



New York State
Office of
Children & Family Services

2008/2009 Office of Children and Family Services Report on Child Fatalities



Andrew M. Cuomo, Governor

Gladys Carrión, Esq., Commissioner

2008/2009 Office of Children and Family Services Report on Child Fatalities

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Child Fatality Data

The New York State Office of Children and Family Services (OCFS), in accordance with Social Services Law (SSL) §20(5), must review a subset of all child fatalities, specifically, child fatalities that are deemed to have occurred within the context of child welfare services. These include:

- Deaths reported to the Statewide Central Register of Child Abuse and Maltreatment (SCR) that allegedly occur as a result of abuse or maltreatment;
- Deaths that occur while the child is in foster care¹; or,
- Death of a child for whom there is an open child protective or preventive services case.

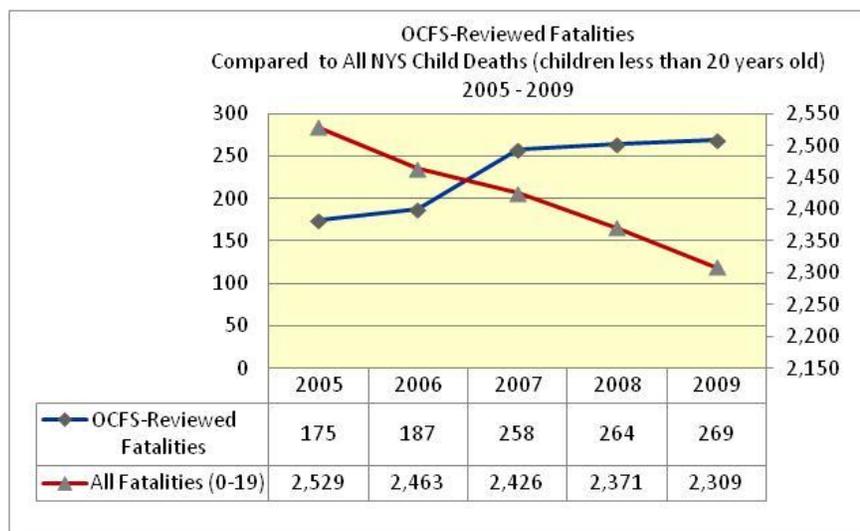
Child deaths that occur within the context of child welfare services are referred to in this document as “OCFS-reviewed fatalities.”

OCFS-reviewed fatalities receive an in-depth review. As set forth in SSL §20(5), when a child dies under one of the conditions described above, OCFS is responsible for:

- Investigating or providing for the investigation of the cause and circumstance surrounding such a death and reviewing each investigation;
- Preparing and issuing a report on each such death, except when a report is issued by an approved local or regional child fatality review team in accordance with SSL §422-b.

In addition, OCFS is required to prepare and issue an annual cumulative report concerning such deaths.

In NYS, according to the New York State Department of Health (DOH) vital statistics, the annual number of child fatalities, statewide, is on the decline. From 2005 to 2009, fatalities for children birth through 19 years declined by nearly 10%.



¹ Child is in the care and custody or custody and guardianship of an authorized agency.

While the total number of NYS child fatalities has steadily decreased, the number of OCFS-reviewed fatalities has increased steadily since 2005. The chart (on the preceding page) illustrates the trend in occurrence of all NYS child fatalities as well as the increase in OCFS-reviewed fatalities, particularly in 2007. The increase corresponds with statutory changes contained in Chapter 485 of the Laws of 2006 which became effective December 2006, and expanded the types of cases that OCFS must review to include deaths that occur while the child is receiving child protective or preventive services.

Geographic Distribution:

In 2009, OCFS reviewed approximately 12% of DOH reported child deaths; however, as the table (right) shows, there is a wide range from county to county, from a low of 0% to a high of 31.6%.

It is suggested that a larger percent of child fatalities reviewed by OCFS may indicate an increased public awareness of child safety issues and the learning benefits related to an in-depth fatality review.

Additional research is required to better understand why reporting is higher in some geographic areas.

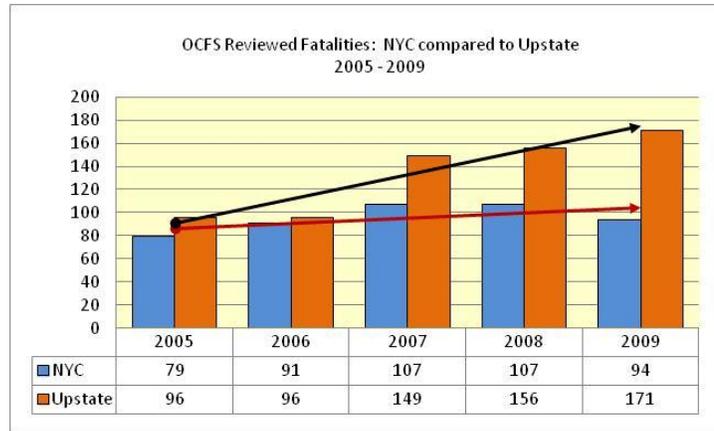
Note:

The total number of OCFS-reviewed fatalities in 2007-2009 was 791. The “Other” category represents seven fatalities that occurred while the child was residing in a residential care setting. Of those seven, five occurred in the 2008/2009 time period. See page 5 for additional information.

NYC OSI (Administration for Children’s Services Office of Special Investigations) investigates SCR reports that involve foster parents, child care providers and ACS staff. This data is not borough-specific; therefore a separate category is listed.

OCFS Reviewed Child Fatalities as a Percent of All Child Fatalities Reported by DOH			
Combined Yrs: 2007-2009	All DOH Reported Child Fatalities	OCFS Reviewed (county) Child Fatalities	%
2007-2009 -->	TOTAL	TOTAL	TOTAL
Chemung	38	12	31.6%
Schuyler	7	2	28.6%
Columbia	21	5	23.8%
Cattaraugus	43	10	23.3%
Steuben	42	9	21.4%
Fulton	19	4	21.1%
Broome	96	20	20.8%
Genesee	29	6	20.7%
Oswego	54	11	20.4%
Sullivan	35	7	20.0%
Tompkins	20	4	20.0%
Chautauqua	56	11	19.6%
Herkimer	26	5	19.2%
Madison	21	4	19.0%
Orleans	22	4	18.2%
Yates	11	2	18.2%
Cayuga	28	5	17.9%
Schenectady	75	12	16.0%
Ontario	40	6	15.0%
Clinton	34	5	14.7%
Delaware	14	2	14.3%
Dutchess	91	13	14.3%
Orange	164	23	14.0%
Washington	22	3	13.6%
Richmond	125	17	13.6%
Niagara	90	12	13.3%
Seneca	8	1	12.5%
Bronx	692	84	12.1%
Monroe	338	41	12.1%
Jefferson	66	8	12.1%
Erie	416	49	11.8%
Albany	129	14	11.6%
Rensselaer	62	7	11.3%
Allegany	18	2	11.1%
Cortland	18	2	11.1%
Suffolk	471	50	10.6%
Onondaga	205	21	10.2%
Westchester	295	30	10.2%
Schoharie	10	1	10.0%
Kings	1,115	108	9.8%
Oneida	79	7	8.9%
Manhattan	400	35	8.8%
Essex	12	1	8.3%
Wyoming	13	1	7.7%
Warren	27	2	7.4%
Ulster	69	5	7.2%
St. Lawrence	42	3	7.1%
Livingston	15	1	6.7%
Putnam	30	2	6.7%
Queens	685	45	6.6%
Chenango	17	1	5.9%
Tioga	17	1	5.9%
Wayne	35	2	5.7%
Nassau	382	20	5.2%
Rockland	99	5	5.1%
Saratoga	57	2	3.5%
Franklin	9	0	0.0%
Greene	7	0	0.0%
Lewis	10	0	0.0%
Montgomery	18	0	0.0%
Otsego	17	0	0.0%
Hamilton	0	0	N/A
St. Regis	0	0	N/A
NYC - OSI	-	19	N/A
Other	-	7	N/A
Statewide	7,106	791	11.1%

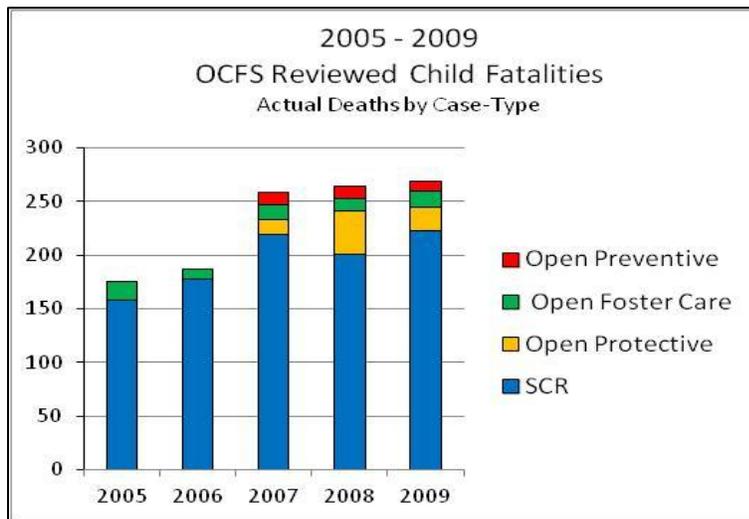
As noted earlier, the number of OCFS-reviewed child fatalities has risen from 175 fatalities in 2005 to 269 in 2009; this represents a 54% increase statewide. Notably, counties outside of NYC experienced a 78% increase over this same time period, while NYC counties saw a 19% increase.



Note that the NYC/Upstate total for 2008 and 2009 combined is 528 fatalities, while the total number of 2008/2009 OCFS-reviewed fatalities is 533. The difference is due to the five fatalities that occurred while the child was in a residential care setting at the time of the fatality under the following manner of death:

- Accidental: involving a train/pedestrian
- Natural (2 fatalities): due to pre-existing medical conditions
- Undetermined (2 fatalities)

Service Type:



Type	2005	2006	2007	2008	2009
SCR	158	178	219	201	223
Services Open at Fatality	17	9	39	63	46
Open Protective	-	-	14	40	22
Open Foster Care	17	9	14	12	15
Open Preventive	-	-	11	11	9
Total				327	315

A total of 533 OCFS-reviewed child fatalities occurred in 2008 and 2009 (264 and 269, respectively). However, OCFS was notified of child fatalities 642 times during that same time period (327 notifications in 2008 and 315 notifications in 2009). In some instances, multiple notifications occur, specifically in reports to the SCR.

SCR reports represent the largest portion of fatalities that require an OCFS review. In 2008 and 2009 combined, there were a total of 424 SCR reports with DOA/Fatality allegations that represented 416 unique child fatalities.

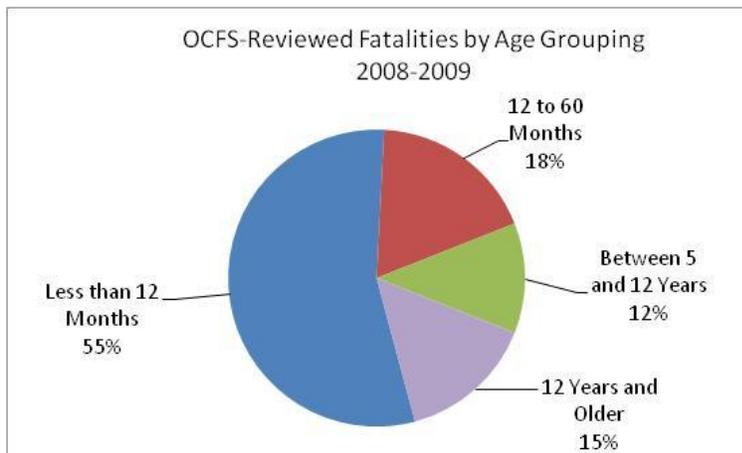
Fatalities involving open preventive and protective services cases represented a significant increase in

reports. Since the implementation of the statutory changes contained in Chapter 485 of the Laws of 2006, a total of 107 fatalities occurred while the family was in an open protective or preventive services case.

Twenty-seven fatalities occurred while the child was in foster care, and this represents 5% of all OCFS-reviewed fatalities (27/533). The official manner of death² can provide reviewers with insight into the fatality. Seventy percent (70%) of the fatalities that occurred while the child was in foster care were related to natural causes and another 26% are either undetermined/unknown or pending. The official manners of death for the 27 fatalities that occurred while the child was in foster care are:

	2008	2009	Total
Natural	9	10	19
Accident	1	1	2
Suicide	0	0	0
Homicide	1	0	1
Undetermined/Unknown	1	2	3
Pending	0	2	2
TOTAL	12	15	27

Age:



According to DOH, fatalities for children less than one year old represent 56% of all fatalities statewide (children ages 0-19). Similarly, children less than one year old consistently represent about 55% of all OCFS-reviewed fatalities. This age distribution has remained stable through 2008 and 2009.

2008				
Age	Less than 12 Months	12 to 60 Months	Between 5 and 12 Years	12 Years and Older
Count	146	49	29	40
Percent	55%	19%	11%	15%
2009				
Age	Less than 12 Months	12 to 60 Months	Between 5 and 12 Years	12 Years and Older
Count	147	48	35	39
Percent	55%	18%	13%	14%

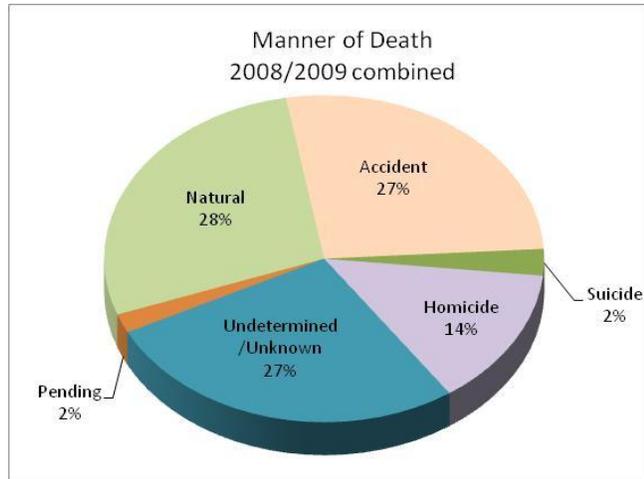
² The official manner of death as stated on the death certificate or the medical examiner/coroner report. The official manner of death may be recorded as: natural, accident, suicide, homicide, undetermined, pending or unknown.

Manner:

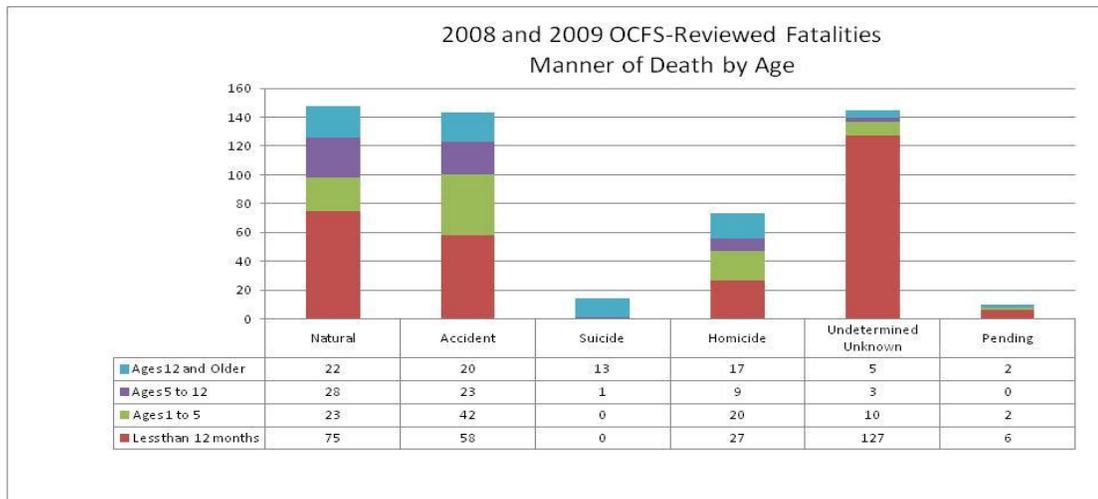
OCFS-reviewed fatalities document the manner of death as it is stated on the death certificate or, if unavailable, the manner of death as stated in the medical examiner/coroner's report.

In 2008 and 2009, the manner of death was pending in only 2% of all OCFS-reviewed fatalities. The data reveals that fatalities determined to be Natural, Accident, and Undetermined/ Unknown are fairly evenly distributed, and they represent just over 80% of all OCFS-reviewed fatalities.

Children less than one year old represent the largest age group for all manners of death, except suicide. Note that this population of children has a significantly higher number of undetermined/unknown manners of death. In 2008 and 2009, 127 (43%) of all infant fatalities did not have a determined or known manner of death.



Manner of death	2008 Total #	2009 Total #	2008 %	2009 %
Natural	75	73	28%	27%
Accident	59	84	22%	31%
Suicide	3	11	1%	4%
Homicide	48	25	18%	9%
Undetermined/ Unknown	76	69	29%	26%
Pending	3	7	1%	3%



A thorough description of the death scene can provide valuable information to assist with identifying the manner of death. The U.S. Department of Health and Human Services has developed a Sudden, Unexplained Infant Death Investigation guidelines booklet and a Reporting Form. OCFS and DOH are developing a work plan to promote the use of government-recommended infant death scene investigation protocols.

Prior CPS, Preventive, Foster Care or Assistance History of Household Members:

In 82% of all OCFS-reviewed fatalities during the period 2008-2009 (439 out of 533 fatalities), one or more members of the household had some history of receiving services or assistance from a local department of social services (LDSS). In 73% of OCFS-reviewed fatalities, there was a previous CPS report. Another 66% of the households received some other type of services or assistance (e.g.: Preventive Services, Foster Care or Temporary Assistance).

Although data shows that 66% of household members experienced some history of LDSS involvement, the level of involvement varies significantly based on the type of service or assistance received. Household members involved in preventive services or foster care cases are subject to in-home assessments, while the recipients of temporary assistance generally are not. In an effort to reduce risks to children, OCFS has engaged in several initiatives to provide information, training, and guidance to caseworkers and other service providers (described on pages 15-20).

Services/Assistance Prior to the Fatality				
Services/Assistance Prior to Fatality	2008	2009	Percent of all 2008 OCFS-Reviewed Fatalities*	Percent of all 2009 OCFS-Reviewed Fatalities
No	45	49	17%	18%
Yes	219	220	83%	82%
CPS Services ONLY				
No	70	80	27%	30%
Yes	194	189	73%	70%
Other (non-CPS) Services/Assistance				
No	88	84	33%	31%
Yes	176	185	66%	69%

*The percentages do not total 100% because some households may have previously received both types of services.

Fatalities Reported to the SCR:

A total of 424 reports to the SCR included a DOA/Fatality allegation; however, the SCR may receive multiple reports for the same fatality. In 2008 and 2009 combined, there were a total of 416 SCR reports that involved a unique DOA/Fatality allegation. Within those 416 SCR reports there were 465 DOA/Fatality allegations. In some reports, multiple perpetrators, each with their own DOA/Fatality allegation, may be named.

Of those 465 DOA/Fatality allegations, 42% were substantiated (197/465), meaning that some credible evidence was found to substantiate the DOA/Fatality allegation. The

Fatalities Reported to the SCR			
	2008	2009	Total
Reports: SCR Reports with Allegation of a Unique DOA/Fatality	198	218	416
Allegations: Unique Allegations of DOA/Fatality	222	243	465
Substantiated Allegations: Distinct Substantiated DOA/Fatality Allegations	99	98	197

substantiation rate for DOA/Fatality allegations is significantly higher than the rate for all allegations. In 2008 and 2009, approximately 24% of all allegations were substantiated.

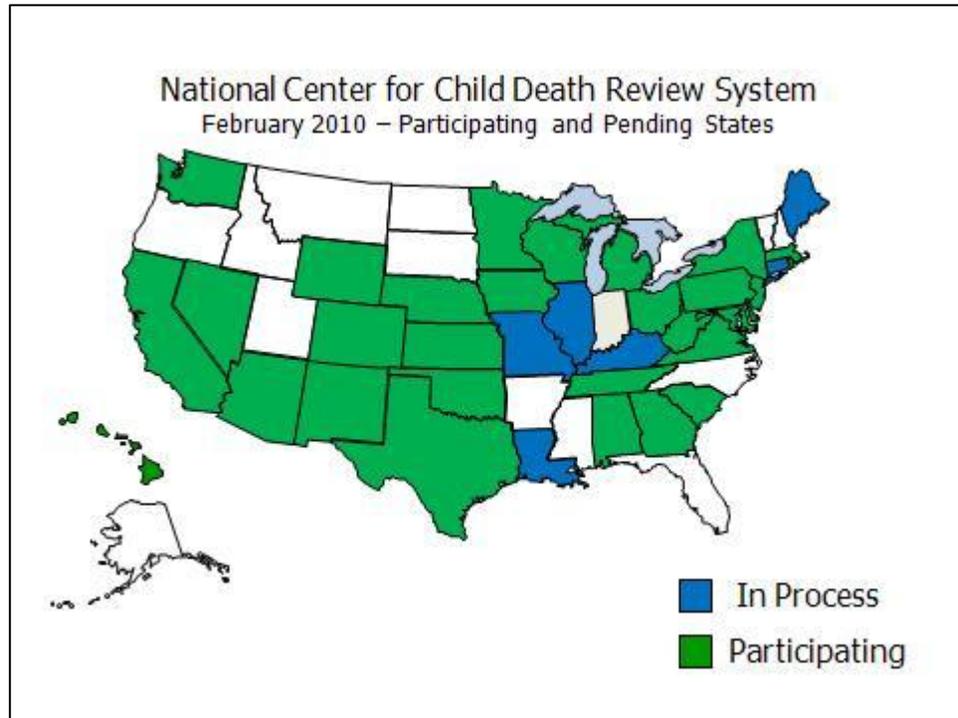
In addition to the DOA/Fatality allegations, there were a total of 880 other allegations identified within the 416 SCR Reports. For the years 2008/2009 combined, 496 out of the 880 allegations were substantiated, resulting in a 56% substantiation rate.

Fatality Reports by Allegation and Allegation Determination						
	2008		2009		2008/2009 Combined	
	Alleged	Substantiated	Alleged	Substantiated	Alleged	Substantiated
DOA / Fatality	222	99	243	98	465	197
Inadequate Guardianship	213	121	223	117	436	238
Lack of Supervision	50	22	69	34	119	56
Lack of Medical Care	36	26	32	18	68	44
Internal Injuries	29	17	32	17	61	34
Parents Drug / Alcohol Misuse	18	11	31	20	49	31
Lacerations / Bruises / Welts	21	15	17	7	38	22
Fractures	16	12	15	8	31	20
Inadequate Food / Clothing / Shelter	9	6	12	8	21	14
Choking / Twisting / Shaking	7	6	6	4	13	10
Swelling / Dislocations / Sprains	1	1	7	4	8	5
Child's Drug / Alcohol Use	2	0	4	3	6	3
Inappropriate Custodial Conduct (IAB only)	2	1	4	1	6	2
Burns / Scalding	3	2	2	1	5	3
Excessive Corporal Punishment	4	4	-	-	4	4
Emotional Neglect	2	1	2	0	4	1
Other, specify	3	3	-	-	3	3
Sexual Abuse	1	1	2	1	3	2
Malnutrition / Failure to Thrive	2	2	1	0	3	2
Educational Neglect	1	1	1	1	2	2

National Center for Child Death Review (NCCDR) Case Reporting: An Enhanced Opportunity

As New York State increases efforts toward preventing unexplained and unexpected fatalities, the need to gather data to identify and analyze detailed trends and patterns over time has become increasingly important.

Therefore, in 2010, OCFS formally joined thirty-one other states by participating in the National Center for Child Death Review (NCCDR). The NCCDR is a National Resource Center funded by the Federal Maternal and Child Health Bureau and operated under the



Michigan Public Health Institute. The mission of NCCDR is to promote, support and enhance child death review methodology and activities at the state, community and national levels.³

Beginning in February 2010, OCFS Regional Offices and approved Child Fatality Review Teams (CFRTs) began utilizing the NCCDR Case Reporting instrument. The NCCDR Case Reporting instrument is a password-protected web-based tool that includes questions related to the child, caregivers, supervisors, circumstances of the event leading to the death and review team findings related to services and prevention. The full NCCDR Case Reporting instrument can be found in Appendix A and is available for viewing at:

<http://www.childdeathreview.org/reports/CDRCaseReportForm2-1-11009.pdf>.

All OCFS-reviewed fatalities and other unexplained/unexpected fatalities that are reviewed by OCFS-approved CFRTs are input into the NCCDR Case Reporting instrument. As of late 2010, over 100 fatalities were input into the data collection system.

³ Additional NCCDR information can be found at: www.childdeathreview.org/

The data and information collected within the NCCDR system provides NYS with the ability to identify trends that may ultimately lead to targeted prevention efforts.

For example, given that approximately 55% of OCFS-reviewed fatalities involve very young children (less than age one), and many of those fatalities occur while the child is sleeping or in a sleep related environment, focused prevention efforts could impact this issue.

