

Death of a Child in the Emergency Department

Committee on Pediatric Emergency Medicine

The death of a child in the Emergency Department (ED) is most often a sudden, unexpected event. A pediatrician working in the ED should remain sensitive to the grief of the family while obtaining a medical and social history and conducting a thorough physical examination and evaluation, attempting to determine the cause of the child's death. Pediatricians are in a unique position to help formulate ED policy and procedure and to help provide support and guidance for the family. In addition, the needs of the nursing staff, emergency medical services responders, and other ancillary personnel involved in the child's care should be considered.

Uniform protocols for the investigation of child and infant deaths would contribute to progress in the understanding of sudden infant death syndrome (SIDS), missed cases of child abuse and neglect, undiagnosed familial genetic diseases, and the detection of public health threats and inadequate medical care.¹

A response to this problem by many states has been the formation of child death review teams.² Since 1978 when the first team originated in Los Angeles, CA, child death review teams have been established to cover 40% of the nation's population. Multiagency child death review involves a systematic multidisciplinary and multiagency process to coordinate and integrate data and resources from coroners and medical examiners, law enforcement, courts, Child Protective Services, and health care providers. Pediatricians are encouraged to support the implementation of child death review teams in their county or state. In addition, they are encouraged to participate in the process as a member of the team.

Emergency departments should have written policies and procedures with accompanying checklists to be instituted in the event of a child's death. Many states have legislated a mandatory request for organ/tissue donation at the time of a child's death. In other states the coroner/medical examiner may want to be notified before the request for donation is made. In either case documentation of the request should be a part of ED procedure and included on any checklist that is used.

The attending physician is responsible for accurate and detailed medical record documentation. This documentation should include details of any resuscitation or other treatment conducted before admission to the hospital or in the ED; notation of the time

of death; the child's history and circumstances leading to the death; the physical examination including core body temperature on arrival and findings on examination of the optic fundi, skin, and genitalia; presumed diagnosis; notation of laboratory or any other evaluation performed in the ED; and notification of the parents and/or guardians, medical examiner, child's physician, Child Protective Services, and police, if indicated.

When possible, documentation should include relative findings from a review of any previous medical records of the patient.

The evaluation to determine the cause of the child's death is initiated in the ED and documented on the medical record. Such an evaluation might include a skeletal survey, cultures, drug screen, photographs of injuries, and forensic evaluation for sexual assault. If the diagnosis of SIDS is being considered, the clinician should be careful to follow the recommendations in the statement from the Committee on Child Abuse on Distinguishing Sudden Infant Death From Child Abuse Fatalities.³

In most circumstances, it is important that evaluation of the child be coordinated with that of the medical examiner. The coroner or medical examiner should be notified of all deaths. It is recommended that autopsies be required on all deaths of children that (1) result from trauma; (2) are unexpected, including SIDS; and (3) are suspicious, obscure, or otherwise unexplained.¹

The police and/or Child Protective Services should be notified as appropriate. All unexpected deaths of children less than 6 years of age, including those that are unanticipated, that are the result of trauma, or of which the circumstances are suspicious, obscure, or otherwise unexplained, require a more comprehensive investigation including an autopsy, an investigation of the circumstances of the death, a review of the child's medical and family history, and a review of information from relevant agencies and health care providers.

Interventional counseling and support for the parents, siblings, and other family members is essential to facilitate a normal grieving process.⁴ Possible resources include social services or chaplaincy. Community resources may be used to provide ongoing counseling or support. The grief of siblings, other family members, or other children involved in the death should not be overlooked.⁵ The ED should have a private, established area where the family may grieve and speak with physicians, nurses, chaplains, social workers, child protection services, or police. Parents should be offered the opportunity to hold or

The recommendations in this policy statement do not indicate an exclusive course of treatment or procedure to be followed. Variations, taking into account individual circumstances, may be appropriate.
PEDIATRICS (ISSN 0031 4005). Copyright © 1994 by the American Academy of Pediatrics.

at least see the deceased child in a timely, sensitive, and private manner.

Personal or referring physicians should be immediately notified of the child's death. They should be encouraged to be involved in the immediate support of the family or in counseling the family regarding autopsy findings in a postmortem conference. Involved and referring physicians should receive a copy of the autopsy report and be responsible for informing the family. For children who do not have a personal physician or in other circumstances, postmortem procedures should ensure that parents receive a written report and explanation of autopsy findings. The timing of the release of the autopsy report should be coordinated with Child Protective Services if warranted.

The pediatrician should also be aware that the death of a child may be particularly stressful for pre-hospital care workers, nursing staff, or other physicians involved in the death. Critical incident stress debriefing has been recognized as a method of addressing the emotional needs of professionals involved in situations such as a child's death.⁶ When the services of a critical incident stress debriefing team are available, they should be initiated within 24 hours after the incident. When critical incident stress debriefing is not available, other community resources such as psychological or psychiatric counseling could be used.

RECOMMENDATIONS

1. Pediatricians should participate in the formation and function of child death review teams in their state and local community.
2. Emergency departments should have written policies in place regarding procedures to follow after a child's death.
3. The medical examiner should be notified of all deaths. Autopsies should be required on all deaths of children that (1) result from trauma; (2) are unexpected, including SIDS; and (3) are suspicious, obscure, or otherwise unexplained.¹
4. All unexpected deaths of children under 6 years of age require a more comprehensive investigation including an autopsy, investigation of the circumstances of the death, review of the child's medical and family history, and a review of information from relevant agencies and health providers.
5. The grief of the family should be addressed using community resources. A private area should be established within EDs for grieving families. Parents should be given the opportunity to hold or at least

see their child in a sensitive, private, and timely manner.

6. Personal or referring physicians should be notified of the child's death. Personal physicians are encouraged to be involved in the support of the family and in holding a postmortem conference when autopsy findings are discussed. This conference should be timed to follow completion of the death scene investigation.
7. Critical incident stress debriefing or other available support resources should be utilized for health care professionals who have been emotionally stressed by the child's death.

COMMITTEE ON PEDIATRIC EMERGENCY MEDICINE, 1993 to 1994

Joseph A. Weinberg, MD, Chairperson
George L. Foltin, MD
J. Alexander Haller, Jr, MD
Dee Hodge III, MD
Marc L. Holbrook, MD
Jane Knapp, MD
William J. Lewander, MD
Calvin C.J. Sia, MD
Robert A. Wiebe, MD

LIAISON REPRESENTATIVES

Jean Athey, PhD, Maternal and Child
Health Bureau
Max L. Ramenofsky, MD, American
College of Surgeons
Robert W. Schafermeyer, MD, American
College of Emergency Physicians

AAP SECTION LIAISONS

Patricia J. Davidson, MD, Section on
Anesthesiology
Michele Moss, MD, Section on Critical
Care
James O'Neill, MD, Section on Surgery

REFERENCES

1. American Academy of Pediatrics, Committees on Child Abuse and Neglect and Community Health Services. Investigation and review of unexpected infant and child deaths. *Pediatrics*. 1993;92:734-735
2. Durfee MJ, Gellert GA, Tilton-Durfee D. Origins and clinical relevance of child death review teams. *JAMA*. 1992;267:3172-3175
3. American Academy of Pediatrics, Committee on Child Abuse and Neglect. Distinguishing sudden infant death from child abuse fatalities. *Pediatrics*. In press
4. Dubin WR, Sarnoff JR. Sudden unexpected death: intervention with the survivors. *Ann Emerg Med*. 1986;15:54-57
5. American Academy of Pediatrics, Committee on Psychosocial Aspects of Child and Family Health. The pediatrician and childhood bereavement. *Pediatrics*. 1992;89:516-518
6. Mitchell JT. When disaster strikes...the critical incident stress debriefing process. *J Emerg Med Services*. 1983;8:36-39

Death of a Child in the Emergency Department
Committee on Pediatric Emergency Medicine
Pediatrics 1994;93;861

Updated Information & Services

including high resolution figures, can be found at:
<http://pediatrics.aappublications.org/content/93/5/861>

Permissions & Licensing

Information about reproducing this article in parts (figures, tables) or in its entirety can be found online at:
<http://www.aappublications.org/site/misc/Permissions.xhtml>

Reprints

Information about ordering reprints can be found online:
<http://www.aappublications.org/site/misc/reprints.xhtml>

American Academy of Pediatrics

DEDICATED TO THE HEALTH OF ALL CHILDREN™



PEDIATRICS®

OFFICIAL JOURNAL OF THE AMERICAN ACADEMY OF PEDIATRICS

Death of a Child in the Emergency Department
Committee on Pediatric Emergency Medicine
Pediatrics 1994;93;861

The online version of this article, along with updated information and services, is located on the World Wide Web at:

<http://pediatrics.aappublications.org/content/93/5/861>

Pediatrics is the official journal of the American Academy of Pediatrics. A monthly publication, it has been published continuously since 1948. Pediatrics is owned, published, and trademarked by the American Academy of Pediatrics, 141 Northwest Point Boulevard, Elk Grove Village, Illinois, 60007. Copyright © 1994 by the American Academy of Pediatrics. All rights reserved. Print ISSN: 1073-0397.

American Academy of Pediatrics

DEDICATED TO THE HEALTH OF ALL CHILDREN™

