CONTRACT

(fee-for-service contract with a federal or Tennessee local or quasi-governmental entity)

Begin Date	End Date	Agency Tracking #	Edison Record ID
01/01/2022	12/31/2026	34301-16622	148350

Contractor Legal Entity Name	Edison Vendor ID
Metropolitan Government of Nashville and Davidson County	4

Subrecipient or Vendor	CFDA #
☐ Subrecipient ☒ Vendor	93.946

Service Caption (one line only)

Postmortem Examinations and Consultations

Funding —

FY	State	Federal	Interdepartmental	Other	TOTAL Contract Amount
2022	64,027	2,800			66,827
2023	128,053	5,600			133,653
2024	128,053	2,800			130,853
2025	128,053				128,053
2026	128,053				128,053
2027	64,027				64,027
TOTAL:	**640,266**	**11,200**			**651,466**

American Recovery and Reinvestment Act (ARRA) Funding: ☐ YES ☐ NO

Budget Officer Confirmation: There is a balance in the appropriation from which obligations hereunder are required to be paid that is not already encumbered to pay other obligations.

Eric Bucholz

CPO USE - GU

Speed Chart (optional)	**Account Code** (optional)
HL00000754	

CONTRACT
BETWEEN THE STATE OF TENNESSEE,
DEPARTMENT OF HEALTH
AND
METROPOLITAN GOVERNMENT OF NASHVILLE AND DAVIDSON COUNTY

This Contract, by and between the State of Tennessee, Department of Health, hereinafter referred to as the “State” and Metropolitan Government of Nashville and Davidson County, hereinafter referred to as the “Contractor,” is for the provision of, Medical Examiner Investigations, Postmortem Examinations and Consultations as further defined in the "SCOPE OF SERVICES."

Contractor Edison Registration ID # 4

A. SCOPE OF SERVICES:

A.1. The Contractor shall provide all service and deliverables as required, described, and detailed herein and shall meet all service and delivery timelines as specified by this Contract.

A.2. Service Definitions. For purposes of this Contract, definitions shall be as follows and as set forth in the Contract:

a. “Complete Autopsy” – An at a minimum *in situ* examination and removal and dissection of organs from the cranial cavity, neck, thoracoabdominal cavities, and pelvis.

b. “County Medical Examiner” – means a physician licensed under 63-6-201 or 63-9-104 and appointed by a county mayor pursuant to 38-7-105;

c. “NAME Accreditation” - is an endorsement by NAME that the office or system provides an adequate environment for a medical examiner in which to practice his or her profession and provides reasonable assurances that the office or system well serves its jurisdiction.

d. “Partial Autopsy” – at a minimum opening and *in situ* examination of the cranial, thoracic, or abdominal cavities.

e. “Regional Forensic Center” (RFC) – means a NAME-accredited facility in Tennessee in which autopsies and other post-mortem examinations are performed pursuant to the Post-Mortem Examination Act (TCA 38-7-101 et seq)

A.3. Services Goals. To reimburse NAME-Accredited Regional Forensic Centers for the performance of post-mortem examinations and subsequent reporting.

A.4. Service Description. Reimbursement claims may be submitted using the Claim for Fees form or other reimbursement invoice approved by the department, accompanying the documentation. Claims for fees submitted pursuant to this contract shall, at a minimum, provide the decedent’s name, age, gender, and race; date of death; county in which death occurred, and the county for which postmortem services are provided (if different); the cause and manner of death as determined by the county medical examiner or his or her designee; the name of the agency or person authorizing or ordering the examination; the name of agency or person providing the service; the service provided; and the associated fee as specified in C.3. Payment Methodology.

The State will reimburse Contractor for the following examination and reporting activities, as needed:

a) Class 1: Investigation of death reported to county medical examiner.

The investigation of a death reported to the county medical examiner pursuant to Tennessee Code Annotated 38-7-101 et seq and performed by a county medical examiner or death

investigator following the guidelines provided by the Office of the State Chief Medical Examiner, including those in which medical examiner jurisdiction is ultimately declined. In all cases, a completed Report of Investigation form (including toxicology if ordered) or other report of investigation approved by the department shall be submitted no more than 14 days following the date that the death was reported.

b) Class 2: Post-mortem examination and consultation: external examination and partial autopsy.

A complete external examination of the body, at least partial autopsy and a written report. The report shall include descriptions of pertinent positive and negative external and internal findings; external and internal injuries or abnormalities; a summary of case findings or list of diagnoses with a written narrative; and opinion regarding cause of death. and manner of death. The report is to be submitted within 120 days of the examination.

c) Class 3: Post-mortem examination and consultation: external examination and complete autopsy.

Complete external examination, a complete autopsy (defined as at a minimum in situ examination and removal and dissection of organs from the cranial cavity, neck, thoracoabdominal cavities, and pelvis) and a written narrative autopsy report signed by the forensic pathologist. The autopsy report shall include descriptions of pertinent positive and negative external and internal findings; external and internal injuries and abnormalities; a review of organ systems, including weights of the brain, heart, lungs, liver, spleen, and kidneys; a summary of case findings or list of diagnoses; and opinion regarding cause and manner of death. The report is to be submitted within 120 days of the examination.

d) Class 4: Post-mortem subspecialist consultation.

A post-mortem examination and consultation of special knowledge or difficulty involving the expenditure of a fee by the forensic pathologist or regional forensic center in the employment of a special consultant such as an odontologist, radiologist, cardiac pathologist, neuropathologist, or forensic anthropologist. This consultation must result in a report which is made part of an autopsy report as specified in Class 2 or 3 above.

e) Class 5: Autopsy performed in the event of the sudden, unexplained death of a child from birth through age 17 following the autopsy protocol established by the Department of Health.

Complete external examination, a complete autopsy (defined as at a minimum in situ examination and removal and dissection of organs from the cranial cavity, neck, thoracoabdominal cavities, and pelvis) and a written narrative autopsy report signed by the forensic pathologist performed in cases of sudden, unexpected deaths of infants or children with no known pre-existing medical history or injuries to account for or explain death. The written narrative autopsy report must include descriptions of pertinent positive and negative external and internal findings; external and internal injuries; a review of organ systems, including histologic examination of major organ systems; a summary of case findings or list of diagnoses, including review of medical records; and opinion regarding cause and manner of death. The narrative autopsy report shall be accompanied by a completed Sudden Unexplained Infant Death Investigation (SUIDI) or Sudden Unexplained Death of a Child (SUDC) reporting form as is appropriate for the age of the decedent: SUIDI form for those less than one year of age, and SUDC form for those between one and seventeen years of age. The report is to be submitted within 120 days of examination of the body.

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f) Class 6: Post-or peri-mortem toxicology profile of body fluids and tissues.

Post-or peri-mortem toxicology performed as part of an examination at a NAME-accredited facility. The toxicology testing results will be included as a part of the report of investigation or autopsy report as specified above.

A.5. Warranty. Contractor represents and warrants that the term of the warranty (“Warranty Period”) shall be the greater of the Term of this Contract or any other warranty generally offered by Contractor, its suppliers, or manufacturers to customers of its goods or services. The goods or services provided under this Contract shall conform to the terms and conditions of this Contract throughout the Warranty Period. Any nonconformance of the goods or services to the terms and conditions of this Contract shall constitute a “Defect” and shall be considered “Defective.” If Contractor receives notice of a Defect during the Warranty Period, then Contractor shall correct the Defect, at no additional charge.

Contractor represents and warrants that the State is authorized to possess and use all equipment, materials, software, and deliverables provided under this Contract.

Contractor represents and warrants that all goods or services provided under this Contract shall be provided in a timely and professional manner, by qualified and skilled individuals, and in conformity with standards generally accepted in Contractor’s industry.

If Contractor fails to provide the goods or services as warranted, then Contractor will re-provide the goods or services at no additional charge. If Contractor is unable or unwilling to re-provide the goods or services as warranted, then the State shall be entitled to recover the fees paid to Contractor for the Defective goods or services. Any exercise of the State’s rights under this Section shall not prejudice the State’s rights to seek any other remedies available under this Contract or applicable law.

A.6. Inspection and Acceptance. The State shall have the right to inspect all goods or services provided by Contractor under this Contract. If, upon inspection, the State determines that the goods or services are Defective, the State shall notify Contractor, and Contractor shall re-deliver the goods or provide the services at no additional cost to the State. If after a period of thirty (30) days following delivery of goods or performance of services the State does not provide a notice of any Defects, the goods or services shall be deemed to have been accepted by the State.

A.7. No funds awarded under this Grant Contract shall be used for lobbying federal, state, or local officials.

B. TERM OF CONTRACT:

This Contract shall be effective on January 1, 2022 (“Effective Date”), and extend for a period of sixty (60) months after the Effective Date (“Term”). The State shall have no obligation for goods or services provided by the Contractor prior to the Effective Date.

C. PAYMENT TERMS AND CONDITIONS:

C.1. Maximum Liability. In no event shall the maximum liability of the State under this Contract exceed Six Hundred Fifty-One Thousand Four Hundred Sixty-Six Dollars ($651,466.00). The payment rates in section C.3 shall constitute the entire compensation due the Contractor for all service and Contractor obligations hereunder regardless of the difficulty, materials or equipment required. The payment rates include, but are not limited to, all applicable taxes, fees, overheads, and all other direct and indirect costs incurred or to be incurred by the Contractor.

The Contractor is not entitled to be paid the maximum liability for any period under the Contract or any extensions of the Contract for work not requested by the State. The maximum liability

represents available funds for payment to the Contractor and does not guarantee payment of any such funds to the Contractor under this Contract unless the State requests work and the Contractor performs said work. In which case, the Contractor shall be paid in accordance with the payment rates detailed in section C.3. The State is under no obligation to request work from the Contractor in any specific dollar amounts or to request any work at all from the Contractor during any period of this Contract.

C.2. Compensation Firm. The payment rates and the maximum liability of the State under this Contract are firm for the duration of the Contract and are not subject to escalation for any reason unless amended.

C.3. Payment Methodology. The Contractor shall be compensated based on the payment rates herein for units of service authorized by the State in a total amount not to exceed the Contract Maximum Liability established in section C.1.

a. The Contractor's compensation shall be contingent upon the satisfactory completion of units, milestones, or increments of service defined in section A.

b. The Contractor shall be compensated for said units, milestones, or increments of service based upon the following payment rates:

Goods or Services Description	**Amount** (per compensable increment)
Class 1: Investigation of death reported to county medical examiner.	**$25.00**
Class 2: Post-mortem examination and consultation: external examination and partial autopsy.	**$100.00**
Class 3: Post-mortem examination and consultation: external examination and complete autopsy.	**$150.00**
Class 4: Post-mortem subspecialist consultation.	**$30.00**
Class 5: Autopsy performed in the event of the sudden, unexplained death of a child from birth through age 17 following the autopsy protocol established by the Department of Health. The narrative autopsy report shall be accompanied by a completed Sudden Unexplained Infant Death Investigation (SUIDI) or Sudden Unexplained Death of a Child (SUDC) reporting form as is appropriate for the age of the decedent: SUIDI form for those less than one year of age, and SUDC form for those between one and seventeen years of age. The report is to be submitted within 120 days of examination of the body.	**$1,250.00**
Class 6: Post-or peri-mortem toxicology profile of body fluids and tissues.	**Amount Determined by Prior Fiscal Year Autopsy Numbers**
Collection of bio sample for each autopsy meeting Sudden Death in Youth Criteria	**$25.00 per bio sample**
Obtain a signed parental consent form for each bio sample for Sudden Death in Youth	**$50.00 per consent form**
Submit an Autopsy Summary form to State Child Fatality Review Coordinator for each Sudden Death in Youth	**$50.00 per form**
Send a Family Interview summary sheet to State Child Fatality Review Coordinator for each Sudden Death in Youth	**$50.00 per form**

Notify State Child Fatality Review Coordinator within 72 hours of child death meeting Sudden Death in Youth criteria utilizing the form provided by Department of Health	**$25.00 per notification**

C.4. Travel Compensation. The Contractor shall not be compensated or reimbursed for travel, meals, or lodging.

C.5. Invoice Requirements. The Contractor shall invoice the State only for completed increments of service and for the amount stipulated in section C.3, above, and present said invoices no more often than monthly, with all necessary supporting documentation, to:

Invoices for Class 1 Reimbursements:

Office of the State Chief Medical Examiner
Andrew Johnson Tower, 7th Floor
710 James Robertson Parkway
Nashville, TN 37243
OSCME.ROI@tn.gov
(844) 860-4511

Invoices for Class 2-6 and SDY Reimbursements:

Margaret Hyder, Deputy Director
Office of the State Chief Medical Examiner
William L. Jenkins Forensic Center
PO Box 70431
Johnson City, TN 37614-1704
Margaret.Hyder@tn.gov
(423) 439-8403

a. Each invoice shall clearly and accurately detail all of the following required information (calculations must be extended and totaled correctly).

(1) Invoice Number (assigned by the Contractor)
(2) Invoice Date
(3) Contract Number (assigned by the State)
(4) Customer Account Name: Tennessee Department of Health, Office of the State Chief Medical Examiner
(5) Customer Account Number (assigned by the Contractor to the above-referenced Customer)
(6) Contractor Name
(7) Contractor Tennessee Edison Registration ID Number Referenced in Preamble of this Contract
(8) Contractor Contact for Invoice Questions (name, phone, and/or fax)
(9) Contractor Remittance Address
(10) Description of Delivered Service
(11) Complete Itemization of Charges, which shall detail the following:

i. Service or Milestone Description (including name & title as applicable) of each service invoiced
ii. Number of Completed Units, Increments, Hours, or Days as applicable, of each service invoiced
iii. Applicable Payment Rate (as stipulated in Section C.3.) of each service invoiced
iv. Amount Due by Service
v. Total Amount Due for the invoice period

b. The Contractor understands and agrees that an invoice under this Contract shall:

(1) include only charges for service described in Contract Section A and in accordance with payment terms and conditions set forth in Contract Section C;
(2) only be submitted for completed service and shall not include any charge for future work;
(3) not include sales tax or shipping charges; and
(4) initiate the timeframe for payment (and any discounts) only when the State is in receipt of the invoice, and the invoice meets the minimum requirements of this section C.5.

C.6. Payment of Invoice. A payment by the State shall not prejudice the State's right to object to or question any payment, invoice, or matter in relation thereto. A payment by the State shall not be construed as acceptance of any part of the work or service provided or as approval of any amount invoiced.

C.7. Invoice Reductions. The Contractor's invoice shall be subject to reduction for amounts included in any invoice or payment theretofore made which are determined by the State, on the basis of audits conducted in accordance with the terms of this Contract, not to constitute proper remuneration for compensable services.

C.8. Deductions. The State reserves the right to deduct from amounts, which are or shall become due and payable to the Contractor under this or any contract between the Contractor and the State of Tennessee any amounts, which are or shall become due and payable to the State of Tennessee by the Contractor.

C.9. Prerequisite Documentation. The Contractor shall not invoice the State under this Contract until the State has received the following documentation properly completed.

a. The Contractor shall complete, sign, and present to the State the "Authorization Agreement for Automatic Deposit Form" provided by the State. By doing so, the Contractor acknowledges and agrees that, once this form is received by the State, payments to the Contractor, under this or any other contract the Contractor has with the State of Tennessee, may be made by ACH; and

b. The Contractor shall complete, sign, and return to the State the State-provided W-9 form. The taxpayer identification number on the W-9 form must be the same as the Contractor's Federal Employer Identification Number or Social Security Number referenced in the Contractor's Edison registration information.

D. STANDARD TERMS AND CONDITIONS:

D.1. Required Approvals. The State is not bound by this Contract until it is signed by the contract parties and approved by appropriate officials in accordance with applicable Tennessee laws and regulations (depending upon the specifics of this contract, said officials may include, but are not limited to, the Commissioner of Finance and Administration, the Commissioner of Human Resources, and the Comptroller of the Treasury).

D.2. Modification and Amendment. This Contract may be modified only by a written amendment signed by all parties hereto and approved by both the officials who approved the base contract and, depending upon the specifics of the contract as amended, any additional officials required by Tennessee laws and regulations (said officials may include, but are not limited to, the Commissioner of Finance and Administration, the Commissioner of Human Resources, and the Comptroller of the Treasury).

D.3. Termination for Convenience. The State may terminate this Contract without cause for any reason. Said termination shall not be deemed a breach of contract by the State. The State shall give the Contractor at least thirty (30) days written notice before the effective termination date.

