



# DEATH SCENE AND DEPUTY CORONER INVESTIGATION PROTOCOL



## For the Evaluation of Sudden Unexpected Infant Death

This *Death Scene and Deputy Coroner Investigation Protocol* (DHS 4439), for the evaluation of sudden, unexpected infant death, has been approved by the California Department of Health Services (CDHS) 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 CDHS would appreciate a copy of this Protocol, as well as the *Standardized Autopsy Protocol* (DHS 4437), to be sent to:

**California Department of Health Services  
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) [cflorez@dhs.ca.gov](mailto:cflorez@dhs.ca.gov) (email)**

Additional copies of the Protocol can be obtained from the CDHS at the contact information listed above or by accessing the CDHS website at [www.mch.dhs.ca.gov/epidemiology](http://www.mch.dhs.ca.gov/epidemiology) or on 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"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced		<input type="checkbox"/> Not Married <input type="checkbox"/> Widowed			
							<input type="checkbox"/> Other (Specify: _____)												
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					
							<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												

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II. SCENE EXAMINATION

1. EMS/Police/Fire/Coroner Scene Response

911 Call: Date: Mo Day Year Time:

EMS Arrival: Date: Mo Day Year Time:

Police Arrival: Date: Mo Day Year Time:

Coroner Arrival: Date: Mo Day Year Time:

Transport:

Ambulance Company: Telephone: Private Vehicle Type: Owned By: Not Taken to a Medical Facility

2. Place Where Death Pronounced

Hospital Name: En Route or DOA E.R. In-patient Address: Street City State Zip Other Site: By Whom: Date: Time:

3. Location Where Infant Found

Residence: Apartment Rooming House Single Detached Condo Multi-Family Occupancy Mobile Home Public Housing Project Other Child Care Facility: Licensed? Relative of Decedent? Mobile Vehicle: Type: Where Parked: Vehicle Location When Infant Found: Address: County Other

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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: \_\_\_\_\_    Time Taken: \_\_\_\_\_    By Whom: \_\_\_\_\_  
                    Mo    Day    Year  
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

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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, Feces, Other, Vomitus, None, Urine, Not Applicable

b. Was Bedding Under Baby Soiled By:

- Blood, Feces, Other, Vomitus, None, Urine, Not Applicable

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: \_\_\_\_\_

- Clothes
- Diapers
- Drug Paraphernalia
- Other (Specify: \_\_\_\_\_)
- 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)**

- Bedding
- None
- Toys
- Other (Specify: \_\_\_\_\_)
- Honey, if fed within 30 Days of Death

**IV. HISTORY OF ATTEMPTED RESUSCITATION**

**26. Attempted Resuscitation**

**a. Mouth-to-Mouth Ventilation?**

- Yes
- No

**b. Bag and Mask Ventilation?**

- Yes
- No

**c. Oral Airway Placement?**

- Yes
- No
- Attempted

**d. Intubation?**

- Yes
- No
- Attempted

**e. Cardiac Compression?**

- Yes
- No

**f. Intravenous Fluids?**

- Yes
- No

**g. Intracardiac Medications?**

- Yes
- No

**h. Intraosseous Lines?**

(catheter in shinbone)

- Yes
- No

**i. Placed on Life Support?**

- Yes
- No
- Duration: \_\_\_\_\_

**j. Body Temperature Taken Near Time of Resuscitation:** \_\_\_\_\_ °F  Rectal  Other Site: \_\_\_\_\_

**k. Initial Cardiac Rhythm Recorded?**

- Yes If yes:  A systole  Other \_\_\_\_\_
- No

**l. Normal Cardiac Rhythm Restored?**

- Yes Duration of CPR: \_\_\_\_\_ minutes
- No

**m. Duration of Survival after Resuscitation** \_\_\_\_\_  Minutes  Hours

**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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**39. History of Injuries or Trauma**

