



# 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 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:

**California Department of Public Health  
Maternal, Child, & Adolescent Health/Office of Family Planning Branch  
Epidemiology and Evaluation Section  
P.O. Box 997420, MS 8304  
Sacramento, CA 95899-7420  
(916) 650-0323 (phone) Carrie.Florez@cdph.ca.gov (email)**

Additional copies of the Protocol can be obtained from the CDPH at the contact information listed above or by accessing the California SIDS Program website at [www.californiasids.com](http://www.californiasids.com).

## 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.		
Mo	Day	Yr									
									(    )		
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 E.R. 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 No License #: No Relative of Decedent? Yes No 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

Please Type or Print

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

13. Postmortem or Perimortem Injuries?

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

DEATH SCENE AND DEPUTY CORONER INVESTIGATION PROTOCOL

Please Type or Print

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 (Size: ...) Conventional Mattress (Size: ...) Water Mattress (Size: ...) Crib (Describe: ...) Other (Specify: ...) 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 (Est. weight: ...) (Est. height: ...) Father (Est. weight: ...) (Est. height: ...) Other Adult (Est. weight: ...) (Est. height: ...) Other Adult (Est. weight: ...) (Est. height: ...) 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 Number of Blankets: Type of Blanket: Blanket(s) Over the Head Number of Blankets: Type of Blanket: Blanket(s) Under Infant Number of Blankets: Type of Blanket: Pacifier Pillows Bumper Pads Plastic Bags Toys (Specify: ...) Other (Specify: ...) None

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

DEATH SCENE AND DEPUTY CORONER INVESTIGATION PROTOCOL

Please Type or Print

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: )

DEATH SCENE AND DEPUTY CORONER INVESTIGATION PROTOCOL

Please Type or Print

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 and Duration field

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

k. Initial Cardiac Rhythm Recorded?

- Yes/No checkboxes with sub-options: If yes, A systole, Other

l. Normal Cardiac Rhythm Restored?

- Yes/No checkboxes and Duration of CPR field

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

n. Location(s) of Resuscitation(s): \_\_\_\_\_

By Whom: \_\_\_\_\_

Agency/ID#: \_\_\_\_\_

DEATH SCENE AND DEPUTY CORONER INVESTIGATION PROTOCOL

Please Type or Print

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: )

**DEATH SCENE AND DEPUTY CORONER INVESTIGATION PROTOCOL**

Please Type or Print

**30. Exposure History**

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

Yes Relationship to Infant: \_\_\_\_\_  No  Unknown  
 Nature of Illness: \_\_\_\_\_

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

**31. Recent Behavior Change?**

Yes (Describe: \_\_\_\_\_)  No

**32. Recent Change in Sleep Pattern?**

Yes (Describe: \_\_\_\_\_)  No

**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 Type: \_\_\_\_\_  No

**36. Feeding History**

a. Food Intolerance?

Yes  
 No  
 Unknown

b. Breast Milk in Diet when Infant Died?

Yes  
 No

c. Formula?

Yes (Type: \_\_\_\_\_)  
 No

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 Where: \_\_\_\_\_  No  
 From: \_\_\_\_\_ to \_\_\_\_\_  
 Mo Day Year 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 License Number: \_\_\_\_\_  No

c. Relative of Decedent?  Yes Relationship: \_\_\_\_\_  No

d. Foster Care?  Yes  No

e. Name of Person Caring for Infant: \_\_\_\_\_

Address: \_\_\_\_\_  
 Street City State Zip  
 \_\_\_\_\_  
 County ( ) Phone

DEATH SCENE AND DEPUTY CORONER INVESTIGATION PROTOCOL

Please Type or Print

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 Meningitis Varicella (Chickenpox) Haemophilus HIB
DTaP Measles, Mumps Rubella (MMR) Hepatitis B

DEATH SCENE AND DEPUTY CORONER INVESTIGATION PROTOCOL

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):

**DEATH SCENE AND DEPUTY CORONER INVESTIGATION PROTOCOL**

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?<br><input type="checkbox"/> Yes (Name: _____)<br><input type="checkbox"/> No   | b. Anticonvulsants?<br><input type="checkbox"/> Yes (Name: _____)<br><input type="checkbox"/> No              | c. Pain Medications?<br><input type="checkbox"/> Yes (Name: _____)<br><input type="checkbox"/> No                 |
| d. Thyroid?<br><input type="checkbox"/> Yes<br><input type="checkbox"/> No                     | e. Hormones?<br><input type="checkbox"/> Yes (Name: _____)<br><input type="checkbox"/> No                     | f. Other Prescription Drugs?<br><input type="checkbox"/> Yes (Name: _____)<br><input type="checkbox"/> No         |
| d. Cold Remedies?<br><input type="checkbox"/> Yes (Name: _____)<br><input type="checkbox"/> No | e. Other Over-the-Counter Drugs?<br><input type="checkbox"/> Yes (Name: _____)<br><input type="checkbox"/> No | f. Other Medications? (Incl. Herbal)<br><input type="checkbox"/> Yes (Name: _____)<br><input type="checkbox"/> 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?  Yes \_\_\_\_\_  No  Unknown
- d. Sudden Unexpected Death of an Infant?  Yes \_\_\_\_\_  No  Unknown
- e. Prematurity?  Yes \_\_\_\_\_  No  Unknown
- f. Chronic or Recurrent Infections?  Yes \_\_\_\_\_  No  Unknown
- g. Pneumonia?  Yes \_\_\_\_\_  No  Unknown
- h. Trauma (Life Threatening)?  Yes \_\_\_\_\_  No  Unknown
- i. Alcohol Abuse?  Yes \_\_\_\_\_  No  Unknown
- j. Drug Abuse?  Yes \_\_\_\_\_  No  Unknown
- k. Serious Physical Mental Illness?  Yes \_\_\_\_\_  No  Unknown
- l. Police Called to Home in Past?  Yes \_\_\_\_\_  No  Unknown
- m. Prior Contact with Social Services?  Yes \_\_\_\_\_  No  Unknown





