



CLINICAL REPORT

Distinguishing Sudden Infant Death Syndrome From Child Abuse Fatalities

Guidance for the Clinician in Rendering
Pediatric Care

AMERICAN ACADEMY OF PEDIATRICS

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NATIONAL ASSOCIATION OF MEDICAL EXAMINERS

ABSTRACT

Fatal child abuse has been mistaken for sudden infant death syndrome. When a healthy infant younger than 1 year dies suddenly and unexpectedly, the cause of death may be certified as sudden infant death syndrome. Sudden infant death syndrome is more common than infanticide. Parents of sudden infant death syndrome victims typically are anxious to provide unlimited information to professionals involved in death investigation or research. They also want and deserve to be approached in a nonaccusatory manner. This clinical report provides professionals with information and suggestions for procedures to help avoid stigmatizing families of sudden infant death syndrome victims while allowing accumulation of appropriate evidence in potential cases of infanticide. This clinical report addresses deficiencies and updates recommendations in the 2001 American Academy of Pediatrics policy statement of the same name.

INTRODUCTION

Approximately 50 years ago, the medical community began a search to understand and prevent sudden infant death syndrome (SIDS).^{1,2} Almost simultaneously, medical professionals were awakened to the realities of child abuse.³⁻⁶ Since then, public and professional awareness of SIDS and fatal child abuse during infancy has increased steadily. More recently, well-validated reports of child abuse and infanticide—intentional suffocation presenting as apparent life-threatening events (ALTEs) and/or apparent SIDS—have appeared in the medical literature and in the lay press.^{7,8} The differentiation between SIDS and fatal child abuse can be a critical diagnostic decision.⁹ Additional funding for research into the causes and prevention of SIDS and child abuse is needed.

For more than a decade, SIDS (also called crib or cot death) has been defined as the sudden death of an infant younger than 1 year that remains unexplained after thorough case investigation, including performance of a complete autopsy, examination of the death scene, and review of the clinical history.¹⁰ Very recently, an expert panel of pediatric and forensic pathologists and pediatricians proposed a new definition of SIDS that is stratified to facilitate research, administrative, and vital-statistics purposes.¹¹ SIDS is the most common cause of death for children between 1 and 6 months of age. The incidence of SIDS peaks between 2 and 4

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The guidance in this report does not indicate an exclusive course of treatment or serve as a standard of medical care. Variations, taking into account individual circumstances, may be appropriate.

The Board of Directors of the National Association of Medical Examiners endorsed this clinical report in February 2006.

Key Words

sudden infant death syndrome, SIDS, child abuse

Abbreviations

SIDS—sudden infant death syndrome
ALTE—apparent life-threatening event
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months of age. Approximately 90% of SIDS cases occur before the age of 6 months.¹²

SIDS is suspected when a previously healthy infant, usually younger than 6 months, apparently dies during sleep, prompting an urgent call for emergency assistance. Often, the infant is fed normally just before being placed in bed to sleep, no outcry is heard, and the infant is found in the position in which he or she had been placed at bedtime or naptime. In some cases, cardiorespiratory resuscitation initiated at the scene is continued without apparent beneficial effect en route to the hospital, where the infant is finally declared dead. Evidence of terminal motor activity, such as clenched fists, may be seen. There may be serosanguineous, watery, blood-tinged, frothy, or mucoid discharge coming from the nose or mouth. Skin mottling and postmortem lividity in dependent portions of the infant's body are commonly found. Review of the medical history, scene investigation, radiographs, and autopsy are unrevealing.

Despite extensive research, our understanding of the causes of SIDS remains incomplete.¹³ The discovery of abnormalities in the arcuate nucleus of the brainstems of some SIDS victims suggests that true SIDS cases likely reflect delayed development of arousal, cardiorespiratory control, or cardiovascular control.^{14,15} When the physiologic stability of such infants becomes compromised during sleep, they may not arouse sufficiently to avoid the noxious insult or condition.¹⁶

The SIDS rates are 2 to 3 times higher among black, Alaska native, and some American Indian populations. SIDS has been linked epidemiologically in research studies to prone sleep position, sleeping on a soft surface, bed sharing, maternal smoking during or after pregnancy, overheating, late or no prenatal care, young maternal age, prematurity, low birth weight, and male gender.^{13,17–25} To date, no definitive evidence establishes causality between SIDS and recurrent cyanosis, apnea, ALTEs, or immunizations during infancy.

In recent years, national campaigns aimed at reducing prone sleeping during infancy have succeeded in dramatically decreasing the prevalence of prone positioning and may be associated with a decrease in the incidence of SIDS in the United States and in other countries.^{16,26–31} Many of these educational campaigns have also emphasized prompt evaluation and treatment of sick infants, appropriate immunizations, breastfeeding, and avoidance of bed sharing, overheating, overdressing or overbundling, gestational or postnatal passive smoke exposure, and soft sleep materials or surfaces.

SIDS: A DIAGNOSIS OF EXCLUSION

The diagnosis of SIDS is exclusionary and requires a complete autopsy, investigation of the circumstances of death,³² and review of case records that fail to reveal another cause of death. Infant deaths without such a comprehensive death investigation and infants that are

autopsied and whose deaths are carefully investigated but reveal substantial and reasonable uncertainty regarding the cause or manner of death should be designated as “undetermined.” Examples of undetermined cases include suspected (but unproven) infant death attributable to infection, metabolic disease, asphyxiation, or child abuse.

A diagnosis of SIDS reflects the clear admission by medical professionals that an infant's death remains unexplained. A young infant's death should be ruled as “attributable to SIDS” when all of the following are true:

- a complete autopsy is performed, including examination of the cranium and the cranial contents, and autopsy findings are compatible with SIDS;
- there is no evidence of acute or remote inflicted trauma, significant bone disease, or significant and contributory unintentional trauma, as judged by skeletal radiologic survey,³³ postmortem examination, and reliable clinical history;
- other causes and/or mechanisms of death are sufficiently excluded, including meningitis, sepsis, aspiration, pneumonia, myocarditis, trauma, dehydration, fluid and electrolyte imbalance, significant congenital defects, inborn metabolic disorders, asphyxia, drowning, burns, or poisoning;
- there is no evidence of toxic exposure to alcohol, drugs, or other substances; and
- thorough death- and/or incident-scene investigation and review of the clinical history reveal no other cause of death.

CHILD ABUSE FATALITIES BY SUFFOCATION

In some cases, it may be difficult or impossible to differentiate between a natural unexplained infant death, an unintentional or accidental infant death, and an unnatural (intentional) infant death. Recent literature has suggested that the index of suspicion for unnatural death should be higher, particularly in families in which an unexplained infant death has occurred previously.³⁴ More recent publications, however, provide some reassurance that a percentage of recurrent, unexplained infant deaths may be, in fact, natural.^{35,36}

Estimates of the incidence of infanticide among cases designated as SIDS range from less than 1% to 5%.^{7,9,37–39} The parents of some infants with recurrent ALTEs have been observed trying to suffocate and harm their infants.^{7,40} In Great Britain, covert video surveillance was used to assess child abuse risk in 39 young children referred for evaluation of recurrent ALTEs.⁷ Abuse was revealed in 33 of 39 cases, with documentation of intentional suffocation observed in 30 patients. Among 41 siblings of the 39 infants in the studies, 12 had previously died suddenly and unexpectedly. Although 11 of these deaths had been classified as SIDS, 4 parents later

admitted to suffocating 8 of these siblings. Other cases previously thought to be multiple SIDS cases within a family^{40,41} have been revealed to be cases of serial homicide by suffocation.^{8,34}

It is difficult, if not impossible, to distinguish at autopsy between SIDS and accidental or deliberate suffocation with a soft object.⁴² However, certain circumstances could indicate the possibility of intentional suffocation, including

- recurrent cyanosis, apnea, or ALTEs occurring only while in the care of the same person;
- age at death older than 6 months;
- previous unexpected or unexplained deaths of 1 or more siblings;
- simultaneous or nearly simultaneous death of twins⁴³;
- previous death of infants under the care of the same unrelated person⁴⁴; or
- evidence of previous pulmonary hemorrhage (such as marked siderophages in the lung).

MANAGEMENT OF SUDDEN UNEXPECTED INFANT DEATH

Most sudden infant deaths occur at home. Parents are shocked, bewildered, and distressed. Parents who are innocent of blame in their child's death often feel responsible nonetheless and imagine ways in which they might have contributed to or prevented the tragedy.⁴⁵ The appropriate medical professional response to every child death must be compassionate, empathic, supportive, and nonaccusatory. Inadvertent comments, as well as unnecessary questioning by medical personnel and investigators, are likely to cause additional stress. It is important for those in contact with parents during this time to remain nonaccusatory even while conducting a thorough death- and/or incident-scene investigation.

Personnel on first-response teams should be trained to make observations at the scene, including position of the infant, marks on the body, body temperature and rigor, type of bed or crib and any defects, amount and position of clothing and bedding, room temperature, type of ventilation and heating, and reaction of the caregivers. Guidelines are available for investigation of the circumstances of sudden, unexplained infant deaths.^{32,37} Paramedics and emergency department personnel should be trained to distinguish normal findings, such as postmortem anal dilation and lividity, from trauma attributable to abuse.^{46,47}

When a previously healthy infant has died unexpectedly in the absence of external evidence of injury or initial history/scene findings suggestive of another cause/manner of death, then a preliminary diagnosis of "possible SIDS" may be given. Assignment of this preliminary diagnosis should not limit or prevent subsequent thorough case investigation. Parents should be

informed that other causes and mechanisms of death will be excluded only by thorough investigation of the circumstances of death, postmortem examination, and review of case records. It should be explained to parents that these procedures might enable them and their physician to understand why their infant died and how other children in the family, including children born later, might be affected. Only after completion of a thorough case investigation (including performance of a complete autopsy, examination of the circumstances of death, and review of the clinical history) that does not reveal another cause of death should a diagnosis of SIDS be assigned as the cause of death.

Depending on local protocols and statutes, if permitted by the medical examiner, the family may be given an opportunity to see and hold the infant once death has been pronounced. It is suggested that an unrelated observer remain with the family throughout this period to serve as a witness should issues regarding postmortem artifacts arise later. A protocol⁴⁸ may help in planning how and when to address the many issues that require attention, including baptism, grief counseling, funeral arrangements, religious support, termination of breastfeeding, and the reactions of surviving siblings.^{45,49} All parents should be provided with information about sudden infant death^{50,51} and the telephone number of the local SIDS support group.⁴⁸

Controversy exists in the medical literature regarding the likelihood of a repetition of SIDS within a sibship.⁵²⁻⁵⁵ When an infant's sudden and unexpected death has been thoroughly evaluated and alternate genetic, environmental, accidental, or inflicted causes of death have been carefully excluded, parents should be informed that the risk of SIDS in subsequent children is not likely increased. Although repetitive sudden and unexpected infant deaths occurring within the same family should compel investigators to consider the possibility of serial homicide,⁸ it is important to remember that serial infant deaths within a sibship can also be explained by a fatal, inheritable disorder, 2 separate and unrelated natural disease processes, or an unrecognized environmental hazard.

In many states, multidisciplinary teams have been established to review child fatalities.^{56,57} Ideally, a multidisciplinary death-review committee should include a child welfare/child protective services social worker, a law enforcement officer, a public health officer, the medical examiner/coroner, a pediatrician with expertise in child maltreatment, a forensic pathologist, a representative of the emergency medical services (EMS) system, a pediatric pathologist, and the local prosecutor. The proceedings of multidisciplinary death-review committees should remain confidential. Sharing data among agencies helps to ensure that deaths attributable to child abuse are not missed and that surviving and subsequent siblings are protected. Some child-fatality teams rou-

tinely review infant deaths attributable to apparent SIDS.

THE IMPORTANCE OF AUTOPSY, SCENE INVESTIGATION, AND CASE REVIEW

The failure to differentiate fatal child abuse or other causes of death from SIDS is costly. In the absence of postmortem examination, investigation of the circumstances of death, and case review, child maltreatment is missed, familial genetic diseases go unrecognized, public health threats are overlooked, inadequate medical care goes undetected, product-safety issues remain unidentified, and progress in understanding the etiology of SIDS and other causes of unexpected infant death is delayed. Inaccurate vital statistics lead to inappropriate allocation of limited health care resources. By thoroughly investigating apparent SIDS cases, the potential hazards of defective infant furniture, water beds, and bean-bag mattresses have been identified and remedied.^{58,59}

If appropriate toxicological tests are not performed, infant deaths attributable to accidental or deliberate poisoning will be missed.^{46,60} For example, occult cocaine exposure is potentially lethal. One review of autopsies performed on stillborns and newborns in Los Angeles, California, in the early 1990s found that 17 (40%) of 43 infants who died before 2 days of age without an obvious cause of death at autopsy had toxicological evidence of cocaine exposure. Obviously, these exposures represent intrauterine exposures.⁶¹ Although the age and circumstances of death of these infants would exclude them from the SIDS population, it is enlightening to review the percentage of occult exposure in this population. A second review of 600 infant deaths revealed evidence of cocaine exposure in 16 infants (2.7%) younger than 8 months who died suddenly and unexpectedly.⁶² "Lethal" concentrations of cocaine and many other drugs in infancy are not yet established.

Neither child abuse nor SIDS is rare. Some young victims of nonlethal child maltreatment will die from SIDS. In such cases, the failure to differentiate objectively between fatal child abuse and SIDS could result in an inappropriate criminal investigation and/or prosecution for homicide.

POSTMORTEM IMAGING

Radiographic skeletal surveys performed before autopsy in cases of possible SIDS may reveal evidence of traumatic skeletal injury or skeletal abnormalities indicative of a naturally occurring illness. Ideally, the skeletal survey should be performed in a manner comparable to that recommended for living infants in whom abuse is suspected^{63,64} and reviewed by a physician experienced in identifying the subtle radiologic alterations seen with abuse, as well as findings that may be confused with inflicted injuries. Thorough documentation of all sites of suspected skeletal injury may require additional proce-

dures that may include specimen resection, high-detail specimen radiography, and histologic analysis. The presence of both old and new traumatic injuries identified on skeletal survey before autopsy may suggest inflicted injuries and may lend focus to the postmortem examination, investigation of the circumstances of death, and police investigation.^{33,65}

PATHOLOGY

The American Academy of Pediatrics and the National Association of Medical Examiners (NAME) endorse universal performance of autopsies on infants who die suddenly and unexpectedly by forensic pathologists experienced in the diagnosis of SIDS.⁶⁶ Postmortem findings in cases of fatal child abuse most often reveal cranial injuries, abdominal trauma (eg, liver laceration, hollow viscous perforation, or intramural hematoma), burns, or drowning as the cause of death.⁶⁷⁻⁷⁰ Although cytomegalovirus inclusion bodies have been identified in some infants who died suddenly and unexpectedly, a definitive causal link between cytomegalovirus infection and SIDS has not been established.⁷¹ Forensic pathologists establish the diagnosis of SIDS by exclusion when, after a thorough investigation including a complete autopsy, they are unable to identify a specific cause for a child's death.⁴⁶

Inborn errors of metabolism⁷²⁻⁷⁴ have been implicated in a small percentage of sudden unexplained deaths in infants with autopsy findings consistent with SIDS. When repetitive, sudden, and unexpected infant deaths occur within a sibship, thorough evaluation to exclude or confirm an inborn error of metabolism is essential. Analysis of blood and bile may facilitate diagnosis of a fatal inborn error of metabolism. Blood tests for evaluation of many metabolic disorders are now available at low cost. Many medical examiners routinely screen all victims of sudden unexpected infant death for inborn errors of metabolism at autopsy. If an inborn error of metabolism is suspected by autopsy findings (eg, hepatic steatosis) or history (eg, previous unexpected deaths in childhood in the family), then the forensic pathologist may elect to retain additional tissues such as brain, liver, kidney, heart, muscle, adrenal gland, and/or pancreas for further analysis, pending the results of the postmortem metabolic screening.

CONCLUSIONS

The following are important components in the evaluation of sudden, unexplained infant deaths:

- accurate history taking by emergency responders and medical personnel at the time of death and immediate transmission of this historical information to the medical examiner or coroner;
- prompt investigation of the scene^{32,37} at which the infant was found lifeless or unresponsive and careful

interviews of household members by knowledgeable individuals with the legal authority and mandate to conduct such investigations;

- appropriate consultations with available medical specialists (eg, pediatrician, pediatric pathologist, pediatric radiologist, and/or pediatric neuropathologist) by medical examiners and coroners;
- complete autopsy performed by a forensic pathologist within 24 hours of death, including examination of the all major body cavities including cranial contents, microscopic examination of major organs, radiographic examination, and toxicological and metabolic screening;
- collection of medical history through interviews of caregivers, interviews of key medical providers, and review of previous medical charts;
- maintenance of an unbiased, nonaccusatory approach to parents during the death-review process;
- consideration of intentional asphyxia in cases of unexpected infant death with a history of recurrent cyanosis, apnea, or ALTEs witnessed only by a single caregiver;
- use of accepted diagnostic categories on death certificates as soon as possible after review;
- prompt imparting of information to parents when results indicate SIDS or accidental or medical causation of death; and
- review of collected data by locally based infant death-review teams⁵⁷ with participation of the medical examiner or coroner.

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REFERENCES

1. Werne J, Garrow I. Sudden apparently unexplained death during infancy. I. Pathologic findings in infants found dead. *Am J Pathol.* 1953;29:633–675
2. Adelson L, Kinney ER. Sudden and unexpected death in infancy and childhood. *Pediatrics.* 1956;17:663–699
3. Caffey J. Multiple fractures in long bones of infants suffering from chronic subdural hematoma. *AJR.* 1946;56:163–173
4. Silverman FN. The roentgen manifestations of unrecognized skeletal trauma in infants. *AJR.* 1953;69:413–427
5. Adelson L. Slaughter of the innocents: a study of forty-six homicides in which the victims were children. *N Engl J Med.* 1961;264:1345–1349
6. Kempe CH, Silverman FN, Steele BF, Droegemueller W, Silver HK. The battered-child syndrome. *JAMA.* 1962;181:17–24
7. Southall DP, Plunkett MC, Banks MW, Falkov AF, Samuels MP. Covert video recordings of life-threatening child abuse: lessons for child protection. *Pediatrics.* 1997;100:735–760
8. Firstman R, Talan J. *The Death of Innocents: A True Story of Murder, Medicine, and High-Stakes Science.* New York, NY: Bantam Books; 1997
9. Reece RM. Fatal child abuse and sudden infant death syndrome: a critical diagnostic decision. *Pediatrics.* 1993;91:423–429
10. Willinger M, James LS, Catz C. Defining the sudden infant death syndrome (SIDS): deliberations of an expert panel convened by the National Institute of Child Health and Human Development. *Pediatr Pathol.* 1991;11:677–684
11. Krous HF, Beckwith B, Byard RW, et al. Sudden infant death syndrome and unclassified sudden infant deaths: a definitional and diagnostic approach. *Pediatrics.* 2004;114:234–238
12. Peterson DR. Clinical implications of sudden infant death syndrome epidemiology. *Pediatrician.* 1988;15:198–203
13. American Academy of Pediatrics, Task Force on Sudden Infant Death Syndrome. The changing concept of sudden infant death syndrome: diagnostic coding shifts, controversies regarding the sleeping environment, and new variables to consider in reducing risk. *Pediatrics.* 2005;116:1245–1255
14. Kinney HC, Filiano JJ, Sleeper LA, Mandell F, Valdes-Despena M, White WF. Decreased muscarinic receptor binding in the arcuate nucleus in sudden infant death syndrome. *Science.* 1995;269:1446–1450
15. Panigrahy A, Filiano JJ, Sleeper LA, et al. Decreased kainate binding in the arcuate nucleus of the sudden infant death syndrome. *J Neuropathol Exp Neurol.* 1997;56:1253–1261
16. American Academy of Pediatrics, Task Force on Infant Sleep Position and Sudden Infant Death Syndrome. Changing concepts of sudden infant death syndrome: implications for infant sleeping environment and sleep position. *Pediatrics.* 2000;105:650–656
17. Hoffman HJ, Damus K, Hillman L, Krongrad E. Risk factors for SIDS. Results of the National Institute of Child Health and Human Development SIDS cooperative epidemiological study. *Ann N Y Acad Sci.* 1988;533:13–30
18. Hoffman HJ, Hillman LS. Epidemiology of the sudden infant death syndrome: maternal, neonatal, and postneonatal risk factors. *Clin Perinatol.* 1992;19:717–737
19. Ponsonby AL, Dwyer T, Gibbons LE, Cochrane JA, Wang YG. Factors potentiating the risk of sudden infant death syndrome associated with prone position. *N Engl J Med.* 1993;329:377–382

20. Kemp JS, Nelson VE, Thach BT. Physical properties of bedding that may increase risk of sudden infant death syndrome in prone-sleeping infants. *Pediatr Res*. 1994;36:7-11
21. Chiodini BA, Thach BT. Impaired ventilation in infants sleeping face down: potential significance for sudden infant death syndrome. *J Pediatr*. 1993;123:686-692
22. Jeffery HE, Megevand A, Page H. Why the prone position is a risk factor for sudden infant death syndrome. *Pediatrics*. 1999;104:263-269
23. MacDorman MF, Cnattingius S, Hoffman HJ, Kramer MS, Haglund B. Sudden infant death syndrome and smoking in the United States and Sweden. *Am J Epidemiol*. 1997;146:249-257
24. Schoendorf KC, Kiely JL. Relationship of sudden infant death syndrome to maternal smoking during and after pregnancy. *Pediatrics*. 1992;90:905-908
25. Fleming PJ, Blair PS, Bacon C, et al. Environment of infants during sleep and risk of sudden infant death syndrome: results of 1993-5 case-control study for confidential inquiry into stillbirths and deaths in infancy. *BMJ*. 1996;313:191-195
26. Willinger M, Hoffman HJ, Wu KT, et al. Factors associated with the transition to non-prone sleep positions of infants in the United States: the National Infant Sleep Position Study. *JAMA*. 1998;280:329-335
27. Mitchell EA, Brunt JM, Everard C. Reduction in mortality from sudden infant death in New Zealand: 1986-92. *Arch Dis Child*. 1994;70:291-294
28. Platt MJ, Pharoah PO. Child health statistical review, 1996. *Arch Dis Child*. 1996;75:527-533
29. Dwyer T, Ponsonby AL, Blizzard L, Newman NM, Cochrane JA. The contribution of changes in prevalence of prone sleeping position to the decline in sudden infant death syndrome in Tasmania. *JAMA*. 1995;273:783-789
30. Wennergren G, Alm B, Oyen N, et al. The decline in the incidence of SIDS in Scandinavia in its relation to risk-intervention campaigns. *Acta Paediatr*. 1997;86:963-968
31. US Public Health Service; American Academy of Pediatrics; SIDS Alliance; Association of SIDS and Infant Mortality Programs. Reduce the risk of sudden infant death syndrome (SIDS). Available at: www.aap.org/new/sids/reduceth.htm. Accessed March 25, 2005
32. Centers for Disease Control and Prevention. Guidelines for death scene investigation of sudden, unexplained infant deaths: recommendations of the Interagency Panel on Sudden Infant Death Syndrome. *MMWR Recomm Rep*. 1996;45(RR-10):1-22
33. Kleinman PK, Blackburn BD, Marks SC, Karellas A, Belanger PL. Radiologic contributions to the investigation and prosecution of cases of fatal infant abuse. *N Engl J Med*. 1989;320:507-511
34. Meadow R. Unnatural sudden infant death. *Arch Dis Child*. 1999;80:7-14
35. Carpenter RG, Waite A, Coombs RC. Repeat sudden unexpected and unexplained infant deaths: natural or unnatural? *Lancet*. 2005;365:29-35
36. Hill R. Multiple sudden infant deaths: coincidence or beyond coincidence? *Paediatr Perinat Epidemiol*. 2004;18:320-326
37. Bass M, Kravath RE, Glass L. Death-scene investigation in sudden infant death. *N Engl J Med*. 1986;315:100-105
38. McClain PW, Sacks JJ, Froehlke RG, Ewigman BG. Estimates of fatal child abuse and neglect, United States, 1979 through 1988. *Pediatrics*. 1993;91:338-343
39. Kukull WA, Peterson DR. Sudden infant death and infanticide. *Am J Epidemiol*. 1977;106:485-486
40. Rosen CL, Frost JD Jr, Bricker T, Tarnow JD, Gillette PC, Dunlavy S. Two siblings with recurrent cardiorespiratory arrest: Munchausen syndrome by proxy or child abuse? *Pediatrics*. 1983;71:715-720
41. Steinschneider A. Prolonged apnea and the sudden infant death syndrome: clinical and laboratory observations. *Pediatrics*. 1972;50:646-654
42. Valdes-Dapena M. The sudden infant death syndrome: pathologic findings. *Clin Perinatol*. 1992;19:701-716
43. Groothuis JR, Altemeier WA, Robarge JP, et al. Increased child abuse in families with twins. *Pediatrics*. 1982;70:769-773
44. Meadow R. Suffocation, recurrent apnea, sudden infant death. *J Pediatr*. 1990;117:351-357
45. Limerick S. Family and health-professional interactions. *Ann N Y Acad Sci*. 1988;533:145-154
46. DiMaio DJ, DiMaio VJM. *Forensic Pathology*. New York, NY: Elsevier Science Publishing Co Inc; 1989:289-321
47. Kirschner RH, Stein RJ. The mistaken diagnosis of child abuse: a form of medical abuse? *Am J Dis Child*. 1985;139:873-875
48. Association of SIDS and Infant Mortality Programs. The unexpected death of an infant or child: standards for services to families. Available at: www.asip1.org/pdf/standards.pdf. Accessed March 25, 2005
49. American Academy of Pediatrics, Committee on Psychosocial Aspects of Child Family Health. The pediatrician and childhood bereavement. *Pediatrics*. 2000;105:445-447
50. First Candle/SIDS Alliance. Available at: www.sidsalliance.org. Accessed February 17, 2005
51. National SIDS/Infant Death Resource Center. Available at: www.sidscenter.org. Accessed February 17, 2005
52. Peterson DR, Chinn NM, Fisher LD. The sudden infant death syndrome: repetitions in families. *J Pediatr*. 1980;97:265-267
53. Oyen N, Skjaerven R, Irgens LM. Population-based recurrence risk of sudden infant death syndrome compared with other infant and fetal deaths. *Am J Epidemiol*. 1996;144:300-305
54. Irgens LM, Skjaerven R, Peterson DR. Prospective assessment of recurrence risk in sudden infant death syndrome siblings. *J Pediatr*. 1984;104:349-351
55. Irgens LM, Oyen N, Skjaerven R. Recurrence of sudden infant death syndrome among siblings. *Acta Paediatr Suppl*. 1993;82(suppl 389):23-25
56. Kaplan SR, Granik LA, eds. *Child Fatality Investigative Procedures Manual*. Chicago, IL: American Bar Association; 1991
57. Granik LA, Durfee M, Wells SJ. *Child Death Review Teams: A Manual for Design and Implementation*. Chicago, IL: American Bar Association; 1991
58. Kemp JS, Thach BT. Sudden death in infants sleeping on polystyrene-filled cushions. *N Engl J Med*. 1991;324:1858-1864
59. Ramanathan R, Chandra S, Gilbert-Barnes E, Franciosi R. Sudden infant death syndrome and water beds [letter]. *N Engl J Med*. 1988;318:1700
60. Perrot LJ, Nawojczyk S. Nonnatural death masquerading as SIDS (sudden infant death syndrome). *Am J Forensic Med Pathol*. 1988;9:105-111
61. Rogers C, Hall J, Muto J. Findings in newborns of cocaine-abusing mothers. *J Forensic Sci*. 1991;36:1074-1078
62. Mirchandani HG, Mirchandani IH, Hellman F, English-Rider R, Rosen S, Laposata EA. Passive inhalation of free-base cocaine ("crack") smoke in infants. *Arch Pathol Lab Med*. 1991;115:494-498
63. American College of Radiology. ACR practice guidelines for skeletal surveys in children. In: *ACR Practice Guidelines and Technical Standards*. Reston, VA: American College of Radiology; 2005:107-111. Available at: www.acr.org/s_acr/bin.asp?TrackID=6&SID=16&DID=12286&CID=5436&VID=26&DOC=File.PDF. Accessed May 17, 2006

64. American Academy of Pediatrics, Section on Radiology. Diagnostic imaging of child abuse. *Pediatrics*. 2000;105:1345–1348
65. Kleinman PK. Postmortem imaging. In: *The Diagnostic Imaging of Child Abuse*. 2nd ed. St Louis, MO: Mosby Inc; 1998:242–246
66. American Academy of Pediatrics, Committee on Child Abuse and Neglect and Committee on Community Health Services. Investigation and review of unexpected infant and child deaths. *Pediatrics*. 1999;104:1158–1160
67. Brown RH. The battered child syndrome. *J Forensic Sci*. 1976; 21:65–70
68. Lauer B, ten Broeck E, Grossman M. Battered child syndrome: review of 130 patients with controls. *Pediatrics*. 1974;54:67–70
69. Scott PD. Fatal battered baby cases. *Med Sci Law*. 1973;13: 197–206
70. Wecht CH, Larkin GM. The battered child syndrome: a forensic pathologist's viewpoint. *Med Trial Tech Q*. 1981;28: 1–24
71. Variend S, Pearse RG. Sudden infant death and cytomegalovirus inclusion disease. *J Clin Pathol*. 1986;39:383–386
72. Howat AJ, Bennett MJ, Variend S, Shaw L, Engel PC. Defects of metabolism of fatty acids in the sudden infant death syndrome. *Br Med J (Clin Res Ed)*. 1985;290:1771–1773
73. Vawter GF, McGraw CA, Hug G, Kozakewich HP, McNaulty J, Mandell F. An hepatic metabolic profile in sudden infant death (SIDS). *Forensic Sci Int*. 1986;30:93–98
74. Harpey JP, Charpentier C, Paturneau-Jonas M. Sudden infant death syndrome and inherited disorders of fatty acid beta-oxidation. *Biol Neonate*. 1990;58(suppl 1):70–80

CELLPHONES DON'T BELONG IN SCHOOL

“You’re a teacher in the New York City public school system. It’s September, and you’re lecturing the class on the structure of an essay. Your students need to know this information to pass your class and the Regents exam, and you, of course, hope that one day our talented students will dazzle and amaze English professors all over the country. You turn your back to write the definition of ‘thesis’ on the chalkboard. It takes about 15 seconds. You turn around to the class expecting to see 25 students scribbling the concept in their notebook. Instead, you see a group of students who have sprung appendages of technology. Jose has grown an earphone. Maria’s thumbs have sprouted a two-way. Man Keung, recently arrived from China, is texting away on a cell phone connected to his wrist. And Christina appears to be playing Mine Sweeper on a Pocket PC on her lap. . . . But as a former New York City public school teacher, I can tell you that cellphones don’t belong in the classroom. A student with a cellphone is an uninterested student, one with a short attention span who cares more about his social life than education.”

Scaccia J. *New York Times*. May 23, 2006

Noted by JFL, MD

Distinguishing Sudden Infant Death Syndrome From Child Abuse Fatalities

Kent P. Hymel and National Association of Medical Examiners

Pediatrics 2006;118;421

DOI: 10.1542/peds.2006-1245

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