

INVESTIGATION DATA

Infant's Information:

Last _____ First _____ M.I. _____ Case # _____

Sex: Male Female Date of Birth ____/____/____ Age _____ SSN _____

Race: White Black/African American Asian/Pacific Islander American Indian/Alaskan Native Hispanic/Latino Other

Infant's Primary Residence:

Address _____ City _____ State _____ Zip _____

Incident Address:

Address _____ City _____ State _____ 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.I. _____ SSN _____

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 ⇨ Specify _____

2. Tell me what happened:

3. Did you notice anything unusual or different about the infant in the last 24 hours? No Yes ⇨ Specify _____

4. Are any other household members recently or currently ill or injured? No Yes ⇨ Specify _____

	Date	Military Time	Location (room)
5. When was the infant LAST PLACED?	____/____/____	____:____	_____
6. When was the infant LAST KNOWN ALIVE?	____/____/____	____:____	_____
7. When was the infant FOUND?	____/____/____	____:____	_____

8. 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 _____ | | | |

9. If the child was not placed in a crib, was one available? Yes No ⇨ Specify _____

10. In what position was the infant LAST PLACED? Sitting On back On side On stomach Unknown

11. In what position was the infant LAST KNOWN ALIVE? Sitting On back On side On stomach Unknown

12. In what position was the infant FOUND? Sitting On back On side On stomach Unknown

13. What was the infant's usual sleeping position? _____

14. FACE position when LAST PLACED? Face down Face up Face right Face left

15. NECK position when LAST PLACED? Head back Chin to chest Neutral Turned

16. FACE position when LAST KNOWN ALIVE? Face down Face up Face right Face left

17. NECK position when LAST KNOWN ALIVE? Head back Chin to chest Neutral Turned

18. FACE position when FOUND? Face down Face up Face right Face left

19. NECK position when FOUND? Head back Chin to chest Neutral Turned

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

21. Was the infant tightly wrapped or swaddled? Yes No ⇨ Specify _____

22. 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	<input type="checkbox"/>	_____	Receiving blankets	<input type="checkbox"/>	_____
Infant/child blankets	<input type="checkbox"/>	_____	Infant/child blankets	<input type="checkbox"/>	_____
Infant/child comforters	<input type="checkbox"/>	_____	Infant/child comforters	<input type="checkbox"/>	_____
Adult comforters/duvets	<input type="checkbox"/>	_____	Adult comforters/duvets	<input type="checkbox"/>	_____
Adult blankets	<input type="checkbox"/>	_____	Adult blankets	<input type="checkbox"/>	_____
Sheets	<input type="checkbox"/>	_____	Sheets	<input type="checkbox"/>	_____
Sheepskin	<input type="checkbox"/>	_____	Sheepskin	<input type="checkbox"/>	_____
Pillows	<input type="checkbox"/>	_____	Pillows	<input type="checkbox"/>	_____
Rubber or plastic sheet	<input type="checkbox"/>	_____	Rubber or plastic sheet	<input type="checkbox"/>	_____
Other	_____				

23. 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 were near the infant's face, nose or mouth?
 Bumper pads Infant pillows Positional supports Stuffed animals Toys Other _____

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

27. Was anyone sleeping with the infant? No Yes ⇨ Complete table below.

Name	Age	Height	Weight	Location in relation to infant (LAST KNOWN ALIVE)	Location in relation to infant (FOUND)	Impaired (intoxicated, tired)
_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____

28. What led you to check on the infant? _____

29. Was there evidence of wedging? No Yes ⇨ Specify _____

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

31. Describe the infant's appearance when found

	Unknown	No	Yes	If yes, describe and specify location
Discoloration around face/nose/mouth	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Secretions (foam, froth)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Skin discoloration (livor mortis)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Pressure marks (pale areas, blanching)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Rash or petechiae (small red spots on skin/membranes/eyes)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Marks on body (scratches, bruises)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

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 _____

33. Did EMS try to resuscitate the infant? No Yes ⇨ Complete table below.

Name	Date	Military Time
_____	____/____/____	____:____
_____	____/____/____	____:____

34. Did anyone other than EMS try to resuscitate the infant? No Yes ⇨ Complete table below.

Name	Date	Military Time
_____	____/____/____	____:____
_____	____/____/____	____:____

35. Please describe what was done as part of resuscitation:

36. Has the parent/caregiver ever had a child die suddenly and unexpectedly? No Yes ⇨ Specify _____

INFANT MEDICAL HISTORY

1. Source of medical information: Doctor Other healthcare provider Medical Record Family
 Mother Father Other _____

2. At any time in the infant's life, did s/he have a history of:

	Unknown	No	Yes			Unknown	No	Yes	
			Within last 3 days	More than 3 days ago				Within last 3 days	More than 3 days ago
*Allergies (<i>food, medication, other</i>)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Excessive sweating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Constipation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lethargy or sleeping more than usual	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Difficulty breathing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fussiness or excessive crying	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Choking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cyanosis (<i>turned blue/gray</i>)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Fever	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
*Abnormal growth or weight gain/loss	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	*Metabolic disorders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
*Cardiac (heart) abnormalities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Vomiting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Seizures or convulsions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Decrease in appetite	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Apnea (<i>stopped breathing</i>)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	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 ⇨ Specify _____

4. In the 72 hours prior to death, was the infant given any vaccinations or medications? No Yes ⇨ Complete table below.
 (*Please include any home remedies, herbal medications, prescription medications, over the counter medications*)

Name of vaccination/medications	Dose last given	Date given	Approx. time	Reason given/comments
_____	_____	____/____/____	____:____	_____
_____	_____	____/____/____	____:____	_____
_____	_____	____/____/____	____:____	_____
_____	_____	____/____/____	____:____	_____

5. Did the infant have any birth defects? No Yes ⇨ Specify _____

INFANT MEDICAL HISTORY CON'T

6. 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, telephone calls and birth)
- | | Most recent visit | Second most recent visit |
|------------------|-------------------|--------------------------|
| Date | ____/____/____ | ____/____/____ |
| Reason for visit | _____ | _____ |
| Action taken | _____ | _____ |
| Physician's name | _____ | _____ |
| Hospital/clinic | _____ | _____ |
| Address | _____ | _____ |
| City, State, Zip | _____ | _____ |
| Phone number | _____ | _____ |
7. Birth hospital name _____
 Street Address _____
 City/State/Zip _____
 Date of discharge ____/____/____
8. What was the infant's length at birth? _____ inches _____ or _____ centimeters
9. What was the infant's weight at birth? _____ pounds _____ ounces _____ or _____ grams
10. Compared to the due date, was the infant born on time, early or late?
 On time Early – How many weeks early? _____ Late – How many weeks late? _____
11. Was the infant a singleton, twin, triplet or higher gestation?
 Singleton Twin Triplet Quadruplet or higher gestation
12. Were there any complications during delivery or birth? *(ex. emergency c-section, child needed oxygen)*
 No Yes ⇒ Specify _____
13. Is the infant able to: Roll over on it's own Lift its head Push or pull itself up

INFANT DIETARY HISTORY

1. On what day and at what approximate time was the infant last fed? ____/____/____ at ____:____
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 feeding)*
- | | Unknown | No | Yes | Quantity | Type and brand |
|---|--------------------------|--------------------------|--------------------------|----------|----------------|
| Breast milk <i>(one/both sides, length of time)</i> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____ | ounces _____ |
| Formula <i>(brand, water source – ex. Similac, tap water)</i> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____ | ounces _____ |
| Cow's milk | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____ | ounces _____ |
| Water <i>(brand, bottled/tap/well)</i> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____ | ounces _____ |
| Other liquids <i>(tea, juice)</i> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____ | ounces _____ |
| Solids | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____ | _____ |
| Other | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____ | _____ |

INFANT DIETARY HISTORY CON'T

5. Was the child ever breast fed? No Yes ⇨ When/how often _____
6. Was a new food introduced in the 24 hours prior to his/her death? No Yes ⇨ Specify (*content, amount, change in formula*)

7. Did death occur while Breast feeding Bottle feeding Eating solid foods Not while feeding
8. Was the infant last placed to sleep with a bottle? Yes No ⇨ Skip to Pregnancy History below
9. Was the bottle propped? (*ex. object used to hold bottle while infant feeding*)
 No Yes ⇨ What object was used to prop the bottle? _____
10. What was the quantity of liquid (*in ounces*) in the bottle? _____

PREGNANCY HISTORY

1. **Information about the infant's birth mother**
 First name _____ Middle name _____
 Last name _____ Maiden name _____
 Date of birth ____/____/____ SSN ____-____-____
 Street address _____
 City/State/Zip _____
 How long has the mother been a resident at this address? _____ years and _____ months
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?
 Physician/provider _____ Hospital/clinic _____
 Street address _____
 City/State/Zip/Phone _____
4. During pregnancy, did the birth mother have any complications? (*ex. high blood pressure, bleeding, gestational diabetes*)
 No Yes ⇨ Specify _____
5. Was the biological mother injured during pregnancy? (*ex. auto accident, fall*)
 No Yes ⇨ Specify _____
6. During pregnancy, did the birth mother use any of the following?

