Alabama Local Child Death Review Team Guidelines

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ACDRS Introduction and Background

The Alabama Child Death Review Law (*Appendix A*) was signed in 1997 and the Alabama Child Death Review System (ACDRS) has been coordinating the review of unexplained and unexpected child deaths in Alabama ever since. The mission of ACDRS is ***to understand how and why children die in Alabama in order to prevent future child deaths***. ACDRS operates under the principle that the death of a child is a community problem. The circumstances involved in most child deaths are too multidimensional for responsibility to rest in any one place.

The word *system* is used in the title because ACDRS is composed of three separate operational units. The State CDR Office is located within the Alabama Department of Public Health (ADPH) and coordinates all ACDRS operations. The State Child Death Review Team (SCDRT) is a 28-member multidisciplinary team of professionals which meets quarterly and serves as the policy arm of ACDRS. Finally, the various Local Child Death Review Teams (LCDRTs), with at least one in every Judicial Circuit throughout the state, are multidisciplinary teams of professionals who meet at least annually to review individual cases.

The CDR process has been called a "social autopsy" because it is based on the belief that environmental, social, economic, educational, health, and behavioral factors all impact the risk, manner, cause, and investigation of deaths. In Alabama, the in-depth multidisciplinary review of all unexplained and/or unexpected child deaths is conducted at the local level by the LCDRTs. The data are then collected and analyzed by the State CDR Office for presentation to the SCDRT and widespread publication and dissemination. If not for the local review process and the information that it provides, none of the other components of ACDRS could operate or hope to accomplish their mission. The work of the LCDRTs is absolutely essential to the operation and success of ACDRS.

Forming a LCDRT

Pursuant to the Alabama Child Death Review Law (*Appendix A*), there shall be at least one multidisciplinary, multi-agency LCDRT in each Judicial Circuit. The respective District Attorneys (DAs) shall be responsible for:

- The organization and meeting of the Team(s) in his/her jurisdiction
- Appointing at least one LCDRT Coordinator to oversee these activities
- Appointing different Coordinators in multi-county Circuits for each individual county with the exception of Jefferson County, all the counties in one Circuit are still considered part of one LCDRT, but county-specific "sub-teams" may meet and review cases independent of one another.

The Coordinator is responsible for identifying and contacting the appropriate members for each Team. A newly-appointed Coordinator inheriting an existing, active LCDRT will usually find that the members have already been identified and have been meeting. A listing of these members should already be on file and will help the new Coordinator tremendously in organizing his/her first LCDRT meeting. If the LCDRT Coordinator, new or otherwise, encounters any barriers to identifying the appropriate members and forming the LCDRT, he/she should contact the State CDR Office for assistance.

The LCDRT may include, but is not limited to, the following members:

- DA and/or designee
- Local Coroner and/or Deputy Coroner(s)
- Medical Examiner and/or Department of Forensic Sciences representative
- Law Enforcement (local, county, and/or state)
- Fire Department and/or EMS representative
- Local Healthcare Provider(s)
- Department of Public Health representative
- Department of Human Resources representative
- Department of Mental Health representative
- Local Child Advocacy Center representative
- Probate or Family Court representative
- Educators

A summary of the roles of the respective Team members can be found on the Role and Confidentiality Agreements all members must sign (*Appendix B, Role and Confidentiality Agreements*). The Coordinator may enlist other members of the community who may be able to contribute to the review process, even if it will be for a single case under review. The knowledge and abilities of individual members should be utilized to enhance team effectiveness. Most of the organizations represented on the LCDRT have corresponding representation on the SCDRT.

Receiving Cases

The issuance of an Alabama Death Certificate in which the deceased has not reached his/her eighteenth birthday triggers an ACDRS case review.

The State CDR Office receives copies of all Death Certificates, and corresponding Birth Abstract if available for infant deaths. State CDR Office staff members conduct a cursory review of all child deaths in Alabama and identify those cases which qualify for an in-depth local review.

NO REVIEW cases
Medical deaths (premature birth, birth defects, cancer, and other medical conditions)

REVIEW cases
All unexplained or unexpected non-medical deaths (vehicle, fire, drown, poison, etc)

In cases where the death was caused by a single identifiable event (e.g., a motor vehicle crash), the case is assigned to the Circuit where that event occurred. Other cases are assigned to the Circuit where the deceased lived and/or died.

The LCDRT Coordinator periodically receives copies of Death Certificates (and corresponding Birth Abstract if available for infant deaths) for the cases assigned to his/her Team. These Death Certificates and Birth Abstracts are **confidential** and must be treated accordingly (*Section 8, Record Storage and Destruction*).

The cases for review are sent from the State CDR Office with a cover letter identifying the year(s) of the cases enclosed. The State CDR Office will not send cases for review until they have been entered in the online data collection system (*Section 7, Submitting Data*). Some LCDRTs receive assigned cases several times per year while other LCDRTs may only receive cases once or twice in a given year (*Appendix C, Average LCDRT Caseload*).

Upon receiving these documents, the Coordinator should:

- Review and ensure that the cases have been assigned to the correct LCDRT based upon the details of each case.
- Determine whether any medical record information needs to be requested beyond what the LCDRT members will be able to bring to or provide for the meeting. If so, such information should be requested in writing well in advance of the meeting date (*Appendix D, Sample Request for Medical Record Information*).

Organizing Meetings

The LCDRT meetings are closed to the public and not subject to the Alabama Open Meetings Act. Every LCDRT must meet at least once per calendar year, but Teams in more populous Circuits may need to meet more often.

The caseload in a particular Circuit will determine how often a LCDRT should meet (*Appendix C, Average LCDRT Caseload*). Once a Coordinator determines that his/her Team has enough outstanding cases to call for a meeting, a meeting date, time, and location will be chosen.

1. The Coordinator should notify all LCDRT members of meeting specifics and cases to be reviewed.
2. Copies of Death Certificates should not be sent to Team members, but it is important to provide them with enough identifying information to search their records for information to provide during the review process.
3. A sample notification form has been provided (*Appendix E, Sample LCDRT Meeting and Case Notification*). These forms should be individually numbered for distribution, then collected and shredded when the review is completed.
4. Keep in mind that all identifying information is confidential. Notification may be mailed or faxed, but unencrypted e-mail is not considered secure for transmission of such information.
5. Some Coordinators provide a blank copy of the Case Report form (*Appendix F*) to each Team member.
6. The State CDR Office should also be notified of the meeting date, time, and location as soon as possible, because staff members try to visit LCDRTs throughout the state.
7. At least one week prior to the meeting, the Coordinator should call Team members to verify attendance.
8. For members unable to attend, discuss the possibility of sending a substitute or copies of any records the Team might need.
9. The Coordinator should also prepare any materials needed for the meeting, such as Case Report forms, Role and Confidentiality Agreements, etc. All documents related to CDR are **confidential** and must be treated accordingly (*Section 8, Record Storage and Destruction*).
10. If the meeting will be facilitated by someone other than the Coordinator (the DA, a Chairperson, etc.), he/she should meet with that person to discuss the cases and materials. In most cases, the Coordinator also serves as the meeting facilitator.

Reviewing Cases

The meeting facilitator (usually, but not always, the Coordinator) should:

- Begin the meeting by ensuring that everyone in attendance has signed a Role and Confidentiality Agreement (*Appendix B*). The signed agreements must remain on file with the Coordinator.
- Make introductions before starting the case reviews in case the Team has not met in some time or has new members.
- Distribute any materials for the meeting (Death Certificate copies, Case Report forms, etc.)
- Remind Team members of the purpose of ACDRS case reviews and the confidential nature of all discussions and materials is recommended before proceeding.

Each case should be reviewed individually.

- The order is not usually important, although, it may be necessary to review a certain case earlier in the meeting if a team member crucial for that case review will have to leave early.
- If you have multiple cases from the same incident (e.g., multiple victims of a single vehicle crash), then it is beneficial to review them consecutively.
- It is advisable to have the Team member with the most information about a case (e.g., the primary investigating officer) present his/her information first when discussing the case.

There are multiple ways to incorporate the Case Report (*Appendix F*) into the Team review process and each Coordinator will have to determine which approach works best for his/her Team.

- Some Teams have an open discussion of the case in general as the Coordinator answers questions in the Case Report (either on paper or directly online) as they are discussed.
- Some Teams use the Case Report to guide the discussion entirely, going through all of the pertinent questions in a stepwise manner.
- Some of these Teams project the Case Report on a screen for Team members to see and follow along as questions are answered online.
- The best approach observed and usually recommended, is to start the review with a brief general discussion of the case and then use the Case Report to guide the further discussion with its specific questions.

The review of each child death should conclude with a Team discussion of how similar deaths might be prevented.

- If a need is identified within the community, the LCDRT can focus its discussion on short- and long-term interventions relating to policy, programs, and practice that will help prevent future deaths.
- Individual organizations or Team members can assume responsibility for pursuing local prevention strategies.
- If the Team believes that a prevention strategy is beyond the scope of local action, they should submit a recommendation to the State CDR Office for state-level action.
- These recommendations are presented to the State CDR Team to guide and inform policy discussions related to prevention strategies and efforts.
- LCDRT actions and recommendations for preventing child death are the goal of the program and the reason for the reviews.

When the meeting ends, the Coordinator must:

- Collect all confidential documents related to the meeting for destruction (*Section 8, Record Storage and Destruction*).
- Ensure that the online Case Report is complete (unless the case is carried forward to a future meeting for completion) and accurate for each case (Section 7, *Submitting Data*).
- Notify the State level staff (if they did not attend the meeting) of how many cases were reviewed and plans for the next meeting.

Submitting Data

ACDRS uses an online data collection system provided and maintained by the National Center for Fatality Review and Prevention currently in use by more than half of the CDR programs in the U.S. It is password-protected and backed-up on secure off-site servers, and the staff members who maintain it at the national level do not have access to state-level confidential identifiers, only statistical review data.

- To access the online system, a User Name and Password is issued by the State CDR Office.
- The State CDR Office is the primary point of contact for any problems or issues that may arise while using the system.
- Once a Coordinator accesses the system, he/she will be able to see qualifying cases assigned to that LCDRT starting with 2008 cases. (Note: 2007 and prior cases were processed under an older, proprietary system which is no longer in use.)
- The Coordinator will not have access to cases assigned to other LCDRTs throughout the state. Only State CDR Staff can access all casesstatewide.

The online Case Report has the same format as the paper version (*Appendix F*). When using the Case Report and the online version, there are "skip patterns" built in and responses will eliminate questions which do not pertain to the case in question (e.g., infant-specific questions will disappear once an older age is entered).

If a Coordinator is completely new to the system, a training broadcast conducted by the State CDR Office is available on the CDR website or by going to

https://mediasite.mihealth.org/Mediasite/Channel/cnpi/browse/null/title-az/null/0/null

NOTE: A case should never be DELETED from the system!

- The cases are initially entered by the State CDR Office and may be modified, completed, edited, etc. at the local level, but a Coordinator should never delete an existing case.
- If the case needs to be changed to "NO REVIEW" status or assigned to a different LCDRT, the State CDR Office must be contacted to make the changes.
- After the completion of a local review and a Case Report for any case, that case should be marked "COMPLETE" in Sections **L** and **N** of the Case Report.
- Once the Case Report is complete, all documents related to the case should be destroyed (*Section 8, Record Storage and Destruction*). This includes the paper copy of the completed Case Report, if there is one.

Once the data is in the online system it is secure, so there is no need to retain a paper record and, in fact, our confidentiality requirements prohibit such.

Record Storage and Destruction

Confidentiality is a top priority for ACDRS because the review process involves confidential information and documents. All documents related to ACDRS cases must be securely stored under lock and key with limited access until the case is completed, and then the documents are destroyed by shredding. This would include all:

- Death Certificates and Birth Abstracts
- Completed Case Reports
- Request for Medical Information or Case Notification forms
- Medical or other records
- Any notes or records generated during the review process

Documents that do not contain any confidential or identifying case-specific information may be retained. This would include these guidelines;

- Blank or sample forms
- Correspondence with the State CDR Office (unless it contains case-specific identifying information)
- Lists or contact information for the LCDRT members.

After a meeting, all confidential documents must be collected before the Team members leave. Once the Case Report is completed, all records or notes should be destroyed by shredding.

The data, once entered in the online system, are secure and routinely backed-up, so there is no need to retain paper copies. Those data are available online for the Coordinator to access at any time in the future, should he/she need to make update or corrections.

Appendix A. Alabama CDR Law

Section 26-16-90

Legislative findings

The Legislature finds and declares that: Every child is entitled to live in safety and in health and to survive into adulthood; there are concerns about the adequacy of efforts in this state to identify deaths; and recognizing that no single agency or person is responsible, that multidisciplinary, multiagency child death review teams are methods of achieving the state policy.

Section 26-16-91

Definitions
The following words and phrases have the following meanings unless the context clearly indicates otherwise:

(1) AUTOPSY. An external and internal examination, medical history, and record review.

(2) CHILD. A person who has not yet reached his or her eighteenth birthday.

(3) CHILD DEATHS TO BE REVIEWED. Those deaths which are unexpected or unexplained.

(4) COMMUNITY. The people and area within the local team jurisdiction.

(5) COUNTY. The county in which a deceased child resided prior to his or her death.

(6) INVESTIGATION. In the context of child death, includes all of the following:

a. A postmortem examination which may be limited to an external examination or may include an autopsy.

b. An inquiry by law enforcement agencies having jurisdiction into the circumstances of the death, including a scene investigation and interview with the child's parents, guardians, or caretakers and the person who reported the child's death.

c. A review of information regarding the child from relevant agencies, professionals, and providers of medical care

.**(7)** LOCAL TEAM. A multidisciplinary, multiagency child death review team established for a county or judicial circuit pursuant to Section **26-16-96**.

(8) MEETING. In-person meetings and conferences as well as those through telephone and other live electronic means. Individual participation in meetings through electronic conferencing may be authorized through the state team chairperson or designee. Local teams may not meet by electronic means.

(9) PERSON ACTING IN A PROFESSIONAL CAPACITY. A health practitioner, law enforcement officer, employee of a local department of social services, undertaker, funeral home director or

employee of a funeral home, or firefighter, who is acting in the course of his or her professional duties.

(10) PROVIDER OF MEDICAL CARE. Any health practitioner who personally provides, or a facility through which is provided, any medical evaluation or treatment, including dental and mental health evaluation or treatment.

(11) STATE TEAM. The State Child Death Review Team

.**(12)** UNEXPECTED/UNEXPLAINED. In referring to a child's death, includes all deaths which, prior to investigation, appear possibly to have been caused by trauma, suspicious or obscure circumstances, child abuse or neglect, or other agents or Sudden Infant Death Syndrome.

Ala. Code § 26-16-91 (1975)

Section 26-16-92

State policy

It is the policy of this state that responding to unexpected/unexplained child deaths is a state and a community responsibility and must include an accurate and complete determination of the cause of death.

Section 26-16-93

State Child Death Review Team – Created

(a) There is hereby created the State Child Death Review Team, referred to in this article as the state team.

(b) The state team shall be situated within the Alabama Department of Public Health for administrative and budgetary purposes.

(c) The state team shall be a multidisciplinary, multiagency review team, composed of 28 members, the first 7 of whom are ex officio. The ex officio members may designate representatives from their particular departments or offices to represent them on the state team who may vote and exercise all other prerogatives of the appointment. The members of the state team shall include all of the following:

(1) The Jefferson County Coroner, Medical Examiner.

(2) The State Health Officer who shall serve as chair.
(3) One member appointed by the Alabama Sheriff's Association.

(4) The Director of the Alabama Department of Forensic Sciences.

(5) The Commissioner of the Alabama Department of Human Resources.

(6) The Commissioner of the Alabama Department of Mental Health.

(7) The Secretary of the Alabama State Law Enforcement Agency.

(8) A pediatrician with expertise in SIDS appointed by the Alabama Chapter, American Academy of Pediatrics.

(9) A health professional with expertise in child abuse and neglect appointed by the Alabama Department of Public Health.

(10) A family practice physician appointed by the Alabama Academy of Family Physicians.

(11) A pediatric pathologist appointed by the Alabama Department of Forensic Sciences.

(12) Eight private citizens appointed by the Governor.

(13) A member of the clergy appointed by the Governor.

(14) A representative of the Alabama Coroner's Association.

(15) A representative of the Alabama Network of Children's Advocacy Centers.

(16) A representative of the Alabama Sheriff's Association.

(17) A representative of the Alabama District Attorney's Association.

(18) A specialist in pediatric emergency medicine appointed by the Alabama Medical Association.

(19) A representative of the Alabama Association of Chiefs of Police.

