FIMR Report Form

National Fatality Review

Case Reporting System

Version 5.1


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

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

SAVING LIVES TOGETHER

Instructions:

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

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

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

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

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

Reminder:

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

Additional paper forms can be ordered from the NCFRP at no charge. Users interested in participating in the NFR-CRS for data entry and reporting should contact the NCFRP.

CASE NUMBER

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

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

☐ Child never left hospital following birth

Death Certificate Number:
Birth Certificate Number:
ME/Coroner Number:
Date Team Notified of Death:

A. CHILD INFORMATION

A1. CHILD INFORMATION (COMPLETE FOR ALL AGES)

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

2. Date of birth: ☐ U/K
mm dd yyyy

3. Date of death: ☐ U/K
mm dd yyyy

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

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

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

7. Sex:
○ Male ○ Female ○ U/K

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

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

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

11. State of death:

12. County of death:

13. Child had disability or chronic illness? ○ Yes ○ No ○ U/K
If yes, check all that apply:
☐ Physical/orthopedic, specify:
☐ Mental health/substance abuse, specify:
☐ Cognitive/intellectual, specify:
☐ Sensory, specify:
☐ U/K

If yes, was child receiving Children's Special Health Care Needs services?
○ Yes ○ No ○ U/K

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

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

16. Was the child up to date with the Centers for Disease Control and Prevention (CDC) immunization schedule?
○ NA ○ Yes ○ No, specify: ○ U/K

If the child never left the hospital following birth, go to Section A3.

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

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

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

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

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

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

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

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

If through CPS:

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

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

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

25. How many months prior to death did child last have contact with a health care provider? ____

A3. COMPLETE FOR ALL FETAL/INFANTS UNDER ONE YEAR

Questions 26 - 41 (Section A2) are intentionally skipped.

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

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

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

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

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

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

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

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

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

- ☐ Lack of money for care
- ☐ Limitations of health insurance coverage
- ☐ Lack of transportation
- ☐ No phone
- ☐ Cultural differences
- ☐ Language barriers
- ☐ Couldn't get provider to take as patient
- ☐ Multiple providers, not coordinated
- ☐ Couldn't get an earlier appointment
- ☐ Lack of child care
- ☐ Lack of family/social support
- ☐ Services not available
- ☐ Distrust of health care system
- ☐ Unwilling to obtain care
- ☐ Didn't know where to go
- ☐ Didn't think she was pregnant
- ☐ Other, specify:
- ☐ U/K

52. Did the mother experience any medical complications in previous pregnancies? ○ N/A ○ Yes ○ No ○ U/K If yes, check all that apply:

- ☐ Previous preterm birth
- ☐ Previous low birth weight birth
- ☐ Previous small for gestational age
- ☐ Previous large for gestational age (greater than 4000 grams)

53. Did the mother use any medications, drugs or other substances during pregnancy? ○ Yes ○ No ○ U/K If yes, check all that apply:

- ☐ Over-the-counter meds
- ☐ Allergy medications
- ☐ Antibiotics
- ☐ Anti-flu/antivirals
- ☐ Anti-depressants/anti-anxiety/anti-psychotics
- ☐ Anti-epileptic
- ☐ Anti-hypertensives
- ☐ Anti-hypothyroidism
- ☐ Arthritis medications
- ☐ Diabetes medications
- ☐ Asthma medications
- ☐ Nausea/vomiting medications
- ☐ Cholesterol medications
- ☐ Sleeping pills
- ☐ Meds to treat preterm labor
- ☐ Meds used during delivery
- ☐ Progesterone/P17
- ☐ Cocaine
- ☐ Heroin
- ☐ Marijuana
- ☐ Methamphetamine
- ☐ Alcohol
- ☐ If alcohol, infant born with fetal effects or syndrome?
- ☐ Meds to treat drug addiction
- ☐ Opioids
- ☐ Other pain meds
- ☐ Other, specify:
- ☐ U/K

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

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

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

56. Level of birth hospital:

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

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

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

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

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

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

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

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

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

62. Did the mother use e-cigarettes or other electronic nicotine products at any time during pregnancy? ○ Yes ○ No ○ U/K

If yes, on average how often? ○ More than once a day ○ Once a day ○ 2-6 days a week ○ 1 day a week or less ○ U/K

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

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

If this was a fetal death, go to Section A4.

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

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

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

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

If the infant never left the hospital following birth, go to Section A4.

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

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

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

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

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

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

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

72. What did the infant have for his/her last meal? Check all that apply:

- ☐ Breast milk
- ☐ Formula, type:
- ☐ Baby food, type:
- ☐ Cereal, type:
- ☐ Other, specify:
- ☐ U/K

A4. FIMR DETAIL FOR ALL INFANTS UNDER ONE YEAR

73. Mother's name: First: Middle: Last: Maiden: ☐ U/K

74. Father's name: First: Middle: Last: ☐ U/K

75. Mother's country of birth: ☐ U/K

76. Father's country of birth: ☐ U/K

77. Mother's residence address: ☐ Same as child ☐ U/K
Street: Apt.
City:
State: Zip: County:

78. Mother's marital status during pregnancy:
◯ Single ◯ Separated
◯ Married ◯ Widowed
◯ Divorced ◯ U/K

79. Number of months between prior pregnancy and this one: ☐ U/K

80. Was mother taking folic acid or a multivitamin prior to this pregnancy?
◯ Yes ◯ No ◯ U/K

81. Mother's employment during pregnancy:
◯ Employed
◯ Unemployed
◯ Student
◯ On disability
◯ Stay-at-home
◯ U/K

If employed, did she think it was physically hard? ◯ Yes ◯ No ◯ U/K

If employed, did she think the job was stressful? ◯ Yes ◯ No ◯ U/K

If employed or student, number of weeks post-delivery started or returned:

If employed or student, who watched the infant? Describe:

82. Mother's pre-pregnancy weight, height, BMI:
Weight in pounds (whole number): lbs ☐ U/K
Height in feet and inches (whole numbers): ft in ☐ U/K
BMI will be calculated automatically if both height and weight are available.
If you don't have height and weight but know the mother's prepregnancy BMI, you can enter it:

83. Mother's pregnancy weight gain or loss in pounds (whole number)
Enter a negative number for weight loss: lbs ☐ U/K

84. Did mother achieve the recommended weight gain? ◯ Yes ◯ No ◯ U/K

85. Mother's age at first pregnancy: ☐ U/K

86. For each previous pregnancy, describe most recent first: ☐ N/A

Preg #	# in gest. (twins=2)	Baby A, B, C, etc	Year of Delivery	Maternal Age	Gestational age in weeks	Birth weight (grams)	Choose one: NSVD	C-Sec	VBAC	Other	Outcome Code*
							Y	Y	Y	Y	
							Y	Y	Y	Y	
							Y	Y	Y	Y	
							Y	Y	Y	Y	
							Y	Y	Y	Y	
							Y	Y	Y	Y	
							Y	Y	Y	Y	

*Outcome Codes:
1 - Full-term, live birth
2 - Premature live birth
3 - Stillbirth > or = 20 weeks
4 - Spontaneous abortion/ miscarriage/ Stillbirth < 20 weeks
5 - Therapeutic abortion
6 - Voluntary abortion
7 - Ectopic
9 - U/K

87. Was mother using birth control in the 3 months prior to this pregnancy?
◯ Yes ◯ No ◯ U/K

If yes, what type?
◯ LARC including implants/IUDs
◯ Oral contraceptives, specify:
◯ Barrier methods (male/female condoms/cervical cap)
◯ Injections (Depo Provera)
◯ Spermicides
◯ Natural, withdrawal, pull out rhythm method
◯ Tubal ligation
◯ Multiple methods
◯ Other, specify:
◯ U/K

If no, was pregnancy: ◯ Unintended ◯ Intended ◯ Mistimed ◯ U/K

88. Where was prenatal care most frequently provided for this pregnancy?
◯ N/A
◯ Private provider's office
◯ County or city health department
◯ Clinic
◯ Managed care organization
◯ Community/neighborhood health center
◯ Other, specify type:
◯ U/K

89. Which type of provider most frequently provided prenatal care for this pregnancy?
◯ N/A
◯ Nurse practitioner
◯ OB
◯ Nurse midwife
◯ Perinatologist
◯ Family physician
◯ Other, specify type:
◯ U/K

90. Was this pregnancy a result of assisted reproductive technology? ◯ Yes ◯ No ◯ U/K If yes, describe:

91. Which of the following tests were performed during this pregnancy?

Performed Y N U/K	Normal/Abnormal? N A U/K	
◯ ◯ ◯	◯ ◯ ◯	CBC
◯ ◯ ◯	◯ ◯ ◯	GTT
◯ ◯ ◯	◯ ◯ ◯	HCT/HGB
◯ ◯ ◯	◯ ◯ ◯	Quad screen, specify abnormal results:
		Antepartum fetal surveillance
◯ ◯ ◯	◯ ◯ ◯	Fetal movement assessment (kick counts)
◯ ◯ ◯	◯ ◯ ◯	Contraction stress test
◯ ◯ ◯	◯ ◯ ◯	Nonstress test
◯ ◯ ◯	◯ ◯ ◯	Biophysical profile

Performed Y N U/K	Normal/Abnormal? N A U/K	
◯ ◯ ◯	◯ ◯ ◯	Measurement of cervical length
◯ ◯ ◯	◯ ◯ ◯	Maturity (L/S ratio)
◯ ◯ ◯	◯ ◯ ◯	Pap smear
◯ ◯ ◯	◯ ◯ ◯	Sickle prep or equivalent
◯ ◯ ◯	◯ ◯ ◯	Ultrasound
◯ ◯ ◯	◯ ◯ ◯	TORCH
◯ ◯ ◯	◯ ◯ ◯	Urine culture
Performed		
◯ ◯ ◯		Rubella titer
		If Rubella titer performed: ◯ Immune ◯ Not immune ◯ U/K

Performed Y N U/K	Positive or negative? P N U/K	
◯ ◯ ◯	◯ ◯ ◯	Antibody screen
◯ ◯ ◯	◯ ◯ ◯	STI culture or test
◯ ◯ ◯	◯ ◯ ◯	Urine toxicology
		If positive, for what?
Performed		
◯ ◯ ◯		Blood type and Rh factor
		If yes, what was blood type?
		If yes, was mother Rh negative? ◯ Yes ◯ No ◯ U/K
◯ ◯ ◯		Other, specify test and results (abnormal/positive/etc.):

92. Did mother receive the following vaccinations during pregnancy? ☐ Tdap ☐ Seasonal flu

93. During this pregnancy and including any previous pregnancies, did the mother have any medical conditions/complications? ○ Yes ○ No ○ U/K

Timeframe

1 - Began previous to this pregnancy and includes previous pregnancies - not current pregnancy
2 - Began previous to this pregnancy AND includes current pregnancy
3 - Began during this current pregnancy
4 - Began during labor and delivery
9 - U/K

Referrals during this pregnancy

1 - No referral, not needed
2 - No referral, already in care
3 - No referral, needed
4 - Referral made, no follow through by mother
5 - Referral made, mother followed through
6 - Referral made, mother followed through, provider did not follow through
9 - U/K

If yes, check all that apply:

	Timeframe	Referral
Cardiovascular		
☐ Hypertension - gestational		
☐ Hypertension - chronic		
☐ Pre-eclampsia		
☐ Eclampsia		
☐ Clotting disorder		
Hematologic		
☐ Folic acid deficiency		
☐ Sickle cell disease		
☐ Anemia (iron deficiency)		
Respiratory		
☐ Asthma		
☐ Pulmonary embolism		
Endocrine/Metabolic		
☐ Diabetes, type 1 chronic		
☐ Diabetes, type 2 chronic		
☐ Diabetes, gestational		
☐ Thyroid		
☐ Polycystic ovarian disease		
Neurologic/Psychiatric		
☐ Addiction disorder		
☐ Eating disorder		
☐ Depression		
☐ Anxiety disorder		
☐ Seizure disorder		
Sexually Transmitted Infections (STI)		
☐ Bacterial vaginosis (BV)		
☐ Chlamydia		
☐ Gonorrhea		
☐ Herpes		
☐ HPV		
☐ Syphilis		
☐ Group B strep		
☐ HIV/AIDS		
☐ Other STI, specify:		

	Timeframe	Referral
Gynecologic		
☐ Uterine/vaginal bleeding		
☐ Chorioamnionitis		
☐ Oligohydramnios		
☐ Polyhydramnios		
☐ Intrauterine growth restriction (IUGR)		
☐ Premature rupture of membranes (PROM)		
☐ Preterm premature rupture of membranes (PPROM)		
☐ Incompetent cervix		
☐ Umbilical cord complications		
☐ Prolapse		
☐ Nuchal cord		
☐ Other cord, specify:		
☐ Placental problems		
☐ Abruption		
☐ Previa		
☐ Other placental, specify:		
Other Complications/Conditions		
☐ UTI		
☐ Decreased fetal movement		
☐ HELLP syndrome		
☐ Maternal developmental delay		
☐ Oral health/dental or gum Infection		
☐ Gastrointestinal		
☐ Maternal genetic disorder		
☐ Abnormal MSAFP		
☐ Preterm labor		
☐ Other, specify:		

94. Did the care provider recommend precautions to prevent premature labor or early labor? ○ Yes ○ No ○ U/K

If yes, what precautions?

- ☐ Took medicine to prevent labor or miscarriage
- ☐ Received progesterone IM or vaginal progesterone
- ☐ Stopped or limited sex during pregnancy
- ☐ Used condoms to prevent infection
- ☐ Doctor sewed the cervix closed (cerclage of incompetent cervix)
- ☐ Had bed rest for one or more weeks at home
  - Was mother able to comply? ○ Yes ○ No ○ U/K
- ☐ Was hospitalized for one or more nights
- ☐ Reduced work hours or stopped working earlier than expected
- ☐ Reduced housework or other physical activities
- ☐ Other, specify:

95. Type of delivery:

- ☐ Routine
- ☐ Emergency
- ☐ Normal spontaneous vaginal delivery (NSVD)
- ☐ Vaginal, induced or augmented
- ☐ Vaginal delivery after C-Section (VBAC)
- ☐ C-Section
- ☐ Forceps
- ☐ Vacuum extraction
- ☐ U/K

If C-Section, why was it done?

- ☐ Failure to progress
- ☐ Fetal distress
- ☐ Macrosomia
- ☐ Placental abruption
- ☐ Placental Previa
- ☐ Malpresentation
- ☐ Repeat C-Section
- ☐ Other, specify:
- ☐ U/K

96. Were there any signs of fetal distress? ○ Yes ○ No ○ U/K

If yes, specify:

97. Were any birth defects noted? ○ Yes ○ No ○ U/K

If yes, specify:

98. Date of mother's discharge from the birth hospital: ○ N/A ○ U/K

____/____/_____

mm / dd / yyyy

99. Was there evidence of injury at death, not including the birth process? ○ Yes ○ No ○ U/K

If yes, what type(s) of injury?

