Georgia Child Fatality Review Investigation Form

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INSTRUCTIONS:

A. Submit reports of all deaths of children under the age of 18 that occurred in the county.
B. Notfiy chairperson of Child Fatality Review Committee within 48 hours of death.
C. For all decedents **OVER** the age of 1 - complete page 1 of this form only
D. For all decedents **UNDER** the age of 1 - complete the entire form
E. All forms should be forwarded to chairperson and State office within 7 days of death.

INVESTIGATION DATA

Decedent's Information:

Last: _____ First: _____ M. _____ Date of Death _____

Sex: ☐ Male ☐ Female Date of Birth ____/____/____ Age _____ SS# _____
Month Day Year

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

Decedent's Primary Residence Address:

Address _____ City _____ County _____ Zip _____

Incident Address:

Address _____ City _____ County _____ Zip _____

Contact Information for Witness:

Relationship to the deceased: ☐ Birth Mother ☐ Birth Father ☐ Grandmother ☐ Grandfather

☐ Adoptive or Foster Parent ☐ Physician ☐ Medical staff ☐ Other _____

Last: _____ First: _____ M. _____ SS # _____

Home Address _____ City _____ County _____ Zip _____

Place of Work _____ City _____ County _____ Zip _____

Phone (H) _____ Phone (W) _____ Date of Birth ____/____/____
Month Day Year

Details of incident:

If decedent is over the age of 1, please stop here. If the decedent is under the age of 1, please continue to Witness Interview Section on page 2 and complete this form in its entirety. Upon completion, forward the form to the chairperson and the State office.

WITNESS INTERVIEW

1 **Are you the usual caregiver?** ☐ Yes ☐ No

2 **Tell me what happened:** _____

3 **Did you notice anything unusual or different about the infant in the last 24 hrs?** ☐ No ☐ Yes ⇨ Describe:

4 **Did the infant experience any falls or injury within the last 72 hrs?** ☐ No ☐ Yes ⇨ Describe:

5 **When was the infant LAST PLACED?**..... ___/___/___ ___:___ _____
Month Day Year Military Time Location (room)

6 **When was the infant LAST KNOWN ALICE (LKA)?** ___/___/___ ___:___ _____
Month Day Year Military Time Location (room)

7 **When was the infant FOUN**..... ___/___/___ ___:___ _____
Month Day Year Military Time Location (room)

8 **Explain how you knew the infant was still alive.** _____

9 **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			

10 **In what position was the infant LAST PLACED?** ☐ Sitting ☐ On Back ☐ On Side ☐ On Stomach ☐ Unknown
Was this the infant's usual sleep position? ☐ Yes ☐ No ⇨ What was the infant's usual position? _____

11 **In what position was the infant LKA?** ☐ Sitting ☐ On Back ☐ On Side ☐ On Stomach ☐ Unknown
Was this the infant's usual sleep position? ☐ Yes ☐ No ⇨ What was the infant's usual position? _____

12 **In what position was the infant FOUND?** ☐ Sitting ☐ On Back ☐ On Side ☐ On Stomach ☐ Unknown
Was this the infant's usual sleep position? ☐ Yes ☐ No ⇨ What was the infant's usual position? _____

13 **FACE position when LAST PLACED?** ☐ Face down on surface ☐ Face up ☐ Face right ☐ Face left

14 **NECK position when LAST PLACED?** ☐ Hyperextended (head back) ☐ Flexed (chin to chest) ☐ Neutral ☐ Turned

15 **FACE position when LKA?** ☐ Face down on surface ☐ Face up ☐ Face right ☐ Face left

16 **NECK psotion when LKA?** ☐ Hyperexd back) ☐ Flexed (chin to chest) ☐ Neutral ☐ Turned

17 **FACE position when FOUND?** ☐ Face down on surface ☐ Face up ☐ Face right ☐ Face left

18 **NECK position when FOUND?** ☐ Hyperexd back) ☐ Flexed (chin to chest) ☐ Neutral ☐ Turned