The Contractor shall be entitled to compensation for satisfactory, authorized service completed as of the termination date, but in no event shall the State be liable to the Contractor for compensation for any service which has not been rendered. Upon such termination, the Contractor shall have no right to any actual general, special, incidental, consequential, or any other damages whatsoever of any description or amount.

D.4. Termination for Cause. If the Contractor fails to properly perform its obligations under this Contract in a timely or proper manner, or if the Contractor violates any terms of this Contract, the State shall have the right to immediately terminate the Contract and withhold payments in excess of fair compensation for completed services. Notwithstanding the above, the Contractor shall not be relieved of liability to the State for damages sustained by virtue of any breach of this Contract by the Contractor.

D.5. Subcontracting. The Contractor shall not assign this Contract or enter into a subcontract for any of the services performed under this Contract without obtaining the prior written approval of the State. If such subcontracts are approved by the State, each shall contain, at a minimum, sections of this Contract below pertaining to "Conflicts of Interest," "Nondiscrimination," and “Records” (as identified by the section headings). Notwithstanding any use of approved subcontractors, the Contractor shall be the prime contractor and shall be responsible for all work performed.

D.6. Conflicts of Interest. The Contractor warrants that no part of the total Contract Amount shall be paid directly or indirectly to an employee or official of the State of Tennessee as wages, compensation, or gifts in exchange for acting as an officer, agent, employee, subcontractor, or consultant to the Contractor in connection with any work contemplated or performed relative to this Contract.

D.7. Nondiscrimination. The Contractor hereby agrees, warrants, and assures that no person shall be excluded from participation in, be denied benefits of, or be otherwise subjected to discrimination in the performance of this Contract or in the employment practices of the Contractor on the grounds of handicap or disability, age, race, color, religion, sex, national origin, or any other classification protected by Federal, Tennessee State constitutional, or statutory law. The Contractor shall, upon request, show proof of such nondiscrimination and shall post in conspicuous places, available to all employees and applicants, notices of nondiscrimination.

D.8. Records. The Contractor shall maintain documentation for all charges under this Contract. The books, records, and documents of the Contractor, insofar as they relate to work performed or money received under this Contract, shall be maintained for a period of five (5) full years from the date of the final payment and shall be subject to audit at any reasonable time and upon reasonable notice by the State, the Comptroller of the Treasury, or their duly appointed representatives. The financial statements shall be prepared in accordance with generally accepted accounting principles.

D.9. Prevailing Wage Rates. All contracts for construction, erection, or demolition or to install goods or materials that involve the expenditure of any funds derived from the State require compliance with the prevailing wage laws as provided in *Tennessee Code Annotated*, Section 12-4-401 *et seq.*.

D.10. Monitoring. The Contractor’s activities conducted and records maintained pursuant to this Contract shall be subject to monitoring and evaluation by the State, the Comptroller of the Treasury, or their duly appointed representatives.

D.11. Progress Reports. The Contractor shall submit brief, periodic, progress reports to the State as requested.

D.12. Strict Performance. Failure by any party to this Contract to insist in any one or more cases upon the strict performance of any of the terms, covenants, conditions, or provisions of this Contract shall not be construed as a waiver or relinquishment of any such term, covenant, condition, or provision. No term or condition of this Contract shall be held to be waived, modified, or deleted except by a written amendment signed by the parties hereto.

D.13. Independent Contractor. The parties hereto, in the performance of this Contract, shall not act as employees, partners, joint venturers, or associates of one another. It is expressly acknowledged by the parties hereto that such parties are independent contracting entities and that nothing in this Contract shall be construed to create a employer/employee relationship or to allow either to exercise control or direction over the manner or method by which the other transacts its business affairs or provides its usual services. The employees or agents of one party shall not be deemed or construed to be the employees or agents of the other party for any purpose whatsoever.

The Contractor, being a Tennessee governmental entity, is governed by the provisions of the Tennessee Government Tort Liability Act, *Tennessee Code Annotated*, Sections 29-20-101 *et seq*., for causes of action sounding in tort. Further, no contract provision requiring a Tennessee political entity to indemnify or hold harmless the State beyond the liability imposed by law is enforceable because it appropriates public money and nullifies governmental immunity without the authorization of the General Assembly.

D.14. State Liability. The State shall have no liability except as specifically provided in this Contract.

D.15. Force Majeure. The obligations of the parties to this Contract are subject to prevention by causes beyond the parties' control that could not be avoided by the exercise of due care including, but not limited to, natural disasters, riots, wars, epidemics, or any other similar cause.

D.16. State and Federal Compliance. The Contractor shall comply with all applicable State and Federal laws and regulations in the performance of this Contract.

D.17. Governing Law. This Contract shall be governed by and construed in accordance with the laws of the State of Tennessee. The Contractor agrees that it will be subject to the exclusive jurisdiction of the courts of the State of Tennessee in actions that may arise under this Contract. The Contractor acknowledges and agrees that any rights or claims against the State of Tennessee or its employees hereunder, and any remedies arising therefrom, shall be subject to and limited to those rights and remedies, if any, available under *Tennessee Code Annotated*, Sections 9-8-101 through 9-8-407.

D.18. Completeness. This Contract is complete and contains the entire understanding between the parties relating to the subject matter contained herein, including all the terms and conditions of the parties' agreement. This Contract supersedes any and all prior understandings, representations, negotiations, and agreements between the parties relating hereto, whether written or oral.

D.19. Severability. If any terms and conditions of this Contract are held to be invalid or unenforceable as a matter of law, the other terms and conditions hereof shall not be affected thereby and shall remain in full force and effect. To this end, the terms and conditions of this Contract are declared severable.

D.20. Headings. Section headings of this Contract are for reference purposes only and shall not be construed as part of this Contract.

D.21. Iran Divestment Act. The requirements of Tenn. Code Ann. § 12-12-101 et. seq., addressing contracting with persons as defined at T.C.A. §12-12-103(5) that engage in investment activities in Iran, shall be a material provision of this Contract. The Contractor certifies, under penalty of perjury, that to the best of its knowledge and belief that it is not on the list created pursuant to Tenn. Code Ann. § 12-12-106.

D.22. Confidentiality of Records. Strict standards of confidentiality of records and information shall be maintained in accordance with applicable state and federal law. All material and information, regardless of form, medium or method of communication, provided to the Contractor by the State or acquired by the Contractor on behalf of the State that is regarded as confidential under state or federal law shall be regarded as "Confidential Information." Nothing in this Section shall permit Contractor to disclose any Confidential Information, regardless of whether it has been disclosed

or made available to the Contractor due to intentional or negligent actions or inactions of agents of the State or third parties. Confidential Information shall not be disclosed except as required or permitted under state or federal law. Contractor shall take all necessary steps to safeguard the confidentiality of such material or information in conformance with applicable state and federal law. The obligations set forth in this Section shall survive the termination of this Contract.

E. SPECIAL TERMS AND CONDITIONS:

E.1. Conflicting Terms and Conditions. Should any of these special terms and conditions conflict with any other terms and conditions of this Contract, these special terms and conditions shall control.

E.2. Communications and Contacts. All instructions, notices, consents, demands, or other communications required or contemplated by this Contract shall be in writing and shall be made by certified, first class mail, return receipt requested and postage prepaid, by overnight courier service with an asset tracking system, or by EMAIL or facsimile transmission with recipient confirmation. Any such communications, regardless of method of transmission, shall be addressed to the respective party at the appropriate mailing address, facsimile number, or EMAIL address as set forth below or to that of such other party or address, as may be hereafter specified by written notice.

The State:

Margaret Hyder, Deputy Director
Office of the State Chief Medical Examiner
William L. Jenkins Forensic Center
PO Box 70431
Johnson City, TN 37614-1704
Margaret.Hyder@tn.gov
Telephone #: (423) 439-8403
FAX #: (423)439-8810

The Contractor:

Jim Diamond, Assistant Director of Finance and Administration
Metropolitan Government of Nashville and Davidson County
2500 Charlotte Avenue
Jim.Diamond@nashville.gov
Telephone # 615-340-5629

All instructions, notices, consents, demands, or other communications shall be considered effectively given upon receipt or recipient confirmation as may be required.

