Reporting Form

SUIDI
Sudden Unexp ained nfant Death nvestigation

INVESTIGATION DATA

Infant's Information: Last: _____ First: _____ M. _____ Case#_____

Sex: ☐ Male ☐ Female Date of Birth____/____/____ Age_____ SS#_____
Month Day Year

Race: ☐ White ☐ Black/African Am. ☐ Asian/Pacific Islander ☐ Am. Indian/Alaskan Native ☐ Hispanic/Latino ☐ Other

Infant's Primary Residence Address:

Address _____ City _____ Zip _____

Incident Address:

Address _____ City _____ Zip _____

Contact Information for Witness:

Relationship to the deceased: ☐ Birth Mother ☐ Birth Father ☐ Grandmother ☐ Grandfather
☐ Adoptive or Foster Parent ☐ Physician ☐ Health Records ☐ Other:

Last _____ First _____ M. _____ SS# _____

Home Address _____ City _____ State _____ Zip _____

Place of Work _____ City _____ State _____ Zip _____

Phone (H) _____ Phone (W) _____ Date of Birth _____

WITNESS INTERVIEW

1 Are you the usual caregiver? ☐ Yes ☐ No _____

2 Tell me what happened:

_____

_____

_____

3 Did you notice anything unusual or different about the infant in the last 24 hrs? ☐ No ☐ Yes ⇨ Describe: _____

_____

4 Did the infant experience any falls or injury within the last 72 hrs? ☐ No ☐ Yes ⇨ Describe: _____

5 When was the infant LAST PLACED? ..... ____/____/____ ____:____ _____
Month Day Year Military Time Location (room)

6 When was the infant ***LAST KNOWN ALIVE (LKA)***? ____/____/____ ____:____ _____
Month Day Year Military Time Location (room)

7 When was the infant ***FOUND***? .... ____/____/____ ____:____ _____
Month Day Year Military Time Location (room)

8 Explain how you knew the infant was still alive. _____

9 Where was the infant - (P)laced, (L)ast known alive, (F)ound (circle P, L, or F in front of appropriate response)?

P L F Bassinet	P L F Bedside co-sleeper	P L F Car seat	P L F Chair
P L F Cradle	P L F Crib	P L F Floor	P L F In a person's arms
P L F Mattress/box spring	P L F Mattress on floor	P L F Playpen	P L F Portable crib
P L F Sofa/couch	P L F Stroller/carriage	P L F Swing	P L F Waterbed

P L F Other _____

WITNESS INTERVIEW (cont.)

10 **In what position was the infant LAST PLACED?** ☐ Sitting ☐ On back ☐ On side ☐ On stomach ☐ Unknown
Was this the infant's usual position? ☐ Yes ☐ No ⇨ What was the infant's usual position? _____

11 **In what position was the infant *LKA*?** ☐ Sitting ☐ On back ☐ On side ☐ On stomach ☐ Unknown
Was this the infant's usual position? ☐ Yes ☐ No ⇨ What was the infant's usual position? _____

12 **In what position was the infant *Found*?** ☐ Sitting ☐ On back ☐ On side ☐ On stomach ☐ Unknown
Was this the infant's usual position? ☐ Yes ☐ No ⇨ What was the infant's usual position? _____

13 **FACE position when *LAST PLACED?*** ☐ Face down on surface ☐ Face up ☐ Face right ☐ Face left

14 **NECK position when *LAST PLACED?*** ☐ Hyperextended (head back) ☐ Flexed (chin to chest) ☐ Neutral ☐ Turned

15 **FACE position when *LKA?*** ☐ Face down on surface ☐ Face up ☐ Face right ☐ Face left

16 **NECK position when *LKA?*** ☐ Hyperextended (head back) ☐ Flexed (chin to chest) ☐ Neutral ☐ Turned

17 **FACE position when *FOUND?*** ☐ Face down on surface ☐ Face up ☐ Face right ☐ Face left

18 **NECK position when *FOUND?*** ☐ Hyperextended (head back) ☐ Flexed (chin to chest) ☐ Neutral ☐ Turned

