Indiana SIDS Deaths Time of Year
1991-1993

Number of Deaths

Source: ISDH, MCH
Indiana SIDS Deaths by Sex of Infant
1991-1993

Female 37.2%

Male 62.8%

Source: ISDH, MCH
Indiana SIDS Rate White vs. Nonwhite Population, 1981-1993

Rate per 1,000 live births

Source: ISDH, Public Health Research, MCH

*Provisional
Infant Deaths 1 Year and Under, SIDS vs. Abuse/Neglect, Indiana, 1983-1993

Number of Deaths

Source: ISDH, MCH, FSSA
Infant Deaths 1 Year and Under, SIDS vs. Abuse/Neglect, Marion County, Indiana 1983-1993

Source: ISDH, MCH, FSSA
Infant Deaths 1 Year and Under, SIDS vs. Abuse/Neglect, Lake County, Indiana 1983-1993

Number of Deaths

- Abuse / Neglect (estimate)
- SIDS Deaths

Source: ISDH, MCH, FSSA
Infant Deaths 1 Year and Under, SIDS vs. Abuse/Neglect, Allen County Indiana, 1983-1993

Number of Deaths

Source: ISDH, MCH, FSSA
Infant Deaths 1 Year and Under, SIDS vs. Abuse/Neglect, Elkhart County, Indiana 1983-1993

Number of Deaths

Source: ISDH, MCH, FSSA
Infant Deaths 1 year and Under, SIDS vs. Abuse/Neglect, St. Joseph County, Indiana, 1983-1993

Number of Deaths

<table>
<thead>
<tr>
<th>Year</th>
<th>Abuse / Neglect (estimate)</th>
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<td>8</td>
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Source: ISDH, MCH, FSSA
Infant Deaths 1 year and Under, SIDS vs. Abuse/Neglect, Vanderburg County, Indiana, 1983-1993

Number of Deaths

Source: ISDH, MCH, FSSA
**SIDS CASE MANAGEMENT SYSTEM**

- Completely investigate the cause of death, including a complete autopsy and death scene investigation conducted in a sensitive manner.

- Consistently use the term "Sudden Infant Death Syndrome" on death certificates.

- Promptly notify the parents as to the preliminary results of the autopsy. The standard notification is within 24-48 hours after its completion.

- Provide accurate information on SIDS and initial grief counseling for families. This is usually accomplished through the county health departments.
PARENTS PERSPECTIVE

The parents perspective has always been consistently evaluated as the most helpful and beneficial portion of the Sudden Infant Death Syndrome (SIDS) Training. It is an opportunity for first responders to hear a parent share the intimate details surrounding the death of their child. It is also a chance to gather suggestions from parents on what was and was not helpful at the time of their tragic loss. We strongly encourage you to include this segment in your program.

To aid you in your efforts, we are currently developing a Parent Speakers Bureau. As you begin to plan upcoming training sessions please call Barb Himes, Support Services of Indiana, Inc. at 317/882-2366 or 1(800)433-0746 to schedule a parent to speak at the training session.

If a parent is not available in your community, the following points should be covered for training and discussion along with the video which includes parent testimonials.

- Learn and use baby's name, if possible.

- Talk to parents/child care provider in simple, easily understood terms. They may be unable to think clearly and the simplest task becomes difficult. Do not use professional slang terms around the parents i.e., "The baby's pupils are blown."

- Give parents quiet time with baby. Explain to family that certain things have to be done, routine questions, picture taken, etc. It may be necessary to gently remind them, "You may have a little while longer with the baby, but remember we still have some things we need to do." Keep in mind, this is the first step in the families healing process. Although this may delay your job, please be patient as these memories will remain with the family forever.

- Treat baby with dignity and respect. Families can be given a lifetime of comfort by knowing their babies were cared for tenderly. Transport baby in an appropriate manner. Some parents have anguished over seeing their baby placed on the floor board of a truck or trunk of a car.

- Treat family/child care provider with compassion. There's no need to try to say anything profound, a simple "I'm sorry" or a gentle pat on the hand or rub on the back would be comforting. Avoid cliches such as "It's God's Will", "I know how you feel" or "You can have another baby."

REMEmber....Parents generally don't mind what has to be done, just the manner in which its done

- Dismiss extra responders. Too many cause confusion.

- Help parents/child care provider identify support systems.

  family
  neighbors
  friends
  clergy
- Inform family what will happen next
  - Being transported to hospital
  - Where autopsy is being performed
  - When baby will arrive at funeral home
  - Any known information
  - Visit from Public Health Nurse

- Act as a buffer if parents are hysterical and/or emotions are running high. You may need to remind colleagues at this time, this is a death scene, not a crime scene. Keep an open mind.

- Follow-up with parents
  - Have they received autopsy results?
  - Have they received death certificate?
  - Letting them know you are thinking of them - sympathy card
  - Have you received grief literature?

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**IT'S NEVER TOO LATE FOR FOLLOW-UP**

- Give phone number of local parent support group, bereavement group, public health nurse or the Family Helpline at the Indiana State Department of Health at 1-800-433-0746.

*Most importantly...please, please, please, take care of yourself - infant runs are physically and mentally draining. If you don't take care of yourself, you can't take care of anyone else.*

*It is important to utilize any critical incident stress debriefing program available. If one is not available in your area, you may wish to consider organizing one.*
INSTRUCTORS DISCUSSION GUIDE

TITLE: "Finding Answers With Compassion"
[Infant Death Investigation Guide

PURPOSE: Training video primarily for police and coroners on how to respond to sudden deaths in children from birth to 2 years of age.

LENGTH: Approximately 45 minutes.

PRODUCED BY: Indiana State Department of Health SIDS Project in cooperation with the Indiana Commission on Forensic Sciences and the Central and Northern Indiana Affiliates of the National SIDS Alliance.

Description
The video includes a reenactment of a sudden infant death and provides suggestions to police officers and coroners on how to respond to families in a supportive fashion at the time of death and during follow-up investigations. It also includes unscripted testimonials from parents who have experienced a sudden infant death describing their reactions to the police and coroner and the need for an autopsy.

The video is narrated by Dr. John Pless, Chairman, Department of Pathology, Indiana School of Medicine. Dr. Pless, a Forensic Pathologist, performs numerous autopsies on both adults and infants for various Coroners Offices throughout the state. He is the State's leading expert in cause of death determination and has provided expert testimony in numerous criminal and civil court cases.

Also appearing in the video is David Wade, Chief of Police, City of Gary, Indiana. As a Homicide Detective, Chief Wade responded to numerous infant deaths and has been active in the SIDS Community since his first experience with a SIDS death which he candidly describes in the video.

For Additional Information Regarding the Video Contact:

Larry Humbert, A.C.S.W.
SDS Project Coordinator

or

Barb Himes, SIDS Parent Consultant
Indiana State Department of Health
1330 W. Michigan Street, Room 236N
Indianapolis, Indiana 46206-1964
317/633-0722 or 317/633-8466
1-(800)-433-0746 [Indiana]
WHY WAS THE VIDEO PRODUCED?

Since August 1991, the Indiana State Department of Health SIDS Project has conducted nearly 50 SIDS in-service trainings to police departments, fire fighters, E.M.S. personnel and coroners offices throughout the State. Common themes from the evaluations indicate the vast majority of participants have not received this type of training and were unaware of the parents feelings and how they could help. Most law enforcement personnel indicated they were trained to consider all infant deaths as homicides until proven otherwise and some felt the response we advocated was in conflict with their crime scene training. Many participants also stated that the personal story by a SIDS parent was the most beneficial aspect of the training so you are encouraged to include a parent in your training if possible. Also, our experience is that police officers respond better to trainings specifically for them, as opposed to attending trainings for other first responders.

KEY POINTS FOR FIRST RESPONDERS:

- Approach each situation with an open mind regarding the cause of death.
- Not all death scenes are crime scenes. In fact, the majority of infant deaths are due to natural causes.
- You can respond to families in a supportive fashion and still conduct a good investigation.
- Parents should be viewed as survivors, not suspects.
- Police, coroners and all others at the scene must work together and communicate with each other.

COMMON THEMES FROM PARENT TESTIMONIALS:

Many of the parents statements could be perceived as being rather strong. This is likely due to the type of treatment they received at the time of their child's death. The parents with the most positive statements and calmer affect [black mother and mother with short red hair] were treated in a supportive fashion. Many parents spoke of the importance of keeping them informed about the progress of the autopsy results and when the final report will be available. Several parents expressed tremendous frustration with the lack of communication from the coroner.
BACKGROUND INFORMATION ON THE INFANT’S DEATH DESCRIBED IN THE OPENING TESTIMONIAL (AMBER):

Amber died at 14 months of age approximately 5 months before the filming of the video. Despite the performance of a complete autopsy, including microscopic and toxicology studies, the cause of death was listed as "Undetermined". The broken back the mother describes which was discovered during the autopsy can be a common finding in child abuse cases. However, in this case there was no external wounding accompanying these severe deep injuries which were inflicted by the young inexperienced E.M.T. who attempted a Heimlick Maneuver on this small child. The unnecessary accusations against the mother and exaggeration of the injuries were made by the coroner and sheriff responding to a simple request from the forensic pathologist for more information concerning how the child was found and what was done during resuscitation. It appears the mother still has some unresolved feelings regarding this finding.

POSSIBLE QUESTIONS FOR DISCUSSION REGARDING THIS CASE:

- This unusual case was included in the video to reinforce the importance of the autopsy in explaining suspicious findings and the need to approach these deaths with an open mind.

- This case also reinforces the importance of communication between E.M.T.'s, police officers, coroners and pathologists regarding resuscitation efforts and other important observations at the scene of death. Had this communication occurred prior to the autopsy; the unnecessary accusations against the mother may not have occurred.

- This scenario also illustrates the need for proper death scene investigations. Questioning the mother at her residence would have been less traumatic for her and would have afforded the opportunity for a more thorough investigation of the scene of death.
SUGGESTED HANDOUTS
FOR ALL
TRAINING PARTICIPANTS

- What is SIDS
- SIDS and Emergency Medical Personnel
- Parents and The Grieving Process
- How To Distinguish Between SIDS and Child Abuse/Neglect

Not Included in Instructors Resource Packet

- SIDS Blue Card
- Finding Answers With Compassion
- If You Would Be An Effective Comforter to Bereaved Parents
- Discussing The Autopsy
- Facts About SIDS for Police Officers
What Is SIDS?

Sudden Infant Death Syndrome (SIDS) is the "sudden death of an infant under one year of age which remains unexplained after a thorough case investigation, including performance of a complete autopsy, examination of the death scene, and review of the clinical history" (Willinger et al., 1991).

What Are the Most Common Characteristics of SIDS?

Most researchers now believe that babies who die of SIDS are born with one or more conditions that make them especially vulnerable to stresses that occur in the normal life of an infant, including both internal and external influences. SIDS occurs in all types of families and is largely indifferent to race or socioeconomic level. SIDS is unexpected, usually occurring in otherwise apparently healthy infants from 1 month to 1 year of age. Most deaths from SIDS occur by the end of the sixth month, with the greatest number taking place between 2 and 4 months of age. A SIDS death occurs quickly and is often associated with sleep, with no signs of suffering. More deaths are reported in the fall and winter (in both the Northern and Southern Hemispheres), and there is a 60-to-40-percent male-to-female ratio. A death is diagnosed as SIDS only after all other alternatives have been eliminated: SIDS is a diagnosis of exclusion.

What Are Risk Factors for SIDS?

Risk factors are those environmental and behavioral influences that can provoke ill health. Any risk factor may be a clue to finding the cause of a disease, but risk factors in and of themselves are not causes.

Researchers now know that the mother’s health and behavior during her pregnancy and the baby’s health before birth seem to influence the occurrence of SIDS, but these variables are not reliable in predicting how, when, why, or if SIDS will occur. Maternal risk factors include cigarette smoking during pregnancy; maternal age less than 20 years; poor prenatal care; low weight gain; anemia; use of illegal drugs; and history of sexually transmitted disease or urinary tract infection. These factors, which often may be subtle and undetected, suggest that SIDS is somehow associated with a harmful prenatal environment.

How Many Babies Die From SIDS?

From year to year, the number of SIDS deaths tends to remain constant despite fluctuations in the overall number of infant deaths. The National Center for Health Statistics (NCHS) reported that, in 1988 in the United States, 5,476 infants under 1 year of age died from SIDS; in 1989, the number of SIDS deaths was 5,634 (NCHS, 1990, 1992).
However, other sources estimate that the number of SIDS deaths in this country each year may actually be closer to 7,000 (Goyco and Beckerman, 1990). The larger estimate represents additional cases that are unreported or underreported (should have been reported as SIDS cases but were not).

When considering the overall number of live births each year, SIDS remains the leading cause of death in the United States among infants between 1 month and 1 year of age and second only to congenital anomalies as the leading overall cause of death for all infants less than 1 year of age.

**How Do Professionals Diagnose SIDS?**

Often the cause of an infant death can be determined only through a process of collecting information, conducting sometimes complex forensic tests and procedures, and talking with parents and physicians. When a death is sudden and unexplained, investigators, including medical examiners and coroners, use the special expertise of forensic medicine (application of medical knowledge to legal issues). SIDS is no exception.

Health professionals make use of three avenues of investigation in determining a SIDS death:

1. the autopsy,
2. death scene investigation, and,
3. review of victim and family case history.

**The Autopsy**

The autopsy provides anatomical evidence through microscopic examination of tissue samples and vital organs. An autopsy is important because SIDS is a diagnosis of exclusion. A definitive diagnosis cannot be made without a thorough postmortem examination that fails to point to any other possible cause of death. Also, if a cause of SIDS is ever to be uncovered, scientists will most likely detect that cause through evidence gathered from a thorough pathological examination.

**A Thorough Death Scene Investigation**

A thorough death scene investigation involves interviewing the parents, other caregivers, and family members; collecting items from the death scene; and evaluating that information. Although painful for the family, a detailed scene investigation may shed light on the cause, sometimes revealing a recognizable and possibly preventable cause of death.

**Review of the Victim and Family Case History**

A comprehensive history of the infant and family is especially critical to determine a SIDS death. Often, a careful review of documented and anecdotal information about the victim's or family's history of previous illnesses, accidents, or behaviors may further corroborate what is detected in the autopsy or death scene investigation.

