Coroner Duties in North Dakota

Connie Kadrmas, MSN, RN
Objectives:

- Discuss who can be a coroner in North Dakota
- Explain what constitutes a coroners case
- Expound on duties while investigating a scene
- Present details of a physical examination
- Review importance of medical and social history
- Describe compilation of death records
- Entail the ways a coroner acts as a counselor
- Provide a summary of coroner duties
Who Can Be a Coroner In North Dakota?

- Licensed Physician (N.D.C.C. 43.17)
- Advanced Practice Registered Nurse or Registered Nurse (N.D.C.C. 43.12.1)
- Physician Assistant (N.D.C.C. 43.17)
- Any other individual determined by the State Forensic Examiner to be qualified to serve as coroner
What Constitutes a Coroner Case?

- Homicide, suicide, or accidental injuries
- Firearm injuries
- Unexplained injuries
- Occupant or pedestrian motor vehicle injuries
- Any death of a minor, including abuse or neglect
- Fire, chemical, electrical, or radiation injuries
- Starvation deaths
- Unidentified or skeletonized human remains
- Drownings
- Suffocation, smothering, or strangulations
- Poisoning or illegal drug use
- Victims in custody of human services, social services, correctional facilities, or law enforcement
- Unexplained, undetermined, and unattended deaths
- Suspected victim of sexual assault
- Any suspicious factor

(N.D.C.C. 11-19.1-01 part 5)
Scene Investigation:

- Initial verbal report (who, when, where, why, how)
- Determining which agencies are involved
- Evidence of last life or illnesses
- Discussing possibilities of organ procurement
- Ensuring death notification
- Investigation of witnesses
- Determining if case should be evaluated by the medical examiner
- Maintaining scene safety
- Pronounce time of death
- Assist as needed
- Develop diagrams or reconstruction of scene
- Having proper equipment
- Multiple fatalities?
- Maintaining dignity of deceased
- Safeguarding personal property
- Determining if scene matches injury
Examining the Deceased:

- Obtaining toxicology kit (eye, heart, and bladder if available) if needed
- Identifying features
- Estimate time of death
- Manner of death
- Identifying and collecting evidence on the body
- Physical characteristics
- Traumatic injuries
Obtaining Medical and Social History:

- Determining medical provider/facility
- Requesting medical records
- Recent health complaints
- Frequent or recent medical visits
- Demographical information collection
- Mental health status
- Understanding cultural and religious concerns
- Medication evaluation, identification, and count
Recordkeeping:

- Death Investigation forms, other narratives, and diagrams
- Report of Coroner’s Investigation
- Death certificate
- Request for Examination/Autopsy
- Sudden Unexplained Infant Death Investigation Reporting Form (SUIDI)
- Paperwork for organ procurement
- Auditor billing forms
Counselor:

- Family
- Law enforcement
- Other responding agencies
- Fair and impartial
- Dealing with personal stress and establishing coping mechanisms
Death is observed or reported \( \rightarrow \) Law enforcement is notified

Coroner is notified, then acts as a liaison throughout case progression
References:

- Saint Louis University School of Medicine, Medicolegal Death Investigator Training Course. *Investigation of Hanging Deaths Fact Sheet*.
- Saint Louis University School of Medicine, Medicolegal Death Investigator Training Course. *Investigative Questions for Hanging Victims*.
VICTIM: (continued)

areas of lividity will appear in back and buttocks.

GROOVE IN NECK: The groove can suggest the type of ligature used by examination of the imprint. A noose of soft material may not leave a groove, eg. silk. Skin folds of obese people and small children may resemble a noose mark after refrigeration. An abraded area of skin often marks the location of the knot.

Any NAILMARKS, SCRATCHES or other INJURIES about the neck region suggest the possibility of manual strangulation - Was this a homicide?

SUICIDAL INDICATORS:
1) Absence of signs of struggle
2) Presence of suicide note
3) History of previous threats and/or attempts
4) Reliable history of emotional depression or alcoholism

HOMICIDAL HANGINGS are rare. Usually homicidal hangings can only be accomplished if the victim is young or person is incapacitated by drink, drugs or disease. It is very difficult to accomplish by one perpetrator. ALWAYS inspect victim for evidence of defense wounds, bruises, scratches, etc.

ACCIDENTAL HANGINGS FALL into 2 categories- (a) hangings that occur during play or when at work, in circumstances which are essentially accidental: and (b) SEXUAL ASPHYXIAL HANGINGS.

SEXUAL ASPHYXIAL HANGING: A ligature is placed about the neck and the constriction of the neck is used to create a state of ecstatic sexual euphoria as result of cerebral hypoxia.

Participants are almost exclusively male, young and predominantly Caucasian. Body is usually found at home in a “private place”. Door is frequently locked from the inside. VICTIM: Occasionally found either naked or partially clothed, may be transvestite attired - genitals may be exposed. Feet are oftentimes touching the floor. Hands, feet and genitals may exhibit some features of bondage. LIGATURE: **PADDING** between the ligature and neck, eg. towel, sock, etc. often found on body. This is to avoid detection of the neck groove by others after sexual ecstasy has been accomplished. SCENE: Usually pornographic materials are in view of the subject. Mirrors are sometimes found in a location that would allow subject to view act. Oftentimes, evidence of previous sexual hanging incidents can be found at the scene, eg. hooks indoors in bedroom, other ligatures, bondage materials. Knot of ligature often of a fail-safe type.

JUDICIAL HANGINGS: The victim is dropped several feet-proportional to his body weight -
INVESTIGATION OF HANGING DEATHS - FACT SHEET

HANGING - Death is caused by the ligature either stopping the arterial blood supply to the brain or blocking the venous return from the brain. Loss of consciousness occurs rapidly which adds increased tension to the neck structures by the added weight of the limp, suspended body. It is NOT necessary for the ligature to completely surround the neck as long as it is applied under the chin so as to compress the sides of the neck.

Deaths are usually suicidal (90%), occasionally accidental (sexual asphyxia), and rarely homicidal.

Hanging can take place in ANY POSITION, provided the pressure on the neck is maintained above that necessary to cause vascular occlusion, eg. kneeling, squatting, seating, suspended, etc.