(20) Chair of the Senate Health Committee or his or her designee and the Chair of the House Health Committee or his or her designee.

(d) Members who are not ex officio shall serve for a three-year term and shall not serve more than two consecutive terms. Terms for these members shall be staggered.

(e) Staffing for the state team shall be provided through the Alabama Department of Public Health using funds appropriated for this article.

(f) The initial meeting of the state team shall be held within 60 days of September 11, 1997. Meetings shall be held at least quarterly thereafter.

(g) Fifteen members shall constitute a quorum for conducting all activities of the state team which may require a vote among the members. A simple majority of members present constituting a quorum shall be required for any affirmative vote.

State Child Death Review Team - Purpose; duties

The purpose of the state team is to decrease the risk and incidence of unexpected/unexplained child injury and death by undertaking all of the following duties:

(1) Identifying factors which make a child at risk for injury or death.

(2) Collecting and sharing information among state team members and agencies which provide services to children and families or investigate child deaths.

(3) Making suggestions and recommendations to appropriate participating agencies regarding improving coordination of services and investigations.

(4) Identifying trends relevant to unexpected/unexplained child injury and death.

(5) Reviewing reports from local child death teams and, upon request of a local team, individual cases of child deaths.

(6) Providing training and written materials to the local teams to assist them in carrying out their duties. Such written materials shall include model protocols for the operation of the local teams.

(7) Developing a protocol for child death investigations, and revising the protocol as needed. The protocol for child death investigations shall not include any activity that causes public scrutiny of the family circumstances surrounding the subject death.

(8) Undertaking a study of the operations of local teams considering training needs and service gaps. If the state team determines that changes to any statute, regulation, or policy is needed to decrease the risk and incidence of child injury and death, it shall propose and recommend changes to such statute, regulation, or policy in its annual report.

(9) Educating the public in Alabama regarding the incidence and causes of child injury and death and the public role in aiding in reducing the risk of such injuries and deaths. The state team shall enlist the support of civil, philanthropic, and public service organizations in its performance of its education duties.

(10) Developing and implementing such procedures and policies as are necessary for its own operation.

(11) Providing the Governor and the Legislature with an annual written report which shall include, but not be limited to, the state team's findings and recommendations for each of its duties; and providing copies of such report to the public.

(12) Determining, by consent of state team members, what protocols should be followed by team members for providing data and/or information to the state team as a whole.

(13) Examining confidentiality and access to information laws, regulations, and policies for agencies with responsibilities for children, including health, public welfare, education, social services, mental health, and law enforcement agencies, and determining whether those laws, regulations, or policies

impede the exchange of information necessary to reduce the risk of injury and death. If the state team determines that such laws, regulations, or policies do impede the necessary exchange of information, it shall take prompt steps to propose and recommend changes to the appropriate state agencies.
Section 26-16-96

Local child death review teams

(a) There are hereby created local child death review teams.

(b) Each county of the state shall be included in a local multidisciplinary, multiagency child death review team's jurisdiction. The district attorney shall initiate the establishment of local teams by convening a meeting of potential team members within 60 days of September 11, 1997. In the absence of the initiation of a child death review team by the district attorney within 60 days of September 11, 1997, the local public health representative will initiate the first team meeting. During this meeting, participants shall recommend whether to establish a team for that county alone or to establish a team with and for the counties within that judicial circuit.

(c) The local team shall include, but not be limited to, all of the following members, the first five of whom are ex officio. The ex officio members may designate representatives from their particular departments or offices to represent them on the local team who may vote and exercise all other prerogatives of the appointment. The members of the local team include the following:

(1) The county health officer.

(2) The director of the county department of human resources.

(3) The county district attorney

.**(4)** The medical examiner.

(5) The local coroner.

(6) An investigator with a local sheriff's department who is familiar with homicide investigation.

(7) An investigator with a local police department who is familiar with homicide investigation.

(8) A pediatrician, or if no pediatrician is available a primary care physician, appointed by the county medical society.

(9) A representative from a local child advocacy center, if one exists.

(d) The local team shall select a chair from among its members. The chair shall serve a term of three years and may serve more than one consecutive term.

(e) Members who are not ex officio shall serve for a three-year term and may succeed themselves but shall not serve more than two consecutive terms. Terms for these members shall be staggered.

(f) The initial meeting of the local team shall be held within 60 days of September 11, 1997.

(g) A quorum for conducting all activities shall be determined by the local team. A simple majority of members present constituting a quorum shall be required for any affirmative vote.

(h) The purpose of the local team is to decrease the incidence of unexpected/unexplained child injury and death by the following means:

(1) Identifying factors which make a child at risk of injury or death.

(2) Sharing information among the agencies which provide services to children and families or which investigate child deaths or provide services.

(3) Improving local investigations of unexpected/unexplained child deaths by participating agencies.

(4) Improving existing services and systems and assisting in the establishment of additional services and systems to fill in gaps in the community.

(5) Identifying trends relevant to unexpected/unexplained child injury and death.

(6) Educating the local public regarding the incidence and causes of child injury and death and the public role in aiding and reducing the risk of such injuries and deaths.

(i) To achieve its purpose, the local team shall perform all the following duties and functions:

(1) Establish and implement a protocol for the local team within two months of receipt of the model protocols from the state team as required by Section **26-16-93**.

(2) Respond by recording all child deaths and reviewing individual unexpected/unexplained child deaths in accordance with protocols from the state team.

(3) Meet as deemed necessary by the local chair, but not less than annually, to review the status of unexpected/unexplained child death cases, propose recommendations for improving coordination of services and investigations between member agencies, and propose changes within the member agencies which shall reduce the risk and incidence of unexpected/unexplained child injury and death.

(4) Collect data as required for submittal to the state team.

(5) Provide reports to the state team following each team meeting which shall include data on child deaths, steps taken to improve coordination of services and investigations, steps taken to implement changes within member agencies, and advice on needed changes to law, policy, and practice which shall aid in reducing the risk and incidence of child injury and death.

(j) At a local team meeting to review unexpected/unexplained child deaths, information shall be provided as specified below, except where otherwise protected by statute, to carry out each of the following of the local team's purpose and duties:

(1) The providers of medical care, the physician representative, or the medical examiner, shall provide pertinent health and medical information regarding a child whose death is being reviewed by the local team.

(2) State, county, or local government agencies shall provide all of the following data on forms developed by the state team for reporting to local child death review teams:

a. Birth information for children who died at less than one year of age including confidential information collected for medical and health use

b. Death information for children who have not reached their eighteenth birthday

c. Law enforcement investigative data, medical examiner investigative data, parole and probation information, and records.

d. Medical care, including dental, mental, and prenatal health care.

e. Pertinent information from any social services agency that provided services to the child or family.

Section 26-16-97

Meetings; disclosure of information; violation; penalties

(a) Meetings of the state team and of local teams shall be closed to the public and not subject to the State Sunshine Law when the state team or local team is discussing a specific child death.

(b) Information identifying a deceased child, a family member, guardian or caretaker of a deceased child, or an alleged or suspected perpetrator of abuse or neglect upon a child, may not be disclosed during a meeting which is open to the public.

(c) Information regarding the involvement of any agency with the deceased child or family may not be disclosed during a public meeting.

(d) Nothing in this section shall be construed as preventing the state team or a local team from requesting the attendance at a team meeting of a person who has information relevant to the team's exercise of its purpose and duties.
(e) Any person who intentionally violates any portion of this section commits a Class C misdemeanor and shall be punished as prescribed by law.

Any person who violates the provisions of confidentiality in any proceedings conducted by either a local team or the state team shall be removed from the team in addition to any other penalty.

Section 26-16-98

Confidentiality of information and records

(a) All information and records acquired by the state team or by a local team, in the exercise of its purpose and duties pursuant to this article, are confidential, exempt from disclosure under Section **41-13-1**, and may only be disclosed as necessary to carry out the team's duties and purposes.

(b) Reports of the state team and of a local team which do not contain any information that would permit the identification of any person to be ascertained shall be public information.

(c) Except as necessary to carry out a team's purpose and duties, members of a team and persons attending a team meeting may not disclose what transpired at a meeting which is not public under Section **26-16-97**, nor shall they disclose any information the disclosure of which is prohibited by this section.

(d) Members of a team, persons attending a team meeting, and persons who present information to a team may release information to such government agencies as is necessary for the purpose of carrying out assigned team duties.

(e) Information, documents, and records of the state team or of a local team are not subject to subpoena, discovery, or introduction into evidence in any civil or criminal proceeding, except that information, documents, and records otherwise available from other sources are not immune from subpoena, discovery, or introduction into evidence through those sources solely because they were presented during proceedings of the team or are maintained by a team.

(f) Moreover, notwithstanding subsections (a) and (b), those criminal records, court records and other records that have been open to public inspection before September 11, 1997, shall remain open.

Section 26-16-99

Duties of coroner/medical examiner

The duties of the coroner/medical examiner shall include the following:

(1) Except in locations where a county medical examiner has jurisdiction, the coroner or a person acting in a professional capacity shall report the death of a child by telecommunications to the medical examiner or his or her representative as soon as possible upon discovery.

(2) Upon receipt of a report of a child death, the county medical examiner or state medical examiner shall determine whether the death appears to be unexpected/unexplained. If the death appears to be unexpected/unexplained, the county medical examiner or state medical examiner shall commence an investigation of the death consisting of a postmortem examination conducted by a state or county medical examiner. Upon the recommendation of the state medical examiner, with authorization from a district attorney, an autopsy may be conducted. A county medical examiner may conduct an autopsy at his or her discretion as authorized by existing statutes. This section should not be interpreted as mandating an autopsy. In a case where an autopsy is not performed, the postmortem examination shall consist of an external examination.

Appendix B. Role and Confidentiality Agreements

Local Child Death Review Team member
Role and Confidentiality Agreement
LCDRT Coordinator

Role

I understand my role as the local team coordinator is vital to the functions of the LCDRT and agree to work closely with my team chair while being responsible for the following:

- Serve as custodian of confidential Death Certificate information sent by the State CDROffice
- Review Death Certificates and request additional information as needed
- Determine meeting date, place, time, and length
- Notify LCDRT Members of meeting and invite ancillary review team members asneeded
- Obtain and keep on file signed role and confidentiality statements of all teammembers
- Complete data collection tools and notify State CDR Office
- Secure all confidential documents until they are destroyed per the LCDRTGuidelines

I agree to review all unexpected/unexplained deaths of children in accordance with ACDR protocol and act as the liaison between the local CDR team and the state CDR office. I agree to make recommendations to improve

coordination of services and or investigations between and within member agencies in order to reduce the risk and incidence of injuries and death to children.
I understand there are to be no meeting minutes taken of local team reviews and no copies of completed data collection tools are to be made.

Confidentiality

Meetings are closed to the public and are not subject to the Open Meetings Law when specific deaths are discussed. Identifying information of the child, family, caretaker, suspected perpetrator, or agency may not be disclosed to the public. Information from records of participating agencies discussed by the team in the exercise of its purposes and duties is confidential and shall not be disclosed outside team meetings. Any person who violates the confidentiality provisions of the Alabama CDR Law commits a Class C misdemeanor and shall be removed from the team. New files with specific case-identifying information shall not be created; therefore, no meeting minutes or personal notes of events discussed shall be taken.

Under the Alabama CDR Law, team members are immune from any and all civil and criminal liability in connection with their good faith participation on the team and all activities associated therewith; however, this immunity is not available in the event any local team member violates the provisions of confidentiality specified in the Alabama CDR Law.
I agree to actively participate on my Local Child Death Review Team and abide by the above stated terms.

Print Name	Signed Name	Date
Mailing Address	Phone Number	Fax Number
City, State, Zip	Email	

Local Child Death Review Team member Role and Confidentiality Agreement District Attorney Representative

Role

I agree to educate team members on the justice system including criminal and civil actions that might be taken against those involved in child deaths. I agree to provide team leadership as needed and any information about previous contact or criminal prosecutions of family members or suspects in child deaths. I understand my participation is vital to the functions of the LCDRT and agree to personally represent the district attorney's office or send a knowledgeable substitute.
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I understand there are to be no meeting minutes taken of local team reviews and no copies of completed data collection tools are to be made.

Confidentiality

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I agree to actively participate on my Local Child Death Review Team and abide by the above stated terms.

Print Name	Signed Name	Date
Mailing Address	Phone Number	Fax Number
City, State, Zip	Email	

Local Child Death Review Team member Role and Confidentiality Agreement Coroner

Role

I agree to educate team members on the justice system including criminal and civil actions that might be taken against those involved in child deaths. I agree to provide team leadership as needed and any information about previous contact or criminal prosecutions of family members or suspects in child deaths. I understand my participation is vital to the functions of the LCDRT and agree to personally represent the district attorney's office or send a knowledgeable substitute.

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Mailing Address	Phone Number	Fax Number
City, State, Zip	Email	

Local Child Death Review Team member
Role and Confidentiality Agreement
Medical Examiner

Role

I agree to educate team members on the justice system including criminal and civil actions that might be taken against those involved in child deaths. I agree to provide team leadership as needed and any information about previous contact or criminal prosecutions of family members or suspects in child deaths. I understand my participation is vital to the functions of the LCDRT and agree to personally represent the district attorney's office or send a knowledgeable substitute.

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Print Name	Signed Name	Date
Mailing Address	Phone Number	Fax Number
City, State, Zip	Email	

Local Child Death Review Team member
Role and Confidentiality Agreement
Law Enforcement

Role

I agree to educate team members on the justice system including criminal and civil actions that might be taken against those involved in child deaths. I agree to provide team leadership as needed and any information about previous contact or criminal prosecutions of family members or suspects in child deaths. I understand my participation is vital to the functions of the LCDRT and agree to personally represent the district attorney's office or send a knowledgeable substitute.

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Print Name	Signed Name	Date
Mailing Address	Phone Number	Fax Number
City, State, Zip	Email	

Local Child Death Review Team member
Role and Confidentiality Agreement
Fire and/or Emergency Medical Services

Role

I agree to educate team members on the justice system including criminal and civil actions that might be taken against those involved in child deaths. I agree to provide team leadership as needed and any information about previous contact or criminal prosecutions of family members or suspects in child deaths. I understand my participation is vital to the functions of the LCDRT and agree to personally represent the district attorney's office or send a knowledgeable substitute.

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Print Name	Signed Name	Date
Mailing Address	Phone Number	Fax Number
City, State, Zip	Email	

Local Child Death Review Team member
Role and Confidentiality Agreement
Local Healthcare Provider

Role

I agree to educate team members on the justice system including criminal and civil actions that might be taken against those involved in child deaths. I agree to provide team leadership as needed and any information about previous contact or criminal prosecutions of family members or suspects in child deaths. I understand my participation is vital to the functions of the LCDRT and agree to personally represent the district attorney's office or send a knowledgeable substitute.

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Mailing Address	Phone Number	Fax Number
City, State, Zip	Email	

Local Child Death Review Team member
Role and Confidentiality Agreement
Public Health Representative

Role

I agree to educate team members on the justice system including criminal and civil actions that might be taken against those involved in child deaths. I agree to provide team leadership as needed and any information about previous contact or criminal prosecutions of family members or suspects in child deaths. I understand my participation is vital to the functions of the LCDRT and agree to personally represent the district attorney's office or send a knowledgeable substitute.

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Print Name	Signed Name	Date
Mailing Address	Phone Number	Fax Number
City, State, Zip	Email	

Local Child Death Review Team member
Role and Confidentiality Agreement
DHR Representative

Role

I agree to educate team members on the justice system including criminal and civil actions that might be taken against those involved in child deaths. I agree to provide team leadership as needed and any information about previous contact or criminal prosecutions of family members or suspects in child deaths. I understand my participation is vital to the functions of the LCDRT and agree to personally represent the district attorney's office or send a knowledgeable substitute.

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Mailing Address	Phone Number	Fax Number
City, State, Zip	Email	

Local Child Death Review Team member
Role and Confidentiality Agreement
Mental Health Representative

Role

I agree to educate team members on the justice system including criminal and civil actions that might be taken against those involved in child deaths. I agree to provide team leadership as needed and any information about previous contact or criminal prosecutions of family members or suspects in child deaths. I understand my participation is vital to the functions of the LCDRT and agree to personally represent the district attorney's office or send a knowledgeable substitute.

