Sudden Unexpected Death in Children (SUDiC) Protocol

May 2015

THIS DOCUMENT MUST NOT BE COPIED

1. Purpose of this document

To provide a protocol for clinical, spiritual and pastoral care and follow-up when a child within Lothian dies suddenly and unexpectedly. This document applies to out-of-hospital and in-hospital deaths.

2. Who should use this document

All staff who are involved in the management of sudden and unexpected deaths in children. This includes staff in the hospital, as well as community settings.

3. To whom this document applies

All infants and children ≤15 years who die suddenly and unexpectedly

4. Contact point

- Dr Jen Browning – 0131 536 0216
  jen.browning@luht.scot.nhs.uk

5. Further reference

- SUDI Scotland Toolkit, NHS QIS 2011
- Protecting Children and Young People – Interim Guidance for Child Protection Committees for Conducting a Significant Case Review - Scottish Executive, March 2007
- NHS Lothian Children's Services Bereavement Policy
- NHS Lothian Children's Services Resuscitation Event Policy
- NHS Lothian Adverse Events Management Policy
- NHS Lothian Mental Health Services and Substance Misuse Directorate (SMD) Process for Adverse event Review for UNEXPECTED DEATH
- Guidelines for the Investigation of Newborn Infants who suffer a Sudden and Unexpected Postnatal Collapse In the First Week of Life. Recommendations from a Professional Group on Sudden Unexpected Postnatal Collapse March 2011

6. Review group

- Dr Jen Browning
- Dr Kathryn Mckenzie, NHS Lothian
- Dr Charlotte Kirk, NHS Lothian
- Dr Steve Cunningham, NHS Lothian
- Dr Graham Mackenzie, NHS Lothian
- Katy Currie, NHS Lothian
- Allana Harper, NHS Lothian
- Jennifer Pyper, NHS Lothian
- Breda Wilson, NHS Lothian
- Marina Copping, NHS Lothian
- Viki Yuille, Procurator Fiscal Office
- William Guild, Police Scotland

7. Review Date

May 2015

Sudden Unexpected Deaths in Children

Contents

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Introduction

A sudden unexpected death in childhood (SUDiC) is deemed to have occurred where there is no known pre-existing condition which would make the death predictable.

Many professionals are involved when a SUDiC occurs. The interactions between the different professionals and agencies have a bearing on the ongoing investigation and in particular the effect the experience has on the parents/ carers. Not all professions will be involved in every SUDiC, but some disciplines such as child protection will be contacted routinely and may become involved if required.

Since the cause of death is not known, a death certificate cannot be issued and the death is not able to be registered. It is therefore routine practice that all SUDiCs are reported to the Procurator Fiscal, on whose behalf the police will act. This practice is well established and the police will automatically be informed of the death by the Scottish Ambulance Service, Emergency Department or in-patient team.

Investigations, which include a post-mortem examination may take several months and begins with the gathering of information from health workers and police. On the rare occasion when death appears to be the result of a criminal act, the police will work sensitively to collect detailed information from the outset.

In some cases a cause of death may be found during post-mortem examination, but for many the post-mortem examination will not explain the death. The term SUDiC or SUDI (Sudden Unexpected Death in Infancy) may therefore be given as a classification of death on the death certificate, as the death is still unexplained. Once all ancillary post-mortem investigations are complete, cases may still remain unexplained. However pathology or circumstantial factors, for example social or parenting issues, may be highlighted as being present, although not causing the death. In these instances SUDI may be entered on a death certificate.

This protocol has been developed to help guide staff through the SUDiC process.

SUDI Reviews

For those infants <24 months whose death remains unexplained after post-mortem a SUDI Review will take place. The SUDI Review is a multidisciplinary case discussion. The meeting is held shortly after the final post-mortem examination report is available, which may be several months after the infant has died. The main participants may include a paediatrician, pathologist, police, GP, health visitor, community midwife, social worker and any other professional relevant to that particular SUDI. The meeting will be held at a suitably convenient time and place for all involved. The purpose is to discuss all aspects of the death, including possible causes or contributing factors to see what lessons can be learned and to plan support for the family, particularly in identifying support needs for any future pregnancies.

(adapted from SUDI Scotland toolkit)

Sudden & Unexpected Postnatal Collapse in the first week of life

Infants who suffer a sudden and unexpected cardiorespiratory collapse within the first week of life should be recognised as having an increased risk of congenital anomaly or metabolic disease as an underlying cause for their collapse. It is important that these infants undergo comprehensive investigation to determine the underlying cause.

For these infants the SUDiC guidelines should be used in conjunction with *Guidelines for the Investigation of Newborn Infants who suffer a Sudden and Unexpected Postnatal Collapse In the First Week of Life. Recommendations from a Professional Group on Sudden Unexpected Postnatal Collapse March 2011.*
http://www.bapm.org/publications/documents/guidelines/SUPC_Booklet.pdf

Deaths from Suspected Self Harm

Deaths from self-harm, either intentional or where the intent is undetermined, are considered as suicides. The death of any young person under 18 years who has committed suicide should have their death reviewed. Review of these deaths can be delayed as it is often unclear who should lead the review.

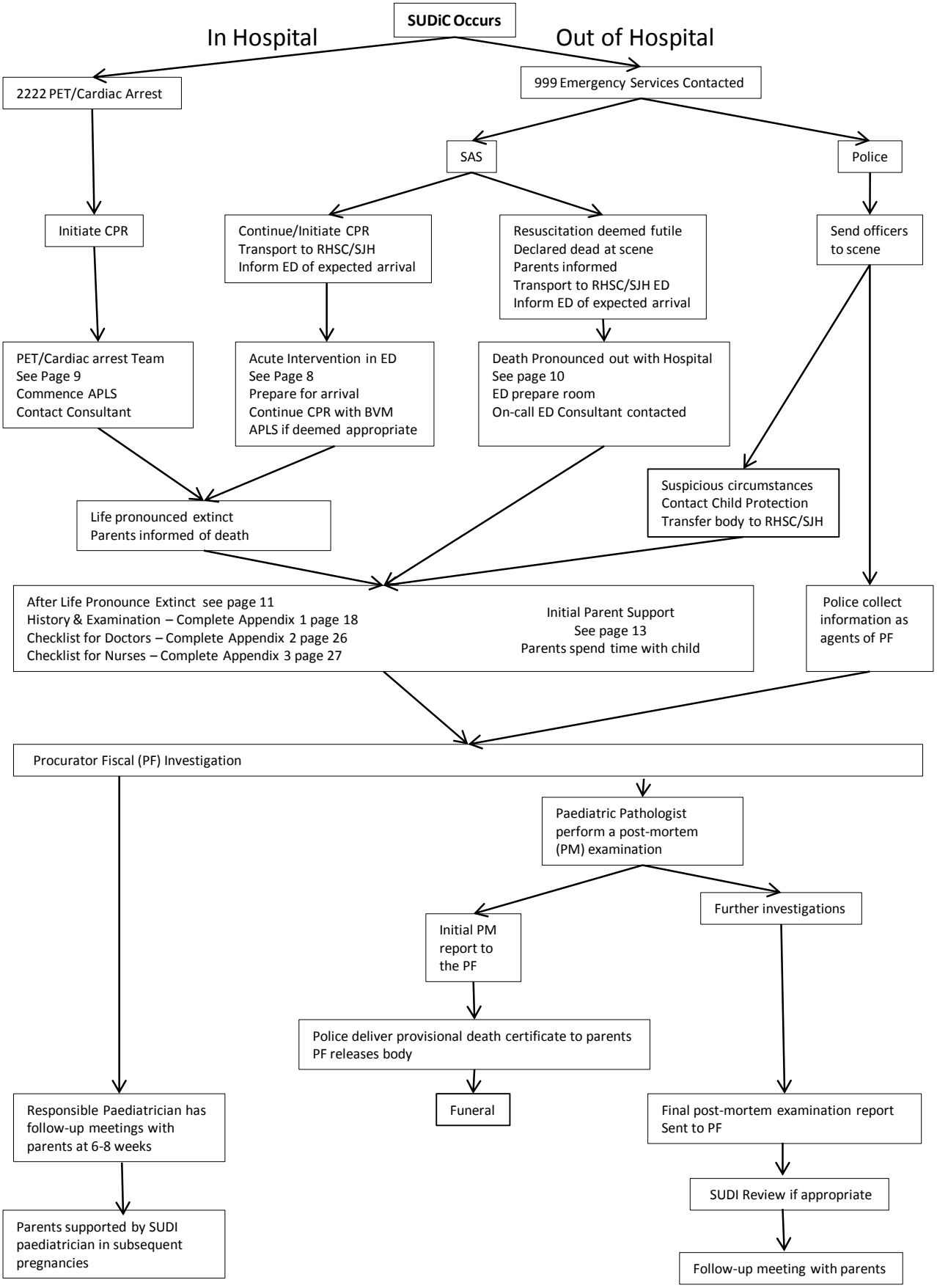
If the young person has been in contact with Child and Adolescent Mental Health Services (CAHMS) or another NHS Lothian mental health service in the last year then the Process for Adverse Event Review for Unexpected Death agreed by mental health services and the SMD should be followed.

If the young person has not been in contact with CAHMS or another NHS Lothian Mental Health Service in the last year then the Child Health Commissioner should identify and agree a lead investigator on the basis of the services that have had contact with the young person in the last year.

If the young person has given birth within the year prior to death a maternal death inquiry form is required to be submitted to Health Care Improvement Scotland. In this instance the Child Health Commissioner should identify whether the investigation is led by Maternity Services or another service, depending on the circumstances of the case.

For further information see NHS Lothian Mental Health Services and Substance Misuse Directorate (SMD) Process for Adverse event Review for UNEXPECTED DEATH available on Intranet

SUDiC Flow Chart



Acute Intervention in the Emergency Department (ED)

If death has been pronounced prior to arrival in ED, go to page 10.

Procedures Ahead of Patient Arrival

- **2222** via switchboard
  Senior ED staff may deem it appropriate not to put out a 2222 call if they feel that the department is adequately resourced, considering both staff availability and current workload
- Contact Consultant on-call for ED
- Prepare for full cardio-pulmonary resuscitation (CPR)
- Plan roles for team including parent supporter
- Agree how parents will be supported
- Ensure quiet room for parents to sit in during and after resuscitation with access to telephone

On Arrival

Assess whether CPR is appropriate:

- CPR with bag-valve-mask (BVM) ventilation should be continued while this decision is being made
- If active resuscitation is deemed appropriate the UK Resuscitation Council guidelines should be followed
- If parents wish to be present during resuscitation explain what is happening. If not present ensure someone keeps them informed

Consider stopping if:

- Senior doctor assesses child has been dead for some time
- Ambulance team report no response to CPR for >20 minutes
- Rigor mortis present
- No response after 20 minutes of full CPR
- Team consent

If parents are not present, Senior Nurse or appropriate medical personnel should, if possible, try to inform them of how the resuscitation is progressing before attempts are stopped.

Senior doctor and nurse inform parents of child's death (ensure they know the name and gender).

Go to page 11 – After life Pronounced Extinct

Acute Intervention in Hospital

Alert Paediatric Emergency Team (PET) RHSC/ Cardiac Arrest Team SJH

- The PET team should be called for all children / young people in respiratory or cardiac arrest as well as all unwell children / young people who breech the PET criteria
- Raise the alarm
    - Use emergency buzzer if available (this will summon help in your individual area)
    - This must be followed by 2222
- Commence Basic Life Support (BLS)
- **2222** via switchboard
    - Clearly state the Ward or clinic and hospital you are in for example: *'Clinical Emergency, Ward 2, RHSC'* and allow the telephonist to repeat it back to you
    - Only provide supplementary information if the location is obscure (e.g. Dr Xs consulting room 18 Millerfield Place)
    - SJH only – state clearly that it is a child
- Send someone to open the locked doors
- When the porter arrives with the defibrillator he/she will attend to the door
- If no help arrives re-dial **2222** and restate the emergency as above
- Continue BLS until help arrives

On arrival of the PET/ Cardiac Arrest Team

- Commence Advanced Paediatric Life Support as per UK resuscitation guidelines
- Ensure the Child's consultant has been made aware of the situation
- If parents wish to be present during resuscitation explain what is happening. If not present ensure someone keeps them informed

Consider stopping if:

- Senior doctor assesses child has been dead for some time
- No response after 20 minutes of full CPR
- Team consent

If parents are not in Resuscitation Room, Senior Nurse or appropriate medical personnel should, if possible, try to inform them of how the resuscitation is progressing before attempts are stopped.

Senior doctor and nurse inform parents of child's death (ensure they know the name and gender).

Go to page 11 – After life Pronounced Extinct

See NHS Lothian Children's Services Resuscitation Event Policy, 2010 (RHSC only)

If Death Pronounced Out with Hospital

All infants and children ≤15 years who have died suddenly and unexpectedly should be taken to hospital even if death is pronounced in the community as recommended in the Kennedy report.[1] This ensures that the SUDiC process is followed correctly for every child. They should be brought to the RHSC ED or SJH ED.

- Ambulance personnel should contact the ED via the Emergency Radio or Emergency Phone to alert them. It is important to state that the infant/child has been declared dead and that resuscitation efforts have ceased

- The ED Department should then contact the on-call ED Consultant who will ensure that the SUDiC guidelines are followed

- As the infant/child has been declared dead in the community the PET team should not be called

- The ED should ensure they have an appropriate room for the infant/child and their family

- The ED should ensure that there is a nurse and doctor waiting to greet the ambulance

- The Clinical Co-ordinator should be informed (RHSC only)

- If there are suspicious circumstances the Police should contact the Child Protection Consultant who will liaise with the ED Consultant and Clinical Coordinator regarding transfer to the RHSC ED/ SJH ED once the body is released from the scene. This should happen as soon as possible.

1. *Royal College of Pathologists and the Royal College of Paediatrics and Child Health. Sudden Unexpected Death in Infancy. Report of a working group convened by the Royal College of Pathologists and the Royal College of Paediatrics and Child Health. Chair: Baroness Helena Kennedy QC. London: Royal College of Pathologists and the Royal College of Paediatrics and Child Health, 2004.*

After Life Pronounced Extinct

This should be followed in **all** SUDiCs.

Parents should be supported throughout – Initial Parent Support page 13.

History & Examination

This should form the basis of a report for the pathologist and should be completed under the supervision of the most senior doctor involved in the resuscitation. This form should be filed in the case notes and should be available for case review.

Use the SUDiC proforma – Appendix 1 (page 18)

If may be as the examining medical staff you are the first to notice injuries or other circumstances giving rise to suspicion. These must be discussed immediately with most senior doctor (ED or Medical Consultant). Then contact:

- Police Scotland immediately on 101 if not present in ED
- On-Call Child Protection Consultant via switchboard
- Procurator Fiscal – Appendix 6 page30

Investigations

- Record all investigations and interventions, including any invasive procedures, whether successful or not
- If samples taken as part of resuscitation attempt:
  - Label samples with "*Freeze and Keep*" stickers and send to lab
  - If already sent to lab, contact lab to arrange for samples to be kept
  - Samples will be kept for at least 2 months
  - PF or pathologist can request samples be kept longer if required
- **When resuscitation efforts have ceased take no further specimens**
  - Only in exceptional circumstances should additional samples be taken in ED
- **DO NOT TAKE:**
  - Cerebro-spinal fluid (CSF)
  - Cardiac blood
  - Skin biopsy
  - Liver biopsy

  after death, without discussion with paediatric pathologist.

  Taking of specimens might contaminate evidence and confuse PM findings.
- Skeletal survey will be done at post-mortem at the RIE. These are then reported at the RHSC by the paediatric radiologists

Other

- Complete **Checklist for Doctor** - Appendix 2 page 26

- Complete **Checklist for Nurse** - Appendix 3 page 27

- Assign "**Responsible Consultant**"

  There may already be a consultant who has ongoing care for the child and knows the family well. This should be the "Responsible Consultant" for follow-up. Otherwise, the following consultants should arrange to see the parents for follow-up:

  - Trauma deaths will be followed up by the ED Consultant
  - Medical deaths will be followed up by the on-call Medical Consultant as family and genetic counselling may be required

  Child protection issues will be dealt with by the Child Protection Consultant

- Report event on **DATIX**

  ALL deaths ≤15 years unexpected or expected need to be logged on DATIX whether they occur in RHSC, SJH, RIE or the community. This is not a criticism of quality of care but to ensure that NHS Lothian is aware of all deaths which are likely to be investigated internally or externally e.g. Procurator Fiscal referrals, where complaints have been or may be made, areas where concerns about the care received by the patient have already been identified. Reporting all sudden and unexpected deaths to DATIX will also allow monitoring by the Quality Improvement team, to provide some reassurance that 'patterns' are being recognised and investigated appropriately.

  See NHS Lothian Adverse Event Management Policy

Initial Parent Support

If the parents are Limited English Proficient, defined as being unable to speak, read, write or understand English at a level that permits an individual to interact effectively with health care providers or social service agencies, then an interpreter must be offered. Interpreting and Translation Service (ITS) provides face-to-face interpreting and some telephone interpreting.

24-hour access to telephone interpreting is provided by "BigWord" and can be organised by:

- Phoning 0800 757 3053
- Entering your access code SJH 88 900 003# RHSC 88 900 004#
- Enter PIN - this is your five digit internal telephone number followed by #
- Enter the language code followed by # (0 helpline)

702 Albanian	712 Dari	995 Italian	741 Nepali	1 Spanish
91 Amharic	713 Dutch	96 Japanese	98 Pashto	998 Swahili
92 Arabic	94 Farsi	3 Korean	5 Polish	729 Tamil
706 Bengali	95 French	520 Kurdish	996 Portuguese	992 Thai
752 Bosnian	545 Gaelic	730 Kurdish (Sorani)	749 Punjabi	773 Tigrinya
707 Bulgarian	4 German	733 Latvian	750 Romanian	764 Turkish
708 Burmese	993 Greek	734 Lingala	997 Russian	709 Twi
93 Cantonese	738 Gujarati	735 Lithuanian	752 Serbian	999 Urdu
752 Croatian	994 Hindi	97 Mandarin	755 Slovak	2 Vietnamese
710 Czech	724 Hungarian	533 Mirpuri	757 Somali	516 Welsh

Telephone interpreting is useful for the initial contact with the parents but a face-to-face interpreter should be organised as soon as possible.

For a face-to-face interpreter or other communication assistance for patients with visual and hearing impairments contact ITS on 0131 242 8181 (Monday-Friday 9am –5pm). Out of hours emergency contact is via the Council's Emergency Services on 0131 200 2000 then press 9 then 1.

Relatives and carers may wish to act as interpreters. They have the advantage of knowing the patient and speaking the same language. Some patients may elect to use a family member or carer as interpreter. However extreme caution needs to be exercised and it is advisable not to use family members and carers except in exceptional circumstances when no other alternatives are available. If a relative is used as an initial interpreter, then an official face-to-face interpreter should be organized as soon as possible.

Offer to listen if parents want to talk but do not give opinion. If asked, repeat explanation of resuscitation. Explain that sudden unexpected deaths in infancy and childhood can occur but there may be no cause found. Reinforce the fact that SUDiC can be due to different causes.

Explain to the parents that when a child dies unexpectedly or the death is unexplained the medical staff are required by law to contact the Procurator Fiscal (PF) who will investigate the death. The PF will instruct the Police to carry out an investigation into the death on his/her behalf. This will involve the Police visiting the place of death and speaking with the child's parents. If the death occurred at home they may take away bedding, bottles and any medicines. They will also speak to the child's GP, relatives or those present at the time of death. The parents may not be able to go back to the house that day or night until the police have finished their investigations. Make sure the parents are not alarmed by the Police enquiry, this is standard procedure. The enquiries will be as quick as possible.

The PF will usually arrange for a post-mortem (PM) examination to try to determine the exact cause of death. This will be carried out by a Paediatric Pathologist at the Royal Infirmary of Edinburgh (RIE), as soon as possible. Further analysis of tissues or organs will be required and

the cause of death may be provisional. These further investigations may take a few months to complete. The PF will update the parents during this time. At the conclusion of their enquiries, the PF will write to the next of kin with the final results of their investigations and offer them a meeting to answer any queries they may have. If the Pathologist wishes to retain any organs for further analysis they will discuss this with the PF. If the PF agrees, he/she will notify the parents of this via the police, who will bring a signed copy to the parents house and discuss how they wish these organs to be disposed of when analysis is complete.

Once the Pathologist has completed his/her initial examination, the PF will release the body to allow the parents to make arrangements for the funeral. The Pathologist will issue a Medical Certificate of the Cause of Death which the Police will bring to the parents home.

Give parents leaflets including the Rainbow Pack and When a Baby or Child dies Suddenly & Unexpectedly which provides further information regarding the SUDiC process.

Children weighing over 2.5kg can be considered for corneal and heart valve tissue donation. The main contraindication in SUDiC is untreated systemic infection. In order for tissue to be viable the body must be in the fridge within ***6hrs of confirmation of death*** or estimated time of death. If the senior doctor dealing with the death feels that tissue donation would be appropriate or if the family enquire whether tissue donation would be feasible, see Appendix 4 page 28.

Allow parents time as to see / hold child before transfer to the mortuary. This should be done under supervision by a member of staff e.g. ED Nurse, Police Officer / Bereavement Carer. All further visits will be supervised by a bereavement carer / clinical co-ordinator. Police & health staff should remain sensitive to the parents' needs.

Parents may wish hand or foot prints or lock of child's hair and this can be arranged via mortuary during PM. Staff should not take hand and foot prints as this may jeopardise further investigations that may be need to be undertaken by the pathologist. Photographs may be taken by parents if requested.

Ensure that every family is made aware of the Hospital's Spiritual & Pastoral Care Service to liaise with faith and belief groups and discuss religious or belief based affirmation of the child, baptism/last rites/religious ceremonies of other faiths and pastoral care of the parents/family. The Chaplin can offer spiritual care for any religion and also those of no religious beliefs. Ask if the family would like to see the hospital chaplain. If yes, contact the on-call generic chaplain via switchboard. Generic chaplain will be able to liaise with faith/belief based group representatives as identified by the family.

Contact the Bereavement Team via switchboard (RHSC only).

For further information regarding the bereavement process, see NHS Lothian Children's Services Bereavement Policy on Intranet.

Good Practice in Staff Support around SUDiC

- Training in clinical management of SUDiC
- Workshop training on “breaking bad news”
- Bereavement Information sessions
- Child Protection awareness training
- Scottish Cot Death Trust literature, study days etc
- Annual Service of Remembrance
- Debrief sessions / significant adverse event management
    - Departmental de-stress session within a week after each event, to be open to other professional groups including non NHS Lothian staff
    - Followed up by formal debrief as part of six monthly Morbidity and Mortality meetings of ED cases, could be open to other professionals
    - Community Nursing staff including the Health Visitor to be involved in the ‘debrief’, where there has been ongoing contact/knowledge/interventions with the child/family

    See NHS Lothian Staff Support following a Significant Adverse Event on Intranet
- Multi-disciplinary feedback and review of cases

Contents of SUDiC Pack

- Sudden Unexpected Death in Children (SUDiC) Protocol
    - History & Examination proforma – Appendix 1
    - Checklists for Doctors and Nurses – Appendix 2 & 3
- Retention Stickers for samples sent to lab
- Selection of Police Production Bags (brown bags)
- Leaflets for parents
    - Rainbow Pack
    - When a Baby or Child dies Suddenly & Unexpectedly Leaflet
    - Support for families after the sudden & unexpected death of a baby or young child leaflet
- Guidelines for the Investigation of Newborn Infants who suffer a Sudden and Unexpected Postnatal Collapse In the First Week of Life. Recommendations from a Professional Group on Sudden Unexpected Postnatal Collapse March 2011
- Bereavement Policy

Members of the Working Group

Lead Author and Chair

Dr Jen Browning	Consultant Emergency Medicine Royal Hospital for Sick Children, Edinburgh

Working Group

Dr Charlotte Kirk	Consultant Child Protection Royal Hospital for Sick Children, Edinburgh
Dr Steve Cunningham	Consultant Paediatrician / SUDI Consultant Royal Hospital for Sick Children, Edinburgh
Dr Kathryn Mckenzie	Consultant Paediatric Pathologist Royal Infirmary of Edinburgh
Dr Graham MacKenzie	Consultant Public Health Medicine NHS Lothian
Katy Currie	Emergency Department Charge Nurse Royal Hospital for Sick Children, Edinburgh
Breda Wilson	Child Protection Advisor Royal Hospital for Sick Children, Edinburgh
Allana Harper	Bereavement Carer Royal Hospital for Sick Children, Edinburgh
Jennifer Pyper	Resuscitation Officer Royal Hospital for Sick Children, Edinburgh
Marina Copping	Clinical Information Manager NHS Lothian
Viki Yuille	Principal Procurator Fiscal Depute Scottish Fatalities Investigation Unit (East)
William Guild	Detective Chief Inspector Police Scotland

Appendix 1 - SUDiC PROFORMA

To be completed by Paediatrician or ED Consultant or under their supervision
Only areas in **BOLD** are required to be completed

Deceased Infant/Child's Information	
Surname: **First name(s):** **Address:** **CHI:** **DOB:** **Ethnicity:** **Sex: Male ☐ Female ☐** **(**Attach Sticker)	 **ED/IP Consultant:** **Consultant responsible for follow-up:**
Date of death: / / **Time death pronounced (24hr clock): :** (If declared dead by SAS use this time)	**Death pronounced by:** **Job title:**

Parent(s) / Carer(s) Details	
Surname: **First name(s):** **Age / DOB:** **Address:** **Telephone:** **Relationship to child:**	**Surname:** **First name(s):** **Age / DOB:** **Address:** **Telephone:** **Relationship to child:**

Sibling(s) Details	
Surname: **First name(s):** **Age / DOB:** **Address:**	**Surname:** **First name(s):** **Age / DOB:** **Address:**
Surname: **First name(s):** **Age / DOB:** **Address:**	**Surname:** **First name(s):** **Age / DOB:** **Address:**

Primary History

(obtained from police / other professionals in attendance eg. paramedics, nurses)

Details of where child was found

Time found (24hr clock):

Address:

Who by:

Who else was present:

Observation when found:

Action taken:

Response to action:

Action taken by paramedics / nurses

Emergency Services/ 2222 call time:

Emergency Services/ 2222 arrival time:

Action during transport:

Please attach Ambulance sheet

Infant Deaths

Time last seen alive (24hr clock):

By whom:

Room infant found in:

Place of sleep:

If co-sleeping:
- adult bed or sofa
- with whom
- between parents or on outside edge

Bedding used:

Clothing used:

Position put down for last sleep:

Position found:

Dummy used:
- Yes / No
- Used on day / night of death

Presence of body fluids at nose / mouth when found

Last feed:
- Time
- Type
- Volume
- With whom

Secondary History (obtained from parent(s) / carer(s))
Events leading up to death
Previous Medical History
Last contact with healthcare:

Allergies	**Drug History / Medications**		
		Dose	**Frequency**
Immunisations			
DTaP/IPV O 2mths O 3mths O 4mths O 3-5yrs **Hib/PCV O 2mths O 3mths O 4mths O 12mths** **Men C O 3mths O 4mths O 12mths** **MMR O 13mths O 3-5yrs**			

Family History

Any previous history of SUDiC or sudden death?
If Yes specify:

Obstetric History

Maternal health during pregnancy: Prescribed medications: Maternal smoking in pregnancy: /day Maternal alcohol in pregnancy: U/week Other substance use:	Where born: Delivery type: Gestational age: Birth wt: Resuscitation at birth: Yes/No If yes give details: Other special care required after birth:

Social History

Number of adults in household & relation to child:

Number of children in household, age & relation to child:

Do any members of household smoke?

Mother – alcohol intake U/week

Father – alcohol intake U/week

Other carer – alcohol intake U/week

Illicit drug use in household?

Resuscitation

Please include all interventions or procedures carried out whether successful or not:

Examination

General subjective impression of nutrition and general care:

Rigor mortis

- **Presence**
- **Pattern**

Livedo

- **Presence**
- **Pattern**

Skin temperature (where taken?)

Vomit

Secretions from mouth

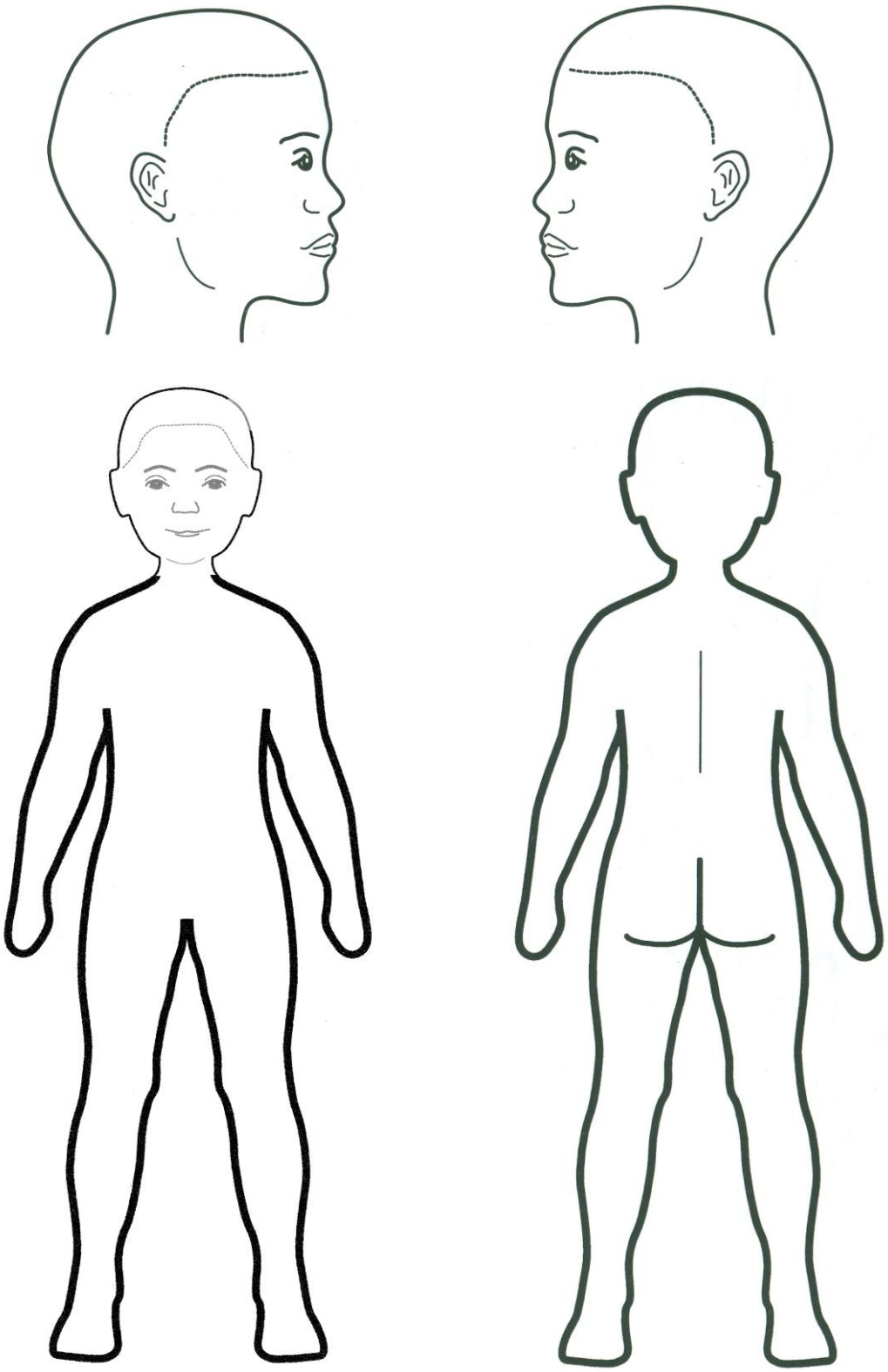
Secretions from nose

Skin

- **Colour**
- **Rash**
- **Jaundice**

Other:

Any injuries? If Yes, please describe on body diagrams



Discussion with parents:

- ☐ Need for Police involvement. Police will note statements from health staff to include any account given to them by parents /carers.
- ☐ Need for PF involvement
- ☐ Need for post-mortem examination within the next week
- ☐ Who will follow up the results of the PM with the parents

Any other observations/comments:

Appendix 2 - SUDiC Checklist for Doctors

Name	_____
DOB	_____
CHI Number	_____
Sticker	

Date ___/___/_____

- ☐ Document history, examination & parent information on proforma *(Appendix 1 page 18)*
- ☐ Document all investigations and interventions whether successful or not
  - ET tubes and cannulae can be removed but ensure position is confirmed and documented prior to removal

  Do **NOT** take further samples after death *(see page 11)*
- ☐ If samples taken as part of resuscitation attempt:
  - Label samples with *"Freeze and Keep*" stickers and send to lab
  - If already sent to lab, contact lab to arrange for samples to be kept
- ☐ Complete DATIX form for **ALL** deaths *(see page 12)*
- ☐ Check TRAK including Community TRAK to determine previous contact healthcare services
- ☐ Complete TRAK Discharge Summary
- ☐ Ensure all documentation, including checklists has been completed and filed in case notes
- ☐ Complete details of responsible consultant on sheet for notes and staple on front of case notes *(Appendix 5, page 29)*
- ☐ Ensure siblings, especially twins, are being reviewed by senior doctor as soon as possible

Ensure the following people have been contacted:

- ☐ Clinical Co-ordinator (RHSC only)
- ☐ Consultant on-call (for ED or ward)
- ☐ On-call Medical Consultant -non-trauma deaths (if child not otherwise known to a consultant)
- ☐ Police if not already present – Police Scotland 101
- ☐ Procurator Fiscal – see Appendix 6 page 30
- ☐ On-call Consultant Paediatrician for Child Protection after discussion with most senior doctor
- ☐ Consultant in Public Health if appropriate (*Appendix 7 page 31*) via switchboard

Ensure the following people are informed the next "working" day

- ☐ Pathology 27177 to inform them of the death
- ☐ Infant/Child's GP
- ☐ On-call Consultant Paediatrician for Child Protection (if not already contacted)
  - Child Protection Advisor will liaise with relevant parties *(Appendix 8 page 32)*
- ☐ Public Health Nurse/Health Visitor (named person) for children under five years
- ☐ Child's nursery or school
- ☐ Any Consultant with on-going care for the child e.g. as out-patient
- ☐ Hospital Chaplain (RHSC 20144, SJH 52188) even if declined to see chaplain previously
- ☐ Radiology Secretary RHSC 20253 that skeletal survey will be taking place

Name _____ **Signed** _____ **Date** _____

Appendix 3 - SUDiC Checklist for Nurses

Name	_____
DOB	_____
CHI Number	_____
Sticker	

Date ___/___/_____

- ☐ Interventions such as ET tubes and cannulae can be removed but ensure position is confirmed and documented prior to removal
- ☐ Try not to wash child, especially hands
- ☐ Attach identity bracelet to child's wrist and ankle
- ☐ Child's clothes and nappy should be placed in brown production bags and labeled. These should be sealed and signed by 2 people before transfer to mortuary with child (unless taken by CID)
- ☐ Complete *Bereavement Handover Sheet*
- ☐ Complete *Keepsake Booklet Request* Form
- ☐ Enter baby's details in pathology register (and police details if relevant)
- ☐ Ensure notes go to Clinical Co-ordinator (or equivalent) to be transported with the child to the RIE

Parents

See Initial Parent Support page 13

- ☐ Ensure Bereavement Carer contacted (via switchboard) RHSC only
- ☐ Ensure Parents have contact details of hospital & name of person they should ask for
- ☐ Ensure that arrangements have been made for the care of other siblings
- ☐ If Child Protection are involved ensure you are aware of the result of the IRD which will decide whether siblings may return home or should only be discharged to a place of safety
- ☐ Give parents information leaflets
  - Rainbow Pack
  - Support for Families
- ☐ Ensure that every family is made aware of the Hospital's Spiritual and Pastoral Care Service
- ☐ Ask if the family would like to see the Chaplain
  - Contact on-call generic Chaplain via switchboard
- ☐ Make sure parents have suitable transport home
- ☐ Document what parents have been told

Name _____ **Signed** _____ **Date** _____

Appendix 4 - Tissue Donation

Children weighing over 2.5kg can be considered for corneal and heart valve tissue donation. In order for tissue to be viable the body must be in the fridge **within 6 hours of confirmation of death or estimated time of death**.

Main Medical Contraindications to Tissue Donation:
- Untreated Systemic infection
- History of malignancy (refer to coordinator for corneal donation)
- History of chronic viral hepatitis or HIV infection.
- Diseases of unknown aetiology (eg multiple sclerosis, Crohns's disease)
- Active multi-system autoimmune diseases
- Active chronic infection
- Risk factors for Creutzfeldt-Jacob's disease or its variant (for example dementia)
- Patients on immunosuppressants

Main Corneal Specific Contraindications to Donation:
- Malignancies: leukaemia, lymphoma, myeloma
- Retinoblastoma
- Malignant tumours of the anterior segment
- Intrinsic Eye disease: Ocular inflammation and any congenital or acquired disorders of the eye, or previous ocular surgery that would preclude successful graft outcome

The above are the major medical conditions that need to be assessed prior to referral. There are detailed criteria for acceptance/deferral that will be discussed with relatives.

If the senior doctor dealing with the death feels that tissue donation would be appropriate or if the family enquire whether tissue donation would be feasible, please contact tissue donation on

0131 536 5751 (***24 HOUR ON-CALL FOR REFERRALS and ADVICE)***

If they agree that the child is suitable they will ask you to approach the family to discuss it with them. If the family agree the tissue donation staff will contact them directly to confirm suitability.

The PF must be informed to give permission for tissue donation. If out of hours, the on-call PF must be contacted. Corneas must be retrieved within 24 hours and heart valves within 48 hours. The tissue is retrieved prior to the PM. The corneas are retrieved by the Ophthalmologists and the eyes cosmetically reconstructed afterwards. The heart valves are retrieved by the paediatric pathologist prior to the PM. If the PF agrees then 4mls of blood is required and must go with the child to the mortuary. The appropriate tubes are kept in the tissue donation folder in the ED.

For further information on tissue donation please refer to the tissue donation site on intranet.

Appendix 5 - Sheet for front of Case Notes

Patient Sticker

Emergency Department/ Ward

Ensure SUDiC proforma completed
Ensure Doctor checklist completed
Ensure Nurse checklist completed

Clinical Co-ordinator will ensure notes are transferred with body to RIE

Pathology Department

PATHOLOGIST: _____

Return Notes to the "Responsible" Consultant

NAME : _____

DEPARTMENT : _____

HOSPITAL : _____

Police Details

Senior Investigating Officer : _____

Contact Officer : _____

Appendix 6 - Reporting a SUDiC to the Procurator Fiscal (PF)

The Procurator Fiscal should be informed of all SUDiCs whatever the circumstances. (Refer to *"Death & the PF"* booklet on intranet for guidance)

To report a death **in office hours** in Lothian use the following number:

- **Scottish Fatalities Investigation Unit 08445 614 110**

Only urgent cases should be reported to the on-call Fiscal. The on-call Fiscal is on duty to deal with emergency situations only. These include cases involving suspected criminality and this includes breaches of Health and Safety laws, eg. accidents in public buildings, and deaths as a result of RTAs. This would also include any death of a child where someone in the household is a drug user.

In SUDiCs where the next of kin have consented to tissue donation you should also contact the on-call Fiscal to check if this can go ahead. You will require the consent of the PF before any tissues can be harvested. See Appendix 4 page 28.

If there is any concerns discuss with the ED/Medical Consultant and if you are unsure err on the safe side and contact the on-call Fiscal. The same applies if you wish to canvas the possibility of donation with the PF before broaching the issue with the next of kin.

To report a death **out of hours** to the **on-call Fiscal**

- **Police Scotland 101** ask for the on-call Fiscal for Lothian & Borders

If the Responsible Consultant wishes a copy of the PM result, this can be obtained by emailing: **SFIUEast@copfs.gsi.gov.uk**

Appendix 7 – Notification to Public Health

Notification of Infectious Disease or Health Risk State

This notification relates to Part 2 (Notifiable Diseases, Notifiable Organisms and Health Risk States) of the Public Health etc. (Scotland) Act 2008. All registered medical practitioners must notify their NHS Board if they have a reasonable suspicion that a patient whom they are attending has one of the diseases set out below**.**

Practitioners should not wait until laboratory confirmation of the suspected disease before notification. Registered medical practitioners are also required to notify any case suffering from a 'health risk state' (HRS), and anyone likely to have been exposed to such a case with an HRS, or the same risk factor. A copy of the Guidance for Registered Medical Practitioners can be accessed at:
http://www.scotland.gov.uk/Topics/Health/NHS-Scotland/publicact/Implementation/Timetable3333

Suspected Diseases include:

Anthrax
Botulism
Brucellosis
Cholera
Clinical syndrome due to E.coli 0157 infection
Diphtheria
Haemolytic Uraemic Syndrome (HUS)
Haemophilus influenzae Type b (Hib)
Measles
Meningococcal disease
Mumps
Necrotizing fasciitis
Paratyphoid
Pertussis
Plague
Poliomyelitis
Rabies
Rubella
Severe Acute Respiratory Syndrome (SARS)
Smallpox
Tetanus
Tuberculosis (respiratory or non-respiratory)
Tularemia
Typhoid
Viral haemorrhagic fevers
West Nile fever
Yellow Fever

Appendix 8 – Child Protection

All SUDiCs should be notified to the Child Protection Team, so that information can be gathered on the family background to enable a decision to be made about invoking Child Protection Procedures. As part of these procedures it may be necessary to call an urgent multiagency strategy meeting.

During Working Hours

Child Protection Team on Extension 20467 or 536 0467

Out Of Hours

On-call Paediatrician for Child Protection via the hospital switchboard after discussion with the ED/Medical Consultant. Can be delayed until the next working day if there are no concerns.

Communication pathway during Normal Working Hours

The Child Protection Consultant and Child Protection Advisors for Acute Services (RHSC 07917 27715 and SJH 07881517489) will liaise and decide who will contact the following :

- Lothian Lead Paediatrician for Child Protection
- Assistant Director for Public Protection
- Executive Director, NHS Lothian for Public Protection (Child Protection consultant will contact via switchboard out of hours if media interest)
- Child Health Commissioner
- Lead Paediatrician for Child Protection for area
- Chief Nurse for area of child's residence
- Clinical Nurse Manager for Child Protection
- Child Protection Advisor for area
- Family Health Visitor or Family Nurse Practitioner for pre-school children
- Team Leader for School Nursing service for school age children