- ☐ Contusion/bruises
- ☐ Abrasions/scratches
- ☐ Fractures
- ☐ Resuscitative marks
- ☐ Cigarette burns
- ☐ Other, specify:
- ☐ Hemorrhage

100. Was a placental pathology performed? ○ Yes ○ No ○ U/K

If yes, describe findings:

101. Payer source for mother's care for the following timeframes (check all that apply):

	Pre	Preg	L&D	Post
None	☐	☐	☐	☐
Private insurance	☐	☐	☐	☐
Medicaid	☐	☐	☐	☐
State plan	☐	☐	☐	☐
Indian Health Service	☐	☐	☐	☐
Other, specify:	☐	☐	☐	☐
U/K	☐	☐	☐	☐

102. Did the mother have stable housing during the pregnancy? ○ Yes ○ No ○ U/K

If no, indicate the type(s) of instability:

- ☐ Mother in jail
- ☐ Homeless
- ☐ Eviction(s)
- ☐ More than 3 moves in past year
- ☐ Other, specify:
- ☐ U/K

103. Did the mother have phone service during the pregnancy?

- ○ Never
- ○ Rarely
- ○ Sometimes
- ○ Most of the time
- ○ Always
- ○ U/K

104. Did the mother have any high-risk prenatal/antepartum encounters? ○ Yes ○ No ○ U/K

If yes, number of visits with primary care provider: _____

If yes, number of L&D/triage/ED visits, excluding the birth: _____

105. Did the mother have any hospitalizations greater than 24 hours prior to labor and delivery excluding the birth? ○ Yes ○ No ○ U/K

If yes, what treatment was recommended?

106. Were any health education topics discussed at any time between the first prenatal care visit and the delivery? ○ Yes ○ No ○ U/K

If yes, which topic(s)?

- ☐ Maternal signs/symptoms that warrant medical attention
- ☐ Where to go for care in case of maternal emergency
- ☐ Current medications
- ☐ Environmental/work hazards
- ☐ Maternal nutrition
- ☐ Weight gain counseling
- ☐ Eating disorders such as anorexia or bulimia
- ☐ Exercise
- ☐ Labor signs
- ☐ Signs and symptoms of pregnancy-induced hypertension
- ☐ HIV testing
- ☐ Mother's vaccinations
- ☐ Risk factors identified by prenatal history
- ☐ Tobacco (Ask, Advise, Assess, Assist, and Arrange)
- ☐ Illicit/recreational drugs
- ☐ Fetal movement monitoring
- ☐ Kick counts
- ☐ Choosing how to feed infant/benefits of breastfeeding
- ☐ Preparing to breastfeed
- ☐ Safe sleep education
- ☐ Importance of keeping postpartum visits
- ☐ Postpartum (perinatal) depression
- ☐ Family planning (spacing, interconception care, etc.)
- ☐ Postpartum family planning/tubal sterilization
- ☐ Other, specify:

107. Were any health education topics discussed at any time between mother's admission and discharge from the birth hospital? ○ Yes ○ No ○ U/K

If yes, which topic(s)?

- ☐ Maternal signs/symptoms that warrant medical attention
- ☐ Where to go for care in case of maternal emergency
- ☐ Current medications
- ☐ Maternal nutrition
- ☐ Eating disorders such as anorexia or bulimia
- ☐ Exercise
- ☐ HIV testing
- ☐ Mother's vaccinations
- ☐ Tobacco (Ask, Advise, Assess, Assist, and Arrange)
- ☐ Illicit/recreational drugs
- ☐ Choosing how to feed infant/benefits of breastfeeding
- ☐ Breastfeeding education
- ☐ Bottle feeding education
- ☐ Safe sleep education
- ☐ Importance of keeping postpartum visits
- ☐ Postpartum (perinatal) depression
- ☐ Family planning (spacing, interconception care, etc.)
- ☐ Postpartum family planning/tubal sterilization
- ☐ Interconception care
- ☐ Other, specify:

108. Were any infant safety topics discussed at any time between the first prenatal care visit and mother's discharge from the birth hospital? ○ Yes ○ No ○ U/K

If yes, which topic(s)?

- ☐ Bath safety
- ☐ Infant care
- ☐ Infant signs/symptoms that warrant medical attention
- ☐ Maternal signs/symptoms that warrant medical attention
- ☐ Parenting skills
- ☐ Protection from falls
- ☐ Abusive Head Trauma/Shaken Baby Syndrome
- ☐ SUID/Safe sleep education
- ☐ Small object avoidance
- ☐ Use of home smoke detector
- ☐ Use of infant car seat
- ☐ Where to go for care in case of infant emergency
- ☐ Other, specify:

109. Did the mother experience any stressors during her pregnancy? ○ Yes ○ No ○ U/K

If yes, which one(s)?

- ☐ A close family member was very sick
- ☐ Separated or divorced from her husband/partner
- ☐ She lost her job
- ☐ Husband/partner lost his job
- ☐ She and her husband/partner argued more than usual
- ☐ Her husband/partner said he did not want her to be pregnant
- ☐ Financial problems
- ☐ Involved in a physical fight
- ☐ She or her husband/partner went to jail
- ☐ Someone very close to her had a problem with drinking alcohol or drugs
- ☐ Physical abuse
- ☐ Sexual abuse
- ☐ Emotional abuse
- ☐ Someone very close to her died
- ☐ Afraid of violence in her neighborhood
- ☐ Other, specify:

110. Was the mother a victim of intimate partner violence?

Mother as victim:	Y	N	U/K	Referral*
Preconception	○	○	○	
Pregnancy	○	○	○	
Postpartum	○	○	○	

* Referral key:

1 - No referral, not needed
2 - No referral, already in service
3 - No referral, needed
4 - Referral made, no follow up by mother
5 - Referral made, mother followed through
6 - Referral made, mother followed through, provider did not follow through
9 - U/K

111. Was the family referred to any health or human services program during or after the pregnancy? ○ Yes ○ No ○ U/K

If any of these are checked, note whether a referral was made using the following responses:

Referral options: 1 - Referral made, no follow through by mother; 2 - Referral made, mother followed through; 3 - Referral made, mother followed through but provider did not follow through; 9 - U/K

☐ Case management	Referral:	☐ Drug treatment program	Referral:
☐ Infant/child health program	Referral:	☐ Smoking cessation program	Referral:
☐ Child Protection Services	Referral:	☐ Alcohol cessation program	Referral:
☐ Legal aid	Referral:	☐ Housing authority	Referral:
☐ Evidence-based home visiting	Referral:	☐ Shelters	Referral:
☐ Family planning	Referral:	☐ Unemployment assistance	Referral:
☐ Mental health service	Referral:	☐ Homemaker/home health aide	Referral:
☐ Infant mental health program	Referral:	☐ Medicaid	Referral:
☐ Genetic evaluation/counseling	Referral:	☐ WIC	Referral:
☐ GED programs	Referral:	☐ TANF	Referral:
☐ Children's Special Health Care Needs services	Referral:	☐ SNAP	Referral:

112. At any time before or during pregnancy or until the infant's death, did the family experience any difficulties in obtaining, communicating, processing, or understanding basic health information and services in order to make informed health decisions? ○ Yes ○ No ○ U/K

If this was a fetal death, go to Section A5.

113. Apgar: 1 min: 5 min: 10 min: ☐ U/K

114. Were neonatal resuscitation measures required or attempted in delivery room? ○ Yes ○ No ○ U/K

If yes, which measure(s)?

