

Child Death Review Case Reporting System

Case Report 2.2S

With Expanded Questions for Sudden and Unexpected Infant Death (SUID)
Effective January 2011

Instructions:

This case report is a component of the web-based CDR Case Reporting System. Version 2.2S is an enhanced version to collect more information on SUID deaths. It must be used in place of Version 2.2 by states participating in the SUID Case Registry Pilot Project and funded by the CDC. It can be used alone as a paper instrument, but its full potential is reached when the data from this form is entered into the CDR Case Reporting System. This system is available to states from the National Center for Child Death Review and requires a data use agreement for state and local data entry. System functions include data entry, case report editing and printing, data download and standardized reports.

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

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

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

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

Most questions have a selection for unknown (U/K). A question should be marked 'unknown' if an attempt was made to find the answer, but no clear or satisfactory response was obtained; questions should be left blank (unanswered) if no attempt was made to find the answer.

'N/A' stands for 'Not Applicable' and should be used if the question is not applicable. For example, use N/A for 'level of education' if child is an infant.

This edition is Version 2.2S, effective January 2011. Additional paper forms can be ordered from the National Center at no charge. Users interested in participating in the web-based case reporting system for data entry and reporting should contact the National Center for Child Death Review.

This form was originally developed by a work group of over 26 persons, representing 18 states and the Maternal and Child Bureau of HRSA/HHS.

The SUID variables were identified in consultation with national SUID experts, in partnership with the CDC Division of Reproductive Health.

Phone: 1-800-656-2434 Email: info@childdeathreview.org Website: www.childdeathreview.org Data entry website: <https://cdrdata.org/>

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CASE NUMBER

_____ / _____ / _____ State / County or Team Number / Year of Review / Sequence of Review	Death Certificate Number: Birth Certificate Number: ME/Coroner Number: Date CDRT Notified of Death:	Case Type: <input type="radio"/> Death <input type="radio"/> Near death/serious Injury <input type="radio"/> Not born alive
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A. CHILD INFORMATION

1. Child's name: First: _____ Middle: _____ Last: _____ <input type="checkbox"/> U/K																														
2. Date of birth: <input type="checkbox"/> U/K mm / dd / yyyy	3. Date of death: <input type="checkbox"/> U/K mm / dd / yyyy	4. Age: <input type="radio"/> Years <input type="radio"/> Months <input type="radio"/> Days <input type="radio"/> Hours <input type="radio"/> Minutes <input type="radio"/> U/K	5. Race, check all that apply <input type="checkbox"/> U/K <input type="checkbox"/> White <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> Black <input type="checkbox"/> Pacific Islander <input type="checkbox"/> Asian, specify: <input type="checkbox"/> American Indian, Tribe: <input type="checkbox"/> Alaskan Native, Tribe:	6. Hispanic or Latino origin? <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> U/K	7. Sex: <input type="radio"/> Male <input type="radio"/> Female <input type="radio"/> U/K																									
8. Residence address: <input type="checkbox"/> U/K Street: _____ Apt. _____ City: _____ County: _____ State: _____ Zip: _____			9. Type of residence: <input type="radio"/> Parental home <input type="radio"/> Relative home <input type="radio"/> Jail/Detention <input type="radio"/> Licensed group home <input type="radio"/> Living on own <input type="radio"/> Other, specify: <input type="radio"/> Licensed foster home <input type="radio"/> Shelter <input type="radio"/> Relative foster home <input type="radio"/> Homeless <input type="radio"/> U/K			10. New residence in past 30 days? <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> U/K																								
11. Residence overcrowded? <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> U/K	12. Child ever homeless? <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> U/K	13. Number of other children living with child: _____ <input type="checkbox"/> U/K	14. Child's weight: <input type="checkbox"/> U/K _____ pounds _____ ounces	15. Child's height: <input type="checkbox"/> U/K _____ feet _____ inches																										
16. Highest education level: <input type="radio"/> N/A <input type="radio"/> Drop out <input type="radio"/> None <input type="radio"/> HS graduate <input type="radio"/> Preschool <input type="radio"/> College <input type="radio"/> Grade K-8 <input type="radio"/> Other, specify: <input type="radio"/> Grade 9-12 <input type="radio"/> U/K <input type="radio"/> Home schooled, K-8 <input type="radio"/> Home schooled, 9-12		17. Child's work status: <input type="radio"/> N/A <input type="radio"/> Employed <input type="radio"/> Full time <input type="radio"/> Part time <input type="radio"/> U/K <input type="radio"/> Not working <input type="radio"/> U/K	18. Did child have problems in school? <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> U/K If yes, check all that apply: <input type="checkbox"/> Academic <input type="checkbox"/> Behavioral <input type="checkbox"/> Truancy <input type="checkbox"/> Expulsion <input type="checkbox"/> Suspensions <input type="checkbox"/> U/K <input type="checkbox"/> Other, specify:		19. Child's health insurance, check all that apply: <input type="checkbox"/> None <input type="checkbox"/> Private <input type="checkbox"/> Medicaid <input type="checkbox"/> State plan <input type="checkbox"/> Other, specify: <input type="checkbox"/> U/K																									
20. Child had disability or chronic illness? <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> U/K If yes, check all that apply: <input type="checkbox"/> Physical, specify: <input type="checkbox"/> Mental, specify: <input type="checkbox"/> Sensory, specify: <input type="checkbox"/> U/K If yes, was child receiving Children's Special Health Care Needs services? <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> U/K		21. Child's mental health (MH): Child had received prior MH services? <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> U/K Child was receiving MH services? <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> U/K Child on medications for MH illness? <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> U/K Issues prevented child from receiving MH services? <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> U/K If yes, specify:		22. Child had history of substance abuse? <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> U/K If yes, check all that apply: <input type="checkbox"/> Alcohol <input type="checkbox"/> Other, specify: <input type="checkbox"/> Cocaine <input type="checkbox"/> Marijuana <input type="checkbox"/> U/K <input type="checkbox"/> Methamphetamine <input type="checkbox"/> Opiates <input type="checkbox"/> Prescription drugs <input type="checkbox"/> Over-the-counter drugs																										
23. Child had history of child maltreatment? If yes, check all that apply: <table style="width:100%; border-collapse: collapse;"> <tr> <td style="width:25%;"><u>As Victim</u></td> <td style="width:25%;"><u>As Perpetrator</u></td> <td style="width:25%;"><u>As Victim</u></td> <td style="width:25%;"><u>As Perpetrator</u></td> </tr> <tr> <td><input type="radio"/> N/A</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/> Physical</td> </tr> <tr> <td><input type="radio"/> No</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/> Neglect</td> </tr> <tr> <td><input type="radio"/> Yes</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/> Sexual</td> </tr> <tr> <td><input type="radio"/> U/K</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/> Emotional/psychological</td> </tr> <tr> <td></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/> U/K</td> </tr> </table> If yes, how was history identified: <input type="radio"/> Through CPS _____ # CPS referrals <input type="radio"/> Other sources _____ # Substantiations				<u>As Victim</u>	<u>As Perpetrator</u>	<u>As Victim</u>	<u>As Perpetrator</u>	<input type="radio"/> N/A	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Physical	<input type="radio"/> No	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Neglect	<input type="radio"/> Yes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Sexual	<input type="radio"/> U/K	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Emotional/psychological		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> U/K	24. Was there an open CPS case with child at time of death? <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> U/K		27. Child had history of intimate partner violence? Check all that apply: <input type="checkbox"/> N/A <input type="checkbox"/> No <input type="checkbox"/> Yes, as victim <input type="checkbox"/> Yes, as perpetrator <input type="checkbox"/> U/K
<u>As Victim</u>	<u>As Perpetrator</u>	<u>As Victim</u>	<u>As Perpetrator</u>																											
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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> U/K																											
				25. Was child ever placed outside of the home prior to the death? <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> U/K																										
				26. Were any siblings placed outside of the home prior to this child's death? <input type="radio"/> No <input type="radio"/> Yes, # _____ <input type="radio"/> U/K																										
28. Child had delinquent or criminal history? <input type="radio"/> N/A <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> U/K If yes, check all that apply: <input type="checkbox"/> Assaults <input type="checkbox"/> Other, specify: <input type="checkbox"/> Robbery <input type="checkbox"/> Drugs <input type="checkbox"/> U/K		29. Child spent time in juvenile detention? <input type="radio"/> N/A <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> U/K		32. If child over age 12, what was child's gender identity? <input type="radio"/> Male <input type="radio"/> Female <input type="radio"/> U/K																										
		30. Child acutely ill during the two weeks before death? <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> U/K		33. If child over age 12, what was child's sexual orientation? <input type="radio"/> Heterosexual <input type="radio"/> Bisexual <input type="radio"/> Gay <input type="radio"/> Questioning <input type="radio"/> Lesbian <input type="radio"/> U/K																										
		31. Are child's parents first generation immigrants? <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> U/K If yes, country of origin:																												

COMPLETE FOR ALL INFANTS UNDER ONE YEAR

34. Gestational age: <input type="checkbox"/> U/K _____ # weeks	35. Birth weight: <input type="checkbox"/> U/K <input type="radio"/> Grams _____ <input type="radio"/> Pounds/ounces _____ /	36. Multiple birth? <input type="radio"/> No <input type="radio"/> U/K <input type="radio"/> Yes, # _____	37. Including the deceased infant, how many pregnancies did the birth mother have? # _____ <input type="checkbox"/> U/K	38. Including the deceased infant, how many live births did the birth mother have? # _____ <input type="checkbox"/> U/K
39. Not including the deceased infant, number of children birth mother still has living? # _____ <input type="checkbox"/> U/K		40. Prenatal care provided during pregnancy of deceased infant? <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> U/K If yes, number of prenatal visits: # _____ <input type="checkbox"/> U/K If yes, month of first prenatal visit? Specify 1-9 __ <input type="checkbox"/> U/K		
41. During pregnancy, did mother (check all that apply): <input type="checkbox"/> Have medical complications/infections? Check all that apply: <input type="checkbox"/> Acute/Chronic Lung Disease <input type="checkbox"/> Eclampsia <input type="checkbox"/> Low MSAFP <input type="checkbox"/> PROM <input type="checkbox"/> Anemia <input type="checkbox"/> Genital Herpes <input type="checkbox"/> Other Infectious Disease <input type="checkbox"/> Renal Disease <input type="checkbox"/> Cardiac Disease <input type="checkbox"/> Hemoglobinopathy <input type="checkbox"/> Pregnancy-Related Hypertension <input type="checkbox"/> Rh Sensitization <input type="checkbox"/> Chorioamnionitis <input type="checkbox"/> High MSAFP <input type="checkbox"/> Preterm Labor <input type="checkbox"/> Uterine Bleeding <input type="checkbox"/> Chronic Hypertension <input type="checkbox"/> Hydramnios/Oligohydramnios <input type="checkbox"/> Previous Infant 4000+ Grams <input type="checkbox"/> Other, specify: <input type="checkbox"/> Diabetes <input type="checkbox"/> Incompetent Cervix <input type="checkbox"/> Previous Infant Preterm/Small for Gestation				
42. Were there access or compliance issues related to prenatal care? <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> U/K If yes, check all that apply: <input type="checkbox"/> Lack of money for care <input type="checkbox"/> Cultural differences <input type="checkbox"/> Multiple providers, not coordinated <input type="checkbox"/> Unwilling to obtain care <input type="checkbox"/> Limitations of health insurance coverage <input type="checkbox"/> Religious objections to care <input type="checkbox"/> Lack of child care <input type="checkbox"/> Intimate partner would not allow care <input type="checkbox"/> Multiple health insurance, not coordinated <input type="checkbox"/> Language barriers <input type="checkbox"/> Lack of family/social support <input type="checkbox"/> Other, specify: <input type="checkbox"/> Lack of transportation <input type="checkbox"/> Referrals not made <input type="checkbox"/> Services not available <input type="checkbox"/> U/K <input type="checkbox"/> No phone <input type="checkbox"/> Specialist needed, not available <input type="checkbox"/> Distrust of health care system				
43. Did mother smoke in the 3 months before pregnancy? <input type="radio"/> No If yes, ___ Average # cigarettes/day <input type="radio"/> Yes (20 cigarettes in a pack) <input type="radio"/> U/K <input type="checkbox"/> U/K quantity		44. Did mother smoke at any time during pregnancy? <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> U/K Trimester 1 Trimester 2 Trimester 3 If yes, _____ _____ _____ Average # cigarettes/day _____ _____ _____ (20 cigarettes in a pack) <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> U/K quantity		
45. Infant ever breastfed? <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> U/K	46. Was mother injured during pregnancy? <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> U/K If yes, describe:	47. Did infant have abnormal metabolic newborn screening results? <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> U/K If yes, was abnormality a fatty acid oxidation error, such as MCAD? <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> U/K If yes, describe: If other abnormalities, describe:		
48. At any time prior to the infant's last 72 hours, did the infant have a history of (check all that apply): <input type="checkbox"/> Infection <input type="checkbox"/> Cyanosis <input type="checkbox"/> Allergies <input type="checkbox"/> Seizures or convulsions <input type="checkbox"/> Abnormal growth, weight gain/loss <input type="checkbox"/> Cardiac abnormalities <input type="checkbox"/> Apnea <input type="checkbox"/> Metabolic disorders <input type="checkbox"/> Other, specify:		49. In the 72 hours prior to death, did the infant have any of the following? Check all that apply: <input type="checkbox"/> Fever <input type="checkbox"/> Vomiting <input type="checkbox"/> Apnea <input type="checkbox"/> Excessive sweating <input type="checkbox"/> Choking <input type="checkbox"/> Cyanosis <input type="checkbox"/> Lethargy/sleeping more than usual <input type="checkbox"/> Diarrhea <input type="checkbox"/> Seizures or convulsions <input type="checkbox"/> Fussiness/excessive crying <input type="checkbox"/> Stool changes <input type="checkbox"/> Other, specify: <input type="checkbox"/> Decrease in appetite <input type="checkbox"/> Difficulty breathing		
50. In the 72 hours prior to death, was the infant injured? <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> U/K If yes, describe cause and injuries:	51. In the 72 hours prior to death, was the infant given any vaccines? <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> U/K If yes, list name(s) of vaccines:	52. In the 72 hours prior to death, was the infant given any medications or remedies? Include herbal, prescription and over-the-counter medications and home remedies. <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> U/K If yes, list name and last dose given:		
53. What did the infant have for his/her last meal? Check all that apply: <input type="checkbox"/> Breast milk <input type="checkbox"/> U/K <input type="checkbox"/> Formula, type: <input type="checkbox"/> Baby food, type: <input type="checkbox"/> Cereal, type: <input type="checkbox"/> Other, specify:				

