

July 2008

Child Death Review Processes – SUDC Protocol

**WARWICKSHIRE BEST PRACTICE MULTI AGENCY
PROTOCOL FOR THE MANAGEMENT OF SUDDEN
UNEXPECTED DEATHS IN INFANTS AND CHILDREN
UNDER 18 (SUDC).**

**Based on the West Midlands Best Practice Protocol for the Management
of Sudden Unexpected Deaths in Infants.**

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PREFACE

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

This Best Practice Multi-agency Protocol is drawn up to meet the requirements of the Statutory Guidance, Working Together to Safeguard Children, 2006, which sets a duty on all LSCBs to have in place arrangements for the thorough and timely evaluation of all unexpected child deaths. Working Together requires that multi agency procedures are in place to undertake a multi agency ‘rapid response’ investigation and evaluation of all the circumstances surrounding each unexpected child death. The information from this investigation will be considered by a LSCB Child Death Overview Panel with a view to ensuring that lessons are learned, common themes identified and actions taken to contribute to preventing children’s deaths, and to safeguarding and promoting the safety and welfare of children in future .

The Multi Agency Protocol has been drawn up with considerable reference to the West Midlands Best Practice Multi Agency Protocol for the investigation of Sudden Unexpected Death in Infancy. Warwickshire Safeguarding Children Board acknowledges the previous work of professionals in the West Midlands area, in Avon and Somerset, and in Wales.

Every attempt has been made to ensure that the guidance contained in the Warwickshire Best Practice Multi-agency Protocol SUDC is consistent with that in the West Midlands Best Practice Multi-agency Protocol for the Management of Sudden Unexpected Infant Deaths. The aim is to ensure that there is a consistent approach to the investigation of sudden unexpected deaths of infants and children across local authority and organisational boundaries. However the Warwickshire Multi Agency Protocol extends the investigation of sudden unexpected deaths to all children from 0 to 18, excluding stillbirths.

It has been jointly developed by the following agencies within Warwickshire:

Warwickshire Police

Warwickshire PCT

West Midlands South Strategic Health Authority

Warwickshire Local Authority Childrens Services

West Midlands Ambulance Service

This Best Practice Multi-Agency Protocol provides guidance and procedures for all professionals involved in the Rapid Response arrangements for the investigation of;

- Sudden, unexpected or unexplained deaths in infants under the age of 2 years, often referred to as ‘cot death’.
- Sudden, unexpected or unexplained deaths of all children aged 0 to 18 years excluding stillbirths and the death of pre-viable babies born before 24 weeks.

This document therefore provides the framework for a comprehensive and sensitive enquiry aimed at establishing the cause of sudden, unexpected deaths in all infants and children under 18 excluding stillbirths.

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.

There will, however, be some deaths, for example in children with a life limiting illness or in profoundly disabled children with a reduced life expectancy, where the death at that time is unexpected. In these cases it will be important for the Health professionals involved to come to a professional and competent decision on whether or not the use of this Protocol would then be appropriate. Full consultation should take place with the Palliative Care professionals working with the child and family

Where children have been supported by the palliative care services, the Palliative Care Lead Paediatrician should always be invited to the Information Sharing and Planning meeting to take part in the decision whether these 'rapid response' arrangements need to be triggered, and in any discussion or feedback to the family.