- ☐ Physical stimulation
- ☐ Intubation
- ☐ Respiratory or cardiac meds for resuscitation
- ☐ Oxygen
- ☐ Other, specify:

115. Disposition from delivery room, did the infant go to:

- ☐ Normal newborn nursery
- ☐ Rooming in
- ☐ Observation/special care nursery (NICU, intensive care or premature nursery)
  - If yes, admitting diagnosis:
- ☐ Transferred to another hospital
- ☐ Other, specify:
- ☐ U/K

116. Were there morbidities noted during the nursery stay? ○ N/A ○ Yes ○ No ○ U/K

If yes, what were they?

- ☐ Perinatal asphyxia
- ☐ Respiratory distress syndrome
- ☐ Convulsion
- ☐ Hypoglycemia (<40)
- ☐ Neonatal sepsis
  - If yes, specify:
- ☐ Anemia due to fetal hemorrhage
- ☐ Perinatal STI infection
  - If yes, specify:
- ☐ Hemolysis
  - If yes, due to: ○ RH ○ ABO ○ Other
  - If other, specify:
- ☐ Hypothermia
- ☐ Hypotonia
- ☐ Temperature instability
- ☐ Delayed feeding adequacy
- ☐ Jaundice
  - If yes, specify highest bilirubin level:
- ☐ Birth injury such as bruising, peripheral nerve damage, cephalohematoma, fractures
  - If yes, specify:
- ☐ Other, specify:

117. Was a urine or meconium toxicology done on the infant? ○ Yes ○ No ○ U/K

If yes, were the results positive or negative? ○ Positive ○ Negative ○ U/K

If positive, for what?

- ☐ Alcohol, including ethanol and methanol
- ☐ Amphetamines
- ☐ Barbiturates
- ☐ Benzodiazepines
- ☐ Marijuana/THC
- ☐ Methadone
- ☐ Cocaine
- ☐ Opioids, codeine, oxycodone
- ☐ Heroin
- ☐ Phencyclidine (PCP)
- ☐ Other, specify:
- ☐ U/K

If the infant never left the hospital following birth, go to Section A5.

118. Date of infant's last discharge from any hospital: ____/____/_____ ☐ U/K

119. Total number of days infant hospitalized: ☐ U/K

120. Infant's disposition (after birth, from any hospital):

○ Home with parents ○ Other, specify: ○ U/K

121. Did the infant have a primary care provider? ○ Yes ○ No ○ U/K

122. Were any medications prescribed for the infant at any discharge?

○ Yes ○ No ○ U/K

If yes, specify:

If yes, were parents instructed in medication administration?

○ Yes ○ No ○ U/K

123. Was the infant technologically dependent on discharge from any hospital visit?

○ Yes ○ No ○ U/K

If yes, describe:

124. After the infant came home from the hospital after delivery, did s/he have to go back into the hospital overnight for any reason?

○ Yes ○ No ○ U/K

If yes, how many nights was the infant in the hospital?

Number of nights: _____ ☐ U/K

If yes, how old was the infant when admitted to the hospital for the last time?

Number of weeks: _____ ☐ U/K

125. Number of outpatient/ambulatory infant encounters : _____ Of these, how many were well child visits?: _____

List encounters. One line per visit. Maximum 12 encounters. Enter those encounters closest to the death if greater than 12.

Who saw infant: Primary Care Physician; Urgent Care; Emergency Department; Other

Age in months: Enter 0 for infants under 30 days. For reviews of children greater than 12 months old, enter "> 12 m"

Who saw infant	Age in months	Reason for visit	Recommended treatment

A5. FIMR MATERNAL INTERVIEW

126. Was a home interview conducted? ○ Yes ○ No, go to Section B

127. Does the mother expect to have any more children?

○ Yes ○ No ○ U/K

If yes, how many? _____ ☐ U/K

When: ☐ U/K

128. Was the mother currently pregnant at time of maternal interview?

○ Yes ○ No ○ U/K

If no, is she currently using birth control?

○ Yes ○ No ○ U/K

If yes, describe type of birth control:

129. How does the mother remember feeling about becoming pregnant?

○ Wanted to be pregnant sooner
○ Wanted to be pregnant later
○ Wanted to be pregnant then
○ Didn't want to be pregnant then or at any time in the future
○ U/K

130. How does the mother describe the time just before her pregnancy?

○ One of the happiest times of her life
○ A happy time with a few problems
○ A moderately hard time
○ A very hard time
○ One of the worst times of her life
○ U/K

131. Did the mother feel she had family or friends who could help with the infant at home?

○ Yes ○ No ○ U/K

If yes, specify who:

132. In the months prior to the infant's death, how often did the mother feel that daily activities were overwhelming?

○ Never ○ Sometimes ○ Very often
○ Almost never ○ Fairly often ○ U/K

133. In the months prior to the infant's death, how often did the mother say that she felt very sad?

○ Never ○ Fairly often
○ Almost never ○ Very often
○ Sometimes ○ U/K

134. According to the mother, was the infant in the same room with someone who was smoking?

○ Yes ○ No ○ U/K

If yes, number of hours per day, maximum 24:

135. According to the mother, did she have a crib, Pack 'n Play, bassinet, bed side sleeper or baby box for the infant? ○ Yes ○ No ○ U/K

If yes, how often did the infant sleep in it?

○ Always ○ Usually ○ Half the time ○ Occasionally ○ Never ○ U/K

If anything other than "always," describe where else the infant slept:

136. Did the mother feel that her infant was ever treated differently or unfairly in getting services? ○ Yes ○ No ○ U/K

If yes, for what reasons?

☐ Race ☐ Marital status ☐ Other, specify:
☐ Culture/ethnic background ☐ Type of insurance
☐ Citizenship status ☐ Ability to pay ☐ U/K

137. How supportive was the father toward the mother during the pregnancy?

○ Not involved ○ Supportive ○ Unsupportive ○ U/K

138. How satisfied was the mother with the father's contribution(s) toward her or the infant's financial support?

○ Very satisfied ○ Somewhat satisfied ○ Not satisfied ○ U/K

139. Were any of the following identified as psychosocial or lifestyle problems experienced by the mother AT ANY TIME in her life, as a child herself, before or during pregnancy or while the infant was still alive?

Mother as a child: ○ Yes ○ No ○ U/K

If yes, which one(s):

☐ Housing inadequate/homeless
☐ Food insecurity
☐ Mother treated violently
☐ Parents or caregiver with substance abuse problem
☐ Parents or caregiver problem drinkers
☐ Parents or caregiver with mental health problems
☐ Parental separation or divorce
☐ Incarcerated household member

Current (during pregnancy or after the birth): ○ Yes ○ No ○ U/K

If yes, which one(s):

☐ Disturbed mother/infant relationship
☐ Mother-physical/developmental disability
☐ Husband/partner-physical/developmental disability
☐ Mother-employment/education needs
☐ Husband/partner-employment/education needs
☐ Inadequate support system
☐ Mother or husband/partner felt "stereotyped" or profiled due to race, gender, class, etc.

140. Did the mother feel that she was ever treated differently or unfairly in getting services? ○ Yes ○ No ○ U/K

If yes, for what reasons?

☐ Race ☐ Type of insurance
☐ Culture/ethnic background ☐ Ability to pay
☐ Citizenship status ☐ Other, specify:
☐ Marital status ☐ U/K

141. During the mother's recent pregnancy, did the mother have others who would have helped her if a problem had come up? (For example, needed a ride to the clinic or needed to borrow money.) ○ Yes ○ No ○ U/K

If yes, describe who would have helped (husband/partner, friend, mother/in-laws, other family, etc.)