Hanging can be accomplished from ANY HEIGHT - of those incompletely suspended: 2/3 have both feet touching the ground/floor.

THE SCENE OF A HANGING:

-Hanging usually occurs at home or place of work.

LIGATURE: Almost any type of ligature can be used, eg. rope, wire, sheet, etc.
- will produce a groove in the neck if ligature has a rough surface. An imprint on the neck surface may be seen.
- the COURSE of the groove will depend upon whether a fixed or running ligature is used:
- FIXED ligature is knotted at the point where the ligature encircles the neck. The side of the noose nearest the suspended portion will be pulled upwards, assuming the shape of an inverted V. The groove of the skin will then have a corresponding course of unmarked skin at the apex of the V because the head has fallen away from the rope/ligature area.
- RUNNING ligature does not have a knot. The noose end passes through a loop of itself. The weight of the body will cause the noose to tighten in a HORIZONTAL position - with a corresponding HORIZONTAL groove. There may be a vertical mark in addition that has been caused by the suspending portion of the ligature.

POINT OF SUSPENSION: Usually one which can be easily reached with or without the aid of a platform, eg. hook, nail, shower curtain rod, support beam.

PLATFORM: Any surface from which a subject can step down to tighten the ligature, eg. stool, chair, table, appliance, ladder, etc. (Failure to find a platform at the scene of a completely suspended subject must arouse suspicion - check to see if anything has been moved prior to your arrival.)

VICTIM:

Face is usually dusky purple, congested and slightly swollen above ligature. Tongue may protrude from mouth and be dark in color due to drying effect. Bloody mucous may be seen about the nose and under the body due to rupture of engorged blood vessels.
Tiny, pin-point hemorrhages (Tardieu's spots) may be present in the face, particularly in the eyelids and conjunctivae.

LIVIDITY: In a suspended body, the livor mortis is usually limited to the lower half of the body and the hands and forearms. NOTE: If body is cut down within 4-5 hours of
INVESTIGATIVE QUESTIONS FOR HANGING VICTIMS:

* Use this page WITH Scene Investigation Form

Location where body was found: ______________________________________________________

Was door locked from inside?  Yes ____  NO ____  Type of lock: __________________________

Position of body:  Suspended completely off floor/ground ___, partially resting on floor/ground ___, kneeling ___, sitting ___, squatting ___, reclining ___, other _______

Were feet on ground?  Yes ____  NO ____  Both feet ____ one foot ______

LIGATURE:
Type:  Rope ____  Wire ____  Other _________________________________

Knot:  Running: ____  Fixed ____  Describe: _________________________________

Was knot of a fail-safe configuration?  Yes ____  No ____

Source from which ligature obtained: ____________________________________________

Texture of ligature:  Coarse ___, Patterned ___, Soft ___, Other ________________

Ligature Length: __________________________  Number of times encircles neck _______

Ligature attached to:  Hook ____  Nail ____  Support beam ____  Other _______

Describe attachment: ____________________________________________________________

Height of point of suspension from floor/ground: _________________________________

Location of ligature knot:  Right side of neck ___, Left ___, Front ___, Back ___, N/A __

Any PADDING between neck and ligature?  Yes ____  No ____  Describe: _________________

PLATFORM:
Chair ___, Table ___, Bench ___, Appliance ___, Ladder ___, Other _________________

Height of platform from ground/floor: _______  Distance from body: __________________

Is platform overturned:  Yes ____  No ____  Any skuff marks on platform?  Yes ____  No ____

If any signs of struggle noted, describe thoroughly: _________________________________
NOTE: If subject is fully suspended and there is no platform found at the scene, check to see if the platform had been moved prior to your arrival.

Condition of Premises: ____________________________________________

Any evidence of struggle? Yes __ No ___ Describe: _______________________

Any pornographic materials near body? Yes ___ No ___ Where: ________________

Any mirror near body? Yes ___ No ___ Could subject view himself from it? Yes ___ NO ___

Any evidence that "suspension incident" had been attempted previously? Yes ___ NO ___

If yes, explain: ______________________________________________________

Was a suicide note found? Yes ___ No ___ Where: _______________________

Note found by: ____________________________ Was handwriting identified? Yes ___ NO ___

(Enclose a copy of the note with your final report)

Subject was found by (name): ____________________________ at (time): _______

*Body was cut down by (name): ____________________________ at (time): _______

Cut ligature below point of suspension and above point where encircles neck; tie with string or tape ligature to illustrate original ligature position. DO NOT untie knot.

BODY:

Describe clothing: _________________________________________________

Was clothing appropriate for this individual, this time and this place? Yes ___ No ___

Was clothing in place? Yes ___ No ___ Describe any variations noted: ________________

Describe any ropes/tapes/bondage materials found on subject and include areas of the body involved: ________________________________________________________________

Was the subject right handed? _____; left handed ___; ambidextrous ____; Unk. _____

** BE SURE TO PHOTOGRAPH BODY WHILE SUSPENDED. ALSO PHOTOGRAPH LIGATURE AND GROOVE IN NECK PRIOR TO CUTTING THE BODY DOWN!

GROOVE IN NECK: Is a groove present in the neck? Yes ___ No ___
Describe areas where groove is seen: __________________________________________

Is there any padding between ligature and neck? Yes ___ No ___ Describe: __________

Is there any pattern seen in the groove? Yes ___ No ___ Describe: __________________

Are any abrasions or scratches seen about the neck? Yes ___ No ___ If yes, describe fully

_____________________________________________________________________________

Location of the knot in relation to the neck: _______________________________________

Location of the apex of the ligature: _____________________________________________

FACIAL DESCRIPTION: Cyanotic _____; bloated _____; other _______________________

Was tongue protruding from mouth? Yes ___ No ___ Color of tongue: __________________

Any blood or bloody fluid seen about face or body? Yes ___ No ___ Describe: __________

_____________________________________________________________________________

**Are pinpoint hemorrhages present in eyelids or conjunctivae? Yes ___ No ___

LIVOR MORTIS found in the following areas: Right foot and leg ___, left foot and leg ___,
buttocks ___, abdomen/pelvic area ___, back ___, chest ___, right hand/forearm ___,
left hand/forearm ___, other ____________________________________________________
<table>
<thead>
<tr>
<th>Name of Decedent (Last, First Middle)</th>
<th>Date of Birth</th>
</tr>
</thead>
<tbody>
<tr>
<td>Address</td>
<td>City</td>
</tr>
<tr>
<td>Age</td>
<td>Sex</td>
</tr>
<tr>
<td>Race</td>
<td>Occupation</td>
</tr>
<tr>
<td>County of Death</td>
<td>Reported by</td>
</tr>
<tr>
<td>Date</td>
<td>Time</td>
</tr>
<tr>
<td>County Coroner</td>
<td>Law Enforcement Agency</td>
</tr>
<tr>
<td>Date</td>
<td>Time</td>
</tr>
<tr>
<td>Place of Incident (i.e., residence, work site)</td>
<td>Location of Incident (address)</td>
</tr>
<tr>
<td>Circumstances (if necessary, add additional sheet)</td>
<td></td>
</tr>
</tbody>
</table>

**Description of Body and/or Injuries**

<table>
<thead>
<tr>
<th>Death Pronounced By</th>
<th>Date Pronounced</th>
<th>Time Pronounced</th>
</tr>
</thead>
<tbody>
<tr>
<td>Place (i.e., ER, Residence, work site)</td>
<td>Location of Pronouncement (Address)</td>
<td></td>
</tr>
</tbody>
</table>

**Coroner’s Case:**  
- [ ] Yes  
- [ ] No

**Autopsy:**  
- [ ] Yes  
- [ ] No

**Toxicology Submitted:**  
- [ ] Yes  
- [ ] No

**Name of Pathologist**

**Cause of Death**

**Manner of Death (Check only one):**  
- [ ] Natural  
- [ ] Accident  
- [ ] Suicide  
- [ ] Homicide  
- [ ] Undetermined  
- [ ] Pending

**Signature of Coroner/Investigator**

*Please print the form for your records prior to clicking the submit button.*
**NORTH DAKOTA CERTIFIER'S WORKSHEET FOR COMPLETING A MEDICAL CERTIFICATION OF DEATH**

**NORTH DAKOTA DEPARTMENT OF HEALTH**

**DIVISION OF VITAL RECORDS**

SFN 58646 (10-2013)

<table>
<thead>
<tr>
<th>1. Decedent's Legal Name (First, Middle, Last)</th>
<th>2. Actual Date of Death</th>
<th>3. Pronounced Date of Death, if different from Actual Pronounced Time of Death, if different from Actual</th>
<th>4. Was the State Medical Examiner or County Coroner Contacted?</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>5. Date of Birth</td>
<td>6. Name of Funeral Home</td>
<td>7. Social Security Number*</td>
<td>8. Place of Death</td>
<td>9. Cause of Death</td>
<td>Part I. Enter the Chain of Events -- diseases, injuries, or complications -- that directly caused the death. DO NOT enter terminal events such as cardiac arrest, respiratory arrest, or ventricular fibrillation without showing the etiology. DO NOT abbreviate. Enter only one cause on a line. Add additional lines if necessary. Approximate Interval Between Onset and Death</td>
</tr>
<tr>
<td>10. Autopsy Performed</td>
<td>11. Autopsy Findings Available to Complete the Cause of Death</td>
<td>12. Tobacco Use Contributed to Death</td>
<td>13. Decedent a Diabetic</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>14. If Female, Decedent was:</td>
<td></td>
<td></td>
<td></td>
<td>Pregnant at time of death</td>
<td></td>
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<tr>
<td>15. Manner of Death. If the Manner of Death is not natural (i.e. the Cause of Death is attributable, at least in part, to an external event and does not solely represent the effects of a natural disease process), the case should be forwarded to a County Coroner for certification.</td>
<td></td>
<td></td>
<td></td>
<td>Natural</td>
<td>Accident</td>
</tr>
<tr>
<td>16. Date of Injury</td>
<td>Time of Injury (Military)</td>
<td>17. Place of Injury (i.e. Decedent's home, construction site, restaurant, wooded area)</td>
<td>18. Injury at Work</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>19. Address Where the Injury Occurred</td>
<td>Apartment Number</td>
<td>Inside City Limits</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>City</td>
<td>County</td>
<td>State</td>
<td>ZIP Code</td>
<td></td>
<td></td>
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<tr>
<td>20. Describe How the Injury Occurred</td>
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<tr>
<td>21. Transportation Injury</td>
<td>If yes, Please Specify</td>
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<tr>
<td>Yes</td>
<td>No</td>
<td>Driver Operator</td>
<td>Passenger</td>
<td>Pedestrian</td>
<td>Other. Specify:</td>
</tr>
<tr>
<td>22. Signature of the Certifier</td>
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<td></td>
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<tr>
<td>23. Name of Certifier</td>
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<td></td>
<td></td>
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<tr>
<td>Address</td>
<td>City</td>
<td>State</td>
<td>ZIP Code</td>
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<tr>
<td>24. Title of Certifier</td>
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<td>25. License Number</td>
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<tr>
<td>26. Date Certified</td>
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</tbody>
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* Based on federal law (42 U.S.C. §§ 652(a)(7) and 666(a)(5)(C)(iv)), the social security number has been determined to be a mandatory data element for this form and will be used for identification purposes. Failure to disclose this information will not affect the validity of this form.

Mail completed form to: Division of Vital Records; 600 E. Boulevard Ave.; Bismarck, ND 58505-0200
Instructions for Certifier’s Worksheet

ITEM 2 - ACTUAL OR PRESUMED TIME OF DEATH
Enter the exact hour and minutes according to a 24 hour clock. If the exact time of death is unknown, enter the approximate time. If the time cannot be approximated enter the time the body is found and identify the date found.

ITEM 9 - CAUSE OF DEATH
Take care to make the entry legible. Use a computer printer with high resolution, typewriter with good black ribbon and clean keys, or print legibly using permanent black ink in complete the CAUSE OF DEATH section. Do not abbreviate conditions entered in section.