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Local Child Death Review Team member
Role and Confidentiality Agreement
Child Advocate

Role

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City, State, Zip	Email	

Local Child Death Review Team member
Role and Confidentiality Agreement
Probate or Family Court Representative

Role

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Local Child Death Review Team member
Role and Confidentiality Agreement
Educator Representative

Role

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Print Name	Signed Name	Date
Mailing Address	Phone Number	Fax Number
City, State, Zip	Email	

Local Child Death Review Team member
Role and Confidentiality Agreement
Other Team Member or Invited Guest

Role

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Mailing Address	Phone Number	Fax Number
City, State, Zip	Email	

Appendix C. Average LCDRT Caseload

Alabama LCDRT Average Annual Caseload

5 year average - 2018 through 2022 - (Revised May 2024)

Case Team	Counties in Circuit	Average Caseload (Cases/Year)
1	Choctaw, Clarke, Washington	4.4
2	Butler, Crenshaw, Lowndes	5.6
3	Barbour, Bullock	1.8
4	Bibb, Dallas, Hale, Perry, Wilcox	7.8
5	Chambers, Macon, Tallapoosa, Randolph	6.8
6	Tuscaloosa	12.8
7	Calhoun, Cleburne	8
8	Morgan	7.8
9	Cherokee, DeKalb	4.2
10A	Jefferson	33.2
10B	Bessemer	8.6
11	Lauderdale	3
12	Coffee, Pike	4.2
13	Mobile	26
14	Walker	5
15	Montgomery	22.8
16	Etowah	6.6
17	Greene, Marengo, Sumter	3.8
18	Shelby	7.8
19	Autauga, Chilton, Elmore	11
20	Henry, Houston	5.8
21	Escambia	2.8
22	Covington	2.8
23	Madison	20.2
24	Fayette, Lamar, Pickens	4
25	Marion, Winston	4.4
26	Russell	2.8
27	Marshall	6.4
28	Baldwin	9.2
29	Talladega	7.8
30	St. Clair	6.6
31	Colbert	2.6
32	Cullman	5.4
33	Dale, Geneva	5.4
34	Franklin	2
35	Conecuh, Monroe	1.4
36	Lawrence	2.6
37	Lee	7.2
38	Jackson	3
39	Limestone	5.8
40	Clay, Coosa	1.4
41	Blount	2.8

Appendix D. Sample Request for Medical Record Information

Alabama Child Death Review System
Request for Medical Record

Information M E M O R A N D U M

Date: _____

To: _____ **From:** _____

_____ _____

_____ _____

Fax: (_____)_____ Fax: (_____) _____

Alabama Act 97-893 states that providers of medical care shall provide medical information regarding a child whose death is being reviewed by a local child death review team. Pursuant to the Act, Circuit_____Local Child Death Review Team requests the medical records on the following deceased children who we believe have been seen at your facility. In an effort to save time and expense, please fax to me the summary discharge information for each visit to your facility.

Name of Deceased	**Birth Date**	**Death Date**	**Approximate Evaluation Dates(s)**

Thank you for your assistance. Medical record information is critical to better understand how and why our children die. If you have any questions, please contact meat (_____)

Appendix E. Sample LCDRT Meeting and Case Notification

Circuit_____
Local Child Death Review Team
Meeting Notice

Meeting Date:_____ Time: From_____To _____

Place:_____ Address: _____

_____

Please review your files for information on the following cases scheduled for review. I have enclosed a blank data questionnaire, so you can see what information we are looking to collect. If you believe it would be helpful to have another professional that has information to share on a death attend our meeting, please contact me and an invitation will be extended.

You are a key member of the team and your participation is extremely important.
Thank you for your efforts in helping us better understand how and why our children have died. Please feel free to call me if you have any questions or comments.

Sincerely,

Jane Doe
Contact Information

Page_____of _____

Copy of

Cases To Be Reviewed

Child's Name:_____ **Mother:** _____

Address:_____ **Father:** _____

_____ **Date of Death:**_____/_____/_____

Age:_____ **Race:**_____ **Sex:**_____ **Date of Birth:**_____/_____/_____

Place of Death:_____ **Cause of Death:**_____

Comments:

Child's Name:_____ **Mother:** _____

Address: _____ **Father:** _____

_____ **Date of Death:**_____/_____/_____

Age:_____ **Race:**_____ **Sex:**_____ **Date of Birth:**_____/_____/_____

Place of Death:_____ **Cause of Death:** _____

Comments:

Child's Name:_____ **Mother:** _____

Address:_____ **Father:** _____

_____ **Date of Death:**_____/_____/_____

Age:_____ **Race:**_____ **Sex:**_____ **Date of Birth:**_____/_____/_____

Place of Death:_____ **Cause of Death:** _____

Must shred after use.

Appendix F. Case Report

Saving Lives Together

CDR REPORT FORM

Version 6.0

National Fatality Review Case Reporting System

Data Entry Website: data.ncfrp.org

Phone: 800-656-2434

Email: info@ncfrp.org

ncfrp.org

@nationalcfrp

SAVING LIVES TOGETHER

Instructions:

This case report is used by Child Death Review (CDR) teams to enter data into the National Fatality Review Case Reporting System (NFR-CRS). The NFR-CRS is available to states and local sites from the National Center for Fatality Review & Prevention (NCFRP) and requires a data use agreement for data entry. The purpose is to collect comprehensive information from multiple agencies participating in a review. The NFR-CRS documents demographics, the circumstances involved in the death, investigative actions, services provided or needed, key risk factors and actions recommended and/or taken by the team to prevent other deaths.

While this data collection form is an important part of the CDR process, it 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.

It is not expected that teams will have answers to all of the questions related to a death. However, over time teams begin to understand the importance of data collection and bring the necessary information to the meeting. The percentage of cases marked "unknown" and unanswered questions decreases as the team becomes more familiar with the form. **The NFR-CRS Data Dictionary is available** as a PDF in the Help menu or as individual help icons in the online data entry system. It contains definitions for each data element and should be referred to when the team is unsure how to answer a question. Use of the data dictionary helps teams improve consistency of data entry.

The form contains three types of questions: (1) select one response as represented by a circle; (2) select multiple responses as represented by a square; and (3) free text responses. This last type is indicated by the words "specify" or "describe."

Many teams ask what is the difference between leaving a question blank and selecting the response "unknown." A question should be marked "unknown" if an attempt was made to find the answer but no clear or satisfactory response was obtained. A question 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 does not apply.

Throughout the form, a plus sign (+) beside a question indicates that the question is skipped for fetal deaths.

Reminder:

Enter identifiable information (**names, dates, addresses, counties**) into the NFR-CRS if your state/local policy allows. Follow your state laws in regards to reporting psychological, substance abuse and HIV/AIDS status. Please check with your fatality review coordinator if you are unsure. For other text fields, such as the **Narrative section or any "specify" or "describe" fields,** do not include specific names, dates of birth, dates of death, references to specific counties, practitioners, or facility names in these text fields. Examples: "Evans County EMS" should be "EMS"; "Evans County Children's Hospital" should be "the children's hospital." **Why this reminder?** Text fields may be shared with approved researchers as noted in the Data Use Agreement in your state or jurisdiction. Therefore, entering identified data into those fields would compromise your responsibility under HIPAA.

Additional paper forms can be ordered from the NCFRP at no charge. Users interested in participating in the NFR-CRS for data entry and reporting should contact the NCFRP. This version includes the Sudden and Unexpected Infant Death (SUID) Case Registry and the Sudden Death in the Young (SDY) Case Registry questions.

CASE NUMBER

_____ /_____/_____/_____

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

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

☐ Child never left hospital following birth

Death Certificate Number:

Birth Certificate Number:

ME/Coroner Number:

Date Team Notified of Death:

A. CHILD INFORMATION

A1. CHILD INFORMATION (COMPLETE FOR ALL AGES)

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

1. Child's name: First: Middle: Last: ☐ U/K

2. Date of birth: ☐ U/K ___/___/___ mm dd yyyy

3. Date of death: ☐ U/K ___/___/___ mm dd yyyy

4. Age+: ○ Years ○ Months ○ Days ○ Hours ○ Minutes ○ U/K _____

5. Race, check all that apply:
☐ Alaska Native, Tribe:
☐ American Indian, Tribe:
☐ Asian, specify:
☐ Black
☐ Native Hawaiian
☐ Pacific Islander, specify:
☐ White
☐ U/K

6. Hispanic or Latino/a origin?
○ Yes ○ No ○ U/K

7. Sex:
○ Male ○ Female ○ U/K

8. Residence address: ☐ U/K
Street: Apt.
City:
State: Zip: County:

9. Child's weight at death+: ☐ U/K
○ Pounds/ounces ___/___
○ Grams/kilograms _____

10. Child's height at death+: ☐ U/K
○ Feet/inches ___/___
○ Cm _____

11. State of death:

12. County of death:

13. Child had disability or chronic illness+?
○ Yes ○ No ○ U/K
If yes, check all that apply:
☐ Physical/orthopedic, specify:
☐ Mental health/substance abuse, specify:
☐ Cognitive/intellectual, specify:
☐ Sensory, specify:
☐ U/K
If yes, was child receiving Children's Special Health Care Needs services? ○ Yes ○ No ○ U/K

14. Were any siblings placed outside of the home prior to this child's death?
○ N/A ○ Yes, # _____ ○ No ○ U/K

15. Child's health insurance, check all that apply+:
☐ None ☐ Medicaid ☐ Indian Health Service ☐ U/K
☐ Private ☐ State plan ☐ Other, specify:

16. Was the child up to date with the Centers for Disease Control and Prevention (CDC) immunization schedule+?
○ NA ○ Yes ○ No, specify: ○ U/K

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

If the child never left the hospital following birth, go to A2.

18. Type of residence:
○ Parental home ○ Relative home ○ Jail/detention
○ Licensed group home ○ Living on own ○ Other, specify:
○ Licensed foster home ○ Shelter
○ Relative foster home ○ Homeless ○ U/K

19. New residence in past 30 days?
○ Yes ○ No ○ U/K

20. Residence overcrowded?
○ Yes ○ No ○ U/K

21. Child ever homeless?
○ Yes ○ No ○ U/K

22. Number of other children living with child:
_____ ☐ U/K

23. Child had history of child maltreatment as victim?
○ Yes ○ No ○ U/K
If yes, check all that apply:
☐ Physical
☐ Neglect
☐ Sexual
☐ Emotional/psychological
☐ U/K
If yes, how was history identified:
○ Through CPS
○ Other sources
If through CPS:
_____ # CPS referrals
_____ # Substantiations

24. Was there an open CPS case with child at time of death?
○ Yes ○ No ○ U/K

25. Was child ever placed outside of the home prior to the death? ○ Yes ○ No ○ U/K

26. How many months prior to death did child last have contact with a health care provider? ____

A2. COMPLETE FOR CHILDREN OVER ONE YEAR OLD

27. Child's highest education level:
○ N/A ○ Home schooled, 9-12
○ None ○ Drop out
○ Preschool ○ HS graduate/GED
○ Grade K-8 ○ College
○ Grade 9-12 ○ U/K
○ Home schooled, K-8

28. Child's work status:
○ N/A
○ Employed
○ Not working
○ U/K

29. Did child have problems in school?
○ N/A ○ Yes ○ No ○ U/K
If yes, check all that apply:
☐ Academic ☐ Expulsion
☐ Truancy ☐ Other, specify:
☐ Suspensions
☐ Behavioral ☐ U/K

30. Child had history of intimate partner violence?
Check all that apply:
☐ N/A
☐ Yes, as victim
☐ Yes, as perpetrator
☐ No
☐ U/K

31. Child had received prior mental health services?

○ N/A ○ Yes ○ No ○ U/K

If yes, check all that apply:

☐ Outpatient
☐ Day treatment/partial hospitalization
☐ Residential

32. Child was receiving mental health services?

○ N/A ○ Yes ○ No ○ U/K

If yes, check all that apply:

☐ Outpatient ☐ Residential
☐ Day treatment/partial hospitalization

33. Child on medications for mental health illness?

○ N/A ○ Yes ○ No ○ U/K

34. Child had emergency department visit for mental health care within the previous 12 months?

○ N/A ○ Yes ○ No ○ U/K

If yes, did the child have a follow-up mental health appointment within 30 days of emergency department visit?

○ Yes ○ No ○ U/K

35. Child was hospitalized for mental health care within the previous 12 months?

○ N/A ○ Yes ○ No ○ U/K

If yes, did the child have a follow-up mental health appointment within 30 days of discharge from the hospital?

○ Yes ○ No ○ U/K

36. Issues prevented child from receiving mental health services?

○ N/A ○ Yes ○ No ○ U/K

If yes, specify:

37. Child had history of substance use or abuse?

○ N/A ○ Yes ○ No ○ U/K

If yes, check all that apply:

☐ Alcohol ☐ Prescription drugs, specify:
☐ Cocaine ☐ Over-the-counter drugs, specify:
☐ Marijuana ☐ Tobacco/nicotine, specify type:
☐ Methamphetamine ☐ Other, specify:
☐ Opioids ☐ U/K

If yes, did the child receive treatment?

○ Yes ○ No ○ U/K

If yes, type? Check all that apply:

☐ Outpatient ☐ Day treatment/partial hospital
☐ Inpatient/detox ☐ Residential

If yes, age at first use: ☐ U/K

38. Child had delinquent or criminal history?

○ N/A ○ Yes ○ No ○ U/K

If yes, check all that apply:

☐ Assault ☐ Weapon offense
☐ Robbery/theft
☐ Drugs/alcohol ☐ Other, specify:
☐ Misbehavior ☐ U/K
(truancy, destruction of property, trespassing)

39. Child spent time in juvenile detention?

○ N/A ○ Yes ○ No ○ U/K

40. Child acutely ill in the two weeks before death?

○ Yes ○ No ○ U/K

41. What was child's gender identity?

○ No identity expressed
○ Male, not transgender
○ Female, not transgender
○ Transgender male
○ Transgender female
○ Non-binary
○ Other, specify:
○ U/K

42. What was child's sexual orientation?

○ No orientation expressed
○ Straight/heterosexual ○ Questioning
○ Gay/lesbian ○ Other, specify:
○ Bisexual ○ U/K

A3. COMPLETE FOR ALL FETAL/INFANTS UNDER ONE YEAR A + symbol means that the question is skipped for fetal deaths.

43. Was this case reviewed by both a Fetal/Infant Mortality Review (FIMR) and Child Death Review (CDR/CFR) team? ○ Yes ○ No ○ U/K

44. Gestational age:

☐ U/K

_____ # weeks

45. Birth weight: ☐ U/K

○ Grams/kilograms _____
○ Pounds/ounces ____/____

46. Multiple gestation pregnancy?

○ Yes, # of fetuses _____
○ No ○ U/K

47. Including the deceased infant, how many pregnancies did the childbearing parent have? # ___ ☐ U/K

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

49. Not including the deceased infant, number of

50. Prenatal care provided during pregnancy of deceased infant? ○ Yes ○ No ○ U/K

children childbearing parent still has living?

_____ ☐ U/K

If yes, number of prenatal visits kept: #_____ ☐ U/K

If yes, what month of pregnancy for first prenatal visit kept. Specify 1-9: ☐ U/K

51. Were there access or barrier issues related to prenatal care? ○ Yes ○ No ○ U/K If yes, check all that apply:

☐ Lack of money for care ☐ Couldn't get provider to take as patient ☐ Services not available ☐ Other, specify:
☐ Limitations of health insurance coverage ☐ Multiple providers, not coordinated ☐ Distrust of health care system
☐ Lack of transportation ☐ Couldn't get an earlier appointment ☐ Unwilling to obtain care ☐ U/K
☐ Cultural differences ☐ Lack of child care ☐ Didn't know where to go
☐ Language barriers ☐ Lack of family/social support ☐ Didn't think they were pregnant

52. During pregnancy, did the childbearing parent have any medical conditions/complications? ○ Yes ○ No ○ U/K If yes, check all that apply:

Cardiovascular
☐ Hypertension - gestational
☐ Hypertension - chronic
☐ Pre-eclampsia
☐ Eclampsia
☐ Clotting disorder

Hematologic
☐ Sickle cell disease
☐ Anemia (iron deficiency)

Respiratory
☐ Asthma

Endocrine/Metabolic
☐ Diabetes, type 1 chronic
☐ Diabetes, type 2 chronic
☐ Diabetes, gestational
☐ Thyroid

Neurologic/Psychiatric
☐ Addiction disorder
☐ Depression
☐ Anxiety disorder
☐ Seizure disorder

Sexually Transmitted Infection (STI)
☐ Bacterial vaginosis (BV)
☐ Chlamydia
☐ Gonorrhea
☐ Herpes
☐ HPV
☐ Syphilis
☐ Group B strep
☐ HIV/AIDS
☐ Other STI, specify:

Gynecologic
☐ Uterine/vaginal bleeding
☐ Chorioamnionitis
☐ Oligohydramnios
☐ Polyhydramnios
☐ Other placental, specify:
☐ Intrauterine growth restriction (IUGR)
☐ Premature rupture of membranes (PROM)
☐ Preterm premature rupture of membranes (PPROM)
☐ Cervical Insufficiency
☐ Prolapse
☐ Preterm labor

Umbilical cord complications
☐ Nuchal cord
☐ Other cord, specify:

Placental problems
☐ Abruption
☐ Previa
☐ Other placental, specify:

Other Condition/Complication
☐ UTI
☐ Decreased fetal movement
☐ HELLP syndrome
☐ Developmental delay
☐ Oral health/dental or gum infection
☐ Gastrointestinal
☐ CBP genetic disorder
☐ Abnormal MSAFP
☐ Obesity
☐ Other, specify:

☐ Polycystic ovarian disease

53. Did the childbearing parent experience any medical complications in previous pregnancies?

○ N/A ○ Yes ○ No ○ U/K If yes, check all that apply:

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

54. Did the childbearing parent use any medications, drugs or other substances during pregnancy?

○ Yes ○ No ○ U/K If yes, check all that apply:

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

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

55. Was the infant/fetus delivered drug expos ○ Yes ○ No ○ U/K

56. Did the infant have neonatal abstinence syndrome (NAS)+? ○ Yes ○ No ○ U/K

57. Level of birth hospital:

○ 1
○ 2

58. At discharge from the birth hospital, was a case manager assigned to the childbearing parent?

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

59. Did the childbearing parent have contact with their care provider within the first 3 weeks postpartum?

○ 3
○ 4

○ Freestanding birth center

○ Home birth

○ Other, specify:

○ U/K

○ Yes ○ No ○ U/K

60. Did the infant have a NICU stay of more than one day+? ○ Yes ○ No ○ U/K

If yes, for what reason(s)? Check all that apply:

☐ Prematurity ☐ Apnea ☐ Hypothermia ☐ Meconium aspiration

☐ Low birth weight ☐ Sepsis ☐ Jaundice ☐ Congenital anomalies

☐ Tachypnea ☐ Feeding difficulties ☐ Anemia ☐ Other, specify:

☐ Drug/alcohol exposure ☐ U/K

61. Did the childbearing parent smoke in the 3 months before pregnancy?

○ Yes ○ No ○ U/K

If yes, ___ Avg # cigarettes/day (20 cigarettes in pack)

☐ U/K quantity

62. Did the childbearing parent during pregnancy? If yes, Trimester 1 Trimester 2 Trimester 3

○ Yes ○ No ○ U/K

_____ _____ Avg # cigarettes/day (20 cigarettes in pack)

☐ ☐ ☐ U/K quantity

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

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

64. Was the childbearing parent injured during pregnancy?

○ Yes ○ No ○ U/K If yes, describe:

65. Did the childbearing parent have postpartum depression?

○ Yes ○ No ○ U/K

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

66. Infant ever breastfed? ○ Yes ○ No ○ U/K

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

If yes, exclusively? ○ Yes ○ No ○ U/K

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

If yes, exclusively? ○ Yes ○ No ○ U/K

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

67. Did infant have abnormal metabolic newborn screening results?

○ N/A ○ Yes ○ No ○ U/K

If yes, describe any abnormality such as a fatty acid oxidation error:

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

68. At any time prior to the infant's last 72 hours, did the infant have a history of (check all that apply):

☐ None ☐ Cyanosis

☐ Infection ☐ Seizures or convulsions

☐ Allergies ☐ Cardiac abnormalities

☐ Abnormal growth, weight gain/loss ☐ Other, specify:

☐ Apnea ☐ U/K

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

☐ None ☐ Decrease in appetite ☐ Difficulty breathing

☐ Fever ☐ Vomiting ☐ Apnea

☐ Excessive sweating ☐ Choking ☐ Cyanosis

☐ Lethargy/sleeping more than usual ☐ Diarrhea ☐ Seizures or convulsions

☐ Stool changes ☐ Other, specify:

☐ Fussiness/excessive crying ☐ U/K

70. In the 72 hours prior to death, was the infant injured?

○ Yes ○ No ○ U/K

71. In the 72 hours prior to death, was the infant given any vaccines?

○ Yes ○ No ○ U/K

72. In the 72 hours prior to death, was the infant given any medications or remedies? Include herbal, prescription, over-the-counter medications and home remedies.

73. What did the infant have for his/her last meal? Check all that apply:

☐ Breast milk

If yes, describe cause and injuries:	If yes, list name(s) of vaccines:	○ Yes ○ No ○ U/K If yes, list name and last dose given:	☐ Formula ☐ Baby food ☐ Cereal ☐ Other, specify: ☐ U/K

B. BIOLOGICAL PARENT INFORMATION

○ **No information available, go to Section C**

1. Parents alive on date of child's death? Even if parent(s) are deceased at time of child's death, please fill out the remaining questions.

Childbearing Biological Parent (CBP) alive: U/K ○ Yes ○ No ○

Non-Childbearing Biological Parent (Non-CBP) alive: U/K ○ Yes ○ No ○

2. Parents' race, check all that apply:

CBP	Non-CBP	
☐	☐	Alaska Native, Tribe:
☐	☐	American Indian, Tribe:
☐	☐	Asian, specify:
☐	☐	Black
☐	☐	Native Hawaiian
☐	☐	Pacific Islander, specify:
☐	☐	White
☐	☐	U/K

3. Parents' Hispanic or Latino/a origin?

CBP	Non-CBP	
○	○	Yes, specify origin:
○	○	No
○	○	U/K

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

CBP	Non-CBP	
____	____	# Years
☐	☐	U/K

5. Parents' employment status:

CBP	Non-CBP	
○	○	Employed
○	○	Unemployed
○	○	On disability
○	○	Stay-at-home
○	○	Retired
○	○	U/K

6. Parents' education:

CBP	Non-CBP	
○	○	< High school
○	○	High school/GED
○	○	College
○	○	Post graduate
○	○	U/K

7. Parents speak and understand English?

CBP	Non-CBP	
○	○	Yes
○	○	No
○	○	U/K

If no, language spoken:

8. Parents first generation immigrant?

CBP	Non-CBP	
○	○	Yes, country of origin:
○	○	No
○	○	U/K

9. Parents on active military duty?

CBP	Non-CBP	
○	○	Yes, specify branch:
○	○	No
○	○	U/K

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

CBP	Non-CBP	
○	○	Yes If yes, check all that apply below:
○	○	No
○	○	U/K

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

11. Parents have substance abuse history?

CBP	Non-CBP	
○	○	Yes

12. Parents ever victim of child maltreatment?

CBP	Non-CBP	
○	○	Yes

13. Parents ever perpetrator of maltreatment?

CBP	Non-CBP	
○	○	Yes

14. Parents have disability or chronic illness?

CBP	Non-CBP	
○	○	Yes

○ ○ No ○ ○ U/K	○ ○ No ○ ○ U/K	○ ○ No ○ ○ U/K	○ ○ No ○ ○ U/K
15. Parents have prior child deaths? CBP Non-CBP ○ ○ Yes ○ ○ No ○ ○ U/K	16. Parents have history of intimate partner violence? CBP Non-CBP ☐ ☐ Yes, as victim ☐ ☐ Yes, as perpetrator ☐ ☐ No ☐ ☐ U/K		17. Parents have delinquent/criminal history? CBP Non-CBP ○ ○ Yes ○ ○ No ○ ○ U/K

C. PRIMARY CAREGIVER(S) INFORMATION

If fetal death, skip to Section D.

1. Primary caregiver(s): Select only one each in columns one and two.

One	Two		One	Two		One	Two	
○		Self, go to Section D	○	○	Foster parent	○	○	Other relative
○	○	Childbearing parent, go to Section D	○	○	DParent's biological parent	○	○	partnerFriend
○	○	Non-childbearing parent, go to Section D	○	○	GrandparentInstitutional staff	○	○	
			○	○	Sibling	○	○	Other, specify:
○	○	Adoptive parent						
○	○	Stepparent				○	○	U/K

2. Caregiver(s) age in years:

One Two

Years

____ ____

☐ ☐ U/K

3. Caregiver(s) sex:

One Two

○ ○ Male

○ ○ Female

○ ○ U/K

4. Caregiver(s) race, check all that apply:

One	Two		One	Two	
☐	☐	Alaska Native, Tribe:	☐	☐	Pacific Islander, specify:
☐	☐	American Indian, Tribe:			
☐	☐	Asian, specify:	☐	☐	White
☐	☐	Black	☐	☐	U/K
☐	☐	Native Hawaiian			

5. Caregiver(s) Hispanic or Latino/a origin?

One Two

○ ○ Yes

○ ○ No

○ ○ U/K

If yes, specify origin:

6. Caregiver(s) employment status:

One Two

○ ○ Employed

○ ○ Unemployed

○ ○ On disability

○ ○ Stay-at-home

○ ○ Retired

○ ○ U/K

7. Caregiver(s) education: One Two ○ ○ < High school ○ ○ High school/GED ○ ○ College	8. Do caregiver(s) speak and understand English? One Two ○ ○ Yes ○ ○ No	9. Caregiver(s) first generation immigrant? One Two ○ ○ Yes, country of origin: ○ ○ No	10. Caregiver(s) on active military duty? One Two ○ ○ Yes, specify branch: ○ ○ No ○ ○ U/K

○ ○ Post graduate ○ ○ U/K	○ ○ U/K If no, language spoken:	○ ○ U/K	

11. Caregiver(s) receive social services in the past twelve months?

One	Two		One	Two		One	Two
○	○	Yes If yes, check all services that apply: WIC Food stamps/SNAP/EBT	☐	☐		☐	☐
○	○	No Home visiting Section 8/housing U/K specify: Soc Sec	☐	☐	Disability (SSI/SSDI)	☐	☐
○	○					☐	☐
			☐	☐	TANF Other, specify:	☐	☐
			☐	☐	Medicaid U/K	☐	☐

12. Caregiver(s) have substance abuse history?			13. Caregiver(s) ever victim of child maltreatment?			14. Caregiver(s) ever perpetrator of maltreatment?			15. Caregiver(s) have disability or chronic illness?		
One	Two		One	Two		One	Two		One	Two	
○	○	Yes	○	○	Yes	○	○	Yes	○	○	Yes
○	○	No	○	○	No	○	○	No	○	○	No
○	○	U/K	○	○	U/K	○	○	U/K	○	○	U/K

16. Caregiver(s) have prior child deaths?			17. Caregiver(s) have history of intimate partner violence?			18. Caregiver(s) have delinquent/criminal history?		
One	Two		One	Two		One	Two	
○	○	Yes	☐	☐	Yes, as victim	○	○	Yes
○	○	No	☐	☐	Yes, as perpetrator	○	○	No
○	○	U/K	☐	☐	No	○	○	U/K
			☐	☐	U/K			

D. SUPERVISOR INFORMATION

Answer this section only if the child ever left the hospital following birth

1. Did child have supervision at time of incident leading to death?

○ Yes, answer D2-16

○ No, not needed given developmental age or circumstances, go to Sec. E

○ No, but needed, answer D3-16

○ Unable to determine, try to answer D3-16

2. How long before incident did supervisor last see child?

Select one:

○ Child in sight of supervisor

○ Minutes _____ ○ Days _____

○ Hours _____ ○ U/K

3. Is supervisor listed in a previous section?

○ Yes, childbearing parent, go to D15

○ Yes, non-childbearing biological parent, go to D15

○ Yes, caregiver one, go to D15

○ Yes, caregiver two, go to D15

○ No

4. Primary person responsible for supervision at the time of incident? Select only one:

○ Adoptive parent	○ Sibling	○ Institutional staff, go to D15
○ Stepparent	○ Other relative	○ Babysitter
○ Foster parent	○ Friend	○ Licensed child care worker
○ Parent's partner	○ Acquaintance	○ Other, specify:
○ Grandparent	○ Hospital staff, go to D15	○ U/K

5. Supervisor's age in years:	6. Supervisor's sex:	7. Supervisor speaks and understands English?	8. Supervisor on active military duty?
☐ U/K	○ Male ○ Female ○ U/K	○ Yes ○ No ○ U/K	

_____		If no, language spoken:	○ Yes ○ No ○ U/K If yes, specify branch:

9. Supervisor has substance abuse history? ○ Yes ○ No ○ U/K	10. Supervisor has history of child maltreatment? As Victim / As Perpetrator ○ ○ Yes ○ ○ No ○ ○ U/K	11. Supervisor has disability or chronic illness? ○ Yes ○ No ○ U/K	12. Supervisor has prior child deaths? ○ Yes ○ No ○ U/K

13. Supervisor has history of intimate partner violence? ☐ Yes, as victim ☐ Yes, as perpetrator ☐ No ☐ U/K	15. At the time of the incident, was the supervisor asleep? ○ Yes ○ No ○ U/K If yes, select the most appropriate description of the supervisor's sleeping period at incident: ○ Night time sleep ○ Day time nap, describe: ○ Day time sleep (for example, supervisor is night shift worker), describe: ○ Other, describe:	16. At time of incident was supervisor impaired? ○ Yes ○ No ○ U/K If yes, check all that apply: ☐ Drug impaired, specify: ☐ Alcohol impaired ☐ Distracted ☐ Absent ☐ Impaired by illness, specify: ☐ Impaired by disability, specify: ☐ Other, specify:
14. Supervisor has delinquent or criminal history? ○ Yes ○ No ○ U/K		

E. INCIDENT INFORMATION

Answer only E7 if the child never left the hospital following birth

1. Was the date of the incident the same as the date of death?
   - ○ Yes, same as date of death
   - ○ No, different than date of death. Enter date of incident: ____/____/____ (mm / dd / yyyy)
   - ○ U/K

2. Approximate time of day that incident occurred?
   - Hour, specify 1-12:____
   - ○ AM
   - ○ PM
   - ○ U/K

3. Place of incident, check all that apply:
   - ☐ Child's home
   - ☐ Relative's home
   - ☐ Friend's home
   - ☐ Licensed foster care home
   - ☐ Relative foster care home
   - ☐ Licensed group home
   - ☐ Licensed child care center
   - ☐ Licensed child care home
   - ☐ Unlicensed child care home
   - ☐ Farm/ranch
   - ☐ School
   - ☐ Indian reservation/trust lands
   - ☐ Military installation
   - ☐ Jail/detention facility
   - ☐ Sidewalk
   - ☐ Roadway
   - ☐ Driveway
   - ☐ Other parking area
   - ☐ State or county park, other recreation area
   - ☐ Hospital
   - ☐ Other, specify:
   - ☐ U/K

4. Type of area: ○ Urban ○ Suburban ○ Rural ○ Frontier ○ U/K

5. Incident state:

6. Incident county:

7. Was the death attributed (either directly or indirectly) to an extreme weather event, emergency medical situation, natural disaster or mass shooting?
   ○ Yes ○ No ○ U/K
   If yes, specify the type of event (e.g., tornado, heat wave, flood, medical crisis, etc.) and general circumstances surrounding the death:
   If yes, specify the name of the event if applicable (e.g., Paradise Wild Fire, Hurricane Irma, COVID-19, etc.):

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

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

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

If yes, by whom?
- ☐ EMS
- ☐ Parent/relative
- ☐ Other caretaker/babysitter
- ☐ Teacher/coach/athletic trainer
- ☐ Other acquaintance
- ☐ Health care professional, if death occurred in a hospital setting
- ☐ Stranger
- ☐ Other, specify:

If yes, type of resuscitation:
- ☐ CPR
- ☐ Automated External Defibrillator (AED)
  - If no AED, was AED available/accessible? ○ Yes ○ No ○ U/K
  - If AED, was shock administered? ○ Yes ○ No ○ U/K
    - If yes, how many shocks were administered?____
- ☐ Rescue medications, including naloxone, specify type:
- ☐ Other, specify:

If yes, was a rhythm recorded?
○ Yes ○ No ○ U/K

If yes, what was the rhythm?
_____

11. At time of incident leading to death, had child used drugs or alcohol?
    ○ N/A ○ Yes ○ No ○ U/K
    If yes, check all that apply:
    - ☐ Alcohol
    - ☐ Cocaine
    - ☐ Marijuana
    - ☐ Methamphetamine
    - ☐ Opioids
    - ☐ Prescription drugs
    - ☐ Over-the-counter drugs
    - ☐ Other, specify:
    - ☐ U/K

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

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

F. INVESTIGATION INFORMATION

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

1. Was a death investigation conducted+? ○ Yes ○ No ○ U/K
   If yes, check all that apply:
   - ☐ Medical examiner
   - ☐ Coroner
   - ☐ ME investigator
   - ☐ Coroner investigator
   - ☐ Law enforcement
   - ☐ Fire investigator
   - ☐ EMS
   - ☐ Child Protective Services
   - ☐ Other, specify:
   - ☐ U/K

   If yes, which of the following death investigation components were completed?

	Yes	No	U/K	If yes, shared with review team?
CDC's SUIDI Reporting Form or jurisdictional equivalent	○	○	○	○ Yes ○ No
Narrative description of circumstances	○	○	○	○ Yes ○ No
Scene photos	○	○	○	○ Yes ○ No
Scene recreation with doll	○	○	○	○ Yes ○ No
Scene recreation without doll	○	○	○	○ Yes ○ No
Witness interviews	○	○	○	○ Yes ○ No

   If yes, was a death scene investigation conducted at the place of incident? ○ Yes ○ No ○ U/K

2. What additional information would the team like to have known about the death scene investigation+?

3. Death referred to[+]:
○ Medical examiner ○ Not referred
○ Coroner ○ U/K

4. Person declaring official cause and manner of death[+]:
○ Medical examiner ○ Hospital physician ○ Mortician ○ U/K
○ Coroner ○ Other physician ○ Other, specify:

5. Autopsy performed? ○ Yes ○ No ○ U/K
If yes, conducted by: ○ Forensic pathologist ○ Unknown type pathologist
○ Pediatric pathologist ○ Other physician
○ General pathologist ○ Other, specify:
○ U/K
If yes, was a specialist consulted during autopsy (cardiac, neurology, etc.)?
○ Yes ○ No ○ U/K If yes, specify specialist:
If no, why not (e.g. parent or caregiver objected)?

6. Were the following assessed either through the autopsy or through information collected prior to the autopsy? Please list any abnormalities/significant findings in F10.

	Yes	No	U/K
Imaging:			
X-ray - single	○	○	○
X-ray - multiple views	○	○	○
X-ray - complete skeletal series	○	○	○
Other imaging, specify (includes MRI, CT scan, photos of the brain, etc):	○	○	○
External Exam:			
Exam of general appearance	○	○	○
Head circumference	○	○	○
Other Autopsy Procedures:			
Gross examination of organs done?	○	○	○
Were weights of any organs taken?	○	○	○

7. Were any of these additional tests performed at or prior to the autopsy? Please list any abnormalities/significant findings in F10.

	Yes	No	U/K
Cultures for infectious disease	○	○	○
Microscopic/histologic exam	○	○	○
Postmortem metabolic screen	○	○	○
Vitreous testing	○	○	○
Genetic testing	○	○	○

8. Was any toxicology testing performed on the child? ○ Yes ○ No ○ U/K
If yes, what were the results? Check all that apply: ☐ Negative ☐ Cocaine ☐ Methamphetamine ☐ Too high Rx drug, specify: ☐ Other, specify:
☐ Alcohol ☐ Marijuana ☐ Opioids ☐ Too high OTC drug, specify: ☐ U/K

9. Was the child's medical history reviewed as part of the autopsy[+]? ○ Yes ○ No ○ U/K
If yes, did this include:
Review of the newborn metabolic screen results? ○ Yes ○ No ○ U/K ○ Not performed
Review of neonatal CCHD screen results? ○ Yes ○ No ○ U/K ○ Not performed

10. Describe any abnormalities or other significant findings noted in the autopsy[+]:

11. What additional information would the team like to have known about the autopsy[+]?

12. Was there agreement between the cause of death listed on the autopsy report and on the death certificate[+]? ○ N/A ○ Yes ○ No ○ U/K
If no, describe the differences:

13. Was a CPS record check conducted as a result of death[+]? ○ Yes ○ No ○ U/K

14. Did the child ever have any injuries that were suspicious of child abuse[+]? ○ Yes ○ No ○ U/K
If yes, what injuries were found?
☐ Skin injury ☐ Broken bones ☐ Abdominal injury
☐ Mouth injury ☐ Head injury ☐ U/K
☐ Burns

15. Did any investigation find evidence of prior abuse[+]? ○ N/A ○ Yes ○ No ○ U/K
If yes, from what source?
☐ From x-rays ☐ From law enforcement
☐ From autopsy ☐ U/K
☐ From CPS review

16. CPS action taken because of death[+]? ○ N/A ○ Yes ○ No ○ U/K
If yes, highest level of action taken because of death:
○ Report screened out and not investigated
○ Unsubstantiated
○ Inconclusive
○ Substantiated
If yes, what services or actions resulted? Check all that apply:
☐ Voluntary services offered ☐ Court-ordered out of home placement
☐ Voluntary services provided ☐ Children removed
☐ Court-ordered services provided ☐ Parental rights terminated
☐ Voluntary out of home placement ☐ U/K

17. If death occurred in licensed setting (see E3), indicate action taken[+]:
○ No action
○ License suspended
○ License revoked
○ Investigation ongoing
○ Other, specify:
○ U/K

G. OFFICIAL MANNER AND PRIMARY CAUSE OF DEATH

1. Enter the cause of death code (ICD-10) assigned to this case by Vital Records using a capital letter and corresponding number (e.g., W75 or V94.4) and include up to one decimal place if applicable: _____ ☐ U/K

2. Enter the following information exactly as written on the death certificate: ☐ U/K
Immediate cause (final disease or condition resulting in death):
a.
Sequentially list any conditions leading to immediate cause of death. In other words, list underlying disease or injury that initiated events resulting in death:
b.
c.
d.

3. Enter other significant conditions contributing to death but not the underlying cause(s) listed in G2 exactly as written on the death certificate: ☐ U/K

4. If injury, describe how injury occurred exactly as written on the death certificate: ☐ U/K

5. Official manner of death from the death certificate:

- ○ Natural
- ○ Accident
- ○ Suicide
- ○ Homicide
- ○ Undetermined
- ○ Pending
- ○ U/K

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

6. Primary cause of death: Choose 1 of the 4 major categories, then a specific cause. For pending, choose most likely cause.

○ From an external cause of injury. Select one:

- ○ Motor vehicle and other transport, go to H1
- ○ Fire, burn, or electrocution, go to H2
- ○ Drowning, go to H3
- ○ Asphyxia, go to H4
- ○ Bodily force or weapon, go to H5
- ○ Fall or crush, go to H6
- ○ Poisoning, overdose or acute intoxication, go to H7
- ○ Undetermined injury, go to I1
- ○ Other cause, go to H9
- ○ U/K, go to I1

○ From a medical cause. Select one and go to H8:

- ○ Asthma/respiratory, specify:
- ○ Cancer, specify:
- ○ Cardiovascular, specify:
- ○ Congenital anomaly, specify:
- ○ COVID-19
- ○ Diabetes
- ○ HIV/AIDS
- ○ Influenza
- ○ Low birth weight
- ○ Malnutrition/dehydration
- ○ Neurological/seizure disorder
- ○ Pneumonia, specify:
- ○ Prematurity
- ○ SIDS
- ○ Other infection, specify:
- ○ Other perinatal condition, specify:
- ○ Other medical condition, specify:
- ○ Undetermined medical cause
- ○ U/K

○ Undetermined if injury or medical cause, go to I1

○ U/K, go to I1

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

H1. MOTOR VEHICLE AND OTHER TRANSPORT

a. Vehicles involved in incident:

Total number of vehicles: _____

Child's	Other primary vehicle	
○	○	None
○	○	Car
○	○	Van
○	○	Sport utility vehicle
○	○	Truck
○	○	Semi/tractor trailer

b. Position of child:

- ○ Driver
- ○ Passenger
  - ○ Front seat
  - ○ Back seat
  - ○ Truck bed
  - ○ Other, specify:
  - ○ U/K
- ○ On bicycle

If passenger, relationship of driver to child:

- ○ Biological parent
- ○ Adoptive parent
- ○ Stepparent
- ○ Foster parent
- ○ Parent's partner
- ○ Grandparent

○	○	RV/bus/school bus			○	Pedestrian	○ Sibling
○	○	Motorcycle				○ Walking	○ Other relative
○	○	Tractor/farm vehicle				○ Boarding/blading	○ Friend
○	○	All terrain vehicle				○ Other, specify:	○ Other, specify:
○	○	Snowmobile				○ U/K	○ U/K
○	○	Bicycle			○	U/K	
○	○	Train/subway/trolley Other, specify:					
○	○						
○	○	U/K					

Autonomous?

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

If bicycle, boarding/blading or other, was the child riding something electric?

○ Yes ○ No ○ U/K

c. Did any of the following contribute to the incident? Check all that apply:

☐ None listed below	☐ Poor sight line
☐ Speeding over limit	☐ Road hazard
☐ Unsafe speed for conditions	☐ Car changing lanes
☐ Recklessness	☐ Driver inexperience
☐ Carelessness	☐ Electronic use e.g., cell phone, smart watch,in-car navigation
☐ Racing, not authorized	
☐ Drug use	☐ Driver distraction
☐ Alcohol use	☐ Ran stop sign or red light
☐ Vehicle ran over child	☐ Other driver error, specify:
☐ Vehicle flipped over	☐ Other, specify:
☐ Poor weather	☐ U/K
☐ Poor visibility	

d. Location of incident, check all that apply:

- ☐ City street
- ☐ Residential street
- ☐ Rural road
- ☐ Highway
- ☐ Intersection
- ☐ Driveway
- ☐ Parking area
- ☐ Off road
- ☐ RR xing/tracks
- ☐ Other, specify:
- ☐ U/K

e. Did driving conditions factor into this incident?

○ Yes ○ No ○ U/K

If yes, check all that apply:

- ☐ Loose gravel
- ☐ Ice/snow
- ☐ Wet
- ☐ Inadequate lighting
- ☐ Other, specify:
- ☐ U/K

f. Incident type:

- ○ Child *not* in/on a vehicle, but struck by vehicle
- ○ Child in/on a vehicle, struck by the other vehicle
- ○ Child in/on a vehicle that struck the other vehicle
- ○ Child in/on a vehicle that struck person/ object/ran off the road
- ○ Other event, specify:

g. Driver who was responsible for the incident. Vehicles include motorized vehicles (cars, SUVs, motorbikes, etc) but also bicycles, skates, scooters, and other wheeled conveyances, whether motorized or not.

- ○ Child was responsible as driver of vehicle, including single vehicle incidents
- ○ Driver of child's vehicle was responsible, including single vehicle incidents
- ○ Driver of the other vehicle was responsible, including child as pedestrian hit by vehicle
- ○ Multiple drivers were responsible, go to j

○ U/K

○ Unable to determine driver responsible, go to j
○ Other, specify:
○ U/K

h. Age and license type of driver responsible for incident, check all that apply:

Age of Driver (if not child) — License type/violation:

○ <16 years — Has no ☐ license
○ 16 to 18 years old — Has a ☐ learner's permit
○ 19 to 21 years old — Has a ☐ graduated license
○ 22 to 29 years old — Has a ☐ full license
○ 30 to 65 years old — Has a ☐ full license that has been restricted
○ >65 years old ☐ Has a suspended license
○ U/K — Was violating ☐ graduated licensing rules
☐ Other, specify:
☐ U/K

i. Total number of occupants in vehicle responsible for incident:

☐ N/A

Total number of occupants: _____ ☐ U/K

Number of teens, ages 14-21: _____ ☐ U/K

j. Was a restraint or safety measure used by the child?

○ Yes ○ No ○ U/K

If yes, select the restraint or safety measures used:

☐ Lap/shoulder belt
☐ Child seat
☐ Belt positioning booster seat
☐ Helmet
☐ U/K

If yes, describe:

H2. FIRE, BURN, OR ELECTROCUTION

a. Ignition, heat or electrocution source:

○ Matches ○ Heating stove ○ Lightning
○ Cigarette lighter ○ Space heater ○ Hot bath water
○ Cigarette or cigar ○ Power line ○ Other, specify:
○ Candles ○ Electrical outlet ○ U/K
○ Cooking stove ○ Electrical wiring

b. Type of incident:

○ Fire, go to c
○ Scald, go to I1
○ Electrocution, go to o
○ U/K, go to I1

c. Type of building on fire:

○ N/A ○ Trailer/mobile home
○ Single home ○ Other, specify:
○ Row home/townhouse ○ U/K
○ Multi-unit (duplex, apartment, condo)

d. Fire started by a person?

○ Yes ○ No ○ U/K

If yes, person's age:

If yes, did the person have a history of starting fires?

○ Yes ○ No ○ U/K

If yes, suspected arson?

○ Yes ○ No ○ U/K

e. Did any factors delay fire department arrival?

○ Yes ○ No ○ U/K

If yes, specify:

f. Were barriers preventing safe exit?

○ Yes ○ No ○ U/K

If yes, check all that apply:

☐ Locked/blocked door ☐ Smoke/fire
☐ Window security bars ☐ Household items/ hoarding
☐ Locked/blocked window
☐ Blocked stairway ☐ Other, specify:
☐ Trapped above first floor ☐ U/K

g. Was the child found in the same location as where the fire started?

○ Yes ○ No ○ U/K

h. Was building a rental property?

○ Yes ○ No ○ U/K

i. Were building/rental codes violated?

○ Yes ○ No ○ U/K

If yes, describe in narrative.

j. Were proper working fire extinguishers

k. Was fire sprinkler system present?

l. Was fire sprinkler system required?

present? ○ Yes ○ No ○ U/K	○ Yes ○ No ○ U/K	○ Yes ○ No ○ U/K
m. Were smoke alarms present? ○ Yes ○ No ○ U/K Were they functioning properly? ○ Yes ○ No ○ U/K	n. Did the child or family (check all that apply): ☐ None listed below ☐ Have a fire escape plan ☐ Practice a home fire drill ☐ Have two or more possible exits from the location as where the child was found ☐ Attempt to put out the fire ☐ U/K	
o. For electrocution, what cause: ○ Lightning/electrical storm ○ Wire/product in water ○ U/K ○ Faulty wiring ○ Child playing with outlet ○ Contact with power line ○ Other, specify:		

H3. DROWNING

a. Where was child last seen before drowning? Select one. ○ In water ○ Near water ○ In yard ○ In bathroom/tub ○ In house ○ In car ○ Other, specify: ○ U/K	b. Drowning location: ○ Open water/pond, go to c ○ Pool, hot tub, spa, go to f ○ Bathtub, go to I1 ○ Other, specify and go to h ○ U/K, go to h	c. For open water, place: ○ Lake ○ Ocean ○ River ○ Quarry or gravel pit ○ Pond ○ Canal/drainage ditch ○ Creek ○ U/K d. Was child boating? ○ Yes ○ No ○ U/K	e. Select all contributing environmental factors. Check all that apply. ☐ None ☐ Dropoff ☐ Weather ☐ Rough waves ☐ Temperature ☐ Flash flood ☐ Current ☐ Water clarity ☐ Riptide/undertow ☐ U/K
f. For pool, type of pool: ○ Above-ground ○ In-ground ○ Hot tub, spa ○ Wading ○ U/K	g. For pool, ownership is: ○ Private ○ Public ○ U/K	h. Flotation device used at time of the incident? ○ N/A ○ No ○ Yes, specify: ○ U/K	i. Did the child depend on a life jacket, swim vest or swim aid while in or around water? ○ N/A ○ No ○ Yes ○ U/K

j. Did barriers/layers of protection e xist to prevent access to w ater? ○Yes ○ No ○U/K

If yes, check all that apply:

☐ Fence
Was it breached?
○ Yes ○ No ○ U/K
If yes, check all that apply:
☐ Climbed fence
☐ Gap in fence
☐ Damaged fence
☐ Fence too short

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

☐ Gate
Was it breached?
○ Yes ○ No ○ U/K
If yes, check all that apply:
☐ Gate left open
☐ Gate unlocked
☐ Gate latch failed
☐ Gap in gate

☐ Door
Was it breached?
○ Yes ○ No ○ U/K
If yes, check all that apply:
☐ Door left open
☐ Door unlocked
☐ Door broken
☐ Door screen torn
☐ Door self-closer failed

☐ Alarm ○ U/K
Was it breached? at apply:
○ Yes ○ : working
If yes, check all t : answered
☐ Alarm no
☐

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

No

Alarm no

k. Local ordinance(s) regulating access to water?

○Yes ○ No ○U/K

If yes, rules violated?

○Yes ○ No ○U/K

l. Select all of the child's water safety skills (without assistance or flotation device):

☐ None of these ☐ Tread water for 1 minute ☐ Swim 25 yards

☐ Float on their back ☐ Find a safe ☐ exit Exit
the water independently from the waterHad ☐ swimming

☐ Step or jump into ☐ Control breathing lessons
water over their head ☐ Return to surface ☐ U/K

m. Child able to swim?