E.3. HIPAA Compliance. The State and Contractor shall comply with obligations under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and its accompanying regulations.

a. Contractor warrants to the State that it is familiar with the requirements of HIPAA and its accompanying regulations, and will comply with all applicable HIPAA requirements in the course of this Contract.

a. Contractor warrants that it will cooperate with the State, including cooperation and coordination with State privacy officials and other compliance officers required by HIPAA and its regulations, in the course of performance of the Contract so that both parties will be in compliance with HIPAA.

b. The State and the Contractor will sign documents, including but not limited to business associate agreements, as required by HIPPA and that are reasonably necessary to keep the State and Contractor in compliance with HIPAA. This provision shall not apply if information received by the State under this Contract is NOT “protected health information” as defined by HIPAA, or if HIPAA permits the State to receive such

information without entering into a business associate agreement or signing another such document.

E.4. Environmental Tobacco Smoke. Pursuant to the provisions of the federal "Pro-Children Act of 1994" and the Tennessee "Children's Act for Clean Indoor Air of 1995," the Contractor shall prohibit smoking of tobacco products within any indoor premises in which services are provided pursuant to this Contract to individuals under the age of eighteen (18) years. The Contractor shall post "no smoking" signs in appropriate, permanent sites within such premises. This prohibition shall be applicable during all hours, not just the hours in which children are present. Violators of the prohibition may be subject to civil penalties and fines. This prohibition shall apply to and be made part of any subcontract related to this Contract.

E.5. Debarment and Suspension. The Contractor certifies, to the best of its knowledge and belief, that it, its current and future principals, its current and future subcontractors and their principals:

a. are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from covered transactions by any federal or state department or agency;

b. have not within a three (3) year period preceding this Contract been convicted of, or had a civil judgment rendered against them from commission of fraud, or a criminal offence in connection with obtaining, attempting to obtain, or performing a public (federal, state, or local) transaction or grant under a public transaction; violation of federal or state antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification, or destruction of records, making false statements, or receiving stolen property;

c. are not presently indicted or otherwise criminally or civilly charged by a government entity (federal, state, or local) with commission of any of the offenses detailed in section b. of this certification; and

d. have not within a three (3) year period preceding this Contract had one or more public transactions (federal, state, or local) terminated for cause or default.

The Contractor shall provide immediate written notice to the State if at any time it learns that there was an earlier failure to disclose information or that due to changed circumstances, its principals or the principals of its subcontractors are excluded, disqualified, or presently fall under any of the prohibitions of sections a-d.

E.6. Federal Funding Accountability and Transparency Act (FFATA). This Contract requires the Contractor to provide supplies and/or services that are funded in whole or in part by federal funds that are subject to FFATA. The Contractor is responsible for ensuring that all applicable requirements, including but not limited to those set forth herein, of FFATA are met and that the Contractor provides information to the State as required.

The Contractor shall comply with the following:

a. Reporting of Total Compensation of the Contractor's Executives.

1) The Contractor shall report the names and total compensation of each of its five most highly compensated executives for the Contractor's preceding completed fiscal year, if in the Contractor's preceding fiscal year it received:

i. 80 percent or more of the Contractor's annual gross revenues from Federal procurement contracts and Federal financial assistance subject to the Transparency Act, as defined at 2 CFR 170.320 (and subawards); and

ii. $25,000,000 or more in annual gross revenues from Federal procurement contracts (and subcontracts), and Federal financial assistance subject to the Transparency Act (and subawards); and

iii. The public does not have access to information about the compensation of the executives through periodic reports filed under section 13(a) or 15(d) of the Securities Exchange Act of 1934 (15 U.S.C. 78m(a), 78o(d)) or section 6104 of the Internal Revenue Code of 1986. (To determine if the public has access to the compensation information, see the U.S. Security and Exchange Commission total compensation filings at http://www.sec.gov/answers/execomp.htm.).

Executive means officers, managing partners, or any other employees in management positions.

(2) Total compensation means the cash and noncash dollar value earned by the executive during the Contractor's preceding fiscal year and includes the following (for more information see 17 CFR 229.402(c)(2)):

i. Salary and bonus.

ii. Awards of stock, stock options, and stock appreciation rights. Use the dollar amount recognized for financial statement reporting purposes with respect to the fiscal year in accordance with the Statement of Financial Accounting Standards No. 123 (Revised 2004) (FAS 123R), Shared Based Payments.

iii. Earnings for services under non-equity incentive plans. This does not include group life, health, hospitalization or medical reimbursement plans that do not discriminate in favor of executives, and are available generally to all salaried employees.

iv. Change in pension value. This is the change in present value of defined benefit and actuarial pension plans.

v. Above-market earnings on deferred compensation which is not tax qualified.

vi. Other compensation, if the aggregate value of all such other compensation (e.g. severance, termination payments, value of life insurance paid on behalf of the employee, perquisites or property) for the executive exceeds $10,000.

b. The Contractor must report executive total compensation described above to the State by the end of the month during which this Contract is awarded.

c. If this Contract is amended to extend its term, the Contractor must submit an executive total compensation report to the State by the end of the month in which the amendment to this Contract becomes effective.

d. The Contractor will obtain a Data Universal Numbering System (DUNS) number and maintain its DUNS number for the term of this Contract. More information about obtaining a DUNS Number can be found at: http://fedgov.dnb.com/webform/

The Contractor's failure to comply with the above requirements is a material breach of this Contract for which the State may terminate this Contract for cause. The State will not be obligated to pay any outstanding invoice received from the Contractor unless and until the Contractor is in full compliance with the above requirements.

E.7. Subject to Funds Availability. The Contract is subject to the appropriation and availability of State and/or Federal funds. In the event that the funds are not appropriated or are otherwise unavailable, the State reserves the right to terminate the Contract upon written notice to the Contractor. Said termination shall not be deemed a breach of Contract by the State. Upon receipt of the written notice, the Contractor shall cease all work associated with the Contract. Should such an event occur, the Contractor shall be entitled to compensation for all satisfactory

and authorized services completed as of the termination date. Upon such termination, the Contractor shall have no right to recover from the State any actual, general, special, incidental, consequential, or any other damages whatsoever of any description or amount.

IN WITNESS WHEREOF, the parties have by their duly authorized representatives set their signatures.

METROPOLITAN GOVERNMENT OF NASHVILLE AND DAVIDSON COUNTY

DocuSigned by:
Gill C Wright III, MD
0460AC21E1CC408...

3/21/2022

Director, Metro Public Health Department — Date

DocuSigned by:
Tené Hamilton Franklin
BEBF0BBF14D14B0...

3/21/2022

Chair, Board of Health — Date

APPROVED AS TO AVAILABILITY OF FUNDS:

DocuSigned by:
Kelly Flannery/mjw
62377A2A8742469...

DS RW   DS TE

3/22/2022

Director, Department of Finance — Date

APPROVED AS TO RISK AND INSURANCE:

DocuSigned by:
Balogun Cobb
68804BF12FD741C...

3/23/2022

Director of Risk Management Services — Date

APPROVED AS TO FORM AND LEGALITY:

Matthew Garth

4/7/2022

Metropolitan Attorney — Date

FILED:

Metropolitan Clerk — Date

DEPARTMENT OF HEALTH:

Lisa Piercey, MD, MBA, FAAP
Commissioner — Date

DocuSign Envelope ID: 9D3A0A08-3C8F-414F-87E9-AA107EC0B222

State of Tennessee
Department of Health
Sudden Unexplained Child Death Investigation Report
For use in children aged 1 year and older

-Investigation Data-

Child's Information:

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

Contact Information for Witness:

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

-Witness Interview-

1. Tell me what happened:

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

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

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

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

7. Describe the child's appearance when found.

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

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

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

☐ Other, specify:

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

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

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

-Child Medical History-

1. Source of medical information:

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

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

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

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

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

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

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

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

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

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

8. Birth Hospital Name:					
Street Address:					
City:		State:		Zip code:	

-Incident Scene Investigation-

1. Where did the incident or death occur?

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

3. Is the site of the incident or death scene a daycare or other childcare setting? ☐ Yes ☐ No → Skip to question **8** below

4. How many children were under the care of the provider at the time of the incident or death? ____________ (Under 18 years old)

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

6. What is the license number and licensing agency for the daycare?

License Number:		Agency:	

7. How long has the daycare been open for business?

8. How many people live at the site of the incident or death scene?

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

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

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

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

-Investigation Summary-

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

2. Arrival times:

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

-Investigator's Notes-

Indicate the task(s) performed:

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

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

-Investigation Diagrams-

Scene Diagram:

Body Diagram:

Lead Death Investigator or Designee:

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

-Summary for Pathologist-

Case Information

Investigator Information:

Name:	Agency:	Phone:

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

Child Information:

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

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

Section	Yes	No	Item
Sleeping Environment	☐ Yes	☐ No	Asphyxia (ex. Wedging, choking, nose/mouth obstruction, neck compression, immersion in water)
	☐ Yes	☐ No	Hyperthermia/Hypothermia (ex. Hot or cold environments)
	☐ Yes	☐ No	Environmental hazards (ex. Carbon monoxide, noxious gases, chemicals, drugs, devices)
Child History	☐ Yes	☐ No	Recent hospitalization
	☐ Yes	☐ No	Previous medical diagnosis
	☐ Yes	☐ No	History of acute life-threatening events (ex. Apnea, seizures, difficulty breathing)
	☐ Yes	☐ No	History of medical care without diagnosis
	☐ Yes	☐ No	Recent fall or other injury
	☐ Yes	☐ No	History of religious, cultural, or ethnic remedies
	☐ Yes	☐ No	Cause of death due to natural causes other than SIDS (ex. Birth defects, complications of pre-term birth)
Family Info	☐ Yes	☐ No	Prior sibling deaths
	☐ Yes	☐ No	Previous encounters with police or social service agencies
	☐ Yes	☐ No	Request for tissue or organ donation
	☐ Yes	☐ No	Objection to autopsy
Exam	☐ Yes	☐ No	Pre-terminal resuscitative treatment
	☐ Yes	☐ No	Death due to trauma (injury), poisoning, or intoxication

Investigator Insight

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

Pathologist

2. Pathologist Information:

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

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Sudden Unexpected Infant Death Investigation
Reporting Form

For use during the investigation of infant (under 1 year of age) deaths that are sudden, unexpected, and unexplained prior to investigation.

INFANT DEMOGRAPHICS

1. **Infant information.** Full name: ______________________ Date of birth: *(mm/dd/yyyy)* __________

   Age: __________ SS#: __________ Case number: ______________________

   Primary residence address: ______________________________________

   City: ______________________ State: ______________ Zip: __________

2. Race: ◯ White ◯ Black/African Am. ◯ Asian/Pacific Islander ◯ Am. Indian/Alaskan Native ◯ Hispanic/Latino ◯ Other
3. Sex: ◯ Male ◯ Female

PREGNANCY HISTORY

1. **Birth mother information.** ☐ Unavailable Full name: ______________________

   Maiden name: ______________________ Date of birth: *(mm/dd/yyyy)* __________ SS#: __________

   Current address: ______________________________________

   ☐ Same as infant's primary residence address above City: ______________________

   State: ______________ Zip: __________ Email address: ______________________

2. How long has the birth mother been at this address? Years: _____ Months: _____ Days: _____
3. Previous address(es) *(cities/counties/states)* in the past 5 years:

   ____

4. Did the birth mother receive prenatal care? ◯ Yes ◯ No ◯ Unknown

   If yes: At how many weeks or months did prenatal care begin? _____ Weeks _____ Months

   How many prenatal care visits were completed? __________

5. Where did the birth mother receive prenatal care? Physician/Provider: ______________________

   Hospital or Clinic: ______________________ Phone: __________

   Address: ______________________________________

   City: ______________________ State: ______________ Zip: __________

6. Did the birth mother have any complications, medical conditions, or injuries during her pregnancy? ◯ Yes ◯ No ◯ Unknown
   (e.g., high blood pressure, bleeding, gestational diabetes, fall, or accident)

   If yes, describe:

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7. During her pregnancy, did the birth mother use any of the following?

Substance	Use	Specify Type	Frequency
Over the counter medications	◯ Yes ◯ No ◯ Unknown		
Prescribed medications	◯ Yes ◯ No ◯ Unknown		
Herbal remedies	◯ Yes ◯ No ◯ Unknown		
Alcohol	◯ Yes ◯ No ◯ Unknown		
Illicit drugs *(e.g., heroin)*	◯ Yes ◯ No ◯ Unknown		
Tobacco *(e.g., cigarettes or e-cigarettes)*	◯ Yes ◯ No ◯ Unknown		
Other	◯ Yes ◯ No ◯ Unknown		

INFANT HISTORY

1. Source of infant medical history information. *(check all that apply)*

   ☐ Doctor ☐ Other health care provider ☐ Medical record ☐ Parent or primary caregiver ☐ Other family member

   ☐ Other, specify: ____________________

2. Were there any complications during delivery or at birth? *(e.g., emergency C-section, or infant needed oxygen)*

   ◯ Yes ◯ No ◯ Unknown *If yes*, describe: ____________________

3. Did the infant have abnormal newborn screening results? ◯ Yes ◯ No ◯ Unknown

   If yes, describe: ____________________

4. Infant's length at birth: ______ ◯ IN ◯ CM

5. Infant's weight at birth: ______ ◯ LBS and OZ ◯ GM

6. Compared to the due date, when was the infant born?

   ◯ Early *(before 37 weeks)* ◯ Late *(after 41 weeks)* ◯ On time How many weeks? ____ Infant's due date: *(mm/dd/yyyy)* __________

7. Was the infant a singleton or multiple birth? ◯ Singleton ◯ Twin ◯ Triplet ◯ Quadruplet or higher

8. Was the infant born with Neonatal Abstinence Syndrome (NAS)? *(NAS is a drug withdrawal syndrome in newborns exposed to substances, like opioids, before birth)* ◯ Yes ◯ No ◯ Unknown

   If yes, did the infant need pharmacologic treatment? ◯ Yes ◯ No ◯ Unknown

9. Fill out the contact information for the infant's regular pediatrician and birth hospital.

Item	Regular Pediatrician	Birth Hospital
Date	*Of last visit:* __________	*Of discharge:* __________
Name of hospital or clinic		
Address		
Phone number		

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10. **Describe the two most recent times the infant was seen by a health care provider.**
(include ER and clinic visits, hospital admissions, observational stays, regular pediatrician, and phone calls)

Visit type	1st most recent visit	2nd most recent visit
Reason for visit		
Action taken		
Date		
Physician's name		
Hospital or clinic		
Address		
Phone number		

11. **Did the infant have any of the following?**

Symptom	Within 72 hrs of incident
Fever	◯ Yes ◯ No ◯ Unknown
Cough	◯ Yes ◯ No ◯ Unknown
Diarrhea	◯ Yes ◯ No ◯ Unknown
Excessive sweating	◯ Yes ◯ No ◯ Unknown
Stool changes	◯ Yes ◯ No ◯ Unknown
Lethargy or sleeping more than usual	◯ Yes ◯ No ◯ Unknown
Difficulty breathing	◯ Yes ◯ No ◯ Unknown
Fussiness or excessive crying	◯ Yes ◯ No ◯ Unknown
Exposure to anyone who was sick *(e.g., at home or at daycare)*	◯ Yes ◯ No ◯ Unknown
Decrease in appetite	◯ Yes ◯ No ◯ Unknown
Falls or injuries	◯ Yes ◯ No ◯ Unknown
Other, specify: ____________________	◯ Yes ◯ No ◯ Unknown

Symptom	Within 72 hrs of incident	At any time
Allergies or allergic reactions *(food, medication, or other)*	◯ Yes ◯ No ◯ Unknown	◯ Yes ◯ No ◯ Unknown
Abnormal growth, weight gain, or weight loss	◯ Yes ◯ No ◯ Unknown	◯ Yes ◯ No ◯ Unknown
Apnea *(stopped breathing)*	◯ Yes ◯ No ◯ Unknown	◯ Yes ◯ No ◯ Unknown
Cyanosis *(turned blue or gray)*	◯ Yes ◯ No ◯ Unknown	◯ Yes ◯ No ◯ Unknown
Seizures or convulsions	◯ Yes ◯ No ◯ Unknown	◯ Yes ◯ No ◯ Unknown
Cardiac *(heart)* abnormalities	◯ Yes ◯ No ◯ Unknown	◯ Yes ◯ No ◯ Unknown
Colic *(frequent prolonged crying/chronic inconsolable fussiness)*	◯ Yes ◯ No ◯ Unknown	◯ Yes ◯ No ◯ Unknown
Feeding issues *(e.g., reflux)*	◯ Yes ◯ No ◯ Unknown	◯ Yes ◯ No ◯ Unknown
Vomiting	◯ Yes ◯ No ◯ Unknown	◯ Yes ◯ No ◯ Unknown
Choking	◯ Yes ◯ No ◯ Unknown	◯ Yes ◯ No ◯ Unknown
Other, specify: ____________________	◯ Yes ◯ No ◯ Unknown	◯ Yes ◯ No ◯ Unknown

If yes to any of the above, describe:

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12. Infant exposed to second hand smoke? *(environmental tobacco smoke)* ◯ Yes ◯ No ◯ Unknown

    If yes, how often? ◯ Frequently *(several times a week)* ◯ Occasionally *(several times a month)* ◯ Unknown

13. In the 72 hours before death, was the infant given any vaccinations or medications? *(include any home remedies, herbal medications, prescription medications, over-the-counter medications)*

Vaccine or medication name	Dose last given	Date given *(mm/dd/yy)*	Approx. time given	Reasons given or comments

14. Was the infant last placed to sleep with a bottle? ◯ Yes ◯ No ◯ Unknown

    If yes, was the bottle propped? *(object used to hold bottle while infant feeds)* ◯ Yes ◯ No ◯ Unknown

    If yes: What object propped the bottle? ____________________

    Could the infant hold the bottle? ◯ Yes ◯ No ◯ Unknown

15. Who was the last person to feed the infant? *(name and familial relationship to infant)*

    ____

16. Did the death occur during feeding? ◯ Breastfeeding ◯ Bottle-feeding ◯ Eating solids ◯ Not during feeding

17. Was the infant ever breastfed? ◯ Yes ◯ No ◯ Unknown *If yes*, for how many months? _______

18. What did the infant consume in the 24 hours prior to death?

Consumed?	If yes, describe	If yes, newly introduced?	If yes, was this the last thing consumed prior to incident?	If last fed, indicate quantity	If last fed, indicate date and time?
☐ Breastmilk		◯ Yes ◯ No ◯ Unknown	◯ Yes ◯ No		
☐ Formula		◯ Yes ◯ No ◯ Unknown	◯ Yes ◯ No		
☐ Water		◯ Yes ◯ No ◯ Unknown	◯ Yes ◯ No		
☐ Other liquids		◯ Yes ◯ No ◯ Unknown	◯ Yes ◯ No		
☐ Solids		◯ Yes ◯ No ◯ Unknown	◯ Yes ◯ No		
☐ Other		◯ Yes ◯ No ◯ Unknown	◯ Yes ◯ No		

19. Among the infant's blood relatives *(siblings, parents, grandparents, aunts, uncles, or first cousins)* was there any...

    Sudden or unexpected death before the age of 50? ◯ Yes ◯ No ◯ Unknown

    Heart disease? *(e.g., cardiomyopathy, Marfan or Brugada syndrome, long or short QT syndrome, or catecholaminergic polymorphic ventricular tachycardia)* ◯ Yes ◯ No ◯ Unknown

    If yes to either, describe: *(include relation to infant)* ____________________

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20. Did the infant have any birth defect(s)? ◯ Yes ◯ No ◯ Unknown

If yes, describe: ______________________________

21. Was the infant able to roll over on his or her own? *(check all that apply)* ☐ Front to back ☐ Back to front

22. Indicate the infant's ability to lift or hold his or her head up. ◯ Unable ◯ 1 second ◯ 5 seconds ◯ ≥10 seconds ◯ Unknown

23. Was the infant meeting or not meeting growth and developmental milestones? *(e.g., sitting up, crawling, rolling over, or feeding well. Include if the caregiver, supervisor, or medical professional had any concerns.)*

24. Is there anything else that may have affected the infant that has not yet been documented? *(e.g., exposed to fumes, infant unusually heavy, placed with positional support or wedge, or international travel)*

INCIDENT SCENE INVESTIGATION

1. Incident scene *(place infant found unresponsive or dead).* Type of location? *(e.g., primary residence, daycare, or grandmother's house)*

____

Address: ______________________________ City: ______________________________

State: ______________________________ Zip: ______________

2. Was the infant in a new or different environment? *(not part of the infant's normal routine)* ◯ Yes ◯ No ◯ Unknown

If yes, describe: ______________________________

3. Did the death occur at a daycare? ◯ Yes ◯ No ◯ Unknown

If yes: How many children younger than 18 years of age were under the care of the provider at the time of the incident? *(including their own children)* ______

How many adults aged 18 years or older were supervising the child(ren)? ______

How long has the daycare been open for business? ______________________________

Is the daycare licensed? ◯ Yes ◯ No ◯ Unknown

If yes: **License number?** ______________ **Licensing agency?** ______________________________

4. How many people live at the incident scene? **Children** *(younger than 18 years)* ______ **Adults** *(18 years or older)* ______

5. What kind of heating or cooling sources were being used at the incident scene? *(e.g., A/C window unit, wood-burning fireplace, or open window)*

____

6. Was there a working carbon monoxide (CO) alarm at the incident scene? ◯ Yes ◯ No ◯ Unknown

7. Indicate the temperature of the room where the infant was found unresponsive, and the surrounding area. *(fill in temperatures)*

Thermostat setting: ______ Thermostat reading: ______ Incident room: ______ Outside: ______ Time of reading: ______________

8. Which of these devices were operating in the room where the infant was found unresponsive? *(check all that apply)*

☐ Fan ☐ Apnea monitor ☐ Humidifier ☐ Vaporizer ☐ Air purifier ☐ None ☐ Unknown

☐ Other, specify: ______________________________

9. What was the source of drinking water at the incident scene? *(check all that apply)*

☐ Public or municipal water ☐ Bottled water ☐ Well water ☐ Unknown

☐ Other, specify: ______________________________

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10. Which of the following were present at the incident scene? *(check all that apply)*

☐ Insects ☐ Mold growth ☐ Smokey smell ☐ Pets ☐ Dampness ☐ Peeling paint ☐ Visible standing water

☐ Presence of alcohol containers ☐ Rodents or vermin ☐ None

☐ Odors or fumes, describe: ______

☐ Presence of prescription drugs, describe: ______

☐ Presence of illicit drugs or drug paraphernalia, describe: ______

☐ Other, describe: ______

11. Describe the general appearance of incident scene. *(e.g., cleanliness, hazards, or overcrowding)*

12. Is there anything else that may have affected the infant that has not yet been documented? *(e.g., drug or alcohol use at scene, history of domestic violence, or child abuse or neglect)*

INCIDENT CIRCUMSTANCES

1. Who was the usual caregiver(s)? *(name(s) and familial relationship to infant)* ______

2. Who was the caregiver(s) at the time of the incident? *(name(s) and familial relationship to infant)*

______

3. Who found the infant unresponsive? *(If caregiver is same as birth mother Skip question #3)*

Full name: ______

Address: ______ City: ______

State: ______ Zip: ______ Date of birth: ______

Email address: ______ Phone number: ______

Work address: ______

Familial relationship to infant? *(e.g., birth mother, grandfather, or adoptive or foster parent)*

______

4. Describe what happened. *(include details about how the infant was found)*

5. Was there anything different about the infant in the last 24 hours? ◯ Yes ◯ No ◯ Unknown

If yes, describe:

6. What was the temperature in the incident room? ◯ Hot ◯ Cold ◯ Normal ◯ Other

7. Was there a crib, bassinet, or portable crib at the place of incidence? ◯ Yes ◯ No ◯ Unknown

If yes, was it in good or usable condition? *(e.g., not broken or not full of laundry)* ◯ Yes ◯ No ◯ Unknown

If no, explain:

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8. Where was the infant (P)laced before death, (L)ast known alive, (F)ound, and (U)sually placed? *(write P, L, F, or U, leave blank if none)*

_____ Crib _____ Portable Crib _____ Waterbed _____ Stroller _____ Playpen/play area *(not portable crib)*

_____ Bassinet _____ Sofa/couch _____ Swing _____ Futon _____ Bouncy chair

_____ Bedside sleeper _____ Chair _____ Baby box _____ Floor _____ Rocking sleeper

_____ Car seat _____ Unknown _____ Held in person's arms _____ In-bed sleeper

_____ Other, specify: _______________

_____ Adult bed — *If yes*, what type? ◯ Twin ◯ Full ◯ Queen ◯ King ◯ Unknown

◯ Other, specify: _______________

9. Describe the condition and firmness of the surface where the infant was found.

____

10. Was the infant wrapped or swaddled? ◯ Yes ◯ No ◯ Unknown

If yes: Describe the arm position. ◯ Arms free and out ◯ Arms in ◯ One arm in and one arm out

