Sudden Unexplained Infant Deaths

1106.1 PURPOSE AND SCOPE

To provide the investigator with general guidelines for the investigation of sudden unexpected infant death syndrome (SUIDS) cases. The expected incidence in the general population is two per one thousand live births.

1106.2 DEFINITIONS

Sudden unexplained infant death syndrome (SUIDS, crib death, or sudden, unexpected death in infancy) is an unpredictable, unpreventable sudden death of an otherwise healthy infant, usually between one and six months of age, in whom the complete post mortem examination fails to reveal a cause of death. It is, therefore, a cause of death based on the exclusion of other significant diseases and unnatural events. A history of a recent mild upper respiratory tract infection (cold, sniffles, congestion, et cetera) is frequently elicited. Death usually occurs silently during sleep.

1106.3 GENERAL

The deputy coroner plays a key role in the management of SIDS cases.He/she often has the initial contact with families shortly after a sudden infant death has occurred, and in some cases it would be the deputy coroner who, having knowledge of these cases, can prevent mishandling by the police or law enforcement agency that may be involved. It is also most important for the investigator to keep in mind that in addition to obtaining necessary information about the victim, he/she also has a responsibility to extend a warm helping hand to the family.

The sergeant in charge of investigations will be contacted on all infant deaths and an investigator from the Major Crimes Unit may respond along with the deputy coroner assigned to the case.

A Crisis Intervention Officer or chaplain may be requested to respond to the scene of any death of a child.

The Health Department is also to be contacted immediately, so the Public Health Nurse can contact the family soon after the death.

1106.4 INVESTIGATION PROTOCOL

The deputy coroner is mandated by Government Code §27491.1 to complete the “Death Scene and Deputy Coroner Investigation Protocol” available through the State Department of Health. The completed form is to be turned in with the original coroner report.

See attachment: SUIDS Scene Investigation Protocol.pdf

Although completion of the above protocol does not exempt the deputy coroner from writing a complete coroner’s report, much of the information from the protocol may be incorporated into the coroner’s report. (Remember the coroner’s report is public information, while the Death Scene Investigation Protocol is confidential.)

Be certain to contact other relatives, friends, and especially the decedent's physician for statements and background information.

1106.5 X-RAYS

In an effort to help eliminate intentional or accidental deaths, **all bodies of infants are to be given full-body x-rays**.

1106.6 EXAMINATION OF THE BODY

Having obtained this brief history, the body can next be examined for size of the child, state of nutrition, does the infant look sick or dehydrated, cleanliness, and old scars and any recent bruise, laceration, or abrasion.

1106.7 EXAMINATION OF THE SLEEPING PLACE

In most sudden infant deaths, the child is found unresponsive or obviously dead in his/her crib or sleeping place. If the infant has been taken from the home and the investigator has examined the body in the hospital, he/she should as soon as possible go to the home to examine where the infant was sleeping. All infants do not have cribs. Some share a bed with an adult. Some cribs are broken or poorly repaired, or have a mattress which does not fill the bottom of the crib. All these things are hazards and may be related to the infant's death, but might not be volunteered by the family and thus go undetected if the investigator did not go to the home. While there, he/she can also determine the state of cleanliness of the home and the care being given to the other children.

Try to obtain the facts while alleviating some of the family's anxieties.This is a difficult task, but then this is a very tragic death.

After the baby has been examined and no trauma or injuries found which might suggest child abuse, do not be surprised that the parents,especially the mother, may want to hold the baby. In the interests of the bereavement process, they should be allowed to do this.

1106.8 POST MORTEM EXAMINATION OF THE BODY

In all cases of suspected sudden infant death syndrome, a complete autopsy must be performed. This means that examination of the neck organs, pharynx, middle ears, and optic nerve are required in all cased where thoracic and abdominal organs and brain reveal no obvious cause of death. Blood, urine, and vitreous humor, as well as tissue sample for toxicology and histology, should also be obtained.

Attachments

SUIDS Scene Investigation Protocol.pdf

DEATH SCENE AND DEPUTY CORONER INVESTIGATION PROTOCOL

For the Evaluation of Sudden, Unexpected Infant Death

This *Death Scene and Deputy Coroner Investigation Protocol* (CDPH 4439), for the evaluation of sudden, unexpected infant death, has been approved by the California Department of Public Health (CDPH) pursuant to Government Code, Section 27491.41. Beginning January 1, 2006, this Protocol is available for use throughout California to assist medical examiners and coroners to establish the mode, manner, and cause of death for all infants one year of age or younger who die suddenly and unexpectedly and in whom the causes of death are not obvious.

