Northamptonshire Safeguarding Children Board

Northamptonshire

Child Death Review and Response Arrangements

June 2016

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1.0 Introduction and the Child Death Review Sub Group

1.1 Statutory Basis of Child Death Review Arrangements

The Local Safeguarding Children Board Regulations 2006, Regulation 6, places a requirement on the NSCB to include within its function, in relation to the deaths of children normally resident in Northamptonshire;

a. Collecting and analysing information about each death with a view to identifying-

   i. Any case giving rise to the need for a review mentioned in Regulation 5(1)(e) **Serious Case Review**;

   ii. Any matters of concern affecting the safety and welfare of children in the area of the authority; and

   iii. Any wider public health or safety concerns arising from a particular death or from a pattern of deaths in that area; and

Putting in place procedures for ensuring that there is a co-ordinated response by the authority, their Board partners and other relevant persons to an unexpected death.

In this connection an unexpected death is one which was not anticipated as a significant possibility 24 hours before the death or where there was similarly unexpected collapse leading to or precipitating the events which lead to the death. This definition is adopted throughout these procedures.

Statutory guidance on the fulfilment of this requirement is contained in **Chapter 5 of Working Together to Safeguard Children (2015)** and these procedures are consistent with that guidance.

1.2 Child Death Review Sub Group Terms of Reference

Within Northamptonshire the functions specified in the regulations and guidance will be undertaken by the Child Death Review Sub Group on behalf of the NSCB. The full terms of reference of the Sub Group are available upon request from the NSCB Business Office.

These terms of reference are applicable to the deaths of all children, aged less than 18 years, normally resident in Northamptonshire and the deaths of other children dying in the county or consequent to an unexpected event in the county.

Inevitably some of these deaths will also be subject of the child death review processes in other LSCB areas. This does not detract from the value of their inclusion within the NSCB Child Death Review Committee remit.

These procedures include provision for cooperation with other LSCBs in collecting information and providing a coordinated response to unexpected child deaths in these circumstances

The procedures necessary for the Child Death Review Committee to fulfil its terms of reference are detailed in section two below. The inter-related procedures for responding to unexpected child deaths, in accordance with item 1 of the Committee's terms of reference are detailed in section three below.

1.3 Child Death Review Sub Group Membership & Meetings

The Child Death Review Sub Group will be chaired by the Lead Paediatrician for Child Deaths a member of the LSCB not directly involved in the provision of services to children. Full details of membership can be found in the Sub Group terms of reference.

The Child Death Review Sub Group will meet bi-monthly. Meetings will be supported and minuted by the NSCB Child Death Review Administrator (hereafter referred to as NSCB Administrator).

The minutes of Child Death Review Sub Group meetings will be circulated to the Chair of the NSCB, all core members of the Group and to any co-opted members attending the relevant meeting.

2. Child Death Review Arrangements including Notifications

2.1 Notification of Deaths

The NSCB Business Office will be notified of the death of any child, aged less than 18 years, normally resident in Northamptonshire or the death of any other child in, or consequent to an unexpected event in, Northamptonshire by:

- The Northamptonshire Police Child Protection Unit Supervisor attending or involved in the investigation of the unexpected death of a child in Northamptonshire or similarly unexpected event, consequent to which a child had died, wherever the death occurred;
- The Medical Practitioner or Paramedic confirming the fact of death of a child in Northamptonshire, whether the death was unexpected or not, unless the Police are involved in the investigation of that death;
- The Coroner's Officer to whom any death of a child in Northamptonshire, or of a child normally resident in the county, is reported;
- Any professional made aware of the death, outside of Northamptonshire, of a child normally resident in the county. (This is particularly relevant to children receiving medical treatment at specialist centres, in out of county respite hospice or foster care placements or on holiday, including abroad);
- First for Wellibeing CIC the Public Health arm of NCC on receipt of notification that a child has died from the Registrar of Births, Deaths and Marriages.

The NSCB Administrator will also accept details of a relevant child death occurring outside of Northamptonshire from another LSCB, professional from an LSCB partner agency or member of the public who suspects that the death may have not been previously notified to the NSCB.

Professional notification of a child death to the NSCB Administrator should be made or confirmed in writing, by email, within 48 hours of becoming aware of the death. The information required is specified in the **Child Death Notification Form**.

On receipt of notification that a child has died the NSCB Administrator will check the child death database for previous notification of the death. If not previously notified, a record on the database will be made of deaths within the remit of the Child Death Review Sub Group. Where details supplied suggest that the death is outside of the remit of the Child Death Review Sub Group, are incomplete or there is variance between any duplicate notifications of the same death, the NSCB Administrator will make any necessary enquiries to ensure that relevant, accurate and complete details are held.

All notifications to the NSCB that a child has died will be acknowledged in writing.

If a child whose death is notified to the NSCB is normally resident outside of Northamptonshire the NSCB Administrator will provide notification of that death to the appropriate LSCB in writing.

2.2 Data Set Collection

For unexpected child deaths occurring in Northamptonshire, or consequent to an event in the county, completion of the form is part of the NSCB unexpected child death response procedure and only verification with the Lead Paediatrician that the response arrangements have been initiated is required.

For some children, particularly those normally resident or who have died consequent to an incident outside of Northamptonshire, another LSCB will also be collecting information on the death. In these cases the NSCB Administrator should liaise with the Administrator for the other LSCB regarding collection of the data set to avoid duplication of requests to professionals. A reciprocal arrangement for the sharing of information obtained following such liaison should be agreed.

In normal circumstances, where the death is not sudden or unexpected, the professional requested to provide the data set information should do so within 14 days of the death. If all information is not available within that time frame, the missing data should be flagged on the Core Data Collection Form and arrangements made for this to be provided to the NSCB Administrator when available.

For unexpected deaths the Lead Paediatrician will forward the Core Data Collection Form to the NSCB Administrator after the multi-agency Case Discussion Meeting, or sooner of all required information is available.

If an incomplete Core Data Collection form is received or there is variance between the information provided and that already held, the NSCB Administrator will make any necessary enquiries to ensure that relevant, accurate and complete details are held.

On receipt of a completed Core Data Collection Form the NSCB Administrator will add the information provided to the record of the death on the NSCB database.

2.3 Data Set Reporting and Analysis

For each meeting of the Child Death Review Sub Group the NSCB Administrator will prepare a summary and statistical report, to include information on recent child deaths, the longer term pattern of child deaths, national and regional comparative baseline data and the

effectiveness of the NSCB child death review and response processes. This, supported by copies of all Core Data Collection Forms completed since the previous meeting will be forwarded to all members attending the meeting.

2.4 Lead Paediatrician Reports On Unexpected Child Deaths

The NSCB Administrator will collate all final reports on unexpected child deaths received from the Lead Paediatrician. At least one week in advance of the Child Death Review Sub Group meeting copies of these reports with any accompanying documents, including the relevant Core Data Collection Forms, will be forwarded to all members attending the meeting.

2.5 Child Death Review Sub Group Meetings

Each meeting of the Child Death Review Committee will:

- Review all new completed child death data sets together with the analysis report of the NSCB Administrator;
- Review all new reports arising from the Unexpected Child Death Response Arrangements;
- Consider the effectiveness of the NSCB Child Death Response and Review Arrangements and other services provided to the families of children who have died;
- Consider whether any matter should be referred to the chair of the NSCB or other action taken in compliance with the Committee's terms of reference. Explicit consideration will be given to the provision of information to the family of each child whose death is reviewed;

2.6 Reporting

The Chair of the Child Death Review Sub Group is responsible for referring to the Chair of the NSCB any matter as agreed by the Sub Group and for monitoring completion of any other action agreed by the group within their terms of reference.

The Sub Group will decide on a case by case basis the information that should be shared with the family of each child whose death is reviewed and the means by which this will be provided.

The annual report from the Sub Group to the NSCB will not report on individual child deaths or include information from which an individual child death can be identified.

The NSCB Administrator is responsible for the compilation of any data returns required by the Department for Education, bodies operating on behalf of that Department or in connection with any other statutory reporting requirements

Information on individual cases will only be provided outside of the NSCB as specified in these procedures or with the explicit agreement of the Child Death Review Sub Group.

2.7 Administrative Arrangements

The NSCB child death database is owned by the Chair of the NSCB and managed by the NSCB Administrator. The database will be operated in accordance with the data protection, audit and information security policies of the host agency for the NSCB Administrator and database.

Complaints received regarding the actions of an individual professional or agency will be directed to the relevant agency and dealt with under that agency's complaints procedure. Any other complaints regarding the application of these procedures by the Sub Group or a professional operating on their behalf will be referred to the Chair of the NSCB.

All media issues relating to the Child Death Review Sub Group will be dealt with by the Northamptonshire Police Press Office on behalf of the NSCB.

The NSCB Business Office, ensure that an up to date and accessible directory of relevant legislation, guidance and information sources is maintained by the NSCB for use by professionals and members of the public.

3.0 Unexpected Child Death Response Arrangements

3.1 Introduction

The following procedures detail the NSCB multi-agency response to the unexpected death of a child. They should be followed by all professionals in conjunction with any relevant policies, procedures and protocols of their own agency.

3.2 Application

These procedures are applicable to the unexpected death of a child, aged less than 18 years, of any natural, unnatural or unknown cause, at home, in hospital or in the community.

An unexpected death is defined as one which 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 which led to the death. This includes the death of a child with an existing medical condition or disability whose death at the time it occurred was not expected as a natural consequence of that condition.

Where there is any doubt about whether a death is unexpected these procedures should be followed.

It is advised that professionals responsible for end of life care to children with terminal conditions identify, document and regularly review the circumstances in which these procedures will not be applied. It should be ensured that the child's family and all staff involved in the care are aware of these decisions.

These procedures are primarily applicable to deaths occurring in Northamptonshire but will also be applied to deaths occurring elsewhere consequent to an unexpected event in Northamptonshire. It will, however, normally be most appropriate for the initial response to be provided under the arrangements of the LSCB where the death occurred.

Similarly, it will normally be appropriate for the initial response to a death occurring in Northamptonshire consequent to an unexpected event elsewhere to be provided by the NSCB, under these procedures, with the further management of the response being undertaken by the LSCB for the area where the event occurred.

In such cases close liaison and cooperation between the Unexpected Child Death Response Arrangements of the respective LSCBs is essential to ensure a coordinated approach and agree appropriate management of the response. The place where the child is normally resident and any agreement between the respective Coroners on jurisdiction should be considered in deciding which LSCB should have primacy.

3.3 Framework for the Response to an Unexpected Child Death

These procedures contain general guidance for all professionals involved in the response to the unexpected death of a child, information about individual agency responsibilities and details of the multi-agency arrangements for the longer term management and assessment of the death.

Multi-agency working will always involve at least HM Coroner, Police, Health and Social Care professionals. Other agencies involved with the family also have a valuable contribution to make.

Each professional must be fully conversant with both their own agency's responsibility and the responsibilities of the other agencies. There should be collaborative and coordinated working at all levels from the earliest call to the emergency services.

The key events described in these procedures are:

- Transfer of the child to an Accident and Emergency Department;
- Initial response and early investigation;
- Early inter-agency information sharing and planning;
- Hospital procedures; *
- Joint Health Service/ Police home visit;
- Liaison with HM Coroner and Post Mortem examination arrangements;
- Multi-agency review and planning arrangements.

The pathway through these events is shown in the flowchart of responsibilities.

* For information regarding the initial hospital procedures please contact the NSCB Business Office

3.4 Relationship to Other Procedures

These procedures are complimentary to and will operate in parallel with or contribute to a number of other processes. These may include:

- Coroner's inquests;

- Criminal investigations;
- Serious Case Reviews;
- Child Protection (Section 47) investigations;
- Health and Safety Executive Investigations;
- Health Service Serious Untoward Incident investigations;
- Provision of Social Care services to family members;
- Provision of primary care and/or hospital treatment to family members;
- NSCB Child Death Review Arrangements (see above in procedures);
- Prison Service investigations;
- Independent Police Complaints Commission investigations;
- Investigations conducted under the HSE / ACPO / NHS Memorandum of Understanding on Investigating Patient Safety Incidents.

Following the unexpected death of a child the Police, acting on behalf of HM Coroner or in the investigation of a crime have primacy in the investigation. Notwithstanding this, all professionals should work within these procedures and ensure that the interface between them and other processes is appropriately managed.

3.5 Principles

The following principles should be adhered to by professionals from all agencies:

- Ensuring that bereaved families are treated with sensitivity and respect, offered appropriate support and kept fully informed;
- Adopting an open minded, proportionate and professional approach to the circumstances;
- Effectively working together and sharing information within a multi-agency response;
- Ensuring that evidence is preserved and that the death is thoroughly investigated;
- Providing a prompt response and ensuring that the investigation is completed expeditiously.

3.6 General Guidance

The unexpected death of a child is a traumatic time for everyone involved. The family will be experiencing extreme grief and shock. Professionals will need to support the family and although the time spent with them may be brief, actions may greatly influence how the family experiences the bereavement for a long time afterwards.

It is the right of every child to have their death properly investigated. Families also desperately want to know what happened, how the event could have occurred, what the cause of death was and whether it could have been prevented. If another child death occurs in the family, a carefully conducted investigation of an earlier death is extremely helpful.

The majority of child deaths occur as a result of natural causes or accidents. Some of these will however have medical implications for other family members or have been contributed to by potentially avoidable factors. In addition, a minority of child deaths are the consequence of, or associated with, abuse or neglect.

The response of all agencies to the death of a child must therefore keep a sensitive balance between a sympathetic and supportive approach to the family and maintaining professionalism towards the investigation.

Unless there are clear and compelling reasons to the contrary, it is inherent in these procedures that all children who die unexpectedly in the community are transferred to a hospital Accident and Emergency Department. This is regardless of whether the chances of successful

resuscitation are thought to be negligible, and specifically so that the response to the death may be effectively managed in accordance with these procedures.

When the Police are concerned that a death may be due to intentional harm, it is important that these procedures are still applied and that all agencies co-operate closely and jointly to determine how best to proceed with the investigation and support of the family.

All professionals must record any information provided by parents, carers or other family members in as much detail as possible. The initial accounts about the circumstances, including timings, must be recorded accurately, contemporaneously and preferably verbatim.

Where the use of any recording equipment is contemplated to assist in the later recall and documenting of information provided by the family, this should only be carried out with the knowledge and agreement of all persons present and the Police Investigating Officer. Any recordings made must be preserved and once used for their primary purpose retained by the Police.

All entries on medical records and other documents relating to the deceased child must be legibly signed, timed and dated, include role or designation and be and clearly attributable to their author.

The following advice is provided for professionals dealing with the family of a child who has died, particularly in the early stages of their bereavement.

- When you arrive always say who you are, why you are there, and how sorry you are about what has happened to the child;
- The family 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 family members space and time to cry, to talk together and to comfort any other children. These moments of grieving are very important;
- It is normal and appropriate for a parent to want physical contact with their dead child. In all but exceptional circumstances, such as when crucial forensic evidence may be lost or interfered with, this should be allowed, albeit with observation by an appropriate professional;
- In talking about the baby preferably use the first name, or, if you don't yet know the name, say 'your baby/son/daughter'. Don't refer to the child as 'it';
- Have respect for the family's religious beliefs and culture. Such issues must be handled sensitively but not to the detriment of the investigation;
- If English is not the family's first language an interpreter should be arranged;
- Take things slowly, allowing the family members to gather their thoughts and tell the story in their own way;
- The parents should be allowed time to ask questions about practical issues. This includes telling them where their child will be taken and when they are likely to be able to see them again. They may also need advice and assistance with funeral arrangements and what to do with their other children;
- 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?'
- At all times be sensitive in the use of mobile phones and other communication equipment. Whenever possible, whilst remaining contactable, such equipment should be turned off when with the family;
- Don't use such phrases as 'suspicious death' or 'Scenes of Crime Officer', and try to avoid comments that might be misunderstood by, or distressing to, the family;
- Parents need to understand the role of the coroner, and the need for a detailed multi-disciplinary investigation, which will include obtaining a comprehensive medical history, a visit to the place where the collapse or other event leading to the death occurred, post mortem examination and meetings between the professionals involved;

- Do not ask their permission for a post mortem but explain sensitively what is involved;
- Parents should be told that they will be informed of the initial post mortem result and other information as it becomes available, but that the final cause of death may not be established for a few weeks or even months;
- Parents need to know to whom they can turn for help and support in their bereavement;
- Written contact names and telephone numbers should be given to the parents.

3.7 Factors That May Arouse Suspicion

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

- Previous child deaths in the family. Two or more unexplained child deaths occurring within the same family is unusual. It should however raise questions about a possible underlying medical or genetic condition as well as concern that the death may be unnatural;
- Previous child protection concerns within the family;
- Inconsistent information. The account given by the parents or carers of the circumstances of the child's death should be documented verbatim. Inconsistencies in the story given on different occasions or to different professionals should raise suspicion, although it is important to be aware that inconsistencies may occur as a result of the shock and trauma of the death;
- Inappropriate delay in seeking help;
- Evidence of drug, alcohol or substance misuse, particularly if the parents are still intoxicated or sedated;
- Evidence of parental mental health problems;
- Previous episodes of unexplained illness, such as cyanotic episodes or acute life threatening events (ALTE);
- Previous and current child protection concerns within the family relating to this child or any siblings;
- Neglect. Observations about the condition of the accommodation, cleanliness, adequacy of clothing, bedding and the temperature of the environment in which the child is found are important. A history of previous concerns about neglect may be relevant;
- Evidence of physical abuse/unexplained injuries, e.g. unexplained bruising/burns/bite marks. However, it is very important to remember that a child may have serious internal injuries without any external evidence of trauma;
- Presence of Blood. The presence of blood must be very carefully noted and recorded. It is found occasionally in cases of natural death. A pinkish frothy residue around the nose or mouth is a normal finding in some children whose deaths are due to the Sudden Infant Death Syndrome. Fresh blood from the nose or mouth is less common, but does occur in some natural deaths. Bleeding from other sites is very uncommon in natural deaths.

