> Gravel pit <input type="radio"/> Pond <input type="radio"/> Canal <input type="radio"/> Creek <input type="radio"/> U/K <input type="radio"/> Ocean		<p>f. For open water, contributing environmental factors:</p> <input type="radio"/> Weather <input type="radio"/> Drop off <input type="radio"/> Temperature <input type="radio"/> Rough waves <input type="radio"/> Current <input type="radio"/> Other, specify: <input type="radio"/> Riptide/undertow <input type="radio"/> U/K		<p>g. If boating, type of boat:</p> <input type="radio"/> Sailboat <input type="radio"/> Commercial <input type="radio"/> Jet ski <input type="radio"/> Other, specify: <input type="radio"/> Motorboat <input type="radio"/> Canoe <input type="radio"/> Kayak <input type="radio"/> U/K <input type="radio"/> Raft		<p>h. For boating, was the child piloting boat?</p> <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K	
<p>i. For pool, type of pool:</p> <input type="radio"/> Above ground <input type="radio"/> In-ground <input type="radio"/> Hot tub, spa <input type="radio"/> Wading <input type="radio"/> U/K		<p>j. For pool, child found:</p> <input type="radio"/> In the pool/hot tub/spa <input type="radio"/> On or under the cover <input type="radio"/> U/K		<p>k. For pool, ownership is:</p> <input type="radio"/> Private <input type="radio"/> Public <input type="radio"/> U/K		<p>l. Length of time owners had pool/hot tub/spa:</p> <input type="radio"/> N/A <input type="radio"/> >1yr <input type="radio"/> <6 months <input type="radio"/> U/K <input type="radio"/> 6m-1 yr	

<p>m. Flotation device used?</p> <p><input type="radio"/> N/A      If yes, check all that apply:</p> <p><input type="radio"/> Yes      <input type="checkbox"/> Coast Guard approved      <input type="checkbox"/> Not Coast Guard approved      <input type="checkbox"/> U/K</p> <p><input type="radio"/> No      <input type="checkbox"/> Jacket      <input type="checkbox"/> Cushion      <input type="checkbox"/> Lifesaving ring      <input type="checkbox"/> Swim rings</p> <p><input type="radio"/> U/K      If jacket:      <input type="checkbox"/> Inner tube</p> <p>Correct size?    <input type="radio"/> Yes    <input type="radio"/> No    <input type="radio"/> U/K      <input type="checkbox"/> Air mattress</p> <p>Worn correctly? <input type="radio"/> Yes    <input type="radio"/> No    <input type="radio"/> U/K      <input type="checkbox"/> Other, specify:</p>		<p>n. What barriers/layers of protection existed to prevent access to water?</p> <p>Check all that apply:</p> <p><input type="checkbox"/> None      <input type="checkbox"/> Alarm, go to r</p> <p><input type="checkbox"/> Fence, go to o      <input type="checkbox"/> Cover, go to s</p> <p><input type="checkbox"/> Gate, go to p      <input type="checkbox"/> U/K</p> <p><input type="checkbox"/> Door, go to q</p>
---	--	---

<p>o. Fence:</p> <p>Describe type:</p> <p>Fence height in ft _____</p> <p>Fence surrounds water on:</p> <p><input type="radio"/> Four sides    <input type="radio"/> Two or less sides</p> <p><input type="radio"/> Three sides    <input type="radio"/> U/K</p>	<p>p. Gate, check all that apply:</p> <p><input type="checkbox"/> Has self closing latch</p> <p><input type="checkbox"/> Has lock</p> <p><input type="checkbox"/> Is a double gate</p> <p><input type="checkbox"/> Opens to water</p> <p><input type="checkbox"/> U/K</p>	<p>q. Door, check all that apply:</p> <p><input type="checkbox"/> Patio door      <input type="checkbox"/> Opens to water</p> <p><input type="checkbox"/> Screen door    <input type="checkbox"/> Barrier between door and water</p> <p><input type="checkbox"/> Steel door</p> <p><input type="checkbox"/> Self-closing    <input type="checkbox"/> U/K</p> <p><input type="checkbox"/> Has lock</p>	<p>r. Alarm, check all that apply:</p> <p><input type="checkbox"/> Door</p> <p><input type="checkbox"/> Window</p> <p><input type="checkbox"/> Pool</p> <p><input type="checkbox"/> Laser</p> <p><input type="checkbox"/> U/K</p>	<p>s. Type of cover:</p> <p><input type="radio"/> Hard</p> <p><input type="radio"/> Soft</p> <p><input type="radio"/> U/K</p>
--	---	---	---	---

<p>t. 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>u. How were layers of protection breached, check all that apply:</p> <p><input type="checkbox"/> No layers breached      <input type="checkbox"/> Gap in fence      <input type="checkbox"/> Door screen torn      <input type="checkbox"/> Cover left off</p> <p><input type="checkbox"/> Gate left open      <input type="checkbox"/> Damaged fence      <input type="checkbox"/> Door self-closer failed      <input type="checkbox"/> Cover not locked</p> <p><input type="checkbox"/> Gate unlocked      <input type="checkbox"/> Fence too short      <input type="checkbox"/> Window left open      <input type="checkbox"/> Other, specify:</p> <p><input type="checkbox"/> Gate latch failed      <input type="checkbox"/> Door left open      <input type="checkbox"/> Window screen torn</p> <p><input type="checkbox"/> Gap in gate      <input type="checkbox"/> Door unlocked      <input type="checkbox"/> Alarm not working</p> <p><input type="checkbox"/> Climbed fence      <input type="checkbox"/> Door broken      <input type="checkbox"/> Alarm not answered      <input type="checkbox"/> U/K</p>		
---	---	--	--

<p>v. 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>w. For bathtub, child in a bathing aid?</p> <p><input type="radio"/> Yes    <input type="radio"/> No    <input type="radio"/> U/K</p> <p>If yes, specify type:</p>	<p>x. 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>y. Lifeguard present?</p> <p><input type="radio"/> N/A      <input type="radio"/> No</p> <p><input type="radio"/> Yes      <input type="radio"/> U/K</p>
--	---	--	---

<p>z. Rescue attempt made?</p> <p><input type="radio"/> N/A      If yes, who? Check all that apply:</p> <p><input type="radio"/> Yes      <input type="checkbox"/> Parent      <input type="checkbox"/> Bystander</p> <p><input type="radio"/> No      <input type="checkbox"/> Other child    <input type="checkbox"/> Other, specify:</p> <p><input type="radio"/> U/K      <input type="checkbox"/> Lifeguard    <input type="checkbox"/> U/K</p>	<p>aa. Did rescuer(s) also drown?</p> <p><input type="radio"/> N/A      <input type="radio"/> No</p> <p><input type="radio"/> Yes      <input type="radio"/> U/K</p> <p>If yes, number of rescuers that drowned: _____</p>	<p>bb. Appropriate rescue equipment present?</p> <p><input type="radio"/> N/A      <input type="radio"/> No</p> <p><input type="radio"/> Yes      <input type="radio"/> U/K</p>
--	--	---

**4. ASPHYXIA**

<p>a. Type of event:</p> <p><input type="radio"/> Suffocation, go to b</p> <p><input type="radio"/> Strangulation, go to c</p> <p><input type="radio"/> Choking, go to d</p> <p><input type="radio"/> Other, specify and go to e</p> <p><input type="radio"/> U/K, go to e</p>	<p>b. If suffocation/asphyxia, action causing event:</p> <p><input type="radio"/> Sleep-related (e.g. bedding, overlay, wedged)      <input type="radio"/> Confined in tight space      <input type="radio"/> Swaddled in tight blanket, but not sleep-related</p> <p><input type="radio"/> Covered in or fell into object, but not sleep-related      <input type="radio"/> Refrigerator/freezer      <input type="radio"/> Wedged into tight space, but not sleep-related</p> <p><input type="radio"/> Plastic bag      <input type="radio"/> Toy chest      <input type="radio"/> Asphyxia by gas, go to G9h</p> <p><input type="radio"/> Dirt/sand      <input type="radio"/> Automobile      <input type="radio"/> Other, specify:</p> <p><input type="radio"/> Other, specify:      <input type="radio"/> Trunk      <input type="radio"/> U/K</p> <p><input type="radio"/> U/K      <input type="radio"/> Other, specify:      <input type="radio"/> U/K</p>
--	---

<p>c. If strangulation, object causing event:</p> <p><input type="radio"/> Clothing      <input type="radio"/> Leash</p> <p><input type="radio"/> Blind cord      <input type="radio"/> Electrical cord</p> <p><input type="radio"/> Car seat      <input type="radio"/> Person, go to G6q</p> <p><input type="radio"/> Stroller      <input type="radio"/> Automobile power window</p> <p><input type="radio"/> High chair      or sunroof</p> <p><input type="radio"/> Belt      <input type="radio"/> Other, specify:</p> <p><input type="radio"/> Rope/string      <input type="radio"/> U/K</p>	<p>d. If choking, object causing choking:</p> <p><input type="radio"/> Food, specify:</p> <p><input type="radio"/> Toy, specify:</p> <p><input type="radio"/> Balloon</p> <p><input type="radio"/> Other, specify:</p> <p><input type="radio"/> U/K</p>	<p>e. Was asphyxia an autoerotic event?</p> <p><input type="radio"/> Yes    <input type="radio"/> No    <input type="radio"/> U/K</p>	<p>g. History of seizures?</p> <p><input type="radio"/> Yes    <input type="radio"/> No    <input type="radio"/> U/K    If yes, # _____</p> <p>If yes, witnessed? <input type="radio"/> Yes    <input type="radio"/> No    <input type="radio"/> U/K</p>
		<p>f. Was child participating in 'choking game' or 'pass out game'?</p> <p><input type="radio"/> Yes    <input type="radio"/> No    <input type="radio"/> U/K</p>	<p>h. History of apnea?</p> <p><input type="radio"/> Yes    <input type="radio"/> No    <input type="radio"/> U/K    If yes, # _____</p> <p>If yes, witnessed? <input type="radio"/> Yes    <input type="radio"/> No    <input type="radio"/> U/K</p>
		<p>i. Was Heimlich Maneuver attempted?</p> <p><input type="radio"/> Yes    <input type="radio"/> No    <input type="radio"/> U/K</p>	

