Do not print this manual or parts thereof as these are likely to become out of date. It will be updated regularly and the amendments will be available from the Safeguarding Children Board website.

****YOU MUST REFRESH THE SCREEN BEFORE READING TO ENSURE YOU HAVE SIGHT OF THE LATEST VERSION****

Stoke-on-Trent & Staffordshire Safeguarding Children Board

CHILD DEATH

SUDDEN UNEXPLAINED DEATH IN CHILDHOOD (SUDIC)

Section I 01

Version 2

Date 02/04/12

Joint Guidance Between Staffordshire & Stoke-on-Trent Local Safeguarding Children Boards

PART 10-C

WHEN A CHILD DIES

C – RESPONDING TO SUDDEN AND UNEXPECTED DEATHS IN CHILDHOOD - (INFANTS & CHILDREN UNDER 18)

DETAILED RAPID RESPONSE PROCEDURES

Implementation Date 1st April 2008

Joint Agency Guidance on behalf of

Staffordshire Local Safeguarding Children Board
Stoke-on-Trent Local Safeguarding Children Board

Key contributors in the writing of this guidance:

Child Death Review Planning Sub-Group

This guidance is based upon the earlier SUDI Protocol and has been revised by members of the Child Death Overview Panel.

CONTENTS

	Page
INTRODUCTION	**4**
GENERAL ADVICE FOR ALL PROFESSIONALS WHEN DEALING WITH THE FAMILY	**6**
INTER-AGENCY WORKING - BRIEF PROCESS MODEL	**7**
FACTORS WHICH MAY AROUSE SUSPICION	**14**
AGENCY GUIDELINES:	
AMBULANCE	**16**
GENERAL PRACTITIONERS/ POLICE SURGEON	**18**
HOSPITAL STAFF/HEALTH PROFESSIONALS	**19**
POLICE	**23**
CHILDREN'S SOCIAL CARE	**28**
HM CORONER and PATHOLOGIST	**33**
CONCLUSION	**35**
Appendices	
GUIDANCE FOR STAFF TAKING HISTORY	**37**
HOSPITAL BASED HEALTH STAFF - GUIDELINES FOR MANAGEMENT OF SUDDEN – UNEXPECTED DEATH IN INFANCY AND IN CHILDREN UNDER THE AGE OF 18	**39**
SEQUENCE OF EVENTS FLOW CHART	**47**
RAPID RESPONSE FLOWCHART	**48**
CONTACT DETAILS	**49**
THE FOUNDATION FOR THE STUDY OF INFANT DEATHS	**51**

BACKGROUND

1. Working Together to Safeguard Children (2010), Chapter 7, provides statutory guidance regarding procedures to be followed when a child dies. The following inter-agency guidance indicates the rapid response to be undertaken by a group of key professionals who come together for the purpose of enquiring into a evaluating each unexpected death of a child.

2. Processes for reviewing the deaths of all children to be undertaken by the Staffordshire and Stoke-on-Trent LSCBs are to be found at Part 10-E (Child Death Overview Panel Procedures).

These detailed procedures should be read in conjunction with: Part 10A - Overview Document Part 10B - Notification Part 10D - Brief Process Model for Rapid Response Procedures, Including Data Collection Requirements Part 10E - Child Death Overview Panel Procedures Part 10F - Standard Documents

INTRODUCTION

3. This document provides direction and guidance for professionals/ agencies involved in dealing with sudden, unexpected and unexplained deaths in all children under 18. In this guidance an unexpected death is defined as the death of a child that was not anticipated as a significant possibility 24 hours before the death, or where there was a similarly unexpected collapse leading to, or precipitating, the events that led to the death.

4. The guidance is not intended to be prescriptive but endeavours to provide guidance to practitioners who are confronted with these tragic circumstances. It gives an insight into the priorities of the professionals, in an attempt to promote a mutual understanding of each agency's role and responsibilities.

5. Every professional may have a different role to play in this process but we must not lose sight of our collective role – ie 'to pursue a collaborative inter-agency response with a view to establishing the precise cause of death'. In following the principles of this guidance we will ensure that the entire evidence gathering and information sharing processes are pursued in a sensitive, vigorous, and effective manner.

Aim of the guidance:

6. The aim of the guidance is to ensure that for every sudden and unexpected death of a child, the agencies:

- understand the reasons for a child's death and the factors, avoidable and otherwise, that may have contributed to it,
- attend to the needs of other children in the household, whilst providing sensitive care and support to all those affected by the death,
- preserve evidence at the place of death and any other relevant location,
- undertake full documentation of all interventions by paramedical and medical staff, including CPR prior to the certification of death,
- obtain a full medical history and a full review of all medical records by medical staff,
- hold a multidisciplinary case discussion to help consider any lessons learnt about how best to safeguard and promote children's welfare in the future,
- ensure referral of the death to the Child Death Review Panel of the Safeguarding Children Boards, who will hold information on all child deaths, explained and unexplained, that occur in children resident or visiting Staffordshire.

(See Part 10E of these procedures).

Definition of infant/child:

7. The principles of this guidance can in the main be applied to the unexpected and unexplained death of any child under the age of eighteen years.

8. Practitioners should remain aware of the need for increased awareness where the death of an infant occurs due to the potential for unlawful acts in relation to the deaths of infants being missed.

9. A thorough multi-agency enquiry will ensue in the event of any unexpected and unexplained child death. The older the child, the more likely it will be that death is suspicious because the probability of death by natural causes decreases with age.

Principles:

10. A sudden unexpected death is a very difficult time for everyone. The time spent with the family may be brief but actions may greatly influence how the family experiences the bereavement for a long time afterwards. A sympathetic and supportive attitude whilst maintaining professionalism towards the investigation is essential. Enquiries and investigations should keep an appropriate balance between forensic and medical requirements and the family's need for support. The following principles should therefore be adhered to by all agencies:

- Sensitivity, open mind and balanced approach.
- Recognition of cultural needs.
- An inter-agency response.
- Sharing of information.
- Appropriate response to the circumstances.
- Preservation of evidence.
- Good record-keeping.

11. Children with a known disability or medical condition should be responded to in the same manner as other children.

GENERAL ADVICE FOR ALL PROFESSIONALS WHEN DEALING WITH THE FAMILY

12. This is a very difficult time for everyone. The time spent with the family may be brief but actions may greatly influence how the family deal with the bereavement for a long time afterwards. A sympathetic and supportive attitude whilst maintaining professionalism towards the investigation is essential. Families should be treated with sensitivity, discretion and respect at all times and professionals should approach their enquiries with an open mind.

13. Remember that people are in the first stages of grief. They may be shocked, numb, withdrawn or hysterical.

14. All professionals must record history and background information given by parents/carers in as much detail as possible. The initial accounts about the circumstances including timings must be recorded verbatim.

15. It is entirely natural for a parent/carer to want to hold or touch the dead child. Providing this is done with a professional (such as a police officer, nurse or social worker) present, it should be allowed in most cases, as it is highly unlikely that forensic evidence will be lost. If however, the death has by this time been considered suspicious, the appropriate Senior Investigating Officer should, where possible, be consulted before a parent/carer is allowed to hold the child.

16. The child should always be handled as if he/she were still alive, remembering to use his/her name at all times as a sign of respect and dignity.

17. All professionals need to take into account any religious and cultural beliefs which may impact on procedures. Such issues must be dealt with sensitively but the importance of the preservation of evidence should not be forgotten.

18. The parents/carers should be allowed time to ask questions about practical issues, this includes telling them where their child will be taken and when they are likely to be able to see him/her again.

19. Where possible, written contact names and telephone numbers should be given.

20. In unexplained child death cases it is likely that an inquest will be conducted by HM Coroner to establish the cause of death.

21. Staff from all agencies need be aware that on occasions, in suspicious circumstances, the early arrest of the parents/carers may be essential in order to secure and preserve evidence and thus effectively conduct the investigation. Professionals must be prepared to provide statements of evidence promptly in these circumstances.

INTER-AGENCY WORKING - BRIEF PROCESS FOR RAPID RESPONSE PROCEDURES

22. Unexpected death in childhood is often a natural tragedy and a priority for all involved in the investigation of such deaths must be the appropriate care of the bereaved family, even in those circumstances in which the child’s death has occurred as a consequence of neglect or abuse. There is nothing to be gained by insensitive behaviour from involved professionals.

BRIEF PROCESS - PHASE 1
USUALLY 0-5 DAYS
RAPID RESPONSE

Ambulance Crew

23. Ambulance staff will usually attempt resuscitation and will take contemporaneous notes of their involvement and observations. The child will usually be transported to the local Accident and Emergency Department.

Child who is taken to Hospital/Dies Unexpectedly in Hospital

24. A child who is confirmed dead in the community will usually be transported to A&E for further assessment. The professional confirming the death will inform the DDUD.

25. Child will be examined by the on-call consultant paediatrician.

26. A detailed history of events will be taken from the parents/carers. For SUDIs see first interview/Home Visit data check list at Part 10-G.

27. A check to the child protection register/successor database re: children subject to a child protection plan will be made.

28. Where the cause of death is uncertain, investigative samples should be taken upon arrival at the hospital and after the death is confirmed. These should be agreed in advance with the coroner. For all children up to 2 years a skeletal survey should be undertaken.

29. When the baby/child is pronounced dead, the consultant clinician involved will inform parents, explaining to them the requirement for contact to be made with the Coroner, the Police and with Children's Social Care.

30. The consultant clinician involved with contact:

- the Coroner
- the Police
- the Designated Paediatrician for unexpected deaths in childhood (DDUD).