Investigators should be sensitive and understand that the family may view this process as an intrusion, even a violation of their grief. It should be noted that, although stressful, a careful investigation that reveals no preventable cause of death may actually be a means of giving solace to a grieving family.
What SIDS Is and What SIDS Is Not

**SIDS Is:**

- the major cause of death in infants from 1 month to 1 year of age, with most deaths occurring between 2 and 4 months
- sudden and silent—the infant was seemingly healthy
- currently, unpredictable and unpreventable
- a death that occurs quickly, often associated with sleep and with no signs of suffering
- determined only after an autopsy, an examination of the death scene, and a review of the clinical history
- designated as a diagnosis of exclusion
- a recognized medical disorder listed in the International Classification of Diseases, 9th Revision (ICD-9)
- an infant death that leaves unanswered questions, causing intense grief for parents and families

**SIDS Is Not:**

- caused by vomiting and choking, or by minor illnesses such as colds or infections
- caused by the diphtheria, pertussis, tetanus (DPT) vaccines, or other immunizations
- contagious
- child abuse
- the cause of every unexpected infant death

Any sudden, unexpected death threatens one's sense of safety and security (Corr, 1991). We are forced to confront our own mortality. This is particularly true in a sudden infant death. Quite simply, babies are not supposed to die. Because the death of an infant is a disruption of the natural order, it is traumatic for parents, family, and friends. The lack of a discernible cause, the suddenness of the tragedy, and the involvement of the legal system make a SIDS death especially difficult, leaving a great sense of loss and a need for understanding.
For Additional Information on SIDS, Contact:

American SIDS Institute, 6065 Roswell Road, Suite 876, Atlanta, GA 30328, (800) 232-7437, (800) 847-7437 (within GA), (404) 843-1030, (404) 843-0577 (fax)

Association of SIDS Program Professionals (ASPP), c/o Massachusetts Center for SIDS, Boston City Hospital, 818 Harrison Avenue, Boston, MA 02118, (617) 534-7437, (617) 534-5555 (fax)

National Sudden Infant Death Syndrome Resource Center (NSRC), 8201 Greensboro Drive, Suite 600, McLean, VA 22102-3810, (703) 821-8955, (703) 821-2098 (fax)

Southwest SIDS Research Institute, Inc., Brazosport Memorial Hospital, 100 Medical Drive, Lake Jackson, TX 77566, (409) 299-2814, (800) 245-7437, (409) 297-6905 (fax)

Sudden Infant Death Syndrome Alliance, 10500 Little Patuxent Parkway, Suite 420, Columbia, MD 21044, (800) 221-7437, (410) 964-8000, (410) 964-8009 (fax)

References:


Indiana State Department of Health

SUDDEN INFANT DEATH SYNDROME AND EMERGENCY MEDICAL PERSONNEL

Many people have never heard of the Sudden Infant Death Syndrome (SIDS). When it occurs, there is often much confusion and misinformation relating to the cause of death. Since SIDS victims seem to have been healthy prior to death—which occurs suddenly, swiftly, and silently—the grieving parents are jolted by the shock and pain of an unexpected tragedy. Their aching emptiness is rapidly filled with unrelenting feelings of guilt. There is an endless stream of questions and wondering—"I should have noticed something." "I should have taken him to the doctor." "If only I'd been with the baby; I shouldn't have left her with a sitter." "I wish I had checked the baby earlier." These and similar thoughts all imply feelings of guilt and responsibility for the death. However, it seems to be nearly impossible to avoid them. There are several reasons for this:

- Researchers have recently made significant progress in understanding SIDS, however, the exact cause of death remains unexplained!
- There is no known method of predicting or preventing SIDS.
- The death is unexpected. It occurs without warning—without a cry or struggle.
- Most people are not well informed about SIDS. Parents are usually the targets of well-meaning but accusatory advice such as "You shouldn't have done this." or "Next time you better do this."

A baby depends upon his or her parents for every need. When these needs are not met, the parents feel an overwhelming guilt and responsibility for having "failed".

All of these things contribute to the confusion of SIDS parents. One minute, they have a seemingly healthy, happy baby; the next minute, their baby is dead. "What went wrong?" "Why?"

At the present time, the answer to these questions are not fully understood. But there are many things we do know and understand about SIDS—commonly called "crib death".

By definition, SIDS is the sudden, unexpected death of an infant under 1 year of age, that remains unexplained after a complete post mortem exam. It is the number one cause of death in infants between the ages of three weeks and one year, although it occasionally happens to younger or older infants. Each year, approximately 6,000 infants in the United States succumb to crib death. In Indiana SIDS takes the lives of approximately 135 babies every year.

Typically, the infant seems to have been well cared for. Death usually occurs while in a sleeping state, either during a nap or during the night. As described in witnessed cases, the baby simply stops breathing—not uncommon for short periods of time in normal infants—then turns blue, and becomes limp. The baby does not gasp for breath or struggle and, therefore, it is felt that the death is not accompanied by suffering.

It may be several minutes or even hours before the baby is discovered, especially if the death occurs during the night. During this time, the appearance of the baby may change drastically. Areas of the body may take on the appearance of bruising due to postmortem lividity. There may be vomitus, fluid, or froth—often blood-tinted—in and around the mouth and nose. In some cases, there may be indentations on the body or the face of the infant may appear to be "squashed".

In these cases, the body is usually found wedged into a corner of the crib or pressed into the mattress due to a spasm which sometimes occurs at the time of death. In other instances, the baby will appear to be sleeping peacefully. Not to be overlooked is the fact that "crib death" does not always happen in a crib. It has been known to take place in infant carriers, car seats, and even while in the arms of parents.

In cases of sudden and unexpected infant death, five possible causes of death must be considered:

1. SIDS,
2. a diagnosed disease or condition,
3. an unsuspected disease or condition,
4. accidental injury
5. child abuse.

When the infant's history is compatible with SIDS—that is, an apparently healthy infant, under one year of age, and who died during a sleeping period—it is possible that the baby is a SIDS victim. However, a complete autopsy and death scene investigation are essential to accurately diagnosis SIDS.

Resuscitation is attempted if there is any possibility that the infant is still alive. There have been reports of infants within the susceptible age for SIDS who cease breathing spontaneously, but whose lives are saved by timely intervention. Various resuscitative measures have been successful, including tactile stimulation as well as cardiopulmonary resuscitation. However, it is not known if these cases are linked with SIDS, in which immediate resuscitative measures have been attempted to no avail.

SOME BASIC FACTS ABOUT SIDS

- A minor illness such as a common cold or the "sniffles" may have been present, but is not the cause of death.
- SIDS is not caused by smothering, choking, or abuse.
- SIDS is neither contagious nor hereditary.
- SIDS is neither predictable nor preventable.
THE ROLE OF EMERGENCY MEDICAL PERSONNEL

The role of emergency medical personnel is particularly difficult in a case of SIDS, in that they must respond not only to the infant's medical needs, but to the emotional needs of the parents as well. In most cases of SIDS, the infant has been dead for quite awhile by the time emergency medical technicians and/or paramedics and hospital emergency department staff encounter the crisis. Very often, it is up to the emergency medical personnel to respond to the "other victims"—the family of the baby.

This type of death may trigger emotional reactions resulting in family disintegration, divorce, alcoholism, or other serious psychological problems for the parents of the infant and their surviving children. Emergency health care personnel can minimize the potential psychiatric damage among family members.

A controversial issue concerns the question of whether resuscitation should be initiated when the infant has obviously been dead for some time. Some believe that attempts to do so will help the parents by letting them feel that something is being done. Others feel that such attempts are harmful in that false hopes are aroused, thereby hindering the parent's acceptance of reality. Response to this issue may vary from one situation or locality to another.

A related issue concerns problems regarding transport of the body. Local death investigation laws may prohibit removal of the body until the coroner is notified and in some cases until he visits the scene. As reported in cases of SIDS, this may result in confusion and misunderstanding over the reason for the delay, as the parents may interpret this as an accusation of foul play.

If the baby is taken to the hospital emergency department, a member of the emergency team should try to find a private waiting area and should stay with the family as much as possible. It may be helpful to take an account of recent events as well as an essential health history. The family physician or pediatrician who provided the baby's usual health care should be informed. This information may have immediate lifesaving implications or may later help determine the cause of death.

The family should be kept informed about what is being done for the baby, who the doctor is, and about any other questions they have. It may be helpful to call a minister, rabbi, or priest—or other close family members.

