Information Sheet

The Role of Health Professionals in the Management of Unexpected Childhood Deaths

Health professionals from a range of backgrounds may become involved at different stages in responding to an unexpected child death. They play a crucial role in the overall outcomes of gathering and interpreting information, and of providing ongoing support to the bereaved family. All health professionals should work with their colleagues within health and in other agencies, working to their own level of professional competence, and within their own professional guidelines. Health professionals will be involved at all stages in the rapid response process.

Immediate Responses

Following an unexpected death in the community, ambulance staff will often be the first responders on the scene. They should assess the child, institute appropriate resuscitation and emergency care, and transfer the child and parents/carers to the nearest hospital with paediatric facilities. This helps to ensure that:

- Resuscitation is continued appropriately and any decision to stop made by an experienced practitioner
- The death of the child can be medically confirmed
- Appropriate help and support can be offered to the family
- The process of investigating the death can be initiated in a co-ordinated manner
- The scene where the child died can be secured

In situations where the child is clearly dead, resuscitation may be inappropriate and this should be considered carefully by the ambulance crew. Even in those situations, it would normally be appropriate to transfer the child to hospital. There will be rare situations where the circumstances of death are such that the child should be left at the scene; this will be decided in consultation with the attending police officers.

Hospital Procedures

Once resuscitation has stopped, a qualified medical practitioner should confirm that the child is dead, and the parents should be notified of this. Often the parents will have been present during the resuscitation and it would normally be appropriate to move to a quiet room where the parents can be supported, and can spend time with their child. An experienced member of the nursing staff should be allocated to remain with the family for ongoing support and sensitive supervision.

An experienced medical practitioner (usually the consultant paediatrician on call) will take an initial history and examine the child; any appropriate medical investigations should be taken according to local protocols agreed with the coroner. Where possible the taking of the history and examination of the child should be done jointly with the attending police officer to avoid repeated questioning of the parents. All findings should be carefully documented, along with any interventions carried out, and information shared.

Steps should be taken to notify certain people of the child's death, including the coroner, general practitioner and members of the rapid response team. In addition the parents may want to contact relatives or friends for support, or a religious leader or bereavement counsellor. The parents should be informed of the purpose and nature of the rapid response process, including the roles of different professionals, the involvement of the coroner and the need for a post-mortem examination.

Consideration should be given to the taking of photographs (both for evidential purposes and for the parents) and mementoes such as hand and foot prints or a lock of hair; and to cleaning and dressing the child. These procedures should be discussed with the attending police officer to ensure that any forensic investigation is not compromised. In most circumstances the parents should be allowed to spend as much time as they wish with their child, and when they do leave the hospital should be given information and contact details so they know who is looking after their child.

Early Responses

An initial information sharing and planning discussion will be held between the lead professionals who will be involved in the investigation, including the lead paediatrician. The paediatrician who attended the child on presentation to the hospital will have important information to contribute on the initial findings and any action taken by health staff in response to the death. Agreement should be reached at that initial discussion as to which health staff should be involved in the ongoing responses, including any joint-agency home visit. A member of the health team should take responsibility for collating all relevant health information on the child and family. This may involve securing hospital and primary care records, and speaking directly to other members of the health care team.

A central part of the management of any unexpected death is an early visit to the family home, and where this is different, the scene of death. This visit enables an holistic evaluation of the circumstances of death, and provides support to the family.
These visits should take place as soon as possible after the death, ideally within 12 hours, and should involve the police, an experienced health professional (a paediatrician or an appropriately trained and supported specialist nurse) and a member of the primary care team. In some situations an early joint visit is not appropriate or practical. In those circumstances the lead paediatrician should liaise closely with the police and consider a later joint visit.

The lead paediatrician should compile a report for the coroner and the pathologist, based upon the information gained about the clinical circumstances of the death. The paediatrician should discuss the clinical and post-mortem findings directly with the pathologist and the police team or coroner's officer, to agree any interim findings on the cause or circumstances of death, and what information should be given to the family.

Later responses

The final case discussion is one of the most important components of the management of an unexpected death; it is here that all the information is brought together and the investigation closed. It will normally take place 2-3 months after the death once all the information has been gathered. This meeting should involve the GP, the health visitor, midwife or school nurse, the hospital team, the lead paediatrician, and the pathologist, along with the investigating police officer, and any other professionals involved. The main purposes are to share information, agree the cause of death and plan future care for the family. The lead paediatrician should prepare a report to be sent to the coroner and should arrange to meet with the parents following this discussion, to clarify what is understood about the cause and circumstances of their child's death, to answer questions and to offer future care and support.

Competencies of health professionals involved in the rapid response

The competencies required by health professionals flow from the key aims to investigate the possible causes of death and to provide ongoing support to the bereaved family. The health professional competencies should be seen in conjunction with the complementary competencies of other professionals including the attending police officer. It would be unusual for any one health professional to possess all the competencies outlined below, but rather these should be seen as competences required within the team.

The key competences required from the health professionals are to:

- Take a medical history, confirm the child's death, examine the child and organise appropriate investigations;
- Initiate the multi-agency rapid response process and share with other professionals any information gained about the circumstances of the child's death or their background. The health professional may lead the investigation, or may be part of the team with other professionals taking the lead;
- Inform the family of their child's death; explain the rapid response process, the purpose and process of the autopsy, common causes of sudden unexpected death and any interventions carried out; listen to the family's concerns and answer questions; be aware of the needs of other family members; provide the family with, or direct the family to, sources of support;
- When undertaking a home visit observe and comment on the environment where the child died and work with other involved professionals to interpret the information gathered;
- Provide a written summary of the case, utilising information gained from all appropriate sources;
- Contribute to a final case discussion to review the factors surrounding the child's death;
- Provide feedback, both written and in person, to the family, informing them of any findings relating to the cause and circumstances of their child's death, and providing them with appropriate information regarding further follow up or support, including any input required in relation to the health of siblings or subsequent children.

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