The NCCDR Case Report tool (excerpt below) has the ability to capture many circumstances that relate specifically to fatalities that occur while the child is sleeping or in a sleeping environment.

H. OTHER CIRCUMSTANCES OF INCIDENT- ANSWER RELEVANT SECTIONS		
1. ANSWER THIS ONLY IF CHILD IS UNDER AGE FIVE: WAS DEATH RELATED TO SLEEPING OR THE SLEEP ENVIRONMENT? <input type="radio"/> No, go to H2 <input type="radio"/> Yes <input type="radio"/> U/K, go to H2		
a. Incident sleep place: <input type="radio"/> Crib If crib, type: <input type="radio"/> Not portable <input type="radio"/> Portable, e.g. pack-n-play <input type="radio"/> Unknown crib type <input type="radio"/> Bassinette <input type="radio"/> Adult bed <input type="radio"/> Waterbed <input type="radio"/> Playpen/other play structure but not portable crib <input type="radio"/> Couch <input type="radio"/> Chair <input type="radio"/> Floor <input type="radio"/> Car seat <input type="radio"/> Stroller <input type="radio"/> Other, specify: <input type="radio"/> U/K		b. Child put to sleep: <input type="radio"/> On back <input type="radio"/> On stomach <input type="radio"/> On side <input type="radio"/> U/K
d. Usual sleep place: <input type="radio"/> Crib If crib, type: <input type="radio"/> Not portable <input type="radio"/> Portable, e.g. pack-n-play <input type="radio"/> Unknown crib type <input type="radio"/> Bassinette <input type="radio"/> Adult bed <input type="radio"/> Waterbed <input type="radio"/> Playpen/other play structure but not portable crib <input type="radio"/> Couch <input type="radio"/> Chair <input type="radio"/> Floor <input type="radio"/> Car seat <input type="radio"/> Stroller <input type="radio"/> Other, specify: <input type="radio"/> U/K		e. Usual sleep position: <input type="radio"/> On back <input type="radio"/> On stomach <input type="radio"/> On side <input type="radio"/> U/K
g. Child in a new or different environment than usual? <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> U/K If yes, specify:		h. Child last placed to sleep with a pacifier? <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> U/K
j. Circumstances when child found: Child's airway was: <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		Child's position most relevant to death: <input type="radio"/> On top of <input type="radio"/> Under <input type="radio"/> Between <input type="radio"/> Wedged into <input type="radio"/> Pressed into <input type="radio"/> Fell or rolled onto <input type="radio"/> Tangled in <input type="radio"/> Other, specify: <input type="radio"/> U/K
k. Caregiver/supervisor fell asleep while feeding child? <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> U/K If yes, type of feeding: <input type="radio"/> Bottle <input type="radio"/> Breast <input type="radio"/> U/K		l. Child sleeping in the same room as caregiver/supervisor at time of death? <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> U/K
m. Child sleeping on same surface with person(s) or animal(s)? <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> U/K If yes, check all that apply: <input type="checkbox"/> With adult(s): # ___ <input type="checkbox"/> #U/K <input type="checkbox"/> With other children: # ___ <input type="checkbox"/> #U/K <input type="checkbox"/> With animal(s): # ___ <input type="checkbox"/> #U/K <input type="checkbox"/> U/K		With what objects or persons, check all that apply: <input type="checkbox"/> Adult(s) <input type="checkbox"/> Water bed mattress <input type="checkbox"/> Clothing <input type="checkbox"/> Child(ren) <input type="checkbox"/> Air mattress <input type="checkbox"/> Cord <input type="checkbox"/> Animal(s) <input type="checkbox"/> Bumper pads <input type="checkbox"/> Plastic bag <input type="checkbox"/> Blanket <input type="checkbox"/> Crib rail <input type="checkbox"/> Wall <input type="checkbox"/> Pillow <input type="checkbox"/> Couch <input type="checkbox"/> Other, specify: <input type="checkbox"/> Comforter <input type="checkbox"/> Chair, type: <input type="checkbox"/> Mattress <input type="checkbox"/> Car seat/stroller <input type="checkbox"/> U/K <input type="checkbox"/> Pillow-top mattress <input type="checkbox"/> Stuffed toy
i. Was a fan being used in the room at the time of death? <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> U/K If yes, type:		
c. Child found: <input type="radio"/> On back <input type="radio"/> On stomach <input type="radio"/> On side <input type="radio"/> U/K		
f. Was there a crib, bassinette or port-a-crib in home for child? <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> U/K		

The Child Fatality Report

When a child dies in circumstances described in SSL §20(5), OCFS is responsible for preparing and issuing an individual child fatality report on specific child deaths, except when a report is issued by an approved CFRT, in accordance with §422-b of the SSL. Pursuant to section 422-b(2) of the SSL, a local or regional CFRT may exercise the same authority as OCFS with regard to the preparation of a fatality report as set forth in §20(5) of the SSL. A fatality report prepared by a local or regional CFRT and approved by OCFS satisfies the obligation to prepare a fatality report as set forth in section 20(5) of the SSL.

Upon notification of a child fatality, per SSL §20(5)(b), OCFS must,

- “... (i) investigate or provide for the investigation of the cause and circumstances surrounding such death,
- (ii) review such investigation, and
- (iii) prepare and issue a report on such death, except where a report is issued by an approved local or regional fatality review team in accordance with section four hundred twenty-two-b of this chapter.”

The purpose of OCFS’s review and monitoring is to address:

- The safety and well-being of children, especially surviving siblings;
- Action to prevent similar fatalities in the future; and
- Appropriate individual and systemic accountability for child welfare actions taken prior to and subsequent to a child fatality.

In most instances, OCFS prepares and issues the required Child Fatality Report. Although Child Fatality Review Teams (CFRTs) issued only eight reports in recent years, CFRTs influence local child fatality work in several ways (See section V: Partnerships for Prevention: Child Fatality Review Teams).

Historically, the individual child fatality report format used by OCFS consisted almost entirely of narrative. This narrative format did not support the ability to aggregate data and identify common variables and risk factors with which to target prevention efforts. With the rising number of fatality reports, OCFS recognized an urgent need to collect child fatality information in a format conducive to ready analysis. Therefore, in 2010, OCFS developed an interim data collection system that would fulfill the individual child fatality and aggregate reporting requirements of SSL §20(5)(b) and complement the data gathered by the NCCDR system. This interim system was implemented while a permanent solution is being developed by OCFS’s Office of Information Technology (IT).

SSL Section 20(5)(a), OCFS shall, "... (iii) prepare and issue a report on such death, except where a report is issued by an approved local or regional fatality review team in accordance with section four hundred twenty-two-b of this chapter."

SSL Section 20(5)(b), "Such a report shall include

- (i) the cause of death, whether from natural or other causes,
- (ii) identification of child protective or other services provided or actions taken regarding such child and his or her family,
- (iii) any extraordinary or pertinent information concerning the circumstances of the child's death,
- (iv) whether the child or the child's family had received assistance, care or services from the social services district prior to the child's death,
- (v) any action or further investigation undertaken by the department or by the local social services district since the death of the child, and
- (vi) as appropriate, recommendations for local or state administrative or policy changes."

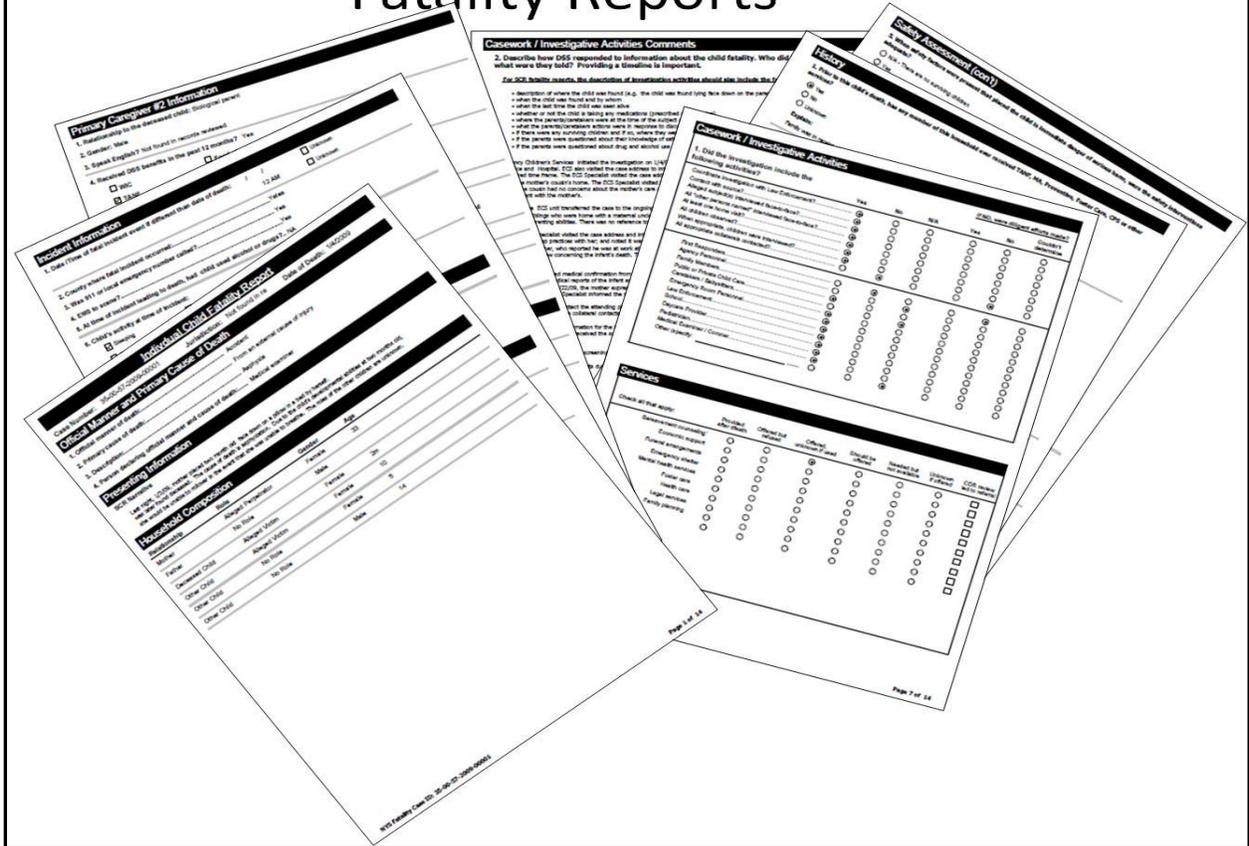
A key benefit of the interim data collection system is that it seamlessly and consistently produces the Child Fatality Report from the data and information input into the system.

Throughout the development of this interim data collection system, the report format underwent considerable changes to improve the relevancy of each report and achieve the following objectives:

- Improve consistency in Child Fatality Reports across NYS;
- Improve data documentation for better statistical analysis;
- Provide local entities with customized, local data reports;
- Improve timeliness in the issuance of Child Fatality Reports.

On the following page is a snapshot example of a revised Child Fatality Report. A complete template of the new Fatality Report can be found in Appendix B.

Revised Format for Individual Fatality Reports



Partnerships for Prevention: Child Fatality Review Teams (CFRTs)

New York State Social Services Law allows Child Fatality Review Teams (CFRTs) to be established at a local or regional level with the approval of OCFS.

According to the NCCDR, a “Child Death Review...is a process that works to understand child deaths in order to prevent harm to other children. It is a collaborative process that brings people together at a state or local level, from multiple disciplines, to share and discuss comprehensive information on the circumstances leading to the death of a child and the response to that death. These reviews can lead to action to prevent other deaths locally, at a state level and nationally.”⁴

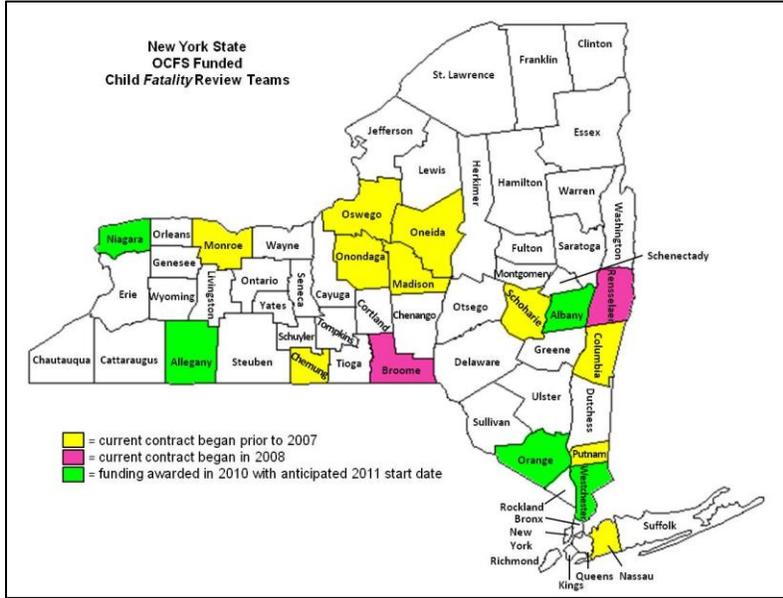
OCFS continues to develop strategies to strengthen and expand benefits of the multi-disciplinary child fatality review. As of 2007, there were nine CFRTs in New York. In 2008, OCFS awarded funds to two additional CFRTs, and five more CFRTs received funding in 2010.

OCFS Funded Child Fatality Review Teams	
County Served	Sponsoring Agency
Albany	Albany County Department of Social Services
Allegany	Southern Tier Health Care Systems, Inc.
Broome	Broome County Health Department
Chemung	Chemung County Department of Social Services
Columbia	Columbia County Department of Social Services
Monroe	Bivona Child Advocacy Center
Nassau	Nassau County Department of Health
Niagara	Niagara County Department of Social Services
Oneida/Madison	Oneida County Department of Social Services
Onondaga	Research Foundation of SUNY
Orange	Orange County Medical Examiner
Oswego	Child Advocacy Center Foundation, Inc.
Putnam	Putnam County Department of Social Services
Rensselaer	Sexual Trauma Abuse Response Team
Schoharie	Child At Risk Response Team of Schoharie County, Inc.
Westchester	Westchester County Department of Law

⁴ A Program Manual for Child Death Review; prepared by The National Center for Child Death Review and Child Death Review Leaders and Advocates throughout the U.S.; September, 2005; p. 1.

An OCFS-approved CFRT, authorized in SSL §422-b, may review the death of any child whose

care and custody or custody and guardianship has been transferred to an authorized agency, any child for whom child protective services has an open case, any child for whom the local department of social services has an open preventive services case, and any child named in a report made to the New York Statewide Central Register of Child Abuse and Maltreatment (SCR) involving the death of the child. A fatality review team may also investigate any unexplained or unexpected death of any child under the age of eighteen.



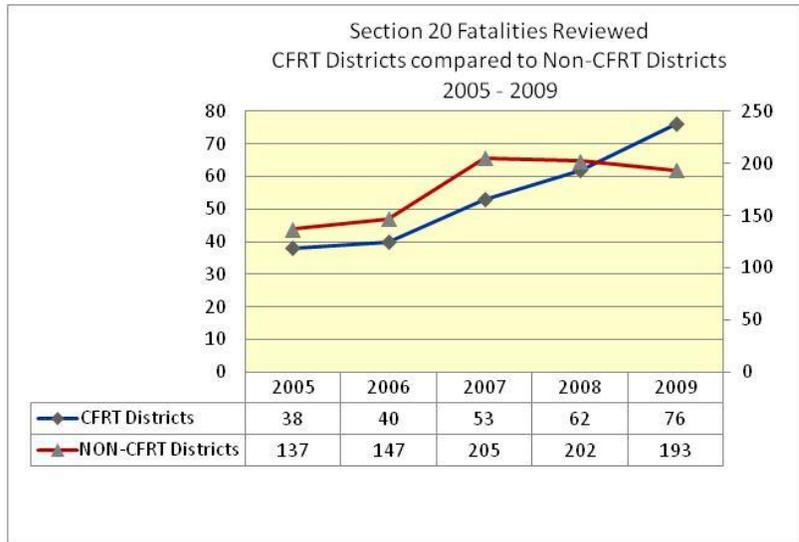
OCFS staff have worked with CFRTs in developing organizational protocols such as mission statements and goals, interagency protocols, confidentiality procedures, and meeting requirements, as required under SSL §422-b.

Data show that counties with approved CFRTs represent a growing percent of OCFS-reviewed fatalities. Statewide from 2005-2009, child fatality reporting to OCFS from non-CFRT counties increased by 41%; however, child fatality reporting to OCFS in CFRT approved counties increased by 100%.

A comprehensive, multidisciplinary review often results in the development of prevention strategies, such as public education and/or systemic improvement.

Throughout 2008-2010, approved CFRTs worked on a variety of prevention activities:

- **Columbia County CFRT:** In July 2009, the CFRT formed a Prevention Subcommittee and during that year, the CFRT prevention educator conducted twenty-eight presentations on various topics, including mandated reporting, shaken baby syndrome, sudden infant death syndrome and safe sleeping; a total of 380 individuals attended these presentations.



ATV Safety and safety for young drivers materials were developed and distributed to CFRT members to bring back to their respective agencies.

- Chemung County CFRT: At the end of 2008, the CFRT partnered with local pediatricians to participate in a “Babies Sleep Safest Alone” campaign. Components of this campaign included: issuing a press release, obtaining media coverage and distributing posters in the community and through the Child Advocacy Center. In 2010, the CFRT joined an existing local suicide prevention initiative. Chemung County CFRT also issued a press release warning of the risks of heatstroke for children left alone in cars.
- Monroe County CFRT: During its first contract year, 2009-2010, the Bivona CFRT launched a Safe Sleep campaign, which included the formation of a local Safe Sleep Coalition. This initiative began after statistics from the previous three years revealed that many infants in Monroe County were dying in unsafe sleep situations. One first step of the Safe Sleep campaign was to share the data and information with over 100 local professionals so that they could, in turn, join in educating parents. In January 2010, this CFRT organized a Safe Sleep mini-conference, which was attended by child welfare professionals and other service providers within the Monroe County area.
- Nassau County CFRT: In 2009, a Safe Sleep informational brochure was distributed to parents of all newborns in the county. Additional prevention information has been distributed on subjects such as water safety, choking prevention and suicide prevention.
- Oneida/Madison Counties CFRT: In 2009, Safe Sleep was a focus for both the Oneida County and Madison County CFRTs. Oneida County distributed cribs as part of its safe sleep initiative. At the end of 2009, the Oneida CFRT produced a public service announcement, in conjunction with a local television station, on child safety seats. The Madison CFRT produced a public service flier entitled “Children Aren’t Waterproof” on the subject of bath safety.
- Onondaga County CFRT: The CFRT began a Safe Sleep initiative in early 2009, based on the increasing number of unsafe sleep situations in 2008. As a result, during 2009, public information about Safe Sleep was posted on roadway billboards. Information was also distributed to health care providers, day care centers and other agencies where infants and families are served. The CFRT Coordinator provided educational outreach to child welfare and other service agencies in 2010 on the subjects of Car Seat Safety and Water Safety.
- Oswego County CFRT: In 2009, the Oswego County CFRT entered into a contract to provide mock motor vehicle accident simulations in county high schools. The program has been well-received and has resulted in many more students signing up for alcohol-free after-prom parties. Additionally, CFRT members partner with a local police department for an annual bicycle safety “Rodeo” event, which teaches bike safety, does bike inspections and distributes free helmets to children. Throughout 2008-2010, the CFRT also partnered with the local hospital to provide and distribute prevention materials regarding Shaken Baby and Safe Sleep.
- Putnam County CFRT: In 2009, the team entered into a contract with its local Health Department to deliver the “Conscious Fathering” program to new and expectant fathers. This program focuses on overall child safety, with an emphasis on the prevention of physical abuse. Safe Sleep is a component of the program. In 2010, the team distributed

information on two important issues: summer water safety and the potential dangers of using sleep positioners when an infant is sleeping.

- Schoharie County CFRT: In 2009, the team joined with the Schoharie County Suicide Prevention Task Force. During 2010, a summer prevention campaign was implemented, and included such topics as: hyperthermia when children are left alone in cars, pool safety, bicycle safety, and how to avoid heatstroke.
- Rensselaer County CFRT: There is a long history of prevention activities with this team, as it has been in existence for a decade. During 2008-2010, the team distributed safe sleep materials. Mandated reporter training is done by the team coordinator. Resource cards were made for CPS workers and first responders in the field who respond to serious injury/fatality cases. These activities were an effort to improve reporting and overall investigations. The CAC/CFRT is now a “Cribs for Kids” partner.

Partnerships for Prevention: NYS Office of Children & Family Services & Department of Health

In 2010, DOH awarded funds to the Research Foundation of SUNY and the School of Social Welfare at Stony Brook University to administer the NYS Center for Sudden Infant Death (NYS Center for SID). A key goal of this initiative is to assist OCFS and DOH in expanding and improving the quality of the child fatality review process. Guidance to this initiative is provided jointly by DOH and OCFS.

OCFS and DOH, along with the NYS Center for SID, are working to complete the following goals:

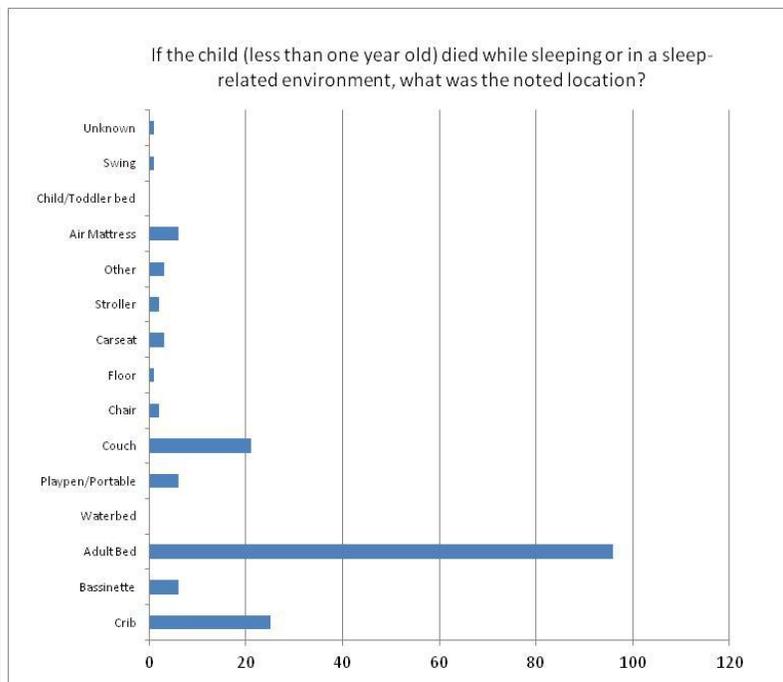
- Increase the number of approved CFRTs;
- Increase the types of fatalities reviewed by approved CFRTs to include all unexpected/unexplained child fatalities;
- Improve effectiveness of CFRTs through quality improvement process;
- Improve local and statewide knowledge base of risk factors that may contribute to child fatalities; and
- Increase distribution of safe sleep information to a broad audience.

Prevention Education and Awareness: Targeting Prevention Efforts to the Youngest Children

Infants less than one year old remain the most at-risk population, representing slightly more than half (55%) of all OCFS-reviewed fatalities. Using combined data from the OCFS interim database system and NCCDR, NYS has implemented concrete processes to collect detailed information related to the cause and circumstances of each OCFS and CFRT-reviewed fatality. This detailed information will, in turn, inform prevention and risk reduction activities across NYS.

Preliminary data tell us that of the 293 infants in OCFS-reviewed fatalities in 2008 and 2009, 173 of those infants died while the child was sleeping or in a sleeping environment, and over half of those children were in an adult bed and may or may not have been bed-sharing.

If the child died while sleeping or in a sleeping environment, what was the location?	Count	Percent
Crib	25	14%
Bassinet	6	3%
Adult Bed	96	55%
Waterbed	0	0%
Playpen/ Portable	6	3%
Couch	21	12%
Chair	2	1%
Floor	1	1%
Carseat	3	2%
Stroller	2	1%
Other	3	2%
Air Mattress	6	3%
Child/ Toddler bed	0	0%
Swing	1	1%
Unknown	1	1%
Total:	173	



Caution should be used in the interpretation of this data. Note that this data does not imply a causal relationship. Although a large majority of infants who die in a sleeping environment are in an adult bed, research indicates that often multiple risk factors are present.

A 2010 OCFS Local Commissioners Memorandum (10-OCFS-LCM-15) titled “Guidance for CPS Investigations of Infant Fatalities and Injuries Involving Unsafe Sleeping Conditions” cites a study published in 2010⁵ that examined 251 SIDS cases in New Jersey and found that 244 of those deaths were associated with one or more risk factors, with only 44 having a single risk

⁵ Barbara M. Ostfeld, Linda Esposito, Harold Perl and Thomas Hegyi; Concurrent Risks in Sudden Infant Death Syndrome, *Pediatrics* 2010; 125, 447-453.

factor. The study identified the percentage of times that each of the following risk factors were associated with the deaths:

- Not placed on back: 70%
- Smoking by one or both parents: 60%
- Upper respiratory infection: 44%
- Bed-sharing: 39%
- Scene risks (for example, use of soft bedding or presence of other children): 31%
- Under 37 week gestational age: 27%

This retrospective review of 244 New Jersey SIDS cases concluded that the presence of a single risk factor is rare, and most of the fatalities reviewed contained multiple risk factors.

Consequently, parent education in New York State should comprehensively address multiple risk factors.

Public Education and Awareness

In recent years, OCFS, DOH, CFRTs, and several organizations have engaged in initiatives to prevent future fatalities. A significant number of strategies have focused on reducing the risks associated with sleep-related fatalities. Several examples are listed below:

New York Loves Safe Babies Campaign

Led by OCFS, this group includes DOH, NYS Center for SIDS, Office of Temporary and Disability Assistance, Healthy Families New York and several community-based organizations that work with families of young children. This group has engaged in efforts that incorporate the concept of safe sleep environments and cultural competency.

In 2008, the Babies Sleep Safest Alone initiative was launched through the distribution of 200,000 brochures and posters to a broad audience ranging from hospitals to the general public. In 2009 and 2010, over 235,000 additional publications were sent to family-serving programs, individuals, county government, health care providers and other organizations. The publications come in a variety of formats such as brochures, tip sheets and memo boards. All materials are available in both English and Spanish; some are available in other languages as well. Materials may be ordered using the order form found in Appendix C or they may be downloaded and ordered on the OCFS website at: <https://www.ocfs.state.ny.us/main/babiesform.htm>

Materials that are available include:

- Helpful Tips to Keep Your Baby Safe (tip sheets)
 - Safe to Sleep
 - Sudden Infant Death Syndrome (SIDS)
 - Traumatic Brain Injury (TBI)
 - Shaken Baby Syndrome (SBS)

- Safe at Play
- In or Around Vehicles
- Keeping Sleeping Babies Safer brochure
- Personalized Safety Tips and Emergency Contact Sheet for Baby Sitters
- “Helpful Strategies for Keeping Infants and Young Children Safe” DVD

New York State Shaken Baby Prevention Program

With funding from the William B. Hoyt Memorial Trust Fund, OCFS partnered with DOH to combine two highly successful shaken baby syndrome (SBS) hospital-based education programs in order to expand outreach to all maternity and birthing hospitals in the state. The successful NYS Shaken Baby Prevention Program, initiated by Western New York’s Kaleida Health, expanded in 2008 to bring this hospital-based education program to all maternity and birthing hospitals throughout the state. With close to 250,000 live births each year, approximately 90% of live births are expected to be reached annually through this educational program. A New York Shaken Baby Prevention Program brochure was developed by the Trust Fund programs for dissemination to the hospitals. The original sites - Western New York, Finger Lakes and Hudson Valley regions - are continuing to research and evaluate the incidence of SBS in their areas.

OCFS: Enhanced Guidance to Caseworkers

Child welfare workers have significant opportunities to interact with the families they serve. Their duties involve the direct observation of families and their home environments. They are in a unique position to identify families that may be providing unsafe sleep conditions for their children, including infants, to provide information on sleep safety to the parents and caretakers of infants and parents-to-be whom they encounter and to see that parents and caretakers take the steps necessary to provide safe sleeping conditions for the children in their care.

In November 2010, OCFS issued a Local Commissioner’s Memorandum (LCM) 10-OCFS-LCM-15, “Guidance for CPS Investigations of Infant Fatalities and Injuries Involving Unsafe Sleeping Conditions.” This LCM focused on the actions taken by CPS staff in investigating reports of deaths or serious injuries made to the SCR involving a sleep-related condition.

In March 2010, OCFS produced a teleconference for local district and voluntary agency staff on the importance of safe sleep environments, entitled “Safe Sleeping Practices for Infants and Young Children.” The teleconference also offered strategies for caseworkers to provide information to parents and other caretakers regarding sleep-related risks and the steps that can be taken to lessen or remove those risks.



Understanding How
and Why Children Die
& Taking Actions to
Prevent Child Deaths

Child Death Review Case Reporting System

Case Report 2.2

Effective January 2011

Instructions:

This case report is a component of the web-based CDR Case Reporting System. It can be used alone as a paper instrument, but its full potential is reached when the data from this form is entered into the *CDR Case Reporting System*. This system is available to states from the National Center for Child Death Review and requires a data use agreement for state and local data entry. System functions include data entry, case report editing and printing, data download and standardized reports.

The purpose of this form is to collect comprehensive information from multiple agencies participating in a child death review. The form documents the circumstances involved in the death, investigative actions, services provided or needed, key risk factors and actions recommended and/or taken by the CDR team to prevent other deaths.

While this data collection form is an important part of the child death review process, the form should not be the central focus of the review meeting. Experienced users have found that it works best to assign a person to record data while the team discussions are occurring. Persons should not attempt to answer every single question in a step by step manner as part of the team discussion. The form can be partially filled out before a meeting.

It is not expected that teams will have answers to all of the questions related to a death. However, over time teams begin understanding the importance of data collection and bring necessary information to the meeting. They find that the percentage of unknowns and unanswered questions decreases as the team becomes more familiar with the form.

The form contains three types of questions: (1) Those that users should only select one response as represented by a circle; (2) Those in which users can select several responses as represented by a square; and (3) Those in which users enter text. This last type is depicted by 'specify' or 'describe'.

Most questions have a selection for unknown (U/K). A question should be marked 'unknown' if an attempt was made to find the answer, but no clear or satisfactory response was obtained; questions should be left blank (unanswered) if no attempt was made to find the answer. 'N/A' stands for 'Not Applicable' and should be used if the question is not applicable. For example, use N/A for 'level of education' if child is an infant.

This edition is Version 2.2, effective January 2011. Additional paper forms can be ordered from the National Center at no charge. Users interested in participating in the web-based case reporting system for data entry and reporting should contact the National Center for Child Death Review.

Phone: 1-800-656-2434 Email: info@childdeathreview.org Website: www.childdeathreview.org Data entry website: <https://cdrdata.org/>

This form was developed by a work group of over 26 persons, representing 18 states and the Maternal and Child Bureau of HRSA/HHS.

Copyright: National Center for Child Death Review Policy and Practice, January 2011

CASE NUMBER

_____ / _____ / _____ State / County or Team Number / Year of Review / Sequence of Review	Death Certificate Number: Birth Certificate Number: ME/Coroner Number:	Case Type: <input type="radio"/> Death <input type="radio"/> Near death/serious Injury <input type="radio"/> Not born alive
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A. CHILD INFORMATION

1. Child's name: First: _____ Middle: _____ Last: _____ <input type="checkbox"/> U/K																													
2. Date of birth: <input type="checkbox"/> U/K	3. Date of death: <input type="checkbox"/> U/K	4. Age: <input type="radio"/> Years <input type="radio"/> Months <input type="radio"/> Days <input type="radio"/> Hours <input type="radio"/> Minutes <input type="radio"/> U/K	5. Race, check all that apply: <input type="checkbox"/> U/K <input type="checkbox"/> White <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> Black <input type="checkbox"/> Pacific Islander <input type="checkbox"/> Asian, specify: <input type="checkbox"/> American Indian, Tribe: <input type="checkbox"/> Alaskan Native, Tribe:	6. Hispanic or Latino origin? <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> U/K	7. Sex: <input type="radio"/> Male <input type="radio"/> Female <input type="radio"/> U/K																								
8. Residence address: <input type="checkbox"/> U/K Street: _____ Apt. _____ City: _____ County: _____ State: _____ Zip: _____			9. Type of residence: <input type="radio"/> Parental home <input type="radio"/> Relative home <input type="radio"/> Jail/Detention <input type="radio"/> Licensed group home <input type="radio"/> Living on own <input type="radio"/> Other, specify: <input type="radio"/> Licensed foster home <input type="radio"/> Shelter <input type="radio"/> Relative foster home <input type="radio"/> Homeless <input type="radio"/> U/K		10. New residence in past 30 days? <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> U/K																								
11. Residence overcrowded? <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> U/K	12. Child ever homeless? <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> U/K	13. Number of other children living with child: _____ <input type="checkbox"/> U/K	14. Child's weight: <input type="checkbox"/> U/K _____ pounds _____ ounces	15. Child's height: <input type="checkbox"/> U/K _____ / _____ feet inches																									
16. Highest education level: <input type="radio"/> N/A <input type="radio"/> Drop out <input type="radio"/> None <input type="radio"/> HS graduate <input type="radio"/> Preschool <input type="radio"/> College <input type="radio"/> Grade K-8 <input type="radio"/> Other, specify: <input type="radio"/> Grade 9-12 <input type="radio"/> U/K <input type="radio"/> Home schooled, K-8 <input type="radio"/> Home schooled, 9-12		17. Child's work status: <input type="radio"/> N/A <input type="radio"/> Employed <input type="radio"/> Full time <input type="radio"/> Part time <input type="radio"/> U/K <input type="radio"/> Not working <input type="radio"/> U/K	18. Did child have problems in school? <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> U/K If yes, check all that apply: <input type="checkbox"/> Academic <input type="checkbox"/> Behavioral <input type="checkbox"/> Truancy <input type="checkbox"/> Expulsion <input type="checkbox"/> Suspensions <input type="checkbox"/> U/K <input type="checkbox"/> Other, specify:		19. Child's health insurance, check all that apply: <input type="checkbox"/> None <input type="checkbox"/> Private <input type="checkbox"/> Medicaid <input type="checkbox"/> State plan <input type="checkbox"/> Other, specify: <input type="checkbox"/> U/K																								
20. Child had disability or chronic illness? <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> U/K If yes, check all that apply: <input type="checkbox"/> Physical, specify: <input type="checkbox"/> Mental, specify: <input type="checkbox"/> Sensory, specify: <input type="checkbox"/> U/K If yes, was child receiving Children's Special Health Care Needs services? <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> U/K		21. Child's mental health (MH): Child had received prior MH services? <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> U/K Child was receiving MH services? <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> U/K Child on medications for MH illness? <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> U/K Issues prevented child from receiving MH services? <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> U/K If yes, specify:		22. Child had history of substance abuse? <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> U/K If yes, check all that apply: <input type="checkbox"/> Alcohol <input type="checkbox"/> Other, specify: <input type="checkbox"/> Cocaine <input type="checkbox"/> Marijuana <input type="checkbox"/> U/K <input type="checkbox"/> Methamphetamine <input type="checkbox"/> Opiates <input type="checkbox"/> Prescription drugs <input type="checkbox"/> Over-the-counter drugs																									
23. Child had history of child maltreatment? If yes, check all that apply: <table style="width:100%; border-collapse: collapse;"> <tr> <td style="width:25%;"><u>As Victim</u></td> <td style="width:25%;"><u>As Perpetrator</u></td> <td style="width:25%;"><u>As Victim</u></td> <td style="width:25%;"><u>As Perpetrator</u></td> </tr> <tr> <td><input type="radio"/> N/A</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/> Physical</td> </tr> <tr> <td><input type="radio"/> No</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/> Neglect</td> </tr> <tr> <td><input type="radio"/> Yes</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/> Sexual</td> </tr> <tr> <td><input type="radio"/> U/K</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/> Emotional/psychological</td> </tr> <tr> <td></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/> U/K</td> </tr> </table> If yes, how was history identified: <input type="radio"/> Through CPS _____ # CPS referrals <input type="radio"/> Other sources _____ # Substantiations				<u>As Victim</u>	<u>As Perpetrator</u>	<u>As Victim</u>	<u>As Perpetrator</u>	<input type="radio"/> N/A	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Physical	<input type="radio"/> No	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Neglect	<input type="radio"/> Yes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Sexual	<input type="radio"/> U/K	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Emotional/psychological		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> U/K	24. Was there an open CPS case with child at time of death? <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> U/K	27. Child had history of intimate partner violence? Check all that apply: <input type="checkbox"/> N/A <input type="checkbox"/> No <input type="checkbox"/> Yes, as victim <input type="checkbox"/> Yes, as perpetrator <input type="checkbox"/> U/K
<u>As Victim</u>	<u>As Perpetrator</u>	<u>As Victim</u>	<u>As Perpetrator</u>																										
<input type="radio"/> N/A	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Physical																										
<input type="radio"/> No	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Neglect																										
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<input type="radio"/> U/K	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Emotional/psychological																										
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> U/K																										
				25. Was child ever placed outside of the home prior to the death? <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> U/K																									
				26. Were any siblings placed outside of the home prior to this child's death? <input type="radio"/> No <input type="radio"/> Yes, # _____ <input type="radio"/> U/K																									
28. Child had delinquent or criminal history? <input type="radio"/> N/A <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> U/K If yes, check all that apply: <input type="checkbox"/> Assaults <input type="checkbox"/> Other, specify: <input type="checkbox"/> Robbery <input type="checkbox"/> Drugs <input type="checkbox"/> U/K		29. Child spent time in juvenile detention? <input type="radio"/> N/A <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> U/K		32. If child over age 12, what was child's gender identity? <input type="radio"/> Male <input type="radio"/> Female <input type="radio"/> U/K																									
		30. Child acutely ill during the two weeks before death? <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> U/K																											
		31. Are child's parents first generation immigrants? <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> U/K If yes, country of origin:		33. If child over age 12, what was child's sexual orientation? <input type="radio"/> Heterosexual <input type="radio"/> Bisexual <input type="radio"/> Gay <input type="radio"/> Questioning <input type="radio"/> Lesbian <input type="radio"/> U/K																									

COMPLETE FOR ALL INFANTS UNDER ONE YEAR

34. Gestational age: <input type="checkbox"/> U/K _____ # weeks	35. Birth weight: <input type="checkbox"/> U/K <input type="radio"/> Grams _____ <input type="radio"/> Pounds/ounces _____/_____	36. Multiple birth? <input type="radio"/> No <input type="radio"/> U/K <input type="radio"/> Yes, # _____	37. Prenatal care provided during pregnancy of deceased infant? <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> U/K If yes, number of prenatal visits: # _____ <input type="checkbox"/> U/K If yes, month of 1st prenatal visit? Specify 1-9 _____ <input type="checkbox"/> U/K
--	--	---	--

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

Have medical complications/infections? Check all that apply:

<input type="checkbox"/> Acute/Chronic Lung Disease	<input type="checkbox"/> Eclampsia	<input type="checkbox"/> Low MSAFP	<input type="checkbox"/> PROM
<input type="checkbox"/> Anemia	<input type="checkbox"/> Genital Herpes	<input type="checkbox"/> Other Infectious Disease	<input type="checkbox"/> Renal Disease
<input type="checkbox"/> Cardiac Disease	<input type="checkbox"/> Hemoglobinopathy	<input type="checkbox"/> Pregnancy-Related Hypertension	<input type="checkbox"/> Rh Sensitization
<input type="checkbox"/> Chorioamnionitis	<input type="checkbox"/> High MSAFP	<input type="checkbox"/> Preterm Labor	<input type="checkbox"/> Uterine Bleeding
<input type="checkbox"/> Chronic Hypertension	<input type="checkbox"/> Hydramnios/Oligohydramnios	<input type="checkbox"/> Previous Infant 4000+ Grams	<input type="checkbox"/> Other, specify:
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Incompetent Cervix	<input type="checkbox"/> Previous Infant Preterm/Small for Gestation	

Smoke tobacco?
 Use illicit drugs?
 Have heavy alcohol use?
 Misuse over-the-counter or prescription drugs?

Experience intimate partner violence?
 Infant born drug exposed?
 Infant born with fetal alcohol effects or syndrome?

39. Were there access or compliance issues related to prenatal care?

<input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> U/K If yes, check all that apply:	<input type="checkbox"/> Lack of money for care <input type="checkbox"/> Limitations of health insurance coverage <input type="checkbox"/> Multiple health insurance, not coordinated <input type="checkbox"/> Lack of transportation <input type="checkbox"/> No phone <input type="checkbox"/> Cultural differences	<input type="checkbox"/> Religious objections to care <input type="checkbox"/> Language barriers <input type="checkbox"/> Referrals not made <input type="checkbox"/> Specialist needed, not available <input type="checkbox"/> Multiple providers, not coordinated <input type="checkbox"/> Lack of child care	<input type="checkbox"/> Lack of family/social support <input type="checkbox"/> Services not available <input type="checkbox"/> Distrust of health care system <input type="checkbox"/> Unwilling to obtain care <input type="checkbox"/> Intimate partner would not allow care <input type="checkbox"/> Other, specify:	<input type="checkbox"/> U/K
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B. PRIMARY CAREGIVER(S) INFORMATION

1. Primary caregiver(s): Select only one per column. <table style="width:100%;"> <tr> <th style="text-align: left;"><u>One</u></th> <th style="text-align: left;"><u>Two</u></th> </tr> <tr> <td><input type="radio"/> Self, go to Section C</td> <td></td> </tr> <tr> <td><input type="radio"/> <input type="radio"/> Biological parent</td> <td></td> </tr> <tr> <td><input type="radio"/> <input type="radio"/> Adoptive parent</td> <td></td> </tr> <tr> <td><input type="radio"/> <input type="radio"/> Stepparent</td> <td></td> </tr> <tr> <td><input type="radio"/> <input type="radio"/> Foster parent</td> <td></td> </tr> <tr> <td><input type="radio"/> <input type="radio"/> Mother's partner</td> <td></td> </tr> <tr> <td><input type="radio"/> <input type="radio"/> Father's partner</td> <td></td> </tr> <tr> <td><input type="radio"/> <input type="radio"/> Grandparent</td> <td></td> </tr> <tr> <td><input type="radio"/> <input type="radio"/> Sibling</td> <td></td> </tr> <tr> <td><input type="radio"/> <input type="radio"/> Other relative</td> <td></td> </tr> <tr> <td><input type="radio"/> <input type="radio"/> Friend</td> <td></td> </tr> <tr> <td><input type="radio"/> <input type="radio"/> Institutional staff</td> <td></td> </tr> <tr> <td><input type="radio"/> <input type="radio"/> Other, specify:</td> <td></td> </tr> <tr> <td><input type="radio"/> <input type="radio"/> U/K</td> <td></td> </tr> </table>	<u>One</u>	<u>Two</u>	<input type="radio"/> Self, go to Section C		<input type="radio"/> <input type="radio"/> Biological parent		<input type="radio"/> <input type="radio"/> Adoptive parent		<input type="radio"/> <input type="radio"/> Stepparent		<input type="radio"/> <input type="radio"/> Foster parent		<input type="radio"/> <input type="radio"/> Mother's partner		<input type="radio"/> <input type="radio"/> Father's partner		<input type="radio"/> <input type="radio"/> Grandparent		<input type="radio"/> <input type="radio"/> Sibling		<input type="radio"/> <input type="radio"/> Other relative		<input type="radio"/> <input type="radio"/> Friend		<input type="radio"/> <input type="radio"/> Institutional staff		<input type="radio"/> <input type="radio"/> Other, specify:		<input type="radio"/> <input type="radio"/> U/K		2. Caregiver(s) age in years: <table style="width:100%;"> <tr> <th style="text-align: left;"><u>One</u></th> <th style="text-align: left;"><u>Two</u></th> </tr> <tr> <td>_____</td> <td>_____</td> </tr> <tr> <td colspan="2" style="text-align: center;"># Years</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td colspan="2" style="text-align: center;">U/K</td> </tr> </table> 3. Caregiver(s) sex: <table style="width:100%;"> <tr> <th style="text-align: left;"><u>One</u></th> <th style="text-align: left;"><u>Two</u></th> </tr> <tr> <td><input type="radio"/> Male</td> <td><input type="radio"/></td> </tr> <tr> <td><input type="radio"/> Female</td> <td><input type="radio"/></td> </tr> <tr> <td><input type="radio"/> U/K</td> <td><input type="radio"/></td> </tr> </table>	<u>One</u>	<u>Two</u>	_____	_____	# Years		<input type="checkbox"/>	<input type="checkbox"/>	U/K		<u>One</u>	<u>Two</u>	<input type="radio"/> Male	<input type="radio"/>	<input type="radio"/> Female	<input type="radio"/>	<input type="radio"/> U/K	<input type="radio"/>	4. Caregiver(s) employment status: <table style="width:100%;"> <tr> <th style="text-align: left;"><u>One</u></th> <th style="text-align: left;"><u>Two</u></th> </tr> <tr> <td><input type="radio"/> Employed</td> <td><input type="radio"/></td> </tr> <tr> <td><input type="radio"/> Unemployed</td> <td><input type="radio"/></td> </tr> <tr> <td><input type="radio"/> On disability</td> <td><input type="radio"/></td> </tr> <tr> <td><input type="radio"/> Stay-at-home</td> <td><input type="radio"/></td> </tr> <tr> <td><input type="radio"/> Retired</td> <td><input type="radio"/></td> </tr> <tr> <td><input type="radio"/> U/K</td> <td><input type="radio"/></td> </tr> </table>	<u>One</u>	<u>Two</u>	<input type="radio"/> Employed	<input type="radio"/>	<input type="radio"/> Unemployed	<input type="radio"/>	<input type="radio"/> On disability	<input type="radio"/>	<input type="radio"/> Stay-at-home	<input type="radio"/>	<input type="radio"/> Retired	<input type="radio"/>	<input type="radio"/> U/K	<input type="radio"/>	5. 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7. Does caregiver(s) speak English? <table style="width:100%;"> <tr> <th style="text-align: left;"><u>One</u></th> <th style="text-align: left;"><u>Two</u></th> </tr> <tr> <td><input type="radio"/> No</td> <td><input type="radio"/></td> </tr> <tr> <td><input type="radio"/> Yes</td> <td><input type="radio"/></td> </tr> <tr> <td><input type="radio"/> U/K</td> <td><input type="radio"/></td> </tr> </table> If no, language spoken: _____	<u>One</u>	<u>Two</u>	<input type="radio"/> No	<input type="radio"/>	<input type="radio"/> Yes	<input type="radio"/>	<input type="radio"/> U/K	<input type="radio"/>	8. Caregiver(s) on active military duty? <table style="width:100%;"> <tr> <th style="text-align: left;"><u>One</u></th> <th style="text-align: left;"><u>Two</u></th> </tr> <tr> <td><input type="radio"/> No</td> <td><input type="radio"/></td> </tr> <tr> <td><input type="radio"/> Yes</td> <td><input type="radio"/></td> </tr> <tr> <td><input type="radio"/> U/K</td> <td><input type="radio"/></td> </tr> </table> If yes, specify branch: _____	<u>One</u>	<u>Two</u>	<input type="radio"/> No	<input type="radio"/>	<input type="radio"/> Yes	<input type="radio"/>	<input type="radio"/> U/K	<input type="radio"/>	9. Caregiver(s) received social services in the past twelve months? <table style="width:100%;"> <tr> <th style="text-align: left;"><u>One</u></th> <th style="text-align: left;"><u>Two</u></th> </tr> <tr> <td><input type="radio"/> No</td> <td><input type="radio"/></td> </tr> <tr> <td><input type="radio"/> Yes</td> <td><input type="radio"/></td> </tr> <tr> <td><input type="radio"/> U/K</td> <td><input type="radio"/></td> </tr> </table> If yes, check all that apply: <table style="width:100%;"> <tr> <th style="text-align: left;"><u>One</u></th> <th style="text-align: left;"><u>Two</u></th> </tr> <tr> <td><input type="checkbox"/> WIC</td> <td><input type="checkbox"/></td> </tr> <tr> <td><input type="checkbox"/> TANF</td> <td><input type="checkbox"/></td> </tr> <tr> <td><input type="checkbox"/> Medicaid</td> <td><input type="checkbox"/></td> </tr> <tr> <td><input type="checkbox"/> Food stamps</td> <td><input type="checkbox"/></td> </tr> <tr> <td><input type="checkbox"/> Other, specify:</td> <td></td> </tr> </table>	<u>One</u>	<u>Two</u>	<input type="radio"/> No	<input type="radio"/>	<input type="radio"/> Yes	<input type="radio"/>	<input type="radio"/> U/K	<input type="radio"/>	<u>One</u>	<u>Two</u>	<input type="checkbox"/> WIC	<input type="checkbox"/>	<input type="checkbox"/> TANF	<input type="checkbox"/>	<input type="checkbox"/> Medicaid	<input type="checkbox"/>	<input type="checkbox"/> Food stamps	<input type="checkbox"/>	<input type="checkbox"/> Other, specify:																																																			
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10. Caregiver(s) have substance abuse history? <table style="width:100%;"> <tr> <th style="text-align: left;"><u>One</u></th> <th style="text-align: left;"><u>Two</u></th> </tr> <tr> <td><input type="radio"/> No</td> <td><input type="radio"/></td> </tr> <tr> <td><input type="radio"/> Yes</td> <td><input type="radio"/></td> </tr> <tr> <td><input type="radio"/> U/K</td> <td><input type="radio"/></td> </tr> </table> If yes, check all that apply: <input type="checkbox"/> Alcohol <input type="checkbox"/> Cocaine <input type="checkbox"/> Marijuana <input type="checkbox"/> Methamphetamine <input type="checkbox"/> Opiates <input type="checkbox"/> Prescription drugs <input type="checkbox"/> Over-the-counter <input type="checkbox"/> Other, specify: <input type="checkbox"/> U/K	<u>One</u>	<u>Two</u>	<input type="radio"/> No	<input type="radio"/>	<input type="radio"/> Yes	<input type="radio"/>	<input type="radio"/> U/K	<input type="radio"/>	11. Caregiver(s) have history of child maltreatment as victim? <table style="width:100%;"> <tr> <th style="text-align: left;"><u>One</u></th> <th style="text-align: left;"><u>Two</u></th> </tr> <tr> <td><input type="radio"/> No</td> <td><input type="radio"/></td> </tr> <tr> <td><input type="radio"/> Yes</td> <td><input type="radio"/></td> </tr> <tr> <td><input type="radio"/> U/K</td> <td><input type="radio"/></td> </tr> </table> If yes, check all that apply: <input type="checkbox"/> Physical <input type="checkbox"/> Neglect <input type="checkbox"/> Sexual <input type="checkbox"/> Emotional/psychological <input type="checkbox"/> U/K _____ # CPS referrals _____ # Substantiations <input type="checkbox"/> Ever in foster care or adopted?	<u>One</u>	<u>Two</u>	<input type="radio"/> No	<input type="radio"/>	<input type="radio"/> Yes	<input type="radio"/>	<input type="radio"/> U/K	<input type="radio"/>	12. Caregiver(s) have history of child maltreatment as a perpetrator? <table style="width:100%;"> <tr> <th style="text-align: left;"><u>One</u></th> <th style="text-align: left;"><u>Two</u></th> </tr> <tr> <td><input type="radio"/> No</td> <td><input type="radio"/></td> </tr> <tr> <td><input type="radio"/> Yes</td> <td><input type="radio"/></td> </tr> <tr> <td><input type="radio"/> U/K</td> <td><input type="radio"/></td> </tr> </table> If yes, check all that apply: <input type="checkbox"/> Physical <input type="checkbox"/> Neglect <input type="checkbox"/> Sexual <input type="checkbox"/> Emotional/psychological <input type="checkbox"/> U/K _____ # CPS referrals _____ # Substantiations <input type="checkbox"/> CPS prevention services? <input type="checkbox"/> Family Preservation services? <input type="checkbox"/> Children ever removed?	<u>One</u>	<u>Two</u>	<input type="radio"/> No	<input type="radio"/>	<input type="radio"/> Yes	<input type="radio"/>	<input type="radio"/> U/K	<input type="radio"/>	13. Caregiver(s) have disability or chronic illness? <table style="width:100%;"> <tr> <th style="text-align: left;"><u>One</u></th> <th style="text-align: left;"><u>Two</u></th> </tr> <tr> <td><input type="radio"/> No</td> <td><input type="radio"/></td> </tr> <tr> <td><input type="radio"/> Yes</td> <td><input type="radio"/></td> </tr> <tr> <td><input type="radio"/> U/K</td> <td><input type="radio"/></td> </tr> </table> If yes, check all that apply: <input type="checkbox"/> Physical, specify: <input type="checkbox"/> Mental, specify: <input type="checkbox"/> Sensory, specify: <input type="checkbox"/> U/K If mental, was caregiver receiving services? <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> U/K	<u>One</u>	<u>Two</u>	<input type="radio"/> No	<input type="radio"/>	<input type="radio"/> Yes	<input type="radio"/>	<input type="radio"/> U/K	<input type="radio"/>
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<p>14. Caregiver(s) have prior child deaths?</p> <p><u>One</u> <u>Two</u></p> <p><input type="radio"/> No</p> <p><input type="radio"/> Yes</p> <p><input type="radio"/> U/K</p>	<p>If yes, cause(s): Check all that apply:</p> <p><u>One</u> <u>Two</u></p> <p><input type="checkbox"/> Child abuse # _____</p> <p><input type="checkbox"/> Child neglect # _____</p> <p><input type="checkbox"/> Accident # _____</p> <p><input type="checkbox"/> Suicide # _____</p> <p><input type="checkbox"/> SIDS # _____</p> <p><input type="checkbox"/> Other # _____</p> <p>Other, specify:</p> <p><input type="checkbox"/> U/K</p>	<p>15. Caregiver(s) have history of intimate partner violence?</p> <p><u>One</u> <u>Two</u></p> <p><input type="checkbox"/> No</p> <p><input type="checkbox"/> Yes, as victim</p> <p><input type="checkbox"/> Yes, as perpetrator</p> <p><input type="checkbox"/> U/K</p>	<p>16. Caregiver(s) have delinquent/criminal history?</p> <p><u>One</u> <u>Two</u></p> <p><input type="radio"/> No</p> <p><input type="radio"/> Yes</p> <p><input type="radio"/> U/K</p> <p>If yes, check all that apply:</p> <p><input type="checkbox"/> Assaults</p> <p><input type="checkbox"/> Robbery</p> <p><input type="checkbox"/> Drugs</p> <p><input type="checkbox"/> Other, specify:</p> <p><input type="checkbox"/> U/K</p>
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C. SUPERVISOR INFORMATION

<p>1. Did child have supervision at time of incident leading to death?</p> <p><input type="radio"/> No, not needed given developmental age or circumstances, go to Sect. D</p> <p><input type="radio"/> No, but needed, answer 3-15</p> <p><input type="radio"/> Yes, answer 2-15</p> <p><input type="radio"/> Unable to determine, try to answer 3-15</p>	<p>2. How long before incident did supervisor last see child? Select one:</p> <p><input type="radio"/> Child in sight of supervisor</p> <p><input type="radio"/> Minutes _____</p> <p><input type="radio"/> Hours _____</p> <p><input type="radio"/> Days _____ <input type="radio"/> U/K</p>	<p>3. Is person a primary caregiver as listed in previous section?</p> <p><input type="radio"/> No</p> <p><input type="radio"/> Yes, caregiver one, go to 15</p> <p><input type="radio"/> Yes, caregiver two, go to 15</p>	
<p>4. Primary person responsible for supervision? Select only one:</p> <p><input type="radio"/> Biological parent <input type="radio"/> Friend</p> <p><input type="radio"/> Adoptive parent <input type="radio"/> Acquaintance</p> <p><input type="radio"/> Stepparent <input type="radio"/> Hospital staff, go to 15</p> <p><input type="radio"/> Foster parent <input type="radio"/> Institutional staff, go to 15</p> <p><input type="radio"/> Mother's partner <input type="radio"/> Babysitter</p> <p><input type="radio"/> Father's partner <input type="radio"/> Licensed child care worker</p> <p><input type="radio"/> Grandparent <input type="radio"/> Other, specify:</p> <p><input type="radio"/> Sibling <input type="radio"/> U/K</p> <p><input type="radio"/> Other relative</p>	<p>5. Supervisor's age in years:</p> <p>_____ <input type="checkbox"/> U/K</p>	<p>6. Supervisor's sex:</p> <p><input type="radio"/> Male</p> <p><input type="radio"/> Female</p> <p><input type="radio"/> U/K</p>	
<p>9. Supervisor has substance abuse history?</p> <p><input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> U/K</p> <p>If yes, check all that apply:</p> <p><input type="checkbox"/> Alcohol</p> <p><input type="checkbox"/> Cocaine</p> <p><input type="checkbox"/> Marijuana</p> <p><input type="checkbox"/> Methamphetamine</p> <p><input type="checkbox"/> Opiates</p> <p><input type="checkbox"/> Prescription drugs</p> <p><input type="checkbox"/> Over-the-counter</p> <p><input type="checkbox"/> Other, specify:</p> <p><input type="checkbox"/> U/K</p>	<p>10. Supervisor has history of child maltreatment?</p> <p><u>As Victim</u> <u>As Perpetrator</u></p> <p><input type="radio"/> No <input type="radio"/> No</p> <p><input type="radio"/> Yes <input type="radio"/> Yes</p> <p><input type="radio"/> U/K <input type="radio"/> U/K</p> <p>If yes, check all that apply:</p> <p><input type="checkbox"/> Physical</p> <p><input type="checkbox"/> Neglect</p> <p><input type="checkbox"/> Sexual</p> <p><input type="checkbox"/> Emotional/psychological</p> <p><input type="checkbox"/> U/K</p> <p>_____ # CPS referrals</p> <p>_____ # Substantiations</p> <p><input type="checkbox"/> Ever in foster care/adopted?</p> <p><input type="checkbox"/> CPS prevention services?</p> <p><input type="checkbox"/> Family Preservation services?</p> <p><input type="checkbox"/> Children ever removed?</p>	<p>11. Supervisor has disability or chronic illness?</p> <p><input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> U/K</p> <p>If yes, check all that apply:</p> <p><input type="checkbox"/> Physical, specify:</p> <p><input type="checkbox"/> Mental, specify:</p> <p><input type="checkbox"/> Sensory, specify:</p> <p><input type="checkbox"/> U/K</p> <p>If mental illness, was supervisor receiving MH services?</p> <p><input type="radio"/> No</p> <p><input type="radio"/> Yes</p> <p><input type="radio"/> U/K</p>	<p>12. Supervisor has prior child deaths?</p> <p><input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> U/K</p> <p>If yes, check all that apply:</p> <p><input type="checkbox"/> Child abuse # _____</p> <p><input type="checkbox"/> Child neglect # _____</p> <p><input type="checkbox"/> Accident # _____</p> <p><input type="checkbox"/> Suicide # _____</p> <p><input type="checkbox"/> SIDS # _____</p> <p><input type="checkbox"/> Other # _____</p> <p>Other, specify:</p> <p><input type="checkbox"/> U/K</p>
<p>13. Supervisor has history of intimate partner violence?</p> <p><input type="checkbox"/> No</p> <p><input type="checkbox"/> Yes, as victim</p> <p><input type="checkbox"/> Yes, as perpetrator</p> <p><input type="checkbox"/> U/K</p>	<p>14. Supervisor has delinquent or criminal history?</p> <p><input type="radio"/> No</p> <p><input type="radio"/> Yes</p> <p><input type="radio"/> U/K</p> <p>If yes, check all that apply:</p> <p><input type="checkbox"/> Assaults <input type="checkbox"/> U/K</p> <p><input type="checkbox"/> Robbery</p> <p><input type="checkbox"/> Drugs</p> <p><input type="checkbox"/> Other, specify:</p>	<p>15. At time of incident was supervisor impaired? <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> U/K</p> <p>If yes, check all that apply:</p> <p><input type="checkbox"/> Drug impaired <input type="checkbox"/> Absent</p> <p><input type="checkbox"/> Alcohol impaired <input type="checkbox"/> Impaired by illness, specify:</p> <p><input type="checkbox"/> Asleep <input type="checkbox"/> Impaired by disability, specify:</p> <p><input type="checkbox"/> Distracted <input type="checkbox"/> Other, specify:</p>	

D. INCIDENT INFORMATION

<p>1. Date of incident event:</p> <p><input type="radio"/> Same as date of death</p> <p><input type="radio"/> If different than date of death: ____/____/____</p> <p><input type="radio"/> U/K</p> <p>(mm/dd/yyyy)</p>	<p>2. Approximate time of day that incident occurred?</p> <p>Hour, specify 1-12 _____</p> <p><input type="radio"/> AM</p> <p><input type="radio"/> PM</p> <p><input type="radio"/> U/K</p>	<p>3. Interval between incident and death: <input type="checkbox"/> U/K</p> <p><input type="checkbox"/> Minutes _____ <input type="checkbox"/> Weeks _____</p> <p><input type="checkbox"/> Hours _____ <input type="checkbox"/> Months _____</p> <p><input type="checkbox"/> Days _____ <input type="checkbox"/> Years _____</p>
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4. Place of incident, check all that apply:											5. Type of area:																		
<input type="checkbox"/> Child's home	<input type="checkbox"/> Licensed group home	<input type="checkbox"/> School	<input type="checkbox"/> Sidewalk	<input type="checkbox"/> Sports area	<input type="checkbox"/> Urban	<input type="checkbox"/> Relative's home	<input type="checkbox"/> Licensed child care center	<input type="checkbox"/> Place of work	<input type="checkbox"/> Roadway	<input type="checkbox"/> Other recreation area	<input type="checkbox"/> Suburban	<input type="checkbox"/> Friend's home	<input type="checkbox"/> Licensed child care home	<input type="checkbox"/> Indian Reservation	<input type="checkbox"/> Driveway	<input type="checkbox"/> Hospital	<input type="checkbox"/> Rural	<input type="checkbox"/> Licensed foster care home	<input type="checkbox"/> Unlicensed child care home	<input type="checkbox"/> Military installation	<input type="checkbox"/> Other parking area	<input type="checkbox"/> Other, specify:	<input type="checkbox"/> Frontier	<input type="checkbox"/> Relative foster care home	<input type="checkbox"/> Farm	<input type="checkbox"/> Jail/detention facility	<input type="checkbox"/> State or county park	<input type="checkbox"/> U/K	<input type="checkbox"/> U/K
6. Incident state: _____											13. Total number of deaths at incident event:																		
7. Incident county: _____											Children, ages 0-18 _____																		
8. Was 911 or local emergency number called? <input type="radio"/> N/A <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> U/K											Adults _____ <input type="radio"/> U/K																		
9. CPR performed before EMS arrived? <input type="radio"/> N/A <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> U/K																													
10. At time of incident leading to the death, had child used alcohol or drugs? <input type="radio"/> N/A <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K																													
11. EMS to scene? <input type="radio"/> N/A <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> U/K																													
12. Child's activity at time of incident, check all that apply: <input type="checkbox"/> Sleeping <input type="checkbox"/> Other, specify: <input type="checkbox"/> Playing <input type="checkbox"/> U/K <input type="checkbox"/> Working <input type="checkbox"/> U/K <input type="checkbox"/> Eating <input type="checkbox"/> Driving/vehicle occupant																													

E. INVESTIGATION INFORMATION

1. Death referred to: <input type="radio"/> Medical examiner <input type="radio"/> Coroner <input type="radio"/> Not referred <input type="radio"/> U/K		2. Person declaring official cause and manner of death: <input type="radio"/> Medical examiner <input type="radio"/> Coroner <input type="radio"/> Hospital physician <input type="radio"/> Other physician <input type="radio"/> Mortician <input type="radio"/> Other, specify: <input type="radio"/> U/K		3. Autopsy performed? <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> U/K If yes, conducted by: <input type="radio"/> Forensic pathologist <input type="radio"/> Pediatric pathologist <input type="radio"/> General pathologist <input type="radio"/> Unknown pathologist <input type="radio"/> Other physician <input type="radio"/> Other, specify: <input type="radio"/> U/K		4. Agencies that conducted a scene investigation, check all that apply: <input type="checkbox"/> Not conducted <input type="checkbox"/> Fire investigator <input type="checkbox"/> Medical examiner <input type="checkbox"/> EMS <input type="checkbox"/> Coroner <input type="checkbox"/> Child Protective Services <input type="checkbox"/> ME investigator <input type="checkbox"/> Other, specify: <input type="checkbox"/> Coroner investigator <input type="checkbox"/> U/K <input type="checkbox"/> Law enforcement			
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5. Toxicology screen? <input type="radio"/> No <input type="radio"/> Yes If yes, check all that apply: <input type="radio"/> U/K				6. X-rays taken? <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> U/K				7. Was a CPS record check conducted as a result of death? <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> U/K	
<input type="checkbox"/> Negative <input type="checkbox"/> Marijuana <input type="checkbox"/> Too high prescription drug, specify:		<input type="checkbox"/> Alcohol <input type="checkbox"/> Methamphetamine <input type="checkbox"/> Too high over-the-counter drug, specify:		<input type="checkbox"/> Cocaine <input type="checkbox"/> Opiates <input type="checkbox"/> Other, specify:		<input type="checkbox"/> U/K			

8. Did investigation find evidence of prior abuse? <input type="radio"/> N/A <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> U/K If yes, from what source? Check all that apply: <input type="checkbox"/> From x-rays <input type="checkbox"/> U/K <input type="checkbox"/> From autopsy <input type="checkbox"/> From CPS review <input type="checkbox"/> From law enforcement		9. CPS action taken because of death? <input type="radio"/> N/A <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> U/K If yes, highest level of action taken because of death: <input type="radio"/> Report screened out and not investigated <input type="radio"/> Unsubstantiated <input type="radio"/> Inconclusive <input type="radio"/> Substantiated If yes, services or actions resulting, check all that apply: <input type="checkbox"/> Voluntary services offered <input type="checkbox"/> Court ordered out-of-home placement <input type="checkbox"/> Voluntary services provided <input type="checkbox"/> Children removed <input type="checkbox"/> Court ordered services provided <input type="checkbox"/> Parental rights terminated <input type="checkbox"/> Voluntary out of home placement <input type="checkbox"/> U/K				10. If death occurred in licensed setting, indicate action taken: <input type="radio"/> N/A <input type="radio"/> No action <input type="radio"/> License suspended <input type="radio"/> License revoked <input type="radio"/> Investigation ongoing <input type="radio"/> U/K	
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F. OFFICIAL MANNER AND PRIMARY CAUSE OF DEATH

1. Official manner of death from the death certificate: <input type="radio"/> Natural <input type="radio"/> Accident <input type="radio"/> Suicide <input type="radio"/> Homicide <input type="radio"/> Undetermined <input type="radio"/> Pending <input type="radio"/> U/K		2. Primary cause of death: Choose only 1 of the 4 major categories, then a specific cause. For pending, choose most likely cause. <input type="radio"/> From an injury (external cause), select one: <input type="radio"/> Motor vehicle and other transport, go to G1 <input type="radio"/> Fire, burn, or electrocution, go to G2 <input type="radio"/> Drowning, go to G3 <input type="radio"/> Asphyxia, go to G4 <input type="radio"/> Weapon, including body part, go to G6 <input type="radio"/> Animal bite or attack, go to G7 <input type="radio"/> Fall or crush, go to G8 <input type="radio"/> Poisoning, overdose or acute intoxication, go to G9 <input type="radio"/> Exposure, go to G10 <input type="radio"/> Undetermined. If under age one, go to G5 & G12. If over age one, go to G12. <input type="radio"/> Other cause, go to G12 <input type="radio"/> U/K, go to G12 <input type="radio"/> From a medical cause, select one: <input type="radio"/> Asthma, go to G11 <input type="radio"/> Cancer, specify and go to G11 <input type="radio"/> Cardiovascular, specify and go to G11 <input type="radio"/> Congenital anomaly, specify and go to G11 <input type="radio"/> HIV/AIDS, go to G11 <input type="radio"/> Influenza, go to G11 <input type="radio"/> Low birth weight, go to G11 <input type="radio"/> Malnutrition/dehydration, go to G11 <input type="radio"/> Neurological/seizure disorder, go to G11 <input type="radio"/> Pneumonia, specify and go to G11 <input type="radio"/> Prematurity, go to G11 <input type="radio"/> SIDS, go to G5 <input type="radio"/> Other infection, specify and go to G11 <input type="radio"/> Other perinatal condition, specify and go to G11 <input type="radio"/> Other medical condition, specify and go to G11 <input type="radio"/> Undetermined. If under age one, go to G5 and G11. If over age one, go to G11. <input type="radio"/> U/K. If under age one, go to G5 and G11. If over age one, go to G11. <input type="radio"/> Undetermined if injury or medical cause, go to G12 go to G12 If under age one, go to G5 & G12.			
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G. DETAILED INFORMATION BY CAUSE OF DEATH: CHOOSE ONE SECTION ONLY, THAT IS SAME AS THE CAUSE SELECTED ABOVE

1. MOTOR VEHICLE AND OTHER TRANSPORT

<p>a. Vehicles involved in incident: Total number of vehicles: _____</p> <table style="width:100%; border-collapse: collapse;"> <tr> <th style="text-align: left; border-bottom: 1px solid black;">Child's</th> <th style="text-align: left; border-bottom: 1px solid black;">Other primary vehicle</th> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/> None</td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/> Car</td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/> Van</td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/> Sport utility vehicle</td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/> Truck</td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/> Semi/tractor trailer</td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/> RV</td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/> School bus</td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/> Other bus</td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/> Motorcycle</td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/> Tractor</td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/> Other farm vehicle</td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/> All terrain vehicle</td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/> Snowmobile</td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/> Bicycle</td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/> Train</td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/> Subway</td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/> Trolley</td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/> Other, specify: _____</td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/> U/K</td> </tr> </table>	Child's	Other primary vehicle	<input type="radio"/>	<input type="radio"/> None	<input type="radio"/>	<input type="radio"/> Car	<input type="radio"/>	<input type="radio"/> Van	<input type="radio"/>	<input type="radio"/> Sport utility vehicle	<input type="radio"/>	<input type="radio"/> Truck	<input type="radio"/>	<input type="radio"/> Semi/tractor trailer	<input type="radio"/>	<input type="radio"/> RV	<input type="radio"/>	<input type="radio"/> School bus	<input type="radio"/>	<input type="radio"/> Other bus	<input type="radio"/>	<input type="radio"/> Motorcycle	<input type="radio"/>	<input type="radio"/> Tractor	<input type="radio"/>	<input type="radio"/> Other farm vehicle	<input type="radio"/>	<input type="radio"/> All terrain vehicle	<input type="radio"/>	<input type="radio"/> Snowmobile	<input type="radio"/>	<input type="radio"/> Bicycle	<input type="radio"/>	<input type="radio"/> Train	<input type="radio"/>	<input type="radio"/> Subway	<input type="radio"/>	<input type="radio"/> Trolley	<input type="radio"/>	<input type="radio"/> Other, specify: _____	<input type="radio"/>	<input type="radio"/> U/K	<p>b. Position of child:</p> <p><input type="radio"/> Driver</p> <p><input type="radio"/> Passenger</p> <p><input type="radio"/> Front seat</p> <p><input type="radio"/> Back seat</p> <p><input type="radio"/> Truck bed</p> <p><input type="radio"/> Other, specify: _____</p> <p><input type="radio"/> U/K</p> <p><input type="radio"/> On bicycle</p> <p><input type="radio"/> Pedestrian</p> <p><input type="radio"/> Walking</p> <p><input type="radio"/> Boarding/blading</p> <p><input type="radio"/> Other, specify: _____</p> <p><input type="radio"/> U/K</p>	<p>c. Causes of incident, check all that apply:</p> <table style="width:100%; border-collapse: collapse;"> <tr> <td><input type="checkbox"/> Speeding over limit</td> <td><input type="checkbox"/> Back over</td> </tr> <tr> <td><input type="checkbox"/> Unsafe speed for conditions</td> <td><input type="checkbox"/> Rollover</td> </tr> <tr> <td><input type="checkbox"/> Recklessness</td> <td><input type="checkbox"/> Poor sight line</td> </tr> <tr> <td><input type="checkbox"/> Ran stop sign or red light</td> <td><input type="checkbox"/> Car changing lanes</td> </tr> <tr> <td><input type="checkbox"/> Driver distraction</td> <td><input type="checkbox"/> Road hazard</td> </tr> <tr> <td><input type="checkbox"/> Driver inexperience</td> <td><input type="checkbox"/> Animal in road</td> </tr> <tr> <td><input type="checkbox"/> Mechanical failure</td> <td><input type="checkbox"/> Cell phone use while driving</td> </tr> <tr> <td><input type="checkbox"/> Poor tires</td> <td><input type="checkbox"/> Racing, not authorized</td> </tr> <tr> <td><input type="checkbox"/> Poor weather</td> <td><input type="checkbox"/> Other driver error, specify: _____</td> </tr> <tr> <td><input type="checkbox"/> Poor visibility</td> <td><input type="checkbox"/> Other, specify: _____</td> </tr> <tr> <td><input type="checkbox"/> Drugs or alcohol use</td> <td><input type="checkbox"/> U/K</td> </tr> <tr> <td><input type="checkbox"/> Fatigue/sleeping</td> <td></td> </tr> <tr> <td><input type="checkbox"/> Medical event, specify: _____</td> <td></td> </tr> </table>	<input type="checkbox"/> Speeding over limit	<input type="checkbox"/> Back over	<input type="checkbox"/> Unsafe speed for conditions	<input type="checkbox"/> Rollover	<input type="checkbox"/> Recklessness	<input type="checkbox"/> Poor sight line	<input type="checkbox"/> Ran stop sign or red light	<input type="checkbox"/> Car changing lanes	<input type="checkbox"/> Driver distraction	<input type="checkbox"/> Road hazard	<input type="checkbox"/> Driver inexperience	<input type="checkbox"/> Animal in road	<input type="checkbox"/> Mechanical failure	<input type="checkbox"/> Cell phone use while driving	<input type="checkbox"/> Poor tires	<input type="checkbox"/> Racing, not authorized	<input type="checkbox"/> Poor weather	<input type="checkbox"/> Other driver error, specify: _____	<input type="checkbox"/> Poor visibility	<input type="checkbox"/> Other, specify: _____	<input type="checkbox"/> Drugs or alcohol use	<input type="checkbox"/> U/K	<input type="checkbox"/> Fatigue/sleeping		<input type="checkbox"/> Medical event, specify: _____		<p>d. Collision type:</p> <p><input type="radio"/> Child <i>not</i> in/on a vehicle, but struck by vehicle</p> <p><input type="radio"/> Child in/on a vehicle, struck by other vehicle</p> <p><input type="radio"/> Child in/on a vehicle that struck other vehicle</p> <p><input type="radio"/> Child in/on a vehicle that struck person/object</p> <p><input type="radio"/> Other event, specify: _____</p> <p><input type="radio"/> U/K</p>
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<p>e. Driving conditions, check all that apply:</p> <table style="width:100%; border-collapse: collapse;"> <tr> <td><input type="checkbox"/> Normal</td> <td><input type="checkbox"/> Other, specify: _____</td> </tr> <tr> <td><input type="checkbox"/> Loose gravel</td> <td></td> </tr> <tr> <td><input type="checkbox"/> Muddy</td> <td><input type="checkbox"/> U/K</td> </tr> <tr> <td><input type="checkbox"/> Ice/Snow</td> <td></td> </tr> <tr> <td><input type="checkbox"/> Fog</td> <td></td> </tr> <tr> <td><input type="checkbox"/> Wet</td> <td></td> </tr> <tr> <td><input type="checkbox"/> Construction zone</td> <td></td> </tr> <tr> <td><input type="checkbox"/> Inadequate lighting</td> <td></td> </tr> </table>	<input type="checkbox"/> Normal	<input type="checkbox"/> Other, specify: _____	<input type="checkbox"/> Loose gravel		<input type="checkbox"/> Muddy	<input type="checkbox"/> U/K	<input type="checkbox"/> Ice/Snow		<input type="checkbox"/> Fog		<input type="checkbox"/> Wet		<input type="checkbox"/> Construction zone		<input type="checkbox"/> Inadequate lighting		<p>f. Location of incident, check all that apply:</p> <table style="width:100%; border-collapse: collapse;"> <tr> <td><input type="checkbox"/> City street</td> <td><input type="checkbox"/> Driveway</td> </tr> <tr> <td><input type="checkbox"/> Residential street</td> <td><input type="checkbox"/> Parking area</td> </tr> <tr> <td><input type="checkbox"/> Rural road</td> <td><input type="checkbox"/> Off road</td> </tr> <tr> <td><input type="checkbox"/> Highway</td> <td><input type="checkbox"/> Railroad crossing/tracks</td> </tr> <tr> <td><input type="checkbox"/> Intersection</td> <td><input type="checkbox"/> Other, specify: _____</td> </tr> <tr> <td><input type="checkbox"/> Shoulder</td> <td></td> </tr> <tr> <td><input type="checkbox"/> Sidewalk</td> <td><input type="checkbox"/> U/K</td> </tr> </table>			<input type="checkbox"/> City street	<input type="checkbox"/> Driveway	<input type="checkbox"/> Residential street	<input type="checkbox"/> Parking area	<input type="checkbox"/> Rural road	<input type="checkbox"/> Off road	<input type="checkbox"/> Highway	<input type="checkbox"/> Railroad crossing/tracks	<input type="checkbox"/> Intersection	<input type="checkbox"/> Other, specify: _____	<input type="checkbox"/> Shoulder		<input type="checkbox"/> Sidewalk	<input type="checkbox"/> U/K																																						
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<input type="checkbox"/> Muddy	<input type="checkbox"/> U/K																																																																						
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<input type="checkbox"/> Fog																																																																							
<input type="checkbox"/> Wet																																																																							
<input type="checkbox"/> Construction zone																																																																							
<input type="checkbox"/> Inadequate lighting																																																																							
<input type="checkbox"/> City street	<input type="checkbox"/> Driveway																																																																						
<input type="checkbox"/> Residential street	<input type="checkbox"/> Parking area																																																																						
<input type="checkbox"/> Rural road	<input type="checkbox"/> Off road																																																																						
<input type="checkbox"/> Highway	<input type="checkbox"/> Railroad crossing/tracks																																																																						
<input type="checkbox"/> Intersection	<input type="checkbox"/> Other, specify: _____																																																																						
<input type="checkbox"/> Shoulder																																																																							
<input type="checkbox"/> Sidewalk	<input type="checkbox"/> U/K																																																																						

<p>g. Drivers involved in incident, check all that apply:</p> <table style="width:100%; border-collapse: collapse;"> <tr> <th style="text-align: left; border-bottom: 1px solid black;">Child as driver</th> <th style="text-align: left; border-bottom: 1px solid black;">Child's driver</th> <th style="text-align: left; border-bottom: 1px solid black;">Driver of other primary vehicle</th> <th style="text-align: left; border-bottom: 1px solid black;">Age of Driver</th> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Responsible for causing incident</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Was alcohol/drug impaired</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Has no license</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Has a learner's permit</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Has a graduated license</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Has a full license</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Has a full license that has been restricted</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Has a suspended license</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>If recreational vehicle, has driver safety certificate</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Other, specify: _____</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Was violating graduated licensing rules:</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Nighttime driving curfew</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Passenger restrictions</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Driving without required supervision</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Other violations, specify: _____</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>U/K</td> </tr> </table>	Child as driver	Child's driver	Driver of other primary vehicle	Age of Driver	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Responsible for causing incident	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Was alcohol/drug impaired	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Has no license	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Has a learner's permit	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Has a graduated license	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Has a full license	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Has a full license that has been restricted	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Has a suspended license	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	If recreational vehicle, has driver safety certificate	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other, specify: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Was violating graduated licensing rules:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Nighttime driving curfew	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Passenger restrictions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Driving without required supervision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other violations, specify: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	U/K	<p>h. Total number of occupants in vehicles:</p> <p>In child's vehicle, including child:</p> <p><input type="checkbox"/> N/A, child was not in a vehicle.</p> <p>Total number occupants: _____ <input type="radio"/> U/K</p> <p>Number teens, ages 14-21 _____ <input type="radio"/> U/K</p> <p>Total number of deaths: _____ <input type="radio"/> U/K</p> <p>Total number teen deaths: _____ <input type="radio"/> U/K</p> <p>In other primary vehicle involved in incident:</p> <p><input type="checkbox"/> N/A, incident was a single vehicle crash.</p> <p>Total number occupants: _____ <input type="radio"/> U/K</p> <p>Number teens, ages 14-21 _____ <input type="radio"/> U/K</p> <p>Total number of deaths: _____ <input type="radio"/> U/K</p> <p>Total number teen deaths: _____ <input type="radio"/> U/K</p>
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<p>i. Protective measures for child, Select one option per row:</p>	<p>Not Needed</p>	<p>Needed, none present</p>	<p>Present, used correctly</p>	<p>Present, used incorrectly</p>	<p>Present not used</p>	<p>Unknown</p>	<p>*If child seat, type:</p> <p><input type="radio"/> Rear facing</p> <p><input type="radio"/> Front facing</p> <p><input type="radio"/> U/K</p>
<p>Airbag</p> <p>Lap belt</p> <p>Shoulder belt</p> <p>Child seat*</p> <p>Belt positioning booster seat</p> <p>Helmet</p> <p>Other, specify: _____</p>	<p><input type="radio"/></p>	<p><input type="radio"/></p> <p><input type="radio"/></p> <p><input type="radio"/></p> <p><input type="radio"/></p> <p><input type="radio"/></p> <p><input type="radio"/></p>	<p><input type="radio"/></p> <p><input type="radio"/></p> <p><input type="radio"/></p> <p><input type="radio"/></p> <p><input type="radio"/></p> <p><input type="radio"/></p>	<p><input type="radio"/></p> <p><input type="radio"/></p> <p><input type="radio"/></p> <p><input type="radio"/></p> <p><input type="radio"/></p> <p><input type="radio"/></p>	<p><input type="radio"/></p> <p><input type="radio"/></p> <p><input type="radio"/></p> <p><input type="radio"/></p> <p><input type="radio"/></p> <p><input type="radio"/></p>	<p><input type="radio"/></p> <p><input type="radio"/></p> <p><input type="radio"/></p> <p><input type="radio"/></p> <p><input type="radio"/></p> <p><input type="radio"/></p>	

2. FIRE, BURN, or ELECTROCUTION																		
a. Ignition, heat or electrocution source: <input type="radio"/> Matches <input type="radio"/> Heating stove <input type="radio"/> Lightning <input type="radio"/> Other explosives <input type="radio"/> Cigarette lighter <input type="radio"/> Space heater <input type="radio"/> Oxygen tank <input type="radio"/> Appliance in water <input type="radio"/> Utility lighter <input type="radio"/> Furnace <input type="radio"/> Hot cooking water <input type="radio"/> Other, specify: <input type="radio"/> Cigarette or cigar <input type="radio"/> Power line <input type="radio"/> Hot bath water <input type="radio"/> U/K <input type="radio"/> Candles <input type="radio"/> Electrical outlet <input type="radio"/> Other hot liquid, specify: <input type="radio"/> Cooking stove <input type="radio"/> Electrical wiring <input type="radio"/> Fireworks		b. Type of incident: <input type="radio"/> Fire, go to c <input type="radio"/> Scald, go to r <input type="radio"/> Other burn, go to t <input type="radio"/> Electrocution, go to s <input type="radio"/> Other, specify and go to t <input type="radio"/> U/K, go to t																
d. Material first ignited: <input type="radio"/> Upholstery <input type="radio"/> Mattress <input type="radio"/> Christmas tree <input type="radio"/> Clothing <input type="radio"/> Curtain <input type="radio"/> Other, specify: <input type="radio"/> U/K		e. Type of building on fire: <input type="radio"/> N/A <input type="radio"/> Single home <input type="radio"/> Duplex <input type="radio"/> Apartment <input type="radio"/> Trailer/mobile home <input type="radio"/> Other, specify: <input type="radio"/> U/K																
f. Building's primary construction material: <input type="radio"/> Wood <input type="radio"/> Steel <input type="radio"/> Brick/stone <input type="radio"/> Aluminum <input type="radio"/> Other, specify: <input type="radio"/> U/K		g. Fire started by a person? <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> U/K If yes, person's age _____ Does person have a history of setting fires? <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> U/K																
h. Did anyone attempt to put out fire? <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> U/K		i. Did escape or rescue efforts worsen fire? <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> U/K																
j. Did any factors delay fire department arrival? <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> U/K If yes, specify:																		
k. Were barriers preventing safe exit? <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> U/K If yes, check all that apply: <input type="checkbox"/> Locked door <input type="checkbox"/> Window grate <input type="checkbox"/> Locked window <input type="checkbox"/> Blocked stairway <input type="checkbox"/> Other, specify: <input type="checkbox"/> U/K		l. Was building a rental property? <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> U/K																
m. Were building/rental codes violated? <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> U/K If yes, describe in narrative.		n. Were proper working fire extinguishers present? <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> U/K																
o. Was sprinkler system present? <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> U/K If yes, was it working? <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> U/K		p. Were smoke detectors present? <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> U/K <table border="0"> <tr> <td style="width: 33%;"> If yes, what type? <input type="checkbox"/> Removable batteries <input type="checkbox"/> Non-removable batteries <input type="checkbox"/> Hardwired <input type="checkbox"/> U/K </td> <td style="width: 33%;"> If yes, functioning properly? <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> U/K <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> U/K <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> U/K <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> U/K </td> <td style="width: 33%;"> If not functioning properly, reason: <table border="0"> <tr> <td style="width: 33%;">Missing batteries</td> <td style="width: 33%;">Other</td> <td style="width: 33%;">U/K</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> </table> Other, specify: </td> </tr> </table> If yes, was there an adequate number present? <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> U/K		If yes, what type? <input type="checkbox"/> Removable batteries <input type="checkbox"/> Non-removable batteries <input type="checkbox"/> Hardwired <input type="checkbox"/> U/K	If yes, functioning properly? <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> U/K <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> U/K <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> U/K <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> U/K	If not functioning properly, reason: <table border="0"> <tr> <td style="width: 33%;">Missing batteries</td> <td style="width: 33%;">Other</td> <td style="width: 33%;">U/K</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> </table> Other, specify:	Missing batteries	Other	U/K	<input type="checkbox"/>								
If yes, what type? <input type="checkbox"/> Removable batteries <input type="checkbox"/> Non-removable batteries <input type="checkbox"/> Hardwired <input type="checkbox"/> U/K	If yes, functioning properly? <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> U/K <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> U/K <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> U/K <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> U/K	If not functioning properly, reason: <table border="0"> <tr> <td style="width: 33%;">Missing batteries</td> <td style="width: 33%;">Other</td> <td style="width: 33%;">U/K</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> </table> Other, specify:	Missing batteries	Other	U/K	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
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<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																
q. Suspected arson? <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> U/K		r. For scald, was hot water heater set too high? <input type="radio"/> N/A <input type="radio"/> No <input type="radio"/> Yes, temp. setting: _____ <input type="radio"/> U/K																
s. For electrocution, what cause: <input type="radio"/> Electrical storm <input type="radio"/> Faulty wiring <input type="radio"/> Wire/product in water <input type="radio"/> Child playing with outlet <input type="radio"/> Other, specify: <input type="radio"/> U/K		t. Other, describe in detail:																

3. DROWNING			
a. Where was child last seen before drowning? Check all that apply: <input type="checkbox"/> In water <input type="checkbox"/> In yard <input type="checkbox"/> On shore <input type="checkbox"/> In bathroom <input type="checkbox"/> On dock <input type="checkbox"/> In house <input type="checkbox"/> Poolside <input type="checkbox"/> Other, specify: <input type="checkbox"/> U/K		b. What was child last seen doing before drowning? <input type="radio"/> Playing <input type="radio"/> Tubing <input type="radio"/> Boating <input type="radio"/> Water-skiing <input type="radio"/> Swimming <input type="radio"/> Sleeping <input type="radio"/> Bathing <input type="radio"/> Other, specify: <input type="radio"/> Fishing <input type="radio"/> Surfing <input type="radio"/> U/K	
c. Was child forcibly submerged? <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> U/K		d. Drowning location: <input type="radio"/> Open water, go to e <input type="radio"/> U/K, go to n <input type="radio"/> Pool, hot tub, spa, go to i <input type="radio"/> Bathtub, go to w <input type="radio"/> Bucket, go to x <input type="radio"/> Well/ cistern/ septic, go to n <input type="radio"/> Toilet, go to z <input type="radio"/> Other, specify and go to n	
e. For open water, place: <input type="radio"/> Lake <input type="radio"/> Quarry <input type="radio"/> River <input type="radio"/> Gravel pit <input type="radio"/> Pond <input type="radio"/> Canal <input type="radio"/> Creek <input type="radio"/> U/K <input type="radio"/> Ocean		f. For open water, contributing environmental factors: <input type="radio"/> Weather <input type="radio"/> Drop off <input type="radio"/> Temperature <input type="radio"/> Rough waves <input type="radio"/> Current <input type="radio"/> Other, specify: <input type="radio"/> Riptide/ undertow <input type="radio"/> U/K	
g. If boating, type of boat: <input type="radio"/> Sailboat <input type="radio"/> Commercial <input type="radio"/> Jet ski <input type="radio"/> Other, specify: <input type="radio"/> Motorboat <input type="radio"/> Canoe <input type="radio"/> Kayak <input type="radio"/> U/K <input type="radio"/> Raft		h. For boating, was the child piloting boat? <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> U/K	
i. For pool, type of pool: <input type="radio"/> Above ground <input type="radio"/> In-ground <input type="radio"/> Hot tub, spa <input type="radio"/> Wading <input type="radio"/> U/K		j. For pool, child found: <input type="radio"/> In the pool/hot tub/spa <input type="radio"/> On or under the cover <input type="radio"/> U/K	
k. For pool, ownership is: <input type="radio"/> Private <input type="radio"/> Public <input type="radio"/> U/K		l. Length of time owners had pool/hot tub/spa: <input type="radio"/> N/A <input type="radio"/> >1yr <input type="radio"/> <6 months <input type="radio"/> U/K <input type="radio"/> 6m-1 yr	

6. WEAPON, INCLUDING PERSON'S BODY PART

<p>a. Type of weapon:</p> <input type="radio"/> Firearm, go to b <input type="radio"/> Sharp instrument, go to j <input type="radio"/> Blunt instrument, go to k <input type="radio"/> Person's body part, go to l <input type="radio"/> Explosive, go to m <input type="radio"/> Rope, go to m <input type="radio"/> Pipe, go to m <input type="radio"/> Biological, go to m <input type="radio"/> Other, specify and go to m <input type="radio"/> U/K, go to m	<p>b. For firearms, type:</p> <input type="radio"/> Handgun <input type="radio"/> Shotgun <input type="radio"/> BB gun <input type="radio"/> Hunting rifle <input type="radio"/> Assault rifle <input type="radio"/> Air rifle <input type="radio"/> Sawed off shotgun <input type="radio"/> Other, specify: <input type="radio"/> U/K	<p>c. Firearm licensed?</p> <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> U/K	<p>d. Firearm safety features, check all that apply:</p> <input type="checkbox"/> Trigger lock <input type="checkbox"/> Magazine disconnect <input type="checkbox"/> Personalization device <input type="checkbox"/> Minimum trigger pull <input type="checkbox"/> External safety/drop safety <input type="checkbox"/> Other, specify: <input type="checkbox"/> Loaded chamber indicator <input type="checkbox"/> U/K
<p>e. Where was firearm stored?</p> <input type="radio"/> Not stored <input type="radio"/> Under mattress/pillow <input type="radio"/> Locked cabinet <input type="radio"/> Other, specify: <input type="radio"/> Unlocked cabinet <input type="radio"/> Glove compartment <input type="radio"/> U/K			<p>f. Firearm stored with ammunition?</p> <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> U/K
<p>g. Firearm stored loaded?</p> <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> U/K			

<p>h. Owner of fatal firearm:</p> <input type="radio"/> U/K, weapon stolen <input type="radio"/> Grandparent <input type="radio"/> Co-worker <input type="radio"/> U/K, weapon found <input type="radio"/> Sibling <input type="radio"/> Institutional staff <input type="radio"/> Self <input type="radio"/> Spouse <input type="radio"/> Neighbor <input type="radio"/> Biological parent <input type="radio"/> Other relative <input type="radio"/> Rival gang member <input type="radio"/> Adoptive parent <input type="radio"/> Friend <input type="radio"/> Stranger <input type="radio"/> Stepparent <input type="radio"/> Acquaintance <input type="radio"/> Law enforcement <input type="radio"/> Foster parent <input type="radio"/> Child's boyfriend <input type="radio"/> Other, specify: <input type="radio"/> Mother's partner or girlfriend <input type="radio"/> Father's partner <input type="radio"/> Classmate <input type="radio"/> U/K	<p>i. Sex of fatal firearm owner:</p> <input type="radio"/> Male <input type="radio"/> Female <input type="radio"/> U/K	<p>j. Type of sharp object:</p> <input type="radio"/> Kitchen knife <input type="radio"/> Switchblade <input type="radio"/> Pocketknife <input type="radio"/> Razor <input type="radio"/> Hunting knife <input type="radio"/> Scissors <input type="radio"/> Other, specify: <input type="radio"/> U/K	<p>k. Type of blunt object:</p> <input type="radio"/> Bat <input type="radio"/> Club <input type="radio"/> Stick <input type="radio"/> Hammer <input type="radio"/> Rock <input type="radio"/> Household item <input type="radio"/> Other, specify: <input type="radio"/> U/K
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<p>l. What did person's body part do? Check all that apply:</p> <input type="checkbox"/> Beat, kick or punch <input type="checkbox"/> Drop <input type="checkbox"/> Push <input type="checkbox"/> Bite <input type="checkbox"/> Shake <input type="checkbox"/> Strangle <input type="checkbox"/> Throw <input type="checkbox"/> Drown <input type="checkbox"/> Burn <input type="checkbox"/> Other, specify: <input type="checkbox"/> U/K	<p>m. Did person using weapon have history of weapon-related offenses?</p> <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> U/K	<p>o. Persons handling weapons at time of incident, check all that apply:</p> <table style="width:100%;"> <tr> <th style="text-align: left;"><u>Fatal</u> and/or <u>Other weapon</u></th> <th style="text-align: left;"><u>Fatal</u> and/or <u>Other weapon</u></th> </tr> <tr> <td><input type="checkbox"/> Self</td> <td><input type="checkbox"/> Friend</td> </tr> <tr> <td><input type="checkbox"/> Biological parent</td> <td><input type="checkbox"/> Acquaintance</td> </tr> <tr> <td><input type="checkbox"/> Adoptive parent</td> <td><input type="checkbox"/> Child's boyfriend or girlfriend</td> </tr> <tr> <td><input type="checkbox"/> Stepparent</td> <td><input type="checkbox"/> Classmate</td> </tr> <tr> <td><input type="checkbox"/> Foster parent</td> <td><input type="checkbox"/> Co-worker</td> </tr> <tr> <td><input type="checkbox"/> Mother's partner</td> <td><input type="checkbox"/> Institutional staff</td> </tr> <tr> <td><input type="checkbox"/> Father's partner</td> <td><input type="checkbox"/> Neighbor</td> </tr> <tr> <td><input type="checkbox"/> Grandparent</td> <td><input type="checkbox"/> Rival gang member</td> </tr> <tr> <td><input type="checkbox"/> Sibling</td> <td><input type="checkbox"/> Stranger</td> </tr> <tr> <td><input type="checkbox"/> Spouse</td> <td><input type="checkbox"/> Law enforcement officer</td> </tr> <tr> <td><input type="checkbox"/> Other relative</td> <td><input type="checkbox"/> Other, specify: <input type="checkbox"/> U/K</td> </tr> </table>	<u>Fatal</u> and/or <u>Other weapon</u>	<u>Fatal</u> and/or <u>Other weapon</u>	<input type="checkbox"/> Self	<input type="checkbox"/> Friend	<input type="checkbox"/> Biological parent	<input type="checkbox"/> Acquaintance	<input type="checkbox"/> Adoptive parent	<input type="checkbox"/> Child's boyfriend or girlfriend	<input type="checkbox"/> Stepparent	<input type="checkbox"/> Classmate	<input type="checkbox"/> Foster parent	<input type="checkbox"/> Co-worker	<input type="checkbox"/> Mother's partner	<input type="checkbox"/> Institutional staff	<input type="checkbox"/> Father's partner	<input type="checkbox"/> Neighbor	<input type="checkbox"/> Grandparent	<input type="checkbox"/> Rival gang member	<input type="checkbox"/> Sibling	<input type="checkbox"/> Stranger	<input type="checkbox"/> Spouse	<input type="checkbox"/> Law enforcement officer	<input type="checkbox"/> Other relative	<input type="checkbox"/> Other, specify: <input type="checkbox"/> U/K	<p>p. Sex of person(s) handling weapon:</p> <p>Fatal weapon:</p> <input type="radio"/> Male <input type="radio"/> Female <input type="radio"/> U/K
<u>Fatal</u> and/or <u>Other weapon</u>	<u>Fatal</u> and/or <u>Other weapon</u>																										
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<p>Other weapon:</p> <input type="radio"/> Male <input type="radio"/> Female <input type="radio"/> U/K																											

q. Use of weapon at time, check all that apply:

<input type="checkbox"/> Self-injury	<input type="checkbox"/> Argument	<input type="checkbox"/> Hunting	<input type="checkbox"/> Russian Roulette	<input type="checkbox"/> Intervener assisting crime victim (Good Samaritan)
<input type="checkbox"/> Commission of crime	<input type="checkbox"/> Jealousy	<input type="checkbox"/> Target shooting	<input type="checkbox"/> Gang-related activity	<input type="checkbox"/> Other, specify:
<input type="checkbox"/> Drive-by shooting	<input type="checkbox"/> Intimate partner violence	<input type="checkbox"/> Playing with weapon	<input type="checkbox"/> Self-defense	<input type="checkbox"/> U/K
<input type="checkbox"/> Random violence	<input type="checkbox"/> Hate crime	<input type="checkbox"/> Weapon mistaken for toy	<input type="checkbox"/> Cleaning weapon	
<input type="checkbox"/> Child was a bystander	<input type="checkbox"/> Bullying	<input type="checkbox"/> Showing gun to others	<input type="checkbox"/> Loading weapon	

7. ANIMAL BITE OR ATTACK

<p>a. Type of animal:</p> <input type="radio"/> Domesticated dog <input type="radio"/> Insect <input type="radio"/> Domesticated cat <input type="radio"/> Other, specify: <input type="radio"/> Snake <input type="radio"/> U/K <input type="radio"/> Wild mammal, specify:	<p>b. Animal access to child, check all that apply:</p> <input type="checkbox"/> Animal on leash <input type="checkbox"/> Animal escaped from cage or leash <input type="checkbox"/> Animal caged or inside fence <input type="checkbox"/> Animal not caged or leashed <input type="radio"/> Child reached in <input type="checkbox"/> U/K <input type="radio"/> Child entered animal area <input type="radio"/> U/K	<p>c. Did child provoke animal?</p> <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> U/K If yes, how?
<p>d. Animal has history of biting or attacking?</p> <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> U/K		

8. FALL OR CRUSH

<p>a. Type:</p> <input type="radio"/> Fall, go to b <input type="radio"/> Crush, go to h	<p>b. Height of fall:</p> <p>_____ feet</p> <p>_____ inches</p> <input type="radio"/> U/K	<p>c. Child fell from:</p> <table style="width:100%;"> <tr> <td><input type="radio"/> Open window</td> <td><input type="radio"/> Natural elevation</td> <td><input type="radio"/> Stairs/steps</td> <td><input type="radio"/> Moving object, specify:</td> <td><input type="radio"/> Animal, specify:</td> </tr> <tr> <td><input type="radio"/> Screen</td> <td><input type="radio"/> Man-made elevation</td> <td><input type="radio"/> Furniture</td> <td><input type="radio"/> Bridge</td> <td><input type="radio"/> Other, specify:</td> </tr> <tr> <td><input type="radio"/> No screen</td> <td><input type="radio"/> Playground equipment</td> <td><input type="radio"/> Bed</td> <td><input type="radio"/> Overpass</td> <td><input type="radio"/> U/K</td> </tr> <tr> <td><input type="radio"/> U/K if screen</td> <td><input type="radio"/> Tree</td> <td><input type="radio"/> Roof</td> <td><input type="radio"/> Balcony</td> <td></td> </tr> </table>	<input type="radio"/> Open window	<input type="radio"/> Natural elevation	<input type="radio"/> Stairs/steps	<input type="radio"/> Moving object, specify:	<input type="radio"/> Animal, specify:	<input type="radio"/> Screen	<input type="radio"/> Man-made elevation	<input type="radio"/> Furniture	<input type="radio"/> Bridge	<input type="radio"/> Other, specify:	<input type="radio"/> No screen	<input type="radio"/> Playground equipment	<input type="radio"/> Bed	<input type="radio"/> Overpass	<input type="radio"/> U/K	<input type="radio"/> U/K if screen	<input type="radio"/> Tree	<input type="radio"/> Roof	<input type="radio"/> Balcony	
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<input type="radio"/> U/K if screen	<input type="radio"/> Tree	<input type="radio"/> Roof	<input type="radio"/> Balcony																			

<p>d. Surface child fell onto:</p> <input type="radio"/> Cement/concrete <input type="radio"/> Grass <input type="radio"/> Gravel <input type="radio"/> Wood floor <input type="radio"/> Carpeted floor <input type="radio"/> Linoleum/vinyl <input type="radio"/> Marble/tile <input type="radio"/> Other, specify: <input type="radio"/> U/K	<p>e. Barrier in place:</p> <p>Check all that apply:</p> <input type="checkbox"/> None <input type="checkbox"/> Screen <input type="checkbox"/> Other window guard <input type="checkbox"/> Fence <input type="checkbox"/> Railing <input type="checkbox"/> Stairway <input type="checkbox"/> Gate <input type="checkbox"/> Other, specify: <input type="checkbox"/> U/K	<p>f. Child in a baby walker?</p> <input type="radio"/> N/A <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> U/K	<p>h. For crush, did child:</p> <input type="radio"/> Climb up on object <input type="radio"/> Pull object down <input type="radio"/> Hide behind object <input type="radio"/> Go behind object <input type="radio"/> Fall out of object <input type="radio"/> Other, specify: <input type="radio"/> U/K	<p>i. For crush, object causing crush:</p> <input type="radio"/> Appliance <input type="radio"/> Television <input type="radio"/> Furniture <input type="radio"/> Walls <input type="radio"/> Playground equipment <input type="radio"/> Animal <input type="radio"/> Tree branch <input type="radio"/> Boulders/rocks	<input type="radio"/> Dirt/sand <input type="radio"/> Person, answer G6q <input type="radio"/> Commercial equipment <input type="radio"/> Farm equipment <input type="radio"/> Other, specify: <input type="radio"/> U/K
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9. POISONING, OVERDOSE OR ACUTE INTOXICATION

a. Type of substance involved, check all that apply:

<u>Prescription drug</u>	<u>Over the counter drug</u>	<u>Cleaning substances</u>	<u>Other substances</u>	<input type="checkbox"/> U/K
<input type="checkbox"/> Antidepressant	<input type="checkbox"/> Diet pills	<input type="checkbox"/> Bleach	<input type="checkbox"/> Plants	
<input type="checkbox"/> Blood pressure medication	<input type="checkbox"/> Stimulants	<input type="checkbox"/> Drain cleaner	<input type="checkbox"/> Alcohol	
<input type="checkbox"/> Pain killer (opiate)	<input type="checkbox"/> Cough medicine	<input type="checkbox"/> Alkaline-based cleaner	<input type="checkbox"/> Street drugs	
<input type="checkbox"/> Pain killer (non-opiate)	<input type="checkbox"/> Pain medication	<input type="checkbox"/> Solvent	<input type="checkbox"/> Pesticide	
<input type="checkbox"/> Methadone	<input type="checkbox"/> Children's vitamins	<input type="checkbox"/> Other, specify:	<input type="checkbox"/> Antifreeze	
<input type="checkbox"/> Cardiac medication	<input type="checkbox"/> Iron supplement		<input type="checkbox"/> Other chemical	
<input type="checkbox"/> Other, specify:	<input type="checkbox"/> Other vitamins		<input type="checkbox"/> Herbal remedy	
	<input type="checkbox"/> Other, specify:		<input type="checkbox"/> Carbon monoxide, go to f	
	<input type="checkbox"/> Cosmetics/personal care products		<input type="checkbox"/> Other fume/gas/vapor	
			<input type="checkbox"/> Other, specify:	

<p>b. Where was the substance stored?</p> <input type="radio"/> Open area <input type="radio"/> Open cabinet <input type="radio"/> Closed cabinet, unlocked <input type="radio"/> Closed cabinet, locked <input type="radio"/> Other, specify: <input type="radio"/> U/K	<p>c. Was the product in its original container?</p> <input type="radio"/> N/A <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> U/K	<p>f. Was the incident the result of?</p> <input type="radio"/> Accidental overdose <input type="radio"/> Medical treatment mishap <input type="radio"/> Adverse effect, but not overdose <input type="radio"/> Deliberate poisoning <input type="radio"/> Acute intoxication <input type="radio"/> Other, specify: <input type="radio"/> U/K	<p>g. Was Poison Control called?</p> <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> U/K If yes, who called: <input type="radio"/> Child <input type="radio"/> Parent <input type="radio"/> Other caregiver <input type="radio"/> First responder <input type="radio"/> Medical person <input type="radio"/> Other, specify: <input type="radio"/> U/K	<p>h. For CO poisoning, was a CO detector present?</p> <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> U/K If yes, how many? _____ Functioning properly? <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> U/K
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10. EXPOSURE

<p>a. Circumstances, check all that apply:</p> <input type="checkbox"/> Abandonment <input type="checkbox"/> Left in car <input type="checkbox"/> Left in room <input type="checkbox"/> Submerged in water <input type="checkbox"/> Injured outdoors	<p>b. Condition of exposure:</p> <input type="checkbox"/> Lost outdoors <input type="checkbox"/> Illegal border crossing <input type="checkbox"/> Other, specify: <input type="checkbox"/> U/K	<p>c. Number of hours exposed:</p> _____ <input type="radio"/> U/K	<p>d. Was child wearing appropriate clothing?</p> <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> U/K
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11. MEDICAL CONDITION

<p>a. How long did the child have the medical condition?</p> <input type="radio"/> In utero <input type="radio"/> Weeks <input type="radio"/> Since birth <input type="radio"/> Months <input type="radio"/> Hours <input type="radio"/> Years <input type="radio"/> Days <input type="radio"/> U/K	<p>b. Was death expected as a result of medical condition?</p> <input type="radio"/> N/A not previously diagnosed <input type="radio"/> No <input type="radio"/> Yes <input type="checkbox"/> But at a later time <input type="radio"/> U/K	<p>c. Was child receiving health care for the medical condition?</p> <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> U/K If yes, within 48 hours of the death? <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> U/K	<p>d. Were the prescribed care plans appropriate for the medical condition?</p> <input type="radio"/> N/A <input type="radio"/> No, specify: <input type="radio"/> Yes <input type="radio"/> U/K
<p>e. Was child/family compliant with the prescribed care plans?</p> <input type="radio"/> N/A <input type="radio"/> No If no, what wasn't compliant? <input type="radio"/> Yes Check all that apply. <input type="radio"/> U/K	<input type="checkbox"/> Appointments <input type="checkbox"/> Medications, specify: <input type="checkbox"/> Medical equipment use, specify: <input type="checkbox"/> Therapies, specify: <input type="checkbox"/> Other, specify: <input type="checkbox"/> U/K	<p>f. Was child up to date with American Academy of Pediatrics immunization schedule?</p> <input type="radio"/> N/A <input type="radio"/> No, specify: <input type="radio"/> Yes <input type="radio"/> U/K	<p>g. Was medical condition associated with an outbreak?</p> <input type="radio"/> No <input type="radio"/> Yes, specify: <input type="radio"/> U/K

h. Was environmental tobacco exposure a contributing factor in death? <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> U/K	i. Were there access or compliance issues related to the death? <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> U/K If yes, check all that apply: <table border="0" style="width: 100%;"> <tr> <td><input type="checkbox"/> Lack of money for care</td> <td><input type="checkbox"/> Language barriers</td> <td><input type="checkbox"/> Caregiver distrust of health care system</td> </tr> <tr> <td><input type="checkbox"/> Limitations of health insurance coverage</td> <td><input type="checkbox"/> Referrals not made</td> <td><input type="checkbox"/> Caregiver unskilled in providing care</td> </tr> <tr> <td><input type="checkbox"/> Multiple health insurance, not coordinated</td> <td><input type="checkbox"/> Specialist needed, not available</td> <td><input type="checkbox"/> Caregiver unwilling to provide care</td> </tr> <tr> <td><input type="checkbox"/> Lack of transportation</td> <td><input type="checkbox"/> Multiple providers, not coordinated</td> <td><input type="checkbox"/> Caregiver's partner would not allow care</td> </tr> <tr> <td><input type="checkbox"/> No phone</td> <td><input type="checkbox"/> Lack of child care</td> <td><input type="checkbox"/> Other, specify:</td> </tr> <tr> <td><input type="checkbox"/> Cultural differences</td> <td><input type="checkbox"/> Lack of family or social support</td> <td></td> </tr> <tr> <td><input type="checkbox"/> Religious objections to care</td> <td><input type="checkbox"/> Services not available</td> <td><input type="checkbox"/> U/K</td> </tr> </table>	<input type="checkbox"/> Lack of money for care	<input type="checkbox"/> Language barriers	<input type="checkbox"/> Caregiver distrust of health care system	<input type="checkbox"/> Limitations of health insurance coverage	<input type="checkbox"/> Referrals not made	<input type="checkbox"/> Caregiver unskilled in providing care	<input type="checkbox"/> Multiple health insurance, not coordinated	<input type="checkbox"/> Specialist needed, not available	<input type="checkbox"/> Caregiver unwilling to provide care	<input type="checkbox"/> Lack of transportation	<input type="checkbox"/> Multiple providers, not coordinated	<input type="checkbox"/> Caregiver's partner would not allow care	<input type="checkbox"/> No phone	<input type="checkbox"/> Lack of child care	<input type="checkbox"/> Other, specify:	<input type="checkbox"/> Cultural differences	<input type="checkbox"/> Lack of family or social support		<input type="checkbox"/> Religious objections to care	<input type="checkbox"/> Services not available	<input type="checkbox"/> U/K
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12. OTHER CAUSE, UNDETERMINED CAUSE OR UNKNOWN CAUSE

Specify cause, describe in detail here or in narrative:

H. OTHER CIRCUMSTANCES OF INCIDENT- ANSWER RELEVANT SECTIONS

1. ANSWER THIS ONLY IF CHILD IS UNDER AGE FIVE: WAS DEATH RELATED TO SLEEPING OR THE SLEEP ENVIRONMENT? No, go to H2 Yes U/K, go to H2

a. Incident sleep place: <input type="radio"/> Crib If crib, type: <input type="radio"/> Not portable <input type="radio"/> Portable, e.g. pack-n-play <input type="radio"/> Unknown crib type <input type="radio"/> Bassinette <input type="radio"/> Adult bed <input type="radio"/> Waterbed	<input type="radio"/> Playpen/other play structure but not portable crib <input type="radio"/> Couch <input type="radio"/> Chair <input type="radio"/> Floor <input type="radio"/> Car seat <input type="radio"/> Stroller <input type="radio"/> Other, specify: <input type="radio"/> U/K	If adult bed, what type? <input type="radio"/> Twin <input type="radio"/> Full <input type="radio"/> Queen <input type="radio"/> King <input type="radio"/> Other, specify: <input type="radio"/> U/K	b. Child put to sleep: <input type="radio"/> On back <input type="radio"/> On stomach <input type="radio"/> On side <input type="radio"/> U/K	c. Child found: <input type="radio"/> On back <input type="radio"/> On stomach <input type="radio"/> On side <input type="radio"/> U/K
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d. Usual sleep place: <input type="radio"/> Crib If crib, type: <input type="radio"/> Not portable <input type="radio"/> Portable, e.g. pack-n-play <input type="radio"/> Unknown crib type <input type="radio"/> Bassinette <input type="radio"/> Adult bed <input type="radio"/> Waterbed	<input type="radio"/> Playpen/other play structure but not portable crib <input type="radio"/> Couch <input type="radio"/> Chair <input type="radio"/> Floor <input type="radio"/> Car seat <input type="radio"/> Stroller <input type="radio"/> Other, specify: <input type="radio"/> U/K	If adult bed, what type? <input type="radio"/> Twin <input type="radio"/> Full <input type="radio"/> Queen <input type="radio"/> King <input type="radio"/> Other, specify: <input type="radio"/> U/K	e. Usual sleep position: <input type="radio"/> On back <input type="radio"/> On stomach <input type="radio"/> On side <input type="radio"/> U/K	f. Was there a crib, bassinette or port-a-crib in home for child? <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> U/K
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g. Child in a new or different environment than usual? <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> U/K If yes, specify:	h. Child last placed to sleep with a pacifier? <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> U/K	i. Was a fan being used in the room at the time of death? <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> U/K If yes, type:
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j. Circumstances when child found: <u>Child's airway was:</u> <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	<u>Child's position most relevant to death:</u> <input type="radio"/> On top of <input type="radio"/> Under <input type="radio"/> Between <input type="radio"/> Wedged into <input type="radio"/> Pressed into <input type="radio"/> Fell or rolled onto <input type="radio"/> Tangled in <input type="radio"/> Other, specify: <input type="radio"/> U/K	<u>With what objects or persons, check all that apply:</u> <table border="0" style="width: 100%;"> <tr> <td><input type="checkbox"/> Adult(s)</td> <td><input type="checkbox"/> Water bed mattress</td> <td><input type="checkbox"/> Clothing</td> </tr> <tr> <td><input type="checkbox"/> Child(ren)</td> <td><input type="checkbox"/> Air mattress</td> <td><input type="checkbox"/> Cord</td> </tr> <tr> <td><input type="checkbox"/> Animal(s)</td> <td><input type="checkbox"/> Bumper pads</td> <td><input type="checkbox"/> Plastic bag</td> </tr> <tr> <td><input type="checkbox"/> Blanket</td> <td><input type="checkbox"/> Crib rail</td> <td><input type="checkbox"/> Wall</td> </tr> <tr> <td><input type="checkbox"/> Pillow</td> <td><input type="checkbox"/> Couch</td> <td><input type="checkbox"/> Other, specify:</td> </tr> <tr> <td><input type="checkbox"/> Comforter</td> <td><input type="checkbox"/> Chair, type:</td> <td></td> </tr> <tr> <td><input type="checkbox"/> Mattress</td> <td><input type="checkbox"/> Car seat/stroller</td> <td><input type="checkbox"/> U/K</td> </tr> <tr> <td><input type="checkbox"/> Pillow-top mattress</td> <td><input type="checkbox"/> Stuffed toy</td> <td></td> </tr> </table>	<input type="checkbox"/> Adult(s)	<input type="checkbox"/> Water bed mattress	<input type="checkbox"/> Clothing	<input type="checkbox"/> Child(ren)	<input type="checkbox"/> Air mattress	<input type="checkbox"/> Cord	<input type="checkbox"/> Animal(s)	<input type="checkbox"/> Bumper pads	<input type="checkbox"/> Plastic bag	<input type="checkbox"/> Blanket	<input type="checkbox"/> Crib rail	<input type="checkbox"/> Wall	<input type="checkbox"/> Pillow	<input type="checkbox"/> Couch	<input type="checkbox"/> Other, specify:	<input type="checkbox"/> Comforter	<input type="checkbox"/> Chair, type:		<input type="checkbox"/> Mattress	<input type="checkbox"/> Car seat/stroller	<input type="checkbox"/> U/K	<input type="checkbox"/> Pillow-top mattress	<input type="checkbox"/> Stuffed toy	
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<input type="checkbox"/> Mattress	<input type="checkbox"/> Car seat/stroller	<input type="checkbox"/> U/K																								
<input type="checkbox"/> Pillow-top mattress	<input type="checkbox"/> Stuffed toy																									

k. Caregiver/supervisor fell asleep while feeding child? <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> U/K If yes, type of feeding: <input type="radio"/> Bottle <input type="radio"/> Breast <input type="radio"/> U/K	l. Child sleeping in the same room as caregiver/supervisor at time of death? <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> U/K	m. Child sleeping on same surface with person(s) or animal(s)? <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> U/K If yes, check all that apply: <input type="checkbox"/> With adult(s): # ___ <input type="checkbox"/> #U/K Adult obese: <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> U/K <input type="checkbox"/> With other children: # ___ <input type="checkbox"/> #U/K Children's ages: _____ <input type="checkbox"/> With animal(s): # ___ <input type="checkbox"/> #U/K Type(s) of animal: _____ <input type="checkbox"/> U/K
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2. WAS DEATH A CONSEQUENCE OF A PROBLEM WITH A CONSUMER PRODUCT? No, go to H3 Yes U/K, go to H3

a. Describe product and circumstances:	b. Was product used properly? <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> U/K	c. Is a recall in place? <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> U/K	d. Did product have safety label? <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> U/K	e. Was Consumer Product Safety Commission (CPSC) notified? <input type="radio"/> No, call 1-800-638-2772 to file report <input type="radio"/> Yes <input type="radio"/> U/K
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3. DID DEATH OCCUR DURING COMMISSION OF ANOTHER CRIME? No Yes U/K

a. Type of crime, check all that apply:

<input type="checkbox"/> Robbery/burglary	<input type="checkbox"/> Other assault	<input type="checkbox"/> Arson	<input type="checkbox"/> Illegal border crossing	<input type="checkbox"/> U/K
<input type="checkbox"/> Interpersonal violence	<input type="checkbox"/> Gang conflict	<input type="checkbox"/> Prostitution	<input type="checkbox"/> Auto theft	
<input type="checkbox"/> Sexual assault	<input type="checkbox"/> Drug trade	<input type="checkbox"/> Witness intimidation	<input type="checkbox"/> Other, specify:	

I. ACTS OF OMISSION OR COMMISSION INCLUDING POOR SUPERVISION, CHILD ABUSE & NEGLECT, ASSAULTS, AND SUICIDE

Type of Act

<p>1. Did any act(s) of omission or commission cause and/or contribute to the death?</p> <p><input type="radio"/> No, go to Section J</p> <p><input type="radio"/> Yes</p> <p><input type="radio"/> Probable</p> <p><input type="radio"/> U/K, go to Section J</p> <p>If yes/probable, were the act(s) either or both?</p> <p>Check all that apply:</p> <p><input type="checkbox"/> The direct cause of death</p> <p><input type="checkbox"/> The contributing cause of death</p>	<p>2. Was the act(s): Check only one per column.</p> <table border="0"> <tr> <td><u>Caused</u></td> <td><u>Contributed</u></td> <td></td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/></td> <td>Unintentional</td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/></td> <td>Intentional</td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/></td> <td>Undetermined intent</td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/></td> <td>U/K</td> </tr> </table>	<u>Caused</u>	<u>Contributed</u>		<input type="radio"/>	<input type="radio"/>	Unintentional	<input type="radio"/>	<input type="radio"/>	Intentional	<input type="radio"/>	<input type="radio"/>	Undetermined intent	<input type="radio"/>	<input type="radio"/>	U/K	<p>3. What acts caused or contributed to the death?</p> <p>Check only one per column and describe in narrative.</p> <table border="0"> <tr> <td><u>Caused</u></td> <td><u>Contributed</u></td> <td></td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/></td> <td>Poor/absent supervision, go to 11</td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/></td> <td>Child abuse, go to 4</td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/></td> <td>Child neglect, go to 9</td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/></td> <td>Other negligence, go to 10</td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/></td> <td>Assault, not child abuse, go to 11</td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/></td> <td>Religious/cultural practices, go to 11</td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/></td> <td>Suicide, go to 28</td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/></td> <td>Medical misadventure, specify and go to 12</td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/></td> <td>Other, specify and go to 11</td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/></td> <td>U/K, go to 11</td> </tr> </table>	<u>Caused</u>	<u>Contributed</u>		<input type="radio"/>	<input type="radio"/>	Poor/absent supervision, go to 11	<input type="radio"/>	<input type="radio"/>	Child abuse, go to 4	<input type="radio"/>	<input type="radio"/>	Child neglect, go to 9	<input type="radio"/>	<input type="radio"/>	Other negligence, go to 10	<input type="radio"/>	<input type="radio"/>	Assault, not child abuse, go to 11	<input type="radio"/>	<input type="radio"/>	Religious/cultural practices, go to 11	<input type="radio"/>	<input type="radio"/>	Suicide, go to 28	<input type="radio"/>	<input type="radio"/>	Medical misadventure, specify and go to 12	<input type="radio"/>	<input type="radio"/>	Other, specify and go to 11	<input type="radio"/>	<input type="radio"/>	U/K, go to 11
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<input type="radio"/>	<input type="radio"/>	U/K, go to 11																																																

<p>4. Child abuse, type. Check all that apply and describe in narrative.</p> <p><input type="checkbox"/> Physical, go to 5</p> <p><input type="checkbox"/> Emotional, specify and go to 11</p> <p><input type="checkbox"/> Sexual, specify and go to 11</p> <p><input type="checkbox"/> U/K, go to 11</p>	<p>5. Type of physical abuse, check all that apply:</p> <p><input type="checkbox"/> Abusive head trauma, go to 6</p> <p><input type="checkbox"/> Chronic Battered Child Syndrome, go to 8</p> <p><input type="checkbox"/> Beating/kicking, go to 8</p> <p><input type="checkbox"/> Scalding or burning, go to 8</p> <p><input type="checkbox"/> Munchausen Syndrome by Proxy, go to 8</p> <p><input type="checkbox"/> Other, specify and go to 8</p> <p><input type="checkbox"/> U/K, go to 8</p>	<p>6. For abusive head trauma, were there retinal hemorrhages?</p> <p><input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> U/K</p> <p>7. For abusive head trauma, was the child shaken?</p> <p><input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> U/K</p> <p>If yes, was there impact?</p> <p><input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> U/K</p>	<p>8. Events(s) triggering physical 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>
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<p>9. Child neglect, check all that apply:</p> <p><input type="checkbox"/> Failure to protect from hazards, specify:</p> <p><input type="checkbox"/> Failure to provide necessities</p> <p><input type="checkbox"/> Food</p> <p><input type="checkbox"/> Shelter</p> <p><input type="checkbox"/> Other, specify:</p> <p><input type="checkbox"/> Failure to seek/follow treatment, specify:</p> <p><input type="checkbox"/> Emotional neglect, specify:</p> <p><input type="checkbox"/> Abandonment, specify:</p> <p><input type="checkbox"/> U/K</p>	<p>10. Other negligence:</p> <p><input type="radio"/> Vehicular</p> <p><input type="radio"/> Other, specify:</p> <p><input type="radio"/> U/K</p>	<p>11. Was act(s) of omission/commission:</p> <table border="0"> <tr> <td><u>Caused</u></td> <td><u>Contributed</u></td> <td></td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/></td> <td>Chronic with child</td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/></td> <td>Pattern in family or with perpetrator</td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/></td> <td>Isolated incident</td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/></td> <td>U/K</td> </tr> </table>	<u>Caused</u>	<u>Contributed</u>		<input type="radio"/>	<input type="radio"/>	Chronic with child	<input type="radio"/>	<input type="radio"/>	Pattern in family or with perpetrator	<input type="radio"/>	<input type="radio"/>	Isolated incident	<input type="radio"/>	<input type="radio"/>	U/K
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<input type="radio"/>	<input type="radio"/>	Isolated incident															
<input type="radio"/>	<input type="radio"/>	U/K															

Person(s) Responsible

<p>12. Is person the caregiver or supervisor in previous section?</p> <table border="0"> <tr> <td><u>Caused</u></td> <td><u>Contributed</u></td> <td></td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/></td> <td>No</td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/></td> <td>Yes, caregiver one, go to 25</td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/></td> <td>Yes, caregiver two, go to 25</td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/></td> <td>Yes, supervisor, go to 26</td> </tr> </table>	<u>Caused</u>	<u>Contributed</u>		<input type="radio"/>	<input type="radio"/>	No	<input type="radio"/>	<input type="radio"/>	Yes, caregiver one, go to 25	<input type="radio"/>	<input type="radio"/>	Yes, caregiver two, go to 25	<input type="radio"/>	<input type="radio"/>	Yes, supervisor, go to 26	<p>13. Primary person responsible for action(s) that caused and/or contributed to death:</p> <p>Select no more than one person for caused and one person for contributed.</p> <table border="0"> <tr> <td><u>Caused</u></td> <td><u>Contributed</u></td> <td><u>Caused</u></td> <td><u>Contributed</u></td> <td><u>Caused</u></td> <td><u>Contributed</u></td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/></td> <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>Self, go to 25</td> <td></td> <td>Grandparent</td> <td></td> <td>Medical provider</td> </tr> <tr> <td></td> <td>Biological parent</td> <td></td> <td>Sibling</td> <td></td> <td>Institutional staff</td> </tr> <tr> <td></td> <td>Adoptive parent</td> <td></td> <td>Other relative</td> <td></td> <td>Babysitter</td> </tr> <tr> <td></td> <td>Stepparent</td> <td></td> <td>Friend</td> <td></td> <td>Licensed child care worker</td> </tr> <tr> <td></td> <td>Foster parent</td> <td></td> <td>Acquaintance</td> <td></td> <td>Other, specify:</td> </tr> <tr> <td></td> <td>Mother's partner</td> <td></td> <td>Child's boyfriend or girlfriend</td> <td></td> <td><input type="radio"/></td> </tr> <tr> <td></td> <td>Father's partner</td> <td></td> <td>Stranger</td> <td></td> <td><input type="radio"/></td> </tr> <tr> <td></td> <td></td> <td></td> <td></td> <td></td> <td>U/K</td> </tr> </table>	<u>Caused</u>	<u>Contributed</u>	<u>Caused</u>	<u>Contributed</u>	<u>Caused</u>	<u>Contributed</u>	<input type="radio"/>		Self, go to 25		Grandparent		Medical provider		Biological parent		Sibling		Institutional staff		Adoptive parent		Other relative		Babysitter		Stepparent		Friend		Licensed child care worker		Foster parent		Acquaintance		Other, specify:		Mother's partner		Child's boyfriend or girlfriend		<input type="radio"/>		Father's partner		Stranger		<input type="radio"/>						U/K					
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	Father's partner		Stranger		<input type="radio"/>																																																																							
					U/K																																																																							

<p>14. Person's age in years:</p> <table border="0"> <tr> <td><u>Caused</u></td> <td><u>Contributed</u></td> <td></td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>U/K</td> </tr> </table> <p>_____ # Years</p>	<u>Caused</u>	<u>Contributed</u>		<input type="checkbox"/>	<input type="checkbox"/>	U/K	<p>15. Person's sex:</p> <table border="0"> <tr> <td><u>Caused</u></td> <td><u>Contributed</u></td> <td></td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/></td> <td>Male</td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/></td> <td>Female</td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/></td> <td>U/K</td> </tr> </table>	<u>Caused</u>	<u>Contributed</u>		<input type="radio"/>	<input type="radio"/>	Male	<input type="radio"/>	<input type="radio"/>	Female	<input type="radio"/>	<input type="radio"/>	U/K	<p>16. Does person speak English?</p> <table border="0"> <tr> <td><u>Caused</u></td> <td><u>Contributed</u></td> <td></td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/></td> <td>No</td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/></td> <td>Yes</td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/></td> <td>U/K</td> </tr> </table> <p>If no, language spoken:</p>	<u>Caused</u>	<u>Contributed</u>		<input type="radio"/>	<input type="radio"/>	No	<input type="radio"/>	<input type="radio"/>	Yes	<input type="radio"/>	<input type="radio"/>	U/K	<p>17. Person on active military duty?</p> <table border="0"> <tr> <td><u>Caused</u></td> <td><u>Contributed</u></td> <td></td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/></td> <td>No</td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/></td> <td>Yes</td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/></td> <td>U/K</td> </tr> </table> <p>If yes, specify branch:</p>	<u>Caused</u>	<u>Contributed</u>		<input type="radio"/>	<input type="radio"/>	No	<input type="radio"/>	<input type="radio"/>	Yes	<input type="radio"/>	<input type="radio"/>	U/K
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<p>18. Person have history of substance abuse?</p> <p><u>Caused</u> <u>Contributed</u></p> <p><input type="radio"/> <input type="radio"/> No <input type="radio"/> <input type="radio"/> Yes <input type="radio"/> <input type="radio"/> U/K</p> <p>If yes, check all that apply:</p> <p><input type="checkbox"/> <input type="checkbox"/> Alcohol <input type="checkbox"/> <input type="checkbox"/> Cocaine <input type="checkbox"/> <input type="checkbox"/> Marijuana <input type="checkbox"/> <input type="checkbox"/> Methamphetamine <input type="checkbox"/> <input type="checkbox"/> Opiates <input type="checkbox"/> <input type="checkbox"/> Prescription drugs <input type="checkbox"/> <input type="checkbox"/> Over-the-counter <input type="checkbox"/> <input type="checkbox"/> Other, specify: <input type="checkbox"/> <input type="checkbox"/> U/K</p>	<p>19. Person have history of child maltreatment as victim?</p> <p><u>Caused</u> <u>Contributed</u></p> <p><input type="radio"/> <input type="radio"/> No <input type="radio"/> <input type="radio"/> Yes <input type="radio"/> <input type="radio"/> U/K</p> <p>If yes, check all that apply:</p> <p><input type="checkbox"/> <input type="checkbox"/> Physical <input type="checkbox"/> <input type="checkbox"/> Neglect <input type="checkbox"/> <input type="checkbox"/> Sexual <input type="checkbox"/> <input type="checkbox"/> Emotional/psychological <input type="checkbox"/> <input type="checkbox"/> U/K</p> <p>_____ # CPS referrals _____ # Substantiations</p> <p><input type="checkbox"/> <input type="checkbox"/> Ever in foster care or adopted?</p>	<p>20. Person have history of child maltreatment as a perpetrator?</p> <p><u>Caused</u> <u>Contributed</u></p> <p><input type="radio"/> <input type="radio"/> No <input type="radio"/> <input type="radio"/> Yes <input type="radio"/> <input type="radio"/> U/K</p> <p>If yes, check all that apply:</p> <p><input type="checkbox"/> <input type="checkbox"/> Physical <input type="checkbox"/> <input type="checkbox"/> Neglect <input type="checkbox"/> <input type="checkbox"/> Sexual <input type="checkbox"/> <input type="checkbox"/> Emotional/psychological <input type="checkbox"/> <input type="checkbox"/> U/K</p> <p>_____ # CPS referrals _____ # Substantiations</p> <p><input type="checkbox"/> <input type="checkbox"/> CPS prevention services? <input type="checkbox"/> <input type="checkbox"/> Family Preservation svcs? <input type="checkbox"/> <input type="checkbox"/> Children ever removed?</p>	<p>21. Person have disability or chronic illness?</p> <p><u>Caused</u> <u>Contributed</u></p> <p><input type="radio"/> <input type="radio"/> No <input type="radio"/> <input type="radio"/> Yes <input type="radio"/> <input type="radio"/> U/K</p> <p>If yes, check all that apply:</p> <p><input type="checkbox"/> <input type="checkbox"/> Physical, specify: <input type="checkbox"/> <input type="checkbox"/> Mental, specify: <input type="checkbox"/> <input type="checkbox"/> Sensory, specify: <input type="checkbox"/> <input type="checkbox"/> U/K</p> <p>If mental, was caregiver receiving services?</p> <p><input type="radio"/> <input type="radio"/> No <input type="radio"/> <input type="radio"/> Yes <input type="radio"/> <input type="radio"/> U/K</p>																																																																																
<p>22. Person have prior child deaths?</p> <p><u>Caused</u> <u>Contributed</u></p> <p><input type="radio"/> <input type="radio"/> No <input type="radio"/> <input type="radio"/> Yes <input type="radio"/> <input type="radio"/> U/K</p>	<p>If yes, check all that apply:</p> <p><u>Caused</u> <u>Contributed</u></p> <p><input type="checkbox"/> <input type="checkbox"/> Child abuse # _____ <input type="checkbox"/> <input type="checkbox"/> Child neglect # _____ <input type="checkbox"/> <input type="checkbox"/> Accident # _____ <input type="checkbox"/> <input type="checkbox"/> Suicide # _____ <input type="checkbox"/> <input type="checkbox"/> SIDS # _____ <input type="checkbox"/> <input type="checkbox"/> Other # _____ Other, specify: <input type="checkbox"/> <input type="checkbox"/> U/K</p>	<p>23. Person have history of intimate partner violence?</p> <p><u>Caused</u> <u>Contributed</u></p> <p><input type="checkbox"/> <input type="checkbox"/> No <input type="checkbox"/> <input type="checkbox"/> Yes, as victim <input type="checkbox"/> <input type="checkbox"/> Yes, as perpetrator <input type="checkbox"/> <input type="checkbox"/> U/K</p>	<p>24. Person have delinquent/criminal history?</p> <p><u>Caused</u> <u>Contributed</u></p> <p><input type="radio"/> <input type="radio"/> No <input type="radio"/> <input type="radio"/> Yes <input type="radio"/> <input type="radio"/> U/K</p> <p>If yes, check all that apply:</p> <p><input type="checkbox"/> <input type="checkbox"/> Assaults <input type="checkbox"/> <input type="checkbox"/> Robbery <input type="checkbox"/> <input type="checkbox"/> Drugs <input type="checkbox"/> <input type="checkbox"/> Other, specify: <input type="checkbox"/> <input type="checkbox"/> U/K</p>																																																																																
<p>25. At time of incident was person, check all that apply:</p> <p><u>Caused</u> <u>Contributed</u></p> <p><input type="checkbox"/> <input type="checkbox"/> Drug impaired? <input type="checkbox"/> <input type="checkbox"/> Alcohol impaired? <input type="checkbox"/> <input type="checkbox"/> Asleep? <input type="checkbox"/> <input type="checkbox"/> Distracted? <input type="checkbox"/> <input type="checkbox"/> Absent? <input type="checkbox"/> <input type="checkbox"/> Impaired by illness? Specify: <input type="checkbox"/> <input type="checkbox"/> Impaired by disability? Specify: <input type="checkbox"/> <input type="checkbox"/> Other? Specify:</p>	<p>26. Does person have, check all that apply:</p> <p><u>Caused</u> <u>Contributed</u></p> <p><input type="checkbox"/> <input type="checkbox"/> Prior history of similar acts? <input type="checkbox"/> <input type="checkbox"/> Prior arrests? <input type="checkbox"/> <input type="checkbox"/> Prior convictions?</p>	<p>27. Legal outcomes in this death, check all that apply:</p> <p><u>Caused</u> <u>Contributed</u></p> <p><input type="checkbox"/> <input type="checkbox"/> No charges filed <input type="checkbox"/> <input type="checkbox"/> Charges pending <input type="checkbox"/> <input type="checkbox"/> Charges filed, specify: <input type="checkbox"/> <input type="checkbox"/> Confession <input type="checkbox"/> <input type="checkbox"/> Plead, specify: <input type="checkbox"/> <input type="checkbox"/> Not guilty verdict <input type="checkbox"/> <input type="checkbox"/> Guilty verdict, specify: <input type="checkbox"/> <input type="checkbox"/> Tort charges, specify: <input type="checkbox"/> <input type="checkbox"/> U/K</p>																																																																																	
For Suicide																																																																																			
<p>28. For suicide, select yes, no or u/k for each question. Describe answers in narrative.</p> <table border="0"> <tr> <td><u>Yes</u></td> <td><u>No</u></td> <td><u>U/K</u></td> <td></td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/></td> <td><input type="radio"/></td> <td>A note was left?</td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/></td> <td><input type="radio"/></td> <td>Child talked about suicide?</td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/></td> <td><input type="radio"/></td> <td>Prior suicide threats were made?</td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/></td> <td><input type="radio"/></td> <td>Prior attempts were made?</td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/></td> <td><input type="radio"/></td> <td>Suicide was completely unexpected?</td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/></td> <td><input type="radio"/></td> <td>Child had a history of running away?</td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/></td> <td><input type="radio"/></td> <td>Child had a history of self mutilation?</td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/></td> <td><input type="radio"/></td> <td>There is a family history of suicide?</td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/></td> <td><input type="radio"/></td> <td>Suicide was part of a murder-suicide?</td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/></td> <td><input type="radio"/></td> <td>Suicide was part of a suicide pact?</td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/></td> <td><input type="radio"/></td> <td>Suicide was part of a suicide cluster?</td> </tr> </table>		<u>Yes</u>	<u>No</u>	<u>U/K</u>		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	A note was left?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Child talked about suicide?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Prior suicide threats were made?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Prior attempts were made?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Suicide was completely unexpected?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Child had a history of running away?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Child had a history of self mutilation?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	There is a family history of suicide?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Suicide was part of a murder-suicide?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Suicide was part of a suicide pact?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Suicide was part of a suicide cluster?	<p>29. For suicide, was there a history of acute or cumulative personal crisis that may have contributed to the child's despondency? Check all that apply:</p> <table border="0"> <tr> <td><input type="checkbox"/> None known</td> <td><input type="checkbox"/> Physical abuse/assault</td> </tr> <tr> <td><input type="checkbox"/> Family discord</td> <td><input type="checkbox"/> Rape/sexual abuse</td> </tr> <tr> <td><input type="checkbox"/> Parents' divorce/separation</td> <td><input type="checkbox"/> Problems with the law</td> </tr> <tr> <td><input type="checkbox"/> Argument with parents/caregivers</td> <td><input type="checkbox"/> Drugs/alcohol</td> </tr> <tr> <td><input type="checkbox"/> Argument with boyfriend/girlfriend</td> <td><input type="checkbox"/> Sexual orientation</td> </tr> <tr> <td><input type="checkbox"/> Breakup with boyfriend/girlfriend</td> <td><input type="checkbox"/> Religious/cultural issues</td> </tr> <tr> <td><input type="checkbox"/> Argument with other friends</td> <td><input type="checkbox"/> Job problems</td> </tr> <tr> <td><input type="checkbox"/> Rumor mongering</td> <td><input type="checkbox"/> Money problems</td> </tr> <tr> <td><input type="checkbox"/> Suicide by friend or relative</td> <td><input type="checkbox"/> Gambling problems</td> </tr> <tr> <td><input type="checkbox"/> Other death of friend or relative</td> <td><input type="checkbox"/> Involvement in cult activities</td> </tr> <tr> <td><input type="checkbox"/> Bullying as victim</td> <td><input type="checkbox"/> Involvement in computer or video games</td> </tr> <tr> <td><input type="checkbox"/> Bullying as perpetrator</td> <td><input type="checkbox"/> Involvement with the Internet, specify:</td> </tr> <tr> <td><input type="checkbox"/> School failure</td> <td><input type="checkbox"/> Other, specify:</td> </tr> <tr> <td><input type="checkbox"/> Move/new school</td> <td><input type="checkbox"/> U/K</td> </tr> <tr> <td><input type="checkbox"/> Other serious school problems</td> <td></td> </tr> <tr> <td><input type="checkbox"/> Pregnancy</td> <td></td> </tr> </table>		<input type="checkbox"/> None known	<input type="checkbox"/> Physical abuse/assault	<input type="checkbox"/> Family discord	<input type="checkbox"/> Rape/sexual abuse	<input type="checkbox"/> Parents' divorce/separation	<input type="checkbox"/> Problems with the law	<input type="checkbox"/> Argument with parents/caregivers	<input type="checkbox"/> Drugs/alcohol	<input type="checkbox"/> Argument with boyfriend/girlfriend	<input type="checkbox"/> Sexual orientation	<input type="checkbox"/> Breakup with boyfriend/girlfriend	<input type="checkbox"/> Religious/cultural issues	<input type="checkbox"/> Argument with other friends	<input type="checkbox"/> Job problems	<input type="checkbox"/> Rumor mongering	<input type="checkbox"/> Money problems	<input type="checkbox"/> Suicide by friend or relative	<input type="checkbox"/> Gambling problems	<input type="checkbox"/> Other death of friend or relative	<input type="checkbox"/> Involvement in cult activities	<input type="checkbox"/> Bullying as victim	<input type="checkbox"/> Involvement in computer or video games	<input type="checkbox"/> Bullying as perpetrator	<input type="checkbox"/> Involvement with the Internet, specify:	<input type="checkbox"/> School failure	<input type="checkbox"/> Other, specify:	<input type="checkbox"/> Move/new school	<input type="checkbox"/> U/K	<input type="checkbox"/> Other serious school problems		<input type="checkbox"/> Pregnancy	
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J. SERVICES TO FAMILY AND COMMUNITY AS A RESULT OF DEATH

1. Services: Select one option per row:	Provided after death	Offered but refused	Offered but U/K if used	Should be offered	Needed but not available	Unknown	CDR review led to referral
Bereavement counseling	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/>
Economic support	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/>
Funeral arrangements	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/>
Emergency shelter	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/>
Mental health services	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/>
Foster care	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/>
Health care	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/>
Legal services	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/>
Family planning	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/>
Other, specify:	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/>

K. PREVENTION INITIATIVES RESULTING FROM THE REVIEW

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

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

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

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

Briefly describe the initiatives:

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

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

L. THE REVIEW MEETING PROCESS

1. Date of first review meeting:	2. Number of review meetings for this case: _____	3. Is review complete? <input type="radio"/> N/A <input type="radio"/> No <input type="radio"/> Yes
4. Agencies at review, check all that apply:		
<input type="checkbox"/> Medical examiner/coroner	<input type="checkbox"/> CPS	<input type="checkbox"/> Other health care
<input type="checkbox"/> Law enforcement	<input type="checkbox"/> Other social services	<input type="checkbox"/> Fire
<input type="checkbox"/> Prosecutor/district attorney	<input type="checkbox"/> Physician	<input type="checkbox"/> EMS
<input type="checkbox"/> Public health	<input type="checkbox"/> Hospital	<input type="checkbox"/> Education
		<input type="checkbox"/> Mental health <input type="checkbox"/> Substance abuse <input type="checkbox"/> Court <input type="checkbox"/> Child advocate <input type="checkbox"/> Others, list:
5. Factors that prevented an effective review, check all that apply:		6. Review meeting outcomes, check all that apply:
<input type="checkbox"/> Confidentiality issues among members prevented full exchange of information		<input type="checkbox"/> Review led to additional investigation
<input type="checkbox"/> HIPAA regulations prevented access to or exchange of information		<input type="checkbox"/> Team disagreed with official manner of death What did team believe manner should be?
<input type="checkbox"/> Inadequate investigation precluded having enough information for review		<input type="checkbox"/> Team disagreed with official cause of death What did team believe cause should be?
<input type="checkbox"/> Team members did not bring adequate information to the meeting		<input type="checkbox"/> Because of the review, the official cause or manner of death was changed
<input type="checkbox"/> Necessary team members were absent		<input type="checkbox"/> Review led to the delivery of services
<input type="checkbox"/> Meeting was held too soon after death		<input type="checkbox"/> Review led to changes in agency policies or practices
<input type="checkbox"/> Meeting was held too long after death		<input type="checkbox"/> Review led to prevention initiatives being implemented
<input type="checkbox"/> Records or information were needed from another locality in-state		<input type="checkbox"/> Local <input type="checkbox"/> State <input type="checkbox"/> National
<input type="checkbox"/> Records or information were needed from another state		
<input type="checkbox"/> Team disagreement on circumstances		
<input type="checkbox"/> Other factors, specify:		

M. NARRATIVE

Use this space to provide more detail on the circumstances of the death, and to describe any other relevant information.
Try not to include identifiers in the narrative.

Continue narrative if necessary on back page

N. FORM COMPLETED BY:

PERSON:
TITLE:
AGENCY:
PHONE:

EMAIL:
DATE COMPLETED:
DATA ENTRY COMPLETED FOR THIS CASE?

For State Program Use Only:
DATA QUALITY ASSURANCE COMPLETED BY STATE

NOTES



The development of this report tool was supported, in part, by Grant No. U49MC00225 from the Maternal and Child Health Bureau (Title V, Social Security Act), Health Resources and Services Administration, Department of Health and Human Services

Data Entry: <https://cdrdata.org>
www.childdeathreview.org
For help email: info@childdeathreview.org
1-800-656-2434

NEW YORK STATE OFFICE OF CHILDREN AND FAMILY SERVICES

CHILD FATALITY REPORT

<p><u>Report Identification Number:</u></p> <p><u>Report prepared by:</u></p> <p><u>Report issued on:</u></p>

This is a report prepared pursuant to section 20(5) of the Social Services Law (SSL). It concerns the case:

- of a report made to the New York Statewide Central Register of Child Abuse and Maltreatment (SCR) involving the death of a child.
- of the death of a child for whom child protective services has an open case
- of the death of a child whose care and custody or custody and guardianship has been transferred to an authorized agency.
- of the death of a child for whom the local department of social services has an open preventive service case.

As mandated by section 20(5) of the SSL, this report contains no information that would identify the deceased child, his or her siblings, the parent, parents or other persons legally responsible for the child, and any members of the deceased child's household. This report may be disclosed to the public by the New York State Office of Children and Family Services (OCFS) pursuant to section 20(5)(c) of the SSL. However, it may be released only after the Commissioner of OCFS has determined that such disclosure is not contrary to the best interests of the deceased child's siblings or other children in the household.

OCFS' review included an examination of actions taken by individual caseworkers and supervisors within the social services district and agencies under contract with the social services district. The observations and recommendations contained in this report reflect OCFS' assessment of the performance of these individuals.

Individual Child Fatality Report

Case ID: 95-2011-00027

Jurisdiction:

Age:

Date of Death:

Official Manner and Primary Cause of Death

Official manner of death:.....

Primary cause of death:.....

Description:.....

Person declaring official manner and cause of death:.....

Presenting Information

Fatality Narrative

Incident Information

Date /Time of fatal incident event if different than date of death: / / AM

Unknown

Unknown

County where fatal incident occurred:.....

Was 911 or local emergency number called?.....

EMS to scene?.....

At time of incident leading to death, had child used alcohol or drugs?.....

Child's activity at time of incident:

Sleeping

Working

Driving / Vehicle occupant

Playing

Eating

Other: Crying

Unknown

Total number of deaths at incident event: Unknown

Children ages 0-18:

Adults:

Child Information

Age:

Gender:

Was there an open CPS case with this child at the time of death?.....

Child had a history of child abuse / maltreatment?.....

Were there any siblings ever placed outside the home prior to this child's death?.....

Was child ever placed outside of the home prior to the death?.....

Was child acutely ill during the two weeks before death?.....

Infants under 1 year old

This infant was part of a multiple birth:

If so, number:

During pregnancy, mother: Was not noted in the case record to have any of the issues listed below

Had medical complications / infections

Had heavy alcohol use

Misused over-the-counter or prescription drugs

Smoked tobacco

Experienced domestic violence

Used illicit drugs

Infant was born: With neither of the issues listed below noted in case record

Drug exposed

With fetal alcohol effects or syndrome

Primary Caregiver #1 Information

Relationship to the deceased child:

Gender:

Speak English?

Received DSS Benefits in the past 12 months:

WIC

Food stamps

TANF

Other:

Medicaid

Has a history of substance abuse?

Alcohol

Methamphetamine

Over-the-counter drugs

Cocaine

Opiates

Other:

Marijuana

Prescription drugs

Unknown type

Has a history of child abuse / maltreatment as a child?

Has a history of child abuse / maltreatment as a perpetrator?

of CPS reports:

Received CPS Services

Children ever removed

of CPS Indications:

Received Preventive Services

Was receiving mental health services?

Has prior child deaths?

Has a history of domestic violence?

No

Yes, as perpetrator

Yes, as victim

Unknown

Has a history of delinquent / criminal activity?

Primary Caregiver #2 Information

Relationship to the deceased child:

Gender:

Speak English?

Received DSS benefits in the past 12 months?

- WIC Food stamps
 TANF Other:
 Medicaid

Has a history of substance abuse?

- Alcohol Methamphetamine Over-the-counter drugs
 Cocaine Opiates Other:
 Marijuana Prescription drugs Unknown type

Has a history of child abuse / maltreatment as a child?

Has a history of child abuse / maltreatment as a perpetrator?

- # of CPS reports: Received CPS Services Children ever removed
of CPS Indications: Received Preventive Services

Was receiving mental health services?

Has prior child deaths?

Has a history of domestic violence?

- No Yes, as perpetrator
 Yes, as victim Unknown

Has a history of delinquent / criminal activity?

Supervisor Information

Did child have supervision at time of incident leading to death?

How long before incident did supervisor last see child?

Is this person a primary caregiver as listed in previous section?

Primary person responsible for supervision at time of incident:

At time of incident was supervisor:

- Drug Impaired Absent
 Alcohol Impaired Impaired by illness:
 Asleep Impaired by disability:
 Distracted Other:

Household Composition

Household	Relationship	Role	Gender	Age

Fatality Report Allegations

Victim	Allegation	Perpetrator	Substantiated
--------	------------	-------------	---------------

☐

History (General)

Was anyone listed in household composition receiving public assistance (TANF, Medicaid, HEAP, Food Stamps, etc.) in NYS at the time of the fatality?

- Yes
- No
- Unable to determine

If Yes, Assistance Recieved

<input type="checkbox"/> TANF	<input type="checkbox"/> Food Stamps	<input type="text"/>
<input type="checkbox"/> Medicaid	<input type="checkbox"/> Other	
<input type="checkbox"/> HEAP	Specify:	

Were preventive or foster care services ever provided to the deceased child, the deceased child's siblings, or any child listed in the household composition?

- Yes
- No
- Unable to determine

If Yes, Services Recieved

<input type="checkbox"/> Preventive	<input type="checkbox"/> Foster Care
-------------------------------------	--------------------------------------

Had a parent of the deceased child been in foster care during the 5 years prior to the fatality?

- Yes
- No
- Unable to determine

Summary:

CPS History

Has any member of this household been previously involved in a reported case of child abuse/maltreatment?

Prior to the report of this child's death?

- Yes **If yes**
- No # CPS Reports:
- Unknown # CPS Reports Indicated:

Since the report of this child's death?

- Yes **If yes**
- No # CPS Reports:
- Unknown # CPS Reports Indicated:

All Allegations :

Prior: Since:

- DOA / Fatality
- Fractures
- Internal Injuries
- Lacerations / Bruises / Welts
- Burns / Scalding
- Excessive Corporal Punishment
- Child's Drug / Alcohol Use
- Poisoning / Noxious Substances
- Choking / Twisting / Shaking
- Lack of Medical Care
- Malnutrition / Failure to Thrive

Prior: Since:

- Inadequate Guardianship
- Swelling / Dislocoations / Sprains
- Educational Neglect
- Emotional Neglect
- Inadequate Food / Clothing / Shelter
- Lack of Supervision
- Abandonment
- Parents Drug / Alcohol Misuse
- Other Prior to: Since:
- Inappropriate Isolation / Restraint

Summary of CPS history:

Summary of known CPS history outside of NYS:

Preventive Services History

Summary of Preventive history:

Placement History

Summary of Placement history:

Legal History

Have any of the following Petitions been filed? Yes No Unable to determine

FCA Article 3 (JD)

Date filed:

Was there a Fact Finding?

- Yes Date:
- No
- Unable to determine

Explain Fact Finding:

Was there a Disposition?

- Yes Date:
- No
- Unable to determine

Explain Disposition:

FCA Article 7 (PINS)

Date filed:

Was there a Fact Finding?

- Yes Date:
- No
- Unable to determine

Explain Fact Finding:

Was there a Disposition?

- Yes Date:
- No
- Unable to determine

Explain Disposition:

FCA Article 10 (CPS)

Date filed:

Was there a Fact Finding?

- Yes Date:
- No
- Unable to determine

Explain Fact Finding:

Was there a Disposition?

- Yes Date:
- No
- Unable to determine

Explain Disposition:

SSL 358-a (Voluntary)

Date filed:

Was there a Fact Finding?

- Yes Date:
- No
- Unable to determine

Explain Fact Finding:

Was there a Disposition?

- Yes Date:
- No
- Unable to determine

Explain Disposition:

Casework / Investigative Activities

Did the Investigation include the following activities?

If NO, were diligent efforts made?

For SCR Reports

	Yes	No	N/A	Yes	No	Couldn't determine
Alleged subject(s) interviewed face-to-face?.....	<input type="radio"/>					
All "other persons named" interviewed face-to-face?.....	<input type="radio"/>					

For ALL Fatality Investigations

Coordinate investigation with Law Enforcement?.....	<input type="radio"/>					
Contact with source?.....	<input type="radio"/>					
At least one home visit?.....	<input type="radio"/>					
All children observed?.....	<input type="radio"/>					
When appropriate, children were interviewed?.....	<input type="radio"/>					

All appropriate Collaterals contacted?

First Responders.....	<input type="radio"/>					
Case Planners.....	<input type="radio"/>					
Agency Personnel.....	<input type="radio"/>					
Family Members.....	<input type="radio"/>					
Public or Private Child Care.....	<input type="radio"/>					
Caretakers / Babysitters.....	<input type="radio"/>					
Emergency Room Personnel.....	<input type="radio"/>					
Law Enforcement.....	<input type="radio"/>					
School.....	<input type="radio"/>					
Daycare Provider.....	<input type="radio"/>					
Pediatrician.....	<input type="radio"/>					
Medical Examiner / Coroner.....	<input type="radio"/>					
Other (specify:	<input type="radio"/>					

Timely entry of progress notes and all other required documentation?

- Yes
- No

If no to any of the above, explain:

Describe how DSS responded to information about the child fatality.

Casework / Investigative Activities Comments

Safety Assessment

Was there an adequate assessment of impending or immediate danger to any surviving children named in the report within 24 hours?

- N/A - There are no surviving children
- N/A
- Yes
- No, explain:
- Unable to Determine, explain:

Is there an approved Initial Safety Assessment for all surviving children within 24 hours?

- N/A - There are no surviving children
- N/A
- Yes
- No
- Unable to Determine

If yes, give date(s):

Completed:

Approved:

Was sufficient information gathered to make the decision recorded on the approved Initial Safety Assessment?

- N/A - There are no surviving children
- Yes
- No
- Unable to Determine

If No, check all that apply:

- Source of report not contacted
- No or insufficient collateral contacts made
- Child not seen or interviewed
- Subject not seen or interviewed
- Previous reports not reviewed
- Strengths in the family not identified
- Visits not made as required
- Key information not obtained, specify
- Other, specify:

Was the safety decision recorded on the approved Initial Safety Assessment appropriate?

- N/A - There are no surviving children
- Yes
- No

If no, check all that apply:

- The safety decision was #1 (No safety factors noted), when the case record documented one or more safety factors
- The safety decision was #1 (No safety factors noted), or #2 (Safety factors do not present immediate or impending danger), but the case documentation indicates a combination of safety factors were present that placed the child(ren) in immediate or impending danger of serious harm.
- Although there were no safety factors that presented an immediate or impending danger to the child(ren), caseworker recorded safety decision #3 and completed a safety plan.
- One or more safety factors were present which placed the child(ren) in impending or immediate danger of serious harm requiring removal to foster care or an alternative placement as the only controlling safety intervention possible, however, caseworker selected safety decision 1, 2, or 3.
- Other

When safety factors were present that placed the child in impending or immediate danger of serious harm, were the safety interventions, including parent/caretaker actions adequate?

- N/A - There are no surviving children
- Yes
- No
- N/A
- Unable to Determine

If no, check all that apply:

- Intervention or parent/caretaker actions controlled only some of the safety factors
- Intervention or parent/caretaker actions aimed at reducing risk of future abuse/maltreatment rather than controlling for immediate safety
- Interventions or parent/caretaker actions chosen did not have sufficient comments associated with them to describe how the controlling interventions will protect the child(ren).
- "Other" chosen as a safety factor without a description of the factor/controlling intervention
- Safety intervention noted but inadequate documentation to see if they were applied
- Other, specify:

If unable to determine, check all that apply:

- Documentation is unclear or insufficient
- Documentation mixes safety interventions and risk reduction intervention
- Other, specify

For any response, check all that apply:

- Child was assessed as having safety factors present and reader does not agree, explain
- Child was assessed as having no safety factors present or safety factors present that did not place the child in impending or immediate danger of serious harm, however, an intervention was put in place, and the intervention is appropriate.
- Child was assessed as having no safety factors present that placed the child in impending or immediate danger requiring a safety intervention and no safety intervention was put in place, reader does not agree, explain:

Were there surviving children in the household that were removed as a result of this fatality report / investigation?

- No other children in this household
- No removal regarding the surviving children
- Yes, Informal removal
- Yes, Court Ordered removal
- N/A - There are no surviving children

Are there any safety issues that need to be referred back to the local district?

- N/A - There are no surviving children
- Yes, explain
- No

Risk Assessment

1. During the course of the investigation, was sufficient information gathered to assess risk to all surviving children in the household?

- N/A, Explain
- N/A - There are no surviving children
- Yes
- No - Adequate for some but not adequate for others. Explain below:
- No - Not adequate for any of the children. Explain below:
- Unable to determine, explain:

2. Was the risk assessment adequate in this case?

- N/A, Explain
- N/A - There are no surviving children
- Yes
- No, explain:
- Unable to determine, explain:

3. Did the protective factors in this case require the LDSS to file a petition in Family Court at anytime during or after the investigation? (Consider either a new Article 10 petition, or follow-up court activity on existing Article 10 petitions)

- N/A - There are no surviving children
- Yes, was required and filed.
- Yes, was required and considered, but not filed, explain:
- Yes, was required, but neither considered nor filed, explain:
- N/A - Not needed for this case.
- Unable to determine, explain:

4. Did the safety factors in the case require the surviving child(ren) to be removed and placed in foster care at anytime during the investigation?

- N/A - There are no surviving children
- Yes - All children needed to be placed in Foster Care and were placed.
- Yes - Some children needed to be placed in Foster Care and were placed.
- Yes - Children needed to be placed in Foster Care but were NOT.
- No children needed to be placed in Foster Care.
- N/A - Caretaker has refused access to the child or fled, or child's whereabouts are unknown
- N/A - Explain
- Unable to determine, explain:

Risk Assessment Profile (RAP)

If the RAP rating was High or Very High, were the reasons selected as to why the family is not receiving services consistent with the case circumstances?

- N/A, Explain
- N/A - There are no surviving children
- N/A - Rating is NOT High or Very High
- N/A - Rating is High or Very High, and the case was opened
- Yes
- No, explain:

Legal / Court Activity

Have any Orders of Protection been issued?

Prior to Fatality

- Yes Effective Dates:
 No From: To:
 Could not determine

Since Fatality

- Yes Effective Dates:
 No From: To:
 Unable to determine

Have criminal charges been filed as a result of this fatality?

- Yes Against who?
 No Charge: Date:
 Pending What was the disposition? Date:

- Yes Against who?
 No Allegation: Date:
 Pending What was the disposition? Date:

Has there been Family Court activity as a result of this fatality?

Services in Response to the Fatality

Check all that apply:	Provided after death	Offered but refused	Offered, unknown if used	Should be offered	Needed but not available	Unknown if offered	CDR review led to referral
Bereavement counseling`	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/>
Economic support	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/>
Funeral arrangements	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/>
Emergency shelter	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/>
Mental health services	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/>
Foster care	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/>
Health care	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/>
Legal services	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/>
Family planning	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/>
Other, specify: Parenting Skills	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/>
Training and Housing.							

Explain as necessary:

Services Provided

Specific to the deceased child that is the subject of this Individual Fatality Report, were services being provided to the following as necessary to achieve safety, permanency, and well-being?

Deceased Child

- Yes
- No
- NA
- Unable to determine

If No, what were the barriers to service provision? (Check all that apply)

- | | |
|---|--|
| <input type="checkbox"/> Waiting list for service | <input type="checkbox"/> Foster parent was not cooperative |
| <input type="checkbox"/> Service was not available | <input type="checkbox"/> No referral for service made |
| <input type="checkbox"/> Service was not approved | <input type="checkbox"/> Service need not identified |
| <input type="checkbox"/> Parent was not cooperative | <input type="checkbox"/> No barriers documented |
| <input type="checkbox"/> Other, explain: | |

Parent(s)

- Yes
- No
- NA
- Unable to determine

If No, what were the barriers to service provision? (Check all that apply)

- | | |
|---|--|
| <input type="checkbox"/> Waiting list for service | <input type="checkbox"/> Foster parent was not cooperative |
| <input type="checkbox"/> Service was not available | <input type="checkbox"/> No referral for service made |
| <input type="checkbox"/> Service was not approved | <input type="checkbox"/> Service need not identified |
| <input type="checkbox"/> Parent was not cooperative | <input type="checkbox"/> No barriers documented |
| <input type="checkbox"/> Other, explain: | |

Foster Parent

- Yes
- No
- NA
- Unable to determine

If No, what were the barriers to service provision? (Check all that apply)

- | | |
|---|--|
| <input type="checkbox"/> Waiting list for service | <input type="checkbox"/> Foster parent was not cooperative |
| <input type="checkbox"/> Service was not available | <input type="checkbox"/> No referral for service made |
| <input type="checkbox"/> Service was not approved | <input type="checkbox"/> Service need not identified |
| <input type="checkbox"/> Parent was not cooperative | <input type="checkbox"/> No barriers documented |
| <input type="checkbox"/> Other, explain: | |

Preventive Services

Did the service provider comply with casework contacts as required by regulations pertaining to the program choice?

- Yes
- No
- N/A
- Insufficient documentation - unable to determine

Did the service provider(s) comply with timeliness and content requirements for progress notes?

- Yes
 - No
 - N/A
 - Insufficient documentation - unable to determine
-

Did the services provided meet the service needs as outlined in the case record?

- Yes
 - No
 - N/A
 - Insufficient documentation - unable to determine
-

Did all service providers comply with mandated reporter requirements?

- Yes
 - No
 - N/A
 - Insufficient documentation - unable to determine
-

If this case was being monitored by CPS, was there documentation that monitoring standard requirements were being met?

- Yes
 - No
 - N/A
 - Insufficient documentation - unable to determine
-

Was there identification of emerging behaviors by any individual in the case composition that constituted a safety/health risk to this child or other children?

- Yes
- No
- N/A
- Insufficient documentation - unable to determine

If yes: By who?

Was the response appropriate to the circumstances?

- Yes
- No
- N/A
- Insufficient documentation - unable to determine

Were the behaviors documented?

- Yes
- No
- N/A
- Insufficient documentation - unable to determine

Foster Care

Date child was placed in care:

How did the child enter care?

- Court order
 - Emergency removal without Court order
 - Voluntary placement
-

Did the agency comply with sibling placement standards?

- N/A
- Yes
- No

Date of placement with most recent caregiver:

Was a criminal history check conducted?

- Yes **Date:**
- No
- Unable to determine

	Yes	No	Unable to determine
Was the child AWOL at the time of death?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
If yes, did the Agency comply with the Absent Without Consent regulations?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Was the most recent placement stable?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Was the certification/approval for the placement residence current?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Did the placement comply with the appropriateness of placement standards?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Did the placement residence comply with the standards applicable to that category of residential program?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Did the foster care provider comply with reporting requirements relating to the death or serious injury of a foster child?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Did the child receive periodic medical examinations as required?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Did the agency provide the foster parents with required information regarding the child's health, handicaps, and behavioral issues?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Did the foster care provider comply with discipline standards?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Did the authorized agency comply with restraint standards?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Where foster parents received enhanced levels of foster care payments because of child need, did foster parents satisfy training and experience	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Was foster parent provided a training program approved by OCFS that prepared the foster parent with appropriate knowledge and skills to meet the needs of the child?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

For any of the above questions that need further explanation, explain below:

Visitation

Was the visitation plan appropriate for this child?

- Yes
- No
- N/A
- Insufficient documentation - unable to determine

Was the most recent required Service Plan Review (SPR) in the records reviewed?

- Yes
- No
- No, a meeting was held, however no Third Party Reviewer was present, therefore it was not considered an SPR
- N/A, explain:

Was there supervision of visits as required?

- Yes
 - No
 - N/A
 - Insufficient documentation - unable to determine
-

Was visitation facilitated in accordance with the regulations?

- Yes
- No
- N/A
- Insufficient documentation - unable to determine

FASP

Was the most recent required FASP approved?

- N/A
 - Yes, approved prior to, or on, the Plan Date
 - Yes, approved after the Plan Date
 - No, explain:
-

If this was a Protective Program Choice (CPS), is the safety assessment in the most recent FASP consistent with the case circumstances?

- N/A
 - Yes
 - No, explain:
-

If this was a Protective Program Choice case, other than foster care intervention, were adequate protective safety interventions in place?

- N/A
 - Yes
 - No explain what additional safety interventions were needed:
-

Was there a current Risk Assessment Profile (Protective-CPS) or Risk Assessment (Non-Protective) in the most recent FASP

- N/A
- Yes
- No, explain:

If there was a risk Assessment Profile, was it consistent with the circumstances?

- Completely
 - No
 - Partially
 - N/A
-

Does the case record document that sufficient steps were taken to safeguard this child's safety while in this placement?

- N/A
 - Yes
 - No , what steps needed to be taken?
-

Casework Contacts

Were face-to-face contacts with the child made with the required frequency?

- Yes
 - No
 - Insufficient documentation - unable to determine
-

Were face-to-face contacts with the child in the child's placement location made with the required frequency?

- Yes
 - No
 - Insufficient documentation - unable to determine
-

Were face-to-face contacts with the parent/ relative/ discharge resource made with the required frequency?

- Yes
 - No
 - Insufficient documentation - unable to determine
-

Were face-to-face contacts with the parent/ relative/ discharge resource in the parent/ relative/ discharge resource's home made with the required frequency?

- Yes
- No
- Insufficient documentation - unable to determine

Were all of the casework contact requirements for contacts with caretakers made, including requirements for contact at the child's placement location?

- Yes
- No
- Insufficient documentation - unable to determine

Closing

Was the level of casework activity, which includes contact with the family and others from the receipt of the report through case conclusion, commensurate with the case circumstances?

- Yes
- No

Other than electronic approvals/rejections, is there any documentation of supervisory/consultation during the investigation

- Yes, case record has detail of the consultation.
- Yes, record notes a consultation took place, but no details noted.
- Yes, signature or initials recorded (other than on FASP)
- No

Was the decision to close the case appropriate?

- Yes
- No
- N/A - case opened or already open for service
- Unable to determine.

If no, check all that apply:

- All children are not assessed as safe.
- The risk of future abuse or maltreatment has not been sufficiently assessed/decreased.
- The family has refused services, however the district should have considered or pursued Family Court action to compel involvement as it would be in the best interest of the child(ren).

Review Findings

Was sufficient information gathered to make a determination for all allegations including those on the intake report as well as any identified in the course of the investigation?

- The CPS report had not yet been determined at the time this Fatality report was issued
- Yes, sufficient information was gathered to determine all allegations.
- No; sufficient information was gathered to determine some allegations only.

List those allegations not addressed:

- No, sufficient information was not gathered to determine any of the allegations.
- Unable to determine - insufficient documentation

Was the determination made by the district to unfound or indicate appropriate?

- Yes
- No
- Unable to determine, specify:

If no, check all that apply:

- The determination did not address some or all of the allegations of child abuse or maltreatment identified during the course of the investigation.
- The determination did not incorporate key information gathered during the investigation.

- Some credible evidence was found to support the allegations contained in the report but the report was unfounded.
 - No credible evidence was found to support the allegations contained in the report but the report was indicated.
 - Does not meet the statutory criteria for child abuse and maltreatment
 - Other, specify:
-

Was sufficient information gathered to make the decision recorded on the Safety Assessment due at the time of the determination?

- Yes
- No
- N/A - No Safety Assessment required - report was determined within 7 days of completing the 7-Day Safety Assessment
- Unable to Determine

If No, check all that apply:

- Source of report not contacted
 - No or insufficient collateral contacts made
 - Child not seen or interviewed
 - Subject not seen or interviewed
 - Previous reports not reviewed
 - Home visit not made
 - Strengths and mitigating circumstances in the family to offset the safety threats were not identified.
 - Key information not obtained, specify:
 - Other, specify:
-

Was the safety decision recorded on the safety assessment at the time of the Investigation Determination appropriate?

- Yes
- No

If no, check all that apply:

- The safety decision was #1 (No safety factors noted), when the case record documented one or more safety factors.
 - The safety decision was #1 (No safety factors noted), or #2 (Safety factors do not present immediate or impending danger), but the case documentation indicates a combination of safety factors were present that placed the child(ren) in immediate or impending danger of serious harm.
 - Although there were no safety factors that presented an immediate or impending danger to the child(ren), caseworker recorded safety decision #3 and completed a safety plan.
 - One or more safety factors were present which placed the child(ren) in impending or immediate danger of serious harm requiring removal to foster care or an alternative placement as the only controlling safety intervention possible, however, caseworker selected safety decision 1, 2, or 3.
 - Other, explain
-

Required Actions

There are no Required Actions

Recommendations

There are no Recommended Actions

Friday, November 04, 2011

Appendix C: Request for Safe Sleep Publications

New York Loves Safe Babies Request for Publications



- Helpful Tips to Keep Your Baby Safe** (English on Front/Spanish on Back)* Quantity
(100 max.)
- Shaken Baby Syndrome (SBS)
 - Sudden Infant Death Syndrome (SIDS)
 - Traumatic Brain Injury (TBI)
 - Safe To Sleep
 - Safe At Play
 - Never Leave Children Unattended In or Around Vehicles

*Arabic, Chinese, and Russian versions are available online at: www.ocfs.state.ny.us/main/publications/

Brochure (Spanish or English)

- Back to Sleep (trifold)

New York Loves Safe Babies DVD: "Helpful Strategies for Keeping Infants and Young Children Safe" (Spanish or English)



- A 30-minute video that illustrates the devastating consequences of SIDS, TBI, and SBS, through the personal stories of three families

Refrigerator Magnets

Quantity
(25 max.)

- Never, Ever Shake A Baby (on reorder)
Tips for calming a crying baby
- Tell everyone you know to Never Shake a Baby
Picture Frame Magnet (Spanish or English)
- Back to Sleep, Safe to Sleep
Picture Frame Magnet (Spanish or English)



Quantity
(25 max.)



Personalized Safety Tips and Emergency Contact Sheet for Baby Sitters (magnetic)

- Provides resource information with Safety Tips for
Babies, and space for emergency telephone numbers
and messages (Also available as tear-off pads, English on
front, Spanish on back)

Mail Materials To:

Name: _____
Address: _____

Telephone: (____) _____

Return Completed Form To:

NYS Children and Family Trust Fund
52 Washington Street – 331 North
Rensselaer, NY 12144
Attn: Judy Richards
Phone: (518) 474-9613 or
Attn: Cheryl Cannon
Phone: (518) 402-6773 or
Fax to: 518-402-6824

Appendix D: Resources and Links

Resource	Contact Information
NYS Office of Children & Family Services	www.ocfs.state.ny.us
NYS Department of Health	www.health.state.ny.us
National Safe Kids Campaign	www.safekids.org
Centers for Disease Control and Prevention	www.cdc.gov
Harborview Injury Prevention & Research Center	http://depts.washington.edu/hiprc
Consumer Product Safety Commission	www.cpsc.gov
Red Cross	www.redcross.org
The United States Lifesaving Association (USLA)	www.usla.org
American Academy of Pediatrics	www.aap.org
Children's Safety Network	http://www.childrensafetynetwork.org/
National Highway Transportation Safety Administration	www.nhtsa.dot.gov
The Think First Injury Prevention Foundation	www.thinkfirst.org/home.asp
Harrison's Hope (Formerly Kids 'N Cars)	www.harrisonshope.org
American Academy of Pediatrics Healthy Child Care America: Back to Sleep Campaign	http://www.healthychildcare.org/section_SIDS.cfm
National Sudden and Unexpected Infant Death / SIDS Resource Center	www.sidscenter.org
Parents, The Anti-Drug	www.theantidrug.com/drug_info
"Teens & Prescription Drugs, An Analysis of Recent Trend on the Emerging Drug Threat" (February 2007) (and related publications)	www.whitehousedrugpolicy.gov/publications
National Rifle Association: "The Eddie Eagle® Gunsafe Program"	www.nrahq.org/safety/eddie
National Center for the Prosecution of Child Abuse (A program of the American Prosecutors' Research Institute APRI)	www.ndaa.org/apri/programs/ncpca/ncpca_home.html
National Center on Shaken Baby Syndrome (Provides technical assistance, research, expertise to investigation professionals, including scene investigation and suspected incidents, legal	www.dontshake.org

professionals, including visual presentation of medical evidence, and medical professionals, including recognizing abusive head trauma)	
U.S. Department of Justice Office of Juvenile Justice and Delinquency Prevention	www.ojjdp.gov/
National Center for Missing and Exploited Children	www.missingkids.com
The National Council of Juvenile & Family Court Judges	www.ncjfcj.org
Publication: - Resource Guidelines: Improving Court Practice in Child Abuse and Neglect Cases - The National Youth Violence Prevention Resource Center	www.safeyouth.org
Child Welfare Information Gateway (Formerly the National Clearinghouse on Child Abuse and Neglect Information)	www.childwelfare.gov
National Center for Child Death Review	www.childdeathreview.org
New York City Administration for Children's Services	www.nyc.gov/html/acs
New York State Office of Children and Family Services (Local District Offices)	www.ocfs.state.ny.us/main/localdss.asp
New York Statewide Central Register of Child Abuse and Maltreatment	1-800-342-3720
National Suicide Prevention Lifeline	1-800-SUICIDE (784-2433)
Suicide Prevention Advocacy Network	www.spanusa.org
New York State Office of Children and Family Services Child Abuse Prevention	ww.ocfs.state.ny.us/main/prevention/
New York State Office of Children and Family Services Babies Sleep Safest Alone Campaign	http://www.ocfs.state.ny.us/main/babiessleepsafestalone/default.htm
New York State Kids' Well-Being Indicators Clearinghouse	http://www.nyskwic.org/index.cfm
New York State Department of Health Sudden Infant Death Syndrome	http://www.health.state.ny.us/diseases/conditions/sids/
New York State Department of Health Injury Prevention	http://www.health.state.ny.us/prevention/injury_prevention/

