Unique Identifier NO:	(Patient ID Label)	Ward
Sudden Child Death Folder	Name: DOB: NHS Number: Hospital Number: Date of Death:	
Status: Draft 1		

This folder should be used whenever a child <18yrs dies in the Emergency Department

Contents:

Unique Identifier NO:

Sudden Child Death Folder

Status: Draft 1

(Patient ID Label)
Name:
DOB:
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Hospital Number:
Date of Death:

Staff Contact List

Please record names and contact details of all staff involved

Include paramedics, reception staff, nursing staff, doctors, ODPs, students, radiographers, porters or anyone who you feel may benefit from being offered a debrief.

Please leave this page in the sister's office in an envelope marked 'FOA Janet Youd- For Debrief'

Please DO NOT leave the list in the patient's notes with contact details on.

A list of the roles and names should be written in the EPR record but NOT personal contact numbers.

Role	Name	Preferred Contact: Email and/or phone or 'No Contact Please'
e.g. Staff Nurse A&E	*e.g. Suzie Smith*	*Email: suzsm11@cht.com or 07777 66666*

Continue over if needed…

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Status: Draft 1

(Patient ID Label)
Name:
DOB:
NHS Number:
Hospital Number:
Date of Death:

Demographic Details

Date:	MRN:
Child's Name:	DOB:
Address:	Religion Christened Yes / No
NHS number	Place of birth
GP name / practice	
Health visitor	School/nursery
Mother's name Address: Contact Tel No (home & mobile)	Father's Name Address: Contact Tel No (home & mobile)
Name and relationship of other adults living at the child's residence:	

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Sibling Details: Name, DOB, School if Appropriate.
Supportive Family Members Name and Tel No: Where are parents going to be staying? Address / telephone
Social worker involved:
Police involved Names and Numbers:
Religious leader contacted? (name)
Interpreter contacted? (name)
Other Family members contacted?

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Emergency Department Section

Role of the Nurse Caring for the Child: **Name:** **Sign:**

(Tick boxes when completed)

Ensure the child continues to be cared for with dignity and respect. ☐

Keep covered with gown and blanket once clothing has been removed.

Ensure clothing and any disposable equipment (eg Drains/ET tubes) is retained for possible forensic examination. Do not throw away until permission form coroner has been given. ☐

Remove E.T Tube, lines and electrodes with **permission from Coroner or Coroner's Officer.** (Ensure this is recorded in clinical notes on EPR) ☐

Apply dressings to any puncture wounds (e.g. Cannulation attempts/ Intraosseous sites). Ensure this is documented in clinical notes on EPR. ☐

Document a child's core temperature and weight. Rectal probe can be found in the Paeds Bay in Resus. (Document on EPR) ☐

Place 2 I.D bands on the child. ☐

Consider hand/foot prints and a lock of hair**. (only with consent of Parents and Coroner's Officer)**: State name of Coroner's Officer who gave consent: ☐

(This can often be done much better at funeral director).

Escort the child for any further investigations (e.g. skeletal survey) ☐

Ensure Death Notice is completed ☐

Escort the child to the mortuary with copy of this folder. **Ensure staff contact list is removed** (Original to be retained by Consultant Paediatrician.) ☐

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Role of the Nurse Caring for the family **Name:** **Sign:**

(Tick boxes when completed)

Ensure the family are kept fully informed of what is happening ☐

Explain the process of informing the coroner's officer and the role of the police ☐

Complete the Demographic Details sheet in the folder ☐

Complete a Paediatric Liaison form ☐

Facilitate access to a telephone if required. ☐

Offer religious leader contact: Name: ☐

Give information leaflet as appropriate. (back of this folder)

Consider on-call chaplain support even if family is not religious. ☐

They are often helpful in providing pastoral care to staff and family. ☐

Ensure drinks are available. ☐

Allow family supervised time to hold their child and say goodbye in agreement with coroner. ☐

Consider offering '4-Louis' box ☐

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Role of the <u>Nurse In-Charge:</u> **Name:** **Sign:**

(Tick when completed)

Ensure the ED and Paediatric Consultants are contacted. ☐

Contact Social Services to see if child is known to them: Document Name of contact and time on EPR. ☐

Ensure the Duty Matron is informed. Document on EPR ☐

Inform Mortuary Staff on-call. ☐

Ensure all notes are photocopied prior to originals leaving department. ☐

Ensure a request is made for a staff debrief. Leave staff contact list in an

Envelope in the Sister's office: FAO: Janet Youd ☐

(If you have any concerns and want advice please feel free to call Janet Youd: Work: 07920818913)

If a change of shift occurs prior to family or child leaving the department please document who responsibility has been handed to:

Nurse Caring for the child on arrival:	Nurse Taking Handover	Date and Time
Nurse Caring for the family on arrival:	Nurse Taking handover	
Nurse In-Charge on arrival:	Nurse Taking Handover	

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Name:
DOB:
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Role of <u>Senior ED Doctor</u> **Name:** **Sign:**

(Tick when completed)

Ensure full EPR documentation of consultation and any resuscitation attempt including medications given and timings. ☐

Support junior medical staff involved. ☐

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Notification List

In addition to ED Consultant and Paediatric Consultant please ensure the following are notified of the death.

	Time and Sign when contacted
Coroner	
Police	
Social services/ OOHs- EDT	
Janet Youd Emergency Nurse Consultant	Can be email. Janet.youd@cht.nhs.uk
On- call chaplain	Consider to support staff or family
GP/HV*	(Will be contacted by safeguarding team)
Child health records*	(Will be contacted by safeguarding team)
Named nurse for Safeguarding Children *	
Chief Nurse or deputy*	
SUDIC Paediatrician*	

* These contacts would normally be made on the next working day unless extenuating circumstances apply.

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Name:
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Section for Paediatrician
Role of Consultant Paediatrician: **Name:** **Sign:**

(Tick boxes when completed)

Inform Coroner's Officer/Police: Name: ☐

Log No:

Where a child's death is planned or expected the Paediatrician may make a decision not to call the Police.

Complete Medical History and Examination Proforma ☐

Request appropriate investigations (e.g Skeletal Survey) and document when done so. ☐

Take appropriate specimens (Bloods/swabs) for investigations and document what has been taken and when. ☐

Ensure family are aware of procedures that will be followed and when they can expect to be contacted and by whom. ☐

If it is a death at home- talk to parents about police process – going to house, collecting bedding, asking questions of family. ☐

If it is a non-trauma death- complete SUDIC referral form ☐

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Information to be collected by the Consultant Paediatrician.
NB: Much of this information will be N/A if the death is from Trauma (e.g Road Collision)

Introduction

The importance of the history being taken by an experienced Paediatrician, with knowledge and understanding of the care of children and sensitivity to the needs of the family, cannot be over-emphasised.

This list is meant as a guide. It cannot be comprehensive, as additional specific questions may arise as a consequence of information given by the parents.

Encouraging the parents to talk spontaneously, with prompts about specific information, is likely to be better than trying to collect a structured history in the more usual way. In recording parents' accounts of events, it is important to use their own words as far as possible. (Ideally, information should be recorded *verbatim.*)

Much of the information is very sensitive. Parents may feel very vulnerable when asked about their sleeping arrangements, alcohol intake or drug use, so great skill is needed in asking the questions in a non-threatening way, with no implication of value judgment or criticism. Parents may ask directly if their alcohol intake has contributed to the child's death; it is very important that the interviewer does not jump to conclusions about such questions, whilst not being dishonest when asked direct questions.

The child

- First name and family name (plus any other names by which the child may be known).
- If possible, obtain the NHS number as this may facilitate access to other records.
- Date of birth and place of birth.

Mother

- Full name (plus any other names by which the mother may be known).
- Full address, including postcode.
- NHS number if possible.
- Date of birth.

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- Phone number (home number and mobile number) and phone number of any available close relative or friend (to facilitate making contact again).
- Address to which mother will be returning when she leaves the hospital, plus phone number there and the name of the person with whom mother will be staying.

Mother's partner and/or father of child

- Full name (including any other names by which he may be known).
- Full address, including postcode.
- Date of birth.
- Phone number (home number and mobile number) and phone number of any available close relative or friend (to facilitate making contact again).
- Address to which father/partner will be returning when he leaves the hospital, plus phone number there and the name of the person with whom he will be staying.

Other members of the household (present and in the recent past)

- Names.
- Dates of birth.
- Relationship to child who has died.

Family medical history

- A detailed account of past medical and social history of all members of immediate family and household.
- Particular note and detailed information (name, date of birth, place of birth) of any previous children.
- Also detailed information on any deaths in infancy or childhood of any offspring, siblings or other close relatives of any member of the current household (to include as much information as possible concerning date of birth, age at death, place of death, cause of death and any other known information).

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Social and family history

- A detailed account of the social structure of the family and of the household, including detailed information on alcohol, tobacco and other drug use, together with information on any prescription or non-prescription medications that may have been present or in use in the household.
- Information on recent changes in composition of the household (e.g. who has come and who has gone, and for what reasons).

Detailed medical history of mother

- Details of past medical and social history of the mother, including any significant past illnesses or injuries.
- Detailed past obstetric history, including detailed information on the pregnancy leading to the birth of the child who has died.

Detailed medical and developmental history of the child who has died

To include:

- Gestation
- Birth weight
- Perinatal or neonatal problems
- Type of feeding (and date and reason for changing type of feeding)
- Growth, development and past assessments (e.g. Health Visitor or GP routine, well-child checks)
- Immunisations
- Any known contact with infection
- Medication (either prescribed or over the counter)
- If possible, obtain the parent-held child health record to copy (return this to the parents after copying it); plot the weight record onto a centile chart.

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A detailed narrative account of the child's feeding, sleeping, activity and health over the two-week period prior to the death

This should include information on:

- Changes in feeding or sleeping patterns
- Changes in place of sleep
- Any social, family or health related changes in routine practices over the past two weeks
- Any illness, accident or other major event affecting other family members in the past two weeks.

A detailed (hour-by-hour) narrative account of events within the 48 hours prior to the child being found dead

A detailed description of:

- Precisely where the child was placed for sleep
- Duration of sleeping period
- Position at the end of the sleeping periods
- Any changes in routine care or routine activity levels
- Any disruptions to normal patterns.
- Information on the activity and location of all significant members of the household
- Information on alcohol intake and recreational drug use by members of the household during this period.

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The final sleep

A very careful description of when and where the child was placed to sleep, including:

- The nature of the surface
- Clothing
- Bedding / arrangement of bedding
- Precise sleeping position
- Who was sharing the surface on which child was sleeping (e.g. bed or sofa)
- How often the child was checked
- When he or she was seen or heard
- The times at which the child awoke for feeds / whether feeds were given
- Whether they were taken well
- Who else was in the room at each stage
- What were the activities of others in the room
- Were they awake
- Where, when and by whom was the child found
- What was the appearance of the child when found
- What was the position of the child when found
- Where was the bedding / were there any covers over the child
- Had the covers and the position of the covers moved
- Were there other objects in the cot or bed adjacent or close to the child (e.g. teddies, dolls, pillows)
- Was the heating on / what type of heating was there

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- Were the windows and/or doors open

Action after child was found

A detailed narrative account of events that followed the discovery of the child collapsed or apparently dead, to include details of:

- When, how and by whom the emergency services were called
- Who was with the child at each stage
- Was resuscitation attempted and if so by whom
- Were any responses obtained from the child
- How long did it take for the emergency services to arrive?

Further specific questions

In addition to the information outlined above, information should be collected on the parents' perception of:

- Whether the child was feeding as well as, or less well than, usual in the past 24–48 hours
- Any vomiting
- Any respiratory difficulty, noisy breathing, in-drawing of the ribs, wheezing or stridor
- Excessive sweating
- Unusual activity
- Unusual behaviour
- Level of alertness
- Difficulty sleeping
- Difficulty waking the child
- Passage of stool and urine (how often and how much)
- Were any healthcare professionals consulted within the past two weeks, the past 48 hours or the past 24 hours

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- If so, who was contacted, what was the problem described to the healthcare professionals and what advice was given
- Was the child seen and assessed by any healthcare professional during the past two weeks?

Whilst most of the medical and social history will be obtained during the initial discussion with the parents in the Emergency Department, a very careful and detailed account of the final 24–48 hours will almost always be considerably supplemented by information collected at the time of the initial home visit and close examination of the circumstances of death.

The home interview and visit to the place where the child died can be very difficult, but may also be of great value in understanding the sequence of events leading to the death. Parents commonly find this home interview, whilst stressful and sometimes painful, very helpful – the fact that the Paediatrician is willing to spend this time with them, helping to understand what has happened to their child may in itself be very important to the family and many questions commonly arise out of this visit (in particular in relation to the factors that may have contributed to the death).

At the end of the interview, it is essential that the Paediatrician spends some time with the family ensuring they know what will happen next, when they will next be contacted by the Paediatrician, when and where the post-mortem will take place, and how they will be informed of the preliminary results.

Time will also be needed for the Paediatrician to help the parents deal with the very powerful emotions that are commonly brought out by this discussion. If conducted sensitively and with awareness of the parents' needs, this interview can have a therapeutic 'debriefing' value for the family – commonly allowing them to talk about some of their feelings for the first time. Parents have commonly reported that this home visit has been an extremely important and very positive aspect of their care.

Unique Identifier NO: **Sudden Child Death Folder** **Status: Draft 1**	(Patient ID Label) Name: DOB: NHS Number: Hospital Number: Date of Death:

Proforma for Sudden Childhood Death to be Completed by Senior Paediatrician

Name	**DOB**
Hospital number	**MRN number**
Date of death	
Death certified by? **Grade:**	
Has hospital checklist been completed? Yes / No (This has a lot of demographic details already and ongoing contact details that will facilitate ongoing care)	
Mother: **Name** **DOB**	**Father:** **Name** **DOB**
	Mother's partner **Name** **DOB**

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Date of Death:

Other members of the household:

Names, DOBs and relationship to deceased child.

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Family medical history:

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Social and Family History:

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Detailed medical history of the mother:

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Detailed medical and developmental history of the child who has died:

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A detailed narrative account of the child's feeding, sleeping, activity and health over the two-week period prior to the death:

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A detailed (hour-by-hour) narrative account of events within the 48 hours prior to the child being found dead:

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The final sleep:

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Action after child was found:

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Date of Death:

Further specific information:

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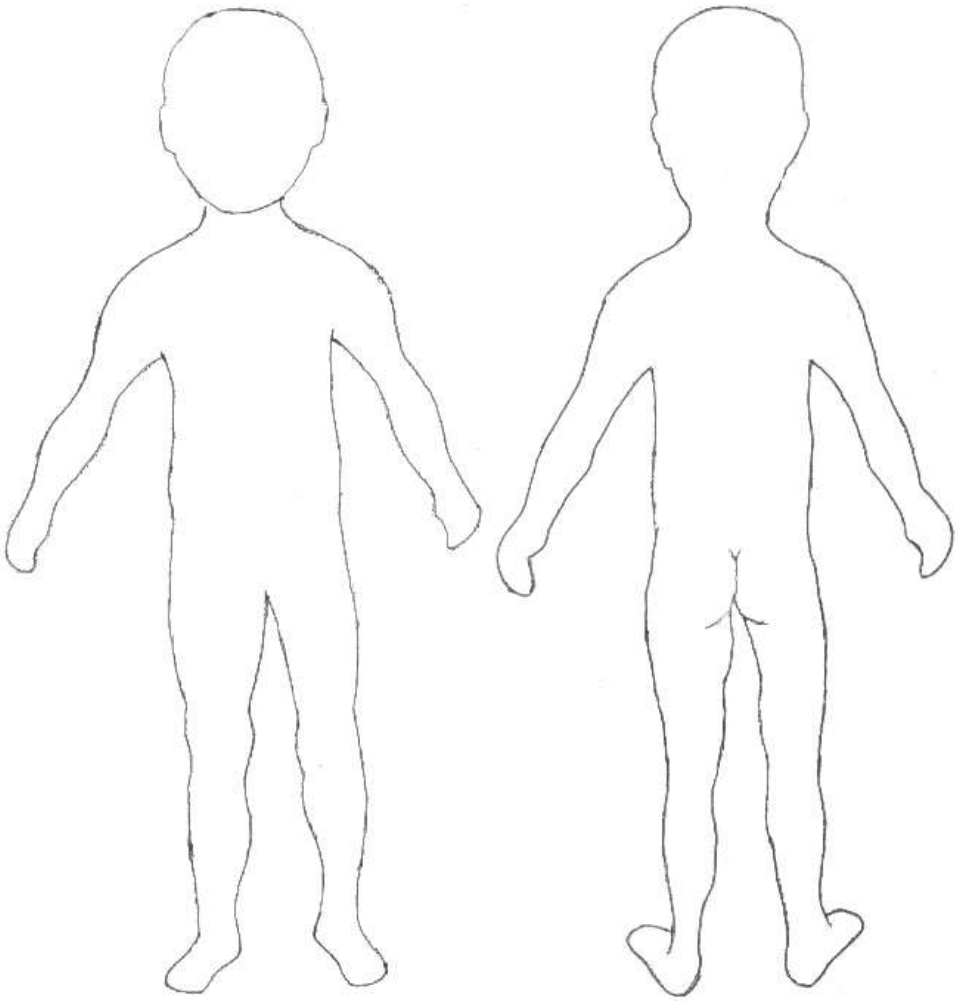
Name:
DOB:
NHS Number:
Hospital Number:
Date of Death:

Examination findings:

Weight:

Rectal Temperature:



PHYSICAL EXAMINATION BODY CHART

Date

Signature

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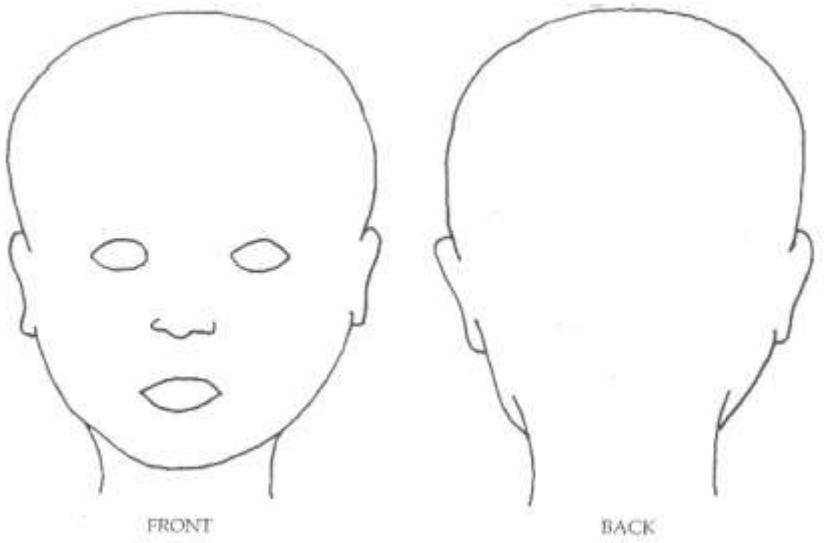
Status: Draft 1

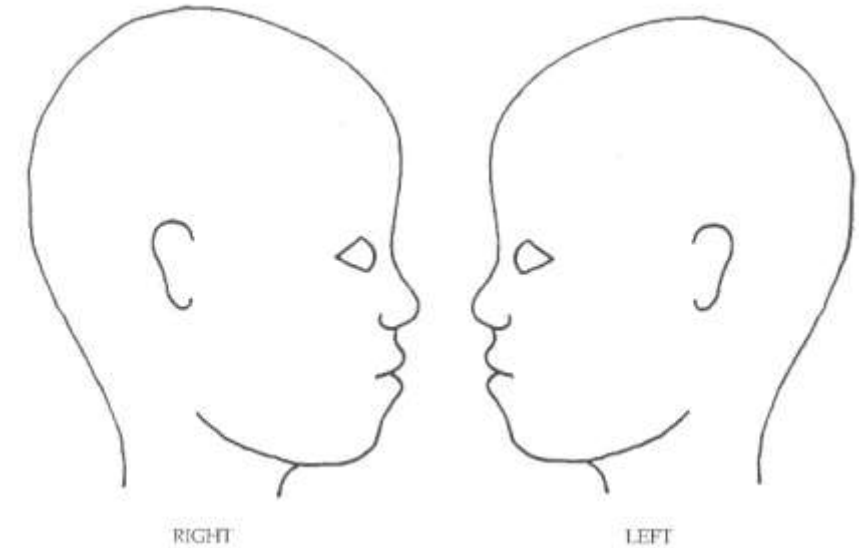
(Patient ID Label)
Name:
DOB:
NHS Number:
Hospital Number:
Date of Death:

BODY CHART 2

Date

Signature





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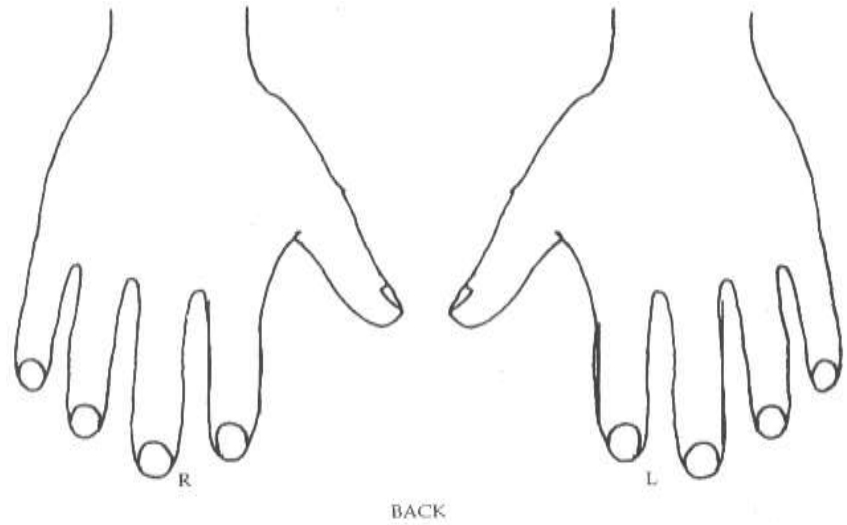
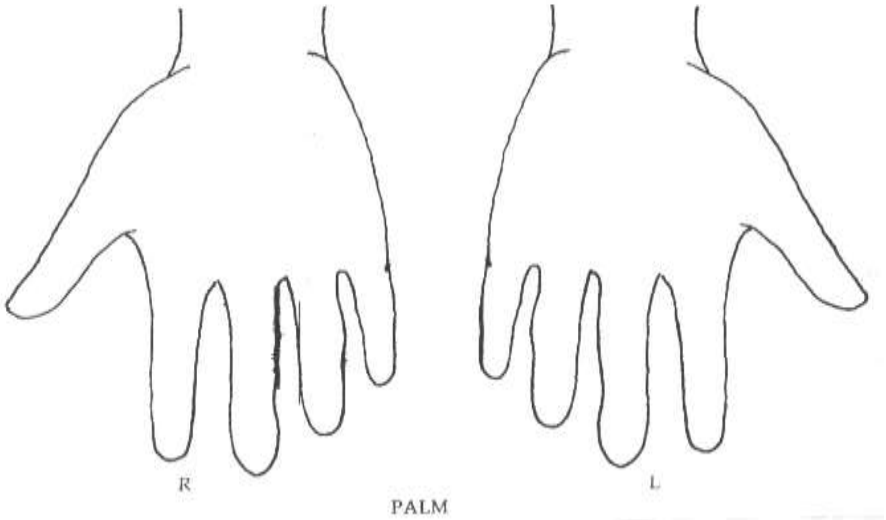
BODY CHART 3

Date





Signature

Unique Identifier NO:

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Name:
DOB:
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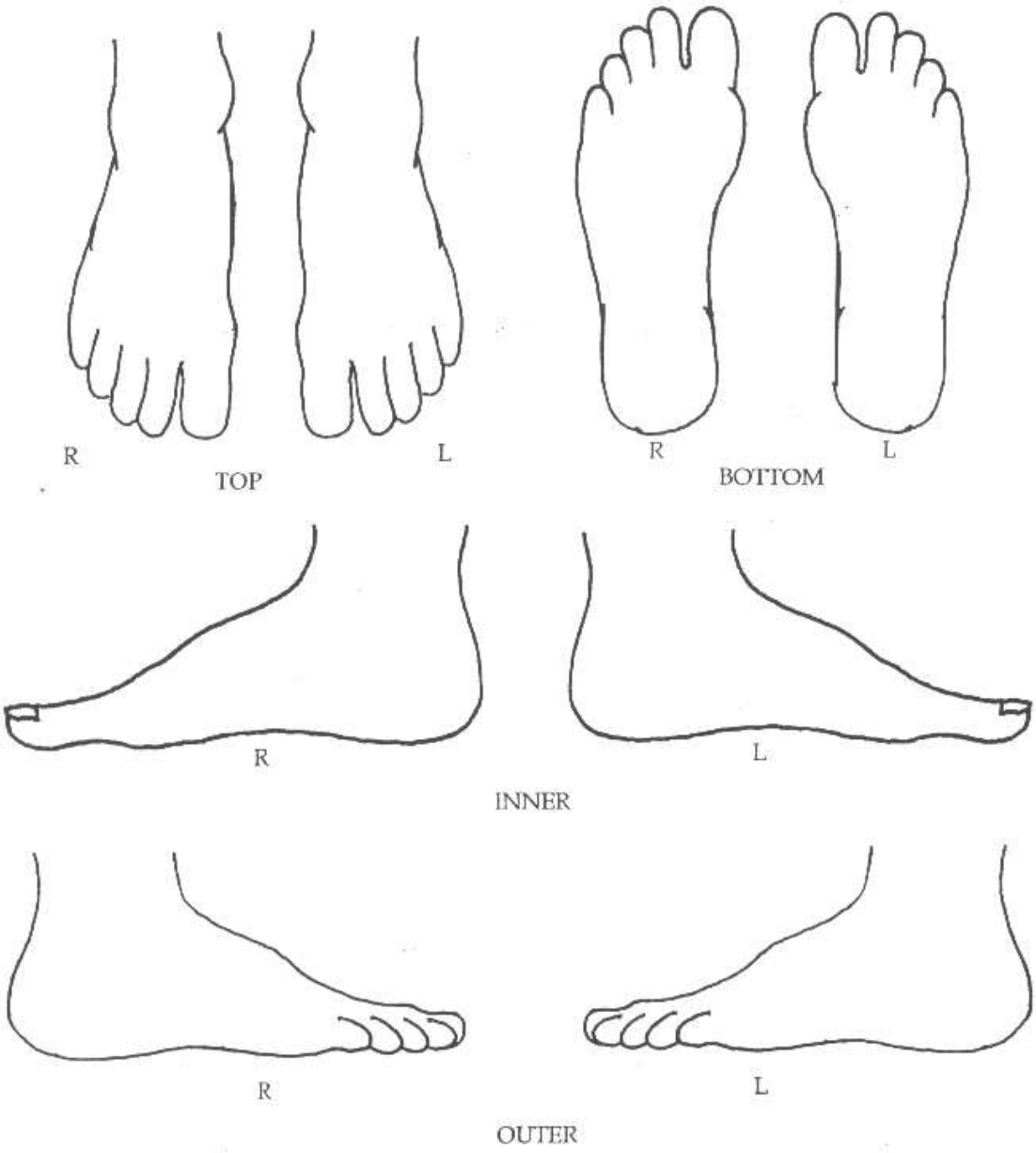
BODY CHART 4



Date

Signature

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Name:
DOB:
NHS Number:
Hospital Number:
Date of Death:

Specimens:

Routine samples to be taken soon after sudden unexpected deaths in infancy.

It is essential that in the case of a suspicious death, post mortem samples are *only* taken with the permission of the Coroner and the Senior Investigating Officer.

In cases where the death appears to be non-suspicious, it is still important to discuss the taking of specimens with the Coroner/Coroner's Officer

If PM will be within 24hours: better to take samples at the post-mortem.

If PM will be delayed longer: samples should be taken in ED.

All samples should be listed and the reports and proforma sent to the pathologist and SUDIC Paediatrician without delay.

Any samples for forensics should be sent to lab with chain of evidence form. This must be handed on, NOT sent up a chute. The chain of evidence form should be provided by and witnessed by a police officer.

Blood samples should be taken from a venous or arterial site (e.g. femoral vein). Cardiac / sagittal sinus puncture is acceptable as long as it is recorded that this has happened and the pathologist informed.

A **single** attempt at femoral venepuncture, cardiac/sagittal sinus puncture, lumbar puncture, urethral catheterisation/suprapubic aspiration should be made and documented. Repeated attempts can distort anatomy and pathology and should be avoided.

Sample	Send to	Test	Handling (info for lab)
Blood (Serum,0.5mls)	Chemistry	U&E's	Normal
Blood (Serum, 1ml)	Chemistry	Toxicology	Spin, store serum at -20^{0}C
Blood (Lithium heparin, 1mls)	Chemistry	Inherited metabolic diseases	Spin, store plasma at -20^{0}C
Blood (Guthrie card)	Chemistry	Inherited metabolic diseases	Normal
Blood (EDTA,0.5mls)	Haematology	FBC	Normal

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Blood (culture bottles, 1ml)	Microbiology	Culture & sensitivity	Normal
Blood (lithium heparin, 5mls)	Cytogenetics	Chromosomes	Normal
Cerebrospinal Fluid#	Microbiology	Culture & sensitivity	Normal
Urine	Chemistry (plain bottle)	Toxicology	Spin, store supernatant at -20^{0}C
Urine	Microbiology	Culture & sensitivity	Normal
Swab from lesion	Microbiology	Culture & sensitivity	Normal
Nasopharyngeal aspirate/swab *	Microbiology & virology	Culture & sensitivity	Normal

#If indicated by history or examination

*Samples must be sent to an appropriate virological laboratory.

Additional samples to be considered after discussion with consultant paediatrician (although not usually required):

1. Skin biopsies for cytogenetic and fibroblast culture.
2. Muscle biopsy if history is suggestive of mitochondrial disorder.
   (NB suture after taking specimen to ensure no bleeding)
3. In suspected carbon monoxide poisoning, blood sample for carboxyhaemoglobin.
4. Per rectal examination

N.B. Where the forensic/paediatric pathologist believes this is necessary to establish the cause and circumstances of the death, the coroner authorizes the retention of samples until his/her legal functions are complete.

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(Patient ID Label)
Name:
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Date of Death:

Referral form for SUDIC Team

Name

Address

DOB

DOD

Brief outline of death – history / any abnormalities in examination

Social concerns

Consultant Paediatrician responsible / on call

SpR Involved

Any other Drs

Full report and copy of the Medical Proforma should also be sent to Dr Eilean Crosbie.