

Law Enforcement Infant/Young Child Death Investigation Checklist

At the Scene

- ☐ Make death scene as big as it needs to be.
- ☐ Document everything: **Doll re-enactment/scene re-creation**. Color photos of the complete scene are recommended. Videotaping may be useful for documentation.
- ☐ Retain all significant items (see item #13 on page 3). **These items may hold emotional significance to the family, so return when no longer needed.**
- ☐ If law enforcement must leave the scene, for example to accompany or assist emergency personnel, direct adults at the scene not to remove any furniture or bedding from the scene; do not wash bedding or clothing related to the child's death.
- ☐ A retrospective visit to the scene will be needed if the child was transported. Obtain consent or search warrant if necessary.

Witnesses

- ☐ The sources for information should come from those with first-hand knowledge of the events surrounding the incident. If language or culture are barriers, make sure you are assisted by a trained and experienced interpreter.
- ☐ Interview all adults, caregivers, and older children at the scene and/or in the household.
- ☐ Obtain signed medical release if possible.

Make sure to include all attachments

- ☐ Document everything, including all correspondence, verbal or written with any other agency.
- ☐ Complete departmental standard investigation form used by your agency. Complete all demographic, technical, historical, and disposition information on the investigation form.
- ☐ Obtain copies of 911 tapes, ambulance run sheets, law enforcement reports, and emergency room reports.

In General

- ☐ Complete infant/young child death scene investigation form in **ink**. Send copy to coroner.
- ☐ Have a resource list at your disposal, including the county attorney, coroner, child advocacy center, grief support organizations, and other relevant agencies.

Date: _____ Time of Call: _____ Case #: _____

NAME OF CHILD: _____ Date and Time of Death: _____

Place of Death (address, city & county): _____

Gender: Male ☐ Female ☐ Age: Months: _____ Days: _____ Date of Birth: _____

Place of Birth (address, facility, city & county) _____

NAME OF CHILD'S HEALTH CARE PROVIDER: _____

Address: _____ Phone: (____) _____

NAME OF MOTHER/FEMALE GUARDIAN: _____

Relationship: _____ Age: _____ Date of Birth: _____

Phone: Evenings: (____) _____ Days: (____) _____ Cell: (____) _____

Current Address: _____ SSN: _____ - _____ - _____

Length of Time at this Address: Years: _____ Months: _____ Date Moved: _____

Last Address: _____

Current Employer: _____ Employer Address: _____

NAME OF FATHER/MALE GUARDIAN: _____

Relationship: _____ Age: _____ Date of Birth: _____

Phone: Evenings: (____) _____ Days: (____) _____ Cell: (____) _____

Current Address: _____ SSN: _____ - _____ - _____

Length of Time at this Address: Years: _____ Months: _____ Date Moved: _____

Last Address: _____

Current Employer: _____ Employer Address: _____

10. Presence of any of the following where the body was found (either dried or fresh):

Blood: ☐ Yes ☐ No

Vomit: ☐ Yes ☐ No

Urine: ☐ Yes ☐ No

Feces: ☐ Yes ☐ No

Other (describe): _____

11. Presence of any of the following where the death occurred if different than where found:

Blood: ☐ Yes ☐ No

Vomit: ☐ Yes ☐ No

Urine: ☐ Yes ☐ No

Feces: ☐ Yes ☐ No

Other (describe): _____

12. Child Diagram

If present, indicate location on diagram.

☐ Yes ☐ No Drainage/discharge from body or orifices

☐ Yes ☐ No Marks or bruises

☐ Yes ☐ No Diagnostic or therapeutic devices

☐ Yes ☐ No Pale pressure mark areas

☐ Yes ☐ No Predominant areas of lividity

13. Condition, surface and contents of the bed, crib, sofa, car seat, bathtub, or other place where body was found:

[Include and retain anything that could have been in contact with child or obstructed the nose or mouth: crib, plastic bag, curtain, tissues, pillow, blanket, feeding bottle, pacifier, stuffed animal, other toys]

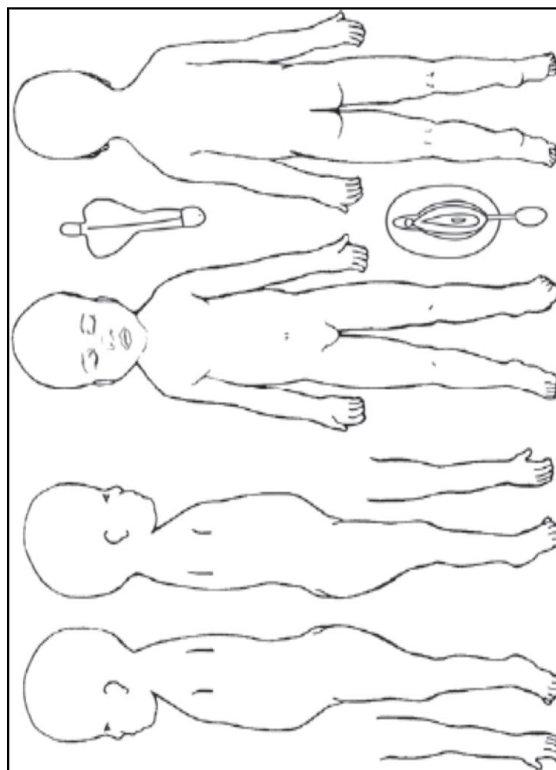
Type/condition of sleeping surface: _____

of blankets/layers: _____ Support of mattress: _____

Distance between mattress and sides of crib: _____

Sturdiness of rails: _____

Other objects that could have been in contact with child (plastic bag, curtain, tissues, pillow, feeding bottle, pacifier, stuffed animal, other toys): _____



14. For child deaths involving bathtub or other water situations:

Depth of water: _____ Temperature of water: _____ Type of container holding water: _____

Location of hot and cold water sources near child: _____

15. For child deaths involving shared sleeping surface, list pets, and/or name(s) of person(s) sleeping with child: _____

Relationship: _____ Age: _____ Date of Birth: _____

Any significant physical, emotional, or other characteristics (overweight, sleepy, drunk, sick): _____

16. Presence of potentially harmful medicines, toxins (fumigants, pesticides, etc.), **tobacco, alcohol, or illegal drugs:** _____

17. Evidence of dampness, visible standing water, or mold growth: _____

18. Types, amounts, and apparent adequacy of the food available for the child: _____

19. Temperature: Outdoor: _____ Indoor: _____ Date/Time noted: _____

Thermostat: Setting: _____ Reading: _____ Date/Time noted: _____

Method of heating or cooling used (e.g., gas, electric, wood, propane, forced air, radiator, electric baseboard, fans, air conditioners): _____

20. **Presence of a functioning carbon monoxide monitor?** ☐ Yes ☐ No
21. **Evidence of alteration of the body or scene:** _____
22. **Resuscitation efforts taken by any caretaker or other person when found:** ☐ Yes ☐ No
By whom: _____ Resuscitation efforts by First Responder(s): _____
23. **All first responders at the scene** [Include EMS, fire & rescue, law enforcement, coroner, police chaplain, and others (not yourself)].
- | Name | Agency | Phone # |
|------|--------|---------|
| | | |
| | | |
| | | |
| | | |
24. **Name of facility where transported:** _____
Arrival Time: _____ Who Transported: _____
Resuscitation efforts at medical facility: _____ Attending Physician: _____
25. **Pronounced by whom:** _____
26. **Scene photos taken:** ☐ Yes ☐ No
27. **Doll reenactment:** ☐ Yes ☐ No
28. **Evidence collected:** ☐ Yes ☐ No
29. **Scene diagram:** ☐ Yes ☐ No
30. **Signed Medical Release Obtained:** ☐ Yes ☐ No
31. **NHHS Protection & Safety notified:** ☐ Yes ☐ No

IMMEDIATE HISTORY

1. **Source of medical information:** ☐ Physician ☐ Other health care provider ☐ Medical Records
☐ Family ☐ Other, specify: _____
2. **Last fed by whom:** Name: _____ Relationship: _____ Date/Time: _____
Contents of last feeding: _____ Amount eaten & appetite: _____
Source of information: _____ Phone: _____
Usual type of feeding (bottle, breast, formula, breast milk, cow's milk, baby food, etc.): _____
3. **Recent Illnesses in Child** (past 72 hours):
☐ Cold ☐ Vomiting ☐ Allergies ☐ Sniffles ☐ Fever/Sweating ☐ Injury
☐ Cough ☐ Drowsy ☐ Wheezing ☐ Diarrhea ☐ Other: _____
☐ Irritable/fussy Specify: _____
4. **Recent Illnesses in Household Members** (past 72 hours):
Illness: _____ Who is affected: _____ Relationship: _____
Illness: _____ Who is affected: _____ Relationship: _____
Illness: _____ Who is affected: _____ Relationship: _____
5. **Recent Illnesses in Any Other Person in Contact with the Child** (day care, church, etc.):
Illness: _____ Who is affected: _____ Relationship: _____
6. **Was Child Taking Medication(s)/Home Remedies:** ☐ Yes ☐ No
If yes, describe medication/home remedy: _____ Amount taken: _____ Time of last dosage: _____
7. **Exposure to Chemicals or Toxins:** ☐ Yes ☐ No
If yes, Name of chemical(s)/toxin(s): _____ When exposed: _____
8. **Recent Injury or Fall:** ☐ Yes ☐ No If yes, describe: _____
9. **Does anyone in household smoke?** ☐ Yes ☐ No If yes, who and how much? _____
10. **Does anyone in household use drugs/alcohol?** ☐ Yes ☐ No If yes, who and how much? _____

11. Does anyone in household have a serious physical or mental illness? ☐ Yes ☐ No
If yes, describe: _____
12. Last time child seen by medical provider: Date: _____ Location: _____
Physician: _____ Reason seen: _____
13. Last immunizations (date and type): _____
14. Have police been called to the home in the past? ☐ Yes ☐ No If yes, describe: _____
15. Prior contact with child protective services? ☐ Yes ☐ No If yes, describe: _____
16. Documented history of child abuse/neglect: ☐ Yes ☐ No If yes, describe: _____

MEDICAL HISTORY

1. Child birth length: _____ inches | centimeters (circle one) 2. Child weight at birth: _____ lbs/oz | grams (circle one)
3. Compared to delivery date was child born: ☐ On time ☐ Early – # weeks? _____ ☐ Late – # weeks? _____
4. If child was from multiple births, how many were:
Born alive _____ Still born _____ Died since birth _____ Still alive _____
5. Were there complications during pregnancy? ☐ Yes ☐ No If yes, describe: _____
6. Were there complications during delivery or at birth? (emergency c-section, child needed oxygen, etc.): ☐ Yes ☐ No
If yes, describe: _____
7. Birth Hospital Name/Location: _____
8. At any time in the child's life did he/she have an incident of:
- | | Yes | No | Unknown | Describe: |
|---------------------------------------|--------------------------|--------------------------|--------------------------|-----------|
| Allergies (food, medication or other) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Abnormal growth or weight gain/loss | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Apnea (stopped breathing) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Cyanosis (turned blue/gray) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Seizures or convulsions | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Cardiac abnormalities | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Metabolic disorders | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Other | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
9. Did the child have any birth defect(s)? ☐ Yes ☐ No Describe: _____
10. Has the child ever been taken to the emergency room and/or hospitalized? ☐ Yes ☐ No
If yes, indicate reason(s), approximate date, name of hospital: _____
11. Immunizations up to date? ☐ Yes ☐ No

PREGNANCY HISTORY

1. At how many weeks did the birth mother begin prenatal care?
_____ Weeks _____ Months _____ No prenatal care _____ Unknown
2. Where did the mother receive prenatal care?
Physician/provider: _____ Hospital/clinic: _____ Phone: _____
Street: _____ City: _____ State: _____ Zip: _____

3. During her pregnancy, did the birth mother have any complications? ☐ Yes ☐ No
If yes, specify: _____
4. Was the birth mother injured during her pregnancy with the child? (e.g., auto accident, falls)
☐ Yes ☐ No If yes, specify: _____
5. During her pregnancy, did she use any of the following?
- | | Yes | No | Unknown | Describe: |
|----------------------------|--------------------------|--------------------------|--------------------------|-----------|
| Over the counter medicines | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Prescription medications | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Herbal remedies | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Cigarettes | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Alcohol | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Other | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
5. Currently, does any caregiver use any of the following?
- | | Yes | No | Unknown | Describe: |
|----------------------------|--------------------------|--------------------------|--------------------------|-----------|
| Over the counter medicines | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Prescription medications | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Herbal remedies | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Cigarettes | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Alcohol | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Other | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
6. Do any of the caregivers have a previous history of any infant/child deaths?
☐ Yes ☐ No If yes, where? _____
Cause of death: _____ Age of child at death: _____

This space for documenting any additional pertinent information

INVESTIGATOR'S NAME: _____ Title: _____
Agency: _____ County: _____ Phone: (____) _____
Signature: _____ Date: _____