- a. **Head Injury?**  Yes (Specify: \_\_\_\_\_)  No
- b. **Loss of Consciousness?**  Yes When: \_\_\_\_\_  No  
 Mo Day Year
- c. **Lethargy?**  Yes  No  No
- d. **Seizure?**  Yes When: \_\_\_\_\_ Type: \_\_\_\_\_  No  
 Mo Day Year
- e. **Fractures?**  Yes (Specify: \_\_\_\_\_)  No
- f. **Suspected Child Abuse?**  Yes  No  
 Access the Child Abuse Central Index (CACI) \*(Obtain directly from index, not from parents. See instructions.)
- g. **Was there documented history of child abuse?**  Yes  No

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

- a. **Respiratory Disease?**  Yes (Describe: \_\_\_\_\_)  No
- b. **Heart Disease?**  Yes (Describe: \_\_\_\_\_)  No
- c. **Apnea (Stopped Breathing)?**  Yes Date: \_\_\_\_\_ How Often: \_\_\_\_\_  No  
 Mo Day Year
- d. **Seizure?**  Yes Date: \_\_\_\_\_ How Often: \_\_\_\_\_  No  
 Mo Day Year
- e. **Other (Specify):** \_\_\_\_\_

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

- a. **Oxygen?**  Never  Yes, Within Last Week  Yes, But Not Within Last Week
- b. **Apnea Monitor?**  Never  Yes, Within Last Week  Yes, But Not Within Last Week
- c. **Antibiotics?**  Never  Yes, Within Last Week  Yes, But Not Within Last Week
- d. **Anticonvulsants?**  Never  Yes, Within Last Week  Yes, But Not Within Last Week
- e. **Other (Specify):** \_\_\_\_\_

**42. Last Seen By Doctor or Health Professional**

- Date Last Seen:** \_\_\_\_\_ Medications prescribed:  Yes  No Type: \_\_\_\_\_  
 Mo Day Year
- a. **Routine Well Baby Exam**  Yes  No  
 If Not Routine Exam, Specify Reason: \_\_\_\_\_
  - b. **Weight:** \_\_\_\_\_ lbs. c. **Height:** \_\_\_\_\_ inches d. **Temperature:** \_\_\_\_\_ °F
  - e. **Name of Health Care Provider:** \_\_\_\_\_
- Address:** \_\_\_\_\_  
 Street City State Zip  
 \_\_\_\_\_  
 County Phone

**43. Immunizations**

- Yes  No
- a. **Most Recent Immunization:** Date: \_\_\_\_\_ Type: \_\_\_\_\_  
 Mo Day Year
  - b. **Total Number of Immunizations Since Birth:**  
 Polio \_\_\_\_\_ Meningitis Varicella (Chickenpox) \_\_\_\_\_ Haemophilus HIB \_\_\_\_\_  
 DTaP \_\_\_\_\_ Measles, Mumps Rubella (MMR) \_\_\_\_\_ Hepatitis B \_\_\_\_\_

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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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**50. History of Fertility Treatment?**

Yes  No

**51. Maternal Health Problems During Pregnancy**

- |                                    |                              |                             |
|------------------------------------|------------------------------|-----------------------------|
| a. Anemia?                         | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| b. Diabetes Mellitus?              | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| c. Required Insulin?               | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| d. High Blood Pressure?            | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| e. Infections?                     | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| f. Physical Trauma?                | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| g. Sexually Transmitted Infection? | <input type="checkbox"/> Yes | <input type="checkbox"/> 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?                 | <input type="checkbox"/> Yes (Describe: _____)                                | <input type="checkbox"/> No | <input type="checkbox"/> Unknown |
| b. Infant/Childhood Death?               | <input type="checkbox"/> Yes How Many: _____ Relationship(s) to Infant: _____ | <input type="checkbox"/> No | <input type="checkbox"/> Unknown |
| Cause of Death: _____                    |   |                             |                                  |
| <b>Relationship to Infant</b>            |   |                             |                                  |
| 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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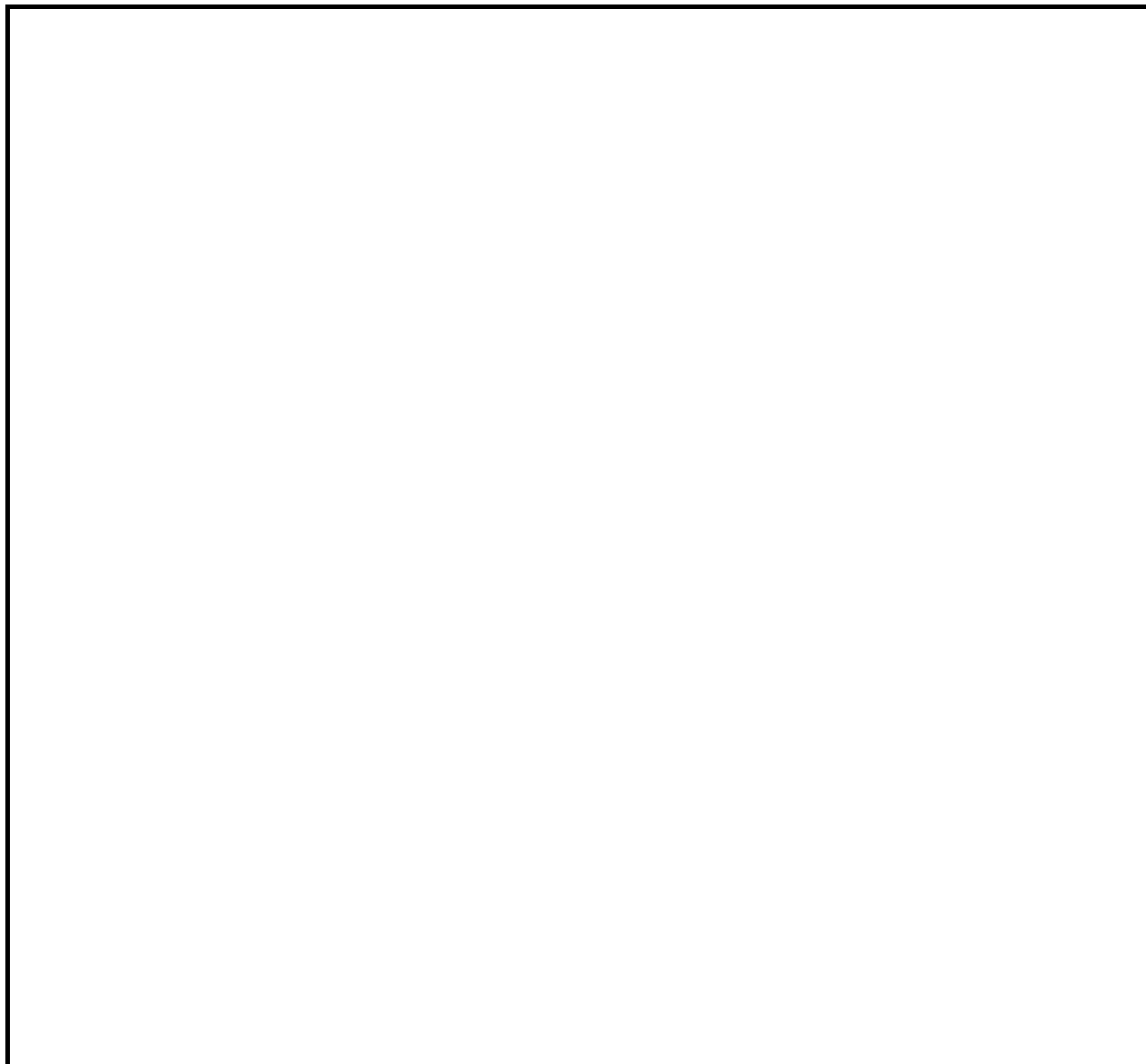
Please Type or Print