19 **What was the infant wearing?** (ex, t-shirt, disposable diaper) _____

20 **Was the infant tightly wrapped or swaddled?** ☐ No ☐ Yes ⇨ Describe: _____

21 **Please indicate the types and numbers of layes 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 (thick)	☐		Infant/child comforters (thick)	☐	
Adult comforters/duvets	☐		Adult comforters/duvets	☐	
Adult blankets	☐		Adult blankets	☐	
Sheets	☐		Sheets	☐	
Sheepskin	☐		Pillows	☐	
Pillows	☐		Other, specify	☐	
Rubber or plastic sheet	☐		Other, specify: _____		
Other, specify: _____					

WITNESS INTERVIEW

22 Which of the following devices were operating in the infant's room?
☐ None ☐ Apnea monitor ☐ Humidifier ☐ Vaporizer ☐ Air purifier Other _____

23 What was the temperature of the infant's room? ☐ Hot ☐ Cold ☐ Normal ☐ Other _____

24 Which of the following items were near the infant's face, nose, or mouth?
☐ Bumper pads ☐ Infant pillows ☐ Positional supports ☐ Stuffed animals ☐ Toys ☐ Other _____

25 Which of the following items were near the infant's reach? ☐ Blankets ☐ Toys ☐ Pillows
☐ Pacifier ☐ Nothing ☐ Other _____

26 Was anyone sleeping with the infant? ☐ No ☐ Yes ⇨ Name these people.

Name	Age	Height	Weight	Location in relation to Infant	Impaired (intoxicated, tired)

27 Was there evidence of wedging? ☐ No ☐ Yes ⇨ Decribe: _____

28 When the infant was found, was s/he: ☐ Breathing ☐ Not breathing

If not breathing, did you witness the infant stop breathing? ☐ No ☐ Yes

29 What had led you to check on the infant? _____

30 Describe the infant's appearwence when found.

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

31 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 ☐ ☐

32 Did anyone else other than EMS try to resuscitate the infant? ☐ No ☐ Yes ⇨ Who and when?

Who _____ ___/___/___ ___ : ___
Month Day Year Military Time

33 Please describe what was done as part of resuscitation:

34 Has the parent/caregiver ever had a child die suddenly and unexpectedly? ☐ No ☐ Yes ⇨ Explain

INFANT MEDICAL HISTORY

1 Source of medical information: ☐ Doctor ☐ Other healthcare provider ☐ Medical record
☐ Mother/primary caregiver: ☐ Family ☐ Other:

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

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

INFANT MEDICAL HISTORY

4 In the 72 hours prior to the infants death, was the infant given any vaccinations or medications?

(Please include any home remedies, herbal medications, prescription medicines, over-thecounter medications.) ☐ No ☐ Yes List below:

Name of vaccination or medication	Dose last given	Date given Month / Day / Year	Approx. time Military time	Reasons given/Comments:
		/ /		
		/ /		
		/ /		
		/ /		

5 At any time in the infant's life, did s/he have a history of ?

	Unknown	No	Yes	Describe:
a) Allergies (food, medication, or other)	☐	☐	☐	⇨
b) Abnormal growth or weight gain/loss	☐	☐	☐	⇨
c) Apnea (stopped breathing)	☐	☐	☐	⇨
d) Cyanosis (turned blue/gray)	☐	☐	☐	⇨
e) Seizures or convulsions	☐	☐	☐	⇨
f) Cardiac (heart) abnormalities	☐	☐	☐	⇨
g) Metabolic disorders	☐	☐	☐	⇨
h) Other, specify	☐	☐	☐	⇨

6 Did the infant have any birth defect(s)? ☐ No ☐ Yes

Describe: _____

7 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, and telephone calls)

	First most recent visit Month / Day / Year	Second most recent visit Month / Day / Year
a) Date	/ /	/ /
b) Reason for visit		
c) Action taken		
d) Physician's name		
e) Hospital /clinic		
f) Address		
g) City		
h) States, ZIP		
i) Phone number	( )	( )

8 Birth hospital name: _____

Street: _____

City: _____ State: _____ Zip: _____

Date of discharge / / Month Day Year

9 What was the infant's length at birth? _____ Inches **or** _____ centimeters

10 What was the infant's weight at birth? _____ Pounds _____ Ounces **OR** _____ Grams

11 Compared to the delivery date, was the infatn born on time, early, or late?

☐ On time ☐ Early___How many weeks early?..... Late__How many weeks late?.....

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

☐ Singleton ☐ Twin ☐ Triplet ☐ Quadruplet or higher gestation

13 Were there any complications during delivery or at birth? ((emergency c-section, child neede oxygen)

☐ No ☐ Yes ⇨ Describe: _____

14 Are there any alerts to pathologist? (previous infant deaths in family, newborn screen results)

☐ No ☐ Yes ⇨ Describe: _____

INFANT DIETARY HISTORY

1 On what day and at what approximate time was the infant last fed? ____/____/____ (Month Day Year) ____:____ (Military Time)

2 What si 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 fed) **?**

	Unknown	No	Yes		Quantity		Specify: (type and brand if applicable)
a) Breast milk (one/both sides, length of time).....	☐	☐	☐	⇨	.....	ounces	.....
b) Formula (brand, water source- ex, Similac, tap water)....	☐	☐	☐	⇨	.....	ounces	.....
c) Cow's milk.....	☐	☐	☐	⇨	.....	ounces	.....
d) Water (brand, bottled, tap, well).....	☐	☐	☐	⇨	.....	ounces	.....
e) Other liquids (teas, juices).....	☐	☐	☐	⇨	.....	ounces	.....
f) Solids.....	☐	☐	☐	⇨	.....	ounces	.....
g) Other.....	☐	☐	☐	⇨	.....	ounces	.....

5 Was a new food introduced in the 24 hours prior to his/her death?

☐ No ☐ Yes ⇨ Describe (ex. Content, amount, change in formula, introduction of solids)

_____

_____

_____

6 Was a new food introduced in the 24 hours prior to his/her death?

☐ Yes ☐ No ⇨ Skip to question **9** below

7 Was the bottle propped? (i.e. object used to hold bottle while infant feeds)

☐ No ☐ Yes ⇨ What object was used to prop the bottle? _____

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

9 Did death occur during? ☐ Breast-feeding ☐ Bottle-feeding ☐ Eating solid foods ☐ Not during feeding

10 Are ther any factors, circumstances, or environmental concerns that may have impacted the infant that have not yet been identified? (ex. Exposed to cigarette smoke or fumes at someone else's home, infant unusually heavy, placed with positional suppots or wedges)

☐ No ☐ Yes ⇨ Describe concerns: _____

_____

_____

_____

PREGNANCY HISTORY

1 Information about the infant's mother:

First Name _____ Middle name _____ Last Name _____

Maiden name _____ Social Sec # _____ DOB: ____/____/____ (Month Day Year)

Current Address: _____ City _____ (State) (Zip)

How long has the birth 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?** (Please specify physician or other health care provider name and address.)

Physician _____ Hospital/Clinic _____

Street City Phone (.....).....

4 During her pregnancy with the infant, did the birth mother have any complications? (ex. High blood pressure, bleeding, gestational diabetes)

☐ No ☐ Yes ⇨ Specify: _____

5 Was the birth mother injured during her pregancy with the infant? (ex. Auto accident, falls)

☐ No ☐ Yes ⇨ Specify: _____

6 During pregnancy, did she use any of the following?

	Unknown	No	Yes	Daily consumption		Unknown	No	Yes	Daily consumption
a) Over the counter medications	☐	☐	☐	_____	d) Cigarettes	☐	☐	☐	_____
b) Prescription medications	☐	☐	☐	_____	e) Alcohol	☐	☐	☐	_____
c) Herbal remedies	☐	☐	☐	_____	f) Other	☐	☐	☐	_____

7 Currently, does any caregiver use any of the following?

	Unknown	No	Yes	Daily consumption		Unknown	No	Yes	Daily consumption
a) Over the counter medications	☐	☐	☐	_____	d) Cigarettes	☐	☐	☐	_____
b) Prescription medications	☐	☐	☐	_____	e) Alcohol	☐	☐	☐	_____
c) Herbal remedies	☐	☐	☐	_____	f) Other	☐	☐	☐	_____

INCIDENT SCENE INVESTIGATION

1 Where did the incident or death occur? _____

2 Was this the primary residence ? ☐ Yes ☐ No

3 Is the site or 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 supercising the child(ren)? _____ (under 18 years old)

6 What is the license number and the 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	☐ Gas furnace or boiler	☐ Wood burning fireplace	☐ Open window(s)
☐ A/C window unit	☐ Electric furnace or boiler	☐ Coal burning furnace	☐ Wood burning stove
☐ Ceiling fan	☐ Electric space heater	☐ Kerosene space heater	
☐ Floor/table fan	☐ Electric baseboard heat	☐ Other	
☐ Window fan	☐ Electric (radiant) ceiling heat	☐ Unknown	

10 Indicate the temperature of the room where the infant was found unresponsive:
_____ Thermostat setting _____ Thermostat reading _____ Actual room temp. _____ Outside temp.

11 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 ☐ Other ☐ Specify: _____
☐ Well ☐ Unknown

12 The site of the incident or death scene has: (cheack all that apply)

☐ Insects	☐ Mold growth	☐ Odors or fumes ⇨ Describe _____
☐ Smoky smell (like cigarettes)	☐ Pets	☐ Presence of alcohol containers
☐ Dampness	☐ Peeling paint	☐ Presence of drug paraphenalia
☐ Visible standing water	☐ Rodents or vermin	☐ Other ⇨ Specify: _____

13 Describe the general appearance of 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 infant that have not yet been identified?

_____
_____
_____

2 Arrival times: Law enforcement scene:.....:..... DSI at scene:.....:..... Infant at hospital.....:.....
Military Time Military Time Military Time

Investigator's Notes

Indicate the task(s) performed.

☐ Additional scene9s)? (forms attached)	☐ Doll reenactment re-creation	☐ Photos or video taken and noted
☐ Materials collected/evidence logged	☐ Referral or counseling	☐ EMS run sheet/report
☐ Notify next of kin or verify notification	☐ 911 tape	

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

_____
_____
_____
_____

INVESTIGATION DIAGRAMS

1 Scene Diagram:

2 Body Diagram:

INVESTIGATION SUMMARY

Case Information

Investigator Information: Name _____ Agency _____ Phone _____

Investigated: ..... / ..... / .... : ..... Pronounced Dead: ..... / ..... / .... : .....
Month Day Year Military Time Month Day Year Military Time

Infant's Information: Last _____ First _____ M. _____ Case # _____

Sex: ☐ Male ☐ Female Date of Birth ..... / ..... / ..... Age. _____
Month Day Year Months

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

Sleeping Environment

1 Indicate whether preliminary investigation suggests any of the following:

Yes	No	
☐	☐	Asphyxia (ex. Overlying, wedging, choking, nose/mouth obstruction, re-breathing, neck compression, immersion in water)
☐	☐	Sharing of sleep surface with adults, children, or pets
☐	☐	Change in sleep condition (ex. Unaccustomed stomach sleep position, location, or sleep surface)
☐	☐	Hyperthermial/Hypothermia (ex. Excessive wrapping, blankets, clothing, or hot or cold environments)
☐	☐	Environmental hazards (ex. Carbon monoxide, noxious gases, chemicals, drugs, devices)
☐	☐	Unsafe sleep condition (ex. Couch/sofa, waterbed, stuffed toys, pillows, soft bedding)

Infant History

☐	☐	Diet (e.g. solids introduced, etc.)
☐	☐	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 other 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)

Family Info

☐	☐	Prior sibling deaths
☐	☐	Previous encounters with police or social service agencies
☐	☐	Request for tissues or organ donation
☐	☐	Objection to autopsy

Exam

☐	☐	Pre-terminal resuscitative treatment
☐	☐	Death due to trauma (injury), positioning, or intoxication

Investigator Insight

☐	☐	Suspicious circumstances
☐	☐	Other alerts for pathologist's attention

Any "Yes" answers should be explained and detailed.

Brief description of circumstances: _____

Pathologist

2 Pathologist Information:

Name _____ Agency _____

Phone ( ) - Fax ( ) -