

CASE NUMBER

_____ / _____ / _____ State / County or Team Number / Year of Review / Sequence of Review	Case Type: <input type="radio"/> Death	Death Certificate Number:
	<input type="radio"/> Near death/serious injury	Birth Certificate Number:
	<input type="radio"/> Not born alive	ME/Coroner Number:
		Date CDRT Notified of Death:

A. CHILD INFORMATION

1. Child's name: First: _____ Middle: _____ Last: _____ <input type="checkbox"/> U/K																										
2. Date of birth: <input type="checkbox"/> U/K mm / dd / yyyy	3. Date of death: <input type="checkbox"/> U/K mm / dd / yyyy	4. Age: <input type="radio"/> Years <input type="radio"/> Months <input type="radio"/> Days <input type="radio"/> Hours <input type="radio"/> Minutes <input type="radio"/> U/K																								
5. Race, check all that apply: <input type="checkbox"/> U/K <input type="checkbox"/> White <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> Black <input type="checkbox"/> Pacific Islander, specify: _____ <input type="checkbox"/> Asian, specify: _____ <input type="checkbox"/> American Indian, Tribe: _____ <input type="checkbox"/> Alaskan Native, Tribe: _____		6. Hispanic or Latino origin? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K																								
7. Sex: <input type="radio"/> Male <input type="radio"/> Female <input type="radio"/> U/K																										
8. Residence address: <input type="checkbox"/> U/K Street: _____ Apt. _____ City: _____ State: _____ Zip: _____ County: _____		9. Type of residence: <input type="radio"/> Parental home <input type="radio"/> Relative home <input type="radio"/> Jail/detention <input type="radio"/> Licensed group home <input type="radio"/> Living on own <input type="radio"/> Other, specify: _____ <input type="radio"/> Licensed foster home <input type="radio"/> Shelter <input type="radio"/> Relative foster home <input type="radio"/> Homeless <input type="radio"/> U/K																								
10. New residence in past 30 days? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K																										
11. Residence overcrowded? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K	12. Child ever homeless? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K	13. Number of other children living with child: _____ <input type="checkbox"/> U/K																								
14. Child's weight: <input type="checkbox"/> U/K <input type="radio"/> Pounds/ounces _____ <input type="radio"/> Grams/kilograms _____		15. Child's height: <input type="checkbox"/> U/K <input type="radio"/> Feet/inches _____ <input type="radio"/> Cm _____																								
16. Highest education level: <input type="radio"/> N/A <input type="radio"/> Drop out <input type="radio"/> None <input type="radio"/> HS graduate <input type="radio"/> Preschool <input type="radio"/> College <input type="radio"/> Grade K-8 <input type="radio"/> Other, specify: _____ <input type="radio"/> Grade 9-12 <input type="radio"/> U/K <input type="radio"/> Home schooled, K-8 <input type="radio"/> Home schooled, 9-12		17. Child's work status: <input type="radio"/> N/A <input type="radio"/> Employed <input type="radio"/> Full time <input type="radio"/> Part time <input type="radio"/> U/K <input type="radio"/> Not working <input type="radio"/> U/K																								
18. Did child have problems in school? <input type="radio"/> N/A <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K If yes, check all that apply: <input type="checkbox"/> Academic <input type="checkbox"/> Behavioral <input type="checkbox"/> Truancy <input type="checkbox"/> Expulsion <input type="checkbox"/> Suspensions <input type="checkbox"/> U/K <input type="checkbox"/> Other, specify: _____		19. Child's health insurance, check all that apply: <input type="checkbox"/> None <input type="checkbox"/> Private <input type="checkbox"/> Medicaid <input type="checkbox"/> State plan <input type="checkbox"/> Indian Health Service <input type="checkbox"/> Other, specify: _____ <input type="checkbox"/> U/K																								
20. Child had disability or chronic illness? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K If yes, check all that apply: <input type="checkbox"/> Physical/orthopedic, specify: _____ <input type="checkbox"/> Mental health/substance abuse, specify: _____ <input type="checkbox"/> Cognitive/intellectual, specify: _____ <input type="checkbox"/> Sensory, specify: _____ <input type="checkbox"/> U/K If yes, was child receiving Children's Special Health Care Needs services? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K		21. Child's mental health (MH): Child had received prior MH services? <input type="radio"/> N/A <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K Child was receiving MH services? <input type="radio"/> N/A <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K Child on medications for MH illness? <input type="radio"/> N/A <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K Issues prevented child from receiving MH services? <input type="radio"/> N/A <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K If yes, specify: _____																								
22. Child had history of substance abuse? <input type="radio"/> N/A <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K If yes, check all that apply: <input type="checkbox"/> Alcohol <input type="checkbox"/> Other, specify: _____ <input type="checkbox"/> Cocaine <input type="checkbox"/> Marijuana <input type="checkbox"/> U/K <input type="checkbox"/> Methamphetamine <input type="checkbox"/> Opiates <input type="checkbox"/> Prescription drugs <input type="checkbox"/> Over-the-counter drugs																										
23. Child had history of child maltreatment? If yes, check all that apply: <table border="1"> <thead> <tr> <th>As Victim</th> <th>As Perpetrator</th> <th>As Victim</th> <th>As Perpetrator</th> </tr> </thead> <tbody> <tr> <td><input type="radio"/> N/A</td> <td><input type="checkbox"/> Physical</td> <td><input type="checkbox"/> Physical</td> <td><input type="checkbox"/> Physical</td> </tr> <tr> <td><input type="radio"/> Yes</td> <td><input type="checkbox"/> Neglect</td> <td><input type="checkbox"/> Neglect</td> <td><input type="checkbox"/> Neglect</td> </tr> <tr> <td><input type="radio"/> No</td> <td><input type="checkbox"/> Sexual</td> <td><input type="checkbox"/> Sexual</td> <td><input type="checkbox"/> Sexual</td> </tr> <tr> <td><input type="radio"/> U/K</td> <td><input type="checkbox"/> Emotional/psychological</td> <td><input type="checkbox"/> Emotional/psychological</td> <td><input type="checkbox"/> Emotional/psychological</td> </tr> <tr> <td></td> <td><input type="checkbox"/> U/K</td> <td><input type="checkbox"/> U/K</td> <td><input type="checkbox"/> U/K</td> </tr> </tbody> </table> If yes, how was history identified: <input type="radio"/> Through CPS <input type="radio"/> # CPS referrals <input type="radio"/> Other sources <input type="radio"/> # Substantiations		As Victim	As Perpetrator	As Victim	As Perpetrator	<input type="radio"/> N/A	<input type="checkbox"/> Physical	<input type="checkbox"/> Physical	<input type="checkbox"/> Physical	<input type="radio"/> Yes	<input type="checkbox"/> Neglect	<input type="checkbox"/> Neglect	<input type="checkbox"/> Neglect	<input type="radio"/> No	<input type="checkbox"/> Sexual	<input type="checkbox"/> Sexual	<input type="checkbox"/> Sexual	<input type="radio"/> U/K	<input type="checkbox"/> Emotional/psychological	<input type="checkbox"/> Emotional/psychological	<input type="checkbox"/> Emotional/psychological		<input type="checkbox"/> U/K	<input type="checkbox"/> U/K	<input type="checkbox"/> U/K	24. Was there an open CPS case with child at time of death? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K
As Victim	As Perpetrator	As Victim	As Perpetrator																							
<input type="radio"/> N/A	<input type="checkbox"/> Physical	<input type="checkbox"/> Physical	<input type="checkbox"/> Physical																							
<input type="radio"/> Yes	<input type="checkbox"/> Neglect	<input type="checkbox"/> Neglect	<input type="checkbox"/> Neglect																							
<input type="radio"/> No	<input type="checkbox"/> Sexual	<input type="checkbox"/> Sexual	<input type="checkbox"/> Sexual																							
<input type="radio"/> U/K	<input type="checkbox"/> Emotional/psychological	<input type="checkbox"/> Emotional/psychological	<input type="checkbox"/> Emotional/psychological																							
	<input type="checkbox"/> U/K	<input type="checkbox"/> U/K	<input type="checkbox"/> U/K																							
		25. Was child ever placed outside of the home prior to the death? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K																								
		26. Were any siblings placed outside of the home prior to this child's death? <input type="radio"/> N/A <input type="radio"/> Yes, # _____ <input type="radio"/> No <input type="radio"/> U/K																								
27. Child had history of intimate partner violence? Check all that apply: <input type="checkbox"/> N/A <input type="checkbox"/> Yes, as victim <input type="checkbox"/> Yes, as perpetrator <input type="checkbox"/> No <input type="checkbox"/> U/K																										
28. Child had delinquent or criminal history? <input type="radio"/> N/A <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K If yes, check all that apply: <input type="checkbox"/> Assaults <input type="checkbox"/> Other, specify: _____ <input type="checkbox"/> Robbery <input type="checkbox"/> Drugs <input type="checkbox"/> U/K		29. Child spent time in juvenile detention? <input type="radio"/> N/A <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K																								
		30. Child acutely ill during the two weeks before death? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K																								
		31. Was any parent a first generation immigrant? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K If yes, country of origin: _____																								
32. If child over age 12, what was child's gender identity? <input type="radio"/> Male <input type="radio"/> Female <input type="radio"/> U/K		33. If child over age 12, what was child's sexual orientation? <input type="radio"/> Heterosexual <input type="radio"/> Lesbian <input type="radio"/> Questioning <input type="radio"/> Gay <input type="radio"/> Bisexual <input type="radio"/> U/K																								

COMPLETE FOR ALL INFANTS UNDER ONE YEAR

34. Gestational age: <input type="checkbox"/> U/K _____ # weeks	35. Birth weight: <input type="checkbox"/> U/K <input type="radio"/> Grams/kilograms _____ <input type="radio"/> Pounds/ounces _____/____	36. Multiple birth? <input type="radio"/> Yes, # _____ <input type="radio"/> No <input type="radio"/> U/K	37. Including the deceased infant, how many pregnancies did the birth mother have? # _____ <input type="checkbox"/> U/K	38. Including the deceased infant, how many live births did the birth mother have? # _____ <input type="checkbox"/> U/K
39. Not including the deceased infant, number of children birth mother still has living? # _____ <input type="checkbox"/> U/K		40. Prenatal care provided during pregnancy of deceased infant? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K If yes, number of prenatal visits: # _____ <input type="checkbox"/> U/K If yes, month of first prenatal visit: Specify 1-9 ____ <input type="checkbox"/> U/K		
41. During pregnancy, did mother (check all that apply): <div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> <p><u>Yes</u> <u>No</u> <u>U/K</u></p> <p><input type="radio"/> <input type="radio"/> <input type="radio"/> Have medical complications/infections?</p> <p><input type="radio"/> <input type="radio"/> <input type="radio"/> Experience intimate partner violence?</p> <p><input type="radio"/> <input type="radio"/> <input type="radio"/> Use illicit drugs?</p> <p><input type="checkbox"/> Infant born drug exposed?</p> <p><input type="radio"/> <input type="radio"/> <input type="radio"/> Misuse OTC or prescription drugs?</p> <p><input type="radio"/> <input type="radio"/> <input type="radio"/> Have heavy alcohol use?</p> <p><input type="checkbox"/> Infant born with fetal alcohol effects or syndrome?</p> </div> <div style="width: 50%;"> <p>If yes, medical complications/infections, check all that apply:</p> <div style="display: flex; flex-wrap: wrap;"> <div style="width: 33%;"> <input type="checkbox"/> Acute/chronic lung disease <input type="checkbox"/> Anemia <input type="checkbox"/> Cardiac disease <input type="checkbox"/> Chorioamnionitis <input type="checkbox"/> Chronic hypertension <input type="checkbox"/> Diabetes <input type="checkbox"/> Eclampsia <input type="checkbox"/> Genital herpes </div> <div style="width: 33%;"> <input type="checkbox"/> Hemoglobinopathy <input type="checkbox"/> High MSAFP <input type="checkbox"/> Hydramnios/oligohydramnios <input type="checkbox"/> Incompetent cervix <input type="checkbox"/> Low MSAFP <input type="checkbox"/> Other infectious disease <input type="checkbox"/> Pregnancy-related hypertension <input type="checkbox"/> Preterm labor </div> <div style="width: 33%;"> <input type="checkbox"/> Previous infant 4000+ grams <input type="checkbox"/> Previous infant preterm/ small for gestation <input type="checkbox"/> PROM <input type="checkbox"/> Renal disease <input type="checkbox"/> Rh sensitization <input type="checkbox"/> Uterine bleeding <input type="checkbox"/> Other, specify: _____ </div> </div> </div> </div>				
42. Were there access or compliance issues related to prenatal care? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K If yes, check all that apply: <div style="display: flex; flex-wrap: wrap;"> <div style="width: 33%;"> <input type="checkbox"/> Lack of money for care <input type="checkbox"/> Limitations of health insurance coverage <input type="checkbox"/> Multiple health insurance, not coordinated <input type="checkbox"/> Lack of transportation <input type="checkbox"/> No phone </div> <div style="width: 33%;"> <input type="checkbox"/> Cultural differences <input type="checkbox"/> Religious objections to care <input type="checkbox"/> Language barriers <input type="checkbox"/> Referrals not made <input type="checkbox"/> Specialist needed, not available </div> <div style="width: 33%;"> <input type="checkbox"/> Multiple providers, not coordinated <input type="checkbox"/> Lack of child care <input type="checkbox"/> Lack of family/social support <input type="checkbox"/> Services not available <input type="checkbox"/> Distrust of health care system </div> <div style="width: 33%;"> <input type="checkbox"/> Unwilling to obtain care <input type="checkbox"/> Intimate partner would not allow care <input type="checkbox"/> Other, specify: _____ <input type="checkbox"/> U/K </div> </div>				
43. Did mother smoke in the 3 months before pregnancy? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K If yes, _____ Avg # cigarettes/day (20 cigarettes in pack) <input type="checkbox"/> U/K quantity		44. Did mother smoke at any time during pregnancy? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K <div style="display: flex; justify-content: space-around; margin-top: 10px;"> <div> <u>Trimester 1</u> If yes, _____ <input type="checkbox"/> U/K quantity </div> <div> <u>Trimester 2</u> If yes, _____ <input type="checkbox"/> U/K quantity </div> <div> <u>Trimester 3</u> If yes, _____ <input type="checkbox"/> U/K quantity </div> </div>		
45. Infant ever breastfed? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K	46. Was mother injured during pregnancy? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K If yes, describe: _____	47. Did infant have abnormal metabolic newborn screening results? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K If yes, was abnormality a fatty acid oxidation error, such as MCAD? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> 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): <input type="checkbox"/> Infection <input type="checkbox"/> Allergies <input type="checkbox"/> Abnormal growth, weight gain/loss <input type="checkbox"/> Apnea <input type="checkbox"/> Cyanosis <input type="checkbox"/> Seizures or convulsions <input type="checkbox"/> Cardiac abnormalities <input type="checkbox"/> Metabolic disorders <input type="checkbox"/> Other, specify: _____		49. In the 72 hours prior to death, did the infant have any of the following? Check all that apply: <input type="checkbox"/> Fever <input type="checkbox"/> Excessive sweating <input type="checkbox"/> Lethargy/sleeping more than usual <input type="checkbox"/> Fussiness/excessive crying <input type="checkbox"/> Decrease in appetite <input type="checkbox"/> Vomiting <input type="checkbox"/> Choking <input type="checkbox"/> Diarrhea <input type="checkbox"/> Stool changes <input type="checkbox"/> Difficulty breathing <input type="checkbox"/> Apnea <input type="checkbox"/> Cyanosis <input type="checkbox"/> Seizures or convulsions <input type="checkbox"/> Other, specify: _____		
50. In the 72 hours prior to death, was the infant injured? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K If yes, describe cause and injuries: _____	51. In the 72 hours prior to death, was the infant given any vaccines? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> 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. <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> 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: <input type="checkbox"/> Breast milk <input type="checkbox"/> Formula, type: _____ <input type="checkbox"/> Baby food, type: _____ <input type="checkbox"/> Cereal, type: _____ <input type="checkbox"/> Other, specify: _____ <input type="checkbox"/> U/K	

B. PRIMARY CAREGIVER(S) INFORMATION

1. Primary caregiver(s): Select only one each in columns one and two. <div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> <p><u>One</u> <u>Two</u></p> <p><input type="radio"/> Self, go to Section C</p> <p><input type="radio"/> Biological parent</p> <p><input type="radio"/> Adoptive parent</p> <p><input type="radio"/> Stepparent</p> <p><input type="radio"/> Foster parent</p> <p><input type="radio"/> Mother's partner</p> <p><input type="radio"/> Father's partner</p> </div> <div style="width: 45%;"> <p><u>One</u> <u>Two</u></p> <p><input type="radio"/> Grandparent</p> <p><input type="radio"/> Sibling</p> <p><input type="radio"/> Other relative</p> <p><input type="radio"/> Friend</p> <p><input type="radio"/> Institutional staff</p> <p><input type="radio"/> Other, specify: _____</p> <p><input type="radio"/> U/K</p> </div> </div>	2. Caregiver(s) age in years: <u>One</u> <u>Two</u> _____ # Years <input type="checkbox"/> <input type="checkbox"/> U/K	3. Caregiver(s) sex: <u>One</u> <u>Two</u> <input type="radio"/> Male <input type="radio"/> Female <input type="radio"/> U/K	4. Caregiver(s) employment status: <u>One</u> <u>Two</u> <input type="radio"/> Employed <input type="radio"/> Unemployed <input type="radio"/> On disability <input type="radio"/> Stay-at-home <input type="radio"/> Retired <input type="radio"/> U/K	5. Caregiver(s) income: <u>One</u> <u>Two</u> <input type="radio"/> High <input type="radio"/> Medium <input type="radio"/> Low <input type="radio"/> U/K
6. Caregiver(s) education: <u>One</u> <u>Two</u> <input type="radio"/> < High school <input type="radio"/> High school <input type="radio"/> College <input type="radio"/> Post graduate <input type="radio"/> U/K	7. Do caregiver(s) speak English? <u>One</u> <u>Two</u> <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K If no, language spoken: _____	8. Caregiver(s) on active military duty? <u>One</u> <u>Two</u> <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K If yes, specify branch: _____	9. Caregiver(s) receive social services in the past twelve months? <u>One</u> <u>Two</u> <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K If yes, check all that apply: <div style="display: flex; justify-content: space-between; margin-top: 10px;"> <div style="width: 45%;"> <input type="checkbox"/> WIC <input type="checkbox"/> TANF <input type="checkbox"/> Medicaid <input type="checkbox"/> Food stamps <input type="checkbox"/> Other, specify: _____ <input type="checkbox"/> U/K </div> <div style="width: 45%;"></div> </div>	

<p>10. Caregiver(s) have substance abuse history?</p> <p><u>One</u> <u>Two</u></p> <p><input type="radio"/> <input type="radio"/> Yes</p> <p><input type="radio"/> <input type="radio"/> No</p> <p><input type="radio"/> <input type="radio"/> U/K</p> <p>If yes, check all that apply:</p> <p><input type="checkbox"/> <input type="checkbox"/> Alcohol</p> <p><input type="checkbox"/> <input type="checkbox"/> Cocaine</p> <p><input type="checkbox"/> <input type="checkbox"/> Marijuana</p> <p><input type="checkbox"/> <input type="checkbox"/> Methamphetamine</p> <p><input type="checkbox"/> <input type="checkbox"/> Opiates</p> <p><input type="checkbox"/> <input type="checkbox"/> Prescription drugs</p> <p><input type="checkbox"/> <input type="checkbox"/> Over-the-counter</p> <p><input type="checkbox"/> <input type="checkbox"/> Other, specify:</p> <p><input type="checkbox"/> <input type="checkbox"/> U/K</p>	<p>11. Caregiver(s) ever victim of child maltreatment?</p> <p><u>One</u> <u>Two</u></p> <p><input type="radio"/> <input type="radio"/> Yes</p> <p><input type="radio"/> <input type="radio"/> No</p> <p><input type="radio"/> <input type="radio"/> U/K</p> <p>If yes, check all that apply:</p> <p><input type="checkbox"/> <input type="checkbox"/> Physical</p> <p><input type="checkbox"/> <input type="checkbox"/> Neglect</p> <p><input type="checkbox"/> <input type="checkbox"/> Sexual</p> <p><input type="checkbox"/> <input type="checkbox"/> Emotional/psychological</p> <p><input type="checkbox"/> <input type="checkbox"/> U/K</p> <p>_____ # CPS referrals</p> <p>_____ # Substantiations</p> <p><input type="checkbox"/> <input type="checkbox"/> Ever in foster care or adopted</p>	<p>12. Caregiver(s) ever perpetrator of maltreatment?</p> <p><u>One</u> <u>Two</u></p> <p><input type="radio"/> <input type="radio"/> Yes</p> <p><input type="radio"/> <input type="radio"/> No</p> <p><input type="radio"/> <input type="radio"/> U/K</p> <p>If yes, check all that apply:</p> <p><input type="checkbox"/> <input type="checkbox"/> Physical</p> <p><input type="checkbox"/> <input type="checkbox"/> Neglect</p> <p><input type="checkbox"/> <input type="checkbox"/> Sexual</p> <p><input type="checkbox"/> <input type="checkbox"/> Emotional/psychological</p> <p><input type="checkbox"/> <input type="checkbox"/> U/K</p> <p>_____ # CPS referrals</p> <p>_____ # Substantiations</p> <p><input type="checkbox"/> <input type="checkbox"/> CPS prevention services</p> <p><input type="checkbox"/> <input type="checkbox"/> Family preservation services</p> <p><input type="checkbox"/> <input type="checkbox"/> Children ever removed</p>	<p>13. Caregiver(s) have disability or chronic illness?</p> <p><u>One</u> <u>Two</u></p> <p><input type="radio"/> <input type="radio"/> Yes</p> <p><input type="radio"/> <input type="radio"/> No</p> <p><input type="radio"/> <input type="radio"/> U/K</p> <p>If yes, check all that apply:</p> <p><input type="checkbox"/> <input type="checkbox"/> Physical, specify:</p> <p><input type="checkbox"/> <input type="checkbox"/> Mental, specify:</p> <p><input type="checkbox"/> <input type="checkbox"/> Sensory, specify:</p> <p><input type="checkbox"/> <input type="checkbox"/> U/K</p> <p>If mental illness, was caregiver receiving MH services?</p> <p><input type="radio"/> <input type="radio"/> Yes</p> <p><input type="radio"/> <input type="radio"/> No</p> <p><input type="radio"/> <input type="radio"/> U/K</p>		
<p>14. Caregiver(s) have prior child deaths?</p> <p><u>One</u> <u>Two</u></p> <p><input type="radio"/> <input type="radio"/> Yes</p> <p><input type="radio"/> <input type="radio"/> No</p> <p><input type="radio"/> <input type="radio"/> U/K</p>	<p>If yes, cause(s): Check all that apply:</p> <p><u>One</u> <u>Two</u></p> <p><input type="checkbox"/> <input type="checkbox"/> Child abuse # _____</p> <p><input type="checkbox"/> <input type="checkbox"/> Child neglect # _____</p> <p><input type="checkbox"/> <input type="checkbox"/> Accident # _____</p> <p><input type="checkbox"/> <input type="checkbox"/> Suicide # _____</p> <p><input type="checkbox"/> <input type="checkbox"/> SIDS # _____</p> <p><input type="checkbox"/> <input type="checkbox"/> Other # _____</p> <p>Other, specify:</p> <p><input type="checkbox"/> <input type="checkbox"/> U/K</p>			<p>15. Caregiver(s) have history of intimate partner violence?</p> <p><u>One</u> <u>Two</u></p> <p><input type="checkbox"/> <input type="checkbox"/> Yes, as victim</p> <p><input type="checkbox"/> <input type="checkbox"/> Yes, as perpetrator</p> <p><input type="checkbox"/> <input type="checkbox"/> No</p> <p><input type="checkbox"/> <input type="checkbox"/> U/K</p>	<p>16. Caregiver(s) have delinquent/criminal history?</p> <p><u>One</u> <u>Two</u></p> <p><input type="radio"/> <input type="radio"/> Yes</p> <p><input type="radio"/> <input type="radio"/> No</p> <p><input type="radio"/> <input type="radio"/> U/K</p> <p>If yes, check all that apply:</p> <p><input type="checkbox"/> <input type="checkbox"/> Assaults</p> <p><input type="checkbox"/> <input type="checkbox"/> Robbery</p> <p><input type="checkbox"/> <input type="checkbox"/> Drugs</p> <p><input type="checkbox"/> <input type="checkbox"/> Other, specify:</p> <p><input type="checkbox"/> <input type="checkbox"/> U/K</p>

C. SUPERVISOR INFORMATION			
<p>1. Did child have supervision at time of incident leading to death?</p> <p><input type="radio"/> Yes, answer 2-15</p> <p><input type="radio"/> No, not needed given developmental age or circumstances, go to Sect. D</p> <p><input type="radio"/> No, but needed, answer 3-15</p> <p><input type="radio"/> Unable to determine, try to answer 3-15</p>	<p>2. How long before incident did supervisor last see child? Select one:</p> <p><input type="radio"/> Child in sight of supervisor</p> <p><input type="radio"/> Minutes _____ <input type="radio"/> Days _____</p> <p><input type="radio"/> Hours _____ <input type="radio"/> U/K</p>	<p>3. Is person a primary caregiver as listed in previous section?</p> <p><input type="radio"/> Yes, caregiver one, go to 15</p> <p><input type="radio"/> Yes, caregiver two, go to 15</p> <p><input type="radio"/> No</p>	
<p>4. Primary person responsible for supervision? Select only one:</p> <p><input type="radio"/> Biological parent <input type="radio"/> Foster parent <input type="radio"/> Grandparent <input type="radio"/> Friend <input type="radio"/> Institutional staff, go to 15 <input type="radio"/> Other, specify:</p> <p><input type="radio"/> Adoptive parent <input type="radio"/> Mother's partner <input type="radio"/> Sibling <input type="radio"/> Acquaintance <input type="radio"/> Babysitter</p> <p><input type="radio"/> Stepparent <input type="radio"/> Father's partner <input type="radio"/> Other relative <input type="radio"/> Hospital staff, go to 15 <input type="radio"/> Licensed child care worker <input type="radio"/> U/K</p>			
<p>5. Supervisor's age in years:</p> <p>_____ <input type="checkbox"/> U/K</p>	<p>6. Supervisor's sex:</p> <p><input type="radio"/> Male <input type="radio"/> Female <input type="radio"/> U/K</p>	<p>7. Does supervisor speak English?</p> <p><input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K</p> <p>If no, language spoken:</p>	<p>8. Supervisor on active military duty?</p> <p><input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K</p> <p>If yes, specify branch:</p>
<p>9. Supervisor has substance abuse history?</p> <p><input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K</p> <p>If yes, check all that apply:</p> <p><input type="checkbox"/> Alcohol</p> <p><input type="checkbox"/> Cocaine</p> <p><input type="checkbox"/> Marijuana</p> <p><input type="checkbox"/> Methamphetamine</p> <p><input type="checkbox"/> Opiates</p> <p><input type="checkbox"/> Prescription drugs</p> <p><input type="checkbox"/> Over-the-counter</p> <p><input type="checkbox"/> Other, specify:</p> <p><input type="checkbox"/> U/K</p>	<p>10. Supervisor has history of child maltreatment?</p> <p><u>As Victim</u> <u>As Perpetrator</u></p> <p><input type="radio"/> <input type="radio"/> Yes</p> <p><input type="radio"/> <input type="radio"/> No</p> <p><input type="radio"/> <input type="radio"/> U/K</p> <p>If yes, check all that apply:</p> <p><input type="checkbox"/> <input type="checkbox"/> Physical</p> <p><input type="checkbox"/> <input type="checkbox"/> Neglect</p> <p><input type="checkbox"/> <input type="checkbox"/> Sexual</p> <p><input type="checkbox"/> <input type="checkbox"/> Emotional/psychological</p> <p><input type="checkbox"/> <input type="checkbox"/> U/K</p> <p>_____ # CPS referrals</p> <p>_____ # Substantiations</p> <p><input type="checkbox"/> <input type="checkbox"/> Ever in foster care/adopted</p> <p><input type="checkbox"/> CPS prevention services</p> <p><input type="checkbox"/> Family preservation services</p> <p><input type="checkbox"/> Children ever removed</p>	<p>11. Supervisor has disability or chronic illness?</p> <p><input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K</p> <p>If yes, check all that apply:</p> <p><input type="checkbox"/> Physical, specify:</p> <p><input type="checkbox"/> Mental, specify:</p> <p><input type="checkbox"/> Sensory, specify:</p> <p><input type="checkbox"/> U/K</p> <p>If mental illness, was supervisor receiving MH services?</p> <p><input type="radio"/> Yes</p> <p><input type="radio"/> No</p> <p><input type="radio"/> U/K</p>	<p>12. Supervisor has prior child deaths?</p> <p><input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K</p> <p>If yes, check all that apply:</p> <p><input type="checkbox"/> Child abuse # _____</p> <p><input type="checkbox"/> Child neglect # _____</p> <p><input type="checkbox"/> Accident # _____</p> <p><input type="checkbox"/> Suicide # _____</p> <p><input type="checkbox"/> SIDS # _____</p> <p><input type="checkbox"/> Other # _____</p> <p>Other, specify:</p> <p><input type="checkbox"/> U/K</p>

