

CALIFORNIA FATAL CHILD ABUSE AND NEGLECT SURVEILLANCE (FCANS) PROGRAM

FCANS DATA COLLECTION FORM FOR CHILD DEATH REVIEW TEAMS

Original Version: September 2000 (with minor edits, September 2002)

Program Description: Under the auspices of the California State Child Death Review Council, the EPIC Branch of the California Department of Health Services has established the Fatal Child Abuse and Neglect Surveillance (FCANS) Program as mandated under Penal Code 11169.9 (Chapter #1012, SB 525, Polanco, 1999). Under this statute, EPIC is responsible for implementing a statewide child abuse and neglect fatality tracking system that incorporates information collected by local child death review teams (CDRTs). This Data Collection Form (Pilot Version), and corresponding software, has been developed by the FCANS Program as a guideline for CDRTs to use in recording their case reviews.

Instructions: The FCANS Program Standards and Protocols information packet, available separately, provides a complete description of the: 1) State mandate; 2) Proposed case review criteria for CDRTs; 3) Matrix for classifying fatal child abuse and neglect; 4) Instructions for completing and submitting the FCANS form to the state; and 5) Instructions on how local CDRTs can be reimbursed for submitting the FCANS form to the state. Please review the packet and the state selection criteria for which cases to submit. If your team determines that a child's death meets the state criteria, please complete the form and submit it for review to the address below. Also for further information, you can contact:

FCANS Program
EPIC Branch, CA Department of Health Services
MS 7214
P.O. Box 997413
Sacramento, CA 95899-7413
(916) 552-9844 or 552-9800
Web Page: <http://www.dhs.ca.gov/epic/>

IDENTIFYING INFORMATION

I. Reporting Team

1. Reporting County	2. Name of Reporter	3. Date of Report
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II. Child Identification

1. Child's name: (First, M. Last) / /		2. Date of Birth (mm/dd/yyyy)	3. Date of Death (mm/dd/yyyy)
4. County of Death	5. Gender <input type="checkbox"/> Female <input type="checkbox"/> Male	6. Age (Only if no dates above): Years (if ≥ 1 y) Months (if < 1 y) Days (if < 1 m) _____	
7. Residence County	8. Zip code	9. Hispanic/Latino Origin <input type="checkbox"/> No <input type="checkbox"/> Yes, specify: _____	10. Race/Ethnicity (check all that apply) <input type="checkbox"/> African Am <input type="checkbox"/> Asian: _____ <input type="checkbox"/> Caucasian <input type="checkbox"/> Native Am <input type="checkbox"/> Pacific Is <input type="checkbox"/> Other: _____

I. Assigned Identification Number:

_____ - _____ - _____

NOTE: First 2 digits for County Number [1-58]; second 2 digits for year; third 4-6 digits are a unique number assigned by the CDRT (e.g. Alameda's first reported case would be 01-00-0001).

For Official State Use Only

Date Received	Reviewed by	Criteria Met	Date Entered
Submitted for Reimbursement (date)	Reimbursement Sent	Approved by	

ID Number: _____

II. Matrix for Classifying Child Abuse and Neglect Fatalities (See Matrix and Guidelines)

Based upon CDRT review:

Child abuse or neglect was not identified in child's life (All FCANS forms will be reimbursed up to contract limits)

CHILD ABUSE OR NEGLECT WAS INVOLVED IN CHILD'S LIFE IN SOME WAY

(Using the Matrix, check all that apply and submit a FCANS Data Collection Form to the state)

<input type="checkbox"/> Child Abuse History	<input type="checkbox"/> Child Neglect History
<input type="checkbox"/> Suspicious/Questionable Child Abuse	<input type="checkbox"/> Suspicious/Questionable Child Neglect
<input type="checkbox"/> Definite Child Abuse Related	<input type="checkbox"/> Definite Child Neglect Related
<input type="checkbox"/> Definite Child Abuse as Primary Cause	<input type="checkbox"/> Definite Child Neglect as Primary Cause

III. CDRT Agency/Records Review

Agency/Records Reviewed: (Check if reviewed)

<input type="checkbox"/> Death Certificate	<input type="checkbox"/> Law Enforcement	<input type="checkbox"/> CPS Records	<input type="checkbox"/> Public Health
<input type="checkbox"/> Coroner's Report	<input type="checkbox"/> CHP	<input type="checkbox"/> Alcohol & Drug	<input type="checkbox"/> Education
<input type="checkbox"/> Autopsy Report	<input type="checkbox"/> EMS	<input type="checkbox"/> Mental Health Records	<input type="checkbox"/> Other, specify: _____
<input type="checkbox"/> Hospital/Medical Records	<input type="checkbox"/> Fire Investigation	<input type="checkbox"/> Probation	<input type="checkbox"/> Other, specify: _____