142. Did the father experience any stressors during mother's pregnancy? ○ Yes ○ No ○ U/K

If yes, which one(s)?

☐ Work or employment problems ☐ Housing problems ☐ Problems with children or other relatives ☐ Other, specify:
☐ Problems with drugs or alcohol ☐ Emotional problems ☐ Problems with the law
☐ Money problems ☐ A death in the family ☐ Health problems

If fetal death or the infant never left the hospital following birth, go to Section B

143. Did the infant ever have an illness for which they weren't seen or treated? ○ Yes ○ No ○ U/K

If yes, what were the barriers?

☐ Lack of money for care ☐ Couldn't get provider to take as a patient ☐ Distrust of health care system
☐ Limitations of health insurance coverage ☐ Multiple providers, not coordinated ☐ Unwilling to obtain care
☐ Lack of transportation ☐ Couldn't get an earlier appointment ☐ Didn't know where to go
☐ No phone ☐ Lack of child care (other children) ☐ Other, specify:
☐ Cultural differences ☐ Lack of family/social support ☐ U/K
☐ Language barriers ☐ Services not available

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B. BIOLOGICAL PARENT INFORMATION

○ No information available, go to Section C

1. Parents alive on date of child's death? Even if parent(s) are deceased at time of child's death, please fill out the remaining questions.

	Yes	No	U/K
Female	○	○	○
Male	○	○	○

2. Parents' race, check all that apply:

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

3. Parents' Hispanic or Latino origin?

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

4. Parents' age in years at time of child's death:

Female	Male	
_____	_____	# Years
☐	☐	U/K

5. Parents' employment status:

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

6. Parents' income:

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

7. Parents' education:

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

8. Parents speak and understand English?

Female	Male	
○	○	Yes
○	○	No
○	○	U/K

If no, language spoken:

9. Parents first generation immigrant?

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

10. Parents on active military duty?

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

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

Female	Male	
○	○	Yes
○	○	No
○	○	U/K

If yes, check all that apply:

Female	Male		Female	Male	
☐	☐	WIC	☐	☐	Section 8/housing
☐	☐	Home visiting, specify:	☐	☐	Social Security Disability Insurance (SSI/SSDI)
☐	☐	TANF	☐	☐	Other, specify:
☐	☐	Medicaid			
☐	☐	Food stamps/ SNAP/EBT	☐	☐	U/K

12. Parents have substance abuse history?

Female	Male	
○	○	Yes
○	○	No
○	○	U/K

If yes, check all that apply:

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

13. Parents ever victim of child maltreatment?

Female	Male	
○	○	Yes
○	○	No
○	○	U/K

If yes, check all that apply:

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

14. Parents ever perpetrator of maltreatment?

Female	Male	
○	○	Yes
○	○	No
○	○	U/K

If yes, check all that apply:

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

15. Parents have disability or chronic illness?

Female	Male	
○	○	Yes
○	○	No
○	○	U/K

If yes, check all that apply:

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

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

○	○	Yes
○	○	No
○	○	U/K

16. Parents have prior child deaths?

Female	Male	
○	○	Yes
○	○	No
○	○	U/K

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

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

17. Parents have history of intimate partner violence?

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

18. Parents have delinquent/criminal history?

Female	Male	
○	○	Yes
○	○	No
○	○	U/K

If yes, check all that apply:

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

C. PRIMARY CAREGIVER(S) INFORMATION

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

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

2. Caregiver(s) age in years:

One	Two	
_____	_____	# Years
☐	☐	U/K

3. Caregiver(s) sex:

One	Two	
○	○	Male
○	○	Female
○	○	U/K

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

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

5. Caregiver(s) Hispanic or Latino origin?

One	Two	
○	○	Yes
○	○	No
○	○	U/K

If yes, specify origin:

6. Caregiver(s) employment status:

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

7. Caregiver(s) income:

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

8. Caregiver(s) education:

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

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

One	Two	
○	○	Yes
○	○	No
○	○	U/K

If no, language spoken:

10. Caregiver(s) first generation immigrant?

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

11. Caregiver(s) on active military duty?

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

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

One	Two		One	Two	
○	○	Yes If yes, check all that apply below:			
○	○	No			
○	○	U/K			
☐	☐	WIC	☐	☐	Food stamps/SNAP/EBT
☐	☐	Home visiting	☐	☐	Section 8/housing
		specify:	☐	☐	Soc Sec Disability (SSI/SSDI)
☐	☐	TANF	☐	☐	Other, specify:
☐	☐	Medicaid	☐	☐	U/K

13. Caregiver(s) have substance abuse history?

One	Two	
○	○	Yes
○	○	No
○	○	U/K

If yes, check all that apply:

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

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

One	Two	
○	○	Yes
○	○	No
○	○	U/K

If yes, check all that apply:

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

15. Caregiver(s) ever perpetrator of maltreatment?

One	Two	
○	○	Yes
○	○	No
○	○	U/K

If yes, check all that apply:

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

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

One	Two	
○	○	Yes
○	○	No
○	○	U/K

If yes, check all that apply:

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

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

○	○	Yes
○	○	No
○	○	U/K

17. Caregiver(s) have prior child deaths?

One	Two	
○	○	Yes
○	○	No
○	○	U/K

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

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

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

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

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

One	Two	
○	○	Yes
○	○	No
○	○	U/K

If yes, check all that apply:

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

D. SUPERVISOR INFORMATION

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

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

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

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

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

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

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

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

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

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

10. Supervisor has history of child maltreatment?

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

If yes, check all that apply:

As Victim	As Perpetrator
☐	☐ Physical
☐	☐ Neglect
☐	☐ Sexual
☐	☐ Emotional/psychological
☐	☐ U/K
_____	_____# CPS referrals
_____	_____# Substantiations
☐	Ever in foster care/adopted
	☐ CPS prevention services
	☐ Family preservation services
	☐ Children ever removed

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

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

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

    Other, specify:
    - ☐ U/K

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

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

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

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

E. INCIDENT INFORMATION

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

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

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

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

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

5. Incident state:

6. Incident county:

7. Was the death attributed (either directly or indirectly) to an extreme weather event, emergency medical situation, natural disaster or mass shooting?

○ Yes ○ No ○ U/K If yes, specify the type of event (e.g., tornado, heat wave, flood, medical crisis, etc.) and general circumstances surrounding the death:

If yes, specify the name of the event if applicable (e.g., Paradise Wild Fire, Hurricane Irma, COVID-19, etc.):

8. Was the incident witnessed? ○ Yes ○ No ○ UK

If yes, by whom?

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

9. Was 911 or local emergency called?

○ N/A ○ Yes ○ No ○ U/K

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

If yes, by whom?

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

If yes, type of resuscitation:

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

If yes, was a rhythm recorded?

○ Yes ○ No ○ U/K

If yes, what was the rhythm?

_____

11. At time of incident leading to death, had child used drugs or alcohol?

○ N/A ○ Yes ○ No ○ U/K

If yes, check all that apply:

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

12. Child's activity at time of incident, check all that apply:

☐ Sleeping ☐ Working ☐ Driving/vehicle occupant ☐ U/K
☐ Playing ☐ Eating ☐ Other, specify:

13. Total number of deaths at incident event, including child:

_____ Children, ages 0-18 ○ U/K
_____ Adults

F. INVESTIGATION INFORMATION

1. Was a death investigation conducted? ○ Yes ○ No ○ U/K

If yes, check all that apply:

☐ Medical examiner ☐ ME investigator ☐ Law enforcement ☐ EMS ☐ Other, specify:
☐ Coroner ☐ Coroner investigator ☐ Fire investigator ☐ Child Protective Services ☐ U/K

If yes, which of the following death investigation components were completed?

