



Understanding How
and Why Children Die

& Taking Actions to
Prevent Child Deaths

Child Death Review Case Report

Version 1, Pilot Test
©January 1, 2005
National Center for Child Death Review

**Version One
Pilot Test
2005**

**Developed by the National Center for Child Death Review
CDR Case Reporting System Action Team
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The purpose of the case report is to provide information to better understand how and why a child died as well as to document the actions proposed by the review team.

This case report should be completed on all deaths reviewed by your CDR team.

The case report will provide your team with documentation on:

1. The comprehensive circumstances of the child's death.
2. Your team's recommendations to prevent other deaths.
3. The factors affecting the quality of your case review process.

This report is available, with a user manual and definitions for all elements as a web-based application. Web users must be approved and registered by their state CDR program. The login for registered users is at www.cdrdata.org

This tool is in a pilot-testing mode through 2005 in selected states. Please provide feedback on the tool to:
The National Center for Child Death Review
1-800-656-2434
email: info@childdeathreview.org

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Action Team Members

*Neil Maniar, Massachusetts, Chair
Susan Anderson, Hawaii
Debora Barnes-Josiah, Nebraska
Robin Bell, Utah and Michigan
Marc Clement, New Hampshire
Carri Cottengim, Georgia
Erin Croughwell, Wyoming
Maurine Hill, Missouri
Neil Hochstadt, Illinois*

*Sally Kerschner, Vermont
Rochelle Manchego, Colorado
Lisa Millet, Oregon
Judy New, Nevada
Diane Pilkey, Washington
Adrianna Pust, Ohio
Faith Vos Winkle, Connecticut
Pat West, Pennsylvania
Steve Wirtz, California*

*Stephanie Bryn, MCHB, HRSA, DHHS, Project Officer
Shkeda Johnson, MCHB, HRSA, DHHS, Project Officer
Mary Overpeck, MCHB, HRSA, DHHS, Epidemiologist
John Park, MCHB, HRSA, DHHS, Epidemiologist
Teri Covington, National Center Director
Sara Rich, National Center Project Coordinator
Lori Corteville, National Center Data Systems Coordinator*

CASE NUMBER

____/____/____/____/____
 State / County / Team Number / Year of Review / Sequence of Review

Death Certificate Number: _____

Birth Certificate Number: _____

A. CHILD INFORMATION

1. Child's name: First: _____ Middle: _____ Last: _____ <input type="checkbox"/> U/K	
2. Date of birth: <input type="checkbox"/> U/K mm / dd / yyyy	5. Race, check all that apply: <input type="checkbox"/> White <input type="checkbox"/> Black, African American <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> Pacific Islander <input type="checkbox"/> Asian, specify: <input type="checkbox"/> American Indian, Tribe: <input type="checkbox"/> Alaskan Native, Tribe: <input type="checkbox"/> U/K
3. Date of death: <input type="checkbox"/> U/K mm / dd / yyyy	8. Residence address: <input type="checkbox"/> U/K Street _____ Apartment _____ City _____ County _____ State _____ Zip _____
4. Age: <input type="checkbox"/> Years <input type="checkbox"/> Months _____ <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> U/K	9. Type of residence: <input type="checkbox"/> Parental home <input type="checkbox"/> Relative's home <input type="checkbox"/> Jail/Detention <input type="checkbox"/> Licensed group home <input type="checkbox"/> Living on own <input type="checkbox"/> Other, specify: <input type="checkbox"/> Licensed foster home <input type="checkbox"/> Shelter <input type="checkbox"/> Relative foster home <input type="checkbox"/> Homeless <input type="checkbox"/> U/K
6. Hispanic or Latino Origin? <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> U/K	7. Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> U/K
10. New residence in past 30 days: <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> U/K	11. Residence overcrowded? <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> U/K
12. Child ever homeless? <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> U/K	13. Number of other children living with child: <input type="checkbox"/> U/K _____
14. Child's weight: <input type="checkbox"/> U/K _____ in pounds	15. Child's height: <input type="checkbox"/> U/K _____ feet _____ inches
16. Highest education level: <input type="checkbox"/> N/A <input type="checkbox"/> Childcare <input type="checkbox"/> Preschool <input type="checkbox"/> K-12 <input type="checkbox"/> Home schooled, K-12 <input type="checkbox"/> Drop out/employed <input type="checkbox"/> Drop out/unemployed	17. Child ever truant? <input type="checkbox"/> N/A <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> U/K
18. 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	19. Child had disability or chronic illness? <input type="checkbox"/> No <input type="checkbox"/> Yes, check all that apply: <input type="checkbox"/> Physical, specify: _____ <input type="checkbox"/> U/K <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="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> U/K
20. Child had history of substance abuse? <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> U/K 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"/> Other street drugs <input type="checkbox"/> Prescription drugs <input type="checkbox"/> Over-the-counter <input type="checkbox"/> U/K	21. At time of incident leading to death, was child alcohol or drug impaired? <input type="checkbox"/> N/A <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> U/K
22. Child had history of child maltreatment? Check all that apply: a. As Victim b. As Perpetrator <input type="checkbox"/> <input type="checkbox"/> N/A <input type="checkbox"/> No <input type="checkbox"/> Yes, Physical <input type="checkbox"/> Yes, Neglect <input type="checkbox"/> Yes, Sexual <input type="checkbox"/> Yes, Emotional <input type="checkbox"/> U/K _____ # CPS reports _____ # Substantiations	23. Was there an open CPS case with child at time of death? <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> U/K
24. Was child ever in foster care? <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> U/K	25. Any siblings in foster care or adoption prior to child's death? <input type="checkbox"/> No <input type="checkbox"/> Yes, # _____ <input type="checkbox"/> U/K
26. 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	27. Child had delinquent or criminal history? <input type="checkbox"/> N/A <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> U/K If yes, check all that apply: <input type="checkbox"/> Assaults <input type="checkbox"/> Robbery <input type="checkbox"/> Drugs <input type="checkbox"/> Other, specify: _____ <input type="checkbox"/> U/K
29. Child acutely ill during the two weeks before death? <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> U/K	30. Are child's parents first generation immigrants? <input type="checkbox"/> No <input type="checkbox"/> Yes, country of origin: _____ <input type="checkbox"/> U/K
31. If child over age 12, what was child's gender identity? <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> U/K	32. If child over age 12, what was child's sexual orientation? <input type="checkbox"/> Heterosexual <input type="checkbox"/> Bisexual <input type="checkbox"/> Gay <input type="checkbox"/> Questioning <input type="checkbox"/> Lesbian <input type="checkbox"/> U/K

COMPLETE FOR ALL INFANTS UNDER ONE YEAR

33. Gestational age: _____ weeks <input type="checkbox"/> U/K	34. Birth weight: _____ <input type="checkbox"/> Grams <input type="checkbox"/> Pounds <input type="checkbox"/> U/K	35. Multiple birth? <input type="checkbox"/> No <input type="checkbox"/> Yes, # _____ <input type="checkbox"/> U/K	36. Number of prenatal visits: _____ <input type="checkbox"/> U/K	37. Month of first prenatal visit: Specify 1-9: _____ <input type="checkbox"/> N/A <input type="checkbox"/> U/K
38. During pregnancy, did mother (check all that apply): <input type="checkbox"/> Have medical complications/infections? <input type="checkbox"/> Use illicit drugs? <input type="checkbox"/> Have heavy alcohol use? <input type="checkbox"/> Smoke tobacco? <input type="checkbox"/> Infant born drug exposed? <input type="checkbox"/> Infant born with fetal alcohol effects <input type="checkbox"/> Experience intimate partner violence? <input type="checkbox"/> Misuse over-the-counter or prescription drugs? <input type="checkbox"/> or syndrome?				

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

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

B. PRIMARY CAREGIVER(S) INFORMATION

<p>1. Primary caregiver: (select up to two)</p> <p>a. One b. Two</p> <p><input type="checkbox"/> Self, Go to Sect. C</p> <p><input type="checkbox"/> <input type="checkbox"/> Biological parent</p> <p><input type="checkbox"/> <input type="checkbox"/> Adoptive parent</p> <p><input type="checkbox"/> <input type="checkbox"/> Step parent</p> <p><input type="checkbox"/> <input type="checkbox"/> Foster parent</p> <p><input type="checkbox"/> <input type="checkbox"/> Mother's partner</p> <p><input type="checkbox"/> <input type="checkbox"/> Father's partner</p> <p><input type="checkbox"/> <input type="checkbox"/> Grandparent</p> <p><input type="checkbox"/> <input type="checkbox"/> Sibling</p> <p><input type="checkbox"/> <input type="checkbox"/> Other relative</p> <p><input type="checkbox"/> <input type="checkbox"/> Friend</p> <p><input type="checkbox"/> <input type="checkbox"/> Institutional staff</p> <p><input type="checkbox"/> <input type="checkbox"/> Other, specify:</p> <p><input type="checkbox"/> <input type="checkbox"/> U/K</p>	<p>3. Caregiver(s) sex:</p> <p>a. One b. Two</p> <p><input type="checkbox"/> <input type="checkbox"/> Male</p> <p><input type="checkbox"/> <input type="checkbox"/> Female</p> <p><input type="checkbox"/> <input type="checkbox"/> U/K</p>	<p>6. Caregiver(s) education:</p> <p>a. One b. Two</p> <p><input type="checkbox"/> <input type="checkbox"/> Less than HS</p> <p><input type="checkbox"/> <input type="checkbox"/> High School</p> <p><input type="checkbox"/> <input type="checkbox"/> College</p> <p><input type="checkbox"/> <input type="checkbox"/> Post Graduate</p> <p><input type="checkbox"/> <input type="checkbox"/> U/K</p>	<p>9. Any caregiver receiving social services in the past twelve months? Check all that apply:</p> <p>a. One b. Two</p> <p><input type="checkbox"/> <input type="checkbox"/> WIC</p> <p><input type="checkbox"/> <input type="checkbox"/> TANF</p> <p><input type="checkbox"/> <input type="checkbox"/> Medicaid</p> <p><input type="checkbox"/> <input type="checkbox"/> Food stamps</p> <p><input type="checkbox"/> <input type="checkbox"/> Other, specify:</p>
<p>2. Age in Years:</p> <p>a. One b. Two</p> <p>_____ # Years</p> <p><input type="checkbox"/> <input type="checkbox"/> U/K</p>	<p>4. Caregiver(s) employment status:</p> <p>a. One b. Two</p> <p><input type="checkbox"/> <input type="checkbox"/> Fulltime</p> <p><input type="checkbox"/> <input type="checkbox"/> Part-time</p> <p><input type="checkbox"/> <input type="checkbox"/> Unemployed</p> <p><input type="checkbox"/> <input type="checkbox"/> On disability</p> <p><input type="checkbox"/> <input type="checkbox"/> Retired</p> <p><input type="checkbox"/> <input type="checkbox"/> U/K</p>	<p>7. Does caregiver(s) speak English?</p> <p>a. One b. Two</p> <p><input type="checkbox"/> <input type="checkbox"/> No</p> <p><input type="checkbox"/> <input type="checkbox"/> Yes</p> <p><input type="checkbox"/> <input type="checkbox"/> U/K</p> <p>If no, language spoken:</p>	<p>10. Caregiver(s) have substance abuse history?</p> <p>a. One b. Two</p> <p><input type="checkbox"/> <input type="checkbox"/> No</p> <p><input type="checkbox"/> <input type="checkbox"/> Yes</p> <p><input type="checkbox"/> <input type="checkbox"/> U/K</p> <p>If yes, check all that apply:</p> <p><input type="checkbox"/> <input type="checkbox"/> Alcohol</p> <p><input type="checkbox"/> <input type="checkbox"/> Cocaine</p> <p><input type="checkbox"/> <input type="checkbox"/> Marijuana</p> <p><input type="checkbox"/> <input type="checkbox"/> Methamphetamine</p> <p><input type="checkbox"/> <input type="checkbox"/> Other street drugs</p> <p><input type="checkbox"/> <input type="checkbox"/> Prescription drugs</p> <p><input type="checkbox"/> <input type="checkbox"/> Over-the-counter</p> <p><input type="checkbox"/> <input type="checkbox"/> U/K</p>
<p>11. Caregiver(s) have history of child maltreatment as a victim? Check all that apply:</p> <p>a. One b. Two</p> <p><input type="checkbox"/> <input type="checkbox"/> No</p> <p><input type="checkbox"/> <input type="checkbox"/> Yes, Physical</p> <p><input type="checkbox"/> <input type="checkbox"/> Yes, Neglect</p> <p><input type="checkbox"/> <input type="checkbox"/> Yes, Sexual</p> <p><input type="checkbox"/> <input type="checkbox"/> Yes, Emotional</p> <p><input type="checkbox"/> <input type="checkbox"/> U/K</p> <p>_____ # CPS referrals</p> <p>_____ # Substantiations</p> <p><input type="checkbox"/> <input type="checkbox"/> Ever in foster care/adopted?</p>	<p>12. Caregiver(s) have history of child maltreatment as a perpetrator? Check all that apply:</p> <p>a. One b. Two</p> <p><input type="checkbox"/> <input type="checkbox"/> No</p> <p><input type="checkbox"/> <input type="checkbox"/> Yes, Physical</p> <p><input type="checkbox"/> <input type="checkbox"/> Yes, Neglect</p> <p><input type="checkbox"/> <input type="checkbox"/> Yes, Sexual</p> <p><input type="checkbox"/> <input type="checkbox"/> Yes, Emotional</p> <p><input type="checkbox"/> <input type="checkbox"/> U/K</p> <p>_____ # CPS referrals</p> <p>_____ # Substantiations</p> <p><input type="checkbox"/> <input type="checkbox"/> CPS prevention services?</p> <p><input type="checkbox"/> <input type="checkbox"/> Family Preservation svcs?</p> <p><input type="checkbox"/> <input type="checkbox"/> Children ever removed?</p>	<p>14. Caregiver(s) have prior child deaths?</p> <p>a. One b. Two</p> <p><input type="checkbox"/> <input type="checkbox"/> No</p> <p><input type="checkbox"/> <input type="checkbox"/> Yes</p> <p><input type="checkbox"/> <input type="checkbox"/> U/K</p> <p>If yes, cause(s): Check all that apply:</p> <p>a. One b. Two</p> <p><input type="checkbox"/> <input type="checkbox"/> Child abuse # __</p> <p><input type="checkbox"/> <input type="checkbox"/> Child neglect # __</p> <p><input type="checkbox"/> <input type="checkbox"/> Accident # __</p> <p><input type="checkbox"/> <input type="checkbox"/> Suicide # __</p> <p><input type="checkbox"/> <input type="checkbox"/> SIDS # __</p> <p><input type="checkbox"/> <input type="checkbox"/> Other # __</p> <p>specify:</p> <p><input type="checkbox"/> <input type="checkbox"/> U/K</p>	<p>15. Caregiver(s) have history of intimate partner violence? Check all that apply:</p> <p>a. One b. Two</p> <p><input type="checkbox"/> <input type="checkbox"/> No</p> <p><input type="checkbox"/> <input type="checkbox"/> Yes, as victim</p> <p><input type="checkbox"/> <input type="checkbox"/> Yes, as perpetrator</p> <p><input type="checkbox"/> <input type="checkbox"/> U/K</p> <p>16. Caregiver(s) have delinquent or criminal history?</p> <p>a. One b. Two</p> <p><input type="checkbox"/> <input type="checkbox"/> No</p> <p><input type="checkbox"/> <input type="checkbox"/> Yes</p> <p><input type="checkbox"/> <input type="checkbox"/> U/K</p> <p>If yes, check all that apply:</p> <p><input type="checkbox"/> <input type="checkbox"/> Assaults</p> <p><input type="checkbox"/> <input type="checkbox"/> Robbery</p> <p><input type="checkbox"/> <input type="checkbox"/> Drugs</p> <p><input type="checkbox"/> <input type="checkbox"/> Other, specify:</p> <p><input type="checkbox"/> <input type="checkbox"/> U/K</p>
<p>13. Caregiver(s) have history of Post Traumatic Stress Disorder?</p> <p>a. One b. Two</p> <p><input type="checkbox"/> <input type="checkbox"/> No</p> <p><input type="checkbox"/> <input type="checkbox"/> Yes, describe circumstances:</p> <p><input type="checkbox"/> <input type="checkbox"/> U/K</p>			

C. SUPERVISOR INFORMATION

<p>1. Did child have supervision at time of incident leading to death?</p> <p><input type="checkbox"/> No, not needed given developmental age or circumstances. Go to Section D.</p> <p><input type="checkbox"/> No, but needed, answer questions 3-15</p> <p><input type="checkbox"/> Yes, answer questions 2-15</p> <p><input type="checkbox"/> Unable to determine, try to answer 3-15</p>	<p>3. Primary person responsible for supervision at time of incident?</p> <p>Select only one:</p> <p><input type="checkbox"/> Biological parent <input type="checkbox"/> Other relative <input type="checkbox"/> U/K</p> <p><input type="checkbox"/> Adoptive parent <input type="checkbox"/> Friend</p> <p><input type="checkbox"/> Step parent <input type="checkbox"/> Acquaintance</p> <p><input type="checkbox"/> Foster parent <input type="checkbox"/> Hospital staff</p> <p><input type="checkbox"/> Mother's partner <input type="checkbox"/> Institutional staff</p> <p><input type="checkbox"/> Father's partner <input type="checkbox"/> Babysitter</p> <p><input type="checkbox"/> Grandparent <input type="checkbox"/> Licensed child care worker</p> <p><input type="checkbox"/> Sibling <input type="checkbox"/> Other, specify:</p>	<p>4. Supervisor's age in years:</p> <p>_____ <input type="checkbox"/> U/K</p> <p>5. Supervisor's sex:</p> <p><input type="checkbox"/> Male <input type="checkbox"/> U/K</p> <p><input type="checkbox"/> Female</p> <p>6. Is person a primary caregiver as listed in previous section?</p> <p><input type="checkbox"/> No, go to next question</p> <p><input type="checkbox"/> Yes, go to question 15</p>
<p>2. How long before incident did supervisor last see child? Check one:</p> <p><input type="checkbox"/> Child in sight of supervisor <input type="checkbox"/> Days _____</p> <p><input type="checkbox"/> Minutes _____ <input type="checkbox"/> U/K</p> <p><input type="checkbox"/> Hours _____</p>		

F. OFFICIAL MANNER AND PRIMARY CAUSE OF DEATH

<p>1. Official manner of death from the death certificate:</p> <p><input type="checkbox"/> Natural</p> <p><input type="checkbox"/> Accident</p> <p><input type="checkbox"/> Suicide</p> <p><input type="checkbox"/> Homicide</p> <p><input type="checkbox"/> Undetermined</p> <p><input type="checkbox"/> Pending</p> <p><input type="checkbox"/> U/K</p>	<p>2. Primary cause of death. Choose only one. For pending, choose most likely cause.</p> <table style="width: 100%;"> <tr> <td style="width: 50%; vertical-align: top;"> <input type="checkbox"/> From an injury (external) cause, select one: <ul style="list-style-type: none"> <input type="checkbox"/> Motor vehicle and other transport, go to G1 <input type="checkbox"/> Fire, burn, or electrocution, go to G2 <input type="checkbox"/> Drowning, go to G3 <input type="checkbox"/> Suffocation or strangulation, go to G4 <input type="checkbox"/> Weapon, including body part, go to G6 <input type="checkbox"/> Animal bite or attack, go to G7 <input type="checkbox"/> Fall or crush, go to G8 <input type="checkbox"/> Poisoning, go to G9 <input type="checkbox"/> Exposure, go to G10 <input type="checkbox"/> Undetermined. If under age one, go to G5 and G12. If over age one, go to G12. <input type="checkbox"/> Other, go to G12 <input type="checkbox"/> U/K, go to G12 </td> <td style="width: 50%; vertical-align: top;"> <input type="checkbox"/> From a medical cause, select one: <ul style="list-style-type: none"> <input type="checkbox"/> Asthma, go to G11 <input type="checkbox"/> Cancer, go to G11 <input type="checkbox"/> Cardiovascular, go to G11 <input type="checkbox"/> Congenital anomaly, go to G11 <input type="checkbox"/> HIV/AIDS, go to G11 <input type="checkbox"/> Influenza, go to G11 <input type="checkbox"/> Low birth weight, go to G11 <input type="checkbox"/> Malnutrition/dehydration, go to G11 <input type="checkbox"/> Neurological/seizure disorder, go to G11 <input type="checkbox"/> Pneumonia, go to G11 <input type="checkbox"/> Prematurity, go to G11 <input type="checkbox"/> SIDS, go to G5 <input type="checkbox"/> Other infection, specify and go to G11 <input type="checkbox"/> Other perinatal condition, specify and go to G11 <input type="checkbox"/> Other medical condition, specify and go to G11 <input type="checkbox"/> Undetermined. If under age one, go to G5 and G11. If over age one, go to G11. <input type="checkbox"/> U/K. If under age one, go to G5 and G11. If over age one, go to G11. </td> </tr> </table>	<input type="checkbox"/> From an injury (external) cause, select one: <ul style="list-style-type: none"> <input type="checkbox"/> Motor vehicle and other transport, go to G1 <input type="checkbox"/> Fire, burn, or electrocution, go to G2 <input type="checkbox"/> Drowning, go to G3 <input type="checkbox"/> Suffocation or strangulation, go to G4 <input type="checkbox"/> Weapon, including body part, go to G6 <input type="checkbox"/> Animal bite or attack, go to G7 <input type="checkbox"/> Fall or crush, go to G8 <input type="checkbox"/> Poisoning, go to G9 <input type="checkbox"/> Exposure, go to G10 <input type="checkbox"/> Undetermined. If under age one, go to G5 and G12. If over age one, go to G12. <input type="checkbox"/> Other, go to G12 <input type="checkbox"/> U/K, go to G12 	<input type="checkbox"/> From a medical cause, select one: <ul style="list-style-type: none"> <input type="checkbox"/> Asthma, go to G11 <input type="checkbox"/> Cancer, go to G11 <input type="checkbox"/> Cardiovascular, go to G11 <input type="checkbox"/> Congenital anomaly, go to G11 <input type="checkbox"/> HIV/AIDS, go to G11 <input type="checkbox"/> Influenza, go to G11 <input type="checkbox"/> Low birth weight, go to G11 <input type="checkbox"/> Malnutrition/dehydration, go to G11 <input type="checkbox"/> Neurological/seizure disorder, go to G11 <input type="checkbox"/> Pneumonia, go to G11 <input type="checkbox"/> Prematurity, go to G11 <input type="checkbox"/> SIDS, go to G5 <input type="checkbox"/> Other infection, specify and go to G11 <input type="checkbox"/> Other perinatal condition, specify and go to G11 <input type="checkbox"/> Other medical condition, specify and go to G11 <input type="checkbox"/> Undetermined. If under age one, go to G5 and G11. If over age one, go to G11. <input type="checkbox"/> U/K. If under age one, go to G5 and G11. If over age one, go to G11.
<input type="checkbox"/> From an injury (external) cause, select one: <ul style="list-style-type: none"> <input type="checkbox"/> Motor vehicle and other transport, go to G1 <input type="checkbox"/> Fire, burn, or electrocution, go to G2 <input type="checkbox"/> Drowning, go to G3 <input type="checkbox"/> Suffocation or strangulation, go to G4 <input type="checkbox"/> Weapon, including body part, go to G6 <input type="checkbox"/> Animal bite or attack, go to G7 <input type="checkbox"/> Fall or crush, go to G8 <input type="checkbox"/> Poisoning, go to G9 <input type="checkbox"/> Exposure, go to G10 <input type="checkbox"/> Undetermined. If under age one, go to G5 and G12. If over age one, go to G12. <input type="checkbox"/> Other, go to G12 <input type="checkbox"/> U/K, go to G12 	<input type="checkbox"/> From a medical cause, select one: <ul style="list-style-type: none"> <input type="checkbox"/> Asthma, go to G11 <input type="checkbox"/> Cancer, go to G11 <input type="checkbox"/> Cardiovascular, go to G11 <input type="checkbox"/> Congenital anomaly, go to G11 <input type="checkbox"/> HIV/AIDS, go to G11 <input type="checkbox"/> Influenza, go to G11 <input type="checkbox"/> Low birth weight, go to G11 <input type="checkbox"/> Malnutrition/dehydration, go to G11 <input type="checkbox"/> Neurological/seizure disorder, go to G11 <input type="checkbox"/> Pneumonia, go to G11 <input type="checkbox"/> Prematurity, go to G11 <input type="checkbox"/> SIDS, go to G5 <input type="checkbox"/> Other infection, specify and go to G11 <input type="checkbox"/> Other perinatal condition, specify and go to G11 <input type="checkbox"/> Other medical condition, specify and go to G11 <input type="checkbox"/> Undetermined. If under age one, go to G5 and G11. If over age one, go to G11. <input type="checkbox"/> U/K. If under age one, go to G5 and G11. If over age one, go to G11. 		

G. DETAILED INFORMATION BY CAUSE OF DEATH: CHOOSE ONE SECTION ONLY matching the cause of death selected above

1. MOTOR VEHICLE AND OTHER TRANSPORT

<p>a. Vehicles involved in incident:</p> <p>Total number of vehicles: _____</p> <p>1. Child's <input type="checkbox"/> 2. Other primary vehicle <input type="checkbox"/></p> <p><input type="checkbox"/> None</p> <p><input type="checkbox"/> Car</p> <p><input type="checkbox"/> Van</p> <p><input type="checkbox"/> Sport utility vehicle</p> <p><input type="checkbox"/> Truck</p> <p><input type="checkbox"/> Semi/tractor trailer</p> <p><input type="checkbox"/> RV</p> <p><input type="checkbox"/> School bus</p> <p><input type="checkbox"/> Other bus</p> <p><input type="checkbox"/> Motorcycle</p> <p><input type="checkbox"/> Tractor</p> <p><input type="checkbox"/> Other farm vehicle</p> <p><input type="checkbox"/> All terrain</p> <p><input type="checkbox"/> Snowmobile</p> <p><input type="checkbox"/> Bicycle</p> <p><input type="checkbox"/> Train</p> <p><input type="checkbox"/> Subway</p> <p><input type="checkbox"/> Trolley</p> <p><input type="checkbox"/> Other, specify: _____</p> <p><input type="checkbox"/> U/K</p>	<p>c. Causes of incident, check all that apply:</p> <p><input type="checkbox"/> Speeding over limit</p> <p><input type="checkbox"/> Unsafe speed for conditions</p> <p><input type="checkbox"/> Recklessness</p> <p><input type="checkbox"/> Ran stop sign or red light</p> <p><input type="checkbox"/> Driver distraction</p> <p><input type="checkbox"/> Driver inexperience</p> <p><input type="checkbox"/> Mechanical failure</p> <p><input type="checkbox"/> Poor tires</p> <p><input type="checkbox"/> Poor weather</p> <p><input type="checkbox"/> Poor visibility</p> <p><input type="checkbox"/> Drugs or alcohol use</p> <p><input type="checkbox"/> Fatigue/sleeping</p> <p><input type="checkbox"/> Medical event, specify: _____</p> <p><input type="checkbox"/> Backover</p> <p><input type="checkbox"/> Poor sight line</p> <p><input type="checkbox"/> Car changing lanes</p> <p><input type="checkbox"/> Road hazard</p> <p><input type="checkbox"/> Animal in road</p> <p><input type="checkbox"/> Cell phone use while driving</p> <p><input type="checkbox"/> Racing, not authorized</p> <p><input type="checkbox"/> Other driver error, specify: _____</p> <p><input type="checkbox"/> Other, specify: _____</p> <p><input type="checkbox"/> U/K</p>	<p>f. Location of incident, check all that apply:</p> <p><input type="checkbox"/> City street</p> <p><input type="checkbox"/> Residential street</p> <p><input type="checkbox"/> Rural road</p> <p><input type="checkbox"/> Highway</p> <p><input type="checkbox"/> Intersection</p> <p><input type="checkbox"/> Shoulder</p> <p><input type="checkbox"/> Sidewalk</p> <p><input type="checkbox"/> Driveway</p> <p><input type="checkbox"/> Parking area</p> <p><input type="checkbox"/> Off road</p> <p><input type="checkbox"/> Railroad crossing/tracks</p> <p><input type="checkbox"/> Other, specify: _____</p> <p><input type="checkbox"/> U/K</p>																																																								
<p>b. Position of child:</p> <p><input type="checkbox"/> Driver</p> <p><input type="checkbox"/> Passenger</p> <p><input type="checkbox"/> Front seat</p> <p><input type="checkbox"/> Back seat</p> <p><input type="checkbox"/> Truck bed</p> <p><input type="checkbox"/> Other, specify: _____</p> <p><input type="checkbox"/> U/K</p> <p><input type="checkbox"/> On bicycle</p> <p><input type="checkbox"/> Pedestrian</p> <p><input type="checkbox"/> Walking</p> <p><input type="checkbox"/> Boarding/blading</p> <p><input type="checkbox"/> Other, specify: _____</p> <p><input type="checkbox"/> U/K</p>	<p>d. Collision type:</p> <p><input type="checkbox"/> Child not in/on a vehicle, but struck by a vehicle</p> <p><input type="checkbox"/> Child in/on a vehicle, struck by other vehicle</p> <p><input type="checkbox"/> Child in/on a vehicle that struck other vehicle</p> <p><input type="checkbox"/> Child in/on a vehicle that struck person or object</p> <p><input type="checkbox"/> Other, specify: _____</p> <p><input type="checkbox"/> U/K</p> <p>e. Driving conditions, check all that apply:</p> <p><input type="checkbox"/> Normal</p> <p><input type="checkbox"/> Loose gravel</p> <p><input type="checkbox"/> Muddy</p> <p><input type="checkbox"/> Ice/Snow</p> <p><input type="checkbox"/> Fog</p> <p><input type="checkbox"/> Wet</p> <p><input type="checkbox"/> Construction zone</p> <p><input type="checkbox"/> Inadequate lighting</p> <p><input type="checkbox"/> Other, specify: _____</p> <p><input type="checkbox"/> U/K</p>	<p>g. Drivers involved in incident, check all that apply:</p> <table style="width: 100%;"> <tr> <th style="width: 33%;">1. Child as driver</th> <th style="width: 33%;">2. Child's driver</th> <th style="width: 33%;">3. Driver of other primary vehicle</th> <th style="width: 33%;">Age of Driver</th> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>_____</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/> Responsible for causing incident</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/> Was alcohol/drug impaired</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/> Has no license</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/> Has a valid license</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/> Has a full license, <i>not</i> graduated</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/> Has a suspended license</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/> Has a graduated license</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/> Was violating graduated licensing rules:</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/> Nighttime driving curfew</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/> Passenger restrictions</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/> Driving w/o required supervision</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/> Other, specify: _____</td> </tr> </table>	1. Child as driver	2. Child's driver	3. Driver of other primary vehicle	Age of Driver	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Responsible for causing incident	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Was alcohol/drug impaired	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Has no license	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Has a valid license	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Has a full license, <i>not</i> graduated	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Has a suspended license	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Has a graduated license	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Was violating graduated licensing rules:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Nighttime driving curfew	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Passenger restrictions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Driving w/o required supervision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Other, specify: _____
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<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____																																																							
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Responsible for causing incident																																																							
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<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Other, specify: _____																																																							
<p>h. Total number of occupants in vehicles:</p> <p>1. In child's vehicle, including child:</p> <p><input type="checkbox"/> N/A</p> <p>Total number occupants: _____ <input type="checkbox"/> U/K</p> <p>Number teens, ages 14-21: _____ <input type="checkbox"/> U/K</p> <p>Total number of deaths: _____ <input type="checkbox"/> U/K</p> <p>Total number teen deaths: _____ <input type="checkbox"/> U/K</p> <p>2. In other primary vehicle involved in incident:</p> <p><input type="checkbox"/> N/A</p> <p>Total number occupants: _____ <input type="checkbox"/> U/K</p> <p>Number teens, ages 14-21: _____ <input type="checkbox"/> U/K</p> <p>Total number of deaths: _____ <input type="checkbox"/> U/K</p> <p>Total number teen deaths: _____ <input type="checkbox"/> U/K</p>																																																										

i. Protective measures for child, check all that apply:	a. Not needed	b. Needed, none present	c. Present, used correctly	d. Present, used incorrectly	e. Present, not used	f. Unknown
Airbag	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lap belt	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Shoulder belt	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Child seat, rear facing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Child seat, front facing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Belt positioning booster seat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Helmet	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other, specify:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

2. FIRE, BURN, or ELECTROCUTION

<p>a. Ignition, heat or electrocution source:</p> <input type="checkbox"/> Matches <input type="checkbox"/> Heating stove <input type="checkbox"/> Lightning <input type="checkbox"/> Other explosives <input type="checkbox"/> Cigarette lighter <input type="checkbox"/> Space heater <input type="checkbox"/> Oxygen tank <input type="checkbox"/> Appliance in water <input type="checkbox"/> Utility lighter <input type="checkbox"/> Furnace <input type="checkbox"/> Hot cooking water <input type="checkbox"/> Other, specify: <input type="checkbox"/> Cigarette or cigar <input type="checkbox"/> Power line <input type="checkbox"/> Hot bath water <input type="checkbox"/> U/K <input type="checkbox"/> Candles <input type="checkbox"/> Electrical outlet <input type="checkbox"/> Other hot liquid, specify: <input type="checkbox"/> Cooking stove <input type="checkbox"/> Electrical wiring <input type="checkbox"/> Fireworks		<p>b. Type of Incident:</p> <input type="checkbox"/> Fire, go to c <input type="checkbox"/> Scald, go to r <input type="checkbox"/> Other burn, go to t <input type="checkbox"/> Electrocution, go to s <input type="checkbox"/> Other, specify and go to t: <input type="checkbox"/> U/K, go to t	
<p>c. For fire, child died from, check only one:</p> <input type="checkbox"/> Burns <input type="checkbox"/> Smoke inhalation <input type="checkbox"/> Other, specify: <input type="checkbox"/> U/K	<p>d. Material first ignited:</p> <input type="checkbox"/> Upholstery <input type="checkbox"/> U/K <input type="checkbox"/> Mattress <input type="checkbox"/> Christmas Tree <input type="checkbox"/> Clothing <input type="checkbox"/> Curtain <input type="checkbox"/> Other, specify:	<p>e. Type of building on fire:</p> <input type="checkbox"/> N/A <input type="checkbox"/> U/K <input type="checkbox"/> Single home <input type="checkbox"/> Duplex <input type="checkbox"/> Apartment <input type="checkbox"/> Trailer/mobile home <input type="checkbox"/> Other, specify:	<p>f. Building's primary construction material:</p> <input type="checkbox"/> Wood <input type="checkbox"/> U/K <input type="checkbox"/> Steel <input type="checkbox"/> Brick/stone <input type="checkbox"/> Aluminum <input type="checkbox"/> Other, specify:
<p>g. Fire started by person?</p> <input type="checkbox"/> No <input type="checkbox"/> Yes, age _____ Person has a history of setting fires? <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> U/K	<p>h. Did anyone attempt to put out fire?</p> <input type="checkbox"/> No <input type="checkbox"/> U/K <input type="checkbox"/> Yes	<p>k. Were barriers preventing safe exit?</p> <input type="checkbox"/> No <input type="checkbox"/> U/K <input type="checkbox"/> Yes, check all that apply: <input type="checkbox"/> Locked door <input type="checkbox"/> Blocked stairway <input type="checkbox"/> Window grate <input type="checkbox"/> Other, specify: <input type="checkbox"/> Locked window <input type="checkbox"/> U/K	
<p>n. Were fire extinguishers present?</p> <input type="checkbox"/> No <input type="checkbox"/> U/K <input type="checkbox"/> Yes	<p>p. Were smoke detectors present?</p> <input type="checkbox"/> No <input type="checkbox"/> U/K <input type="checkbox"/> Yes If yes, type and number of detectors, Check all that apply: <input type="checkbox"/> With removable batteries, # _____ <input type="checkbox"/> Missing batteries, # _____ <input type="checkbox"/> Other reason not working # _____ <input type="checkbox"/> With non-removable batteries, # _____ <input type="checkbox"/> Missing batteries, # _____ <input type="checkbox"/> Other reason not working # _____ <input type="checkbox"/> Hardwired, # _____ <input type="checkbox"/> Not working, # _____ <input type="checkbox"/> U/K	<p>q. Suspected arson?</p> <input type="checkbox"/> No <input type="checkbox"/> U/K <input type="checkbox"/> Yes	<p>s. For electrocution, cause:</p> <input type="checkbox"/> Electrical storm <input type="checkbox"/> Faulty wiring <input type="checkbox"/> Wire/product in water <input type="checkbox"/> Child playing with outlet <input type="checkbox"/> Other, specify: <input type="checkbox"/> U/K
<p>o. Was sprinkler system present?</p> <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, working? <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> U/K	<p>t. Other, describe in detail:</p>		

3. DROWNING

<p>a. Where was child right before drowning? Check all that apply:</p> <input type="checkbox"/> In water <input type="checkbox"/> Near open water <input type="checkbox"/> On shore <input type="checkbox"/> On dock <input type="checkbox"/> In bathroom <input type="checkbox"/> Poolside <input type="checkbox"/> Other, specify: <input type="checkbox"/> U/K	<p>b. Activity before drowning: check only one:</p> <input type="checkbox"/> Playing near water <input type="checkbox"/> Boating <input type="checkbox"/> Swimming <input type="checkbox"/> Bathing <input type="checkbox"/> Fishing <input type="checkbox"/> Surfing <input type="checkbox"/> Tubing <input type="checkbox"/> Water-skiing <input type="checkbox"/> Other, specify: <input type="checkbox"/> U/K	<p>c. Was child forcibly submerged?</p> <input type="checkbox"/> No <input type="checkbox"/> U/K <input type="checkbox"/> Yes	<p>e. For open water, place:</p> <input type="checkbox"/> Lake <input type="checkbox"/> Ocean <input type="checkbox"/> River <input type="checkbox"/> Quarry <input type="checkbox"/> Pond <input type="checkbox"/> Gravel pit <input type="checkbox"/> Creek <input type="checkbox"/> Canal <input type="checkbox"/> U/K
		<p>d. Drowning location:</p> <input type="checkbox"/> Open water, go to e <input type="checkbox"/> Pool, hot tub, spa, go to i <input type="checkbox"/> Bath tub, go to v <input type="checkbox"/> Bucket, go to w <input type="checkbox"/> Well/ cistern/ septic, go to m <input type="checkbox"/> Toilet, go to y <input type="checkbox"/> Other, specify and go to m: <input type="checkbox"/> U/K, go to m	<p>f. Contributing environmental factors:</p> <input type="checkbox"/> Weather <input type="checkbox"/> Drop off <input type="checkbox"/> Temperature <input type="checkbox"/> Other, specify: <input type="checkbox"/> Current <input type="checkbox"/> Rip tide <input type="checkbox"/> U/K

<p>g. For boating, type of boat:</p> <input type="checkbox"/> Sailboat <input type="checkbox"/> Jet ski <input type="checkbox"/> Motorboat <input type="checkbox"/> Canoe <input type="checkbox"/> Kayak <input type="checkbox"/> Raft <input type="checkbox"/> Commercial boat <input type="checkbox"/> Other, specify: <input type="checkbox"/> U/K	<p>i. For pool, type of pool:</p> <input type="checkbox"/> Above ground <input type="checkbox"/> In-ground <input type="checkbox"/> Wading <input type="checkbox"/> Hot tub, spa <input type="checkbox"/> U/K	<p>i. Flotation device used?</p> <input type="checkbox"/> N/A <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> U/K If yes, type: (Check all that apply) <input type="checkbox"/> Coast Guard approved <input type="checkbox"/> Jacket Correct size? <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> U/K Worn correctly? <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> U/K <input type="checkbox"/> Cushion <input type="checkbox"/> Lifesaving Ring <input type="checkbox"/> Not Coast Guard approved <input type="checkbox"/> Swim rings <input type="checkbox"/> Other, specify: <input type="checkbox"/> Inner tube <input type="checkbox"/> Air mattress <input type="checkbox"/> U/K
<p>h. For boating, child piloting boat?</p> <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> U/K	<p>k. Length of time owners had pool/hot tub/spa:</p> <input type="checkbox"/> N/A <input type="checkbox"/> >1yr <input type="checkbox"/> <6 months <input type="checkbox"/> U/K <input type="checkbox"/> 6m-1 yr	

<p>m. What barriers/layers of protection existed to prevent access to water?</p> Check all that apply: <input type="checkbox"/> None <input type="checkbox"/> Gate, go to o <input type="checkbox"/> Alarm, go to q <input type="checkbox"/> Fence, go to n <input type="checkbox"/> Door, go to p <input type="checkbox"/> Cover, go to r <input type="checkbox"/> U/K	<p>n. Fence:</p> Describe type: Fence height in ft _____ Fence surrounds water: <input type="checkbox"/> Four sides <input type="checkbox"/> Two sides <input type="checkbox"/> Three sides <input type="checkbox"/> U/K
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<p>o. Gate, check all that apply:</p> <input type="checkbox"/> Has self closing latch <input type="checkbox"/> Is a double gate <input type="checkbox"/> U/K <input type="checkbox"/> Has lock <input type="checkbox"/> Opens to water	<p>q. Alarm, check all that apply:</p> <input type="checkbox"/> Door <input type="checkbox"/> Window <input type="checkbox"/> Pool <input type="checkbox"/> Laser <input type="checkbox"/> U/K	<p>r. Type of cover:</p> <input type="checkbox"/> Hard <input type="checkbox"/> Soft <input type="checkbox"/> U/K Approved? <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> U/K	<p>p. Door, check all that apply:</p> <input type="checkbox"/> Patio door <input type="checkbox"/> Has lock <input type="checkbox"/> Screen door <input type="checkbox"/> Opens to water <input type="checkbox"/> Steel door <input type="checkbox"/> Barrier between door and water <input type="checkbox"/> Self closing <input type="checkbox"/> U/K	<p>s. Local ordinance(s) regulating access?</p> <input type="checkbox"/> No <input type="checkbox"/> U/K <input type="checkbox"/> Yes If yes, rules violated? <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> U/K
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<p>t. How were layers of protection breached, check all that apply:</p> <input type="checkbox"/> No layers breached <input type="checkbox"/> Gap in gate <input type="checkbox"/> Fence too short <input type="checkbox"/> Door screen torn <input type="checkbox"/> Alarm not working <input type="checkbox"/> Other, specify: <input type="checkbox"/> Gate left open <input type="checkbox"/> Climbed fence <input type="checkbox"/> Door left open <input type="checkbox"/> Door self-closer failed <input type="checkbox"/> Alarm not answered <input type="checkbox"/> U/K <input type="checkbox"/> Gate unlocked <input type="checkbox"/> Gap in fence <input type="checkbox"/> Door unlocked <input type="checkbox"/> Window left open <input type="checkbox"/> Cover left off <input type="checkbox"/> Gate latch failed <input type="checkbox"/> Damaged fence <input type="checkbox"/> Door broken <input type="checkbox"/> Window screen torn <input type="checkbox"/> Cover not locked					
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<p>u. Child able to swim?</p> <input type="checkbox"/> N/A <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> U/K	<p>w. Warning sign or label posted?</p> <input type="checkbox"/> N/A <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> U/K	<p>y. Rescue attempt made?</p> <input type="checkbox"/> N/A <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> U/K If yes, who? Check all that apply: <input type="checkbox"/> Parent <input type="checkbox"/> Other, specify: <input type="checkbox"/> Other child <input type="checkbox"/> Lifeguard <input type="checkbox"/> U/K <input type="checkbox"/> Bystander	<p>z. Did rescuer(s) also drown?</p> <input type="checkbox"/> N/A <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> U/K _____ Number persons aa. Appropriate rescue equipment present? <input type="checkbox"/> N/A <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> U/K
<p>v. For bathtub, child in a bathing aid?</p> <input type="checkbox"/> No <input type="checkbox"/> U/K <input type="checkbox"/> Yes, specify type:	<p>x. Lifeguard present?</p> <input type="checkbox"/> N/A <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> U/K		

4. SUFFOCATION OR STRANGULATION

<p>a. Action causing suffocation, check only one:</p> <input type="checkbox"/> Suffocated in bedding or product or by overlay while in a sleeping environment. Also answer Section H1. <input type="checkbox"/> Strangled by, check all that apply: <input type="checkbox"/> Clothing <input type="checkbox"/> Blind cord <input type="checkbox"/> Car seat <input type="checkbox"/> Stroller <input type="checkbox"/> High chair <input type="checkbox"/> Belt <input type="checkbox"/> Rope/string <input type="checkbox"/> Leash <input type="checkbox"/> Electrical cord <input type="checkbox"/> Person, answer question G6q. <input type="checkbox"/> Other, specify: <input type="checkbox"/> U/K	<input type="checkbox"/> Covered in or fell into object but not sleep-related: <input type="checkbox"/> Plastic bag <input type="checkbox"/> Dirt/Sand <input type="checkbox"/> Other, specify: <input type="checkbox"/> U/K <input type="checkbox"/> Confined in tight space: <input type="checkbox"/> Refrigerator/freezer <input type="checkbox"/> Toy chest <input type="checkbox"/> Other box <input type="checkbox"/> Automobile <input type="checkbox"/> Trunk <input type="checkbox"/> Other, specify: <input type="checkbox"/> U/K	<input type="checkbox"/> Choked on object: <input type="checkbox"/> Food, specify: <input type="checkbox"/> Toy, specify: <input type="checkbox"/> Balloon <input type="checkbox"/> Other, specify: <input type="checkbox"/> U/K <input type="checkbox"/> Swaddled in tight blanket, but not sleep related. <input type="checkbox"/> Wedged into tight space, not sleep related, specify: <input type="checkbox"/> By gas, answer G9h. <input type="checkbox"/> Autoerotic asphyxiation <input type="checkbox"/> Other, specify: <input type="checkbox"/> U/K	<p>b. History of seizures?</p> <input type="checkbox"/> No <input type="checkbox"/> U/K <input type="checkbox"/> Yes If yes, # _____ If yes, witnessed? <input type="checkbox"/> No <input type="checkbox"/> U/K <input type="checkbox"/> Yes <p>c. History of apnea?</p> <input type="checkbox"/> No <input type="checkbox"/> U/K <input type="checkbox"/> Yes If yes, # _____ If yes, witnessed? <input type="checkbox"/> No <input type="checkbox"/> U/K <input type="checkbox"/> Yes <p>d. Was Heimlich Maneuver attempted?</p> <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> U/K
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5. SIDS AND UNDETERMINED CAUSE UNDER ONE YEAR OF AGE

<p>a. Child exposed to 2nd-hand smoke? <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> U/K If yes, how often <input type="checkbox"/> Frequently <input type="checkbox"/> Occasionally <input type="checkbox"/> U/K</p>	<p>b. Child overheated? <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> U/K If yes, Outside temp ____ deg. F Check all that apply: <input type="checkbox"/> Room too hot, temp ____ deg. F <input type="checkbox"/> Too much bedding <input type="checkbox"/> Too much clothing</p>	<p>c. History of seizures? <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> U/K If yes, # ____ If yes, witnessed? <input type="checkbox"/> No <input type="checkbox"/> U/K <input type="checkbox"/> Yes</p>	<p>d. History of apnea? <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> U/K If yes, # ____ If yes, witnessed? <input type="checkbox"/> No <input type="checkbox"/> U/K <input type="checkbox"/> Yes</p>
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e. For SIDS, go to Section H, page 9. For undetermined injury cause to infants also complete G12, page 9, then go to Section H. For undetermined or unknown medical cause to infants also complete G11, page 8, then go to Section H.

6. WEAPON, INCLUDING BODY PART

<p>a. Type of weapon: <input type="checkbox"/> Firearm, go to b <input type="checkbox"/> Sharp instrument, go to j <input type="checkbox"/> Blunt instrument, go to k <input type="checkbox"/> Person's body part, go to l <input type="checkbox"/> Explosive, go to m <input type="checkbox"/> Rope, go to m <input type="checkbox"/> Pipe, go to m <input type="checkbox"/> Biological, go to m <input type="checkbox"/> Other, specify and go to m: <input type="checkbox"/> U/K, go to m</p>	<p>b. For firearms, type: <input type="checkbox"/> Handgun <input type="checkbox"/> Shotgun <input type="checkbox"/> BB gun <input type="checkbox"/> Hunting rifle <input type="checkbox"/> Assault rifle <input type="checkbox"/> Air rifle <input type="checkbox"/> Sawed off shotgun <input type="checkbox"/> Other, specify: <input type="checkbox"/> U/K</p>	<p>d. Firearm safety features, check all that apply: <input type="checkbox"/> Trigger lock <input type="checkbox"/> Personalization device <input type="checkbox"/> External safety/drop safety <input type="checkbox"/> Loaded chamber indicator <input type="checkbox"/> Magazine disconnect <input type="checkbox"/> Minimum trigger pull <input type="checkbox"/> Other, specify: <input type="checkbox"/> U/K</p>	<p>e. Where was firearm stored: <input type="checkbox"/> Not stored <input type="checkbox"/> Locked cabinet <input type="checkbox"/> Unlocked cabinet <input type="checkbox"/> Glove compartment <input type="checkbox"/> Under mattress/pillow <input type="checkbox"/> Other, specify: <input type="checkbox"/> U/K</p>
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	<p>c. Firearm licensed? <input type="checkbox"/> No <input type="checkbox"/> U/K <input type="checkbox"/> Yes</p>	<p>f. Firearm stored with ammunition? <input type="checkbox"/> No <input type="checkbox"/> U/K <input type="checkbox"/> Yes</p>	<p>g. Firearm stored loaded? <input type="checkbox"/> No <input type="checkbox"/> U/K <input type="checkbox"/> Yes</p>
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<p>h. Owner of fatal firearm: <input type="checkbox"/> U/K, weapon stolen <input type="checkbox"/> U/K weapon found <input type="checkbox"/> Self <input type="checkbox"/> Biological parent <input type="checkbox"/> Adoptive parent <input type="checkbox"/> Stepparent <input type="checkbox"/> Foster parent <input type="checkbox"/> Mother's partner</p>	<p><input type="checkbox"/> Father's partner <input type="checkbox"/> Grandparent <input type="checkbox"/> Sibling <input type="checkbox"/> Spouse <input type="checkbox"/> Other relative <input type="checkbox"/> Friend <input type="checkbox"/> Acquaintance <input type="checkbox"/> Child's boyfriend/girlfriend <input type="checkbox"/> Classmate</p>	<p><input type="checkbox"/> Co-worker <input type="checkbox"/> Institutional staff <input type="checkbox"/> Neighbor <input type="checkbox"/> Gang member <input type="checkbox"/> Stranger <input type="checkbox"/> Law enforcement <input type="checkbox"/> Other, specify: <input type="checkbox"/> U/K</p>	<p>i. Sex of owner of fatal firearm: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> U/K</p> <p>j. Type of sharp object: <input type="checkbox"/> Kitchen knife <input type="checkbox"/> Switchblade <input type="checkbox"/> Pocketknife <input type="checkbox"/> Razor <input type="checkbox"/> Hunting knife <input type="checkbox"/> Scissor <input type="checkbox"/> Other, specify: <input type="checkbox"/> U/K</p>	<p>k. Type of blunt object: <input type="checkbox"/> Bat <input type="checkbox"/> Club <input type="checkbox"/> Stick <input type="checkbox"/> Hammer <input type="checkbox"/> Rock <input type="checkbox"/> Household item <input type="checkbox"/> Other, specify: <input type="checkbox"/> U/K</p>
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<p>l. What did body part do? Check all that apply: <input type="checkbox"/> Beat <input type="checkbox"/> Drop <input type="checkbox"/> Kick <input type="checkbox"/> Punch <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>	<p>m. Did person using weapon have history of similar offense? <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> U/K</p> <p>n. Does anyone in child's family have a history of weapon offenses or die of weapons-related causes? <input type="checkbox"/> No <input type="checkbox"/> Yes, describe circumstances <input type="checkbox"/> U/K</p>	<p>o. Persons handling weapons at time of incident, check all that apply:</p> <table border="0"> <tr> <td>1. Fatal</td> <td>2. Other weapon</td> <td>1. Fatal</td> <td>2. Other weapon</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/> Self</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/> Friend</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/> Biological parent</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/> Acquaintance</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/> Adoptive parent</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/> Child's boyfriend/girlfriend</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/> Stepparent</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/> Classmate</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/> Foster parent</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/> Co-worker</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/> Mother's partner</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/> Institutional staff</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/> Father's partner</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/> Neighbor</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/> Grandparent</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/> Rival gang member</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/> Sibling</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/> Stranger</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/> Spouse</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/> Law enforcement officer</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/> Other relative</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/> Other, specify: <input type="checkbox"/> U/K</td> </tr> </table>	1. Fatal	2. Other weapon	1. Fatal	2. Other weapon	<input type="checkbox"/>	<input type="checkbox"/> Self	<input type="checkbox"/>	<input type="checkbox"/> Friend	<input type="checkbox"/>	<input type="checkbox"/> Biological parent	<input type="checkbox"/>	<input type="checkbox"/> Acquaintance	<input type="checkbox"/>	<input type="checkbox"/> Adoptive parent	<input type="checkbox"/>	<input type="checkbox"/> Child's boyfriend/girlfriend	<input type="checkbox"/>	<input type="checkbox"/> Stepparent	<input type="checkbox"/>	<input type="checkbox"/> Classmate	<input type="checkbox"/>	<input type="checkbox"/> Foster parent	<input type="checkbox"/>	<input type="checkbox"/> Co-worker	<input type="checkbox"/>	<input type="checkbox"/> Mother's partner	<input type="checkbox"/>	<input type="checkbox"/> Institutional staff	<input type="checkbox"/>	<input type="checkbox"/> Father's partner	<input type="checkbox"/>	<input type="checkbox"/> Neighbor	<input type="checkbox"/>	<input type="checkbox"/> Grandparent	<input type="checkbox"/>	<input type="checkbox"/> Rival gang member	<input type="checkbox"/>	<input type="checkbox"/> Sibling	<input type="checkbox"/>	<input type="checkbox"/> Stranger	<input type="checkbox"/>	<input type="checkbox"/> Spouse	<input type="checkbox"/>	<input type="checkbox"/> Law enforcement officer	<input type="checkbox"/>	<input type="checkbox"/> Other relative	<input type="checkbox"/>	<input type="checkbox"/> Other, specify: <input type="checkbox"/> U/K	<p>p. Sex of person(s) handling weapon</p> <p>Fatal weapon <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> U/K</p> <p>Other weapon <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> U/K</p>
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q. Use of weapon at time, check all that apply:

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

7. ANIMAL BITE OR ATTACK

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

a. Type: <input type="checkbox"/> Fall, go to b <input type="checkbox"/> Crush, go to h	b. Height of fall: <input type="checkbox"/> U/K _____ feet _____ inches	d. Surface child fell onto: <input type="checkbox"/> Cement/concrete <input type="checkbox"/> Grass <input type="checkbox"/> Gravel <input type="checkbox"/> Wood floor <input type="checkbox"/> Carpeted floor <input type="checkbox"/> Linoleum/vinyl <input type="checkbox"/> Marble/tile <input type="checkbox"/> Other, specify: <input type="checkbox"/> U/K	e. Barriers in place, check all that apply: <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
c. Child fell from: <input type="checkbox"/> Open window <input type="checkbox"/> Furniture <input type="checkbox"/> Screen <input type="checkbox"/> Bed <input type="checkbox"/> No screen <input type="checkbox"/> Roof <input type="checkbox"/> U/K if screen <input type="checkbox"/> Moving object, specify: <input type="checkbox"/> Natural elevation <input type="checkbox"/> Bridge <input type="checkbox"/> Man-made elevation <input type="checkbox"/> Overpass <input type="checkbox"/> Playground equipment <input type="checkbox"/> Balcony <input type="checkbox"/> Tree <input type="checkbox"/> Other, specify: <input type="checkbox"/> Stairs/steps <input type="checkbox"/> U/K		f. Was child in a baby walker? <input type="checkbox"/> N/A <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> U/K	
h. For crush, did child: <input type="checkbox"/> Climb up on object <input type="checkbox"/> Pull object down <input type="checkbox"/> Hide behind object <input type="checkbox"/> Go behind object <input type="checkbox"/> Fall out of object <input type="checkbox"/> Other, specify: <input type="checkbox"/> U/K		i. For crush, object causing crush: <input type="checkbox"/> Appliance <input type="checkbox"/> Boulders/rocks <input type="checkbox"/> Motor vehicle <input type="checkbox"/> Television <input type="checkbox"/> Dirt/sand <input type="checkbox"/> Back over <input type="checkbox"/> Furniture <input type="checkbox"/> Person, answer question G6q, page 7 <input type="checkbox"/> Roll over <input type="checkbox"/> Walls <input type="checkbox"/> Commercial equipment <input type="checkbox"/> Other, specify: <input type="checkbox"/> Playground equipment <input type="checkbox"/> Farm equipment <input type="checkbox"/> U/K <input type="checkbox"/> Animal <input type="checkbox"/> Other, specify: <input type="checkbox"/> Tree branch <input type="checkbox"/> U/K	

9. POISONING

a. Type of poison involved, check all that apply: <div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> Prescription drug: <input type="checkbox"/> Antidepressant <input type="checkbox"/> Blood pressure medication <input type="checkbox"/> Pain killer (opiate) <input type="checkbox"/> Pain killer (non-opiate) <input type="checkbox"/> Methadone <input type="checkbox"/> Cardiac medication <input type="checkbox"/> Other, specify: Over the counter drug: <input type="checkbox"/> Diet pills <input type="checkbox"/> Stimulants <input type="checkbox"/> Cough medicine <input type="checkbox"/> Pain medication <input type="checkbox"/> Children's vitamins <input type="checkbox"/> Iron supplement <input type="checkbox"/> Other vitamins <input type="checkbox"/> Other, specify: <input type="checkbox"/> Cosmetics/personal care products </div> <div style="width: 45%;"> Cleaning substances: <input type="checkbox"/> Bleach <input type="checkbox"/> Drain cleaner <input type="checkbox"/> Alkaline-based cleaner <input type="checkbox"/> Solvent <input type="checkbox"/> Other, specify: Other substances: <input type="checkbox"/> Plants <input type="checkbox"/> Alcohol <input type="checkbox"/> Street drugs <input type="checkbox"/> Pesticide <input type="checkbox"/> Antifreeze <input type="checkbox"/> Other chemical <input type="checkbox"/> Herbal remedy <input type="checkbox"/> Carbon monoxide, go to h <input type="checkbox"/> Other fume/gas/vapor <input type="checkbox"/> Other, specify: Unknown <input type="checkbox"/> </div> </div>	b. Where was the poison stored? <input type="checkbox"/> Open area <input type="checkbox"/> Open cabinet <input type="checkbox"/> Closed cabinet, unlocked <input type="checkbox"/> Closed cabinet, locked <input type="checkbox"/> Other, specify: <input type="checkbox"/> U/K	g. Was Poison Control called? <input type="checkbox"/> No <input type="checkbox"/> U/K <input type="checkbox"/> Yes If yes, who called: <input type="checkbox"/> Child <input type="checkbox"/> Parent <input type="checkbox"/> Other caregiver <input type="checkbox"/> First responder <input type="checkbox"/> Medical person <input type="checkbox"/> Other, specify: <input type="checkbox"/> U/K	
c. Was the product in its original container? <input type="checkbox"/> N/A <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> U/K		h. For CO poisoning, was a CO detector present? <input type="checkbox"/> No <input type="checkbox"/> U/K <input type="checkbox"/> Yes If yes, how many? ____ Functioning properly? <input type="checkbox"/> No <input type="checkbox"/> U/K <input type="checkbox"/> Yes	
d. Did the container contain a child-safety cap? <input type="checkbox"/> N/A <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> U/K		e. If prescription, was it for child? <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> U/K	
f. Was the poisoning the result of? <input type="checkbox"/> Accidental overdose <input type="checkbox"/> Medical treatment mishap <input type="checkbox"/> Adverse effect, but not overdose <input type="checkbox"/> Deliberate poisoning			

10. ENVIRONMENTAL EXPOSURE

a. Circumstances, check all that apply: <input type="checkbox"/> Abandonment <input type="checkbox"/> Injured outdoors <input type="checkbox"/> Left in car <input type="checkbox"/> Lost outdoors <input type="checkbox"/> Left in room <input type="checkbox"/> Other, specify: <input type="checkbox"/> Submerged in water <input type="checkbox"/> U/K	b. Condition of exposure: <input type="checkbox"/> Hyperthermia <input type="checkbox"/> Hypothermia <input type="checkbox"/> U/K _____ Ambient temp, degrees F	c. Number of hours exposed: _____ <input type="checkbox"/> U/K
		d. Clothing appropriate? <input type="checkbox"/> No <input type="checkbox"/> U/K <input type="checkbox"/> Yes

11. MEDICAL CONDITION

a. How long did the child have the medical condition? <input type="checkbox"/> Since birth <input type="checkbox"/> Hours <input type="checkbox"/> Days <input type="checkbox"/> Weeks <input type="checkbox"/> Months <input type="checkbox"/> Years <input type="checkbox"/> U/K	b. Was death expected as a result of the medical condition? <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> But at a later time <input type="checkbox"/> U/K	c. Was child receiving health care for the medical condition? <input type="checkbox"/> No <input type="checkbox"/> Yes Within 48 hours of the death? <input type="checkbox"/> No <input type="checkbox"/> U/K <input type="checkbox"/> Yes <input type="checkbox"/> U/K	d. Was child/family compliant with prescribed care plans? <input type="checkbox"/> No, check all that apply: <input type="checkbox"/> Appointments <input type="checkbox"/> U/K <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"/> Yes <input type="checkbox"/> U/K
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<p>e. Were the prescribed care plans appropriate for the medical condition?</p> <p><input type="checkbox"/> No, specify:</p> <p><input type="checkbox"/> Yes</p> <p><input type="checkbox"/> U/K</p>	<p>h. Were there compliance or access issues related to the death?</p> <p><input type="checkbox"/> No <input type="checkbox"/> U/K</p> <p><input type="checkbox"/> Yes, check all that apply:</p> <table border="0"> <tr> <td><input type="checkbox"/> Lack of money for care</td> <td><input type="checkbox"/> Multiple providers, not coordinated</td> </tr> <tr> <td><input type="checkbox"/> Limitations of health insurance coverage</td> <td><input type="checkbox"/> Lack of child care</td> </tr> <tr> <td><input type="checkbox"/> Multiple health insurance, not coordinated</td> <td><input type="checkbox"/> Lack of family/social support</td> </tr> <tr> <td><input type="checkbox"/> Lack of transportation</td> <td><input type="checkbox"/> Services not available</td> </tr> <tr> <td><input type="checkbox"/> No phone</td> <td><input type="checkbox"/> Caregiver distrust of health care system</td> </tr> <tr> <td><input type="checkbox"/> Cultural differences</td> <td><input type="checkbox"/> Caregiver unskilled in providing care</td> </tr> <tr> <td><input type="checkbox"/> Religious objections to care</td> <td><input type="checkbox"/> Caregiver unwilling to provide care</td> </tr> <tr> <td><input type="checkbox"/> Language barriers</td> <td><input type="checkbox"/> Caregiver's partner would not allow care</td> </tr> <tr> <td><input type="checkbox"/> Referrals not made</td> <td><input type="checkbox"/> Other, specify:</td> </tr> <tr> <td><input type="checkbox"/> Specialist needed, not available</td> <td><input type="checkbox"/> U/K</td> </tr> </table>	<input type="checkbox"/> Lack of money for care	<input type="checkbox"/> Multiple providers, not coordinated	<input type="checkbox"/> Limitations of health insurance coverage	<input type="checkbox"/> Lack of child care	<input type="checkbox"/> Multiple health insurance, not coordinated	<input type="checkbox"/> Lack of family/social support	<input type="checkbox"/> Lack of transportation	<input type="checkbox"/> Services not available	<input type="checkbox"/> No phone	<input type="checkbox"/> Caregiver distrust of health care system	<input type="checkbox"/> Cultural differences	<input type="checkbox"/> Caregiver unskilled in providing care	<input type="checkbox"/> Religious objections to care	<input type="checkbox"/> Caregiver unwilling to provide care	<input type="checkbox"/> Language barriers	<input type="checkbox"/> Caregiver's partner would not allow care	<input type="checkbox"/> Referrals not made	<input type="checkbox"/> Other, specify:	<input type="checkbox"/> Specialist needed, not available	<input type="checkbox"/> U/K
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<input type="checkbox"/> Referrals not made	<input type="checkbox"/> Other, specify:																				
<input type="checkbox"/> Specialist needed, not available	<input type="checkbox"/> U/K																				
<p>f. Was child up to date with immunization schedule?</p> <p><input type="checkbox"/> No, specify:</p> <p><input type="checkbox"/> Yes</p> <p><input type="checkbox"/> U/K</p>																					
<p>g. Was medical condition associated with an outbreak?</p> <p><input type="checkbox"/> No</p> <p><input type="checkbox"/> Yes, specify:</p> <p><input type="checkbox"/> U/K</p>																					

12. OTHER CAUSE AND CAUSE OR MANNER UNDETERMINED

Specify cause, describe in detail:

H. OTHER CIRCUMSTANCES OF INCIDENT-ANSWER RELEVANT SECTIONS

1. DEATH OCCURRED WHILE CHILD SLEEPING OR IN A SLEEPING ENVIRONMENT

No, go to H2 Yes U/K

<p>a. Incident sleep place:</p> <p><input type="checkbox"/> Crib</p> <p><input type="checkbox"/> Bassinette</p> <p><input type="checkbox"/> Twin mattress</p> <p><input type="checkbox"/> Full size mattress</p> <p><input type="checkbox"/> Waterbed</p> <p><input type="checkbox"/> Playpen</p> <p><input type="checkbox"/> Couch</p> <p><input type="checkbox"/> Chair</p> <p><input type="checkbox"/> Floor</p> <p><input type="checkbox"/> Carseat/stroller</p> <p><input type="checkbox"/> Other, specify:</p> <p><input type="checkbox"/> U/K</p>	<p>d. Usual sleep place:</p> <p><input type="checkbox"/> Crib</p> <p><input type="checkbox"/> Bassinette</p> <p><input type="checkbox"/> Twin mattress</p> <p><input type="checkbox"/> Full size mattress</p> <p><input type="checkbox"/> Waterbed</p> <p><input type="checkbox"/> Playpen</p> <p><input type="checkbox"/> Couch</p> <p><input type="checkbox"/> Chair</p> <p><input type="checkbox"/> Floor</p> <p><input type="checkbox"/> Carseat/stroller</p> <p><input type="checkbox"/> Other, specify:</p> <p><input type="checkbox"/> U/K</p>	<p>g. Position and location of child when found:</p> <p>Child found: (Check one)</p> <p><input type="checkbox"/> With face and body unobstructed</p> <p><input type="checkbox"/> Under</p> <p><input type="checkbox"/> Between</p> <p><input type="checkbox"/> Wedged into</p> <p><input type="checkbox"/> Pressed into</p> <p><input type="checkbox"/> Fell or rolled onto</p> <p><input type="checkbox"/> Tangled in</p> <p><input type="checkbox"/> Other, specify:</p> <p><input type="checkbox"/> U/K</p> <p>With what object or where: (Check all that apply)</p> <p><input type="checkbox"/> Adult(s)</p> <p><input type="checkbox"/> Child(ren)</p> <p><input type="checkbox"/> Animal(s)</p> <p><input type="checkbox"/> Blanket</p> <p><input type="checkbox"/> Pillow</p> <p><input type="checkbox"/> Comforter</p> <p><input type="checkbox"/> Mattress, specify type:</p> <p><input type="checkbox"/> Water bed mattress</p> <p><input type="checkbox"/> Crib rail</p> <p><input type="checkbox"/> Couch</p> <p><input type="checkbox"/> Chair, type:</p> <p><input type="checkbox"/> Car seat/stroller</p> <p><input type="checkbox"/> Stuffed toy</p> <p><input type="checkbox"/> Other toy, specify:</p> <p><input type="checkbox"/> Clothing</p> <p><input type="checkbox"/> Cord</p> <p><input type="checkbox"/> Plastic bag</p> <p><input type="checkbox"/> Other plastic, specify:</p> <p><input type="checkbox"/> Other, specify:</p> <p><input type="checkbox"/> U/K</p>	<p>h. Child fell asleep while feeding?</p> <p><input type="checkbox"/> No</p> <p><input type="checkbox"/> Yes</p> <p><input type="checkbox"/> Bottle</p> <p><input type="checkbox"/> Breast</p> <p><input type="checkbox"/> U/K</p>
<p>b. Child put to sleep:</p> <p><input type="checkbox"/> On back</p> <p><input type="checkbox"/> On stomach</p> <p><input type="checkbox"/> On side</p> <p><input type="checkbox"/> U/K</p>	<p>e. Usual sleep position:</p> <p><input type="checkbox"/> On back</p> <p><input type="checkbox"/> On stomach</p> <p><input type="checkbox"/> On side</p> <p><input type="checkbox"/> U/K</p>		<p>i. Child sleeping on same surface with person(s) or animal(s), check all that apply:</p> <p><input type="checkbox"/> With adult(s): Number: ____ <input type="checkbox"/> U/K</p> <p>Adult obese: <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> U/K</p> <p><input type="checkbox"/> With other children: Number: ____ <input type="checkbox"/> U/K</p> <p>Ages:</p> <p><input type="checkbox"/> With animal(s): Number: ____ <input type="checkbox"/> U/K</p> <p>Type: <input type="checkbox"/> U/K</p>
<p>c. Child found:</p> <p><input type="checkbox"/> On back</p> <p><input type="checkbox"/> On stomach</p> <p><input type="checkbox"/> On side</p> <p><input type="checkbox"/> U/K</p>	<p>f. Child in new environment?</p> <p><input type="checkbox"/> No</p> <p><input type="checkbox"/> Yes, specify:</p> <p><input type="checkbox"/> U/K</p>		

2. DEATH A CONSEQUENCE OF A PROBLEM WITH A CONSUMER PRODUCT

No, go to H3 Yes U/K

<p>a. Describe product:</p>	<p>b. Was product used properly?</p> <p><input type="checkbox"/> No</p> <p><input type="checkbox"/> Yes</p> <p><input type="checkbox"/> U/K</p>	<p>c. Recall in place?</p> <p><input type="checkbox"/> No</p> <p><input type="checkbox"/> Yes</p> <p><input type="checkbox"/> U/K</p>	<p>d. Did product have appropriate safety label?</p> <p><input type="checkbox"/> No</p> <p><input type="checkbox"/> Yes</p> <p><input type="checkbox"/> U/K</p>	<p>e. Was Consumer Product Safety Commission notified?</p> <p><input type="checkbox"/> No, call 1-800-638-2772 to file report</p> <p><input type="checkbox"/> Yes</p> <p><input type="checkbox"/> U/K</p>
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3. DEATH OCCURRED DURING COMMISSION OF A CRIME OTHER THAN INCIDENT CAUSING DEATH

No Yes U/K

a. Type of crime, check all that apply:

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

<p>23. Person has prior child deaths?</p> <p>a. Caused b. Contributed</p> <p><input type="checkbox"/> <input type="checkbox"/> No</p> <p><input type="checkbox"/> <input type="checkbox"/> Yes</p> <p><input type="checkbox"/> <input type="checkbox"/> U/K</p> <p>If yes, check all that apply:</p> <p><input type="checkbox"/> <input type="checkbox"/> Child abuse # ___</p> <p><input type="checkbox"/> <input type="checkbox"/> Child neglect # ___</p> <p><input type="checkbox"/> <input type="checkbox"/> Accident # ___</p> <p><input type="checkbox"/> <input type="checkbox"/> Suicide # ___</p> <p><input type="checkbox"/> <input type="checkbox"/> SIDS # ___</p> <p><input type="checkbox"/> <input type="checkbox"/> Other, specify: # ___</p> <p><input type="checkbox"/> <input type="checkbox"/> U/K</p>	<p>24. Person has a history of Post Traumatic Stress Disorder?</p> <p>a. Caused b. Contributed</p> <p><input type="checkbox"/> <input type="checkbox"/> No</p> <p><input type="checkbox"/> <input type="checkbox"/> Yes, describe:</p> <p><input type="checkbox"/> <input type="checkbox"/> U/K</p>	<p>25. At time of incident, was person, (Check all that apply):</p> <table style="width:100%;"> <tr> <td style="width:33%;"> <p>a. Caused b. Contributed</p> <p><input type="checkbox"/> <input type="checkbox"/> Drug impaired?</p> <p><input type="checkbox"/> <input type="checkbox"/> Alcohol impaired?</p> <p><input type="checkbox"/> <input type="checkbox"/> Asleep?</p> <p><input type="checkbox"/> <input type="checkbox"/> Distracted?</p> <p><input type="checkbox"/> <input type="checkbox"/> Absent?</p> </td> <td style="width:33%;"> <p>a. Caused b. Contributed</p> <p><input type="checkbox"/> <input type="checkbox"/> Impaired by illness?</p> <p>Specify:</p> <p><input type="checkbox"/> <input type="checkbox"/> Impaired by disability?</p> <p>Specify:</p> <p><input type="checkbox"/> <input type="checkbox"/> Other? Specify:</p> </td> </tr> </table>	<p>a. Caused b. Contributed</p> <p><input type="checkbox"/> <input type="checkbox"/> Drug impaired?</p> <p><input type="checkbox"/> <input type="checkbox"/> Alcohol impaired?</p> <p><input type="checkbox"/> <input type="checkbox"/> Asleep?</p> <p><input type="checkbox"/> <input type="checkbox"/> Distracted?</p> <p><input type="checkbox"/> <input type="checkbox"/> Absent?</p>	<p>a. Caused b. Contributed</p> <p><input type="checkbox"/> <input type="checkbox"/> Impaired by illness?</p> <p>Specify:</p> <p><input type="checkbox"/> <input type="checkbox"/> Impaired by disability?</p> <p>Specify:</p> <p><input type="checkbox"/> <input type="checkbox"/> Other? Specify:</p>
<p>a. Caused b. Contributed</p> <p><input type="checkbox"/> <input type="checkbox"/> Drug impaired?</p> <p><input type="checkbox"/> <input type="checkbox"/> Alcohol impaired?</p> <p><input type="checkbox"/> <input type="checkbox"/> Asleep?</p> <p><input type="checkbox"/> <input type="checkbox"/> Distracted?</p> <p><input type="checkbox"/> <input type="checkbox"/> Absent?</p>	<p>a. Caused b. Contributed</p> <p><input type="checkbox"/> <input type="checkbox"/> Impaired by illness?</p> <p>Specify:</p> <p><input type="checkbox"/> <input type="checkbox"/> Impaired by disability?</p> <p>Specify:</p> <p><input type="checkbox"/> <input type="checkbox"/> Other? Specify:</p>			
<p>26. Does person have (check all that apply):</p> <p>a. Caused b. Contributed</p> <p><input type="checkbox"/> <input type="checkbox"/> Prior history of similar acts?</p> <p><input type="checkbox"/> <input type="checkbox"/> Prior arrests?</p> <p><input type="checkbox"/> <input type="checkbox"/> Prior convictions?</p>	<p>27. Legal outcomes in this death, check all that apply:</p> <table style="width:100%;"> <tr> <td style="width:33%;"> <p>a. Caused b. Contributed</p> <p><input type="checkbox"/> <input type="checkbox"/> No charges filed</p> <p><input type="checkbox"/> <input type="checkbox"/> Charges pending</p> <p><input type="checkbox"/> <input type="checkbox"/> Charges filed, specify:</p> <p><input type="checkbox"/> <input type="checkbox"/> Confession</p> </td> <td style="width:33%;"> <p>a. Caused b. Contributed</p> <p><input type="checkbox"/> <input type="checkbox"/> Plead, specify:</p> <p><input type="checkbox"/> <input type="checkbox"/> Not guilty verdict</p> <p><input type="checkbox"/> <input type="checkbox"/> Guilty verdict, sentence:</p> <p><input type="checkbox"/> <input type="checkbox"/> Tort charges, specify:</p> <p><input type="checkbox"/> <input type="checkbox"/> U/K</p> </td> </tr> </table>	<p>a. Caused b. Contributed</p> <p><input type="checkbox"/> <input type="checkbox"/> No charges filed</p> <p><input type="checkbox"/> <input type="checkbox"/> Charges pending</p> <p><input type="checkbox"/> <input type="checkbox"/> Charges filed, specify:</p> <p><input type="checkbox"/> <input type="checkbox"/> Confession</p>	<p>a. Caused b. Contributed</p> <p><input type="checkbox"/> <input type="checkbox"/> Plead, specify:</p> <p><input type="checkbox"/> <input type="checkbox"/> Not guilty verdict</p> <p><input type="checkbox"/> <input type="checkbox"/> Guilty verdict, sentence:</p> <p><input type="checkbox"/> <input type="checkbox"/> Tort charges, specify:</p> <p><input type="checkbox"/> <input type="checkbox"/> U/K</p>	
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For Suicide

<p>28. For suicide, check each question and describe answers in narrative:</p> <p>a. Yes b. No c. U/K</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> A note was left?</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Child talked about suicide?</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Prior suicide threats were made?</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Prior attempts were made?</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Suicide was completely unexpected?</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Child had received prior mental health services?</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Child was receiving mental health services?</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Child was on medications for mental illness?</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Issues prevented child from receiving mental health services? Specify:</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Child had a history of running away?</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Child had a history of self mutilation?</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> There is a family history of suicide?</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Suicide was part of a murder-suicide?</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Suicide was part of a suicide pact?</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Suicide was part of a suicide cluster?</p>	<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 style="width:100%;"> <tr> <td style="width:50%;"> <p><input type="checkbox"/> No history</p> <p><input type="checkbox"/> Family discord</p> <p><input type="checkbox"/> Parents' divorce/separation</p> <p><input type="checkbox"/> Argument with parents/caregivers</p> <p><input type="checkbox"/> Argument with boyfriend/girlfriend</p> <p><input type="checkbox"/> Breakup with boyfriend/girlfriend</p> <p><input type="checkbox"/> Argument with other friends</p> <p><input type="checkbox"/> Rumor mongering</p> <p><input type="checkbox"/> Suicide by friend or relative</p> <p><input type="checkbox"/> Other death of friend or relative</p> <p><input type="checkbox"/> Bullying as victim</p> <p><input type="checkbox"/> Bullying as perpetrator</p> <p><input type="checkbox"/> School failure</p> <p><input type="checkbox"/> Move/new school</p> <p><input type="checkbox"/> Other serious school problems</p> <p><input type="checkbox"/> Pregnancy</p> </td> <td style="width:50%;"> <p><input type="checkbox"/> Physical abuse/assault</p> <p><input type="checkbox"/> Rape/sexual abuse</p> <p><input type="checkbox"/> Problems with the law</p> <p><input type="checkbox"/> Drugs/alcohol</p> <p><input type="checkbox"/> Sexual orientation</p> <p><input type="checkbox"/> Religious/cultural issues</p> <p><input type="checkbox"/> Job problems</p> <p><input type="checkbox"/> Money problems</p> <p><input type="checkbox"/> Gambling problems</p> <p><input type="checkbox"/> Involvement in cult activities</p> <p><input type="checkbox"/> Involvement in computer or video games</p> <p><input type="checkbox"/> Involvement with the Internet, specify:</p> <p><input type="checkbox"/> Other, specify:</p> <p><input type="checkbox"/> U/K</p> </td> </tr> </table>	<p><input type="checkbox"/> No history</p> <p><input type="checkbox"/> Family discord</p> <p><input type="checkbox"/> Parents' divorce/separation</p> <p><input type="checkbox"/> Argument with parents/caregivers</p> <p><input type="checkbox"/> Argument with boyfriend/girlfriend</p> <p><input type="checkbox"/> Breakup with boyfriend/girlfriend</p> <p><input type="checkbox"/> Argument with other friends</p> <p><input type="checkbox"/> Rumor mongering</p> <p><input type="checkbox"/> Suicide by friend or relative</p> <p><input type="checkbox"/> Other death of friend or relative</p> <p><input type="checkbox"/> Bullying as victim</p> <p><input type="checkbox"/> Bullying as perpetrator</p> <p><input type="checkbox"/> School failure</p> <p><input type="checkbox"/> Move/new school</p> <p><input type="checkbox"/> Other serious school problems</p> <p><input type="checkbox"/> Pregnancy</p>	<p><input type="checkbox"/> Physical abuse/assault</p> <p><input type="checkbox"/> Rape/sexual abuse</p> <p><input type="checkbox"/> Problems with the law</p> <p><input type="checkbox"/> Drugs/alcohol</p> <p><input type="checkbox"/> Sexual orientation</p> <p><input type="checkbox"/> Religious/cultural issues</p> <p><input type="checkbox"/> Job problems</p> <p><input type="checkbox"/> Money problems</p> <p><input type="checkbox"/> Gambling problems</p> <p><input type="checkbox"/> Involvement in cult activities</p> <p><input type="checkbox"/> Involvement in computer or video games</p> <p><input type="checkbox"/> Involvement with the Internet, specify:</p> <p><input type="checkbox"/> Other, specify:</p> <p><input type="checkbox"/> U/K</p>
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J. SERVICES TO FAMILY AND COMMUNITY AS A RESULT OF DEATH

1. Services, check all that apply:	a. Provided	b. Offered but	c. Needed but	d. Should be	e. Unknown	f. CDR review led
	after death	not wanted	not available	offered		to referral
Bereavement counseling	<input type="checkbox"/>					
Economic support	<input type="checkbox"/>					
Funeral arrangements	<input type="checkbox"/>					
Emergency shelter	<input type="checkbox"/>					
Mental health services	<input type="checkbox"/>					
Foster care	<input type="checkbox"/>					
Health care	<input type="checkbox"/>					
Legal services	<input type="checkbox"/>					
Family planning	<input type="checkbox"/>					
Other, specify:	<input type="checkbox"/>					

K. PREVENTION INITIATIVES RESULTING FROM THE REVIEW

<p>1. Could the death have been prevented?</p> <p><input type="checkbox"/> No, probably not</p> <p><input type="checkbox"/> Yes, probably</p> <p><input type="checkbox"/> Team could not determine</p>	<p>2. Did the team or team members conduct any assessment of the risk factors and possible resources, services, programs or initiatives related to the prevention of this type of death?</p> <table style="width:100%;"> <tr> <td style="width:50%;"> <p><input type="checkbox"/> No</p> <p><input type="checkbox"/> Yes If yes, check all that apply</p> <p><input type="checkbox"/> U/K</p> </td> <td style="width:50%;"> <p><input type="checkbox"/> Literature review</p> <p><input type="checkbox"/> Presentation by expert(s)</p> <p><input type="checkbox"/> Data collection/analysis</p> <p><input type="checkbox"/> Review programs, services, resources</p> <p><input type="checkbox"/> Contact existing groups, agencies</p> <p><input type="checkbox"/> Other, specify:</p> </td> </tr> </table>	<p><input type="checkbox"/> No</p> <p><input type="checkbox"/> Yes If yes, check all that apply</p> <p><input type="checkbox"/> U/K</p>	<p><input type="checkbox"/> Literature review</p> <p><input type="checkbox"/> Presentation by expert(s)</p> <p><input type="checkbox"/> Data collection/analysis</p> <p><input type="checkbox"/> Review programs, services, resources</p> <p><input type="checkbox"/> Contact existing groups, agencies</p> <p><input type="checkbox"/> Other, specify:</p>
<p><input type="checkbox"/> No</p> <p><input type="checkbox"/> Yes If yes, check all that apply</p> <p><input type="checkbox"/> U/K</p>	<p><input type="checkbox"/> Literature review</p> <p><input type="checkbox"/> Presentation by expert(s)</p> <p><input type="checkbox"/> Data collection/analysis</p> <p><input type="checkbox"/> Review programs, services, resources</p> <p><input type="checkbox"/> Contact existing groups, agencies</p> <p><input type="checkbox"/> Other, specify:</p>		
<p>3. What specific change(s) does the team believe should occur to prevent other deaths and to keep children safe, healthy and protected?</p> <p><input type="checkbox"/> Individual: _____</p> <p><input type="checkbox"/> Community: _____</p> <p><input type="checkbox"/> Agency: _____</p>			

4. To effect this change, what specific recommendations and/or actions resulted from the review? Check all that apply: No recommendations made, go to Section L

	a. Current Action Stage			b. Type of Action		c. Level of Action		
	1. Recommendation	2. Planning	3. Implementation	1. Short term	2. Long term	1. Local	2. State	3. Nat'l
Education	Media campaign	<input type="checkbox"/>						
	School program	<input type="checkbox"/>						
	Community safety project	<input type="checkbox"/>						
	Provider education	<input type="checkbox"/>						
	Parent education	<input type="checkbox"/>						
	Public forum	<input type="checkbox"/>						
	Other education	<input type="checkbox"/>						
Agency	New policy(ies)	<input type="checkbox"/>						
	Revised policy(ies)	<input type="checkbox"/>						
	New program	<input type="checkbox"/>						
	New services	<input type="checkbox"/>						
	Expanded services	<input type="checkbox"/>						
Law	New law/ordinance	<input type="checkbox"/>						
	Amended law/ordinance	<input type="checkbox"/>						
	Enforcement of law/ordinance	<input type="checkbox"/>						
Environment	Modify a consumer product	<input type="checkbox"/>						
	Recall a consumer product	<input type="checkbox"/>						
	Modify a public space	<input type="checkbox"/>						
	Modify a private space(s)	<input type="checkbox"/>						
	Other, specify:	<input type="checkbox"/>						

Briefly describe the strategies:

5. Who took responsibility for championing the prevention strategies? Check all that apply:

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

6. Number of person(s)/agency(ies) responsible for prevention strategies:

- _____ Individual member(s) of team
- _____ Member agency(ies) of team
- _____ Person/Agency(ies) not on team
- U/K

L. THE REVIEW MEETING PROCESS

1. Number of review meetings for this case: _____ 2. Is review complete? No Yes

3. Agencies at review, check all that apply:

- Medical examiner/coroner
- Law enforcement
- Prosecutor/district attorney
- Public health
- CPS
- Other social services
- Physician
- Hospital records staff
- Other health care
- Fire
- EMS
- Education
- Mental health
- Substance abuse
- Court
- Child advocate
- Others, list:

4. Factors that prevented an effective review, check all that apply:

- Confidentiality issues among members prevented full exchange of information.
- HIPAA regulations prevented access to or exchange of information.
- Inadequate investigation precluded having enough information for review.
- Team members did not bring adequate information to the meeting.
- Necessary team members were absent.
- Meeting was held too soon after death.
- Meeting was held too long after death.
- Records or information were needed from another locality in-state.
- Records or information were needed from another state.
- Team disagreement on circumstances.
- Other factors, specify:

5. Review meeting outcomes, check all that apply:

- Review led to additional investigation.
- Team disagreed with official manner of death.
What did team believe manner should be?
- Team disagreed with official cause of death.
What did team believe cause should be?
- Because of the review, the official cause or manner of death was changed.
- Review led to the delivery of services.
- Review led to changes in agency policies or practices.
- Review led to prevention initiatives being implemented.
 - Local
 - State
 - National

M. NARRATIVE

Use this space to provide more detail on the circumstances of the death, and to describe any other relevant information

N. FORM COMPLETED BY:

PERSON:

DATE:

TITLE:

PHONE:

AGENCY:

EMAIL:

SIGNATURE:

DATA ENTRY COMPLETED FOR THIS CASE? Yes No

NOTES:

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www.childdeathreview.org
email: info@childdeathreview.org
1-800-656-2434
2438 Woodlake Circle, Suite 240
Okemos, MI 48864