



MISSOURI DEPARTMENT OF SOCIAL SERVICES
MISSOURI CHILD FATALITY REVIEW PROGRAM

DEATH SCENE INVESTIGATIVE CHECKLIST FOR CHILD FATALITIES

STAT
PO BOX 208
JEFFERSON CITY, MO 65102-0208
(573) 751-5980
(800) 487-1626

INSTRUCTIONS

When a child dies suddenly and unexpectedly, or suspiciously, a thorough evaluation/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 checklist should be used as a guide to your investigation of the scene of a sudden and unexplained or suspicious death, especially to a child under the age of one. Completing all information appropriate to the fatality will help the pathologist determine how and why the child died. For assistance, call (800) 487-1626.

The questions in the checklist 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, but the possibility should not be overlooked. An empathetic, non-confrontational approach is both appropriate and effective.

Complete as many sections as possible. If appropriate, attach this form to your investigation report. Submit a copy to the Medical Examiner's Office prior to the autopsy.

Because the child will probably have already been transported to a hospital or other facility, it is important that, based on evidence and witness accounts, you try to recreate the scene to approximate actual events. This may include the use of dolls or silhouettes to reconstruct location and position of body. Attempt to acquire scene and reconstruction photographs as appropriate.

Contact your Prosecuting Attorney's Office to ensure that all laws and regulations are followed in the search of the area, the interviewing of witnesses, and the collection of evidence. Only use procedures and forms approved by your agency and prosecutor. Sample forms are available from STAT.

VICTIM IDENTIFIERS AND PRE-NATAL HISTORY

1. CHILD'S NAME	2. SOCIAL SECURITY NUMBER
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3. SCENE ADDRESS

4. DATE OF BIRTH	5. DATE OF DEATH	6. RACE OF CHILD	7. SEX
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8. DECEDENT'S ADDRESS

9. MOTHER'S NAME

10. MOTHER'S ADDRESS

11. MOTHER'S TELEPHONE NUMBER	12. MOTHER'S DATE OF BIRTH	13. MOTHER'S SOCIAL SECURITY NUMBER
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14. GESTATION IN WEEKS	15. BIRTH WEIGHT	16. KNOWN MATERNAL PRE-NATAL HEALTH PROBLEMS (DIABETES, HYPERTENSION, ETC.)? <input type="checkbox"/> NO <input type="checkbox"/> YES <input type="checkbox"/> UNKNOWN
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IF YES, DESCRIBE

17. WAS MOTHER TAKING PRESCRIPTION MEDICATION FOR ABOVE MEDICAL CONDITION DURING PREGNANCY?
 NO YES UNKNOWN **If yes, what type of medication?**

18. PRE-NATAL MATERNAL CIGARETTE, ALCOHOL OR DRUG USAGE? <input type="checkbox"/> NO <input type="checkbox"/> YES <input type="checkbox"/> UNKNOWN	IF YES, <input type="checkbox"/> Alcohol <input type="checkbox"/> Cigarettes <input type="checkbox"/> Cocaine <input type="checkbox"/> Heroin <input type="checkbox"/> Marijuana <input type="checkbox"/> Methamphetamine <input type="checkbox"/> Other
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19. KNOWN COMPLICATIONS OF PREGNANCY OR DELIVERY?
 NO YES UNKNOWN **If yes, explain:**

20. LOCATION OF BIRTH AND NAME OF FACILITY

21. ATTENDING MEDICAL PRACTITIONER

22. BIRTH DEFECTS OR OTHER ABNORMALITIES OF DECEDENT AT BIRTH, DESCRIBE:

23. ANY FAMILY HISTORY OF SIDS OR OTHER INFANT DEATH?
 NO YES UNKNOWN

IF YES, DESCRIBE DETAILS INCLUDING DATE OF DEATH AND LOCATION OF OCCURRENCE:

EVENTS SURROUNDING DEATH

24. PLACE OF FATAL EVENT (E.G., IN CRIB, IN CAR)?	25. DEATH WITNESSED? <input type="checkbox"/> NO <input type="checkbox"/> YES If yes, provide detail in narrative.
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26. WHO FOUND CHILD?	TIME FOUND
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27. STATUS OF CHILD WHEN FOUND <input type="checkbox"/> Dead <input type="checkbox"/> Unresponsive <input type="checkbox"/> In Distress <input type="checkbox"/> Unsure	28. WHEN WAS CHILD LAST SEEN ALIVE (TIME, WHERE, BY WHOM)?
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29. DESCRIBE CONDITION OF CHILD WHEN LAST SEEN:

30. MEDICAL ASSISTANCE SUMMONED? <input type="checkbox"/> NO <input type="checkbox"/> YES	31. 911 CALL? <input type="checkbox"/> NO <input type="checkbox"/> YES If yes, obtain tapes.
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32. 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
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33. CONVEYED TO A MEDICAL FACILITY? <input type="checkbox"/> NO <input type="checkbox"/> YES	WHERE?	NAME AND ADDRESS OF FACILITY
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34. WHO PRONOUNCED CHILD DEAD?

CONDITION OF CHILD

35. BODY TEMPERATURE (DEGREES)	TIME	METHOD	SWEATY? <input type="checkbox"/> NO <input type="checkbox"/> YES
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36. LIVOR MORTIS <input type="checkbox"/> NO <input type="checkbox"/> YES	TIME	WHERE OBSERVED?	CONSISTENT WITH POSITION WHEN FOUND? <input type="checkbox"/> NO <input type="checkbox"/> YES (See Question 44)
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37. RIGOR MORTIS <input type="checkbox"/> NO <input type="checkbox"/> YES	TIME	38. HEMORRHAGE OF EYES, LIPS OR EARS? <input type="checkbox"/> NO <input type="checkbox"/> YES
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39. CHILD APPEARS CLEAN, WELL NOURISHED AND CARED FOR
 NO YES **If no, explain in narrative.**

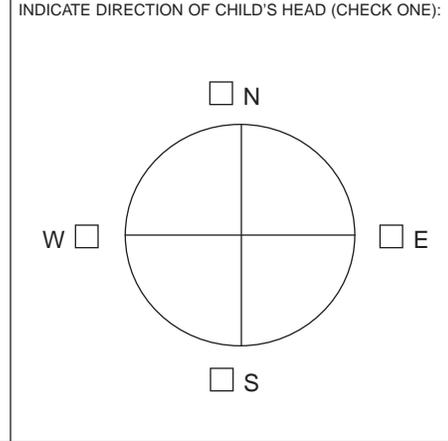
40. CLOTHING CLEAN? <input type="checkbox"/> NO <input type="checkbox"/> YES	RIGHT SIZE? <input type="checkbox"/> NO <input type="checkbox"/> YES	CLOTHING REMOVED AFTER DEATH? <input type="checkbox"/> NO <input type="checkbox"/> YES	CLOTHING TYPE
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41. DIAPERS USED? (COLLECT AS NECESSARY) <input type="checkbox"/> NO <input type="checkbox"/> YES	WET? <input type="checkbox"/> NO <input type="checkbox"/> YES	SOILED? <input type="checkbox"/> NO <input type="checkbox"/> YES
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42. ARE THERE BIRTHMARKS OR INJURIES OF ANY TYPE, INCLUDING BRUISES, SCRAPES, CUTS, BURNS OR DIAPER RASH?
 NO YES **If yes, describe colors, shapes, sizes and locations in narrative. Ensure that necessary photos are taken if possible.**

POSITION OF CHILD

43. SKETCH POSITION OF CHILD AND IDENTIFY WHERE IN CRIB, BED, OR OTHER PLACE
IF BABY IS NOT PRESENT, ENSURE THAT PHOTOS ARE TAKEN OF POSITIONED DOLL OR SILHOUETTE.



