



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/4.5SIDSProtocol.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 | <input type="checkbox"/> Male <input type="checkbox"/> Female | | | |
| Home Address (Number, Street) | | | | | | Time of Death | | | |
| | | | | | | <input type="checkbox"/> Found <input type="checkbox"/> Pronounced | | | |
| City | | | State | | Zip Code | | County | | |
| Primary Language Spoken in Home | | | | | | Social Security No. of Decedent | | | |
| <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other _____ <input type="checkbox"/> Interpreter Needed | | | | | | | | | |
| Mother's Name | | | Relationship | | | Race/Ethnicity | | Marital Status | |
| Last | | First | MI | <input type="checkbox"/> Natural <input type="checkbox"/> Adoptive <input type="checkbox"/> Step <input type="checkbox"/> Other (Specify: _____) | | | <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Not Married <input type="checkbox"/> Widowed | | |
| Date of Birth | | | Age | Yrs. of Education | CDL # | | Telephone No. | | On Public Assistance? |
| Mo | Day | Yr | | | | | () | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Address (If Different from Infant) | | | | City | | | State | | Zip Code |
| | | | | | | | | | |
| Father's Name | | | | Relationship | | | Race/Ethnicity | | |
| Last | | First | | MI | <input type="checkbox"/> Adoptive <input type="checkbox"/> Other <input type="checkbox"/> Natural <input type="checkbox"/> 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 | | <input type="checkbox"/> Male <input type="checkbox"/> Female | | |
| | | | | | | | <input type="checkbox"/> Male <input type="checkbox"/> Female | | |
| | | | | | | | <input type="checkbox"/> Male <input type="checkbox"/> Female | | |
| | | | | | | | <input type="checkbox"/> Male <input type="checkbox"/> 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

EMS Arrival:
Date: Mo Day Year

Time:

Time:

Police Arrival:
Date: Mo Day Year

Coroner Arrival:
Date: Mo Day Year

Time:

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

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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 No Unknown Where:
b. Bruises: Yes No Unknown Where:
c. Lacerations: Yes No Unknown Where:
d. Other Injuries: Yes No Unknown Specify:

13. Postmortem or Perimortem Injuries?

Yes (Describe:) No Unknown
If Yes, Were Injuries Related to Resuscitation? Yes No Unknown

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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, Conventional Mattress, Water Mattress, Crib, Other, Floor, Bassinet, Couch, Car Bed/Seat, Chair, Bean Bag, Drawer, Playpen

16. Co-Sleeping

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

If Yes, describe others in "Bed":

- Mother, Father, Other Adult, 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, Blanket(s) Over the Head, Blanket(s) Under Infant, Pacifier, Toys, None, Pillows, Bumper Pads, Plastic Bags, Other (Specify: _____)

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

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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: _____)

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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: _____

- Checkboxes for: Clothes, Diapers, Drug Paraphernalia, Other, Feeding Formulas, Over the Counter Drugs, Folk Remedies, Medications, Trace Evidence, Unwashed or Partially Consumed Bottles, None.

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

- Checkboxes for: Bedding, None, Toys, Other, Honey, if fed within 30 Days of Death.

IV. HISTORY OF ATTEMPTED RESUSCITATION

26. Attempted Resuscitation

a. Mouth-to-Mouth Ventilation?

- Yes/No checkboxes

b. Bag and Mask Ventilation?

- Yes/No checkboxes

c. Oral Airway Placement?

- Yes/No/Attempted checkboxes

d. Intubation?

- Yes/No/Attempted checkboxes

e. Cardiac Compression?

- Yes/No checkboxes

f. Intravenous Fluids?

- Yes/No checkboxes

g. Intracardiac Medications?

- Yes/No checkboxes

h. Intraosseous Lines? (catheter in shinbone)

- Yes/No checkboxes

i. Placed on Life Support?

