Nebraska Law Enforcement Infant/Young Child Death Investigation Checklist

At the Scene

- ❑ Make death scene as big as it needs to be.
- ❑ Document everything: **Doll re-enactment/scene re-creation**. Color photos of the complete scene are recommended. Videotaping may be useful for documentation.
- ❑ Retain all significant items (see item #13 on page 3). **These items may hold emotional significance to the family, so return when no longer needed.**
- ❑ If law enforcement must leave the scene, for example to accompany or assist emergency personnel, direct adults at the scene not to remove any furniture or bedding from the scene; do not wash bedding or clothing related to the child's death.
- ❑ A retrospective visit to the scene will be needed if the child was transported. Obtain consent or search warrant if necessary.

Witnesses

- ❑ The sources for information should come from those with first-hand knowledge of the events surrounding the incident. If language or culture are barriers, make sure you are assisted by a trained and experienced interpreter.
- ❑ Interview all adults, caregivers, and older children at the scene and/or in the household.
- ❑ Obtain signed medical release if possible.

Attachments to the Nebraska Infant/Young Child Death Form or Department Procedures

- ❑ Document everything, including all correspondence, verbal or written with any other agency.
- ❑ Complete departmental standard investigation form used by your agency. Complete all demographic, technical, historical, and disposition information on the investigation form.
- ❑ Obtain copies of 911 tapes, ambulance run sheets, law enforcement reports, and emergency room reports.

In General

- ❑ Complete infant/young child death scene investigation form in **ink.** Send copy to coroner.
- ❑ Have a resource list at your disposal, including the county attorney, coroner, child advocacy center, grief support organizations, and other relevant agencies.

Date: _____ Time of Call: _____ Case #: _____

NAME OF CHILD: _____ Date and Time of Death: _____

Place of Death (address, city & county): _____

Gender: Male ☐ Female ☐ Age: Months: _____ Days: _____ Date of Birth: _____

Place of Birth (address, facility, city & county) _____

NAME OF CHILD'S HEALTH CARE PROVIDER: _____

Address: _____Phone: (___) _____

NAME OF MOTHER/FEMALE GUARDIAN: _____

Relationship: _____ Age: _____ Date of Birth: _____

Phone: Evenings: (___) _____ Days: (___) _____ Cell: (___) _____

Current Address: _____ SSN: _____-_____-_____

Length of Time at this Address: Years: _____ Months: _____ Date Moved: _____

Last Address: _____

Current Employer: _____ Employer Address: _____

NAME OF FATHER/MALE GUARDIAN: _____

Relationship: _____ Age: _____ Date of Birth: _____

Phone: Evenings: (___) _____ Days: (___) _____ Cell: (___) _____

Current Address: _____ SSN: _____-_____-_____

Length of Time at this Address: Years: _____ Months: _____ Date Moved: _____

Last Address: _____

Current Employer: _____ Employer Address: _____

Names of all caregivers, i.e.; live-in partners, babysitters, etc., for past 30 days: _____

_____

Siblings (#, age, gender): _____

GUARDIAN(S) PREFERRED LANGUAGE: _____

INTERPRETER NAME: _____ **PHONE**: (___) _____

SCENE

1. **Last time child was seen alive**: _____ By whom: _____ Relationship: _____
2. **Time child was found unresponsive**: _____ By whom: _____ Relationship: _____
3. **Geographic location where the body was found** (single/multiple dwellings; general quality): _____

_____

Death scene sketch

4. **Location of the body when first seen by officer** (crib, bed, car seat, floor, sofa, **and** in which room):

_____

5. **Position of the body when first seen by officer** (on left/right side, stomach, back, **and** facing up, down, side; covered or obstructed nose/mouth etc.): _____
6. **Condition of the body when first seen by officer**:

   Temperature: ☐ cold to touch ☐ warmer than room temperature

   Flexibility: ☐ rigid/stiff ☐ flexible

   Discoloration: ☐ Yes ☐ No If yes, color and where located: _____
7. **Activity of child when first seen by Law Enforcement**:

   Breathing? ☐ Yes ☐ No Conscious? ☐ Yes ☐ No

   Moving? ☐ Yes ☐ No If yes, describe _____
8. **Type and condition of clothing worn by child**:

   Fit child? ☐ Yes ☐ No Clean? ☐ Yes ☐ No

   Dry? ☐ Yes ☐ No Torn? ☐ Yes ☐ No

   Other (describe): _____
9. **Condition of diaper/underpants** (soiled, wet, dry): _____

10. **Presence of any of the following where the body was found** (either dried or fresh):

Blood: ☐ Yes ☐ No Vomit: ☐ Yes ☐ No

Urine: ☐ Yes ☐ No Feces: ☐ Yes ☐ No

Other (describe): _____

11. **Presence of any of the following where the death occurred if different than where found**:

Blood: ☐ Yes ☐ No Vomit: ☐ Yes ☐ No

Urine: ☐ Yes ☐ No Feces: ☐ Yes ☐ No

Other (describe): _____

_____

12. **Child Diagram**

If present, indicate location on diagram.

