



CHILD DEATH INVESTIGATION WORKSHEET

1st Judicial Medical Examiner

FLORIDA



Decedent Information

Child's Name: _____ Social Security Number: _____

Scene Address: _____

Date of Death: ___/___/___ Date of Birth: ___/___/___ Age: ___ Race: _____ Sex: _____

Child's Permanent Address: _____

Informant Information

Informant's Name: _____ Relationship: _____

Informant's Address: _____

Telephone: (H) () _____ (W) () _____ (C) () _____

Parent Information

Mother's Name: _____ Date of Birth: ___/___/___ SSN: _____

Mother's Address: _____

Telephone: (H) () _____ (W) () _____ (C) () _____

Father's Name: _____ Date of Birth: ___/___/___ SSN: _____

Father's Address: _____

Telephone: (H) () _____ (W) () _____ (C) () _____

Caregiver Information

Caregiver's Name: _____ Relationship: _____

Caregiver's Address: _____

Telephone: (H) () _____ (W) () _____ (C) () _____

Sibling Information

| | | | |
|------------|------------|---------------------|---------------|
| Age: _____ | Sex: _____ | Relationship: _____ | Health: _____ |
| Age: _____ | Sex: _____ | Relationship: _____ | Health: _____ |
| Age: _____ | Sex: _____ | Relationship: _____ | Health: _____ |
| Age: _____ | Sex: _____ | Relationship: _____ | Health: _____ |
| Age: _____ | Sex: _____ | Relationship: _____ | Health: _____ |
| Age: _____ | Sex: _____ | Relationship: _____ | Health: _____ |
| Age: _____ | Sex: _____ | Relationship: _____ | Health: _____ |

Parent / Caregiver Social History

| | Mother | Father | Caregiver |
|---------------------------|--------------------------|--------------------------|--------------------------|
| Smoker | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Alcohol User | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Illicit Drug User | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Prescription Drug User | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Domestic Violence History | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Mental Illness | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Child / Sexual Abuse | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| DCF Complaints | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Frequent LE Calls | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

MATERNAL HABITS DURING PREGNANCY

| | | |
|--|------------------------------|-----------------------------|
| Cigarette Smoker (Packs per Day/Week/Month) _____ | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Alcohol User (Amount per Day/Week/Month) _____ | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Illicit Drugs User Type: _____ Frequency: _____ | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Prescription Drug User (mood altering) Type: _____ Frequency: _____ | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Type: _____ Frequency: _____ | | |
| Type: _____ Frequency: _____ | | |
| Type: _____ Frequency: _____ | | |

MATERNAL COMPLICATIONS DURING PREGNANCY

| | | |
|--|------------------------------|-----------------------------|
| Was Mother Injured Specify: _____ | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Health Complications (htn, bleeding, and diabetes) Specify: _____ | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

Number of prior pregnancies: _____ Number of prior terminations: _____

Additional "YES" Answer Explanation:

CHILD MEDICAL HISTORY

| | | |
|--|------------------------------|-----------------------------|
| Prenatal Care | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Allergies (Food, Medication, or other) | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Abnormal Growth | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Apnea | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Cyanosis | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Cardiac Abnormalities | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Metabolic Disorders | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Birth Defects | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Complications at Birth | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Premature | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Previous Child Deaths in Family | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Normal Physical Development | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Normal Mental Development | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

Explain "YES" Answers:

Name & Telephone Number of Delivering Physician: () _____, _____
Name & Telephone Number of Hospital: () _____, _____
Name & Telephone Number of Pediatrician: () _____, _____

Birth Weigh: _____ lbs. _____ oz. Birth Length: _____ in.

of Weeks Gestation _____ Birthing Method: Vaginal C-Section

Medical Treatment or Hospitalization since Birth:

Last seen by Pediatrician: ____/____/____

In the past 72 hours, did the child have:

- | | | | |
|--------------------|---|-----------------------|---|
| Fever | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown | Diarrhea | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown |
| Cough | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown | Chest Congestion | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown |
| Nasal Congestion | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown | Teething | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown |
| Excessive Sweating | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown | Stool Changes | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown |
| Lethargy | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown | Difficulty Breathing | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown |
| Fussiness | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown | Apnea | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown |
| Excessive Crying | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown | Cyanosis | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown |
| Irritable | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown | Seizures | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown |
| Decreased Appetite | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown | Vomiting | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown |
| Choking | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown | Vaccinations | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown |
| Alcohol Use | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown | Prescription Drug Use | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown |
| Illicit Drug Use | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown | OTC Medicines | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown |
| Home remedies | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown | Herbal Medicines | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown |

Explain "YES" Answers:

In the past several months, did the child have:

- | | | | | |
|--------------------------------|------------------------------|-----------------------------|----------------------------------|------------------------------|
| Behavior Problems at School | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown | <input type="checkbox"/> N/A |
| Behavior Problems at Home | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown | <input type="checkbox"/> N/A |
| Behavior Problems with Friends | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown | <input type="checkbox"/> N/A |
| Bullying | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown | <input type="checkbox"/> N/A |
| Bullied | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown | <input type="checkbox"/> N/A |
| Pressure to Perform | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown | <input type="checkbox"/> N/A |
| Learning Disability | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown | <input type="checkbox"/> N/A |
| Special Education | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown | <input type="checkbox"/> N/A |
| Alternative School | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown | <input type="checkbox"/> N/A |
| Home School | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown | <input type="checkbox"/> N/A |
| Incarcerations | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown | <input type="checkbox"/> N/A |

| | | | | |
|-------------------------------------|------------------------------|-----------------------------|----------------------------------|------------------------------|
| Probation | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown | <input type="checkbox"/> N/A |
| Drop in Academic Performance | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown | <input type="checkbox"/> N/A |
| Drop in Athletic Performance | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown | <input type="checkbox"/> N/A |
| Drop in Extra-curricular Activities | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown | <input type="checkbox"/> N/A |
| Diagnosed Depression | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown | <input type="checkbox"/> N/A |
| Physical Abuse History | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown | <input type="checkbox"/> N/A |
| Sexual Abuse History | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown | <input type="checkbox"/> N/A |
| Sexually Active | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown | <input type="checkbox"/> N/A |
| Heterosexual | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown | <input type="checkbox"/> N/A |
| Homosexual | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown | <input type="checkbox"/> N/A |
| Bi-Sexual | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown | <input type="checkbox"/> N/A |
| Pregnant or Caused Pregnancy | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown | <input type="checkbox"/> N/A |
| Recent Parental Divorce | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown | <input type="checkbox"/> N/A |
| Recent Loss of Parent | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown | <input type="checkbox"/> N/A |
| Recent Loss of Caregiver | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown | <input type="checkbox"/> N/A |
| Recent Loss of Friend | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown | <input type="checkbox"/> N/A |
| Recent Loss of Employment | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown | <input type="checkbox"/> N/A |
| Recent Loss of Pet | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown | <input type="checkbox"/> N/A |
| Recent Loss of Romantic Partner | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown | <input type="checkbox"/> N/A |
| Recent Change of School | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown | <input type="checkbox"/> N/A |
| Participation in Choking Game | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown | <input type="checkbox"/> N/A |
| Autoerotic Behavior | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown | <input type="checkbox"/> N/A |
| Medication Grab Bag | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown | <input type="checkbox"/> N/A |
| Prior Suicide Attempts | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown | <input type="checkbox"/> N/A |
| Prior Self Injury | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown | <input type="checkbox"/> N/A |

Explain "YES" Answers:

SCENE INVESTIGATION

SCENE:

| | | | | |
|-------------------------------|------------------------------|-----------------------------|----------------------------------|------------------------------|
| Primary Residence | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown | <input type="checkbox"/> N/A |
| Care Giver Residence/Facility | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown | <input type="checkbox"/> N/A |
| Indoors | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown | <input type="checkbox"/> N/A |
| Outdoors | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown | <input type="checkbox"/> N/A |
| Vehicle | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown | <input type="checkbox"/> N/A |
| Water | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown | <input type="checkbox"/> N/A |

Explain "YES" Answers:

If with Caregiver, give number of other children under the age of 18 in providers care _____

License #: _____ Issuing Agency: _____

Provider Years of Service: _____ # of Foster Children: _____ # in Household: _____

