The Foundation for the Study of Infant Death's
'Responding when a baby dies' campaign

Sudden unexpected deaths in infancy: A suggested approach for police and coroner's officers

These guidelines are compatible with and compliment the Association of Chief Police Officers (ACPO)' 'Guidelines on investigating infant deaths' published in 2002

Introduction

We hope that this paper may help those who have the very difficult task of responding to sudden unexpected deaths in infancy. The paper is in two parts: the first outlines the background and the main issues involved, the second gives practical suggestions for officers who have to deal with bereaved families. The recommendations draw on the experience of police forces and of bereaved parents from throughout the country, and compliment the ACPO 'Guidelines on investigating infant deaths' published in 2002.

Summary of main points

- Most sudden and unexpected infant deaths result from natural causes.
- The investigation of sudden and unexpected infant deaths should keep a balance between medical and forensic requirements. This is best achieved by a police officer and a paediatrician working in collaboration.
- Police visits to the home should be kept to a minimum, and should be carried out by trained officers in plain clothes.
- Bereaved parents must always be treated with great sensitivity. They should be allowed to express their grief, for example by holding the baby unless there are overtly suspicious circumstances.
- It is important to ensure that bereaved parents have adequate support, both immediate and ongoing.

Part 1 - Background and main issues

Sudden and unexpected deaths in infancy

Over 600 babies die unexpectedly every year in the UK. After post mortem examination arranged by the coroner, a cause is found in about half; those which remain partially or wholly unexplained are called sudden infant deaths syndrome (SIDS), sudden infant death, sudden unexpected death in infancy, unascertained or cot death. Cot death is most common in babies age 8 to 16 weeks; it is rarer in babies less than a month or more than six months old. It can occur at any time of day and in any situation, but is most frequent in the cot at night. Cot death remains the most common kind of death in babies under one year, more common than leukaemia or meningitis.

There has recently been concern that some cases of homicide may have gone unrecognised among the deaths registered as cot death. However the most comprehensive study ever into sudden and unexpected infant deaths in this country, carried out between 1993 and 1996, found that maltreatment or poor care caused or contributed to only a very small proportion of the deaths (ref CESDI SUDI report). Such concerns though have led some pathologists and coroners to give the cause of death as "unascertained". The practice varies among different coroners and use of the term unascertained does not necessarily mean the death is suspicious. The CESDI SUDI study showed that the great majority of unexpected infant deaths arise from natural causes. Thus the vast majority of parents who have had a cot death have suffered one of the most painful tragedies that life has to offer and need our support and sympathy, and it is unnecessary to compound their grief by insensitive investigation or unjust suspicion.

The dilemma

On the other hand it is clearly important to identify those few parents who have been responsible for their baby's death, not only in the interests of justice but also because they may go on to harm a future baby. Unfortunately it is often very difficult to distinguish between natural and unnatural

death in infancy. This presents us with a dilemma: how can we scrutinise all unexpected infant deaths with thoroughness and expertise, but at the same time ensure that the majority of parents who are innocent are treated with appropriate sensitivity and understanding? This dilemma calls for a high degree of skill on the part of all concerned, especially the police.

The social background

Following the recent decline in the number of cot deaths, the majority now occur in the most disadvantaged families (ref CESDI SUDI report). This is also true of many other illnesses and of accidents in childhood. The fact that a death has occurred in a disadvantaged family does not therefore mean that it is more likely to be unnatural. Another effect of the decline in cot deaths is that the proportion of deaths that are unnatural will have increased, though they still remain a small minority.

Police arrangements

Often uniformed police arrive responding to a 999 call. It can be very distressing for parents when a number of uniformed police and marked cars arrive. It is important that the uniformed police are given clear guidelines on what they should do and whom they should contact to follow up the investigations. It is therefore recommended that the task of talking with the parents should be the responsibility of an officer who has had training and experience in dealing with sensitive family issues.

A multi-agency approach

Investigation of unexpected infant death has some features in common with child protection work, and best results are likely to be achieved by co-operation between the relevant agencies. Expertise in the causes of natural death in babies rests mainly with paediatricians and paediatric pathologists; these specialists are also trained in the detection of non-accidental injury and unnatural death in children. It is therefore essential that the police and social services departments should liaise with paediatricians and paediatric pathologists in the investigation of unexpected infant deaths. FSID recommends that in each health Trust or area there should be a designated paediatrician who has responsibility for responding to unexpected infant deaths. This paediatrician is advised to make contact with his opposite number in the police force so that they can agree joint arrangements for the investigation of unexpected infant deaths.

Such arrangements may include:

1. A strategy discussion, soon after the death, between the supervising police officer and the designated paediatrician (and other senior professionals as appropriate) to agree the approach to the investigation and to ensure continuing collaboration.
2. A joint visit to the home, made at an early stage, by the paediatrician and a police officer/ coroner's officer to interview the parents and collect all the relevant information. If separate visits are preferred, then the paediatrician and the police officer should confer soon afterwards to share their findings and discuss their interpretation.
3. Collation of medical records (*e.g.* from maternity, accident and paediatric departments of hospitals, and from the general practitioner and health visitor) and extraction of relevant information. This is best done by the paediatrician in collaboration with the police officer/ coroner's officer.
4. Compilation of a briefing, from the information obtained from the home visit and from the records, to be available for the pathologist before he/she begins the post-mortem examination. This briefing is of great value to the pathologist in identifying the cause of death, but is often inadequate under present arrangements.

Note: these measures would be carried out under the auspices of the coroner.

The post-mortem examination

The pathologist who does the post-mortem examination following an unexpected infant death needs to be trained both in finding the medical cause and in identifying the minority of deaths that are unnatural. Paediatric pathologists are most suited to the former task. However there may be occasions when the coroner wishes to instruct a forensic pathologist, in which case the forensic and a paediatric pathologist should work together.

NB

Please ensure that all parents are given a copy of the DOH's leaflet 'A guide to the post mortem examination procedure involving a baby or child' (reference 29768/A)
and that the content is discussed. Every parent should be given the opportunity to donate tissue for research, education and audit. Please ensure that the consent form for parents 'Post mortem examination on a baby or child ordered by the coroner' (reference 29773) is explained. Don't assume that someone else has already discussed the post mortem and tissue retention with the family. Always check with the parents. The leaflets are available to download from www.dh.gov.uk

Case discussion

Sometimes even the most expert post-mortem examination may not be able to distinguish between a natural and an unnatural death, for example between a genuine cot death and a death caused by smothering. The best evidence may then come <u>not</u> from the post-mortem examination, but from a detailed review of all the antecedents and circumstances of the death. FSID recommends that after any sudden unexpected infant death a case discussion should be held for this purpose between all the professionals who may be able to contribute information. This discussion should take place as soon as the results of post-mortem <u>tests</u> are available. Participants should include the paediatrician, the pathologist, the coroner or coroner's officer, the general practitioner and the health visitor (and the social worker, if one is involved). It may also be appropriate for a police officer to attend.

Preservation of evidence and the needs of parents

There may sometimes be a conflict between the responsibility of police officers to preserve evidence, and the parents' need to grieve the loss of their baby. For example a police officer may sometimes not allow a mother to hold her baby after death, or may feel obliged to take away items such as clothing or toys. Such actions can be very hurtful to bereaved parents. While the need to preserve evidence is recognised, before taking such actions police officers should bear in mind that most unexpected infant deaths arise from natural causes. It is most unlikely that allowing the father or mother to hold the baby would make it harder to identify an unnatural cause of death: in any case it is probable that the parents will have held the baby either not long before the death or after the death before the police arrive.

Part II - Practical details

Visiting the home

- The behaviour of the first professionals to visit can have a lasting effect on the family's later feelings about the death.
- Visits to the home should be kept to a minimum. In most cases parents should not be

subjected to repeated questioning by different people about the same events. It is recommended that a joint visit to the home is made soon after the death by the paediatrician and the police officer.

- Visiting officers, so far as possible, should not be in uniform, should not arrive in marked cars and should silence mobile phones
- If you're the first to arrive the parents may expect you to try and revive the baby, even if it is hopeless. Be prepared to make the attempt. Check that the ambulance has been called. The pathologist will need to be told who has attempted resuscitation.
- If it is necessary to take a witness statement and the parents are taken to the police station it is important to make their surroundings as pleasant as possible.