IV. DEATH INVESTIGATION INFORMATION

A. General Information

1. Cause of Death from death certificate or autopsy report _____ _____ _____		2. Manner of Death (from death certificate or autopsy) <input type="checkbox"/> Natural <input type="checkbox"/> Injury (Accident) <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined <input type="checkbox"/> Pending	
3. Other Significant Contributing Conditions, but not related to cause given above: _____			
4. Place of Event/Injury: <input type="checkbox"/> Known (check below) <input type="checkbox"/> Unknown <input type="checkbox"/> Child's home <input type="checkbox"/> Licensed child care <input type="checkbox"/> Residential care <input type="checkbox"/> Highway <input type="checkbox"/> Work place <input type="checkbox"/> School <input type="checkbox"/> Relative's home <input type="checkbox"/> Unlicensed child care <input type="checkbox"/> Public road <input type="checkbox"/> Farm <input type="checkbox"/> Other private prop <input type="checkbox"/> Friend's home <input type="checkbox"/> Foster home <input type="checkbox"/> Private drive <input type="checkbox"/> Hospital <input type="checkbox"/> Other: _____			
5. County of Event/Injury (if different) _____		7. Scene Investigation conducted? <input type="checkbox"/> Law Enforcement <input type="checkbox"/> Coroner's Office <input type="checkbox"/> Fire Investigation <input type="checkbox"/> Not Applicable <input type="checkbox"/> Other: _____ <input type="checkbox"/> Unknown	
6. Date of Event/Injury (if different) _____		10. Toxicological Screening? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> NA	
8. Autopsy Performed? <input type="checkbox"/> Yes full <input type="checkbox"/> Yes partial: _____ If Yes: <input type="checkbox"/> Coroner <input type="checkbox"/> Hospital <input type="checkbox"/> No <input type="checkbox"/> NA <input type="checkbox"/> Unknown		9. X-rays taken? <input type="checkbox"/> Yes Type: _____ <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> NA	

B. Supervision at time of injury/illness

1. Relationship of primary person(s) responsible at time of injury/illness for supervising child: (Check all that apply): <input type="checkbox"/> Bio Father (Skip to 4) <input type="checkbox"/> Step Father <input type="checkbox"/> Bio Mother (Skip to 4) <input type="checkbox"/> Step Mother <input type="checkbox"/> Sibling <input type="checkbox"/> Mother's BF <input type="checkbox"/> Father's GF <input type="checkbox"/> Friend <input type="checkbox"/> Foster Mother <input type="checkbox"/> Foster Father <input type="checkbox"/> Child Care <input type="checkbox"/> Acquaintance <input type="checkbox"/> Other Relative <input type="checkbox"/> Unknown <input type="checkbox"/> More than one (check all) <input type="checkbox"/> No supervision needed <input type="checkbox"/> Other: _____		4. Did neglect/lack of adequate care contribute to death? <input type="checkbox"/> Yes, Neglect (based on Matrix guidelines) <input type="checkbox"/> Yes, Inadequate care only <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> NA	
2. Age of Supervisor(s): _____		5. If Yes, specify type of neglect/inadequate care—Failure to: <input type="checkbox"/> Provide adequate supervision/protection <input type="checkbox"/> Seek, obtain or follow through with medical care <input type="checkbox"/> Provide necessary food, clothing or shelter <input type="checkbox"/> Protect fetus/child during pregnancy <input type="checkbox"/> Other: _____ <input type="checkbox"/> Unknown <input type="checkbox"/> NA	
1. Gender <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Unknown		6. If neglect/lack of adequate supervision, was supervisor? <input type="checkbox"/> Alcohol Intoxicated <input type="checkbox"/> Under influence of illicit drugs <input type="checkbox"/> Mentally Ill <input type="checkbox"/> Developmental delay <input type="checkbox"/> Preoccupied <input type="checkbox"/> Asleep <input type="checkbox"/> Not present <input type="checkbox"/> Other: _____	

ID Number: _____

V. BACKGROUND INFORMATION

A. Biological Parents

1. Mother's name: (First, M. Last) / / AKA's: _____		2. Date of Birth	3. Age (if DOB unavailable)
4. Hispanic/Latino Origin <input type="checkbox"/> Yes Specify: _____ <input type="checkbox"/> No	5. Race/Ethnicity (check all that apply) <input type="checkbox"/> African Am <input type="checkbox"/> Asian: _____ <input type="checkbox"/> Caucasian <input type="checkbox"/> Native Am <input type="checkbox"/> Pacific Is <input type="checkbox"/> Other: _____	1. Marital Status <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Single <input type="checkbox"/> Live in <input type="checkbox"/> Other: _____	
7. Father's name: (First, M. Last) / / AKA's: _____		8. Date of Birth	9. Age (if DOB unavailable)
10. Hispanic/Latino Origin <input type="checkbox"/> Yes, specify: _____ <input type="checkbox"/> No	11. Race/Ethnicity (check all that apply) <input type="checkbox"/> African Am <input type="checkbox"/> Asian: _____ <input type="checkbox"/> Caucasian <input type="checkbox"/> Native Am <input type="checkbox"/> Pacific Is <input type="checkbox"/> Other: _____		

B. Infant Deaths (< 1 year old)

1. Birth Certificate #	2. Gestational age at birth: <input type="checkbox"/> Unknown <input type="checkbox"/> Full Term (37+) <input type="checkbox"/> Pre-term (<37)	3. Birth weight: <input type="checkbox"/> Unknown <input type="checkbox"/> Normal (2500+ GMS) <input type="checkbox"/> LBW (< 2500 GMS)
4 Number of prenatal visits <input type="checkbox"/> None <input type="checkbox"/> 1-3 <input type="checkbox"/> 4-6 <input type="checkbox"/> 7-9 <input type="checkbox"/> >9 <input type="checkbox"/> Unknown	5. First prenatal visit? <input type="checkbox"/> 1 st trim ester <input type="checkbox"/> 2 nd trimester <input type="checkbox"/> 3 rd trimester <input type="checkbox"/> None <input type="checkbox"/> Unknown	6. Multiple births? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown 7 Medical complications during pregnancy <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
8. Neonatal complications <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	9. Smoking during pregnancy <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
10. Alcohol use during pregnancy <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	11. Drug use during pregnancy <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
12. Medical/Public Health Services received postnatal?		

C. Family/Child Background

1. Relationship of Primary Caregiver to Child <input type="checkbox"/> Bio Mother (Skip to 7) <input type="checkbox"/> Step Mother <input type="checkbox"/> Bio Father (Skip to 7) <input type="checkbox"/> Step Father <input type="checkbox"/> Sibling <input type="checkbox"/> Mother's BF <input type="checkbox"/> Father's GF <input type="checkbox"/> Friend <input type="checkbox"/> Foster Mother <input type="checkbox"/> Foster Father <input type="checkbox"/> Child Care <input type="checkbox"/> Acquaintance <input type="checkbox"/> Other Relative <input type="checkbox"/> Unknown <input type="checkbox"/> Institutional staff <input type="checkbox"/> Other: _____		2. DOB of Primary Caregiver	3. Age (if no DOB)	4. Gender <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Unknown
5. Hispanic/Latino Origin <input type="checkbox"/> Yes, specify: _____ <input type="checkbox"/> No		6. Race/Ethnicity (check all that apply) <input type="checkbox"/> African Am <input type="checkbox"/> Asian: _____ <input type="checkbox"/> Caucasian <input type="checkbox"/> Native Am <input type="checkbox"/> Pacific Is <input type="checkbox"/> Other: _____		
1. Other children in home <input type="checkbox"/> Yes # sibs: ___ #others: ___ <input type="checkbox"/> No <input type="checkbox"/> Unknown	2. Medical Insurance Status of Child <input type="checkbox"/> MediCal/Gov't. <input type="checkbox"/> Private <input type="checkbox"/> Uninsured/Self <input type="checkbox"/> Unknown	3. Child Disabilities <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown If Yes <input type="checkbox"/> Physical <input type="checkbox"/> Developmental <input type="checkbox"/> Sensory		
4. Child's School History Attending school <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> Academic problems noted <input type="checkbox"/> Attendance problems noted <input type="checkbox"/> Suspension/Expulsion <input type="checkbox"/> Other: _____		5. Child's mental health history History of problems <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown Received treatment <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown Medication <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		
6. Child's contact with legal system (WIC 601 & 602) <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA (< 8 yr. old) <input type="checkbox"/> Unknown If Yes, <input type="checkbox"/> Crime involved - Specify: _____ <input type="checkbox"/> Non-criminal - Specify: _____		7. Other life problems for child <input type="checkbox"/> Runaway at time of death <input type="checkbox"/> Runaway in past <input type="checkbox"/> Hx of Suicidal actions <input type="checkbox"/> Hx of Suicidal ideation <input type="checkbox"/> Hx of Abuse/Neglect <input type="checkbox"/> Current emotional crisis <input type="checkbox"/> Impaired at time (ETOH/drugs) <input type="checkbox"/> Other: _____		

ID Number: _____

D. Family Violence History

1. Prior CPS History <input type="checkbox"/> Yes If Yes: <input type="checkbox"/> Referral(s) only <input type="checkbox"/> Substantiated <input type="checkbox"/> None Noted <input type="checkbox"/> Unknown	2. Current CPS Activities Open case at time of child death? <input type="checkbox"/> Yes If Yes, For: <input type="checkbox"/> This Child <input type="checkbox"/> Other Children <input type="checkbox"/> No, but informal services had been offered to family <input type="checkbox"/> No <input type="checkbox"/> Unknown Case opened for other children due to this child's death? <input type="checkbox"/> Yes, removed <input type="checkbox"/> Yes, opened <input type="checkbox"/> No <input type="checkbox"/> Unknown
3. Have other children in family died? <input type="checkbox"/> Yes, Number: ___ <input type="checkbox"/> No <input type="checkbox"/> Unknown	
2. Were any child deaths considered abuse/neglect related? <input type="checkbox"/> Yes <input type="checkbox"/> Suspicious <input type="checkbox"/> No <input type="checkbox"/> Unknown	
5. History of Domestic/Intimate Partner Violence: <input type="checkbox"/> Yes, LE Report <input type="checkbox"/> Yes, Other documented <input type="checkbox"/> No <input type="checkbox"/> Unknown If yes, did child witness DV? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	

VIII. CAUSE AND CIRCUMSTANCES OF DEATH

Death due to: <input type="checkbox"/> Intentional Injury (go to VIII-A) <input type="checkbox"/> Unintentional Injury (go to VIII-B) <input type="checkbox"/> Natural Causes (go to VIII-C) <input type="checkbox"/> Undetermined (COMPLETE ALL RELEVANT SECTIONS)
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A. Intentional Injury Cause:

1. If Cause was injury, was injury intentional (assault/aggression/homicide)? <input type="checkbox"/> Yes <input type="checkbox"/> No (go to VIII-B) <input type="checkbox"/> Undetermined Intent (Complete VIII-A & B)	2. Was child intended target? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
3. Who inflicted injury? <input type="checkbox"/> Self inflicted (go to VIII-A2) <input type="checkbox"/> Inflicted by Parent/Caregiver <input type="checkbox"/> Inflicted by Other <input type="checkbox"/> Undetermined		
4. Method/Type of Assaultive Injury (check all that apply) <input type="checkbox"/> Head Trauma <input type="checkbox"/> Arson <input type="checkbox"/> Battery/Struck <input type="checkbox"/> SBS <input type="checkbox"/> Burned (scalded) <input type="checkbox"/> Sexual Assault <input type="checkbox"/> Struck against surface <input type="checkbox"/> Choked/Strangled <input type="checkbox"/> Thrown <input type="checkbox"/> Cut/Stabbed <input type="checkbox"/> Struck by object <input type="checkbox"/> Firearm <input type="checkbox"/> Other, Specify: _____ <input type="checkbox"/> NA	5. Precipitating Event (check all that apply): <input type="checkbox"/> Crying <input type="checkbox"/> Intimate partner violence <input type="checkbox"/> Disciplining <input type="checkbox"/> Revenge toward another <input type="checkbox"/> Feeding difficulties <input type="checkbox"/> During another crime <input type="checkbox"/> Toilet training <input type="checkbox"/> Random <input type="checkbox"/> Substance use <input type="checkbox"/> Gang related <input type="checkbox"/> Other: _____	
6. Primary Suspect's Relationship to Victim (check all that apply) <input type="checkbox"/> Bio Father (Skip to 9) <input type="checkbox"/> Step Father <input type="checkbox"/> Self Inflicted <input type="checkbox"/> Bio Mother (Skip to 9) <input type="checkbox"/> Step Mother <input type="checkbox"/> Sibling <input type="checkbox"/> Mother's BF <input type="checkbox"/> Father's GF <input type="checkbox"/> Child Care <input type="checkbox"/> Foster Mother <input type="checkbox"/> Foster Father <input type="checkbox"/> Stranger <input type="checkbox"/> Acquaintance <input type="checkbox"/> Other Relative <input type="checkbox"/> Friend <input type="checkbox"/> NA <input type="checkbox"/> Institutional staff <input type="checkbox"/> Other _____ <input type="checkbox"/> Unknown	7. Primary Suspect Characteristics Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Unk Age: _____ Ethnicity: Hispanic/Latino <input type="checkbox"/> Yes <input type="checkbox"/> No Race: <input type="checkbox"/> African Am <input type="checkbox"/> Asian: _____ <input type="checkbox"/> Caucasian <input type="checkbox"/> Native Am <input type="checkbox"/> Pacific Is <input type="checkbox"/> Other: _____	
8. Name of Primary suspect: (First, M. Last) _____ / / DOB: _____ AKA's: _____	9. Name of Other Suspect(s): (if more than one): _____ / / DOB: _____ AKA's: _____	
10. Did Primary Suspect Display Prior Risk Behaviors? <input type="checkbox"/> Verbal threats <input type="checkbox"/> Prior CAN perpetrator <input type="checkbox"/> Hx of DV/Intimate Partner Violence <input type="checkbox"/> Criminal history <input type="checkbox"/> Hx of committing other violence <input type="checkbox"/> Alcohol problem/abuse <input type="checkbox"/> Drug problem/abuse <input type="checkbox"/> Mental health problems <input type="checkbox"/> Other: _____	11. Other Suspect Characteristics Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Unknown Age: _____ Ethnicity: Hispanic/Latino <input type="checkbox"/> Yes <input type="checkbox"/> No Race: <input type="checkbox"/> African Am <input type="checkbox"/> Asian: _____ <input type="checkbox"/> Caucasian <input type="checkbox"/> Native Am <input type="checkbox"/> Pacific Is <input type="checkbox"/> Other: _____	
11. Number of suspects arrested <input type="checkbox"/> None <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> # _____	12. Rpts submitted: SHR <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk CACI <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> NA	13. Submitted to DA for prosecution <input type="checkbox"/> Yes <input type="checkbox"/> Pending <input type="checkbox"/> No <input type="checkbox"/> Unk <input type="checkbox"/> NA
14. DA action taken <input type="checkbox"/> Charges Files <input type="checkbox"/> Suspect Only <input type="checkbox"/> Pending/In progress <input type="checkbox"/> No Action <input type="checkbox"/> Unknown	15. Legal Outcome (Update if new information becomes available) <input type="checkbox"/> Conviction: Sentence _____ <input type="checkbox"/> Plead: Sentence _____ <input type="checkbox"/> Acquittal <input type="checkbox"/> Other: _____	

ID Number: _____

A. Intentional Injury Cause: 2 - Suicide

1. If self inflicted injury, any prior suicidal history? Yes, <input type="checkbox"/> Ideation <input type="checkbox"/> Attempts <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> Other, specify: _____	2. Method Used: <input type="checkbox"/> Firearm <input type="checkbox"/> Hanging <input type="checkbox"/> Knife <input type="checkbox"/> Poisoning <input type="checkbox"/> Other, specify: _____
3. Contributing Conditions (check all that apply): <input type="checkbox"/> Alcohol <input type="checkbox"/> Argument w/ parents <input type="checkbox"/> Drugs <input type="checkbox"/> Breakup/argument w/ G/BF <input type="checkbox"/> Depression Hx <input type="checkbox"/> Death of loved one <input type="checkbox"/> Failed accomplishment <input type="checkbox"/> Family history of suicide <input type="checkbox"/> School problems <input type="checkbox"/> Personal/Family economics <input type="checkbox"/> Neglect/abuse <input type="checkbox"/> Harassment <input type="checkbox"/> Other: _____	4. Other Indicators of Intent: <input type="checkbox"/> Victim note <input type="checkbox"/> Previous threats <input type="checkbox"/> Prior comments <input type="checkbox"/> Symbolic method/place <input type="checkbox"/> Symbolic date <input type="checkbox"/> Possible cluster suicide <input type="checkbox"/> Unknown <input type="checkbox"/> Other: _____ <input type="checkbox"/> Apparently Unexpected
5. Preventive Measures (if applicable): Gun safety devices: Present <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown Proper Use <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown Mental Health Treatment: Accessible <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown Used <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown Hot line: Available <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown Used <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown Other, specify: _____	

B. Unintentional Injury Cause:

1. If Cause was Injury, was injury unintentional? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Undetermined Intent <input type="checkbox"/> Unknown <input type="checkbox"/> NA
2. If Unintentional/Undetermined, what was the mechanism or circumstance: (go to VIII- B2-B10) <input type="checkbox"/> Burn <input type="checkbox"/> Drowning <input type="checkbox"/> Electrocution <input type="checkbox"/> Fall <input type="checkbox"/> Fire <input type="checkbox"/> Firearm <input type="checkbox"/> Poisoning/Overdose <input type="checkbox"/> Suffocation/Strangulation <input type="checkbox"/> Vehicular <input type="checkbox"/> Other, specify _____

B. Unintentional Injury Cause: 1 - Burn

1. If Burn, Source of Burn (other than fire): <input type="checkbox"/> Hot Liquid, specify: _____ <input type="checkbox"/> Appliance <input type="checkbox"/> Heater <input type="checkbox"/> Cigarette <input type="checkbox"/> Chemicals <input type="checkbox"/> Other, specify: _____	2. Victim's primary activity prior to burn: <input type="checkbox"/> Bathing <input type="checkbox"/> Playing <input type="checkbox"/> Sleeping <input type="checkbox"/> Cooking <input type="checkbox"/> Smoking <input type="checkbox"/> Other, specify: _____
3. Immersion Incident: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	4. Site(s) of fatal burn on the victim: _____
5. Prevention measures (if applicable): Appropriate Water Temperature <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown Other, specify: _____	

B. Unintentional Injury Cause: 2 - Drowning

1. If Drowning, Place of drowning: <input type="checkbox"/> Ocean <input type="checkbox"/> Lake <input type="checkbox"/> River <input type="checkbox"/> Irrigation/Drainage <input type="checkbox"/> Canal <input type="checkbox"/> Creek <input type="checkbox"/> Pond <input type="checkbox"/> Bath tub <input type="checkbox"/> Bucket <input type="checkbox"/> Pool <input type="checkbox"/> Spa/Hot tub <input type="checkbox"/> Other Location (Specify) _____	2. If Pool or Spa/Hot tub, type: <input type="checkbox"/> Apartment Pool/spa <input type="checkbox"/> Public swimming pool/spa <input type="checkbox"/> Child's Residential Swimming Pool/tub <input type="checkbox"/> Other's Residential Swimming Pool/tub <input type="checkbox"/> Hotel/motel <input type="checkbox"/> Other, specify: _____
3. Child's activity: <input type="checkbox"/> Bathing <input type="checkbox"/> Boating <input type="checkbox"/> Swimming <input type="checkbox"/> Wading <input type="checkbox"/> Playing <input type="checkbox"/> Other: _____ <input type="checkbox"/> Unknown	
4. Prevention Measures (if applicable): Property line fence <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown If yes, gate closed <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown Gate locked <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown Isolation fencing <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown If yes, gate closed <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown Gate locked <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown Local Isolation Fencing Ordinance <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown Specify (i.e., more restrictive): _____ Other Safety Barrier <input type="checkbox"/> Present, specify: _____ <input type="checkbox"/> In Use <input type="checkbox"/> Functioning Properly Floatation Device <input type="checkbox"/> Present, specify: _____ <input type="checkbox"/> In Use <input type="checkbox"/> Functioning Properly Warning signs posted <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown Life guard present <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown Could child swim <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown Swim alone <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown Use of baby bath seat <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown CPR Knowledge <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> Other, specify: _____	

ID Number: _____

B. Unintentional Injury Cause: 3 - Electrocutation

1. If Electrocutation, source of electricity: <input type="checkbox"/> Electrical wire <input type="checkbox"/> Electrical outlet <input type="checkbox"/> Water contact <input type="checkbox"/> Appliance/tool, specify: _____ <input type="checkbox"/> Other, specify: _____	
2. Was Source Defective? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> NA	3. Prevention Measures (if applicable): <input type="checkbox"/> Yes specify: _____ <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> NA

