Sudden Unexplained Infant Death Investigation
SUIDI
Reporting Form

INVESTIGATION DATA

Infant's Information:

Last ______________________________ First ____________________________ M.I. _______ Case # ____________________________________

Sex: ☐ Male ☐ Female Date of Birth ____/____/____ Age ___________ SSN ____________________________________

Race: ☐ White ☐ Black/African American ☐ Asian/Pacific Islander ☐ American Indian/Alaskan Native ☐ Hispanic/Latino ☐ Other

Infant's Primary Residence:

Address ____ City ___________________________ State ____________ Zip ____________

Incident Address:

Address ____ City ___________________________ State ____________ Zip ____________

Contact Information for Witness:

Relationship to the deceased

☐ Birth mother ☐ Birth father ☐ Grandmother ☐ Grandfather

☐ Adoptive or foster parent ☐ Physician ☐ Health records ☐ Other ____________________

Last ________________________________ First ___________________________ M.I. _______ SSN ____________________________________

Home Address ____ City ___________________________ State ____________ Zip ____________

Place of Work ____ City ___________________________ State ____________ Zip ____________

Phone (H) ____________________________________ Phone (W) ______________________________________ Date of Birth ____/____/______

WITNESS INTERVIEW

1. Are you the usual caregiver? ☐ Yes ☐ No ⇨ Specify ____

2. Tell me what happened:

____

____

3. Did you notice anything unusual or different about the infant in the last 24 hours? ☐ No ☐ Yes ⇨ Specify __________________

____

4. Are any other household members recently or currently ill or injured? ☐ No ☐ Yes ⇨ Specify _________________________

____

	Date	Military Time	Location *(room)*
5. When was the infant LAST PLACED?	_____/_____/_____	_____:_____	______________________
6. When was the infant LAST KNOWN ALIVE?	_____/_____/_____	_____:_____	______________________
7. When was the infant FOUND?	_____/_____/_____	_____:_____	______________________

8. Where was the infant – (P)laced, (L)ast known alive, (F)ound? *(circle P, L, or F in front of appropriate response)*

P L F Bassinet
P L F Bedside co-sleeper
P L F Car seat
P L F Chair
P L F Cradle
P L F Crib
P L F Floor
P L F In a person's arms
P L F Mattress/box spring
P L F Mattress on floor
P L F Playpen
P L F Portable crib
P L F Sofa/couch
P L F Stroller/carriage
P L F Swing
P L F Waterbed
P L F Other ______________________________

9. If the child was not placed in a crib, was one available? ☐ Yes ☐ No ⇨ Specify ______________________

10. In what position was the infant LAST PLACED? ☐ Sitting ☐ On back ☐ On side ☐ On stomach ☐ Unknown

11. In what position was the infant LAST KNOWN ALIVE? ☐ Sitting ☐ On back ☐ On side ☐ On stomach ☐ Unknown

12. In what position was the infant FOUND? ☐ Sitting ☐ On back ☐ On side ☐ On stomach ☐ Unknown

13. What was the infant's usual sleeping position? ______________________

14. FACE position when LAST PLACED? ☐ Face down ☐ Face up ☐ Face right ☐ Face left

15. NECK position when LAST PLACED? ☐ Head back ☐ Chin to chest ☐ Neutral ☐ Turned

16. FACE position when LAST KNOWN ALIVE? ☐ Face down ☐ Face up ☐ Face right ☐ Face left

17. NECK position when LAST KNOWN ALIVE? ☐ Head back ☐ Chin to chest ☐ Neutral ☐ Turned

18. FACE position when FOUND? ☐ Face down ☐ Face up ☐ Face right ☐ Face left

19. NECK position when FOUND? ☐ Head back ☐ Chin to chest ☐ Neutral ☐ Turned

20. What was the infant wearing? *(ex. t-shirt, disposable diaper)* ______________________

21. Was the infant tightly wrapped or swaddled? ☐ Yes ☐ No ⇨ Specify ______________________

22. Please indicate the types and numbers of layers of bedding both over and under infant *(not including wrapping blanket)*

Bedding UNDER Infant	None	Number	Bedding OVER Infant	None	Number
Receiving blankets	☐	_____	Receiving blankets	☐	_____
Infant/child blankets	☐	_____	Infant/child blankets	☐	_____
Infant/child comforters	☐	_____	Infant/child comforters	☐	_____
Adult comforters/duvets	☐	_____	Adult comforters/duvets	☐	_____
Adult blankets	☐	_____	Adult blankets	☐	_____
Sheets	☐	_____	Sheets	☐	_____
Sheepskin	☐	_____	Sheepskin	☐	_____
Pillows	☐	_____	Pillows	☐	_____
Rubber or plastic sheet	☐	_____	Rubber or plastic sheet	☐	_____

Other ______________________________

23. Which of the following devices were operating in the infant's room
☐ None ☐ Apnea monitor ☐ Humidifier ☐ Vaporizer ☐ Air Purifier ☐ Other ______________________

24. What was the temperature of the infant's room? ☐ Hot ☐ Cold ☐ Normal ☐ Other ______________________

25. Which of the following were near the infant's face, nose or mouth?

☐ Bumper pads ☐ Infant pillows ☐ Positional supports ☐ Stuffed animals ☐ Toys ☐ Other ______________________

26. Which of the following were within the infant's reach?

☐ Blankets ☐ Toys ☐ Pillows ☐ Pacifier ☐ Nothing ☐ Other ______________________

27. Was anyone sleeping with the infant? ☐ No ☐ Yes ⇨ Complete table below.

Name	Age	Height	Weight	Location in relation to infant (LAST KNOWN ALIVE)	Location in relation to infant (FOUND)	Impaired (intoxicated, tired)

28. What led you to check on the infant? ______________________

29. Was there evidence of wedging? ☐ No ☐ Yes ⇨ Specify ______________________

30. When the infant was found, was s/he: ☐ Breathing ☐ Not breathing
If not breathing, did you witness the infant stop breathing? ☐ Yes ☐ No

31. Describe the infant's appearance when found

	Unknown	No	Yes	If yes, describe and specify location
Discoloration around face/nose/mouth	☐	☐	☐	
Secretions (foam, froth)	☐	☐	☐	
Skin discoloration (livor mortis)	☐	☐	☐	
Pressure marks (pale areas, blanching)	☐	☐	☐	
Rash or petechiae (small red spots on skin/membranes/eyes)	☐	☐	☐	
Marks on body (scratches, bruises)	☐	☐	☐	
Other	☐	☐	☐	

32. What did the infant feel like when found *(check all that apply)* ☐ Sweaty ☐ Warm to touch ☐ Cool to touch
☐ Limp, flexible ☐ Rigid, stiff ☐ Unknown ☐ Other ______________________

33. Did EMS try to resuscitate the infant? ☐ No ☐ Yes ⇨ Complete table below.

Name	Date	Military Time
	____/____/____	____:____
	____/____/____	____:____

34. Did anyone other than EMS try to resuscitate the infant? ☐ No ☐ Yes ⇨ Complete table below.

Name	Date	Military Time
	____/____/____	____:____
	____/____/____	____:____

WITNESS INTERVIEW CON'T

35. Please describe what was done as part of resuscitation:

____

____

____

36. Has the parent/caregiver ever had a child die suddenly and unexpectedly? ☐ No ☐ Yes ⇨ Specify ____________

____

INFANT MEDICAL HISTORY

1. Source of medical information: ☐ Doctor ☐ Other healthcare provider ☐ Medical Record ☐ Family

☐ Mother ☐ Father ☐ Other ____________

2. At any time in the infant's life, did s/he have a history of:

	Unknown	No	Yes: Within last 3 days	Yes: More than 3 days ago		Unknown	No	Yes: Within last 3 days	Yes: More than 3 days ago
*Allergies *(food, medication, other)*	☐	☐	☐	☐	Diarrhea	☐	☐	☐	☐
Excessive sweating	☐	☐	☐	☐	Constipation	☐	☐	☐	☐
Lethargy or sleeping more than usual	☐	☐	☐	☐	Difficulty breathing	☐	☐	☐	☐
Fussiness or excessive crying	☐	☐	☐	☐	Choking	☐	☐	☐	☐
Cyanosis *(turned blue/gray)*	☐	☐	☐	☐	Fever	☐	☐	☐	☐
*Abnormal growth or weight gain/loss	☐	☐	☐	☐	*Metabolic disorders	☐	☐	☐	☐
*Cardiac (heart) abnormalities	☐	☐	☐	☐	Vomiting	☐	☐	☐	☐
Seizures or convulsions	☐	☐	☐	☐	Decrease in appetite	☐	☐	☐	☐
Apnea (*stopped breathing*)	☐	☐	☐	☐	Other				

* Specify:

____

3. In the 72 hours prior to death, was the infant injured or did s/he have any other condition(s) not mentioned?
☐ No ☐ Yes ⇨ Specify ____________

4. In the 72 hours prior to death, was the infant given any vaccinations or medications? ☐ No ☐ Yes ⇨ Complete table below.
(Please include any home remedies, herbal medications, prescription medications, over the counter medications)

Name of vaccination/medications	Dose last given	Date given	Approx. time	Reason given/comments
		___/___/___	___:___	
		___/___/___	___:___	
		___/___/___	___:___	
		___/___/___	___:___	

5. Did the infant have any birth defects? ☐ No ☐ Yes ⇨ Specify ____________

____

INFANT MEDICAL HISTORY CON'T

6. Describe the two most recent times that the infant was seen by a physician or health care provider:
(Include emergency department visits, clinic visits, hospital admissions, observational stays, telephone calls and birth)

	Most recent visit	Second most recent visit
Date	______/______/______	______/______/______
Reason for visit		
Action taken		
Physician's name		
Hospital/clinic		
Address		
City, State, Zip		
Phone number		

7. Birth hospital name ______________________________

Street Address ______________________________

City/State/Zip ______________________________

Date of discharge _____/_____/_____

8. What was the infant's length at birth? ________ inches ________ or ________ centimeters

9. What was the infant's weight at birth? ________ pounds ________ ounces ________ or ________ grams

10. Compared to the due date, was the infant born on time, early or late?

☐ On time ☐ Early – How many weeks early? __________ ☐ Late – How many weeks late? __________

11. Was the infant a singleton, twin, triplet or higher gestation?

☐ Singleton ☐ Twin ☐ Triplet ☐ Quadruplet or higher gestation

12. Were there any complications during delivery or birth? *(ex. emergency c-section, child needed oxygen)*

☐ No ☐ Yes ⇨ Specify ______________________________

____

13. Is the infant able to: ☐ Roll over on it's own ☐ Lift its head ☐ Push or pull itself up

INFANT DIETARY HISTORY

1. On what day and at what approximate time was the infant last fed? _____/_____/_____ at ______:______

2. What is the name of the person who last fed the infant? ______________________________

3. What is his/her relationship to the infant? ______________________________

4. What foods and liquids was the infant fed in the last 24 hours? *(include last feeding)*

	Unknown	No	Yes	Quantity		Type and brand
Breast milk *(one/both sides, length of time)*	☐	☐	☐		ounces	
Formula *(brand, water source – ex. Similac, tap water)*	☐	☐	☐		ounces	
Cow's milk	☐	☐	☐		ounces	
Water *(brand, bottled/tap/well)*	☐	☐	☐		ounces	
Other liquids *(tea, juice)*	☐	☐	☐		ounces	
Solids	☐	☐	☐			
Other	☐	☐	☐			

INFANT DIETARY HISTORY CON'T

5. Was the child ever breast fed? ☐ No ☐ Yes ⇨ When/how often ______

6. Was a new food introduced in the 24 hours prior to his/her death? ☐ No ☐ Yes ⇨ Specify *(content, amount, change in formula)*

______

______

7. Did death occur while ☐ Breast feeding ☐ Bottle feeding ☐ Eating solid foods ☐ Not while feeding

8. Was the infant last placed to sleep with a bottle? ☐ Yes ☐ No ⇨ Skip to Pregnancy History below

9. Was the bottle propped? *(ex. object used to hold bottle while infant feeding)*
☐ No ☐ Yes ⇨ What object was used to prop the bottle? ______

10. What was the quantity of liquid (*in ounces*) in the bottle? ______

PREGNANCY HISTORY

1. **Information about the infant's birth mother**

First name ______ Middle name ______

Last name ______ Maiden name ______

Date of birth ______/______/______ SSN ______-______-______

Street address ______

City/State/Zip ______

How long has the mother been a resident at this address? ______ years and ______ months

2. At how many weeks or months did the birth mother begin prenatal care?
______ weeks ______ months ☐ No prenatal care ☐ Unknown

3. Where did the birth mother receive prenatal care?

Physician/provider ______ Hospital/clinic ______

Street address ______

City/State/Zip/Phone ______

4. During pregnancy, did the birth mother have any complications? *(ex. high blood pressure, bleeding, gestational diabetes)*
☐ No ☐ Yes ⇨ Specify ______

5. Was the biological mother injured during pregnancy? *(ex. auto accident, fall)*
☐ No ☐ Yes ⇨ Specify ______

6. During pregnancy, did the birth mother use any of the following?

	Unknown	No	Yes	Daily use		Unknown	No	Yes	Daily use
OTC medications	☐	☐	☐	______	Cigarettes	☐	☐	☐	______
Prescription medications	☐	☐	☐	______	Alcohol	☐	☐	☐	______
Herbal remedies	☐	☐	☐	______	Other	☐	☐	☐	______

7. Currently, does **ANY** caregiver use any of the following?

	Unknown	No	Yes	Daily use		Unknown	No	Yes	Daily use
OTC medications	☐	☐	☐	______	Cigarettes	☐	☐	☐	______
Prescription medications	☐	☐	☐	______	Alcohol	☐	☐	☐	______
Herbal remedies	☐	☐	☐	______	Other	☐	☐	☐	______

INCIDENT SCENE INVESTIGATION

1. Where did the incident or death occur? ______________________________

2. Was this the infant's primary residence? ☐ Yes ☐ No

3. Is the site of the incident or death scene a daycare or other childcare setting? ☐ Yes ☐ No ⇨ Skip to question 8 below

4. How many children were under the care of the provider at the time of the incident or death? __________ *(under 18 years)*

5. How many adults were supervising the child/children?

   __________ *(18 years or older)* __________ *(under 18 years)*

6. What is the license number and licensing agency for the daycare?

   License number ______________________ Agency ______________________

7. How long has the daycare been open for business? ______________________________

8. How many people live at the site of the incident or death?

   _________ *(18 years or older)* _________ *(under 18 years)*

9. Who was present at the time of the incident or death?

Name	Age	Relationship with infant

10. Which of the following heating or cooling sources were being used? *(check all that apply)*

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

11. Indicate the temperature of the room where the infant was found unresponsive

    ______ Thermostat setting ______ Thermostat reading ______ Actual room temperature ______ Outside temperature

12. What was the source of drinking water at the site of the incident or death scene? *(check all that apply)*

☐ Public/municipal water source	☐ Bottled water	
☐ Well	☐ Unknown	☐ Other ______________________

13. The site of the incident or death scene has *(check all that apply)*

☐ Insects/rodents/vermin	☐ Mold growth	☐ Presence of alcohol containers
☐ Smoky smell	☐ Pets	☐ Presence of drug paraphernalia
☐ Dampness	☐ Peeling paint	☐ Presence of prescription medications
☐ Visible standing water	☐ Odors or fumes	☐ Other ______________________

14. Describe the general appearance of the incident or death scene *(ex. cleanliness, hazards, overcrowding)*

    ____

    ____

15. Does law enforcement have any prior records on the family, caregiver or deceased? ☐ No ☐ Yes ⇨ Specify

____

____

16. Does Social Services or CPS have any prior records on the family, caregiver or deceased? ☐ No ☐ Yes ⇨ Specify

____

____

17. Are there any factors, circumstances or environmental concerns about the incident scene investigation that may have impacted the infant that have not yet been identified? ☐ No ☐ Yes ⇨ Specify

____

____

18. Law enforcement at scene _____/_____/_____ at ______:______ Investigator at scene _____/_____/_____ at ______:______

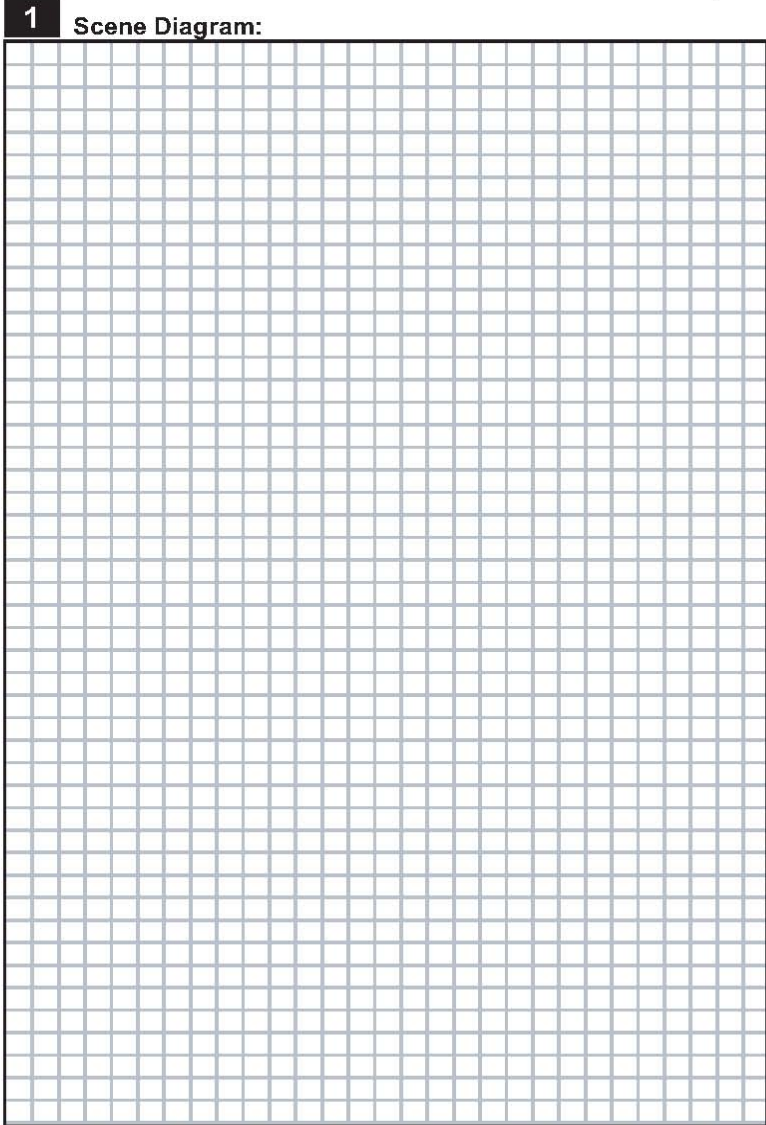
Infant at hospital _____/_____/_____ at ______:______ Investigator at hospital _____/_____/_____ at ______:______

19. If more than one person was interviewed, does the information differ? ☐ No ☐ Yes ⇨ Specify

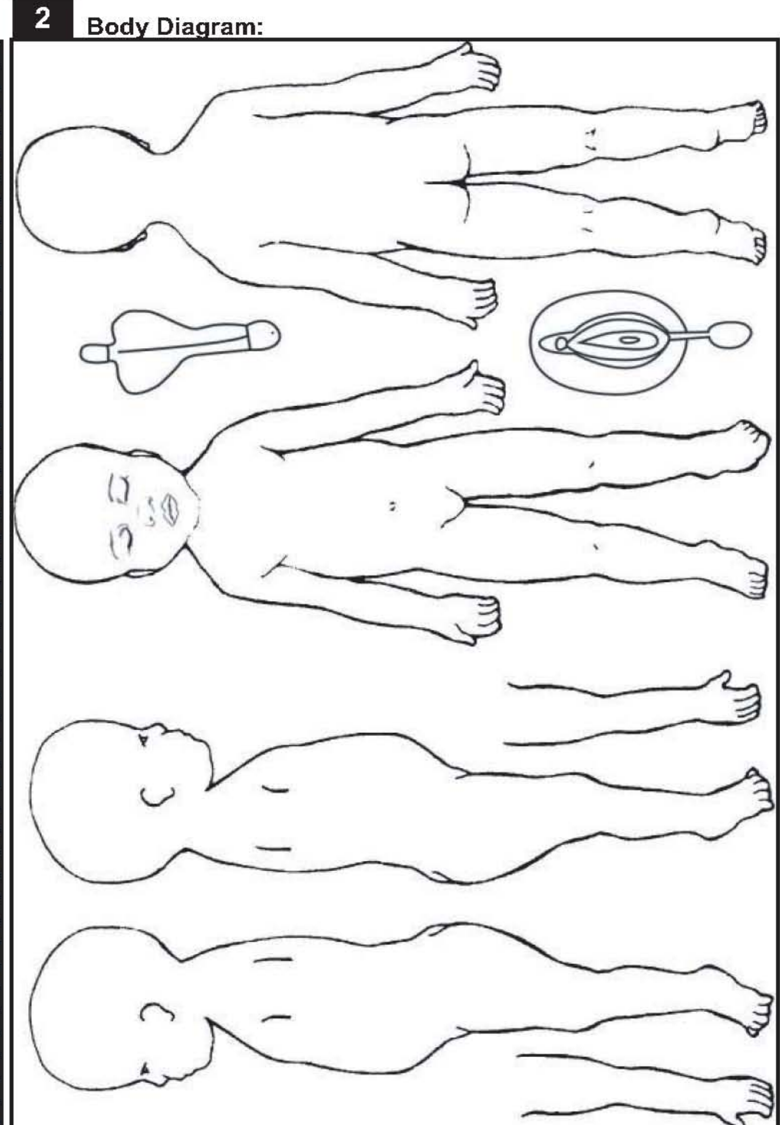
____

____

1 Scene Diagram:



2 Body Diagram:



SUMMARY FOR PATHOLOGIST

Investigator Information:

Name ____ Agency _____________________________________ Phone _________________________

Investigated _____/_____/_____ at ______:______ Pronounced _____/_____/_____ at ______:______

Infant Information:

Last _____________________________ First ___________________________ M.I. _______ Case # ___________________________________

Sex: ☐ Male ☐ Female Date of Birth ____/____/____ Age ___________ SSN ____________________________________

Race: ☐ White ☐ Black/African American ☐ Asian/Pacific Islander ☐ American Indian/Alaskan Native ☐ Hispanic/Latino ☐ Other

Indicate whether preliminary investigation suggests any of the following: ***(if yes, specify below)***

Yes	No	
☐	☐	Asphyxia *(ex. overlying, wedging, choking, nose/mouth obstruction, re-breathing, neck compression, immersion in water)*
☐	☐	Unsafe sleeping conditions *(ex. couch/sofa, waterbed, stuffed toys, pillows, soft bedding or co-sleeping)*
☐	☐	Change in sleeping condition *(ex. unaccustomed stomach sleep position, location or sleep surface)*
☐	☐	Hyperthermia/Hypothermia *(ex. excessive wrapping, blankets, clothing or hot or cold environments)*
☐	☐	Environmental hazards *(ex. carbon monoxide, noxious gases, chemicals, drugs, devices)*
☐	☐	Diet *(ex. new food/liquid, change in formula)*
☐	☐	Recent hospitalization
☐	☐	Previous medical diagnosis
☐	☐	History of acute life-threatening events *(ex. apnea, seizures, difficulty breathing)*
☐	☐	History of medical care without diagnosis
☐	☐	Recent fall or injury
☐	☐	History of religious, cultural or ethnic remedies
☐	☐	Cause of death due to natural causes other than SIDS *(ex. birth defects, complications of preterm birth)*
☐	☐	Prior sibling death
☐	☐	Previous encounters with police or social service agencies
☐	☐	Request for tissue or organ donation
☐	☐	Objection to autopsy
☐	☐	Pre-terminal resuscitative treatment
☐	☐	Death due to trauma *(injury)*, poisoning or intoxication
☐	☐	Suspicious circumstances
☐	☐	Other alerts for pathologist's attention

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