

SECTION 12.2

**GREATER MANCHESTER
PROCEDURE
FOR THE MANAGEMENT OF
SUDDEN UNEXPECTED DEATH
IN CHILDHOOD
(RAPID RESPONSE)**

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1. INTRODUCTION

- 1.1.1 This procedure provides direction for professionals from agencies involved when a child (0-18 years) dies suddenly and unexpectedly.
- 1.1.2 Together with principles to follow and a definition, the procedure contains general advice and guidance for dealing with a sudden unexpected death and for inter-agency working. Each agency has its own specific guidelines that will complement this procedure (appendices)
- 1.1.3 All sudden unexpected deaths come within the remit of the coroner who has exclusive jurisdiction and control of the body of the deceased child. Individual circumstances are likely to require individual solutions and the coroner will always be willing to discuss specific arrangements between the hours of 07.00 and 23.00. Outside these hours the coroner should only be contacted in cases of absolute urgency.
- 1.1.4 Families should be treated with sensitivity, discretion and respect at all times, and professionals should approach their enquiries with an open mind.

1.2 Background

The Children Act 2004 and Working Together 2006

- 1.2.1 One of the Local Safeguarding Children Board's functions, set out in Regulation 6 of the Children Act 2004, in relation to the deaths of any children normally resident in their area is as follows:
 - putting in place procedures for ensuring that there is a coordinated response by the Authority, their Board partners and other relevant persons to an unexpected death.
- 1.2.2 Each unexpected death of a child is a tragedy for the family and subsequent enquiries/investigations should keep an appropriate balance between forensic and medical requirements and the family's need for support. Children with a known disability or a medical condition should be responded to in the same manner as other children.
- 1.2.3 A minority of unexpected deaths are the consequence of abuse or neglect, or are found to have abuse or neglect as an associated factor. In all cases, enquiries should seek to understand the reasons for the child's death, address the possible needs of other children in the household, the needs of all family members, and also consider any lessons to be learnt about how best to safeguard and promote children's welfare in the future.

- 1.2.4 A number of different agencies will become involved throughout the process of establishing the cause of the death.
- 1.2.5 This procedure is not intended to cover all aspects of sudden unexpected death but endeavours to provide direction to practitioners who are confronted with these tragic circumstances. In most cases the process will be lead by the paediatrician for sudden unexpected death in childhood unless there are suspicious circumstances, in which case the police will take over. It is acknowledged that each death has unique circumstances and each professional involved has their own experience and expertise which will be drawn upon in their handling of individual cases. Nevertheless, there are common aspects to the management of a sudden unexpected death that it is important to share in the interests of good practice and achieving a consistent approach for every child no matter what the circumstances.
- 1.2.6 This procedure gives an insight into the priorities for those professionals involved, in an attempt to promote a mutual understanding of each agency's roles and responsibilities. Professionals need to strike a balance between the sensitivities of supporting the bereaved family, and securing and preserving anything that may aid in an understanding of why the child died.
- 1.2.7 When a child, whether a Greater Manchester resident or not, dies outside their usual area of residence, there should be discussion amongst the professionals involved as to which Authority's procedure should be followed and which Authority should take the lead. In the event of disagreement the appropriate coroner will direct.

1.3 AIM

To ensure there is a coordinated multi-agency response for all sudden and unexpected child deaths by:

- Close multi agency working, with sharing of information between clinical staff, pathologist, police, children's social care, any other relevant agency, and coroner's services.
- Establishing, as far as possible, the cause of death
- Preserving evidence at the place of death
- Documenting fully all interventions by paramedical and medical staff, including resuscitation prior to the certification of death
- Completing a full medical history and examination
- Reviewing all medical records
- A pathologist (and if necessary a forensic pathologist) investigating the cause of death
- Offering sensitive care and support to all affected by the death
- Identifying and managing any risk to other siblings / children
- Preserving all potential evidence in support of a potential prosecution or childcare proceedings.

2. DEFINITIONS

- 2.1 An unexpected death is defined as the death of a child, in any setting, 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.
- 2.2 The paediatrician responsible for sudden unexpected deaths in childhood (SUDC paediatrician) should be consulted where professionals are uncertain about whether the death is unexpected. If in doubt, this protocol should be followed until the available evidence enables a different decision to be made. In exceptional cases the Coroner should be consulted subject to the provision of paragraph 1.1.3.

3. PRINCIPLES

- 3.1. When dealing with sudden unexpected death all agencies must follow five common principles, especially when having contact with family members.
 - Caring and sensitivity, keeping an open mind and balanced approach.
 - An inter agency response
 - Sharing of information
 - Proportionate response to the circumstances
 - Preservation of evidence

All items on this list are equal in importance.

- 3.2. In applying the above principles individuals and agencies should ensure that their actions are legal, necessary, relevant and proportionate in order to comply with the Children Acts (1989 and 2004) and the Human Rights Act 1998.

4. GENERAL ADVICE FOR ALL PROFESSIONALS WHEN DEALING WITH THE FAMILY

- 4.1 **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 deals with the bereavement for a long time afterwards. A sympathetic and supportive attitude whilst maintaining professionalism towards the investigation is essential.**
- 4.2 Grief reactions will vary; individuals may be shocked, numb, withdrawn or hysterical.
- 4.3 Handle the child with naturalness and respect, as if the child were still alive.
- 4.4 Always refer to the child by name.
- 4.5 Deal sensitively with religious beliefs and cultural differences, while remembering the importance of evidence preservation.
- 4.6 Parents will need to be given time and opportunity to ask questions.
- 4.7 Give your written contact name and telephone number to the family.
- 4.8 Practical issues will need to be addressed (where the child will go, what will happen, when they see the child) and communicated to parents.
- 4.9 In suspicious circumstances early arrest of the perpetrator may be essential to secure and preserve crucial evidence for an effective investigation to take place. In such cases, the prompt provision of accurate information and written statements from important witnesses within the family will be necessary.
- 4.10 In all cases a post-mortem examination will be performed unless a registered medical practitioner is able to provide a Medical Certificate of the Cause of Death, or the Coroner otherwise decides.
- 4.11 When an unexplained child death occurs it is likely that an inquest will be conducted by HM Coroner.

5. INTERAGENCY WORKING

- 5.1 There should be a multi-agency approach involving collaboration of all disciplines and agencies.
- 5.2 All unexpected child deaths must be treated initially as a multi-agency safeguarding investigation. Surviving siblings may well be the subject of enquiry under Section 47 of the Children Act 1989 and as such will be managed according to Local Safeguarding Children Board Procedures. The immediate protection of any siblings takes priority. If a S.47 enquiry is required this element of the investigation will be discussed at the first strategy meeting of the rapid response team. If this is unlikely to occur within 24 hours a strategy discussion should take place in line with LSCB procedures.
- 5.3 Children who die unexpectedly at home should **always** be taken to the A&E Department **not** the mortuary. This allows for the earliest possible examination/assessment of the child by a senior clinician. Resuscitation should be attempted unless clearly inappropriate. The only exception to this is where the police Senior Investigating Officer (SIO) directs otherwise on the grounds of preserving evidence in a suspicious death.
- 5.4 The police must be informed as soon as possible if any person under 18 years dies 'unexpectedly'. No person should 'assume' that the police have been notified. Repeated calls to the police are better than none at all. Early contact with the police enables the prompt recovery of evidence that could otherwise be lost.
- 5.5 The parents/carers should be allocated a member of staff to care for them and should normally be given the opportunity to hold and spend time with their child while in the A&E Department. If there is suspicion against any particular person/s, the police SIO may request that access to the child's body be restricted. This request should be facilitated by hospital staff, where it is safe to do so. Without exception, parents/carers who are allowed access to the body should be supervised throughout by a health professional or police officer. Every consideration should be given to the cultural and religious sensitivities of grieving parent/carers. If any person mishandles the child's body in any way, the body should be removed from them, provided it is safe to do so. Details of any mishandling should be recorded in the child's health record. The name/s of all professionals who supervise in this way should be recorded on the child's health record as they may later prove to be potential witnesses.
- 5.6 Parents/carers should not be allowed to wash the child's body as important forensic evidence could be destroyed by allowing this to happen. Parents/carers should be offered a photograph of the child. They may also be offered a lock of hair and hand/foot prints (mementoes) at a later stage. However, these should not be taken until the pathologist has fully examined the body at post mortem and agreed they can be taken. At this point they should be obtained and delivered promptly to the parents/carers. The police should be informed of any request from the parents/carers for mementoes. Responsibility for arranging the taking and delivery of mementos lies with the police SIO.

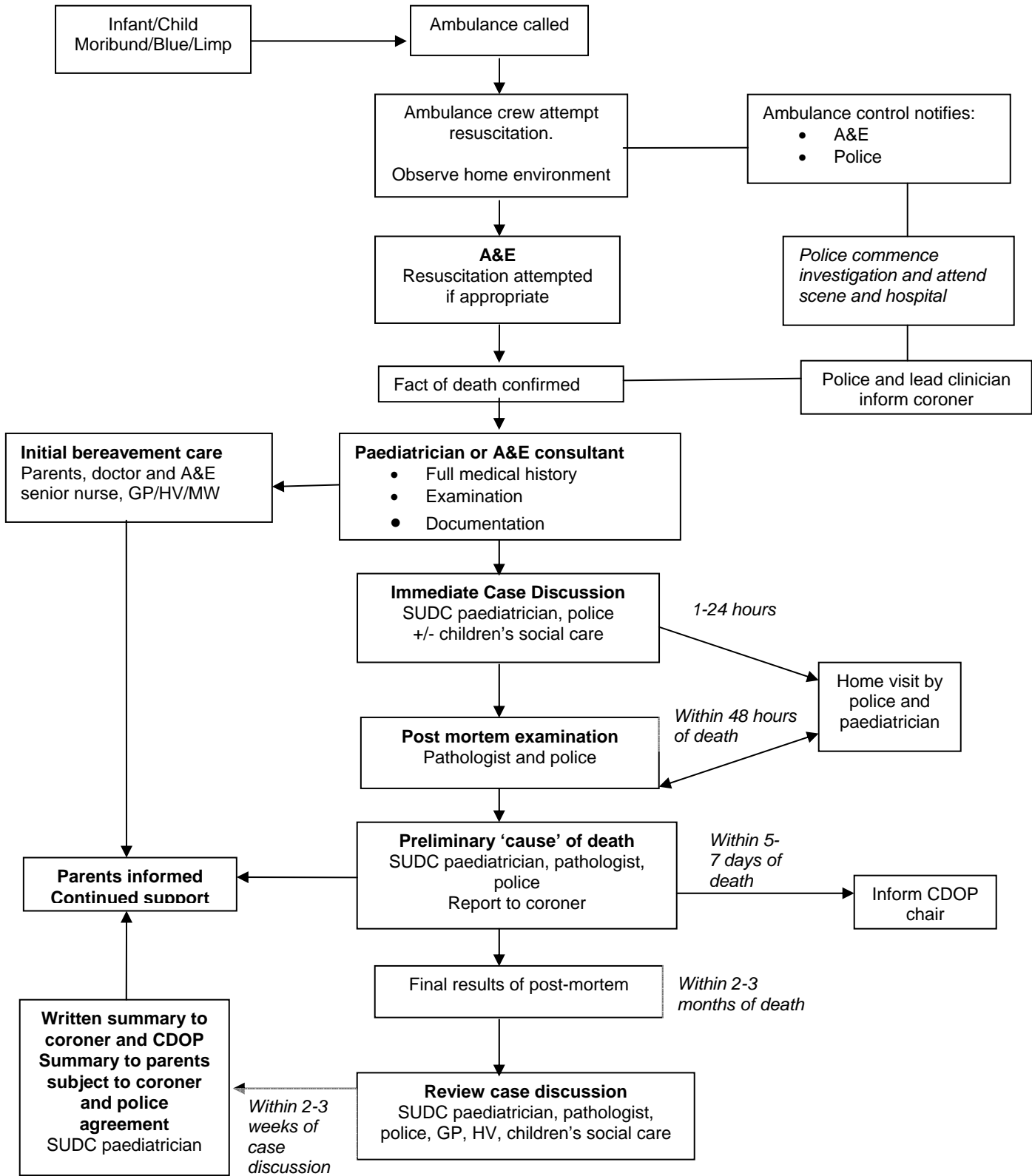
- 5.7 Once fact of death has been confirmed, the body and personal clothing/possessions should be handled as little as possible. Whilst the death remains unexplained, the possibility that a crime may have been committed (not necessarily by the parents or carers) cannot be ruled out.
- 5.8 It should be remembered that babies and children who have been unlawfully killed, can sometimes present without any externally visible injuries.
- 5.9 As soon as possible after arrival in A&E the child should be examined by the on call paediatrician (consultant in paediatrics, or A&E consultant if no paediatric service provided by the Trust) and a careful history should be taken from the parents/carers. Any details given should be carefully recorded. Particular attention should be paid to any apparent changes or inconsistencies in accounts given about the events leading up to the death. Any accounts given should be brought to the early attention of the police. In cases of language difficulty an interpreter must be used rather than English speaking family or friends, to ensure accuracy in the communication of this vital information.
- 5.10 As soon as death has been confirmed the following will be contacted:
- The coroner by the police and the lead clinician
 - SUDC paediatrician, GP and children's services by the senior clinician
- 5.11 When the child is pronounced dead, the paediatrician or senior A&E clinician should break the news to the parents. The paediatrician will explain police and coroner involvement and the need for a post mortem examination.
- 5.12 In all cases an immediate case discussion should be held (within 1 hour of the SUDC paediatrician being available) between the senior investigating police officer, the on call paediatrician and the SUDC paediatrician – to agree their approach and to ensure continuing close collaboration as frequently as necessary, often by telephone.
- 5.13 Confirmation of agreed decisions and actions and timescale for completion (to be recorded by each party within existing systems). The SUDC paediatrician will minute the discussion and distribute the actions to the relevant individuals.
- 5.14 When a baby or older child dies in a non-hospital setting, the SIO and SUDC paediatrician should decide whether a visit to the place where the child died should be undertaken. This should almost always take place for infants (under 2 years) who die unexpectedly. As well as deciding if the visit should take place, it should also be decided how soon (within 24 hours) and who should attend. It is likely to be the SIO and SUDC paediatrician who will visit, talk with the parents and inspect the scene. They may make this visit together, or they may visit separately and then confer. After this visit the SIO, SUDC paediatrician, GP, health visitor or school nurse and children's social care representative should review whether there is any additional information that could raise concerns about the possibility of abuse or neglect having contributed to the child's death. If there are concerns about surviving children in the household local procedures for managing child protection enquiries should be followed.

- 5.15 The on call paediatrician and SUDC paediatrician should liaise with the pathologist and provide information on the clinical circumstances of the death, the history and the relevant medical and social records.
- 5.16 The paediatrician who confirms the fact of death must notify the coroner.
- 5.17 The coroner will order a post mortem examination to be carried out as soon as possible, preferably within 48 hours, by the most appropriate pathologist/s.
- 5.18 The SUDC paediatrician will ensure parents, GP, and relevant community nurse(s) are informed of the initial post mortem results, unless directed not to by the coroner.
- 5.19 A review case discussion meeting should be convened and chaired by the SUDC paediatrician as soon as the full post mortem tests are available, approximately 8-12 weeks after the death. This meeting (at the GP surgery, if possible) should involve the GP, health visitor, school nurse (if appropriate) midwife (if appropriate), children's community nurse (if appropriate) and any other paediatrician if involved, pathologist(s), senior investigating police officer, coroner's officer and where appropriate social worker, bereavement support worker ambulance and A&E staff. All relevant information concerning the circumstances of the death, the child's history, family history and subsequent investigations should be reviewed and the core data set completed. The main purpose is to share information, agree the cause of death and plan future care for the family. There must be an explicit discussion of the possibility of abuse or neglect and, if no evidence is identified to suggest maltreatment, this should be documented as part of the report of the meeting. The report should be sent to the CDOP and to the coroner, who should take the case discussion information into consideration in the conduct of the inquest and in the cause of death notified to the Registrar of Births and Deaths.
- 5.20 The SUDC paediatrician should, subject to coroner's and police approval, write a detailed letter to the parents, giving information concerning the cause of the child's death and make arrangements to meet them to explain the contents of the letter, answer any questions, and offer future care and support.
- 5.21 If significant concerns are raised at any stage about the possibility of abuse or neglect, a decision may be taken for the police to become the 'lead agency'. The police should be informed immediately if significant suspicion arises so as to ensure any further interviews with the family accord with the requirements of the Police and Criminal Evidence Act 1984. Children's services and police may convene a child protection strategy meeting to decide how to proceed with the child protection investigation.
- 5.22 If there are grounds for considering initiating a serious case review LSCB procedures should be followed.
- 5.23 Managers in all agencies should be proactive in ensuring the well-being of their staff, both during and after dealing with childhood deaths.

INFORMATION SHARING

- 5.24 **Section 10 Children Act (CA) 2004:** statutory guidance states that good information sharing is key to successful collaborative working and that arrangements under s10 CA 2004 should ensure that information is shared for strategic planning purposes and to support effective service delivery.
- 5.25 **Section 11 CA 2004:** places a duty of bodies within the NHS to make arrangements to ensure that their functions are discharged with regard to the need to safeguard and promote the welfare of children
- 5.26 **Paragraph 7.4 Working Together to Safeguard Children** (HM Government 2006) sets out the regulations relating to child deaths review functions and this includes collecting and analysing information about each death.
- 5.27 Having expressed or implied powers does not mean that the Human Rights Act 1998, the Common Law Duty on Confidentiality and the Data Protection Act 1998 can be disregarded.
- 5.28 **Human Rights Act 1998: Article 8. 2:** the right to respect for private and family can be legitimately interfered with where it 'is in accordance with the law and is necessary ... in the interests of ... protection of health and morals or the protection of rights and freedoms of others.
- 5.29 The sharing of information within the Child Death Overview Processes is a function set out in regulation 6 under s. 13 CA 2004 and therefore is in accordance with the law. It can be seen as a proportionate response in relation to the pressing social need for the protection of health and morals or the protection of rights and freedom of others.
- 5.30 **Common Law Duty of Confidentiality:** The common law provides that where there is a confidential relationship, the person receiving the confidential information is under a duty not to pass on the information to a third party. The duty is not absolute and can be shared without breaching the common law duty if there is an overriding public interest in disclosure.
- 5.31 **Data Protection Act 1998**
Information sharing within the Child Death Overview Processes is a statutory function and the Data Protection Act therefore permits the sharing of information without express consent of the subjects.

6. RECOMMENDED SEQUENCE OF EVENTS



Throughout the process of investigating a sudden unexpected death managers must consider the need to initiate a Serious Case Review

7 POLICE

Appendix 'A'

Introduction

- 7.1.1** The first aim of any police investigation into the report of an unexplained death is to determine, through the systematic gathering and analysis of evidence and information, whether a homicide or some other criminal offence has been committed. The second aim is to report the full circumstances of the death to the coroner and assist, as far as possible, his/her investigation.
- 7.1.2** The duty of H.M. Coroner is to establish the identity of the deceased and how, when and where s/he died. All police staff should be aware that, once a person has died, the body must not be interfered with in any way, unless authorised by H.M. Coroner either directly or through this protocol.
- 7.1.3** Throughout their investigation into the report of an unexplained death of a person under eighteen years, the police will take any action necessary to safeguard the wellbeing of any other children or young persons, such as siblings, who are considered to be at risk of harm.
- 7.1.4** The death of a person under 18 will not be investigated by the police in cases where a doctor is able to issue a 'medical certificate of cause of death', provided there are no suspicions of improper practice by that doctor in connection with that process. A 'medical certificate of cause of death' is usually issued in cases in which a doctor has treated the deceased for a diagnosed serious illness or condition from which s/he was expected to die at that time.
- 7.1.5** The police investigation into the unexpected death of any person under 18 in Greater Manchester will be led by a Detective Inspector (D.I) or Detective Chief Inspector (D.C.I). For the purposes of this protocol, that officer will be referred to as the police 'senior investigating officer' (S.I.O).
- 7.1.6** Further guidance on investigating child deaths is given in chapter 7 of 'Working Together to Safeguard Children 2006'. The latter document sets out how agencies, including the police, should operate in response to an unexpected child or young person's death and is 'statutory' guidance. As such, any deviation from the guidance should be capable of being justified before a judicial or public hearing. The previously mentioned document should be read in conjunction with this protocol.
- 7.1.7** This protocol has been written to give all personnel involved in the investigation of such deaths a better understanding of the role of other agencies in the process. Whilst the police element of this protocol has been approved by GMP command, it does not necessarily represent force policy. When dealing with such investigations, GMP staff should always refer to the more detailed guidance published in Chief Constable's Orders.
- 7.1.8** There are three new and 'key' features advocated by Chapter 7 of 'Working Together' and this protocol, which are central to the multi-agency model of investigation:

- Primary Care Trusts within Greater Manchester will have access to a consultant paediatrician who is designated to engage quickly with the police and other agencies after the unexpected death of a person under 18 occurs. This consultant will become known as the '**SUDC paediatrician**' and will be available 24/7 on a 'call out' basis. A consultant paediatrician at the hospital where the child is first taken will engage initially in preservation of life procedures, initial history taking and medical examination. Once death is confirmed the 'SUDC paediatrician' will be consulted and hand over of the case agreed. The 'SUDC paediatrician' will then take over responsibility for all medical aspects of the investigation into why the child died and liaison with the deceased's family and other agencies.
- The death will also trigger the coming together of a team of professionals from a number of agencies, co-ordinated by the SUDC paediatrician. This process will become known as the '**Rapid Response**'. Key team members will include the SUDC paediatrician, police SIO, health visitor or school nurse, GP and others where relevant e.g. midwife, mental health professional, social worker. In essence, this team of professionals will have the knowledge, expertise, information and resources to be able to contribute towards a thorough 'joint' investigation into why the child or young person died.
- When a person under 18 dies unexpectedly in a non-hospital setting, the police SIO and SUDC paediatrician should make a decision about whether a '**joint police/health professional visit**' to the place where the child died should be undertaken. This should almost always take place for infants (under 2) who die unexpectedly in a dwelling. If the death, trauma or collapse occurred in a place other than the home location, consideration should also be given to visiting and examining the home. Similarly, if the child had been living in different locations in the time leading up to death, consideration should be given to 'joint visits' to them. As well as deciding if the 'joint visit/s' should take place, it should be decided how soon (within 24 hours) and who should attend. Wherever possible the police SIO should take part in any 'joint visit' on behalf of the police. The police and SUDC paediatrician will visit, talk with the parents/carers and inspect/assess the scene. If a 'joint visit' is considered inappropriate, they may visit the location/s separately and then later confer. The purpose of a 'joint visit' is to identify all possible factors (from both a police and medical perspective) that may help explain why the child died.

Police attendance at the scene – Initial action

- 7.2.1** It is important for all police staff to remember that the majority of initially unexplained child deaths are not the result of criminality. Police action therefore needs to be carefully balanced between giving (and demonstrating) utmost consideration for the needs of an innocent, grieving family and carrying out a thorough investigation into a 'potential' homicide. In certain circumstances, it can be one of the most difficult tightropes the police have to tread.

- 7.2.2** The selection of an officer to attend a report of the sudden unexplained death of a child or young person should be carefully considered. If circumstances allow, operational control room staff should consult divisional supervisors on this matter. The officer being sent should have the skills, experience and emotional strength to cope with such a demanding incident.
- 7.2.3** In an 'emergency' situation, the quickest resource should be sent to the scene. The first officer should give first aid if necessary and immediately obtain medical help if there is any chance whatsoever that the child or young person may still be alive or capable of being resuscitated. In these circumstances, where the death is confirmed, a 'detective' officer should be sent to the scene in an un-liveried vehicle as soon as possible.
- 7.2.4** Police attendance at the scene, particularly that of uniform staff, should be kept to the minimum required. Several officers unnecessarily arriving at a home or hospital where a child or young person has just died could prove very distressing to relatives/carers.
- 7.2.5** In a 'non emergency' situation where the death has already been confirmed at the time of reporting (e.g. by N.W.A.S or hospital doctor) a 'detective' officer should be sent to the scene or hospital as the first response, unless this would involve any 'unreasonable' delay.
- 7.2.6** The officer/s attending the scene should give immediate consideration to the safety of all other children at the location. Depending upon the circumstances of the death and the conditions in which other children may be found, the officer/s may need to take prompt action to secure their safety and wellbeing. In extreme cases, this may require the use a police protection order.
- 7.2.7** Upon arrival at the scene or hospital, the 'detective' should immediately take charge of the investigation, ensuring all aspects of scene protection, evidence preservation and 'urgent' witness/suspect management are addressed until the S.I.O arrives or otherwise directs action. The detective may need to call upon other resources to help achieve this. All police action should be undertaken in the most low key and least intrusive way possible, having regard to the circumstances of the case. If the death has occurred inside a home, it is highly unlikely that police cordon tape will be needed outside.
- 7.2.8** Where the child/young person has been taken to hospital, the detective should ask to view the body to observe and make a written record of any suspicious marks, injuries or other relevant features. When viewing a body, police staff should be aware that any medical equipment used as part of the resuscitation process might still be attached. Tubes and other equipment may have been cut to a short length by hospital staff.
- 7.2.9** From the outset of any investigation all police staff, particularly the S.I.O, should be aware that a child who presents without any physical external or internal injury whatsoever, could still have been unlawfully killed. The mere absence of physical injuries should never therefore be taken as proof that foul play was not involved.

7.2.10 All police action should be carried out with empathy, sensitivity and understanding, even when it is suspected that a criminal offence may have been committed.

Guidance for dealing with grieving parents/carers

7.2.11 Police attendance, in itself, will be likely to increase parents'/carers' levels of distress. They are likely to need a sensitive explanation of the reason for police involvement and actions they take. The following statements may help in this process:

- The police carry out an investigation on behalf of the coroner into 'every' case of sudden and unexplained death.
- When any child/young person dies unexpectedly, an in-depth investigation by all agencies is carried out due to their potential vulnerability.
- The police conduct their investigation in the knowledge that the majority of deaths in children transpire to be from natural causes.
- Valuable lessons may be learned during the investigation that can be used to prevent further deaths of children.
- The police investigation is carried on in parallel with a rigorous medical investigation. Both investigations have the same aim - simply to find out why their child died.

In most cases, parents / carers will welcome the efforts being made to answer this vital question, a question that may haunt them until the truth is known

7.2.12 The following advice is offered for consideration in dealing with parents / carers:

- Say who you are, why you are there and how sorry you are to hear what has happened to the child/young person. Establish the child's name quickly and always use this in conversations with those that are grieving.
- If you have a need to handle the child, do so gently and caringly, as if s/he were still alive.
- In the first stages of grief, people may react in different ways, displaying shock, numbness, anger and hysteria. Be patient. Allow the parents/carers space and time to cry, talk together and comfort any other children. These early moments of grieving are very important.
- It is entirely natural for a parent/carer to want to hold or touch the dead child/young person, indeed it is known to help with the grieving process. You should allow this to happen provided it is done with a professional (e.g. police officer or nurse) being present throughout, as in most cases it is highly unlikely that any important forensic evidence will be lost. You should make a record of all

such contact with the body, together with details of who supervised it. If however, you consider the death to be suspicious, you should consult the S.I.O before allowing this to happen. If, for any reason, you are unable to consult the S.I.O at that time, you should prevent all persons from unnecessarily handling/touching the body until you have done so. Any instructions given by the police S.I.O in this regard should be passed to the A & E staff immediately if the child/young person is at (or is being taken to) hospital.

- Discourage the parents/carers from washing the child or changing the clothing or nappy at this stage. You may wish to explain to them that it is your job to try to make sure that no changes are made to the child/young person or his / her clothing until s/he is examined by doctors at hospital. Also explain that this is standard procedure and that it will help to give doctors the best chance of finding out why their child died.
- You should be prepared to answer practical questions such as where the child will be taken and when can they next see him/ her? You should always be certain of the responses you give. Giving inaccurate information could later prove highly distressing to the parents/carers.
- Be sensitive to any religious or cultural needs or beliefs. Parents/carers from some religions and cultures hold strong beliefs that bodies must be buried within certain timescales. They are likely to suffer additional anguish if they feel that the post mortem will delay that process. Arranging their contact with religious leaders or elders who are used to dealing with these issues may give them great comfort.
- If you experience any language difficulties whatsoever with parents/carers, you should arrange for the attendance of an interpreter as soon as possible. An English - speaking family member or friend may need to be used initially in urgent cases. In this event, you should consult the appointed S.I.O about the need to obtain an 'independent' interpreter as soon as possible to ensure accuracy in the conveyance, interpretation and recording of information provided by parents/carers.
- Most parents/carers feel guilty when their child has died. When talking to them try to ask 'open' questions e.g. Tell me what happened? Avoid questions that sound in any way critical such as, 'Why didn't you.....?'
- A thorough and successful police investigation is more likely to be achieved if at all times parents/carers are treated with sensitivity and respect by all officers. This applies even if they are suspected of committing a crime against the child or young person.

7.2.13 When the death of the child/young person at a scene is beyond all doubt, the officer should make a 'visual' check of the body and its surroundings. A written record should be made of any suspicious marks or injuries on the body and details passed to the S.I.O. as soon as possible.

Diagnosis of fact of death

7.2.14 North West Ambulance Service paramedics and technicians are now qualified to diagnose 'fact' of death. When necessary, they will do this in every case where they are called to the scene of the death of a child or young person. If the death appears to be suspicious, they will try to minimise contamination of the scene and body whilst performing this function.

Removal of the body from a scene – Death appears 'suspicious'

7.2.15 If, after 'fact' of death has been diagnosed, the death appears to be 'suspicious', the NWAS crew should remain with the body at the scene until the first police officer arrives. In these circumstances, the S.I.O should always be consulted before the body is removed from the scene either by NWAS or undertakers.

7.2.16 On average the NWAS crew will be available at the scene for 30 minutes following their arrival time whilst they complete records about the incident. Subject to the exigencies of their service they will transport the body to A&E, if requested to do so by the police SIO, within that timeframe.

Removal of the body from a scene – Death 'does not appear suspicious'

7.2.17 If, after 'fact' of death has been diagnosed, there do not appear to be any suspicious circumstances; the NWAS crew will (subject to the exceptions' listed below) immediately take the child/young person's body to the local A&E Department.

The following benefits accrue from this action:

- The knowledge that the child/young person is being taken to A&E rather than a mortuary can soften the early impact on the grieving family/carers
- The grieving family/carers can attend A&E, with the child, where they may receive immediate medical and social support
- Any perceived risk to a surviving twin or siblings can be assessed & addressed
- Early examination of the child/young person's body by a consultant and/or SUDC paediatrician will inform the early stages of the police investigation.

The only 'exceptions' to the above are as follows:

- If a police officer directs that the body should not be moved
- If the body is considered to pose a health risk
- If 'other exceptional reasons' exist that justify not taking the body to A&E (e.g. a major incident has occurred involving a high volume of admissions to A&E unit/s)

7.2.18 Where any of these exceptions apply, details should be recorded in police/NWAS records and brought to the attention of the police S.I.O.

7.2.19 Where the body is not moved to the A&E, the police S.I.O should always be consulted before any arrangements are made for removal of the body to the mortuary by undertakers.

7.2.20 Where necessary, the police may be able to arrange transport to the hospital for the immediate next of kin.

Obtaining information from parents/carers and the scene

7.2.21 As well as basic details for the death report, the 'detective' officer that initially attends should try to obtain and record the following information:

- Full details of the child/young person who has died,
- Details of the family/carer
- The circumstances leading up to the death.

In addition, the 'detective' officer should, if relevant, observe/note any features at the scene of the death that may have a bearing on why the child/young person died. This information should be passed to the S.I.O

No further 'in-depth' questioning should normally take place without the S.I.O's approval. The S.I.O will later determine the interview strategy.

Repeated questioning of the parent/carer by different officers should be avoided.

7.2.22 When considering the need to question parents/carers, officers (including S.I.Os) should be aware of the need for the 'duty' consultant or SUDC paediatrician to also interview them to obtain full 'medical' history.

Death reported from the hospital

7.2.23 Hospital staff may refer an unexplained death of a person under 18 to GMP, following admittance via A & E or where s/he has died on a ward.

7.2.24 Upon attendance at hospital, the first officer should liaise with any A&E staff that have examined the child/young person or spoken to parents/carers to establish what is known so far. Also to ensure that the parents/carers have been informed of the need for police involvement so that the introduction of the officer should not come as a surprise to them.

7.2.25 The officer should deal with family/carers as per guidance given previously in this protocol.

7.2.26 The officer (detective if in attendance) at the hospital should, with the appropriate lawful authority or consent, make an early attempt to recover, label and secure any nappy, clothing or possessions taken from the child by hospital staff that may be important to the investigation. Items taken should be treated as potential exhibits and packaged separately to avoid any risk of contamination. They may later require forensic examination. Assurances should be given to parents/carers that the items will be returned to them in the best possible condition.

Informing the duty SIO

7.2.27 As soon as the officer (detective if in attendance) is able to confirm the death and obtain basic details of the incident, s/he should communicate these to the Operational Control Room asking for the duty 'divisional' S.I.O to be informed and requested to attend as soon as possible

Formal identification of the body

7.2.28 The 'detective' officer in attendance should, in consultation with the SIO, ensure that formal evidence of identification of the child or young person's body by an 'appropriate' relative/carer is 'sensitively' obtained.

7.2.29 The releasing of the child's/young person's body at hospital before being taken to the mortuary is often one of the most distressing times for parents/carers and great patience, understanding and empathy is needed.

7.2.30 It is rare for parents/carers to ask to accompany their child to the actual mortuary and this should not be encouraged. However, if specifically requested, they may be taken into the public reception area. Parents/carers should be accompanied by a police officer at all times whilst in the mortuary. They should not be given access to any other part of the mortuary where strict health and safety rules apply.

Responsibilities of the Police Senior Investigating Officer

7.3.1 The S.I.O should assess the circumstances of the death, develop strategy and deploy staff to explore all reasonable lines of enquiry. Success in child protection demands this level of rigour, as does the memory of the child that died.

7.3.2 Throughout the investigation, the S.I.O should, wherever possible, follow the guidance contained in Chapter 7 of 'Working Together to Safeguard Children'. Any deviation may later need to be justified to a court.

7.3.3 If at any stage the S.I.O has grounds to suspect a homicide, arrangements may be made for the MIT (Major Incident Team) to take over the investigation.

7.3.4 As per the direction in 'Working Together', any 'joint visit' to the home by the S.I.O and SUDC paediatrician should ideally occur within 24 hours of the death. The S.I.O should consult the dedicated SUDC paediatrician as soon as possible to determine whether or not this will take place. Due to time constraints, this consultation may need to be conducted by telephone. A balance must be struck between any delay that may be caused in trying to arrange a joint visit and the potential loss of evidence if the police do not attend the scene promptly. There may be little point in a SUDC paediatrician visiting a 'home' scene if the police have already removed/seized items of interest. This should be discussed with the SUDC paediatrician and an action plan agreed.

- 7.3.5** Where the death is considered 'suspicious', the S.I.O may decide that a 'joint' visit to the scene, prior to the recovery of all potential forensic evidence, is inappropriate. When a decision is made that a joint home visit will not take place, the S.I.O should record the reasoning for this.
- 7.3.6** Wherever possible, the S.I.O should arrange to view the body him/herself at the earliest opportunity, even if a junior detective officer has previously completed this action. This should ensure that the SIO is aware, at first hand, of all visible injuries or marks of concern on the body before the post mortem takes place.

Informing the Coroner's Liaison Officer

- 7.3.7** During office hours, the coroner's liaison officer for the division should be notified as soon as possible. His/her experience and expertise in dealing with sudden deaths and bereaved families should be used to the full. The S.I.O should maintain close liaison with the C.L.O throughout his/her investigation.

Witness / suspect management / interview strategy

- 7.3.8** The S.I.O should determine his/her interview strategy in respect of all persons of relevance to the investigation. Police, health and children's services staff should work in close collaboration when planning interviews to avoid all unnecessary repeated questioning of parents/carers. The SUDC paediatrician will wish to obtain a detailed medical history from the parents/carers. The advantages and disadvantages of a 'joint interview' by the police and SUDC paediatrician should be discussed, having regard to the particular circumstances of the case.
- 7.3.9** If any doubt exists that the parents/carers do not fully understand English, arrangements should be made for the attendance of an interpreter as soon as possible.
- 7.3.10** Even in 'non-suspicious' cases, the S.I.O should consider the benefits of asking parents/carers to agree to be video interviewed. This could be facilitated at the divisional P.P.I.U. suite. Alternatively, an audio-recorded interview may be considered. The benefits to the parents/carers of such recorded interviews are that it reduces the risk of anything said being misunderstood or misinterpreted and may avoid the need for further interview. Extreme care should be taken to ensure that parents/ carers are not made to feel like suspects, when they are not.

Intelligence strategy

- 7.3.11** The S.I.O should determine his/her intelligence strategy. Where necessary, this should include researching all key persons present around the time of death on police databases.
- 7.3.12** Valuable information may be made available about the dead child and any other persons of interest e.g. parents/carers, by partner agencies at case meetings. Data protection authorities may be needed by these agencies if the consent of the 'other' persons has not already been obtained. Local data sharing protocols may help in this process.
- 7.3.13** Teaching staff of school age children can hold extensive and invaluable information about the child, parents/carers and siblings that may not be available from other agencies.
- 7.3.14** The S.I.O should ensure the dissemination of all useful intelligence gleaned during and at the conclusion of his/her investigation.
- 7.3.15** Any intelligence gleaned may be useful and even crucial to other agencies and should, if possible, be shared with them on a needs basis.

Scene strategy, evidence recovery and imaging

- 7.3.16** The S.I.O should determine his/her imaging, scene examination, and search and seizure strategy. If possible, this should be done in consultation with the SUDC paediatrician. The S.I.O must ensure s/he has lawful authority or consent to carry out any proposed action.
- 7.3.17** Wherever possible, a Crime Scene Investigator (C.S.I.) should be requested to attend to photograph any injuries, suspicious marks or features on the body before it is moved.
- 7.3.18** If the SUDC paediatrician has not attended the scene, the S.I.O should consider using the images captured to brief him/her and, in suspicious cases, the 'forensic' pathologist before post mortem.
- 7.3.19** Any other staff member involved in the search should be fully briefed beforehand and the process conducted in a highly sensitive manner. Where items are to be removed from the house, it should be explained to the parents that this is standard procedure and may help to find out why their child has died. The S.I.O should be able to justify to the parents/carers, the need to take every single item taken/seized. Assurances should be given that the items will be returned to them in the best possible condition.
- 7.3.20** Police visits to the home should be kept to a minimum. A comprehensive plan by the S.I.O (in consultation with the SUDC or 'duty' consultant paediatrician) to capture all potential evidence in one visit should, in most cases, avoid any need to disturb the

family again. Repeated police visits may unnecessarily increase the apprehensions of the parents/carers that they are under suspicion and potentially cause them embarrassment.

Post Mortems

- 7.3.21** If there is any suspicion or concern whatsoever that a criminal act may have been a factor in the child's death, the S.I.O should ask the coroner to hold a Home Office post mortem using a forensic pathologist. In these circumstances, depending on the age of the child, the coroner may direct that a paediatric pathologist conduct a 'joint' post mortem with the forensic pathologist.
- 7.3.22** If a 'non-Home Office' post mortem is to be held, there will not normally be any need for any police staff to attend. Neither would the non-Home Office pathologist expect a personal briefing from the police before this type of post mortem took place. If an S.I.O wished to attend a non-Home Office post mortem or send a representative, s/he would need to obtain prior authority from the coroner and make early arrangements with the pathologist in question.
- 7.3.23** Under no circumstances should an S.I.O seek to delay the start of a non-Home Office post mortem purely so an officer can attend.
- 7.3.24** If during a non-Home Office post mortem a pathologist uncovered something suspicious, s/he would immediately stop the procedure and contact the coroner and the police. The coroner would then decide whether to continue or re-convene the post mortem with the additional involvement of a forensic pathologist.
- 7.3.25** Having regard to the circumstances of the death and the age of the child, the pathologist/s will consider the need for a skeletal survey of the body. If the child is under the age of 2 years, a skeletal survey should be undertaken in every case. A paediatric radiologist will interpret any survey conducted. The S.I.O should establish the outcomes of these examinations as soon as possible.
- 7.3.26** Upon receipt of a written post mortem report from the pathologist/s, the Coroner will provide a copy to the SUDC paediatrician and the S.I.O.
- 7.3.27** Under the requirements of the Human Tissue Act 2004, the next of kin will be informed of all human tissue samples taken from the body at post mortem. The next of kin must be consulted regarding their wishes about the retention of the tissue for research purposes, the return to them for burial/cremation or sensitive disposal by other means. The Coroner's Liaison Officer will address these issues on behalf of the coroner.

Obtaining mementos for parents/carers from the body

7.3.28 The S.I.O will be responsible for ensuring that parents/carers, in every case, are asked whether or not they would like the following mementoes from the child/young person's body:

- Lock of hair.
- Handprints
- Footprints

Parent/s carers should be encouraged to accept the mementoes. Experience has shown that these very personal and tangible items become highly treasured keepsakes that may offer them great comfort in times ahead. If the parents/carers decline the offer, it should be made clear to them that once the child/young person is buried or cremated, this opportunity will be lost.

Parents/carers should not be offered plaster casts of hands or feet. These are notoriously difficult and time-consuming to obtain and cannot be provided. If parents/carers specifically request plaster casts, they should be advised that funeral directors may be willing to obtain them but may charge them for this service.

7.3.29 Once all forensic requirements have been addressed the police S.I.O will be responsible for ensuring that any mementoes requested by the parents/carers are obtained from the body during or after the post mortem. Mortuary technicians at the Central Manchester & Manchester Children's University hospital, where most child post mortems will take place, have agreed to obtain the mementoes. Separate guidance will be issued to police staff regarding how to arrange the taking of such mementoes and their delivery to parents/carers. Such mementoes are usually treasured by parents/carers and any delay in presentation of them should be avoided.

7.3.30 Wherever possible, special boxes will be used for the presentation of mementoes to parents/ carers.

Informing the coroner of the death

7.3.31 The S.I.O should ensure that the police C.L.O. formally reports the death to the coroner during 'office hours'. The coroners covering Greater Manchester have stated that they do not require to be routinely notified of a child/young person's death outside office hours. However, if the S.I.O or a health professional is experiencing any difficulties dealing with such a death and requires the coroner's advice, s/he may contact the coroner at any time (including weekends and public holidays) outside the hours of 2300 to 0700. Separate guidance has been issued to GMP staff about the exceptional circumstances in which coroners require to be contacted between the hours of 2300 & 0700.

7.3.32 At the conclusion of the investigation the S.I.O should, in consultation with the SUDC paediatrician and to locally agreed timescales, submit a report to the coroner giving full details of the extent and outcome of the police investigation.

Attending multi-agency case meetings

7.3.33 The S.I.O (or where unavailable his/her nominated representative) should fully engage in all multi-agency meetings outlined in chapter 7 of 'Working Together'. In suspicious cases, the police S.I.O will lead the case meetings. In all other cases, the SUDC paediatrician will lead the meetings.

7.3.34 At these meetings, professionals will agree a co-ordinated action plan. The plan will be delivered by named individuals from the various agencies being tasked with specific responsibilities within a set timeframe.

7.3.35 Any suspicion or concern arising from the police investigation should be shared with senior staff from the other key agencies involved as soon as possible.

7.3.36 The SUDC paediatrician should review all medical records relating to the dead child and relevant family members. S/he should consult the S.I.O about any information contained in them that could potentially assist the police investigation. This should include medical records held by A & E, hospital paediatrician/consultant, community nurses (includes health visitors, school nurses and children's community nurses) and the child's general practitioner. If the S.I.O requires a copy of any medical record for the purposes of his/her investigation, consent issues for any living person may need to be addressed or other legal authority obtained.

7.3.37 Any surviving siblings may be the subject of enquiry under Section 47 of the Children Act 1989 (child protection investigation). The police element of any such enquiry would be led by local P.P.I.U staff and managed according to Local Safeguarding Children Board Procedures. If a s.47 enquiry was required, this would be discussed at the first strategy meeting of the rapid response team. If this was unlikely to occur within 24 hours, a separate strategy discussion should take place.

7.3.38 During the investigation, S.I.Os should liaise closely with Children's Services personnel if there is any chance that care proceedings may be commenced in respect of siblings of the dead child/young person. This will help to ensure that any potentially criminal investigation is not inadvertently compromised by the disclosure of information during such proceedings.

7.3.39 All agencies have the same ultimate aim, which is to establish why the child died. As such, the S.I.O should very much view the investigation as a joint, collaborative enterprise.

Keeping parents/carers informed

- 7.3.40** Wherever possible, bereaved parents/carers should be kept up to date with all progress made during the investigation, unless this could compromise any intended police action. Care should be taken to avoid any duplication of effort, particularly in regard to any direct contact with the parents/carers. The communication strategy for parents/carers should be an agenda item at the meetings.
- 7.3.41** Important information should only be withheld from parents/carers, if absolutely necessary. In such circumstances honesty and transparency about police actions and intentions form a critical part of winning the respect and cooperation of parents/carers without which an effective and comprehensive investigation may not be possible.

Public Protection Units (P.P.I.U.s) and Safeguarding Vulnerable Persons Unit (S.V.P.U)

- 7.4.1** During their investigation, all S.I.Os should draw on the knowledge and expertise of staff in the divisional 'Public Protection Investigation Unit' and HQ based 'Safeguarding Vulnerable Persons Unit'.
- 7.4.2** P.P.I.U staff have specialist skills, knowledge and experience within the field of interagency child protection. As such they have a vital role to play in supporting the investigation into the death of any child or young person within the definition of this protocol. The S.I.O should liaise with his/her P.P.I.U at the earliest opportunity.
- 7.4.3** The P.P.I.U staff will address any wider child protection issues including assessing any risk posed to a living sibling or unborn child and taking any action necessary by either invoking police protection procedures or by supporting an application by the Local Authority for an Emergency Protection Order.
- 7.4.4** The S.V.P.U. is responsible for attending Child Protection Case Conferences in respect of all children who are the subject of a 'child protection plan' across the force area. When a child who is currently the subject of a 'child protection plan' dies and a multi-agency investigation commences, staff from this unit will contact the police S.I.O for further information.
- 7.4.5** The S.V.P.U. is also responsible for attending and reporting on all child deaths to the Local Safeguarding Children's Board (LSCB) and Child Death Overview Panel (CDOP) in each Local Authority area. Staff from the S.V.P.U will complete a Child Notification Form for every child or young person's death coming to the attention of the police. This will include details of the child / young person, the family/carers and the circumstances. This is a requirement on all agencies. The LSCB administrators will then request a second, more detailed form, to be completed. This will also be completed by staff from the S.V.P.U.
- 7.4.6** In cases where a child dies in circumstances where abuse or neglect is suspected to be a feature, the CDOP may decide to hold a Serious Case Review (SCR). Police

representation at a SCR will be the S.V.P.U Detective Inspector. S.I.O.s should expect contact from this unit following their involvement in such cases.

Road Deaths

7.5.1 The investigation of a road death involving a victim under the age of 18 years will be led by a Road Policing S.I.O (a uniform sergeant or inspector). The road policing S.I.O and his/her staff should, as far as possible, follow the relevant guidance contained in chapter 7 of 'Working Together to Safeguard Children' and consider the contents of this protocol.

Returning property to bereaved families/carers

7.6.1 Items should be returned in person to parents/carers by the police as soon as possible after the Coroner has finished his/her investigation. Parents / carers should first be contacted and sensitively reminded about what items had originally been taken by the police. They should be asked whether they want the items back. If any items are unclean or, for example, still contain food or juice, the police should ask permission to wash them before they are returned. Official labels or wrappings should always be removed.

7.6.2 Where possible, items should be returned in respectful and presentable containers. In many cases, this meeting with parents / carers may represent their final contact with the police concerning the death of their child.

Sources of advice for cultural, religious and diversity issues when dealing with unexplained deaths of children

7.7.1 GMP staff can obtain guidance from the following associations / sources:

- Black & Asian Police Association
- Christian Police Association
- Disability Support Network
- Jewish Police Association
- Lesbian & Gay Staff Association
- Muslim Police Association
- Diversity Command

Contact details are available on the GMP Force intranet site.

8 AMBULANCE PROTOCOL

Appendix B

- 8.1** When the ambulance service is called to the scene of a sudden unexpected death or collapse / cardiac arrest of a child (0-18 years) the attending crew must notify the Paramedic Emergency Control Room at the first available opportunity without delaying patient treatment.

It is then the responsibility of the Control Centre to notify the police in ALL such cases.

8.2 Resuscitation Attempts

- 8.2.1** When resuscitation is indicated:

- Full resuscitation must be performed according to local protocol.
- The receiving Emergency Department must be contacted via the Control Centre with information on the child's clinical condition and the estimated time of arrival (ETA)
- All the information including history, observations of the scene and resuscitation details must be documented on the patient report form and passed onto the staff at the receiving unit.
- If circumstances allow, any other information should be passed on to the receiving doctor or police; i.e. background history, living conditions, comments made by those at scene.
- Anything suspicious should be reported directly to both police and the receiving doctor at the hospital.
- A copy of the patient report form should be left with a senior nurse or doctor dealing with the child.

8.3 Diagnosis of fact of death

- 8.3.1** The Ambulance Crew will diagnose 'fact' of death in every case in which they are called to the scene of the death of a child or young person. They will try to minimise contamination of the scene and body whilst performing this function provided doing so does not adversely affect any viable resuscitation attempt.

8.4 Removal of the body from a scene – Death appears 'suspicious'

- 8.4.1** If, after 'fact' of death has been diagnosed the death appears to be 'suspicious', the NWS crew should remain with the body at the scene until the first police officer arrives. In these circumstances, the SIO should be consulted before the body is removed from the scene by NWS. The first police officer at the scene should have the means to identify and contact the duty police SIO for this purpose.
- 8.4.2** On average the NWS crew will be available at the scene for 30 minutes following their arrival time whilst they complete records about the incident. Subject to the exigencies of their service they will transport the body to A&E, if requested to do so by the police SIO, within that timeframe.

8.5 Removal of the body from a scene – Death ‘does not appear suspicious’

8.5.1 If, after ‘fact’ of death has been diagnosed there ‘do not appear to be any suspicious circumstances’, the NWS crew will (subject to ‘exceptions’ listed below) immediately take the child/young person’s body to the local A&E Department.

The only ‘exceptions’ to the above are as follows:

- If any police officer directs that the body should not be moved
- If the body is considered to pose a health risk
- If ‘other exceptional reasons’ exist that justify not taking the body to A&E e.g. major incident or hospital on divert (If hospital on divert, discuss with A&E department coordinator as body may still go to A&E depending on reason for divert).

Where any of these exceptions apply, details should be recorded in police/NWS records and brought to the attention of the police SIO.

If a relative or carer wishes to travel to the hospital with the child, this should be permitted. Where necessary, the police may arrange transport to the hospital for any other immediate next of kin that wish to attend.

8.6 Other action to be taken after death has been established

8.6.1 In the case of a child between the ages of 2-18 years the GP can be informed via the Control Centre however there is no obligation for them to attend.

8.6.2 As far as possible make arrangements for the support of the bereaved (contact relatives, neighbours, priest etc)

8.6.3 Obtain police PIN or collar number from the officer attending and record on the appropriate documentation.

8.6.4 Complete all documentation as comprehensively as possible and provide a copy to the police.

9 THE GENERAL PRACTITIONER (GP) Appendix C

- 9.1 The GP may be called to the scene first. In such cases they should adhere to the same principles as Ambulance Staff (Appendix B).
- 9.2 If there are no signs of life the GP may certify the fact of death and will inform the police, via Police Control. The police and GP will inform the coroner. The GP will inform the A&E consultant or paediatrician at the hospital to which the child will be taken. The child should **not** go directly to the mortuary.
- 9.3 The GP should carefully record (verbatim) any account given by parents/carers of the circumstances leading up to the death and bring this to the attention of the police
- 9.4 The GP will be involved in providing ongoing advice and support for the family.
- 9.5 Whenever possible the Review Case Discussion meeting will be held at the GP surgery to facilitate the attendance of the GP.
- 9.5 Additional guidance for GPs and health visitors, particularly in relation to the longer term care of the family, can be obtained from the Foundation for the Study of Infant Deaths publications (www.fsid.org.uk):
- “Guidelines for general practitioners when a baby dies suddenly and unexpectedly”***
- “Guidelines for health visitors and midwives when a baby dies suddenly and unexpectedly”***
- 9.6 These booklets are written specifically for dealing with unexpected infant deaths but many of the principles apply to other child deaths.

EMERGENCY DEPARTMENT

- 10.1** As soon as the emergency department is notified that the ambulance crew is attending the scene of 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
- 10.2** Full resuscitation should normally be commenced unless clearly inappropriate.
- 10.3** The identities of people present and their relationship to the child must be ascertained.
- 10.4** To identify the possible cause of death a detailed history should be obtained (using the proforma below as a guide). The comments of parents/carers at all stages must be recorded in detail (verbatim if possible) in case of discrepancies or if suspicious circumstances develop.
- 10.5** The site and route of any intervention e.g. venepuncture, failed cannulation, interosseous needle, should be documented on a body chart. An endotracheal tube may be removed altogether (if the death is not suspicious) but only if there is documented clinical evidence of correct placement of the tube. If there is doubt that the endotracheal tube is not correctly placed, the fact must be noted and the tube left in situ.
- 10.6** A full general examination should be undertaken by the paediatrician/emergency consultant noting any rashes, injuries on the child, signs of dehydration etc, and state of any clothing or bed linen. The examination should include a retinal examination if possible.
- 10.7** All items of clothes and personal possessions should be placed in plastic bags and retained. They may not be returned without prior consultation with the police and coroner. They should be kept safe from any contamination and brought to the attention of the police as soon as possible. Staff should be aware that some or all of the items could later be sent for forensic examination.
- 10.8** Do not wash the body. Photographs may be taken and given to the parents according to the local protocol. In all cases locks of hair, and hand/foot prints (up to 5 years age) will be taken after the post mortem, and with parents' consent. This will be arranged by the police SIO.
- 10.9** Prior to death, blood, urine and CSF specimens can be taken for toxicology, metabolic and septic work-up. The proforma must accurately record which tests have been obtained. The paediatrician must ensure that all results of pre-mortem tests are forwarded to the coroner and pathologist.

- 10.10** If the child is dead on arrival at hospital or when the fact of death is certified, the attending doctor should inform the police as soon as possible. It will be the dual responsibility of the police and senior clinician to inform the coroner.
- 10.11** If initial history suggests the possibility that metabolic disease may contribute to the death then the lead clinician should consult with a paediatric metabolic consultant. If specimens are to be taken this should only be with specific agreement of the coroner and subject to the A&E/ward being licensed under the Human Tissue Act.
- 10.12** When the fact of death is certified the senior clinician should contact the SUDC paediatrician and discuss the immediate case management and arrangements for hand over.
- 10.12** A skeletal survey will usually be carried out in children under 2 years old (and considered in older children) as part of the post mortem and interpreted by a paediatric radiologist.
- 10.13** Children's social care for the area in which the child was resident should be contacted to ascertain if the child and any siblings are known, and in what capacity.
- 10.14** Other professionals also need to be informed. This should be done in consultation with the NHS Trust checklist.
- 10.15** The parents/carers will need time to accept the information. Staff should be prepared for a range of reactions from bereaved individuals.
- 10.16** Explain that the police and the coroner must be informed and that a post-mortem will be necessary to try to ascertain the cause of death. It is very probable that tissues (sometimes whole organs) and fluids will be taken during the post mortem examination and retained for detailed examination in the laboratory; information will be given about exactly what has been retained after the post mortem by the Coroner's staff or by the police. Some of the tissues taken are made into wax blocks and glass slides for microscopic examination. Following the Coroner's/police investigation, the family are given the opportunity to have any whole organs, the wax blocks and glass slides either returned to them or subjected to respectful disposal; in the case of blocks and slides there is also the option of retention in a secure system so that future examination is possible.
- 10.17** Explain that the child's, and any sibling's medical records will be reviewed and that the SUDC paediatrician will contact the parent's GP to ascertain if there is any relevant family history.
- 10.18** A record should be made at every stage of contact with the family. This should include which health professionals were present at each contact. Careful documentation is required to include the full history and the verbatim comments and demeanour of the parents/carers (see proforma).
- 10.19** The parents/carers/family members should be encouraged to see and hold the child whilst discreetly accompanied by a professional. However, if the death appears

suspicious, the police SIO should be consulted before allowing this. At no stage should staff place themselves at risk in this situation.

- 10.20** A member of staff should accompany the child to the mortuary. The child should not be left unattended until in the mortuary.
- 10.21** The trust's hospital checklist should be completed according to local practice.
- 10.21** Inform the SUDC paediatrician. Following the Initial Case Discussion, the SUDC paediatrician will liaise with the GP, HV and/or school nurse, and children's community nurse (if appropriate) to decide on appropriate follow-up for the family.

UNEXPECTED DEATH OF A CHILD ON A WARD

- 10.22** If a clinician has concerns when a child dies unexpectedly on a ward and the death is unexplained, the clinician should discuss the case with the coroner. If the clinician is then not able to issue a death certificate this protocol should be followed.

11 SUDC PAEDIATRICIAN

Appendix E

- 11.1 Provide telephone advice and attend promptly when on call if necessary.
- 11.2 The SUDC paediatrician will take the lead in the medical investigation
- in communication with other health care professionals
 - in communication with other agencies (police, coroner's office and children's social care).
- 11.3 Ensure all multi-agency strategy discussions/meetings take place
- 11.4 Co-ordinate immediate case discussion with acute paediatrician, police, children's social care and relevant health professionals (within 24 hours).

The following should be considered at the immediate case discussion:

- Background information/ presentation of the sudden unexpected death including details of any explanations given by parents/carers to ambulance, hospital or police staff
- Background information of the child, family & significant others to check if the child and or siblings are known to children's social care or subject to a child protection plan.
- Consideration of safeguarding issues of surviving children
- Outstanding/ Immediate child protection issues
- Nature of suspicions
- Consider what other records should be reviewed (e.g. adult health records for persons living / visiting the home). Police to obtain consent if individuals refuse.
- Consideration of requesting blood and urine samples from parents/carers to indicate any level of intoxication or drug use
- Scene Management (including advising on taking items for further examination and imaging requirements)
- Appropriateness of joint home visit by police and SUDC paediatrician and need for interpreter.
- Contact with the coroner
- Timing of post mortem and briefing of pathologist
- Restrictions on viewing body
- Significant police action taken or proposed (e.g. arrest of suspect, obtaining statements)
- Immediate support of the bereaved (e.g. allocation of Family Liaison Officer (FLO) or named point of contact)
- Co-ordination of professional's contact with the family including the paediatrician meeting with the family. This may be appropriately done jointly with police.
- Agreed point of contact with mortuary and bereavement staff/access of family to deceased
- Status of the enquiry/ investigation (criminal/ Section 47)
- Time and date of review case discussion meeting
- Staff welfare

The SUDC paediatrician will minute the discussion and distribute the actions and timescales to the relevant individuals.

- 11.5** Discuss with senior investigating officer and if appropriate, arrange to visit the family at home, preferably with the police and as soon as possible after the death, to talk with the family and to examine the environment in which the child collapsed or died (which may not be in the family home).
- 11.6** Collate all relevant medical records, including sibling's health records. Notes of previous hospital, community, Obstetric, A&E Department attendances must be obtained including records of the use of NHS facilities in other areas. Seek information on any relevant parental health problems from GP.
- 11.7** Together with the hospital paediatrician provide information for the pathologist prior to the post mortem.
- 11.8** Organise the review case discussion as soon as the results of the post mortem are available (2-3 months) and document in the child's record.
- 11.9** Prepare a written summary of the review case discussion and ensure it is distributed to all relevant professionals including the coroner.
- 11.10** After discussion with the coroner, offer to meet the family to explain the outcome of the case discussion, including the cause of the infant's death, and send the family a full written report in accessible language.
- 11.11** Ensure the family is fully notified and supported at all stages.

Information to be collated by the SUDC paediatrician (in A&E or at home visit)

This list is meant as a guide. Specific additional questions may arise as a consequence of information given by the parents. Encourage the parents to talk spontaneously with prompts rather than try to take a structured history. Record verbatim where possible.

The child

- First name and family name (plus any other names)
- NHS number
- Date and place of birth
- Ethnicity

Mother

- Full name (plus any other names)
- Full address including postcode.
- NHS number
- Date of birth
- Ethnicity
- First language
- Phone numbers and phone numbers of any available close relative of friend.
- Address mother will be using plus phone number if different from home

Mother's partner and/or father of the child

- Full name (plus any other names)
- Full address including post code
- Date of birth
- Ethnicity
- First language
- Phone numbers and phone numbers of any available close relative of friend.
- Address father will be using plus phone number if different from home

Other members of the household (present and recent past)

- Names
- Dates of birth
- Relationship to the child who has died.

Family Medical History

- Detailed past medical and social history of family and household
- Details (including name, date of birth, place of birth) of previous children.
- Detailed information on any deaths in infancy or childhood of any offspring, siblings or other close relatives of other members of the household.

Social history

- Social structure of family and household, including detail on alcohol, tobacco and other drug use, with information on any prescription or non-prescription medications that may have been present or in use in the household.

- Recent changes in composition of the household (who has come, who has gone and for what reasons).

Medical history of the mother

- Past medical and social history including past illnesses and injuries
- Obstetric history, including detail of the pregnancy of the child who died.

Medical and developmental history of the child

To include:

- Gestation
- Birth weight
- Perinatal or neonatal problems
- Type of feeding (dates and reasons for changing feeding)
- Growth, development and past assessments
- Immunisations
- Any known contact with infection
- Medication (prescribed and over the counter)
- If possible obtain parent held record to copy (and return to parents); plot the growth record onto centile chart.
- If under care of midwife, obtain the Midwifery Record.

Detailed narrative account of the baby/child's feeding, sleeping, activity and health over the 2 week period prior to the death

- Changes in feeding and sleeping patterns
- Changes in place of sleep
- Changes in individuals responsible for providing care to the child
- Social, family or health related changes in routine
- Any illness, accident or other major event affecting other family members.

Detailed (hour-by-hour) narrative of events within the 48 hours prior to the child being found dead (if appropriate)

- Precisely where the child was placed for sleep
- Duration of sleeping period
- Position at end of sleeping period
- Any changes in routine care or activity levels
- Any disruptions to normal patterns
- Activity and location of significant household members
- Alcohol and recreational drug use by members of the family

The final sleep (if appropriate)

A very careful description of when and where the child was placed to sleep, including:

- The nature of the surface
- Clothing
- Bedding
- Arrangement of bedding
- Precise sleeping position
- Who was sharing the surface on which the child was sleeping

- How often the child was checked
- When he or she was seen or heard
- The time at which the child awoke for feeds
- Whether feeds were given
- Whether they were taken well
- Who else was in the room at each stage
- What were the activities of others in the room
- Where, when and by whom was the baby found
- What was the appearance of the child when found
- What was the position of the child when found
- Where was the bedding
- Were there any covers over the child
- Had the covers and the position of the covers moved
- Were there any other objects adjacent or close to the child (e.g. teddies, pillows)
- Was the heating on
- What type of heating
- Were the window and/or doors open or closed

Action after the child was found

A detailed narrative to include:

- When, how and by whom the emergency services were called
- Who was with the child at each stage
- Was resuscitation attempted and if so by whom
- Were any responses obtained from the child
- How long did it take for the emergency services to arrive

Further questions

The parents' perception of

- Whether the child was feeding as well as, or less well than usual in the past 24-48 hours
- Any vomiting
- Any respiratory difficulty, noisy breathing, in-drawing of the ribs, wheezing or stridor
- excessive sweating
- Unusual activity
- Unusual behaviour
- Level of alertness
- Difficulty sleeping
- Difficulty waking
- Passage of stool and urine flow (how often and how much)
- Where any health care professionals consulted in the last 2 weeks
- If so, who was contacted, what was the problem described, what advice was given
- Was the child seen and assessed by any health care professional in the last 2 weeks?

COMMUNITY PRACTITIONERS: HEALTH VISITING, SCHOOL NURSING AND CHILDREN'S COMMUNITY NURSING GUIDELINES

- 12.1.1 The gathering of relevant information from community practitioners such as health visitors, school nurses and children's community nursing staff following a sudden unexpected child death is required to aid the investigative process by the coroner.
 - 12.1.2 The need to support the professionals involved with the family prior to the death of the child must be recognized.
 - 12.1.3 The community practitioner will make the child's community health record available to the SUDC paediatrician and discuss any concerns e.g. failure to thrive, neglect, parental problems such as substance use, domestic abuse, mental ill health and learning difficulties.
 - 12.1.4 The community practitioner will contribute to any multi-agency meetings and will provide written reports as requested
 - 12.1.4 The community practitioner involved with the child/family should work closely with the GP to provide bereavement support for the family.
- 12.2 If the community practitioner is first on the scene
- 12.2.1 Dial 999 and ask for an ambulance to attend the scene immediately.
 - 12.2.2 Attempt resuscitation or procede as instructed by the ambulance service. If the indications are that the child is dead and no active resuscitation has been attempted, the body should remain in situ pending the arrival of the police.
 - 12.2.3 The position of the child and the condition in which it was found must be recorded together with any comments/explanations from any person present. Bring this explanation to the notice of the police or SUDC paediatrician. Try not to disturb the scene, i.e do not touch or move anything.
 - 12.2.4 When the paramedics arrive, spend time listening to the parents and offering support.
 - 12.2.5 If the parent/carer goes to the hospital with the child, ensure that appropriate arrangements are made for the care of siblings. Record details of who is caring for the children.
 - 12.2.6 If the mother is alone, ensure that she has the appropriate family support. Give the parents a work telephone number where you can be contacted.

- 12.2.7** Inform your line manager and the named nurse for safeguarding children of the action taken
- 12.2.8** As soon as possible after the incident (within 24 hours) make a precise and thorough record of the event in the child's record, making particular reference to:
- a. Any inappropriate delay in seeking help,
 - b. The position of the child, its surroundings and the condition in which it was found,
 - c. Inconsistent explanations - accounts should be recorded verbatim in quotes where appropriate,
 - d. Evidence of high risk behaviour eg domestic abuse, drugs/alcohol use,
 - e. Parent's reaction/demeanour,
 - f. Unexplained injury e.g bruises, burns, bites, presence of blood,
 - g. Neglect issues.
 - h. General condition of the accommodation

NB: If the records have already been secured, record on a continuation sheet which can be added to the child's records.

12.3 When a child has died

- 12.3.1** Check to ensure that all known agencies working with the child have been informed of the child's death eg, paediatric AHP's, audiology, midwifery services, community paediatricians, Children's Centres etc so as to avoid appointments being sent.
- 12.3.2** Inform the Child Health Department to avoid appointments being sent
- 12.3.3** Contact the family to acknowledge the death of their child, and offer support as required.
- 12.3.4** In the case of an infant death ensure that the parents/carers have a copy of the infant death booklet and the help line number of the Foundation for the Study of Infant Death - 020 7233 2090 or 0870787 0554 (Both of these numbers are valid at the time of writing the procedure. A phone card is available for parents to use the help line free of charge from helpline staff.)
- 12.3.5** Assess the support that the parents/carers/siblings/grandparents require. Where the family is in need of intensive support consider alternatives, e.g. FSID Befriender Service.
- 12.3.6** If the mother was breast feeding, discuss and advise on the suppression of lactation and refer to the GP where necessary.
- 12.3.7** Ensure that the parents/carers have your work contact number.
- 12.3.8** Ensure that community health records are available to the SUDC paediatrician; be available to attend any subsequent multi-agency meetings and to provide written reports as requested.

12.4 In the months following the death:

- 12.4.1** Arrange a home visit again after the funeral and during the following weeks, in consultation with the family.
- 12.4.2** Make sure that the parents have your work contact number.
- 12.4.3** Assess whether additional support is required to assist parents/siblings cope with their grief and arrange as appropriate.
- 12.4.5** Remember the first anniversary of the child's birth and death and consider a visit at those times
- 12.4.6** In the case of Sudden Unexpected Infant Deaths offer support with the subsequent babies via the Care of the Next Infant (CONI) Scheme.
- 12.4.7** Access any support you may require for yourself, eg staff counselling service/ supervision.

13.1 Introduction

These guidelines inform midwives of the procedures in the event of the unexpected death of a child. This can be a difficult time for everybody. Additional support can be obtained from the designated/named professionals and CONI Coordinators.

13.1.1 Records will be secured by the named professionals as soon as the death has been notified. A copy will be made available for the midwives. This is a precautionary measure until the situation is clarified.

- Midwives should also refer to their own organisation's procedures/protocols
- All midwives should be competent to deal with the issues of bereavement
- On-going care and support will be provided by the midwife until the end of the postnatal episode of care unless the family specifically request another member of the team or the midwife is a witness and the employing organisation advises against a particular person visiting. In this event, check with your line manager/legal department and make careful notes of the events.

13.2 If the midwife is first on the scene

13.2.1 When an unexpected fresh stillbirth or sudden unexpected death has occurred without the presence of a health professional, or if the birth has been concealed, the midwife must assess the baby and the mother's medical condition and immediately call the paramedic services who will inform the police. The midwife should not complete the medical certificate of stillbirth and the GP should be informed (Northwest Local Supervising Authorities Guidance for Supervisors of Midwives 2005)

13.2.2 Where the midwife has arrived after the birth and there is evidence of maceration or gross abnormality she may complete the medical certificate of stillbirth if confident that the baby cannot have shown signs of life. In this event the coroner's office will not need to be informed (NLSAGSM 2005)

13.2.2 CPR should be attempted if appropriate. If the indications are that the baby is dead and no active resuscitation has been attempted, the body and placenta should remain in situ pending the arrival of the police.

13.2.3 The position of the baby and the condition in which it was found must be noted together with any comments/explanations of the mother or any other person at the scene. Try not to disturb the scene, i.e. do not touch or move anything.

13.2.4 When the paramedics arrive, spend time listening to the parents and offer support.

13.2.5 If the parent/carer goes to the hospital with the baby, ensure that appropriate arrangements are made for the care of the siblings.

13.2.6 If the mother is alone, ensure that she has the appropriate family support.

13.2.7 Give the parents/family a work telephone number where you can be contacted.

13.2.8 If the mother's condition requires obstetric intervention, she should be transferred with a midwife to the nearest maternity unit, whether she is booked there or not

13.2.9 If the baby is not resuscitated the body will be taken to a hospital A&E department.

13.2.10 Parents and family members may have access to the baby's body as agreed at the Initial Case Discussion. An appropriate professional **MUST ALWAYS** be present.

13.2.11 If the midwife has any relevant information about the pregnancy or the family, this should be reported directly to the police and A&E staff as soon as possible.

13.2.12 As soon as possible and within 24 hours, make a precise and thorough record of the event in the baby's record, making particular reference to:

- a. Any inappropriate delay in seeking help,
- b. The position of the baby and the condition in which it was found.
- c. Inconsistent explanations - accounts should be recorded verbatim in quotes,
- d. Evidence of drugs/alcohol abuse,
- e. Parents reaction/demeanour,
- f. Unexplained injury e.g bruises, burns, bites, presence of blood,
- g. Neglect issues.
- h. Position of the baby and its surroundings
- i. General condition of the accommodation
- j. Evidence of high risk behaviour eg domestic violence

NB if the records have already been secured, use a continuation sheet which can be added to the child's records at a later date.

13.2.14 Midwifery staff involved in the case should be offered support and the opportunity to speak to their Supervisor of Midwives.

13.2.15 The family GP and health visitor must be informed as soon as possible.

13.2.16 In the case of a death on the maternity unit, also contact : Supervisor of Midwives, coordinator on delivery suite and Head of Midwifery."

13.3 If you learn later that a baby has died

13.3.1 Check that the following agencies/professionals are informed of the infant's death.

- a. Medical records department/maternity/children's hospitals to avoid follow up appointments being sent.
- b. Child health department to avoid appointments /reminders being sent
- c. The family GP in case s/he has not already been contacted by the police/hospital
- d. Health visitor
- e. Audiology department if the infant has been referred for follow up or has not yet had neonatal screening.
- f. Named midwife safeguarding children and the relevant line manager
- g. School Nurse if there are older siblings in the family
- h. Any other department to which the infant has been referred/seen if follow up appointments are possible, e.g. Sure Start, Social Care

- i. Known research projects in the area, which might result in a questionnaire being sent to parents/carers.
- j. Local Supervising Authority and Supervisor of Midwives
- k. CEMACH Office

13.3.2 The midwife holding case responsibility for mother and baby should contact the family to acknowledge the death, offer condolences and answer any question.

13.3.3 Discuss the support the parents/carers/extended family require. If there is inadequate support, consider more intensive midwifery support or alternatives/FSID Befriender Service.

13.3.4 If the mother was breast feeding, discuss and advise on the suppression of lactation and give appropriate support. Refer to the GP if necessary.

13.3.5 Ensure that the midwifery records are available to the SUDC Paediatrician and be available to attend any subsequent multi-agency meeting. If still visiting the mother photocopy the hand held records and take the originals to the meeting.

13.3.6 Be prepared to provide a Statement of Evidence if requested and seek advice from the designated nurse / named midwife.

13.4 The next pregnancy:

13.4.1 Ensure that the C.O.N.I. co-ordinator has been notified as soon as possible.

13.4.2 In the ante-natal period ensure that the family Health Visitor and GP are aware of the pregnancy and forthcoming delivery.

13.4.3 Scrutinise previous records to ascertain whether it is necessary to inform any other professional/agency of the pregnancy. e.g social worker.

13.4.4 Ensure that the previous infant death is highlighted in the maternity records.

13.4.5 Ensure that the family receives appropriate support during the pregnancy, delivery, and post-natal period.

13.4.6 Ensure evidence based practice is shared with carers in respect of the following specific risk factors:

- **co-sleeping**
- **ingestion of prescribed medication/ substances,**
- **sleeping positions,**
- **smoking**
- **temperature control.**

Use your local C.O.N.I. Co-ordinator for advice, support, guidance and for up to date research.

14 CHILDRENS SOCIAL CARE

Appendix H

- 14.1** In the first instance A&E staff will check with Children's Social Care whether the deceased or any child within the same family is or has been known to children's services and if so, in what capacity.
- 14.2** Children's Social Care staff will check whether the child and or siblings is subject to a child protection plan, and for any previous concern about the well being of the deceased or any other child in the family. Such information will be given to the A&E Department and/or SUDC paediatrician in confidence.
- 14.3** If the family of the deceased child are existing or recent clients of Children's Social Care, the line manager will inform the child's social worker and or consider the need for a social worker to be allocated to the family.
- 14.4** If the family is not known, then the primary support to family will be given by health workers and the police. However, should these agencies believe that Children's Social Care support or services will be helpful then this should be given priority.
- 14.5** The social worker will liase with the police SIO and SUDC paediatrician and share information.
- 14.6.** Where a social worker is to be involved and after discussion with the SUDC paediatrician, s/he will contact the family and offer support either directly or via other appropriate agencies. Such help will depend upon the family's willingness to accept it.
- 14.7** If the death appears to be suspicious and there are other children in the family, Section 47 of the Children Act 1989 requires the Local Authority to institute a child protection enquiry. This should be done in accordance with LSCB procedures. The immediate protection of any other children in the family will take priority.
- 14.8** If a S.47 enquiry is required this element of the investigation will be discussed at the first strategy meeting of the rapid response team to ensure that there is clarity in relation to the various strands of the investigation, roles and timescales.

15 THE ROLE OF THE CORONER, CORONER'S OFFICER AND PATHOLOGIST

- 15.1** After the fact of death is certified, the coroner has control of the body. Medical samples should only be taken by the pathologist.
- 15.2** In **all** cases of children under 2 years old, prior to the post mortem examination, a full skeletal survey will be conducted and interpreted by a paediatric radiologist. Skeletal surveys in older children will be considered on an individual case basis.
- 15.3** The decision to involve a paediatric pathologist in a post-mortem examination will be made by the coroner on an individual case basis.
- 15.4** If a post-mortem examination reveals suspicious circumstances, it will be halted. The post-mortem will then be continued jointly with a Home Office pathologist, following consultation with the police Senior Investigating Officer (SIO).
- 15.5** If the circumstances of the death are suspicious from the outset, the SIO will consult the coroner who may direct a joint PM by a Home Office pathologist (who will take the lead) and a paediatric pathologist. If the paediatric pathologist does not agree the contents of a report proposed by the Home Office pathologist then each of them will issue a separate report.
- 15.6** The SIO and the SUDC paediatrician or on call paediatrician will liaise to ensure that as much information as possible is provided to the pathologist before the PM. This will include a summary compiled by the SUDC paediatrician of the full medical history including any relevant background information concerning the family and any concerns raised by any other agency.
- 15.7** The hospital is responsible for ensuring that the results of any pre-mortem samples are forwarded to the coroner and the pathologist.
- 15.8** The coroner's officer must ensure that all relevant professionals who wish to attend the PM are informed of the time and place.
- 15.9** In the event of a "suspicious death", the SIO (or appointed representative), exhibits officer and photographer from the Force Imaging Unit should attend the PM.
- 15.10** The PM shall be carried out promptly. All persons involved with this protocol will cooperate to this end. All investigations are to be concluded within the shortest possible time to enable:
- The prompt funeral of the child.
 - The expeditious conclusion of the inquest or criminal proceedings into the death of the child.
- 15.11** A paediatric PM will usually involve the taking of material for histological examination and this will be explained to the family by the paediatric or emergency

- consultant or the most senior doctor present. If the pathologist carrying out the PM examination wishes to retain a whole organ (solely for the purpose of establishing the cause of death) he/she will ask the permission of the coroner first. The coroner, through his/her officer, will enquire of the family as to their wishes for the ultimate disposal of the organ so retained.
- 15.12** All samples taken at PM are under the control of the coroner and must be labelled, identified and dealt with in accordance with this protocol.
- 15.13** Hand/foot prints and locks of hair will only be taken after the PM (not in A&E).
- 15.14** The interim results of any PM will be communicated immediately to the coroner. The SUDC paediatrician may be instructed to keep some information strictly confidential by the coroner. However, in homicide case all information will be passed to the police SIO.
- 15.15** Within forty-eight hours of the PM the pathologist will provide to the coroner in writing the following information:
- The preliminary PM pathological findings (if any).
 - The preliminary cause of death if ascertained.
 - Details of material retained for further examination (if any).
- 15.16** Coroners will brief their staff within seventy-two hours of the death with the information appropriate to share with other agencies. This information will be available to those within this protocol who telephone the coroner's office. Those receiving such information will treat the same with confidentiality.
- 15.17** The final written PM report should be made available to the coroner within fourteen days of the conclusions of post mortem and subsequent investigations. The list of samples taken and the results of subsequent tests should all be documented.
- 15.18** Upon receipt of a written PM report the coroner will provide a copy to the SUDC paediatrician and SIO. The SIO must ensure that the local PPIU is provided with a copy of the report. No other agency will be allowed access to the pathologist's report without prior approval from the coroner. Permission should always be sought by an agency if the contents of the report could potentially affect the agency's future actions.
- 15.19** The SUDC paediatrician will have the responsibility of convening a "Review Case Discussion" as soon as the PM has concluded. Relevant agencies and the coroner must be consulted.
- 15.20** There is within this protocol agreement for the collection of medical samples, radiological examination and care of intravascular and surgical lines. This must be followed and any proposed deviation discussed with the coroner.
- 15.21** In non suspicious cases, the police Coroner's Liaison Officer will review and collate all the required reports and statements relating to the death so as to formulate an

inquest file for the coroner's attention. In "suspicious" cases the actions of this officer will be directed by the police SIO.

15.22 Samples to be taken by pathologist

The following tests will be carried out in the majority of infants *and children* dying suddenly and unexpectedly (providing the coroner agrees) -:

Bacteriology –

- blood cultures,
- lung culture,
- The CSF (from either nuchal or lumbar site)
- Spleen
- Myocardium
- Bowel contents

Virology – (most commonly PCR rather than culture – but the method of detection will be the decision of the virology department)

- Lung
- CSF
- Trachea (dry swab put into transport medium)
- Per-nasal swab (dry swab put into transport medium)
- Blood (in EDTA bottle)
- Bowel contents
- Myocardium
- Spleen

Metabolic studies – The following specimens to go to Willink (if material is available)

- Blood (can be heart blood or peripheral blood) – approx 1ml in EDTA
- Blood, small quantities- If there isn't enough blood to be sent up for metabolic studies a "Newborn screening" card can be used. The cards are available in the Mortuary and detailed instructions as to how to send one is on the back of the card. The card has an expiry date and needs to go in a special bag (in specimen reception). Request "SUDI Protocol" on the card.
- Urine – as much as possible
- Bile – where available
- Skin biopsy for freezing in DMSO with a view to proceeding to fibroblast culture if indicated by the above studies or by any pathological findings.
- Frozen sections of muscle, liver, kidney, myocardium stained with Oil Red O. These will usually be fixed into paraffin blocks following examination – but in the event of identification of a large amount of lipid within one or more of the tissues – further studies may be appropriate and it may be prudent to contact the Willink for advice

Notes –

- *The skin biopsy is to be taken using sterile forceps and a clean blade following swabbing of the skin site with alcohol. The axilla is suggested as a suitable site.*
- *It is to be placed in Wash medium supplied by the Willink laboratory. A supply of this is to be kept in the freezer in the Histopathology department, with a small number of tubes containing it to be kept in the mortuary fridge. As a sample of wash is removed from the freezer it is to be labelled with the date of removal and must be kept for one month only from the date of removal*
- *Blocks with the other tissues taken for diagnostic purposes. This is to be recorded in histopathology.*

- *In any case with a history suggestive of metabolic disease or in those cases found to have suggestive features such as a cardiomyopathy at post mortem, it is suggested that the pathologist contacts the Willink to ask for advice)*

Toxicology - usually it is prudent to contact the Coroner to ask if he/she wants this to be carried out and also to ask in which laboratory it is to be carried out. At the time of writing – Mrs Leeming and Mr Pollard wish specimens to be sent to Eurofins in most cases, where as other Coroners expect the pathologist to decide if the MRI laboratory or the Forensic Science service laboratory at Chorley is to be used. In general the following specimens are required, though they may be some variation between laboratories and for specialist investigations prior contact with the toxicology staff may be prudent.

- Whole blood – in a sterile universal container. In adults peripheral blood is recommended to avoid stomach contamination but this is very unlikely in an infant and heart blood is usually adequate (and maybe the only blood easily available).
- Whole blood in a fluoride container (for alcohol and CO)
- If solvents are suspected (not likely in SUDI cases) then the special glass bottle provided in the MRI kit is needed
- Urine (this is by far the best material for screening)
- In some cases (not routine but perhaps where there is strong evidence that poisoning may be involved) the following may be relevant
- Stomach contents (into sterile dry container)
- The Liver (approximately a 2x2x2cm cube into a sterile dry container)

Vitreous humour for biochemical studies (if available) – in infants this is usually to look for renal failure, dehydration or salt poisoning rather than diabetic states and if only a small sample is obtained the specimen needs to be placed in a sterile universal container rather than one containing fluoride. MRI toxicology laboratory carry out this investigation.

Histology is performed on all major tissues usually –

- Small and large intestine (including mesenteric lymph node)
- Thymus
- Pancreas
- Adrenals
- Kidneys
- The Spleen
- Liver
- Myocardium
- Trachea
- Larynx
- Lungs
- Brain (cervical spinal cord in some cases)
- Thyroid
- Rib to include costochondral junction

With a number of pieces taken from the most pertinent – the lungs (each lobe is usually sampled), the myocardium (each ventricle), the brain (with several pieces taken from the brainstem, the cerebellum, the basal ganglia, the hippocampus and the cerebral cortex). It is up to the consultant pathologist to decide exactly how many pieces are taken.

- The lung samples taken for histology are subject to Perl's staining looking for haemosiderin laden macrophages

16. Death in secure accommodation including while under escort

Deaths in Young Offenders Institute (YOI)

- 16.1** Since April 2004 the Prisons Probation Ombudsman's Fatal Incidents Investigation Team has been responsible for investigations into deaths in YOIs. *
- 16.2** When a young person dies in a YOI the Prisons and Probation Ombudsman will be the lead agency in the investigation into the death.
- 16.3** The YOI must provide the LSCB and the Youth Justice Board (YJB) with a copy of any initial incident report and any relevant documentation in connection with the care that person received while in that establishment.
- 16.4** It is expected that the investigation led through the Prisons Probation Ombudsman's Fatal Incidents Investigation Team will be multi-agency in gathering the relevant information to decide on the appropriate course of action. Their procedure will supersede the procedure outlined for the rapid response team.

Death in a Local Authority Secure Children's Home (LASCH)

- 16.5** When a young person dies in a LASCH, the LSCB rapid response team for the area in which the LASCH is located will lead the investigation into the death.
- 16.6** The manager of the LASCH and the Youth Offending Service (YOS) where the young person was living at the time of sentence or remand will prepare a local management report (LMR) for the YJB. The report should contain:
- An analysis of events surrounding the incident
 - A chronology of the young person's time under the care of the provider
 - Documentary and supporting evidence
 - Recommendations for operational practice and or training

Death of a young person while under the care of an escort

- 16.5** If a young person dies while being escorted to secure accommodation then the LSCB for the area in which the accommodation is located will be the lead agency for the investigation into the death. The rapid response team for that area will lead the investigation.
- 16.6** The YJB will commission a LMR from the service provider and if there are any practice implications beyond specific escorting issues then the YJB will also request a LMR from the secure establishment and the relevant YOS.

*YJB serious incidents guidance

18 SOURCES OF SUPPORT FOR FAMILIES

18.1 THE FOUNDATION FOR THE STUDY OF INFANT DEATHS

FSID has a help line offering support and information to anyone who has suffered the sudden death of an infant. A card for parents to use the help line free of charge is provided by FSID. Requests for the card can be made by parents or professionals. The help line is also available for family, friends, and those professionals involved with the death. The telephone advisors personally answer the telephone every day of the year.

FSID Help line: 020 7233 2090
9am to 11pm, Monday to Friday
6-11pm on weekends and Bank Holidays

FSID has a wide range of leaflets and information for bereaved families and professionals. It also has a network of befrienders, who are previously bereaved parents. Arrangements can be made for befrienders to contact the bereaved family to offer additional support.

www.fsid.org.uk

18.2 **The Gaddum Centre**, Children and Families Bereavement Service

Gaddum House,
6 Great Jackson St,
Manchester M15 4AX
0161 834 6069
www.gaddumcentre.co.uk

18.3 **Cruse Bereavement Care** Central Hall, Oldham Street, MANCHESTER, M1 1WT 0161 236 8103

Compassionate Friends National Helpline

Understanding, support and encouragement to parents after the death of a child or children

Helpline open every day of the year: 10am - 4pm & 6.30pm - 10.30pm

0845 123 2304

www.tcf.org.uk

Victim Support and Witness Service for Greater Manchester

National Victim Supportline: **0845 30 30 900**

www.victimsupport-gm.co.uk

USEFUL CONTACTS FOR PROFESSIONALS

Appendix L

On call SUDC Paediatrician:

GMP

Rebecca Rice, Information Access Team Leader,
Greater Manchester Police HQ,
Chester House, Boyer Street, Stretford, M60 ORE

0161 872 5050

0161 856 2668

Children's Social Care, Emergency Duty Teams	Telephone
Bolton	01204 337407
Bury	0161 253 6606
Manchester	0161 255 8250
Oldham	0161 770 6936
Rochdale	0845 121 2975
Salford	0161 603 4500
Stockport	0161 718 2118
Tameside	0161 342 2222
Trafford	0161 912 5199
Wigan	01942 828300

Coroner's Offices	Coroner	Telephone
Manchester	Mr NS Meadows	0161 830 4338
Bury, Rochdale, Oldham	Mr SR Nelson	01706 649922
Trafford, Stockport, Tameside	Mr JS Pollard	0161 476 0971
Wigan, Bolton, Salford	Mrs J Leeming	01204 338799

PCT	SUDC paediatrician	Telephone
Bolton		
Bury		
Manchester		
Oldham		
Rochdale		
Salford		
Stockport		
Tameside		

Trafford		
Wigan		

:

Crown Prosecution Service. Complex Casework Unit: 5th Floor Sunlight House, Quay Street Manchester M60 3PS. Tel 0161 827 4700

SUDC Steering Group

Dave Law (GMP)	0161 856 5199
Diana Jellinek (Manchester PCT)	0161 248 1217
Kate Rose (Salford Social Services)	
Hilary Smith (RMCH)	
Mr Nelson (HM Coroner)	
Melanie Newbould (RMCH)	
Julie Bloor (SHA)	
Elham Abbas (Wigan NHS)	
Ravi Bhadoria (Wigan NHS)	
Mikala Dawson (FSID)	
Sarah Dixon (CMMC)	
Helen Lambert (NWAS)	
Jean Rollinson (Salford PCT)	