

# DEATH SCENE INVESTIGATION

## State of Michigan Protocols

### to Determine Cause and Manner of a Sudden and Unexplained Child Death



#### INSTRUCTIONS:

When a child dies suddenly and unexpectedly, a thorough investigation of the scene is necessary to accurately determine the cause and manner of death. The scene investigation should happen as soon as possible after the child's death, optimally within 24 hours.

This report should be used as a guide to your investigation of the scene of a sudden and unexplained death, especially to a child under the age of two. Completing all or parts of this report will help your Medical Examiner determine how and why the child died.

The questions in this report will lead you through a thorough investigation. It is not expected that you will be able to answer all of the questions. You should attempt to interview witnesses, EMS and emergency room personnel, child care providers, law enforcement, and other persons from the scene.

In conducting the investigation, criminality or negligence should not be assumed. An empathetic, non-confrontational approach is both appropriate and effective.

Complete as many sections as possible. Attach this form to your investigation report. Submit a copy to the Medical Examiner's Office within 24 hours.

Because the child will probably have already been transported to a hospital or other facility, it is important that you try to recreate the scene to approximate actual events. Attempt to acquire scene photographs as appropriate.

Contact your Prosecuting Attorney's Office to ensure that all laws and regulations are followed in your search of the area, the interviewing of witnesses, and the collection of evidence. Use only forms that have been approved by your local prosecutor. Sample forms are enclosed from the Michigan State Police.

1. Child's Name:			
2. Scene Address:			
3. Date of Birth:	4. Date of Death:	5. Race of Child:	6. Sex:
7. Date/Time of Investigation:		8. Case Number:	
9. Investigator's Name:		10. Agency/Department:	

### EVENTS SURROUNDING DEATH

11. Place of Fatal Event: (e.g. in crib, in car)	12. Death Witnessed: <input type="checkbox"/> No <input type="checkbox"/> Yes <b>Provide Detail in Narrative</b>
13. Who Found Child:	Time Found:
14. Status of Child When Found: <input type="checkbox"/> Dead <input type="checkbox"/> Unresponsive <input type="checkbox"/> In Distress <input type="checkbox"/> Unsure	
15. When Was Child Last Seen Alive: Time: _____ By Whom: _____ Where: _____	
16. Describe Condition of Child When Last Seen:	
17. Medical Assistance Summoned: <input type="checkbox"/> No <input type="checkbox"/> Yes	18. 911 Call <input type="checkbox"/> No <input type="checkbox"/> Yes <b>Obtain Tapes</b>
19. Resuscitation Attempted: <input type="checkbox"/> No <input type="checkbox"/> Yes By Whom: _____ History of Previous Resuscitation: <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Unknown	
20. Conveyed to a Medical Facility: <input type="checkbox"/> No <input type="checkbox"/> Yes Where: _____ Name and Address of Facility: _____	
21. Who Pronounced Child Dead:	

### CONDITION OF CHILD

22. Body Temperature: Degrees: _____ Time: _____ Method: _____	Sweaty <input type="checkbox"/> No <input type="checkbox"/> Yes
23. Livor Mortis: <input type="checkbox"/> No <input type="checkbox"/> Yes Time: _____ Where Observed: _____ Consistent with Position When Found (See Question 32): <input type="checkbox"/> No <input type="checkbox"/> Yes	
24. Rigor Mortis: <input type="checkbox"/> No <input type="checkbox"/> Yes Time: _____	
25. Hemorrhage of Eyes, Lips or Ears: <input type="checkbox"/> No <input type="checkbox"/> Yes	
26. Child Appears Clean, Well Nourished and Cared for: <input type="checkbox"/> No <input type="checkbox"/> Yes	<b>If No, Explain in Narrative</b>
27. Clothing Clean: <input type="checkbox"/> No <input type="checkbox"/> Yes Right Size: <input type="checkbox"/> No <input type="checkbox"/> Yes	Clothing Removed After Death: <input type="checkbox"/> No <input type="checkbox"/> Yes Clothing Type: _____
28. Diapers Used: <input type="checkbox"/> No <input type="checkbox"/> Yes <b>Collect as Necessary</b>	Wet: <input type="checkbox"/> No <input type="checkbox"/> Yes Soiled: <input type="checkbox"/> No <input type="checkbox"/> Yes

29. Are there Birthmarks or Injuries of Any Type, Including Bruises, Scrapes, Cuts, Burns, or Diaper Rash:

No  Yes

**Describe Colors, Shapes, Sizes and Locations in Narrative.**

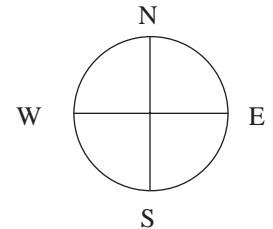
**Ensure That Necessary Photos Are Taken if Possible**

### POSITION OF CHILD

30. Sketch Position of Child and Identify Where in Crib, Bed, or Other Place Found:

**Ensure That Photos are Taken of Doll or Silhouette in Position.**

Indicate Direction of Child's Head: Circle One:



31. Was Child Moved from Original Position:  No  Yes Why:

32. Position When Discovered:(Refer Back to Question 23)

<u>BODY</u>	<u>BODY PINNED</u>	<u>HEAD AND NECK</u>	<u>USUAL SLEEPING POSITION</u>
<input type="checkbox"/> On Stomach	<input type="checkbox"/> Pinned Vertically	<input type="checkbox"/> Face Directly Up	<input type="checkbox"/> On Stomach
<input type="checkbox"/> On Back	<input type="checkbox"/> Pinned Horizontally	<input type="checkbox"/> Face Directly Down	<input type="checkbox"/> On Back
<input type="checkbox"/> Seated Upright	<input type="checkbox"/> Other Wedging	<input type="checkbox"/> Face to Right	<input type="checkbox"/> Seated Upright
<input type="checkbox"/> Left Side	<input type="checkbox"/> Not Pinned	<input type="checkbox"/> Face to Left	<input type="checkbox"/> Left Side
<input type="checkbox"/> Right Side		<input type="checkbox"/> Neck Flexed to Chin	<input type="checkbox"/> Right Side
		<input type="checkbox"/> Neck Extended Back	

33. Was Airway Obstructed When Discovered:

Airway Not Obstructed  Right Nostril Blocked  Object Covering Mouth  Objects Near Face  
 Both Nostrils Blocked  Left Nostril Blocked  Object Covering Nose

34. Describe any Objects Covering Nose, Mouth, or Face:

35. If Child was Found Face Down, is there a Visible Cup, Pocket, or Depression in the Bedding:

No  Yes Depth: Diameter:

36. Is there a Visible Crease on Face, Neck, or Hands from Pillows or Bedding:  No  Yes

37. Material Found in Nose or Mouth:

None  Formula  Bloody Froth  Blood Tinged Secretion  
 Mucous  Vomit  Dried Secretion  Other  
 Food  Froth  Urine or Stool

38. Secretion Found on:  Blanket     Sheet     Clothing     Pillow     Other

None     Formula     Bloody Froth     Blood Tinged Secretion

Mucous     Vomit     Dried Secretion     Other

Food     Froth     Urine or Stool

39. Face in Contact with Wet Materials:     No     Yes    Describe:

40. If Found while Sleeping, Was Child Sleeping Alone:     No     Yes

If No, Who was Child Sleeping with:

41. Is there any Possibility of Overlying: For Example, too Little Room for too Many People, Recent Alcohol or Other Drug Consumption by Person Sleeping with Child:     No     Yes    **Explain in Narrative**

42. Is there an Apnea Monitor in the Home:     No     Yes    **Download Information from Monitor**

Was Child On Monitor at Time of Death:     No     Yes    **Collect Monitor as Evidence**

**SOCIAL AND ENVIRONMENTAL CONDITIONS**

43. Who Does Child Live with:

44. Who had Responsibility for Child at Time of Death:

**In Narrative, Describe Activities of Caregivers During Days Leading Up to the Death**

45. Have Family Members or Caretakers Been Reported for Past Abuse or Neglect:     No     Yes

For Domestic Violence:     No     Yes

**Contact FIA to Obtain Information from Protective Services**

46. List Child Care Providers: Licensed:

Unlicensed:

47. Do Siblings Ever Watch Child Unattended:     No     Yes

48. Are there Any Cultural Practices that May Have Influenced the Death?     No     Yes

If Yes, Explain Fully in the Narrative

49. Description of Dwelling:

50. Cleanliness of Dwelling:     Below Average     Above Average     Average

51. Number of Children Living at Address:    Number of Adults Living at Address:

Overcrowding:     No     Yes

52. List all Materials and Objects Near Child When Found, Including Bed, Sheets, Pillows, Covers, Toys, Household Objects, etc. If Crib, Fill Out Optional Crib Checklist at End of Report.

53. Could any of These Materials & Objects Have Influenced the Death:     No     Yes

If Yes, Describe in Narrative

54. Are there any Environmental Hazards:     No     Yes

Tobacco Smoke     High Room Temp     Recent Remodeling     Tobacco     Animals

Drugs or Alcohol     Low Room Temp     Toxic Gases     Lead     Other

Medicines     Unusual Dampness     Toxic Products     Electrical

55. Room Temperature:    Heating/Cooling Source:

Outside Temperature:    Proximity of Child to Heat/Cooling Source:

## OPTIONAL CHECKLIST FOR DEFECTIVE CRIBS

1. Manufacturer:

2. Any Crack, Splits, Toe Holds, Old Paint:

3. Measure Space Between Mattress and Sides of Crib (Should be Less Than One Inch):

4. Measure Space Between Rails (Should be Less than 2 3/8"):

5. Measure Distance Between Top of Mattress and Top of Rails (Should be More than 26"):

6. Measure Distance from Floor to Mattress:

Top of Railing to Floor with Railing Up:

Down:

7. What is the Surface of the Floor:

What is Mattress Surface:

8. Do Rails Fall Down when Shaken or Pushed on:

9. Can Rails be Pulled Away from Sides of Crib:

10. Does Mattress Fit Securely or Does it Move Around:

11. Can Toys or Objects Be Wedged in Mattress:

## CHECKLIST FOR DISCRETIONARY COLLECTION OF EVIDENCE

Clothing

Medicines

Baby Bottles

Toys

Bedding

Drug Paraphernalia

Formula/Food

Equipment

Diapers

Folk Remedies

Honey, if fed  
within 30 Days

Other

Trace Evidence Collected: List

## ALL WITNESSES, RESPONDERS, AND OTHER PERSONS AT SCENE

List All Persons at Scene During Time Child Died:

Name

Address

Relationship

**NARRATIVE**

INVESTIGATOR'S SIGNATURE:

DATE:

**SEND COPY TO LOCAL MEDICAL EXAMINER'S OFFICE**