



INVESTIGATION DATA

Infant's Last Name	Infant's First Name	Middle Name	Case Number
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Sex: Date of Birth: Age: SS#:

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

Infant's Primary Residence:

Address: City: County: State: Zip:

Incident Address: City: County: State: Zip:

Contact Information for Witness:

Relationship to deceased: Birth Mother Birth Father Grandmother Grandfather

Adoptive or Foster Parent Physician Health Records Other Describe:

Last: First: M.: SS#:

Address: City: State: Zip:

Work Address: City: State: Zip:

Home Phone: Work Phone: Date of Birth:

WITNESS INTERVIEW

1 Are you the usual caregiver?

No Yes

2 Tell me what happened:

3 Did you notice anything unusual or different about the infant in the last 24 hrs?

No Yes Specify:

4 Did the infant experience any falls or injury within the last 72 hrs?

No Yes Specify:

5 When was the infant LAST PLACED?

Date: Military Time: : Location (room):

6 When was the infant LAST KNOWN ALIVE(LKA)?

Date: Military Time: : Location (room):

7 When was the infant FOUND?

Date: 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 (write P, L, or F in front of appropriate response)?

<input type="checkbox"/> Bassinet	<input type="checkbox"/> Bedside co-sleeper	<input type="checkbox"/> Car seat	<input type="checkbox"/> Chair
<input type="checkbox"/> Cradle	<input type="checkbox"/> Crib	<input type="checkbox"/> Floor	<input type="checkbox"/> In a person's arms
<input type="checkbox"/> Mattress/box spring	<input type="checkbox"/> Mattress on floor	<input type="checkbox"/> Playpen	<input type="checkbox"/> Portable crib
<input type="checkbox"/> Sofa/couch	<input type="checkbox"/> Stroller/carriage	<input type="checkbox"/> Swing	<input type="checkbox"/> Waterbed
<input type="checkbox"/> Other - describe: <input type="text"/>			

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 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 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 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			Other, specify:		
Rubber or plastic sheet					
Other, specify:					

22 Which of the following devices were operating in the infant's room?
 None Apnea monitor Humidifier Vaporizer Air purifier Other -

23 In was the temperature in the infant's room? Hot Cold Normal Other -

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

25 Which of the following items were within the infant's reach?
 Blankets Toys Pillows Pacifier Nothing Other -

26 Was anyone sleeping with the infant? No Yes

Name of individual sleeping with infant	Age	Height	Weight	Location in relation to infant	Imparement (intoxication, tired)

27 Was there evidence of wedging? No Yes - Describe:

28 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.)

29 What had led you to check on the infant?

30 Describe the infant's appearance when found.

Appearance	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				

31 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:

32 Did anyone else other than EMS try to resuscitate the infant? No Yes

Who? Date: Military time: :

33 Please describe what was done as part of resuscitation:

34 Has the parent/caregiver ever had a child die suddenly and unexpectedly? No Yes

Explain:

INFANT MEDICAL HISTORY

1 Source of medical information: Doctor Other healthcare provider Medical record Family

Mother/primary caregiver Other:

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

Condition	Unknown	No	Yes	Condition	Unknown	No	Yes
a) Fever				k) Apnea (stopped breathing)			
h) Diarrhea				e) Decrease in appetite			
b) Excessive sweating				l) Cyanosis (turned blue/gray)			
i) Stool changes				f) Vomiting			
c) Lethargy or sleeping more than usual				m) Seizures or convulsions			
j) Difficulty breathing				g) Choking			
d) Fussiness or excessive crying				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 infant's death, was the infant given any vaccinations or medications? No Yes

(Please include any home remedies, herbal medications, prescription medicines, over-the-counter medications.)