The coroner shall state on the death certificate that Sudden Infant Death Syndrome (SIDS) was the cause of death when the coroner's findings are consistent with the following definition:

> **The sudden death of an infant one year of age or younger which is unexpected by the infant's history and where a thorough postmortem examination including an autopsy, death scene investigation and review of the infant's medical history fails to demonstrate an adequate cause of death.**

If this Protocol is used and completed for the investigation of a sudden, unexplained infant death, the CDPH would appreciate a copy of this Protocol, as well as the *Standardized Autopsy Protocol* (CDPH 4437), to be sent to:

Maternal, Child, and Adolescent Health Division
California Department of Public Health
P.O. Box 997420, MS 8304
Sacramento, CA 95899-7420
(916) 650-0323 **(phone)** **Carrie.Florez@cdph.ca.gov** **(email)**

Additional copies of this Protocol can be obtained from the CDPH at the contact information listed above or by accessing the CDPH website at http://www.cdph.ca.gov/programs/SIDS/Pages/4.5SIDSProtocal.aspx

DEATH SCENE AND DEPUTY CORONER INVESTIGATION PROTOCOL

Please Type or Print

I. DEMOGRAPHICS

Decedent's Name			Investigating Agency's Case No.	Coroner's Case No.
Last	First	MI		

Date of Birth			Date of Death			Sex	Decedent's Race/Ethnicity
Mo	Day	Yr	Mo	Day	Yr	☐ Male ☐ Female	

Home Address (Number, Street)	Time of Death
	☐ Found ☐ Pronounced

City	State	Zip Code	County

Primary Language Spoken in Home	Social Security No. of Decedent
☐ English ☐ Spanish ☐ Other _____ ☐ Interpreter Needed	

Mother's Name			Relationship	Race/Ethnicity	Marital Status
Last	First	MI	☐ Natural ☐ Adoptive ☐ Step ☐ Other (Specify:_____)		☐ Married ☐ Separated ☐ Divorced ☐ Not Married ☐ Widowed

Date of Birth			Age	Yrs. of Education	CDL #	Telephone No.	On Public Assistance?
Mo	Day	Yr				( )	☐ Yes ☐ No

Address (If Different from Infant)	City	State	Zip Code

Father's Name			Relationship	Race/Ethnicity
Last	First	MI	☐ Adoptive ☐ Other ☐ Natural ☐ Step	

Date of Birth			Age	Yrs. of Ed.	CDL #	Telephone No.
Mo	Day	Yr				( )

Address (If Different from Infant)	City	State	Zip Code

Other Caregiver's Names		Date of Birth			Address
Last	First	Mo	Day	Yr	Number, Street

Siblings	Date of Birth			Age	Sex
	Mo	Day	Yr		☐ Male ☐ Female
					☐ Male ☐ Female
					☐ Male ☐ Female
					☐ Male ☐ Female

Other Adults in Residence	Date of Birth			Age	Relationship
	Mo	Day	Yr		

Other Children in Residence (Non-Siblings)	Date of Birth			Age	Relationship
	Mo	Day	Yr		

DEATH SCENE AND DEPUTY CORONER INVESTIGATION PROTOCOL

Please Type or Print

II. SCENE EXAMINATION

1. EMS/Police/Fire/Coroner Scene Response

911 Call:
Date: _____ (Mo Day Year)
Time: _____

EMS Arrival:
Date: _____ (Mo Day Year)
Time: _____

Police Arrival:
Date: _____ (Mo Day Year)
Time: _____

Coroner Arrival:
Date: _____ (Mo Day Year)
Time: _____

Transport:

Ambulance Company: _____ Telephone: _____

Private Vehicle Type: _____ Owned By: _____

Not Taken to a Medical Facility (Skip to Question 3)

2. Place Where Death Pronounced

Hospital Name: _____ En Route or DOA ☐ In-patient

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

Other Site: _____

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

By Whom: _____ Date: _____ (Mo Day Year) Time: _____

3. Location Where Infant Found

☐ **Residence:** ☐ Apartment ☐ Rooming House ☐ Single Detached ☐ Condo
☐ Multi-Family Occupancy ☐ Mobile Home ☐ Public Housing Project
☐ Other (Specify: _____)

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

_____ (County) _____ (Phone)

☐ **Child Care Facility:** Licensed? ☐ Yes License #: _____ ☐ No
Relative of Decedent? ☐ Yes Relationship: _____ ☐ No

☐ **Mobile Vehicle:** Type: _____ Where Parked: ☐ Street ☐ Off Road

Vehicle Location When Infant Found:

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

_____ (County)

☐ **Other** (Specify: _____)

DEATH SCENE AND DEPUTY CORONER INVESTIGATION PROTOCOL

Please Type or Print

4. Clothing on Body at Time Found Unresponsive

☐ Intact ☐ Partially Clothed ☐ Unclothed ☐ Clothing Inventory (List: _____)

5. Clothing Soiled By (Check all that apply)

☐ Blood ☐ Urine ☐ Feces ☐ Vomitus ☐ Mucus ☐ Food ☐ None

☐ Other (Specify: _____)

6. Diaper

a. Type: ☐ Cloth ☐ Disposable ☐ None ☐ Unknown

b. Diaper Contents: ☐ Dry ☐ Blood ☐ Feces ☐ Urine ☐ Foreign Material ☐ Unknown

c. Removed After Death? ☐ Yes ☐ No ☐ Unknown ☐ Other (Specify: _____)

7. Postmortem Changes When Found

a. Rigor Mortis ☐ Yes ☐ No

b. Blanching ☐ Yes ☐ No

c. Lividity ☐ Yes ☐ No ☐ Consistent with Infant's Position When Found ☐ Fixed

8. Body Warm to Touch?

☐ Yes ☐ No

9. Body Temperature

Date Taken: _____ (Mo Day Year) Time Taken: _____ By Whom: _____

Temperature: _____ °F ☐ Rectal ☐ Other Site: _____ ☐ Unknown

10. Mouth and Nostrils

☐ Occluded ☐ Secretions ☐ Vomitus ☐ Blood ☐ Foreign Objects ☐ Other (Specify: _____)

