NATIONAL CFRP
Center for Fatality Review & Prevention

# FIMR REPORT FORM

*Version 7.0*

## National Fatality Review Case Reporting System

Data Entry Website: data.ncfrp.org
Phone: 800-656-2434
Email: info@ncfrp.org



# Learning Together, Protecting Tomorrows

## Instructions:

This form is used by Fetal and Infant Mortality Review (FIMR) teams to enter information into the Pediatric National Fatality Review-Case Reporting System (Pediatric NFR-CRS). States and jurisdictions use this system through a data use agreement with the National Center for Fatality Review and Prevention (National Center).

The form helps teams collect comprehensive information from all agencies participating in a review. It includes questions about the child, the circumstances of the death, investigative actions, services provided or needed, risk factors, and any actions the team recommends to prevent future deaths.

## How to Use the Form During Review Meetings

The form supports the review process, but it should not guide the entire meeting. Many teams find it helpful to assign one person to enter information while the team talks. You do not need to discuss or answer every question in order. It is normal not to have answers to every question. As teams gain experience, they better understand the importance of data collection and bring the necessary information to the meeting. Over time, fewer questions are left blank or marked "unknown."

The Pediatric NFR-CRS Data Dictionary is available at https://ncfrp.org/what-we-do/pediatric-data/, in the "Help" menu of the Pediatric NFR-CRS, or as individual help icons next to each question when doing data entry. Using it when unsure how to answer a question helps teams improve data consistency and quality.

## Types of Questions

The form includes:

1. Single choice questions (marked with a circle)
2. Multiple choice questions (marked with a square/checkbox)
3. Open text questions (often labeled "specify" or "describe")

A plus sign (+) next to a question means it does not apply to fetal deaths.

## Understanding Missing vs. Unknown

Many teams ask the difference between leaving a question blank and selecting the response "unknown."

- Unknown: Select "unknown" if an attempt was made to find the information, but there was no clear answer.
- Blank: Leave the question blank/unanswered if no attempt was made to find the information.
- N/A (Not applicable): Select "N/A" for questions that do not apply to the death.

## Privacy and Confidentiality

You may enter identifiable information (e.g., names, dates, addresses, counties) if your state/local policy allows. Follow state laws about reporting psychological, substance misuse, and HIV/AIDS information. Please check with your fatality review coordinator if you are unsure.

However, do not include identifiable information in open text fields such as the Narrative or any "specify" or ''describe" boxes. This includes specific names, any dates, references to specific counties, practitioners, or facility names. Examples:

- Use "the child," "mother of child," "father of child," not their names.
- Use "EMS," not "Smith County EMS."
- Use "the children's hospital," not "Smith County Children's Hospital."

This rule exists because text fields may be shared with approved researchers under your state or jurisdiction's data use agreement. Including identifiable information in these fields could violate the Health Insurance Portability and Accountability Act (HIPAA).

## Need Help or Want to Participate?

Teams interested in using the Pediatric NFR-CRS for data entry and reporting can contact the National Center (info@ncfrp.org). This version includes the SUID (Sudden Unexpected Infant Death) and SDY (Sudden Death in the Young) Case Registry questions.

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## CASE NUMBER

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

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

Death Certificate Number:

Birth Certificate Number:

ME/Coroner Number:

☐ Child never left hospital following birth

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+?
○ N/A ○ Yes ○ No, specify: ○ U/K

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

If the child never left the hospital following birth, go to Section 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) intentionally skipped. A + symbol means that the question is 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 mother have?
# ☐ U/K

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

49. Not including the deceased infant, number of children mother 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
Week or month of first prenatal visit kept? Specify: Month ☐ 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
- ☐ Limitations of health insurance coverage
- ☐ Lack of transportation
- ☐ Cultural differences
- ☐ Language barriers
- ☐ Couldn't get provider to take as patient
- ☐ Multiple providers, not coordinated
- ☐ Couldn't get an earlier appointment
- ☐ Lack of child care
- ☐ Lack of family/social support
- ☐ Services not available
- ☐ Distrust of health care system
- ☐ Unwilling to obtain care
- ☐ Didn't know where to go
- ☐ Didn't think she was pregnant
- ☐ Other, specify:
- ☐ U/K

53. Did the mother experience any medical complications in previous pregnancies? ○ N/A ○ Yes ○ No ○ U/K

If yes, check all that apply:

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

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

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

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

55. Was the infant/fetus delivered 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 mother?

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

59. Did the mother have contact with her 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
- ☐ Low birth weight
- ☐ Tachypnea
- ☐ Drug/alcohol exposure
- ☐ Apnea
- ☐ Sepsis
- ☐ Feeding difficulties
- ☐ Hypothermia
- ☐ Jaundice
- ☐ Anemia
- ☐ Meconium aspiration
- ☐ Congenital anomalies
- ☐ Respiratory distress/failure
- ☐ Other, specify:
- ☐ U/K

61. Did the mother 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 mother smoke at any time during pregnancy?

○ Yes ○ No ○ U/K

If yes,

| Trimester 1 | Trimester 2 | Trimester 3 | |
|---|---|---|---|
| | | | Avg # cigarettes/day (20 cigarettes in pack) |
| ☐ | ☐ | ☐ | U/K quantity |

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

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

64. Was the mother injured during pregnancy? ○ Yes ○ No ○ U/K

If yes, describe:

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

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

66. Infant ever received human milk? ○ Yes ○ No ○ U/K

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

If yes, exclusively? ○ Yes ○ No ○ U/K

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

If yes, exclusively? ○ Yes ○ No ○ U/K

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

67. Did infant have abnormal 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
- ☐ Infection
- ☐ Allergies
- ☐ Abnormal growth, weight gain/loss
- ☐ Apnea
- ☐ Cyanosis
- ☐ Seizures or convulsions
- ☐ Cardiac abnormalities
- ☐ Other, specify:
- ☐ U/K

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

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

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(s) and last dose given:

73. What did the infant have for his/her last meal? Check all that apply:
☐ Human 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 mother: First: Middle: Last: Maiden: ☐ U/K

