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Infant Death Investigation Checklist

Arizona Report Form, Version 1.0

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Arizona Department of Health Services (fax: 602-542-1843)

CHILD

Name:		SSN:
Home Address:		
Incident Address:		
Date of Birth:	Date of Death:	Estimated Time of Death:

MOTHER OR CAREGIVER #1

Name:	Other Names Used:	SSN:
Address:		DL#:
Date of Birth:	Other States Where Resided:	
Telephone (include area code):		Smoker? ☐ No ☐ Yes
Evidence/History of Substance Use? ☐ No ☐ Yes ☐ Last 24 Hours ☐ Unknown		

FATHER OR CAREGIVER #2

Name:	Other Names Used:	SSN:
Address:		DL#:
Date of Birth:	Other States Where Resided:	
Telephone (include area code):		Smoker? ☐ No ☐ Yes
Evidence/History of Substance Use? ☐ No ☐ Yes ☐ Last 24 Hours ☐ Unknown		

CAREGIVER AT TIME OF DEATH (if other than parent)

Name:	Other Names Used:	SSN:
Address:		DL#:
Date of Birth:	Other States Where Resided:	
Telephone (include area code):		Smoker? ☐ No ☐ Yes
Evidence/History of Substance Use? ☐ No ☐ Yes ☐ Last 24 Hours ☐ Unknown		
Relationship to child:	How long cared for child:	

CAREGIVER(S) AT TIME OF DEATH INFORMATION

1. Primary Caregiver Column 1: Secondary Caregiver Column 2:

One	Two	
☐	☐	Biological parent
☐	☐	Adoptive parent
☐	☐	Step parent
☐	☐	Foster parent
☐	☐	Mother's partner
☐	☐	Father's partner
☐	☐	Grandparent
☐	☐	Sibling
☐	☐	Other relative
☐	☐	Friend/Neighbor
☐	☐	Unknown
☐	☐	Daycare Provider
		☐ Licensed
		☐ Unlicensed
☐	☐	Other Specify:

2. Caregiver(s) age in years

One	Two	
___	___	# years
☐	☐	Unknown

3. Caregiver(s) Sex:

One	Two	
☐	☐	Male
☐	☐	Female
☐	☐	Unknown

4. Caregiver(s) employment status:

One	Two	
☐	☐	Employed
☐	☐	Unemployed
☐	☐	On disability
☐	☐	Stay-at-home
☐	☐	Retired
☐	☐	Unknown

5. Caregiver(s) substance use history

One	Two	
☐	☐	No
☐	☐	Yes
☐	☐	Unknown

If yes, check all that apply

☐	☐	Alcohol
☐	☐	Cocaine
☐	☐	Marijuana
☐	☐	Methamphetamine
☐	☐	Opiates
☐	☐	Prescriptions
☐	☐	Over the counter
☐	☐	Unknown
☐	☐	Other, Specify:

6. Caregiver(s) have prior child death:

One	Two	
☐	☐	No
☐	☐	Yes
☐	☐	Unknown

If yes, cause(s) Check all that apply

☐	☐	Abuse #___
☐	☐	Neglect #___
☐	☐	Accident #___
☐	☐	Suicide #___
☐	☐	SIDS #___
☐	☐	Unknown #___
☐	☐	Other #___

MEDICAL EXAMINERS OFFICE FAX NUMBERS

Apache	**(866) 593-6192**
Cochise	**(520) 724-8610**
Coconino	**(928) 779-7056**
Gila	**(928) 474-1658**
Graham	**(928) 348-4033**
Greenlee	**(520) 724-8610**
La Paz	**(520) 724-8610**
Maricopa	**(602) 506-1546**
Mohave	**(928) 505-5889**
Navajo	**(928) 532-6054**
Pima	**(520) 724-8610**
Pinal	**(520) 866-7296**
Santa Cruz	**(520) 724-8610**
Yavapai	**(928) 771-3504**
Yuma	**(928) 336-1608**

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Incident State: ☐ Arizona ☐ Other, Specify **Incident County:**	**Was 911 or local emergency number called?** ☐ N/A ☐ No ☐ Yes ☐ Unknown	**CPR performed before EMS arrived?** ☐ N/A ☐ No ☐ Yes ☐ Unknown	**During resuscitation was child:** ☐ Injured ☐ Shaken ☐ Jostled ☐ Other, specify:	**EMS responded to scene?** ☐ N/A ☐ No ☐ Yes ☐ Unknown	**Child's activity at time of incident, check all that apply:** ☐ Sleeping ☐ Playing ☐ Working ☐ Eating ☐ In vehicle ☐ Unknown ☐ Other Specify:	**Total number of deaths at incident event:** Children (Ages 0-18): Adults: ☐ Unknown

What led someone to check on the infant? _____

Who was in the home when the child was found? _____

Describe child's appearance when found:	**No**	**Yes**	**Unknown**	**Describe/specify location:**	**First Assessed by:**
Discoloration around face/nose/mouth	☐	☐	☐		☐ EMS
Secretions (foam, froth)	☐	☐	☐		☐ ER
Skin discoloration (livor mortis)	☐	☐	☐		☐ PD
Pressure marks (pale areas, blanching)	☐	☐	☐		
Rash or petechiae (small, red blood spots on skin, membranes, or eyes)	☐	☐	☐		
Marks on body (scratches or bruises)	☐	☐	☐		
Infant moved prior to being found	☐	☐	☐		

Time frame information:

Time Found _____ **Last Seen Alive** _____ **Time Police Called** _____ **Call Type:** ☐ **911** ☐ **Regular** ☐ **Other, specify:** _____

Last Feeding Time _____

Person Calling _____

What did the child feel like when found? (check all that apply)

☐ **Sweaty** ☐ **Warm to touch** ☐ **Cool to touch** **Surface body temperature:**

☐ **Limp, flexible** ☐ **Rigid, stiff** ☐ **Unknown** **Temperature at hospital:**

☐ **Other, Specify:**

SUFFOCATION/ASPHYXIA

A. Type of Event

☐ Suffocation, go to **B**.

☐ Strangulation, go to **C**.

☐ Choking, go to **D**.

B. If suffocation/asphyxia, action causing event:

☐ Sleep-related (e.g. bedding, overlay, wedged) ☐ Confined in tight space ☐ Swaddled in tight blanket, not sleep related

☐ Covered in or fell into object, not sleep related ☐ Refrigerator/freezer ☐ Wedged into tight space, but not sleep related

☐ Plastic bag ☐ Toy chest ☐ Asphyxia by gas

☐ Dirt/Sand ☐ Automobile ☐ Unknown

☐ Unknown ☐ Trunk ☐ Other, Specify:

☐ Other, Specify: ☐ Unknown

☐ Other, Specify:

C. If strangulation, object causing event:

☐ Clothing ☐ High chair ☐ Electrical cord

☐ Blind cord ☐ Belt ☐ Automobile power window or sunroof

☐ Car seat ☐ Rope/string ☐ Unknown ☐ Person

☐ Stroller ☐ Leash ☐ Other, Specify:

D. If choking, object causing choking:

☐ Food, Specify:

☐ Toy, Specify:

☐ Balloon ☐ Unknown

☐ Other, Specify:

OTHER CIRCUMSTANCES OF INCIDENT – ANSWER RELEVANT SECTIONS

DID DEATH OCCUR WHILE CHILD SLEEPING OR IN A SLEEPING ENVIRONMENT? ☐ No ☐ Yes

A. **INCIDENT** sleep place:	If adult bed, What type?	C. Child put to sleep:	D. Child found:
☐ Crib ☐ Playpen ☐ Car seat/Stroller ☐ Bassinette ☐ Couch ☐ Unknown ☐ Adult bed ☐ Chair ☐ Other, Specify: ☐ Waterbed ☐ Floor	☐ Twin ☐ King ☐ Full ☐ Unknown ☐ Queen ☐ Other, Specify:	☐ On back ☐ On Stomach ☐ On side ☐ Unknown By Whom:	☐ On back ☐ On Stomach ☐ On side ☐ Unknown By Whom:

E. Was there a crib, bassinette, or port-a-crib in home for child? ☐ No ☐ Yes ☐ Unknown

F. **USUAL** sleep place:	If adult bed, what type?	G. **USUAL** sleep position:	H. Child in new or different environment?
☐ Crib ☐ Playpen ☐ Car seat/Stroller ☐ Bassinette ☐ Couch ☐ Unknown ☐ Adult bed ☐ Chair ☐ Other, Specify: ☐ Waterbed ☐ Floor	☐ Twin ☐ King ☐ Full ☐ Unknown ☐ Queen ☐ Other, Specify:	☐ On back ☐ On Stomach ☐ On side ☐ Unknown	☐ No ☐ Yes ☐ Unknown

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CIRCUMSTANCES when child found:

Child's airway was:

- ☐ Unobstructed by person or object
- ☐ Fully obstructed by person or object
- ☐ Partially obstructed by person or object
- ☐ Unknown

Child's position most relevant to death:

- ☐ On top of
- ☐ Under
- ☐ Between
- ☐ Wedged into
- ☐ Pressed into
- ☐ Fell or rolled onto
- ☐ Tangled in
- ☐ Unknown
- ☐ Other, Specify:

With what objects or persons? Check all that apply:

- ☐ Adult
- ☐ Child(ren)
- ☐ Animal(s)
- ☐ Blanket
- ☐ Pillow
- ☐ Comforter
- ☐ Mattress
- ☐ Bumper pads
- ☐ Waterbed mattress
- ☐ Air mattress
- ☐ Pillow-top mattress
- ☐ Crib rail
- ☐ Couch
- ☐ Car seat/stroller
- ☐ Stuffed toy
- ☐ Chair, Type:
- ☐ Clothing
- ☐ Cord
- ☐ Plastic bag
- ☐ Wall
- ☐ Unknown
- ☐ Other, Specify:

Child sleeping on same surface with person(s) or animal(s)? Check all that apply:

- ☐ With adults: Number:_____ Adult obese: ☐ No ☐ Yes ☐ Unknown Alcohol/Drugs? ☐ No ☐ Yes
- ☐ With other child(ren): Number:_____ Child(ren)'s ages:
- ☐ With animal(s): Number:_____ Type(s) of animals:
- ☐ Unknown ☐ Number Unknown

What food/liquids was the child fed in the last 24 hours?	**No**	**Yes**	**Unknown**	**Quantity (Specify type & brand, if applicable)**
Breast milk (one/both sides, length of time)	☐	☐	☐	ounces
Formula (brand, water source – ex. Similac, tap water)	☐	☐	☐	ounces
Was the formula mixed according to directions?	☐	☐	☐	
Cow's milk	☐	☐	☐	ounces
Water (brand, bottled, tap, well)	☐	☐	☐	ounces
Other liquids (juices, teas)	☐	☐	☐	ounces
Solids, specify:	☐	☐	☐	ounces
Other, specify:	☐	☐	☐	ounces

Was a new food introduced in the 24 hours prior the child's death?

☐ No ☐ Yes ☐ Unknown If yes, describe:

Was the child last placed to sleep with a bottle?

☐ No ☐ Yes ☐ Unknown **How was formula prepared:**

Was the bottle propped on object while feeding?

☐ No ☐ Yes ☐ Unknown If yes, what object used?

What was the quantity of liquid (in ounces) in the bottle?

Did the death occur during:	☐ Breastfeeding	☐ Bottle feeding	☐ Eating solid foods	☐ Not during feeding

RECENT MEDICAL HISTORY

Source of medical information:

☐ Mother/primary care giver ☐ Family ☐ Doctor ☐ Medical records ☐ Other healthcare provider ☐ Other, Specify:

In the 72 hours prior to death, did the child have: (check all that apply)

	No	**Yes**	**Unknown**		**No**	**Yes**	**Unknown**
Fever	☐	☐	☐	Diarrhea	☐	☐	☐
Excessive sweating	☐	☐	☐	Difficulty breathing	☐	☐	☐
Weakness or sleeping more than usual	☐	☐	☐	Cough/wheezing	☐	☐	☐
Fussiness or excessive crying	☐	☐	☐	Apnea (stopping breathing)	☐	☐	☐
Decrease in appetite	☐	☐	☐	Cyanosis (turned blue/gray)	☐	☐	☐
Vomiting	☐	☐	☐	Seizures or convulsions	☐	☐	☐
Choking	☐	☐	☐	Other, Specify:			

In the 72 hours prior to death, was the child injured or did child have any other condition(s) not mentioned?

☐ No ☐ Yes If yes, describe:

In the 72 hours prior to the death, did the child receive any vaccinations, medications, or exposure to any chemicals?
(Please include any home remedies, herbal medications, prescription medicines or over-the-counter medications including "cough, cold medicine")

☐ No ☐ Yes If yes, describe/list:

Any recent visit to a medical provider?

☐ No ☐ Yes If yes, When? Doctor/Facility: Why?

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HEALTH INFORMATION

Child's Primary Care Physician: **Phone: ( )** **Last Visit: When?** **Why:**

Allergies: **Birth defects:**

Medications:

Has the child been immunized? ☐ No ☐ Yes ☐ Unknown **Date of last immunization:**

Immunizations current? ☐ No ☐ Yes ☐ Unknown **If immunized within the last 30 days, specify type:**

Does the child use any home monitors? ☐ No ☐ Yes **Type/Brand:**

If Yes, was child on home monitor at time of death? ☐ No ☐ Yes

Anyone else in household or other contacts (e.g. daycare) recently ill? ☐ No ☐ Yes

Family history of genetic/inheritable disease(s)? ☐ No ☐ Yes, Specify:

BIRTH INFORMATION

Birth place (home, hospital name and location):

Birth complications? ☐ No ☐ Yes **If yes, specify:**

Gestational Age	Birth Weight:	Multiple Birth?	# of prenatal visits	Month of first prenatal visit
☐ Unknown ____ weeks	☐ Unknown ____ grams pounds/ounces	☐ No ☐ Yes, #____	☐ Unknown # ____	Specify 1-9: ____ ☐ Unknown ☐ None

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

☐ Smoke tobacco ☐ Experience intimate partner violence ☐ Heavy alcohol use ☐ Misuse OTC or prescription drugs
☐ Use illicit drugs ☐ Child born drug exposed ☐ Child born with fetal alcohol effects or syndrome

☐ During pregnancy, did mother have medical complications/infections? (check all that apply) Specify type, if known

	Type		Type
☐ Lung Disease	____	☐ Preterm Labor	____
☐ Heart Disease	____	☐ Premature Rupture Membrane	____
☐ Blood Disorder	____	☐ Vaginal Bleeding	____
☐ Infectious Disease	____	☐ Diabetes Mellitus	____
☐ Familial Genetic Disorder		☐ Other	____

Were there access or compliance issues related to prenatal care?

☐ No
☐ Yes
If yes, check all that apply:
☐ Unknown

☐ Lack of money for care
☐ Limited or no health insurance coverage
☐ Lack of transportation
☐ Lack of child care
☐ No phone

☐ Religious objections to care
☐ Cultural differences
☐ Unwilling to obtain care
☐ Did not know care needed
☐ Other, specify:

SCENE DOCUMENTATION

Photos of Death Scene Taken? ☐ No ☐ Yes

Property Seized? ☐ No ☐ Yes **What Agency Seized Property?**

Formula? ☐ No ☐ Yes **Bottles/Contents?** ☐ No ☐ Yes **Bedding?** ☐ No ☐ Yes **Crib?** ☐ No ☐ Yes

Other, Specify:

Was there an open CPS case with child at time of death? ☐ No ☐ Yes ☐ Unk

Was the child ever placed outside of the home prior to death? ☐ No ☐ Yes **Date of Placement:**

Were any siblings placed outside of the home prior to this child's death? ☐ No ☐ Yes **Date of Placement:**

PERSON COMPLETING FORM

Name (please print or type):

Agency:

Telephone: ( ) **Fax: ( )** **Date:**

Signature: **Date Signed:**

ADDITIONAL COMMENTS: **(Include information about additional caregivers/supervisors or circumstances. Attach additional pages as necessary)**