

Cot deaths: the aftermath

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The legal consequences of cot death

THE investigation of sudden death is under the control of the Coroner in England, Wales and Northern Ireland, and the Procurator Fiscal in Scotland. For all practical purposes the process of enquiry is the same and the term coroner will be used to describe both systems. In England and Wales there are some 200 coroners, most of them part-time. The majority are either barristers or solicitors but some are medically qualified. Whether or not a death is investigated by a particular coroner depends on the mode of death and whether it has occurred in the coroner's geographical area — this usually conforms to a local government boundary.

Opinions vary among coroners as to whether to use their own plain clothes officers to make enquiries into cot deaths or whether to call upon uniformed police officers. These enquiries may be distressing to parents. The police try to be tactful and to cause the minimum of distress but the recent controversial statement by a pathologist that the majority of cot deaths are caused by parental intervention may regrettably lead to a hardening of their attitude. It should be noted that in one study of deaths reported by H.M. Coroner for Inner North London, a criminal cause was found in only one per cent of sudden infant deaths.¹ The Broderick Report (1971) on coroners and death certification says on the subject of cot death: 'A coroner should consider with the greatest care whom he should ask to visit the home and attempt to obtain from the parents relevant information about the history of events leading to the death.'

Parental reactions to the coroner's enquiry

It is during the first two days after the death of a child that the most intensive of the coroner's enquiries will be taking place — a time when the parents will still be in a state of shock. Most parents will have only a hazy idea of the coroner's duty. The more lurid forms of crime reporting in the daily papers may be their only source of information. They almost certainly will not know him or his officers. The fact that the coroner is making enquiries may in the eyes of the parents imply criticism of their actions.

The attitude of the investigating officers and whether or not they regard the household as a 'scene of crime' is important. One mother reports that she was visited, at hourly intervals, by a uniformed constable, a police sergeant and a police inspector after the discovery of her dead child, each one asking the same questions and giving the explanation that they were 'just checking the story'. Visits by uniformed police officers may be alarming to the parents, and to friends and neighbours their presence can arouse unjustified suspicions. This can be damaging later when bereaved parents are trying to live a normal life again within their own community.

The child's clothing and bedding may be photographed and taken away for forensic examination. While the necessity for this can be understood, if it is done without adequate explanation it can cause distress. The vital distinction needs to be drawn between investigation and accusation.

A number of cot deaths are reported to the police before the medical services or the coroner are contacted, and the police may be the first to arrive.

The picture is not all bleak and many parents testify to the humane way in which the police conducted their enquiries and the support they received from them.

Parents and the health services

General practitioners, health visitors and accident and emergency departments all have to deal with the consequences of cot death. Each of these has a different way of working and their attitude towards parents and towards cot death influences the way in which they react. The family doctor and the health visitor can often provide all the help and support that parents require but the shock of a cot death can strain the relationship between doctor and patient and also between the professions involved.

Cot death victims are often taken to hospital accident departments in the hope that everything possible will be done to revive the child. The reception given by the accident and emergency department may be crucial to the subsequent reaction of the parents to the death.

In some hospitals the policy is that a dead person may not be brought into the accident department and the death is certified in the ambulance on the way to the mortuary. There is no place for such a policy in the management of cot death and the child should always be taken inside the hospital.

The death of the child may be confirmed to the parents by an inexperienced junior doctor. The handling of the parents will be influenced by the emotional trauma felt by the doctor. This can lead to a process of detachment which enables the doctor to cope, but may result in a coolness of approach to the parents which may be interpreted as indifference. In a study of 50 cot deaths, 29 deaths were confirmed in an accident department.² This confirmation of death was made by a junior casualty doctor in 28 cases and by a doctor experienced in paediatrics in only one case. Training in the reactions to death experienced by parents and doctors would seem to be essential for doctors working in a hospital accident department.

Of all the professionals involved, the health visitor may have had most contact with the child and family when a cot death occurs, and may feel the shock most acutely. It is essential that the health visitor be informed of a death as soon as possible if embarrassing and painful episodes are to be avoided.