**5. SIDS AND UNDETERMINED CAUSE UNDER ONE YEAR OF AGE**

<p>a. Child overheated?    <input type="radio"/> Yes    <input type="radio"/> No    <input type="radio"/> U/K</p> <p>If yes, outside temp _____ degrees F</p> <p>Check all that apply:</p> <p><input type="checkbox"/> Room too hot, temp _____ degrees F</p> <p><input type="checkbox"/> Too much bedding</p> <p><input type="checkbox"/> Too much clothing</p>	<p>b. History of seizures?</p> <p><input type="radio"/> Yes    <input type="radio"/> No    <input type="radio"/> U/K</p> <p>If yes, # _____</p> <p>If yes, witnessed?</p> <p><input type="radio"/> Yes    <input type="radio"/> No    <input type="radio"/> U/K</p>	<p>c. History of apnea?</p> <p><input type="radio"/> Yes    <input type="radio"/> No    <input type="radio"/> U/K</p> <p>If yes, # _____</p> <p>If yes, witnessed?</p> <p><input type="radio"/> Yes    <input type="radio"/> No    <input type="radio"/> U/K</p>
--	---	--

d. For SIDS, go to Section H, page 12. For undetermined injury cause to infants also complete G12, page 12, then go to Section H. For undetermined or unknown medical cause to infants also complete G11, page 11, then go to Section H.

## 6. WEAPON, INCLUDING PERSON'S BODY PART

<p>a. Type of weapon:</p> <input type="radio"/> Firearm, go to b <input type="radio"/> Sharp instrument, go to j <input type="radio"/> Blunt instrument, go to k <input type="radio"/> Person's body part, go to l <input type="radio"/> Explosive, go to m <input type="radio"/> Rope, go to m <input type="radio"/> Pipe, go to m <input type="radio"/> Biological, go to m <input type="radio"/> Other, specify and go to m <input type="radio"/> U/K, go to m	<p>b. For firearms, type:</p> <input type="radio"/> Handgun <input type="radio"/> Shotgun <input type="radio"/> BB gun <input type="radio"/> Hunting rifle <input type="radio"/> Assault rifle <input type="radio"/> Air rifle <input type="radio"/> Sawed off shotgun <input type="radio"/> Other, specify: <input type="radio"/> U/K	<p>c. Firearm licensed?</p> <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K	<p>d. Firearm safety features, check all that apply:</p> <input type="checkbox"/> Trigger lock <input type="checkbox"/> Magazine disconnect <input type="checkbox"/> Personalization device <input type="checkbox"/> Minimum trigger pull <input type="checkbox"/> External safety/drop safety <input type="checkbox"/> Other, specify: <input type="checkbox"/> Loaded chamber indicator <input type="checkbox"/> U/K																											
		<p>e. Where was firearm stored?</p> <input type="radio"/> Not stored <input type="radio"/> Under mattress/pillow <input type="radio"/> Locked cabinet <input type="radio"/> Other, specify: <input type="radio"/> Unlocked cabinet <input type="radio"/> Glove compartment <input type="radio"/> U/K	<p>f. Firearm stored with ammunition?</p> <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K																											
		<p>g. Firearm stored loaded?</p> <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K																												
<p>h. Owner of fatal firearm:</p> <input type="radio"/> U/K, weapon stolen <input type="radio"/> U/K, weapon found <input type="radio"/> Self <input type="radio"/> Biological parent <input type="radio"/> Adoptive parent <input type="radio"/> Stepparent <input type="radio"/> Foster parent <input type="radio"/> Mother's partner <input type="radio"/> Father's partner	<input type="radio"/> Grandparent <input type="radio"/> Sibling <input type="radio"/> Spouse <input type="radio"/> Other relative <input type="radio"/> Friend <input type="radio"/> Acquaintance <input type="radio"/> Child's boyfriend or girlfriend <input type="radio"/> Classmate	<input type="radio"/> Co-worker <input type="radio"/> Institutional staff <input type="radio"/> Neighbor <input type="radio"/> Rival gang member <input type="radio"/> Stranger <input type="radio"/> Law enforcement <input type="radio"/> Other, specify: <input type="radio"/> U/K	<p>i. Sex of fatal firearm owner:</p> <input type="radio"/> Male <input type="radio"/> Female <input type="radio"/> U/K	<p>j. Type of sharp object:</p> <input type="radio"/> Kitchen knife <input type="radio"/> Switchblade <input type="radio"/> Pocketknife <input type="radio"/> Razor <input type="radio"/> Hunting knife <input type="radio"/> Scissors <input type="radio"/> Other, specify: <input type="radio"/> U/K	<p>k. Type of blunt object:</p> <input type="radio"/> Bat <input type="radio"/> Club <input type="radio"/> Stick <input type="radio"/> Hammer <input type="radio"/> Rock <input type="radio"/> Household item <input type="radio"/> Other, specify: <input type="radio"/> U/K																									
<p>l. What did person's body part do? Check all that apply:</p> <input type="checkbox"/> Beat, kick or punch <input type="checkbox"/> Drop <input type="checkbox"/> Push <input type="checkbox"/> Bite <input type="checkbox"/> Shake <input type="checkbox"/> Strangle <input type="checkbox"/> Throw <input type="checkbox"/> Drown <input type="checkbox"/> Burn <input type="checkbox"/> Other, specify: <input type="checkbox"/> U/K	<p>m. Did person using weapon have history of weapon-related offenses?</p> <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K	<p>n. Does anyone in child's family have a history of weapon offenses or die of weapons-related causes?</p> <input type="radio"/> Yes, describe circumstances: <input type="radio"/> No <input type="radio"/> U/K		<p>o. Persons handling weapons at time of incident, check all that apply:</p> <table style="width:100%;"> <tr> <th style="text-align: left;">Fatal and/or Other weapon</th> <th style="text-align: left;">Fatal and/or Other weapon</th> </tr> <tr> <td><input type="checkbox"/> Self</td> <td><input type="checkbox"/> Friend</td> </tr> <tr> <td><input type="checkbox"/> Biological parent</td> <td><input type="checkbox"/> Acquaintance</td> </tr> <tr> <td><input type="checkbox"/> Adoptive parent</td> <td><input type="checkbox"/> Child's boyfriend or girlfriend</td> </tr> <tr> <td><input type="checkbox"/> Stepparent</td> <td><input type="checkbox"/> Classmate</td> </tr> <tr> <td><input type="checkbox"/> Foster parent</td> <td><input type="checkbox"/> Co-worker</td> </tr> <tr> <td><input type="checkbox"/> Mother's partner</td> <td><input type="checkbox"/> Institutional staff</td> </tr> <tr> <td><input type="checkbox"/> Father's partner</td> <td><input type="checkbox"/> Neighbor</td> </tr> <tr> <td><input type="checkbox"/> Grandparent</td> <td><input type="checkbox"/> Rival gang member</td> </tr> <tr> <td><input type="checkbox"/> Sibling</td> <td><input type="checkbox"/> Stranger</td> </tr> <tr> <td><input type="checkbox"/> Spouse</td> <td><input type="checkbox"/> Law enforcement officer</td> </tr> <tr> <td><input type="checkbox"/> Other relative</td> <td><input type="checkbox"/> Other, specify: <input type="checkbox"/> U/K</td> </tr> </table>	Fatal and/or Other weapon	Fatal and/or Other weapon	<input type="checkbox"/> Self	<input type="checkbox"/> Friend	<input type="checkbox"/> Biological parent	<input type="checkbox"/> Acquaintance	<input type="checkbox"/> Adoptive parent	<input type="checkbox"/> Child's boyfriend or girlfriend	<input type="checkbox"/> Stepparent	<input type="checkbox"/> Classmate	<input type="checkbox"/> Foster parent	<input type="checkbox"/> Co-worker	<input type="checkbox"/> Mother's partner	<input type="checkbox"/> Institutional staff	<input type="checkbox"/> Father's partner	<input type="checkbox"/> Neighbor	<input type="checkbox"/> Grandparent	<input type="checkbox"/> Rival gang member	<input type="checkbox"/> Sibling	<input type="checkbox"/> Stranger	<input type="checkbox"/> Spouse	<input type="checkbox"/> Law enforcement officer	<input type="checkbox"/> Other relative	<input type="checkbox"/> Other, specify: <input type="checkbox"/> U/K	<p>p. Sex of person(s) handling weapon:</p> <p>Fatal weapon:</p> <input type="radio"/> Male <input type="radio"/> Female <input type="radio"/> U/K	
Fatal and/or Other weapon	Fatal and/or Other weapon																													
<input type="checkbox"/> Self	<input type="checkbox"/> Friend																													
<input type="checkbox"/> Biological parent	<input type="checkbox"/> Acquaintance																													
<input type="checkbox"/> Adoptive parent	<input type="checkbox"/> Child's boyfriend or girlfriend																													
<input type="checkbox"/> Stepparent	<input type="checkbox"/> Classmate																													
<input type="checkbox"/> Foster parent	<input type="checkbox"/> Co-worker																													
<input type="checkbox"/> Mother's partner	<input type="checkbox"/> Institutional staff																													
<input type="checkbox"/> Father's partner	<input type="checkbox"/> Neighbor																													
<input type="checkbox"/> Grandparent	<input type="checkbox"/> Rival gang member																													
<input type="checkbox"/> Sibling	<input type="checkbox"/> Stranger																													
<input type="checkbox"/> Spouse	<input type="checkbox"/> Law enforcement officer																													
<input type="checkbox"/> Other relative	<input type="checkbox"/> Other, specify: <input type="checkbox"/> U/K																													
<p>q. Use of weapon at time, check all that apply:</p> <table style="width:100%;"> <tr> <td><input type="checkbox"/> Self injury</td> <td><input type="checkbox"/> Argument</td> <td><input type="checkbox"/> Hunting</td> <td><input type="checkbox"/> Russian roulette</td> <td><input type="checkbox"/> Intervener assisting crime victim (Good Samaritan)</td> </tr> <tr> <td><input type="checkbox"/> Commission of crime</td> <td><input type="checkbox"/> Jealousy</td> <td><input type="checkbox"/> Target shooting</td> <td><input type="checkbox"/> Gang-related activity</td> <td></td> </tr> <tr> <td><input type="checkbox"/> Drive-by shooting</td> <td><input type="checkbox"/> Intimate partner violence</td> <td><input type="checkbox"/> Playing with weapon</td> <td><input type="checkbox"/> Self-defense</td> <td><input type="checkbox"/> Other, specify:</td> </tr> <tr> <td><input type="checkbox"/> Random violence</td> <td><input type="checkbox"/> Hate crime</td> <td><input type="checkbox"/> Weapon mistaken for toy</td> <td><input type="checkbox"/> Cleaning weapon</td> <td></td> </tr> <tr> <td><input type="checkbox"/> Child was a bystander</td> <td><input type="checkbox"/> Bullying</td> <td><input type="checkbox"/> Showing gun to others</td> <td><input type="checkbox"/> Loading weapon</td> <td><input type="checkbox"/> U/K</td> </tr> </table>						<input type="checkbox"/> Self injury	<input type="checkbox"/> Argument	<input type="checkbox"/> Hunting	<input type="checkbox"/> Russian roulette	<input type="checkbox"/> Intervener assisting crime victim (Good Samaritan)	<input type="checkbox"/> Commission of crime	<input type="checkbox"/> Jealousy	<input type="checkbox"/> Target shooting	<input type="checkbox"/> Gang-related activity		<input type="checkbox"/> Drive-by shooting	<input type="checkbox"/> Intimate partner violence	<input type="checkbox"/> Playing with weapon	<input type="checkbox"/> Self-defense	<input type="checkbox"/> Other, specify:	<input type="checkbox"/> Random violence	<input type="checkbox"/> Hate crime	<input type="checkbox"/> Weapon mistaken for toy	<input type="checkbox"/> Cleaning weapon		<input type="checkbox"/> Child was a bystander	<input type="checkbox"/> Bullying	<input type="checkbox"/> Showing gun to others	<input type="checkbox"/> Loading weapon	<input type="checkbox"/> U/K
<input type="checkbox"/> Self injury	<input type="checkbox"/> Argument	<input type="checkbox"/> Hunting	<input type="checkbox"/> Russian roulette	<input type="checkbox"/> Intervener assisting crime victim (Good Samaritan)																										
<input type="checkbox"/> Commission of crime	<input type="checkbox"/> Jealousy	<input type="checkbox"/> Target shooting	<input type="checkbox"/> Gang-related activity																											
<input type="checkbox"/> Drive-by shooting	<input type="checkbox"/> Intimate partner violence	<input type="checkbox"/> Playing with weapon	<input type="checkbox"/> Self-defense	<input type="checkbox"/> Other, specify:																										
<input type="checkbox"/> Random violence	<input type="checkbox"/> Hate crime	<input type="checkbox"/> Weapon mistaken for toy	<input type="checkbox"/> Cleaning weapon																											
<input type="checkbox"/> Child was a bystander	<input type="checkbox"/> Bullying	<input type="checkbox"/> Showing gun to others	<input type="checkbox"/> Loading weapon	<input type="checkbox"/> U/K																										

