Carolen Bailey papers

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MINNESOTA SUDDEN INFANT DEATH CENTER
Children's Health Center
Pathology Department
2525 Chicago Avenue
Minneapolis, MN 55404

Telephone: (612) 926-8115

Thank you for your film request. We will be sending you the film:

A Call For Help for your presentation

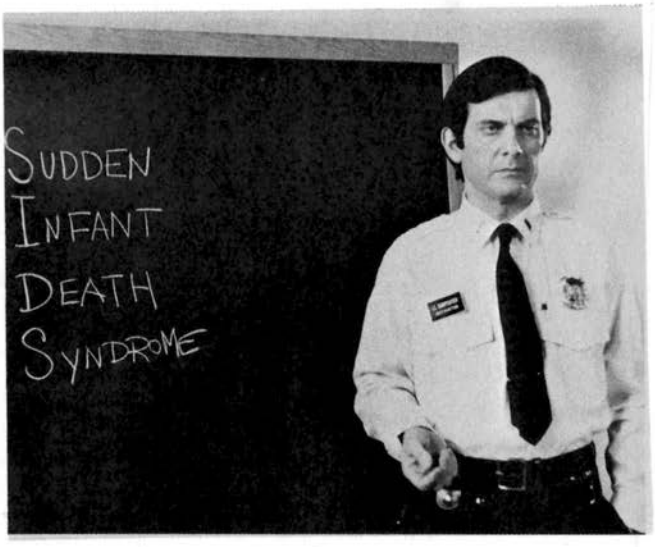
on December 27, 1982.

This is a 16 mm film which runs for about 25 minutes. If you should require additional materials or information, please let us know. Thank you for your interest in SIDS education.

Kathleen Fernbach, PHN
Coordinator
Minnesota Sudden Infant Death Center

A CALL FOR HELP

FREE LOAN 16mm TRAINING FILM



The sudden and unexpected deaths of apparently thriving infants and the response techniques used by the law enforcement officer in such cases is the subject of a new 16MM film entitled "A Call for Help." The Sudden Infant Death Syndrome (SIDS) represents an appalling tragedy to families of victims and is a major cause of infant mortality. The response techniques used by the police officer can have a great effect on this tragic situation and on any post investigation of the incident which may have to occur.

Under funds provided by the U.S. Department of Health, Education and Welfare, the International Association of Chiefs of Police is distributing free loan prints of the 16MM film "A Call for Help." The free loan film explains SIDS, the appearance of the SIDS victim, and the general response techniques to keep in mind when an officer responds to an infant death situation. To receive a copy on a free two day loan basis, complete this card and return it to the International Association of Chiefs of Police.

16MM	20 MINUTES	COLOR

☐ Please send me a free loan print of "A Call for Help". I understand that this print must be returned in 2 days after receipt.

NAME _____

TITLE _____

AGENCY _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

PHONE NUMBER _____

STAMP

INTERNATIONAL ASSOCIATION OF CHIEFS OF POLICE
ELEVEN FIRSTFIELD ROAD
GAITHERSBURG, MARYLAND 20760

SUDDEN INFANT DEATH SYNDROME

SIDS is a definite disease and is the number 1 cause of death in infants between the ages of 2 weeks and 1 year.

1 in every 350 live births will be a victim of *SIDS* – approximately 8,000 babies annually in the United States.

SIDS **cannot** be predicted or prevented.

SIDS is **not** caused by suffocation.

SIDS is **not** contagious.

SIDS is **not** hereditary.

For further information about the SUDDEN INFANT DEATH SYNDROME contact:

This pamphlet supplements "Facts About Sudden Infant Death Syndrome" published by the National Sudden Infant Death Syndrome Foundation, 310 So. Michigan Ave., Chicago, Ill. 60604.

209NF

FACTS ABOUT

Sudden Infant Death Syndrome for Police Officers

WHAT IS SIDS?

Sudden infant death syndrome (also called crib death) is the unexpected death of an apparently healthy infant which remains unexplained after a complete post mortem. Annually, 8,000 thriving well-cared for infants die as victims of this disease for which there is no known cause or cure.

TYPICAL HISTORY

The infant, usually between one and six months of age, is put to bed for its normal night or nap time sleep. There is no suspicion of any illness or indication of distress. Sometime later, from several minutes to the following morning, the infant is found, lifeless, in its crib. There has been no struggle or outcry noted. The baby may still be lying in the same position in which it was last observed or it may be wedged toward the side of the crib. Occasionally, there is a pinkish froth coming from the nose or mouth or fluid may be on the bedding.

THE PARENTS REACTION

The universal reaction of the parents who lost a baby under these unpredictable circumstances is to question "Was it my fault?" They must be assured that there is no way to predict or prevent SIDS on the basis of present medical knowledge. We are able to assure parents that their baby did not suffocate in its bedclothes or choke on regurgitated milk.

We can also assure them that their baby did not suffer. Death is sudden; almost instantaneous in most cases. A careful and thorough autopsy is of great value in alleviating parents' feelings of guilt and self-accusation (as well as the only way to eliminate any other cause of death). Autopsies are required, by law, in all cases of sudden, unexpected, unexplained death in many areas. The National Foundation for Sudden Infant Death, Inc. is working diligently to see that such laws are put into effect in all areas of the United States. Experience has shown that it is vital for parents to know the exact cause of their infant's death.

HOW CAN A POLICE OFFICER HELP?

Very frequently, the police officer is the first to arrive at the home after the infant is discovered. The officer entering this unhappy situation can do little to reduce the sorrow, but he is in a position to help prevent the self-incrimination which is so conspicuous a part of the sudden infant death syndrome. Obviously, neither a police officer nor a physician can diagnose the cause of death without the results of an autopsy in hand but a careless remark at this time can devastate the family. The greatest tact is called for on the part of the officer who is questioning parents concerning the circumstances surrounding the infant's death. Regrettably, some policemen (and others) immediately on the scene, have actually reinforced the parents conviction that they were

somehow to blame for the death. Most unfortunate of all, is the SIDS family who, in a state of shock and sorrow, is treated with suspicion or is accused of abuse or neglect by those investigating the death. Inter-familial accusations, life-long feelings of guilt, difficulty with siblings and even divorce and suicide are frequently the result of this tragic death and its immediate aftermath. SIDS families should be treated with the same degree of compassion and sympathy as any other family who loses a dearly loved infant to any other disease. While the police officer may understandably feel helpless to deal with the shock and grief of the family, he can do the family a great service by telling them of the possibility that their baby was a victim of the sudden infant death syndrome; that it is the leading cause of death in infants between the ages of one week and one year; that if SIDS is the cause of death, there is a parent's organization to which they can turn for information and aid; and, most importantly, it is NOT a predictable or preventable occurance so that they will not blame themselves for the death.

CONTENT OUTLINE

A Call for Help

I. Treatment of SIDS family at home.

A. Make no assumptions about cause of problem or death.

B. Do not pronounce infant dead.

C. Make parents feel that something is being done - this may involve beginning infant CPR.

D. Explain what you are doing, or where you are taking the infant.

E. Make no statement about the condition of the child.

F. Arrange to transport parents to hospital.

G. Help arrange for someone to care for siblings.

II. Possible parental emotional reactions to be encountered by first responder.

A. Each family, and each family member, is unique and will respond to the death in a unique way--not necessarily as you would react.

B. Factors which may affect responses of family members.

1. Individual personalities.

2. Situation of death.

3. Meaning child had to individual.

4. Individual characteristics of marriage relationship.

5. Cultural background.

C. Types of reactions.

1. Bereavement.

a. Must understand that grief is a natural process experienced when loved one dies.

b. Grief is related to the manner of death.

1) Illness allows time to prepare for the death.

2) Sudden, unexpected deaths often result in a more intense and disruptive grief.

2. Guilt.

   a. Common reaction in SIDS families.

   b. May be overwhelming, thus aggravating the normal grief process.

   c. Sources of guilt.

      1) Self-accusations.

         a) "I killed my baby."

         b) What parents might have done or failed to do to prevent death.

      2) Others blame parents.

         a) Other family members.

         b) First responder--must never make assumptions or accusations.

   d. May transfer to first responder--e.g., "If they had only arrived sooner, my baby would be alive."

3. Extremes.

   a. Most difficult to deal with.

      1) First responders tend to retaliate.

      2) First responders tend to ignore parents.

   b. Hysteria.

      1) Crying and wailing.

      2) Physically acting out.

   c. Anger.

      1) Verbal or nonverbal.

      2) Directed toward others--may result in abuse aimed at responder.

         a) Swearing.

         b) Name calling.

         c) "You don't know what you're doing."

d. Frustration--physically acted out.

1) Throwing things.

2) Hitting things.

III. How to deal with SIDS survivors.

A. Be in command of your own feelings and behavior at all times.

B. Act in a calm, efficient manner.

C. Exhibit kind concern.

D. Take command of the situation.

E. Protect the family from any further stress.

IV. Obtaining information.

A. Observe scene of SIDS incident.

1. Toys or foreign objects in crib?

2. Medications involved? - especially adult.

3. Position of child in crib - may account for marks on infant.

4. General appearance of scene.

B. Parents.

1. Encourage parents to talk.

2. Pay attention to the information they volunteer - much of the vital information will be naturally forthcoming.

C. Direct Questioning.

1. Offer to postpone questioning.

2. Do not:

a. Ask leading questions.

b. Ask suspicious questions.

c. Show that you doubt their capabilities as parents. (e.g., "Did you drop your baby?")

