

# Infant Death Investigation Guidelines

## For Emergency Medical Services, Law Enforcement and Medical Examiners/Coroners

The Federal Centers for Disease Control and Prevention (CDC) and the American Academy of Pediatrics (AAP) have published the following guidelines for investigating sudden, unexplained infant deaths:

1. Recognize roles and responsibilities regarding prompt, thorough and sensitive investigation of unexpected infant deaths
2. Establish priorities for investigation of such deaths
3. Provide tools for use in the field when investigating such deaths
4. Provide tools for educating first responders, investigators, medical examiners/coroners and others involved with investigating such deaths
5. Respect the role that language or culture may play in the investigation of unexpected infant deaths and
6. Provide recommended standards for investigating such deaths

When an infant dies suddenly and unexpectedly, it is vitally important that a thorough and complete investigation be conducted to determine the cause and manner of death. The Guidelines provide investigators with recommendations for investigation and documentation.

In 1996, the CDC published the following reasons for a standard protocol for sudden, unexplained infant death scene investigation:

1. To generate a single, reasonable hypothesis for the cause, manner, and mechanism of death
2. To assist the pathologist, medical examiner, or coroner in ruling in or ruling out natural causes of death, child abuse or neglect, or injury
3. To identify public health threats, such as those related to consumer products or unsafe health practices
4. To use the opportunity to provide parents and caregivers information about grief counseling, support groups, and healthy infant-care practices
5. To provide information on sudden infant deaths to epidemiologists and agencies with an interest in the welfare of children

A thorough infant death investigation should include the following:

1. Complete death scene investigation and documentation, including photographic documentation
2. and re-enactment of the death scene with the person who found the deceased
3. Scene investigation and/or re-enactment with photos to assess sleep environment
4. Contact with the infant's health care provider(s) and gathering of medical records regarding past
5. medical history including prenatal history

6. Information gathered from social services and law enforcement agencies regarding their contact
7. with the family and caregivers
8. Complete autopsy with thorough documentation, including photographic documentation of
9. pertinent positives and negatives including the cranium and cranial contents;
10. Histology
11. Toxicology (drug and alcohol screens)
12. Pediatric Trauma Radiology series
13. Vitreous Chemistry
14. Expanded metabolic screen if not already done when baby was born
15. Information from metabolic screening labs)
16. Appropriate consultation with available medical specialists by medical examiners and coroners (e.g. pediatrician, pediatric pathologist, radiologist, pediatric neuropathologist, etc)
17. Consideration of intentional asphyxiation in cases of unexpected infant death with a history of recurrent cyanosis, apnea, or an apparent life threatening event (ALTE) witnessed only by a single caretaker or in a family with previous unexplained infant death(s)
18. Maintenance of a supportive approach to parents during the investigation process
19. Additional studies as deemed necessary

### Which Infant Deaths Require Investigation

The Infant Death Investigation Committee recommends that **ALL** deaths of children from birth to 24 months undergo a complete investigation unless a physician can provide a medical diagnosis to explain the death and is prepared to sign the death certificate. This includes presumed natural and accidental deaths, as well as homicides.

### The following list of unexpected infant deaths requiring investigation might be considered as guidelines for California Teams:

1. Unnatural deaths including violent deaths (homicidal, suicidal, or accidental)
2. Deaths associated with burns or chemical, electrical, or radiational injury
3. Deaths under suspicious circumstances
4. Deaths that occur during, in association with, or as the result of diagnostic, therapeutic, or anesthetic procedures
5. Deaths due to neglect
6. Unexpected deaths of persons not disabled by recognizable disease
7. Unexpected deaths of persons notwithstanding a history of underlying disease
8. Deaths in which a fracture of a major bone (femur, humerus, tibia, etc.) has occurred within the past six months
9. Deaths occurring outside of a licensed health care facility
10. Deaths of unborn or newborn infants in which there has been maternal use of or exposure to unprescribed controlled substances
11. Deaths occurring in an emergency department
12. Deaths of persons arriving at an emergency department “dead on arrival”

### 13. Deaths in a family or child care facility with a previous infant death or near death

#### Professionals Investigating Unexpected Deaths

Investigation of unexpected deaths requires the participation of numerous persons. The professionals who visit the scene of an infant/child death differ from county to county. Law enforcement officers are almost always present. A first responder team may include fire and rescue personnel, paramedics, or emergency medical technicians. The medical examiner/coroner and the county attorney may visit the scene if required. In some of the larger metropolitan counties, the medical examiner's office has death scene investigators. Collaboration among agencies enhances the ability to determine accurately the cause and circumstances of death. Information about the death of one child may lead to prevention strategies to save the life of another child. (American Academy of Pediatrics).