Action by professionals when a child dies unexpectedly

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Rapid Response Procedure:

Action by professionals when a child dies unexpectedly

1. Introduction

1.1 Each death of a child is a tragedy, and enquiries should keep an appropriate balance between forensic and medical requirements, and supporting the family at a difficult time. Since April 2008 there has been a requirement for professionals to undertake a rapid response to unexpected deaths to ensure the best possible understanding of the cause of death and any contributory factors.

1.2 This procedure sets the minimum standard for Hampshire, Southampton, Portsmouth and Isle of Wight's rapid response to an unexpected death in infancy or childhood as outlined in statutory guidance, Chapter 5, "Child Death Reviews", Working Together to Safeguard Children (2015). Individual organisations can augment this document with additional guidance for staff members as required.

1.3 The aim of the procedure is to ensure that the 4LSCB rapid response is an appropriate and coherent balance between the bereaved family's need for sensitive, empathetic care; the need to identify and preserve anything which might explain why the child has died and the need to conclude investigations expeditiously so that the child's funeral is not delayed unnecessarily.

1.4 Professionals' time spent with the family may be brief but the events and words used can greatly influence how the family deals with their bereavement in the long term. It is essential to maintain a sympathetic and supportive attitude, while objectively and professionally seeking to identify the cause of death.

2. Definitions

2.1 In this guidance an unexpected death is defined as the death of an infant or child which was not anticipated as a significant possibility for example, 24 hours before the death; or where there was an unexpected collapse or incident leading to or precipitating the events which lead to the death.

2.2 The designated paediatrician or specialist nurse from the service providing the rapid response to unexpected deaths in childhood should be consulted where professionals are uncertain about whether the death is unexpected. If in doubt, the processes for unexpected child deaths should be followed until the available evidence enables a different decision to be made.

2.3 Every Clinical Commissioning Group (CCG) must identify a designated paediatrician for unexpected deaths in childhood who will:

- Ensure that relevant professionals (ie coroner, police and local authority social care) are informed of the death
- Coordinate the team of professionals (involved before and/or after the death) which is convened when a child dies unexpectedly (accessing professionals from specialist agencies as necessary to support the core team)

- Convene multiagency discussions after the initial and final post-mortem examination results are available.
- Advise on the organisation of services for unexpected deaths in childhood

2.4 Within the 4LSCB area, the immediate health service response will be provided by hospital staff in conjunction with specialist nurses from the local community services (Solent NHS trust and Southern Health NHS trust). The designated professionals will oversee these arrangements and provide support and advice where required.

3. Rapid Response (general principles)

3.1 The process of the rapid response is summarised in the flow chart at appendix 1. When a child dies suddenly and unexpectedly, the consultant clinician (in a hospital setting) or the professional confirming the fact of death (if the child is not taken immediately to an Accident and Emergency Department) should inform the coroner and police, and also contact the specialist nursing team who will inform the designated paediatrician. The police will begin an investigation into the sudden or unexpected death on behalf of the coroner. The clinicians should initiate an immediate information sharing and planning discussion between the lead agencies (ie health, police and local authority children's social care) to decide what should happen next and who will do it. The joint responsibilities of the professionals involved with the child include:

- Responding quickly to the child's death in accordance with the locally agreed procedures
- Maintaining a rapid response protocol with all agencies, consistent with the Kennedy principles and current investigative practice from the association of Chief Police Officers
- Making immediate enquiries into and evaluating the reasons for and circumstances of the death, in agreement with the coroner
- Liaising with the coroner and pathologist
- Undertaking the types of enquiries/investigations that relate to the current responsibilities of their respective organisations
- Collecting information about the death
- Providing support to the bereaved family, involving them in meetings as appropriate, referring to specialist bereavement services where necessary and keeping them up to date with information about the child's death
- Gaining consent early from the family for the examination of their medical notes

3.2 Within the 4LSCB area, the health service contribution to the rapid response will be led by specialist nurses from the district in which the child is normally resident, in conjunction with the hospital clinicians who have confirmed the death.

3.3 It must be remembered that, in most cases, the unexpected death of a child is the result of natural causes, and is a tragedy for the family. However, if there are concerns that abuse or neglect may have been a factor, immediate consideration must be given regarding the needs of other children in the household. Guidance should be followed as provided in the 4LSCB Safeguarding procedures http://4lscb.proceduresonline.com with a strategy meeting to consider the welfare of all children in the household held and chaired separately from rapid response discussions.

3.4 If there is a criminal investigation, the team of professionals must consult the lead police investigator who will in turn liaise with the Crown Prosecution Service to ensure that their enquiries do not prejudice any criminal proceedings. Any further multiagency meetings will be chaired by the Police.

3.5 For any child who dies in a secure children's home, the Prisons and Probation Ombudsman will carry out an investigation. In order to assist the Ombudsman to carry out these investigations, secure children's homes are required to notify the Ombudsman of the death and to comply with requirements at regulation 40(2) of the Children's Homes (England) Regulations 2015 to facilitate that investigation

3.6 Where a child dies unexpectedly in a health care setting, all registered providers of healthcare services must notify the Care Quality Commission of the death of a service user, but NHS providers may discharge this duty by notifying NHS England.

3.7 Where a young person dies at work, the Health and Safety Executive should be informed.

3.8 Youth Offending Teams' reviews of safeguarding and public protection incidents (including the deaths of children under their supervision) should also feed into the CDOP child death processes.