HYGIENE:

| | | | | |
|-----------------------------|-------------------------------|-------------------------------|----------------------------------|------------------------------|
| Hygiene of Child | <input type="checkbox"/> Good | <input type="checkbox"/> Fair | <input type="checkbox"/> Poor | <input type="checkbox"/> N/A |
| Condition of Clothing | <input type="checkbox"/> Good | <input type="checkbox"/> Fair | <input type="checkbox"/> Poor | <input type="checkbox"/> N/A |
| General Cleanliness of Home | <input type="checkbox"/> Good | <input type="checkbox"/> Fair | <input type="checkbox"/> Poor | <input type="checkbox"/> N/A |
| Cleanliness of Room | <input type="checkbox"/> Good | <input type="checkbox"/> Fair | <input type="checkbox"/> Poor | <input type="checkbox"/> N/A |
| Insect Activity in Home | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown | <input type="checkbox"/> N/A |
| Rodent Activity in Home | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown | <input type="checkbox"/> N/A |
| Indoor Pets | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown | <input type="checkbox"/> N/A |
| Mold | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown | <input type="checkbox"/> N/A |

Explain "YES" Answers:

Source of Drinking Water (i.e. Public, Well, Bottled) _____

DEVELOPMENT:

| | | | | |
|------------------------------|------------------------------|-----------------------------|----------------------------------|------------------------------|
| Child can Roll | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown | <input type="checkbox"/> N/A |
| Child can Sit | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown | <input type="checkbox"/> N/A |
| Child can Lift Head | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown | <input type="checkbox"/> N/A |
| Child can Pull Up | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown | <input type="checkbox"/> N/A |
| Child can Push Up | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown | <input type="checkbox"/> N/A |
| Child can Stand (unassisted) | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown | <input type="checkbox"/> N/A |
| Child can Crawl (unassisted) | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown | <input type="checkbox"/> N/A |
| Child can Walk (unassisted) | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown | <input type="checkbox"/> N/A |
| Child can Climb | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown | <input type="checkbox"/> N/A |
| Child can Open Doors | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown | <input type="checkbox"/> N/A |
| Child can Swim | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown | <input type="checkbox"/> N/A |

Child's Current Height: _____ inches Child's Current Weight: _____ lbs.

Explain "YES" Answers:

SLEEPING CONDITIONS:

| | | | | |
|----------------------------|------------------------------|-----------------------------|----------------------------------|------------------------------|
| Child was Co-Sleeping | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown | <input type="checkbox"/> N/A |
| Child was in Crib | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown | <input type="checkbox"/> N/A |
| Was a Crib Available | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown | <input type="checkbox"/> N/A |
| Child was in Adult Bed | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown | <input type="checkbox"/> N/A |
| Child was in Makeshift Bed | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown | <input type="checkbox"/> N/A |
| Bassinet | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown | <input type="checkbox"/> N/A |
| Sofa / Chair | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown | <input type="checkbox"/> N/A |
| Stroller | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown | <input type="checkbox"/> N/A |
| Playpen | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown | <input type="checkbox"/> N/A |
| Floor | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown | <input type="checkbox"/> N/A |
| Car Seat | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown | <input type="checkbox"/> N/A |
| Bouncer | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown | <input type="checkbox"/> N/A |
| Swing | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown | <input type="checkbox"/> N/A |
| Mattress | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown | <input type="checkbox"/> N/A |
| Waterbed | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown | <input type="checkbox"/> N/A |

| | | | | |
|------------------------|------------------------------|-----------------------------|----------------------------------|------------------------------|
| Receiving Blanket | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown | <input type="checkbox"/> N/A |
| Child Blanket | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown | <input type="checkbox"/> N/A |
| Adult Blanket | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown | <input type="checkbox"/> N/A |
| Pillow | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown | <input type="checkbox"/> N/A |
| Sheet | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown | <input type="checkbox"/> N/A |
| Plastic Sheet | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown | <input type="checkbox"/> N/A |
| Stuffed Animals / Toys | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown | <input type="checkbox"/> N/A |
| Bumper Pad | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown | <input type="checkbox"/> N/A |
| Pacifier | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown | <input type="checkbox"/> N/A |

Explain "YES" Answers:

Usual sleeping position (i.e. Face up, Face down, Head turned R or L) _____

Position when child was placed _____

Position when child was found _____

If Co-Sleeping, Physical Characteristics of Co-Sleeper (i.e. Sex, Height, Weight, Intoxicated)

NUTRITION:

| | | | | |
|--|------------------------------|-----------------------------|----------------------------------|------------------------------|
| Bottle Fed | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown | <input type="checkbox"/> N/A |
| Formula | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown | <input type="checkbox"/> N/A |
| Milk | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown | <input type="checkbox"/> N/A |
| Juice | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown | <input type="checkbox"/> N/A |
| Water | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown | <input type="checkbox"/> N/A |
| Other Liquid | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown | <input type="checkbox"/> N/A |
| Breast Fed | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown | <input type="checkbox"/> N/A |
| Solid Foods | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown | <input type="checkbox"/> N/A |
| Well Developed | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown | <input type="checkbox"/> N/A |
| Malnourished | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown | <input type="checkbox"/> N/A |
| New Food Introduction (within past 24 hours) | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown | <input type="checkbox"/> N/A |
| Known Food Allergies | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown | <input type="checkbox"/> N/A |
| Death Occurred during Feeding | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown | <input type="checkbox"/> N/A |

Explain "YES" Answers:

Last Meal: ____/____/____ @ _____ hrs.

Describe (i.e. Type of Food, Quantity) _____

Name of person who fed the decedent _____

Relationship to the decedent _____

BODY OBSERVATION:

- | | | | | |
|---|------------------------------|-----------------------------|----------------------------------|------------------------------|
| Discoloration of Face/Nose/Mouth | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown | <input type="checkbox"/> N/A |
| Secretions (i.e. Foam, Froth, Blood Tinged) | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown | <input type="checkbox"/> N/A |
| Skin Discoloration | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown | <input type="checkbox"/> N/A |
| Pressure Marks | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown | <input type="checkbox"/> N/A |
| Rash | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown | <input type="checkbox"/> N/A |
| Petechiae (i.e. Skin, Eyes) | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown | <input type="checkbox"/> N/A |
| Scratches | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown | <input type="checkbox"/> N/A |
| Bruises | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown | <input type="checkbox"/> N/A |
| Lacerations | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown | <input type="checkbox"/> N/A |
| Abrasions | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown | <input type="checkbox"/> N/A |
| Incisions | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown | <input type="checkbox"/> N/A |
| Burns | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown | <input type="checkbox"/> N/A |
| Sweaty | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown | <input type="checkbox"/> N/A |
| Limp or Flexible | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown | <input type="checkbox"/> N/A |
| Rigid or Stiff | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown | <input type="checkbox"/> N/A |
| Warm to Touch | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown | <input type="checkbox"/> N/A |
| Cool to Touch | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown | <input type="checkbox"/> N/A |
| Nose or Mouth Covered | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown | <input type="checkbox"/> N/A |
| Bottle used at Sleep | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown | <input type="checkbox"/> N/A |
| Bottle Propped | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown | <input type="checkbox"/> N/A |
| When Found (Breathing?) | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown | <input type="checkbox"/> N/A |
| Body Moved | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown | <input type="checkbox"/> N/A |

Body Temperature (Temp____*F) Rectal Liver (Circle One)

Explain "YES" Answers:

ENVIROMENTAL CONDITION:

- | | | | | |
|-----------------------------|------------------------------|-----------------------------|----------------------------------|------------------------------|
| Heater in Use (Temp:____*F) | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown | <input type="checkbox"/> N/A |
| A/C in Use (Temp:____*F) | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown | <input type="checkbox"/> N/A |
| Odors or Fumes | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown | <input type="checkbox"/> N/A |
| Apnea Monitor | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown | <input type="checkbox"/> N/A |
| Humidifier | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown | <input type="checkbox"/> N/A |
| Vaporizer | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown | <input type="checkbox"/> N/A |
| Air Purifier | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown | <input type="checkbox"/> N/A |
| Medication Present | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown | <input type="checkbox"/> N/A |
| Illegal Drug Use | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown | <input type="checkbox"/> N/A |
| Alcohol Use | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown | <input type="checkbox"/> N/A |

Explain "YES" Answers:

MEDICAL INTERVENTION:

First Responder Efforts

Yes

No

Unknown

N/A

EMS Efforts

Yes

No

Unknown

N/A

Explain "YES" Answers:

VEHICLE RELATED:

Driver

Yes

No

Unknown

N/A

Passenger

Yes

No

Unknown

N/A

Pedestrian

Yes

No

Unknown

N/A

Seatbelt in Use

Yes

No

Unknown

N/A

Ejected

Yes

No

Unknown

N/A

Distraction (i.e. Cell phone, Changing Music)

Yes

No

Unknown

N/A

Drag Racing

Yes

No

Unknown

N/A

Sleep Deprived

Yes

No

Unknown

N/A

Explain "YES" Answers:

OTHER FACTORS:

History of Infant Deaths or Other Child Deaths

Yes

No

Unknown

N/A

Explain "YES" Answers:

Describe any other Factors, Circumstances or Environmental concerns that may have contributed to the child's death that have not yet been identified:

Did the child experience any falls or injuries in the past 72 hours? _____

Was the child supposed to be awake or asleep? _____

What led to a well being check? _____

Any other household members recently or currently ill or injured?

If in a body of water, feet from water's edge: _____ in. / ft., depth of water: _____ in. / ft.

PRELIMINARY SUGGESTION

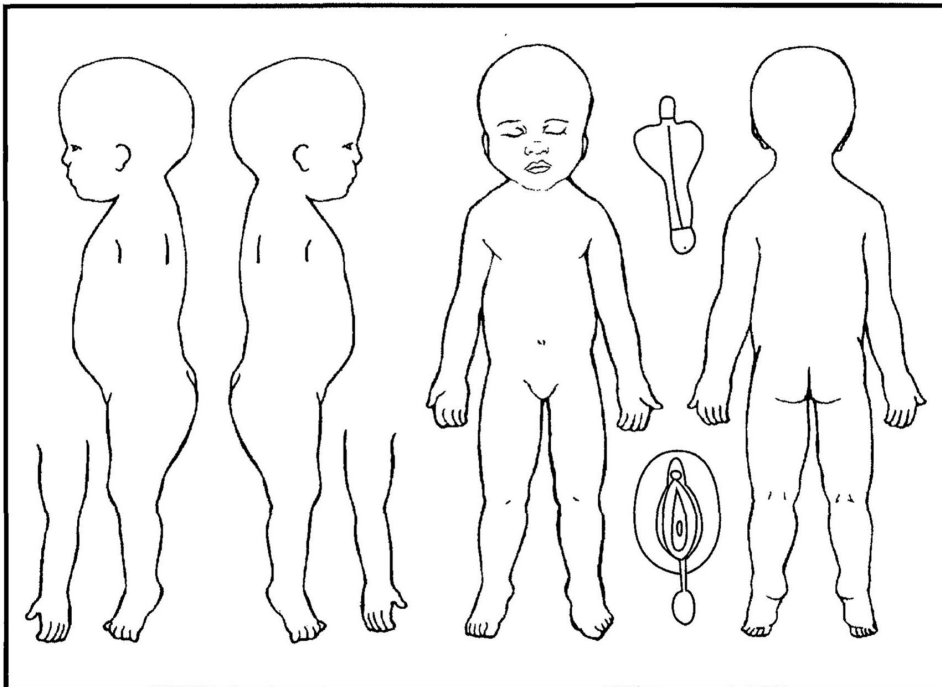
| | | | | |
|--|------------------------------|-----------------------------|----------------------------------|------------------------------|
| Overlay | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown | <input type="checkbox"/> N/A |
| Wedge | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown | <input type="checkbox"/> N/A |
| Obstruction | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown | <input type="checkbox"/> N/A |
| Re-breathing | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown | <input type="checkbox"/> N/A |
| Compression | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown | <input type="checkbox"/> N/A |
| Immersion | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown | <input type="checkbox"/> N/A |
| Co-Sleeping | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown | <input type="checkbox"/> N/A |
| Unsafe Sleeping Condition | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown | <input type="checkbox"/> N/A |
| Hyperthermia | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown | <input type="checkbox"/> N/A |
| Hypothermia | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown | <input type="checkbox"/> N/A |
| Recent Hospitalization | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown | <input type="checkbox"/> N/A |
| Acute Life Threatening Event | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown | <input type="checkbox"/> N/A |
| Recent Trauma | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown | <input type="checkbox"/> N/A |
| Previous Police or Social Service Visits | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown | <input type="checkbox"/> N/A |
| Autopsy Objection | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown | <input type="checkbox"/> N/A |
| Suspicious Activity | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown | <input type="checkbox"/> N/A |
| Drug or Alcohol Activity | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown | <input type="checkbox"/> N/A |
| Abuse | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown | <input type="checkbox"/> N/A |

