Sudden Unexpected Death in Infants and Children (SUDIC) Case Record Templates for Emergency Department

* Before Commencement of Documentation

Appendix 1: Emergency Department: Arrival and Resuscitation Record (1A, 1B, 1C)

Appendix 2: History Record (2A, 2B, 2C, 2D)

Appendix 3: Physical Examination Record (3A, 3B, 3C)

Appendix 4: Collecting Post Mortem Samples

Appendix 5: Investigations Undertaken after Failed Resuscitation

Appendix 6: Form A – Notification of Child Death

Appendix 7: Contact Personnel List

SUDI JT Guidelines 2015 - guidelines & appendices - revised 24 07 15.pdf

* Before commencement of documentation

- Read the guidelines
- Take a copy with you when you go to see the parents/carers
- Check available records that may give you some background information
- While completing the documents if certain sections are not applicable enter NA (not applicable), rather than leaving the section blank
- Parents/carers feel less threatened if certain direct/leading questions are asked as a part of the protocol document
- Seek advice from a senior member of the team if unsure about any section of the guidelines or the documentation process
- The description should be factual without any interpretation
- Record the details accurately
- Do not use jargon or acronyms
- For measurement purpose refer to:
  - Centimetre as: cm
  - Gram as: g
  - Kilogram as: kg
  - Millilitres as ml
  - Milligrams as: mg
- For description of time use 24:00h clock if possible otherwise state am/pm clearly and ensure that the date is appropriately advanced by +1 after midnight
- Enter the SURNAME in CAPITAL letters
- Record parents'/carers' full name along with their date of birth

Proforma for the management of Sudden Unexplained Death in Children

APPENDIX 1A: EMERGENCY DEPARTMENT ARRIVAL AND RESUSCITATION RECORD

(To be completed by the Duty Consultant Paediatrician)

Child/Hospital Details			
Child's Name:		**Date of Birth:**	
Hospital Number:		**Date of Death and Time:**	
Hospital Name:		**Place of Death eg ED/Other (Specify):**	
Name of A&E Consultant:		**Signature:**	
Name of A&E Resuscitation Nurse:		**Signature:**	
Date:		**Time:**	

Date / time when the child was found dead or collapsed:	
Date / time when ambulance/police were informed:	
Who called the ambulance?	

Arrival of Ambulance Team at the Scene		
Time ambulance team arrived at the scene:		
Condition of the infant as reported by the ambulance team:		
	YES	**NO**
Did the parents/carers undertake resuscitation?		
Did the child show any signs of life?		
Did the child show signs of rigor mortis?		
Did the child show signs of post mortem lividity?		
What was the room temperature?		
What was the child's temperature?		
Was resuscitation carried out (by the ambulance team)?		
- External cardiac massage given?		
- Bag and mask ventilation?		
- Oxygen by mask?		
- Endotracheal intubation undertaken?		
- Were any drugs given?		

(If Yes to drugs, please specify name and the dose):		
Were any intravenous fluids given?		
(If Yes to intravenous fluids, please specify name and volume):		
Did the team observe any signs of parental/carer alcohol intoxication?		
(If yes to intoxication, please give details):		
Any other observations reported by the ambulance team:		

Arrival in the Emergency Department			
Time of arrival in the A&E:			
Condition of the child upon arrival:			
		Yes	No
Was there any sign of life			
Did the child show signs of rigor mortis?			
Did the child show signs of post mortem lividity?			
What was the rectal temperature upon arrival:			

Any Other Comments:

Proforma for the management of Sudden Unexplained Death in Children

APPENDIX 1B: EMERGENCY DEPARTMENT ARRIVAL AND RESUSCITATION RECORD

(To be completed by the Emergency Department Duty Consultant Paediatrician)

Child/Hospital Details			
Child's Name:		**Date of Birth:**	
Hospital Number:		**Date of Death and Time:**	
Hospital Name:		**Place of Death eg ED/Other (Specify):**	
Name of A&E Consultant:		**Signature:**	
Name of A&E Resuscitation Nurse:		**Signature:**	
Date:		**Time:**	

	YES	**NO**
Was resuscitation undertaken (in ED)?		
Did the child show any signs of life?		
- External Cardiac Massage?		
- Endortracheal Intubation (Type and Size):		
- Time of intubation:		
- Who intubated the child?		
- Assisted ventilation with bag and mask?		
- Assisted ventilation with the endotracheal tube?		
- Defibrillation?		

Time of first vascular access:	
Type of vascular access (veinous/introsseus)	
Intravenous fluids given (name and volume given):	
Drugs given (name and dose):	
Chest drain/pericardiac tap/other procedures (specify):	

Total duration of the resuscitation:	
Time death declared:	
Doctor pronouncing the life extinct:	
Times parents informed:	
(This will always be done by the ED Consultant or the Duty Consultant Paediatrician)	

Any Other Comments:

(The Emergency Department Resuscitation sheets will be completed by the E D Consultant who leads the resuscitation procedure)

Proforma for the management of Sudden Unexplained Death in Children

APPENDIX 1C: INVESTIGATIONS AND TESTS TAKEN AT RESUSCITATION

**(To be completed by Emergency Department Duty Consultant Paediatrician.
The ED Nurse responsible for resuscitation documentation should keep a log of all investigations undertaken during the resuscitation.)**

Child/Hospital Details			
Child's Name:		**Date of Birth:**	
Hospital Number:		**Date of Death and Time:**	
Hospital Name:		**Place of Death eg ED/Other (Specify):**	
Name of A&E Consultant:		**Signature:**	
Name of A&E Resuscitation Nurse:		**Signature:**	
Date:		**Time:**	

Type of Test	Date & Time	Results	Tick if pending
Blood			
Urine			
Stool			
CSF			
Swab			
X-ray			
CT Scan			
MRI Scan			
Photographs			

Type of Test	Date & Time	Results	Tick if pending
Others			
Any Other Comments:			

Proforma for the management of Sudden Unexplained Death in Children

APPENDIX 2A: HISTORY RECORD

(To be completed by the Duty Consultant Paediatrician)

Child/Hospital Details			
Child's Name:		**Date of Birth:**	
Hospital Number:		**Date of Death and Time:**	
Hospital Name:		**Place of Death eg ED/Other (Specify):**	
Name of A&E Consultant:		**Signature:**	
Date:		**Time:**	

Circumstances of the Event	
Source of Information:	
Name of Paren(t) / Carer(s)	**Relationship to Child**

Date & Time when the child was found collapsed/dead:	
Name of the person who found the child collapsed/dead:	
Was it at home or at another place?	
If other than home, state the address:	
Which room of the House: *(Child's own bedroom/parental bedroom/other-please specify)*	
Where was the child found? *(Parental bed/cot/basket/sofa/other-please specify)*	
If parental bed, who was with the infant?	
If parental bed, what was the size *(single/double?)*	
What was the condition of the child?	
What position was the child found? *(Prone/Supine/other-please specify)*	
Was the baby's face covered with blankets or any other clothing?	

Did the child's mouth or nose appear blocked? *(If Yes, please give details)*	
Was there any evidence of vomiting? *(If Yes, please give details)*	
Was there any evidence of bleeding? If so, describe *(site, fresh whole blood/ serosanguinous/blood clots)*	
What made the carer see to the child? *(Feeding time/nappy change/ crying/too quiet/interval since previous contact/other-please specify)*	
Was the child on an apnoea alarm monitor? *(Should the infant/child be in an apnoea alarm monitor)*	
What time was the child last seen alive?	
Who was the person who last saw the child alive?	
What was the reason for attendance? (Feeding/changing, etc, please specify)	
What was the condition of the child?	
Who were the persons who looked after the child in the last twelve hours?	
Account preceding the event (record verbatim)	

Any Other Comments:

Proforma for the management of Sudden Unexplained Death in Children

APPENDIX 2B: HISTORY RECORD

(To be completed by the Duty Consultant Paediatrician)

Child/Hospital Details			
Child's Name:		**Date of Birth:**	
Hospital Number:		**Date of Death and Time:**	
Hospital Name:		**Place of Death eg ED/Other (Specify):**	
Name of A&E Consultant:		**Signature:**	
Date:		**Time:**	

SYMPTOMS IN THE LAST 72 HOURS				
How was the infant/child fed? Breast or Formula? (Name):				
Feeding pattern	**Type**	**Volume**	**Frequency**	**Additives**