In All Cases where a Child has Died Unexpectedly

Information Sharing/Planning - Case Discussion 1

31. The DDUD is responsible for co-ordinating the multi-agency response.

32. The DDUD or their representative informs the Coroner, the Police, the on-call paediatrician, Children's Social Care, the Health Visitor/School Nurse to initiate an immediate information sharing/planning discussion

between the lead agencies - (Police, Health, Children's Social Care). This will usually occur on the telephone and may be a series of discussions.

33. As soon as is possible the DDUD will inform the Central Point of Contact (Child Death Overview Panel Co-ordinator) of the death via telephone, following up by forwarding Form A - Notification of a Child Death. They will further inform the relevant Director of Public Health.

34. Children's Social Care may, at this point, have already been contacted by A&E/The Police, dependent upon the circumstances of the case. They should make checks to the CPR/successor database recording children subject to a child protection plan for the deceased child, surviving siblings and any child living in the same household. The client information system should be checked in relation to the deceased child, survising siblings, any children living in the same household, parents, carers and other relevant adults.

35. All cases regarding unexpected death in childhood should be allocated to a Safeguarding Team within Children's Social Care, unless a caseholding social worker is in place. Depending upon the circumstances of the death, CSC involvement may be brief, making case closure after the immediate information sharing discussion appropriate. Case closure should be agreed with the DDUD and the Police.

36. The need to invoke the child protection procedures in relation to surviving siblings should be given immediate consideration by Children's Social Care.

37. If the child has died away from home, contact with other LAs should be undertaken by Children's Social Care.

38. For deaths in hospitals the Trusts serious incidents protocol should be triggered. Deaths in custodial settings should result in liaison with the Prisons and Probation Ombudsman.

39. This information sharing/planning discussion should agree what should happen next and who should do what. It should confirm the lead health/police/social care professionals to aid subsequent contacts. Urgent contact should be made with other agencies involved and this will normally be undertaken by Children's Social Care on behalf of involved agencies.

40. The purpose of this meeting/discussion will be:

- **For each agency to share information from previous knowledge** of the family and records. In particular any reference to the circumstances of the child's death, previous or ongoing child protection concerns, previous unexplained or unusual death in the family, neglect, failure to thrive, parental substance abuse, mental illness or domestic violence. Information is also required about family members and others involved with the child.

- **To collate all relevant information** to share with the pathologist and to update the CORE DATA SET (Form B's).

- **To plan any subsequent Joint Agency Investigation**, including the means for reviewing actions and in meeting identifiable time-scales.

- **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 in relation to surviving children. To consider the need for any other action e.g. health overview for any other child in the family.

- **To ensure appropriate support is provided to the family, including a co-ordinated bereavement care plan.**

- **Agree a mechanism for managing any potential media interest.**

- **To consider staff welfare and support.**

41. Professionals invited to the case discussion will include:

- **Health –** The DDUD in Childhood, the Consultant Paediatrician, doctor confirming death, GP, Health Visitor or School Nurse, Designated and/or Named Nurses for Child Protection.

- **Children's Social Care –** a senior manager of at least Team Manager/Team Co-ordinator status from the relevant Children's Social Work Team, where there are child protection concerns about the deceased child or surviving siblings, and/or the caseworker allocated to the family.

- **Police –** The Senior Investigating Officer (SIO) and a representative from the Child Abuse Investigation Unit, or appropriate representation from the Police in line with the allocated SIO.

- **Other Professionals –** Ambulance service, Police Family Liaison Officer, Coroner's Officer (Coroner will always be invited), Pathologist, Education representative, and any other relevant interested professional.

42. If a strategy meeting is required regarding surviving siblings this should occur as soon as possible and always within 72 hours. Immediate actions to protect surviving siblings may be required.

43. The police will undertake an investigation on behalf of the coroner in accordance with ACPO guidelines regarding the sudden or unexpected death of a child. On many occasions these investigations will be undertaken by divisional or other specialist staff other than members of the Child Abuse Investigation Unit (CAIU), albeit CAIU staff will be available for consultation and advice at all times.

44. The coroner is likely to order a post-mortem and a report of all information collected must be included in a report to the coroner. Completion of this action will be co-ordinated by the senior investigating officer, with overall responsibility for investigation into the death.

45. The senior investigating police officer/DDUD, will decide if a home visit is needed when children have died unexpectedly in a non hospital setting, who should be involved in this visit and when it will occur.

46. Such a visit should occur within 24 hours of the death and should always be considered for sudden infant deaths.

47. For most unexpected child deaths the Coroner will order a post mortem examination.

48. The DDUD will continue to collect information and share this with the pathologist and the coroner.

49. The Police Officer in Charge should ensure that a report of all known information is provided to the Coroner within 28 days.

DATA COLLECTION - CORE DATA SET FORM B - AGENCY REPORT FORM (SEE PART 10-G) During this initial stage all agencies should start to complete Form B with information they hold. The CDOP Co-ordinator will collate all Form B's upon completion of agency involvement.

BRIEF PROCESS - PHASE 2
USUALLY 5-7 DAYS

Case Discussion 2 - Following the Preliminary Results of the Post Mortem Examination Becoming Available

50. The DDUD is responsible for co-ordinating this case discussion, between the DDUD, the pathologist and senior investigating police officer. The Coroner should be informed of the initial results and Children's Social Care should be updated.

51. The discussion may be conducted via telephone. More complex cases may require the DDUD to convene a meeting of involved professionals.

52. This discussion may trigger a child protection referral for surviving siblings or referral for a potential serious case review.

DATA COLLECTION - CORE DATA SET FORM B - AGENCY REPORT FORM (SEE PART 10-G) FORMS B2-B11 During this second stage all agencies should continue to populate their own agency copy of Form B. The DDUD should ensure completion of any relevant supplementary Form B2-B11 specific circumstance recording forms (See Part 10-G).

FORM B COLLATION Each agency should complete Form B (it is not expected each agency will complete all parts) and forward it to the CDOP Co-ordinator who will collate the Form B into one document in advance of the Final Case Discussion.

BRIEF PROCESS - PHASE 3
USUALLY 8-12 WEEKS

Case Discussion following the Final Results of the Post Mortem

53. This should generally be an actual meeting which the DDUD is responsible for convening. Those professionals involved with the child/family and those reviewing the death should be invited.

54. Possible attendees will include:
    DDUD
    GP
    Health Visitor/School Nurse
    Paediatrician/s
    Pathologist or Pathology Report
    Police Senior Investigating Officers
    Coroner or Coroners Officer
    Social Worker (where relevant)

55. The purpose of this meeting is to:

- share information to identify the cause of death/contributory factors
- plan future care of the family
- inform the inquest
- identify potential learning
- explicit discussion of abuse/neglect causing or contributing to the death
- agree process for sharing detailed information about the cause of death
- agree the provision of ongoing support to families, including how parents will be informed about the outcome of the meeting.

56. The results of the post mortem examination should be shared with the parents and this should be arranged by the DDUD. This sharing must be consistent with the requirements of the Coroner and Police enquiries.

DATA COLLECTION - CORE DATA SET FORM'S B-B11 - The CDOP Co-ordinator will make a collated Form B available for this final case discussion.

DATA COLLECTION - ANALYSIS PROFORMA FORM C - (See Part 10-G) The group of professionals called together by the DDUD for the Final Case Discussion should complete Form C - Analysis Proforma.

DATA COLLECTION - AUDIT TOOL FOR RAPID RESPONSE FORM D - (See Part 10-G) The group of professionals called together by the DDUD for the final case discussion should complete Form D - Audit Tool for Rapid Response.

DATA COLLECTION - POST MORTEM INFORMATION FORM B11 - SUMMARY OF POST MORTEM FINDINGS This form should be presented to/forwarded to the Final Case Discussion from the Pathologist

57. All minutes and data collection sets from this final case discussion should be forwarded to the Child Death Overview Panel Co-ordinator and the Coroner.

58. If Children's Social Care have continued as contributors to all 3 stages, the file of the deceased child should be closed at this point if ongoing support services are not required by the family. Cases of surviving siblings may need to remain open.

DETAILED AGENCY GUIDANCE TO SUPPORT THE BRIEF PROCESS MODEL

FACTORS WHICH MAY AROUSE SUSPICION

59. There are certain factors in the history or examination of the child which may give rise to concern about the circumstances surrounding the death. If any such factors are identified, it is important that the information is documented and shared with senior colleagues and relevant professionals in other key agencies involved in the investigation. A list of such factors has been produced. The list is not exhaustive and is intended only as a guide.

- **Previous apparent life threatening events.**

- **Previous frequent hospital admissions.**

- **Previous/current child protection concerns within the family relating to the child or siblings.**

- **Inappropriate delay in seeking help.**

- **Inconsistent explanations.**

  The account given by the parents/carers of the circumstances of death should be documented verbatim. Any inconsistencies in the story given on different occasions should arouse suspicion, although it is important to bear in mind that some inconsistencies may occur as a result of the shock and trauma caused by the death.

- **Evidence of Drug/Alcohol Abuse**

  Including noting if the parents/carers are still intoxicated.

- **Evidence of Parental Mental Health Problems**

  It must be remembered that parents will be very distressed and an immediate assessment of any previous mental health difficulties may not be possible. However, a history of confirmed mental health problems would require further assessment.

- **Unexplained injury**

  An examination of the child should seek to establish the presence or otherwise of unexplained bruising/burns/bite marks, especially multiple bruises etc to the; face, ears, limbs, trunk and mouth, particularly the fraenulum – ie the narrow fold of mucous membrane preventing the lips from moving too far away from the gums which can be torn through such actions as force feeding.

  Explanations as to how the injuries occurred should be placed under detailed scrutiny when:

  (a) The explanation changes with time or questioning.

(b) The ‘accident’ was beyond the child’s development, eg under 8 months children are not usually walking and therefore do not fall over unaided. They can of course fall from height.

(c) The injuries are burns, scalds, bite marks or injuries to bone.

- **Bruising in babies under 6 months**

  All bruising in babies under 6 months should be scrutinised.

- **Petechial haemorrhages**

  These may or may not be present with suffocation and absence is not conclusive either way but their presence should be noted and discussed with the Paediatrician or Pathologist.

- **Neglect Issues**

  Observations about the condition of the accommodation, general hygiene and cleanliness, the availability of food, adequacy of clothing and bedding and temperature of the environment in which the child is found are important. This will assist in determining whether there may be any underlying neglect issues involved.

- **Concealed births**

  These types of deaths normally involve very young or disturbed mothers giving birth ‘unknowingly’ until the onset of labour or in secret. A crucial part of any such investigation will be to establish whether the infant ever had an independent existence from the mother.

  (In cases such as these prosecutions may not always be appropriate and the CPS should be consulted where there are concerns that the mother did not fully understand the nature and quality of her actions.)

Factors which are found in most sudden *infant* deaths:

60. It is equally important, especially for non-medical professionals, to recognise that other significant presenting factors, in isolation should not arouse suspicion. The following factors are commonly found in sudden infant deaths:

- Froth emerging from the mouth and nose. This froth results from the expulsion of air and mucus from the lungs after death. Sometimes the froth may be blood stained – this does not mean that the death was unnatural;

- Small quantities of gastric contents around the mouth. This does not mean that death was caused by inhalation of vomit. Often there is slight regurgitation immediately after death;

- Purple discoloration of the parts of the face and body that were lying downwards. This is not bruising, but is caused by the draining of blood in the skin after death. For the same reason the parts that were lying upwards may be very pale;

- Covering of the child's head by the bedclothes has often been a feature of cot death in the past, and probably contributes *to* death through accidental asphyxia or overheating;

- Wet clothing or bedding (this is usually caused by excessive sweating before death);

Additional point of note

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

AGENCY GUIDELINES

AMBULANCE STAFF:

61. Immediate notification to the police is required by the ambulance service when they are called to the scene of an unexplained child death.

62. The recording of the initial call to the ambulance service should be retained in case it is required for evidential purposes.

63. Ambulance staff should follow their national training manual as follows:

- Do not automatically assume that death has occurred.

- Clear the airway and if there is any doubt about death, apply full CPR.

- Take note of how the body was found – position, clothing etc.

- Inform the accident and emergency department giving estimated time of arrival and patient's condition.

- Transport the child to the accident and emergency department (and not straight to the mortuary).

- Pass on all relevant information to the accident and emergency department.

- Consider and take note of if any injury is compatible with the history given.

64. The first priority of all persons attending the scene is the preservation of life. The primary role of the ambulance staff will not be compromised by any other professional at the scene.

65. It is recognised that most cases are not criminal in nature and unless death of the child is apparent the ambulance crew will attempt resuscitation and take the child direct to the accident and emergency department. This should be the normal sequence of events; however, it is quite conceivable that confirmation of death could be conducted at the scene without transport to hospital. This is particularly possible where death can rapidly be confirmed due to severe injuries incompatible with life in accordance with the guidelines issued in this respect by the Joint Royal Colleges Ambulance Liaison Committee.

66. The option of rapid transport to hospital in the situation of resuscitation must be left to the discretion of the ambulance crew. However, this is not an option in cases where death has occurred and the circumstances are suspicious – in which case, the body should only be removed with permission of the Coroner.

67. Ambulance staff will remain alert to the role of other professionals and, if first on the scene, will note the position of the child, the clothing worn and the circumstances of how the child was found.

68. If the circumstances allow, note any comments made by the carers, any background history, any possible drug/alcohol misuse and the conditions of the living accommodation. Any such information must be passed on to the receiving Doctor and the Police.

69. Any suspicions should also be reported directly to the Police and to the receiving Doctor at the Hospital as soon as possible.

70. The passing of information to the Police or Hospitals does not breach patient confidentiality as it is done in the interests of the parties concerned (ie other siblings or future children).

GENERAL PRACTITIONERS/POLICE SURGEON:

71. There are times when a GP is called to the scene first. In such circumstances they should adhere to the same general principles as for the ambulance staff.

72. It is important for the GP to contact the police or Coroner's office if they are the first on the scene (taking into account the primary responsibility of saving life/confirming death). It is advised that the best route for this is to contact the police control room. This should be done through the Police Area Control Room.

73. As with all sudden deaths, when the child has not been removed from the scene, a doctor must attend to confirm death. When the circumstances are obviously suspicious this must be a Police Surgeon. If at hospital, then the resident doctor will confirm death.

74. The GP and/or Police Surgeon has the responsibility to record the history and background information and to share this information at any subsequent discussion.

75. The GP and/or Police Surgeon confirming the fact of death should consult the designated paediatrician with responsibility for unexpected deaths in childhood, who will ensure that relevant professionals (ie the Coroner, the police and LA children's social care) are informed of the death. This task may be undertaken by a person on behalf of the designated paediatrician. This will ensure the correct response under the terms of this guidance. Ensure other professionals contacted are provided with the name of the designated doctor with responsibility.

The Designated Doctor for Unexpected Deaths in Childhood for South Staffordshire is:

Dr Azhar Manzoor
Queen's Hospital
Belvedere Road
Burton On Trent
DE13 0RB
Telephone: 01283 511511 Ext 4360
Mobile: 07951 924576

The Designated Doctor for Unexpected Deaths in Childhood for North Staffordshire is:

Dr Martin Samuels
Academic Department of Paediatrics (Ward 87, CGH)
University Hospital of North Staffordshire
Stoke-on-Trent
Staffordshire
ST4 6QG
Telephone number: 01782 552832
Fax: 01782 553478
Mobile: 07710 673965

Dr Alex Tabor
Consultant Paediatrician
Academic Department of Paediatrics
University Hospital of North Staffordshire
Ground Floor Annexe Norton Unit (City General Site)
Stoke-on-Trent
Staffordshire
ST4 6QG

Tel: 01782 552832
Fax: 01782 553 478
Mobile: 07712 632322

76. Additional guidance for GPs and health visitors, particularly in relation to the longer term care of the family, can be obtained from two Foundation for Sudden Infant Deaths publications:

    'Guidelines for GPs when 'cot death' (SIDS) occurs'
    and
    'Guidelines for health visitors when 'cot death' (SIDS) occur'

    Whilst these booklets are written specifically for dealing with 'cot deaths' (SIDS), many of the principles will apply to other child deaths. The SSCB guidance on child death review panels at Part 10E of these procedures should also be viewed as necessary.

77. The family and possibly the GP/Police Surgeon attending the scene will be notified of the multi-agency case discussion to ensure appropriate representation. The GP and Paediatrician should liaise regarding any follow up consultation required with parents.

<u>HOSPITAL STAFF/HEALTH PROFESSIONALS</u>:

Initial action:

78. Detailed guidelines for Accident & Emergency and Paediatric staff are included at Appendix 'A'. More general guidance for the benefit of all professionals is as follows:

79. As soon as the Emergency Department is notified that the ambulance crew is attending the scene of an infant/child death the nurse in charge must notify:-

- The on-call Paediatric/Resuscitation Team.
- The on-call Paediatric Consultant.
- The on-call Emergency Department consultant.
- If available, the Designated Doctor for Unexpected Deaths in Childhood (DDUD).

80. If there is any doubt about the duration of the collapse, full resuscitation must be commenced.

81. The identity of the people present and their relationship to the child needs to be ascertained. Attention should be paid to their general demeanour and initial responses.

82. To identify the possible cause of death a detailed history should be obtained. The first history is extremely important and ideally should be obtained by an experienced paediatrician. The comments of carer/parents must be recorded in detail at all stages by health professionals in case of future discrepancies or if suspicious circumstances develop.

83. All items of clothes/bedding must be retained for subsequent examination. They may not be returned without prior consultation with the Coroner. Such items may also be required by the Police Scenes of Crime Officer, dependent upon the level of suspicion/concerns surrounding admission.

84. Samples will need to be taken prior to and following death. (See Appendix B). The hospital must ensure that all results of pre-mortem tests are forwarded to the examining pathologist. Following death, samples will only be obtained with the Coroner's permission. (Each hospital will need to be aware of their local Coroner's position on taking specimens.)

85. If the child is **dead on arrival** at hospital or when death is confirmed, the attending doctor should speak directly to the Coroner (or Coroner's Officer).

86. If the child is dead upon arrival at the hospital or subsequently dies from an unexplained death, the hospital must immediately check that the police have been notified. Contact should be made with the Police Area Control Room.

87. A skeletal survey should always be carried out and reported by a paediatric radiologist for children up to the age of 2 years. Where there are suspicious circumstances this should be discussed with the Coroner and/or Police.

Subsequent action:

88. Notes of previous hospital, Obstetric, Emergency Department attendances must be obtained. The Child Protection Register (successor database) should also be checked for the child, any siblings and other children in the household. The attending Consultant Paediatrician should prepare if possible, a detailed report for the pathologist in readiness for the post mortem and liaise with the designated paediatrician(s) for child deaths about reviewing all other medical information in relation to this child and other household members.

89. Other professionals also need to be informed. This should be done in consultation with the NHS Trust checklist. If the circumstances are suspicious this should be done in conjunction with the Police.

90. A detailed history should be obtained as sensitively as possible during resuscitation and as appropriate afterwards. Detailed records including who is present and what was said should be made. The Paediatrician should obtain background information including a full medical history, a family history, siblings, history of any other infant deaths and concerns regarding this incident or previous incidents.

91. Aspects of the history will have to be obtained at various stages by different professionals; this is especially important in the administration of medical support. Taking the history is a good opportunity for professionals to make an assessment of the veracity of the carers' story as well as their demeanour and attitude. The professionals responsible for speaking to the carers will, in the first instance, be dictated by circumstances. In the majority of cases this is likely to be the most senior paediatrician but in apparent cases, of child abuse, providing circumstances allow, it will probably be the Police.

92. Hospital staff may wish to supply bereaved parents with a lock of hair, or foot or handprints. This must be with the Coroner's permission. Police should only object to these considerations if there is good reason to believe it would jeopardise the investigation, and it is highly unlikely that this would be the case.

93. Unless the circumstances of death are suspicious the parents/ carers/family members should be allowed to see and hold their child whilst discreetly accompanied by a professional. The Record must be maintained continuously by the professional in attendance.

94. If there is any lack of agreement between medical staff and the police about the handling of the body then the Coroner's Officer must be

informed at once in order that the Coroner can decide on the appropriate course of action.

95. It will be necessary to explain to the parents or carers that the Coroner has to be informed and that a post-mortem will be necessary to try to discover the cause of death. The paediatrician will also explain that tissue blocks including frozen samples and slides will be taken and will be retained permanently as part of pathology records. However larger tissue samples or whole organs will not ordinarily be retained. Parents should be further advised that according to statutory procedures Children's Social Care will also be informed of the child's death to ensure full information sharing.

96. The paediatrician should speak directly to the Coroner or Coroner's Officer. If the circumstances are suspicious this should be done in conjunction with the Police.

97. The comments of parents/carers must be recorded by health professionals in detail in case future discrepancies or suspicious circumstances develop.

98. The child's body should not be left unattended until in the mortuary. When the child's body is taken to the mortuary, a professional should be present. It is not essential for the police to undertake the role.

99. As soon as possible after the child's death, the Designated Doctor for Child Deaths (DDUD) and Senior Investigating Police Officer, accompanied by the family's GP or Health Visitor (School Nurse) if possible, should visit the family at home or at the site of the child's collapse or death (which may not have occurred in the family's home) to talk through in great detail the events leading up to the infant's death and to carry out a very careful and systematic examination of the site of the infant's death. They should again emphasise the routine nature of the visit and the purpose of the investigation as trying to find out the cause of death. Consideration however should be given to the appropriateness/helpfulness of family participation in visits to some death scenes (eg in the case of a fatal road traffic accident).

100. After the home visit and 'death scene' investigation, the Senior Investigating Police Officer, the Designated Doctor for Child Deaths (DDUD), the GP and Health Visitor (School Nurse) should, further review any significant concerns that may have arisen about the possibility of neglect or abuse having contributed to the infant's death. If significant concerns have been raised, the police may institute a 'crime scene' investigation at this stage, but this is rarely necessary or appropriate.

101. The Health Visitor's (School Nurse) role will be largely dictated by the age of the child and presence of other siblings. Dependent upon the level of contact with the family it is likely that the Health Visitor will have amassed a great deal of information relevant to the child's death. Early liaison with the Health Visitor must, therefore, be established as soon as possible. The Designated Nurse for Child Protection will be responsible for co-ordinating all Health Visitor involvement.

102. The Designated Doctor for Unexpected Child Deaths should convene a further multi-agency discussion (usually by telephone) very shortly after the initial post mortem results are available (usually within 5-7 days of the death). The Police, Children's Social Care, the pathologist, paediatrician and other involved professionals should be party to this discussion.

103. Following the final results of the post mortem examination becoming available the Designated Doctor for Unexpected Deaths in Childhood (DDUD) should convene and chair a case discussion meeting. This should involve those professionals who knew the child and family and those involved in investigating the death. The main purpose of this case discussion is to share information to identify the cause of death and/or those factors that may have contributed to the death and then to plan future care for the family. The Child Death Review Panel Co-ordinator should ensure that agencies at the final case discussion are provided with a collated form B.

POLICE:

104. It is important for Police Officers to remember that for most unexplained child deaths, death will have been the result of natural causes. Their actions therefore need to be a careful balance between consideration for the bereaved family and the potential of a crime having been committed. It should also be recognised that strands of any subsequent investigation may differ due to factors such as the age of the child, circumstances of the death (SUDI, Road Traffic Collision, Drugs related, accident self harm or apparent suicide). *Close and early liaison needs to occur in every case between the Senior Investigating Officer and the Senior Paediatrician/DDUD.*

105. In any case of sudden, unexpected and 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 their sudden and unexplained death fully investigated in order that a cause of death can be identified, and homicide excluded.

106. If the police are the first professionals to attend the scene then urgent medical assistance should be requested as the first priority.

Who should attend?

107. Dependant upon the circumstances of the death police attendance should be kept to the minimum required. Several Police Officers arriving at the scene can be distressing, especially if they are uniformed officers in marked police cars.

108. This however will clearly be dictated by the manner and circumstances of the death, ie it may be appropriate and indeed essential for the safety of others for numbers of officers to attend (ie RTC).

109. A Detective Inspector who should be familiar with this guidance must immediately take charge of the investigation in all cases of sudden unexplained child deaths, whether or not there are any obvious suspicious circumstances. This Officer should also attend the scene. If, in exceptional circumstances, the Detective Inspector is unable to immediately visit the scene, he/she must ensure that a suitably experienced Detective Sergeant attends and reports directly to the Detective Inspector. Any delegation of duties to other Police ranks should be approved by the Detective Inspector.

110. The Detective Inspector or designated Senior Investigating Officer 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. This will include:

- Where applicable, liaison with, and/or attendance of a Child Abuse Investigation Unit Officer. This should be arranged through the Duty Officer in the area control room or the designated Senior Investigating Officer. In the case of older children it may be more appropriate for investigation by divisional and/or CID staff and this should be a consideration of the designated Senior Investigating Officer attending.

- Notification and attendance of a Scenes of Crime Officer. First contact should be made with the Senior SOCO on duty who will decide who to resource to the scene(s). Other consideration may be members of the Accident Investigation Unit (AIU) or other appropriate specialisms as required.

- Liaison with a Senior Investigating Officer (SIO) from the Major Investigations Unit (MIU), who should also attend the scene in suspicious cases. In the case of a fatal non stop Road Traffic Collision a SIO should take responsibility, in other road traffic related deaths it will be the responsibility of a suitably trained SIO in this area.

- Consideration of attendance/early involvement of a Family Liaison Officer which may also be appropriate under certain circumstances.

111. The police officer in charge of the investigation will also be responsible for considering the attendance of and/or early notification to other professionals:

- Attendance of a doctor to confirm death (when the body has not been removed from the scene). This must be a Police Surgeon if the circumstances are suspicious. If at hospital, then the resident doctor will certify death.

- The Coroner's Officer must be notified as soon as possible. In exceptional circumstances, the Coroner and/or pathologist may find it necessary to visit the scene.

- Some paediatricians are willing to attend the scene and assist the investigating officer to establish the likely cause of death. In any event early liaison with the paediatrician is essential. The post of the Designated Doctor for Unexpected Deaths in Childhood (DDUD) is being developed.

- Liaison with Children's Social Care to ensure that appropriate records are checked. This should normally be carried out by a member of the Child Abuse Investigation Unit. This would be facilitated out of hours through the Duty Officer or the Central Referrals Unit in duty time.

Initial action:

112. The provision of medical assistance to the child is obviously the first priority. If an ambulance is not already in attendance then one must be immediately requested unless it is absolutely clear that the child has been dead for some time. If this is the case then a Doctor will need to be called to confirm death. This will be a Police Surgeon if there are any overt suspicions as to the cause of death.

113. With regard the attendant circumstances and safety considerations the first Officer at the scene must make a visual check of the child and its surroundings, noting any obvious signs of injury. It must be established whether the body has been moved and the current position of the child should be recorded. All other relevant matters should also be recorded – the SIO in attendance is responsible for ensuring this is done.

114. An early record of events from persons present at the scene or time of the death and in many cases this will be the parent/carer is essential, including details of the child's recent health. The paediatrician usually takes this first history at the hospital; they will obtain a full and careful history from the parents/carers, on the events preceding the child's death and events after the discovery of the death.

115. Consideration should be given to the parents/carers/persons present being interviewed separately to avoid the possibility of each contaminating the others version of events. Clearly, someone who has knowingly killed a child or been involved in any way with the suspicious death of that 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 or significant witness is likely to be

in a state of shock and possibly confused. Repeat questioning by different police officers should be avoided at this stage if at all possible. However, Officers should always consider the behavioural response of those concerned and take particular note of inappropriate or unusual responses to child deaths, eg remoteness, insensitivity to circumstances, indifference to the death, disposal of articles.

116. 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 (where the circumstances are such). Investigators should seek this account, as it may prove useful should a different version be provided later. (See Appendix A relevant for anyone taking a history Consultant Paediatrician/ SUDI Paediatrician/ Police Officer)

117. The preservation of the scene and the level of investigation will be relevant and appropriate to presenting factors. Consideration should be given to:

- Commencing a scene log.
- General preservation of the scene.
- Arranging for photographs and video of the scene/other rooms etc.
- Specialist attendance ie Accident Investigation Unit etc.
- Where applicable (ie SUDI) obtain the temperature of the scene and note/evidence factors such as the condition of accommodation, general hygiene and the availability of food/drink.
- Again where applicable and certainly in the case of a baby or infant 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. Otherwise this can remain for the joint visit. (In the case of an infant/baby the child's nappy and clothing should remain on the child but arrangements should be made for them to be seized at the hospital). *Clothing and nappy should only be seized following discussion with the attending paediatrician.*
- Retain any items such as the child's used bottles, cups, food, medication which may have been administered.

The above is not an exhaustive list of actions and, as is intended by this document, should be treated as a guide. They will not be necessary in every case.

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

Further and subsequent Police action:

119. Police Officers need to be aware of other professional's responsibilities, ie resuscitation attempts, taking details from parents, examination of the dead child and looking after the welfare needs of the family. They may need to wait until some of these things have happened and take details from these professionals before being introduced to the parents. This is where liaison and joint working is essential as there may be urgent evidential reasons why the police need to take urgent action. It should be noted that a parent must be available to give consent and (if practicable) be present if examination of any siblings is urgently required.