19 **What was the infant wearing?** *(ex. t-shirt, disposable diaper)* _____

20 **Was the infant tightly wrapped or swaddled?** ☐ No ☐ Yes ⇨ Describe: _____

21 **Please indicate the types and numbers of layers of bedding both over and under infant (not including wrapping blanket):**

Bedding UNDER Infant	None	Number	Bedding OVER Infant	None	Number
Receiving blankets	☐		Receiving blankets	☐	
Infant/child blankets	☐		Infant/child blankets	☐	
Infant/child comforters (thick)	☐		Infant/child comforters *(thick)*	☐	
Adult comforters/duvets	☐		Adult comforters/duvets	☐	
Adult blankets	☐		Adult blankets	☐	
Sheets	☐		Sheets	☐	
Sheepskin	☐		Pillows	☐	
Pillows	☐		Rubber or plastic sheet	☐	
Rubber or plastic sheet	☐		Other, specify:		
Other, specify:					

Which of the following devices were operating in the infant's room?
☐ None ☐ Apnea monitor ☐ Humidifier ☐ Vaporizer ☐ Air Purifier ☐ Other _____

24 What was the temperature of the infant's room? ☐ Hot ☐ Cold ☐ Normal ☐ Other _____

_____

25 Which of the following items were near the infant's face, nose, or mouth?
☐ Bumper pads ☐ Infant pillows ☐ Positional supports ☐ Stuffed animals ☐ Toys ☐ Other _____

26 Which of the following items were within the infant's reach? ☐ Blankets ☐ Toys ☐ Pillows
☐ Pacifier ☐ Nothing ☐ Other _____

27 Was anyone sleeping with the infant? ☐ No ☐ Yes ⇨ Name these people.

Name	Age	Height	Weight	Location in Relation to Infant	Impaired (intoxicated, tired)

28 Was there evidence of wedging? ☐ No ☐ Yes ⇨ Describe: _____

29 When the infant was found, was s/he: ☐ Breathing ☐ Not breathing
If not breathing, did you witness the infant stop breathing? ☐ No ☐ Yes

WITNESS INTERVIEW (cont.)

30 **What had led you to check on the infant?** _____

31 **Describe infant's appearance when found.**

	Unknown	No	Yes	Describe and specify location:
a) Discoloration around face/nose/mouth	☐	☐	☐	⇨ _____
b) Secretions (foam, froth)	☐	☐	☐	⇨ _____
c) Skin discoloration (livor mortis)	☐	☐	☐	⇨ _____
d) Pressure marks (pale areas, blanching)	☐	☐	☐	⇨ _____
e) Rash or petechiae (small, red blood spots on skin, membranes, or eyes)	☐	☐	☐	⇨ _____
f) Marks on body (scratches or bruises)	☐	☐	☐	⇨ _____
g) Other	☐	☐	☐	⇨ _____

32 **What did the infant feel like when found?** *(Check all that apply.)*

☐ Sweaty ☐ Warm to touch ☐ Cool to touch
☐ Limp, flexible ☐ Rigid, stiff ☐ Unknown
☐ Other ⇨Specify: ..... _____

33 **Did anyone else other than EMS try to resuscitate the infant?** ☐ No ☐ Yes ⇨Who and when?

Who _____ ___/___/___ ___:___
Month Day Year Military Time

34 **Please describe what was done as part of resuscitation:**

_____

_____

_____

35 **Has the parent/caregiver ever had a child die suddenly and unexpectedly?** ☐ No ☐ Yes ⇨Explain

_____

INFANT MEDICAL HISTORY

1 **Source of medical information:**

☐ Mother/primary caregiver ☐ Doctor ☐ Other healthcare provider ☐ Medical record
☐ Family ☐ Other:

2 **In the 72 hours prior to death, did the infant have:**

	Unknown	No	Yes		Unknown	No	Yes
a) Fever	☐	☐	☐	h) Diarrhea	☐	☐	☐
b) Excessive sweating	☐	☐	☐	i) Stool changes	☐	☐	☐
c) Lethargy or sleeping more than usual	☐	☐	☐	j) Difficulty breathing	☐	☐	☐
d) Fussiness or excessive crying	☐	☐	☐	k) Apnea (stopped breathing)	☐	☐	☐
e) Decrease in appetite	☐	☐	☐	l) Cyanosis (turned blue/gray)	☐	☐	☐
f) Vomiting	☐	☐	☐	m) Seizures or convulsions	☐	☐	☐
g) Choking	☐	☐	☐	n) Other, specify:	_____		

3 **In the 72 hours prior to death, was the infant injured or did s/he have any other condition(s) not mentioned?**

☐ No ☐ Yes ⇨Describe: _____

4 **In the 72 hours prior to the infants death, was the infant given any vaccinations or medications?**
(Please include any home remedies, herbal medications, prescription medicines, over-the-counter medications.)

☐ No ☐ Yes ⇨List below

Name of vaccination or medication	Dose last given	Date given (Month / Day / Year)	Approx. time (Military : Time)	Reasons given/ comments:
1		___/___/___	___:___	
2		___/___/___	___:___	
3		___/___/___	___:___	
4		___/___/___	___:___	

INFANT MEDICAL HISTORY (cont.)

5 **At any time in the infant's life, did s/he have a history of?**

	Unknown	No	Yes	Describe:
a) Allergies (food, medication, or other)	☐	☐	☐	⇨ _____
b) Abnormal growth or weight gain/loss	☐	☐	☐	⇨ _____
c) Apnea (stopped breathing)	☐	☐	☐	⇨ _____
d) Cyanosis (turned blue/gray)	☐	☐	☐	⇨ _____
e) Seizures or convulsions	☐	☐	☐	⇨ _____
f) Cardiac (heart) abnormalities	☐	☐	☐	⇨ _____
g) Metabolic disorders	☐	☐	☐	⇨ _____
h) Other	☐	☐	☐	⇨ _____

6 **Did the infant have any birth defects(s)?** ☐ No ☐ Yes

Describe: _____

7 **Describe the two most recent times that the infant was seen by a physician or health care provider:**
(Include emergency department visits, clinic visits, hospital admissions, observational stays, and telephone calls)

	First most recent visit	Second most recent visit
a) Date	___/___/___ (Month Day Year)	___/___/___ (Month Day Year)
b) Reason for visit	_____	_____
c) Action taken	_____	_____
d) Physician's name	_____	_____
e) Hospital/clinic	_____	_____
f) Address	_____	_____
g) City, ZIP	_____	_____
h) Phone number	( ) - _____	( ) - _____

8 **Birth hospital name:**

Street

City _____ State _____ ZIP _____

Date of discharge ___/___/___ (Month Day Year)

9 **What was the infant's length at birth?** _____ inches _____ or _____ centimeters

10 **What was the infant's weight at birth?** _____ pounds _____ ounces _____ or _____ grams

11 **Compared to the delivery date, was the infant born on time, early, or late?**

☐ On time ☐ Early - How many weeks early? ☐ Late - How many weeks late? _____

12 **Was the infant a singleton, twin, triplet, or higher gestation?**

☐ Singleton ☐ Twins ☐ Triplet ☐ Quadruplet or higher gestation

13 **Were there any complications during delivery or at birth?** *(emergency c-section, child needed oxygen)*

☐ No ☐ Yes ⇨Describe the complications: _____

_____

_____

14 **Are there any alerts to pathologist?** *(previous infant deaths in family, newborn screen results)*

☐ No ☐ Yes ⇨Specify: _____

_____

_____

INFANT DIETARY HISTORY

1 **On what day and at what approximate time was the infant last fed?**

____/____/____ (Month / Day / Year) ____:____ (Military Time)

2 **What is the name of the person who last fed the infant?** _____

3 **What is his/her relationship to the infant?** _____

4 **What foods and liquids was the infant fed in the last 24 hours** *(include last fed)***?**

	Unknown	No	Yes		Quantity	Specify: *(type and brand if applicable)*
a) Breast milk (one/both sides, length of time)	☐	☐	☐	⇨	_____ ounces	_____
b) Formula (brand, water source - ex. Similac, tap water)	☐	☐	☐	⇨	_____ ounces	_____
c) Cow's milk	☐	☐	☐	⇨	_____ ounces	_____
d) Water (brand, bottled, tap, well)	☐	☐	☐	⇨	_____ ounces	_____
e) Other liquids (teas, juices)	☐	☐	☐	⇨	_____ ounces	_____
f) Solids	☐	☐	☐	⇨	_____	
g) Other	☐	☐	☐	⇨	_____	

5 **Was a new food introduced in the 24 hours prior to his/her death?**

☐ No ☐ Yes ⇨Describe *(ex. content, amount, change in formula, introduction of solids)*

_____

_____

_____

6 **Was the infant last placed to sleep with a bottle?**

☐ Yes ☐ No ⇨Skip to question **9** below

7 **Was the bottle propped?** *(i.e., object used to hold bottle while infant feeds)*

☐ No ☐ Yes ⇨ What object was used to prop the bottle? _____

8 **What was the quantity of liquid (in ounces) in the bottle?** _____

9 **Did death occur during?** ☐ **Breast-feeding** ☐ **Bottle-feeding** ☐ **Eating solid foods** ☐ **Not during feeding**

10 **Are there any factors, circumstances, or environmental concerns that may have impacted the infant that have not yet been identified?** (ex. exposed to cigarette smoke or fumes at someone else's home, infant unusually heavy, placed with positional supports or wedges)

☐ No ☐ Yes ⇨ Describe concerns: _____

_____

_____

_____

PREGNANCY HISTORY

1 **Information about the infant's birth mother:**

First name _____ Middle name _____

Last name _____ Maiden name _____

Date of birth: ____/____/____ (Month / Day / Year) SS # _____-____-____

Current Address _____ City _____ State _____ ZIP _____

How long has the birth mother been a resident at this address? _____ Years and _____ Months

Previous Address _____ City _____ State _____

2 **At how many weeks or months did the birth mother begin prenatal care?**

_____ Weeks _____ Months ☐ No prenatal care ☐ Unknown

3 **Where did the birth mother receive prenatal care?** *(Please specify physician or other health care provider name and address.)*

Physician/provider _____ Hospital/clinic _____ Phone (____) ____-____

Street _____ City _____ State _____ ZIP _____

PREGNANCY HISTORY (cont.)

4 **During her pregnancy with the infant, did the biological mother have any complications?**
(ex. high blood pressure, bleeding, gestational diabetes)

☐ No ☐ Yes ⇨ Specify _____

5 **Was the biological mother injured during her pregnancy with the infant?** *(ex. auto accident, falls)*

☐ No ☐ Yes ⇨ Specify _____

6 **During her pregnancy, did she use any of the following?**

	Unknown	No	Yes	Daily consumption		Unknown	No	Yes	Daily consumption
a) Over the counter medications	☐	☐	☐	_____	d) Cigarettes	☐	☐	☐	_____
b) Prescription medications	☐	☐	☐	_____	e) Alcohol	☐	☐	☐	_____
c) Herbal remedies	☐	☐	☐	_____	f) Other	☐	☐	☐	_____

7 **Currently, does any caregiver use any of the following?**

	Unknown	No	Yes	Daily consumption		Unknown	No	Yes	Daily consumption
a) Over the counter medications	☐	☐	☐	_____	d) Cigarettes	☐	☐	☐	_____
b) Prescription medications	☐	☐	☐	_____	e) Alcohol	☐	☐	☐	_____
c) Herbal remedies	☐	☐	☐	_____	f) Other	☐	☐	☐	_____

INCIDENT SCENE INVESTIGATION

1 **Where did the incident or death occur?** _____

2 **Was this the primary residence?** ☐ Yes ☐ No

3 **Is the site of the incident or death scene a daycare or other childcare setting?**

☐ Yes ☐ No ⇨Skip to question **8** below

4 **How many children were under the care of the provider at the time of the incident or death?** _____ *(under 18 years or older)*

5 **How many adults were supervising the child(ren)?** _____ *(18 years or older)*

6 **What is the license number and licensing agency for the daycare?**

License number: _____ Agency: _____

7 **How long has the daycare been open for business?** _____

8 **How many people live at the site of the incident or death scene?**

_____ Number of adults (18 years or older) _____ Number of children (under 18 years old)

9 **Which of the following heating or cooling sources were being used? (Check all that apply.)**

☐ Central air	☐ Gas furnace or boiler	☐ Wood burning fireplace	☐ Open window(s)
☐ A/C window unit	☐ Electric furnace or boiler	☐ Coal burning furnace	☐ Wood burning stove
☐ Ceiling fan	☐ Electric space heater	☐ Kerosene space heater	
☐ Floor/table fan	☐ Electric baseboard heat	☐ Other ⇨Specify	_____
☐ Window fan	☐ Electric *(radiant)* ceiling heat	☐ Unknown	

10 **Indicate the temperature of the room where the infant was found unresponsive:**

_____ Thermostat setting _____ Thermostat reading _____ Actual room temp. _____ Outside temp.

11 **What was the source of drinking water at the site of the incident or death scene?** *(Check all that apply.)*

☐ Public/municipal water source	☐ Bottled water	☐ Other ⇨Specify _____
☐ Well	☐ Unknown	

12 **The site of the incident or death scene has: (check all that apply)**

☐ Insects	☐ Mold growth	☐ Odors or fumes ⇨Describe:
☐ Smoky smell (like cigarettes)	☐ Pets	☐ Presence of alcohol containers
☐ Dampness	☐ Peeling paint	☐ Presence of drug paraphenalia
☐ Visible standing water	☐ Rodents or vermin	☐ Other ⇨Specify _____

13 **Describe the general appearance of incident scene:** *(ex. cleanliness, hazards, overcrowding, etc.)*

_____

_____

INVESTIGATION SUMMARY

1 **Are there any factors, circumstances, or environmental concerns about the incident scene investigation that may have impacted the infant that have not yet been identified?**

2 **Arrival times:** **Law enforcement at scene:** ____ : ____ Military Time **DSI at scene:** ____ : ____ Military Time **Infant at hospital:** ____ : ____ Military Time

Investigator's Notes

Indicate the task(s) performed.

- ☐ Additional scene(s)? (forms attached)
- ☐ Doll reenactment/scene re-creation
- ☐ Photos or video taken and noted
- ☐ Materials collected/evidence logged
- ☐ Referral for counseling
- ☐ EMS run sheet/report
- ☐ Notify next of kin or verify notification
- ☐ 911 tape

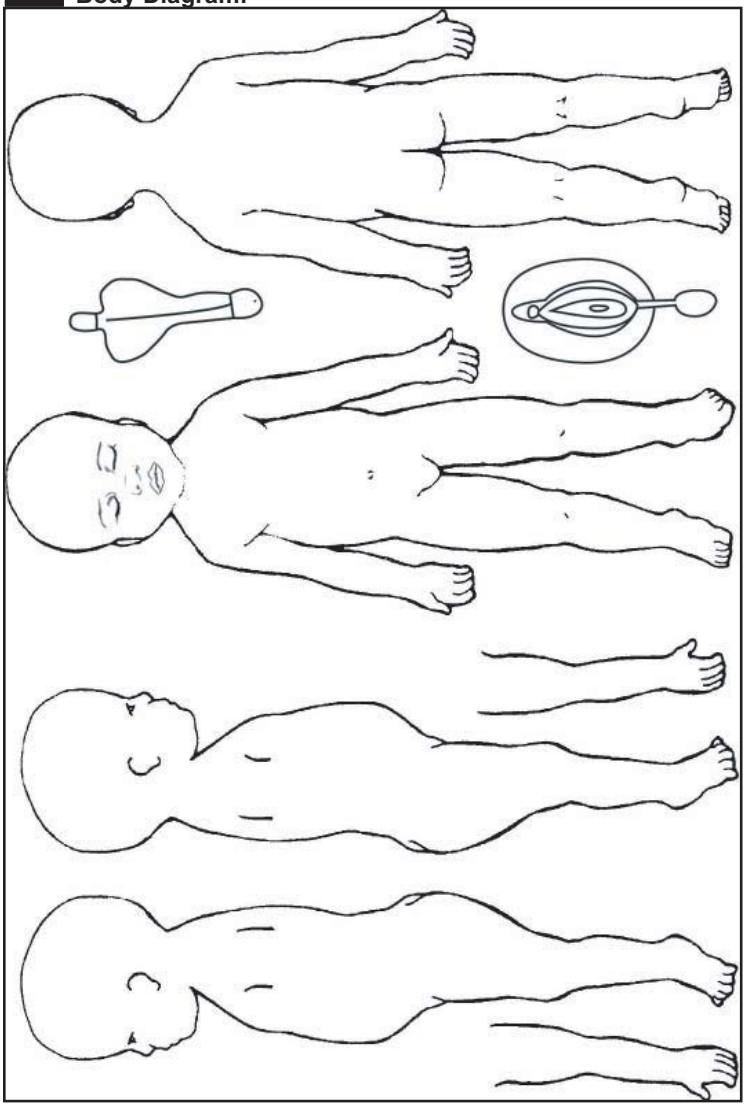
If more than one person was interviewed, does the information differ?

