Death of a Child in the Emergency Department

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The death of a child in the emergency department (ED) is one of the most challenging problems facing ED clinicians. This revised technical report and accompanying policy statement reaffirm principles of patient- and family-centered care. Recent literature is examined regarding family presence, termination of resuscitation, bereavement responsibilities of ED clinicians, support of child fatality review efforts, and other issues inherent in caring for the patient, family, and staff when a child dies in the ED. Appendices are provided that offer an approach to bereavement activities in the ED, carrying out forensic responsibilities while providing compassionate care, communicating the news of the death of a child in the acute setting, providing a closing ritual at the time of terminating resuscitation efforts, and managing the child with a terminal condition who presents near death in the ED.

Keywords: Death of a child; Emergency department

Introduction

When emergency clinicians are faced with an imminent child death in the emergency department (ED), they must carry out many complex tasks. They must treat a patient experiencing an acute and evolving medical situation, establish a compassionate relationship with family they have likely never met before, and support and work in team fashion with their colleagues as they acknowledge the human limitations to remedy a medical crisis. Many of the clinical, operational, legal, ethical, and spiritual layers to this complex care are discussed in this report and are listed in Table 1. The infrequency of these events and the magnitude of the tragedy combine to make the death of a child in the ED one of the most challenging problems facing emergency health care providers.

Despite the relative infrequency of these events, there is considerable diversity in the clinical presentation of the death of a child in the ED. In this technical report, child death in the ED is considered broadly, encompassing acute unanticipated trauma or illness, stillbirth or extreme preterm birth at the margin of viability, the child declared dead on arrival, the child who dies shortly after passing through the ED, and even the child with a known life span–limiting condition for whom the ED becomes the location of end-of-life care.

This technical report builds on the original technical report published in *Pediatrics* in 2005[1] in support of the 2002 joint statement of the American Academy of Pediatrics (AAP) and American College of Emergency Physicians (ACEP)[2] and a companion article published in *Annals of Emergency Medicine* in 2003.[3] These earlier publications called for a patient- and family-centered and team-oriented approach to the provision of compassionate care while respecting social, spiritual, and cultural diversity. They outlined responsibilities of the ED staff involved in the care of the child, including the responsibility to facilitate organ procurement and obtain consent for postmortem examinations; to facilitate the identification of medical examiner cases and the reporting of potential maltreatment cases; to assist team members, including emergency medical services (EMS) personnel, with managing critical incident stress; to notify the primary care provider and other clinicians/specialists; and to delineate the responsibility of follow-up of autopsy reports or other medical information. This revised report, as well as the accompanying revised policy statement of the same title,[4] reaffirms those principles and examines recent literature regarding family presence during attempted resuscitation, recommendations regarding termination of resuscitation efforts, organ donation, benefit of autopsy, practicing procedures on the newly deceased, benefit of continued contact with surviving

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TABLE 1
Essential Components of Care in the ED When a Child Dies.

Clinical
Resuscitation best practice
Termination of resuscitation
Identifying, validating, and respecting advanced care directives
Operational
Staff training in communication
Team response (including readily available support staff such as security, child life, chaplaincy, social work)
Family presence policy
Dealing with media [a]
Communication with medical home
Defusing/debriefing for team
Private location for family to be with deceased, means and location to conduct rituals
Legal and Forensic
Organ donation
Autopsy
Working with police and coroner/medical examiner
Child protective services
Child fatality review team
Documentation in medical record
Preservation of evidence
Ethical
Resuscitation: how long is too long?
Prolongation of resuscitation efforts for family presence/organ donation
Practice on newly deceased
Initiation of resuscitation at the border of viability in extreme preterm birth
Spiritual and Emotional
Needs of family, including saying goodbye, memory making
Needs of multidisciplinary team
Envisioning a "good death" in the ED
Follow-up Care for Family
Helping family to know everything was done
Assisting family in explaining to siblings, family, friends
Assisting family in locating community support to address grief and bereavement
Plan for postautopsy meeting to answer questions
Plan for scheduled follow-ups and marking of meaningful dates
Follow-up Care for Team
Scheduled voluntary defusing/debriefing with all members of the emergency care team who wish to participate

[a] Not covered in this report.

family members, and working to support state, local, and national child fatality review teams. New observations regarding the need for and the most effective ways to provide communication training, reflections on the effect of patient death on providers, and definitions of a "good death" are also reviewed. Additional existing resources from the emergency care literature are identified. Observations from venues outside the ED but with potential application to the ED setting are considered. Finally, a reconsideration of what can be called success in pediatric resuscitation is offered.

Background

Data from the National Center for Health Statistics for the most recent year completed (2009) revealed that there were 73 million children younger than 18 years residing in the United States.[5] Although the portion of the population younger than 18 years is roughly 30% of the total population, fewer than 2% (48 000) of deaths occur in this age range. This statistic is strikingly different from a century ago, when 30% of all deaths were in children younger than 5 years. These data reflect progress in child health but also underscore that child death, unlike parental or spousal death, is no longer an expected part of life. In industrialized nations, child death stands out as a singular tragedy and an increasingly uncommon event in the professional lives of clinicians, even those whose practice is exclusively pediatric.

Beginning in 2006, the Health Care Cost and Utilization Project has provided a national database of ED visits with the Nationwide Emergency Department Sample.[6] Fewer than 3% of all ED patient visits were children younger than 1 year; deaths in that age group accounted for 1.9% of all ED deaths. Patients 1 to 17 years of age accounted for 18% of all ED visits and another 2% of ED deaths. In total, the percentage of ED deaths among patients younger than 18 years is less than 4%, occurring less than once per 15 000 ED visits. Because of the relative infrequency of child death in the ED setting, few emergency clinicians have extensive experience with child death.

Beyond the relative infrequency of this event, there are other formidable challenges in managing pediatric deaths, including the following:

- deciding when to terminate resuscitative efforts;
- deciding when not to initiate resuscitative efforts;
- managing painful or distressing symptoms in pediatric patients;
- ascertaining family wishes or identifying existing advance directives;
- managing family presence in the setting of attempted pediatric resuscitation;
- communicating with and caring for the family;