



ADDITIONAL INVESTIGATIVE SCENE FORMS

Table of Contents

Body Diagram.....	A
EMS Interview.....	B
Hospital Interview.....	C
Immunization Record.....	D
Infant Exposure History.....	E
Informant Contact.....	F
Law Enforcement Interview.....	G
Materials Collection Log.....	H
Non Professional Responder Interview.....	I
Parental Information.....	J
Primary Residence Investigation.....	K
Scene Diagram.....	L

Infant's Information

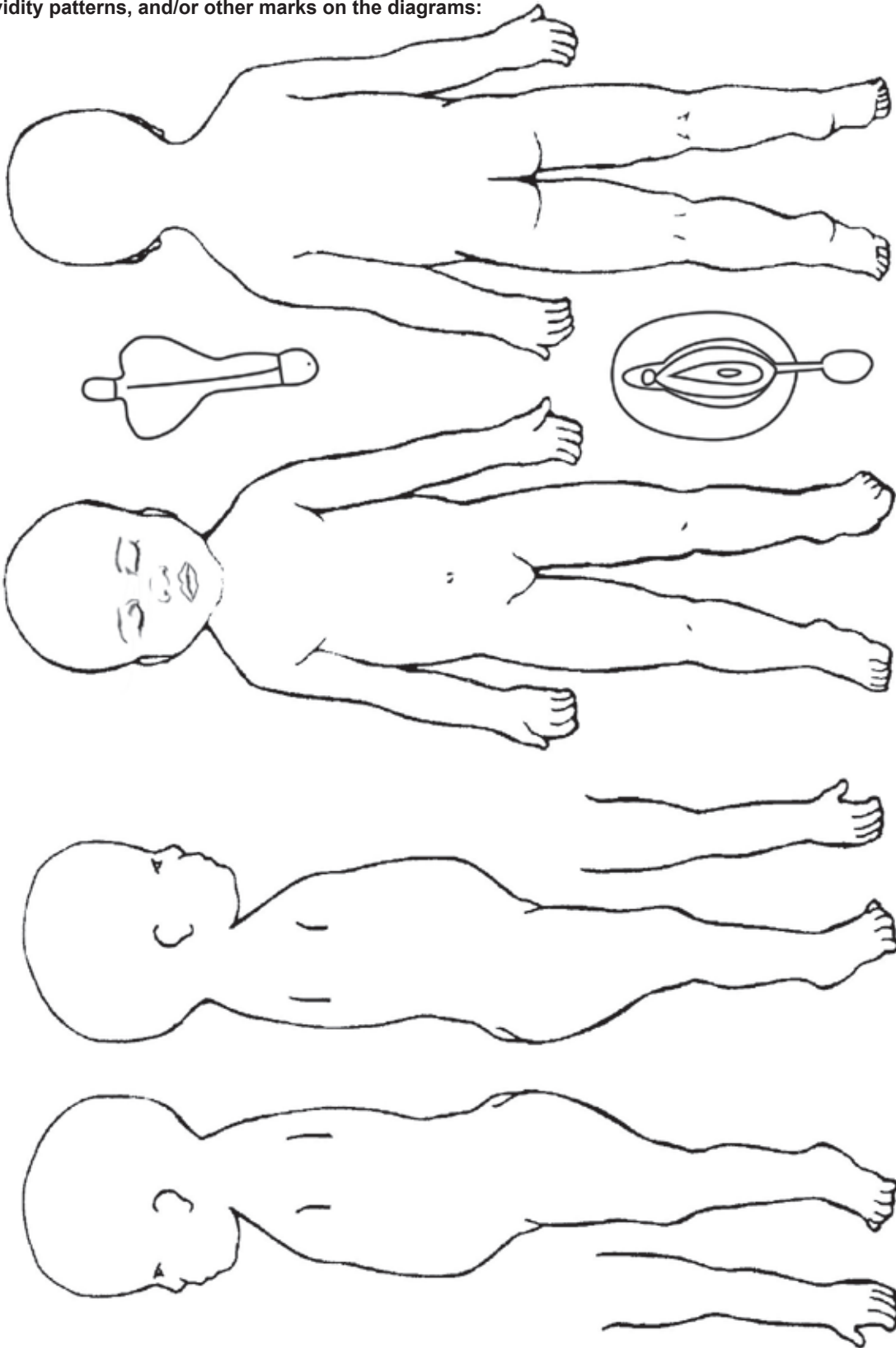
Last Name

First Name

Middle

Case Number

1 Draw lividity patterns, and/or other marks on the diagrams:



A - BODY DIAGRAM

SUIDI 5-5-06 pg A

Section Completed by (name)	Month	Day	Year	Military Time	In person	Telephone	Other
				:			

Infant's Information

Last Name	First Name	Middle	Case Number
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

1 Information about the EMS responder:

Last name	First name	Agency		
<input type="text"/>	<input type="text"/>	<input type="text"/>		
Date/Time Dispatched:	Month	Day	Year	Military Time
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

2 Who called 911?

Last name	First name	Relationship (example aunt)
<input type="text"/>	<input type="text"/>	<input type="text"/>

3 What date and time did you arrive?

Month	Day	Year	Military Time
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

4 Was anyone doing CPR when EMS arrived?

No	Yes	Who?
<input type="text"/>	<input type="text"/>	<input type="text"/>

5 Where was the infant when you arrived at the scene? (ex. crib, arms of caregiver)

<input type="text"/>

6 Describe infant's appearance when found.

Appearance	No	Yes	Describe and specify location:
a) Discoloration around face/nose/mouth	<input type="text"/>	<input type="text"/>	<input type="text"/>
b) Secretions (foam, froth)	<input type="text"/>	<input type="text"/>	<input type="text"/>
c) Skin discoloration (livor mortis)	<input type="text"/>	<input type="text"/>	<input type="text"/>
d) Pressure marks (pale, blanching)	<input type="text"/>	<input type="text"/>	<input type="text"/>
e) Rash or petechiae (small, red blood spots on skin, membranes or eyes)	<input type="text"/>	<input type="text"/>	<input type="text"/>
f) Marks on body (scratch on nose)	<input type="text"/>	<input type="text"/>	<input type="text"/>