What age was the infant weaned and what was the current regime?	
What time did the child have the last meal (in older child)?	
Did the child appear ill or unwell during the last 72 hours? *(If Yes, please give details)*	
Was the child feeding poorly? *(If Yes, please give details)*	
Did the child cry persistently or have poor sleep? *(If Yes, please give details)*	

Last Medical Attention	**Date**	**Reason**
Health Visitor		
GP Reason		
Emergency Department		
Any injury not reported? *(If Yes, please give details)*		

Last Medical Attention	**Date**	**Reason**

Child's Past Medical History			
Place of Birth:		Mode of Delivery:	
Gestation:		Birth Weight:	
APGAR Score/ Resuscitation at birth:			

	YES	**NO**
Did the infant require admission to the neonatal unit?		
(If Yes to the above question, please give details)		
Was the developmental progress normal?		
(If No to the above question, please give details)		
Was the child thriving and showing normal growth?		
(If No to the above question, please give details)		
Was the immunisation up-to-date?		
Any known allergies?		
(if Yes to the above question, please give details)		

Any Other Comments:

In older children the history needs to expand to include details about schooling and social interaction.

Proforma for the management of Sudden Unexplained Death in Children

APPENDIX 2C: HISTORY RECORD

(To be completed by the Duty Consultant Paediatrician)

Child/Hospital Details			
Child's Name:		**Date of Birth:**	
Hospital Number:		**Date of Death and Time:**	
Hospital Name:		**Place of Death eg ED/Other (Specify):**	
Name of A&E Consultant:		**Signature:**	
Date:		**Time:**	

Names, Ages, Relationships of those living/residing in the household (other than mother, siblings)		
Name	**Age**	**Relationship to Child**

Family History **Complete for mother, current partner, and other adults in the house, (e.g. father of other children, grandparents, day time carer or other household resident)**				
	Mother	**Father/Partner**	**Other Family Member/Carer**	**Other Family Member/Carer**
Date of Birth & Age				
Occupation				
Smoking (per day)				
Epilepsy (Y/N) *(If Yes, give details)*				
Sudden Adult Death (SAD) *(If Yes, give details)*				
Sudden Unexpected Death in Children				

Family History **Complete for mother, current partner, and other adults in the house, (e.g. father of other children, grandparents, day time carer or other household resident)**				
(If Yes, give details)				
Psychiatric Illness (Y/N) *(If Yes, give details)*				
Violence (Y/N) *(If Yes, give details)*				
Convictions (Y/N) *(If Yes, give details)*				
Alcoholic *(amount, type and when last taken)*				
Drugs *(name and time when last taken)*				
Other State *(epilepsy, diabetes, severe learning disabilities, cerebral palsy, etc)*				

Any Other Comments:

Proforma for the management of Sudden Unexplained Death in Children

APPENDIX 2D: HISTORY RECORD

(To be completed by the Duty Consultant Paediatrician)

Child/Hospital Details			
Child's Name:		**Date of Birth:**	
Hospital Number:		**Date of Death and Time:**	
Hospital Name:		**Place of Death eg ED/Other (Specify):**	
Name of A&E Consultant:		**Signature:**	
Date:		**Time:**	

Siblings		
Name	**Date of Birth**	**Sex**

Sibling History:	Name	Name	Name	Name	Name	Name
SIDS						
ALTE						
Seizure Disorder						
Medical condition						
Psychiatric Illness						
Substance Abuse						
Previous Non-						

Sibling History:	**Name**	**Name**	**Name**	**Name**	**Name**	**Name**
Accidental Injury						
Currently Subject to a Child Protection Plan						
Behavioural Disorder						
Violence						
Other						

Any Other Comments:

APPENDIX 3A: PHYSICAL EXAMINATION RECORD

(To be completed by the Duty Consultant Paediatrician)

Child/Hospital Details			
Child's Name:		**Date of Birth:**	
Hospital Number:		**Date of Death and Time:**	
Hospital Name:		**Place of Death eg ED/Other (Specify):**	
Name of A&E Consultant:		**Signature:**	
Date:		**Time:**	

	Please give details
Weight (kg):	
Length:	
Head Circumference (cm):	
Ophthalmic Examination: *(contact Ophthalmologist if required)*	
Pre-intubation Mouth Examination:	
ENT Examination:	
Sites of Medical Intervention:	
Any Visible Bleeding or Discharge:	
Photographs Required: *(Contact Senior Investigating Officer to arrange)* - Facial - Upper body - Entire body front - Entire body back	
Examination of Musculoskeletal System: Spine, Skull, Chest, Upper and Lower Limbs	
Describe and Measure any visible bruises, lacerations or signs of injury: *(Use body diagrams in Appendices 3B and 3C)*	

Observations About Parent(s) /Carer(s)	
Were there any inconsistencies in the history? If so, give details:	
Did parent(s)/carer(s) appear under the influence of alcohol? If so, give details.	
Any other observations?	

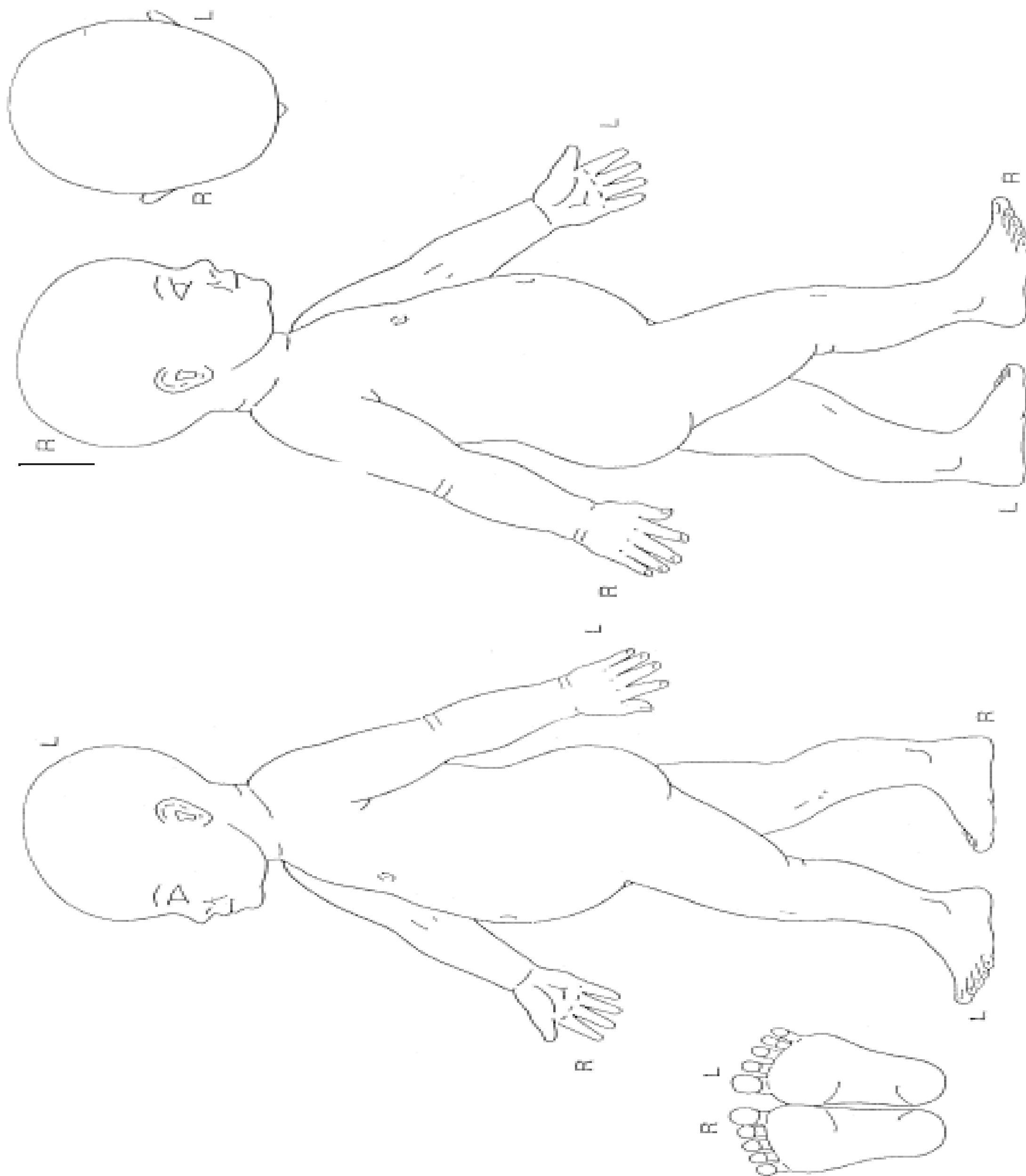
Any Other Comments:

Proforma for the management of Sudden Unexplained Death in Children

APPENDIX 3B: PHYSICAL EXAMINATION RECORD

(To be completed by the Duty Consultant Paediatrician)

Child/Hospital Details			
Child's Name:		**Date of Birth:**	
Hospital Number:		**Date of Death and Time:**	
Hospital Name:		**Place of Death eg ED/Other (Specify):**	
Name of A&E Consultant:		**Signature:**	
Date:		**Time:**	

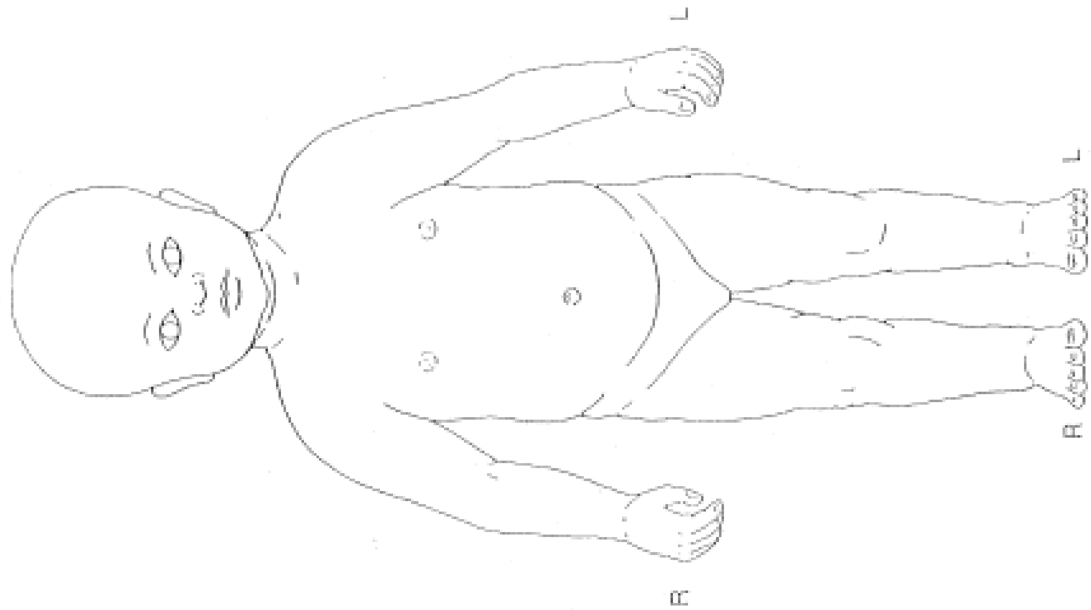


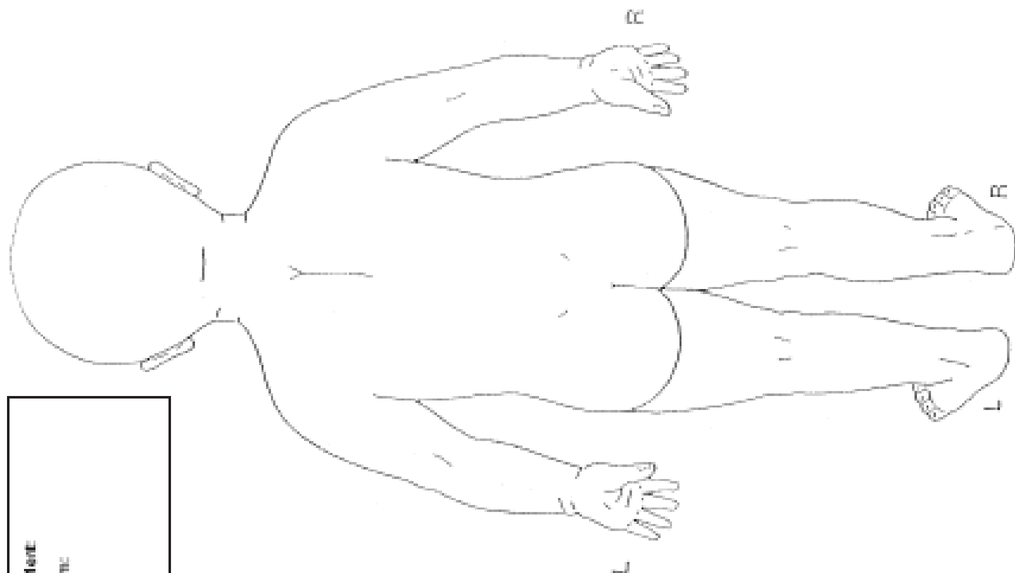
Proforma for the management of Sudden Unexplained Death in Children

APPENDIX 3C: PHYSICAL EXAMINATION RECORD

(To be completed by the Duty Consultant Paediatrician)

Child/Hospital Details			
Child's Name:		**Date of Birth:**	
Hospital Number:		**Date of Death and Time:**	
Hospital Name:		**Place of Death eg ED/Other (Specify):**	
Name of A&E Consultant:		**Signature:**	
Date:		**Time:**	





APPENDIX 4: COLLECTING POST MORTEM SAMPLES

1. All investigations listed below will be undertaken at post mortem. However, if for various reasons the post mortem is delayed and/or cannot be undertaken, the various pathology samples and investigations are required (see the list below).

2. Please discuss with the Coroner and/or the Pathologist before taking any samples or undertaking any further investigations.
3. All pathology samples must be collected in respective collecting media and appropriately labelled with the child's name, hospital number date and time and duly signed.

4. A record must be made of all samples taken and documented in the notes.

5. Appropriate laboratory requisition forms must be filled in if the samples are being sent to the local laboratory.

6. If the samples are being collected to accompany the body (as per advice of the Coroner or the Pathologist), these samples must be labelled and sealed in specially designed police bags and handed over to the police.

7. Discuss with the Coroner and the Radiologist if an immediate skeletal survey or radiology is required.

8. Discuss with the SIO if any photography is required.

Blood culture: Aerobic & Anaerobic cultures

Blood: Viral studies (5ml clotted blood)

Blood chemistry Neonatal screening blood test card (5ml Lithium Heparin) for

- Hb CO (Carboxy Haemoglobin)
- MetHb (Methaemoglobin)
- Liver function tests
- Amino acids*
- MCAD (Medium Chain Acyl-CoA-dehydrogense)*

Blood: drug assay (5ml clotted)*
(Opiates, Benzodiazepines, Alcohol, Salicylates, Paracetamol)
Blood: EDTA sample 2ml for Metabolic screen (Organic and Fatty acids)* & DNA studies
Urine sample (Suprapubic aspiration) for Infection, Drug assay, acy l-carnitine, MCAD, Conitine assay, Organic and Amino acids
Swab visible blood before cleaning

Photographs for post mortem: Specific photograph for suspected injuries or external anomaly (ies)
Skeletal survey before post mortem: (AP and lateral views)

Independent check for ETT localisation (or capnograph trace)

* *these tests can be done on either blood or urine*

Proforma for the management of Sudden Unexplained Death in Children

APPENDIX 5: INVESTIGATIONS AND TESTS UNDERTAKEN AFTER FAILED RESUSCITATION

(To be completed by the Duty Consultant Paediatrician)

Child/Hospital Details			
Child's Name:		**Date of Birth:**	
Hospital Number:		**Date of Death and Time:**	
Hospital Name:		**Place of Death eg ED/Other (Specify):**	
Name of A&E Consultant:		**Signature:**	
Date:		**Time:**	

	YES	**NO**
Blood culture		
Aerobic		
Anaerobic		
Blood Viral studies (5ml clotted blood)		
Urine sample (Suprapubic for infection, drugs, acy l-carnitine, MCAD),		
organic and amino acids		
Blood chemistry		
Neonatal screening **blood test card**		
Blood (5ml Lithium Heparin)		
Hb CO (Carboxy Haemoglobin)		
MetHb (Methaemoglobin)		
Liver function tests		
Amino acids*		
MCAD (Medium Chain Acyl-CoA-dehydrogense)*		
Blood drug assay (5ml clotted)*		
(Opiates, Benzodiazepines, Alcohol, Salicylates, Paracetamol)		
Blood (EDTA sample 2ml) for		
Metabolic screen (Organic and Fatty acids)*		
DNA studies		
Swab visible blood before cleaning		
Photographs for autopsy (Discuss with SIO)		
Specific photograph		
? NAI		
External anomaly		
Skeletal survey before post mortem:(discuss with radiologist)		
Independent check for ETT localisation		
* these tests can be done on either blood or urine		

Proforma for the Management of all Child Deaths

APPENDIX 6: FORM A – NOTIFICATION OF CHILD DEATH

(To be completed following confirmation of a child death)

Notification to be reported to the Child Death Overview Panel (CDOP) Manager (or equivalent):			
CDOP:	PAN Cheshire CDOP Administrator	**Email:**	CDOP@cheshireeast.gcsx.gov.uk
Tel:	01606 288923		

The information on these forms and the security for transferring it to the CDOP Co-ordinator should be clarified and agreed with your local Caldicott guardian.

If there are a number of agencies involved, liaison should take place to agree which agency will submit the Notification.

Child's Details		
Full Name of Child:		
Any aliases:		
Date of Birth: **Age in days/ months/ years:**		**NHS No**
Address:		
Postcode:		
School / Nursery, etc:		
Date & Time of Death:	**Time**	
Other Significant Family Members:		

Referral Details	
Date of Referral:	
Name of Referrer:	
Agency:	
Address:	
Tel Number:	
Email:	

Details of the Death	
Location of death or fatal event ***(Give address if different from above)***	
Death expected?	
Reported to Coroner:	
Reported to Registrar:	
Has a medical certificate of cause of death been issued?	
Post mortem examination:	

Notification Details:
Please outline circumstances leading to notification.

Check List of Notification:	
Persons Notified	**Please tick**
Coroner	
Child Death Co-Ordinator	
Designated Doctor for Child Deaths	
CDOP Nurse	
Named Nurse for Safeguarding Children	
Health Visitor (Paediatric Liaison)	
Designated Nurse for Safeguarding Children	

APPENDIX 7: CONTACT PERSONNEL

Coroner's Office

Mr Nicholas Rheinberg
HM Coroner Cheshire

In hours 01925-444216
Safe fax 01925-444219
Out of hrs 077 300 75820
nrheinberg@warrington.gov.uk

Monday – Friday 08:00 to 16:00

To report a death or seek advice contact:

Chester District
01925 442473/4

Crewe District
01925 442479/81

Macclesfield District
01925 442478/83

Warrington District
01925 442475/6/7

Alternatively contact the Coroner's office in Warrington: 01925 444216.

The office is closed for thirty minutes from 12:30 each day

OUT OF HOURS

The Coroner: 077 300 75820
nrheinberg@warrington.gov.uk

Form A – Child Death Notification

All Form A's to be sent to:
Pan-Cheshire CDOP Admin
CDOP@cheshireeast.gcsx.gov.uk
Tel: 01606 288923

SUDDEN UNEXPECTED DEATH IN INFANTS AND CHILDREN (SUDIC)

Designated Doctors for Child Deaths and SUDIC/CDOP Nurses

Warrington

Dr Nisar Mir (SUDIC & CONI)
In hours 01925-662215
Safe fax 01925-662009
nisar.mir@whh.nhs.uk

CDOP Nurse – vacant post

Crewe and Macclesfield

Dr Arumugavelu Thirumurugan
In hours: 01270 612294
Safe fax: 01270 273491
a.thirumurugan@nhs.net

Specialist Nurse for CDOP – Janice Bleasdale
In hours: 01606 288923
Mobile: 07920 765220
jbleasdale@nhs.net

Chester

Dr: Rajiv Mittal
In hours: 01244 364802
Safe fax: 01244 365089
rmittall@nhs.net

Specialist Nurse for Safeguarding/CDOP
Sharon Dodd
In hours: 01244 393332
sharon.dodd@nhs.net

Halton

Dr Suprio Bhattacharyya
In hours: 01928-593029
Safe fax: 01928-569532
Suprio.Bhattacharyya@hsthpct.nhs.uk