

**SUDDEN UNEXPECTED EARLY NEONATAL DEATH OR COLLAPSE IN PREVIOUSLY HEALTHY TERM INFANTS IN THE FIRST 7 DAYS OF LIFE****Australian Paediatric Surveillance Unit**Please contact the APSU (02) 98453005; [apsu@chw.edu.au](mailto:apsu@chw.edu.au) if you have any questions about this form.

Please keep a record of the child's unit number in your APSU folder

*Instructions: Please answer each question by ticking the appropriate box or writing your response in the space provided. DK=Don't Know***REPORTING CLINICIANS DETAILS** 1. APSU Dr Code/Name: /\_\_\_\_\_ 2. Month/Year of Report: /3. Date questionnaire completed: //**PATIENT DETAILS** 4. First 2 letters of first name:  5. First 2 letters of surname:  6. Postcode of family: 7. Date of Birth: // 8. Time of birth \_\_\_\_\_ 9. Sex: M F

10. Parents birth country: Mother \_\_\_\_\_ Father \_\_\_\_\_

**If this patient is primarily cared for by another physician who you believe will report the case, please complete the questionnaire details above this line and return to APSU. Please keep the patient's name and other details in your records. If no other report is received for this child we will contact you for information requested in the remainder of the questionnaire.***The primary clinician caring for this child is: Name:* \_\_\_\_\_*Hospital:* \_\_\_\_\_11. History obtained from: Mother Father Midwife Other, specify: \_\_\_\_\_12. Parents work as health care providers: Mother: Y N DK Father: Y N DK13. Infant's ethnicity: Aboriginal Torres Strait Islander Both Aboriginal and Torres Strait Islander Caucasian Asian  
Pacific Islander Middle Eastern African Other, specify: \_\_\_\_\_14. Date of collapse? // Time: \_\_\_\_\_15. Was infant discharged from hospital prior to collapse/death: Y N If YES, date of discharge: //**LABOUR AND BIRTH**16. Gestation Weeks Days 17. Gestation determined according to: Ultrasound < 20 weeks LMP18. Birth Weight g DK 19. Length cm DK 20. Head circumference cm DK21. Multiple gestation: Y N DK If YES, Details: Twins Triplets Quadruplets Other: \_\_\_\_\_22. Place of birth: Labour ward Operating theatre Birth Centre Home

23. If not at home, please provide the name of facility: \_\_\_\_\_ 24. State: \_\_\_\_\_

25. Mode of delivery: Vaginal Vaginal Breech Ventouse Forceps Caesarean26. Was the onset of labour: Spontaneous Induced No Labour27. Fever in labour? Y N DK If yes, specify maximum temperature \_\_\_\_\_28. Vaginal swab last trimester? Y N DK If yes, specify result \_\_\_\_\_29. Analgesia during labour? Y N DK If YES, please specify:Epidural, Specify drug used: \_\_\_\_\_ Spinal, specify drug used: \_\_\_\_\_Opiates? Y N If YES, Oral IMI Date and time of last dose prior to delivery \_\_\_\_\_General anaesthesia Benzodiazepines Other, specify: \_\_\_\_\_30. Meconium stained liquor: Y N DK 31. Apgar scores: 1 min: \_\_\_\_\_ DK; 5 min: \_\_\_\_\_ DK; 10 min: \_\_\_\_\_ DK32. Arterial cord gas: pH: \_\_\_\_\_ Base deficit: \_\_\_\_\_ Lactate: \_\_\_\_\_ Not Done DK33. Resuscitation required at birth: Y N DK If YES, which of the following: Oxygen Bag and mask Intubation CPR34. Feeding: Breast Formula Combination35. Congenital anomalies: Y N DK If YES, details: \_\_\_\_\_36. Blood sugar monitoring: Y N DK If YES, reason for monitoring (eg. SGA, IDDM): \_\_\_\_\_**ANTENATAL/POSTNATAL DETAILS AND PARENTAL HISTORY**37. Age of Mother:  38. Primigravida: Y N If No, how many live births ≥ 20 weeks gestation for this woman: \_\_\_\_\_39. Maternal Antenatal Care: Hospital Midwife clinic GP Other: \_\_\_\_\_ No Antenatal Care DK40. Gestation at beginning of antenatal care: \_\_\_\_\_ weeks DK41. Maternal chronic medical conditions: Y N DK If YES, specify: \_\_\_\_\_42. History of previous pregnancy resulting in: Stillbirth: Number: \_\_\_\_\_ Neonatal death: Number: \_\_\_\_\_ Sudden collapse: Number: \_\_\_\_\_

