Isle of Wight Rapid Response Procedure –

Action by professionals when a child dies unexpectedly

1. Definition

An unexpected death is defined as the death of an infant or child (less than 18 years old) which:

- Was not anticipated as a significant possibility for example, 24 hours before the death;

or

- Where there was a similarly unexpected collapse or incident leading to or precipitating the events which led to the death.

The child death healthcare professional (referred to as the Designated Paediatrician in Working Together 2013) is responsible for unexpected deaths[1] in childhood. They should be consulted where professionals are uncertain about whether the death is unexpected. If in doubt, the processes for unexpected child deaths should be followed until the available evidence enables a different decision to be made.

In some areas or settings the person who takes the lead as the child death health care professional may not be referred to as the Designated Paediatrician as this may not be their job title. However, there should be in every setting a health care professional who is responsible for unexpected deaths in childhood.

For the purpose of this practice guidance, all those under the age of 18 years will be referred to as a child.

2. Principles

It must be remembered that, in most cases, the unexpected death of a child is the result of natural causes, and is a tragedy for the family.

The following principles should be adhered to at all times:

- Respect, sensitivity, open mind, and discretion;
- Achieving a balance between forensic and medical requirements and family support;
- A multi-disciplinary approach;
- Sharing of information;
- Ensuring equality of service;
- Recognising cultural needs, including language, faith and ethnicity;
- Preserving evidence;
- Good record keeping;

[1] Ensures that relevant professionals (i.e. coroner, police, and local authority social are) are informed of the death; coordinate the team of professionals (involved before and/or after the death) which is convened when a child who dies unexpectedly (accessing professionals from specialist agencies as necessary to support the core team). Convene multi-agency discussions after the initial and final post mortem results are available (Working Together 2013, Chapter 5, page 77)

- Working to the guidance as set out in Working Together 2013 and the standards described in this document; and
- Conducting enquiries expeditiously so that there are no unnecessary delays for the funeral.

If there are concerns that abuse or neglect may have been a factor, immediate consideration should be given regarding the needs of other children in the household. Guidance should be followed as provided in the 4LSCB Safeguarding procedures http://4lscb.proceduresonline.com

3. The rapid response process

The role of the rapid response is to provide a co-ordinated response to an unexpected death and ensure appropriate and timely support is provided to the family. The rapid response is co-ordinated by the child death healthcare professional in the setting or area where the death occurs. An on-call rota of designated professionals for responding to unexpected child deaths will be maintained in each hospital setting.

When a child dies unexpectedly, the lead paediatrician should initiate and chair an immediate information sharing and planning meeting, usually within 4 hours, between the lead agencies (i.e. child death healthcare professional, police and local authority children's social care) to decide what should happen next and who will do it. See **Appendix 6** for roles and responsibilities of police. This may 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. The joint responsibilities of the professionals involved with the child include:

- Responding quickly to the child's death in accordance with the locally agreed procedures;
- Maintaining a rapid response protocol with all agencies, consistent with the Kennedy principles and current investigative practice from the Association of Chief Police Officers[2];
- Making immediate enquiries into and evaluating the reasons for and circumstances of the death, in agreement with the coroner;
- Liaising with the coroner and the pathologist;
- Undertaking the types of enquiries/investigations that relate to the current responsibilities of their respective organisations.
- Collecting information about the death;
- Providing support to the bereaved family, referring to specialist bereavement services where necessary and keeping them up to date with information about the child's death; and
- Gaining consent early from the family for the examination of their medical notes.
- To consider any safeguarding concerns to siblings/any other children living in the household, and to consider the need for child protection procedures.

If there are child protection concerns regarding children in the household, a strategy meeting under child protection procedures must take place.

[2] ACPO guide to investigating child deaths 2014

Also take account of:

- Where there are ongoing criminal proceedings, the Crown Prosecution Service in conjunction with police should be consulted about appropriate action by the rapid response to avoid prejudicing any criminal prosecution;
- Where a child dies unexpectedly, all registered providers of healthcare services must notify the Care Quality Commission of the death of a service user – but **NHS providers may discharge this duty by notifying the National Health Service Commissioning Board** (Regulation 16 of the Care Quality Commission (Registration) Regulations 2009);
- Where a young person dies at work, the Health and Safety Executive should be informed;
- Youth offending teams reviews of safeguarding and public protection incidents (including the deaths of children under their supervision) should also feed into the CDOP child death processes.

3.1 Skeletal Survey/Samples/Examination

A skeletal survey needs to be performed in all unexplained infant deaths cases, and consideration given in all children over 2, at the designated hospital. In cases where the hospital does not have facilities to undertake the skeletal surveys, the responsibility will fall to the coroner's officer to make the necessary arrangements.

A copy of the skeletal survey will be required; this copy will accompany the child to the post mortem and also be reported on by a consultant radiologist who has experience 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 a specialist paediatric radiologist reviews the x-rays as soon as possible. **This MUST be a full skeletal survey, not a babygram.**

In children where the cause of death or factors contributing to it are uncertain, investigative samples should be taken once the death is confirmed. These include the standard set for unexpected child deaths 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 or senior police officer acting on behalf of the Coroner. Additional samples must be subject to authorisation from the coroner. See **Appendix 10** for unexpected child death sample information.

A consultant paediatrician or designated paediatrician will also examine the child. The following points should be considered when examining the child:

- 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, if there are concerns, the child needs to be weighed and measured and this information plotted on a centile chart.
- Upon attendance at hospital note where blood has collected in the child's body it is important this is noted as soon as possible as this will give an indication of the child's position at the time of death.

See **Appendix 10** for Body Maps.

3.2 History Taking

The consultant paediatrician (or designated healthcare professional) and senior investigating police officer will obtain a detailed history from the parents/carers. It should be agreed beforehand whether this is police or health led (in the majority of cases, the process will be led by health). The history taking usually begins in Accident & Emergency. The purpose of obtaining this information is to understand the cause of death and identify anything suspicious about it. The history will be recorded contemporaneously in the hospital notes.

During the initial contact with the family, they should be told of the further stages of the investigation, including the need for and nature of the post mortem examination. The discussion with parents about the details of the post mortem examination should be done in conjunction with Coroner's officers.

3.3 Home Visit

For all children under 2 years of age, who have died suddenly and unexpectedly, a home visit should be undertaken. The senior investigating police officer and the senior healthcare professional will conduct the home visit within 24 hours. The home visit provides an opportunity to take a more careful history, to inspect the death scene and to try and alleviate some of the family's concerns.

The reason for the home visit must be fully explained to parents/carers. Every effort should be made to accommodate their wishes without compromising any police investigation. Detailed information regarding the home visit can be found in **Appendix 11**. Information from the home visit should be recorded on the hospital records.

In respect of older children a home visit will be determined as necessary dependent upon the circumstances of the death.

Where the location of the death is different to the home address of the child, an additional visit to the home address may be arranged if deemed necessary. Consideration should be given at the immediate information sharing and planning meeting as to which professionals should attend the visit. Normally this will involve the senior investigating officer and a designated health professional. Where possible a member of the primary care team, or some other professional known to the family should also attend. There may be situations where, for pragmatic reasons, or because of the nature of the death a joint visit is not possible or appropriate, or where the police need to visit the scene of death early to gather forensic evidence.

After this visit the senior investigating police officer, visiting health care professional, GP, health visitor or school nurse and local authority children's social care representative should

consider whether there is any information to raise concerns that neglect or abuse contributed to the child's death.

If for any reason separate visits are conducted, the relevant professionals should confer in their assessment. In addition, the Paediatrician should view any police video recording and/or photographs of the scene of death. The video and/or photographs of the scene of death should also be made available to the pathologist.

3.4 Suspicious Deaths

If the police determine that there should be early consultation with the CPS then they will decide at what point in the rapid response process it would be beneficial contact them.

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.

The chair of the Local Safeguarding Children Board must be informed where there are concerns that a serious case review may be required.

3.5 When a child is obviously dead

Where a child is obviously dead it may not be appropriate to use the Ambulance Service. In these instances, the police will arrange for the child to be conveyed to the receiving facility at the nearest hospital utilising the police approved undertaker. There will be circumstances, for example deaths in the open air in the public view, where the senior investigating police officer will consider the use of an ambulance to convey the child to the hospital to prevent undue harm to the public.

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 Accident & Emergency Department.

Upon arrival at hospital the Rapid response Procedure must be fully implemented.

3.6 Further Information Gathering

Within 48 working hours of the death, the child death healthcare professional will need to ensure further information will need to be gathered to support the investigation into the cause and circumstances of death. The purpose of gathering this information is to provide a comprehensive account to the pathologist, to assist them in identifying a cause of death. All practitioners play a role in this and must be prepared to share information with other members of the multi-agency team. The following agencies should be contacted and relevant information sought from them (this list is not exhaustive):

- General practitioner
- Senior community paediatrician
- Named/lead NHS Trust safeguarding children professionals
- Health visitor/ school nurse/midwife
- Children's services via the MASH

- Adult services
- Other relevant health professionals involved in the previous care of the child
- Police child abuse investigation team
- Education (including early years)

4. Meetings

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 on-going 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 Child Death Overview Panel to make recommendations in cases of preventable deaths.

These meetings will be chaired by the child death healthcare professional and they will arrange for the recording and dissemination of minutes.

There are 4 types of meeting:

Initial discussion (within approximately 2-4 hours of the death)

Phase 1: Initial meeting (between 4 and 48 hours of the death) (AKA Phase 1 meeting)

Phase 2: Multi-Agency meeting (between post mortem and 14 days of the death) (AKA Phase 2 meeting)

Phase 3: Final Multi-Agency meeting (within 6 months of the death) (AKA Phase 3 meeting)

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.

4.1 Multi-Agency meeting (AKA Phase 2 meeting)

At a time relevant to the case, but within 14 days, there must be a further professionals meeting or phone conversation after the initial post mortem, so those relevant professionals are able to discuss the findings and interpret their relevance.

The purpose of this meeting is to share information between key agencies involved with the child before their life and after their death, to agree any subsequent actions.

The initial post mortem report should be available for discussion to those relevant professionals available to discuss the findings and interpret their relevance.

Once all information has been shared, the chair of the meeting will establish whether there are any safeguarding concerns for the other siblings/children in the family. Support for the family must also be considered, as should support for all professionals involved.

Professionals usually invited to this meeting include:

- Designated child death paediatrician (child death health care professional\0
- Ambulance Service
- Police
- Children's services
- GP
- Health visitor/school nurse/midwife
- Nursery/school/college
- Hospital staff
- Pathologist (if relevant)
- Coroners Officer

4.2 Final Multi-Agency meeting (AKA Phase 3 meeting)

As soon as possible, usually 3 – 6 months after the child's death (once the results of all relevant investigations have been obtained), a final case discussion meeting is held. This meeting will be convened by the child death healthcare 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.

At this case discussion 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 and Form C completed for submission to the Child Death Overview Panel (CDOP).

If, however, the death is subject to an on-going criminal investigation, the meeting should not be held without the police first seeking the views of the Crown Prosecution Service.

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 child death healthcare professional. This meeting should involve the GP, health visitor, paediatrician(s), pathologist, 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 child death 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.

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. 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.

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.

Notes will be kept by the designated chair of the meeting and this record will subsequently be distributed for ratification by those attending the meeting.

Upon receipt of the final post mortem report, arrangements should be made for the appropriate paediatrician to 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 medical investigation of family members or subsequent children for metabolic or other familial disorders.

A copy of the notes of any 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. Meeting notes should be forwarded to the Coroner.

Appropriate information should also be made available to the relevant staff about the outcome of any processes/enquiries following the final case discussion. This will facilitate audit, highlight good practice and assist with identifying any lessons to be learned.

5. Individual agency responsibilities

Each partner agency should identify a senior member of staff, with relevant experience, to be responsible for advising on the implementation of rapid response, and the use of the agreed rapid response procedure. In some instances, this could be the person who is a member of the Child Death Overview Panel (CDOP). All agencies will ensure relevant staff have attended rapid response training in the last 2 years so that they are aware of how to discharge their responsibilities.

The child death healthcare professional will be able to advise on the commissioning and organisation of services from Paediatricians with expertise in undertaking enquiries into unexpected childhood deaths, and the medical investigative services also required such as radiology, laboratory and histopathology.

The Designated Paediatrician for deaths in childhood will be a member of the CDOP. This is a separate role to the Designated Doctor for child protection, but does not necessarily need to

be filled by a different person. Where there is more than one Designated Paediatrician role in the LSCB area, one individual will be nominated to be a member of the CDOP.

6. Care of parents /carers / family members

In circumstances when a child has died in, or been taken to a hospital, a member of the hospital staff should be allocated to remain with them and support them throughout the process.

The parents should normally be allowed to hold and spend time with their child, if they wish. The allocated member of staff should maintain a discreet presence at this time.

If spoken English is not the preferred language of the parents / carers, interpreting services should be contacted if required. This should be communicated to the attending Paediatrician who should inform other members of the Rapid response. This also applies to any other additional requirements that parents / carers may have, in relation to physical disability for example.

When a child dies in the LSCB area but their parents live or are staying abroad, careful consideration needs to be given as to how best to contact the parents and convey the information of the death of their child.

Unless sharing information may jeopardise a police investigation or criminal trial, parents / carers should always be kept up-to-date about any new findings. A member of the rapid response should be designated from the outset to liaise with the family.

7. Attempting resuscitation and conveying children to hospital who have died

Children who die unexpectedly should be taken to the Accident and Emergency Department if any attempt is to be made at resuscitation. Resuscitation should always be initiated unless clearly inappropriate. Children should not be removed from the scene if forensic examination is required.

Children will usually be conveyed to hospital by staff from the Ambulance Service, and may also be accompanied by officers from the Police. However, this will not always be the case, as sometimes family or friends will take them.

If commenced, resuscitation should be continued according to the *U.K Resuscitation Guidelines* (2010), until an experienced Paediatrician has made the decision to stop. This will usually be the Consultant paediatrician on-call.

When the child is pronounced dead, the Consultant paediatrician should inform the parents / carers, having first reviewed all the available information. They should explain about the future involvement of the Police, the Coroner and the Rapid response

Children dying at home or in a hospice or other setting who have been undergoing end of life care will not usually be considered to have died unexpectedly, and a rapid response to such deaths is rarely indicated.

When a child with a known life limiting or life threatening condition dies in a manner or at a time that was not anticipated, the Rapid response should liaise closely and promptly with a

member of the medical, palliative or end of life care team who knows the child and family, to jointly determine how best to respond to that child's death. Where an end of life plan has been agreed by the end of life care team and is in place, this should be followed unless there are pressing reasons not to do so. For example, the Coroner decides where the child's body may be taken and this decision may be different to what was set out in the family's prepared plan. This death will be subject to local Coronial guidelines if the Doctor is unable to issue a Medical Certificate of the Cause of Death.

8. Informing the Coroner

The doctor who has certified the death should inform the Coroner's Office as soon as practicable unless the death was expected and is known to be completely natural, in which case a Medical Certificate for the Cause of Death (MCCD) will be issued. They should also ensure the designated healthcare professional for child deaths is informed using the 'Initial Notification' Form A.

There is generally no on-call Coroner for out of hour referrals and in such cases the death should be reported at the outset of the next working day. However, in all sudden and unexpected deaths the police will need to be informed of the death. This must happen without delay so that they can commence enquiries on behalf of the Coroner. Where the police are involved they will complete a sudden death report form, which will be available to the Coroner. But the clinician is still required to report the death and to advise the Coroner of the medical aspects.

9. Response when a child dies following admission to a hospital ward

The above process should also be followed when a child dies unexpectedly following admission to a hospital ward.

10. Immediate response to the unexpected death of a child in the community

10.1. Professionals first on the scene

If the first professionals at the scene are not medical professionals, they must request assistance as the main priority. Any professional should always commence resuscitation unless it is clearly not appropriate.

If the child is not taken immediately to the Accident & Emergency Department, the professional who certifies the death should inform the Coroner and ensure the designated healthcare professional for child deaths is also notified.

Ambulance personnel cannot certify the cause of death; they can only confirm the fact of death. A doctor must carry out the certification.

10.2 Removing the body from the scene

In most circumstances, it will be appropriate to remove the child's body from the scene and take it to the Accident & Emergency Department as soon as possible. However, if there are concerns that the death may be suspicious then the body should remain in place. The ambulance service paramedics, in conjunction with the senior investigating police officer, should make this decision. This would require ambulance service personnel to confirm 'life

extinct', and the senior investigating police officer to state that the body cannot be removed until forensic examination is complete.

In most circumstances the child will already have been held or moved by a carer, therefore removing the body to the Accident & Emergency Department would not usually jeopardise an investigation.

11. Involvement of the Coroner and Pathologist

The Coroner will order a post mortem examination to be carried out, if they consider it necessary. The most appropriate pathologist available will carry this out at that time, who may be either a Paediatric or Forensic Pathologist, or both. They will conduct the examination according to the guidance and protocols laid down by the Royal College of Pathologists.

The child death healthcare professional should share information gathered from other professionals involved in responding to the child's death and share it with the pathologist conducting the post mortem, to inform the process.

Where the cause of death has not been determined at the post mortem examination or the death may have been unnatural, the Coroner will in due course hold an inquest.

On receipt of an initial report of a death of a child, the LSCB(s) with an interest in this information should inform the Coroner of the address(es) to which future information should be supplied. The CDOP Administrator should inform the Coroner of their interest in the case, and submit a request to be informed of the date of inquest once listed, so that a representative can attend at the discretion of HM Coroner, and ask questions as a 'properly interested person'.

If any information comes to the attention of the LSCB that it believes should be drawn to the attention of the Coroner, then the LSCB will supply it to the Coroner as a matter of urgency.

The CDOP has a clear relationship and agreed channels of communication with the local Coronial Service.

All information collected by the rapid response should be included in a report provided by the child death healthcare professional for the Coroner, which should be delivered within **28 days** of the death of the child, unless there is vital information not yet available.

12. Good Practice Points for all Professionals Involved

The first professional on the scene, whether ambulance personnel, Police or GP, should note the position of the child, the clothing worn and the circumstances of how the child was found. Those remaining at the scene should be asked not to disturb or move items around where the child was found until the Police, and also possibly the Paediatrician, have viewed it.

Any comments made by parents, any background history, any possible substance misuse or other factors, and the living conditions should be noted and reported to the receiving Doctor at the hospital. Any special requirements the parents / carers may have, such as communication needs or related to physical disability, should also be communicated to the receiving Doctor.

The following points are important to note:

- Remember that you are dealing with people who are in the first stage of grief. They may be shocked, numb, withdrawn, or hysterical;
- Always consider the need for an interpreter if spoken English is not the preferred language of the family;
- Ask the child's name and use it at all times;
- Always handle the child as though s/he were alive;
- It is entirely natural for a parent/carer to want to hold or touch the dead child. Providing this is done with a supportive professional (such as a Police Officer, Nurse or Social Worker) present, it should be allowed in most cases, as it is highly unlikely that forensic evidence will be lost. If, however, the death is by this time considered suspicious, the Senior Investigating Officer should, where possible, be consulted before a parent/carer is allowed to hold the child;
- Record carefully what parents say about the circumstances leading up to the death. This includes both early explanations and also later comments, which may produce conflicting accounts;
- Record history and background information in as much detail as possible and without delay; professionals from all agencies may be required to provide statements of evidence;
- Allow parents time to ask questions;
- Explain to parents what will happen next, where their child will be taken and when they will be able to see him/her again;
- Explain to parents that all cases of sudden unexpected death must be referred to the Coroner and must be the subject of a multi-agency investigation;
- If a post mortem examination is required, explain sensitively to parents about why it is necessary and what is involved;
- Take into account any religious and cultural beliefs that may have an impact on procedures and handle discussion of these with sensitivity, but with due regard to the importance of preserving evidence;
- Avoid technical terms and jargon and when giving information, check it has been understood by parents;
- Your time with the family may be brief, but your presence at this tragic time may have great significance for them in time to come. It is vital to be sympathetic and supportive whilst maintaining a professional approach and to be mindful of the needs of siblings and other family members.

13. Factors that may raise concern

Any information identified by professionals in the course of their involvement that could give rise to concern or provide important information to the investigation must be shared immediately with the other professionals involved. Such factors (not in order of priority) include:

- Previous child deaths in the same family;
- Previous child protection concerns in the same family;
- Previous unexplained illnesses or injuries;

- Inappropriate delays in seeking help;
- Inconsistent explanations;
- Evidence of drug/alcohol abuse;
- Evidence of parental mental health problems;
- Unexplained injuries or bleeding;
- Neglect issues.

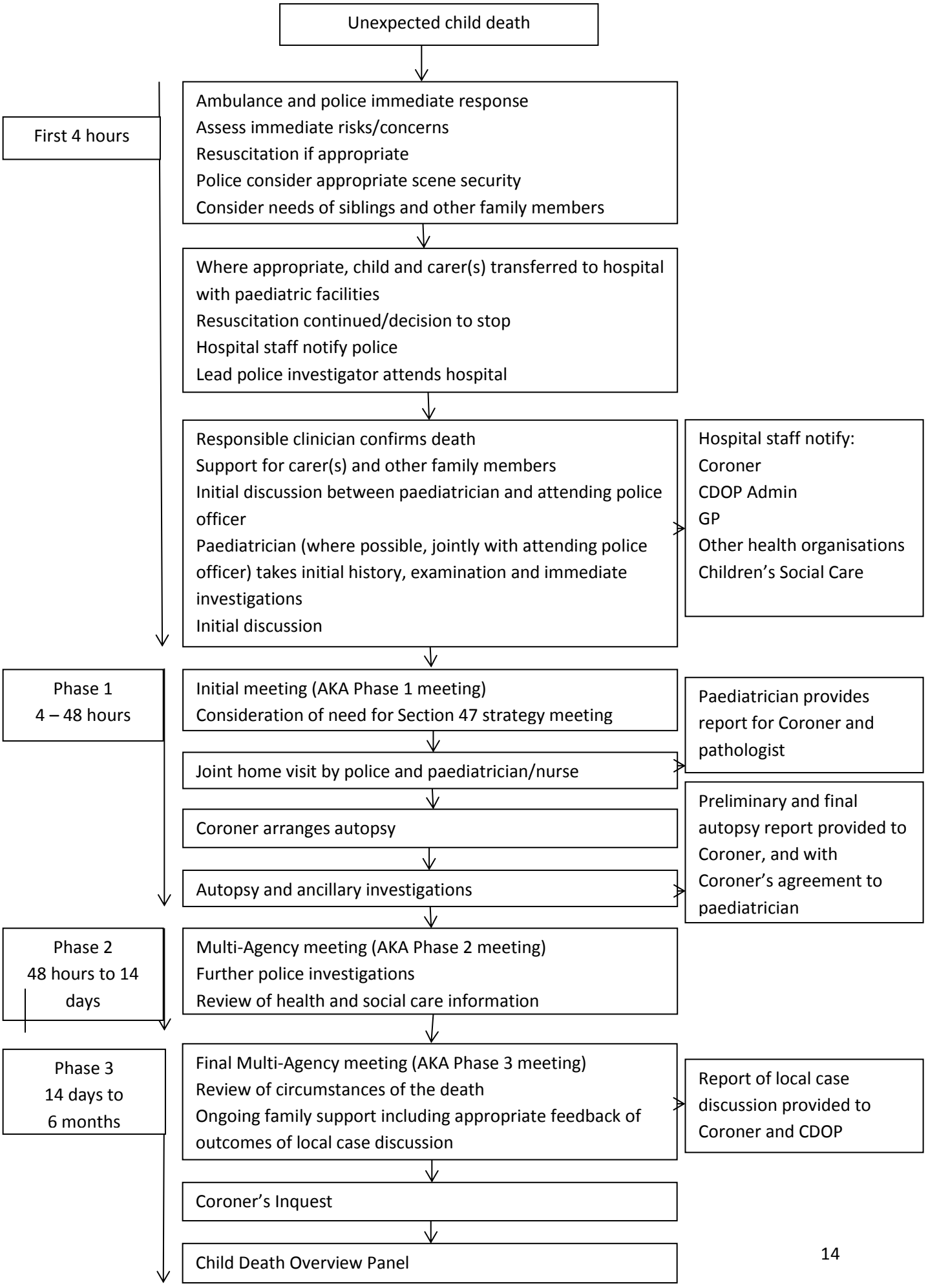
14. Training

Using agreed training materials, the Local Safeguarding Children Board has invested in training for staff from member agencies to understand and put into practice the new child death review processes. This involves being able to take immediate action, provide appropriate support and care to the family, look at how and why children die and see if there are any lessons to be learned to help to prevent future deaths.

The purpose of these courses has been to develop expertise locally, based on our experience and what parents have feedback to the LSCB since implementing the new local review of children's deaths.

A training course **Unexpected Child Death – Multiagency Rapid Response** provides staff, who are likely to be more directly involved when a child dies, with the basic skills to carry out an investigation into involvement and services provided to the child and family by agencies/organisations that knew them. The course is facilitated and assisted by designated professionals who lead on the rapid response process on behalf of their agency.

Flow chart : Process for rapid response to the unexpected death of a child



Appendices

Appendix 1 ROLES AND RESPONSIBILITIES

Appendix 2 THE ROLE OF THE AMBULANCE SERVICE

Appendix 3 THE ROLE OF HOSPITAL HEALTH PROFESSIONALS

Appendix 4 THE ROLE OF PAEDIATRICIANS

Appendix 5 THE ROLE OF GENERAL PRACTITIONERS

Appendix 6 THE ROLE OF THE POLICE

Appendix 7 THE ROLE OF CHILDREN'S SERVICES

Appendix 8 THE ROLE OF THE CORONER AND THE POST-MORTEM

Appendix 9 THE ROLE OF THE CROWN PROSECUTION SERVICE

Appendix 10 SUDIC SAMPLE INFORMATION

Appendix 11 THE HOME VISIT

Appendix 12 AUDIT TOOL FOR RAPID RESPONSE

Appendix 1

ROLES AND RESPONSIBILITIES

GENERAL ADVICE FOR ALL PROFESSIONALS

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.

A sympathetic and supportive attitude, whilst maintaining professionalism towards the investigation, is essential.

Many parents value photographs of their child 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.

The parents and other close relatives should normally be given the opportunity to hold and spend time with their child. 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 child. 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.

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, or 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.

Appendix 2

THE ROLE OF THE AMBULANCE SERVICE

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 Rapid response Procedure is being triggered (which covers all child deaths under the age of 18)

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

The ambulance staff should (adapted from national training manual):

- Not automatically assume that the death has occurred.
- Clear the airway and if in doubt about death, apply full CPR.
- Inform the A&E Department giving estimated time of arrival and patient's condition
- Transport the child to the local A&E Department
- 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 in the house.
- Note any injury and any explanation offered.
- Pass on all relevant information to the Health Professionals and/or A&E staff or investigating police officer.
- The patient clinical record is to be completed in full as a record of attendance or treatment of the patient.

Ambulance service response to 999 calls to child death cases

Category 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 Emergency 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 inappropriate

d) **Non-ambulance response:**

- GP confirms child deceased

- No 999 call made and child confirmed dead at scene

- GP informs Police/Coroner who take actions as outlined in protocol

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.

Appendix 3

THE ROLE OF HOSPITAL HEALTH PROFESSIONALS (in conjunction with the Designated Child Death Health Care Professional)

An experienced member of staff should be allocated to care for the parents, to offer explanations of what is happening and provide them with support, including cultural and religious. The allocated member of staff will remain with the family throughout the period to explain what is happening and the procedures being undertaken, particularly those that look alarming. The parents should be given the option of being present during the resuscitation.

A senior medical practitioner, usually the consultant paediatrician, should confirm that the child is dead. When the child is pronounced dead, the lead doctor should break the news to the parents, having first reviewed all the available information, in the privacy of an appropriate room. The allocated member of staff to the family should be present at this time.

Once a child is confirmed dead the coroner and the police should be informed immediately.

The parents need to be told that the coroner has to be informed because their child has died suddenly and the police have a responsibility to investigate the death. For families with an established contact with a particular social worker, it will be important to inform and involve this known social worker at an early stage.

Parents also need to be informed of the child death review process. Since 1 April 2008 Local Safeguarding Children Boards (LSCBs) are required to review the deaths of all children in their area, as outlined in Working Together to Safeguard Children, 2013 (Chapter 5).

The overall principle of the child death review process is to learn lessons and reduce incidence of preventable child deaths in the future. It is a statutory requirement in the Children and Young Persons Act 2008 that each LSCB must make arrangements for the receipt of notifications from registrars and to publish those arrangements. The Coroners (Amendment) Rules 2008 also place a duty on Coroners to inform an LSCB for the area in which the child died that there will be an inquest or post-mortem.

In addition, in order for LSCBs to fulfil their responsibilities for reviewing deaths, every LSCB should be informed of all deaths of children normally resident in its geographical area.

The parents should be told that in the majority of cases the coroner will order a post-mortem examination and that this will be carried out by a pathologist with special expertise in diseases of children (paediatric pathologist). The family do have the option of approaching the Coroner if they have views as to whether a post-mortem examination should take place. The family will also 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. The nature and purpose of the post-mortem examination briefly explained to the parents in understandable terms and they should be given a copy of the relevant literature. More detailed information regarding the role of the Coroner and the post-mortem examination will be fully explained to parents by the Coroner's officer. It is important the Coroner's officer undertakes this role in order to ensure the correct and appropriate information is shared with parents.

It is important that normally, the parents and other close relatives are given an opportunity to hold and spend quiet time with their child. Professional presence should be discreet at this time. **In relation to children who have died, the skeletal survey must always take place prior to parents having any unsupervised contact with their child**, unless the senior investigating police officer has explicitly agreed that unsupervised contact may take place.

Many parents value photographs of their child taken at this time, along with mementos such as handprints and a lock of hair. Only in exceptional circumstances should mementos not be offered e.g. when the death is being investigated as suspicious. In this circumstance the senior investigating police officer should be asked for approval.

Broader safeguarding and health issues must be considered around other siblings especially where there is a twin. Consideration should be given to admitting the surviving twin to hospital overnight for observations and investigation.

Appendix 4

THE ROLE OF PAEDIATRICIANS (in conjunction with the designated child death healthcare professional)

In most circumstances, the consultant paediatrician on-call will be responsible for the immediate responses in hospital, including any decision to stop resuscitation, confirming the death and breaking news to the parents. The paediatrician should:

- Take an initial history from the parents, in conjunction with the attending Police officer (See Appendix 6)
- Examine the child
- Carry out appropriate investigations with the consent of the coroner
- In the case of infants, request a full skeletal survey is performed and interpreted by a paediatric radiologist
- In the case of older children determine the extent of any necessary x-rays
- Consider with police whether photographs should be taken of any visible injuries
- Ensure complete and accurate documentation of history, examination, investigations and any interventions and discussions.
- Ensure results of skeletal survey/x-rays and all investigations are passed on to the pathologist.

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. The aim should be for the child death healthcare professional and senior investigating police officer 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 child death healthcare professional on-call and agree precise arrangements and timing for them to meet the family at the most appropriate time.

The attending paediatrician should participate in the initial information sharing and planning meeting. Subsequent management may remain with the attending paediatrician or pass over to the paediatrician with responsibility for child deaths and/or the designated child death healthcare professional.

The paediatrician should be made aware of which pathologist will be conducting the post-mortem examination and provided with their contact details. This will enable the paediatrician to ensure that the pathologist is fully informed prior to the post-mortem examination with a written report and/or a copy of the medical record pro forma and possibly by direct discussion.

Following the post-mortem examination the pathologist, with the coroner's approval, should discuss the initial findings with the lead healthcare professional, who should arrange to inform the family of the findings.

The professional confirming the child's death is responsible for completing the Notification of Death (Form A) which is sent to the CDOP Administrator. See the IOWSCB website for the Notification of Death (Form A).

The family must be told at this time that the coroner will need to be informed because the child has died suddenly and unexpectedly and that, as a matter of routine practice, the police and children's services also have to investigate the death. The paediatrician must explain that possible medical causes of the child'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.

Appendix 5

THE ROLE OF GENERAL PRACTITIONERS

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.

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.

If the child has been dead for some time, the GP will inform the police (it is advised that this is best done via the police emergency number, 999), who will inform the coroner.

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 GP and ambulance service are not utilised, the force approved undertakers should be contacted.

The GP will further be involved in providing on-going advice and counselling for the family, in collaboration with other professionals.

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

Additional guidance for GP and health visitors, particularly in relation to the longer term care of the family, is available from the Lullaby Trust (www.lullabytrust.org.uk).

Appendix 6

THE ROLE OF THE POLICE

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 the police, will always lead the investigation, supported by the designated 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.

A senior investigating police officer will be appointed to lead the investigation. The role of the police is:

- To be part of the rapid response team which are 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.

The appointed senior investigating police officer from the rapid response team will remain with the case, including where suspicious circumstances have been ruled out. This will also involve reporting in person to the Child Death Overview Panel for relevant deaths they have led on later on in the review process.

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 are 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 police. This does not however preclude the senior investigating police officer from utilising certain elements of the protocol e.g. initial information sharing and planning meeting.

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 on-going child death review process. To ensure a consistently high standard of police input to the investigation a specially trained police officer will support the investigation into all child death incidents. This may involve taking over from the initial on call senior investigating police officer where appropriate.

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.

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 2013 (Chapter 5).

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.**

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

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 ensure the room temperature is checked as soon as possible. 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.

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.

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'.

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. Procedures exist that allow paramedics to pronounce life extinct do apply in cases of children. The child death healthcare professional must be informed so that the rapid response procedure can be affected.

Where a child is obviously dead it will not be appropriate to use the ambulance service, and an undertaker service will be used. See Appendix 2.

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.

Upon arrival at hospital officers must ensure the rapid response procedure is fully implemented, checking a senior investigating police officer has been informed.

The senior investigating police officer will attend the scene as soon as possible. This will be a 24/7 365-day resource in each local policing area. The senior investigating police officer should consult with the child death health care professional 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 senior investigating police officer should attend the scene of the death together will be made.

The senior investigating police officer will ensure that the 'scenes' are identified and preserved. The crime scene officer will attend the incident and take appropriate action as directed by the senior investigating police officer, which will always include photographing and/or recording of the scene of the child's collapse.

Where necessary a Family Liaison Officer will be appointed in conjunction with any hospital services for the bereaved.

The senior investigating police officer will ensure that the coroner's officer, appropriate hospital paediatrician and CDOP are notified of the death.

After making the necessary arrangements for scene preservation, the senior investigating police officer will liaise with the designated 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.

Unless the death is viewed as suspicious the procedures for joint paediatric/police history taking will take effect. Crown Prosecution Service 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 child death 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 senior investigating police officer 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.

Following the initial planning and information sharing meeting or case discussion with the paediatrician, the senior investigating police officer 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 Appendix 11).

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 Detective Superintendent must discuss and seek permission for the procedure with the coroner and duty senior investigating police officer**. If a forensic post mortem is undertaken an adequately briefed member of the investigation team and crime scene investigator/crime scene manager will attend.

In those cases that become a criminal investigation the police will work closely with the Crown Prosecution Service and will follow current arrangements regarding pre-charge advice.

Appendix 7

THE ROLE OF CHILDREN'S SERVICES

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 designated paediatrician.

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.

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.

Where concerns exist at the initial case discussion meeting, children's services will convene an immediate strategy meeting in line with multi-agency child protection procedures for safeguarding children.

Arrangements need to be in place to notify the Chair 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.

Appendix 8

THE ROLE OF THE CORONER AND THE POST-MORTEM

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.

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 only the coroner's officer shares this information as any misinformation may cause additional distress to the family.**

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.

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, a forensic pathologist should accompany the paediatric 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.

Prior to commencing the post-mortem examination, the pathologist should be given a full written briefing on the history, a report from the radiologist 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 coroner's overriding discretion and the pathologist's professional judgement.

In all instances there s hould be a full discussion between the 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.

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.

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.

The pathologist should arrange a number of investigations.

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.

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.

The preliminary result may well be 'not yet ascertained'.

The final report must be notified in writing within seven days to the coroner. The coroner will disseminate the report accordingly. This will ensure the final meeting is triggered and a final report is completed.

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.

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.

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.

Death Certificate

At the conclusion of the inquest, the coroner will notify the registrar of deaths to enable a death certificate to be issued.

Appendix 9

THE ROLE OF THE CROWN PROSECUTION SERVICE

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.

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.

The senior investigating police officer in any criminal investigation of a sudden unexpected child death 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.

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.

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

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.

Appendix 10

SUDIC SAMPLE INFORMATION

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)	Clinical chemistry	Normal	U&Es
blood (serum) brown top 1 ml	Clinical chemistry	spin, store serum - 20ºC	toxicology (City Hosp)
blood Li Heparin orange top 1 ml	Clinical chemistry	spin, store plasma - 20ºC	inherited metabolic disease (BCH)
blood Li Heparin orange top 5 ml	Clinical chemistry	normal (keep unseparated)	chromosomes (consider if dysmorphic)
blood Fluoride yellow top 2 ml	Clinical Chemistry	collect pre-mortem spin, store plasma - 20ºC	3 OH Butyrate, FFA, lactate (BCH)
blood EDTA	Haematology	Normal	FBC
blood cultures	Microbiology blood culture incubator	if insufficient blood, aerobic only	C&S
blood from syringe onto newborn blood spot screening	Clinical Chemistry	normal (fill in card, don't put in plastic bag)	inherited metabolic disease (BCH)
Nasopharyngeal swab	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	spin, store supernatant	Toxicology

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

Inform Designated Doctor for Child Protection, if not already done:

Christopher.Magier@iow.nhs.uk / 01983 534944

Skin biopsy tissue culture within 24 hours. Consider **muscle biopsy** – rarely needed, do only after discussing with the Inherited Metabolic Disease (IMD) laboratory. Contact details:

Clinical Biochemistry Department
University Hospital Southampton
General Enquires 023 8120 6464
Clinical Advice bleep 023 8077 7222; bleep number 2612

Take a full **history**, using special history / examination sheet to record this information. This sheet will be also used by the 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; if only a small volume available, set up aerobic in preference; put in incubator at 37ºC (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
- previous infant death in family
- 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 Inherited Metabolic Disease (IMD) laboratory for advice. Contact details:

Clinical Biochemistry Department
University Hospital Southampton
General Enquires 023 8120 6464
Clinical Advice bleep 020 8077 7222; bleep number 2612

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 +4ºC until transported to IMD at BCH. Transport within 24 hours of collection – before sending sample discuss with duty biochemist at the 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 -20ºC dried blood spots directly from syringe onto newborn blood spot screening card fluoride specimen (if available pre-mortem) separate, freeze plasma at -20ºC **Urine –** in plain bottle spin and freeze supernatant at -20ºC

Skin biopsy for tissue culture at +4ºC 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 -20ºC

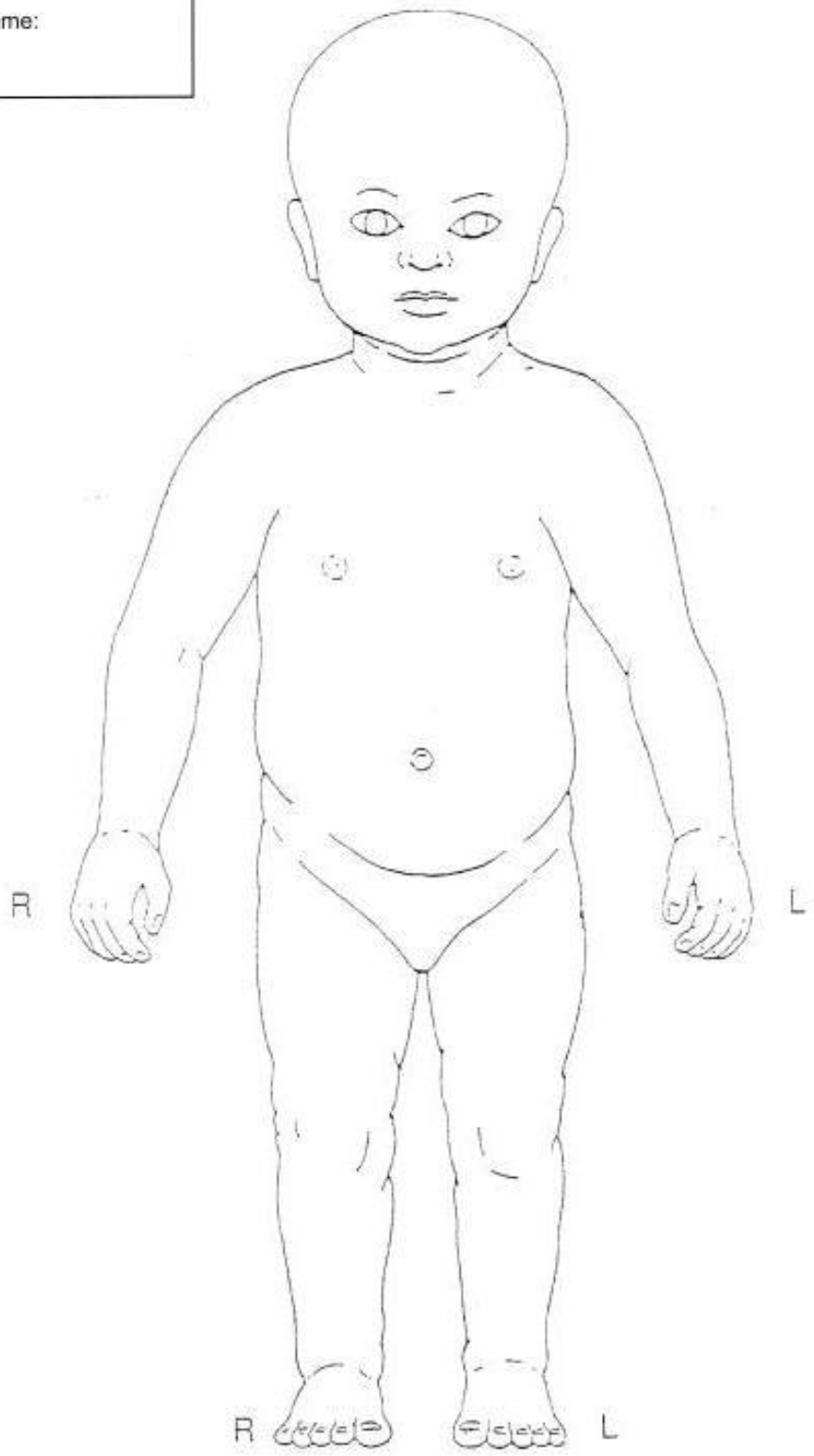
Urine – plain bottle – spin and freeze supernatant at -20ºC

Skeletal survey (X-ray) as soon as possible (ideally within 24 hours) and prior to transfer.

Others – FBC and blood for chromosomes especially if dysmorphic.

Child's Name:.....DOB:.....NHS No:.....

Date of Exam:
Examiner Name:
Signature:

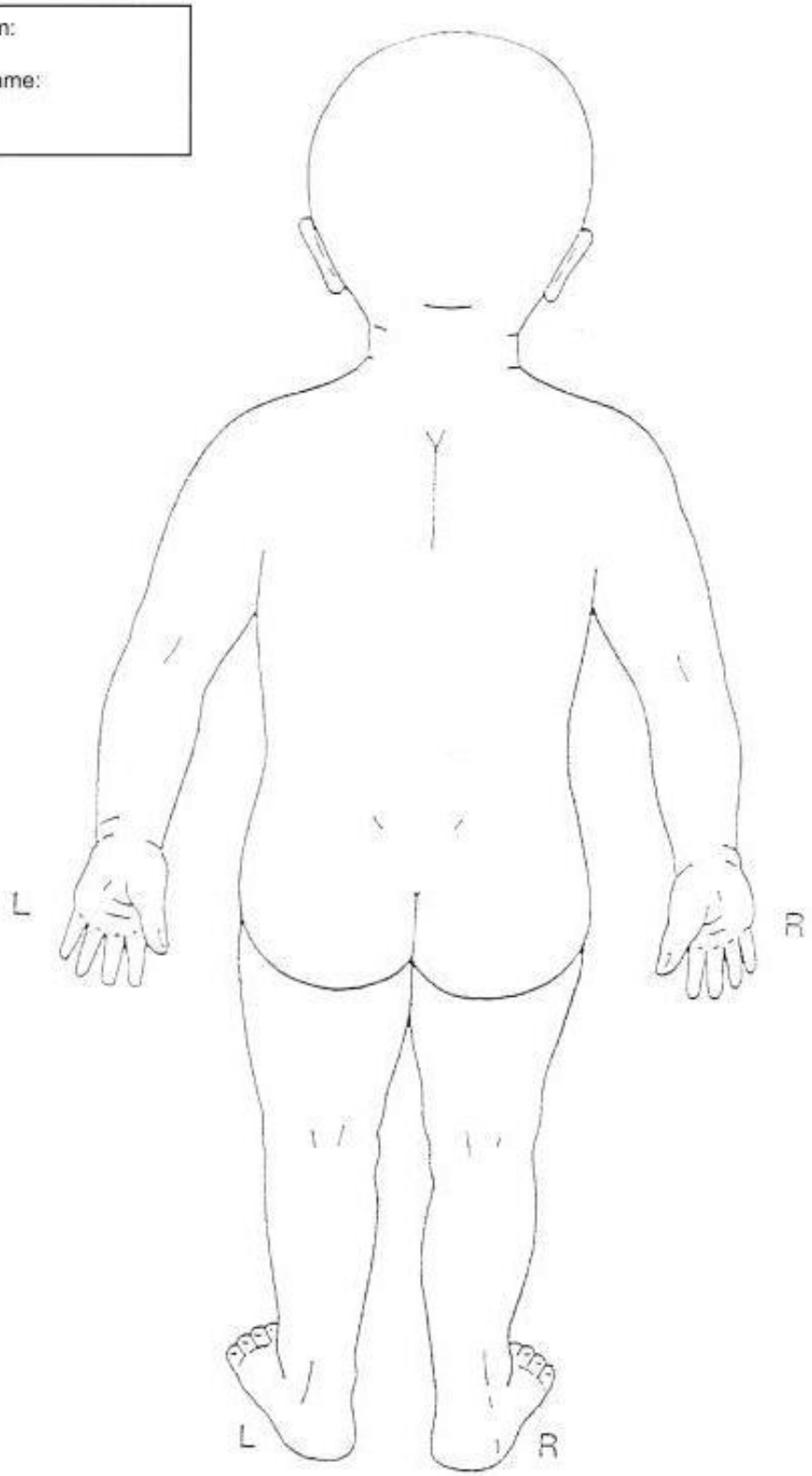


Pages not needed should be **crossed through and initialled** and **not** removed from record

202

Child's Name:.....DOB:.....NHS No:.....

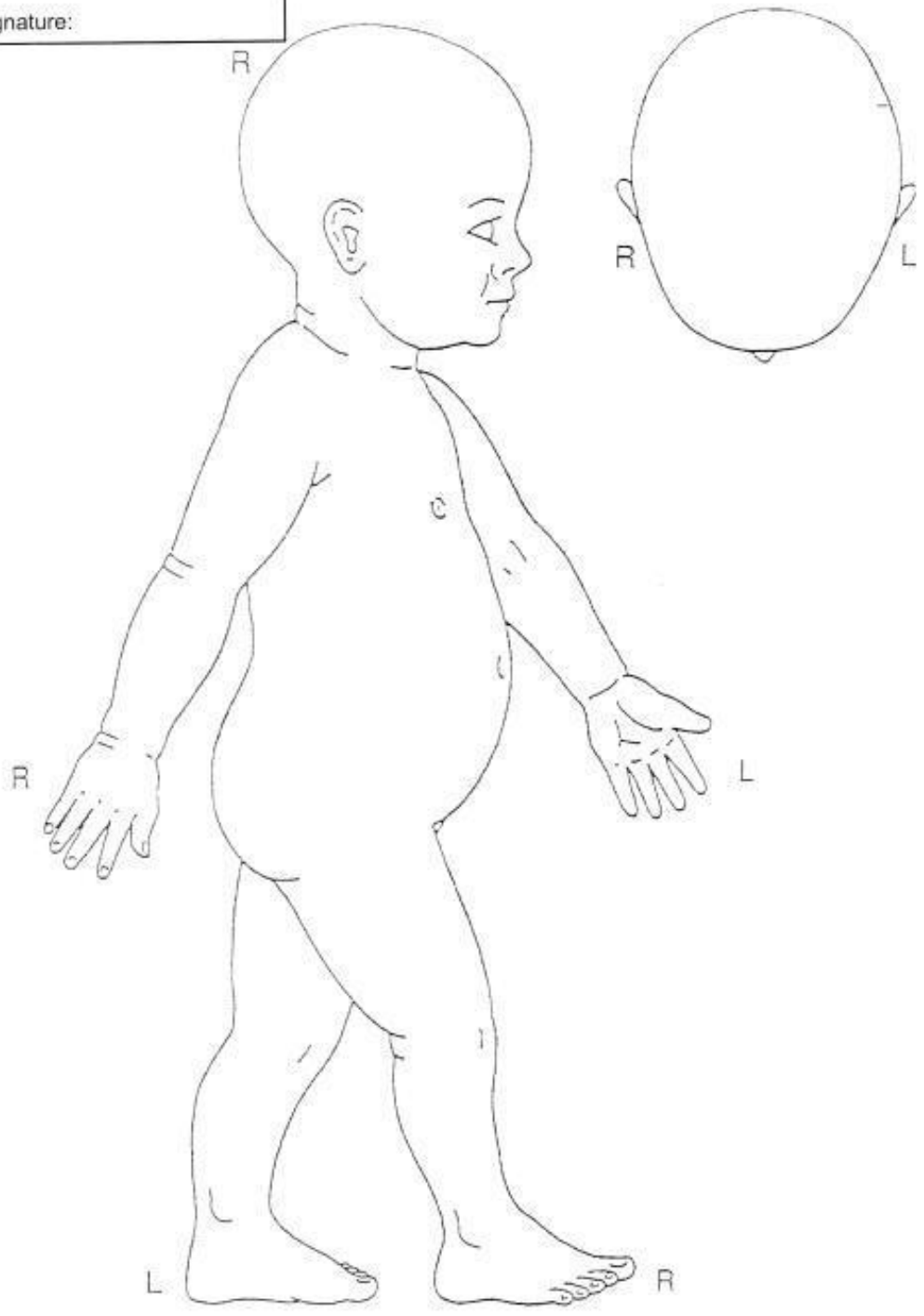
Date of Exam:
Examiner Name:
Signature:



Pages not needed should be **crossed through and initialled** and **not** removed from record

Child's Name:.....DOB:.....NHS No:.....

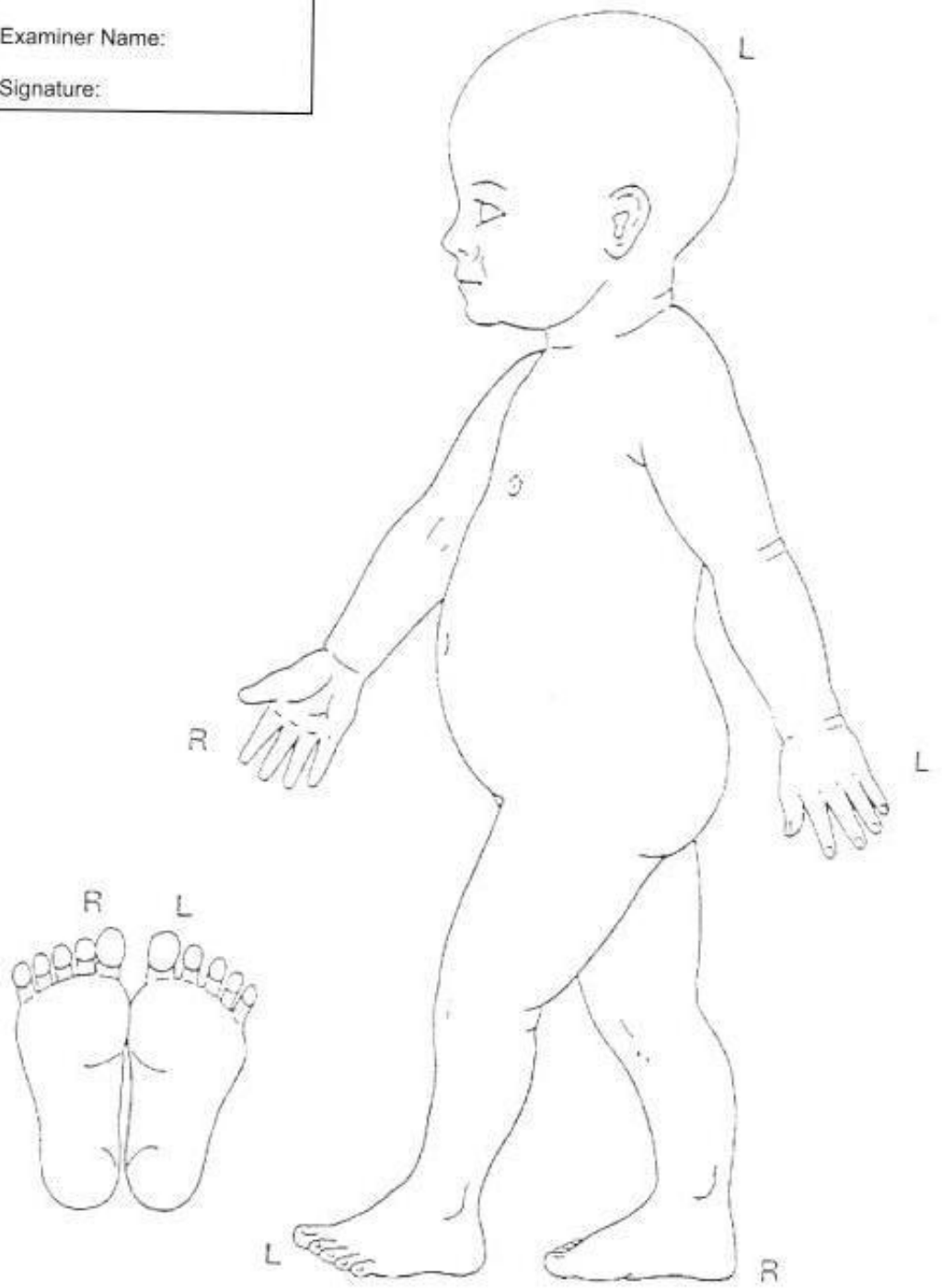
Date of Exam:
Examiner Name:
Signature:



Pages not needed should be **crossed through and initialled** and **not** removed from record

Child's Name:.....DOB:.....NHS No:.....

Date of Exam:
Examiner Name:
Signature:



Pages not needed should be **crossed through and initialled** and **not** removed from record

205

Appendix 11

THE HOME VISIT

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

Whenever possible the child death 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 child death healthcare professional/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/suspicions regarding abuse and/or neglect then the senior investigating police 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.

- 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.

Where applicable complete a detailed sketch of the plan of the room with measurements and orientation. 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 child death 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 12

AUDIT TOOL FOR RAPID RESPONSE

To be completed for each unexpected child death

1.	**Date of Death:**	/ /		
	Age of Child:	y m d	Age Not known ☐	
2.	**Who notified the rapid response team of the death?** (Please tick all that apply)			
	Ambulance Control	☐	Hospital Emergency Dept	☐
	Not notified	☐	Not known	☐
	Other (please specify)			
3.	**How soon after discovery of the death was the child notified to the team?**			
	Within 2 hours	☐	Within 24 hours	☐
	Next working day	☐	Not known	☐
	Later (please specify)			
4.	**Was an initial history taken in hospital, if so by whom?** (tick all that apply)			
	Paediatrician	☐	Emergency Dept Doctor	☐
	Police Officer	☐	No history taken	☐
	Not known	☐		
	Other (please specify)	☐		
5.	**Was the child examined in hospital, if so by whom?** (tick all that apply)			
	Paediatrician	☐	Child not examined	☐
	Emergency Dept Doctor	☐	Not known	☐
	Police Officer	☐		
	Other (please specify)	☐		
6.	**Were appropriate laboratory investigations carried out?**			
	All investigations according to local protocol	☐	Not appropriate	☐
	Some investigations	☐	Not known	☐
	No investigations	☐		
	If any difficulties in carrying out investigations, what were the reasons for this?			

7.	**Were the parents offered the following care and support?** (tick all that apply)			
	Allowed to hold their child	☐	Offered written information	☐
	Offered photographs and mementos	☐	Given contact numbers	☐
	Offered bereavement counselling or religious support	☐	Informed about the post mortem	☐
	Given information about the rapid response process	☐	Not appropriate	☐
	Not known	☐		
8.	**Was an early multi-agency information sharing and planning meeting held, if so when was this held?** (tick all that apply)			
	Yes – telephone discussions	☐	Same day	☐
	Yes – sit down meeting	☐	Later (please specify)	☐
	No	☐	Not known	☐
9.	**Did a joint agency home visit take place?**			
	Yes	☐	Not appropriate	☐
	No	☐	Not known	☐
	If so, when did this take place?			
	Same day	☐	Later (please specify)	☐
	Next working day	☐	Not known	☐
	Who took part in the home visit? (tick all that apply)			
	General paediatrician	☐	General practitioner	☐
	SUDI paediatrician	☐	Health visitor / midwife	☐
	Police officer (Child Abuse)	☐	Bereavement support worker	☐
	Police officer (other)	☐	Social worker	☐
	Scenes of crime / forensic officer	☐	Not known	☐
	Other (please specify)	☐		
	If a joint agency home visit did not take place, please specify why.			

10.	**Was an autopsy carried out? If so by whom?** (tick all that apply)			
	Yes	☐	No	☐
	General hospital pathologist	☐	Paediatric pathologist	☐
	Forensic pathologist	☐	Not known	☐
	Other (please specify)	☐		
	If so, when did this take place?			
	Same day	☐	Later (please specify)	☐
	Next working day	☐	Not known	☐
11.	**Was there a final case discussion?**			
	Yes	☐	Not yet, but planned	☐
	No	☐	Not known	☐
	How long after the death did this take place?			
	Within 2 months	☐	Later (please specify)	☐
	2 – 4 months	☐	Not known	☐
	If an inquest was held / planned, did the final case discussion precede or follow the inquest?			
	Preceded the inquest	☐	Followed the inquest	☐
	No inquest held	☐	Not known	☐
	Who attended the final case discussion? (tick all that apply)			
	General paediatrician	☐	General practitioner	☐
	SUDI paediatrician	☐	Health visitor / midwife	☐
	Police officer (Child Abuse)	☐	Bereavement support worker	☐
	Police officer (other)	☐	Social worker	☐
	Scenes of crime / forensic officer	☐	Not known	☐
	Other (please specify)	☐		
	Were the family informed of the outcome of the final case discussion?			
	Yes – through a home visit	☐	Yes – by letter	☐
	Yes – by telephone	☐	Yes – other	☐
	No	☐	Not known	☐

12.	**What was the final cause of death?**			
	Death from natural causes	☐	SIDS	☐
	Accident	☐	Homicide	☐
	Suicide	☐	Cause of death not established	☐
	Not known	☐		
	Other (please specify)	☐		
13.	**Were any concerns of a child protection nature identified?**			
	Yes	☐	No	☐
	Not known	☐		
14.	**Was the case referred on to the CPS for a criminal investigation?**			
	Yes	☐	No	☐
	Not known	☐		