☐ No ☐ Yes ⇨ Detail any differences, inconsistencies of relevant information: (ex. placed on sofa, last known alive on chair.)

INVESTIGATION DIAGRAMS

1 **Scene Diagram:**

2 **Body Diagram:**



SUMMARY FOR PATHOLOGIST

Case Information

Investigator Information: Name _____ Agency _____ Phone _____

Investigated: _____/ _____ / _____ _____ : _____ Pronounced Dead: _____/ ____ / _____ _____ : _____
Month Day Year Military Time Month Day Year Military Time

Infant's Information: Last _____ First _____ M. _____ Case # _____

Sex: ☐ Male ☐ Female Date of Birth _____ / _____ / _____ Age _____
Month Day Year Months

Race: ☐ White ☐ Black/African Am. ☐ Asian/Pacific Islander ☐ Am. Indian/Alaskan Native ☐ Hispanic/Latino ☐ Other

Sleeping Environment

1 **Indicate whether preliminary investigation suggests any of the following:**

Yes	No	
☐	☐	Asphyxia *(ex. overlying, wedging, choking, nose/mouth obstruction, re-breathing, neck compression, immersion in water)*
☐	☐	Sharing of sleeping surface with adults, children, or pets
☐	☐	Change in sleeping condition *(ex. unaccustomed stomach sleep position, location, or sleep surface)*
☐	☐	Hyperthermia/Hypothermia *(ex. excessive wrapping, blankets, clothing, or hot or cold environments)*
☐	☐	Environmental hazards *(ex. carbon monoxide, noxious gases, chemicals, drugs, devices)*
☐	☐	Unsafe sleeping conditions *(ex. couch/sofa, waterbed, stuffed toys, pillows, soft bedding)*

Infant History

☐	☐	Diet *(ex. solids introduction etc.)*
☐	☐	Recent hospitalization
☐	☐	Previous medical diagnosis
☐	☐	History of acute life-threatening events *(ex. apnea, seizures, diffi culty breathing)*
☐	☐	History of medical care without diagnosis
☐	☐	Recent fall or other injury
☐	☐	History of religious, cultural, or ethnic remedies
☐	☐	Cause of death due to natural causes other than SIDS *(ex. birth defects, complications of preterm birth)*

Family Info

☐	☐	Prior sibling deaths
☐	☐	Previous encounters with police or social service agencies
☐	☐	Request for tissue or organ donation
☐	☐	Objection to autopsy

Exam

☐	☐	Pre-terminal resuscitative treatment
☐	☐	Death due to trauma (injury), poisoning, or intoxication

Investigator Insight

☐	☐	Suspicious circumstances
☐	☐	Other alerts for pathologist's attention

Any "Yes" answers should be explained and detailed.

Brief description of circumstances: _____

Pathologist

2 **Pathologist Information:**

Name _____ Agency _____

Phone (_____) _____ - _____ Fax (_____) _____ - _____