Personal Paper

Death of my baby

WENDY VALERIE HARMAN

The only reason for the existence of this account of the horror that followed the "sudden, unexpected death" of my 10-week-old son, a "cot death," is the knowledge that if I cannot write it it is highly unlikely ever to be written. At feed time, about 6 pm on Monday 16 November 1979, I found Charles dead in his cot—I knew instantly that my adorable baby was dead. He did not stir when I entered his room, he lay motionless on his tummy, with his head face down and white. I picked up his small lifeless body; his eyes were closed and puffy, and he was cold. I tried mouth-to-mouth resuscitation and banged his chest but nothing would coax life back into his blue-grey little face. I knew he was gone for ever.

My baby was now a statistic: *the one* in 500 live births who die silently and without warning. He had hitherto been an apparently normal, healthy, happy, and responsive baby. I was overwhelmed by total disbelief coupled with an obsession to know why he had died—I now know that I shall probably never be any wiser.

My doctor came hurriedly in response to my call and confirmed that Charles was indeed dead. He used the telephone several times and asked if he could take my baby to the hospital for tests. He explained that these tests should be done as soon as possible. I agreed, and Charles was taken away.

Later that evening, when my husband Bob had returned from work and his parents had arrived to take care of our 3½-year-old son, we drove to the accident and emergency department of the hospital where our doctor had taken Charles. We were there for the final goodbye, and when approached by a porter we explained the situation. He told us to sit in the waiting-room, where there were at least six people. We were extremely shocked and distressed and sobbing loudly, so could not face being stared at by bemused strangers; nor did we feel that our grief would cheer up these people, who were presumably awaiting news of their loved ones. Instead, we shuffled about in the corridor for a considerable time until we were eventually put into a vacant room, where we were sensitively quizzed by a young doctor. I recounted the events of the past 24 hours, and he recorded them.

We were then told that we would be able to see our baby as soon as the "police escort" had arrived. We were much impressed by this apparent show of consideration by the police. I remember thinking how thoughtful it was of them to provide two officers to ensure a safe journey to the mortuary and then home for two obviously distraught parents.

We waited nearly two hours and were utterly horrified to discover that the police were there for two reasons only: to take a statement from me and to officiate at the identification of the body.

After the ghastly formalities, during which we had seen Charles through a glass screen after the grotesque drawing back

of purple curtains reminiscent of a puppet show or unveiling of a plaque, Bob asked if he could hold the baby. He was told that he could not "because he was somewhere else and there was no one to bring him back." Lines like that belong in black comedies, not real mortuaries. We were, however, assured that we would be able to see him at the undertaker's; we were in no mood to argue. Had we known what was to come, we would have.

The necropsy was performed the next morning. We later went to the funeral parlour to see Charles, and we wish we hadn't. His skull, which was covered only by a very fair down, was lopsided and his mouth was crooked. He had very obviously been chopped open; he was also as cold and white as marble when we kissed him goodbye. He was unrecognisable, no longer our baby, not even visibly or tangibly flesh and blood. This was a never-to-be-forgotten sight, a most distressingly hideous farewell, the more so as it would have been easily avoidable.

A further blow was the appearance of a local reporter, who turned up on our doorstep within 18 hours of the death; what is more, she knew the result of the necropsy before we did. Inquiries about this most distasteful event showed that as a matter of course the police release daily information concerning sudden deaths and crime to the press. There are occasions when the police are most grateful to the media for co-operation and any "newsy" items not supplied are seen as being deliberately hushed up and therefore all the more worthy of investigation. The freedom of the press is such that they can print anything they want. This particular reporter said that she would print her story whether we spoke to her or not. She, like all journalists, believes that she has some god-given right to "inform," at whatever the cost to the individual, irrespective of the value of the information. She must have been thrilled to see her story make the front page of our local paper, with no attempt at explaining "cot death" whatsoever. The bias was towards sensationalism, and the article was billed as "mystery death"—she printed full details of our names and address. Do reporters sleep at night?

What helps

Suppression of lactation

As my baby was fully breast-fed I was presented with the immediate problem of superfluous milk. The unimaginable misery caused by my physical craving to feed, the discomfort, and the inevitable four-hourly let down of milk, which left me soaked and constantly physically and mentally reminded, made suppression imperative. Bromocriptine tablets were prescribed, and they began to work very quickly.

Sleeping pills

Not surprisingly, sleep was elusive. The result of the necropsy, "sudden unexpected death," merely enlarged the question mark over all my questions. I dreaded going to bed because natural

Surrey

WENDY VALERIE HARMAN

relaxation was impossible. I could still "hear" Charles crying in my semi-sleep and was unable to prevent the massive surges of adrenaline from startling me and tensing my muscles into readiness to leap from my bed, like a sprinter poised on starting blocks, but with no race to run—sleeping tablets were absolutely necessary. I took a modest dose of nitrazepam (Mogadon), which went a long way to ensuring the rest I needed at night and also provided a valuable degree of continued minor sedation through an appreciable part of the next day. A bad night produced a dreadful day. The thought of a guaranteed nightmare-free night was a great comfort.

Keeping busy

My husband was able to return to his work routine shortly after the death (he is a solicitor), and this helped to occupy his mind. It was more difficult for me, as that dead baby *was* my routine; both actively and intellectually I was thrown into a vacuum. The all-consuming emotion is that of experiencing what feels like first-degree robbery, the ultimate theft. At first I could not understand why everyday life outside our house continued as before. I was offended by the unfeeling normality of the milkman delivering and the sun rising. How could this atomic explosion not devastate everything around me?

To avoid stewing in my own miserable thoughts, I kept extremely busy and saw as many of my friends as I could. This provided me with a much needed distraction and was a means by which I could show my friends that I was still me and that I had not become a person "kissed by death," transformed, and to be avoided at all cost. Milling around in bustling shopping centres was another diversion. I was treated there like any other, not as a focal point—another step on the path back to normal.

Another pregnancy

Our 3½-year-old son was again an only child; the title of brother had been snatched back. I could write at length about him but will limit myself to saying that he developed a morbid fascination with death and a jarring habit of making remarks like "You looked after me when I was a baby, so I didn't die, why did you kill Charles?" and "I don't like churches because they have boxes with dead babies in them." Now, however, he has almost completely ceased his references to death and will allow my husband and me outside his range of vision. Also, he now has a perfectly healthy sister, born a few weeks ago.

Positive outlook

After a tragedy such as this, which mocks and wounds every instinctive fibre for justice and logic, there inevitably follows a mental quest for some comprehension, all the epic cliché-ridden questions pose themselves, but as yet no explanations have arrived in blinding flashes, and I do not expect them to.

Without leaping into the zone of the spiritual (I'm a self-confessed "Don't know,") I can say only that sometimes it helps to think that time is the sole barrier separating me from my child and he has merely returned to wherever it was he came from. Sometimes I tell myself that I am unable to make a judgment until I have reached the end of the story, and of course there is always another page to turn—I know only that I cannot allow it to remain a 100%-negative experience.

*Last but not least: The Foundation for the Study of Infant Deaths.**

This organisation has provided us with much valuable, up-to-date information. It offers to the bereaved a service by which they can telephone local volunteers, many of whom have lost babies in this way, to obtain consolation, advice, or discussion of any topic.

* 5th Floor, 4 Grosvenor Place, London SW1X 7HD (01-235 1721 or 01-245 9421).

I personally did not make use of this facility. The thought of two people crying down the telephone at each other, coupled with the knowledge that there are no words that would bring Charles back, which is the only thing that would really make me feel any better, deterred me. I can, however, see that some people would be able to draw comfort from this type of contact. Furthermore, I would strongly urge anyone connected with a "cot death" (and yes, I *do* mean all you doctors) to contact this level-headed organisation, which is also responsible for a great deal of the research into this enigmatic syndrome.

What hinders

Denial of physical contact with the newly deceased

It is nothing less than shameful that we were deprived of the parting touch we felt we needed *when* we needed it, and that time was before the pathologist had disfigured our child. I am sure the hospital operates an admirable, co-operative, advisory (how do you choose an undertaker?), and supportive service for the bereaved, but apparently only between 9 am and 5 pm—we really must try to die at a time convenient to the administration. Surely someone could have found a way to comply with our humble request to be with our child?

The press

I really do not feel that I need to elaborate on this theme. Sadly, I cannot see how a change may be brought about.

Police involvement

The police element was unpleasant, although I understand why sudden deaths must be documented and bodies identified. Nevertheless, we should at some stage have been forewarned and prepared (again, perhaps the hospital was culpable). In any event I find it very difficult to forgive those concerned for making us wait two extremely agonising hours solely for the purpose of processing police paperwork.

The death certificate

I fail to see why the registration of the death cannot be done by post. There were no complicated questions to be answered, and it would have spared me the anguish of sitting next to a young mother with her small, live baby. The registrar must spend all day alternating between "congratulations" and "my condolences." It was like a surrealist play.

£9 Death grant

I understand that the death certificate may be traded in for a grant of £9 from the Government towards funeral expenses. This sum of money is so insulting that we decided not to claim it as a Government obliged to be that mean obviously needed £9 more than we did.

Reference to guilt

If the bereaved mother does not initially feel guilty she certainly will shortly thereafter be dinned by the many "professionals" who repeatedly tell her *not* to feel guilty. It is about as effective as telling a child who has broken a leg not to think about it, while constantly reminding him of his injury by saying, "Now your leg doesn't really hurt, does it?" *ad infinitum*.

I appreciate the message and its motive but would recommend a rephrased positive approach—that is, "I am so very sorry that this has happened to your baby. You did everything possible by caring so well for him. This was an unpreventable tragedy."

Public ignorance

How sad it is that death is taboo and the sudden inexplicable death of a baby therefore doubly so. It causes people to react in many different ways towards the bereaved. Nobody wants a big unmanageable emotional scene. Some friends are willing and able to take the plunge and make the effort to be companionable or offer help; some are just obliterated by fear, horror, or embarrassment into varying degrees of hurtful evasion. A few have even crossed the road to get away from me, as though they were in danger of picking up some foul disease. I knew why they did it, but the knowing did not help.

It is difficult not to feel that if one in 500 normal healthy adults died unexpectedly in this way a massive research programme, with all the attendant publicity, would be launched. Largely because babies cannot speak or vote and therefore have no identity, the subject remains for the most part a "no-no topic," firmly locked out of universal consciousness. In addition there is a natural rejection of the phenomenon that people can die of invisible and nameless maladies. This is essentially totally unacceptable. Therefore, for many, it cannot be.

I am fortunate that most of my friends know about this syndrome; I shudder at the thought of others in less informed milieux, who must inevitably also have to contend with pronounced hints of maternal negligence—a most unpleasant stigma.

"Are you getting over it?"

I empathise with anyone groping around for the "right" remark, which is far less easy to define than the "wrong" one, and must commend any person for any expression of sympathy; it takes courage to broach the subject of death. I will nevertheless state a personal aversion to the inquiry, "Are you getting over it?" To hypersensitive ears like mine this implies the demotion of the catatonic disaster to the level of a minor passing ailment, such as a cold. The simple answer is, "No, I'll never get over it, I'll never accept it, but I know it happened and I have to live with it."

All these factors make the loss even harder to bear.

(Accepted 13 October 1980)

Hospital Topics

An evaluation of the functions of the short-stay observation ward in the accident and emergency department

VERA DALLOS, G L MOUZAS

According to one estimate, there are about 250 accident and emergency departments in Britain,¹ and several reports have been published about them.¹⁻⁴ The report that first introduced the term "accident and emergency department" (an attempt to upgrade the previously called casualty department) recommended that 30-35 beds for every 100 000 population should be provided in the hospital wards for emergency cases, but these beds were rarely set aside.³ The report of the Nuffield Provincial Hospitals Trust² also referred to the fact that few departments had properly designated short-period observation beds, and went further in suggesting that these constituted a "facility that is really essential for a good casualty service."

The report of the Joint Consultants Committee¹ stated more emphatically that there is a need for short-stay beds for some patients with so-called minor injuries, both to prepare them for operation, as well as for postoperative care, and occasionally for some patients with social problems. There are still, however, no national statistics available showing the number of such beds or wards, their possible functions and use, or the average duration of stay of patients admitted to them. In this preliminary paper we attempt to evaluate the functions of such beds in short-stay observation wards at Whipps Cross Hospital

and Chase Farm Hospital and the importance of these wards to the accident and emergency departments in which they are situated, as well as to the hospitals concerned and the communities they serve.

Whipps Cross Hospital

Whipps Cross Hospital is a 930-bed district general hospital on the eastern outskirts of London. Its accident and emergency department deals with 65 000 new patients each year and is one of the major units of its type in London. The 12-bed observation ward is connected by a corridor to the accident and emergency department. It is under the charge of the accident and emergency consultant and assistants, but the hospital duty registrars have admission rights between 5.00 pm and 9.00 am and at weekends. Patients admitted during the night are reviewed in the morning by the accident and emergency consultant and the ward team (psychiatric registrar, observation ward nursing officer, senior social worker (who is attached to the department), and community liaison nursing officer). The ward has its own nursing establishment, and the nursing officer in charge has both general and psychiatric registration.

The use of beds is flexible, and facilities exist for treating men and women in the same ward, which is used as a multidisciplinary short-stay observation ward. The policy for admission of patients to its beds was agreed between the accident and emergency consultant and the medical staff committee of Whipps Cross Hospital. The agreed duration of stay is from 24 to 48 hours, after which time the patient is either admitted to the main hospital or discharged. The accident and emergency department does not run outpatient clinics except to follow up patients needing dressings or further attention to minor trauma. If outpatient care is required the patient is referred to the appropriate specialist clinic.

Whipps Cross Hospital, London E11

VERA DALLOS, MB, MRCP, consultant in charge, accident and emergency department

Chase Farm Hospital, Enfield, Middlesex

G L MOUZAS, MD, FICS, consultant in charge, accident and emergency department