NATIONAL CFRP
Center for Fatality Review & Prevention

Saving Lives Together

FIMR REPORT FORM

Version 6.0

National Fatality Review Case Reporting System

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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 related to a death. However, over time teams begin to understand the importance of data collection and bring the necessary information to the meeting. The percentage of cases marked "unknown" and unanswered questions decreases as the team becomes more familiar with the form. **The NFR-CRS Data Dictionary is available** as a PDF in the Help menu or as individual help icons in the online data entry system. It contains definitions for each data element and should be referred to when the team is unsure how to answer a question. Use of the data dictionary helps teams improve consistency of data entry.

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

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

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

Reminder:

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

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

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)

A + symbol means that the question is skipped for fetal deaths.

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

6. Hispanic or Latino/a 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 ☐ Medicaid ☐ Indian Health Service ☐ U/K
☐ Private ☐ State plan ☐ Other, specify:

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

17. Household income:
○ High ○ Medium ○ Low ○ U/K

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

18. 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

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

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

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

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

23. Child had history of child maltreatment as victim?
○ Yes ○ No ○ U/K
If yes, check all that apply:
☐ Physical
☐ Neglect
☐ Sexual
☐ Emotional/psychological
☐ U/K
If yes, how was history identified:
○ Through CPS
○ Other sources
If through CPS:
_____ # CPS referrals
_____ # Substantiations

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

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

26. 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 27 - 42 (Section A2) are intentionally skipped; + means skipped for fetal deaths.

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

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

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

46. Multiple gestation pregnancy?
○ Yes, # of fetuses _____
○ No ○ U/K

47. Including the deceased infant, how many pregnancies did the childbearing parent have? # ___ ☐ U/K

48. Including the deceased infant, how many live births did the childbearing parent have? # _____ ☐ U/K

49. Not including the deceased infant, number of children childbearing parent still has living?
#____ ☐ U/K

50. 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

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

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

53. Did the childbearing parent experience any medical complications in previous pregnancies?

○ N/A ○ Yes ○ No ○ U/K ☐ Previous preterm birth ☐ Previous small for gestational age
If yes, check all that apply: ☐ Previous low birth weight birth ☐ Previous large for gestational age (greater than 4000 grams)

54. Did the childbearing parent use any medications, drugs or other substances during pregnancy?

○ Yes ○ No ○ U/K If yes, check all that apply:

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

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

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

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

57. Level of birth hospital:

○ 1
○ 2
○ 3
○ 4
○ Freestanding birth center
○ Home birth
○ Other, specify:
○ U/K

58. At discharge from the birth hospital, was a case manager assigned to the childbearing parent?

○ N/A, childbearing parent did not go to a birth hospital ○ Yes ○ No ○ U/K

59. Did the childbearing parent have contact with their care provider within the first 3 weeks postpartum?

○ Yes ○ No ○ U/K

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

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

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

61. Did the childbearing parent smoke in the 3 months before pregnancy?

○ Yes
○ No
○ U/K

If yes, ___ Avg # cigarettes/day (20 cigarettes in pack)
☐ U/K quantity

62. Did the childbearing parent 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

63. Did the childbearing parent 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

64. Was the childbearing parent injured during pregnancy?

○ Yes ○ No ○ U/K If yes, describe:

65. Did the childbearing parent have postpartum depression?

○ Yes ○ No ○ U/K

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

66. 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

67. 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.

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

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

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

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

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

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

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

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

A4. FIMR DETAIL FOR ALL INFANTS UNDER ONE YEAR A + symbol means that the question is skipped for fetal deaths.

74. Name of childbearing biological parent (CBP): First: Middle: Last: Maiden: ☐ U/K

75. Name of non-childbearing biological parent (Non-CBP): First: Middle: Last: ☐ U/K

76. Childbearing parent's country of birth: ☐ U/K

77. Non-childbearing biological parent's country of birth: ☐ U/K

78. Childbearing parent's residence address: ☐ Same as child
Street: ☐U/K
Apt.
City:
State: Zip: County:

79. Childbearing parent's marital status during pregnancy:
○ Single ○ Separated
○ Married ○ Widowed
○ Divorced ○ U/K

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

81. Was childbearing parent taking folic acid or a multivitamin prior to this pregnancy?
○ Yes ○ No ○U/K

82. Childbearing parent's employment during pregnancy:
○ Employed
○ Unemployed
○ On disability
○ Stay-at-home
○ Student
○ U/K
If employed, did they think it was physically hard? ○ Yes ○ No ○ U/K
If employed, did they 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:

83. Childbearing parent'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 pre-pregnancy BMI, you can enter it:

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

85. Did childbearing parent achieve the recommended weight gain?
○ Yes ○ No ○U/K

86. Childbearing parent's age at first pregnancy: ☐ U/K

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

*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

Preg #	# in gest. (twins=2)	Baby A, B, C, etc	Year of Delivery	CBP 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	

88. Was childbearing parent 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

89. 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

90. 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

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

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

Performed Y N U/K	Normal/Abnormal? N A U/K		Performed Y N U/K	Normal/Abnormal? N A U/K		Performed Y N U/K	Positive or negative? P N U/K	
○○○	○○○	CBC	○○○	○○○	Measurement of cervical length	○○○	○○○	Antibody screen
○○○	○○○	GTT	○○○	○○○	Maturity (L/S ratio)	○○○	○○○	STI culture or test
○○○	○○○	HCT/HGB	○○○	○○○	Pap smear	○○○	○○○	Urine toxicology
○○○	○○○	Quad screen, specify	○○○	○○○	Sickle prep or equivalent			Positive for what?
		abnormal results:	○○○	○○○	Ultrasound	Performed		
		Antepartum fetal surveillance	○○○	○○○	TORCH	○○○		Blood type and Rh factor
○○○	○○○	Fetal movement	○○○	○○○	Urine culture			If yes, what was blood type?
		assessment (kick counts)	Performed					If yes, was CBP Rh negative?
○○○	○○○	Contraction stress test	○○○	Rubella titer				○ Yes ○ No ○ U/K
○○○	○○○	Nonstress test		If Rubella titer performed	○ Immune	○○○		Other, specify test and
○○○	○○○	Biophysical profile			○ Not immune			results (abnormal/
					○ U/K			positive/etc.):

93. Did the childbearing parent receive the following vaccinations during pregnancy? ☐ Tdap ☐ Seasonal flu

94. During this pregnancy and including any previous pregnancies, did the childbearing parent have any medical conditions/complications?