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

If yes, was a death scene investigation conducted at the place of incident? ○ Yes ○ No ○ U/K

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

3. Death referred to:

○ Medical examiner ○ Not referred
○ Coroner ○ U/K

4. Person declaring official cause and manner of death:

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

5. Autopsy performed? ○ Yes ○ No ○ U/K

If yes, conducted by:
○ Forensic pathologist
○ Pediatric pathologist
○ General pathologist
○ Unknown type pathologist
○ Other physician
○ Other, specify:
○ U/K

If yes, was a specialist consulted during autopsy (cardiac, neurology, etc.)?

○ Yes ○ No ○ U/K If yes, specify specialist:

If no, why not (e.g. parent or caregiver objected)?

6. Were the following assessed either through the autopsy or through information collected prior to the autopsy? Please list any abnormalities/significant findings in F10.

Yes	No	U/K	Imaging:
○	○	○	X-ray - single
○	○	○	X-ray - multiple views
○	○	○	X-ray - complete skeletal series
○	○	○	Other imaging, specify (includes MRI, CT scan, photos of the brain, etc):

Yes	No	U/K	External Exam:
○	○	○	Exam of general appearance
○	○	○	Head circumference
			Other Autopsy Procedures:
○	○	○	Was a gross examination of organs done?
○	○	○	Were weights of any organs taken?

7. Were any of these additional tests performed at or prior to the autopsy? Please list any abnormalities/significant findings in F10.

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

8. Was any toxicology testing performed? ◯ Yes ◯ No ◯ U/K

If yes, what were the results? Check all that apply: ☐ Negative ☐ Alcohol ☐ Cocaine ☐ Marijuana ☐ Methamphetamine ☐ Opioids ☐ Too high Rx drug, specify: ☐ Too high OTC drug, specify: ☐ Other, specify: ☐ U/K

9. Was the child's medical history reviewed as part of the autopsy? ◯ Yes ◯ No ◯ U/K

If yes, did this include: Review of the newborn metabolic screen results? ◯ Yes ◯ No ◯ U/K ◯ Not performed

Review of neonatal CCHD screen results? ◯ Yes ◯ No ◯ U/K ◯ Not performed

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

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

12. Was there agreement between the cause of death listed on the autopsy report and on the death certificate? ◯ N/A ◯ Yes ◯ No ◯ U/K

If no, describe the differences:

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

14. Did any investigation find evidence of prior abuse? ◯ N/A ◯ Yes ◯ No ◯ U/K

If yes, from what source? Check all that apply:

☐ X-rays ☐ U/K
☐ Autopsy
☐ CPS review
☐ Law enforcement

15. CPS action taken because of death? ◯ N/A ◯ Yes ◯ No ◯ U/K

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

◯ Report screened out and not investigated
◯ Unsubstantiated
◯ Inconclusive
◯ Substantiated

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

☐ Voluntary services offered
☐ Voluntary services provided
☐ Court-ordered services provided
☐ Voluntary out of home placement
☐ Court-ordered out of home placement
☐ Children removed
☐ Parental rights terminated
☐ U/K

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

◯ No action
◯ License suspended
◯ License revoked
◯ Investigation ongoing
◯ Other, specify:
◯ U/K

G. OFFICIAL MANNER AND PRIMARY CAUSE OF DEATH

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

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

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

a.

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

b.

c.

d.

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

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

5. Official manner of death from the death certificate:

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

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

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

◯ Motor vehicle and other transport, go to H1
◯ Fire, burn, or electrocution, go to H2
◯ Drowning, go to H3
◯ Unintentional asphyxia, go to H4
◯ Assault, weapon or person's body part, go to H5
◯ Fall or crush, go to H6
◯ Poisoning, overdose or acute intoxication, go to H7
◯ Undetermined injury, go to I2
◯ Other cause, go to H9
◯ U/K, go to I2

◯ From a medical cause. Select one:

◯ Asthma/respiratory, specify and go to H8
◯ Cancer, specify and go to H8
◯ Cardiovascular, specify and go to H8
◯ Congenital anomaly, specify and go to H8
◯ COVID-19, go to H8
◯ Diabetes, go to H8
◯ HIV/AIDS, go to H8
◯ Influenza, go to H8
◯ Low birth weight, go to H8
◯ Malnutrition/dehydration, go to H8
◯ Neurological/seizure disorder, go to H8
◯ Pneumonia, specify and go to H8
◯ Prematurity, go to H8
◯ SIDS, go to H8
◯ Other infection, specify and go to H8
◯ Other perinatal condition, specify and go to H8
◯ Other medical condition, specify and go to H8
◯ Undetermined medical cause, go to H8
◯ U/K, go to H8

◯ Undetermined if injury or medical cause, go to I2

◯ U/K go to I2

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

H1. MOTOR VEHICLE AND OTHER TRANSPORT

a. Vehicles involved in incident:

Total number of vehicles: _____

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

b. Position of child:

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

If passenger, relationship of driver to child:

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

c. Causes of incident, check all that apply:

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

d. Collision type:

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

e. Driving conditions, check all that apply:

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

f. Location of incident, check all that apply:

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

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

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

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

h. Total number of occupants in vehicles:

In child's vehicle, including child:

☐ N/A, child was not in a vehicle

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

In other primary vehicle involved in incident:

☐ N/A, incident was a single vehicle crash

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

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

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

*If child seat, type:

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

H2. FIRE, BURN, OR ELECTROCUTION

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

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

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

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

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

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

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

If yes, person's age _____

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

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

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

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

If yes, specify:

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

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

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

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

If yes, describe in narrative.

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

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

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

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

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

Other, specify:

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

q. Suspected arson? ○ Yes ○ No ○ U/K

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

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

t. Other, describe in detail:

H3. DROWNING

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

o. Fence:

Describe type:

Fence height in ft _____

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

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

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

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

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

t. Local ordinance(s) regulating access to water?

○ Yes ○ No ○ U/K

If yes, rules violated?

○ Yes ○ No ○ U/K

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

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

w. For bathtub, child in a bathing aid?

○ Yes ○ No ○ U/K

If yes, specify type:

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

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

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

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

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

If yes, number of rescuers that drowned: _____

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

H4. UNINTENTIONAL ASPHYXIA

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

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

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

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

e. Was asphyxia an autoerotic event?

○ N/A ○ Yes ○ No ○ U/K

f. Was child participating in 'choking game' or 'pass out game'?

○ N/A ○ Yes ○ No ○ U/K

g. History of seizures?

○ Yes ○ No ○ U/K If yes, #_____

If yes, witnessed? ○ Yes ○ No ○ U/K

h. History of apnea?

○ Yes ○ No ○ U/K If yes, #_____

If yes, witnessed? ○ Yes ○ No ○ U/K

i. Was Heimlich Maneuver attempted?