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

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

Medical history	Unknown	No	Yes	Describe
a) Allergies (<i>food, medication, or other</i>)				
b) Abnormal growth or weight gain/loss				
c) Apnea (<i>stopped breathing</i>)				
d) Cyanosis (<i>turned blue/gray</i>)				
e) Seizures or convulsions				
f) Cardiac (<i>heart</i>) abnormalities				

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		
b) Reason for visit		
c) Action taken		
d) Physician's name		
e) Hospital/clinic		
f) Address		
g) City		
h) State, ZIP		
i) Phone number		

8 Birth hospital name: Discharge date:

Street address:

City: State: Zip:

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? Late - how many weeks?

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

Singleton Twin Triplet Quadrupelet or higher gestation

13 Were there any complications during delivery or at birth? (*emergency c-section, child needed oxygen*) Yes No

Describe:

14 Are there any alerts to the pathologist? (*previous infant deaths in family, newborn screen results*) Yes No

Specify:

INFANT DIETARY HISTORY

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

Date: 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)?

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

5 Was a new food introduced in the 24 hours prior to his/her death? No Yes

If yes, describe (ex. content, amount, change in formula, introduction of solids)

6 Was the infant last placed to sleep with a bottle? Yes No - if no, skip to question **9** below

7 Was the bottle propped? (i.e., object used to hold bottle while infant feeds) No Yes

If yes, what object was used to prop the bottle?

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

9 Did the 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

If yes, - describe:

PREGNANCY HISTORY

1 Information about the infant's birth mother:

First name: Last name:
 Middle name: Maiden name:
 Birth date: SS#:

Street address: City: State: Zip:

How long has the birth mother been at this address? Years: Months:

Previous Address:

2 At how many weeks or months did the birth mother begin prenatal care? No parental care Unknown

Weeks: Months:

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 address: City: State: Zip:

PREGNANCY HISTORY (cont.)

4 At how many weeks or months did the birth mother begin prenatal care? No Yes
(ex. high blood pressure, bleeding, gestational diabetes)
 Specify:

5 Was the birth 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		Unknown	No	Yes	Daily
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		Unknown	No	Yes	Daily
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? No Yes

3 Is the site of the incident or death scene a daycare or other childcare setting? Yes No - If no, skip to question **8**

4 How many children (under age 18) were under the care of the provider at the time of the incident or death?

5 How many adults (age 18 and over) were supervising the child(ren)?

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)*

<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 furnace	<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"/> Electric (radiant) ceiling heat	<input type="checkbox"/> Window fan	<input type="checkbox"/> Unknown

Other - specify:

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 Bottled water Well Unknown Other - Specify:

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

<input type="checkbox"/> Insects	<input type="checkbox"/> Mold growth	<input type="checkbox"/> Smoky smell <i>(like cigarettes)</i>
<input type="checkbox"/> Pets	<input type="checkbox"/> Dampness	<input type="checkbox"/> Presence of alcohol containers
<input type="checkbox"/> Peeling paint	<input type="checkbox"/> Visible standing water	<input type="checkbox"/> Presence of drug paraphenalia
<input type="checkbox"/> Rodents or vermin	<input type="checkbox"/> Odors or fumes - Describe: <input style="width: 200px;" type="text"/>	

Other - specify:

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

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

	Military time
Law enforcement at scene:	: :
DSI at scene:	: :
Infant at hospital:	: :

