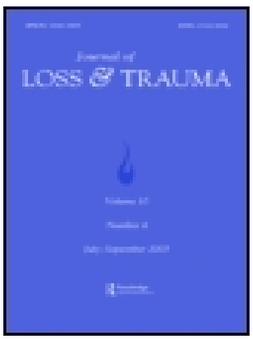

Routledge
Taylor & Francis Group

Journal of Loss and Trauma

International Perspectives on Stress & Coping

ISSN: 1532-5024 (Print) 1532-5032 (Online) Journal homepage: http://www.tandfonline.com/loi/upil20

EMS Treatment of Families in an Ambiguous Out-of-Hospital Child Death: The Role of Attribution Errors

Anita P. Barbee , Becky F. Antle, Mary E. Fallat, Richard Forest & Mary E. McClure

To cite this article: Anita P. Barbee , Becky F. Antle, Mary E. Fallat, Richard Forest & Mary E. McClure (2017): EMS Treatment of Families in an Ambiguous Out-of-Hospital Child Death: The Role of Attribution Errors, Journal of Loss and Trauma, DOI: 10.1080/15325024.2017.1358572

To link to this article: http://dx.doi.org/10.1080/15325024.2017.1358572

Accepted author version posted online: 26 Jul 2017.
Published online: 26 Jul 2017.

JOURNAL OF LOSS AND TRAUMA
https://doi.org/10.1080/15325024.2017.1358572

Routledge
Taylor & Francis Group

EMS Treatment of Families in an Ambiguous Out-of-Hospital Child Death: The Role of Attribution Errors

Anita P. Barbee[a], Becky F. Antle[a], Mary E. Fallat[b], Richard Forest[c], and Mary E. McClure[b]

[a]Kent School of Social Work, University of Louisville, Louisville, Kentucky, USA; [b]Department of Surgery, School of Medicine, University of Louisville, Louisville, Kentucky, USA; [c]Pediatric Bereavement Care Program, Norton Children's Hospital and Norton Healthcare, Louisville, Kentucky, USA

ABSTRACT

Sometimes children die from maltreatment. However, when first responders enter a scene to save the life of a dying child, the cause of the health problem cannot be immediately determined. EMS professionals are taught to enact the medically appropriate protocols in a family-centered way. This study examines five case studies of infant deaths. When there is ambiguity as to why the death might have occurred, EMS and other emergency personnel seem to be more judgmental and this attitude affects their behavior toward family members. Family members have a more difficult time coping with the loss as a result.

KEYWORDS

Attributions; child death; coping; EMS

When a child dies at home or in an out-of-hospital situation, the death must be investigated by police and an autopsy must be conducted on the child as a matter of protocol (Krous & Byard, 2001). Sometimes, the death occurs as a result of child maltreatment, so due diligence in this type of case is very important to ensure the safety of any other children in the home and so that justice is served (Jenny & Isaac, 2006). However, when first responders enter a scene to save the life of a dying child, the cause of the health problem cannot be immediately determined. The primary goal is to save the child's life, if possible. The secondary goal should be to enact the medically appropriate protocols in a patient- and family-centered way (Henderson & Knapp, 2005; Mace & Brown, 2006; O'Malley, Brown, & Krug, 2008).

There is a growing body of research about the nature of the interaction of EMS and other professionals with family members once they come on the scene of a child who is dying or who has died in an out-of-hospital setting (Becker, Aswegan, Bradley, & Schoenwetter, 2013; Bremer, Dahlbert, & Sandman, 2012; Fallat et al., 2016, under review). Studies find that parents and other family members want more communication and compassion from

CONTACT Anita P. Barbee anita.barbee@louisville.edu Kent School of Social Work, 202 Julius John Oppenheimer Hall, 2217 S 3rd Street, University of Louisville, Louisville, KY 40292.

these professionals than they typically receive (Fallat et al., under review). Studies of EMS professionals report that they believe they are respectful of families and doing everything they can to save lives (Fallat et al., 2016). Thus, there is a disconnect between what EMS and other professionals think they are doing and how they are communicating, versus how families perceive these interactions.

While this disconnect is described across different types of child death situations, attribution theory (Heider, 1958; Kelley, 1973) may help explain instances when the discrepancy is likely to be more pronounced. When people attempt to discern the cause of a problem, two processes can operationally contribute to the difference between perceptions of parents and EMS providers. The first of these is called the actor-observer effect or actor-observer bias (Jones & Nisbett, 1971). Many studies have found that an "actor" in a situation tends to make external or situational attributions for behaviors or problems. In this case, parents who find that an infant child is not breathing after a nap assumes that something happened to the child's brain or heart to cause the child to stop breathing. They also may be in possession of the knowledge that nothing untoward was done to harm their child. So, an external cause, such as unexpected and inexplicable illness that beset the child, seems most reasonable to family members. Typically, "observers" who happen upon a scene like this do not know if the parent or another adult in the home intentionally or accidently harmed the child or whether the cause of the suffocation was sudden infant death syndrome (SIDS). Unfortunately, it is common for observers to make an internal or person-centered attribution for the cause of the problem, such as the parent or their partner caused the suffocation of the child through child abuse or neglect. Another term for people's tendency to jump to an internal rather than an external attribution for the behavior of others is the fundamental attribution error (Schwartz, 2006). The fundamental attribution error describes the tendency of humans to *value* dispositional explanations for behavior, particularly the behavior of others, over situational explanations. This occurs because the other person and his or her behavior is salient and vivid, whereas situational factors are subtle and easily overlooked or ignored. Because attention is focused on the person, more person-centered explanations are generated. Focusing on the person as the source of a problem can give the observer a feeling of efficacy and justice, because people can be retrained or punished, whereas situations often are often uncontrollable. The reason it is an "error" is because the causes of most problems are complex, so jumping to a person-centered explanation is likely to be inaccurate.

The preference for person-centered explanations also may stimulate a confirmation bias, or a tendency to ask questions and look for answers to support the hypothesis of personal rather than situational causality (Darley & Gross, 2000). If family members are unconventional in any way or differ

from the "norm" this may be a signal that they are members of the outgroup and thus prone to character flaws. If family members behave in ways that are not considered proper for a stressful situation (e.g., showing no emotion or showing too much emotion), this too may confirm their person-centered bias (e.g., they were not sad enough—perhaps they did something wrong or don't really love their child). Thus, the disconnect between EMS perceptions of helpfulness and family member perceptions of coolness or criticalness may be most pronounced when the cause of death is ambiguous and suspicion of child maltreatment is high. In this type of case, professionals may entertain an internal rather than an external attribution about the cause of death and act accordingly. This may make family members feel judged rather than supported.

The current study examined interviews with parents regarding five cases of sudden unexpected death in infancy (SUDI) to understand the interactional patterns between parents in this type of death situation and the professionals they encountered at home and at the hospital.

Method

Interviews for this analysis were extracted from part of a larger study (Fallat et al., 2016). The study received University of Louisville Institutional Review Board approval in August 2013 and approval by Norton HealthCare in September of 2013. All participants completed informed consent forms.

Potential parents for participation were recruited from the Bereavement Intervention Program (BIP) at Kosair Children's Hospital (KCH) in Louisville, Kentucky. The BIP began in 1995, initially serving 18–25 traumatically bereaved families per year. Currently the Pediatric Bereavement Care Coordinator follows 100–120 bereaved families annually (Oliver, Sturtevant, Scheetz, & Fallat, 2001) and the bereaved family database contains approximately 700 families, including at least 43 whose children experienced sudden, unanticipated deaths in the recent past. The BIP database was screened for deaths after out-of-home (OOH) cardiopulmonary arrest (CPA). Beginning with families whose child died at least three months previously, letters were sent by pastoral care explaining the study and requesting permission to call and explore interest in participating in an interview. A card to decline and opt out of the study was enclosed; if it was not returned within 10 days, the study coordinator made an exploratory call. If the parent was interested, a range of dates for participation was offered. Parents could discontinue participation any time thereafter, even during the interview. All parents received a list of grief resources relevant to their own community. A $50 compensation for inconvenience and time taken to participate was provided to family members.

Table 1. Multiple case study analysis of key characteristics of situations and reactions.

	Case 1: AA Single Mother; Poor	Case 2: AA Single Mother, Grand; Poor	Case 3: White, Married Couple; Working Class	Case 4: White, Married Couple; Middle Class	Case 5: White, Married Couple; Lower Middle Class
Child characteristics and history	No known health problems; 6-month-old boy	No known health problems; 4-month-old boy	No known health problems; 1-month-old boy	Premature baby, heart issues; 9-month-old boy	Previous heart surgery 3-month-old boy
Discovery of child not breathing	Check after a nap	Check after a nap	Check after a nap	Check after a nap	Check after a nap
Call to 911	Disclosed no previous problems	Disclosed no previous problems	Disclosed no previous problems	Disclosed illness	Disclosed illness
EMS arrives	Quick arrival	Quick arrival	Quick arrival	Quick arrival	Quick arrival
EMS treatment	Pick child up, hold like a doll, police called, police interview mother and take bed materials while EMS treating child in apartment	Quickly move to ambulance but fail to put clothes or blanket on child in winter; send coroner to house within half hour of leaving house	Work on infant in house and in ambulance	Scoop and run to ambulance	Scoop and run to ambulance
EMS to ambulance and leaving scene	EMS eventually take child to hospital. Will not allow mother to ride along. She rides with police	EMS eventually take child to hospital. Will not allow mother to ride along, suggests she follow in her car	EMS eventually take child to hospital. Initially say father can ride along, then change minds	EMS offer parent to ride along in the ambulance	EMS offer parent to ride along in the ambulance
Hospital scene	Staff rude to mother, irritated with her as they work on child	Staff rude to mother, someone follows her entire time in hospital	Not much interaction with hospital staff	Staff are warm and supportive of parents	Staff are warm and supportive of parents
Child declared dead	Give no condolences, no instructions regarding touching or holding child after death	Give no condolences, no instructions regarding touching or holding child after death, no privacy	Give no condolences, no instructions regarding touching or holding child after death	Give condolences and tell parents protocol for saying goodbye to infant child	Give condolences and tell parents protocol for saying goodbye to infant child
Parental reaction to child death	In shock, kissed and touched baby	Said goodbye but afraid to touch	Said goodbye but did not touch or hold	Held baby while said goodbye	Held baby while said goodbye
Parental coping after the child death	Parent could not sleep in apartment, ruminates about EMS treatment	Still ruminates about taking child out with no clothes, coroner arrival	Father copes, parents seek therapy, mother has alcohol dependence	Have social support, mutual parental support, cope okay after loss	Some rumination but overall cope okay with loss

Family interviews

After contacting about 50 parents through letters and e-mails and having phone conversations with the parents of 15 children, a total of 11 parents (including one grandparent) were interviewed by two authors (AB and RF) regarding the death of 7 children. Of those, 5 of the children had died from sudden unexpected death in infancy (SUDI). These five cases were examined further using a multiple case study analysis (Stake, 2013) in order to understand how EMS providers react to situations with greater or lesser levels of ambiguity.

In the original study, in addition to demographic information, families were asked to answer a few questions. Family members discussed their interpretation of the events in the OOH setting, focusing specifically on the communication and actions of EMS and related emergency personnel (firefighters, police, medical examiner, emergency department personnel, social workers, chaplains). Participants were also asked to describe helpful, neutral, or harmful behaviors engaged in by the professionals in this stressful situation.

In a multiple-case study analysis, records are analyzed with an emphasis on a particular idea or concept. Our research question centered on understanding how parents were treated differently when the situation was ambiguous. To analyze the five cases, a table was generated laying out each step in the sequence of events that unfolded the day their infant child died. Reported reactions of EMS and other professionals for each case were recorded to see if any patterns emerged (see Table 1).

Results

In this portion of the larger qualitative study, five of the infant children, all boys, died of SUDI. The sequence of events was the same for each case, but there were differences in reactions of professionals to the families and how families coped after the death when comparing cases with more versus less ambiguity for the reason for the sudden death. Case One involved an African American mother living with her 2-year old daughter and a seemingly healthy 6-month old infant. The mother had laid the infant down to sleep on her bed and went to study in the next room. When she returned several hours later, the infant boy was not breathing and was cold. She immediately called EMS, who arrived promptly. The EMS professionals held the infant up asking if he was a doll. The mother interpreted this action as disrespectful to her son. EMS did try to resuscitate the infant, but were largely noncommunicative about the procedures they were engaged in or the purpose of their interventions. The mother remained calm during the event due, in part, to the fact that she was currently in training to become a nurses' aide, and to keep the scene

calm for her older child. The mother said, "I wonder if the EMS professionals dismissed me because they thought I hurt my baby. Since I did not act in a hysterical way and was calm the whole time, I wonder if they thought I was a monster."

The police arrived while EMS was working on the child and examined the room where he had died. The police took the bed covers as evidence, in case there was any wrongdoing. The EMS crew decided to transport the baby to the hospital, but the mother was not allowed in the ambulance. She and her daughter rode in the back of the police car instead. She also wondered if the presence of police prohibited EMS professionals from allowing her to ride with her son to the hospital.

At the hospital, the nurses and doctors continued resuscitation efforts for a while before pronouncing death. The mother was allowed to see her child before the coroner came, but was given no instructions as to whether she could touch him or not. The mother reported that the hospital staff were cold to her and showed no compassion toward her regarding the death of her baby. The mother believed that EMS staff conveyed their negative attributions to the hospital staff, which is why they in turn were impersonal and uncommunicative.

She was so upset after her child died in the apartment that she was unable to be in that space and stayed with friends from church for a few weeks. A caseworker from Child Protective Services visited her the following week, but did not open a case. It took three months before she received the death certificate and knew that her child had, in fact, died of SUDI. When asked about her experience with all of these emergency professionals, the mother replied, "I wish they had shown my son and me some respect. There was no compassion. No one reassured me while they were working on my son. No one said they were sorry for my loss after he was gone." When asked why she thought these signs of respect and compassion were missing, she replied, "I think they thought I hurt my son, so they judged me and acted accordingly."

The second case involved another African American family including a maternal grandmother, mother, and presumably healthy four-month-old infant son. In the second situation, the infant was sleeping in a crib in the mother's room. He was breathing when she left for work that morning. Usually the grandmother was awakened by him a few hours later, but that particular morning, she awoke on her own and immediately went to check on her grandson. He was not breathing. She called EMS, who came promptly. The mother arrived shortly afterward. EMS swooped in, and, without explanation, picked the baby up and carried him to the ambulance. The infant only had on a diaper and both the mother and grandmother were distressed to see EMS take him outside in winter without clothes or a blanket. When the EMS providers said they were taking the infant to the hospital, the mother was not

allowed in the ambulance, but was encouraged to drive to the hospital. The grandmother remained behind and was at home to receive the police and coroner. No one had told the mother or grandmother that the child was dead; thus, the presence of the coroner was the first clue and added to the grandmother's distress. She said, "I couldn't believe the coroner showed up so quickly. That means they knew my grandson was dead, but no one had the courtesy to tell the family."

At the hospital, the mother was allowed in the room with her son as they worked on him. According to the mother, the medical team working on him seemed to give up resuscitation efforts quickly. She said in describing that scene, "The doctor and nurses were irritable with me and said in a gruff voice that he was gone and there was nothing more they could do." From her first entry into the hospital, someone from the hospital talked to her and never allowed her to be alone. She really wanted time alone with her son, time to tell the father about the incident, and time to grieve, but she said, "It was like they didn't trust me. They sent this person to stay by my side the whole time. It was very annoying. I had no privacy. I couldn't even explain what had happened to the baby's father. She was ALWAYS there." She and the child's father were allowed to say goodbye to their son, but were given no instructions about touching him, which interfered with their ability to give him a proper goodbye.

The final three cases involved husband and wife Caucasian families with a one-month-old, nine-month old, and a three-month-old son, respectively. In the third case, the healthy one-month-old infant son was found limp, not breathing and with no heartbeat. In the call to EMS, the 911 operator asked if the family had a defibrillator to shock his heart. The mother was taken aback by such a question since most young people do not have a specialized and expensive machine like that at home. The mother began following the 911 operator's instructions to give her son CPR. EMS arrived quickly, took over CPR and took the baby to the ambulance. The mother described the initial interaction: "The first EMS workers that came in didn't really say much, didn't really talk much, they didn't seem to have much compassion, you know, and it was just kinda like, they took over for me, which I was grateful for, but they didn't, you know, they weren't reassuring, they weren't compassionate, they were just kinda stone. And that bothered me…. They didn't even pretend like we had hope."

Then the police arrived and, according to the mother, rudely asked questions about the incident. The mother reported that she was in shock and could not cry. "I could just sit there, you know, once they had taken over and done their stuff. The cops kinda treated me bad. Maybe, and I'm guessing, because I wasn't crying or, you know, blubbering or, you know, they were kinda treating me like I did something wrong, like I was a criminal. But I was trying to stay positive even in the worst situation so at that point we still had hope."

She wanted to say to them, "Be nice to me. Because you don't know what the situation is yet. You know, treat me like what really happened. Like it was a freak of nature thing that happens and you know, obviously, I didn't do anything. I wasn't in charge of anything. He had his full autopsy. It wasn't me, but they made me feel like they thought it was me."

At first the police told the father that he could ride in the ambulance with EMS, so the father went out to the back of the ambulance, waiting to get in and knocking on the door. No one acknowledged that he was there. A few minutes later, the police officer told him he could not ride down there with his son. The father went on to say, "And they sat outside our house for I couldn't tell you how long. When they pulled off, they didn't even try to turn the lights on, try to turn the sirens on, nothing. They didn't even pretend like we had hope. And that's always gonna stick with me. How long they sat out there and they pulled off like it wasn't even nothing. Like it was just nothing."

In the fourth case, the infant son had had health problems as a premature baby and had just gotten a clean bill of health the day before at his nine-month checkup at the pediatrician's office. The mother and son were asleep on the floor of the living room taking a morning nap. When the mother woke up, she noticed that her son was not breathing. She called 911 and related that he was a child who had a history of heart difficulties. EMS rushed to the scene and quickly took the boy to the ambulance and then on to the hospital. The mother was allowed to ride in the ambulance up front with the driver. The father joined them at the hospital. The baby was declared dead soon upon arrival. The family was able to be alone with their son to say goodbye to him. They were given clear instructions about the fact that they could kiss him goodbye, but could not pick him up or move him in any way because of the pending investigation.

Both parents noted that everyone was kind to them during the process. EMS acknowledged their presence, but quickly moved the son to the ambulance for care. The nurses and doctors at the hospital were sympathetic to their pain and gave their condolences. The detective was clear that he had to ask them questions as a formality since it was obvious they had not harmed their son. Later we will discuss possible reasons why professionals were respectful and compassionate toward this family and not so toward the first three families interviewed.

In the fifth case, a set of Caucasian parents had a female toddler and a three-month-old baby son who had needed heart surgery after his premature birth. He was not breathing. When EMS saw the infant, they scooped him up and ran to the truck while doing CPR on him. The mother ran with them with the boy's red medical binder explaining that he was a heart baby and telling them about his heart condition. She said, "They ran to the truck. I've never seen EMS run. While doing CPR. They were doing CPR running to the truck.

And I ran out there with his red binder. Saying he's a heart baby and, you know, trying to explain what his condition was. But they were all real nice."

They worked on the baby for over 30 min in the ambulance before going to the hospital. The EMS providers asked if one of the parents was going to ride in the ambulance and the father sat up front with the driver. The father said that he would have taken a shorter route. At the hospital, the nurses entertained the toddler so the parents could learn about their son's death. They were told not to touch or pick up their dead son. Fifteen minutes later a detective arrived. The family had no time to grieve before they had to answer questions about the death. But, neither parent noted any disrespect by EMS, police, or emergency room personnel.

Discussion

Among these five SUDI deaths, three were totally unexpected. None of the three infants had a preexisting health issue. In all three of these cases, parents felt that EMS personnel and police were unkind and judgmental. In the other two cases, the infant had a preexisting health problem. The aggrieved and nonaggrieved families differed on three structural dimensions: (a) race: two of the three aggrieved families were African American, while one was Caucasian like the fourth and fifth family; (b) in terms of family structure: two of the aggrieved families were led by single mothers, but the third was a two-parent family, as were the nonaggrieved fourth and fifth families; and (c) social class: the first family lived in an apartment complex for single mothers going to college, near the projects; the second lived in a low-income apartment complex, and the third lived in a small home and had a lower middle-class background. Both parents in the third case dressed like artists with an array of colorful tattoos adorning their bodies. By contrast, the nonaggrieved fourth family lived in a house in a middle-class neighborhood and the fifth family was also living in a lower middle-class neighborhood, but presented as traditional. All three demographic factors could have played a role in the behavior of the professionals, but because these factors did not uniformly differ between the aggrieved and nonaggrieved groups, another explanation may be more parsimonious.

The ambiguity of the preexisting health status of the children may have made the most difference in EMS judgments about the first three families. In the fourth case, the infant had been born prematurely and had been monitored carefully as a result of health risks. In the fifth case, the child had needed heart surgery so problems due to a weak or damaged heart were foreseeable. Such health risks would give EMS professionals external, uncontrollable explanations for the latter two deaths. In the first three cases in which EMS professionals were perceived to be judgmental, there was no ready explanation for the deaths. Such ambiguity opened the possibility that the children

had been maltreated. In these cases, professionals including EMS, police, and emergency room staff may have jumped to an internal attribution for the cause of death. They may have guessed that the parent harmed or neglected their baby, leading to intentional or accidental suffocation. Other demographic variables such as race, poverty, or unconventionality (single motherhood, artistic dress, unexpected emotional reactions) could have been used to confirm that initial judgment. And, while the EMS workers might have been too professional to fully commit to that conclusion, it did seem to interfere with their display of empathy, open communication, and accommodation. Although EMS personnel were not overtly condemnatory, the distressed parent felt the judgment and disrespect, and perceived all other EMS behavior in that light. Worse, perceiving EMS disapproval added to the guilt the parents felt about their child's SUDI death.

Other research has found that making internal or controllable attributions for a victim's behavior or situations leads onlookers to feelings of anger and a proclivity to help less (Schmidt & Weiner, 1988). It is logical that when professionals make these attributions, it may affect their behavior toward families. However, first responders should be trained to completely suspend judgment and treat all families worried about their child's imminent death, or who are grieving the death of their child, with empathy, compassion, and respect. Even if a parent has harmed his or her child, he or she still loves the child and will still feel the sting of death. It should be the job of EMS professionals, emergency room nurses, physicians, and other hospital personnel to focus on providing high-quality medical care in a family-centered way so that the remaining family members will feel confident that everything was done to save their child, and that they were supported during the ordeal. Communicating in a way to ensure that family members feel respected is key to the ability of family members to cope with the death of their child (Fallat, Wright, & Barbee, in press).

Because police detectives and the coroner are always called to the scene of a child death, EMS and other medical professionals could leave the *investigation of the cause of death* and *any judgments about the cause of death or about the parents* to law enforcement. Recognizing that all medical providers are required to *report* suspected abuse to Child Protective Services, this may create a bias for EMS to regard the parent as guilty until proven innocent. However, once a report is made, this releases the EMS provider of responsibility for the investigation into the causes of any potential child maltreatment to other professionals. Releasing this burden will free them to treat the family with kindness and compassion. Similarly, police officers and coroners also should be respectful in tone and not rush to judgment in ambiguous cases, since it takes time to determine the cause of death. They should be confident that they have the responsibility and tools to resolve the case and ensure that justice is done. In the meantime, grieving parents should be treated as innocent of any harm-doing.

Summary

There are underlying themes that we have learned from these interviews, including that (a) it is human nature to jump to the conclusion that parents were at fault in the death of an infant; (b) EMS and other emergency care providers seem to reveal their negative personal impressions about parents directly to the parents and other professionals on the scene and at the hospital; and (c) parents feel the judgment and are distressed by it at a time when they should feel supported during the most stressful and traumatic event of their live, that is, when their child is dying or has recently died.

EMS and other emergency professionals are charged with delivering patient- and family-centered care, especially when children are the patients. These health care workers need to be better educated in lay terms about the actor-observer effect, the fundamental attribution error, and confirmation bias so that they can overcome the tendency to judge parents when children are dying or have died in an out-of-hospital setting. This training should include advice on how to dismiss these attributions and cognitive errors so that they do not personally become angry at the parents they are trying to serve and instead can feel compassion and empathy toward them. EMS providers and other emergency personnel need to be better trained in patient- and family-centered care so they can help families cope with the tragic death of their child.

Future research is needed to confirm the observations of this small qualitative study using a larger sample to replicate these findings and add to the larger literature on this problem. This research should include a sample that explores possible mediators such as preexisting health of the child, social class, race, and other variables that may impact the attribution processes suggested by this research. Interviews of EMS and other medical professionals regarding their attributions and treatment of families experiencing SUDI deaths would illuminate the alternative views from the viewpoint of providers regarding these difficult situations.

Funding

The study was conducted as part of a federally funded HRSA, EMSC Targeted Issues Grant No. H34MC26204: Compassionate Options for Pediatric EMS (COPE).

Notes on contributors

Dr. Anita Barbee is Professor and Distinguished University Scholar at the Kent School of Social Work at the University of Louisville. She was co-principal investigator and evaluator on the HRSA-funded grant Compassionate Options for Pediatric EMS (COPE) and is co-principal investigator on a Substance Abuse and Mental Health Services Administration (SAMHSA) funded Level III Center for the Promotion of Recovery and Resilience of Traumatized Children and Youth.

Dr. Becky Antle is Professor and University Scholar at the Kent School of Social Work at the University of Louisville. She is the evaluator on two trauma-related grants, one funded by the Children's Bureau as well as a SAMHSA Level III Center focused on traumatized children and youth.

Dr. Mary Fallat is the Hirikati S. Nagaraj Endowed Professor and Chief of Pediatric Surgery in the Department of Surgery in the School of Medicine at the University of Louisville. She is principal investigator on the HRSA funded grant Compassionate Options for Pediatric EMS (COPE).

Dr. Richard Forest is the Chaplain at the Pediatric Bereavement Care Program at Norton Children's Hospital, which is part of the Norton Healthcare System in Louisville, Kentucky. He has worked with bereaved families for over 20 years.

Ms. Mary McClure is a Research Nurse in Pediatric Surgery in the Department of Surgery at the University of Louisville. She currently runs the COPE project on a day-to-day basis.

ORCID

Anita P. Barbee http://orcid.org/0000-0002-3951-1276

References

Becker, T. K., Aswegan, A., Bradley, R. N., & Schoenwetter, D. J. (2013). Ethical challenges in emergency medical services: Controversies and recommendations. *Prehospital Disease Medicine*, *8*(5), 488–497. doi:10.1017/s1049023x13008728

Bremer, A., Dahlbert, K., & Sandman, L. (2012). Balancing between closeness and distance: Emergency medical services personnel's experiences of caring for families at out-of-hospital cardiac arrest and sudden death. *Prehospital Disaster Medicine*, *27*(1), 42–52. doi:10.1017/s1049023x12000167

Darley, J. M., & Gross, P. H. (2000). A hypothesis-confirming bias in labelling effects. In C. Stangor (Ed.), *Stereotypes and prejudice: Essential readings*. (pp. 212–225). Psychology Press.

Fallat, M., Barbee, A. P., Forest, R., McClure, M., Henry, K.., & Cunningham, M. R. (2016). Family-centered practice during pediatric death in an out of hospital setting. *Prehospital Emergency Care*, *20*(6), 798–807. doi:10.1080/10903127.2016.1182600

Fallat, M., Barbee, A. P., Forest, R, McClure, M, Henry, K., & Cunningham, M. R. (under review). Family views of EMS interventions during pediatric death in an out-of-hospital setting. *Prehospital Emergency Care*.

Fallat, M., Wright, T. N., & Barbee, A. P. (in press). Communication in pediatric care settings. In D. E. Wesson & B. Naik-Mathuria (Eds.), *Pediatric trauma: Pathophysiology, diagnosis, and treatment* (2nd ed.). New York, NY: Taylor & Francis.

Heider, F. (1958). *The psychology of interpersonal relations*. New York, NY: Wiley.

Henderson, D. P., & Knapp, J. F. (2005). Report of the national consensus conference on family presence during pediatric cardiopulmonary resuscitation and procedures. *Pediatric Emergency Care*, *21*(11), 787–791.

Jenny, C., & Isaac, R. (2006). The relation between child death and child maltreatment. *Archives of Disease in Childhood*, *91*(3), 265–269. doi:10.1136/adc.2004.066696

Jones, E. E., & Nisbett, J. (1971). *The actor and the observer: Divergent perceptions of the causes of behavior*. New York, NY: General Learning Press.

Kelley, H. (1973). The process of causal attribution. *American Psychologist*, *28*(2), 107–128. doi:10.1037/h0034225

Krous, H. F., & Byard, R. W. (2001). *International standardized autopsy protocol for sudden unexpected infant death. Appendix I. Sudden infant death syndrome: Problems, progress and possibilities* (pp. 319–333). London, UK: Arnold.

Mace, S. E., & Brown, K. (2006). Patient-and-family-centered care and the role of the emergency physician providing care to a child in the emergency department. *Annual Emergency Medicine*, *48*(5), 643–645.

Oliver, R. C., Sturtevant, J. P., Scheetz, J. P., & Fallat, M. E. (2001). Beneficial effects of a hospital bereavement intervention program following traumatic childhood death. *Journal of Trauma*, *50*(3), 440–448. doi:10.1097/00005373-200103000-00007

O'Malley, P. J., Brown, K., & Krug, S. E. (2008). Committee on pediatric emergency medicine. Patient-and-family-centered care of children in the emergency department. *Pediatrics*, *22*(2), e511–e521.

Schmidt, G., & Weiner, B. (1988). An attribution-affect-action theory of behavior replications of judgments of help-giving. *Personality and Social Psychology Bulletin*, *14*(3), 610–621. doi:10.1177/0146167288143021

Schwarz, N. (2006). Attitude research: Between Ockham's Razor and the fundamental attribution error. *Journal of Consumer Research*, *33*(1), 19–21. doi:10.1086/504124

Stake, R. E. (2013). Multiple case study analysis. Guilford Press.