B. PRIMARY CAREGIVER(S) INFORMATION

1. Primary caregiver(s): Select only one each in column one and two. <table style="width:100%; border: none;"> <tr> <td style="width:50%; border: none;"> <table style="width:100%; border: none;"> <tr> <td style="text-align: center;"><u>One</u></td> <td style="text-align: center;"><u>Two</u></td> </tr> <tr> <td><input type="radio"/> Self, go to Section C</td> <td><input type="radio"/> Grandparent</td> </tr> <tr> <td><input type="radio"/> Biological parent</td> <td><input type="radio"/> Sibling</td> </tr> <tr> <td><input type="radio"/> Adoptive parent</td> <td><input type="radio"/> Other relative</td> </tr> <tr> <td><input type="radio"/> Stepparent</td> <td><input type="radio"/> Friend</td> </tr> <tr> <td><input type="radio"/> Foster parent</td> <td><input type="radio"/> Institutional staff</td> </tr> <tr> <td><input type="radio"/> Mother's partner</td> <td><input type="radio"/> Other, specify:</td> </tr> <tr> <td><input type="radio"/> Father's partner</td> <td><input type="radio"/> U/K</td> </tr> </table> </td> <td style="width:50%; border: none;"> <table style="width:100%; border: none;"> <tr> <td style="text-align: center;"><u>One</u></td> <td style="text-align: center;"><u>Two</u></td> </tr> <tr> <td>_____ # Years</td> <td><input type="checkbox"/> <input type="checkbox"/> U/K</td> </tr> </table> 3. Caregiver(s) sex: <table style="width:100%; border: none;"> <tr> <td style="text-align: center;"><u>One</u></td> <td style="text-align: center;"><u>Two</u></td> </tr> <tr> <td><input type="radio"/> Male</td> <td><input type="radio"/> Female</td> </tr> <tr> <td><input type="radio"/> U/K</td> <td><input type="radio"/> U/K</td> </tr> </table> </td> </tr> </table>		<table style="width:100%; border: none;"> <tr> <td style="text-align: center;"><u>One</u></td> <td style="text-align: center;"><u>Two</u></td> </tr> <tr> <td><input type="radio"/> Self, go to Section C</td> <td><input type="radio"/> Grandparent</td> </tr> <tr> <td><input type="radio"/> Biological parent</td> <td><input type="radio"/> Sibling</td> </tr> <tr> <td><input type="radio"/> Adoptive parent</td> <td><input type="radio"/> Other relative</td> </tr> <tr> <td><input type="radio"/> Stepparent</td> <td><input type="radio"/> Friend</td> </tr> <tr> <td><input type="radio"/> Foster parent</td> <td><input type="radio"/> Institutional staff</td> </tr> <tr> <td><input type="radio"/> Mother's partner</td> <td><input type="radio"/> Other, specify:</td> </tr> <tr> <td><input type="radio"/> Father's partner</td> <td><input type="radio"/> U/K</td> </tr> </table>	<u>One</u>	<u>Two</u>	<input type="radio"/> Self, go to Section C	<input type="radio"/> Grandparent	<input type="radio"/> Biological parent	<input type="radio"/> Sibling	<input type="radio"/> Adoptive parent	<input type="radio"/> Other relative	<input type="radio"/> Stepparent	<input type="radio"/> Friend	<input type="radio"/> Foster parent	<input type="radio"/> Institutional staff	<input type="radio"/> Mother's partner	<input type="radio"/> Other, specify:	<input type="radio"/> Father's partner	<input type="radio"/> U/K	<table style="width:100%; border: none;"> <tr> <td style="text-align: center;"><u>One</u></td> <td style="text-align: center;"><u>Two</u></td> </tr> <tr> <td>_____ # Years</td> <td><input type="checkbox"/> <input type="checkbox"/> U/K</td> </tr> </table> 3. 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Caregiver(s) employment status: <table style="width:100%; border: none;"> <tr> <td style="text-align: center;"><u>One</u></td> <td style="text-align: center;"><u>Two</u></td> </tr> <tr> <td><input type="radio"/> Employed</td> <td><input type="radio"/> Unemployed</td> </tr> <tr> <td><input type="radio"/> On disability</td> <td><input type="radio"/> Stay-at-home</td> </tr> <tr> <td><input type="radio"/> Retired</td> <td><input type="radio"/> U/K</td> </tr> </table>	<u>One</u>	<u>Two</u>	<input type="radio"/> Employed	<input type="radio"/> Unemployed	<input type="radio"/> On disability	<input type="radio"/> Stay-at-home	<input type="radio"/> Retired	<input type="radio"/> U/K	5. Caregiver(s) income: <table style="width:100%; border: none;"> <tr> <td style="text-align: center;"><u>One</u></td> <td style="text-align: center;"><u>Two</u></td> </tr> <tr> <td><input type="radio"/> High</td> <td><input type="radio"/> Medium</td> </tr> <tr> <td><input type="radio"/> Low</td> <td><input type="radio"/> U/K</td> </tr> </table>	<u>One</u>	<u>Two</u>	<input type="radio"/> High	<input type="radio"/> Medium	<input type="radio"/> Low	<input type="radio"/> U/K
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<input type="radio"/> Male	<input type="radio"/> Female																																																	
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<u>One</u>	<u>Two</u>																																																	
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<u>One</u>	<u>Two</u>																																																	
<input type="radio"/> Employed	<input type="radio"/> Unemployed																																																	
<input type="radio"/> On disability	<input type="radio"/> Stay-at-home																																																	
<input type="radio"/> Retired	<input type="radio"/> U/K																																																	
<u>One</u>	<u>Two</u>																																																	
<input type="radio"/> High	<input type="radio"/> Medium																																																	
<input type="radio"/> Low	<input type="radio"/> U/K																																																	
6. Caregiver(s) education: <table style="width:100%; border: none;"> <tr> <td style="text-align: center;"><u>One</u></td> <td style="text-align: center;"><u>Two</u></td> </tr> <tr> <td><input type="radio"/> < High school</td> <td><input type="radio"/> High school</td> </tr> <tr> <td><input type="radio"/> College</td> <td><input type="radio"/> Post Graduate</td> </tr> <tr> <td><input type="radio"/> U/K</td> <td></td> </tr> </table>	<u>One</u>	<u>Two</u>	<input type="radio"/> < High school	<input type="radio"/> High school	<input type="radio"/> College	<input type="radio"/> Post Graduate	<input type="radio"/> U/K		7. Do caregiver(s) speak English? <table style="width:100%; border: none;"> <tr> <td style="text-align: center;"><u>One</u></td> <td style="text-align: center;"><u>Two</u></td> </tr> <tr> <td><input type="radio"/> No</td> <td><input type="radio"/> Yes</td> </tr> <tr> <td><input type="radio"/> U/K</td> <td></td> </tr> </table> If no, language spoken:	<u>One</u>	<u>Two</u>	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> U/K		8. Caregiver(s) on active military duty? <table style="width:100%; border: none;"> <tr> <td style="text-align: center;"><u>One</u></td> <td style="text-align: center;"><u>Two</u></td> </tr> <tr> <td><input type="radio"/> No</td> <td><input type="radio"/> Yes</td> </tr> <tr> <td><input type="radio"/> U/K</td> <td></td> </tr> </table> If yes, specify branch:	<u>One</u>	<u>Two</u>	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> U/K		9. Caregiver(s) received social services in the past twelve months? <table style="width:100%; border: none;"> <tr> <td style="text-align: center;"><u>One</u></td> <td style="text-align: center;"><u>Two</u></td> <td style="text-align: center;"><u>One</u></td> <td style="text-align: center;"><u>Two</u></td> </tr> <tr> <td><input type="radio"/> No</td> <td><input type="radio"/> Yes</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/> WIC</td> </tr> <tr> <td><input type="radio"/> U/K</td> <td></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/> TANF</td> </tr> <tr> <td></td> <td></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/> Medicaid</td> </tr> <tr> <td></td> <td></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/> Food stamps</td> </tr> <tr> <td></td> <td></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/> Other, specify:</td> </tr> </table>	<u>One</u>	<u>Two</u>	<u>One</u>	<u>Two</u>	<input type="radio"/> No	<input type="radio"/> Yes	<input type="checkbox"/>	<input type="checkbox"/> WIC	<input type="radio"/> U/K		<input type="checkbox"/>	<input type="checkbox"/> TANF			<input type="checkbox"/>	<input type="checkbox"/> Medicaid			<input type="checkbox"/>	<input type="checkbox"/> Food stamps			<input type="checkbox"/>	<input type="checkbox"/> Other, specify:			
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		<input type="checkbox"/>	<input type="checkbox"/> Other, specify:																																															

<p>10. Caregiver(s) have substance abuse history?</p> <p><u>One</u> <u>Two</u></p> <p><input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> U/K</p> <p>If yes, check all that apply:</p> <p><input type="checkbox"/> Alcohol</p> <p><input type="checkbox"/> Cocaine</p> <p><input type="checkbox"/> Marijuana</p> <p><input type="checkbox"/> Methamphetamine</p> <p><input type="checkbox"/> Opiates</p> <p><input type="checkbox"/> Prescription drugs</p> <p><input type="checkbox"/> Over-the-counter</p> <p><input type="checkbox"/> Other, specify:</p> <p><input type="checkbox"/> U/K</p>	<p>11. Caregiver(s) ever victim of child maltreatment?</p> <p><u>One</u> <u>Two</u></p> <p><input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> U/K</p> <p>If yes, check all that apply:</p> <p><input type="checkbox"/> Physical</p> <p><input type="checkbox"/> Neglect</p> <p><input type="checkbox"/> Sexual</p> <p><input type="checkbox"/> Emotional/psychological</p> <p><input type="checkbox"/> U/K</p> <p>_____ # CPS referrals</p> <p>_____ # Substantiations</p> <p><input type="checkbox"/> Ever in foster care or adopted?</p>	<p>12. Caregiver(s) ever perpetrator of maltreatment?</p> <p><u>One</u> <u>Two</u></p> <p><input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> U/K</p> <p>If yes, check all that apply:</p> <p><input type="checkbox"/> Physical</p> <p><input type="checkbox"/> Neglect</p> <p><input type="checkbox"/> Sexual</p> <p><input type="checkbox"/> Emotional/psychological</p> <p><input type="checkbox"/> U/K</p> <p>_____ # CPS referrals</p> <p>_____ # Substantiations</p> <p><input type="checkbox"/> CPS prevention services?</p> <p><input type="checkbox"/> Family Preservation services?</p> <p><input type="checkbox"/> Children ever removed?</p>	<p>13. Caregiver(s) have disability or chronic illness?</p> <p><u>One</u> <u>Two</u></p> <p><input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> U/K</p> <p>If yes, check all that apply:</p> <p><input type="checkbox"/> Physical, specify:</p> <p><input type="checkbox"/> Mental, specify:</p> <p><input type="checkbox"/> Sensory, specify:</p> <p><input type="checkbox"/> U/K</p> <p>If mental, was caregiver receiving services?</p> <p><input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> U/K</p>
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<p>14. Caregiver(s) have prior child deaths?</p> <p><u>One</u> <u>Two</u></p> <p><input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> U/K</p>	<p>If yes, cause(s): Check all that apply:</p> <p><u>One</u> <u>Two</u></p> <p><input type="checkbox"/> Child abuse # _____</p> <p><input type="checkbox"/> Child neglect # _____</p> <p><input type="checkbox"/> Accident # _____</p> <p><input type="checkbox"/> Suicide # _____</p> <p><input type="checkbox"/> SIDS # _____</p> <p><input type="checkbox"/> Other # _____</p> <p>Other, specify:</p> <p><input type="checkbox"/> U/K</p>	<p>15. Caregiver(s) have history of intimate partner violence?</p> <p><u>One</u> <u>Two</u></p> <p><input type="checkbox"/> No <input type="checkbox"/> Yes, as victim <input type="checkbox"/> Yes, as perpetrator <input type="checkbox"/> U/K</p>	<p>16. Caregiver(s) have delinquent/criminal history?</p> <p><u>One</u> <u>Two</u></p> <p><input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> U/K</p> <p>If yes, check all that apply:</p> <p><input type="checkbox"/> Assaults</p> <p><input type="checkbox"/> Robbery</p> <p><input type="checkbox"/> Drugs</p> <p><input type="checkbox"/> Other, specify:</p> <p><input type="checkbox"/> U/K</p>
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C. SUPERVISOR INFORMATION

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

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

Adoptive parent Mother's partner Sibling Acquaintance Babysitter

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

<p>5. Supervisor's age in years:</p> <p>_____ <input type="checkbox"/> U/K</p>	<p>6. Supervisor's sex:</p> <p><input type="radio"/> Male <input type="radio"/> Female <input type="radio"/> U/K</p>	<p>7. Does supervisor speak English?</p> <p><input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> U/K</p> <p>If no, language spoken:</p>	<p>8. Supervisor on active military duty?</p> <p><input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> U/K</p> <p>If yes, specify branch:</p>
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<p>9. Supervisor has substance abuse history?</p> <p><input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> U/K</p> <p>If yes, check all that apply:</p> <p><input type="checkbox"/> Alcohol</p> <p><input type="checkbox"/> Cocaine</p> <p><input type="checkbox"/> Marijuana</p> <p><input type="checkbox"/> Methamphetamine</p> <p><input type="checkbox"/> Opiates</p> <p><input type="checkbox"/> Prescription drugs</p> <p><input type="checkbox"/> Over-the-counter</p> <p><input type="checkbox"/> Other, specify:</p> <p><input type="checkbox"/> U/K</p>	<p>10. Supervisor has history of child maltreatment?</p> <p><u>As Victim</u> <u>As Perpetrator</u></p> <p><input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> U/K</p> <p>If yes, check all that apply:</p> <p><input type="checkbox"/> Physical</p> <p><input type="checkbox"/> Neglect</p> <p><input type="checkbox"/> Sexual</p> <p><input type="checkbox"/> Emotional/psychological</p> <p><input type="checkbox"/> U/K</p> <p>_____ # CPS referrals</p> <p>_____ # Substantiations</p> <p><input type="checkbox"/> Ever in foster care/adopted?</p> <p><input type="checkbox"/> CPS prevention services?</p> <p><input type="checkbox"/> Family preservation services?</p> <p><input type="checkbox"/> Children ever removed?</p>	<p>11. Supervisor has disability or chronic illness?</p> <p><input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> U/K</p> <p>If yes, check all that apply:</p> <p><input type="checkbox"/> Physical, specify:</p> <p><input type="checkbox"/> Mental, specify:</p> <p><input type="checkbox"/> Sensory, specify:</p> <p><input type="checkbox"/> U/K</p> <p>If mental illness, was supervisor receiving MH services?</p> <p><input type="radio"/> No</p> <p><input type="radio"/> Yes</p> <p><input type="radio"/> U/K</p>	<p>12. Supervisor has prior child deaths?</p> <p><input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> U/K</p> <p>If yes, check all that apply:</p> <p><input type="checkbox"/> Child abuse # _____</p> <p><input type="checkbox"/> Child neglect # _____</p> <p><input type="checkbox"/> Accident # _____</p> <p><input type="checkbox"/> Suicide # _____</p> <p><input type="checkbox"/> SIDS # _____</p> <p><input type="checkbox"/> Other # _____</p> <p>Other, specify:</p> <p><input type="checkbox"/> U/K</p>
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<p>10. X-rays taken? <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> U/K For infants, if yes, were there abnormal results? <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> U/K If abnormal, describe:</p>	<p>11. For infants, describe any significant findings not addressed above:</p>																																																						
<p>12. For infants, was there agreement between the cause of death listed on the pathology report and on the death certificate? <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> U/K If no, describe the differences:</p>																																																							
<p>13. For infants, was a death scene investigation performed? <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> U/K If yes, which of the following death scene investigation components were completed?</p> <table style="width:100%; border-collapse: collapse;"> <thead> <tr> <th style="text-align: left;">No</th> <th style="text-align: left;">Yes</th> <th style="text-align: left;">U/K</th> <th style="text-align: left;">If yes, shared with CDR team?</th> <th style="text-align: left;">No</th> <th style="text-align: left;">Yes</th> </tr> </thead> <tbody> <tr> <td><input type="radio"/></td> <td><input type="radio"/></td> <td><input type="radio"/></td> <td>CDC's SUIDI Reporting Form or jurisdictional equivalent</td> <td><input type="radio"/></td> <td><input type="radio"/></td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/></td> <td><input type="radio"/></td> <td>Narrative description of circumstances</td> <td><input type="radio"/></td> <td><input type="radio"/></td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/></td> <td><input type="radio"/></td> <td>Scene photos</td> <td><input type="radio"/></td> <td><input type="radio"/></td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/></td> <td><input type="radio"/></td> <td>Scene recreation with doll</td> <td><input type="radio"/></td> <td><input type="radio"/></td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/></td> <td><input type="radio"/></td> <td>Scene recreation without doll</td> <td><input type="radio"/></td> <td><input type="radio"/></td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/></td> <td><input type="radio"/></td> <td>Witness interviews</td> <td><input type="radio"/></td> <td><input type="radio"/></td> </tr> </tbody> </table>	No	Yes	U/K	If yes, shared with CDR team?	No	Yes	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	CDC's SUIDI Reporting Form or jurisdictional equivalent	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Narrative description of circumstances	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Scene photos	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Scene recreation with doll	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Scene recreation without doll	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Witness interviews	<input type="radio"/>	<input type="radio"/>	<p>14. Agencies that conducted a scene investigation, check all that apply:</p> <table style="width:100%; border-collapse: collapse;"> <tr> <td><input type="checkbox"/> Not conducted</td> <td><input type="checkbox"/> Fire investigator</td> </tr> <tr> <td><input type="checkbox"/> Medical examiner</td> <td><input type="checkbox"/> EMS</td> </tr> <tr> <td><input type="checkbox"/> Coroner</td> <td><input type="checkbox"/> Child Protective Services</td> </tr> <tr> <td><input type="checkbox"/> ME investigator</td> <td><input type="checkbox"/> Other, specify:</td> </tr> <tr> <td><input type="checkbox"/> Coroner investigator</td> <td></td> </tr> <tr> <td><input type="checkbox"/> Law enforcement</td> <td><input type="checkbox"/> U/K</td> </tr> </table>	<input type="checkbox"/> Not conducted	<input type="checkbox"/> Fire investigator	<input type="checkbox"/> Medical examiner	<input type="checkbox"/> EMS	<input type="checkbox"/> Coroner	<input type="checkbox"/> Child Protective Services	<input type="checkbox"/> ME investigator	<input type="checkbox"/> Other, specify:	<input type="checkbox"/> Coroner investigator		<input type="checkbox"/> Law enforcement	<input type="checkbox"/> U/K
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<p>15. Was a CPS record check conducted as a result of death? <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> U/K</p>																																																							
<p>16. Did investigation find evidence of prior abuse? <input type="radio"/> N/A <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> U/K If yes, from what source? Check all that apply: <input type="checkbox"/> From x-rays <input type="checkbox"/> U/K <input type="checkbox"/> From autopsy <input type="checkbox"/> From CPS review <input type="checkbox"/> From law enforcement</p>	<p>17. CPS action taken because of death? <input type="radio"/> N/A <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> U/K</p> <table style="width:100%; border-collapse: collapse;"> <tr> <td style="width:50%; vertical-align: top;"> <p>If yes, highest level of action taken because of death:</p> <input type="radio"/> Report screened out and not investigated <input type="radio"/> Unsubstantiated <input type="radio"/> Inconclusive <input type="radio"/> Substantiated</td> <td style="width:50%; vertical-align: top;"> <p>If yes, services or actions resulting, check all that apply:</p> <input type="checkbox"/> Voluntary services offered <input type="checkbox"/> Voluntary services provided <input type="checkbox"/> Court ordered services provided <input type="checkbox"/> Voluntary out of home placemen <input type="checkbox"/> Court ordered out of home placement <input type="checkbox"/> Children removed <input type="checkbox"/> Parental rights terminated <input type="checkbox"/> U/K</td> </tr> </table>	<p>If yes, highest level of action taken because of death:</p> <input type="radio"/> Report screened out and not investigated <input type="radio"/> Unsubstantiated <input type="radio"/> Inconclusive <input type="radio"/> Substantiated	<p>If yes, services or actions resulting, check all that apply:</p> <input type="checkbox"/> Voluntary services offered <input type="checkbox"/> Voluntary services provided <input type="checkbox"/> Court ordered services provided <input type="checkbox"/> Voluntary out of home placemen <input type="checkbox"/> Court ordered out of home placement <input type="checkbox"/> Children removed <input type="checkbox"/> Parental rights terminated <input type="checkbox"/> U/K																																																				
<p>If yes, highest level of action taken because of death:</p> <input type="radio"/> Report screened out and not investigated <input type="radio"/> Unsubstantiated <input type="radio"/> Inconclusive <input type="radio"/> Substantiated	<p>If yes, services or actions resulting, check all that apply:</p> <input type="checkbox"/> Voluntary services offered <input type="checkbox"/> Voluntary services provided <input type="checkbox"/> Court ordered services provided <input type="checkbox"/> Voluntary out of home placemen <input type="checkbox"/> Court ordered out of home placement <input type="checkbox"/> Children removed <input type="checkbox"/> Parental rights terminated <input type="checkbox"/> U/K																																																						
F. OFFICIAL MANNER AND PRIMARY CAUSE OF DEATH																																																							
<p>1. Official manner of death from the death certificate:</p> <input type="radio"/> Natural <input type="radio"/> Accident <input type="radio"/> Suicide <input type="radio"/> Homicide <input type="radio"/> Undetermined <input type="radio"/> Pending <input type="radio"/> U/K	<p>2. Primary cause of death: Choose only 1 of the 4 major categories, then a specific cause. For pending, choose most likely cause.</p> <table style="width:100%; border-collapse: collapse;"> <tr> <td style="width:33%; vertical-align: top;"> <input type="radio"/> <u>From an injury (external cause), select one and answer 2a:</u> <input type="radio"/> Motor vehicle and other transport, go to G1 <input type="radio"/> Fire, burn, or electrocution, go to G2 <input type="radio"/> Drowning, go to G3 <input type="radio"/> Asphyxia, go to G4 <input type="radio"/> Weapon, including body part, go to G6 <input type="radio"/> Animal bite or attack, go to G7 <input type="radio"/> Fall or crush, go to G8 <input type="radio"/> Poisoning, overdose or acute intoxication, go to G9 <input type="radio"/> Exposure, go to G10 <input type="radio"/> Undetermined. If under age one, go to G5 & G12 If over age one, go to G12 <input type="radio"/> Other cause, go to G12 <input type="radio"/> U/K, go to G12</td> <td style="width:33%; vertical-align: top;"> <input type="radio"/> <u>From a medical cause, select one:</u> <input type="radio"/> Asthma, go to G11 <input type="radio"/> Cancer, specify and go to G11 <input type="radio"/> Cardiovascular, specify and go to G11 <input type="radio"/> Congenital anomaly, specify and go to G11 <input type="radio"/> HIV/AIDS, go to G11 <input type="radio"/> Influenza, go to G11 <input type="radio"/> Low birth weight, go to G11 <input type="radio"/> Malnutrition/dehydration, go to G11 <input type="radio"/> Neurological/seizure disorder, go to G11 <input type="radio"/> Pneumonia, specify and go to G11 <input type="radio"/> Prematurity, go to G11 <input type="radio"/> SIDS, go to G5 <input type="radio"/> Other infection, specify and go to G11 <input type="radio"/> Other perinatal condition, specify and go to G11 <input type="radio"/> Other medical condition, specify and go to G11 <input type="radio"/> Undetermined. If under age one, go to G5 and G11. If over age one, go to G11. <input type="radio"/> U/K. If under age one, go to G5 and G11. If over age one, go to G11.</td> <td style="width:33%; vertical-align: top;"> <input type="radio"/> <u>Undetermined if injury or medical cause, go to G12:</u> <input type="radio"/> <u>go to G12</u> <input type="radio"/> <u>If under age one, go to G5 & G12.</u></td> </tr> </table>	<input type="radio"/> <u>From an injury (external cause), select one and answer 2a:</u> <input type="radio"/> Motor vehicle and other transport, go to G1 <input type="radio"/> Fire, burn, or electrocution, go to G2 <input type="radio"/> Drowning, go to G3 <input type="radio"/> Asphyxia, go to G4 <input type="radio"/> Weapon, including body part, go to G6 <input type="radio"/> Animal bite or attack, go to G7 <input type="radio"/> Fall or crush, go to G8 <input type="radio"/> Poisoning, overdose or acute intoxication, go to G9 <input type="radio"/> Exposure, go to G10 <input type="radio"/> Undetermined. If under age one, go to G5 & G12 If over age one, go to G12 <input type="radio"/> Other cause, go to G12 <input type="radio"/> U/K, go to G12	<input type="radio"/> <u>From a medical cause, select one:</u> <input type="radio"/> Asthma, go to G11 <input type="radio"/> Cancer, specify and go to G11 <input type="radio"/> Cardiovascular, specify and go to G11 <input type="radio"/> Congenital anomaly, specify and go to G11 <input type="radio"/> HIV/AIDS, go to G11 <input type="radio"/> Influenza, go to G11 <input type="radio"/> Low birth weight, go to G11 <input type="radio"/> Malnutrition/dehydration, go to G11 <input type="radio"/> Neurological/seizure disorder, go to G11 <input type="radio"/> Pneumonia, specify and go to G11 <input type="radio"/> Prematurity, go to G11 <input type="radio"/> SIDS, go to G5 <input type="radio"/> Other infection, specify and go to G11 <input type="radio"/> Other perinatal condition, specify and go to G11 <input type="radio"/> Other medical condition, specify and go to G11 <input type="radio"/> Undetermined. If under age one, go to G5 and G11. If over age one, go to G11. <input type="radio"/> U/K. If under age one, go to G5 and G11. If over age one, go to G11.	<input type="radio"/> <u>Undetermined if injury or medical cause, go to G12:</u> <input type="radio"/> <u>go to G12</u> <input type="radio"/> <u>If under age one, go to G5 & G12.</u>																																																			
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<p>3. For infants, enter the following information exactly as written on the death certificate:</p> <p>Immediate Cause (final disease or condition resulting in death):</p> <p>a.</p> <p>Sequentially list any conditions leading to immediate cause of death. In other words, list underlying disease or injury that initiated events resulting in death:</p> <p>b.</p> <p>c.</p> <p>d.</p>																																																							
<p>4. For infants, enter other significant conditions contributing to death but not an underlying cause(s) listed in F3 exactly as written on the death certificate:</p>																																																							
<p>5. For infants, if external cause in F2, describe how injury occurred exactly as written on the death certificate:</p>																																																							

G. DETAILED INFORMATION BY CAUSE OF DEATH: CHOOSE ONE SECTION ONLY, THAT IS SAME AS THE CAUSE SELECTED ABOVE

1. MOTOR VEHICLE AND OTHER TRANSPORT

<p>a. Vehicles involved in incident: Total number of vehicles: _____</p> <table style="width:100%; border-collapse: collapse;"> <tr> <th style="text-align: left; border-bottom: 1px solid black;">Child's</th> <th style="text-align: left; border-bottom: 1px solid black;">Other primary vehicle</th> </tr> <tr> <td><input type="radio"/> None</td> <td><input type="radio"/> None</td> </tr> <tr> <td><input type="radio"/> Car</td> <td><input type="radio"/> Car</td> </tr> <tr> <td><input type="radio"/> Van</td> <td><input type="radio"/> Van</td> </tr> <tr> <td><input type="radio"/> Sport utility vehicle</td> <td><input type="radio"/> Sport utility vehicle</td> </tr> <tr> <td><input type="radio"/> Truck</td> <td><input type="radio"/> Truck</td> </tr> <tr> <td><input type="radio"/> Semi/tractor trailer</td> <td><input type="radio"/> Semi/tractor trailer</td> </tr> <tr> <td><input type="radio"/> RV</td> <td><input type="radio"/> RV</td> </tr> <tr> <td><input type="radio"/> School bus</td> <td><input type="radio"/> School bus</td> </tr> <tr> <td><input type="radio"/> Other bus</td> <td><input type="radio"/> Other bus</td> </tr> <tr> <td><input type="radio"/> Motorcycle</td> <td><input type="radio"/> Motorcycle</td> </tr> <tr> <td><input type="radio"/> Tractor</td> <td><input type="radio"/> Tractor</td> </tr> <tr> <td><input type="radio"/> Other farm vehicle</td> <td><input type="radio"/> Other farm vehicle</td> </tr> <tr> <td><input type="radio"/> All terrain vehicle</td> <td><input type="radio"/> All terrain vehicle</td> </tr> <tr> <td><input type="radio"/> Snowmobile</td> <td><input type="radio"/> Snowmobile</td> </tr> <tr> <td><input type="radio"/> Bicycle</td> <td><input type="radio"/> Bicycle</td> </tr> <tr> <td><input type="radio"/> Train</td> <td><input type="radio"/> Train</td> </tr> <tr> <td><input type="radio"/> Subway</td> <td><input type="radio"/> Subway</td> </tr> <tr> <td><input type="radio"/> Trolley</td> <td><input type="radio"/> Trolley</td> </tr> <tr> <td><input type="radio"/> Other, specify:</td> <td></td> </tr> <tr> <td><input type="radio"/> U/K</td> <td></td> </tr> </table>	Child's	Other primary vehicle	<input type="radio"/> None	<input type="radio"/> None	<input type="radio"/> Car	<input type="radio"/> Car	<input type="radio"/> Van	<input type="radio"/> Van	<input type="radio"/> Sport utility vehicle	<input type="radio"/> Sport utility vehicle	<input type="radio"/> Truck	<input type="radio"/> Truck	<input type="radio"/> Semi/tractor trailer	<input type="radio"/> Semi/tractor trailer	<input type="radio"/> RV	<input type="radio"/> RV	<input type="radio"/> School bus	<input type="radio"/> School bus	<input type="radio"/> Other bus	<input type="radio"/> Other bus	<input type="radio"/> Motorcycle	<input type="radio"/> Motorcycle	<input type="radio"/> Tractor	<input type="radio"/> Tractor	<input type="radio"/> Other farm vehicle	<input type="radio"/> Other farm vehicle	<input type="radio"/> All terrain vehicle	<input type="radio"/> All terrain vehicle	<input type="radio"/> Snowmobile	<input type="radio"/> Snowmobile	<input type="radio"/> Bicycle	<input type="radio"/> Bicycle	<input type="radio"/> Train	<input type="radio"/> Train	<input type="radio"/> Subway	<input type="radio"/> Subway	<input type="radio"/> Trolley	<input type="radio"/> Trolley	<input type="radio"/> Other, specify:		<input type="radio"/> U/K		<p>b. Position of child:</p> <p><input type="radio"/> Driver</p> <p><input type="radio"/> Passenger</p> <p style="margin-left: 20px;"><input type="radio"/> Front seat</p> <p style="margin-left: 20px;"><input type="radio"/> Back seat</p> <p style="margin-left: 20px;"><input type="radio"/> Truck bed</p> <p style="margin-left: 20px;"><input type="radio"/> Other, specify:</p> <p style="margin-left: 40px;"><input type="radio"/> U/K</p> <p><input type="radio"/> On bicycle</p> <p><input type="radio"/> Pedestrian</p> <p style="margin-left: 20px;"><input type="radio"/> Walking</p> <p style="margin-left: 20px;"><input type="radio"/> Boarding/blading</p> <p style="margin-left: 20px;"><input type="radio"/> Other, specify:</p> <p style="margin-left: 40px;"><input type="radio"/> U/K</p> <p><input type="radio"/> U/K</p>	<p>c. Causes of incident, check all that apply:</p> <table style="width:100%; border-collapse: collapse;"> <tr> <td><input type="checkbox"/> Speeding over limit</td> <td><input type="checkbox"/> Back over</td> </tr> <tr> <td><input type="checkbox"/> Unsafe speed for conditions</td> <td><input type="checkbox"/> Rollover</td> </tr> <tr> <td><input type="checkbox"/> Recklessness</td> <td><input type="checkbox"/> Poor sight line</td> </tr> <tr> <td><input type="checkbox"/> Ran stop sign or red light</td> <td><input type="checkbox"/> Car changing lanes</td> </tr> <tr> <td><input type="checkbox"/> Driver distraction</td> <td><input type="checkbox"/> Road hazard</td> </tr> <tr> <td><input type="checkbox"/> Driver inexperience</td> <td><input type="checkbox"/> Animal in road</td> </tr> <tr> <td><input type="checkbox"/> Mechanical failure</td> <td><input type="checkbox"/> Cell phone use while driving</td> </tr> <tr> <td><input type="checkbox"/> Poor tires</td> <td><input type="checkbox"/> Racing, not authorized</td> </tr> <tr> <td><input type="checkbox"/> Poor weather</td> <td><input type="checkbox"/> Other driver error, specify:</td> </tr> <tr> <td><input type="checkbox"/> Poor visibility</td> <td></td> </tr> <tr> <td><input type="checkbox"/> Drugs or alcohol use</td> <td><input type="checkbox"/> Other, specify:</td> </tr> <tr> <td><input type="checkbox"/> Fatigue/sleeping</td> <td></td> </tr> <tr> <td><input type="checkbox"/> Medical event, specify:</td> <td><input type="checkbox"/> U/K</td> </tr> </table>	<input type="checkbox"/> Speeding over limit	<input type="checkbox"/> Back over	<input type="checkbox"/> Unsafe speed for conditions	<input type="checkbox"/> Rollover	<input type="checkbox"/> Recklessness	<input type="checkbox"/> Poor sight line	<input type="checkbox"/> Ran stop sign or red light	<input type="checkbox"/> Car changing lanes	<input type="checkbox"/> Driver distraction	<input type="checkbox"/> Road hazard	<input type="checkbox"/> Driver inexperience	<input type="checkbox"/> Animal in road	<input type="checkbox"/> Mechanical failure	<input type="checkbox"/> Cell phone use while driving	<input type="checkbox"/> Poor tires	<input type="checkbox"/> Racing, not authorized	<input type="checkbox"/> Poor weather	<input type="checkbox"/> Other driver error, specify:	<input type="checkbox"/> Poor visibility		<input type="checkbox"/> Drugs or alcohol use	<input type="checkbox"/> Other, specify:	<input type="checkbox"/> Fatigue/sleeping		<input type="checkbox"/> Medical event, specify:	<input type="checkbox"/> U/K	<p>d. Collision type:</p> <p><input type="radio"/> Child <i>not</i> in/on a vehicle, but struck by vehicle</p> <p><input type="radio"/> Child in/on a vehicle, struck by other vehicle</p> <p><input type="radio"/> Child in/on a vehicle that struck other vehicle</p> <p><input type="radio"/> Child in/on a vehicle that struck person/object</p> <p><input type="radio"/> Other event, specify:</p> <p><input type="radio"/> U/K</p>
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<p>e. Driving conditions, check all that apply:</p> <table style="width:100%; border-collapse: collapse;"> <tr> <td><input type="checkbox"/> Normal</td> <td><input type="checkbox"/> Other, specify:</td> </tr> <tr> <td><input type="checkbox"/> Loose gravel</td> <td></td> </tr> <tr> <td><input type="checkbox"/> Muddy</td> <td><input type="checkbox"/> U/K</td> </tr> <tr> <td><input type="checkbox"/> Ice/Snow</td> <td></td> </tr> <tr> <td><input type="checkbox"/> Fog</td> <td></td> </tr> <tr> <td><input type="checkbox"/> Wet</td> <td></td> </tr> <tr> <td><input type="checkbox"/> Construction zone</td> <td></td> </tr> <tr> <td><input type="checkbox"/> Inadequate lighting</td> <td></td> </tr> </table>	<input type="checkbox"/> Normal	<input type="checkbox"/> Other, specify:	<input type="checkbox"/> Loose gravel		<input type="checkbox"/> Muddy	<input type="checkbox"/> U/K	<input type="checkbox"/> Ice/Snow		<input type="checkbox"/> Fog		<input type="checkbox"/> Wet		<input type="checkbox"/> Construction zone		<input type="checkbox"/> Inadequate lighting		<p>f. Location of incident, check all that apply:</p> <table style="width:100%; border-collapse: collapse;"> <tr> <td><input type="checkbox"/> City street</td> <td><input type="checkbox"/> Driveway</td> </tr> <tr> <td><input type="checkbox"/> Residential street</td> <td><input type="checkbox"/> Parking area</td> </tr> <tr> <td><input type="checkbox"/> Rural road</td> <td><input type="checkbox"/> Off road</td> </tr> <tr> <td><input type="checkbox"/> Highway</td> <td><input type="checkbox"/> Railroad crossing/tracks</td> </tr> <tr> <td><input type="checkbox"/> Intersection</td> <td><input type="checkbox"/> Other, specify:</td> </tr> <tr> <td><input type="checkbox"/> Shoulder</td> <td></td> </tr> <tr> <td><input type="checkbox"/> Sidewalk</td> <td><input type="checkbox"/> U/K</td> </tr> </table>	<input type="checkbox"/> City street	<input type="checkbox"/> Driveway	<input type="checkbox"/> Residential street	<input type="checkbox"/> Parking area	<input type="checkbox"/> Rural road	<input type="checkbox"/> Off road	<input type="checkbox"/> Highway	<input type="checkbox"/> Railroad crossing/tracks	<input type="checkbox"/> Intersection	<input type="checkbox"/> Other, specify:	<input type="checkbox"/> Shoulder		<input type="checkbox"/> Sidewalk	<input type="checkbox"/> U/K
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<p>g. Drivers involved in incident, check all that apply:</p> <table style="width:100%; border-collapse: collapse;"> <tr> <th style="text-align: left; border-bottom: 1px solid black;">Child as driver</th> <th style="text-align: left; border-bottom: 1px solid black;">Child's driver</th> <th style="text-align: left; border-bottom: 1px solid black;">Driver of other primary vehicle</th> <th style="text-align: left; border-bottom: 1px solid black;">Age of Driver</th> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Responsible for causing incident</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Was alcohol/drug impaired</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Has no license</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Has a learner's permit</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Has a graduated license</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Has a full license</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Has a full license that has been restricted</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Has a suspended license</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>If recreational vehicle, has driver safety certificate</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Other, specify:</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Was violating graduated licensing rules:</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Nighttime driving curfew</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Passenger restrictions</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Driving without required supervision</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Other violations, specify:</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>U/K</td> </tr> </table>	Child as driver	Child's driver	Driver of other primary vehicle	Age of Driver	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Responsible for causing incident	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Was alcohol/drug impaired	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Has no license	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Has a learner's permit	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Has a graduated license	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Has a full license	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Has a full license that has been restricted	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Has a suspended license	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	If recreational vehicle, has driver safety certificate	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other, specify:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Was violating graduated licensing rules:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Nighttime driving curfew	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Passenger restrictions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Driving without required supervision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other violations, specify:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	U/K	<p>h. Total number of occupants in vehicles:</p> <p>In child's vehicle, including child:</p> <p><input type="checkbox"/> N/A, child was not in a vehicle.</p> <p>Total number occupants: _____ <input type="radio"/> U/K</p> <p>Number teens, ages 14-21: _____ <input type="radio"/> U/K</p> <p>Total number of deaths: _____ <input type="radio"/> U/K</p> <p>Total number teen deaths: _____ <input type="radio"/> U/K</p> <p>In other primary vehicle involved in incident:</p> <p><input type="checkbox"/> N/A, incident was a single vehicle crash.</p> <p>Total number occupants: _____ <input type="radio"/> U/K</p> <p>Number teens, ages 14-21: _____ <input type="radio"/> U/K</p> <p>Total number of deaths: _____ <input type="radio"/> U/K</p> <p>Total number teen deaths: _____ <input type="radio"/> U/K</p>
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<p>i. Protective measures for child,</p> <p>Select one option per row:</p>	<table style="width:100%; border-collapse: collapse;"> <tr> <th style="text-align: left; border-bottom: 1px solid black;">Not Needed</th> <th style="text-align: left; border-bottom: 1px solid black;">Needed, none present</th> <th style="text-align: left; border-bottom: 1px solid black;">Present, used correctly</th> <th style="text-align: left; border-bottom: 1px solid black;">Present, used incorrectly</th> <th style="text-align: left; border-bottom: 1px solid black;">Present not used</th> <th style="text-align: left; border-bottom: 1px solid black;">Unknown</th> </tr> <tr> <td>Airbag</td> <td><input type="radio"/></td> <td><input type="radio"/></td> <td><input type="radio"/></td> <td><input type="radio"/></td> <td><input type="radio"/></td> </tr> <tr> <td>Lap belt</td> <td><input type="radio"/></td> <td><input type="radio"/></td> <td><input type="radio"/></td> <td><input type="radio"/></td> <td><input type="radio"/></td> </tr> <tr> <td>Shoulder belt</td> <td><input type="radio"/></td> <td><input type="radio"/></td> <td><input type="radio"/></td> <td><input type="radio"/></td> <td><input type="radio"/></td> </tr> <tr> <td>Child seat*</td> <td><input type="radio"/></td> <td><input type="radio"/></td> <td><input type="radio"/></td> <td><input type="radio"/></td> <td><input type="radio"/></td> </tr> <tr> <td>Belt positioning booster seat</td> <td><input type="radio"/></td> <td><input type="radio"/></td> <td><input type="radio"/></td> <td><input type="radio"/></td> <td><input type="radio"/></td> </tr> <tr> <td>Helmet</td> <td><input type="radio"/></td> <td><input type="radio"/></td> <td><input type="radio"/></td> <td><input type="radio"/></td> <td><input type="radio"/></td> </tr> <tr> <td>Other, specify:</td> <td><input type="radio"/></td> <td><input type="radio"/></td> <td><input type="radio"/></td> <td><input type="radio"/></td> <td><input type="radio"/></td> </tr> </table>	Not Needed	Needed, none present	Present, used correctly	Present, used incorrectly	Present not used	Unknown	Airbag	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Lap belt	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Shoulder belt	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Child seat*	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Belt positioning booster seat	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Helmet	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Other, specify:	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<p>*If child seat, type:</p> <p><input type="radio"/> Rear facing</p> <p><input type="radio"/> Front facing</p> <p><input type="radio"/> U/K</p>
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Other, specify:	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>																																													

2. FIRE, BURN, or ELECTROCUTION

a. Ignition, heat or electrocution source: <input type="radio"/> Matches <input type="radio"/> Heating stove <input type="radio"/> Lightning <input type="radio"/> Other explosives <input type="radio"/> Cigarette lighter <input type="radio"/> Space heater <input type="radio"/> Oxygen tank <input type="radio"/> Appliance in water <input type="radio"/> Utility lighter <input type="radio"/> Furnace <input type="radio"/> Hot cooking water <input type="radio"/> Other, specify: <input type="radio"/> Cigarette or cigar <input type="radio"/> Power line <input type="radio"/> Hot bath water <input type="radio"/> U/K <input type="radio"/> Candles <input type="radio"/> Electrical outlet <input type="radio"/> Other hot liquid, specify: <input type="radio"/> Cooking stove <input type="radio"/> Electrical wiring <input type="radio"/> Fireworks			b. Type of incident: <input type="radio"/> Fire, go to c <input type="radio"/> Scald, go to r <input type="radio"/> Other burn, go to t <input type="radio"/> Electrocution, go to s <input type="radio"/> Other, specify and go to t <input type="radio"/> U/K, go to t		c. For fire, child died from: <input type="radio"/> Burns <input type="radio"/> Smoke inhalation <input type="radio"/> Other, specify: <input type="radio"/> U/K													
d. Material first ignited: <input type="radio"/> Upholstery <input type="radio"/> Mattress <input type="radio"/> Christmas tree <input type="radio"/> Clothing <input type="radio"/> Curtain <input type="radio"/> Other, specify: <input type="radio"/> U/K	e. Type of building on fire: <input type="radio"/> N/A <input type="radio"/> Single home <input type="radio"/> Duplex <input type="radio"/> Apartment <input type="radio"/> Trailer/mobile home <input type="radio"/> Other, specify: <input type="radio"/> U/K	f. Building's primary construction material: <input type="radio"/> Wood <input type="radio"/> Steel <input type="radio"/> Brick/stone <input type="radio"/> Aluminum <input type="radio"/> Other, specify: <input type="radio"/> U/K	g. Fire started by a person? <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> U/K If yes, person's age _____ Does person have a history of setting fires? <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> U/K		h. Did anyone attempt to put out fire? <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> U/K i. Did escape or rescue efforts worsen fire? <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> U/K j. Did any factors delay fire department arrival? <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> U/K If yes, specify:													
k. Were barriers preventing safe exit? <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> U/K If yes, check all that apply: <input type="checkbox"/> Locked door <input type="checkbox"/> Window grate <input type="checkbox"/> Locked window <input type="checkbox"/> Blocked stairway <input type="checkbox"/> Other, specify: <input type="checkbox"/> U/K		l. Was building a rental property? <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> U/K	m. Were building/rental codes violated? <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> U/K If yes, describe in narrative.		n. Were proper working fire extinguishers present? <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> U/K													
o. Was sprinkler system present? <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> U/K If yes, was it working? <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> U/K		p. Were smoke detectors present? <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> U/K <table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 33%; border-right: 1px solid black; vertical-align: top;"> If yes, what type? <input type="checkbox"/> Removable batteries <input type="checkbox"/> Non-removable batteries <input type="checkbox"/> Hardwired <input type="checkbox"/> U/K </td> <td style="width: 33%; border-right: 1px solid black; vertical-align: top;"> If yes, functioning properly? <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> U/K <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> U/K <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> U/K <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> U/K </td> <td style="width: 33%; vertical-align: top;"> If not functioning properly, reason: <table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 33%;">Missing batteries</td> <td style="width: 33%;">Other</td> <td style="width: 33%;">U/K</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> </table> Other, specify: _____ </td> </tr> </table> If yes, was there an adequate number present? <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> U/K		If yes, what type? <input type="checkbox"/> Removable batteries <input type="checkbox"/> Non-removable batteries <input type="checkbox"/> Hardwired <input type="checkbox"/> U/K	If yes, functioning properly? <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> U/K <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> U/K <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> U/K <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> U/K	If not functioning properly, reason: <table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 33%;">Missing batteries</td> <td style="width: 33%;">Other</td> <td style="width: 33%;">U/K</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> </table> Other, specify: _____	Missing batteries	Other	U/K	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If yes, what type? <input type="checkbox"/> Removable batteries <input type="checkbox"/> Non-removable batteries <input type="checkbox"/> Hardwired <input type="checkbox"/> U/K	If yes, functioning properly? <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> U/K <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> U/K <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> U/K <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> U/K	If not functioning properly, reason: <table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 33%;">Missing batteries</td> <td style="width: 33%;">Other</td> <td style="width: 33%;">U/K</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> </table> Other, specify: _____	Missing batteries	Other	U/K	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
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<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																
q. Suspected arson? <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> U/K	r. For scald, was hot water heater set too high? <input type="radio"/> N/A <input type="radio"/> No <input type="radio"/> Yes, temp. setting: _____ <input type="radio"/> U/K	s. For electrocution, what cause: <input type="radio"/> Electrical storm <input type="radio"/> Faulty wiring <input type="radio"/> Wire/product in water <input type="radio"/> Child playing with outlet <input type="radio"/> Other, specify: <input type="radio"/> U/K		t. Other, describe in detail:														

3. DROWNING

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

6. WEAPON, INCLUDING PERSON'S BODY PART

<p>a. Type of weapon:</p> <input type="radio"/> Firearm, go to b <input type="radio"/> Sharp instrument, go to j <input type="radio"/> Blunt instrument, go to k <input type="radio"/> Person's body part, go to l <input type="radio"/> Explosive, go to m <input type="radio"/> Rope, go to m <input type="radio"/> Pipe, go to m <input type="radio"/> Biological, go to m <input type="radio"/> Other, specify and go to m <input type="radio"/> U/K, go to m	<p>b. For firearms, type:</p> <input type="radio"/> Handgun <input type="radio"/> Shotgun <input type="radio"/> BB gun <input type="radio"/> Hunting rifle <input type="radio"/> Assault rifle <input type="radio"/> Air rifle <input type="radio"/> Sawed off shotgun <input type="radio"/> Other, specify: <input type="radio"/> U/K	<p>c. Firearm licensed?</p> <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> U/K	<p>d. Firearm safety features, check all that apply:</p> <input type="checkbox"/> Trigger lock <input type="checkbox"/> Magazine disconnect <input type="checkbox"/> Personalization device <input type="checkbox"/> Minimum trigger pull <input type="checkbox"/> External safety/drop safety <input type="checkbox"/> Other, specify: <input type="checkbox"/> Loaded chamber indicator <input type="checkbox"/> U/K
<p>e. Where was firearm stored?</p> <input type="radio"/> Not stored <input type="radio"/> Under mattress/pillow <input type="radio"/> Locked cabinet <input type="radio"/> Other, specify: <input type="radio"/> Unlocked cabinet <input type="radio"/> Glove compartment <input type="radio"/> U/K			<p>f. Firearm stored with ammunition?</p> <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> U/K
<p>g. Firearm stored loaded?</p> <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> U/K			

<p>h. Owner of fatal firearm:</p> <input type="radio"/> U/K, weapon stolen <input type="radio"/> Grandparent <input type="radio"/> Co-worker <input type="radio"/> U/K, weapon found <input type="radio"/> Sibling <input type="radio"/> Institutional staff <input type="radio"/> Self <input type="radio"/> Spouse <input type="radio"/> Neighbor <input type="radio"/> Biological parent <input type="radio"/> Other relative <input type="radio"/> Rival gang member <input type="radio"/> Adoptive parent <input type="radio"/> Friend <input type="radio"/> Stranger <input type="radio"/> Stepparent <input type="radio"/> Acquaintance <input type="radio"/> Law enforcement <input type="radio"/> Foster parent <input type="radio"/> Child's boyfriend <input type="radio"/> Other, specify: <input type="radio"/> Mother's partner or girlfriend <input type="radio"/> Father's partner <input type="radio"/> Classmate <input type="radio"/> U/K	<p>i. Sex of fatal firearm owner:</p> <input type="radio"/> Male <input type="radio"/> Female <input type="radio"/> U/K	<p>j. Type of sharp object:</p> <input type="radio"/> Kitchen knife <input type="radio"/> Switchblade <input type="radio"/> Pocketknife <input type="radio"/> Razor <input type="radio"/> Hunting knife <input type="radio"/> Scissors <input type="radio"/> Other, specify: <input type="radio"/> U/K	<p>k. Type of blunt object:</p> <input type="radio"/> Bat <input type="radio"/> Club <input type="radio"/> Stick <input type="radio"/> Hammer <input type="radio"/> Rock <input type="radio"/> Household item <input type="radio"/> Other, specify: <input type="radio"/> U/K
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<p>l. What did person's body part do? Check all that apply:</p> <input type="checkbox"/> Beat, kick or punch <input type="checkbox"/> Drop <input type="checkbox"/> Push <input type="checkbox"/> Bite <input type="checkbox"/> Shake <input type="checkbox"/> Strangle <input type="checkbox"/> Throw <input type="checkbox"/> Drown <input type="checkbox"/> Burn <input type="checkbox"/> Other, specify: <input type="checkbox"/> U/K	<p>m. Did person using weapon have history of weapon-related offenses?</p> <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> U/K	<p>n. Does anyone in child's family have a history of weapon offenses or die of weapons-related causes?</p> <input type="radio"/> No <input type="radio"/> Yes, describe circumstances: <input type="radio"/> U/K	<p>o. Persons handling weapons at time of incident, check all that apply:</p> <table style="width:100%;"> <tr> <th style="text-align: left;"><u>Fatal</u> and/or <u>Other weapon</u></th> <th style="text-align: left;"><u>Fatal</u> and/or <u>Other weapon</u></th> </tr> <tr> <td><input type="checkbox"/> Self</td> <td><input type="checkbox"/> Friend</td> </tr> <tr> <td><input type="checkbox"/> Biological parent</td> <td><input type="checkbox"/> Acquaintance</td> </tr> <tr> <td><input type="checkbox"/> Adoptive parent</td> <td><input type="checkbox"/> Child's boyfriend or girlfriend</td> </tr> <tr> <td><input type="checkbox"/> Stepparent</td> <td><input type="checkbox"/> Classmate</td> </tr> <tr> <td><input type="checkbox"/> Foster parent</td> <td><input type="checkbox"/> Co-worker</td> </tr> <tr> <td><input type="checkbox"/> Mother's partner</td> <td><input type="checkbox"/> Institutional staff</td> </tr> <tr> <td><input type="checkbox"/> Father's partner</td> <td><input type="checkbox"/> Neighbor</td> </tr> <tr> <td><input type="checkbox"/> Grandparent</td> <td><input type="checkbox"/> Rival gang member</td> </tr> <tr> <td><input type="checkbox"/> Sibling</td> <td><input type="checkbox"/> Stranger</td> </tr> <tr> <td><input type="checkbox"/> Spouse</td> <td><input type="checkbox"/> Law enforcement officer</td> </tr> <tr> <td><input type="checkbox"/> Other relative</td> <td><input type="checkbox"/> Other, specify: <input type="checkbox"/> U/K</td> </tr> </table>	<u>Fatal</u> and/or <u>Other weapon</u>	<u>Fatal</u> and/or <u>Other weapon</u>	<input type="checkbox"/> Self	<input type="checkbox"/> Friend	<input type="checkbox"/> Biological parent	<input type="checkbox"/> Acquaintance	<input type="checkbox"/> Adoptive parent	<input type="checkbox"/> Child's boyfriend or girlfriend	<input type="checkbox"/> Stepparent	<input type="checkbox"/> Classmate	<input type="checkbox"/> Foster parent	<input type="checkbox"/> Co-worker	<input type="checkbox"/> Mother's partner	<input type="checkbox"/> Institutional staff	<input type="checkbox"/> Father's partner	<input type="checkbox"/> Neighbor	<input type="checkbox"/> Grandparent	<input type="checkbox"/> Rival gang member	<input type="checkbox"/> Sibling	<input type="checkbox"/> Stranger	<input type="checkbox"/> Spouse	<input type="checkbox"/> Law enforcement officer	<input type="checkbox"/> Other relative	<input type="checkbox"/> Other, specify: <input type="checkbox"/> U/K	<p>p. Sex of person(s) handling weapon:</p> <p>Fatal weapon:</p> <input type="radio"/> Male <input type="radio"/> Female <input type="radio"/> U/K
<u>Fatal</u> and/or <u>Other weapon</u>	<u>Fatal</u> and/or <u>Other weapon</u>																											
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<input type="checkbox"/> Spouse	<input type="checkbox"/> Law enforcement officer																											
<input type="checkbox"/> Other relative	<input type="checkbox"/> Other, specify: <input type="checkbox"/> U/K																											
<p>Other weapon:</p> <input type="radio"/> Male <input type="radio"/> Female <input type="radio"/> U/K																												

q. Use of weapon at time, check all that apply:

<input type="checkbox"/> Self-injury	<input type="checkbox"/> Argument	<input type="checkbox"/> Hunting	<input type="checkbox"/> Russian Roulette	<input type="checkbox"/> Intervener assisting crime victim (Good Samaritan)
<input type="checkbox"/> Commission of crime	<input type="checkbox"/> Jealousy	<input type="checkbox"/> Target shooting	<input type="checkbox"/> Gang-related activity	<input type="checkbox"/> Other, specify:
<input type="checkbox"/> Drive-by shooting	<input type="checkbox"/> Intimate partner violence	<input type="checkbox"/> Playing with weapon	<input type="checkbox"/> Self-defense	<input type="checkbox"/> U/K
<input type="checkbox"/> Random violence	<input type="checkbox"/> Hate crime	<input type="checkbox"/> Weapon mistaken for toy	<input type="checkbox"/> Cleaning weapon	
<input type="checkbox"/> Child was a bystander	<input type="checkbox"/> Bullying	<input type="checkbox"/> Showing gun to others	<input type="checkbox"/> Loading weapon	

7. ANIMAL BITE OR ATTACK

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

8. FALL OR CRUSH

<p>a. Type:</p> <input type="radio"/> Fall, go to b <input type="radio"/> Crush, go to h	<p>b. Height of fall:</p> <p>_____ feet</p> <p>_____ inches</p> <input type="radio"/> U/K	<p>c. Child fell from:</p> <table style="width:100%;"> <tr> <td><input type="radio"/> Open window</td> <td><input type="radio"/> Natural elevation</td> <td><input type="radio"/> Stairs/steps</td> <td><input type="radio"/> Moving object, specify:</td> <td><input type="radio"/> Animal, specify:</td> </tr> <tr> <td><input type="radio"/> Screen</td> <td><input type="radio"/> Man-made elevation</td> <td><input type="radio"/> Furniture</td> <td><input type="radio"/> Bridge</td> <td><input type="radio"/> Other, specify:</td> </tr> <tr> <td><input type="radio"/> No screen</td> <td><input type="radio"/> Playground equipment</td> <td><input type="radio"/> Bed</td> <td><input type="radio"/> Overpass</td> <td><input type="radio"/> U/K</td> </tr> <tr> <td><input type="radio"/> U/K if screen</td> <td><input type="radio"/> Tree</td> <td><input type="radio"/> Roof</td> <td><input type="radio"/> Balcony</td> <td></td> </tr> </table>	<input type="radio"/> Open window	<input type="radio"/> Natural elevation	<input type="radio"/> Stairs/steps	<input type="radio"/> Moving object, specify:	<input type="radio"/> Animal, specify:	<input type="radio"/> Screen	<input type="radio"/> Man-made elevation	<input type="radio"/> Furniture	<input type="radio"/> Bridge	<input type="radio"/> Other, specify:	<input type="radio"/> No screen	<input type="radio"/> Playground equipment	<input type="radio"/> Bed	<input type="radio"/> Overpass	<input type="radio"/> U/K	<input type="radio"/> U/K if screen	<input type="radio"/> Tree	<input type="radio"/> Roof	<input type="radio"/> Balcony	
<input type="radio"/> Open window	<input type="radio"/> Natural elevation	<input type="radio"/> Stairs/steps	<input type="radio"/> Moving object, specify:	<input type="radio"/> Animal, specify:																		
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<input type="radio"/> U/K if screen	<input type="radio"/> Tree	<input type="radio"/> Roof	<input type="radio"/> Balcony																			

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

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

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

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

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

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

<p>h. Was environmental tobacco exposure a contributing factor in death?</p> <p><input type="radio"/> No</p> <p><input type="radio"/> Yes</p> <p><input type="radio"/> U/K</p>	<p>i. Were there access or compliance issues related to the death? <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> U/K If yes, check all that apply:</p> <table border="0"> <tr> <td><input type="checkbox"/> Lack of money for care</td> <td><input type="checkbox"/> Language barriers</td> <td><input type="checkbox"/> Caregiver distrust of health care system</td> </tr> <tr> <td><input type="checkbox"/> Limitations of health insurance coverage</td> <td><input type="checkbox"/> Referrals not made</td> <td><input type="checkbox"/> Caregiver unskilled in providing care</td> </tr> <tr> <td><input type="checkbox"/> Multiple health insurance, not coordinated</td> <td><input type="checkbox"/> Specialist needed, not available</td> <td><input type="checkbox"/> Caregiver unwilling to provide care</td> </tr> <tr> <td><input type="checkbox"/> Lack of transportation</td> <td><input type="checkbox"/> Multiple providers, not coordinated</td> <td><input type="checkbox"/> Caregiver's partner would not allow care</td> </tr> <tr> <td><input type="checkbox"/> No phone</td> <td><input type="checkbox"/> Lack of child care</td> <td><input type="checkbox"/> Other, specify:</td> </tr> <tr> <td><input type="checkbox"/> Cultural differences</td> <td><input type="checkbox"/> Lack of family or social support</td> <td></td> </tr> <tr> <td><input type="checkbox"/> Religious objections to care</td> <td><input type="checkbox"/> Services not available</td> <td><input type="checkbox"/> U/K</td> </tr> </table>	<input type="checkbox"/> Lack of money for care	<input type="checkbox"/> Language barriers	<input type="checkbox"/> Caregiver distrust of health care system	<input type="checkbox"/> Limitations of health insurance coverage	<input type="checkbox"/> Referrals not made	<input type="checkbox"/> Caregiver unskilled in providing care	<input type="checkbox"/> Multiple health insurance, not coordinated	<input type="checkbox"/> Specialist needed, not available	<input type="checkbox"/> Caregiver unwilling to provide care	<input type="checkbox"/> Lack of transportation	<input type="checkbox"/> Multiple providers, not coordinated	<input type="checkbox"/> Caregiver's partner would not allow care	<input type="checkbox"/> No phone	<input type="checkbox"/> Lack of child care	<input type="checkbox"/> Other, specify:	<input type="checkbox"/> Cultural differences	<input type="checkbox"/> Lack of family or social support		<input type="checkbox"/> Religious objections to care	<input type="checkbox"/> Services not available	<input type="checkbox"/> U/K
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<input type="checkbox"/> Religious objections to care	<input type="checkbox"/> Services not available	<input type="checkbox"/> U/K																				

12. OTHER CAUSE, UNDETERMINED CAUSE OR UNKNOWN CAUSE

Specify cause, describe in detail:

H. OTHER CIRCUMSTANCES OF INCIDENT- ANSWER RELEVANT SECTIONS

1. ANSWER THIS ONLY IF CHILD IS UNDER AGE FIVE: WAS DEATH RELATED TO SLEEPING OR THE SLEEP ENVIRONMENT? No, go to H2 Yes U/K, go to H2

<p>a. Incident sleep place:</p> <p><input type="radio"/> Crib</p> <p>If crib, type:</p> <p><input type="radio"/> Not portable</p> <p><input type="radio"/> Portable, e.g. pack-n-play</p> <p><input type="radio"/> Unknown crib type</p> <p><input type="radio"/> Bassinette</p> <p><input type="radio"/> Adult bed</p> <p><input type="radio"/> Waterbed</p> <p><input type="radio"/> Playpen/other play structure but not portable crib</p> <p><input type="radio"/> Couch</p> <p><input type="radio"/> Chair</p> <p><input type="radio"/> Floor</p> <p><input type="radio"/> Car seat</p> <p><input type="radio"/> Stroller</p> <p><input type="radio"/> Other, specify:</p> <p><input type="radio"/> U/K</p>	<p>If adult bed, what type?</p> <p><input type="radio"/> Twin</p> <p><input type="radio"/> Full</p> <p><input type="radio"/> Queen</p> <p><input type="radio"/> King</p> <p><input type="radio"/> Other, specify:</p> <p><input type="radio"/> U/K</p>	<p>b. Child put to sleep:</p> <p><input type="radio"/> On back</p> <p><input type="radio"/> On stomach</p> <p><input type="radio"/> On side</p> <p><input type="radio"/> U/K</p>	<p>c. Child found:</p> <p><input type="radio"/> On back</p> <p><input type="radio"/> On stomach</p> <p><input type="radio"/> On side</p> <p><input type="radio"/> U/K</p>
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<p>d. Usual sleep place:</p> <p><input type="radio"/> Crib</p> <p>If crib, type:</p> <p><input type="radio"/> Not portable</p> <p><input type="radio"/> Portable, e.g. pack-n-play</p> <p><input type="radio"/> Unknown crib type</p> <p><input type="radio"/> Bassinette</p> <p><input type="radio"/> Adult bed</p> <p><input type="radio"/> Waterbed</p> <p><input type="radio"/> Playpen/other play structure but not portable crib</p> <p><input type="radio"/> Couch</p> <p><input type="radio"/> Chair</p> <p><input type="radio"/> Floor</p> <p><input type="radio"/> Car seat</p> <p><input type="radio"/> Stroller</p> <p><input type="radio"/> Other, specify:</p> <p><input type="radio"/> U/K</p>	<p>If adult bed, what type?</p> <p><input type="radio"/> Twin</p> <p><input type="radio"/> Full</p> <p><input type="radio"/> Queen</p> <p><input type="radio"/> King</p> <p><input type="radio"/> Other, specify:</p> <p><input type="radio"/> U/K</p>	<p>e. Usual sleep position:</p> <p><input type="radio"/> On back</p> <p><input type="radio"/> On stomach</p> <p><input type="radio"/> On side</p> <p><input type="radio"/> U/K</p>	<p>f. Was there a crib, bassinette or port-a-crib in home for child?</p> <p><input type="radio"/> No</p> <p><input type="radio"/> Yes</p> <p><input type="radio"/> U/K</p>
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<p>g. Child in a new or different environment than usual?</p> <p><input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> U/K If yes, specify:</p>	<p>h. Child last placed to sleep with a pacifier?</p> <p><input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> U/K</p>	<p>i. Was a fan being used in the room at the time of death?</p> <p><input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> U/K If yes, type:</p>
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j. Circumstances when child found:

<p><u>Child's airway was:</u></p> <p><input type="radio"/> Unobstructed by person or object</p> <p><input type="radio"/> Fully obstructed by person or object</p> <p><input type="radio"/> Partially obstructed by person or object</p> <p><input type="radio"/> U/K</p>	<p><u>Child's position most relevant to death:</u></p> <p><input type="radio"/> On top of</p> <p><input type="radio"/> Under</p> <p><input type="radio"/> Between</p> <p><input type="radio"/> Wedged into</p> <p><input type="radio"/> Pressed into</p> <p><input type="radio"/> Fell or rolled onto</p> <p><input type="radio"/> Tangled in</p> <p><input type="radio"/> Other, specify:</p> <p><input type="radio"/> U/K</p>	<p><u>With what objects or persons, check all that apply:</u></p> <table border="0"> <tr> <td><input type="checkbox"/> Adult(s)</td> <td><input type="checkbox"/> Water bed mattress</td> <td><input type="checkbox"/> Clothing</td> </tr> <tr> <td><input type="checkbox"/> Child(ren)</td> <td><input type="checkbox"/> Air mattress</td> <td><input type="checkbox"/> Cord</td> </tr> <tr> <td><input type="checkbox"/> Animal(s)</td> <td><input type="checkbox"/> Bumper pads</td> <td><input type="checkbox"/> Plastic bag</td> </tr> <tr> <td><input type="checkbox"/> Blanket</td> <td><input type="checkbox"/> Crib rail</td> <td><input type="checkbox"/> Wall</td> </tr> <tr> <td><input type="checkbox"/> Pillow</td> <td><input type="checkbox"/> Couch</td> <td><input type="checkbox"/> Other, specify:</td> </tr> <tr> <td><input type="checkbox"/> Comforter</td> <td><input type="checkbox"/> Chair, type:</td> <td></td> </tr> <tr> <td><input type="checkbox"/> Mattress</td> <td><input type="checkbox"/> Car seat/stroller</td> <td><input type="checkbox"/> U/K</td> </tr> <tr> <td><input type="checkbox"/> Pillow-top mattress</td> <td><input type="checkbox"/> Stuffed toy</td> <td></td> </tr> </table>	<input type="checkbox"/> Adult(s)	<input type="checkbox"/> Water bed mattress	<input type="checkbox"/> Clothing	<input type="checkbox"/> Child(ren)	<input type="checkbox"/> Air mattress	<input type="checkbox"/> Cord	<input type="checkbox"/> Animal(s)	<input type="checkbox"/> Bumper pads	<input type="checkbox"/> Plastic bag	<input type="checkbox"/> Blanket	<input type="checkbox"/> Crib rail	<input type="checkbox"/> Wall	<input type="checkbox"/> Pillow	<input type="checkbox"/> Couch	<input type="checkbox"/> Other, specify:	<input type="checkbox"/> Comforter	<input type="checkbox"/> Chair, type:		<input type="checkbox"/> Mattress	<input type="checkbox"/> Car seat/stroller	<input type="checkbox"/> U/K	<input type="checkbox"/> Pillow-top mattress	<input type="checkbox"/> Stuffed toy	
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<input type="checkbox"/> Pillow-top mattress	<input type="checkbox"/> Stuffed toy																									

<p>k. Caregiver/supervisor fell asleep while feeding child? <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> U/K</p> <p>If yes, type of feeding:</p> <p><input type="radio"/> Bottle</p> <p><input type="radio"/> Breast</p> <p><input type="radio"/> U/K</p>	<p>l. Child sleeping in the same room as caregiver/supervisor at time of death?</p> <p><input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> U/K</p>	<p>m. Child sleeping on same surface with person(s) or animal(s)? <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> U/K</p> <p>If yes, check all that apply:</p> <p><input type="checkbox"/> With adult(s): # ___ <input type="checkbox"/> #U/K Adult obese: <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> U/K</p> <p><input type="checkbox"/> With other children: # ___ <input type="checkbox"/> #U/K Children's ages: _____</p> <p><input type="checkbox"/> With animal(s): # ___ <input type="checkbox"/> #U/K Type(s) of animal: _____</p> <p><input type="checkbox"/> U/K</p>
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2. WAS DEATH A CONSEQUENCE OF A PROBLEM WITH A CONSUMER PRODUCT? No, go to H3 Yes U/K, go to H3

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

a. Type of crime, check all that apply:

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

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

Type of Act

1. Did any act(s) of omission or commission cause and/or contribute to the death? <input type="radio"/> No, go to Section J <input type="radio"/> Yes <input type="radio"/> Probable <input type="radio"/> U/K, go to Section J If yes/probable, were the act(s) either or both? Check all that apply: <input type="checkbox"/> The direct cause of death <input type="checkbox"/> The contributing cause of death	2. Was the act(s): Check only one per column. Act that: <table border="0"> <tr> <td><u>Caused</u></td> <td><u>Contributed</u></td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/> Unintentional</td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/> Intentional</td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/> Undetermined intent</td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/> U/K</td> </tr> </table>	<u>Caused</u>	<u>Contributed</u>	<input type="radio"/>	<input type="radio"/> Unintentional	<input type="radio"/>	<input type="radio"/> Intentional	<input type="radio"/>	<input type="radio"/> Undetermined intent	<input type="radio"/>	<input type="radio"/> U/K	3. What acts caused or contributed to the death? Check only one per column and describe in narrative. <table border="0"> <tr> <td><u>Caused</u></td> <td><u>Contributed</u></td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/> Poor/absent supervision, go to 11</td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/> Child abuse, go to 4</td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/> Child neglect, go to 9</td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/> Other negligence, go to 10</td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/> Assault, not child abuse, go to 11</td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/> Religious/cultural practices, go to 11</td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/> Suicide, go to 28</td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/> Medical misadventure, specify and go to 12</td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/> Other, specify and go to 11</td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/> U/K, go to 11</td> </tr> </table>	<u>Caused</u>	<u>Contributed</u>	<input type="radio"/>	<input type="radio"/> Poor/absent supervision, go to 11	<input type="radio"/>	<input type="radio"/> Child abuse, go to 4	<input type="radio"/>	<input type="radio"/> Child neglect, go to 9	<input type="radio"/>	<input type="radio"/> Other negligence, go to 10	<input type="radio"/>	<input type="radio"/> Assault, not child abuse, go to 11	<input type="radio"/>	<input type="radio"/> Religious/cultural practices, go to 11	<input type="radio"/>	<input type="radio"/> Suicide, go to 28	<input type="radio"/>	<input type="radio"/> Medical misadventure, specify and go to 12	<input type="radio"/>	<input type="radio"/> Other, specify and go to 11	<input type="radio"/>	<input type="radio"/> U/K, go to 11
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4. Child abuse, type. Check all that apply and describe in narrative. <input type="checkbox"/> Physical, go to 5 <input type="checkbox"/> Emotional, specify and go to 11 <input type="checkbox"/> Sexual, specify and go to 11 <input type="checkbox"/> U/K, go to 11	5. Type of physical abuse, check all that apply: <input type="checkbox"/> Abusive head trauma, go to 6 <input type="checkbox"/> Chronic Battered Child Syndrome, go to 8 <input type="checkbox"/> Beating/kicking, go to 8 <input type="checkbox"/> Scalding or burning, go to 8 <input type="checkbox"/> Munchausen Syndrome by Proxy, go to 8 <input type="checkbox"/> Other, specify and go to 8 <input type="checkbox"/> U/K, go to 8	6. For abusive head trauma, were there retinal hemorrhages? <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> U/K 7. For abusive head trauma, was the child shaken? <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> U/K If yes, was there impact? <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> U/K	8. Events(s) triggering physical abuse, check all that apply: <input type="checkbox"/> None <input type="checkbox"/> Crying <input type="checkbox"/> Toilet training <input type="checkbox"/> Disobedience <input type="checkbox"/> Feeding problems <input type="checkbox"/> Domestic argument <input type="checkbox"/> Other, specify: <input type="checkbox"/> U/K
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9. Child neglect, check all that apply: <input type="checkbox"/> Failure to protect from hazards, specify: <input type="checkbox"/> Failure to provide necessities <input type="checkbox"/> Food <input type="checkbox"/> Shelter <input type="checkbox"/> Other, specify: <input type="checkbox"/> Failure to seek/follow treatment, specify: <input type="checkbox"/> Emotional neglect, specify: <input type="checkbox"/> Abandonment, specify: <input type="checkbox"/> U/K	10. Other negligence: <input type="radio"/> Vehicular <input type="radio"/> Other, specify: <input type="radio"/> U/K	11. Was act(s) of omission/commission: <table border="0"> <tr> <td><u>Caused</u></td> <td><u>Contributed</u></td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/> Chronic with child</td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/> Pattern in family or with perpetrator</td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/> Isolated incident</td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/> U/K</td> </tr> </table>	<u>Caused</u>	<u>Contributed</u>	<input type="radio"/>	<input type="radio"/> Chronic with child	<input type="radio"/>	<input type="radio"/> Pattern in family or with perpetrator	<input type="radio"/>	<input type="radio"/> Isolated incident	<input type="radio"/>	<input type="radio"/> U/K
<u>Caused</u>	<u>Contributed</u>											
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<input type="radio"/>	<input type="radio"/> Isolated incident											
<input type="radio"/>	<input type="radio"/> U/K											

Person(s) Responsible

12. Is person the caregiver or supervisor in previous section?	13. Primary person responsible for action(s) that caused and/or contributed to death: Select no more than one person for caused and one person for contributed.
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<u>Caused</u>	<u>Contributed</u>	<u>Caused</u>	<u>Contributed</u>	<u>Caused</u>	<u>Contributed</u>
<input type="radio"/>	<input type="radio"/> No	<input type="radio"/>	<input type="radio"/> Self, go to 25	<input type="radio"/>	<input type="radio"/> Grandparent
<input type="radio"/>	<input type="radio"/> Yes, caregiver one, go to 25	<input type="radio"/>	<input type="radio"/> Biological parent	<input type="radio"/>	<input type="radio"/> Sibling
<input type="radio"/>	<input type="radio"/> Yes, caregiver two, go to 25	<input type="radio"/>	<input type="radio"/> Adoptive parent	<input type="radio"/>	<input type="radio"/> Other relative
<input type="radio"/>	<input type="radio"/> Yes, supervisor, go to 26	<input type="radio"/>	<input type="radio"/> Stepparent	<input type="radio"/>	<input type="radio"/> Friend
		<input type="radio"/>	<input type="radio"/> Foster parent	<input type="radio"/>	<input type="radio"/> Acquaintance
		<input type="radio"/>	<input type="radio"/> Mother's partner	<input type="radio"/>	<input type="radio"/> Child's boyfriend or girlfriend
		<input type="radio"/>	<input type="radio"/> Father's partner	<input type="radio"/>	<input type="radio"/> Stranger
		<input type="radio"/>		<input type="radio"/>	<input type="radio"/> Medical provider
				<input type="radio"/>	<input type="radio"/> Institutional staff
				<input type="radio"/>	<input type="radio"/> Babysitter
				<input type="radio"/>	<input type="radio"/> Licensed child care worker
				<input type="radio"/>	<input type="radio"/> Other, specify:
				<input type="radio"/>	<input type="radio"/> U/K

<p>14. Person's age in years:</p> <p><u>Caused</u> <u>Contributed</u></p> <p>_____ _____ # Years</p> <p><input type="checkbox"/> <input type="checkbox"/> U/K</p>	<p>15. Person's sex:</p> <p><u>Caused</u> <u>Contributed</u></p> <p><input type="radio"/> <input type="radio"/> Male</p> <p><input type="radio"/> <input type="radio"/> Female</p> <p><input type="radio"/> <input type="radio"/> U/K</p>	<p>16. Does person speak English?</p> <p><u>Caused</u> <u>Contributed</u></p> <p><input type="radio"/> <input type="radio"/> No</p> <p><input type="radio"/> <input type="radio"/> Yes</p> <p><input type="radio"/> <input type="radio"/> U/K</p> <p>If no, language spoken:</p>	<p>17. Person on active military duty?</p> <p><u>Caused</u> <u>Contributed</u></p> <p><input type="radio"/> <input type="radio"/> No</p> <p><input type="radio"/> <input type="radio"/> Yes</p> <p><input type="radio"/> <input type="radio"/> U/K</p> <p>If yes, specify branch:</p>
<p>18. Person have history of substance abuse?</p> <p><u>Caused</u> <u>Contributed</u></p> <p><input type="radio"/> <input type="radio"/> No</p> <p><input type="radio"/> <input type="radio"/> Yes</p> <p><input type="radio"/> <input type="radio"/> U/K</p> <p>If yes, check all that apply:</p> <p><input type="checkbox"/> <input type="checkbox"/> Alcohol</p> <p><input type="checkbox"/> <input type="checkbox"/> Cocaine</p> <p><input type="checkbox"/> <input type="checkbox"/> Marijuana</p> <p><input type="checkbox"/> <input type="checkbox"/> Methamphetamine</p> <p><input type="checkbox"/> <input type="checkbox"/> Opiates</p> <p><input type="checkbox"/> <input type="checkbox"/> Prescription drugs</p> <p><input type="checkbox"/> <input type="checkbox"/> Over-the-counter</p> <p><input type="checkbox"/> <input type="checkbox"/> Other, specify:</p> <p><input type="checkbox"/> <input type="checkbox"/> U/K</p>	<p>19. Person have history of child maltreatment as victim?</p> <p><u>Caused</u> <u>Contributed</u></p> <p><input type="radio"/> <input type="radio"/> No</p> <p><input type="radio"/> <input type="radio"/> Yes</p> <p><input type="radio"/> <input type="radio"/> U/K</p> <p>If yes, check all that apply:</p> <p><input type="checkbox"/> <input type="checkbox"/> Physical</p> <p><input type="checkbox"/> <input type="checkbox"/> Neglect</p> <p><input type="checkbox"/> <input type="checkbox"/> Sexual</p> <p><input type="checkbox"/> <input type="checkbox"/> Emotional/psychological</p> <p><input type="checkbox"/> <input type="checkbox"/> U/K</p> <p>_____ _____ # CPS referrals</p> <p>_____ _____ # Substantiations</p> <p><input type="checkbox"/> <input type="checkbox"/> Ever in foster care or adopted?</p>	<p>20. Person have history of child maltreatment as a perpetrator?</p> <p><u>Caused</u> <u>Contributed</u></p> <p><input type="radio"/> <input type="radio"/> No</p> <p><input type="radio"/> <input type="radio"/> Yes</p> <p><input type="radio"/> <input type="radio"/> U/K</p> <p>If yes, check all that apply:</p> <p><input type="checkbox"/> <input type="checkbox"/> Physical</p> <p><input type="checkbox"/> <input type="checkbox"/> Neglect</p> <p><input type="checkbox"/> <input type="checkbox"/> Sexual</p> <p><input type="checkbox"/> <input type="checkbox"/> Emotional/psychological</p> <p><input type="checkbox"/> <input type="checkbox"/> U/K</p> <p>_____ _____ # CPS referrals</p> <p>_____ _____ # Substantiations</p> <p><input type="checkbox"/> <input type="checkbox"/> CPS prevention services?</p> <p><input type="checkbox"/> <input type="checkbox"/> Family Preservation svcs?</p> <p><input type="checkbox"/> <input type="checkbox"/> Children ever removed?</p>	<p>21. Person have disability or chronic illness?</p> <p><u>Caused</u> <u>Contributed</u></p> <p><input type="radio"/> <input type="radio"/> No</p> <p><input type="radio"/> <input type="radio"/> Yes</p> <p><input type="radio"/> <input type="radio"/> U/K</p> <p>If yes, check all that apply:</p> <p><input type="checkbox"/> <input type="checkbox"/> Physical, specify:</p> <p><input type="checkbox"/> <input type="checkbox"/> Mental, specify:</p> <p><input type="checkbox"/> <input type="checkbox"/> Sensory, specify:</p> <p><input type="checkbox"/> <input type="checkbox"/> U/K</p> <p>If mental, was caregiver receiving services?</p> <p><input type="radio"/> <input type="radio"/> No</p> <p><input type="radio"/> <input type="radio"/> Yes</p> <p><input type="radio"/> <input type="radio"/> U/K</p>
<p>22. Person have prior child deaths?</p> <p><u>Caused</u> <u>Contributed</u></p> <p><input type="radio"/> <input type="radio"/> No</p> <p><input type="radio"/> <input type="radio"/> Yes</p> <p><input type="radio"/> <input type="radio"/> U/K</p>	<p>If yes, check all that apply:</p> <p><u>Caused</u> <u>Contributed</u></p> <p><input type="checkbox"/> <input type="checkbox"/> Child abuse # _____</p> <p><input type="checkbox"/> <input type="checkbox"/> Child neglect # _____</p> <p><input type="checkbox"/> <input type="checkbox"/> Accident # _____</p> <p><input type="checkbox"/> <input type="checkbox"/> Suicide # _____</p> <p><input type="checkbox"/> <input type="checkbox"/> SIDS # _____</p> <p><input type="checkbox"/> <input type="checkbox"/> Other # _____</p> <p>Other, specify:</p> <p><input type="checkbox"/> <input type="checkbox"/> U/K</p>	<p>23. Person have history of intimate partner violence?</p> <p><u>Caused</u> <u>Contributed</u></p> <p><input type="checkbox"/> <input type="checkbox"/> No</p> <p><input type="checkbox"/> <input type="checkbox"/> Yes, as victim</p> <p><input type="checkbox"/> <input type="checkbox"/> Yes, as perpetrator</p> <p><input type="checkbox"/> <input type="checkbox"/> U/K</p>	<p>24. Person have delinquent/criminal history?</p> <p><u>Caused</u> <u>Contributed</u></p> <p><input type="radio"/> <input type="radio"/> No</p> <p><input type="radio"/> <input type="radio"/> Yes</p> <p><input type="radio"/> <input type="radio"/> U/K</p> <p>If yes, check all that apply:</p> <p><input type="checkbox"/> <input type="checkbox"/> Assaults</p> <p><input type="checkbox"/> <input type="checkbox"/> Robbery</p> <p><input type="checkbox"/> <input type="checkbox"/> Drugs</p> <p><input type="checkbox"/> <input type="checkbox"/> Other, specify:</p> <p><input type="checkbox"/> <input type="checkbox"/> U/K</p>
<p>25. At time of incident was person, check all that apply:</p> <p><u>Caused</u> <u>Contributed</u></p> <p><input type="checkbox"/> <input type="checkbox"/> Drug impaired?</p> <p><input type="checkbox"/> <input type="checkbox"/> Alcohol impaired?</p> <p><input type="checkbox"/> <input type="checkbox"/> Asleep?</p> <p><input type="checkbox"/> <input type="checkbox"/> Distracted?</p> <p><input type="checkbox"/> <input type="checkbox"/> Absent?</p> <p><input type="checkbox"/> <input type="checkbox"/> Impaired by illness? Specify:</p> <p><input type="checkbox"/> <input type="checkbox"/> Impaired by disability? Specify:</p> <p><input type="checkbox"/> <input type="checkbox"/> Other? Specify:</p>	<p>26. Does person have, check all that apply:</p> <p><u>Caused</u> <u>Contributed</u></p> <p><input type="checkbox"/> <input type="checkbox"/> Prior history of similar acts?</p> <p><input type="checkbox"/> <input type="checkbox"/> Prior arrests?</p> <p><input type="checkbox"/> <input type="checkbox"/> Prior convictions?</p>	<p>27. Legal outcomes in this death, check all that apply:</p> <p><u>Caused</u> <u>Contributed</u></p> <p><input type="checkbox"/> <input type="checkbox"/> No charges filed</p> <p><input type="checkbox"/> <input type="checkbox"/> Charges pending</p> <p><input type="checkbox"/> <input type="checkbox"/> Charges filed, specify:</p> <p><input type="checkbox"/> <input type="checkbox"/> Confession</p> <p><input type="checkbox"/> <input type="checkbox"/> Plead, specify:</p> <p><input type="checkbox"/> <input type="checkbox"/> Not guilty verdict</p> <p><input type="checkbox"/> <input type="checkbox"/> Guilty verdict, specify:</p> <p><input type="checkbox"/> <input type="checkbox"/> Tort charges, specify:</p> <p><input type="checkbox"/> <input type="checkbox"/> U/K</p>	

For Suicide

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

<u>Yes</u>	<u>No</u>	<u>U/K</u>		<u>Yes</u>	<u>No</u>	<u>U/K</u>	
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	A note was left?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Child had a history of self mutilation?
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Child talked about suicide?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	There is a family history of suicide?
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Prior suicide threats were made?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Suicide was part of a murder-suicide?
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Prior attempts were made?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Suicide was part of a suicide pact?
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Suicide was completely unexpected?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Suicide was part of a suicide cluster?
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Child had a history of running away?				

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

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

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

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

K. PREVENTION INITIATIVES RESULTING FROM THE REVIEW

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

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

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

Briefly describe the initiatives:

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

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

L. THE REVIEW MEETING PROCESS

1. Date of first review meeting:	2. Number of review meetings for this case: _____	3. Is review complete? <input type="radio"/> N/A <input type="radio"/> No <input type="radio"/> Yes
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4. Agencies at review, check all that apply:

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

5. For **infants**, were the following data sources available at the review?

Check all that apply:

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

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

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

7. Review meeting outcomes, check all that apply:

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

8. For **infants**, describe the factor(s) that directly contributed to this death:

9. For **infants**, which of the factors that directly contributed to this death are modifiable?

10. For **infants**, list any recommendations to prevent deaths from similar causes or circumstances in the future:

11. For **infants**, what additional information would the team like to know about the death scene investigation?

12. For **infants**, what additional information would the team like to know about the autopsy?

M. NARRATIVE

Use this space to provide more detail on the circumstances of the death and to describe any other relevant information.
Try not to include identifiers in the narrative.

Continue narrative if necessary on next page

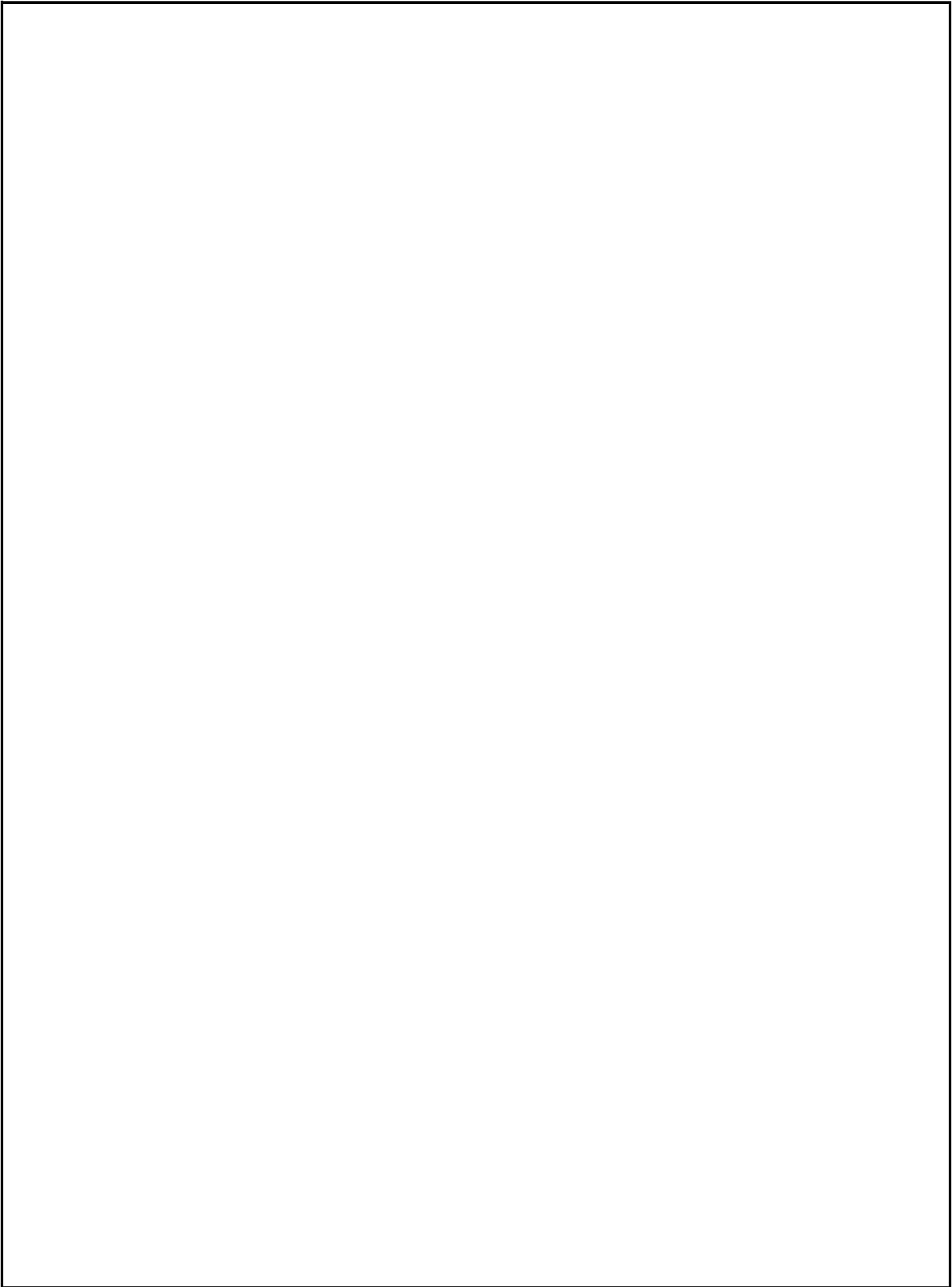
N. FORM COMPLETED BY:

PERSON:
TITLE:
AGENCY:
PHONE:

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

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

NOTES





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Data Entry: <https://cdrdata.org>
www.childdeathreview.org
For help, email: info@childdeathreview.org
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