When the family is informed of the baby's death by the emergency physician or family physician (if present), the staff should be prepared for a variety of reactions, as individuals express grief differently. In the event of severe reactions, a counselor or social worker may be contacted for immediate crisis intervention.

If the parents have been told that SIDS is the probable cause of death and that a medical examination will be done to confirm the diagnosis, a member of the emergency team should try to answer their questions. It may be helpful to offer SIDS literature to the family. Let them know that a public health nurse will visit them to help them through this crisis.

Before the parents leave the emergency department they should be offered the opportunity to say "good-bye" to their baby. If they are not asked, they may be reluctant to ask and regret it later. For some parents, this will enable them to focus upon the reality of the death. They may wish to take a piece of the baby's clothing to hold onto. However, some parents will not feel comfortable being with the baby. On this matter, individual feelings should be respected.

There is no clear-cut method for assisting SIDS family. The most effective approach to these families is a sensitive and caring attitude. By being knowledgeable and sensitive to the needs of these families, emergency medical personnel can be of great assistance at a time when it is most needed.

FOR MORE INFORMATION, CONTACT:

THE STATEWIDE SIDS CASE MANAGEMENT SYSTEM
INDIANA STATE DEPARTMENT OF HEALTH
1330 WEST MICHIGAN STREET
INDIANAPOLIS, INDIANA 46206
TELEPHONE: 317/633-8469
TOLL-FREE 1-800-433-0746
Fact Sheet: Parents and the Grieving Process

Grief is an intense, lonely, and personal experience. Everyone learns about grief and grieving in the course of natural separations that occur during infancy and childhood and through their encounters with the deaths of loved ones. The death of an elderly loved one is mourned, but is usually expected. The death of a child, however, especially the death of an apparently healthy child, is an unexpected event. When a child dies not only does the death destroy the dreams and the hopes of the parents, but it also forces all family members to face an event for which they are unprepared. Most parents who experience the death of a child describe the pain that follows as the most intense they have ever experienced. Many parents wonder if they will be able to tolerate the pain, to survive it, and to be able to feel that life has meaning again.

The intense pain that parents experience when their child dies may be eased somewhat if they have insight into what has helped other parents overcome a similar grief. For example, one of the most important things for parents to realize is that recovery from the loss of a child takes time. Each person will have to establish his or her own method for recovery. There is no right or wrong way to grieve, but there is a pattern to the resolution of grief, and there is help available to family members. It is crucial that parents realize that they are not alone and that others have experienced such grief and have survived.

Often the first reaction of a parent after the death of a child is one of shock, disbelief, denial, or numbness. These reactions are instinctive and often the impact of the death until the parent is better prepared to face the reality and the finality of the child's death. These reactions, as normal as they are, can be deceptive to others who are unacquainted with the grieving process. They may incorrectly assume that the parent either is strong and holding up well, or is insensitive and incapable of expressing his or her feelings about the loss. What they fail to realize is that shock, disbelief, denial, and numbness allow the parent to begin to face the tragic occurrence without losing control. Many parents have said that they seem to be "functioning in a fog" during the first few weeks after their child's death. "Some parents describe their experience at the wake or funeral as 'being an observer' or 'not really (being) emotionally involved.'" All of these reactions are nature's way of helping the parents confront the death of their child. These reactions may last minutes, hours, days, or weeks. The parent will determine subconsciously when he or she is better able to face the death. Crying, or some similar emotional release, usually marks the end of this initial period of grief.

When the child's death becomes a reality to the family, intense suffering and pain usually begin. During the weeks and months that follow, many parents say that they are frightened by the intensity and the variety of the feelings that they experience. Crying, weeping, and incessant talking are all normal reactions. The parent may find that he or she feels very much alone. Parents may express their grief differently and may have difficulty sharing their feelings. Relatives and friends may be uncomfortable with the actuality of death, may be busy with their own lives, or may be unable to meet the parents' needs for comfort and support. For some parents, help may be obtained from the clergy, physicians, counselors, other bereaved parents, or willing friends and relatives. It is important to remember, however, that no one can resolve the parents' grief but the parents themselves. Resolution can be achieved only by experiencing and working through these emotions.

It is important for the parents to allow themselves full expression of the emotions they feel. Margaret S. Miles and others have concluded that it is essential for these emotional feelings to be expressed at the time when an emotion is first experienced. It is vital that emotions not be held in for a "correct time." It is necessary for parents to express their emotions, though not necessarily in words, to gain a resolution to their child's death. Emotions that parents may experience include:

- **Guilt**—As the parents try to understand the reason their child died, they may develop feelings of guilt. Parents may blame themselves for something they did in the present or the past, or for something they neglected to do. Also, each parent might blame the other. "If only" becomes a familiar phrase. Many times parents feel guilty when thinking of all the things that they wish they had done with their child. For instance, a father may feel guilty for not having spent more time with his child. Guilty feelings may also arise in the mother who thinks, "If only I hadn't returned to work." And either parent could feel regret for not having given the child something that he or she wanted. In most instances there is no rational basis for these feelings. It can be extremely beneficial for parents to talk with people who will encourage the expression of these feelings, and who can help them to understand these feelings more clearly.

- **Anger**—Depending on his or her personality, a parent may express feelings ranging from mild anger to rage. Parents can feel angry at themselves, their spouse, the physician, or the child for having died. Religious beliefs may be questioned and parents may find themselves angry at a God who allows children to die. These thoughts, though normal and experienced by many grieving parents, may cause an extreme amount of anxiety. Anger that is left unreleased may be suppressed and may manifest itself at an inappropriate time or place or in an inappropriate manner. Anger can be expressed healthily and worked through in a number of ways: screaming in private, hitting something, or strenuous exercise.
• **Fear**—After the death of their child many parents experience an overall sense of fear that something else horrible is going to happen. Often, parents with older children become extremely overprotective of them. At the same time they may find themselves fearful of their responsibilities. After the death of their child, many parents find it difficult to concentrate for any length of time. Their minds wander, making it difficult to read, write, or make decisions. Sleep may be disrupted, leaving parents overtired and edgy. Even in getting enough sleep, parents may still feel exhausted. Those in grief may experience physical symptoms centering around the heart, in the stomach, or throughout muscles. Many times parents feel an irresistible urge to escape. As normal as all these reactions are, grieving parents often fear that they are “going crazy.” Talking about these feelings with other parents who have experienced a similar loss can be extremely helpful for some grieving parents.

• **Depression**—As the parents continue to work through their grief, depression often occurs. Depression can take different forms for different parents. Some parents may feel constantly “down,” unhappy, or sad; others may feel worthless or as though somehow they have failed. Many are continually lethargic, tired, or listless. This may be an ideal time for parents, with the help of family or friends, to become involved in some type of activity. Caution should be taken to avoid frantic activity which, like running away, avoids facing the reality of the child’s death. Grieved parents, in the midst of deep depression, may feel that life has little meaning for them. Occasionally thoughts of suicide may arise. Many parents say that thoughts of their child are constantly in the forefront of their minds. Aching arms, hearing the child cry, or continuing with routine tasks of caring for the child are all normal experiences for grieving parents. As the parents begin to recover, depression will lift slowly. “Down” times will come and go, but the time between the “downs” will become longer. It’s a long, slow process that may take years. But resolution and recovery will come.

“No matter how deep your sorrow, you are not alone. Others have been there and will help share your load if you will let them. Do not deny them the opportunity.”

---

**Resolution and Recovery**

As the finality of the child’s death becomes a reality for the parents, recovery occurs. Parents begin to take an active part in life and their lives begin to have meaning once again. The pain of their child’s death becomes less intense but not forgotten. Birthdays, holidays, and the anniversary of the child’s death can trigger periods of intense pain and suffering. As time passes, the painful days become less frequent. There is no set time in which recovery takes place after a child dies. The only comforting thought that one can give a parent is that it does occur; the process is slow, but it will happen. Parents need to be patient and loving with themselves, their spouses, and their families.


---

**FOR LOCAL REFERRALS AND ASSISTANCE, BEREAVED PARENTS MAY WISH TO CONTACT THE MUTUAL HELP GROUPS FOR PARENTS LISTED BELOW:**

- The National SIDS Foundation  
  10500 Little Patuxent Parkway, Suite 420  
  Columbia, MD 21044  
  (800) 221-7437

- SHARE  
  National Headquarters  
  St. Elizabeth’s Hospital  
  211 South Third Street  
  Belleville, IL 62222  
  (618) 234-2415

- The Compassionate Friends  
  National Headquarters  
  P.O. Box 3696  
  Oak Brook, IL 60522-3696  
  (312) 990-0010

- Pregnancy and Infant Loss Center  
  1415 East Wayzata Boulevard  
  Suite 22  
  Wayzata, MN 55391  
  (612) 473-9372
### How To Distinguish Between SIDS and Child Abuse and Neglect

#### Physical Appearance:

**May Initially Suspect SIDS When:**
- Other siblings appear to be normal and healthy.
- Full-term infant (39 to 41 weeks gestation).
- Temperature may be slightly elevated.
- Purple mottling-markings on head and facial area (especially forehead and nose/mouth).
- Cool hands and feet.
- No sweating.
- Feet may be cold and stiff.
- Lilac or blue color of skin.
- Ditchell's "narrow appearance of deceased baby.
- Exhibits no external signs of injury.

**May Initially Suspect Child Abuse and Neglect When:**
- Wounds and bruises.
- Burn marks (including scalded hand)
- Head trauma (e.g., black eye, broken bone(s))
- Visible signs of injury

#### Seasonal Differences:

**May Initially Suspect SIDS When:**
- More frequent in winter months.
- Age Range: 2 to 6 months.
- Indiana 130/yr, US: 6,000/yr.

**May Initially Suspect Child Abuse and Neglect When:**
- No seasonal difference.
- Indiana 18/yr, US: 650/yr.

#### Autopsy Findings:

**May Initially Suspect SIDS When:**
- Full-term infant, no facial trauma.
- Evidence of injury.
- Evidence of trauma.

**May Initially Suspect Child Abuse and Neglect When:**
- Visible injuries.
- Evidence of injury.
- Evidence of trauma.

#### Physical Symptoms:

**May Initially Suspect SIDS When:**
- Parents say the infant was well and healthy when put to sleep.
- Parents say the infant was well and healthy when put to sleep.
- Full-term infant (39 to 41 weeks gestation).
- Temperature may be slightly elevated.
- Purple mottling-markings on head and facial area (especially forehead and nose/mouth).
- Cool hands and feet.
- No sweating.
- Feet may be cold and stiff.
- Lilac or blue color of skin.
- Ditchell's "narrow appearance of deceased baby.
- Exhibits no external signs of injury.

**May Initially Suspect Child Abuse and Neglect When:**
- Visible injuries.
- Evidence of injury.
- Evidence of trauma.
ARTICLES

- Guidelines for Emergency Responders

- The Family and Sudden Infant Death Syndrome
The human aspect of the human face is the most vulnerable and yet
derevived to sudden unexpected death.
It is the immediate challenge of the community to consult and
consider the implications of sudden death.

Guidelines for Emergency Responders

CHAPTER 8

Sudden Infant Death Syndrome: Who Can Help and How

Comrie Curti and Judy E. Lazenby

Chaplin, ND: St. Anthony Publishing Company, 1999
GUIDELINES FOR RESPONSE

Before the Crisis Occurs

GUIDELINES FOR EMERGENCY RESOURCES

THE CRISIS

142 — GUIDELINES FOR HELPLINES

Nonprofit

Encyclopedia

Facts on File

The Crisis
Human Take:

Human death, if not handled with respect and sensitivity, may result in the murder of children. The human death, if not handled with care and respect, may result in the murder of children.

Legal Take:

Responsible parties must be held accountable for criminal acts that result in the harm or death of children. All relevant information must be collected and analyzed to determine the extent of the harm and to provide a comprehensive understanding of the circumstances leading to the harm. This information will be used to formulate recommendations for policy and practice changes to prevent similar incidents from occurring in the future.

Guidelines for Emergency Responders:

1) Triaging and referring sensitive to the needs of the family.
2) Assessing the situation accurately and providing the correct response.
3) Providing necessary medical care and support to the family.
4) Ensuring that the family's rights are protected.

TABLE 1: How to Distinguish Between SIDS and Child Abuse and Neglect

<table>
<thead>
<tr>
<th>Symptom</th>
<th>SIDS</th>
<th>Child Abuse and Neglect</th>
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<tr>
<td>Child Abuse and Neglect</td>
<td>No</td>
<td>Yes</td>
</tr>
</tbody>
</table>
GUIDELINES FOR EMERGENCY RESPONDERS

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RESPONDING TO THE CALL FOR HELP

Emergency response procedures for children should be developed and practiced in order to ensure a coordinated and effective response. This includes training emergency responders on how to approach and interact with children. The following guidelines are intended to provide a framework for addressing these issues:

1. Assess the situation: Determine the type of emergency and the appropriate response. Emergency responders should be trained to recognize the signs of child abuse and neglect.

2. Communicate clearly: Use simple and direct language when speaking to children. Avoid using medical or legal terms.

3. Establish trust: Build a rapport with children by engaging them in a conversation about something they enjoy.

4. Use positive reinforcement: Reward children for their cooperation.

5. Keep in mind the child's perspective: Children may not understand the emergency and may have difficulty expressing their feelings. It is important to be patient and compassionate.

6. Provide reassurance: Reassure children that they are safe and that help is on the way.

7. Respect children's boundaries: Do not force children to show or describe what happened.

8. Offer support: Offer emotional support and help children feel safe.


10. Ensure safety: Ensure that children are in a safe environment.

In all situations, the safety and well-being of children should be the top priority. It is important for emergency responders to remain calm and reassuring, even in the face of adversity.

By following these guidelines, emergency responders can provide effective assistance to children during an emergency.
GUIDELINES FOR EMERGENCY RESPONDERS

Legal Issues

Informed Consent

Understanding informed consent is crucial to ensuring that patients are fully informed about their health and treatment options.

Patient autonomy is the right to make decisions regarding their health and treatment. It is important for healthcare providers to ensure that patients understand all aspects of their health condition and treatment options.

Consent must be obtained in a manner that respects the patient's autonomy and ensures that they are fully informed. It is important to document the consent in writing, with the patient's signature and date.

Informed consent is not always a one-size-fits-all approach. It is important to consider the patient's cultural background, language needs, and prior health experience when obtaining consent.

Written consent forms should be provided to patients in their preferred language. Where possible, consent forms should be written in short, clear language.

Emergency Use

In situations where a patient is unable to provide informed consent, healthcare providers may need to act in the patient's best interest.

In such cases, providers should document the circumstances and the decision-making process in the patient's medical record.

Emergency medical situations may require immediate treatment without obtaining formal consent. However, it is important to try to obtain consent as soon as possible.

Emergency care should be provided in a manner that respects the patient's autonomy and ensures that they are fully informed. It is important to document the consent in writing, with the patient's signature and date.

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There are many reasons why a family may need help with their financial situation. It's important to understand the causes of financial strain and to provide support and resources to help families find solutions. This can include offering financial advice, assistance with budgeting, or referring them to local resources.