11. Hydration

Mucus Membranes Dry? ☐ Yes (Describe: _____) ☐ No

Skin Tenting Present? ☐ Yes ☐ No

Eyes Sunken? ☐ Yes ☐ No

12. Evidence of Trauma? (Provide Photographic Documentation & Completed Diagrams at the End of this Protocol)

a. **Abrasions:**
☐ Yes Where: _____
☐ No
☐ Unknown

b. **Bruises:**
☐ Yes Where: _____
☐ No
☐ Unknown

c. **Lacerations:**
☐ Yes Where: _____
☐ No
☐ Unknown

d. **Other Injuries:**
☐ Yes Specify: _____
☐ No
☐ Unknown

13. Postmortem or Perimortem Injuries?

☐ Yes (Describe: _____) ☐ No ☐ Unknown

If Yes, Were Injuries Related to Resuscitation? ☐ Yes ☐ No ☐ Unknown

DEATH SCENE AND DEPUTY CORONER INVESTIGATION PROTOCOL

Please Type or Print

III. DEATH SCENE/CIRCUMSTANCES OF DEATH

14. Room Where Infant Found

☐ Decedent's Bedroom ☐ Parent's Bedroom

☐ Other (Specify: _____)

Photographs Taken? ☐ Yes ☐ No By Whom: _____ Agency: _____

15. Sleeping Site Where Infant Found

☐ Adult Bed (Size: _____)
☐ Conventional Mattress (Size: _____)
☐ Water Mattress (Size: _____)
☐ Crib (Describe: _____)
☐ Other (Specify: _____)

☐ Floor ☐ Bean Bag
☐ Bassinet ☐ Drawer
☐ Couch ☐ Playpen
☐ Car Bed/Seat
☐ Chair

16. Co-Sleeping

Infant sleeping in "Bed" with someone else? ☐ Yes ☐ No

If Yes, describe others in "Bed":

☐ Mother (Est. weight: _____) (Est. height: _____)
☐ Father (Est. weight: _____) (Est. height: _____)
☐ Other Adult (Est. weight: _____) (Est. height: _____)
☐ Other Adult (Est. weight: _____) (Est. height: _____)

☐ Other Children (Total Num: _____)

Age	Est. weight	Est. height

Describe relative position of Infant (Also use diagram in Section VII):

☐ Between 1 individual and edge of bed ☐ Between 1 individual and wall ☐ Between 2 individuals

17. Objects in Bed With Infant When Found Unresponsive (Check all that apply)

☐ Blanket(s) Over or Around Infant Number of Blankets: _____ Type of Blanket: _____
☐ Blanket(s) Over the Head Number of Blankets: _____ Type of Blanket: _____
☐ Blanket(s) Under Infant Number of Blankets: _____ Type of Blanket: _____
☐ Pacifier ☐ Pillows ☐ Bumper Pads ☐ Plastic Bags
☐ Toys (Specify: _____) ☐ Other (Specify: _____)
☐ None

18. Bedding (Check all that apply)

a. **Was Bedding Over Baby Soiled By:**

☐ Blood ☐ Vomitus ☐ Urine
☐ Feces ☐ None ☐ Not Applicable
☐ Other (Specify: _____)

b. **Was Bedding Under Baby Soiled By:**

☐ Blood ☐ Vomitus ☐ Urine
☐ Feces ☐ None ☐ Not Applicable
☐ Other (Specify: _____)

19. Infant Placed

☐ On Back ☐ On Side ☐ On Stomach

Date: _____ (Mo Day Year) Time: _____ By Whom: _____

20. Infant's State Immediately Prior To Being Found Unresponsive

☐ Awake ☐ Asleep ☐ Unknown

Body Position of Infant When Last Seen Alive: ☐ On Back ☐ On Side ☐ On Stomach

DEATH SCENE AND DEPUTY CORONER INVESTIGATION PROTOCOL
Please Type or Print

21. Infant Found Unresponsive

Date: _____ (Mo Day Year) Time: _____ By Whom: _____

a. **Body Position:**
- ☐ On Back
- ☐ On Side
- ☐ On Stomach

b. **Face Position:**
- ☐ Face Down
- ☐ Face to Side
- ☐ Face Up

c. **Head Position:**
- ☐ Neutral
- ☐ Tilted Left
- ☐ Tilted Right

d. **Neck Position:**
- ☐ Extended Backwards
- ☐ Flexed Forward
- ☐ Neutral
- ☐ Unknown

e. **Baby Sweaty When Found:**
- ☐ Yes
- ☐ No

f. **Material in Nose or Mouth When Found:**
- ☐ No
- ☐ Bloody
- ☐ Other (Specify: _____)

22. Environmental Factors at Location Where Infant Found

a. **Temperature:** ☐ Outside: _____ °F ☐ Inside _____ °F ☐ Estimate

b. **General Quality of Housing:**
☐ Below Standard ☐ Standard ☐ Above Standard

c. **General Quality of Neighborhood:**
☐ Good ☐ Poor

d. **Heating:**
☐ On ☐ Off

Type: ☐ Electric ☐ Fireplace ☐ Forced Air ☐ Gas ☐ Kerosene ☐ Oven
☐ Propane ☐ Wood Stove ☐ Other (Specify: _____) ☐ None

e. **Air Conditioning:**
☐ On ☐ Off

Type: ☐ Central ☐ Fan ☐ Swamp Cooler ☐ None ☐ Other (Specify: _____)

f. **Room Ventilation:** (Check all that apply)
☐ Fan On ☐ Open Windows ☐ None ☐ Unknown ☐ Other (Specify: _____)

g. **Bedside Humidifier/Vaporizer:**
☐ On ☐ Off ☐ None

h. **Floor in Room Where Baby Found:**
☐ Carpet ☐ Concrete ☐ Dirt ☐ Linoleum ☐ Wood
☐ Other (Specify: _____)

i. **Housekeeping:**
☐ Neat and Clean ☐ Cluttered but Clean ☐ Filthy and Cluttered
☐ Other (Specify: _____)

DEATH SCENE AND DEPUTY CORONER INVESTIGATION PROTOCOL

Please Type or Print

23. If Residence or Child Care Facility

Number of Adults: _____ Number of Children: _____

24. Physical Items Collected - Mandatory When Available (Check all that apply)

Collected by: _____

- ☐ Clothes
- ☐ Diapers
- ☐ Drug Paraphernalia
- ☐ Feeding Formulas
- ☐ Over the Counter Drugs
- ☐ Folk Remedies
- ☐ Medications
- ☐ Trace Evidence
- ☐ Unwashed or Partially Consumed Bottles
- ☐ None
- ☐ Other (Specify: _____)

25. Discretionary Items Collected If Relevant (Check all that apply)

- ☐ Bedding
- ☐ Toys
- ☐ Honey, if fed within 30 Days of Death
- ☐ None
- ☐ Other (Specify: _____)

IV. HISTORY OF ATTEMPTED RESUSCITATION

26. Attempted Resuscitation

a. **Mouth-to-Mouth Ventilation?**
- ☐ Yes
- ☐ No

b. **Bag and Mask Ventilation?**
- ☐ Yes
- ☐ No

c. **Oral Airway Placement?**
- ☐ Yes
- ☐ No
- ☐ Attempted

d. **Intubation?**
- ☐ Yes
- ☐ No
- ☐ Attempted

e. **Cardiac Compression?**
- ☐ Yes
- ☐ No

f. **Intravenous Fluids?**
- ☐ Yes
- ☐ No

g. **Intracardiac Medications?**
- ☐ Yes ☐ No

h. **Intraosseous Lines?** (catheter in shinbone)
- ☐ Yes ☐ No

i. **Placed on Life Support?**
- ☐ Yes Duration: _____
- ☐ No

j. **Body Temperature Taken Near Time of Resuscitation:** _____ °F ☐ Rectal ☐ Other Site: _____

k. **Initial Cardiac Rhythm Recorded?**
- ☐ Yes If yes: ☐ A systole ☐ Other _____
- ☐ No

l. **Normal Cardiac Rhythm Restored?**
- ☐ Yes Duration of CPR: _____ minutes _____
- ☐ No

m. **Duration of Survival after Resuscitation** _____ ☐ Minutes ☐ Hours

n. **Location(s) of Resuscitation(s):** _____

By Whom: _____

Agency/ID#: _____

DEATH SCENE AND DEPUTY CORONER INVESTIGATION PROTOCOL

Please Type or Print

V. MEDICAL HISTORY

27. Infant Ill Within 48 Hours Before Death

a. **Runny Nose?**
- ☐ Yes
- ☐ No

b. **Vomiting?**
- ☐ Yes (How Many Times: _____)
- ☐ No

c. **Diarrhea?**
- ☐ Yes (How Many BM's: _____)
- ☐ No

d. **Pneumonia?**
- ☐ Yes
- ☐ No

e. **Body Temperature?**
- ☐ Yes (Temperature: _____ °F)

If yes: ☐ Rectal ☐ Other site: _____
- ☐ No

f. **Seizure/Convulsion?**
- ☐ Yes (Date: _____) Mo Day Year
- ☐ No

g. **Cough?**
- ☐ Yes If yes: ☐ Productive
- ☐ No

h. **Respiratory Distress?**
- ☐ Yes (Date: _____) Mo Day Year
- ☐ No

i. **Constipation?**
- ☐ Yes
- ☐ No

j. **Poor Feeding?**
- ☐ Yes
- ☐ No

k. **Poor Appetite?**
- ☐ Yes
- ☐ No

l. **Colic (Abdominal Cramps)?**
- ☐ Yes
- ☐ No

m. **Other** (Specify: _____)

28. Infant Ill 48 Hours to 2 Weeks Before Death

a. **Runny Nose?**
- ☐ Yes
- ☐ No

b. **Vomiting?**
- ☐ Yes (How Many Times: _____)
- ☐ No

c. **Diarrhea?**
- ☐ Yes (How Many BM's: _____)
- ☐ No

d. **Pneumonia?**
- ☐ Yes
- ☐ No

e. **Body Temperature?**
- ☐ Yes (Temperature: _____ °F)

If yes: ☐ Rectal ☐ Other site: _____
- ☐ No

f. **Seizure/Convulsion?**
- ☐ Yes (Date: _____) Mo Day Year
- ☐ No

g. **Cough?**
- ☐ Yes If yes: ☐ Productive
- ☐ No

h. **Respiratory Distress?**
- ☐ Yes (Date: _____) Mo Day Year
- ☐ No

i. **Constipation?**
- ☐ Yes
- ☐ No

j. **Poor Feeding?**
- ☐ Yes
- ☐ No

k. **Poor Appetite?**
- ☐ Yes
- ☐ No

l. **Colic (Abdominal Cramps)?**
- ☐ Yes
- ☐ No

m. **Other** (Specify: _____)