PART I (Chain of events leading directly to death)

- Only one cause should be entered on each line. Line (a) MUST ALWAYS have an entry. DO NOT leave blank. Additional lines may be added if necessary.
- If the condition on Line (a) resulted from an underlying condition, put the underlying condition on Line (b), and so on, until the full sequence is reported. ALWAYS enter the underlying cause of death on the lowest used line in Part 1.
- For each cause indicate the best estimate of the interval between the presumed onset and the date of death. The terms “unknown” or “approximately” may be used. General terms, such as minutes, hours, or days, are acceptable, if necessary. DO NOT leave blank.
- The terminal event (for example, cardiac arrest or respiratory arrest) should not be used. If a mechanism of death seems most appropriate to you for line (a), then you must always list its cause(s) on the line(s) below it (for example, cardiac arrest due to coronary artery atherosclerosis or cardiac arrest due to blunt impact to chest).
- If an organ system failure such as congestive heart failure, hepatic failure, renal failure, or respiratory failure is listed as a cause of death, always report its etiology on the line(s) beneath it (for example, renal failure due to Type I diabetes mellitus).
- When indicating neoplasms as a cause of death, include the following: 1) primary site or that the primary site is unknown, 2) benign or malignant, 3) cell type or that the cell type is unknown, 4) grade of neoplasm, and 5) part or lobe of organ affected. (For example, a primary well-differentiated squamous cell carcinoma, lung, left upper lobe.)
- Always report the fatal injury (for example, stab wound of chest), the trauma (for example, transaction of subclavian vein), and impairment of function (for example, air embolism).

PART II (Other significant conditions)

- Enter all diseases or conditions contributing to death that were not reported in the chain of events in Part 1 and that did not result in the underlying cause of death. See attached examples.
- If two or more possible sequences resulted in death, or if two conditions seem to have added together, report in Part 1 the one that, in your opinion, most directly caused death. Report in Part II the other conditions or diseases.

CHANGES TO CAUSE OF DEATH
Should additional medical information or autopsy findings become available that would change the cause of death originally reported, the original death certificate should be amended by the certifying physician by immediately reporting the revised cause of death to the State Vital Records Office.

ITEMS 10 and 11 - AUTOPSY
- Enter “Yes” if either a partial of full autopsy was performed. Otherwise enter “No.”
- Enter “Yes” if autopsy findings were available to complete the cause of death; otherwise enter “No.” Leave item blank if no autopsy was performed.

ITEM 12- TOBACCO USE CONTRIBUTED TO DEATH
Check “yes” if, in your opinion, the use of tobacco contributed to death. For example, tobacco use contributes to many deaths due to emphysema or lung cancer. Tobacco use may contribute to some heart disease and cancers of the head and neck. Tobacco use should also be reported in deaths due to fires started by smoking. For example, tobacco use may contribute to deaths due to a wide variety of cardiovascular, respiratory, neoplastic, metabolic, and other diseases. Check yes, if in your clinical judgment, tobacco use contributed to this particular death.

ITEM 14 - IF FEMALE, WAS DECEDENT PREGNANT AT TIME OF DEATH OR WITHIN PAST YEAR?
This information is important in determining pregnancy-related mortality.

ITEM 15 - MANNER OF DEATH
- Always check Manner of Death, which is important: 1) determining accurate causes of death; 2) in processing insurance claims, and 3) in statistical studies of injuries and death.
- Indicate “Pending investigation” if the manner of death cannot be determined whether due to an accident, suicide, or homicide within the statutory time limit for the death certificate. This should be changed later to one of the other terms.
- Indicate “Could not be Determined” ONLY when it is impossible to determine the manner of death.

ITEMS 16 - 21 - ACCIDENT OR INJURY - to be filled out in all cases of death due to injury or poisoning
ITEM 16 - DATE AND TIME OF INJURY
Enter the exact month, day, and year of injury. Spell out the name of the month. DO NOT use a number for the month. (Remember, the date of injury may differ from the date of death). Estimates may be provided with “Approx.” placed before the date. Enter the exact hour and minutes of injury or use your best estimate. Use a 24-hour clock.

ITEM 17 - PLACE OF INJURY
Enter the general place (such as restaurant, vacant lot, or home) where the injury occurred. DO NOT enter firm or organization names. (For example, enter “factory” not “Standard Manufacturing, Inc.”).

ITEM 18 - INJURY AT WORK
Complete if anything other than natural disease is mentioned in Part I or Part II of the medical certification, including homicides, suicides, and accidents. This includes all motor vehicle deaths. The item must be completed for decedents ages 14 years or over and may be completed for those less than 14 years of age if warranted. Enter “Yes” if the injury occurred at work. Otherwise enter “No”. An injury may occur at work regardless of whether the injury occurred in the course of the decedent’s “usual” occupation. Examples of injury at work and injury not at work follow:

Injury at work
- Injury while working or in vocational training on job premises.
- Injury while on break or at lunch or in parking lot on job premises.
- Injury while working for pay or compensation, including at home.
- Injury while working as a volunteer law enforcement official, etc.
- Injury while traveling on business, including to/from business contacts.

Injury not at work
- Injury while engaged in personal recreational activity on job premises.
- Injury while a visitor (not on official work business) to job premises.
- Homemaker working at homemaking activities.
- Injury while working as a volunteer law enforcement official, etc.
- Student in school.
- Working for self for no profit (mowing yard, repairing own roof, hobby).
- Commuting to or from work.

ITEM 19 - ADDRESS WHERE INJURY OCCURRED
Enter the complete address where the injury occurred, including zip code.

ITEM 20 - HOW INJURY OCCURRED
Enter a brief but specific and clear description of how the injury occurred. Explain the circumstances or cause of the injury. Specify type of gun or type of vehicle (e.g., car, bulldozer, train, etc.) when relevant to circumstances. Indicate if more than one vehicle included; specify type of vehicle decedent was in.

ITEM 21 - TRANSPORTATION INJURY
Specify role of decedent (e.g. driver, passenger). Driver/operator and passenger should be designated for modes other than motor vehicles such as bicycles. Other applies to watercraft, aircraft, animal, or people attached to outside of vehicles (e.g. surfers).

Rationale: Motor vehicle accidents are a major cause of unintentional deaths; details will help determine effectiveness of current safety features and laws.

REFERENCES
For more information on how to complete the medical certification section of the death certificate, refer to tutorial at http://www.TheNAME.org and resources including instructions and handbooks available by request from NCHS, Room 820, 6525 Belcrest Road, Hyattsville, Maryland 20782-2003 or at www.cdc.gov/nchs/about/major/dvs/handbk.htm.
**REQUEST FOR EXAMINATION/AUTOPSY**

NORTH DAKOTA DEPARTMENT OF HEALTH
STATE FORENSIC EXAMINER
SFN 59166 (6-2015)

<table>
<thead>
<tr>
<th>Decedent (Last, First, Middle)</th>
<th>Race</th>
<th>Sex</th>
<th>Age</th>
<th>Date of Birth</th>
</tr>
</thead>
<tbody>
<tr>
<td>Home Address (Street)</td>
<td>City</td>
<td>State</td>
<td>Zip Code</td>
<td></td>
</tr>
<tr>
<td>Next of Kin (Last, First, Middle)</td>
<td>Relationship</td>
<td>Telephone Number</td>
<td></td>
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</tr>
<tr>
<td>Address (Street)</td>
<td>City</td>
<td>State</td>
<td>Zip Code</td>
<td></td>
</tr>
<tr>
<td>Funeral Home (Name)</td>
<td>Telephone Number</td>
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</table>

<table>
<thead>
<tr>
<th>Coroner</th>
<th>County</th>
<th>Telephone Number</th>
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<tbody>
<tr>
<td>Death Reported By</td>
<td>Investigating Agency</td>
<td>Telephone Number</td>
</tr>
<tr>
<td>Death Pronounced By</td>
<td>Date Pronounced</td>
<td>Time Pronounced</td>
</tr>
<tr>
<td>Place (i.e., ER, Residence, work site)</td>
<td>Location (Address)</td>
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</tr>
<tr>
<td>Identified By</td>
<td>Relationship</td>
<td>Method</td>
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</table>

**CIRCUMSTANCES**

<table>
<thead>
<tr>
<th>Type of Injury or onset of illness</th>
<th>Date of Injury or Illness</th>
<th>Time of Injury</th>
</tr>
</thead>
<tbody>
<tr>
<td>Place of Injury</td>
<td>Location (Address)</td>
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</tr>
<tr>
<td>Medical History</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Brief narrative of circumstances (continue on additional page if needed)

An examination/autopsy is requested to be performed by the State Forensic Examiner on the body of

Signature of Coroner | County | Date |

Please print the form for your records prior to clicking the submit button.
### INVESTIGATION DATA

<table>
<thead>
<tr>
<th>Infant's Last Name</th>
<th>Infant's First Name</th>
<th>Middle Name</th>
<th>Case Number</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Sex:**
- [ ] Male
- [ ] Female

**Date of Birth:**

**Age:**

**SS#:**

**Race:**
- [ ] White
- [ ] Black/African Am.
- [ ] Asian/Pacific Isl.
- [ ] Am. Indian/Alaskan Native
- [ ] Hispanic/Latino
- [ ] Other

**Infant's Primary Residence:**

<table>
<thead>
<tr>
<th>Address</th>
<th>City</th>
<th>County</th>
<th>State</th>
<th>Zip</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Incident Address:**

<table>
<thead>
<tr>
<th>Address</th>
<th>City</th>
<th>County</th>
<th>State</th>
<th>Zip</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Contact Information for Witness:**

<table>
<thead>
<tr>
<th>Relationship to deceased</th>
<th>Birth Mother</th>
<th>Birth Father</th>
<th>Grandmother</th>
<th>Grandfather</th>
<th>Adoptive or Foster Parent</th>
<th>Physician</th>
<th>Health Records</th>
<th>Other Describe</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Last:**

**First:**

**M.:**

**SS#:**

**Address:**

<table>
<thead>
<tr>
<th>City</th>
<th>County</th>
<th>State</th>
<th>Zip</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Work Address:**

<table>
<thead>
<tr>
<th>City</th>
<th>State</th>
<th>Zip</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Home Phone:**

**Work Phone:**

**Date of Birth:**

### WITNESS INTERVIEW

1. **Are you the usual caregiver?**
   - [ ] No
   - [ ] Yes

2. **Tell me what happened:**
   

3. **Did you notice anything unusual or different about the infant in the last 24 hrs?**
   - [ ] No
   - [ ] Yes
   

4. **Did the infant experience any falls or injury within the last 72 hrs?**
   - [ ] No
   - [ ] Yes
   

5. **When was the infant LAST PLACED?**
   - Date:
   - Military Time:
   - Location (room):

6. **When was the infant LAST KNOWN ALIVE (LKA)?**
   - Date:
   - Military Time:
   - Location (room):

7. **When was the infant FOUND?**
   - Date:
   - Military Time:
   - Location (room):

8. **Explain how you knew the infant was still alive.**

9. **Where was the infant - (P)laced, (L)ast known alive, (F)ound (write P, L, or F in front of appropriate response)?**
   - [ ] Bassinet
   - [ ] Cradle
   - [ ] Mattress/box spring
   - [ ] Sofa/couch
   - [ ] Other - describe:
   - [ ] Bedside co-sleeper
   - [ ] Crib
   - [ ] Mattress on floor
   - [ ] Stroller/carriage
   - [ ] Car seat
   - [ ] Floor
   - [ ] Playpen
   - [ ] Swing
   - [ ] In a person's arms
   - [ ] Portable crib
   - [ ] Waterbed
In what position was the infant LAST PLACED?  
<table>
<thead>
<tr>
<th>Sitting</th>
<th>On back</th>
<th>On side</th>
<th>On stomach</th>
<th>Unknown</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>No</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| Was this the infant’s usual position?  
| Yes     | No      |          |            |         |

In what position was the infant LKA?  
<table>
<thead>
<tr>
<th>Sitting</th>
<th>On back</th>
<th>On side</th>
<th>On stomach</th>
<th>Unknown</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>No</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| Was this the infant’s usual position?  
| Yes     | No      |          |            |         |

In what position was the infant FOUND?  
<table>
<thead>
<tr>
<th>Sitting</th>
<th>On back</th>
<th>On side</th>
<th>On stomach</th>
<th>Unknown</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>No</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| Was this the infant’s usual position?  
| Yes     | No      |          |            |         |

Face position when LAST PLACED?  
<table>
<thead>
<tr>
<th>Face down on surface</th>
<th>Face up</th>
<th>Face right</th>
<th>Face left</th>
</tr>
</thead>
</table>

Neck position when LAST PLACED?  
<table>
<thead>
<tr>
<th>Hyperextended (head back)</th>
<th>Flexed (chin to chest)</th>
<th>Neutral</th>
<th>Turned</th>
</tr>
</thead>
</table>

Face position when LKA?  
<table>
<thead>
<tr>
<th>Face down on surface</th>
<th>Face up</th>
<th>Face right</th>
<th>Face left</th>
</tr>
</thead>
</table>

Neck position when LKA?  
<table>
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<tr>
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<th>Neutral</th>
<th>Turned</th>
</tr>
</thead>
</table>

Face position when FOUND?  
<table>
<thead>
<tr>
<th>Face down on surface</th>
<th>Face up</th>
<th>Face right</th>
<th>Face left</th>
</tr>
</thead>
</table>

Neck position when FOUND?  
<table>
<thead>
<tr>
<th>Hyperextended (head back)</th>
<th>Flexed (chin to chest)</th>
<th>Neutral</th>
<th>Turned</th>
</tr>
</thead>
</table>

What was the infant wearing? (ex. t-shirt, disposable diaper)  

Was the infant tightly wrapped or swaddled?  
<table>
<thead>
<tr>
<th>No</th>
<th>Yes - describe:</th>
</tr>
</thead>
</table>

Please indicate the types and numbers of layers of bedding both over and under infant (not including wrapping blanket):  

<table>
<thead>
<tr>
<th>Bedding UNDER Infant</th>
<th>None</th>
<th>Number</th>
<th>Bedding OVER Infant</th>
<th>None</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Receiving blankets</td>
<td></td>
<td></td>
<td>Receiving blankets</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Infant/child blankets</td>
<td></td>
<td></td>
<td>Infant/child blankets</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Infant/child comforters (thick)</td>
<td></td>
<td></td>
<td>Infant/child comforters (thick)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Adult comforters/duvets</td>
<td></td>
<td></td>
<td>Adult comforters/duvets</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Adult blankets</td>
<td></td>
<td></td>
<td>Adult blankets</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sheets</td>
<td></td>
<td></td>
<td>Sheets</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sheepskin</td>
<td></td>
<td></td>
<td>Pillows</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pillows</td>
<td></td>
<td></td>
<td>Other, specify:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rubber or plastic sheet</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Which of the following devices were operating in the infant’s room?  
<table>
<thead>
<tr>
<th>None</th>
<th>Apnea monitor</th>
<th>Humidifier</th>
<th>Vaporizer</th>
<th>Air purifier</th>
<th>Other -</th>
</tr>
</thead>
</table>

In was the temperature in the infant’s room?  
<table>
<thead>
<tr>
<th>Hot</th>
<th>Cold</th>
<th>Normal</th>
<th>Other -</th>
</tr>
</thead>
</table>

Which of the following items were near the infant’s face, nose, or mouth?  
<table>
<thead>
<tr>
<th>Bumper pads</th>
<th>Infant pillows</th>
<th>Positional supports</th>
<th>Stuffed animals</th>
<th>Toys</th>
<th>Other -</th>
</tr>
</thead>
</table>

Which of the following items were within the infant’s reach?  
<table>
<thead>
<tr>
<th>Blankets</th>
<th>Toys</th>
<th>Pillows</th>
<th>Pacifier</th>
<th>Nothing</th>
<th>Other -</th>
</tr>
</thead>
</table>

Was anyone sleeping with the infant?  
<table>
<thead>
<tr>
<th>No</th>
<th>Yes</th>
</tr>
</thead>
</table>

Name of individual sleeping with infant  

Age | Height | Weight | Location in relation to infant | Impairment (intoxication, tired) |
|-----|--------|--------|-------------------------------|---------------------------------|

Was there evidence of wedging?  
<table>
<thead>
<tr>
<th>No</th>
<th>Yes - Describe:</th>
</tr>
</thead>
</table>

When the infant was found, was s/he:  
<table>
<thead>
<tr>
<th>Breathing</th>
<th>Not Breathing</th>
</tr>
</thead>
</table>

If not breathing, did you witness the infant stop breathing?  
<table>
<thead>
<tr>
<th>No</th>
<th>Yes</th>
</tr>
</thead>
</table>
**WITNESS INTERVIEW (cont.)**

29. **What had led you to check on the infant?**

30. **Describe the infant’s appearance when found.**

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

31. **What did the infant feel like when found?** *(Check all that apply.)*

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

   Other - specify:

32. **Did anyone else other than EMS try to resuscitate the infant?**

   - No
   - Yes

   Who? ________________ Date: ________________ Military time: __ : __

33. **Please describe what was done as part of resuscitation:**

34. **Has the parent/caregiver ever had a child die suddenly and unexpectedly?**

   - No
   - Yes

   Explain:

**INFANT MEDICAL HISTORY**

1. **Source of medical information:**
   - Doctor
   - Other healthcare provider
   - Medical record
   - Family
   - Mother/primary caregiver
   - Other

2. **In the 72 hours prior to death, did the infant have:**

<table>
<thead>
<tr>
<th>Condition</th>
<th>Unknown</th>
<th>No</th>
<th>Yes</th>
<th>Condition</th>
<th>Unknown</th>
<th>No</th>
<th>Yes</th>
</tr>
</thead>
</table>
   a) Fever   |         |    |    | k) Apnea (stopped breathing) |         |    |    |
   b) Diarrhea|         |    |    | e) Decrease in appetite      |         |    |    |
   c) Excessive sweating |         |    |    | l) Cyanosis (turned blue/gray) |         |    |    |
   d) Stool changes |         |    |    | f) Vomiting                  |         |    |    |
   e) Lethargy or sleeping more than usual |         |    |    | m) Seizures or convulsions   |         |    |    |
   f) Difficulty breathing |         |    |    | g) Choking                   |         |    |    |
   g) Fussiness or excessive crying |         |    |    | n) Other, specify:           |         |    |    |

3. **In the 72 hours prior to death, was the infant injured or did s/he have any other condition(s) not mentioned?**

   - No
   - Yes - describe:

4. **In the 72 hours prior to the infants death, was the infant given any vaccinations or medications?**

   *(Please include any home remedies, herbal medications, prescription medicines, over-the-counter medications.)*

   - No
   - Yes

   **Name of vaccination or medication** | **Dose last given** | **Date given** | **Approx. time (Military Time)** | **comments**
   --------------------------------------|---------------------|----------------|-------------------------------|-------------------|
   1.                                    |                     |                |                               |                   |
   2.                                    |                     |                |                               |                   |
   3.                                    |                     |                |                               |                   |
   4.                                    |                     |                |                               |                   |
At any time in the infant's life, did s/he have a history of?

Medical history Unknown No Yes Describe

a) Allergies (food, medication, or other)
b) Abnormal growth or weight gain/loss
c) Apnea (stopped breathing)
d) Cyanosis (turned blue/gray)
e) Seizures or convulsions
f) Cardiac (heart) abnormalities

Did the infant have any birth defects(s)?  No Yes
Describe:

Describe the two most recent times that the infant was seen by a physician or health care provider:
Include emergency department visits, clinic visits, hospital admissions, observational stays, and telephone calls

First most recent visit Second most recent visit

a) Date
b) Reason for visit
c) Action taken
d) Physician's name
e) Hospital/clinic
f) Address
g) City
h) State, ZIP
i) Phone number

Birth hospital name: Discharge date:

Street address:
City: State: Zip:

What was the infant's length at birth? ______ inches or ______ centimeters

What was the infant's weight at birth? ______ pounds ______ ounces or ______ grams

Compared to the delivery date, was the infant born on time, early, or late?
On time Early - how many weeks? Late - how many weeks?

Was the infant a singleton, twin, triplet, or higher gestation?
Singleton Twin Triplet Quadrupelet or higher gestation

Were there any complications during delivery or at birth? (emergency c-section, child needed oxygen) Yes No
Describe:

Are there any alerts to the pathologist? (previous infant deaths in family, newborn screen results) Yes No
Specify:
On what day and at what approximate time was the infant last fed?

<table>
<thead>
<tr>
<th>Date:</th>
<th>Military Time:</th>
</tr>
</thead>
</table>

What is the name of the person who last fed the infant?

What is his/her relationship to the infant?

What foods and liquids was the infant fed in the last 24 hours (include last fed)?

<table>
<thead>
<tr>
<th>Food</th>
<th>Unknown</th>
<th>No</th>
<th>Yes</th>
<th>Quantity (ounces)</th>
<th>Specify: (type and brand)</th>
</tr>
</thead>
<tbody>
<tr>
<td>a) Breast milk (one/both sides, length of time)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>b) Formula (brand, water source - ex. Similac, tap water)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>c) Cow’s milk</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>d) Water (brand, bottled, tap, well)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>e) Other liquids (teas, juices)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>f) Solids</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>g) Other</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Was a new food introduced in the 24 hours prior to his/her death?  
No  Yes

If yes, describe (ex. content, amount, change in formula, introduction of solids)

Was the infant last placed to sleep with a bottle?  
Yes  No - if no, skip to question 9 below

Was the bottle propped? (i.e., object used to hold bottle while infant feeds)  
No  Yes

If yes, what object was used to prop the bottle?

What was the quantity of liquid (in ounces) in the bottle?

Did the death occur during?  
Breast-feeding  Bottle-feeding  Eating solid foods  Not during feeding

Are there any factors, circumstances, or environmental concerns that may have impacted the infant that have not yet been identified?  
(ex. exposed to cigarette smoke or fumes at someone else’s home, infant unusually heavy, placed with positional supports or wedges)

No  Yes

If yes, - describe:

Information about the infant’s birth mother:

First name:  Last name:

Middle name:  Maiden name:

Birth date:  SS#:  

Street address:  City:  State:  Zip:  

How long has the birth mother been at this address?  
Years:  Months:

Previous Address:

At how many weeks or months did the birth mother begin prenatal care?  
No parental care  Unknown

Weeks:  Months:

Where did the birth mother receive prenatal care?  
(Please specify physician or other health care provider name and address.)

Physician/provider:  Hospital/clinic:  Phone:  

Street address:  City:  State:  Zip:  

Page 5
**PREGNANCY HISTORY (cont.)**

4. At how many weeks or months did the birth mother begin prenatal care? [ ] No [ ] Yes
   (ex. high blood pressure, bleeding, gestational diabetes)
   Specify:

5. Was the birth mother injured during her pregnancy with the infant? [ ] No [ ] Yes
   (ex. auto accident, falls)
   Specify:

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

<table>
<thead>
<tr>
<th>Unknown</th>
<th>No</th>
<th>Yes</th>
<th>Daily</th>
</tr>
</thead>
<tbody>
<tr>
<td>a) Over the counter medications</td>
<td>d) Cigarettes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>b) Prescription medications</td>
<td>e) Alcohol</td>
<td></td>
<td></td>
</tr>
<tr>
<td>c) Herbal remedies</td>
<td>f) Other</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

7. Currently, does any caregiver use any of the following?

<table>
<thead>
<tr>
<th>Unknown</th>
<th>No</th>
<th>Yes</th>
<th>Daily</th>
</tr>
</thead>
<tbody>
<tr>
<td>a) Over the counter medications</td>
<td>d) Cigarettes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>b) Prescription medications</td>
<td>e) Alcohol</td>
<td></td>
<td></td>
</tr>
<tr>
<td>c) Herbal remedies</td>
<td>f) Other</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**INCIDENT SCENE INVESTIGATION**

1. Where did the incident or death occur?

2. Was this the primary residence? [ ] No [ ] Yes

3. Is the site of the incident or death scene a daycare or other childcare setting? [ ] Yes [ ] No - If no, skip to question 9

4. How many children (under age 18) were under the care of the provider at the time of the incident or death?

5. How many adults (age 18 and over) were supervising the child(ren)?

6. What is the license number and licensing agency for the daycare?
   License number: 
   Agency: 

7. How long has the daycare been open for business?

8. How many people live at the site of the incident or death scene?
   Number of adults (18 years or older): 
   Number of children (under 18 years old):

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

<table>
<thead>
<tr>
<th>Central air</th>
<th>Gas furnace or boiler</th>
<th>Wood burning fireplace</th>
<th>Open window(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>A/C window unit</td>
<td>Electric furnace or boiler</td>
<td>Coal burning furnace</td>
<td>Wood burning stove</td>
</tr>
<tr>
<td>Ceiling fan</td>
<td>Electric space heater</td>
<td>Kerosene space heater</td>
<td>Floor/table fan</td>
</tr>
<tr>
<td>Electric baseboard heat</td>
<td>Electric (radiant) ceiling heat</td>
<td>Window fan</td>
<td>Unknown</td>
</tr>
<tr>
<td>Other - specify:</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

10. Indicate the temperature of the room where the infant was found unresponsive:

| Thermostat setting | Thermostat reading | Actual room temp. | Outside temp. |

11. What was the source of drinking water at the site of the incident or death scene? (Check all that apply)

| Public/municipal water | Bottled water | Well | Unknown | Other - Specify: |

12. The site of the incident or death scene has: (check all that apply)

<table>
<thead>
<tr>
<th>Insects</th>
<th>Mold growth</th>
<th>Smoky smell (like cigarettes)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pets</td>
<td>Dampness</td>
<td>Presence of alcohol containers</td>
</tr>
<tr>
<td>Peeling paint</td>
<td>Visible standing water</td>
<td>Presence of drug paraphernalia</td>
</tr>
<tr>
<td>Rodents or vermin</td>
<td>Odors or fumes - Describe:</td>
<td></td>
</tr>
<tr>
<td>Other - specify:</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

13. Describe the general appearance of incident scene: (ex. cleanliness, hazards, overcrowding, etc.)
   Specify:
Are there any factors, circumstances, or environmental concerns about the incident scene investigation that may have impacted the infant that have not yet been identified?

Arrival times

<table>
<thead>
<tr>
<th>Military Time</th>
<th>Law enforcement at scene:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>DSI at scene:</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Infant at hospital:</td>
</tr>
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</tbody>
</table>

Investigator’s Notes

1. Indicate the task(s) performed

- Additional scene(s)? (forms attached)
- Materials collected/evidence logged
- Notify next of kin or verify notification
- Doll reenactment/scene re-creation
- Referral for counseling
- Photos or video taken and noted
- EMS run sheet/report
- 911 tape

2. If more than one person was interviewed, does the information differ?

- [ ] No
- [ ] Yes

If yes, detail any differences, inconsistencies of relevant information: (ex. placed on sofa, last known alive on chair.)

INVESTIGATION DIAGRAMS

1. Scene Diagram:

2. Body Diagram:
### Investigator information
Name: ____________________  Agency: ____________________  Phone: ____________________

<table>
<thead>
<tr>
<th>Date</th>
<th>Military time</th>
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<tbody>
<tr>
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</table>

<table>
<thead>
<tr>
<th>Investigated:</th>
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<tbody>
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</table>

<table>
<thead>
<tr>
<th>Pronounced dead:</th>
<th></th>
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</table>

### Infant's information:
Last: ____________________  First: ____________________  M: ____________________  Case #: ____________________

Sex:  
- [ ] Male
- [ ] Female

Date of Birth: ____________________  Age: ____________________

Race:  
- [ ] White
- [ ] Black/African Am.
- [ ] Asian/Pacific Islander
- [ ] Am. Indian/Alaskan Native
- [ ] Hispanic/Latino
- [ ] Other: ____________________

### Indicate whether preliminary investigation suggests any of the following:

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
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</thead>
<tbody>
<tr>
<td>Asphyxia (ex. overlying, wedging, choking, nose/mouth obstruction, re-breathing, neck compression, immersion in water)</td>
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<tr>
<td>Sharing of sleep surface with adults, children, or pets</td>
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<tr>
<td>Change in sleep condition (ex. unaccustomed stomach sleep position, location, or sleep surface)</td>
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<tr>
<td>Hyperthermia/Hypothermia (ex. excessive wrapping, blankets, clothing, or hot or cold environments)</td>
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<tr>
<td>Environmental hazards (ex. carbon monoxide, noxious gases, chemicals, drugs, devices)</td>
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<tr>
<td>Unsafe sleep condition (ex. couch/sofa, waterbed, stuffed toys, pillows, soft bedding)</td>
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<tr>
<td>Diet (e.g., solids introduced, etc.)</td>
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<tr>
<td>Recent hospitalization</td>
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<tr>
<td>Previous medical diagnosis</td>
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<tr>
<td>History of acute life-threatening events (ex. apnea, seizures, difficulty breathing)</td>
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<tr>
<td>History of medical care without diagnosis</td>
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<tr>
<td>Recent fall or other injury</td>
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<tr>
<td>History of religious, cultural, or ethnic remedies</td>
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<tr>
<td>Cause of death due to natural causes other than SIDS (ex. birth defects, complications of preterm birth)</td>
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<tr>
<td>Prior sibling deaths</td>
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<td>Previous encounters with police or social service agencies</td>
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<tr>
<td>Request for tissue or organ donation</td>
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<tr>
<td>Objection to autopsy</td>
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<tr>
<td>Pre-terminal resuscitative treatment</td>
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<tr>
<td>Death due to trauma (injury), poisoning, or intoxication</td>
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<tr>
<td>Suspicious circumstances</td>
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<tr>
<td>Other alerts for pathologist's attention</td>
<td></td>
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</tbody>
</table>

Any "Yes" answers above should be explained in detail (description of circumstances):

### Pathologist information
Name: ____________________

Agency: ____________________  Phone: ____________________  Fax: ____________________