However the following should be noted and are present in many infant deaths:

- Froth emerging from the mouth and nose. This froth results from the expulsion of air and mucus from the lungs after death. Sometimes the froth may be blood- stained - this does not mean that the death was unnatural;
- Small quantities of gastric contents around the mouth. This does not mean that death was caused by inhalation of vomit. Often there is slight regurgitation after death;

- Purple discoloration of the parts of the face and body that were lying downwards. This is not bruising, but is caused by the draining of blood in the skin after death. For the same reason the parts that were lying upwards may be very pale;
- Covering of the child's head by the bedclothes. This has often been a feature of cot death in the past, and probably contributes to death through accidental asphyxia or overheating;
- Wet clothing or bedding. This is usually caused by excessive sweating before death;
- If the child looks as though he/she has been roughly handled, remember that this may be the result of attempts at resuscitation.

4.0 Agency Response -Procedures for each Agency

4.1 Ambulance Service

This section should be read in conjunction with the General Guidance above and applied in the context of the procedures applicable to other agencies.

Following receipt of a call to the Ambulance Control Centre the nearest available emergency response will be sent to the scene, supported by a second emergency response if possible.

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

The Ambulance Control Centre will immediately notify the Police Force Control Room when there is a call to the scene of an unexpected child death or this is reported by the attending ambulance staff. The member of staff calling should specify that the child death response procedures are being initiated and provide details of the child and circumstances.

Ambulance staff should not assume death and unless clearly inappropriate they should clear the airway and apply full cardiopulmonary resuscitation.

Children should always be taken to the Accident and Emergency Department. Older children will usually be taken to the Accident and Emergency Department, unless they have obviously been dead for some time and the circumstances of death present a clear and compelling reason for the body to remain at the scene for forensic examination.

A child must be taken to the Accident & Emergency Department. The child should not be taken straight to the mortuary even if they appear to have been dead for some time and the fact of death has been confirmed before arrival at the hospital.

The Accident and Emergency Department should be informed, giving an estimated time of arrival and the child's condition.

The family should also be taken to the hospital to ensure receipt of appropriate medical and social support wherever possible.

All professionals attending the scene should note the position of the child, the clothing worn and the circumstances of how the child was found.

Any persons at the scene should be asked not to disturb or move items around where the child was found until it has been seen by the Paediatrician and/or Police. It should be stressed that this can be extremely important in helping the family to understand why the child has died.

If the circumstances allow, any comments made by the carers or others present, any background history, any possible drug misuse and the conditions of the living accommodation should be noted.

The patient clinical record is to be completed in full as a record of attendance and treatment of the patient. Printouts from any monitoring equipment used should be retained with the record. All information from the scene and any concerns should be reported directly to the Police and to the receiving doctor at the hospital as soon as possible.

If the child's body is to remain at the scene the ambulance staff should await the arrival of the Police Investigating Officer.

There will be times when a GP, Health Visitor or Community Nurse is the first professional to attend. In such circumstances that professional should adhere to the same general principles as the ambulance staff and an ambulance should be called as an emergency.

The Northamptonshire Service Improvement Manager of East Midlands Ambulance Service will always be invited to the multi-agency Information Sharing and Planning Meeting and Case Review Meeting.

4.2 General Practitioners/Health Visitors/Community Nursing Staff

This section should be read in conjunction with the General Guidance above and applied in the context of the procedures applicable to other agencies.

Occasionally the GP, Health Visitor or Community Nurse will be the first professional to attend the scene of the unexpected death of a child.

Primary healthcare professionals should not assume death and unless clearly inappropriate they should clear the airway and apply full cardiopulmonary resuscitation. An emergency ambulance should always be called to the scene.

The professional should ensure that ambulance staff take the child to the Accident and Emergency Department rather than to the mortuary, even when the fact of death has been confirmed at home or elsewhere. It is preferable that verification of death is deferred until the child is transferred to the Accident and Emergency Department.

It is important that if a health professional is the first at the scene they take responsibility for contacting the Police. They should specify that the child death response procedures are being initiated and provide details of the child and circumstances.

All professionals attending the scene should note the position of the child, the clothing worn and the circumstances of how the child was found.

Any persons at the scene should be asked not to disturb or move items around where the child was found until it has been seen by the Paediatrician and/or Police. It should be stressed that this can be extremely important in helping the family to understand why the child has died.

If the circumstances allow, any comments made by the carers or others present, any background history, any possible drug misuse and the conditions of the living accommodation should be noted.

Primary healthcare staff are very important in supporting the family following the death of a child. They should visit the family at home as soon as is convenient and will be involved in providing ongoing advice, support and counselling for the family, in collaboration with other professionals. This process will be coordinated as detailed below in the inter-agency working section of these procedures.

Additional guidance for primary healthcare staff, particularly in relation to the longer term care of the family, is available from the Foundation for the Study of Infant Deaths.

Primary healthcare staff should make notes available to the professionals involved in the investigation of the child's death.

Those involved with the family will always be invited to the multi-agency Information Sharing and Planning Meeting and Case Review Meeting and should attend wherever possible.

4.3 Hospitals

Introduction

This section should be read in conjunction with the General Guidance above and applied in the context of the procedures applicable to other agencies.

These procedures will be followed when a child dies within a hospital in Northamptonshire or is brought to an Accident and Emergency Department having died in the community. In addition to procedures for hospital staff, there are those which may be undertaken by other health service staff in the initial response to the death of a child. Procedures detailed here relate to:

The initial hospital response to the death of a child;

- Inter-agency liaison and planning;
- Agency notification and information gathering;
- Care of the child's family;
- History taking from the family; and

- Examination of the child's body and obtaining early samples and x-rays.

The management of the health service response to the death of a child must be undertaken by a Consultant Paediatrician and within these procedures that person is referred to as the Responsible Paediatrician. In the initial stages of the response that role will be undertaken by the on call Consultant Paediatrician for the relevant hospital who will retain that responsibility until it is handed over to the Lead Paediatrician for Child Deaths (Lead Paediatrician).

Notwithstanding the central role of the Responsible Paediatrician, each professional needs to know their role and the role of others in the investigation of the death and the provision of support to the family.

The on-call doctor undertaking the Responsible Paediatrician role at the hospital and the Nurse allocated to support the family will always be invited to the multi-agency Information Sharing and Planning Meeting and Case Review Meeting and should attend wherever possible. Other hospital staff may also be invited to attend these meetings if they have relevant contribution to make.

Initial Response

On arrival at the hospital the child should be taken to an appropriate area in the Accident and Emergency Department. Should the unexpected death of a child occur elsewhere in the hospital (e.g. in a children's ward or maternity unit) these procedures should be followed at that location.

The family should be provided with privacy. A Nurse should be allocated to look after the family and to keep them informed about what is happening. The Nurse should record any medical or other information provided by the family.

The child should immediately be assessed and death confirmed or resuscitation started in accordance with hospital protocols. Unless it is clear that the baby has been dead for some time (for example when rigor mortis or blood pooling are evident), resuscitation should always be initiated.

Subject to the approval of the medical staff involved, the parents should be given the option of being present during resuscitation. The allocated Nurse should stay with them to explain what is happening.

The on call Consultant Paediatrician should be immediately notified and will thereafter be responsible for management of the response to the child's death and ensuring that these procedures are followed until this is taken over by the Lead Paediatrician.

At the same time the Police will be notified by telephone call to the Police Control Room. The member of staff calling should specify that the child death response procedures are being initiated and provide details of the child and circumstances.

Once the fact of the child's death has been confirmed, any IV cannulae, ET tubes and other equipment may be removed from the child after checking that tubes have been correctly placed. This should be documented clearly in the medical notes.

Any clothing removed and any items of clothing or bedding brought in with the child should be placed in labelled specimen bags and give to the Police Investigating Officer. The clothing may assist the Pathologist and occasionally be required for forensic examination. A record must be made of who removed the items and handed them to the Police. Clothing may not be returned to the parents until the Coroner agrees.

The child's body should not be washed or "cleaned up" as this may interfere with the Pathologist's investigation. The child may be wrapped in a clean blanket. Where cleaning of the child's body is considered essential the Police Investigating Officer and Responsible Paediatrician must be consulted as it may be appropriate for the body to be photographed and / or swabbed before being cleaned.

The Responsible Paediatrician will contact the Lead Paediatrician and agree an appropriate point for that doctor to assume responsibility for management of the case. The Police Investigating Officer will be informed of the decision reached.

Inter-agency liaison and planning

The Responsible Paediatrician and the Police Investigating Officer will liaise at an early stage to:

- Share all currently available information on the death;
- Plan the urgent review of all records held at the hospital;
- Agree responsibility for notifying other agencies and professionals of the death and obtaining relevant information from their records;

- Plan initial actions to be undertaken jointly by health and Police professionals including:
- Examination of the child's body, obtaining urgent post mortem samples and a skeletal survey;
- Depending on the circumstances of the case and availability of expertise, the skeletal survey may be undertaken as part of the forensic post mortem
- Obtaining a full history from the family;
- Formal identification of the child's body;
- Provision of care and support to the family.

- Agree arrangements for liaison with the Pathologist;
- Identify and coordinate any other actions required by the agencies own policies and protocols;
- Agree the point at which responsibility for multi-agency management of the case will be handed over to the Lead paediatrician.

There should be a clear agreement in each case on specific roles and responsibilities.

The liaison process should be ongoing as new information is received.

If any child protection concerns arising from the circumstances of the death are identified the appropriate Social Care professional should be requested to attend the hospital and a formal Strategy Meeting should be held under NSCB Child Protection Procedures.

If there are indications that the death is suspicious and an immediate forensic post mortem examination is to take place, the examination of the child's body, skeletal survey and taking of samples should be deferred for the Pathologist to carry out. This may also affect the manner in which the history is obtained and may necessitate the on call Paediatrician carrying out some of the functions of the Lead Paediatrician, particularly in respect of briefing of the Pathologist (see paragraph 4.4 for the Lead Paediatrician role in briefing the Pathologist).

At the conclusion of their actions at the hospital the Responsible Paediatrician, Police Investigating Officer and, if present, Social Worker should agree a record of what has been done, what actions are outstanding and who is responsible for their completion.

Agency notification and information gathering

The sharing of information between agencies at an early stage following the report of an unexpected infant death is vital to the planning of the multi-agency response.

The following should be notified of the child's death, requested to check their records for relevant information relating to the child or other family members and to ensure that any appointments for the deceased child are cancelled:

- Designated Nurse for Child Protection at the provider organisations- NHFT, NGH and KGH (who will notify, obtain information from and facilitate liaison with the GP, Health Visitor and School Nurse);Procedures for notification of relevant professionals within their organisations should be undertaken.
- Social Care for the area where the child is normally resident, or Out of Hours Team (who will notify and obtain information from the Northamptonshire Review and Conference Service);
- Other relevant health professionals involved in the previous care of the child;
- Police Child Protection Unit (to include all Police databases including PNC and PND);
- Education establishments, if applicable (including any nursery or other provision attended by the child).

Where the child is normally resident outside of Northamptonshire the corresponding professionals in the home area should be notified and asked to check their records in addition to the Northamptonshire professionals.

All records held by the hospital in respect of the child and any siblings should be obtained and reviewed by the Responsible Paediatrician. The original records will be required by the Pathologist and a copy should therefore be produced for retention by the hospital. Additional copies will be required by the Lead Paediatrician and may be requested by the Police.

As a minimum any relevant information held by Social Care and the hospital should be obtained whilst the child and family are still at the hospital. The urgency with which checks of other records should be requested will be dependent upon the circumstances of the death. They should however be completed as far as is possible prior to the post mortem examination taking place.

Care of the child's family

When the child has been pronounced dead, the Responsible Paediatrician should break the news to the parents, having first reviewed all the available information. The interview should be in the privacy of an appropriate room. The allocated Nurse should also be present.

The family should be treated with respect and honesty. They should be allowed to ask questions at any stage. Unless there is an obvious cause of death, it is usually best to say that an opinion cannot be given at that stage.

Parents should, in all but exceptional circumstances, be allowed to hold and spend time with their child. Professional presence should be discreet but vigilant during parents' time with their child.

Mementos should be offered routinely. If there are marks on the child's body which might be masked by taking mementos these areas must be avoided. Details must be recorded in the medical notes (e.g. lock of hair cut or palm or sole prints taken).If mementos are not taken in the Accident and Emergency Department the Coroner's Officer should be notified and a request made to arrange these after the post mortem examination.

The family should be informed that the death must be notified to HM Coroner and that formal identification of the child's body to the Police and a post mortem examination will be required. It should be sensitively explained to the family what this involves and that tissue samples will be taken for examination under the microscope. They should be told where this will be done and that if it is to be at a specialist centre, that the child will normally be returned to the hospital afterwards. They will usually be able to spend time with their baby after the post mortem examination.

The family should also be informed that to ensure that the investigation into the death of a child is as effective as possible and that the family are properly supported a number of agencies, including the Police, Health Service, Social Care and Education will be involved and will meet to plan any further actions that each will take. Details should be provided of any action planned, including any visit to the home address and of the need to obtain a comprehensive history from the family.

It is important to ensure that someone is looking after any other young children in the family. The family should be offered help in contacting other family members or close friends, employers, the hospital chaplain or other religious leader if the parents wish.

The Care of Next Infant (CONI) scheme operates to support families with children born following a cot death. The programme offers a flexible approach with supportive measures including weekly health visitor home visitors, apnoea monitors, weighing scales/charts and symptom diaries. If there are other young children in the family and especially if the dead child is from a multiple birth, urgent institution of the CONI scheme should be considered.

If the child is a twin the other twin should be assessed immediately and admitted for a period of observation and investigation. It must be emphasised to the family that the admission of the surviving twin is because of the possibility of a natural medical condition. If the family decline the offer of admission, this should prompt an urgent reconsideration of the family's needs and the health needs of the surviving twin.

The family should be given copies of current guidance leaflets in accordance with hospital policy and advised of organisations which provide support to bereaved families (see Appendix 5: Useful Contacts and Information). An offer should be made to facilitate contact with these organisations and further support for the family should be provided in accordance with existing hospital policies.

Before they leave the hospital the family should know where their child will be, and the contact details for the relevant co-ordinator whom they can contact if they wish to visit their child.

They should also be provided with contact details for the Lead Paediatrician, the Police Investigating Officer (or Family Liaison Officer if appointed) and the Coroner's Officer.

History taking from the child's family

The Responsible Paediatrician should take a detailed history from the parents / carers. The identity of the people present and their relationship to the child needs to be ascertained and detailed records made of who was present and what was said.

It will normally be appropriate to undertake the history taking in conjunction with the Police present to avoid duplicating the task.

Unless there are indications that the death may be suspicious it will not be appropriate to separate the parents / carers to obtain the history from them, although note should be made of who provides the information. If the death is suspicious the Police Investigating Officer will take this into account when planning the taking of the history.

Appendix 6: Child Death History Checklist is provided as a guide to areas which should be covered in the history taking. It cannot be regarded as exhaustive, as additional specific questions may arise as a consequence of information provided by the family. Some parts of the checklist are applicable to all children who have died. Others will be relevant only for children under the age of 2 and older children where there is no readily identifiable external cause of death or where the child had a chronic medical condition or disability.

Discretion is needed as to the amount of detail that should be sought in the first instance and the immediate history should be obtained first. If a visit to the home address is planned, a lot of the background information can be obtained from the medical records or during that visit. If, however, such a visit is not feasible, it will be necessary to cover as much ground as possible whilst at the hospital.

Encouraging the parents to talk spontaneously with prompts about specific information is likely to be better than trying to collect a structured history. In recording the accounts of parents / carers it is important to use their own words as far as possible. Ideally, information should be recorded verbatim.

Much of the information is very sensitive. Parents may feel very vulnerable when asked about their sleeping arrangements, alcohol intake or drug use, so great skills is needed in asking the questions in a non-threatening way, with no implication of value judgement or criticism.

Examination of the child's body

Unless there are indications that the death is suspicious and an immediate forensic post mortem examination is to take place the Responsible Paediatrician should undertake a full general examination of the child's body. A consultant in emergency medicine may also need to be involved and for children over 16 years, may be more appropriate.

This examination should be conducted with the Police Investigating Officer present.

Any marks and injuries should be documented on a body chart. This should include the site and route of any intervention in resuscitation, for example, venepuncture or intra-osseous needle insertion.

The examination should include the genitalia for any signs of injury and fundoscopy for retinal haemorrhage (preferably by a Consultant Ophthalmologist).

An ear temperature should be taken immediately on presentation, using a low reading thermometer if necessary. Care should be taken to examine the ear and record the findings before the temperature is taken.

Full growth measurements (length, weight and head circumference) should be taken and plotted on centile charts. The child's general appearance, cleanliness and descriptions of any blood or secretions around nose or on clothes should also be noted.

The child's body should not be washed or "cleaned up" as this may interfere with the Pathologist's investigation.

Any visible marks and injuries should be photographed by a Police Forensic Investigator.

Any clothing removed should be placed in labelled specimen bags and give to the Police Investigating Officer. The clothing may assist the Pathologist and occasionally be required for forensic examination. A record must be made of who removed the clothing and handed it to the Police. Clothing may not be returned to the parents until HM Coroner agrees.

Obtaining samples

If any laboratory investigations were taken during resuscitation, these should be clearly documented.

Unless there are indications that the death is suspicious and an immediate forensic post mortem examination is to take place, samples for medical investigations should be taken routinely as soon as possible after death. The recommended samples for children under 2 years are detailed in Appendix 7: Routine Samples. For older children the Paediatrician should consider which of the investigations detailed at Appendix 7: Routine Samples are indicated on the basis of the medical history. If there is definite external evidence of injury early samples should only be taken after discussion with the Police and Pathologist, as this could interfere with the interpretation of injuries at post mortem examination. However, the only opportunity to identify or exclude some medical conditions is by taking samples at or shortly after death and this should not be unnecessarily missed.

A contemporaneous and accurate record should be made of the site from which all samples are taken.

A chain of responsibility must be established for all samples taken. One individual must take the samples to the laboratory. Laboratory staff receiving samples must sign for them and advised of the need for continuity of responsibility. This should be documented in the medical notes.

The laboratory should be asked to store any samples that cannot be analysed straight away.

Skeletal survey

A full skeletal survey should be undertaken. Depending on the availability of staff with the requisite expertise and the circumstances of the case, the skeletal survey will be undertaken either locally or as part of the post mortem examination. The responsible paediatrician should advise the police so that the necessary arrangements can be made. Expertise If undertaken locally, it should be reported by a Consultant radiologist

The radiology must be a full skeletal survey not a 'babygram'. The British Society of Paediatric Radiology, have developed standards for skeletal surveys in suspected non-accidental injury (NAI) in children and these should be followed.

Home Visit

Consideration will be given to a joint visit to the home address (or to the place where the child collapsed / died if different) by the Lead Paediatrician (or alternative senior health professional experienced in responding to unexpected child deaths) and the Police Investigating Officer.

Where the death is considered suspicious the arrangements for the visit will be considered by the Police in the context of the overall investigation and particularly the forensic strategy for the scene.

Such visits should take place as soon as possible and in any case within 24 hours of the death. Arrangements should be made to ensure that the scene of the child's collapse and / or death is left undisturbed until the visit takes place. At the discretion of the Police Investigating Officer, the Police may have visited the scene of death immediately and be maintaining a presence there.

The Police Investigating Officer will arrange for the scene to be photographed by a Police Forensic Investigator. This should normally take place towards the end of the home visit when the Police Investigating Officer is in a position to set parameters for the Forensic Investigator.

There may also be a need to remove items from the scene. This will be undertaken by the Police Forensic Investigator and the decision to take items will be made by the Police Investigating Officer in conjunction with the lead Paediatrician.

4.4 Lead Paediatrician

The Lead Paediatrician for Child Deaths will be notified by the Responsible Paediatrician of the death of a child in hospital or who has been brought to an Accident and Emergency Department having died in the community.

The Lead Paediatrician will thereafter have responsibility for ensuring that the health service response to the death is in accordance with these procedures and should agree with the Responsible Paediatrician the point at which he/she will take over that role the operational management of the response. In most circumstances this will be when the initial response at the hospital is completed.

The Lead Paediatrician will obtain from the Responsible Paediatrician a full report on the initial response to the child's death. This should include details of any outstanding actions and the Lead Paediatrician should, in conjunction with the Police Investigating Officer, arrange for these to be completed.

The Lead Paediatrician will also, at the earliest opportunity, obtain and review all medical records relating to the child.

The Lead Paediatrician should provide the Pathologist with all medical records relating to the child and details of any x-rays and tests carried out. The original x-ray films, test results and any unexamined samples should also be provided to the Pathologist. These should be transferred in such a way that their evidential integrity is maintained.

Copies of the original records should be retained by the Lead Paediatrician to facilitate management of the investigation and review process and provided to the original record holder and the Police Investigating Officer.

The Lead Paediatrician will, in conjunction with the Police Investigating Officer, fully brief the Pathologist and should include all information obtained during the initial investigation, a full medical report based on the history given by the parents in hospital, examination of the child immediately after death, information obtained during the home visit and examination of all relevant medical and social records. In very young babies this might include obstetric records. Any photography of the scene or of the child at presentation or in the Accident and Emergency Department should be provided to the Pathologist prior to starting the post mortem.

Inadequate briefing may result in failure to carry out the tests that might lead to the identification of a cause of death.

Thereafter the Lead Paediatrician will ensure that the NSCB Administrator is aware of the child's death and is responsible for managing the multi-agency planning and review arrangements, as detailed below.

The interim findings of the post mortem examination should be provided in writing by the Pathologist to HM Coroner, the Police Investigating Officer and the Lead Paediatrician immediately after the post mortem examination is completed.

The final report on the post mortem examination should be similarly provided to HM Coroner, the Police Investigating Officer and the Lead Paediatrician.

4.5 Police

Introduction

This section should be read in conjunction with the General Guidance above and applied in the context of the procedures applicable to other agencies.

In respect of the unexpected death of a child the Police have a number of inter-related responsibilities:

- To investigate the circumstances of the death on behalf of HM Coroner;
- To establish if a crime has been committed and if so, to investigate that crime;
- To participate in the NSCB response to the death as described in these procedures including contributing to any action required to protect other children in the family from any identified child protection risks.

Procedures detailed here relate to:

- Investigative Responsibility;
- Receipt of call and deployment;
- Child deaths at hospitals outside of Northamptonshire;
- Initial attendance;
- Inter-agency liaison and planning;
- Agency notification and information gathering;
- Care of the child's family;
- History taking from the child's family;
- Examination of the child's body and obtaining samples and x-rays;
- Identification;
- Home visit;
- Reporting the death to HM Coroner;
- Post mortem examination;
- Multi-agency arrangements.

These should be followed in conjunction with and additional to any other procedures applicable to the circumstances of the death (e.g. Road Traffic Collision SOP; ACPO Murder Investigation Manual).

Investigative Responsibility

Lead responsibility for the investigation of the unexpected death of a child will be the undertaken by:

- If at the outset or subsequently there any indications that the death of a child is suspicious, a Senior Investigating Officer;
- If the child is under 2 years of age and the death is not the result of a road traffic collision, a Senior Investigating Officer;
- If the death results from a Road Traffic Collision, a Road Policing Unit Investigator;
- In all other cases a Child Protection Unit Supervisor.

If a Child Protection Unit Supervisor is not the lead investigator, one will work with the lead investigator to provide advice and assistance, particularly in relation to the application of these procedures.

The Lead Investigator, or Child Protection Unit Supervisor if delegated by the Lead Investigator to undertake responsibilities under these procedures, is referred to as the Police Investigating Officer.

If at any point in the investigation there are indications that the death is suspicious the duty Senior Investigating Officer will be contacted and will assume lead responsibility for the investigation.

Receipt of call and deployment

The Force Control Room will be responsible for the initial deployment of resources to the death of a child, irrespective of the origin of the notification or the circumstances of the death.

For any child death occurring outside of a hospital, the Ambulance Service will be notified and requested to send an emergency ambulance if not already in attendance.

If a road traffic collision is involved, the initial deployment will be in accordance with the Road Traffic Collision SOP. In addition the duty Child Protection Unit Supervisor will be contacted to assist the lead investigator.

In all other circumstances a grade 1 deployment will be made to the place where the incident occurred and the hospital where the child has been taken. Police attendance should be kept to the minimum required and where possible consideration should be given to utilising plain clothed officers and unmarked vehicles.

The duty Lead Investigator (see above) will then be contacted to assume management of the investigative response. If not the Lead Investigator, the duty Child Protection Unit Supervisor will also be contacted.

In normal circumstances it will be appropriate for the Child Protection Unit Supervisor to attend the hospital where the child has been taken and to liaise with the Responsible Paediatrician regarding implementation of these procedures.

Child deaths at hospitals outside of Northamptonshire

If, following an incident in Northamptonshire, the child has been taken to a hospital outside of Northamptonshire, the relevant Police force will be contacted and requested to initiate their LSCB procedures for an initial response to the death of a child at the hospital.

In these circumstances the Child Protection Unit Supervisor will be responsible for:

- Liaison with Police force and other agencies where the hospital is located to ensure a coordinated initial response;
- Notification, as soon as possible, to the Lead Paediatrician for Child Deaths of the circumstances of the death and the response provided.

Initial attendance

If an ambulance is not present one must be called immediately, and consideration given to attempting to revive the child, unless it is absolutely clear that the child has been dead for some time. The first police officer to arrive, or any other professional, may be expected by the parents to try and revive the baby, even if it is hopeless, and should be prepared for this.

Police officers need to be aware of and coordinate their actions with the responsibilities and roles of other professionals, e.g. resuscitation attempts, taking details from the parents, examination of the child and looking after the welfare needs of the family.

The first officer attending the scene of a child's death or the hospital where the child has been taken will assume control of the situation, commence a scene log and preserve the scene. The preservation of the scene will be appropriate to presenting factors and as directed by the Lead Investigator. An explanation should be given to the parents/carers that this is routine in order to assist in determining how the child died. Unless the death is clearly suspicious, there is no reason why parents cannot hold their dead child. This should however take place under the discreet observation of a Police officer.

The police should consider obtaining blood samples for alcohol and toxicology from the carers of the child if the circumstances indicate that this would contribute to the investigation. This should be done in a timely way to optimize the relevance of the results that are obtained

The first officer at the scene should note the position of the child, the clothing worn and the circumstances of how the child was found. Any comments made by the carers or others present, any background history, and the conditions of the living accommodation should also be noted.

Children under 2 years of age should always be taken to the Accident and Emergency Department by ambulance and older children will usually be, unless obviously dead for some time and the circumstances of death require the body to remain at the scene for forensic examination. If the parents / carers wish to accompany the child to hospital this should be facilitated. They should however be accompanied by a Police Officer.

At the hospital it will only in exceptional circumstances be necessary to evidentially preserve technical equipment, the ambulance or whole areas of the hospital. Setting realistic and appropriate parameters will prevent unnecessarily tying up facilities that may be required for the treatment of others.

Inter-agency liaison and planning

If the child's body is not removed to hospital the Police Investigating Officer will contact the Lead Paediatrician for Child Deaths and coordinate subsequent action which complies with these procedures. In any other case the Police Investigating Officer will liaise with the on call Consultant Paediatrician at the hospital (Responsible Paediatrician)

At the hospital the Police Investigating Officer and the Responsible Paediatrician will liaise at an early stage to:

- Share all currently available information on the death;
- Plan the urgent review of all records held at the hospital;
- Agree responsibility for notifying other agencies and professionals of the death and obtaining relevant information from their records;
- Plan initial actions to be undertaken jointly by health and Police professionals including:
    - Examination of the child's body, obtaining urgent post mortem samples and a skeletal survey;
    - Obtaining a full history from the family;
    - Formal identification of the child's body;
    - Provision of care and support to the family.
- Plan a visit to the home address or other place where the child died;
- Agree arrangements for liaison with the Pathologist;
- Identify and coordinate any other actions required by the agencies own policies and protocols;
- Agree the point at which responsibility for multi-agency management of the case will be handed over to the Lead Paediatrician.

There should be a clear agreement in each case on specific roles and responsibilities.

The liaison process should be ongoing as new information is received.

If any child protection concerns arising from the circumstances of the death are identified the appropriate Social Care professional should be requested to attend the hospital and a formal Strategy Meeting should be held under NSCB Child Protection Procedures.

If there are indications that the death is suspicious and an immediate forensic post mortem examination is to take place the examination of the child's body, skeletal survey and taking of samples should deferred for the Pathologist to carry out. This may also affect the manner in which the history is obtained and the briefing of the Pathologist by the Responsible Paediatrician.

At the conclusion of the initial liaison process at the hospital the Responsible Paediatrician, Police Investigating Officer and, if present, Social Worker should agree a record of what has been done, what actions are outstanding and who is responsible for their completion.

Agency notification and information gathering

The sharing of information between agencies at an early stage following the report of an unexpected infant death is vital to the planning of the multi-agency response.

The following should be notified of the child's death, requested to check their records for relevant information relating to the child or other family members and to ensure that any appointments for the deceased child are cancelled:

- General practitioner;
- Designated Child Protection Professionals;
- Health Visitor and/or School Nurse;
- Social Care for the area where the child is normally resident (or Out of Hours Team);
- If the child who has died is in the care of the local authority (Looked after child), the police should work with social care to put in place arrangements to inform the birth parents of the child who has died. This should be handled sensitively depending on the circumstances.
- Northamptonshire Review and Conference Service (this will be done by Social Care);
- Other relevant health professionals involved in the previous care of the child;
- Police Child Protection Unit (to include all Police databases);
- Education, if indicated (including any nursery or other provision attended by the child).

Where the child is normally resident outside of Northamptonshire the corresponding professionals in the home area should be notified and asked to check their records in addition to the Northamptonshire professionals.

All records held by the hospital in respect of the child and any siblings should be obtained and reviewed by the Responsible Paediatrician. The Police Investigating Officer should request copies of these and any obtained from other agencies, for the information of HM Coroner.

The originals of medical records will only be seized by the Police where the circumstances of the death are such that there are concerns over preserving the evidential integrity of the records.

As a minimum any relevant information held by Social Care and the hospital should be obtained whilst the child and family are still at the hospital. The urgency with which checks of other records should be requested will be dependent upon the circumstances of the death. They should however be completed as far as is possible prior to the post mortem examination taking place.

Care of the child's family

Initial care of the family will normally be undertaken by hospital staff with longer term support provided by primary health care professionals. The Police should however assist with this wherever possible and where a Family Liaison Officer has been appointed it will normally be appropriate for that officer to work closely with the relevant health service professional.

Parents should, in all but exceptional circumstances, be allowed to hold and spend time with their child. Professional presence should be discreet but vigilant during parents' time with their child.

Mementos should be offered routinely. If mementos are not taken in the Accident and Emergency Department the Coroner's Officer should be notified and a request made to arrange these after the post mortem examination.

The family should be informed that the death must be notified to HM Coroner and that formal identification of the child's body to the Police and a post mortem examination will be required. It should be sensitively explained to the family what this involves and that tissue samples will be taken for examination under the microscope. The family should be informed where this will be done and that if it is to be at a specialist centre, that the child will normally be returned to the hospital afterwards. They will usually be able to spend time with their child after the post mortem examination.

The family should also be informed that to ensure that the investigation into the death of a child is as effective as possible and that the family are properly supported a number of agencies, including the Police, Health Service, Social Care and Education will be involved and will meet to plan any further actions that each will take. Details should be provided of any action planned, including any visit to the home address and of the need to obtain a comprehensive history from the family.

It is important to ensure that someone is looking after any other young children in the family. The family should be offered help in contacting other family members or close friends, employers, the hospital chaplain or other religious leader if the parents wish.

Before they leave the hospital the family should know where their child will be, and the contact details for the relevant co-ordinator whom they can contact if they wish to visit their child.

They should also be provided with contact details for the Lead Paediatrician, the Police Investigating Officer (or Family Liaison Officer if appointed) and the Coroner's Officer.

History taking from the child's family

Often medical staff interview parents before the police arrive at hospital in an effort to establish the circumstances surrounding the child's collapse. This account should be obtained by the Police Investigating Officer.

The Responsible Paediatrician will normally take a detailed history from the parents / carers and a Police Officer should be involved in this to avoid duplicating the task. Repeat questioning of the parent by different police officers or other professionals should be avoided.

The identity of the people present and their relationship to the child needs to be ascertained and detailed records made of who was present and what was said.

Unless there are indications that the death is suspicious it will not be appropriate to separate the parents / carers to obtain the history from them, although note should be made of who provides the information. If the death is suspicious the Police Investigating Officer will decide whether any interviews with the parents / carers need to be carried out under the Police and Criminal Evidence Act, 1984 and how this may fit into the overall investigation plan.

Appendix 6: Child Death History Checklist is provided as a guide to areas which should be covered in the history taking. It cannot be regarded as comprehensive, as additional specific questions may arise as a consequence of information provided by the family. Some parts of the checklist are applicable to all children who have died. Others will be relevant only for children under the age of 2 and older children where there is no readily identifiable external cause of death or where the child had a chronic medical condition or disability.

Discretion is needed as to the amount of detail that should be sought in the first instance and the immediate history should be obtained first. If a visit to the home address is planned, a lot of the background information can be obtained from the medical records or during that visit. If, however, such a visit is not feasible, it will be necessary to cover as much ground as possible whilst at the hospital.

Encouraging the parents to talk spontaneously with prompts about specific information is likely to be better than trying to collect a structured history. In recording the accounts of parents / carers it is important to use their own words as far as possible. Ideally, information should be recorded verbatim.

Much of the information is very sensitive. Parents may feel very vulnerable when asked about their sleeping arrangements, alcohol intake or drug use, so great skills is needed in asking the questions in a non-threatening way, with no implication of value judgement or criticism.

Examination of the child's body examination and obtaining samples and x-rays

Unless there are indications that the death is suspicious and an immediate forensic post mortem examination is to take place the Responsible Paediatrician should undertake a full general examination of the child's body. A Consultant in emergency medicine may also need to be involved and for children over 16 years, may be more appropriate.

The Police Investigating Officer should be present when this is conducted and ensure that all marks and injuries are recorded along with the Responsible Paediatrician's opinion on their cause.

The child's general appearance, cleanliness and descriptions of any blood or secretions around nose or on clothes should also be noted. The child's body should not be washed or "cleaned up" as this may interfere with the Pathologist's investigation.

Any visible marks and injuries should be photographed by a Police Forensic Investigator.

Any clothing removed should appropriately packaged and retained by the Police. Care should be taken to ensure the evidential integrity and continuity of all exhibits and samples, including any taken during attempts at resuscitation, and the Police Investigating Officer or Forensic Investigator should advise hospital staff on these issues.

Identification

The Police Investigating Officer should ensure that wherever possible the child's body is formally identified at the hospital, or at least prior to the post mortem examination taking place, and that continuity of identification is maintained through to the post mortem examination.

At each stage in the chain of continuity, appropriate witness statements must be obtained.

Where the death is considered suspicious the arrangements for the visit will be considered by the Police in the context of the overall investigation and particularly the forensic strategy for the scene.

The Police Investigating Officer will arrange for the scene to be photographed by a Forensic Investigator. This should normally take place towards the end of the home visit when the Police Investigating Officer is in a position to set parameters for the Forensic Investigator.

There may also be a need to remove items from the scene. This will be undertaken by the Police Forensic Investigator and the decision to take items will be made by the Police Investigating Officer in conjunction with the Responsible Paediatrician.

Bedding will only be taken if there are obvious signs of forensic value such as blood, vomit or other residues. The routine collection of bedding is neither necessary for any investigative purpose, nor appropriate for the family. Items such as the child's used bottles, cups, food or medication together with any used nappies will normally be taken. There is no need to retain any other clothing unless the child's clothes have been changed prior to the arrival of the police.

If any medical equipment has been used for the child (e.g. syringe drivers, portable ventilators) these should be taken after advice is obtained on how to preserve any internal records settings.

If it is necessary to remove items from the house, this should be done with consideration for the parents. It should be explained that this may help to find out why their child has died. Parents / carers should be asked if they want the items returned.

At the earliest opportunity after the investigation is completed, any items the family wish to have returned, should be returned to them. All police documentation will be removed and the property will be returned if appropriate in new/clean wrapping/bags. If soiled articles were taken, parents/carers should be asked about their return, and if they would like them cleaned prior to return. An appointment should be made with the parents/carers to return any property, remembering that this could be a significant event for them

Reporting the death to HM Coroner

In all cases the Coroner's Officer must be notified and provided with full details of the circumstances of the death as soon as possible in accordance with normal Police procedures in order that HM Coroner may be briefed.

The statements relating to identification of the child's body should be forwarded to the Coroner's Officer as soon as possible to enable an Inquest to be opened.

The Police Investigating Officer and the Coroner's Officer should continue close liaison throughout the investigation.

Post mortem examination

The Police Investigating Officer is responsible for:

- Arranging for a post mortem examination;
- Arranging for the child's body to be conveyed to the hospital where the post mortem examination is to take place;
- Informing all relevant professionals of the time and place of the post mortem examination, including the Lead Paediatrician and the Coroner's Officer;
- Informing the family of the time and place of the post mortem examination;
- Liaising with the family about mementos if these have not been taken in the Accident and Emergency Department;
- Liaising with family regarding retention of tissue and organs and obtaining necessary signatures.

The Coroner's Officer will be able to advise and assist with these arrangements.

A Family Liaison Officer, if appointed or Child Protection Unit Officer should normally undertake those actions involving contact with the family.

If possible the post mortem examination should be completed within 48 hours of the child's death.

In all cases, the post mortem examination should be carried out by a Paediatric Pathologist.

If there are any concerns that the death may be suspicious nature, a Home Office Pathologist will be used in conjunction with a paediatric Pathologist. Where a Pathologist is qualified both as a forensic and paediatric Pathologist they may complete the post mortem examination on their own.

The Police Investigating Officer, in conjunction with the Responsible Paediatrician must ensure that the Pathologist is provided with full details of the circumstances, including all information obtained during their initial investigation.

All relevant medical records, which in young babies will include obstetric records, x-rays and test results, together with any photographs, should be provided to the Pathologist prior to starting the post mortem examination.

Inadequate briefing may result in failure to carry out the tests that might lead to the identification of a cause of death.

The Police Investigating Officer should attend the post mortem examination. If this is not possible, then they must send a representative who is aware of all the facts of the case. A Forensic Investigator must attend all post mortem examinations conducted by a Home Office Pathologist.

Following the receipt of the post mortem report, a joint visit to the family should be offered by the police and lead paediatrician to explain the contents of the report and provide an opportunity to the family to raise any issues concerning the investigation of their childs death.

Multi-agency arrangements

The Child Protection Unit Supervisor and, if different, the Lead Investigator should attend the multi-agency Information Sharing and Planning Meeting and Case Review Meeting.

The Child Protection Unit Supervisor will notify the NSCB Administrator of the child's death.

4.6 Social Care

This section should be read in conjunction with the General Guidance above and applied in the context of the procedures applicable to other agencies.

Children's Social Care may hold information in respect of a child who has died or their family. The duty Social Worker for the area where the child lived or the Out of Hours Team will be contacted by either the Police or the Responsible Paediatrician as part of the initial information gathering procedure and should share any information held.

The Social Worker informed of the death of a child must notify the Northamptonshire Review and Conference Service of the circumstances and request that the presence of a Child Protection Plan be established.

Social Care may become more directly involved in the initial response to the death of a child either where there are specific support needs of the family, especially if there are other children, or where there are child protection concerns arising from the circumstances of the death.

If the child who has died is in the care of the local authority (Looked after child), the police should work with social care to put in place arrangements to inform the birth parents of the child who has died. This should be handled sensitively depending on the circumstances.

Any child protection concerns will be addressed in accordance with NSCB procedures and Social Care has lead responsibility for these issues, which will be jointly investigated with the Police and other agencies as appropriate. If any action is considered necessary in advance of the multi-agency Information Sharing and Planning Meeting the Social Worker should coordinate this with the Health and Police professionals responding to the child death. In all but exceptional circumstances this should be through convening a formal child protection strategy meeting.

The Head of Safeguarding and Corporate Parenting will always be invited to the multi-agency Information Sharing and Planning Meeting and Case Review Meeting and will nominate an attendee.

4.7 Coroner's Officer and Pathologist

This section should be read in conjunction with the General Guidance above and applied in the context of the procedures applicable to other agencies.

Any child whose death is unexpected should be taken to the Accident and Emergency Department unless already a patient at the hospital. If, for any reason, a child's body is taken directly to the mortuary, the mortuary or Coroner's Officer will immediately inform the duty Child Protection Unit Supervisor and the Lead Paediatrician. Those professionals will thereafter coordinate subsequent action which complies with these procedures.

The Coroner's Officer will be notified of a child's death in accordance with existing Police policies by the Police Investigating Officer.

The Coroner's Officer is thereafter responsible for briefing HM Coroner and making the necessary arrangements to have an inquest opened.

The Coroner's Officer should advise and assist the Police Investigating Officer in relation to:

- Arranging for a post mortem examination;
- Arranging for the child's body to be conveyed to the hospital where the post mortem examination is to take place;
- Informing all relevant professionals of the time and place of the post mortem examination, including the Lead Paediatrician and the Coroner's Officer;
- Informing the family of the time and place of the post mortem examination;
- Liaising with the family about mementos if these have not been taken in the Accident and Emergency Department;
- Liaising with family regarding retention of tissue and organs and obtaining necessary signatures.

Thereafter the Coroner's Officer is responsible for:

- When interim and final post mortem reports are received from the Pathologist, forwarding copies of these to the Lead Paediatrician, Police Investigating Officer and GP;
- Ensuring effective communication between those professionals involved in the multi-agency response to the child's death and HM Coroner;
- Ensuring that the family's wishes regarding disposal of any body tissues retained from the post mortem examination are made known to the Pathologist and HM Coroner;
- Ensuring that the child's body is released for burial or cremation as soon as possible, obtaining the required written confirmation from the Pathologist and Police Investigating Officer that this may occur.

If possible the post mortem examination should be completed within 48 hours of the child's death.

In all cases, the post mortem examination should be carried out by a Paediatric Pathologist.

If there are any concerns that the death may be suspicious nature, a Home Office Pathologist will be used in conjunction with a paediatric Pathologist. Where a Pathologist is qualified both as a forensic and paediatric Pathologist they may complete the post mortem examination on their own.

If during the post mortem examination a Pathologist becomes at all concerned that there may be suspicious circumstances, they must halt the post-mortem and inform the Coroner's Officer and Police Investigating Officer.

