AN ABSTRACT OF THE THESIS OF

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Title: "All the things you ask of me": Law Enforcement Experiences of Infant Death Investigation

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The sudden and unexpected death of a seemingly healthy infant sets in motion a number of linked processes with potentially complex and far-reaching ramifications. While individuals, families and communities grapple with the shock and heartbreak associated with the loss of a young life, a chain of multidisciplinary investigative responsibilities is initiated to address the question of causation. Currently, very little is known about how infant death investigations are carried out, and perhaps more importantly, how variability within structures and processes influence individual or aggregate case outcomes.

The purpose of this study was to examine the lived experiences of law enforcement officials charged with investigating sudden unexpected infant deaths (SUID) in nine Pacific Northwest jurisdictions. Data collected from open-ended, semi-structured interviews (n=26) revealed three dynamic and

interrelated tensions experienced by law enforcement during the process of infant death investigation. Study participants described navigating: 1) emotional situations when professional neutrality fails; 2) high-stakes under-resourced investigations; and 3) interactions with parents who must be considered simultaneously as victims and potential suspects. Ultimately, these tensions are amplified by multiple institutional constraints and hegemonic norms and values that characterize law enforcement as an occupational culture.

Recommendations for mitigating these tensions also emerged from participants' narratives and were considered in the context of greater law enforcement culture. These recommendations include: 1) Recognizing the exceptionality of infant death investigation; 2) Prioritizing the process of infant death investigation; 3) Clearly defining and delineating roles and responsibilities; and, 4) Developing specialized multi-agency response teams.

Overall, this research reveals law enforcement as much more than the oversimplified and caricaturized, aggressive figures commonly portrayed in popular and mass media. Through their own narratives, we see officers struggling to manage one of the many difficult roles they must play. Their stories also reveal occupational norms and values that serve them well in other circumstances, but falter in the context of infant death investigations. Ultimately, this research reveals that, with so much at stake and with all the varied and critical things we ask of law enforcement, we must turn a critical lens inward on the systems that both sustain and constrain the efficacy of this critical police function.

“All the things you ask of me”: Law Enforcement Experiences of Infant Death Investigation

by
Jennifer R. Schindell

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I understand that my thesis will become part of the permanent collection of Oregon State University libraries. My signature below authorizes release of my thesis to any reader upon request.

Jennifer R. Schindell, Author

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Dispatcher: "Ma'am. Ma'am! I need you to calm dow-"

Woman: "Is somebody coming? Please somebody help my baby! Please … He was fine…[breathless sobbing] I don't think he is breathing! I need help! Please send someone…"[1]

The sudden and unexpected death of a seemingly healthy infant sets in motion a number of linked processes with potentially complex and far-reaching ramifications. While individuals, families and communities grapple with the shock and heartbreak associated with the loss of a young life, a chain of multidisciplinary investigative responsibilities is initiated to address the question of causation. Sudden infant deaths are often complex puzzles— complicated clinical, psychosocial and epidemiologic phenomena – in which family members and caregivers are usually grieving victims. Unfortunately, some infant deaths result from fatal injuries, neglect or other unthinkable acts perpetrated by the very family members or caregivers expected to protect that young life.

In some jurisdictions throughout the United States, specially trained investigators manage the sensitive and complicated process of interacting with

[1] The text of this call is an amalgam of several calls edited to convey the content of such calls, while also protecting the identity of the victims.

the infant death scene and witnesses (Graham 2009; Pasquale-Styles 2007). In other jurisdictions, law enforcement officials – those tasked with responding to any event resulting in a cry for help - are charged with this weighty responsibility. Currently, very little is known about how infant death investigations are carried out, or how these processes influence investigators and case outcomes.

The purpose of this study was to examine the lived experiences of law enforcement officials charged with investigating sudden unexpected infant deaths (SUID) in nine Pacific Northwest jurisdictions. Using data collected from open-ended, semi-structured interviews (n=26), I explore dynamic tensions that emerge within the context of law enforcement culture generally, and the unique and rare context of SUID investigations specifically. Using thick description to create an "experience near" (Geertz 1973), this work examines law enforcement experiences and perspectives during emotionally charged, high-stakes infant death investigations that are often complicated by multiple sources of ambiguity and other barriers to successful completion. Specifically, I identify three major tensions that function to increase the difficulty of these investigations. Study participants described struggling to navigate: 1) emotional situations when professional neutrality fails; 2) high-stakes under-resourced investigations; and 3) interactions with parents who must be considered simultaneously as victims and suspects. Fortunately, the stories of law enforcement participants also reveal suggestions for reform. Officers' narratives provided a foundation upon which to build recommendations that I argue will help to improve the efficacy of

investigations, while simultaneously reducing tensions experienced by the investigators and parents involved in the tragic scenario of a sudden infant death.

Study Background

In the United States, infants who die suddenly and unexpectedly are referred to either a medical examiner or coroner to determine *cause* and *manner* of death (Camperlengo 2012; CDC 2007; Hickman 2007; SWGMDI 2014). "Cause of death" is a medical opinion as to the underlying disease or injury progression ultimately resulting in the death (Adams 2006; CDC 2007). "Manner of death" is typically classified as: Natural, Accident, Homicide, Suicide or Undetermined – See Table 1.

Accurate determination of cause and manner of any death is essential for both the individual case and the dependent, aggregate statistics these cases give rise to. Cause and manner of death are recorded on death certificates, which in turn serve various critical functions in the United States, including: evidence in court cases, data for medical research, and determination of local, statewide, regional and national priorities for public health funding and interventions (Adams 2006; CDC 2007; Swain et al. 2005). When a previously healthy infant dies suddenly and without apparent reason, cause and manner of death determination take on particular significance because, even in high-resource countries, the cause of most sudden unexpected infant deaths (SUIDs) remains unknown (Kemkes 2009; Moon 2007). A separate and concerning reality of infant death investigation is that some infant murders remain undetected and

unresolved because they cannot be distinguished from unexplained natural deaths by autopsy alone (Firstman & Talan 2001; Hymel 2010; Jenny and Isaac 2006; Weber et al. 2012).

Table 1 – Standard Manner of Death Classifications

Because infants are not capable of intentionally taking their own lives (SUICIDE), manner of death in an infant case must generally be classified as one of the following:

NATURAL: due exclusively to natural disease
Examples: viral myocarditis, inborn errors of metabolism, etc.

ACCIDENT: due to an unintentional outside action or event
Examples: accidental asphyxiation, accidental traumatic injuries from a motor vehicle crash, accidental exposure to carbon monoxide, etc.

HOMICIDE: occurring at the hand of another individual
Examples: inflicted injury, intentional smothering, deliberate poisoning, etc.

UNDETERMINED: the investigation failed to yield sufficient evidence or information to clearly identify manner of death

(CDC 2006; Spitz 2006; Swain 2005)

Though the medical examiner or coroner bears ultimate responsibility of certifying the cause and manner for a sudden unexpected infant death, medicolegal death investigations unfold as multidisciplinary endeavors dependent upon information obtained from a variety of sources (Bajanowski 2006; Newton and Vandeven 2006; Platt 2005; Weber and Sebire 2009). Law enforcement officials invariably play a significant role in the SUID process (Bajanowski 2006; Byard and Jensen 2008; Landi 2005; Weyland 2004). In smaller and/or poorly funded jurisdictions, law enforcement may serve as the

sole investigators of deaths. However, even when designated medicolegal death investigators participate on behalf of the coroner or medical examiner, law enforcement officials can still contribute significantly to a case. Law enforcement patrol representatives are often among the first to arrive at any death scene, and they, therefore, have the potential to significantly influence the trajectory of any investigation (Geberth 2006). In addition, law enforcement investigators bear the burden of any resultant criminal investigation for cases determined to be prosecutable.

Among death investigations, SUID investigations stand out as unique in their complexity, difficulty, ambiguity and reliance upon high-quality, detailed and nuanced information from a variety of sources outside of the autopsy suite (Landi et al. 2005; Newton 2006; O'Neal 2007). The relative success or failure of the entire investigation may hinge upon tasks, such as the initial scene response and witness/caregiver interviews, routinely performed by on the ground investigators, such as law enforcement (Diebold Hargrave 2011; Knight 2005; Landi et al. 2005). As is the case in any medicolegal death investigation inquiry, outcomes depend on which questions are asked, the manner in which the questions are administered, and the ways in which responses are interpreted (Byard 2008; Geberth 2006; Pasquale-Styles 2007; Platt and Kohler 2006). The influence of these factors on infant death investigations are magnified by the need to navigate completion of these investigative tasks, while interacting with witnesses who may be responsible for criminal acts against the child (Firstman

and Talan 1997; Hymel 2010; Jenny and Isaac 2006; Southall 1997), but are more commonly grieving caregivers suffering the greatest tragedy of their lives.

It is clearly imperative, from a public safety perspective, that cases of homicide be uncovered. It is equally vital that any cloud of suspicion be removed from innocent caregivers who will have to live with the outcomes of the investigation and the impacts of the devastating loss. In addition, modifiable risk factors and areas for further research need to be identified. None of these goals can be accomplished without a complete and competent investigation (AAP 2011; Corey et al. 2007; Knight 2005; Omalu 2007).

Decades of research and popular discourse detail efforts to better understand the causes of SUID (Beckwith 2003; Byard and Krous 2001; Hymel 2010; Firstman and Talan 1997; Krous 2004; Willinger 1991), yet scientific studies have failed to reveal a pathognomic cause for the vast majority of these deaths (Moon 2007; Weber et al. 2012). Research has, however, uncovered disturbingly consistent inconsistency in both investigative practices and interpretation of the resultant data (Camperlengo 2012; Kim et al. 2012; Krous 2004; Landi 2005; Graham 2009). Of the approximately 5,000 SUID cases reported annually in the United States, cause of death remains unknown in the vast majority of these cases (CDC 2011). Attempts to understand the common causes of SUID have thus been thwarted by a lack of standardization in both data collection (AAP 2011; Corey 2007; Diebold Hargrave 2011) and subsequent interpretation (CDC 1996; Kim 2012). Though the release of national guidelines, endorsed by the Centers for Disease Control and Prevention (CDC), National

Association of Medical Examiners (NAME) and American Academy of Pediatrics (AAP) represents a significant step in the right direction, participation is currently voluntary (Hanzlick 2001), portions of the guidelines remain vaguely defined (Weber and Sebire 2009), and enormous variation in implementation has been noted (AAP 2011; Graham 2009; Landi 2005; Moon 2007; Pasqualone 2007).

As researchers have struggled to identify the most common cause of death for infants in the postnatal period, the larger context of death investigation has come under increased scrutiny. Gaps and inconsistencies in US medicolegal death investigation systems have been documented as negatively impacting both public health and public safety programs (Drake 2011; NAS 2009). In its 2009 report, *Strengthening Forensic Science in the United States: A Path Forward,* the National Academies of Sciences (NAS) described the US death investigation system as "fragmented" (p49), "hodgepodge"(p246), "inadequate" (p250) and functioning within a "deficient" (p18) forensic science community. As a result, more attention has recently been placed on the state of medicolegal death investigation systems across jurisdictions. Increasing attention has also been placed on the resulting impacts of medicolegal death investigation on the criminal justice system, public health policy, and on health care delivery. Yet, very little attention has been paid to the role of law enforcement within either the larger medicolegal death investigation structure or in the specific realm of infant death investigation. This research seeks to contribute to a deeper understanding of law enforcement officials' perspectives on, and experiences

with, infant death investigation practice on the ground. In so doing, we take a step toward improving both the quality of individual infant death investigations and the ability to more accurately interpret and utilize aggregate statistics.

Researcher Positionality

I began the planning for this project as a Board Certified medicolegal death investigator with a decade of experience. However, my interest in the topic began years earlier when, as a critical care Registered Nurse, I cared for victims of a variety of traumatic events, including motor vehicle collisions, gunshot wounds and drug overdoses. It was in the emergency department, intensive care unit, and helicopter/medivac settings that I first became aware of what seemed to be enormous variation in the roles and responses of law enforcement associated with these events. At times, law enforcement representatives participated immediately and expertly guided interactions; at other times they were merely a fleeting presence, seeming to have no significant impact on either the collection of information or physical evidence. In still other cases, law enforcement was conspicuous in its absence. Over the years, I witnessed potential physical evidence being discarded, heard participants and witnesses share details about traumatic events that were not documented, and came to wonder how victims and suspects of these forensic investigations are ultimately influenced by the pieces of information that never make it to the decision makers. How are we as a society or as care providers influenced by the "partial truths" (Clifford 1986) we measure? By what is seen and what is missed, what is recorded and what is discarded? These questions compelled me to learn more

about the medicolegal system, and ultimately lead me to a career change and an enduring passion for what transpires at the intersection between science, medicine and the criminal justice system.

I received my first formal introduction to infant death investigation over the course of a 2001 death investigation internship. For reasons I would soon come to understand, infant death investigation received particular attention in the curriculum. I learned that Sudden Infant Death Syndrome or "SIDS" is a diagnosis of exclusion—a diagnosis for which there is no means of objective proof (Fred 2013). I found that subjective variables, interpreted according to "whims" (Beckwith 2003:286) or "diagnostic preferences" (AAAP 2011:1342) were being used to make a determination of SIDS. I came to understand SIDS is considered by some to be a "dustbin diagnosis" (Emery 1989; Weber 2011). I was surprised to learn this diagnosis of SIDS was often applied to cases without completion of an investigation adequate to rule out other potential causes of death— a fact made more startling by the realization that, even with a thorough autopsy, there is no way to differentiate between SIDS and some forms of homicide. It was during this internship that I was first exposed to grieving parents so grateful for compassionate handling and definitive answers; or parents so frustrated by ambiguous and unsatisfying conclusions. It was also during this internship that I first experienced the bittersweet satisfaction of revealing criminal activities, and thus initiating the criminal justice process aimed at ensuring the offender would not be able to harm another child. Seeing first hand the impacts of infant death investigation affected me greatly, and has

propelled a decade of study aimed at improving death investigation practice and systems.

Because there is currently no set degree program, curriculum or educational requirement to become a death investigator in the US (ABMDI 2015), I utilized my previous training and experience as a critical care nurse as a foundation upon which to build a medicolegal education. I apprenticed with a variety of subject matter experts in multiple jurisdictions, and—always with an eye toward interdisciplinary—attended trainings advertised for medicolegal death investigators, forensic scientists, prosecuting attorneys, law enforcement, crime scene investigators, and forensic pathologists. I joined various associated organizations and began attending regional, national and international conferences dedicated to improving death investigation and other related forensic disciplines. Thus, this project has been informed by over a decade of participant observation and "observing participation" (Bernard 2011). My various roles as student, educator, researcher and medicolegal death investigator have facilitated access to more than 100 infant death investigations in geographically disparate jurisdictions. This positionality has granted me a nuanced understanding of the practices, procedures and circumstances discussed by participants in this study.

Infant death investigation outcomes have the potential to impact individual well-being, public safety, public heath, research agendas, and educational campaigns. Recognizing that human beings are "biological, social, cultural and political entities engaged in complex, dynamic relationships with

one another and our environments", Fuentes and McDade (2007:19) argue that the holistic tradition of anthropology is particularly well equipped to illuminate challenges, opportunities and implications for human biology and health. In the realm of infant death and infant death investigation, all of the power of law enforcement is brought to bear on the nuanced and delicate investigation of a phenomenon not yet fully understood by the medical or scientific community. Here, in the act of infant death investigation, high stakes research meet the criminal justice system in a space where a confounding biological mystery, known to be influenced by environment and cultural practices, unfolds in a setting complicated by what Firstman and Talan call "the politics of grief" (2010:292)

My training in medical anthropology has convinced me that applied, biocultural medical anthropology has a lot to offer the world of infant death investigation. Biocultural theory and methods, as proposed by Goodman and Leatherman (1998), are focused on exposing critical intersections between biology, culture and power. In the context of infant death investigation, these intersections offer us a chance to evaluate biocultural dimensions of unexplained infant death, as well as to make explicit what extensive socialization into the occupational cultures of those investigating infant death may obscure.

Inspired by a biocultural medical approach, I have focused this project in the space Johnson-Hanks describe as the "fault line of disciplinary difference" (2007:5)— that is, at the powerful intersections of law enforcement, medicine, biology and culture. Whereas the medicolegal system has privileged the

acquisition of clinical/biological data, very little attention has been paid to the larger cultural or political economic contexts of the systems in which infant death investigations unfold.

In the pages that follow, I explore participants' experiences of infant death investigation, describing in particular the supports, barriers and psychosocial impacts they endure when called to the scene of an SUID. In Chapter Two, I review the relevant body of literature on infant death investigation in order to contextualize this research and to expose the areas most in need of further investigation. In Chapter Three, I detail the methods used in this study, describing the rationale for specific methods within the context of the law enforcement world where I am both a relative insider (medicolegal death investigator) and an outsider (medical anthropologist/researcher). I present key findings in Chapter Four as I examine themes that emerged from participants' narratives. The stories of their work reveal three dynamic tensions that I argue function to further complicate these difficult investigations. In Chapter Five, I discuss directions for possible reform as informed by my findings and the ethnographic context of law enforcement as a distinctive occupational culture. Finally, in Chapter Seven, I conclude with a summary of findings, reflect on the limitations and strengths of the findings and offer suggestions for future research.

Chapter 2: Literature Review

In this study, I explore the experiences and perspectives of law enforcement officers involved in sudden unexplained infant death (SUID) investigations. In order to understand the significance of their investigative roles and the greater implications of their findings, it is critical to first have an understanding of the existing body of literature on SUID and SUID investigations. In this chapter, I provide a review of pertinent literature on the topic, and in so doing, reveal a series of critical gaps.

I begin with an overview of evolving discourses on primary causes of death among US infants. Next, I introduce salient features of the growing body of literature on best practice in infant death investigation. I conclude this chapter by contextualizing the practice of infant death investigation within the larger system of death investigation in the United States. Overall, I argue that a review of the literature makes evident the biocultural dimensions of SUID and the concomitant need for a more holistic and thorough assessment of the ways culture and power dynamics influence the "science" of infant death investigation.

Primary Causes of Death in US Infants: Evolving Discourses

Each year in the United States, approximately 5,000 infants are reported to die suddenly and without an obvious cause; more than half of these SUIDs are ultimately attributed to sudden infant death syndrome (SIDS), making SIDS the greatest cause of infant death in the postnatal period (1-12 months of age) (AAP 2011; Kim et al. 2012). "Unknown cause" holds the second place position— a fact that is particularly interesting when the definition of SIDS is considered (see

Figure 1). The National Institute of Child Health and Human Development (NICHD 2015) describes SIDS as a "sudden and silent medical disorder that can happen to an infant that seems healthy". However, as of yet, there are no physical exam or laboratory findings that can prove the existence of SIDS as a unique, specific or definable medical disorder (McKenna 1996; Moon 2007).

