Child Abuse

Pocket Atlas Series

Volume Five

Child Fatality and Neglect

STM **Learning**, Inc.

Leading Publisher of Scientific, Technical, and Medical Educational Resources

Saint Louis

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Our Mission

To become the world leader in publishing and information services on child abuse, maltreatment, diseases, and domestic violence. We seek to heighten awareness of these issues and provide relevant information to professionals and consumers.

A portion of our profits is contributed to nonprofit organizations dedicated to the prevention of child abuse and the care of victims of abuse and other children and family charities.

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Preface

While people have always wondered how children die, it is only in the last 40 years that interdisciplinary teams have been created formally to understand deaths and to consider methods of prevention. Previous efforts to address individual causes of child death now are being supplemented by a more systematic approach.

In 1994, I was the guest editor of a special issue of the American Professional Society on the Abuse of Children's newsletter, the *Advisor*. It was titled "Special Issues on Child Fatalities" and had contributions from multiple authors, some of whom are included in this book. In 1995, the US Advisory Board on Child Abuse and Neglect issued an important work titled *A Nation's Shame: Fatal Child Abuse and Neglect in the United States*. Although focusing only on child abuse deaths, its incisive findings and recommendations for child death review are (sadly) just as relevant years later.

In creating this book, certain goals were paramount: determine a comprehensive outline of the fields and issues involved in child deaths and death review, consider more strongly all causes of death beyond what some teams have as their focus, assemble top authors in their respective fields, and include an international perspective. The photographic chapters in this book depict many of the possible manners of death in children and allow interdisciplinary team members who may have limited experience with actual deaths and autopsies to better understand the findings in such cases. With a wide range of detail about child fatalities, this reference will help these dedicated professionals to better understand and prevent the deaths of children.

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Chapter 1

The Child Death Specialist

Kathleen Diebold, MA

In 1991, Missouri initiated a comprehensive child fatality review program designed to establish more accurate determinations of child deaths and to develop a database providing ongoing surveillance of all childhood fatalities. The program has evolved and adapted to meet new challenges throughout the years; however, the objectives have remained the same: to identify potentially fatal risks to infants and children and to respond with multilevel prevention strategies.[1] Missouri's child fatality review program has been used as a model by other states.

Missouri legislation requires that every county in Missouri establish a multidisciplinary panel to examine the deaths of all children younger than 18 years.[2] Every infant aged 1 week to 1 year who dies in a sudden, unexplained manner must have an autopsy.[1] As a result of this initiative, the need for a child death specialist arose. The complexity of infant death scene investigations, coupled with the rapidly growing knowledge base needed to adequately understand child deaths, created the need for child death specialists in smaller medical examiner jurisdictions that can only employ part-time death investigators who are extensively trained in all areas of child deaths. Larger medical examiner offices employ full-time investigators who have the opportunity to accrue the necessary experience required to become skilled in all areas of child death investigations.

Without an extensive circumstantial *and* scene investigation in addition to an autopsy, a meaningful cause and manner of death may be impossible to determine. Experts who specialize in infant death investigations (ie, child death specialists) can assimilate the rapidly increasing amount of information in this area as well as conduct complex death scene investigations, which are necessary to adequately understand infant deaths.

Conducting an Infant Death Scene Investigation

When conducting an investigation, the child death specialist should neither automatically assume nor overlook the possibility of criminality or negligence. Investigators should assume an empathetic, nonconfrontational approach, which is both appropriate and effective.

In addition to interviewing witnesses, child death specialists may work in tandem with prosecutors, emergency medical services (EMS) personnel, juvenile officers, medical examiners/coroners, law enforcement officers, public health providers and/or physicians, and department of family services workers when investigating a case. Often, EMS personnel, law enforcement officers, fire department officials, and the medical examiner investigator work together to process the scene and determine what happened when the child died. By contacting the family's pediatrician, the investigator can ascertain whether the pediatrician had any red flags with regard to the child's care, welfare, or family dynamics and can obtain a better understanding of the child's overall health as well as any medical issues or complications. The child's entire medical record and birth chart should be obtained from the pediatrician and birth hospital. The pediatrician can also provide information about whether the child has ever been seen at local hospitals after birth. A call to the department of family services hotline can provide information regarding prior reports on the family, siblings, or other individuals living in the residence.

Investigating and Re-Creating an Infant Death Scene: Unsafe Sleep

When an infant dies suddenly and unexpectedly during sleep, a thorough understanding of the death scene is necessary to accurately determine the cause and manner of death. The re-creation of the infant death scene is a critical element in determining both the cause and manner of death. The diagnosis of sudden infant death syndrome (SIDS) should not be automatically assumed. Many people do not realize the hazards of unsafe sleeping and may not realize a pillow could suffocate an infant. They may not be capable of accurately describing the scene verbally; therefore, the re-creation of the death scene provides the investigator a visual representation of the infant's sleep position. Child death specialists do not need to perform scene re-creations of sleeping positions of toddlers or older children because they are developmentally capable of righting themselves if they accidentally roll over.

There are potentially 2 individuals who have firsthand knowledge of the sleep positions: the individual who placed the infant down to sleep (the "placer") and the individual who found the infant unresponsive (the "finder"). Both positions, which could be the same if the infant did not move after being placed down to sleep, are of interest and need to be documented with photographs.

The re-creation is a highly emotional task and is performed after all interviews are completed. The re-creation starts with the child death specialist explaining to the parents or caregivers why it is necessary and the importance of using the doll as an investigative tool to document the exact sleep environment. The child death specialist demonstrates the articulation of the doll's arms, legs, and head. The doll is handed to the placer who is asked to demonstrate the exact position of the infant when placed down to sleep. The placer is asked to verify and recreate the sleeping environment using any pillows, blankets, toys, or other materials that were used and to demonstrate if the infant was cosleeping or bed sharing with another individual. This position is then photographed. The finder is asked to perform the same task, demonstrating the infant's environment when found. The re-creation serves as the "picture" of the infant death scene, much like a photograph of an adult death scene.

Prior to leaving the scene, the child death specialist should debrief family members and provide them with the office policy and a timeline for release of reports, a contact name and telephone number for them to call if they have further questions, and information on SIDS resources.

The following are important tips to remember:

— A death scene investigation is always necessary when an infant dies, even if the infant is transported to a hospital.

— Recreating the scene with the use of a re-creation doll is a critical part of the investigation.

— Document both the placed and found positions.

— To ensure that the scene is accurately recreated, the individuals who actually witnessed the scene (placer and finder) should always be the ones to recreate the scene.

Describing the Infant Death Scene

During an infant death scene investigation, an accurate description of the infant's sleeping environment and the identification of the infant's placed and found positions are critical. A written narrative with a thorough, accurate account of all information obtained at the

infant death scene will need to be completed, and the following are important details that should be noted by the child death specialist:

— Body position of the infant, with particular attention to the position of the nose and mouth, eg, facedown on surface, face up, face right, face left, any items obstructing nose/mouth, wedged

— Bedding and/or other objects located near the infant, eg, bumper pads, pillows, blankets, positional supports, stuffed animals, toys, family pets

— Whether the infant was cosleeping/bed sharing, eg, sleeping in the same room or sleeping in the same bed

— Type of surface on which the infant was sleeping, eg, sofa/couch, adult bed [mattress], water bed, crib, bassinet, car seat, floor

— Social history of caregiver(s), family, infant, siblings, and other individuals living in the residence

— Pregnancy history of mother, eg, prenatal care, gestation, complications during pregnancy or delivery, trauma during pregnancy, number of pregnancies and live births, prescription medications, alcohol, cigarettes, illicit drugs, herbal remedies

— Events surrounding the death, eg, changes in the infant's behavior or medications, new foods introduced in the past 72 hours, witnesses of the death, status of infant when found, resuscitation attempts, EMS involvement, movement to medical facility

— Condition of the infant, eg, hygiene, nourishment, clothing clean and of appropriate size and season, diaper used, birthmarks or visible injuries, livor mortis, rigor mortis, body temperature

— Environmental conditions, eg, presence of insects, smoky smell [cigarettes], dampness, visible standing water, mold growth, pets, peeling paint, odors or fumes, alcohol containers, drug paraphernalia

— Checklist for the discretionary collection of evidence, eg, clothing, bedding, diapers, medicines, baby bottles, formula/food, honey, toys, equipment, drug paraphernalia, folk remedies

— Details of all witnesses, responders, and other persons at scene, eg, name, address, phone number, relationship

Sleep-Related Deaths

Case Study 1-1

This 8-week-old boy and his 2-year-old sibling were in the care of their paternal grandfather and his girlfriend. The children had been dropped off for the weekend the previous evening around 10:00 PM. The infant was given half of a bottle between 10:30 and 11:00 PM. At approximately 1:00 AM the infant and his sibling were placed down to sleep on top of a comforter on a full-sized bed located against the wall in the spare bedroom. The sibling was sleeping on the inside of the bed near the wall. The infant was placed down on his right side. A row of pillows was placed around the outside of the bed in an attempt to keep the infant from falling out of bed.

The grandfather, his girlfriend, and the 2 year old woke up at 8:00 AM. The girlfriend walked into the bedroom to check on the infant. She found the infant in a prone position, with his nose and mouth facedown into the comforter. She turned him over and found him blue, cold to the touch, and unresponsive. EMS was called. The grandfather performed cardiopulmonary resuscitation (CPR) as instructed by EMS. The infant was pronounced dead upon EMS arrival at 8:35 AM.

The infant was born with medical complications, including bilateral clubfeet, missing ribs, a hole in his heart, a closed right ear canal, absent left testis, and left intestine bulging out of his left side. All of these were confirmed during autopsy, and a thin, old, left occipital subdural membrane was found. The cause of death was suffocation, and the manner of death was accident.

Figure 1-1-a. *Scene re-creation of the placed position.*

Figures 1-1-b *and* ***c.*** *Scene re-creation of the found position.*

Sleep-Related Deaths

Case Study 1-2

The mother of this 3-month-old boy placed him in his crib around 11:30 PM. The crib was next to the mother's bed. Around 2:00 AM the mother woke up to the infant crying. She picked him up, changed his diaper, and fed him a bottle. She brought him into her full-sized bed along with his crib blanket and a small crib-sized comforter. He was placed in a prone position in the middle of her bed. The mother woke up around 8:30 AM and found the infant still lying prone, with his face and nose down into the bedding. Froth was coming out of his nose and mouth, he appeared grayish, and he was unresponsive. EMS was called, and the mother attempted CPR as instructed by EMS until personnel arrived. The infant was pronounced dead at the scene.

The mother's bed had a fitted sheet, the infant's crib comforter, and another full-sized comforter on the bed. There were 2 standard-sized pillows at the head of the bed. Also on the bed were a white cloth, a baby bib, and a small suitcase that was open and contained a pile of clothing and a teddy bear. There was a baby bottle with formula between the comforter and the suitcase. Secretion was noted on the bed where the infant was found facedown.

Autopsy findings included petechial hemorrhages of the epicardium, thymus, and lungs; frothy fluid from the nose; and moderate acute chronic inflammation of the laryngeal mucosa. The cause of death was suffocation, and the manner of death was accident.

Figure 1-2-a. *Bed showing blood-tinged secretion spot.*

Figure 1-2-b. *Scene re-creation of the placed position.*

Figure 1-2-a

Figure 1-2-b

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