1. Introduction

- Being called to a death of an infant, child or adolescent is one of the most difficult experiences that an ambulance clinician will encounter. They are usually the first professionals to arrive at the scene, and, at the same time as making difficult judgements about resuscitation, they have to deal with the devastating initial shock of the parents/carer.

- Despite the recent fall in incidence,* sudden unexpected death in infancy (SUDI) remains the largest single cause of death in infants aged one month to one year. SUDI can also occasionally occur in children older than one year of age.

- In 50% of SUDI a specific cause for the death is found, either from a careful investigation of the circumstances or from post-mortem findings.

- The vast majority of SUDI occur from natural causes. 10% of SUDI are thought to arise from some form of maltreatment by their parents/carers and so a joint paediatric and police investigation is required for all SUDIs. When informed of a SUDI, ambulance control should notify the police Child Abuse Investigation Team to initiate this process.

- This document draws on national experiences and is in accord with the recommendations of the Kennedy Report.

2. Multi-Agency Approach

The Kennedy Report requires a multi-agency approach to the management of SUDI, in which all the professionals involved keep each other informed and collaborate.

Objectives

The main objectives for ambulance clinicians when called to a child death are:

- Resuscitation (refer to Paediatric Basic (BLS) and Advanced Life Support (ALS) guidelines) should be attempted in all cases, unless there is a condition unequivocally associated with death or a valid advance decision (refer to Recognition of Life Extinct (ROLE) guideline).

- Detecting a pulse in a sick infant can be extremely difficult so the absence of peripheral pulses is not a reliable indication of death. Similarly, a sick infant may have marked peripheral cyanosis and cold extremities (refer to paediatric medical and trauma emergencies guidelines).

- It is better for parents/carer to know that resuscitation was attempted but failed, than to be left feeling that something that might have saved their infant was not done.

- Once resuscitation has been initiated, the infant should be transported at once to the nearest suitable emergency department, with resuscitation continuing en-route.

Care of the family

- The initial response of professionals (and you will probably be the first on the scene) will affect the family profoundly.

- Having experienced this hugely distressing event, parents/carers exhibit a variety of reactions (e.g. overwhelming grief, anger, confusion, disbelief or guilt). Be prepared to deal with any of these feelings with sympathy and sensitivity, remembering some reactions may be directed at you as a manifestation of their distress.

- Think before you speak. Chance remarks may cause offence and may be remembered indefinitely (e.g. ‘I’m sorry he looks so awful’).

- Avoid any criticism of the parents/carers, either direct or implied.

- Ask the child’s name and use it when referring to them (do not refer to the child as ‘it’).

- If possible, do not put children in body bags. It is known that relatives do not perceive very traumatic events in the way that unrelated onlookers might and it is important they are allowed to see, touch and hold their loved one.

- Explain what you are doing at every stage.

- Allow the parents/carers to hold the child if they so wish (unless there are obvious indications of trauma), as long as it does not interfere with clinical care.

- The parents/carers will need to accompany you when you take the infant to hospital. If appropriate, offer to take one or both in the ambulance. Alternatively ensure that they have other means of transport, and that they know where to go.

- If they have no telephone, offer to help in contacting a relative or friend who can give immediate support, such as looking after other children or making sure the premises are secure.

Document

- Time arrived on scene.

- The situation in which you find the infant (e.g. position in cot, bedding, proximity to others, room temperature, etc).

- A brief description from the parents/carers of the events that led up to them finding the dead child (e.g. when last seen alive, health at that time, position when found, etc). The police and community paediatrician will go through these events in greater detail, but the parent/carer’s initial statement to you may be particularly valuable in the investigation.

- Write all this information down as soon as you have the opportunity, giving times and other details as precisely as possible.

Communication with other agencies

- After you have arrived at the house and confirmed that the infant is dead or moribund, the police child abuse investigation team must be informed (see your locally agreed procedure – Figure 12 shows South Central’s Child Death Procedures flowchart, as an example).

- In unexpected child deaths, advise the parents/carers that the death will be reported to the Coroner, and that they will be interviewed by the Coroner’s Officer and the police in due course.

* The national ‘Reduce the Risk’ campaign of 1991 advocating infants sleep on their backs produced a dramatic reduction (70%) in sudden infant deaths.
Death of a Child, Including Sudden Unexpected Death in Infancy, Children and Adolescents (SUDICA)

- Share the information you have collected with the police and with relevant health professionals.