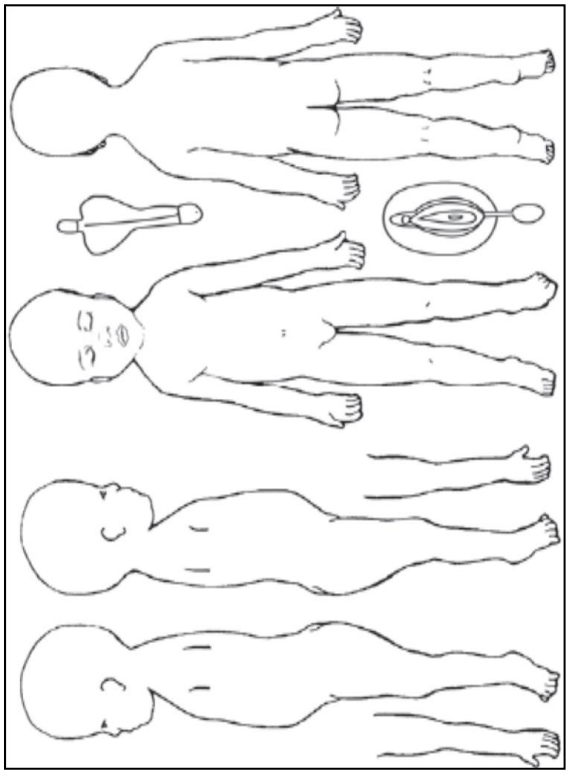
☐ Yes ☐ No Drainage/discharge from body or orifices

☐ Yes ☐ No Marks or bruises

☐ Yes ☐ No Diagnostic or therapeutic devices

☐ Yes ☐ No Pale pressure mark areas

☐ Yes ☐ No Predominant areas of lividity



13. **Condition, surface and contents of the bed, crib, sofa, car seat, bathtub, or other place where body was found**: [Include and retain anything that could have been in contact with child or obstructed the nose or mouth: crib, plastic bag, curtain, tissues, pillow, blanket, feeding bottle, pacifier, stuffed animal, other toys]

Type/condition of sleeping surface:

_____

# of blankets/layers: _____ Support of mattress:

_____

Distance between mattress and sides of crib: _____

Sturdiness of rails: _____

Other objects that could have been in contact with child (plastic bag, curtain, tissues, pillow, feeding bottle, pacifier, stuffed animal, other toys): _____

14. **For child deaths involving bathtub or other water situations**:

Depth of water: _____ Temperature of water: _____ Type of container holding water: _____

Location of hot and cold water sources near child: _____

15. **For child deaths involving shared sleeping surface, list pets, and/or name(s) of person(s) sleeping with child**: _____

Relationship: _____ Age: _____ Date of Birth: _____

Any significant physical, emotional, or other characteristics (overweight, sleepy, drunk, sick): _____

16. **Presence of potentially harmful medicines, toxins** (fumigants, pesticides, etc.), **tobacco, alcohol, or illegal drugs**:

_____

17. **Evidence of dampness, visible standing water, or mold growth**: _____

18. **Types, amounts, and apparent adequacy of the food available for the child**: _____

19. **Temperature**: Outdoor: _____ Indoor: _____Date/Time noted: _____

Thermostat: Setting: _____ Reading: _____Date/Time noted: _____

Method of heating or cooling used (e.g., gas, electric, wood, propane, forced air, radiator, electric baseboard, fans, air conditioners):

_____

20. **Presence of a functioning carbon monoxide monitor**? ☐ Yes ☐ No

21. **Evidence of alteration of the body or scene**: _____

22. **Resuscitation efforts taken by any caretaker or other person when found**: ☐ Yes ☐ No

By whom: _____ Resuscitation efforts by First Responder(s): _____

23. **All first responders at the scene** [Include EMS, fire & rescue, law enforcement, coroner, police chaplain, and others (not yourself)].

Name	**Agency**	**Phone #**

24. **Name of facility where transported**: _____

Arrival Time: _____Who Transported: _____

Resuscitation efforts at medical facility: _____Attending Physician_____

25. **Pronounced by whom**: _____

26. **Scene photos taken**: ☐ Yes ☐ No 27. **Doll reenactment**: ☐ Yes ☐ No

28. **Evidence collected**: ☐ Yes ☐ No 29. **Scene diagram**: ☐ Yes ☐ No

30. **Signed Medical Release Obtained**: ☐ Yes ☐ No 31**. NHHS Protection & Safety notified**: ☐ Yes ☐ No

IMMEDIATE HISTORY

1. **Source of medical information**: ☐ Physician ☐ Other health care provider ☐ Medical Records ☐ Family ☐ Other, specify: _____

2. **Last fed by whom**: Name: _____ Relationship: _____ Date/Time_____

Contents of last feeding: _____ Amount eaten & appetite: _____

Source of information: _____Phone: _____

Usual type of feeding (bottle, breast, formula, breast milk, cow's milk, baby food, etc.): _____

3**. Recent Illnesses in Child** (past 72 hours):

☐ Cold ☐ Vomiting ☐ Allergies ☐ Sniffles ☐ Fever/Sweating ☐ Injury

☐ Cough ☐ Drowsy ☐ Wheezing ☐ Diarrhea ☐ Other: _____

☐ Irritable/fussy Specify: _____

4. **Recent Illnesses in Household Members** (past 72 hours):

Illness: _____ Who is affected: _____ Relationship: _____

Illness: _____ Who is affected: _____ Relationship: _____

Illness: _____ Who is affected: _____ Relationship: _____

5. **Recent Illnesses in Any Other Person in Contact with the Child** (day care, church, etc.):

Illness: _____ Who is affected: _____ Relationship: _____

6. **Was Child Taking Medication(s)/Home Remedies**: ☐ Yes ☐ No

If yes, describe medication/home remedy: _____ Amount taken: _____Time of last dosage: _____

7. **Exposure to Chemicals or Toxins**: ☐ Yes ☐ No

If yes, Name of chemical(s)/toxin(s): _____ When exposed: _____

8. **Recent Injury or Fall**: ☐ Yes ☐ No If yes, describe: _____

9. **Does anyone in household smoke**? ☐ Yes ☐ No If yes, who and how much? _____

_____

10. **Does anyone in household use drugs/alcohol**? ☐ Yes ☐ No If yes, who and how much? _____

_____

11. **Does anyone in household have a serious physical or mental illness**? ☐ Yes ☐ No

If yes, describe: _____

12. **Last time child seen by medical provider**: Date: _____ Location: _____

Physician: _____ Reason seen: _____

13. **Last immunizations** (date and type): _____

14. **Have police been called to the home in the past**? ☐ Yes ☐ No If yes, describe: _____

_____

15. **Prior contact with child protective services**? ☐ Yes ☐ No If yes, describe: _____

_____

16. **Documented history of child abuse/neglect**: ☐ Yes ☐ No If yes, describe: _____

_____

MEDICAL HISTORY

1. **Child birth length**: _____ inches | centimeters (circle one) 2. **Child weight at birth**: _____ lbs/oz | grams (circle one)
3. **Compared to delivery date was child born**: ☐ On time ☐ Early – # weeks? _____ ☐ Late – # weeks? _____
4. **If child was from multiple births, how many were:**

Born alive _____ Still born_____ Died since birth _____ Still alive _____

5. **Were there complications during pregnancy**? ☐ Yes ☐ No If yes, describe: _____
6. **Were there complications during delivery or at birth**? (emergency c-section, child needed oxygen, etc.): ☐ Yes ☐ No

If yes, describe: _____

7. **Birth Hospital Name/Location**: _____

_____

8. **At any time in the child's life did he/she have an incident of**:

	Yes	No	Unknown	Describe:
Allergies (food, medication or other)	☐	☐	☐	_____
Abnormal growth or weight gain/loss	☐	☐	☐	_____
Apnea (stopped breathing)	☐	☐	☐	_____
Cyanosis (turned blue/gray)	☐	☐	☐	_____
Seizures or convulsions	☐	☐	☐	_____
Cardiac abnormalities	☐	☐	☐	_____
Metabolic disorders	☐	☐	☐	_____
Other	☐	☐	☐	_____

9. **Did the child have any birth defect(s)**? ☐ ☐ Describe: _____
10. **Has the child ever been taken to the emergency room and/or hospitalized**? ☐ Yes ☐ No

If yes, indicate reason(s), approximate date, name of hospital: _____

_____

11. **Immunizations up to date**? ☐ Yes ☐ No

PREGNANCY HISTORY

1. **At how many weeks did the birth mother begin prenatal care**?

_____ Weeks _____ Months _____ No prenatal care _____ Unknown

2. **Where did the mother receive prenatal care**?

Physician/provider: _____ Hospital/clinic: _____ Phone: _____

Street: _____ City: _____ State: _____ Zip: _____

3. **During her pregnancy, did the birth mother have any complications**? ☐ Yes ☐ No

   If yes, specify: _____

4. **Was the birth mother injured during her pregnancy with the child**? (e.g., auto accident, falls)

   ☐ Yes ☐ No If yes, specify: _____

5. **During her pregnancy, did she use any of the following**?

	Yes	No	Unknown	Describe:
Over the counter medicines	☐	☐	☐	_____
Prescription medications	☐	☐	☐	_____
Herbal remedies	☐	☐	☐	_____
Cigarettes	☐	☐	☐	_____
Alcohol	☐	☐	☐	_____
Other	☐	☐	☐	_____

5. **Currently, does any caregiver use any of the following**?

	Yes	No	Unknown	Describe:
Over the counter medicines	☐	☐	☐	_____
Prescription medications	☐	☐	☐	_____
Herbal remedies	☐	☐	☐	_____
Cigarettes	☐	☐	☐	_____
Alcohol	☐	☐	☐	_____
Other	☐	☐	☐	_____

6. **Do any of the caregivers have a previous history of any infant/child deaths**?

   ☐ Yes ☐ No If yes, where? _____

   Cause of death: _____ Age of child at death: _____

This space for documenting any additional pertinent information

INVESTIGATOR'S NAME: _____ Title: _____

Agency: _____ County: _____ Phone: (___) _____

Signature: _____ Date: _____