	Unknown	No	Yes	Daily use		Unknown	No	Yes	Daily use
OTC medications	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	Cigarettes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Prescription medications	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	Alcohol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Herbal remedies	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
7. Currently, does **ANY** caregiver use any of the following?

	Unknown	No	Yes	Daily use		Unknown	No	Yes	Daily use
OTC medications	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	Cigarettes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Prescription medications	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	Alcohol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Herbal remedies	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

INCIDENT SCENE INVESTIGATION

1. Where did the incident or death occur? _____
2. Was this the infant's 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*)
5. How many adults were supervising the child/children?
_____ (*18 years or older*) _____ (*under 18 years*)
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?
_____ (*18 years or older*) _____ (*under 18 years*)
9. Who was present at the time of the incident or death?

Name	Age	Relationship with infant
_____	_____	_____
_____	_____	_____
_____	_____	_____
10. Which of the following heating or cooling sources were being used? (*check all that apply*)

<input type="checkbox"/> Central air	<input type="checkbox"/> Gas furnace or boiler	<input type="checkbox"/> Wood burning fireplace	<input type="checkbox"/> Open window (s)
<input type="checkbox"/> A/C window unit	<input type="checkbox"/> Electric furnace or boiler	<input type="checkbox"/> Coal burning fireplace	<input type="checkbox"/> Wood burning stove
<input type="checkbox"/> Ceiling fan	<input type="checkbox"/> Electric space heater	<input type="checkbox"/> Kerosene space heater	
<input type="checkbox"/> Floor/table fan	<input type="checkbox"/> Electric baseboard heat	<input type="checkbox"/> Unknown	
<input type="checkbox"/> Window fan	<input type="checkbox"/> Electric (radiant) ceiling heat	<input type="checkbox"/> Other _____	
11. Indicate the temperature of the room where the infant was found unresponsive
_____ Thermostat setting _____ Thermostat reading _____ Actual room temperature _____ Outside temperature
12. What was the source of drinking water at the site of the incident or death scene? (*check all that apply*)

<input type="checkbox"/> Public/municipal water source	<input type="checkbox"/> Bottled water	
<input type="checkbox"/> Well	<input type="checkbox"/> Unknown	<input type="checkbox"/> Other _____
13. The site of the incident or death scene has (*check all that apply*)