In the event of a financial crisis, it's important to work collaboratively with the family to develop a plan that addresses their specific needs. This may involve setting realistic goals, identifying sources of income, and developing a budget that reflects their priorities.

It's also important to provide ongoing support and encouragement to help families stay on track with their goals. This may involve regular check-ins, providing additional resources, or simply being a listening ear.

By working together to find solutions, families can overcome financial strain and regain control of their lives.
GUIDELINES FOR EMERGENCY RESPONSES

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152—GUIDELINES FOR PREVENTING

...
CONCLUSION

Long after the initial contact with the Funeral Director ends, the grief of the bereaved family could be better understood and supported by the family and friends. If the family is able to express their feelings and grief through open communication, it can be easier to deal with the emotions that arise. The family’s grief is normal and expected, and it is important for them to acknowledge and work through their feelings. Communication and support from friends and family members can be critical in the healing process.

NEXT STEPS: THE FUNERAL AND BEYOND

In the end, the family’s grief and loss continue. It is important for family and friends to be there for them, offering support and love. By being present and offering help, family and friends can play an important role in the healing process. 

Guidelines for Emergency Responders

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REFERENCES

Carey, P. B. (1987). "Baby pictures and not breathing." Emphasizing responsible infant care immediately following the discovery of the need for the infant's oxygen and respiration are often neglected or even overlooked. The infant's condition and the need for oxygen and respiration are essential for survival and the infant's ability to breathe. Therefore, it is crucial that caregivers are well-trained in infant resuscitation.

In reality, few nurses come to the hospital with sudden infant death syndrome (SIDS) certification. The lack of training for infant resuscitation is alarming. It is crucial to provide infants with immediate and effective intervention. The infant's condition and the need for oxygen and respiration are essential for survival and the infant's ability to breathe. Therefore, it is crucial that caregivers are well-trained in infant resuscitation.

Death can be viewed from three perspectives: clinical, legal, and human. Clinical death is defined as the irreversible loss of brain function and is considered the end of life. Legal death is defined as the moment when the heart stops beating and the heartbeat is no longer detected. Human death is defined as the moment when the brain stops functioning and the individual is declared deceased.

Guidelines for Emergency Responders


The Family and Sudden Infant Death Syndrome

Without Danger of Anoxia

The sudden and unexpected death of an infant or young child from causes that are not immediately apparent is a tragic event. In the United States, there is a well-known phenomenon called the SIDS (Sudden Infant Death Syndrome). This term describes the sudden and unexpected death of a seemingly healthy infant, typically during sleep. The cause of SIDS is not yet fully understood, but it is believed to be related to a combination of factors, including genetics, environment, and lifestyle.

The Psychological Impact and Management

The loss of a child is a traumatic event for the family. It can cause intense grief, shock, and disbelief. Parents may experience a range of emotions, including guilt, anger, and shame. It is important for families to seek support from loved ones, professionals, and support groups. Counseling and therapy can be beneficial in processing the emotions and finding ways to cope with the loss.

In addition to emotional support, parents may need to deal with practical issues, such as funeral arrangements, legal and financial matters, and school projects. It is important to take care of oneself during this time, and to allow oneself to express emotions and seek support from others.

The Family and Sudden Infant Death Syndrome

When no Danger of Anoxia

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The family and support network syndrome.

They may not fully comprehend the gravity of the situation. To help them, you
need to be open and honest. Use simple, clear language. Help them understand the
possibilities and limitations. Encourage them to ask questions and express
their feelings. 

Encourage them to seek support from others who have experienced similar situations.

For some families, this can be a difficult process. It can take time to come to terms with the
news. It is important to be patient and understanding. 

Psychological effects of AIDS on survivors.
women, who appeared more depressed and withdrawing [6]. Sometimes feelings of grief, sorrow, and helplessness can be intense. In women, it seemed to be more apparent and more pervasive.

In several years, I noticed that my attention was directed towards the depressed and withdrawn women more than towards the men. One person received more of the group's attention than the others. It was the one who seemed the most depressed and withdrawn. I began to notice that during group discussions, the men would often speak up and share their experiences, while the women would remain silent. This pattern continued throughout the sessions, and it was evident that the women were not as engaged in the discussions.

When I asked them why they were not participating, they explained that they were not feeling well and did not have the energy to participate. I encouraged them to share their thoughts and feelings, and I promised to be there for them. I also suggested that they might benefit from individual therapy, which could help them express their emotions more effectively.

In this way, I was able to help them understand that their feelings were normal and that it was okay to express them. I also explained that it was important for them to take care of themselves and to seek help when they needed it. Over time, they began to feel more comfortable sharing their thoughts and feelings with the group and with me.

In my opinion, it is crucial to recognize the impact of depression on individuals and to provide them with the necessary support. By listening and responding to their needs, we can help them overcome their challenges and improve their quality of life.
The family and sudden infant death syndrome

The family and sudden infant death syndrome (SIDS) is a tragic and often mysterious phenomenon. It is a leading cause of death in infants between the ages of 1 and 12 months, and it is a devastating experience for the families involved.

In recent years, medical research has made significant strides in understanding the factors that contribute to SIDS. While the exact cause of SIDS remains unknown, scientists have identified several risk factors, including prematurity, low birth weight, and a family history of SIDS.

One of the most challenging aspects of SIDS is the lack of a definitive cause. This makes it difficult for families to understand and accept the loss of their baby. The grief and loss experienced by these families can be profound, and they often feel isolated and unsupported.

Support from friends, family, and community resources can be invaluable during this time. It is important for caregivers to provide emotional support and to help families navigate the resources available to them.

SIDS research continues to evolve, and advances in medical technology and understanding of infant physiology offer hope for the future. With continued research and support, we can work together to reduce the impact of SIDS on families and our communities.

The Family and Sudden Infant Death Syndrome (SIDS)

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THE FAMILY AND SUDDEN INNATE DEATH SYNDROME

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Although the ideal family may or may not be a perfect fit, it is not a closed universe anymore.

The concept of psychological impact and management is crucial for understanding the effects of sudden infant death syndrome (SIDS) on families. Families often experience a range of emotions, including grief, shock, and confusion. Immediate support and counseling can help families navigate these difficult times.

Health Professionals:

It is crucial for health professionals to provide support and guidance during such a time of distress. They can help families understand the available resources and support networks. It is important to offer a non-judgmental space where families can express their feelings and receive reassurance.

Although the ideal family may or may not be a perfect fit, it is not a closed universe anymore.
Supporting Children

The Family and Support

An early intervention program, "Finding the Right Fit," was developed to address the needs of young children with autism spectrum disorder. The program is designed to provide support and intervention for families, caregivers, and educators. The approach is based on evidence-based practices and focuses on enhancing social, communication, and adaptive skills.

The program includes individualized support, parent education, and training in evidence-based strategies. It also provides opportunities for families to connect with other families and professionals.

The success of the program is measured through pre- and post-assessments, which evaluate children's progress in key areas.

Supporting children who have lost a child, the decision to have another child is difficult.
The Family and Sudden Infant Death Syndrome / 119

THE FAMILY AND SUDDEN INFANT DEATH SYNDROME / 119

References


ADDITIONAL RESOURCES

- SIDS Resource List
- First Responders Literature Order Form
- Indiana Family Helpline Flyer
- SIDS Case Management Flow Chart
# S.I.D.S. RESOURCE LIST

## SUDDEN INFANT DEATH SYNDROME PROJECT
Indiana State Department of Health  
Maternal and Child Health Services  
1330 West Michigan Street  
Indianapolis, IN 46206-1964

<table>
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<th>Role</th>
<th>Name</th>
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<th>Phone 2</th>
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<tbody>
<tr>
<td>Project Coordinator</td>
<td>Larry Humbert, A.C.S.W.</td>
<td>317/633-0722</td>
<td></td>
</tr>
<tr>
<td>Parent Consultant</td>
<td>Barb Himes</td>
<td>317/633-8466</td>
<td></td>
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<tr>
<td>Administrative Assistant</td>
<td>Susan Hopkins</td>
<td>317/633-8459</td>
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Parents and Professionals may also contact the S.I.D.S. Project Staff of the Indiana State Department of Health at:  
Indiana Family Helpline  
1-800-433-0746

## LOCAL SUPPORT NETWORKS

### CENTRAL INDIANA SIDS ALLIANCE
Serves Marion, Hamilton, Southern Boone, Hendricks, Johnson, Shelby and Hancock

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<thead>
<tr>
<th>Role</th>
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<tr>
<td>Central Indiana SIDS Alliance</td>
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### NORTHERN INDIANA SIDS ALLIANCE

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<tr>
<td>Elkhart County</td>
<td>Gladys Stevens</td>
<td>219/262-0245</td>
</tr>
<tr>
<td>St. Joseph County</td>
<td>Cathy Rosenthal</td>
<td>219/259-4836</td>
</tr>
<tr>
<td>Marshall, Kosciusko, Noble County</td>
<td>LuAnn Kolbe</td>
<td>219/546-5464</td>
</tr>
<tr>
<td>Cass County, Michigan</td>
<td>Lyn LaPierre</td>
<td>616/699-5886</td>
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### ALLEN, ADAMS, DEKALB, HUNTINGTON, WELLS and WHITLEY COUNTIES

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<tr>
<td>Allen County</td>
<td>Denise Lock</td>
<td>219/483-6393</td>
</tr>
<tr>
<td>Wells County</td>
<td>Suzanne Washler</td>
<td>219/337-5360</td>
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### VANDERBURGH COUNTY

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<tr>
<td>Vanderburgh County</td>
<td>Carol Palmer</td>
<td>812/428-0102</td>
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<tr>
<td>Home</td>
<td></td>
<td>812/863-0348</td>
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<tr>
<td>Work</td>
<td></td>
<td>802/827-1867</td>
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<tr>
<td>Jo Sayle, Vanderburgh County Health Dept.</td>
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### CLAY, PUTNAM, HENDRICKS, MONTGOMERY and PARKE COUNTIES

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<tr>
<td>Clay County</td>
<td>Gloria Beau</td>
<td>317/657-0003</td>
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### CLARK and FLOYD COUNTIES

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<tr>
<td>Clark County</td>
<td>Maria Donohue</td>
<td>812/283-0559</td>
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### MORGAN COUNTY

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<tbody>
<tr>
<td>Morgan County</td>
<td>Judi Grebel</td>
<td>317/831-5059</td>
</tr>
<tr>
<td>Theresa Staggs</td>
<td></td>
<td>317/831-7511</td>
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### JACKSON COUNTY

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<tbody>
<tr>
<td>Jackson County</td>
<td>Bena Jones</td>
<td>812/497-2405</td>
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### TIPPECANOE, BENTON, NORTHERN BOONE, CARROLL, CLINTON, FOUNTAIN, WARREN and WHITE

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<tr>
<th>County</th>
<th>Contact Person</th>
<th>Phone 1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tippecanoe County</td>
<td>Jackie Bahler, Kathryn Weil Center</td>
<td>317/449-5133</td>
</tr>
<tr>
<td>Benton County</td>
<td>Marcia Muller, Tippecanoe County Health Dept.</td>
<td>317/423-9221</td>
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### FULTON, WHITE, STARKE, PULASKI, CASS and JASPER COUNTIES

<table>
<thead>
<tr>
<th>County</th>
<th>Contact Person</th>
<th>Phone 1</th>
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</thead>
<tbody>
<tr>
<td>Fulton County</td>
<td>Joan Lauder, Pulaski Memorial Hospital</td>
<td>219/946-6131 \ Ext. 1180</td>
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</tbody>
</table>
# FIRST RESPONDER'S ORDER FORM

**Sudden Infant Death Syndrome Project**
1-800-433-0746 or 317/633-8459

<table>
<thead>
<tr>
<th>PAMPHLETS FOR FAMILIES</th>
<th>Quantity</th>
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<tbody>
<tr>
<td>Crib Death</td>
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<tr>
<td>Facts About SIDS for Child Care Providers</td>
<td></td>
</tr>
<tr>
<td>For Grandparents... A Double Grief</td>
<td></td>
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<tr>
<td>Healing a Father's Grief</td>
<td></td>
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<tr>
<td>SIDS Blue Card (Fact Card)</td>
<td></td>
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<tr>
<td>Robots and Goodbyes: A Grief Storybook</td>
<td>$1.50 each</td>
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<thead>
<tr>
<th>HANDOUTS (1 page each)</th>
<th>Quantity</th>
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<tbody>
<tr>
<td>Apnea and Other Apparent Life-Threatening Events</td>
<td></td>
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<tr>
<td>Infantine Apnea and SIDS</td>
<td></td>
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<tr>
<td>Parents and the Grieving Process</td>
<td></td>
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<tr>
<td>SIDS Information for the EMT</td>
<td></td>
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<tr>
<td>The Grief of Children</td>
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<tr>
<td>What is SIDS?</td>
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<thead>
<tr>
<th>INFORMATION FOR PROFESSIONALS</th>
<th>Quantity</th>
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<tbody>
<tr>
<td>Infant Death: Guidelines for Support of Parents in the Emergency Department and the Delivery of Death Notification</td>
<td></td>
</tr>
<tr>
<td>How to Distinguish Between SIDS and Child Abuse and Neglect</td>
<td></td>
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<tr>
<td>SIDS and Emergency Medical Personnel</td>
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<tr>
<th>INFANT DEATH SUPPORT SERIES</th>
<th>Quantity</th>
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<tr>
<td>Finding Answers with Compassion</td>
<td></td>
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<tr>
<td>Facts About SIDS for Police Officers</td>
<td></td>
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<tr>
<td>Discussing the Autopsy</td>
<td></td>
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<tr>
<td>If You Would Be An Effective Comforter to Bereaved Parents</td>
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</table>

Enclose a check or money order for the pamphlet entitled "Robots and Goodbyes: A Grief Storybook". Make check or money order payable to Indiana State Department of Health.

**SEND PAMPHLETS AND BROCHURES TO:**

NAME: ___________________________
ADDRESS: ________________________
CITY/STATE/ZIP: __________________
PHONE: __________________________

**AREA CODE** __________________

**COMPLETE AND RETURN TO:**

INDIANA STATE DEPARTMENT OF HEALTH
MATERNAL AND CHILD HEALTH SERVICES
1330 WEST MICHIGAN STREET
P.O. BOX 1964
INDIANAPOLIS, IN 46206-1964
The Indiana State Department of Health's TOLL-FREE telephone helpline.
Call to locate or receive information on:

- PREGNANCY HEALTH CARE
- WIC SITES / BREASTFEEDING SUPPORT
- HEALTHWATCH PROVIDERS
- CHILDREN'S SPECIAL HEALTH CARE SERVICES
- CHILD / ADOLESCENT HEALTH CARE
- MEDICAID PROVIDERS
- WOMEN'S HEALTH / FAMILY PLANNING SERVICES
- SUBSTANCE ABUSE PROGRAMS
- IMMUNIZATION / LEAD SCREENING SITES
- EMERGENCY SHELTERS / FOOD PANTRIES
- SUPPORT GROUPS
- SUDDEN INFANT DEATHS (SIDS)
- GENETIC/NEWBORN SCREENING SERVICES
- GED / JOB TRAINING SITES
- DAY CARE / RESPITE CARE
- STOP SMOKING / DRINKING PROGRAMS
- DENTAL CARE SERVICES
- MEDICAID TRANSPORTATION PROVIDERS

and MUCH MORE....

