Merseyside Joint Agency Protocol

SUDDEN UNEXPECTED DEATH IN CHILDHOOD (S.U.D.i.C)

For Children aged 0 to under 18 Years

May 2024

Dear Colleagues,

The original Merseyside SUDI protocol was first launched in September 2002. The revisions have taken into consideration updates of Working Together to Safeguard Children, experience, research and the reports of a working group chaired by Baroness Helena Kennedy QC, with the most recently revised publication occurring in November 2016. It is our view that this protocol represents the best standard of investigation and service available given the resources and infrastructure of this region.

The investigation of all sudden and unexpected deaths must be of the highest forensic standard. This is necessary for the care of the bereaved, the needs of our justice system and the good of our society. The investigation of sudden and unexpected infant and child deaths deserves no less.

It must be remembered that the great majority of SUDiC cases are natural tragedies. The care of bereaved loved ones is a priority in all cases. Sensitivity, compassion and support do not detract from the thorough and detailed investigation required. For the good of all it is important that the cause of death is found not a cause of death.

This process will take time, and to ensure a funeral can take place in a reasonable time frame, a Coroner's investigation/inquest will be opened in almost every case. Every care will be taken at such investigations to follow the ethos of this protocol so far as sensitivity of the subject matter is concerned.

To ensure a consistently high standard of care and investigation we have adopted and recommend to you this revised protocol as being the standard by which sudden and unexpected deaths of infants and children is to be carried out in Merseyside.

Julie Goulding
HM Senior Coroner for Sefton, St Helens & Knowsley

André Rebello OBE
HM Senior Coroner for Liverpool and Wirral

Anita Bhardwaj
HM Area Coroner for Liverpool and Wirral

This protocol has been drawn up in consultation with:

- Liverpool Safeguarding Children Partnership
- Sefton Safeguarding Children Partnership
- Knowsley Safeguarding Children Partnership
- St. Helens Safeguarding Children Partnership
- Wirral Safeguarding Children Partnership
- H.M. Senior Coroner, Liverpool and Wirral
- H.M. Senior Coroner, Sefton, Knowsley and St. Helens
- North West Ambulance Service
- Merseyside Police
- Representatives of all agencies involved in the SUDiC process

This is the fourth version of the SUDiC protocol that replaced the SUDI and SUDC protocols from 2012.

This is the guidance document to be used by agencies for unexpected child deaths from 0-18 years old.

The efforts of all who have contributed to this document are acknowledged and greatly appreciated.

CONTENTS

1. INTRODUCTION

1.1 This guidance provides a framework for the investigation and care of families following the Sudden Unexpected Death in Childhood (SUDiC: 0 up to 18 years). Each agency will have internal guidelines that will complement this protocol.

1.2 The Sudden Unexpected Death of an Infant or Child (SUDiC) is a death that was not anticipated as a significant possibility 24 hours before the death, or where there was a seemingly unexpected collapse, leading to, or precipitating the events that led to the death. This also includes the unexpected death of a child with disabilities or a chronic medical condition, or suspected self-harm. Where there is uncertainty, the Designated Doctor for Child Death (once in post) is to be consulted. In the event that the designated doctor is not available, consultation should take place with the designated paediatrician. If in doubt, follow the SUDiC process. However, once commenced, the agreement of HM Coroner is required before 'standing down' the process. This is achieved through liaison between Merseyside Police and HM Coroner.

1.3 The protocol uses the generic term 'child' to refer to all age groups from a new-born baby to a young person up to the age of 18 years.

1.4 It also describes some of the factors that may raise concern about the circumstances surrounding the death. If factors in the environment, history or examination raise suspicions or concerns about the circumstances surrounding the death, the SUDiC protocol should be followed, including incidents where non-accidental injury is thought to have resulted in the death of a child.

1.5 The guidance should be used irrespective of the place of death: at home, in the community, in hospital (Accident & Emergency or Ward), abroad or outside of the area of usual residence or, in the case of a stillbirth/out of hospital delivery when no medical professional was in attendance.

1.6 The protocol details a multi-agency approach that will strive to achieve:

- Sensitive care and support to all affected by the death
- Preservation of any evidence at the place of death
- Documentation of all interventions by paramedics and medical staff – including resuscitation prior to death
- Completion of full medical history by medical staff
- Review of the medical records of the deceased
- Paediatric pathologist (and if necessary, forensic pathologist) investigating the cause of death
- A multi-agency case discussion

1.7 It is essential that every professional involved in a SUDiC case must be fully aware of this guidance and should keep thorough records.

2. AIMS

2.1 The aim of the SUDiC Protocol is to provide an effective response to sudden, unexplained death in childhood by:

- Establishing as far as possible, the cause of death
- Providing care and support to all those who are impacted by the death
- Identifying any modifiable or contributary factors
- Ensuring the family is kept fully informed and supported
- Meeting statutory obligations as outlined in Working Together to Safeguard Children
- Identifying areas where lessons can be learnt to reduce the likelihood of future child deaths

3. PRINCIPLES

3.1 When dealing with Sudden Unexpected Death in Childhood, all agencies should follow these common principles, especially when dealing with family members:

- Adopt a sensitive, open-minded and balanced approach
- An inter-agency approach
- Sharing information
- Appropriate response to the circumstances
- Preservation of evidence
- Awareness of religious and cultural differences

3.2 The investigation of a SUDiC case is a multi-agency responsibility and all professionals involved are inter-dependent for sharing information with a proficient level of expertise. This guidance should be read as a whole, not just the section related to the professional's role.

3.3 All professionals and agencies should ensure that their actions are legal, necessary and proportionate.

3.4 Following the death of a child

- No matter how brief your time with the family, your attitude and actions will be remembered.
- Maintain a supportive attitude whilst remaining professional.
- Grief reactions vary – some people may be shocked and numb; others may be hysterical.
- An appropriate professional should be discreetly present with the family as the child is handled.
- Handle the child naturally and with respect, as if they were still alive.
- Always refer to the child by their name.
- Deal sensitively with religious beliefs and cultural differences – but remember the importance of preservation of evidence.
- Parents/Carers should be asked about any specific religious or cultural considerations they would like to be observed.
- Parents/Carers will need time to ask questions.

- Written information should be given to the family, which will allow them to review this at their own pace. Where possible, provide names and contact details for relevant agencies and personnel.
- Practical matters will need to be addressed and the family updated – where the child will go, what will happen and when parents can see them.
- In unexplained child death cases, an investigation will be pursued by Police to inform HM Coroner to determine if it is necessary to progress an inquest.
- In many cases, a post-mortem will occur. This will be authorised by HM Coroner.
- All agencies should be aware that on rare occasions, in the event of suspicious circumstances, the early arrest of parents/carers may be necessary to secure and preserve evidence.
- Professionals should be prepared to provide statements of evidence where there are suspicious circumstances. Local procedures should be followed.

The unexpected death of a child is perhaps the most devastating trauma and grief that any person can sustain. Parents/Carers will go through different emotions, ranging from shock, disbelief, guilt and anger. There will be added stress posed with Police investigations and potential post-mortem and inquest. Whilst professionals have guidance and procedures for dealing with the sudden unexpected death of a child, for parents it is a tragic experience, with each component potentially adding further trauma. Hence, it is of paramount importance that the professionals dealing with SUDiC are fully trained with the SUDiC guidelines. Experience has taught us, that lack of certain knowledge at key points can have devastating effects for the family and adversely affects their subsequent relationships with professionals and the health care system.

4. DEFINITIONS

4.1 *Expected and Explained*
A child expected to die and cause of death is explained.

Example: A child with cancer who dies in hospice/hospital.

This guidance does not need to be followed.

Death in a hospice is generally expected and explained. However, if there have been concerns raised about the circumstances of the death, this should be discussed with HM Coroner.

4.2 *Expected and Unexplained*
A child expected to die, but the cause of death is not explained by the condition.

Example: A child with cancer who dies in unexplained circumstances.

The responsible clinician (GP, Consultant Paediatrician, ED Consultant) should discuss the case with the HM Coroner to decide if an investigation is needed as per the SUDiC protocol.

4.3 *Unexpected and Explained*
An unexpected death of a child where the cause of death is explained.

Example: A child who dies of sepsis following burns sustained in a house fire.

In these circumstances, the SUDiC protocol should be followed as the events that led to the death were unexpected. If the child dies at a much later date, as a result of injuries sustained in an accident, a conversation should take place with HM Coroner as to if the protocol needs to be followed.

4.4 *Unexpected and Unexplained*
The unexpected death of a child where there is no clear cause of death.

Example: A child found dead at home with no apparent reason why, or a child who collapses and dies in the community.

Follow the SUDiC protocol.

5. UNUSUAL CLINICAL SITUATIONS

There are some circumstances which are not clear and may need discussion with the designated doctor for child death/paediatrician or others in the multi-agency team such as:

5.1 *A child who is unwell at the time of presentation, but who deteriorates quickly and dies of presumed sepsis and multi-organ failure.*
In this situation, this is a sudden and unexpected infection – most life-threatening cases of sepsis in children are. However, from the time at which septic shock is established, the child's death can be anticipated despite the best efforts of medical staff. If the attending paediatrician can certify that the death is due to sepsis, there will be no need for a SUDiC investigation. However, if there is insufficient evidence to certify the cause of death, the case should be discussed with HM Coroner and the SUDiC process initiated. HM Coroner can modify/step this down if they feel that the investigation is no longer required. A home visit would not usually be completed unless specific concerns were raised.

5.2 *A child who is successfully resuscitated from an out-of-hospital cardiac arrest, who may survive for a period of time and dies subsequently.*
The child may live for days or weeks prior to death, sometimes with life-sustaining care being withdrawn following discussion with family. As the initial cardiac arrest was sudden and unexpected, the Police may have secured the scene, but cannot do this indefinitely. This sort of scenario should be discussed with Designated Doctor for Child Death as despite the child remaining alive, a joint visit may be required as important information may be found that can assist both the Police and the team treating the child.

5.3 *A child with a life limiting/threatening condition who dies suddenly and unexpectedly.*
If a child with a diagnosed condition dies suddenly or following a brief illness, a SUDiC investigation may not be required. If there are concerns, the lead health professional should consult with HM Coroner. However, if the death was unexpected, the lead heath professional should discuss with the joint agency response team and clinical team who have knowledge of the child and family to reach a decision if a SUDiC investigation should be started. If in doubt – professionals should seek consultation with HM Coroner/Designated Doctor for Child Death.

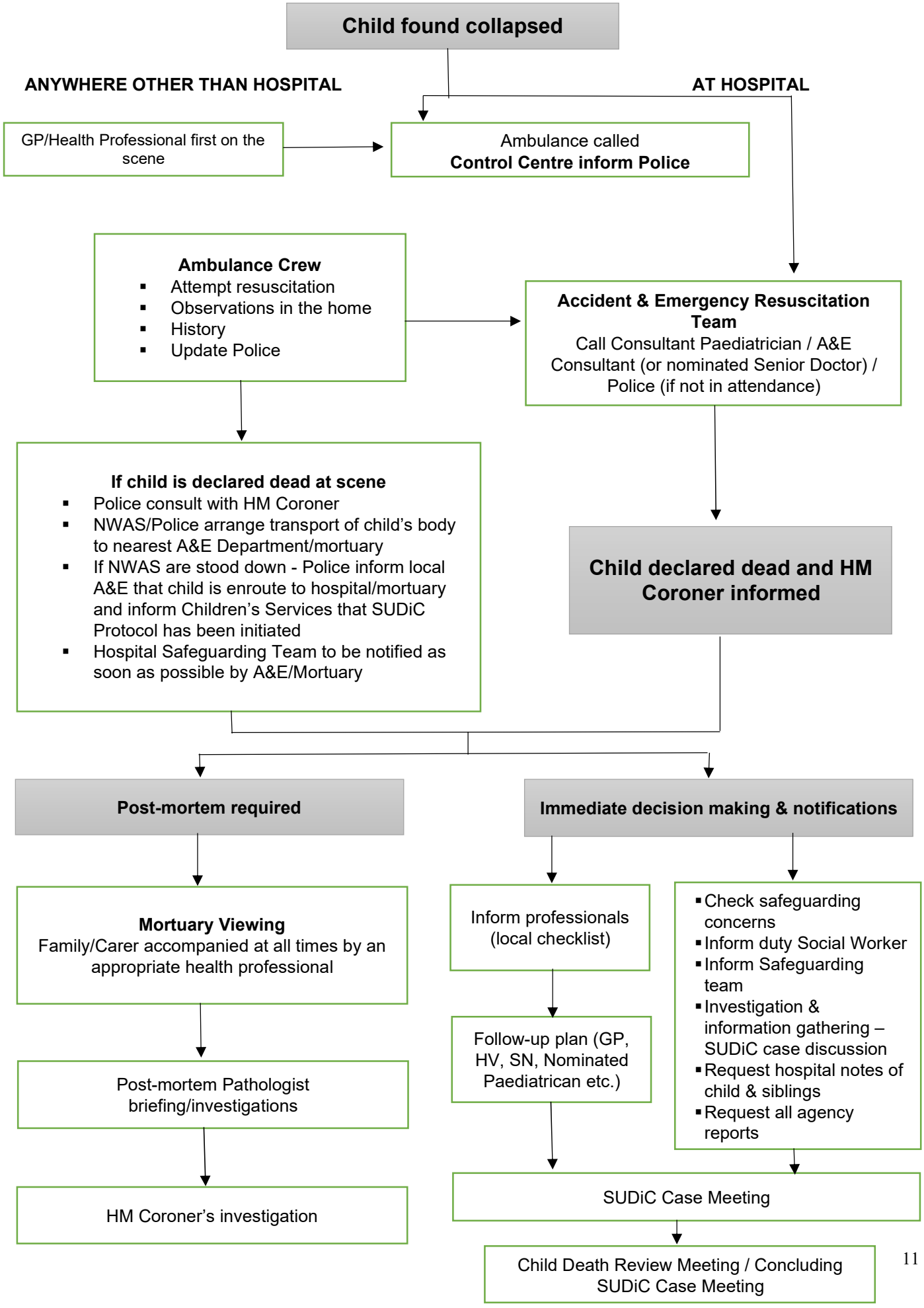
5.4 *Twins/Multiple Births have an increased risk of SIDS compared to single births. Risk varies in different studies – including prematurity, low birth weight and zygosity.*

The immediate concern of a family who has lost one child to SIDS is that they may lose the surviving child. Research has shown an increased rate of this happening, so where families have lost one child, the surviving child(ren) should be admitted to a paediatric unit for close monitoring for at least 24 hours.

Investigations should be completed around infections, inherited disease or underlying cardiac conditions. Follow-up support should also be identified prior to discharge.

In most areas, this is by enrolling the infant on the CONI (Care Of Next Infant) programme, which is a programme managed by the Lullaby Trust and usually delivered by Health Visitors (this is not currently available in Knowsley). This will coordinate on-going support for bereaved parents.

Flowchart – Recommended Sequence of Events:



6. GUIDANCE FOR ALL AGENCIES

6.1 All professionals attending a child death, in the community or in hospital, should abide by the following principles:

6.1.1 If the family is not currently known to agencies, primary support should be provided to the family via Police and Health workers. Should these agencies believe additional support is required, appropriate actions should be taken to secure this.

6.1.2 If the child shows any sign of life, or where it is deemed resuscitation is indicated, it should be commenced, and the child should be taken immediately to the nearest Accident and Emergency Department. Alder Hey Children's Hospital only accept admissions to their A&E for children up to the age of 16. In cases where the child is over 16, they should be transported to the nearest adult A&E.

6.1.3 In circumstances where the child is clearly deceased, the child's body should remain at the scene until the Detective Inspector authorises removal of the body. It should be remembered, that in most cases, the cause of death is natural and there is little evidential benefit in delaying moving the body.

6.1.4 Where the child's death has been confirmed outside of a hospital, the child should be taken to the nearest hospital Accident and Emergency Department with paediatric inpatient facilities. This allows for the earliest possible examination/assessment of the child by a senior clinician. However, HM Coroner or the Detective Inspector can direct otherwise on the grounds of preserving evidence in suspicious circumstances. **For Alder Hey Children's Hospital, please follow Appendix D as you may be directed to attend the Mortuary and not A & E**. If it is not possible for NWAS staff to convey the child to the mortuary, Merseyside Police will assume responsibility for informing the local A&E department and will arrange for the Coroner's Removal Service to transport them. The receiving hospital should be provided with information about the child including their name, DOB, address and next of kin etc.

6.1.5 If there are concerns that the child may have died in suspicious circumstances, the child should be minimally handled (i.e.: not washed, no mementoes taken). The DI/HM Coroner may stipulate 'no touch visits'. Visiting/handling restrictions need to be clarified prior to a bereavement visit happening. Medical devices should be left in situ for examination during the post-mortem.

6.1.6 No decision should be made or implied regarding the post-mortem without discussion with HM Coroner. ***The authority for carrying out a post-mortem or not, rests with HM Coroner alone.*** Parent's views can be recorded, but they should be advised that the decision is made by HM Coroner.

6.2 All unexpected child deaths must be reviewed on a multi-agency basis.

6.2.1 In all cases, within 24 hours of the child's death, a SUDiC Case Discussion/Strategy Meeting will be convened by the A&E Consultant/Consultant Paediatrician, involving a

Children's Services Team Manager, the Police and a nominated representative from Education if the child was of school age.

6.2.2. Where necessary, this meeting can take place via Teams/telephone. Any decisions made should be recorded by all involved on the agreed form.

6.2.3 Within 72 hours of a child's death, a multi-agency SUDiC Strategy Meeting will be convened, unless otherwise directed by HM Coroner. This will be arranged by the relevant Local Authority Safeguarding / Quality Assurance Unit (hereafter referred to as the Safeguarding Unit). **The minutes of this meeting should be made available to the Pathologist as this may influence the approach to the examination/interpretation of findings.**

6.2.4 At all stages through the enquiries, consideration should be given to the needs of the surviving children in the family. It may be necessary to complete a Single Assessment, using the local assessment framework incorporating the child's development, parental capacity and family/environmental factors. This may trigger Section 47 enquiries and an initial Child Protection Conference, should safeguarding concerns be identified.

6.2.5 Throughout the process of investigating a SUDiC, Managers must consider if they need to initiate a Child Safeguarding Practice Review (previously Serious Case Review).

6.2.6 It is considered good practice to keep all case files relating to SUDiCs for 25 years from the date of death.

6.2.7 Ensure all professionals involved in SUDiCs have appropriate support, which could include staff counselling.

6.2.8 There are agencies who can help support families and professionals dealing with the sudden loss of a child in Appendix N.

7. INTER-AGENCY WORKING

7.1.1 The Duty Consultant Paediatrician and DI from Police will inform HM Coroner of any deaths of children who meet the criteria for applying this protocol and will ensure that a full multi-agency investigation takes place.

7.1.2 In cases where the child has been confirmed as deceased within the community and not transported to Accident and Emergency, the DI, Consultant Paediatrican and HM Coroner will liaise to decide where the child's body will be transported to and if a post-mortem will take place.

7.1.3 Where parents want to stay with their child and there is no reason to prevent this, it should be supported as long as there is a professional there to support the parents and visiting/handling restrictions have been clarified as per 6.1.5 above.

7.2 SUDiC Case Discussions/Strategy Meetings

The following areas must be covered in all SCDs. However, the list is not exhaustive, and each case should be considered on an individual basis.

- Background information about the incident
- Background information about the child, the family and any significant others (Children's Services to check if the family is known and in what context)
- Nature of concerns (if any)
- Consideration of the safeguarding needs of other children
- Contact with HM Coroner and outcome
- Request blood samples from parents/carers using the Blood Test Consent Form (Appendix G) – if refused, suggest urine samples.
- Scene management as appropriate
- Immediate support of the bereaved (allocation of Family Liaison Officer or named point of contact)
- Consider any restrictions required when viewing the child's body
- Coordination of professionals contact with the family, including the Paediatrician's meeting with the family. It may be appropriate to do this jointly with Police.
- Significant Police action where needed (arrest of suspect, obtaining statements)
- Timing of post-mortem and briefing of pathologist
- Status of the enquiry (Section 47 [Child Protection]/Section 17 [Child in Need]/Criminal Investigation)
- Consider liaison with Consultant in Communicable Disease Control/Director of Public Health if appropriate
- Time and date of SUDiC strategy meeting
- Staff welfare

All information that may be relevant to the child's death, irrespective of sensitivity, should be shared at the case discussion/strategy meetings.

7.3 Recording of Strategy Meetings

7.3.1 The key points of the strategy meeting will be recorded by the Senior Investigating Officer (SIO) on the proforma (Appendix I). This will clearly document the agreed decisions, actions and outcomes as well as who is responsible for progressing them. A copy of the document will be shared with all agencies involved in the strategy meeting at the earliest opportunity, but prior to the follow-up strategy meeting. This will enable all information to be included in the next meeting.

7.3.2 Each agency, on receipt of the strategy meeting document, will ensure that it is input on to their agency system.

7.3.3 If, following consultation with HM Coroner, a decision is made not to proceed with the SUDiC strategy meeting an agreement has to be reached as to how professionals working

with the family will be kept informed of the outcome and by whom, the reasons for this outcome should be clearly recorded.

7.4 SUDiC Strategy Meetings

7.4.1 Chairing the Meeting

- The meeting should be chaired by staff from the relevant Local Authority Safeguarding Unit
- If the child dies in an area where they are not usually resident, discussions should be held between the Safeguarding Unit where the child is usually resident and the Safeguarding Unit from the area where they died to decide as to who should chair the strategy meeting. If it is agreed that the meeting will be chaired by the external Safeguarding Unit, the resident Safeguarding Unit should satisfy themselves that the agenda is appropriately covered.

7.4.2 The Chairperson is responsible for:

- Ensuring that scene videos/photographs taken by the Police are shared with relevant professionals for consideration in the meeting.
- Ensuring the Chair of their Local Safeguarding Children's Partnership is made aware of the child's death.
- Ensuring the Chair of the Child Safeguarding Practice Review Group/Serious Incident Review Group is aware of the child's death. The Chair will then decide if a meeting should be convened to consider the circumstances of the death and whether the circumstances meet the threshold for a Child Safeguarding Practice Review/Management Review.
- Ensuring all agreed decisions and actions are distributed to a representative of all agencies present and those who have sent apologies.
- Ensuring all decisions made 'in absentia' are actioned by the Chair to the respective agency and discussed promptly with the relevant individual/agency.

7.4.3 There is an agreed proforma for the initial and review SUDiC Strategy Meetings which will help all participants to consider the aspects requiring discussion (Appendix J and K). **Copies of meeting minutes should be forwarded to HM Coroner, the Pathologist, LSCP and CDOP within 10 working days**. The meeting should consider a press strategy, where this is appropriate. All SUDiC meetings should explicitly discuss if there is a possibility that abuse/another safeguarding issue has contributed to the death. If there is no evidence to suggest a safeguarding issue, this should be recorded in the minutes of the meeting.

7.5 Attendance

It is the responsibility of all agencies to manage attendance at the strategy meeting and ensure those attending are able to provide the relevant information and make decisions on behalf of their respective agency. In the event that any agency invited cannot be present, they should always ensure their information is conveyed in a written report detailing their involvement.

7.5.1 Each SUDiC will be unique, but in considering appropriate attendance, the following may assist:

- Health – Health visitor, health practitioner, GP, designated/named health professionals for safeguarding children, pathologist, nominated paediatrician, CAMHS professionals, Designated Doctor for Child Death, Hospice
- Social Care – Duty Manager and assigned Social Worker if appropriate
- Police – Senior Investigating Officer, Protecting Vulnerable Persons Unit representative, Family Liaison Officer and Coroner's Officer
- Education – Designated Safeguarding Lead from School, Early Years Care Provider
- Others – NWAS (or alternative ambulance service), Youth Justice professionals, Drug and Alcohol Team, Respite workers, Voluntary Agencies and any other agency involved with the child/family

7.5.2 As the purpose of the meeting is to share information – all attendees should come with any information they have which might help to understand the circumstances of the child's death. This information needs to be shared with the Pathologist, HM Coroner and CDOP. Attendees should also share any information which will help to understand the family circumstances better to inform decision making.

7.5.3 Attendees will be involved in the planning for any further steps/subsequent investigations.

7.6 In all cases where HM Coroner is involved, the Coroner's consent should be sought for the pathologist's findings to be shared at the final SUDiC Strategy Meeting.

7.7 Where an inquest has been opened and adjourned, until the final hearing, HM Coroner and all relevant parties should be informed promptly should any new information come to light – for example, expert evidence in care proceedings.

7.8 NHS Patient Safety Incident Investigations:

NHS Patient Safety Incident Investigations (PSII), when initiated, should inform the SUDiC Case Discussion/Strategy Meetings through providing a detailed analysis of patient safety incidents that may have contributed towards the death by way of a Reporting Form. A locally led PSII (or other agreed method of investigation) may be required alongside the CDOP review, to explore the decisions made/actions taken and potential for learning. The goal being to understand why the decision/action was deemed appropriate at the time it was taken. Trusts would feed actions into this quality improvement work.

Maternity and neonatal incidents meeting the Healthcare Safety Investigations Branch (HSIB) criteria or Special Healthcare Authority (SpHA) criteria when in place:
The approach is to refer to HSIB or SpHA for an independent PSII. The goal is to allow the Trust to respond to recommendations from external referred agency/organisation as required. The Trust would feed actions into quality improvement work.

7.9 Merseyside and Isle of Man Child Death Overview Panel

Information from the joint agency review process outlined in the protocol should be fed to CDOP for any child normally resident in Isle of Man, Knowsley, Liverpool, Sefton, St Helens or Wirral. This will allow for the information to be considered as part of the Child Death Review Process.

8. FACTORS THAT SUGGEST A DEATH MAY BE SUSPICIOUS

8.1 There are certain factors in the history or examination of the child which may give rise to concerns about the circumstances surrounding the child's death. If any factors are identified, it is important that the information is documented and shared with senior colleagues, HM Coroner and relevant professionals involved in the investigation. The following list is not exhaustive and is intended only as a guide:

Previous child deaths - There are some rare, genetic disorders which can cause multiple cot deaths (SIDS) within a single family – in such cases, extended family history should be obtained, and the involvement of a clinical geneticist may be helpful.

Previous safeguarding concerns within the family - Relating to the child or to their siblings. Including concealed pregnancies/births.

History/evidence of domestic abuse

Delay in seeking help - without an adequate explanation.

Inconsistent explanations - The account given by the parent/carer(s) of the circumstances of the death should be documented verbatim. Any inconsistencies in the account given on different occasions should raise suspicions, although it is important to remember that some inconsistencies may occur as a result of shock and trauma caused by the death. Explanations of how injuries occurred should be placed under detailed scrutiny when:

- The explanation changes with time or questioning
- The accident was beyond the child's development (for example, children between 2 and 8 months old are not usually walking and therefore do not fall unaided. They can of course, fall from a height).

Evidence of drug/alcohol abuse - particularly if the parent/carer(s) are still intoxicated.

Evidence of significant parental mental health problems - including fabricated and induced illness.

Unexplained injury - Any evidence of major bleeding or injury (cranial, bony, visceral or soft tissue) is highly suspicious unless proven otherwise. An examination of the child should seek

to establish the presence or otherwise of unexplained bruising/burn/bite marks/presence of blood including:

- Multiple bruises to the face, ears, limbs or trunk
- Bruising to immobile children or bruising that is out of context with the child's development
- Fingerprint bruises and linear bruises are highly suspicious
- The frenulum – the narrow fold of mucous membrane preventing the lips from moving too far from the gums – can be torn through such actions as force-feeding (but could also happen during vigorous resuscitation)
- Petechial haemorrhages may or may not be present with suffocation – and its absence is not conclusive either way – but presence should be noted and discussed with a paediatrician/ophthalmologist/pathologist.

Presence of blood - the presence of blood must arouse suspicion – although it is occasionally found 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 Sudden Infant Death Syndrome (SIDS).

Neglect issues - observations about the physical condition of the child and of the accommodation, general hygiene and cleanliness, the availability of food, adequacy of clothing and bedding as well as the temperature of the environment in which the child was found is important. This will assist in determining if there are any underlying neglect issues involved.

Shaking injuries - These injuries can present with non-specific symptoms ranging from apnoea, apparent life-threatening events (ALTE), seizures, unexplained drowsiness and/or sudden loss of consciousness. Diagnosis of shaking injuries from either CT scan or retinal injuries requires specialist expertise and utmost caution must be exercised prior to diagnosis. Photographs of the retina for signs of haemorrhage may prove invaluable. An experienced paediatric ophthalmologist may be able to differentiate between a shaking haemorrhage and one caused by other causes.
During resuscitation, a screening test of blood clotting disorders should be carried out promptly as brain injuries will eventually cause a similar effect. A photographic record should be made of all injuries immediately.

Abusive Head Trauma - These injuries can present similarly to shaking injuries and therefore photographs may prove to be invaluable.

Previous convictions of parents/carers in particular for violence to children - Police will be able to share this information with all other professionals at the SUDiC meetings.

Live births resulting in neonatal death after concealed pregnancy - A concealed pregnancy is described as a woman/girl who hides the fact that she is pregnant, or where a professional has a suspicion that a pregnancy is being concealed or denied, or where there is a significant delay in accessing antenatal care.

The SUDiC process should be followed for all such cases.

9. ROLES OF PROFESSIONALS

9.1 AMBULANCE SERVICE (NWAS)

9.1.1 When the ambulance service is called to the scene of a sudden unexpected and unexplained death of a child, the attending crew must notify the Ambulance Emergency Operations Centre (EOC). **The EOC will inform the Police at the Joint Contact Centre regarding the nature of the call at the earliest possible opportunity, without delaying access to treatment.**

9.1.2 The recording of the initial call to the ambulance services must be retained for evidence purposes.

9.1.3 Ambulance staff should not assume that death has occurred. If the child shows any signs of life, or where it is deemed that resuscitation is indicated, this should be commenced and the child must be immediately transported to the nearest Accident and Emergency department.

9.1.4 The first ambulance staff on scene should:

- Obtain a history surrounding the death
- Note the position of the child and the clothing

9.1.5 Resuscitation:

- Resuscitation, if indicated, should be continued according to the Joint Royal Colleges Ambulance Liaison Committee Guidelines (JRCALC), Resuscitation (Diagnosis of Death) Procedure (2021) unless a healthcare professional, usually a NWAS Paramedic or a member of the medical staff, has made a decision that it is appropriate to stop further efforts. This will be carried out in line with revised Diagnosis of Death Procedure.
- When transferring the critically unwell child, the EOC should pre-alert the receiving Emergency Department with information about the child's condition and expected time of arrival.
- At hospital the completed Patient Report Form, with details of history, observations at scene and resuscitation information, should be handed over to the relevant hospital staff along with a verbal handover of events, including any concerns or suspicions.
- The Police, if present at this point, may wish to arrange interviews with the crew members who must immediately pass on any concerns, suspicions or observations which they have witnessed or heard.

9.1.6 If the child is dead at the scene and further active resuscitation is not considered appropriate, then the body should remain in-situ, pending the arrival of the Police. The crew will be careful to protect the scene and preserve any evidence until the Police arrive. The body should then be taken by ambulance to the local Accident and Emergency department unless the Detective Inspector/Senior Investigating Officer in consultation with HM Coroner directs otherwise. In cases where NWAS crew are stood down by Police, the responsibility

for liaison with the local receiving Accident and Emergency Department regarding an estimated time of arrival passes to Police.
It is not recommended to leave the scene until the destination is confirmed and contact made with the relevant team at the receiving hospital to ensure they are prepared for the arrival of the child and potentially bereaved family.

9.1.7 In cases where the circumstances are deemed to be suspicious, the child should only be moved with the agreement of the Senior Investigating Officer and HM Coroner.

9.1.8 The following should be taken into account in accordance with the JRCALC Resuscitation (Diagnosis of Death) Procedure 2021 and documented by the ambulance crew when assessing a sudden death:

- Information supplied by those present
- History given about the incident
- Medical assessment
- Observation of the scene
- The position and condition of the child's body
- The condition of the clothing
- The conditions at the place where the child's body was found
- Presence of drug paraphernalia
- Security of the property
- Anything considered to be out of the ordinary

9.1.9 Please note - NWAS have their own SUDiC Procedure which should be followed.

9.1.10 Action after death has been established:

- It is not necessary for a medical practitioner (e.g., GP) to attend to confirm the fact of death as this can be done by NWAS staff (NWAS staff will refer to the Resuscitation (Diagnosis of Death) Procedure 2021).
- The crew will inform the relatives (if applicable) that the police will need to attend and notify EOC to ensure police have been alerted.
- Where a sudden death has occurred (except when there are clearly suspicious circumstances and upon Police instruction), and the death has been confirmed by completion of the Diagnosis of Death form by the appropriate NWAS professional, the Senior Investigating Officer, on arrival, may request the attendance of the Police Force Medical Examiner (FME) if there are any concerns.
- Where the child has been pronounced deceased at the scene, if NWAS are transporting the body, they must contact **the nearest Accident and Emergency department** to inform them that the SUDiC Protocol has been triggered and request that arrangements are made to receive the deceased child. An estimated time of arrival will be agreed. If NWAS are 'stood down' and dismissed from the scene by Police, or if it is not possible for NWAS to transport the deceased child, it is then the responsibility of the Police to make arrangements for HM Coroner's Removal Service to transport them and Police should also contact the Accident and Emergency department and agree an estimated time of arrival for the child.
- If the nearest Accident and Emergency Department is Alder Hey Children's Hospital, there are unique arrangements in place for receiving deceased patients. Please refer to Appendix D for this process flowchart.

- Children under the age of 16 who have not experienced their collapse in Liverpool, should not routinely be taken directly to Alder Hey Children's Hospital, unless at the direction of HM Coroner. They should be transported to their nearest Accident and Emergency Department.
- The joint agency review process requires that the body is examined by a paediatrician and the initial information gathering and support for the family is initiated. This takes place in the area defined within each hospital's internal procedure, usually the Accident and Emergency Department, but it can take place in the bereavement suite.
- The EOC will inform the Senior Clinician for the provision of ongoing support to the crew.
- If possible, the crew will make arrangements for the immediate support of the bereaved adults/children (contacting relatives, neighbours, priest etc.)
- The ambulance crew will complete the appropriate documentation, Patient Report Form, with internal notification by telephone to the NWAS Safeguarding Team via the NWAS Support Centre.
- If possible, the crew will record details of the Police Officer dealing with the case, including the incident log number.

9.2 COMMUNITY HEALTH PRACTITIONERS (Health Visitor, School Nurse, Community Nurse)

9.2.1 If a Community Health Practitioner is the first on the scene and they become aware of the sudden unexpected death of a child, they should dial 999 and ask for an ambulance to attend the scene immediately. The Practitioner may attempt resuscitation as instructed by the ambulance service. If the indications are that the child is dead and no active resuscitation has been attempted, the body should remain in-situ until the arrival of the Police.

9.2.2 The position of the child and the condition in which they were found must be noted together with any comments or explanations provided by the parents/carers or anyone else at the scene. Try not to disturb the scene (do not touch or remove anything).

9.2.3 When paramedics arrive, spend time listening to the parents/carers and offer support. If parents/carers go to hospital with the child, ensure that appropriate arrangements are made for the care of any siblings.

9.2.4 If the parent/carer is alone, ensure that they have appropriate family support. Provide them with a work telephone number where you can be contacted.

9.2.5 The gathering of relevant information from the health visitor, community practitioners, school nurse and community nurse when a sudden unexpected child death occurs is required to help aid the investigative process by HM Coroner. Community Health Practitioners should, as soon as possible after the incident (and within 24 hours), make a precise and thorough record of the event in the child's record making particular reference to:

- Any delay in seeking help
- The position of the child, the surroundings and the condition in which the child was found

- Inconsistent explanations – accounts should be recorded verbatim in quotation marks
- Evidence of drugs/alcohol abuse
- Parent's reaction/demeanour
- Unexplained injury e.g., bruises, burns, bites, presence of blood
- Neglect issues
- General condition of the accommodation
- Evidence of domestic abuse

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

9.2.6 The Named Nurse/Safeguarding Children's Specialist Nurse should be notified immediately as well as the relevant line manager. This is to ensure that records can be secured quickly, other relevant professionals are informed and the nominated CDOP lead for the area is notified of the death.

9.2.7 Records must be reviewed for evidence of any known involvement with other professionals/departments. They must be contacted and informed of the death of the child as per your organisational processes. You may wish to consider the following:

- The Child Health Department/Information Service to avoid immunization appointment reminders being sent
- Local Children's Hospitals/Health departments to ensure that follow up appointments are not sent
- The family GP (if they have not already been contacted by Police/Hospital)
- The School Nurse for any other siblings in the family
- The Health Visitor if there are any pre-school age siblings
- Community dental health

9.2.8 Contact the family to acknowledge the death, offer condolences and answer any questions the parents/carers may have.