Investigator's Notes

1 Indicate the task(s) performed

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

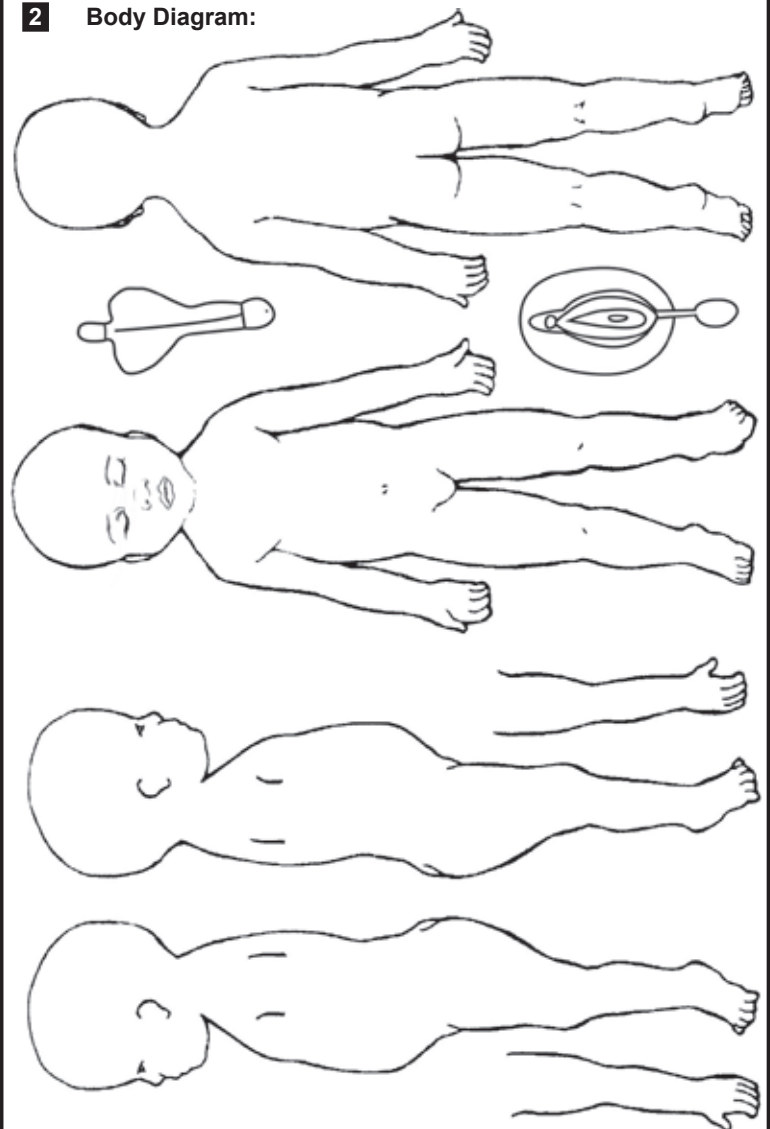
2 If more than one person was interviewed, does the information differ? No Yes

If 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

1 Investigator information Name: Agency: Phone:

	Date	Military time
Investigated:	:	:
Pronounced dead:	:	:

2 Infant's information: Last: First: M: Case #:

Sex: Male Female Date of Birth: Age:

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	
<input type="checkbox"/>	<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"/>	<input type="checkbox"/>	Sharing of sleep surface with adults, children, or pets
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Change in sleep condition (<i>ex. unaccustomed stomach sleep position, location, or sleep surface</i>)
<input type="checkbox"/>	<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"/>	<input type="checkbox"/>	Environmental hazards (<i>ex. carbon monoxide, noxious gases, chemicals, drugs, devices</i>)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Unsafe sleep condition (<i>ex. couch/sofa, waterbed, stuffed toys, pillows, soft bedding</i>)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Diet (<i>e.g., solids introduced, etc.</i>)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Recent hospitalization
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Previous medical diagnosis
<input type="checkbox"/>	<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"/>	<input type="checkbox"/>	History of medical care without diagnosis
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Recent fall or other injury
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	History of religious, cultural, or ethnic remedies
<input type="checkbox"/>	<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"/>	<input type="checkbox"/>	Prior sibling deaths
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Previous encounters with police or social service agencies
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Request for tissue or organ donation
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Objection to autopsy
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Pre-terminal resuscitative treatment
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Death due to trauma (injury), poisoning, or intoxication
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Suspicious circumstances
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other alerts for pathologist's attention

Infant History

Family Info

Exam

Investigator Insight

Any "Yes" answers above should be explained in detail (description of circumstances):

Pathologist

2 Pathologist information Name:

Agency: Phone: Fax: