

The "CPOD" and SUIDI: Tools for 1st Responders to Child Fatalities

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Dover, Delaware

Patti Toth, J.D.

WA State Criminal Justice Training Commission

ptoth@cjtc.state.wa.us

Realize that defense attorneys are much better at defending these cases now than they used to be

- *Child Abuse Law News* - www.childabuselaw.info
- *Nat'l Child Abuse Defense & Resource Center* - www.falseallegation.org

It is often not immediately obvious whether a child's serious injury or sudden unexpected death is the result of disease, accident, neglect or inflicted injury. Accurate identification of inflicted versus accidental injuries or natural deaths is necessary to protect surviving children, to learn how to prevent future avoidable injuries and deaths, and, when appropriate, to hold culpable offenders accountable. Child death review is an important component in this effort, but must be informed by complete and reliable information. First responders to sudden unexplained child deaths or near-deaths often hold the key to understanding what happened. What they do, or don't do, in the critical first few hours frequently determines whether child abuse and neglect is recognized or not.

- **Are child deaths different?**
- **Are child deaths more challenging?**
- **What are the most common mistakes in these investigations?**

Sudden Unexpected Infant Death

The sudden and unexpected death of an infant due to a variety of natural or unnatural causes

Examples:

- SIDS
- Natural diseases
- Unsafe sleeping environments
- Trauma
- Poisons and other toxins
- Homicide
- Unknown causes

Sudden Infant Death Syndrome (SIDS)

The sudden death of an infant under one year of age *which remains unexplained*
AFTER:

- Thorough case investigation
- *Complete autopsy*
- Examination of the death scene
- *Review of the clinical history*

SIDS is the 3rd leading cause of infant mortality

“Abusive Head Trauma” (AKA “Shaken Baby Syndrome”)

- Collection of injuries, usually includes:
 - *Brain swelling from direct brain damage*
 - Retinal hemorrhages or other eye damage
 - *Bleeding under membrane that covers & protects the brain*
- Often little or no outward signs of injury
- Caused by violent shaking; may or may not also include some kind of throwing or impact
- *Often triggered by incessant crying*
- Annual incidence in US = over 1500

- Results of AHT/SBS: death or permanent brain damage in majority of cases
- Inflicted head trauma is # 1 traumatic cause of death in children under age 2
- Head injury is # 1 cause of traumatic death in children under age 5 in US
- Majority of Vs are under 1 year of age
- Common stories from caretakers:
 - Fall, from a bed, down stairs, from a couch/chair
 - Caretaker just “found” the child not breathing and shook baby in effort to revive

Where are we today?

- 4600 sudden unexpected infant deaths per year
- *SIDS accounts for about ½ of these*
- No national standards regarding infant death investigations

SIDS is the only cause of infant mortality that has seen a significant decrease over the last decade across the U.S. This reduction in infant mortality is credited, in part, to the Back-to-Sleep campaign and an increased recognition of unsafe sleep conditions.

The decrease in SIDS deaths may be explained by an increase in other death causes and a shift in diagnostic coding (i.e., asphyxia/suffocation, undetermined). This thought is in keeping with the American Academy of Pediatrics (AAP) 2005 policy statement, “The Changing Concept of Sudden Infant Death Syndrome:

Diagnostic Coding Shifts, Controversies Regarding the Sleeping Environment, and New Variables to Consider in Reducing Risk.”

- Many infant deaths that would have been called SIDS a decade ago are now labeled unsafe sleeping conditions.

Is it SIDS, suffocation, or SUID?

There is ongoing debate regarding the diagnoses of these types of deaths: under what circumstances should they be called SIDS, suffocations, or undetermined?

National research suggests that the decrease in SIDS, especially since '99, can be explained by an increase in other causes of death. The term SUID is being used with more frequency & professionals are asking “Should we say SIDS or SUID?”

The CDC includes causes of deaths attributed to SIDS, suffocation, wedging, & overlay in the SUID classification. Regardless of the terminology, the longstanding challenge has been inaccurate reporting. Many infant death cases are not investigated, & when they are, cause-of-death data are not collected & reported consistently.

Some causes of suffocation:

- Accidental suffocation and strangulation in bed
- Other accidental hanging and strangulation
- Inhalation and ingestion of food causing obstruction of respiratory tract
- Confined to or trapped in a low oxygen environment
- Other specified threats to breathing
- Unspecified threat to breathing
- Assault by hanging, strangulation and suffocation
- Hanging, strangulation and suffocation, undetermined intent

US Child Abuse Statistics from the CDC:

- Deaths due to CAN in 2006 = 1520
- Annual costs of CAN – \$24 billion (legal & healthcare)
- Over 3,800 infants less than one week of age were documented victims of physical abuse

Age: According to the US Department of Health and Human Services (DHHS), *Child Maltreatment 2006*, more than three-quarters (78%) who died as result of CAN in the US were younger than 4 years of age; 11.9% were 4-7 years of age.

Race: According to the US Department of Health and Human Services (DHHS), *Child Maltreatment 2006*, nearly one-half (43%) of all fatalities nationally were white children. More than one-quarter were African-American and nearly one-fifth (17%) were Hispanic children. Children of other race categories collectively accounted for 10.7%.

Child Deaths due to Neglect

- Physical abuse is most visible form of abuse
- Easier to recognize and report
- Neglect covers a broad spectrum and may have no outward signs, so is often missed
- Some examples of neglect deaths:
 - Unsafe sleeping environment
 - Children left in cars
 - Drowning
 - Medical neglect
 - Abandoned babies
- National data confirms there are more child neglect than physical abuse fatalities
- Child neglect deaths may be overlooked and closed as accidental by law enforcement and CPS. Emotions could cloud judgment and ability to recognize neglect.

Abuse & Neglect Deaths are Under-Reported

Research indicates that child fatalities are under-reported. Studies in Colorado and North Carolina have estimated that as many as 50 to 60 percent of child deaths resulting from abuse or neglect are not recorded as such.

Some of the deaths labeled as accidents, child homicides, and/or Sudden Infant Death Syndrome (SIDS) might be attributed to child abuse or neglect if:

- More comprehensive investigations conducted
- More consensus in the coding of abuse on death certificates

Physical Abuse - Crying, toilet training and feeding are the most common triggers of physical abuse.

Common factors noted in the deaths of children in numerous physical abuse cases:

- Young males between the ages of 18-30 who are unemployed and often providing primary childcare
- Many of these males are unattached nonbiological fathers with an inability to cope and lack of parenting skills
- Often histories of substance abuse, domestic violence, animal abuse or criminal history of aggressive or violent behavior

Substance Abuse - Substance abuse is one of the most common risk factors present in the death of a child from abuse or neglect

- Often overlooked and not given appropriate consideration
- Approximately 50% to 80% of all child abuse and neglect cases substantiated by CPS involve some degree of substance abuse by the child's parents
- At least two-thirds of patients in drug abuse treatment centers say they were physically or sexually abused as children

Special SIDS Training Req'd

At least **eleven states** require special training about SIDS for child care personnel, firefighters, emergency medical technicians or law enforcement officials: Arizona, California, Florida, Indiana, Minnesota, Nebraska, Tennessee, Texas, Washington, West Virginia and Wisconsin

Impetus for WA State's First Responder Project

- Children's Justice Task Force
- RCW 43.103.100 (4): *counties req'd to use a protocol endorsed by the Washington state forensic investigations council for scene investigations of the SUID*
- **WA State Ombudsman's 2005 Annual Report**
 - Reviewed 2004 child deaths (*w/DSHS involvement*)
 - *< 1 year: 53% < 2 years old: 61%*
 - ME or coroner designations:
 - *Accidental or natural/medical: 53%*
 - Homicide: 12.5%
 - *Suicide: 11.5%*
 - Undetermined: 23%
 - Abuse or neglect involved in over 2/3
 - <http://www.governor.wa.gov/ofco/05rpt/index.htm>

("Undetermined" is assigned as the manner of death when the medical examiner believes that there is insufficient evidence or information, especially about intent, to assign the manner of death as Natural, Accident, Homicide or Suicide)

WA State First Responder "CPOD" Guidelines

Developing Statewide Guidelines

- No mandate to utilize the protocol developed
- *Challenge:* how to make these guidelines relevant and responsive to needs of various professionals throughout the state
- *Solution:* 12 *open-to-anyone* "brainstorming" meetings throughout the state

One-Day Training Curriculum

- Multidisciplinary audience
- Wide range: experience and responsibility
- Multidisciplinary training team and presentations
- Introduction to CPOD Guidelines
- Introduction to SUIDI Evidence Collection Form

SHB 1333: RCW 26.44.185 (1) (2007)

Revised county child abuse investigation protocols must:

"...incorporate the statewide guidelines for first responders to child fatalities developed by the criminal justice training commission."

The “C-POD” Collaboration Preservation Observation Documentation

- **Collaboration:** *Ensure an **immediate, coordinated** investigation of **all** unexpected child deaths & serious injury*
- **Preservation:** *Maintain scene as it was when child (or injury) was discovered until evidence is seized, is documented, and/or circumstances are demonstrated or reconstructed*
- **Observation:** *Be aware and conscience of everything with the environment - suspend assumptions*
- **Documentation:** *Immediately record everything about the scene, the child, and witnesses*

User-friendly Format

- Portable
- Customize-able
- Plastic sleeves
- 3 x 5 cards
- Locality-specific cards can be created & inserted

COLLABORATION:

Immediate, Coordinated Investigative Response

- *Immediate LE & CPS coordination & information exchange*
- Utilize free medical consultation resource (**WA state**)
- *Agree who takes lead at scene*
- Decisions re: protective custody
- *Best practice = report to both CPS and LE*
- **Coordination between Law Enforcement & CPS**
 - CPS – call local LE agency w/ jurisdiction
 - LE – call local CPS office

PRESERVATION:

Scene Integrity; Evidence Preservation

- Discuss w/EMS: minimize disruption of scene as much as possible
- *Clear understanding about who is in charge of managing scene*
- Scene: tough to enlarge, can always be reduced
- *Things **not** to do*

Securing the Scene

- One of the most difficult tasks - how do you secure the scene if you don't know whether a crime has been committed?

- Minimize access to scene by nonessential personnel, bystanders & arriving family members
- Minimize disruption of the scene by persons already present
- **Avoid using yellow “crime scene” tape**
- Use natural barriers, neutral tape, scene log
- If you have to leave, make sure that other back up has arrived

OBSERVATION:

Be Alert & Perceptive

- Don't let biases interfere
- *Pay attention to everyone and everything*
- Other children?
- *Anything that seems out-of-place*

DOCUMENTATION:

Insure All Key Information Is Captured Effectively

- Photos, videos
- Statements from all 1st responders
- Timeline
- All pertinent witnesses
- Reconstructing child's position – “placer” and “finder”
- Using dolls

Dolls (Infant-size) for Demonstrations and Reconstructions

- Placer & finder photos are critical
- Video of the suspect demonstrating what happened is extremely valuable
- **National Center on Shaken Baby Syndrome:** www.dontshake.com
Life-like dolls: \$35 each
- Featureless SUIDI Investigation dolls
Little Angels – <http://suididolls.com/>
Orders: suididolls@gmail.com: \$38 + S/H

Toddler Size Dolls

- Excellent for both toddler death and serious injury/near-death cases
- Check on E-Bay – “Craft Dolls”
 - **“35” Time Out Pouting Corner Doll Ready to Stuff & Dress”**
- Stuff it yourself - \$6.99
- Comes in both white & brown fabric
- Can dress it (keeps it cleaner) and use 16 oz. fishing weights in socks, hat, etc. to customize weight, depression patterns

HOW

Identify Individuals at the Scene

- Identify everyone present and why they are there
- All persons already present
- Those who arrive during the investigation
- All who had contact with the child during the past 24-72 hours

Determine who is necessary to the investigation

Ask non-essential persons to leave after obtaining contact info

People to keep at the scene:

- Had contact w/child within the past 24 hours
- Placed child to sleep
- Who found the infant
- Who last saw the child alive
- Mother and father or other primary caregivers

Reassure Necessary Individuals

- Keep them informed of your actions and plans
- Ensure them their participation is important
- Provide them with a comfortable place to wait
- Obtain complete contact information

Control the Environment

- Intense emotional and physical grief
- Children, esp. infants, are not expected to die
- Great sense of disbelief
- Oftentimes many are in shock
- The sight of a dead child's body is traumatic
- You too will probably experience extreme emotions

Steps to Establish Control

- Designate an incident commander
- Identify potential problems
- Establish rapport
- Evaluate the potential for a productive interview
- Make sure you can make later contact

Potential Problems

- Wide range of emotions and behaviors
- Conflict with family if resuscitation is discontinued and when infant is removed
- Influx of bystanders and family
- Child/infant will be moved more than once and scene distorted
- Disorganization among responders: EMS, police and medical investigators
- Scene may be left unsecured

Establish Rapport

- Maintain a supportive, professional attitude
- Tell the family or others that you are
- working with them
- Address persons with respect
- Use the term “we”, instead of “I” or “me”
- Sit or stand with them
- Maintain lines of communication
- Be honest
- Don’t be afraid to ask the difficult questions
- Avoid stating that you *understand* how they feel
- Ask what they need and want and paraphrase back
- Ask them to identify any resources they need to help them
- Provide opportunities for families and others to ask questions
- Do not be judgmental in your questions or interactions
- Refer to those at the scene, and the child, by their names
- Avoid euphemisms in describing the child’s status (e.g., “passed away,” “gone,” etc.)
- Do not use the term SIDS or suggest SIDS as a possible cause of death
- Explain to the parents/caregivers that there will be an investigation
- Do not be overly silent, as this may imply guilt to the parents
- Do not rush through your investigation or rush the family

Confronting Resistance

- Best way to = expect it
- Don’t be drawn into it

Empathize

- Acknowledge the behavior
- Do not make assumptions
- Do not personalize their behavior
- Do not make value judgments
- Acknowledge the child’s death directly
- Keep your emotions neutral

Reassure

- Calmly yet firmly explain all procedures
- Explain resuscitation process, transport decisions, and further actions to be taken by hospital personnel or medical examiner
- Tell the family that responders are doing everything they can
- Allow parents/caregivers time to see and hold child
- Wrap child in a blanket and not a death sheet

Removal of the Deceased Child from Caregivers

Within the context of jurisdictional protocols:

- Allow the family to have as much time as they need with their child
- Allow parents/caregivers to give you objects to take with the child
- Arrange transport for the family
- Allow religious or cultural practices that the family wants
- Allow the family the opportunity to create memories

Observe and respond to escalating violence

- Separate the agitated individual from others, using as little force as necessary
- Utilize good listening skills, maintain a calm demeanor, use eye contact and listen intently
- Don't isolate the person behind closed doors
- Avoid touching the person
- Acknowledge their emotions as directly related to the death of the child
- Try to engage cooperation
- Avoid displaying any weapons or open show of force, unless necessary
- If necessary take the person by force according to your agency's protocols

Take Care of Yourselves

- Critical incident stress de-briefing

HOW: Actions versus Attitudes

Treat the scene like a crime scene, but don't treat the caretakers like criminals.

Every child, every time.

Create Partnerships with EMS

EMS as Part of the MDT

Making LE report

- Should not assume hospital or someone else is making a report
- Multiple layers of reports are not a problem
- Doesn't have to be "proof positive", common sense approach

Scene Observation

- What was noticed when EMS first arrived?
- Has the scene changed between EMS arrival and the arrival of law enforcement?

Statements of Caregivers

- Caregiver's statements at scene v. 911 call
- Evolution of story
- Are caregiver's statements consistent from beginning to all professionals?

EMS Roles

1. Insure safety & provide any medical aid needed to save or assist the child
2. If child is pronounced dead, do not move the body
3. Make sure Law Enforcement has been notified
4. Document all adults and children present
5. Document all statements and demeanor of speakers
6. Document all your observations of the environment ASAP
7. Child's developmental level: consider & record relevant observations
8. Be alert to possible signs of abuse & neglect
9. Use free medical consultation resource
10. Notify CPS to report any suspicion of abuse or neglect of **any child** present at the scene
11. Participate in local multidisciplinary team (MDT) meetings to review child abuse cases

Concerns Raised:

- Are EMS & paramedics mandated reporters?
 - What does your state law say?
- EMS should not be investigators – their role is solely medical
 - Patient becomes surviving family when a child has died
 - Info relevant to the investigation will also assist the pathologist doing the autopsy
- Is HIPAA a bar to reporting and sharing info?

Sharing Information and Confidentiality Concerns

HIPAA = *Health Insurance Portability and Accountability Act*

HIPAA Exceptions: Law Enforcement Access

- As permitted by judicial official: court order, warrant, subpoena, summons
- Administrative subpoena, IF:
 - Info relevant & material to a legitimate investigation
 - Specific request limited in scope to meet intended purpose
 - Non-identifying information could not substitute for info sought
- Restricted access for purpose of identifying or locating suspects
- If an individual has died as result of suspected criminal activity
- Crime on premises
- Averting a serious threat to health or safety
- Jails, prisons, law enforcement custody
- Reporting crimes in emergencies (NOT abuse, neglect or DV which are covered in a special exception)
- Info re: suspected crime victims, with consent
- Info re: suspected crime victims, without consent if an emergency or victim is incapacitated, IF:
 - Necessary to determine if crime committed and won't be used against victim

- LE activity depends on disclosure & would be materially affected by waiting for consent
- Disclosure is in the best interest of victim (per judgment of health care provider)

HIPAA Exceptions for Law Enforcement and Social Service Agencies' Access

- When required by law: mandatory reporting laws
- Victims of abuse, neglect or DV, **if** one of the following exists:
 - ***Disclosure required by law***,
 - Victim consents, OR
 - Disclosure is authorized by law and either:
 - **Is necessary to prevent serious harm, or**
 - Will not be used against the victim and
 - Immediate action is needed (can't wait for consent)
- When disclosure has taken place under 'victims of abuse, neglect or DV' exception, health care provider must promptly inform the victim, unless:
 - Informing the victim or victim's representative would place victim at risk of serious harm, OR
 - The victim's representative is the person responsible for the abuse, neglect or DV

SUIDI (Sudden Unexplained Infant Death Investigation) Forms

CDC's Sudden, Unexplained Infant Death Initiative

- <http://www.cdc.gov/SIDS/SUID.htm>
- SUIDI form: <http://www.cdc.gov/SIDS/PDF/SUIDIforms.pdf>
- Curriculum Guide & training materials:
<http://www.cdc.gov/sids/TrainingMaterial.htm>
- Resources from national training academies:
<http://suidi.orainc.com/resources.php>

SUIDI Goals

- Standardize & improve data collection at child death scenes
- Promote consistent classification of cause of death
- Improve national reporting of SUID on death certificates
- Improve collaboration of law enforcement, OCS, PCP, ME office
- Use collected data to prevent future deaths

“SUIDI Top 25”

- Information considered vital by the forensic pathologist (pre-autopsy)
- Reflects structure of SUIDI reporting form & standardizes crucial national SUIDI data
 1. Case information
 2. Asphyxia.
 3. Sharing sleep surfaces.
 4. Change in sleep conditions.
 5. Hyperthermia/hypothermia.
 6. Environmental hazards (carbon monoxide, chemicals, etc.).
 7. Unsafe sleeping condition.
 8. Diet.
 9. Recent hospitalizations.
 10. Previous medical diagnosis.
 11. History of acute life-threatening events.
 12. History of medical care without diagnosis.
 13. Recent fall or other injury.
 14. History of religious, cultural, or ethnic remedies.
 15. Cause of death due to natural causes other than SIDS.
 16. Prior sibling deaths.
 17. Previous encounters with police or social service agencies.
 18. Request for tissue or organ donation.
 19. Objection to autopsy.
 20. Pre-terminal resuscitative treatment.
 21. Death due to trauma (injury), poisoning, or intoxication.
 22. Suspicious circumstances.
 23. Other alerts for pathologist’s attention.
 24. Description of circumstances (what happened?).
 25. Pathologist Information (name/agency/phone).

“SUIDI Top 25” Categories

- **Case Information**: case #, names, addresses, etc.
- **Sleeping Environment**: factors related to sleeping conditions
- **Infant History**: things you find out specifically about the infant
- **Family Information**: things you should find out about (or from) the family
- **Exam**: things related to medical treatment or medical diagnosis/analysis
- **Investigator Insights**: things lead investigator should do or provide to ME

Sleeping Environment

- Asphyxia
- Sharing of the sleep surface
- Change in sleep condition
- Hypothermia or hyperthermia
- Environmental hazards
- Unsafe sleep conditions

Safe Sleep Interventions

Strategies recommended by Amer. Academy of Pediatrics (AAP):

1. Baby sleeps by self in a crib, portable crib or bassinet
2. Always placed on his or her back to sleep
3. Sleep area free of soft items - blankets, comforters, stuffed animals, etc.
4. Face is kept uncovered during sleep for easy breathing
5. Smoke-free environment
6. Not dressed too warmly to prevent overheating
7. Firm mattress with a tightly fitted sheet

Infant History

- Diet
- Recent hospitalization
- Previous medical diagnosis
- History of acute life-threatening events (ALTEs)
- History of medical care without diagnosis
- Recent falls or other injuries
- History of religious, cultural, or other remedies
- Cause of death due to natural causes other than SIDS

Traditional Healing Practices: *Coining & Cupping*

Mongolian Spots can look like bruises, but are actually just birth marks and are common, especially in children of color

Family Information

- Prior sibling deaths
- Previous encounters with police or social service agencies
- Requests for tissue or organ donation
- Objection to autopsy

Exam

- Preterminal resuscitative treatment
- Death due to trauma, poisoning, or intoxication

[Note 2008 FL CADR report recommendation: *Law enforcement agencies & DCF should perform field drug testing of caregivers, when indicated, as part of their protocols for the investigation of unexpected deaths of infants & children.*]

Investigator Insights

- Description of circumstances
- Suspicious circumstances
- Other alerts for pathologist's attention
- *Does the story match what you see?*

SUIDI Additional Investigative Forms

(can be downloaded from: <http://suidi.orainc.com/resources.php>)

- Additional investigative forms that can be used to collect info about the circumstances and to document personal contacts and collection of evidence
- Can be used in addition to the SUIDI Reporting Form, but this information is not thought to be essential prior to autopsy
- Designed as a questionnaire
- Each of these forms can be used alone if desired

A. Body Diagram:

This diagram is a larger version of the diagram included in the SUIDI Reporting Form. It can be used in place of the smaller version. The diagram can be used to note bruises, discoloration and other observations such as the following:

- Discoloration around face, nose, or mouth
- Secretions (drainage or discharge from anywhere on the body)
- Skin discoloration (livor mortis)
- Pressure mark areas (pale areas, blanching)
- Rash or petechiae (small, red blood spots on skin, on membranes, or in eyes)
- Marks on body (scratches or bruises).
- Location of medical devices (e.g., breathing tube, gastrostomy feeding tube)
- Body temperature

B. EMS Interview

The investigator uses this form to gather information from emergency medical service (EMS) personnel who responded to the scene. It can be used to augment the EMS run sheet if the sheet is not available.

C. Hospital interview

The investigator uses this form to gather information from the hospital emergency department personnel who treated the infant. This form can be used to augment the hospital records. The form can be used to interview hospital personnel if the medical records are not available.

D. Immunization Record

The investigator uses this form to document all immunizations the infant received since birth. The investigator can get this information from the parent or caregiver's immunization records or from medical records at the infant's clinic. To date, there is no evidence supporting an association between immunizations and SIDS.

E. Infant Exposure History

The investigator uses this form to identify all persons who were in contact with the infant in the 24 hours before the infant's death. This form may be used to document day care contacts or people attending large family or community gatherings.

F. Informant Contact

The investigator uses this form to track contact information for each person interviewed.

G. Law Enforcement Interview

The investigator uses this form to gather information from law enforcement personnel who responded to the scene. This information can be collected from interviews with law enforcement personnel and by reviewing law enforcement reports.

H. Materials Collection Log

The investigator uses this form to keep a detailed, descriptive list of all items recovered from the incident or death scene.

I. Nonprofessional Responder

The investigator uses this form to gather information from the first nonprofessional (e.g., caregiver, neighbor) who responded to the infant at the scene.

J. Parental Information

The investigator uses this form to gather contact information about the infant's mother, father and/or other primary caregivers.

K. Primary Residence Investigation

The investigator uses this form to describe the infant's primary residence if the incident or death did NOT occur at the primary residence.

L. Scene Diagram

The investigator uses this form to diagram multiple scenes or when a larger diagram is needed to document the scene. This form is used to document the immediate area surrounding the infant when the infant was discovered dead, unresponsive, or in distress. The investigator uses the form to record observations, such as the following—

- North direction.
- Windows and doors.
- Wall lengths and ceiling height.
- Location of furniture, including infant's bed or sleep surface.
- Location of infant's body when found.
- Position of other people or animals found near the infant.
- Location of heating and cooling devices and other objects in room.

Improving the Response to Child Fatalities

- Multidisciplinary team approach, w/expanded participation (EMS, 911 dispatchers, etc.)
- Consistent use of CDC's SUIDI forms
- Participation in (expanded) child death review (CDR)
- ID'ing & including serious injury cases in protocols and review processes
- Pay attention to emotional aspects and impact on investigators
- Improved LE/CPS coordination
- Immediate scene investigations for **all** sudden unexpected child deaths
- Better **documentation** of the scene and of statements
 - Photos & videos
 - Use **dolls** to reconstruct, and to demonstrate
- More autopsies
 - Not at funeral homes
 - By forensic pathologists

National Resources

- National Center on Child Fatality Review: <http://www.ican-ncfr.org/>
- National MCH Center for Child Death Review: <http://www.childdeathreview.org/>
- National Center on Shaken Baby Syndrome: www.dontshake.com
- OJJDP/ FVTC National Child Abuse Investigation trainings:
www.fvtc.edu/childprotecttraining

PLEASE, don't ask me if I'm over it yet.

I'll never be over it.

PLEASE, don't tell me she's in a better place.

She isn't here with me.

PLEASE, don't say at least she isn't suffering.

I haven't come to terms with why she had to suffer at all.

PLEASE, don't tell me you know how I feel,

Unless you have lost a child.

PLEASE, don't ask me if I feel better.

Bereavement isn't a condition that clears up.

PLEASE, don't tell me at least you had her for so many years.

What year would you choose for your child to die?

PLEASE, don't tell me God never gives us more than we can bear.

PLEASE, just say you are sorry.

PLEASE, just say you remember my child, if you do.

PLEASE, just let me talk about my child.

PLEASE, mention my child's name.

PLEASE, just let me cry.