

## INTRODUCTION

Being called to a death of a child or infant is one of the most difficult experiences that ambulance clinicians 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/carers.

Despite the recent fall in incidence, sudden unexpected death in infancy (SUDI) remains the single largest category of death in infants from one month to one year. It may also occasionally occur in older children. A specific cause is found for about half of all SUDI, either from a careful investigation of the circumstances or from post mortem examination and tests.

It is estimated that about 10% of SUDI may arise from some form of maltreatment by carers. This means that the police should be informed about all cases of SUDI to carry out an investigation. However it should be remembered that the large majority of SUDI arise from natural causes, and parents/carers should always be treated with compassion and sensitivity.

This document draws on the experience of ambulance clinicians throughout the country. The guidelines it sets out are in accord with the recommendations of the Kennedy Report<sup>1</sup>.

## MULTI-AGENCY APPROACH

The Kennedy Report<sup>1</sup> 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 deal with the sudden unexpected death of an infant are:

- resuscitation (**refer to child resuscitation guidelines**) should be attempted in all cases, unless there is a condition unequivocally associated with death or a valid advance directive (**refer to recognition of life extinct by ambulance clinician guideline**)
- it may be very difficult to feel a pulse in a sick infant (**refer to medical and trauma emergencies in children**), so the absence of peripheral pulses is not by itself a reliable indication of death. Similarly, a sick infant may have marked peripheral cyanosis and cold extremities

- it is better for parents/carers 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.

The parents/carers have just suffered one of the worst shocks that life can offer, and may exhibit a variety of reactions, such as overwhelming grief, anger, confusion, disbelief or guilt, so 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 cause a lasting impression and may cause offence e.g. **"I'm sorry he looks so awful"**.

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

Ask the infant's name and use it when talking about the infant (try to avoid referring to the infant 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 infant 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.

# Dealing with the Death of a Child (Including Sudden Unexpected Death in Infancy (SUDI))

## Document:

- when you arrive
- the situation in which you find the infant e.g. position in cot, bedding, proximity to others, room temperature, etc.,
- a quick description from the parents/carers of the events leading up to their finding the infant dead, e.g. when last seen alive, health at that time, position when found, etc. The police and a paediatrician will want to go into these things in greater detail, but what the parents/carers say initially 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, inform the police (if this is an agreed procedure).

Advise the parents/carers that the death, being unexpected, has to be reported to the coroner, and that they will be interviewed by the coroner's officer and the police.

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

Participate in the design, implementation and audit of your area's multi-agency protocol, in which the ambulance clinicians have an important role.

Find out about the multi-disciplinary case discussion, which should be convened by the paediatrician about eight weeks after the death, and attend it if possible.

## Transferring the infant

Always take the infant 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 may occasionally be necessary to remind a doctor that taking the infant to a hospital is now the preferred procedure, as recommended by the Kennedy Report).<sup>1</sup>

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 and parents/carers can talk with a paediatrician and be put in touch with other support services.

Forewarn the emergency department of your arrival, asking them to be ready to take over resuscitation if you have set it in progress.

## 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.

It is usual (and important) to sit down and "have a cup of tea" with others involved in the resuscitation attempt.

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.

Most local paediatricians or the medical director of the ambulance service would be happy to discuss the episode further if required.

The failed resuscitation of a child weighs heavily on most people's shoulders and it is very important to remember that that vast majority of children who arrest outside hospital will die, whoever is there, or whatever is done. Such an outcome is almost never the fault of those attempting resuscitation; they will have done their best.

## CONCLUSION

Many parents/carers have told the Foundation for the Study of Infant Deaths how important the actions and attitudes of ambulance clinicians were to them, and most speak very highly of the way they and their infant 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.

# Dealing with the Death of a Child (Including Sudden Unexpected Death in Infancy (SUDI))

## Key Points – Dealing With the Death of a Child (Including Sudden Unexpected Death in Infancy)

- SUDI is one of the most emotionally traumatic and challenging events.
- Resuscitation should always be attempted unless there is a condition unequivocally associated with a death or a valid advance directive.
- 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.
- Collect information pertaining to the situation in which you find the baby, history of events, and any significant past medical history.
- Follow agreed protocols with regards to interagency communication and informing the police.
- When appropriate explain to the family that the death, being unexpected, has to be reported to the coroner, and that they will be interviewed by the coroner's office and the police.

## REFERENCE

- <sup>1</sup> Royal College of Pathologists and the Royal College of Paediatrics and Child Health. Sudden unexpected death in infancy. Report of a working group convened by the Royal College of Pathologists and the Royal College of Paediatrics and Child Health. Chair: Baronness Helena Kennedy QC. London: Royal College of Pathologists and the Royal College of Paediatrics and Child Health, 2004.

## METHODOLOGY

Refer to methodology section.