Sudden Unexpected Infant Death
Investigation Reporting Form

Recommended for use with infant deaths, less than 12 months of age, that are: 1) "Sudden" referring to the circumstance where the onset of symptoms is within 24 hours or less from death and 2) "Unexpected" referring to individuals considered to be in good health, had a chronic but stable condition, or a new illness not considered to be life threatening.

INFANT DEMOGRAPHICS

1. **Infant Information. Full name:** _____ **Date of birth:** _____
   Age:_____ **SS#:**_____ **Case number:** _____
   Primary residence address: _____
   City:_____ **State:** _____ **Zip:**_____
2. **Race:** ◯ White ◯ Black/African Am. ◯ Asian/Pacific Islander ◯ Am. Indian/Alaskan Native ◯ Hispanic/Latino ◯ Other
3. **Sex:** ◯ Male ◯ Female

PREGNANCY HISTORY

1. **Birth mother information.** ◯ Unavailable **Full name:** _____
   Maiden name:_____ **Date of birth:**_____ **SS#:**_____
   Current address*:* _____
   City:_____ **State:**_____ **Zip:**_____
   ◯ Same as infant's primary residence address above
   Email address:_____
2. **How long has the birth mother been at this address?** Years:_____ Months:_____ Days:_____
3. **Previous address(es) (cities/counties/states) in the past 5 years:** _____
   _____
4. **Did the birth mother receive prenatal care?** ◯Yes ◯ No ◯ Unknown
   If yes: At how many weeks or months did prenatal care begin?_____ ◯Weeks ◯Months
   Approximately how many prenatal care visits?_____
5. **Where did the birth mother receive prenatal care?**
   Physician/Provider's name:_____ Hospital/Clinic name:_____ Phone:_____
   Street Address:_____ City:_____ State:_____ Zipcode:_____
6. **Did the birth mother have any complications/medical conditions or injuries during her pregnancy?** *(e.g., high blood pressure, bleeding, gestational diabetes, fall, accident)* ◯Yes ◯No ◯Unknown
   If yes, specify: _____
7. **During her pregnancy, did the birth mother use any of the following?** *(indicate yes (Y), no (N), or unknown (UNK) for all that apply)*

Substance	Y, N, UNK	Specify Type	Frequency
Over the counter medications			
Prescribed medications			
Herbal remedies			
Alcohol			
Illicit drugs (e.g., heroin)			
Tobacco (e.g., cigarettes, e-cigarettes)			
Other			

INFANT HISTORY

1. **Source of infant medical history information.** *(check all that apply)* ◯Doctor ◯Other healthcare provider ◯Medical record ◯Parent/primary caregiver ◯Other family ◯Other, specify:_____
2. **Were there any complications during delivery or at birth?** *(e.g., emergency C-section, infant needed oxygen)* ◯Yes ◯No ◯Unk **If yes, describe:**_____
3. **Did the infant have abnormal newborn screening results?** ◯Yes ◯No ◯Unk **If yes, describe:**_____
4. **Infant's length at birth:**_____ ◯IN ◯CM
5. **Infant's weight at birth:**_____ ◯LBS and OZ ◯GM
6. **Compared to the due date, when was the infant born?** ◯Early (before 37 weeks) - How many weeks?_____ ◯Late (after 41 weeks) - How many weeks?_____ ◯On time Infant's due date (mm/dd/yyyy): _____
7. **Was the infant a singleton or multiple birth?** ◯Singleton ◯Twin ◯Triplet ◯Quadruplet or higher
8. **Was the infant born with Neonatal Abstinence Syndrome (NAS)?** (NAS is a drug withdrawal syndrome in newborns exposed to substances, like opioids, before birth) ◯Yes ◯No ◯Unknown
   If yes, did the infant need pharmacologic treatment ◯Yes ◯No ◯ Unknown
9. **What is the contact information for the infant's regular pediatrician and birth hospital?**

Item	Regular Pediatrician	Birth Hospital
Date	*Of last visit:*	*Of discharge:*
Name and hospital/clinic		
Address		
Phone number		

10. **Describe the two most recent times the infant was seen by a healthcare provider (if applicable).** *Include ER and clinic visits, hospital admissions, observational stays, regular pediatrician, and phone calls.*

Visit type	1st most recent visit	2nd most recent visit
Reason for visit		
Action taken		
Date		
Physician's name		
Hospital or clinic		
Address		
Phone number		

11. **Did the infant have any of the following?** *(indicate yes (Y), no (N), or unknown (UNK) for all that apply)*

Symptom	Within 72 hrs of Incident	Symptom	At any time	Within 72 hrs of Incident
Fever		Allergies or allergic reactions *(food, medication, or other)*		
Cough				
Diarrhea		Abnormal growth or weight gain or weight loss		
Excessive sweating		Apnea *(stopped breathing)*		
Stool changes		Cyanosis *(turned blue/gray)*		
Lethargy or sleeping more than usual		Seizures or convulsions		
Difficulty breathing		Cardiac *(heart)* abnormalities		
Fussiness or excessive crying		Feeding issues *(e.g., reflux, allergies)*		
Exposure to anyone who was sick *(e.g., at home, daycare)*		Colic (e.g., frequent prolonged crying, or chronic inconsolable fussiness)		
Decrease in appetite		Vomiting		
Falls/injuries		Choking		
Other, specify:		Other, specify:		

If yes to any of the above, describe: _____

12. **Infant exposed to second hand smoke?** *(environmental tobacco smoke)* ◯ Yes ◯ No ◯ Unknown
    If yes, how often? ◯ Frequently *(several times a week)* ◯ Occasionally *(several times a month)* ◯ Unknown
13. **In the 72 hours prior to death, was the infant given any vaccinations or medications?** *(include any home remedies, herbal medications, prescription medicines, over-the-counter medications)*

Vaccine or medicine name	Dose last given	Date given *(mm/dd/yy)*	Approx. time *(military)*	Reasons given or comments

14. **Was the infant last placed to sleep with a bottle?** ◯ **Yes** ◯ **No** ◯ **Unknown**
    If yes: Was the bottle propped? (i.e., object used to hold bottle while infant feeds) ◯ Yes ◯ No ◯ Unknown
    If yes: What object propped the bottle?
    Could the infant hold the bottle? ◯ **Yes** ◯ **No** ◯ **Unknown**
15. **Who was the last person to feed the infant? (name and relationship to infant)** _____
16. **Did the death occur during feeding?** ◯ **Breastfeeding** ◯ **Bottle-Feeding** ◯ **Eating Solids** ◯ **Not during feeding**
17. **Was the infant ever breast fed?** ◯ Yes ◯ No ◯ Unknown **If yes, how many months?** _____
18. **What did the infant consume in 24 hours prior to death?**

Consumed?	If yes, describe	If yes, newly introduced? *Y/N/UNK*	If yes, was this last consumed prior to incident?	If last fed, date and time?	If last fed, indicate quantity
☐ Breastmilk	*For example, fed from one or both sides of the breast, and length of time baby nursed?*				
☐ Formula	*For example, brand and water source?*				
☐ Water	*For example, brand, bottled, tap, and well?*				
☐ Other liquids	*For example teas, juices, water, and cow's milk?*				
☐ Solids					
☐ Other					

19. **Among the infant's blood relatives** (siblings, parents, grandparents, aunts or uncles, or first cousins) **was there any:**
    Sudden or unexpected death before the age of 50? ◯ Yes ◯ No ◯ Unknown
    Heart disease? *(e.g., cardiomyopathy, Marfan or Brugada syndrome, long or short QT syndrome, or catecholaminergic polymorphic ventricular tachycardia)* ◯ **Yes** ◯ **No** ◯ **Unknown**
    If yes to either, describe: *(include relation to infant)* _____
20. **Did the infant have any birth defect(s)?** ◯ Yes ◯ No ◯ Unknown **If yes, describe:** _____
21. **Was the infant able to roll over on his or her own? (check all that apply)** ◯ **Front to back** ◯ **Back to front**
22. **Indicate infant's ability to lift or hold his or her head up.** ◯ **Unable** ◯ **1 second** ◯ **5 seconds** ◯ **≥10 seconds** ◯ **Unknown**
23. **Was the infant meeting or not meeting growth and developmental milestones** *(e.g., sitting up, crawling, rolling over, or feeding well)***? Include if the caregiver, supervisor, or medical professional had any concerns.**
    _____
    _____
24. **Is there anything else that may have affected the infant that has not yet been documented?** *(e.g., exposed to fumes, infant unusually heavy, placed with positional support or wedge, or international travel)* _____
    _____
    _____

INCIDENT SCENE INVESTIGATION (Place infant found unresponsive or dead)

1. **Incident location type:** *(e.g., primary residence, day care, grandma's house)* _____
   Address:_____ **City:**_____ **State:**_____ **Zip:**_____
2. **Was the infant in a new or different environment? (not part of the infant's normal routine)** ◯ **Yes** ◯ **No** ◯ **Unknown If yes, describe:**
3. **Did the death occur at a daycare?** ◯ Yes ◯ No ◯ Unknown
   If yes: How many children (under 18 years) were under the care of the provider at the time of the incident or death? (including their own children) _____
   How many adults (18 years or older) were supervising the child(ren)? _____
   How long has the daycare or school been open for business? _____
   Is the daycare licensed? ◯ Yes ◯ No ◯ Unknown
   If yes, License No.:_____ **Licensing agency:** _____
4. **How many people live at the site of the incident or death scene?** Children (under 18)_____ Adults (18 or older)_____
5. **What kind of heating or cooling sources were being used?** *(e.g., A/C window unit, wood burning fireplace, or open window)*_____
6. **Was there a working carbon monoxide (CO) detector in home?** ◯ Yes ◯ No ◯ Unknown
7. **Indicate the temperature of the room where the infant was found unresponsive, and the surrounding area.** *(fill in temperatures)*
   Thermostat setting:_____ **Thermostat reading:**_____ **Actual room:**_____ **Outside:**_____ **Time of reading:**_____
8. **Which of these devices were operating in the room where the infant was found unresponsive?** *(check all that apply)*
   ◯ None ◯ Fan ◯ Apnea monitor ◯ Humidifier ◯ Vaporizer ◯ Air purifier ◯ Unknown
   ◯ Other, specify:_____
9. **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 water ◯ Unknown
   ◯ Other, specify:_____
10. **Indicate if the incident site or death scene had obvious indication of any of the following.** *(check all that apply)*
    ◯ Insects ◯ Mold growth ◯ Smokey smell ◯ Pets ◯ Dampness ◯ Peeling paint ◯ Visible standing water
    ◯ Presence of alcohol containers ◯ None ◯ Rodents or vermin ◯ Odors or fumes, describe:_____
    ◯ Presence of prescription drugs, describe:_____
    ◯ Presence of illicit drugs or drug paraphernalia, describe:_____
    ◯ Other, specify:_____
11. **Describe the general appearance of incident scene.** *(e.g., cleanliness, hazards, overcrowding)* _____
    _____
    _____
12. **Is there anything else that may have affected the infant that has not yet been documented?** (e.g., drug and alcohol use at scene, history of domestic violence, child abuse, neglect)_____
    _____
    _____

INCIDENT CIRCUMSTANCES

1. **Who is the usual caregiver?** (name(s) and familial relationship to infant)_____
2. **Who was the caregiver at the time of incident?** (name(s) and familial relationship to infant)
   _____
3. **Witness Information. Relationship to deceased.** *(check all that apply)* ◯ Birth mother ◯ Birth father ◯ Grandmother ◯ Grandfather ◯ Adoptive/foster parent ◯ Physician ◯ Health records ◯ Other, describe:_____
   Full Name:_____ **Address:**_____
   City:_____ **State/Zip:**_____ **Date of birth:**_____
   Email address:_____ **Phone Number:**_____
   Work address:_____
4. **Describe what happened.** *(include details about how the infant was found)* _____
   _____
   _____
   _____

5. **Was there anything unusual or different about the infant in the last 24 hours?** ◯**Yes** ◯**No** ◯**Unknown**
   If yes, specify:_____
6. **What was the temperature in the incident room?** ◯Hot ◯Cold ◯Normal ◯Other
   Did the infant experience any falls or injury in the last 72hrs? ◯Yes ◯No ◯Unknown
7. **Was there a crib, bassinet, or portable crib at the place of incidence?** ◯Yes ◯No ◯Unknown
   If yes, was it in good or usable condition? (e.g., not broken or not full of laundry) ◯Yes ◯No ◯Unknown
   If no, explain: _____
8. **Where was the infant (P)laced before death, (L)ast known alive, (F)ound, and (U)sually placed?** (write P, L, F, or U, leave blank if none)
   ◯Crib ◯Portable crib ◯Waterbed ◯Stroller ◯Playpen/play area (not portable crib)
   ◯Bassinet ◯Sofa/couch ◯Swing ◯Futon ◯Bouncy chair
   ◯Bedside sleeper ◯Chair ◯Baby box ◯Floor ◯Rocking sleeper
   ◯Car seat ◯Unknown ◯Held in person's arms ◯In-bed sleeper
   ◯Other, specify: _____
   ◯Adult bed **If yes, what type?** ◯Twin ◯Full ◯Queen ◯King ◯Unknown ◯Other, specify: _____
9. **Describe the condition and firmness of the surface where the infant was found:**
   _____
10. **Was the infant wrapped or swaddled?** ◯**Yes** ◯**No** ◯**Unknown**
    If yes: Describe the arm position? ◯**Arms free and out** ◯**Arms in** ◯**One arm in and one arm out**
    Describe swaddle: *(include blanket type and tightness)* _____
11. **What was the infant wearing?** *(e.g., t-shirt, disposable diaper)*_____
12. **What was the infant's usual sleep position?** ◯Sitting ◯Back ◯Stomach ◯Side ◯Unknown
13. **Describe the circumstances of infant when last placed by caregiver, last know alive, and found.**

	Placed	Last Known Alive	Found
Date			
Time			
Location (e.g., living room or bedroom)			
Position (e.g., sitting, back, stomach, side, or unknown)			
Face position (e.g., down, up, left, right, or unknown)			
Neck position (e.g., hyperextended or head back, hyperextended or chin to chest, neutral, or turned)			

14. **Was the infant's airway obstructed by a person or object when found?** *(includes obstruction of the mouth or nose, or compression of the neck or chest)* ◯Unobstructed ◯Fully obstructed ◯Partially obstructed ◯Unknown
    If fully or partially, what was obstructed or compressed? *(check all that apply)* ◯Nose ◯Mouth ◯Chest ◯Neck

15. Indicate the items present in the sleep environment and their relation to the infant when the infant was found.

Item	Present?			If yes, position in relation to infant?				If yes, did object obstruct the infant's mouth, nose, chest or neck?		
	Yes	No	Unk	Over	Under	Next to	Unk	Yes	No	Unk
Adult(s) (18 years or older)	○	○	○	○	○	○	○	○	○	○
Other child(ren) (under 18 years)	○	○	○	○	○	○	○	○	○	○
Animal(s)	○	○	○	○	○	○	○	○	○	○
Mattress	○	○	○	○	○	○	○	○	○	○
Comforter, quilt, other	○	○	○	○	○	○	○	○	○	○
Fitted sheet	○	○	○	○	○	○	○	○	○	○
Thin blanket	○	○	○	○	○	○	○	○	○	○
Pillow(s)	○	○	○	○	○	○	○	○	○	○
Cushion	○	○	○	○	○	○	○	○	○	○
Nursing or u-shaped pillow	○	○	○	○	○	○	○	○	○	○
Sleep positioner (wedge)	○	○	○	○	○	○	○	○	○	○
Bumper pads	○	○	○	○	○	○	○	○	○	○
Clothing (not on a person)	○	○	○	○	○	○	○	○	○	○
Crib railing or side	○	○	○	○	○	○	○	○	○	○
Wall	○	○	○	○	○	○	○	○	○	○
Toy(s)	○	○	○	○	○	○	○	○	○	○
Other, specify:	○	○	○	○	○	○	○	○	○	○

If yes, to adult(s) or child(ren) sharing sleep surface with the infant, complete table below. ○ **NA**

Name of individual(s) sharing sleep surface with infant	Relationship to infant	Age	Height	Weight	Impaired by drugs or alcohol? *Y/N/UNK*	Fell asleep feeding infant? *Y/N/UNK*

If yes to impaired, describe: _____

16. Were there any secretions present at the scene? ○**Yes** ○**No** ○**Unknown** **If yes, describe: (include where they were found)** _____

17. Was there evidence of wedging? *(wedging definition: obstruction of the nose or mouth, or compression of the neck or chest as a result of being stuck or trapped between inanimate objects)* ○Yes ○No ○Unknown
If yes, describe: _____

18. Was there evidence of overlay? *(overlay definition: obstruction of the nose or mouth, or compression of the neck or chest as a result of a person rolling on top of or against an infant)* ○Yes ○No ○Unknown
If yes, describe: _____

19. Was the infant breathing when found? ○Yes ○No ○Unknown
If no, did anyone witness the infant stop breathing? ○Yes ○No ○Unknown

20. Describe the infant's appearance when found. *(indicate all that apply)*

Appearance	Y/N/UNK	Describe and specify location
Discoloration around face, nose, or mouth		
Secretions or fluids *(e.g., foam, froth, urine)*		
Skin discoloration *(e.g., livor mortis, pale areas, darkness, color changes)*		
Pressure marks *(e.g., pale areas, blanching)*		
Rash or petechiae *(e.g., small, red blood spots on skin/membrane/eyes)*		
Marks on body *(e.g., scratches, bruises)*		
Other		

21. 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:_____

22. Did EMS respond? ◯ Yes ◯ No ◯ Unknown **If yes, was the infant transported?** ◯ Yes ◯ No ◯ Unknown

23. Was resuscitation attempted? ◯ Yes ◯ No ◯ Unknown
If yes: By whom? *(e.g., EMS, bystander, parent)*_____ **Date:**_____ **Time:**_____
Type of compression? *(check all that apply)* ◯ Two finger ◯ One hand ◯ Two hands
Was rescue breathing done? ◯ Yes ◯ No ◯ Unknown

The following questions refer to the caregiver(s) at the time of death.

24. Has the caregiver-at-the-time-of-death ever had a child die suddenly and unexpectedly? ◯ Yes ◯ No ◯ Unknown
If yes, explain: *(include familial relationship of child and infant, and cause of death)*_____

25. Were the infant and caregiver in the same room at the time of the incident, but not sharing the same sleep surface? ◯ **Yes** ◯ **No** ◯ **Unknown** ◯ **N/A - sharing a sleep surface**

26. Was the infant's caregiver using any of the following during the incident? *(indicate all that apply)*

	Yes	No	Unk	Frequency
Over the counter medications	◯	◯	◯	_____
Prescription medications	◯	◯	◯	_____
Opioids	◯	◯	◯	_____
Tobacco, specify: (e.g., cigarettes or e-cigarettes)	◯	◯	◯	_____
Alcohol	◯	◯	◯	_____
Herbal remedies	◯	◯	◯	_____
Other, specify:	◯	◯	◯	_____

Was the infant's caregiver-at-the-time-of-death asked to consent to blood/urine for testing? ◯ Yes ◯ No ◯ Unknown
If yes, what were the results? _____

INVESTIGATION SUMMARY

1. Arrival dates and times.

Person(s) involved	Hospital	Incident Scene
Infant		N/A
Law enforcement		
Death investigator		

2. Agencies conducting an investigation? *(check all that apply)* ◯ Child protective services ◯ State police ◯ Death investigator from medical examiner or coroner office ◯ Local law enforcement ◯ Other, specify:_____

3. Indicate when the form was completed. Date: (mm/dd/yyyy)_____ **Time:**_____

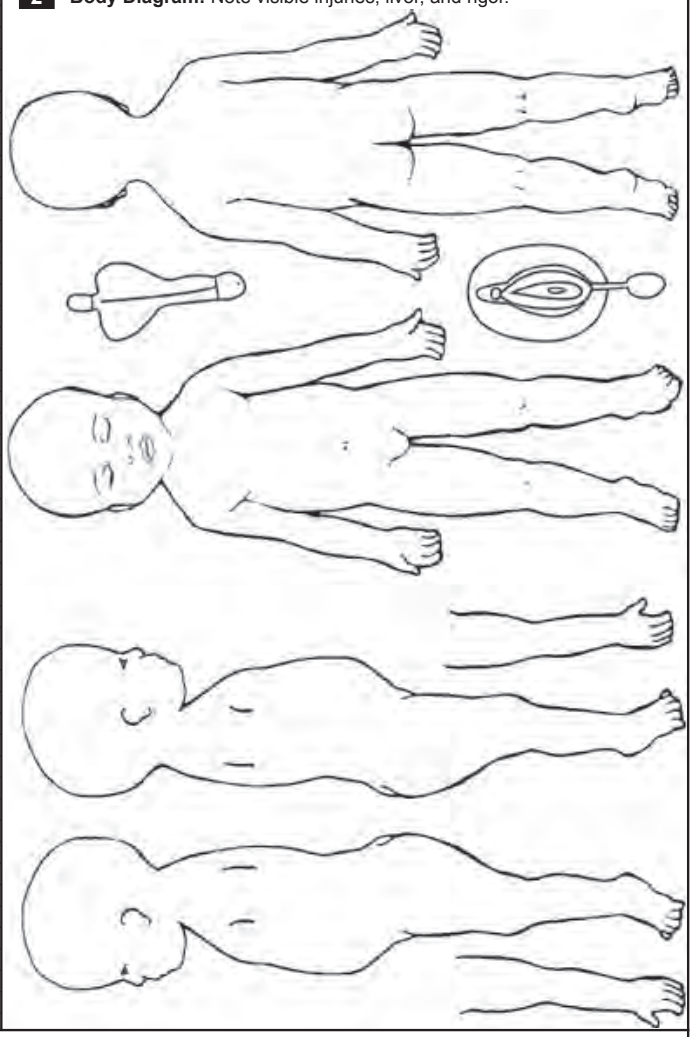
4. **If more than one person was interviewed, does the information provided differ?** ◯Yes ◯No ◯NA
   If yes, detail any differences, inconsistencies of relevant information. *(e.g., placed on sofa, last known alive on chair)*
   _____
   _____
   _____

5. **Indicate the task(s) performed.** *(check all that apply)* ◯Additional scene(s) (forms attached) conducted
   ◯ Photos or video taken ◯Materials collected/evidence logged ◯Next of kin notified ◯911 tape obtained
   ◯ EMS run sheet or report obtained ◯ Doll reenactment or scene re-creation performed
6. **Was the family offered grief counseling services?** ◯Yes ◯No ◯Unknown
   Provide "Help For Families" Brochure created at https://sudc.org/research-medical-info/help-for-families-brochure
7. **Was a doll scene reenactment performed?** ◯Yes ◯No ◯Unknown
   If no, why?_____
   If yes: How was it documented? ◯Photographed ◯Videoed Other, specify: _____
   Where was it performed? ◯Incident scene ◯Hospital ◯Other, specify: _____
   Date and time performed:_____
   Photos/video provided to the pathologist? ◯Yes ◯No ◯Unknown

INVESTIGATION DIAGRAMS

1 **Scene Diagram:** Illustrate the childs's sleep environment.

2 **Body Diagram:** Note visible injuries, livor, and rigor.



3. **Scene and doll reenactment photos:** include with form.

SUMMARY FOR PATHOLOGIST

1. **Investigator information. Name:**_____ **Agency:** _____
   Phone:_____ **Email address:**_____
2. **Investigated date:**_____ **Time:**_____
3. **Pronounced date:**_____ **Time:**_____
4. **Estimated time of death: Date: (mm/dd/yyyy)** _____ **Time:** _____
5. **Location of death:** *(e.g., home or hospital)* _____
6. **Data sources consulted to complete this form** *(check all that apply)* ○ Infant medical records ○ Birth records ○ Prenatal records ○ Witness interview ○ Other, specify:_____ ○ Photos/videos from caregivers demonstrating injuries, developmental milestone, or medical concerns
7. **Indicate whether preliminary investigation suggests any of the following.** *(indicate all that apply)*

		Yes	No
Sleeping Environment	Asphyxia *(e.g., evidence of overlying, wedging, choking, nose or mouth obstruction, re-breathing, neck or chest compression, or immersion in water)*	○	○
	Sharing of sleep surface with adults, children, or pets	○	○
	Change in sleep condition *(e.g., unaccustomed stomach sleep position, location, or sleep surface)*	○	○
	Hyperthermia or hypothermia *(e.g., excessive wrapping, blankets, clothing, or hot or cold environments)*	○	○
	Environmental hazards *(e.g., carbon monoxide, noxious gases, chemicals, drugs, or devices)*	○	○
	Unsafe sleep condition (e.g., non-supine, couch, adult bed, stuffed toys, pillows, or soft bedding)	○	○
Infant History	Diet *(e.g., solids introduced)*	○	○
	Recent hospitalization	○	○
	Previous medical diagnosis	○	○
	History of acute life threatening events *(e.g., apnea, seizures, or difficulty breathing)*	○	○
	History of medical care without diagnosis	○	○
	Recent fall or other injury	○	○
	History of religious, cultural or alternative remedies	○	○
	Cause of death due to natural causes not SIDS *(e.g., birth defects or complications of preterm birth)*	○	○
Family Information	Prior sibling deaths	○	○
	Sudden/unexpected death before the age of 50 or heart disease (e.g., *cardiomyopathy, Marfan or Brugada syndrome, long or short QT syndrome, catecholaminergic polymorphic ventricular tachycardia*) among the infant's blood relatives (siblings, parents, grandparents, aunts/uncles or first cousins)	○	○
	Previous encounters with police or social service agencies	○	○
	Request for tissue or organ donation	○	○
	Family interested in participating in research studies, if possible	○	○
	Objection to autopsy	○	○
Exam	Pre-terminal resuscitative treatment	○	○
	Signs of trauma/injury, poisoning, or intoxication	○	○
	Suspicious circumstances	○	○

If yes to any of the above, explain in detail: *(description of circumstances)* _____

_____

_____

_____

_____

_____

8. Medical examiner or pathologist information. Name: _____
Agency: _____
Phone: _____ **Fax:** _____
Email address: _____

This form is available at https://sudpeds.com