

## **Pediatric Death in the ED: Communicating News, Administrative Duties, Care Initiatives**

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## COMMUNICATING NEWS

The unexpected death of a child is always hard and painful to the family and to the ED staff (albeit in a much different and less intense way). Caregivers must be prepared to ensure the child's family gets the care they need despite the emotional demands the situation places on caregivers.

### 1. Preparation

A. Prepare the family by providing information during the treatment/resuscitation process. If death seems likely, ideally a chaplain, social worker, or nurse will become the family's link to the treatment process. As the situation deteriorates, that person needs to be able to say to the family, "The team needs you to know that..."

- ...they are working very hard to keep his heart beating."
- ...they've started CPR because the heart is not beating on its own."
- ...the injuries are severe and may be life-threatening."
- ...there may be no way to control the severe bleeding. The bleeding is life-threatening."

B. Before meeting the family

- Ensure there is no blood on the clothes of anyone who will meet the family.
- Ensure there is privacy for the conversation.
- Know the child's name.
- Know with whom you will be talking and the emotional state of parents and their supporters; support services will assist.
- Children in attendance will likely remain with the family. Work with support services to determine a course of action. Children should not be automatically excluded from the notification, but they should not stay if witnessing the emotional outburst, hearing the description of what happened, and/or being present for questions and answers would likely be traumatic.
- Focus your attention on the parents rather than the calmest or most distressed person(s).
- Relate with caring voice tones and mannerisms.
- Use understandable language. Avoid medical jargon and acronyms.
- Give your name and describe your area of medical expertise (e.g., orthopedics, neurosurgery, surgery, etc.).
- The patient and family's memory of you and the hospital will be formed by both your competency and your compassion.

### 2. Delivering the death notification

A. Speak with the family as soon as possible.

B. Identify the parents.

C. If the parents are seated, when possible sit near them. Don't tell them to sit down, but instead ask, "Can we sit down?"

- D. Assume the parents have only one thing on their mind: Is their child alive? Given this, be prepared to deliver the news compassionately and quickly.
- E. Communicating the news:
  - a. Be calm and paced.
  - b. Identify yourself and your role in the treatment and convey the outcome
  - c. Example: "I'm Dr. Smith. I have been taking care of (name of child) since she/he arrived. I have hard news to share. I am so very sorry to tell you that (child's name) has died."
- F. When a death notification is given, expect an emotional expression. Use support services to assist at this time.
- G. Immediately after the notification is given, typically the parents/family will be so emotionally overwhelmed that it is impossible for them to ask their questions are. Do not press them for their questions at the time of the death notification or to seek information you may need about what happened. Return later for these.
- H. Convey condolences, avoid any statement that is trite or patronizing. Resist the urge to try and "fix" their pain with platitudes. Say, "Again, I am so sorry. I will come back in a little while to answer questions and talk with you about what will happen next."

## ADMINISTRATIVE DUTIES

When anyone dies, there are standard duties that must be performed in order to document the death with the appropriate authorities and prepare the body for burial or cremation.

### Notifications:

1. Coroner. The coroner should be called in the event of a child's death in the ED. While jurisdictions vary in their requirements, typically the coroner is called when the death is unnatural or unexplained. See Appendix for more on coroner notification criterion.

**The CORONER** has absolute authority to regulate visitation.

The body should **NOT** be cleaned or bathed.

All medical devices should remain in place.

The patient's clothing and accompanying items should be preserved.

2. Organ Procurement Organization. The local organ procurement organization must be notified of each death in order to assess for the possibility of tissue donation.

3. Primary Care Physician. The child's primary care physician should be notified of their death.

4. Funeral Home. If the coroner releases the body, the funeral home of the family's designation should be notified of the body's availability.

### Documentation:

1. Report of Death. Each state has procedures for reporting deaths to the local health department and state Bureau for Vital Statistics. These reports are filed by the funeral home. Some states use a Provisional Report of Death to help facilitate this. This provisional report will often include information such as:

Demographics: Name, age, race, date/time of death, location of death, location of residence,

Name of individual certifying the death. Typically attending physician or coroner.

Notification of Organ Procurement Organization.

Authorization for release to a funeral home.

2. Electronic Medical Record. Each facility should document the child's death in the patient chart. Entries typically include date/time of death, name of physician who pronounced the death, name of the coroner contacted and their disposition, contact with the organ procurement organization, and notification of the funeral home (if the coroner has released the body).

## CARE INITIATIVES

### In-hospital

1. Visitation. If the coroner consents, the family should be given the opportunity to spend time with the child in the ED. The coroner has authority to regulate the number of family members who may visit and what contact is allowed. This visitation must be supervised by hospital staff (nurse, chaplain, and/or social worker).
2. Memory Making. If your facility has the capacity and the consent of the coroner, providing items such as hand molds, fingerprint medallions, hand and footprints, etc. can be meaningful for the family. Often these can be made by a child life therapist.
3. Resources. Provision should be made for support resources to be on hand and given to a family as they process the death. Information about local support groups and brochures and booklets that discuss grief reactions observed in adults and siblings can be useful tools.
4. Staff support. The death of a child in the ED can be stressful for even the most seasoned professionals. Provisions to assist the staff in processing the emotional toll left by such an event are crucial to enhance staff retention and resilience. Peer-led initiatives such as Critical Incident Stress Management (CISM) can be a useful tool in this regard. Staff trained in Psychological First Aid can help assess distress levels and refer to more focused interventions when needed.

### Follow-up

Support for the family should not end with their leaving the hospital. Hospital based bereavement programs provide ongoing support by sending letters and making phone calls to check in with the family, assess coping strategies and assisting with the location of relevant support resources. A model of one such program is seen below.

#### General Contours of a Three-Phase Bereavement Intervention Program

- A. Contact 1: Chaplain sees all patients' families at the time of death.
- B. Contact 2: The initiative derives its uniqueness from its in-home contacts with the bereaved parents. A chaplain meets with the parents in their home or at the funeral home during the week following the death. This contact is intended for the expression of condolences, to solicit and, if possible, answer questions about their child's medical treatment and to describe future initiatives.
- C. Contact 3: Two or more months after the death, after contacts by telephone and letter, the chaplain returns to the parents' home to assess grieving patterns and provide needed guidance. Additionally, the parents and chaplain have together arranged to go to a local restaurant to meet with 15 or more of the parents' supporters (e.g., coworkers, neighbors, family members, church members, etc.). Following a meal (paid for by the grant), the chaplain discusses with these supporters ways they can assist the bereaved parents and addresses myths associated with bereavement.

- D. While not all parents choose to engage in a supporter meeting, surveys of the parents and supporters that do participate strongly suggest that the interventions have been helpful and appreciated.

Appendix. Criterion for coroner notification.

Reasons for contacting the coroner following a pediatric death vary by jurisdiction. In some locales, any death of a person under the age of 18 years of age requires the notification of the local coroner. However, the following are standard reasons for coroner contact:

- A. Homicide or other violent act.
- B. Suicide.
- C. Presence of drugs or poisons in decedent's body.
- D. Motor vehicle crash and the operator of the motor vehicle left the scene of the crash or the body was found in or near a roadway or railroad.
- E. Decedent was in a state mental institution or mental hospital when there was previous medical history to explain the death, or while decedent was in police custody, or jail, or penal institution, except pursuant to a sentence of death.
- F. Motor vehicle crash and an external examination of the body does not reveal a lethal traumatic injury.
- G. Fire or explosion.
- H. Indication of child abuse prior to death.
- I. Other than natural causes.
- J. Human skeletonized remains are found.
- K. When the circumstances of death cannot rule out the commission of a crime.
- L. Drowning.
- M. Sudden infant death syndrome.
- N. Airplane crash.
- O. Decedent is under the age of 40, and there is no past medical history to explain death.
- P. Death occurs at the worksite, and there is no apparent cause of death such as an injury when industrial toxins may have contributed to the cause of death.
- Q. Body is to be cremated, and there is no past history to explain the death.
- R. Death is sudden and unexplained.
- S. Decedent was not receiving treatment by a licensed physician, and there is no ascertainable medical history to indicate the cause of death.