Sudden Unexplained Infant Death Investigation

SUIDI Reporting Form

INVESTIGATION DATA

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

Sex: ☐ Male ☐ Female Date of Birth ____/____/____ (Month / Day / Year) Age ____ (Months) SS# _____

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

Infant's Primary Residence Address:

Address _____ City _____ County _____ State ____ Zip _____

Incident Address:

Address _____ City _____ County _____ State ____ Zip _____

Contact Information for Witness:

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

Last _____ First _____ M. _____ SS # _____

Home Address _____ City _____ State _____ Zip _____

Place of Work _____ City _____ State _____ Zip _____

Phone (H) _____ Phone (W) _____ Date of Birth ____/____/____ (Month / Day / Year)

WITNESS INTERVIEW

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

2 **Tell me what happened:** _____

_____

_____

_____

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

_____

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

_____

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

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

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

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

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

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

P L F Other _____

WITNESS INTERVIEW (cont.)

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

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

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

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

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

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

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

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

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

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

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

_____

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

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

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

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

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

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

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

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

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

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

WITNESS INTERVIEW (cont.)

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

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

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

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

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

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

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

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

_____

_____

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

_____

INFANT MEDICAL HISTORY

1 **Source of medical information:** ☐ Doctor ☐ Other healthcare provider ☐ Medical record
☐ Mother/primary caregiver ☐ Family ☐ Other: _____

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

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

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

☐ No ☐ Yes ⇨ Describe: _____

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

☐ No ☐ Yes ⇨ List below:

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

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

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

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

Describe: _____

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

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

8 **Birth hospital name:** _____

Street _____

City _____ State _____ Zip _____

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

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

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

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

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

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

☐ Singleton ☐ Twin ☐ Triplet ☐ Quadruplet or higher gestation

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

☐ No ☐ Yes ⇨ Describe the complications: _____

_____

_____

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

☐ No ☐ Yes ⇨ Specify: _____

_____

_____

INFANT DIETARY HISTORY

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

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

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

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

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

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

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

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

_____

_____

_____

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

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

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

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

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

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

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

☐ No ☐ Yes ⇨ Describe concerns: _____

_____

_____

_____

PREGNANCY HISTORY

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

First name _____ Middle name _____

Last name _____ Maiden name _____

Date of Birth: _____/_____/_____ SS # _____-_____-_____
Month Day Year

Current Address: _____ City _____ _____ _____
State Zip

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

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

_____ Weeks _____ Months ☐ No prenatal care ☐ Unknown

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

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

Street _____ City _____ _____ _____
State Zip

PREGNANCY HISTORY (cont.)

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

☐ No ☐ Yes ⇨ Specify: _____

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

☐ No ☐ Yes ⇨ Specify: _____

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

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

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

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

INCIDENT SCENE INVESTIGATION

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

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

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

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

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

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

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

License number: _____ Agency: _____

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

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

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

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

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

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

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

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

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

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

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

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

_____

_____

_____

INVESTIGATION SUMMARY

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

_____

_____

2 **Arrival times:** Law enforcement at scene: _____:_____ (Military Time) DSI at scene: _____:_____ (Military Time) Infant at hospital: _____:_____ (Military Time)

Investigator's Notes

Indicate the task(s) performed.

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

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

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

_____

_____

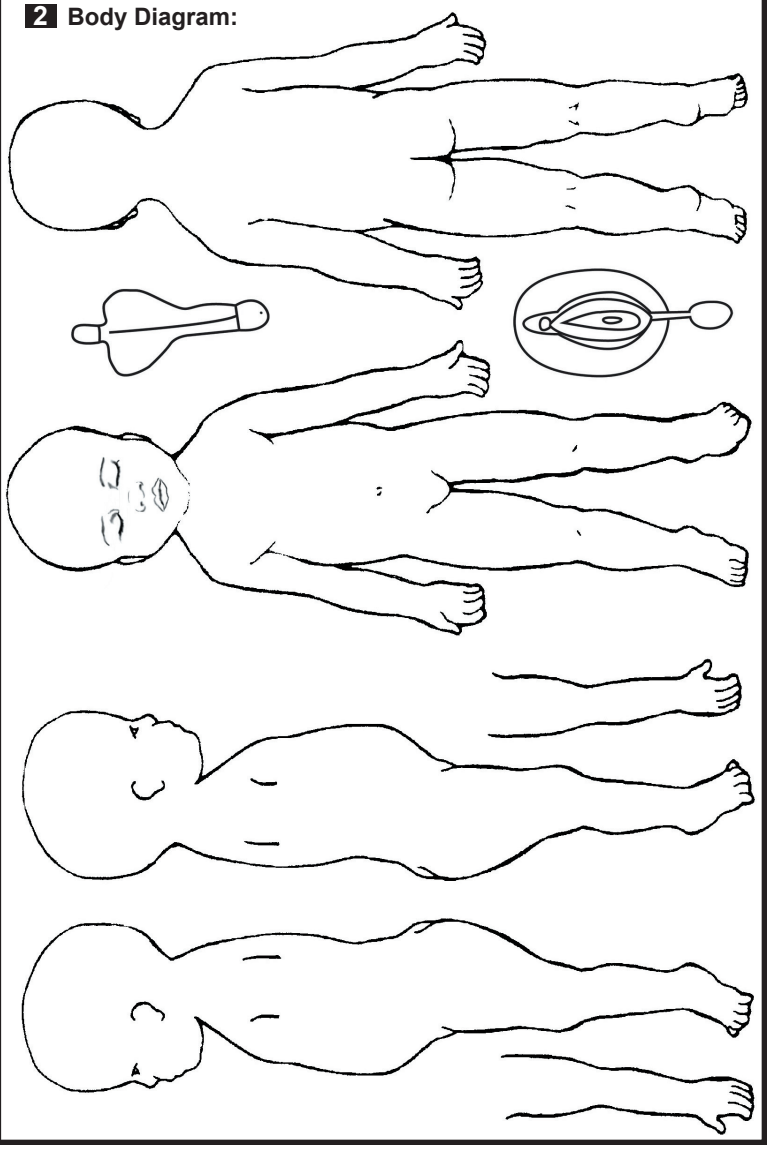
_____

_____

INVESTIGATION DIAGRAMS

1 **Scene Diagram:**

2 **Body Diagram:**



SUMMARY FOR PATHOLOGIST

Case Information

Investigator Information: Name _____ Agency _____ Phone _____

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

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

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

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

1 Indicate whether preliminary investigation suggests any of the following:

Sleeping Environment

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

Infant History

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

Family Info

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

Exam

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

Investigator Insight

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

Any "Yes" answers should be explained and detailed.

Brief description of circumstances: _____

_____

_____

_____

_____

_____

_____

2 Pathologist Information:

Pathologist

Name _____ Agency _____

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