POLICY UNDER REVIEW
Please note that this policy is under review. It does, however, remain current Trust policy subject to any recent legislative changes, national policy instruction (NHS or Department of Health), or Trust Board decision. For guidance, please contact the Author/Owner.

Death In Children up to 18 years of age - Emergency Department Policy

V2.1 (interim)

May 2017
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1. **Introduction**

1.1. Working Together to Safeguard Children 2010 lays out statutory guidance on how organisations should work together to safeguard and promote the welfare of children. Within this guidance is a requirement for Local Safeguarding Children Boards to undertake reviews into all deaths of children under 18 years of age who are normally resident in their area. In order to make this process as effective and informative as possible the four SW Peninsula LSCBs (Cornwall and Isles of Scilly, Devon, Plymouth and Torbay) have agreed to a joint process, sharing resources and information to improve the quality of outcomes. As a Joint Child Death Overview Protocol it is to be adhered to by all agencies.

1.2. The death of a child is a traumatic time for everyone involved. The family will be experiencing extreme grief, and where the death is unexpected, the family will also be in a state of shock. Professionals will need to support the family in understanding what has happened and why.

1.3. An unexpected death, for the purposes of this process, is defined as a death that was not anticipated as a significant possibility, for example 24 hours before the death, or where there was a similarly unexpected collapse or incident leading to or precipitating the events that led to the death.

1.4. The majority of unexpected child deaths occur as a result of natural causes or accident and are a tragedy for each family. A minority of unexpected deaths are the result of abuse or neglect or have such abuse or neglect as a contributing factor. In all cases enquiries should seek to understand the reasons for the child’s death, address the possible needs of other children in the household and other family members, and consider any lessons that can be learnt to safeguard other children in the future.

1.5. Child Death Overviews will seek to identify patterns and trends in child deaths that may be used to safeguard children in the future.

1.6. The Peninsula Child Death Overview process will be supported by a multidisciplinary Rapid Response Team (RRT) for unexpected deaths collating the minimum data set, and information from other agencies involved with the child, and feeding this information into the joint Child Death Overview Panel (CDOP) for reviews to be undertaken.

1.7. Linked to this Joint Protocol is a set of working practices for each agency to ensure the information regarding child deaths is properly recorded and collated to inform the review process.

1.8. This version supersedes any previous versions of this document.

2. **Purpose of this Policy**

2.1. From April 2008 there is a statutory responsibility for Local Safeguarding Children’s Board (LSCB’s) to review all child deaths (Chapter 7, Working to Together to Safeguard Children 2006 and 2010).
2.2. There are two processes;
- Process 1. A rapid multi-agency response to investigate the unexpected death of a child (less than 18 years).
- Process 2. An overview of all child deaths by a Local Child Death Overview Panel (CDOP).

2.3. Key messages will be disseminated by the CDOP and it is anticipated that information will be fed into a national dataset.

2.4. South West Peninsula Arrangements:
- The LSCBs for Devon, Plymouth, Torbay and Cornwall & Isles of Scilly have agreed common practices and procedures to be followed in the event of the death of a child.
- A South West Peninsula Rapid Response Team (RRT) will be made up of three specialist practitioners (total 1.5wte) who will help in the co-ordinated response to an unexpected death of a child in the South West Peninsula.
- There is a shared CDOP for the four LSCBs within the Peninsula. This Panel will sit in Plymouth on a monthly basis and is chaired by an independent chair.
- The CDOP has a fixed core membership and other co-opted members.
- To provide guidance for Emergency Department (ED) and paediatric medical and nursing staff and the RRT on the initial and early response when infant or child dies unexpectedly.
- To promote high quality, consistent care with emphasis given to the needs and welfare of the family.

2.5. Most unexpected deaths occur during infancy (SUDI) and within this group 60-70% may be unexplained (Sudden infant Death Syndrome - SIDS).

2.6. Most unexpected deaths in older children result from accidents, and particularly from road traffic accidents. Deaths occurring as a result of suicide in teenagers are increasing.

2.7. Very few deaths result from non-accidental injury (approx. 6% of SUDI) or have non-accidental harm as a contributory factor (approx. 8% of SUDI).

2.8. The investigation into a sudden unexpected death requires close multi-agency communication, cooperation and collaboration to help determine the cause of death or/and the contributing factors and to address the needs of the family.

2.9. It is important to look closely for a specific medical cause and to recognise when abuse or neglect may have occurred. It is also of utmost importance not to wrongly accuse families when they are bereaved following a natural tragedy and all families must be treated with care and respect.

2.10. Following ‘accidental’ death, consideration should be given as to whether this was due to neglect, if there were contributing factors and whether there are lessons to be learnt to help prevent further accidental deaths.

2.11. The principles of management included in this guideline apply to all unexpected deaths in infancy and childhood. The investigations stated are those that have been
agreed with the Coroners from the SW Peninsula for the investigation of sudden unexpected death in infants and children < 2 years. The history and circumstances of a death of an older child will provide pointers to the necessary investigations and these should be carried out under the direction of the coroner.

2.12. If there is an indication at any stage that abuse or neglect may have caused or contributed to the child’s death, the concern should be discussed with the investigating police officer and agreement reached as to how the investigation should proceed.

2.13. In a small minority of cases, where there is strong evidence that the death was due to unnatural causes, the Police and Criminal Evidence Act 1984 demands that the suspect’s rights are protected and certain legal restrictions apply in terms of how they are spoken to and by whom. The Police will take on the role of the lead agency and will initiate a criminal investigation.

2.14. More often, whilst concerns may arise about abuse or neglect, it is less clear how significant this is in relation to the cause of the child’s death. Immediate instigation of criminal proceedings will be exceedingly distressing to parents and may also interfere with the collection of important medical information and may make it harder to establish the cause of death. The Police may agree to the normal investigation process and may appoint a family liaison officer to maintain close and continued contact with the family while the investigation is proceeding.

2.15. The police will usually adopt the role of lead agency when children die in certain specific circumstances including deaths due to fires, drowning, poisoning and suspected suicide.

2.16. Children dying at the scene of a road traffic accident may not usually be brought to the emergency department and the medical information will be obtained from the hospital and primary care records and from the post mortem examination.

2.17. In all unexpected deaths, Children’s Social Care should be informed. Where abuse or neglect is suspected, the initial multi-agency discussion should take the form of a strategy discussion which should include consideration of the other children in the family and further action should be taken following guidance laid out in ‘Working Together to Safeguard Children 2010.’ A Child Protection strategy meeting should be arranged in all cases where abuse or neglect may have contributed to the death and in possible suicide.

3. **Scope**

3.1. This Policy applies to all medical professionals managing cases of children who have died suddenly up the age of 18 years. They will instigate the initial investigation and management in the ED when an infant or child is brought to the ED having died unexpectedly or been found moribund and died following admission to the ED. This includes children dying in specific circumstances including death from fires, drowning, poisoning, and suspected suicides.
4. **Definitions / Glossary**

- **ALTE**: Apparent Life Threatening Event
- **CDOP**: Child Death Overview Panel
- **CDR**: Child Death Review
- **CT**: Care Trust
- **CSC**: Children’s Social Care
- **DCSF**: Department for Children, Schools and Families
- **DESIGNATED DOCTOR**: Peninsula wide role to advise and support CDOP
- **ED**: Emergency Department (formerly known as A&E)
- **GP**: General Practitioner (family doctor)
- **HDU**: High Dependency Unit
- **HV**: Health Visitor
- **ITU**: Intensive Treatment Unit
- **LSCB**: Local Safeguarding Children Board
- **NICU**: Neonatal Intensive Care Unit
- **OOH**: Out of Hours Services (Serco, Cornwall)
- **PNC**: Police National Computer
- **RRT**: Rapid Response Team
- **RC Path**: Royal College of Pathologists
- **RCPCH**: Royal College of Paediatrics and Child Health
- **SCBU**: Special Care Baby Unit
- **SCR**: Serious Case Review
- **SID**: Sudden Infant Death
- **SUDI**: Sudden Unexplained Death (in) Infants

**Definition of Unexpected Death of a Child**

The death of a child that was not anticipated as a significant possibility, for example 24 hours before the death, or where there was a similarly unexpected collapse leading to or precipitating the events that lead to death.

5. **Ownership and Responsibilities**

5.1. **Role of the Named Doctor for the Child Death Review**

5.2. The Named Doctor for the Child Death Review will ensure that training is provided for all relevant health professionals. This will include induction training for new paediatric trainee doctors. The named doctor will provide advice on a case by case basis for any unexpected child death.
5.3. Role of the Managers

5.4. Line managers are responsible for ensuring that all medical staff are aware of and have received training in the Child Death Review Process including the Rapid Response for unexpected child deaths.

5.5. Role of Consultant Paediatrician for Under 16 year olds and Senior ED Doctor in children aged 16-17 year olds.

- Explain need for investigation into the cause of death and the role of the Coroner and the Police (investigate death on behalf of Coroner). Also the requirement to inform Social Care.
- Explain own role in the medical investigation;
- Finding out about the previous health of child and obtaining information regarding the circumstances around the time of the child’s death
- Examining the child’s body; and taking specimens, as required.
- Arranging skeletal survey which is performed in the mortuary as required.
- Explain that the Coroner will require a post mortem and provide information as to where and when this will be carried out as soon as possible.
- Explain procedure gently and need for pathologist to retain organs and small sections of tissue for analysis. The Coroner will provide the option of returning the organs to the family after analysis. Organs/tissue sections will not be kept for research purposes unless the family consent to this.
- Discuss the need to take a skin biopsy (in the case of SUDI) and provide the patient information leaflet (Appendix 9) before obtaining written consent (Appendix 10).
- Inform the Coroner and discuss the case and management plan.
- Inform the Rapid Response Practitioners, Social Care and the Community Paediatrician on call.
- Initiate multi-agency Strategy discussion (usually between health, police and social care). Document all discussions and action points. Obtain contact names.
- Complete notification form and send to local trust co-ordinator (Appendix 8).
- Explain that a professionals meeting (Local Case Discussion Meeting) will be held after 2-3 months when all the investigation results are available to look at the likely cause of death and the outcome of this meeting will immediately be conveyed to the family in person.
- Explain that a police officer, +/- rapid response team member, +/-paediatrician, will visit the home/scene of death to seek additional information from the parents and to look at where the child died.
- Parents should be asked politely not to tidy their homes until after this visit and it may be preferable for them to stay with friends or relation until after the home visit.

5.6. Role of Family Support Nurse

- An experienced nurse should be allocated to support the family as soon as the child is brought into ED and should;
- Provide a quiet, private room for the family
- Remain with the family as required and at all times when the parents are with their child unless otherwise agreed with Police
- Obtain background information – (Appendix 5)
- Provide explanations of the investigative process as appropriate (or defer to others)
- Closely liaise with Lead Nurse and Lead Senior Doctor
- Contact relatives / religious leaders as requested by family
- Provide bereavement support leaflet with phone numbers appended, The Lullaby Trust's leaflets 'The Child Death Review. A guide for parents and carers' is available in ED.
- After contacting the Bereavement Office for a time to bring the baby to the mortuary then the Family Support Nurse will accompany the baby the mortuary.
- During out of hours contact the head porter for access to the mortuary.
- Ensure parents have adequate support when they leave and transport home

5.7. Role of Lead Nurse / Liaison Health Visitor.

A Senior Nurse should be appointed to:

- Check whether child has a child protection plan.
- Inform the Police Child Abuse Investigation Team (Community Support Unit) – this may have already been done before the infant arrives in hospital.
- Remove all clothes and place in labelled brown-paper bag. This will need to be sent to the mortuary with the infant’s body.
- Place child in shawl / blanket.
- Help Lead Senior Doctor during examination of child’s body, collection and labelling of specimens.
- Inform laboratory staff that specimens will be forwarded to the laboratory.
- Take photographs, handprints and lock of hair as requested by the family.
- Ensure documentation is completed (Appendix 4 and 5.) and copy of notes made.
- As soon as possible in working hours, inform:
  - Health Visitor and Paediatric Liaison Health Visitor.
  - Midwife (if appropriate).
  - General Practitioner.
  - Child Health Information Department.
6. Standards and Practice

**EMERGENCY DEPARTMENT FLOW CHART**

**CHILD (<18 YRS) FOUND LIFELESS OUT OF HOSPITAL**

**EXPECTED DEATH**
- Certified dead at scene

**UNEXPECTED DEATH**
- Resuscitation ongoing by paramedics
- Certified dead at scene

**AMBULANCE ARRIVES IN ED**
- **Allocated Nurse**
  - Greet parents at door.
  - Provide quiet room.
  - Give option to be present at resuscitation.
  - Offer Chaplain.
  - Refer to child by name and correct gender.

**ED Resuscitation Area**
- Resuscitation (if appropriate) according to current APLS guidelines.
- Time recorded
- **Resuscitation unsuccessful** (Medical Consultant leads)
  - Declares death and notifies parents if not present.
  - Notify the coroner +/- Police if not already informed.*
  - Consultant to remove ETT and IV access noting site on body map. ETT position must be checked by second person before removal. If any concerns discuss with coroner before removal.
  - Complete documentation, check list and Child Death Notification forms**
  - Contact Consultant Community Paediatrician when available *

**Multi-agency strategy meeting/discussion**

**Staff Debrief**

**MORTUARY**
- ED informed.
- ED notifies;
  - on call/service paediatrician.
  - liaison Health Visitor.
  - child health records.
- Notification form completed.

**If Unexpected Death**
- Take full history, examination and investigations in liaison with coroner.
- Remove clothes, place in labelled brown paper bag.
- Cover/wrap in blanket.
- Organise skeletal survey if required.
- Contact Duty Social Worker to discuss any involvement including siblings (eg Child Protection Plan)*
- Contact Rapid Response Team (RRT)*
- Contact SWAST lead Chris Rogers*
- Contact CAMHS for any involvement with the child+/or family
- Explain PM, the role of the coroner, tissue retention and further investigations including skin biopsy and possible visit to home/death scene.
- Obtain written consent from parents for skin biopsy. (See Appendices 9, 10 and 11)
- Complete DATIX form

**If Expected Death**
- Transfer to mortuary with agreement of coroner

If the death is suspicious or suspected suicide:
Do NOT take any investigations, before discussion with police and coroner. They MUST lead the process. Examination of child is still important. Any samples may need to go in their 'evidence bags' and signed (brought by the police)

*For Contact numbers see Appendix 12
**For Child Notification Form see Appendix 8
6.1. **Transfer to Local Hospital Emergency Department (ED)**

- Infants and children who die suddenly and unexpectedly in the community should be brought to the ED and not to the mortuary except for those who die at the scene of a RTC and when medical assessment and investigations are not likely to be possible, for example, if the body is decomposed. Exceptionally, at a potential crime scene, the police may decide not to move the body.

6.2. **Resuscitation**

- Resuscitation should be initiated or continued according to the National UK 2010 Guidelines unless it is apparent that the child has been dead for some time.

- A preliminary history including details of medical conditions and recent history of illness should be obtained.

- A number of investigations may be performed during resuscitation incl. glucose, blood gas, blood cultures, FBC, U&E, LFTs, ammonia.

- Resuscitation should be continued until an experienced doctor (ICU, ED or Paediatric Consultant) has made the decision that it is appropriate to stop.

- Parents may wish to be present during the resuscitation and if a decision has been taken to discontinue resuscitation the reasons for this should be explained to them.

- If the child dies despite resuscitation and the lead consultant is happy that the resuscitation ran in accordance with APLS guidelines, the consultant may remove the IV / IO / IA lines after the site of these lines and site of any unsuccessful attempt to gain vascular access should be recorded on a body map. If an endotracheal tube has been inserted this should be also removed after the position is confirmed (preferably by someone other than person inserting it). **The coroner should be contacted if there are any concerns regarding this and the lines and tubes left in situ.**

- Full details of the resuscitation including those present should be recorded.
6.3. History

6.4. With the agreement of the family the medical and social history can be taken with a Child Abuse Investigation Officer being present. This avoids unnecessary duplication and distress for the family.

6.5. The following outlines the history to be taken following unexpected death in infancy. This can also be used as guidance for deaths occurring in older children but the circumstances will inform the detailed history that is required.

- Record parents / carers account verbatim.
- Obtain name, address, date of birth, phone numbers of parents and other carers, including relationship to the child. (Appendix 3).
- Obtain family medical history, including name, DOB, place of birth of previous children and detailed information of any deaths in infancy or childhood of siblings / other close relatives.
- Social. Include family’s structure, alcohol, tobacco or drug use and information about any prescription or non-prescription medication in household. Note recent changes in composition of household.
- Medical and obstetric history of mother

6.6. Infant/child

- Obtain birth, medical and developmental history. Include immunisations, feeding, contact with infection and medications. Obtain copy of the Child Health Record, if available. Plot weight record onto centile chart.
- History of any trauma and ED/hospital admission or attendance.
- Detailed account of child’s feeding, sleeping, activity and health over the 2-week period prior to the death.
- Detailed (hour by hour) narrative account of events within the 48 hours prior to the infant/child being found dead

6.7. The final sleep (Infant)

- A very careful description of when and where the infant placed to sleep, including nature and arrangement of bedding, sleeping position, bed or sofa sharing.
- When he or she was heard or last seen
- When feeds were given
- Who else was in the room
- Who found the baby
- What was the appearance and position of the baby and where was the bedding.
- Type of heating
- Action after baby was found
- Specific questions to assess the baby’s health within the previous 48 hours, including contact with health care professionals

Much of the medical and social history will be obtained at the initial discussion but this is likely to be supplemented by information collected at the time of the initial home visit.
6.8. Rapid Response Team (RRT)– Interface with Hospital Staff

6.9. Background:

- The unexpected death of a baby or child is a highly traumatic and disruptive event.
- Professionals will want to respond swiftly to the event, both in terms of support to the family and in investigating what caused the death.
- The Rapid Response specialist practitioner is intended to support the acute trust paediatrician. The acute trust paediatrician continues to have a duty of care to the family of the deceased child.
- The Rapid Response is commissioned during office hours, Monday - Friday. This means that local paediatricians, on occasion, may have to complete the rapid response process out of hours.

6.10. Operating Guidance:

- When a child dies in the community, their body will (in most cases) be brought by ambulance to the Emergency Department.
- The receiving paediatrician in the Emergency Department will inform the Peninsula CDOP Office of the death (tel 01752 434161). The Rapid Response Team check this answerphone from 7 am, Monday-Friday. The Rapid Response Practitioner will make contact with the Emergency Department as soon as possible.
- The Lead Paediatrician (or ED Consultant in the case of a child aged 16-18 yrs) involved with the child or RRT lead practitioner will hold a telephone multi-agency discussion involving Health, Police, and Social Care to share information and determine whether a home visit is required. Accurate records should be kept of the discussions. Further phone discussion may be required, as further information comes to light.
- The parents/carers will be kept informed from the outset of the nature of the information gathering and the multi-disciplinary approach including the Coroner, with its objective of trying to understand and explain why their child/ren died.
- The RRT Specialist Practitioner/Police will take the lead in making arrangements to visit the home scene and investigating the relevant circumstances.
- This work will be done in collaboration with the lead paediatrician/ED Consultant/Named Doctor.
- In possible criminal circumstances, the police crime team will take the lead, eg: traffic collision, suicide, homicide, abuse.

6.11. Discussion Following Preliminary Post Mortem Findings:

- The Coroner’s Officer receives the preliminary post-mortem report from the pathologist.
If the Coroner approves, this discussion should be led by the lead paediatrician involved with the child or by the RRT Lead Specialist Practitioner, if appropriate. It will normally take place by telephone and will be a multi disciplinary discussion involving (as appropriate) the pathologist, police, Social Care and sometimes other relevant healthcare professionals, to review any further information that has come to light and that may raise additional concerns about safeguarding issues.

- A record should be made of this discussion.
- With the approval of the Coroner, arrangements should be made as soon as possible to inform the family of the preliminary results.


In The Event Of A Sudden Unexpected Death Telephone 01752 434161 (Peninsula Child Death Overview Office, Plymouth)

This is an Answerphone - please leave a message:

6.13. Details To Include:
- Referring Paediatrician’s detail
- Acute Trust name and Telephone number (ability to contact referrer or nominee essential)
- Brief summary of case, name and DOB
- Attending Police Officer’s name and contact number

6.14. Rapid Response criteria (for guidance only)
- All children under two years old
- Asthmatic cases
- Epilepsy cases
- Diabetic cases

Trust Named Doctor for Child Death Review:
Dr Roger Jenkins

Designated Doctor for Child death Review
Dr Beth Enderby (Consultant Paediatrician based in Exeter)

Rapid Response Team:
Peninsula Service Manager / Lead for Rapid Response:
Carol Evason-Coombe 07789 270844 c.evason-coombe@nhs.net

Specialist Practitioner:
Nicky Hughes 07785 332652 nickyhughes1@nhs.net
6.15. Multi-Agency Discussion - Police, Paediatrician, Social Care, +/- RRT member, +/- CAMHS.

The multi-agency sharing of information, from the onset, is vital to a complete and correct approach. This should take place as soon as possible, usually in the ED with police present and other professionals on the phone.

6.16. Information Gathering

- Details of incident history, presentation and examination.
- Comprehensive family history.
- Birth history and previous health of the child, including any involvement with CAMHS.
- Details and health status of any siblings.
- Parental health (physical and mental).
- Previous child protection issues.
- Previous unexplained or unusual deaths in the family.
- Issues of neglect or failure to thrive.
- Previous and/or unusual presentations of the child and/or siblings to medical staff.
- Ambulance, NHS direct.
- Incidents of domestic violence.
- Parental drug or alcohol misuse.
- Any criminal records of the parents.
- Collation and cross-referencing of multi-agency information in a chronological outline.

6.17. Caring for the family

- Express sympathy and refer to child respectfully by name and correct gender.
- Assist in contacting other members of family/employer or provide phone.
- Arrange interpreter if needed.
- Offer hospital chaplain. Very experienced and will sit with the family if they wish.
- Can be present at resuscitation. Family may also wish baby/child blessed before they ‘say goodbye’.
- Hospital chaplain will also support their community clergy and can jointly officiate in funeral service.
- Parents may cuddle baby/child with a member of staff or police in attendance to observe.
- If not a suspicious death, ask police if parents may be left in private with baby/child.
- Allow as much time as the family needs.
- Family may leave toy or religious jewellery to accompany child.
- No baby items should be returned to the parents without consultation with the police officer or Coroner.
- Ensure the family knows where their child will be and give Coroner’s Officer contact telephone number for procedural queries and for making arrangements to see their child in the Chapel of Rest.
- Suppression of lactation prescription if indicated.
Provide bereavement support leaflet with contact numbers appended. The Lullaby Trust's leaflet 'The Child Death Review. A guide for parents and carers.' is available in ED.

### 6.18. Mementoes

- Photographs: A photograph should be taken unless family specifically state they do not wish one to be taken. A digital camera or Polaroid camera will be available in ED or to borrow from the Neonatal Unit.
- The photograph(s), lock of hair, and hand and foot prints can be kept on file in a dedicated place in the ED if not immediately required. Parents may change their minds at a later date. There are memory boxes for staff to give out to parents.
- The family may wish to bring in their own mementoes and this can be arranged with the Mortuary or with the funeral director after the post mortem.
- All mementoes should be documented in the medical records (include location where kept if not immediately given to parents).

### 6.19. Saying goodbye

- Parent may wish to say goodbye to their child in the ED or in the chapel of rest before the child is taken to the mortuary. This is a poignant moment and should be conducted with optimal dignity and support.
- Siblings may also wish to say goodbye to their brother or sister and should be given an opportunity to do so.
- The support nurse should accompany the family to the police car which will take the family home or to relatives.
6.20. **INVESTIGATIONS FOLLOWING SUDDEN UNEXPECTED CHILD DEATH >2 YEARS including 16-18 year olds.**

Investigations should be carried out after discussion with the coroner when children are 2 years and over.

The initial history may give pointers to the investigations required

Consider:

- Undertaking investigations as for SUDI when there are no pointers as to possible cause of death (more likely in the younger children)
- Performing full infection screen where possible history of sepsis (including viral screen)
- Performing metabolic screen including acyl carnitine profile where history of developmental delay, history of life threatening events or hypoglycaemic episodes
- Anti-convulsant levels if history of epilepsy (discuss with biochemistry lab as to most appropriate test and which blood bottles)
- Skeletal survey if any injuries found
- **Need for screening for ‘Drugs of abuse’ in the older children on urine**
  These are routinely:
  - Opiates, Amphetamines, Benzodiazepines, Cocaine, and Methadone
  - Paracetamol and Salicylate levels will need a blood sample (clear tube)
  - Alcohol or anti-freeze levels will need a blood sample in a grey-topped tube
  - If there are any other drugs you wish to test for, please page the biomedical scientist ex 2547 or bleep 3006.

6.21. **INVESTIGATIONS FOLLOWING DEATH DUE TO POISONING, DROWNING, FIRES and SUSPECTED SUICIDE OR HOMICIDE**

Investigations and examination should only be carried out after discussion with the police and the coroner for instructions on processing and the potential need for chain of evidence forms.

However it is still important that the child is examined and that relevant investigations for each case such as toxicology and viral screen are taken.
7. Dissemination and Implementation
7.1. All staff will be made aware of new version of document via e mail and Child Death Review meetings. Any relevant training needs to be discussed with named doctor.

8. Monitoring compliance and effectiveness

<table>
<thead>
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<th>Element to be monitored</th>
<th>Adherence to guideline, in particular processes set out in section 6. Correct completion of documentation in Appendix’s 3,4,5 and 10</th>
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<td>Lead</td>
<td>Named Doctor for Child Death Review - Dr Roger Jenkins</td>
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<tr>
<td>Tool</td>
<td>Case by case review</td>
</tr>
<tr>
<td></td>
<td>Child Death review</td>
</tr>
<tr>
<td>Frequency</td>
<td>Per case and at CDR every quarter</td>
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<tr>
<td>Reporting arrangements</td>
<td>At child death review or via Named Doctor for Child Death Review – Dr Roger Jenkins</td>
</tr>
<tr>
<td>Acting on recommendations and Lead(s)</td>
<td>Child Death Review</td>
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<td>Named Doctor for Child Death Review – Dr Roger Jenkins</td>
</tr>
<tr>
<td>Change in practice and lessons to be shared</td>
<td>Required changes to practice will be identified and actioned within 4 months where possible. A lead member of the team will be identified to take each change forward where appropriate. Lessons will be shared with all the relevant stakeholders</td>
</tr>
</tbody>
</table>

9. Updating and Review
9.1. This policy will be reviewed every three years, unless new evidence comes to light and requires a change in practice.

10. Equality and Diversity

10.1. This document complies with the Royal Cornwall Hospitals NHS Trust service Equality and Diversity statement which can be found in the ‘Equality, Diversity & Human Rights Policy’ or the Equality and Diversity website

10.2. Equality Impact Assessment
10.3. The Initial Equality Impact Assessment Screening Form is at Appendix 2.
### Appendix 1. Governance Information

<table>
<thead>
<tr>
<th>Document Title</th>
<th>Death in Children up to 18 years old- Emergency Department Policy.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date Issued/Approved:</td>
<td>May 2014</td>
</tr>
<tr>
<td>Date Valid From:</td>
<td>May 2014</td>
</tr>
<tr>
<td>Date Valid To:</td>
<td>May 2017</td>
</tr>
<tr>
<td>Directorate / Department responsible (author/owner):</td>
<td>Main author: Dr R Jenkins, Named Doctor for Child Death Review – Cornwall and Isles of Scilly&lt;br&gt;Co-Authors: Dr Julia Harvey&lt;br&gt;Consultant Community Paediatrician&lt;br&gt;Named Doctor for Child Death Review for Cornwall and IOS&lt;br&gt;Contributors: Dr Debbie Galbraith – Designated Doctor Cornwall&lt;br&gt;Dr Charles Holme – Designated Doctor Devon&lt;br&gt;Dr Carolyn Adcock – Designated Doctor Plymouth&lt;br&gt;Dr Lorraine Dibble – Designated Doctor - Torbay&lt;br&gt;Dr Ian Higginson – ED Consultant – PHNT&lt;br&gt;Mrs Sarah Shelley – Named Nurse Child Protection – PHNT&lt;br&gt;Dr Anne Hicks – ED Consultant – PHNT&lt;br&gt;Dr Jane Dunlop – Specialist Registrar R.D. &amp; E&lt;br&gt;Dr Deborah Smith Ringer – Research Midwife R.D. &amp; E&lt;br&gt;Mrs Jan Barnfield – ED Sister PHNT</td>
</tr>
<tr>
<td>Contact details:</td>
<td>01872 254516</td>
</tr>
<tr>
<td>Brief summary of contents</td>
<td>Policy for practitioners working in ED and responding to a sudden unexpected child death.</td>
</tr>
<tr>
<td>Suggested Keywords:</td>
<td>Paediatric, Child, Death, Review, Childhood, Paediatrics, unexpected, rapid response, sudden</td>
</tr>
<tr>
<td>Target Audience</td>
<td>RCHT</td>
</tr>
<tr>
<td></td>
<td>✔</td>
</tr>
<tr>
<td>Executive Director responsible for Policy:</td>
<td>Kim O’Keeffe</td>
</tr>
<tr>
<td>Date revised:</td>
<td>May 2017</td>
</tr>
<tr>
<td>-----------------------------------</td>
<td>------------------------------------</td>
</tr>
<tr>
<td>This document replaces (exact title of previous version):</td>
<td>Royal Cornwall Hospital Emergency Department Child Death Overview Protocol (Children &lt;18 Years)</td>
</tr>
<tr>
<td>Approval route (names of committees)/consultation:</td>
<td>Child Health Medical Director ED Consultants Designated Doctor for Child Protection Clinical Biochemistry Directorate Audit and Guidelines Meeting Divisional Board meeting</td>
</tr>
<tr>
<td>Divisional Manager confirming approval processes</td>
<td>David Smith</td>
</tr>
<tr>
<td>Name and Post Title of additional signatories</td>
<td>None</td>
</tr>
<tr>
<td>Signature of Executive Director giving approval</td>
<td></td>
</tr>
<tr>
<td>Publication Location (refer to Policy on Policies – Approvals and Ratification):</td>
<td>Internet &amp; Intranet ✔ Intranet Only</td>
</tr>
<tr>
<td>Document Library Folder/Sub Folder</td>
<td>Paediatrics</td>
</tr>
<tr>
<td>Links to key external standards</td>
<td></td>
</tr>
</tbody>
</table>
## Version Control Table

<table>
<thead>
<tr>
<th>Date</th>
<th>Version No</th>
<th>Summary of Changes</th>
<th>Changes Made by (Name and Job Title)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jul 11</td>
<td>V1.0</td>
<td>Initial Issue</td>
<td>Dr Julia Harvey Consultant Community Paediatrician Named Doctor for Child Death Review for Cornwall and IOS</td>
</tr>
<tr>
<td>May 14</td>
<td>V2.0</td>
<td>Full review and re write of content. Re format, inclusion of new body maps and updated forms to print.</td>
<td>Dr Julia Harvey Consultant Community Paediatrician Named Doctor for Child Death Review for Cornwall and IOS Tabitha Fergus- Deputy ward manager-Child Health -format</td>
</tr>
<tr>
<td>May 17</td>
<td>V2.1</td>
<td>Updated interim policy awaiting new national guidance late 2017. Updates to contact names and numbers.</td>
<td>Dr Roger Jenkins, Named Doctor for Child Death Review – Cornwall and Isles of Scilly</td>
</tr>
</tbody>
</table>

---

**All or part of this document can be released under the Freedom of Information Act 2000**

**This document is to be retained for 10 years from the date of expiry.**

**This document is only valid on the day of printing**

**Controlled Document**

This document has been created following the Royal Cornwall Hospitals NHS Trust Policy on Document Production. It should not be altered in any way without the express permission of the author or their Line Manager.
Appendix 2. Initial Equality Impact Assessment Form

<table>
<thead>
<tr>
<th>Name of the strategy / policy / proposal / service function to be assessed (hereafter referred to as <em>policy</em>) (Provide brief description): Death In Children up to 18 years of age - Emergency Department Policy.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Directorate and service area: Child Health Is this a new or existing Policy? existing</td>
</tr>
<tr>
<td>Name of individual completing assessment: T. Fergus Telephone: 01872 252800</td>
</tr>
<tr>
<td>2. Policy Objectives* To provide clear guidance and investigations following sudden unexpected child death.</td>
</tr>
<tr>
<td>3. Policy – intended Outcomes*</td>
</tr>
<tr>
<td>4. *How will you measure the outcome? Audit and serious case review, child death review</td>
</tr>
<tr>
<td>5. Who is intended to benefit from the policy? Families and staff caring for these families.</td>
</tr>
<tr>
<td>6a) Is consultation required with the workforce, equality groups, local interest groups etc. around this policy? no</td>
</tr>
<tr>
<td>b) If yes, have these *groups been consulted?</td>
</tr>
<tr>
<td>C). Please list any groups who have been consulted about this procedure.</td>
</tr>
</tbody>
</table>

7. The Impact
Please complete the following table.

Are there concerns that the policy could have differential impact on:

<table>
<thead>
<tr>
<th>Equality Strands:</th>
<th>Yes</th>
<th>No</th>
<th>Rationale for Assessment / Existing Evidence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td></td>
<td>X</td>
<td></td>
</tr>
</tbody>
</table>

Death in Children up to 18 years old - Emergency Department Policy.
<table>
<thead>
<tr>
<th>Category</th>
<th>X</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sex (male, female, trans-gender / gender reassignment)</td>
<td></td>
</tr>
<tr>
<td>Race / Ethnic communities /groups</td>
<td>X</td>
</tr>
<tr>
<td>Disability - learning disability, physical disability, sensory impairment and mental health problems</td>
<td>X</td>
</tr>
<tr>
<td>Religion / other beliefs</td>
<td>X</td>
</tr>
<tr>
<td>Marriage and civil partnership</td>
<td>X</td>
</tr>
<tr>
<td>Pregnancy and maternity</td>
<td>X</td>
</tr>
<tr>
<td>Sexual Orientation, Bisexual, Gay, heterosexual, Lesbian</td>
<td></td>
</tr>
</tbody>
</table>

You will need to continue to a full Equality Impact Assessment if the following have been highlighted:
- You have ticked “Yes” in any column above and
- No consultation or evidence of there being consultation- this excludes any policies which have been identified as not requiring consultation. or
- Major service redesign or development

8. Please indicate if a full equality analysis is recommended. Yes No

9. If you are not recommending a Full Impact assessment please explain why.

No impact

<table>
<thead>
<tr>
<th>Signature of policy developer / lead manager / director</th>
<th>T.Fergus</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date of completion and submission</td>
<td>September 2013</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Names and signatures of members carrying out the Screening Assessment</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
</tr>
<tr>
<td>2.</td>
</tr>
</tbody>
</table>

Keep one copy and send a copy to the Human Rights, Equality and Inclusion Lead, c/o Royal Cornwall Hospitals NHS Trust, Human Resources Department, Knowledge Spa, Truro, Cornwall, TR1 3HD

A summary of the results will be published on the Trust’s web site.

Signed _____T.fergus___________

Date _____May 2014___________
### Appendix 3. Unexpected Child Death Document

**Sample only. Available on forms to Print. CHA3377 V1**

**Full History**

Using parent interview and review of all medical records including parent-held records.

<table>
<thead>
<tr>
<th>Field</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Surname</td>
<td></td>
</tr>
<tr>
<td>First name</td>
<td></td>
</tr>
<tr>
<td>Hospital Number</td>
<td></td>
</tr>
<tr>
<td>Police Case Number</td>
<td></td>
</tr>
<tr>
<td>Date of Birth</td>
<td></td>
</tr>
<tr>
<td>Birthweight</td>
<td></td>
</tr>
<tr>
<td>NHS Number</td>
<td></td>
</tr>
<tr>
<td>Date of Death</td>
<td></td>
</tr>
<tr>
<td>Deceased Weight</td>
<td></td>
</tr>
<tr>
<td>Postcode</td>
<td></td>
</tr>
<tr>
<td>Gestation at Birth</td>
<td></td>
</tr>
<tr>
<td>Apgars</td>
<td></td>
</tr>
<tr>
<td>Sex</td>
<td>M / F</td>
</tr>
<tr>
<td>Twin?</td>
<td>Yes / No</td>
</tr>
<tr>
<td>Congenital abnormality</td>
<td></td>
</tr>
<tr>
<td>Allergies</td>
<td></td>
</tr>
<tr>
<td>Neonatal problems</td>
<td></td>
</tr>
<tr>
<td>Immunisations</td>
<td></td>
</tr>
<tr>
<td>Feeding (SUDI)</td>
<td>Breast, Bottle</td>
</tr>
<tr>
<td>Age solids introduced</td>
<td></td>
</tr>
<tr>
<td>Last seen by</td>
<td>(Circle as appropriate)</td>
</tr>
<tr>
<td>GP, HV, Child health clinic, School nurse</td>
<td></td>
</tr>
<tr>
<td>Current feeding</td>
<td></td>
</tr>
<tr>
<td>NHS Direct?</td>
<td>Yes / No</td>
</tr>
<tr>
<td>Regular Health Check-Ups?</td>
<td>Yes / No</td>
</tr>
</tbody>
</table>
Illnesses (Medical history):
<table>
<thead>
<tr>
<th>Health in last 2 weeks:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Health in last 24 hours:</th>
</tr>
</thead>
</table>
## Full History

<table>
<thead>
<tr>
<th>Medication:</th>
<th>Contact with infection (including animals):</th>
</tr>
</thead>
</table>

**Circumstances of Scene:**

**Sleep routine and details of final sleep (SUDI)**

<table>
<thead>
<tr>
<th>Time found:</th>
<th>Time put to bed:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Position of body:</th>
<th>Last checked:</th>
</tr>
</thead>
</table>

**Blankets, bedding and clothing: (SUDI)**

**Night time feeds: (SUDI)**

<table>
<thead>
<tr>
<th>Last feed: (SUDI)</th>
</tr>
</thead>
</table>
### Full History continued...

#### The Mother

<table>
<thead>
<tr>
<th>Age:</th>
<th>Total number of children:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Occupation:</td>
<td>Ethnic Group:</td>
</tr>
<tr>
<td>Drugs: (including habit forming)</td>
<td>Smoking:</td>
</tr>
<tr>
<td>Illnesses:</td>
<td>Alcohol:</td>
</tr>
</tbody>
</table>

Other Comments:

#### The Father:

<table>
<thead>
<tr>
<th>Age:</th>
<th>Total number of children:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Occupation:</td>
<td>Ethnic Group:</td>
</tr>
<tr>
<td>Past marriages / Live-in relationships?</td>
<td>Yes / No</td>
</tr>
<tr>
<td>Children from other partners?</td>
<td>Yes / No</td>
</tr>
<tr>
<td>Drugs: (including habit forming)</td>
<td>Smoking:</td>
</tr>
<tr>
<td>Illnesses:</td>
<td>Alcohol:</td>
</tr>
</tbody>
</table>

Other Comments:

#### Other Children in the family: (Including any children by previous partners)

<table>
<thead>
<tr>
<th>Name:</th>
<th>Age:</th>
<th>Health:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Other Comments:
Full History continued...

**Other relevant family history**

<table>
<thead>
<tr>
<th>Recent Travel:</th>
<th>Cultural Practices:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Other adults live in household:</td>
<td>Religious faith / tradition:</td>
</tr>
<tr>
<td>Child Care Providers:</td>
<td>Social Issues:</td>
</tr>
<tr>
<td>Play groups / Schools:</td>
<td>Who child lives with:</td>
</tr>
<tr>
<td>Who had responsibility at time of death?</td>
<td>Who has legal parental responsibility?</td>
</tr>
</tbody>
</table>

Other Comments:

---

Further family comments / verbatim description:
EXAMINATION

- Rectal temperature should be taken with a low reading thermometer as soon as possible after the infant is brought into the ED.
- Record on body map any marks of abrasions, skin rashes, skin discolouration including dependent livido or identifiable injuries. Record all puncture sites including Note cleanliness, state of hydration, presence or absence of organomegaly. Weigh and measure head circumference.

**Physical Examination**

<table>
<thead>
<tr>
<th>Rectal Temp (low reading thermometer)</th>
<th>Date/Time</th>
</tr>
</thead>
</table>

| Interval from death                  |           |

<table>
<thead>
<tr>
<th>Full Growth Measurement</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Length:</td>
<td>Head circumference:</td>
</tr>
<tr>
<td>Weight:</td>
<td>Centile:</td>
</tr>
</tbody>
</table>

- Retinal Examination
- State of nutrition and hygiene, evidence of dehydration?
- Any marks or evidence of injury: (Should also be drawn on body chart below)
  - NB Check genitalia and back.
  - Check mouth: Is the frenulum intact
- Look for petechiae behind ears, in axillae, palate and conjunctiva.
- Look for hepatomegaly
- Document presence of any discolouration of the skin, particularly dependent livido. (Where possible, it is important to document livido within a few hours of death to help identify the body's position at death.)

**Date: ..................................................**  **Time: ..................................................**

**Signature: ............................................**  **PRINT NAME: .............................................**

**Title: .................................................**
### SAMPLES REQUIRED FOLLOWING SUDDEN UNEXPECTED INFANT DEATH (< 2 YEARS)

NOTE: After death is certified the body is under the jurisdiction of the coroner. The following investigations follow national guidelines and have been agreed by the Devon, Plymouth, Torbay and Cornwall Coroners. The femoral route is preferred for blood sampling. If after 2 attempts this is not successful, then the intra-cardiac route can be used but may affect cardiac integrity for the post-mortem examination.

<table>
<thead>
<tr>
<th>BLOOD TESTS</th>
<th>SIGNATURE</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Haematology:</strong></td>
<td></td>
</tr>
<tr>
<td>Plasma for FBC and save.</td>
<td></td>
</tr>
<tr>
<td><strong>Biochemistry:</strong></td>
<td></td>
</tr>
<tr>
<td>Electrolytes, CRP, LFTs, Magnesium, bone.</td>
<td></td>
</tr>
<tr>
<td>Paracetamol and salicylate levels</td>
<td></td>
</tr>
<tr>
<td>Glucose, Lactate, 30H Butyrate, Free Fatty Acids</td>
<td></td>
</tr>
<tr>
<td>Plasma amino acids</td>
<td></td>
</tr>
<tr>
<td>Guthrie spots for DBS Acylcarnitine</td>
<td></td>
</tr>
<tr>
<td><strong>Blood Culture</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Chromosomes</strong> for cytogenetics if dysmorphic</td>
<td></td>
</tr>
<tr>
<td><strong>URINE:</strong> SPA only. Do not send the nappy.</td>
<td></td>
</tr>
<tr>
<td>Microbiology for MC+S (Supra-pubic aspirate may fail as bladder usually empty)</td>
<td></td>
</tr>
<tr>
<td>Biochemistry for 'Drugs of Abuse', urine amino acids and organic acids and urinary sugars.</td>
<td></td>
</tr>
<tr>
<td><strong>CEREBRAL SPINAL FLUID:</strong> Microscopy for MC+S and Viral PCR</td>
<td></td>
</tr>
<tr>
<td>Biochemistry for save until further instructions</td>
<td></td>
</tr>
<tr>
<td><strong>SWABS:</strong> Throat for MC+S</td>
<td></td>
</tr>
<tr>
<td>Any identifiable lesions on skin for MC+S</td>
<td></td>
</tr>
<tr>
<td><strong>STOOL:</strong> Culture for MC+S and virology, then freeze sample</td>
<td></td>
</tr>
<tr>
<td><strong>NASOPHARYNGEAL ASPIRATE</strong></td>
<td></td>
</tr>
<tr>
<td>Microbiology for MC+S, Viral culture and immunofluorescence</td>
<td></td>
</tr>
<tr>
<td><strong>SKIN BIOPSY</strong> for fibroblast culture if &gt;24hrs to obtaining post mortem. Obtain written consent from parents. (See parent information sheet, consent form and skin biopsy SOP in Appendix 9, 10 and 11). Use punch biopsy set to take a full depth skin biopsy from the thigh, buttock or back of shoulder of infant. This should be approx 0.5 cms diameter. Place in sterile saline, fill in genetics form and send to biochem to be sent to Bristol Genetics laboratory, Southmead.</td>
<td></td>
</tr>
<tr>
<td><strong>SKELETAL SURVEY</strong> To be arranged by Acute Consultant Paediatrician with Dr Simon Thorogood</td>
<td></td>
</tr>
</tbody>
</table>

All investigations for biochemistry and haematology have pre-prepared forms that can be found in the SUDI trolley in ED as a SUDI 'pack'. There are photographs of which bottles are required for these tests in the individual packs.

All the investigations for microbiology will need forms to be filled out. Please ensure that these are clearly labelled as 'child death' or 'SUDI'.

If you are using the last SUDI pack from the trolley please ensure that you let biochemistry know.

If you feel that any other tests are required it is really important that you contact the coroner as well as the appropriate lab beforehand.

If there is any suspicion of Non-accidental Head Injury (NAHI) please see the link below for Bristol Childrens Hospital guidelines and possible investigations:


Death in Children up to 18 years old-Emergency Department Policy.
Appendix 4: Skin Maps. **Sample only.** Available on Forms to Print CHA3374, CHA3375, CHA3376.
Name of person completing form: ................................................................. Date: ...........................................
Name of person completing form: _____________________________________________ Date: ____________________________
Appendix 5. Background Information Sheet and Nursing Checklist. Sample Only. Available from Forms to print-CHA3380
<table>
<thead>
<tr>
<th>CHECKLIST (for Nursing Staff)</th>
<th>Signature</th>
<th>Date/time</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Check if child subject to Child Protection Plan</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2 Clothing removed and placed in labelled brown paper bag</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3 Background information completed (Appendix 4).</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4 List names / titles of staff at resuscitation:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5 List names and relationship of family / friends present at resuscitation:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6 Contact numbers provided Written information provided</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7 Bereavement support leaflet, (incl telephone numbers) FSID The Lullaby Trust's leaflet 'The Child Death Review - A guide for parents and carers' is available in ED</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8 Contact family, friends and religious leaders as requested</td>
<td></td>
<td></td>
</tr>
<tr>
<td>9 Photocopy medical records originals go with child to mortuary.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>10 Confirm arrangements for family to get home.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>11 Consider advice on lactation/ school nurse.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Appendix 6. Parent/Carer Information. **Sample Only.** Available on Forms to Print-CHA3382

<table>
<thead>
<tr>
<th>PARENT / CARER SUPPORT INFORMATION</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>The Lullaby Trust</strong></td>
<td><strong>Cruse:</strong></td>
</tr>
<tr>
<td>Specialist support for bereaved parents.</td>
<td>Bereavement support.</td>
</tr>
<tr>
<td>Telephone helpline: 0808 802 6868</td>
<td>Counselling helpline. Support Groups</td>
</tr>
<tr>
<td><a href="http://www.lullabytrust.org.uk">www.lullabytrust.org.uk</a></td>
<td><a href="http://www.cruse.org.uk">www.cruse.org.uk</a></td>
</tr>
<tr>
<td><strong>Cruse Bereavement Care</strong></td>
<td><strong>The Compassionate Friends:</strong></td>
</tr>
<tr>
<td>Helpline Tel: 0844 477 9400</td>
<td>Bereavement Support for child loss.</td>
</tr>
<tr>
<td></td>
<td>Helpline, One-to-one meetings,</td>
</tr>
<tr>
<td></td>
<td>Local groups, Online ‘meeting point’.</td>
</tr>
<tr>
<td></td>
<td><a href="http://www.tcf.org.uk">www.tcf.org.uk</a></td>
</tr>
<tr>
<td><strong>The Compassionate Friends</strong></td>
<td><strong>The Child Death Helpline:</strong></td>
</tr>
<tr>
<td>Supporting Family After a Child Dies</td>
<td>Bereavement helpline for child loss</td>
</tr>
<tr>
<td>Helpline Tel: 0845 123 2304</td>
<td>Free phone number for all mobiles: 0808 800 6019</td>
</tr>
<tr>
<td></td>
<td><a href="http://www.childdeathhelpline.org.uk">www.childdeathhelpline.org.uk</a></td>
</tr>
<tr>
<td><strong>CHILD DEATH HELPLINE</strong></td>
<td><strong>Winston’s Wish:</strong></td>
</tr>
<tr>
<td>Helpline Tel: 0800 282986</td>
<td>Guidance and support for families with bereaved siblings</td>
</tr>
<tr>
<td></td>
<td>Information and activity packs.</td>
</tr>
<tr>
<td></td>
<td><a href="http://www.winstonswish.org.uk">www.winstonswish.org.uk</a></td>
</tr>
<tr>
<td><strong>Winston’s Wish</strong></td>
<td><strong>Penhaligon’s Friends:</strong></td>
</tr>
<tr>
<td>the charity for bereaved children</td>
<td>Changing bereaved childrens lives</td>
</tr>
<tr>
<td>Helpline Tel: 0845 2030405 (local call rate)</td>
<td><a href="http://www.penhaligonfriends.org.uk">www.penhaligonfriends.org.uk</a></td>
</tr>
</tbody>
</table>

- DOH leaflet ‘Guide to post-mortem” and “Guide to coroner’s proceedings”
- Information to support siblings
- The family may wish to cancel commercial mailings about baby products via www.mpsonline.org.uk/bmpsfs
- Paediatrician Tel: ____________________________
- Family Health Visitor Tel: ________________________
- Hospital Chaplain: Office Tel: ______________________
- Funeral Director Tel: ____________________________
- Main Hospital Switchboard: ________________________
- Coroners Office: ________________________________
Appendix 7. Peninsula child death rapid response guidance

IN THE EVENT OF A SUDDEN UNEXPECTED DEATH TELEPHONE: 01752 434161 (Peninsula Child Death Overview office, Plymouth)

This is an answer phone - please leave a message:

DETAILS TO INCLUDE:
Referring Paediatrician’s details
Acute Trust name and Telephone number (ability to contact referrer or nominee essential)
Brief summary of case, Name and DOB
Attending Police Officer’s name and contact number

Rapid Response criteria (for guidance only)

All children under two years old
Asthmatic cases
Epilepsy cases
Diabetic cases
Suicides

Rapid Response Team:
Peninsula Service Manager / Lead for Rapid Response:
Carol Evason-Coombe 07789 270844 c.evason-coombe@nhs.net

Specialist Practitioner:
Nicky Hughes 07785 332652 nickyhughes1@nhs.net
Appendix 8. Notification of child death in SW Peninsula. Sample Only. Available from Forms to Print-CHA3381

NOTIFICATION OF CHILD DEATH IN SW PENINSULA
Send to your local Child Death Review Co-ordinator
Sue Dash at susandash@nhs.net (Telephone: 01872 254616),
who will notify the SW Peninsula CDOP Office
(email: PCHCIC.swcddop@nhs.net Enquiries: 01752 434161)

PLEASE PRINT INFORMATION

Date of Referral: __________________

Referred by: ____________________

Agency: _________________________

Address: ________________________

Tel No: _________________________ e-mail: ____________________________

NAME OF CHILD: ____________________________

Date of birth: ____________________________ Time of birth, gestation and birth weight (Neonatal only): ____________________________

If gestation 24 weeks or below, was this a planned termination of pregnancy? Yes / No

Gender: ____________________________ NHS No: ____________________________

Ethnicity: _________________________

Address: _________________________

Date of death: ____________________________ Time of death: ____________________________

Place of death: ____________________________

Death Certificate issued? Yes / No If yes, by whom was it signed? ____________________________

ANY KNOWN OR SUSPECTED CAUSE OF DEATH

DEATH – please delete as appropriate

Expected / Unexpected

Next of Kin (Name[s], date[s] of birth and address[es])

Mother: ____________________________ DOB: ____________________________

Father: ____________________________ DOB: ____________________________

Any siblings: ____________________________

An unexpected death is defined as the death of an infant or child (less than 18 years old) that was not anticipated as a significant possibility, for example 24 hours before the death, or where there was a similarly unexpected collapse or incident leading to or precipitating the events which led to the death. (Working Together to Safeguard Children, HM Government, 2013)

SW Peninsula Child Death Overview Panel Notification Form v6 25.7.16
Appendix 9. Skin Biopsy in Babies and Children - Information for Parents and Carers

**What is a skin biopsy?**
Taking a “biopsy” means obtaining a sample of tissue from part of the body. Every part of our body is made of cells, and although we are made up of many different types of cells, they all share the same genetic code. This includes the cells in our skin. A punch skin biopsy is a simple procedure that removes a piece of skin tissue for medical investigation.

**What is the purpose of a skin biopsy?**
The piece of skin that is biopsied contains cells called fibroblasts. These can be examined under a microscope or grown (“cultured”) in the laboratory. The cultured cells can then be tested to look for genetic abnormalities. They can also help us to work out if there is a “metabolic” disorder – an illness caused by problems with chemical processes inside the body’s cells.

The reason for your child’s biopsy will be discussed with you fully by your child’s doctors.

**How is a skin biopsy done?**
The whole procedure takes a few minutes only. The biopsy consists of a tiny circular piece of skin, about 2 millimetres. It is usually taken from the top of the thigh at the front.

The skin biopsy needle is gently inserted into your child’s skin, rotated and a small circle of skin is carefully removed. The sample of skin will be sent to the laboratories for examination under a microscope and/or to grow cells from the underneath surface.

**What will happen to the biopsy sample?**
The skin biopsy sample is sent to Bristol Genetics Laboratory. The DNA is removed from some of the fibroblast cells for genetic investigation and indefinite frozen storage if you have given your consent for this. Other fibroblast cells are cultured, frozen and stored indefinitely if this has been requested and you have given your consent. Please note that the process of culturing fibroblast cells is not always successful.

Storage of DNA and fibroblasts can be important, because unfortunately medical investigations - including skin biopsy tests - do not always reveal the cause of a child’s illness at the time. In such cases, new information or future scientific knowledge can sometimes point to a possible cause that can be checked for in the stored samples. Growing fibroblasts often takes 4-6 weeks, so if metabolic tests have been requested the results may be available within 6-8 weeks. However, sometimes more specialised tests have to be sent away to a different laboratory that doesn’t do such tests frequently, and results of these can take up to six months to come back. Analysing the genes responsible for a disease (carried on the DNA) can also take several months.
### Appendix 10. Skin Biopsy in Babies and Children - Consent Form for Parents and Carers - Sample only. Available from Forms to Print- CHA3373 V1

#### Skin Biopsy in Babies and Children Consent Form for Parents and Carers

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>I have been shown the parent information sheet on skin biopsy in babies</td>
<td></td>
<td></td>
</tr>
<tr>
<td>and children.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I have been given an opportunity to talk to ................................</td>
<td></td>
<td></td>
</tr>
<tr>
<td>about the skin biopsy, to ask questions and have them answered to my</td>
<td></td>
<td></td>
</tr>
<tr>
<td>satisfaction.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I understand that the sample will be sent to the Regional Genetics</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Laboratory in Bristol for analysis.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I understand the skin biopsy sample is for the purpose of genetic and/or</td>
<td></td>
<td></td>
</tr>
<tr>
<td>metabolic testing.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I understand that it is possible that the cells from the skin biopsy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>may not grow in the laboratory and that this may limit the information</td>
<td></td>
<td></td>
</tr>
<tr>
<td>that is available.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I agree to the long term storage of the skin biopsy sample.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I understand that no future tests will be done on the skin biopsy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>sample without my permission.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I agree to health professionals sharing information from analysis of the</td>
<td></td>
<td></td>
</tr>
<tr>
<td>skin biopsy with me and members of my family (as appropriate).</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I understand that I have the right to withdraw my consent to storage of</td>
<td></td>
<td></td>
</tr>
<tr>
<td>this sample in the future if I wish.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Signed** .................................................................................................................. (Parent / Legal Guardian)  
**Name** .................................................................................................................. Date ..............................................  
**Witnessed by:**  
**Signed** .................................................................................................................. (Doctor)  
**Name** .................................................................................................................. Date ..............................................
Appendix 11. Skin Biopsy Sampling Guide

Purpose and indications

Skin biopsy is used to culture fibroblasts and chondrocytes in order to diagnose chromosomal abnormalities and metabolic disorders.

A skin biopsy should be obtained immediately post-mortem in cases of sudden unexpected neonatal death, or unexplained death following sudden unexpected postnatal collapse.

Laboratory processing and investigation

Fibroblasts from skin biopsy samples are used to extract DNA which is then stored indefinitely as long as appropriate consent is documented on the consent form.

Fibroblast cells can also be cultured by the Genetics Laboratory, and the resulting cell culture stored indefinitely in liquid nitrogen. This enables future further DNA extraction and metabolic testing. Cultured fibroblasts are always stored indefinitely in cases of sudden unexpected childhood death, or following pregnancy loss with evidence of fetal anomaly. In other situations, long term storage of cultured fibroblasts requires a specific request. Appropriate consent should be obtained (see below).

It is important to note that fibroblast culture from skin biopsy is not always successful.

Consent

When a skin biopsy is undertaken post-mortem as part of sudden unexpected death investigation, the necessary investigations including skin biopsy should be discussed with the parents and this discussion should be documented clearly in the patient’s notes.

In all cases, explanation should include both the process itself and the need for DNA and skin fibroblast storage to enable future genetic or metabolic investigation should this be needed. Written informed consent is expected by the Human Tissue Authority, and the specific skin biopsy information sheet (Appendix 9) and consent form (Appendix 10) can be used.

Parental consent for DNA and Fibroblast storage should be documented in the patient’s notes along with a filed copy of the signed consent form.
Setting

In all cases, respect the dignity of the baby, whether living or deceased. Sampling can take place in any clinical area of the Neonatal Unit, but the following must be observed:

1. Invite the baby’s parents to leave while the sample is taken.
2. Ask all other parents or visitors to leave the clinical area while the sampling takes place.
3. Ensure that the cot or incubator space is adequately screened to ensure privacy.

Location of equipment for neonatal use

Please see ED and NNU specific SOPs

Biopsy method

1. Make sure that the area you are sampling is clean. An infected or contaminated skin specimen will cause the fibroblast culture to fail. Use sterile instruments and gloves.
2. Clean the skin for 30 seconds with an alcohol or chlorhexadine based solution. Rinse with sterile water and allow to dry.
3. Pull the skin around the biopsy area tight, to immobilise the skin. The area recommended to sample from is the antero-lateral aspect of the upper thigh.
4. Place the disposable biopsy punch tool at a perpendicular angle to the skin surface, then introduce it firmly onto the skin.
5. The punch ‘needle’ should be rotated back and forth to allow the cutting edge to carry the punch down through the tissue. The guard on the sterile biopsy punch tool will prevent too deep a penetration.
6. Withdraw the punch ‘needle’ whilst applying pressure on the puncture site. This will obtain the specimen. Remove the specimen gently from the punch using a needle.
7. If the cylindrical specimen remained in situ, gently lift it from the site using a 21 gauge needle (forceps may crush the specimen and damage it so it will not culture). Cut the specimen free from its base with tiny iris scissors or a scalpel. (diagram overleaf)
8. Place the specimen in a sterile universal container and use sterile normal saline to cover the sample. Ensure the lid is replaced snugly.
9. Apply pressure to the site and close with Steristrips®, and cover with a dry dressing. In living patients the area should be covered with a pressure dressing to stop any bleeding.
Sample Handling and Processing

1. The skin biopsy is posted by the RCH Biochemistry laboratory to the Bristol Genetics Laboratory.

2. Label the container and the Bristol Genetics lab request slip with correct patient details, hospital, consultant, and date/time of sampling.

3. Write “Fibroblast culture for storage” on the request slip. Where skin biopsy is undertaken post-mortem as an investigation following sudden unexpected neonatal death, “SUDI” should also be written on the request slip.

4. Place the container into a sealed lab specimen plastic bag, and put the lab request slip in the bag’s pocket.

5. Place the specimen pot into one of the specific cardboard boxes provided (kept on Child Death Review trolley in ED, also kept in Neonatal Unit Bereavement Cupboard, in the NNU Housekeepers’ Room).

6. The box should then be sent to the RCH Biochemistry labs ASAP for storing in their fridge until it can be sent to Bristol Genetics Lab at Southmead Hospital during office hours. Do not freeze.

7. (FYI: further clarification re: cytogenetics testing can be found on the back of the lab slip)

8. Please document in the medical records where the skin biopsy has been taken and document discussion with parents and consent if applicable.

9. For skin biopsy specimens taken post-mortem, the investigations sheet from the Child Death Policy must be completed by the person taking the samples. This will be used for auditing purposes in the future.
Appendix 12. Punch Biopsy

Punch Biopsy Photos

Punch Biopsy Diagram

United Bristol Hospitals Trust, (photo)  http://www.ubht.nhs.uk/eDerm/punch_biopsy.htm
Appendix 13. Contact List

Doctor pronouncing death must inform coroner and police

POLICE: if not already present and for Senior Critical Incident Officer call 101

CORONER: Dr. Emma Carlyon, sec: 01872 324438 or contact through RCH switchboard

CORONER’S OFFICERS: (Office hours) 01872 227191

PAEDIATRIC CONSULTANT: Notify via RCH switchboard

COMMUNITY PAEDIATRIC CONSULTANT: Notify via RCH switchboard

RAPID RESPONSE TEAM: 01752 434161

GP (GP name) (tel)

HEALTH VISITOR (HV name) (tel)

SOCIAL SERVICES (Social Worker) (tel)

Multi-Agency Referral Unit 0300 123 1116 (office hours)
Duty Social Worker 01208 251300 (Bodmin Hospital switchboard)

MORTUARY: ext. 2555

CHAPLAIN: 24 hours via hospital switchboard (with family consent)

BEREAVEMENT OFFICE: EXT: 2713

Child’s own consultant specialists if relevant (Consultant name)

MEDICAL RECORDS: Sue Dash, ext. 4516
(to mark ‘deceased’ on PAS and cancel pending appointments)

COMMUNITY CHILD HEALTH RECORDS, Sue Dash, ext. 4516
(to cancel immunisation letters)
Appendix 14. Useful Telephone Numbers

ROYAL CORNWALL HOSPITAL  switchboard  Tel: 01872 250000
EMERGENCY DEPARTMENT  Tel: 3111/3113
PAEDIATRIC DEPARTMENT (Consultants)  via switchboard
Dr S Bedwani  Dr A Collinson  Dr O Elmasry  Dr S Goyal
Dr S Harris  Dr Y Kumar  Dr K Mallam  Dr P Munyard
Dr S Padmanabhan  Dr A Prendiville  Dr S Robertson  Dr M Thorpe
Dr C Williams

HOSPITAL CHAPLAIN  (24 hours via hospital switchboard)  ext 2883

COMMUNITY CHILD PROTECTION PAEDIATRICIANS  via switchboard
Dr Roger Jenkins  Consultant Community Paediatrician &
Named Doctor for Child Death Review
Dr Gina Clarke  Consultant Community Paediatrician
Dr Julia Harvey  Consultant Community Paediatrician
Dr Jo Lewis  Consultant Community Paediatrician
Dr Eleanor McCartney  Consultant Community Paediatrician

CHILD PROTECTION NURSES
Wendy Perkin  Named Nurse for Child Protection, RCHT  01872 254551

SOUTH WESTERN AMBULANCE SERVICE
Chris Rogers  Named Professional for Safeguarding
(Leave message if no reply)  07779 083168

SOCIAL SERVICES (Emergency Dept can access via Hospital Intranet)
Office Hours:  Multi-Agency Referral Unit  0300 123 1116
Out of hours:  Duty Social worker  01208 251300

POLICE
Switchboard (ask for CID)  101
Child Protection Police Officers  As above

CORONER'S OFFICERS  01872 227191
CORNWALL CORONER  Dr Emma Carlyon  01872 324438
Devon Coroner  Dr Elizabeth Earland  01392 383636
Plymouth Coroner  Mr Ian Arrow  01752 204636
Torbay Coroner  Mr Ian Arrow  01803 380705

PAEDIATRIC PATHOLOGISTS (Post-mortem)
Dr Ostojic/Dr Marton/Dr Philip Cox  0121 627 2719
Birmingham Women's Hospital, Metchley Park Road, Edgbaston, Birmingham, B15 2TG

Death in Children up to 18 years old-Emergency Department Policy.