<p>5. Official manner of death from the death certificate:</p> <p> <input type="radio"/> Natural <input type="radio"/> Accident <input type="radio"/> Suicide <input type="radio"/> Homicide <input type="radio"/> Undetermined <input type="radio"/> Pending <input type="radio"/> U/K </p> <hr/> <p>If Homicide: <u>Yes</u></p> <p>Child abuse? <input type="checkbox"/></p> <p>Child neglect? <input type="checkbox"/></p> <p>Complete Section I, Acts of Omission or Commission</p> <hr/> <p>If Suicide: Complete Section I, Acts of Omission or Commission</p>	<p>6. Primary cause of death: Choose only 1 of the 4 major categories, then a specific cause. For pending, choose most likely cause.</p> <table style="width: 100%;"> <tr> <td style="width: 33%; vertical-align: top;"> <input type="radio"/> <u>From an injury (external cause). Select one and answer F4:</u> <input type="radio"/> Motor vehicle and other transport, go to G1 <input type="radio"/> Fire, burn, or electrocution, go to G2 <input type="radio"/> Drowning, go to G3 <input type="radio"/> Asphyxia, go to G4 <input type="radio"/> Weapon, including body part, go to G5 <input type="radio"/> Animal bite or attack, go to G6 <input type="radio"/> Fall or crush, go to G7 <input type="radio"/> Poisoning, overdose or acute intoxication, go to G8 <input type="radio"/> Exposure, go to G9 <input type="radio"/> Undetermined, go to H1 <input type="radio"/> Other cause, go to G11 <input type="radio"/> U/K, go to H1 </td> <td style="width: 33%; vertical-align: top;"> <input type="radio"/> <u>From a medical cause. Select one:</u> <input type="radio"/> Asthma, go to G10 <input type="radio"/> Cancer, specify and go to G10 <input type="radio"/> Cardiovascular, specify and go to G10 <input type="radio"/> Congenital anomaly, specify and go to G10 <input type="radio"/> Diabetes, go to G10 <input type="radio"/> HIV/AIDS, go to G10 <input type="radio"/> Influenza, go to G10 <input type="radio"/> Low birth weight, go to G10 <input type="radio"/> Malnutrition/dehydration, go to G10 <input type="radio"/> Neurological/seizure disorder, go to G10 <input type="radio"/> Pneumonia, specify and go to G10 <input type="radio"/> Prematurity, go to G10 <input type="radio"/> SIDS, go to G10 <input type="radio"/> Other infection, specify and go to G10 <input type="radio"/> Other perinatal condition, specify and go to G10 <input type="radio"/> Other medical condition, specify and go to G10 <input type="radio"/> Undetermined, go to G10 <input type="radio"/> U/K, go to G10 </td> <td style="width: 33%; vertical-align: top;"> <input type="radio"/> <u>Undetermined if injury or medical cause. go to H1</u> <input type="radio"/> <u>U/K go to H1</u> </td> </tr> </table>	<input type="radio"/> <u>From an injury (external cause). Select one and answer F4:</u> <input type="radio"/> Motor vehicle and other transport, go to G1 <input type="radio"/> Fire, burn, or electrocution, go to G2 <input type="radio"/> Drowning, go to G3 <input type="radio"/> Asphyxia, go to G4 <input type="radio"/> Weapon, including body part, go to G5 <input type="radio"/> Animal bite or attack, go to G6 <input type="radio"/> Fall or crush, go to G7 <input type="radio"/> Poisoning, overdose or acute intoxication, go to G8 <input type="radio"/> Exposure, go to G9 <input type="radio"/> Undetermined, go to H1 <input type="radio"/> Other cause, go to G11 <input type="radio"/> U/K, go to H1	<input type="radio"/> <u>From a medical cause. Select one:</u> <input type="radio"/> Asthma, go to G10 <input type="radio"/> Cancer, specify and go to G10 <input type="radio"/> Cardiovascular, specify and go to G10 <input type="radio"/> Congenital anomaly, specify and go to G10 <input type="radio"/> Diabetes, go to G10 <input type="radio"/> HIV/AIDS, go to G10 <input type="radio"/> Influenza, go to G10 <input type="radio"/> Low birth weight, go to G10 <input type="radio"/> Malnutrition/dehydration, go to G10 <input type="radio"/> Neurological/seizure disorder, go to G10 <input type="radio"/> Pneumonia, specify and go to G10 <input type="radio"/> Prematurity, go to G10 <input type="radio"/> SIDS, go to G10 <input type="radio"/> Other infection, specify and go to G10 <input type="radio"/> Other perinatal condition, specify and go to G10 <input type="radio"/> Other medical condition, specify and go to G10 <input type="radio"/> Undetermined, go to G10 <input type="radio"/> U/K, go to G10	<input type="radio"/> <u>Undetermined if injury or medical cause. go to H1</u> <input type="radio"/> <u>U/K go to H1</u>
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G. DETAILED INFORMATION BY CAUSE OF DEATH: CHOOSE ONE SECTION ONLY, THAT IS SAME AS THE CAUSE SELECTED ABOVE

1. MOTOR VEHICLE AND OTHER TRANSPORT

<p>a. Vehicles involved in incident:</p> <p>Total number of vehicles: _____</p> <table style="width: 100%;"> <tr> <th style="text-align: left;"><u>Child's</u></th> <th style="text-align: left;"><u>Other primary vehicle</u></th> </tr> <tr><td><input type="radio"/></td><td><input type="radio"/> None</td></tr> <tr><td><input type="radio"/></td><td><input type="radio"/> Car</td></tr> <tr><td><input type="radio"/></td><td><input type="radio"/> Van</td></tr> <tr><td><input type="radio"/></td><td><input type="radio"/> Sport utility vehicle</td></tr> <tr><td><input type="radio"/></td><td><input type="radio"/> Truck</td></tr> <tr><td><input type="radio"/></td><td><input type="radio"/> Semi/tractor trailer</td></tr> <tr><td><input type="radio"/></td><td><input type="radio"/> RV</td></tr> <tr><td><input type="radio"/></td><td><input type="radio"/> School bus</td></tr> <tr><td><input type="radio"/></td><td><input type="radio"/> Other bus</td></tr> <tr><td><input type="radio"/></td><td><input type="radio"/> Motorcycle</td></tr> <tr><td><input type="radio"/></td><td><input type="radio"/> Tractor</td></tr> <tr><td><input type="radio"/></td><td><input type="radio"/> Other farm vehicle</td></tr> <tr><td><input type="radio"/></td><td><input type="radio"/> All terrain vehicle</td></tr> <tr><td><input type="radio"/></td><td><input type="radio"/> Snowmobile</td></tr> <tr><td><input type="radio"/></td><td><input type="radio"/> Bicycle</td></tr> <tr><td><input type="radio"/></td><td><input type="radio"/> Train</td></tr> <tr><td><input type="radio"/></td><td><input type="radio"/> Subway</td></tr> <tr><td><input type="radio"/></td><td><input type="radio"/> Trolley</td></tr> <tr><td><input type="radio"/></td><td><input type="radio"/> Other, specify:</td></tr> <tr><td><input type="radio"/></td><td><input type="radio"/> U/K</td></tr> </table>	<u>Child's</u>	<u>Other primary vehicle</u>	<input type="radio"/>	<input type="radio"/> None	<input type="radio"/>	<input type="radio"/> Car	<input type="radio"/>	<input type="radio"/> Van	<input type="radio"/>	<input type="radio"/> Sport utility vehicle	<input type="radio"/>	<input type="radio"/> Truck	<input type="radio"/>	<input type="radio"/> Semi/tractor trailer	<input type="radio"/>	<input type="radio"/> RV	<input type="radio"/>	<input type="radio"/> School bus	<input type="radio"/>	<input type="radio"/> Other bus	<input type="radio"/>	<input type="radio"/> Motorcycle	<input type="radio"/>	<input type="radio"/> Tractor	<input type="radio"/>	<input type="radio"/> Other farm vehicle	<input type="radio"/>	<input type="radio"/> All terrain vehicle	<input type="radio"/>	<input type="radio"/> Snowmobile	<input type="radio"/>	<input type="radio"/> Bicycle	<input type="radio"/>	<input type="radio"/> Train	<input type="radio"/>	<input type="radio"/> Subway	<input type="radio"/>	<input type="radio"/> Trolley	<input type="radio"/>	<input type="radio"/> Other, specify:	<input type="radio"/>	<input type="radio"/> U/K	<p>b. Position of child:</p> <table style="width: 100%;"> <tr> <td style="width: 50%; vertical-align: top;"> <input type="radio"/> Driver <input type="radio"/> Passenger <input type="radio"/> Front seat <input type="radio"/> Back seat <input type="radio"/> Truck bed <input type="radio"/> Other, specify: <input type="radio"/> U/K <input type="radio"/> On bicycle <input type="radio"/> Pedestrian <input type="radio"/> Walking <input type="radio"/> Boarding/blading <input type="radio"/> Other, specify: <input type="radio"/> U/K <input type="radio"/> U/K </td> <td style="width: 50%; vertical-align: top;"> <p>If passenger, relationship of driver to child:</p> <input type="radio"/> Biological parent <input type="radio"/> Adoptive parent <input type="radio"/> Stepparent <input type="radio"/> Foster parent <input type="radio"/> Mother's partner <input type="radio"/> Father's partner <input type="radio"/> Grandparent <input type="radio"/> Sibling <input type="radio"/> Other relative <input type="radio"/> Friend <input type="radio"/> Other, specify: <input type="radio"/> U/K </td> </tr> </table>	<input type="radio"/> Driver <input type="radio"/> Passenger <input type="radio"/> Front seat <input type="radio"/> Back seat <input type="radio"/> Truck bed <input type="radio"/> Other, specify: <input type="radio"/> U/K <input type="radio"/> On bicycle <input type="radio"/> Pedestrian <input type="radio"/> Walking <input type="radio"/> Boarding/blading <input type="radio"/> Other, specify: <input type="radio"/> U/K <input type="radio"/> U/K	<p>If passenger, relationship of driver to child:</p> <input type="radio"/> Biological parent <input type="radio"/> Adoptive parent <input type="radio"/> Stepparent <input type="radio"/> Foster parent <input type="radio"/> Mother's partner <input type="radio"/> Father's partner <input type="radio"/> Grandparent <input type="radio"/> Sibling <input type="radio"/> Other relative <input type="radio"/> Friend <input type="radio"/> Other, specify: <input type="radio"/> U/K	<p>c. Causes of incident, check all that apply:</p> <table style="width: 100%;"> <tr> <td style="width: 50%; vertical-align: top;"> <input type="checkbox"/> Speeding over limit <input type="checkbox"/> Unsafe speed for conditions <input type="checkbox"/> Recklessness <input type="checkbox"/> Ran stop sign or red light <input type="checkbox"/> Driver distraction <input type="checkbox"/> Driver inexperience <input type="checkbox"/> Mechanical failure <input type="checkbox"/> Poor tires <input type="checkbox"/> Poor weather <input type="checkbox"/> Poor visibility <input type="checkbox"/> Drugs or alcohol use <input type="checkbox"/> Fatigue/sleeping <input type="checkbox"/> Medical event, specify: </td> <td style="width: 50%; vertical-align: top;"> <input type="checkbox"/> Back/front over <input type="checkbox"/> Flipover <input type="checkbox"/> Poor sight line <input type="checkbox"/> Car changing lanes <input type="checkbox"/> Road hazard <input type="checkbox"/> Animal in road <input type="checkbox"/> Cell phone use while driving <input type="checkbox"/> Racing, not authorized <input type="checkbox"/> Other driver error, specify: <input type="checkbox"/> Other, specify: <input type="checkbox"/> U/K </td> </tr> </table>	<input type="checkbox"/> Speeding over limit <input type="checkbox"/> Unsafe speed for conditions <input type="checkbox"/> Recklessness <input type="checkbox"/> Ran stop sign or red light <input type="checkbox"/> Driver distraction <input type="checkbox"/> Driver inexperience <input type="checkbox"/> Mechanical failure <input type="checkbox"/> Poor tires <input type="checkbox"/> Poor weather <input type="checkbox"/> Poor visibility <input type="checkbox"/> Drugs or alcohol use <input type="checkbox"/> Fatigue/sleeping <input type="checkbox"/> Medical event, specify:	<input type="checkbox"/> Back/front over <input type="checkbox"/> Flipover <input type="checkbox"/> Poor sight line <input type="checkbox"/> Car changing lanes <input type="checkbox"/> Road hazard <input type="checkbox"/> Animal in road <input type="checkbox"/> Cell phone use while driving <input type="checkbox"/> Racing, not authorized <input type="checkbox"/> Other driver error, specify: <input type="checkbox"/> Other, specify: <input type="checkbox"/> U/K
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g. Drivers involved in incident, check all that apply:

Child as driver	Child's driver	Driver of other primary vehicle	Child as driver	Child's driver	Driver of other primary vehicle
Age of Driver	Age of Driver		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Has a graduated license
<input type="radio"/>	<input type="radio"/> <16 years		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Has a full license
<input type="radio"/>	<input type="radio"/> 16 to 18 years old		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Has a full license that has been restricted
<input type="radio"/>	<input type="radio"/> 19 to 21 years old		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Has a suspended license
<input type="radio"/>	<input type="radio"/> 22 to 29 years old		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> If recreational vehicle, has driver safety certificate
<input type="radio"/>	<input type="radio"/> 30 to 65 years old		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Other, specify:
<input type="radio"/>	<input type="radio"/> >65 years old		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Was violating graduated licensing rules:
<input type="radio"/>	<input type="radio"/> U/K age		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Nighttime driving curfew
<input type="checkbox"/>	<input type="checkbox"/> Responsible for causing incident		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Passenger restrictions
<input type="checkbox"/>	<input type="checkbox"/> Was alcohol/drug impaired		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Driving without required supervision
<input type="checkbox"/>	<input type="checkbox"/> Has no license		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Other violations, specify:
<input type="checkbox"/>	<input type="checkbox"/> Has a learner's permit		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> U/K

h. Total number of occupants in vehicles:

In child's vehicle, including child:

☐ N/A, child was not in a vehicle

Total number of occupants: _____ ☐ U/K

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

Total number of deaths: _____ ☐ U/K

Total number of teen deaths: _____ ☐ U/K

In other primary vehicle involved in incident:

☐ N/A, incident was a single vehicle crash

Total number of occupants: _____ ☐ U/K

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

Total number of deaths: _____ ☐ U/K

Total number of teen deaths: _____ ☐ U/K

i. Protective measures for child,

Select one option per row:

Not

Needed

Needed,

none present

Present, used

correctly

Present, used

incorrectly

Present,

not used

U/K

Airbag

☐

☐

☐

☐

☐

☐

Lap belt

☐

☐

☐

☐

☐

☐

Shoulder belt

☐

☐

☐

☐

☐

☐

Child seat*

☐

☐

☐

☐

☐

☐

Belt positioning booster seat

☐

☐

☐

☐

☐

☐

Helmet

☐

☐

☐

☐

☐

☐

Other, specify:

☐

☐

☐

☐

☐

☐

*If child seat, type:

☐ Rear facing

☐ Front facing

☐ U/K

2. FIRE, BURN, OR ELECTROCUTION

a. Ignition, heat or electrocution source:

☐ Matches

☐ Heating stove

☐ Lightning

☐ Other explosives

☐ Cigarette lighter

☐ Space heater

☐ Oxygen tank

☐ Appliance in water

☐ Utility lighter

☐ Furnace

☐ Hot cooking water

☐ Other, specify:

☐ Cigarette or cigar

☐ Power line

☐ Hot bath water

☐ Candles

☐ Electrical outlet

☐ Other hot liquid, specify:

☐ Cooking stove

☐ Electrical wiring

☐ Fireworks

☐ U/K

b. Type of incident:

☐ Fire, go to c

☐ Scald, go to r

☐ Other burn, go to t

☐ Electrocution, go to s

☐ Other, specify and go to t

☐ U/K, go to t

c. For fire, child died from:

☐ Burns

☐ Smoke inhalation

☐ Other, specify:

☐ U/K

d. Material first ignited:

☐ Upholstery

☐ Mattress

☐ Christmas tree

☐ Clothing

☐ Curtain

☐ Other, specify:

☐ U/K

e. Type of building on fire:

☐ N/A

☐ Single home

☐ Duplex

☐ Apartment

☐ Trailer/mobile home

☐ Other, specify:

☐ U/K

f. Building's primary construction material:

☐ Wood

☐ Steel

☐ Brick/stone

☐ Aluminum

☐ Other, specify:

☐ U/K

g. Fire started by a person?

☐ Yes

☐ No

☐ U/K

If yes, person's age _____

Does person have a history of setting fires?

☐ Yes

☐ No

☐ U/K

h. Did anyone attempt to put out fire?

☐ Yes

☐ No

☐ U/K

i. Did escape or rescue efforts worsen fire?

☐ Yes

☐ No

☐ U/K

j. Did any factors delay fire department arrival?

☐ Yes

☐ No

☐ U/K

If yes, specify:

k. Were barriers preventing safe exit?

☐ Yes ☐ No ☐ U/K

If yes, check all that apply:

☐ Locked door

☐ Window grate

☐ Locked window

☐ Blocked stairway

☐ Other, specify:

☐ U/K

l. Was building a rental property?

☐ Yes

☐ No

☐ U/K

o. Was sprinkler system present?

☐ Yes

☐ No

☐ U/K

If yes, was it working?

☐ Yes

☐ No

☐ U/K

m. Were building/rental codes violated?

☐ Yes

☐ No

☐ U/K

If yes, describe in narrative.

n. Were proper working fire extinguishers present?

☐ Yes

☐ No

☐ U/K

p. Were smoke detectors present? ☐ Yes ☐ No ☐ U/K

If yes, what type?

☐ Removable batteries

☐ Non-removable batteries

☐ Hardwired

☐ U/K

If yes, functioning properly?

☐ Yes

☐ No

☐ U/K

☐ Yes

☐ No

☐ U/K

☐ Yes

☐ No

☐ U/K

If not functioning properly, reason:

Missing batteries

Other

U/K

☐

☐

☐

☐

☐

☐

☐

☐

☐

Other, specify:

If yes, was there an adequate number present? ☐ Yes ☐ No ☐ U/K

<p>q. Suspected arson?</p> <p><input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K</p>	<p>r. For scald, was hot water heater set too high?</p> <p><input type="radio"/> N/A</p> <p><input type="radio"/> Yes, temp. setting: _____</p> <p><input type="radio"/> No</p> <p><input type="radio"/> U/K</p>	<p>s. For electrocution, what cause:</p> <p><input type="radio"/> Electrical storm</p> <p><input type="radio"/> Faulty wiring</p> <p><input type="radio"/> Wire/product in water</p> <p><input type="radio"/> Child playing with outlet</p> <p><input type="radio"/> Other, specify:</p> <p><input type="radio"/> U/K</p>	<p>t. Other, describe in detail:</p>	
<p>3. DROWNING</p>				
<p>a. Where was child last seen before drowning? Check all that apply:</p> <p><input type="checkbox"/> In water <input type="checkbox"/> In yard</p> <p><input type="checkbox"/> On shore <input type="checkbox"/> In bathroom</p> <p><input type="checkbox"/> On dock <input type="checkbox"/> In house</p> <p><input type="checkbox"/> Poolside <input type="checkbox"/> Other, specify:</p> <p><input type="checkbox"/> U/K</p>	<p>b. What was child last seen doing before drowning?</p> <p><input type="radio"/> Playing <input type="radio"/> Tubing</p> <p><input type="radio"/> Boating <input type="radio"/> Waterskiing</p> <p><input type="radio"/> Swimming <input type="radio"/> Sleeping</p> <p><input type="radio"/> Bathing <input type="radio"/> Other, specify:</p> <p><input type="radio"/> Fishing</p> <p><input type="radio"/> Surfing <input type="radio"/> U/K</p>	<p>c. Was child forcibly submerged?</p> <p><input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K</p>	<p>d. Drowning location:</p> <p><input type="radio"/> Open water, go to e <input type="radio"/> U/K, go to n</p> <p><input type="radio"/> Pool, hot tub, spa, go to i</p> <p><input type="radio"/> Bathtub, go to w</p> <p><input type="radio"/> Bucket, go to x</p> <p><input type="radio"/> Well/cistern/septic, go to n</p> <p><input type="radio"/> Toilet, go to z</p> <p><input type="radio"/> Other, specify and go to n</p>	
<p>e. For open water, place:</p> <p><input type="radio"/> Lake <input type="radio"/> Quarry</p> <p><input type="radio"/> River <input type="radio"/> Gravel pit</p> <p><input type="radio"/> Pond <input type="radio"/> Canal</p> <p><input type="radio"/> Creek <input type="radio"/> U/K</p> <p><input type="radio"/> Ocean</p>	<p>f. For open water, contributing environmental factors:</p> <p><input type="radio"/> Weather <input type="radio"/> Drop off</p> <p><input type="radio"/> Temperature <input type="radio"/> Rough waves</p> <p><input type="radio"/> Current <input type="radio"/> Other, specify:</p> <p><input type="radio"/> Riptide/undertow <input type="radio"/> U/K</p>	<p>g. If boating, type of boat:</p> <p><input type="radio"/> Sailboat <input type="radio"/> Commercial</p> <p><input type="radio"/> Jet ski <input type="radio"/> Other, specify:</p> <p><input type="radio"/> Motorboat</p> <p><input type="radio"/> Canoe</p> <p><input type="radio"/> Kayak <input type="radio"/> U/K</p> <p><input type="radio"/> Raft</p>	<p>h. For boating, was the child piloting boat?</p> <p><input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K</p>	
<p>i. For pool, type of pool:</p> <p><input type="radio"/> Above ground</p> <p><input type="radio"/> In-ground <input type="radio"/> Hot tub, spa</p> <p><input type="radio"/> Wading <input type="radio"/> U/K</p>	<p>j. For pool, child found:</p> <p><input type="radio"/> In the pool/hot tub/spa</p> <p><input type="radio"/> On or under the cover</p> <p><input type="radio"/> U/K</p>	<p>k. For pool, ownership is:</p> <p><input type="radio"/> Private</p> <p><input type="radio"/> Public</p> <p><input type="radio"/> U/K</p>	<p>l. Length of time owners had pool/hot tub/spa:</p> <p><input type="radio"/> N/A <input type="radio"/> >1yr</p> <p><input type="radio"/> <6 months <input type="radio"/> U/K</p> <p><input type="radio"/> 6m-1 yr</p>	
<p>m. Flotation device used?</p> <p><input type="radio"/> N/A</p> <p><input type="radio"/> Yes</p> <p><input type="radio"/> No</p> <p><input type="radio"/> U/K</p> <p>If yes, check all that apply:</p> <p><input type="checkbox"/> Coast Guard approved <input type="checkbox"/> Not Coast Guard approved <input type="checkbox"/> U/K</p> <p><input type="checkbox"/> Jacket <input type="checkbox"/> Cushion <input type="checkbox"/> Lifesaving ring</p> <p>If jacket:</p> <p>Correct size? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K</p> <p>Worn correctly? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K</p> <p><input type="checkbox"/> Swim rings</p> <p><input type="checkbox"/> Inner tube</p> <p><input type="checkbox"/> Air mattress</p> <p><input type="checkbox"/> Other, specify:</p>			<p>n. What barriers/layers of protection existed to prevent access to water?</p> <p>Check all that apply:</p> <p><input type="checkbox"/> None <input type="checkbox"/> Alarm, go to r</p> <p><input type="checkbox"/> Fence, go to o <input type="checkbox"/> Cover, go to s</p> <p><input type="checkbox"/> Gate, go to p <input type="checkbox"/> U/K</p> <p><input type="checkbox"/> Door, go to q</p>	
<p>o. Fence:</p> <p>Describe type:</p> <p>Fence height in ft _____</p> <p>Fence surrounds water on:</p> <p><input type="radio"/> Four sides <input type="radio"/> Two or less sides</p> <p><input type="radio"/> Three sides <input type="radio"/> U/K</p>	<p>p. Gate, check all that apply:</p> <p><input type="checkbox"/> Has self-closing latch</p> <p><input type="checkbox"/> Has lock</p> <p><input type="checkbox"/> Is a double gate</p> <p><input type="checkbox"/> Opens to water</p> <p><input type="checkbox"/> U/K</p>	<p>q. Door, check all that apply:</p> <p><input type="checkbox"/> Patio door <input type="checkbox"/> Opens to water</p> <p><input type="checkbox"/> Screen door <input type="checkbox"/> Barrier between door and water</p> <p><input type="checkbox"/> Steel door <input type="checkbox"/> U/K</p> <p><input type="checkbox"/> Self-closing <input type="checkbox"/> U/K</p> <p><input type="checkbox"/> Has lock</p>	<p>r. Alarm, check all that apply:</p> <p><input type="checkbox"/> Door</p> <p><input type="checkbox"/> Window</p> <p><input type="checkbox"/> Pool</p> <p><input type="checkbox"/> Laser</p> <p><input type="checkbox"/> U/K</p>	<p>s. Type of cover:</p> <p><input type="radio"/> Hard</p> <p><input type="radio"/> Soft</p> <p><input type="radio"/> U/K</p>
<p>t. Local ordinance(s) regulating access to water?</p> <p><input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K</p> <p>If yes, rules violated?</p> <p><input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K</p>	<p>u. How were layers of protection breached? Check all that apply:</p> <p><input type="checkbox"/> No layers breached <input type="checkbox"/> Gap in fence <input type="checkbox"/> Door screen torn <input type="checkbox"/> Cover left off</p> <p><input type="checkbox"/> Gate left open <input type="checkbox"/> Damaged fence <input type="checkbox"/> Door self-closer failed <input type="checkbox"/> Cover not locked</p> <p><input type="checkbox"/> Gate unlocked <input type="checkbox"/> Fence too short <input type="checkbox"/> Window left open <input type="checkbox"/> Other, specify:</p> <p><input type="checkbox"/> Gate latch failed <input type="checkbox"/> Door left open <input type="checkbox"/> Window screen torn</p> <p><input type="checkbox"/> Gap in gate <input type="checkbox"/> Door unlocked <input type="checkbox"/> Alarm not working</p> <p><input type="checkbox"/> Climbed fence <input type="checkbox"/> Door broken <input type="checkbox"/> Alarm not answered <input type="checkbox"/> U/K</p>			
<p>v. Child able to swim?</p> <p><input type="radio"/> N/A <input type="radio"/> No</p> <p><input type="radio"/> Yes <input type="radio"/> U/K</p>	<p>w. For bathtub, child in a bathing aid?</p> <p><input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K</p> <p>If yes, specify type:</p>	<p>x. Warning sign or label posted?</p> <p><input type="radio"/> N/A <input type="radio"/> No</p> <p><input type="radio"/> Yes <input type="radio"/> U/K</p>	<p>y. Lifeguard present?</p> <p><input type="radio"/> N/A <input type="radio"/> No</p> <p><input type="radio"/> Yes <input type="radio"/> U/K</p>	
<p>z. Rescue attempt made?</p> <p><input type="radio"/> N/A</p> <p><input type="radio"/> Yes</p> <p><input type="radio"/> No</p> <p><input type="radio"/> U/K</p> <p>If yes, who? Check all that apply:</p> <p><input type="checkbox"/> Parent <input type="checkbox"/> Bystander</p> <p><input type="checkbox"/> Other child <input type="checkbox"/> Other, specify:</p> <p><input type="checkbox"/> Lifeguard <input type="checkbox"/> U/K</p>		<p>aa. Did rescuer(s) also drown?</p> <p><input type="radio"/> N/A <input type="radio"/> No</p> <p><input type="radio"/> Yes <input type="radio"/> U/K</p> <p>If yes, number of rescuers that drowned: _____</p>	<p>bb. Appropriate rescue equipment present?</p> <p><input type="radio"/> N/A <input type="radio"/> No</p> <p><input type="radio"/> Yes <input type="radio"/> U/K</p>	

4. ASPHYXIA									
a. Type of event: <input type="radio"/> Suffocation, go to b <input type="radio"/> Strangulation, go to c <input type="radio"/> Choking, go to d <input type="radio"/> Other, specify and go to e <input type="radio"/> U/K, go to e			b. If suffocation/asphyxia, action causing event: <div style="display: flex; flex-wrap: wrap;"> <div style="width: 33%;"> <input type="radio"/> Sleep-related (e.g. bedding, overlay, wedged) <input type="radio"/> Covered in or fell into object, but not sleep-related <div style="margin-left: 20px;"> <input type="radio"/> Plastic bag <input type="radio"/> Dirt/sand <input type="radio"/> Other, specify: <input type="radio"/> U/K </div> </div> <div style="width: 33%;"> <input type="radio"/> Confined in tight space <input type="radio"/> Refrigerator/freezer <input type="radio"/> Toy chest <input type="radio"/> Automobile <div style="margin-left: 20px;"> <input type="radio"/> Trunk <input type="radio"/> Other, specify: <input type="radio"/> U/K </div> <input type="radio"/> Other, specify: <input type="radio"/> U/K </div> <div style="width: 33%;"> <input type="radio"/> Swaddled in tight blanket, but not sleep-related <input type="radio"/> Wedged into tight space, but not sleep-related <input type="radio"/> Asphyxia by gas, go to G8h <input type="radio"/> Other, specify: <input type="radio"/> U/K </div> </div>						
c. If strangulation, object causing event: <div style="display: flex; flex-wrap: wrap;"> <div style="width: 50%;"> <input type="radio"/> Clothing <input type="radio"/> Blind cord <input type="radio"/> Car seat <input type="radio"/> Stroller <input type="radio"/> High chair <input type="radio"/> Belt <input type="radio"/> Rope/string </div> <div style="width: 50%;"> <input type="radio"/> Leash <input type="radio"/> Electrical cord <input type="radio"/> Person, go to G5q <input type="radio"/> Automobile power window or sunroof <input type="radio"/> Other, specify: <input type="radio"/> U/K </div> </div>			d. If choking, object causing choking: <input type="radio"/> Food, specify: <input type="radio"/> Toy, specify: <input type="radio"/> Balloon <input type="radio"/> Other, specify: <input type="radio"/> U/K		e. Was asphyxia an autoerotic event? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K		g. History of seizures? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K If yes, # ____ If yes, witnessed? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K		
					f. Was child participating in 'choking game' or 'pass out game'? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K		h. History of apnea? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K If yes, # ____ If yes, witnessed? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K		
					i. Was Heimlich Maneuver attempted? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K				
5. WEAPON, INCLUDING PERSON'S BODY PART									
a. Type of weapon: <input type="radio"/> Firearm, go to b <input type="radio"/> Sharp instrument, go to j <input type="radio"/> Blunt instrument, go to k <input type="radio"/> Person's body part, go to l <input type="radio"/> Explosive, go to m <input type="radio"/> Rope, go to m <input type="radio"/> Pipe, go to m <input type="radio"/> Biological, go to m <input type="radio"/> Other, specify and go to m <input type="radio"/> U/K, go to m			b. For firearms, type: <input type="radio"/> Handgun <input type="radio"/> Shotgun <input type="radio"/> BB gun <input type="radio"/> Hunting rifle <input type="radio"/> Assault rifle <input type="radio"/> Air rifle <input type="radio"/> Sawed off shotgun <input type="radio"/> Other, specify: <input type="radio"/> U/K		c. Firearm licensed? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K		d. Firearm safety features, check all that apply: <div style="display: flex; flex-wrap: wrap;"> <div style="width: 50%;"> <input type="checkbox"/> Trigger lock <input type="checkbox"/> Personalization device <input type="checkbox"/> External safety/drop safety <input type="checkbox"/> Loaded chamber indicator </div> <div style="width: 50%;"> <input type="checkbox"/> Magazine disconnect <input type="checkbox"/> Minimum trigger pull <input type="checkbox"/> Other, specify: <input type="checkbox"/> U/K </div> </div>		
			e. Where was firearm stored? <input type="radio"/> Not stored <input type="radio"/> Under mattress/pillow <input type="radio"/> Locked cabinet <input type="radio"/> Other, specify: <input type="radio"/> Unlocked cabinet <input type="radio"/> Glove compartment <input type="radio"/> U/K		f. Firearm stored with ammunition? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K				
					g. Firearm stored loaded? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K				
h. Owner of fatal firearm: <div style="display: flex; flex-wrap: wrap;"> <div style="width: 33%;"> <input type="radio"/> U/K, weapon stolen <input type="radio"/> U/K, weapon found <input type="radio"/> Self <input type="radio"/> Biological parent <input type="radio"/> Adoptive parent <input type="radio"/> Stepparent <input type="radio"/> Foster parent <input type="radio"/> Mother's partner <input type="radio"/> Father's partner </div> <div style="width: 33%;"> <input type="radio"/> Grandparent <input type="radio"/> Sibling <input type="radio"/> Spouse <input type="radio"/> Other relative <input type="radio"/> Friend <input type="radio"/> Acquaintance <input type="radio"/> Child's boyfriend or girlfriend <input type="radio"/> Classmate </div> <div style="width: 33%;"> <input type="radio"/> Co-worker <input type="radio"/> Institutional staff <input type="radio"/> Neighbor <input type="radio"/> Rival gang member <input type="radio"/> Stranger <input type="radio"/> Law enforcement <input type="radio"/> Other, specify: <input type="radio"/> U/K </div> </div>					i. Sex of fatal firearm owner: <input type="radio"/> Male <input type="radio"/> Female <input type="radio"/> U/K		j. Type of sharp object: <input type="radio"/> Kitchen knife <input type="radio"/> Switchblade <input type="radio"/> Pocketknife <input type="radio"/> Razor <input type="radio"/> Hunting knife <input type="radio"/> Scissors <input type="radio"/> Other, specify: <input type="radio"/> U/K		k. Type of blunt object: <input type="radio"/> Bat <input type="radio"/> Club <input type="radio"/> Stick <input type="radio"/> Hammer <input type="radio"/> Rock <input type="radio"/> Household item <input type="radio"/> Other, specify: <input type="radio"/> U/K
l. What did person's body part do? Check all that apply: <input type="checkbox"/> Beat, kick or punch <input type="checkbox"/> Drop <input type="checkbox"/> Push <input type="checkbox"/> Bite <input type="checkbox"/> Shake <input type="checkbox"/> Strangle <input type="checkbox"/> Throw <input type="checkbox"/> Drown <input type="checkbox"/> Burn <input type="checkbox"/> Other, specify: <input type="checkbox"/> U/K			m. Did person using weapon have history of weapon-related offenses? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K n. Does anyone in child's family have a history of weapon offenses or die of weapons-related causes? <input type="radio"/> Yes, describe circumstances: <input type="radio"/> No <input type="radio"/> U/K		o. Persons handling weapons at time of incident, check all that apply: <div style="display: flex;"> <div style="flex: 1;"> <u>Fatal and/or Other weapon</u> <input type="checkbox"/> Self <input type="checkbox"/> Biological parent <input type="checkbox"/> Adoptive parent <input type="checkbox"/> Stepparent <input type="checkbox"/> Foster parent <input type="checkbox"/> Mother's partner <input type="checkbox"/> Father's partner <input type="checkbox"/> Grandparent <input type="checkbox"/> Sibling <input type="checkbox"/> Spouse <input type="checkbox"/> Other relative </div> <div style="flex: 1;"> <u>Fatal and/or Other weapon</u> <input type="checkbox"/> Friend <input type="checkbox"/> Acquaintance <input type="checkbox"/> Child's boyfriend or girlfriend <input type="checkbox"/> Classmate <input type="checkbox"/> Co-worker <input type="checkbox"/> Institutional staff <input type="checkbox"/> Neighbor <input type="checkbox"/> Rival gang member <input type="checkbox"/> Stranger <input type="checkbox"/> Law enforcement officer <input type="checkbox"/> Other, specify: <input type="checkbox"/> U/K </div> </div>				p. Sex of person(s) handling weapon: Fatal weapon: <input type="radio"/> Male <input type="radio"/> Female <input type="radio"/> U/K Other weapon: <input type="radio"/> Male <input type="radio"/> Female <input type="radio"/> U/K