○ N/A ○ No

○ Yes ○ U/K

n. Warning sign or label posted?

○ N/A ○ No

○ Yes ○ U/K

o. Lifeguard present?

○ N/A
○ Yes
○ No
○ U/K

p. Rescue attempt made? ○N/A ○Yes ○ No ○U/K

If yes, who? Check all that apply:

☐ ☐
☐ ☐
☐ ☐
☐ ☐
Parent/relativeEMS/first responder

If yes, did rescuer(s)

○
○
○
also drown?

Other childBystanderYes LifeguardOther, specify:No

Other adultU/KU/K

q. Appropriate rescue equipment present?

○N/A ○Yes ○No ○

If yes, was it used?

○Yes ○No ○U/K U/K

If no, describe:

H4. ASPHYXIA

a. Type of event:

○ Sleep-related, go to I1

○ Not sleep-related, go to b

○ U/K, go to b

b. If not sleep-related, was the event:

○ Suffocation, go to c

○ Strangulation, go to d

○ Choking, go to e

c. If suffocation, was the child:

○Covered in or fell into object

○Confined in tight space

○Wedged into tight space, specify:

	○ Other, go to I1	○ Other, specify:
d. If strangulation, object causing event: ○ Clothing ○ Electrical cord ○ Blind cord ○ Person, go to H5l ○ Car seat ○ Automobile power window or sunroof ○ Belt ○ Other, specify: ○ Rope/string ○ Leash ○ U/K	e. If choking, object causing choking: ○ Food, specify: ○ Toy, specify: ○ Vomit/gastric contents ○ Other, specify: ○ U/K	f. If choking, was Heimlich Maneuver attempted? ○ Yes ○ No ○ U/K

H5. BODILY FORCE OR WEAPON

a. Was the death a result of a weapon?	b. Type of weapon:	c. For firearms, type:	d. Was the firearm considered a smart firearm, e.g., uses a fingerprint lock, RFID watch?	e. Was firearm kept loaded?
○ Yes, go to b ○ No, death due to bodily force, go to l ○ U/K, go to b	○ Firearm, go to c ○ Knife or sharp instrument, go to l ○ Rope, go to l ○ Other, specify and go to l ○ U/K, go to l	○ Handgun ○ Shotgun ○ Rifle, specify: ○ 3D gun ○ Other, specify: ○ U/K	○ Yes ○ No ○ U/K	○ Yes ○ No ○ U/K If no, was the ammunition stored locked? ○ Yes ○ No ○ U/K

f. Was the firearm kept locked?	i. Was the person handling the firearm the owner?	l. Use of weapon at time, check all that apply:
○ Yes ○ No ○ U/K	○ Yes ○ No ○ U/K	☐ Self injuryHunting ☐ ☐ Commission of crimeTarget ☐ shooting ☐ Drug dealing/trading ☐ Playing with weapon ☐ Drive-by shootingShowing ☐ gun to others ☐ Random violenceRussian ☐ roulette ☐ Child abuse ☐ Gang-related activity ☐ Child was a bystander ☐ Self-defense ☐ Argument Cleaning weapon ☐ ☐ JealousyLoading weapon ☐ ☐ Intimate partner ☐ violenceOther, specify: ☐ Hate crime
g. Did the shooter of the firearm have permission to use the firearm at the time of incident? ○ Yes ○ No ○ U/K	j. Owner of fatal firearm: ○ Caregiver ○ Other family member ○ Child's significant other ○ Friend/acquaintance ○ Stranger ○ Other, specify: ○ U/K	
h. Did the caregiver or supervisor know a firearm was present at the time of	k. Was the firearm stolen? ○ Yes	

incident? ○ Yes ○ No ○ U/K	○ No ○ U/K	☐ Bullying ☐ U/K

m. Type of bodily force used. Check all that apply:

☐ Beat, kick or ☐ punch ☐ Bite ☐ Throw ☐ Other, ☐ specify: ☐
☐ Drop ☐ Shake ☐ Drown ☐ ☐
☐ ☐ Push ☐ Strangle/choke ☐ Burn ☐ U/K ☐ ☐

H6. FALL OR CRUSH

a. Type:

○ Fall, go to b
○ Crush, go to g

b. Height of fall:

_____ feet
_____ ☐ inches
U/K

c. Child fell from:

○ Open window ○ Natural elevation ○ Stairs/steps ○ Moving object, specify: ○ Animal, specify:

Screen? ○ ○ ○
No
U/K if screen

○ Man-made
○
○
○
elevation Furniture Bridge Other, specify:
screen Playground equipment Bed Overpass Tree Roof Balcony U/K

d. Surface child fell onto:

○ ○
○ ○
○ ○
○
○ ○
Cement/concrete Linoleum/vinyl
Grass Marble/tile
Gravel Other, specify:
Wood floor
Carpeted floor U/K

e. Barrier in place, check all that apply::

☐ None Stairway ☐
☐ Screen Gate ☐
☐ Other window ☐ guard Other,
☐ specify: ☐
☐ Fence U/K
Railing

f. Was child pushed, dropped or thrown?

○ Yes ○ No ○ U/K

If yes, go to H5l

g. For crush, did child:

○ Climb up on
○ object Pull object
○ down
○
○ Hide behind object
○ Go behind object
○ Fall out of object
○ Other, specify:

U/K

h. For crush, object causing crush:

○ ○
○ ○
○ ○
○ ○
○
○
○ ○
○ ○
Appliance Boulders/rocks
Television Dirt/sand
Furniture Person, go to H5l
Walls Commercial
Playground equipment equipment Farm equipment Animal Other, specify:

Tree branch U/K

H7. POISONING, OVERDOSE OR ACUTE INTOXICATION

a. Type of substance involved, check all that apply and note source, storage, and route of administration of substance: ☐ U/K

Source of Substance
1 = Bought from dealer or stranger (Prescription or illicit only)
2 = Bought from friend or relative
3 = From friend or relative for free
4 = Took from friend or relative without asking
5 = Own prescription (Prescription only)
6 = Bought from store/pharmacy (OTC or other substances only)
7 = Other
9 = U/K

Stored in locked cabinet?
Yes
No
U/K

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

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

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

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

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

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

b. Was the incident the result of?
○ Accidental overdose/acute intoxication
○ Medical treatment mishap
○ Deliberate poisoning
○ Other, specify:
○ U/K

c. Did the child have a prescription for a controlled substance within the previous 24 months?
○ Yes ○ No ○ U/K

d. Did child have a non-fatal overdose within the previous 12 months?
○ Yes
○ No
○ U/K

e. Was Poison Control contacted?
○ Yes
○ No
○ U/K

f. For CO poisoning, was a CO alarm present?
○ Yes
○ No
○ U/K

H8. MEDICAL CONDITION

This section is skipped for fetal deaths+

a. How long did the child have the medical condition?
○ In utero
○ Since birth
○ < 1 day
○ 1-6 days
○ 7-30 Days
○ 1-11 months
○ >= 1 year
○ U/K

b. Was the death expected as a result of the medical condition?
☐ N/A, not previously diagnosed
○ Yes ○ No ○ U/K
☐ But at a later date

c. Was child receiving health care for the medical condition?
○ Yes ○ No ○ U/K
If yes, within 48 hours of the death?
○ Yes ○ No ○ U/K
If yes, was the care plan appropriate for the medical condition?
○ N/A ○ Yes ○ No ○ U/K
If no, specify:

d. Did the family experience barriers that prohibited following the care plan?
○ N/A
○ Yes
○ No
○ U/K
If yes, what treatment components were not completed? Check all that apply.
☐ Appointments
☐ Medications, specify:
☐ Medical equipment use, specify:
☐ Therapies, specify:
☐ Other, specify:
☐ U/K

e. In the week prior to the death, did the child experience any changes to medical care?
○ Yes, describe:
○ No
○ U/K

f. Was the medical condition associated with an outbreak?
○ Yes, specify:
○ No
○ U/K
If yes, was the child vaccinated?
○ Yes ○ No ○ U/K

g. Was the death potentially caused by a medical error?
○ Yes ○ No ○ U/K

h. Was the medical condition that caused the death a result of a complication or side effect of a previous illness, injury, condition, or medical treatment?
○ Yes ○ No ○ U/K

H9. OTHER KNOWN INJURY CAUSE

Specify cause, describe in detail:

I. OTHER CIRCUMSTANCES OF INCIDENT - ANSWER RELEVANT SECTIONS

I1. SUDDEN AND UNEXPECTED DEATH IN THE YOUNG (SDY)

This section displays online based on your state's settings.

Section I1: OMB No. 0920-1092, Exp. Date: 9/30/2025

a. Was this death:A
- ○ homicide?
- ○ A suicide?
- ○ An overdose?If any of these apply, go to Section I2,
- ○ A result of an external cause that was the obvious and only reason for the fatal injury?THIS IS NOT AN SDY CASE.
- ○ Expected within 6 months due to terminal illness?
- ○ None of the above, go to I1b THIS IS AN SDY CASE
- ○ U/K, go to I1b

b. Did the child have a history of any of the following acute conditions or symptoms within 72 hours prior to death?

Symptom	Present w/in 72 hours of death		
Cardiac	Yes	No	U/K
Chest pain	○	○	○
Dizziness/lightheadedness	○	○	○
Fainting	○	○	○
Palpitations	○	○	○
Neurologic			
Concussion	○	○	○
Confusion	○	○	○
Convulsions/seizure	○	○	○
Headache	○	○	○
Head injury	○	○	○
Respiratory			
Asthma	○	○	○
Pneumonia	○	○	○
Difficulty breathing	○	○	○
Other Acute Symptoms			
Fever	○	○	○
Muscle aches/cramping	○	○	○
Vomiting	○	○	○
Other, specify:	○		

c. At any time more than 72 hours preceding death did the child have a personal history of any of the following chronic conditions or symptoms?

Symptom	Present more than 72 hours of death		
Cardiac	Yes	No	U/K
Chest pain	○	○	○
Dizziness/lightheadedness	○	○	○
Fainting	○	○	○
Palpitations	○	○	○
Neurologic			
Concussion	○	○	○
Confusion	○	○	○
Convulsions/seizure	○	○	○
Head injury	○	○	○
Respiratory			
Difficulty breathing	○	○	○
Other			
Other, specify:	○		

d. Did the child have any prior serious injuries (e.g. near drowning, car accident, brain injury)?

○ Yes ○ No ○ U/K

If yes, describe:

e. Had the child in the past ever been diagnosed by a medical professional for the following?

Condition	Diagnosed	Condition	Diagnosed	Condition	Diagnosed
Blood disease	Y N U	**Cardiac (continued)**	Y N U	**Neurologic (continued)**	Y N U
Sickle cell disease	○ ○ ○	High cholesterol	○ ○ ○	Neurodegenerative disease	○ ○ ○
Sickle cell trait	○ ○ ○	Hypertension	○ ○ ○	Stroke/mini stroke/	○ ○ ○
Thrombophilia (clotting disorder)	○ ○ ○	Myocarditis (heart infection)	○ ○ ○	TIA- Transient Ischemic	
Cardiac	Y N U	Pulmonary hypertension	○ ○ ○	Attack	
	○ ○ ○		○ ○ ○		
Abnormal electrocardiogram (EKG or ECG)		Sudden cardiac arrest		Central nervous system infection (meningitis	○ ○ ○
		Neurologic	Y N U		
Aneurysm or aortic dilatation	○ ○ ○	Anoxic brain Injury or encephalitis)	○ ○ ○		
	○ ○ ○	Arrhythmia/arrhythmia syndrome		Traumatic brain injury/ **Respiratory**	Y N U
Cardiomyopathy	○ ○ ○	head injury/concussion	○ ○ ○	Apnea	○ ○ ○
Congenital heart disease	○ ○ ○	Brain tumor	○ ○ ○	Asthma	○ ○ ○
Coronary artery abnormality	○ ○ ○	Brain hemorrhage	○ ○ ○	Pulmonary embolism	○ ○ ○
Endocarditis	○ ○ ○	Developmental brain disorder	○ ○ ○	Pulmonary hemorrhage	○ ○ ○
Heart failure	○ ○ ○	Epilepsy/seizure disorder	○ ○ ○	Respiratory arrest	○ ○ ○
Heart murmur		Febrile seizure			

Condition (continued)	Diagnosed		Diagnosed		Diagnosed
Other	Y N U		Y N U		Y N U
Connective tissue disease	○ ○ ○	Kidney disease	○ ○ ○	Oncologic disease treated by chemotherapy or radiation	○ ○ ○
	○ ○ ○	Mental illness/psychiatric disease	○ ○ ○		
Endocrine disorder, other: thyroid, adrenal, pituitary	○ ○ ○	Metabolic disease	○ ○ ○	Prematurity	○ ○ ○
		Muscle disorder or muscular dystrophy	○ ○ ○	Congenital disorder/ genetic syndrome	○ ○ ○
Hearing problems or deafness	○ ○ ○			Other, specify:	○ ○ ○

If a more specific diagnosis is known, provide any additional information:

If any cardiac conditions above are selected, what cardiac treatments did the child have? Check all that apply:

☐ None

☐ Cardiac ablation

☐ Cardiac device placement (implanted cardioverter defibrillator (ICD) or pacemaker or Ventricular Assist Device (VAD))

☐ Heart surgery

☐ Interventional cardiac catheterization

☐ Heart transplant

☐ Other, specify:

☐ U/K

Diabetes

f. Did the child have any blood relatives (brothers, sisters, parents, aunts, uncles, cousins, grandparents or other more distant relatives) with the following diseases, conditions or symptoms?

Y	N	U	**Deaths**
○	○	○	Sudden unexpected death before age 50

If yes, the type of event, which relative, and relative's age at death (for example, brother at age 30 who died in an unexplained motor vehicle accident (driver of car)):

Heart Disease	Y	N	U	**Symptoms**
Heart condition/heart attack or stroke before age 50	○	○	○	Febrile seizures
	○	○	○	Unexplained fainting

If yes, describe:

g. Has any blood relative (siblings, parents, aunts, uncles, cousins, grandparents) had genetic testing?

○ Yes ○ No ○ U/K

If yes, describe the test/gene tested, reason for testing, family member tested, and results:

○ ○ ○ Aortic aneurysm or aortic rupture

○ ○ ○ Arrhythmia (fast or irregular heart rhythm)

○ ○ ○ Cardiomyopathy Connective tissue disease

○ ○ ○ Congenital heart diseaseMitochondrial disease

Neurologic Disease Muscle disorder or muscular dystrophy

○ ○ ○ Epilepsy or convulsions/seizureThrombophilia

○ ○ ○ Other neurologic diseaseOther diseases that are

Other Diagnoses

○ ○ ○ Congenital deafness

○ ○ ○

○ ○ ○

○ ○ ○

○ ○ ○ (clotting disorder)

○ genetic or run in families, specify:

Was a gene mutation found?

○ Yes ○ No ○ U/K

h. In the 72 hours prior to death was the child taking any prescribed medication(s)? ○ Yes ○ No ○ U/K

If yes, describe:

i. Within 2 weeks prior to death had the child:

	N/A	Yes	No	U/K
Taken extra doses of prescribed medications	○	○	○	○
Missed doses of prescribed medications	○	○	○	○
Changed prescribed medications, describe:	○	○	○	○

j. Was the child compliant with their prescribed medications?

○ N/A ○ Yes ○ No ○ U/K

If not compliant, describe why and how often:

k. Was the child taking any of the following substance(s) within 24 hours of death?

Check all that apply:

☐ Over-the-counter medicine ☐ Alcohol

☐ Energy drinks ☐ Illegal drugs

☐ Caffeine ☐ Legalized marijuana

☐ Performance enhancers ☐ Other, specify:

☐ Supplements

☐ Tobacco ☐ U/K

If yes to any items above, describe:

l. Did the child experience any of the following stimuli at time of incident or within 24 hours of the incident? **At**

	incident			**Within 24 hrs of incident**		
Stimuli	Yes	No	U/K	Yes	No	U/K
Physical activityIf yes to	○	○	○	○	○	○
	○	○	○	○	○	○
Driving	○	○	○	○	○	○
Visual/video game stimuli	○	○	○	○	○	○
Emotional stimuli	○	○	○	○	○	○
Auditory stimuli/startle	○	○	○	○	○	○
Physical traumaOther	○			○		

physical activity, describe type of activity:

Sleep deprivationAt incidentWithin 24 hours of incident

specify:

Other, specify:At incident

Within 24 hours of incident

m. Was the child an athlete? ○ N/A ○ Yes ○ No ○ U/K

If yes, type of sport: Competitive ○ Recreational ○ U/K

If competitive, did the child participate in the 6 months prior to death? ○ Yes ○ No ○ U/K

n. Did the child ever have any of the following **uncharacteristic** symptoms during or within 24 hours after physical activity? Check all that apply:

- ☐ Chest pain
- ☐ Palpitations
- ☐ Convulsions/seizure
- ☐ Shortness of breath/difficulty breathing
- ☐ Dizziness/lightheadedness
- ☐ Other, specify:
- ☐ Fainting
- ☐ U/K

If yes to any item, describe type of physical activity and extent of symptoms:

o. For child age 12 or older, did the child receive a pre-participation exam for a sport? ○ N/A ○ Yes ○ No ○ U/K

If yes:

Was it done within a year prior to death? ○ Yes ○ No ○ U/K

Did the exam lead to restrictions for sports or otherwise?