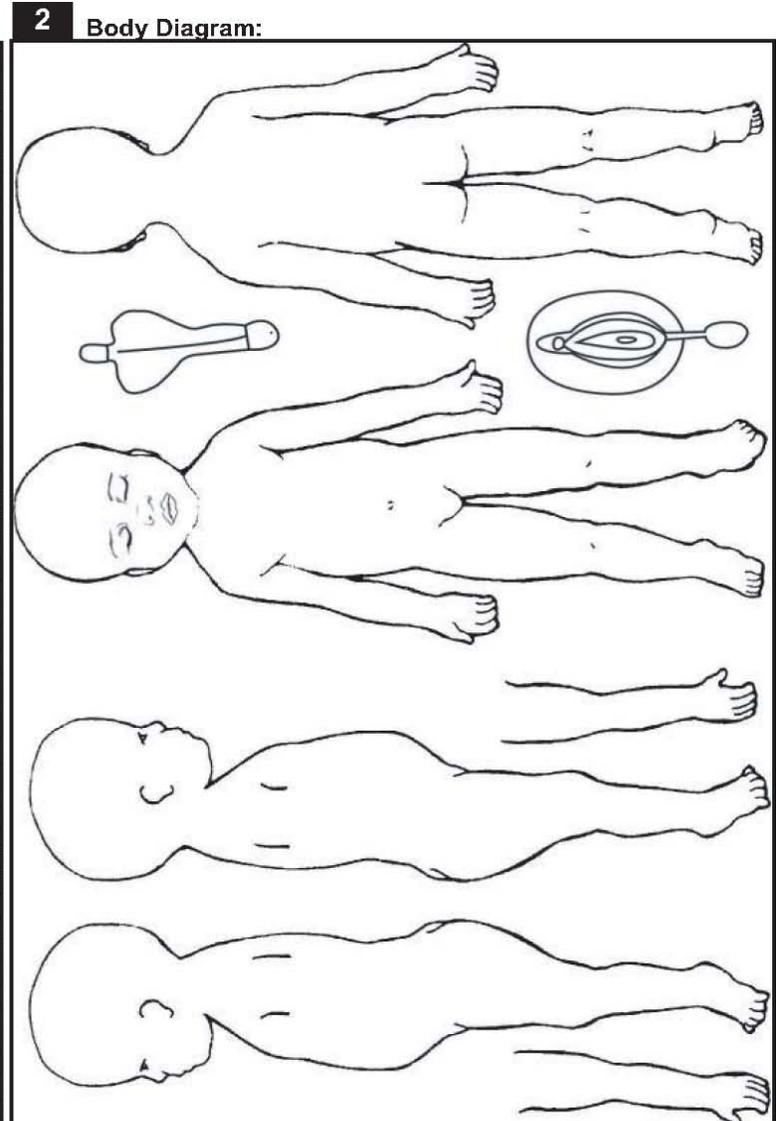
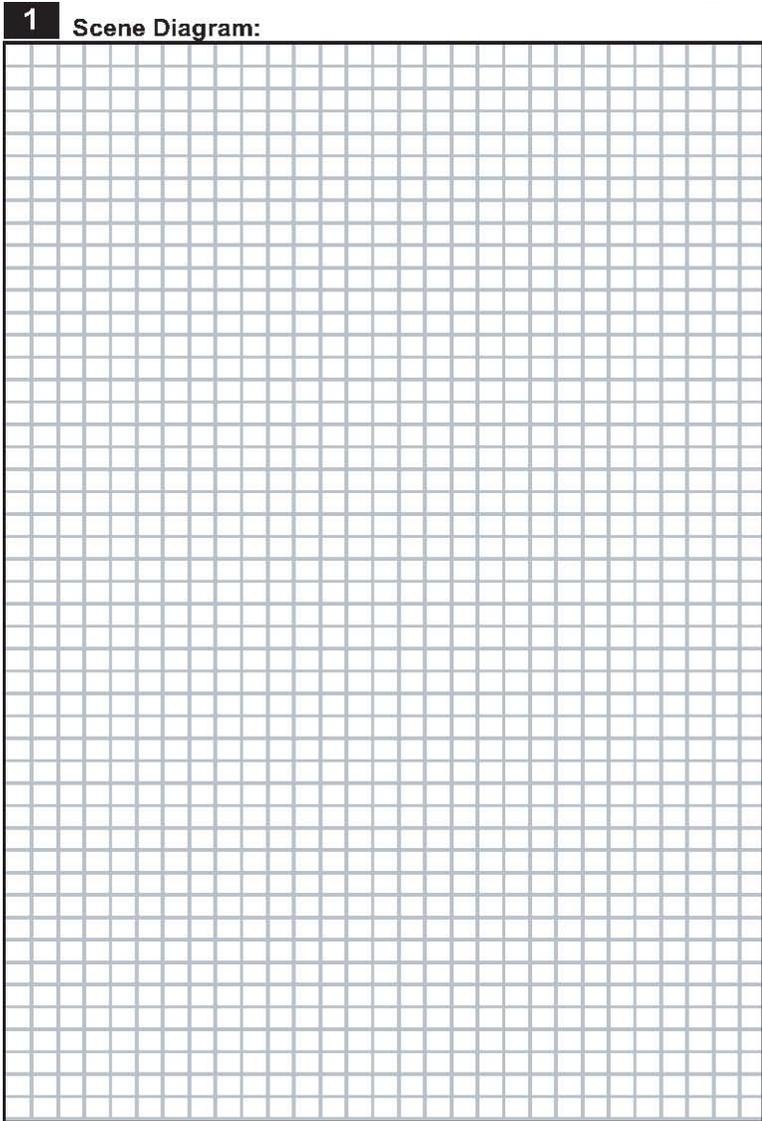
<input type="checkbox"/> Insects/rodents/vermin	<input type="checkbox"/> Mold growth	<input type="checkbox"/> Presence of alcohol containers
<input type="checkbox"/> Smoky smell	<input type="checkbox"/> Pets	<input type="checkbox"/> Presence of drug paraphernalia
<input type="checkbox"/> Dampness	<input type="checkbox"/> Peeling paint	<input type="checkbox"/> Presence of prescription medications
<input type="checkbox"/> Visible standing water	<input type="checkbox"/> Odors or fumes	<input type="checkbox"/> Other _____
14. Describe the general appearance of the incident or death scene (*ex. cleanliness, hazards, overcrowding*)

15. Does law enforcement have any prior records on the family, caregiver or deceased? No Yes ⇨ Specify

16. Does Social Services or CPS have any prior records on the family, caregiver or deceased? No Yes ⇨ Specify

17. 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? No Yes ⇨ Specify

18. Law enforcement at scene ____/____/____ at ____:____ Investigator at scene ____/____/____ at ____:____
Infant at hospital ____/____/____ at ____:____ Investigator at hospital ____/____/____ at ____:____
19. If more than one person was interviewed, does the information differ? No Yes ⇨ Specify



Investigator Information:

Name _____ Agency _____ Phone _____
 Investigated ____/____/____ at ____:____ Pronounced ____/____/____ at ____:____

Infant Information:

Last _____ First _____ M.I. _____ Case # _____
 Sex: Male Female Date of Birth ____/____/____ Age _____ SSN _____
 Race: White Black/African American Asian/Pacific Islander American Indian/Alaskan Native Hispanic/Latino Other

Indicate whether preliminary investigation suggests any of the following: (if yes, specify below)

- | Yes | No | |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | Asphyxia (<i>ex. overlying, wedging, choking, nose/mouth obstruction, re-breathing, neck compression, immersion in water</i>) |
| <input type="checkbox"/> | <input type="checkbox"/> | Unsafe sleeping conditions (<i>ex. couch/sofa, waterbed, stuffed toys, pillows, soft bedding or co-sleeping</i>) |
| <input type="checkbox"/> | <input type="checkbox"/> | Change in sleeping condition (<i>ex. unaccustomed stomach sleep position, location or sleep surface</i>) |
| <input type="checkbox"/> | <input type="checkbox"/> | Hyperthermia/Hypothermia (<i>ex. excessive wrapping, blankets, clothing or hot or cold environments</i>) |
| <input type="checkbox"/> | <input type="checkbox"/> | Environmental hazards (<i>ex. carbon monoxide, noxious gases, chemicals, drugs, devices</i>) |
| <input type="checkbox"/> | <input type="checkbox"/> | Diet (<i>ex. new food/liquid, change in formula</i>) |
| <input type="checkbox"/> | <input type="checkbox"/> | Recent hospitalization |
| <input type="checkbox"/> | <input type="checkbox"/> | Previous medical diagnosis |
| <input type="checkbox"/> | <input type="checkbox"/> | History of acute life-threatening events (<i>ex. apnea, seizures, difficulty breathing</i>) |
| <input type="checkbox"/> | <input type="checkbox"/> | History of medical care without diagnosis |
| <input type="checkbox"/> | <input type="checkbox"/> | Recent fall or injury |
| <input type="checkbox"/> | <input type="checkbox"/> | History of religious, cultural or ethnic remedies |
| <input type="checkbox"/> | <input type="checkbox"/> | Cause of death due to natural causes other than SIDS (<i>ex. birth defects, complications of preterm birth</i>) |
| <input type="checkbox"/> | <input type="checkbox"/> | Prior sibling death |
| <input type="checkbox"/> | <input type="checkbox"/> | Previous encounters with police or social service agencies |
| <input type="checkbox"/> | <input type="checkbox"/> | Request for tissue or organ donation |
| <input type="checkbox"/> | <input type="checkbox"/> | Objection to autopsy |
| <input type="checkbox"/> | <input type="checkbox"/> | Pre-terminal resuscitative treatment |
| <input type="checkbox"/> | <input type="checkbox"/> | Death due to trauma (<i>injury</i>), poisoning or intoxication |
| <input type="checkbox"/> | <input type="checkbox"/> | Suspicious circumstances |
| <input type="checkbox"/> | <input type="checkbox"/> | Other alerts for pathologist's attention |

