#### **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.

person(s	ross the box below to indicate that you have informed the parent(s)/ ) with parental responsibility that their information may be shared er 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 prodedures 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

- 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.

- Please complete all dates in the format DD/MM/YYYY, and times using the 24hr clock, e.g. 18:00.
- 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.





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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.

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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.

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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: Q1.2 (10) First name: Q1.2 (11) If address details are identical to parent/person with parental responsibity 1, please indicate here: Q1.2 (12) Address: - Street number/name Address: - Street Address: - Town/City Postcode: Q1.2 (13) Relationship to the infant: Mother Father Other (please specify below) Q1.2 (14) Date of birth: Q1.2 (15) Telephone: Q1.2 (16) Ethnic origin: United Kingdom (white): England, South East Asia: China Scotland, Northern Ireland, Wales South East Asia: Other Europe: Irish (Please specify below) Other non-European: North Africa, Europe: Other (please specify below) South America etc Other non-European: Middle East Africa: Caribbean Islands (Saudi Arabia, Iran etc) Africa: Mainland Africa Any other non-European (excluding North Africa) (Please specify below) Africa: Other (please specify below) Other (Please specify below) South Asia: India or African Indian Not disclosed South Asia: Pakistan Not known South Asia: Bangladesh

Parent/person with parental responsibility 2



#### 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.

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This care SUI	S SECCE OF (2) V Pillov  (2) V Yes	tion any i lease Vas a ket ro	detainfarrie cor	mils a at(s)/mple ming ming mfant No	ny a /chike te as used Infar Othe	dispection down and plant plan	ct of presence ceep ceep ceep ceep ceep ceep ceep	the sent.d applied the er special sleep sl	ALL plica infar	quoble.  It in  elow	position [	tion? N N N N Not	lothir ot kr	not b	ed ed	oplica	n of t	to ir	n-hos	
This care SUI	S SECCE OF (2) V Pillov  (2) V Yes	tion any i lease Vas a ket ro	detainfarrie cor	mils a at(s)/mple ming ming mfant No	ny a /chike te as used Infar Othe	dispection down and plant plan	ct of presence ceep ceep ceep ceep ceep ceep ceep	the sent.d applied the er special sleep sl	ALL plica infar	quoble.  It in  elow	position [	tion? N N N N Not	lothir ot kr	not b	ed ed	oplica	n of t	to ir	n-hos	



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Τι	uck	ed ir	1						Sv	vadd	led			Loos	se					
O	the	r (ple	ease	spec	ify be	elow)			No	ne				Not	knov	vn				
Q2.6 (5	5) W	hat	bedo	ding	was	used	d for	the	infar	its la	st sl	eep?	? (ple	ease	cros	s all t	hat a	apply	)	
Bla	ank	et							Sleep	bag			Duve	et						
Ot	her	(ple	ase s	speci	fy be	low)			None	<b>:</b>			Not I	know	n					
Q2.6 (6	6) W	as t	he b	eddi	ng o	ver t	he ir	ıfant	's fa	ce aı	nd he	ead v	vher	fou	nd?					
Ye	es			[	N	lo				] No	t knc	wn								
Q2.6 (7	') W	as a	pille	ow u	sed	for s	leep	?												
Ye	es				N	lo				No	t kno	wn								
Q2.6 (8	-	as a	ın ele	ectri	c bla	nket	use	d?		-										
Ye	es				\	lo				No	t kno	wn								
Q2.6 (9		hat_		_				the				-		ease	cross	all t			)	
∐ Ve		[		yjam	,	·	suit)	[		-		othin				L	_	oat		
Ha	at —		^	lapp:	y onl	/				Other	(plea	ase s	peci	fy be	low)	L	N	ot kr	iown	
Q2.6 (1	10)	Wha	t typ	e of	mat	tress	was	use	ed or	the	infa	nts c	ot/b	ed?	(plea	se cı	oss	all th	at ap	ply)
F	PVC	C/pla	stic c	cover	ed				Part	ially (	covei	red		Re	emov	able	cove	r	I	oam
	Othe	er (p	lease	e spe	cify I	oelow	/)		Not	know	/n			No	t app	olicat	ole			
1 1			•											_			•	•		
Q2.6 (1	<b>11)</b> Yes			mat No		s sec			_	N	ot kr	own								
Q2.6 (1	Yes	[	N	Ю	tres	Not a	applio viou	cable	e [	for o		hou	ıseh	old n	neml	oers'	?			



Section 5. 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



	1 (4) suscita				ampl	es (p	erip	hera	al or i	ntra	·OSS	eus)	take	n du	ring	card	lio p	ulmo	onary	/	
	Cultu	ire							Urea	ı & el	ectro	lytes	;								
	Gluc	ose/3	OH-	buty	rate				Bloo	d spo	ot on	Guth	nrie c	ard f	or ca	arnitii	ne				
	Othe	r (ple	ase	speci	fy be	low)			None	е											
	Not k	knowi	า																		
S	ectio	n 3.2	2 Gr	owt	h (p	leas	e us	se U	IK-W	/HO	gro	wth	ref	erer	nce (	chai	ts)				
Q3	.2 (1)	Last	live	weig	ht: (	gram	s)						Date	wei	ghed	:					
							Cen	tile			/		/						N	ot kn	own
Q3	.2 (2)	Last	live	leng	th me	easu	rme	nt: (	cm)			I	Date	mea	sure	d:					
		].					Cent	tile			]/[		/					] [	N	ot kn	own
Q3	.2 (3)	Last ]. [	head	d circ	eumf		<b>ce m</b> Cent		urem	ent:	(cm)	) [	Date /	mea	sure	d:		] [	N	ot kn	own
Q3	.2 (4)	Weig	ht at	dea	th: (	gram	s)														
								Cer	ntile			Not I	know	'n							
Q3.	2 (5) V	Vas t	he ir	nfant	diag	ınos	ed w	rith,	or re	ferre	d fo	r, <b>fal</b> i	terin	g we	eight	gair	1?				
	Yes						No						Not I	know	'n						
Q3	.2 (6)	If yes	s, ple	ase	give	deta	ils b	elov	v:												



#### 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)														
Q3.3 (2) Was the ear or skin temperature recorded using a:  Digital thermometer Chemical strip														
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)  Nose Anus Frenulum														
Nose Anus Frenulum Genitalia Other (please specify below) 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														

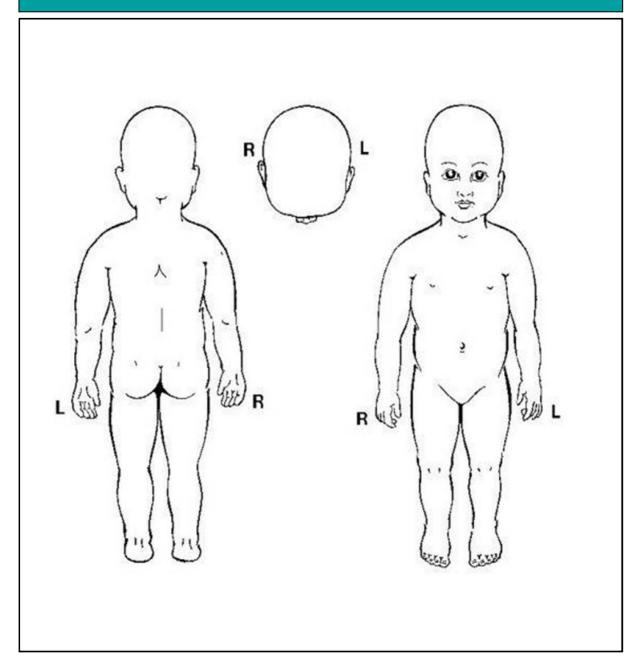


Q3.3 (9)	)* Was	fran	k blo	od f	rom	the i	nose	pres	sent'	? \	es [	N	lo _	]				
Q3.3 (1	Q3.3 (10) Were bloodstained secretions from the nose present? Yes No																	
Q3.3 (11) Was any other nasal discharge present? (please specify below)  Yes No																		
Y	es	No																
Q3.3 (1)	2)* Wa	s the	ere bl	lood	fron	n the	moı	uth?	Y	es [	No	• <u> </u>						
Q3.3 (1	3) We	re blo	odst	aine	d se	creti	ons	from	the	mou	th p	rese	nt?	Ye	s	] No		
Q3.3 (1	4)* Wa	s the	ere bl	lood	fron	n the	ears	s?	Yes		No [							
Q3.3 (1	5)* Wa	as ab	domi	nal d	diste	ntio	n pre	sent	?	Yes		No [						
Q3.3 (1) (use (	6) Wei gentle						orgar	nome	egaly	pre:	sent	?	Yes		No [			
Q3.3 (1	7)** W	as th	ere a	sto	ol pr	eser	t in	the n	app	y?	Yes		No [					
Q3.3 (1	8)** W	as th	e na <sub>l</sub>	рру ч	wet?	Υ	′es [		No									
Post m	ortem	chai	nges	obs	erve	d:												
Q3.3 (1	9) Wa	s rigo	or mo	ortis	pres	ent?	Υ	es [		N	0 [	]						
	0) Was lo is a lourat	redd	ish b	lue,	netli	ke	•	Yes		N	lo 🗌	]						



#### 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.







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Sec	Section 4: Infant and family  The majority of this information will be known by the parent(s)/person(s) with parental																			
	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. Obstatric details																			
	<b>4.1 Obstetric details</b> Alternative source of information: maternity/primary care health records																			
Alte	Alternative source of information: maternity/primary care health records																			
Q4.1	Q4.1 (1) Where was the infant born?																			
=	Maternity unit (please specify below)  Home  Other (please specify below)  Not known																			
	Not known																			
Q4.1	(2) [	Did t	he m	othe	r atte	end a	antei	natal	care	e?	Yes	s 🗌		No		[	N	lot kı	nowr	l
Q4.1	(3)	At wi	hat g	esta	tion	was	the 1	iirst l	book	king a	appo	ointm	ent?	? [		] [	N	lot kı	nowr	l
Q4.1	(4) [	Did t	he m	othe	r exp	oerie	nce	any <sub> </sub>	prob	lems	in p	regr	anc	<b>y?</b> (p	leas	e cro	ss al	I that	t app	ly)
	Rais	ed bl	ood I	oress	ure		Dial	oetes	;					] In	ıfecti	on		Blee	ding	
	Pre-e	eclan	npsia	ı			Oth	er (pl	ease	spe	cify b	elow	<i>'</i> ) [	N	one			Not k	know	n
				l																



Q4.1 (5) What was the	type of deliver	<b>'y?</b>				
Spontaneous verte	x	ntouse			Lift-out force	eps
Mid cavity forceps	Rota	ational f	iorceps		Assisted br	reech
Breech extraction	Pre-	-labour	caesarean se	ection	Caesarean onset of lat	section after oour
Not known						
Q4.1 (6) During pregr did the mother smok						Not known
Q4.1 (7) During pregn did the mother consu				0)		Not known
Q4.1 (8) During pregn None Other medication  Q4.1 (9) Please give for	Methad	done own	Anti-de	pressants	other take?	
None Other medication  Q4.1 (9) Please give for	Methad Not kno	done own pelow fo	Anti-de	epressants	Gestation	
None Other medication	Methad Not kno	done own	Anti-de	pressants		Duration
None Other medication  Q4.1 (9) Please give for	Methad Not kno	done own pelow fo	Anti-de	epressants	Gestation	Duration
None Other medication  Q4.1 (9) Please give for	Methad Not kno	done own pelow fo	Anti-de	epressants	Gestation	Duration
None Other medication  Q4.1 (9) Please give for	Methad Not kno	done own pelow fo	Anti-de	epressants	Gestation	Duration
None Other medication  Q4.1 (9) Please give for	Methad Not kno	done own pelow fo	Anti-de	epressants	Gestation	Duration
None Other medication  Q4.1 (9) Please give for	Methad Not kno	done own pelow fo	Anti-de	epressants	Gestation	Duration
None Other medication  Q4.1 (9) Please give for	Methad Not kno	done own pelow fo	Anti-de	epressants	Gestation	Duration
None Other medication  Q4.1 (9) Please give for	Methad Not kno	done own pelow fo	Anti-de	epressants	Gestation	Duration



4.2 Infant's perinatal health  Alternative source of information: maternity/primary care records  4.2 (1) Was the infant a: Singleton Twin Triplet Quad or greater Not known  4.2 (2) Gestational age when born: (weeks) Not known  4.2 (3) Weight at birth: (grams) Not known  4.2 (4) Length at birth: (cm) Not known  4.2 (5) Head circumference at birth: (cm) Centile Not known  4.2 (6) Was the infant admitted to a Neonatal Unit? (includes SCBU/NICU) Yes No Not known	ubstances	Frequency	Route	Duration
Alternative source of information: maternity/primary care records  4.2 (1) Was the infant a: Singleton Twin Triplet Quad or greater Not known  4.2 (2) Gestational age when born: (weeks) Not known  4.2 (3) Weight at birth: (grams) Centile Not known  4.2 (4) Length at birth: (cm) Centile Not known  4.2 (5) Head circumference at birth: (cm) Centile Not known  4.2 (6) Was the infant admitted to a Neonatal Unit? (includes SCBU/NICU) Yes No Not known  4.2 (7) If yes, please specify reason and give details below (please cross all that apply): Prematurity Breathing problems Other (please specify below)	aoota			
Alternative source of information: maternity/primary care records    4.2 (1) Was the infant a:   Singleton   Twin   Triplet   Quad or greater   Not known   A.2 (2) Gestational age when born: (weeks)   Not known				
Alternative source of information: maternity/primary care records  Al.2 (1) Was the infant a: Singleton Twin Triplet Quad or greater Not known  Al.2 (2) Gestational age when born: (weeks) Not known  Al.2 (3) Weight at birth: (grams) Centile Not known  Al.2 (4) Length at birth: (cm) Centile Not known  Al.2 (5) Head circumference at birth: (cm) Centile Not known  Al.2 (6) Was the infant admitted to a Neonatal Unit? (includes SCBU/NICU) Yes No Not known  Al.2 (7) If yes, please specify reason and give details below (please cross all that apply): Prematurity Breathing problems Other (please specify below)				
Alternative source of information: maternity/primary care records  24.2 (1) Was the infant a: Singleton Twin Triplet Quad or greater Not known  24.2 (2) Gestational age when born: (weeks) Not known  24.2 (3) Weight at birth: (grams) Centile Not known  24.2 (4) Length at birth: (cm) Centile Not known  24.2 (5) Head circumference at birth: (cm) Centile Not known  24.2 (6) Was the infant admitted to a Neonatal Unit? (includes SCBU/NICU) Yes No Not known  24.2 (7) If yes, please specify reason and give details below (please cross all that apply): Prematurity Breathing problems Other (please specify below)				
Alternative source of information: maternity/primary care records  24.2 (1) Was the infant a: Singleton Twin Triplet Quad or greater Not known  24.2 (2) Gestational age when born: (weeks) Not known  24.2 (3) Weight at birth: (grams) Centile Not known  24.2 (4) Length at birth: (cm) Centile Not known  24.2 (5) Head circumference at birth: (cm) Centile Not known  24.2 (6) Was the infant admitted to a Neonatal Unit? (includes SCBU/NICU) Yes No Not known  24.2 (7) If yes, please specify reason and give details below (please cross all that apply): Prematurity Breathing problems Other (please specify below)				
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) Not known  Q4.2 (4) Length at birth: (cm) Not known  Q4.2 (5) Head circumference at birth: (cm) 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)				
Alternative source of information: maternity/primary care records  24.2 (1) Was the infant a: Singleton Twin Triplet Quad or greater Not known  24.2 (2) Gestational age when born: (weeks) Not known  24.2 (3) Weight at birth: (grams) Centile Not known  24.2 (4) Length at birth: (cm) Centile Not known  24.2 (5) Head circumference at birth: (cm) Centile Not known  24.2 (6) Was the infant admitted to a Neonatal Unit? (includes SCBU/NICU) Yes No Not known  24.2 (7) If yes, please specify reason and give details below (please cross all that apply): Prematurity Breathing problems Other (please specify below)				
Alternative source of information: maternity/primary care records  24.2 (1) Was the infant a: Singleton Twin Triplet Quad or greater Not known  24.2 (2) Gestational age when born: (weeks) Not known  24.2 (3) Weight at birth: (grams) Centile Not known  24.2 (4) Length at birth: (cm) Centile Not known  24.2 (5) Head circumference at birth: (cm) Centile Not known  24.2 (6) Was the infant admitted to a Neonatal Unit? (includes SCBU/NICU) Yes No Not known  24.2 (7) If yes, please specify reason and give details below (please cross all that apply): Prematurity Breathing problems Other (please specify below)				
A4.2 (1) Was the infant a: Singleton Twin Triplet Quad or greater Not known  Q4.2 (2) Gestational age when born: (weeks) 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)	4.2 Infant's perinatal hea	lth		
Q4.2 (1) Was the infant a:   Singleton	Alternative source of informa	ation: maternity/pri	mary care rec	ords
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) Not known  Q4.2 (4) Length at birth: (cm) Not known  Q4.2 (5) Head circumference at birth: (cm) 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)		(in the control of th	Then y con-	
Not known   Not		Triplet	Quad or greate	r 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)	Q4.2 (2) Gestational age when	born: (weeks)		Not known
Q4.2 (4) Length at birth: (cm)  Q4.2 (5) Head circumference at birth: (cm)  Q4.2 (5) Head circumference at birth: (cm)  Q4.2 (6) Was the infant admitted to a Neonatal Unit? (includes SCBU/NICU)  Q4.2 (7) If yes, please specify reason and give details below (please cross all that apply):  Q4.2 (7) If yes, please specify reason and give details below (please specify below)	Q4.2 (3) Weight at birth: (gram	s)		NOT KHOWH
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)		Centi	ile	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)	Q4.2 (4) Length at birth: (cm)			
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)		Centi	ile	Not known
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)	O4 2 (5) Hoad circumference a	+ hirth: (cm)		
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)	Q4.2 (5) flead circumlerence a	t birtii. (Ciii)		
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)		Centi	ile 📙	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)	Q4.2 (6) Was the infant admitte	ed to a Neonatal Uni	it? (includes S	SCBU/NICU)
Prematurity Breathing problems Other (please specify below)	Yes No	Not known		
Prematurity Breathing problems Other (please specify below)	Ω4 2 (7) If ves, please specify r	eason and give det	ails below (ple	ase cross all that apply):
		g p. 00.0	] 011101 ([5.00.2.2	opoc, 20.0,
	I I INOLKHOWH			



## 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? Not known Yes No 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) Not known 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	d with a General Practice?	Yes No Not know
Q4.3 (7) If yes please provide Name:	General Practitioner's details:	
Name.		
Name of Medical Practice		
Address - Street number/name	<del></del>	
Address - Street		
Address - Town/City		
Postcode		
Telephone Number		
Q4.3 (8) What was the date of	f the last Health Visitor contact?	
/ / /		
O4 3 (9) Do parents have the	 Child Health Record/Red Book	detailing all
medical checks/immunisatio		, actaining an
Yes No	Not known	
Please cross below if the infa	ant received their scheduled im	nmunisations - only ask if age
appropriate	Date received:	. •
Q4.3 (10) Birth	Date received.	Not known
BCG, HBV		
O4 2 (44) 9 weeks		Not known
Q4.3 (11) 8 weeks DTaP/IPV/Hib, PCV	/ / /	
_		
Q4.3 (12) 12 weeks		Not known
DTaP/IPV/Hib, MenC	/	
Q4.3 (13) 16 weeks		Not known
DTaP/IPV/Hib, MenC, PCV		
		Not known
<b>Q4.3 (14) 12 - 13 months</b> Hib/MenC, MMR, PCV		THOU KNOWN



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Yes (please specif	y below)	No		Not known	
Q4.3 (16) Date(s):	Details of	illness/hea	alth problem(	(s):	
	ļ				
4.3 (17) Was the infan	t seen by a do	octor or he	alth visitor o	ther than for r	outine checks?
Yes (please specif	y below)	☐ No		lot known	
4.3 (18) Date of visit(s	s). Posson f	or visit(s):			
	s). neason i	or visit(s).			
	nt on anv med	iootion?	Yes	No	Not known
14.3 (19) Was the infan	,	ication?			
			1es		
94.3 (20) If yes, please	e describe bel	ow:			
4.3 (20) If yes, please		ow:	Frequency	Route	Duration
94.3 (20) If yes, please	e describe bel	ow:		Route	Duration
94.3 (20) If yes, please	e describe bel	ow:		Route	Duration
94.3 (20) If yes, please	e describe bel	ow:		Route	Duration
24.3 (20) If yes, please	e describe bel	ow:		Route	Duration
Q4.3 (19) Was the infan	e describe bel	ow:		Route	Duration



Q4.3	3 (21	) Wh	ich l	nealt	hcar	e pro	ofess	siona	ıl did	l the	infa	nt las	st se	e?						
	] Er	nerg	ency	Med	icine		] G	ener	al Pr	actiti	oner		] He	ealth	visito	or				
	Mi	idwife	Э				] P	aedia	atricia	an			Ot	her (	plea	se sp	ecify	belo	ow)	
	Not known																			
		,			,	,	_		,		_	,		_	,			,	,	
Q4.3	24.3 (22) Please give details of the last healthcare professional to see the infant:																			
Nam	lame																			
Job	Title				-		•	-			-		•		•			-		
	ı	I	l	I.	I		1			<u> </u>	1		1					I	ı	
Wor	k tel	epho	ne n	umb	er															
			1	<u>I</u>			1				1	J								
Worl	k em	ail a	ddre	ss														_	_	
		1																		



4.4 Infant's general health during the 72 hours prior to dea	th	
4.4 Illiant's general ficular during the 72 hours prior to dea		
This information should be obtained from the parent(s)/person(s) v responsibility. Primary/secondary care health records may be of ass this period.		ailable, for
If necessary additional information may be provided in section 5 and attached if clearly headed with the question name/number.	d extra sheet	s may be
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 (eg increased / decreased crying, activity, feeding and altered sleep page 1.5 p. 1.5 p. 2.5 p		
4.5 Infant's medical history		
<b>4.5 Infant's medical history</b> Alternative source of information: primary/secondary care health re This section refers to prior medical conditions and any concerns no involved in the infant's care.		sionals
Alternative source of information: primary/secondary care health re This section refers to prior medical conditions and any concerns no involved in the infant's care.		sionals
Alternative source of information: primary/secondary care health rethrest to prior medical conditions and any concerns no involved in the infant's care.  Q4.5 (1)Did the infant have any known history of medical conditions?	ted by profes	
Alternative source of information: primary/secondary care health rethins section refers to prior medical conditions and any concerns no involved in the infant's care.  Q4.5 (1)Did the infant have any known history of medical conditions?	ted by profes	
Alternative source of information: primary/secondary care health rethins section refers to prior medical conditions and any concerns no involved in the infant's care.  Q4.5 (1)Did the infant have any known history of medical conditions?	ted by profes	
Alternative source of information: primary/secondary care health rethrest to prior medical conditions and any concerns no involved in the infant's care.  Q4.5 (1)Did the infant have any known history of medical conditions?	ted by profes	
Alternative source of information: primary/secondary care health re This section refers to prior medical conditions and any concerns no	ted by profes	
Alternative source of information: primary/secondary care health rethrest to prior medical conditions and any concerns no involved in the infant's care.  Q4.5 (1)Did the infant have any known history of medical conditions?	ted by profes	
Alternative source of information: primary/secondary care health rethrest to prior medical conditions and any concerns no involved in the infant's care.  Q4.5 (1)Did the infant have any known history of medical conditions?	ted by profes	
Alternative source of information: primary/secondary care health rethins section refers to prior medical conditions and any concerns no involved in the infant's care.  Q4.5 (1)Did the infant have any known history of medical conditions?	ted by profes	



Were	ANY concerns not	ed by profession	onals regra	ading the following?	(major or minor)
Q4.5 (4 Q4.5 (5 Q4.5 (6 Q4.5 (7	B) A: Health B: Parenting C: Social B) D: Growth C) E: Other B) If yes, please de	Yes Yes Yes Yes Yes Yes Yes	No No No No No No No	Not known  Not known  Not known  Not known  Not known	
<b>A</b> :					
В:					
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** Solids Formula Mixed breast / formula 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? Q4.6 (4) If Yes, for how many weeks? No Not known Yes Q4.6 (5) Was anything added to the formula milk? Yes (please specify below) Not applicable Not known No 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** Solids Formula 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) Agitated Usual self Quiet and settled 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 Pram Sofa Infant bouncing seat Car seat Armchair Other (please specify below) Not known



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L																				$\perp$														
C	4.7	(9) V	Vhat	was	the	prox	imity	of t	he p	erso	ns(s	) co-	slee	ping	with	the	infaı	nt?																
	□ Direct contact       □ Close, not touching       □ Arm's length         □ Other (please specify below)       □ Not applicable       □ Not known																																	
[		Othe	r (ple	ase	spec	ify be	elow)			No	ot app	olicat	ole				Not	knov	vn															
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Q4.7	24.7 (13) If the infant was not placed on their back to sleep, please indicate the reason why?  Infant comfort  Medical advice  Fear of choking																				
	]	nfan	t con	nfort							Med	dical	advid	е			F	ear o	f choł	king	
	] (	Othe	r (ple	ase	speci	fy be	low)				Not	knov	wn								
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Q4	<b>l.7</b>	(15)	Wha	at wa	s the	pos	itior	of t	the i	nfan	t whe	en fo	und	?							
[		On	back			On tu	mmy	/ (fac	ce to	side	)			On tu	mmy	(fac	e into	o mat	tress)	)	
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Q4	I.7	(17)	Was	a d	umm	y us	ed ro	utir			-	perio	ods?								
		Yes	3		<u> </u>	No			No	t kno	own										
Q4	<b>l.7</b>	(18)	Was	a dı	umm	y us	ed fo	r th	e sta	rt of	this	slee	p?								
[		Yes			No	_			lot kı				=								



4.8	Fan	nily	hist	ory																
	s info			sho	uld b	e ob	tain	ed fr	om 1	the p	oarei	nt(s)	/per	son(	s) w	ith p	arer	ntal		
for fam mei furt	all fa ily h	mily istor s <b>Ol</b> detai	mer y of <b>NLY</b> . Is of	mber med Plea the	rs, in lical ase g med	iclud prob give lical	ing i lems the i prob	non- s, ple elati lem	biolo ease ionsl (s) ir	ogica com nip c n the	I relation of the specific relationship in th	ation e the e fan ice p	is. Q ese d nily i provid	4.8 ques mem ded.	(13), tions ber( Plea	(14) for s) e. se g	refe biolo .g. m	ers to ogica nothe	o an al far er ar	nily nd any
	eces iched														5 an	d ext	tra s	heet	s ma	ay be
Q4.8	(1) V	Vhat	is th	e nu	mbe	r of a	adult	s in	hous	seho	ld?				N	lot kr	nown			
Q4.8	(2) V Moth		is th	eir r	elatio	onsh	ip to	the	infa	`	pleas ather		oss a	all tha	at app	oly)				
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Q4.8				_			-			•			_	¬						
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	8 (5) Iseho							scho	ool a	ge cl	hildr	en in	the					Not k	now	n
	(6) V ne in						o of a	any a	addit	iona	l pre	scho	ool a	ge c	hildr	en				
	Siblir	ng(s)	-		Ot	her (	pleas	se sp	ecify	belo	w)			Not	appli	cable	)			



Dog Cat	Other (please specify below)	None Not known
I.8 (8) Is there any histo	ory of collapse or sudden death of	a relative on either side of the far
Yes No	Not known	
4.8 (9) If Yes, please sp	pecify relative below:	
4.8 (10) Please specify	v age at death: ( years )	
	tails of second relative if necessar	y balow:
4.5 (11) Flease give del	talls of second relative if fiecessar	y below.
4.8 (12) Please specify	age at death: ( years )	
	mily history of medical problems?	(please cross all that apply)
ciude parents, siblings a	and children from previous marriages	☐ Matabalia
Cardina	Neurological	Metabolic
Cardiac		
Sleep disorder  Not known  34.8 (14) Please give de	Other	None  above and the relationship of the
Sleep disorder  Not known  Q4.8 (14) Please give de	letails of all condition(s) specified a	
Sleep disorder  Not known  Q4.8 (14) Please give de	letails of all condition(s) specified a	
Sleep disorder  Not known  34.8 (14) Please give de	letails of all condition(s) specified a	
Sleep disorder  Not known  Q4.8 (14) Please give de	letails of all condition(s) specified a	
Sleep disorder  Not known  Q4.8 (14) Please give de	letails of all condition(s) specified a	
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Sleep disorder  Not known  Q4.8 (14) Please give de	letails of all condition(s) specified a	
Sleep disorder  Not known  Q4.8 (14) Please give de	letails of all condition(s) specified a	



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#### 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:
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:



4.11 Prescribed medi	cation				
Alternative source of info	ormation: prin	nary ca	re health rec	ords.	
If the mother is listed as medication is the same a and do not complete the	as that listed i				
Q4.11 (1) Is parent/person medication?	with parental	respon	sibility 1 pres	scribed any	of the following
Q4.11 (2) Please cross if	this informati	on is id	entical to tha	t given in Se	ection 4.1
Anti-depressants		Methad	done	Othe	r medication
None		Not kn	own		
Q4.11 (3) Please give deta	ils below:				
Prescribed medication	Prescribed by	Dose	Frequency	Route	Duration
Q4.11 (4) Is parent/person medication?	with parental	respon	sibility 2 pres	scribed any	of the following
Q4.11 (5) Please cross if	this informati	on is id	entical to tha	t given in Se	ection 4.1
Anti-depressants	Meti	nadone		Other med	dication
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 infor	rmation: primary care health records.
<b>4.12 (1)Were any of the fol</b> (please cross all that apply)	lowing household members a habitual user of illegal substance(s)?
Parent/person with pare	ental responsibility 1 (please specify below)
Parent/person with pare	ental responsibility 2 (please specify below)
Other household memb	er (please specify below)
None	
 ⊋4.12 (2) Person	Substance(s):
I.12 (3) Had any of the follo please cross all that apply)	owing used illegal substances in the 24 hours prior to the infant's de
Parent/person with parer	ntal responsibility 1 (please specify below)
Parent/person with parer	ntal responsibility 2 (please specify below)
Other household member	er (please specify below)
None	
 ⊋4.12 (4) Person	Substance(s):



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.

Please continue on separate sheet(s) as necessary

**Section 5: Additional information** 

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

Surn	name	<b>)</b> :																			
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PLEASE RETAIN THE ORIGINAL FOR FURTHER COMPLETION

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

Suri	name	:																			
Firs	t nan	ne:	•	•	•		•	•	•	•	•		•	•	•	•	•		•	•	_
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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