PUBLIC HEALTH

CASE NUMBER

_____/_____/_____/_____

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

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

Death Certificate Number:

Birth Certificate Number:

ME/Coroner Number:

Date CDRT Notified of Death:

A. CHILD INFORMATION

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

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

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

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

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

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

7. Sex: ○ Male ○ Female ○ U/K

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

As Victim	As Perpetrator		As Victim	As Perpetrator	
	○	N/A	☐	☐	Physical
○	○	Yes	☐	☐	Neglect
○	○	No	☐	☐	Sexual
○	○	U/K	☐	☐	Emotional/psychological
			☐	☐	U/K
If yes, how was history identified:					
○	○	Through CPS	_____	_____	# CPS referrals
○	○	Other sources	_____	_____	# Substantiations

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

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

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

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

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

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

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

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

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

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

COMPLETE FOR ALL INFANTS UNDER ONE YEAR

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

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

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

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

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

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

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

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

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

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

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

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

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

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

44. Did mother smoke at any time during pregnancy?
○ Yes ○ No ○ U/K
If yes, Trimester 1 _____ Trimester 2 _____ Trimester 3 _____ Avg # cigarettes/day (20 cigarettes in pack)
☐ ☐ ☐ U/K quantity

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

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

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

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

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

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

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

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

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

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

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

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

B. PRIMARY CAREGIVER(S) INFORMATION

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

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

2. Caregiver(s) age in years:

One	Two	
_____	_____	# Years
☐	☐	U/K

3. Caregiver(s) sex:

One	Two	
○	○	Male
○	○	Female
○	○	U/K

4. Caregiver(s) employment status:

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

5. Caregiver(s) income:

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

6. Caregiver(s) education:

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

7. Do caregiver(s) speak English?

One	Two	
○	○	Yes
○	○	No
○	○	U/K

If no, language spoken:

8. Caregiver(s) on active military duty?

One	Two	
○	○	Yes
○	○	No
○	○	U/K

If yes, specify branch:

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

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

If yes, check all that apply

10. Caregiver(s) have substance abuse history?

One Two
- Yes
- No
- U/K

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

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

One Two
- Yes
- No
- U/K

If yes, check all that apply:
- Physical
- Neglect
- Sexual
- Emotional/psychological
- U/K
- _____ _____ # CPS referrals
- _____ _____ # Substantiations
- Ever in foster care or adopted

12. Caregiver(s) ever perpetrator of maltreatment?

One Two
- Yes
- No
- U/K

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

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

One Two
- Yes
- No
- U/K

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

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

14. Caregiver(s) have prior child deaths?

One Two
- Yes
- No
- U/K

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

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

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

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

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

One Two
- Yes
- No
- U/K

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

C. SUPERVISOR INFORMATION

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

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

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

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

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

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

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

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

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

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

10. Supervisor has history of child maltreatment?

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

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

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

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

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

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

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

J. SERVICES TO FAMILY AND COMMUNITY AS A RESULT OF DEATH

1. Services: Select one option per row:	Provided after death	Offered but refused	Offered but U/K if used	Should be offered	Needed but not available	U/K	CDR review led to referral
Bereavement counseling	○	○	○	○	○	○	☐
Debriefing for professionals	○	○	○	○	○	○	☐
Economic support	○	○	○	○	○	○	☐
Funeral arrangements	○	○	○	○	○	○	☐
Emergency shelter	○	○	○	○	○	○	☐
Mental health services	○	○	○	○	○	○	☐
Foster care	○	○	○	○	○	○	☐
Health services	○	○	○	○	○	○	☐
Legal services	○	○	○	○	○	○	☐
Genetic counseling	○	○	○	○	○	○	☐
Other, specify:	○	○	○	○	○	○	☐

K. PREVENTION INITIATIVES RESULTING FROM THE REVIEW

☐ **Mark this case to edit/add prevention actions at a later date**

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

2. What specific recommendations and/or initiatives resulted from the review? Check all that apply: ☐ No recommendations made, go to Section L

		Current Action Stage			Type of Action		Level of Action		
		Recommendation	Planning	Implementation	Short term	Long term	Local	State	National
Education	Media campaign	○	○	○	☐	☐	☐	☐	☐
	School program	○	○	○	☐	☐	☐	☐	☐
	Community safety project	○	○	○	☐	☐	☐	☐	☐
	Provider education	○	○	○	☐	☐	☐	☐	☐
	Parent education	○	○	○	☐	☐	☐	☐	☐
	Public forum	○	○	○	☐	☐	☐	☐	☐
	Other education	○	○	○	☐	☐	☐	☐	☐
Agency	New policy(ies)	○	○	○	☐	☐	☐	☐	☐
	Revised policy(ies)	○	○	○	☐	☐	☐	☐	☐
	New program	○	○	○	☐	☐	☐	☐	☐
	New services	○	○	○	☐	☐	☐	☐	☐
	Expanded services	○	○	○	☐	☐	☐	☐	☐
Law	New law/ordinance	○	○	○	☐	☐	☐	☐	☐
	Amended law/ordinance	○	○	○	☐	☐	☐	☐	☐
	Enforcement of law/ordinance	○	○	○	☐	☐	☐	☐	☐
Environment	Modify a consumer product	○	○	○	☐	☐	☐	☐	☐
	Recall a consumer product	○	○	○	☐	☐	☐	☐	☐
	Modify a public space	○	○	○	☐	☐	☐	☐	☐
	Modify a private space(s)	○	○	○	☐	☐	☐	☐	☐
	Other, specify:	○	○	○	☐	☐	☐	☐	☐

Briefly describe the initiatives:

3. Who took responsibility for championing the prevention initiatives? Check all that apply:

☐ N/A, no strategies	☐ Mental health	☐ Law enforcement	☐ Advocacy organization	☐ Other, specify:
☐ No one	☐ Schools	☐ Medical examiner	☐ Local community group	
☐ Health department	☐ Hospital	☐ Coroner	☐ New coalition/task force	
☐ Social services	☐ Other health care providers	☐ Elected official	☐ Youth group	☐ U/K

L. THE REVIEW MEETING PROCESS

1. Date of first CDR meeting:

2. Number of CDR meetings for this case: _____

3. Is CDR complete? ○ N/A ○ Yes ○ No

4. Agencies at CDR meeting, check all that apply:

☐ Medical examiner/coroner	☐ CPS	☐ Other health care	☐ Mental health	☐ Military
☐ Law enforcement	☐ Other social services	☐ Fire	☐ Substance abuse	☐ Others, list:
☐ Prosecutor/district attorney	☐ Physician	☐ EMS	☐ Court	
☐ Public health	☐ Hospital	☐ Education	☐ Child advocate	