4. Immediate Response (generally within 2-4 hours of the child's death)

4.1 When a child dies unexpectedly at home or in the community, he or she should normally be taken to an Accident and Emergency Department rather than a mortuary. In some circumstances, the police may decide that it is inappropriate to move the child's body immediately, for example because forensic examinations are needed. There will also be occasions when it is appropriate for the child to be taken direct to the mortuary. Further guidance for South Central Ambulance Service and Hampshire Constabulary is given in appendix 2 and appendix 3

4.2 If the ambulance service is called to attend, the crew should assess the child, and should attempt resuscitation unless this is clearly inappropriate. (See appendix 2)

4.3 Any professional attending the scene at the time of the child's death should note the child's position, the clothing worn, and the circumstances of how the child was found. In addition, professionals should record any comments made by carers, and any features in the child's environment which appear unusual. All information should be documented and passed to the rapid response team. Those remaining at the scene should be asked not to disturb or move items until the Police have viewed it.

4.4 When transferring a child to hospital, the ambulance service should contact the police and hospital and give an estimated time of arrival.

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

4.6 When the child's death has been confirmed, a senior paediatrician, usually the duty consultant paediatrician, should inform the parents. This should normally be done in a private area with the allocated member of staff present. The parents should be given the

opportunity to ask questions and replies should avoid technical terms or jargon (see appendix 3).

4.7 As soon as possible after arrival at a hospital, the child should be examined by a senior paediatrician, and a detailed history should be taken from the parents or carers. The purpose of obtaining this information is to understand the cause of death and identify anything suspicious about it.

4.8 The paediatrician should contact the police (if not already in attendance), the coroner, and the specialist nurse on duty for the rapid response (service available in working hours only). Contact details are given in appendix 5. The nursing team will notify the designated paediatrician for unexpected child deaths. The police will begin an investigation into the sudden or unexpected death on behalf of the coroner. In most cases police officers will attend the home address and/or the place where the child's collapse occurred as part of their immediate response. This offers an initial assessment of the circumstances of the death and early identification of any features which might raise suspicion. This visit is in addition to the joint visits discussed in Section 5 below.

4.9 There are advantages in the duty consultant paediatrician and attending police officer taking the history jointly. The history should be documented both in hospital records and the Hampshire Constabulary child death booklet. In some circumstances, the parents may be too distressed to give any detailed history, and so this can be deferred to a home visit (see appendix 6).

4.10 Examination of the child should include consideration of any features to suggest illness or injury, together with a record of the body temperature and presence of any discolouration. Any relevant findings should be recorded on body maps.

4.11 Following the unexpected death of an infant, samples should be taken as set out in appendix 7. Blood should be taken from peripheral sites and cardiac stabs should be avoided. Where there is difficulty obtaining blood samples, priority should be given to blood culture, and blood spots for metabolic investigations. CSF will be obtained by the pathologist. Where it is likely that a post-mortem will be undertaken within the next 24hr, it may be more appropriate for all samples to be taken by the pathologist. For older children, the clinical history will inform collection of samples. In some circumstances (eg suspected inherited metabolic disorders) clinicians may need to contact colleagues for advice on which samples should be collected and how they should be transferred to the appropriate laboratory.

4.12 Skeletal surveys will be undertaken immediately prior to the post-mortem and reported by a paediatric radiologist.

4.13 The family should normally be allowed to spend time with their child and receive mementos such as a lock of hair, photographs, and hand or foot prints subject to the agreement of the attending police officer. The family should be supervised and supported during this time.

4.14 The duty paediatrician should consider the need to examine other children in the household to assess their health and wellbeing. Hospital admission may be required if siblings are showing signs or symptoms of illness, and for the co-twin of any infant dying suddenly and unexpectedly.

4.15 Before leaving the department, the family should be advised of the next steps, including the requirement for the death to be referred to the coroner, and for detailed enquiries to be undertaken by police and health professionals as outlined in Working Together 2015.

4.16 The duty paediatrician and attending police officer should discuss the information obtained at this point, and agree who will share this with the pathologist and specialist nurse.

4.17 Hospital staff should notify the following of the child's death, together with any other departments/organisations listed in internal policies:

- Child death overview panel (by completion of a Form A by the clinician confirming the child's death)
- GP
- Child health department
- Children's social care

4.18 Where the circumstances of the death appear suspicious, or where there are concerns that abuse or neglect have contributed to the death, the chair of the Local Children's Safeguarding Board (LSCB) and the local authority chief executive officer should also be informed.

5 Gathering and Sharing Further Information (within 24-48 hrs of the child's death)

5.1 If the child has died at home or in the community, the lead police investigator and duty paediatrician, and the specialist nurse (if available) should decide whether there should be a joint visit to the place where the child died, how soon (ideally within 24 hours), and who should attend. This should almost always take place for cases of sudden infant death, and where possible the visit should be undertaken jointly by the lead police investigator and specialist nurse.

5.2 The home visit provides an opportunity to take a more careful history, to view the place where the child died, and to continue to provide support and information to the family. Details of the home visit should be recorded both in the Hampshire Constabulary child death booklet and in the specialist nurse's records.

5.3 Where the location of the death is different to the home address of the child, an additional visit to the home address may be required.

5.4 If the circumstances of the death are suspicious and a criminal investigation has commenced, it will be essential to preserve the scene of the child's death and a joint visit may not be appropriate.