Talking with parents

- When you arrive say who you are and why you have come, and say how sorry you are about what has happened to the baby.
- The parents will be in the first stages of grief and may react in a variety of ways, such as shock, numbness, anger or hysteria. Allow the parents space and time to hold the baby, to cry, to talk together and to comfort any other children. These early moments of grieving are very important.
- In talking about the baby preferably use the first name, or, if you don't yet know the name, say "your baby," or "he" or "she." Don't refer to the baby as "it."
- Have respect for the family's religious beliefs and culture. If they don't speak English well, arrange for an interpreter.
- Take things slowly, allowing the parents to gather their thoughts and tell the story in their own way.
- Be prepared to answer practical questions, for example about where the baby will be taken and when they can next see the baby.
- Most parents feel guilty when their baby has died. When talking to them try to ask questions in a neutral way, for example "Would you like to tell me what happened?" Avoid questions that could sound critical, such as "Why didn't you….?"
- Don't use such phrases as "suspicious death" or "scene of crime," and try to avoid comments that might be misunderstood or distressing to the parents.

Collecting evidence

- If it is necessary to handle the baby, this should be done with great care, as if he/she were still alive. For example wrap the baby in a shawl if he/she has to be taken anywhere.
- Although it is unlikely the removal of items will have serve any purpose, if you feel that it is necessary to remove any items, ask the parents' permission, explaining that the purpose is to help the pathologist. There is no need for further explanation.
- The hypothesis that the cot mattress may give off toxic gases has never been substantiated and is not a reason to remove the mattress.
- If it is thought necessary to take photographs of where the baby died, explain that this is routine and doesn't mean you think the circumstances are suspicious. Avoid the term 'death scene'.
- Explain that all unexpected deaths have to be reported to the coroner, who will routinely require a post-mortem examination. Give the parents a copy of the Department of Health's leaflet *"Guide to the post-mortem examination."*

Appearance of the dead baby

The following features may commonly be found in a baby who has died suddenly from natural causes:

- Small quantities of gastric contents around the mouth. This does not mean that death was caused by inhalation of vomit. Often there is slight regurgitation immediately after death.
- Froth emerging from the mouth and nose. This froth results from the expulsion of air and mucus from the lungs after death. Sometimes the froth may be blood-stained - this does not mean that the death was unnatural.
- Purple discoloration of the parts of the face and body that were lying downwards. This is not bruising, but is caused by the draining of blood in the skin after death. For the same reason the parts that were lying upwards may be very pale.
- Covering of the baby's head by the bedclothes. This has often been a feature of cot death in the past, and probably contributes to death through accidental asphyxia or overheating. Parents are now advised to arrange the bedclothes so that this cannot happen.
- Wet clothing or bedding. This is usually caused by excessive sweating before death.
- If the baby looks as though he/she has been roughly handled, remember that this may be the result of attempts at resuscitation.

Support for parents

- Offer to telephone relatives or friends who might support the parents, and to telephone employers to explain that they'll be absent.
- FSID operates a Helpline (**0870 787 0554**), personally answered, that provides information and support both for parents and for professionals. Parents are offered a phone card to enable them to use the Helpline free of charge.
- Parents should also be given a copy of FSID's leaflet *"When a baby dies suddenly and unexpectedly."* Explain briefly that the information will help them with decisions they have to make.
- Families often very much want to keep a memento of their baby, for example a photograph, a lock of hair or a handprint. Such a request should be respected whenever possible.

Continuing Support

- Parents need to be kept informed of where the baby has been taken and what is happening.
- It is important that parents should be kept informed during any wait for the funeral or for an inquest.
- If belongings have been taken away offer to return them to the family. Be sensitive about how the articles are labelled and prepared. For example, clothing should not be washed without asking the parents and a dirty nappy should not be returned.

References

- CESDI SUDI Studies, Sudden unexpected deaths in infancy. Editors, Peter Fleming, Pete Blair, Chris Bacon and Jem Berry. The Stationery Office, 2000. ISBN 0-11-322299-8
- FSID Fact File 1

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