○ Yes ○ No ○ U/K

H5. ASSAULT, WEAPON OR PERSON'S BODY PART

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

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

c. Firearm licensed?
- ○ Yes ○ No ○ U/K

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

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

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

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

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

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

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

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

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

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

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

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

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

p. Sex of person(s) handling weapon:

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

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

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

H6. FALL OR CRUSH

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

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

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

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

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

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

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

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

H7. POISONING, OVERDOSE OR ACUTE INTOXICATION

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

Source codes:
1 = Bought from dealer or stranger (Prescription or illicit only)
2 = Bought from friend or relative
3 = From friend or relative for free
4 = Took from friend or relative without asking
5 = Own prescription (Prescription only)
6 = Bought from store/pharmacy (OTC or other substances only)
7 = Other
9 = U/K

Prescription drug/source
- ☐ __ Antidepressant
- ☐ __ Pain medication (opioids)
- ☐ __ Pain medication (non-opioids)
- ☐ __ Methadone
- ☐ __ Other Rx, specify:

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

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

Illicit drugs/source
- ☐ __ Pain medication (opioids)
- ☐ __ Pain medication (non-opioids)
- ☐ __ Methadone
- ☐ __ Cocaine
- ☐ __ Heroin
- ☐ __ Other illicit drug, specify:

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

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

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

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

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

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

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

H8. MEDICAL CONDITION

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

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

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

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

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

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

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

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

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

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

H9. OTHER KNOWN INJURY CAUSE

Specify cause, describe in detail:

I. OTHER CIRCUMSTANCES OF INCIDENT - ANSWER RELEVANT SECTIONS

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

a. Incident sleep place:

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

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

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

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

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

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

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

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

d. Usual sleep place:

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

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

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

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

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

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

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

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

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

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

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

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

If fully or partially obstructed, describe obstruction in detail:

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

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

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

p. Was there a reliable, non-conflicting witness account of how the child was found? ○Yes ○No ○U/K

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

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

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

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

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

t. Is there a scene re-creation photo available for upload? ○Yes ○No If yes, upload here. Only one photo allowed.
Select photo that demonstrates position and location of child's body and airway (nose, mouth, neck, and chest). Size must be less than 6 mb and in .jpg or .gif format.

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

a. Describe product and circumstances:

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

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

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

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

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

a. Type of crime, check all that apply:

☐ Robbery/burglary	☐ Other assault	☐ Arson	☐ Illegal border crossing	☐ U/K
☐ Interpersonal violence	☐ Gang conflict	☐ Prostitution	☐ Auto theft	
☐ Sexual assault	☐ Drug trade	☐ Witness intimidation	☐ Other, specify:	

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

a. Did child abuse, neglect, poor or absent supervision or exposure to hazards cause or contribute to the child's death?
- ◯ Yes/probable
- ◯ No, go to next section
- ◯ U/K, go to next section

If yes/probable, choose primary reason:
- ◯ Child abuse, go to I5b
- ◯ Child neglect, go to I5f
- ◯ Poor/absent supervision, go to I5h
- ◯ Exposure to hazards, go to I5g

b. Type of child abuse, check all that apply:
- ☐ Abusive head trauma, go to I5c
- ☐ Chronic Battered Child Syndrome, go to I5e
- ☐ Beating/kicking, go to I5e
- ☐ Scalding or burning, go to I5e
- ☐ Munchausen Syndrome by Proxy, go to I5e
- ☐ Sexual assault, go to I5h
- ☐ Other, specify and go to I5h
- ☐ U/K, go to I5e

c. For abusive head trauma, were there retinal hemorrhages?
◯ Yes ◯ No ◯ U/K

d. For abusive head trauma, was the child shaken?
◯ Yes ◯ No ◯ U/K

If yes, was there impact?
◯ Yes ◯ No ◯ U/K

e. Events(s) triggering child abuse, check all that apply:
- ☐ None
- ☐ Crying
- ☐ Toilet training
- ☐ Disobedience
- ☐ Feeding problems
- ☐ Domestic argument
- ☐ Other, specify:
- ☐ U/K

f. Child neglect, check all that apply:
- ☐ Failure to provide necessities
  - ☐ Food
  - ☐ Shelter
  - ☐ Other, specify:
- ☐ Failure to provide supervision
- ☐ Emotional neglect, specify:
- ☐ Abandonment, specify:
- ☐ Failure to seek/follow treatment, specify:

If yes, was this due to religious or cultural practices?
◯ Yes ◯ No ◯ U/K

☐ Exposure to hazards:
Do not include child's own behavior.
- ◯ Hazard(s) in sleep environment (including sleep position and surface sharing)
- ◯ Fire hazard
- ◯ Unsecured medication/poison
- ◯ Firearm hazard
- ◯ Water hazard
- ◯ Motor vehicle hazard
- ◯ Other hazard, specify:

g. Exposure to hazards:
Do not include child's own behavior.
- ◯ Hazard(s) in sleep environment (including sleep position and surface sharing)
- ◯ Fire hazard
- ◯ Unsecured medication/poison
- ◯ Firearm hazard
- ◯ Water hazard
- ◯ Motor vehicle hazard
- ◯ Maternal substance use during pregnancy
- ◯ Other hazard, specify:

h. Was poverty a factor?
◯ Yes ◯ No ◯ U/K

If yes, explain in Narrative

I7. LIFE STRESSORS

Please indicate all stressors that occurred around or affected the decedent and may have contributed to the death.

a. Life stressors - Social/economic

☐ None listed	☐ Discrimination	☐ Neighborhood discord	☐ Money problems	☐ Housing instability	☐ Pregnancy
☐ Racism	☐ Poverty	☐ Job problems	☐ Food insecurity	☐ Witnessed violence	☐ Pregnancy scare

J. PERSON RESPONSIBLE (OTHER THAN DECEDENT)

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

2. What act(s)? Enter information for the first person under "One" and if there is a second person, use column "Two." Describe acts in narrative.

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

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

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

4. Is person listed in a previous section?

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

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

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

6. Person's age in years:

One	Two	
____	____	# Years
☐	☐	U/K

7. Person's sex:

One	Two	
◯	◯	Male
◯	◯	Female
◯	◯	U/K

8. Person speaks and understands English?

One	Two	
◯	◯	Yes
◯	◯	No
◯	◯	U/K

If no, language spoken:

9. Person on active military duty?

One	Two	
◯	◯	Yes
◯	◯	No
◯	◯	U/K

If yes, specify branch:

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

One	Two	
○	○	Yes
○	○	No
○	○	U/K

If yes, check all that apply:

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

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

One	Two	
○	○	Yes
○	○	No
○	○	U/K

If yes, check all that apply:

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

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

One	Two	
○	○	Yes
○	○	No
○	○	U/K

If yes, check all that apply:

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

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

One	Two	
○	○	Yes
○	○	No
○	○	U/K

If yes, check all that apply:

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

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

One	Two	
○	○	Yes
○	○	No
○	○	U/K

14. Person(s) have prior child deaths?

One	Two	
○	○	Yes
○	○	No
○	○	U/K

If yes, check all that apply:

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

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

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

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

One	Two	
○	○	Yes
○	○	No
○	○	U/K

If yes, check all that apply:

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

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

One	Two	
○	○	Yes
○	○	No
○	○	U/K

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

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

18. At time of incident was person impaired?

One			Two		
○ Yes	○ No	○ U/K	○ Yes	○ No	○ U/K

If yes, check all that apply:

One	Two	
☐	☐	Drug impaired, specify:
☐	☐	Alcohol impaired
☐	☐	Distracted
☐	☐	Absent

One	Two	
☐	☐	Impaired by illness, specify:
☐	☐	Impaired by disability, specify:
☐	☐	Other, specify:

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

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

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

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

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

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

If yes, select one option per row:

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

L. FINDINGS IDENTIFIED DURING THE REVIEW

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

1. Describe any significant challenges faced by the child, the family, the systems with which they interacted, or the response to the incident. These could be related to demographics, overt or inadvertent actions, the way systems functioned, or other environmental characteristics. (See Data Dictionary for examples.)

2. Describe any notable positive elements in this case. They could be demographic, behavioral, or environmental characteristics that may have promoted resiliency in the child or family, the systems with which they interreacted or the response to the incident. (See Data Dictionary for examples).