**Transferring the infant**
- The infant should be taken to the nearest appropriate emergency department, not direct to a mortuary. This should apply even when the infant has clearly been dead for some time and a doctor has certified death at home (it will on occasions be necessary to remind a doctor that taking the infant to a hospital is now the preferred procedure, as recommended by Kennedy).
- The main reasons for taking the infant to the hospital rather than the mortuary are that at hospital an immediate examination can be made by a paediatrician, early samples can be taken for laboratory tests, parents/carers can talk with the paediatricians and other local support services can be contacted.
- Pre-alert the emergency department of your arrival, asking them to be ready to take over resuscitation if this is ongoing.

**Support for ambulance clinicians**
- The death of a child is very distressing for all those involved, and opportunities for debriefing or counselling should be available for ambulance clinicians.
- Follow local procedures for post critical incident debriefing local guidelines/processes.
- Some clinicians will feel ongoing distress. This is normal but should be recognised and other forms of therapy, from informal support from colleagues, to formal counselling, may be required.

- As part of the ambulance service safeguarding processes, information from local paediatricians and ambulance service safeguarding leads will be available if required for further discussion.
- Unsuccessful resuscitation attempts on children weigh heavily on many people’s shoulders and it is very important to remember that the vast majority of children who arrest outside hospital will die, whoever is there, or whatever is done – less than 10% of paediatric out-of-hospital cardiac arrests survive. Such outcomes are almost never the fault of those attempting resuscitation who will have done everything possible to help that child.

**Conclusion**
- Findings from the Foundation for the Study of Infant Deaths have shown that parents/carers regard the actions and attitudes of ambulance clinicians to them as really important and speak very highly of the way both they and their child were treated.
- Your role is not only essential for immediate practical reasons but also has a great influence on how the family deals with the death long after the initial crisis is over.

**Further Reading**
http://www.dcsf.gov.uk/everychildmatters/
A guide to inter-agency working to safeguard and promote the welfare of children.

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**KEY POINTS**

**Death of a Child (Including Sudden Unexpected Death in Infancy, Children and Adolescents)**
- A child death is one of the most emotionally traumatic and challenging events that an ambulance clinician will encounter.
- Resuscitation should always be attempted unless there is a condition unequivocally associated with death or a valid advance decision.
- Communication and empathy are essential, and the family must be treated with compassion and sensitivity throughout.
- Ensure the family is aware of where you are taking their infant/child.
- Collect information pertaining to the situation in which you find the child, a history of events and any significant past medical history.
- Follow agreed protocols with regards to inter-agency communication and informing the police.
- In unexpected deaths, when appropriate explain to the family that the death will be reported to the Coroner and that they will be interviewed by the Coroner’s Officer and the police in due course.
**Death of a Child, Including Sudden Unexpected Death in Infancy, Children and Adolescents (SUDICA)**

**Arrive at scene**
- **Expected child death**
  - Care plan available
  - Recognise life extinct
  - Contact named clinician; leave child at home

- **Unexpected child death – questionable crime scene**
  - Viable resuscitation
  - Commence resuscitation
  - No obvious cause of death
  - Commence resuscitation
  - Ask ambulance control to contact police

- **Unexpected child death – obvious crime scene**
  - Condition unequivocally associated with death
  - Commence resuscitation
  - Obvious cause of death
  - Advised by child death DI to take child and parents to ED
  - Crime scene declared; leave child at scene; inform ambulance control

**Pre-alert and take to appropriate ED that is prepared to accept sudden deaths in children**

**Conditions unequivocally associated with death in children younger than 18 years:**
1. Massive cranial and cerebral destruction
2. Hemiplegia or similar massive injury
3. Decomposition/putrefaction
4. Incineration

**NB** The Royal College of Paediatrics and Child Health is starting a review of the whole SUDICA process and its advice will be passed on to all pre-hospital clinicians in due course. In the meantime the presence of rigor mortis and hypostasis should not preclude resuscitation in children unless there is other substantial evidence to suggest that they are clearly beyond help.

*Child Death Detective Inspector* – A Detective Inspector who is trained in the management of child death incidents to ensure the multi-agency investigation is commenced and evidence gathered to ascertain the full facts of the child’s death.

**Figure 1.2** – Example of a local child death procedure from South Central Ambulance Service – reproduced with kind permission.

**General Guidance**

March 2016

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