DHS

CASE NUMBER

_____/_____/_____/_____

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

Case Type: ◯ Death ◯ Near death/serious injury ◯ Not born alive

Death Certificate Number:

Birth Certificate Number:

ME/Coroner Number:

Date CDRT Notified of Death:

A. CHILD INFORMATION

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

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

7. Sex: ◯ Male ◯ Female ◯ U/K

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

9. 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

10. New residence in past 30 days? ◯ Yes ◯ No ◯ U/K

11. Residence overcrowded? ◯ Yes ◯ No ◯ U/K

12. Child ever homeless? ◯ Yes ◯ No ◯ U/K

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

14. Child's weight: ☐ U/K
◯ Pounds/ounces _____/_____
◯ Grams/kilograms _____

15. Child's height: ☐ U/K
◯ Feet/inches _____/_____
◯ Cm _____

16. Highest education level:
◯ N/A ◯ Drop out
◯ None ◯ HS graduate
◯ Preschool ◯ College
◯ Grade K-8 ◯ Other, specify:
◯ Grade 9-12 ◯ U/K
◯ Home schooled, K-8
◯ Home schooled, 9-12

17. Child's work status:
◯ N/A
◯ Employed
◯ Full time
◯ Part time
◯ U/K
◯ Not working
◯ U/K

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

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

20. 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

21. Child's mental health (MH):
Child had received prior MH services? ◯ N/A ◯ Yes ◯ No ◯ U/K
Child was receiving MH services? ◯ N/A ◯ Yes ◯ No ◯ U/K
Child on medications for MH illness? ◯ N/A ◯ Yes ◯ No ◯ U/K
Issues prevented child from receiving MH services? ◯ N/A ◯ Yes ◯ No ◯ U/K
If yes, specify:

22. Child had history of substance abuse? ◯ N/A ◯ Yes ◯ No ◯ U/K
If yes, check all that apply:
☐ Alcohol ☐ Other, specify:
☐ Cocaine
☐ Marijuana ☐ U/K
☐ Methamphetamine
☐ Opiates
☐ Prescription drugs
☐ Over-the-counter drugs

23. Child had history of child maltreatment? If yes, check all that apply:

As Victim	As Perpetrator		As Victim	As Perpetrator	
	◯	N/A	☐	☐	Physical
◯	◯	Yes	☐	☐	Neglect
◯	◯	No	☐	☐	Sexual
◯	◯	U/K	☐	☐	Emotional/psychological
			☐	☐	U/K
If yes, how was history identified:					
◯	◯	Through CPS	_____	_____	# CPS referrals
◯	◯	Other sources	_____	_____	# 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. Were any siblings placed outside of the home prior to this child's death? ◯ N/A ◯ Yes, # _____ ◯ No ◯ U/K

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

28. Child had delinquent or criminal history? ◯ N/A ◯ Yes ◯ No ◯ U/K
If yes, check all that apply:
☐ Assaults ☐ Other, specify:
☐ Robbery
☐ Drugs ☐ U/K

29. Child spent time in juvenile detention? ◯ N/A ◯ Yes ◯ No ◯ U/K

30. Child acutely ill during the two weeks before death? ◯ Yes ◯ No ◯ U/K

31. Was any parent a first generation immigrant? ◯ Yes ◯ No ◯ U/K
If yes, country of origin:

32. If child over age 12, what was child's gender identity?
◯ Male
◯ Female
◯ U/K

33. If child over age 12, what was child's sexual orientation?
◯ Heterosexual ◯ Lesbian ◯ Questioning
◯ Gay ◯ Bisexual ◯ U/K

COMPLETE FOR ALL INFANTS UNDER ONE YEAR

34. Gestational age: ☐ U/K
_____ # weeks

35. Birth weight: ☐ U/K
○ Grams/kilograms _____
○ Pounds/ounces _____/_____

36. Multiple birth?
○ Yes, # _____
○ No ○ U/K

37. Including the deceased infant, how many pregnancies did the birth mother have? # ___ ☐ U/K

38. Including the deceased infant, how many live births did the birth mother have? # ___ ☐ U/K

39. Not including the deceased infant, number of children birth mother still has living? #_____ ☐ U/K

40. Prenatal care provided during pregnancy of deceased infant? ○ Yes ○ No ○ U/K
If yes, number of prenatal visits: #_____ ☐ U/K If yes, month of first prenatal visit: Specify 1-9 __ ☐ U/K