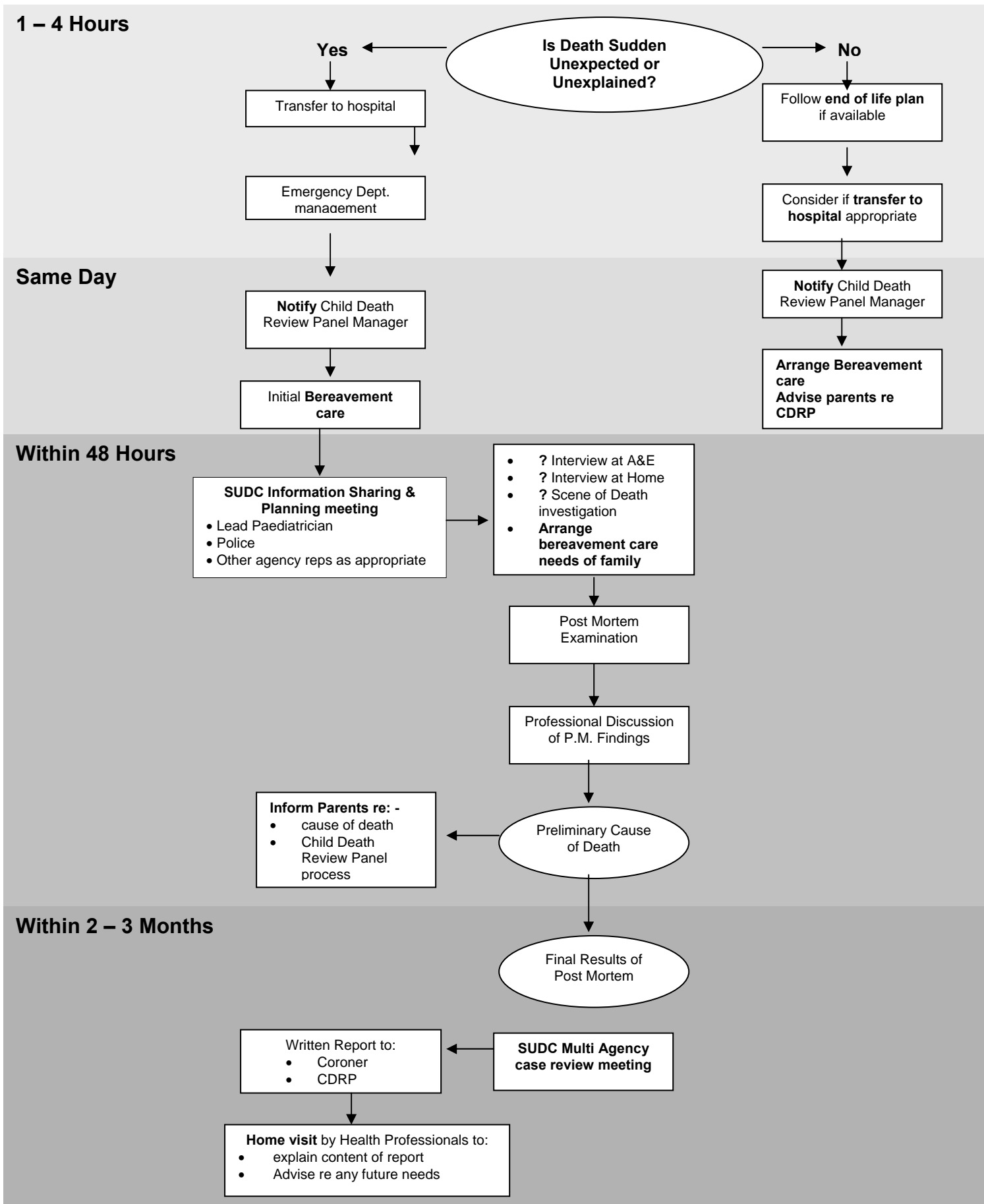
PRINCIPLES

When dealing with an unexpected or unexplained child death, all agencies need to follow five common principles:

- A sensitive, open-minded and balanced approach
- An inter-agency response
- Sharing of information
- An appropriate response to the circumstances
- Preservation of evidence

(It is considered that all of the above are of equal importance)

The joint agency approach for the investigation of sudden unexpected or unexplained death in children aged 0 –18



This flowchart represents the overall Rapid Response process. Discussion needs to take place between the lead professionals as to which parts of this process should be completed in an individual case.

Supplementary guidelines have been drawn up for specific cases, such as deaths of children suffering from life limiting illnesses. These are available for practitioners on the Every Child Matters website

2. INTER-AGENCY WORKING: OVERVIEW OF THE PROCESS

Wherever the cause of a child's death is not apparent and it is not possible to issue a death certificate this protocol should be followed and a multi-agency rapid response to the death should take place.

All sudden and unexpected or unexplained deaths in children are notified to the Coroner and consideration given to the need for a full Police/Coroner investigation to take place

The initial call to the emergency services should trigger the pathway so that the Police and Paediatrician are informed.

In the case of the death of an older child, the lead Police Officer and Paediatrician will agree which elements of this protocol are to be followed depending on the circumstances of that particular case. For example, in the case of a child who dies as a result of a road traffic accident it may not be appropriate or necessary for a home visit to be done.

2.1 The Information-Sharing and Planning Meeting

Police, Health and where relevant the Local Authority Children's Services will collate information, and the lead Paediatrician will convene and chair an initial **Information-Sharing and Planning Meeting**. The meeting will be convened within 2 working days of the sudden, unexpected or unexplained death, and in any event prior to the post-mortem examination. (In some situations where appropriate this meeting may take place by phone.)

The **Information-Sharing and Planning Meeting** will include the investigating Police Officer, the Responsible Paediatrician, relevant Health professionals and Local Authority Children's Services professionals. It will take place prior to the post-mortem examination.

The purpose of this meeting is:

- To plan and determine the process of the investigation and arrange for the family support needs to be met
- To collate all relevant information to share with the Pathologist.

- To determine which professional/agency will lead the multi-agency investigation.
- For each agency to share information from previous knowledge of the family and records, with particular reference to the circumstances of the child's death. This would include details of previous or ongoing child protection or child care concerns, previous unexplained or unusual deaths in the family, neglect, failure to thrive, parental substance misuse, parental mental ill-health, domestic abuse, previous hospitalisation and GP visits, etc. Is there a "Significant Concern"?
- To enable consideration of any child protection risks to siblings/any other children living in the household, and to consider the need for child protection procedures.
- To ensure a co-ordinated bereavement care plan for the family.
- To discuss any need for action in respect of other children in the family (e.g. health overview).
- To ensure that a date is arranged for the **Multi Agency Case Review Meeting** within 4 months.

Those involved in the **Information-Sharing and Planning Meeting** should include:

- **Health** - The doctor who confirmed the death, the named Health Visitor or School Nurse for the child, the community midwife if appropriate, the General Practitioner, the hospital Consultant Paediatrician (and/or the Responsible Paediatrician), the named professionals for Child Protection, and the Ambulance Service.
- **Local Authority Children's Services** - The Children's Services Team Manager.
- **Police** - Child Protection Team Detective Inspector.
- **Other contributors** - Education (where the child was attending school or nursery) and any other agency/person who may have a contribution to make, e.g. Drug/Alcohol Services, .
- If child protection concerns are identified when the information is shared this meeting will become a strategy meeting under child protection procedures, and the Chair of the Warwickshire Safeguarding Children Board will be notified.

- There must be a further professionals' meeting or phone conversation after the post-mortem, so those relevant professionals are able to discuss the findings and interpret their relevance.

2.2 The Case Review Meeting

- A multi-agency **Case Review Meeting** is to be held as soon as possible once the results of all relevant investigations have been obtained, usually 8-12 weeks after the child's death. The minutes and decisions of the **Initial Information Sharing and Planning Meeting** should be available at this meeting.
- This meeting will be initiated by the Police. The main purpose of this meeting is to establish the cause of the child's death and to plan the future care and support for the family, achieved through sharing of information.
- At this case discussion meeting, all relevant information concerning the circumstances of the death, the child's history, family history and subsequent investigations should be reviewed. The cause of the child's death should be established if possible.
- The parents must be fully informed of the outcome of the meeting at a separate meeting with the SUDI Paediatrician and GP or Health Visitor.
- During the meeting there must be 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.
- A report of the multi agency Case Review meeting will be completed by the Chair of the meeting using the agreed format. This record will subsequently be distributed for ratification by those attending the meeting. **No other notes will be recorded at the meeting.**
- After the multi-agency case review meeting, the lead Paediatrician, in close consultation with the Pathologist, should write a detailed report on the available information concerning the cause of the infant's death as a letter to the parents.
- Arrangements should be made for appropriate health professionals to see the parents to explain the content of this report, and to identify and plan the provision of any future additional care or support needs.
- The record of the multi-agency case review meeting should be communicated by report to the Coroner. The information available from this meeting will potentially be of great value to the Coroner in the

organisation and conduct of the inquest, and will ensure that correct information is included in the final registration of the cause of death notified to the Registrar of Births and Deaths.

- It is important for each agency to ensure that cases are audited/reviewed against the standards set out in this protocol and included in the Child Death Review Panel's annual report to the Local Safeguarding Children Board.

3. The Roles and Responsibilities of Health Professionals

3.1 This section sets out the issues to be considered by health professionals, their roles, responsibilities and process to be followed. This incorporates the care of the family throughout the episode, Ambulance Staff, Hospital Staff, General Practitioners and Primary Care health staff.

3.2 Ambulance Service

In most circumstances the child would be transferred to hospital for immediate management in the A&E Department

The first professional on the scene should note the appearance, the environment and the circumstances of how the child was found.

If circumstances allow, note any comments made by the parents/carers, any background history, any possible substance misuse and the conditions of the living accommodation.

Any information and concerns, must be passed to the receiving doctor and the Police as soon as possible.

In some circumstances where the child is obviously dead and the circumstances appear suspicious the child should not be moved until discussions have taken place with the Police.

3.3 Hospital Health Professionals

The emphasis would be on the immediate medical response of resuscitation and the initial history taking usually accompanied by a police officer.

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

Staff need to make an assessment of the capacity of the parents to engage with the processes unfolding around them. It must be noted that shock of the situation may impede their understanding; for others language, health or mental capacity needs to be taken into account.

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

The parents also need to be told that the Coroner will be informed as the child has died suddenly and the Police have a responsibility to investigate the death. The lead doctor must explain that possible medical causes of the death will be explored.

- The parents must be informed that in the majority of cases the coroner will order a post-mortem examination and that this will be carried out by a Pathologist with special expertise in diseases of children (paediatric pathologist). The nature and purpose of the post-mortem should be explained to the parents in understandable terms and they should be given a copy of the relevant literature.
- Suitable supportive information should be given to the parents in their bereavement. (See Appendix 1 & 2)
- It is important that normally, the parents and other close relatives are given an opportunity to hold and spend quiet time with their child. Professional presence should be discreet at this time.
- Many parents value photographs of their child taken at this time, along with mementoes such as handprints and a lock of hair. Only in very exceptional circumstances should mementoes not be taken i.e. when the death is being investigated as suspicious. In this circumstance the senior Investigating officer should be asked for approval.

The lead doctor/paediatrician together with the Police Officer, should take an initial history from the parents, still being supported by the allocated member of staff.

The paediatrician should then make a thorough examination of the child.

Broader safeguarding issues must be considered around other siblings especially where there is a twin.

Staff, at the **earliest** opportunity, should contact children's social care to ascertain whether the child is subject to a child protection plan or whether the child or other siblings are known to the service.

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

Within 24 hours of the child being admitted to A&E, communication with:

- Primary Care should be contacted, in particular the Health Visitor or School Nurse
- Community Midwives (if appropriate).
- Administrative systems in the Hospital and Primary Care need to be informed, to prevent routine appointments being sent out.
- General Practitioner
- Children's Services (Education & Children's Social Care)
- Formal Notification to the Co-Ordinator for Child Death Reviews

3.4 General Practitioner (GP)

The GP may be the first to be called in the event of a child's death or may be called by the Ambulance team. Resuscitation should be commenced if appropriate.

In the event of the child having been dead for some time, the GP will inform the police who will inform the coroner. The GP should also inform the consultant paediatrician on call to which the child will be taken.

When the death has been determined in the home by the GP, and the ambulance service is not used the approved undertakers should be contacted.

The GP will be involved in the ongoing support to the family in collaboration with other professionals.

GP's should ensure that accurate records are kept in case of court proceedings.

GP's should attend (where possible) the Information Sharing or Planning Meeting, (convened within 2 working day's of the child's death) or be prepared to share relevant information they have about the family or other children.

3.5 Primary Care Health Staff

(eg Community Midwife, Health Visitor, School Nurse, Community Children Nurses etc)

Community Health Staff who are involved with the family, should be informed within 1 working day of the child's death.

When the Information Sharing and Planning Meeting is convened (within 2 working day's of the child's death), they should be prepared to share any relevant information they have about the child(ren) and family.

Community Health Staff may be involved in a bereavement plan for the family.

Community Health Staff will carry out any health actions required for other children within the family.

4. The Role of the Police

The role of the Police when investigating an unexpected childhood death is defined as:

- To support the family during the very distressing time following their child's death.
- The protection of life, i.e. responsibilities to safeguard other siblings in the event of abuse or neglect.
- To assess whether or not any criminal offences may have taken place and work with the Crown Prosecution Service in cases involving potential prosecution of offenders.
- To work with partner agencies in establishing how and why the child died.

In any case of sudden, unexpected or unexplained infant/child death the police have a duty to investigate the death on behalf of the Coroner. The purpose of the investigation of such deaths is firstly to determine whether there is criminal involvement by any person. Every child who dies deserves the right to have its sudden and unexplained death fully investigated in order that a cause of death can be identified, and homicide excluded.

The Police response should be in accordance with the ACPO/NPIA Guidelines contained within the Murder Investigation Manual. The Kennedy Protocol endorsed these guidelines and will form the basis of actions to be undertaken.

It is important for police officers to remember that most unexpected child deaths will have been the result of natural causes. A proportion however are caused deliberately by violence or by maliciously administered substances, whilst others may be, at least in part, attributable to negligent parenting. Factors that raise suspicion may become apparent at any time during the process, from an early stage through to many months after the death. The difficulty faced by the Police in such investigations is to reconcile the traditional criminal investigation approach with the knowledge that the majority of these incidents do not involve a criminal act. Each case must be approached with an open mind, balancing the needs of the investigation with the needs of the bereaved family.

Police training necessarily focuses upon the need to secure and preserve evidence from the outset, as failure to do so may lead to a lost opportunity.

Working with agency partners is key to establishing a cause of death through securing and preserving information and evidence, whilst providing a sensitive and caring service to the bereaved family. If, at any point in the process, suspicion is raised that the child may have been murdered, the standard approach contained within these procedures should cease and a murder investigation should commence.

In all cases, irrespective of whether the cause of death appears to involve a criminal act, the Police can play a significant role in supporting the multi-agency investigation. A rapid response process will be initiated involving partner agency staff, working in close collaboration with the aim of establishing cause of death. A Detective Inspector familiar with these procedures, when available the DI Child Protection Unit, will be responsible for leading such investigations to ensure a consistently high standard of Police input.

Initial action

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

In most cases, the police will receive a call that the Ambulance Service has already taken the child to the Emergency Department and that resuscitation was unsuccessful. When a call is received by the police that an infant has been found lifeless, and has **not** been transferred to the Emergency Department, the first officers to be dispatched to the incident will often be uniform officers with little or no expertise in such investigations. Recognisance must be taken of the above paragraph. These first responders will be responsible for initiating the police response and taking immediate steps to meet the objectives outlined above.

Duties of first responders

If the Police are the first professionals to attend the scene ahead of Ambulance staff, urgent medical assistance should be requested as the first priority.

Upon initial attendance officers should take note of the environment in which the child was found, including noting the position and appearance of the child, which persons were present, the temperature of the room, any obvious hazards, and any signs of negligent care. It should be ascertained whether the child has been moved and careful consideration taken of any signs of injury.

The response must be expeditiously initiated. The Detective Inspector must be notified who will assume the role of Senior Investigating Officer (SIO), and

attend the scene as soon as possible. This officer will retain overall responsibility for the investigation.

In most cases the child will be transported to the local Accident and Emergency Department. If the police are aware of the case before the child has been taken to a hospital, then the child's body must be accompanied for the purposes of continuity of identification. It is recommended that the body should be taken to a casualty department rather than a mortuary, firstly to enable any chance of resuscitation and secondly to enable an early expert physical examination by a paediatrician.

An early record of events from the parent/carer is essential, including details of the child's recent health. This will enable appropriate actions to be conducted based on facts provided and initial scene assessments.

The Detective Inspector will be responsible for determining the appropriate involvement of other police resources depending upon the circumstances and any suspicions that may arise during initial assessment.

Scene Preservation

The SIO must ensure that scenes are identified and preserved. This will include the home address (or location where the child was prior to death) and the child. The preservation of the scene and the level of investigation will be relevant and appropriate to presenting factors.

It is important that officers secure the relevant address in a discreet manner, e.g.. a plain clothes officer in a plain vehicle placed at the address or family members leave the address and the premises are secured. This is particularly relevant when the child has been removed to hospital prior to Police attendance. The premises need to remain secure pending a decision by the SIO as to the timing of a home visit or other examination. This will be conducted by the SIO in conjunction with the Responsible Paediatrician. The primary reason for a home visit is to establish whether factors at the home address may have contributed to the child's death and this should be effectively communicated to the child's parents.

Whenever possible, and particularly in suspicious cases, a police officer should be present during the examination of the child, and should note the condition of the child, including hygiene, and any injuries or other findings reported by the medical staff. Police officers should work with the medical staff to ensure an appropriate chain of evidence when samples are taken for forensic purposes. Normally the clothing should remain with the child; however when clothing, nappies or equipment has been removed, this should be retained by the Police and separately bagged.

In most case, especially where there are not immediate suspicious circumstances, the family should be allowed to spend time with their child, with a member of staff present to supervise. The parents should be allowed to hold their child and the family or health staff should be allowed to take

photographs or mementos. These rarely interfere with any evidence gathering.

Forensic assessment of the scenes will be undertaken by Scenes of Crime Officers at the direction of the SIO. This will always include photographing and video recording of the house where the child collapsed. Room temperature should be taken and factors noted such as condition of accommodation, general hygiene and availability of food and drink. The collecting of bedding and clothing should be considered but only if there are signs of forensic value such as blood, vomit or other residues. Items administered to the child and their containers e.g medication and bottles, should be seized. It is important that, as far as possible, the environment is left as found on attendance to allow a joint examination of the scene to be undertaken with the Responsible Paediatrician. (Nappies and clothing should remain on the child but arrangements should be made for them to be seized at the hospital).

Subsequent Action

After making the necessary arrangements for scene preservation, the SIO will liaise with the Responsible Paediatrician at the hospital and other agencies to ensure that the protocol is put into effect.

In all cases where the child is taken directly to a hospital arrangements must be made for a consultant paediatrician to be informed of the child's death, in order that an appropriate examination of the body can be made. A physical external examination recorded by way of photographs should be undertaken by medical staff and police at the earliest possible stage in order to record any suspicious or unidentifiable marks.

Unless the death is viewed as suspicious a full history will be taken from the parents jointly by a Paediatrician and the SIO or nominee. This may be taken initially in hospital and supplemented at the home visit. The Paediatrician will usually take this first history, obtaining full and accurate details on the events preceding the child's death and events after discovery. If there are significant suspicions that the death may be unnatural, the suspect's rights must be protected and interviews conducted in accordance with PACE. In the event of the death being suspicious the SIO will decide upon the appropriate course of action, which may include the arrest of a suspect.

Consideration should be given to the carers being interviewed separately to avoid the possibility of each contaminating the others version of events. Clearly, someone who has knowingly killed a child is likely to lie to cover up for their actions so any conflicting accounts should raise suspicion. It must not be forgotten, however, that any bereaved person is likely to be in a state of shock and possibly confused. Repeat questioning of the parent/carer by different police officers should be avoided at this stage if at all possible. However, Officers should always consider the behavioural response of the parents and take particular note of inappropriate or unusual responses to child deaths, e.g. remoteness, insensitivity to circumstances, indifference to the death, disposal of articles.

Police officers will need to be mindful that medical staff will usually have taken a preliminary history at the hospital in an effort to establish the circumstances surrounding the child's collapse. Investigators should seek this account, as it may prove useful should a different version be provided later.

Following the initial meeting with the Paediatrician, the SIO will make themselves available to conduct a joint home visit with the Responsible Paediatrician, in order to gain a clearer understanding of how the child died.

Other Initial Actions

The SIO will ensure that the Coroner's Officer is notified of the child's death and the appropriate report completed.

Initial police action will also include the early checking of relevant systems/records. All internal police checks will be conducted immediately and other agencies e.g. Children's Services, Adult Services and Health, requested to check their relevant records. This should include, as appropriate, all family members who are deemed close to the deceased, e.g. parents, siblings, foster children, etc. Where there are child protection concerns these records will need to be secured.

Appointment of a Family Liaison Officer may be appropriate and should be considered in each case.

Where there is any suggestion of overlaying or neglect, consideration should be given to the request of blood samples from carers for alcohol/drug examination. This must be carefully deliberated by the SIO in relation to the status of the carers (suspects or otherwise) and issues around consent.

A full skeletal survey should be requested and this should be carried out and interpreted by a paediatric radiologist, to ensure the best possible result. It is important that the skeletal survey includes the whole body and that findings are made available to the pathologist.

In all cases, the police should request that a post-mortem is carried out by a Paediatric Pathologist. In any case where the death is suspicious, a forensic post-mortem must take place. This should be conducted by a Home Office Paediatric Pathologist or a Home Office Pathologist and Paediatric Pathologist. The investigating officer must give a full briefing to the pathologist(s), including showing of the video and photographs of the scene if available, and sharing of all information gathered thus far.

The SIO will attend the Information Sharing and Planning Meeting, which will take place at the earliest opportunity and include all relevant professionals. This responsibility applies in all cases where the cause of death is suspicious or unascertained. The meeting should be convened within 24 hours of the death by the SIO in association with the Responsible Paediatrician, relevant health professionals and Social Care professionals prior to the post-mortem

examination. This enables information to be shared between all relevant agencies, and for the ongoing management of the investigation and support to the family to be carried out in a planned manner. This should include details of previous or ongoing child protection concerns relating to the subject child and/or any siblings/children of the household. If any child protection concerns are identified, this meeting should continue as a formal strategy meeting under S47 of the Children Act 1989. The meeting will also consider information relating to any potential criminal acts and agree the conduct and timing of any criminal investigation.

Subsequent Action

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

As soon as possible, usually 4 months after the child's death, a multi-agency case review meeting will be held. The main purposes of this meeting are to establish where possible the cause of the child's death and any contributory factors; to plan for any ongoing care of the family; and to support and debrief all professionals involved in responding to the death. The SIO or nominee should always attend this meeting, even when there has not been a criminal investigation, so as to contribute to appropriate information sharing and joint working. If the death is subject of an ongoing criminal investigation, no such meeting should be held without the Police first seeking the views of The Crown Prosecution Service as to how and when the meeting should be held, what information may be shared and how the discussion should be recorded.

5. The Role of Warwickshire Children's Services

Warwickshire Children's Services and/or Adult Services may hold information in respect of a child/family and should share this information with the investigating Police Officer and/or the Responsible Paediatrician.

Requests for information 'out of hours' which may only contain basic information from the Child Protection database **must** always be followed up as soon as possible with further more detailed record checks during office hours.

When there is the sudden and unexpected, or unexplained death of a child, Children's Services must consider whether immediate further investigation is required to safeguard the welfare of siblings or other children in the household. Children's Services shall engage in this procedure even if not previously involved with the family.

Children's Services must check records on notification of an unexplained child death and ascertain what information is known or involvement there

has been with the deceased child, his siblings or the family and must consider whether:

- There is family referral history on Children's Services records.
- There has been contact with the Adult Social Care Services
- There is any relevant information from Educational and other LA Children's services relating to the child or family and
- the child or the family are known to other children's voluntary or community organisations

If the child and/or family are known to Children's Services (open or closed case) other than merely through school attendance at a local or other school or registered day care provider, the Operations Manager must inform the Assistant Head of Service, Safeguarding who should consider the need to

- Secure the file
- Ensure that no additional recording or deletion occurs
- Inform the Head of Service – Children in Need, Chair of the Warwickshire Safeguarding Children Board and the Director for Children, Young People and Families.

Where there are immediate child protection concerns, Children's Services will become involved in their role as the statutory agency, and will then become the lead agency for the welfare of the child(ren) whilst the Police will lead any criminal investigation. There may then be a particular need to ensure the protection of the remaining children in the family.

If the child who died was in the care of approved foster carers, care staff, school staff or registered childminders at the time of death, the same procedure applies with the additional need to inform the service manager responsible for looked after children / staff concerned and Ofsted / Government Office West Midlands.

A senior Children's Services representative will always be invited to the initial Information Sharing and Planning meeting and to the follow-up Case Review meeting. It is important to stress that the initial meeting could also move into a Strategy Meeting regarding the safety of any other children.

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

Where there are diverging views about the relevance of a previous unexplained death within a family of a child (normally under age two) practitioners should maintain an open mind and use normal analytical tools

in sifting relevant information in order to determine the likely risk of harm to other children in the future.

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

The Coroner must be informed after any unnatural or sudden death of unknown cause, and will order an investigation into the circumstances and cause of that death. After the death is pronounced, the Coroner has control of the body.

The Coroner's officer will inform the family of HM Coroner's roles and procedures and keep the family informed of the child's movements until the Coroner has signed release paperwork for the child at the opening of the inquest. **It is important this information is shared only by the Coroner's officer as any misinformation may cause additional distress to the family.**

As the legal authority charged with the investigation and certification of all unexpected deaths, the Coroner must be kept informed of all significant information obtained from the multi-professional communications and interviews with parents.

The post-mortem examination will be ordered by the Coroner, and should be carried out within 2 working days of the child's death (whenever possible) by a Pathologist with recent expertise and training in paediatric pathology. If "Significant Concern" has been raised about the possibility of neglect or abuse having contributed to the child's death, the paediatric pathologist should be accompanied by a forensic pathologist and a joint post-mortem protocol should be followed with the attendance of a Senior Investigating Police Officer. If at any stage during a post-mortem in the absence of a forensic pathologist the paediatric pathologist becomes concerned that the death may be a consequence of abuse, the procedure must be stopped. The examination should recommence as a joint procedure by a forensic pathologist together with the paediatric pathologist, in the presence of the Senior Investigating Police Officer or other designated Police representative. This is all subject to the Coroners overriding discretion.

Prior to commencing the post-mortem examination, the pathologist should be given a full written briefing on the history, a report from the radiographer relating to the skeletal survey and the physical findings at presentation, and the findings of the death scene investigation by the paediatrician and investigating Police Officer. In those areas where a video recording at the death scene has been made, it is very helpful for the pathologist to have the opportunity to view the video and discuss it with the paediatrician(s) and Police Officer prior to commencing the post-mortem examination. Other photographs of the child that may have been taken at presentation or in the A&E Department should also be made available. All subject to the Coroners overriding discretion and the pathologists professional judgement.

In all instances there should be where possible a full discussion between the consultant paediatrician and the pathologist both before and after the post-mortem examination to identify outstanding or unsuspected issues and to ensure accurate understanding of information.

The Protocols of the Royal College of Pathologists and the recent recommendations of the CESDI 2000 report, regarding post-mortem protocol in SIDS/SUDS/SUDI should be followed. All subject to the Coroners overriding discretion and the pathologists professional judgement.

There should be a policy in place with clear information to the family about what organs and/or tissue samples have been retained to allow discussion of options for disposal. The family's wishes regarding disposal must be made known to the pathologist and the Coroner.

A number of investigations should be arranged by the pathologist.

If the paediatrician has arranged any similar investigations before death, these must be made available to the pathologist and the Coroner prior to the post-mortem.

It is vital that all samples taken are properly labelled and exhibited and movement of exhibits should be closely controlled with a clear audit trail. Having agreed upon which samples are to be submitted for further examination, no further work should be commissioned on any of those samples, without prior discussion with the Senior Investigating Police Officer. The reason for this is to ensure that disclosure can be managed through careful control of exhibits and their movements.

A further multi-agency discussion, particularly with the paediatrician and the pathologist after the post-mortem is required to discuss any preliminary findings.

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

The final result must be notified in writing to the Coroner as soon as it is known. The final report should then be sent to the Coroner immediately the final result is known and in any event no later than seven days. With the prior consent of the Coroner, a copy of the post mortem report will also be sent simultaneously to the responsible Paediatrician (via designated Paediatric representatives for each area). This will ensure the final meeting is triggered and a final report is completed.

The report from the multi-agency local case discussion meeting should in all cases be sent to the Coroner, and in some instances the Coroner's Officer will choose to be present at this meeting. This report will ensure that, where the cause of death has been certified by the Coroner without an inquest, any new or more accurate information is appropriately notified to the Registrar of Births and Deaths for onward transmission to the Office for National Statistics.

For those instances in which the Coroner has ordered an inquest, the information from the local case discussion meeting will inform and assist the conduct of the inquest.

Where the information available to the Final Case Discussion shows that the death meets the international definition of sudden infant death syndrome (SIDS) i.e. *‘the death is unexpected, and remains unexplained after a careful review of the history, examination of the circumstances of death and the conduct of a full post-mortem examination to an agreed protocol’* – then the death should in all cases be registered as being due to SIDS. The medical cause of death and the conclusion is for the Coroner to decide, having regard to the evidence at the inquest.

Appendix 1

Pointers for all professionals in talking with bereaved parents

(taken from advice given by the Foundation for the Study of Infant Death)

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

Appendix 2

The Foundation for the Study of Infant Deaths

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

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

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

The help-line is also available for family and friends and those professionals involved with the death.

The Foundation has a wide range of leaflets and information for bereaved families and professionals. It also has a network of befrienders, who are bereaved parents. Arrangements can be made for a befriender to contact the bereaved family to offer additional support. A free phone card is available from the FSID for parents, to enable contact with The Foundation.

The Child Bereavement Trust – Training, information and support for professionals working with bereaved parents and children, especially babies.

01494 446648

Information and support line – 0845 357 1000

Child Death Helpline – a helpline for anyone affected by the death of a child, of any age, under any circumstances, however long ago. Helpline is staffed by parents who have experienced the loss of a child in the past.

Helpline available 7-10 pm every evening and 10am – 1pm, Monday, Wednesday and Friday. 0800 282986 (Freephone)

Winston's Wish – Winston's Wish Family Line offers support, information and guidance to all those caring for a child or young person who has been bereaved.

An interactive website is also available: www.winstonswish.org.uk

Family Line 0845 20 30 40 5 (available Mon – Fri 9.30 am – 4.30 pm)

General phone line – 01452 394377

A directory of local and national organisations who offer support on a variety of areas related to Bereavement, including organ donation and translation services, is available from the Child Death Review Manager, 01926 742279.

**Appendix 3
Local case Discussion: Avon Clinicopathological classification
of SUDI.**

Date of LCD meeting:..... Place of LCD meeting.....

Name:..... Date of Birth.....

Hospital Date of death.....

Hospital unit number..... Place of Postmortem:.....

Paediatrician Pathologist

GP HV

Police Child Protection officer

Others present at LCD meeting.....

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Not at LCD meeting but include in circulation of
report:.....

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Review of case management: any issues identified

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Review of ongoing support needs identified

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Avon Clinico-Pathological Classification System				
Classification →	0	IA	II	III
Criteria ↓	Criteria not collected	No factors / non-contributory factors	Possible/ Probable contributory factors	Explained
History				
Social				
<i>Infant medical</i>				
<i>Family medical</i>				
<i>Final events</i>				
Examination				
<i>External examination of child</i>				
Death-Scene Examination				
<i>Observation</i>				
Pathology				
Radiology				
<i>Toxicology</i>				
<i>Micro/Virology</i>				
<i>Gross pathology/ Histology</i>				
<i>Biochemistry/ Metabolic</i>				
<i>Other Investigations</i>				
Other criteria				
<i>Abuse/neglect</i>				
Services needed/provided				
<i>Specify ...</i>				
Overall Classification*				

* Equivalent to the highest classification in the grid

Brief explanation of specific notable/contributory or explanatory factors

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Appendix 4. LABORATORY INVESTIGATIONS

Note: After death is certified, the body is under the jurisdiction of the Coroner and complex investigations should be discussed with the Coroner first. Agreement for standard investigations may be arranged in advance.

Sample	Send to	Handling	Test
Blood cultures – aerobic and anaerobic 1 ml	Microbiology	If insufficient blood, aerobic only. May be obtained from femoral puncture. Do not attempt cardiac puncture	Culture and sensitivity
Blood	Haematology	Normal	Full blood count Consider carboxyhaemoglobin
Blood	Clinical chemistry	Normal	Electrolytes
Blood (serum) 1–2 ml	Clinical chemistry Spin,	store serum at – 20°C	Toxicology
Blood from Guthrie card (if available)	Clinical chemistry	Normal (fill in card; do not put into plastic bag)	Inherited metabolic diseases, carnitine
Blood (Lithium heparin) 1–2 ml	Cytogenetics	Normal – keep unseparated	Chromosomes (if dysmorphic)
Cerebrospinal fluid (CSF) (a few drops)	Microbiology	Normal	Microscopy, culture and sensitivity
Nasopharyngeal aspirate	Virology	Normal	Viral cultures, immunofluorescence and DNA amplification techniques*
Nasopharyngeal aspirate	Microbiology	Normal	Culture and sensitivity
Swabs from any identifiable lesions	Microbiology	Normal	Culture and sensitivity
Urine (if available)	Clinical chemistry	Obtain on filter paper by squeezing nappy Spin, store supernatant at–	Toxicology, inherited diseases

		20°C metabolic	
Urine (if available)	Microbiology	Normal	Microscopy, culture and sensitivity
Throat Swab	Microbiology	Normal	Microscopy, culture and sensitivity
Skin biopsy	Will need co-ordination with on-call pathology team	Unless autopsy will be done within 24 hours	Fibroblast culture
Liver biopsy	Will need co-ordination with on-call pathology team to process and freeze specimen	Usually done at autopsy, unless there is likely to be a significant delay	

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

Examination of child; points to consider:

- Injuries, bruising, petechiae
- Examination of fraenum and genitalia
- Lividity
- Retinal haemorrhage
- Enlarged organs or masses
- Systems examination
- Rectal temperature
- Skull palpation - fracture
- Other fractures
- Nutrition/growth
- Upon attendance at hospital note where blood has collected in the child's body, as this will give an indication of the child's position at the time of death. It is important this is noted as soon as possible.

Appendix 5. Tests undertaken by medical professionals.

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

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

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

Skin biopsy tissue culture within 24 hours.

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

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

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

Radiology – **skeletal survey**.

Investigations

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

Infections

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

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

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

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

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

consanguineous parents

older age at death (over 6 months)

previous infant death in family

history of hypotonia or developmental delay

hepatomegaly or hepato-splenomegaly.

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

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

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

Specimens required

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

dried blood spots directly from syringe onto Guthrie card

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

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

Skin biopsy for tissue culture at +4°C in viral culture medium. (See next page for detail.)

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

Forensic specimens – remember to maintain the chain of evidence

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

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

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

Others – FBC and blood for chromosomes especially if dysmorphic.

APPENDIX 6. PHYSICAL EXAMINATION

To be carried out by consultant paediatrician and CPT supervisor/manager – CSI to be utilised for photographs etc where relevant.

Physical examination carried out by:

- Rectal Temp (low reading thermometer) _____
Date/Time _____ and interval from death _____

- Full Growth Measurements Centile

length	_____	_____
head circumference	_____	_____
weight	_____	_____

- Retinal Examination

- State of nutrition and hygiene

- Marks, Livido, Bruises or evidence of injury – To include any medical puncture sites and failed attempts: **(Should also be drawn on body chart)**
 - NB: Check genitalia and back.
 - Check mouth: Is the fraenum of lips/tongue intact?

- **Further Details, observations and comments**

- List all drugs given at hospital and any interventions carried out at resuscitation

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- Document direct observation of position of endotracheal tube prior to removal

Date, Time

Signature(s)

Appendix 7 FREEDOM OF INFORMATION ACT AND DATA PROTECTION

Freedom of Information Act

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

Data Protection

Please refer to Appendix 6, of the Inter-Agency Child Protection Procedures, Information Sharing in Child Protection.