**DEATH SCENE AND DEPUTY CORONER INVESTIGATION PROTOCOL**

Please Type or Print

**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



# DEATH SCENE AND DEPUTY CORONER INVESTIGATION PROTOCOL

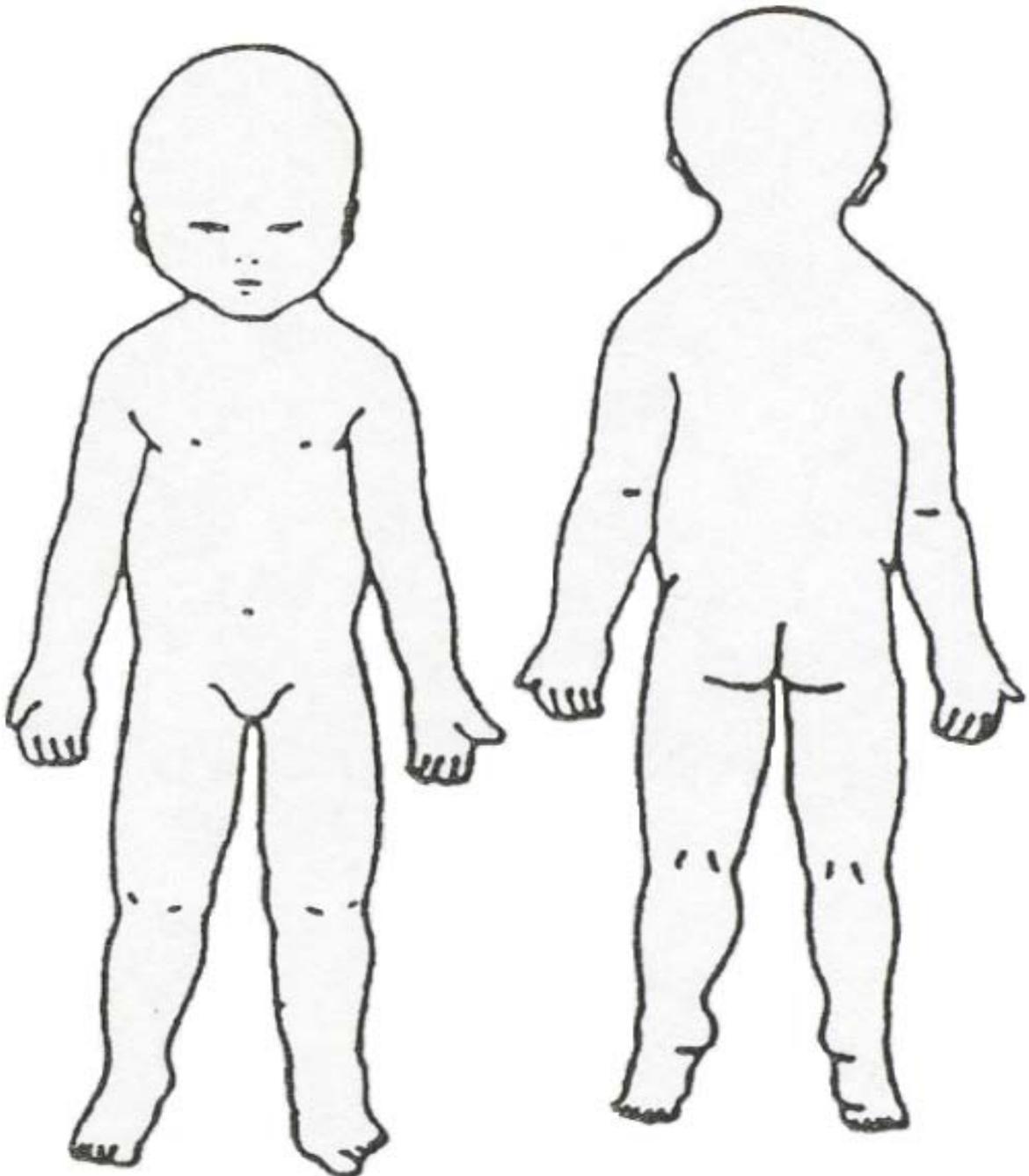
Please Type or Print

## 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



**IX. SUPPLEMENT**

Empty space for supplement content.