The Pathologist must be provided with full details of the circumstances. This briefing is best done by the Responsible Paediatrician, in conjunction with the Police Investigating Officer, and should include all information obtained during their initial investigation including the history given by the parents in hospital, examination of the child immediately after death, information obtained during the home visit and examination of all relevant records.

Inadequate briefing may result in failure to carry out the tests that might lead to the identification of a cause of death.

The Responsible Paediatrician should provide the Pathologist with all relevant medical records, which in young babies will include obstetric records, and details of any x-rays and tests carried out. The original x-ray films, test results and any unexamined samples should be provided to the Pathologist. These should be transferred in such a way that their evidential integrity is maintained.

If documents to be forwarded should be copied and the copies retained in place of the originals. Additional copies should be made for the Lead Paediatrician to facilitate management of the investigation and review process and for the Police Investigating Officer.

The Police Investigating Officer should attend the post mortem. If this is not possible, then they must send a representative who is aware of all the facts of the case. A Forensic Investigator must attend all post mortem examinations conducted by a Home Office Pathologist. The Responsible Paediatrician may also attend. Where this does not occur there must be adequate discussion between the Paediatrician and the Pathologist both before and after the post mortem examination.

The interim findings of the post mortem examination should be provided in writing by the Pathologist to HM Coroner, the Police Investigating Officer and the Lead Paediatrician immediately after the post mortem examination is completed.

The final report on the post mortem examination should be similarly provided to Coroner, the Police Investigating Officer and the Lead Paediatrician.

The Lead Paediatrician, through the Coroner's Officer, will ensure that HM Coroner is made aware of any information arising from the multi-agency Information Sharing and Planning Meeting or Case Review Meeting which may impact on HM Coroner's view determination of cause of death and whether an inquest should be held.

Notwithstanding the above, if the death is from natural causes, HM Coroner will notify the Registrar as to the medical cause of death to enable the death to be registered and a death certificate issued. If the death is not 'natural', this notification to the Registrar may be delayed pending the outcome of criminal proceedings or an inquest.

HM Coroner, the Pathologist and the Coroner's Officer will always be invited to the multi-agency Information Sharing and Planning Meeting and Case Review Meeting.

5.0 Inter Agency Working - Sharing Information and Meetings

5.1 Information Sharing and Planning Meeting

A multi-agency Information Sharing and Planning Meeting will be convened by the Lead Paediatrician within 3 days of the unexpected death of a child.

Whenever possible, the meeting should be held at the family GP's surgery.

The Lead Paediatrician will arrange for the meeting to be minuted and for these to be distributed within 24 hours of the meeting. Any disagreement with the content of the minutes should be raised with the Lead Paediatrician immediately.

This meeting will be chaired by the Lead Paediatrician and will include information and/or representation from:

- The Responding Paediatrician or other Consultant who dealt with the family immediately after the death;
- The child's GP;

- The child's Health Visitor;
- A Children's Social Care Manager;
- The Police Investigating Officer;
- The Police Child Protection Unit Supervisor who dealt with the family immediately after the death;
- A Coroner's Officer;
- A representative from any school or nursery attended by the child;
- Any other relevant professional providing services to the child or family;
- Where the child was normally resident in and / or the event leading to the death took place in another LSCB area, appropriate professionals from the other area(s).

The purpose of this meeting is to:

- Share information held by all agencies in current or previous case notes or other records;
- Coordinate agency contribution to and involvement in the investigation of the child's death;
- Ensure a co-ordinated bereavement care plan is in place for the family;
- Explicitly consider whether there are any child protection risks to siblings or other children in the household;
- Explicitly decide whether the circumstances should be referred to the LSCB for consideration of holding a Serious Case Review;
- Ensure that all relevant agencies and professionals have been notified of the child's death;
- Agree what information from the meeting will be shared with the family and who will provide this to them. Generally there should be complete openness with the family unless this could undermine a criminal or Section 47 Enquiry;
- Where the child was normally resident in and / or the event leading to the death took place in another LSCB area, coordinate the respective LSCB Unexpected Child Death Response Arrangements and the involvement of agencies in each of the areas. Whichever LSCB is to take primacy in the investigation these arrangements should include provision of the NSCB Core Data Set and final report on the death to the NSCB Child Death Review Sub Group.

If any child protection risks are identified at or prior to the meeting it will adopt the dual function of a formal child protection strategy meeting.

At or after the meeting the Lead Paediatrician will complete of the LSCB Core Data Collection Form (Appendix 2: Child Death Review Data Collection Form). If this form is able to be completed it will be forwarded to the NSCB Administrator. If further information is required, this form should be retained until the multi-agency Case Review Meeting has been held.

If the initial results of the post mortem examination are not available at the time of the meeting a contingency should be agreed for when they are available. In most cases this will involve telephone contact between relevant professionals but in some circumstances, (e.g. if the post mortem examination identifies abuse of the child) it will be more appropriate for the Lead Paediatrician to re-convene the meeting.

Following the meeting the identified professional will provide the family with the information agreed.

5.2 Case Review Meeting

A multi-agency Case Review Meeting will be convened by the Lead Paediatrician as soon as possible after the final post mortem result is available (the timing will vary according to circumstances, but should be no more than 8 - 12 weeks after the death).

Whenever possible, the meeting should be held at the family GP's surgery.

The Lead Paediatrician will arrange for the meeting to be minuted. Any disagreement with the content of the minutes should be raised with the Lead Paediatrician.

his meeting will be chaired by the Lead Paediatrician and will include:

- The Paediatrician or other Consultant who dealt with the family immediately after the death;
- The child's GP;
- The child's Health Visitor;
- The Pathologist wherever possible;
- A Children's Social Care Manager;
- The lead Police Investigator;
- The Child Protection Unit Supervisor who dealt with the family immediately after the death;
- A Coroner's Officer;
- A representative from any school or nursery attended by the child;
- Any other relevant professional providing services to the child or family
- Where the child was normally resident in and / or the event leading to the death took place in another LSCB area, appropriate professionals from the other area(s).

The purpose of this meeting is to:

- Review all relevant information concerning the death, the child's history, family history and subsequent investigation;
- Ensure that no information has been overlooked. Any further tests or opinions which may shed light on the cause of death may be recommended to the appropriate agency;
- If necessary complete the NSCB Core Data collection Form (Appendix 2: Child Death Review Data Collection Form);
- Complete an assessment of factors that contributed to the death and agree a classification of it according to avoid ability. The NSCB Assessment of Contributory Factors Form should be used to record this assessment (Appendix 4: Assessment of Contributory Factors Form);
- Explicitly comment on the presence or not of concerns about abuse and neglect causing or contributing to the death. If there is no evidence of maltreatment this should be documented;
- Explicitly consider whether there are any unaddressed child protection risks to siblings or other children in the household and if so what action should be taken and by whom;
- Review the effectiveness of the response provided by agencies and professionals to the death and identify any elements of good practice or potential lessons to be learnt;
- Comment on the quality of any services provided by agencies to the child and / or family prior to the death and identify any elements of good practice or potential lessons to be learnt;
- Explicitly decide whether the circumstances should be referred to the NSCB for consideration of holding a Serious Case Review;

- Agree how accurate and appropriate information regarding the findings of the investigation will be shared with the family and by whom. Generally there should be complete openness with the family unless this could undermine a criminal or Section 47 Enquiry;
- To review whether the support and guidance for the family is adequate and to plan for counselling and any further services required;
- Consider the need, and if so prepare a plan for any future pregnancies;
- Where the child was normally resident in and / or the event leading to the death took place in another LSCB area, consider the information needs of the LSCB and how these will be addressed. This will normally be through providing copies of the documents prepared for the NSCB.

When appropriate, this meeting will mark the closure of the investigation into the child's death. The precise timing will depend on the progress of the Police/HM Coroner investigations.

Families should be provided with information from the meeting at the earliest opportunity, usually by the Lead Paediatrician or the Paediatrician responsible for the child's care and a member of the primary health care team. The parents should also be provided with written information on the outcome of the investigation.

Where the Police and / or Social Care are conducting a criminal and / or Section 47 Enquiry, the Lead Paediatrician should discuss with the lead professional for the relevant agency(ies) what information should be shared, how and when. Where a Police Family Liaison Officer has been appointed the involvement of that professional in this process should be considered.

Following the multi-agency Case Review Meeting the Lead Paediatrician will provide an agreed record of the meeting and all reports to HM Coroner.

The agreed record of the meeting, the completed NSCB Core Data Collection Form (Appendix 2: Child Death Review Data Collection Form) and the NSCB Assessment of Contributory Factors Form (Appendix 4: Assessment of Contributory Factors Form) will also be forwarded to the NSCB Administrator for consideration by the Child Death Review Committee and the LSCBs for any other area as agreed at the meeting.