○ Yes ○ No ○ U/K

If yes, specify restrictions:

Questions p through v: Answer if "Epilepsy/Seizure Disorder" is answered Yes in question e above (Diagnosed for a medical condition)

p. How old was the child when diagnosed with epilepsy/seizure disorder?

Age 0 (infant) through 20 years: _____

☐ U/K

q. What were the underlying cause(s) of the child's seizures? Check all that apply:

- ☐ Brain injury/trauma, specify:
- ☐ Brain tumor
- ☐ Cerebrovascular
- ☐ Central nervous system infection
- ☐ Developmental brain disorder
- ☐ Genetic/chromosomal
- ☐ Idiopathic or cryptogenic
- ☐ Other acute illness or injury other than epilepsy
- ☐ Other, specify:
- ☐ U/K

r. What type(s) of seizures did the child have? Check all that apply:

- ☐ Non-convulsive
- ☐ Convulsive (grand mal seizure or generalized tonic-clonic seizure)
- ☐ Occur when exposure to strobe lights, video game, or flickering light (reflex seizure)
- ☐ U/K

s. Describe the child's epilepsy/seizures (not including the seizure at time of death). Check all that apply:

- ☐ Last less than 30 minutes
- ☐ Last more than 30 minutes (status epilepticus)
- ☐ Occur in the presence of fever (febrile seizure)
- ☐ Occur in the absence of fever
- ☐ Occur when exposed to strobe lights, video game, or flickering light (reflex seizure)

t. How many seizures did the child have in the year preceding death?

○ 0/never ○ 2 ○ More than 3
○ 1 ○ 3 ○ U/K

u. Did treatment for seizures include anti-epileptic drugs?

○ Yes ○ No ○ U/K

If yes, how many different types of antiepileptic drugs did the child take?

○ 1 ○ 4 ○ More than 6
○ 2 ○ 5 ○ U/K
○ 3 ○ 6

v. Was night surveillance used?

○ Yes ○ No ○ U/K

I2. ANSWER THIS ONLY IF CHILD IS UNDER AGE FIVE:

Yes, go to I2a No, go to I2tU/K, go to I2a **WAS DEATH RELATED TO SLEEPING OR THE ○ SLEEP ○ ○ ENVIRONMENT[+]?**

a. Incident sleep place:

CribAdult bedRocking-inclined If adult bed, what type? If car seat, was car seat

If crib, type:WaterbedsleeperTwinsecured in seat of car?

Not portableFutonStrollerFull ○ Yes ○ No ○ U/K

PortableCouchSwingQueen

Unknown crib

BassinetFloorOther,

Bed side sleeperCar

Baby box

typeChairBouncy chairKing

specify:Other, specify:

seatU/KU/K

b. Child put to sleep:	c. Child found:	e. Usual sleep position:	f. Was there any type of crib, portable crib or bassinet in home for child?
○ On back ○ On stomach ○ On side ○ U/K	○ On back ○ On stomach ○ On side ○ U/K	○ On back ○ On stomach ○ On side ○ U/K	○ Yes ○ No ○ U/K

d. Usual sleep place:

CribAdult bedRocking- inclinedIf adult bed, what type?

If crib,

Not

Unknown crib

BassinetFloorOther, specify:

Bed side sleeperCar seatU/K

Baby box

typeChairBouncy chair

type:WaterbedsleeperTwinKing

portableFutonStrollerFullOther, specify:

PortableCouchSwingQueenU/K

g. Child in a new or different environment than usual?	h. Child last placed to sleep with a pacifier?	i. Child wrapped or swaddled in blanket when last placed?
○ Yes ○ No ○ U/K If yes, describe why:	○ Yes ○ No ○ U/K	○ Yes ○ No ○ U/K If yes, describe:

j. Child overheated? ○ Yes ○ No ○ U/K	k. Child exposed to second hand smoke?
Check all that apply: ☐ Room too hot, temp ____ degrees F ☐ Too much bedding ☐ Too much clothing	○ Yes ○ No ○ U/K If yes, how often: ○ Frequently ○ U/K ○ Occasionally

l. Child's face when found:	m. Child's neck when found:	n. Child's airway when found (includes was obstructed? nose, mouth, neck
○ Down ○ Up ○ To left or right side ○ U/K	○ Hyperextended (head back) ○ Hypoextended (chin to chest) ○ Neutral ○ Turned U/K	○ compressed Unobstructed by ○ ○ Fully obstructed by person or Partially obstructed by person or ○ describe obstruction in object U/K

If fully or partially obstructed, what

☐ and/or ☐ chest): NoseChest

☐ person or ☐ objectMouthU/K

☐

objectNeck compressed

detail: If fully or partially obstructed,

o. Objects in child's sleep environment and relation to airway obstruction:

	Present?			On top of child			Under child		Next to child around child		Tangled			obstruct airway?		
	Yes	No	U/K					U/K			Yes	No	UK			
Adult(s)	○	○	○	☐			☐	☐	☐	☐	○	○	○	→	If adult(s) obstructed airway, describe relationship of adult to child (for example, childbearing parent):	
Other child(ren)	○	○	○	☐			☐	☐	☐	☐	○	○	○			
Animal(s)	○	○	○	☐			☐	☐	☐	☐	○	○	○			
Mattress	○	○	○	☐			☐	☐	☐	☐	○	○	○			
Comforter, quilt, or other	○	○	○	☐			☐	☐	☐	☐	○	○	○			
Fitted sheet	○	○	○	☐			☐	☐	☐	☐	○	○	○			
Thin blanket/flat sheet	○	○	○	☐			☐	☐	☐	☐	○	○	○			
Pillow(s)	○	○	○	☐			☐	☐	☐	☐	○	○	○			
Cushion	○	○	○	☐			☐	☐	☐	☐	○	○	○			
Nursing or U shaped pillow	○	○	○	☐			☐	☐	☐	☐	○	○	○			
Sleep positioner (wedge)	○	○	○	☐			☐	☐	☐	☐	○	○	○			
Bumper pads	○	○	○	☐			☐	☐	☐	☐	○	○	○			
Clothing	○	○	○	☐			☐	☐	☐	☐	○	○	○			
Bottle	○	○	○	☐			☐	☐	☐	☐	○	○	○			
Wearable monitor	○	○	○	☐			☐	☐	☐	☐	○	○	○			
Crib railing/side	○	○	○	☐			☐	☐	☐	☐	○	○	○			
Wall	○	○	○	☐			☐	☐	☐	☐	○	○	○			
Toy(s)	○	○	○	☐			☐	☐	☐	☐	○	○	○			
Other(s), specify:																
_____	○			☐			☐	☐	☐	☐	○	○	○			
_____	○			☐			☐	☐	☐	☐	○	○	○			

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

q. Caregiver/supervisor fell asleep while feeding child?

○Yes ○No ○ U/K

If yes, type of feeding: ○ Bottle ○ Breast ○ U/K

r. Child sleeping in the same room as caregiver/supervisor at time of death?

○Yes ○No ○U/K

s. Child sleeping on same surface with person(s) or animal(s)?

○ Yes ○ No ○ U/K

If yes, reasons stated for sleeping that apply: same surface, check all

☐ _____

☐

☐ To feedAdult obese: U/K

☐ To sootheWith other children: # _____# U/K Children's ages:_____

☐ Usual sleep patternWith animal(s): # _____# U/K Type(s) of animal: _____

☐ No infant bed availableU/K

☐ Home/living space overcrowded Other, specify:

U/K

on If yes, check all that apply:With adult(s): #

☐ # U/K

○Yes ○No ○

t. Is there a scene re-creation photo available for upload? ○ Yes ○No If yes, upload here. Only one photo allowed.

Select photo that demonstrates position and location of child's body and airway (nose, mouth, neck, and chest). Size must be less than 6 mb and in .jpg or .gif format.

I3. WAS DEATH A CONSEQUENCE OF A PROBLEM WITH A CONSUMER PRODUCT*? ○ Yes ○ No, go to I4 ○ U/K, go to I4

a. Describe product and circumstances:

b. Was product used properly?
○ Yes ○ No ○ U/K

c. Was a recall in place at the time of the incident?
○ Yes ○ No ○ U/K

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

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

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

a. Type of crime, check all that apply:
☐ Robbery/burglary ☐ Other assault ☐ Arson ☐ Illegal border crossing ☐ U/K
☐ Interpersonal violence ☐ Gang conflict ☐ Prostitution ☐ Auto theft
☐ Sexual assault ☐ Drug trade ☐ Witness intimidation ☐ Other, specify:

I5. CHILD ABUSE, NEGLECT, POOR SUPERVISION AND EXPOSURE TO HAZARDS

a. Did child abuse, neglect, poor or absent supervision or exposure to hazards cause or contribute to the child's death?
○ Yes/probable
○ No, go to next section
○ U/K, go to next section

If yes/probable, choose primary reason:
○ Child abuse, go to I5b
○ Child neglect, go to I5f
○ Poor/absent supervision, go to I5h
○ Exposure to hazards, go to I5g

b. Type of child abuse, check all that apply:
☐ Abusive head trauma, go to I5c
☐ Chronic Battered Child Syndrome, go to I5e
☐ Beating/kicking, go to I5e
☐ Scalding or burning, go to I5e
☐ Munchausen Syndrome by Proxy, go to I5e
☐ Sexual assault, go to I5h
☐ Other, specify and go to I5h
☐ U/K, go to I5e

c. For abusive head trauma, were there retinal hemorrhages?
○ Yes ○ No ○ U/K

d. For abusive head trauma, was the child shaken?
○ Yes ○ No ○ U/K
If yes, was there impact?
○ Yes ○ No ○ U/K

e. Events(s) triggering child abuse. check all that apply:
☐ None
☐ Crying
☐ Toilet training
☐ Disobedience
☐ Feeding problems
☐ Domestic argument
☐ Other, specify:
☐ U/K

f. Child neglect, check all that apply:
☐ Failure to provide necessities
☐ Food
☐ Shelter
☐ Other, specify:
☐ Failure to provide supervision
☐ Emotional neglect, specify:
☐ Abandonment, specify:
☐ Failure to seek/follow treatment, specify:
If yes, was this due to religious or cultural practices?
○ Yes ○ No ○ U/K

☐ Exposure to hazards:
Do not include child's own behavior.
○ Hazard(s) in sleep environment (including sleep position and surface sharing)
○ Fire hazard
○ Unsecured medication/poison
○ Firearm hazard
○ Water hazard
○ Motor vehicle hazard
○ Other hazard, specify:

g. Exposure to hazards:
Do not include child's own behavior.
○ Hazard(s) in sleep environment (including sleep position and surface sharing)
○ Fire hazard
○ Unsecured medication/poison
○ Firearm hazard
○ Water hazard
○ Motor vehicle hazard
○ Childbearing parent substance use during pregnancy
○ Other hazard, specify:

h. Was poverty a factor? ○ Yes ○ No ○ U/K If yes, explain in Narrative

I6. SUICIDE

a. Child's history. Check all that have ever applied:
☐ None listed below
☐ Involved in sports
☐ Involved in activities (not sports)
☐ Viewed, posted or interacted on social media
If yes, specify platform(s):
☐ History of running away
☐ History of fearfulness, withdrawal or anxiety
☐ History of explosive anger, yelling or disobeying
☐ History of head injury
If yes, when was the last head injury? _____
☐ Death of a peer, friend or family member
If yes, specify relationship to child: _____
When did death occur: _____
Was death a suicide? ○ Yes ○ No ○ U/K

b. Was the child ever diagnosed with any of the following? Check all that apply.
☐ None listed below
☐ Anxiety spectrum disorder
☐ Depressive spectrum disorder
☐ Bipolar spectrum disorder
☐ Disruptive, impulse control or conduct disorder
☐ Eating disorder
☐ Substance-related or addictive disorders
☐ Other, specify:
☐ U/K

c. Did child have a suicide safety plan (a document that helps individuals when experiencing thoughts of suicide to help them avoid intense suicidal crisis)?
○ Yes ○ No ○ U/K

d. Check all suicidal behaviors/attempts that ever applied:
☐ None listed below
☐ Preparatory behavior #__
☐ Aborted attempt #__
☐ Interrupted attempt #__
☐ Non-fatal attempt #__
☐ U/K

e. Did the child ever communicate any suicidal thoughts, actions or intent?
○ Yes ○ No ○ U/K
If yes, with whom? _____

f. Was there evidence the death was planned or premeditated?
○ Yes ○ No ○ U/K

g. Did the death occur under circumstances where it would likely be observed and intervened by others?
○ Yes ○ No ○ U/K

h. Did the child ever have a history of non-suicidal self-harm, such as cutting or burning oneself? ○ Yes ○ No ○ U/K

i. Warning signs (https://youthsuicidewarningsigns.org) w/in 30 days of death:
Check all that apply:

- ☐ None listed below
- ☐ Talked about or made plans for suicide
- ☐ Expressed hopelessness about the future
- ☐ Displayed severe/overwhelming emotional pain or distress
- ☐ Expressed perceived burden on others
- ☐ Showed worrisome behavioral cues or marked changes in behavior
- ☐ U/K

j. Child experienced a known crisis within 30 days of the death?
○ Yes ○ No ○ U/K
If yes, explain:

k. Suicide was part of: Check all that apply.
☐ None listed below ☐ A contagion, copy-cat or imitation ☐ A murder-suicide
☐ A cluster ☐ A suicide pact

I7. LIFE STRESSORS

Please indicate all stressors that were present for this child and family around the time of death.

a. Life stressors - Social/economic

- ☐ None listed below
- ☐ Racism
- ☐ Discrimination
- ☐ Poverty
- ☐ Neighborhood discord
- ☐ Job problems
- ☐ Money problems
- ☐ Food insecurity
- ☐ No phone
- ☐ Housing instability
- ☐ Witnessed violence
- ☐ Tobacco exposure
- ☐ Lack of transportation
- ☐ Cultural differences
- ☐ Language barriers
- ☐ Lack of child care
- ☐ Pregnancy
- ☐ Pregnancy scare

b. Life stressors - Medical

- ☐ None listed below
- ☐ Lack of family or social support for care
- ☐ Caregiver distrust of health care system
- ☐ Caregiver unskilled in providing care
- ☐ Lack of money for care
- ☐ Services not available
- ☐ Multiple providers, not coordinated
- ☐ Limitations of health insurance
- ☐ Provider bias
- ☐ Felt dismissed by provider
- ☐ Lack of provider-family compatibility

c. Life Stressors- Relationships

- ☐ None listed below
- ☐ Family discord
- ☐ Argument w/ parents/caregivers
- ☐ Parents' divorce/separation
- ☐ Parents' incarceration
- ☐ Breakup
- ☐ Argument with significant other
- ☐ Social discord
- ☐ Argument with friends
- ☐ Isolation
- ☐ Bullying as victim
- ☐ Bullying as perpetrator
- ☐ Cyberbullying as victim
- ☐ Cyberbullying as a perpetrator
- ☐ Peer violence as a victim
- ☐ Peer violence as a perpetrator
- ☐ Stress due to gender identity
- ☐ Stress due to sexual orientation

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

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

e. Technology (age 5 and over)

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

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

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

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

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

h. Life stressors - Describe any other life stressors:

I8. DEATHS DURING THE COVID-19 PANDEMIC (complete for all ages)

a. For the 12 months before the child's death, did the family experience any disruptions or significant changes to the following? Check all that apply:

- ☐ None listed below
- ☐ School
- ☐ Daycare
- ☐ Employment
- ☐ Social services (like unemployment assistance, TANF, WIC)
- ☐ Living environment
- ☐ Medical care
- ☐ Mental health or substance use/abuse care
- ☐ Home-based services (non-child welfare)
- ☐ Child welfare services
- ☐ Legal proceedings within criminal, civil, or family courts
- ☐ Other, specify:
- ☐ U/K

b. For the 12 months before the child's death, did the child's family live in an area with an official stay at home order? ○ Yes ○ No ○ U/K
If yes, was the stay at home order in place at the time of the child's death? ○ Yes ○ No ○ U/K

c. Was the child exposed to COVID-19 within 14 days of death? ○ Yes ○ No ○ U/K If yes, describe:

d. Did the child have medical evidence of a significant inflammatory syndrome (including for example, fever, laboratory evidence of inflammation, and involvement of two or more organs) requiring hospitalization in the week before death? ○ Yes ○ No ○ U/K
If yes, was the child diagnosed with MIS-C? ○ Yes ○ No ○ U/K

e. Was the child eligible for a COVID-19 vaccination? ○ Yes ○ No ○ U/K
If eligible, did they receive their first dose? ○ Yes ○ No ○ U/K If yes, approx. number of weeks before death: ____
If eligible and received their first dose, which option best represents their vaccination status? ○ Partially vaccinated ○ Fully vaccinated ○ U/K

f. For infants or fetal deaths only, did the childbearing parent receive their COVID-19 vaccination? ○ Yes ○ No ○ U/K
If yes, when did they receive their first dose?

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

If yes, which option best represents their vaccination status? ○ Partially vaccinated ○ Fully vaccinated ○ U/K

g. Select the one option that best describes the impact of COVID-19 on this child's death:

- ○ COVID-19 was the immediate or underlying cause of death
- ○ COVID-19 was diagnosed at autopsy or child was suspected to have COVID-19
- ○ COVID-19 indirectly contributed to the death but was not the immediate or underlying cause of death
- ○ The childbearing parent contracted COVID-19, specify:
  - ○ Before pregnancy
  - ○ 1st trimester
  - ○ 2nd trimester
  - ○ 3rd trimester
  - ○ After delivery
  - ○ U/K
- ○ Other, specify:
- ○ COVID-19 had no impact on this child's death
- ○ U/K

h. Did COVID-19 impact the team's ability to conduct this fatality review?

○ Yes ○ No ○ U/K

If yes, check all that apply:

- ☐ Unable to obtain records
- ☐ Team members unable to attend review
- ☐ Remote reviews negatively impacted review process
- ☐ Team leaders redirected to COVID-19 response

J. PERSON RESPONSIBLE (OTHER THAN DECEDENT)

This section is skipped for fetal deaths+

1. Did a person or persons other than the child do something or fail to do something that caused or contributed to the death?
   - ○ Yes/probable
   - ○ No, go to K
   - ○ U/K, go to K

2. What act(s)? Enter information for the first person under "One" and if there is a second person, use column "Two." Describe acts in narrative.

One	Two		One	Two	
○	○	Child abuse	○	○	Exposure to hazards
○	○	Child neglect	○	○	Assault, not child abuse
○	○	Poor/absent supervision	○	○	Other, specify:
			○	○	U/K

3. Did the team have information about the person(s)?

One	Two	
○	○	Yes
○	○	No, go to K

4. Is person listed in a previous section?

One	Two	
○	○	Yes, childbearing parent, go to J17
○	○	Yes, non-childbearing biological parent, go to J17
○	○	Yes, caregiver one, go to J17
○	○	Yes, caregiver two, go to J17
○	○	Yes, supervisor, go to J19
		No

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

One	Two		One	Two		One	Two	
○	○	Adoptive parent	○	○	Sibling	○	○	Medical provider
○	○	Stepparent	○	○	Other relative	○	○	staff
○	○	Foster parent	○	○	Institutional child care	○	○	
○	○	Friend	○	○		○	○	
○	○	Babysitter	○	○				
○	○	Parent's partner or boyfriend				○	○	Grandparent
○	○	Acquaintance				○	○	Child's girlfriend
○	○	Licensed worker						Other, specify:
○	○	Stranger						
○	○	U/K						

6. Person's age in years:

One	Two	
____	____	# Years

7. Person's sex:

One	Two	
○	○	Male
○	○	Female

8. Person speaks and understands English?

One	Two	
○	○	Yes
○	○	No

9. Person on active military duty?

One	Two	
○	○	Yes
○	○	No

☐ ☐ U/K	○ ○ U/K	○ ○ U/K If no, language spoken:	○ ○ U/K If yes, specify branch:
10. Person(s) have history of substance abuse? One Two ○ ○ Yes ○ ○ No ○ ○ U/K	11. Person(s) have history of child maltreatment as victim? One Two ○ ○ Yes ○ ○ No ○ ○ U/K	12. Person(s) have history of child maltreatment as a perpetrator? One Two ○ ○ Yes ○ ○ No ○ ○ U/K	13. Person(s) have disability or chronic illness? One Two ○ ○ Yes ○ ○ No ○ ○ U/K
14. Person(s) have prior child deaths? One Two ○ ○ Yes ○ ○ No ○ ○ U/K	15. Person(s) have history of intimate partner violence? One Two ☐ ☐ Yes, as victim ☐ ☐ Yes, as perpetrator ☐ ☐ No ☐ ☐ U/K	16. Person(s) have delinquent/criminal history? One Two ○ ○ Yes ○ ○ No ○ ○ U/K	
17. At the time of the incident, was the person asleep? One Two If yes, select the most appropriate Night time sleep ○ ○ Yes description of the person's sleeping Daytime nap, describe: ○ ○ No period in addition to Daytime sleep (for example, person is night shift worker), describe: ○ ○ U/K Other, describe:		One Two ○ ○ ○ ○ ○ ○ ○ ○	

18. At time of incident was person impaired?

One	Two
○ Yes	○ Yes
○ No	○ No
○ U/K	○ U/K

If yes, check all that apply:

One	Two		One	Two	
☐	☐	Drug impaired, specify:	☐	☐	Impaired by illness, specify:
☐	☐	Alcohol impaired			
☐	☐	Distracted	☐	☐	Impaired by disability, specify:
☐	☐	Absent			
			☐	☐	Other, specify:

19. Person(s) have, check all that apply:

One	Two	
☐	☐	Prior history of similar acts
☐	☐	Prior arrests
☐	☐	Prior convictions

20. Legal outcomes in this death, check all that apply:

One	Two	
☐	☐	No charges filed
☐	☐	Charges pending
☐	☐	Charges filed, specify:
☐	☐	Charges dismissed
☐	☐	Confession
☐	☐	Plead, specify:
☐	☐	Not guilty verdict
☐	☐	Guilty verdict, specify:
☐	☐	Tort charges, specify:
☐	☐	U/K

K. SERVICES TO FAMILY AND COMMUNITY AS A RESULT OF THE DEATH

1. Were new or revised services recommended or implemented as a result of the death? ○ Yes ○ No ○ U/K If yes, select one option per row:

	Referred for service before review	Review led to referral	Referral needed, not available	N/A	U/K
Bereavement counseling	○	○	○	○	○
Debriefing for professionals	○	○	○	○	○
Economic support	○	○	○	○	○
Funeral arrangements	○	○	○	○	○
Emergency shelter	○	○	○	○	○
Mental health services	○	○	○	○	○
Foster care	○	○	○	○	○
Health services	○	○	○	○	○
Legal services	○	○	○	○	○
Genetic counseling	○	○	○	○	○
Home visiting	○	○	○	○	○
Substance abuse Other, specify:	○	○	○	○	○
	○	○	○	○	○

L. FINDINGS IDENTIFIED DURING THE REVIEW

○ **Mark this case to edit/add findings at a later date**

1. Describe any significant challenges faced by the child, the family, the systems with which they interacted, or the response to the incident. These could be related to demographics, overt or inadvertent actions, the way systems functioned, or other environmental characteristics. (See Data Dictionary for examples.)

2. Describe any notable positive elements in this case. They could be demographic, behavioral, or environmental characteristics that may have promoted resiliency in the child or family, the systems with which they interacted or the response to the incident. (See Data Dictionary for examples).

3. List any recommendations and/or initiatives that could be implemented to prevent deaths from similar causes or circumstances in the future:

4. Were new or revised agency services, policies or practices recommended or implemented as a result of the review ○Yes ○No ○U/K

If yes, select all that apply and describe:

☐ Child welfare Describe:Education Describe: ☐ Law enforcement Describe:Mental health
☐ Describe: ☐
☐ ☐
☐ Public health Describe:EMS ☐
☐ Coroner/medical examiner Describe:Substance abuse ☐ Describe:
Courts Describe:Other, specify: Describe:
☐ Health care systems Describe:

5. Could the death have been prevented? ○ Yes, probably ○ No, probably not ○ Team could not determine

M. THE REVIEW MEETING PROCESS

1. Date of first review meeting:

2. Number of review meetings for this case: ____

3. Is review complete? ○ N/A ○ Yes ○ No

4. Agencies and individuals at review meeting, check all that apply:

☐ Medical examiner/coroner/pathologist ☐ CPS ☐ Fire ☐ Indian Health Services/Military organization ☐ Death investigator ☐ Other social services ☐ EMS ☐ Tribal ☐ Home visiting ☐ Others, list: ☐ Domestic violence ☐ Law enforcement ☐ Physician ☐ Faith based

Prosecutor/district attorney Nurse Education Healthy Start
Public health Hospital Mental health Court
HMO/managed care Other health care Substance abuse Child advocate

5. Were the following data sources available at the review meeting?

Check all that apply:

Vital statistics

☐ Birth certificate - full form
☐ Death certificate

Health records

☐ Child's medical records or clinical history, including vaccinations

6. Did any of the following factors reduce meeting effectiveness, check all that apply:

☐ None
☐ Confidentiality issues among members prevented full exchange of information
☐ HIPAA regulations prevented access to or exchange of information
☐ Inadequate investigation precluded having enough information for review
☐ Team members did not bring adequate information to the meeting

☐ Hospital records

☐ Childbearing parent's obstetric and prenatal information

☐ Newborn screening results

☐ Mental health records

☐ Substance abuse treatment records

Investigation records

☐ Autopsy/pathology reports
☐ CDC's SUIDI Reporting Form
☐ Jurisdictional equivalent of the CDC SUIDI Reporting Form
☐ Law enforcement records
☐ Social service records
☐ Child protection agency records
☐ EMS run sheet

Other

☐ Home visiting
☐ School records

☐ 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:

. Review meeting outcomes, check all that apply:

☐ Team disagreed with official manner of death. What did team believe manner should be?
☐ Team disagreed with official cause of death. What did team believe cause should be?
☐ Because of the review, the official cause or manner of death was changed

. SUID AND SDY CASE REGISTRY

This section displays online based on your state's settings.

ection N: OMB No. 0920-1092, Exp. Date: 9/30/2025

ublic reporting burden of this collection of information is estimated to average 10 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data eeded, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB control umber. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to: CDC/ATSDR Reports Clearance Officer; 1600 Clifton Road NE, S D-74, Atlanta, Georgia 30333; ATTN: PRA (0920-1092)

. Is this an SDY or SUID case? ○ Yes ○ No If no, go to Section O

. Did this case go to Advanced Review for the SDY Case Registry?

○ N/A ○ Yes ○ No

If yes, date of first Advanced Review meeting:

3. Notes from Advanced Review meeting (include case details that helped determine SDY categorization and any ways to improve the review) or reason why case did not go to Advanced Review:

. Professionals at the Advanced Review meeting, check all that apply:

☐ CardiologistDeath ☐ investigatorGeneticist or genetic ☐ counselorPediatrician ☐
☐ CDR ☐ ☐ ☐ representativeEpileptologistNeurologistPublic
☐ health representative ☐ CoronerForensic pathologist/medical ☐ examinerNeonatologistOthers, specify: ☐

. Did the Advanced Review team believe the autopsy was comprehensive? ○ Yes ○ No ○ U/K

6. If autopsy performed, did the ME/coroner/pathologist use the SDY Autopsy Guidance or Summary? ○ N/A ○ Yes ○ No ○ U/K

Was a specimen saved for the SDY Case Registry?

○ N/A ○ Yes ○ No ○ U/K

Was a specimen sent to the SDY Case Registry biorepository?

○ N/A ○ Yes ○ No ○ U/K

9. Did the family consent to have DNA saved as part of the SDY Case Registry?

○ N/A ○ Yes ○ No ○ U/K

If no, why not?
○ Consent was not attempted
○ Consent was attempted but follow up was unsuccessful
○ Consent was attempted but family declined
○ Other, specify:

0. Categorization for SDY Case Registry (choose only one):

○ Excluded from SDY Case RegistryExplained neurological, ○ specify:Explained other, ○ specify:Unexplained, SUDEP
○ Unexplained, incomplete case informationExplained infant ○ suffocationUnexplained, ○ possible cardiacUnexplained death
○ Explained cardiac, specify: (under age 1)Unexplained, possible cardiac ○ and SUDEP

1.Categorization for SUID Case Registry (choose only one):

○ Excluded (other explained causes, not suffocation)If possible death scene investigationmechanism(s) leading to the death, check all that apply:
○ Unexplained: Incomplete case information
○ Unexplained: No unsafe sleep factors
○ Unexplained: Unsafe sleep factors
○ Unexplained: Possible suffocation with unsafe sleep factors
Explained: Suffocation with unsafe sleep factors

☐ Soft bedding
☐ Wedging
☐ Overlay
☐ Other, specify:

Unexplained: No autopsy or suffocation or explained suffocation, select the primary

. NARRATIVE

01. NARRATIVE

se this space to provide more detail on the circumstances of the death and to describe any other relevant information.
O NOT INCLUDE IDENTIFIERS IN THE NARRATIVE such as names, dates, addresses, and specific service providers. Consider the following uestions: What was the child doing? Where did it happen? How did it happen? What went wrong? What was the quality of supervision? What was the njury cause of death? The Narrative is included in de-identified downloads, and per MPHI/NCFRP's data use agreement with your state, HIPAA identifying nformation should not be recorded in this field.

. FORM COMPLETED BY:

erson:

itle:

gency:

hone:

Email:

Date completed:

Data entry completed for this case? ☐

For State Program Use Only:

Data quality assurance completed by state? ☐

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Data Entry: https://data.ncfrp.org

www.ncfrp.org info@ncfrp.org 1-800-656-2434 Facebook and Twitter: NationalCFRP

Appendix G. ACDRS Definitions

ACDRS Definitions

Cases That Meet the Criteria for Review – These are cases involving the deaths in Alabama of infants and children from live birth to less than 18 years of age whose deaths are considered unexpected or unexplained.

Cause of Death – Found in Item #45 on an Alabama Death Certificate, this refers to the primary underlying cause of a death which is the disease or injury/action initiating the sequence of events that leads directly to death, or the circumstances of the accident or violence that produced the fatal injury.

Reviewed Cases – This term includes those cases that were reviewed by a LCDRT and completed in the ACDRS database.

Manner of Death – Found in Item #49 on an Alabama Death Certificate, this is one of six general categories (Accident, Homicide, Suicide, Undetermined Circumstances, Pending Investigation, or Natural Causes) assigned to each death case.

Preventability – For ACDRS purposes, preventability refers to the ability of an individual or community to reasonably have done something to alter the conditions that led to the child's death, thereby preventing the child's death, or reasonably do something now to reduce the likelihood of future deaths.

Sudden Infant Death Syndrome (SIDS) – This is a very specific type of SUID (see below) in infants from one month to one year old in which all external contributing causes are eliminated through complete autopsy and toxicology, review of the clinical history, and thorough death scene investigation.

Sudden Unexplained Infant Death (SUID) – This is a broad term used to describe sudden infant deaths from a variety of both internal and external causes.

Unexpected/Unexplained – In referring to a child's death, this category includes all deaths that, prior to investigation, appear possibly to have been caused by trauma, suspicious or obscure circumstances, child abuse or neglect, other agents, or SIDS.

Appendix H. Common ACDRS Acronyms

Common ACDRS Acronyms

AAP	**American Academy of Pediatrics**
ACDRS	**Alabama Child Death Review System**
ADPH	**Alabama Department of Public Health**
ADFS	**Alabama Department of Forensic Sciences**
AHI	**Abusive Head Injury**
AHT	**Abusive Head Trauma**
CDC	**Centers for Disease Control and Prevention**
FIMR	**Fetal and Infant Mortality Review**
LCDRT	**Local Child Death Review Team**
SIDS	**Sudden Infant Death Syndrome**
SCDRT	**State Child Death Review Team**
SBS	**Shaken Baby Syndrome (AHI/AHT is preferred)**
SUDC/SUDIC	**Sudden Unexplained Death in Childhood**
SUDI	**Sudden Unexplained Death in Infancy (SUID is preferred)**
SUID	**Sudden Unexplained Infant Death**
SUIDI	**Sudden Unexplained Infant Death Investigation**