## 7. ANIMAL BITE OR ATTACK

<p>a. Type of animal:</p> <input type="radio"/> Domesticated dog <input type="radio"/> Insect <input type="radio"/> Domesticated cat <input type="radio"/> Other, specify: <input type="radio"/> Snake <input type="radio"/> Wild mammal, specify: <input type="radio"/> U/K	<p>b. Animal access to child, check all that apply:</p> <input type="checkbox"/> Animal on leash <input type="checkbox"/> Animal escaped from cage or leash <input type="checkbox"/> Animal caged or inside fence <input type="checkbox"/> Animal not caged or leashed <input type="radio"/> Child reached in <input type="checkbox"/> U/K <input type="radio"/> Child entered animal area <input type="radio"/> U/K	<p>c. Did child provoke animal?</p> <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K If yes, how?
		<p>d. Animal has history of biting or attacking?</p> <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K

## 8. FALL OR CRUSH

<p>a. Type:</p> <input type="radio"/> Fall, go to b <input type="radio"/> Crush, go to h	<p>b. Height of fall:</p> <p>_____ feet</p> <p>_____ inches</p> <input type="checkbox"/> U/K	<p>c. Child fell from:</p> <table style="width:100%;"> <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																		

<p>d. Surface child fell onto:</p> <input type="radio"/> Cement/concrete <input type="radio"/> Grass <input type="radio"/> Gravel <input type="radio"/> Wood floor <input type="radio"/> Carpeted floor <input type="radio"/> Linoleum/vinyl <input type="radio"/> Marble/tile <input type="radio"/> Other, specify: <input type="radio"/> U/K	<p>e. Barrier in place:</p> <p>Check all that apply:</p> <input type="checkbox"/> None <input type="checkbox"/> Screen <input type="checkbox"/> Other window guard <input type="checkbox"/> Fence <input type="checkbox"/> Railing <input type="checkbox"/> Stairway <input type="checkbox"/> Gate <input type="checkbox"/> Other, specify: <input type="checkbox"/> U/K	<p>f. Child in a baby walker?</p> <input type="radio"/> N/A <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K	<p>h. For crush, did child:</p> <input type="radio"/> Climb up on object <input type="radio"/> Pull object down <input type="radio"/> Hide behind object <input type="radio"/> Go behind object <input type="radio"/> Fall out of object <input type="radio"/> Other, specify: <input type="radio"/> U/K	<p>i. For crush, object causing crush:</p> <input type="radio"/> Appliance <input type="radio"/> Television <input type="radio"/> Furniture <input type="radio"/> Walls <input type="radio"/> Playground equipment <input type="radio"/> Animal <input type="radio"/> Tree branch <input type="radio"/> Boulders/rocks <input type="radio"/> Dirt/sand <input type="radio"/> Person, answer G6q <input type="radio"/> Commercial equipment <input type="radio"/> Farm equipment <input type="radio"/> Other, specify: <input type="radio"/> U/K
<p>g. Was child pushed, dropped or thrown?</p> <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K <p>If yes, go to G6q</p>				

**9. POISONING, OVERDOSE OR ACUTE INTOXICATION**

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

<u>Prescription drug</u>	<u>Over-the-counter drug</u>	<u>Cleaning substances</u>	<u>Other substances</u>	<input type="checkbox"/> U/K
<input type="checkbox"/> Antidepressant	<input type="checkbox"/> Diet pills	<input type="checkbox"/> Bleach	<input type="checkbox"/> Plants	
<input type="checkbox"/> Blood pressure medication	<input type="checkbox"/> Stimulants	<input type="checkbox"/> Drain cleaner	<input type="checkbox"/> Alcohol	
<input type="checkbox"/> Pain killer (opiate)	<input type="checkbox"/> Cough medicine	<input type="checkbox"/> Alkaline-based cleaner	<input type="checkbox"/> Street drugs	
<input type="checkbox"/> Pain killer (non-opiate)	<input type="checkbox"/> Pain medication	<input type="checkbox"/> Solvent	<input type="checkbox"/> Pesticide	
<input type="checkbox"/> Methadone	<input type="checkbox"/> Children's vitamins	<input type="checkbox"/> Other, specify:	<input type="checkbox"/> Antifreeze	
<input type="checkbox"/> Cardiac medication	<input type="checkbox"/> Iron supplement		<input type="checkbox"/> Other chemical	
<input type="checkbox"/> Other, specify:	<input type="checkbox"/> Other vitamins		<input type="checkbox"/> Herbal remedy	
	<input type="checkbox"/> Other, specify:		<input type="checkbox"/> Carbon monoxide, go to f	
	<input type="checkbox"/> Cosmetics/personal care products		<input type="checkbox"/> Other fume/gas/vapor	
			<input type="checkbox"/> Other, specify:	

<p>b. Where was the substance stored?</p> <input type="radio"/> Open area <input type="radio"/> Open cabinet <input type="radio"/> Closed cabinet, unlocked <input type="radio"/> Closed cabinet, locked <input type="radio"/> Other, specify: <input type="radio"/> U/K	<p>c. Was the product in its original container?</p> <input type="radio"/> N/A <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> U/K	<p>f. Was the incident the result of?</p> <input type="radio"/> Accidental overdose <input type="radio"/> Medical treatment mishap <input type="radio"/> Adverse effect, but not overdose <input type="radio"/> Deliberate poisoning <input type="radio"/> Acute intoxication <input type="radio"/> Other, specify: <input type="radio"/> U/K	<p>g. Was Poison Control called?</p> <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K <p>If yes, who called:</p> <input type="radio"/> Child <input type="radio"/> Parent <input type="radio"/> Other caregiver <input type="radio"/> First responder <input type="radio"/> Medical person <input type="radio"/> Other, specify: <input type="radio"/> U/K	<p>h. For CO poisoning, was a CO detector present?</p> <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K <p>If yes, how many?          _____          Functioning properly?  <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K       </p>
	<p>d. Did container have a child safety cap?</p> <input type="radio"/> N/A <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> U/K			
	<p>e. If prescription, was it child's?</p> <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K			