75. Name of father: First: Middle: Last: ☐ U/K

76. Mother's country of birth: ☐ U/K

77. Father's country of birth: ☐ U/K

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

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

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

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

82. Did mother have a primary care provider prior to this pregnancy?
○ Yes ○ No ○ U/K

83. Mother's employment during pregnancy:
○ Employed
○ Unemployed
○ On disability
○ Stay-at-home
○ U/K

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

If employed, did she think it 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:

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

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

86. Did mother achieve the recommended weight gain?
○ Yes ○ No ○ U/K

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

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

| Preg # | # in gest. (twins = 2) | Baby A, B, C, etc. | Year of delivery | Mother's Age | Gestational age in weeks | Birth weight (grams) | Choose one: NSVD | C-Sec | VBAC | Other | Outcome code* |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | | | | |
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*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

89. Was mother using birth control in the 3 months prior to this pregnancy? ○ Yes ○ No ○ U/K
If yes, what type?
○ LARC including implants/IUDs
○ Oral contraceptives, specify:
○ Barrier methods (male/female condoms/cervical cap)
○ Injections (Depo Provera)
○ Spermicides
○ Natural, withdrawal, pull out, rhythm method
○ Tubal ligation
○ Multiple methods
○ Other, specify:
○ U/K
If no, was pregnancy: ○ Unintended ○ Intended ○ Mistimed ○ U/K

90. 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

91. 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

92. Did mother receive doula services in this pregnancy?
○ Yes ○ No ○ U/K

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

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

| Performed Y N U/K | Normal/Abnormal? N A U/K | |
|---|---|---|
| ○ ○ ○ | ○ ○ ○ | CBC |
| ○ ○ ○ | ○ ○ ○ | GTT |
| ○ ○ ○ | ○ ○ ○ | HCT/HGB |
| ○ ○ ○ | ○ ○ ○ | Non-invasive prenatal screening (NIPS)/Cell free DNA, specify results: |

| Performed Y N U/K | Normal/Abnormal? N A U/K | |
|---|---|---|
| ○ ○ ○ | ○ ○ ○ | Measurement of cervical length |
| ○ ○ ○ | ○ ○ ○ | Maturity (L/S ratio) |
| ○ ○ ○ | ○ ○ ○ | Pap smear |
| ○ ○ ○ | ○ ○ ○ | Sickle prep or equivalent |
| ○ ○ ○ | ○ ○ ○ | Ultrasound |
| ○ ○ ○ | ○ ○ ○ | TORCH |
| ○ ○ ○ | ○ ○ ○ | Urine culture |

| Performed Y N U/K | Positive or negative? P N U/K | |
|---|---|---|
| ○ ○ ○ | ○ ○ ○ | Antibody screen |
| ○ ○ ○ | ○ ○ ○ | STI culture or test |
| ○ ○ ○ | ○ ○ ○ | Urine toxicology |

Positive for what?

Antepartum fetal surveillance

| | | |
|---|---|---|
| ○ ○ ○ | ○ ○ ○ | Fetal movement assessment (kick counts) |
| ○ ○ ○ | ○ ○ ○ | Contraction stress test |
| ○ ○ ○ | ○ ○ ○ | Nonstress test |
| ○ ○ ○ | ○ ○ ○ | Biophysical profile |

Performed

○ ○ ○ Rubella titer

If Rubella titer performed:

○ Immune
○ Not immune
○ U/K

Performed

○ ○ ○ Blood type and Rh factor

If yes, what was blood type? ☐

If yes, was mother Rh negative? ○ Yes ○ No ○ U/K

○ ○ ○ Other, specify test and results (abnormal/positive/etc.)

95. Did the mother receive the following vaccinations during pregnancy? ☐ Tdap ☐ Seasonal flu ☐ COVID-19 ☐ RSV

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

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

**Referrals during this pregnancy**
1 - No referral, not needed
2 - No referral, already in care
3 - No referral, needed
4 - Referral made, services not provided
5 - Referral made, services provided
9 - U/K

If yes, check all that apply:

| Cardiovascular | Timeframe | Referral |
|---|---|---|
| ☐ Hypertension - gestational | | |
| ☐ Hypertension - chronic | | |
| ☐ Pre-eclampsia | | |
| ☐ Eclampsia | | |
| **Hematologic** | | |
| ☐ Anemia (iron deficiency) | | |
| ☐ Clotting disorder | | |
| ☐ Sickle cell disease | | |
| **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)** | | |
| ☐ Chlamydia | | |
| ☐ Gonorrhea | | |
| ☐ Herpes | | |
| ☐ HPV | | |
| ☐ Syphilis | | |
| ☐ HIV/AIDS | | |
| ☐ Other STI, specify: | | |

| Gynecologic | Timeframe | Referral |
|---|---|---|
| ☐ Uterine/vaginal bleeding | | |
| ☐ Chorioamnionitis | | |
| ☐ Oligohydramnios | | |
| ☐ Polyhydramnios | | |
| ☐ FGR/IUGR | | |
| ☐ Premature rupture of membranes (PROM) | | |
| ☐ Preterm premature rupture of membranes (PPROM) | | |
| ☐ Cervical insufficiency | | |
| ☐ Bacterial vaginosis (BV) | | |
| ☐ Group B strep | | |
| **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 | | |
| ☐ Mother developmental delay | | |
| ☐ Oral health/dental or gum infection | | |
| ☐ Gastrointestinal | | |
| ☐ Mother genetic disorder | | |
| ☐ Abnormal MSAFP | | |
| ☐ Preterm labor | | |
| ☐ Obesity | | |
| ☐ Other, specify: | | |

97. 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?

| | | | |
|---|---|---|---|
| ☐ Medication (tocolysis) to prevent labor or miscarriage | ○ Yes | ○ No | ○ U/K |
| ☐ Progesterone intermuscular or vaginal | ○ Yes | ○ No | ○ U/K |
| ☐ Stopped or limited sex during pregnancy | ○ Yes | ○ No | ○ U/K |
| ☐ Placement of cervical cerclage | ○ Yes | ○ No | ○ U/K |
| ☐ Bed rest for one or more weeks at home | ○ Yes | ○ No | ○ U/K |
| ☐ Hospitalization 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 |

98. Type of delivery:

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

If C-Section, why was it done?

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

99. Were there any signs of non-reassuring fetal status or fetal distress? ○ Yes ○ No ○ U/K

What sign(s) of fetal address?