B. Unintentional Injury Cause: 4 - Fall

1. If Fall, child fell from: <input type="checkbox"/> Open window With Screens? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> Balcony/Porch <input type="checkbox"/> Stairs/steps <input type="checkbox"/> Natural elevation <input type="checkbox"/> Same height <input type="checkbox"/> Opening in surface <input type="checkbox"/> Crib/Bed <input type="checkbox"/> Furniture <input type="checkbox"/> Other, specify: _____	
2. Height of fall:	3. Prevention Measures (if applicable): <input type="checkbox"/> Protective Guards/Railings/Screens <input type="checkbox"/> (Risk) Baby walker <input type="checkbox"/> Other Specify _____

B. Unintentional Injury Cause: 5 - Fire

1. If Fire (Non-arson), source of fire: <input type="checkbox"/> Matches <input type="checkbox"/> Lighter <input type="checkbox"/> Cigarette <input type="checkbox"/> Space Heater <input type="checkbox"/> Furnace <input type="checkbox"/> Fireplace <input type="checkbox"/> Faulty Wiring <input type="checkbox"/> Gas Explosion <input type="checkbox"/> Cooking appliance used as heating source? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> Combustible liquid <input type="checkbox"/> Explosives/fireworks <input type="checkbox"/> Other, specify: _____ <input type="checkbox"/> Unknown		2. (Opt) Type of Structure: <input type="checkbox"/> Wood frame <input type="checkbox"/> Brick/Stone <input type="checkbox"/> Trailer <input type="checkbox"/> Other, specify: _____ <input type="checkbox"/> Unknown <input type="checkbox"/> NA
3. Victim's primary activity prior to fire (if not the fire starter): <input type="checkbox"/> Cooking <input type="checkbox"/> Playing <input type="checkbox"/> Smoking <input type="checkbox"/> Sleeping <input type="checkbox"/> Other, specify: _____		4. Where was the victim found? <input type="checkbox"/> Hiding <input type="checkbox"/> In bed <input type="checkbox"/> Stairway <input type="checkbox"/> Close to exit <input type="checkbox"/> Other, specify: _____
5. Who Started Fire? <input type="checkbox"/> Victim <input type="checkbox"/> Other - Age: ____ <input type="checkbox"/> No One <input type="checkbox"/> Unknown		6. Activity of Person who started the fire: <input type="checkbox"/> Cooking <input type="checkbox"/> Playing <input type="checkbox"/> Smoking <input type="checkbox"/> Suspected Arson <input type="checkbox"/> Other, specify: _____
7. Was the person a known fire starter? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		
8. Prevention measures (if applicable): Smoke Detector: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk Placed Properly: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk Function: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk Sprinklers <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk Placed Properly: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk Function: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk Fire Extinguisher <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk Placed Properly: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk Function: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk Fire Escape Plan <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk Did Child Know Plan? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown (If known fire starter) Fire Starter Intervention: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> Other, specify: _____		

B. Unintentional Injury Cause: 6 - Firearm

1. If Firearm, location of incident: <input type="checkbox"/> Victim's residence <input type="checkbox"/> Owner's residence <input type="checkbox"/> Shooter residence <input type="checkbox"/> Public place, specify: _____ <input type="checkbox"/> Other, specify: _____ <input type="checkbox"/> Unknown		2. Access to firearm (Where did person get gun?): <input type="checkbox"/> Victim's residence <input type="checkbox"/> Owner's residence <input type="checkbox"/> Shooter's residence <input type="checkbox"/> Brought to site of incident <input type="checkbox"/> Other, specify: _____ <input type="checkbox"/> Unknown	
3. Owner of Firearm: <input type="checkbox"/> Victim <input type="checkbox"/> Unknown <input type="checkbox"/> Victim's family member, specify: _____ <input type="checkbox"/> Another in residence, specify: _____ <input type="checkbox"/> Friend, specify: _____ <input type="checkbox"/> Friend's parent/family member, specify: _____ <input type="checkbox"/> Other, specify: _____		4. Person handling firearm at time of incident (Check all that apply): <input type="checkbox"/> Victim <input type="checkbox"/> Owner <input type="checkbox"/> Family member <input type="checkbox"/> Friend/Acquaintance <input type="checkbox"/> Stranger <input type="checkbox"/> Other, specify: _____ <input type="checkbox"/> Unknown	
5. Type of Firearm: <input type="checkbox"/> Handgun <input type="checkbox"/> Rifle/Shotgun <input type="checkbox"/> Military/assault <input type="checkbox"/> Other specify: _____		6. Firearm Category: <input type="checkbox"/> Derringer <input type="checkbox"/> Revolver <input type="checkbox"/> Semi Auto <input type="checkbox"/> Automatic <input type="checkbox"/> Other, specify: _____	
7. Age of person handling firearm (if not victim): _____		8. Prior criminal record of person using firearm: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	

ID Number: _____

B. Unintentional Injury Cause: 6 – Firearm (Continued)

9. Purpose of handling the firearm:				
<input type="checkbox"/> Cleaning	<input type="checkbox"/> Loading	<input type="checkbox"/> Demonstrating	<input type="checkbox"/> Playing/Curiosity	<input type="checkbox"/> Self Defense
<input type="checkbox"/> Target Shooting	<input type="checkbox"/> Hunting	<input type="checkbox"/> Assault/Intent to harm	<input type="checkbox"/> Other Crime	
<input type="checkbox"/> Other, specify: _____		<input type="checkbox"/> Unknown		
10. Prevention measures (if applicable):				
Safety Training: Person using firearm: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown				
Owner of firearm: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown				
Safe Storage: Locked cabinet/box: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Used properly: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			
Safety Device/Trigger Lock <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Used properly: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			
Stored unloaded: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown				
Ammunition stored separately <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown				
<input type="checkbox"/> Other, specify: _____				

B. Unintentional Injury Cause: 7 - Poisoning/Overdose

1. Poisoning/Overdose, type of poisoning/overdose (specify):				
<input type="checkbox"/> Over the counter medication	<input type="checkbox"/> Prescribed medicine	Whose: <input type="checkbox"/> child <input type="checkbox"/> other		
<input type="checkbox"/> Chemical	<input type="checkbox"/> Alcohol	<input type="checkbox"/> Illegal drug	<input type="checkbox"/> Carbon Monoxide/other gas	<input type="checkbox"/> Food product
<input type="checkbox"/> Herbal remedy	<input type="checkbox"/> Other, specify: _____	<input type="checkbox"/> Unknown		
2. Location of Poison:		3. (Opt.) Activity of victim prior to poisoning:		
<input type="checkbox"/> Cabinet	<input type="checkbox"/> Counter/table/floor	<input type="checkbox"/> Outside/garage	Specify: _____	
<input type="checkbox"/> Other, specify: _____			<input type="checkbox"/> Unknown	
4. Prevention Measures (if applicable):				
<input type="checkbox"/> Stored out of reach	<input type="checkbox"/> Locked/Latched	<input type="checkbox"/> Unlocked/Unlatched		
<input type="checkbox"/> Child Resistant Packaging	<input type="checkbox"/> CO detector	<input type="checkbox"/> Ipecac syrup available		
<input type="checkbox"/> Poison Center called				

B. Unintentional Injury Cause: 8 - Strangulation/Suffocation

1. If Strangulation/Suffocation, circumstances of event:		2. Object causing event:		
<input type="checkbox"/> Adult Overlay	<input type="checkbox"/> Choking on Object	<input type="checkbox"/> Balloon	<input type="checkbox"/> Bedding	<input type="checkbox"/> Body
<input type="checkbox"/> Confinement, specify: _____		<input type="checkbox"/> Food	<input type="checkbox"/> Plastic bag	<input type="checkbox"/> Toy
<input type="checkbox"/> Positional Asphyxia		<input type="checkbox"/> Rope/string/cord	<input type="checkbox"/> Unknown	
<input type="checkbox"/> Strangled by Object, specify: _____		<input type="checkbox"/> Small object specify: _____		
<input type="checkbox"/> Other, specify: _____		<input type="checkbox"/> Other, specify: _____		
3. Location of victim:		4. Preventive measures (if applicable):		
<input type="checkbox"/> Adult bed	<input type="checkbox"/> Couch	<input type="checkbox"/> Crib	<input type="checkbox"/> Hazardous design of bed/crib	
<input type="checkbox"/> Held in Arms	<input type="checkbox"/> Playing	<input type="checkbox"/> Floor	<input type="checkbox"/> Improper use of bedding	<input type="checkbox"/> Soft bedding
<input type="checkbox"/> Non-sleeping area	<input type="checkbox"/> Unknown		<input type="checkbox"/> Safety cord mechanism	<input type="checkbox"/> Sleeping with others
<input type="checkbox"/> Other, specify: _____			<input type="checkbox"/> Other, specify: _____	

B. Unintentional Injury Cause: 9 - Vehicular

1. If child was in/on a vehicle, type of vehicle:		2. If Vehicular, activity/position of child:			
<input type="checkbox"/> Car	<input type="checkbox"/> Truck/RV	<input type="checkbox"/> Van/SUV	<input type="checkbox"/> Driver/Operator	<input type="checkbox"/> Pedestrian	
<input type="checkbox"/> Motorcycle	<input type="checkbox"/> Farm Vehicle	<input type="checkbox"/> Water Craft	<input type="checkbox"/> Passenger: <input type="checkbox"/> Front seat <input type="checkbox"/> Back seat		
<input type="checkbox"/> All Terrain	<input type="checkbox"/> Bicycle	<input type="checkbox"/> Unknown	<input type="checkbox"/> Other, specify: _____		
<input type="checkbox"/> Other-Non-motorized	<input type="checkbox"/> NA				
<input type="checkbox"/> Other, specify: _____					
3. Other vehicles involved (check all that apply):		4. Location of Injury:			
<input type="checkbox"/> Car	<input type="checkbox"/> Truck/RV	<input type="checkbox"/> Van/SUV	<input type="checkbox"/> Highway	<input type="checkbox"/> Roadway/Street	<input type="checkbox"/> Intersection
<input type="checkbox"/> Motorcycle	<input type="checkbox"/> Farm Vehicle	<input type="checkbox"/> Water Craft	<input type="checkbox"/> Off Road	<input type="checkbox"/> Sidewalk/Side of Rd	<input type="checkbox"/> Water
<input type="checkbox"/> All Terrain	<input type="checkbox"/> Bicycle	<input type="checkbox"/> Unknown	<input type="checkbox"/> Railroad crossing/tracks	<input type="checkbox"/> Driveway	<input type="checkbox"/> Parking lot
<input type="checkbox"/> Other-Non-motorized	<input type="checkbox"/> NA		<input type="checkbox"/> NA	<input type="checkbox"/> Unknown	
<input type="checkbox"/> Other, specify: _____			<input type="checkbox"/> Other, specify: _____		
5. Age of driver at fault: _____		6. Was an operator of MV cited or charged with crime?			
<input type="checkbox"/> Unknown		<input type="checkbox"/> Citation (e.g., speeding, running stop light)	<input type="checkbox"/> Reckless Driving		
<input type="checkbox"/> NA		<input type="checkbox"/> DUI	<input type="checkbox"/> Negligent Manslaughter	<input type="checkbox"/> Unknown	
		<input type="checkbox"/> Other, specify: _____			