3. Ask about:

   a. What happened?

   b. Who found baby?

   c. Who else was in the house.

   d. Notice anything unusual in child's room.

   e. Any sign of illness?

   f. Medical history of infant*

V. Treatment of SIDS family at hospital emergency room.

   A. Keep parents informed about child's status, what is being done, etc.

   B. Offer sympathy and compassion.

      1. "Anything I can do?"

      2. Offer to:

         a. Make phone calls.

         b. Get some coffee for parents.

      3. Sympathetic ear--Listen!

   C. All medical information (pronouncement of death) must come from the physician.

*EMTs may need to obtain this early to help determine course of treatment.

Minnesota Sudden Infant Death Center
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Considerations for Delivering Tragic News

1. Learn as much as you can about the people to receive the news as possible

2. Go with another officer if at all possible

3. Be certain you have located the right people

4. Get off of the doorstep and in a private place if possible

5. Get all adult family members together

6. Get them seated and prepare them for the news - comfortable setting

7. Be direct

   - give who, how, when, where with as much detail as you have when they request details "She didn't suffer"

8. Ask recipients how else you can be helpful

   - is there someone else you'd like to have with you now?

Schreiber 4/73

4. SIDS parents experience severe psychological reactions to the death of their child: shock, guilt, and grief. Police officers can help relieve the immediate anguish of a bereaved family by:

... Explaining briefly the Sudden Infant Death Syndrome.
... Ensuring the parents that they could not have prevented the death.
... Advising the parents of possible guilt reaction of siblings.
... Conducting the investigation in a patient, sympathetic manner.

5. When interviewing the parents of a SIDS victim, the police officer has a multiple responsibility. Discuss this responsibility in light of the following:

... If SIDS is the apparent cause of death, the officer should tell the parents at the beginning of the interview.
... The nonaccusatory nature of the questions should be explained to the parents.
... Questioning should be carried out in an interview, not interrogation, fashion.
... The interview must be stopped and the Miranda warning given if, during the interview, the parents become suspects.
... A brief medical history of the family is needed for the medical examiner's inquiry.
... At the end of the interview, the officer should make certain that the parents are aware of long-term assistance provided by family doctors, public health services, and SIDS organizations to help families recover from the SIDS tragedy.

6. The autopsy and official cause of death are important aspects of a SIDS death investigation. Discuss the problems involved:

A. Autopsy
... Autopsies are not always made because of expense and lack of trained pathologists.
... If autopsy is to be made, the officer should help arrange it and be present if possible.
... If autopsy is not made, medical examiner should provide other confirmatory evidence.
... An autopsy must be made whenever the parents are to be charged criminally.

B. Cause of Death
... Before closing his case, the officer must obtain a determination of death from the medical examiner.
... To reduce the parents' suffering, cause of the child's death should be established as quickly as possible.
... Standard practice should be to notify the parents after gross examination of corpse.
... If a notification system does not exist in your jurisdiction, police records could be used to demonstrate the need for one.
... There is a major problem in the terminology of stating cause of death—accurate diagnosis is essential for the parents' well-being and effective investigation.

NOTES

Sudden Infant Death Syndrome

AKA "crib death"

Investigation of cases where the Sudden Infant Death Syndrome is the suspected cause of a child's death is a difficult job for police officers. Essentially, the officer performs two tasks that can conceivably conflict. First, he must conduct an investigation that leads to determination of cause of death. Second, he must protect the SIDS family from unnecessary anguish related to the tragedy itself and the investigation that follows.

Training Key #208

Leading cause of death under 1 yr. of age

Every year 8,000 to 10,000 infants in the United States are victims of the Sudden Infant Death Syndrome (SIDS), an unpredictable killer that usually strikes children between the ages of two weeks and four months.

The typical SIDS case involves an apparently healthy infant who has suddenly died overnight in his crib. There has been no attendant illness. There is no indication that the child struggled or cried out while dying. There are no identifiable causal signs of death. The death is a tragic shock to the parents—and a mystery to doctors.

Peak 2-4 mos., 90% under 6 mos.

What Is SIDS?

Although the occurrence of sudden, unexplained infant deaths has been recognized since antiquity, there is much confusion about SIDS among both the general public and the medical profession. Not until recently has significant medical research of SIDS been conducted, and doctors are still not sure of the true cause of SIDS.

The hypothesis most generally accepted by physicians is that the "death blow" in SIDS is caused by spasms of the larynx (laryngospasm). It is thought that laryngospasm is triggered by a mild, nonspecific virus infection of the upper respiratory tract and possibly by other factors such as neurological maldevelopment.[1] Death usually occurs as the result of complete upper airway obstruction, which takes place suddenly during sleep and evokes from the child a brief, noiseless ~~struggle.~~ Every proven case of SIDS has occurred while the victim was asleep.

no cries

Death due to lack of oxygen

Initial Response of Police Officer

Para-medics

In most jurisdictions, the ambulance services and the police department simultaneously respond to an emergency call of this kind. When the police officer is first to arrive at the scene of an apparent SIDS death, he should immediately, but carefully, initiate resuscitation efforts if the infant does not display the characteristic signs of death.

The skin of a corpse is extremely pale, and the lips and nails lose color as blood circulation stops. The muscles relax (muscular flaccidity), and the limbs lose their rigidity. If the body is moved, the head has a tendency to dangle, as if the neck were broken. Body waste is expelled. Rigor mortis and post-mortem lividity (settling of the blood), observable signs of certain death, occur more quickly in the case of an infant than in an adult, usually within three hours.

At the same time that the officer is determining whether the infant is dead or alive, he should be noting mentally the general condition of the house, behavior of persons present, position of the body, remarks made by the parents or other witnesses, medical action taken, and other facts related to the incident. At the earliest opportunity, he should record these observations.

The officer should determine what, if any, resuscitation or other first-aid efforts the parents made to revive the child. Some bruises or marks on the corpse might be the result of such efforts.

To establish the infant's death position, the officer should ask the parents how the child was resting when they found him. Observation of post-mortem lividity, if it is present, will verify the death position. The officer should note the presence of any froth, foam, or foreign matter in the mouth or nose of the victim and collect samples of these substances if possible.

Sometimes the position of death is one that is not readily associated with SIDS. For example, if an infant is found wedged in a corner of his crib and fully covered with blankets, parents and officers alike may assume that the child suffocated. Police officers should not be misled by this position, for it has been conclusively demonstrated that a healthy infant cannot smother in his own bedclothes. This position indicates that either someone smothered the child, or the infant was in this unusual position when SIDS struck.

[1] Abraham B. Bergman, *A Study in the Management of Sudden Infant Death Syndrome in the United States* (National Institute of Child Health and Human Development), 1972.

In many cases, a blood-tinged froth is discharged from the infant's nostrils, staining his clothing. Police officers should not mistake this for a sign that fatal internal bleeding has occurred. When the case of death is SIDS, such froth is due to pulmonary edema (accumulation of serous fluid in the lungs).

If possible, the infant's clothing should be left on the body for a medical examiner to inspect. When this is not possible, the officer should either gather the clothing or instruct medical personnel to retain it. The stains on the garments will be of value to the medical examiner in determining the cause of death. Any medication that the infant may have consumed should be identified and sent with the child to the hospital for medical evaluation.

Unlike in most death investigations, an apparent SIDS victim is removed as soon as possible to a hospital so as not to unduly upset the family. The parents usually accompany the infant but should be discouraged from driving themselves because of their emotional state. The officer should help arrange transportation for the parents. If possible a neighbor or relative may drive the parents or they may ride in the ambulance. If local regulations permit, the officer should drive the parents to the hospital and use the occasion to obtain further information about the incident.

After the infant of an apparent SIDS has been removed, an extensive investigation of the death scene can be conducted. The officer should ensure that photographs of the general death scene are taken. The place of death, typically a bassinet, crib, adult bed, or sofa, should be photographed from several angles. Items possibly connected to cause of death, such as a toy attached to the crib, should be photographed and removed for laboratory examination.

The infant's bedding is standard physical evidence and should be collected for scientific examination. Unusual or dangerous articles such as paint chips or a plastic bag and consumables and their containers such as medicines and milk bottles should be gathered if they are found near the death scene.

The officer should consider the general appearance of the house to determine whether the parents have been neglectful or hazardous conditions exist. For example, the possibility of a gas leak from a faulty heating system should be investigated.

Interviewing the Parents

The interview following a sudden death is difficult for both the parents and the officer. Parents, as well as other family members, experience intense psychological reactions including extreme shock, guilt, and grief. The officer must be aware of and sensitive to the traumatic condition of the parents; within this framework, he must conduct a proper investigative interview.

Although each parent reacts to the child's death in his or her own way, there are general behavioral characteristics that the officer should expect and be prepared for when interviewing a SIDS family.

Initially, the parents' shock and anguish may leave them temporarily uncommunicative, capable only of expressing the disbelief that their child could have died so suddenly. They may be unable to answer direct, simple questions, and their behavior may be erratic.

Because the origin of SIDS is not known, the parents' sense of loss is followed or accompanied by deep feelings of guilt. They may verbalize this guilt by openly accusing themselves of some form of neglect, such as having overlooked signs of illness or not having exercised proper parental care. When the officer does not suspect neglect or abuse, he should help alleviate the parents' guilt feelings by explaining what is known about SIDS and emphasizing that SIDS is neither preventable nor predictable.

The police officer should also be attentive to the reactions of siblings in a SIDS family. It is not uncommon for brothers and sisters of the deceased to believe that they have *willed* the event and are responsible for the infant's death. Not wanting a new competitor for parental attention, they may have jealously wished that the infant would die or *go away*. The possibility of such a reaction by siblings should be explained to the parents so that they may correct the situation.

The pattern of SIDS parents experiencing an overwhelming sense of loss and guilt generally culminates with intense grief. Immediate and sustained grief reactions are inevitable but the specific expression of these feelings vary among individuals. Some may weep openly, while others may suppress their feelings. Family members may exhibit denial (refusal to accept the infant's death), anger, mild or severe depression, and vague somatic sensations (*heartache* or *stomach pains*).

If at this point in the investigation the findings are indicative of SIDS, the officer should frankly state so. The grieving family again should be reassured that it is in no way responsible for the death. The officer should then explain that certain questions, some of which may cause embarrassment or seem to imply responsibility for the child's death, are routine and necessary to complete the investigation. The nonaccusatory nature of the questions should be emphasized—and the questioning should be delivered in interview rather than interrogation fashion.

Questions that should be asked include the following:

- Have the child, parents, other children, or recent visitors been ill in any way?
- Are there pets in the house?
- Did any pet sleep with or bite the child?
- Has there been any recent chemical spraying inside or outside of the house?
- Has there been any extermination—if so, by whom and what type of chemical was used?
- What are the parents' occupations—does any parent work around toxic material that could inadvertently be brought into the house?
- Have any of the other children ever climbed into the crib with the infant?
- Has a sibling every laid on top of the infant?
- Have other children recently played *doctor* with infant as patient?
- Do other children in the family have access to medicines?
- Was the child sleeping with older children or adults, did they ever lay on top of the infant?
- What were the parents' condition the night of the death, had they been drinking?
- Have the parents ever disciplined the child by spanking?
- How severe were the spankings?
- Has the child suffered any recent or old injuries?
- Did anyone drop the child or did he fall recently?
- When and what did the infant last eat?

The preceding questions are general guidelines that the officer can use to help determine the possibility of criminal action with regard to the infant's death. If during the questioning inconsistent accounts of the death are given by the parents or signs of child abuse (such as unrealistic expectations of the infant's behavior) are revealed, the officer should be alert to the possibility of homicide. If the nature of the questioning changes and the parents become suspects in a criminal case, the interview must stop and the Miranda warning given.

To help the medical examiner explore possible causes of death, the police officer should discretely obtain from the parents a brief sketch of the medical history of the mother and child. Symptoms of recent illness, if any, should be noted, and inquiry as to the mother's health during pregnancy should be made, especially with regard to any complications or injuries incurred during gestation including premature birth. Past miscarriages or difficult pregnancies should be noted as well. The parents should be informed that medical records of the infant will be needed by the medical examiner for review.

At the end of the interview, the officer should suggest that the family seek long-term assistance to overcome the psychological reactions to the infant's death. Often this help is best provided by the family doctor, priest, or minister. If the family does not have a physician, the officer should refer the parents to the public health service. Generally, the public health service has trained nurses who provide family counseling in the home. The factual information about SIDS provided by medical personnel helps the family to better understand its feelings and answer the inevitable questions raised by relatives and friends.

In some cities there are SIDS organizations, whose membership is composed of parents who have lost children to SIDS. Often SIDS families gain much comfort from contact with others who have experienced the same tragedy.

Regardless of the counseling service suggested, the police officer should make certain that the family knows of the availability of long-term assistance.

The Autopsy

An important aspect of the death investigation is the autopsy. Although it is strongly advocated that autopsies be performed in all cases of sudden death, this is not always possible because of the expense involved and the shortage of trained pathologists. If an autopsy is to be made, the police officer should help make arrangements for it and establish lines of inquiry for the medical examiner. Also, the officer should be present during the autopsy.

When an autopsy cannot be performed, the officer should expect, and request if necessary, the medical examiner to establish other confirmatory evidence by post-mortem studies such as chest x-ray, lumbar puncture, and blood culture.

An autopsy must be made whenever criminal charges are to be placed against the parents (or other persons) of the dead infant. Except in urgent circumstances, the parents should not be charged before the autopsy reports the cause of death. For example, in one case an officer mistook the post-mortem lividity on the infant's body for bruises and immediately arrested the parents. Later, the autopsy certified the cause of death as SIDS. Needless to say, the officer had caused the family extreme and unnecessary mental anguish.

Stating the Cause of Death

To properly close his case, the police officer must obtain a diagnosis of the infant's death from the medical examiner. Generally, diagnoses are made at one of three times: after gross examination of the body, after microscopic examination, or after some other physical examination of the corpse. The significance of these three intervals is in the length of time it takes to complete them. A lengthy time between the death and notification of the parents of the cause of their infant's death can have an adverse emotional impact on the family. If, for example, the diagnosis is not provided until after microscopic examination of the body, which usually takes from one to four weeks, the parents suffer terribly during this period of uncertainty. It should be standard procedure to establish a reasonable diagnosis immediately after gross examination of the body. This is scientifically feasible and a humane practice. If later discoveries are made, such as an unsuspected genetic condition, the family can be notified by the medical examiner.

There should exist a notification system by which SIDS parents are informed quickly of the cause of their child's death. Usually this is best handled by the medical examiner, who can provide a detailed medical explanation if necessary. Unfortunately, many communities do not have such a system, leaving the initiative to obtain information to shocked and bereaved parents. When a notification system does not exist, the police can use official records to demonstrate the need for one. A recommended procedure is for the medical examiner to send to the parents a brief letter certifying the official cause of death and a fact sheet about SIDS. These documents serve to alleviate the parents' anguish and help to explain the infant's death to relatives and friends.

A major problem exists with the terminology used in officially listing SIDS as the cause of death. Although the term Sudden Infant Death Syndrome is widely used in current medical literature and almost unanimously accepted by pediatricians, there is a *time lag* in its universal application within the medical profession.

An incredible variety of terms is used to explain sudden infant deaths. It is common for parents to be given one cause of death by the medical examiner and another cause by the family physician. When terms such as upper respiratory infection or pneumonia are used to identify SIDS, the parents suffer profound guilt because pneumonia, for example, is a disease that can be successfully treated.

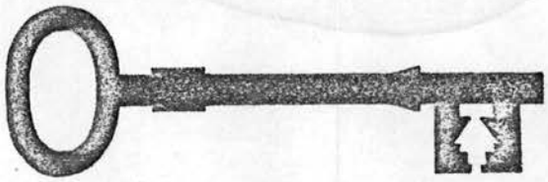
The use of substitute terminology for SIDS in stating the cause of death not only emotionally injures or confuses the parents—it also complicates the officer's job. When a medical examiner certifies the cause of an infant's death as being suffocation, for example, there are many investigative ramifications. When the cause of death is SIDS, it should be recorded as such so that the case may be closed. Conversely, when the cause of death is not known or possibly involves parental neglect or abuse, it should not be labeled SIDS just to bring the investigation to an expeditious conclusion.

Summary

Sudden Infant Death Syndrome is the name given to a puzzling disease that without warning strikes infants in their sleep. Although SIDS kills more infants under four months of age than any other disease, the medical profession currently has no way of predicting or preventing it.

Investigating an apparent SIDS death is a most challenging assignment for a police officer. He must follow routine investigative procedures to determine the cause of the infant's death without further burdening the bereaved family.

Parents of SIDS victims experience extreme psychological reactions—not the least of which is guilt—to the sudden death of their child. The police officer can help to ease this guilt by emphasizing to the parents the inexplicable nature of SIDS. In addition, the officer should make certain that the bereaved family is aware of organizations that offer long-term assistance to SIDS parents.



Discussion Guide

NOTES

1. Neither the cause of nor a cure for the Sudden Infant Death Syndrome has been discovered by medical science. Discuss what *is* known about this baffling killer.

... Each year SIDS kills 8,000 to 10,000 infants between the ages of two weeks and four months.
... SIDS occurs while its victims are sleeping.
... SIDS attacks infants who are otherwise apparently healthy.
... SIDS rarely if ever elicits from its victims cries or other indications of struggle.
... Death in SIDS usually results from a complete upper airway obstruction, preceded by spasms of the larynx.

2. The initial response of a police officer to an apparent SIDS death involves several distinct functions that are carried out almost simultaneously.

