

# Elements in a Standard Elder Death Scene Form

DOCUMENT ALL FINDINGS IN DETAIL

## INVESTIGATIVE INFORMATION

### Decedent

Decedent Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Social Security Number \_\_\_\_\_ Race \_\_\_\_\_ Sex \_\_\_\_\_ Marital Status \_\_\_\_\_

Home Address \_\_\_\_\_

Height \_\_\_\_\_ Weight \_\_\_\_\_

Next of Kin (Relationship) \_\_\_\_\_

Contact Information \_\_\_\_\_

Next of Kin Notification (Date/Time/by Whom) \_\_\_\_\_

### Events of Death

Address of Incident \_\_\_\_\_

Name of Facility \_\_\_\_\_

Date/Time of Death \_\_\_\_\_

Name of Person who Pronounced \_\_\_\_\_

Last Known Alive Date/Time \_\_\_\_\_

Last Seen By \_\_\_\_\_

Date and Time Discovered \_\_\_\_\_

Who Discovered \_\_\_\_\_ Location \_\_\_\_\_

Ambulance/Emergency Medical Services \_\_\_\_\_

Body Position \_\_\_\_\_

Intervention by First Responders \_\_\_\_\_

General Physical Appearance (clean, unclean, unkempt, body odor) \_\_\_\_\_

Clothing (appropriate for season, soiled, urine/fecal-stained) \_\_\_\_\_

Law Enforcement Agency \_\_\_\_\_

Reporting Officer \_\_\_\_\_ Department Service Number (DSN) \_\_\_\_\_

Time Call Received \_\_\_\_\_ Law Enforcement Report Number \_\_\_\_\_

Medicolegal Death Investigator Name \_\_\_\_\_

	Yes	No	Unknown
Lividity/Consistent with Body Position	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If Not, Explain \_\_\_\_\_

<b>Date and Time of Assessment</b>	<b>Yes</b>	<b>No</b>	<b>Unknown</b>
Rigor Mortis/Date and Time of Assessment _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Decubitus Ulcers (Location and Stage)_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Injuries and Explanation for Injury _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Contusions_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lacerations_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Abrasions_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Burns_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Petechiae_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fractures (Note: If from Fall, Date/Time of Fall and Surface Type) _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Evidence of Restraints (Method, Body Location, How Long) _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Body Temperature (Warm/Cool/Cold-if no Auxiliary/Liver Temp Taken/ Date and Time of Assessment _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Environmental Temperature (Macro and Micro Environment): _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

### **Hospice Deaths**

Hospice Agency\_\_\_\_\_

Primary Nurse Contact Information \_\_\_\_\_

Date Entered Program \_\_\_\_\_

Decedent Clean and Well-Cared for?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Are Medications in Order?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Suspicious Circumstances? (Detailed Description)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

\_\_\_\_\_

\_\_\_\_\_

### **Medical/Social/Psychiatric History**

Recent Complaints\_\_\_\_\_

Primary Care Physician/Office/Exchange Phone Numbers\_\_\_\_\_

\_\_\_\_\_

Primary Care Physician/Notified Date and Time\_\_\_\_\_

Primary Care Physician or Medical Examiner/Coroner to Sign Death Certificate\_\_\_\_\_

Treated For\_\_\_\_\_

Dementia/Other Cognitive Impairment (Specify)\_\_\_\_\_

Medications Prescribed (Note Absence of Medications that should be Current or Others on Scene that are not Prescribed to Decedent):\_\_\_\_\_

\_\_\_\_\_

	Yes	No	Unknown
Medication Compliance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Name of Person who Administers Medication(s)_____			
Pharmacy_____			
Recent Hospitalizations (Location, Admission/Discharge Date/Admitting Diagnosis)_____			
_____			
Degree of Independence (Competency, Activities of Daily Living)_____			
_____			
Ambulatory Status/Mobility Aids (Walker, Wheelchair, Crutches, Motorized Scooter):_____			
_____			
Social History:			
Tobacco Use	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Alcohol Use (Type/Number of Containers/Empty or Full)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____			
Prescription Drug Abuse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Illicit Drug Use (Paraphernalia Present/Describe)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____			
Psychiatric Physician/Office/Exchange Phone Numbers_____			
Treated For_____			

### Environment Information

Type of Dwelling (Own Residence, Other Residence, Institution)\_\_\_\_\_

Name of Institution\_\_\_\_\_

License Information\_\_\_\_\_

Exterior Condition Description\_\_\_\_\_

Interior Condition Description\_\_\_\_\_

Ambient Temperature\_\_\_\_\_

Number of Residents\_\_\_\_\_

Caregiver(s) Name(s)/Qualifications/Type of Care Provided\_\_\_\_\_

\_\_\_\_\_

History of Caregiver(s) History of Alcohol/Illicit Drug Use	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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### POSSIBLE INDICATORS OF PHYSICAL, SEXUAL AND EMOTIONAL ABUSE, NEGLECT, FINANCIAL EXPLOITATION – COMPLETE APPROPRIATE SECTION(S)

Physical Abuse	Yes	No	Unknown
Self-Report (Prior to Death)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Contusions (Head, Neck, Extremities)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Periorbital Ecchymosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

<b>Physical Abuse (Continued)</b>	<b>Yes</b>	<b>No</b>	<b>Unknown</b>
Lacerations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Injuries Consistent with Ligatures/Restraints	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Open Wounds	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Untreated Injuries	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Injuries (In Various Stages of Healing)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fractures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Thermal Injuries	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Neck Injuries	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bite Marks	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Medication-Over/Under	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Broken Eyeglasses	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Traumatic Alopecia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Sexual Abuse</b>			
Self-Report (Prior to Death)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Injuries (Internal/External) Oral/Genital/Anal Areas	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Internal Bleeding	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Torn/Bloody Underclothes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
History: Difficulty Walking/Sitting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sexually Transmitted Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Frequent Urinary Tract Infections	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Neglect/Cruelty</b>	<b>Yes</b>	<b>No</b>	<b>Unknown</b>
Self-Report (Prior to Death)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dehydration	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Malnutrition	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Untreated Health Conditions/Injuries	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Non-Compliance to Medical/Psychiatric Treatment/Care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Failure to Get Medical/Dental Care (Document Reason Given for Non-Compliance)_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Weight Loss	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Medications (Over/Under)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lack of Essential Services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lack of Assistive Devices	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Abandonment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Inappropriate Clothing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Inadequate heating/Cooling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

<b>Neglect/Cruelty (Continued)</b>	<b>Yes</b>	<b>No</b>	<b>Unknown</b>
Bed Sores	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Shared Living Arrangements	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Unsafe Environment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fleas/Lice/Roaches/Rodents	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fecal/Urine Odor	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fecal/Urine Stained Bedding/Seating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Excoriated Skin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lock/Chains on Interior Doors	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Emotional Abuse</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Self-Report (Prior to Death)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Upset/Agitation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Withdrawn/Non-Responsive	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Unusual Behavior	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Unexplained Withdrawal. Sudden Change in Alertness, Unusual Depression, etc.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Financial Exploitation</b>			
Self-Report (Prior to Death)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Unemployed Adults Reside in Home	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sudden Changes in Banking Habits	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
New Names on Signature Card(s)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Unauthorized Withdrawal(s)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Abrupt Changes in Will	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Disappearance of Funds/Possessions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Unpaid Bills/Adequate Funds	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Forged Signature for Transactions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Appearance of Previously Uninvolved Relative_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sudden Transfer of Assets	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Unlicensed Personal Care Home	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dehydration/Malnutrition	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lack of Medical Attention	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Unsafe Living Conditions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Unsanitary Living Conditions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Inappropriate Clothing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lack of Assistive Devices	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Shared Living Arrangements	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

## LONG-TERM CARE FACILITY INFORMATION

### Physical Condition and Quality of Care

Documentation but Untreated Injuries	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Undocumented Injuries and Fractures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Multiple, Untreated, or Undocumented Pressure Sores	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Medical Orders Not Followed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dietary Orders Not Followed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Poor Oral Care, Poor Hygiene, and Lack of Cleanliness of Resident (e.g., Unchanged Adult Diapers, Untrimmed Finger and Toenails)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Malnourished Residents with No Explanation for Low Weight	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bruising in Non-Ambulatory Residents	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bruising in Unusual Locations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Family has Statements and Facts Concerning Poor Care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Level of Care for Residents with Non-Attentive Family Members	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

### Facility Characteristics

Lack of Bed Linens	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Unchanged Linens	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Strong Odors (Urine/Feces)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Trash Cans That Have Not Been Emptied	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

### Facility Characteristics (Continued)

Housekeeping Issues (Overflowing Trashcans, Strong odors, Food Left on Trays, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
History of Similar Problems (Regulations/License)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

### Inconsistencies Between

Medical Records, Statements Made by Staff Members, and/or What is Viewed by Investigator	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Statements Given by Different Groups	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
The Reported Time of Death and Condition of the Body	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

### Staff Behaviors

Staff Members who Follow the Investigator too Closely	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lack of Knowledge or Concern About a Resident	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Evasiveness, Both Unintended and Purposeful, Verbal and Nonverbal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Facility's Unwillingness to Release Medical Records	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

This list is intended only as an investigative tool and is not considered an exhaustive list. Many items on this list were compiled from information obtained from the following sources:

- 1) Dyer CB, Sanchez L, Kim L, et al. Factors that impact the determination by medical examiners of elder mistreatment as a cause of death in older people [Internet]. Washington: U.S. Department of Justice; 2008 Jul [cited 2014 Jul 28]. 73 p. Available from: <https://www.ncjrs.gov/pdffiles1/nij/grants/223288.pdf>.
- 2) Lindbloom E, Brandt J, Hawes C, et al. The role of forensic science in identification of mistreatment deaths in long-term care facilities: final report [Internet]. Washington: U.S. Department of Justice; 2005 Apr [cited 2014 Jul 28]. 91 p. Available from: <https://www.ncjrs.gov/pdffiles1/nij/grants/209334.pdf>.
- 3) Why should I care about elder abuse? [Internet]. Orange (CA): National Center on Elder Abuse; [cited 2014 Jun 12]. Available from:  
[http://www.ncea.aoa.gov/Resources/Publication/docs/NCEA\\_WhyCare\\_508.pdf](http://www.ncea.aoa.gov/Resources/Publication/docs/NCEA_WhyCare_508.pdf).  
[http://www.ncea.aoa.gov/Resources/Publication/docs/NCEA\\_WhyCare\\_508.pdf](http://www.ncea.aoa.gov/Resources/Publication/docs/NCEA_WhyCare_508.pdf)