ID Number: _____

B. Unintentional Injury Cause: 9 – Vehicular (Continued)

<p>7. Contributing factors of incident: (Check all that apply)</p> <p><input type="checkbox"/> Speeding <input type="checkbox"/> Road conditions <input type="checkbox"/> Poor weather <input type="checkbox"/> Recklessness <input type="checkbox"/> Driver error <input type="checkbox"/> Mechanical failure <input type="checkbox"/> Alcohol/Other Drugs Use – Impairment <input type="checkbox"/> Child Impaired, specify: _____ <input type="checkbox"/> Driver of child’s vehicle, specify: _____ <input type="checkbox"/> Driver of other vehicle, specify: _____ <input type="checkbox"/> Other, specify: _____</p>	<p>8. Prevention Measures (Check all that apply):</p> <table border="1"><thead><tr><th></th><th>Used Correctly</th><th>Used Incor</th><th>Not Used</th><th>Present</th><th>Unknown</th></tr></thead><tbody><tr><td>Airbag</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr><tr><td>Shoulder Belt</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr><tr><td>Lap Belt</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr><tr><td>Infant Car Seat</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr><tr><td>Toddler Seat</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr><tr><td>Helmet</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr><tr><td>Other Equipment</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr><tr><td>specify _____</td><td></td><td></td><td></td><td></td><td></td></tr><tr><td><input type="checkbox"/> Unknown</td><td></td><td></td><td></td><td><input type="checkbox"/> NA</td><td></td></tr></tbody></table>		Used Correctly	Used Incor	Not Used	Present	Unknown	Airbag	<input type="checkbox"/>	Shoulder Belt	<input type="checkbox"/>	Lap Belt	<input type="checkbox"/>	Infant Car Seat	<input type="checkbox"/>	Toddler Seat	<input type="checkbox"/>	Helmet	<input type="checkbox"/>	Other Equipment	<input type="checkbox"/>	specify _____						<input type="checkbox"/> Unknown				<input type="checkbox"/> NA																													
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B. Unintentional Injury Cause: 10 - Other Injury

1. If Other Injury, cause/circumstance of death (if not listed above): <input type="checkbox"/> Other Injury, specify: _____	
2. Other Protective Factors not mentioned above?	3. Other Risk Factors not mentioned above?

C. Natural Cause: ALL

1. If Natural Causes, what category? <input type="checkbox"/> SIDS <input type="checkbox"/> Perinatal Conditions <input type="checkbox"/> Congenital Anomalies <input type="checkbox"/> Infectious & Parasitic Diseases <input type="checkbox"/> AIDS <input type="checkbox"/> Diseases of the Heart <input type="checkbox"/> Malignant Neoplasms <input type="checkbox"/> Pneumonia & Influenza <input type="checkbox"/> Other, specify: _____ <input type="checkbox"/> Undetermined, Natural	
2. For SIDS and Undetermined Infant Cases: Normal sleeping position: <input type="checkbox"/> On stomach <input type="checkbox"/> On back <input type="checkbox"/> On side <input type="checkbox"/> Varies <input type="checkbox"/> Unknown Position of Infant when found: <input type="checkbox"/> On stomach <input type="checkbox"/> On back <input type="checkbox"/> On side <input type="checkbox"/> Not noted If on stomach: <input type="checkbox"/> Face down <input type="checkbox"/> Face to side <input type="checkbox"/> Not noted Infant sleeping alone: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown Location of Infant when found: <input type="checkbox"/> Crib <input type="checkbox"/> Playpen <input type="checkbox"/> Other bed <input type="checkbox"/> Couch <input type="checkbox"/> Floor <input type="checkbox"/> Not noted Other, specify: _____ Type of bedding: <input type="checkbox"/> Firm mattress/cushion <input type="checkbox"/> Soft mattress/cushion <input type="checkbox"/> Thick/layered blankets <input type="checkbox"/> Other: _____ Objects inhibiting child’s breathing: <input type="checkbox"/> Pillow <input type="checkbox"/> Blanket <input type="checkbox"/> Toy <input type="checkbox"/> Body <input type="checkbox"/> Other: _____ Infant Healthy: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown Cigarette Exposure: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown Other circumstances: _____	

D. Brief Case Scenario (For ALL Child Deaths, especially CAN, questionable, and undetermined deaths)

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