GUIDELINES FOR CLINICAL MANAGEMENT IN HOSPITAL SUDDEN UNEXPECTED DEATH IN CHILDREN (SUDiC)
1. **Purpose of this document**
   To provide guidelines for clinical, spiritual and pastoral care and follow-up when a child is brought to hospital within NHS Lothian with sudden and unexpected death, or dies unexpectedly while in hospital.

2. **Who should use this document**
   All medical and nursing staff who are likely to be 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**
   Infants and children who are brought to Emergency Department (ED) with sudden and unexpected death. It also applies to sudden and unexpected deaths in children and young people who are in-patient in hospitals.

4. **Contact point**
   Dr Jen Browning – 0131 536 0216
   Prof Jacqueline Mok – 0131 536 0467
   Dr Kathryn Mckenzie – 0131 242 7172

5. **Further reference**

6. **Review group**
   Prof Jacqueline Mok
   Dr Jen Browning
   Dr Kathryn Mckenzie
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   Christine Ball
   Paul Kelly/Dahrlene Tough

7. **Review Date**
   July 2013
**Introduction**

**Sudden Unexpected Deaths in Children**

“Sudden Deaths” are best defined as any death which occurs suddenly, is unexpected and not proceeded by any known illness or disease, which occurred anywhere, either from violence by others, suicide or accident, where the cause of death is unknown or undetermined, and where the circumstances give rise to suspicion (*Protecting Children and Young People: Significant Incident Review*, Scottish Executive 2006).

Only a small number of children die in Scotland and while the majority of such deaths are the result of natural causes, physical defects or accidents, a small proportion are avoidable, having been caused by the commission or omission of an act i.e. through neglect, violence, malicious administer of substances or by the careless use of drugs. Because of the relatively small number of child deaths in an area the size of Lothian or Scotland, the figures can vary substantially year by year. For 2009, using General Register Office for Scotland data, the figures for Scotland and Lothian were as shown (using mutually exclusive categories, and excluding still births). Based on the national figures the number of deaths in children aged 1 week to 14 years inclusive in Lothian would be expected to be between 30-35 per annum.

Although international comparisons are difficult, with differences in data collection systems and information collected, there are some countries with lower rates of mortality at some stages of childhood.

**Graph: Number of child deaths in Scotland and Lothian for 2009**

(Source: GROS website)

<table>
<thead>
<tr>
<th></th>
<th>Scotland</th>
<th>Lothian</th>
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<tbody>
<tr>
<td>Perinatal (excluding stillbirths)</td>
<td>120</td>
<td>21</td>
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<tr>
<td>1 week - 1 year</td>
<td>115</td>
<td>12</td>
</tr>
<tr>
<td>1-4 years</td>
<td>41</td>
<td>9</td>
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<td>5-9 years</td>
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<td>10-14 years</td>
<td>32</td>
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One of the implications of Article 2 of the Human Rights Act 1998 is that public authorities have a responsibility to investigate the cause of a suspicious or unlawful death. This will help to support the grieving parents and relatives of the child and it will also enable medical services to understand the cause of death and, if necessary, to formulate interventions to prevent future deaths.
In Scotland, the Procurator Fiscal has a duty to investigate all sudden, suspicious, accidental, unexpected and unexplained deaths and any deaths occurring in circumstances causing serious public concern. The Procurator Fiscal’s right and duty to investigate such deaths derives from Scottish Common Law (i.e. custom and practice which has developed over the centuries and now has the force of law) and it is reinforced by the Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976. As such, the police act as the agents of the Procurator Fiscal and have a duty to secure any information or evidence that establishes the true cause of death.

The police, therefore, have a key role in the investigation of infant and child deaths, and their prime responsibility is to the child, as well as to siblings and any future children who may be born into the family concerned.

There are occasions where the cause of death cannot be established. In infant cases pathologists may classify the death as Unascertained, pending investigations; Sudden Unexplained Death in Infancy (SUDI) or may record the cause of death as Sudden Infant Death Syndrome (by definition a death due to natural causes which have not been determine).

The 6 guiding principles that underpin the work of professionals dealing with any infant or child death investigations are:

- Sensitivity
- Open mind / balanced approach
- Appropriate response to the circumstances
- An inter-agency response
- Sharing of information
- Preservation of evidence

When a death of a child is reported to the police a Senior Investigating Officer (SIO) should always be appointed to oversee the investigation, whether or not there are any obvious suspicious circumstances.