○ Yes ○ No ○ U/K

Timeframe	Referrals during this pregnancy
1 - Began previous to this pregnancy and includes previous pregnancies - not current pregnancy	1 - No referral, not needed
2 - Began previous to this pregnancy AND includes current pregnancy	2 - No referral, already in care
3 - Began during this current pregnancy	3 - No referral, needed
4 - Began during labor and delivery	4 - Referral made, services not provided
9 - U/K	5 - Referral made, services provided
	9 - U/K

If yes, check all that apply:

Cardiovascular	Timeframe	Referral
☐ Hypertension - gestational		
☐ Hypertension - chronic		
☐ Pre-eclampsia		
☐ Eclampsia		
☐ Clotting disorder		
Hematologic		
☐ Sickle cell disease		
☐ Anemia (iron deficiency)		
Respiratory		
☐ Asthma		
Endocrine/Metabolic		
☐ Diabetes, type 1 chronic		
☐ Diabetes, type 2 chronic		
☐ Diabetes, gestational		
☐ Thyroid		
☐ Polycystic ovarian disease		
Neurologic/Psychiatric		
☐ Addiction 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:		

Gynecologic	Timeframe	Referral
☐ Uterine/vaginal bleeding		
☐ Chorioamnionitis		
☐ Oligohydramnios		
☐ Polyhydramnios		
☐ Intrauterine growth restriction (IUGR)		
☐ Premature rupture of membranes (PROM)		
☐ Preterm premature rupture of membranes (PPROM)		
☐ Cervical Insufficiency		
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		
☐ CBP developmental delay		
☐ Oral health/dental or gum infection		
☐ Gastrointestinal		
☐ CBP genetic disorder		
☐ Abnormal MSAFP		
☐ Preterm labor		
☐ Obesity		
☐ Other, specify:		

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

If yes, what precautions?	If yes for a precaution, was there a barrier or system issue that prevented the advice from being followed?
☐ Took medicine to prevent labor or miscarriage	○ Yes ○ No ○ U/K
☐ Received progesterone IM or vaginal progesterone	○ Yes ○ No ○ U/K
☐ Stopped or limited sex during pregnancy	○ Yes ○ No ○ U/K
☐ Used condoms to prevent infection	○ Yes ○ No ○ U/K
☐ Placement of cervical cerclage	○ Yes ○ No ○ U/K
☐ Had bed rest for one or more weeks at home	○ Yes ○ No ○ U/K
☐ Was hospitalized for one or more nights	○ Yes ○ No ○ U/K
☐ Reduced work hours or stopped working earlier than expected	○ Yes ○ No ○ U/K
☐ Reduced housework or other physical activities	○ Yes ○ No ○ U/K
☐ Other, specify:	○ Yes ○ No ○ U/K

96. 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

97. Were there any signs of fetal distress? ○ Yes ○ No ○ U/K
If yes, specify:

98. Were any birth defects noted? ○ Yes ○ No ○ U/K
If yes, specify:

99. Date of childbearing parent's discharge from the birth hospital:
____/_____/_____ ○ N/A ○ U/K
mm / dd / yyyy

100. 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
- ☐ Fractures
- ☐ Cigarette burns
- ☐ Hemorrhage
- ☐ Abrasions/scratches
- ☐ Resuscitative marks
- ☐ Other, specify:

101. Was a placental pathology performed?

- ○ Yes
- ○ No
- ○ U/K

If yes, describe findings:

102. Payer source for childbearing parent'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	☐	☐	☐	☐

103. Did the childbearing parent have stable housing during the pregnancy? ○ Yes ○ No ○ U/K
If no, indicate the type(s) of instability:

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

104. Did the childbearing parent have phone service during the pregnancy?

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

105. Did the childbearing parent 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: _____

106. Did the childbearing parent 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?

107. Did childbearing parent die as a result of a pregnancy related condition? ○ Yes ○ No ○ U/K

108. Did childbearing parent die as a result of a pregnancy associated condition? ○ Yes ○ No ○ U/K

109. 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)?

- ☐ Signs/symptoms that warrant medical attention in the childbearing parent
- ☐ Where to go for care in case of emergency
- ☐ Current medications
- ☐ Environmental/work hazards
- ☐ Childbearing parent nutrition
- ☐ Weight gain counseling
- ☐ Eating disorders such as anorexia or bulimia
- ☐ Exercise
- ☐ Labor signs
- ☐ Signs and symptoms of pregnancy-induced hypertension
- ☐ HIV testing
- ☐ Childbearing parent'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:

110. Were any health education topics discussed at any time between childbearing parent's admission and discharge from the birth hospital?

○ Yes ○ No ○ U/K

If yes, which topic(s)?

- ☐ Signs/symptoms that warrant medical attention in the childbearing parent
- ☐ Where to go for care in case of emergency
- ☐ Current medications
- ☐ Childbearing parent nutrition
- ☐ Eating disorders such as anorexia or bulimia
- ☐ Exercise
- ☐ HIV testing
- ☐ Childbearing parent'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:

111. Were any infant safety topics discussed at any time between the first prenatal care visit and childbearing parent'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
- ☐ Signs/symptoms that warrant medical attention in the childbearing parent
- ☐ 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:

112. Did the childbearing parent experience any stressors during the pregnancy? ○ Yes ○ No ○ U/K If yes, which one(s)?

- ☐ A close family member was very sick
- ☐ Separated or divorced from partner
- ☐ Lost job
- ☐ Partner lost job
- ☐ Childbearing parent and partner argued more than usual
- ☐ Childbearing parent's partner said they did not want the childbearing parent to be pregnant
- ☐ Financial problems
- ☐ Involved in a physical fight
- ☐ Childbearing parent or partner went to jail
- ☐ Someone very close to the childbearing parent had a problem with drinking alcohol or drugs
- ☐ Physical abuse
- ☐ Sexual abuse
- ☐ Emotional abuse
- ☐ Someone very close to them died
- ☐ Afraid of violence in their neighborhood
- ☐ Other, specify:

113. Was the childbearing parent a victim of intimate partner violence? * Referral key:

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

1 - No referral, not needed
2 - No referral, already in service
3 - No referral, needed
4 - Referral made, services not provided
5 - Referral made, services provided
9 - U/K

114. 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, services not provided 2 - Referral made, services provided 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	Referral:	☐ SNAP	Referral:

115. 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.