**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



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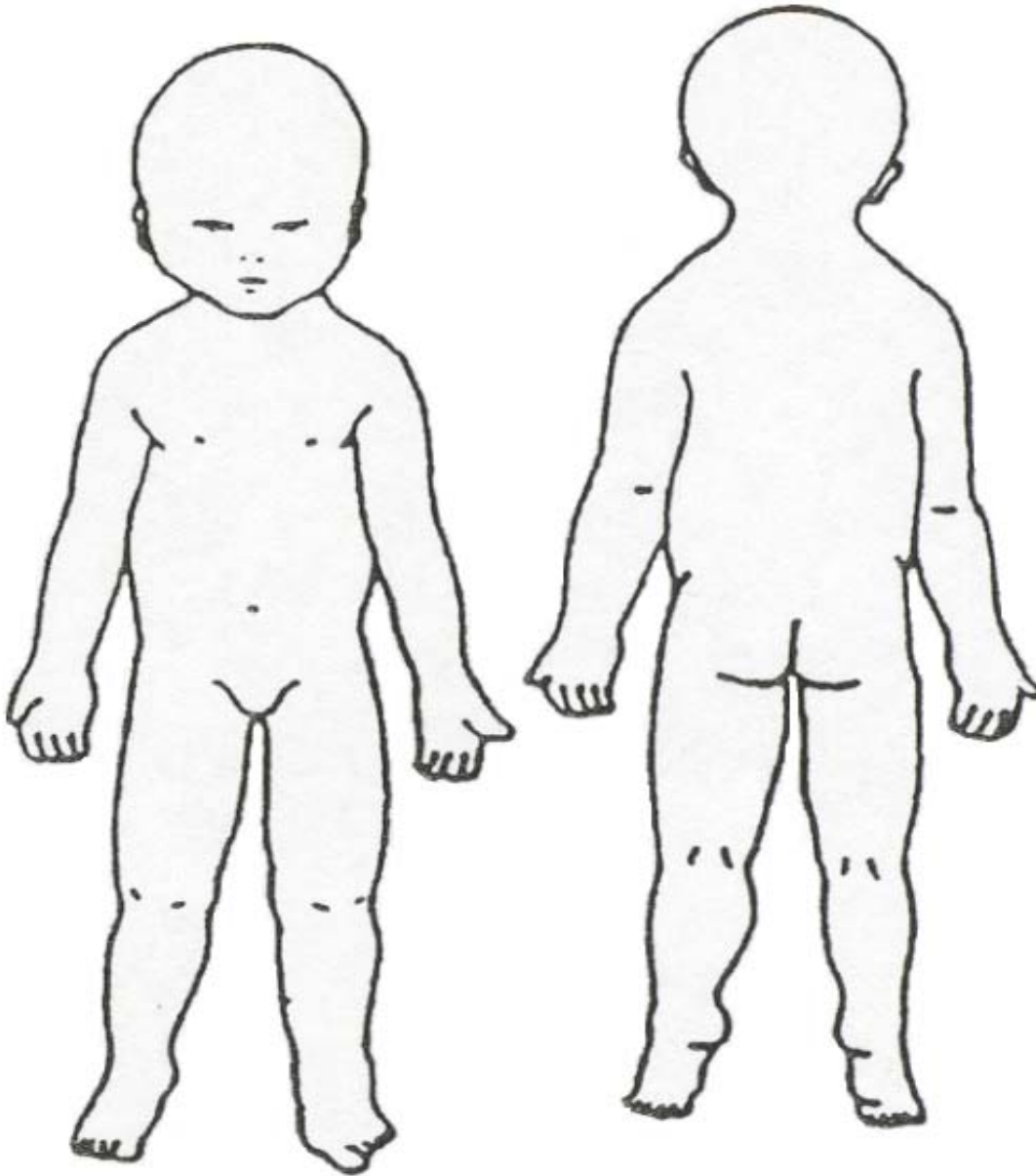
Please Type or Print

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



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**IX. SUPPLEMENT**