120. 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 to the hospital for the purposes of continuity of identification. It is recommended that the body should be taken to a hospital casualty department rather than a mortuary, firstly to enable any chance of resuscitation and secondly to make it easier to get an early expert physical examination by a paediatrician. Individual circumstances/age of the child/manner of death may impact on any action of this nature.

121. In all cases where the body is taken directly to a hospital or a mortuary 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.

122. The officer in charge of the investigation will liaise with the paediatrician and, request in liaison with the DDUD, ensure an initial case discussion between all relevant professionals at the earliest opportunity. This responsibility applies in all cases where the cause of death is suspicious or unascertained.

123. A 'sudden death' report must be completed at an early stage and forwarded to the Coroner.

124. In all cases, the police should request 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 <u>or</u> a Home Office Pathologist and Paediatric Pathologist. (Coroner needs to be consulted re this issue – are older children presently subject to a standard PM). A full skeletal survey where considered appropriate by the SIO 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. The investigating officer must give a full briefing to the pathologist(s), including showing of the video and photographs of the scene, and sharing of all information gathered thus far.

125. Items of property should be returned as soon as possible and in any event after the Coroner's verdict or the conclusion of the investigation. Parents must be asked in person if they wish for the items to be returned. The return of these items should be handled sensitively.

CHILDREN'S SOCIAL CARE, STAFFORDSHIRE:

126. It is important for social work staff to remember that the majority of sudden child deaths are from natural causes. Action taken therefore needs to be carefully considered in maintaining a balance between sensitive consideration of the needs of the bereaved family, the potential for a serious crime having been committed and otherwise in managing any uncertainty.

127. Initial information about a sudden death may come from a limited number of sources, usually the Police or health service staff. It may also be received at a limited number of access points, including the First Response Team a local Area Service office, via staff managing the Register of children subject to a child protection plan or via the Emergency Duty Service.

128. In any event, whatever the ways and means of receiving this information, the information should be passed to the Team Manager/ Senior Practitioner at the First Response Team or the Team Manager/Senior Practitioner of the Emergency Duty Service (EDS) who will arrange for the following to occur.

- Establish the named Paediatrician responsible for managing the child's case. This person is responsible for the initiation of an immediate information-sharing and planning discussion between health, police and social care to decide what should happen next and who will do what. (See Working Together, 2006, 7.35).
- Ensuring a formal enquiry is made to ascertain if the child was subject to a child protection plan (formally the child protection register).

- Establishing a contact point with the Police, usually via the Police Child Abuse Investigation Unit, in gathering as much information as may be immediately available.

- Contact the Child Death Review Panel co-ordinator to ascertain if they have received the formal notification of the child's death. If they have not, this notification should be completed and forwarded.

- Identify whether there are any other children identified within the family network whose welfare may need to be safeguarded.

- Ensure that any Children's Social Care staff who may already be in contact with the family are appropriately informed.

- Refer the case to the appropriate safeguarding team. This should occur even in the case where there are no remaining siblings as social care

attendance at the multi-agency discussion after any post-mortem will be required. Please note - for deaths occurring out of hours it is likely that the first strategy discussion will be conducted by the Emergency Duty Service. The EDS should also assess the need to act to safeguard any surviving children should risk issues be immediately apparent, in accord with the procedures noted at Part 4 of the Inter-Agency Safeguarding Procedures.

- Ensure that senior staff are advised appropriately. The Assistant Director, Specialist Safeguarding (01785 277026) and the SSCB Manager (01785 277151) should be advised of all deaths via e mail. The Head of Service for Safeguarding for the particular locality the referral is made to should be informed immediately by telephone. If the child/siblings are an open case to other than a Safeguarding Team the relevant Head of Service should also be informed via telephone. The Head of Service whose team has case responsibility will be responsible for co-ordinating the flow of information regarding the outcomes of any investigation to senior staff. Out of Hours the Assistant Director on call should be informed.

129. The Staffordshire Safeguarding Children Board Manager should:

- Review referral information and advise the relevant Assistant Director if a notification to Ofsted is required via the 'Notification of serious Child Care Incidents' form.

- Ensure the appropriate securing of agency records.

- Liaise appropriately with operational staff in establishing the outcome of enquiries.

- Consider whether the criteria for a serious case review might apply and, if necessary, trigger the necessary arrangements for making recommendations to the Chair of LSCB Serious Case Review sub-group and Chair of the LSCB.

- Liaise appropriately with the Chair of LSCB and other agencies.

130. The team manager of the safeguarding team allocated the child's case should:

- Give early consideration to the need for convening a strategy meeting*, in consultation with the police and paediatrician,*

- Keep the Head of Service informed of any significant developments.

- **In relation to surviving siblings/children within the subjects household,** the strategy meeting should be convened at the earliest opportunity and particularly in the event of consideration needing to be given to the immediate protection of surviving siblings. Established

procedures for conducting strategy meetings in these circumstances will apply. (see Part 4 of these procedures)

- Ensure that the Department continues, as appropriate, to contribute to the investigation conducted following the sudden and unexpected death of a child. In addition to early information sharing and/or strategy discussions in relation to surviving siblings, there should be subsequent case discussions following the preliminary results of the post mortem examination becoming available and following the final results of the post mortem examination becoming available regarding the child who has died.

131. Even when the death of a child does not appear suspicious and/or there are no surviving siblings, Children's Social Care may need to remain involved until the final case discussion following the post mortem. The Initial Case Discussion should seek to establish the level of input required for Children's Social Care.

132. In all cases the allocated social worker should complete the Data Collection Form B. A copy should be retained on the child's case file. A copy should be forwarded by secure post to the Child Death Overview Panel Co-ordinator.

STOKE ON TRENT VULNERABLE CHILDREN AND CORPORATE PARENTING DIVISION: CHILDREN'S SERVICES (updated 5/01/12**)**

133. It is important for social work staff to remember that the majority of sudden child deaths are from natural causes. Action taken therefore needs to be carefully considered in maintaining a balance between sensitive consideration of the needs of the bereaved family, the potential for a serious crime having been committed and otherwise in managing any uncertainty.

134. Initial information about a sudden death may come from a limited number of sources, usually the police or health service staff. It may also be received at a limited number of access points, including the Advice and Referral Team, based at the Swann House, Boothen Road, Stoke-on-Trent, or the Emergency Duty Team etc.

135. In any event, whatever the ways and means of receiving this information, the details must be passed to the Principal Manager / Practice Manager of the team where the case is allocated. If the case is not an open case, the information must be passed onto the Principal Manager / Practice Manager of the Advice and Referral Team, based at the Swann House, Boothen Road, Stoke-on-Trent.

136. The Principal Manager / Practice Manager should:

A) Establish the named Paediatrician responsible for managing the child / young person's case. This person is responsible for the initiation of an immediate information sharing and planning discussion between health, police and children's services to decide what should happen next and who will do what.

B) Establish contact with the investigating police officer, and together they will determine the need to convene a strategy meeting

C) Ensure a formal enquiry is made to ascertain if the child / young person is/ has previously been subject to a child protection plan (or formerly the child protection register).

D) Identify whether there are any other children known to be within the family network whose welfare may need to be safeguarded.

E) Ensure that any Children's Services (VC&CP) staff who may already be involved with the family are appropriately informed.

F) Ensure that a Critical Case Briefing is prepared and forwarded to the appropriate Strategic Manager, and in all cases, to the Strategic Manager Safeguarding, Quality Assurance.

G) Ensure that the Division contributes to any further information sharing/strategy meetings/investigative procedures as appropriate.

H) Contact the Child Death Overview Panel Coordinator to ascertain if they have received the formal notification of the child / young person's death on the minimum data set for notification. If they have not, this notification should be completed and forwarded to:

CDOP Co-ordinator, Lindum House, 2 Diamond Way, Stone ST15 0SD.

Telephone: 0300 123 4455 Fax: 01785 235047

I) Keep the On Call Manager informed of any significant developments

J) Give early consideration to the need for convening a strategy meeting, in consultation with the police, and paediatrician, in relation to surviving siblings / children within the subject household.

137 If the child/siblings are an open case, then the appropriate Strategic Manager must be informed. The Strategic Manager whose team has case responsibility will be responsible for coordinating the flow of information regarding the outcomes of any investigation to senior management.

138 **Please note – for deaths occurring out of hours** it is likely that the first strategy discussion where one is necessary will be conducted by the Emergency Duty Team. The EDT should also assess the need to act to safeguard any surviving children should risk issues be immediately apparent in accordance with relevant policy and procedures

EDT should address points A to D outlined above immediately and pass the information to the 'On Call Manager' at the time. It is the responsibility of the On Call Manager to inform senior managers (i.e. Assistant Director/ Strategic Manager Safeguarding, Quality Assurance) of the presenting event and current position. **It is also a requirement that EDT pass the information to the allocated team or the Duty team for completion of points E onwards.** EDT will telephone the relevant team at 08.30 the next working day to ensure that the information is brought to the attention of the Practice/Principal Manager.

139 The Strategic Manager Safeguarding Quality & Assurance should:

- Ensure that the Assistant Director (VC&CP) and the Safeguarding Children Board Manger are informed at the earliest opportunity.

- Ensure the appropriate securing of agency records if appropriate

- Contact the investigating police officer (who has overall co-ordinating responsibility) and offer to Chair the strategy meeting where one is held.

140 The SCB Manager should liaise with the Child Death Overview Panel Administrator and will if necessary ensure that:

- The appropriate documentation is completed

- The key SCR sub committee members have been informed – for information purposes at this stage

- The Independent Chair of the SCB is informed – for information purposes at this stage

- Review referral information and advise the Assistant Director Vulnerable Children &Corporate Parenting Division and the SCB Independent Chair if a notification to Ofsted is required, from which the Serious Case Review procedures will apply.

- Liaise appropriately with operational staff in establishing the outcome of enquiries.

- Consider whether the criteria for a serious case review might apply and, if necessary, trigger the necessary arrangements for making recommendations to the Chair of the SCR sub committee in respect of commencing the SCR process.

- Arrange for all appropriate agency case records are secured in the event of any potential for serious case review.

141 Even when the death of a child does not appear suspicious and /or there are no surviving siblings, Children's Services should remain involved at least until the final case discussion following the post mortem. If there is no

continuing role for children's services, the case can then be closed. Where there are no surviving siblings, children's services will record the information as an initial contact for the child who has died.

142 Ensure that the Division continues as appropriate to contribute to the investigation conducted following the sudden and unexpected death of a child. In addition to early information sharing and / or strategy discussions in relation to surviving siblings, there should be subsequent case discussions following the preliminary results of the post mortem examination becoming available and following the final results of the post mortem examination becoming available regarding the child / young person who has died.

---

143 The generally agreed principle is that if after an evaluation of all the facts there are no grounds for suspecting anything other than a natural death, the post-mortem can be conducted by a Paediatric Pathologist. If during the post-mortem the Pathologist becomes at all concerned that there may be suspicious circumstances, he/she must halt the post-mortem and a Home Office Pathologist be contacted.

144 If the Coroner has any concerns, having been made aware of all the facts, that the death may be of a suspicious nature, then if the Home Office Pathologist has no paediatric experience the post-mortem should be conducted in conjunction with a Paediatric Pathologist. The Coroner and Senior Police Investigating Officer will liaise concerning these arrangements.

145 Both the Coroner and the Pathologist must be provided with a full history at the earliest possible stage. This will include a full medical history from the Paediatrician, any relevant background information concerning the child and the family and any concerns raised by any agency. The SUDI Paediatrician/ Designated Doctor for Unexpected Deaths in Childhood (DDUD)/Consultant Paediatrician is responsible for ensuring that this is done.

146 The Coroner's Officer will ensure that all relevant professionals are informed of the time and place the post-mortem will be conducted as soon as it is known.

147 The Senior Investigating Officer should attend all Home Office post-mortems. If this is not possible, then he/she must send a representative of a supervisory rank who is aware of all the facts of the case. A Scene of Crime Officer must also attend all post-mortems conducted by a Home Office Pathologist. The Consultant Paediatrician should also be invited to attend.

148 During the post-mortem the Pathologist may require the following to be taken; swabs, blood, urine, bile and gastric aspirate for toxicology and metabolic investigations. They will also need a full list of investigations conducted by the Paediatrician, skeletal x-rays, etc so that they can

determine what other tests/ investigations need completing to assist them in finding the cause of death. The investigations may depend on the age of the child and any factors suspected to be involved in the cause of death.

149 The interim or final findings of the post-mortem should be provided immediately after the post-mortem examination is completed. The interim result may well be “awaiting histology/virology/toxicology” etc.

150 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 within fourteen days of the final result being known.

151 All professionals must endeavour to conclude their investigations expeditiously. This should include the post-mortem results such as histology.

152 The Coroner will always endeavour to secure release of the body for funeral arrangements as soon as possible. The funeral of the dead child must not be delayed unnecessarily.

153 The preliminary results of the post mortem examination should be discussed by the SUDI paediatrician/DDUD, pathologist, and senior investigating police officer, as soon as possible. (Usually within 48 hours) However the coroner must be immediately informed of the initial results. When a Home Office Pathologist has been used, the Pathologist should provide an interim report within two working days of the post-mortem, either orally or in pro-forma. This should be followed by a more detailed written report provided to the Investigating Officer, via the Coroner. The contents of these reports should be inform local data collection.

154 The Investigating Officer should ensure that a copy is forwarded to the Child Death Overview Panel Co-ordinator for inclusion on file for future reference. The report must not be shared with other agencies without the permission of the Coroner. Permission should always be sought by an agency if the content of the report could potentially affect the agency’s future actions. The Consultant Paediatrician (responsible for the follow up) may request a copy of the post-mortem from the Coroner’s office. This cannot be released without the Coroner’s permission.

155 The senior investigating police officer must continue to maintain close liaison with the Coroner/Coroner’s Officer throughout the course of any police investigation.

CONCLUSION:

156 In the context of this guidance professionals within Staffordshire and Stoke-on-Trent are highly unlikely to experience more than 100 infant/child deaths in any given year. Of these we anticipate up to 25 will be sudden or unexpected. Data from the FSID indicates that in terms of SUDI the number is likely to be closer to 7 or 8. Given these figures it is not unrealistic to expect that each death should be thoroughly investigated.

157 By carefully following the principles laid down in this guidance, collaboratively we will enable a thorough assessment, in order that a cause of death can be identified, support provided for the family and ensuring protection where the cause is thought to be un-natural.

GUIDANCE FOR STAFF TAKING HISTORY (ACCIDENT & EMERGENCY AND PAEDIATRIC STAFF)

All agencies involved with these child death procedures should complete Form B - Agency Report form. This is additional guidance for staff taking history.

The relevant history will depend upon the age of the child, but where applicable should at least include:

- Who saw the child last?
- What condition was the child in?
- When the child was last fed, with what, and by whom?
- Who put the child to bed and how?
- Who found the child to be dead?
- How did the child look when found (blue, pink, stiff etc.)?
- Who else was in the house at the time of discovery?
- Who was there/with the child in preceding 24 hours?
- Where was the child sleeping in relation to the parents/carers and in what?
- Who was in the child's room/bed?
- What was the sleeping position of the child?
- How much clothing or wrapping was used on the child and what was the room temperature where the child was found?
- Was bedding over/under the child? Was bedding tucked?
- Was an electric blanket used?
- Was an infant intercom in place?
- Detailed account of child's behaviour 48-72 hours prior to death, ie health of the child the day before.
- Has the child had any illnesses since birth or been seen by a Doctor for a health problem?
- Has child received injections? If so, for what and when?
- Was the child breast fed?
- Has the child attended clinic or been medically examined? If so, by whom, date and venue.
- Has the child been admitted or taken to a hospital or clinic? If so, which hospital/clinic, when, what for?
- Were they furnished with a booklet detailing medical checks, examinations, dates etc? (The parent-held Child Health Record often known as the Red Book). If so, where is that?
- Was the child born prematurely and what was his/her weight at birth?
- What type of delivery?
- Did the child require special treatment after birth?

- Was child discharged from hospital with mother? If not, did he/she require special treatment?
- Do the parents, other members of the household or carers smoke? If so, was the child in a smoke free environment or not?
- Was there heating in the house? Was there heating in the child's room? What type of heating?
- Have there been any previous child deaths in that or extended family? If so full details.
- Have either of the carers been involved in earlier relationships where they have had children? If so, obtain full details of any significant events in the lives of those children.
- Who are the child's and family's GP.
- Full details of parents/carers contact addresses, telephone numbers etc. (Furnish with your contact details).
- What guidance have the parents received with regard to SIDS from the medical profession prior to or since the birth of their child?

These issues are explored usually by the paediatrician, but investigating officers may wish to explore some aspects in more detail.

Appendix 'B'

HOSPITAL BASED HEALTH STAFF GUIDELINES FOR MANAGEMENT OF SUDDEN UNEXPECTED DEATH IN INFANCY AND IN CHILDREN UNDER THE AGE OF 18

All children under 18 years old who die suddenly and unexpectedly

Inform Consultant Paediatrician

Take essential specimens (blood and urine) as soon after death as possible if not taken before (see investigations). If you suspect a metabolic cause, contact the IMD lab at BCH – 0121 333 9942. The investigations refer to those children under the age of 2, investigations on older children will depend on the age of the child and the circumstances of the death

CONTENTS

1. **Summary** of Management

2. **History and Examination**

3. **Investigations** – (samples needed to exclude congenital, infectious, metabolic or forensic causes)

4. Technique of **skin biopsy**

5. **Forensic** Aspects – (Coroner, Child Protection)

6. **Breaking the news** – Most senior paediatrician should be involved
   Local bereavement support

7. Some facts about **SIDS**

Inform GP, HV and Community Child Health Dept. and hospital records to cancel out-patient appointments, immunisations etc

Equipment required for investigation

For blood specimens: -	2 x lithium heparin bottles 2 x EDTA (haematology) bottles 2 x plain bottles (no anti-coagulant) 1 x Guthrie card Syringes and needles
For urine: -	3 x plain bottles 20 ml syringe and no. 1 (green) needle for SPA
For microbiology: -	3 x plain swabs Viral transport medium General transport medium Aerobic and anaerobic blood culture bottles
For skin biopsy: -	Forceps Size 15 scalpel and no. 3 handle 25G (blue) needles Cotton wool balls Hibitane in spirit Viral transport medium

1. Summary of Management

1. Break news to parents, explain about the urgency and nature of investigations and the obligation to inform the Coroner but **do not delay taking specimens whilst you take a history and examine the baby**.

2. Inform Coroner and obtain permission to take specimens.

3. **Blood** – heart stab within 30 mins of death if possible and preferably *not more than 4 hours.*

U & E, and FBC	refrigerate
0.5ml in Lith heparin (for IMD at BCH)	spin, -80ºC
0.5ml serum for **toxicology** (clotted)	spin, -80ºC
Blood spots onto Guthrie card directly (from syringe)	dry at room temp
Blood culture into Pedsplus/F and Anaerobic/F	to incubator at 37ºC

Fluoride spec (if available pre-mortem) lactate, 3-HB, FFA to IMD at BCH
Chromosomes – if dysmorphic

4. **Urine** SPA – bladder stab into 3 plain bottles
1/3 to microbiology

1/3 to toxicology (spin and freeze)
1/3 to biochemistry amino and organic acids, oligos – spin and freeze

5. **Nasopharyngeal swab** if <8 hrs post-mortem for virology transport medium º4C – any other body fluids, wound swabs etc in fridge for **microbiology.**

6. Consider **Skin biopsy** – to IMD at BCH for tissue culture.

7. Consider **muscle biopsy** – contact IMD at BCH

8. Complete **clinical examination** – injuries, bruising, petechiae, retinal haemorrhage, rectal temperature, any skull fracture?

9. In infants less than 2 years of age, Explain to parents about SUDI; encourage to hold baby, bereavement support.

10. Radiology – **skeletal survey.**

11. Check if the child is subject to a Child Protection Plan (formerly CPR).

12. Inform GP, HV/SN, Community Child Health and Records and cancel appointments.

Blood and urine specimens for biochemistry to IMD lab at BCH (0121 333 9942)

2. History and Examination

The child should have his/her set of notes made up.

It is important to record all details accurately, note date and time and sign the records as they may form part of the evidence if there is subsequently a criminal investigation. Questions need to be asked with great care and sensitivity to avoid any suggestion of criticism of care given or habits (eg smoking or not breast feeding)

Questions to ask

Detailed account of final 24 hours
Who found the child?
What time?
How was the child? – position in cot or in parent's bed, covered by blankets or duvet, clothing, froth at mouth or nose, vomit or blood on sheets etc
What did they do? – eg call an ambulance, attempt resuscitation
When was the child last thought to be alright? eg at 2 a.m. feed
Any minor illness e.g. snuffles, cough, d & v recently?
Normal sleeping arrangements
Normal feeding and sleeping patterns and any unusual events recently
(and others for older children)

Birth history including any problems with the pregnancy and whether breast or bottle fed

Past medical history – admissions, visits to A & E, illnesses etc.
Medication, allergies, immunisations

Family history
Any explained deaths in or previous SIDS?
Parents ages, occupations, smoking, alcohol or drug (including medicinal) usage, general health
Mother's parity and obstetric history
Sibling's ages, schools attended any health problems?

Social History – housing, heating, household composition etc known drugs/alcohol used

Examination

Careful and complete physical examination
Look for any **external marks** – bruises or injuries and petechiae, **palpate skull** for fracture or bogginess, look in fundus for **retinal haemorrhages**
Record **rectal temperature** and any other signs of illness

3. Investigations

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

Infections
Blood cultures, into aerobic and anaerobic bottles, but if only a small volume available, set up aerobic in preference put in incubator at 37ºC if out of hours
Urine by SPA into sterile bottle for microscopy and culture, save in refrigerator.
Nasopharyngeal swab if <8hrs 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.
Signs 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 hepatosplenomegaly
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 or via switchboard at BCH).

In addition to blood and urine samples, skin biopsy and muscle biopsies should be performed if possible. Skin biopsy should be possible in District hospitals, follow the technique overleaf and put the specimen in viral culture medium in a fridge at +4ºC until transported to IMD to BCH.

Specimens required
Blood – at least 0.5ml in lithe hep separate freeze at -80ºC
Dried blood spots directly from syringe onto Guthrie card
Fluoride spec (if available pre-mortem)
Urine - in plain bottle spin and freeze at -80ºC
Skin biopsy for tissue culture at +4ºC
Muscle biopsy for metabolic, cryostat and EM studies

Forensic specimens – remember to maintain the chain of evidence.

Blood – 0.5ml clotted – spin and freeze
Urine – plain bottle – spin and freeze
Skeletal survey

Others – FBC and blood for chromosomes especially if dysmorphic

4. Technique of Skin Biopsy

The procedure detailed below is for obtaining a skin biopsy suitable for culture and for subsequent investigations for inherited metabolic disorders.

The most important aspect is **STRICT ASEPSIS** using a "no touch" technique.

Materials: Forceps – fine non-bend watch makers forceps are best but
Dissecting forceps may be used
Size 15 scalpel blade and a No. 3 handle
21 gauge blue needle
Cotton wool balls and gallipots
Hibitane in spirit
bottles of culture medium obtained from Cell Culture Laboratory
(or microbiology locally)

Sample requirements: at least 1 cubic mm of skin, approximately 2 mm x 2 mm.

PROCEDURE

There is a high-risk of infection in most post-mortem specimens and possible failure of culture.

1. Take the biopsy from over the scapula as this leaves less obvious damage.
2. Swab the area with Hibitane in alcohol
3. Pierce the skin with a modest sized needle (23 G. blue) and lift up to produce tenting.
4. Lop of the top of the tent to produce a piece of skin about 2 mm with round “O” shape
5. Put immediately into a culture medium bottle.

The biopsies should be obtained as soon as possible after death – delay may jeopardise the success of the fibroblast culture. Successful culture is unlikely if biopsy is taken more than 48 hours post-mortem.

The sample should be sent to the Inherited Metabolic Disease laboratory as soon as possible by special transport. If transport cannot be arranged immediately, the sample should be stored at +4ºC. The biopsy has to set up in culture or banked within 24 hours of being taken. (NB THE SAMPLE SHOULD NOT BE FROZEN).

The request form accompanying the sample should give clinical details along with the date and time of sampling.

The specimen should be sent to bacteriology in viral culture medium (obtained from microbiology technician on-call).

5. Forensic Aspects

By law, all sudden deaths must be reported to the Coroner and the possibility of infanticide or child abuse (poisoning etc) must not be forgotten.

Contact the Coroner and obtain permission to obtain specimens, discuss whether it would be more appropriate for a specialist perinatal pathologist to perform the autopsy.

Medical records may become legal documents.

Take and record a detailed history including an account of the circumstances surrounding the death and whose care the child was in when found dead. Record the name of the person giving the history, date and time and sign the record.

Examine the body and record any bruises or marks.

Blood and urine for toxicology should be spun and frozen.

Document all specimens taken, label and ensure an unbroken chain of evidence. This may mean handing the specimens to a police officer directly, or having the lab technician sign on receiving them in the laboratory.

Record the site from which specimens were taken e.g. cardiac stab, SPA, skin and muscle biopsy sites.

Arrange for a skeletal survey and X-ray any other specific area if indicated.

Check if the child is subject to a Child Protection Plan (formerly the Child Protection Register), particularly important if there are any young siblings or a twin. Must be undertaken in all cases.

6. Breaking the News and what to tell parents

- find a quiet room and give your bleep to another doctor - take a nurse with you
- know the name and sex of the child
- make sure that there is another relative or friend to support the parent and if possible both parents are present – don't start until everyone has arrived unless this will cause undue delay
- don't take a long time telling them what has happened, they will probably have guessed already and will appreciate you getting to the point
- if the child was brought in dead, explain that it wasn't possible to do anything that would have brought the baby back to life
- if resuscitation was attempted explain that everything possible was done to save the baby but unfortunately, he/she died
- explain the need to take specimens as soon as possible, and if skin or muscle biopsies are being performed explain how and why. It may be appropriate for another doctor to take specimens whilst the senior doctor talks to parents
- go slowly, leaving pauses for them to take in what you have said, ask questions or just have a cry
- answer questions and give whatever explanations are available, but tell them that the Coroner has to be informed and a post-mortem has to take place to find out whether there was an identifiable cause for the baby's death
- explain that a consultant paediatrician will see them after the Coroner's investigations are completed and this will take a few weeks

- if mother was breast feeding advise about stopping lactation

- encourage parents to hold baby, offer photos and bereavement support (SANDS, local cot death support group etc)

7. Some facts about SIDS

Age – 2-4 months – 95% under 6 months
Rare under 1 month or over 1 year
Males>females Winter

Minor illnesses common in preceding 24 hours but most are healthy

Incidence 0.4-1.3 per 1,000 live births

Aetiology unknown likely to be multi-factorial
SIDS is not caused by immunisations (they decrease the risk)

High Risk

Maternal factors – young age, increased parity, short inter-pregnancy interval, twin pregnancy, poor ante-natal care, anaemia, smoking during pregnancy UTI in pregnancy, low socia-economic status, drug use, family history of SIDS

Neonatal factors – IUGR, birth asphyxia, prematurity <1500g, apnoeas.

Post-natal factors – cigarette smoke exposure, prone sleeping, thermal stress, bottle fed, non central heating, co-sleeping, falling asleep on the sofa/ arm of the chair with the baby, recent febrile illness, soft sleeping surface, swaddling

NB Similar risk factors for SIDS, prematurity and NAI

Reduce the Risk

Back to sleep and feet to foot (put feet to foot of cot, lying on back)

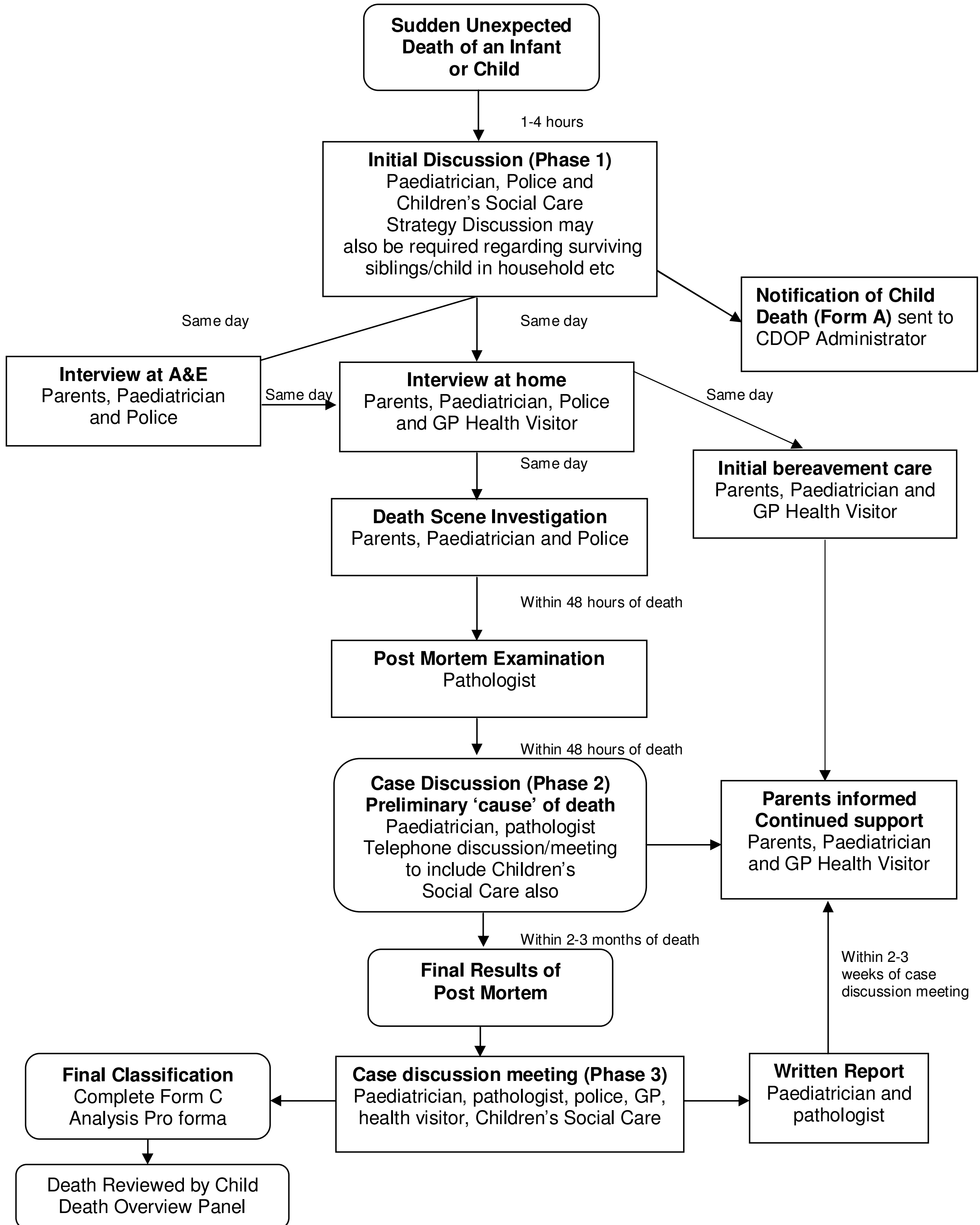
No smoking

Avoid overheating

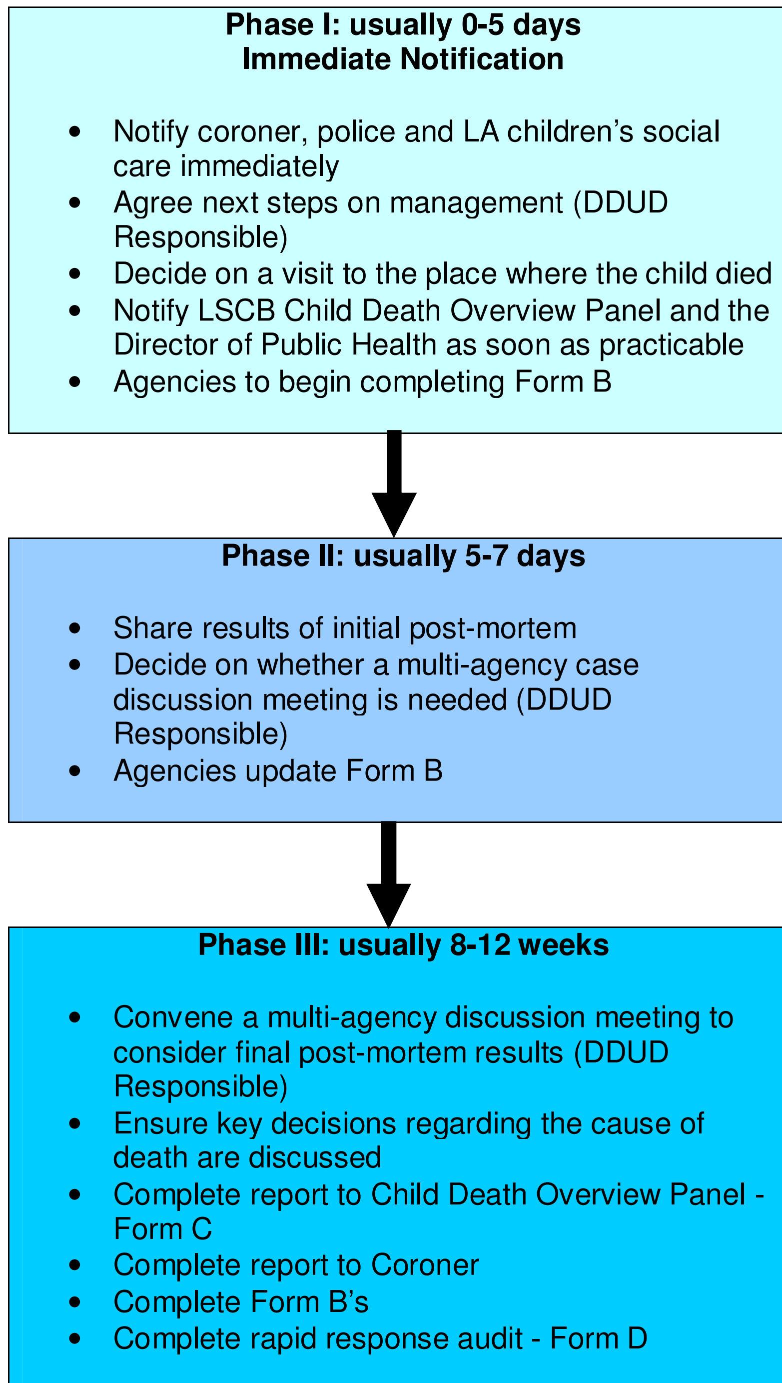
Breast feed and seek medical help if concerned about baby

Appendix 'C'

SEQUENCE OF EVENTS



RAPID RESPONSE FLOWCHART



CONTACT DETAILS

	IN HOURS	OUT OF HOURS	FAX
DESIGNATED DOCTORS FOR UNEXPECTED DEATH IN CHILDHOOD			
S. STAFFS:	01283 511511 Ex 4360	017951 924576	
N. STAFFS:	01782 552832	07710 673965	01782 553478
AMBULANCE SERVICE			
H. M. CORONERS:			
N. STAFFS:	01782 234777		01782 232074
S. STAFFS:	01785 276127 or 01785 276126	01785 819210 07730 420 293 (mobile)	01785 276128 (in hours) 01785 819210 (out of hours)
DESIGNATED NURSES:			
N. STAFFS and City of S-O-T	01782 304411 07831 317628	No out of hours	01782 305219
S. STAFFS	01785 258556	No out of hours	01785 225576
PAEDIATRICIANS:			
N. STAFFS	01782 552832	01782 715444	01782 713946
S. STAFFS	01543 420426		01543 420434
POLICE:			
General for all Depts/Divs	0300 123 44 55	0300 123 44 55	
Child Protection Unit	0300 123 44 55		
Child Abuse Investigation (Det Insp)	01785 235290		

	IN HOURS	OUT OF HOURS	FAX
<u>Children's Social Care</u>: **Staffordshire County Council** Children and Lifelong Learning Directorate – First Response **Stoke-on-Trent** Children and Young People's Services	 08001313126 01782 235100	EDT 01785 354030/1 (01785 854223 9am x 6pm) 01782 330221	
<u>FSID:</u>	0870 787 0554	0870 787 0554	

THE FOUNDATION FOR THE STUDY OF INFANT DEATHS

1. The Foundation for the Study of Infant Deaths (FSID) aims to prevent sudden infant death and promote baby health. To carry out these aims the FSID:

    - Funds research.
    - Supports families whose babies have died.
    - Disseminates information about cot death and baby care to health.

2. FSID has a help line offering support and information to anyone who has suffered the sudden death of an infant. (Staffed between 0900-1800 hrs and 1800 hrs-2300 hrs in the evenings). The help line (see Appendix 'D') is also available for family, friends and those professionals involved in the death. A wide range of leaflets is available.

3. FSID also has a network of befrienders, who have experienced the death of a child. Arrangements can be made for befrienders to contact the bereaved family to offer additional support.

4. It should be noted that the FSID provides support into sudden infant deaths only, focusing in the main on deaths of infants under 12 months of age. However, the FSID will gladly accept referrals for all deaths in children under 2 years.

5. It is important that professionals are aware of the FSID and advise all grieving relatives accordingly.

Statistical Data of Relevance to Investigators:

6. Each year in England and Wales over 3,500 babies die, most of them in the first week of life.

7. Around 600 die suddenly and unexpectedly some time between one week and their first birthday. In about 300 of these the cause is not found at post-mortem examination, but the death is thought to be natural: the death is then registered as Sudden Infant Death Syndrome (or 'cot death' or 'unascertained'). About 30 cases of homicide in babies are recognised each year.

8. At present in our population about one baby in 1,600 dies each year from cot death (January 2003). The chance of a particular baby dying from cot death varies greatly according to the risk factors that are present in the family. For example, if the mother is under 27 and has more than one previous child, and if both parents are unemployed and

are smokers, the likelihood of a cot death is around one in 200. If none of these factors apply, then the likelihood is far less – around one in 8,500.

9. FSID runs a programme called Care of Next Infant (CONI) which supports families who have had a previous cot death. This programme is active and running in Staffordshire.