

**West Mercia
Multi-Agency Protocol
for the
Management of**

**SUDDEN & UNEXPECTED
DEATHS IN INFANTS &
CHILDREN**



**WEST MERCIA
CONSTABULARY**
TOGETHER - WORKING FOR SAFETY AND JUSTICE

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PREFACE

In the spectrum of child health and safety, child fatalities represent only a small portion of all injuries, illnesses and disabilities in children. Yet they are profound events that have a great impact on families and communities. Focusing attention on understanding and preventing even one child's death can serve as the foundation to help prevent poor health outcomes, injuries, disabilities or deaths in a far greater number of children. This new protocol on responding to child deaths empowers the review process with the aim of increasing the understanding of the causes of child deaths. It will enable a better multi agency response to children at risk and the development of child health and safety services, legislation, policies, and prevention programmes to increase public awareness. It is fully compliant with the procedures within working together to safeguard Children and the Children Act 2004.

The Protocol deals with the investigation of sudden and unexpected deaths in infants and children under the age of 18 where the death was not expected. It has been jointly developed by the following agencies within the Local Authorities of Herefordshire, Worcestershire, Shropshire, & Telford and Wrekin which are coterminous with the five West Mercia Constabulary basic command units.

Worcestershire Safeguarding Children Board
Shropshire Safeguarding Children Board
Herefordshire Safeguarding Children Board
Telford & Wrekin Safeguarding Children Board
West Mercia Police
West Midlands Strategic Health Authority
West Mercia Coroners
Foundation for Study into Infant Deaths
Crown Prosecution Service
West Midlands Ambulance Service

This document provides the framework for a comprehensive and sensitive enquiry aimed at establishing the cause of sudden unexplained deaths in infants and Children under 18 and is compliant with the Children Act 2004 and the wider Safeguarding Children agenda.

1. INTRODUCTION

1.1 The development of a National response to Child Death

1.1.2 A number of child death reviews have highlighted the lack of guidance for professionals in dealing with unexplained deaths in children. The CESDI 2000 research (Confidential Enquiry into Stillbirths and Deaths in Infancy/the CESDI Sudden Unexpected Death in Infancy studies) also highlights the need for establishing a pathway for investigating sudden unexplained deaths in infancy (SUDI).

In 2003, three high profile criminal cases involving the prosecution of mothers for causing the death of their babies created considerable public consternation. In all three cases mothers had suffered the loss of more than one infant. The repetition of sudden deaths without explanation raised suspicion amongst professionals, and in the absence of any eye-witness evidence of harmful conduct, Police investigations relied upon medical expertise, particularly that of paediatricians and pathologists. Such evidence, when placed under careful scrutiny, raised serious concerns about the role of the expert witness in the Courts, the standard of proof, the quality of evidence, and the procedures adopted for the investigation of sudden unexpected and unexplained deaths in children. It became apparent that there was a need for greater emphasis upon a coherent multi-disciplinary and multi-agency approach, to ensure that each SUDIC incident is investigated and managed to the highest possible standard.

The Presidents of The Royal College of Pathologists and The Royal College of Paediatrics and Child Health recognised the seriousness of the events that were unfolding and established a Working Group to consider the implications of these cases for the medical profession. The overriding concern was that steps should be taken to prevent miscarriages of justice while protecting the interests and safety of children. This working group was chaired by Baroness Helena Kennedy QC, and resulted in a national multi agency protocol for the care and investigation into sudden infant death.

The Children Act 2004 has placed requirements on Local Safeguarding Children Boards to extend services in the field of Child deaths to all unexpected deaths of children, (under 18 years), where the death was not foreseen 24 hrs earlier. The implementation of rapid response teams of lead professionals and child death overview panels are two key changes to the way we approach and investigate child death. This Multi Agency Protocol is intended to provide guidance and set common minimum standards of investigation for practitioners who are confronted with these tragic circumstances. It is acknowledged that each such death has unique circumstances and each professional involved has their own experience and expertise, which, quite rightly, is drawn upon in their handling of individual cases. Nevertheless, there are common aspects to the management of unexplained child deaths, which it is important to share in the interest of good practice and of achieving a consistent approach.

In any sudden and unexplained death of an infant, the lead lies with the Coroner and the Police. However, this protocol sets out how **ALL** of the partner agencies must work together.

The Protocol gives an insight into the priorities of those professionals involved, in an attempt to promote a mutual understanding of each agency's roles and responsibilities. Professionals need to strike a balance between the sensitivities of bereaved families, and ensuring a proper investigation is undertaken, to aid families in arriving at an understanding of why their child died.

2. WHAT IS IN THE BEST PRACTICE PROTOCOL

- 2.1 The Protocol contains general advice and guidance in dealing with such deaths along with information concerning inter-agency working. It describes some of the factors that may arouse concern about the circumstances surrounding the death and reflects the requirements of the Children Act 2004.
- 2.2 For the purpose of this protocol which deals with the investigation of sudden and unexpected deaths of infants and children under the age of 18 (SUDIC), an infant will be defined as any child under the age of 2.
- 2.3 Procedures relating to the rapid response of a core group of professionals are covered within the protocol in accordance with Chapter 7 of Working Together to Safeguard Children. On some occasions it will be appropriate for the key professional attending such incidents to consider the relevant resources required to attend the initial report.

3. INTER-AGENCY WORKING: OVERVIEW OF THE PROCESS

Relevant Child Deaths

- 3.1 Relevant deaths will include infant deaths and all other deaths up to 18 years, subject to the relevant professional opinion on the unexpected nature of the death. Relevant deaths may also include deaths out of the Local Safeguarding Children Board areas, where the rapid response element would not be invoked but the death may still be subject to the initial case review meeting and subsequent follow up. The application of certain aspects of the protocol will depend upon the age of the child, e.g. the taking of samples.

Overview of the process

- 3.2 Those professionals involved (before or after the death) with a child who dies unexpectedly should come together to enquire into and evaluate the child's death. An on-call rota for responding to unexpected child deaths will be maintained by each relevant agency, linked to the relevant Health services in each Police / Local Safeguarding Children Board area.
The work of the team convened in response to each child's death will be co-ordinated by a local designated SUDIC paediatrician responsible for unexpected deaths in childhood. LSCBs may choose to designate particular

professionals to be standing members of a team because of their roles and particular expertise.

The professionals who come together as a team will carry out their normal functions – i.e. as a paediatrician, GP, nurse, health visitor, midwife, mental health professional, social worker, probation or police officer – in response to the unexpected death of a child in accordance with this protocol. They should also work according to a protocol agreed with the local coronial service.

All sudden unexplained deaths in children are notified to the Coroner and a full Police/Coroner investigation will take place. A Detective Inspector trained as a senior investigating police officer will support the investigation which will comprise of a multi-agency team, with a remit to enquire into the circumstances surrounding the child's death including:

- Responding quickly to the unexpected death of a child
- Making immediate enquiries into and evaluating the reasons for and circumstances of the death, in agreement with the Coroner
- Undertaking the types of enquiries/investigations that relate to the current responsibilities of their respective organisations when a child dies unexpectedly. This includes liaising with those who have ongoing responsibilities for other family members
- Collecting information in a standard, nationally agreed manner
- Following the death through and maintaining contact at regular intervals with family members and other professionals who have ongoing responsibilities for other family members, to ensure they are informed and kept up-to-date with information about the child's death.

4. RESPONDING TO THE UNEXPECTED DEATH OF A CHILD

4.1 The type of response to each child's unexpected death will depend to a certain extent on the age of the child and the circumstances, for example in some open-air deaths, it may be wholly inappropriate for all rapid response team critical professional assets to attend a scene. In such cases the Senior Investigating Police Officer will, in conjunction with a senior healthcare professional, make a decision on scene attendance in non-infant deaths. However some key actions underpin all subsequent work. As well as deciding when a visit should take place to facilitate family history taking, it should be decided who should attend. This will need to take account of the family's wishes and the time of day amongst other factors in each case.

4.2 It is likely to be a senior investigating police officer and a SUDIC health care professional (experienced in dealing with child deaths and who may be a paediatrician) who carry out the home visit, preferably together.

4.3 Concerns about surviving children living in or connected with the family should be dealt with in accordance with par. 4.9. If there are grounds at an early

stage for a serious case review, the procedures at Appendix 5 should be followed.

- 4.4 The process and procedures are described in full in each agency section. An outline is set out below and in the flow chart at Appendix 5.
- 4.5 There should be collaborative working at all levels from the earliest call to the emergency services. The Senior Investigating Police Officer (SIPO) who initially attends the scene of a child death may not always be one of the 5 specialist Public Protection Unit officers within West Mercia Constabulary. In those cases the appointment of the specialist Public Protection Unit Detective Inspector will be discussed as part of the Initial Case Discussion meeting after the initial response and on a case by case basis. All Police Senior Investigating Officers will be trained to a national accreditation programme in serious and major crime.
- 4.6 The initial call to the emergency services will trigger the agreed pathway at Appendix 7, so that the Police, Paediatrician and Coroner are informed. Where the death is not in the A & E and the child is not taken immediately to the Hospital, the professional confirming the death should inform the designated paediatrician with responsibility for unexpected deaths of children.
- 4.7 Where a child has died in, or been taken to, a hospital their parents / carers should be allocated a member of staff to remain with and support them throughout the process. The parents should be given an opportunity where possible to spend time with their child, during which a member of staff will keep a discreet presence. Once initial procedures have concluded, and within 24 hours, a joint decision will be made around family liaison and longer-term allocation of resources. Where this paragraph applies, the SIPO will deploy staff to both the hospital and the scene of the death.
- 4.8 When a child dies unexpectedly, the on call or designated paediatrician should initiate an initial case discussion, usually within 4 hours, between the lead agencies (i.e. SUDIC healthcare professional, police and LA Children's Social Care) to decide what should happen next and who will do what. This will also include the Coroner's Officer and consultant paediatrician on call and any others who are involved (e.g. the GP if called out by family or, for older children, the professional certifying the fact of death if s/he has already been involved in the child's care/death). The agreed plan should include a commitment to collaborate closely and communicate as often as necessary, often by telephone. Where the death occurred in a hospital, the plan should also address the actions required by the Trust's Serious Incident Protocol. Where the death occurred in a custodial setting the Senior Police Investigating Officer will co ordinate the initial case discussion meeting, including appropriate liaison with the investigator from the Prisons and Ombudsman.

There will be circumstances that prevent the relevant professionals coming together within a short time of the death, for example where they have directly been involved in the care of the patient for some hours leading up to the death in hospital. The SUDIC health care professional will in such cases ensure all relevant and available information is presented for the initial case discussion.

- 4.9 In such cases, any immediate concerns for other children in the family or in regular contact with the family, will result in a referral to Children's Services and consideration of convening a strategy discussion. (See 5.4 re meetings)
- 4.10 The early case discussion meeting will take place usually within 4 hours prior to the post mortem. Where it is clear from the outset that the death is suspicious, and a criminal investigation has formally commenced, the Crown Prosecution Service must be consulted prior to the initial planning and information sharing meeting taking place. Any strategy discussion concerning surviving siblings must not be delayed as a result of this requirement and communication by telephone is an acceptable means for seeking this authority, usually by the Senior Investigating Police Officer.
- 4.11 The chair of the LSCB must be informed where there are concerns that a serious case review may be required.

5. MEETINGS

- 5.1 Fundamental to the functions of rapid response and the longer-term overview of all child deaths is collaborative working at all levels and information sharing. As a part of this process, there is a need for a number of formal meetings and discussions to be held. It is expected that all agencies will support the response to child deaths by making facilities and resources available to meet this ongoing review process. Records of any meetings carried out by the rapid response team are crucial in supporting the overview process at the end of the formal procedures in all child deaths. It is vital for accurate and accountable records to be maintained in order for the Overview Panel to make recommendations in cases of preventable deaths. There are 3 types of meeting;
- Initial Case Discussion meeting (approximately 4 hours)
 - Early Information Sharing and Planning meeting (48 hours)
 - Later Case Review meeting (3 months)
- 5.2 It is also crucial that accurate records of meetings and discussions are maintained and can be readily retrieved. The reason for this is to enable the management of disclosure in any subsequent Court proceedings, whether criminal or otherwise. Failings in this area can have serious consequences both in terms of potential miscarriages of justice and for individuals and organisations.
- 5.3 The purpose of the early information sharing and planning meeting convened by the SUDIC healthcare professional is:
- For each agency to share information from previous knowledge of the family and records, with particular reference to the circumstances of the child's death. This would include details of previous or ongoing child protection concerns, previous unexplained or unusual deaths in the family, neglect, failure to thrive, parental substance misuse, parental mental ill-health, domestic abuse, previous hospitalisation and GP visits, etc. Is there a "Significant Concern"?

- To enable consideration of any child protection risks to siblings/any other children living or visiting the household, and to consider the need for child protection procedures.
- To discuss any need for action in respect of other children in the family (e.g. health overview).
- To ensure a co-ordinated bereavement care plan for the family.
- To decide which information may be shared with the family.
- To collate all relevant information to share with the Pathologist.

Those involved could include:

- i) **Health** - The doctor who certified death, the named Health Visitor/ School Nurse for the child, the community midwife if appropriate, the General Practitioner, the on call Consultant Paediatrician and SUDIC health care professional, and the named professionals for Child Protection.
- ii) **Children's Services** - The Children's Services Team Manager or the Emergency Duty Team social worker.
- iii) **Police** - Child Abuse Investigation Unit Detective Inspector or appointed SIPO.
- iv) **Other contributors** - Ambulance Service (if applicable) and Education (where the child was attending school or nursery) and any other agency/person who may have a contribution to make, e.g. Women's Aid, CAMHS, Military, Prison service.

- 5.4 If there are child protection concerns regarding children in the household, a strategy meeting under child protection procedures must take place. The presence of a uniform Police Inspector with skills in operational planning is recommended for this meeting
- 5.5 There must be a further professionals' meeting or phone conversation after the post-mortem, so those relevant professionals are able to discuss the findings and interpret their relevance.
- 5.6 As soon as possible, usually 3 – 6 months after the infant's death (once the results of all relevant investigations have been obtained), a multi-agency Case Review meeting is to be held. This meeting will be convened by the SUDIC health care professional. The main purpose of this meeting is to establish the cause of the child's death and for future care planning for the family, achieved through sharing of information.

5.7 **If, however, the death is subject of an ongoing criminal investigation, no such meeting should be held without the Police first seeking the views of 'Prosecuting Counsel' or CPS.**

A view will be sought on the following issues:

- Should the meeting be held?
- What should be the format and scope?
- Who should attend the meeting?
- How should the meeting be recorded?
- Any other pertinent issues

The meeting will usually be chaired by the SUDIC healthcare professional. This meeting should involve the GP, Health Visitor, Paediatrician(s), Pathologist, and Coroner's Officer, Senior Investigating Police Officer and, where appropriate, a senior representative from Children's Services.

Families will not be invited to these meetings, as the large number of professionals present and the very technical and detailed nature of some of the discussion will make the meeting inappropriate for bereaved parents. Many parents would be likely to find such a meeting intimidating and distressing.

The parents must, however, be informed of the outcome of the meeting by the SUDIC healthcare professional, or the Paediatrician responsible for the child's care. Other professionals may also be present, for example at the wish of the family, on a case by case basis.

5.8 At this case review meeting, all relevant information concerning the circumstances of the death, the child's history, family history and subsequent investigations should be reviewed. The cause of the child's death should be established if possible. The Avon clinicopathological classification of sudden unexpected infant deaths will be used in considering all of the potentially contributory factors that may be relevant (see Appendix 2). In some cases, the Coroner's Officer will wish to attend these meetings; in others, the Police will attend both as the investigating agency and as the Coroner's representative.

5.9 During the meeting there must be an explicit discussion of the possibility of neglect or abuse as a contributory factor to the infant's death. .

5.10 If no evidence is identified to suggest neglect or abuse as contributory factors, this should be documented as part of the report of this meeting.

5.11 The quality of medical and social care that was given to the child and family should also be discussed at this meeting, identifying any shortcomings and appropriate measures to improve future care. For these reasons, holding such a meeting even in those instances in which a complete and sufficient medical (natural) explanation has been found for the death may be of value.

5.12 Notes of the meeting will be kept by the Designated Paediatrician chairing the meeting. This should include completion of The Avon clinicopathological classification of sudden unexpected infant deaths form (Appendix 2) and any

ancillary summary, as deemed necessary. This record will subsequently be distributed for ratification by those attending the meeting.

- 5.13 After the multi-agency case review meeting, the SUDIC health care professional, in close consultation with the Pathologist, should write a detailed report on the available information concerning the cause of the child's death as a letter to the parents. Arrangements should be made for the appropriate paediatrician and the GP or Health Visitor to jointly see the parents to explain the content of this report. They will answer any further questions that the parents may have, and make plans for any future additional care and support that may be appropriate, including the question of further investigation of family members or subsequent children for metabolic or other familial disorders.
- 5.14 A copy of the notes of the meeting should be sent to each of the agencies involved. This may be of great importance in assessing the possibility of risk (particularly from metabolic or other familial conditions) to surviving and future children in the family.
- 5.15 **The SUDIC Healthcare professional will provide the Coroner with copies of the record of the meeting and letter to parents.** The information available from this meeting will potentially be of great value to the Coroner in the organisation and conduct of the inquest, and will ensure that correct information is included in the final registration of the cause of death notified to the Registrar of Births and Deaths.
- 5.16 Finally, the record of the multi-agency case review, a copy of the SUDIC healthcare professional's report and a copy of the Child Death Protocol audit document should be forwarded to the relevant Local Safeguarding Children Board. This information may assist in any serious case review and be a formal requirement for the ongoing work of the Child Death Overview Panel for the respective LSCB area.
- 5.17 Appropriate information should also be made available to the relevant staff about the outcome of any processes/ enquiries following the final case review. This will facilitate audit, highlight good practice and assist with identifying any lessons to be learned.

6. GENERAL ADVICE FOR ALL PROFESSIONALS

- 6.1 The behaviour of the first professionals to come into contact with the family can have a lasting effect on the family's later feelings about the death. Remember that people are in the first stages of grief. They may be shocked, numb, withdrawn or hysterical.
- 6.2 The death of a child is a very difficult time for everyone. Time spent with the family now may be brief, but actions may greatly influence how the family deal with the bereavement for a long time afterwards. A sympathetic and supportive attitude, whilst maintaining professionalism towards the investigation, is essential.

- 6.3 All professionals must record the history and background information given by parents/carers in as much detail as possible. The initial accounts about the circumstances, including timings, must be recorded accurately and contemporaneously.
- 6.4 It is normal and appropriate for parents/carers to want physical contact with their dead child. In all but exceptional circumstances (such as where the parents are obvious suspects and crucial forensic evidence may be lost or interfered with) this should be allowed, however it must be under observation by an appropriate professional.
- 6.5 The child should always be handled as if he/she were still alive; remembering to use his/her name at all times as a sign of respect and dignity.
- 6.6 All professionals need to take into account any religious and cultural beliefs, which may impact on procedures. Such issues must be dealt with sensitively but the importance of the preservation of evidence should remain paramount.
- 6.7 Following the death of their child, parents need to be consoled and supported. The family will need to be told that the death of their child will require a detailed multi-disciplinary investigation, which will include a comprehensive medical and post-mortem examination and meetings between the professionals involved. They need to be aware that the investigation will involve the Police, health and Children's Services. The Police and Health professionals may want to visit the scene of the child's death as soon as possible. Utmost sensitivity should be displayed in imparting this information. All professionals involved in this process will need to be aware of the requirements of the law, but also be very sensitive to the distress of the family.
- 6.8 The Coroner must be informed of all such deaths and the parents and family must be made aware of this procedure and that a Coroner's post-mortem will be necessary. Additionally an inquest may well be necessary. This will normally be explained by the Coroner's officer.
- 6.9 Where possible, written contact names and telephone numbers should be given and the leaflet from the Foundation for the Study of Infant Death should be made available.
- 6.10 If any language or communication difficulties become apparent it will be crucial to arrange for relevant support immediately as communication with the family is central to this process.
- 6.11 Professionals from all agencies need to be aware that on occasions, in suspicious circumstances, the early arrest of the parent/carer may be essential in order to secure and preserve evidence and thus effectively conduct the investigation.
- 6.12 Professionals also need to be aware of the constraints placed on the Police by the Police and Criminal Evidence Act (PACE) that determines how

suspects may be questioned and the length of time they may be detained without charge.

6.13 Agency professionals will be requested to provide statements of evidence promptly in the above circumstances.

6.14 Pointers for all professionals in talking with bereaved parents (taken from advice given by the FSID)

- *When you arrive always say who you are and why you are there, and how sorry you are about what has happened to the child.*
- *The parents will be in the first stages of grief and may react in a variety of ways, such as shock, numbness, anger or hysteria. Allow the parents space and time to cry, to talk together and to comfort any other children. These early moments of grieving are very important. Parents may want to hold their child and this can be facilitated, if appropriate, but may need to be supervised.*
- *In talking about the child preferably use the first name, or, if you don't yet know the name, say 'your child', or 'he' or 'she'. Don't refer to the child as 'it'.*
- *Have respect of the family's religious beliefs and culture.*
- *If English is not the family's first language, or communication difficulties are identified, relevant support should be arranged.*
- *Take things slowly, allowing the parents to gather their thoughts and tell the story in their own way.*
- *Be prepared to answer practical questions, for example about where the child will be taken and when they can next see him/her.*
- *Most parents feel guilty when their child has died. When talking to them try to ask questions in a neutral way, e.g. 'Would you like to tell me what happened?' Avoid questions that sound critical, such as 'Why didn't you?'*
- *Don't use such phrases as 'suspicious death' or 'scene of crime', and try to avoid comments that might be misunderstood by, or distressing to, the parents.*

7. THE FOUNDATION FOR THE STUDY OF INFANT DEATHS

7.1 The Foundation for the Study of Infant Deaths has a help-line offering support and information to anyone who has suffered the sudden death of an infant.

**Help-line: 0870 787 0554 (9.00 am – 11.00 pm weekdays;
6.00 pm – 11.00 pm weekends)**

Enquiries: 0870 787 0885 (9.00 am – 5.00 pm weekdays).

- 7.2 The help-line is also available for family and friends and those professionals involved with the death.
- 7.3 The Foundation has a wide range of leaflets and information for bereaved families and professionals. It also has a network of befrienders, who are themselves bereaved parents. Arrangements can be made for a befriender to contact the bereaved family to offer additional support. A free phone card is available from the FSID for parents, to enable contact with The Foundation. (www.fsid.org.uk).
- 7.4 Publications available:
- Protocols for A&E Departments
 - Protocols for Ambulance Staff
 - Protocols for General Practitioners
 - Protocols for Midwives
 - Protocols for Health Visitor
 - Protocols for Police and Coroner's Officers
 - Good Practice for Paediatricians

8. THE ROLES AND RESPONSIBILITIES OF HEALTH PROFESSIONALS

- 8.1 This section sets out the issues to be considered by health professionals, their roles, responsibilities and process to be followed. Contained within this section are details regarding:
- Care of the parents
 - Ambulance Service
 - Approved undertaker where child is obviously deceased.
 - General Practitioners
 - Hospital procedures.
- 8.2 There should be a multi-disciplinary and multi-agency approach to the sudden unexplained death of a child. This will also place greater emphasis on support for the family at the time of the event and afterwards in the form of information giving and counselling.
- 8.3 Each Health Trust should ensure that health professionals are aware of their own and other's role in the investigation and management of a child's death.
- 8.4 Detailed, accurate and contemporaneous records should be kept by all professionals of history taking, medical examinations and discussions with parents and other professionals, health or otherwise. The importance of full and accurate record keeping must be emphasised for the purposes of disclosure and transparency.
- 8.5 The role of the health professionals will include:

- Sharing and pooling of information from all health sources, i.e. General Practitioner, NHS direct, community midwife, health visitor, school nurse, community paediatrician, senior nurse child protection, any hospital or community unit the child has attended, etc.
- In association with the Police, checking with Children's Services for relevant information.
- The medical examination of the child, history taking and liaison with the Pathologist before and after the post-mortem.
- There should always be consideration of a home visit by a trained health professional. This should be a joint home visit by police and the SUDIC healthcare professional. If separate visits are made they should confer on their assessment.
- Any Police recording of the scene of death should be viewed by the paediatrician (and made available to the Pathologist).
- The receiving hospital (normally in the area where the child resides) should arrange for a full skeletal survey in all cases of unexpected infant or child death. In cases where the hospital does not have the facilities to undertake the skeletal surveys, the responsibility will fall to the Coroner's officer to make the necessary arrangements. Consideration in other cases of child deaths for a skeletal survey should be made on a case by case basis.
- Two copies of the skeletal survey will be required. One copy to accompany the child to the post mortem and the second copy to be reported on by a Consultant Radiologist experienced in interpreting paediatric x-rays. In instances where the receiving hospital does not have the facility to complete the skeletal survey, then the Coroner's Officer will make the necessary arrangements for the skeletal survey to be undertaken prior to post mortem.
- The receiving hospital will ensure forensic samples are obtained prior to the child being transferred for post mortem.

LABORATORY INVESTIGATIONS

In children under 2 years where the cause of death or factors contributing to it are uncertain investigative samples should be taken once death is confirmed. These include the standard set for SUDI and have been agreed with the coroner. If there is definite external evidence of injury early samples should only be taken after

discussion with the coroner. Additional samples must be subject to authorisation from the Coroner.

- Samples must be sent to an appropriate virological laboratory.
- See **Appendix 4** for further information regarding laboratory tests.

Examination of child; points to consider:

- Injuries, bruising, petechiae
- Examination of fraenum and genitalia
- Lividity
- Retinal haemorrhage
- Enlarged organs or masses
- Systems examination
- Rectal temperature
- Skull palpation - fracture
- Other fractures
- Nutrition/growth, the child needs to be weighed & measured. (length, weight, and head circumference should be taken and plotted on a centile chart.
- Upon attendance at hospital note where blood has collected in the child's body, as this will give an indication of the child's position at the time of death. It is important this is noted as soon as possible.
 - An On-Call Paediatrician should initiate and attend the initial and subsequent information sharing and planning meetings. (see Section 5)
 - The Paediatric team will ensure immediate support is afforded for the family. It will be important to ensure clear communication between Police Family Liaison Officer and Hospital support to prevent duplication and meet the wishes of the family.
 - The paediatric team will ensure that the immediate health needs of any siblings, especially a twin, are met.
 - Note: After death is certified, the body is under the jurisdiction of the Coroner and complex investigations should be discussed with the Coroner first. Agreement for standard investigations may be arranged in advance.

8.6 Care of the Parents

Immediately upon their arrival at the hospital, parents should be allocated an experienced / trained nurse to care for them, explain what is happening and provide them with facilities to contact friends, other family members and cultural or religious support. The member of staff allocated to the family should ensure that they are kept fully informed during the course of the resuscitation and, subject to the approval of the medical staff involved, the parents should be given the option to be present during the resuscitation. The allocated member of staff should stay with the parents throughout this period

to explain what is going on, particularly the procedures that may look alarming, such as cutting off clothing or attempts at vascular access, including the use of intraosseous needles or intubation.

Staff will need to make an assessment of the capacity of the parents to engage in the processes unfolding around them. For some, the shock of the situation will impede their understanding; for others, there may be issues of language, health or mental capacity that need to be taken into account. If there is a possibility that the family may become witnesses or defendants in criminal proceedings, the Police will need to make an early judgement about whether they should be seen as 'vulnerable witnesses', and perceptions of the allocated member of staff will be of benefit in arriving at a decision.

Immediate responsibility for providing information and co-ordinating appropriate care and support to the family should rest with the on-call paediatric team (almost always led by the consultant paediatrician on call). Whilst senior staff from the disciplines of emergency medicine and/or intensive care may have been involved in the resuscitation, it is generally more appropriate for continuing pastoral care of the family and liaison with the primary care team or other agencies to be the responsibility of the consultant paediatrician on call, or the paediatrician with special responsibility for SUDIC.

The Consultant Paediatrician on call should, as part of the initial assessment, take a detailed and careful history of events leading up to and following the discovery of the child's collapse. (See Appendix 1 history pro-forma). The aim should be for the designated paediatrician / senior healthcare professional and SIPO to obtain a joint history, but this should not preclude any urgent history taking that may be required at an early stage. It is important that, as far as possible, the parents' or carers' account of events should be recorded verbatim. At an early stage of the process, the on-call paediatrician should make contact with the paediatrician with special responsibility for SUDIC (the 'SUDIC healthcare professional') and agree precise arrangements and timing for the SUDIC healthcare professional to meet the family at the most appropriate time. Whenever possible this should be before the family leave the hospital.

The parents and other close relatives should normally be given the opportunity to hold and spend time with their baby. Professional presence during such times should be discreet. Such quiet time is very important for families. The skeletal survey must always take place prior to parents having any **unsupervised** contact with their baby. An opportunity should be given for the parents to see their child before the post mortem and this should be arranged through the Coroner, FLO & Mortuary staff as soon as possible.

Many parents value photographs of their baby taken at this time, along with handprints or footprints and a lock of hair. Again, only in very exceptional circumstances should such mementoes not be taken, i.e. when the death is being investigated as suspicious. In this instance the Senior Investigating Police Officer should be asked for their approval.

When the baby has been pronounced dead, the on-call Consultant Paediatrician should break the news to the parents, having first reviewed all the available information, this should be in the privacy of an appropriate room.

The member of staff allocated to care for the family should also be present at this time.

The family must also be told at this time that the Coroner will need to be informed because the baby has died suddenly and unexpectedly and that, as a matter of routine practice, the Police & Children's services also have to investigate the death. The paediatrician must explain that possible medical causes of the infant's death will be very carefully and thoroughly sought.

Unless the cause of death is immediately apparent to the paediatrician (e.g. the typical rash of meningococcal septicaemia), it is important to explain to the parents that the cause of the death is not yet known and that the aim of the investigation is to establish the cause of death. The parents must be informed that in the majority of cases, the Coroner will order a post-mortem examination and that this may be carried out by a Pathologist with special expertise in diseases of children (a paediatric pathologist), just as if the child had a rare or serious disease and was being referred to a specialist in life.

The post mortem will take place at a site authorised by each individual Coroner, the site in some instances will be outside the geographical area of the Coroner's jurisdiction. The Coroner's undertaker will arrange transport of the child both to and from the post mortem site. The nature and purpose of the post-mortem should be explained to the parents in understandable terms and they should be given a copy of the NHS leaflet on the post-mortem examination. It is important that the family know where the post-mortem will be carried out, and are fully informed throughout by the Coroner's officer of all movements of the baby, what the approximate timescale will be and when they will be able to see the child again.

Parents may, in certain circumstances, be entitled to be represented at a post-mortem examination by a legally qualified medical practitioner. (Coroners Rules, 1984).

Part of the role of the paediatrician at this stage is to give the family help, information and support in their bereavement. This may be helped by the use of leaflets such as those published by the Foundation of the Study of Infant Deaths.

9. AMBULANCE STAFF

9.1 The Ambulance Service will notify the police and relevant hospital immediately when they are called to the scene of an unexplained child death. This will generally be undertaken by the Ambulance Control contacting the Police Control Room and hospital.

The Ambulance Service will need to clarify that the Child Death Protocol is being triggered (which covers all child deaths under the age of 18).

9.2 The recording of the initial call to the Ambulance Service should be retained in case it is required for evidential purposes.

9.3 Ambulance staff should (adapted from national training manual):

Mercia Region Multi-Agency Protocol for the Management of Sudden and Unexpected Deaths in Children and Infants.

- a) Not automatically assume that the death has occurred.
- b) Clear the airway and if in any doubt about death, apply full CPR.
- c) Inform the A&E Department giving estimated time of arrival and patient's condition.
- d) Transport the child to the local A&E Department (for exceptions to this rule see paragraph 9.4).
- e) Take note of the position and location of the child and excesses in room temperature e.g. if the room feels excessively warm or cold, home conditions and who is present at the house.
- f) Note any injury and any explanation offered.
- g) Pass on all relevant information to the health professionals and/or A&E staff or investigating Police Officer.
- h) The patient clinical record is to be completed in full as a record of attendance or treatment of the patient.

9.4 West Midlands Ambulance Service response to 999 calls to child death cases

999 call → Ambulance Emergency Operations Centre → 999 Ambulance

Cat A response - Options and actions:

- a) **Child requires resuscitation:**
 - Nearest A&E department with parents.
 - A & E alerted by Emergency Operations Centre.
 - A & E alerts Paediatric Resuscitation Team.
- b) **Child found to be recently dead, not fit for resuscitation:**
 - Nearest A&E department with parents.
 - A&E alerted by Emergency Operations Centre.
 - A&E calls down Paediatric Registrar Team.
 - Child and parents taken to agreed facility.
- c) **Child found obviously dead:**
 - Ambulance crew alert Emergency Operations Centre who call the Police.
 - After handover to the police, ambulance crew leave.
 - Police arrange appropriate care for parents and arrange via approved undertaker to convey the child to receiving facility at the nearest A & E department unless circumstances dictate this as inappropriate.
- d) **Non ambulance response.**
 - G.P confirms child deceased.
 - No 999 call made and child confirmed dead at scene.

- G.P informs Police / Coroner who take actions as outlined in protocol. (see para 4.1)

9.5 The first professional on the scene (e.g. Ambulance, GP) should note the position of the child, the clothing worn and the circumstances in which the child was found. If the circumstances allow, note any comments made by the parents / carers, any background history, any possible substance misuse, domestic abuse and the conditions of the living accommodation. Any such information must be passed on to the receiving doctor, the Police and the Consultant Paediatrician.

9.6 Any concern must be reported directly to the Police and to the receiving doctor at the hospital as soon as possible.

9.7 Approved undertaker

9.7.1 Where a child is obviously dead it will not be appropriate to use the Ambulance Service. The Police will arrange for the child to be conveyed to the receiving facility at the nearest hospital utilising the Force approved undertaker. There will be circumstances, for example deaths in the open air in the public view, where the SIPO will consider the use of an ambulance to convey the child to the hospital to prevent undue harm to the public.

9.7.2 Officers will need to ensure they give the undertaker details of the child or infants-age and approximate size, this will assist in planning transportation of the child. Under normal circumstances the infant will be transported in a Moses basket.

9.7.3 The race and religion (where known) should be shared with the undertaker, as there may be specific requirements for the handling of deceased persons.

9.7.4 The police will also arrange for the family to be transported to the hospital to be with their child at the receiving facility, which will be within the local A & E Department.

9.7.5 Upon arrival at hospital officers must ensure the SUDIC protocol is fully implemented.

10. COMMUNITY MIDWIVES

This guidance for the Community Midwifery service needs to be read in conjunction with the further guidance for health professionals

If there are still signs of life, resuscitation measures must be commenced and an ambulance called. The on call Consultant Paediatrician in A&E should be informed of the infants impending arrival.

If the indications are that the infant is dead and no active resuscitation has been attempted, the police must be called and the body should remain in situ until they arrive.

The position of the infant and the condition it was found in must be noted together with any comments/ explanations given by the mother or any person at the scene.

In **ALL** cases the infant's body must be taken to a hospital A&E.

The Infant's body **MUST NOT** be taken directly to the mortuary.

The midwife attending **MUST** take a detailed record of the incident. Comments made by parents must also be recorded.

Midwives should ensure that all communications with other professionals (health or otherwise) are carefully and accurately recorded, bearing in mind the potential disclosure issues in any subsequent court proceedings.

If the Midwife has any relevant information about the pregnancy or the family, they should report this directly to the police and receiving doctor at the hospital as soon as possible.

11. GENERAL PRACTITIONERS

- 11.1 This guidance for the GP needs to be read in conjunction with the further guidance for health professionals.
- 11.2 The GP may be the first to be called in the event of a child's death, or may be called by the Ambulance Service.
- 11.3 If there are still signs of life, resuscitation measures must be commenced and an ambulance called. The on-call Consultant Paediatrician in A&E should be informed of the child's impending arrival.
- 11.4 If the child has been dead for some time, the GP will inform the Police (it is advised that this is best done via Police Control Room Tel: 08457 444 888), who will inform the Coroner.
- 11.5 Subject to Paragraph 9.4, the GP should ensure that the ambulance Service take the child to the A&E Department rather than the mortuary. However when death has been determined at home by the G.P and ambulance service are not utilised, the force approved undertakers should be contacted. (See paragraph 9.7 for full details).
- 11.6 The GP will further be involved in providing ongoing advice and counselling for the family, in collaboration with other professionals.
- 11.7 The GP should ensure that all communication with other professionals (health or otherwise) are carefully and accurately recorded, bearing in mind the potential disclosure issues in any subsequent court proceedings.
- 11.8 Additional guidance for GP and health visitors, particularly in relation to the longer term care of the family, is available from the Foundation for the Study of Infant Deaths (www.fsid.org.uk).

12. HOSPITAL PROCEDURES

Mercia Region Multi-Agency Protocol for the Management of Sudden and Unexpected Deaths in Children and Infants.

- 12.1 Outlined in the following paragraphs is an overview of the process to be followed by staff at the Hospital.
- 12.2 There is a need for there to be clear pathways and a clear understanding of the Multi-Agency Protocol, so that the same process is implemented following a unexpected child death eg;
- A&E Department
 - Paediatric ward / Maternity unit
 - Community hospital
 - General practitioner at home/surgery
 - GP deputising service
 - Private hospital / hospice
- 12.3 For the care pathway to be triggered it is imperative that the Consultant Paediatrician on call is informed by the Senior Investigating Police Officer and/or Coroner's Office or the General Practitioner if the child dies at home. All of these children must be taken directly to the A&E Department subject to paragraph 9.4, where the Consultant Paediatrician would attend.
- 12.4 All receiving facilities within A&E departments for sudden unexpected deaths in children **must** record the details. The resuscitation team prepares for the arrival of the child, the receptionist locates the child and parents / carers medical records and expedites their immediate delivery. A check should be made to ascertain if the child is subject to a child protection plan.
- 12.5 When the baby or child is brought to the A&E Department, resuscitation may still be ongoing and the Consultant Paediatrician will be notified immediately. Similarly if the child dies in the hospital, the Coroner, Police and designated Paediatrician / senior healthcare professional on call must be notified and agreement reached regarding the role of Health.
- 12.6 It is expected that the lead role will initially be taken by the Consultant Paediatrician on call. At a later stage this responsibility will transfer to the senior SUDIC healthcare professional. The local Health Trust protocol should define which Health care professional adopts this role and when.
- 12.7 Each Health Trust should have a care pathway in place, which reflects all aspects of this guidance, so that all relevant staff are aware of their roles and of actions to be taken. This should be reinforced through training and supervision.
- 12.8 The Strategic Health Authority Designated Doctor/Nurse should be kept informed of all child deaths within this procedure. Where the death occurred outside the hospital a discussion between the Consultant Paediatrician and SIPO will take place to ensure the notification is completed.
- 12.9 The Coroner must be informed of all such deaths. The Coroner's Officer will explain the role of the Coroner and the procedures fully to the parents and family. The Coroner's Officer will also make the family aware that the Coroner's investigation is carried out by the Police, and that it will be necessary for the Police to visit the scene of the death and to talk to the family

as soon as possible. This information will be given sensitively to the family by the Coroner's Officer, who will also give the family practical advice and information on what happens to their baby/child.

All professionals involved in this process will need to be aware of the requirements of the law, but also to be very sensitive of the distress of the family.

12.10 The Police and/or Coroner's Officer will have their own procedures to follow in respect of such deaths in addition to the Multi-Agency Protocol.

12.11 Once life has been pronounced extinct, the responsibility for the body falls to the Coroner. In agreement with the Police and the Coroner, the on call consultant paediatrician / designated paediatrician will:

- Undertake a careful medical examination
- Jointly with the Police, obtain a full history from the parents/carers (Appendix 1)
- With the implicit permission of the Coroner, **'with the knowledge of the parents'** obtain samples/conduct medical investigations (Appendix 4)
- Arrange for a full skeletal survey, (In cases where the hospital does not undertake the skeletal surveys, the responsibility will fall to the Coroner's officer to make the necessary arrangements).
- Organise collection of information from the other professionals.

12.12 If the death has been identified as 'suspicious', and a Home Office Pathologist contacted, the Police will become the lead agency, In all other instances the Hospital process, whilst joint Police/Health, should be led by the Responsible Paediatrician. In suspicious cases the Police & Criminal Evidence Act will be adhered to.

12.13 Medical Examination

All findings must be carefully documented in writing and child protection body diagrams, (**see Appendix 11**) used as necessary, with metric measurements recorded on any marks/bruises.

12.14 Initial photographs/video imagery will be taken for future reference. Such photographs should include metric and colour scales and should be properly labelled and stored (to provide continuity of evidence). Police Scenes of Crimes Officers will be responsible for provision of photography services. Records should be signed, timed and dated. Abbreviations should not be used.

12.15 The investigations to be carried out and samples to be obtained at the hospital have been agreed with HM Coroners within the West Mercia. **Samples post death may only be taken with implicit previous agreement of the local Coroner. In addition any investigations performed before death, e.g. during resuscitation, should be checked and made available to the Pathologist.**

Consideration must be given to consultation with Police Forensic specialists with regard to continuity and collection and storage of samples with a view to maintaining the chain of evidence.

12.16 History Taking

A very carefully recorded history obtained from the parents/carers is clearly vital. They will undoubtedly have been asked pertinent questions and given accounts during the early stages, but a full detailed history will not have been obtained. The Paediatrician and Senior Investigating Police Officer will obtain the history, the process being led by the paediatrician. The history will be recorded contemporaneously in the History pro-forma (Appendix 1) and may be further supplemented by detail obtained during a joint Police/Health home visit.

It may not be possible to obtain the full history from grieving parents in an initial interview, it is recognised that this may be gleaned over two or more interviews.

12.17 Skeletal Survey

This needs to be performed in all infant death cases, and consideration given in cases of children over the age of 2, at the designated hospital. In cases where the hospital does not have the facilities to undertake the skeletal surveys, the responsibility will fall to the Coroner's Officer to make the necessary arrangements. Two copies of the skeletal survey will be required; one copy to accompany the child to the post mortem and the second copy to be reported on by a Consultant Radiologist experienced in interpreting paediatric x-rays.

If the surveys have to be performed out of hours and reported on by the local Consultant Radiologist, it is recommended that the x-rays be reviewed by a specialist paediatric radiologist as soon as possible.

This MUST be a full skeletal survey, not a babygram.

12.18 Collection and Sharing of Information

The Coroner's Officer, Senior Investigating Police Officer and the Responsible Paediatrician need to liaise regarding collection of all relevant information. There should be a clear agreement in each case on specific roles and responsibilities.

12.19 **The following agencies should be contacted and relevant information sought from them:**

- General Practitioner
- Senior Community Paediatrician
- Named/lead NHS Trust child protection professionals
- Health visitor/ School Nurse and/or midwife
- Children's Services and Adult and Community Services, requesting the information that they hold (which will include the existence of an action plan for any relevant child).

- Other relevant health professionals involved in the previous care of the child
- Police Child Abuse Investigation Unit
- Education (Including early years)
(the above list is not exhaustive).

12.20 If the baby/child is a twin under the age of 2 the other twin should be assessed **immediately** and consideration should be given to admitting him/her for a period of observation and investigation. It must be emphasised to the family that the admission of the surviving twin is because of the possibility of a natural medical condition.

12.21 If the family decline the offer of admission, this should prompt an urgent reconsideration of the family's needs and the health needs of the surviving twin.

12.22 Within 24hrs (usually the same day), a home visit should be undertaken by the Senior Investigating Police Officer and the senior SUDIC health professional. This visit showed itself to be of great value in the CESDI/SUDI studies, providing the opportunity to take a more careful history, to inspect the death scene and to try and meet some of the family's concerns. The Senior Investigating Police Officer will also need to visit the home address and wherever possible this visit should be done jointly with the senior health professional or, if separate visits are made, the relevant professionals should confer in their assessment.

12.23 In addition, the SUDIC healthcare professional should view any police recording of the scene of death.

12.24 Briefing of the Pathologist

All information needs to be brought together at the initial information sharing and planning meeting, in particular any issues of concern. This information must be available to the Pathologist before the post-mortem.

As reported in the CESDI 2000 report, this was the single most important factor in enabling a correct diagnosis. Inadequate briefing may result in failure to carry out the tests that might lead to the identification of a cause of death, whether natural or unnatural.

12.25 This briefing is best done by the SUDIC healthcare professional, in consultation with the SIPO/Coroner's Officer. A full medical report based on the history given by the parents in hospital, immediate examination of the baby, information obtained during the home visit and perusal/consultation of all relevant medical and social records. In very young babies this might include obstetric records.

13. CHILDREN'S SERVICES

13.1 Social Care Services (Adult or Children's services) may hold information in respect of a child/family and should share this information with the Senior Investigating Police Officer and/or the Responsible Paediatrician.

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- 13.2 Requests for information 'out of hours' which may only contain basic information, including whether the child has a child protection / child in need plan with Children's Services, **must** always be followed up as soon as possible with further more detailed record checks during office hours. A Children's Services Manager will always be invited to the initial planning and information sharing meeting and follow up meeting.
- 13.3 Where there are immediate child protection concerns, Children's Services has a statutory responsibility and will then become the lead agency for the welfare of the child(ren) whilst the Police will lead any criminal investigation. There may then be a particular need to ensure the protection of the remaining children in the family. Children's Services will convene an immediate strategy meeting in line with inter-agency Child Protection Procedures for Safeguarding Children.
- 13.4 A Children's Services' manager will always be invited to the initial planning and information sharing meeting and to the follow-up meeting. Where concerns exist at the initial case discussion meeting and where necessary Children's Services will arrange a Strategy Meeting to take place.

Arrangements need to be in place to notify the Chairs of the Local Safeguarding Children Boards of any sudden and unexpected death of an infant or child, and for whom there are concerns, so that consideration can be given to the necessity for a serious case review.

14. THE ROLE OF THE CORONER AND THE POST-MORTEM

- 14.1 The Coroner must be informed after any unnatural or sudden death of unknown cause, and will order an investigation into the circumstances and cause of that death. After the death is pronounced, the Coroner has control of the body.
- 14.2 The Coroner's Officer will inform the family of HM Coroner's roles and procedures and keep the family informed of the child's movements until the Coroner has signed release paperwork for the child at the opening of the inquest. **It is important this information is shared only by the Coroner's Officer as any misinformation may cause additional distress to the family.**
- 14.3 As the legal authority charged with the investigation and certification of all unexpected deaths, the Coroner must be kept informed of all significant information obtained from the multi-professional communications and interviews with parents.
- 14.4 The post-mortem examination will be ordered by the Coroner, and should be carried out (within 2 working days of the child's death whenever possible) by a Pathologist with recent expertise and training in paediatric pathology. If "Significant Concern" has been raised about the possibility of neglect or abuse having contributed to the child's death, the Paediatric Pathologist should be

accompanied by a Forensic Pathologist and a joint post-mortem protocol should be followed with the attendance of a Senior Investigating Police Officer. If at any stage during a post-mortem in the absence of a Forensic Pathologist the Paediatric Pathologist becomes concerned that the death may be a consequence of abuse, the procedure must be stopped. The examination should recommence as a joint procedure by a Forensic Pathologist together with the Paediatric Pathologist, in the presence of the Senior Investigating Police Officer or other designated Police representative. This is all subject to the Coroner's overriding discretion.

- 14.5 Prior to commencing the post-mortem examination, the Pathologist should be given a full written briefing on the history, a report from the radiographer relating to the skeletal survey, the physical findings at presentation and the findings of the death scene investigation by the Paediatrician and Senior Investigating Police Officer. In those areas where a recording at the death scene has been made, it is very helpful for the Pathologist to have the opportunity to view the recording and discuss it with the Paediatrician(s) and Police Officer prior to commencing the post-mortem examination. Other photographs of the child that may have been taken at presentation or in the A&E Department should also be made available. All subject to the Coroners overriding discretion and the Pathologist's professional judgement.
- 14.6 In all instances there should be a full discussion between the Consultant Paediatrician and the Pathologist both before and after the post-mortem examination to identify outstanding or unsuspected issues and to ensure accurate understanding of information. This discussion will allow for explanations to be sought on clinical issues, for example, medical equipment that may remain in proximity to the deceased or equipment that has been removed.
- 14.7 The Protocols of the Royal College of Pathologists and the recent recommendations of the CESDI 2000 report, regarding post-mortem protocol in SIDS/SUDS/SUDI should be followed. All subject to the Coroner's overriding discretion and the pathologist's professional judgement.
- 14.8 There should be a policy in place with clear information to the family about what organs and/or tissue samples have been retained to allow discussion of options for disposal. The family's wishes regarding disposal must be made known to the Pathologist and the Coroner.
- 14.9 A number of investigations should be arranged by the pathologist.
- 14.10 If the Paediatrician has arranged any similar investigations before death, these must be made available to the Pathologist and the Coroner prior to the post-mortem.
- 14.11 It is vital that all samples taken are properly labelled and exhibited and movement of exhibits should be closely controlled with a clear audit trail. Having gained authority from the Coroner upon which samples are to be submitted for further examination, no further work should be commissioned on any of those samples, without prior discussion with the Senior Investigating Police Officer. The reason for this is to ensure that disclosure can be managed through careful control of exhibits and their movements.

- 14.12 The preliminary result may well be 'not yet ascertained'.
- 14.13 The final result must be notified in writing to the Coroner as soon as it is known. The final report should then be sent to the Coroner immediately the final result is known and in any event no later than seven days. With the prior consent of the Coroner, a copy of the post mortem report will also be sent simultaneously to the responsible Paediatrician (via designated Paediatric representatives for each area). This will ensure the final meeting is triggered and a final report is completed.
- 14.14 The report from the multi-agency local case discussion meeting should in all cases be sent to the Coroner, and in some instances the Coroner's Officer will choose to be present at this meeting. This report will ensure that, where the cause of death has been certified by the Coroner without an inquest, any new or more accurate information is appropriately notified to the Registrar of Births and Deaths for onward transmission to the Office for National Statistics.
- 14.15 For those instances in which the Coroner has ordered an inquest, the information from the local case discussion meeting will inform and assist the conduct of the inquest.
- 14.16 Where the information available to the inquest shows that the death meets the international definition of sudden infant death syndrome (SIDS) i.e. *'the death is unexpected, and remains unexplained after a careful review of the history, examination of the circumstances of death and the conduct of a full post-mortem examination to an agreed protocol'* – then the death should in all cases be registered as being due to SIDS. The medical cause of death and the conclusion is for the Coroner to decide, having regard to the evidence at the inquest.
- 14.17 **Death Certificate**
At the conclusion of the inquest, the Coroner will notify the Registrar of Deaths to enable a death certificate to be issued.

15. THE ROLE OF THE POLICE

- 15.1 All sudden unexpected deaths in children are notified to the Coroner and a full Police/Coroner investigation will take place. When a child/baby dies suddenly and unexpectedly the Coroner, and therefore the Police, will always lead the investigation, supported by the SUDIC Healthcare professional responsible for unexpected child deaths. Unexpected death is the death of a child that was not anticipated as a significant possibility 24 hours before the death, or where there was a similarly collapse leading to or precipitating the events that led to the death.
- 15.2 A Senior Investigating Police Officer from the Local Criminal Investigation department will be appointed to lead the investigation. At the initial case discussion the SIPO and SUDIC Healthcare Professional will discuss the benefit of appointing the local Detective Inspector from the Public Protection Unit for the longer-term investigation and role of the SIPO. A list of those

standing Police members of the rapid response team is attached at Appendix 6.

15.3 The role of the Police is:

- To be part of the rapid response team which is seeking to establish the cause of the child's death.
- Protection of life, i.e. responsibilities to safeguard other siblings/children in the event of abuse or neglect in conjunction with Children's services.
- Conduct a criminal investigation when appropriate and work with the Crown Prosecution Service in cases involving potential prosecution of offenders.

15.4 The appointed SIPO from the rapid response team cadre will remain with the case subject to paragraph 4.3 above, including where suspicious circumstances have been ruled out. This will also involve reporting in person to the Child Death Overview Panels for relevant deaths they have led on later on in the review process.

15.5 The vast majority of such deaths are from natural causes and do not involve abuse or neglect. A small proportion of so called "cot deaths" are, however, caused deliberately by violence, by maliciously administered substances or by the careless use of drugs. Investigating officers must be aware that as the number of genuine unexplained deaths decreases, the proportion of all infant deaths which could be attributed to homicide is likely to increase. When during the Infant and child death process it is established that the child was murdered, the protocol and written records should be handed over and a murder investigation should commence led by a Detective Superintendent from the West Mercia Constabulary MIU. This does not however preclude the Senior Investigating Officer from utilising certain elements of the protocol. e.g initial information sharing and planning meeting.

15.6 Irrespective of whether the cause of death appears to involve a criminal act, the Police have a significant role in the multi-agency investigation and ongoing child death review process. To ensure a consistently high standard of Police input to the investigation a specially trained Detective Inspector from the Child Abuse Investigation Unit will support the investigation into all child death incidents. This may involve taking over from the initial on call SIPO where appropriate.

15.7 The aim of any investigation will be to establish, as far as possible, the cause of the child's death. Each case must be approached with an open mind, balancing the needs of the investigation with the needs of the bereaved family.

15.8 One of the practical difficulties for investigators is that factors or evidence that raise suspicion may become apparent at any time during the process, from an early stage through to many months after the death. Police training necessarily focuses upon the need to secure and preserve evidence from the outset, as failure to do so may lead to a lost opportunity. The difficulty faced by the Police in child and infant death investigation is to reconcile the

traditional criminal investigation approach with the knowledge that the majority of these cases do not involve a criminal act. The processes agreed within this protocol aim to enable the multi-agency team to secure and preserve information and evidence, whilst providing a sensitive and caring service to the bereaved family and meeting the aims of Working Together to Safeguard Children 2006.

15.9 The Police Process

If the Police are the first professionals to attend the scene, urgent medical assistance should be requested as the first priority. **The type of response to each child's unexpected death will depend to a certain extent on the age of the child and the circumstances, for example in some open air deaths it may be wholly inappropriate for critical professional assets to attend a scene. However some key actions underpin all subsequent work including consideration to deploy a rapid response team.**

15.10 Child Death – Initial action

The first Police Officer to arrive, or any other professional, may be expected by the parents to try and revive the baby, even if it is hopeless, and should be prepared for this. The Pathologist will need to be informed of any attempted resuscitation. Officers should introduce themselves to the parents and take care to explain their presence. They should express their sympathy and establish the baby's name, using the name at all times as if the baby is still alive. An open mind must be kept and awareness that the death may have been caused as a result of;

- Natural causes
- Neglect
- Accident
- Deliberate harm

15.11 Upon initial attendance at the scene, usually at the home of the child, officer(s) should note any excess in the room temperature where the child was found. e.g. excessive warmth or cold. The Senior Investigating Police Officer should bring a thermometer to the scene and check the room temperature as soon as possible, as room temperature can play an important factor in child deaths. If the room has been ventilated for some time, consider if possible taking the temperature in a drawer in the room containing clothing, as this will tend to hold the original room temperature

15.12 Police attendance should be kept to the minimum. Several Police Officers arriving at the house can be distressing, especially if they are uniformed officers in marked Police cars. Visiting officers, so far as possible, should not be in uniform, and should not arrive in marked cars.

15.13 Attending officers should at all times be sensitive in the use of personal radios and mobile phones, etc. If at all possible, the officers liaising with the family, whilst remaining contactable, should have such equipment turned off. Care should be taken to avoid terms such as referring to 'scenes of crime' and 'suspicious death'.

15.14 As with all sudden deaths in children and babies there should be immediate consideration of transferring the child to the A&E Department. When the

circumstances are obviously suspicious and the child/baby is obviously dead but has not been removed from the scene, a Police Surgeon will attend to certify death. Provisions that allow paramedics to in some cases pronounce life extinct do not apply in cases of children. Clearly, even if a Police Surgeon (FME) attends the scene, the SUDIC healthcare professional must be informed so that the Protocol can be effected.

- 15.15 Where a child is obviously dead it will not be appropriate to use the Ambulance Service, and an undertaker service will be used. See paragraph 9.4. ambulance deployment.
- 15.16 The police will also arrange for the family to be transported to the hospital to be with their child at the receiving facility, which will be within the local A & E Department.
- 15.17 Upon arrival at hospital officers must ensure the Child Death Protocol is fully implemented, checking a (SIPO) has been informed.
- 15.18 A Detective Inspector (SIPO) from the Crime Management Unit will attend the scene as soon as possible, and will become the Senior Investigating Police Officer (SIPO). This will be a 24/7 365-day resource on each Divisional area. The SIPO should consult with the designated paediatrician and report the death in order for the initial case discussion (can be by phone) to take place within 4 hrs of the death being reported. At this early stage a decision whether a paediatrician, or a nurse trained in responding to childhood deaths, and the SIPO should attend the scene of the death together will be made.
- 15.19 The SIPO will ensure that the 'scenes' are identified and preserved. Scenes of Crime Officers will attend the incident and take appropriate action as directed by the SIPO, which will always include photographing and recording of the scene of the child's collapse.
- 15.20 Where necessary a Family Liaison Officer will be appointed in conjunction with any hospital services for the bereaved.
- 15.21 The SIPO will ensure that the Coroner's Officer and appropriate Hospital paediatrician are notified of the death.
- 15.22 After making the necessary arrangements for scene preservation, the SIPO will liaise with the Responsible Paediatrician at the hospital and other agencies to ensure that the protocol is implemented and a timescale is agreed for the initial planning and information sharing meeting prior to the post mortem.
- 15.23 Unless the death is viewed as suspicious the procedures for joint paediatric/Police history taking will take effect. CPS approval will be sought where the death is suspicious and before any joint agency action is taken, although this must not cause unnecessary delay to any Strategy meetings where there is a possible risk to other children. Under the Police and Criminal Evidence Act 1984, if the SUDIC Healthcare professional or the Police Officer has significant suspicions that the death may be unnatural, the law demands that the suspect's rights are protected and certain legal restrictions apply in terms of how they can be spoken to, and by whom. In the event of the death

being suspicious the SIPO will decide upon the appropriate course of action, which may or may not include the arrest of a suspect. There are strict legal requirements placed upon the Police when conducting a criminal investigation that govern the way in which people are questioned and evidence secured/preserved.

- 15.24 Following the initial planning and information sharing meeting or case discussion with the Paediatrician, the SIPO will make themselves available to conduct a joint home visit with a health specialist, in order to gain a clearer understanding of how the child died. This will take into account the circumstances in each case, particularly the wishes and feelings of the parents and family at the time. (See Home visit professional guidance, appendix 8).
- 15.25 In those circumstances when the death is suspicious, a forensic Home Office Pathologist will conduct a joint post-mortem with a Paediatric Pathologist. **Where a forensic Post Mortem is considered necessary, the SIPO must discuss and seek permission for the procedure with the Coroner & Duty senior investigating officer.** If a forensic post mortem is undertaken the SIPO and Scenes of Crime Officer will attend.
- 15.26 In those cases that become a criminal investigation the Police will work closely with the Crown Prosecution Service (CPS) and will follow current arrangements regarding pre-charge advice.

16. FACTORS WHICH MAY CAUSE CONCERN

- 16.1 Certain factors in the history or examination of the child may give rise to concern about the circumstances surrounding the death. If any such factors are identified, it is important that the information is documented and shared with senior colleagues and relevant professionals in other key agencies involved in the investigation. The following list is not exhaustive and is intended only as a guide.
- 16.2 Previous child deaths: two deaths occurring within the same family is extremely unusual, however the possibility of genetically natural disease, environmentally determined natural disease or accident must still be considered.
- 16.3 It is reasonable to say that the relative probability of child abuse in a family with multiple sudden infant deaths is higher than the probability of child abuse in a family with a single sudden infant death, but the possibility of natural disease must be emphasised.
- 16.4 Previous episodes of unexplained illness, such as cyanotic episodes or acute life threatening events (ALTE).
- 16.5 Previous and current child protection concerns within the family relating to this child or the siblings.
- 16.6 Inappropriate delay in seeking medical help.

- 16.7 Inconsistent explanations: the account given by the parents/carers of the circumstances of death should be documented verbatim. Any inconsistencies in the story given on different occasions should arouse suspicions, although it is important to bear in mind that some inconsistencies may occur as a result of the shock and trauma caused by the death.
- 16.8 Evidence of drug/alcohol abuse – particularly if the parents/carers are still intoxicated.
- 16.9 Evidence of parental mental health problems.
- 16.10 Evidence of a history of domestic abuse in the household/family
- 16.11 Evidence of physical abuse/unexplained injuries, e.g. unexplained bruising/burns/bite marks. However, it is very important to remember that a child may have serious internal injuries without any external evidence of trauma.
- 16.12 Although the presence of blood may arouse suspicion, it can be found in cases of natural death. A pinkish frothy residue around the mouth or nose is a normal finding in some children whose deaths are due to Sudden Infant Death Syndrome.
- 16.13 Neglect: observations about the condition of the accommodation, hygiene, cleanliness, availability of food, adequacy of clothing and bedding and the temperature of the environment where the child is found are important. This will assist in determining whether there may be any underlying neglect issues involved.
- 16.14 However, the following should be noted and are present in many infant deaths:
- Froth emerging from the mouth and nose. This froth results from the expulsion of air and mucus from the lungs after death. Sometimes the froth may be blood-stained – this does not mean that the death was unnatural.
 - Small quantities of gastric contents around the mouth. This does not mean that death was caused by inhalation of vomit. Often there is slight regurgitation after death.
 - Purple discoloration of the parts of the face and body that were lying downwards. This is not bruising, but is caused by the draining of blood in the skin after death. For the same reason the parts that were lying upwards may be very pale.
 - Covering of the child's head by the bedclothes. This has often been a feature of cot death in the past, and probably contributes to death through accidental asphyxia or overheating.
 - Wet clothing or bedding (this is usually caused by excessive sweating before death).

- If the child looks as though he/she has been roughly handled, remember that this may be the result of attempts at resuscitation.
- Co-sleeping with a parent.

17. CROWN PROSECUTION SERVICE

- 17.1 The Crown Prosecution Service has now assumed the statutory duty for charging. They have responsibility for deciding on any charge likely to arise out of the death of an infant, i.e. all offences triable on indictment only and all either way offences, which will be dealt with in the Crown Court.
- 17.2 The Crown Prosecution Service provides 'Pre-Charge Advice' to the police. The aim is to advise the police on the evidence at an early stage, and to identify evidence that needs to be obtained in order to build strong cases, which will then become successful prosecutions when brought to court.
- 17.3 The Senior Investigating Police Officer in any criminal investigation of a SUDIC will liaise with the Crown Prosecution Service for advice as to the future conduct of the case, as soon as it becomes apparent that neglect or abuse may be factors in the death.
- 17.4 At the initial stage the officer should contact the Unit Head for the Basic Command Unit where the death occurred, to identify a lawyer with the relevant knowledge, experience and training to take on the case.
- 17.5 The CPS Lawyer will consider the evidence with the officer and provide a Case Action Plan, identifying:
- Any further enquiries that need to be carried out
 - Any other evidence that needs to be obtained.
 - Any further reports that need to be obtained
- 17.6 Any necessary further evidence or action identified by the CPS lawyer will need to be obtained before the charging decision is made. The CPS lawyer will consider all the evidence submitted in conjunction with the officer. The CPS Lawyer will then make the charging decision.

Irrespective of whether or not a decision has been made to charge prior to the final multi-agency case review meeting, the minutes/record of the meeting will be submitted to the CPS Lawyer.

18. AUDIT

- 18.1 Local Safeguarding Children Boards will assume responsibility for audit and review of SUDIC cases. (See Appendix 3 – Audit Document). The Boards are

established across Worcestershire, Herefordshire, Shropshire, Telford and Wrekin.

- 18.2 There is now a statutory requirement for LSCB partner agencies to identify a senior manager with responsibility for audit/review of SUDIC investigations. It is important for each agency to ensure that cases are reviewed against the standards set out in this protocol. We all have a responsibility to identify problems encountered so that we strive towards the highest quality process possible. It may well be the case that these managers develop a suitable multi-agency forum to assist in the process of managing standards of investigation and case management.

19. FREEDOM OF INFORMATION ACT AND DATA PROTECTION

Freedom of Information Act

No anticipated difficulties in publishing the entire protocol. Note, however, that ACPO guidelines (which are not contained in the protocol) are a restricted document and should not be published.

Data Protection

The rules around disclosure will apply in each individual case, guidance should be sought from relevant agency legal departments.

Destruction Policy

Albeit this is a matter for each agency, West Mercia Constabulary are likely to introduce a policy of retaining documents from all SUDIC investigations for a minimum period of 10 years.

Appendix 1

Investigation of Sudden Unexplained Death in Infancy and Children – Mercia region

HISTORY PROFORMA

1. Identification Data:

Name of Child	Sex M/F
DOB	Date of Death
Address:	Ethnicity*
Postcode	
Initial Case Discussion – 4hrs (see page 42)	
Early Information sharing and planning meeting – 48 hrs (see Appendix 10)	

Name of father (+address if different from child)	DOB
Name of mother (+address if different from child)	DOB
Name of partner (if relevant + address)	DOB

GP Name & Address:
Consultant :
SUDI Consultant:

2. Details of transport of child to Hospital:

Place of death: Home address as above / Another location (specify) / DGH (specify)		
Time found :	Time arrived in A&E :	
Resuscitation carried out ?	Y/N	Where? At scene of death / Ambulance / A&E
By whom: carers / GP / ambulance crew/hosp staff / others (specify)		

Certification of death	Date	Time	Location	By whom?
------------------------	------	------	----------	----------

3. History

Taken in A&E by:

Taken at home visit by:

History given by:

Relationship to child :

Events surrounding death :

Child found by - Mother/father/partner/Other (specify)

Time found

Who called emergency services?

-

Child last seen alive Date Time

By whom

Who looked after child in last 24 hrs?

Resuscitation Y/N

By whom?

If Y, describe

(basic life support, blew on face, slapped on back etc)

Any response?

The Final Sleep - description of when and where the baby was put to sleep

When put down?

Where?

Any change from usual?

Sleep position: prone / supine / side

Anyone else in the bed /cot?

What was baby wearing?

Bed coverings

How often checked

Last checked?

Last heard?

Did baby wake – when?

Who found baby?

What time?

Position of bedding / covers

What did the baby look like?

Any blood in mouth or nostrils?

Mercia Region Multi-Agency Protocol for the Management of Sudden and Unexpected Deaths in Children and Infants.

HISTORY

Taken in A&E by:

Taken at home visit by:

History given by:
Relationship to child:

The Final Sleep - the room

Does anyone else sleep in the room usually?
Anyone else in the room this time?
Objects in or near the bed?
Was the heating on?
What type of heating?
What was the temperature in the room?
Were the windows / doors open?
Condition of accommodation

Feeding:

Time of last feed
Type of feed
Quantity
Any change from usual?
Was the baby feeding as well as or less well than usual in the past 24-48 hours?

Any vomiting in last 48 hrs?
Any vomitus when found?

Detailed account of last 24 – 48 hrs

Any changes to routine or feeding
unusual cry/irritability/fever/ medication given
breathing difficulties or coughing
difficulties with sleeping or waking
unusual activity or alertness

Last seen by a doctor

Date Time Where?
Why?

HISTORY

Taken in A&E by:

Taken at home visit by:

History given by:
Relationship to child:

FAMILY HISTORY**MOTHER:**

Age: Parity:

Occupation: Ethnic group:

Past marriages / Live-in relationships? Yes / No How long has mother lived with father?

Children from other partners? Yes / No

Drugs (including habit forming):

Smoking:

Alcohol

Illnesses / disabilities:

Other comments:

FATHER:

Age: Other children:

Occupation: Ethnic group

Past marriages / Live-in relationships? Yes / No How long has father lived with mother?

Children from other partners? Yes / No Was father living with child at time of death? Y/N

Drugs (including habit forming)

Smoking:

Alcohol

Illnesses / disabilities:

Other comments:

CHILDREN IN THE FAMILY: (Including any children by previous partners)

Name: Health

Age:

Name: Health

Age:

Name: Health

Age:

Name: Health

Age:

Any previous childhood deaths in the family?

HISTORY**Taken in A&E by:****Taken at home visit by:**

History given by:

Relationship to child :

PAST MEDICAL HISTORY

Birth History

Pregnancy
Delivery
Gestation Birth Weight
Apgar score
Perinatal problems

Type of feeding at birth
Feeding now
Weight gain in last few weeks?

Routine checks eg 6 week medical?
Immunisations

Previous illnesses?
Previous hospital admissions?

Previous unexplained illness eg cyanotic episodes, acute life threatening events (ALTE)
Excessive sweating?
Episodes of pallor?

Any past respiratory difficulties eg noisy breathing or wheezing?
Contacts with infections
Allergies
Medication

SOCIAL HISTORY

Type of housing?
Number of people in household?
Family on benefits or income support?
Recent major life events in family eg move house?

Child or family known to social services?
Any family mental health problems?
Maternal depression PNDS?

HISTORY

Taken in A&E by:

Taken at home visit by:

History given by:
Relationship to child:

Initial case discussion

Home visit on(date) by:

Name.....Signed.....Designation.....Base.....

Name.....Signed.....Designation.....Base.....

Appendix 2

The Avon Clinicopathological Classification of SUDIC

Name:.....

Study Number.....

Date of death.....

Date of Birth.....

Hospital

Hospital unit number.....

Mercia Region Multi-Agency Protocol for the Management of Sudden and Unexpected Deaths in Children and Infants.

Place of Post-mortem:.....
 Paediatrician*.....
 HV*.....
 Child Protection officer*.....

Pathologist*.....
 GP*.....
 Research HV*.....
 Others present at LCD meeting.....

(*note if present at Local Case Discussion meeting)

Classification **	0	I A	I B	II A	II B	III
Contributory or potentially "causal" Factors	Information not collected	No factors identified	Present but not likely to have contributed to ill health or to death.	Present, and may have contributed to ill health, or possibly to death	Present and certainly contributed to ill health, and probably contributed to the death	Present, and provides a complete and sufficient cause of death
Social factors						
Non-accidental injury/ evidence of abuse or harm						
Past Medical history						
Family history						
History of final events						
Death-scene examination						
Radiology						
Toxicology						
Microbiology / Virology						
Gross pathology						
Histology						
Biochemistry						
Metabolic investigations						
Special investigations (e.g. histochemistry)						
Other (specify)						
Overall classification **						

**** This will equal the highest individual classification listed above. NB an entry (0, I, II, or III) MUST be made on every line of the grid. A brief free text explanation of each notable factor should also be given below: (continue over page if necessary)**

.....

**Appendix 3
Audit Document**

**Sudden Unexpected Death in Childhood (SUDIC) Protocol
Audit Checklist**

Name of Child	
D.o.B.	
D.o.D	
Address	

Did Ambulance Service inform the Police and the Hospital that SUDI protocol applies?

Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
-----	--------------------------	----	--------------------------

Did the Paediatrician

a) Confirm the death with the Police?

Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
-----	--------------------------	----	--------------------------

b) Give the name of the lead Consultant?

Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
-----	--------------------------	----	--------------------------

Did the Police inform:

a) Social Care?

Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
-----	--------------------------	----	--------------------------

b) Coroner

Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
-----	--------------------------	----	--------------------------

Was home visit carried out within 24 hours?

Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
-----	--------------------------	----	--------------------------

If yes

Attended by Police	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Attended by Paediatrician?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Health Professional?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Other?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>

Please state

Did Police convene information sharing meeting within two working days?

Yes No

If no, why

If yes

Attended by Police?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Attended by responsible Paediatrician?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Attended by carer?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Attended by Social Care?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>

Multi-Agency Case Review

Did the Police convene M.A.C.R.?

Yes _____ No _____

Date Held

Attendance

Police	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Coroner	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Responsible Paediatrician	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Social Care	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
GP	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Health Visitor	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>

Other:

Please state:

Findings

Once completed, this form should be sent to your local Safeguarding Board Lead Officer at:

.....

Appendix 4 tests undertaken by medical professionals.

Obtain specimens: Blood 10–15 mls (heart stab if needed) within 30 mins of death if possible and preferably not >4hrs; **Urine (SPA); Nasopharyngeal swab.**

Sample	send to	handling	Test
blood (serum) brown top 1 ml	Clinical chemistry	normal	U&Es
blood (serum) brown top 1 ml	Clinical chemistry	spin, store serum - 20°C	toxicology (City Hosp)
blood Li Heparin orange top 1 ml	Clinical chemistry	spin, store plasma - 20°C	inherited metabolic disease (BCH)
?blood Li Heparin orange top 5 ml	Clinical chemistry	normal (keep unseparated)	chromosomes (if dysmorphic)
blood Fluoride yellow top 2 ml	Clinical Chemistry	collect pre-mortem spin, store plasma - 20°C	3 OH Butyrate, FFA, lactate (BCH)
blood EDTA red top 1 ml	Haematology	normal	FBC
blood cultures aerobic/anaerobic 2 ml	Microbiology blood culture incubator	if insufficient blood, aerobic only	C&S
blood from syringe onto neo natal blood spot screening	Clinical Chemistry	normal (fill in card, don't put in plastic bag)	inherited metabolic disease (BCH)
Nasopharyngeal swab viral culture medium	Microbiology	<8hrs from death	virology
Other swabs	Microbiology	normal	C&S (as indicated)
Urine (SPA) 2 mls	Microbiology	normal	C&S
Urine (SPA) 2 mls	Clinical Chemistry	spin, store supernatant -20°C	Toxicology (City Hosp)

Urine (SPA) mls	2	Clinical Chemistry	spin, store supernatant -20°C	amino and organic acids, oligosaccharides (BCH)
---------------------------	---	-----------------------	----------------------------------	--

Inform Consultant Paediatrician for Child Protection, if not already done.

Skin biopsy tissue culture within 24 hours.

Consider **muscle biopsy** – rarely needed, do only after discussing with IMD lab. Inherited Metabolic Disease (IMD) lab at BCH (0121 333 9942) – normal working hours.

Take a full **history**, using special history / examination sheet to record this information. This sheet will be used also by Consultant Paediatrician at subsequent visits, and any information not possible to collect initially can be collected then.

Complete **clinical examination** – rectal temperature, injuries, bruising, petechiae, retinal haemorrhage, dysmorphic, nourishment, any skull fracture? Record on special history / examination sheet.

Radiology – **skeletal survey**.

Investigations

Consider **infection, inherited metabolic disorders** and **forensic** causes.

Infections

blood cultures into aerobic and anaerobic bottles; if only a small volume available, set up aerobic in preference; put in incubator at 37°C (Microbiology dept.) if out of hours.

Urine by SPA into sterile bottle for microscopy and culture, save in refrigerator.

Nasopharyngeal swab if <8 hrs post-mortem: put in viral transport medium in fridge.

Swabs from any wounds or body fluids for microbiology into fridge.

Inherited metabolic disorders (IMD) are rare, but can cause death without significant prodromal symptoms and infection can precipitate an attack. Factors suggesting metabolic disorder include:

consanguineous parents

older age at death (over 6 months)

previous infant death in family

history of hypotonia or developmental delay

hepatomegaly or hepato-splenomegaly.

These disorders may result in hyperammonaemia, hypoglycaemia without ketonuria, cardiomyopathy, or apnoeic attacks. Investigation is limited post-mortem by specimens available and interval between death and tissue sampling time.

If you suspect a metabolic disorder contact the IMD lab at BCH for advice (0121 333 9942)

In addition to blood and urine samples, skin biopsy should be performed if possible – follow the technique below and put the specimen in viral culture medium in Clinical Chemistry fridge at +4°C until transported to IMD at BCH. Transport within 24 hours of collection – before sending sample discuss with duty biochemist at IMD lab if normal working day, or on-call MLSO for Clinical Chemistry at BCH if weekend / holiday.

Specimens required

Blood – at least 1 ml in lithium heparin separate, freeze plasma at -20°C

dried blood spots directly from syringe onto Guthrie card

fluoride specimen (if available pre-mortem) separate, freeze plasma at -20°C

Urine – in plain bottle spin and freeze supernatant at -20°C

Skin biopsy for tissue culture at +4°C in viral culture medium.

Muscle biopsy rarely may be needed – get advice from IMD at BCH if metabolic disorder suspected.

Forensic specimens – remember to maintain the chain of evidence

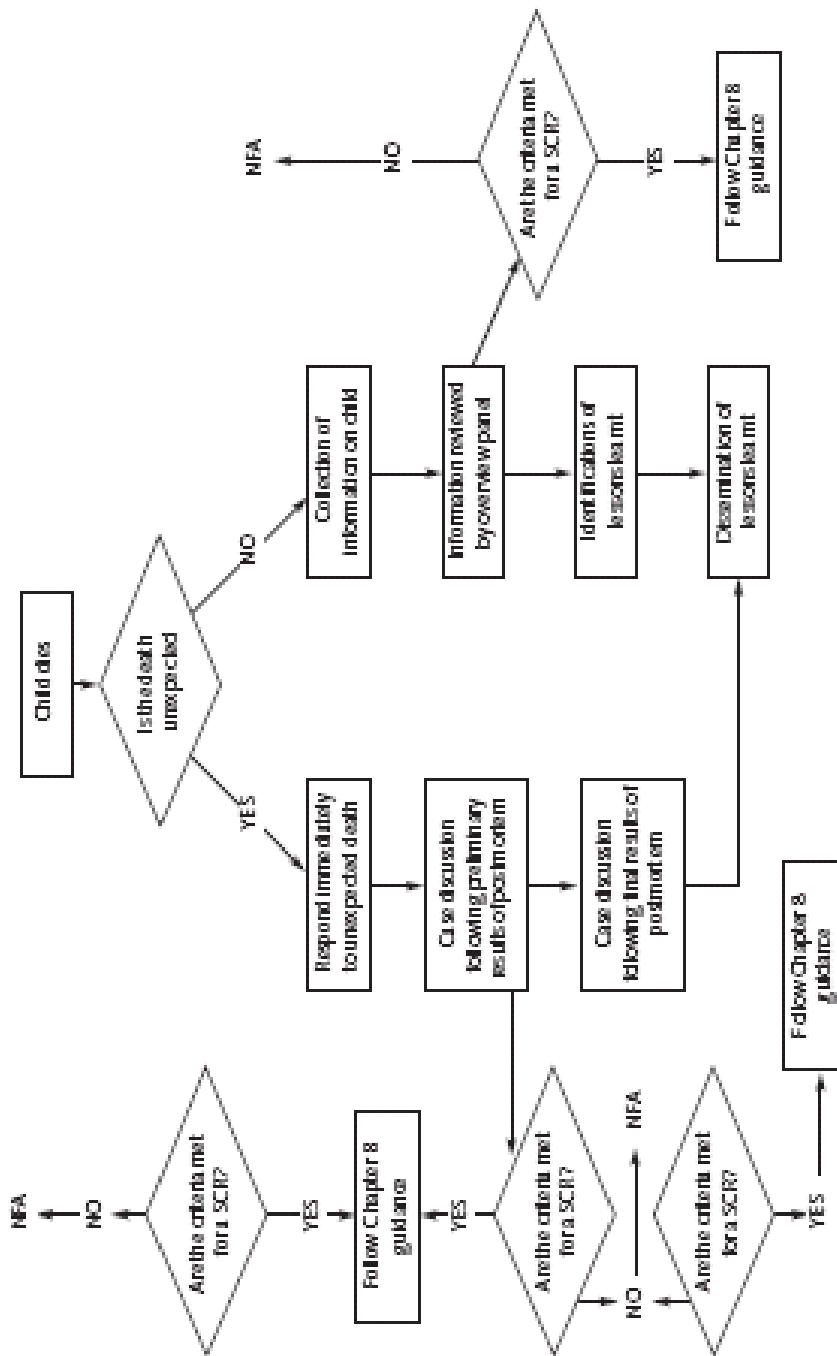
Blood – 1 ml clotted – spin and freeze serum at -20°C

Urine – plain bottle – spin and freeze supernatant at -20°C

Skeletal survey (X-ray) when convenient after death.

Others – FBC and blood for chromosomes especially if dysmorphic.

Flow chart 6: Interface between the child death and serious case review processes



APPENDIX 5

APPENDIX 6

Rapid Response Team Standing Members

Police SIPO's

Herefordshire	–	DI Alan Mardell
Telford and Wrekin	–	DI Nick Haggitt
Shropshire	–	DI Jason Wells
North Worcestershire	–	DI Leighton Harding
South Worcestershire	–	DI Jon Wallis

The above SIPO's are also supported by a number of other trained Detective Inspectors within West Mercia Constabulary on call cadre operating 24-hours 365 days a year.

Health Service

Telford & Wrekin

Designated Doctor – Dr M. Ganesh
Designated Nurse – Audrey Scott –Ryan
Responsible SUDIC Paediatrician – Dr D. Bell
Acute Paediatrics – Dr F.Hinde

Herefordshire

Responsible SUDIC Paediatrician – Dr Neil Fraser

Worcestershire

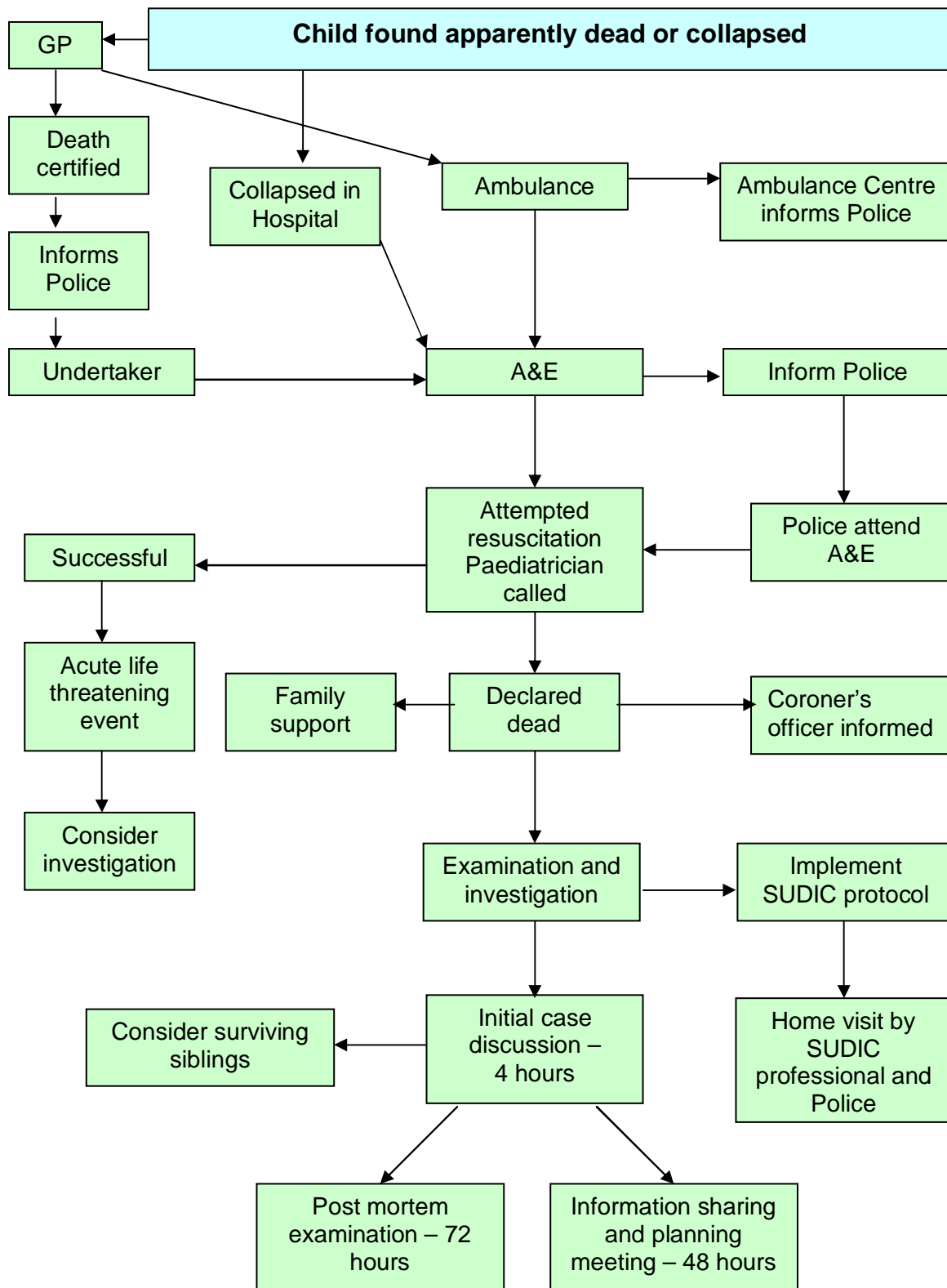
Responsible SUDIC Paediatrician – Dr Andrew MILLS
Designated Nurse – Catherine Whitehouse

Coroner's Officers

Telford and Wrekin	-	Julie Hartridge
	-	Claire Edwards
South Worcestershire	-	Mandy Bayliss
	-	Richard Boulter
	-	Robert Taylor
Shropshire	-	Ceri Sheppard
	-	Mr Jenkins
North Worcestershire	-	Pete Stockton
	-	Chris Chetwyn
	-	
Herefordshire	-	Maggie Oliver

APPENDIX 7

Agreed Pathway of Professional Responsibilities



APPENDIX 8

Mercia Region Multi-Agency Protocol for the Management of Sudden and Unexpected Deaths in Children and Infants.

Home Visit

The Home Visit should be undertaken within 24 hours (usually the same day).

Whenever possible the SUDIC healthcare professional or the Named Nurse should undertake a joint visit with the police to take a more careful history, to inspect the death scene and to try and meet some of the family's concerns. If this is not possible, and separate visits are made, the relevant professionals should liaise closely and confer in their assessment as soon as possible after their visit.

The role of the Designated Paediatrician/Named Nurse at this visit is to: -

- Undertake a careful review of the history and the events leading up to the child's death
- Undertake an assessment of the environment
- Identify and help to understand factors that may have contributed to/caused the death
- Provide information and support to the family

Contribute

- Knowledge of normal child development and abilities
- Understanding and knowledge of childhood illnesses and their likely courses
- Knowledge of developmental physiology

The role of the Police at this visit is to: -

- *Assist to identify the cause of death or contributory factors*
- *Identify suspicious circumstances*
- *Identify inconsistencies in history*
- *Ensure appropriate handling of evidence*
-

Ensure PACE and other legal rules observed (whenever appropriate)

Forensic considerations

On occasions the Police may visit the scene of the death immediately in the absence of the family to investigate the scene and ensure any disturbance is minimised prior to the home visit with the parents.

If there are significant concerns/suspicious regarding abuse and/or neglect then the Senior Investigating Officer will take over the scene and lead the investigation. There is very rarely any value in seizing bedding etc and this may prevent the later investigation of the circumstances of the death.

Reviewing the circumstances of the death.

Full History

This should include -

- A detailed narrative account of the events leading up to the death, including places visited, people seen and activities undertaken.

- A detailed sequential account of events in the last 24-48 hours, and the last few weeks, and any changes from normal practice/routine.
- Clarify any uncertainties in the medical or family history.
- A detailed family and household history.
- Use of alcohol, smoking and/or other substances.
- Recent exposure to infections.
-

Allow the parents to go at their own pace and use their own words and to decide where the initial discussions in the home take place.

Scene Review at Home

When the parents are ready return to the scene of the death.

The last sleep/final events.

- Who was there and when they were there?
- If appropriate, the position the child was put down to sleep in and any movement from this position?
- Who last saw/heard the child, where were they and was there anything unusual about this?

Do not push the parents to return to the scene of the death immediately, only when they are ready to do so. This process may involve visiting more than one room and parents should be allowed to decide the order of the rooms visited.

In the case of younger children consideration can be given to using a doll or teddy to allow the parents to demonstrate exactly what happened. Parents will sometimes suggest this but do not push them to do so.

Review and examination of the room.

- Size, orientation, contents, 'clutter'
- Is the room cramped, is there space for an adult to stand comfortably beside the cot/bed?
- Is the room cluttered, is more than 50% of the floor space visible (excluding fixed furniture)?

Is the room dirty, is there rubbish on the floor/surfaces, are there dirty stains on the floor or furnishings?

- Ventilation, windows and doors (were they open or shut?)
- Heating (including times switched on and off), measure the temperature.
- Position of the bed/cot in relation to other objects in the room (especially radiators/heaters).
- Any movements or changes noted by the parents in any objects in the room.

Sleep environment.

- Is the cot/Moses basket/bed on a secure base, is it defective in any way?
- Is the sleeping space cluttered, is there space all around where the child lay, were there any potential sites for wedging or entrapment?
- Is the bedding dirty or worn, is there adult size bedding, cushions or pillows, how many layers was the baby wrapped in?
- If the child was in a pushchair or car seat, was the child strapped in securely and safely?

- Is there anything overhanging the sleeping space other than a fixed cot mobile?
- Are there any other identifiable hazards in the room?

Position of the child.

- In what position was the child put down/last seen, was there any over-wrapping, overheating or any restriction to ventilation or breathing or risk of smothering?
- What position was the child when found, was there anything unusual about this?

Document all observations made of the room, sleep environment, the position of the child and the parent’s account (Appendix).

Complete a detailed sketch of the plan of the room with measurements and orientation (Appendix. A compass and ultrasound ‘tape measure’ will be required). The room temperature should be recorded (a thermometer will be required). This is best done using a ‘drawer temperature’ as this remains fairly constant.

Parents need time to talk and start to deal with how they feel. Professionals need to spend time with the family offering support, information and appropriate reassurance. The family may need help to identify where to go and what to do.

Ensure the family know what will happen next, where their child will be, for how long and who will organise their return.

Give contact details to the family for key professionals.

Collation of Information

The SUDIC Healthcare professional should collate all information collected by those involved in responding to the child’s death and share it with the Pathologist conducting the post-mortem in order to inform this process.

All information collected relating to the circumstances of the death, including a review of all medical, social and educational records must be included in a report for the Coroner. This report should be delivered to the Coroner within 28 days of the death unless some of the crucial information is not yet available.

Appendix 9

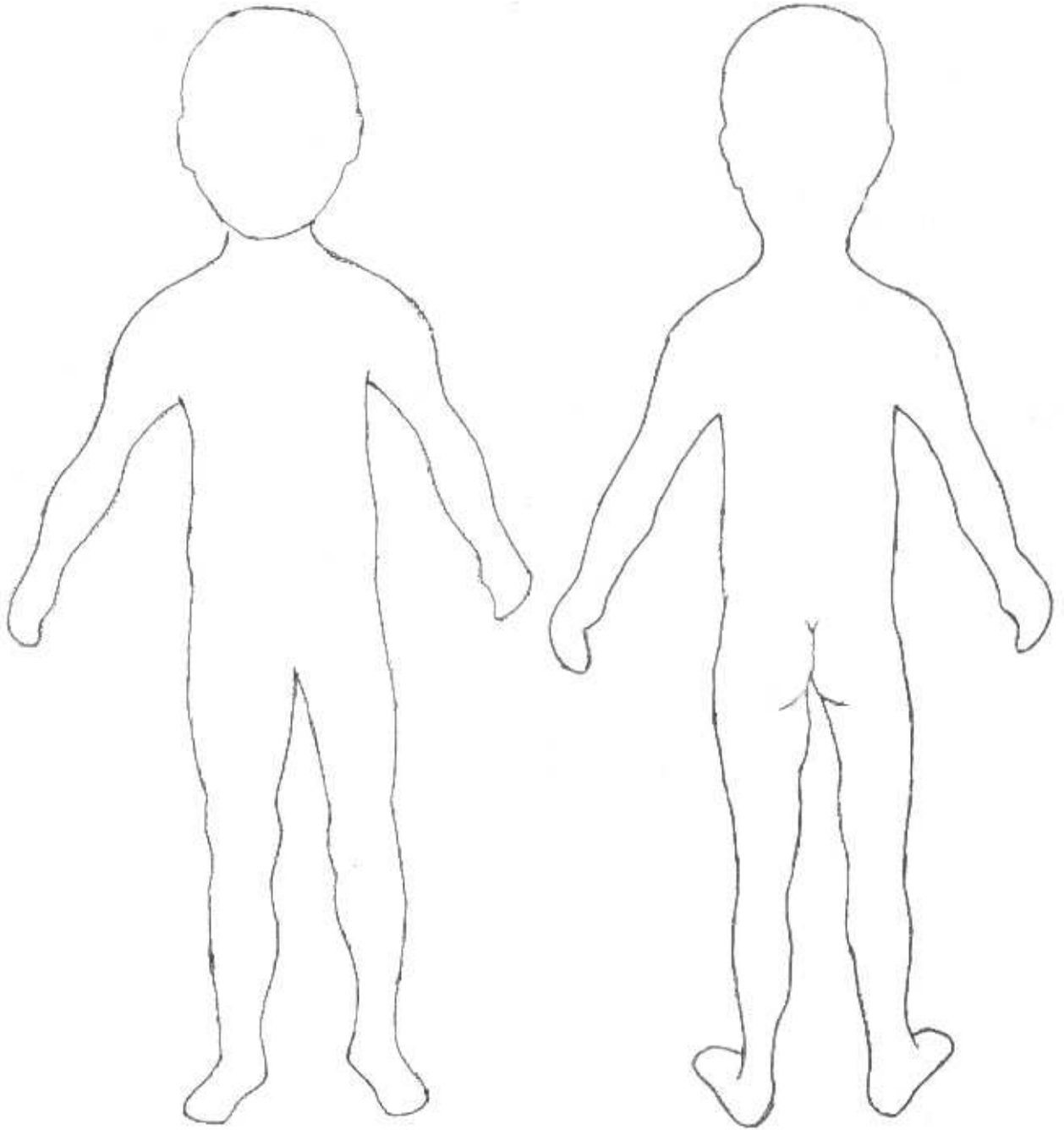
GLOSSARY OF TERMS

- | | |
|---------|--------------------------------------|
| A and E | Accident and Emergency |
| ACPO | Association of Chief Police Officers |

ALTE	Acute Life Threatening Events
BCU	Basic Command Unit
CESDI	Confidential Enquiry into Still Births and Deaths in Infancy
CPS	Crown Prosecution Service
FLO	Family Liaison Officer
FSID	Foundation for the Study of Infant Deaths
GP	General Practitioner
IMD	Inherited Metabolic Disorders
LSCB	Local Safeguarding Children's Board
MACR	Multi Agency Case Review
PPU	Public Protection Unit
SIDS	Sudden Infant Death Syndrome
SIPO	Senior Investigating Police Officer
SUDIC	Sudden Unexplained Deaths in Infants and Children

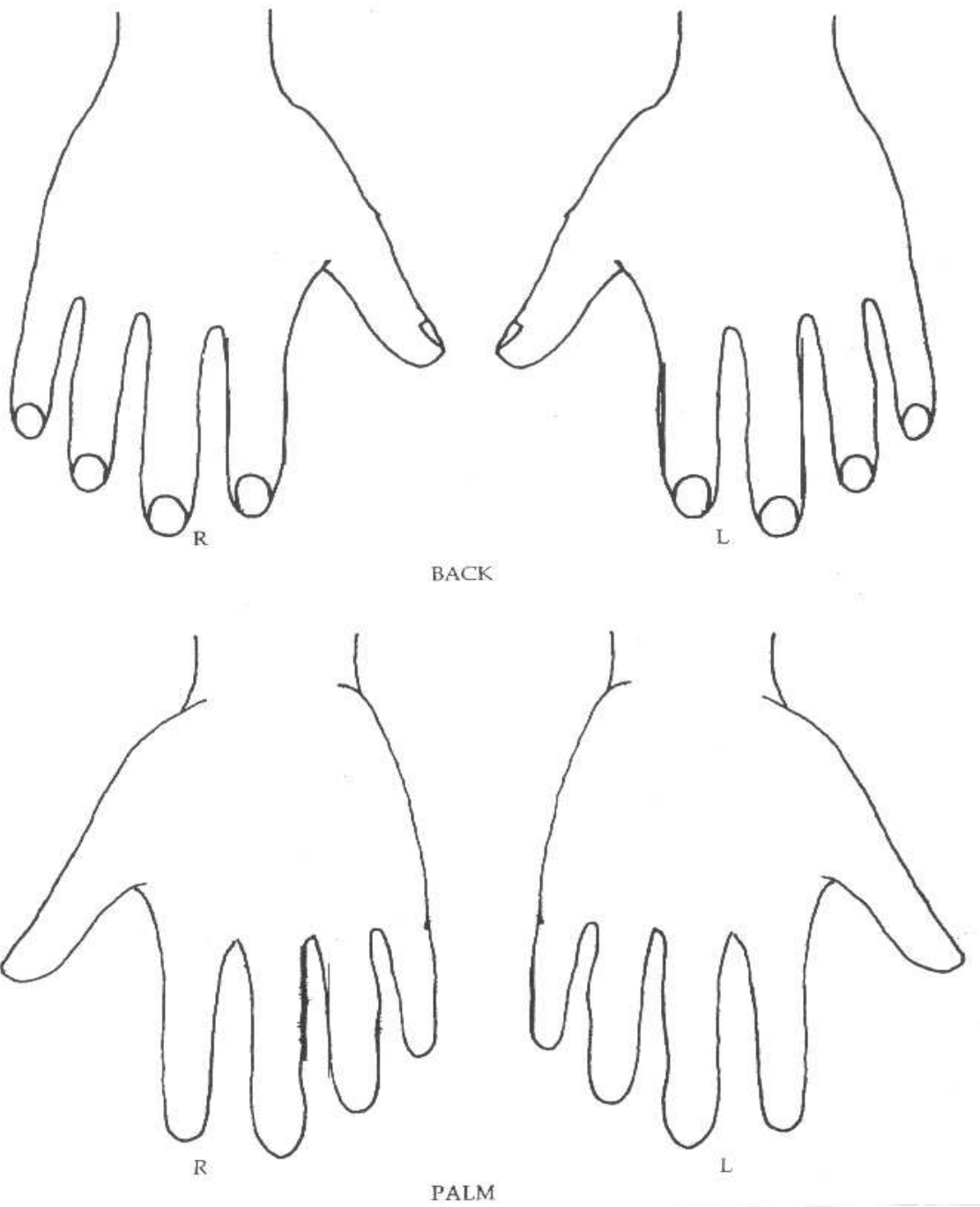
Appendix 10

Early planning and information sharing meeting



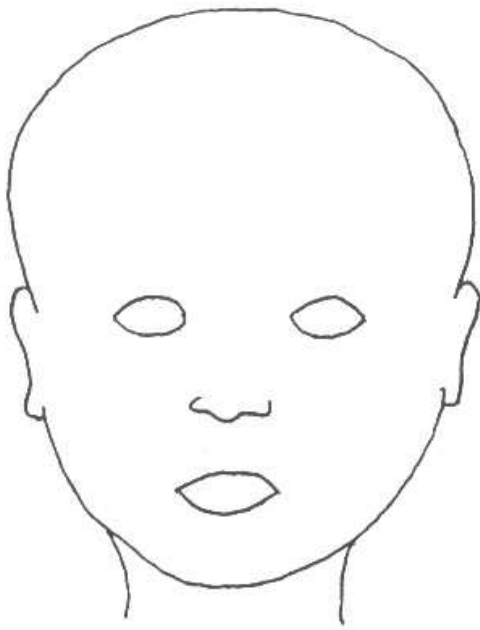
Name:
Date of Birth:
(Or Hospital ID Label)

Body Chart 2

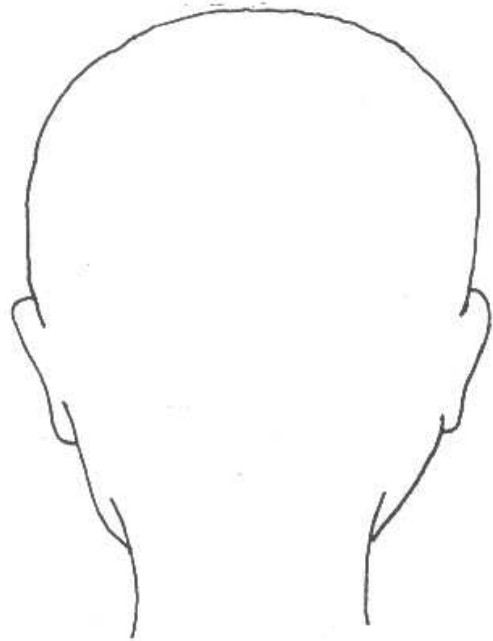


Name: Date of Birth: (Or Hospital ID Label)

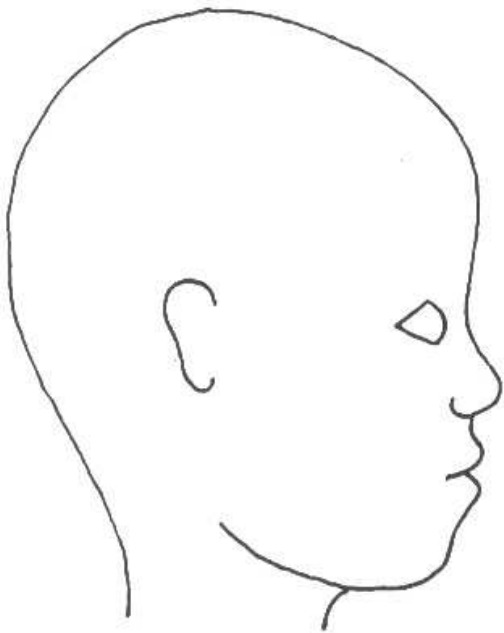
Body Chart 3



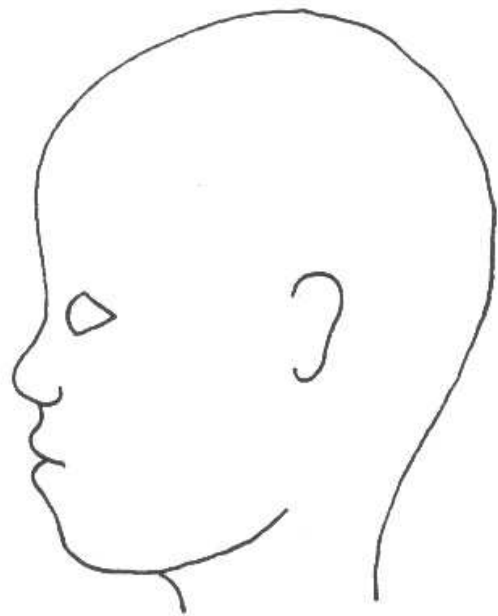
FRONT



BACK



RIGHT



LEFT

