West Mercia Multi-Agency Protocol

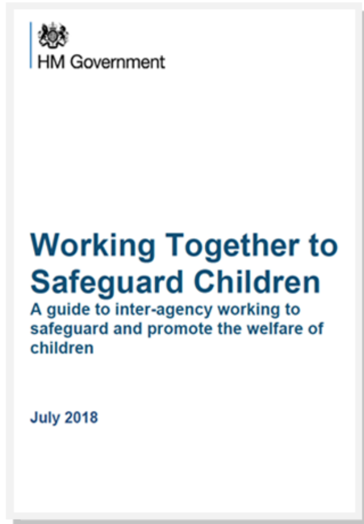
Joint Agency Response

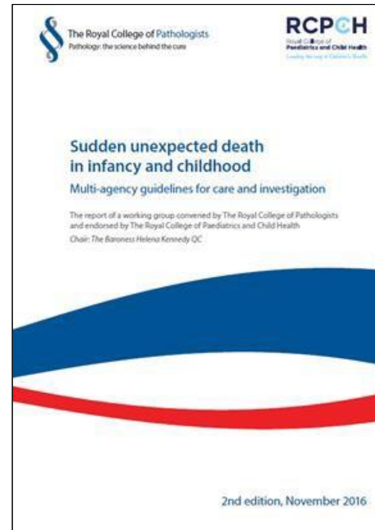
SUDDEN & UNEXPECTED DEATHS IN INFANTS & CHILDREN

Protocol Approval August 2022 - Review Date August 2025

This protocol has been reviewed ensuring compliance with Working Together to Safeguard Children: A guide to inter-agency working to safeguard and promote the welfare of children (July 2018) Working Together to Safeguard Children July 2018 and the principles laid out in Sudden and unexpected death in infancy and childhood: Multi-agency guidance for care and investigation 2nd edition (November 2016) - often referred to as The Kennedy Report 2016.

This protocol will be reviewed 3 years hence or sooner; in light of significant national and/or local policy change.





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1. INTRODUCTION

The death of any child is a tragedy. Every parent has a right to have such an event properly investigated.

This Protocol deals with the investigation of sudden and unexpected deaths in infants and children, live births (excluding stillbirths and planned terminations) under the age of 18 years.

It has been jointly developed by partners within Herefordshire, Worcestershire, Shropshire, Telford & Wrekin which are coterminous with the five West Mercia Police Local Policing Areas:

- Herefordshire and Worcestershire NHS
- Herefordshire and Worcestershire Heath and Care NHS Trust
- Herefordshire Council (Public Health).
- Worcestershire County Council (Public Health)
- Worcestershire Acute Hospitals Trust
- Wye Valley NHS Trust
- Shropshire, Telford, and Wrekin Integrated Care System
- West Mercia Police

And shared with:

- West Mercia Coroners
- West Midlands Ambulance Service

This Best Practice Multi-Agency Protocol is drawn up to meet the requirements of the Statutory Guidance Child Death Review Statutory and Operational Guidance (England) (publishing.service.gov.uk), which builds on the statutory guidance set out in Chapter 5 of Working Together to Safeguard Children 2018 (publishing.service.gov.uk). This places a duty on all child death review partners to have arrangements in place for the thorough and timely investigation and evaluation of all the circumstances surrounding each sudden and unexpected child death through a Joint Agency Response (previously referred to as 'Rapid Response'). The information from this investigation will be considered by Child Death Overview Panel (CDOP) with a view to ensuring that lessons are learned, common themes identified, and actions taken to contribute to preventing children's deaths and to safeguard and promote the safety and welfare of children in the future.

1.1 Age range covered by this document

The majority of this document will focus on children aged 0–24 months, but in order to be consistent with *Working Together,* which covers all children aged 0–18 years, it is suggested that most of the principles in these guidelines broadly apply to all unexpected deaths in children from birth (excluding stillbirths) to age 18, although there will be exceptions.

The remit of this document will therefore include unexpected deaths in the early neonatal period, unexpected deaths for which a natural cause is not immediately apparent and deaths from external causes including accidents, suicides, and possible homicides (recognising that where a police criminal investigation is required, all other multi-agency

processes must be consistent with any police investigation priorities).

The principles also recognise that the exact process followed may require modification according to the age of the child and specific circumstances and clearly in some cases the questions asked of families and some professionals will be different and the investigation maybe broader. The older a child is, the less dependent he or she is on adults, and hence the likely causes of death will differ. *For ease of reading the term 'child' is used throughout and relates to the term baby, infant or child.*

This protocol uses the principles as laid out by Baroness Kennedy in Sudden Unexpected Death in Infancy and Childhood, Multi-agency Guidelines for Care and Investigation, November 2016 The Kennedy Report 2016.

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

1.2 Terminology

Designated paediatrician for unexpected deaths in childhood
Also referred to as 'designated paediatrician', this is a senior paediatrician responsible for coordinating responses to unexpected childhood deaths. This is a statutory role, with responsibilities set out in Working Together to Safeguard Children, July 2018 Working Together to Safeguard Children 2018.

Family
The term 'family' is normally used in these guidelines to refer to parents or primary carers. It may also include extended family members.

Lead Health Professional
For each unexpected child death, a lead health professional should be appointed to coordinate the health response to that death. This lead health professional will take responsibility for ensuring that all health responses are implemented, and for on-going liaison with the police and other agencies. This will normally be the designated paediatrician for unexpected deaths in childhood, or another health professional with appropriate training and expertise in responding to unexpected child deaths. Where no out-of-hours rota for responding to unexpected child deaths exists in a locality, the role of lead health professional should be taken by the senior attending paediatrician. This role should then be handed over to the appropriate health professional at the earliest opportunity. Where the role of lead health professional is taken by a specialist nurse or someone other than the designated paediatrician, they must be supported in the role by the designated paediatrician.

Post-mortem Examination
This is the medical term for 'autopsy'. In most cases this will involve an examination by a specialist pathologist including opening of the body and head, collection of samples for ancillary investigations and microscopic examination of tissue samples. The results of all such investigations are usually required before a medical cause of death can be provided.

SUDI (sudden unexpected death in infancy)
This refers to the presentation of a sudden unexpected death in an infant up to 24 months of age.

SUDC (sudden unexpected death in childhood)
This refers to the presentation of sudden unexpected death in a child above 24 months. These guidelines are primarily intended for use in infancy (SUDI) but may be applied to older children in appropriate circumstances.

SUDI/SUDC (sudden unexpected death in infancy/childhood)
This encompasses all cases in which there is death (**or collapse leading to death**) of a child, which would not have been reasonably expected to occur 24 hours previously and in whom no pre-existing medical cause of death is apparent. This is a descriptive term used at the point of presentation and will include those deaths for which a cause is ultimately found ('explained SUDI/SUDC') and those that remain unexplained following investigation. While many of these guidelines may be applied if required, they are therefore not necessarily intended to be applied to cases with a previously diagnosed medical condition in which a medical certificate of cause of death can be provided.

SIDS (sudden infant death syndrome)
This refers to the sudden and unexpected death of an infant (usually) less than 12 months of age, with onset of the lethal episode apparently occurring during normal sleep, which remains unexplained after a thorough investigation including performance of a complete post- mortem examination and review of the circumstances of death and the clinical history.

SUDI, unexplained
This is the preferred term for use in cases in which there is no clear cause of death and there are no features to suggest unnatural death or inflicted injury, but in which the circumstances do not fit the criteria for SIDS (for example, deaths in which the history, scene or circumstances suggest a high likelihood of asphyxia but in which positive evidence of accidental asphyxia is lacking).

Unascertained
This is a legal term often used by Coroners, pathologists and others involved with death investigation, where the medical cause of death has not been determined to the appropriate legal standard, which is usually the balance of probabilities.

1.3 Unusual Clinical Situations

There are situations that are not clear-cut. Each situation should be dealt with on a case by case basis and might need consultation with the designated paediatrician and others in the Joint Agency Team. In deaths which require consideration of whether the SUDI/SUDC definition is met, HM Coroner should always be involved in any discussions.

- ***An infant is born out of hospital (e.g., home) with no healthcare professional inattendance (this may be because of a concealed pregnancy), and it is not clear if the baby was stillborn or born alive prior to death.***

In this situation, where the infant is newly born, it is vital the mother receives an obstetric assessment and should be taken to the nearest hospital with maternity facilities along with the baby. A Joint Agency Response should be initiated, and a discussion will need to be held between relevant professionals with regard to the gestation of the baby. A referral made to HM Coroner and consideration as to whether a Post Mortem needs to take place should also be discussed. Health professionals may be able to advise if the baby was stillborn.

- ***An infant or child who is unwell at the time of presentation but who deteriorates rapidly and dies of possible septic shock and multi-organ failure due to presumed sepsis.***

In this situation, the condition has arisen suddenly and unexpectedly, as most life-threatening cases of sepsis in infants and children do, but from the time that septic shock has become established, death can be anticipated despite the best efforts of paediatric intensive care unit (PICU) staff. If the attending paediatrician can certify the death as being due to sepsis, there is no requirement for a SUDIC investigation. If there is insufficient evidence to certify death, the case must be discussed with the Coroner and the SUDIC process initiated. This can be modified if the Coroner feels that no further investigation is required. In any event, a home visit would not normally be undertaken in such cases unless concerns were raised.

- ***An infant or child is successfully resuscitated from an out-of-hospital arrest but dies subsequently or who may survive for a period of time.***

In this situation, the infant or child might live for days or weeks before dying, usually through withdrawal of care following discussions with the family. As the out-of-hospital arrest was sudden and unexpected, and the prognosis was poor, the police may secure the scene at home but will not be able to do this indefinitely. Thus, such a presentation should be discussed with the designated paediatrician in order for a home visit to be undertaken, despite the infant or child remaining alive, as important information might be found that can assist the treatingteam and police.

- ***An infant or child with a life-limiting or life-threatening condition who dies suddenly and unexpectedly.***

If an infant or child with a recognised life-limiting or life-threatening condition dies suddenly or following a brief illness, a SUDIC investigation might not be required. If there are concerns, the lead health professional should liaise with the Coroner. In any event, if the death was not expected, the lead health professional should have a discussion with other members of the joint agency response team, and the clinical team who know the infant or child and family and reach a decision on whether a SUDIC investigation should be initiated. Again, if in doubt, the designated lead health professional should consult with the Coroner.

- ***Twins and multiples***

Twins and multiples have around twice the risk of SIDS compared with singletons. **When one twin dies from SIDS, the surviving twin should be admitted to an inpatient paediatric unit for close monitoring for at least 24 hours**. Investigations to exclude infection, inherited metabolic disease or an underlying cardiac condition should be undertaken. Follow-up support should be organised prior to discharge. In most areas, this will be provided by enrolling an infant on the 'Care of Next Infant' (CONI) programme a national programme managed by The Lullaby Trust, usually delivered by health visitors, which coordinates additional support to bereaved parents.

- ***When a new-born infant suddenly collapses and dies on a neonatal unit***

Consideration should be given as to whether a joint agency response is required. In most situations this would not be appropriate.

- ***When an infant or child dies abroad***

If any CDOP is made aware of an infant or child death abroad by any other source other than the Foreign, Commonwealth & Development Office (FCDO) then the FCDO Global Response Centre should be contacted on **0207 008 5000.** This is a 24/7, every day of the year number, which will ensure the caller is routed to the appropriate part of the FCDO. They can also manage issues out of hours etc. Death abroad: further information - GOV.UK (www.gov.uk)

On-going CDOP issues and requests for information are managed by the FCDO Coroner liaison officer, currently Jennifer Ugbomah coroner.liaisonofficer@fcdo.gov.uk

2. THE SUDIC PROCESS

These guidelines provide a framework for professionals in responding to the sudden unexpected death of an infant or young child up to the age of 24 months. Many of the principles should normally be applied to unexpected deaths in older children.

The aims of the response are to:

a) establish, as far as is possible, the cause or causes of the infant or child death
b) identify any potential contributory or modifiable factors
c) provide ongoing support to the family
d) ensure that all statutory obligations are met
e) learn lessons in order to reduce the risks of future infant or child deaths.

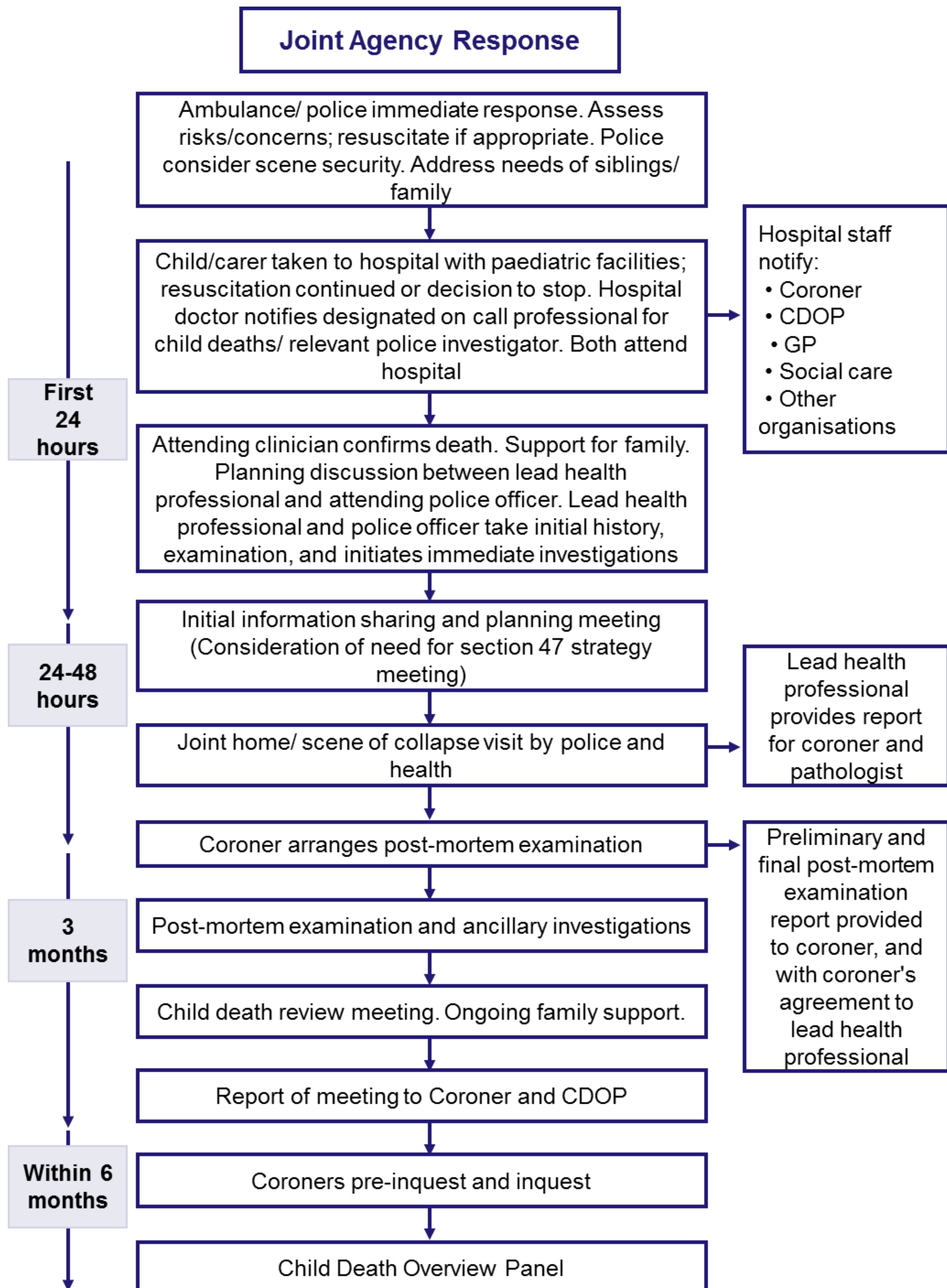
2.1 An unexpected death may be sufficiently explained – by its clinical presentation, or early laboratory or radiological findings - so that the attending doctor is able to issue a medical certificate of the cause of death (MCCD). In those situations, it may not be necessary or appropriate to institute these guidelines. In all unexpected deaths where a medical practitioner is unable to issue a MCCD, it is the responsibility of the Coroner to determine the cause of death and to ensure all statutory requirements around registration are met. However, to do this, the Coroner is dependent on the information provided by the professionals involved in caring for the child and responding to the death. All professionals involved in this joint agency response have a responsibility to work with the Coroner in achieving these aims.

2.2 No action in relation to the deceased child should be taken by any professional without the prior agreement of the Coroner. A standard response should be agreed in advance to avoid the need to consult on every case. This could include agreement on a standard set of investigations to be taken, along with agreement on appropriate mementos for the family. Where there is any doubt about the appropriateness of a course of action, the Coroner should be consulted first. If there is any suggestion of neglect or abuse, the professionals must contact the Coroner immediately and the senior police investigator shall initiate investigations according to agreed police procedures.

2.3 The joint agency response consists of the following essential components. While the way in which these are implemented may vary in accordance with local priorities, needs and resources, no response should be considered complete without these core components:

a) careful multi-agency planning of the response and information sharing meetings
b) ongoing consideration of the psychological and emotional needs of the family, including referral for bereavement support
c) initial assessment and management, including a detailed and careful history, examination of the child, preliminary medical and forensic investigations, and immediate care of the family, including siblings
d) an assessment of the environment and circumstances of the death
e) a standardised and thorough post-mortem examination
f) a final multi-professional case discussion meeting.

The Joint Agency Response
Child Death Review Statutory and Operational Guidance (England), October 2018



In this flow-chart, CDOP is used to represent the group established by CDR Partners that conducts the final stage of the child death review process.

3. MULTI-AGENCY PLANNING

3.1 A multi-agency approach is key to the effective investigation of an unexpected death and support for the family. Such an approach should be initiated at the point of presentation and should continue throughout the process. This requires all professionals to keep each other informed, to share relevant information and to work collaboratively.

3.2 All infants and children found collapsed or dead should be taken to the nearest emergency department with the facilities for resuscitation of the infant or child, including the presence of trained resident paediatricians and an anaesthetics team. As soon as possible after the arrival of the child in the emergency department, a lead health professional should be assigned. This may be the on-call consultant paediatrician or, if an older child not falling under the Hospital Paediatric Team remit, someone from the attending Emergency Department Team and/or Adult Physician Team or, where suitable arrangements exist, a designated paediatrician for unexpected childhood deaths (also referred to as 'designated paediatrician') or specialist nurse. This lead health professional will take responsibility for ensuring that all health responses are implemented, and for ongoing liaison with the police and other agencies. This same process should still be applied if the child has not been brought to the emergency department for any reason.

3.3 Where no out-of-hours specialist provision for SUDIC exists, the on-call paediatrician or Emergency Department Clinician should take the role of lead health professional but may transfer this responsibility to the specialist health team on the next working day. When the responsibility for lead health professional is transferred from one professional to another, there must be a clear handover of responsibilities, and the other lead professionals in other agencies, including the police, children's social care and the Coroner's office, should be notified.

3.4 The police should be contacted as soon as possible after the arrival of the child in the emergency department, if this has not already been done, and arrangements made for the senior police investigator designated to lead the investigation of the death to attend. This investigator should be experienced in child abuse/death investigation cases.

If such an investigator is not immediately available, a handover to such a qualified investigator should occur as soon as possible and prior to any multi-agency meeting.

The investigator should have knowledge of and adhere to the following five national policing principles for dealing with unexpected child deaths:

- Balanced approach between sensitivity and the investigative mind-set
- Multi-agency response
- Sharing of information
- Appropriate response to the circumstances
- Preservation of evidence

Further guidance on the police response to child death is contained at Appendix 1 of The Kennedy Report 2016

3.5 Local children's social care services should also be contacted and asked to check immediately their records relating to the child, the immediate family members, other members of the household and others with whom the child has lived. Any relevant information identified by children's social care should be promptly shared with the police

and the paediatrician or Emergency Department Clinician.

3.6 On some occasions, particularly if concerns have been raised about neglect, non-accidental harm or unusual circumstances of the death, the police may appoint a family liaison officer to maintain close and continued contact with the family over the few days after the death. If a family liaison officer is appointed, the family must be given clear and accurate information on his/her role.

3.7 Certain factors in the history or examination of the child may give rise to concerns 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, the Coroner and relevant professionals in other key agencies involved in the investigation. All injuries should be recorded immediately and again subsequently, and the lead investigator should arrange a photographic record.

Factors that suggest a death may be suspicious

The following factors are not put forward as a definitive list but rather to highlight certain factors which, when considered together, may give rise to a higher level of suspicion and merit more detailed investigation. They should be considered in the overall context of the death and wider family environment. The presence of such factors may reinforce the need for an investigative forensic post-mortem examination. It is also important to note that the absence of such factors does not mean the death cannot be suspicious, and the death should be investigated to ascertain circumstances and cause.

- Previous or on-going child safeguarding concerns
- Previous sibling deaths (e.g., unexplained SUDIC)
- Delay in seeking help
- Inconsistent explanations
- Unexplained injury, either on the body now or at previous medical visits.
- History of domestic abuse
- Evidence of past or present drug or alcohol abuse
- Evidence of parental mental health problems
- Neglect issues
- Previous convictions of parents or carers, in particular violence to children
- If the child had a learning or physical disability or significant pre-existing medical condition
- Abusive head trauma

3.8 An initial information-sharing and planning discussion should take place before the family leaves the emergency department. This should, as a minimum, include the lead health professional and police investigator, and should desirably include (or if not, take account of information shared from) children's social care and the ambulance crew. These discussions should be face to face in the emergency department where possible but may need to be telephone based. Ambulance crews should not routinely be detained from returning to operational response by this process, but clear records and access to the crew by the police, if necessary, should be facilitated by the respective Ambulance Trust at the earliest opportunity.

3.9 The initial discussion should review the history and circumstances of the death, any immediate background information from health, police or social services, and any concerns

arising from these. In particular, consideration should be given to the safety and well-being of any other children in the household.

3.10 If, at any stage, concerns are raised that abuse or neglect may have contributed to the child's death, or any other significant concerns emerge about possible child protection issues, an initial multi-agency strategy discussion/meeting should be convened by children's social care. In these circumstances, the police will normally take the lead in investigating the death and the joint agency response should be adapted to take account of all forensic requirements.

3.11 The lead health professional and the police investigator should review and plan the ongoing approach to information gathering and assessment. This should include consideration of any outstanding medical investigations, notification of all appropriate agencies, arrangements for the post-mortem examination and plans for a visit to the home/scene.

3.12 The lead health professional should contact the family's GP and health visitor or midwife as soon as possible to ensure they are fully informed, and to obtain any additional relevant medical, social, or family information. In all initial and subsequent meetings with the family, consideration should be given to including a member of the primary care team where possible to provide ongoing care and support to the family.

3.13 As soon as possible after the death, a further information-sharing and planning meeting should be held. This early meeting is a key action as part of the joint agency response and will normally take place during normal working hours to ensure all relevant professionals can attend. The meeting should ideally be face to face, and should include the lead health professional, the police investigator, the primary care team, children's social care and any other relevant professionals who know the child or family. The Coroner's officer may be invited to this meeting. One of those present should be tasked to take and circulate notes from the meeting. A copy of the minutes of the meeting should be sent to the Coroner, pathologist, all agencies involved in the meeting and the local/regional Child Death Overview Panel (CDOP) administrator/coordinator.

3.14 The meeting will review all information available at that stage and will identify what further investigations are required and the ongoing support needs of the family.

3.15 Following the home visit, and once the results of the post-mortem examination are known, further discussion should take place between the lead health professional, police investigator and Coroner's officer, to review any emerging information, discuss what is known about the cause of death and any contributory factors, determine what further investigations or enquiries are needed, and confirm what information can be provided to the family, how and by whom. These discussions may take the form of telephone discussions or further multi-agency meetings, particularly where the circumstances are complex or where there are many professionals involved.

4. FAMILY SUPPORT

4.1 Immediately upon their arrival at the hospital, the family should be allocated a member of staff to care for them, explain what is happening and provide them with facilities to contact friends, other family members and cultural or religious support.

4.2 Where attempts are made at resuscitation, the member of staff allocated to the family should ensure that the family is kept fully informed during the course of the resuscitation and subject to the approval of the medical staff involved, the family should be given the option to be present during the resuscitation. The allocated member of staff should stay with the family throughout this period to explain what is going on.

4.3 It will normally be appropriate for the family to hold and spend time with their child once death has been confirmed. This may happen in appropriate circumstances after discussion with the lead investigator, even if there are suspicions of possible abuse or neglect contributing to the child's death, but there must be a discreet professional presence.

4.4 Consideration should be given to the capacity of the family to engage in the processes unfolding around them. Particular consideration should be given to issues of language, health, or mental capacity. Further considerations must also be given to the faith and culture of the child and their family.

4.5 Where English is not the family's first language, every attempt should be made to provide a translation/interpreting service, including out-of-hours provision, for example through Language Line. Family members, particularly children, should not act as interpreters for their parents.

4.6 Responsibility for providing ongoing information and coordinating appropriate care and support for the family is shared between the lead health professional, police investigator and Coroner's officer. There needs to be clear liaison between these three as to who will take responsibility for each aspect of care and support.

4.7 The family should be told at an early stage that, because their child's death was unexpected, the Coroner will need to be informed and there will need to be a police investigation. This must be explained to the family in a sensitive way, emphasising that these are routine procedures that are followed in any unexpected child death.

4.8 The purpose and process of the joint agency response should be explained to the family, emphasising that all professionals are working together to try and help them understand why their child has died and to support them.

4.9 The family should be informed that, as part of this process, information will be shared with their primary care team, social services, and other relevant professionals.

4.10 Unless the cause of death is immediately apparent, the family should be informed that the Coroner is likely to order a post-mortem examination. The family should be informed about the post-mortem examination, including the likely venue and timing, any arrangements for moving their child, and the likelihood that tissues will be retained during the post-mortem examination. This information should be provided in a sensitive and meaningful manner.

4.11 The family should be made aware that it may take several weeks to secure the

results of the post-mortem examination and for the Coroner to come to a conclusion. Every effort should be made to keep the family informed at each stage of the process. The family should receive regular telephone calls from either the healthcare professional supporting the family or the Coroner's office to let them know how matters are proceeding. The Lullaby Trust reports that families greatly appreciate such calls, even if this is to tell them that a further delay is expected.

4.12 Written information is important and valuable to the family because much of the detail of what is discussed can be forgotten or lost in the immediate stress of their child's death. It is important that the family are provided with relevant and up to date information but are not overwhelmed by this. NHS England produces comprehensive guidance, ***'When a child dies' - A guide for parents and carers*** which can be shared with families at the earliest opportunity [NHS England » Learning from deaths: Information for families](). Details of local support and national organisations are also included in the guidance.

4.13 A list of some of the national bereavement support organisations and their contact details is provided at **Appendix 10**. Most families do seek immediate support from external agencies following the unexpected death of their child, and their involvement with the family over a period of time needs to be factored in as part of the wider multi-agency response.

4.14 The family should be clearly informed of the names and contact details of the lead professionals responsible for the joint agency response, including the lead health professional, police investigator and Coroner's officer. If it becomes necessary to transfer responsibilities between professionals, the family should be informed of this and introduced to any new professionals involved.

4.15 The family must be given clear details of whom to contact, both in working hours and out of hours, should they have any questions or concerns.

4.16 Under the Police and Criminal Evidence Act 1984, if the police investigator has suspicions that the death may be a crime, 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. This is particularly relevant where the possible suspect is a family member. **It should be noted that Section 66 of the Serious Crime Act 2015 amends Section 1(2) (b) of the 1933 Children and Young Persons Act, such that it is now an offence when a child dies through suffocation while sleeping with an adult, where the adult is under the influence of alcohol or 'prohibited drugs'. The definition of sleeping location has also been updated to include any furniture or surface - it is no longer restricted to 'beds'.**

4.17 As part of the explanation about the post-mortem examination given to the family, the lead health professional or Coroner's officer should explain that tissue samples will be taken and that, following the Coroner's investigation, the family can then determine the fate of the tissue according to the Human Tissue Act 2004.