- Yes/No checkboxes, Duration: _____

j. Body Temperature Taken Near Time of Resuscitation: _____ °F [Rectal/Other Site checkboxes]

k. Initial Cardiac Rhythm Recorded? [Yes/No checkboxes, A systole/Other options]

l. Normal Cardiac Rhythm Restored? [Yes/No checkboxes, Duration of CPR: _____ minutes]

m. Duration of Survival after Resuscitation [Minutes/Hours checkboxes]

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

By Whom: _____

Agency/ID#: _____

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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): _____

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30. Exposure History

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

Yes No Unknown Relationship to Infant: Nature of Illness:

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

31. Recent Behavior Change?

Yes No (Describe:)

32. Recent Change in Sleep Pattern?

Yes No (Describe:)

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 No Type:

36. Feeding History

a. Food Intolerance?

Yes No Unknown

b. Breast Milk in Diet when Infant Died?

Yes No

c. Formula?

Yes No (Type:)

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 No Where: 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 No License Number:

c. Relative of Decedent? Yes No Relationship:

d. Foster Care? Yes No

e. Name of Person Caring for Infant:

Address: Street City State Zip County Phone

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39. History of Injuries or Trauma

- a. Head Injury?
b. Loss of Consciousness?
c. Lethargy?
d. Seizure?
e. Fractures?
f. Suspected Child Abuse?
g. Was there documented history of child abuse?

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

- a. Respiratory Disease?
b. Heart Disease?
c. Apnea (Stopped Breathing)?
d. Seizure?
e. Other (Specify):

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

- a. Oxygen?
b. Apnea Monitor?
c. Antibiotics?
d. Anticonvulsants?
e. Other (Specify):

42. Last Seen By Doctor or Health Professional

Date Last Seen: Medications prescribed:
a. Routine Well Baby Exam
b. Weight: lbs.
c. Height: inches
d. Temperature: °F
e. Name of Health Care Provider:
Address: Street City State Zip
County Phone

43. Immunizations

a. Most Recent Immunization:
b. Total Number of Immunizations Since Birth:
Polio
DTaP
Meningitis Varicella (Chickenpox)
Measles, Mumps Rubella (MMR)
Haemophilus HIB
Hepatitis B

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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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Please Type or Print

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? | <input type="checkbox"/> Yes | _____ | <input type="checkbox"/> No <input type="checkbox"/> Unknown |
| d. Sudden Unexpected Death of an Infant? | <input type="checkbox"/> Yes | _____ | <input type="checkbox"/> No <input type="checkbox"/> Unknown |
| e. Prematurity? | <input type="checkbox"/> Yes | _____ | <input type="checkbox"/> No <input type="checkbox"/> Unknown |
| f. Chronic or Recurrent Infections? | <input type="checkbox"/> Yes | _____ | <input type="checkbox"/> No <input type="checkbox"/> Unknown |
| g. Pneumonia? | <input type="checkbox"/> Yes | _____ | <input type="checkbox"/> No <input type="checkbox"/> Unknown |
| h. Trauma (Life Threatening)? | <input type="checkbox"/> Yes | _____ | <input type="checkbox"/> No <input type="checkbox"/> Unknown |
| i. Alcohol Abuse? | <input type="checkbox"/> Yes | _____ | <input type="checkbox"/> No <input type="checkbox"/> Unknown |
| j. Drug Abuse? | <input type="checkbox"/> Yes | _____ | <input type="checkbox"/> No <input type="checkbox"/> Unknown |
| k. Serious Physical Mental Illness? | <input type="checkbox"/> Yes | _____ | <input type="checkbox"/> No <input type="checkbox"/> Unknown |
| l. Police Called to Home in Past? | <input type="checkbox"/> Yes | _____ | <input type="checkbox"/> No <input type="checkbox"/> Unknown |
| m. Prior Contact with Social Services? | <input type="checkbox"/> Yes | _____ | <input type="checkbox"/> No <input type="checkbox"/> Unknown |

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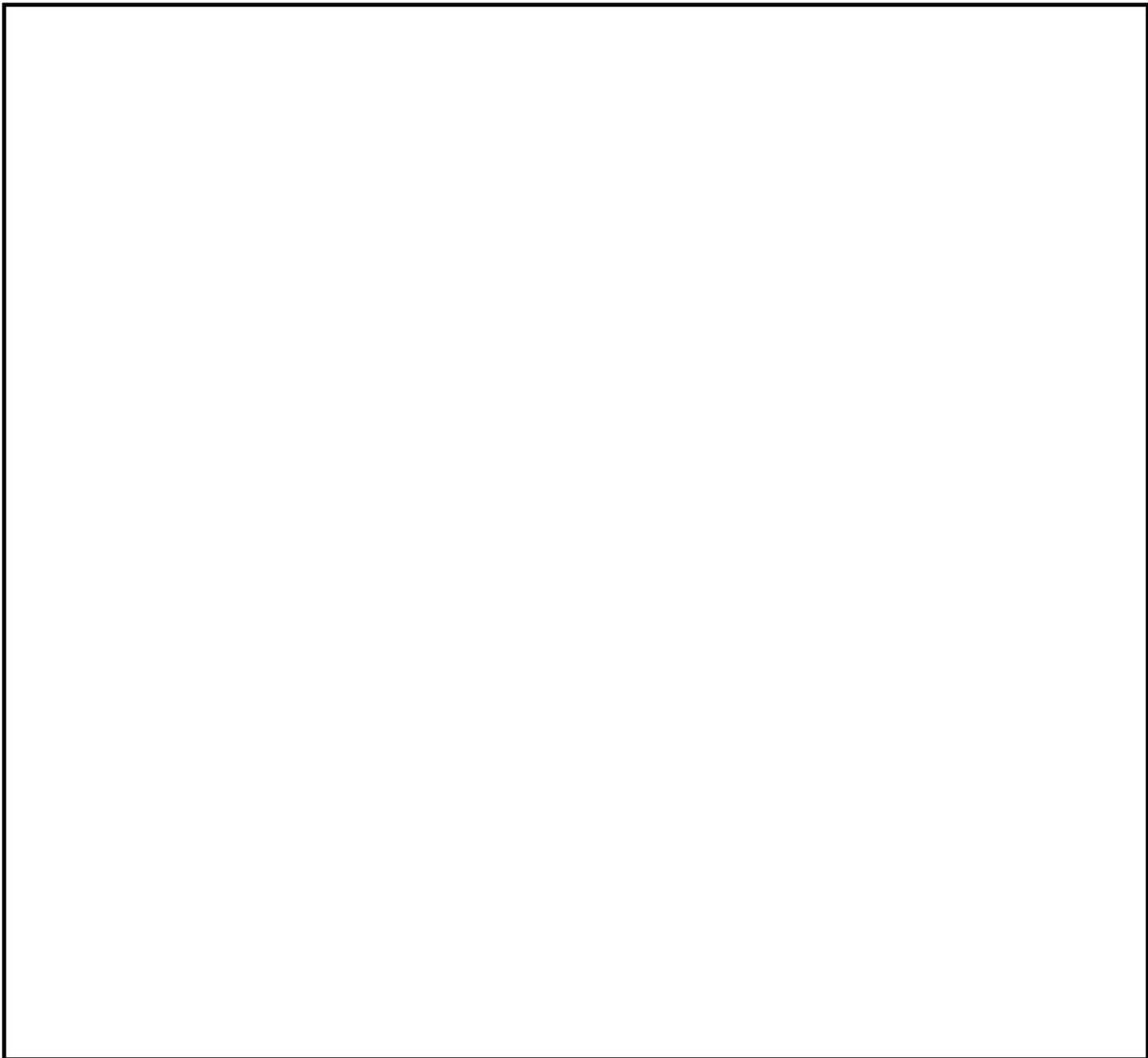
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VII. ROOM DIAGRAM

