# Form for the Diagnosis of Death using Neurological Criteria for Children 2 months to <18 years {abbreviated guidance version}

This form is consistent with and should be used in conjunction with, the AoMRC (2008) A Code of Practice for the Diagnosis and Confirmation of Death and has been endorsed for use by the following institutions: Faculty of Intensive Care Medicine, Intensive Care Society, Paediatric Intensive Care Society and National Organ Donation Committee: Paediatric Subgroup.

HOSPITAL ADDRESSOGRAPH or

Surname
First Name
Date of Birth
NHS

**Primary Diagnosis:**

**Evidence for Irreversible Brain Damage of Known Aetiology:**

**Diagnostic caution is advised in certain 'Red Flag' patient groups. See Page 3 for details**

## Exclusion of Reversible Causes of Coma and Apnoea

| | 1st Test Dr One | 1st Test Dr Two | 2nd Test Dr One | 2nd Test Dr Two |
|---|---|---|---|---|
| **Is the coma due to depressant drugs? Drug Levels (if taken):** | **Yes / No** | **Yes / No** | **Yes / No** | **Yes / No** |
| **Is the patient's body temperature ≤34°C?** | **Yes / No** | **Yes / No** | **Yes / No** | **Yes / No** |
| **Is the coma due to a circulatory, metabolic or endocrine disorder?** | **Yes / No** | **Yes / No** | **Yes / No** | **Yes / No** |
| **Is the apnoea due to neuromuscular blocking agents, other drugs or a non brain-stem cause (*e.g.* cervical injury, any neuromuscular weakness)?** | **Yes / No** | **Yes / No** | **Yes / No** | **Yes / No** |

## Tests for Absence of Brain-Stem Reflexes

| | 1st Test Dr One | 1st Test Dr Two | 2nd Test Dr One | 2nd Test Dr Two |
|---|---|---|---|---|
| **Do the pupils react to light?** | **Yes / No** | **Yes / No** | **Yes / No** | **Yes / No** |
| **Is there any eyelid movement when each cornea is touched in turn?** | **Yes / No** | **Yes / No** | **Yes / No** | **Yes / No** |
| **Is there any motor response when supraorbital pressure is applied?** | **Yes / No** | **Yes / No** | **Yes / No** | **Yes / No** |
| **Is the gag reflex present?** | **Yes / No** | **Yes / No** | **Yes / No** | **Yes / No** |
| **Is the cough reflex present?** | **Yes / No** | **Yes / No** | **Yes / No** | **Yes / No** |
| **Is there any eye movement during or following caloric testing in each ear?** | **Yes / No** | **Yes / No** | **Yes / No** | **Yes / No** |

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**Patient Name:** **NHS Number:**

| Apnoea Test | | | | |
|---|---|---|---|---|
| | 1st Test Dr One | 1st Test Dr Two | 2nd Test Dr One | 2nd Test Dr Two |
| Arterial Blood Gas pre apnoea test check: (Starting $PaCO_2 \geq 6.0$ kPa and starting pH <7.4) | 1st Test<br>Starting $PaCO_2$:<br><br>Starting pH: | | 2nd Test<br>Starting $PaCO_2$:<br><br>Starting pH: | |
| Is there any spontaneous respiration within 5 (five) minutes following disconnection from the ventilator? | Yes / No | Yes / No | Yes / No | Yes / No |
| Arterial Blood Gas Result post apnoea test: $PaCO_2$ should rise > 0.5 kPa . | 1st Test<br>Final $PaCO_2$:<br><br>*Perform lung recruitment* | | 2nd Test<br>Final $PaCO_2$:<br><br>*Perform lung recruitment* | |
| Document any Ancillary Investigations Used to Confirm the Diagnosis or any required Clinical Variance from AoMRC (2008) Guidance | | | | |

| Completion of Diagnosis | | |
|---|---|---|
| Are you satisfied that death has been confirmed following the irreversible cessation of brain-stem function? | YES / NO | YES / NO |
| Legal time of death is when the 1st Test indicates death due to the absence of brain-stem reflexes.<br><br>Death is confirmed following the 2nd Test. | Date:<br>Time:<br><br>Dr One<br>Name<br>Grade<br>GMC Number<br>Signature<br><br>Dr Two<br>Name<br>Grade<br>GMC Number<br>Signature | Date:<br>Time:<br><br>Dr One<br>Name<br>Grade<br>GMC Number<br>Signature<br><br>Dr Two<br>Name<br>Grade<br>GMC Number<br>Signature |

*It remains the duty of the two doctors carrying out the testing to be satisfied with the aetiology, the exclusion of all potentially reversible causes, the clinical tests of brain-stem function and of any ancillary investigations so that each doctor may independently confirm death following irreversible cessation of brain-stem function.*

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**Guidance Summary of the AoMRC and RCPCH Guidance**

The diagnosis of death by neurological criteria should be made by at least two medical practitioners who have been registered for more than five years and are competent in the conduct and interpretation of brain-stem testing. Both doctors should be competent in the diagnosis of death by neurological criteria it is recommended that one of the doctors should be a paediatrician and at least one should be a consultant.

Testing should be performed completely and successfully on two occasions with both doctors present. Doctor One may perform the tests while Doctor Two observes; this would constitute the first set. Roles may be reversed for the second set.

Diagnostic caution is advised in the following 'Red Flag' patient groups.
(Based on the literature and unpublished case reports.)

1. Testing **<6 hours** of the loss of the last brain-stem reflex
2. Testing **<24 hours** where aetiology primarily anoxic damage
3. **Hypothermia** (24-hour observation period following re-warming to normothermia recommended)
4. Patients with **any neuro-muscular disorders**
5. **Steroids** given in space occupying lesions such as abscesses
6. Prolonged **fentanyl** infusions
7. Aetiology **primarily** located to the **brain-stem or posterior fossa**

**Evidence for Irreversible Brain Damage of Known Aetiology**

- There should be no doubt that the child's condition is due to **irreversible brain damage of known aetiology**. Occasionally it may take a period of continued clinical observation and investigation to be confident of the irreversible nature of the prognosis. The timing of the first test and the timing between the two tests should be adequate for the reassurance of all those directly concerned. **If in doubt wait and seek advice.**

**Drugs**

- The child should not have received any drugs that might be contributing to the unconsciousness, apnoea and loss of brainstem reflexes (narcotics, hypnotics, sedatives or tranquillisers). Where there is any doubt specific drug levels should be carried out (midazolam less than < 10mcg/L, thiopentone <5mg/L). Alternatively consider ancillary investigations.
- There should be no residual effect from any neuromuscular blocking agents (atracurium, vecuronium or suxamethonium), consider the use of peripheral nerve stimulation.
- Renal or hepatic impairment and immaturity may prolong metabolism / excretion of these drugs.

**Temperature, Circulatory, Metabolic or Endocrine Disorders**

- Prior to testing aim for: temperature > 34°C, mean arterial pressure should be consistently maintained at age appropriate levels, maintenance of normocarbia and avoidance of hypoxia, acidaemia or alkalaemia (PaCO2 <6.0 kPa, PaO2 >10 kPa and pH 7.35-7.45).
- Serum $Na^+$ should be between 115-160 mmol/L; Serum $K^+$ should be > 2 mmol/L; Serum $PO_4^{3-}$ and $Mg^{2+}$ should not be profoundly elevated (>3.0 mmol/L) or lowered (<0.5 mmol/L) from normal.
- Blood glucose should be between 3.0-20 mmol/L before each brain-stem test.
- If there is any clinical reason to expect endocrine disturbances, then it is obligatory to ensure appropriate hormonal assays are undertaken.

**Brain Stem Reflexes**

- Pupils should be fixed in diameter and unresponsive to light.
- There should be no corneal (blink) reflex (care should be taken to avoid damage to cornea).
- Eye movement should not occur when each ear is instilled, over one minute, with 20 -50 mls of ice cold water, head 30°. Each ear drum should be clearly visualised before the test.

- There should be no motor response within the cranial nerve or somatic distribution in response to supraorbital pressure. Reflex limb and trunk movements (spinal reflexes) may still be present.
- There should be no gag reflex following stimulation to the posterior pharynx or cough reflex following suction catheter placed down the trachea to the carina.

**Apnoea Test**

- End tidal carbon dioxide can be used to guide the starting of each apnoea test but should not replace the pre and post arterial $paCO_2$.
- Oxygenation and cardiovascular stability should be maintained through each apnoea test.
- **Confirm $PaCO_2$ ≥6.0 kPa and pH < 7.4.** In patients with chronic $CO_2$ retention, or those who have received intravenous bicarbonate, confirm $PaCO_2$ >6.5 kPa and the pH <7.4 .
- Either use a CPAP circuit (eg Mapleson C or Ayres T piece) or disconnect the patient from the ventilator and administer oxygen via a catheter in the trachea at a rate of 2-6L/minute.
- There should be no spontaneous respiration within a minimum of 5 (five) minutes following disconnection from the ventilator.
- **Confirm that the $PaCO_2$ has increased from the starting level by more than 0.5 kPa.**
- At the conclusion of the apnoea test, manual recruitment manoeuvres should be carried out before resuming mechanical ventilation and ventilation parameters normalised.

**Ancillary Investigations**

- Ancillary investigations are **NOT** required for the diagnosis and confirmation of death using neurological criteria. Any ancillary or confirmatory investigation should be considered **ADDITIONAL** to the fullest clinical testing and examination carried out to the best of the two doctors capabilities in the given circumstances.

**Organ Donation**

- National professional guidance advocates the confirmation of death by neurological criteria wherever this seems a likely diagnosis and regardless of the likelihood of organ donation.
- NICE guidance and PICS Standards recommends that the specialist nurse for organ donation (SN-OD) should be notified at the point when the clinical team declare the intention to perform brain-stem death tests and this is supported by GMC guidance.

**Further Reading**

Academy of Medical Royal Colleges (2008) "A Code of Practice for the Diagnosis and Confirmation of Death" www.aomrc.org.uk
GMC (2010) "Treatment and care towards the end of life." www.gmc-uk.org
Heran et al (2008) "A review of ancillary tests in evaluating brain death." Can J Neurol Sci; 35:409–19
NICE (2011) "Organ Donation for Transplantation" www.nice.org.uk
Report from the Organ Donation Taskforce (2008) "Organs for Transplant" www.webarchive.nationalarchives.gov.uk
Paediatric Intensive Care Society (2014) "PICS Organ Donation Standards" http://picsociety.uk/resources/
Wijdicks E (2001) "The Diagnosis of Brain Death" NEJM 344:1215-21

**Form authorship and feedback**

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