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

Sudden Unexplained Infant Death Investigation

SUIDI Reporting Form

ADDITIONAL INVESTIGATIVE SCENE FORMS

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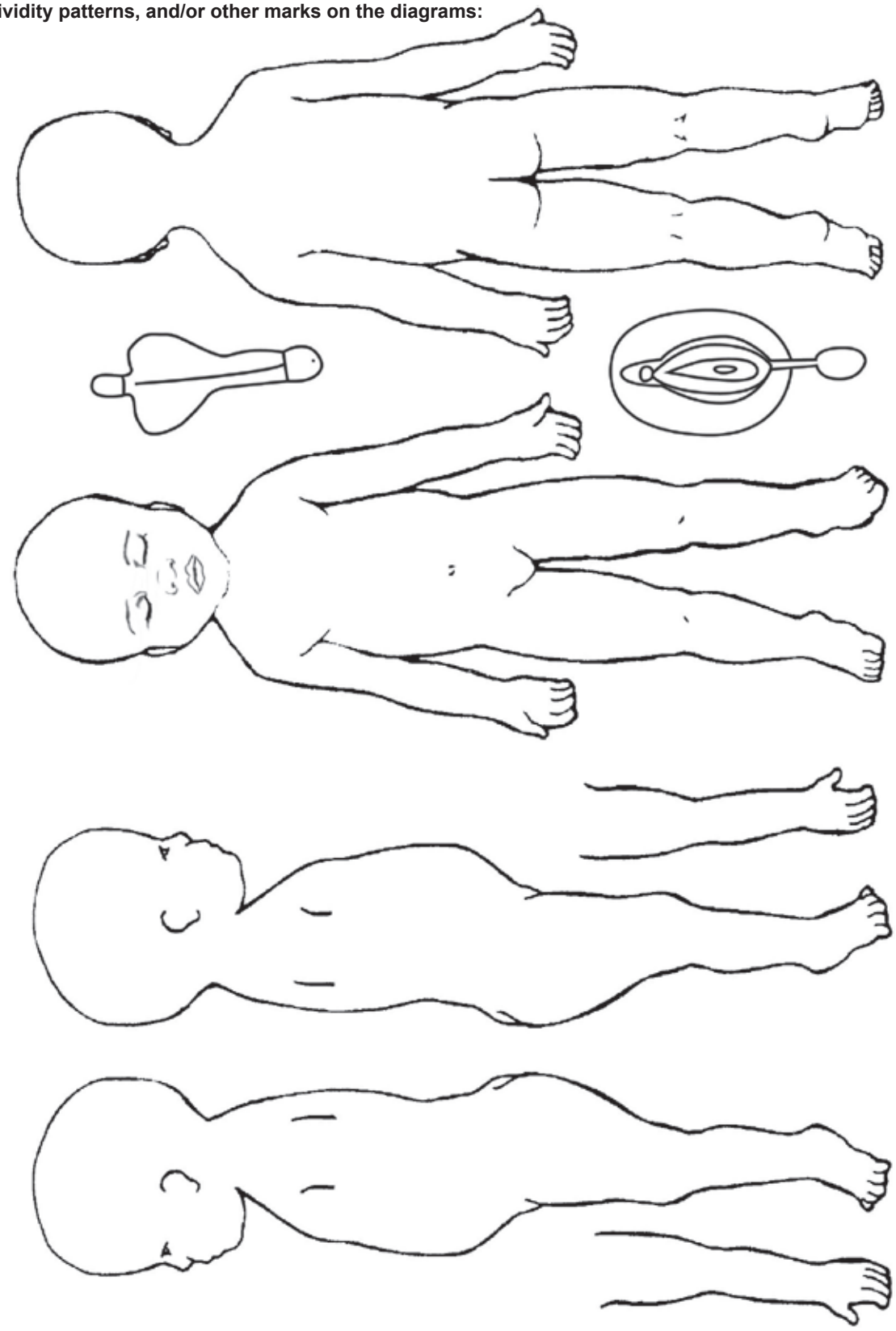
Infant's Information

Last Name	First Name	Middle	Case Number

A - BODY DIAGRAM

1 **Draw lividity patterns, and/or other marks on the diagrams:**



Section Completed by (name)	Month	Day	Year	Military Time	In person	Telephone	Other
				:			

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A - BODY DIAGRAM

Infant's Information

Last Name	First Name	Middle	Case Number

1 **Information about the EMS responder:**

Last name	First name	Agency

	Month	Day	Year	Military Time
Date/Time Dispatched:				:

2 **Who called 911?**

Last name	First name	Relationship *(example aunt)*

3 **What date and time did you arrive?**

Month	Day	Year	Military Time
			:

4 **Was anyone doing CPR when EMS arrived?**

No	Yes	Who?

5 **Where was the infant when you arrived at the scene?** *(ex. crib, arms of caregiver)*

6 **Describe infant's appearance when found.**

Appearance	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, blanching)			
e) Rash or petechiae (small, red blood spots on skin, membranes or eyes)			
f) Marks on body (scratch on nose)			
g) Other			
h) Unknown			

7 **How did the infant feel when found?**

Sweaty	Warm to touch	Cool to touch	Rigid, stiff	Limp, flexible	Unknown	Other - specify

8 **Did you administer resuscitative efforts?** If Yes - *check all that were done below,* If No - Skip to No. 13 on next page.

CPR	IV/IO Access	Gastric Tube	Infant immobilized	Medications	Intubation	Electric shock

Other - Specify:

9 **List all emergency medications given to the infant:**

Name of Medication	Dose	Route	Military Time
1.			:
2.			:
3.			:
4.			:
5.			:

Continued on the next page ►

B - EMS INTERVIEW

10 **Describe the nature and duration of resuscitation efforts and treatments.**

11 **Describe any injuries sustained by infant during resuscitative efforts (if any):**

12 **At what date and approximate time were the resuscitative efforts terminated?**

Not terminated by EMS	Month	Day	Year	Military Time
				:

13 **What was the name of the authorizing medical control physician who pronounced death?**

Last name	First name	Agency

14 **What was the final disposition of the infant?**

Left at the scene	Released to funeral home	Morgue	ME/C facility

Transported to the hospital - Specify	Other - Specify	Name of person who received the infant

15 **Describe the reaction of the caregiver(s) to the infant's death:**

16 **Additional comments from the EMS personnel:** *(Describe concerns with scene or what happened)*

Investigator's Notes

Indicate the task(s) performed	EMS Run Report/Sheet	911 Tape

Section Completed by (name)	Month	Day	Year	Military Time	In person	Telephone	Other
				:			

Infant's Information

Last Name	First Name	Middle	Case Number

1 **On what day and at what approximate time did the infant arrive at the hospital?**

Month	Day	Year	Military Time
			:

2 **Hospital Information:**

Hospital Name: Address:

3 **Name of physician responsible for treatment at hospital.**

Name: Phone:

4 **Name physician who signed the death certificate.**

Name: Phone:

5 **What was the level of consciousness upon arrival at the hospital?**

☐ Breathing ☐ Not breathing ☐ Responsive ☐ Unresponsive ☐ Dead

What did the infant look like upon arrival at the hospital? (*Check all that apply)*

Appearance	No	Yes	Describe and specify location:
a) Discolorations			
b) Secretions			
c) Livor mortis			
d) Pale areas around nose or mouth			
e) Retinal hemorrhages			
f) Cutaneous petechiae			
g) Bruising or other injury			
h) Suspicion of inflicted trauma			
i) Malnourished			
j) Other			

6 **How did the infant feel upon arrival at the hospital?**

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

Other - Specify:

7 **List all treatments and procedures (T&P) administered to the infant at the hospital:**

Treatment or Procedure	Approx. Time	Outcome
1.	:	
2.	:	
3.	:	
4.	:	

8 **Hospital staff's comments regarding family's reaction to infant's death.**

Investigator's Notes

Indicate the task(s) performed Obtain medical records or code sheet ☐ Secure evidence and release infant's property ☐

Section Completed by (name)	Month	Day	Year	Military Time	In person	Telephone	Other
				:			

C - HOSPITAL INTERVIEW

Infant's Information

Last Name	First Name	Middle	Case Number

D - IMMUNIZATION RECORD

1 **Indicate information source** *(Check appropriate box)*

- ☐ Biological Mother/Father
- ☐ Grandmother/Father
- ☐ Adoptive or Foster Parents
- ☐ Physician
- ☐ Health Records
- ☐ Other (specify):

2 **Has the infant ever received immunizations or shots?**

Yes	No - (stop)

Please list all of the immunizations the infant has ever been given <u>or attach record.</u>

Immunization:	Month	Day	Year	Comments/Reactions:
Hepatitis B #1				
Hepatitis B #2				
Hepatitis B #3				
Diphtheria, Tetanus, Pertussis #1 (DPT)				
Diphtheria, Tetanus, Pertussis #2 (DPT)				
Diphtheria, Tetanus, Pertussis #3 (DPT)				
Haemophilus Influenzae Type b #1 (Hib)				
Haemophilus Influenzae Type b #2 (Hib)				
Haemophilus Influenzae Type b #3 (Hib)				
Inactivated Poliovirus #1 (Polio)				
Inactivated Poliovirus #2 (Polio)				
Inactivated Poliovirus #3 (Polio)				
Measles, Mumps, Rubella (MMR)				
Varicella (Chicken Pox)				
Pneumococcal				
Influenza (Flu)				
Hepatitis A #1				
Hepatitis A #2				
Other/Specify:				

3 **Are the immunizations up to date?**

Yes	No	Unknown

Section Completed by (name)	Month	Day	Year	Military Time	In person	Telephone	Other
				:			

Infant's Information

Last Name	First Name	Middle	Case Number

1 **Identify all persons who were in contact with the infant in the 24 hours prior to the infant's death.**

(being in the same room, living in/staying in/visiting the infant's primary residence - if more than 3 persons, use additional pages)

	Person 1			Person 2			Person 3		
a) Last name									
b) First name									
c) Maiden name *(if applicable)*									
d) Relationship to infant									
e) Street									
f) City									
h) DOB	Month	Day	Year	Month	Day	Year	Month	Day	Year
i) Where did contact with the infant occur (*ex. house, daycare, playground)*									
j) Date of last contact with the infant	Month	Day	Year	Month	Day	Year	Month	Day	Year
k) Approximate time of last contact with the infant *(Military Time)*	:			:			:		
l) During the week prior to the infant's death, was this person sick? *(If "Yes", explain the circumstances below)*	Yes	No	Unknown	Yes	No	Unknown	Yes	No	Unknown
	Explain:			Explain:			Explain:		
m) For persons biologically related to the infant *(d above)* are there any known conditions/diseases that run in the family? *(down syndrone)*	Yes	No	NA	Yes	No	NA	Yes	No	NA
	Explain:			Explain:			Explain:		
n) Has this person experienced the death of any of their own children or of any other children while in their care?	Yes	No	Unknown	Yes	No	Unknown	Yes	No	Unknown
	Explain:			Explain:			Explain:		
I) Child's name									
II) Relationship to caregiver									
III) Date of death	Month	Day	Year	Month	Day	Year	Month	Day	Year
IV) Child's age at death (years or months if <2 years)									
V) Cause of death									
VI) Place of death (City/State)									

	No	Yes	If yes - please describe
2 **Did the infant visit a location with large numbers of people within the last 24 hours?**			
3 **Are there any factors, circumstances, or environmental concerns?** *(ex. mother smoked while breast feeding, exposed to a large number of people at church or a public event, air travel)*			

Continued on the next page ►

4 Daycare

	Yes	No
Did the infant visit a daycare in the 24 hours prior to the death?		

How many adults were supervising the children? Number of people (18 years or older)

	No	Yes	If yes - specify
Were any of these adults sick?			

How many children were under the care of the provider at that day? Number of people (18 years or older)

Identify any children in daycare who were sick and were in contact or close proximity to the infant in the 24 hours prior to the death?

	Child 1			Child 2			Child 3		
a) First name of child									
b) Last name of child									
c) Date of birth	Month	Day	Year	Month	Day	Year	Month	Day	Year
d) Where did contact with the infant occur *(ex. house, daycare, play-ground)*									
e) Date of last contact with the infant	Month	Day	Year	Month	Day	Year	Month	Day	Year
f) Approximate time of last contact with the infant									
g) During the week prior to the infant's death, was this person sick? *(If "Yes", explain the circumstances)*	Yes	No	Unknown	Yes	No	Unknown	Yes	No	Unknown
	Explain:			Explain:			Explain:		

If more than 3 children, use additional pages

Section Completed by (name)	Month	Day	Year	Military Time	In person	Telephone	Other
				:			

Infant's Information

Last Name	First Name	Middle	Case Number

1 **For each informant interviewed, please obtain the following information:**

Informant 1

a) First/Last Name:	
a) Maiden (if applicable):	
c) Relationship to Infant:	
d) Address (H):	
e) City:	
f) Address (W):	
g) City:	
h) State:	
h) Zip:	
i) Phone 1:	
j) Phone 2:	

Informant 2

a) First/Last Name:	
a) Maiden (if applicable):	
c) Relationship to Infant:	
d) Address (H):	
e) City:	
f) Address (W):	
g) City:	
h) State:	
h) Zip:	
i) Phone 1:	
j) Phone 2:	

Informant 3

a) First/Last Name:	
a) Maiden (if applicable):	
c) Relationship to Infant:	
d) Address (H):	
e) City:	
f) Address (W):	
g) City:	
h) State:	
h) Zip:	
i) Phone 1:	
j) Phone 2:	

Informant 4

a) First/Last Name:	
a) Maiden (if applicable):	
c) Relationship to Infant:	
d) Address (H):	
e) City:	
f) Address (W):	
g) City:	
h) State:	
h) Zip:	
i) Phone 1:	
j) Phone 2:	

Informant 5

a) First/Last Name:	
a) Maiden (if applicable):	
c) Relationship to Infant:	
d) Address (H):	
e) City:	
f) Address (W):	
g) City:	
h) State:	
h) Zip:	
i) Phone 1:	
j) Phone 2:	

Informant 6

a) First/Last Name:	
a) Maiden (if applicable):	
c) Relationship to Infant:	
d) Address (H):	
e) City:	
f) Address (W):	
g) City:	
h) State:	
h) Zip:	
i) Phone 1:	
j) Phone 2:	

Section Completed by (name)	Month	Day	Year	Military Time	In person	Telephone	Other
				:			

F - INFORMANT CONTACT

F - INFORMANT CONTACT

Infant's Information

Last Name	First Name	Middle	Case Number

Information about the Law Enforcement officer:

Last name	Middle name	Last name

Phone number	Agency

Date and time dispatched: Month ____ Day ____ Year ____ Military Time ____ : ____

Who called? ____ Relationship *(ex. aunt):* ____

1 **What date and time did you arrive?**

Month	Day	Year	Military Time
			:

2 **What did the infant look like when you arrived at the scene?**

Appearance	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, blanching)*			
e) Rash or petechiae *(small, red blood spots on skin, membranes or eyes)*			
f) Marks on body *(scratch on nose)*			
g) Other			
h) Unknown			

3 **How did the infant feel when found?**

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

Other - Specify: ____

4 **How would you describe the surface on which the infant was placed?**

Condition of surface (check all that apply): ☐ Soft ☐ Firm ☐ Lumpy ☐ Concave ☐ Stained ☐ Wet

5 **Describe condition:** (check all that apply):

☐ Broken ☐ Worn ☐ Repaired ☐ Clean ☐ Dirty

6 **Describe what the scene looked like upon arrival:**

____

7 **Describe what law enforcement did at the scene:**

____

8 **Describe the person's reactions to the infant's death:**

Individual	No	Yes	Specify:
Mother			
Father			
Placer			
Finder			
Last Known Alive			
Other			

Continued on the next page ►

8 **Are there any known prior contacts with law enforcement?**

Individual	No	Yes	Reason for contact	Outcome
Mother				
Father				
Placer				
Finder				
Last Known Alive				
Other				

9 **What was the final disposition of the infant?**

☐ Left at the scene ☐ Released to funeral home ☐ Morgue ☐ ME/C facility

☐ Transported to the hospital - Specify:

☐ Other - Specify:

(Indicate facility name and name of person who received the infant)

10 **Have there been any contacts/complaints to social services regarding this family and other siblings in the home?**

Yes	No - (stop)

11 **Total number of contacts with social services:**

12 **List up to two most recent contacts with social services.**

	Month	Day	Year
Date contacted:			

Caseworker name:

Agency name:

Reason for contact:

Outcome:

Comments:

	Month	Day	Year
Date contacted:			

Caseworker name:

Agency name:

Reason for contact:

Outcome:

Comments:

Section Completed by (name)	Month	Day	Year	Military Time	In person	Telephone	Other
				:			

Infant's Information

Last Name	First Name	Middle	Case Number

8 **Describe all items recovered from the site of the incident or death scene:**

Item	Evidence No.	Origin	Description	Disposition	Name of person collecting
1) Baby bottles					
2) Pacifier					
3) Formula					
4) Bedding					
5) Infant's last diaper					
6) Clothing					
7) Apnea monitor					
8) Infant sleep surface					
9) Medicines *(include home remedies)*					
10)					
11)					
12)					
13)					
14)					
15)					
16)					
17)					
18)					
19)					
20)					
21)					
22)					
23)					
24)					
25)					
26)					
27)					
28)					
29)					
30)					

H - MATERIALS COLLECTION LOG

Section Completed by (name)	Month	Day	Year	Military Time	In person	Telephone	Other
				:			

Infant's Information

Last Name	First Name	Middle	Case Number

1 **Information about the person who was the first non-professional responder to the infant:**

Last name	Middle name	Last name

Phone number	Relationship to infant

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

2 **What led you to respond?**

3 **When the infant was found, was s/he:**

☐ breathing ☐ not breathing ☐ unresponsive

If not breathing, did you witness the infant stop breathing? ☐ yes ☐ no

4 **Describe infant's appearance when found.**

Appearance	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, blanching)*			
e) Rash or petechiae *(small, red blood spots on skin, membranes or eyes)*			
f) Marks on body *(scratch on nose)*			
g) Other			
h) Unknown			

5 **How did the infant feel when found?**

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

Other - Specify:

6 **What date and time were the first resuscitative efforts given?**

Month	Day	Year	Military Time
			:

7 **Where were resuscitative efforts conducted?**

8 **Describe what you did as part of the resuscitative efforts (ex. pushed on chest and breathed into mouth and nose):**

9 **Have you ever received any First Aid and/or CPR training?**

☐ No ☐ Yes When:

Describe:

Section Completed by (name)	Month	Day	Year	Military Time	In person	Telephone	Other
				:			

I - NONPROFESSIONAL RESPONDER INTERVIEW

I - NONPROFESSIONAL RESPONDER INTERVIEW

Infant's Information

Last Name	First Name	Middle	Case Number

Indicate information source

☐ Biological Mother/Father ☐ Grandmother/Father ☐ Adoptive or Foster Parents ☐ Physician ☐ Health Records

Other - Specify:

1 Information about the infant's mother:

First name: Middle name: Last name:

DOB: SS#: Maiden name:

Current address:

Street: City: State: Zip:

How long has the mother been a resident of this state? Years: Months:

Has the mother ever lived in a state other than this one? ☐ No ☐ Yes

List all previous states:

2 Information about the infant's biological mother:

First name: Middle name: Last name:

DOB: SS#: Maiden name:

Current address:

Street: City: State: Zip:

How long has the mother been a resident of this state? Years: Months:

Has the mother ever lived in a state other than this one? ☐ No ☐ Yes

List all previous states:

3 Information about the infant's father:

First name: Middle name: Last name:

DOB: SS#:

Current address:

Street: City: State: Zip:

How long has the father been a resident of this state? Years: Months:

Has the father ever lived in a state other than this one? ☐ No ☐ Yes

List all previous states:

4 Information about the infant's biological father:

First name: Middle name: Last name:

DOB: SS#:

Current address:

Street: City: State: Zip:

How long has the father been a resident of this state? Years: Months:

Has the father ever lived in a state other than this one? ☐ No ☐ Yes

List all previous states:

Continued on the next page ►

5 **Information about the infant's other primary caregivers:** (ex. babysitter while parents are at work)

First name: | Middle name: | Last name:

DOB: | SS#: | Maiden name:

Current address:

Street: | City: | State: | Zip:

How long has the caregiver been a resident of this state? Years: | Months:

Has the mother ever lived in a state other than this one? ☐ No ☐ Yes

List all previous states:

6 **Information about the infant's other primary caregivers:**

First name: | Middle name: | Last name:

DOB: | SS#: | Maiden name:

Current address:

Street: | City: | State: | Zip:

How long has the caregiver been a resident of this state? Years: | Months:

Has the mother ever lived in a state other than this one? ☐ No ☐ Yes

List all previous states:

7 **Information about the infant's other primary caregivers:**

First name: | Middle name: | Last name:

DOB: | SS#: | Maiden name:

Current address:

Street: | City: | State: | Zip:

How long has the caregiver been a resident of this state? Years: | Months:

Has the mother ever lived in a state other than this one? ☐ No ☐ Yes

List all previous states:

Section Completed by (name)	Month	Day	Year	Military Time	In person	Telephone	Other
				:			

Infant's Information

Last Name	First Name	Middle	Case Number

Complete this form only if the scene of the incident or death scene is *NOT* the primary residence.

1 **Address of primary residence:**

Street: | City: | State: | Zip:

2 **How many people live at the infant's primary residence?**

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

3 **What type of building is the primary residence?**

- ☐ Apartment
- ☐ Multifamily home
- ☐ Institution (ex. shelter)
- ☐ Single family house
- ☐ Mobile home
- ☐ Other Specify:

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

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

5 **The infant's primary residence has:** *(Check all that apply)*

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

Other - specify:

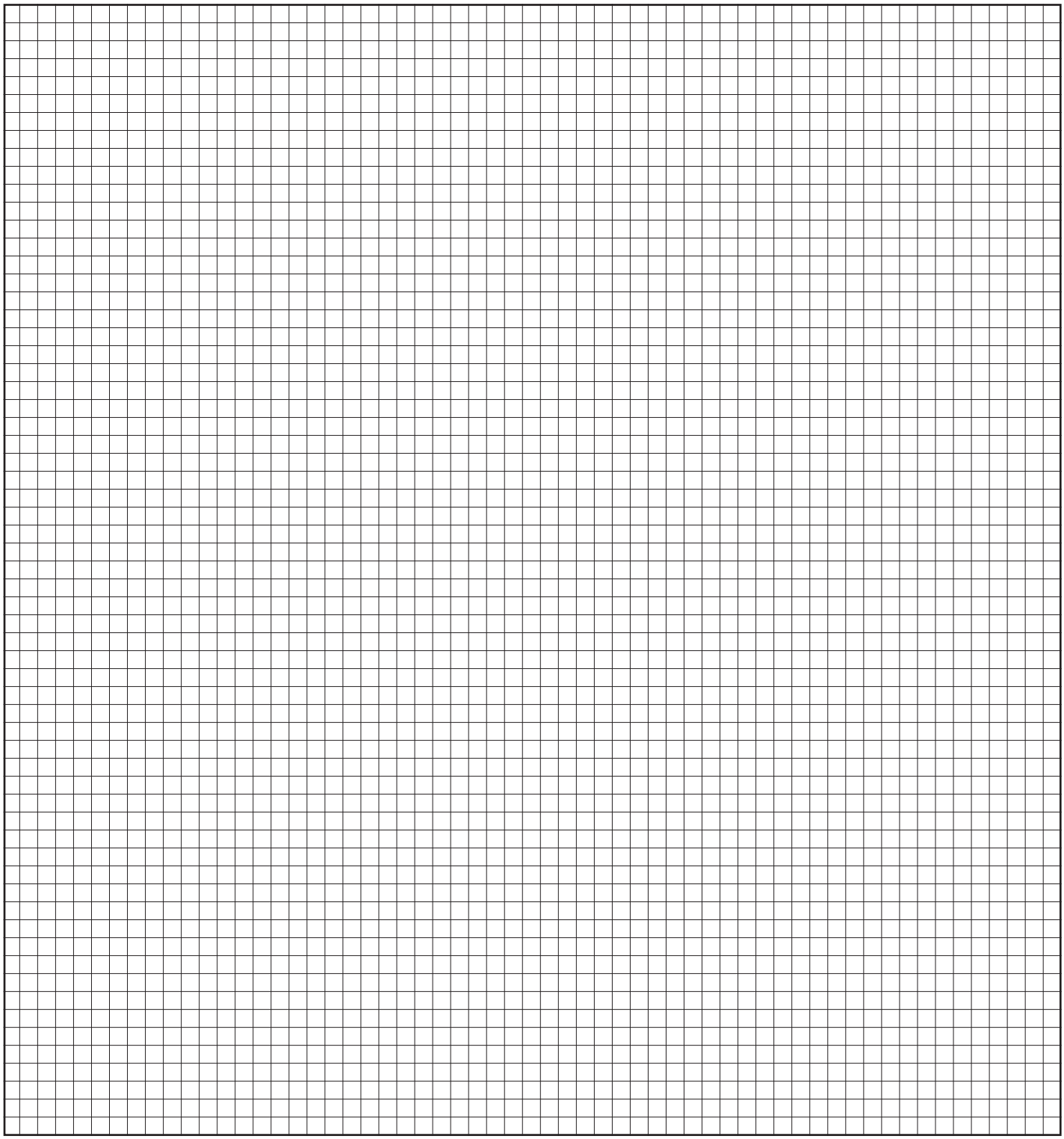
6 **What was the source of drinking water at the infant's primary residence?** *(Check all that apply)*

- ☐ Public/Municipal water source
- ☐ Well
- ☐ Bottled water
- ☐ Unknown
- ☐ Other - specify:

7 **What is the general appearance of the infant's primary residence?** *(ex. cleanliness, hazards, overcrowding, etc.)*

Section Completed by (name)	Month	Day	Year	Military Time	In person	Telephone	Other
				:			

K - PRIMARY RESIDENCE INVESTIGATION

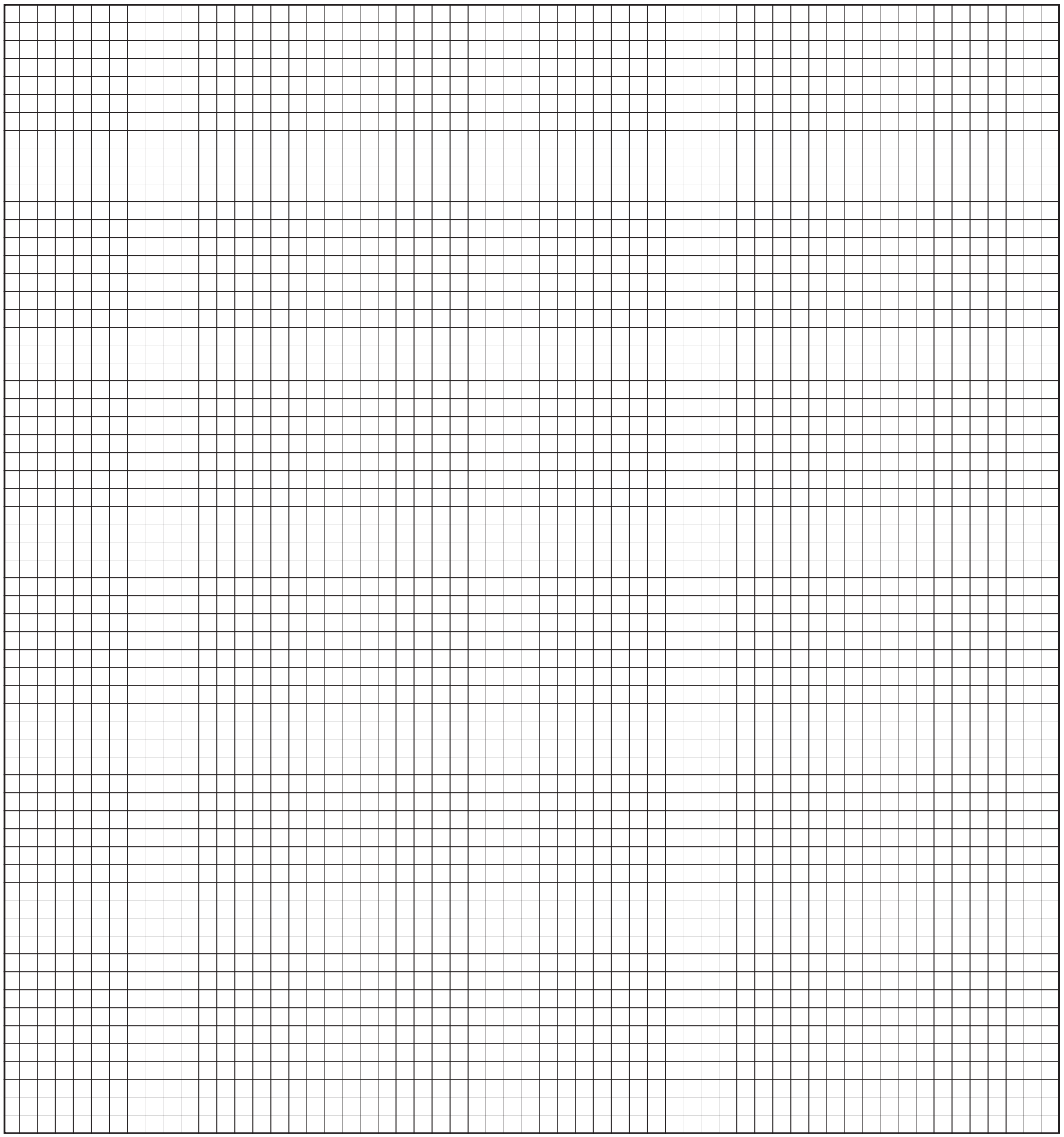


Infant's Information

last name	first name	middle	case number

1 **Draw the following on the scene diagram.** *(For people and objects, give the name, show location, show position)*

a) Room dimensions and North Direction
b) Crib, bed or sleep surface
c) Infant's position when found
d) Those sharing the same sleeping surface
e) Furniture and other objects in room
f) Heating and cooling sources
g) Items in contact with the infant



L - SCENE DIAGRAM

Section Completed by (name)	Month	Day	Year	Military Time	In person	Telephone	Other
				:			

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L - SCENE DIAGRAM