5.5 Within 48 hours of the child's death, there should be a meeting to share information about the child and the family circumstances with a view to understanding the circumstances of the child's death. Depending on the circumstances, this meeting may take place before or after any home visit. The meeting will normally be convened by the specialist nursing team, unless the circumstances have given rise to a criminal investigation. The following should be invited to contribute:

- senior investigating officer
- specialist nurse and/or designated doctor for unexpected deaths ambulance staff
- paediatrician(s) and other health care professionals contributing to the child's care
- GP
- health visitor or school nurse
- local authority children's social care representative
- education services (including early years)
- coroner's officer

5.6 The meeting should review the information available to date, and consider whether there are any additional sources of information which should be explored. Those with relevant information should be invited to submit a Form B for review by the rapid response team and for forwarding to the Child Death Overview Panel (CDOP). Minutes of this meeting will be shared with the pathologist, coroner and CDOP.

5.7 Those present should also consider whether there is any information to raise concerns that neglect or abuse contributed to the child's death and whether a separate section 47 strategy meeting is required to consider the safety and welfare of other children in the household. Factors that may raise concern include:

- previous child deaths in the family
- previous or existing child protection concerns
- features of neglect
- unexplained injuries
- indications that the parents or carers were intoxicated or otherwise unable to offer care or supervision to the child

5.8 If abuse or neglect are known or suspected, the specialist nurse should inform the Local Children's Safeguarding Board (LSCB) Chair so that there can be consideration of the need for a serious case review. (See appendix 5 for contact details.)

5.9 Those present should identify who is best able to provide continuing support to the family, and who will inform the family of the initial post mortem results when these are available. Disclosure of post mortem findings should only occur with the coroner's agreement.

5.10 If there is a criminal investigation, the team of professionals must consult the lead police investigator who in turn will liaise with the Crown Prosecution Service to ensure that their enquiries do not prejudice any criminal proceedings. If the child dies in custody, there will be an investigation by the Prisons and Probation Ombudsman (or by the Independent Police Complaints Commission in the case of police custody). Organisations who worked with the child will be required to cooperate with that investigation.

5.11 These procedures should also be followed when a child dies in hospital after a sudden unexpected illness or incident, including situations where the cause of death is known.

6. Involvement of Coroner and Pathologist

6.1 If a doctor is not able to issue a medical certificate of the cause of death, the lead professional or investigator must report the child's death to the coroner in accordance with a protocol agreed with the local coronial service. The coroner must investigate violent or unnatural death, or death of no known cause, and all deaths where a person is

in custody at the time of death. The coroner will then have jurisdiction over the child's body at all times. Unless the death is natural a public inquest will be held.

6.2 The coroner will order a post mortem examination to be carried out as soon as possible by the most appropriate pathologist available (this may be a paediatric pathologist, forensic pathologist or both) who will perform the examination according to the guidelines and protocols laid down by the Royal College of Pathologists. The designated paediatrician or rapid response lead healthcare professional will collate and share information about the circumstances of the child's death with the pathologist in order to inform this process.

7. Action after the Post Mortem

7.1 Although the results of the post mortem belong to the coroner, it should be possible for the designated paediatrician or specialist nurse, the pathologist, and the lead police investigator to discuss the findings as soon as possible, and the coroner should be informed immediately of the initial results. If these results suggest evidence of abuse or neglect as a possible cause of death, the paediatrician/lead clinician should inform the police and local authority children's social care immediately. He or she should also inform the LSCB Chair so that they can consider whether the criteria are met for initiating an SCR.

7.2 Shortly after the initial post mortem results become available, the designated paediatrician or specialist nurse should convene a second multi-agency case discussion, including all those who knew the family and were involved in investigating the child's death. The professionals should review any further available information, including any that may raise concerns about safeguarding issues. The meeting should be formally chaired and minuted, and the minutes will be shared with CDOP and the coroner.

7.3 If the death is unnatural or the cause of death cannot be confirmed, the coroner will hold an inquest (and an inquest will always be held where the death takes place in custody or other state detention). Professionals and organisations who are involved in the child death review process must cooperate with the coroner and provide him/her with a joint report about the circumstances of the child's death. Where possible, this should not be led by the clinician who was responsible for the care of the child when they died. This report should include a review of all relevant medical, local authority social care and educational records on the child. The report should be delivered to the coroner within 28 days of the death unless crucial information is not yet available. The minutes of the rapid response meetings will normally fulfil this requirement.

7.4 Professionals should provide the coroner with all the evidence the coroner requires to carry out his or her statutory duty to establish who died, where, when and how. Coroners have a power (under section 32 and Schedule 5 of the Coroners and Justice Act 2009) to require someone to provide evidence to the coroner, or give evidence at an inquest.

7.5 The meeting should review arrangements for family support, and identify who will inform family members of the final post mortem findings when these become available, and make arrangements to discuss these if required.

8. Final case Discussion (1-6months after the child's death)

8.1 A third multi-agency case discussion should be convened by the designated paediatrician or specialist nurse as soon as the final post mortem result is available. This is in order to share information about the cause of death or factors that may have contributed to the

death and to plan future care of the family. Invitations should be sent to the GP, health visitor/school nurse, paediatrician(s), nursing staff, senior investigating police officer, rapid response specialist nurse and children's social care manager, and to any other professionals who have contributed to the rapid response.

8.2 At this case discussion meeting, all relevant information concerning the circumstances of the death, the child's history, family history and subsequent investigations should be reviewed. The cause of the child's death should be discussed (if ascertained) and a Form C completed, identifying any contributory factors. For infant deaths, the Avon clinico-pathological classification template may also be completed (see appendix 8).

8.3 Those present should identify how detailed information about the cause of the child's death will be shared, and by whom, with the parents, and who will offer the parents on-going support. It is good practice for the lead healthcare professional or consultant responsible for the child's care to meet the family to discuss the post mortem findings, answer any questions, and ensure that arrangements have been made for any further investigations or opinions in relation to future or surviving children.

8.4 The designated paediatrician or specialist nurse should arrange for a record of the discussion to be sent to the coroner to inform the inquest, and to the relevant CDOP, to inform their child death review discussion.

8.5 Appropriate information should also be shared with relevant staff and NHS trusts to inform internal reviews of the deaths of children treated by those organisations.

8.6 The rapid response process should be audited using the template at appendix 9, and the findings summarised and reported to the LSCB and to relevant commissioning organisations.

9 Appendices

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

9.2 The role of the ambulance service

9.3 Pointers for all professionals in talking to bereaved parents

9.4 The role of the police

9.5 Local contact details and links to forms and documents

9.6 Undertaking a home visit

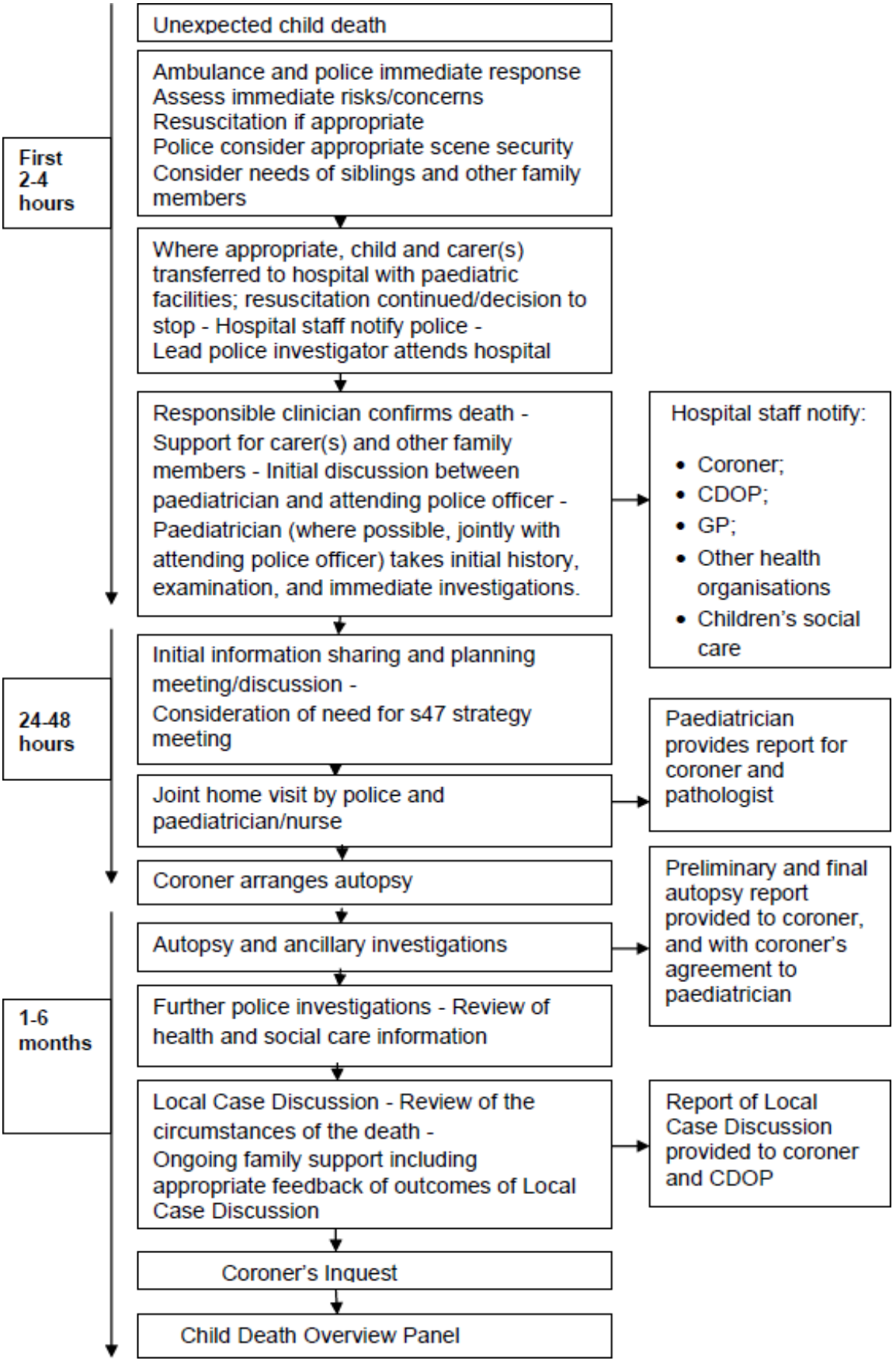
9.7 Suggested samples following unexpected infant death

9.8 Avon clinic-pathological classification for infant deaths

9.9 Audit tool for rapid response

Appendix 1

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



Appendix 2

The role of the ambulance service

The Ambulance Service will notify the police and relevant hospital immediately when they are called to the scene of an unexplained child death. This will generally be undertaken by the ambulance control contacting the police control room and hospital.

The Ambulance Service will need to clarify that the Rapid response Procedure is being triggered (which covers all child deaths under the age of 18)

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

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

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

Ambulance service response to 999 calls to child death cases

999 call Ambulance Emergency Operations Centre 999 Ambulance

Category A response – Options and actions:

a) **Child requires resuscitation:**

- Nearest A&E department with parents
- A&E alerted by Emergency Operations Centre
- A&E alerts Paediatric Resuscitation Team

b) **Child found to be recently dead, not fit for resuscitation:**

- Nearest A&E department with parents
- A&E alerted by Emergency Operations Centre
- A&E calls down Paediatric Emergency Team
- Child and parents taken to agreed facility

c) **Child found obviously dead:**

- Ambulance crew alert Emergency Operations Centre who call the Police
- After handover to the police, ambulance crew leave- Police arrange appropriate care for parents and arrange via approved undertaker to convey the child to receiving facility at the nearest A&E department unless circumstances dictate this inappropriate

d) **Non-ambulance response:**

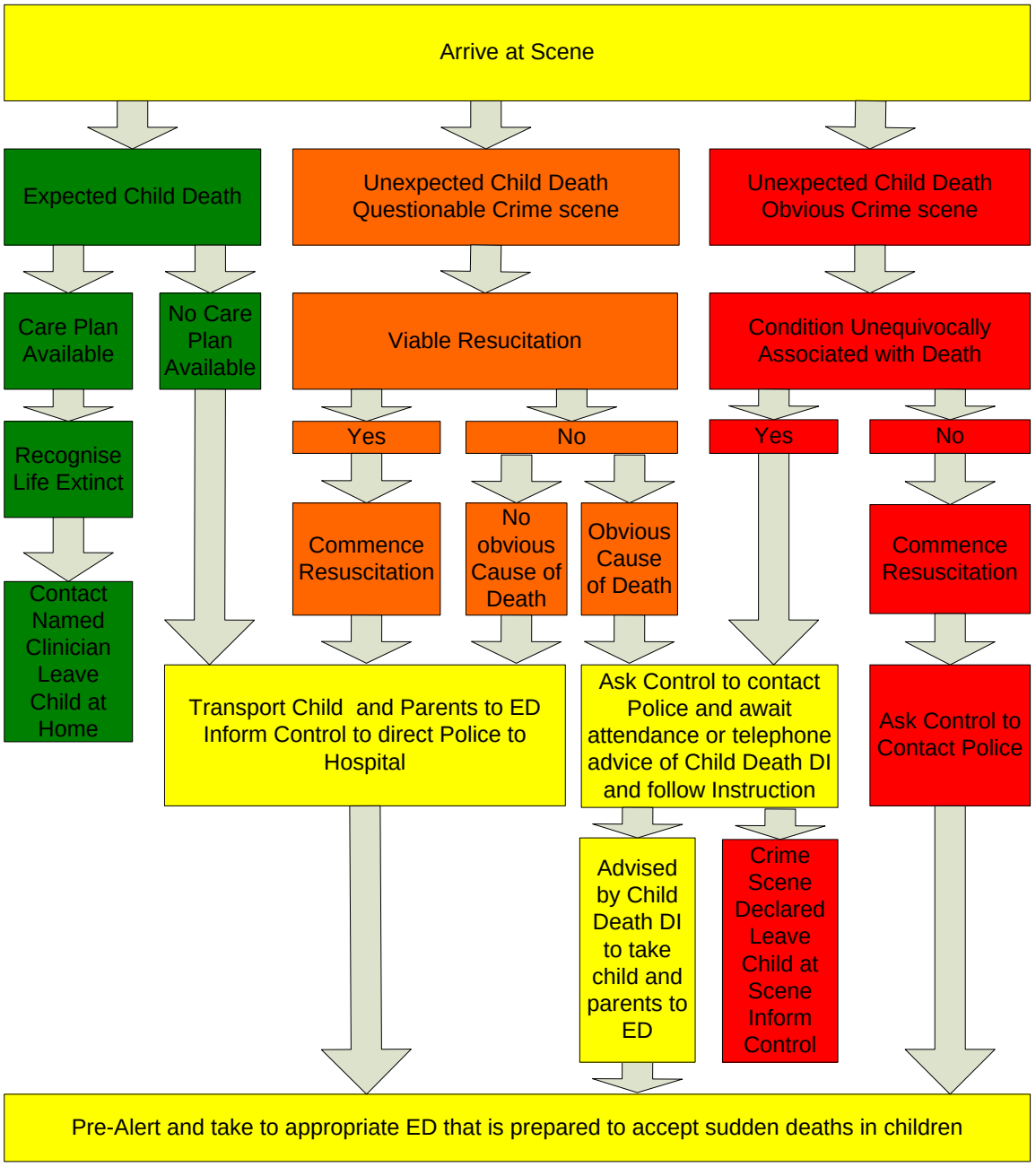
- GP confirms child deceased
- No 999 call made and child confirmed dead at scene
- GP informs Police/Coroner who take actions as outlined in protocol

The first professional on the scene (e.g. Ambulance, GP) should note the position of the child, the clothing worn and the circumstances in which the child was found. If the circumstances allow, note any comments made by the parents/carers, any background history, any possible substance misuse, domestic abuse and the conditions of the living accommodation. Any such information must be passed on to the receiving doctor, the Police and the Consultant paediatrician

DEATH PROCEDURE

Collaborative Procedure between South Central Ambulance Service,

Hampshire Police and Thames Valley Police



Conditions Unequivocally Associated with Death in children less than 18 years –

1. Massive cranial and cerebral destruction
2. Hemicorporectomy
3. Massive truncal injury incompatible with life including decapitation
4. Decomposition / Putrefaction
5. Incineration

Hypostasis and Rigor Mortis are not to be considered in children these should all be conveyed.

Appendix 3

Pointers for all professionals in talking with bereaved parents (taken from advice given by the FSID):

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

Appendix 4

THE ROLE OF THE POLICE

All sudden unexpected deaths in children are notified to the coroner and a full police/coroner investigation will take place.

Unexpected death is the death of a child that was not anticipated as a significant possibility 24 hours before the death, or where there was a similar collapse leading to or precipitating the events that led to the death.

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

- To be part of the rapid response team which are seeking to establish the cause of the child's death
- Protection of life, i.e. responsibilities to safeguard other siblings/children in the event of abuse or neglect in conjunction with children's services.
- Conduct a criminal investigation when appropriate and work with the Crown Prosecution Service in cases involving potential prosecution of offenders.
- In cases where there are no suspicious circumstances police will conduct proportionate enquires under the guidance of the coroner in order that any inquest is fully informed as to the facts surrounding the death.

The appointed Detective Inspector will be trained in responding to child deaths and will supervise the police investigation until its conclusion, including where suspicious circumstances have been ruled out. This will also involve ensuring the Child Death Overview Panel is fully informed of the circumstances of the death for their review process.

The vast majority of such deaths are from natural causes and do not involve abuse or neglect. A small proportion of so called "cot deaths" are, however, caused deliberately by violence, by maliciously administered substances or by the careless use of drugs. Investigating officers must be aware that as the number of genuine unexplained deaths decreases, the proportion of all infant deaths which could be attributed to homicide are likely to increase. When during the Infant and child death process there is a suspicion that the child was killed unlawfully the Detective Inspector supervising the investigation will liaise directly with the duty senior investigating officer and a murder investigation should commence led by the Major Crime Team.

The Child Death trained Detective Inspector will then take the lead in the rapid response procedure until its conclusion and keep the appointed SIO regularly updated.

The aim of any investigation will be to establish, as far as possible, the cause of the child's death. Each case must be approached with an open mind, balancing the needs of the investigation with the needs of the bereaved family.

One of the practical difficulties for investigators is that factors or evidence that raise suspicion may become apparent at any time during the process, from an early stage through to many months after the death. Police training necessarily focuses upon the need to secure and preserve evidence from the outset, as failure to do so may lead to a lost opportunity. The difficulty faced by the police in child and infant death investigation is to

reconcile the traditional criminal investigation approach with the knowledge that the majority of these cases do not involve a criminal act. The processes agreed within this protocol aim to enable the multi-agency team to secure and preserve information and evidence, whilst providing a sensitive and caring service to the bereaved family and meeting the aims of Working Together to Safeguard Children 2015.

The police process

If the police are the first professionals to attend the scene, urgent medical assistance should be requested as the first priority. The type of response to each child's unexpected death will depend to a certain extent on the age of the child and the circumstances. However some key actions underpin all subsequent work including consideration to deploy a rapid response team.

Child death – initial action

The first police officer to arrive, or any other professional, may be expected by the parents to try and revive the infant or child, even if it is hopeless, and should be prepared for this. The pathologist will need to be informed of any attempted resuscitation. Officers should introduce themselves to the parents and take care to explain their presence. They should express their sympathy and establish the baby's name, using the name at all times as if the baby is still alive. An open mind must be kept and awareness that the death may have been caused as a result of

- Natural causes
- Neglect
- Accident
- Deliberate harm

Upon attendance at the scene, usually at the home of the child, officer(s) should note any excess in the room temperature where the child was found e.g. excessive warmth or cold. The senior investigating police officer should ensure the room temperature is checked as soon as possible. If the room has been ventilated for some time, consider if possible taking the temperature in a drawer in the room containing clothing, as this will tend to hold the original room temperature.

Police attendance should be kept to the minimum. Several police officers arriving at the house can be distressing, especially if they are uniformed officers in marked police cars. Visiting officers, so far as possible, should not be in uniform, and should not arrive in marked cars. There will be occasions when uniformed officers will have to attend the scene of a child death e.g. responding to a 999 report of a child collapsing and police attending in order to engage their duty to preserve life. In these circumstances the Control Room should contact the on call CAIT DI at the earliest opportunity to seek guidance on whether uniformed officers should remain at the scene and what roles they will undertake. Attending officers should at all times be sensitive in the use of personal radios and mobile phones, etc. If at all possible, the officers liaising with the family, whilst remaining contactable, should have such equipment turned off. Care should be taken to avoid terms such as referring to 'scenes of crime' and 'suspicious death'.

As with all sudden deaths in infants and children, there should be immediate consideration of transferring the child to the A&E department. When the circumstances are obviously suspicious and the child/baby is obviously dead but has not been removed

from the scene, the duty Detective inspector for Child Death must be informed immediately in order that key scene considerations can be made to ensure evidence is all available evidence is preserved. The specialist nursing team must be informed so that the rapid response procedure can be initiated.

Where a child is obviously dead it will still be appropriate in most cases to use the ambulance service to remove the child to the local A and E Dept. There will be occasions when a hospital mortuary will be the best place to remove the child and this decision will be made by the Duty CAIT DI after consulting with paramedics and/or A and E department e.g. teenage suicides where it is obvious the child has been dead for some time, or children involved in road traffic accidents where death has been pronounced at the scene and there would be no benefit to removing the child to A and E. This decision will have to take into consideration whether the wider family may benefit from the resources and support available through A and E in the immediate hours after death as opposed to the mortuary.

Where a death of a child has occurred as a result of a road traffic collision then trained traffic officers will take primacy for the police investigation, liaison with the coroners and completion of the file for inquest purposes. However there should be early consolation between the Officer in charge of the accident investigation and the CAIT DI. In all case the CAIT DI will lead in coordinating and managing the phased multi agency meetings within the Rapid Response framework.

Where a death has taken place within Hampshire and the Isle of Wight in an area where British Transport Police have primacy over the investigation the on Call CAIT DI will still be contacted as soon as the death is confirmed. The CAIT DI will liaise with BTP investigation team and take the lead in coordinating and managing the phased multi agency meetings within the Rapid Response framework.

The police will also arrange for the family to be transported to the hospital to be with their child at the receiving facility, which will be within the local A & E department

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

The senior investigating police officer will attend the scene as soon as possible. The senior investigating police officer should consult with the health care professional treating the child and report the death to the specialist nurse on duty for Child Death covering the area where the child died, in order for an initial case discussion to take place (within the first few hours of the death being reported). At an early stage a decision whether a paediatrician, or a specialist nurse trained in responding to childhood deaths, and the senior investigating police officer should attend the scene of the death together will be made. In cases where a specialist nurse or paediatric consultant is not immediately available to undertake a scene visit, police will carry out a “golden hour” initial single agency scene visit. If this is the case then a second joint visit should then be arranged at the earliest opportunity. It is recognised that there may be some circumstances where this second visit could be conducted by health professionals on their own and the reasons for this should be documented by the SIO.

The senior investigating police officer will ensure that the ‘scenes’ are identified and preserved. Crime Scene Investigators will attend the incident and take appropriate action as directed by the senior investigating police officer, which may include photographing and/or recording of the scene of the child’s collapse.

Where the death is being treated as suspicious then a Family Liaison Officer will be appointed in conjunction with any hospital services for the bereaved.

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

After making the necessary arrangements for scene preservation, the senior investigating police officer will liaise with the treating paediatrician at the hospital and other agencies to ensure that the protocol is implemented and a timescale is agreed for the initial planning and information sharing meeting prior to the post mortem.

Unless the death is viewed as suspicious the procedures for joint paediatric/police history taking will take effect. Under the Police and Criminal Evidence Act 1984, if the specialist nurse or the police officer has significant suspicions that the death may be unnatural, the law demands that the suspect's rights are protected and certain legal restrictions apply in terms of how they can be spoken to, and by whom. In the event of the death being suspicious the senior investigating police officer will decide upon the appropriate course of action, which may or may not include the arrest of a suspect. There are strict legal requirements placed upon the police when conducting a criminal investigation that govern the way in which people are questioned and evidence secured/preserved.

Following the initial multi agency planning and information sharing meeting or case discussion with the paediatrician, the senior investigating police officer will make themselves available to conduct a joint home visit with a specialist nurse, in order to gain a clearer understanding of how the child died. This will take into account the circumstances in each case, particularly the wishes and feelings of the parents and family at the time.

Appendix 5

Contact details

1 Hampshire Constabulary

Ring 101 and ask for the Detective Inspector on call for unexpected child deaths

2 Specialist nurses

Hampshire	02392 372780
Portsmouth	02392 816740
Southampton	02380 716671
Isle of Wight	01983 524081 ext 5412

3 Designated doctors

Hampshire	Dr Sheila Peters	023 8062 7645 (secretary)/02380 627667
Portsmouth	Awaiting appointment	
Southampton	Dr Hilary Smith	07786707318 (administrator)/0238120 6961
Isle of Wight	Dr Chris Magier	01983 534944

4 **Local Safeguarding Children Board managers**
(for deaths requiring consideration of a serious case review)

Southampton	lscb@southampton.gov.uk	023 80 832995
Hampshire	hscb@hants.gov.uk	01962 876230
Isle of Wight	LSCB@iow.gov.uk	01983 814545
Portsmouth	pscb@portsmouthcc.gov.uk	02392 841540

5 Sources of information

Working Together to Safeguard Children 2015

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/419595/Working_Together_to_Safeguard_Children.pdf

Forms relating to child death processes

https://www.gov.uk/government/publications/child-death-reviews-forms-for-reporting-child-deaths

Appendix 6

Home Visit

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

Whenever possible the specialist nurse should undertake a joint visit with the police to take a detailed history, inspect the death scene and to try to meet some of the family's concerns. If this is not possible, and separate visits are made, the relevant professionals should liaise closely and confer in their assessment as soon as possible after their visit.

The role of the child death healthcare professional at this visit is to: -

- Undertake a careful review of the history and the events leading up to the child's death
- Undertake an assessment of the environment
- Identify and help to understand factors that may have contributed to/caused the death
- Provide information and support to the family

Contribute

- Knowledge of normal child development and abilities
- Understanding and knowledge of childhood illnesses and their likely courses
- Knowledge of developmental physiology

The role of the Police at this visit is to:

- Assist to identify the cause of death or contributory factors
- Identify suspicious circumstances
- Identify inconsistencies in history
- Ensure appropriate handling of evidence
- Ensure PACE and other legal rules observed (whenever appropriate)

Forensic considerations

On occasions the police may visit the scene of the death immediately in the absence of the family to investigate the scene and ensure any disturbance is minimised prior to the home visit with the parents.

If there are significant concerns/suspicions regarding abuse and/or neglect then the senior investigating police officer will take over the scene and lead the investigation. There is very rarely any value in seizing bedding etc and this may prevent the later investigation of the circumstances of the death.

Reviewing the circumstances of the death

Full history

This should include -

- A detailed narrative account of the events leading up to the death, including places visited, people seen and activities undertaken.
- A detailed sequential account of events in the last 24-48 hours, and the last few weeks, and any changes from normal practice/routine.
- Clarify any uncertainties in the medical or family history.
- A detailed family and household history.
- Use of alcohol, smoking and/or other substances.
- Recent exposure to infections.

Scene review at Home

When the parents are ready return to the scene of the death.

The last sleep/final events.

- Who was there and when they were there?
- If appropriate, the position the child was put down to sleep in and any movement from this position?
- Who last saw/heard the child, where were they and was there anything unusual about this?

In the case of younger children consideration can be given to using a doll or teddy to allow the parents to demonstrate exactly what happened. Parents will sometimes suggest this but do not push them to do so.

Review and examination of the room.

- Size, orientation, contents, 'clutter'
- Is the room cramped, is there space for an adult to stand comfortably beside the cot/bed?
- Is the room cluttered, is more than 50% of the floor space visible (excluding fixed furniture)?

Is the room dirty, is there rubbish on the floor/surfaces, are there dirty stains on the floor or furnishings?

- Ventilation, windows and doors (were they open or shut?)
- Heating (including times switched on and off), measure the temperature if possible.
- Position of the bed/cot in relation to other objects in the room (especially radiators/heaters).
- Any movements or changes noted by the parents in any objects in the ro

Sleep environment.

- Is the cot/Moses basket/bed on a secure base, is it defective in any way?
- Is the sleeping space cluttered, is there space all around where the child lay, were there any potential sites for wedging or entrapment?
- Is the bedding dirty or worn, is there adult size bedding, cushions or pillows, how many layers was the baby wrapped in?
- If the child was in a pushchair or car seat, was the child strapped in securely and safely?
- Is there anything overhanging the sleeping space other than a fixed cot mobile?
- Are there any other identifiable hazards in the room?

Position of the child

- What position was the child put down/last seen, was there any over- wrapping, overheating or any restriction to ventilation or breathing or risk of smothering?
- What position was the child when found, was there anything unusual about this?

Document all observations made of the room, sleep environment, the position of the child and the parent's account. Where applicable complete a detailed sketch of the plan of the room with measurements and orientation.

Parents need time to talk and start to deal with how they feel. Professionals need to spend time with the family offering support, information and appropriate reassurance. The family may need help to identify where to go and what to do.

Ensure the family know what will happen next, where their child will be, for how long and who will organise their return.

Give contact details to the family for key professionals.

Collation of Information

The child death healthcare professional should collate all information collected by those involved in responding to the child's death and share it with the Pathologist conducting the post-mortem in order to inform this process.

Appendix 7

Suggested samples following sudden unexpected death in infants

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

Sample	send to	handling	Test
blood (serum)	Clinical chemistry	Normal	U&Es
blood (serum)	Clinical chemistry	spin, store serum -	toxicology
blood Li Heparin orange top 1 ml **and** newborn blood spot card	Clinical chemistry	Spin, store plasma -20ºC Complete card, don't put into plastic bag	inherited metabolic disease
blood Fluoride yellow top 2 ml	Clinical Chemistry	collect pre-mortem spin, store plasma -	3 OH Butyrate, FFA, lactate
blood EDTA pink top 2-5ml	Clinical genetics	Normal (keep unseparated)	Store for genetic testing
blood EDTA	Haematology	Normal	FBC
blood cultures	Microbiology blood culture incubator	if insufficient blood, aerobic only	C&S
blood (serum) brown top 1 ml	Clinical chemistry	spin, store serum -20ºC	Toxicology (samples also taken at post mortem)
Nasopharyngeal swab	Microbiology	<8hrs from death	Virology
Other swabs	Microbiology	Normal	C&S (as indicated)
Urine (SPA) 2 mls	Microbiology	Normal	C&S
Urine (SPA) 2 mls	Clinical Chemistry	spin, store supernatant	Toxicology
Urine (SPA) 2 mls	Clinical Chemistry	spin, store supernatant-20ºC	amino and organic acids, oligosaccharides

If history suggests benefit from skin biopsy or muscle biopsy, this **must** be discussed with the coroner before any samples are taken and advice sought from the laboratory on handling and transfer

Appendix 8

Local case Discussion: Avon Clinico-pathological classification of SUDI.

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

Name: …….. Date of Birth: ……

Hospital: …….. Date of death: ……..

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

Paediatrician*: …….. Pathologist*: ……..

GP*: …….. HV*: ……

Child Protection officer*: ……..

Others present at LCD meeting: …….

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Not present at LCD meeting but include in circulation of report: ……

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Review of case management: any issues identified:

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Review of ongoing support needs identified: .....

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Appendix 8 Avon Clinico-Pathological Classification System						
Classification →	0	IA	IB	IIA	IIB	III
Criteria ↓	Criteria not collected	No factors identified	Notable factors	Possible contributory	Probable contributory	Explained
History						
Social						
Infant medical						
Family medical						
Final events						
Examination						
External examination of child						
Death-Scene Examination						
Observation						
Pathology						
Radiology						
Toxicology						
Micro/Virology						
Gross pathology/ Histology						
Biochemistry/ Metabolic						
Other Investigations						
Other criteria						
Abuse/neglect						
Specify						
Specify						
Overall Classification*						

** Equivalent to the highest classification in the grid*

Brief explanation of specific notable/contributory or explanatory factors

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Appendix 9

Audit tool for Rapid response

To be completed for each unexpected child death

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

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

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

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