☐ Bradycardia ☐ Meconium stained fluid
☐ Decreased/no fetal movement ☐ Respiratory distress
☐ Fetal heart tone changes ☐ Other, specify:
☐ Intrauterine fetal death (IUFD)

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

If yes, specify:

102. 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. Date of mother's discharge from the birth hospital:

☐☐/☐☐/☐☐☐☐ mm dd yyyy ○ N/A ○ U/K

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

If yes, describe findings:

104. Payer source for mother's care for the following timeframes, check all that apply:

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

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

If no, indicate type(s) of instability:

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

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

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

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

If yes, number of visits with primary care provider:

If yes, number of visits with Maternal Fetal Medicine specialist:

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

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

If yes, what treatment was recommended?

109. Did mother die as a result of a pregnancy related condition? ○ Yes ○ No ○ U/K

110. Did mother die as a result of a pregnancy associated condition? ○ Yes ○ No ○ U/K

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

If yes, what topic(s)?

☐ Signs/symptoms that warrant medical attention in the mother
☐ Where to go for care in case of emergency
☐ Current medications
☐ Environmental/work hazards
☐ Mother nutrition
☐ Weight gain counseling
☐ Eating disorders such as anorexia or bulimia
☐ Exercise
☐ Labor signs
☐ Signs and symptoms of pregnancy-induced hypertension
☐ HIV testing
☐ Mother's vaccinations
☐ Risk factors identified by prenatal history
☐ Tobacco (Ask, Advise, Assess, Assist, and Arrange)
☐ Illicit/recreational drugs
☐ Fetal movement monitoring
☐ Kick counts
☐ Choosing how to feed infant/benefits of human milk
☐ 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:

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

If yes, which topic(s)?

- ☐ Signs/symptoms that warrant medical attention in the mother
- ☐ Where to go for care in case of emergency
- ☐ Current medications
- ☐ Mother nutrition
- ☐ Eating disorders such as anorexia or bulimia
- ☐ Exercise
- ☐ HIV testing
- ☐ Mother's vaccinations
- ☐ Tobacco (Ask, Advise, Assess, Assist, and Arrange)
- ☐ Illicit/recreational drugs
- ☐ Choosing how to feed infant/benefits of human milk
- ☐ 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:

113. Were any infant safety topics discussed at any time between the first prenatal care visit and mother's discharge from the birth hospital?

○ Yes ○ No ○ U/K If yes, which topic(s)?

- ☐ Bath safety
- ☐ Infant care
- ☐ Infant signs/symptoms that warrant medical attention
- ☐ Signs/symptoms that warrant medical attention in the mother
- ☐ 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:

114. Did the mother 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
- ☐ Mother and partner argued more than usual
- ☐ Mother's partner said they did not want the mother to be pregnant
- ☐ Financial problems
- ☐ Involved in physical fight
- ☐ Mother or partner went to jail
- ☐ Someone very close to the mother had a problem with drinking alcohol or drugs
- ☐ Physical abuse
- ☐ Sexual abuse
- ☐ Emotional abuse
- ☐ Someone close to mother died
- ☐ Afraid of violence in neighborhood
- ☐ Other, specify:

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

| Mother as victim | Y | N | U/K | Referral?* |
|---|---|---|---|---|
| Preconception | ○ | ○ | ○ | |
| Pregnancy | ○ | ○ | ○ | |
| Postpartum | ○ | ○ | ○ | |

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

116. 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: | ☐ Smoking cessation program | Referral: |
| ☐ Social worker | Referral: | ☐ Alcohol cessation program | Referral: |
| ☐ Infant/child health program | Referral: | ☐ Housing authority | Referral: |
| ☐ Child Protection Services | Referral: | ☐ Shelters | Referral: |
| ☐ Legal aid | Referral: | ☐ Unemployment assistance | Referral: |
| ☐ Evidence-based home visiting | Referral: | ☐ Homemaker/home health aide | Referral: |
| ☐ Family planning | Referral: | ☐ Medicaid | Referral: |
| ☐ Mental health service | Referral: | ☐ Social Security Disability Insurance (SSDI) | Referral: |
| ☐ Infant mental health program | Referral: | ☐ WIC | Referral: |
| ☐ Genetic evaluation/counseling | Referral: | ☐ TANF | Referral: |
| ☐ GED programs | Referral: | ☐ SNAP | Referral: |
| ☐ Children's Special Health Care Needs | Referral: | ☐ Dietitian/nutritionist | Referral: |
| ☐ Substance use treatment | Referral: | ☐ Bereavement/chaplain | Referral: |

117. 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.

118. Apgar: 1 min: ____ 5 min: ____ 10 min: ____ ☐ U/K

119. Were neonatal resuscitation measures required or attempted in delivery room?

○ Yes ○ No ○ U/K

If yes, which measure(s)?

- ☐ Physical stimulation
- ☐ Chest compressions
- ☐ Suctioning
- ☐ Intubation
- ☐ Respiratory or cardiac meds for resuscitation
- ☐ Positive pressure ventilation
- ☐ Oxygen
- ☐ Other, specify:

120. 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

121. 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, specify: ____
- ☐ Hemolysis

If yes, due to: ○ RH ○ ABO ○ Other

If other, specify: ____

- ☐ Hypothermia
- ☐ Hypotonia
- ☐ Temperature instability
- ☐ Delayed feeding adequacy
- ☐ Jaundice, specify highest bilirubin level: ____

- ☐ Birth injury such as bruising, peripheral nerve damage, cephalohematoma, fractures; If yes, specify: ____
- ☐ Other, specify: ____

122. Was a urine, meconium, or cord blood 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)
- ☐ U/K
- ☐ Other, specify: ____

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

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

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

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

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

127. 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

128. Was the infant technologically dependent on discharge from any hospital visit? ○ Yes ○ No ○ U/K

If yes, describe: ____

129. 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?
Age in weeks: ____ ☐ U/K

130. 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 |
|---|---|---|---|
| | | | |
| | | | |
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## A5. FIMR PARENTAL/CAREGIVER INTERVIEW

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

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

If no, why not?
- ○ Contact was not attempted
- ○ Contact was attempted but follow up was unsuccessful
- ○ Contact was attempted but family declined

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

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

133. How does the mother remember feeling about becoming pregnant?
- ○ Wanted to be pregnant sooner
- ○ Wanted to be pregnant later
- ○ Wanted to be pregnant then
- ○ Didn't want to be pregnant then or at any time in the future
- ○ U/K

134. Were any of the following identified as psychosocial or lifestyle problems experienced by the mother AT ANY TIME in her life, as a child, before or during pregnancy?