Describe swaddle. *(include blanket type and tightness)* _______________

11. What was the infant wearing? *(e.g., t-shirt or disposable diaper)* _______________

12. What was the infant's usual sleep position? ◯ Sitting ◯ Back ◯ Stomach ◯ Side ◯ Unknown

13. Describe the circumstances of infant when last placed by caregiver, last known alive, and found.

	Placed	Last known alive	Found
Date			
Time			
Location *(e.g., living room or bedroom)*			
Position *(e.g., sitting, back, stomach, side, or unknown)*			
Face position *(e.g., down, up, left, right, or unknown)*			
Neck position *(e.g., hyperextended or head back, hyperextended or chin to chest, neutral, or turned)*			

14. Was the infant's airway obstructed by a person or object when found? *(includes obstruction of the mouth or nose, or compression of the neck or chest)*

◯ Unobstructed ◯ Fully obstructed ◯ Partially obstructed ◯ Unknown

If fully or partially, what was obstructed or compressed? *(check all that apply)* ☐ Nose ☐ Mouth ☐ Chest ☐ Neck

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15. Indicate the items present in the sleep environment and their positional relation to the infant when the infant was found.

Item	Present?	If yes, position in relation to infant?	If yes, did object obstruct the infant's mouth, nose, chest, or neck?
Adult(s) *(18 years or older)*	◯ Yes ◯ No ◯ Unknown	◯ Over ◯ Under ◯ Next to ◯ Unknown	◯ Yes ◯ No ◯ Unknown
Other child(ren) *(younger than 18 years)*	◯ Yes ◯ No ◯ Unknown	◯ Over ◯ Under ◯ Next to ◯ Unknown	◯ Yes ◯ No ◯ Unknown
Animal(s)	◯ Yes ◯ No ◯ Unknown	◯ Over ◯ Under ◯ Next to ◯ Unknown	◯ Yes ◯ No ◯ Unknown
Mattress	◯ Yes ◯ No ◯ Unknown	◯ Over ◯ Under ◯ Next to ◯ Unknown	◯ Yes ◯ No ◯ Unknown
Comforter, quilt or other	◯ Yes ◯ No ◯ Unknown	◯ Over ◯ Under ◯ Next to ◯ Unknown	◯ Yes ◯ No ◯ Unknown
Fitted sheet	◯ Yes ◯ No ◯ Unknown	◯ Over ◯ Under ◯ Next to ◯ Unknown	◯ Yes ◯ No ◯ Unknown
Thin blanket	◯ Yes ◯ No ◯ Unknown	◯ Over ◯ Under ◯ Next to ◯ Unknown	◯ Yes ◯ No ◯ Unknown
Pillow(s)	◯ Yes ◯ No ◯ Unknown	◯ Over ◯ Under ◯ Next to ◯ Unknown	◯ Yes ◯ No ◯ Unknown
Cushion	◯ Yes ◯ No ◯ Unknown	◯ Over ◯ Under ◯ Next to ◯ Unknown	◯ Yes ◯ No ◯ Unknown
Nursing or u-shaped pillow	◯ Yes ◯ No ◯ Unknown	◯ Over ◯ Under ◯ Next to ◯ Unknown	◯ Yes ◯ No ◯ Unknown
Sleep positioner *(wedge)*	◯ Yes ◯ No ◯ Unknown	◯ Over ◯ Under ◯ Next to ◯ Unknown	◯ Yes ◯ No ◯ Unknown
Bumper pads	◯ Yes ◯ No ◯ Unknown	◯ Over ◯ Under ◯ Next to ◯ Unknown	◯ Yes ◯ No ◯ Unknown
Clothing *(not on a person)*	◯ Yes ◯ No ◯ Unknown	◯ Over ◯ Under ◯ Next to ◯ Unknown	◯ Yes ◯ No ◯ Unknown
Crib railing or side	◯ Yes ◯ No ◯ Unknown	◯ Over ◯ Under ◯ Next to ◯ Unknown	◯ Yes ◯ No ◯ Unknown
Wall	◯ Yes ◯ No ◯ Unknown	◯ Over ◯ Under ◯ Next to ◯ Unknown	◯ Yes ◯ No ◯ Unknown
Toy(s)	◯ Yes ◯ No ◯ Unknown	◯ Over ◯ Under ◯ Next to ◯ Unknown	◯ Yes ◯ No ◯ Unknown
Other, specify: ______________	◯ Yes ◯ No ◯ Unknown	◯ Over ◯ Under ◯ Next to ◯ Unknown	◯ Yes ◯ No ◯ Unknown

If yes to adult(s) or child(ren) sharing sleep surface with the infant, complete table below. ☐ NA

Name of individual(s) sharing sleep surface with infant	Relationship to infant	Age	Height	Weight	Impaired by drugs or alcohol?	Fell asleep feeding infant?
					◯ Yes ◯ No ◯ Unknown	◯ Yes ◯ No ◯ Unknown
					◯ Yes ◯ No ◯ Unknown	◯ Yes ◯ No ◯ Unknown
					◯ Yes ◯ No ◯ Unknown	◯ Yes ◯ No ◯ Unknown

If yes to impaired, describe: ______________________________

16. Were there any secretions present at the scene? ◯ Yes ◯ No ◯ Unknown

If yes, describe: *(include where they were found)*

____

17. Was there evidence of wedging? *(wedging is an obstruction of the nose or mouth, or compression of the neck or chest as a result of being stuck or trapped between inanimate objects)* ◯ Yes ◯ No ◯ Unknown

If yes, describe: ______________________________

18. Was there evidence of overlay? *(overlay is an obstruction of the nose or mouth, or compression of the neck or chest as a result of a person rolling on top of or against an infant)* ◯ Yes ◯ No ◯ Unknown

If yes, describe: ______________________________

19. Was the infant breathing when found? ◯ Yes ◯ No ◯ Unknown

If no, did anyone witness the infant stop breathing? ◯ Yes ◯ No ◯ Unknown

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20. Describe the infant's appearance when found. *(indicate all that apply)*

Appearance	Present?	Describe and specify location
Discoloration around face, nose, or mouth	◯ Yes ◯ No ◯ Unknown	
Secretions or fluids *(e.g., foam, froth, or urine)*	◯ Yes ◯ No ◯ Unknown	
Skin discoloration *(e.g., livor mortis, pale areas, darkness, or color changes)*	◯ Yes ◯ No ◯ Unknown	
Pressure marks *(e.g., pale areas, or blanching)*	◯ Yes ◯ No ◯ Unknown	
Rash or petechiae *(e.g., small, red blood spots on skin, membrane, or eyes)*	◯ Yes ◯ No ◯ Unknown	
Marks on body *(e.g., scratches or bruises)*	◯ Yes ◯ No ◯ Unknown	
Other: ____________	◯ Yes ◯ No ◯ Unknown	

21. 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, specify: ____________

22. Did EMS respond? ◯ Yes ◯ No ◯ Unknown
If yes, was the infant transported? ◯ Yes ◯ No ◯ Unknown

23. Was resuscitation attempted? ◯ Yes ◯ No ◯ Unknown
If yes: By whom? *(e.g., EMS, bystander, or parent)* ____________

Date: *(mm/dd/yyyy)* ________ Time: ________

Was rescue breathing done? ◯ Yes ◯ No ◯ Unknown

Type of compression? *(check all that apply)*
☐ Two finger ☐ One hand ☐ Two hands

The following questions refer to the caregiver(s) at the time of death.

24. Has the caregiver ever had a child under their care die suddenly and unexpectedly? ◯ Yes ◯ No ◯ Unknown
If yes, explain: *(include familial relationship of child and infant, and cause of death)*

____

25. Were the infant and caregiver in the *same room* at the time of the incident, but not sharing the same sleep surface?
◯ Yes ◯ No ◯ Unknown ◯ N/A - sharing a sleep surface

26. Was the infant's caregiver using any of the following during the incident? *(indicate all that apply)*

Substance	Caregiver used?	Frequency
Over the counter medications	◯ Yes ◯ No ◯ Unknown	
Prescription medications	◯ Yes ◯ No ◯ Unknown	
Opioids	◯ Yes ◯ No ◯ Unknown	
Tobacco, specify: *(e.g., cigarettes or e-cigarettes)* ____________	◯ Yes ◯ No ◯ Unknown	
Alcohol	◯ Yes ◯ No ◯ Unknown	
Herbal remedies	◯ Yes ◯ No ◯ Unknown	
Other, specify: ____________	◯ Yes ◯ No ◯ Unknown	

Was the infant's caregiver asked to consent to blood or urine for drug/alcohol testing? ◯ Yes ◯ No ◯ Unknown

If yes, what were the results? ____________

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1. Arrival dates and times.

Person(s) involved	Hospital	Incident scene
Infant		N/A
Law enforcement		
Death investigator		

2. Agencies conducting an investigation? *(check all that apply)* ☐ Child protective services
   ☐ Death investigator from medical examiner or coroner office ☐ Law enforcement, specify: ____________
   ☐ Other, specify: ____________

3. Indicate when the form was completed. Date: *(mm/dd/yyyy)* ________ Time: ________

4. If more than one person was interviewed, does the information provided differ? ◯ Yes ◯ No ◯ N/A
   If yes, detail any differences or inconsistencies of relevant information. *(e.g., placed on sofa or last known alive on chair)*
   ____

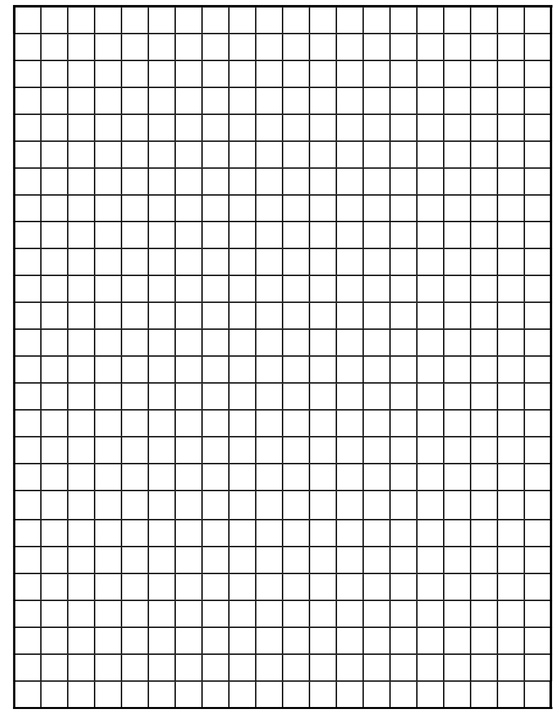
5. Indicate the task(s) performed. *(check all that apply)* ☐ Additional scene(s) *(forms attached)* conducted ☐ Photos or video taken
   ☐ Materials collected or evidence logged ☐ Next of kin notified ☐ 911 tape obtained ☐ EMS run sheet or report obtained
   ☐ Witness(es)/caregiver(s) interviewed

6. Was the family offered grief counseling services? ◯ Yes ◯ No ◯ Unknown

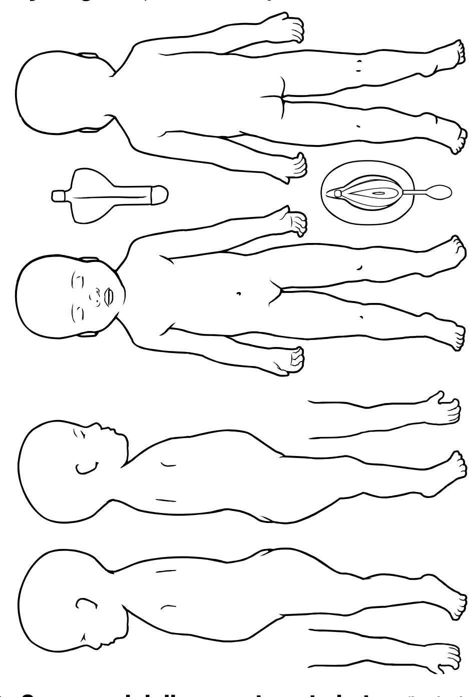
7. Was a doll scene reenactment performed? ◯ Yes ◯ No ◯ Unknown
   If no, why? ____________
   If yes: How was it documented? *(check all that apply)* ☐ Photographed ☐ Videoed ☐ Other, specify: ____________
   Where was it performed? ◯ Incident scene ◯ Hospital ◯ Other, specify: ____________
   Indicate when the doll reenactment was performed. Date performed: *(mm/dd/yyyy)* ________ Time performed: ________
   Were photos provided to the pathologist? ◯ Yes ◯ No ◯ Unknown
   Do the scenarios given during the doll reenactment(s) match what was seen during the preliminary investigation?
   ◯ Yes ◯ No ◯ N/A

INVESTIGATION DIAGRAMS

1. **Scene diagram** *(illustrate the infant's sleep environment)*



2. **Body diagram** *(note visible injuries, livor mortis, or rigor mortis)*



3. **Scene and doll reenactment photos** *(include with form)*

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1. **Investigator information.** Name: ____________ Agency: ____________

   Phone: ____________ Email address: ____________

2. Indicate when the investigation took place. Date: *mm/dd/yyyy)* ________ Time: ________

3. Indicate when the infant was pronounced dead. Date: *(mm/dd/yyyy)* ________ Time: ________

4. Indicate when it is estimated the infant died. Date: *(mm/dd/yyyy)* ________ Time: ________

5. Location of death: *(e.g., home or hospital)* ____________

6. Data sources consulted to complete this form. *(check all that apply)* ☐ Infant medical records ☐ Birth records ☐ Prenatal records
   ☐ Witness interview ☐ Photos/videos from caregivers demonstrating injuries, developmental milestone, or medical concerns
   ☐ Other, specify: ____________

7. Indicate whether preliminary investigation suggests any of the following. *(indicate all that apply)*

Sleeping Environment	Yes	No
Asphyxia *(e.g., evidence of overlying, wedging, choking, nose or mouth obstruction, re-breathing, neck or chest compression, or immersion in water)*	○	○
Sharing of sleep surface with adults, children, or pets	○	○
Change in sleep condition *(e.g., unaccustomed stomach sleep position, location, or sleep surface)*	○	○
Hyperthermia or hypothermia *(e.g., excessive wrapping, blankets, clothing, or hot or cold environments)*	○	○
Environmental hazards *(e.g., carbon monoxide, noxious gases, chemicals, drugs, or devices)*	○	○
Unsafe sleep condition *(e.g., non-supine, couch, adult bed, stuffed toys, pillows, or soft bedding)*	○	○

Infant History	Yes	No
Diet *(e.g., solids introduced)*	○	○
Recent hospitalization	○	○
Previous medical diagnosis	○	○
History of acute life threatening events *(e.g., apnea, seizures, or difficulty breathing)*	○	○
History of medical care without diagnosis	○	○
Recent fall or other injury	○	○
History of religious, cultural or alternative remedies	○	○
Cause of death due to natural causes other than SIDS *(e.g., birth defects or complications of preterm birth)*	○	○

Family Information	Yes	No
Prior sibling deaths	○	○
Sudden or unexpected death before the age of 50 or heart disease (*e.g., cardiomyopathy, Marfan or Brugada syndrome, long or short QT syndrome, catecholaminergic polymorphic ventricular tachycardia*) among the infant's blood relatives (*e.g., siblings, parents, grandparents, aunts, uncles, or first cousins*)	○	○
Previous encounters with police or social service agencies	○	○
Request for tissue or organ donation	○	○
Objection to autopsy	○	○

Exam	Yes	No
Preterminal resuscitative treatment	○	○
Signs of trauma or injury, poisoning, or intoxication	○	○

Other	Yes	No
Suspicious circumstances	○	○
Other alerts for pathologist's attention	○	○

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***If yes to any of the above*, explain in detail:** *(description of circumstances)*

8. Medical examiner or pathologist information.

Name: ______________________________

Agency: ______________________________

Phone: __________ Fax: __________ Email address: ______________________________

Visit https://www.cdc.gov/sids/SUIDRF.htm for Additional Investigative Scene Forms of Body Diagram, EMS Interview, Hospital Interview, Immunization Record, Infant Exposure History, Informant Contact, Law Enforcement Interview, Materials Collection Log, Non Professional Responder Interview, Parental Information, Primary Residence Investigation, and Scene Diagram.