g) Other	<input type="text"/>	<input type="text"/>	<input type="text"/>
h) Unknown	<input type="text"/>	<input type="text"/>	<input type="text"/>

7 How did the infant feel when found?

Sweaty	Warm to touch	Cool to touch	Rigid, stiff	Limp, flexible	Unknown	Other - specify
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

8 Did you administer resuscitative efforts? If Yes - check all that were done below, If No - Skip to No. 13 on next page.

CPR	IV/IO Access	Gastric Tube	Infant immobilized	Medications	Intubation	Electric shock
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Other - Specify: <input type="text"/>						

9 List all emergency medications given to the infant:

Name of Medication	Dose	Route	Military Time
1. <input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
2. <input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
3. <input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
4. <input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
5. <input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Continued on the next page ►

10 Describe the nature and duration of resuscitation efforts and treatments.

11 Describe any injuries sustained by infant during resuscitative efforts (if any):

12 At what date and approximate time were the resuscitative efforts terminated?

Not terminated by EMS	Month	Day	Year	Military Time
				:

13 What was the name of the authorizing medical control physician who pronounced death?

Last name	First name	Agency

14 What was the final disposition of the infant?

Left at the scene	Released to funeral home	Morgue	ME/C facility
Transported to the hospital - Specify		Other - Specify	Name of person who received the infant

15 Describe the reaction of the caregiver(s) to the infant's death:

16 Additional comments from the EMS personnel: *(Describe concerns with scene or what happened)*

Investigator's Notes

EMS Run Report/Sheet

911 Tape

Indicate the task(s) performed

Section Completed by (name)	Month	Day	Year	Military Time	In person	Telephone	Other
				:			

Infant's Information

Last Name	First Name	Middle	Case Number

1 On what day and at what approximate time did the infant arrive at the hospital?

Month	Day	Year	Military Time
			:

2 Hospital Information:

Hospital Name: Address:

3 Name of physician responsible for treatment at hospital.

Name: Phone:

4 Name physician who signed the death certificate.

Name: Phone:

5 What was the level of consciousness upon arrival at the hospital?

Breathing
 Not breathing
 Responsive
 Unresponsive
 Dead

What did the infant look like upon arrival at the hospital? (Check all that apply)

Appearance	No	Yes	Describe and specify location:
a) Discolorations			
b) Secretions			
c) Livor mortis			
d) Pale areas around nose or mouth			
e) Retinal hemorrhages			
f) Cutaneous petechiae			
g) Bruising or other injury			
h) Suspicion of inflicted trauma			
i) Malnourished			
j) Other			

6 How did the infant feel upon arrival at the hospital?

Sweaty
 Warm to touch
 Cool to touch
 Rigid, stiff
 Limp, flexible
 Unknown

Other - Specify:

7 List all treatments and procedures (T&P) administered to the infant at the hospital:

Treatment or Procedure	Approx. Time	Outcome
1.	:	
2.	:	
3.	:	
4.	:	

8 Hospital staff's comments regarding family's reaction to infant's death.

Investigator's Notes

	Obtain medical records or code sheet	Secure evidence and release infant's property
Indicate the task(s) performed	<input style="width:300px;" type="text"/>	<input style="width:300px;" type="text"/>

Section Completed by (name)	Month	Day	Year	Military Time	In person	Telephone	Other
				:			

Infant's Information

Last Name	First Name	Middle	Case Number

1 Indicate information source (Check appropriate box)

Biological Mother/Father
 Grandmother/Father
 Adoptive or Foster Parents
 Physician
 Health Records
 Other (specify):

2 Has the infant ever received immunizations or shots?

Yes No - (stop)

--	--

Please list all of the immunizations the infant has ever been given or attach record.

Immunization:	Month	Day	Year	Comments/Reactions:
Hepatitis B #1				
Hepatitis B #2				
Hepatitis B #3				
Diphtheria, Tetanus, Pertussis #1 (DPT)				
Diphtheria, Tetanus, Pertussis #2 (DPT)				
Diphtheria, Tetanus, Pertussis #3 (DPT)				
Haemophilus Influenzae Type b #1 (Hib)				
Haemophilus Influenzae Type b #2 (Hib)				
Haemophilus Influenzae Type b #3 (Hib)				
Inactivated Poliovirus #1 (Polio)				
Inactivated Poliovirus #2 (Polio)				
Inactivated Poliovirus #3 (Polio)				
Measles, Mumps, Rubella (MMR)				
Varicella (Chicken Pox)				
Pneumococcal				
Influenza (Flu)				
Hepatitis A #1				
Hepatitis A #2				
Other/Specify:				

3 Are the immunizations up to date?

Yes No Unknown

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Section Completed by (name)	Month	Day	Year	Military Time	In person	Telephone	Other
				:			

Infant's Information

Last Name	First Name	Middle	Case Number

1 Identify all persons who were in contact with the infant in the 24 hours prior to the infant's death.
(being in the same room, living in/staying in/visiting the infant's primary residence - if more than 3 persons, use additional pages)

	Person 1			Person 2			Person 3		
a) Last name									
b) First name									
c) Maiden name <i>(if applicable)</i>									
d) Relationship to infant									
e) Street									
f) City									
h) DOB	Month	Day	Year	Month	Day	Year	Month	Day	Year
i) Where did contact with the infant occur <i>(ex. house, daycare, playground)</i>									
j) Date of last contact with the infant	Month	Day	Year	Month	Day	Year	Month	Day	Year
k) Approximate time of last contact with the infant <i>(Military Time)</i>	:			:			:		
l) During the <u>week</u> prior to the infant's death, was this person sick? <i>(If "Yes", explain the circumstances below)</i>	Yes	No	Unknown	Yes	No	Unknown	Yes	No	Unknown
	Explain:			Explain:			Explain:		
m) For persons biologically related to the infant <i>(d above)</i> are there any known conditions/diseases that run in the family? <i>(down syndrome)</i>	Yes	No	NA	Yes	No	NA	Yes	No	NA
	Explain:			Explain:			Explain:		
n) Has this person experienced the death of any of their own children or of any other children while in their care?	Yes	No	Unknown	Yes	No	Unknown	Yes	No	Unknown
	Explain:			Explain:			Explain:		
l) Child's name									
II) Relationship to caregiver									
III) Date of death	Month	Day	Year	Month	Day	Year	Month	Day	Year
IV) Child's age at death (years or months if <2 years)									
V) Cause of death									
VI) Place of death (City/State)									

E - INFANT EXPOSURE HISTORY

2 Did the infant visit a location with large numbers of people within the last 24 hours?

3 Are there any factors, circumstances, or environmental concerns?
(ex. mother smoked while breast feeding, exposed to a large number of people at church or a public event, air travel)

	No	Yes	If yes - please describe

Continued on the next page ►

4 Daycare

Did the infant visit a daycare in the 24 hours prior to the death? Yes No

How many adults were supervising the children? Number of people (18 years or older)

Were any of these adults sick? No Yes If yes - specify

How many children were under the care of the provider at that day? Number of people (18 years or older)

Identify any children in daycare who were sick and were in contact or close proximity to the infant in the 24 hours prior to the death?

	Child 1			Child 2			Child 3		
a) First name of child									
b) Last name of child									
c) Date of birth	Month	Day	Year	Month	Day	Year	Month	Day	Year
d) Where did contact with the infant occur (ex. house, daycare, play-ground)									
e) Date of last contact with the infant	Month	Day	Year	Month	Day	Year	Month	Day	Year
f) Approximate time of last contact with the infant									
g) During the week prior to the infant's death, was this person sick? (If "Yes", explain the circumstances)	Yes	No	Unknown	Yes	No	Unknown	Yes	No	Unknown
	Explain:			Explain:			Explain:		

If more than 3 children, use additional pages

Section Completed by (name)	Month	Day	Year	Military Time	In person	Telephone	Other
<input style="width: 90%; height: 20px;" type="text"/>	<input style="width: 40px; height: 20px;" type="text"/>	<input style="width: 40px; height: 20px;" type="text"/>	<input style="width: 40px; height: 20px;" type="text"/>	<input style="width: 40px; height: 20px;" type="text"/>	<input style="width: 40px; height: 20px;" type="text"/>	<input style="width: 40px; height: 20px;" type="text"/>	<input style="width: 40px; height: 20px;" type="text"/>

Infant's Information

Last Name	First Name	Middle	Case Number

1 For each informant interviewed, please obtain the following information:

Informant 1

a) First/Last Name:	
a) Maiden (if applicable):	
c) Relationship to Infant:	
d) Address (H):	
e) City:	
f) Address (W):	
g) City:	
h) State:	
h) Zip:	
i) Phone 1:	
j) Phone 2:	

Informant 4

a) First/Last Name:	
a) Maiden (if applicable):	
c) Relationship to Infant:	
d) Address (H):	
e) City:	
f) Address (W):	
g) City:	
h) State:	
h) Zip:	
i) Phone 1:	
j) Phone 2:	

Informant 2

a) First/Last Name:	
a) Maiden (if applicable):	
c) Relationship to Infant:	
d) Address (H):	
e) City:	
f) Address (W):	
g) City:	
h) State:	
h) Zip:	
i) Phone 1:	
j) Phone 2:	

Informant 5

a) First/Last Name:	
a) Maiden (if applicable):	
c) Relationship to Infant:	
d) Address (H):	
e) City:	
f) Address (W):	
g) City:	
h) State:	
h) Zip:	
i) Phone 1:	
j) Phone 2:	

Informant 3

a) First/Last Name:	
a) Maiden (if applicable):	
c) Relationship to Infant:	
d) Address (H):	
e) City:	
f) Address (W):	
g) City:	
h) State:	
h) Zip:	
i) Phone 1:	
j) Phone 2:	

