U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Disease Control and Prevention
Division of Reproductive Health
Maternal and Infant Health Branch
Atlanta, Georgia 30333

CDC

Sudden Unexplained Infant Death Investigation

# SUIDI Reporting Form

Reset Form

## INVESTIGATION DATA

| Infant's Last Name | Infant's First Name | Middle Name | Case Number |
|---|---|---|---|
| | | | |

Sex: ☐ Male ☐ Female Date of Birth _____ Age: _____ SS#: _____

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

**Infant's Primary Residence:**

Address: _____ City: _____ County: _____ State: _____ Zip: _____

Incident Address: _____ City: _____ County: _____ State: _____ Zip: _____

**Contact Information for Witness:**

Relationship to deceased: ☐ Birth Mother ☐ Birth Father ☐ Grandmother ☐ Grandfather

☐ Adoptive or Foster Parent ☐ Physician ☐ Health Records ☐ Other Describe: _____

Last: _____ First: _____ M.: _____ SS#: _____

Address: _____ City: _____ State: _____ Zip: _____

Work Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Date of Birth: _____

## WITNESS INTERVIEW

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

**2** **Tell me what happened:**

_____

**3** **Did you notice anything unusual or different about the infant in the last 24 hrs?**

☐ No ☐ Yes Specify: _____

**4** **Did the infant experience any falls or injury within the last 72 hrs?**

☐ No ☐ Yes Specify: _____

**5** **When was the infant LAST PLACED?**

Date: _____ Military Time: _____ Location (room): _____

**6** **When was the infant LAST KNOWN ALIVE(LKA)?**

Date: _____ Military Time: _____ Location (room): _____

**7** **When was the infant FOUND?**

Date: _____ Military Time: _____ Location (room): _____

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

_____

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

| | | | |
|---|---|---|---|
| ☐ Bassinet | ☐ Bedside co-sleeper | ☐ Car seat | ☐ Chair |
| ☐ Cradle | ☐ Crib | ☐ Floor | ☐ In a person's arms |
| ☐ Mattress/box spring | ☐ Mattress on floor | ☐ Playpen | ☐ Portable crib |
| ☐ Sofa/couch | ☐ Stroller/carriage | ☐ Swing | ☐ Waterbed |
| ☐ Other - describe: | | | |

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

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

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

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

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

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

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

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

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

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

**20** **Was the infant tightly wrapped or swaddled?** ☐ No ☐ Yes - describe: _____

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

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

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

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

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

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

**26** **Was anyone sleeping with the infant?** ☐ No ☐ Yes

| Name of individual sleeping with infant | Age | Height | Weight | Location in relation to infant | Impairment (intoxication, tired) |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

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

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

## WITNESS INTERVIEW (cont.)

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

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

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

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

☐ Sweaty ☐ Warm to touch ☐ Cool to touch ☐ Limp, flexible ☐ Rigid, stiff ☐ Unknown

☐ Other - specify:

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

Who? Date: Military time: :

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

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

Explain:

## INFANT MEDICAL HISTORY

**1** **Source of medical information:** ☐ Doctor ☐ Other healthcare provider ☐ Medical record ☐ Family

☐ Mother/primary caregiver ☐ Other:

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

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

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

☐ No ☐ Yes - describe:

**4** **In the 72 hours prior to the infants death, was the infant given any vaccinations or medications?** ☐ No ☐ Yes

*(Please include any home remedies, herbal medications, prescription medicines, over-the-counter medications.)*

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

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

| Medical history | Unknown | No | Yes | Describe |
|---|---|---|---|---|
| a) Allergies *(food, medication, or other)* | | | | |
| b) Abnormal growth or weight gain/loss | | | | |
| c) Apnea *(stopped breathing)* | | | | |
| d) Cyanosis *(turned blue/gray)* | | | | |
| e) Seizures or convulsions | | | | |
| f) Cardiac (*heart*) abnormalities | | | | |

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

Describe:

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

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

**8** **Birth hospital name:** Discharge date:

Street address:

City: State: Zip:

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

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

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

☐ On time ☐ Early - how many weeks? ☐ Late - how many weeks?

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

☐ Singleton ☐ Twin ☐ Triplet ☐ Quadrupelet or higher gestation

**13** **Were there any complications during delivery or at birth?** *(emergency c-section, child needed oxygen)* ☐ Yes ☐ No

Describe:

**14** **Are there any alerts to the pathologist?** *(previous infant deaths in family, newborn screen results)* ☐ Yes ☐ No

Specify:

## INFANT DIETARY HISTORY

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

Date: _____ Military Time: ____ : ____

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

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

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

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

**5** **Was a new food introduced in the 24 hours prior to his/her death?** ☐ No ☐ Yes

If yes, describe *(ex. content, amount, change in formula, introduction of solids)*

_____

**6** **Was the infant last placed to sleep with a bottle?** ☐ Yes ☐ No - if no, skip to question **<u>9</u>** below

**7** **Was the bottle propped?** (i.e., object used to hold bottle while infant feeds) ☐ No ☐ Yes

If yes, what object was used to prop the bottle? _____

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

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

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

☐ No ☐ Yes

If yes, - describe: _____

## PREGNANCY HISTORY

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

First name: _____ Last name: _____

Middle name: _____ Maiden name: _____

Birth date: _____ SS#: _____

Street address: _____ City: _____ State: ____ Zip: _____

How long has the birth mother been at this address? Years: _____ Months: _____

Previous Address: _____

**2** **At how many weeks or months did the birth mother begin prenatal care?** ☐ No prenatal care ☐ Unknown

Weeks: _____ Months: _____

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

Physician/ Provider: _____ Hospital/clinic: _____ Phone: _____

Street address: _____ City: _____ State: ____ Zip: _____

## PREGNANCY HISTORY (cont.)

4 **During her pregnancy with the infant, did the mother have any complications?** ☐ No ☐ Yes
*(ex. high blood pressure, bleeding, gestational diabetes)*

Specify:

5 **Was the birth mother injured during her pregnancy with the infant?** *(ex. auto accident, falls)* ☐ No ☐ Yes

Specify:

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

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

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

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

## INCIDENT SCENE INVESTIGATION

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

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

3 **Is the site of the incident or death scene a daycare or other childcare setting?** ☐ Yes ☐ No - If no, skip to question **8**

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

5 **How many adults (age 18 and over) were supervising the child(ren)?**

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

License number: Agency:

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

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

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

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

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

☐ Other - specify:

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

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

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

☐ Public/municipal water ☐ Bottled water ☐ Well ☐ Unknown ☐ Other - Specify:

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

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

☐ Other - specify:

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

Specify:

## INVESTIGATION SUMMARY

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

**2** **Arrival times**

| | Military time |
|---|---|
| Law enforcement at scene: | : |
| DSI at scene: | : |
| Infant at hospital: | : |

## Investigator's Notes

**1** **Indicate the task(s) performed**

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

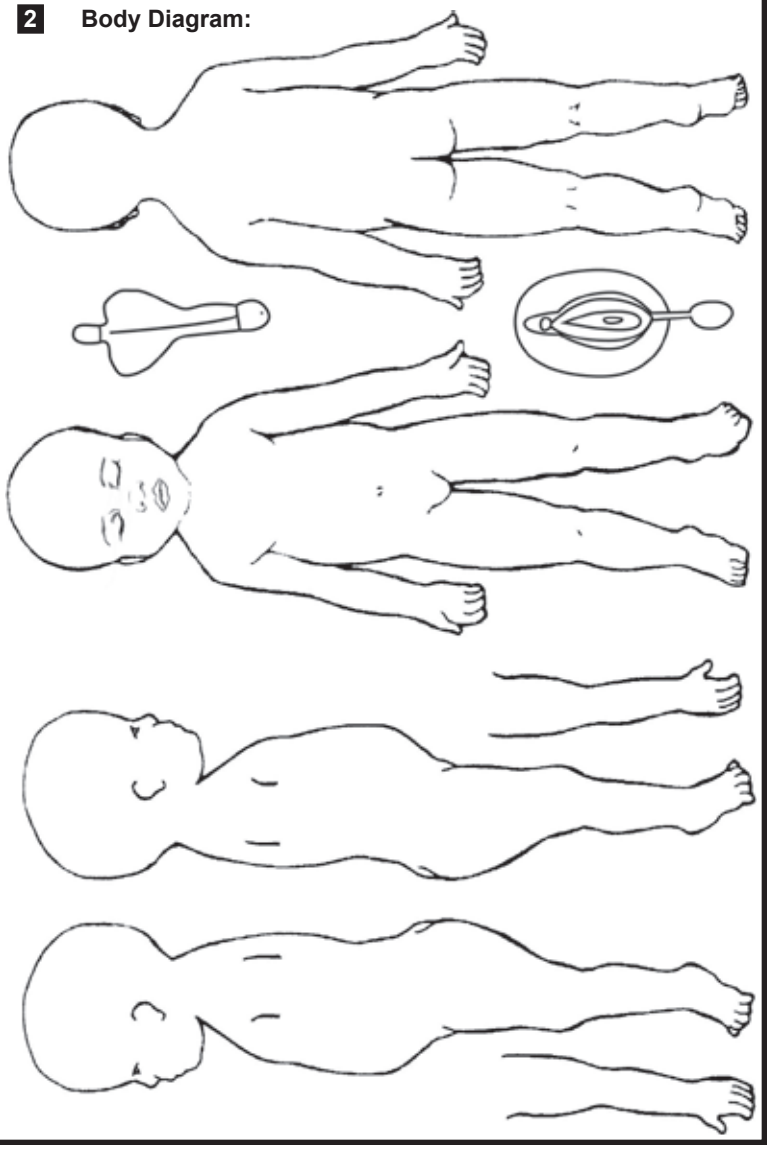
**2** **If more than one person was interviewed, does the information differ?** ☐ No ☐ Yes

If yes, detail any differences, inconsistencies of relevant information: *(ex. placed on sofa, last known alive on chair.)*

## INVESTIGATION DIAGRAMS

**1** **Scene Diagram:**

**2** **Body Diagram:**



Case Information

**1 Investigator information** Name: _____ Agency: _____ Phone: _____

| | Date | Military time |
|---|---|---|
| Investigated: | | : |
| Pronounced dead: | | : |

**2 Infant's information:** Last: _____ First: _____ M: _____ Case #: _____

Sex: ☐ Male ☐ Female Date of Birth: _____ Age: _____

Race: ☐ White ☐ Black/African Am. ☐ Asian/Pacific Islander

☐ Am. Indian/Alaskan Native ☐ Hispanic/Latino ☐ Other: _____

Sleeping Environment | Infant History | Family Info | Exam | Investigator Insight

**1 Indicate whether preliminary investigation suggests any of the following:**

| Yes | No | |
|---|---|---|
| ☐ | ☐ | Asphyxia *(ex. overlying, wedging, choking, nose/mouth obstruction, re-breathing, neck compression, immersion in water)* |
| ☐ | ☐ | Sharing of sleep surface with adults, children, or pets |
| ☐ | ☐ | Change in sleep condition *(ex. unaccustomed stomach sleep position, location, or sleep surface)* |
| ☐ | ☐ | Hyperthermia/Hypothermia *(ex. excessive wrapping, blankets, clothing, or hot or cold environments)* |
| ☐ | ☐ | Environmental hazards *(ex. carbon monoxide, noxious gases, chemicals, drugs, devices)* |
| ☐ | ☐ | Unsafe sleep condition *(ex. couch/sofa, waterbed, stuffed toys, pillows, soft bedding)* |
| ☐ | ☐ | Diet (*e.g., solids introduced, etc.*) |
| ☐ | ☐ | Recent hospitalization |
| ☐ | ☐ | Previous medical diagnosis |
| ☐ | ☐ | History of acute life-threatening events *(ex. apnea, seizures, difficulty breathing)* |
| ☐ | ☐ | History of medical care without diagnosis |
| ☐ | ☐ | Recent fall or other injury |
| ☐ | ☐ | History of religious, cultural, or ethnic remedies |
| ☐ | ☐ | Cause of death due to natural causes other than SIDS *(ex. birth defects, complications of preterm birth)* |
| ☐ | ☐ | Prior sibling deaths |
| ☐ | ☐ | Previous encounters with police or social service agencies |
| ☐ | ☐ | Request for tissue or organ donation |
| ☐ | ☐ | Objection to autopsy |
| ☐ | ☐ | Pre-terminal resuscitative treatment |
| ☐ | ☐ | Death due to trauma (injury), poisoning, or intoxication |
| ☐ | ☐ | Suspicious circumstances |
| ☐ | ☐ | Other alerts for pathologist's attention |

Any "Yes" answers above should be explained in detail (description of circumstances):

_____

Pathologist

**2 Pathologist information** Name: _____

Agency: _____ Phone: _____ Fax: _____