MON. - FRI. 7:30 A.M. TO 6:00 P.M.
ANSWERING MACHINE AVAILABLE AT ALL OTHER TIMES
SIDS CASE MANAGEMENT SYSTEM
FLOW CHART

SUSPECTED SIDS DEATH

| |
| |

COUNTY CORONER NOTIFIED
Duties
— orders autopsy
— communicates results of preliminary autopsy results to family in writing or by phone within 24-48 hours
— notifies public health nurse *
— communicates final autopsy results to family when report is available

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PUBLIC HEALTH NURSE NOTIFIED
Duties
— contacts family to schedule home visit
— conducts home visit and gives literature to family
— contacts local SIDS support group or SIDS parent contact (if available)
— makes follow-up calls and/or visits, if needed
— submits home visit report to Indiana State Department of Health, MCH Services

| |
| |

INDIANA STATE DEPARTMENT OF HEALTH
Duties
— sends SIDS Community Council letter to family that includes toll-free phone number
— receives copy of death certificate, creates case file and computerizes record
— reimburses public health nurse for completed home visits upon receipt of report form and claim voucher

* In Marion County, coroner notifies Maternal and Child Health Services who then notifies Prenatal Care Coordination Teams.

* In Putnam County, home visits are conducted by staff of Health Services Clinic of Putnam County, Ruth Ralph, Director.

* In Pulaski County, home visits are conducted by Nurse from Pulaski Memorial Hospital, Amy Bean.

* In Miami County, home visits are conducted by Jennifer Trobaugh, Social Services Director. (Dukes Memorial Hospital)
Note: Completion of this course does not meet the requirement for competency at the Hazmat Awareness and Operations Levels as set forth by OSHA 1910.120 and NFPA 472.

Course Objectives for Hazardous Materials for EMS Responders

At the completion of this course, the student
1. Shall be able to satisfy the knowledge competencies for First Responder Awareness and Operations Levels as set forth by OSHA 1910.120 and NFPA 472. Skill competencies are not included in this lesson.
2. Shall have the knowledge to complete the following tasks:
   a. Analyze a hazardous materials incident to determine the magnitude of the problem in terms of outcomes by completing the following tasks:
      i. Survey the hazardous materials incident to identify the containers and materials involved, determine whether hazardous materials have been released and evaluate the surrounding conditions
      ii. Collect hazard and response information from MSDS; CHEMTREC/CANUTEC/SETIQ; local, state, and federal authorities; and shipper/manufacturer contacts
      iii. Predict the likely behavior of a material as well as its container
      iv. Estimate the potential harm at a hazardous materials incident
3. Plan an initial response within the capabilities and competencies of available personnel, personal protective equipment, and control equipment by completing the following tasks:
   a. Describe the response objectives for hazardous materials incidents
   b. Describe the defensive options available for a given response objective
   c. Determine whether the personal protective equipment provided is appropriate for implementing each defensive option
   d. Identify the emergency decontamination procedures
4. Implement the planned response to favorably change the outcomes consistent with the local emergency response plan and the organization's standard operating procedures by completing the following tasks:
   a. Establish and enforce scene control procedures including control zones, emergency decontamination, and communications
   b. Initiate an incident management system (IMS) for hazardous materials incidents
   c. Understand the limitations of the average EMS responder regarding limited manpower, equipment, resources, etc.
   d. Perform defensive control functions identified in the local emergency response plan of action
5. Evaluate the progress of the actions taken to ensure that the response objectives are being met safely, effectively, and efficiently by completing the following tasks:
   a. Evaluate the status of the defensive actions taken in accomplishing the response objectives
   b. Communicate the status of the planned response

Surveying the Hazardous Materials Incident.

Given examples of both facility and transportation scenarios involving hazardous materials, the student shall survey the incident to identify the containers and materials involved, determine whether hazardous materials have been released, and evaluate the surrounding conditions and also shall meet the following requirements:

1. Given three examples each of liquid, gas, and solid hazardous materials, including various hazard classes, the student shall identify the general shapes of containers in which the hazardous materials are typically found.
2. Given examples of the following tank cars, the student shall identify each tank car by type as follows:
   a. Cryogenic liquid tank cars
   b. High-pressure tube cars
   c. Nonpressure tank cars
   d. Pneumatically unloaded hopper cars
   e. Pressure tank cars
3. Given examples of the following intermodal tanks, the student shall identify each intermodal tank by type and identify at least one material and its hazard class that is typically found in each tank as follows:
   a. Nonpressure intermodal tanks, such as the following:
   b. IM-101 (IMO Type 1 internationally) portable tank
   c. IM-102 (IMO Type 2 internationally) portable tank
   d. Pressure intermodal tanks
   e. Specialized intermodal tanks, such as the following:
      i. Cryogenic intermodal tanks
      ii. Tube modules
4. Given examples of the following cargo tanks, the student shall identify each cargo tank by type as follows:
   a. Nonpressure liquid tanks
   b. Low pressure chemical tanks
   c. Corrosive liquid tanks
   d. High pressure tanks
   e. Cryogenic liquid tanks
   f. Dry bulk cargo tanks
   g. Compressed gas tube trailers

5. Given examples of the following tanks, the student shall identify at least one material, and its hazard, that is typically found in each tank as follows:
   a. Nonpressure tank
   b. Pressure tank
   c. Cryogenic liquid tank

6. Given examples of the following nonbulk packages, the student shall identify each package by type as follows:
   a. Bags
   b. Carboys
   c. Cylinders
   d. Drums

7. Given examples of the following radioactive material containers, the student shall identify each container/package by type as follows:
   a. Type A
   b. Type B
   c. Industrial
   d. Excepted
   e. Strong, tight containers

8. Given examples of facility and transportation containers, the student shall identify the markings that differentiate one container from another.

9. Given examples of the following marked transport vehicles and their corresponding shipping papers, the student shall identify the vehicle or tank identification marking as follows:
   a. Rail transport vehicles, including tank cars
   b. Intermodal equipment including tank containers
   c. Highway transport vehicles, including cargo tanks

10. Given examples of facility containers, the student shall identify the markings indicating container size, product contained, and/or site identification numbers.

11. Given examples of facility and transportation situations involving hazardous materials, the student shall identify the name(s) of the hazardous material(s) in each situation.

12. The student shall identify the following information on a pipeline marker:
   a. Product
   b. Owner
   c. Emergency telephone number

13. Given a pesticide label, the student shall identify each of the following pieces of information, then match the piece of information to its significance in surveying the hazardous materials incident:
   a. Name of pesticide
   b. Signal word
   c. Pest control product (PCP) number (in Canada)
   d. Precautionary statement
   e. Hazard statement
   f. Active ingredient

14. Given a label for a radioactive material, the student shall identify vertical bars, contents, activity, and transport index.

15. The student shall identify and list the surrounding conditions that should be noted by the first responders when surveying hazardous materials incidents.

16. The student shall give examples of ways to verify information obtained from the survey of a hazardous materials incident.

17. The student shall identify at least three additional hazards that could be associated with an incident involving criminal or terrorist activity.

**Collecting Hazard and Response Information.**

Given known hazardous materials, the student shall collect hazard and response information using MSDS; CHEMTREC/CANUTEC/SETIQ; local, state, and federal authorities; and contacts with the shipper/manufacturer and also shall meet the following requirements: