State of Tennessee
Department of Health

Sudden Unexplained Child Death Investigation Report

For use in children aged 1 year and older

-Investigation Data-

Child's Information:

Last Name:	First Name:		M.
Sex: ☐ M ☐ F	DOB: / /	SS#:	Case#:
Race: ☐ White ☐ Black/African Am. ☐ Asian/Pacific Islander ☐ Other			Ethnicity: ☐ Hispanic/Latino
Primary Address:	City:	St:	Zip:
Incident Address:	City:	St:	Zip:

Contact Information for Witness:

Relationship to the deceased: ☐ Birth Mother ☐ Birth Father ☐ Grandmother ☐ Adoptive or Foster Parents ☐ Physician			
☐ Health Records ☐ Other:_____			
Last Name:	First Name:	M.	SS#
Home Address:	City:	St:	Zip:
Place of work:	City:	St:	Zip:
Phone (H): ( )	Phone (W): ( )	Date of Birth: / /	

-Witness Interview-

1. Tell me what happened:

2. Did you notice anything unusual or different about the child in the last 24 hours? ☐ No ☐ Yes → Describe:

3. Did the child experience any falls or injury within the last 72 hours? ☐ No ☐ Yes → Describe:

4. When was the child **LAST KNOWN ALIVE (LKA)**?	/ /	:	
	Month Day Year	Military Time	Location (Room)
5. When was the child **FOUND**?	/ /	:	
	Month Day Year	Military Time	Location (Room)

6. Explain how you knew the child was still alive.

7. Describe the child's appearance when found.

		Describe and specify location:
a) Discoloration around face/nose/mouth	☐Unknown ☐ No ☐Yes	
b) Secretions (foam, froth)	☐Unknown ☐ No ☐Yes	
c) Skin discoloration (livor mortis)	☐Unknown ☐ No ☐Yes	
d) Pressure marks (pale areas, blanching)	☐Unknown ☐ No ☐Yes	
e) Rash or petechiae (small red blood spots on skin, membranes, or eyes)	☐Unknown ☐ No ☐Yes	
f) Marks on body (scratches or bruises)	☐Unknown ☐ No ☐Yes	
g) Other	☐Unknown ☐ No ☐Yes	

8. What did the child feel like when found? (Check all that apply)

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

☐ Other, specify:

9. Did anyone else other than EMS try to resuscitate the child? ☐ No ☐Yes Who:_____ When: / / (Month Day Year) : (Military Time)

10. Please describe what was done as part of the resuscitation:

11. Has the parent/caregiver ever had a child die suddenly and unexpectedly? ☐ No ☐ Yes → Describe:

-Child Medical History-

1. Source of medical information:

☐ Doctor ☐ Other health care provider ☐ Medical record ☐ Parent/primary caregiver ☐ Family ☐ Other

2. In the 72 hours prior to death, did the child have:

a) Fever	☐Unknown ☐ No ☐Yes	h) Diarrhea	☐Unknown ☐ No ☐Yes
b) Excessive sweating	☐Unknown ☐ No ☐Yes	i) Stool changes	☐Unknown ☐ No ☐Yes
c) Lethargy or sleeping more than usual	☐Unknown ☐ No ☐Yes	j) Difficulty breathing	☐Unknown ☐ No ☐Yes
d) Fussiness or excessive crying	☐Unknown ☐ No ☐Yes	k) Apnea (stopped breathing)	☐Unknown ☐ No ☐Yes
e) Decrease in appetite	☐Unknown ☐ No ☐Yes	l) Cyanosis (turned blue/gray)	☐Unknown ☐ No ☐Yes
f) Vomiting	☐Unknown ☐ No ☐Yes	m) Seizures or convulsions	☐Unknown ☐ No ☐Yes
g) Choking	☐Unknown ☐ No ☐Yes	n) Other, specify:	

3. In the 72 hours prior to death, was the child injured or did s/he have any other condition(s) not mentioned? ☐No ☐Yes →Describe:

4. In the 72 hours prior to death, was the child given any medications or vaccinations? ☐ No ☐ Yes → List Below: (please include any home remedies, herbal medications, over-the-counter medications)

Name of medication or vaccination	Dose last given	Date given (Month Day Year)	Approx. Time (Military Time)	Reason given/comments:
		/ /	:	
		/ /	:	
		/ /	:	
		/ /	:	

5. At any time in the child's life, did s/he have a history of?		Describe
a) Allergies (food, medication or other)	☐Unknown ☐ No ☐Yes →	
b) Abnormal growth or weight loss/gain	☐Unknown ☐ No ☐Yes →	
c) Apnea (stopped breathing)	☐Unknown ☐ No ☐Yes →	
d) Cyanosis (turned blue/gray)	☐Unknown ☐ No ☐Yes →	
e) Seizures or convulsions	☐Unknown ☐ No ☐Yes →	
f) Cardiac (heart) abnormalities	☐Unknown ☐ No ☐Yes →	
g) Other	☐Unknown ☐ No ☐Yes →	

6. Did the child have any birth defects? ☐ No ☐ Yes → Describe:

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

	First most recent visit	Second most recent visit
a) Date	_____/_____/_____ Month Day Year	_____/_____/_____ Month Day Year
b) Reason for visit:		
c) Action taken:		
d) Physician's Name:		
e) Hospital/Clinic:		
f) Address:		
g) City, Zip code:		
f) Phone number:	( ) -	( ) -

8. Birth Hospital Name:

Street Address:					
City:		State:		Zip code:	

-Incident Scene Investigation-

1. Where did the incident or death occur?

2. Was this the primary residence? ☐ No ☐ Yes

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 old)

5. How many adults were supervising the child(ren)? _____ (18 years or older)

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 scene?

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

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

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

10. Describe the general appearance of the incident scene: (ex. Cleanliness, hazards, overcrowding, etc.)

-Investigation Summary-

1. Are there any factors, circumstances, or environmental concerns about the incident scene investigation that may have impacted the child that have not yet been identified?

2. Arrival times:

Law enforcement at scene:	: Military time	DSI at scene:	: Military time	Child at hospital:	: Military time

-Investigator's Notes-

Indicate the task(s) performed:

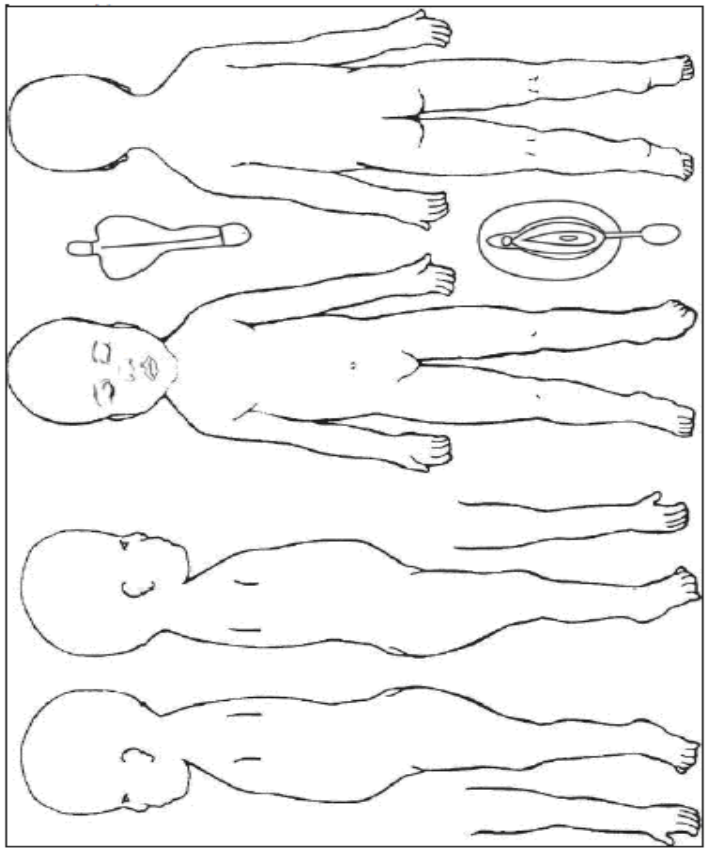
☐ Additional scenes(s)? (Forms attached)	☐ Doll reenactment/scene re-creation	☐ Photos or video taken and noted
☐ Materials collected/evidence logged	☐ Referral for counseling	☐ EMS run sheet/report
☐ Notify next of kin or verify notification	☐ 911 tape	
☐ Other (explain)		

If more than one person was interviewed, does the information differ? ☐ No ☐ Yes → Detail any differences, inconsistencies of relevant information: (ex. Placed on sofa, last known alive on chair)

-Investigation Diagrams-

Scene Diagram:

Body Diagram:



Lead Death Investigator or Designee:

Signature:	Title:	Date:
Signature:	Title:	Date:

-Summary for Pathologist-

Case Information

Investigator Information:

Name:	Agency:	Phone:

Investigated:	/ /	:	Pronounced dead:	/ /	:
	Month Day Year	Military Time		Month Day Year	Military Time

Child Information:

Last Name:	First:	M.	Case#
Sex: ☐ Male ☐ Female	Date of Birth: / /	Age: _____Years _____Months	
Race: ☐ White ☐ Black/African Am. ☐ Asian/Pacific Islander ☐ Other		Ethnicity: ☐ Hispanic/Latino	

Sleeping Environment

1. Indicate whether preliminary investigation suggests any of the following:

☐ Yes ☐ No	Asphyxia (ex. Wedging, choking, nose/mouth obstruction, neck compression, immersion in water)
☐ Yes ☐ No	Hyperthermia/Hypothermia (ex. Hot or cold environments)
☐ Yes ☐ No	Environmental hazards (ex. Carbon monoxide, noxious gases, chemicals, drugs, devices)

Child History

☐ Yes ☐ No	Recent hospitalization
☐ Yes ☐ No	Previous medical diagnosis
☐ Yes ☐ No	History of acute life-threatening events (ex. Apnea, seizures, difficulty breathing)
☐ Yes ☐ No	History of medical care without diagnosis
☐ Yes ☐ No	Recent fall or other injury
☐ Yes ☐ No	History of religious, cultural, or ethnic remedies
☐ Yes ☐ No	Cause of death due to natural causes other than SIDS (ex. Birth defects, complications of pre-term birth)

Family Info

☐ Yes ☐ No	Prior sibling deaths
☐ Yes ☐ No	Previous encounters with police or social service agencies
☐ Yes ☐ No	Request for tissue or organ donation
☐ Yes ☐ No	Objection to autopsy

Exam

☐ Yes ☐ No	Pre-terminal resuscitative treatment
☐ Yes ☐ No	Death due to trauma (injury), poisoning, or intoxication

Investigator Insight

Any "Yes" answers should be explained and detailed. Brief description of circumstances:

Pathologist

2. Pathologist Information:

Name:	Agency:
Phone: ( ) -	Fax: ( ) -