CHILDREN’S SERVICES

GUIDELINES FOR MANAGEMENT IN ACCIDENT AND EMERGENCY

SUDDEN DEATH IN INFANTS
(sudden death in older children –some aspects may apply)

Most sudden and unexpected deaths in babies will be ‘cot deaths’ or the sudden infant death syndrome (SIDS) but occasionally overwhelming infection or trauma may be responsible.

These guidelines are drawn up to try and ensure that everything is done correctly and compassionately.

1. Preparation
   Ambulance priority call for a dying or dead child will alert the Paediatric SHO and Registrar to go immediately to A&E to await arrival with Casualty staff. The child must be brought into the resuscitation bay, not certified in the ambulance.

2. NOTIFY THE CONSULTANT PAEDIATRICIAN IMMEDIATELY PLEASE. CONSULTANT MUST ATTEND TO SUPERVISE RESUSCITATION AND HISTORY TAKING

3. Resuscitation
   a. Indications for starting resus.
      No vital signs but also no rigor mortis or stasis.
   b. Indications for stopping
      The decision to discontinue is made by the Senior Paediatrician based on history of asystole, response and temperature with a low reading thermometer NB cold water drowning.
   C Indications for not starting
      Rigor mortis or significant stasis

4. History from Parents
   During the resuscitation a doctor should inform the parents and take a history, away from the child, which should be clearly documented and will inform the resus. This is easier before death is pronounced as everyone is less upset.

   History as in Appendix II pp 57-61 Kennedy report
5. **Parents care and supervision**

The parents may be taken to the relatives room and comforted until one of the Paediatricians can see them or present in the resuscitation but supported by a member of staff.

When the child is dead it is important to say clearly but gently that this is so. The parents will then need to go over in great detail what has happened to help them cope. If at all possible, the Consultant Paediatrician will attend for forensic and supportive input.

Parents must be told that the Coroner will be informed and that there will be an examination of the body and that the police and social services are required to be informed also, by law even if the circumstances are not suspicious.

*Fig 1 p 46 Kennedy report*

6. **Police**

The police are informed by the nursing staff in A&E, or ambulance control, and the parents should be asked to stay until the police are clear about identification and are satisfied that they have all the information they need. A senior nurse should be responsible for making sure the police have all the demographic information they need and indicate if the medical team have any suspicion that the history and findings are inconsistent with a cot death.

They will also need the details of staff members involved (names and designation).

The police will need to interview the family and will require access to a confidential phone line. The child’s clothing, bed linen and nappy must be preserved.

Those first attending the scene may be uniformed officers and the parents should be warned. A member of staff should be with the child until all photographs and X rays are taken (for forensic and supportive purposes), and until the family depart if appropriate.

They will inform the DI on duty who will then attend ASAP.

*Phone no 01483-571212 also for coroner out of hours. Link to p49 table2*
Investigations

A drawing should be made of any injuries prior to or during resuscitation-annotated as to type and cause clearly identified. Photographs are not mandatory.

Agreement between Surrey Coroner and Surrey CDOP

Medical investigations

During attempted resuscitation, various investigations may be initiated including urea and electrolytes, full blood count, blood sugar, blood culture and gases, blood, and urine for metabolic studies.

After death:

a) **In children under 2 years** - samples for medical investigations should be taken routinely as soon as possible. The recommended samples in Table 1 have been agreed by the Surrey Coroner. If there is definite external evidence of injury early samples should only be taken after discussion with the Coroner/Coroner’s officer, as this could interfere with the interpretation of injuries at post mortem. However, the only opportunity to identify or exclude some medical conditions is by taking samples at or shortly after death and this should not be missed.

**Routine minimum samples to be taken immediately after Sudden Unexpected Deaths in children under 2 years** - 2004 National Working Party Recommendations

Take blood from a venous/arterial site if possible eg femoral vein. Cardiac puncture can make PM findings difficult to interpret.

<table>
<thead>
<tr>
<th>Taken</th>
<th>Sample Description</th>
<th>Send to</th>
<th>Handling</th>
<th>Test</th>
<th>Results</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blood (Fluoride)</td>
<td>1 ml</td>
<td>Clinical biochemistry</td>
<td>Spin, store plasma at -20 C</td>
<td>3 OH butyrate, sugar, FFA, Lactate</td>
<td></td>
</tr>
<tr>
<td>Blood cultures – aerobic and anaerobic</td>
<td>1 ml</td>
<td>Microbiology, locally</td>
<td>If insufficient blood, aerobic only</td>
<td>Culture and Sensitivity</td>
<td></td>
</tr>
<tr>
<td>Blood from syringe onto 2 Guthrie cards</td>
<td></td>
<td>Paediatric Clinical Biochemistry lab at St.Thomas’ Hospital</td>
<td>In usual Guthrie envelopes–do not put into plastic bag.</td>
<td>Acyl carnitines and other Inborn errors of metabolism (IEM)</td>
<td></td>
</tr>
<tr>
<td>Blood 1 ml lithium heparin</td>
<td></td>
<td>Paediatric Clinical Biochemistry lab</td>
<td>Spin, store plasma at -20 C</td>
<td>Amino acids and other tests for Inborn errors of metabolism (IEM)</td>
<td></td>
</tr>
<tr>
<td>Blood EDTA 1</td>
<td>Genetics, St</td>
<td>Do not</td>
<td>DNA extraction-ask</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sample</td>
<td>Lab</td>
<td>Procedure</td>
<td>Lab to save</td>
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<tr>
<td><strong>Blood</strong> (serum) 1–2 ml (if sufficient)</td>
<td>Biochemistry, locally</td>
<td>Spin, store serum at -20°C</td>
<td>Save for Toxicology</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Blood</strong> 1–2 ml</td>
<td>Cytogenetics, St George's</td>
<td>Normal – keep unseparated</td>
<td>Chromosomes</td>
<td></td>
<td></td>
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<tr>
<td><strong>CSF</strong> a few drops</td>
<td>Microbiology locally</td>
<td>Normal</td>
<td>M.C.S.</td>
<td></td>
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<tr>
<td><strong>Urine</strong> if available (obtain by squeezing nappy)</td>
<td>Biochemistry, locally</td>
<td>Spin, store supernatant at -20°C</td>
<td>Organic acids and other (IEM) Toxicology</td>
<td></td>
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<tr>
<td><strong>Swabs</strong> from any identifiable lesions</td>
<td>Microbiology</td>
<td>Normal</td>
<td>Culture and sensitivity</td>
<td></td>
<td></td>
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<tr>
<td><strong>Nasopharyngeal aspirate</strong></td>
<td>Microbiology</td>
<td>Normal</td>
<td>Viral cultures, immunofluorescence, DNA amplification.</td>
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<tr>
<td><strong>Nose and throat swabs</strong></td>
<td>Microbiology</td>
<td>Normal</td>
<td>Culture and sensitivity</td>
<td></td>
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</table>

**Additional samples to be considered after discussion with consultant paediatrician**

1. Skin biopsy for fibroblast culture
2. Muscle biopsy if history suggestive of mitochondrial disorder

**Delays can compromise or invalidate cultures and metabolic tests**

Virology samples must be sent to an appropriate laboratory

1. Always consider sending blood for toxicology

If the post mortem is to take place within 24 hours of death, arrangements can be made by the paediatrician for samples to be taken by the pathologist.
8. **Saying Goodbye**  
Most parents like to see and hold their baby and say 'goodbye' and this can be gently encouraged. **Parents should not be left alone with the child for medicolegal reasons.** A nurse is designated to supervise and support parental contact. The nurses and/or parents will dress and, perhaps wash, the baby. If other relatives are keen to come we try to keep the baby in A&E until they have visited.

9. **Keepsakes**  
Photographs, locks of hair and hand/foot prints can be provided

10. **Coroner** - needs to be informed  
After the P.M. the Coroner’s Office will contact the family and advise them when the body will be released. He will issue the death certificate

<table>
<thead>
<tr>
<th>Phone</th>
<th>01483-637300</th>
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<tbody>
<tr>
<td></td>
<td>8.00-16.30</td>
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<td></td>
<td>or via police OOH</td>
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11. **Child death review team need to be informed**  
See link

12. **Chaplain**  
The hospital chaplain, Judith Allford is happy to be involved--
Other religious leader as appropriate.

- Jabeen Quereshi is the Asian outreach worker and very helpful, office hours,

<table>
<thead>
<tr>
<th>Phone</th>
<th>01372-833319</th>
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<tbody>
<tr>
<td></td>
<td>air call via switchboard</td>
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<tr>
<td></td>
<td>mobile 07790 994224</td>
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13. **Further information**  
Booklets - The Cot Death Foundation leaflet about cot death and one with advice about telling the child’s brothers and sisters, grandparents etc  
In Paediatric A/E folder

| Phone | 24hr SIDS helpline 0207-235-1721. |

14. **Follow up**  
The Consultant Paediatrician will arrange to see them to explain the findings from PM-(which will take at least 6 weeks) and to counsel the family. They will be told about the CONI programme coordinated by Dr Tracy Lawson, Neonatal consultant and Michelle Wolfendale, Paediatric Liaison nurse

| Dr Tracy Lawson sec 2546 |

15. **Inform**  
- GP  
- Health visitor  
- Community child health  
- Hospital social worker
16. Bereavement counselling
   Discuss bereavement counselling with the parents. Cruse bereavement care or
   Foundation for the Study of Infant death can provide counselling.

Dr. Alison Groves

Ratified by………………………………………………… on ..........................2014

Consultant Paediatrician
Date: July 2014
Presented at the Paediatric Clinical Guideline Forum on 7th April 2014
Ratified by Dr Gillian Baksh, Children’s Services Clinical Governance Lead on 23rd July
Review date: July 2017