116 Apgar: 1 min: 5 min: 10 min: ☐ U/K

117. 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:

118. 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

119. 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:

120. 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.

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

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

123. Infant's disposition (after birth, from any hospital):
○ Home with parents ○ Other, specify: ○ U/K

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

125. 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

126. Was the infant technologically dependent on discharge from any hospital visit? ○ Yes ○ No ○ U/K
If yes, describe:

127. 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

128. 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 PARENTAL/CAREGIVER INTERVIEW A + symbol means that the question is skipped for fetal deaths.

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

The following questions focus on the experience of the biological parents.

130. How does the childbearing parent describe the time just before pregnancy?
- ○ One of the happiest times of their life
- ○ A happy time with a few problems
- ○ A moderately hard time
- ○ A very hard time
- ○ One of the worst times of their life
- ○ U/K

131. How does the childbearing parent 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

132. Were any of the following identified as psychosocial or lifestyle problems experienced by the childbearing parent AT ANY TIME in their life, as a child, before or during pregnancy?

Childbearing parent as a child:

○ Yes ○ No ○ U/K

If yes, which one(s):

- ☐ Housing unstable/inadequate/homeless
- ☐ Food insecurity
- ☐ 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 (before or during pregnancy):

○ Yes ○ No ○ U/K

If yes, which one(s):

- ☐ Disturbed parent/infant relationship
- ☐ Childbearing parent-physical/developmental disability
- ☐ Non-childbearing biological parent-physical/developmental disability
- ☐ Childbearing parent-employment/education needs
- ☐ Non-childbearing biological parent-employment/education needs
- ☐ Inadequate support system
- ☐ Childbearing or non-childbearing biological parent felt "stereotyped" or profiled due to race, gender, class, etc.

133. How supportive was the non-childbearing biological parent toward the childbearing parent during the pregnancy?

○ Not involved ○ Supportive ○ Unsupportive ○ U/K

134. During the childbearing parent's recent pregnancy, did they have others who would have helped 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 (significant other, friend, in-laws, other family, etc.):

135. Did the childbearing parent feel that they were ever treated differently or unfairly in getting services? ○ Yes ○ No ○ U/K

If yes, for what reasons?

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

136. Was the childbearing parent currently pregnant at time of parental interview? ○ Yes ○ No ○ U/K

If no, are they currently using birth control?

- ○ Yes, describe type of birth control:
- ○ No
- ○ Trying to get pregnant
- ○ U/K

137. Does the childbearing parent expect to have any more children?

○ Yes ○ No ○ U/K

If yes, how many? _____ ☐ U/K

When: ☐ U/K

138. Did the non-childbearing biological parent experience any stressors during the pregnancy?

○ Yes ○ No ○ U/K

If yes, which one(s)?

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

The following questions ask about the primary caregiver, who may be the childbearing biological parent or someone else.

139. Were any of the following identified as psychosocial or lifestyle problems experienced by the caregiver while the infant was still alive?

Current (after the birth):

○ Yes ○ No ○ U/K

If yes, which one(s):

- ☐ Disturbed caregiver/infant relationship
- ☐ Caregiver-physical/developmental disability
- ☐ Caregiver's significant other-physical/developmental disability
- ☐ Caregiver-employment/education needs
- ☐ Caregiver's significant other-employment/education needs
- ☐ Inadequate support system
- ☐ Caregiver felt "stereotyped" or profiled due to race, gender, class, etc.

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

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

141. In the months prior to the infant's death, how often did the caregiver say that they felt very sad?

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

142. Did the caregiver feel they had family or friends who could help with the infant at home[+]?

○ Yes ○ No ○ U/K

If yes, specify who:

143. Did the caregiver feel that their infant was ever treated differently or unfairly in getting services[+]? ○ Yes ○ No ○ U/K

If yes, for what reasons?

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

144. How satisfied was the caregiver with the caregiver's significant other's contribution(s) toward their or the infant's financial support?
○ Very satisfied ○ Somewhat satisfied ○ Not satisfied ○ U/K

145. According to the caregiver, did they have a crib, portable crib or bassinet 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:

146. According to the caregiver, 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:

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

147. 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	

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.
Childbearing Biological Parent (CBP) alive: ○ Yes ○ No ○ U/K
Non-Childbearing Biological Parent (Non-CBP) alive: ○ Yes ○ No ○ U/K

2. Parents' race, check all that apply:

CBP	Non-CBP	
☐	☐	Alaska Native, Tribe:
☐	☐	American Indian, Tribe:
☐	☐	Asian, specify:
☐	☐	Black
☐	☐	Native Hawaiian
☐	☐	Pacific Islander, specify:
☐	☐	White
☐	☐	U/K

3. Parents' Hispanic or Latino/a origin?

CBP	Non-CBP	
○	○	Yes, specify origin:
○	○	No
○	○	U/K

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

CBP	Non-CBP	
_____	_____	# Years
☐	☐	U/K

5. Parents' employment status:

CBP	Non-CBP	
○	○	Employed
○	○	Unemployed
○	○	On disability
○	○	Stay-at-home
○	○	Retired
○	○	U/K

6. Parents' education:

CBP	Non-CBP	
○	○	< High school
○	○	High school/GED
○	○	College
○	○	Post graduate
○	○	U/K

7. Parents speak and understand English?

CBP	Non-CBP	
○	○	Yes
○	○	No
○	○	U/K

If no, language spoken:

8. Parents first generation immigrant?

CBP	Non-CBP	
○	○	Yes, country of origin:
○	○	No
○	○	U/K

9. Parents on active military duty?

CBP	Non-CBP	
○	○	Yes, specify branch:
○	○	No
○	○	U/K

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

CBP	Non-CBP	
○	○	Yes
○	○	No
○	○	U/K

If yes, check all that apply below:

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

11. Parents have substance abuse history?

CBP	Non-CBP	
○	○	Yes
○	○	No
○	○	U/K

12. Parents ever victim of child maltreatment?

CBP	Non-CBP	
○	○	Yes
○	○	No
○	○	U/K

13. Parents ever perpetrator of maltreatment?

CBP	Non-CBP	
○	○	Yes
○	○	No
○	○	U/K

14. Parents have disability or chronic illness?

CBP	Non-CBP	
○	○	Yes
○	○	No
○	○	U/K

15. Parents have prior child deaths?

CBP	Non-CBP	
○	○	Yes
○	○	No
○	○	U/K

16. Parents have history of intimate partner violence?

CBP	Non-CBP	
☐	☐	Yes, as victim
☐	☐	Yes, as perpetrator
☐	☐	No
☐	☐	U/K

17. Parents have delinquent/criminal history?

CBP	Non-CBP	
○	○	Yes
○	○	No
○	○	U/K

C. PRIMARY CAREGIVER(S) INFORMATION

If fetal death, skip to Section D.

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
○	○	Childbearing parent, go to Section D	○	○	Parent's partner	○	○	Friend
○	○	Non-childbearing biological parent, go to Section D	○	○	Grandparent	○	○	Institutional staff
			○	○	Sibling	○	○	Other, specify:
○	○	Adoptive parent						
○	○	Stepparent				○	○	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	
☐	☐	Alaska Native, Tribe:	☐	☐	Pacific Islander, specify:
☐	☐	American Indian, Tribe:			
☐	☐	Asian, specify:	☐	☐	White
☐	☐	Black	☐	☐	U/K
☐	☐	Native Hawaiian			

5. Caregiver(s) Hispanic or Latino/a 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) education:

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

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

One	Two	
○	○	Yes
○	○	No
○	○	U/K

If no, language spoken:

9. Caregiver(s) first generation immigrant?

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

10. Caregiver(s) on active military duty?

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

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

One	Two	
○	○	Yes
○	○	No
○	○	U/K

If yes, check all services that apply:

One	Two		One	Two	
☐	☐	WIC	☐	☐	Food stamps/SNAP/EBT
☐	☐	Home visiting	☐	☐	Section 8/housing
		specify:	☐	☐	Soc Sec Disability (SSI/SSDI)
☐	☐	TANF	☐	☐	Other, specify:
☐	☐	Medicaid	☐	☐	U/K

12. Caregiver(s) have substance abuse history?

One	Two	
○	○	Yes
○	○	No
○	○	U/K

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

One	Two	
○	○	Yes
○	○	No
○	○	U/K

14. Caregiver(s) ever perpetrator of maltreatment?

One	Two	
○	○	Yes
○	○	No
○	○	U/K

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

One	Two	
○	○	Yes
○	○	No
○	○	U/K

16. Caregiver(s) have prior child deaths?

One	Two	
○	○	Yes
○	○	No
○	○	U/K

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

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

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

One	Two	
○	○	Yes
○	○	No
○	○	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, childbearing parent, go to D15
   - ○ Yes, non-childbearing biological parent, 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	○ Sibling	○ Institutional staff, go to D15
○ Stepparent	○ Other relative	○ Babysitter
○ Foster parent	○ Friend	○ Licensed child care worker
○ Parent's partner	○ Acquaintance	○ Other, specify:
○ Grandparent	○ Hospital staff, go to D15	○ 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

10. Supervisor has history of child maltreatment?

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

11. Supervisor has disability or chronic illness? ○ Yes ○ No ○ U/K

12. Supervisor has prior child deaths? ○ Yes ○ No ○ 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

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 only E7 if the child never 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
☐ Indian reservation/trust lands
☐ Military installation
☐ Jail/detention facility
☐ Sidewalk
☐ Roadway
☐ Driveway
☐ Other parking area
☐ State or county park, 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, including naloxone, 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
____ Adults
☐ U/K

F. INVESTIGATION INFORMATION

A + symbol means that the question is skipped for fetal deaths.

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:
○	○	○	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 on the child? ○ 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 the child ever have any injuries that were suspicious of child abuse+? ○ Yes ○ No ○ U/K

If yes, what injuries were found?
☐ Skin injury ☐ Broken bones ☐ Abdominal injury
☐ Mouth injury ☐ Head injury ☐ U/K
☐ Burns

15. Did any investigation find evidence of prior abuse+? ○ N/A ○ Yes ○ No ○ U/K

If yes, from what source? Check all that apply:
☐ From x-rays ☐ From law enforcement
☐ From autopsy ☐ U/K
☐ From CPS review

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

If yes, highest level of action taken because of death:
○ Report screened out and not investigated
○ Unsubstantiated
○ Inconclusive
○ Substantiated

If yes, what services or actions resulted? Check all that apply:
☐ Voluntary services offered
☐ Voluntary services provided
☐ Court-ordered services provided
☐ Voluntary out of home placement
☐ Court-ordered out of home placement
☐ Children removed
☐ Parental rights terminated
☐ U/K

17. If death occurred in licensed setting (see E3), indicate action taken+:
○ No action
○ License suspended
○ License revoked
○ Investigation ongoing
○ Other, specify:
○ U/K

G. OFFICIAL MANNER AND PRIMARY CAUSE OF DEATH

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

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

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

a.

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

b.

c.

d.

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

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

5. Official manner of death from the death certificate:

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

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

○ From an external cause of injury. Select one:

- ○ Motor vehicle and other transport, go to H1
- ○ Fire, burn, or electrocution, go to H2
- ○ Drowning, go to H3
- ○ Asphyxia, go to H4
- ○ Bodily force or weapon, 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 and go to H8:

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

○ 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/bus/school bus
○	○	Motorcycle
○	○	Tractor/farm vehicle
○	○	All terrain vehicle
○	○	Snowmobile
○	○	Bicycle
○	○	Train/subway/trolley
○	○	Other, specify:
○	○	U/K

Autonomous?

	N/A	Yes	No	U/K
Child's vehicle	○	○	○	○
Other vehicle	○	○	○	○

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
- ○ Parent's partner
- ○ Grandparent
- ○ Sibling
- ○ Other relative
- ○ Friend
- ○ Other, specify:
- ○ U/K

If bicycle, boarding/blading or other, was the child riding something electric?

○ Yes ○ No ○ U/K

c. Did any of the following contribute to the incident? Check all that apply:

- ☐ None listed below
- ☐ Speeding over limit
- ☐ Unsafe speed for conditions
- ☐ Recklessness
- ☐ Carelessness
- ☐ Racing, not authorized
- ☐ Drug use
- ☐ Alcohol use
- ☐ Vehicle ran over child
- ☐ Vehicle flipped over
- ☐ Poor weather
- ☐ Poor visibility
- ☐ Poor sight line
- ☐ Road hazard
- ☐ Car changing lanes
- ☐ Driver inexperience
- ☐ Electronic use e.g., cell phone, smart watch,in-car navigation
- ☐ Driver distraction
- ☐ Ran stop sign or red light
- ☐ Other driver error, specify:
- ☐ Other, specify:
- ☐ U/K

d. Location of incident, check all that apply:

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

e. Did driving conditions factor into this incident?

○ Yes ○ No ○ U/K

If yes, check all that apply:

- ☐ Loose gravel
- ☐ Ice/snow
- ☐ Wet
- ☐ Inadequate lighting
- ☐ Other, specify:
- ☐ U/K

f. Incident type:

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

g. Driver who was responsible for the incident. Vehicles include motorized vehicles (cars, SUVs, motorbikes, etc.) but also bicycles, skates, scooters, and other wheeled conveyances, whether motorized or not.

- ○ Child was responsible as driver of vehicle, including single vehicle incidents
- ○ Driver of child's vehicle was responsible, including single vehicle incidents
- ○ Driver of the other vehicle was responsible, including child as pedestrian hit by vehicle
- ○ Multiple drivers were responsible, go to j
- ○ Unable to determine driver responsible, go to j
- ○ Other, specify:
- ○ U/K

h. Age and license type of driver responsible for incident, check all that apply:

Age of Driver (if not child)

- ○ <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

License type/violation:

- ☐ Has no license
- ☐ Has a learner's permit
- ☐ Has a graduated license
- ☐ Has a full license
- ☐ Has a full license that has been restricted
- ☐ Has a suspended license
- ☐ Was violating graduated licensing rules
- ☐ Other, specify:
- ☐ U/K

i. Total number of occupants in vehicle responsible for incident: ☐ N/A

Total number of occupants: _____ ☐ U/K

Number of teens, ages 14-21: _____ ☐ U/K

j. Was a restraint or safety measure used by the child?

○ Yes ○ No ○ U/K

If yes, select the restraint or safety measures used: If yes, describe:

- ☐ Lap/shoulder belt
- ☐ Child seat
- ☐ Belt positioning booster seat
- ☐ Helmet
- ☐ U/K

H2. FIRE, BURN, OR ELECTROCUTION

a. Ignition, heat or electrocution source:

- ○ Matches
- ○ Cigarette lighter
- ○ Cigarette or cigar
- ○ Candles
- ○ Cooking stove
- ○ Heating stove
- ○ Space heater
- ○ Power line
- ○ Electrical outlet
- ○ Electrical wiring
- ○ Lightning
- ○ Hot bath water
- ○ Other, specify:
- ○ U/K

b. Type of incident:

- ○ Fire, go to c
- ○ Scald, go to I2
- ○ Electrocution, go to o
- ○ U/K, go to I2

c. Type of building on fire:

- ○ N/A
- ○ Single home
- ○ Row home/townhouse
- ○ Multi-unit (duplex, apartment, condo)
- ○ Trailer/mobile home
- ○ Other, specify:
- ○ U/K

d. Fire started by a person?

○ Yes ○ No ○ U/K

If yes, person's age:

If yes, did the person have a history of starting fires?

○ Yes ○ No ○ U/K

If yes, suspected arson?

○ Yes ○ No ○ U/K

e. Did any factors delay fire department arrival?

○ Yes ○ No ○ U/K

If yes, specify:

f. Were barriers preventing safe exit?

○ Yes ○ No ○ U/K

If yes, check all that apply:

- ☐ Locked/blocked door
- ☐ Window security bars
- ☐ Locked/blocked window
- ☐ Blocked stairway
- ☐ Trapped above first floor
- ☐ Smoke/fire
- ☐ Household items/ hoarding
- ☐ Other, specify:
- ☐ U/K

g. Was the child found in the same location as where the fire started?

○ Yes ○ No ○ U/K

h. Was building a rental property?

○ Yes ○ No ○ U/K

i. Were building/rental codes violated?

○ Yes ○ No ○ U/K

If yes, describe in narrative.

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

k. Was fire sprinkler system present?

○ Yes ○ No ○ U/K

l. Was fire sprinkler system required?

○ Yes ○ No ○ U/K

m. Were smoke alarms present?

○ Yes ○ No ○ U/K

Were they functioning properly?

○ Yes ○ No ○ U/K

n. Did the child or family (check all that apply):

- ☐ None listed below
- ☐ Have a fire escape plan
- ☐ Practice a home fire drill
- ☐ Have two or more possible exits from the location as where the child was found
- ☐ Attempt to put out the fire
- ☐ U/K

o. For electrocution, what cause:

○ Lightning/electrical storm ○ Contact with power line ○ Child playing with outlet ○ U/K

○ Faulty wiring ○ Wire/product in water ○ Other, specify:

H3. DROWNING

a. Where was child last seen before drowning? Select one.

○ In water
○ Near water
○ In yard
○ In bathroom/tub
○ In house
○ In car
○ Other, specify:
○ U/K

b. Drowning location:

○ Open water/pond, go to c
○ Pool, hot tub, spa, go to f
○ Bathtub, go to I2
○ Other, specify and go to h
○ U/K, go to h

c. For open water, place:

○ Lake ○ Ocean
○ River ○ Quarry or gravel pit
○ Pond ○ Canal/drainage ditch
○ Creek ○ U/K

d. Was child boating?

○ Yes ○ No ○ U/K

e. Select all contributing environmental factors. Check all that apply.

☐ None ☐ Dropoff
☐ Weather ☐ Rough waves
☐ Temperature ☐ Flash flood
☐ Current ☐ Water clarity
☐ Riptide/undertow ☐ U/K

f. For pool, type of pool:

○ Above-ground
○ In-ground ○ Hot tub, spa
○ Wading ○ U/K

g. For pool, ownership is:

○ Private
○ Public
○ U/K

h. Flotation device used at time of the incident?

○ N/A ○ No
○ Yes, specify: ○ U/K

i. Did the child depend on a life jacket, swim vest or swim aid while in or around water?

○ N/A ○ No
○ Yes ○ U/K

j. Did barriers/layers of protection exist to prevent access to water? ○Yes ○ No ○U/K

If yes, check all that apply:

☐ Fence
Was it breached?
○ Yes ○ No ○ U/K
If yes, check all that apply:
☐ Climbed fence
☐ Gap in fence
☐ Damaged fence
☐ Fence too short

☐ Gate
Was it breached?
○ Yes ○ No ○ U/K
If yes, check all that apply:
☐ Gate left open
☐ Gate unlocked
☐ Gate latch failed
☐ Gap in gate

☐ Door
Was it breached?
○ Yes ○ No ○ U/K
If yes, check all that apply:
☐ Door left open
☐ Door unlocked
☐ Door broken
☐ Door screen torn
☐ Door self-closer failed

☐ Alarm
Was it breached?
○ Yes ○ No ○ U/K
If yes, check all that apply:
☐ Alarm not working
☐ Alarm not answered

☐ Cover
Was it breached?
○ Yes ○ No ○ U/K
If yes, check all that apply:
☐ Cover left off
☐ Cover not locked

Fence surrounds water on:

○ Four sides ○ Two or one side
○ Three sides ○ U/K

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

○ Yes ○ No ○ U/K

If yes, rules violated?

○ Yes ○ No ○ U/K

l. Select all of the child's water safety skills (without assistance or flotation device):

☐ None of these
☐ Float on their back independently
☐ Step or jump into water over their head
☐ Tread water for 1 minute
☐ Find a safe exit from the water
☐ Control breathing
☐ Return to surface
☐ Swim 25 yards
☐ Exit the water
☐ Had swimming lessons
☐ U/K

m. Child able to swim?

○ N/A ○ No
○ Yes ○ U/K

n. Warning sign or label posted?

○ N/A ○ No
○ Yes ○ U/K

o. Lifeguard present?

○ N/A
○ Yes
○ No
○ U/K

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

If yes, who? Check all that apply:

☐ Parent/relative ☐ EMS/first responder
☐ Other child ☐ Bystander
☐ Lifeguard ☐ Other, specify:
☐ Other adult ☐ U/K

If yes, did rescuer(s) also drown?

○ Yes
○ No
○ U/K

q. Appropriate rescue equipment present?

○ N/A ○ Yes ○ No ○ U/K

If yes, was it used?

○ Yes ○ No ○ U/K

If no, describe:

H4. ASPHYXIA

a. Type of event:

○ Sleep-related, go to I2
○ Not sleep-related, go to b
○ U/K, go to b

b. If not sleep-related, was the event:

○ Suffocation, go to c
○ Strangulation, go to d
○ Choking, go to e
○ Other, go to I2

c. If suffocation, was the child:

○ Covered in or fell into object
○ Confined in tight space
○ Wedged into tight space, specify:
○ Other, specify:

d. If strangulation, object causing event:

○ Clothing ○ Electrical cord
○ Blind cord ○ Person, go to H5l
○ Car seat ○ Automobile power window or sunroof
○ Belt ○ Other, specify:
○ Rope/string
○ Leash ○ U/K

e. If choking, object causing choking:

○ Food, specify:
○ Toy, specify:
○ Vomit/gastric contents
○ Other, specify:
○ U/K

f. If choking, was Heimlich Maneuver attempted?

○ Yes ○ No ○ U/K

H5. BODILY FORCE OR WEAPON

a. Was the death a result of a weapon?
- ○ Yes, go to b
- ○ No, death due to bodily force, go to l
- ○ U/K, go to b

b. Type of weapon:
- ○ Firearm, go to c
- ○ Knife or sharp instrument, go to l
- ○ Rope, go to l
- ○ Other, specify and go to l
- ○ U/K, go to l

c. For firearms, type:
- ○ Handgun
- ○ Shotgun
- ○ Rifle, specify:
- ○ 3D gun
- ○ Other, specify:
- ○ U/K

d. Was the firearm considered a smart firearm, e.g., uses a fingerprint lock, RFID watch?
- ○ Yes
- ○ No
- ○ U/K

e. Was firearm kept loaded?
- ○ Yes
- ○ No
- ○ U/K

If no, was the ammunition stored locked?
- ○ Yes
- ○ No
- ○ U/K

f. Was the firearm kept locked?
- ○ Yes
- ○ No
- ○ U/K

g. Did the shooter of the firearm have permission to use the firearm at the time of incident?
○ Yes ○ No ○ U/K

h. Did the caregiver or supervisor know a firearm was present at the time of incident?
○ Yes ○ No ○ U/K

i. Was the person handling the firearm the owner? ○ Yes ○ No ○ U/K

j. Owner of fatal firearm:
- ○ Caregiver
- ○ Other family member
- ○ Child's significant other
- ○ Friend/acquaintance
- ○ Stranger
- ○ Other, specify:
- ○ U/K

k. Was the firearm stolen?
- ○ Yes
- ○ No
- ○ U/K

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

m. Type of bodily force used. Check all that apply:
- ☐ Beat, kick or punch
- ☐ Drop
- ☐ Push
- ☐ Bite
- ☐ Shake
- ☐ Strangle/choke
- ☐ Throw
- ☐ Drown
- ☐ Burn
- ☐ Other, specify:
- ☐ U/K