41. During pregnancy, did mother (check all that apply):

Yes	No	U/K	
○	○	○	Have medical complications/infections?
○	○	○	Experience intimate partner violence?
○	○	○	Use illicit drugs?
		☐	Infant born drug exposed?
○	○	○	Misuse OTC or prescription drugs?
○	○	○	Have heavy alcohol use?
		☐	Infant born with fetal alcohol effects or syndrome?

If yes, medical complications/infections, check all that apply:

- ☐ Acute/chronic lung disease
- ☐ Anemia
- ☐ Cardiac disease
- ☐ Chorioamnionitis
- ☐ Chronic hypertension
- ☐ Diabetes
- ☐ Eclampsia
- ☐ Genital herpes
- ☐ Hemoglobinopathy
- ☐ High MSAFP
- ☐ Hydramnios/oligohydramnios
- ☐ Incompetent cervix
- ☐ Low MSAFP
- ☐ Other infectious disease
- ☐ Pregnancy-related hypertension
- ☐ Preterm labor
- ☐ Previous infant 4000+ grams
- ☐ Previous infant preterm/ small for gestation
- ☐ PROM
- ☐ Renal disease
- ☐ Rh sensitization
- ☐ Uterine bleeding
- ☐ Other, specify:

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

- ☐ Lack of money for care
- ☐ Limitations of health insurance coverage
- ☐ Multiple health insurance, not coordinated
- ☐ Lack of transportation
- ☐ No phone
- ☐ Cultural differences
- ☐ Religious objections to care
- ☐ Language barriers
- ☐ Referrals not made
- ☐ Specialist needed, not available
- ☐ Multiple providers, not coordinated
- ☐ Lack of child care
- ☐ Lack of family/social support
- ☐ Services not available
- ☐ Distrust of health care system
- ☐ Unwilling to obtain care
- ☐ Intimate partner would not allow care
- ☐ Other, specify:
- ☐ U/K

43. Did mother smoke in the 3 months before pregnancy?
○ Yes
○ No
○ U/K
If yes, ___ Avg # cigarettes/day (20 cigarettes in pack)
☐ U/K quantity

44. Did mother smoke at any time during pregnancy?
○ Yes ○ No ○ U/K

If yes,	Trimester 1	Trimester 2	Trimester 3	
	_____	_____	_____	Avg # cigarettes/day (20 cigarettes in pack)
	☐	☐	☐	U/K quantity

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

46. Was mother injured during pregnancy? ○ Yes ○ No ○ U/K
If yes, describe:

47. Did infant have abnormal metabolic newborn screening results? ○ Yes ○ No ○ U/K
If yes, was abnormality a fatty acid oxidation error, such as MCAD? ○ Yes ○ No ○ U/K
If yes, describe: If other abnormalities, describe:

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

- ☐ Infection
- ☐ Allergies
- ☐ Abnormal growth, weight gain/loss
- ☐ Apnea
- ☐ Cyanosis
- ☐ Seizures or convulsions
- ☐ Cardiac abnormalities
- ☐ Metabolic disorders
- ☐ Other, specify:

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

- ☐ Fever
- ☐ Excessive sweating
- ☐ Lethargy/sleeping more than usual
- ☐ Fussiness/excessive crying
- ☐ Decrease in appetite
- ☐ Vomiting
- ☐ Choking
- ☐ Diarrhea
- ☐ Stool changes
- ☐ Difficulty breathing
- ☐ Apnea
- ☐ Cyanosis
- ☐ Seizures or convulsions
- ☐ Other, specify:

50. In the 72 hours prior to death, was the infant injured? ○ Yes ○ No ○ U/K
If yes, describe cause and injuries:

51. In the 72 hours prior to death, was the infant given any vaccines? ○ Yes ○ No ○ U/K
If yes, list name(s) of vaccines:

52. In the 72 hours prior to death, was the infant given any medications or remedies? Include herbal, prescription and over-the-counter medications and home remedies. ○ Yes ○ No ○ U/K
If yes, list name and last dose given:

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

- ☐ Breast milk
- ☐ Formula, type:
- ☐ Baby food, type:
- ☐ Cereal, type:
- ☐ Other, specify:
- ☐ U/K

B. PRIMARY CAREGIVER(S) INFORMATION

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

One	Two	One	Two
○	Self, go to Section C	○	○ Grandparent
○	○ Biological parent	○	○ Sibling
○	○ Adoptive parent	○	○ Other relative
○	○ Stepparent	○	○ Friend
○	○ Foster parent	○	○ Institutional staff
○	○ Mother's partner	○	○ Other, specify:
○	○ Father's partner	○	○ 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) employment status:

One	Two	
○	○	Employed
○	○	Unemployed
○	○	On disability
○	○	Stay-at-home
○	○	Retired
○	○	U/K

5. Caregiver(s) income:

One	Two	
○	○	High
○	○	Medium
○	○	Low
○	○	U/K

6. Caregiver(s) education:

One	Two	
○	○	< High school
○	○	High school
○	○	College
○	○	Post graduate
○	○	U/K

7. Do caregiver(s) speak English?

One	Two	
○	○	Yes
○	○	No
○	○	U/K

If no, language spoken:

8. Caregiver(s) on active military duty?

One	Two	
○	○	Yes
○	○	No
○	○	U/K

If yes, specify branch:

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

One	Two		One	Two	
☐	☐	Yes	☐	☐	WIC
☐	☐	No	☐	☐	TANF
☐	☐	U/K	☐	☐	Medicaid
			☐	☐	Food stamps
			☐	☐	Other, specify:
			☐	☐	U/K

If yes, check all that apply

10. Caregiver(s) have substance abuse history?

One Two
☐ ☐ Yes
☐ ☐ No
☐ ☐ U/K

If yes, check all that apply:
☐ ☐ Alcohol
☐ ☐ Cocaine
☐ ☐ Marijuana
☐ ☐ Methamphetamine
☐ ☐ Opiates
☐ ☐ Prescription drugs
☐ ☐ Over-the-counter
☐ ☐ Other, specify:
☐ ☐ U/K

11. Caregiver(s) ever victim of child maltreatment?

One Two
☐ ☐ Yes
☐ ☐ No
☐ ☐ U/K

If yes, check all that apply:
☐ ☐ Physical
☐ ☐ Neglect
☐ ☐ Sexual
☐ ☐ Emotional/psychological
☐ ☐ U/K

_____ _____ # CPS referrals
_____ _____ # Substantiations
☐ ☐ Ever in foster care or adopted

12. Caregiver(s) ever perpetrator of maltreatment?

One Two
☐ ☐ Yes
☐ ☐ No
☐ ☐ U/K

If yes, check all that apply:
☐ ☐ Physical
☐ ☐ Neglect
☐ ☐ Sexual
☐ ☐ Emotional/psychological
☐ ☐ U/K

_____ _____ # CPS referrals
_____ _____ # Substantiations
☐ ☐ CPS prevention services
☐ ☐ Family preservation services
☐ ☐ Children ever removed

13. Caregiver(s) have disability or chronic illness?

One Two
☐ ☐ Yes
☐ ☐ No
☐ ☐ U/K

If yes, check all that apply:
☐ ☐ Physical, specify:
☐ ☐ Mental, specify:
☐ ☐ Sensory, specify:
☐ ☐ U/K

If mental illness, was caregiver receiving MH services?
◉ ◉ Yes
◉ ◉ No
◉ ◉ U/K

14. Caregiver(s) have prior child deaths?

One Two
☐ ☐ Yes
☐ ☐ No
☐ ☐ U/K

If yes, cause(s): Check all that apply:

One Two
☐ ☐ Child abuse # _____
☐ ☐ Child neglect # _____
☐ ☐ Accident # _____
☐ ☐ Suicide # _____
☐ ☐ SIDS # _____
☐ ☐ Other # _____
Other, specify:
☐ ☐ U/K