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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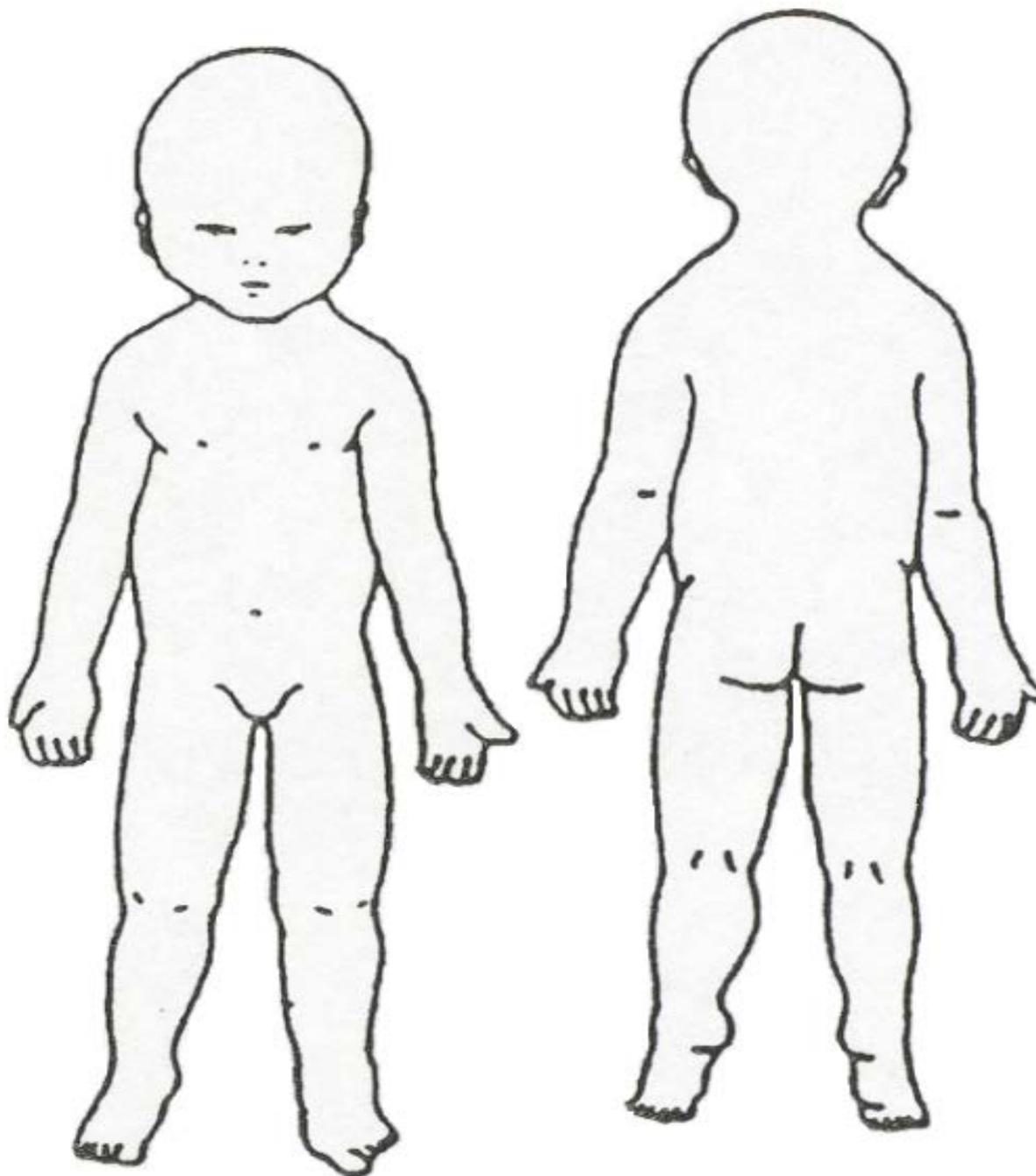
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VIII. BODY DIAGRAM

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

Empty box for supplement content.