Explain "YES" Answers:

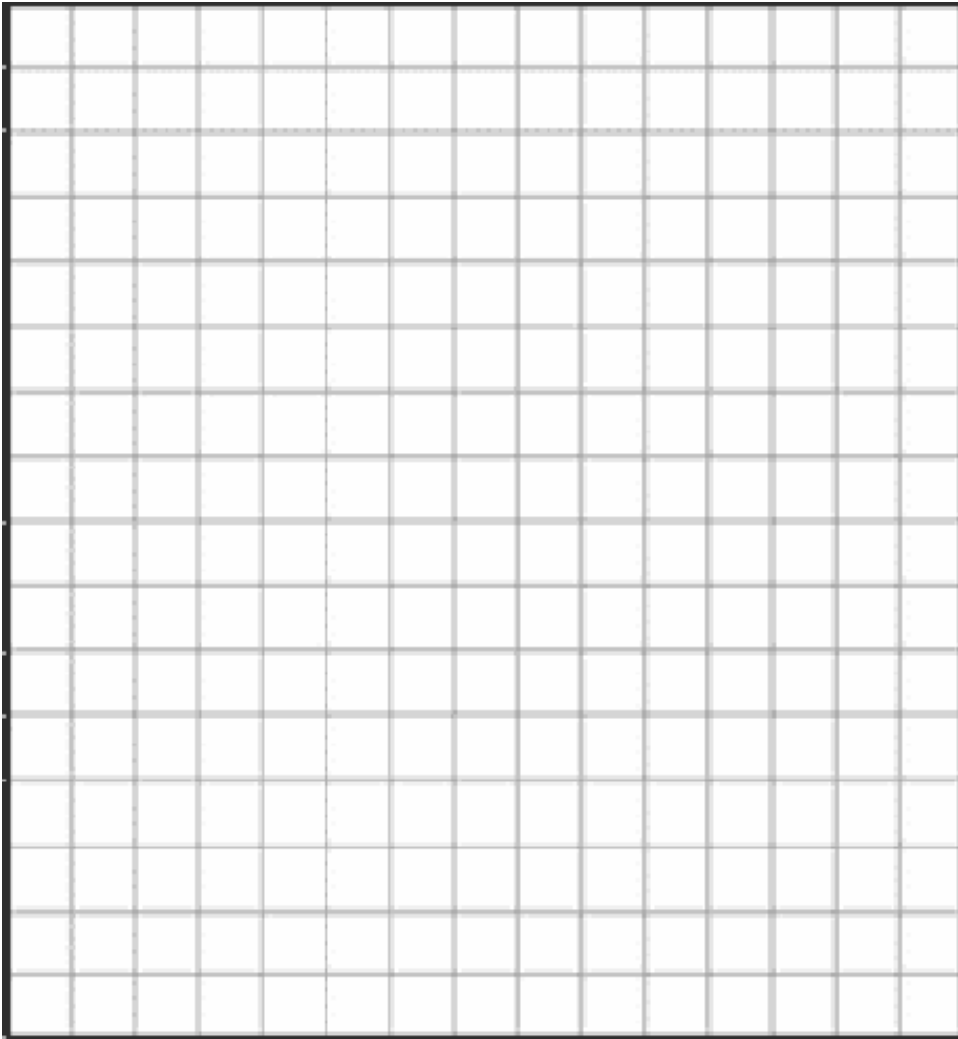
SUSPECTED MANNER:

Natural Homicide Suicide Pending Undetermined

DOCUMENT ANY SIGNIFICANT SCENE FINDINGS



SCENE SKETCH TO INCLUDE POSITION OF CHILD



When a child dies under the age of 16 dies unexpectedly an investigation of the scene(s) is imperative to determine the cause and manner of death. Due to most children being transported peri-mortem multiple scenes may exist. This work sheet should be used as a guide to perform the most accurate investigation possible.

In addition, use a manikin or doll to recreate the position and circumstances surrounding the death. Photograph the recreation along with completion of a body diagram and scene sketch.

INVESTIGATOR:

Name: _____

Title: _____

Date of Investigation: ____/____/____

LE Agency: _____

LE Investigator: _____

LE Agency Case #: _____