**Mother 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
- ☐ Mother-physical/developmental disability
- ☐ Father-physical/developmental disability
- ☐ Mother-employment/education needs
- ☐ Father-employment/education needs
- ☐ Inadequate support system
- ☐ Mother or father felt “stereotyped” or profiled

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

○ Not involved ○ Supportive ○ Unsupportive ○ U/K

136. During the mother’s recent pregnancy, did she 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.) ☐

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

If yes, for what reasons?

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

138. Was the mother currently pregnant at time of parental interview?

○ Yes ○ No ○ U/K

If no, is she currently using birth control?

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

139. Does the mother expect to have any more children? ○ Yes ○ No ○ U/K

If yes, how many? ☐ ☐ U/K If yes, when? ☐ ☐ U/K

140. Did the father 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 mother or someone else.

141. 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

142. 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

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

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

144. 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: ☐

145. 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?

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

146. 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

147. 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:

148. 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

149. 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
- ☐ Limitations of health insurance coverage
- ☐ Lack of transportation
- ☐ No phone
- ☐ Cultural differences
- ☐ Language barriers
- ☐ Couldn't get provider to take as a patient
- ☐ Multiple providers, not coordinated
- ☐ Couldn't get an earlier appointment
- ☐ Lack of child care (other children)
- ☐ Lack of family/social support
- ☐ Services not available
- ☐ Distrust of health care system
- ☐ Unwilling to obtain care
- ☐ Didn't know where to go
- ☐ Other, specify:
- ☐ U/K

## 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.

Mother alive: ○ Yes ○ No ○ U/K Father alive: ○ Yes ○ No ○ U/K

2. Parents' race, check all that apply:

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

3. Parents' Hispanic or Latino/a origin?

| Mother | Father | |
|---|---|---|
| ○ | ○ | Yes, specify origin: |
| ○ | ○ | No |
| ○ | ○ | U/K |

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

| Mother | Father | |
|---|---|---|
| | | # Years |
| ☐ | ☐ | U/K |

5. Parents' employment status:

| Mother | Father | |
|---|---|---|
| ○ | ○ | Employed |
| ○ | ○ | Unemployed |
| ○ | ○ | On disability |
| ○ | ○ | Stay-at-home |
| ○ | ○ | Retired |
| ○ | ○ | U/K |

6. Parents' education:

| Mother | Father | |
|---|---|---|
| ○ | ○ | < High school |
| ○ | ○ | High school/ GED |
| ○ | ○ | College |
| ○ | ○ | Post graduate |
| ○ | ○ | U/K |

7. Parents speak and understand English?

| Mother | Father | |
|---|---|---|
| ○ | ○ | Yes |
| ○ | ○ | No |

If no, language spoken:

○ ○ U/K

8. Parents first generation immigrant?

| Mother | Father | |
|---|---|---|
| ○ | ○ | Yes, country of origin: |
| ○ | ○ | No |
| ○ | ○ | U/K |

9. Parents on active military duty?

| Mother | Father | |
|---|---|---|
| ○ | ○ | Yes, specify branch: |
| ○ | ○ | No |
| ○ | ○ | U/K |

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

| Mother | Father | |
|---|---|---|
| ○ | ○ | Yes |
| ○ | ○ | No |
| ○ | ○ | U/K |

If yes, check all that apply below:

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

11. Parents have substance abuse history?

| Mother | Father | |
|---|---|---|
| ○ | ○ | Yes |
| ○ | ○ | No |
| ○ | ○ | U/K |

12. Parents ever victim of child maltreatment?

| Mother | Father | |
|---|---|---|
| ○ | ○ | Yes |
| ○ | ○ | No |
| ○ | ○ | U/K |

13. Parents ever perpetrator of maltreatment?

| Mother | Father | |
|---|---|---|
| ○ | ○ | Yes |
| ○ | ○ | No |
| ○ | ○ | U/K |

14. Parents have disability or chronic illness?

| Mother | Father | |
|---|---|---|
| ○ | ○ | Yes |
| ○ | ○ | No |
| ○ | ○ | U/K |

15. Parents have prior child deaths?

| Mother | Father | |
|---|---|---|
| ○ | ○ | Yes |
| ○ | ○ | No |
| ○ | ○ | U/K |

16. Parents have history of intimate partner violence?

| Check all that apply: | Mother | Father | |
|---|---|---|---|
| | ☐ | ☐ | Yes, as victim |
| | ☐ | ☐ | Yes, as perpetrator |
| | ☐ | ☐ | No |
| | ☐ | ☐ | U/K |

17. Parents have delinquent/criminal history?

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

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 |

If no, language spoken:

| | | |
|---|---|---|
| ○ | ○ | U/K |

9. Caregiver(s) first generation immigrant?

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

10. Caregivers 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 that apply:

| One | Two | | One | Two | |
|---|---|---|---|---|---|
| ☐ | ☐ | WIC | ☐ | ☐ | Section 8/housing |
| ☐ | ☐ | Home visiting, specify: | ☐ | ☐ | Social Security Disability Insurance (SSI/SSDI) |
| ☐ | ☐ | TANF | ☐ | ☐ | Other, specify: |
| ☐ | ☐ | Medicaid | | | |
| ☐ | ☐ | Food stamps/SNAP/EBT | ☐ | ☐ | 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 child ever left 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
- ○ Hours
- ○ Days
- ○ U/K

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

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

5. Supervisor's age in years: ☐ U/K

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

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

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

9. Supervisor has substance abuse history?
- ○ Yes
- ○ No
- ○ U/K

10. Supervisor has history of child maltreatment?

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

11. Supervisor has a 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 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 distracted or 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
- ☐ Hotel/motel
- ☐ 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, etc.):

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

9. Was 911 or local emergency called?
- ○ NA
- ○ Yes
- ○ No
- ○ U/K

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

If yes, check all that apply:
- ☐ Alcohol
- ☐ Over-the-counter drugs
- ☐ U/K
- ☐ Cocaine
- ☐ Prescription drugs
- ☐ Marijuana
- ☐ Opioids
- ☐ Methamphetamine
- ☐ Other, specify:

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

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

## F. INVESTIGATION INFORMATION

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 scans, photos of 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/prior to the autopsy? Please list any abnormalities/significant findings in F10 or Narrative.

| 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
- ☐ Cocaine
- ☐ Methamphetamine
- ☐ Too high Rx drug, specify:
- ☐ Other, specify:
- ☐ Alcohol
- ☐ Marijuana
- ☐ Opioids
- ☐ Too high OTC drug, 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+?
○ NA ○ Yes ○ No ○ U/K
If no, describe 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+?
○ NA ○ Yes ○ No ○ U/K If yes, from what source?
☐ From x-rays ☐ From law enforcement
☐ From autopsy ☐ U/K
☐ From CPS review

16. CPS action taken because of death+? ○ NA ○ 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 ☐ U/K
☐ Voluntary services provided
☐ Court-ordered services provided
☐ Voluntary out of home placement
☐ Court-ordered out of home placement
☐ Children removed
☐ Parental rights terminated

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

☐ If manner of death was not Natural or Suicide, check this box if it is possible that the child intended to hurt themselves. If checked, complete the Suicide Section (I6) to note other risk factors in the child's life.

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 I1
- ○ Other cause, go to H9
- ○ U/K, go to I1

○ 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/dehyration
- ○ 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 I1
○ U/K, go to I1

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

### H1. MOTOR VEHICLE AND OTHER TRANSPORT

a. Vehicles involved in incident:
Total number of vehicles: ☐

| Child's | Other primary vehicle |
|---|---|
| ○ | ○ None |
| ○ | ○ Car |
| ○ | ○ Van |
| ○ | ○ Sport utility vehicle |
| ○ | ○ Truck |
| ○ | ○ Semi/tractor trailer |
| ○ | ○ RV/bus/school bus |
| ○ | ○ Motorcycle |
| ○ | ○ Tractor/farm vehicle |
| ○ | ○ All terrain vehicle |
| ○ | ○ Snowmobile |
| ○ | ○ Bicycle |
| ○ | ○ Train/subway/trolly |
| ○ | ○ Scooter |
| ○ | ○ Skateboard |
| ○ | ○ Other, specify: ☐ |
| ○ | ○ U/K ☐ |

b. Position of child:
- ○ Driver
- ○ Passenger
  - ○ Front seat
  - ○ Back seat
  - ○ Truck bed
  - ○ Other, specify: ☐
  - ○ U/K
- ○ On bicycle
- ○ Pedestrian
  - ○ Walking
  - ○ Boarding/blading
  - ○ Other, specify: ☐
  - ○ U/K
- ○ U/K

If passenger, relationship of driver to child:
- ○ Biological parent
- ○ Adoptive parent
- ○ Stepparent
- ○ Foster parent
- ○ Parent's partner
- ○ Grandparent
- ○ Sibling
- ○ Other relative
- ○ Friend
- ○ Other, specify: ☐
- ○ U/K

Autonomous?

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

Was child riding or powered by 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
- ☐ Vehicle 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
- ☐ Railroad crossing/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
- ☐ Flooding
- ☐ 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 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) | License type/violation: |
|---|---|
| ○ <16 years | ☐ Has no license |
| ○ 16 to 18 years old | ☐ Has a learner's permit |
| ○ 19 to 21 years old | ☐ Has a graduated license |
| ○ 22 to 29 years old | ☐ Has a full license |
| ○ 30 to 65 years old | ☐ Has a full license that has been restricted |
| ○ >65 years old | ☐ Has a suspended license |
| ○ U/K | ☐ Was violating graduated license 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:
- ☐ Lap/shoulder belt
- ☐ Child seat
- ☐ Belt positioning booster seat
- ☐ Helmet
- ☐ U/K

If yes, describe: ☐

## 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 I1
- ○ Electrocution, go to o
- ○ U/K, go to I1

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
If yes, 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 fire
- ☐ U/K

o. For electrocution, what cause:
- ○ Lightning/electrical storm
- ○ Faulty wiring
- ○ Contact with power line
- ○ Wire/product in water
- ○ Child playing with outlet
- ○ Other, specify:
- ○ U/K

## H3. DROWNING

a. Where was child last seen before drowning? Selct 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 h
- ○ Other, specify and go to h
- ○ U/K, go to h

c. For open water, place:
- ○ Lake
- ○ River
- ○ Pond
- ○ Creek
- ○ Ocean
- ○ Quarry or gravel pit
- ○ Canal/drainage ditch
- ○ U/K

d. Was child boating?
○ Yes ○ No ○ U/K

e. Select all contributing environmental factors. Check all that apply.
- ☐ None
- ☐ Weather
- ☐ Temperature
- ☐ Current
- ☐ Riptide/undertow
- ☐ Dropoff
- ☐ Rough waves
- ☐ Flash flood
- ☐ Water clarity
- ☐ U/K

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

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

h. Did child have an illness or medical condition that may have contributed to the drowning? If yes, check all that apply.
○ Yes ○ No ○ U/K
- ☐ Autism
- ☐ Developmental disability
- ☐ Epilepsy or seizure disorder
- ☐ Febrile seizure
- ☐ Other, specify:
- ☐ U/K

i. How deep was water where child was last seen?
- ○ N/A, child last seen on land
- ○ <6 inches
- ○ 6-11 inches
- ○ 12-23 inches
- ○ 2-6 feet
- ○ >6 feet
- ○ U/K

j. What temperature was water at time of submersion?
- ○ 0-32° F
- ○ 33-60° F
- ○ 61-80° F
- ○ >80° F
- ○ U/K

k. Flotation device used at time of the incident?
- ○ N/A
- ○ Yes, specify:
- ○ No
- ○ U/K

l. Did the child depend on a life jacket, swim vest, or swim aid while in or around water? ○ N/A ○ Yes ○ No ○ U/K

m. 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
Fence surrounds water on:
○ Four Sides
○ Three sides
○ Two or one side
○ U/K

☐ 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
☐ Pet door/flap

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

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

n. Local ordinance(s) regulating access to water?
○ Yes ○ No ○ U/K
If yes, were rules violated?
○ Yes ○ No ○ U/K

o. 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

p. Child able to swim?
○ N/A ○ Yes ○ No ○ U/K
Child's swimming level:
○ Beginner
○ Intermediate
○ Advanced
○ U/K

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

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

s. Rescue attempt made? ○ N/A ○ Yes ○ No ○ U/K
If yes, who?
☐ Parent/relative
☐ Other child
☐ Lifeguard
☐ Other adult
☐ EMS/first responder
☐ Bystander
☐ Other, specify:
☐ U/K
If yes, did rescuer(s) also drown?
○ Yes
○ No
○ U/K

t. 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 asphyxia event:
○ Sleep-related, go I1
○ Not sleep-related, including intentional hangings, 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 I1

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

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

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

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

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

If no, was 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
- ○ U/K
- ○ Other, specify:

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

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

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

## 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
- ○ Natural elevation
- ○ Man-made elevation
- ○ Playground equipment
- ○ Tree
- ○ Stairs/steps
- ○ Balcony
- ○ Furniture
- ○ Bed
- ○ Roof
- ○ Bridge
- ○ Overpass
- ○ Moving object, specify:
- ○ U/K
- ○ Animal, specify:
- ○ Other, specify:

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
- ○ Boulder/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?**
Y = Yes
N = No
U = U/K

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

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

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

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

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

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

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 ○ 7-30 days
○ Since birth ○ 1-11 months
○ < 1 day ○ >= 1 year
○ 1-6 days ○ 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 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 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
- Air mattress
- 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
- Air mattress
- 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 | U/K |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Adult(s) | ○ | ○ | ○ | ☐ | ☐ | ☐ | ☐ | ☐ | ○ | ○ | ○ |
| Other child | ○ | ○ | ○ | ☐ | ☐ | ☐ | ☐ | ☐ | ○ | ○ | ○ |
| Animal(s) | ○ | ○ | ○ | ☐ | ☐ | ☐ | ☐ | ☐ | ○ | ○ | ○ |
| Mattress | ○ | ○ | ○ | ☐ | ☐ | ☐ | ☐ | ☐ | ○ | ○ | ○ |
| Comforter, quilt, or blanket | ○ | ○ | ○ | ☐ | ☐ | ☐ | ☐ | ☐ | ○ | ○ | ○ |
| 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, mother):

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

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

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

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

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

If yes, check all that apply:
☐ With adult(s): # ☐ U/K
Adult obese: ○ Yes ○ No ○ U/K
☐ With other children: # ☐ U/K Children's ages:
☐ With animals: # ☐ U/K Type(s) of animals:
☐ 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 RELATED TO 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. Was a recall in place at the time of the incident?
○ Yes ○ No ○ U/K

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

e. Were any of the following regulatory agencies notified of the incident?
○ None ○ Consumer Product Safety Commission ○ Food and Drug Administration
○ National Highway Transportation Safety Administration ○ U/K

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

a. Type of crime, check all that apply:

☐ Robbery/burglary ☐ Other assault ☐ Arson ☐ Illegal border crossing ☐ U/K
☐ Interpersonal violence ☐ Gang conflict ☐ Sex work ☐ 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:

☐ Physical abuse, select type below:
- ☐ Abusive head trauma/shaking, go to I5c
- ☐ Chronic Battered Child Syndrome, go to I5e
- ☐ Beating/kicking, go to I5e
- ☐ Scalding or burning, go to I5e
- ☐ Use of weapon, go to I5e
- ☐ Drowning, go to I5e
- ☐ Asphyxia/suffocation, go to I5e

☐ Sexual assault, go to I5h
☐ Emotional abuse, go to I5h
☐ Other, specify and go to I5h
☐ U/K, go to I5e

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

○ Yes ○ No ○ U/K

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

○ Yes ○ No ○ U/K

If child shaken, 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
○ Mother 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
☐ Discrimination ☐ Job problems ☐ Housing instability ☐ Cultural differences ☐ Pregnancy
☐ Poverty ☐ Money problems ☐ Witnessed violence ☐ Language barriers ☐ Pregnancy scare
☐ 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 ☐ Negative provider assumptions

c. Life Stressors - Relationships

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

d. Life stressors - School (age 5 and over)

☐ None listed below ☐ Extracurricular activities
☐ School failure ☐ New school
☐ Pressure to succeed ☐ Other school problems

e. Technology (age 5 and over)

☐ None listed below ☐ Restriction of technology
☐ Electronic gaming ☐ Social media
☐ Texting

f. Life stressors - Transitions (age 5 and over)

☐ None listed below
☐ Release from hospital
☐ Transition from any level of mental health care to another (e.g. inpatient to outpatient, inpatient to residential, etc.)
☐ Release from juvenile justice facility
☐ End of school year/school break
☐ Transition to/from child welfare system
☐ Release from immigrant detention center

g. Life stressors - Trauma (age 5 and over)

☐ None listed below
☐ Rape/sexual assault
☐ Previous abuse (emotional/physical)
☐ Family/domestic violence

h. Life stressors - Describe any other life stressors:

## I8. DEATHS DURING THE COVID-19 PANDEMIC (complete for all ages if death occurred during federal emergency declaration (3/13/20-5/11/23))

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, approximate 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 mother receive her COVID-19 vaccination? ○ Yes ○ No ○ U/K

If yes, when did she receive her first dose?

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

If yes, which option best represents her 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 mother contracted COVID-19, specify:
  - ○ Before pregnancy
  - ○ 1st trimester
  - ○ 2nd trimester
  - ○ 3rd trimester
  - ○ After delivery
  - ○ 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, mother, go to J17 |
| ○ | ○ | Yes, father, go to J17 |
| ○ | ○ | Yes, caregiver one, go to J17 |
| ○ | ○ | Yes, caregiver two, go to J17 |
| ○ | ○ | Yes, supervisor, go to J19 |
| ○ | ○ | No |

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

| One | Two | | One | Two | | One | Two | |
|---|---|---|---|---|---|---|---|---|
| ○ | ○ | Adoptive parent | ○ | ○ | Acquaintance | ○ | ○ | Other, specify: |
| ○ | ○ | Stepparent | ○ | ○ | Child's boyfriend or girlfriend | | | |
| ○ | ○ | Foster parent | | | | | | |
| ○ | ○ | Parent's partner | ○ | ○ | Stranger | | | |
| ○ | ○ | Grandparent | ○ | ○ | Medical provider | | | |
| ○ | ○ | Sibling | ○ | ○ | Institutional staff | | | |
| ○ | ○ | Other relative | ○ | ○ | Babysitter | | | |
| ○ | ○ | Friend | ○ | ○ | Licensed child care worker | ○ | ○ | 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
○ ○ No
If no, language spoken:
○ ○ U/K

9. Person on active military duty?
One Two
○ ○ Yes
○ ○ No
○ ○ U/K
If yes, specify branch:

10. Person(s) have history of substance abuse?
One Two
○ ○ Yes
○ ○ No
○ ○ U/K

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?
Check all that apply:
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 distracted or impaired?
One
○ Yes ○ No ○ U/K
Two
○ Yes ○ No ○ U/K

If yes, check all that apply:

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

One Two
☐ ☐ Distracted
☐ ☐ Absent

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

One Two
☐ ☐ Other, specify:

19. Person(s) have, check all that apply:
One Two
☐ ☐ Prior history of similar acts
☐ ☐ Prior arrests
☐ ☐ Prior convictions

20. Legal outcomes in this death, check all that apply:
One Two
☐ ☐ No charges filed
☐ ☐ Charges pending
☐ ☐ Charges filed, specify:
☐ ☐ Charges dismissed
☐ ☐ Confession
☐ ☐ Plead, specify:

One Two
☐ ☐ 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:
- ☐ Law enforcement — Describe:
- ☐ Public health — Describe:
- ☐ Coroner/medical examiner — Describe:
- ☐ Courts — Describe:
- ☐ Health care systems — Describe:
- ☐ Education — Describe:
- ☐ Mental health — Describe:
- ☐ EMS — Describe:
- ☐ Substance abuse — Describe:
- ☐ Other, specify: — Describe:

5. Could the death have been prevented? ○ Yes, probably ○ No, probably not ○ Team could not determine/come to consensus ○ Not enough information to 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
- ☐ WIC
- ☐ Epidemiologist
- ☐ HMO/managed care
- ☐ CPS
- ☐ Other social services
- ☐ Physician
- ☐ Nurse
- ☐ Midwife
- ☐ Dietitian/nutritionist
- ☐ 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
- ☐ Community representative
- ☐ 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
- ☐ Hospital records
- ☐ Mother'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
- ☐ Water-related DSI protocol
- ☐ 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 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/National Center'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
- Y N U Preconception care
- Y N U Postpartum visit kept
- Y N U Pregnancy planning/BC education ☐ Before ☐ During ☐ After
- Y N U Dental/oral care ☐ Before ☐ During ☐ After
- Y N U Chronic disease control education ☐ Before ☐ During ☐ After
- Y N U Weight mgmt/dietitian ☐ Before ☐ During ☐ After
- Y N U Bereavement referral

***2. Medical: Mother***

P C
- 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

***2. Medical: Mother (cont.)***
- 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 infection:
- P C Multiple gestation #
- P C Weight: BMI:
- P C Insufficient/excess weight gain
- P C Poor nutrition
- P C Gestational hypertension
- 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

***2. Medical: Mother (cont.)***
- P C Oligohydramnios
- P C 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:

**O2. FIMR ISSUES SUMMARY (cont.) (Ps/Cs)** P = Present / C = Contributing

***3. Family Planning***
- Ⓟ Ⓒ Intended pregnancy
- Ⓟ Ⓒ Unintended pregnancy
- Ⓟ Ⓒ Unwanted pregnancy
- Ⓟ Ⓒ No birth control
- Ⓟ Ⓒ Failed contraceptive
- Ⓟ Ⓒ Lack of knowledge: methods
- Ⓟ Ⓒ Lack of resources
- Ⓟ Ⓒ Other, specify:

***4. Substance Use***
- Ⓟ Ⓒ Positive drug test
- Ⓟ Ⓒ No drug test
- Ⓟ Ⓒ Tobacco use: hx, not current
- Ⓟ Ⓒ Tobacco use: current
- Ⓟ Ⓒ Alcohol use: hx, not current
- Ⓟ Ⓒ Alcohol use: current
- Ⓟ Ⓒ Marijuana use: hx, not current
- Ⓟ Ⓒ Marijuana use: current
- Ⓟ Ⓒ Illicit drug use: hx, not current
- Ⓟ Ⓒ Illicit drug use: current, type:
- Ⓟ Ⓒ Use of un-pres meds: type:
- Ⓟ Ⓒ OTC/Rx meds: type:
- Ⓟ Ⓒ Other, specify:

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

***6. Medical: Fetal/Infant***
- Ⓟ Ⓒ Pre-viable fetus
- Ⓟ Ⓒ LBW (<2500 grams)
- Ⓟ Ⓒ VLBW (<1500 grams)
- Ⓟ Ⓒ ELBW (<750 grams)
- Ⓟ Ⓒ Gestational age: <28 weeks
- Ⓟ Ⓒ Gestational age: 28-31 weeks
- Ⓟ Ⓒ Gestational age: 32-36 weeks
- Ⓟ Ⓒ Gestational age: 37-40 weeks
- Ⓟ Ⓒ Gestational age: >40 weeks
- Ⓟ Ⓒ Fetal Growth Restriction
- Ⓟ Ⓒ Congenital anomaly
- Ⓟ Ⓒ Infection/sepsis
- Ⓟ Ⓒ Failure to thrive
- Ⓟ Ⓒ Birth injury
- Ⓟ Ⓒ Feeding problem
- Ⓟ Ⓒ Respiratory Distress Syndrome
- Ⓟ Ⓒ Developmental delay
- Ⓟ Ⓒ Inappropriate level of care
- Ⓟ Ⓒ Positive drug test
- Ⓟ Ⓒ Other, specify:

***7. Pediatric Care***
- Ⓟ Ⓒ Standard of care not met
- Ⓟ Ⓒ Inadequate assessment
- Ⓟ Ⓒ No pediatric care
- Ⓟ Ⓒ Lack of referrals

***7. Pediatric Care (cont.)***
- Ⓟ Ⓒ Missed aptmnt/immunizations
- Ⓟ Ⓒ Multiple providers/sites
- Ⓟ Ⓒ Inappropriate use of ER
- Ⓟ Ⓒ Other, specify:

***8. Environment***
- Ⓟ Ⓒ Unsafe neighborhood
- Ⓟ Ⓒ Substandard housing
- Ⓟ Ⓒ Overcrowding
- Ⓟ Ⓒ Second-hand smoke
- Ⓟ Ⓒ Little/no breastfeeding
- Ⓟ Ⓒ Improper formula prep/feeding
- Ⓟ Ⓒ Unsafe sleep location
- Ⓟ Ⓒ Objects in sleep environment
- Ⓟ Ⓒ Infant overheating
- Ⓟ Ⓒ Not back sleep position
- Ⓟ Ⓒ Lack of adult supervision
- Ⓟ Ⓒ Other, specify:

***9. Injuries***
- Ⓟ Ⓒ Suffocation/strangulation
- Ⓟ Ⓒ Abusive head trauma
- Ⓟ Ⓒ General trauma
- Ⓟ Ⓒ Other, specify:

***10. Social Support***
- Ⓟ Ⓒ Lack of family support
- Ⓟ Ⓒ Lack of neighbors/community support
- Ⓟ Ⓒ Lack of partner support
- Ⓟ Ⓒ Single parent
- Ⓟ Ⓒ Living alone
- Ⓟ Ⓒ <12th grade education
- Ⓟ Ⓒ Special education
- Ⓟ Ⓒ Physical/cognitive disability
- Ⓟ Ⓒ Other, specify:

***11. Partner/Caregiver***
- Ⓟ Ⓒ Employment ○ Yes ○ No
- Ⓟ Ⓒ Hx of mental illness
- Ⓟ Ⓒ Substance or tobacco use/abuse: hx, specify:
- Ⓟ Ⓒ Substance or tobacco use/abuse: current, specify:
- Ⓟ Ⓒ Other, specify:

***12. Family Transition***
- Ⓟ Ⓒ Frequent/recent moves
- Ⓟ Ⓒ Living in shelter/homeless
- Ⓟ Ⓒ Concern re: citizenship
- Ⓟ Ⓒ Divorce/separation
- Ⓟ Ⓒ Multiple partners
- Ⓟ Ⓒ Prison/parole/probation (Mother)
- Ⓟ Ⓒ Prison/parole/probation (Father)
- Ⓟ Ⓒ Major illness/death in family
- Ⓟ Ⓒ Other, specify:

***13. Mental Health/Stress***
- Ⓟ Ⓒ Hx of mental illness (Mother)
- Ⓟ Ⓒ Depression/anxiety/mental illness during pregnancy
- Ⓟ Ⓒ Depression/anxiety/mental illness in postpartum period
- Ⓟ Ⓒ Multiple stresses
- Ⓟ Ⓒ Social chaos
- Ⓟ Ⓒ Employment ○ Yes ○ No
- Ⓟ Ⓒ Concern about enough money

***13. Mental Health/Stress (cont.)***
- Ⓟ Ⓒ Work/employment problems
- Ⓟ Ⓒ Child(ren) with special needs
- Ⓟ Ⓒ Problems with family/relatives
- Ⓟ Ⓒ Lack of grief support
- Ⓟ Ⓒ Other, specify:

***14. Family Violence/Neglect***
- Ⓟ Ⓒ Hx of abuse (Mother), specify:
- Ⓟ Ⓒ Current abuse (Mother), specify:
- Ⓟ Ⓒ Hx of abuse (Father), specify:
- Ⓟ Ⓒ Current abuse (Father), specify:
- Ⓟ Ⓒ Hx child abuse: this child
- Ⓟ Ⓒ Hx child abuse: other child
- Ⓟ Ⓒ Current child abuse: this child
- Ⓟ Ⓒ Current child abuse: other child
- Ⓟ Ⓒ Hx child neglect: this child
- Ⓟ Ⓒ Hx child neglect: other child
- Ⓟ Ⓒ Current child neglect: this child
- Ⓟ Ⓒ Current child neglect: other child
- Ⓟ Ⓒ CPS referrals
- Ⓟ Ⓒ Police reports
- Ⓟ Ⓒ Other, specify:

***15. Culture***
- Ⓟ Ⓒ Language barriers
- Ⓟ Ⓒ Beliefs re: pregnancy/health
- Ⓟ Ⓒ Other, specify:

***16. Payment for Care***
- Ⓟ Ⓒ Private
- Ⓟ Ⓒ Medicare
- Ⓟ Ⓒ Medicaid
- Ⓟ Ⓒ Self-pay/medically indigent
- Ⓟ Ⓒ Other, specify:

***17. Services Provided***
- Ⓟ Ⓒ Inadequate information
- Ⓟ Ⓒ Lack of WIC (eligible)
- Ⓟ Ⓒ Parent/child not eligible
- Ⓟ Ⓒ Lack of Home Visiting (eligible)
- Ⓟ Ⓒ Poor provider to provider communication
- Ⓟ Ⓒ Poor provider to patient communication
- Ⓟ Ⓒ Client dissatisfaction
- Ⓟ Ⓒ Dissatisfaction – support services
- Ⓟ Ⓒ Lack of child care
- Ⓟ Ⓒ Other, specify:

***18. Transportation***
- Ⓟ Ⓒ No public transportation
- Ⓟ Ⓒ Inadequate/unreliable
- Ⓟ Ⓒ Other, specify:

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

***20. Other***
- Ⓟ Ⓒ Other, specify:

## P. FORM COMPLETED BY:

Person: _____ Email: _____

Title: _____ Date completed: ___/___/____

Agency: _____ Data entry completed for this case? ☐

Phone: _____

**For State Program Use Only:**

Data quality assurance completed by state? ☐

NATIONAL CFRP
Center for Fatality Review & Prevention

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