A. Review the procedures that are part of the officer's initial response.
... Determine if the infant is alive.
... If so, administer first aid.
... Avoid disturbing the scene as much as possible.
... Observe position of infant at time of arrival.
... Note presence of froth, foam, or foreign matter in victim's mouth and nose, if possible collect samples.
... Note remarks made by parents for possible indications of a homicide.
... Ensure that medical examiner receives bedclothes of infant.

B. Review the characteristic signs of death.
... Skin of dead body has general pallor. pale
... Color disappears from lips and nails.
... Muscles relax causing body to conform to contour of surface on which it rests.
... Extremities are limp.
... When body is moved, the head has a tendency to dangle, as if the neck was broken.
... If the body has been dead for more than three hours, rigor mortis and post-mortem lividity are usually present.

C. Discuss how the officer can help arrange hospital transportation for the parents.
... Parents should not be allowed to drive themselves because of emotional state.
... Parents should ride with friend or relative.
... When this is not desirable the parents could ride in the ambulance or in a squad car if it is not prohibited by regulations.

3. After the infant's body has been removed to the hospital, the officer should conduct a thorough investigation of the death scene. Review the following actions:

... General photographs should be taken of the death scene.
... The place of death, typically a crib, sofa, or bassinet, should be photographed from several angles.
... Objects attached to the crib or bed or otherwise found near the body should be photographed and collected for scientific analysis.
... The last milk bottle used by the infant as well as medicines and other containers should be removed for laboratory examination.
... The possibility of household hazards should be evaluated.

Artist-inventor Nancy Burson estimates that she is about six months and $150,000 away from images and use… tors." Says Burson, "We will h… electronic clones."

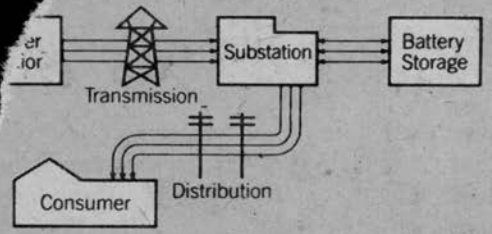
Update: Crib Death

Sudden Infant Death Syndrome (SIDS), which each year kills more than 8000 "normal" infants in their first year of life, may soon become a thing of the past.

Initial reports on a new treatment indicate that thiamine, a form of B vitamin, has been 100% effective in treating babies who are prone to SIDS, which is more commonly known as crib death.

Drs. Derrick Lonsdale and Richard H. Nodar of the Cleveland Clinic Foundation in Ohio found that "near misses"—babies who had suffered respiratory failure but were resuscitated—had developed characteristic brain stem abnormalities that could contribute to SIDS. Thiamine, effective in treating certain brain-damaged adults, was found to work with infants, too, and researchers are hopeful that this may give them a clue to which babies are prone to SIDS—and how to prevent it.

Testing babies for brain stem abnormalities and treating them with thiamine "could go a long way towards eliminating crib deaths," says Dr. James T. Nealis, director of the SIDS program at the Jacksonville Neurological Institute in Florida.



How battery storage works.

A new concept in electric energy is the use of advanced lead acid, zinc chloride, and sodium-sulfur batteries to store electricity produced economically (often using coal or nuclear power) during the off-peak night time hours for use during the day. In contrast, power to meet peak demand is often generated with expensive oil-burning units. In addition to helping utilities conserve oil, batteries are expected to provide a flexible, stable, non-polluting and compact way to store power.

A prototype battery test facility, which will be managed by the Public Service Electric and Gas company, is jointly funded by PSE&G and hundreds of electric companies through their membership in the Electric Power Research Institute (EPRI) and by the Department of Energy.

Conservation will help us get through the years, but we must build reliable and safe nuclear and coal plants now. Our way of life and our economic security are at stake.

For more information about the electric industry's conservation and research efforts and the pressing need to build power plants now, write to the Edison Electric Institute, Dept. O, 1111 19th Street, N.W., Washington, D.C. 20036.

Edison Electric Institute
The association of electric companies

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keep going.

"It's hard, th
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to your level.

10-2-81

MULTNOMAH COUNTY

MULTNOMAH COUNTY SHERIFF

Sudden Infant Death

1/4 to 1/5 o/o of auto accidents (8-10,000 a year) in small population of 0-6 mos.

1 per 350 per live births

✓ Very seasonal disease — 80% occur late fall, winter, early Spring (April to)

Noted cluster pattern of deaths in large city.

Not seen in new-born nursery. Most in 2-4 mos. (peak)

Oldest 14 mos., youngest seen 10 days.

Males predominant (3-2 bias)

Inverse correlation with birth weigh (higher with pre-maturas, 8× greater).

* Always ask birth weight.

Occurs across social-economic levels, but more commonly in lower social-economic, inner city (2-3×).

Infant who is thought to be previously healthy. No one notices in reality subtle changes which are not detectable in routine physician check.

½ have recent history of cold, sniffles, running nose, low-grade diarhea (no pneumonia).

Most found in morning when go to wake up baby or after aft nap. - sleep.

MULTNOMAH COUNTY

MULTNOMAH COUNTY SHERIFF

* If death has occurred while infant is awake, there's something screwy about it (not necessarily homicide).

Definitely not suffocation, choking on milk, fever - over-whelming infection, hereditary/congenital, pollution

Increased incidents if already occurred in family (not hereditary but social-ee.)

2 primary problems:
1. medical (diagnosis, cause)

Probably a defect in control of respiration during sleep - 20 seconds or more. Spells are increased by virus, etc.

2. Human problem.

Expected reaction is parents (particularly mother) will blame themselves. Believe temperature too cold, devastating disease she should have recognize, smoking, choking on milk, blanket suffocated). Be sure not to reinforce this. Siblings may also feel guilt. Divorce, suicide, etc. may result. 1x husband beat wife believing she did it. Programs available to deal with these guilt feelings. Public health nurses have been trained in grief reaction for follow-up.

Have been cases of SIDS actually prosecuted.

(3)

MULTNOMAH COUNTY

Some responses:

Denial
mutual blame
Irrational

✓ If encounter, probability is SID (exceptions when death is questionable)

- By treating them this way, even if murder, will likely get more information.

treat them sympathetically & let them ventilate. The loss of this infant is probably the most devastating event in their lifetime.

✓ Most found in cribs (but elsewhere - drawers, back seats where sleep)

✓ Most face-down (but most sleep this way).

✓ Most scenes disturbed (not deliberate) but normal response to grab baby). Must determine exactly how baby was position (if on back, probably moved).

✓ Blanket may cover nose & mouth (assume suffocation)

✓ 50-60% have discharge from nose, froth on pillow (~~not~~ simply fluid building up in nose). a little blood may be present.

Autopsy of SID — constellation of pathological findings changes in lungs — small hemorrages Some hemorrages on heart

(4)

MULTNOMAH COUNTY

Fluffy pink lungs without hemorrages in suffocation should not have difficulty in differentiating in most cases.

Do have accidental, mechanical suffocation.

- Very important to re-position infant. Can't ignore what was at scene.

Post-mortem marks on head/body from crib slats.

✓ In 1974 federal law "Hazardous Cribs" - all cribs same size slats distance, mattresses.

Still see choking but stats - people pass cribs from generation to generation.

Ex. - baloon in voice box

History alone can give direction - sniffles, no external injuries

Asked what fed, formula esp. if mother a dummy (too much salt in formula)

* Overhead on "Information Offered to SIDS Parents"

Cannot be prevented
It is a real disease
not suffocation
not communicable

SUDDEN INFANT DEATH SYNDROME

SIDS is a definite disease and is the number 1 cause of death in infants between the ages of 2 weeks and 1 year.

1 in every 350 live births will be a victim of *SIDS* – approximately 8,000 babies annually in the United States.

SIDS **cannot** be predicted or prevented.

SIDS is **not** caused by suffocation.

SIDS is **not** contagious.

SIDS is **not** hereditary.

For further information about the SUDDEN INFANT DEATH SYNDROME contact:

This pamphlet supplements "Facts About Sudden Infant Death Syndrome" published by the National Sudden Infant Death Syndrome Foundation, 310 So. Michigan Ave., Chicago, Ill. 60604.

209NF

FACTS ABOUT

Sudden Infant Death Syndrome for Police Officers

WHAT IS SIDS?

Sudden infant death syndrome (also called crib death) is the unexpected death of an apparently healthy infant which remains unexplained after a complete post mortem. Annually, 8,000 thriving well-cared for infants die as victims of this disease for which there is no known cause or cure.

TYPICAL HISTORY

The infant, usually between one and six months of age, is put to bed for its normal night or nap time sleep. There is no suspicion of any illness or indication of distress. Sometime later, from several minutes to the following morning, the infant is found, lifeless, in its crib. There has been no struggle or outcry noted. The baby may still be lying in the same position in which it was last observed or it may be wedged toward the side of the crib. Occasionally, there is a pinkish froth coming from the nose or mouth or fluid may be on the bedding.