Informant 6

a) First/Last Name:	
a) Maiden (if applicable):	
c) Relationship to Infant:	
d) Address (H):	
e) City:	
f) Address (W):	
g) City:	
h) State:	
h) Zip:	
i) Phone 1:	
j) Phone 2:	

Section Completed by (name)	Month	Day	Year	Military Time	In person	Telephone	Other
				:			

Infant's Information

Last Name	First Name	Middle	Case Number

Information about the Law Enforcement officer:

Last name	Middle name	Last name

Phone number	Agency

Date and time dispatched:

Month	Day	Year	Military Time
			:

Who called? Relationship (ex. aunt):

1 What date and time did you arrive?

Month	Day	Year	Military Time
			:

2 What did the infant look like when you arrived at the scene?

Appearance	No	Yes	Describe and specify location:
a) Discoloration around face/nose/mouth	<input type="checkbox"/>	<input type="checkbox"/>	
b) Secretions (<i>foam, froth</i>)	<input type="checkbox"/>	<input type="checkbox"/>	
c) Skin discoloration (<i>livor mortis</i>)	<input type="checkbox"/>	<input type="checkbox"/>	
d) Pressure marks (<i>pale, blanching</i>)	<input type="checkbox"/>	<input type="checkbox"/>	
e) Rash or petechiae (<i>small, red blood spots on skin, membranes or eyes</i>)	<input type="checkbox"/>	<input type="checkbox"/>	
f) Marks on body (<i>scratch on nose</i>)	<input type="checkbox"/>	<input type="checkbox"/>	
g) Other	<input type="checkbox"/>	<input type="checkbox"/>	
h) Unknown	<input type="checkbox"/>	<input type="checkbox"/>	

3 How did the infant feel when found?

Sweaty
 Warm to touch
 Cool to touch
 Rigid, stiff
 Limp, flexible
 Unknown

Other - Specify:

4 How would you describe the surface on which the infant was placed?

Condition of surface (check all that apply): Soft
 Firm
 Lumpy
 Concave
 Stained
 Wet

5 Describe condition: (check all that apply):

Broken
 Worn
 Repaired
 Clean
 Dirty

6 Describe what the scene looked like upon arrival:

7 Describe what law enforcement did at the scene:

8 Describe the person's reactions to the infant's death:

Individual	No	Yes	Specify:
Mother	<input type="checkbox"/>	<input type="checkbox"/>	
Father	<input type="checkbox"/>	<input type="checkbox"/>	
Placer	<input type="checkbox"/>	<input type="checkbox"/>	
Finder	<input type="checkbox"/>	<input type="checkbox"/>	
Last Known Alive	<input type="checkbox"/>	<input type="checkbox"/>	
Other	<input type="checkbox"/>	<input type="checkbox"/>	

Continued on the next page ►

8 Are there any known prior contacts with law enforcement?

Individual	No	Yes	Reason for contact	Outcome
Mother				
Father				
Placer				
Finder				
Last Known Alive				
Other				

9 What was the final disposition of the infant?

Left at the scene
 Released to funeral home
 Morgue
 ME/C facility
 Transported to the hospital - Specify: _____
 Other - Specify: _____
(Indicate facility name and name of person who received the infant)

10 Have there been any contacts/complaints to social services regarding this family and other siblings in the home?

Yes No - (stop)

--	--

11 Total number of contacts with social services:

--

12 List up to two most recent contacts with social services.

Date contacted: Month Day Year

--	--	--

Caseworker name: _____

Agency name: _____

Reason for contact: _____

Outcome: _____

Comments: _____

Date contacted: Month Day Year

--	--	--

Caseworker name: _____

Agency name: _____

Reason for contact: _____

Outcome: _____

Comments: _____

Section Completed by (name)	Month	Day	Year	Military Time	In person	Telephone	Other
				:			

Infant's Information

Last Name	First Name	Middle	Case Number

8 Describe all items recovered from the site of the incident or death scene:

Item	Evidence No.	Origin	Description	Disposition	Name of person collecting
1) Baby bottles					
2) Pacifier					
3) Formula					
4) Bedding					
5) Infant's last diaper					
6) Clothing					
7) Apnea monitor					
8) Infant sleep surface					
9) Medicines <i>(include home remedies)</i>					
10)					
11)					
12)					
13)					
14)					
15)					
16)					
17)					
18)					
19)					
20)					
21)					
22)					
23)					
24)					
25)					
26)					
27)					
28)					
29)					
30)					

H - MATERIALS COLLECTION LOG

Section Completed by (name)	Month	Day	Year	Military Time	In person	Telephone	Other
				:			

Infant's Information

Last Name	First Name	Middle	Case Number

1 Information about the person who was the first non-professional responder to the infant:

Last name	Middle name	Last name
Phone number	Relationship to infant	
<input type="checkbox"/> Male	<input type="checkbox"/> Female	Age: <input style="width:50px;" type="text"/>
		Date of Birth: <input style="width:100px;" type="text"/>

2 What led you to respond?

3 When the infant was found, was s/he:

breathing
 not breathing
 unresponsive
 If not breathing, did you witness the infant stop breathing?
 yes
 no

4 Describe infant's appearance when found.

Appearance	No	Yes	Describe and specify location:
a) Discoloration around face/nose/mouth			
b) Secretions (<i>foam, froth</i>)			
c) Skin discoloration (<i>livor mortis</i>)			
d) Pressure marks (<i>pale, blanching</i>)			
e) Rash or petechiae (<i>small, red blood spots on skin, membranes or eyes</i>)			
f) Marks on body (<i>scratch on nose</i>)			
g) Other			
h) Unknown			

5 How did the infant feel when found?

Sweaty
 Warm to touch
 Cool to touch
 Rigid, stiff
 Limp, flexible
 Unknown
 Other - Specify:

6 What date and time were the first resuscitative efforts given?

Month	Day	Year	Military Time
			:

7 Where were resuscitative efforts conducted?

8 Describe what you did as part of the resuscitative efforts (ex. pushed on chest and breathed into mouth and nose):

9 Have you ever received any First Aid and/or CPR training?

No
 Yes
 When:
 Describe:

Section Completed by (name)	Month	Day	Year	Military Time	In person	Telephone	Other
				:			

I - NONPROFESSIONAL RESPONDER INTERVIEW

Infant's Information

Last Name	First Name	Middle	Case Number

Indicate information source

Biological Mother/Father
 Grandmother/Father
 Adoptive or Foster Parents
 Physician
 Health Records

Other - Specify:

1 Information about the infant's mother:

First name: Middle name: Last name:
 DOB: SS#: Maiden name:

Current address:
 Street: City: State: Zip:

How long has the mother been a resident of this state? Years: Months:

Has the mother ever lived in a state other than this one? No Yes

List all previous states:

2 Information about the infant's biological mother:

First name: Middle name: Last name:
 DOB: SS#: Maiden name:

Current address:
 Street: City: State: Zip:

How long has the mother been a resident of this state? Years: Months:

Has the mother ever lived in a state other than this one? No Yes

List all previous states:

3 Information about the infant's father:

First name: Middle name: Last name:
 DOB: SS#:

Current address:
 Street: City: State: Zip:

How long has the father been a resident of this state? Years: Months:

Has the father ever lived in a state other than this one? No Yes

List all previous states:

4 Information about the infant's biological father:

First name: Middle name: Last name:
 DOB: SS#:

Current address:
 Street: City: State: Zip:

How long has the father been a resident of this state? Years: Months:

Has the father ever lived in a state other than this one? No Yes

List all previous states:

Continued on the next page ►

5 Information about the infant's other primary caregivers: (ex. babysitter while parents are at work)

First name: Middle name: Last name:
 DOB: SS#: Maiden name:

Current address:

Street: City: State: Zip:

How long has the caregiver been a resident of this state? Years: Months:

Has the mother ever lived in a state other than this one? No Yes

List all previous states:

6 Information about the infant's other primary caregivers:

First name: Middle name: Last name:
 DOB: SS#: Maiden name:

Current address:

Street: City: State: Zip:

How long has the caregiver been a resident of this state? Years: Months:

Has the mother ever lived in a state other than this one? No Yes

List all previous states:

7 Information about the infant's other primary caregivers:

First name: Middle name: Last name:
 DOB: SS#: Maiden name:

Current address:

Street: City: State: Zip:

How long has the caregiver been a resident of this state? Years: Months:

Has the mother ever lived in a state other than this one? No Yes

List all previous states:

Section Completed by (name)	Month	Day	Year	Military Time	In person	Telephone	Other
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Infant's Information

Last Name	First Name	Middle	Case Number

Complete this form only if the scene of the incident or death scene is *NOT* the primary residence.

1 Address of primary residence:

Street: City: State: Zip:

2 How many people live at the infant's primary residence?

Number of adults (*18 years or older*): Number of children (*under 18 years old*):

3 What type of building is the primary residence?

<input type="checkbox"/> Apartment	<input type="checkbox"/> Multifamily home	<input type="checkbox"/> Institution (ex. shelter)
<input type="checkbox"/> Single family house	<input type="checkbox"/> Mobile home	<input type="checkbox"/> Other Specify: <input style="width:200px;" type="text"/>

4 Which of the following heating or cooling sources were being used? (*Check all that apply*)

<input type="checkbox"/> Central air	<input type="checkbox"/> Gas furnace or boiler	<input type="checkbox"/> Wood burning fireplace	<input type="checkbox"/> Open window(s)
<input type="checkbox"/> A/C window unit	<input type="checkbox"/> Electric furnace or boiler	<input type="checkbox"/> Coal burning furnace	<input type="checkbox"/> Wood burning stove
<input type="checkbox"/> Ceiling fan	<input type="checkbox"/> Electric space heater	<input type="checkbox"/> Kerosene space heater	<input type="checkbox"/> Floor/table fan
<input type="checkbox"/> Electric baseboard heat	<input type="checkbox"/> Electric (radiant) ceiling heat	<input type="checkbox"/> Window fan	<input type="checkbox"/> Unknown
<input type="checkbox"/> Other - specify: <input style="width:400px;" type="text"/>			

5 The infant's primary residence has: (*Check all that apply*)

<input type="checkbox"/> Insects	<input type="checkbox"/> Mold growth	<input type="checkbox"/> Smoky smell (<i>like cigarettes</i>)
<input type="checkbox"/> Pets	<input type="checkbox"/> Dampness	<input type="checkbox"/> Presence of alcohol containers
<input type="checkbox"/> Peeling paint	<input type="checkbox"/> Visible standing water	<input type="checkbox"/> Presence of drug paraphenalia
<input type="checkbox"/> Rodents or vermin	<input type="checkbox"/> Odors or fumes - Describe: <input style="width:200px;" type="text"/>	
Other - specify: <input style="width:400px;" type="text"/>		

6 What was the source of drinking water at the infant's primary residence? (*Check all that apply*)

<input type="checkbox"/> Public/Municipal water source	<input type="checkbox"/> Bottled water
<input type="checkbox"/> Well	<input type="checkbox"/> Unknown
<input type="checkbox"/> Other - specify: <input style="width:400px;" type="text"/>	

7 What is the general appearance of the infant's primary residence? (*ex. cleanliness, hazards, overcrowding, etc.*)

K - PRIMARY RESIDENCE INVESTIGATION

Section Completed by (name)	Month	Day	Year	Military Time	In person	Telephone	Other
				:			

K - PRIMARY RESIDENCE INVESTIGATION

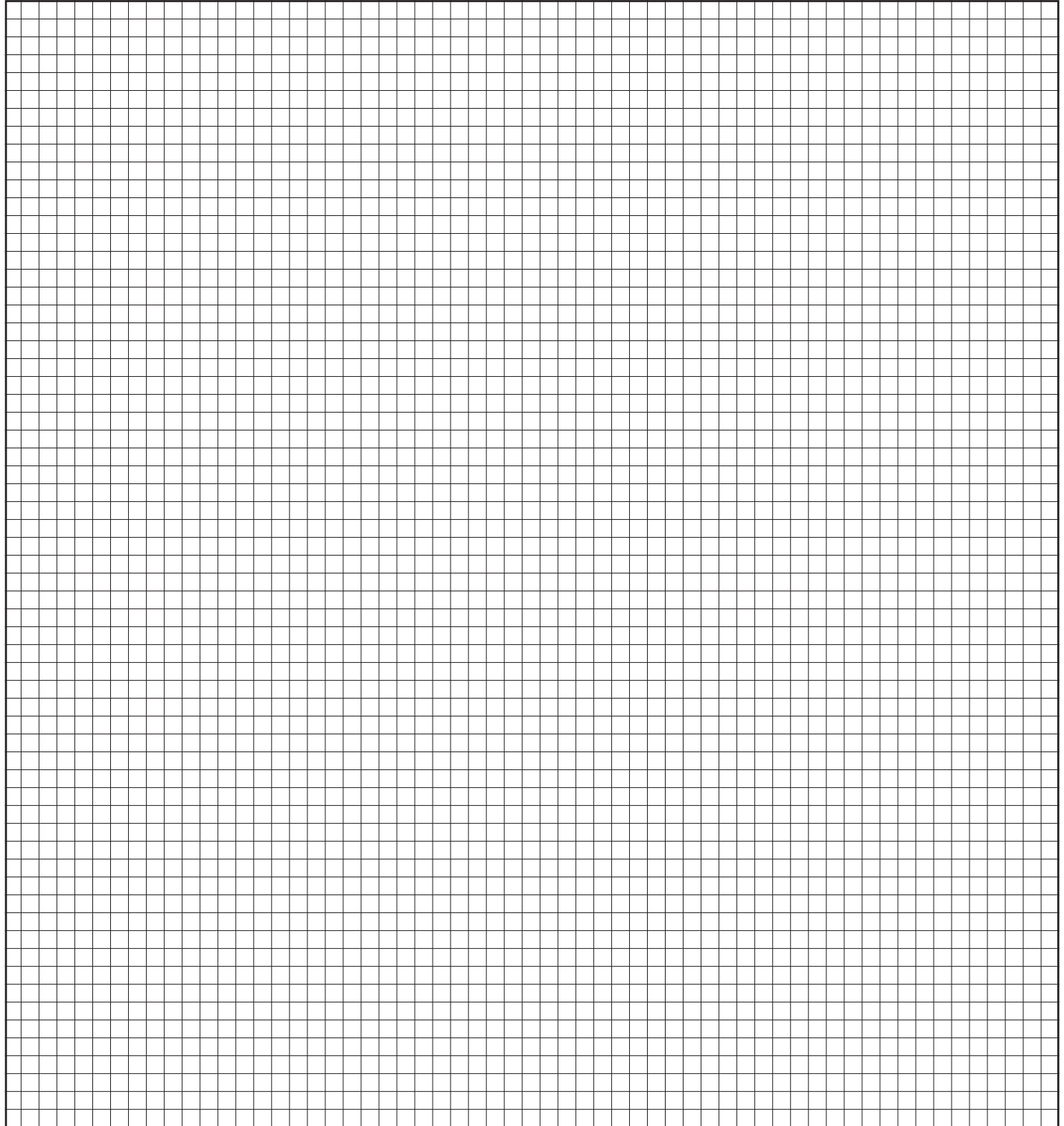
A large rectangular area filled with a fine grid of small squares, intended for handwritten notes or calculations. The grid covers most of the page's width and height.

Infant's Information

last name	first name	middle	case number

1 Draw the following on the scene diagram. *(For people and objects, give the name, show location, show position)*

- a) Room dimensions and North Direction
- b) Crib, bed or sleep surface
- c) Infant's position when found
- d) Those sharing the same sleeping surface
- e) Furniture and other objects in room
- f) Heating and cooling sources
- g) Items in contact with the infant



Section Completed by (name)	Month	Day	Year	Military Time	In person	Telephone	Other
				:			