4.18 Since by definition the cause of death in SUDIC is not known, it is important that all organs are examined carefully during the post-mortem examination. For this reason, the potential beneficial effects that organ donation may afford bereaved families are not available in the case of SUDIC. If a family voluntarily raises this possibility, they should be sensitively informed that it is not an option in their child's case.

4.19 In situations where a child has an unexpected cardiac arrest, is resuscitated, and

stabilised on an intensive care unit, but a decision is made subsequently to withdraw care, there may be opportunities for organ donation if the cause of death is known. Each case should be considered in the context of the specific circumstances regarding organ and tissue donation, and the possibility should be discussed with the Coroner and family at an early stage.

4.20 Consideration should be given to any practical support needs the family might have, for example, support with suppressing breast milk production, housing or employment-related needs, and support with any anxiety-related symptoms such as sleep disturbance. Many of these issues will be best addressed through the primary care team, who should be kept informed of the process of the joint agency response at all stages.

5. INITIAL ASSESSMENT AND MANAGEMENT

5.1 On receipt of a 999 call, indicating that a child has been found unexpectedly collapsed or dead, the call centre should immediately notify ambulance control to dispatch an ambulance crew and, where appropriate, a first responder. The police should also be notified, and an officer dispatched to the scene. This officer should ideally be an appropriately qualified investigator, and every effort should be made for this officer to attend in plain clothes.

5.2 On arrival at the scene, the first responder or ambulance crew should carry out an immediate appraisal of the circumstances. Unless there are clear indications that the child has been dead for some time, appropriate resuscitation should be started and continued until the child is brought to hospital.

5.3 The paramedic/ambulance crew should inform the emergency department of the hospital that a child has been found unexpectedly collapsed or dead and to have the resuscitation team on standby and anticipating the arrival of the child.

5.4 The first responder/ambulance crew should elicit a very brief initial account of the circumstances and whether there are any child medical issues, such as any relevant past medical history or current medication for the child. They should note their impressions of the environment in which the child was found, and any concerns about care. A copy of the ambulance crew's record should be provided to the lead health professional and police investigator.

5.5 Unless there are exceptional reasons not to, the child should be brought immediately to an emergency department with paediatric care. Resuscitation should be continued en-route to the hospital. The default position should always be to attend the emergency department, but where a death is declared at the scene a discussion will be required with the consultant paediatrician, or Emergency Department if in the case of an older child they do not fall under the remit of the Hospital Paediatric Team, to agree if the child can be brought direct to the mortuary. With the death of older children where the cause of death is more apparent (for example, stabbing or a train-related disturbance), a decision may be made to transfer straight to mortuary facilities or to remain in situ at the crime scene to allow other forensic processes to take place under the guidance of the senior police investigator. In such cases it must be ensured that bereavement support is in place.

5.6 Arrangements should be made for the family to attend the emergency department, either accompanying the child in the ambulance or separately. Consideration should be given to the care and welfare of any other children in the home. The attending police could assist with these arrangements.

5.7 The attending police investigators should undertake an initial appraisal of the environment where the child died or was found. This may include brief questioning of the family, but the priority is to get the child with the family to an emergency department. Police interviewing should not delay this departure. Further priorities are to ensure the safety of others, including other children in the home, and to maintain the integrity of the environment. The police investigators should assist the ambulance crew in these arrangements.

5.8 If there are signs that the child is clearly dead and has been for some time, for example, the development of rigor mortis or dependent livido, resuscitation would not be appropriate. This should be discussed with the family. In most circumstances, it will still

be appropriate to transfer the child and family to an emergency department with Paediatric facilities where the joint agency response may be initiated, the child can be examined, and appropriate immediate medical investigations carried out.

5.9 If there are immediate indications of abuse, neglect or an assault contributing to the death, the police should take the lead in the management, under the direction of an investigating officer. In such circumstances, and if the child is clearly dead, it may not be appropriate to move the child and the scene should be secured as for any potential crime scene.

5.10 In the emergency department, the care of the family and the investigation of the cause of the death should follow a similar course, whether resuscitation has been attempted.

5.11 The decision to stop resuscitation should be made by a senior medical practitioner (usually the consultant paediatrician or consultant in emergency medicine) after discussion with the resuscitation team and the family.

5.12 Where a child is successfully resuscitated, they should be stabilised and moved to a paediatric or adult intensive care facility. Subsequent discussions regarding ongoing intensive care or the withdrawal of care should involve the intensive care team, the family, and the police investigator. Consideration should be given to the timing of any withdrawal of intensive care, support for the family around the decision, and the appropriate timing and process of the joint agency investigation, including a home visit.

5.13 Once a decision has been made to stop resuscitation, an appropriately qualified medical practitioner should confirm that the child is dead, in accordance with established guidelines. Confirmation of the fact of death and the time should be recorded in the child's notes.

5.14 When the child has been pronounced dead, the lead health professional (normally the on-call consultant paediatrician) should inform the family, having first reviewed all the available information. This interview 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.

5.15 Once death has been confirmed, the consultant paediatrician 'on-call' or the attending Emergency Department Senior Clinician or the designated SUDI paediatrician should carefully and thoroughly examine the child. The police investigator should be present while this happens. A particular note should be made of any marks, abrasions, rashes, evidence of dehydration or identifiable injuries at this time, in addition to a detailed general examination. The presence of any discolouration of the skin, particularly dependent livido, should be carefully and accurately documented, along with other post-mortem changes such as frothy blood-stained fluid from the airways and rigor mortis. Where possible, the eyes should be examined by direct fundoscopy for the presence of retinal haemorrhages. All findings should be carefully documented in the notes and on a body chart **(see Appendix 1)**. The child should be weighed and measured (length and head circumference), and the measurements plotted on a centile chart. The deceased child should be re-examined where practicable to note any external marks that might not have been present on initial examination, particularly if trauma is being considered as a possible causative factor in the child's death. More details are provided at Appendix 4 of The Kennedy Report 2016

5.16 If resuscitation has been attempted, any intravenous, intra-arterial, or intra-osseous lines inserted for this purpose should only be removed following discussion with the police or Coroner. All medical interventions, including sites of attempted vascular access, should be carefully documented on a body chart. If an intravascular cannula has been inserted and it is thought that it may have contributed to failed resuscitation (for example, by causing a pneumothorax), it should not be removed.

5.17 If an endotracheal tube has been inserted, this may be removed after its correct placement in the trachea has been confirmed by direct laryngoscopy (preferably by someone other than the person who inserted it) and the case discussed with the police or Coroner. The size and position of the tube should be documented.

5.18 Once the child has been examined and all findings recorded, along with medical or police photographs where indicated, and sampling taken, the child can be cleaned and dressed and given to the family to hold if they wish, unless there are suspicious findings that preclude such actions. If they wish, the family should be offered the option of cleaning and dressing their child in an appropriate setting. This may be particularly important in certain cultures.

5.19 Health staff in the emergency department should offer the family the option of mementos being taken such as handprints, footprints, a lock of hair and photographs. This should be done sensitively, recognising that this can be important for many families but will not be wanted by all. If there are suspicious circumstances surrounding the death,the taking of mementos should be discussed with the investigating officer to ensure this does not interfere with any investigation; in such circumstances it may be appropriate to delay this until after the post-mortem examination. It should be clearly documented what mementos have been taken and from where.

5.20 All emergency department staff should follow the general principles of family support outlined above.

5.21 The consultant paediatrician or senior medical practitioner should ensure that the joint agency response is initiated by contacting the designated paediatrician or specialist nurse (depending on local arrangements) at the earliest possibility and initiating an information sharing and planning discussion with the police investigator and children's social care, as detailed above.

5.22 The lead health professional (consultant paediatrician 'on-call', Emergency Department Senior Clinician, designated paediatrician, or specialist nurse) should take a detailed and careful history from the family **(see Appendix 3)**. Where possible, this should be carried out with the police investigator to avoid the need for repeated questioning.

5.23 Where there are any suspicious circumstances surrounding the child's death, it may be necessary for the police to interview separately the child's parents or primary carers at the time of death. In such circumstances, it is still important to obtain a full and careful medical history. A coordinated plan of who talks to the family and when should be agreed between the senior police investigator and the lead health professional. In some SUDIC cases there may be an element of alcohol and/or drug use by the parents or carers which may be a cause or contributory factor in the child's death (i.e., in a co-sleeping / overlay incident. Senior police investigators are trained to identify the circumstances where it may be necessary to obtain the consent from the parents or carers to provide voluntary blood and urine samples for toxicology. This must be carefully deliberated by the senior police investigator in relation to the status of the parents or carers i.e., suspects or otherwise and

issues around consent. It is considered legal, necessary, and proportionate to request voluntary samples in certain circumstances where the grounds and necessity criteria for arrest are not satisfied. Each case must be assessed on its own merits. In cases where it is premature to determine that a criminal offence has been committed to designate a parent or carer a suspect, it is recommended that a form of words be used to request a voluntary blood and urine samples. The purpose of this form of words is to provide a framework that facilitates an ethical request for consensual samples. In such circumstances the senior police investigator is asked to consider that this request be made with compassion and sensitivity and that *no* caution is used in making the request of parents or carers:

I now need to ask you if you are willing to provide blood or urine samples for use in the investigation into the death of your child. You do not need to provide these samples and I have no legal power to compel this. However, these samples can assist us in investigating the tragic circumstances of a child's death. However, I do need to make you aware that there are certain circumstances where the presence of drugs or alcohol can render someone liable to prosecution for criminal offences. Do you provide consent for blood or urine samples to be taken?

5.24 The history should include a careful review of the past medical history, including pregnancy and birth, the child's growth and development, any relevant social and family history, and the events leading up to and following the discovery of the child's collapse. It is important that, as far as possible, the family's account of events should be recorded *verbatim*. The Personal Child Health Record ('Red Book') may also be an important source of information. The police may have removed it from the scene, or it can be accessed at the home visit. Relevant family history, birth details, immunisation status, growth trajectory, outcome from routine reviews and other information about the child may be found in it. The information obtained from these sources, including the ambulance record should be recorded on a locally agreed SUDIC proforma, commenced in hospital, and taken to the home visit.

5.25 The new checklist for JAR professionals should be used if suicide is suspected. The checklist has been developed in conjunction with the NHS England Children and Young People's Mental Health Policy Team with input from the CDOP community. The questions are designed to support good postvention support for communities affected by the suicide of a child or young person, to enhance the level of detail provided at notification stage, to support quick national action where appropriate and to inform Coroner's investigations **(see Appendix 2)**.

5.26 The taking of a history is an ongoing process, rather than a one-off event. All details obtained should be carefully recorded and shared with the lead professionals. Any gaps identified can be covered in later meetings with the family.

5.27 During the process of resuscitation, various medical investigations may be initiated, including blood samples for electrolytes and blood cultures. If these have not been obtained during resuscitation, they should be obtained via a post-mortem sample, along with blood for metabolic investigations, according to Table 1. Any samples collected post-mortem must be removed from the body on Human Tissue Act (HTA) licensed premises. The police investigator should arrange for appropriate documentation and transportation. Any samples collected post-mortem are the property of the Coroner.

5.28 A **single** attempt at a femoral or cardiac aspiration should be made by a competent practitioner. Repeated attempts should be avoided as they may compromise the integrity of the cardiac anatomy. Blood samples should ideally be taken from a venous or arterial

site, such as the femoral vein, rather than cardiac puncture, which should be avoided in potential forensic cases.

5.29 A **single** attempt at urethral catheterisation or supra-pubic aspiration should be made and, if urine is obtained, it should be sent for microscopy and culture, metabolic investigations, and toxicology according to Table 1.

5.30 A **single** attempt at a lumbar puncture should be made and, if obtained, a sample of cerebrospinal fluid sent for microscopy and culture. If sufficient, a sample should be frozen for future metabolic investigation.

5.31 Any stool or urine passed by the child, together with any gastric or nasopharyngeal aspirate obtained, should be carefully labelled and frozen after samples have been sent for bacterial culture and for virology. If the nappy is wet or soiled, it should be removed, labelled and frozen.

5.32 The lead health professional should arrange for a full radiological skeletal survey or other appropriate imaging to be undertaken. This should be undertaken at the local hospital prior to transfer of the child for post-mortem examination. It should be performed and reported by an experienced paediatric radiologist prior to the post-mortem examination being commenced. For children over 24 months, the need for such imaging should be discussed with the designated paediatrician. Imaging investigations should be reported on as soon as possible in order to identify or rule out bony injuries, as this may change the focus of the investigation.

5.33 Details of the recommended samples to be taken and the purposes for which they are intended are given in Table 1. It is essential that samples for various metabolic tests are obtained as soon as possible after death. Empirically, it appears sensible that other samples, such as for microbiology and toxicology, are also obtained at this time but evidence does not suggest clear differences in yield between samples obtained in the emergency department and those obtained at post-mortem examination.

5.34 The lead health professional should ensure that all relevant professionals and organisations are informed of the child's death, including the Coroner, the GP and health visitor or midwife, the Child Health Information System, and the local Child Death Overview Panel.

5.35 A careful account of the resuscitation should be recorded in the child's notes, including the methods used, duration and personnel involved. The history and examination findings should be carefully documented. All actions taken following the death should be documented in the child's notes, along with details of information shared with the family and with other professionals.

Table 1: Routine suggested samples to be taken immediately after sudden and unexpected deaths in infancy and childhood

Specimen & Technique	Samples & volumes	Indication	Handling/Destination	Test	Purpose
Blood 10 – 15 mls total Cardiac stab only if sufficient blood not available via femoral/large artery or vein. Single attempt only at femoral or cardiac stab	**1st Priority Blood Samples**				
	1ml EDTA (purple) and 1ml Fluoride (grey bottle)	Only send if indicated. Each case should be assessed individually	Clinical Chemistry Spin, store serum at -20°C	Toxicology	Identification of poisoning (intentional and non-intentional)
	1 ml Aerobic bottle 1ml Anaerobic bottle If insufficient blood aerobic bottle only	All cases	Microbiology	Culture & Sensitivity	Identification of infection
	Blood spots from syringe onto the new-born blood spot screening card (NBBSS) (previously known as the Guthrie card)	All age < 2yrs Age > 2yrs if clinically indicated	Clinical Chemistry Fill in card – do not put into plastic bag	Inherited metabolic diseases	Specific investigations for metabolic disorders. Also consider retrieving results of initial neo-natal screening tests
	5mls Lithium (green) bottle	Only if dysmorphic features noted	Regional Genetics Lab Birmingham Women's Hospital	Chromosomes	Identification of genetic disorder
	Blood	If CO Poisoning suspected	Clinical Chemistry	Carboxyhemoglobin level	To exclude CO poisoning
	2nd Priority Blood Samples = if blood available				
	2 ml Fluoride Oxalate (grey bottle)	All age < 2 yrs	Clinical Chemistry	Glucose, Lactate, 3hydroxybutyrate & Free fatty acids	Identification of hypo/hyperglycaemia and metabolic disorders
	1.5 ml lithium heparin (green bottle)		Clinical Chemistry Spin, store serum/plasma at -80°C	Amino acids, acyl carnitines U&Es and creatinine if sufficient sample	Identification of electrolyte disturbances, including hypernatraemia and metabolic disorders

Specimen & Technique	Samples & volumes	Indication	Handling/Destination	Test	Purpose
CSF Lumbar puncture	Routine samples in sterile universal container Do not take if any suspicion of cranial trauma	Only if indicated on clinical history & examination	Microbiology	Microscopy, Culture & Sensitivity	Identification of infection
Swabs & secretions	NPA (Nasopharyngeal Aspirate), or Viral nasal swab (pink viral culture medium swab)	All cases	Virology Discuss with Consultant Microbiologist	SUDIC Virology Screen (PCR)	Identification of viral infections
	NPA or throat swab		Microbiology	Culture and sensitivity	Identification of infection
	Swabs from any identifiable lesions		Microbiology	Culture and sensitivity	Identification of infection
Urine Nappy - if wet nappy available, store nappy at -80°C Aseptic catheterisation or SPA - single attempt only	2mls minimum, 6mls ideal in Universal Container (white top)	If either poisoning or inherited metabolic disease suspected	Clinical Chemistry Spin & store at -20°C	Toxicology Inherited Metabolic diseases	Identification of a) poisons and b) organic acids profile indicating metabolic disorders

Faeces	If passed by the child	Age < 2yrs	Microbiology	MC&S Virology	
			Clinical Chemistry Wet or Soiled nappies should be removed, labelled and frozen		

Skin biopsy Take from upper, inner arm.	Send to laboratory in viral culture medium	Age < 2yrs	Clinical Chemistry Store at $4^{o}C$ Request transfer to BCH Metabolic Lab. within 24 hours of collection. Inform Duty Biochemist at BCH IMD Laboratory, or the On-call MLSO out-of-hours)	Fibroblast culture	DNA culture for identification of specific metabolic and genetic disorders Important to obtain as soon as possible as fibroblast cultures taken more than 48 hours after death may not grow

Muscle Biopsy	Muscle sample	A muscle biopsy is rarely required. Only take a biopsy if there are specific concerns and after discussion with Inherited Metabolic Disease Laboratory, BCH on 0121 333 9942. Consider if: ○ Consanguinity ○ previous infant death in family ○ older age at death (over 6 months) ○ history of hypotonia or developmental delay ○ hepatomegaly or hepato-splenomegaly Sampling technique and handling as advised by Metabolic Laboratory

6. ASSESSMENT OF THE ENVIRONMENT AND CIRCUMSTANCES OF DEATH

6.1 As soon as possible after the child's death, the lead health professional (designated paediatrician, specialist nurse or on-call paediatrician) and police investigator should visit the family at home or at the site of the child's collapse or death **(see Appendix 4)**. Professionals should be satisfied that appropriate guidance from their organisation in relation to covid-19 is followed.

6.2 The purpose of this visit is to obtain further, more detailed information about the circumstances and environment in which the child lived and, if pertinent, died and to provide the family with information and support.

6.3 This visit should normally take place within daylight hours. If there is likely to be a delay in arranging the joint visit, the police investigator should consider whether the police should carry out an initial visit to review the environment, ascertain whether there are any forensic requirements and appropriately record what is found. Unless there are clear forensic reasons to do so, the environment within which the child died should be left undisturbed so that it can be fully assessed jointly by the police and health professionals, in the presence of the family.

6.4 The lead health professional with the police investigator should inform the family of the nature and purpose of this home visit. Time should be allowed for the family to go at their own pace, respecting that they may find it difficult to talk through the events or go into the room where the child has died. Allowance should be made for others, such as grandparents or family friends, to be present to support the parents.

6.5 The lead health professional with the police investigator should review the key elements of the history, allowing the family to elaborate on any particular aspects and to clarify any points that were unclear or missing from the initial history. Particular note should be made of any observations made by the family in the days before the child's death. They may have taken photographs or video clips on a mobile phone that could shed light on the child's state before death.

6.6 If the child died at home, when the family is ready, the police investigator and lead health professional should review the environment where the child died. It can be very helpful at this stage for appropriate family members to be present to describe in detail the final events, for example how the child was put to sleep and how they were found.

6.7 If pertinent to the circumstances of death, consideration should be given to reconstruction of the sleeping environment, for example, with the use of a doll or prop. There is no strong evidence that this provides a more accurate understanding of the mode or circumstances of death, but it may prove helpful, particularly if the account is not clear, or if there are indications of possible overlaying or asphyxiation. Anatomically proportioned dolls are available for this purpose, or the family could use a cuddly toy to illustrate how and where the child was lying. Care should be taken not to further distress the family if a reconstruction is required.

6.8 The police lead investigator should consider whether to request crime scene investigators to take photographs or a video of the scene of the child's death, and whether any items should be seized for further forensic investigation. Other possible relevant recordings, such as room temperature, are detailed within the police-approved professional practice guidance for investigators. It is rarely necessary to seize bedding or clothing, and these rarely add anything to the investigation. However, there may be circumstances when

an infant's cot or other sleeping environment needs to be taken for further examination. This should only be taken after the joint visit, so all items can be seen first in situ. Similarly, there may be circumstances where an infant's feeding bottle, other feeds or medications need to be taken for further analysis.

6.9 After reviewing the information, the lead health professional and police investigator should discuss their findings so far with the family, taking care not to jeopardise any further investigation if there are concerns around possible abuse or neglect. The family should be informed of the further investigations that will need to be carried out, including the post-mortem examination, and how and when they will be informed of the results.

6.10 Information may be given to the family at this stage, in general terms, around possible causes of unexpected child death. It is important, however, to emphasise that it is not possible to give a definitive cause of death until all investigations are complete, and that the ultimate decision on the cause of death rests with the Coroner.

6.11 The family should be given clear information about who they can contact for support or advice, including contact details for local bereavement support and relevant local or national organisations such as the Lullaby Trust **(see Appendix 9)**.

7. THE INITIAL CASE DISCUSSION

7.1 Following the home visit, the lead health professional and police investigator should review all information gathered to date. This may be done through an initial case discussion within a multi-agency meeting, particularly where there are complex circumstances surrounding the child's death.

7.2 Following this review, the lead health professional should prepare a report of the initial findings, to include details of the history, initial examination of the child and findings from the home visit, as well as an account of any medical investigations and procedures carried out. This may be done using a standard proformas, such as in Appendices 1, 2 and 3, and added to as the investigation proceeds.

7.3 This report should be made available to the pathologist, the Coroner, and the police investigator as soon as possible, and preferably prior to the post-mortem examination.

8. THE POST-MORTEM EXAMINATION

8.1 The aim of the investigation is to establish, as far as is possible, the cause of death and in order to do this, it is important that the medical processes are similar to those of a child with a rare condition requiring special investigation in a tertiary centre. The investigation should be carried out by specially trained pathologists with an emphasis on multi-agency working, involving close collaboration and the sharing of information between hospital- and community-based clinical staff, the pathologist, the police, social services, and the Coroner's service. The investigation will concentrate not just on the child, but will consider the family history, past events, and the circumstances. These factors can be helpful in determining why a child died. All parts of the process should be conducted with sensitivity, discretion and respect for the family and the child who has died.

8.2 A key aspect of these guidelines is that all staff involved should retain an open mind, knowing that some deaths will be a consequence of neglect or abuse, but recognising that the majority are natural tragedies. All agencies have a duty of care to the family as well as to the child who has died and other surviving children.

8.3 The post-mortem examination will be ordered by the Coroner and should be carried out by a pathologist with up-to-date expertise in paediatric pathology. If significant concerns have 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 examination protocol should be followed. More details are provided at Appendix 6) of The Kennedy Report 2016. If the paediatric pathologist becomes concerned at any stage during a post-mortem examination that the death may be a consequence of abuse and a forensic pathologist is not present, 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 lead police investigator or other designated police representative.

8.4 Families have the right to be represented at the post-mortem examination by a medical practitioner of their choice, provided they have notified the Coroner of their wishes.

8.5 Prior to commencing the examination, the pathologist should be fully briefed on the history and physical findings at presentation and on the findings of the death scene investigation by the lead health professional or police investigator. Other photographs of the child that may have been taken at presentation or in the emergency department should also be made available.

8.6 The post-mortem examination procedure must include, where it had been deemed to be required, a full radiological skeletal survey or other appropriate imaging, reported by a radiologist with paediatric training and experience.

8.7 At the post-mortem examination, tissue samples, other specimens and frozen samples will be obtained as in Table 1 (page 22) and other samples may be taken as deemed necessary by the pathologist in order to ascertain the cause of death.

8.8 Whole organs will not routinely be retained, but when this is deemed necessary by the pathologist, the Coroner and the family must be informed, and the family given the opportunity in due course for return of such samples to the body if appropriate. If the family has requested that tissue or organs be donated for future use when the Coroner's investigation has concluded, there should be a record made of the purposes for which the material can be used (to ensure it

is not used for other purposes) and that the appropriate person has given their consent. This is particularly important where the mother/parents of the child are under 18 and their parents may wish to make decisions about tissue retention on their behalf.

8.9 The Coroner should be immediately informed of the initial results of the post- mortem examination, which may also, with the Coroner's permission, be discussed with the lead health professional and lead police investigator as required.

8.10 If the initial post-mortem examination findings suggest evidence of neglect or abuse, the police investigation team and children's social care should immediately be informed, and further investigations set in process.

8.11 Once the initial post-mortem examination findings are known, the lead health professional and the police investigator should, with the Coroner's permission, arrange to meet the family to discuss the initial findings. It is important at that stage to emphasise that the findings are preliminary, that further investigations may be required, and that it is not possible, at that stage, to draw any conclusions about the cause of death.

8.12 The following procedure should be followed once the initial results of the post-mortem examination are known, to allow the Coroner to proceed appropriately with the investigation.

a) If, after the initial post-mortem examination, a complete and sufficient cause of death is found, this must be given as the cause of death at this stage.
b) If, in the light of initial findings (including the circumstances of the death), the pathologist feels that there is no clear or sufficient cause of death, whether or not there are some concerns about the possibility that abuse, or neglect might have contributed, they should give the initial medical cause of death to the Coroner as 'undetermined pending further investigation'. In these circumstances, the Coroner should open an investigation and issue a Coroner's interim certificate of the fact of death and allow the funeral to proceed unless there are valid reasons to delay. Opening an investigation or proceeding to inquest will thus have no attached stigma and the use of holding terms such as 'undetermined pending further investigations' should not indicate connotations of suspicion.
c) If, during the initial post-mortem examination, findings emerge that clearly identify neglect or abuse as the most likely explanation for the death, the police and the Coroner should be informed of this. The Coroner should open and adjourn an inquest and will still be able to issue a Coroner's interim certificate of the cause of death and release the body for funeral purposes as soon as practicable. The police will initiate a criminal investigation under the requirements of the Police and Criminal Evidence Act, 1984 https://www.gov.uk/guidance/police-and- criminal-evidence-act-1984-pace-codes-of-practice

8.13 Whatever the interim cause of death as determined by the initial post-mortem examination findings, it is important to continue to pursue other aspects of the joint agency response, including providing ongoing support to the family and investigating other factors that may have contributed to the child's death. Such factors may have important implications for the family or for the provision of services to other families.

8.14 As part of the explanation about the post-mortem examination given to the family the lead health professional or Coroner's officer must explain that, according to the Coroners (Investigation) Regulations 2013, tissue samples will be taken and that, following the Coroner's investigation, the family can determine the fate of the tissue according to the

Human Tissue Act 2004 guidelines. Information given to the Lullaby Trust by bereaved families suggests that this approach will be acceptable to the great majority of bereaved families, who are willing to wait for confirmation of the precise cause of death provided they are kept informed and are meanwhile able to proceed with the funeral arrangements.

9. THE FINAL CHILD DEATH REVIEW MEETING

9.1 As soon as possible, once the results of all relevant investigations have been obtained, a multi-disciplinary local case discussion meeting should be held. The purposes of this meeting are to:

- review all information pertaining to the circumstances of the death, the background history, and findings of investigations in order to determine, as far as is possible, the likely cause of death and any contributory factors
- identify any lessons arising from the case that may help prevent future deaths
- consider any on-going support needs of the family, including any information needs and care requirements of current and subsequent children
- offer a supportive environment for the professionals involved to reflect on the case andtheir involvement

9.2 The local case discussion meeting should ideally take place before the Coroner's inquest and before the Child Death Overview Panel (CDOP) reviews the death. A report from the meeting should go to the Coroner to assist in his or her investigation. A report should also go to the CDOP to assist in their review of the case and in identifying learning arising from the case. A suitable proforma such as the CDOP Analysis Form or the Avon clinicopathological classificationmay be used to record the conclusions of the meeting.

9.3 The final Child Death Review Meeting should be chaired by the lead health professional for the Joint Agency Response.

9.4 Each child's death requires unique consideration and where possible, should engage professionals across the pathway of care. The following professionals may be invited, depending on their ability to contribute meaningfully to a discussion on the circumstances of the child's death:

- hospital or community healthcare staff involved with the child at the end of his/her life, and those known to the family prior to this event
- pathologist, if a post-mortem examination has taken place, or placental histology has been reported in the case of a neonatal death
- other professional peers from relevant hospital departments and community services; patient safety team if a serious incident investigation has taken place
- coroner's officer if the case has been referred to the coroner
- senior police investigator if there is a Joint Agency Response; or
- other practitioners for example social work, ambulance and fire services, primary care clinicians, school nurse, head teacher, representatives from voluntary organisations.

9.5 Parents should be informed of the meeting by their key worker and have an opportunity to contribute. Family members do not attend the meeting to allow full candour among those attending.

9.6 During this case discussion meeting, it is important that there is an explicit discussion of the possibility of neglect or abuse as a contributory factor to the child'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 both 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.

9.7 If there are concerns of a child protection nature, the use of other medical experts may be required. They should be commissioned in line with responsibilities as per the current Criminal Procedure Rules. These procedures also include the use of an experts' meeting. Other parallel procedures may also be happening, such as family court procedures, if there are any siblings who need safeguarding. It is important that all information sharing takes into account the protocols within Disclosure of Information in Cases of Alleged Child Abuse and Linked Criminal and Care Directions Hearings 2013 https://www.cps.gov.uk/publication/2013-protocol-and-good-practice-model-2013-protocol-disclosure-information-cases.

9.8 Arrangements should be made for the most appropriate professional(s) to meet with the family after the meeting, to give feedback from the discussion as soon as possible. Normally this would be the lead health professional with the police investigator and/or a member of the primary care team. Parents should be provided with a verbal update of the summary of the findings. The local case discussion meeting should agree what information can be fed back to the family, how and by whom, and this should be agreed with the Coroner. Normally it will be appropriate to feedback the full conclusions of the final case discussion, bearing in mind that the final conclusion on the cause of death is the responsibility of the Coroner at inquest.

9.9 At this stage, unless there are ongoing concerns, the conclusions of the local case discussion can be shared with the family. It is important, however, to stress that the decision on the final registered cause of death rests with the Coroner, who will be informed by, but not bound by, the findings of the multi-agency investigation. This may also be an opportunity to obtain the wishes of the family with regards to the fate of organs and tissue that were retained during the post-mortem examination, if they have not already made their wishes known.

10. THE ROLE OF THE CORONER

10.1 Coroners are independent judicial office holders who have statutory duties to investigate deaths. The whole of England and Wales is divided into separate geographical jurisdictions, usually by grouping several local authorities together, and each is covered by a senior Coroner and their team.

10.2 Coroners, by virtue of their statutory duties, have a vital role in the investigation of sudden and unexpected deaths of infants and children, since most of these deaths will come under their jurisdiction.

10.3 Coroners investigate deaths that are reported to them by medical practitioners (GPs or hospital doctors) and sometimes by the registrar of births and deaths. At present there are no statutory criteria for doctors reporting deaths to the Coroner (sometimes known as referrals), but doctors are advised in the notes to the Medical Certificate of Cause of Death to use the criteria that registrars must use. For details, see the Chief Coroner's Guidance No.23 Report of Death to the Coroner https://www.judiciary.uk/wp-content/uploads/2016/07/guidance-no-23-report-of-death.pdf

10.4 When a senior Coroner is made aware that the body of a deceased person is within that Coroner's area, they must conduct an investigation into that person's death as soon as is practicable if the Coroner has reason to suspect that the death was violent or unnatural, that the cause of death is unknown, or the deceased died while in custody or otherwise in state detention (Coroners and Justice Act 2009).

10.5 This means that most sudden and unexpected deaths of children are reported to the Coroner by doctors. The Coroner will then take initial legal possession of the body of the child and open an investigation into the death.

10.6 The body of the child will pass to the legal custody of the Coroner, either within a hospital or public mortuary, and the Coroner will investigate the death with the aid of specialist Coroner's officers and other appropriate professionals. This has the potential to cause immense distress to the grieving family and it is recommended that this is sensitively explained to them. This will then be followed up by the Coroner's officer.

10.7 It is the Coroner who will order, and post mortem examination required, which in suspicious deaths will be in conjunction with the police.

10.8 Following any examination, the body of the child can usually be promptly released back to their family, for funeral arrangements to be put in place.

10.9 Once the jurisdiction of the Coroner is engaged, the Coroner's officer is the main point of contact with the family. This contact should be timely, sensitive, and regular. These investigations are often protracted by virtue of their complexity and some families need weekly updates, often by phone, others less so. Contact should meet each particular family's needs. Specifically, the family should be informed early of the Coroner's involvement, the need for and timing of any post-mortem examination, their right to be represented there should they so wish, whether an investigation or inquest has been opened so that they may attend any inquest opening, and the dates of any investigation reviews, pre-inquest reviews and inquests. They should be advised of any delays and that any inquest will be heard as soon as possible.

10.10 The family should always be asked if they have any concerns in relation to the death of their child for example, in relation to any treatment or care that the child may have received.

10.11 The family should also be informed that inquests are public hearings, except in very limited circumstances, and that press and public often attend to listen to proceedings.

10.12 The family will be formally designated 'Interested Persons' for the purposes of the Coroner's investigation, and as such will be entitled to appropriate disclosure from the Coroner and to make submissions as to the conduct of the inquiry. During any inquest, the family will be entitled to ask relevant questions of witnesses, either in person or through a legal representative, and to make submissions on the law.

10.13 The purpose of an Inquest is laid down in statute. It is important to stress that it is not an adversarial process, instead it is an investigative Court hearing to determine who the person was that died and how, when and where they came by their death, the medical cause of death, and certain personal particulars that are required for registering the death. In some cases, where it can be argued that the State may not have appropriately upheld a person's right to life, the remit broadens to encompass the circumstances in which the death occurred. The Coroner will call and examine theevidence and, usually without a jury, record the answers to the questions listed above on a public document called the Record of Inquest. The family is always a central party in an inquest.

10.14 Not all deaths reported to the Coroner proceed to Inquest, although most unexpected deaths of children do. In many cases the Coroner may, as a result of preliminary inquiries, conclude that the death is from natural causes. In such cases the Coroner will not open a formal investigation (or hold an inquest). Instead, the Coroner will sign the case off to the local registrar of births and deaths as a natural cause of death on Form 100A (without a post-mortem examination) or Form 100B (with a post-mortem examination).

10.15 If the Coroner's duty to investigate a death is triggered (see paragraph 10.4above), the Coroner will open a formal investigation, which will usually lead to an inquest. Following an Inquest, the Coroner will complete the Record of Inquest, which is a public document, and refer details of the Coroner's findings and conclusions to the registrar on Form Rev 99.

10.16 Once a Coroner has opened an investigation or inquest, they will issue an 'Interim Certificate of the Cause of Death'. If the medical cause of death is known, the Coroner will record it on the certificate. Usually this is not the case, and the cause of death is then simply recorded as 'the precise cause of death is not known', in line with the wording on such certificates for all Coroners' cases in such a situation.

10.17 The Coroner has a duty under the law to make a finding as to the medical cause of death. If the medical cause of death is known following the inquest, it is recorded on the Record of Inquest and the Rev 99 form and passed to the registrar.

10.18 If the medical cause of death cannot be ascertained, it should be recorded on the Record of Inquest and Rev 99 as 'Unascertained'. If the Coroner feels, however, that there is sufficient evidence to describe the death as a SIDS death, they could, if they wished, enter 'Unascertained (SIDS)' on the Record of Inquest (and Rev 99). This would accord with the collection of statistical data by the Office for National Statistics, which distinguishes between (i) Sudden infant deaths (R95) and (ii) Unascertained infant deaths(R99).

10.19 The Coroner's inquiry is aided by many other agencies, including doctors, hospitals, police, social services, Local Safeguarding Children Boards (LSCBs) and pathologists. Some of these agencies may also become Interested Persons, for example,the police or the treating physician. The Coroner must notify the LSCB if they decide to open an investigation or order a post-mortem examination of a person under the age of 18 years.

10.20 All agencies, and indeed all individuals, who have pertinent information are under a duty to disclose this to the Coroner in a fully unredacted format. The Coroner has both common law and statutory powers to enforce disclosure.

10.21 Some of the agencies and individuals will be Interested Persons to the Coroner's investigation and as such, like the family, will be entitled to all relevant and appropriate disclosure from the Coroner. The Coroner has a statutory duty to disclose information such as post-mortem examination reports to LSCBs.

10.22 An agency or individual providing information to the Coroner may request that that information is redacted before it is onward disclosed by the Coroner to the Interested Persons in the case. In specific circumstances the Coroner may agree to this, for example if the information is not relevant to the Coroner's inquiry or release of it may compromise future criminal proceedings.

10.23 Because the duties of the Coroner are engaged by the body of the deceased person lying within their area, these duties will arise in respect of children who die abroad of arguably unnatural or unknown cause and whose bodies are returned to England and Wales. The duties of the Coroner do not arise if the child is buried or cremated abroad. The Coroner taking responsibility will usually be the Coroner covering the area to which the child's body is brought for funeral arrangements. The investigation of deaths that occur abroad is often difficult due to problems securing evidence. The Foreign and Commonwealth Office usually assists by making contact with foreign authorities on behalf of the Coroner, as the Coroner has no power to summon evidence or witnesses outside England and Wales.

10.24 Following the inquest, Interested Persons, including the family, may request a disc of the proceedings as recorded.

10.25 If, during the course of an Inquiry, the Coroner identifies matters that, if changed, may prevent future deaths, they have a duty to report these matters to agencies or individuals who they believe may have power to take such action.

11. CHILD DEATH OVERVIEW PANELS

11.1 The Child Death Overview Panel (CDOP) is set up to systematically gather comprehensive data on children's deaths, to identify notable and potentially remediable factors, and to learn lessons and make recommendations to reduce the risk of future child deaths. The statutory basis of the CDOPs is documented in Working Together to Safeguard Children July 2018

11.2 The CDOP Coordinator or Administrator should be notified according to local protocol whenever a child dies.

11.3 Following the final Child Death Review Meeting a report and any other relevant supporting documentation should be sent to the CDOP coordinator along with the draft analysis form for review at CDOP.

11.4 The CDOP is a multi-agency panel that meets on a regular basis to review all children's deaths. Cases of sudden unexpected deaths should normally be scheduled for discussion at the CDOP after the conclusion of the full joint agency response, including the final Child Death Review Meeting and the Coroner's inquiry.

11.5 The CDOP should review all relevant information provided on the case from the different agencies involved; it should consider any relevant contributory factors in each domain (factors intrinsic to the child, parenting capacity, family and environment, service delivery) and form an opinion as to the relevance of such factors. The CDOP should form an opinion on the cause and category of the child's death, and on whether they consider the death to have been preventable according to the definition in *Working Together*. The CDOP should consider any learning arising from their review and any appropriate recommendations.

11.6 Coroners have a duty to notify the child death review partners for the area in which the child died or where the child's body was found within three working days of deciding to investigate a death or commission a post-mortem (Page 101 of Working Together 2018)

11.7 Parents should be informed by the Joint Agency Response team about the role and purpose of the CDOP and offered the opportunity to submit information to the CDOP. ***'When a child dies'*** **leaflet** should be offered to the family.

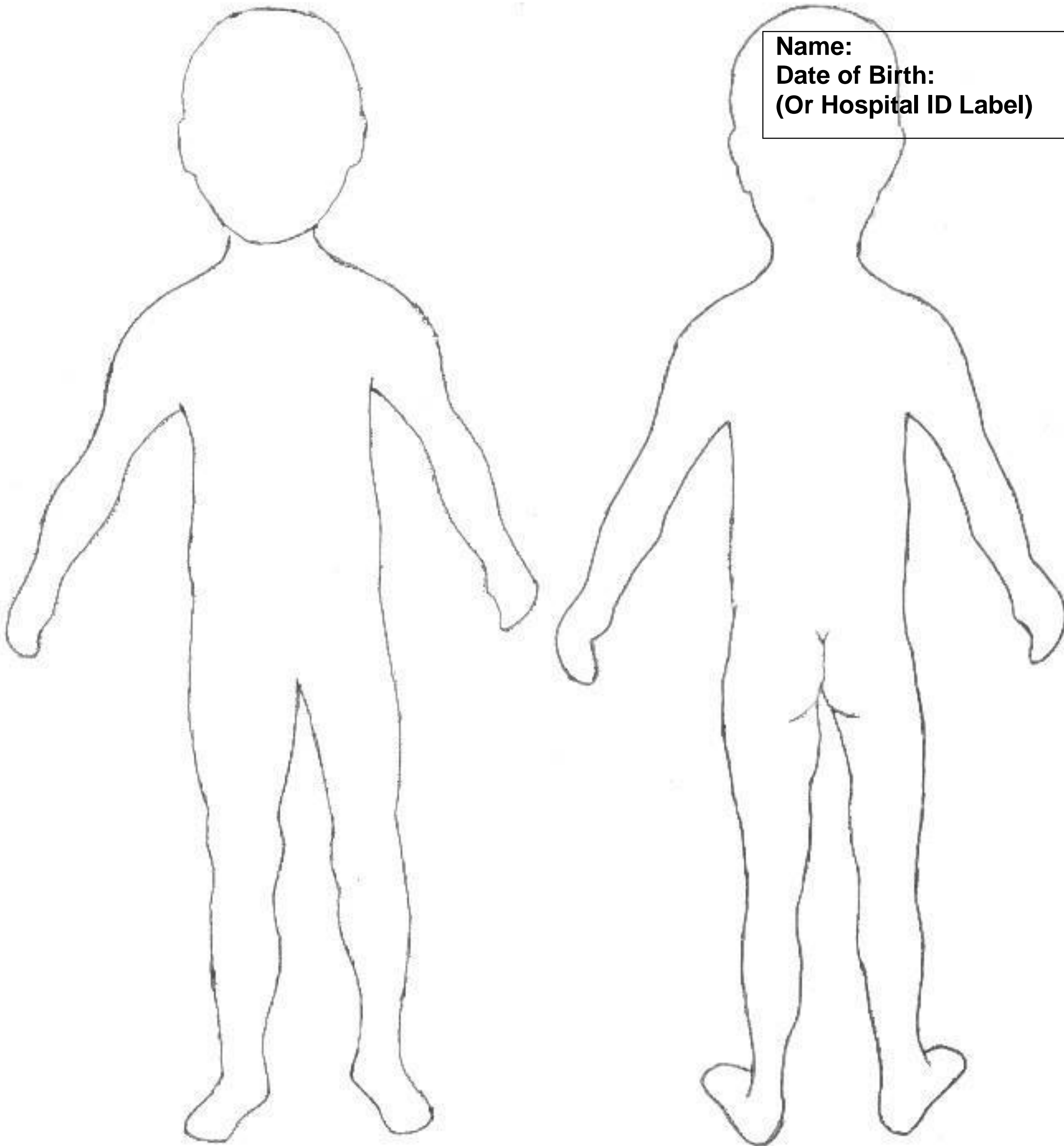
11.8 Each CDOP has the statutory duty to review the deaths of all children resident in their area, irrespective of place of death. When the death has taken place abroad, the local CDOP is advised to seek advice and help from the local senior Coroner first; the CDOP may also need assistance and help from agencies abroad, including police involved in the investigation of the death of the child in question. **See page 8,** ***when a child dies abroad,*** for advice on what to do at the time of the child death abroad being notified to CDOP.

Appendix 1

Appendices 1 to 3 are examples of proforma please use the agreed local bodymaps

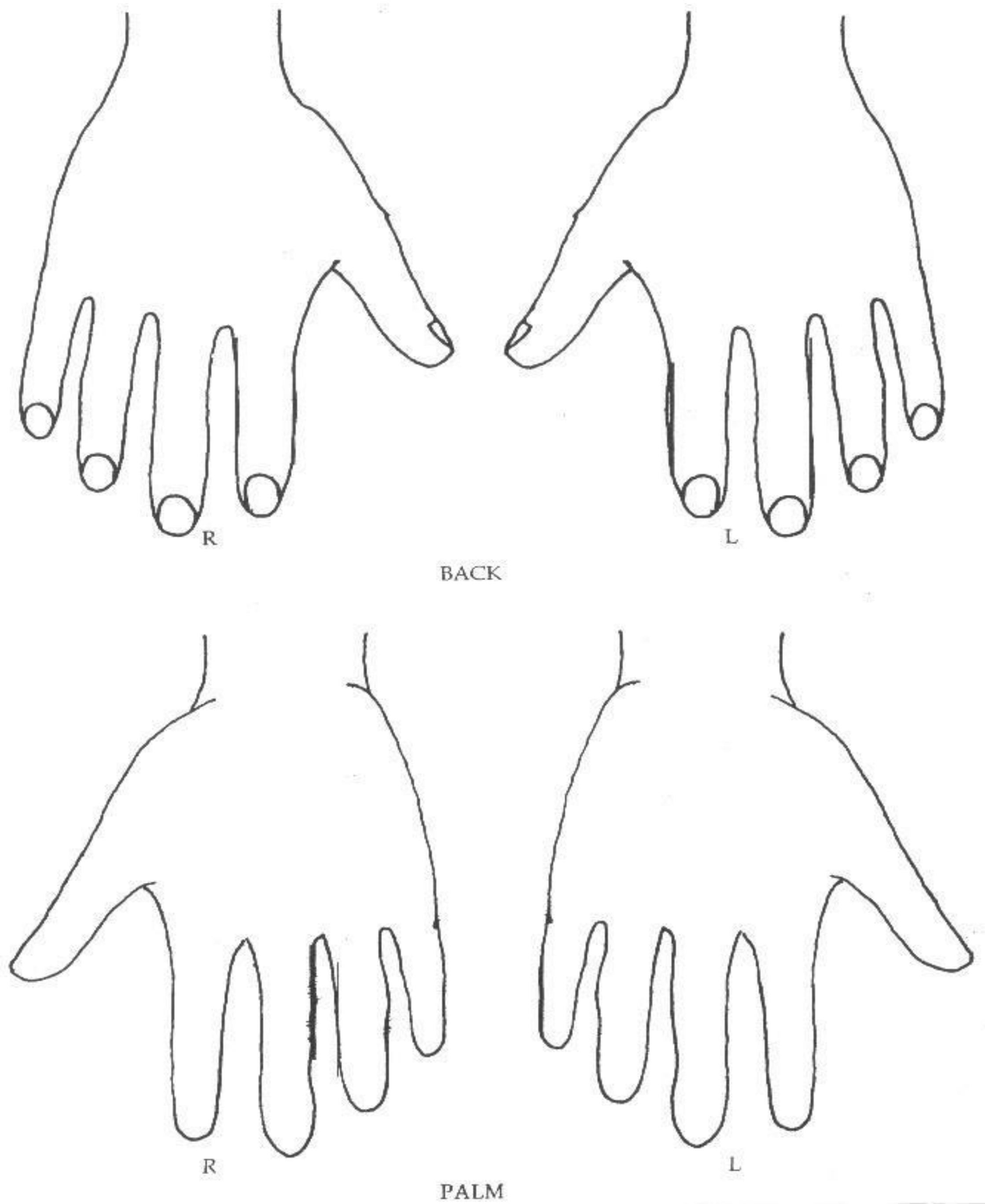
Body Chart 1

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



Body Chart 2

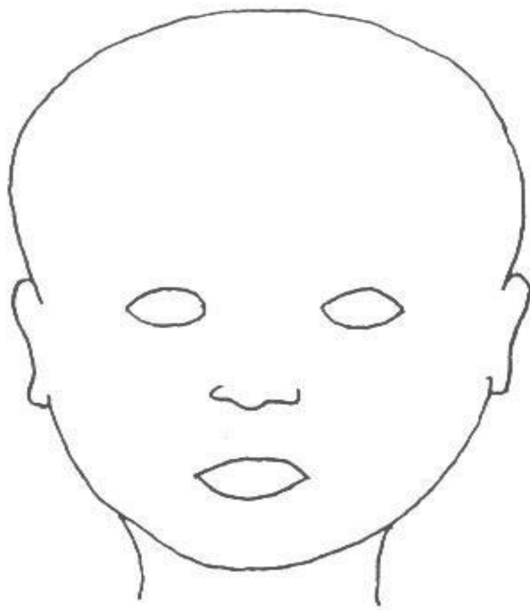
Example only – please use the agreed local body maps

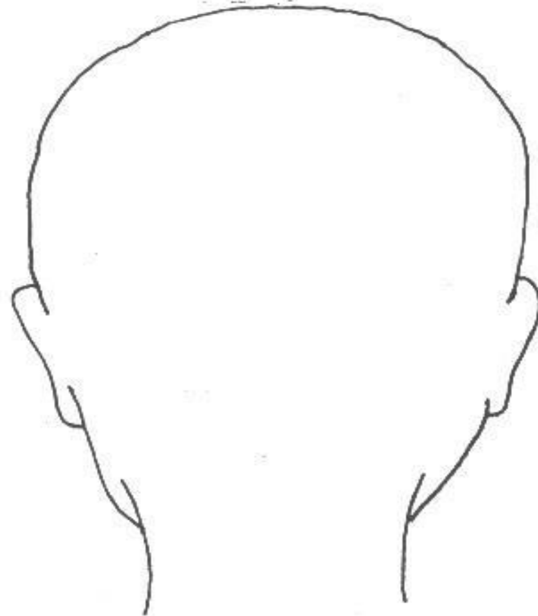


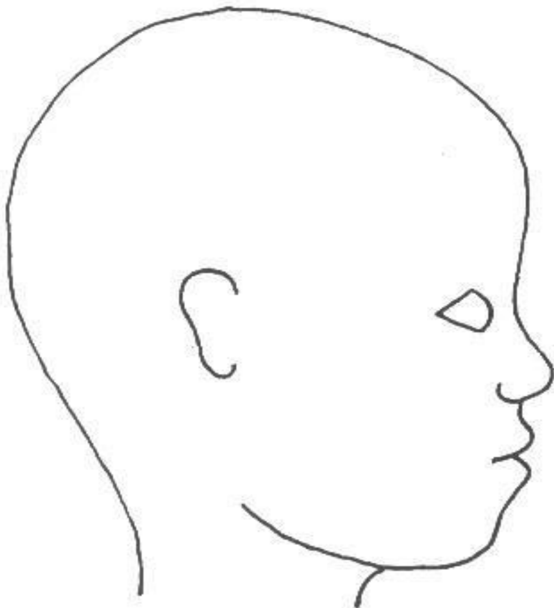
Name: **Date of Birth:** **(Or Hospital ID Label)**

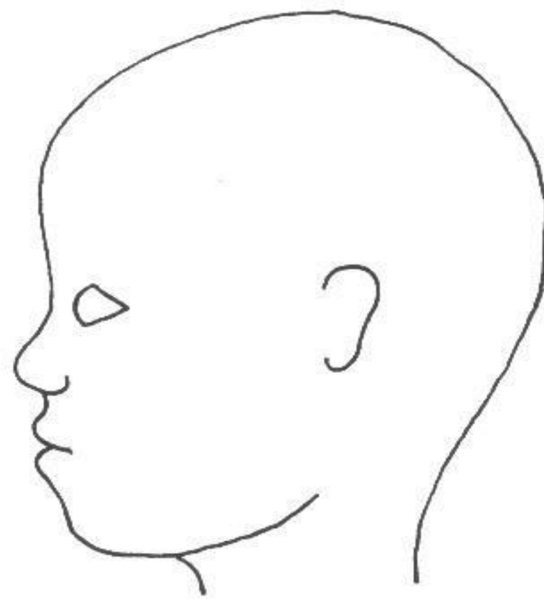
Body Chart 3

Examples only – please use the agreed local body maps









APPENDIX 2

JOINT AGENCY RESPONSE CHECKLIST FOR SUSPECTED SUICIDE IN CHILDREN AND YOUNG PEOPLE (CYP)

Who is this document for?

- Any professional who may be part of a joint agency response in cases of suspected suicide

Purpose of the document

- To provide a prompt to professionals on questions to ask when speaking with families after a child or young person has died and suicide is suspected
- To ensure as much detail as possible is collected for inclusion in the report to the coroner. This will enable good postvention support to the family and others who knew the child following death. It will also enable quick escalation of any concerns to a national level to support fast action e.g., removal of content from social media platforms

How to use this document

- This document can be added to local SUDIC protocols and printed out if needed.

Checklist

Events surrounding death	☐ Who found the CYP, where when and how? ☐ What was the appearance of the CYP when found? ☐ Who called emergency services? ☐ When was the CYP last seen alive and by whom/where? ☐ Details of any resuscitation at home, by ambulance crew, and in hospital ☐ Details of circumstances around the death including any witnesses ☐ Are the details of the circumstances of death in accordance with the developmental stage of the CYP? Could the CYP have managed to do this unaided? (This is particularly relevant for CYP with disabilities) Indicators of intent to die by suicide ☐ Was there a suicide note? (Written or electronic) ☐ Had the CYP made any statements to others that they intended to take their own life? ☐ What was the method of suicide?
Detailed narrative account of last 24-48 hours	☐ Give a detailed account of the last 24-48 hours including all activities, social contact and routines as known by the family. ☐ Were there any particularly stressful events? ☐ How was the CYP mood and behaviour?
Health history and risks	**Mental health and physical health history** ☐ What, if any, physical or mental health conditions did the CYP have? (previous/current)

	☐ Give details of any current or previous contact with Child and Young People's Mental Health Services (CYPMHS)[1] or substance misuse services including if referred and on waiting list. ☐ If the CYP was under the care of a mental health trust or provider, please include the name of the trust or provider. ☐ Was the CYP under the care of their GP or private counsellor/therapist for assessment or treatment of mental health needs? (previous / current or awaiting) ☐ Has the CYP ever been admitted to a CYPMH inpatient bed or detained under the MHA? ☐ Did the CYP have a diagnosis of autism spectrum disorder (ASD) and/or attention deficit hyperactivity disorder (ADHD) or other neuro-developmental condition or Learning Disability. **Vulnerabilities and risk-taking behaviours:** ☐ Has the CYP previously self-harmed (including self-poisoning), experienced suicidal ideation or attempted suicide? If yes, please describe when and how many instances ☐ Have there been any other suspected or confirmed suicides in the CYP's education/social circles? ☐ Did the CYP take any alcohol or drugs (including prescription drugs)? If yes, give details of what was taken and how regularly ☐ Were any drugs or alcohol consumed in the 48 hours before death? If yes, please give details ☐ Did the CYP access any social media platforms, chatrooms, or websites with suicide related content? ☐ Did the CYP experience any bullying or cyber-bullying? If yes, please give details of any social media involvement including what (known) social media platforms were used and whether there were any concerning interactions/content on there. ☐ Had the CYP ever been subject to school suspension or exclusion / or truanted from school or college. ☐ Did the CYP experience any difficulties because of their gender identity / sexual identity ☐ Had the CYP experienced any significant relationship losses e.g., due to bereavement, relationship break down etc ☐ Had the CYP had any contact with social care services? (previous/current) Or been adopted/fostered/looked after? This should include kinship and guardian carers. ☐ Had the CYP ever runaway or been reported missing? ☐ Had the CYP ever been in contact with the law/criminal justice system? ☐ Did the CYP have support from any other service (including voluntary or 3rd sector services) or were they a member of any other network/community e.g., faith or LGBTQ communities etc.
Family and social history of the CYP	☐ What is the household composition? ☐ Did the CYP regularly spend time in more than one household? ☐ Did any family members or carers have any previous or current physical or mental health conditions? If yes, did any of these things impact on the child's relationship with their parent or their role as carer ☐ Did any family members or carers have alcohol or substance misuse problems? ☐ Was there conflict in family relationships or concerns about household functioning including domestic violence?

[1] Previously known as CAMHS (Child & Adolescent Mental Health Service)

	☐ Are there any concerns the CYP experienced abuse or neglect (emotional, psychological, physical, or sexual) of any kind? ☐ Were there any issues with the CYP's immigration status? ☐ Was the CYP an asylum seeker? Where they accompanied or unaccompanied?

Appendix 3

History Proforma

Example only – please use locally agreed adapted templates

Investigation of Sudden and unexpected Death in CHILDHOOD			
HISTORY PROFORMA			
1. IDENTIFICATION DATA:			
Name of Child:		**Sex:**	M / F
Other Names know by:			
Date of Birth:		**Ethnicity:**	
Place of Birth:			
Date of Death:			
Address:			
Postcode:			
Name of Father:		**Date of Birth:**	
Address: (if different from child)			
Name of Father's Partner: (if relevant)			
Address: (if relevant)			
Name of Mother		**Date of Birth:**	
Address: (if different from child)			
Name of Mother's Partner (if relevant)		**Date of Birth:**	
Address: (if relevant)			
GP Name:			
GP Address:			
Hosp Number:			
Consultant:			
SUDC			

Paediatrician:	
Details of Transport of Child to Hospital:	

2. Place OF DEATH

		Home address as above:
		DGH (specify):
		Another Location (specify)

Time Found:										
Time Arrived in A&E?										
Resuscitation carried out?							Yes		No	
Where?		At scene of death			Ambulance				A&E	
By whom:	Carers		GP		Ambulance Crew		Hospital		Other	

Certification of death:	**Date**	**Time**	**Location**	**By whom?**

3. HISTORY

Taken into A&E by:								
Taken at home visit by:								
History given by:								
Relationship to child:								
Events surrounding death:								
Child found by:	Mother		Father		Partner		Other	
Time found:								
Who called emergency services?								
Access to Emergency Phone?								
Child last seen alive?	Date:		Time:					
By whom?								
Who looked after child? in last 24 hours?								
Resuscitation?	Yes		No					
By whom?								
If yes, describe how? (basic life support, blew on face, slapped on back etc)								
Any response?	Yes		No					

4. THE FINAL SLEEP ***(description of when and where the baby was put to sleep)***

When put down?	
Where?	
Any change from usual?	

How was the child placed down to sleep?	prone		supine		Side	
How was the child found?	prone		supine		Side	
Anyone else in the bed/cot?	Yes				No	
Dummy?	Yes				No	
What was child wearing?						
Bed coverings?						
Type, condition, and quality ofMattress?						
How often checked?						
Who by?						
Time Last checked?						
Time Last heard?						
Did child wake?	Yes				No	
When?						
Who found the child?						
What time?						
Position of bedding/covers?						
What did the child look like?						
Any blood in mouth of nostrils?	Yes				No	
Additional Comments:						

5. THE FINAL SLEEP *(*The Room*)*				
Does anyone else sleep in the room usually?	Yes		No	
Anyone else in the room this time?	Yes		No	
Objects in or near the bed?	Yes		No	
Was the heating on?	Yes		No	
What type of heating?				
What was the temperature in the room?				
Was there evidence of over wrapping or overheating?				
Were the windows/doors open?	Yes		No	
Was there any restriction or potential restriction to ventilation or breathing?				

6. FEEDING (where applicable)
Time of last feed?

Type of feed?				
Quantity?				
Any change from usual?	Yes		No	
Was the baby feeding as well or less well? than usual in the past 24-48 hours?				
Any vomiting in last 48 hours?	Yes		No	
Any vomitus when found?	Yes		No	
Other Comments:				

7. DETAILED ACCOUNT OF LAST 24-48 HOURS				
Any changes to routine or feeding?	Yes		No	
Unusual cry/irritability/fever/medication given?	Yes		No	
Breathing difficulties or coughing?	Yes		No	
Wet nappies in 24 hours?	Yes		No	
Difficulties with sleeping or walking?	Yes		No	
Unusual activity or alertness?	Yes		No	
Cyanotic/Apnoeic Episodes?	Yes		No	
Changes in Environment Temperature?	Yes		No	
Other Comments:				

8. LAST SEEN BY A DOCTOR
Date?
Time?
Where?
Why?

9. FAMILY HISTORY				
Mother				
Age:	Marital Status:			
Occupation:	Ethnic Group:			
Past marriages/live-in relationships?	Yes		No	
How long has mother lived with father? Was Mother living with child at time of death?				
Children from other Partners?	Yes		No	
Drugs (including habit forming)?	Yes		No	
Smoking?	Yes		No	
Alcohol?	Yes		No	
Illness/Disabilities?	Yes		No	
Other comments:				

Father			
Age:	Marital Status:		
Occupation:	Ethnic Group:		
Past marriages/live-in relationships?	Yes		No
How long has father lived with mother?			
Was father living with child at time of death?	Yes		No
Children from other Partners?	Yes		No
Drugs (including habit forming)?	Yes		No
Smoking?	Yes		No
Alcohol?	Yes		No
Illness/Disabilities?	Yes		No
Other comments:			

Children in the family: (Including any children by previous partners)

Name:	Age:
Health:	
Name:	Age:
Health:	
Name:	Age:
Health:	
Name:	Age:
Health:	
Any previous childhood deaths in the family?	Yes / No
Additional Comments:	

10 PAST MEDICAL HISTORY
Birth History:
Height/Weight of Mother prior to pregnancy?
Pregnancy:
Delivery:
Gestation:
Birth Weight:

Apgar score:				
Perinatal problems?	Yes		No	
SCBU?	Yes		No	
Type of feeding at birth?				
Feeding now? Breast, bottle? If latter – what milk formula?				
Any recent changes to feeding routines?				
Weight gain in last few weeks?	Yes		No	
Routine checks e.g., 6 weeks medical?	Yes		No	
Immunisations?	Yes		No	
Previous illnesses?	Yes		No	
Previous hospital admissions?	Yes		No	
Previous unexplained illness e.g., cyanotic episodes, acute life threatening events (ALTE):	Yes		No	
Excessive sweating?	Yes		No	
Episodes of pallor?	Yes		No	
Any past respiratory difficulties e.g., noisy breathers or wheezing?	Yes		No	
Contacts with infections?	Yes		No	
Allergies?				
Medication?				
Over the counter medicines (Gripe Water/Paracetamol, etc)?				
Other Comments:				
MOTHER'S OBSTETRIC History:				
Details of previous pregnancies and pregnancy outcomes:				
11 SOCIAL HISTORY				
Type of housing?				
Number of people in household?				
Family on benefits or income support?	Yes		No	
Recent major life events in family?	Yes		No	
Child or family known to Social Services?	Yes		No	
Any family mental health problems?	Yes		No	
Maternal depression PNDS?	Yes		No	
Other Comments:				

12 IMMEDIATE INFORMATION SHARING AND PLANNING MEETING/DISCUSSION			
Signed:		**Date:**	
Designation:		**Base:**	
Signed:		**Date:**	
Designation:		**Base:**	
Signed:		**Date:**	
Designation:		**Base:**	
Home visit on:	**(date)**	**By:**	

Appendix 4

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/suspicions 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 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.

Complete a detailed sketch of the plan of the room with measurements and orientation (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.

Home Visit Review Form

Example only – please use locally agreed adapted templates

Child's name:	
Date of Birth:	
Date of Death:	
Address:	
Date of scene visit:	
Persons present:	

Room

- Size
- Orientation
- Contents
- "Clutter"
- Ventilation (windows and doors – open or shut)
- Heating (including times switched on/off
- Measure drawer temperature ◦C

Sleep Environment

- Location
- Position of bed/cot in relation to other objects in room
- Mattress
- Bedding
- Objects

Position of baby

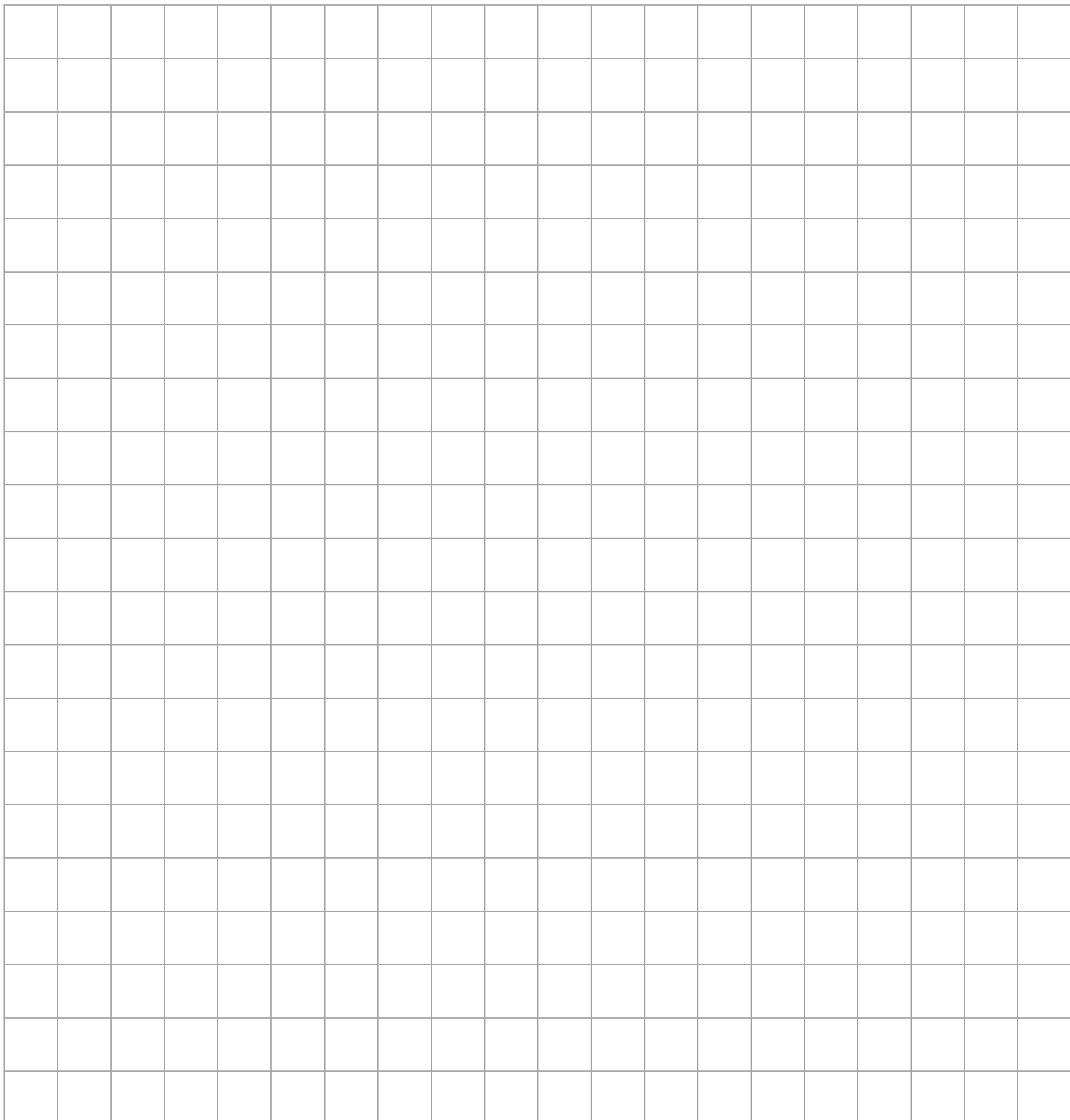
- When put down
- When found

	Yes/No
Any evidence of over-wrapping or over-heating?	

Any restriction to ventilation or breathing?	
Any risk of smothering?	
Any potential hazards?	
Any evidence of neglectful care?	

Diagram of Scene

- North/South orientation
- Room measurements
- Location of doors
- Windows
- Heating
- Any furniture and objects in the room



Appendix 5

Herefordshire & Worcestershire JAR Arrangements [Health]

In Herefordshire the resident Acute Paediatric Consultant acts as the designated health professional, always, until handing over to the SUDIC professional. The Acute Consultant is the first point of contact:

Hereford County Hospital 01432 355444
On-call Consultant bleep 071

Dr Simon Meyrick, Designated SUDIC Paediatrician
Hereford County Hospital
Wye Valley NHS Trust
Stonebow Road Hereford
HR1 2ER
Tel 01432 364145
Hospital switchboard 01432 355444
Mobile 07899 997041
simon.meyrick@nhs.net

In Worcestershire the SUDIC investigation is provided by the SUDIC nurses 7 days a week from 0830-1630, out of hours this is provided by the on-call Consultant Paediatrician. The on-call nurse or consultant is contacted via hospital switchboard: Worcestershire Royal Hospital 01905 763333, Alexandra Hospital Redditch: 01527 503030.

Donna Steward, SUDIC Lead Nurse
Mobile: 07912 784135 d.steward1@nhs.net

Lauren Woolhouse, SUDIC Administrator
Mobile 07918 741868 lauren.woolhouse@nhs.net

Dr Jenny Edmunds, SUDIC Lead Paediatrician
Mobile: 07764 766469
Tel: 01905 681071 jennifer.edmunds@nhs.net

Polly Lowe, Herefordshire, and Worcestershire Child Death Overview Panel Coordinator
Public Health,
Worcestershire County Council,
County Hall,
Spetchley Road, Worcester.
WR5 2NP
Tel 01905 843199
plowe@worcestershire.gov.uk

Jayne Williams, CDOP Administrator
Public Health,
Worcestershire County Council
County Hall,
Spetchley Road, Worcester.
WR5 2NP
cdr@worcestershire.gov.uk

Appendix 6

Shropshire and Telford & Wrekin JAR Arrangements [Health]
In Shropshire and Telford & Wrekin there is a SUDIC Lead Nurse, Doctor, and Administrator. The SUDIC Lead Nurse is the first point of contact.

The SUDIC Lead Nurse at the time of guideline implementation is:

Ms Bea Jones
Nurse Specialist Child Death Reviews
Shropshire Community Health NHS Trust
Child Death Overview Panel, Halesfield, Telford, Shropshire, TF7 4BF
Office 01952 580312 or
01952 580387 (Safeguarding Children Office)

Mobile 07826 901962
Email bernadette.jones1@nhs.net
Shropcom.cdop@nhs.net
Availability Mon-Fri 09.00-17.00

The Shropshire SUDIC Lead Doctor:

Dr Sam Postings
Associate Specialist in Community Paediatrics, Child Death Overview Panel Lead Paediatrician and Named Doctor for Safeguarding,
Shropshire Community Health NHS Trust
Stepping Stones Child Development Centre, Telford, Shropshire

Office 01952 56738 (medical secretaries)
Email ,samj.postings1@nhs.net
Availability Mon-Thur 08.00-18.00

The CDOP Administrator is:

Sam Wheatley
CDOP Administrator and Secretary to Head of Safeguarding
Shropshire Community Health NHS Trust, Halesfield 6, Telford, TF7 4BF

Office 07811 731984
Email sam.wheatley@nhs.net and Shropcom.CDOP@nhs.net

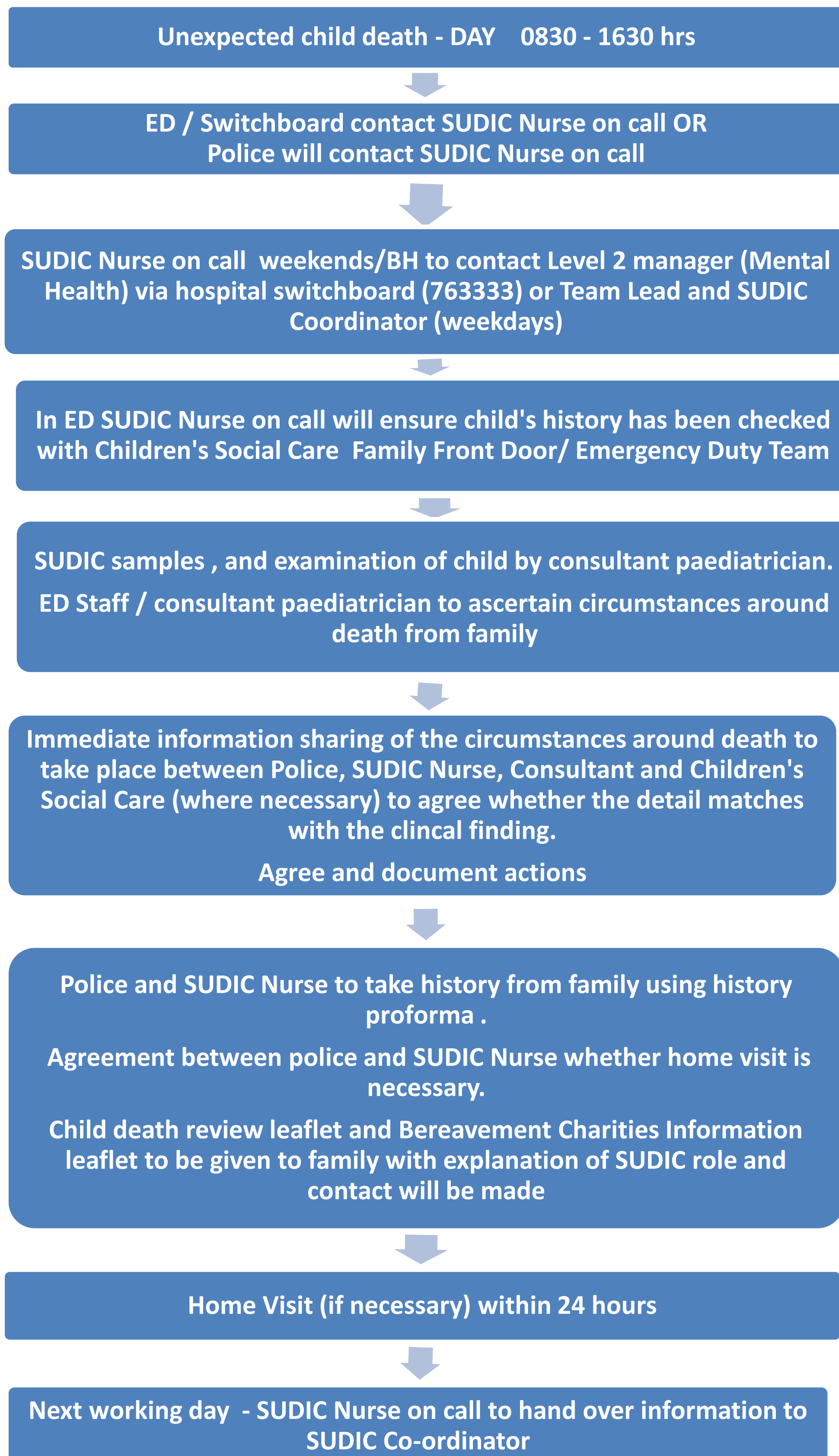
Out of hours: The **Acute 'on-call' Paediatrician** acts as the designated health professional until handing over to one of the SUDIC professionals, unless the child is over the age of 16 years when the responsibility may fall to the Emergency Department Clinicians:

Shrewsbury and Telford Hospitals NHS Trust (SaTH):

The Royal Shrewsbury Hospital 01743 261000
The Princess Royal Hospital, Telford 01952 641222

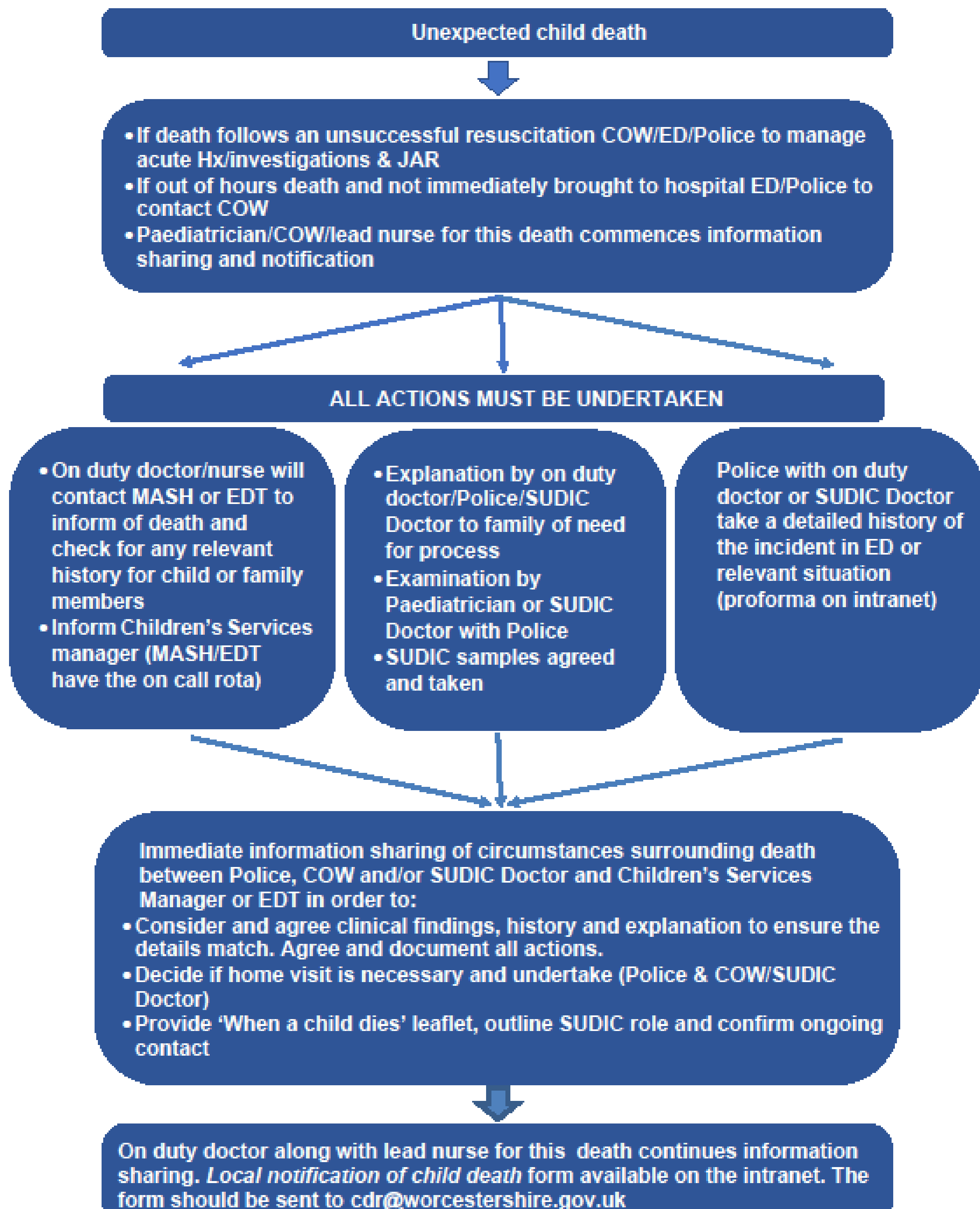
Appendix 7

Worcestershire SUDIC Pathway
Worcestershire SUDIC Nurse on Call: 08.30-16.30, 7 days a week and inclusive of bank holidays.



Appendix 8

Herefordshire SUDIC Pathway



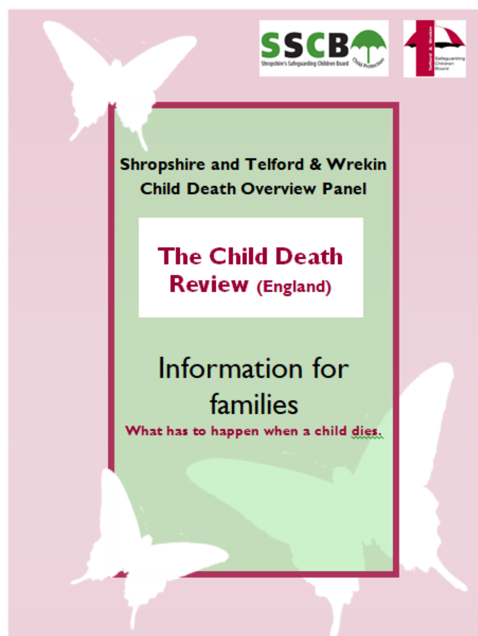
If SUDIC Doctor is not available ALL designated roles will be undertaken by the Paediatrician on duty (COW) or a professional allocated to that role by COW.

Appendix 9

Information for families and carers

Written information is important and valuable to families because much of the detail of what is discussed can be forgotten or lost in the immediate stress of their child's death. It is important that the family are provided with relevant and up to date information but are not overwhelmed by this. The Lullaby Trust produces comprehensive guidance, **'*When a child dies' - A guide for parents and carers*** which can be shared with families at the earliest opportunity When a child dies – A guide for parents and carers (lullabytrust.org.uk). Details of local support and national organisations are also included in the guidance to provide to the family.

Local leaflets are available via the appropriate websites:
This is only via staff intranet in Herefordshire & Worcestershire



Shropshire and Telford & Wrekin Child Death Overview Panel

Herefordshire and Worcestershire Child Death Overview

Appendix 10

Bereavement Support

Name & Contact Information	Support Offered:
Bliss www.bliss.org.uk 0207 378 1122	Offers support for families of premature babies.
Childhood Bereavement UK www.childbereavementuk.org **Helpline** (Bereavement support line for families and professionals) 0800 02 888 40 enquiries@childbereavementuk.org	Supports families when a baby/child of any age dies.
The Lullaby Trust www.lullabytrust.org.uk Bereavement Support: 0808 802 686 support@lullabytrust.org.uk	Confidential support to anyone affected by the sudden and unexpected death of a baby or young toddler.
SANDS Stillbirth & neonatal death www.sands.org.uk Sands Helpline 0808 164 3332 helpline@sands.org.uk	Support for anyone affected by the death of a baby, before, during or shortly after birth.
Brake – road safety charity www.brake.org.uk 0808 800 0401	Offers emotional support for victims of road traffic collisions and bereaved family and friends.
Compassionate Friends www.tcf.org.uk 0345 123 2304	Support for bereaved parents, siblings and grandparents who have suffered the death of a child.

Cruse Bereavement Care www.cruse.org.uk 0808 808 1677	Help for anyone bereaved by death to understand their grief and cope with their loss.
Survivors of Bereavement by Suicide (SOBS) https://uksobs.org 0300 111 5065	National charity providing dedicated support to adults who have been bereaved by suicide
Hope House Hospice Counselling and Bereavement Support Hope House Children's Hospices counselling@hopehouse.org.uk or call the Sunstone Centre on 01691 672618 counselling@tygobaith.org.uk or call Conwy Court on 01492 554443	Counselling and bereavement support is available to anyone who has been affected by the death of a baby, child, or young person up to the age of 25 years. Their death may have occurred in any circumstances. This support is available to children, young people, adults, couples, and whole families who live in Shropshire, Cheshire, Mid or North Wales. You do not need to have had any prior contact with Hope House Children's Hospices.
Winston's Wish Bereavement support ask@winstonswish.org Tel 08088 020 021	Charity that provides advice, guidance and bereavement support to children, young people, families, and professionals. A specialist team provides emotional and practical bereavement support services, peer support and drop in sessions. They also provide specialist suicide bereavement support following a death through suicide.
Worcestershire Suicide Bereavement Support Support for those who have been bereaved or affected by suicide | Worcestershire County Council Contact: Gill Stanton, Suicide Liaison Worker worcs.bbs@victimsupport.org.uk or call 01905 947933	The service provides emotional support, practical help, and signposting to other organisations. The service is free, confidential, and available to residents of Worcestershire, of any age.