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

4. Were new or revised agency services, policies or practices recommended or implemented as a result of the review? ◯ Yes ◯ No ◯ U/K

If yes, select all that apply and describe:

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

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

M. THE REVIEW MEETING PROCESS

1. Date of first review meeting:

2. Number of review meetings for this case: _____

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

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

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

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

Check all that apply:

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

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

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

7. Review meeting outcomes, check all that apply:

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

O. NARRATIVE

O1. NARRATIVE

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

O2. FIMR ISSUES SUMMARY (Ps/Cs)

P = Present / C = Contributing

1. Pre-/Inter-/Post-conception Care

Y N U Preconception care
Y N U Postpartum visit kept
Y N U Pregnancy planning/BC education
☐ Before ☐ During ☐ After
Y N U Dental/oral care
☐ Before ☐ During ☐ After
Y N U Chronic disease control education
☐ Before ☐ During ☐ After
Y N U Weight mgmt/dietitian
☐ Before ☐ During ☐ After
Y N U Bereavement referral

2. Medical: Mother

P C Early teen (17 and under) pregnancy
P C Late teen (18 & 19) pregnancy
P C Pregnancy >35 yrs
P C Cord problem
P C Placental abruption
P C Placenta Previa
P C Chorioamnionitis
P C Pre-existing diabetes
P C Gestational diabetes
P C Cervical insufficiency
P C Previous abnormal PAP
P C Infection: BV
P C Infection: Group B Strep
P C Infection: Urinary tract infection
P C STI - _____
P C Other source of infection: ____
P C Multiple gestation #
P C Mother's weight BMI:
P C Insufficient/excess weight gain
P C Poor nutrition
P C Pre-existing hypertension
P C Preeclampsia
P C Eclampsia
P C Preterm labor
P C Pregnancy <18 m apart
P C PROM
P C PPROM
P C Prolonged Rupture of Membrane
P C Pre-existing dental/oral issues
P C Oligo-/Polyhydramnios
P C Previous SABs or miscarriages#
P C Previous Therapeutic ab # /Vol ab #
P C Previous fetal loss #
P C Previous infant loss #_____
P C Previous LBW delivery
P C Previous preterm delivery
P C VBAC this pregnancy
P C Previous C-Section: #
P C C-Section this pregnancy
P C Previous ectopic pregnancy
P C First pregnancy <18 yrs old
P C >4 Live births
P C Assist reprod tech:
P C Other, specify:

3. Family Planning

P C Intended pregnancy
P C Unintended pregnancy
P C Unwanted pregnancy
P C No birth control
P C Failed contraceptive
P C Lack of knowledge: methods
P C Lack of resources
P C Other, specify:

4. Substance Use

P C Positive drug test
P C No drug test
P C Tobacco use: hx, not current
P C Tobacco use: current
P C Alcohol use: hx, not current
P C Alcohol use: current
P C Illicit drug use:hx, not current
P C Illicit drugs: current: type:____
P C Use of un-pres meds: type: ___
P C OTC/Rx meds: type: ____
P C Other, specify:

5. Prenatal Care/Delivery

P C Standard of care not met
P C Inadequate assessment
P C No prenatal care
P C Late entry to prenatal care
P C Lack of progesterone therapy
P C Lack of referrals
P C Missed appointments
P C Multiple providers/sites
P C Lack of dental assessment
P C Lack of dental care
P C Inappropriate use of ER
P C Other, specify:

6. Medical: Fetal/Infant

P C Non-viable fetus
P C LBW (<2500 grams)
P C VLBW (<1500 grams)
P C ELBW (<750 grams)
P C Intrauterine Growth Restriction
P C Congenital anomaly
P C Prematurity
P C Infection/sepsis
P C Failure to thrive
P C Birth injury
P C Feeding problem
P C Respiratory Distress Syndrome
P C Developmental delay
P C Inappropriate level of care
P C Positive drug test
P C Other, specify:

7. Pediatric Care

P C Standard of care not met
P C Inadequate assessment
P C No pediatric care
P C Lack of referrals
P C Missed aptmnt/immunizations
P C Multiple providers/sites
P C Inappropriate use of ER
P C Other, specify:

8. Environment

P C Unsafe neighborhood
P C Substandard housing
P C Overcrowding
P C Second-hand smoke
P C Little/no breastfeeding
P C Improper formula prep/feeding
P C Improper/no car seat use
P C Unsafe sleep location
P C Objects in sleep environment
P C Infant overheating
P C Not back sleep position
P C Apnea monitor, misuse
P C Lack of adult supervision
P C Other, specify:

9. Injuries

P C Suffocation/strangulation
P C Abusive head trauma
P C General trauma
P C Other, specify:

10. Social Support

P C Lack of family support
P C Lack of neighbors/ community support
P C Lack of partner/FOB support
P C Single parent
P C Living alone
P C <12th grade education
P C Special education
P C Physical/cognitive disability
P C Other, specify:

11. Partner/Father of Baby/Caregiver

P C Employment ○ Yes ○ No
P C Hx of mental illness
P C Substance or tobacco use/abuse: hx specify:
P C Substance or tobacco use/abuse: current specify:
P C Other, specify:

12. Family Transition

P C Frequent/recent moves
P C Living in shelter/homeless
P C Concern re: citizenship
P C Divorce/separation
P C Multiple partners
P C Mom: prison/parole/probation
P C FOB: prison/parole/probation
P C Major illness/death in family
P C Other, specify:

13. Mental Health/Stress

P C Hx of mental illness (mom)
P C Depression/anxiety/mental illness during pregnancy
P C Depression/anxiety/mental illness in postpartum period
P C Multiple stresses
P C Social chaos
P C Employment ○ Yes ○ No
P C Concern about enough money

13. Mental Health/Stress (continued)

P C Work/employment problems
P C Child(ren) with special needs
P C Problems with family/relatives
P C Lack of grief support
P C Other, specify:

14. Family Violence/Neglect

P C History of abuse (mom), specify:
P C Current abuse (mom), specify:
P C History of abuse (FOB), specify:
P C Current abuse (FOB), specify:
P C Hx child abuse: this infant
P C Hx child abuse: other child
P C Current child abuse: this infant
P C Current child abuse: other child
P C Hx child neglect: this infant
P C Hx child neglect: other child
P C Current child neglect: this infant
P C Current child neglect: other child
P C CPS referrals
P C Police reports
P C Other, specify:

15. Culture

P C Language barriers
P C Beliefs re: pregnancy/health
P C Other, specify:

16. Payment for Care

P C Private
P C Medicare
P C Medicaid
P C Self-pay/medically indigent
P C Other, specify:

17. Services Provided

P C Inadequate information
P C Lack of WIC (eligible)
P C Mother/child not eligible
P C Lack of Home Visiting (eligible)
P C Poor provider to provider communication
P C Poor provider to patient communication
P C Client dissatisfaction
P C Dissatisfaction – support services
P C Lack of child care
P C Other, specify:

18. Transportation

P C No public transportation
P C Inadequate/unreliable
P C Other, specify:

19. Documentation

P C Inconsistent/unclear information
P C Missing data
P C No death scene investigation
P C No doll re-enactment
P C Other, specify:

20. Other

P C Other, specify:

P. FORM COMPLETED BY:

Person:
Title:
Agency:
Phone:

Email:
Date completed:
Data entry completed for this case? ☐

For State Program Use Only:
Data quality assurance completed by state? ☐

NATIONAL CFRP
Center for Fatality Review & Prevention

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

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