

State of Michigan Sudden & Unexplained Child Death Scene Investigation Form



Instructions:

Please fill out this form as much as possible and attach it to your investigation report.

Return a copy to the Medical Examiner's Office within 24 hours.

Contact your Prosecuting Attorney's Office to ensure all laws and regulations are followed.

Endorsed by the Michigan Association of Medical Examiners, Michigan State Police, Michigan Association of Chiefs of Police, Michigan Sheriffs' Association, Prosecuting Attorneys Association of Michigan, Michigan Department of Health and Human Services, Michigan Public Health Institute

Child, Caregiver and Family Demographic Information

Name and contact information for person(s) being interviewed:

Interviewee's relationship to child:

Child's name:

Date of birth:

Child also known as:

Date of death:

Race/ethnicity of child (Caucasian, African American, Native American, Asian, Hispanic, Bi-racial, Other):

Child's skin tone:

Child's sex: **M F**

Scene address where child was found unresponsive:

Address(es) where child has been in the last 12 hours:

Who had responsibility for child at time of death? (list address):

Who has legal custody of child? (list address):

Who does child primarily live with? (list address):

Other care providers (list address):

Was anyone else present when the child died? (list address):

Family and Social Conditions

Number of persons living at scene:

Number of individuals under 18 years of age at the scene:

Was the child being supervised by a minor? Yes No

Is the site of the incident or death scene a day care or other child care setting? Yes No

If yes: Day Care Unlicensed Day Care Foster Care Relative's Home Other

How many children were under the care of the provider at the time of incident or death?

Are there any cultural practices that may have contributed to the death? Yes No

Describe:

Child's Health History (Obtain Medical Records)

Source of medical information:

Doctor Other Health Care Provider Medical Record Mother/primary caregiver Family Other

Name(s) of child's health care provider(s):

Has the child been sick in the last 2 weeks? Yes No

If yes, describe:

Was child taken for treatment? Yes No

If yes, where or to whom?

Did child receive any medications in the last 2 weeks? Yes No

If yes, list home remedies, herbal/prescription/over the counter medications, vaccinations - get name, dose last given, date/time/reason given. Obtain containers if possible.

Has the child had any serious illness or injury in the past? (lung disease, heart disease, stopped breathing, seizure, broken bones, head injuries, other illness, other injuries or allergies):

Did child have any birth defects? Yes No Has child received appropriate well visits? Yes No

Has child ever been hospitalized? Yes No

If yes, why and where?

Did the infant visit a location with a large number of people within the last 24 hours? Yes No

Has child been exposed to any ill persons or pets recently? Yes No

Does child attend daycare? Yes No If yes: licensed non-licensed relative

Name and address of caregiver(s):

Describe any recent travel by child or caregivers:

Does any caregiver use over the counter or prescription medications, herbal remedies, cigarettes, alcohol, other?

Describe:

Is there a family history of infections, abuse/neglect, mental illness, pneumonia, prematurity, birth defects, trauma, other infants who died suddenly, other medical issue?

Have any family members or others who have been around the baby been reported for past child abuse / neglect or domestic violence, been in the foster care system, or been convicted of a crime? Yes No

Contact Children's Protective Services to obtain any CPS history on family.

Birth History

Birth place name and address:

How long was the infant in the hospital? Infant's weight at birth: Infant's length at birth:

Was the infant born on time, early or late? Vaginal or c-section?

Was the infant a twin, triplet or more?

Did the infant have any health issues when born? Yes No
Any birth defects?

At how many weeks/months did mother begin prenatal care? Did she have regular prenatal visits? Yes No

Where did mother receive prenatal care?

Any problems of pregnancy or maternal health problems? Yes No
If yes, explain:

Was mother injured at any time during her pregnancy? Yes No

During pregnancy, was mother taking OTC/Rx medications or herbal remedies for any of the above conditions? Yes No
If yes, list medications used:

List complete contact information for birth mother, including current address, how long she has been at address, phone number and maiden name:

Feeding History

Time child last ate:

Name of the person who last fed the infant: What is his/her relationship to the infant?

Is child usually bottle fed or breast fed? Bottle Breast
What foods and/or liquids were fed in the last 24 hours?

How much? (Have caregiver show/describe anything that was mixed in.)

List any feeding difficulties:

Was a new food introduced in the 24 hours prior to his/her death? Yes No

Was the infant last placed to sleep with a bottle? Yes No If yes, was the bottle propped? Yes No
What was the quantity of liquid (in ounces) in the bottle?

Did caregiver fall asleep while feeding child? Yes No

Any known food intolerances or allergies? Yes No
Describe:

Condition of Child

Describe condition/behavior of child during the last 24 hrs:	Anything unusual with the child's behavior or appearance?
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When Last Known Alive

Time the child was last known alive:
By whom? (list address):

Explain how they knew the infant was still alive:

What was the infant wearing when last known alive?

When Found Unresponsive

Time the child found unresponsive:
By whom? (list address):

How was the child when found unresponsive? (Leave open ended but can give examples such as breathing, not breathing):

What did the infant feel like when found unresponsive? (check all that apply)
 Sweaty Limp, flexible Rigid, stiff Warm to touch Cool to touch Other Unknown

What was the infant wearing when found unresponsive?

Was the infant wrapped or swaddled? Yes No Any discolorations around the face, nose or mouth? Yes No

Were there any secretions? (foam, froth): Yes No Any pressure marks? (pale, blanching): Yes No

Any rash or petechiae? (Small, red blood spots on skin, membranes or eyes): Yes No

Body temp if known (degree, time, method):

Were there any birthmarks or injuries of any type, including bruises, scrapes, burns or diaper rash? Yes No
Describe shapes and sizes:

Position of Child (Conduct Doll Reenactment and Photograph)

Child Last Placed

Where was the infant last placed? (bassinet, crib, car seat, adult bed, swing, etc):

If adult bed, what size? (twin, double, queen, king):

In what room and what proximity to people?

Who placed the infant? (list address):

In what position was the infant last placed?
 Sitting Back Right side Left side Stomach
 Other Unknown

Was this the infant's usual position? Yes No

Was child placed to sleep w/a pacifier? Yes No

What was the child's **face** position when last placed?
 Face Down Face Up Face Right Face Left
 Other Unknown

What was child's neck position when last placed?
 Hyperextended Flexed Neutral Turned Other
 Unknown

Child Last Known Alive

Where was the infant last known alive? (bassinet, crib, car seat, adult bed, swing, etc):

If adult bed, what size? (twin, double, queen, king):

In what room and what proximity to people?

In what position was the infant last known alive?
 Sitting Back Right side Left side Stomach Other Unknown

Was this the infant's usual position?

Yes No

What was the infant's **face** position when last known alive? Face Down Face Up Face Right Face Left Other
 Unknown

What was the infant's neck position when last known alive? Hyperextended Flexed Neutral Turned Other
 Unknown

Child Found Unresponsive

Where was the infant found unresponsive? (bassinet, crib, car seat, adult bed, swing, etc):

If adult bed, what size? (twin, double, queen, king):

In what room and what proximity to people?

Was this the infant's usual sleep place? Yes No

In what position was the infant found unresponsive?
 Sitting Back Right side Left side Stomach Other Unknown

Was this the infant's usual position?

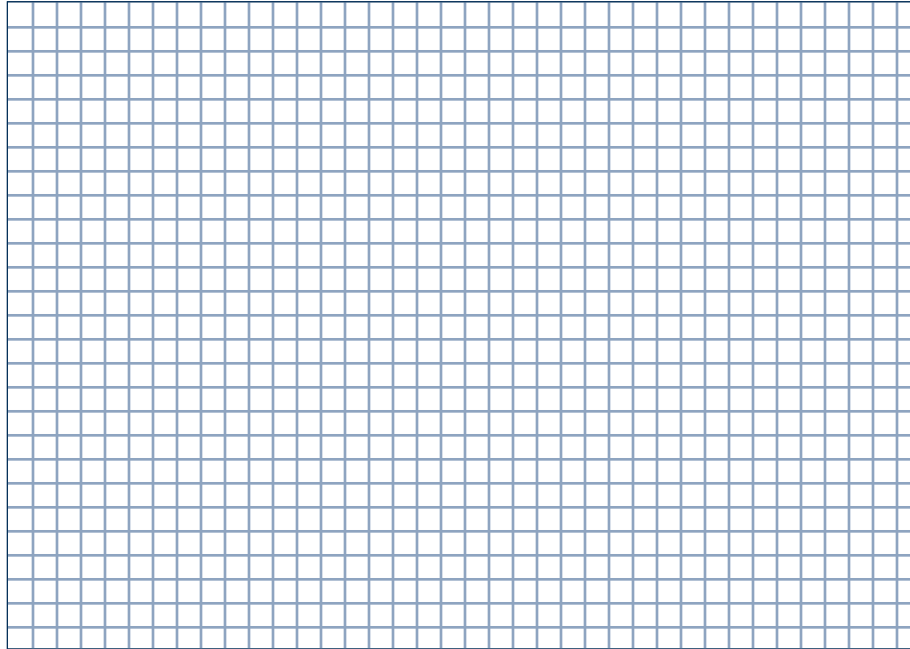
Yes No

What was the infant's **face** position when found unresponsive? Face Down Face Up Face Right
 Face Left Other Unknown

What was the infant's neck position when found unresponsive? Hyperextended Flexed Neutral
 Turned Other Unknown

If found face down, was there a visible cup, pocket or depression in bedding? Yes No
 If yes, investigator try to measure diameter and obtain photos. Attach photos to report. **Diameter:**

Draw the following: Infant's position when last placed and when found. Indicate direction of child's head.



Was it hard to get child out of a space?

Yes No

Was the child's body pinned?

Yes No

If pinned, vertically or horizontally?

Vertical Horizontal

If child was **NOT** in a crib or bassinet at the time of death, was one available in the home? Yes No

Possible Obstructions (Doll Reenactment, Photograph, Evidence Collection)

List all materials and objects near child when found, including blankets, sheets, pillows, bumper pads, stuffed animals, household items, etc, and note any of those objects that were found blocking child's nose and/or mouth:

Indicate types and numbers of layers of bedding, both over and under infant:

Secretion found on any blanket, sheet, clothing, pillow, other? Yes No

If yes, list types of secretions (blood, purge, vomit, etc):

Was child sleeping alone? Yes No

If no, who was child sleeping with?

List for all persons sleeping with child - name, age, height, weight, and location in relation to infant:

Name	Age	Height	Weight	Location

When child was found unresponsive, were any arms, legs or other parts of person's body covering child? Yes No

Were persons sleeping with child intoxicated at the time?

Yes No

Was there recent alcohol or other drug consumption by person(s) sleeping with child? Yes No

Were persons sleeping with child overtired at the time?

Yes No

Picture of body for documentation - ASAP after death.



PBT results:

Breathalyzer results:

Blood/urine results:

Does reenactment match lividity patterns?

Yes No

Does family/caregiver story match doll reenactment?

Yes No

Environmental Conditions (Photograph and Evidence Collection)

When the child was found unresponsive, was the room temperature too warm, too cold, or just about right?

Current temperature in the room where the child was found unresponsive:

Thermostat setting:

Thermostat reading:

Outside temperature:

Heating or cooling sources being used at time of death:

- Central Air A/C Unit Ceiling Fan Floor/Table Fan Window Fan Open Window(s) Gas Furnace/Boiler
 Electric Furnace/Boiler Space Heater Baseboard Heater Electric Radiant Fireplace (Wood) Fireplace (Coal)
 Kerosene Heater Wood Burning Stove Other Unknown

Where was the child found in proximity to the heating/cooling source?

Any devices operating in the infant's room? Collect apnea monitor as evidence.

- None Apnea Monitor Humidifier Vaporizer Air Purifier Other

Describe the general appearance of the incident scene (cleanliness, hazards, overcrowding):

Child exposed to second-hand smoke? Yes No

Describe any environmental hazards at the scene (insects, smokey smell, dampness, mold, pets, peeling paint, vermin, odors or fumes, presence of alcohol containers or drug paraphernalia, prescription or OTC drugs, electric hazards, other):

Source of drinking water at the scene: Public/Municipal Well Bottled Unknown Other

Investigator Activities

Investigator Name:

Agency:

Phone:

Date Completed:

Date and time child pronounced dead:

Name of authorizing physician who pronounced child dead:

Times - law enforcement at scene, other investigator at scene, infant at hospital:

Evidence Collection

Describe all items recovered from the site of the incident or death scene:

Evidence #	Origin	Description	Disposition	Collector's Name

EMS/First Responder Contact

Was there a response to the scene? Yes No

Was anyone doing CPR when EMS arrived? Yes No

Name of agency(ies):

Did EMS administer resuscitative efforts? Yes No

If yes, list what was done:

Conveyed to a medical facility? Yes No

If yes, name and address:

Was there evidence of livor mortis (lividity)? Yes No

If yes, describe:

Was there evidence of rigor mortis? Yes No

EMS run sheet/report obtained

911 tape obtained

Photos or video taken and noted

Doll reenactment/scene recreation

- Interviews completed with parents and other caregivers, physicians, witnesses, first responders, others as appropriate
- Notify next of kin or verify notification
- Referral(s) for counseling
- Other agencies informed and involved as appropriate: public health (especially for bereavement support), social services, prosecuting attorney.
- Other law enforcement investigation as appropriate
- Other scenes visited and investigated as appropriate

Alerts to Pathologist

Are there any factors, circumstances, or concerns that may have impacted the infant that have not yet been identified?

If more than one person was interviewed, does the information differ? Yes No
 Detail any discrepancies of relevant information:

Does the caregiver's explanation fit with investigative findings? Yes No

Indicate whether preliminary investigation may suggest the following (check all that apply):

- Asphyxia
- Diet issues
- Recent hospitalization
- Previous medical diagnosis
- Change in sleeping condition
- Sharing of sleeping surface with adults, children or pets
- Hyperthermia/hypothermia
- Environmental hazards
- Unsafe sleeping conditions
- History of acute life-threatening events
- History of medical care without diagnosis
- Recent fall or other injury
- History of religious, cultural or ethnic remedies
- Medical history that could indicate natural death
- Previous deaths of children in home or family
- Previous encounters with police or children's protective services
- Request for tissue or organ donation
- Objection to autopsy
- Pre-terminal resuscitative treatment
- Death possibly due to trauma (injury), poisoning or overdose
- Suspicious circumstances
- Other alerts for pathologist's attention

Pathologist information

Name: _____ Agency: _____

Phone: _____ Fax: _____

Date and Time when this form was shared with Pathologist:

For additional copies or for information, contact:

Keeping Kids Alive

The Michigan Child Death Review Program

Michigan Public Health Institute

2455 Woodlake Circle

Okemos MI 48864

PH: (517) 324-7330

FAX: (517) 324-7365

www.keepingkidsalive.org

Additional Notes/Narrative: