

I. OTHER CIRCUMSTANCES OF INCIDENT - ANSWER RELEVANT SECTIONS

11. SUDDEN AND UNEXPECTED DEATH IN THE YOUNG (SDY)

This section displays online based on your state's settings.

Section 11: OMB No. 0920-1092, Exp. Date: 4/30/2022

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?
 - A suicide?
 - An overdose?
 - A result of an external cause that was the obvious and only reason for the fatal injury?
 - Expected within 6 months due to terminal illness?
 - None of the above, go to 11b THIS IS AN SDY CASE
 - U/K, go to 11b

If any of these apply, go to Section 12, THIS IS NOT AN SDY CASE.

b. Did the child have a history of any of the following acute conditions or symptoms within 72 hours prior to death?

U/K for all

Symptom	Present w/in 72 hours of death			Other Acute Symptom	Present w/in 72 hours of death		
	Yes	No	U/K		Yes	No	U/K
Cardiac				Fever	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Chest pain	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Heat exhaustion/heat stroke	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Dizziness/lightheadedness	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Muscle aches/cramping	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Fainting	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Slurred speech	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Palpitations	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Vomiting	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Neurologic				Other, specify:	<input type="radio"/>		
Concussion	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>				
Confusion	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>				
Convulsions/seizure	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>				
Headache	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>				
Head injury	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>				
Psychiatric symptoms	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>				
Paralysis (acute)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>				
Respiratory							
Asthma	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>				
Pneumonia	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>				
Difficulty breathing	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>				

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? U/K for all

Symptom	Present more than 72 hours of death		
	Yes	No	U/K
Cardiac			
Chest pain	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Dizziness/lightheadedness	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Fainting	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Palpitations	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Neurologic			
Concussion	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Confusion	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Convulsions/seizure	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Headache	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Head injury	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Respiratory			
Difficulty breathing	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Other			
Slurred speech	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Other, specify:	<input type="radio"/>		

d. Did the child have any prior serious injuries (e.g. near drowning, car accident, brain injury)?

Yes No U/K If yes, describe:

e. Had the child ever been diagnosed by a medical professional for the following? U/K for all

Condition	Diagnosed			Condition	Diagnosed			Condition	Diagnosed		
	Yes	No	U/K		Yes	No	U/K		Yes	No	U/K
Blood disease				Neurologic				Other			
Sickle cell disease	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Anoxic brain Injury	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Connective tissue disease	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Sickle cell trait	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Traumatic brain injury/ head injury/concussion	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Diabetes	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Thrombophilia (clotting disorder)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Brain tumor	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Endocrine disorder, other: thyroid, adrenal, pituitary	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Cardiac				Brain aneurysm	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Hearing problems or deafness	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Abnormal electrocardiogram (EKG or ECG)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Brain hemorrhage	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Kidney disease	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Aneurysm or aortic dilatation	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Developmental brain disorder	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Mental illness/psychiatric disease	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Arrhythmia/arrhythmia syndrome	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Epilepsy/seizure disorder	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Metabolic disease	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Cardiomyopathy	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Febrile seizure	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Muscle disorder or muscular dystrophy	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Commotio cordis	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Mesial temporal sclerosis	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Oncologic disease treated by chemotherapy or radiation	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Congenital heart disease	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Neurodegenerative disease	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Prematurity	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Coronary artery abnormality	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Stroke/mini stroke/ TIA-Transient Ischemic Attack	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Congenital disorder/ genetic syndrome	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Coronary artery disease (atherosclerosis)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Central nervous system infection (meningitis or encephalitis)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Other, specify:	<input type="radio"/>		
Endocarditis	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Respiratory							
Heart failure	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Apnea	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>				
Heart murmur	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Asthma	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>				
High cholesterol	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Pulmonary embolism	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>				
Hypertension	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Pulmonary hemorrhage	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>				
Myocarditis (heart infection)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Respiratory arrest	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>				
Pulmonary hypertension	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>								
Sudden cardiac arrest	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>								

If a more specific diagnosis is known, provide any additional information:

If any cardiac conditions above are selected, what cardiac treatments did the child have? Check all that apply: None

- Cardiac ablation
- Cardiac device placement
(implanted cardioverter defibrillator (ICD)
or pacemaker or Ventricular Assist Device (VAD))
- Heart surgery
- Interventional cardiac
catheterization
- Heart transplant
- Other, specify:
 U/K

f. Did the child have any blood relatives (brothers, sisters, parents, aunts, uncles, cousins, grandparents or other more distant relatives) with the following diseases, conditions or symptoms? U/K for all

Y N U/ **Deaths**

Sudden unexpected death before age 50

If yes, describe the type of event, which relative, and relative's age at death (for example, brother at age 30 who died in an unexplained motor vehicle accident (driver of car)):

Heart Disease

- Heart condition/heart attack or stroke before age 50
- Aortic aneurysm or aortic rupture
- Arrhythmia (fast or irregular heart rhythm)
- Cardiomyopathy
- Congenital heart disease

Neurologic Disease

- Epilepsy or convulsions/seizure
- Other neurologic disease

Y N U/K

Symptoms

- Febrile seizures
- Unexplained fainting
- Other Diagnoses**
- Congenital deafness
- Connective tissue disease
- Mitochondrial disease
- Muscle disorder or muscular dystrophy
- Thrombophilia (clotting disorder)
- Other diseases that are genetic or run in families, specify:

g. Has any blood relative (siblings, parents, aunts, uncles, cousins, grandparents) had genetic testing?

Yes No U/K

If yes, describe the test/gene tested, reason for testing, family member tested, and results:

Was a gene mutation found?

Yes No U/K

h. In the 72 hours prior to death was the child taking any prescribed medication(s)?

Yes No U/K

If yes, describe:

i. Within 2 weeks prior to death had the child:

	<u>N/A</u> <u>Yes</u> <u>No</u> <u>U/K</u>
Taken extra doses of prescribed medications	<input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/>
Missed doses of prescribed medications	<input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/>
Changed prescribed medications, describe:	<input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/>

j. Was the child compliant with their prescribed medications?

N/A Yes No U/K

If not compliant, describe why and how often:

k. Was the child taking any of the following substance(s) within 24 hours of death?

Check all that apply:

- Over-the-counter medicine
- Recent/short term prescriptions
- Energy drinks
- Caffeine
- Performance enhancers
- Diet assisting medications
- Supplements
- Tobacco
- Alcohol
- Illegal drugs
- Legalized marijuana
- Other, specify:
 U/K

If yes to any items above, describe:

l. Did the child experience any of the following stimuli at time of incident or within 24 hours of the incident? U/K for all at time of incident

U/K for all within 24 hours of incident

Stimuli	At incident			Within 24 hrs of incident		
	Yes	No	U/K	Yes	No	U/K
Physical activity	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Sleep deprivation	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Driving	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Visual stimuli	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Video game stimuli	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Emotional stimuli	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Auditory stimuli/startle	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Physical trauma	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Other, specify:	<input type="radio"/>			<input type="radio"/>		

If yes to physical activity, describe type of activity:

At incident Within 24 hours of incident

Other specify:

At incident Within 24 hours of incident

m. Was the child an athlete? N/A Yes No U/K

If yes, type of sport: Competitive Recreational U/K

If competitive, did the child participate in the 6 months prior to death? Yes No U/K

n. Did the child ever have any of the following **uncharacteristic** symptoms during or within 24 hours after physical activity? Check all that apply:

- Chest pain
- Confusion
- Convulsions/seizure
- Dizziness/lightheadedness
- Fainting
- Headache
- Palpitations
- Shortness of breath/difficulty breathing
- Other, specify:
 U/K

If yes to any item, describe type of physical activity and extent of symptoms:

o. For child age 12 or older, did the child receive a pre-participation exam for a sport?

N/A Yes No U/K

If yes:

Was it done within a year prior to death? Yes No U/K

Did the exam lead to restrictions for sports or otherwise? Yes No U/K

If yes, specify restrictions:

Questions p through v: Answer if "Epilepsy/Seizure Disorder" is answered Yes in question e above (Diagnosed for a medical condition)		
<p>p. How old was the child when diagnosed with epilepsy/seizure disorder? Age 0 (infant) through 20 years: _____ <input type="checkbox"/> U/K</p>	<p>r. What type(s) of seizures did the child have? Check all that apply:</p> <p><input type="checkbox"/> Non-convulsive <input type="checkbox"/> Convulsive (grand mal seizure or generalized tonic-clonic seizure) <input type="checkbox"/> Occur when exposure to strobe lights, video game, or flickering light (reflex seizure) <input type="checkbox"/> U/K</p>	<p>t. How many seizures did the child have in the year preceding death? <input type="radio"/> 0/never <input type="radio"/> 2 <input type="radio"/> More than 3 <input type="radio"/> 1 <input type="radio"/> 3 <input type="radio"/> U/K</p>
<p>q. What were the underlying cause(s) of the child's seizures? Check all that apply:</p> <p><input type="checkbox"/> Brain injury/trauma, specify: <input type="checkbox"/> Genetic/chromosomal <input type="checkbox"/> Brain tumor <input type="checkbox"/> Mesial temporal sclerosis <input type="checkbox"/> Cerebrovascular <input type="checkbox"/> Idiopathic or cryptogenic <input type="checkbox"/> Central nervous system infection <input type="checkbox"/> Other acute illness or injury other than epilepsy <input type="checkbox"/> Degenerative process <input type="checkbox"/> Other, specify: <input type="checkbox"/> Developmental brain disorder <input type="checkbox"/> U/K <input type="checkbox"/> Inborn error of metabolism</p>	<p>s. Describe the child's epilepsy/seizures (not including the seizure at time of death). Check all that apply:</p> <p><input type="checkbox"/> Last less than 30 minutes <input type="checkbox"/> Last more than 30 minutes (status epilepticus) <input type="checkbox"/> Occur in the presence of fever (febrile seizure) <input type="checkbox"/> Occur in the absence of fever <input type="checkbox"/> Occur when exposed to strobe lights, video game, or flickering light (reflex seizure)</p>	<p>u. Did treatment for seizures include anti-epileptic drugs? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K</p> <p>If yes, how many different types of anti-epileptic drugs did the child take? <input type="radio"/> 1 <input type="radio"/> 4 <input type="radio"/> More than 6 <input type="radio"/> 2 <input type="radio"/> 5 <input type="radio"/> U/K <input type="radio"/> 3 <input type="radio"/> 6</p>
<p>v. Was night surveillance used? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K</p>		

12. ANSWER THIS ONLY IF CHILD IS UNDER AGE FIVE: WAS DEATH RELATED TO SLEEPING OR THE SLEEP ENVIRONMENT? Yes, go to I2a No, go to I2s U/K, go to I2a

<p>a. Incident sleep place:</p> <table style="width:100%;"> <tr> <td><input type="radio"/> Crib</td> <td><input type="radio"/> Adult bed</td> <td><input type="radio"/> Car seat</td> <td style="border-left: 1px solid black;"><input type="radio"/> If adult bed, what type?</td> <td><input type="radio"/> If futon,</td> </tr> <tr> <td> If crib, type:</td> <td><input type="radio"/> Waterbed</td> <td><input type="radio"/> Rock 'n Play</td> <td><input type="radio"/> Twin</td> <td><input type="radio"/> Bed position</td> </tr> <tr> <td><input type="radio"/> Not portable</td> <td><input type="radio"/> Futon</td> <td><input type="radio"/> Stroller</td> <td><input type="radio"/> Full</td> <td><input type="radio"/> Couch position</td> </tr> <tr> <td><input type="radio"/> Portable, e.g. Pack 'n Play</td> <td><input type="radio"/> Playpen/other play structure, not a portable crib</td> <td><input type="radio"/> Swing</td> <td><input type="radio"/> Queen</td> <td><input type="radio"/> U/K</td> </tr> <tr> <td><input type="radio"/> Unknown crib type</td> <td></td> <td><input type="radio"/> Bouncy chair</td> <td><input type="radio"/> King</td> <td><input type="radio"/> If car seat, was car seat secured in seat of car?</td> </tr> <tr> <td><input type="radio"/> Bassinet</td> <td><input type="radio"/> Couch</td> <td><input type="radio"/> Other, specify:</td> <td><input type="radio"/> Other, specify:</td> <td><input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K</td> </tr> <tr> <td><input type="radio"/> Bed side sleeper</td> <td><input type="radio"/> Chair</td> <td><input type="radio"/> U/K</td> <td><input type="radio"/> U/K</td> <td></td> </tr> <tr> <td><input type="radio"/> Baby box</td> <td><input type="radio"/> Floor</td> <td></td> <td></td> <td></td> </tr> </table>				<input type="radio"/> Crib	<input type="radio"/> Adult bed	<input type="radio"/> Car seat	<input type="radio"/> If adult bed, what type?	<input type="radio"/> If futon,	If crib, type:	<input type="radio"/> Waterbed	<input type="radio"/> Rock 'n Play	<input type="radio"/> Twin	<input type="radio"/> Bed position	<input type="radio"/> Not portable	<input type="radio"/> Futon	<input type="radio"/> Stroller	<input type="radio"/> Full	<input type="radio"/> Couch position	<input type="radio"/> Portable, e.g. Pack 'n Play	<input type="radio"/> Playpen/other play structure, not a portable crib	<input type="radio"/> Swing	<input type="radio"/> Queen	<input type="radio"/> U/K	<input type="radio"/> Unknown crib type		<input type="radio"/> Bouncy chair	<input type="radio"/> King	<input type="radio"/> If car seat, was car seat secured in seat of car?	<input type="radio"/> Bassinet	<input type="radio"/> Couch	<input type="radio"/> Other, specify:	<input type="radio"/> Other, specify:	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K	<input type="radio"/> Bed side sleeper	<input type="radio"/> Chair	<input type="radio"/> U/K	<input type="radio"/> U/K		<input type="radio"/> Baby box	<input type="radio"/> Floor			
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<p>b. Child put to sleep:</p> <p><input type="radio"/> On back <input type="radio"/> On stomach <input type="radio"/> On side <input type="radio"/> U/K</p>	<p>c. Child found:</p> <p><input type="radio"/> On back <input type="radio"/> On stomach <input type="radio"/> On side <input type="radio"/> U/K</p>	<p>e. Usual sleep position:</p> <p><input type="radio"/> On back <input type="radio"/> On stomach <input type="radio"/> On side <input type="radio"/> U/K</p>	<p>f. Was there any type of crib, Pack 'n Play, bassinet, bed side sleeper or baby box in home for child? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K</p>
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<p>d. Usual sleep place:</p> <table style="width:100%;"> <tr> <td><input type="radio"/> Crib</td> <td><input type="radio"/> Baby box</td> <td><input type="radio"/> Floor</td> <td style="border-left: 1px solid black;"><input type="radio"/> If adult bed, what type?</td> </tr> <tr> <td> If crib, type:</td> <td><input type="radio"/> Adult bed</td> <td><input type="radio"/> Car seat</td> <td><input type="radio"/> Twin <input type="radio"/> King</td> </tr> <tr> <td><input type="radio"/> Not portable</td> <td><input type="radio"/> Waterbed</td> <td><input type="radio"/> Rock 'n Play</td> <td><input type="radio"/> Full <input type="radio"/> Other, specify:</td> </tr> <tr> <td><input type="radio"/> Portable, e.g. Pack 'n Play</td> <td><input type="radio"/> Futon</td> <td><input type="radio"/> Stroller</td> <td><input type="radio"/> Queen <input type="radio"/> U/K</td> </tr> <tr> <td><input type="radio"/> Unknown crib type</td> <td><input type="radio"/> Playpen/other play structure, not a portable crib</td> <td><input type="radio"/> Swing</td> <td></td> </tr> <tr> <td><input type="radio"/> Bassinet</td> <td></td> <td><input type="radio"/> Bouncy chair</td> <td><input type="radio"/> If futon,</td> </tr> <tr> <td><input type="radio"/> Bed side sleeper</td> <td><input type="radio"/> Couch</td> <td><input type="radio"/> Other, specify:</td> <td><input type="radio"/> Bed position</td> </tr> <tr> <td></td> <td><input type="radio"/> Chair</td> <td><input type="radio"/> U/K</td> <td><input type="radio"/> Couch position</td> </tr> <tr> <td></td> <td></td> <td></td> <td><input type="radio"/> U/K</td> </tr> </table>				<input type="radio"/> Crib	<input type="radio"/> Baby box	<input type="radio"/> Floor	<input type="radio"/> If adult bed, what type?	If crib, type:	<input type="radio"/> Adult bed	<input type="radio"/> Car seat	<input type="radio"/> Twin <input type="radio"/> King	<input type="radio"/> Not portable	<input type="radio"/> Waterbed	<input type="radio"/> Rock 'n Play	<input type="radio"/> Full <input type="radio"/> Other, specify:	<input type="radio"/> Portable, e.g. Pack 'n Play	<input type="radio"/> Futon	<input type="radio"/> Stroller	<input type="radio"/> Queen <input type="radio"/> U/K	<input type="radio"/> Unknown crib type	<input type="radio"/> Playpen/other play structure, not a portable crib	<input type="radio"/> Swing		<input type="radio"/> Bassinet		<input type="radio"/> Bouncy chair	<input type="radio"/> If futon,	<input type="radio"/> Bed side sleeper	<input type="radio"/> Couch	<input type="radio"/> Other, specify:	<input type="radio"/> Bed position		<input type="radio"/> Chair	<input type="radio"/> U/K	<input type="radio"/> Couch position				<input type="radio"/> U/K
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	<input type="radio"/> Chair	<input type="radio"/> U/K	<input type="radio"/> Couch position																																				
			<input type="radio"/> U/K																																				

<p>g. Child in a new or different environment than usual? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K If yes, describe why:</p>	<p>h. Child last placed to sleep with a pacifier? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K</p>	<p>i. Child wrapped or swaddled in blanket? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K If yes, describe:</p>
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<p>j. Child overheated? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K If yes, outside temp ____ degrees F Check all that apply:</p> <p><input type="checkbox"/> Room too hot, temp ____ degrees F <input type="checkbox"/> Too much bedding <input type="checkbox"/> Too much clothing</p>	<p>k. Child exposed to second hand smoke? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K If yes, how often: <input type="radio"/> Frequently <input type="radio"/> U/K <input type="radio"/> Occasionally</p>
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<p>l. Child's face when found:</p> <p><input type="radio"/> Down <input type="radio"/> Up <input type="radio"/> To left or right side <input type="radio"/> U/K</p>	<p>m. Child's neck when found:</p> <p><input type="radio"/> Hyperextended (head back) <input type="radio"/> Hypoextended (chin to chest) <input type="radio"/> Neutral <input type="radio"/> Turned <input type="radio"/> U/K</p>	<p>n. Child's airway when found (includes nose, mouth, neck and/or chest):</p> <p><input type="radio"/> Unobstructed by person or object <input type="radio"/> Fully obstructed by person or object <input type="radio"/> Partially obstructed by person or object <input type="radio"/> U/K</p>	<p>If fully or partially obstructed, what was obstructed?</p> <p><input type="checkbox"/> Nose <input type="checkbox"/> Chest compressed <input type="checkbox"/> Mouth <input type="checkbox"/> U/K <input type="checkbox"/> Neck compressed</p> <p>If fully or partially obstructed, describe obstruction in detail:</p>
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o. Objects in child's sleep environment and relation to airway obstruction:

Objects:	Present?		If present, describe position of object:					If present, did object obstruct airway?				
	Ye	No	U/K	On top	Under	Next	Tangled	U/K	Yes	No		U/K
				of child	child	to child	around child	U/K				
Adult(s)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	→ If adult(s) obstructed airway, describe relationship of adult to child (for example, biological mother):
Other child(ren)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Animal(s)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Mattress	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Comforter, quilt, or other	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Fitted sheet	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Thin blanket/flat sheet	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Pillow(s)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Cushion	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Boppy or U shaped pillow	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Sleep positioner (wedge)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Bumper pads	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Clothing	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Crib railing/side	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Wall	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Toy(s)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Other(s), specify:				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
	<input type="radio"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	

p. Was there a reliable, non-conflicting witness account of how the child was found? Yes No U/K

q. Caregiver/supervisor fell asleep while feeding child?
 Yes No U/K
 If yes, type of feeding: Bottle Breast U/K

r. Child sleeping in the same room as caregiver/supervisor at time of death?
 Yes No U/K

s. Child sleeping on same surface with person(s) or animal(s)? Yes No U/K

If yes, reasons stated for sleeping on same surface, check all that apply:

- To feed
- To soothe
- Usual sleep pattern
- No infant bed available
- Home/living space overcrowded
- Other, specify: _____
- U/K

If yes, check all that apply:

- With adult(s): # _____ # U/K
 Adult obese: Yes No U/K
- With other children: # _____ # U/K Children's ages: _____
- With animal(s): # _____ # U/K Type(s) of animal: _____

t. Is there a scene re-creation photo available for upload? Yes No If yes, upload here. Only one photo allowed.
 Select photo that demonstrates position and location of child's body and airway (nose, mouth, neck, and chest). Size must be less than 6 mb and in .jpg or .gif format.

13. WAS DEATH A CONSEQUENCE OF A PROBLEM WITH A CONSUMER PRODUCT? Yes No, go to I4 U/K, go to I4

a. Describe product and circumstances:

b. Was product used properly? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K	c. Is a recall in place? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K	d. Did product have safety label? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K	e. Was Consumer Product Safety Commission (CPSC) notified? <input type="radio"/> Yes <input type="radio"/> No, go to www.saferproducts.gov to report <input type="radio"/> U/K
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14. DID DEATH OCCUR DURING COMMISSION OF ANOTHER CRIME? Yes No, go to I5 U/K, go to I5

a. Type of crime, check all that apply:

- Robbery/burglary Other assault Arson Illegal border crossing U/K
- Interpersonal violence Gang conflict Prostitution Auto theft
- Sexual assault Drug trade Witness intimidation Other, specify: _____

15. CHILD ABUSE, NEGLECT, POOR SUPERVISION AND EXPOSURE TO HAZARDS

<p>a. Did child abuse, neglect, poor or absent supervision or exposure to hazards cause or contribute to the child's death?</p> <p><input type="radio"/> Yes/probable</p> <p><input type="radio"/> No, go to next section</p> <p><input type="radio"/> U/K, go to next section</p> <p>If yes/probable, choose primary reason:</p> <p><input type="radio"/> Child abuse, go to I5b</p> <p><input type="radio"/> Child neglect, go to I5f</p> <p><input type="radio"/> Poor/absent supervision, go to I5h</p> <p><input type="radio"/> Exposure to hazards, go to I5g</p>	<p>b. Type of child abuse, check all that apply:</p> <p><input type="checkbox"/> Abusive head trauma, go to I5c</p> <p><input type="checkbox"/> Chronic Battered Child Syndrome, go to I5e</p> <p><input type="checkbox"/> Beating/kicking, go to I5e</p> <p><input type="checkbox"/> Scalding or burning, go to I5e</p> <p><input type="checkbox"/> Munchausen Syndrome by Proxy, go to I5e</p> <p><input type="checkbox"/> Sexual assault, go to I5h</p> <p><input type="checkbox"/> Other, specify and go to I5h</p> <p><input type="checkbox"/> U/K, go to I5e</p>	<p>c. For abusive head trauma, were there retinal hemorrhages?</p> <p><input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K</p>	<p>e. Events(s) triggering child abuse, check all that apply:</p> <p><input type="checkbox"/> None</p> <p><input type="checkbox"/> Crying</p> <p><input type="checkbox"/> Toilet training</p> <p><input type="checkbox"/> Disobedience</p> <p><input type="checkbox"/> Feeding problems</p> <p><input type="checkbox"/> Domestic argument</p> <p><input type="checkbox"/> Other, specify:</p> <p><input type="checkbox"/> U/K</p>
<p>d. For abusive head trauma, was the child shaken?</p> <p><input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K</p> <p>If yes, was there impact?</p> <p><input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K</p>			

<p>f. Child neglect, check all that apply:</p> <table style="width:100%;"> <tr> <td style="width:50%;"> <input type="checkbox"/> Failure to provide necessities</td> <td style="width:50%;"> <input type="checkbox"/> Exposure to hazards:</td> </tr> <tr> <td><input type="checkbox"/> Food</td> <td>Do not include child's own behavior.</td> </tr> <tr> <td><input type="checkbox"/> Shelter</td> <td><input type="radio"/> Hazard(s) in sleep environment</td> </tr> <tr> <td><input type="checkbox"/> Other, specify:</td> <td>(including sleep position and surface sharing)</td> </tr> <tr> <td><input type="checkbox"/> Failure to provide supervision</td> <td><input type="radio"/> Fire hazard</td> </tr> <tr> <td><input type="checkbox"/> Emotional neglect, specify:</td> <td><input type="radio"/> Unsecured medication/poison</td> </tr> <tr> <td><input type="checkbox"/> Abandonment, specify:</td> <td><input type="radio"/> Firearm hazard</td> </tr> <tr> <td><input type="checkbox"/> Failure to seek/follow treatment, specify:</td> <td><input type="radio"/> Water hazard</td> </tr> <tr> <td>If yes, was this due to religious or cultural practices?</td> <td><input type="radio"/> Motor vehicle hazard</td> </tr> <tr> <td><input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K</td> <td><input type="radio"/> Other hazard, specify:</td> </tr> </table>	<input type="checkbox"/> Failure to provide necessities	<input type="checkbox"/> Exposure to hazards:	<input type="checkbox"/> Food	Do not include child's own behavior.	<input type="checkbox"/> Shelter	<input type="radio"/> Hazard(s) in sleep environment	<input type="checkbox"/> Other, specify:	(including sleep position and surface sharing)	<input type="checkbox"/> Failure to provide supervision	<input type="radio"/> Fire hazard	<input type="checkbox"/> Emotional neglect, specify:	<input type="radio"/> Unsecured medication/poison	<input type="checkbox"/> Abandonment, specify:	<input type="radio"/> Firearm hazard	<input type="checkbox"/> Failure to seek/follow treatment, specify:	<input type="radio"/> Water hazard	If yes, was this due to religious or cultural practices?	<input type="radio"/> Motor vehicle hazard	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K	<input type="radio"/> Other hazard, specify:	<p>g. Exposure to hazards:</p> <p>Do not include child's own behavior.</p> <p><input type="radio"/> Hazard(s) in sleep environment (including sleep position and surface sharing)</p> <p><input type="radio"/> Fire hazard</p> <p><input type="radio"/> Unsecured medication/poison</p> <p><input type="radio"/> Firearm hazard</p> <p><input type="radio"/> Water hazard</p> <p><input type="radio"/> Motor vehicle hazard</p> <p><input type="radio"/> Maternal substance use during pregnancy</p> <p><input type="radio"/> Other hazard, specify:</p>	<p>h. Was poverty a factor?</p> <p><input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K</p> <p>If yes, explain in Narrative</p>
<input type="checkbox"/> Failure to provide necessities	<input type="checkbox"/> Exposure to hazards:																					
<input type="checkbox"/> Food	Do not include child's own behavior.																					
<input type="checkbox"/> Shelter	<input type="radio"/> Hazard(s) in sleep environment																					
<input type="checkbox"/> Other, specify:	(including sleep position and surface sharing)																					
<input type="checkbox"/> Failure to provide supervision	<input type="radio"/> Fire hazard																					
<input type="checkbox"/> Emotional neglect, specify:	<input type="radio"/> Unsecured medication/poison																					
<input type="checkbox"/> Abandonment, specify:	<input type="radio"/> Firearm hazard																					
<input type="checkbox"/> Failure to seek/follow treatment, specify:	<input type="radio"/> Water hazard																					
If yes, was this due to religious or cultural practices?	<input type="radio"/> Motor vehicle hazard																					
<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K	<input type="radio"/> Other hazard, specify:																					

16. SUICIDE

<p>a. Child's history. Check all that have <u>ever</u> applied:</p> <p><input type="checkbox"/> None listed below</p> <p><input type="checkbox"/> Involved in sports</p> <p><input type="checkbox"/> Involved in activities (not sports)</p> <p><input type="checkbox"/> Viewed, posted or interacted on social media</p> <p>If yes, specify platform(s):</p> <p><input type="checkbox"/> History of running away</p> <p><input type="checkbox"/> History of fearfulness, withdrawal or anxiety</p> <p><input type="checkbox"/> History of explosive anger, yelling or disobeying</p> <p><input type="checkbox"/> History of head injury</p> <p>If yes, when was the last head injury? _____</p> <p><input type="checkbox"/> Death of a peer, friend or family member</p> <p>If yes, specify relationship to child: _____</p> <p>When did death occur: _____</p> <p>Was death a suicide <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K</p>	<p>b. Was the child ever diagnosed with any of the following? Check all that apply.</p> <p><input type="checkbox"/> None listed below</p> <p><input type="checkbox"/> Anxiety spectrum disorder</p> <p><input type="checkbox"/> Depressive spectrum disorder</p> <p><input type="checkbox"/> Bipolar spectrum disorder</p> <p><input type="checkbox"/> Disruptive, impulse control or conduct disorder</p> <p><input type="checkbox"/> Eating disorder</p> <p><input type="checkbox"/> Substance-related or addictive disorders</p> <p><input type="checkbox"/> Other, specify:</p> <p><input type="checkbox"/> U/K</p>	<p>d. Did the child <u>ever</u> communicate any suicidal thoughts, actions or intent?</p> <p><input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K</p> <p>If yes, with whom? _____</p>
		<p>e. Was there evidence the death was planned or premeditated?</p> <p><input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K</p>
		<p>f. Did the death occur under circumstances where it would likely be observed and intervened by others?</p> <p><input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K</p>
		<p>g. Did the child ever have a history of non-suicidal self-harm, such as cutting or burning oneself?</p> <p><input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K</p> <p>If yes <input type="checkbox"/> Reported to others <input type="checkbox"/> Other, specify:</p> <p><input type="checkbox"/> Noted on autopsy</p>

<p>h. Warning signs (https://youthsuicidewarningsigns.org) w/in 30 days of death. Check all that apply:</p> <table style="width:100%;"> <tr> <td style="width:50%;"> <input type="checkbox"/> None listed below</td> <td style="width:50%;"> <input type="checkbox"/> Expressed perceived burden on others</td> </tr> <tr> <td><input type="checkbox"/> Talked about or made plans for suicide</td> <td><input type="checkbox"/> Showed worrisome behavioral cues or marked changes in behavior</td> </tr> <tr> <td><input type="checkbox"/> Expressed hopelessness about the future</td> <td><input type="checkbox"/> U/K</td> </tr> <tr> <td><input type="checkbox"/> Displayed severe/overwhelming emotional pain or distress</td> <td></td> </tr> </table>	<input type="checkbox"/> None listed below	<input type="checkbox"/> Expressed perceived burden on others	<input type="checkbox"/> Talked about or made plans for suicide	<input type="checkbox"/> Showed worrisome behavioral cues or marked changes in behavior	<input type="checkbox"/> Expressed hopelessness about the future	<input type="checkbox"/> U/K	<input type="checkbox"/> Displayed severe/overwhelming emotional pain or distress		<p>i. Child experienced a known crisis within 30 days of the death?</p> <p><input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K</p> <p>If yes, explain:</p>	<p>j. Suicide was part of: Check all that apply.</p> <p><input type="checkbox"/> None listed below <input type="checkbox"/> A suicide pact</p> <p><input type="checkbox"/> A cluster <input type="checkbox"/> A murder-suicide</p> <p><input type="checkbox"/> A contagion, copy-cat or imitation</p>
<input type="checkbox"/> None listed below	<input type="checkbox"/> Expressed perceived burden on others									
<input type="checkbox"/> Talked about or made plans for suicide	<input type="checkbox"/> Showed worrisome behavioral cues or marked changes in behavior									
<input type="checkbox"/> Expressed hopelessness about the future	<input type="checkbox"/> U/K									
<input type="checkbox"/> Displayed severe/overwhelming emotional pain or distress										

17. LIFE STRESSORS Please indicate all stressors that were present for this child around the time of death.

<p>a. Life stressors - Social/economic</p> <p><input type="checkbox"/> None listed below <input type="checkbox"/> Housing instability</p> <p><input type="checkbox"/> Racism <input type="checkbox"/> Witnessed violence</p> <p><input type="checkbox"/> Discrimination</p> <p><input type="checkbox"/> Poverty <input type="checkbox"/> Pregnancy</p> <p><input type="checkbox"/> Neighborhood discord <input type="checkbox"/> Pregnancy scare</p> <p><input type="checkbox"/> Job problems</p> <p><input type="checkbox"/> Money problems</p> <p><input type="checkbox"/> Food insecurity</p>	<p>b. Life stressors - Relationships (age 5 and over)</p> <table style="width:100%;"> <tr> <td style="width:33%;"> <input type="checkbox"/> None listed below</td> <td style="width:33%;"> <input type="checkbox"/> Argument with friends</td> <td style="width:33%;"> <input type="checkbox"/> Stress due to sexual orientation</td> </tr> <tr> <td><input type="checkbox"/> Family discord</td> <td><input type="checkbox"/> Bullying as a victim</td> <td><input type="checkbox"/> Stress due to gender identity</td> </tr> <tr> <td><input type="checkbox"/> Argument with parents/caregivers</td> <td><input type="checkbox"/> Bullying as a perpetrator</td> <td></td> </tr> <tr> <td><input type="checkbox"/> Parents' divorce/separation</td> <td><input type="checkbox"/> Cyberbullying as a victim</td> <td></td> </tr> <tr> <td><input type="checkbox"/> Parents' incarceration</td> <td><input type="checkbox"/> Cyberbullying as a perpetrator</td> <td></td> </tr> <tr> <td><input type="checkbox"/> Argument with significant other</td> <td><input type="checkbox"/> Peer violence as a victim</td> <td></td> </tr> <tr> <td><input type="checkbox"/> Breakup with significant other</td> <td><input type="checkbox"/> Peer violence as a perpetrator</td> <td></td> </tr> <tr> <td><input type="checkbox"/> Social discord</td> <td><input type="checkbox"/> Isolation</td> <td></td> </tr> </table>	<input type="checkbox"/> None listed below	<input type="checkbox"/> Argument with friends	<input type="checkbox"/> Stress due to sexual orientation	<input type="checkbox"/> Family discord	<input type="checkbox"/> Bullying as a victim	<input type="checkbox"/> Stress due to gender identity	<input type="checkbox"/> Argument with parents/caregivers	<input type="checkbox"/> Bullying as a perpetrator		<input type="checkbox"/> Parents' divorce/separation	<input type="checkbox"/> Cyberbullying as a victim		<input type="checkbox"/> Parents' incarceration	<input type="checkbox"/> Cyberbullying as a perpetrator		<input type="checkbox"/> Argument with significant other	<input type="checkbox"/> Peer violence as a victim		<input type="checkbox"/> Breakup with significant other	<input type="checkbox"/> Peer violence as a perpetrator		<input type="checkbox"/> Social discord	<input type="checkbox"/> Isolation		<p>c. Life stressors - School (age 5 and over)</p> <p><input type="checkbox"/> None listed below</p> <p><input type="checkbox"/> School failure</p> <p><input type="checkbox"/> Pressure to succeed</p> <p><input type="checkbox"/> Extracurricular activities</p> <p><input type="checkbox"/> New school</p> <p><input type="checkbox"/> Other school problems</p>
<input type="checkbox"/> None listed below	<input type="checkbox"/> Argument with friends	<input type="checkbox"/> Stress due to sexual orientation																								
<input type="checkbox"/> Family discord	<input type="checkbox"/> Bullying as a victim	<input type="checkbox"/> Stress due to gender identity																								
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<input type="checkbox"/> Breakup with significant other	<input type="checkbox"/> Peer violence as a perpetrator																									
<input type="checkbox"/> Social discord	<input type="checkbox"/> Isolation																									

<p>d. Life stressors - Technology (age 5+)</p> <p>Stress/negative consequences due to:</p> <input type="checkbox"/> None listed below <input type="checkbox"/> Electronic gaming <input type="checkbox"/> Texting <input type="checkbox"/> Restriction of technology <input type="checkbox"/> Social media	<p>e. Life stressors - Transitions (age 5 and over)</p> <input type="checkbox"/> None listed below <input type="checkbox"/> Release from hospital <input type="checkbox"/> Transition from any level of mental health care to another (e.g. inpatient to outpatient, inpatient to residential outpatient to inpatient, etc.)	<p>f. Life stressors - Trauma (age 5 and over)</p> <input type="checkbox"/> None listed below <input type="checkbox"/> Rape/sexual assault <input type="checkbox"/> Previous abuse (emotional/physical) <input type="checkbox"/> Family/domestic violence
		<p>g. Life stressors - Describe any other life stressors: (age 5 and over)</p>

18. COVID-19-RELATED DEATHS

<p>a. For the 12 months before the child's death, did the family experience any disruptions or significant changes to the following?</p> <p>Check all that apply:</p> <input type="checkbox"/> None listed below <input type="checkbox"/> School <input type="checkbox"/> Daycare <input type="checkbox"/> Employment <input type="checkbox"/> Social services (such as unemployment assistance, TANF, WIC) <input type="checkbox"/> Living environment <input type="checkbox"/> Medical care <input type="checkbox"/> Mental health or substance use/abuse care <input type="checkbox"/> Home-based services (non-child welfare) <input type="checkbox"/> Child welfare services <input type="checkbox"/> Legal proceedings within criminal, civil, or family courts <input type="checkbox"/> Other <input type="checkbox"/> U/K <p>Describe:</p>	<p>c. Was the child exposed to COVID-19 within 14 days of death?</p> <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K <p>If yes, describe:</p>	
<p>b. For the 12 months before the child's death, did the child's family live in an area with an official stay at home order?</p> <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K <p>If yes, was the stay at home order in place at the time of the child's death?</p> <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K	<p>d. Select the one option that best describes the impact of COVID-19 on this child's death:</p> <input type="radio"/> COVID-19 was the immediate or underlying cause of death <input type="radio"/> COVID-19 was diagnosed at autopsy or the child was suspected to have COVID-19 <input type="radio"/> COVID-19 indirectly contributed to the death but was not the immediate or underlying cause of death <input type="radio"/> The birthing parent contracted COVID-19 during pregnancy <input type="radio"/> Other, specify: <input type="radio"/> COVID-19 had no impact on this child's death <input type="radio"/> U/K	
		<p>e. Did COVID-19 impact the team's ability to conduct this fatality review?</p> <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K <p>If yes, check all that apply:</p> <input type="checkbox"/> Unable to obtain records <input type="checkbox"/> Team members unable to attend review <input type="checkbox"/> Remote reviews negatively impacted review process <input type="checkbox"/> Team leaders redirected to COVID-19 response
		<p>f. Did the child have medical evidence of a significant inflammatory syndrome (including for example fever, laboratory evidence of inflammation, and involvement of two or more organs) requiring hospitalization in the week before death?</p> <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K <p>If yes, was the child diagnosed with MIS-C?</p> <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K

J. PERSON RESPONSIBLE (OTHER THAN DECEDENT)

<p>1. Did a person or persons other than the child do something or fail to do something that caused or contributed to the death?</p> <input type="radio"/> Yes/probable <input type="radio"/> No, go to Section K <input type="radio"/> U/K, go to Section K	<p>2. What act(s)? Enter information for the first person under "One" and if there is a second person, use column "Two." Describe acts in narrative.</p> <table border="0"> <tr> <td><u>One</u></td> <td><u>Two</u></td> <td><u>One</u></td> <td><u>Two</u></td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/></td> <td><input type="radio"/></td> <td><input type="radio"/></td> </tr> <tr> <td></td> <td>Child abuse</td> <td></td> <td>Exposure to hazards</td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/></td> <td><input type="radio"/></td> <td><input type="radio"/></td> </tr> <tr> <td></td> <td>Child neglect</td> <td></td> <td>Assault, not child abuse</td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/></td> <td><input type="radio"/></td> <td><input type="radio"/></td> </tr> <tr> <td></td> <td>Poor/absent supervision</td> <td></td> <td>Other, specify:</td> </tr> <tr> <td></td> <td></td> <td><input type="radio"/></td> <td><input type="radio"/></td> </tr> <tr> <td></td> <td></td> <td></td> <td>U/K</td> </tr> </table>	<u>One</u>	<u>Two</u>	<u>One</u>	<u>Two</u>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>		Child abuse		Exposure to hazards	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>		Child neglect		Assault, not child abuse	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>		Poor/absent supervision		Other, specify:			<input type="radio"/>	<input type="radio"/>				U/K	<p>3. Did the team have information about the person(s)?</p> <table border="0"> <tr> <td><u>One</u></td> <td><u>Two</u></td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/></td> </tr> <tr> <td></td> <td>Yes</td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/></td> </tr> <tr> <td></td> <td>No, go to Section K</td> </tr> </table>	<u>One</u>	<u>Two</u>	<input type="radio"/>	<input type="radio"/>		Yes	<input type="radio"/>	<input type="radio"/>		No, go to Section K																																																																			
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<p>4. Is person listed in a previous section?</p> <table border="0"> <tr> <td><u>One</u></td> <td><u>Two</u></td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/></td> </tr> <tr> <td></td> <td>Yes, biological mother, go to J17</td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/></td> </tr> <tr> <td></td> <td>Yes, biological father, go to J17</td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/></td> </tr> <tr> <td></td> <td>Yes, caregiver one, go to J17</td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/></td> </tr> <tr> <td></td> <td>Yes, caregiver two, go to J17</td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/></td> </tr> <tr> <td></td> <td>Yes, supervisor, go to J19</td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/></td> </tr> <tr> <td></td> <td>No</td> </tr> </table>	<u>One</u>	<u>Two</u>	<input type="radio"/>	<input type="radio"/>		Yes, biological mother, go to J17	<input type="radio"/>	<input type="radio"/>		Yes, biological father, go to J17	<input type="radio"/>	<input type="radio"/>		Yes, caregiver one, go to J17	<input type="radio"/>	<input type="radio"/>		Yes, caregiver two, go to J17	<input type="radio"/>	<input type="radio"/>		Yes, supervisor, go to J19	<input type="radio"/>	<input type="radio"/>		No	<p>5. Primary person(s) responsible for action(s): Select one for each person responsible.</p> <table border="0"> <tr> <td><u>One</u></td> <td><u>Two</u></td> <td><u>One</u></td> <td><u>Two</u></td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/></td> <td><input type="radio"/></td> <td><input type="radio"/></td> </tr> <tr> <td></td> <td>Adoptive parent</td> <td></td> <td>Grandparent</td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/></td> <td><input type="radio"/></td> <td><input type="radio"/></td> </tr> <tr> <td></td> <td>Stepparent</td> <td></td> <td>Sibling</td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/></td> <td><input type="radio"/></td> <td><input type="radio"/></td> </tr> <tr> <td></td> <td>Foster parent</td> <td></td> <td>Other relative</td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/></td> <td><input type="radio"/></td> <td><input type="radio"/></td> </tr> <tr> <td></td> <td>Mother's partner</td> <td></td> <td>Friend</td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/></td> <td><input type="radio"/></td> <td><input type="radio"/></td> </tr> <tr> <td></td> <td>Father's partner</td> <td></td> <td>Acquaintance</td> </tr> <tr> <td></td> <td></td> <td><input type="radio"/></td> <td><input type="radio"/></td> </tr> <tr> <td></td> <td></td> <td></td> <td>Child's boyfriend or girlfriend</td> </tr> <tr> <td></td> <td></td> <td><input type="radio"/></td> <td><input type="radio"/></td> </tr> <tr> <td></td> <td></td> <td></td> <td>Stranger</td> </tr> </table>		<u>One</u>	<u>Two</u>	<u>One</u>	<u>Two</u>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>		Adoptive parent		Grandparent	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>		Stepparent		Sibling	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>		Foster parent		Other relative	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>		Mother's partner		Friend	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>		Father's partner		Acquaintance			<input type="radio"/>	<input type="radio"/>				Child's boyfriend or girlfriend			<input type="radio"/>	<input type="radio"/>				Stranger	<table border="0"> <tr> <td><u>One</u></td> <td><u>Two</u></td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/></td> </tr> <tr> <td></td> <td>Medical provider</td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/></td> </tr> <tr> <td></td> <td>Institutional staff</td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/></td> </tr> <tr> <td></td> <td>Babysitter</td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/></td> </tr> <tr> <td></td> <td>Licensed child care worker</td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/></td> </tr> <tr> <td></td> <td>Other, specify:</td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/></td> </tr> <tr> <td></td> <td>U/K</td> </tr> </table>	<u>One</u>	<u>Two</u>	<input type="radio"/>	<input type="radio"/>		Medical provider	<input type="radio"/>	<input type="radio"/>		Institutional staff	<input type="radio"/>	<input type="radio"/>		Babysitter	<input type="radio"/>	<input type="radio"/>		Licensed child care worker	<input type="radio"/>	<input type="radio"/>		Other, specify:	<input type="radio"/>	<input type="radio"/>		U/K
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<p>6. Person's age in years:</p> <table border="0"> <tr> <td><u>One</u></td> <td><u>Two</u></td> </tr> <tr> <td>_____</td> <td>_____</td> </tr> <tr> <td></td> <td># Years</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td></td> <td>U/K</td> </tr> </table>	<u>One</u>	<u>Two</u>	_____	_____		# Years	<input type="checkbox"/>	<input type="checkbox"/>		U/K	<p>7. Person's sex:</p> <table border="0"> <tr> <td><u>One</u></td> <td><u>Two</u></td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/></td> </tr> <tr> <td></td> <td>Male</td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/></td> </tr> <tr> <td></td> <td>Female</td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/></td> </tr> <tr> <td></td> <td>U/K</td> </tr> </table>	<u>One</u>	<u>Two</u>	<input type="radio"/>	<input type="radio"/>		Male	<input type="radio"/>	<input type="radio"/>		Female	<input type="radio"/>	<input type="radio"/>		U/K	<p>8. Person speaks and understands English?</p> <table border="0"> <tr> <td><u>One</u></td> <td><u>Two</u></td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/></td> </tr> <tr> <td></td> <td>Yes</td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/></td> </tr> <tr> <td></td> <td>No</td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/></td> </tr> <tr> <td></td> <td>U/K</td> </tr> </table> <p>If no, language spoken:</p>	<u>One</u>	<u>Two</u>	<input type="radio"/>	<input type="radio"/>		Yes	<input type="radio"/>	<input type="radio"/>		No	<input type="radio"/>	<input type="radio"/>		U/K	<p>9. Person on active military duty?</p> <table border="0"> <tr> <td><u>One</u></td> <td><u>Two</u></td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/></td> </tr> <tr> <td></td> <td>Yes</td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/></td> </tr> <tr> <td></td> <td>No</td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/></td> </tr> <tr> <td></td> <td>U/K</td> </tr> </table> <p>If yes, specify branch:</p>	<u>One</u>	<u>Two</u>	<input type="radio"/>	<input type="radio"/>		Yes	<input type="radio"/>	<input type="radio"/>		No	<input type="radio"/>	<input type="radio"/>		U/K																																																												
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