THE PARENTS REACTION

The universal reaction of the parents who lost a baby under these unpredictable circumstances is to question "Was it my fault?" They must be assured that there is no way to predict or prevent SIDS on the basis of present medical knowledge. We are able to assure parents that their baby did *not* suffocate in its bedclothes or choke on regurgitated milk. We can also assure them that their baby did not suffer. Death is sudden; almost instantaneous in most cases. A careful and thorough autopsy is of great value in alleviating parents' feelings of guilt and self-accusation (as well as the only way to eliminate any other cause of death). Autopsies are required by law, in all cases of sudden, unexpected, unexplained death in many areas. The National Foundation for Sudden Infant Death, Inc. is working diligently to see that such laws are put into effect in all areas of the United States. Experience has shown that it is vital for parents to know the exact cause of their infant's death.

HOW CAN A POLICE OFFICER HELP?

Very frequently, the police officer is the first to arrive at the home after the infant is discovered. The officer entering this unhappy situation can do little to reduce the sorrow, but he is in a position to help prevent the self-incrimination which is so conspicuous a part of the sudden infant death syndrome. Obviously, neither a police officer nor a physician can diagnose the cause of death without the results of an autopsy in hand but a careless remark at this time can devastate the family. The greatest tact is called for on the part of the officer who is questioning parents concerning the circumstances surrounding the infant's death. Regrettably, some policemen (and others) immediately on the scene, have actually reinforced the parents conviction that they were somehow to blame for the death. Most unfortunate of all, is the SIDS family who, in a state of shock and sorrow, is treated with suspicion or is accused of abuse or neglect by those investigating the death. Interfamilial accusations, life-long feelings of guilt, difficulty with siblings and even divorce and suicide are frequently the result of this tragic death and its immediate aftermath. SIDS families should be treated with the same degree of compassion and sympathy as any other family who loses a dearly loved infant to any other disease. While the police officer may understandably feel helpless to deal with the shock and grief of the family, he can do the family a great service by telling them of the possibility that their baby was a victim of the sudden infant death syndrome; that it is the leading cause of death in infants between the ages of one week and one year; that if SIDS is the cause of death, there is a parent's organization to which they can turn for information and aid; and, most importantly, it is NOT a predictable or preventable occurance so that they will not blame themselves for the death.

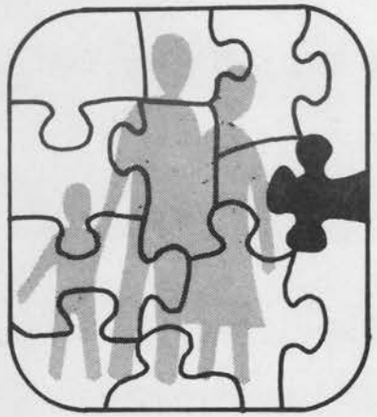
MINNESOTA SUDDEN INFANT DEATH CENTER

The Center distributes information about SIDS to both health care professionals and to the concerned public. Its staff consults with supportive agencies and parent groups. And they help families find mental health assistance, which is so often essential after a SIDS death.

For information or assistance.

Minnesota Sudden Infant Death Center
Children's Health Center, Pathology Department
2525 Chicago Avenue South
Minneapolis, MN 55404
(612) 874-6285

This pamphlet has been prepared by the Minnesota Department of Health for the Minnesota Sudden Infant Death Center. It was supported by grant #MCH-000044-01-0 awarded by HEW Bureau of Community Health Services to Children's Health Center, Minneapolis, MN.



MINNESOTA SUDDEN INFANT DEATH CENTER

Children's Health Center
Pathology Department
2525 Chicago Avenue
Minneapolis, MN 55404 (612) 874-6285

The baby died.
No one knows exactly why.

For Mother, the loss is a painful, aching emptiness.
She's tortured by self-doubt about her abilities as a mother.
"What could I have done?
What did I do wrong?"
And Dad . . . he too feels terribly responsible.
"If only I had taken the time to check on the baby before going to bed that night.
Perhaps this wouldn't have happened if I weren't always so busy with work."
The baby's big brother, only a first grader, can't help but be affected by the loss.
"Mom cries all the time.
Dad hardly talks to me anymore.
I didn't mean it when I said that I hated the baby."

8,000 Victims a Year . . .
And Nobody Knows Why

The baby's death was not predictable nor was it preventable. The cause . . . a disease called SIDS, Sudden Infant Death Syndrome.

Every year SIDS takes the lives of about 140 Minnesota babies. And across the nation this year some 8,000 seemingly normal, healthy babies will die of SIDS. It's the leading cause of death among infants from one month to one year of age.

We don't know why SIDS occurs. Until recently SIDS has been treated as an obscure and baffling mystery. However, serious research is now underway to provide more information about SIDS. There also is growing public awareness of this as a specific disease.

We know that SIDS –

Is not hereditary, nor is it contagious. SIDS can strike any family, but it is not a danger to others in the family nor to the neighbors.

Usually occurs during a sleep period. It's more common at night than during the day. And SIDS is more likely to occur in the winter months.

Is not caused by external suffocation. Often called "Crib death," many-mistakenly believe that the baby became entangled in its blankets and suffocated.

Is not caused by neglect or a change in child care methods. There is no relationship between breast feeding and SIDS. The victim does not cry and often shows no sign of having been disturbed in sleep. Choking on mucus or regurgitation is not the reason for death.

Victims generally appear perfectly healthy. Sometimes the baby will have a mild cold.

Without an autopsy, SIDS can't even be positively identified as the cause of death. The autopsy confirms the absence of abuse, infection, malformation and other known causes of death.

SIDS . . .
It Strikes Without Warning

SIDS strikes quickly . . . there is no way to prepare for it.

The sudden unexpected nature of SIDS involves many people who may or may not be well informed about the disease.

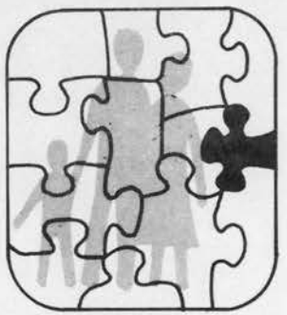
The police who often receive the initial call from a terrified parent or babysitter.

The ambulance driver and the emergency room people who must try to calm and aid the family while also attempting to help the baby.

The doctor whose job is to inform the family of the shattering news and to discuss SIDS as the suspect disease.

The coroner whose autopsy is the only way to make a positive diagnosis of SIDS.

The public health nurse or mental health professional who provides comfort, support and counseling to grieving families after the baby's death.



MINNESOTA SUDDEN INFANT DEATH CENTER

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The Focus . . .
Family Counseling

In Minnesota, a center has been established to serve the needs of SIDS victim families. Called the Minnesota Sudden Infant Death Center, it acts as the central link for people who work with SIDS families.

The Center's staff obtains information from the coroner to identify SIDS cases. They then refer the cases to public health nurses who arrange for home visits to the family.

The public health nurse can give the family facts about SIDS to offset needless guilt and anguish. Experience has shown that families are very receptive to the comfort and guidance a health professional can provide.

The Center also refers the family to a group of parents who have experienced the same loss, the Minnesota Chapter of the National Sudden Infant Death Syndrome Foundation. These parents are people with a sincere interest in helping others understand SIDS as well as their own feelings of grief and guilt.

One of the Center's most important jobs is to help more people, both the general public and health care professionals, understand SIDS . . . the tragedy of the disease and its devastating effect on the family.

The Center distributes information about SIDS to both health care professionals and to the concerned public. Its staff consults with supportive agencies and parent groups. And they help families find mental health assistance, which is so often essential after a SIDS death.

Sample

Sudden Infant Death Syndrome
Police Presentation
(2 presentations - total time 3 hours)

I. Introduction and Description of Center

II. Definition

III. Name of disease
- A. Crib death - lay term but may give misunderstanding
  - 1. Does not have to occur in a crib (examples)
  - 2. Not due to defective crib
- B. Explanation of significance of each letter S-I-D-S

IV. Extent
- A. Most common cause of death between 1 week - 1 year of age
- B. Over 10,000/year/U.S.
- C. One death every 45 minutes
- D. May give local incidence

V. Extent
- A. Age
- B. Birth weight
- C. During sleep (sudden, silent, no warning)
- D. Socioeconomic level
- E. Race
- F. Sex
- G. Seasonal
- H. Time of day

VI. Cause
- A. Unknown - research
- B. Things we know does not cause SIDS
- C. 1. Suffocation
  - a. "overlaying"
  - b. bed clothes
  - 2. Choking
  - 3. Injury
  - 4. Contagious infection
  - 5. Inherited
- C. At this time cannot be predicted or prevented

VII. Appearance of infant
- A. Body usually moved before police or rescue arrive
- B. Bed clothes
- C. Position in crib (face down, etc.)
- D. May be limp or tight fisted
- E. Body may be warm or cold
- F. Bloody drainage from nose and mouth
- G. Lividity vs. bruises
- H. Dirty diaper
- I. Diaper rash

VIII. SIDS vs. Child Abuse

Due to the suddenness of the death with no apparent cause, may be confused with child abuse

A. Incidence
   1. 10,000 SIDS vs. less than 1,000 deaths from child abuse/year U.S.
   2. Small percentage of 1,000 child abuse deaths occur in infancy.

B. Physical findings in child abuse
   1. Bruises, burns, cuts, whelts
   2. Old scars (in various stages of healing)
   3. Malnutrition
   4. Other abused children in home

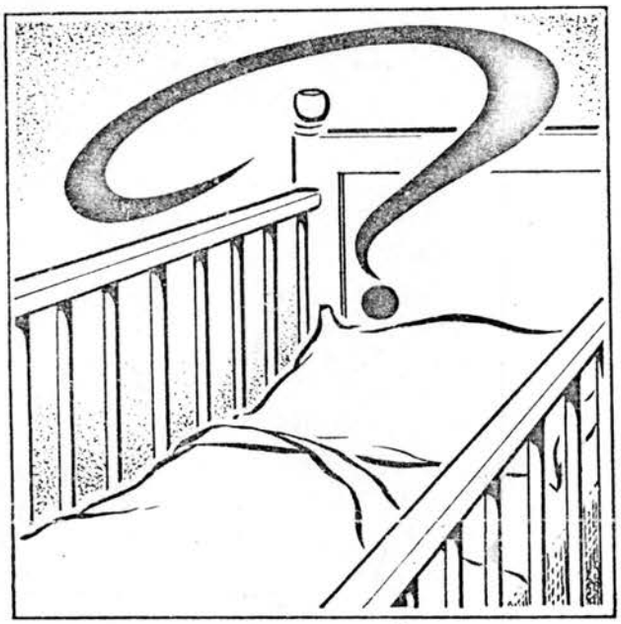
C. Don't read into normal SIDS findings
   1. small infant vs. malnourished child
   2. normal marks - slight scratches, etc.
   3. bloody drainage from nose and mouth
   4. diaper rash not a sign of reject or trauma
   5. environmental objects - not an influence

D. Suspicious cases should be pursued only after autopsy

IX. Slides

X. Questions

crib death or murder



by — Dr. A. R. Bainborough, Pathologist;
Dr. L. J. Kotkas, Psychiatrist and
Insp. R. D. Michelson, Lethbridge Police Department, Associate Editor

Insp. R. D. Michelson
Royal Canadian Mounted Police

The suddenness in which death can come to infants is sadly known to many police officers, doctors and coroners. It is accompanied by the usual grief, self-blame or allegations of negligence. The symptoms are often alike and the story is usually that the baby had been unwell, though not seriously ill, and "fussed" somewhat during the night but by morning was dead. The suggestion of suffocation by bedding or vomit is always present and requires consideration but it usually happens that death has been brought about with unbelievable speed by broncho-pneumonia.

This is one of the most common causes of unexpected infant death and it requires considerable tact and understanding by police officers. The sudden tragedy of a child's death and grief of parents can bring about the problem of a police officer taking it for granted that the case is an easy one or uncomplicated. Suspicion is easy to dismiss if one wishes to look another way or to find only one particular thing. This inherent danger often results in the pathologist, whose duty it is to determine the cause of death, not being told some of the significant circumstances.

And so it was the evening of March 23, 1967 when police were called to a basement suite where a five-month-old baby had died quite suddenly. Rather quickly it was concluded that death was the result of an acute respiratory infection. There was, in fact, a history of this ailment and a somewhat repeated croup. The baby had been found dead by a babysitter about a half hour after being placed in bed. The mother, a nurse, was working and not at home.

It seemed to be a common story of a baby dying from broncho-pneumonia. Predetermined conclusions caused a minor bloody discharge from the nose to be overlooked and later explained as being consistent with the conclusions already reached. The fact that death was in the early evening instead of the more usual morning discovery was also brushed aside in a hurried attempt to conclude the obvious.

At the autopsy, when the pathologist found minimal congestion of the lungs, kidneys and brain and considering the facts as they were known and appeared to him, it was not unusual to conclude that this was "compatible with the so-called 'Sudden Death Syndrome' in infants".

This was an error that was well on its way to being repeated by police officers called at midnight

on September 2, 1970 some three years later, to a home where a two-and-one-half-year-old boy had been found dead in his crib by a resident babysitter. There was the usual human reaction to the sudden tragedy. The boy had been put to bed about 9:00 p.m., apparently well, but "fussed" and cried a little at 12:30 a.m. He was found dead about ten minutes later. It was an ordinary police case and like the other, an apparent "crib death".

The findings at autopsy were the same as those which characterize "crib death" — failure of blood clotting, empty bladder, confluent interstitial hemorrhages in the lungs. The same signs are also compatible with the child having died of asphyxia. Two things pointed to the latter: petechiae [crimson, purple discolouration] in the skin of the eyelids and the child's age. "It is only when there has been compression of veins of the neck, or a severe struggle to breathe, that petechiae are common in the skin and conjunctivae." Unexplained "crib death" usually occurs in infants under six months of age. This child was two-and-one-half-years-old. Before the cause of death could be considered established, the result of a culture of the lungs was needed; this requires from one to several days.

The pathologist's earlier conclusions were however made known to police as an investigative guide, together with an observation by a member of his office staff that the babysitter was the same person as in the other infant's death three years earlier. This illustrates the importance of a pathologist having some background of a case or preferably visiting the scene whenever practical in questionable cases.

Now the repetitive murder is no rarity in the annals of crime but most repetitive murders are motivated by financial gain. What could be the possible reason for child murder in unrelated and separate cases? Fortunately, early success finally gives way to suspicion and detection even though there are not the usual motives. Suspicion caused a police review of the 1967 file and an investigation into the background of the 25-year-old professional babysitter.

She was no problem to talk to and recalled the earlier case well, — how she had discovered the unconscious infant and tried to give mouth to mouth resuscitation but failed. She had succeeded a few days earlier when she had found the infant unconscious then and was quite proud of her achievement. She went on to recall other cases, other times, when she had been babysitting and saved a child's life. Once, in 1969, she had saved a life when she discovered a cat lying across the face of a baby. In 1970, a similar incident involving another baby and another cat was prevented from tragedy by her timely action. Another case was not as successful and doctors worked more than an hour before the child recovered. She was praised for her actions and credited with saving the baby.

Concluding the obvious caused problems in the early stages of both investigations but an opposite error would have resulted if the obvious had not now been recognized. It didn't matter that the culture from the lungs had not yet had time for incubation. Police action was made urgent by the suspect's insistence that she be permitted to attend to yet another babysitting job, newly acquired.

Police responsibility was clear. She was taken into custody pursuant to Section 435 of the Criminal Code on the reasonable and probable grounds that she had committed an indictable offence. Before custody was questioned or became a problem, she gave a statement confessing that she had suffocated the two-and-one-half-year-old boy with a pillow. She gave no reason. Subsequently, she confessed to suffocating the infant three years earlier with her hand over its face and again gave no reason. The cat story too, was false and she had brought about unconsciousness to one baby twice and another once by pillows held over their faces. In each case she was able to revive them and emerged somewhat of a heroine. No other motive was clearly established but her actions might be categorized by the legal steps eventually taken. Two charges of murder and two of attempted murder cleared police files.

It was clear to all who had contact with her, and from the facts of her previous history, that she was mentally and emotionally very abnormal, but there was initially some difficulty in finding a diagnostic category that would fit her. She had been previously assessed as being clearly mentally retarded many times and throughout her childhood behaved abnormally and attended opportunity classes. Yet testing after the murders showed her intelligence to be normal. She had been treated many times for her mental state in hospital and there was clear evidence of very strange and bizarre behaviour in the past and yet on a superficial contact with her she seemed mentally quite normal. The most likely explanation is that she was a childhood schizophrenic; such children are often mistaken for being mentally retarded. As she grew older she was able to

increase her intelligence as measured by tests, and she concurrently became more independent, making her own living (in addition to social assistance) by, of all things, professional babysitting! She made herself feel better by "helping" children and it is likely that it was only when they couldn't be helped and continued to cry for their mothers in spite of her efforts, that she put them out of what she may have thought was their misery. Her mental condition was schizophrenia.

On November 25, 1970, the accused was ordered confined to a mental institution on a Lieutenant-Governor's order under the provisions of Section 527 of the Criminal Code.

Reviewing the details of this case brings into focus the type of investigation and the findings required to separate infanticide from "crib death":

1) Every case of infant death from cause unknown deserves a complete investigation, including an autopsy.

2) The background of those people who could have been in the immediate vicinity of the infant should be checked, especially with regard to mental retardation, mental disease and depressions, marital insecurity and instability, economic hopelessness, etc. Questions must be asked: Was the child wanted by parents, welcomed by siblings and others in the household and were the inconveniences created by the presence of the infant resented? Had the child or another child in the family suffered injuries under unusual circumstances (the battered child syndrome)?

3) The infant's room and other rooms in the home should be searched for a pillow or bed clothes that might bear suspicious stains. In this case, the pillow used by the babysitter was stained with secretions. An unsuccessful attempt was made to extract cells from this stain for sex chromosome studies. Had cells been found it might have been possible to determine if they had arisen from the nose and mouth of a male or female, information which would be useful in cases such as this.

4) If the infant is over six months old and especially if it is over a year old, "crib death" is an untenable diagnosis and infections, poisons, allergic reactions, head injuries, aspiration of food, etc., must be suspected. If the findings of asphyxia, especially petechiae in the skin, are present and are not associated with substantive evidence of other causes of death, there needs to be further investigation into unusual activity in the home. This may require the help of the family physician, clergyman and psychiatrist.

5) If the infant is between three and six months of age, the period during which most "crib deaths" occur, infanticide is less often considered but there are investigators who feel a proportion of these deaths may result from parental attempts to quiet crying. Instances of "crib death" at home are most common in areas of high density population, during the winter months and during the hours of 6:00 a.m. and 10:a.m. Any questioning of overwrought parents in such circumstances requires an understanding and tender approach so that injury is not accentuated: fact finding without accusation.

Reference:

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* * *

How many "crib deaths" might be murders? Certainly there are some being reported now in Alberta. Three cases were reported by Prof. Keith Pearce (University of Calgary) at the West Regional Meeting of the Psychiatric Association in Vancouver, "in print", and so far only have been reported in a news item and editorial in the "Medical Post" February 23, and several letters to the Editor March 23.

The Pathological findings in some cases are often indistinguishable from suffocation. The peak incidence in spring and fall of the year is more reminiscent of depression and suicide, and incidently motor accidents, and moreover other aspects of its occurrence, i.e.: in poverty and poorer housing areas, could lead to the suggestion that depression and child murder might be the cause of more of these cases. Psychiatric investigation should perhaps be requested in many of these cases but would be difficult except in special circumstances.

Where there is reason for suspicion, what cooperation could the law officer expect from the psychiatrist? Very little, if there is reason to believe that a parent, possibly already suicidally depressed,

may have committed the act while half asleep or in a trance and not consciously aware of the action, and hence could be inappropriately punished. An "amicus curiae" (friend of the court) who knew how the evidence might be used would perhaps be more co-operative. In many cases, it would be necessary for the psychiatrist to warn the person that he was acting for the court and that information given might be used against him. This kind of concern might be the reason there has been little said or written about raising the question of murder in these cases to date. Patients are used to having doctors respect their confidence and doctors are punished when they don't. They are in a bind. There are ways of rendering evidence from a patient inadmissible in court, but these aren't generally known. Prof. Pearce suggests that evidence can be taken with the patient being given an intravenous drug, and that while this will facilitate obtaining the very important information, that could prevent other tragedies, the evidence is not admissable in court.

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COLOUR-CODED CARDS DISCONTINUED

As the result of a recent survey to determine the value of the Criminal Identification Card System, (Colour Coded) a decision has been reached to cease publication of all categories with the exception of V.I.P. (yellow).

All existing cards may be destroyed bearing in mind that they are considered confidential. The policy affecting members of the R.C.M.P. with regard to such destruction is clear. Other agencies should consult their regulations governing destruction of confidential material.

F.P.S. files, from which the information on the Colour Coded cards originated, are still being retained as in the past. This information will continue to be available to all departments upon request.

Sample

Delaware Valley SIDS Community Resource Center
Children's Hospital
One Children's Center
Philadelphia, Pa. 19104
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APPENDIX G

POLICE PROGRAM DESCRIPTION

S U D D E N I N F A N T D E A T H S Y N D R O M E
...the No. 1 Infant "Killer"...

Program

9:00am to 9:15am — Introduction
7:00pm to 7:15pm

The three goals of this program are to assure that:

1. Police officers will conduct thorough investigations of sudden infant deaths in accordance with legal requirements?
2. Police officers will conduct these investigations in a sympathetic but professional manner that does not add unnecessary anguish for grief-stricken parents
3. Police officers will be knowledgeable about the Sudden Infant Death Syndrome

9:15am to 10:15am — Lecture #1
7:15pm to 8:15pm

What is the Sudden Infant Death Syndrome:

Through discussion and the use of visual aids the following points will be covered:

1. Characteristics of SIDS
2. Normal appearances of a SIDS infant after death
3. Contrasts between SIDS and child abuse victims

10:15am to 10:30am — Break
8:15pm to 8:30pm

10:30am to 11:00am — Movie: "After Our Baby Died"
8:30pm to 9:00pm

This movie deals with normal parental reactions to the loss of an infant and includes recent theories about the causes of SIDS.

11:00am to 12:00pm — Lecture #2
9:00pm to 10:00pm

The Police Investigation of Sudden Infant Deaths

The following points will be covered:

1. Review of infant resuscitation
2. Sample interview techniques and appropriate questions to ask of crib death parents.
3. Explanation of autopsy procedures and findings
4. Utilization of the Delaware Valley SIDS Community Resource Center

The Delaware Valley Sudden Infant Death Syndrome Community Resource Center

SUDDEN INFANT DEATH SYNDROME
FACTS FOR POLICE OFFICERS

1. Medical science has not yet discovered the cause of or a cure for Sudden Infant Death Syndrome but we do know that:

   ...Each year SIDS kills 10,000 infants between the ages of 2 weeks and one year
   ...SIDS occurs while its victims are sleeping
   ...SIDS attacks infants who are otherwise apparently healthy
   ...SIDS occurs silently, without warning
   A SIDS victim may have as normal, routine signs of death:
   ...A small amount of blood-tinged fluid in his nose and mouth
   ...Bruise-like marks on the body where blood settled after death ("dependent pooling")
   ...Rumpled covers or his head face down in the bed clothes

2. The initial (police officer) response to an apparent SIDS death involves several distinct functions carried out almost simultaneously:

   ...Determine if the infant is alive
      ...If so, initiate resuscitation and proceed to a hospital emergency room
      ...If not, on arrival observe the infant's physical appearance and setting
   ...Deliver the bed clothes with the infant's body to the morgue
   ...Assist the family if possible in other necessary arrangements. i.e. call their doctor or clergyman, release of the body for autopsy, funeral arrangements etc.
   ...Do not allow parents to drive themselves to the hospital. They should ride with friends or relatives.
   ...Parents could ride in the ambulance or in a squad car if not prohibited by regulations
   ...Wait to conduct a ~~criminal~~ investigation until the autopsy has shown a concrete indication of unnatural death ?

3. SIDS parents experience severe psychological reactions to the death of their infants: shock, grief, guilt. They react as individuals, not necessarily as "you would act", a variety of reactions are quite normal:

   ...Parents may be emotionally convinced they "killed their baby". Despite their excessive guilt feelings, however, they can give a consistent story without evasive answers.
   ...or Parents may be glassy-eyed, tearless, dazed. They may appear vague and confused, giving an inconsistant story with evasive answers.
   ...They may be hysterical, incoherent, unable to recall clearly what happened

The Children's Hospital of Philadelphia • [illegible] Center • Philadelphia, Pennsylvania 19104 • (215) [illegible]

[illegible], M.D. Project Director • [illegible], Jr. Program Coordinator • Carolyn [illegible], R.N. Counseling Director • [illegible], R.N. [illegible]

BUT TO REPEAT: Criminal investigation should be instigated only after positive autopsy findings of signs of an unnatural death.

Police officers can help to relieve the immediate anguish of a bereaved family by:

...Explaining briefly the Sudden Infant Death Syndrome, "crib death"
...Assuring the parents that they could not have prevented the death
...Advising the parents of possible guilt reactions of siblings
...Conducting the investigation in a patient, sympathetic manner
...Explaining that the required autopsy can determine that SIDS was the cause of death

4. When interviewing the parents of a probable SIDS victim, the police officer has multiple responsibilities as a professional providing emergency services.

...The officer should tell the parents at the beginning of the interview that SIDS is the apparent cause of death
...The nonaccusatory nature of the questions should be explained to the parents
...Questioning should be conducted as an interview, not as an interrogation
...At the end of the interview, the police officer should make certain that the parents know of the assistance to SIDS families provided by the Delaware Valley SIDS Community Resource Center - GR2-2229)

5. Sample questions for the routine investigation of Infant deaths:

...What happened?
...Who found the baby?
...What did that person do?
...Who last saw the baby alive?
...What time was that?
...Who else was in the house?
...How was the infant that day?
...How would you describe the infant's general health?
...Was there any sign of illness?
...Were any medications given to the baby?
...When did the baby last eat?

6. Other SIDS Facts:

...SIDS rarely occurs after one year of age
...SIDS cannot be predicted or prevented, even by a physician
...SIDS is not the result of suffocation, aspiration, regurgitation, choking, or a milk allergy
...SIDS is not hereditary; there is no greater chance for it to occur in one family than in another
...There appears to be no suffering; death occurs very rapidly, usually during sleep
...SIDS is not contagious
...Many SIDS victims were born prematurely or had low birth weights
...More male babies die of SIDS than female babies, in a ratio of 3:2
...10,000 infants in the U.S. die of SIDS annually, while child abuse deaths total only 600

Chester County Police School (Nov. 3, 1975)

SUDDEN INFANT DEATH SYNDROME EVALUATION

1. Are you able to adequately explain Sudden Infant Death Syndrome?

Yes_____ No_____

2. Do you think that you could tell the difference between traumatic injuries and normal death characteristics in infants?

Yes_____ No_____

3. Please indicate your response to our presentation of the following topics by checking the appropriate column:

Topic	Good	More Emphasis Needed	Less Emphasis Needed
A. Facts about SIDS	_____	_____	_____
B. SIDS vs. Child Abuse	_____	_____	_____
C. Police Role in Crisis	_____	_____	_____
D. Normal Parent Reaction	_____	_____	_____
E. Police Interview	_____	_____	_____
F. Autopsy results	_____	_____	_____

4. Was the movie helpful to you as a police officer?

Yes_____ No_____

5. Do you agree with the police approach to SIDS management outlined to you today?

Yes_____ No_____

Please explain:

6. What other comments can you offer to help improve this program for other police officers?

Special Article

Approaching the Problem of Sudden Infant Death Syndrome

RALPH A. FRANCIOSI, M.D.*

SUDDEN INFANT DEATH Syndrome (SIDS) or crib death is the leading cause of infant death after the first week of life. Any program directed to SIDS should have social and scientific goals. The social goals include identification of SIDS cases, emotional support of the SIDS family, and education about SIDS. The scientific goals are detection of cause(s) and prevention.

Any efforts directed towards SIDS will have far reaching implications regarding infant death. These efforts will stimulate insight into the physiology of infancy and produce an understanding of grief and mourning in families experiencing infant death. In 1975 there were 55,581 deaths in infants less than one year of age. This accounted for 2.8% of the total deaths in the United States. The causes listed were: anoxia, 26%; anomalies, 16%; immaturity, 10%; hyaline membrane disease, 9%; pneumonia, 6%; and accidents, 2%. In the broad category of anoxia cases of SIDS would be classified.

Medical progress is exposing causes of infant death which are not easily understood or treated. Disappearing are deaths due to disease which can be treated by antibiotics or prevented by vaccines. Persisting are problems related to newborns, birth defects and accidents. The leading cause of infant death is SIDS and although the death is related to anoxia, the cause or causes are not well understood.

The epidemiological data available show that 90% of SIDS cases occur before six months of age and 99% below one year of age. Almost every case is associated with a sleep period. Approximately two-thirds of SIDS cases have had some abnormality in the perinatal period, e.g., prematurity. An upper respiratory infection is present in 40-50% of cases.

Theories that are presently tenable implicate hypoxia during sleep as the final pathway in SIDS. It is suggested that this hypoxia may have several causes, one being brain stem lesions and another obstruction of the upper airway. The first implies that lesions can compromise involuntary centers for respiration and cardiovascular control in the brain stem. The latter suggests that in young infants the upper airway is critical to oxygen intake and may be compromised, e.g., viscid secretions.

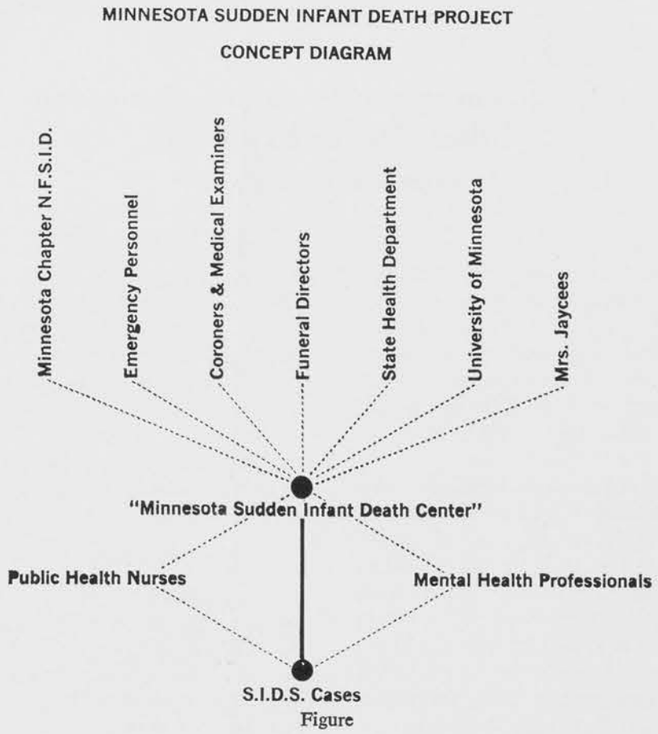
Concept of Minnesota SIDS Program

The approach to SIDS in Minnesota is based upon a cooperative effort of existing resources that relate to SIDS cases (Figure). The coordination of these resources implies, first, an educational effort about SIDS to the various groups and then development of a system based upon a coordination of these resources. The use of consultants will be restricted to areas of education or other areas in which there is a severe deficit of resources.

Role of SIDS Center

The Sudden Infant Death Center has the role of coordinating the Minnesota SIDS Program through a coordinator and a secretary. The Center maintains communication with the various resources listed in the Figure. Following identification of the SIDS case, the case is referred to the Center. After notification the Center informs the appropriate public health nursing agency in the county where the SIDS case occurred. The public health nurses establish contact with the family and hopefully arrange a home visit. The nurse can assess the necessity for further counseling of the parents, siblings or other family members. A request for counseling can be directed to the coordinator at the Center who informs the mental health consultant. The consultant can then speak to the nurse and assess the situation and obtain the appropriate mental health input, preferably

*Project Director of Minnesota Sudden Infant Death Syndrome Program and Director of Laboratories at Children's Health Center, Minneapolis.



Figure

within the community of occurrence.

The Center will work closely with the Maternal and Child Health Section of the State Health Department to educate about SIDS. The initial educational effort would be to public health nursing agencies in Minnesota. The mental health aspects of SIDS will be stressed so that the nurses can utilize this training during their contact with SIDS families. In addition, an educational program will be directed at medical and nonmedical professionals.

Identification of SIDS Case

The responsibility of explaining an unexpected death falls upon coroners and medical examiners as defined by states in their death investigation laws. Since SIDS cases cannot be identified without a complete autopsy, this forms the basis of identification. Following identification, notification of the SIDS Center allows the remainder of the program to operate.

Counseling SIDS Families

The tragedy of SIDS affects both parents and siblings. Parents react with a feeling that error in omission or commission caused death. This feeling is compounded by any contacts after the death which reinforce their guilt. Hopefully, under the SIDS Program educational efforts directed to emergency personnel responding at the scene, e.g., policemen, firemen, paramedics, emergency personnel in hospitals, funeral directors, coroners and medical examiners, would lessen the likelihood that guilt would be compounded. The referral of a family to the SIDS Center by one of the above mentioned groups will allow the intervention of public health nurses and consultants in mental health. The effect of death on siblings is dependent upon their level of maturity. Young children below the age of five years view death as a separation and reversible. Children five to nine years old view death as an event that is not final and under their control. Children above the

SUDDEN INFANT DEATH SYNDROME—FRANCIOSI

age of nine years realize that death is an irreversible phenomenon and that it can happen to them. There is also the realization in adolescents that death is usually associated with severe illness or old age but can occur at all ages. An awareness that Sudden Infant Death Syndrome does affect siblings allows parents to address this problem.

Role of Minnesota Chapter of NFSIDS

The Minnesota Chapter of the National Foundation of Sudden Infant Death Syndrome is one of 43 parent chapters in the United States. These parents, who have experienced Sudden Infant Death Syndrome, are willing to reach out and help others. The chapter maintains a mailing address and phone number which is similar to the Minnesota Sudden Infant Death Center. The chapter, however, is a separate entity and has officers who handle chapter business. In addition, the chapter is responsible for maintaining area contacts in various parts of Minnesota to provide support for new SIDS parents, as well as educating the public about the effect of SIDS upon parents and siblings.

Role of Volunteer Groups

Selection by the Mrs. Jaycees of Minnesota of SIDS as a two-year commitment beginning June 1, 1976, is an example of volunteer input. The Mrs. Jaycees have 215 chapters throughout the state of Minnesota. These chapters are integrated into districts and then into a state organization. Their primary role is involvement in community activities. The Mrs. Jaycees have a state chairwoman, Mrs. Pam Reinert, who is responsible for coordinating the SIDS effort in Minnesota. The initial phase of the project is an educational awareness among chapter members of the social impact of SIDS. The second phase will be an indepth educational effort directed towards various community groups involved in the management of SIDS cases, e.g., police, firemen, nurses, physicians, coroners, medical examiners, funeral directors and clergy.

The Minnesota Association of Funeral Directors is conducting an educational campaign to alert funeral directors to the problem of SIDS. Once this is accomplished, indepth seminars will be held at the School of Mortuary Science, University of Minnesota, to address the role of funeral directors in acute grief counseling. Mr. Phillip Iacavino, the Executive Director of the Minnesota Funeral Directors' Association, and Dr. Robert Slater, the Professor and Chairman of the Department of Mortuary Science at the University of Minnesota, are spearheading this effort.

Summary

The Minnesota Sudden Infant Death Syndrome Program attempts to lessen the social impact of SIDS by focusing on case identification, counseling and education. The program is coordinated at the Sudden Infant Death Center. Through input from various groups involved in Sudden Infant Death Syndrome, e.g., emergency personnel, nurses, physicians, coroners, medical examiners, clergy, funeral directors, and mental health personnel, the coordinator can assist the family during this crisis. The assistance consists of public health nurse visits, counseling by mental health personnel, and alerting community resources, e.g., clergy.

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