Title	**Sudden Unexpected Death in Children (SUDiC) – Guideline for management in the Emergency Department**
Document Type	Guideline
Version Number	V4
CGQ & RDS ID Number	
Approval/Issue date	March 2023
Review date	March 2026
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Significant resource implications (financial/workload)	None Noted
Approved by	Clare Irving – Clinical Director for Paediatrics – Approved at Child Health Business Meeting
Health Inequality Impact Assessment (HIIA)(only statutory for policies)	N/R

Sudden Unexpected Death in Children (SUDiC) Guideline for Management in the Emergency Department

Updated March 2023
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Contents

1.0 Purpose

To provide clear guidance for Clinical care and follow up when a child within NHS Borders dies suddenly and unexpectedly. This document applies to out of hospital and in hospital deaths.

2.0 Scope

For use by all staff who are involved in the management of sudden and unexpected deaths in children. This includes staff in the hospital, as well as community settings.

The guidelines apply to all infants and children ≤ 15 years who die suddenly and unexpectedly.

3.0 Introduction

'Sudden deaths' are best defined as any death which occurs suddenly, is unexpected and not preceded by any known illness or disease, which occurred anywhere, either from violence by others, suicide or accident, where the cause of death is unknown or undetermined and where the circumstances give rise to suspicion.[1]

In Scotland, The Procurator Fiscal has a duty to investigate all sudden, suspicious, accidental, unexpected and unexplained deaths and any deaths occurring in circumstances causing serious public concern. The Procurator Fiscal's right and duty to investigate such deaths derives from Scottish Common Law (i.e. custom and practice which has developed over the centuries and now has the force of law) and it is reinforced by the Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976. As such, the Police act as the agents of the Procurator Fiscal and have a duty to secure information or evidence that establishes the true cause of death. The Police therefore have a key role in the investigation of infant and child deaths, and their prime responsibility is to the child, as well as to siblings and any future children who may be born into the family concerned.

The 6 guiding principles that underpin the work of professionals dealing with any infant or child death investigations are:

- Sensitivity
- Open mind / balanced approach
- Appropriate response to the circumstances
- An inter-agency response
- Sharing of information
- Preservation of evidence

It is important that the Police and hospital / medical staff establish a collaborative approach to any such investigation. Information sharing between Police and Health

[1] Protecting children & young people: Significant incident review, Scottish Executive 2006

staff is expected to ensure that a comprehensive picture of what is jointly known is established in early course and updated throughout any investigation.

4.0 Instruction for Ambulance Crew

All babies and children ≤15 years should be taken to the Borders General Hospital Emergency department by the ambulance crew, not directly to the mortuary.

If the baby or child is transferred out of area (e.g. if another hospital is geographically closer and resuscitation ongoing) this should be communicated to the on-call paediatrician at the BGH.

The ED consultant, ED nurse in charge or Consultant Paediatrician on call may, in rare instances, make the decision to send the body directly to the mortuary. In these circumstances the General Services Supervisor should be contacted as soon as possible on Bleep 6059. An Intimation of Death (IOD form) must be completed by the senior clinician (ED or Paediatrics). These documents are stored within the mortuary.

5.0 Emergency Department Guidelines for Medical Management of SUDiC

Procedures ahead of patient arrival
Call:

- **2222 via switchboard**
- Paediatric team, including senior children's nurse
- Consultant Paediatrician
- Emergency Department Consultant (if available)
- Prepare for full cardiopulmonary resuscitation (CPR)
- Plan roles for team including parent supporter
- Agree how parents will be supported
- Ensure quiet room for parents to sit in during and after resuscitation with access to telephone if needed

5.1 On arrival at the Emergency Department

Assess whether CPR is appropriate:

- CPR with bag-valve-mask (BVM) ventilation should be continued while this decision is being made

- If active resuscitation is deemed appropriate the UK Resuscitation Council guidelines should be followed Resuscitation Council UK Guidelines

- If hypothermia is likely to be the cause of cardiac arrest, start to re-warm and

- Commence CPR with BVM or ET ventilation (if VF recorded on ECG, defibrillation may be effective only when core temperature is >34^{0}C)

- Use this guideline for priority of laboratory samples (see page 8)

- If infant / child is clearly dead on arrival, no samples should be taken

- Give parents opportunity to be present during resuscitation and explain what is happening. If parents are not present, ensure they are kept informed of progress.

5.2 Consider stopping CPR if

- Senior doctor assesses child has been dead for some time
- Ambulance team report no response to CPR for >20 minutes
- Rigor mortis present
- No response after 20 minutes of full CPR
- Team Consent
- If parents are not in the resuscitation room, senior nurse or appropriate medical personnel should, if possible, try to inform them of how the resuscitation is progressing before attempts are stopped.

5.3 After life pronounced extinct

- Consultant Paediatrician / Senior doctor should inform parents of child's death - ensure they know the name and gender

- Consultant Paediatrician / Senior doctor will take further details from parents:

- Complete the interventions / history and examination proforma (Appendix 1)

- Explain procedure (see page5 'Initial Parent Support')

- After consultation with the Senior Investigating Police Officer, offer parents opportunity to hold child with appropriate supervision by a member of staff e.g. ED Nurse, Police Officer /Nurse.

- Give parents appropriate leaflets within SUDiC Box.

- Since **no samples should be taken once death is declared**, ensure that all those taken during CPR are sent to laboratory (see Investigations, page 8)

- Endotracheal tubes and cannulae can be removed but ensure position is confirmed and documented prior to removal.
  Baby / Child should not be washed
  Retain clothes (and nappy) in production bag for Police

- Inform Police if not already present

- Initiate an Interagency Referral Discussion (IRD) between Health, Social Work and Police, by contacting Child Protection Unit during daytime hours (01896 664580) or social work Emergency Duty Team (EDT) 01896 752111 or Lothian and Borders Police out of hours (0131 311 3131). This IRD should not be closed until an initial cause of death has been determined and passed to the procurator fiscal.

- Clarify address of baby /child. If they are from out of area contact on call paediatrician from their local hospital. Pass details of paediatrician to police/ pathologist for ongoing communication.

- Email Child Death Review Team

- Ensure Primary Care Team are informed of death as soon as possible. If necessary, message can be left with Out of Hours service to inform GP in morning

- Inform Child Health Admin the next working day

- Complete Appendix 2 – Checklist for Doctors

- Complete Appendix 3 – Checklist for Nurse

The Consultant Paediatrician / Senior Doctor should ensure that all the above actions have been completed

6.0 Initial Parent Support

- Consider the need for interpreter / Translator services 24-hour Translator Language Line Tel: 08453109900 (Code L47668) For a face-to-face interpreter or other communication assistance for patients with visual and hearing impairments contact F2F Alpha Translating & Interpreting Services on 01315589003 24/7 no code required – Complete IMF FORM (See Appendix 7)

- Relatives and carers may wish to act as interpreters. However extreme caution needs to be exercised and it is advisable not to use family members and carers except in exceptional circumstances when no other alternatives are available. If a relative is used as an initial interpreter, then an official face-to-face interpreter should be organized as soon as possible.

- Offer to listen if parents want to talk but do not give opinion. If asked, repeat explanation of the resuscitation. Explain that sudden unexpected deaths in infancy and childhood can occur but there may be no cause found. Reinforce the fact that SUDiC can be due to different causes.

- Explain to the parents that when a child dies unexpectedly or the death is unexplained the Medical staff are required by law to contact the Procurator Fiscal (PF) who will investigate the death. The PF will instruct the Police to carry out an investigation into the death on his/her behalf.

  This will involve the Police visiting the place of death and speaking with the child's parents. If the death occurred at home they may take away bedding, bottles and any medicines. They will also speak to the child's GP, relatives or those present at the time of death. The parents may not be able to go back to the house that day or night until the police have finished their investigations.

  Make sure the parents are not alarmed by the Police enquiry, this is standard procedure. The enquiries will be as quick as possible so that the Medical Certificate of the Cause of Death can be issued.

- The PF will usually arrange for a post-mortem (PM) examination to try to determine the exact cause of death. This will be carried out by a Paediatric Pathologist as soon as possible. Sometimes further analysis of tissues or organs is required and the cause of death may be provisional. These further investigations may take a few months to complete. The PF will update the parents during this time.

- However, once the Pathologist has completed his/her initial examination, the body will be
  released to allow the parents to make arrangements for the funeral. Once this is completed, the Pathologist will issue a Medical Certificate of the Cause of Death which the Police will bring to the Parents home.

- Children weighing over 2.5kg can be considered for corneal and heart valve tissue donation.
  If the senior doctor dealing with the death feels that tissue donation would be appropriate or if the family enquire whether tissue donation would be feasible, see Appendix 6.

- After consultation with the Senior Investigating Police Officer, allow parents time as to see / hold child before transfer to the mortuary, this should be done under supervision by a member of staff e.g. ED Nurse, Police Officer /Nurse.

- Parents may wish form Memory Making to take place including hand or foot prints or lock of child's hair. This can be arranged via the mortuary during PM (Ensure Memory Making Request form is completed) (Appendix 8). Staff in ED should not take hand and foot prints as this may jeopardise further investigations that may need to be undertaken by the pathologist.

- Ensure that every family is made aware of the Hospital's Spiritual & Pastoral Care Service. The on-call generic chaplain can be contacted via switchboard. Information should be provided to the family on Bereavement Support available.

7.0 History and Examination

This should form the basis of a report for the pathologist and should be completed by the Consultant Paediatrician or most Senior Doctor involved in the resuscitation and should be available for case review.
Please use the attached proforma – Appendix 1

Primary History
Can be obtained from parents, paramedics, GP, Emergency Department staff)

Time found
Symptoms preceding the event
Observation on state / position of child when found
Action taken
- Stimulation
- Shaking
- Mouth to mouth
- ECM
- Other

Response to action
Emergency Services call
Action during transport

Secondary History – questions must be age appropriate
Obtained from parents

Details of recent health
Past history of illness
Date of last contact with healthcare
Prescribed medication(s) at death
Birth History
- Gestational age
- Birth weight
- Any neonatal intensive care
- Did mother smoke during pregnancy

Immunisation details and dates
Social history
- Who lives at home
- Does either parent smoke? (state details)
- Either parent on medication (state type e.g. antidepressants, sleeping tablets, methadone)

Family history
- Family history of illness – parents and siblings
- Any history of a previous child of either parent dying suddenly or collapsing?

Circumstances surrounding death
- Who was in the house at the time of the death?
- Had anyone in the house taken alcohol on the day / night of death (state details)
- Had anyone in the house used illegal drugs on day / night of death (state details)

Questions specific to infant death:

Time last seen alive
Time of last feed (state whether breast, formula and/or solids) and how well taken
Dummy used routinely?
Dummy used on day / night of death?
Sleep location at death
- If co-sleeping, state whether adult bed or sofa, with whom, whether between parents or on outside edge

Position put down for last sleep and position found
Presence of body fluids at nose / mouth when found? (state details)

Examination – Chart observations on body map (Appendix 1 – proforma)

Inspection

General subjective impression of nutrition and general care
Rigor mortis
Ear / skin temperature
Jaundice
Skin rash
Bruises and other injuries
Swelling over skull
Vomits
Blood / blood stained secretions from mouth
Secretions from nose – describe
Blood from ears
Abdominal distension
Gentle palpation
- Abdominal masses / organomegaly

Injury to anus or genitalia

8.0 Investigations

Record all investigations and interventions, including any invasive procedures, whether successful or not.

If child is actively resuscitated take essential investigations for treatable causes as clinically indicated

If <u>blood samples</u> are taken during CPR the following list gives the order of priority.

1. Blood Culture (1ml)
2. Urea & Electrolytes (lithium heparin tube 0.7mls)
3. Glucose/3 OH-butyrate (fluoride oxalate tube 0.4ml)
4. Blood spot on Guthrie card for carnitine (cards are available in ED SUDiC pack)
5. **Any remaining sample available, place in lithium heparin tube and retain in Biochemistry Department**
6. **Document findings of any X-rays taken before death**

After death is declared DO NOT take any further specimens.

Taking of samples might contaminate evidence and confuse post mortem findings

If endo-tracheal tubes are removed their position should be recorded to avoid later confusion over cause of injuries.

9.0 Suggested SUDiC pack for Emergency Department

1. **ED Guidelines for Management of SUDiC**
2. **History, Examination and Investigation Sheets (Appendix 1)**
3. **Checklists for Doctors and Nurses (Appendices 2 +3)**
4. **Guthrie Cards**
5. **'What happens next' Leaflet for bereaved parents**
6. **Scottish Cot Death Trust Information Leaflet for Bereaved Parents of infant**
7. **Memory Making Request form (if memory making cannot be completed at BGH)**
8. **IMF Form for Alpha translating and Interpreting Services Face to Face.**

APPENDIX 1 - SUDiC PROFORMA

A copy of this will be provided to the pathologist before the post mortem examination. It should be completed by the attending Consultant Paediatrician or, in exceptional circumstances, Emergency Department Consultant and should be available for case review.

Surname: **First names (s):** **Address:** **Unit no:** **DOB:**	**Date:** **Time:** **Consultant:**

Attach sticker

Primary History
Time found: **Who by:** **Who else was at the address at the same time?** **Who had been caring for the infant in the preceding 24hrs?** **Observation when found:** **Action taken:** **Response to action:** **Emergency Services call:**

Action during transport:

Please attach Ambulance sheet

Events leading up to death

Infant Deaths

Time last seen alive

Last feed
- Time
- Type
- How well taken

Dummy used
- Yes/No
- Used on day / night of death

Sleep location at death

If in cot, was the infant put to sleep with his feet close to the bottom of the cot?

What type of mattress was used? Was it second hand?

If co-sleeping
- adult bed or sofa
- with whom
- between parents or on outside edge
- was anything used to keep the infant in position?

Position found – was the bedding over the face?

Presence of body fluids at nose / mouth when found

Was\there heating in the room? What type? Did the room feel too hot or too cold?

Previous medical history

Last contact with healthcare:

Birth history

Birth weight Last live weight	

Drug history / Medications

Dose	Frequency

Family history

Allergies

Immunisations

2 months 6 in 1 (Diptheria Tetanus Pertussis Polio, Hib, Hep B) Men B, Rotavirus ☐

3 months 6 in 1, Rotavirus, Pneumococcal ☐

4months 6 in 1, Men B ☐

12-13months Hib/MenC Men B, MMR, Pneumococcal ☐

Pre-School 4 in 1 (Diptheria Tetanus Pertussis Polio) MMR ☐

12-13 years HPV x 2 doses 1st ☐ 2nd ☐

14 years Tetanus/Diptheia/Polio MenACWY ☐

Any other-
BCG:☐
Flu: ☐
Hep B: ☐

Social history

Who lives at home?

Does either parent smoke? (give details)

Either parent on medication? (state type e.g. antidepressants, sleeping tablets, methadone)

Any concerns regarding parental alcohol or drug use?

Resuscitation Notes

Investigations

Examination

General subjective impression of nutrition & general care

Rigor mortis
- Presence
- Pattern

Skin temperature (where taken?)

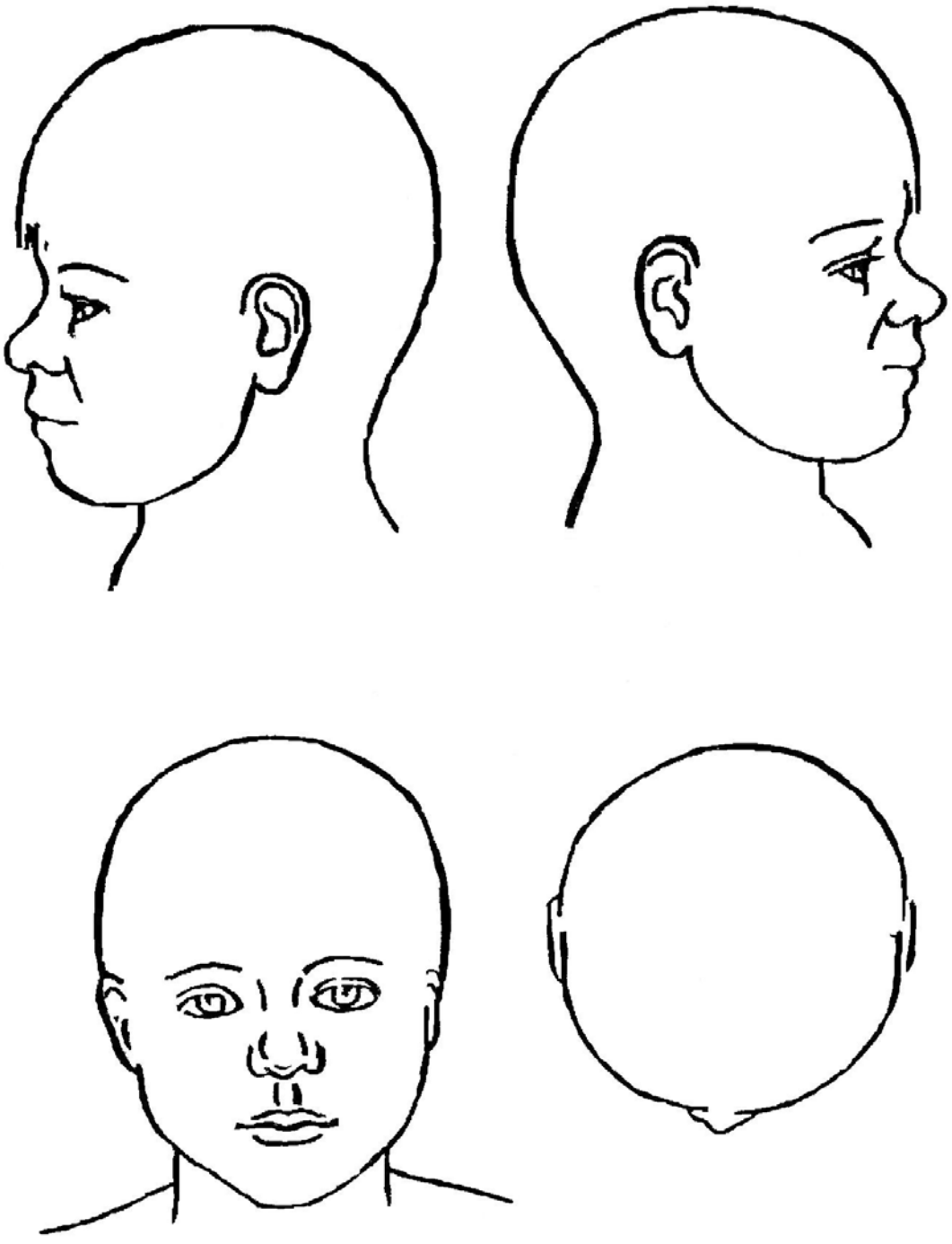
Vomits

Secretions from mouth

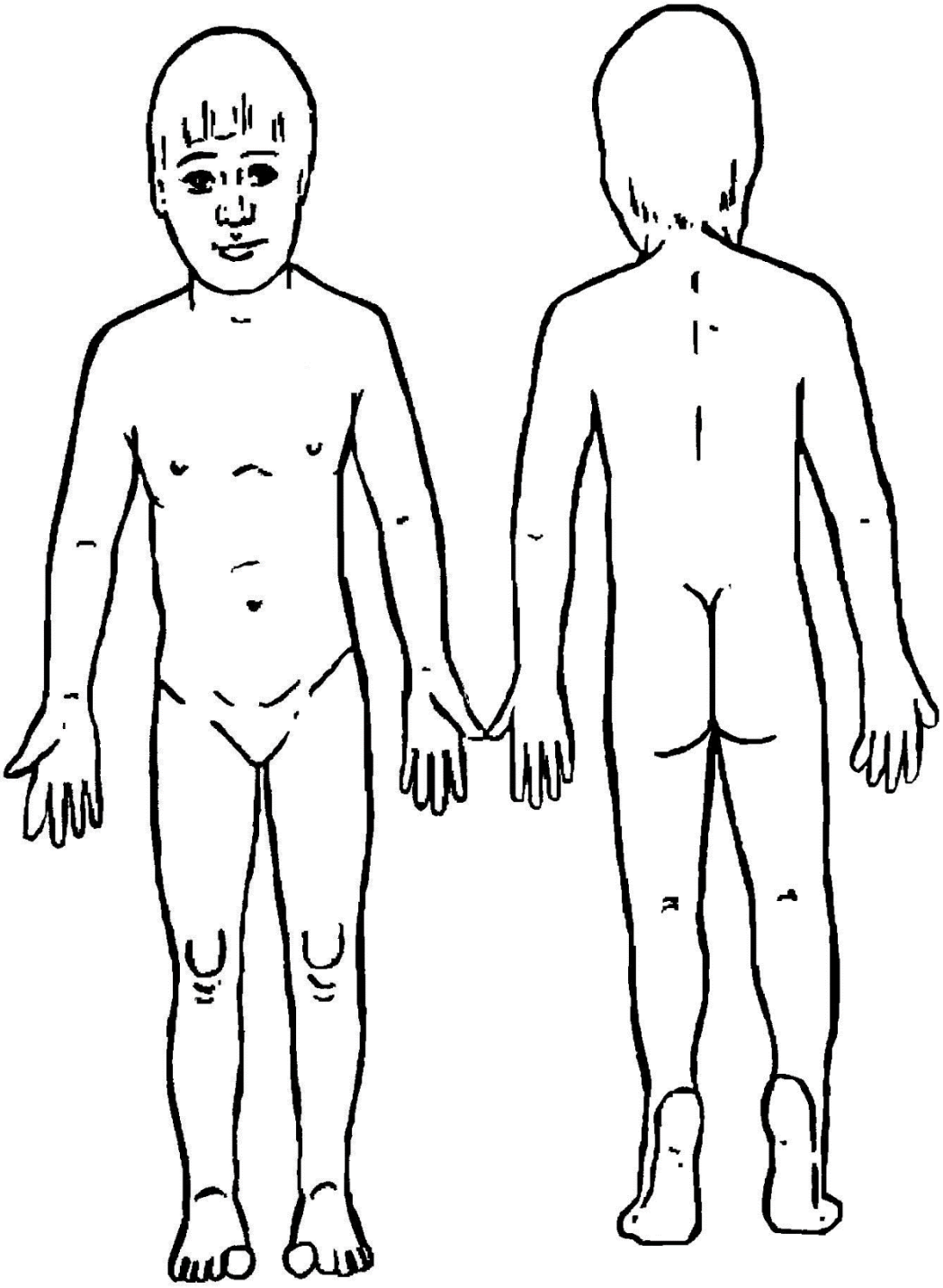
Skin
- Colour
- Rash
- Jaundice

Any injuries? If yes, please describe on body diagrams

Patient sticker



Patient sticker



Appendix 2 – SUDiC Checklist for Doctors

Date _ /_ /_

- O Document history and examination proforma (Appendix1)

- O Document all investigations and interventions whether successful or not
  - ET tubes and cannulae can be removed but ensure position is confirmed and documented prior to removal

- O If samples taken as part of resuscitation attempt:
  - Label samples with 'Freeze and Keep' and send to the lab
  - If already sent to lab, contact lab to arrange for samples to be kept

  Do NOT take further samples after death

Ensure the following people have been contacted:

- O Hospital Bleep Holder
- O Police / Procurator Fiscal
- O Interagency Referral Discussion should take place between police/health/duty social work
- O Pathology Department
- O NHS Borders Management On Call
- O Child's GP (if out of hours then contact BECS and let them know as they can make contact with the child's own GP and may have a supportive role for the bereaved parents)
- O Child Health Information Team/Paediatric Secretaries
- O Child Death Review Team via email on BOR.childrensreviews@borders.scot.nhs.uk
- O **Ensure DATIX is completed.**

After initial management:

- O Inform lead for SUDI
- O See SUDI Scotland website for timeline for ongoing support and follow-up - www.sudiscotland.org.uk
- O Complete SUDI Scotland 'History and Examination' proforma. See instructions on page 2 of form.

Name **Signed** **Date**

Appendix 3 – SUDiC Checklist for Nurses

Date _ /_ /_

- O Interventions such as ET tubes and cannulae can be removed but ensure position is confirmed and documented prior to removal
- O The baby / child should not be washed
- O Attach identity bracelet to child's wrist and ankles
- O Each item of clothing and nappy should be placed in a separate brown production bag and a label sellotaped to the outside of each bag before transfer to the mortuary with the child (unless taken by CID)
- O Ensure all documentation has been completed

Parents

- O See Initial Parent Support (page 6)
- O Ensure any other siblings are taken care of
- O Offer parents information leaflets – Rainbow pack (stored in Sudic Box and ward 15)
- O Ensure that the family is made aware of the Hospital's Spiritual and Pastoral Care Service. Ask if the family would like to see the chaplain (please note this is not available out of hours)
- O Ensure that Bereavement Support information is given/offered to the family – please document if this has been done or not.
- O Ensure the parents have the telephone number for the Consultant Paediatrician involved in the case
- O Make sure parents have suitable transport home

Name Signed Date

Appendix 4 – Reporting a SUDiC to the Procurator Fiscal

Step 1 – Does the death need to be reported to the PF?

It is the duty of the appropriate Procurator Fiscal to enquire into all sudden, suspicious, accidental, unexpected and unexplained deaths. Any death which the circumstances or evidence suggest may fall into one or more of the following categories must be reported to the Procurator Fiscal: -

Step 2 – Are the Police involved?

If there is any suggestion of any suspicious circumstances or anything to suggest that the death was not due to natural causes, the Police should already be involved. They should also have contacted the PF who may wish to speak to you. If the Police are already involved there is no onus on you to contact the PF as the Police will do so.
However, it may be that as the examining medical staff you are the first to notice the injuries or other circumstances giving rise to suspicion. If this is the case contact the Police immediately then the PF.

Step 3 – Out of hours, if the death is reportable, should it be reported to the on-call Fiscal or can it wait until the next working day?

The on-call Fiscal is on duty to deal with emergency situations only. These include cases involving suspected criminality and this includes breaches of Health and Safety laws e.g. accidents in public buildings and deaths as a result of RTAs. This would also include any death of a child where someone in the household is a drug user.

The following non-urgent deaths should be reported to the appropriate PF's office on the next working day:

- Deaths which fall into the mandatory, but non-urgent, reporting categories e.g. death due to certain illnesses or children in foster care
- Non-urgent deaths which cannot be certified as the cause of death is not clear
- Non-urgent deaths which you may be able to certify but would like to discuss the issue of certification before doing so

Telephone Numbers

Out of Hours	On-call Fiscal (Lothian and Borders Police)	0131 311 3131
In office hours	Selkirk PF Office	01750 20345 or 03000203000
	Jedburgh PF office	01835 862345

Appendix 5 – Notification to Public Health

Notification of Infectious Disease or Health Risk State
This notification relates to Part 2 (Notifiable Diseases, Notifiable Organisms and Health Risk States) of the Public Health etc. (Scotland) Act 2008. All registered medical practitioners must notify their NHS Board if they have a reasonable suspicion that a patient whom they are attending has one of the diseases set out below**.**
Practitioners should not wait until laboratory confirmation of the suspected disease before notification. Registered medical practitioners are also required to notify any case suffering from a 'health risk state' (HRS), and anyone likely to have been exposed to such a case with an HRS, or the same risk factor. A copy of the Guidance for Registered Medical Practitioners can be accessed at:
http://www.scotland.gov.uk/Topics/Health/NHSScotland/publicact/Implementation/Timetable3333

Clinical Data
Suspected Diseases include:
Anthrax
Botulism
Brucellosis
Cholera
Clinical syndrome due to E.coli 0157 infection
Diphtheria
Haemolytic Uraemic Syndrome (HUS)
Haemophilus influenzae Type b (Hib)
Measles
Meningococcal disease
Mumps
Necrotizing fasciitis
Paratyphoid
Pertussis
Plague
Poliomyelitis
Rabies
Rubella
Severe Acute Respiratory Syndrome (SARS)
Smallpox
Tetanus
Tuberculosis (respiratory or non-respiratory)
Tularemia
Typhoid
Viral haemorrhagic fevers
West Nile fever
Yellow Fever

Appendix 6 - Tissue Donation

The PF must be informed to give permission for tissue donation. If out of hours, the on-call PF must be contacted.

Children weighing over 2.5kg can be considered for corneal and heart valve tissue donation. In order for tissue to be viable the body must be in the fridge within 6hrs of confirmation of death or estimated time of death.

Main Medical Contraindications to Tissue Donation:
- Untreated Systemic infection
- History of malignancy (refer to coordinator for corneal donation)
- History of chronic viral hepatitis or HIV infection.
- Diseases of unknown aetiology (e.g. multiple sclerosis, Crohns's disease)
- Active multi-system autoimmune diseases
- Active chronic infection
- Risk factors for Creutzfeldt-Jacob's disease or its variant (for example dementia)
- Patients on immunosuppressant's

Main Corneal Specific Contraindications to Donation:
- Malignancies: leukaemia, lymphoma, myeloma
- Retinoblastoma
- Malignant tumours of the anterior segment
- Intrinsic Eye disease: Ocular inflammation and any congenital or acquired disorders of the eye, or previous ocular surgery that would preclude successful graft outcome

The above are the major medical conditions that need to be assessed prior to referral. There are detailed criteria for acceptance/deferral that will be discussed with relatives.

If the senior doctor dealing with the death feels that tissue donation would be appropriate or if the family enquire whether tissue donation would be feasible, please contact tissue donation on

Tissue Donor Coordinators can be contacted via their pager on 07623513987 – please leave your name and full telephone number including standard dialling code. This is a 24/7 service. You will be called back ASAP.

If they agree that the child is suitable they will ask you to approach the family to discuss it with them. If the family agree the tissue donation staff will contact them directly to confirm suitability.

Corneas must be retrieved within 24 hours and heart valves within 48 hours.
The tissue is retrieved prior to the PM. The corneas are retrieved by the Ophthamologists and the eyes cosmetically reconstructed afterwards. The heart valves are retrieved by the paediatric pathologist prior to the PM.

Appendix 7 – Interpretation Monitoring Form (IMF)

INTERPRETATION MONITORING FORM (IMF)

(For Face to Face and Telephone Interpretation and British Sign Language)

Any bookings made MUST be confirmed by completing an Interpretation Monitoring Form

The information entered in this form will assist you in giving the required details to the chosen agency when you book an interpreter. This information is confidential under the Data Protection Act. After booking an interpreter, **this form should be emailed to** equality@borders.scot.nhs.uk for payment, tracking and monitoring purposes and a copy retained in the patient's records/case notes – **failure to do so may result in your department being charged**

PATIENT DETAILS	
Patient Name:	
Date of Birth:	Gender: Male ☐ Female ☐ Other ☐

INTERPRETATION DETAILS	
1. Telephone Interpretation ☐ **IMPORTANT: Must always be considered as first option**	
2. Face to Face Interpretation in Person ☐ Face to Face Interpretation by Video ☐ **IMPORTANT: Must only be used if meets Guidelines criteria** **(see extract overleaf or http://intranet/microsites/index.asp?siteid=92&uid=39 for full Guidelines)**	
3. British Sign Language ☐ **IMPORTANT: Sufficient notice must be given to allow a BSL Interpreter to be sourced**	
Language required:	
Name of Interpretation Company Used:	
Date Required:	Time: am or pm
Venue:	Duration:(approx) hours
Any Additional Information:	

REQUESTED BY	
Your name: (please print)	Telephone No:
Your Department:	Your Designation:
Signed:	Date:

PERSON COMPLETING THIS FORM MUST:
1. **Contact** the Interpretation Company direct to book the interpreter
2. **Email** a copy of the **Interpretation Monitoring Form** to equality@borders.scot.nhs.uk (for payment, tracking & monitoring purposes)
3. **Note** that requests for a particular named interpreter cannot be guaranteed. The Interpretation Company will allocate according to availability

If you still require further assistance please telephone Public Health on 01896 825560

Appendix 7 Continued – IMF Form

When an interpreter should be used

Staff must establish if a patient or service user requires an interpreter - they should not decide unilaterally that a person's English is adequate.

Interpreting may be provided by face to face interpreting, or via telephone or video interpreting. The decision as to which means of interpreting is appropriate to use lies with the professional judgement of the health care professional.

Using telephone interpreting should be regarded as the first option except in the following circumstances:

- Interpreting session lasts more than 30 minutes
- Patient uses non-verbal communication such as British Sign Language, DeafBlind Manual, Moon, Makaton etc.
- Patient has a communication, cognitive or learning disability which would make telephone interpreting difficult
- Child or Adult Support and Protection
- Where conversation needs to be recorded for legal reasons
- Bereavement and breaking bad news (life threatening diagnosis)
- Ethically difficult or challenging situations

For out-of-hours services, or when assistance is required to identify the language spoken, a telephone interpretation service is available through LanguageLine on 0845 310 9900.

It is the responsibility of NHS Borders staff to engage the interpreter – it is not the responsibility of the patient. Staff are required to prepare well in advance, where appropriate, for any appointments and to assume full responsibility to apply the procedure as described in this section. (There is no cost to the patient)

Other than for simple care and comfort situations an interpreter should be used when providing care to a Limited English Proficient patient. An interpreter from a CHOSEN COMPANY must be used where effective communication is critical to patient care outcomes such as:

- admission/initial assessment
- history taking and care planning
- consent for treatments and research
- high risk / life threatening situations
- pre-operative procedures including patient identification and identification of operation site
- Mental Health Tribunals
- explanation of medication or treatments

Appendix 8 – Memory Making Request Form

Children's Services Memory Making Request Form (when a child has been transferred to RHCYP for Hospital PM and memory making has not been completed prior to transfer)	Addressograph, or Name DOB CHI
Date of Death :	Name & Number of Professional contact (BGH):
Parent/Guardian (1)	Parent/Guardian (2) if different from (1)
Full Name:	Full Name:
Address:	Address:
Telephone Number:	Telephone Number:

Instructions for Memory Making Parent/Guardian has given verbal and/or written consent for the following: (written consent for photographs).

Footprints: YES ☐ NO ☐	Handprints : YES ☐ NO ☐
Fingerprints: YES ☐ NO ☐	Lock of hair: YES ☐ NO ☐
Photographs to be taken: YES ☐ NO ☐	
Address that completed Items should be sent to if different from above: (Please send special delivery)	Address –

To be completed by person(s) carrying out procedures	
Name(s):	Date of procedure:
Footprints taken: YES ☐ NO ☐	Handprints taken : YES ☐ NO ☐
Fingerprints taken YES ☐ NO ☐	Lock of hair taken: YES ☐ NO ☐
Photographs taken: YES ☐ NO ☐	
Photographs taken by:	
Memory Making items sent by special delivery to parents: YES☐ NO ☐	Date sent:
Receipt of Memory Making items confirmed:	YES ☐ NO ☐