**10. EXPOSURE**

<p>a. Circumstances, check all that apply:</p> <input type="checkbox"/> Abandonment <input type="checkbox"/> Left in car <input type="checkbox"/> Left in room <input type="checkbox"/> Submerged in water <input type="checkbox"/> Injured outdoors <input type="checkbox"/> Lost outdoors <input type="checkbox"/> Illegal border crossing <input type="checkbox"/> Other, specify: <input type="checkbox"/> U/K	<p>b. Condition of exposure:</p> <input type="radio"/> Hyperthermia <input type="radio"/> Hypothermia <input type="radio"/> U/K <p>_____ Ambient temp, degrees F</p>	<p>c. Number of hours exposed:</p> <p>_____</p> <input type="checkbox"/> U/K	<p>d. Was child wearing appropriate clothing?</p> <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K
--	---	--	--

**11. MEDICAL CONDITION**

<p>a. How long did the child have the medical condition?</p> <input type="radio"/> In utero <input type="radio"/> Weeks <input type="radio"/> Since birth <input type="radio"/> Months <input type="radio"/> Hours <input type="radio"/> Years <input type="radio"/> Days <input type="radio"/> U/K	<p>b. Was death expected as a result of medical condition?</p> <input type="radio"/> N/A not previously diagnosed <input type="radio"/> Yes <input type="checkbox"/> But at a later date <input type="radio"/> No <input type="radio"/> U/K	<p>c. Was child receiving health care for the medical condition?</p> <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K <p>If yes, within 48 hours of the death?</p> <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K	<p>d. Were the prescribed care plans appropriate for the medical condition?</p> <input type="radio"/> N/A <input type="radio"/> Yes <input type="radio"/> No, specify: <input type="radio"/> U/K
<p>e. Was child/family compliant with the prescribed care plans?</p> <input type="radio"/> N/A <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K <p>If no, what wasn't compliant?          Check all that apply.</p> <input type="checkbox"/> Appointments <input type="checkbox"/> Medications, specify: <input type="checkbox"/> Medical equipment use, specify: <input type="checkbox"/> Therapies, specify: <input type="checkbox"/> Other, specify: <input type="checkbox"/> U/K		<p>f. Was child up to date with American Academy of Pediatrics immunization schedule?</p> <input type="radio"/> N/A <input type="radio"/> Yes <input type="radio"/> No, specify: <input type="radio"/> U/K	<p>g. Was medical condition associated with an outbreak?</p> <input type="radio"/> Yes, specify: <input type="radio"/> No <input type="radio"/> U/K

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

i. Were there access or compliance issues related to the death?  Yes  No  U/K If yes, check all that apply:

<input type="checkbox"/> Lack of money for care	<input type="checkbox"/> Language barriers	<input type="checkbox"/> Caregiver distrust of health care system
<input type="checkbox"/> Limitations of health insurance coverage	<input type="checkbox"/> Referrals not made	<input type="checkbox"/> Caregiver unskilled in providing care
<input type="checkbox"/> Multiple health insurance, not coordinated	<input type="checkbox"/> Specialist needed, not available	<input type="checkbox"/> Caregiver unwilling to provide care
<input type="checkbox"/> Lack of transportation	<input type="checkbox"/> Multiple providers, not coordinated	<input type="checkbox"/> Caregiver's partner would not allow care
<input type="checkbox"/> No phone	<input type="checkbox"/> Lack of child care	<input type="checkbox"/> Other, specify:
<input type="checkbox"/> Cultural differences	<input type="checkbox"/> Lack of family or social support	
<input type="checkbox"/> Religious objections to care	<input type="checkbox"/> Services not available	<input type="checkbox"/> U/K

**12. OTHER CAUSE, UNDETERMINED CAUSE OR UNKNOWN CAUSE**

Specify cause, describe in detail:

**H. OTHER CIRCUMSTANCES OF INCIDENT- ANSWER RELEVANT SECTIONS**

**1. ANSWER THIS ONLY IF CHILD IS UNDER AGE FIVE: WAS DEATH RELATED TO SLEEPING OR THE SLEEP ENVIRONMENT?**  Yes, go to H1a  No, go to H1r  U/K, go to H1r

<p>a. Incident sleep place:</p> <input type="radio"/> Crib <input type="radio"/> Playpen/other play structure If crib, type: but not portable crib <input type="radio"/> Not portable <input type="radio"/> Couch <input type="radio"/> Portable, e.g. pack-n-play <input type="radio"/> Chair <input type="radio"/> Unknown crib type <input type="radio"/> Floor <input type="radio"/> Bassinette <input type="radio"/> Car seat <input type="radio"/> Adult bed <input type="radio"/> Stroller <input type="radio"/> Waterbed <input type="radio"/> Other, specify: <input type="radio"/> Futon <input type="radio"/> U/K	<p>If adult bed, what type?</p> <input type="radio"/> Twin <input type="radio"/> Full <input type="radio"/> Queen <input type="radio"/> King <input type="radio"/> Other, specify: <input type="radio"/> U/K <hr/> If futon, <input type="radio"/> Bed position <input type="radio"/> U/K <input type="radio"/> Couch position	<p>b. Child put to sleep:</p> <input type="radio"/> On back <input type="radio"/> On stomach <input type="radio"/> On side <input type="radio"/> U/K	<p>c. Child found:</p> <input type="radio"/> On back <input type="radio"/> On stomach <input type="radio"/> On side <input type="radio"/> U/K
		<p>e. Usual sleep position:</p> <input type="radio"/> On back <input type="radio"/> On stomach <input type="radio"/> On side <input type="radio"/> U/K	<p>f. Was there a crib, bassinette or port-a-crib in home for child?</p> <input type="radio"/> Yes <input type="radio"/> U/K <input type="radio"/> No

<p>d. Usual sleep place:</p> <input type="radio"/> Crib <input type="radio"/> Playpen/other play structure If crib, type: but not portable crib <input type="radio"/> Not portable <input type="radio"/> Couch <input type="radio"/> Portable, e.g. pack-n-play <input type="radio"/> Chair <input type="radio"/> Unknown crib type <input type="radio"/> Floor <input type="radio"/> Bassinette <input type="radio"/> Car seat <input type="radio"/> Adult bed <input type="radio"/> Stroller <input type="radio"/> Waterbed <input type="radio"/> Other, specify: <input type="radio"/> Futon <input type="radio"/> U/K	<p>If adult bed, what type?</p> <input type="radio"/> Twin <input type="radio"/> Full <input type="radio"/> Queen <input type="radio"/> King <input type="radio"/> Other, specify: <input type="radio"/> U/K <hr/> If futon, <input type="radio"/> Bed position <input type="radio"/> U/K <input type="radio"/> Couch position	<p>g. Child in a new or different environment than usual?</p> <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K If yes, specify:
		<p>h. Child last placed to sleep with a pacifier?</p> <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K
		<p>i. Was child wrapped or swaddled in blanket?</p> <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K If yes, describe:
		<p>j. Child exposed to second hand smoke?</p> <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K If yes, how often: <input type="radio"/> Frequently <input type="radio"/> U/K <input type="radio"/> Occasionally

<p>k. Child face when found:</p> <input type="radio"/> Down <input type="radio"/> Up <input type="radio"/> To left or right side <input type="radio"/> U/K	<p>l. Child neck when found:</p> <input type="radio"/> Hyperextended (head back) <input type="radio"/> Hypoextended (chin to chest) <input type="radio"/> Neutral <input type="radio"/> U/K	<p>m. Child's airway was:</p> <input type="radio"/> Unobstructed by person or object <input type="radio"/> Fully obstructed by person or object <input type="radio"/> Partially obstructed by person or object <input type="radio"/> U/K	<p>If fully or partially obstructed, what was obstructed?</p> <input type="checkbox"/> Nose <input type="checkbox"/> U/K <input type="checkbox"/> Mouth <input type="checkbox"/> Chest compressed
---	--	---	---

<p>n. Objects in child's sleep environment in relation to airway obstruction:</p> <p style="text-align: center;">If present, describe position of object:</p> <table border="1"> <thead> <tr> <th rowspan="2">Objects:</th> <th colspan="3">Present?</th> <th colspan="4">If present, did object obstruct airway?</th> </tr> <tr> <th>Yes</th> <th>No</th> <th>U/K</th> <th>On top of child</th> <th>Under child</th> <th>Next to child</th> <th>Tangled around child</th> <th>U/K</th> </tr> </thead> <tbody> <tr><td>Adult(s)</td><td><input type="radio"/></td><td><input type="radio"/></td><td><input type="radio"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td>Other child(ren)</td><td><input type="radio"/></td><td><input type="radio"/></td><td><input type="radio"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td>Animal(s)</td><td><input type="radio"/></td><td><input type="radio"/></td><td><input type="radio"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td>Mattress</td><td><input type="radio"/></td><td><input type="radio"/></td><td><input type="radio"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td>Comforter, quilt, or other</td><td><input type="radio"/></td><td><input type="radio"/></td><td><input type="radio"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td>Thin blanket/flat sheet</td><td><input type="radio"/></td><td><input type="radio"/></td><td><input type="radio"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td>Pillow(s)</td><td><input type="radio"/></td><td><input type="radio"/></td><td><input type="radio"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td>Cushion</td><td><input type="radio"/></td><td><input type="radio"/></td><td><input type="radio"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td>Boppy or U shaped pillow</td><td><input type="radio"/></td><td><input type="radio"/></td><td><input type="radio"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td>Sleep positioner (wedge)</td><td><input type="radio"/></td><td><input type="radio"/></td><td><input type="radio"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td>Bumper pads</td><td><input type="radio"/></td><td><input type="radio"/></td><td><input type="radio"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td>Clothing</td><td><input type="radio"/></td><td><input type="radio"/></td><td><input type="radio"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td>Crib railing/side</td><td><input type="radio"/></td><td><input type="radio"/></td><td><input type="radio"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td>Wall</td><td><input type="radio"/></td><td><input type="radio"/></td><td><input type="radio"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td>Toy(s)</td><td><input type="radio"/></td><td><input type="radio"/></td><td><input type="radio"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td>Other(s), specify:</td><td><input type="radio"/></td><td><input type="radio"/></td><td><input type="radio"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td></td><td><input type="radio"/></td><td><input type="radio"/></td><td><input type="radio"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> </tbody> </table>	Objects:	Present?			If present, did object obstruct airway?				Yes	No	U/K	On top of child	Under child	Next to child	Tangled around child	U/K	Adult(s)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/>	Other child(ren)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/>	Animal(s)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/>	Mattress	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/>	Comforter, quilt, or other	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/>	Thin blanket/flat sheet	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/>	Pillow(s)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/>	Cushion	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/>	Boppy or U shaped pillow	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/>	Sleep positioner (wedge)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/>	Bumper pads	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/>	Clothing	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/>	Crib railing/side	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/>	Wall	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/>	Toy(s)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/>	Other(s), specify:	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/>		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/>	<p>o. Caregiver/supervisor fell asleep while feeding child?</p> <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K If yes, type of feeding: <input type="radio"/> Bottle <input type="radio"/> U/K <input type="radio"/> Breast																																																																				
Objects:		Present?			If present, did object obstruct airway?																																																																																																																																																																					
	Yes	No	U/K	On top of child	Under child	Next to child	Tangled around child	U/K																																																																																																																																																																		
Adult(s)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																																																																																																																																		
Other child(ren)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																																																																																																																																		
Animal(s)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																																																																																																																																		
Mattress	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																																																																																																																																		
Comforter, quilt, or other	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																																																																																																																																		
Thin blanket/flat sheet	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																																																																																																																																		
Pillow(s)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																																																																																																																																		
Cushion	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																																																																																																																																		
Boppy or U shaped pillow	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																																																																																																																																		
Sleep positioner (wedge)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																																																																																																																																		
Bumper pads	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																																																																																																																																		
Clothing	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																																																																																																																																		
Crib railing/side	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																																																																																																																																		
Wall	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																																																																																																																																		
Toy(s)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																																																																																																																																		
Other(s), specify:	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																																																																																																																																		
	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																																																																																																																																		
		<p>p. Child sleeping in the same room as caregiver/supervisor at time of death?</p> <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K																																																																																																																																																																								
		<p>q. Child sleeping on same surface with person(s) or animal(s)?</p> <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K If yes, check all that apply: <input type="checkbox"/> With adult(s): # _____ #U/K Adult obese: <input type="radio"/> Yes <input type="radio"/> U/K <input type="radio"/> No <input type="checkbox"/> With other children: # _____ #U/K Children's ages: _____ <input type="checkbox"/> With animal(s): # _____ #U/K Type(s) of animal: _____ <input type="checkbox"/> U/K																																																																																																																																																																								

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

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

**2. WAS DEATH A CONSEQUENCE OF A PROBLEM WITH A CONSUMER PRODUCT?**  Yes  No, go to H3  U/K, go to H3

a. Describe product and circumstances:	b. Was product used properly? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K	c. Is a recall in place? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K	d. Did product have safety label? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K	e. Was Consumer Product Safety Commission (CPSC) notified? <input type="radio"/> Yes <input type="radio"/> U/K <input type="radio"/> No, call 1-800-638-2772 to file report
--	---	--	---	---

**3. DID DEATH OCCUR DURING COMMISSION OF ANOTHER CRIME?**  Yes  No  U/K

a. Type of crime, check all that apply:

<input type="checkbox"/> Robbery/burglary	<input type="checkbox"/> Other assault	<input type="checkbox"/> Arson	<input type="checkbox"/> Illegal border crossing	<input type="checkbox"/> U/K
<input type="checkbox"/> Interpersonal violence	<input type="checkbox"/> Gang conflict	<input type="checkbox"/> Prostitution	<input type="checkbox"/> Auto theft	
<input type="checkbox"/> Sexual assault	<input type="checkbox"/> Drug trade	<input type="checkbox"/> Witness intimidation	<input type="checkbox"/> Other, specify:	

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

**TYPE OF ACT**

<p>1. Did any act(s) of omission or commission cause and/or contribute to the death?</p> <p><input type="radio"/> Yes <input type="radio"/> No, go to Section J <input type="radio"/> Probable <input type="radio"/> U/K, go to Section J</p> <p>If yes/probable, were the act(s) either or both? Check all that apply:</p> <p><input type="checkbox"/> The direct cause of death <input type="checkbox"/> The contributing cause of death</p>	<p>2. What act(s) caused or contributed to the death? Check only one per column and describe in narrative.</p> <table border="0"> <tr> <td style="text-align: center;"><u>Caused</u></td> <td style="text-align: center;"><u>Contributed</u></td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/> Poor/absent supervision, go to 10</td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/> Child abuse, go to 3</td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/> Child neglect, go to 8</td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/> Other negligence, go to 9</td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/> Assault, not child abuse, go to 10</td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/> Religious/cultural practices, go to 10</td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/> Suicide, go to 27</td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/> Medical misadventure, specify and go to 11</td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/> Other, specify and go to 10</td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/> U/K, go to 10</td> </tr> </table>	<u>Caused</u>	<u>Contributed</u>	<input type="radio"/>	<input type="radio"/> Poor/absent supervision, go to 10	<input type="radio"/>	<input type="radio"/> Child abuse, go to 3	<input type="radio"/>	<input type="radio"/> Child neglect, go to 8	<input type="radio"/>	<input type="radio"/> Other negligence, go to 9	<input type="radio"/>	<input type="radio"/> Assault, not child abuse, go to 10	<input type="radio"/>	<input type="radio"/> Religious/cultural practices, go to 10	<input type="radio"/>	<input type="radio"/> Suicide, go to 27	<input type="radio"/>	<input type="radio"/> Medical misadventure, specify and go to 11	<input type="radio"/>	<input type="radio"/> Other, specify and go to 10	<input type="radio"/>	<input type="radio"/> U/K, go to 10
<u>Caused</u>	<u>Contributed</u>																						
<input type="radio"/>	<input type="radio"/> Poor/absent supervision, go to 10																						
<input type="radio"/>	<input type="radio"/> Child abuse, go to 3																						
<input type="radio"/>	<input type="radio"/> Child neglect, go to 8																						
<input type="radio"/>	<input type="radio"/> Other negligence, go to 9																						
<input type="radio"/>	<input type="radio"/> Assault, not child abuse, go to 10																						
<input type="radio"/>	<input type="radio"/> Religious/cultural practices, go to 10																						
<input type="radio"/>	<input type="radio"/> Suicide, go to 27																						
<input type="radio"/>	<input type="radio"/> Medical misadventure, specify and go to 11																						
<input type="radio"/>	<input type="radio"/> Other, specify and go to 10																						
<input type="radio"/>	<input type="radio"/> U/K, go to 10																						

<p>3. Child abuse, type. Check all that apply and describe in narrative.</p> <p><input type="checkbox"/> Physical, go to 4 <input type="checkbox"/> Emotional, specify and go to 10 <input type="checkbox"/> Sexual, specify and go to 10 <input type="checkbox"/> U/K, go to 10</p>	<p>4. Type of physical abuse, check all that apply:</p> <p><input type="checkbox"/> Abusive head trauma, go to 5 <input type="checkbox"/> Chronic Battered Child Syndrome, go to 7 <input type="checkbox"/> Beating/kicking, go to 7 <input type="checkbox"/> Scalding or burning, go to 7 <input type="checkbox"/> Munchausen Syndrome by Proxy, go to 7 <input type="checkbox"/> Other, specify and go to 7</p> <p><input type="checkbox"/> U/K, go to 7</p>	<p>5. For abusive head trauma, were there retinal hemorrhages? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K</p> <p>6. For abusive head trauma, was the child shaken? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K</p> <p>If yes, was there impact? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K</p>	<p>7. Events(s) triggering physical abuse, check all that apply:</p> <p><input type="checkbox"/> None <input type="checkbox"/> Crying <input type="checkbox"/> Toilet training <input type="checkbox"/> Disobedience <input type="checkbox"/> Feeding problems <input type="checkbox"/> Domestic argument <input type="checkbox"/> Other, specify: <input type="checkbox"/> U/K</p>
--	--	---	---

<p>8. Child neglect, check all that apply:</p> <table border="0"> <tr> <td><input type="checkbox"/> Failure to protect from hazards, specify:</td> <td><input type="checkbox"/> Failure to seek/follow treatment, specify:</td> </tr> <tr> <td><input type="checkbox"/> Failure to provide necessities</td> <td><input type="checkbox"/> Emotional neglect, specify:</td> </tr> <tr> <td><input type="checkbox"/> Food</td> <td><input type="checkbox"/> Abandonment, specify:</td> </tr> <tr> <td><input type="checkbox"/> Shelter</td> <td><input type="checkbox"/> U/K</td> </tr> <tr> <td><input type="checkbox"/> Other, specify:</td> <td></td> </tr> </table>	<input type="checkbox"/> Failure to protect from hazards, specify:	<input type="checkbox"/> Failure to seek/follow treatment, specify:	<input type="checkbox"/> Failure to provide necessities	<input type="checkbox"/> Emotional neglect, specify:	<input type="checkbox"/> Food	<input type="checkbox"/> Abandonment, specify:	<input type="checkbox"/> Shelter	<input type="checkbox"/> U/K	<input type="checkbox"/> Other, specify:		<p>9. Other negligence:</p> <p><input type="radio"/> Vehicular <input type="radio"/> Other, specify: <input type="radio"/> U/K</p>	<p>10. Was act(s) of omission/commission:</p> <table border="0"> <tr> <td style="text-align: center;"><u>Caused</u></td> <td style="text-align: center;"><u>Contributed</u></td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/> Chronic with child</td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/> Pattern in family or with perpetrator</td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/> Isolated incident</td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/> U/K</td> </tr> </table>	<u>Caused</u>	<u>Contributed</u>	<input type="radio"/>	<input type="radio"/> Chronic with child	<input type="radio"/>	<input type="radio"/> Pattern in family or with perpetrator	<input type="radio"/>	<input type="radio"/> Isolated incident	<input type="radio"/>	<input type="radio"/> U/K
<input type="checkbox"/> Failure to protect from hazards, specify:	<input type="checkbox"/> Failure to seek/follow treatment, specify:																					
<input type="checkbox"/> Failure to provide necessities	<input type="checkbox"/> Emotional neglect, specify:																					
<input type="checkbox"/> Food	<input type="checkbox"/> Abandonment, specify:																					
<input type="checkbox"/> Shelter	<input type="checkbox"/> U/K																					
<input type="checkbox"/> Other, specify:																						
<u>Caused</u>	<u>Contributed</u>																					
<input type="radio"/>	<input type="radio"/> Chronic with child																					
<input type="radio"/>	<input type="radio"/> Pattern in family or with perpetrator																					
<input type="radio"/>	<input type="radio"/> Isolated incident																					
<input type="radio"/>	<input type="radio"/> U/K																					

**PERSON(S) RESPONSIBLE**

<p>11. Is person the caregiver or supervisor in previous section?</p> <table border="0"> <tr> <td style="text-align: center;"><u>Caused</u></td> <td style="text-align: center;"><u>Contributed</u></td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/> Yes, caregiver one, go to 24</td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/> Yes, caregiver two, go to 24</td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/> Yes, supervisor, go to 25</td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/> No</td> </tr> </table>	<u>Caused</u>	<u>Contributed</u>	<input type="radio"/>	<input type="radio"/> Yes, caregiver one, go to 24	<input type="radio"/>	<input type="radio"/> Yes, caregiver two, go to 24	<input type="radio"/>	<input type="radio"/> Yes, supervisor, go to 25	<input type="radio"/>	<input type="radio"/> No	<p>12. Primary person responsible for action(s) that caused and/or contributed to death: Select no more than one person for caused and one person for contributed.</p> <table border="0"> <tr> <td style="text-align: center;"><u>Caused</u></td> <td style="text-align: center;"><u>Contributed</u></td> <td style="text-align: center;"><u>Caused</u></td> <td style="text-align: center;"><u>Contributed</u></td> <td style="text-align: center;"><u>Caused</u></td> <td style="text-align: center;"><u>Contributed</u></td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/> Self, go to 24</td> <td><input type="radio"/></td> <td><input type="radio"/> Grandparent</td> <td><input type="radio"/></td> <td><input type="radio"/> Medical provider</td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/> Biological parent</td> <td><input type="radio"/></td> <td><input type="radio"/> Sibling</td> <td><input type="radio"/></td> <td><input type="radio"/> Institutional staff</td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/> Adoptive parent</td> <td><input type="radio"/></td> <td><input type="radio"/> Other relative</td> <td><input type="radio"/></td> <td><input type="radio"/> Babysitter</td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/> Stepparent</td> <td><input type="radio"/></td> <td><input type="radio"/> Friend</td> <td><input type="radio"/></td> <td><input type="radio"/> Licensed child care worker</td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/> Foster parent</td> <td><input type="radio"/></td> <td><input type="radio"/> Acquaintance</td> <td><input type="radio"/></td> <td><input type="radio"/> Other, specify:</td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/> Mother's partner</td> <td><input type="radio"/></td> <td><input type="radio"/> Child's boyfriend or girlfriend</td> <td><input type="radio"/></td> <td><input type="radio"/> U/K</td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/> Father's partner</td> <td><input type="radio"/></td> <td><input type="radio"/> Stranger</td> <td></td> <td></td> </tr> </table>	<u>Caused</u>	<u>Contributed</u>	<u>Caused</u>	<u>Contributed</u>	<u>Caused</u>	<u>Contributed</u>	<input type="radio"/>	<input type="radio"/> Self, go to 24	<input type="radio"/>	<input type="radio"/> Grandparent	<input type="radio"/>	<input type="radio"/> Medical provider	<input type="radio"/>	<input type="radio"/> Biological parent	<input type="radio"/>	<input type="radio"/> Sibling	<input type="radio"/>	<input type="radio"/> Institutional staff	<input type="radio"/>	<input type="radio"/> Adoptive parent	<input type="radio"/>	<input type="radio"/> Other relative	<input type="radio"/>	<input type="radio"/> Babysitter	<input type="radio"/>	<input type="radio"/> Stepparent	<input type="radio"/>	<input type="radio"/> Friend	<input type="radio"/>	<input type="radio"/> Licensed child care worker	<input type="radio"/>	<input type="radio"/> Foster parent	<input type="radio"/>	<input type="radio"/> Acquaintance	<input type="radio"/>	<input type="radio"/> Other, specify:	<input type="radio"/>	<input type="radio"/> Mother's partner	<input type="radio"/>	<input type="radio"/> Child's boyfriend or girlfriend	<input type="radio"/>	<input type="radio"/> U/K	<input type="radio"/>	<input type="radio"/> Father's partner	<input type="radio"/>	<input type="radio"/> Stranger		
<u>Caused</u>	<u>Contributed</u>																																																										
<input type="radio"/>	<input type="radio"/> Yes, caregiver one, go to 24																																																										
<input type="radio"/>	<input type="radio"/> Yes, caregiver two, go to 24																																																										
<input type="radio"/>	<input type="radio"/> Yes, supervisor, go to 25																																																										
<input type="radio"/>	<input type="radio"/> No																																																										
<u>Caused</u>	<u>Contributed</u>	<u>Caused</u>	<u>Contributed</u>	<u>Caused</u>	<u>Contributed</u>																																																						
<input type="radio"/>	<input type="radio"/> Self, go to 24	<input type="radio"/>	<input type="radio"/> Grandparent	<input type="radio"/>	<input type="radio"/> Medical provider																																																						
<input type="radio"/>	<input type="radio"/> Biological parent	<input type="radio"/>	<input type="radio"/> Sibling	<input type="radio"/>	<input type="radio"/> Institutional staff																																																						
<input type="radio"/>	<input type="radio"/> Adoptive parent	<input type="radio"/>	<input type="radio"/> Other relative	<input type="radio"/>	<input type="radio"/> Babysitter																																																						
<input type="radio"/>	<input type="radio"/> Stepparent	<input type="radio"/>	<input type="radio"/> Friend	<input type="radio"/>	<input type="radio"/> Licensed child care worker																																																						
<input type="radio"/>	<input type="radio"/> Foster parent	<input type="radio"/>	<input type="radio"/> Acquaintance	<input type="radio"/>	<input type="radio"/> Other, specify:																																																						
<input type="radio"/>	<input type="radio"/> Mother's partner	<input type="radio"/>	<input type="radio"/> Child's boyfriend or girlfriend	<input type="radio"/>	<input type="radio"/> U/K																																																						
<input type="radio"/>	<input type="radio"/> Father's partner	<input type="radio"/>	<input type="radio"/> Stranger																																																								

<p>13. Person's age in years:</p> <p><u>Caused</u>    <u>Contributed</u></p> <p>_____    _____ # Years</p> <p><input type="checkbox"/>    <input type="checkbox"/> U/K</p>	<p>14. Person's sex:</p> <p><u>Caused</u>    <u>Contributed</u></p> <p><input type="radio"/>    <input type="radio"/> Male</p> <p><input type="radio"/>    <input type="radio"/> Female</p> <p><input type="radio"/>    <input type="radio"/> U/K</p>	<p>15. Does person speak English?</p> <p><u>Caused</u>    <u>Contributed</u></p> <p><input type="radio"/>    <input type="radio"/> Yes</p> <p><input type="radio"/>    <input type="radio"/> No</p> <p><input type="radio"/>    <input type="radio"/> U/K</p> <p>If no, language spoken:</p>	<p>16. Person on active military duty?</p> <p><u>Caused</u>    <u>Contributed</u></p> <p><input type="radio"/>    <input type="radio"/> Yes</p> <p><input type="radio"/>    <input type="radio"/> No</p> <p><input type="radio"/>    <input type="radio"/> U/K</p> <p>If yes, specify branch:</p>																																																								
<p>17. Person have history of substance abuse?</p> <p><u>Caused</u>    <u>Contributed</u></p> <p><input type="radio"/>    <input type="radio"/> Yes</p> <p><input type="radio"/>    <input type="radio"/> No</p> <p><input type="radio"/>    <input type="radio"/> U/K</p> <p>If yes, check all that apply:</p> <p><input type="checkbox"/>    <input type="checkbox"/> Alcohol</p> <p><input type="checkbox"/>    <input type="checkbox"/> Cocaine</p> <p><input type="checkbox"/>    <input type="checkbox"/> Marijuana</p> <p><input type="checkbox"/>    <input type="checkbox"/> Methamphetamine</p> <p><input type="checkbox"/>    <input type="checkbox"/> Opiates</p> <p><input type="checkbox"/>    <input type="checkbox"/> Prescription drugs</p> <p><input type="checkbox"/>    <input type="checkbox"/> Over-the-counter</p> <p><input type="checkbox"/>    <input type="checkbox"/> Other, specify:</p> <p><input type="checkbox"/>    <input type="checkbox"/> U/K</p>	<p>18. Person have history of child maltreatment as victim?</p> <p><u>Caused</u>    <u>Contributed</u></p> <p><input type="radio"/>    <input type="radio"/> Yes</p> <p><input type="radio"/>    <input type="radio"/> No</p> <p><input type="radio"/>    <input type="radio"/> U/K</p> <p>If yes, check all that apply:</p> <p><input type="checkbox"/>    <input type="checkbox"/> Physical</p> <p><input type="checkbox"/>    <input type="checkbox"/> Neglect</p> <p><input type="checkbox"/>    <input type="checkbox"/> Sexual</p> <p><input type="checkbox"/>    <input type="checkbox"/> Emotional/psychological</p> <p><input type="checkbox"/>    <input type="checkbox"/> U/K</p> <p>_____    _____ # CPS referrals</p> <p>_____    _____ # Substantiations</p> <p><input type="checkbox"/>    <input type="checkbox"/> Ever in foster care or adopted</p>	<p>19. Person have history of child maltreatment as a perpetrator?</p> <p><u>Caused</u>    <u>Contributed</u></p> <p><input type="radio"/>    <input type="radio"/> Yes</p> <p><input type="radio"/>    <input type="radio"/> No</p> <p><input type="radio"/>    <input type="radio"/> U/K</p> <p>If yes, check all that apply:</p> <p><input type="checkbox"/>    <input type="checkbox"/> Physical</p> <p><input type="checkbox"/>    <input type="checkbox"/> Neglect</p> <p><input type="checkbox"/>    <input type="checkbox"/> Sexual</p> <p><input type="checkbox"/>    <input type="checkbox"/> Emotional/psychological</p> <p><input type="checkbox"/>    <input type="checkbox"/> U/K</p> <p>_____    _____ # CPS referrals</p> <p>_____    _____ # Substantiations</p> <p><input type="checkbox"/>    <input type="checkbox"/> CPS prevention services</p> <p><input type="checkbox"/>    <input type="checkbox"/> Family preservation services</p> <p><input type="checkbox"/>    <input type="checkbox"/> Children ever removed</p>	<p>20. Person have disability or chronic illness?</p> <p><u>Caused</u>    <u>Contributed</u></p> <p><input type="radio"/>    <input type="radio"/> Yes</p> <p><input type="radio"/>    <input type="radio"/> No</p> <p><input type="radio"/>    <input type="radio"/> U/K</p> <p>If yes, check all that apply:</p> <p><input type="checkbox"/>    <input type="checkbox"/> Physical, specify:</p> <p><input type="checkbox"/>    <input type="checkbox"/> Mental, specify:</p> <p><input type="checkbox"/>    <input type="checkbox"/> Sensory, specify:</p> <p><input type="checkbox"/>    <input type="checkbox"/> U/K</p> <p>If mental illness, was person receiving MH services?</p> <p><input type="radio"/>    <input type="radio"/> Yes</p> <p><input type="radio"/>    <input type="radio"/> No</p> <p><input type="radio"/>    <input type="radio"/> U/K</p>																																																								
<p>21. Person have prior child deaths?</p> <p><u>Caused</u>    <u>Contributed</u></p> <p><input type="radio"/>    <input type="radio"/> Yes</p> <p><input type="radio"/>    <input type="radio"/> No</p> <p><input type="radio"/>    <input type="radio"/> U/K</p> <p>If yes, check all that apply:</p> <p><u>Caused</u>    <u>Contributed</u></p> <p><input type="checkbox"/>    <input type="checkbox"/> Child abuse # _____</p> <p><input type="checkbox"/>    <input type="checkbox"/> Child neglect # _____</p> <p><input type="checkbox"/>    <input type="checkbox"/> Accident # _____</p> <p><input type="checkbox"/>    <input type="checkbox"/> Suicide # _____</p> <p><input type="checkbox"/>    <input type="checkbox"/> SIDS # _____</p> <p><input type="checkbox"/>    <input type="checkbox"/> Other # _____</p> <p>Other, specify:</p> <p><input type="checkbox"/>    <input type="checkbox"/> U/K</p>	<p>22. Person have history of intimate partner violence?</p> <p><u>Caused</u>    <u>Contributed</u></p> <p><input type="checkbox"/>    <input type="checkbox"/> Yes, as victim</p> <p><input type="checkbox"/>    <input type="checkbox"/> Yes, as perpetrator</p> <p><input type="checkbox"/>    <input type="checkbox"/> No</p> <p><input type="checkbox"/>    <input type="checkbox"/> U/K</p>	<p>23. Person have delinquent/criminal history?</p> <p><u>Caused</u>    <u>Contributed</u></p> <p><input type="radio"/>    <input type="radio"/> Yes</p> <p><input type="radio"/>    <input type="radio"/> No</p> <p><input type="radio"/>    <input type="radio"/> U/K</p> <p>If yes, check all that apply:</p> <p><input type="checkbox"/>    <input type="checkbox"/> Assaults</p> <p><input type="checkbox"/>    <input type="checkbox"/> Robbery</p> <p><input type="checkbox"/>    <input type="checkbox"/> Drugs</p> <p><input type="checkbox"/>    <input type="checkbox"/> Other, specify:</p> <p><input type="checkbox"/>    <input type="checkbox"/> U/K</p>																																																									
<p>24. At time of incident was person impaired?</p> <p><u>Caused</u>    <u>Contributed</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> <p><u>Caused</u>    <u>Contributed</u></p> <p><input type="checkbox"/>    <input type="checkbox"/> Drug impaired</p> <p><input type="checkbox"/>    <input type="checkbox"/> Alcohol impaired</p> <p><input type="checkbox"/>    <input type="checkbox"/> Asleep</p> <p><input type="checkbox"/>    <input type="checkbox"/> Distracted</p> <p><input type="checkbox"/>    <input type="checkbox"/> Absent</p> <p><input type="checkbox"/>    <input type="checkbox"/> Impaired by illness, specify:</p> <p><input type="checkbox"/>    <input type="checkbox"/> Impaired by disability, specify:</p> <p><input type="checkbox"/>    <input type="checkbox"/> Other, specify:</p>	<p>25. Does person have, check all that apply:</p> <p><u>Caused</u>    <u>Contributed</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>26. Legal outcomes in this death, check all that apply:</p> <p><u>Caused</u>    <u>Contributed</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>																																																									
<b>FOR SUICIDE</b>																																																											
<p>27. For suicide, select yes, no or u/k for each question. Describe answers in narrative.</p> <table style="width:100%; border-collapse: collapse;"> <tr> <td style="width:33%;"><u>Yes</u></td> <td style="width:33%;"><u>No</u></td> <td style="width:33%;"><u>U/K</u></td> <td style="width:33%;"></td> <td style="width:33%;"><u>Yes</u></td> <td style="width:33%;"><u>No</u></td> <td style="width:33%;"><u>U/K</u></td> <td style="width:33%;"></td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/></td> <td><input type="radio"/></td> <td>A note was left</td> <td><input type="radio"/></td> <td><input type="radio"/></td> <td><input type="radio"/></td> <td>Child had a history of self mutilation</td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/></td> <td><input type="radio"/></td> <td>Child talked about suicide</td> <td><input type="radio"/></td> <td><input type="radio"/></td> <td><input type="radio"/></td> <td>There is a family history of suicide</td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/></td> <td><input type="radio"/></td> <td>Prior suicide threats were made</td> <td><input type="radio"/></td> <td><input type="radio"/></td> <td><input type="radio"/></td> <td>Suicide was part of a murder-suicide</td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/></td> <td><input type="radio"/></td> <td>Prior attempts were made</td> <td><input type="radio"/></td> <td><input type="radio"/></td> <td><input type="radio"/></td> <td>Suicide was part of a suicide pact</td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/></td> <td><input type="radio"/></td> <td>Suicide was completely unexpected</td> <td><input type="radio"/></td> <td><input type="radio"/></td> <td><input type="radio"/></td> <td>Suicide was part of a suicide cluster</td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/></td> <td><input type="radio"/></td> <td>Child had a history of running away</td> <td></td> <td></td> <td></td> <td></td> </tr> </table>				<u>Yes</u>	<u>No</u>	<u>U/K</u>		<u>Yes</u>	<u>No</u>	<u>U/K</u>		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	A note was left	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Child had a history of self mutilation	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Child talked about suicide	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	There is a family history of suicide	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Prior suicide threats were made	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Suicide was part of a murder-suicide	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Prior attempts were made	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Suicide was part of a suicide pact	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Suicide was completely unexpected	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Suicide was part of a suicide cluster	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Child had a history of running away				
<u>Yes</u>	<u>No</u>	<u>U/K</u>		<u>Yes</u>	<u>No</u>	<u>U/K</u>																																																					
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	A note was left	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Child had a history of self mutilation																																																				
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Child talked about suicide	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	There is a family history of suicide																																																				
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Prior suicide threats were made	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Suicide was part of a murder-suicide																																																				
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Prior attempts were made	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Suicide was part of a suicide pact																																																				
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Suicide was completely unexpected	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Suicide was part of a suicide cluster																																																				
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Child had a history of running away																																																								

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

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

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

1. Services:	<u>Provided</u>	<u>Offered but</u>	<u>Offered but</u>	<u>Should be</u>	<u>Needed but</u>		<u>CDR review</u>
Select one option per row:	<u>after death</u>	<u>refused</u>	<u>U/K if used</u>	<u>offered</u>	<u>not available</u>	<u>U/K</u>	<u>led to referral</u>
Bereavement counseling	<input type="radio"/>	<input type="checkbox"/>					
Debriefing for professionals	<input type="radio"/>	<input type="checkbox"/>					
Economic support	<input type="radio"/>	<input type="checkbox"/>					
Funeral arrangements	<input type="radio"/>	<input type="checkbox"/>					
Emergency shelter	<input type="radio"/>	<input type="checkbox"/>					
Mental health services	<input type="radio"/>	<input type="checkbox"/>					
Foster care	<input type="radio"/>	<input type="checkbox"/>					
Health care	<input type="radio"/>	<input type="checkbox"/>					
Legal services	<input type="radio"/>	<input type="checkbox"/>					
Family planning	<input type="radio"/>	<input type="checkbox"/>					
Other, specify:	<input type="radio"/>	<input type="checkbox"/>					

**K. PREVENTION INITIATIVES RESULTING FROM THE REVIEW**

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

1. Could the death have been prevented?  Yes, probably  No, probably not  Team could not determine
2. What specific recommendations and/or initiatives resulted from the review? Check all that apply:  No recommendations made, go to Section L

	<u>Current Action Stage</u>			<u>Type of Action</u>		<u>Level of Action</u>			
	<u>Recommendation</u>	<u>Planning</u>	<u>Implementation</u>	<u>Short term</u>	<u>Long term</u>	<u>Local</u>	<u>State</u>	<u>National</u>	
Education	Media campaign	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/>				
	School program	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/>				
	Community safety project	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/>				
	Provider education	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/>				
	Parent education	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/>				
	Public forum	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/>				
	Other education	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/>				
Agency	New policy(ies)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/>				
	Revised policy(ies)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/>				
	New program	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/>				
	New services	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/>				
	Expanded services	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/>				
Law	New law/ordinance	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/>				
	Amended law/ordinance	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/>				
	Enforcement of law/ordinance	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/>				
Environment	Modify a consumer product	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/>				
	Recall a consumer product	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/>				
	Modify a public space	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/>				
	Modify a private space(s)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/>				
Other, specify:	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/>					

Briefly describe the initiatives:

3. Who took responsibility for championing the prevention initiatives? Check all that apply:

<input type="checkbox"/> N/A, no strategies	<input type="checkbox"/> Mental health	<input type="checkbox"/> Law enforcement	<input type="checkbox"/> Advocacy organization	<input type="checkbox"/> Other, specify:
<input type="checkbox"/> No one	<input type="checkbox"/> Schools	<input type="checkbox"/> Medical examiner	<input type="checkbox"/> Local community group	
<input type="checkbox"/> Health department	<input type="checkbox"/> Hospital	<input type="checkbox"/> Coroner	<input type="checkbox"/> New coalition/task force	
<input type="checkbox"/> Social services	<input type="checkbox"/> Other health care providers	<input type="checkbox"/> Elected official	<input type="checkbox"/> Youth group	<input type="checkbox"/> U/K

**L. THE REVIEW MEETING PROCESS**

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 at review, check all that apply:

<input type="checkbox"/> Medical examiner/coroner	<input type="checkbox"/> CPS	<input type="checkbox"/> Other health care	<input type="checkbox"/> Mental health	<input type="checkbox"/> Military
<input type="checkbox"/> Law enforcement	<input type="checkbox"/> Other social services	<input type="checkbox"/> Fire	<input type="checkbox"/> Substance abuse	<input type="checkbox"/> Others, list:
<input type="checkbox"/> Prosecutor/district attorney	<input type="checkbox"/> Physician	<input type="checkbox"/> EMS	<input type="checkbox"/> Court	
<input type="checkbox"/> Public health	<input type="checkbox"/> Hospital	<input type="checkbox"/> Education	<input type="checkbox"/> Child advocate	

5. Were the following data sources available at the review?

Check all that apply:

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

6. Factors that prevented an effective review, check all that apply:

- Confidentiality issues among members prevented full exchange of information
- HIPAA regulations prevented access to or exchange of information
- Inadequate investigation precluded having enough information for review
- Team members did not bring adequate information to the meeting
- Necessary team members were absent
- Meeting was held too soon after death
- Meeting was held too long after death
- Records or information were needed from another locality in-state
- Records or information were needed from another state
- Team disagreement on circumstances
- Other factors, specify:

7. Review meeting outcomes, check all that apply:

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

8. Describe the factor(s) that directly contributed to this death:

9. Which of the factors that directly contributed to this death are modifiable?

10. List any recommendations to prevent deaths from similar causes or circumstances in the future:

11. What additional information would the team like to know about the death scene investigation?

12. What additional information would the team like to know about the autopsy?

**M. 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.

Continue narrative if necessary on next page

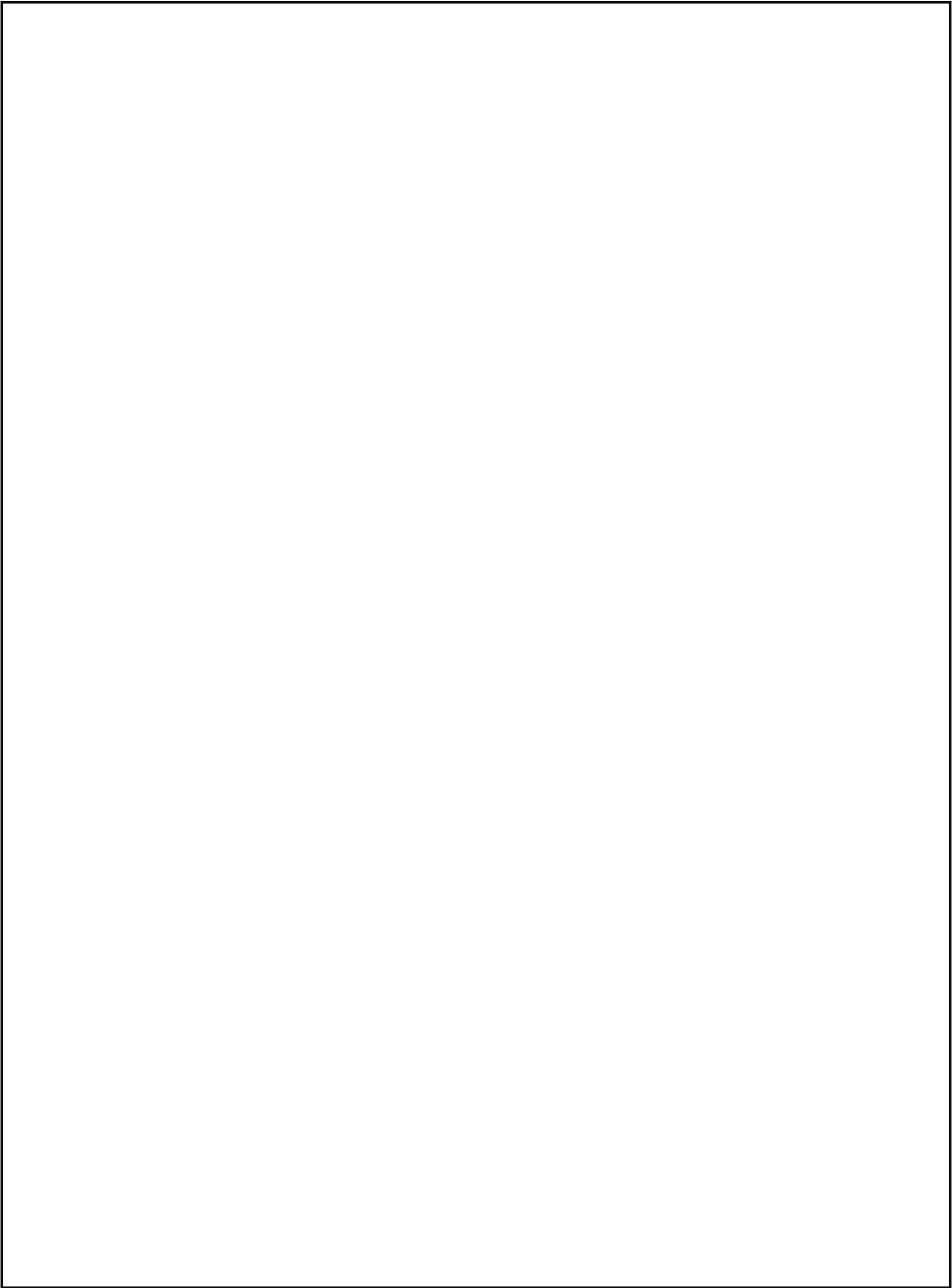
**N. FORM COMPLETED BY:**

PERSON:  
TITLE:  
AGENCY:  
PHONE:

EMAIL:  
DATE COMPLETED:  
DATA ENTRY COMPLETED FOR THIS CASE?

For State Program Use Only:  
DATA QUALITY ASSURANCE COMPLETED BY STATE

## NOTES





The development of this report tool was supported, in part, by Grant No. U49MC00225  
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 funding from the US Centers for Disease Control and Prevention, Division of Reproductive Health

Data Entry: <https://cdrdata.org>  
[www.childdeathreview.org](http://www.childdeathreview.org)  
For help, email: [info@childdeathreview.org](mailto:info@childdeathreview.org)  
1-800-656-2434