<p>q. Use of weapon at time, check all that apply:</p> <table style="width: 100%;"> <tr> <td><input type="checkbox"/> Self injury</td> <td><input type="checkbox"/> Argument</td> <td><input type="checkbox"/> Hunting</td> <td><input type="checkbox"/> Russian roulette</td> <td><input type="checkbox"/> Intervener assisting crime victim (Good Samaritan)</td> </tr> <tr> <td><input type="checkbox"/> Commission of crime</td> <td><input type="checkbox"/> Jealousy</td> <td><input type="checkbox"/> Target shooting</td> <td><input type="checkbox"/> Gang-related activity</td> <td></td> </tr> <tr> <td><input type="checkbox"/> Drive-by shooting</td> <td><input type="checkbox"/> Intimate partner violence</td> <td><input type="checkbox"/> Playing with weapon</td> <td><input type="checkbox"/> Self-defense</td> <td><input type="checkbox"/> Other, specify:</td> </tr> <tr> <td><input type="checkbox"/> Random violence</td> <td><input type="checkbox"/> Hate crime</td> <td><input type="checkbox"/> Weapon mistaken for toy</td> <td><input type="checkbox"/> Cleaning weapon</td> <td></td> </tr> <tr> <td><input type="checkbox"/> Child was a bystander</td> <td><input type="checkbox"/> Bullying</td> <td><input type="checkbox"/> Showing gun to others</td> <td><input type="checkbox"/> Loading weapon</td> <td><input type="checkbox"/> U/K</td> </tr> </table>					<input type="checkbox"/> Self injury	<input type="checkbox"/> Argument	<input type="checkbox"/> Hunting	<input type="checkbox"/> Russian roulette	<input type="checkbox"/> Intervener assisting crime victim (Good Samaritan)	<input type="checkbox"/> Commission of crime	<input type="checkbox"/> Jealousy	<input type="checkbox"/> Target shooting	<input type="checkbox"/> Gang-related activity		<input type="checkbox"/> Drive-by shooting	<input type="checkbox"/> Intimate partner violence	<input type="checkbox"/> Playing with weapon	<input type="checkbox"/> Self-defense	<input type="checkbox"/> Other, specify:	<input type="checkbox"/> Random violence	<input type="checkbox"/> Hate crime	<input type="checkbox"/> Weapon mistaken for toy	<input type="checkbox"/> Cleaning weapon		<input type="checkbox"/> Child was a bystander	<input type="checkbox"/> Bullying	<input type="checkbox"/> Showing gun to others	<input type="checkbox"/> Loading weapon	<input type="checkbox"/> U/K
<input type="checkbox"/> Self injury	<input type="checkbox"/> Argument	<input type="checkbox"/> Hunting	<input type="checkbox"/> Russian roulette	<input type="checkbox"/> Intervener assisting crime victim (Good Samaritan)																									
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<input type="checkbox"/> Random violence	<input type="checkbox"/> Hate crime	<input type="checkbox"/> Weapon mistaken for toy	<input type="checkbox"/> Cleaning weapon																										
<input type="checkbox"/> Child was a bystander	<input type="checkbox"/> Bullying	<input type="checkbox"/> Showing gun to others	<input type="checkbox"/> Loading weapon	<input type="checkbox"/> U/K																									
<p>6. ANIMAL BITE OR ATTACK</p>																													
<p>a. Type of animal:</p> <table style="width: 100%;"> <tr> <td><input type="radio"/> Domesticated dog</td> <td><input type="radio"/> Insect</td> </tr> <tr> <td><input type="radio"/> Domesticated cat</td> <td><input type="radio"/> Other, specify:</td> </tr> <tr> <td><input type="radio"/> Snake</td> <td></td> </tr> <tr> <td><input type="radio"/> Wild mammal, specify:</td> <td><input type="radio"/> U/K</td> </tr> </table>		<input type="radio"/> Domesticated dog	<input type="radio"/> Insect	<input type="radio"/> Domesticated cat	<input type="radio"/> Other, specify:	<input type="radio"/> Snake		<input type="radio"/> Wild mammal, specify:	<input type="radio"/> U/K	<p>b. Animal access to child, check all that apply:</p> <table style="width: 100%;"> <tr> <td><input type="checkbox"/> Animal on leash</td> <td><input type="checkbox"/> Animal escaped from cage or leash</td> </tr> <tr> <td><input type="checkbox"/> Animal caged or inside fence</td> <td><input type="checkbox"/> Animal not caged or leashed</td> </tr> <tr> <td><input type="radio"/> Child reached in</td> <td><input type="checkbox"/> U/K</td> </tr> <tr> <td><input type="radio"/> Child entered animal area</td> <td></td> </tr> <tr> <td><input type="radio"/> U/K</td> <td></td> </tr> </table>		<input type="checkbox"/> Animal on leash	<input type="checkbox"/> Animal escaped from cage or leash	<input type="checkbox"/> Animal caged or inside fence	<input type="checkbox"/> Animal not caged or leashed	<input type="radio"/> Child reached in	<input type="checkbox"/> U/K	<input type="radio"/> Child entered animal area		<input type="radio"/> U/K		<p>c. Did child provoke animal?</p> <p><input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K</p> <p>If yes, how?</p>							
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<input type="radio"/> Child reached in	<input type="checkbox"/> U/K																												
<input type="radio"/> Child entered animal area																													
<input type="radio"/> U/K																													
		<p>d. Animal has history of biting or attacking?</p> <p><input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K</p>																											
<p>7. FALL OR CRUSH</p>																													
<p>a. Type:</p> <p><input type="radio"/> Fall, go to b</p> <p><input type="radio"/> Crush, go to h</p>	<p>b. Height of fall:</p> <p>_____ feet</p> <p>_____ inches</p> <p><input type="checkbox"/> U/K</p>	<p>c. Child fell from:</p> <table style="width: 100%;"> <tr> <td><input type="radio"/> Open window</td> <td><input type="radio"/> Natural elevation</td> <td><input type="radio"/> Stairs/steps</td> <td><input type="radio"/> Moving object, specify:</td> <td><input type="radio"/> Animal, specify:</td> </tr> <tr> <td><input type="radio"/> Screen</td> <td><input type="radio"/> Man-made elevation</td> <td><input type="radio"/> Furniture</td> <td><input type="radio"/> Bridge</td> <td><input type="radio"/> Other, specify:</td> </tr> <tr> <td><input type="radio"/> No screen</td> <td><input type="radio"/> Playground equipment</td> <td><input type="radio"/> Bed</td> <td><input type="radio"/> Overpass</td> <td></td> </tr> <tr> <td><input type="radio"/> U/K if screen</td> <td><input type="radio"/> Tree</td> <td><input type="radio"/> Roof</td> <td><input type="radio"/> Balcony</td> <td><input type="radio"/> U/K</td> </tr> </table>			<input type="radio"/> Open window	<input type="radio"/> Natural elevation	<input type="radio"/> Stairs/steps	<input type="radio"/> Moving object, specify:	<input type="radio"/> Animal, specify:	<input type="radio"/> Screen	<input type="radio"/> Man-made elevation	<input type="radio"/> Furniture	<input type="radio"/> Bridge	<input type="radio"/> Other, specify:	<input type="radio"/> No screen	<input type="radio"/> Playground equipment	<input type="radio"/> Bed	<input type="radio"/> Overpass		<input type="radio"/> U/K if screen	<input type="radio"/> Tree	<input type="radio"/> Roof	<input type="radio"/> Balcony	<input type="radio"/> U/K					
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<input type="radio"/> U/K if screen	<input type="radio"/> Tree	<input type="radio"/> Roof	<input type="radio"/> Balcony	<input type="radio"/> U/K																									
<p>d. Surface child fell onto:</p> <p><input type="radio"/> Cement/concrete</p> <p><input type="radio"/> Grass</p> <p><input type="radio"/> Gravel</p> <p><input type="radio"/> Wood floor</p> <p><input type="radio"/> Carpeted floor</p> <p><input type="radio"/> Linoleum/vinyl</p> <p><input type="radio"/> Marble/tile</p> <p><input type="radio"/> Other, specify:</p> <p><input type="radio"/> U/K</p>	<p>e. Barrier in place:</p> <p>Check all that apply:</p> <p><input type="checkbox"/> None</p> <p><input type="checkbox"/> Screen</p> <p><input type="checkbox"/> Other window guard</p> <p><input type="checkbox"/> Fence</p> <p><input type="checkbox"/> Railing</p> <p><input type="checkbox"/> Stairway</p> <p><input type="checkbox"/> Gate</p> <p><input type="checkbox"/> Other, specify:</p> <p><input type="checkbox"/> U/K</p>	<p>f. Child in a baby walker?</p> <p><input type="radio"/> N/A</p> <p><input type="radio"/> Yes</p> <p><input type="radio"/> No</p> <p><input type="radio"/> U/K</p>	<p>h. For crush, did child:</p> <p><input type="radio"/> Climb up on object</p> <p><input type="radio"/> Pull object down</p> <p><input type="radio"/> Hide behind object</p> <p><input type="radio"/> Go behind object</p> <p><input type="radio"/> Fall out of object</p> <p><input type="radio"/> Other, specify:</p> <p><input type="radio"/> U/K</p>	<p>i. For crush, object causing crush:</p> <table style="width: 100%;"> <tr> <td><input type="radio"/> Appliance</td> <td><input type="radio"/> Dirt/sand</td> </tr> <tr> <td><input type="radio"/> Television</td> <td><input type="radio"/> Person, go to G5q</td> </tr> <tr> <td><input type="radio"/> Furniture</td> <td><input type="radio"/> Commercial equipment</td> </tr> <tr> <td><input type="radio"/> Walls</td> <td><input type="radio"/> Farm equipment</td> </tr> <tr> <td><input type="radio"/> Playground equipment</td> <td><input type="radio"/> Other, specify:</td> </tr> <tr> <td><input type="radio"/> Animal</td> <td></td> </tr> <tr> <td><input type="radio"/> Tree branch</td> <td><input type="radio"/> U/K</td> </tr> <tr> <td><input type="radio"/> Boulders/rocks</td> <td></td> </tr> </table>	<input type="radio"/> Appliance	<input type="radio"/> Dirt/sand	<input type="radio"/> Television	<input type="radio"/> Person, go to G5q	<input type="radio"/> Furniture	<input type="radio"/> Commercial equipment	<input type="radio"/> Walls	<input type="radio"/> Farm equipment	<input type="radio"/> Playground equipment	<input type="radio"/> Other, specify:	<input type="radio"/> Animal		<input type="radio"/> Tree branch	<input type="radio"/> U/K	<input type="radio"/> Boulders/rocks										
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<input type="radio"/> Tree branch	<input type="radio"/> U/K																												
<input type="radio"/> Boulders/rocks																													
<p>8. POISONING, OVERDOSE OR ACUTE INTOXICATION</p>																													
<p>a. Type of substance involved, check all that apply:</p> <table style="width: 100%;"> <tr> <td style="vertical-align: top;"> <p><u>Prescription drug</u></p> <p><input type="checkbox"/> Antidepressant</p> <p><input type="checkbox"/> Blood pressure medication</p> <p><input type="checkbox"/> Pain killer (opiate)</p> <p><input type="checkbox"/> Pain killer (non-opiate)</p> <p><input type="checkbox"/> Methadone</p> <p><input type="checkbox"/> Cardiac medication</p> <p><input type="checkbox"/> Other, specify:</p> </td> <td style="vertical-align: top;"> <p><u>Over-the-counter drug</u></p> <p><input type="checkbox"/> Diet pills</p> <p><input type="checkbox"/> Stimulants</p> <p><input type="checkbox"/> Cough medicine</p> <p><input type="checkbox"/> Pain medication</p> <p><input type="checkbox"/> Children's vitamins</p> <p><input type="checkbox"/> Iron supplement</p> <p><input type="checkbox"/> Other vitamins</p> <p><input type="checkbox"/> Other, specify:</p> <p><input type="checkbox"/> Cosmetics/personal care products</p> </td> <td style="vertical-align: top;"> <p><u>Cleaning substances</u></p> <p><input type="checkbox"/> Bleach</p> <p><input type="checkbox"/> Drain cleaner</p> <p><input type="checkbox"/> Alkaline-based cleaner</p> <p><input type="checkbox"/> Solvent</p> <p><input type="checkbox"/> Other, specify:</p> </td> <td style="vertical-align: top;"> <p><u>Other substances</u></p> <p><input type="checkbox"/> Plants</p> <p><input type="checkbox"/> Alcohol</p> <p><input type="checkbox"/> Street drugs</p> <p><input type="checkbox"/> Pesticide</p> <p><input type="checkbox"/> Antifreeze</p> <p><input type="checkbox"/> Other chemical</p> <p><input type="checkbox"/> Herbal remedy</p> <p><input type="checkbox"/> Carbon monoxide, go to f</p> <p><input type="checkbox"/> Other fume/gas/vapor</p> <p><input type="checkbox"/> Other, specify:</p> </td> <td style="vertical-align: top;"> <p><input type="checkbox"/> U/K</p> </td> </tr> </table>					<p><u>Prescription drug</u></p> <p><input type="checkbox"/> Antidepressant</p> <p><input type="checkbox"/> Blood pressure medication</p> <p><input type="checkbox"/> Pain killer (opiate)</p> <p><input type="checkbox"/> Pain killer (non-opiate)</p> <p><input type="checkbox"/> Methadone</p> <p><input type="checkbox"/> Cardiac medication</p> <p><input type="checkbox"/> Other, specify:</p>	<p><u>Over-the-counter drug</u></p> <p><input type="checkbox"/> Diet pills</p> <p><input type="checkbox"/> Stimulants</p> <p><input type="checkbox"/> Cough medicine</p> <p><input type="checkbox"/> Pain medication</p> <p><input type="checkbox"/> Children's vitamins</p> <p><input type="checkbox"/> Iron supplement</p> <p><input type="checkbox"/> Other vitamins</p> <p><input type="checkbox"/> Other, specify:</p> <p><input type="checkbox"/> Cosmetics/personal care products</p>	<p><u>Cleaning substances</u></p> <p><input type="checkbox"/> Bleach</p> <p><input type="checkbox"/> Drain cleaner</p> <p><input type="checkbox"/> Alkaline-based cleaner</p> <p><input type="checkbox"/> Solvent</p> <p><input type="checkbox"/> Other, specify:</p>	<p><u>Other substances</u></p> <p><input type="checkbox"/> Plants</p> <p><input type="checkbox"/> Alcohol</p> <p><input type="checkbox"/> Street drugs</p> <p><input type="checkbox"/> Pesticide</p> <p><input type="checkbox"/> Antifreeze</p> <p><input type="checkbox"/> Other chemical</p> <p><input type="checkbox"/> Herbal remedy</p> <p><input type="checkbox"/> Carbon monoxide, go to f</p> <p><input type="checkbox"/> Other fume/gas/vapor</p> <p><input type="checkbox"/> Other, specify:</p>	<p><input type="checkbox"/> U/K</p>																				
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<p>b. Where was the substance stored?</p> <p><input type="radio"/> Open area</p> <p><input type="radio"/> Open cabinet</p> <p><input type="radio"/> Closed cabinet, unlocked</p> <p><input type="radio"/> Closed cabinet, locked</p> <p><input type="radio"/> Other, specify:</p> <p><input type="radio"/> U/K</p>	<p>c. Was the product in its original container?</p> <p><input type="radio"/> N/A <input type="radio"/> No</p> <p><input type="radio"/> Yes <input type="radio"/> U/K</p>	<p>f. Was the incident the result of?</p> <p><input type="radio"/> Accidental overdose</p> <p><input type="radio"/> Medical treatment mishap</p> <p><input type="radio"/> Adverse effect, but not overdose</p> <p><input type="radio"/> Deliberate poisoning</p> <p><input type="radio"/> Acute intoxication</p> <p><input type="radio"/> Other, specify:</p> <p><input type="radio"/> U/K</p>	<p>g. Was Poison Control called?</p> <p><input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K</p> <p>If yes, who called:</p> <p><input type="radio"/> Child</p> <p><input type="radio"/> Parent</p> <p><input type="radio"/> Other caregiver</p> <p><input type="radio"/> First responder</p> <p><input type="radio"/> Medical person</p> <p><input type="radio"/> Other, specify:</p> <p><input type="radio"/> U/K</p>	<p>h. For CO poisoning, was a CO detector present?</p> <p><input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K</p> <p>If yes, how many?</p> <p>_____</p> <p>Functioning properly?</p> <p><input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K</p>																									
<p>d. Did container have a child safety cap?</p> <p><input type="radio"/> N/A <input type="radio"/> No</p> <p><input type="radio"/> Yes <input type="radio"/> U/K</p>																													
<p>e. If prescription, was it child's?</p> <p><input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K</p>																													

9. EXPOSURE																																																																																																																																																																																																																																			
a. Circumstances, check all that apply: <input type="checkbox"/> Abandonment <input type="checkbox"/> Lost outdoors <input type="checkbox"/> Left in car <input type="checkbox"/> Illegal border crossing <input type="checkbox"/> Left in room <input type="checkbox"/> Other, specify: <input type="checkbox"/> Submerged in water <input type="checkbox"/> U/K <input type="checkbox"/> Injured outdoors		b. Condition of exposure: <input type="radio"/> Hyperthermia <input type="radio"/> Hypothermia <input type="radio"/> U/K _____ Ambient temp, degrees F		c. Number of hours exposed: _____ <input type="checkbox"/> U/K																																																																																																																																																																																																																															
d. Was child wearing appropriate clothing? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K																																																																																																																																																																																																																																			
10. MEDICAL CONDITION																																																																																																																																																																																																																																			
a. How long did the child have the medical condition? <input type="radio"/> In utero <input type="radio"/> Weeks <input type="radio"/> Since birth <input type="radio"/> Months <input type="radio"/> Hours <input type="radio"/> Years <input type="radio"/> Days <input type="radio"/> U/K		b. Was death expected as a result of the medical condition? <input type="radio"/> N/A not previously diagnosed <input type="radio"/> Yes <input type="checkbox"/> But at a later date <input type="radio"/> No <input type="radio"/> U/K		c. Was child receiving health care for the medical condition? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K If yes, within 48 hours of the death? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K																																																																																																																																																																																																																															
d. Were the prescribed care plans appropriate for the medical condition? <input type="radio"/> N/A <input type="radio"/> Yes <input type="radio"/> No, specify: <input type="radio"/> U/K																																																																																																																																																																																																																																			
e. Was child/family compliant with the prescribed care plans? <input type="radio"/> N/A <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K If no, what wasn't compliant? Check all that apply. <input type="checkbox"/> Appointments <input type="checkbox"/> Medications, specify: <input type="checkbox"/> Medical equipment use, specify: <input type="checkbox"/> Therapies, specify: <input type="checkbox"/> Other, specify: <input type="checkbox"/> U/K			f. Was child up to date with American Academy of Pediatrics immunization schedule? <input type="radio"/> N/A <input type="radio"/> Yes <input type="radio"/> No, specify: <input type="radio"/> U/K																																																																																																																																																																																																																																
g. Was the medical condition associated with an outbreak? <input type="radio"/> Yes, specify: <input type="radio"/> No <input type="radio"/> U/K																																																																																																																																																																																																																																			
h. Was environmental tobacco exposure a contributing factor in death? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K		i. Were there access or compliance issues related to the death? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K If yes, check all that apply: <input type="checkbox"/> Lack of money for care <input type="checkbox"/> Language barriers <input type="checkbox"/> Caregiver distrust of health care system <input type="checkbox"/> Limitations of health insurance coverage <input type="checkbox"/> Referrals not made <input type="checkbox"/> Caregiver unskilled in providing care <input type="checkbox"/> Multiple health insurance, not coordinated <input type="checkbox"/> Specialist needed, not available <input type="checkbox"/> Caregiver unwilling to provide care <input type="checkbox"/> Lack of transportation <input type="checkbox"/> Multiple providers, not coordinated <input type="checkbox"/> Caregiver's partner would not allow care <input type="checkbox"/> No phone <input type="checkbox"/> Lack of child care <input type="checkbox"/> Other, specify: <input type="checkbox"/> Cultural differences <input type="checkbox"/> Lack of family or social support <input type="checkbox"/> Religious objections to care <input type="checkbox"/> Services not available <input type="checkbox"/> U/K																																																																																																																																																																																																																																	
11. OTHER KNOWN INJURY CAUSE																																																																																																																																																																																																																																			
Specify cause, describe in detail:																																																																																																																																																																																																																																			
H. OTHER CIRCUMSTANCES OF INCIDENT - ANSWER RELEVANT SECTIONS																																																																																																																																																																																																																																			
1. SUDDEN AND UNEXPECTED DEATH IN THE YOUNG																																																																																																																																																																																																																																			
Section H1: OMB No. 0920-1092, Exp. Date: 12/31/2018 Public 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 needed, 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 number. 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, MS D-74, Atlanta, Georgia 30333; ATTN: PRA (0920-1092)																																																																																																																																																																																																																																			
a. Was this death a homicide, suicide, overdose, injury with the external cause as the only and obvious cause of death or a death which was expected within 6 months due to terminal illness? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K If yes, go to Section H2																																																																																																																																																																																																																																			
b. Did the child have a history of any of the following acute conditions or symptoms within 72 hours prior to death? <input type="checkbox"/> U/K for all			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? <input type="checkbox"/> U/K for all																																																																																																																																																																																																																																
<table border="1" style="width:100%; border-collapse: collapse; font-size: x-small;"> <thead> <tr> <th style="text-align: left;">Symptom</th> <th colspan="3">Present w/in 72 hours of death</th> <th colspan="3">Present w/in 72 hours of death</th> </tr> <tr> <th></th> <th>Yes</th> <th>No</th> <th>U/K</th> <th></th> <th>Yes</th> <th>No</th> <th>U/K</th> </tr> </thead> <tbody> <tr> <td>Cardiac</td> <td></td> <td></td> <td></td> <td>Other Acute Symptoms</td> <td></td> <td></td> <td></td> </tr> <tr> <td>Chest pain</td> <td><input type="radio"/></td> <td><input type="radio"/></td> <td><input type="radio"/></td> <td>Fever</td> <td><input type="radio"/></td> <td><input type="radio"/></td> <td><input type="radio"/></td> </tr> <tr> <td>Dizziness/lightheadedness</td> <td><input type="radio"/></td> <td><input type="radio"/></td> <td><input type="radio"/></td> <td>Heat exhaustion/heat stroke</td> <td><input type="radio"/></td> <td><input type="radio"/></td> <td><input type="radio"/></td> </tr> <tr> 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4. DID DEATH OCCUR DURING COMMISSION OF ANOTHER CRIME? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K 																																														
a. Type of crime, check all that apply: <table style="width: 100%; margin-top: 5px;"> <tr> <td><input type="checkbox"/> Robbery/burglary</td> <td><input type="checkbox"/> Other assault</td> <td><input type="checkbox"/> Arson</td> <td><input type="checkbox"/> Illegal border crossing</td> <td><input type="checkbox"/> U/K</td> </tr> <tr> <td><input type="checkbox"/> Interpersonal violence</td> <td><input type="checkbox"/> Gang conflict</td> <td><input type="checkbox"/> Prostitution</td> <td><input type="checkbox"/> Auto theft</td> <td></td> </tr> <tr> <td><input type="checkbox"/> Sexual assault</td> <td><input type="checkbox"/> Drug trade</td> <td><input type="checkbox"/> Witness intimidation</td> <td><input type="checkbox"/> Other, specify:</td> <td></td> </tr> </table>					<input type="checkbox"/> Robbery/burglary	<input type="checkbox"/> Other assault	<input type="checkbox"/> Arson	<input type="checkbox"/> Illegal border crossing	<input type="checkbox"/> U/K	<input type="checkbox"/> Interpersonal violence	<input type="checkbox"/> Gang conflict	<input type="checkbox"/> Prostitution	<input type="checkbox"/> Auto theft		<input type="checkbox"/> Sexual assault	<input type="checkbox"/> Drug trade	<input type="checkbox"/> Witness intimidation	<input type="checkbox"/> Other, specify:																												
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1. Did any act(s) of omission or commission cause and/or contribute to the death? <input type="radio"/> Yes <input type="radio"/> No, go to Section J <input type="radio"/> Probable <input type="radio"/> U/K, go to Section J If yes/probable, were the act(s) either or both? Check all that apply: <input type="checkbox"/> The direct cause of death <input type="checkbox"/> The contributing cause of death		2. What act(s) caused or contributed to the death? Check only one per column and describe in narrative. <table style="width: 100%; margin-top: 5px;"> <tr> <th style="text-align: center; width: 50%;"><u>Caused</u></th> <th style="text-align: center; width: 50%;"><u>Contributed</u></th> </tr> <tr><td><input type="radio"/></td><td><input type="radio"/> Poor/absent supervision, go to 10</td></tr> <tr><td><input type="radio"/></td><td><input type="radio"/> Child abuse, go to 3</td></tr> <tr><td><input type="radio"/></td><td><input type="radio"/> Child neglect, go to 8</td></tr> <tr><td><input type="radio"/></td><td><input type="radio"/> Other negligence, go to 9</td></tr> <tr><td><input type="radio"/></td><td><input type="radio"/> Assault, not child abuse, go to 10</td></tr> <tr><td><input type="radio"/></td><td><input type="radio"/> Religious/cultural practices, go to 10</td></tr> <tr><td><input type="radio"/></td><td><input type="radio"/> Suicide, go to 27</td></tr> <tr><td><input type="radio"/></td><td><input type="radio"/> Medical misadventure, specify and go to 11</td></tr> <tr><td><input type="radio"/></td><td><input type="radio"/> Other, specify and go to 10</td></tr> <tr><td><input type="radio"/></td><td><input type="radio"/> U/K, go to 10</td></tr> </table>			<u>Caused</u>	<u>Contributed</u>	<input type="radio"/>	<input type="radio"/> Poor/absent supervision, go to 10	<input type="radio"/>	<input type="radio"/> Child abuse, go to 3	<input type="radio"/>	<input type="radio"/> Child neglect, go to 8	<input type="radio"/>	<input type="radio"/> Other negligence, go to 9	<input type="radio"/>	<input type="radio"/> Assault, not child abuse, go to 10	<input type="radio"/>	<input type="radio"/> Religious/cultural practices, go to 10	<input type="radio"/>	<input type="radio"/> Suicide, go to 27	<input type="radio"/>	<input type="radio"/> Medical misadventure, specify and go to 11	<input type="radio"/>	<input type="radio"/> Other, specify and go to 10	<input type="radio"/>	<input type="radio"/> U/K, go to 10																				
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8. Child neglect, check all that apply: <input type="checkbox"/> Failure to protect from hazards, specify: <input type="checkbox"/> Failure to provide necessities <input type="checkbox"/> Food <input type="checkbox"/> Shelter <input type="checkbox"/> Other, specify: <input type="checkbox"/> Failure to seek/follow treatment, specify: <input type="checkbox"/> Emotional neglect, specify: <input type="checkbox"/> Abandonment, specify: <input type="checkbox"/> U/K		9. Other negligence: <input type="radio"/> Vehicular <input type="radio"/> Other, specify: <input type="radio"/> U/K		10. Was act(s) of omission/commission: <table style="width: 100%; margin-top: 5px;"> <tr> <th style="text-align: center; width: 50%;"><u>Caused</u></th> <th style="text-align: center; width: 50%;"><u>Contributed</u></th> </tr> <tr><td><input type="radio"/></td><td><input type="radio"/> Chronic with child</td></tr> <tr><td><input type="radio"/></td><td><input type="radio"/> Pattern in family or with perpetrator</td></tr> <tr><td><input type="radio"/></td><td><input type="radio"/> Isolated incident</td></tr> <tr><td><input type="radio"/></td><td><input type="radio"/> U/K</td></tr> </table>	<u>Caused</u>	<u>Contributed</u>	<input type="radio"/>	<input type="radio"/> Chronic with child	<input type="radio"/>	<input type="radio"/> Pattern in family or with perpetrator	<input type="radio"/>	<input type="radio"/> Isolated incident	<input type="radio"/>	<input type="radio"/> U/K																																
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11. Is person the caregiver or supervisor in previous section? <table style="width: 100%; margin-top: 5px;"> <tr> <th style="text-align: center; width: 50%;"><u>Caused</u></th> <th style="text-align: center; width: 50%;"><u>Contributed</u></th> </tr> <tr><td><input type="radio"/></td><td><input type="radio"/> Yes, caregiver one, go to 24</td></tr> <tr><td><input type="radio"/></td><td><input type="radio"/> Yes, caregiver two, go to 24</td></tr> <tr><td><input type="radio"/></td><td><input type="radio"/> Yes, supervisor, go to 25</td></tr> <tr><td><input type="radio"/></td><td><input type="radio"/> No</td></tr> </table>		<u>Caused</u>	<u>Contributed</u>	<input type="radio"/>	<input type="radio"/> Yes, caregiver one, go to 24	<input type="radio"/>	<input type="radio"/> Yes, caregiver two, go to 24	<input type="radio"/>	<input type="radio"/> Yes, supervisor, go to 25	<input type="radio"/>	<input type="radio"/> No	12. Primary person responsible for action(s) that caused and/or contributed to death: Select no more than one person for caused and one person for contributed. <table style="width: 100%; margin-top: 5px;"> <tr> <th style="text-align: center; width: 25%;"><u>Caused</u></th> <th style="text-align: center; width: 25%;"><u>Contributed</u></th> <th style="text-align: center; width: 25%;"><u>Caused</u></th> <th style="text-align: center; width: 25%;"><u>Contributed</u></th> </tr> <tr><td><input type="radio"/></td><td><input type="radio"/> Self, go to 24</td><td><input type="radio"/></td><td><input type="radio"/> Grandparent</td></tr> <tr><td><input type="radio"/></td><td><input type="radio"/> Biological parent</td><td><input type="radio"/></td><td><input type="radio"/> Sibling</td></tr> <tr><td><input type="radio"/></td><td><input type="radio"/> Adoptive parent</td><td><input type="radio"/></td><td><input type="radio"/> Other relative</td></tr> <tr><td><input type="radio"/></td><td><input type="radio"/> Stepparent</td><td><input type="radio"/></td><td><input type="radio"/> Friend</td></tr> <tr><td><input type="radio"/></td><td><input type="radio"/> Foster parent</td><td><input type="radio"/></td><td><input type="radio"/> Acquaintance</td></tr> <tr><td><input type="radio"/></td><td><input type="radio"/> Mother's partner</td><td><input type="radio"/></td><td><input type="radio"/> Child's boyfriend or girlfriend</td></tr> <tr><td><input type="radio"/></td><td><input type="radio"/> Father's partner</td><td><input type="radio"/></td><td><input type="radio"/> Stranger</td></tr> </table>			<u>Caused</u>	<u>Contributed</u>	<u>Caused</u>	<u>Contributed</u>	<input type="radio"/>	<input type="radio"/> Self, go to 24	<input type="radio"/>	<input type="radio"/> Grandparent	<input type="radio"/>	<input type="radio"/> Biological parent	<input type="radio"/>	<input type="radio"/> Sibling	<input type="radio"/>	<input type="radio"/> Adoptive parent	<input type="radio"/>	<input type="radio"/> Other relative	<input type="radio"/>	<input type="radio"/> Stepparent	<input type="radio"/>	<input type="radio"/> Friend	<input type="radio"/>	<input type="radio"/> Foster parent	<input type="radio"/>	<input type="radio"/> Acquaintance	<input type="radio"/>	<input type="radio"/> Mother's partner	<input type="radio"/>	<input type="radio"/> Child's boyfriend or girlfriend	<input type="radio"/>	<input type="radio"/> Father's partner	<input type="radio"/>	<input type="radio"/> Stranger
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13. Person's age in years: <table style="width: 100%; margin-top: 5px;"> <tr> <th style="text-align: center; width: 50%;"><u>Caused</u></th> <th style="text-align: center; width: 50%;"><u>Contributed</u></th> </tr> <tr> <td style="text-align: center;">_____ # Years</td> <td style="text-align: center;">_____ # Years</td> </tr> <tr> <td style="text-align: center;"><input type="checkbox"/> U/K</td> <td style="text-align: center;"><input type="checkbox"/> U/K</td> </tr> </table>	<u>Caused</u>	<u>Contributed</u>	_____ # Years	_____ # Years	<input type="checkbox"/> U/K	<input type="checkbox"/> U/K	14. Person's sex: <table style="width: 100%; margin-top: 5px;"> <tr> <th style="text-align: center; width: 50%;"><u>Caused</u></th> <th style="text-align: center; width: 50%;"><u>Contributed</u></th> </tr> <tr><td><input type="radio"/> Male</td><td><input type="radio"/> Male</td></tr> <tr><td><input type="radio"/> Female</td><td><input type="radio"/> Female</td></tr> <tr><td><input type="radio"/> U/K</td><td><input type="radio"/> U/K</td></tr> </table>	<u>Caused</u>	<u>Contributed</u>	<input type="radio"/> Male	<input type="radio"/> Male	<input type="radio"/> Female	<input type="radio"/> Female	<input type="radio"/> U/K	<input type="radio"/> U/K	15. Does person speak English? <table style="width: 100%; margin-top: 5px;"> <tr> <th style="text-align: center; width: 50%;"><u>Caused</u></th> <th style="text-align: center; width: 50%;"><u>Contributed</u></th> </tr> <tr><td><input type="radio"/> Yes</td><td><input type="radio"/> Yes</td></tr> <tr><td><input type="radio"/> No</td><td><input type="radio"/> No</td></tr> <tr><td><input type="radio"/> U/K</td><td><input type="radio"/> U/K</td></tr> </table> If no, language spoken:	<u>Caused</u>	<u>Contributed</u>	<input type="radio"/> Yes	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> No	<input type="radio"/> U/K	<input type="radio"/> U/K	16. Person on active military duty? <table style="width: 100%; margin-top: 5px;"> <tr> <th style="text-align: center; width: 50%;"><u>Caused</u></th> <th style="text-align: center; width: 50%;"><u>Contributed</u></th> </tr> <tr><td><input type="radio"/> Yes</td><td><input type="radio"/> Yes</td></tr> <tr><td><input type="radio"/> No</td><td><input type="radio"/> No</td></tr> <tr><td><input type="radio"/> U/K</td><td><input type="radio"/> U/K</td></tr> </table> If yes, specify branch:	<u>Caused</u>	<u>Contributed</u>	<input type="radio"/> Yes	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> No	<input type="radio"/> U/K	<input type="radio"/> U/K													
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<p>17. Person have history of substance abuse?</p> <p><u>Caused</u> <u>Contributed</u></p> <p><input type="radio"/> <input type="radio"/> Yes</p> <p><input type="radio"/> <input type="radio"/> No</p> <p><input type="radio"/> <input type="radio"/> U/K</p> <p>If yes, check all that apply:</p> <p><input type="checkbox"/> <input type="checkbox"/> Alcohol</p> <p><input type="checkbox"/> <input type="checkbox"/> Cocaine</p> <p><input type="checkbox"/> <input type="checkbox"/> Marijuana</p> <p><input type="checkbox"/> <input type="checkbox"/> Methamphetamine</p> <p><input type="checkbox"/> <input type="checkbox"/> Opiates</p> <p><input type="checkbox"/> <input type="checkbox"/> Prescription drugs</p> <p><input type="checkbox"/> <input type="checkbox"/> Over-the-counter</p> <p><input type="checkbox"/> <input type="checkbox"/> Other, specify:</p> <p><input type="checkbox"/> <input type="checkbox"/> U/K</p>	<p>18. Person have history of child maltreatment as victim?</p> <p><u>Caused</u> <u>Contributed</u></p> <p><input type="radio"/> <input type="radio"/> Yes</p> <p><input type="radio"/> <input type="radio"/> No</p> <p><input type="radio"/> <input type="radio"/> U/K</p> <p>If yes, check all that apply:</p> <p><input type="checkbox"/> <input type="checkbox"/> Physical</p> <p><input type="checkbox"/> <input type="checkbox"/> Neglect</p> <p><input type="checkbox"/> <input type="checkbox"/> Sexual</p> <p><input type="checkbox"/> <input type="checkbox"/> Emotional/psychological</p> <p><input type="checkbox"/> <input type="checkbox"/> U/K</p> <p>_____ # CPS referrals</p> <p>_____ # Substantiations</p> <p><input type="checkbox"/> <input type="checkbox"/> Ever in foster care or adopted</p>	<p>19. Person have history of child maltreatment as a perpetrator?</p> <p><u>Caused</u> <u>Contributed</u></p> <p><input type="radio"/> <input type="radio"/> Yes</p> <p><input type="radio"/> <input type="radio"/> No</p> <p><input type="radio"/> <input type="radio"/> U/K</p> <p>If yes, check all that apply:</p> <p><input type="checkbox"/> <input type="checkbox"/> Physical</p> <p><input type="checkbox"/> <input type="checkbox"/> Neglect</p> <p><input type="checkbox"/> <input type="checkbox"/> Sexual</p> <p><input type="checkbox"/> <input type="checkbox"/> Emotional/psychological</p> <p><input type="checkbox"/> <input type="checkbox"/> U/K</p> <p>_____ # CPS referrals</p> <p>_____ # Substantiations</p> <p><input type="checkbox"/> <input type="checkbox"/> CPS prevention services</p> <p><input type="checkbox"/> <input type="checkbox"/> Family preservation services</p> <p><input type="checkbox"/> <input type="checkbox"/> Children ever removed</p>	<p>20. Person have disability or chronic illness?</p> <p><u>Caused</u> <u>Contributed</u></p> <p><input type="radio"/> <input type="radio"/> Yes</p> <p><input type="radio"/> <input type="radio"/> No</p> <p><input type="radio"/> <input type="radio"/> U/K</p> <p>If yes, check all that apply:</p> <p><input type="checkbox"/> <input type="checkbox"/> Physical, specify:</p> <p><input type="checkbox"/> <input type="checkbox"/> Mental, specify:</p> <p><input type="checkbox"/> <input type="checkbox"/> Sensory, specify:</p> <p><input type="checkbox"/> <input type="checkbox"/> U/K</p> <p>If mental illness, was person receiving MH services?</p> <p><input type="radio"/> <input type="radio"/> Yes</p> <p><input type="radio"/> <input type="radio"/> No</p> <p><input type="radio"/> <input type="radio"/> U/K</p>																																																		
<p>21. Person have prior child deaths?</p> <p><u>Caused</u> <u>Contributed</u></p> <p><input type="radio"/> <input type="radio"/> Yes</p> <p><input type="radio"/> <input type="radio"/> No</p> <p><input type="radio"/> <input type="radio"/> U/K</p>	<p>If yes, check all that apply:</p> <p><u>Caused</u> <u>Contributed</u></p> <p><input type="checkbox"/> <input type="checkbox"/> Child abuse # _____</p> <p><input type="checkbox"/> <input type="checkbox"/> Child neglect # _____</p> <p><input type="checkbox"/> <input type="checkbox"/> Accident # _____</p> <p><input type="checkbox"/> <input type="checkbox"/> Suicide # _____</p> <p><input type="checkbox"/> <input type="checkbox"/> SIDS # _____</p> <p><input type="checkbox"/> <input type="checkbox"/> Other # _____</p> <p>Other, specify:</p> <p><input type="checkbox"/> <input type="checkbox"/> U/K</p>	<p>22. Person have history of intimate partner violence?</p> <p><u>Caused</u> <u>Contributed</u></p> <p><input type="checkbox"/> <input type="checkbox"/> Yes, as victim</p> <p><input type="checkbox"/> <input type="checkbox"/> Yes, as perpetrator</p> <p><input type="checkbox"/> <input type="checkbox"/> No</p> <p><input type="checkbox"/> <input type="checkbox"/> U/K</p>	<p>23. Person have delinquent/criminal history?</p> <p><u>Caused</u> <u>Contributed</u></p> <p><input type="radio"/> <input type="radio"/> Yes</p> <p><input type="radio"/> <input type="radio"/> No</p> <p><input type="radio"/> <input type="radio"/> U/K</p> <p>If yes, check all that apply:</p> <p><input type="checkbox"/> <input type="checkbox"/> Assaults</p> <p><input type="checkbox"/> <input type="checkbox"/> Robbery</p> <p><input type="checkbox"/> <input type="checkbox"/> Drugs</p> <p><input type="checkbox"/> <input type="checkbox"/> Other, specify:</p> <p><input type="checkbox"/> <input type="checkbox"/> U/K</p>																																																		
<p>24. At time of incident was person impaired?</p> <p><u>Caused</u> <u>Contributed</u></p> <p><input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K</p> <p>If yes, check all that apply:</p> <p><u>Caused</u> <u>Contributed</u></p> <p><input type="checkbox"/> <input type="checkbox"/> Drug impaired</p> <p><input type="checkbox"/> <input type="checkbox"/> Alcohol impaired</p> <p><input type="checkbox"/> <input type="checkbox"/> Asleep</p> <p><input type="checkbox"/> <input type="checkbox"/> Distracted</p> <p><input type="checkbox"/> <input type="checkbox"/> Absent</p> <p><input type="checkbox"/> <input type="checkbox"/> Impaired by illness, specify:</p> <p><input type="checkbox"/> <input type="checkbox"/> Impaired by disability, specify:</p> <p><input type="checkbox"/> <input type="checkbox"/> Other, specify:</p>	<p>25. Does person have, check all that apply:</p> <p><u>Caused</u> <u>Contributed</u></p> <p><input type="checkbox"/> <input type="checkbox"/> Prior history of similar acts</p> <p><input type="checkbox"/> <input type="checkbox"/> Prior arrests</p> <p><input type="checkbox"/> <input type="checkbox"/> Prior convictions</p>	<p>26. Legal outcomes in this death, check all that apply:</p> <p><u>Caused</u> <u>Contributed</u></p> <p><input type="checkbox"/> <input type="checkbox"/> No charges filed</p> <p><input type="checkbox"/> <input type="checkbox"/> Charges pending</p> <p><input type="checkbox"/> <input type="checkbox"/> Charges filed, specify:</p> <p><input type="checkbox"/> <input type="checkbox"/> Charges dismissed</p> <p><input type="checkbox"/> <input type="checkbox"/> Confession</p> <p><input type="checkbox"/> <input type="checkbox"/> Plead, specify:</p> <p><input type="checkbox"/> <input type="checkbox"/> Not guilty verdict</p> <p><input type="checkbox"/> <input type="checkbox"/> Guilty verdict, specify:</p> <p><input type="checkbox"/> <input type="checkbox"/> Tort charges, specify:</p> <p><input type="checkbox"/> <input type="checkbox"/> U/K</p>																																																			
<p>FOR SUICIDE</p>																																																					
<p>27. For suicide, select yes, no or u/k for each question. Describe answers in narrative.</p>																																																					
<table style="width:100%;"> <tr> <th style="text-align: center;"><u>Yes</u></th> <th style="text-align: center;"><u>No</u></th> <th style="text-align: center;"><u>U/K</u></th> <th></th> </tr> <tr> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/></td> <td>A note was left</td> </tr> <tr> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/></td> <td>Child talked about suicide</td> </tr> <tr> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/></td> <td>Prior suicide threats were made</td> </tr> <tr> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/></td> <td>Prior attempts were made</td> </tr> <tr> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/></td> <td>Suicide was completely unexpected</td> </tr> <tr> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/></td> <td>Child had a history of running away</td> </tr> </table>	<u>Yes</u>	<u>No</u>	<u>U/K</u>		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	A note was left	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Child talked about suicide	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Prior suicide threats were made	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Prior attempts were made	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Suicide was completely unexpected	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Child had a history of running away	<table style="width:100%;"> <tr> <th style="text-align: center;"><u>Yes</u></th> <th style="text-align: center;"><u>No</u></th> <th style="text-align: center;"><u>U/K</u></th> <th></th> </tr> <tr> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/></td> <td>Child had a history of self mutilation</td> </tr> <tr> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/></td> <td>There is a family history of suicide</td> </tr> <tr> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/></td> <td>Suicide was part of a murder-suicide</td> </tr> <tr> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/></td> <td>Suicide was part of a suicide pact</td> </tr> <tr> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/></td> <td>Suicide was part of a suicide cluster</td> </tr> </table>	<u>Yes</u>	<u>No</u>	<u>U/K</u>		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Child had a history of self mutilation	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	There is a family history of suicide	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Suicide was part of a murder-suicide	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Suicide was part of a suicide pact	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Suicide was part of a suicide cluster
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<p>28. For suicide, was there a history of acute or cumulative personal crises that may have contributed to the child's despondency? Check all that apply:</p>																																																					
<p><input type="checkbox"/> None known</p> <p><input type="checkbox"/> Family discord</p> <p><input type="checkbox"/> Parents' divorce/separation</p> <p><input type="checkbox"/> Argument with parents/caregivers</p> <p><input type="checkbox"/> Argument with boyfriend/girlfriend</p> <p><input type="checkbox"/> Breakup with boyfriend/girlfriend</p> <p><input type="checkbox"/> Argument with other friends</p> <p><input type="checkbox"/> Rumor mongering</p>	<p><input type="checkbox"/> Suicide by friend or relative</p> <p><input type="checkbox"/> Other death of friend or relative</p> <p><input type="checkbox"/> Bullying as victim</p> <p><input type="checkbox"/> Bullying as perpetrator</p> <p><input type="checkbox"/> School failure</p> <p><input type="checkbox"/> Move/new school</p> <p><input type="checkbox"/> Other serious school problems</p> <p><input type="checkbox"/> Pregnancy</p>	<p><input type="checkbox"/> Physical abuse/assault</p> <p><input type="checkbox"/> Rape/sexual abuse</p> <p><input type="checkbox"/> Problems with the law</p> <p><input type="checkbox"/> Drugs/alcohol</p> <p><input type="checkbox"/> Sexual orientation</p> <p><input type="checkbox"/> Religious/cultural issues</p> <p><input type="checkbox"/> Job problems</p> <p><input type="checkbox"/> Money problems</p>	<p><input type="checkbox"/> Gambling problems</p> <p><input type="checkbox"/> Involvement in cult activities</p> <p><input type="checkbox"/> Involvement in computer or video games</p> <p><input type="checkbox"/> Involvement with the Internet, specify:</p> <p><input type="checkbox"/> Other, specify:</p> <p><input type="checkbox"/> U/K</p>																																																		