43. Maternal complications during pregnancy: Hypertension:  Y  N  DK Diabetes:  Y  N  DK

IF yes  type 1  type 2  Gestational Diabetes  Other complications, If Yes please specify \_\_\_\_\_

44. Maternal Infertility  Y  N  DK; If YES, Medications inducing ovulation?  IVF?

45. Does the father smoke?:  Y  N  DK If YES, number per day: \_\_\_\_\_  DK

46. Significant Family History? (i.e. consanguinity, genetic conditions):  Y  N  DK If YES, please specify \_\_\_\_\_

### PRESENTATION AND DIAGNOSIS

47. Who found the baby?  Mother  Father  Midwife  Other – please specify: \_\_\_\_\_

48. Who was in the room at the time of death or collapse?  Mother  Father  Medical or Nursing Staff

Other – please specify: \_\_\_\_\_

49. Where did the collapse occur:  Postnatal ward  Delivery suite  Nursery  Home  Other, please specify: \_\_\_\_\_

50. Position infant was last placed:  Prone  Supine  Left Lateral  Right Lateral  DK

51. Place found:  Cot  Carer's chest  Carer's abdomen

In bed with another person sharing/co-sleeping; Provide details: \_\_\_\_\_

Other, please specify: \_\_\_\_\_  DK

52. Maternal Position at time of infant collapse, if co-sleeping :  Supine  Sitting  Lateral position  Other  DK

53. Position infant when found:  Right lateral  Left lateral  Supine  Prone  DK

54. Was the infant using a dummy at the time of collapse? :  Y  N  DK

55. Temperature of room:  Warm  Cool  Normal  DK

56. Date and time of last observation/check before being found: Date:  /  /  Time: \_\_\_\_\_  DK

57. At last check was baby thought to be:  Feeding  Awake, but not feeding  Asleep

58. Last observations: RR: \_\_\_\_\_  DK PR: \_\_\_\_\_  DK BP: \_\_\_\_\_  DK Temp: \_\_\_\_\_ C  DK

59. Did the infant have an acute illness in the last 24 hours prior to collapse  Y  N  DK if YES, please provide details: \_\_\_\_\_

60. In the 24 hours prior to the collapse, were any of the following noted:  Fever  Poor Feeding  Sweating  Lethargy

Vomiting  Difficulty breathing  Excessive crying  Apnoea  Cyanosis  Other, please specify: \_\_\_\_\_

61. History of trauma/fall in 24 hours prior to collapse:  Y  N  DK If YES, please specify: \_\_\_\_\_

62. Date and time of last feed: Date:  /  /  Time: \_\_\_\_\_  DK  Bottle  Breast  Both

63. Who last fed the infant:  Mother  Father  Midwife  Other – please specify: \_\_\_\_\_  DK

64. Details of last maternal medications, including analgesia:

Date  /  /  - Time \_\_\_\_\_ Name: \_\_\_\_\_ Dose: \_\_\_\_\_

Date  /  /  - Time \_\_\_\_\_ Name: \_\_\_\_\_ Dose: \_\_\_\_\_

Date  /  /  - Time \_\_\_\_\_ Name: \_\_\_\_\_ Dose: \_\_\_\_\_

### MANAGEMENT AT TIME OF COLLAPSE

65. Was the baby dead on arrival  Y  N *If YES, go to Q 92*

66. What did the baby feel like when found:  warm  cool  stiff  limp

67. Condition when found: RR: \_\_\_\_\_  DK PR: \_\_\_\_\_  DK BP: \_\_\_\_\_  DK T: \_\_\_\_\_  DK Sats (SaO<sub>2</sub>) \_\_\_\_\_  DK

68. Initial Resuscitation:  Suction  Oxygen  Intubation  CPR  Adrenaline  Naloxone  None  DK

69. Resuscitation details: Time to heart rate > 80 \_\_\_\_\_ Time to spontaneous respirations: \_\_\_\_\_

70. Post collapse intial venous/arterial/capillary blood gas: pH \_\_\_\_\_ Base Excess \_\_\_\_\_ Lactate \_\_\_\_\_ HC0<sub>3</sub> \_\_\_\_\_  Not Done

Date and time blood gas sample taken: Date  /  /  Time \_\_\_\_\_

### MANAGEMENT FOLLOWING COLLAPSE

71. Infant weight:  g - Date  /  /  72. Ventilation:  Y  N  DK – If Yes, duration: \_\_\_\_\_

73. Inotropic support:  Y  N  DK – If YES, duration: \_\_\_\_\_

74. Hypoxic Ischaemic Encephalopathy?  Y  N  DK If YES, Grade: Grade 1  Grade 2  Grade 3  DK

75. Induced Hypothermia:  Y  N  DK If YES, details: \_\_\_\_\_

**INVESTIGATIONS**

76. Full Blood Count :  Y  N  DK If YES, any abnormality? \_\_\_\_\_
77. Infection Screen:  Y  N  DK If YES, please indicate:  Blood culture  Urine culture  CSF culture  Nasopharyngeal aspirate; Findings: \_\_\_\_\_
78. Chest X-ray:  Y  N  DK If YES, result: \_\_\_\_\_
79. Chromosomes/Karyotype testing:  Y  N  DK If YES, Result: \_\_\_\_\_
80. Metabolic Screen:  Y  N  DK – If YES, please specify results for: Glucose \_\_\_\_\_ Calcium \_\_\_\_\_  
Electrolytes \_\_\_\_\_ Ammonia \_\_\_\_\_ LFT \_\_\_\_\_ Urine metabolic screen \_\_\_\_\_
81. Newborn screening test?  Y  N  DK If YES, normal or abnormal(details): \_\_\_\_\_
82. Brain MRI scan performed?  Y  N  DK If YES, findings: \_\_\_\_\_
83. Bedside aEEG (Brainz) EEG?  Y  N  DK If YES, main findings: \_\_\_\_\_
84. Formal EEG?  Y  N  DK If YES, main findings: \_\_\_\_\_
85. Head ultrasound?  Y  N  DK If YES, findings: \_\_\_\_\_
86. Echocardiography?  Y  N  DK If YES, findings: \_\_\_\_\_
87. Placenta histopathology?  Y  N  DK If YES, main findings: \_\_\_\_\_

**OUTCOME**

88. Did the baby survive?  Y  N  DK **If NO, go to Q 92**
89. Full sucking feeds at discharge?  Y  N  DK
90. Any neurological impairment at discharge?  Y  N  DK If YES, describe \_\_\_\_\_
91. Neurodevelopment follow up organised?  Y  N  DK
92. If baby died, date, time and place of death: Date //, Time: \_\_\_\_\_ Place: \_\_\_\_\_
93. Was a post-mortem conducted:  Y  N  DK If YES, where was the PM conducted? \_\_\_\_\_
94. Pathologist/s who conducted PM:  Forensic  Paediatric  Perinatal  DK
95. Was the post-mortem a Coroner's case:  Y  N  DK – If YES, specify the forensic centre: \_\_\_\_\_
96. Cause of death identified on PM?  Y  N  DK If YES, please specify: \_\_\_\_\_
97. PM findings (esp congenital anomalies, inborn errors of metabolism etc.): \_\_\_\_\_

**Thank you for your help with this research project. Please return this questionnaire to the APSU in the reply-paid envelope or Fax to 02 98453082. Australian Paediatric Surveillance Unit, Kid's Research Institute, Locked Bag 4001, Westmead NSW 2145**

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