Any health visitor who is involved in dealing with parents after a cot death needs to be aware of the psychological reactions to bereavement, particularly the initial feelings of bewilderment and hostility. The health visitor is likely to be closely involved with a family if any subsequent child is born and the support and involvement of the health visitor with the family at the time of death can emphasize that the health visitor is someone the family can turn to for advice and support.³

The family's general practitioner may be called when the child is discovered dead. However, the tendency towards larger group practices and the increasing use of deputizing services means that this is becoming less frequent. It is in the cities, and in particular the inner cities, where the general practitioner is less likely to be on call out of hours and where the incidence of cot death is highest.

The initial sharing of grief with a known doctor can be helpful for bereaved parents and if the doctor is not personally available immediately after the death, arrangements should be made for the doctor to be informed so that a visit to the parents can be made as soon as possible. Parents may well be hostile to the doctor, especially if the child has been seen recently by the doctor, as is often the case. However, this hostility is usually only a

manifestation of grief. Early contact by the doctor and continuing support can restore confidence. A small study of families where cot death has occurred has shown that few parents change their general practitioner after the death.^{2,4,5}

There will be pressure on the family doctor to prescribe some sort of psychotropic drug to help the parents cope with this crisis, particularly anxiolytics or night sedation. In general terms this should be resisted. Grief can be prolonged if managed with anxiolytics or antidepressant drugs. The grief reaction appears to have a therapeutic role in the adjustment necessary after bereavement. In one study of parents, 44 out of 50 mothers were offered tranquilizers by the general practitioner. Of these 44, nine refused the offer and three accepted the drugs but did not use them. Of the remainder 16 found the drugs useful, six only possibly useful and 10 found them to be of no use at all. The prescription of a short-acting hypnotic drug for a few days may be helpful, particularly for the period between the death of the child and the funeral.⁵

The family doctor may be asked to look at siblings of the dead child in the belief that some contagious illness has been responsible for the death. Such requests should be dealt with sympathetically. In the cases of cot death which have occurred in my own practice, each one has been followed by an increase in the rate of consultation of young mothers who are worried by non-specific symptoms in their children. A similar increase occurred in the number of referrals to the doctor by health visitors. The doctor too may experience feelings of insecurity and doubt when treating children, particularly if the cot death victim had been seen a few hours before death. It is important that doctors learn to recognize and accept these feelings within themselves and discuss them with colleagues. Other members of the primary care team may also need support, particularly if they have had dealings with the family around the time of death. Everybody feels guilty, even when the diagnosis of cot death is confirmed.

Psychological reactions to cot death

The death of a child is difficult to accept even for those with strong religious convictions.^{6,7} The sudden loss of an apparently fit child is devastating and the effect on the family is profound.

The parents

The parents of a cot death child feel the loss most strongly. It is the mother who tends to be thought of as the principal victim although the father's response can be just as important.⁸ When a mother discovers the death she will scream and cry for help. There is usually an initial denial of the death of the child and frantic efforts at resuscitation may be made, even hours afterwards. The mother may pick up the child and run to a neighbour or relative or even to the local casualty department. Many parents have a vivid recollection of the moment of discovery, but the succeeding few hours are often lost from memory.

The body of the child will be taken from the parents either at home or in hospital. Mothers may have intense feelings about the body of the child and may express resentment and frustration when it is removed; they may even need to be physically restrained. Mothers have been known to carry the child's body with them for some hours. In contrast, some mothers may feel total detachment from the corpse and may even express feelings of revulsion neither wishing to see the child nor hold it. The autopsy may be seen as an act of desecration and parents may find it difficult to accept.⁹ Burial may not seem final to a mother and some have described the urge to dig up the body to find out if the child is really dead. One mother kept a vigil

by the grave for some 14 days after the death of her child. The feelings of the mother for the body may be the same as her feelings for the living child and during cold or wet weather she may be upset at the thought of the child exposed to the elements.

During the first two weeks after the death of the child both parents will often need to cry.¹⁰ Fathers, in particular, can find this a difficult problem and often express feelings of shame for this apparent weakness. Crying can be triggered off by some reminder of the child — an object, a situation or a particular household task. Some mothers find that they can continue with the daily routine of household chores and particularly caring for other children, but others cannot. All parents describe an initial feeling of physical numbness which can last weeks or even months and which only wears off gradually. They may also feel considerable anger towards outside agencies who may be held responsible for the death or who caused upset around the time of death. Many mothers report intense feelings of anger towards other parents whom they regard as less than perfect or even negligent. A frightening feeling experienced by all the mothers interviewed by the author was the urge to 'baby snatch' other children from prams when they were out shopping or visiting friends. Mothers describe the intense urge to hold another living child, yet fear the adverse publicity involved.¹¹

Psychiatric morbidity in parents, particularly the mother, has not been extensively studied.¹² There have been studies of widows and widowers after the death of their spouse which suggest an increase in psychiatric disorders in the first 12 months after bereavement. An increased mortality from cardiovascular disorders has also been noted. A preliminary report by Buglass¹³ from a study in Birmingham describes six cases in which cot death has been followed by psychiatric disorders which appear to be directly related to the death. One case, an overdose by the mother four weeks after the death of the child, typifies the stress in the husband-wife relationship. In that case, when the mother went to take her usual tablet of diazepam, her husband taunted her for the need to take tranquilizers, telling her to 'swallow the lot', which she did. In an interview, the husband was angry and resentful that support and sympathy had been shown to his wife but not to him.

The father often feels eclipsed by the concern and sympathy shown to his wife. It is difficult for him to work through his grief because in the normal male peer groups expressions of sympathy are usually perfunctory. In addition he may have to support his wife as she works through her grief. Not surprisingly this can lead to an impairment in his performance at work and so an additional mental strain is added. Many fathers will therefore present to the family doctor with vague stress symptoms such as chest pain, fatigue, headaches, insomnia or dyspepsia. These occasions should be taken as an opportunity to explore the father's feelings and anxieties.

Problems arise where the mother has been sterilized in the puerperium or where the father has had a vasectomy during the course of the pregnancy. The author has experienced three cases where a request for the reversal of sterilization has been made. In one case the request was made by the 33-year-old mother, not because a further pregnancy was immediately planned, but because she wanted the freedom to decide whether or not to have a further child. Reversal of sterilization carries a low success rate and the outcome is often unsatisfactory. However, some parents do apply for adoption. Cot death accounts for half of infant mortality¹¹ and those who recommend sterilization should be aware of the risks. There is a good case to be made for delaying sterilization after a birth until the child is 12 months old.

The surviving children

The reaction of surviving children to a cot death can be a curious mixture.¹⁴ The studies of bereavement among children have largely been confined to those where a parent has died and little work has been done on the feelings of children after the death of a sibling. It is known that a proportion of children referred to a child guidance clinic will be those who have been bereaved and the majority will show depressive symptoms. The concept of death develops very slowly in children and although by three years of age children are aware of the existence of death they do not appreciate its irreversibility; this only emerges at about 10 years of age.

In the case of cot death, siblings will be affected by several factors. The surviving children tend to be young and are therefore confused by the death and the sudden disappearance of the 'new baby'. They may feel a measure of guilt and a fear that they were somehow responsible, stemming from their resentment at the new arrival. The young child will be disturbed by the fuss which occurs when the death is discovered, the arrival of police, ambulance and neighbours, and the handing over of the child to be cared for by a friend or relative. The child may be left in the care of others for hours or even days until the parents are able to cope, and this adds to the bewilderment of the child. The grief and loss of control shown by the parents, can cause confusion and even fear.

Therefore, siblings may display a variety of disturbed behaviours. An increased attachment to one or other parent is common. There may be a refusal to go to sleep and nightmares are common; this only adds to the burden of the parents. Refusal to eat may occur and food fads which had been successfully overcome may reappear. The degree of disturbed behaviour shown by children often reflects the way a family shows its feelings among each other. If the parents do not normally show any emotion, the children may also try to suppress their feelings.

How we can help

Often the simplest way to help is by listening. When a cot death occurs, the general practitioner is probably the person best fitted to explain the postmortem findings to the parents; he will often be the most familiar and trusted medical adviser. The general practitioner should be aware of some of the factors associated with cot death and be prepared for some searching questions from the parents. The general practitioner should not discuss speculative ideas with parents. Some of the psychological sequelae to be expected are described here and a knowledge and acceptance of these will assist those doctors who have to cope with the consequences of cot death.

It is often difficult to assess whether or not one's counselling has been of help to families. Reassurance probably only comes to the doctor if a subsequent child is born to the family and is brought to the doctor for care.

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