15. Caregiver(s) have history of intimate partner violence?

One Two
☐ ☐ Yes, as victim
☐ ☐ Yes, as perpetrator
☐ ☐ No
☐ ☐ U/K

16. Caregiver(s) have delinquent/criminal history?

One Two
☐ ☐ Yes
☐ ☐ No
☐ ☐ U/K

If yes, check all that apply:
☐ ☐ Assaults
☐ ☐ Robbery
☐ ☐ Drugs
☐ ☐ Other, specify:
☐ ☐ U/K

C. SUPERVISOR INFORMATION

1. Did child have supervision at time of incident leading to death?
○ Yes, answer 2-15
○ No, not needed given developmental age or circumstances, go to Sect. D
○ No, but needed, answer 3-15
○ Unable to determine, try to answer 3-15

2. How long before incident did supervisor last see child? Select one:
○ Child in sight of supervisor
○ Minutes _____ ○ Days _____
○ Hours _____ ○ U/K

3. Is person a primary caregiver as listed in previous section?
○ Yes, caregiver one, go to 15
○ Yes, caregiver two, go to 15
○ No

4. Primary person responsible for supervision? Select only one:
○ Biological parent ○ Foster parent ○ Grandparent ○ Friend ○ Institutional staff, go to 15 ○ Other, specify:
○ Adoptive parent ○ Mother's partner ○ Sibling ○ Acquaintance ○ Babysitter
○ Stepparent ○ Father's partner ○ Other relative ○ Hospital staff, go to 15 ○ Licensed child care worker ○ U/K

5. Supervisor's age in years: _____ ☐ U/K

6. Supervisor's sex: ○ Male ○ Female ○ U/K

7. Does supervisor speak English? ○ Yes ○ No ○ U/K
If no, language spoken:

8. Supervisor on active military duty? ○ Yes ○ No ○ U/K
If yes, specify branch:

9. Supervisor has substance abuse history?
○ Yes ○ No ○ U/K

If yes, check all that apply:
☐ Alcohol
☐ Cocaine
☐ Marijuana
☐ Methamphetamine
☐ Opiates
☐ Prescription drugs
☐ Over-the-counter
☐ Other, specify:
☐ U/K

10. Supervisor has history of child maltreatment?

As Victim As Perpetrator
◉ ◉ Yes
◉ ◉ No
◉ ◉ U/K

If yes, check all that apply:
☐ ☐ Physical
☐ ☐ Neglect
☐ ☐ Sexual
☐ ☐ Emotional/psychological
☐ ☐ U/K
_____ _____ # CPS referrals
_____ _____ # Substantiations
☐ Ever in foster care/adopted
☐ CPS prevention services
☐ Family preservation services
☐ Children ever removed

11. Supervisor has disability or chronic illness?
◉ Yes ◉ No ◉ U/K

If yes, check all that apply:
☐ Physical, specify:
☐ Mental, specify:
☐ Sensory, specify:
☐ U/K

If mental illness, was supervisor receiving MH services?
◉ Yes
◉ No
◉ U/K

12. Supervisor has prior child deaths?
◉ Yes ◉ No ◉ U/K

If yes, check all that apply:
☐ Child abuse # _____
☐ Child neglect # _____
☐ Accident #_____
☐ Suicide # _____
☐ SIDS # _____
☐ Other # _____
Other, specify:
☐ U/K

13. Supervisor has history of intimate partner violence?
- ☐ Yes, as victim
- ☐ Yes, as perpetrator
- ☐ No
- ☐ U/K

14. Supervisor has delinquent or criminal history?
○ Yes ○ No ○ U/K

If yes, check all that apply:
- ☐ Assaults ☐ Drugs ☐ U/K
- ☐ Robbery ☐ Other, specify:

15. At time of incident was supervisor impaired? ○ Yes ○ No ○ U/K

If yes, check all that apply:
- ☐ Drug impaired, specify:
- ☐ Alcohol impaired
- ☐ Asleep
- ☐ Distracted
- ☐ Absent
- ☐ Impaired by illness, specify:
- ☐ Impaired by disability, specify:
- ☐ Other, specify:

D. INCIDENT INFORMATION

1. Date of incident event:
- ○ Same as date of death
- ○ If different than date of death: ___/___/___ (mm/dd/yyyy)
- ○ U/K

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

3. Interval between incident and death: ☐ U/K
- ☐ Minutes ____ ☐ Weeks ____
- ☐ Hours ____ ☐ Months ____
- ☐ Days ____ ☐ Years ____

4. 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
- ☐ Place of work
- ☐ Indian reservation/ trust lands
- ☐ Military installation
- ☐ Jail/detention facility
- ☐ Sidewalk
- ☐ Roadway
- ☐ Driveway
- ☐ Other parking area
- ☐ State or county park
- ☐ Sports area
- ☐ Other recreation area
- ☐ Hospital
- ☐ Other, specify:
- ☐ U/K

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

6. Incident state:

7. Incident county:

8. Death state:

9. Death county:

10. 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:

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

12. 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, specify type:
- ☐ Other, specify:

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

If yes, what was the rhythm?
_____

13. At time of incident leading to death, had child used drugs or alcohol?
○ N/A ○ Yes ○ No ○ U/K

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

15. Total number of deaths at incident event:
- ____ Children, ages 0-18 ○ U/K
- ____ Adults

E. INVESTIGATION INFORMATION

1. Death referred to:
- ○ Medical examiner
- ○ Coroner
- ○ Not referred
- ○ U/K

2. Person declaring official cause and manner of death:
- ○ Medical examiner ○ Mortician
- ○ Coroner ○ Other, specify:
- ○ Hospital physician
- ○ Other physician ○ U/K

3. Autopsy performed? ○ Yes ○ No ○ U/K

If yes, conducted by:
- ○ Forensic pathologist ○ Other physician
- ○ Pediatric pathologist ○ Other, specify:
- ○ General pathologist
- ○ Unknown pathologist ○ U/K

If no, why not (e.g. parent or caregiver objected)?

If yes, was a specialist consulted during autopsy (cardiac, neurology, etc.)?
○ Yes ○ No ○ U/K If yes, specify specialist:

4. Were the following assessed either through the autopsy or through information collected prior to the autopsy? Please list any abnormalities/significant findings in E8.

	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:			
Was a gross examination of organs done?	○	○	○
Were weights of any organs taken?	○	○	○

5. Were any of these additional tests performed at or prior to the autopsy? Please list any abnormalities/significant findings in E8.

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

6. Was any toxicology testing performed?

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

☐ Negative ☐ Opiates ☐ Too high Rx drug, specify:
☐ Alcohol ☐ Marijuana ☐ Too high OTC drug, specify:
☐ Cocaine ☐ Methamphetamine ☐ Other, specify:
☐ U/K

7. 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

8. Describe any abnormalities checked in E4 or E5 or other significant findings noted in the autopsy:

9. Was there agreement between the cause of death listed on the pathology report and on the death certificate? ○ N/A ○ Yes ○ No ○ U/K

If no, describe the differences:

10. Was a death scene investigation performed? ○ Yes ○ No ○ U/K

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

Yes	No	U/K		If yes, shared with CDR 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

11. Agencies that conducted a scene investigation, check all that apply:

☐ Medical examiner
☐ Coroner
☐ ME investigator
☐ Coroner investigator
☐ Law enforcement
☐ Fire investigator
☐ EMS
☐ Child Protective Services
☐ Other, specify:

☐ U/K

12. Was a CPS record check conducted as a result of death? ○ Yes ○ No ○ U/K

13. Did any investigation find evidence of prior abuse?

○ N/A ○ Yes ○ No ○ U/K

If yes, from what source?

Check all that apply:

☐ From x-rays ☐ U/K
☐ From autopsy
☐ From CPS review
☐ From law enforcement

14. 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, services or actions resulting, check all that apply:

☐ Voluntary services offered
☐ Voluntary services provided
☐ Court-ordered services provided
☐ Voluntary out of home placement
☐ Court-ordered out of home placement
☐ Children removed
☐ Parental rights terminated
☐ U/K

15. If death occurred in licensed setting (see D4), indicate action taken:

○ No action
○ License suspended
○ License revoked
○ Investigation ongoing
○ Other, specify:
○ U/K

F. 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 F2 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