

MEDICAL - IN CONFIDENCE (WHEN COMPLETED)



www.sudiscotland.org.uk

Sudden Unexpected Death in Infancy (SUDI) History and Examination Form

version 1 - created 2011

Informing parent(s)/person(s) with parental responsibility of information sharing:

Parent(s)/person(s) with parental responsibility must be informed that information gathered will be shared with other agencies involved, such as the police and the social work department. This is to avoid duplication of the questions asked by the agencies involved.

Where possible, please liaise with other professionals before obtaining information from parent(s)/person(s) with parental responsibility.

Please cross the box below to indicate that you have informed the parent(s)/ person(s) with parental responsibility that their information may be shared with other agencies

Type of case:

- Infant discovered out of hospital
- Neonatal SUDI prior to discharge from hospital

Please refer to instructions listed on page 2



Instructions:

- 1 To be completed by the healthcare professionals involved in a SUDI.
- 2 Guidance on where to find the relevant information and how to complete each section is included within this form.

Guidance on the appropriate actions and procedures for emergency department and paediatric staff involved in a SUDI can be found in the Professional Guidance section of the SUDI Scotland website:
www.sudiscotland.org.uk
- 3 Within 48 hours of the infant's death, **PRIOR** to the post-mortem examination, please submit a copy of the form to the following:
 - i The pathologist conducting the post-mortem examination.
 - ii The SUDI paediatrician for your area. (Contact details are available at: www.sudiscotland.org.uk)
 - iii SUDI Co-ordinator, Healthcare Improvement Scotland, Elliott House, 8-10 Hillside Crescent, Edinburgh, EH7 5EA.

PLEASE RETAIN THE ORIGINAL FOR FURTHER COMPLETION
- 4 Please complete the remainder of this form within 6 weeks of the date of death of the infant and submit a copy of the completed form to:
 - i The pathologist who conducted the post-mortem examination.
 - ii The SUDI paediatrician for your area. (Contact details are available at: www.sudiscotland.org.uk)

and send **THE ORIGINAL** form to: **SUDI Co-ordinator, Healthcare Improvement Scotland, Elliott House, 8-10 Hillside Crescent, Edinburgh, EH7 5EA.**
- 5 Please complete all dates in the format DD/MM/YYYY, and times using the 24hr clock, e.g. 18:00.
- 6 Please place an in the appropriate box, or write your answer in black ink where indicated. If you answer incorrectly, please fill in the box completely and reselect your desired answer.
- 7 Please complete answers in clear, legible upper-case writing.

Office use only

REF

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DATE

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Section 1: Demographics

The majority of this information should be available from the emergency department, hospital notes or Patient Administration System (PAS).

However, some of this information may need to be asked directly of the parent(s)/person(s) with parental responsibility.

1.1 Infant's details

Q1 (1) Surname:

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Q1 (2) First name:

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Q1 (3) Middle name(s):

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Q1 (4) Gender:

Male
 Female
 Indeterminate

Q1 (5) Date of birth:

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Affix hospital patient ID label

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Q1 (6) CHI number:

--	--	--	--	--	--	--	--	--	--	--	--	--	--

Q1 (7) Date of death:

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Q1 (8) Time death pronounced:

(24 hour clock)

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Q1 (9) Who pronounced the death?

Emergency Department Doctor
 General Practitioner
 Other (please specify below)

Paediatrician
 Police Casualty Surgeon
 Not known

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1.2 Parent(s) or person(s) with parental responsibility

Section 1.2 does not apply to non-parental carer(s) (eg nursery nurse, family friend). The details of these persons are requested in Section 2.1.

Parent/person with parental responsibility 1

This refers to the biological or adoptive parent or any person with parental responsibility for the infant.

Q1.2 (1) Surname:

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Q1.2 (2) First name:

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Q1.2 (3) Address: - Street number/name

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Address: - Street

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

Address: - Town/City

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Postcode:

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Q1.2 (4) Relationship to infant:

- Mother
 Father
 Other (please specify below)

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Q1.2 (5) Date of birth:

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Q1.2 (6) Telephone:

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Q1.2 (7) Ethnic origin:

- | | |
|---|---|
| <input type="checkbox"/> United Kingdom (white): England, Scotland, Northern Ireland, Wales | <input type="checkbox"/> South East Asia: China |
| <input type="checkbox"/> Europe: Irish | <input type="checkbox"/> South East Asia: Other (Please specify below) |
| <input type="checkbox"/> Europe: Other (please specify below) | <input type="checkbox"/> Other non-European: North Africa, South America etc |
| <input type="checkbox"/> Africa: Caribbean Islands | <input type="checkbox"/> Other non-European: Middle East (Saudi Arabia, Iran etc) |
| <input type="checkbox"/> Africa: Mainland Africa (excluding North Africa) | <input type="checkbox"/> Any Other non-European (Please specify below) |
| <input type="checkbox"/> Africa: Other (please specify below) | <input type="checkbox"/> Other (Please specify below) |
| <input type="checkbox"/> South Asia: India or African Indian | <input type="checkbox"/> Not disclosed |
| <input type="checkbox"/> South Asia: Pakistan | <input type="checkbox"/> Not known |
| <input type="checkbox"/> South Asia: Bangladesh | |

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Parent/person with parental responsibility 2
This refers to the biological or adoptive parent or any person with parental responsibility for the infant.

Q1.2 (8) Not applicable (eg single parent)

Q1.2 (9) Surname:

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Q1.2 (10) First name:

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Q1.2 (11) If address details are identical to parent/person with parental responsibility 1, please indicate here:

Q1.2 (12) Address: - Street number/name

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

Address: - Street

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Address: - Town/City

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Postcode:

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Q1.2 (13) Relationship to the infant:

Mother Father Other (please specify below)

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Q1.2 (14) Date of birth:

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Q1.2 (15) Telephone:

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Q1.2 (16) Ethnic origin:

- United Kingdom (white): England, Scotland, Northern Ireland, Wales
- Europe: Irish
- Europe: Other (please specify below)
- Africa: Caribbean Islands
- Africa: Mainland Africa (excluding North Africa)
- Africa: Other (please specify below)
- South Asia: India or African Indian
- South Asia: Pakistan
- South Asia: Bangladesh
- South East Asia: China
- South East Asia: Other (Please specify below)
- Other non-European: North Africa, South America etc
- Other non-European: Middle East (Saudi Arabia, Iran etc)
- Any other non-European (Please specify below)
- Other (Please specify below)
- Not disclosed
- Not known



Section 2: Initial history prior to hospital presentation

This section requests basic details regarding when and how the infant was discovered, and any actions undertaken by the person(s) who discovered the infant and those responding to an emergency call (General Practitioner, Police, Scottish Ambulance Service (SAS)). This section should **NOT** include actions undertaken in hospital.

The majority of this information should be available from liaising with the professionals first in attendance (eg Police, SAS). Consider attaching SAS and police reports **in addition** to this form. Where no professionals were in attendance the parents should be consulted.

2.1 Initial history

Q2.1 (1) Time the infant was discovered: :
(24 hour clock)

Q2.1 (2) What was the type of location where the infant was discovered?

Private residence Hospital Other (please specify below) Not known

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Q2.1 (3) Address at which the infant was discovered:

If address details are identical to section 1.2, please indicate here:

- Identical to parent/person with parental responsibility 1
 Identical to parent/person with parental responsibility 2

Q2.1 (4) If different to parent/person with parental responsibility, please specify below:

Address: - Street number/name

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Address: - Street

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Address: - Town/City

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Postcode:

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Q2.1 (5) Was this the infant's usual residence? Yes No Not known

Q2.1 (6) If no, where does the infant usually reside?

- Identical to parent/person with parental responsibility 1
- Identical to parent/person with parental responsibility 2
- Other (please detail information in Section 5)

Q2.1 (7) Who was at this address at the time that the infant was found? (please cross all that apply)

- Parent/person with parental responsibility 1 Parent/person with parental responsibility 2
- Siblings Other (please specify below)
- Not known

Q2.1 (8) Who was caring for the infant in the preceding 24 hours? (please cross all that apply)

- Parent/person with parental responsibility 1 Parent/person with parental responsibility 2
- Professional carer (please specify below) Other (please specify below)
- Not known

Q2.1 (9) Who discovered the infant? (please cross all that apply)

- Parent/person with parental responsibility 1 Parent/person with parental responsibility 2
- Professional carer (please specify below) Other (please specify below)

2.2 Initial observations

Q2.2 (1) How was the infant when found? (please cross all that apply)

- Blue Pink Stiff Cold Other (please specify below)



Q2.2 (2) Were bodily fluids present around the nose/mouth when the infant was found?

(please cross all that apply)

- Nil
 Blood stained
 Frothy
 Vomit
 Mucus
 Other (please specify below)
 Not known

2.3 Initial actions taken by parent(s)/person(s) with parental responsibility or other non-healthcare professional

Q2.3 (1) Were the emergency services called? Yes No Not known

Q2.3 (2) What initial actions were taken? (please cross all that apply)

- Mouth-to-mouth
 Stimulation (including light shaking)
 None
 Cardiac massage
 Other (please specify below)
 Not known

Q2.3 (3) What was the response of the infant to the action(s)?

- Signs of life No response Other (please specify below) Not applicable



Q2.3 (4) What other actions were undertaken?

- None
 Removal of clothing
 Removal of bedding
 Other (please specify below)
 Not known

2.4 Action taken by the Scottish Ambulance Service/healthcare professionals attending the site where the infant was discovered/on route to hospital

Q2.4 (1) What actions were undertaken? (please cross all that apply)

- | | |
|--|---|
| <input type="checkbox"/> Bag and mask | <input type="checkbox"/> Stimulation |
| <input type="checkbox"/> Cardiac massage | <input type="checkbox"/> Defibrillation |
| <input type="checkbox"/> Medication (please specify below) | <input type="checkbox"/> Other (please specify below) |
| <input type="checkbox"/> None | <input type="checkbox"/> Not applicable |



Q2.5 (6) Was there adequate ventilation in the room where the infant was sleeping?
(windows, vents, fans, etc)

- Yes (please specify below) No Not known

Q2.5 (7) Was smoke (eg cigarette smoke) present?

- Yes No Not known

Q2.5 (8) Was there any evidence of neglect? (please cross all that apply)

- Substance misuse Alcohol misuse Hazards (eg sharp instruments)
(please specify below)
- Other (please specify below) None Not known

2.6 Sleep environment - bedding

This section details any aspect of the environment that raised a concern for the safety or care of any infant(s)/children present. **ALL** questions may not be applicable to in-hospital SUDI, please complete as deemed applicable.

Q2.6 (1) Was anything used to keep the infant in position?

- Blanket roll Infant positioner Nothing used
- Pillow Other (please specify below) Not known

Q2.6 (2) Was the infant put down to sleep with their feet close to the bottom of the cot?

- Yes No Not applicable Not known

Q2.6 (3) Was the bedding in place when the infant was found?

- Yes No (please specify below) Not known Not applicable



Q2.6 (4) What was the arrangement of the bedding for the infants last sleep?

- Tucked in Swaddled Loose
 Other (please specify below) None Not known

Q2.6 (5) What bedding was used for the infants last sleep? (please cross all that apply)

- Blanket Sleepbag Duvet
 Other (please specify below) None Not known

Q2.6 (6) Was the bedding over the infant's face and head when found?

- Yes No Not known

Q2.6 (7) Was a pillow used for sleep?

- Yes No Not known

Q2.6 (8) Was an electric blanket used?

- Yes No Not known

Q2.6 (9) What clothing was used for the infants last sleep? (please cross all that apply)

- Vest Pyjama (sleep suit) Daytime clothing Coat
 Hat Nappy only Other (please specify below) Not known

Q2.6 (10) What type of mattress was used on the infants cot/bed? (please cross all that apply)

- PVC/plastic covered Partially covered Removable cover Foam
 Other (please specify below) Not known Not applicable

Q2.6 (11) Was this mattress second-hand?

- Yes No Not applicable Not known

Q2.6 (12) Was this mattress previously used for other household members?

- Yes No Not applicable Not known

Q2.6 (13) If yes, for how many others? Not applicable Not known



Section 3: Hospital procedures and infant examination

This section is for documenting all interventions and procedures carried out during the resuscitation attempt, and findings from the examination once death has been pronounced. The majority of this information should be available in the emergency department/hospital notes.

3.1 Emergency department procedures

Please complete in conjunction with Section 3.4 - the infant body map.

Please attach copies of notes taken in the emergency department, including the handover from the Scottish Ambulance Service, to this form.

Q3.1 (1) Was resuscitation attempted? Yes No Not known

Q3.1 (2) If yes, please describe the resuscitation procedure and medications administered below:

If no, please state why not:

Q3.1 (3) Please describe any interventions/procedures carried out during the examination, after death, below:

Please note any marking to body, and removal of ET tubes, cannulae, etc.

Please cross if **NO** interventions/procedures carried out



Q3.1 (4) Were blood samples (peripheral or intra-osseus) taken during cardio pulmonary resuscitation (CPR)?

- Culture
- Urea & electrolytes
- Glucose/3 OH-butyrates
- Blood spot on Guthrie card for carnitine
- Other (please specify below)
- None
- Not known

Section 3.2 Growth (please use UK-WHO growth reference charts)

Q3.2 (1) Last live weight: (grams) Date weighed:

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 Centile

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 Not known

Q3.2 (2) Last live length measurement: (cm) Date measured:

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 Centile

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 Not known

Q3.2 (3) Last head circumference measurement: (cm) Date measured:

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 Centile

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 Not known

Q3.2 (4) Weight at death: (grams)

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 Centile

--	--

 Not known

Q3.2 (5) Was the infant diagnosed with, or referred for, faltering weight gain?
 Yes No Not known

Q3.2 (6) If yes, please give details below:



3.3 Features present

Please complete in conjunction with section 3.4 (infant body map).

Questions marked with * indicate features that must be immediately brought to the attention of the police. Questions marked with ** indicate objects that must be placed in a production bag and retained for the police.

Q3.3 (1) What was the recorded ear/skin temperature? (degrees centigrade)

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Q3.3 (2) Was the ear or skin temperature recorded using a:

<input type="checkbox"/> Digital thermometer	<input type="checkbox"/> Chemical strip
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Q3.3 (3)* Was there swelling over the skull? Yes No

Q3.3 (4)* Were the fontanelles bulging? Yes No

Q3.3 (5)* Were there any bruises/other injuries? (please cross all that apply)

<input type="checkbox"/> Nose	<input type="checkbox"/> Anus	<input type="checkbox"/> Frenulum
<input type="checkbox"/> Genitalia	<input type="checkbox"/> Other (please specify below)	<input type="checkbox"/> None

Q3.3 (6) Was jaundice present? Yes No

Q3.3 (7)* Was a skin rash present? Yes No

Q3.3 (8) Was vomitus present? Yes No



Q3.3 (9)* Was frank blood from the nose present? Yes No

Q3.3 (10) Were bloodstained secretions from the nose present? Yes No

Q3.3 (11) Was any other nasal discharge present? (please specify below)

Yes No

Q3.3 (12)* Was there blood from the mouth? Yes No

Q3.3 (13) Were bloodstained secretions from the mouth present? Yes No

Q3.3 (14)* Was there blood from the ears? Yes No

Q3.3 (15)* Was abdominal distention present? Yes No

Q3.3 (16) Were abdominal masses/organomegaly present? (use gentle abdominal palpation) Yes No

Q3.3 (17)** Was there a stool present in the nappy? Yes No

Q3.3 (18)** Was the nappy wet? Yes No

Post mortem changes observed:

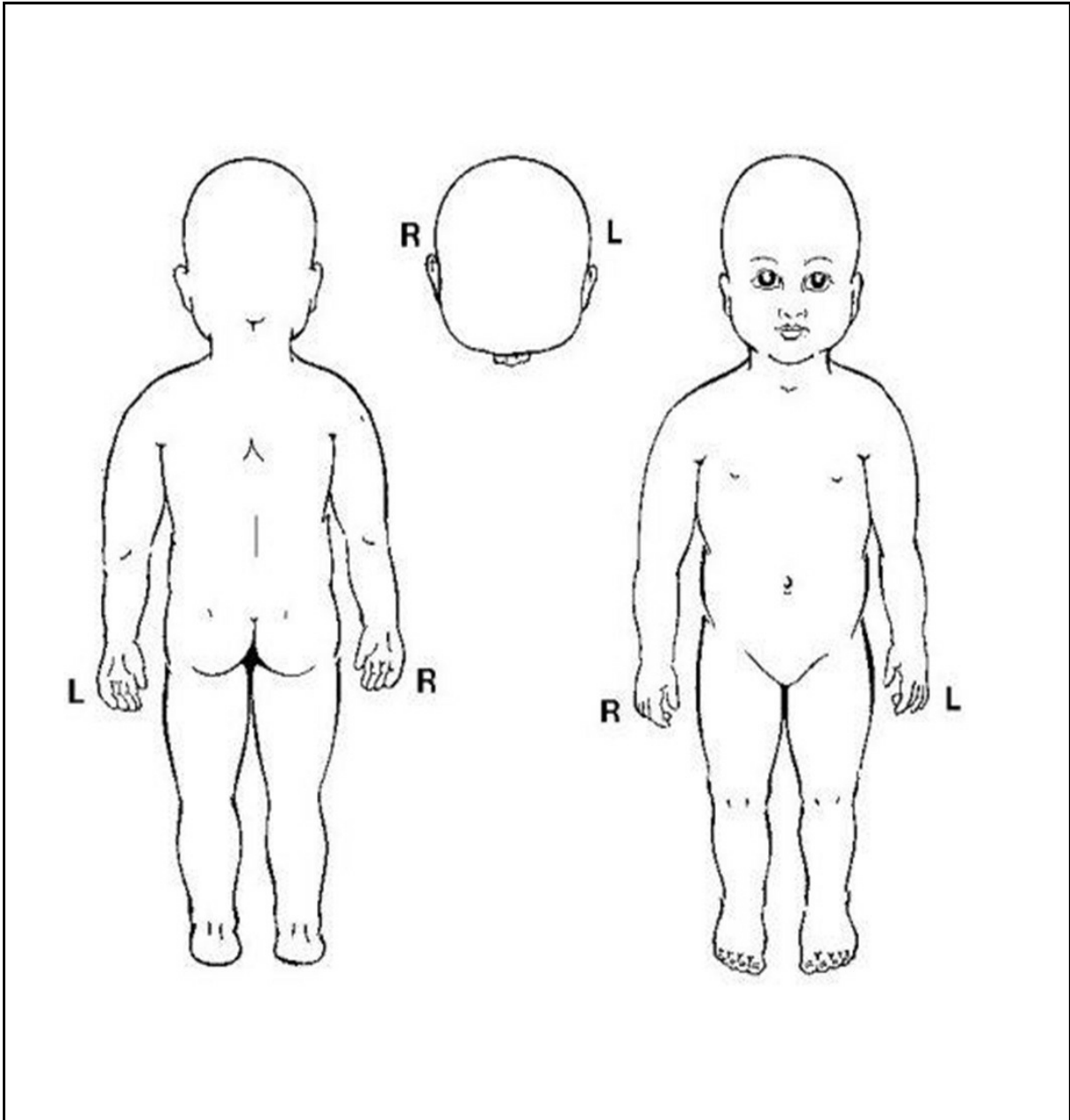
Q3.3 (19) Was rigor mortis present? Yes No

Q3.3 (20) Was livedo present? (livedo is a reddish blue, netlike discolouration of the skin) Yes No



3.4 Infant body map

Please mark all features present on the infant's body after death is pronounced, including any sites of interventional procedures undertaken such as venous cannulation/intraosseous needle insertion. Please note any marking to the infant's body or injuries incurred during a resuscitation attempt if undertaken.



Section 4: Infant and family

The majority of this information will be known by the parent(s)/person(s) with parental responsibility, however many other sources can be used to obtain these details.

4.1 Obstetric details

Alternative source of information: maternity/primary care health records

Q4.1 (1) Where was the infant born?

- Maternity unit (please specify below) Home Other (please specify below)
 Not known

Q4.1 (2) Did the mother attend antenatal care? Yes No Not known

Q4.1 (3) At what gestation was the first booking appointment? Not known

Q4.1 (4) Did the mother experience any problems in pregnancy? (please cross all that apply)

- Raised blood pressure Diabetes Infection Bleeding
 Pre-eclampsia Other (please specify below) None Not known



Q4.1 (5) What was the type of delivery?

- Spontaneous vertex Ventouse Lift-out forceps
 Mid cavity forceps Rotational forceps Assisted breech
 Breech extraction Pre-labour caesarean section Caesarean section after onset of labour
 Not known

Q4.1 (6) During pregnancy, how many cigarettes did the mother smoke per day? (please indicate if 0)

--	--

Not known

Q4.1 (7) During pregnancy, how many units of alcohol did the mother consume per week? (please indicate if 0)

--	--

Not known

Q4.1 (8) During pregnancy what prescribed medication did the mother take?

- None Methadone Anti-depressants
 Other medication Not known

Q4.1 (9) Please give further details below for all medications:

Prescribed medication	Prescribed by	Dose	Frequency	Route	Gestation commenced	Duration



Q4.1 (10) During the pregnancy was the mother a user of illegal substances?

Yes No Not known

Q4.1 (11) If yes, please give details below for all substances:

Substances	Frequency	Route	Duration

4.2 Infant's perinatal health
 Alternative source of information: maternity/primary care records

Q4.2 (1) Was the infant a:

Singleton Twin Triplet Quad or greater Not known

Q4.2 (2) Gestational age when born: (weeks) Not known

Q4.2 (3) Weight at birth: (grams)
 Centile Not known

Q4.2 (4) Length at birth: (cm)
 Centile Not known

Q4.2 (5) Head circumference at birth: (cm)
 Centile Not known

Q4.2 (6) Was the infant admitted to a Neonatal Unit? (includes SCBU/NICU)

Yes No Not known

Q4.2 (7) If yes, please specify reason and give details below (please cross all that apply):

Prematurity Breathing problems Other (please specify below)
 Not known



4.3 Infant's postnatal health

Alternative source of information: primary/secondary care health records. The infants red book will be a useful source of information, if available. This section does **NOT** refer to known pre-existing medical conditions - see Section 4.5.

Q4.3 (1) Was other special care required after birth? Yes No Not known

Q4.3 (2) If yes, please specify reason and give details below:

- Feeding problems Temperature control problems
 Infection Other (please specify below)

Q4.3 (3) What was the age of the infant when discharged home? (days)

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/> Not known
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Q4.3 (4) Was the infant's discharge home delayed? Yes No Not known

Q4.3 (5) If yes, please specify reason:



Q4.3 (6) Is the infant registered with a General Practice?

Yes No Not known

Q4.3 (7) If yes please provide General Practitioner's details:

Name:

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Name of Medical Practice

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Address - Street number/name

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Address - Street

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Address - Town/City

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Postcode

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Telephone Number

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Q4.3 (8) What was the date of the last Health Visitor contact?

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Q4.3 (9) Do parents have the Child Health Record/Red Book, detailing all medical checks/immunisations/examinations?

Yes No Not known

Please cross below if the infant received their scheduled immunisations - only ask if age appropriate

		Date received:											
Q4.3 (10) Birth BCG, HBV	<input type="checkbox"/>	<table border="1"><tr><td></td><td></td><td>/</td><td></td><td></td><td>/</td><td></td><td></td><td></td><td></td></tr></table>			/			/					Not known <input type="checkbox"/>
		/			/								
Q4.3 (11) 8 weeks DTaP/IPV/Hib, PCV	<input type="checkbox"/>	<table border="1"><tr><td></td><td></td><td>/</td><td></td><td></td><td>/</td><td></td><td></td><td></td><td></td></tr></table>			/			/					Not known <input type="checkbox"/>
		/			/								
Q4.3 (12) 12 weeks DTaP/IPV/Hib, MenC	<input type="checkbox"/>	<table border="1"><tr><td></td><td></td><td>/</td><td></td><td></td><td>/</td><td></td><td></td><td></td><td></td></tr></table>			/			/					Not known <input type="checkbox"/>
		/			/								
Q4.3 (13) 16 weeks DTaP/IPV/Hib, MenC, PCV	<input type="checkbox"/>	<table border="1"><tr><td></td><td></td><td>/</td><td></td><td></td><td>/</td><td></td><td></td><td></td><td></td></tr></table>			/			/					Not known <input type="checkbox"/>
		/			/								
Q4.3 (14) 12 - 13 months Hib/MenC, MMR, PCV	<input type="checkbox"/>	<table border="1"><tr><td></td><td></td><td>/</td><td></td><td></td><td>/</td><td></td><td></td><td></td><td></td></tr></table>			/			/					Not known <input type="checkbox"/>
		/			/								



Q4.3 (15) Has the infant had any illnesses/health problems since birth?

Yes (please specify below) No Not known

Q4.3 (16) Date(s): Details of illness/health problem(s):

Date(s)	Details of illness/health problem(s)

Q4.3 (17) Was the infant seen by a doctor or health visitor other than for routine checks?

Yes (please specify below) No Not known

Q4.3 (18) Date of visit(s): Reason for visit(s):

Date of visit(s)	Reason for visit(s)

Q4.3 (19) Was the infant on any medication? Yes No Not known

Q4.3 (20) If yes, please describe below:

Prescribed medication	Prescribed by	Dose	Frequency	Route	Duration



Q4.3 (21) Which healthcare professional did the infant last see?

- Emergency Medicine
 General Practitioner
 Health visitor
 Midwife
 Paediatrician
 Other (please specify below)
 Not known

Q4.3 (22) Please give details of the last healthcare professional to see the infant:

Name

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Job Title

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

Work telephone number

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

Work email address



4.4 Infant's general health during the 72 hours prior to death

This information should be obtained from the parent(s)/person(s) with parental responsibility. Primary/secondary care health records may be of assistance, if available, for this period.

If necessary additional information may be provided in section 5 and extra sheets may be attached if clearly headed with the question name/number.

Q4.4 (1) Were any changes in the health of the infant noted in the 72 hours prior to death? Yes No

Q4.4 (2) Please describe any changes in behaviour, feeding, sleeping and general health (eg increased / decreased crying, activity, feeding and altered sleep pattern) below:

4.5 Infant's medical history

Alternative source of information: primary/secondary care health records.
This section refers to prior medical conditions and any concerns noted by professionals involved in the infant's care.

Q4.5 (1) Did the infant have any known history of medical conditions? Yes No

Q4.5 (2) Please describe any history of pre-existing medical conditions below:



Were ANY concerns noted by professionals regarding the following? (major or minor)

Q4.5 (3) A: Health Yes No Not known

Q4.5 (4) B: Parenting Yes No Not known

Q4.5 (5) C: Social Yes No Not known

Q4.5 (6) D: Growth Yes No Not known

Q4.5 (7) E: Other Yes No Not known

Q4.5 (8) If yes, please describe ANY concerns below:

A:	
B:	
C:	
D:	
E:	



Section 4.6 Infant feeding

Alternative source of information: primary care health records.

Q4.6 (1) How was the infant usually fed? (please cross all that apply)

- Breast
 Formula
 Mixed breast / formula
 Solids
 Weaning foods
 Not known

Q4.6 (2) If formula / weaning food used, please specify the brand and type below? (eg SMA Gold)

Q4.6 (3) Was the infant ever breast fed?

- Yes
 No
 Not known

Q4.6 (4) If Yes, for how many weeks?

--	--

Q4.6 (5) Was anything added to the formula milk?

- Yes (please specify below)
 No
 Not applicable
 Not known

Q4.6 (6) Time of last feed: (24 hour clock)

		:		
--	--	---	--	--

- Not known

Q4.6 (7) What was this feed? (please cross all that apply)

- Breast
 Formula
 Solids
 Not known

Q4.6 (8) Who fed the infant last?

- Parent/person with parental responsibility 1
 Parent/person with parental responsibility 2
 Professional carer (please specify below)
 Other (please specify below)

Q4.6 (9) Did the infant take the usual amount of feed?

- Yes
 No
 Not applicable
 Not known

Q4.6 (10) Was the infant left alone with a bottle to feed?

- Yes
 No
 Not applicable
 Not known



4.7 Last sleep

This information should be obtained directly from the person(s) present for the infant's last sleep and where possible the person(s) who discovered the infant. Questions relating to the day-to-day care of the infant will need to be asked of the parent(s)/person(s) with parental responsibility.

Q4.7 (1) Time last seen/known to be alive: (24 hour clock) : Not known

Q4.7 (2) Who saw the the infant last?

- Parent/person with parental responsibility 1 Parent/person with parental responsibility 2
 Professional carer (please specify below) Other (please specify below)

Q4.7 (3) How did the infant seem then? (please cross all that apply)

- Usual self Quiet and settled Agitated
 Crying Flushed Rapid breathing
 Gasping for breath Pale Other (please specify below)
 Not known

Q4.7 (4) What room was the infant found in?

- Parent(s) bedroom Own bedroom Living room
 Other (please specify below) Not known

Q4.7 (5) What was the place of last sleep?

- Cot Carry cot Moses basket Adult bed
 Infant bouncing seat Car seat Pram Sofa
 Armchair Other (please specify below) Not known



Q4.7 (6) Was it regular practice for the infant to co-sleep with other(s), for any sleep?

- Yes No Not known

Q4.7 (7) Was the infant co-sleeping during their last sleep?

- Yes No Not known

Q4.7 (8) If Yes, please specify with whom:

- Parent/person with parental responsibility 1 Parent/person with parental responsibility 2
 Professional carer (please specify below) Other (please specify below)
 Not known

Q4.7 (9) What was the proximity of the persons(s) co-sleeping with the infant?

- Direct contact Close, not touching Arm's length
 Other (please specify below) Not applicable Not known

Q4.7 (10) Who placed the infant for their last sleep?

- Parent/person with parental responsibility 1 Parent/person with parental responsibility 2
 Professional carer (please specify below) Other (please specify below)
 Not known

Q4.7 (11) What position was the infant placed down in for their last sleep?

- On back On side On tummy
 Other (please specify below) Not known

Q4.7 (12) What position was the infant usually put down to sleep?

- On back On side On tummy
 Other (please specify below) Not known



Q4.7 (13) If the infant was not placed on their back to sleep, please indicate the reason why?

- Infant comfort Medical advice Fear of choking
 Other (please specify below) Not known

Q4.7 (14) Was the infant found between two surfaces? (eg mattress and headboard)

- Yes (please describe below) No Not known

Q4.7 (15) What was the position of the infant when found?

- On back On tummy (face to side) On tummy (face into mattress)
 On side Other (please specify below) Not known

Q4.7 (16) Was the infant's sleep pattern?

- Established Variable Not known

Q4.7 (17) Was a dummy used routinely for sleep periods?

- Yes No Not known

Q4.7 (18) Was a dummy used for the start of this sleep?

- Yes No Not known



4.8 Family history

This information should be obtained from the parent(s)/person(s) with parental responsibility.

Q4.8 (8) - (12) refers to family history of collapse or sudden death, please provide details for all family members, including non-biological relations. Q4.8 (13)/(14) refers to any family history of medical problems, please complete these questions for biological family members **ONLY**. Please give the relationship of the family member(s) e.g. mother and any further details of the medical problem(s) in the space provided. Please give details of all infectious contacts, such as influenza, under question Q4.8 (15)/(16).

If necessary additional information may be provided in Section 5 and extra sheets may be attached if clearly headed with the question name/number.

Q4.8 (1) What is the number of adults in household? Not known

Q4.8 (2) What is their relationship to the infant? (please cross all that apply)

- Mother Father
 Adult sibling(s) Professional carer (please specify below)
 Other (please specify below)

Q4.8 (3) What is the number of school age children in the household? Not known

Q4.8 (4) What is their relationship to the infant? (please list all)

- Sibling(s) Other (please specify below) Not applicable

Q4.8 (5) What is the number of preschool age children in the household? (including this infant) Not known

Q4.8 (6) What is the relationship of any additional preschool age children to the infant? (please list all)

- Sibling(s) Other (please specify below) Not applicable



Q4.8 (15) Has the infant had any recent infectious contacts? (colds, vomiting/diarrhoea, rashes etc)

- Yes No Not known

Q4.8 (16) If yes, please specify: (please cross all that apply)

- Cold Influenza Diarrhoea
 Vomiting Joint pain Rash
 Cough Other (please specify below) Not known

Q4.8 (17) Have any people in the household been diagnosed with any of the following conditions?

(please cross all that apply)

- Depression Anxiety Phobia
 Personality disorder Psychosis Bi-polar affective disorder
 Eating disorder Other (please specify below) None
 Not known

4.9 Smoking
 Alternative source of information: primary care health records.

Q4.9 (1) Do any members of the household smoke (regularly or otherwise)?

- Yes No Not known

Q4.9 (2) If yes, please specify who:

- Parent/person with parental responsibility 1 Parent/person with parental responsibility 2
 Other (please specify below) Not known

Q4.9 (3) Do any household members smoke?

- Inside house Only outside Not applicable Not known



4.10 Alcohol use

Alternative source of information: primary care health records.

Q4.10 (1) What is the approximate number of alcohol units consumed by parent/person with parental responsibility 1 in an average week? (eg 5, 25, 70)

Units Non drinker Not known

Q4.10 (2) What is the approximate number of alcohol units consumed by parent/person with parental responsibility 2 in an average week? (eg 5, 25, 70)

Units Non drinker Not known

Q4.10 (3) Had parent/person with parental responsibility 1 consumed alcohol in the 24 hours prior to the infant's death?

Non drinker Yes No Not known

Q4.10 (4) If yes, please state the approximate number of units consumed: Not known

Q4.10 (5) Had parent/person with parental responsibility 2 consumed alcohol in the 24 hours prior to the infant's death?

Non drinker Yes No Not known

Q4.10 (6) If yes, please state the approximate number of units consumed: Not known



4.11 Prescribed medication

Alternative source of information: primary care health records.

If the mother is listed as a person with current parental responsibility and her prescribed medication is the same as that listed in Section 3.1, please indicate this in the box provided and do not complete the table.

Q4.11 (1) Is parent/person with parental responsibility 1 prescribed any of the following medication?

Q4.11 (2) Please cross if this information is identical to that given in Section 4.1

Anti-depressants

Methadone

Other medication

None

Not known

Q4.11 (3) Please give details below:

Prescribed medication	Prescribed by	Dose	Frequency	Route	Duration

Q4.11 (4) Is parent/person with parental responsibility 2 prescribed any of the following medication?

Q4.11 (5) Please cross if this information is identical to that given in Section 4.1

Anti-depressants

Methadone

Other medication

None

Not known

Q4.11 (6) Please give the details below:

Prescribed medication	Prescribed by	Dose	Frequency	Route	Duration



4.12 Illegal substance use

Alternative source of information: primary care health records.

Q4.12 (1) Were any of the following household members a habitual user of illegal substance(s)?
(please cross all that apply)

- Parent/person with parental responsibility 1 (please specify below)
- Parent/person with parental responsibility 2 (please specify below)
- Other household member (please specify below)
- None

Q4.12 (2) Person

Substance(s):

Person	Substance(s)

Q4.12 (3) Had any of the following used illegal substances in the 24 hours prior to the infant's death?
(please cross all that apply)

- Parent/person with parental responsibility 1 (please specify below)
- Parent/person with parental responsibility 2 (please specify below)
- Other household member (please specify below)
- None

Q4.12 (4) Person

Substance(s):

Person	Substance(s)



Section 5: Additional information

This space is provided for any information that is relevant to the SUDI and has not been asked for elsewhere in the form. It may also be used to provide additional space for an answer to a question for which there was not adequate space provided in the main body of the form. Please give the number and name of the question(s) if the space is used for this purpose. Please attach additional sheet(s) to the form if necessary. Please give the number and name of questions on any additional sheets and attach to the form securely.

[A large rectangular area with horizontal lines, intended for providing additional information.]

Please continue on separate sheet(s) as necessary



Section 6A: Details of the person responsible for completing this form within the first 48 hours prior to the post-mortem examination

Surname:

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First name:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

Job title:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

Contact email address:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

Organisation name:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

Address: - Street number/name

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

Address: - Street

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

Address: - Town/City

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Postcode:

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Signature:

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Date:

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Time: (24 hour clock)

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Within 48 hours of the infant's death, PRIOR to the post-mortem examination, please submit A COPY of the form to:

- * The pathologist conducting the post-mortem examination.
- * The SUDI paediatrician for your area.
(Contact details are available at: www.sudiscotland.org.uk)
- * SUDI Co-ordinator, Healthcare Improvement Scotland,
Elliott House, 8-10 Hillside Crescent, Edinburgh, EH7 5EA.

PLEASE RETAIN THE ORIGINAL FOR FURTHER COMPLETION



Section 6B: Details of the person responsible for completing the remainder of this form within 6 weeks

Surname:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

First name:

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Job title:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

Contact email address:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

Organisation name:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

Address: - Street number/name

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Address: - Street

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Address: - Town/City

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Postcode:

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Signature:

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Date:

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Time: (24 hour clock)

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Upon completion of the remainder of this form within 6 weeks of the Date of Death of the infant, please submit **A COPY** of the form to:

- * The pathologist conducting the post-mortem examination.
- * The SUDI paediatrician for your area.
(Contact details are available at: www.sudiscotland.org.uk)

and send **THE ORIGINAL** form to: **SUDI Co-ordinator, Healthcare Improvement Scotland, Elliott House, 8-10 Hillside Crescent, Edinburgh, EH7 5EA.**

PLEASE RETAIN A COPY FOR YOUR REFERENCE