9.2.9 Ensure that child's health records are available to the nominated paediatrician as required (unless already secured) and be available to attend the SUDiC strategy meetings.

<u>In the months following the death:</u>

9.2.10 It is considered good practice for community practitioners such as the school nurse, to liaise with colleagues in education and Children's Social Care regarding how best to support the family. Where there are other health professionals involved, close liaison is essential to ensure that appropriate and timely interventions are delivered to the family where necessary.

9.2.11 Assist in the assessment of if the family need additional help in coping with their grief – signpost to appropriate support agencies are detailed in Appendix M.

9.2.12 Ensure that the records manager for the organisation is advised that the child's records should be retained for 25 years after the date of death.

9.2.13 Access any support you may require for yourself – such as through staff counselling/named nurse.

9.3 MIDWIFE

These guidelines will inform midwives of the procedures they will be expected to follow in the event of the unexpected death of an infant. This can be a difficult time for everybody and additional support can be obtained from the designated/named professionals and from the Care Of the Next Infant (CONI) coordinators where applicable.

9.3.1 Records will be secured by the named midwife as soon as possible after the death has been notified. A copy will be made available for the midwives. This is a precautionary measure until the situation is clarified. Midwives should also refer to their own organisation's procedures/protocols where available.

9.3.2 There is an expectation that ongoing care and support will be provided by the midwife until the end of the postnatal episode of care unless:

- the family specifically request another member of the team; **or**
- the midwife is a witness in the case and the employing organisation advises against a particular person visiting. In this event, check with your line manager/legal department and make careful notes of the events.

9.3.3 If the community midwife is first on the scene:

- When an unexpected fresh stillbirth or SUDiC has occurred without the presence of a health professional, or if the birth has been concealed, the midwife must assess the infant and the mother's medical condition and dial 999 and request for an ambulance to attend the scene immediately.
- CPR should be attempted if deemed appropriate by the attending midwife and the child should be taken immediately to the nearest Accident and Emergency department via ambulance. If the indications are that the child is dead and no active resuscitation has been attempted, the body should remain in situ pending the arrival of the police.
- Where the midwife has arrived after the birth, the position of the infant, and the condition in which it was found, must be noted together with any comments/explanations from the mother or any other person at the scene. Try not to disturb the scene, i.e., do not touch, move or disturb anything.
- When the paramedics arrive, spend time listening to the parents/carers and offer support.
- If the parent/carer(s) go to the hospital with the child, ensure that appropriate arrangements are made for the care of any siblings, if necessary.
- If the mother is alone, ensure that she has appropriate family support.
- Give the parent/carers/family a work telephone number where you can be contacted.
- If the mother's condition requires obstetric intervention, she should be transferred to the **nearest** maternity unit, whether she is booked in there or not. A midwife must accompany the mother in the ambulance.

9.3.4 If the child is not resuscitated, in most cases the infant's body will be taken to the nearest A&E department, as per 6.1.4. NWAS will convey the child but if unable to do so the police

will arrange transfer utilising the Coroner's Removal Service. Notifying the hospital is the responsibility of NWAS if transporting, or the Police if using the Coroner's Removal Service.

9.3.5 Parent/carers and family members may have access to the child, in circumstances as agreed at a SUDiC Strategy Meeting/Case Discussion. An appropriate professional must always be present.

9.3.6 If the midwife has any relevant information about the pregnancy or the family, this should be reported directly to the police and receiving doctors at the hospital as soon as possible.

9.3.7 As soon as possible after the incident, but within 24 hours, make a precise and thorough report of the event in the infant's record, making particular reference to:

- Any inappropriate delay in seeking help
- The position of the infant, their surroundings and the condition in which they were found
- Inconsistent explanations - accounts should be recorded verbatim in quotes where appropriate
- Evidence of drugs/alcohol abuse
- Parent/carers' reaction/demeanour
- Unexplained injury e.g., bruises, burns, bites, presence of blood
- Neglect issues
- General condition of the accommodation
- Evidence of domestic abuse

9.3.8 As soon as possible the senior midwifery manager must be informed and the SUDiC notification form (Appendix C) should be completed and forwarded to the designated nurse for the area, for onward transmission to the strategic health authority.

9.3.9 Midwifery staff involved in the case should be offered support and the opportunity to speak to their supervisor.

9.3.10 The family GP, health visitor and CDOP Nurse (where applicable) must also be informed as soon as possible.

9.3.11 If you learn later that a sudden infant death has occurred, best practice requires that the midwife should check that all relevant agencies and professionals have been informed of the child's death.

9.3.12 The existing midwife should contact the family to acknowledge the death, offer condolences and answer any questions that the parents/carers may have.

9.3.13 Discuss the nature of the support that the parents/carers/extended family require. If there is inadequate support available, consider the need for more intensive midwifery support or consider alternatives detailed in Appendix N.

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

9.3.15 Ensure that the midwifery records are available to the nominated paediatrician as required and be available to attend the SUDiC strategy meeting. If still visiting the mother, photocopy the handheld records and ensure the originals are available to the professional attending the SUDiC strategy meeting.

9.3.16 Be prepared to provide a statement of evidence if requested and seek advice from the designated nurse/named midwife.

9.3.17 The next pregnancy:

- Ensure that, where available, the care of the next infant (CONI) co-ordinator for the relevant trust has been notified as soon as possible, following the trust procedures.
- In the antenatal period ensure that the family health visitor and GP are aware of the pregnancy and forthcoming delivery.
- Scrutinise previous records to ascertain whether it is necessary to inform any other professional/agency of the pregnancy. e.g., Children's Social Care.
- Ensure that the history of the sudden infant death is highlighted in the maternity records.
- Ensure that the family receives appropriate support during the pregnancy, delivery, and postnatal period.
- Ensure evidence-based practice is shared with carers in respect of the following more specific risk factors such as:
  - co-sleeping following the ingestion of prescribed medication and substances
  - sleep positions
  - smoking
  - temperature control; **and**
  - where available, use your local CONI coordinator for advice, support, guidance and for up-to-date research.

9.4 GENERAL PRACTITIONER

9.4.1 The GP may be called to the scene first, in such cases, they should assess the medical condition of the child and dial 999 and ask for an ambulance to attend the scene immediately.

9.4.2 As soon as possible (within 24 hours), the GP should make a precise and thorough record of the event in the child's record making particular reference to:

- Any inappropriate delay in seeking help
- The position of the child, the surroundings and the condition in which the child was found
- Inconsistent explanations – accounts should be recorded verbatim in quotation marks
- Evidence of drugs/alcohol abuse
- Parent's reaction/demeanour
- Unexplained injury e.g., bruises, burns, bites, presence of blood
- Neglect issues
- General condition of the accommodation
- Evidence of domestic abuse

9.4.3 It is important for the GP to contact the Police or Coroner's Office if they are the first on the scene. If required to certify the child's death GPs must take into account, the regulations regarding death certification and inform HM Coroner and/or the Police accordingly. They

should also ensure that the paediatric liaison staff, for the hospital in the area where the child resided, is made aware of the death. This is achieved through the GP informing the practice manager who should take responsibility for contacting paediatric liaison staff so that the Child Death Overview Panel (CDOP) process can be initiated.

9.4.4 The GP will be requested to attend the SUDiC strategy meeting and should prioritise attendance.

9.4.5 Alternatively, a discussion between the GP and the Nominated Paediatrician may enable the GP's information to be shared at the SUDiC case meeting. The Named GP for Safeguarding Children may assist in this process if there is any difficulty.

9.4.6 Additional guidance for GPs, particularly in relation to the longer-term care of the family, can be obtained from the agencies detailed in Appendix M.

9.5 ACCIDENT & EMERGENCY STAFF

9.5.1 As soon as the Accident & Emergency is notified that an ambulance crew is attending the scene of a possible child death, the A&E Nurse in Charge must notify the following:

- The on-call paediatrician/resuscitation team
- The on-call consultant paediatrician
- The on-call Accident & Emergency department consultant

9.5.2 In a situation where a child has been pronounced dead outside of a hospital, NWAS must contact **the nearest Accident & Emergency department** with Paediatric inpatient facilities, to inform them that the SUDiC Protocol has been triggered and request that they make arrangements for hospital staff to receive the deceased child. This liaison will include an estimated time of arrival for the child to the hospital.
If, following consultation between HM Coroner and the Police it is decided that NWAS will be discharged from the scene and the Coroner's Removal Service will be transporting the child, the Police will assume responsibility for the liaison with hospital staff to agree an estimated time of arrival for the child.
Where the receiving hospital has been agreed as Alder Hey Children's Hospital, please follow the process flowchart at Appendix D.
9.5.3 Unless specifically directed by HM Coroner, children under 16 years old who did not experience their collapse in Liverpool, or who do not usually reside in Liverpool should not be taken to Alder Hey Children's Hospital. They should always be taken to their nearest A&E Department.

<u>Initial assessment of the child who has died unexpectedly/presenting moribund</u>

9.5.4 Resuscitation – the great majority of children found collapsed or dead, will be brought immediately to an A&E Department where resuscitation will be initiated or continued. Resuscitation, once commenced, should be continued according to the Advanced Paediatric Life Support Protocol until an experienced doctor (usually the Consultant Paediatrican/on call A&E Consultant) has made a decision that is appropriate to stop further efforts.

9.5.5 On occasion, it may be apparent to the attending doctor/paramedic that a child found collapsed out of hospital has been dead for some time and attempted resuscitation is inappropriate. Please follow the guidance above regarding next steps.

9.5.6 The care of the family and investigation of the cause of death should follow a similar course, whether or not resuscitation has been attempted.

9.5.7 All access sites (i.e., venepuncture/intraosseous needle) need to be left in situ, or if removed, sites need to be carefully recorded. Endotracheal tubes need to either be left in situ or removed only after correct placement in the trachea has been independently confirmed by direct laryngoscopy (by someone other than the person inserting the tube and preferably also independent from resuscitation attempts).

History and Examination

9.5.8 Following confirmation of death, the SUDiC proforma (Appendix A), with sections relevant to the child's age should be completed by the Consultant Paediatrican in A&E or the nominated senior doctor. Consideration should be given to requesting photographs of any skin discolouration or unusual marks or injuries as soon as possible as this may help in estimating time of death as well as the position in which the child was lying.

Investigations

9.5.9 During the process of resuscitation, if any blood is obtained for investigations, some should be preserved for cultures and sensitivity. Samples deteriorate rapidly following death, so testing should be completed prior to, at the time of death or shortly after resuscitation attempts have stopped.
Should there be difficulty in obtaining samples and the post-mortem is likely to be delayed for more than 48 hours, there is an expectation that blood is obtained by cardiac swab wherever possible. If this is not possible, HM Coroner and the pathologist should be informed. Investigations undertaken should be clearly demarcated in order to inform the pathologist.

9.5.10 Post-mortem blood samples should be taken as soon after the death as possible to improve the possibility of diagnosis. Where the cause of death is explained, e.g., major trauma this may not be necessary.

9.5.11 If the post-mortem is to be conducted within 24 hours of death, blood samples may be more appropriately taken by the pathologist at the beginning of the post-mortem.

9.5.12 Any stool or urine passed by the child, together with any gastric or nasopharyngeal aspirate obtained should be carefully labelled and frozen after samples have been sent for bacteria, culture and virology testing. If the nappy/underwear is wet or soiled, it should be removed, labelled and frozen.

Referral to the Coroner and Transfer

9.5.13 Not all SUDiCs will require a post-mortem. If HM Coroner deems that a post-mortem is not required, the child should go to the mortuary in the hospital where they presented.

9.5.14 If a post-mortem is required, Police will liaise with the Hospital arrange for the transfer to the relevant hospital, for a child under the age of 16 this is usually Alder Hey Children's Hospital, using the Coroner's Removal Service.

9.5.15 Parents may express a wish to transport their child in their own vehicle. If HM Coroner has declared that no post-mortem is going to take place and is satisfied that the body can be released, this request should be considered an acceptable request and facilitated where possible. There is no legislation that prevents families from doing so if they wish, they just need to be provided with the appropriate documentation from the hospital the child is being discharged from to enable them to do so.

Care of the Parents/Carers

9.5.16 Immediately upon arrival at the hospital parent/carer(s) should be allocated a member of staff to care for them, explain what is happening and to keep them fully informed during the course of resuscitation.

9.5.17 Once the child has been pronounced dead, the Consultant Paediatrician, A&E Consultant or the nominated doctor should break the news to the parent/carers. The member of staff allocated to care for the family should be present at this time.

9.5.18 The family must also be informed at this time that HM Coroner will need to be notified due to the child dying suddenly and unexpectedly and that as a matter of routine practice, the Police may have to investigate the death. The Paediatrician must explain the possible medical causes of the child's death will also be carefully and thoroughly sought.

9.5.19 Prior to leaving A&E, parents should be provided with written contact details for the Family Liaison Officer/bereavement worker. The family should be aware of how to arrange to see the child and the next steps in the investigation process.

9.5.20 In certain circumstances, for example where there has been co-sleeping, the Police will ask parent/carer(s) for blood samples to test for alcohol/drugs and will be provided with a consent form advising them of their rights. If parent/carer(s) are unable to provide a blood sample, they should be requested to provide a urine sample.

Initial Multi-agency Communication

9.5.21 It is the duty of A&E staff to inform:

- Bereavement care services
- Children's Social Care
- Police
- Nominated Paediatrician
- Coroner's Office
- Named Nurse and Designated Nurse
- Midwifery service (if the child is under 28 days old)

- Designated Doctor for Child Death

9.5.22 A&E staff should ensure that the original completed SUDiC proforma medical record accompanies the child to the mortuary for the pathologist carrying out the post-mortem. A copy should also be given to the nominated paediatrician.

9.5.23 It is the responsibility of the A&E Consultant/Consultant Paediatrican to take part in the SUDiC case discussion with Police and Children's Social Care.

9.6 CHILDREN'S SOCIAL CARE

9.6.1 Children's Social Care must be contacted whenever a child dies, and the death is unexpected.

9.6.2 In the first instance, Hospital staff will make contact with Children's Social Care to check if the child is known or has been known to them and in what capacity.

9.6.3 Children's Social Care staff will complete checks in their operating system as to if the child is known to services, an open case (under Section 17 – Child in Need, or Section 47 – subject to a Child Protection Plan), a Looked After Child, including those who are Looked After at home. This information will be shared with the A&E department.

9.6.4 Social care staff will, in all cases, report the death to their Team Manager who will be responsible for informing the Safeguarding Unit Manager. The Safeguarding Unit Manager will be responsible for informing the Head of Service, Director of Children's Services and ensuring the Chair of the Local Safeguarding Children's Partnership is informed.

9.6.5 If the death appears suspicious and/or there are concerns that a child has suffered, or that another child may suffer harm as a result of abuse then this should be referred directly to the local Children's Social Care services following formal Safeguarding Children Partnership Arrangements procedures. Children's Social Care will complete the necessary assessments, including multi-agency Section 47 enquiries as necessary.

9.6.6 The Social Care Manager will be responsible for agreeing with the Senior Investigating Officer from Police an appropriate course of action. This will be deemed a SUDiC case discussion and will involve liaison with a number of other professionals. This discussion should be conducted as a multi-agency strategy meeting involving Police, Social Care and Health as a minimum. It should take place as soon as possible – but within 24 hours of the child's death at the latest – and be recorded by the senior Police officer on the appropriate forms for the respective LSCP area. A SUDiC strategy meeting should be convened to take place within 3 days of the child's death.

9.6.7 SUDiC strategy meetings must always include detailed discussion on surviving children relating to their needs, including safeguarding if there are concerns about abuse or neglect. In all cases, a Single Assessment must be undertaken regarding the surviving children once enquiries have been completed. The outcome of this should be conveyed to the SUDiC strategy meeting. There must be an accurate record of agreements made and a copy sent to the SIO who will be responsible for correspondence with HM Coroner.

9.6.8 SUDiC strategy meetings must always include detailed discussion and consideration of if the case meets the criteria (set out in Working Together to Safeguard Children), to be referred to the Serious Incident Review Group (SIRG) for consideration of a Practice Learning Review or if a Serious Incident Notification is required.
The Chair of SIRG, in conjunction with partner agencies, will consider whether the circumstances relating to a child's death warrant discussion at a Rapid Review meeting, which determine if the threshold for a Practice Learning Review has been met.

9.6.9 If post-mortem results are not known at the point of the SUDiC strategy meeting, contact between key agencies must be maintained to convey relevant information as soon as it becomes available. Usually between the Police and Chair of the strategy meeting/Safeguarding Unit.

9.6.10 At the conclusion of the initial strategy meeting, the Chair must convene a further meeting within timescales to consider the results of any medical tests in addition to the welfare of the family. The strategy meetings for all SUDiC cases should be chaired by a member of the Safeguarding Unit, who is responsible for the recording of the meeting. It is the Chair's responsibility to ensure an appropriate action plan is compiled based on all information and tasks are shared between agencies.

9.6.11 Agreement should be sought at the earliest opportunity as to who will liaise with family.

9.6.12 The Safeguarding Unit Manager is responsible for monitoring all SUDiC cases, including keeping the Chair of the LSCP, CDOP and SUDiC Implementation Group informed as appropriate.

9.6.13 Should concerns come to light, during the course of the post-mortem that indicate the possibility of a non-accidental injury, Children's Social Care will be informed. Notwithstanding that pathology investigations are ingoing and interim results may be inconclusive, in any case where the pathologist is satisfied that an injury may have contributed to the child's death and there is a possibility that injury may have been caused by the parent or carer – or another family member – the pathologist will prepare a statement setting out interim findings and detailing any further investigations to be undertaken. Such a statement will be provided to HM Coroner and Children's Social Care.

9.6.14 Upon receipt of such statement, Children's Social Care shall immediately seek legal advice with a view to court proceedings being issued in respect of any surviving siblings.

9.6.15 In cases where court proceedings are issued in respect siblings, the Coroner's Officer will liaise with Children's Social Care prior to any decision being taken to release the body for burial.

9.7 HM CORONER & PATHOLOGIST

It is the duty of HM Coroner to establish the medical cause of the death, where it is not known, and to enquire about the cause, whether it was due to violence or was otherwise unnatural or of an unknown cause. HM Coroner may do this by ordering a post-mortem.

During a post-mortem, the pathologist may determine that an injury has contributed to the child's death and there is a possibility that said injury was caused by a parent, carer or other person. The pathologist will prepare a statement setting out interim findings and detailing any further investigations to be undertaken. Pathology investigations will likely be ongoing and interim results may be inconclusive. The statement will be provided to HM Coroner and Children's Social Care.

If the cause of death is unnatural or is not ascertained after a post-mortem then an investigation will be opened. This will give time for further tests and analysis to be carried out on retained material from the examination without unnecessarily delaying the funeral. If a natural cause of death cannot be established by these post-mortem investigations, the investigation will progress to an Inquest.

The inquest is an inquiry to find out who has died, when where and how he/she died and by what means the medical cause of death arose. However, where necessary in order to avoid a breach of any Convention rights (within the Human Rights Act 1998 (c.42)), the purpose mentioned in subsection (1)(b) is to be read as including the purpose of ascertaining in what circumstances the deceased came by his or her death; together with information needed by the Registrar of Deaths, so that the death can be registered.

An inquest is not a trial or litigation. It is a limited inquiry into the facts surrounding a death. It is not the job of HM Coroner to establish culpability for the death, as a criminal trial would do.

9.7.1 After the death has been certified, HM Coroner has control of the body. Mementos and medical samples should only be taken with prior consultation.

9.7.2 Where HM Coroner has confirmed a post-mortem is required, in most cases this will be completed by a paediatric pathologist. If the child is an older adolescent, the post-mortem may be carried out by a general histopathologist as the paediatric specialism is no longer required, due to the child's body being similar size etc. to that of an adult. If there are suspicious or unexplained circumstances, at the discretion of HM Coroner, a Home Office Pathologist may take the lead role in the post-mortem. If the paediatric pathologist does not agree with the contents of the report proposed by the Home Office Pathologist, then each pathologist will issue a separate report.

9.7.3 In all cases of SUDiC in children under the age of 2 years old, a full skeletal survey will be taken at the time of post-mortem.

9.7.4 Both HM Coroner and the pathologist must be provided with a copy of the completed SUDiC medical proforma, which should include:

- A full medical history from the paediatrician including examination findings, treatment offered, clinical diagnosis etc.
- Any relevant background information concerning the child and/or family from any agency
- Any concerns raised by any agency

The Senior Investigating Officer (SIO) is responsible for ensuring that this is provided.

9.7.5 The Coroner's Officer or the Police SIO must ensure that all relevant professionals are informed of the time and place of the post-mortem examination. This should be carried out

promptly as soon as the pathologist has been informed. The Coroner's Officer should also ensure that the results of all investigations initiated during the post-mortem (i.e., toxicology, forensic science tests) are forwarded to the pathologist as soon as they become available.

9.7.6 The SIO should attend the post-mortem investigation, if this is not possible then they must send a representative who is aware of all of the facts of the case. A Crime Scene Investigator must attend all post-mortem examinations conducted by a Home Office pathologist. The Consultant Paediatrican should also be invited to attend.

9.7.7 The nominated Paediatrician must ensure that a clear, high-resolution copy of the following documents accompany the body to the mortuary where the post-mortem will take place:

- Hospital case records
- Ambulance notes
- Emergency Department notes
- SUDIC Documentation Form
- Obstetric/delivery notes of the mother if the child is under 3 months old
- Report of the Police scene and report containing summary of relevant events/day(s) prior to death
- GP Records
- Strategy meeting notes

The nominated Paediatrican must also ensure that all results of any post-mortem samples are forwarded to HM Coroner and the pathologist.

9.7.8 A paediatric post-mortem will always involve the taking of tissue samples for histological examination and Paediatric or Emergency Department Consultant/most senior doctor present will explain to the family that samples will be taken. It is the responsibility of HM Coroner's Officer to ensure that instructions are taken with regard to tissue samples.
There are guidelines for the agreement of collection of medical samples/radiological examination, which must be followed and any proposed deviation from these should be discussed with HM Coroner.

9.7.9 If the pathologist carrying out the post-mortem wishes to retain a whole organ (for the purpose of establishing cause of death) they will ask for the permission of HM Coroner first. HM Coroner will, through the Coroner's Officer, discuss with the family their wishes in relation to the future storage or disposal of blocks and slides as well as any organs or tissues retained, whether taken under the Coroner's authority or under the Police and Criminal Evidence Act (PACE) 1984. It is important that the family's wishes are clear in respect of the retained human material for when the Coroner's jurisdiction finished and should criminal investigation no longer require the retained material as evidence under PACE. The family's decision should be communicated to the pathologist in a written format by the Coroner's Officer.

9.7.10 All professionals must endeavour to conclude their investigations promptly in order to facilitate the finalisation of the post-mortem examination report. The funeral of the deceased child must not be delayed unnecessarily.

9.7.11 Interim findings of the post-mortem will be discussed with HM Coroner immediately by a short, emailed report after the macroscopy and also in person or by telephone with the SIO immediately after the completion of the post-mortem examination and they will be updated

with significant results as they become available. HM Coroner will use their discretion as to what information will be passed to the Paediatric Consultant. HM Coroner will endeavour to be as helpful as possible with the provision of information, the Paediatrican may be instructed to keep some information strictly confidential. Once agreed in terms of information to be shared, these findings can then be shared in subsequent multi-agency discussions.

9.7.12 Following the post-mortem, there must be a discussion between the pathologist and the nominated paediatrician regarding the necessity for the pathologist to attend the SUDiC strategy meeting. As the pathologist may not be able to attend all multi-agency meetings, the minutes of these **must** be sent to the pathologist.

9.7.13 The final written post-mortem report should be made available within 14 days of the conclusions of investigations, a list of samples taken, and the results of subsequent tests and location of samples currently held.

9.7.14 The final report should be sent to HM Coroner, when all investigations have been completed and the results of all tests have been made available to the pathologist. If for any reason there will be an undue delay, the pathologist will discuss with HM Coroner.

9.7.15 The pathologist will send the written post-mortem report to HM Coroner and a copy to the Designated Doctor for Child Deaths, who should liaise with the Duty Consultant Paediatrician. HM Coroner's Officers will supply the SIO with a copy of the report.

9.7.16 The SIO should ensure that a copy of the post-mortem examination report is forwarded to the PVP for inclusion on file for future reference. The post-mortem report must not be shared with other agencies, without the permission of HM Coroner. Permission should always be sought by an agency if the content of the report could potentially affect the agency's future actions.

9.7.17 The nominated paediatrician (responsible for follow-up) may request a copy of the post-mortem examination report from the Coroner's Office. This cannot be released without the permission of HM Coroner.

9.7.18 A post-mortem is not subject to consent and takes place irrespective of the parents' wishes. The pathologist will inform HM Coroner about any samples taken during the post-mortem. In relation to tissue disposal, (i) ordinary paediatric post-mortems – tissue subject to normal rules; (ii) forensic post-mortems – tissue retained under Police and Criminal Evidence Act (PACE) and remains outside of HM Croner rules whether or not the death subsequently becomes non-suspicious leading to a Coroner's inquest. Coroner's Officers will consult with the family as to the ultimate disposition of these samples, the choices being for the tissues to be preserved as part of the permanent medical record, returned to the parents (i.e., funeral director), used for the purpose of medical research or respectfully disposed of.

9.7.19 Notwithstanding that pathology investigations are on-going and interim results may be inconclusive, in any case where the pathologist is satisfied that an injury may have contributed to the child's death and there is a possibility that the injury may have been caused by the parent(s)/carer(s) of the child, or another family member, the pathologist will prepare a statement setting out these interim findings and detailing the further investigations to be

undertaken. Such a statement shall be provided to HM Coroner and Children's Social Care. Upon receipt of such statement, Children's Social Care will immediately seek legal advice with a view to court proceedings being issued in respect of any surviving sibling(s). In cases where court proceedings are issued in respect of siblings, Children's Social Care or the Family Court will liaise with HM Coroner's Office prior to any decision being taken to release the body to the family or estate for funeral in a timely manner. HM Coroner will wish to release a body for funeral as soon as there is no evidential reason for retention.

9.8 FAMILY ENGAGEMENT & BEREAVEMENT SUPPORT

9.8.1 In a situation where a child has been pronounced deceased at the scene and the mortuary staff have been alerted that the child is due to arrive at the mortuary, bereavement staff should also be alerted to ensure they are present to receive the deceased child. If a bereavement care worker is not available, it is the Trust's responsibility to allocate a member of staff to care for the family and ensure that appropriate bereavement support is provided.

9.8.2 Particular consideration should be given to:

- The capacity of the family to engage in the processes unfolding around them
- Language issues, health or mental capacity – where English is not the first language, every attempt should be made to provide translation/interpreting services, including out of hours. Children should not be used as an interpreter for the family.
- Faith and religious culture of the child and family

It should be remembered that bereaved parents may be in a state of extreme shock when their child has died. They may not be able to process or retain information and it is common that information will need to be repeated over time. The booklet "*When a Child Does – A Guide for Parents and Carers*" should be given to all bereaved families or carers.

9.8.3 The bereavement care worker* will:

- Attend the hospital and assist in offering immediate care to the family
- Work closely with hospital staff to identify people arriving and their relationship to the child
- Organise the communication process with the parents and can be present throughout the process of information gathering and sharing to offer support if the family would prefer this
- Assist hospital staff with documentation and contact with other departments/agencies
- Liaise with hospital staff and assist with the transfer of the child to mortuary/bereavement suite where necessary
- Arranging parental contact with senior paediatrician where resuscitation has been discontinued
- Discuss with parents regarding specific religious or cultural needs
- Assist family with practical issues i.e.: informing family/friends, travel arrangements
- Support parents during their contact with the deceased child if there are no restrictions in place regarding contact
- Ensure that parents are informed about additional support available – see Appendix M
- Ensure that parents are informed about the Child Death Review Process

9.8.4 The Bereavement Care Service* will:

- Liaise with HM Coroner and Police regarding arrangements for the family to view the child at the bereavement suite
- Be the named point of contact for the hospital in the continuing support for families
- Assist with the coordination and continuity of support between the family, hospital staff and outside agencies

**Or allocated member of staff/service where a specific bereavement support worker or service is not available.*

9.8.5 The family should be told at an early stage that because their child's death was unexpected that HM Coroner will need to be informed and that the Police will need to complete an investigation. This should be explained in a sensitive way, emphasizing that these are routine procedures followed with any unexpected child death.

9.8.6 The purpose of the Joint Agency Response should be explained to the family, emphasizing that professionals are working together to try to help them to understand why their child has died and to support them. The family should be informed that, as part of this process, information will be shared with their primary care team, social care and other relevant professionals.

9.8.7 Unless the cause of death is immediately apparent, the family should be informed that HM Coroner may have to order a post-mortem examination. The family should be informed about the examination, the likely venue/timing and any arrangements for moving their child, as well as the likelihood of tissues being retained during the exam. This information should be communicated in a sensitive and meaningful manner.

9.8.8 The family should also be made aware that it may take several weeks to secure the results of a post-mortem and for HM Coroner to come to a conclusion. Every effort should be made to keep the family updated at each stage of the process. The family should have regular telephone calls from either the healthcare/key worker supporting the family or the Coroner's Officer to let them know how things are proceeding. The Lullaby Trust has told us that families greatly appreciate such calls, even if this is to tell them that a delay is expected.

9.8.9 Written information is important and valuable to the family. Much of the detail of what is discussed can be forgotten or lost in the immediate stress of their child's death. It is important that the family are provided with relevant and up to date information but are not overwhelmed by this. Details of local and national support organisations, information about the post-mortem (NHS leaflet) and the Child Death Review Process (CDOP leaflet is available from Coroner's Officers or Registrars), should also be provided to the family. A list of bereavement support organisations is provided in Appendix N. Families' engagement with these support agencies should be factored in as part of the wider multi-agency response.

9.8.10 The family must be provided with clear details of their key worker/alternative contact – both in working hours and out of hours should they have any questions or concerns. If it becomes necessary to transfer responsibilities between professionals, the family should be informed of this and introduced to any new professional involved.

9.8.11 At the time of the child's death, other professionals may provide vital support to the family – including, but not limited to the GP, clinical psychologist, social worker, family support worker, midwife, health visitor/school nurse, palliative care team, chaplaincy and pastoral

support team. In all cases it is the duty of the key worker to ensure that there is clarity regarding each professional's role and that the family does not receive mixed messages.

9.9 THE ROLE OF THE POLICE

9.9.1 Every child who dies deserves to have their sudden and unexpected death fully investigated in order to exclude homicide and to identify a cause of death. The Police investigation should determine the circumstances surrounding the death and ascertain any criminal involvement by any person. Sudden and unexpected deaths will always be treated initially as suspicious and will remain so until determined otherwise. Police have a duty to investigate SUDiCs on behalf of HM Coroner (who must be notified as soon as possible).

9.9.2 Article 2 of the Human Rights Act (1998) states that everyone's right to life will be protected by law. This requires public authorities to establish the cause of death.
The Police have a key role in the investigation of child deaths. Their prime responsibility is to the child as well as to the siblings and any future children which may be born into the family concerned.

9.9.3 It is important to remember that in the vast majority of child deaths, the cause is natural and therefore there needs to be a careful balance between consideration for the bereaved family and the potential of a crime having been committed. The principles of the **'Golden Hour'** still apply.

9.9.4 For the purposes of the protocol, the 'scene' refers to the child's home, or the place where the child was immediately prior to his/her death. On some occasions, the child will still be at the scene when the Police and other professionals attend. On other occasions, the child may have been taken to hospital. In each case, the principles remain the same. In such a situation where there may be two scenes, resources will need to be allocated accordingly. It is important to note that even if the child has already been moved, professionals visiting the home/place of death should still treat it as a potential scene.

9.9.5 In **ALL** cases of sudden, unexpected death – whether immediately suspicious or not, this protocol will be followed unless HM Coroner determines otherwise.
The Police should adhere to the five national principles for dealing with SUDiC, whilst being mindful of religious and cultural differences:

- Balance between sensitivity and investigation mindset
- An awareness of religious and cultural differences
- Multi-agency responsibility
- Sharing information
- Appropriate response to the circumstances
- Preservation of evidence

The DI in command of the investigation should have completed the National Child Death Training. The DI should make an initial assessment and if necessary, escalate the investigation to the duty Senior Investigating Officer. All suspicious deaths should be referred to the duty SIO.

9.9.6 Deployment:

- It is the responsibility of the Force Contact Centre and Area Supervision to ensure that appropriate personnel attend the scene.
- If Police are the first professionals to attend the scene, urgent medical assistance should be requested as the first priority.
- Police attendance should be kept to the minimum required. Several Police officers arriving at a house can be distressing, especially if they are uniformed officers in marked Police cars.
- A Detective Inspector must attend the scene to ensure a consistently high standard of Police input. If the child has already been removed from the scene to the hospital, it may be beneficial for the DI to attend the hospital initially. This allows for assessment of the child in conjunction with the on-duty consultant paediatrician. Updates can also be provided to the family at hospital.
- Levels of Police attendance should be subject to constant review by the DI present. At an appropriate time, the DI should explain to the bereaved family the reason for Police attendance. Parents need to understand that the Police have a duty to investigate on behalf of HM Coroner and to be reassured that this happens in all cases where a child dies suddenly and unexpectedly.
- Officers should, *at all times*, be sensitive to the use of personal radios and mobile phones. If possible, the officers liaising with the family, whilst remaining contactable, should have such equipment turned off.

9.9.7 Initial Action & Investigation:

The provision of medical assistance to the child is a priority. If an ambulance is not already in attendance, then one must be requested immediately, unless it is absolutely clear that the child has been dead for some time. If NWAS have not confirmed the death of the child and completed the Diagnosis of Death Form, a Forensic Medical Examiner (FME) will need to be called to certify death. If the child has already been taken to hospital, death will be certified by hospital doctor.

The first officer at the scene must liaise with paramedics and make a visual check of the child and their surroundings, noting any obvious signs of injury, any obvious hazards and note the persons present. It must be established if the child has been moved and the current position should be recorded.

Officers initially attending scene should record the following:

- Basic medical history of the child and family including any previous child death.
- Where the child was and the sleeping position, if covered, state what with.
- What the child was wearing.
- When the infant/child was last fed, by whom and food content.
- If applicable, when the child's nappy was last changed, by whom and where is it now.
- Has the child been well up until time of death.
- Time the child was last seen alive and by whom.
- If applicable, what caused the adult to look at/check the child.
- Temperature of the scene.
- Condition of accommodation.
- General hygiene and availability of food and drink.
- Parents: any alcohol/tobacco/medication use – last taken/current state.

- Residents of the home, those present at the time of the child's death and recent visitors to the home

See Appendix I for more information.

Officers attending the scene should be aware of the cultural issues and needs of the family. A record of event from the parent(s)/carer(s) describing the circumstances leading up to the child being found dead is essential, including details of the child's recent health. All comments should be recorded. Any conflicting accounts should raise suspicion, but it must not be forgotten that any bereaved person is likely to be in a state of shock and possibly confused. Attending officers should ask appropriate questions to establish the circumstances of the death but avoid progressing the questioning to interview.

The Duty SIO should be informed at the earliest opportunity and will liaise with the Protecting Vulnerable Persons (PVP) unit as soon as practicable. The SIO will decide on the appropriate investigation strategy.

The form used by Police to notify HM Coroner of a sudden death (Form 97) must be completed at an early stage by the reporting officer and forwarded to HM Coroner's Office. The DI has a duty to ensure that this form is completed to a high standard and in a timely manner.

9.9.8 Questions relating to the child's recent health can be recorded on the F97 under the appropriate heading. They should include basic medical history for the child and family. Other details thought to be pertinent to the child's death, should also be included.

9.9.9 The Detective Inspector and PVP should become involved at the earliest opportunity. The DI will decide on the appropriate investigation team.

9.9.10 Police officers need to be aware of other professionals' responsibilities i.e.: resuscitation attempts, taking details from parents/carers, examination of the child's body and looking after the welfare needs of the family.
It may be necessary for Police officers to wait until some procedures have been completed.

9.9.11 There may be evidential reasons for Police to take urgent action. This is where liaison and joint working is essential. It is advised that PVP is utilised for such liaison wherever possible.

9.9.12 The Detective Inspector attending the scene will be responsible for:

- Requesting the attendance of a Crime Scene Investigator (CSI)
- Questioning of family/witnesses. This should be undertaken sensitively. Consideration should be given to speaking to the parents/carers separately to avoid any confusion between versions of events. This should be assessed against the support needs of the parents/carers.
- The seizure of any evidence which may assist in identifying the cause of death and explaining the reasons for the seizure to the family. Any items administered to the child e.g.: containers/medication/bottles/packaging should be seized.

- Evidencing factors of neglect which may have contributed to the death – e.g.: the temperature at the scene, condition of the accommodation, general hygiene, sleep space and availability of food/drink.
- Obtaining written statements from non-familial witnesses at appropriate venues – **this will not be done at A&E or the mortuary.**
- Checking force systems – PNC, PND, Niche, Corvus and Storm
- Family members/those supervising the child prior to the incident should be requested to provide blood samples for alcohol/drug testing (use the blood test consent form – Appendix H). The blood sample should be taken at the hospital, not at their home address. If unable to provide a blood sample, a urine sample should be requested.
- Family members/those supervising the child prior to the incident should be informed that they have the right to seek legal advice prior to volunteering blood/urine samples.
- A Force Medical Examiner (FME) or qualified and trained Health Care Professional (HCP) should be contacted at the earliest opportunity for this purpose.
- Officers must provide the FME/HCP with an RTA blood sampling kit (available at all custody suites) in order to assist in obtaining the samples. The samples should not be taken in the custody suite, unless the person is in Police custody.
- The blood sample should be appropriately labelled and sent to the forensic laboratory by Police along with the appropriate documentation.

9.9.13 The Detective Inspector will be responsible for:

- The allocation of a Family Liaison Officer (FLO)
- Coordination and attendance at any strategy meetings/discussions
- **At the SUDiC strategy meetings the DI will present photographs of the scene – <u>but not of the deceased child</u> – for consideration of the risk factors for the attending partner agencies.**
- All policy decisions will be clearly and appropriately recorded including if a joint visit to the family with Police/health professional is needed. If there are no suspicious circumstances or previous police involvement the meeting will be co-ordinated by the relevant safeguarding unit.
- Obtaining written statements or Achieving Best Evidence (ABE) accounts from family members at appropriate venues. **This will not be done in A&E or the mortuary.**

9.9.14 HM Coroner must be notified as soon as possible. HM Coroner will direct the DI as appropriate. It will be the decision of HM Coroner as to whether a joint paediatric and Home Office post-mortem will be required.

9.9.15 Children's Social Care and the on-call Paediatrican – and in Alder Hey, the on-call Rainbow Consultant – need to be informed of the death as soon as practicable.

9.9.16 In most cases, the child will be taken directly to the hospital A&E Department. Arrangements must be made for a Consultant in A&E/Paediatrican to be informed in order to complete the appropriate examination of the child's body prior to the post-mortem.

9.9.17 It is important that arrangements are made for the child's body to be taken to the A&E Department in all Merseyside Hospitals with the exception of Alder Hey, where the child may

go directly to the mortuary, please refer to Appendix D. In a situation where a child has been pronounced dead at the scene, NWAS must contact the A&E department and inform them that the SUDiC Protocol has been triggered and make arrangements for the deceased child to be received. A&E will then liaise with NWAS to confirm arrangements and agree an estimated time of arrival. If it is not possible for NWAS to transport the deceased child, they should inform Merseyside Police, who will the make arrangements with the Coroner's Removal Service to convey the child. In these cases, Merseyside Police will assume responsibility for liaising with the A&E Department and providing an estimated time of arrival on behalf of the Coroner's Removal Service.

Police vehicles must not be used at any time to transport a deceased child.

9.9.18 In cases where the death is thought to be suspicious, the approach within this protocol should cease and a murder investigation should commence. In these circumstances, the child should remain in-situ until the SIO directs otherwise. HM Coroner's Removal Service will be used to transport the child to the relevant mortuary. A Police patrol will accompany the child to the mortuary.

9.9.19 NWAS staff will complete a proforma statement documenting their involvement which will be handed to Police.

9.9.20 Issues of continuity of identification must be considered. Preferably, this will be performed by a Police Officer at the scene, but could also be done by HM Coroner's Officer, appropriately and sensitively. The child should be handled as if he/she were alive.

9.9.21 The mortuary technician must be informed if the child's family will be attending and if there are any visiting restrictions imposed.

9.9.22 If parents/carers want to accompany their child to the mortuary, this should usually be facilitated – ensuring they are accompanied by an investigating officer, FLO or Coroner's Officer, as appropriate.

9.9.23 Handling of the child should be kept to a minimum and should always be supervised by a Police Officer. This applies to parents/carers wanting to touch or hold the child at the hospital/bereavement suite. It is entirely natural for a parent/carer to want to hold or touch their chid. Providing that there is a professional present (Police officer, nurse etc.) in most cases it should be allowed as it is unlikely that it would cause a loss of any forensic evidence. If the death is being considered as suspicious the SIO **MUST** be consulted before a parent/ carer is permitted to hold the child.

9.9.24 In most cases delay in release of the body by HM Coroner is routine. This is to allow toxicology and other testing to take place. This should be sensitively explained to the family.

9.9.25 Post-Mortem:
It is the role of the Inspector/SIO to attend the post-mortem and brief the pathologist(s) with the following:

- A copy of the completed hospital medical pro-forma (Appendix A) dependent on the age of the child

- The sequence of events leading to the death, preferably with photographs/video with the following information:
    - The position that the child's body was found in, by the person who found the, or in relation to the person if there was bed sharing
    - Details of the scene
    - Any history of smoking/alcohol consumption/drug use with details of substance, amounts and timing by either parents/carers or the child
    - Copy of case notes of obstetric and paediatric period where relevant
    - Copy of GP records
    - Copy of ambulance attendance sheet
    - Details of resuscitation – where/by whom/when
    - List of investigations initiated/samples taken by A&E doctors and when results are available

HM Coroner is to be informed of the above details together with any useful information or developments. This can be facilitated trough the relevant Coroner's Officer.

9.9.26 Pathology Investigation Findings

Notwithstanding that pathology investigations are on-going and interim results may be inconclusive, in any case where the pathologist is satisfied that an injury may have contributed to the child's death and there is a possibility that said injury may have been caused by the parent(s) of the child, or other family member, the pathologist will prepare a statement setting out interim findings and detailing any further investigations to be undertaken. The statement will be provided to HM Coroner and Children's Social Care.

Upon receipt of such statement, Children's Social Care shall immediately seek legal advice with a view to court proceedings being issued in respect of any surviving sibling(s). In cases where court proceedings are issued in respect of siblings, the Coroner's Office will liaise with Social Care prior to decisions being taken to release the body for burial.

9.9.27 Recovery & Removal of Property

If it is considered necessary to remove items from the scene(s), this should be done with consideration for the parents/carers. Sensitively explain that doing this may help to find out why their child has died. For babies, this may include handheld maternity records/'the red book' (child's personal health record). Any articles, including clothing/feeding bottles, recovered from the scene should be correctly secured and documented. Collection of clothing/bedding should be considered if there are signs, they may be of forensic value, such as blood/vomit/other residues.

Parents should be asked if they wany any articles kept back as part of the investigation.
If family have indicated they want the articles returned, ensure they are presentable and that any labels/wrappings are removed before they are returned. Establish if they want the items returned in a 'clean' condition.

Return any items as soon as possible after the Coroner's verdict or at the conclusion of the investigation. The term investigation covers any possible trial or appeal process.

A checklist for investigators accompanies this protocol (Appendix I).

Investigating officers should also comply with the relevant ACPO 2014 “A Guide to Investigating Child Deaths” and guidance on infant deaths contained in the ACPO 2006 Murder Investigation Manual (MIM).

Once the SUDiC protocol commences, it can only be stood down at the direction of HM Coroner, no other agency can take on this responsibility.

Police take ultimate responsibility for the investigation. They will liaise with HM Coroner to establish if the protocol is being stood down and confirm the outcome to agencies.

9.9.28 Transport of the deceased child

Parents may express a wish to transport their child in their own vehicle. If HM Coroner has declared that no post-mortem is going to take place and is satisfied that the body can be released, this request should be considered an acceptable request and facilitated where possible. There is no legislation that prevents families from doing so if they wish, they just need to be provided with the appropriate documentation from the hospital the child is being discharged from to enable them to do so.

9.10 HOSPITAL WARDS/MATERNITY UNITS

9.10.1 If a child is found collapsed within the hospital, a resuscitation team will be called, and resuscitation attempted.

9.10.2 If death is pronounced, the family will be supported by a senior member of staff and the local bereavement policy will be followed.

9.10.3 The senior person on duty/on call will inform the Police and implement the SUDiC protocol.

9.10.4 The location where the child was found collapsed should be treated as a potential crime scene and processed accordingly – i.e.: nothing should be moved/touched as much as possible.

9.10.5 A Crime Scene Investigator (CSI) will attend. Exhibits will be recorded and taken as appropriate e.g.: bedding clothing, medical equipment, food/drink.

9.10.6 The SUDiC medical proforma should be completed by the consultant paediatrician/nominated senior doctor. Consideration should be given to asking for photographs of any skin discolouration/unusual marks or injuries as soon as possible and ideally before the child is moved.

9.10.7 All information and records will be updated and maintained. Health records will be secured by named professionals until the situation is clarified.

9.10.8 Staff should be offered support and de-briefing wherever possible. Please refer to your local policies.

9.10.9 The most appropriate member of staff should attend the SUDiC strategy meeting, which must be considered as a priority.

9.10.10 Ensure that the GP, Health Visitor/School Health are notified.

Please note: Maternity hospitals and Neonatal Units may also refer to additional guidance contained within the following: ***'Guidelines for the Investigation of Newborn Infants Who Suffer a Sudden and Unexpected Postnatal Collapse in the First Week of Life (March 2011)'.***

9.11 EDUCATION & EARLY YEARS SETTINGS

Education and Early Years Providers will be contacted whenever a child dies.

9.11.1 Education and Early Years staff will check if any members of the family are known. This check will include a search of the safeguarding system.

9.11.2 All information relating to the child – education/personal records/files must be secured at the point of notification.

9.11.3 Each educational/early years setting must have designated person with a responsibility for safeguarding. Each Local Authority will have a designated person within the Education Service with a safeguarding responsibility. It is the responsibility of these designated professionals to share information regarding the sudden and unexpected death of a child.

9.11.4 A nominated education lead/early years manager/safeguarding coordinator should be invited to a SUDiC strategy meeting, which should take place within 3 days of the child's death. The invitations should come from the Local Authority Safeguarding Unit. Attendance at SUDiC strategy meetings should be prioritised. It is expected that the designated person will contribute and attend all strategy meetings and that once actions are identified, they will ensure that actions are carried out. The designated person will maintain liaison with the Chair of the SUDiC strategy meeting.

9.11.5 A decision will be made at the SUDiC Strategy meeting regarding who should maintain liaison with the family.

9.11.6 Education/Early Years Providers will be requested to complete an agency return form for the Child Death Overview Panel (CDOP) process following contact from the CDOP Team.

9.12 ROLE OF HM CORONER'S OFFICER

9.12.1 The Coroner's Officer works under the direction of HM Coroner. The Officer liaises with all persons having an interest in the death (i.e., bereaved families, witnesses, police, doctors, pathologists, funeral directors, solicitors, social workers, registrars etc.) with a view to investigating all those matters to be determined at the inquest (see above). In the case of

sudden deaths, where the death is considered suspicious the police will take the lead on investigation. The officer reviews and collates all the required reports and statements relating to the death for HM Coroner.

9.12.2 If the pathologist carrying out the post-mortem examination wishes to retain a whole organ (solely for the purpose of establishing the cause of death) he will ask the permission of HM Coroner. HM Coroner, through the officer, will discuss with the family their wishes in relation to the future storage or disposal of blocks and slides as well as any organs or tissues retained. The family's decision should be communicated to the pathologist(s) in a written format by the Coroner's Officer.

9.13 KEYWORKER

The processes following the death of a child are complex, particularly where there are multiple investigation and coordination required across these investigations. In recognition of this, bereaved families should be given a single, named point of contact to whom they can ask for information on the Child Death Review Process and who can signpost them to sources of support.

9.13.1 It is the responsibility of the organisation where the child was certified dead to identify a keyworker for the family. The role could be taken by a range of practitioners, for example:

- In the cases of children with long term conditions, the family may already be well known to a member of the specialist multi-disciplinary team such as a clinical nurse specialist, and this person may be well placed to continue in a key worker role after the child has died.
- In the cases of children with acute conditions (sepsis), the child/family may not have been known to any health care practitioners before the child's admission to hospital and a key worker might instead be a member of the bereavement support team.

9.13.2 In criminal and coronial cases, the Police family liaison (where deployed) and the Coroner's Officer provide vital support to parents in relation to all elements of those investigations. In such situations, the key worker might play a supporting role in ensuring that the wider needs of the family are being met.

9.13.3 Regardless of professional background, this person should:

- Be a reliable and readily accessible point of contact for the family after the death.
- Help coordinate meetings between the family and professionals as required.
- Be able to provide information on the Child Death Review Process and the course of any investigations pertaining to the child.
- Liaise as required with the Coroner's Officer and Police Family Liaison Officer.
- Represent the 'voice' of the parents at professional meetings, ensuring that their questions are effectively addressed and provide feedback to the family afterwards.
- Signpost to expert bereavement support if required.

9.13.4 The Keyworker should have the following competencies:

- An empathic approach, an ability to listen to and be with people in distress
- Strong communication and interpersonal skills in challenging and distressing circumstances
- Ability to maintain appropriate boundaries with families

- Sufficient experience and confidence to effectively represent the family at professional meetings
- Ability to quickly develop a thorough understanding of the child death review process in order to support the family through the process and answer any questions they may have
- If the Keyworker is not already familiar with the child death review process – they should contact the local CDOP Manager or Designated Doctor for Child Death. They can also refer to the leaflet 'When a Child Dies: A Guide for Parents and Carers.

9.13.5 The Keyworker should be appropriately supported as follows:

- *Time* – how much time needed for the role will vary greatly from case to case. It is important that all organisations are flexible in enabling the keyworker to support the family as required, over the weeks and months following the child's death.
- *Team Support* – Families should expect to be able to contact their Keyworker, or a member of their team during normal working hours. Given shift patterns and annual leave, all keyworkers should be part of a team who are able to cover any absences.
- *Individual Support* – Working with bereavement can be stressful. The Keyworker and their line manager should agree to a plan to ensure that they are appropriately supported in the role, including opportunities for debriefing and supervision.

9.14 (NOMINATED) PAEDIATRICIAN

All areas should nominate a paediatrician to co-ordinate the ongoing information gathering and investigation. In most areas this will be a community paediatrician, but in some circumstances, it may be a hospital paediatrician.

9.14.1 The nominated paediatrician should be informed as soon as possible after the child's death.

9.14.2 The nominated paediatrician may be involved in the SUDiC case discussion/SUDiC strategy meeting.

9.14.3 Prior to the SUDiC strategy meeting, the nominated paediatrician will request and review all hospital records for the child. The records may be secured at this time if the death is being treated as suspicious. GP records should be requested at the same time.

9.14.4 If agreed at the SUDiC strategy meeting, the nominated paediatrician may arrange to meet with the family for further information gathering.

9.14.5 If the nominated paediatrician meets with the family prior to the post-mortem, any additional information should be communicated to the pathologist.

9.14.6 The nominated paediatrician should consider further investigation of the family (e.g., ECG, genetics referral) if this is a second death or there is a family history.

9.14.7 If the child is known to have had complex needs, the nominated paediatrician should discuss this with the child's usual paediatrician.

9.14.8 The nominated paediatrician should attend the SUDiC strategy meeting, having collated all medical records and, if available, the initial post-mortem results.

9.14.9 A follow up meeting should be offered to the family with either the nominated paediatrician or the paediatrician involved in the resuscitation. This needs to be an item on the SUDiC review meeting agenda. The timing of the meeting may vary, but there should always be a meeting once the final post-mortem results are known.

9.15 MORTUARY STAFF

In a situation where a child has been pronounced deceased at the scene, NWAS must contact the nearest Accident & Emergency department with paediatric inpatient facilities to inform them that the SUDiC protocol has been triggered and request they make arrangements for the mortuary/bereavement staff to receive the deceased child. The A&E department staff member will then liaise back with NWAS to confirm the arrangements have been made and agree an estimated time of arrival.
In the event that NWAS are 'stood down' or cannot convey the deceased child the Coroner's Removal Service should be utilised through liaison with Merseyside Police. In these cases, Merseyside Police will assume responsibility for contacting the A&E department/mortuary to make arrangements and agree an estimated time of arrival for the deceased child.
In either case, the minimum identifying information should be supplied for the receiving hospital to ensure that the correct processes are completed with the relevant information.

9.15.1 Should a child be taken directly to the mortuary in any hospital, they should be transferred to the local A&E department for examination by a consultant paediatrician (see A&E Section) as the SUDiC Proforma will need to be completed and samples may be required. Please refer to Appendix D for specific flowcharts for Alder Hey Children's Hospital.

9.15.2 The care of the family and investigation of the cause of death should follow a similar course whether or not resuscitation has been attempted.

9.15.3 Mortuary staff at Alder Hey should follow the procedure outlined in Appendix D to ensure correct processes are followed.
A&E should also be notified, in case visitors arrive in the department enquiring about the child or family.

9.15.4 Whilst the child's body remains under the control of HM Coroner, this should not impede the processes within the SUDiC Protocol from taking place – including notification of the relevant Doctor to complete examinations as needed.

APPENDIX A - Hospital SUDiC Proforma Medical Record

SUDDEN UNEXPECTED DEATH IN CHILDHOOD (SUDiC) - PROFORMA MEDICAL RECORD	
Time: ____ : _____	Date: ____ / ____ / _____
Name:	Name of Doctor:
Date of Birth: ___ / ___ / ____	Grade:
Hospital Number:	Signature:

A&E CHECKLIST		
Arrival in A&E Department:	Time: ____ : ____	Date: ____ / ____ / _____
Mode of arrival: Accompanied by: Condition of baby/child on arrival: What Cardio-Pulmonary Resuscitation was applied?		
Death certified at:	Time: ____ : ____	Date: ____ / ____ / _____

HISTORY	
History taken from:	☐ Mother ☐ Father ☐ Carer ☐ Other (specify) _____ Name _____
When infant was found:	Time: ____ : ____ Date: ____ / ____ / _____
Position of infant when found:	☐ prone ☐ supine ☐ other
Room found in:	☐ own bedroom ☐ parent's bedroom ☐ living room Other (specify):
Location:	☐ cot ☐ bed ☐ basket ☐ sofa Other (specify):

Circumstances:	Co-sleeping: Clothes: Bed covers: Smoking in room: Heating: Windows / doors:
Body fluids on face / bed:	☐ vomitus ☐ blood ☐ mucous
Last feeding:	Time: ____ : ____ By whom: ☐ breast ☐ bottle ☐ solids Did child feed normally:
What prompted carer to check child:	☐ feeding time ☐ nappy change ☐ crying ☐ quiet Other:

History of event (including account preceding event and any relevant circumstances/illness/injury):

What was the reported condition of the baby/child when found?

Action taken?

When/who called ambulance?

Who was with baby/child?

Was resuscitation attempted?

Any response?

How long until ambulance arrived?

Person who looked after the infant in the last 12 hours:

Last seen alive: Time: ____ : ____ By whom:

Symptoms in the last 72 hours:

Feeding:

Recent illness:

Behaviour and sleep:

	Breast / bottle / solids	Volume	Frequency	Additives
Normal feeding pattern:				

PAST HISTORY

Pregnancy / Delivery / Birth History:

Gestation:

Birth weight:

APGAR Score/Resuscitation at birth:

Admission to SCBU:

Developmental Progress/Growth:

Immunisation:

Significant medical problems:

A&E Attendances:

Hospital Attendances:

Medication:

Allergies:

Other:

Last visit to: Health Visitor: Date: ___ / ___ / _____ Reason:

GP visit: Date: ___ / ___ / _____ Reason: A&E

Dept: Date: ___ / ___ / _____ Reason:

Any recent minor injuries not seen by health professionals:

Professionals involved in child's care:

GP: Name: _____ Date last seen: ___ / ___ / _____

Reason: _____

Health Visitor: Name: _____ Date last seen: ___ / ___ / _____

Reason : _____

School Nurse: Name: _____ Date last seen: ___ / ___ / _____

Reason : _____

Consultant(s): Name: _____ Date last seen: ___ / ___ / _____

Reason: _____

Name: _____ Date last seen: ___ / ___ / _____

Reason: _____

RELEVANT FAMILY HISTORY

Previous Miscarriages / Stillbirths:

Previous SUDiC / ALTE / other deaths:

Any significant past medical history:

SOCIAL HISTORY

Mother: Married ☐ Co-habiting ☐ Separated ☐ Other ☐

Complete the following section for mother, father, and any other adults in house (e.g., mum's current partner (if not dad), father of other children, grandparents, daytime carer or other household resident)

	Mother	Father	Other adult
Name			
DOB			
Relationship to child			
Occupation			

Significant medical problems (*including mental health problems)*			
Domestic violence			
Smoking			
Alcohol *(amount, type & time last taken)*			
Prescription drugs / other drugs *(name & time last taken)*			

OTHER HOUSEHOLD MEMBERS Details of those living in the household (not detailed above) state relationship (e.g., parent, carer, lodger etc) and provide any relevant information

SIBLINGS			
Names: 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____	Sex: ____ ____ ____ ____ ____ ____	Date of Birth: ___ / ___ / ____ ___ / ___ / ____ ___ / ___ / ____ ___ / ___ / ____ ___ / ___ / ____ ___ / ___ / ____	Residential address *(if different to mother)* _____ _____ _____ _____ _____ _____

DOCUMENTATION OF PHYSICAL EXAMINATION

General appearance:

Rectal Temperature_____ ºC

State of nutrition and cleanliness:

Weight_____ kg

Visible signs of injury / bleeding:

Was there anything abnormal noted in the mouth at intubation?

Examination:

Ophthalmic:

ENT:

Mouth:

Skull / scalp:

Spine:

Chest:

Abdomen:

Genitalia:

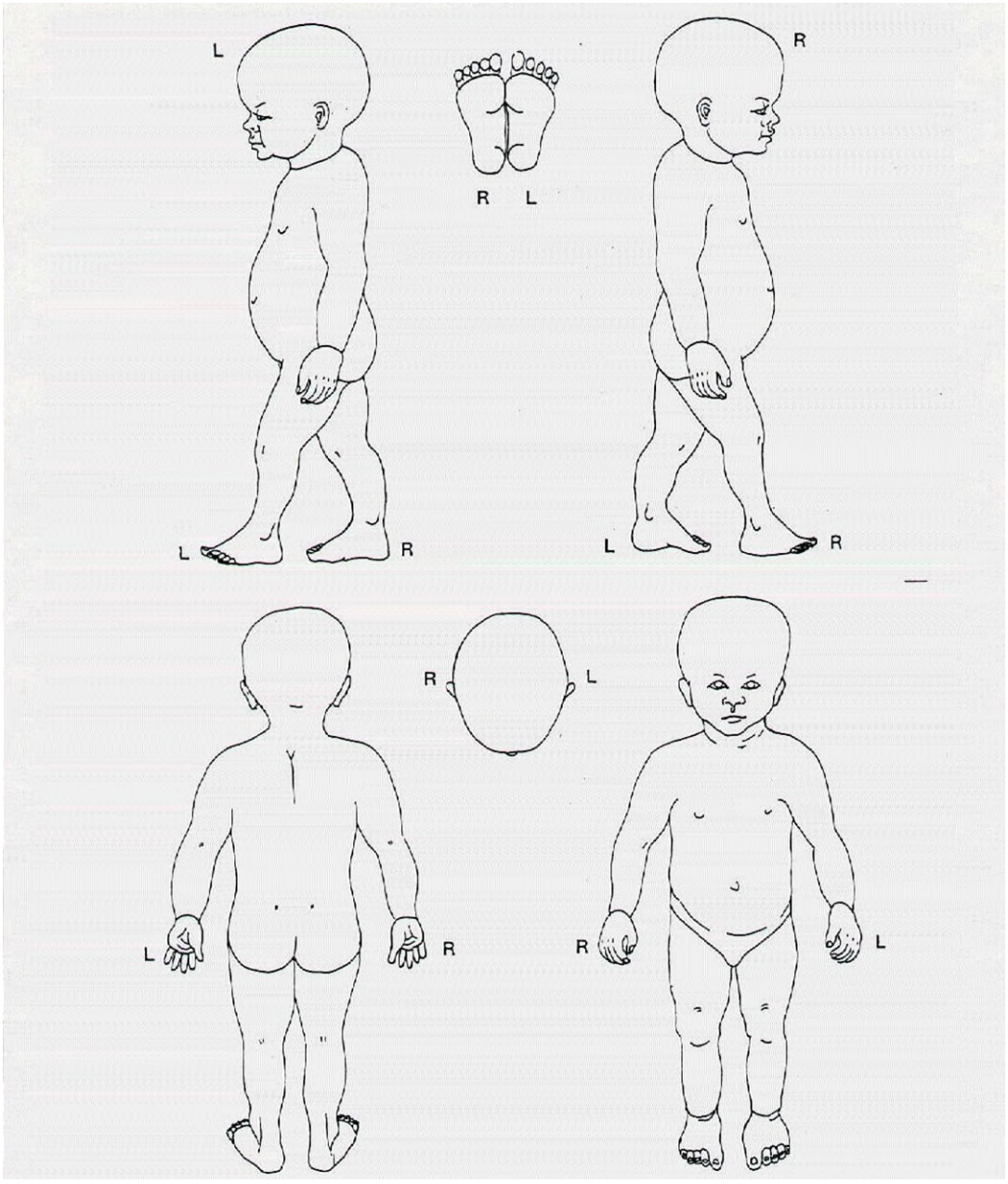
Upper limbs:

Lower limbs:

PHYSICAL EXAMINATION (continued)

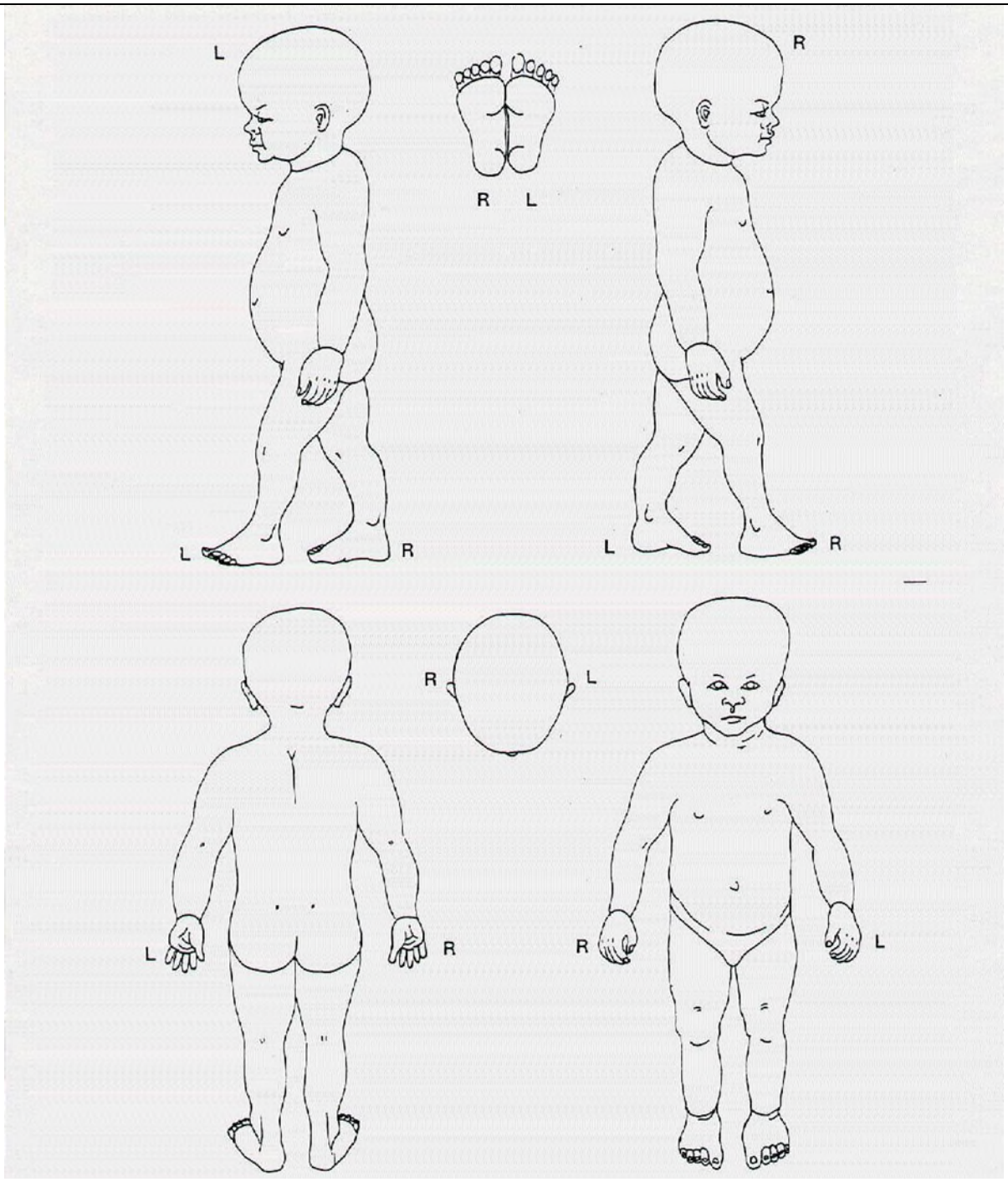
Observe & measure any visible bruises, lacerations or signs of injury (list and mark on body chart)

Photographs taken Yes ☐ No ☐



SITES OF MEDICAL INTERVENTION

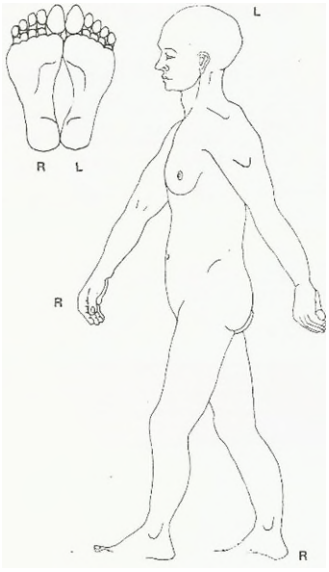
Sites of medical intervention (list & mark on body chart)

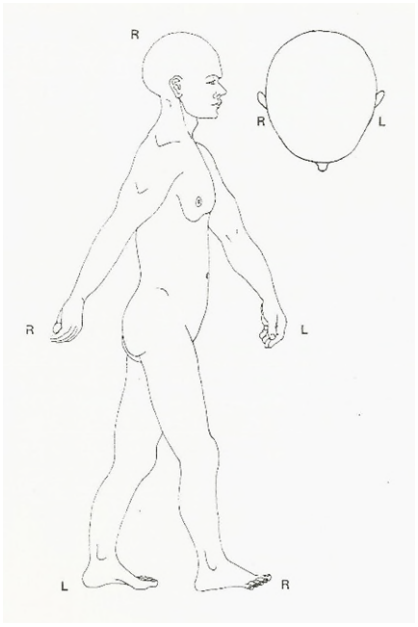


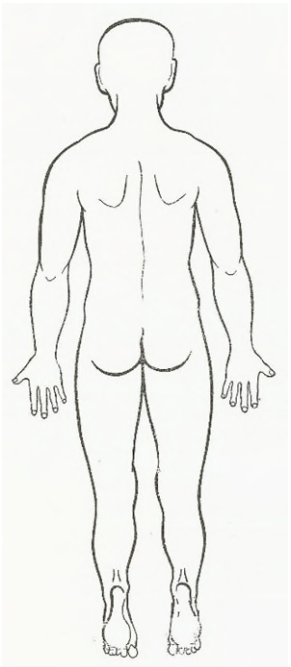
PHYSICAL EXAMINATION (continued)

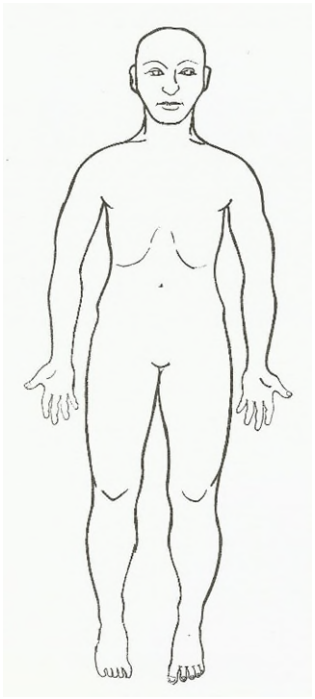
Observe & measure any visible bruises, lacerations or signs of injury (list and mark on body chart

Photographs taken Yes ☐ No ☐



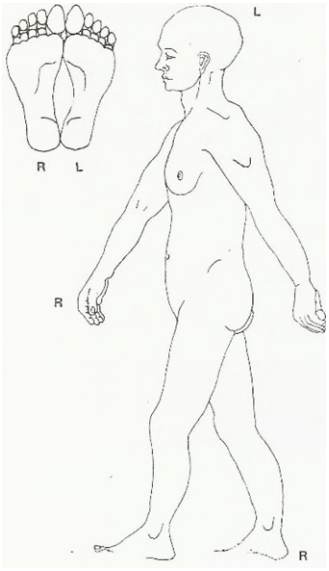


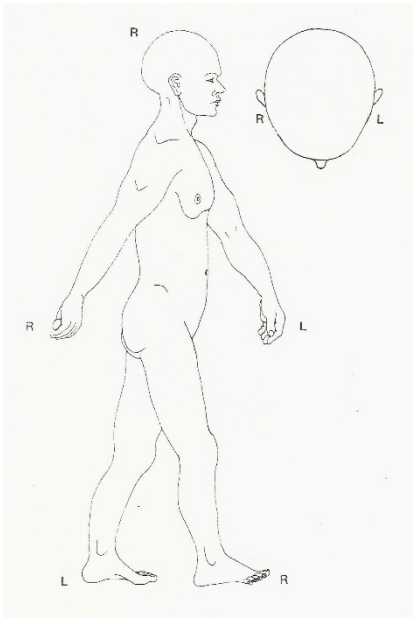


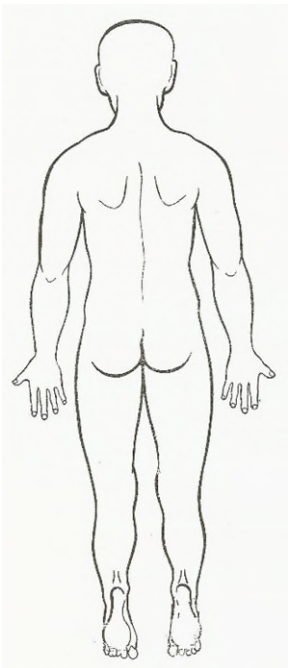


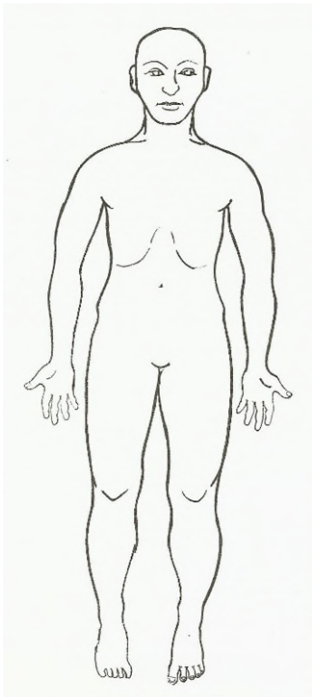
SITES OF MEDICAL INTERVENTION

Sites of medical intervention (list & mark on body chart)









SAMPLES TAKEN (if any)

Blood culture		Yes ☐	No ☐
Blood Chemistry	U&E	Yes ☐	No ☐
	Glucose	Yes ☐	No ☐
	Liver function tests	Yes ☐	No ☐
	Amino Acids	Yes ☐	No ☐
	MCAD - medium chain Acyl-CoA-dehydrogenase *(Guthrie card)*	Yes ☐	No ☐
EDTA sample	Metabolic screen (Organic & Fatty acids)	Yes ☐	No ☐
	Hb CO (Carboxy Haemoglobin	Yes ☐	No ☐
	MetHb (Methemoglobin)	Yes ☐	No ☐
	DNA studies	Yes ☐	No ☐
Haematology	FBC	Yes ☐	No ☐
	Blood Group	Yes ☐	No ☐
	Clotting screen	Yes ☐	No ☐
	Other (specify):		
Drug assay	Blood (5ml clotted blood)	Yes ☐	No ☐
	Urine	Yes ☐	No ☐
	(for Alcohol, Opiates, Benzodiazepines, Salicylates, Paracetamol)		
Swab visible blood *(before cleaning)*		Yes ☐	No ☐
Urine sample *(suprapubic for drugs)*		Yes ☐	No ☐
Photographs of injuries		Yes ☐	No ☐

Radiological examination (as appropriate) _____ _____ _____	Yes ☐	No ☐
Lateral x-ray neck for ETT localisation	Yes ☐	No ☐
Direct visualisation of ETT through cords by independent observer	Yes ☐	No ☐
Name: _____ Grade: _____ Signature: _____		
Other investigations:		
Additional Information:		
CONTACT LIST FOR STRATEGY MEETING		

Social Care Involved in discussion

Name: _____ Contact No: _____ Yes ☐ No ☐

Police Senior Investigating Officer

Name: _____ Contact No: _____

Community Paediatrician on call Yes ☐ No ☐

Name: _____ Contact No: _____

Child's own Paediatrician (Alder Hey or other Trust, if applicable) Yes ☐ No ☐

Name: _____ Contact No: _____

Bereavement Care Services Yes ☐ No ☐

Name: _____ Contact No: _____

Pathologist Yes ☐ No ☐

Name: _____ Contact No: _____

General Practitioner Yes ☐ No ☐

Name: _____ Contact No: _____

CAMHS (if applicable) Yes ☐ No ☐

Name: _____ Contact No: _____

Other (specify) _____ Yes ☐ No ☐

DOCUMENTATION OF CASE DISCUSSION

APPENDIX B – NOMINATED COMMUNITY PAEDIATRICIAN PROFORMA RECORD

SUDDEN UNEXPECTED DEATH IN INFANCY (SUDI)
NOMINATED COMMUNITY PAEDIATRICIAN PROFORMA RECORD

(Also for use with unexplained Acute Life Threatening Events requiring resuscitation & Intensive Care intervention*)

Infant Name:	Name of Doctor:
Date of Birth: ___ / ___ / ____	Grade:
Hospital Number:	Signature:

CHECKLIST TO BE COMPLETED BY THE NOMINATED COMMUNITY PAEDIATRICIAN

Please refer to the "SUDI proforma medical notes" completed in A&E. Any gaps should be noted and the information completed subsequently after review of the notes & discussion with the Police.

1. Have hospital records of the child and any siblings been requested? YES / NO

2. Have Primary Care records of the child and any siblings been requested? YES / NO

3. Has an interview with the family been arranged for the collection of further information? YES / NO

Conducted by: ☐Health Visitor ☐Nominated Paediatrician

Venue: ☐Home ☐Bereavement Suite

Details: _____

4. Has a Case Discussion been convened by the Senior Investigating Officer? YES / NO
(involving the Nominated Paediatrician and Social Services)

5. Have the decisions made during the strategy discussion been recorded in the proforma medical notes? YES / NO

6. Has a discussion taken place with the Pathologist who is going to carry out the post mortem to communicate any significant information arising from the strategy discussion? YES / NO

7. Has the Strategy Meeting been arranged? YES / NO

Date: ___ / ___ / ____ Time: ____ : ____ Venue: _____

8. Has information from all medical records been collated for the Strategy Meeting? YES / NO

9. Have ongoing bereavement support arrangements for the family been discussed with the Bereavement Care Team? YES / NO
(& any relevant information passed on following the strategy meeting)

CASE DISCUSSION NOTES

Date / Time		Sign

Infant Name: Date of Birth: ____ / ____ / _____

STRATEGY MEETING / FOLLOW-UP NOTES

Date / Time		Sign

Infant Name:	Name of Doctor:
Date of Birth: ___ / ___ / ____	Grade:
Hospital Number:	Signature:

STRATEGY MEETING / FOLLOW-UP NOTES

Date / Time		Sign

Infant Name: Date of Birth: ____ / ____ / _____

STRATEGY MEETING / FOLLOW-UP NOTES

Date / Time Sign

APPENDIX C - Health Notification Form

SUDDEN UNEXPLAINED DEATH IN INFANCY (SUDiC)
Notification / Incident Form

This form is to be completed by a health professional when:

a) **a child under the age of 18 years dies at home and is taken to an A&E dept.**
b) **a child under the age of 18 years dies in an A&E dept, maternity unit or paediatric ward**
c) **a child for whom they have professional responsibility is notified to them as a SUDiC**

Name of Child	Date of Birth	Date of Death	Time of Death

Home Address	**Address Child Found**
Tel.	Tel.

Name of Mother	**Name of Father**	**Name of Main Carer** (If different from parents)
D.O.B:	D.O.B:	Relationship:

Professionals Involved With The Family:

Name	Discipline	Contact Details
GP -	N/A	
HV/ School Nurse	N/A N/A	
Other		

Details of circumstances surrounding child death:

Details of professionals involved in the SUDiC, if known:

	Name	Contact Details
Police S.I.O		
Com. Paediatrician		
SW Team Manager		

Are the circumstances thought to be suspicious (please delete) YES / NO

Was the child transferred to Alder Hey Hospital (please delete) YES / NO

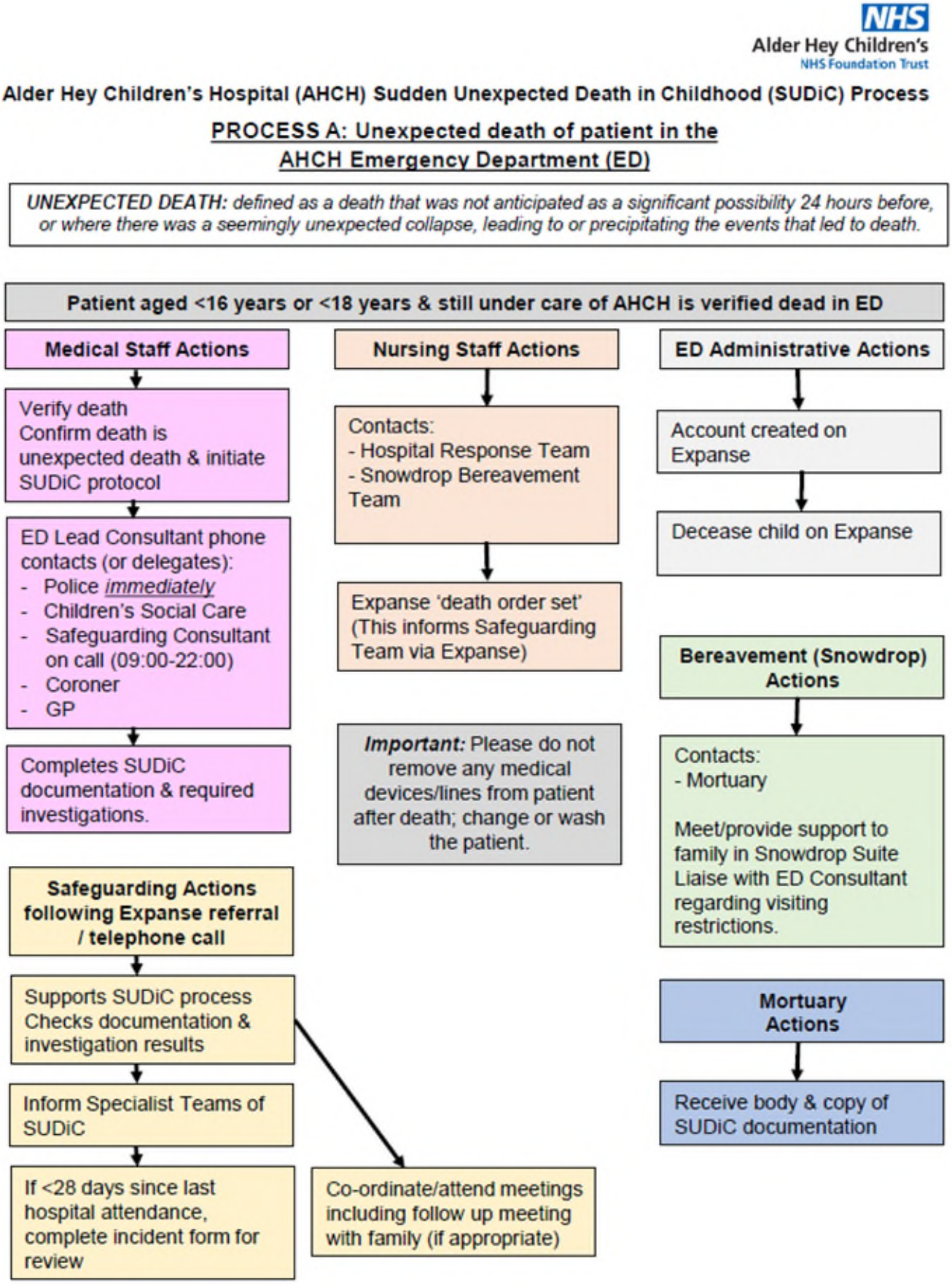
Date of S.U.D.i.C Strategy Meeting:_____

Time:

Venue of Meeting:

Name & Signature: _____ Designation:_____

APPENDIX D – Alder Hey Children's Hospital Flowcharts



Alder Hey Children's NHS Foundation Trust

Alder Hey Children's Hospital (AHCH) Sudden Unexpected Death in Childhood (SUDiC) Process

PROCESS B: Unexpected death of a patient admitted to AHCH (not in ED)

UNEXPECTED DEATH: defined as a death that was not anticipated as a significant possibility 24 hours before, or where there was a seemingly unexpected collapse, leading to or precipitating the events that led to death.

Patient receiving inpatient medical care is an unexpected death on a ward or in other clinical area

Medical Staff Actions

Verify death
Confirm is unexpected death & initiates / continues SUDiC protocol

Lead/on call Consultant telephone contacts (or delegates):
- Police *immediately*
- Safeguarding Consultant on call (09:00-22:00)
- Coroner
- GP

NB Trainee Doctor would contact on call consultant for patient's lead team.

Safeguarding Action following telephone call

Attends ward, completes SUDiC documentation & advises on needed investigations

Supports SUDiC process

Contacts Children's Social Care
Inform Specialist Teams of SUDiC

If <28 days since last hospital attendance, complete incident form for review

Nursing Staff Actions

Contacts:
- Ward Nurse in Charge
- Hospital Response Team who will inform Senior Manager on Call (SMOC)
- Snowdrop Bereavement Team

Expanse 'death order set' (This informs Safeguarding Team via Expanse)

Important: Please do not remove any medical devices/lines from patient after death, change or wash the patient or their bed. The bed space/room may need to be treated as a possible crime scene.

Co-ordinate/attend meetings including follow up meeting with family (if appropriate)

Administrative Actions

Decease child on Expanse

Mortuary Actions

Receive body & copy of SUDiC documentation

Bereavement (Snowdrop) Actions

Contacts:
- Mortuary.

Meet/provide support to family in Snowdrop Suite
Liaise with ED Consultant regarding visiting restrictions.

NHS
Alder Hey Children's
NHS Foundation Trust

Alder Hey Children's Hospital (AHCH) Sudden Unexpected Death in Childhood (SUDiC) Process

PROCESS C: Patient dies in the community – no resuscitation ongoing

Patient aged <16 years or <18 years & still under care of AHCH is verified dead in the community.
AHCH is nearest hospital with paediatric services to the current location of deceased patient.

↓

NWAS / Coroner / Police contact AHCH switchboard prior to moving patient.
If AHCH Emergency Department (ED) is contacted, they should redirect call to switchboard.
Switchboard transfer call to the Mortuary Team 08:30-17:00 ext 2219 or to 'on call' if out of hours.
Switchboard are unable authorise the transfer of a patient.

↓

Mortuary Team collect 'minimum data set' information from caller:

- Is the death an unexpected death (SUDiC)? - Deceased patient's: name, date of birth, address
- Police Officer in Charge / Senior Investigating Officer:
  - Name, rank, collar number, telephone number
- Coroner's name (should be Liverpool Coroner)
- Date and time of verification of death, brief circumstances regarding the death
- Current location and estimated time of arrival at Alder Hey
- Are the parents coming to the hospital?

↓

Transfer of patient confirmed by Mortuary Team

Mortuary Actions:

- Attend AHCH to receive body.
- 24/7 email Safeguarding Duty Team (see below)
- 09:00 – 22:00 also telephone Safeguarding Consultant via switchboard.
- Response Team notification.
- If family attending, telephone Bereavement Team.
- Create account on Expanse if new patient.
- Decease patient on Expanse.

→ **Bereavement (Snowdrop) Actions** → Meet/provide support to family in Snowdrop Suite. Liaise with Safeguarding Consultant regarding visiting restrictions.

→ **Safeguarding Actions** → Completes SUDiC documentation. Plus, steps as for PROCESS B flow chart. Expanse death order set.

<u>If concern over verification of death</u>: Access the 'One Response' system to view NWAS records. If required, liaise with ED Consultant / ED Senior Doctor who can view these records.
<u>If concern over anything disclosed or observed:</u> Telephone Safeguarding Consultant, email if out of hours: duty-safeguarding@alderhey.nhs.uk, or inform police depending on level of concern.
<u>If body is transferred without prior notification:</u> Patient's body should remain in transport as place of dignity whilst above process happens to ensure they are received at the correct location or re-directed.
<u>If concern that steps do not follow process:</u>
Escalate to Safeguarding Consultant On Call via switch 09:00-22:00 or Senior Manager on call

APPENDIX E - Liverpool Women's Hospital Flowchart

Sudden unexpected death of an Infant or child 0-18 years at LWH (SUDIC)

Inform HM Coroner & Merseyside Police immediately by telephone.
Any sudden and/or unexpected death of an infant MUST be referred to the coroner
Medical team to complete Coroner referral via online portal in addition to phone call to coroner and Merseyside Police. A request can be made to the Police not to attend in uniform to minimise alarm to other families on the ward area.
If in working hours, please ring Safeguarding Team as priority following contact with Police and HM Coroner and notify the Named Doctor Safeguarding Children (Dr Emily Hoyle).

- Please complete the following:
  - safeguarding referral
  - incident form
  - inform the relevant local authority (based on family postcode)
  - OOH, inform site manager to escalate to Exec on call and email Named Doctor for information.
  - Paediatric Liaison Notification.

SUDiC initiated by Coroner

HM Coroner will request post-mortem examination.
HM Coroner will decide if this is a joint PM with the Home office (Forensic) or if paediatric pathologist PM only
NB: The SUDiC protocol must be followed irrelevant of the type of PM requested.

SUDiC process will be led by HM Coroner and Police

Immediate Location of Child / Infant Death

Within the hospital, the location where the child was found collapsed should be treated as a potential crime scene and processed accordingly.
Do not touch, move or disturb anything around the bed/cot.
Merseyside Police will attend and will record and remove items from around the bed/cot as appropriate e.g. bedding, clothing, feed, medical equipment etc.

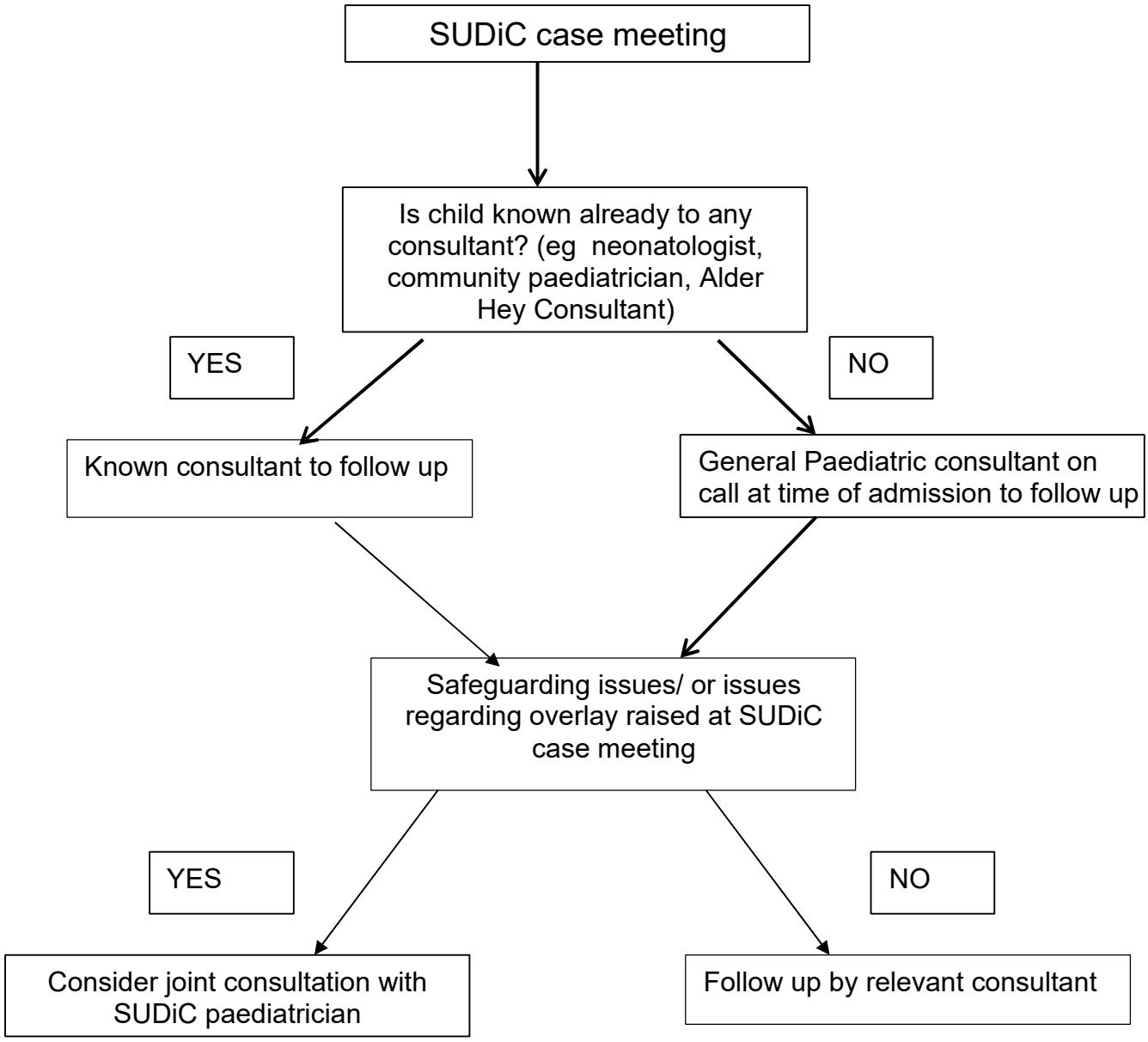
The Named Midwife / Named Nurse for Safeguarding Children will lead and co-ordinate the Trust response to the SUDiC following the reporting to the Police and HM Coroner.
All information, documentation and medical records will be updated and maintained. All health records will be secured by the Named Midwife / Nurse – in working hours / next working day, the safeguarding team will download all medical records and save on secure safeguarding drive.

SUDiC strategy meeting should be called by the LA within 24 hours of the notification of death.
This will be arranged by the LA and the Named Doctor Safeguarding Children +/- Lead Consultant and the Named Midwife / Nurse /Head of Safeguarding will attend.
SUDIC case meeting will be held withing 3 working days of death, and ongoing SUDIC meetings as required pending the final corners report.

Key message: Any sudden and/or unexpected death of an infant must be reported to the coroner and police informed
Please refer to Pan Merseyside SUDiC protocol on LWH intranet

APPENDIX F - SUDiC Follow Up Flowchart – Wirral

Follow Up of SUDiC Families

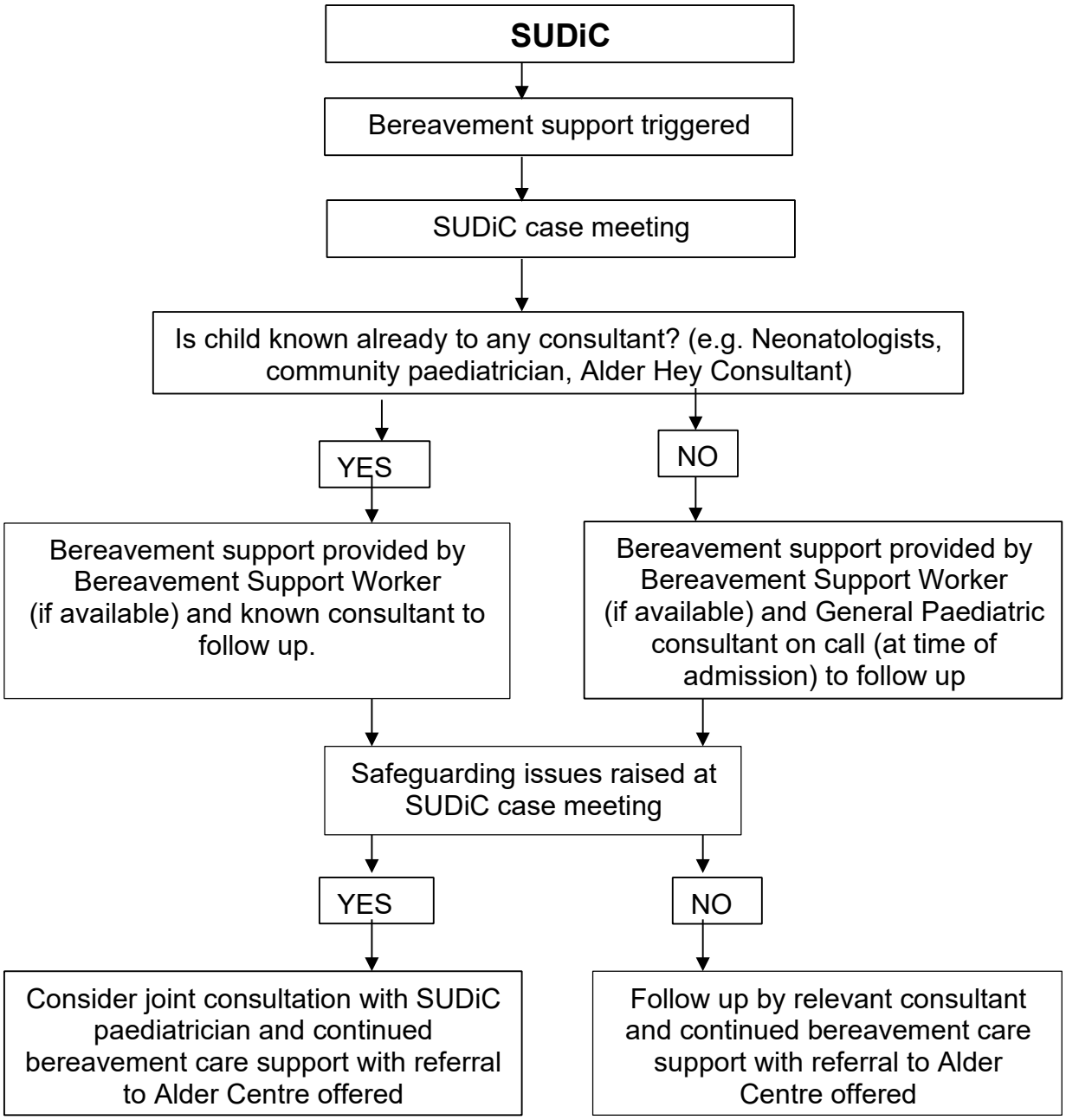


Notes:

- CDOP Paediatrician or named nurse for safeguarding will attend SUDiC case meeting and will then contact relevant paediatrician to arrange follow-up.
- Minutes of SUDiC case meeting to be forwarded to relevant consultant.
- Relevant social information to be passed on e.g., is it appropriate to see parents together or separately?
- Follow up usually to be offered at around 6 weeks following death however SUDiC panel to advise if FU required sooner

APPENDIX G – SUDiC Follow Up Flowchart – Merseyside except Wirral

Bereavement Support for SUDiC Families



Notes

- CDOP paediatrician and/or named nurse for safeguarding will attend SUDiC case meeting and will then contact relevant paediatrician to arrange follow up.
- Minutes of SUDiC case meeting to be forwarded to relevant consultant.
- Relevant social information to be passed on to relevant Consultant and BCS (e.g., is it appropriate to see parents together or separately?)
- Follow up usually to be offered at around 6 weeks following death however SUDiC panel to advise if follow up required sooner

APPENDIX H

CONSENT FORM FOR BLOOD/URINE TESTING

You have been asked to provide a voluntary sample of blood for analysis. This is a routine part of the investigation process.

The sample will be screened for alcohol and drugs. If the test results show considerable amounts of substances within your blood this may be used against you in criminal proceedings and/or family court proceedings.

In exceptional circumstances or, in the event that blood cannot be taken, a urine sample may be given.

I have read the above and have had it explained to me and I agree to provide a sample.

Signature ……

Date/Time ……..

APPENDIX I – Merseyside Police Checklist

Post-mortem

It is the role of the senior detective to attend the post-mortem examination and to fully brief the pathologists with the following:

a. A copy of the completed medical pro-forma.

b. Continuity / sequence of all events leading to the death, preferably with photographs / video with the following information:

- The position in which the baby was found and, if co-sleeping, the position in relation to the co-sleeper(s).
- The child's clothes.
- Details of the bedding.
- Room temperature and type of heating.
- Any history of smoking / alcohol consumption / drug use in the house with details of amounts and timing.
- Time of last feed including details of food given by whom and when.

c. Copy case notes of obstetric and paediatric period.

d. Copy of GP record.

e. Copy of ambulance attendance sheet.

f. Details of any resuscitation including by whom and when.

g. List of investigations initiated, or samples taken by the A&E Doctors and any results when available.

When dealing with SUDiC all agencies need to follow 5 common principles, especially when having contact with the family:

- Adopt a sensitive, open-minded, balanced approach.
- An inter-agency response.
- Appropriate sharing of information.
- Appropriate response to the circumstances.
- Preservation of evidence.

Further reading - available on the intranet

Investigators Check List

- ✓ If first on scene liaise with Paramedics, make a visual check of child and scene, note visible injuries and establish original position and current position of child.
- ✓ Follow “Golden Hour” principles.
- ✓ Identify scene(s) and parameters.
- ✓ Note the location of any objects proximal to the body of the child, which may have some relevance and preserve them in situ.
- ✓ Establish family tree.
- ✓ Prepare a ‘timeline’ of movement of the infant, parent(s) / carer(s) over previous 24 hours (including all present and siblings).
- ✓ Record temperature of the scene.
- ✓ List all people present at scene and, if possible, note the clothing worn by people at the scene other than professionals.
- ✓ Note general hygiene and availability of food and drink (neglect issue).
- ✓ CSI to video / photograph the scene.
- ✓ Record parent(s) / carer(s) current demeanour, include details of alcohol, tobacco, drugs, medication taken and when.
- ✓ Obtain and record early account from parent(s) / carer(s) and include:
    - Medical history of the child and family including previous infant death.
    - Medication prescribed / administered to the infant (seize).
    - Where infant was, sleeping position and clothing worn.
    - When last fed, by whom and food content. Seize if possible.
    - When nappy last changed and by whom. Seize if possible.
    - Health and demeanour of child 48-72hrs prior to death.
    - Last seen alive and by whom.
    - What caused adult to look / check on infant.
- ✓ Complete Form 97 and forward to Coroners Officer ASAP.
- ✓ Request blood samples from the parent(s) / carer(s) using the consent to blood / urine testing form under Appendix H SUDiC Protocol.
- ✓ Detective inspector to co-ordinate Strategy Discussion / Meeting.

APPENDIX J – Initial Strategy Meeting Agenda

Sudden Unexpected Death in Childhood (0-18 years)

Agenda for Initial Strategy Meeting

Professionals invited should make every effort to attend or provide details via a written report or discussion with the Chair beforehand.

Every strategy meeting held should confirm the following at the start of the meeting:

- Family details with names and dates of birth identifying clearly the deceased infant or child and their date of death.
- Address of mother, father, siblings.
- Details of any significant others.
- Ethnicity; gender; any disabilities of family members.

Agenda Items

1. Introductions and Apologies

2. Information relating to the SUDiC

3. Details of strategy discussion: date, time; agreed action plan and agency participants, initial investigation outcome; photographic evidence of scene (not child) available

4. Were blood tests from parents/supervising adults requested and if so, what was the outcome?

5. Background information for the child, family and significant others: *this should include health prior to any incident; history of any safeguarding issues relating to the infant/child or any other family members*

6. Current or previous involvement with agencies/services: specify which agency/services, in what capacity and with whom: *obtain a summary of the extent of involvement*

7. Consideration of safeguarding issues for surviving children

8. Results of post-mortem (interim as appropriate); testing progressed; briefing of Pathologist regarding strategy discussion

9. Contact with Coroner

10. Summary of information

11. Plan of investigation: s17/s47/criminal investigation/scene management/statements/ interviews/consideration for Practice Learning Review Process/Serious Incident notification.

12. Restrictions on viewing the infant/child's body: any amendments required

13. Co-ordination of professionals' contact with the family: specify who, what and when: consider follow up meeting with Consultant/ Community Paediatrician

14. Support strategy for bereaved family: specify who, what and when. Consider FLO/bereavement support worker/social worker/health practitioner/school/education

15. Agreed information to be fed back to family: what, by whom and when

16. Staff welfare

17. Press strategy

18. Review date: set for 8-16 weeks from initial meeting, convene as an interim if necessary, when a further final date should be set

COMPILE AGREED ACTION PLAN AND TIMESCALES

SUDiC Strategy Meeting Chair needs to ensure that copies of strategy meeting notes are sent to the Coroner; LSCP; and CDOP within 10 working days and that the SUDiC monitoring form is completed and returned to CDOP at CDOPTeam@liverpool.gov.uk

APPENDIX K - Review Strategy Meeting Agenda

Sudden Unexpected Death in Childhood (0-18 years)

Agenda for Review Strategy Meeting

Professionals invited should make every effort to attend or provide details via a written report or discussion with the Chair beforehand.

Agenda Items

1. Introductions and apologies
2. Information relating to the progress of the SUDiC action plan including progress of investigation and results of any tests pursued
3. Feedback on progress of any other investigations undertaken e.g., s47, criminal
4. Feedback regarding contact with Consultant/Community Paediatrician
5. Information relating to bereavement support and the wellbeing of family members
6. Contact with Coroner and status of Inquest
7. Summary of progress and any outstanding issues
8. Confirm ongoing support strategy for bereaved family and others if required:
9. Agreed information to be fed back to family: what, by whom and when
10. Staff welfare
11. Press strategy
12. Review date: if the current meeting is deemed an interim and a further review strategy is felt necessary

COMPILE AGREED ACTION PLAN AND TIMESCALES

SUDiC Strategy Meeting Chair needs to ensure a copy of the review strategy meeting notes are sent to HM Coroner, LSCP, and CDOP within 10 working days.

APPENDIX L - Agency Invitation List

AGENCIES TO BE INVITED TO SUDiC STRATEGY MEETINGS FOR 0-2 YEARS

- Consultant Paediatrician or colleague presenting information relating to child death
- Hospital Named Nurse and/or Safeguarding Children Specialist Nurse
- North West Ambulance Service
- Merseyside Police: SIO or representative
- Bereavement Services
- Maternity Hospital – Midwifery Services
- Health Visitor and Safeguarding Children Specialist Nurse
- Any agencies involved with the family: Potential agencies:
    - Children's Centre/Nursery
    - School
    - Merseycare
    - Drug/Alcohol Services
    - Voluntary Agency
    - Housing representative if appropriate
    - Merseyside Probation
    - Any agency known to be involved with the family

FOR 2-18 YEARS:

- Remove MATERNITY HOSPITAL unless appropriate to include based on circumstances
- Include EDUCATION
- Include SCHOOL HEALTH and SAFEGUARDING CHILDREN SPECIALIST NURSE
- Consider YOUTH OFFENDING SERVICE

APPENDIX M: PROFORMA FOR RECORDING INITIAL STRATEGY MEETINGS

CONFIDENTIAL

SUDDEN UNEXPECTED DEATH IN INFANCY/CHILDHOOD
INITIAL STRATEGY MEETING

Minutes of Meeting held on (date/time)
In (venue)

Present:

Apologies:

Minutes:

Family Composition:

Name of child:
Gender:
Date of birth:
Date and time of death:
Address:
Ethnicity:
Disabilities:

Mother's name:
Mother's date of birth:
Mother's address (if different from above):
Ethnicity:
Disabilities:

Father's name:
Father's date of birth:
Father's address (if different from above):
Ethnicity:
Disabilities:

Sibling's name:
Sibling's date of birth:
Sibling's address (if different from above):
Ethnicity:
Disabilities:

Significant family member's name:
Significant family member's date of birth:
Significant family member's address (if different from above):
Ethnicity:
Disabilities:

	Agenda Item	**Action**
1.	**Introductions and Apologies**	
2.	**Information relating to the SUDI/SUDC including photographic evidence of the scene**	
3.	**Details of strategy discussion, date; time; agreed action plan and agency participants; initial investigations outcome**	
4.	**Were blood tests from parents/supervising adults requested and if so, what was the outcome?** **If blood tests were refused were urine tests requested**	
5.	**Background information for the child, family and significant others** (this should include health prior to any incident, history of any safeguarding issues relating to the infant/child or any other family members)	
6.	**Current or previous involvement with agencies/services: specify which agency/services, in what capacity and with whom** (obtain a summary of the extent of involvement)	

7.	**Consideration of safeguarding issues for surviving children**	
8.	**Results of post-mortem (interim as appropriate); testing progressed; briefing of Pathologist regarding strategy discussions**	
9.	**Contact with Coroner**	
10.	**Summary of information**	
11.	**Plans of investigations: s17/s47/criminal investigations/scene management/statements/interviews/consideration for Practice Learning Review Process/Serious Incident Notification**	
12.	**Restrictions on viewing the infant/child's body: any amendments required**	
13.	**Co-ordination of professionals contact with the family: specify who, what and when: consider follow up meeting with Consultant/Community Paediatrician**	

14.	**Support strategy for bereaved family: specify who, what and when. Consider FLO/bereavement support worker/social worker/health practitioner/school-education**	
15.	**Agreed information to be fed back to family: what, by whom and when**	
16.	**Staff welfare**	
17.	**Press strategy**	
18.	**Review date** (set for 8-16 weeks from initial meeting, convene as an interim if necessary, when a further final date should be set)	
19.	**Referral for Practice Learning Review Consideration** Does the information relating to this child death require consideration by the Serious Incident Review Group? If so, the relevant LSCP procedures for notification to SIRG should be followed.	

Name
Designation

ACTION PLAN

	Action	By Whom	Timescale	Outcome
1.				
2.				
3.				
4.				
5.				
6.				
7.				

APPENDIX N

SUPPORT AGENCIES

Alder Centre
Providing bereavement care and education for anyone affected by the death of a child of any age
www.aldercentre.org.uk
0151 252 5391
Alder.centre@alderhey.nhs.net

Bereaved Parents Support Organisations Network (BPSON)
Umbrella body for organisations supporting bereaved parents
www.bpson.org.uk
enquiries@bpson.org.uk

Bereaved Parent Support, Care for the Family
Peer support for bereaved parents, including a telephone befriending service
www.careforthefamily.org.uk/bps
029 2081 0800

Bliss
Information and support for families of babies born premature or sick
www.bliss.org.uk
0808 801 0322
hello@bliss.org.uk

Care for the Family
Peer support for any parent whose son or daughter has died at any age, in any circumstance and at any stage of their journey of grieving
www.cff.org.uk/bps
029 2081 0800
bps@cff.org.uk

Child Bereavement UK
Training for professionals, support for families and directory of local support services
www.childbereavementuk.org
0800 02 888 40

Child Death Helpline
For anyone affected by the death of a child of any age from any cause
www.childdeathhelpline.org.uk
0800 282 986 or 0808 800 6019

The Compassionate Friends
Peer support for bereaved parents and their families
www.tcf.org.uk
0845 123 2304

The Lullaby Trust
Support for anyone affected by the sudden death of a baby or young child
www.thelullabytrust.org.uk
0808 802 6868
support@lullabytrust.org.uk

Sands
For anyone who has been affected by the death of a baby
https://www.uk-sands.org/support
0808 164 3332

Survivors of Bereavement by Suicide
Support for people over 18 who have been bereaved by suicide
https://uksobs.org/
0300 111 5065

Twins Trust
Support for anyone affected by the death of a multiple
www.twinstrust.org/
0800 138 0509
enquiries@twintrust.org

Winston's Wish
Supporting children and their families after the death of a parent or sibling
www.winstonswish.org.uk
08088 020 021

There are also a number of useful organisations who hold information about the smaller, specialised and local organisations for bereaved families.

The Childhood Bereavement Network
www.childhoodbereavementnetwork.org.uk

A Child of Mine
www.achildofmine.org.uk

At A Loss .Org
www.ataloss.org

The Good Grief Trust
www.thegoodgrieftrust.org

HOSPITAL CONTACT NUMBERS

HOSPITAL	CONTACT NUMBER
Aintree	0151 525 5980
Alder Hey	0151 228 4811
Arrowe Park	0151 678 5111
Liverpool Women's	0151 708 9988
Ormskirk	01695 656358
Royal Liverpool	0151 706 2000
Southport	01704 547471
Walton Centre	0151 525 3611
Whiston	0151 426 1600