44. WAS CHILD MOVED FROM ORIGINAL POSITION? <input type="checkbox"/> NO <input type="checkbox"/> YES	WHY?
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45. POSITION WHEN DISCOVERED (REFER BACK TO QUESTION 43):		
BODY		
<input type="checkbox"/> On Stomach <input type="checkbox"/> On Back <input type="checkbox"/> Seated Upright <input type="checkbox"/> Left Side <input type="checkbox"/> Right Side		
BODY PINNED		
<input type="checkbox"/> Pinned Vertically <input type="checkbox"/> Pinned Horizontally <input type="checkbox"/> Other Wedging <input type="checkbox"/> Not Pinned		
HEAD AND NECK		
<input type="checkbox"/> Face Directly Up <input type="checkbox"/> Face Directly Down <input type="checkbox"/> Face to Right <input type="checkbox"/> Face to Left <input type="checkbox"/> Neck Flexed to Chin <input type="checkbox"/> Neck Extended Back		
USUAL SLEEPING POSITION		
<input type="checkbox"/> On Stomach <input type="checkbox"/> On Back <input type="checkbox"/> Seated Upright <input type="checkbox"/> Left Side <input type="checkbox"/> Right Side		
46. WAS AIRWAY OBSTRUCTED WHEN DISCOVERED?		
<input type="checkbox"/> Airway Not Obstructed <input type="checkbox"/> Right Nostril Blocked <input type="checkbox"/> Object Covering Mouth <input type="checkbox"/> Objects Near Face		
<input type="checkbox"/> Both Nostrils Blocked <input type="checkbox"/> Left Nostril Blocked <input type="checkbox"/> Object Covering Nose		
47. DESCRIBE ANY OBJECTS COVERING NOSE, MOUTH OR FACE:		
48. IF CHILD WAS FOUND FACE DOWN, IS THERE A VISIBLE CUP, POCKET OR DEPRESSION IN THE BEDDING?		
<input type="checkbox"/> NO <input type="checkbox"/> YES Depth: _____ Diameter: _____		
49. IS THERE A VISIBLE CREASE ON FACE, NECK OR HANDS FROM PILLOWS OR BEDDING?		
<input type="checkbox"/> NO <input type="checkbox"/> YES		
50. MATERIAL FOUND IN NOSE OR MOUTH:		
<input type="checkbox"/> None <input type="checkbox"/> Formula <input type="checkbox"/> Bloody Froth <input type="checkbox"/> Blood Tinged Secretion		
<input type="checkbox"/> Mucous <input type="checkbox"/> Vomit <input type="checkbox"/> Dried Secretion <input type="checkbox"/> Other		
<input type="checkbox"/> Food <input type="checkbox"/> Froth <input type="checkbox"/> Urine or Stool		
51. SECRETION FOUND ON:		
<input type="checkbox"/> Blanket <input type="checkbox"/> Sheet <input type="checkbox"/> Clothing <input type="checkbox"/> Pillow <input type="checkbox"/> Other Item		
52. WHAT TYPE OF SECRETION		
<input type="checkbox"/> None <input type="checkbox"/> Formula <input type="checkbox"/> Bloody Froth <input type="checkbox"/> Blood Tinged Secretion		
<input type="checkbox"/> Mucous <input type="checkbox"/> Vomit <input type="checkbox"/> Dried Secretion <input type="checkbox"/> Other Secretion		
<input type="checkbox"/> Food <input type="checkbox"/> Froth <input type="checkbox"/> Urine or Stool		
53. FACE IN CONTACT WITH WET MATERIALS		DESCRIBE:
<input type="checkbox"/> NO <input type="checkbox"/> YES		
54. IF FOUND WHILE SLEEPING, WAS CHILD SLEEPING ALONE?		
<input type="checkbox"/> NO <input type="checkbox"/> YES If no, who was child sleeping with?		
55. DESCRIBE BED AND/OR OTHER SLEEPING SURFACE.		
56. LIST ALL MATERIALS AND OBJECTS NEAR CHILD WHEN FOUND, INCLUDING BED, SHEETS, PILLOWS, COVERS, TOYS, HOUSEHOLD OBJECTS, ETC.		
57. COULD ANY OF THESE MATERIALS AND OBJECTS HAVE INFLUENCED THE DEATH?		
<input type="checkbox"/> NO <input type="checkbox"/> Yes If yes, describe in narrative.		
58. 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.		
<input type="checkbox"/> NO <input type="checkbox"/> YES If yes, explain in narrative.		
59. IS THERE AN APNEA MONITOR IN THE HOME?		WAS CHILD ON MONITOR AT TIME OF DEATH?
<input type="checkbox"/> NO <input type="checkbox"/> YES Download information from monitor.		<input type="checkbox"/> NO <input type="checkbox"/> YES Collect monitor as evidence.
SOCIAL AND ENVIRONMENTAL CONDITIONS		
60. WHO DOES CHILD LIVE WITH?		61. WHO HAD RESPONSIBILITY FOR CHILD AT TIME OF DEATH? IN NARRATIVE, DESCRIBE ACTIVITIES OF CAREGIVERS DURING DAYS LEADING UP TO THE DEATH.
62. HAVE FAMILY MEMBERS OR CARETAKERS BEEN REPORTED FOR PAST ABUSE OR NEGLECT?		FOR DOMESTIC VIOLENCE?
<input type="checkbox"/> NO <input type="checkbox"/> YES Contact Hotline to obtain information. (800-392-3738)		<input type="checkbox"/> NO <input type="checkbox"/> YES
63. LIST CHILD CARE PROVIDERS - LICENSED		UNLICENSED
64. DO SIBLINGS EVER WATCH CHILD UNATTENDED?		65. ARE THERE ANY CULTURAL PRACTICES THAT MAY HAVE INFLUENCED THE DEATH?
<input type="checkbox"/> NO <input type="checkbox"/> YES If yes, age:		<input type="checkbox"/> NO <input type="checkbox"/> YES If yes, explain fully in the narrative.
66. DESCRIPTION OF DWELLING:		
67. CLEANLINESS OF DWELLING		
<input type="checkbox"/> BELOW AVERAGE <input type="checkbox"/> ABOVE AVERAGE <input type="checkbox"/> AVERAGE		
68. NUMBER OF CHILDREN LIVING AT ADDRESS		NUMBER OF ADULTS
		OVERCROWDED?
		<input type="checkbox"/> NO <input type="checkbox"/> YES

69. ARE THERE ANY ENVIRONMENTAL HAZARDS?

NO YES

If yes, check all that apply.

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

70. ROOM TEMPERATURE

OUTSIDE TEMPERATURE

HEATING/COOLING SOURCE

PROXIMITY OF CHILD TO HEAT/COOLING SOURCE

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

LOCATION FOUND

DISPOSITION AND PRESENT LOCATION

PHOTOS TAKEN?

NO YES

If yes, by whom?

ALL WITNESSES, RESPONDERS, AND OTHER PERSONS AT SCENE

List all persons at scene during time child died.

NAME

ADDRESS

RELATIONSHIP

NARRATIVE (USE ADDITIONAL PAGES AS NECESSARY)

71. DATE/TIME OF INVESTIGATION

72. CASE NUMBER

73. INVESTIGATOR'S NAME

74. AGENCY/DEPARTMENT