H6. FALL OR CRUSH

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

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 H5l

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 H5l
- ○ 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, storage, and route of administration of substance: ☐ U/K

Source of Substance
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

Stored in locked cabinet?
Yes
No
U/K

How substance was **taken**
1 = In utero
2 = Orally
3 = Nasally
4 = Intravenously
5 = Through skin
9 = U/K

Prescription drug	Source	Stored	Taken
☐ Antidepressant/antianxiety		Y N U	
☐ Anticonvulsant		Y N U	
☐ Antipsychotic		Y N U	
☐ Benzodiazepines		Y N U	
☐ Medications for substance use disorder (e.g. Methadone, buprenorphine, naltrexone)		Y N U	
☐ Non-opioid pain medication		Y N U	
☐ Opioid pain medication (including fentanyl)		Y N U	
☐ Stimulants		Y N U	
☐ Other Rx, specify:		Y N U	

Was it child's prescription? ○ Yes ○ No ○ U/K

Over-the-counter drug	Source	Stored	Taken
☐ Antihistamine		Y N U	
☐ Cold medicine		Y N U	
☐ Pain medication		Y N U	
☐ Other OTC, specify:		Y N U	

Illicit drugs	Source	Stored	Taken
☐ Cocaine		Y N U	
☐ Heroin		Y N U	
☐ Illicitly manufactured fentanyl/fentanyl analogs		Y N U	
☐ Marijuana/THC		Y N U	
☐ Methamphetamine		Y N U	
☐ Other, specify:		Y N U	

Other substances	Source	Stored	Taken
☐ Alcohol		Y N U	
☐ Battery		Y N U	
☐ Carbon monoxide		Y N U	
☐ Other fume/gas/vapor		Y N U	
☐ Other, specify:		Y N U	

b. Was the incident the result of?
○ Accidental overdose/acute intoxication
○ Medical treatment mishap
○ Deliberate poisoning
○ Other, specify:
○ U/K

c. Did the child have a prescription for a controlled substance within the previous 24 months?
○ Yes ○ No ○ U/K

d. Did child have a non-fatal overdose within the previous 12 months?
○ Yes
○ No
○ U/K

e. Was Poison Control contacted?
○ Yes
○ No
○ U/K

f. For CO poisoning, was a CO alarm present?
○ Yes
○ No
○ U/K

H8. MEDICAL CONDITION

This section is skipped for fetal deaths+

a. How long did the child have the medical condition?
○ In utero
○ Since birth
○ < 1 day
○ 1-6 days
○ 7-30 Days
○ 1-11 months
○ >= 1 year
○ U/K

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

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
If yes, was the care plan appropriate for the medical condition?
○ N/A ○ Yes ○ No ○ U/K
If no, specify:

d. Did the family experience barriers that prohibited following the care plan?
○ N/A
○ Yes
○ No
○ U/K
If yes, what treatment components were not completed? Check all that apply.
☐ Appointments
☐ Medications, specify:
☐ Medical equipment use, specify:
☐ Therapies, specify:
☐ Other, specify:
☐ U/K

e. In the week prior to the death, did the child experience any changes to medical care?
○ Yes, describe:
○ No
○ U/K

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

g. Was the death potentially caused by a medical error?
○ Yes ○ No ○ U/K

h. Was the medical condition that caused the death a result of a complication or side effect of a previous illness, injury, condition, or medical treatment?
○ 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 I2t ○ U/K, go to I2a

a. Incident sleep place:

- ○ Crib
  - If crib, type:
    - ○ Not portable
    - ○ Portable
    - ○ Unknown crib type
- ○ Bassinet
- ○ Bed side sleeper
- ○ Baby box
- ○ Adult bed
- ○ Waterbed
- ○ Futon
- ○ Couch
- ○ Chair
- ○ Floor
- ○ Car seat
- ○ Rocking-inclined sleeper
- ○ Stroller
- ○ Swing
- ○ Bouncy chair
- ○ Other, specify:
- ○ U/K

If adult bed, what type?
- ○ Twin
- ○ Full
- ○ Queen
- ○ King
- ○ Other, specify:
- ○ 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, portable crib or bassinet in home for child? ○ Yes ○ No ○ U/K

d. Usual sleep place:

- ○ Crib
  - If crib, type:
    - ○ Not portable
    - ○ Portable
    - ○ Unknown crib type
- ○ Bassinet
- ○ Bed side sleeper
- ○ Baby box
- ○ Adult bed
- ○ Waterbed
- ○ Futon
- ○ Couch
- ○ Chair
- ○ Floor
- ○ Car seat
- ○ Rocking-inclined sleeper
- ○ Stroller
- ○ Swing
- ○ Bouncy chair
- ○ Other, specify:
- ○ U/K

If adult bed, what type?
- ○ Twin
- ○ Full
- ○ Queen
- ○ King
- ○ Other, specify:
- ○ 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 when last placed? ○ Yes ○ No ○ U/K
If yes, describe:

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

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

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: _____
☐ U/K

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 ○ U/K
If no, go to www.saferproducts.gov to report

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
- ○ Childbearing parent 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 were present for this child and family around the time of death.

a. Life stressors - Social/economic

☐ None listed below	☐ Neighborhood discord	☐ No phone	☐ Lack of transportation	☐ Lack of child care
☐ Racism	☐ Job problems	☐ Housing instability	☐ Cultural differences	☐ Pregnancy
☐ Discrimination	☐ Money problems	☐ Witnessed violence	☐ Language barriers	☐ Pregnancy scare
☐ Poverty	☐ Food insecurity	☐ Tobacco exposure		

b. Life stressors - Medical

☐ None listed below	☐ Caregiver unskilled in providing care	☐ Multiple providers, not coordinated	☐ Felt dismissed by provider
☐ Lack of family or social support for care	☐ Lack of money for care	☐ Limitations of health insurance	☐ Lack of provider-family compatibility
☐ Caregiver distrust of health care system	☐ Services not available	☐ Provider bias	

c. Life Stressors- Relationships

☐ None listed below	☐ Parents' incarceration	☐ Argument with friends	☐Cyberbullying as victim	☐ Stress due to gender identity
☐ Family discord	☐ Breakup	☐ Isolation	☐Cyberbullying as a perpetrator	
☐ Argument w/ parents/caregivers	☐ Argument with significant other	☐ Bullying as victim	☐Peer violence as a victim	☐ Stress due to sexual orientation
☐ Parents' divorce/separation	☐ Social discord	☐ Bullying as perpetrator	☐Peer violence as a perpetrator	

h. Life stressors - Describe any other life stressors:

I8. DEATHS DURING THE COVID-19 PANDEMIC (complete for all ages)

a. For the 12 months before the child's death, did the family experience any disruptions or significant changes to the following? Check all that apply:

- ☐ None listed below
- ☐ School
- ☐ Daycare
- ☐ Employment
- ☐ Social services (like unemployment assistance, TANF, WIC)
- ☐ Living environment
- ☐ Medical care
- ☐ Mental health or substance use/abuse care
- ☐ Home-based services (non-child welfare)
- ☐ Child welfare services
- ☐ Legal proceedings within criminal, civil, or family courts
- ☐ Other, specify:
- ☐ U/K

b. For the 12 months before the child's death, did the child's family live in an area with an official stay at home order? ○Yes ○No ○U/K

If yes, was the stay at home order in place at the time of the child's death? ○Yes ○No ○U/K

c. Was the child exposed to COVID-19 within 14 days of death? ○Yes ○No ○U/K If yes, describe:

d. Did the child have medical evidence of a significant inflammatory syndrome (including for example, fever, laboratory evidence of inflammation, and involvement of two or more organs) requiring hospitalization in the week before death? ○Yes ○No ○U/K

If yes, was the child diagnosed with MIS-C? ○Yes ○No ○U/K

e. Was the child eligible to receive a COVID-19 vaccination? ○ Yes ○ No ○ U/K

If eligible, did they receive their first dose? ○ Yes ○ No ○ U/K If yes, approx. number of weeks before death: ____

If eligible and received their first dose, which option best represents their vaccination status? ○ Partially vaccinated ○ Fully vaccinated ○ U/K

f. For infants or fetal deaths only, did the childbearing parent receive their COVID-19 vaccination? ○ Yes ○ No ○ U/K

If yes, when did they receive their first dose?

○ Before pregnancy ○ 3rd trimester
○ 1st trimester ○ After delivery
○ 2nd trimester ○ U/K

If yes, which option best represents their vaccination status? ○ Partially vaccinated ○ Fully vaccinated ○ U/K

g. Select the one option that best describes the impact of COVID-19 on this child's death:

○ COVID-19 was the immediate or underlying cause of death
○ COVID-19 was diagnosed at autopsy or child was suspected to have COVID-19
○ COVID-19 indirectly contributed to the death but was not the immediate or underlying cause of death
○ The childbearing parent contracted COVID-19, specify:
  ○ Before pregnancy ○ 3rd trimester
  ○ 1st trimester ○ After delivery
  ○ 2nd trimester ○ U/K
○ Other, specify:
○ COVID-19 had no impact on this child's death
○ U/K

h. Did COVID-19 impact the team's ability to conduct this fatality review? ○ Yes ○ No ○ U/K

If yes, check all that apply:

☐ Unable to obtain records
☐ Team members unable to attend review
☐ Remote reviews negatively impacted review process
☐ Team leaders redirected to COVID-19 response

J. PERSON RESPONSIBLE (OTHER THAN DECEDENT)

This section is skipped for fetal deaths+

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 K
○ U/K, go to 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 K

4. Is person listed in a previous section?

One	Two	
○	○	Yes, childbearing parent, go to J17
○	○	Yes, non-childbearing biological parent, 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	○	○	Sibling	○	○	Medical provider
○	○	Stepparent	○	○	Other relative	○	○	Institutional staff
○	○	Foster parent	○	○	Friend	○	○	Babysitter
○	○	Parent's partner	○	○	Acquaintance	○	○	Licensed child care worker
○	○	Grandparent	○	○	Child's boyfriend or girlfriend	○	○	Other, specify:
			○	○	Stranger	○	○	U/K

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	If no, language spoken:
○	○	No	
○	○	U/K	

9. Person on active military duty?

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

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

One	Two	
○	○	Yes
○	○	No
○	○	U/K

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

One	Two	
○	○	Yes
○	○	No
○	○	U/K

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

One	Two	
○	○	Yes
○	○	No
○	○	U/K

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

One	Two	
○	○	Yes
○	○	No
○	○	U/K

14. Person(s) have prior child deaths?

One	Two	
○	○	Yes
○	○	No
○	○	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

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

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

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

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

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

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

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

If yes, select one option per row:

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

L. 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 interacted or the response to the incident. (See Data Dictionary for examples).

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

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

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

Vital statistics

- ☐ Birth certificate - full form
- ☐ Death certificate

Health records

- ☐ Child's medical records or clinical history, including vaccination
- ☐ Hospital records
- ☐ Childbearing parent's obstetric and prenatal information
- ☐ Newborn screening results
- ☐ Mental health records
- ☐ Substance abuse treatment records

Investigation records

- ☐ Autopsy/pathology reports
- ☐ CDC's SUIDI Reporting Form
- ☐ Jurisdictional equivalent of the CDC SUIDI Reporting Form
- ☐ Law enforcement records
- ☐ Social service records
- ☐ Child protection agency records
- ☐ EMS run sheet

Other

- ☐ Home visiting
- ☐ School 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:

- ☐ 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

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: Childbearing parent (CBP)

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 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

7. Pediatric Care (Continued)

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 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/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 Prison/parole/probation (CBP)
P C Prison/parole/probation (Non-CBP)
P C Major illness/death in family
P C Other, specify:

13. Mental Health/Stress

P C Hx of mental illness (CBP)
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
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

Childbearing parent:
P C Hx of abuse (CBP), specify:
P C Current abuse (CBP), specify:
Non-childbearing biological parent:
P C Hx of abuse (Non-CBP), specify:
P C Current abuse (Non-CBP), 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 Parent/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? ☐

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

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