# SUDDEN DEATH POLICY

Includes notification form for
Sudden Unexplained Death in Infancy

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<tr>
<th>First Issued</th>
<th>Issue Version</th>
<th>Purpose of Issue/Description of Change</th>
<th>Planned Review Date</th>
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<tbody>
<tr>
<td>January 2007</td>
<td>One</td>
<td>Outlines the process that staff are required to follow in the event of a sudden death</td>
<td>2009</td>
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<tr>
<th>Named Responsible Officer:-</th>
<th>Approved by</th>
<th>Date</th>
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<tr>
<td>Patient Safety Improvement Advisor</td>
<td>General Policy Group</td>
<td>January 2007</td>
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**Policy File:** General Policy

- Impact Assessment Screening Complete- Date:- Jan 07
- Full Impact Assessment Required- No

No 30
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SUDDEN DEATH POLICY

This policy applies where the death of the individual is beyond reasonable doubt – if in any doubt commence basic life support or contact emergency services.

POLICY STATEMENT

It is the policy of Wirral PCT to ensure that all suddenly deceased individuals, either in their own home, care setting or on PCT premises are dealt with in a dignified and respectful manner.

POLICY AIM

The policy will outline the process that staff are required to follow in the event of a sudden death.

POLICY OUTCOMES

- The sudden death of a patient will be dealt with in a timely, sensitive and caring manner, respecting the dignity, religious and cultural beliefs of patients, relatives and carers.
- All staff will adhere to related PCT Policies
- All staff will work co-operatively with emergency services and the Coroners Office.

TARGET GROUP

All directly employed staff, bank staff and students on placements.

CROSS REFERENCE to related PCT Policies:-

- Policy for when Resuscitation is no longer appropriate
- Basic life support policy
- Paediatric basic life support policy
- Incident Reporting Policy
- Health Records Policy
- Vulnerable Adult Policy
- Failure to Gain Access Policy
- Sudden Unexpected Death in Infancy Policy (April 2006) Safe Guarding Children’s Board
- Domestic Violence Policy

National Guidance

Help is at Hand – Department of Health (2006) publication
DEFINITIONS:
Deaths fall into two main categories, expected death or sudden unexpected death:

1. **Expected deaths**: Those whereby the General Practitioner/Consultant/Medical Officer concerned has diagnosed the patient as suffering from a terminal illness and has been seen by a registered medical practitioner within the previous 14 days and is not a case reportable to the coroner (in the community the registered medical practitioner is usually the patients own GP)

   *There is an expectation that any known Health and Safety Risk will have been shared by the Medical Officer concerned with any other Medical Officer or health agency who will be dealing with the individual.*

2. **Sudden death**: is any violent or unnatural death, a death of which the cause is unknown or unanticipated and may also include those that occur in unexplained or suspicious circumstances.

3. **Unexpected death**: this term is specifically used when deaths occur in unexplained or suspicious circumstances.

**In the event of a sudden death**:–

- Try not to disturb the scene, i.e don’t touch, move or disturb anything.
- Do not remove any parental drug administration equipment or any life prolonging equipment prior to the police attending the scene
Pathway in the Event of a Sudden Death

Risk Assess the situation to maintain Health and Safety

**Member of staff responding to a Sudden Death**

Only applies where the death of an individual is beyond reasonable doubt

- **Expected Death**
  - With no related incident reports eg drug errors
  - Inform GP and if notifiable Coroner

- **Sudden Death**
  - In either patients home or on PCT premises – *do not disturb the scene*
  - Phone emergency number applicable to the area. Clearly state where emergency crew must attend – give directions if necessary
  - If staff arrive at someone’s home, cannot gain access but can see the individual, the emergency services must be called

- **Sudden Unexpected Death in Infancy**
  - Phone emergency number applicable to the area
  - Wait for emergency services to arrive
  - Death will be confirmed by the ambulance crew
  - Ambulance Control will notify Police
  - No health professional should remove any equipment from a dead child until death confirmed by a medical practitioner, the environment should be disturbed as little as possible
  - Inform your line manager
  - Complete incident form before end of working shift
  - Make thorough notes in health care records
  - Inform child’s GP
  - Inform Senior Nurse for Safeguarding Children

- **Expected Death**
  - With no related incident reports eg drug errors
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  - Make thorough notes in health care records
  - Inform child’s GP
  - Inform Senior Nurse for Safeguarding Children

**Sudden Death Policy**

5/16
**Line Managers** in the event of an unexpected death you must also:-

- Inform the PCT Patient Safety & Quality Improvement Advisor immediately, they will decide if STEIS needed
- Inform the Head of Provider Services, who will inform Communications Lead
- Inform the Service Manager for your area
- If death is suspicious – contact Police
- Liaise with the police and with the Coroner’s Office in cases of Sudden Death
- Inform the Health and Safety Manager – if any related risk issues
- If out of hours contact the on-duty manager, through Arrowe Park Hospital switchboard. Tel: 0151 678 5111
- If contacting a GP, use GP Out of Hours service after 18.30 hrs and at weekends
- After discussion with emergency services, agree most sensitive way of informing next of kin
- Collect and secure the completed patient record the same working day
Pathway in the Event of a Sudden Death at Walk in Centre
/Minor Injuries Unit at Victoria Central Hospital

Risk Assess the situation to maintain Health and Safety

Member of staff responding to a Sudden Death
Only applies where the death of an individual is beyond reasonable doubt

If in any doubt commence basic life support

Sudden Death
If doctor on duty

Doctor verifies death

Doctor contacts Coroners Office Tel: 625 2207 during normal office hours otherwise contact Police
• No health professional should remove any equipment from a dead patient until death confirmed by a medical practitioner

Sudden Death
If no doctor on duty

Phone emergency number applicable to the area. Clearly state where crew are to attend

Death will be verified by the ambulance crew
No health professional should remove any equipment from a dead patient until authorised by Police or Coroner and documented same in patient records

Sudden Unexpected Death in Infancy

Phone emergency number applicable to the area. Clearly state where crew are to attend

• Wait for emergency services to arrive
Death will be confirmed by the ambulance crew
Ambulance Control will notify Police who will invoke SUDI protocol
• No health professional should remove any equipment from a dead child until death confirmed by a medical practitioner.
• Complete incident form before end of working shift
• Complete health care records
• Inform child’s GP
• Inform Senior Nurse for Safeguarding Children

Nurse in charge to contact Coroners Office Tel:
625 2207 during normal office hours otherwise contact Police

Coroners Office or Police arrange for body to be removed

• Complete incident form before the end of working shift
• Complete health care records
• Inform GP

Coroners Office or Police arrange for body to be removed

• Complete incident form before the end of working shift
• Complete health care records
• Inform GP

Complete ‘Sudden Unexpected Death in Infancy’ notification form Appendix C
**Nurse in Charge** in the event of an unexpected death must also:-

- Inform the PCT Patient Safety & Quality Improvement Advisor immediately, they will decide if SteIS needed
- Inform the Head of Provider Services, who will inform Communications Lead
- Inform the Service Manager for your area
- If death is suspicious – contact Police
- Liaise with the police and with the Coroners Office in cases of Sudden Death
- Inform the Health and Safety Manager – if any related risk issues
- If out of hours contact the on-duty manager, through Arrowe Park Hospital switchboard. Tel: 0151 678 5111
- If contacting a GP, use GP Out of Hours service after 18.30 hrs and at weekends
- After discussion with emergency services, agree most sensitive way of informing next of kin
- Collect and secure the completed patient record the same working day
Pathway in the Event of a Sudden Death at Walk in Centre at Arrowe Park Hospital

Risk Assess the situation to maintain Health and Safety

Member of staff responding to a Sudden Death
Only applies where the death of an individual is beyond reasonable doubt

If in any doubt commence basic life support

Sudden Death

Nurse in Charge to contact Accident & Emergency Department to request a doctor to verify death

Sudden Unexpected Death in Infancy

Phone emergency number applicable to the area

- Wait for emergency services to arrive
- Death will be confirmed by the ambulance crew
- Ambulance Control will notify Police who will invoke SUDI protocol

- No health professional should remove any equipment from a dead child until death confirmed by a medical practitioner
- Complete incident form before end of working shift
- Complete health care records
- Inform child's GP
- Inform Senior Nurse for Safeguarding Children

Coroners Office or Police arranges for body to be removed

- Steps may be taken to maintain the dignity of the individual, disturb as little as possible
- Complete incident form before the end of working shift
- Complete health care records
- Inform GP

Complete ‘Sudden Unexpected Death in Infancy’ notification form
Appendix C
Nurse in Charge in the event of an unexpected death must also:

- Inform the PCT Patient Safety & Quality Improvement Advisor immediately, they will decide if STEIS needed
- Inform the Head of Provider Services, who will inform Communications Lead
- Inform the Service Manager for your area
- Liaise with the police and with the Coroners Office in cases of Sudden Death
- If death is suspicious – contact Police
- Inform the Health and Safety Manager – if any related risk issues
- If out of hours contact the on-duty manager, through Arrowe Park Hospital switch board. Tel: 0151 678 5111
- If contacting a GP, use GP Out of Hours service after 18.30 hrs and at weekends
- After discussion with emergency services, agree most sensitive way of informing next of kin
- Collect and secure the completed patient record the same working day

IN ALL CIRCUMSTANCES

Nurse in Charge or Service Lead must inform the Patient Safety & Quality Improvement Advisor in the event of a sudden unexpected death. This will apply to the named situations above and those that may occur outside of the given pathways.
STAFF SUPPORT

Arrangements for staff support following a sudden death incident will be made by the line manager and via Occupational Health if necessary.

INCIDENT REPORTING

Any incident that occurs relating to the circumstances of the death or during the care of the deceased must be reported to the line manager. Trust incident reporting procedures must be followed.

TRAINING

Service managers to link KSF outlines and staff responsibilities to any identified learning opportunities at individual PDR’s and service training plans in order to fulfil the expectations of this policy.

EQUALITY AND DIVERSITY

Staff need to be familiar with the contents of the resource file ‘Wirral Ethnic Minorities Information and Resource File’ (June 2003) Published by Wirral Ethnic Health Advisory Group.

RESPONSIBILITIES OF MANAGERS

It is the responsibility of all managers to include awareness of this policy at induction, during PDR reviews when applicable to KSF outlines and at team meetings when launched or updated.

If relevant to service area managers need to raise staff awareness of responsibilities in relation to the:-
- Sudden Unexpected Death in Infancy Policy (April 2006) Safe Guarding Children’s Board

RESPONSIBILITIES OF STAFF

To comply with PCT policies and:-
- Attend Basic Life Support update sessions every year
- Attend Equality and Diversity training sessions at least every 2 years
- Attend yearly Advanced Life Support updates, if specified for role
Memo of Understanding – Medical Director of GP Out of Hours

Unexpected Death – Pathway for GP Out of Hours

Expected Death

- Found dead at home
- No contact with doctor (previous 14 days) if patient is not known to the pronouncing doctor
- Sudden MI – even if history of IHD
- Police need to break in (no answer and Police do not feel suspicious death)

Call may come directly to Out of Hours

Police

GP visit to confirm death if unexpected or if specific problems eg Asbestosis/Alcohol etc. if patient is not known to pronouncing doctor

North West Ambulance Service

Their Policy to call GP OOH to confirm death

GP Visit

Police then refer to Coroner

? Suspicious

Police

Police Surgeon

Coroner

Police service would only call Police Surgeon (Forensic Doctor) if they feel that there were suspicious circumstances.

If sudden death and Police Officer DOES NOT feel the circumstances are suspicious then their policy is to call that patient’s doctor or the GP OOH to confirm death prior to calling their own undertaker and referring to the Coroner.

Doctor is ONLY confirming death NOT deciding if suspicious or not. If doctor has concerns that death is “suspicious” then should advise Police and document. Ultimately it is the Police Officer’s decision that the Police Surgeon is called.

Sudden Death Policy
12/16
Sudden Unexpected Death Infant
If the Health Visitor is first on the scene

1. Dial 999 and ask for an Ambulance to attend the scene immediately.

2. Attempt resuscitation if trained or as instructed by the Ambulance Service. If the indications are that the baby is dead and no active resuscitation has been attempted, the body should remain in situ pending the arrival of the Police.

3. The position of the baby and the condition in which it was found, must be noted together with any comments/explanations of the parent/guardian or any other person at the scene. Try not to disturb the scene, i.e. don’t touch, move or disturb anything.

4. When the Paramedics arrive, spend time listening to the parents and offering support.

5. If the parent/carer goes to the hospital with the baby, ensure that appropriate arrangements are made for the care of the siblings if necessary.

6. If the mother is alone, ensure that she has the appropriate family support. Give the parents a work telephone number where you can be contacted.

7. As soon as possible after the incident and within 24 hours make a precise and thorough record of the event in the child’s record. Making particular reference to:
   a. Any inappropriate delay in seeking help
   b. The position of the baby and the condition in which it was found
   c. Inconsistent explanations - accounts should be recorded verbatim in quotes where appropriate
   d. Evidence of drugs/alcohol abuse
   e. Parents reaction/demeanour
   f. Unexplained injury e.g bruises, burns, bites, presence of blood
   g. Neglect issues
   h. Position of the baby and its surroundings
   i. General condition of the accommodation
   j. Evidence of high risk behaviour eg domestic violence

NB if the records have already been secured, record on a continuation sheet which can be added to the child’s records.

8. Ensure that Appendix C SUDI/ALTE Notification/ Incident Form of the SUDI Protocol is completed and forwarded to the Designated Nurse for the area for onward transmission to the Strategic Health Authority.

Reference
Sudden Unexpected Death in Infancy (2006)
This form is to be completed by a health professional when:

a) a child under the age of 24 months dies at home and is taken to an Accident and Emergency (A&E) Department

b) a child under the age of 24 months dies on an A&E Department, maternity Unit or paediatric ward

c) a child for whom they have professional responsibility is notified to them as a S.U.D.I or Acute Life Threatening Event (ALTE)

<table>
<thead>
<tr>
<th>Name of Child</th>
<th>Date of Birth</th>
<th>Date of Death</th>
<th>Time of Death</th>
</tr>
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<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
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<table>
<thead>
<tr>
<th>Home Address</th>
<th>Address Child Found</th>
</tr>
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<tbody>
<tr>
<td>Tel.</td>
<td>Tel.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Name of Mother</th>
<th>Name of Father</th>
<th>Name of Main Carer (If different from parents)</th>
</tr>
</thead>
<tbody>
<tr>
<td>D.o.b</td>
<td>D.o.b</td>
<td>Relationship:</td>
</tr>
</tbody>
</table>

Professionals involved with the family:

<table>
<thead>
<tr>
<th>Name</th>
<th>Discipline</th>
<th>Contact Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>GP</td>
<td></td>
<td>N/A</td>
</tr>
<tr>
<td>HV/Nurse</td>
<td></td>
<td>N/A</td>
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</table>

Had the child been in the care of the SW Team

Details of professionals involved in the SUDI, if known.

<table>
<thead>
<tr>
<th>Name</th>
<th>Contact details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Police S.I.O</td>
<td></td>
</tr>
<tr>
<td>Community Paediatrician</td>
<td></td>
</tr>
<tr>
<td>SW Team Manager</td>
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Are the circumstances thought to be suspicious (please delete)  YES / NO

Was the baby transferred to Alder Hey Hospital (please delete)  YES / NO

Date of S.U.D.I Strategy Meeting ____________________________  Time ____________________________

Venue of Meeting ___________________________________________  Date ____________________________

Name & Signature __________________________________________  Designation _______________  Base _________________  Tel ___________________

This form to be faxed to (please see full policy details on PCT intranet site details)

- The Designated Nurse and Doctor for the area who will notify: the relevant DPH and Senior Manager for notification to the SHA, and the Police Public Protection Unit fax 0151 777 4782
- The relevant Safeguarding Unit

GLOSSARY OF TERMS / ABBREVIATIONS

SUDDEN UNEXPLAINED DEATH IN INFANCY (S.U.D.I.) Notification / Incident Form

Sudden Death Policy
14/16
ALTE – Acute Life Threatening Event

Dob – date of birth

GP – General Practitioner

HV – Health visitor

IHD – Ischaemic Heart disease

MI – Myocardial Infarction

MRAS – Merseyside Regional Ambulance Service

DPH – Director of Public Health

PDR – Personal Development Review

SHA – Strategic Health Authority

SIO – Senior Investigating Officer

StEIS – Strategic Electronic Information System to report adverse events to the Strategic Health Authority

SW – Social worker

SUDI – Sudden Unexplained Death of an Infant
Audit Tool

1. Is the definition of a sudden death clear?
2. Is pathway in event of sudden death clear (page 5)?
3. Is it clear who to contact in the event of sudden unexpected death in infancy?
4. In sudden unexpected death of an infant, is it clear what to do if Health visitor is first on the scene?
5. Does the pathway for GPOOH (appendix A) clearly state who should be contacted?