29. Medications Within 48 Hours Prior to Death

a. **Antibiotics?**
- ☐ Yes (Name: _____)
- ☐ No

b. **Anticonvulsants?**
- ☐ Yes (Name: _____)
- ☐ No

c. **Aspirin?**
- ☐ Yes
- ☐ No

d. **Acetaminophen (Tylenol)?**
- ☐ Yes
- ☐ No

e. **Ibuprofen (Motrin/Advil)?**
- ☐ Yes
- ☐ No

f. **Cold Remedies?**
- ☐ Yes (Name: _____)
- ☐ No

g. **Folk Remedies?**
- ☐ Yes (Type: _____)
- ☐ No

h. **Other** (Specify): _____

DEATH SCENE AND DEPUTY CORONER INVESTIGATION PROTOCOL

Please Type or Print

30. Exposure History

a. **Was the decedent recently exposed to an ill person?**

☐ Yes Relationship to Infant: _____ ☐ No ☐ Unknown

Nature of Illness: _____

b. **Was decedent recently exposed to an ill animal?** ☐ Yes Type: _____ ☐ No ☐ Unknown

31. Recent Behavior Change?

☐ Yes (Describe: _____) ☐ No

32. Recent Change in Sleep Pattern?

☐ Yes (Describe: _____) ☐ No

33. Usual Sleep Position?

☐ On his/her side ☐ On his/her back ☐ On his/her stomach

34. Pacifier Used?

☐ Yes ☐ No

35. Tobacco Smoke Exposure?

☐ Yes ☐ No

Other Smoke Exposure?

☐ Yes Type: _____ ☐ No

36. Feeding History

a. **Food Intolerance?**
- ☐ Yes
- ☐ No
- ☐ Unknown

b. **Breast Milk in Diet when Infant Died?**
- ☐ Yes
- ☐ No

c. **Formula?**
- ☐ Yes (Type: _____)
- ☐ No

d. **Time of Last Feeding Before Death:** _____

e. **Amount of Food Taken (oz.):** _____ ☐ Unknown

f. **Diet (Other than Formula):** _____

g. **Honey Within 30 Days of Death?** ☐ Yes ☐ No ☐ Unknown

37. Recent History of Infant Traveling

☐ Yes Where: _____ ☐ No

From: _____ (Mo Day Year) to _____ (Mo Day Year)

38. Was the Infant Cared for by Someone Other Than Parents?

☐ Yes ☐ No

a. **If yes, for how long?** _____

b. **Child Care Provider?** ☐ Yes License Number: _____ ☐ No

c. **Relative of Decedent?** ☐ Yes Relationship: _____ ☐ No

d. **Foster Care?** ☐ Yes ☐ No

e. **Name of Person Caring for Infant:** _____

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

_____ (County) _____ (Phone)

DEATH SCENE AND DEPUTY CORONER INVESTIGATION PROTOCOL

Please Type or Print

39. History of Injuries or Trauma

a. **Head Injury?** ☐ Yes (Specify: _____) ☐ No

b. **Loss of Consciousness?** ☐ Yes When: _____ (Mo Day Year) ☐ No

c. **Lethargy?** ☐ Yes ☐ No ☐ No

d. **Seizure?** ☐ Yes When: _____ (Mo Day Year) Type: _____ ☐ No

e. **Fractures?** ☐ Yes (Specify: _____) ☐ No

f. **Suspected Child Abuse?** ☐ Yes ☐ No

Access the Child Abuse Central Index (CACI) *(Obtain directly from index, not from parents. See instructions.)

g. **Was there documented history of child abuse?** ☐ Yes ☐ No

40. Previous Illness (May need to contact Mother, Obstetrics, Delivery Records)

a. **Respiratory Disease?** ☐ Yes (Describe: _____) ☐ No

b. **Heart Disease?** ☐ Yes (Describe: _____) ☐ No

c. **Apnea (Stopped Breathing)?** ☐ Yes Date: _____ (Mo Day Year) How Often: _____ ☐ No

d. **Seizure?** ☐ Yes Date: _____ (Mo Day Year) How Often: _____ ☐ No

e. **Other** (Specify): _____

41. Aside From that Used in Resuscitation, Did Infant Previously Require? (Answer Every Question)

a. **Oxygen?**	☐ Never	☐ Yes, Within Last Week	☐ Yes, But Not Within Last Week
b. **Apnea Monitor?**	☐ Never	☐ Yes, Within Last Week	☐ Yes, But Not Within Last Week
c. **Antibiotics?**	☐ Never	☐ Yes, Within Last Week	☐ Yes, But Not Within Last Week
d. **Anticonvulsants?**	☐ Never	☐ Yes, Within Last Week	☐ Yes, But Not Within Last Week

e. **Other** (Specify): _____

42. Last Seen By Doctor or Health Professional

Date Last Seen: _____ (Mo Day Year) Medications prescribed: ☐ Yes ☐ No Type: _____

a. **Routine Well Baby Exam** ☐ Yes ☐ No If Not Routine Exam, Specify Reason: _____

b. **Weight:** _____ lbs. c. **Height:** _____ inches d. **Temperature:** _____ °F

e. **Name of Health Care Provider:** _____

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

_____ (County) _____ (Phone)

43. Immunizations

☐ Yes ☐ No

a. **Most Recent Immunization:** Date: _____ (Mo Day Year) Type: _____

b. **Total Number of Immunizations Since Birth:**

Polio		Meningitis Varicella (Chickenpox)		Haemophilus HIB	
DTaP		Measles, Mumps Rubella (MMR)		Hepatitis B	

DEATH SCENE AND DEPUTY CORONER INVESTIGATION PROTOCOL

Please Type or Print

44. Hospitalizations

Hospitalized Other Than at Birth? ☐ Yes ☐ No

Reason: _____ Date: _____ (Mo / Day / Year)

Hospital: _____ Phone: _____

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

45. Surgeries (Not Previously Noted)

Did Infant Ever Have Surgery? ☐ Yes ☐ No

Reason: _____ Date: _____ (Mo / Day / Year)

Hospital: _____ Phone: _____

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

46. Birth History

a. **Place of Birth?** ☐ Home ☐ Hospital

☐ Other (Specify: _____) _____ (County)

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

b. **Are Decedent's Mother and Father Blood Related?** ☐ Yes ☐ No

c. **Birth Weight:** _____ lbs. _____ ozs. ☐ Unknown

d. **Multiple Birth?** ☐ Yes (Specify: Twin, Triplet, etc.: _____) ☐ No

e. **Infant Delivered:** ☐ Vaginally ☐ Breech ☐ C-Section

47. Prenatal Care

Did the Decedent's Mother Receive Prenatal Care? ☐ Yes ☐ No

a. Physician/Health Care Provider: _____

b. Month of Gestation When Care Began: _____

c. Estimated Number of Prenatal Visits: _____

48. Illnesses During First Week of Life

a. **Prematurity?**	☐ Yes	(# wks gestation: _____)	☐ No
b. **Resuscitation in Delivery Room?**	☐ Yes		☐ No
c. **Neonatal Intensive Care Unit?**	☐ Yes		☐ No
d. **Apnea?**	☐ Yes		☐ No
e. **Neonatal Lung Disorder?**	☐ Yes		☐ No
f. **Seizure?**	☐ Yes		☐ No
g. **Jaundice Requiring Treatment?**	☐ Yes		☐ No
h. **Meconium Aspiration?**	☐ Yes		☐ No

i. **Other** (Specify: _____)

49. Mother's Pregnancy History

Number of Previous Pregnancies: _____ Number of Live Births: _____

Number of Miscarriages/Abortions (spontaneous and/or induced): _____

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50. History of Fertility Treatment?

☐ Yes ☐ No

51. Maternal Health Problems During Pregnancy

a. **Anemia?**	☐ Yes	☐ No
b. **Diabetes Mellitus?**	☐ Yes	☐ No
c. **Required Insulin?**	☐ Yes	☐ No
d. **High Blood Pressure?**	☐ Yes	☐ No
e. **Infections?**	☐ Yes	☐ No
f. **Physical Trauma?**	☐ Yes	☐ No
g. **Sexually Transmitted Infection?**	☐ Yes	☐ No

h. **Other** (Specify: _____)

52. Maternal Medications During Pregnancy

a. **Antibiotics?**
☐ Yes (Name: _____) ☐ No

b. **Anticonvulsants?**
☐ Yes (Name: _____) ☐ No

c. **Pain Medications?**
☐ Yes (Name: _____) ☐ No

d. **Thyroid?**
☐ Yes ☐ No

e. **Hormones?**
☐ Yes (Name: _____) ☐ No

f. **Other Prescription Drugs?**
☐ Yes (Name: _____) ☐ No

d. **Cold Remedies?**
☐ Yes (Name: _____) ☐ No

e. **Other Over-the-Counter Drugs?**
☐ Yes (Name: _____) ☐ No

f. **Other Medications? (Incl. Herbal)**
☐ Yes (Name: _____) ☐ No

53. Alcohol Use

Maternal Alcohol Use During Pregnancy? ☐ Yes Greatest # of Drinks at One Time: _____ ☐ No

54. Controlled Substances/Drugs

Maternal Use of Controlled Substances/Drugs During Pregnancy?

☐ Yes (Type: _____) ☐ No

55. Tobacco

Maternal Use of Tobacco During Pregnancy? ☐ Yes # of Cigarettes per Day: _____ ☐ No

56. Family History

a. **Congenital Anomalies?** ☐ Yes (Describe: _____) ☐ No ☐ Unknown

b. **Infant/Childhood Death?**

☐ Yes How Many: _____ Relationship(s) to Infant: _____ ☐ No ☐ Unknown

Cause of Death: _____

		Relationship to Infant		
c. **SIDS?**	☐ Yes	_____	☐ No	☐ Unknown
d. **Sudden Unexpected Death of an Infant?**	☐ Yes	_____	☐ No	☐ Unknown
e. **Prematurity?**	☐ Yes	_____	☐ No	☐ Unknown
f. **Chronic or Recurrent Infections?**	☐ Yes	_____	☐ No	☐ Unknown
g. **Pneumonia?**	☐ Yes	_____	☐ No	☐ Unknown
h. **Trauma (Life Threatening)?**	☐ Yes	_____	☐ No	☐ Unknown
i. **Alcohol Abuse?**	☐ Yes	_____	☐ No	☐ Unknown
j. **Drug Abuse?**	☐ Yes	_____	☐ No	☐ Unknown
k. **Serious Physical Mental Illness?**	☐ Yes	_____	☐ No	☐ Unknown
l. **Police Called to Home in Past?**	☐ Yes	_____	☐ No	☐ Unknown
m. **Prior Contact with Social Services?**	☐ Yes		☐ No	☐ Unknown

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VI. WITNESSES AND INTERVIEWS

57. Interviews Conducted With Persons Who Have Knowledge of the Circumstances of Death

1. Name: _____ (First) _____ (Middle) _____ (Last)

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

   Phone: _____ Relationship to Decedent: _____ DOB _____ (Mo Day Year) CDL#: _____

2. Name: _____ (First) _____ (Middle) _____ (Last)

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

   Phone: _____ Relationship to Decedent: _____ DOB _____ (Mo Day Year) CDL#: _____

3. Name: _____ (First) _____ (Middle) _____ (Last)

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

   Phone: _____ Relationship to Decedent: _____ DOB _____ (Mo Day Year) CDL#: _____

58. Person(s) With Infant Before Death (24 hours)

1. Name: _____ (First) _____ (Middle) _____ (Last)

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

   Phone: _____ Relationship to Decedent: _____ DOB _____ (Mo Day Year) CDL#: _____

2. Name: _____ (First) _____ (Middle) _____ (Last)

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

   Phone: _____ Relationship to Decedent: _____ DOB _____ (Mo Day Year) CDL#: _____

59. First Responder

1. Name: _____ (First) _____ (Middle) _____ (Last)

   ID Number: _____ Phone: _____

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

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60. Family Member Who May Be Contacted

1. Name: _____ (First) _____ (Middle) _____ (Last)

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

   Phone: _____ Relationship to Decedent: _____ DOB _____ (Mo Day Year)

61. Name and ID Numbers of Individuals Completing This Form

1. Name: _____ (First) _____ (Middle) _____ (Last)

   ID Number: _____ Phone: _____

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

2. Name: _____ (First) _____ (Middle) _____ (Last)

   ID Number: _____ Phone: _____

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

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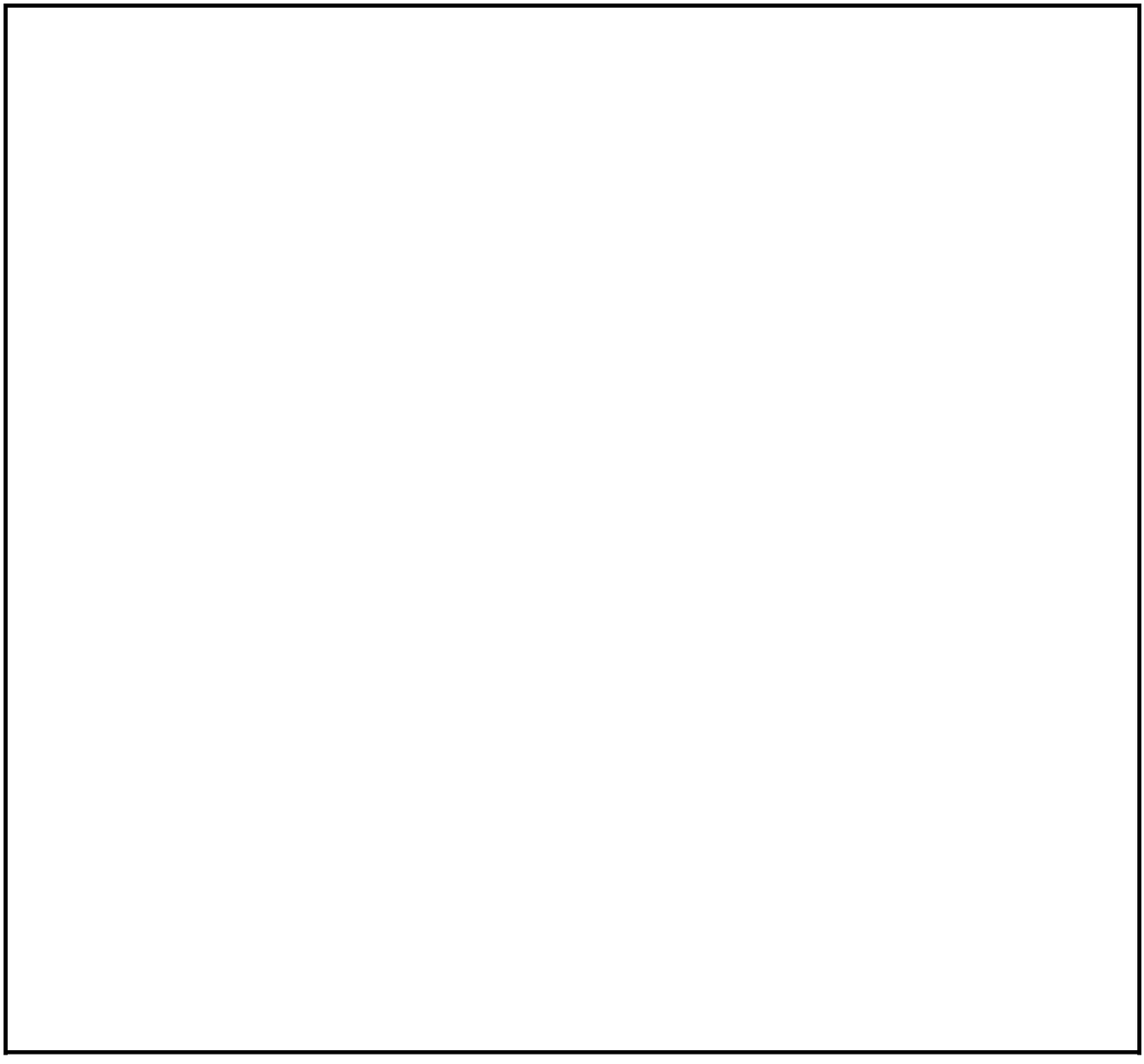
VII. ROOM DIAGRAM

62. Use figure to indicate the characteristics of the room where infant was found unresponsive.

Indicate the following on the diagram (check when done):

- ☐ North Direction
- ☐ Windows and doors
- ☐ Wall Lengths
- ☐ Ceiling height ____
- ☐ Location of furniture
- ☐ Location of crib, bed or other sleep surface
- ☐ Location of infant when found
- ☐ Location of other items and individuals in bed
- ☐ Location of other objects in room
- ☐ Location of heating and cooling supplies and returns



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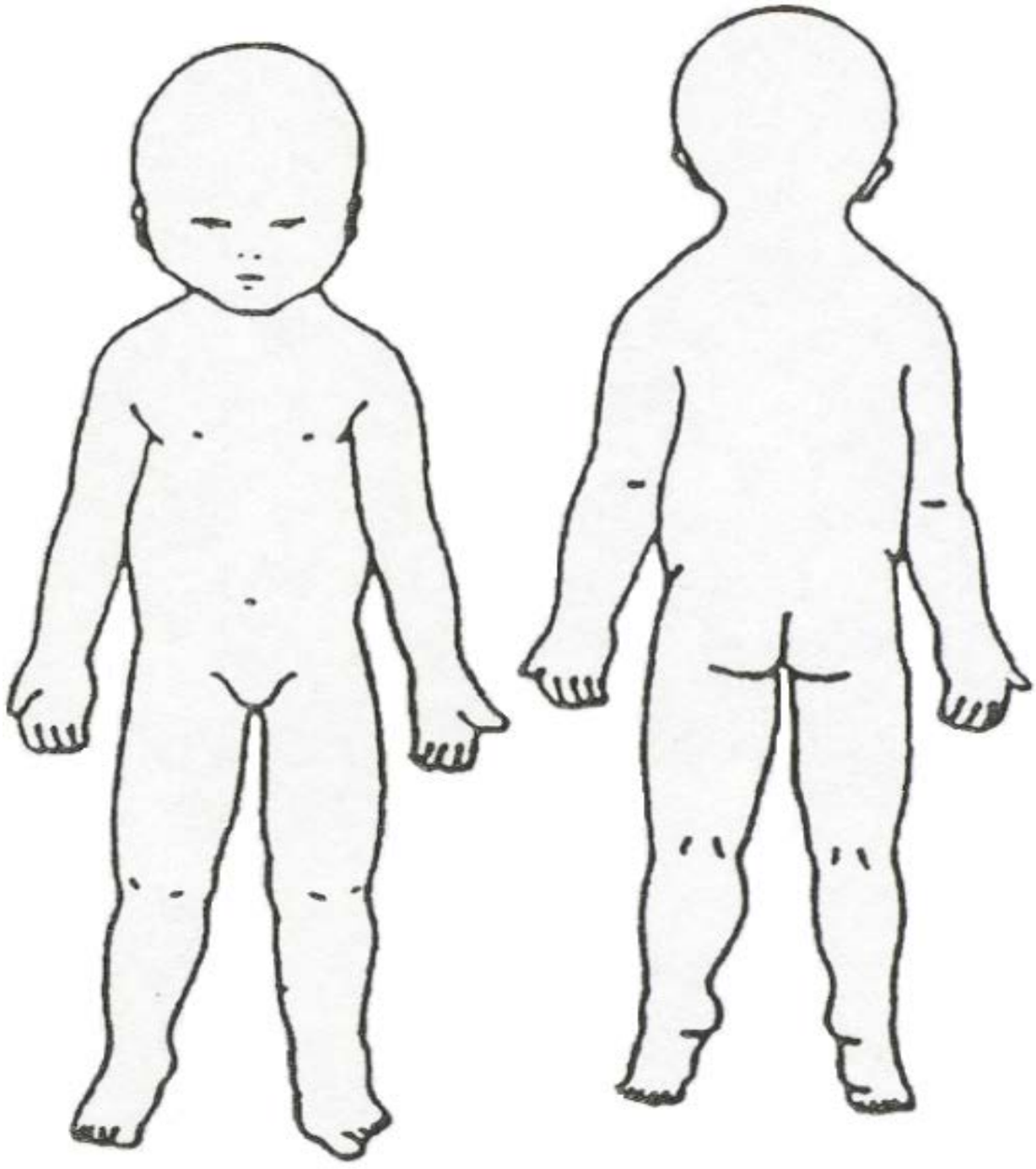
VIII. BODY DIAGRAM

63. Use diagram below to indicate any of the checked items.

Check all that apply and indicate on the diagram:

- ☐ Drainage or discharge from body or orifices
- ☐ Marks or bruises
- ☐ Location of diagnostic or therapeutic devices
- ☐ Pale pressure mark areas
- ☐ Predominate areas of lividity



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IX. SUPPLEMENT