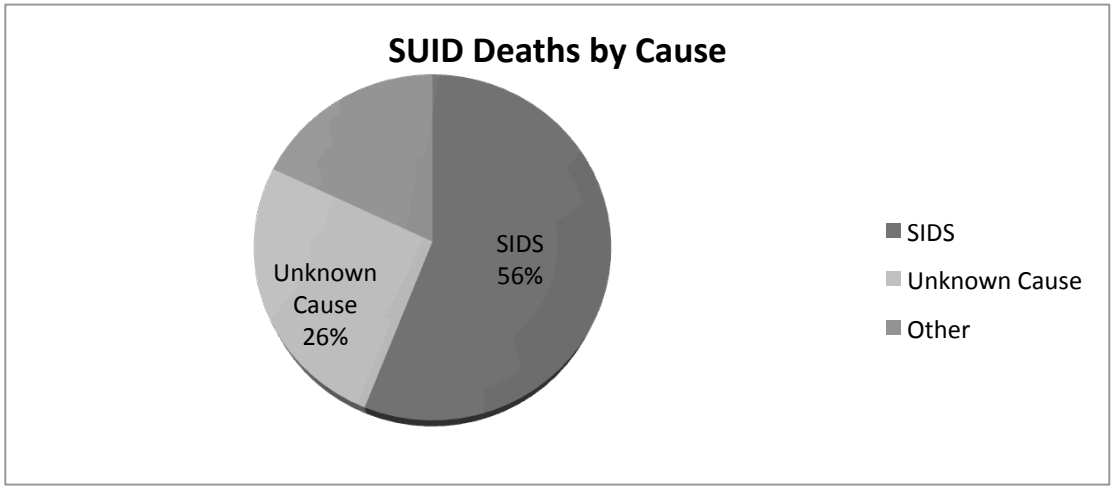

Figure 1 - Breakdown of Sudden Unexpected Infant Death by Cause

(Source: CDC Fast Facts 2011)

Beckwith (2003) explains that the term "sudden infant death syndrome" was first proposed in 1969 to focus attention and research on a category of poorly understood deaths with consistent clinical, epidemiological, and pathological features suggesting a common cause or mechanism of death. The definition (see Table 2) was intentionally left "as general as possible" in order to "encourage use of the diagnostic term without excluding any cases that might later be found to be due to the same cause or mechanism"(Beckwith 2003:287).

Unfortunately, the lack of limiting criteria made SIDS distinguishable from other causes of infant death only by "subjective and permissive variables that can be interpreted according to the whims of the diagnosing pathologist" (Beckwith 2003:287). SIDS, as a diagnosis of exclusion (Landi 2005), is merely the diagnosis that remains after all other differential possibilities have been excluded. As such, a SIDS diagnosis is the result of an ongoing "educated guess" (Fred 2013:380) influenced by both the scope of potential differential diagnoses recognized, and the diligence with which others are excluded. Emery (1989) and Rogman (2001) have argued that the insertion of the word "Syndrome" after the phrase, "Sudden Infant Death" functionally changed the term from a description into what amounts to a "diagnostic dustbin" (Emery 1989; Rogman 2001) that retains any infant death which remains unexplained after a thorough investigation—or those for which an adequate investigation was never undertaken.

Recognizing some of the problems associated with such a vague and permissive definition, the National Institute of Child Health and Human Development convened an expert panel in 1989 to examine the issue. The result was a slight modification to the original definition, limiting application of the term to deaths occurring within the first year of life, and specifying that a thorough investigation should include examination of the death scene and a review of the medical history. In 2004, a panel of invited experts, including pediatrics pathologists, forensic pathologists and pediatricians, with delegates representing Europe, North American and Australasia, met in San Diego,

California to once again reexamine the SIDS definition (Krous et al. 2004). This meeting, sponsored by a private SIDS Foundation, resulted in an internationally discussed and widely accepted definition (Bajanowski et al. 2007), incorporating the knowledge that most of these cases are associated with a period of sleep and urging a more thorough analysis of the circumstances of the death (see Table 2). Subsets to the SIDS definition were also delineated and stratified at this meeting with the aim of facilitating research (Krous et al. 2004)

The 2004 San Diego redefinition of SIDS was considered a useful step toward more precise monitoring of changing epidemiologic patterns and more valid international comparisons. The proposal also represented attempts to facilitate more accurate investigation, diagnosis and categorization of unexpected infant death cases. The authors of the San Diego definition cautioned that this, and each subsequent iteration, of the SIDS concept, would need to be continually reformulated and refined to incorporate accumulated knowledge gained from these complex and challenging cases (Krous et al. 2004).

At the heart of each SIDS definition iteration is a simple fact: The first ("SIDS") and second ("Unknown") cause of death in infants are both unidentified, though the designation of SIDS in use today indicates, at least in theory, that other causes were ruled out. By far, the leading cause of post-neonatal mortality in the United States then is simply unknown.

Table 2 - A Definitional History of SIDS (significant modifications are underlined)

1969 Definition of SIDS:

The sudden death of any infant or young child, which is unexpected by history, and in which a thorough post-mortem examination *fails to demonstrate an adequate cause of death (*emphasis added).

(Beckwith 2003; Krous et al. 2004)

1989 Definition of SIDS:

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.

(Beckwith 2003; Willinger et al. 1991)

2004 definition of SIDS:

The sudden unexpected death of an infant under one year of age, with the fatal episode apparently occurring during sleep, that *remains unexplained* after a thorough investigation, including performance of a complete autopsy and review of the circumstances of death and the clinical history."

(Krous et al. 2004; Weber and Sebire 2011)

Although the term SIDS was introduced to draw attention to a category of deaths with consistent features, thereby suggesting a shared mechanism of death, a common initiating mechanism has yet to be identified. Common terminal mechanisms are believed to include a progressive asphyxia, bradycardia, hypotension, metabolic acidosis, and "ineffectual gasping leading to death" (AAP Technical Report: 1348).

The incidence of SIDS peaks between two and four months of age with approximately 90% of diagnosed cases occurring before six months (Hymel 2010; McKenna 1996]. Many experts agree that factors such as immature

cardiorespiratory autonomic control, alone or in combination with a failure of arousal responsiveness from sleep are to blame (AAP 2011; Moon et al. 2007). Kemkes (2009) has also noted that infants comprising the most vulnerable age group lack motor skills necessary to adequately respond to any potential asphyxiation environment or situation. In other words, these infants, generally cannot lift their heads, significantly reposition or remove themselves from an unsafe position, object or individual.

Furthermore, SIDS is commonly regarded to be multifactoral in origin. Byard and Jensen (2008) describe SIDS as, not a single disease with one cause, but instead as a "heterogenous amalgam of underlying predispositions and external factors" (p1170). One common contextual construct for understanding SIDS deaths is the "Triple-Risk Model" (AAP 2011). This widely cited model attempts to organize current knowledge of SIDS deaths and focuses on the overlapping circumstances in which a: 1) vulnerable infant; at a 2) critical developmental period; 3) dies while under the influence of outside stressors. The triple risk hypothesis posits that infants will die of SIDS only if he or she posses all three factors, and that the vulnerability lies latent until the infant enters the crucial developmental period and is simultaneously exposed to an exogenous stressor. It can also be argued that the entire first year of life is a critical developmental period for the distinctly altricial and vulnerable human infant, as all manner of outside stressors pose a threat during this period.

Despite the fact that the underlying causes of SIDS deaths are unknown, rates have declined considerably from 130.3 deaths per 100,000 live births in

1990 to 55.7 deaths per 100,000 live births in 2001 (CDC 2015). At the same time as SIDS deaths were decreasing, numbers of other SUID deaths, such as those due to suffocation, wedging, overlying, poisoning, and those due to "unknown/unspecific" cause were increasing (Kim et al. 2012). The shift is now understood to be a result of a combination of more effective interventions, improvements in how infant death investigations are conducted, and changes in how causes of death are determined (AAP 2011; Kim et al. 2012)

Improved investigative protocols and more consistent interpretation of resultant data have allowed for a greater recognition of the complexity of the relationships between environmental, socioeconomic and biological variables in infant death (Byard and Krous 2001). For example, national campaigns like the 1994 "Back to Sleep" movement endorsed placement of infants in a non-prone position and are believed to be associated with a genuine decrease in SIDS numbers (AAP 2011). It is noteworthy that concurrent campaigns emphasized the importance of prompt medical evaluation for ill infants, scheduled immunizations, breastfeeding, and avoidance of bed sharing, overheating, over bundling, gestational or postnatal cigarette smoke exposure, and soft sleep materials and surfaces (Hymel 2010).

Though the current SIDS population remains exceedingly heterogeneous (Hymel 2010; McKenna 1996), and to date, no single, consistent criterion or pathological marker can be used to either predict potential SIDS victims or identify them upon post mortem autopsy (McKenna 1996), specific risk factors have been identified (see Table 3). Ball and Volpe (2013) note that, in the United

States, SIDS disproportionately affects African American, Alaskan Native and Native American communities. McKenna (1996) notes that SIDS rates are lowest in many Asian cultures, as well as in Swedish, Finnish, Norwegian, English and Israeli populations. Among these groups, mothers tend to be older, they rarely smoke during pregnancy, and they tend to place their infants in the supine or side position for sleep. In addition, parents in these cultural groups commonly sleep either in contact with, or at least in sensory proximity to, their infants during the first year of life and/or breastfeed intensively for the first six months of life.

McKenna further notes that, in the United States, SIDS rates are highest among Native Americans and poor African Americans infants with unmarried mothers who are less than 20 years of age, smoke during their pregnancies, and lack access to prenatal care. Hauck (2001) and others have also acknowledged that although SIDS strikes infants from all socioeconomic backgrounds, research has consistently shown that lower socioeconomic status, variously measured, is associated with a higher risk of SIDS. Kemkes (2009) has argued that poverty as a risk factor could explain both child maltreatment and SIDS, as economic downturns not only correlate with premature death in infancy, but also with increased physical abuse and neglect. As each additional risk factor in SIDS cases is identified, the need for comprehensive infant death investigations becomes even clearer.

Table 3 – Common Characteristics of SIDS deaths

Common characteristics of SIDS deaths

- occurs suddenly without warning, often during periods of sleep.
- cause unknown after a thorough investigation
- not known to be due to suffocation, aspiration abuse or neglect
- peak incidence at 2 to 4 months of age

Modifiable Risk Factors

- smoking and substance abuse (prenatal or postnatal exposure)
- prone (face down) and side sleeping positions
- soft sleep surfaces and loose bedding
- overheating
- bedsharing with intoxicated individual, caregiver who smokes or anyone other than a biological parent

(Source: CDC SUIDI Training Academy 2008)

One risk factor for SIDS—bed-sharing—remains controversial. While it is recommended against in the United States, bed-sharing is a common practice in many cultures (Weber et al. 2012). Ball and Volpe (2012) point out that the question of where, and with whom, babies sleep involves biology, history, cultural values, context and motivation to determine outcomes. They also recognized that infants who sleep in a separate room from their parents are at increased risk of SIDS when compared to infants who sleep in the same bedroom. McKenna and Mosko explain that bed-sharing is just one of many forms of co-sleeping, and that "while all bed-sharing represents a more intimate type of co-sleeping, not all co-sleeping takes the form of bed-sharing. Moreover, safe bed-sharing can now be distinguished from unsafe bed-sharing." (2001:261)

"Unsafe bed sharing" is an important concept as improved investigations have revealed that some sleep-related infant deaths result from various forms of accidental asphyxiation. In the bed-sharing environment, McKenna and Mosko note that: "the quality of care the infant receives from the caregiver once in bed is partially determined by the nature of their social relationship outside of the bed, which often helps to explain the parent's reasons for co-sleeping" (p 260). This continuum of parent-infant sleep proximity along with numerous confounding factors, such as sleep surface and other micro-environmental considerations make clear the need for detailed and sensitive data collection at every infant death investigation. Also made clear is the need for a more nuanced and culturally sensitive, biocultural, public health approach to the discussion of infant sleep practices. Unfortunately, the association of both positive and negative infant outcomes with sleep location, are functions of context and the characteristics of individual parents and environments, a fact which significantly complicates public health messaging (Ball and Volpe 2012) (see Table 4). A crude and overly simplistic approach to the discussion of infant sleep location no doubt leads to ineffective messaging that may be ignored by target populations.

McKenna (1996) expresses no surprise that childcare practices prove so important to infant death prevention, "as several different lines of evidence indicate that the social care of infants is practically synonymous with physiological regulation (p207)." McKenna further asserts that: "the overall environment in which SIDS deficits find expression may be as important to understanding SIDS as the primary deficits themselves." Kemkes (2009) notes

that anthropological interest in the topic of infant death has advanced the conversation about sleep practices and, as a result, the SIDS phenomenon is of renewed interest among social and behavioral scientists. By differentiating between the adaptive benefits conferred through infant-parent proximity and the role of modern sleep environment factors, a deeper understanding of risks associated with sleep environment may be possible. Weber (2012) has argued that the most important factor influencing the risks and benefits of bed-sharing has to do with the overall characteristics of the social and physical environments within which bed sharing occurs and further suggests that risk is not conferred by bed-sharing per se, but is modified by the circumstances in which co-sleeping occurs— that is, it is the context and manner in which such practices are performed that make them safe or unsafe.

Table 4 – Summary of AAP Recommendations for a Safe Sleep Environment

Summary of Recommendations for a Safe Sleep Environment

- Supine sleep positioning
- Use of a firm sleep-surface
- Breastfeeding
- Room-sharing without bed-sharing
- Soft and loose objects kept from crib
- Routine immunization
- Consideration of a pacifier
- Avoidance of soft bedding and overheating
- Avoidance of exposure to tobacco smoke, alcohol and illicit drugs

(Source: AAP 2011)

Anthropologists are not alone in calling for a more nuanced understanding of the role sleep environment plays in SUIDs. Knight and colleagues (2005) acknowledge that the actual hazard associated with co-sleeping may be related to confounding factors such as sleeping on surfaces not intended for infants; parental exhaustion or intoxication; and co-sleeping with non-caregivers, or "non-elective co-sleeping with a disinterested caregiver due to socioeconomic factors" (p32).

McKenna (1996) has argued that for a valid understanding of the potential benefits and risks of co-sleeping/bed-sharing to ever be achieved:

> "…anthropologists, forensic pathologists, and epidemiologists must work together. New ethnographically sensitive and appropriate epidemiological variables and categories must be defined that more precisely capture, describe and classify the diverse social and physical environmental factors that characterize and differentiate co-sleeping environments, as well as the social and physical characteristics of the participants." (p213)

Finally, with reference to the undetected causes of infant death in the United States, Firstman (1997) notes that infanticide has often been avoided in past discussions. This, he believes is partially explained by the apparent belief among US researchers and pubic health professionals, that SIDS would someday be explained and that murder was a wholly separate issue, not to be discussed by those tasked with caring for the health of infants. Unfortunately, as Firstman points out, the reality of the SIDS enigma is that some forms of murder and SIDS are currently indistinguishable. He warns that, while we must not lose sight of the fact that the vast majority of SIDS deaths are not suspicious, this assertion

also makes it easier for some other babies to "slip away, victims of the perfect crime" (2012:613). If the person who would normally press for action is the accused, who will answer the call to speak for that child?

Spitz (2006) notes that infants do indeed fall victim to homicide, and in general, that the younger the child is at the time of the event, the more likely it is that a parent is responsible. He further notes that because infants can be killed without visible injuries, these cases can be mistaken for natural deaths. It is suspected that between 1% and 5% of deaths classified as SIDS may actually be due to abuse or neglect (Hymel et al. 2010). Others allege that overlooked infanticide cases represent 5-10% of reported SIDS deaths (Emery 1989), while some believe the actual number is even greater (Spitz 2006). Indeed, recent research and popular press publications strongly suggest that the index of suspicion for inflicted death should be higher (Diamond 2012; Firstman and Talan 2001; Jenny and Isaac 2006; Southall 1997; Spitz 2006). Furthermore, while murder may be one of the least common causes of infant death, it may also be one of the most preventable (Firstman 1997).

Perhaps the best known example of missed infanticide is recounted in Firstman and Talan's book, *The Death of Innocents: A True Story of Murder, Medicine, and High-Stakes Science*. *The Death of Innocents* examines the emotionally charged intersection of SIDS and murder, describing in exquisite detail the story of one woman who "got away" with murdering five of her children over a twenty-year period. Misguided medicine, bad science and

inadequate investigation prevented justice from being served and ultimately allowed the murder of four additional children after the first went undetected.

Another poignant example of the importance of considering accidental asphyxiation or purposeful suffocation in SUID cases was revealed in a British study utilizing covert video surveillance to assess risk in 39 young children previously suspected to be victims of maltreatment (Southall 1997). Abuse was revealed in 33 of the 39 cases, and intentional suffocation was observed in 30 of those cases. Of 41 siblings associated with the focal children, 12 had died suddenly and unexpectedly; 11 of those deaths had been classified as SIDS, and four parents later admitted to suffocating eight of those siblings.

The frequency with which infants die at the hands of their caregivers is unknown, but what is known is that fatal child maltreatment has, and will continue to be, mistaken for SIDS unless infant death investigation practices are improved (Hymel 2010). The messy and entangled nature of SIDS, "unknown," and infanticide as causal designations make clear the need for highly nuanced investigative procedures that facilitate rather than preclude differential diagnosis. Thus, I turn to a review of the literature on best practices in infant death investigation.

Best Practices in Infant Death Investigation

In 1992, recognizing that no uniform procedure was in place for the collection or evaluation of SUID information, the US Senate and House of Representatives recommended establishment of a standard SUID scene investigation protocol. As a result, the Centers for Disease Control and Prevention (CDC) released

guidelines, recommendations, and a Sudden Unexplained Infant Death Investigation Report Form (SUIDIRF) intended for use by death investigators, medical examiners, coroners, and police officers (MMWR 1996). Over the course of the following decade, the SUIDIRF was revised and additional guidelines and training resources were developed. In 2004, the CDC and partners (see Table 5) launched a Sudden Unexplained Infant Death Investigation Initiative.

Table 5 – Select CDC SUID Initiative Partners

"FEDERAL PARTNERS"
Federal Bureau of Investigation
National Institute of Justice
Consumer Product Safety Commission
Indian Health Service
Department of Defense
Health Resources and Services Administration
National Institutes of Health
National Center for Health Statistics
Office of Minority Health (DHHS)
"PROFESSIONAL MEDICAL ASSOCIATIONS"
American Medical Association
American Academy of Pediatrics
National Association of Medical Examiners
International Association of Forensic Nurses
"LAW ENFORCEMENT AGENCIES"
National District Attorney's Association
International Association of Chiefs of Police
National Sheriff's Association
"SIDS ORGANIZATIONS AND ADVOCACY GROUPS"
First Candle/SIDS Alliance
CJ Foundation for SIDS
Association of SIDS and Infant Mortality Programs
March of Dimes
(Source: CDC SUIDI Training Academy 2008)

The initial goals of the CDC SUID Initiative were to: 1) standardize and improve data collected at the death scene; 2) promote consistent cause of death determination/diagnosis; 3) improve national reporting of SUID on death certificates; and 4) prevent SUIDs by more proactively identifying those at risk. In the last decade, activities have expanded to include the development and dissemination of the Sudden Unexplained Infant Death Investigation Reporting Form (SUIDIRF) and training materials via regional, train-the-trainer academies presented to multidisciplinary teams of five participants from each US state between 2006 and 2008 (CDC SUIDI Training Academy 2008).

The CDC published guidelines for the training and investigation of SUIDs in 2007; these guidelines were endorsed by the National Association of Medical Examiners (NAME), American Board of Medicolegal Death Investigators (ABMDI), and the American Association of Pediatrics (AAP). That same year, the NAME Ad Hoc Committee on Sudden Unexplained Infant Death published a white paper to address, among other related issues, a "bare minimum" set of recommendations to define the scope of investigation required for unexpected infant deaths. In 2010, the AAP and NAME again reaffirmed a 2006 clinical report intended to provide professionals with guidelines to aid in accumulation of evidence, while avoiding causing unnecessary distress to the survivors. Together these documents describe a series of actions identified as key components of any infant death investigation (see Table 6).

Table 6 – Summary of select SUID investigation components.[2]

- Confirmation or pronouncement of death according to jurisdictional responsibilities
- Recognition and determination of varying jurisdictional and statutory responsibilities which apply to agencies and individual representatives
- Determination of scene safety from potential threats
- Prompt investigation of the scene where incidents leading to the death are thought to have occurred, all witnesses interviewed, potential evidence recognized, documented and preserved according to evidence collection laws and chain of custody
- Identification of infant's original position when first found unresponsive as precisely as possible (through demonstrations such as doll reenactment)
- Written and photographic documentation of the scene and body[3]
- Collection of medical history through interview and review of medical charts
- Establishment of the presence of any previous unexplained deaths of siblings
- Identification of previous social services or police contacts (with out-of-jurisdiction contacts as needed)
- At least one radiograph of infant (complete skeletal series is recognized as the gold standard)
- Complete autopsy performed by a forensic pathologist (including associated metabolic, toxicological and microscopic analysis)
- Maintenance of an unbiased, nonaccusatory approach to parents
- Consideration of intentional asphyxia in "certain cases"
- Prompt imparting of information and assistance to parents "when results indicate natural or accidental causation"

[2] The 2007 NAME document states that scene investigation should be conducted "by a medical examiner or coroner or a person known to, and acting officially on behalf of, the medical examiner or coroner." (p272). The 2010[2006] NAME and AAP document endorses prompt investigation of the scene by "knowledgeable individuals with the legal authority and mandate to conduct such investigations" (p425-426) and further recommends "emergency responders and medical personnel" obtain accurate histories of the event and immediately transmit the information to the medical examiner or coroner.

[3] Video photography has since been recognized as a valuable ancillary infant death scene documentation method (O'Neal & Schindell 2011)

Currently, national guidelines for infant death investigation best practices are focused on which tasks must be completed and what information must be obtained in order to accurately identify cause and manner of death in a case of SUID. Yet, little is known about how these guidelines are actually implemented on the ground across various jurisdictions and within various systems-level configurations.

Infant Death Investigation Systems in the United States

Investigation of SUID is a specialized form of inquiry that takes place within the context of preexisting death investigation structures and practices in any given jurisdiction. In the United States, approximately 2,342 medical examiner and coroner offices (ME/Cs) are responsible for investigating and certifying cause and manner of death for cases that fall within their jurisdiction, as determined by state code (NAS 2009). As a general rule, ME/C jurisdiction includes, but is not limited to, any deaths that are overtly traumatic or suspicious, or any deaths (such as SUIDs) that are unexpected, or initially unexplained.

Death investigation serves numerous purposes, as Hanzlick (in NAS 2003) notes:

> Death investigations carry broad societal importance for criminal justice and public health. Death investigations provide evidence to convict the guilty and protect the innocent, whether they are accused of murder, child maltreatment, neglect, or other crimes. Death investigations aid civil litigation, such as malpractice, personal injury, or life insurance claims. Death investigations are critical for many aspects of public health practice and research, including surveillance, epidemiology, and prevention programs, most often in injury prevention and control but also in prevention

> of suicide, violence, and substance abuse. And death investigations are emerging as critically important in evaluating the quality of health care and the nation's response to bioterrorism.

By population, approximately half of the United States is served by a coroner system and the other half by a medical examiner system (MLDI 2003) (see Table 7). Qualifications, authority and responsibilities of medical examiners and coroners vary by jurisdiction. Medical examiners are generally appointed, and the focus within this medicolegal death investigation structure is upon the medical knowledge of the professionals involved. Coroners are typically elected, and while some are highly trained medical professionals, others may possess little, or no specific medical expertise. In both structures, training and experience with regard to medicolegal subjects, criminal justice, and forensic science vary greatly by jurisdiction and by individual.

Regardless of system type, a majority (80%) of death investigations are handled at the level of the nation's 3,137 counties (NAS 2009). Twenty states are organized on some variation of a statewide structure, while the others are organized by county, region or district (Hanzlick 2006). Two thirds of the ME/C offices in the United States serve a population of less than 50,000 people (1,361 or 68%), and every one in five offices serves populations of less than 10,000 people (Hickman 2007). As Bonnie (in NAS 2003:3) has argued, there is little risk of dissent when one asserts that there is no "system" of death investigation in this country. Rather, the structure and practice of death investigation varies widely as a result of differing state laws, local authorities and regional customs. Little is known about the precise degree of variation across jurisdictions—

or the impact of this variation on case outcomes. Furthermore, in spite of the fact that law enforcement participate within both the medical examiner and coroner systems, even less is known about their roles and experiences within these varied systems.

Table 7 – Summary of US Death Investigations System Structures

Reported Death Investigation System Structure
16 states - Centralized Statewide Medical Examiner System
7 states - County Level Medical Examiner System
14 states - County Level Coroner System
13 states - Mixed Medical Examiner and Coroner System
(Hickman 2007)
ME/C Office Placement
Most (43%) operate as independent offices within the city, county or state government. Some are associated with public safety or law enforcement and the minority (14%) function under forensic laboratory or health departments.
(MLDI 2003)

Concerns about the adequacy of death investigation in the United State have been raised for many decades, "by all the constituencies that have a stake in the accuracy of data related to the circumstances of death and in the official determinations based on them" (MLDI 2003:vii). Merging concerns about the adequacy of death data and "general concerns about all aspects of forensic science" (MLDI 2003:vii) led the National Institute of Justice (NIJ) to ask the Institute of Medicine (IOM) to conduct a workshop examining the interface

between the medicolegal death investigation and criminal justice systems. Presentations and opinions expressed at this March 2003 workshop, demonstrated that, "current practices of medicolegal death investigation in this country are in substantial need of improvement" (MLDI 2003viii). The report identified death investigation as a "political orphan" (p64) and presented the workshop as a starting point for further study and reform of both the criminal justice system and the public health and health care systems. It should be noted that this report situated law enforcement as distinct and separate from the medicolegal death investigators of the ME/C offices and made little or no mention of the specific role of law enforcement in death investigation.

In 2005, recognizing significant improvements were also needed in other forensic science disciplines, the US Congress directed the National Academy of Sciences to undertake a study culminating in the 2009 report mentioned above called *Strengthening Forensic Science in United States: A Path Forward.* Broadly, the report revealed a "hodgepodge and multiplicity of systems and controlling statutes" (p246) and described enormous disparity among existing forensic science practice within federal, state and local law enforcement jurisdictions. The report also noted that the vast majority of criminal law enforcement is handled at the state and local level, and that available resources, extent of services offered, and level of expertise provided by medical examiners, varied widely across jurisdictions.

These findings aligned with the 2003 workshop report, which recognized that positioning of death investigation as a local responsibility had lead to, "wide

variation in the scope, extent, and quality of investigations"(2003:9). The report further noted that local, county-based systems were superior with regard to communication, travel, and investigative response time, but that the lack of a sufficient population or tax base may preclude their success.

In addition to detailing concerns about variability and quality in US ME/C systems, these reports make note of a paucity of research on death investigation related topics. Bonnie and Hanzlik (in MLDI 2003) assert that the absence of research precludes development of an evidence-base for the field. The most frequently cited reasons for a lack of research were: isolation from academic institutions, lack of academic institutional support, and time constraints (as the first priority of ME/C staff is to serve their jurisdiction). Overall, the reports call for both basic and applied research, conducted in collaboration between forensic science, ME/C representatives and the broader science communities.

Finally, one recommendation of the 2009 NAS report was the formation of a scientific working group to build consensus standards and improve practices. As a result, in 2011, a Scientific Working Group for Medicolegal Death Investigation (SWIGMDI) was formed. Among the SWGMDI's first activities, was a 2011 survey asking NAME, ABMDI and International Association of Coroners and Medical Examiner (IAC&ME) respondents to list their top three priorities for research in the fields of forensic pathology and medicolegal death investigation. A descriptive analysis of the results revealed the leading priority to be "systems-related" and the second to be "pediatric-related" with nearly half of the

responses relating to "SIDS/SUID/Sudden death." The final report from this survey concludes by stating:

> Finally, "systems" research is needed within the MDI community. These system needs encompass broad areas, from identification of the most effective provision of MDI services within geographically different and demographically diverse communities to basic practice parameters involved in MDI, such as the ruling of manner of death, investigation needed in certain types of death or death scenes, etc.
>
> In summary, there are diverse and collaborative needs within the practice, system, and environment of medicolegal death investigation. Research in these areas would aid in addressing basic health, wellness, psychiatric, and public health needs of the United States and internationally. Furthermore this information can then be translated to prevent these deaths and better diagnose and treat living patients as well as enhance the medicolegal community's role in the courts and the criminal and civil justice systems.

A review of the literature on causes of infant death, best practices in infant death investigation and infant death investigation systems in the United States reveals a series of critical gaps in knowledge about what causes infant death and how the practice of infant death investigation is carried out. This review also makes evident the biocultural dimensions of SUID and the concomitant need for a more holistic and thorough assessment of the ways culture and power dynamics influence the "science" of infant death investigation.

The purpose of this study is to examine the lived experiences and perspectives of law enforcement officials charged with investigating sudden unexpected infant deaths (SUID) in nine Pacific Northwest jurisdictions. Using data collected from open-ended, semi-structured interviews, I explore tensions that emerge within the context of law enforcement culture and medicolegal death investigations generally, and the unique and rare context of SUID

investigations specifically. This study enables a critical evaluation of the impact of investigative practices on individual case outcomes and on the aggregate infant death statistics widely used to guide public health policy and health care priorities. Where better to start with an understanding of death investigation practices than with the most vulnerable of our citizens? Where better to apply anthropological efforts than in an understanding of events occurring at the intersection of biology, culture and political economy?

In the chapter that follows, I describe the methods used in this study to examine the experiences of law enforcement officers on the front lines of infant death investigation. I also provide rationale for specific methods employed and discuss efforts to control for bias in an area of study already so familiar to me.

Chapter 3 – Methods

The purpose of this study was to examine the lived experiences of law enforcement officials charged with investigating sudden unexpected infant deaths (SUID) in nine Pacific Northwest jurisdictions. Specifically, I aimed to answer three questions: 1) How is the practice of infant death investigation experienced by law enforcement officials?; 2) How do core values and features of police occupational culture affect the efficacy of infant death investigations?; and 3) Are there aspects of the law enforcement infant death investigation response that may be improved? In order to answer these research questions, I utilized an ethnographic approach intended to reveal detailed and contextualized information about law enforcement experience of this sensitive and complicated topic.

Ethnographic methods, described by Kleinman and Benson (2006) as *the* "core methodology" of anthropology, are undertaken with the goal of understanding a phenomenon from the perspective of the research subjects themselves. These methods have often been applied to police research (Skogan 2004) and commonly involve a period of participant observation in which the researcher becomes immersed in the situation or environment under study; the goal is to gain deep knowledge and insights not otherwise accessible to the researcher. I engaged in over a decade-long period of participant observation before completing open-ended, semi-structured interviews with twenty-six law

enforcement officials, representing seven different law enforcement jurisdictions.

PARTICIPANT OBSERVATION

I started this project as an insider of sorts, a "complete participant" in the process of death investigation for nearly a decade. Then, upon beginning my research, I became what Bernard (2011) describes as an "observing participant" in the process of infant death investigation. Over the course of my career, I participated in all aspects of the infant death investigation process, contributing to dozens of cases. I have engaged in numerous scene investigations, family and caregiver interviews, physical examinations of bodies, autopsies, interactions with prosecutors, pediatricians and other stakeholders, and trials. Throughout these processes, I have collaborated closely with law enforcement representing many jurisdictions.

Though I was a full participant in the process of infant death investigation, it was always in the role of medicolegal death investigator and not as a law enforcement representative. As a result, I do not hold full "insider" status from the perspective of law enforcement participants. My status as "insider" or "outsider" fluctuated depending on the environment, circumstances and presence of other individuals who were positioned along this continuum. My ability to understand, and fluently speak, the lingo of law enforcement granted me a degree of "insider status", as did my training and experience as a collaborator, trainer and medicolegal death investigator. However, my position outside of the rigid chain of command structure imposed on law enforcement

served to highlight my outsider status. Further positioning me as an outsider, is the fact that I do not carry a weapon to work, do not place people under arrest, and do not hold the responsibilities associated with "protecting and serving" the public in the same way law enforcement officials do. I do not bear the explicit responsibility of running toward danger when others are running away, and I do not bear any direct responsibility for holding a suspect accountable for a crime—though I am expected to help identify when a crime may have occurred. I was acutely aware of my "outsider within" status throughout the duration of this study (Watts 2006).

Though the lines of my status positioning were blurred and changed depending upon the topic and circumstances, there is no doubt my extensive professional experience with both law enforcement and the practice of infant death investigation added greatly to this research. Understanding of the specialized language spoken by law enforcement assisted with development of interview questions worded to help elicit contextually rich and useful information (Bernard 2011). Further, the knowledge and experiences I acquired by performing the act of infant death investigation has allowed for a deeper understanding of events described by the participants.

Another benefit of participant observation was the opportunity to build rapport and trust, thereby increasing the probability that participants would speak openly about sensitive topics. Bernard (2011) notes that increased rapport and trust lowers reactivity, and thus, increases validity of the information obtained. Approaching law enforcement with hopes of discussing

such a sensitive, and complicated topic required intimate knowledge of both the subject matter and the subject population. For that reason, an extended period of participant observation was indispensible in obtaining quality data.

RECRUITMENT

A pre-existing understanding of law enforcement structure and culture guided my approach to the recruitment of participants for this study. The explicitly hierarchical "chain of command" structure within each law enforcement agency necessitated a request for permission to recruit law enforcement participants from the Commanding Officers for each agency. I contacted the command staff representing each of the nine jurisdictions targeted in this study due to their proximity to Oregon State University. In addition to granting approval for the project, the command staff each agreed to email recruitment letters (See Appendix A), accompanied by letters of support (see Appendix B) to those under their command. Of the nine jurisdictions contacted, a single office declined to participate, citing staffing issues. Based on the office size and demographics of the population served, the declining offices represented the jurisdiction least likely to participate in an infant death investigation, and thus their lack of participation is unlikely to have significantly influenced findings.

Inclusion criteria were defined as all "sworn" criminal law enforcement officers currently employed in nine Pacific Northwest jurisdictions. Eligibility criteria encompassed all city police, county deputies, and state troopers whose duties may include participation in an infant death investigation. This includes,

any patrol officers/deputies, detectives, or officials operating in a supervisory role. In order to protect the identities of participants, I do not disclose agency names or the names of any participants; all place and person names are pseudonyms.

Following receipt of the recruitment letter, accompanied by a letter of support by his or her commanding officer, a voluntary sample of law enforcement officials (n = 26) contacted me by telephone or email, self-identifying as willing participants. The response rates for each agency ranged from 0% to 33%. Participants included law enforcement officials with a broad range of infant death experience from very little direct experience to reported involvement in more than twenty cases. Some of the more experienced individuals expressed a desire to share "hard-earned" knowledge and perspectives. Others with no infant death investigation experience indicated they chose to participate out of a desire to "learn" or "help", or because they simply felt the topic was "important". A significant number of participants explicitly stated they would not have participated in the study had they not "known", "trusted", or "felt comfortable" with me as a result of prior interactions.

OPEN-ENDED, SEMI-STRUCTURED INTERVIEWS

After receiving Institutional Review Board (IRB) approval for the ethical and non-coercive treatment of research participants, a voluntary sample of twenty-six law enforcement officials, representing seven separate jurisdictions, were interviewed during a two-month period in the spring of 2014. All interviews took place in either a police department or Sheriff's office. All but one interview

occurred while the participants were on-duty. This option was explicitly approved by all command staff and meant that officers did not have to sacrifice any of their off-duty time to participate.

Data for this project comes from a voluntary sample of officers. I had originally planned to use theoretical sampling for this study, in which case I would have stopped interviewing once I had reached concept saturation—that is, no new information was being added to the emerging theoretical models (Bernard 2011; Bradley et al. 2007; Charmaz 2008). Though details of individual stories varied, a number of broad and reoccurring conceptual themes began to emerge early on and were saturated after 19 or 20 interviews. Because the remaining six officers were enthusiastic about participating, I decided to interview all volunteers, thus exceeding the number needed for concept saturation. Before beginning interviews, potential participants were given an informed consent document to read and sign. Participants were encouraged to ask questions about the study and the contents of the consent document before deciding whether to participate.

The Institutional Review Board had previously expressed concern over the potentially distressing nature of the interview questions and had instructed me to develop a list of counseling referrals for participants. I was aware that each agency maintained Employee Assistance Program (EAP) contracts for confidential counseling services, so I identified the three programs contracted to provide services to the seven agencies represented in the study. A list of those EAP programs and contact information was made available to each participant at

the end of the interview. Though none of the participants expressed a plan to utilize the EAP contacts, some did state that it was helpful to talk about their experiences, suggesting (among other things) that current debriefing practices may be inadequate.

All interviews were audio-recorded, with the written consent of participants, allowing me to remain completely engaged in a conversational style of interviewing appropriate for discussion of this sensitive and potentially distressing topic. I utilized an interview guide (see Appendix C) to structure the data collection process, yet added follow-up questions when needed and omitted, rearranged or reworded other questions as needed to maintain a conversational flow. Semi-structured interviewing enables the researcher to follow leads and to prompt participants to elaborate as they share their experiences and is also useful when interviewing populations focused on efficient use of time (Bernard 2011). Each participant was granted the opportunity to fully describe his or her experiences, and I was careful to make sure each interviewee had shared everything they wished to before concluding the interview. Interviews ranged from 17 to 100 minutes, with an average interview length of approximately 45 minutes.

DATA ANALYSIS

Audio-recorded interview were transcribed into Word documents and analyzed using consensus coding (Bradley et al. 2007; Russell 2006) with the principal investigator (Cheyney) and a modified grounded theory approach described by Charmaz (2008). Grounded theory offers a systematic means of generating

theoretical schema from data that has the potential to explain, interpret and guide practice (Coyne 1997). In this case, the overall strategy behind application of a modified grounded theory approach was to reveal unanticipated findings. Because I did not enter into this research as an unbiased or neutral observer, my goal was to privilege the voices and perspectives of law enforcement participants. To that end, I did not begin with preconceived categories assumed, from my experiences, to be germane to the participant's experiences. Though my experiences certainly influenced the lens I brought to the work, a modified grounded theory approach allowed me to encounter unexpected perspectives and insights as they emerged from the narratives officers shared (Wedland 2010).

Charmaz (2008) notes that a central tenet of grounded theory is "minimization of preconceived ideas about the research problem and the data" (p155) and explains that by engaging in reflexivity and invoking grounded theory strategies, researchers can pursue substantive topics in which they hold a decided stake. The utilization of a modified grounded theory approach reflects an explicit focus on the emergent, inductive and more open-ended aspects of this qualitative research method, rather than the positivistic and logico-deductive theorizing of original grounded theory methods (Charmaz 2014).

During the process of data coding, labels representing recurrent themes were attached to sections of data. Transcripts were reviewed sentence-by sentence and more than one code was allowed per sentence as needed. Subsequent analysis resulted in coalescence, further division and refinement of

codes, which were ultimately organized into three themes. All themes emerged from the interview transcripts themselves; we did not begin with any *a priori* codes. Pre-existing knowledge assisted in identifying a starting point for the data collection, but in the words of Breckenridge and Jones, this [pre-existing] knowledge was, "awarded no relevance until validated or dismissed by the formulation of the emerging theory." (2009:120)

Consensus coding is motivated by the acknowledgement that different researchers, with different lenses, may identify additional themes or recognize connections that the other misses. The "outsider" perspective offered by the principal investigator (Cheyney) provided an expanded point of view and a level of protection against any pre-conceived notions or biases emerging from my positionality. While most of our themes overlapped, we met and discussed all differences until we came to consensus on the identification of key tensions and their potential relationships to one another. We believe this approach allowed for a more comprehensive analysis of the content shared and that consensus coding combined with grounded theory provided some measure of protection against the weaknesses of indigenous research (Bernard 2011).

During the process of data analysis, we continually returned to law enforcement narratives to check conceptual models against interview content. Ultimately, we were able to identify three key tensions. In the chapter that follows, I provide an overview of participant characteristics, as well as an analysis of these tensions as they emerged from interviewee's experiences of investigating sudden, unexplained infant deaths.

Chapter 4 Results

Qualitative analysis of interview and participant observation data revealed three key themes, dynamic tensions or ambiguities that officers described feeling challenged by during infant death investigations: 1) "We fake it very well most of the time": Navigating emotional situations when professional neutrality fails; 2) "This isn't something you can wing": Navigating high-stakes under-resourced investigations; and 3) "Walking a real fine line": Navigating interactions with parents—victims or suspects?

Below, I describe each of these themes in detail, using the officers'[4] voices to provide an "experience near" (Geertz 1973). By seeing the world of SUID investigations through the eyes of law enforcement officials, we gain a more nuanced understanding of how law enforcement experience infant death investigation generally, and the barriers to quality investigation more specifically. I argue, that law enforcement experiences help to illuminate the structural mechanisms that increase the complexity of this already difficult undertaking. Thankfully, contained within these narratives, are also possible directions for reform.

Sample Characteristics

Twenty-six law enforcement officials, representing seven jurisdictions volunteered to be interviewed over the course of this study. In addition to the seven agencies represented, participants reported previous employment in an

[4] Both participants and the referenced literature used the terms "law enforcement official" and "police officer" interchangeably. As such, they are used interchangeably in this study.

additional thirteen law enforcement jurisdictions in three different states. As such, interviewees were able to speak to a wide variety of experiences across multiple systems. All but six participants reported experience in both patrol and detective capacities. Four of those six, reported additional experience in patrol supervisory capacities. Collectively, participants had a mean of 19 years of law enforcement experience, with a range of four to forty years within the sample. Five women and twenty-one men participated with a collective mean age of forty-five years.

All participants identified as Euro-American descent with the exception of one participant who reported mixed ancestry. Six participants had earned Master's degrees and another eleven had earned Bachelor's degrees. The remaining nine had attended some college (see Table 8 for a summary of sample characteristics).

Table 8 – Summary of Sample Characteristics

Age	Mean = 44.65	Range 33-63		
Sex	Male 80.1%	Female 19.2%		
Highest level of education	Some college not equal to a degree N=6	Associates Degree N=3	Bachelor's Degree N=11	Master's Degree N=6
Years of Law Enforcement Experience	Mean=19.1 years	Range 4-40 years		

Tension I: "We fake it very well most of the time": Navigating emotional situations when professional neutrality fails

The most fundamental expectation of law enforcement officials is that they will protect and serve the people in their communities. For this reason, they are regularly called upon to confront and manage the dangerous or unpleasant situations other citizens are able to avoid. Police officers are expected to tolerate high levels of suffering, to restore order to chaos, and generally to see things "set right." All of these responsibilities require that law enforcement officials overcome or attempt to minimize what would otherwise be very normal reactions to the often-disturbing scenarios they are called to manage. Behaving professionally and effectively is understood by study participants and their colleagues to require emotional control and at least the outward appearance of being unmoved by scenes and scenarios that, in the absence of training, would certainly warrant an emotional reaction. Officers learn early on that the inability to hide emotions of fear, disgust or sadness can inhibit their ability to complete their expected duties. Law enforcement officers assert that they must, out of necessity, distance themselves from significant emotional engagement when acting in a professional capacity. There is no room for weakness, squeamishness, avoidance, unrestrained anger or paralyzing fear when community safety, health, or justice is at risk.

Though some law enforcement officials do become hardened after years of repeated exposure, the visage of stoicism displayed by some is by no means an

accurate indication of their experience of an event. Rather, this maintenance of composure, or "professional neutrality", reflects a conscious effort arising from a sense of duty or obligation—a sense of duty explicitly called for in their code of ethics[5] (see Table 9). Law enforcement officials have learned that unchecked emotional responses render them less effective at managing the high-stakes situations in which they commonly function. Rather than stemming from a lack of feeling, from any sort of bravado or display of *machismo*, law enforcement officials describe "keeping it together" as a matter of survival. However, some scenes and cases, by virtue of their uniqueness, magnitude, or pathos, challenge even the most sage and experienced officers in their efforts to disassociate from or to depersonalize evidence of suffering.

Table 9: Select Law Enforcement Code of Ethics Components

As a Law Enforcement Officer, my fundamental duty is to serve humanity; to safeguard lives and property; to protect the innocent against deception, the weak against oppression or intimidation, and the peaceful against violence or disorder.
I will maintain courageous calm in the face of danger, scorn, or ridicule; develop self-restraint; and be constantly mindful of the welfare of others.
I will never act officiously or permit personal feelings, prejudices, animosities, or friendships to influence my decisions.
I will constantly strive to achieve these objectives and ideals, dedicating myself to my chosen profession . . . Law Enforcement.

[5] Codes of ethics are used as instructional aids for law enforcement departments to help officers define standards and expectations of behavior. Individual agencies construct their own codes based upon the standards laid out by law enforcement associations.

The participants interviewed for this study universally described infant death investigations as the most emotionally challenging of the cases in which they had ever been involved. Their narratives reveal a significant and dynamic tension that results from the need they feel to quell, or at least keep well-hidden, overpowering emotional responses. Whereas participants describe finding ways to manage, or even enjoy the challenges and ultimate resolution in other forms of death investigation, they consistently referred to infant death investigation in a different light. Craig, a new detective with minimal infant death investigation experience explained, "Even at an adult death investigation, emotions are through the roof. At a child or infant death, it is ten times worse." Gus, a veteran detective who has investigated numerous infant deaths, agreed: "Infant death investigations are difficult… sensitive… more so than other death investigations… and they are personal. Most death investigations don't bother me at all. Child[6] death investigations do. And I think that probably everyone would say that sort of thing."

Mace, another veteran detective, made the following distinction: "If you work a case where the victim is a drug dealer who put themselves in a situation of danger and got killed, that is one thing, but a child is different. It is different. I don't know how to say it, but that child is helpless... Everybody understands that the child is unblemished and didn't put themselves into that position. They had no choice, and everybody recognizes the seriousness of this, because if something [bad] happened, the child couldn't fight back."

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[6] Though participants were asked specifically about infant deaths, many used the term "infant" and "child" interchangeably in their narratives.

The vast majority of infant deaths are not due to homicide, but the inherent and incontrovertible innocence of the infant engages a very personal and protective response from law enforcement. Sue observed:

> It's very interesting to work with all men, because you see what is real with them and that [infant death] is real. They don't want to talk about it, they don't want to look at it… It's kinda like the sacred "no." There are no photos up, there are no photos in briefing, there is no, "Hey, come look at this." There is none of that. It's like a closed door investigation for lack of a better term, like put on a different pedestal out of respect to the process… because they are bothered by it, and they'll tell you they're bothered, or they'll tell me they're bothered.

The profoundly difficult to manage emotional response evoked by these cases, juxtaposed with the pressure to "keep it professional" (read unemotional) adds to the weight of these experiences and leads officers to single infant or child death cases out as the most difficult parts of their jobs. Within this first tension, three subthemes emerged with regard to the to emotional impacts occurring in the distinctive spaces or contexts in which infant investigations unfold.

The Impact of Emotions at the Scene

The raw emotional undercurrents present at the site of an infant death investigation can produce tension around the very act of responding to the scene. These are not the moments that law enforcement train for with anticipation; these are the calls they respond to with dread. A radio call for an unresponsive infant is sobering; officers describe, "bracing" themselves as they drive toward something they would rather be driving away from. In Trey's words: "They are brutally emotional…I don't want to be a part of them." Matthew agreed: "Working on an infant death case is horrific. There is just nothing good

about it... You have to be there, but you don't want to be." Sue summarized a common sentiment: "Being called to an infant death investigation is the last thing I want to do today, or ever for that matter."

Despite the trauma law enforcement describe experiencing at these scenes, they recognize this as one of the many unavoidable parts of their job. As Trey reflected: "It is emotionally difficult, but you still have a job to do, so you better get your game face on." Wayne agreed:

> Whatever freak out or panic or grief or whatever is being communicated by the parents, the cops are feeling all that inside too. We just don't have the luxury, because we are supposed to be the ones that know what we are doing. Be in charge, Fix the situation. Can you imagine if I just started bursting out crying? I mean the parents would be like: "Holy shit! Who's going to fix this?" I'm supposed to be the one… So yeah, that's an aspect, we fake it very well most of the time. I guarantee that there is stuff that we're just going to take home and think, "Oh shit, what the hell?"

A few participants described consciously attempting to harness the emotional energy of an infant death as a source of motivation, yet most participants considered overt empathy and any displays of emotion as potential liabilities. Robert said: "Death investigations can be awkward enough for law enforcement, and [infant death] makes it more awkward. When you have all these grieving people around, the emotions get to you, and you may not use your best judgment." Tim warned: "When you are overwhelmed emotionally, you miss things because you are so stressed… It is hard to actually listen to people in a stressful situation and actually absorb what is being said. You could miss something that could make a difference in the case. That is serious." Walt, a forty year veteran of law enforcement, reflected: "Some law enforcement are affected

and are still able to maintain focus and do an excellent job. Others go in, basically half-shocked by the type of investigation and they are looking at their watch and can't wait until they get out of there."

Though most participants recognized the need for a measured and meticulous response at infant death investigations, participants also admitted that feelings of discomfort can result in an urge to rush the process. Trey acknowledged: "I think we sometimes try to speed the process up and try to get everything done so we can get out of that situation. I mean that is how I was." He continued: "Let's face it, if you respond to the death of an elderly person, you can be calm, relaxed, they have lived their life… but with an infant, you want to get in and out. I know people probably don't want to admit that, but it's true… it's because it [an infant death] is such a horrible thing. Nobody wants to be there." Trey went on describing his first infant death scene experience:

> I walked into the house and just stood there for a while. Dad's there, crying over the baby, and I'm like: "What do I do now?"…It's just I didn't know what to do. It's different with infants; I don't care what anybody says. I remember thinking: "I just need to wake this child up." "What do I do with the parents?" "How will I talk with the parents?" I can remember, just walking the other way – nothing to say, thinking: "I don't want to be involved in any conversation with them."

Trey doesn't believe his experience is unique and expressed concern about the ability of law enforcement to complete an adequate investigation under the weight of such emotion: "I think an infant death is very hard on everybody, and I think that most officers aren't going to say anything about it. But it affects them to the point where maybe they can't do a good investigation

without the proper training. I can remember responding. I see the child laying right there, and it was like: “Oh, what do I do now? What do I do?!”

In some circumstances, law enforcement may have the luxury of giving in to the self-protective instinct and leaving the situation. Chris remembered one such incident with gratitude: “I was only in the room for about thirty seconds, and I thought: “No, I have to get out of here. I am going to get really emotionally connected, and I need to back away.” Fortunately, there was someone else to step in, so it didn’t have to be me.” Chris recognized the potential impact of the case on his own wellbeing, while other participants recognized the potential impact of their emotions on the case or on the parents. Gus, who has investigated a number of homicides, said: “I think the first step in not letting an infant homicide slip by is to not give in to the urge to think: “I don’t want to put these parents through any more grief. I want to just believe their story, and let’s be done with this as quickly as possible.” Robert agreed with the need to slow things down, but with an eye on needs of the parents: ”It is that fine line. People err, in my opinion, on the emotional side versus getting the job done correctly. We have to get the job done correctly so that families have answers.”

Study participants who are also parents (N=22) recognized their position as a particularly significant barrier to emotional detachment and the performance of professional depersonalization. Wayne, in reflecting on an investigation where the deceased child bore a striking resemblance to his own daughter, said:

> They could have been twins. That was so tough. I had to kind of constantly remind myself: “Your daughter is at home, and she is

> fine." It is hard to separate sometimes. Even then, these people have just lost their daughter, so you can relate to that. You almost don't have a choice about whether or not you step into their shoes in your head, you know? You almost just get put in them, and you get what they must be going through. Yes, we have got a job to do, but it's hard to separate sometimes. If we stay very task-oriented, it can be easier, but then you get almost robotic and can mess things up that way too. So it is kind of a fine line.

Wayne went on to describe a compounding and paradoxical sense of guilt over feeling emotional: "I start thinking about those parents and what they're going through, and in some ways, it seems selfish to say: 'You know I'm having a really hard time with this." Well, yeah, but I get to go home and see my daughter, so who is really having a hard time with it? It kind of makes you feel bad at the same time for, you know, feeling bad… So it gets weird."

Wayne attempted to harness his empathy and direct it toward a successful investigation, but he describes this tactic as coming at a personal cost:

> You know exactly what is at stake for those parents. You know exactly what they are losing, and you know exactly how important it is. And, that is the driving force behind a desire to do this investigation the best that I can, put everything into it, and leave no stone unturned, because at the end of the day, that is what I have to live with. The child is already dead, I can't do anything about that. It is up to me to find out why and how, so you can help close this chapter in those parents' lives. So it can be a good thing in the fact that it makes you relate to them, and makes you vested in it yourself, but at the same time, it's a double-edged sword. That emotional connection wears on people.

As challenging as officers found the investigation scene, participants generally felt that the tensions between emotional expression/suppression and the performance of professionalism only intensified as they moved from the scene to the autopsy. The second subtheme describes the lived experience of navigating this tension within the space of the autopsy room.

The Impact of Emotions at Autopsy

Contrary to images portrayed by some popular media, the autopsy suite is neither common, nor comfortable ground for most law enforcement officials. The sights, sounds, and odors that accompany the autopsy process are tolerable to some law enforcement, but to many are simply unbearable. Tim, a thirty-year veteran with extensive death investigation experience in multiple jurisdictions, described infant autopsies this way: "They are just brutally emotional. They are to me, out of all the things I have done in my career, probably the top two or three most disturbing things I have ever seen. That's one thing you can't shake out of your head for awhile." Reflecting on one of the first autopsies he attended, Trey described walking in and seeing the young child on the table: "All I could think was: 'Give me that thing, I'm going to bring it back to life. You know? I didn't even know what to do." Trey went on to explain that his next thought was, "to start looking behind me for the place where I was going to fall." Trey made it through that autopsy, but wonders how much he was really able to contribute to the investigation when so much of his energy was spent trying to maintain his composure.

On rare occasions, the law enforcement official may concede defeat. Tim described an autopsy when another officer simply left the room: "He left in the middle of one because emotionally he just couldn't do it. We were all like, 'Wait, he can't leave,' but looking back that was just a macho response. I can't give you one good reason why police have to be at the autopsy of a child." Donald, veteran

detective of dozens of homicide investigations, dose see distinct value in attending the autopsy:

> I firmly believe law enforcement should be there. Attending the autopsy puts the medical examiner's findings into context and perspective for me… All those little details are extremely important. While I can generally rely on the pathologist to document all that stuff, if I don't see it for myself, I just can't quite put it where it belongs… I would be very hesitant to do any homicide investigation without having either myself or another detective in the autopsy room communicating with the pathologist. I have become dependent on it, and going there and seeing these things for yourself, motivates you. "Oh my God! I cannot believe this little child has twelve broken ribs!" It would be an understatement to say that motivates you.

Yet, this motivation comes with a price. Wayne compared the anxiety and exhaustion of a child autopsy with other aggressive, high-stress law enforcement activities: "We do crazy things like go kick in doors, but that stuff is just hollow compared to a child's death." Referring to his first child autopsy, Wayne went on to say: "That is the most tired I have ever been. After that autopsy, I was just extremely, physically tired—just very, very drained. I remember that feeling, and I hadn't done any exercise. It's not like I was out running miles; it's just the mental fatigue. So when you put yourself in that, you have to be able to deal with those negative effects… but again, that is part of the job."

Craig also described child autopsies as the most stressful of law enforcement activities and was among the many participants who expressed an acceptance that the task may be unavoidable: "I have never been to one, and I don't want to. If I have to go to one, I will, because I signed up for the job to serve people. But, it is one of those things in your career you hope you never have to do. You hope to never have to shoot somebody. You hope to never have

to go to a child's autopsy." After attending his first child autopsy, Walt remembered asserting that he, "never needed to go to another one." Yet, Walt similarly acknowledged: "I wouldn't refuse to go. As long as there was somebody else that could go do that job though, I wouldn't go." Trey summarized a sentiment expressed by many: "Somebody has to do the hard things we do, otherwise they wouldn't get done."

Recognizing the unique and powerful impact of emotions in these cases, Walt expressed concern for the quality of investigations and warned that law enforcement must, "recognize that if they are uncomfortable to the point they cannot do the type of investigation they need to do, they need to let someone know." Yet participants described how difficult it was to admit to their level of discomfort, at least until after the task is complete. Pete reflected on how such a "strong work ethic" (socialization into the "appropriate" performance of law enforcement) comes at great personal cost:

> I was volunteered to go to the autopsy. My boss did ask me if that would be ok, and I said: 'Yeah, I will be fine.' I shouldn't have gone, but I am not going to say no to my job. I am learning how to say no after ten years of being here, but part of that is just work ethic. Some of it is just, well, my dad worked, actually my whole family worked blue collar jobs, and you just busted your ass, you did what the boss said. Well, shit, I had three hours of sleep before I went there, and I was already up for 30 hours or something before that. I finally lost it when I got back home, and my son was saying the same things the suspect told me the little boy was saying, right before he suffocated him.

Some offered suggestions for how to mitigate the stress associated with autopsy observation. Matthew, for example, noted that sending two people has helped to alleviate some of the emotional difficulty: "Nobody should have to do

that by themselves. It helps to have somebody to talk to or to just take your mind off things on the drive back." He notes there are added benefits from an investigative standpoint as well: "Two sets of eyes pick up on two different sets of information, and what one person misses the other picks up." Wayne, agreed:

> Looking from the outside in, it was a really good thing we sent multiple detectives to that autopsy. Otherwise I would have just been fumbling and not really effective. There was all kinds of stuff going through my mind, and maybe it was just me being uninformed and not knowledgeable about how it works, but I was more worried about, "How are these poor parents going to have a funeral?" Stuff like that. Of course after the fact, I saw that everything goes back in place perfectly. But, I remember I felt like I had these responsibilities, and I felt useless. It didn't really matter what all I was *supposed* to do. I mean I was writing down all these weights and stuff, and do I know what it matters if this weighs this much or if that is normal, or good, or bad? No, but it kept me busy and maybe it was important. I don't know… That was a big day, a rough day; it was a weird day. All I could think about was: "Man, I really just want to go home and see my daughter." It is very difficult to balance the personal and the professional.

Participants further noted that the personal impacts of emotional engagement do not fade away once the professional duties are complete. Though George and others find strength in, "working for the child who cannot speak for himself", the resultant emotional suffering follows them home long after the work is done.

The Impact of Emotions After the Work is Done

For officers who have worked on infant and child death investigations, there is a strong sense that something "follows them home" in a way that is not true or the same for other death scene experiences. Mace describes the impact of one child death saying: "Those cases have been the most emotionally and

mentally draining over time. They are exhausting cases—you go home, but you don't want to go home, and you are lucky if you get some sleep because you can't turn it off. " Donald, an officer who has participated in a number of child death investigations, still vividly remembers one of his first: "That one kept me awake for three nights, three or four nights, I didn't sleep at all. That's when I figured I had to learn to turn it off." Donald has learned over time how to cope and "leave things at work." However, he pointed out that other law enforcement officials, especially when it comes to infant death investigation, are not always that fortunate: "I know other officers that can't [turn it off] and they either get out of the business, they develop health issues, or they become dependent on alcohol or drugs. Some wind up going down the spiral of poor performance, and end up losing their job, from the stress. I've seen the gamut, and I feel very fortunate to be able to turn it off…most of the time that is.

While, all participants readily described the emotional toll an infant death investigation takes, some also described taking the additional step of asking for help managing these effects. Trey reflected on the period of time right after an infant death investigation is complete:

> I don't know who would be the one that does this, but I think that the officers probably need to get some sort of talk after an infant death. You know, from somebody. Big, tough, strong officers, they really don't want it on the outside, but on the inside they're probably screaming for it, you know, just a release. We talk amongst ourselves after a death or whatever, but some sort of, and I don't want to say a professional counselor or anything, but just someone to listen. Not to give advice on how to do things differently or anything like that. Just: "What happened? Alright, if you need anything give me a call." Individual is better so people can let their guard down a little bit. If you get officers in a group setting, you're not going to get the whole truth of what's on their

> mind… you know you never get over the infant deaths. It's always in the back of your mind. That's the way I feel about it, and I'm sure others feel that way too, they are just not going to tell you.

Officers' narratives make evident the immense power of occupational culture and their explicit socialization into the performance of stoic, strong (non-emotive), "professional" investigations. They must perform their duties, even when they feel like they may "fall apart." The resulting tension they are left to negotiate—between what they feel and what they can show they feel—was acknowledged by some as a potent source of poor mental health for officers. In Mace's words:

> Something that comes to mind for me right away when I think about infant death is the emotional impact, the PTSD stuff. Cops are supposed to be tough. They are supposed to be macho… all that crap. I think we are getting better as a profession at acknowledging that this stuff is not easy, it is not business as usual. You can go months on a case like that [an infant death], no time off, working all the time. And no, "Hey, you are doing a good job." Being a cop can be a thankless job. But providing that recognition and support, that's the agency's responsibility as a whole, and the individual has to either seek that help or not. Or, use their own support systems if they can.

Similarly, Pete, in sharing his reaction to a violent child murder case he investigated, said: "See, usually stuff doesn't bother me while it's going down, and you don't think about it when you're just go, go, go. But finally, when I got home, my wife was worried about me for a while because she knew what was going on, but I was like: 'I'm fine, I'll talk about it when I'm done. I don't want to talk about it now'. And I was fine because I was moving, but when it was over, it caught up to me, and I finally broke down."

Though these narratives reveal a strong motivation to ensure infant deaths are investigated correctly, they also reveal myriad ways in which emotional reactions and struggles can have negative consequences, for both the investigators and potentially for the case. Stories reveal that law enforcement officials struggle to "keep it together" for the greater good of the case as they attempt to navigate this first tension in the context of the scene, the autopsy and the time following the close of a case. Below I discuss how this tension is exacerbated by uncertainty and other forms of discomfort in the context of what participants experience as inadequate preparation and support for these difficulty scenarios.

TENSION II: "This is not something you can just wing": Navigating high-stakes, under-resourced investigations

When called to an infant death, law enforcement officials struggle to keep overwhelming emotions at bay because there is a job to be done. However, as this second theme illustrates, law enforcement struggles with additional dynamic tensions during an infant death investigation. Participants in this study articulated a strong desire to get the job done well, yet expressed a lack of critical preparation, support and resources needed to accomplish that task. To further compound this tension, participants consistently identified infant death investigation as one of the most demanding and "high-consequence" situations encountered in law enforcement.

Participants in this study rated infant death investigation as, or among, the most significant and demanding events they may ever encounter. Both the patrol officers/deputies, who are usually the first on scene and therefore responsible for critical initial decisions, and detectives who are generally called in to either assist or assume responsibility for the resultant investigation, shared this opinion. Regardless of the nature of the death (natural, accident or homicide) participants compared infant death investigation to the experience of a homicide investigation by virtue of the importance placed on the task and the resultant pressure experienced by investigators. Participants also categorized infant death investigation as among the other most "high-stakes", "high-stress" and "high-consequence" situations they ever encounter. Also included in this category were vehicle pursuits and officer-involved shootings.

Kelly, for example, in discussing the need to "prepare for the worst" said: "I may never get into a shooting, but it is one of those things… I know the potential is there, and I have to be prepared to respond if it happens. Infant death is one of those things. It is *that* important. It may be one of the most important things that we do. It's high stakes. I mean you are talking a little kid…" Matthew described the magnitude of the pressure he felt while participating in an infant death investigation this way: "That's the most weight I've ever felt on an investigation. You don't want to mess that up. There is a lot of pressure involved there." Cindy agreed: "The consequences of failing or making a mistake are pretty bad for you, or your victim, or a fellow citizen… That is where a lot of my anxiety comes from about my job." Chris similarly described sources of

anxiety: “So many things are my responsibility coming in initially and because it is an intense emotional event anyway, plus the fact that it may be a crime, and a significant one at that…. “ George summarized the words of many participants in saying: “We just want to do everything right.” Unfortunately, participants identified a number of common factors experienced as barriers to “doing it right”, including the subthemes of inexperience, a lack of training, and inadequate structural support. These critical barriers complicate this second tension between high-stakes outcome and chronic critical resource shortage.

Inexperience

Using data collected from a 2005 survey of US medical examiner and coroner (ME/C) offices, Camperlengo and colleagues (2012) found that most investigate only a few infant deaths each year, and as a result, medicolegal professionals rarely have the opportunity to hone infant-specific investigative skills. Given that each medical examiner and coroner commonly interface with multiple law enforcement agencies, this begs the question: How might even lower numbers impact law enforcement agencies? Very low numbers and the fact that officers have a multitude of other responsibilities to master, combine to make it difficult for officers to acquire the experience that would ensure their competency. Participants discussed the multiple ways they fear inexperience can negatively impact case outcomes.

John, a supervisor with eight years of experience as a detective, has not yet participated in an infant death investigation. He expresses concern that his lack of experience may make it possible that critical tasks could get overlooked

or forgotten: “We don’t do these all the time, so we never get good enough to become comfortable or remember everything we need to do or should do.” In reflecting on the importance of experience, Mace said: “At the end of the day, no matter what kind of case, whether it’s a child death or anything, obviously investigators make mistakes all the time, small, big, medium large whatever the case may be, and you look at it and just apply for the next time so you don’t make the same mistakes … You are going to fail in a case, you are going to work through it, you are going to make decisions—good or bad—there are consequences… and hopefully for the next one you don’t make the same mistakes.”

Recognizing that mistakes are more likely with inexperience, participants expressed the need for mentors, especially for new investigators. Donald said: “Someone who has been there and has gone through this before— there is nothing better. There is no better education tool than experience, and that is kind of a catch-22. Someone has to suffer horribly for folks like me to get that experience.” Participants acknowledged that a formal system of mentorship is unlikely to happen. Law enforcement officials are commonly asked to simply do their best, regardless of inadequate preparation or support. Craig, in talking about the fact that he has not yet participated in a child death investigation said:

> I know it may not happen, but for as new as I am, I would want a senior investigator there to assist… If I were a parent of a child, I would want the best investigator possible doing that job. I’d want an investigator that’s done it before. You know, it’s the exact same thing as a doctor. When I go to the doctor, I don’t want a doctor that is in training or is straight out of med school doing open-heart surgery on me. To be honest, I think it is a huge injustice to a family to not have an experienced investigator assisting.

Participants recognize that critical investigative tasks suffer as a result of inexperience. Chris spoke specifically about the importance (and the difficulty) of interviewing the parents: "That's a difficult role, and this is not something we deal with that much, so we are not very practiced at it. So, it makes that activity, the dealing with the grieving parent part, even more difficult." Similarly, Taylor reflected on his first infant death investigation saying: "I wish I'd asked better questions." He noted that even by his second child death investigation, he was "much more comfortable" asking" the right questions." Casey, spoke from the perspective of not only a veteran law enforcement officer, but also from the wisdom of a father who suffered the loss of an infant to SIDS decades prior:

> I am not going to say that I am the best cop that has ever walked, but I have learned so much over the 26 years that I've been a cop. I have come so far in my own investigative style. So, while I would be the last to throw stones, I would almost venture to say it's a position that somebody who is not tenured shouldn't be in. Somebody that's at a journeyman level of some kind shouldn't be in the position of trying to be a 24 year old talking and working with these types of investigations without some life experience. You don't dare miss the one intentional death in these cases, and so there is just a point at which you have to be willing to offend and ask the hard questions.

Experienced investigators recognize that successful infant death investigations are dependent on the prompt acquisition of detailed and nuanced information from the scene and from the caregivers. Thus any lack of experience can be a critical barrier to the overall success of the investigation. In the absence of experience, law enforcement cannot develop the necessary skills, techniques or confidence. Tim warned: "We only have one shot at each of these cases, so we must be prepared, and that requires rehearsal or training. You have to be ready

for an infant death investigation; it is not something you can just wing. The cases are too complex and there is too much riding on it..." Trey agreed: I think all new officers come in and expect to run after people, chase people and arrest them, but they don't expect to show up at a scene where there's an infant death. I know because I have been there. It traumatizes them, and they don't know what to do. They are like: 'I know how to handcuff people and arrest people, but I don't know what to look for at an infant death scene.' I know we don't always do everything to the level we could, and that is probably the reason some of these cases go unsolved."

The Next Best Thing to Experience

In the absence of adequate experience, and with little hope of ensuring the presence of an experienced mentor, participants discussed what they saw as "the next best option." Wayne said: "Obviously, the alternative to experience, the easy one, is more training— a lot more training, just across the board. I mean to have your first infant autopsy be the one that you're responsible for and not knowing anything about how that is conducted or the whole doll reenactment thing, that is just too much to ask. Plus, it is bad for the investigation." Doll reenactments are a critical part of many infant death investigations; they allow investigators to learn from the caregivers the precise location and position in which this infant was last known to be alive, as well as where the baby was found deceased. Discussing his first experience with this gold-standard investigative tool, Wayne described being unprepared: "She [another investigator] brought out a baby that was a doll, and said 'Hey, will you run the

camera?' while she walked the baby sitter through all that stuff. It was like it was on the fly. When, you know, there could have been some training that would at least break you in some. That would have let me feel a lot more confident. You know something like: "This is what the Medical Examiner needs from you. This is what the doctors need from you.' I basically had no idea what anyone was doing that first time".

A number of participants mentioned training they receive at "the academy," referencing the basic law enforcement training new hires attend as preparation for their role in any law enforcement agency. Academy training is where new officers are indoctrinated into the culture of law enforcement and given the basic knowledge they will need to begin building their career-long education and expertise. Trey, spoke of the need for attention to infant death investigation early in the process of law enforcement education:

> Starting from the academy, with training afterwards. Mandated training, I mean. You can incorporate it into whatever, but at least have some sort of updates... because if they don't have that when they respond to something like an infant death, it's going to be traumatic all over again… instead of; "Oh, I know what to do." So, it should start from the time they get hired, go to the academy and then with follow up afterwards. Detectives should also have specialized training. The whole thing is we don't have money for training, but we all need it. We can't afford not to have it.

Craig agreed that infant death investigation training should extend beyond the academy and should be mandatory:

> The only training that I've received specifically on infant death was in the academy, and that was roughly five and a half years ago. Part of that is probably my fault for taking training more in narcotics and more stuff that I am interested in doing more often. But even homicide classes are more oriented towards adults with a very small blurb on infant death. So, I don't think it's something

> that's widely pushed for in the law enforcement world, to get that training out there. I mean you go on the [training] website, and it's like: 'Tactical training, Tactical training, Narcotics, Sex Abuse," and stuff like that. Nobody wants to go into a child's death.

Jack, a military veteran with extensive overseas investigative experience, echoed this desire for more training due to a lack of experience. He went on to explain the discomfort and intimidation he feels in relationship to child death investigation:

> I have been through everything the department mandates, including specialized detective training, but I still don't feel very comfortable. If a parent says, "My kid wasn't breathing…" Well now what? Where do you start? Never having had kids, I have no idea and I've been scared to death of kids and I don't wanna screw this up. I would defer to either detective or others who have been at this longer. I need to lean on their years of experience and advice because I haven't ever been that guy… It's very intimidating.

Acknowledging both the infrequency with which law enforcement encounter these cases, and the commonly expressed preference to avoid them altogether, Robert argued for more training, especially given that stakes are so high: "More training. Train, train, train. It's one of those things we hope we never have to do. I'm thankful that I've only had to be involved with one, but you need the training. You need to stay up on it because you need to be sharp when it happens." Matthew summarized his concerns over the current state of inadequate training this way: "I think homicides go undetected sometimes… I think as a whole, law enforcement nationwide is probably missing it [homicide] sometimes because we just aren't looking for the right things… we are not well-trained."

Money and Manpower

Though training and experience are a critical preparatory step, experienced investigators warn that other forms of support must be provided for the duration of the investigation. The most heavily cited form of support required during the investigation process is the approval of adequate funding to ensure an abundance of help at these difficult scenes. Donald cautioned: "Once you get the knowledge and experience, you still don't know it all. It is critical to know who and what your resources are, to reach out and get help, because you are never going to know it all. There is no one person who can do these [infant deaths] by themselves."

Recognizing how much is riding on the process and the outcome of an infant death investigation, participants argued for the need for physical support in the form of additional "manpower" on the scene. "Manpower" is an emic term, utilized by both male and female study participants during interviews and in the everyday interactions observed during participant observation. It is used to reference the number of individuals called to a scene and/or assigned to assist with investigations.

During interviews, officers discussed a spectrum of possible manpower responses to an infant death, ranging from an individual patrol officer to an "all hands on deck" scenario. Tim reminisced about an early infant death investigation, in which he was alone at the scene and unable to ascertain the location of the infant from the crying mother: "It reminded me of a movie, and I kind of see it— because it was stressful and I was there by myself—I kind of see it as though I was watching myself from above when I think about it. Like I was

out of my body looking down on what was happening. Isn't that weird? I get there, and the mom is on the front porch, and she is crying. I cannot get from her where the kid is. Because the call just came in 'dead baby', I don't know what is going on." Tim went on to explain that, because he was alone at the scene, he had to leave the mother alone and hysterical while he searched the residence and surrounding property for the baby. Trey described the importance of sending as much help as possible to the scene immediately: "If it ends up you don't need the help, then you just send them away and say 'We've got this covered'. They can always be sent away, but it is always harder to get the manpower in the first place then to send it away…"

Participants described a variety of potential uses for the additional manpower. Tim remembered an infant death scene in which two law enforcement officials were needed, just to attend to the baby: "I found the baby on the mom's bed, he was blue. Just blue, blue, like you hear about. So, I started giving the baby mouth-to-mouth… I felt like there was some hope… We started CPR right away, and he hadn't been dead long." Tim successfully resuscitated this infant, only to learn he died some twenty days later [likely from an anoxic brain injury]. Similarly, Wayne discussed a situation where he was grateful for a show of support at the scene of a child death: "You know, it kind of goes without saying, even the Chief was out there, and so it was kind of an all hands on deck as far as that investigation goes…That's nothing more than making it a priority, because I mean, I'm sure he had administrative stuff that he was supposed to do at that time, but there was more help needed, so he was there."

The emotional toll, the high-stakes nature, the immense workload of such cases, and the lack of experience combined to lead participants to argue that infant death cases should receive special treatment. Trey said of the need for special priority consideration in case of a child death: "Even if the death is not suspicious, these should get more attention, definitely. It is time consuming, I get it, but isn't it important enough? To me, it's more important than a pursuit. Even though pursuit is really dangerous, you know, and could have huge liability. These could have huge liability if we make a mistake. That's just my thoughts, and I know that sometimes that won't, that can't happen, but why couldn't we make that happen?"

One of the first, and most important tasks to be completed at the scene was identified by participants as "freezing the scene". Definitions of this concept vary slightly, but the general consensus is that, upon recognizing any possibility of suspicion, the first responding officer bears the important duty of immediately halting any movement or change occurring at the scene. This is generally accomplished by limiting access to the area and maintaining the setting in as near the original condition as possible. The goal is to ensure the context and any associated evidence are not inadvertently or purposefully altered. At the same time the scene is being secured, a call goes out to all any available personnel and allocated resources, to respond and begin the meticulous and time-consuming process of analyzing and documenting the scene findings. Chris reflected on this important duty:

> Much of an infant death investigation goes against the grain of law enforcement training, especially a patrol function. They are

> fortunately rare, so we kind of stumble through a bit, getting everyone's roles set to begin with, but the first thing that I will look at or I will be blamed for doing something wrong in the patrol function is if I don't freeze everything and make sure that nothing has been moved. That is my responsibility coming in initially, and this is an intense emotional event anyway, plus the fact that it may be a crime and a significant one at that. I would be at fault if anything went wrong because I am the first one on scene.

Trey agreed with the importance of freezing the scene, then expressed a strong desire to quickly hand over responsibility for what comes next. He said: "I think we should get there, lock it down, and have someone come in that knows what they're doing –just so that we, as officers, don't miss anything. Honestly, for me, it's 'Call out the major teams.' The patrol officer responds, and will lock the scene down, but let's call out the professionals that specialize."

Tim agreed a specialized response is ideal, but still recognizes the importance of utilizing all available resources, including regular patrol and their supervisors: "Who will focus on the parents? If you don't focus on the parents right away, you are going to regret it, but if you are so worried about what the medics are going to do, the evidence gathering, taking photographs, etc. Are you really going to do a good job with the parents? You have got to be able to focus on it; I think that's the key." Like Tim, several participants noted that patrol and detectives cannot focus on any individual assignments unless someone – generally the on-duty supervisor – remains on the "outside" to make sure that everything else gets taken care of. Rather than becoming absorbed by any one intensive investigative role, this person watches the big picture, providing support where needed. In addition to the provision of support through

oversight and logistics, participants also saw a need for adequate relief staff and, in Wayne's words, approval for overtime for:

> …as long as is needed… If I had to put a time frame on it, I don't think I could. They [infant deaths] are never going to be short cases. I mean, if you say you have completed a baby death in two days, then you did a piss-poor investigation, regardless if it was accidental or not… It is one of those things; you do 24, 36 hours straight without taking a break or going home to get sleep… When the last baby death was going on, we didn't touch anything else. Nothing dope related, nothing property related, all that stuff takes a back seat.

Annie agreed: "It's really important that we give these cases 100%, 110% of an investigation, and doing the best job we can… and if that means we have to sacrifice a little bit, like in the sleep realm, that we should be wiling to do. But, we also have to have support from the command staff."

Some experienced administrative representatives, like Tim, consider child death as such a high priority that budgeting should not even be a consideration: "You think of cost in these situations; that is just part of the gig. You do this job as an agency. I think the cost is a zero factor." Wayne agreed with the need for prioritized funding and further expressed a desire for an equitable distribution of funds among all agencies interested in working together: "In the end it comes down to money and manpower. I think the magic wand would be if some rich person would say: 'Here, I'm going to have an outstanding police training budget for the whole county. That would be another thing too, not only for us as an individual agency, but for other agencies, so that everybody is on the same page, and knows if another agency has a death, we're willing to help."

Participants recognize infant death investigation to be a critical task and express a strong desire to ensure a successful outcome. Yet, they consistently report feeling unprepared for the task of infant death investigation. They navigate this tension between high-stakes and low-resources, citing lack of experience, training and support as major barriers to "doing their job"—that is, to adequately serving the needs of the parents *and* the investigation. Further more, the stakes are recognized as high, whether the cause is medical, accidental or foul play, but the idea that some oversight on their part may put future children at risk plagues officers during and after investigations. Participants recognized a variety of ways in which their failure could leave other children at risk, including cases resulting from an unidentified environmental risk such as carbon monoxide and the unthinkable cases where parents have confessed to the serial murders of multiple children over time. Participants were clear: the lack of resource allocation is an unacceptable reason for a failed investigation. Trey summarized this common sentiment when he said: "The bigger picture is, 'let's find the truth'. Let's not worry about budgets and money and whatever. Especially with something as important as infant death."

Tension 3: "Walking a real fine line": Navigating interactions with parents— victims or suspects?

The third major tension that emerged from these narratives is a product of the ambiguous scene and physical examination findings commonly encountered in infant death investigations. Cause of death is rarely apparent from the outset

and there may be no visible difference between an infant who has succumbed to a previously undiagnosed medical problem and an infant who was murdered. This reality is of deep concern to the law enforcement officials actively navigating time-sensitive scene management decisions and delicate interactions with the parents. Lacking any clear indications that a crime was committed, law enforcement struggle with how best to ensure their involvement contributes toward a successful outcome.

Overall, participants defined a "successful infant death investigation" as one in which their presence and efforts somehow "make things better." Participants generally feel they can make things better by discovering "the truth" and providing support to the parents; unfortunately, these aims can prove to be paradoxical in the case of infant death. If investigators focus only on the immediate needs of the grieving parents[7], they risk an inadequate investigation, and one negative consequence of an inadequate investigation is further suffering for innocent parents searching for answers.

With no physical exam or scene findings upon which to base decisions, law enforcement are left to blindly maneuver through these high-emotion, high-stakes scenarios with no clear path and no solid footing. Within this third tension, three subthemes emerged that help to illustrate the ways law enforcement officials experience and manage the "fine line" between parents as victims versus suspects.

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[7] The terms "parents" and "caregivers" were often used interchangeably by participants in acknowledgment of the fact that the person caring for the deceased is not always a biological parent.

Bad Stuff Happens

Where as it may be difficult for the general public to comprehend that a parent or other trusted caregiver could intentionally inflict serious harm on a child, veteran law enforcement are all too aware of this reality. As Wayne explains: "Unfortunately, the other side of doing this job is that you get opened up to a world where bad stuff happens all the time." Walt described some heart-wrenching, eye-opening cases involving children over the course of his career: "We had many instances where parents tortured their children, beat them with coat hangers, made them sit in cold bath water all day, not feed them. That will make you see real quickly what people are really capable of… and I've learned you can't always judge a book from its cover." George agreed with the need for objectivity in these cases:

> We, as investigators and as an agency need to go into the situation without any preconceived notions. Just go and follow wherever the facts take you. You cannot make judgments, "This is a good family, so things must be ok." Or, "This looks like a bad guy, therefore it must be a bad things," You must follow the facts. Get your facts first then make your theories. Don't get your theories to then suit your facts. Have that order correct.

Joan, too, has been exposed to these realities and argues for an objective analysis of an infant death:

> I have seen people do things I never would have imagined they were capable of. I have watched videos of kids being beaten on nanny-cams, read or heard confessions from parents who have done horrible things… One mother confessed to pinching the baby's nose and covering its face with her body. She said it took the baby a few minutes to completely die… and maybe the scariest

> things was there was no physical sign on the child! She then flipped him over, and put him face down so it looked like he suffocated on a pillow or something by himself. So, if you go into these [infant deaths] thinking no parent could ever kill their child, you are not going to be a very good investigator. Or, this is not the kind of case you should work.

Participants recognized that bad things happen, and they struggle to find balance at the intersection of what Donald described as, "the harshness of a criminal investigation and the human kindness aspect." Matthew, who specializes in the investigation of physical and sexual crimes against children, said:

> I'm finding anything done with children, infant or above, you walk a real fine line because you are walking into somebody's life and potentially the most horrific incident they could ever fathom in their life. You as an investigator have got to be fair to the child to make sure you figure out what happened. In the same breath, you have got to be fair to the parents.

Many participants described a powerful tension between their desire to provide compassion and due respect to the parents, and their duty to represent the child by ensuring no crime has been committed. Nigel explained it this way: "Our number one role is to determine if this is criminal event and, if so, who is responsible… Unfortunately, if it is a crime, the parents are usually going to be the suspects, and if they did something, I want to find out. But if they didn't do anything and the child just died, then this is the worst day of their life. So, it is hard to balance that." Sue summarized the difficulties this way: "You have so many things that could have happened, and you have a victim who can't talk *and* if the kid was hurt, all your answers are coming from your suspects." Law enforcement investigating infant death must dwell in the ambiguity of an

unknown cause, while simultaneously attempting to ensure the integrity of the case without causing further distress for the devastated caregivers.

Trey justifies any short-term discomfort with an eye on the end goal: "They [the parents] may automatically feel like they're suspects, but we have to let them know: 'This is what we have got going on. We are going to try to help you figure out the reason for your child's death.'" Some fortunate participants have found comfort in overt support from the parents. Chris remembered a case where the parents told him: "You can look anywhere you want, and you can go anywhere you want." Chris noted: "It turns out, they were as interested in finding out why their child died as we were."

Cindy argued that carefully considering the parents as suspects is an essential task, saying she approaches each investigation: "hoping for the best, but preparing for the worst… I think it's an injustice to the family if you don't." She sees this strategy as a from of respect, "for the agency you represent, for the family, and for the victim." Matthew, and others, also made note of the fact that *disproving* a crime – as opposed just *assuming* no crime - ultimately helps the parents: "We may not believe it is criminal, but that is not good enough. We have to try to prove it is not." With an eye toward justice, law enforcement struggle to obtain objective information from parents who are likely grieving victims, but must still be "ruled out" as suspects. Mace said: "It is just a delicate investigation cause you don't want to trample on people having probably the worst day of their life, but again you've got to have the integrity to do the investigation. It's kind of a hard balance."

The only thing participants fear more than mistreating parents, is overlooking a homicide or mishandling potential evidence. Approaching a death investigation as a potential homicide impacts every aspect of law enforcement interactions with the people and physical spaces involved. Mishandling either may destroy any hope of a successful prosecution, should a crime be revealed.

Seasoned investigators know well, the sinking feeling of recognizing, after the scene and documentation have been compromised, that a death may have been a homicide. This is the central challenge at any death scene; overreaction and overly suspicious interpretation may result in a misuse of resources and the potentially inappropriate treatment of grieving victims. At the other end of the spectrum, failure to proceed with caution and *just enough* suspicion can irreparably harm investigative and prosecutorial abilities. Craig explained:

> It is kind of double-sided because in an infant death, to me, you have multiple victims. Of course you have the infant that died, but you also have the family members that just lost an infant. Then, the victims may also be suspects, so it is difficult to go into a highly emotional situation like that. It is very heinous, tricky and difficult… Nothing would be worse than not treating it as a potential homicide, and then get halfway through, and realizing it actually was

Donald agreed with the importance of considering the potential of homicide early on and argued for an objective pursuit of "the truth," with no regard for outcome:

> To me what makes a successful infant death investigation is accurate determination of the facts that clearly outline what happened to the child. Sometimes that protects the parents or other people that take care of the child because they did nothing wrong. Sometimes it puts the parents in a situation where they are going to prison for killing their child… You have to be fair, you have to be logical, and you have to be accurate. Sometimes fair

> and accurate may not necessarily go together, but the duty of law enforcement is to the victim, not to the parents. And, sometimes that doesn't go together very well.

Donald went on to describe finding solace and strength in the end goal:

> Trying to deal with an infant death or any child death is always difficult. You are thinking: "My gosh, this poor innocent kid never had the chance to live, never had the chance to do anything… Not a lot can be done about it now but to seek justice for what was done, and when you get that justice, or at least what our society believes to be justice, that is job satisfaction. That is why I got into this business.

An Absolute and Total Lack of Physical Evidence

As law enforcement struggle with the possibility that an infant death may have been inflicted, their efforts are further stymied by the fact that infant death scenes are frequently devoid of overt physical evidence or other obvious indications of whether the death is a result of natural, accidental or criminal events. In other forms of homicide investigation, the location where the body is discovered often yields an abundance of physical evidence. Infant death investigation, by contrast, is experienced by law enforcement as "enigmatic; instead of looking for possible wrongdoing, [law enforcement] often must focus their efforts on establishing an overwhelming lack of evidence." (Weyland, 2004:11) If an infant dies at the hands of a trusted caregiver, the scene may be completely lacking in useful physical evidence. The perpetrators [and evidence of their physical presence] are expected at the scene, and the "weapon" may be a hand, a pillow or any other household object. None of these items will likely appear out of place or offer useful information about what happened. As Donald explained: "I never did like working on suffocation cases, because there is

frequently not enough evidence. Just getting the cause and manner of death is difficult enough. There is an absolute and total lack of physical evidence. Zero… none. It just isn't there."

Chris echoed the words of several participants as he explained in detail the discomfort this reality causes for law enforcement:

> Usually the problem is finding who the bad guy is, not figuring out what caused the death. If we have a shooting, there is a hole in the guy, and that is why he is dead. These cases are usually not that way… they don't speak to what caused the child to die. They're difficult because there's usually no physical evidence on the scene… We want to be able to be able to make a decision, and you can't really do that in baby cases… We are kind of spinning our wheels, and it's a very uncomfortable feeling from a law enforcement perspective. It's a very difficult situation, not only because of the emotional element, but also because we want to make a quick decision and fix things or set things back to the way they were. There's no way you can fix that and the best you can do is make an arrest, and that doesn't fix things either… It just goes against everything that we want to do in law enforcement and all we are accustomed to doing.

Chris contrasts his role in infant death investigation with his "more comfortable role" as a traffic deputy:

> My assignment right now is on the traffic team, and I like it because I can take immediate action on things that I see that are wrong. For example, in drunk driving investigations, you go to the training, and you follow a certain protocol, and you know at the end you can make a good decision to arrest that person or not arrest them. I can feel good about the decision afterwards because there are other things I can do to corroborate my decision. I can stand on my decision and know that I made a good one. That doesn't exist with child cases… What if there isn't a bruise? Does that mean there's not a crime? Well of course not. There still could be a crime. I want to be able to rely on myself and the people around me to make a decision, and this is a not a case where you can do that.

In the 4th edition of his widely referenced homicide investigation

handbook, Vernon Geberth reminds investigators that the cardinal rule in homicide cases is to protect and preserve the crime scene, stating: "The initial actions taken by the police at the homicide crime scene will or may eventually determine whether or not the crime is ever solved or the guilty person brought to justice." (2006:xi). However, before a crime scene can be protected, it must be identified as such. How can law enforcement make this determination at the scene of an infant death without overt, measurable physical evidence to indicate a crime has occurred? Lacking any "smoking gun", investigators struggle with decision-making in the context of a potential homicide scene. Participants reveal a dynamic tension within their efforts to balance critical, time-sensitive, scene-management decisions with the immediate, emotional needs of the parents.

The manner in which law enforcement are expected to manage the scene of a suspected a homicide is the inverse of what they recognize may be the best environment for a grieving family. Jack explains: "If you treat it [the scene] like you would any other homicide, you lock the scene down… you essentially say: 'This is ours now.'" This act of freezing the scene and assuming control of its contents is a fundamental step in a homicide investigation, but it is not one taken lightly in the context of an infant death that is only *possibly* a homicide. The potential impact on the family is not lost on participants, especially in the context of little, or no, compelling evidence. Matthew remembers taking control of a home where a child died. He was acutely aware of how this act, "prevented mom and grandmother from being with their grieving family in their safety zone." He further reflected: "I just have to wonder if there is another way we

could do that. Like I said, it is a balancing act. We have to be good and thorough, protect the evidence, protect the scene, but in the same breath, it is potentially just a horrific accident, and it is the worst day of their life, ever. And they are going to remember how we handled it."

Participants struggle with these scenarios because they care about the families, the cases and their communities. Geberth recognizes the importance of this fact and states that homicides are usually solved for this very reason, "because the detective cares" (2006:xxxiv). However, Geberth's handbook goes on to point out that successful investigators put this caring into action by becoming advocates for the victim *and* the surviving family. Participants in this study describe struggling between caring about these two potentially conflicting parties, especially since they know there is likely to be no physical evidence on which to base decisions.

A Balancing Act

Finally, participants spoke at length about the specific difficulty of knowing how to manage family members or caregivers who are most likely innocent, grieving victims, suffering the greatest tragedy of their lives, while maintaining the simultaneous and ever-present awareness that they could be guilty of unthinkable acts against the child.

As Gus explained:

> The part I find the most difficult about infant death, is that you have to balance between thinking of the parents as suspects in the child's homicide and being respectful of the fact that they're parents of the child that has just died, and maybe they didn't necessarily do anything wrong. But then again, maybe they did. Even if they did, you still have to be cognizant of the fact that their

child just died. I think that is easily one of the most difficult things.

Some participants readily acknowledged an inability to balance their response, and offered justification for why they approach these cases in a particular manner. Tim explained: "I don't know that I've done a very good job. I probably tend to err on the side of being too compassionate, because it just feels like the alternative of accusing somebody or not being sure… is just something that, I am going to have to live with, and for these people to have lost their child… it is just unimaginable, and I don't want to be responsible for making it worse." While Tim describes himself as tending to err on the side of treating the caregivers as victims, George takes the opposite approach:

> I err on the side of suspect because, well, people don't like cops anyway, and if they're not going to like me, that's okay. But I owe them some integrity to the investigation to make sure that we have the right attitude going into it as opposed to just assuming it's a terrible accident and then messing the whole thing up from the get-go with assumptions. So, I kind of err on the side of suspect.

Even if law enforcement officials develop concerns that the death is due to abuse or neglect, they must balance their reaction in order to ensure the continued cooperation of the witnesses. As Gus explains, this is not always easy to accomplish:

> With some of the parents, it's not always the easiest thing to do because you're coming to a scene and the house is filthy, and they're obviously drug-involved, and you develop an idea real quick that this child was at best, a victim of neglect, if not malice. Then you draw a conclusion about these people: that they had no right having this child in the first place, and they had no right to keep the child, and you become angry at them. You have to try to not let these things show.

Joan summarized the need for a delicately balanced approach that ensures acquisition of the information necessary to get to "the truth", obtained in a manner that investigators can live with if the investigation reveals the parents have done no wrong. She said: "It is a complicated case, a real fine line, to address a grieving loved one and also not completely rule them out as a suspect… to be able to communicate with people that are related to the deceased, and to try to tactfully get what you need from them. To consider them a suspect, but treat them like a grieving person that deserves just that." Chris summarized the tension expressed by many participants when he said: "There's no easy way to deal with the parents, and there are lots of ways to do it wrong."

Even when investigators do "everything right", they still struggle with the outcomes. Donald reflected on a case in which the circumstances revealed the father likely murdered the child, but the father never did confess: "I am certain he did it, but we had no physical evidence. It has crossed my mind more than once, because I questioned that dad pretty hard, 'What if I'm wrong… and what if I have treated him unfairly?'"

Participants never seem to lose sight of the unthinkable possibility that they may unjustly accuse a parent of homicide. They also dread the possible revelation that the parent was in any way culpable for an accidental situation. The stakes are high and self-blame can run rampant. Trey spoke of a scene in which a father inadvertently caused the death of his infant in a co-sleeping context. The father was visiting from out of town, and so the sleeping arrangements deviated from the infant's norm. Despite his best efforts and

intentions to protect his child, the infant died beside him that night on the sofa. Trey recounted the story: "The father asked me several times. He said: 'Just kill me, please kill me. If I reach for your gun will you please shoot me?' I kept saying: 'Just get away from me. Get back! Get back! Let me give you some help here or something.' And he said" 'I am going to reach for your gun. I have to die. I can't believe I did this.'"

Unfortunately, there are times when the uncomfortable truth is that parents inadvertently contributed to the death in some manner. Walt described how a fear of inducing self-blame in caregivers caused him to avoid questions that may have revealed "the truth" of the case:

> They [our trainer] just hammered the point that you could destroy these peoples' lives forever if you indicate there is something they did that could have contributed to this death. So, in the investigations I went to, I was always aware of that… You maybe wouldn't ask the questions that needed to be asked.

Some participants readily admitted to shying away from any potential for blaming. Others have experienced the regret of missing an opportunity to reveal all the facts of the case. Casey spoke from the perspective of both a multi-decade law enforcement veteran, and a parent who has lost an infant: "When there are unanswered questions as to why your child died, you can't blame the other car driver, you can't blame cancer, you can't blame… you know it's not about the blame to begin with, but you can't even name it." Casey also noted that the inability to name the cause leaves the potential for an unknown risk to other children. Whether that risk is a dangerous parent, an environmental hazard, unsafe sleeping conditions or a genetic/congenital cause: "You have the added

burden of liability, if you have another child in the home and you know it, and you don't educate them, and then another child dies... It would be hard to live with that."

These stories paint a picture of ordinary people with a powerful sense of duty and obligation, placed in unenviable positions and asked to complete bewildering tasks. Participants' narratives reveal that officers experience infant death investigations as complicated, high-stakes endeavors, fraught with ambiguity, overwhelming emotions and inadequate support. Fortunately, also within these stories, are hints at possible directions for reform. In the next chapter, I examine four specific recommendations that emerged from interviews, expanding upon and discussing them within the unique occupational culture of law enforcement.

Chapter 5 - Discussion

This research has identified three dynamic and interrelated tensions experienced by law enforcement during the process of infant death investigation. Study participants described navigating: 1) emotional situations when professional neutrality fails; 2) high-stakes under-resourced investigations; and 3) interactions with parents who must be considered simultaneously as victims and suspects. Ultimately, these tensions are amplified by multiple institutional constraints and hegemonic norms and values that characterize law enforcement as an occupational culture. As a result of these tensions and the ambiguities that arise as officers attempt to navigate the precarious waters of SUIDs, law enforcement officials experience individual-level distress, as well as a collective sense of decreased effectiveness in scenarios that have potentially significant consequences for individual well-being, public safety and public health. Findings from this project suggest that current practices in infant death investigation (at least within the research jurisdictions) are in need of closer examination. Thankfully, participants' narratives also hold the seeds of possible reform.

An examination of emergent themes indicate four possible interventions that I argue could improve the efficacy of SUID investigation, while reducing the tension, and vicarious trauma experienced by law enforcement in this context. These include: 1) recognizing the exceptionality of infant death investigation; 2) prioritizing the process of infant death investigation; 3) clearly defining and

delineating roles and responsibilities; and, 4) developing specialized multi-agency response teams.

The "normal" experiences of law enforcement officials are unique relative to citizens not engaged daily in efforts to restore or maintain public safety. Loftus (2010) notes that law enforcement norms, beliefs and values shape everyday decisions, practices and experiences. She further contends that shared assumptions and practices transcend or outweigh any areas of difference, making police culture an identifiable and relatively cohesive occupational culture. In the pages that follow, I discuss recommendations for possible reform, as informed by my findings and the ethnographic context of law enforcement as a distinctive occupational culture.

A Culture Set Apart

> *The day a new recruit steps through the doors of a police academy, he leaves society to enter a "profession" that does more than give him a job: it defines who [he] is. For all the years that he remains, closed to the sphere of its rituals and its absurdities in the town working began, until he takes the ransom money of his pension and retires, he will be a cop." (Ahern 1972:3 in Crank 2004)*

Trice, (2003) asserts that occupations are distinct cultures, in and of themselves. Individuals make explicit and purposeful decisions, sacrifices and life decisions as they enter and remain in an occupation. Members of an occupation lay claim to a specialized body of knowledge and the right to perform a distinguishing set of tasks. Occupation-based cultural forms are expressed through language, gestures, symbols, physical artifacts, rituals and ceremonies (Trice 2003). These features, he explains, in addition to the unique traits perceived as characteristic

of members of an occupation, define individual cultures. Occupation-as-culture, in turn, offers identity, a way in which we recognize each other and ourselves.

Golubović (2011) asserts that the adoption of a group identity satisfies the need for belonging and provides a collective security from the unknown; Van Maanen (1977:176 in Trice 1993) has argued that occupations may provide "the single most important source of identity for individuals living in modern industrial societies". This group identity is central within in law enforcement – an occupation claimed by some members as a "calling" (Loftus 2010) or a "brotherhood". Gilmartin (1990) observes that though this "brotherhood" is no longer exclusively a male domain, it is indeed a closed social unit whose membership extends only to other law enforcement.

While law enforcement individuals act out their occupational identities in a variety of ways, members of law enforcement organizational culture share core, defining features related to their legal authority, their socially legitimized power to coerce, and their likelihood of engaging in high-risk activities (Loftus 2010). As a result, they develop a distinctive worldview shaped by the combined features of this unique social situation. Skolnick explains that law enforcement officials tend to view situations and events through common cognitive lenses and argues that, "the strength of those lenses may be weaker or stronger depending upon certain conditions, but they are grounded upon the same axis." (1964:42). Conti (2009) agrees that a number of cultural elements have been shown to transcend individual differences.

Some features of police culture have become almost cliché in their orthodoxy; Loftus (2010) argues that these cultural mores arise as officers adapt to the demands of their vocation and are then communicated and reinforced through on-the-job socialization. Among the more common recurring attributes of law enforcement described by Loftus are: an exaggerated sense of mission, the desire for exciting, crime-oriented work, celebration of masculine exploits, overt demonstrations of the willingness to use force, unremitting suspicion, cynicism and pessimism, displays of defensive solidarity with colleagues, conservative views on politics and morality, simplistic, decontextualized understanding of criminality, intolerance towards those who challenge the status quo.

Recently, Crank (2004) and others have argued that too much emphasis has been placed on certain durable cultural themes of police work – particularly the use of force, coercion, danger and corruption. Garriot (2013: xvi) warns that historically, "generalized, and yet narrow" concepts of policing have caricaturized, oversimplified and decontextualized the phenomenon of policing. Thus, while there are some traits that many, even most, law enforcement officials might identify as core values, it is important not to over-state uniformity of belief and behavior. A sophisticated understanding of law enforcement as an occupational culture requires the acknowledgement of regional differences, sub-cultural role differentiation and other forms of uniqueness moderated by various social markers within police ranks including gender, age, race, experience level, and life experience. That said, one common cultural component pervasive throughout the jurisdictions represented in my sample, is the

positioning of individual officers within the strict hierarchical structure that flows from the paramilitary organization of US law enforcement.

The "chain of command" in law enforcement structure means that individuals are both agents and targets of pervasive power differentials—at once holding power over citizens and subordinates, while subject to the power and control of their superiors and the greater criminal justice system. Any attempts at understanding law enforcement culture or influencing law enforcement behavior must therefore, take into account legal and institutional demands and constraints along side cultural norms and values. Though cultural change may be initiated on an individual level, it is through membership in the larger group that individual actors obtain the power and social authority that they engage during the course of infant death investigations.

My findings reveal that many conventional features of law enforcement culture— both ideological and behavioral—are at odds with the needs of infant death investigation. This dissonance exists from the outset of any investigation and is only compounded by institutionally imposed constraints and limitations. For these reasons, my recommendations move from the individual-level to the institutional- or structural-level. I begin with the assertion that law enforcement culture, as a whole, is a mismatch for the process of infant death investigation.

Recommendation 1: Recognize the exceptionality of infant death investigation.

My findings indicate that the law enforcement officials in this sample struggle to adapt their "normal" occupational rules, behaviors and values in the context of

infant death investigations. Further, participants described an often-overwhelming and undeniable emotional reaction that strips away the layers of protection they typically engage as a shield from the emotional distractions of their work. As a result, law enforcement officials experience a deep ambiguity and sense of vulnerability when responding to infant death.

Crank and Caldero (2001) have described police culture as an onion—a metaphor designed to emphasize a heart or protected center, shielded from the violence and suffering of the outside world by many layers. Police culture, they explain, "…has a heart that animates every police officer and gives meaning to police work. The heart is how police officers feel and think about their work, how they celebrate their victories and morn their losses. It is how they do their work and how it is meaningful to them." (Crank and Caldero 2001:155) Law enforcement officials make sense of the work they do through commitment to "the noble cause and belief that they can make a contribution to society" (Crank 2004:59). Yet, participants' narratives show all the ways normative strategies for protecting the heart fail in this context. As Crank, notes: "There is little opportunity in work such as this to celebrate the human spirit …cops see something different. They see human flesh unadorned by custom. They see it for what it is, vulnerable, weak, sometimes hideously damaged, occasionally putrefying, desiccated and maggot-filled. Cops are true outsiders—they know what human beings look like without benefit of social trappings" (2004:170).

One way law enforcement officials cope with the traumas they witness, is through the development of a measure of coarseness toward the human

condition—what Crank has termed "grit". This grit is a way of coping with their work. Grit hardens them to suffering, allows them to witness the effects of incredible brutality and to dissociate enough to do their jobs; it allows for some self-preservation. Participants in this study provide numerous examples of embodied "grit", yet their narratives also reveal a counter-narrative in which the emotional impact of infant death investigation overwhelms their standard coping mechanisms. The line of fracture they envision between themselves and the public—the "we/they" mentality that may normally course through their social interactions— dissolves away leaving them unshielded from the torrent of emotion evoked by an infant death.

As law enforcement struggle with emotional impacts far beyond their capabilities to manage, they struggle with proper application of another core cultural product and tool, namely *suspicion*. Suspicion is a widely shared attribute of police culture resulting from the occupational environment in which law enforcement officials operate (Crank 2004). New officers learn quickly that a hefty dose of suspicion will serve them well, as one of their principle concerns is the ability to establish the veracity of information with which they are presented (Innes 2002). Crank notes that suspicion, as a social skill, is generally not considered desirable: "No one would list 'suspicious' on their top ten list of admired personality characteristics. This element, so important to a police officer's craft will never endear them to outsiders" (2004:152). Participants in this study described suspicion as a critical and required component of their

death investigation tool kit. Suspicion is a product of previous experiences that compels law enforcement to look beyond face value.

In the case of SUIDs, however, participants described suspicion as problematic. Though some deaths are the result of nefarious activity, the vast majority of infant deaths are not criminal in nature and, even the most hardened of law enforcement can struggle with the concept of adults harming innocent children. Furthermore, officers recognize, and do not take lightly, the potential ramifications of mistakenly accusing or even suggesting the culpability of caregivers. For these reasons, some law enforcement officials simply choose to dispense with suspicion at infant death scenes. Those who choose to retain their suspicion struggle with the proper dosage and application. Crank has argued that one special contribution of law enforcement is that they may see what is hidden or disguised to the rest of us. As such, he describes suspicion as "the special craft of policing" (2004:145). Without proper application of this craft, law enforcement loses their "ability to pierce the veil of misdirection, to find the truth behind the lie" (Crank 2004:153).

Thus, officers confronting infant death are left in an untenable position, where the application of suspicion feels wrong and failing to properly apply it may put future children at risk. Guy, Mastracci, and Newman (2008, in Schaible and Gecas 2010) similarly observed that law enforcement officials often suffer from paradoxical expectations in their obligation to be both "nicer than nice" and "tougher than tough". Schaible and Gecas explored the consequences of incompatible and inconsistent expectations of police and argued that the

discrepancy between emotions felt and the emotional displays (either required or considered appropriate in a particular context) results in "emotional exhaustion". Participants in this study offered countless examples of emotional exhaustion resulting from struggles between the emotions experienced and those thought to be appropriate, effective or professional. Saville (2006:1) warns that even the "strong, silent type" stereotype performed by many police officers— who may be expected to "grin and bear emotional crises and then shake them off at the end of the shift"—cannot suppress human emotions without suffering serious consequences.

Overall, the cultural mores and coping mechanisms that may serve law enforcement well during other interactions, fall apart in context of SUIDs. Minimization of emotional impacts and engagement of suspicion as a form of "common sense" are at odds with the realities of infant deaths, where police find themselves constrained by occupational standards and norms they cannot perform. Those in power need to make this dissonance between business-as-usual and the exceptionality of infant death investigation explicit—the text of training and debriefing, rather than the subtext. This is a critical first step.

Recommendation 2: Prioritize the process of infant death investigation.

Participants described the need for improved institutional support in the form of training for, and financial supports during, infant death investigations. This recommendation will require an organization-level paradigm shift. Most law enforcement professionals are employed by bureaucratic professional

organizations (Glissmeyer, Bishop, and Fass 2007:459), and any structural or institutional constraints hold exceptional weight in the context of the rigidly, hierarchical system of law enforcement. Even if individual law enforcement officials seek to prioritize infant death investigation, their actions and abilities – their agency - is significantly constrained by the structural forces they operate within. Organizational features, such as training, long-term planning, and budgetary decisions, are critical to the prioritization of infant death investigations, yet among the numerous other eventualities for which law enforcement must prepare, the relatively infrequency of infant death investigations can cause them to be overlooked. Structural supports tend to be focused on the most common scenarios and often on those crimes or public safety threats that are perceived as "real" police work—that is, those that involve the symbolic rites of search, chase and capture (Crank 2004, Skolnick and Woodworth 1967) and not the less common, tedious and emotionally-taxing SUID. Given the finite number of training hours and dollars, topics more closely aligned with law enforcement cultural identity may win out.

Hawk and Dabney (2014) have argued that law enforcement prioritizations are operationalized and justified largely as a result of unit culture and perceptions of victim deservedness. Infants are readily recognized by law enforcement as "true victims" (2014:1143), as such, individual law enforcement officials can be motivated to work hard and long for this cause if they understand their mission. Law enforcement culture highly values and rewards the desire to successfully complete any "mission" with which they are tasked. However, as

this work reveals, in the case of infant death investigation, good intentions are not enough; they must be bolstered by adequate training and preparation. As Crank summarizes: "Cops want effectiveness, and effectiveness does not occur with a limited arsenal." (2004:130).

All of the participants in this study expressed a need for more extensive training. Due to the complexity of SUID cases, and the infrequency with which they occur, law enforcement would benefit from an initial, detailed training, provided by subject matter experts, followed by periodic reviews and updates. As I asked participants to expand on what would be most helpful, many requested a model of training commonly referred to as a "case review" approach. A case review approach utilizes presentation of actual cases to offer real-world examples of mistakes made, challenges overcome, and lessons learned. Law enforcement use the stories told in case reviews as an additional means of acquiring experience in the form of "knowledge by example" (Crank 2004:217).

In addition to prioritizing time and funding for training in advance of an infant death, organizational prioritization should be clear and unwavering during the investigation. Participants in this study explained that, at a minimum, this should include immediate diversion of all available personnel and prompt approval of overtime and call-back pay requests for any investigative staff, ancillary staff and extra patrol needed to either support or relieve those working at the scene. Participants were clear: the strain of being assigned to a high-stakes infant death investigation without adequate training or structural support is unacceptable. For in the case of infant death, personal liberty, personal well-

being, public health and public safety are all potentially at stake. Interviewees were in agreement: there is no tenable argument against prioritizing training and resource allocation for such a critical task.

Recommendation 3: Clearly define roles and responsibilities.

Participants in this study expressed a profound sense of ambiguity and uncertainty with regard to their specific roles and responsibilities in the process of infant death investigation. This uncertainty was made evident over the course of participant observation, where I observed enormous variation in how both individuals and agencies responded to SUID cases. I also noted that, due to rotational shifts and temporary detective assignments, it was extremely rare for the same team of individuals to ever work together on more than one infant death.

My third recommendation stems directly from the explicit requests of participants and receives robust support from the literature on law enforcement culture and identity. Situational uncertainty is a hallmark of the law enforcement experience. "The unknown in all its forms… haunts police officers. It is most likely something trivial, sometimes a hassle, perhaps dangerous, unpredictably deadly. It [the unknown] is always a dilemma to be solved" (Crank 2004:141). Crank observes that officers deal with the unknown on a day-to-day basis and develop broad cultural adaptations to these unknown situations— from the trivial to the dangerous. Routine procedures develop and can be considered as summations of police experience; an indication of how the police as an

occupational culture has successfully responded to similar cases and difficult situations in the past (Innes 2002). Law enforcement also lean on "common sense" formed from previous experiences with similar events. Common sense, like other elements of culture, is not innate, but taught through example and derived from an accumulation of wisdom, habits and ways of thinking over time; it is what any clear-thinking person would do in the same situation. (Crank 2004). Yet, participants described "clear thinking" to be a challenge in the context of infant death investigations and the infrequency with which individuals and agencies confront this task severely hampers the development of either a common sense approach or routine procedures. As such, clear roles and responsibilities must be defined for all individual, responding officers.

Responsibilities should be divided into "manageably relevant 'strips' of information" (Hawk and Dabney 2014:1132) and, when possible, careful consideration should be given to the assignment of roles. Experience and comfort levels should both be taken into consideration as individuals struggling with lack of experience, knowledge gaps and/or profound emotional discomfort are not as well equipped to handle sensitive or critical tasks. Law enforcement officials responding to infant deaths deserve adequate supports and mentoring, and the families of deceased children deserve well-equipped officers.

Findings from this study suggest that the roles and responsibilities required during the initial portion of the investigation—the period surrounding the first law enforcement contact and the portion managed by the first responding patrol officers—to be among the most critical and the most

uncomfortable. Upon arrival at the scene, responding officers may be faced with an infant who requires a life-saving intervention, who was just whisked away by medics, only to be declared dead later at the hospital, or who may already be declared dead at the scene. They may be faced with an unpredictable number of family members to manage and assist, "through-the-roof" emotions, a scene to secure, and critical observations they cannot afford to miss.

Participants in this study, and particularly the first responding patrol officers and deputies, recommended the use of checklists as a method for communicating specific responsibilities to each member of the investigative team. They also noted that checklists simultaneously serve several other important purposes in an infant death investigation. Lists help provide a reminder of all the many things individuals may forget due to fatigue, emotional strain, overload, and the pressures of multitasking under very stressful circumstances. Officers also described a sense of security this "prop" provides to inexperienced and/or overwhelmed law enforcement, giving them something to touch, hold, and look at, as a way of regaining their bearings when the scene feels out of their control. Furthermore some participants recognize that checklists serve as an overt and important display to the parents and other caregivers that each infant death is handled the same way, therefore assuaging any implications of suspicion.

The use of checklists has been promoted as an effective strategy for reducing errors of omission. Checklists are also advocated as method to simplify decision-making and decrease undesirable variation (Idahosa and Kahn 2012).

Ultimately, however, effectiveness hinges on implementation, understanding of the rationale behind the contents, and buy-in toward the process (Conley et al. 2011). For these reasons, I recommend the development of local jurisdiction-specific checklists. Specific components to be included on the checklist must develop through a process of collaboration between local law enforcement and the medical examiner or coroner's office for that jurisdiction. Inclusion of support and input from other stakeholders, such as prosecutors and emergency medical staff, could lead to comprehensive *and* realistic checklist tools with high potential for buy-in from participating agencies.

Recommendation 4: Develop specialized, multi-agency response teams.

Participants revealed a lack of experience, knowledge and resources to be significant impediments to the competent investigation of infant death. This fourth, and final, proposal incorporates the previous three suggestions and requires the greatest degree of collaboration. It is, I argue, the method by which agencies can best leverage limited experience, knowledge, and resources to insure an appropriate response to infant death investigations.

Writing about federal law enforcement coordination, Bjelopera and Finklea explain that the development of specialty groups is an effective way of surmounting jurisdictional limitations, while leveraging expertise, money and human resources (2014:2). Much like regional response teams for motor vehicle accident investigations provide access to individuals with specialized training and experience, and just as mass fatality teams provide logistical support beyond the capabilities of any one jurisdiction, a regional infant death investigation team

can ensure access to knowledge and resources beyond that found in any one agency.

The formation of multi-jurisdictional teams is not without challenges. Cultural similarities and differences across agencies must be given due consideration during efforts at multi-organization collaborations. Gehl (2004) has argued that this can be especially difficult in the context of law enforcement cultures where barriers, including paramilitary structuring, politics and regionalization, organized labor issues, and resource limitations, can prevent smooth articulations between agencies. He further notes that law enforcement cultural practices, "sometimes drive and often derail" effective multi-agency collaboration efforts (2004:3). One notable barrier identified by Gehl, is the concept of "turf"— a term resulting from organizational thinking anchored in notions of jurisdiction and "organizational memories". Bjelopera and Finklea recognize that overlapping jurisdiction and authority can contribute to "interagency turf battles" (2014:9), but note the significant benefits of collaborative efforts in pooling resources and knowledge.

Bolstered by participants' requests and observations, I argue that the formation of multi-agency infant death investigation response teams is a logical solution to problems of inadequate experience and resources. By making clear the roles and responsibilities of individual members and by incorporating cooperative agreements allowing the primary investigating agency to retain ultimate control over any contentious issues, any concerns over "turf" in the context of infant death investigation could be ameliorated.

Much like the implementation of agency checklists, the effectiveness of a multi-jurisdictional team that includes smooth articulations with the ME/C would hinge on the implementation process, understanding of rationale and buy-in (Conley et al. 2011). Each agency (i.e. occupational subculture) would require equal representation and voice in the process. If infant death investigation is recognized as an exceptional law enforcement activity and treated as a priority, with roles and responsibilities clearly defined, perhaps the formation of a regional response team for infant death investigation is not such a far stretch.

Participants' narratives reveal a pervasive individual-level motivation for change in practice related to infant death investigation. Findings from this study illustrate the ways the tensions and ambiguities experienced by law enforcement during infant death investigations not only fail to effectively moderate the trauma experienced by victims and law enforcement alike, but also threaten the effectiveness of investigations. The four evidence-based recommendations described above may help to improve the efficacy of infant death investigation. Improved investigations on an individual case level will, in turn, contribute to improved aggregate statistics, bringing us one step closer to removing "unknown" as the leading cause of neonatal infant death. These suggestions may also serve to decrease the tensions experienced by law enforcement during investigations and bring us one step closer to the larger goal of reducing preventable death among the youngest members of our society. In Trey's words:

"Can we just make sure that there are no more infant deaths? It would be awesome if you could just do that."

Chapter 6 - Conclusion

The purpose of this study was to examine the lived experiences of law enforcement officials charged with the unenviable task of investigating sudden unexpected infant deaths. Specifically, I aimed to answer three questions: 1) How is the practice of infant death investigation experienced by law enforcement officials?; 2) How do core values and features of police occupational culture affect the efficacy of infant death investigations?; and 3) Are there aspects of the law enforcement infant death investigation response that may be improved?

In the preceding pages, I have examined law enforcement participants' experiences of infant death investigation through open-ended, semi-structured interviews and a decade of participant observation. Through the analysis of interview transcripts and field notes, I have identified three dynamic and interrelated tensions experienced by law enforcement during the process of infant death investigation. Participants described struggling to navigate: 1) emotional situations when professional neutrality fails; 2) high-stakes under-resourced investigations; and 3) interactions with victims who may be suspects. Collectively, I have argued that these tensions function to complicate high-stakes investigations and may also decrease their efficacy.

Based on my analysis of key themes, a discussion of their significance within the context of previous work on sudden unexplained infant death and the theoretical body of literature on law enforcement occupational culture, I have

proposed four evidence-based recommendations. These recommendations may help to improve the efficacy of investigations, while reducing tensions and vicarious trauma experienced by both law enforcement and parents involved in the tragic scenario of an unexplained death of a child. These recommendations involve: 1) Recognizing the exceptionality of infant death investigation; 2) Prioritizing the process of infant death investigation; 3) Clearly defining and delineating roles and responsibilities; and, 4) Developing specialized multi-agency response teams.

Study Strengths and Limitations

The purpose of ethnographic research is to gain a rich, deep and culturally contextualized understanding of a social phenomenon as described by cultural insiders (Bernard 2011). As such, my goal was to study and write about the occupational culture of law enforcement engaged in SUID investigations, providing an "experience near" (Geertz 1973) for those who have never been called to one of these scenes. Though the goal of ethnography is not to generalize, I suspect that some of what I uncovered is likely applicable in other jurisdictions.

Study Strengths and Limitations

Approaching law enforcement with the hopes of discussing such a sensitive and complicated topic required intimate knowledge of both the subject matter and the subject population. As such, my extensive professional experience working with law enforcement, and specifically my work with infant death investigation, is a strength of this work. An extended period of participant

observation granted me an understanding of the language and customs of the subject population, and the knowledge and experiences I acquired by studying and performing infant death investigations allowed for a deeper understanding of events described by the participants. Several participants acknowledged that my status contributed to their willingness to participate and, further, to speak frankly about the subject. I am confident that most participants did speak openly about their experiences as similar stories and themes were reaffirmed across narratives, jurisdictions, and separate agencies over the course of the study suggesting some measure of internal validity (LeCompe and Goetz 1982).

A second strength of this project was the application of a modified grounded theory approach along with the utilization of consensus coding. The modified grounded theory approach allowed me to identify emergent themes rather than reifying pre-existing, *a priori* categories, topics or issues. This explicit effort to privilege the perspective of the participants resulted in novel information that may not have been revealed had I approached the topic with predetermined hypotheses. Consensus coding has also been shown to improve reliability and validity in qualitative work (Hayes and Krippendorff 2007; Lumbard, Synder-Duch, and Campanella Bracken 2002) and was especially helpful in this process as Dr. Cheyney and I noticed codes and themes the other may have overlooked. Whereas Dr. Cheyney readily focused on the political-economic and structural forces influencing findings, my tendency was to focus on the applied and on-the-ground significance. There were also circumstances in which my intimate knowledge of the subject matter caused me to neglect some

discussions of law enforcement culture or infant death investigation processes – writing them off as "common knowledge" or "business as usual" – when they actually required significant contextual elaboration or explanation. Collectively, our unique worldviews and relative insider/outsider positionalities allowed for a more comprehensive and nuanced analysis of interview narratives.

A significant limitation of this study is that, due to time constraints, I was not able to formally return findings to participants and solicit their reactions to my interpretations. Despite careful attempts to practice reflexivity and to mitigate any preconceived notions and biases, there can be no doubt that my own cultural lens and professional experiences influenced interpretation of the data. What I saw and what I missed was only partially mediated by the consensus coding process. An important future project will be to examine the degree to which my findings are determined to be accurate and representative by those who participated in this project.

Another limitation (and potential strength) of this study is that it only answers the research questions within the context and parameters of my research locale. There is no way to predict how findings might differ in other jurisdictions, particularly in those with different medicolegal structures or in those with significantly larger populations. High-density population centers will experience correspondingly higher numbers of infant deaths annually, and law enforcement in those areas may have a greater opportunity to adapt to SUID investigations. To my knowledge, this project represents the first attempt to understand law involvement experiences in the realm of infant death

investigation. Another very important next step would be to take these findings to law enforcement officials in other jurisdictions, using them as a starting point for discussion.

Suggestions for Future Research

I would like to see this study replicated in other law enforcement agencies and regions, particularly those serving larger urban areas. It would also be useful to solicit medical examiner and coroner investigators experiences with infant death investigation. Comparing and contrasting findings between law enforcement and medicolegal death investigators could help to illuminate the overlaps and differences between systems that often apply very different approaches to death investigation.

Finally, although these findings lay the foundation for discussions aimed at improving infant death investigation, the voices of those arguably most affected by this process are conspicuous in their absence. Accessing the voices of parents, and other caregivers, who have been through an infant death investigation may seem an intimidating prospect. However, I suspect that a significant number of parents, if given enough time and support, would welcome the opportunity to tell their stories and to contribute in some meaningful way to any project aimed at improving this process (Martin 1998, www.cjsids.org). Participants in this study revealed concerns for the well-being of parents to be a primary source of distraction and unease. By improving our understanding of both the short- and long-term effects of investigative procedures on parents, we can better assist law enforcement in their efforts to perform high-quality

investigations, while simultaneously providing the appropriate care to grieving parents.

When an otherwise healthy infant dies suddenly and unexpectedly, clinicians, criminal justice authorities, medicolegal representatives, and much more often than not, the parents, all struggle with the same question: "Why?" In these cases, ultimate responsibility for determination of cause and manner of death determination rests with the medical examiner or coroner, but participant observation in medicolegal jurisdictions across the United States has revealed enormous variation in the involvement of medical examiner and coroner representatives. The one constant I have observed across the country is the involvement of law enforcement officers.

Another constant I have observed, is that law enforcement officials are asked to manage all manner of challenging, and often high-stakes, tasks the rest of us are either unwilling or incapable of handling on our own. They answer our calls for help, and as a result they routinely encounter the most overwhelming, bizarre, dangerous and frightening of situations. As the "abnormal" becomes their "normal", law enforcement officials develop cultural traits and tools that are both products of, and protections against, the realities they face. This research reveals law enforcement as much more than the oversimplified and caricaturized "macho", "authoritative", or "aggressive" figures often portrayed in popular and mass media. Through their own narratives, we see officers struggling to manage one of the many of the difficult roles they must play. Their

stories also reveal that occupational norms and values, which may serve them well in many other circumstances, falter in the context of infant death investigations. With so much at stake, and with all the varied and critical things we ask of law enforcement, we must also provide support for the process of infant death investigation. Simultaneously, we must also turn the critical lens inward on the systems that both sustain and constrain the efficacy of this important police function. I conclude with the words of a poem that hangs on the wall at one of the participating law enforcement agencies:

I AM THE OFFICER

I have been where you fear to be
I have seen what you fear to see
I have done what you fear to do
All these things I have done for you

I am the person you lean on
The one you cast your scorn upon
The one you bring your troubles to
All of these people I've been for you

The one you asked to stand apart
The one you feel should have no heart
The one you call the officer in blue
But I'm a person, just like you

And through the years I've come to see
That I am not always what you ask of me
So take this badge, take this gun
Will you take it?… Will anyone?

And when you watch a person die
And hear a battered baby cry
Then do you think that you can be
All the things you ask of me?

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APPENDIX A: Recruitment Letter

May 4, 2014

Attn: All [redacted] County Deputies, Troopers and Officers

We are writing to invite you to participate in a research project designed to help up gain a more complete understanding of the roles and experiences of law enforcement in infant death investigation. Your perspective and input are being sought because of the critical role law enforcement plays in this sort of investigation. We welcome the participation of any [redacted] law enforcement officials, including: new hires, patrol, detectives and administration. No prior infant death investigation experience is required.

Dr. Melissa Cheyney, Medical Anthropologist at Oregon State University, is the Principal Investigator. Jennifer Schindell, a [redacted] is the student researcher.

If you agree to participate, we will ask a series of open-ended questions expected to take between fifteen and sixty minutes, depending upon the amount of information you wish to share. Interviews may be conducted at your place of business or another location that is convenient for you. Please feel free to refer other individuals from your agency that may be willing to be interviewed about their experiences with infant death investigation.

We plan to record and transcribe the interviews. If you prefer we do not use an audio recorder, we will take notes on your responses. All materials from this project will be stored securely and you will not be identified by your real name. Pseudonyms or false names will be used in all reports and publications that result. You will not be paid for participating, though your agency has agreed to allow you to participate while on the clock.

If you express interest in participation, you still will have the opportunity to ask questions before deciding whether to begin the interview.

If you are interested in participating please email Jennifer Schindell at:
schindej@onid.orst.edu
We thank you in advance for your time and consideration.

Sincerely,

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APPENDIX B: Sample Letter of Support

January 14, 2014

Attn: Institutional Review Board (IRB)
Office of Research Integrity
8308 Kerr Administration Building
Oregon State University
Corvallis, OR 97331-2140

Dear IRB Members:

This letter is in support of Jennifer Schindell's proposal for a research project to be carried out at the [redacted] County Sheriff's Office. I understand that this student is conducting this project as part of their requirements for the Master of Medical Anthropology program at Oregon State University and will have the opportunity to present their research findings in other venues.

I understand that the Institutional Review Board (IRB) at Oregon State University is concerned with protecting the confidentiality, privacy, and well-being of research participants. Further, it is my understanding that the student will additionally be advised in this project by her academic advisor, Dr. Melissa Cheyney.

I do not have concerns about the study based on conversations with the student. Furthermore, I will allow personnel under my command to participate while on duty and agree to disseminate recruitment information to them via email.

This agency recognizes the importance of improved understanding of infant death investigation practice, supports this student's plan and approves of the project, including recruitment of participants and data collection, through our agency.

Should you have additional questions or concerns please don't hesitate to contact me at [redacted].

Sincerely,

[redacted]

APPENDIX C: Interview Guide – Page 1 of 2

SAMPLE INTERVIEW QUESTIONS
PRINCIPAL INVESTIGATOR: MELISSA CHEYNEY
STUDENT INVESTIGATOR: JENNIFER SCHINDELL

Age -

Sex -

Education Level -

Race/Ethnicity –

Preferred Pseudonym? -

INFANT DEATH INVESTIGATION EXPERIENCES -
Have you ever participated in infant death investigation(s) in any capacity?
How many? Your role(s)? Where?

What are the first three words that come to mind when you hear the phrase "infant death investigation"?

What do you believe to be the role of law enforcement in infant death investigation?

Other than law enforcement, who participates in the infant death investigation process?
What are their roles?

Would you be willing to tell me about your most memorable infant death investigation experiences?
Memorable aspects? Difficult aspects?
Past feelings of success? Past regrets?

What all do you think should be included in a "complete" or "thorough" investigation of an infant death?

What is your estimate of how long an infant death investigation generally takes to complete?

Please share your thoughts related to the following concepts-
How would you define this?
Do you have any thoughts or feelings about this?
"SIDS and SUID" "Infant death scene" "Sleep environment" "Doll reenactment"
"Autopsy" "Traumatic Injury" "Suffocation" "Infanticide or Infant Homicide"
Standardized infant death investigation forms such as the CDC "SUIDIRF"

APPENDIX C: Interview Guide – Page 2 of 2

PERSONAL EXPERIENCE WITH INFANTS -
Do you have any experience caring for, or raising an infant?

LAW ENFORCEMENT EXPERIENCE -
What is your current title? How long have you been in this position?

What is your agency size?
Staff breakdown, shift coverage, number of detectives, etc. ?

What size area does your jurisdiction cover?
Approximately population?

RECOMMENDATIONS
Do you have any recommendations for improving how law enforcement is trained and/or supported in their completion of scene investigation and/or caregiver interviews?

CONCLUSION
Are there any issues related to infant death investigation we have not addressed that are important to you that? If so, please add any additional comments now before we complete the interview.

REMINDER: Provide confidential counseling referral list to each participant.