It is important that the police and hospital / medical staff establish a collaborative approach to any such investigation. While it is appreciated that police and health professionals have specific duties to perform, they should be sensitive to the nature of the inquiry and respect each other's role. Information sharing between police and health staff is expected to ensure that a comprehensive picture of what is jointly known is established in early course and updated throughout any investigation.

More specialist tasks during such an investigation include:

1. Interviewing child witnesses
2. Obtaining other background information from specialist police databases and other agency records
3. Liaison with the relevant Local Authority Social Work services to ensure their records are checked, including the Child Protection Register (and previous registrations if possible) and to involve them in an interagency referral discussion (IRD)

On occasions where the child / family was not resident in or had recently moved to the area in which the death occurred, the SIO will ensure that enquiry is made with other police forces and partner agencies in the area the child resided or is known to have recently resided.

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1 Note: All of the above principles are of equal importance and in applying the principles individuals and agencies should ensure that all actions undertaken are legal, necessary, relevant and proportionate in order to comply with the requirements of the Human Rights Act 1998.
It is recognised that the investigation into a death of an infant / child is particularly challenging. Notwithstanding, it is essential that a full and thorough investigation takes place and that it is undertaken in a tactful, sensitive and sympathetic manner. The investigation requires a joint approach with collaboration between professionals to ensure that the fullest information is gathered and considered.
Acute Intervention in the Emergency Department (ED)

If life has been pronounced extinct prior to arrival in ED, go to page 8.

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 if in resuscitation room
- Ensure quiet room for parents to sit in during and after resuscitation with access to telephone
- Check other children are safe while parents at ED.

On Arrival at ED

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 hypothermia is likely to be cause of cardiac arrest, start to re-warm. Commence CPR with BVM or endo-tracheal (ET) ventilation and external cardiac massage (ECM). If electro-cardiogram (ECG) shows ventricular fibrillation (VF), defibrillation may be effective only when temperature >34°C.
- 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 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.
Acute Intervention in Hospital

Alert the Paediatric Emergency Team (PET) / Cardiac Arrest Team
St John’s Hospital (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
  - If no respiratory effort, give up to 5 effective rescue breaths
  - If the pulse < 60 beats per minute then commence chest compressions
  - Leave the emergency buzzer alarming until help has arrived, to ensure that the emergency team finds the location quickly.
  - If no help available, perform basic life support for one minute then phone for help yourself

- 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…
  Dial 2222 and restate the emergency as above.

- Continue basic life support until help arrives.

On arrival of the Paediatric Emergency Team/ 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.

See NHS Lothian Children’s Services Resuscitation Event Policy, 2010 (RHSC only)
**After Life Pronounced Extinct**

This should be followed in all cases where resuscitation attempts have not been initiated, are stopped or are unsuccessful.

- Senior doctor and nurse inform parents of child’s death
  - Ensure they know the name and gender

- Agree who will take further details from parents and explain
  - Procurator Fiscal (PF) notification and need for police involvement as agents of the PF
  - Need for Fiscal Post-Mortem (PM)
  - The Medical Certificate of the Cause of Death will not be issued until after PM
  - Initial cause of death may be provisional

- Give parents leaflets (Rainbow pack) and if appropriate offer parents Scottish Cot Death Trust Information leaflet.

- Ensure the Bereavement Team has been contacted (RHSC only)
  - Family Support Nurse
    - RHSC extension 20056 / bleep 9316
    - Bereavement Carer through switchboard if out-of-hours

- 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

- Inform Police if not already present

- Complete Appendix 1 (pg 17) - Checklist for Doctor

- Complete Appendix 2 (pg 18) - Checklist for Nurse

- Complete Appendix 3 (pg 19)– SUDiC Proforma

- 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.

- Report incident on DATIX. This is 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.
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 321 3053 and then entering your access code followed by#. All EDs and wards should have information on the interpreting service and access codes. 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. AWAITING ADVICE FROM PAT STRAW

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 so that the Medical Certificate of the Cause of Death can be issued.

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 Edinburgh Royal Infirmary, as soon as possible. Sometimes further analysis of tissues or organs is 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.

However, once the Pathologist ha completed his/her initial examination, the body will be released to allow the parents to make arrangements for the funeral. Once this is completed, the Pathologist will issue a Medical Certificate of the Cause of Death which the Police will bring to the parents home.
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.

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 27).

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 or Family Support Nurse.
- All further visits will be supervised by a bereavement carer / family support nurse / 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. ED nurses should not to take hand and foot prints as this may jeopardise further investigations that may need to be undertaken by the pathologist.

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. 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.

For further information regarding the bereavement process, see NHS Lothian Children’s Services Bereavement Policy, 2010.
History and Examination

This should form the basis of a report for the pathologist and should be completed by the most senior doctor involved in the resuscitation. This form should be filed in the case notes and should be available for case review. Please use the attached proforma – Appendix 3 (page 19).

Primary History

Can be obtained from parents, police, ambulance staff, GP, ED or ward staff – Please see national toolkit - http://www.sudiscotland.org.uk/index.aspx

Time found
- Symptoms preceding event
- Observation on state / position of child when found
- Action taken
  - Stimulation
  - Shaking
  - Mouth to mouth
  - ECM
  - Other
- Response to action
- Emergency Services call
- Action during transport

Secondary History – questions must be age appropriate

Obtained from parents
- Details of recent health
- Past history of illness
- Date of last contact with healthcare
- Prescribed medication(s) at death
- Birth history
  - Gestational Age
  - Birth weight
  - Any Neonatal Intensive Care
  - Did mother smoke during pregnancy
- Immunisation details and dates
- Social history
  - Who lives at home?
  - Does either parent smoke? (state details)
  - Either parent on medication? (state type e.g. antidepressants, sleeping tablets, methadone)
  - Child minding
- Family history
  - Family history of illness – parents and siblings - availability of parents’ and siblings records
  - Any history of a previous child of either parent dying suddenly or collapsing?
  - Have there been any domestic abuse incidents?
  - Ethnicity
  - Recent travel abroad
  - Pets
- Circumstances surrounding death
  - Who was in the house at the time of the death?
  - Had anyone in the house taken alcohol on the day / night of death? (state details)
  - Had anyone in the house used illegal drugs on day / night of death? (state details)
Questions specific to infant death:
- Time last seen alive
- Time of last feed (state whether breast, formula and/or solids) and how well taken
- Dummy use routinely?
- Dummy use on day/night of death?
- Sleep location at death
  - If co-sleeping, state whether adult bed or sofa, with whom, whether between parents or on outside edge.
- Position put down for last sleep and position found
- Presence of body fluids at nose/mouth when found? (state details)

EXAMINATION - Chart observations on body map

Inspection
- General subjective impression of nutrition and general care
- Rigor mortis
- Ear/Skin temperature
- Jaundice
- Skin rash
- Bruises and other injuries
- Swelling over skull
- Vomits
- Blood/blood stained secretions from mouth
- Secretions from nose – describe
- Blood from ears
- Abdominal distension
- Gentle abdominal palpation
  - Abdominal masses/organomegaly
- Injury to anus or genitalia
Investigations

- Record all investigations and interventions, including any invasive procedures, whether successful or not.

- If child is actively resuscitated take essential investigations for treatable causes as clinically indicated and follow CPR protocol.

- **When CPR is abandoned take no further specimens**
  - Many samples will be taken at PM
  - 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.*

- 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.

- Skeletal survey will be done at post-mortem at the Royal Infirmary. These are then reported at the RHSC by the paediatric radiologists
  - The doctor should alert the RHSC radiology secretary that a skeletal survey is being done to ensure that it is reported as soon as possible.
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 / critical incident 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 to be involved in the ‘debrief’, where there has been ongoing contact/knowledge/interventions with the child/family.

- Multi-disciplinary feedback and review of cases.
Contents of SUDiC Pack

- Hospital Guidelines for Management of SUDiC.
- Bereavement Policy.
- History, Examination and Investigation sheets.
- Body maps for children.
- Checklists for Doctors and Nurses.
- Retention Stickers for samples sent to lab.
- Selection of Police Production Bags (brown bags).
- Scottish Cot Death Trust Information for Bereaved Parents (if appropriate)
- When a Child Dies in Hospital Leaflet.
- Rainbow Pack (when available will replace “When your Child Dies in Hospital” Leaflet)
Members of the Working Group

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Working Group

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               Royal Hospital for Sick Children, Edinburgh

Kate Mitchell  Family Support Nurse
               Royal Hospital for Sick Children, Edinburgh

Jackie Mitchell  Staff Side Representative

Christine Ball  Senior Procurator Fiscal Depute
               Edinburgh Procurator Fiscal’s Office
               Crown Office and Procurator Fiscal Service

Paul Kelly  Clinical Governance and Quality Lead
            Scottish Ambulance Service

Dahrlene Tough  Clinical Governance and Quality Lead
                Scottish Ambulance Service

DS Lesley Boal  Detective Superintendent
                Lothian and Borders Police
Appendix 1 - SUDiC Checklist for Doctors

<table>
<thead>
<tr>
<th>Name</th>
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<td>DOB</td>
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<tr>
<td>Number</td>
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☐ Document history, examination & parent information on proforma *(Appendix 3 page 19)*
☐ 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
☐ 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
Do **NOT** take further samples after death *(see page 13)*
☐ Complete “Free from Infection” form
☐ Complete “Review of Deaths” form
☐ Complete DATIX form
☐ 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 28)*
☐ Ensure siblings, especially twins, are being reviewed by senior doctor as soon as possible

**Ensure the following people have been contacted:**
☐ Hospital Clinical Co-ordinator
☐ Consultant on-call (for ED or ward)
☐ On-call Medical Consultant -non-trauma deaths (if child not otherwise known to a consultant)
☐ Procurator Fiscal *(Appendix 6 page 29)* - Can be deferred to next working day if appropriate
☐ On-call Consultant Paediatrician for Child Protection (via switchboard) after discussion with most senior doctor
☐ Consultant in Public Health if appropriate *(Appendix 8 on page 32)* via switchboard

**Ensure the following people are informed the next “working” day**
☐ ED to phone Pathology on 27177 to inform them of the death
☐ Child’s GP - if in working hours
☐ On-call Consultant Paediatrician for Child Protection (if not already contacted)
☐ Child Protection Advisor will liaise with relevant parties *(see flowchart – Appendix 7 page 31)*
☐ Public Health Nurse/Health Visitor for children under five years old.
☐ 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
☐ Alert Radiology Secretary RHSC on 20253 that skeletal survey will be taking place

Name __________________ Signed ________________ Date __________
## Appendix 2 - SUDiC Checklist for Nurses

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<th>Name</th>
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**Interventions**

- 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 and labelled in brown production bags before transfer to mortuary with child (unless taken by CID).
- Complete *Bereavement Discharge Summary*.
- Complete *Information for Family Support Staff Form*.
- Complete *Keepsake Booklet Request Form*.
- Enter baby’s details in pathology register (and police details if relevant).
- Ensure notes go to Family Support Nurse (or equivalent) to be transported with the child to the Royal Infirmary Edinburgh.

**Parents**

- Ensure Bereavement Carer/Family Support Nurse contacted (via switchboard) RHSC only.
- See Initial Parent Support *(page 9)*.
- Ensure that arrangements have been made for the care of other siblings.
- Give parents information leaflets
  - Rainbow Pack
  - Scottish Cot Death Trust (if appropriate).
- 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.

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<td>Date</td>
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### Deceased Child’s Information

<table>
<thead>
<tr>
<th>Surname:</th>
<th>ED/IP Consultant:</th>
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<tr>
<td>First name(s):</td>
<td></td>
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<tr>
<td>Address:</td>
<td></td>
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<tr>
<td>CHI:</td>
<td></td>
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<tr>
<td>DOB:</td>
<td>Ethnicity:</td>
</tr>
<tr>
<td>Sex: Male □ Female □</td>
<td>(Attach Sticker)</td>
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<tr>
<td>Date of death: / /</td>
<td>Death pronounced by:</td>
</tr>
<tr>
<td>Time death pronounced (24hr clock): :</td>
<td>Job title:</td>
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### Parent(s) / Carer(s) Details

<table>
<thead>
<tr>
<th>Surname:</th>
<th>Surname:</th>
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<tbody>
<tr>
<td>First name(s):</td>
<td>First name(s):</td>
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<tr>
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<td>Ethnicity:</td>
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<td>Address:</td>
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<td>Telephone:</td>
<td>Telephone:</td>
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<tr>
<td>Relationship to child:</td>
<td>Relationship to child:</td>
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### Primary History

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

#### Details of where child was found

<table>
<thead>
<tr>
<th>Time found (24hr clock):</th>
<th>Observation when found:</th>
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<tbody>
<tr>
<td>Address:</td>
<td></td>
</tr>
<tr>
<td>Who by:</td>
<td></td>
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<tr>
<td>Who else was present:</td>
<td>Action taken:</td>
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Response to action:
### Action taken by paramedics / nurses

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<tr>
<th>Action taken by paramedics / nurses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency Services/ 2222 call time:</td>
</tr>
<tr>
<td>Emergency Services/ 2222 arrival time:</td>
</tr>
<tr>
<td>Action during transport:</td>
</tr>
</tbody>
</table>

Please attach Ambulance sheet

### Secondary History

(secondary history obtained from parent(s) / carer(s))

<table>
<thead>
<tr>
<th>Events leading up to death</th>
</tr>
</thead>
</table>
### Infant Deaths

<table>
<thead>
<tr>
<th>Time last seen alive (24hr clock):</th>
<th>Dummy used:</th>
</tr>
</thead>
<tbody>
<tr>
<td>By whom:</td>
<td>- Yes / No</td>
</tr>
<tr>
<td>Room infant found in:</td>
<td>- Used on day / night of death</td>
</tr>
<tr>
<td>Place of sleep:</td>
<td>Presence of body fluids at nose / mouth when found</td>
</tr>
<tr>
<td>If co-sleeping:</td>
<td>Last feed:</td>
</tr>
<tr>
<td>- adult bed or sofa</td>
<td>- Time</td>
</tr>
<tr>
<td>- with whom</td>
<td>- Type</td>
</tr>
<tr>
<td>- between parents or on outside edge</td>
<td>- Volume</td>
</tr>
<tr>
<td>Bedding used:</td>
<td>- With whom</td>
</tr>
<tr>
<td>Clothing used:</td>
<td>Usual feeding pattern:</td>
</tr>
<tr>
<td>Position put down for last sleep:</td>
<td></td>
</tr>
<tr>
<td>Position found:</td>
<td></td>
</tr>
</tbody>
</table>

### Obstetric History

<table>
<thead>
<tr>
<th>Maternal health during pregnancy:</th>
<th>Where born:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prescribed medications:</td>
<td>Delivery type:</td>
</tr>
<tr>
<td>Maternal smoking in pregnancy:</td>
<td>Gestational age:</td>
</tr>
<tr>
<td>Maternal alcohol in pregnancy:</td>
<td>Birth wt:</td>
</tr>
<tr>
<td>Other substance use:</td>
<td>Resuscitation at birth: Yes/No</td>
</tr>
<tr>
<td></td>
<td>If yes give details:</td>
</tr>
<tr>
<td>Other special care required after birth:</td>
<td></td>
</tr>
</tbody>
</table>
### Previous Medical History

Last contact with healthcare:

<table>
<thead>
<tr>
<th>Allergies</th>
<th>Drug History / Medications</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Dose</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Immunisations</th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>DTaP/IPV</td>
<td>2mths O</td>
<td>3mths O</td>
<td>4mths O</td>
<td>3-5yrs O</td>
</tr>
<tr>
<td>Hib/PCV</td>
<td>2mths O</td>
<td>3mths O</td>
<td>4mths O</td>
<td>12mths O</td>
</tr>
<tr>
<td>Men C</td>
<td>3mths O</td>
<td>4mths O</td>
<td>12mths O</td>
<td></td>
</tr>
<tr>
<td>MMR</td>
<td>13mths O</td>
<td>3-5yrs O</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Family History

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

### 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? (give details)

Any mental health problems in household? (give details)

Mother – alcohol intake U/week

Father – alcohol intake U/week

Other carer – alcohol intake U/week

Illicit drug use in household?
<table>
<thead>
<tr>
<th>Resuscitation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Please include all interventions or procedures carried out whether successful or not:</td>
</tr>
</tbody>
</table>
### Examination

General subjective impression of nutrition and general care:

Rigor mortis
- Presence
- Pattern

Livedo
- Presence
- Pattern

Skin temperature (where taken?)

Vomits

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 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, Crohn’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 folder in the ED.
Appendix 5 - Sheet for front of Case Notes

**Emergency Department/ Ward**

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

Family Support Nurse will ensure notes are transferred with body to RIE

**Pathology Department**

PATHOLOGIST: ________________________________

**Return Notes to the “Responsible” Consultant**

NAME: _________________________________

DEPARTMENT: _________________________________

HOSPITAL: _________________________________
Appendix 6 - Reporting a SUDiC to the Procurator Fiscal

Step 1: Does the death need to be reported to the PF?

Refer to Death & the PF booklet for guidance (copy in folder or on-line

This lists the reporting categories. If there is any doubt as to whether the case should be reported, either in or out of office hours, err on the safe side and report it. Telephone numbers are included overleaf.

The PF should be informed of all SUDiCs whatever the circumstances.

However, it may be that as the examining medical staff you are the first to notice the injuries or other circumstances giving rise to suspicion. If this is the case contact the police immediately and then the PF. If this occurs out-with office hours contact the on-call PF Depute by calling Bilston Force Communications on 0131 311 3131 and asking for the on-call or duty Fiscal. In such cases you should also contact the Child Protection Team if the police have not already done so.

Step 2: In the evenings or at weekends, if the death is reportable, should it be reported to the on-call Fiscal or can it wait until the next working day?

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 reportable cases where the next of kin have consented to organ 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 organs can be harvested and in such cases the Pathologist instructed by the PF may attend and assist with the harvesting of the organs. The fact that organ donation may take place does not however, as a ground alone, make the death reportable, if everything else is unremarkable and the death can be certified.

The following non-urgent deaths should be reported to the appropriate PF’s office on the next working day:

- Deaths which fall into the mandatory, but non-urgent, reporting categories, eg death due to certain illnesses or children in foster care
- Non-urgent deaths which cannot be certified as the cause of death is not clear
- Non-urgent deaths which you may be able to certify but would like to discuss the issue of certification before doing so

Of course if there is any suggestion of suspicion, follow the instructions above and again 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.
Step 3: Which PF Office should the death be reported to?

Generally, deaths should be reported to the office in the area in which the person dies. However, there are two exceptions to this:

- Where a person dies as a result of an accident or deliberate act by another, the death must be reported to the PF in the area where the accident or act occurred. A good example of this is a RTA in the Borders and the patient is taken to RHSC and dies there. The death should be reported to the Borders Fiscal as that Fiscal will investigate the death and the events leading up to it.
- Where a person is admitted to hospital and dies a matter of hours after admission. If they live out-with the hospital area, eg. Haddington but die in the RHSC, the death should be reported to the Haddington Fiscal.

If you are in doubt, report the death to the office you think most appropriate and the PF can pass the report on to the correct office.

Step 4: Information for the Next of Kin in PF cases:

In non-suspicious cases that are to be reported to the PF, the next of kin can be told that the case is being reported due to its sudden nature and that the police may make enquiries on behalf of the PF. Thereafter the PF will write to the next of kin if there is to be a PM. At the conclusion of their enquiries, which may take some time, the PF will again 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.

When appropriate explain that the death being unexpected, must be reported to the Procurator Fiscal, and that the police will act on behalf of the Procurator Fiscal in gathering information. Any specific queries should be addressed to the police officers involved.

The PF will keep in touch with the family regarding the investigation. If the responsible Consultant wishes a copy of the PM result, this can be obtained by emailing: lbdeaths@copfs.gsi.gov.uk

Telephone Numbers

To report a death in office hours in Lothian and Borders use the following numbers:
Edinburgh Procurator Fiscal’s Office Deaths Unit 08445614110
Haddington Procurator Fiscal’s Office 08445613324
Linlithgow Procurator Fiscal’s Office 08445614240
Selkirk Procurator Fiscal’s Office 08445614301
Jedburgh Procurator Fiscal’s Office 08445614295

To report a death out of hours to the on-call Fiscal call 0131 311 3131 and ask for the appropriate on-call Fiscal for the area you are reporting to.
Appendix 7 – Child Protection Services Communication Pathway

All sudden and unexpected deaths in children should be notified to the Child Protection Paediatric team, so that information can be gathered on the family background to enable a decision to be made about invoking Child Protection procedures.

1. During Working Hours

Contact the following:

- Child in RHSC – call Child Protection Paediatric Team (20467 or 536 0467) and Child Protection Advisor for LUHD (07917 277 415)
- Child in St John’s – call Child Protection Paediatric Team (01506 524412) and Child Protection Advisor for West Lothian (07734 397 350)

The Child Protection Advisor will liaise with the Child Protection Paediatrician and a decision made as to who will contact the following:

- Lead Paediatrician for the area
- Child Protection Advisor for the area
- Clinical Director, Children’s services
- The Executive Director, NHS Lothian, with responsibility for Child Protection
- Nurse Consultant for Vulnerable Children (07867 905 885)
- Designated Doctor for Vulnerable Children
- The Child Health Commissioner
- Chief Nurse for area of child’s residence
- Family Health Visitor for pre-school children
- Team Leader for School Nursing Service for school age children

2. Out of Hours

Contact the on–call Consultant Paediatrician for Child Protection via switchboard after discussion with the most senior doctor. If it is decided that NHS Lothian should be informed of the circumstances, the Consultant Paediatrician for Child Protection should contact the Executive Director. Phone hospital switchboard (0131 536 1000) and ask for the on call Executive Director.
Appendix 8 – 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

Clinical Data
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