

During the COVID-19 pandemic, the central aims of the JAR still apply. While the circumstances in which a JAR is required are unchanged, how they are enacted may need to change depending on circumstances and you may need to refer to the Child deaths during the COVID-19 Pandemic: Guidance for Professionals

The Management of Sudden and Unexpected Deaths in Childhood (SUDC)*

**Blackburn with Darwen, Blackpool & Lancashire
Guidelines**

***Children aged under 18**

October 2019



**Lancashire
Constabulary**
police and communities together



The Management of Sudden and Unexpected Deaths in Childhood

Part I: Guidelines

This part covers the principles and practice of the management of sudden unexpected death in children being those under 18 years of age.

Part II: Roles & Responsibilities

This part covers individual roles and responsibilities in relation to the management of a sudden unexpected death in childhood.

Table of Contents

THE MANAGEMENT OF SUDDEN AND UNEXPECTED DEATHS IN CHILDHOOD (SUDC) PART I	5
1. INTRODUCTION	6
1.1 Principles	7
1.2 Terminology	7
1.3 Definitions	7
1.4 SUDC Nurse Contact Details	8
2. IMMEDIATE DECISION MAKING AND NOTIFICATIONS	9
2.1 Issuing an MCCD (Medical Certificate of the Cause of Death) or referral to Coroner	9
Issuing an MCCD (Medical Certificate of the Cause of Death) or referral to Coroner	9
2.2 Coroner's Contact Details	9
2.3 The Post Mortem Examination	9
2.4 What immediate decisions are needed if the death is regarded as unexpected?	10
3. INVESTIGATION AND INFORMATION GATHERING	12
3.1 Joint Agency Response	12
3.2 Initial Assessment and Management	12
3.3 JOINT AGENCY RESPONSE FLOW CHART	14
3.4 Emergency Department	15
3.5 Confirmation of death	15
3.6 Examination of the body	15
3.7 Initial History Taking	16
3.8 Assessment of the environment and circumstances of death	18
3.9 Initial information sharing and gathering	19
4. INITIAL SUDC MEETING	20
4.1 Initial Strategy Meeting	20
4.2 HM Coroner	21
4.3 Post Mortem Examination	22
5. ORGAN & TISSUE DONATION	27
5.1 Consent/Authorisation	27
6. CHILD DEATH REVIEW MEETING (CDRM)	29
6.1 Aims of the CDRM	29
6.2 Who should attend the CDRM?	30
6.3 Where should the meeting take place?	30
6.4 When should the meeting occur?	30
6.5 Family Engagement	31
7. REVIEW OF CHILD DEATH AT CHILD DEATH OVERVIEW PANEL (CDOP)	32
7.1 Child Death Overview Panel Meeting	32
7.2 CDOP Panel Membership & Responsibilities	32

7.3 Notifying CDOP	32
8. UNUSUAL CLINICAL SITUATIONS & SPECIFIC SITUATIONS	34
8.1 Unusual Clinical Situations	34
9. SPECIFIC SITUATIONS	35
9.1 Deaths overseas of children normally resident in England	35
9.2 Children with learning disabilities	35
9.3 Deaths of children in adult healthcare settings	36
9.4 Inpatient Mental Health Settings	36
9.5 Deaths in custody	37
9.6 Deaths by Road Traffic Collisions	37
9.7 Suicide and Self-harm	38
9.8 Guidance for CAMHS and ELCAS teams following the sudden unexpected death of a school aged child	40
9.9 Concealed and denied pregnancy	41
9.10 Cross Boundary working	41
9.11 Mass fatalities	42
10. FAMILY ENGAGEMENT AND BEREAVEMENT SUPPORT	43
10.1 The team around the family	43
10.2 What Bereaved Parents Should Expect Following Their Child's Death	44
10.3 End of Life Planning for Children and Young People with Life Limiting/Life Shortening Conditions	45
10.4 When a child dies and an NHS Serious Incident Investigation is instigated	45
THE MANAGEMENT OF SUDDEN UNEXPECTED DEATHS IN CHILDHOOD (SUDC) PART II	47
11. ROLE OF THE SUDC NURSE	48
12. ROLE OF THE POLICE	50
13. CHILDREN'S SOCIAL CARE	51
14. AMBULANCE GUIDELINES	52
15. HOSPITAL STAFF	54
15.1 Unexpected death of a child on a ward	57
15.2 Deaths of Babies Never Discharged From Hospital	57
15.3 Concealed and denied pregnancy	58
15.4 Staff Welfare	58
16. THE GENERAL PRACTITIONER (GP)	59
17. COMMUNITY HEALTH PROFESSIONAL	60
18. MIDWIFE	61
18.1 Deaths of infants never discharged from hospital	62
18.2 Concealed and denied pregnancy	63
19. CORONER AND PATHOLOGIST	64
20. REFERENCES	66
21. TERMINOLOGY	67
APPENDIX 1 CRITERIA FOR REFERRAL OF DEATHS TO CORONER	71

APPENDIX 2 EXAMINATION OF THE INFANT WHO HAS DIED SUDDENLY AND UNEXPECTEDLY	72
APPENDIX 3 FINAL SLEEP CHECKLIST	76
APPENDIX 4 IDENTIFICATION AND REFERRAL FOR POTENTIAL ORGAN DONORS	77
APPENDIX 5 SUPPORT FOR THE BEREAVED	79
APPENDIX 6 BEREAVEMENT RESOURCES	80
APPENDIX 7 POLICE REQUESTS FOR BLOOD AND/OR URINE SAMPLES	83
APPENDIX 8 RECOMMENDED FORM OF WORDS TO BE USED FOR <i>VOLUNTARY</i> SAMPLES REQUEST	84

THE MANAGEMENT OF SUDDEN AND UNEXPECTED DEATHS IN CHILDHOOD (SUDC) PART I

Part I: Guidelines

This part covers the principles and practice of the management of sudden unexpected death in children being those under 18 years of age.

1. INTRODUCTION

The death of a child is a devastating loss and profoundly affects bereaved parents as well as siblings, grandparents, extended family, friends and professionals who were involved in caring for the child in any capacity. Families experiencing such a tragedy should be met with empathy and compassion. They need clear and sensitive communication. They also need to understand what happened to their child and know that people will learn from what happened. The process of expertly reviewing all children's deaths is grounded in deep respect for the rights of children and their families, with the intention of preventing future child deaths.

This protocol aims to set out the processes to be followed when responding to, investigating and reviewing the sudden and unexpected death of a child, from any cause. No guidance document could adequately do justice to the complexity that unfolds after the death of a child. However, this protocol will attempt to clarify processes and set out high-level principles for how professionals across all agencies in the child death review process should work together.

This document complies with, and should be read in conjunction with the following statutory and operational guidance:

Working Together to Safeguard Children, HM Government (2018)

Child Death Review Statutory and Operational Guidance, HM Government (2018)

Sudden and Unexpected Death in Infancy and Childhood: Multiagency Guidelines for Care and Investigation (2016): *The report of a working group convened by the Royal College of Pathologists and endorsed by The Royal College of Paediatricians and Child Health (Kennedy Guidelines).*

For the purpose of this protocol a child is defined as a child or young person from birth (excluding both those babies who are stillborn and planned terminations of pregnancy carried out within the law) up to the age of 18 years. This includes the death of any live-born baby where a death certificate is issued. In the event that the birth is not attended by a healthcare professional a Joint Agency Response (previously referred to as a Rapid Response) should be triggered and initial enquiries made to determine whether or not the child was born alive. For the avoidance of doubt, it does not include stillbirths, late foetal loss, or terminations of pregnancy (of any gestation) carried out within the law:

- Stillbirth: baby born without any signs of life after 24 weeks gestation
- Late foetal loss: where a pregnancy ends before 24 weeks gestation

The response does however include stillbirths where no healthcare professional was in attendance. For example, this would include circumstances where a child is born apparently unexpectedly in a domestic dwelling, or elsewhere.

This protocol also refers to those children who die unexpectedly in the early neonatal period, unexpected deaths for which a natural cause is not immediately apparent, and deaths from external causes, including accidents, suicides and possible homicides (recognising that where a Police criminal investigation is required, all other multi-agency processes must be consistent with any Police investigation priorities). This document also recognises that the exact process followed may require modification according to the age of the child and the specific circumstances.

All cases of unexpected deaths will receive a Joint Agency Response. Although this guidance applies to most cases, specific circumstances may dictate the investigation. The multidisciplinary approach may deviate from the guidance after due consideration and discussions with relevant professionals such as the Coroner, Police, SUDC Nurse, clinicians and colleagues from other agencies. All decision-making processes should be documented to inform the Child Death Overview Panel (CDOP). Whatever actions are taken by the relevant agencies, adherence to recommended procedures will be under public scrutiny at any criminal trial or Coroner's inquest.

This protocol does not include expected deaths due to natural disease processes. In those cases of children, with existing life-threatening conditions or complex needs which threaten life, and the child dies in a manner or at a time that was not anticipated, the Joint Agency Response Team will liaise closely and promptly with a member of the medical, palliative or end-of-life care team who knows the child and family, to jointly determine how best to respond to that child's death.

The aims of the Joint Agency Response in all unexpected child deaths are to:

- establish, as far as is possible, the cause or causes of the child's death
- identify any potential contributory or modifiable factors
- provide ongoing support to the family
- ensure all statutory obligations are met
- learn lessons in order to reduce the risks of future deaths

1.1 Principles

When dealing with sudden unexpected child deaths all agencies need to follow these common principles:

- A sensitive, caring, open minded and balanced approach
- An interagency response
- Sharing of information
- Appropriate response to the circumstances
- Preservation of evidence

1.2 Terminology

Please refer to Appendix 1 for further information.

1.3 Definitions

The definition of an **unexpected death** is defined as the death of an infant or child (less than 18 years old) which was not anticipated as a significant possibility for example, 24 hours before the death; or where there was a similarly unexpected collapse or incident leading to or precipitating the events which led to the death.

In cases where clarity is needed to establish if the death is unexpected or expected a discussion with the SUDC Nurse and Paediatrician (or appropriate medical professional) should take place. The decision made and rationale for the decision should be clearly documented.

The Child Death Review Guidance (HM Government 2018) broadens the unexpected death definition and states that a Joint Agency Response should be triggered if a child's death:

- Is or could be due to external causes;
- Is sudden and there is no immediately apparent cause of death (incl. SUDC);
- Occurs in custody, or where the child was detained under the Mental Health Act;
- Where the initial circumstances raise any suspicions that the death may not have been natural;
- In the case of a stillbirth where no healthcare professional was in attendance, and
- If a child is brought to hospital, near death and is successfully resuscitated but is expected to die in the following days.

In any of these circumstances, the SUDC Nurse/on-call Consultant Paediatrician and Police should be contacted immediately so as to initiate the Joint Agency Response

1.4 SUDC Nurse Contact Details

The SUDC Nurses provide a Blackburn with Darwen, Blackpool & Lancashire SUDC Service and can be contacted Monday-Sunday, including Bank Holidays, between the hours of 9am-5pm. The SUDC Nurses are based at:

2ND Floor, Daisyfield Mill, Appleby Street, Blackburn, BB1 3BL

Contact details:

Lindsay Hargreaves, SUDC Administrator: (01254) 283997
Safeguarding Team office telephone number: (01254) 283399
Joanne Birch, Lead SUDC Nurse: 07930852073
Julie Roach, Specialist SUDC Nurse: 07956626389
Louise Masters, Specialist SUDC Nurse: 07973 967094

The SUDC Nurse Duty rota can be accessed:

On Sherlock (Police Intranet)
In all five Emergency Departments (ED):

Royal Blackburn Hospital ED, Haslingden Road, Blackburn, BB2 3HH
Blackpool Victoria Hospital ED, Whinney Heys Road, Blackpool, FY3 8NR
Lancaster Royal Infirmary ED, Ashton Road, LA1 4RP
Ormskirk and District General Hospital, Dicconson Way, Wigan Road, Ormskirk, L39 2AZ
Royal Preston Hospital, Sharoe Green Lane, Fulwood, Preston, PR2 9HT

2. IMMEDIATE DECISION MAKING AND NOTIFICATIONS

This section relates to the immediate actions to be taken following the unexpected death of a child.

2.1 Issuing an MCCD (Medical Certificate of the Cause of Death) or referral to Coroner

This section relates to the immediate actions to be taken following the unexpected death of a child.

Issuing an MCCD (Medical Certificate of the Cause of Death) or referral to Coroner

An unexpected death may be sufficiently explained – by its clinical presentation, or early laboratory or radiological findings - so that the attending doctor is able to issue a MCCD. In this situation it may not be necessary or appropriate to institute these guidelines.

However, some of these deaths may be regarded as unexpected but explained. In which case, information should still be shared with the SUDC Nurse.

In all unexpected deaths where a medical practitioner is unable to issue a MCCD, it is the responsibility of the Coroner to determine the cause of death and to ensure that all statutory requirements around registration are met. In order to do this, the Coroner is dependent on the information provided by the professionals involved in caring for the child and responding to the death. All professionals involved in the Joint Agency Response have a responsibility to work with the Coroner in achieving these aims.

No action in relation to the deceased child should be taken by any professional without the prior agreement of the Coroner. In Lancashire, a standard response has been agreed. The Lead Police Investigator and hospital staff will inform the Coroner of an unexpected child death. After discussion, generally the Police will take the lead on this according to local arrangements with each of the Coroner's office of all unexpected deaths of children. The Chief Coroner has issued guidance on which deaths should be reported to the Coroner (see Appendix 2).

2.2 Coroner's Contact Details

Lancashire: HM Senior Coroner - Dr James Adeley (01772 536536)

Blackpool: HM Senior Coroner – Mr Alan Wilson (01253 477128)

Following notification, the Coroner may decide one of the following:

- That there is no need for further investigation – the attending doctor can then issue the MCCD without any coronial action;
- That the MCCD is agreed but that a coronial Form 100A or 100B (no further Coroner investigation) will be provided to the local registrar to support the cause of death; or
- The rationale for investigation is accepted, in which case no MCCD is issued. At the conclusion of the investigation the Coroner will notify the cause of death to the registrar.

2.3 The Post Mortem Examination

In deaths where a MCCD can be issued a hospital post mortem examination may still provide information as to why a child has died. It is the right of the parents to request a hospital post mortem examination if this is their wish and the Coroner is not investigating the death. It is therefore good practice to inform the family of the benefits of a post mortem examination and what the process entails, so that they can make an informed decision regarding giving their consent for one to occur. If the family wish to pursue a hospital post mortem examination this will be arranged without involvement of the Coroner.

If the Coroner requires a post mortem examination as part of his/her investigation parental consent is not required and parents cannot refuse the examination.

2.4 What immediate decisions are needed if the death is regarded as unexpected?

North West Ambulance Service (NWAS) are more often than not the professionals to notify the Police that a child has been found unresponsive or deceased and that they are en route to the nearest Emergency Department. Limited details may be known at this stage however, the Police should inform the SUDC Nurse and a decision is made as to whether the death or potential death, meets the criteria for a Joint Agency Response.

If the child's death falls within the definition of an unexpected death, then a Joint Agency Response is initiated. The Police and SUDC Nurse attend the Emergency Department, or depending on the circumstances, the scene of death and the investigation and information gathering process begins (see Section 3).

Similarly, if the child dies in hospital, i.e., on the ward or in NICU and the death is regarded as unexpected, a Joint Agency Response should be initiated but tailored to meet the circumstances.

The Police/SUDC Nurse need to contact Children's Social Care promptly. The Police/SUDC Nurse should telephone the MASH (Multi-Agency Safeguarding Hub) in the area in which the child died, or the Emergency Duty Team, if out of hours. This is to inform Children's Social Care that a child has died and to establish if the child/family are known to Children's Social Care. In relation to any children who are not allocated to a Social Worker, any siblings would be considered by MASH in relation to support needs. It is likely that targeted support would be offered, as well as a decision to take no further action if no concerns are identified.

If a child from out of area dies in Lancashire, contact should be made with the Children's Social Care in the area in which they normally reside in order to notify and gather information. Lancashire Children's Social Care would also be notified.

On notification of a child death, each Local Authority should follow their own procedures as stated below:

For children in **Blackburn with Darwen**, the Head of Service would be notified of any child death open or previously open to Children's Social Care (i.e. if a Child and Family Assessment has been completed, Child in Need, Child Protection or Looked After). The Head of Service will ascertain full details as far as possible from Police and any other service, and ensure that all files are secured and locked down. The Head of Service will ensure there is a referral to CDOP and inform Ofsted and the national Child Safeguarding Practice Review (CSPR) Panel, where applicable, using the Notification Form for Serious Childcare Incidents (Ofsted). In urgent situations, the Director of Children's Services should telephone Ofsted and then complete the form. The SUDC Nurse will also inform the Director of Education for Blackburn with Darwen should there be an unexpected death of a school aged child.

If a child in **Lancashire** (Lancashire County Council) has died and abuse or neglect is suspected or if there is a sudden unexplained death of a child/young person (no suspicious circumstances at the time) a significant event form must be completed on the day of the incident and submitted via the full line management route, Head of Service for the District, Director of Children's Services, Head of Service SIA, Safeguarding Manager. The Safeguarding Manager will collate a full response and will brief the relevant Directors and Heads of Service and where appropriate will notify Ofsted and the National Child Safeguarding Practice Review (CSPR) Panel, where applicable.

If a child in **Blackpool** has died the MASH are informed and notify the Director of Children's Services (DCS), Assistant Director & Head of Safeguarding Quality Review Service & PSW. MASH undertake partnership agency checks within 2 hours. A significant Information form is completed and provided to DCS, Assistant Director and Head of Safeguarding Quality Review & PSW. The Head of Safeguarding Quality Review & PSW informs Safeguarding Partnership Business Manager, Ofsted and the National Child Safeguarding Practice Review (CSPR) Panel, where applicable, using the Notification Form for Serious Childcare Incidents.

The Police will commence checks immediately in order to identify if the family are known to the Police for any reason. Such checks may inform immediate decision making processes in relation to the case.

Where there is any doubt about the appropriateness of a course of action, the Coroner should be consulted first. If there is any suggestion of neglect or abuse, the professionals must contact the Coroner immediately, and the Lead Police Investigator shall initiate investigations according to agreed Police procedures.

The SUDC Administrator will inform relevant senior NHS managers by email that there has been an unexpected death of a child and that a briefing regarding the circumstances will be sent out later on that working day.

Throughout the immediate decision making and notifications process, consideration should be given to how best to support the family. Parents/carers must be informed of all decisions being made regarding their child. Full explanations regarding the process and any available support should be given by either clinical staff or an identified 'key worker'.

3. INVESTIGATION AND INFORMATION GATHERING

After immediate decisions have been taken and notifications made, a number of investigations may then follow. This will vary depending on the circumstances of the case, and may run in parallel. Timescales will vary greatly from case to case.

3.1 Joint Agency Response

The Joint Agency Response consists of the following essential components. No response should be considered complete without these core components:

- careful multi-agency planning of the response
- ongoing consideration of the psychological and emotional needs of the family, including referral for bereavement support
- initial assessment and management, including a detailed and careful history, examination of the child, preliminary medical and forensic investigations, and immediate care of the family, including siblings
- an assessment of the environment and circumstances of the death
- a standardised and thorough post-mortem examination
- a final multi-professional case discussion meeting

The sequence of procedures is set out in Figure 1, pg. 14.

3.2 Initial Assessment and Management

On receipt of a 999 call indicating that an infant/child has been found unexpectedly collapsed or dead, the call centre should notify NWS ambulance control to dispatch an ambulance crew and, where appropriate, a first responder.

NWS should notify the Police and an officer should be deployed to the scene. Officers are also deployed to the hospital.

The Police must contact the SUDC Nurse on duty as soon as possible so decisions can be made regarding the initial management of the case. ***Early contact also enables the SUDC Nurse to travel to the relevant Emergency Department. This is important as it can take time depending on where in the county the nurse is. The Police and SUDC Nurse should agree a mutually convenient time to meet in the Emergency Department. (This requirement obviously does not apply in cases where the SUDC Nurse Service is not available due to working hour provision).***

On arrival at the scene, the first responder or ambulance crew should carry out an immediate appraisal of the circumstances. Unless there is clear indication that the child has been dead for some time, appropriate resuscitation should be started and continued until the child is brought into hospital.

The Paramedic/ambulance crew should inform the Emergency Department at the hospital that a child has been found unexpectedly collapsed or dead and to have the resuscitation team on standby and anticipating the arrival of the child.

The first responder/ambulance crew should elicit a very brief initial account of the circumstances and whether there are any medical issues, such as relevant past medical history or current medication of the child. They should note their impressions of the environment in which the child was found and any concerns about care. ***A copy of the ambulance crew's record should be provided to the SUDC Nurse and Police.***

Unless there are exceptional reasons not to, the child should always be brought to the nearest Emergency Department with a Paediatric facility. ***The default position should always be to attend the Emergency Department. Importantly, this process facilitates the physical examination of the child by the Lead Investigator and SUDC Nurse/ on call Consultant Paediatrician.***

However, with older children/young people, where the cause of death may be more apparent (for example a road traffic collision or suicide) a decision should be made as to the most appropriate place to transfer the child. This may be to go directly to the mortuary. Equally, it may be appropriate to take the child directly to the mortuary if decomposition has led to the risk of biohazard.

In these circumstances the Police/SUDC Nurse should liaise with the on call Consultant Paediatrician at the hospital. A discussion should take place as to where the most appropriate place is to transfer the child. The rationale for the decision must be clearly recorded. If it is agreed that the child should be taken directly to the mortuary, the Consultant Paediatrician must attend the mortuary to undertake the joint examination of the child as part of the SUDC investigation. However, if the Lead Police Investigator has concerns of loss evidence then the Paediatric joint examination may not be required, the decision to go ahead will be at the direction of the Lead Police Investigator. ***Preservation of evidence is paramount.***

If the child does not attend the Emergency Department and goes directly to the mortuary, the mortuary procedures for receiving a child, should reflect those of the Emergency Department, in that relevant professionals are notified of the child's death, as they would if the child had been admitted to the Emergency Department.

It is important to remember that all children, regardless of their age, deserve the right to a thorough investigation into their unexpected death, even if it appears obvious how they may have died.

Occasionally, a child declared deceased at the scene may need to remain in situ if there are any concerns regarding criminality. This is to allow other forensic processes to take place under the guidance of the Lead Police Investigator.

Regardless of where the child is transferred to, arrangements should be made for the family to attend the Emergency Department or mortuary, either accompanying the child in the ambulance or separately.

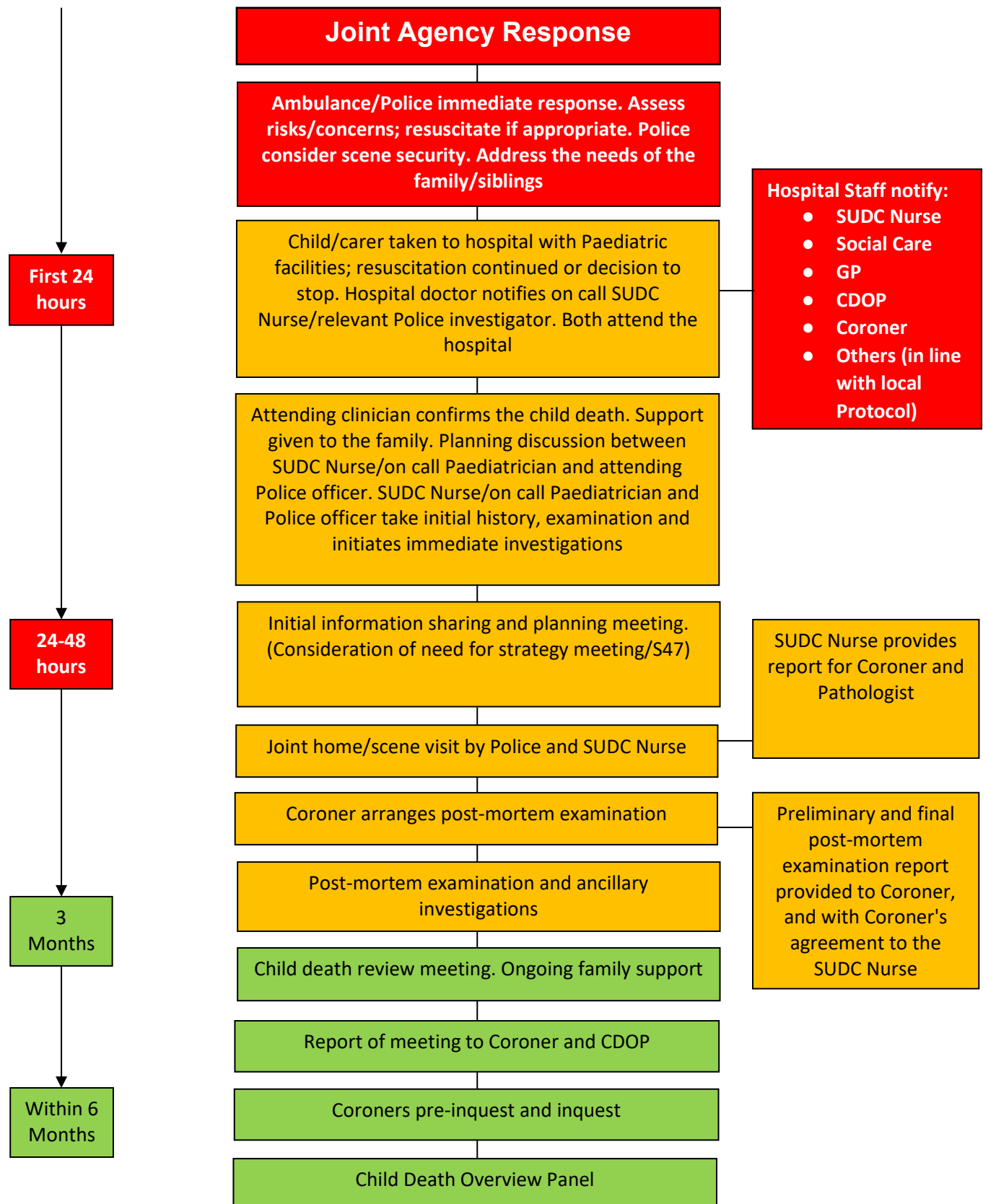
Consideration should be given to the care and welfare of any other children in the home. The attending Police Officer could assist with this.

The attending Police Officer at the scene/home address should undertake an appraisal of the environment where the child has died or was found. This may include taking a brief history from the family. ***A full and detailed account should not be taken at this stage.*** The priority is to get the child with the family to the Emergency Department. Further priorities are to ensure the safety of others, including other children in the home, and to maintain the integrity of the environment.

If there are immediate indications of abuse, neglect or assault contributing to the death, the Police will take the lead in the management, under the direction of the Lead Police Investigator. In such circumstances, and if the child is clearly dead, it may not be appropriate to move the child and the scene should be secured as for any potential crime scene.

3.3 JOINT AGENCY RESPONSE FLOW CHART

In clear suspicious cases the Lead Investigator will lead on the investigation and the child's body may remain at the scene initially.



3.4 Emergency Department

3.5 Confirmation of death

The decision to stop resuscitation should be made by a senior medical practitioner (usually the Consultant Paediatrician or Consultant in Emergency Medicine) after consultation with the resuscitation team.

Once a decision has been made to stop resuscitation, an appropriately qualified medical practitioner should confirm the child is dead, in accordance with established guidelines. Confirmation of the fact of death and the time should be recorded in the child's notes.

When the child has been pronounced dead a member of the resuscitation team, usually the on call Consultant Paediatrician, should inform the family. This should be done in the privacy of an appropriate room. An Emergency Department Nurse, usually a Paediatric Nurse, is allocated to care for the family and should be present at this time.

Emergency Department staff should follow their own SUDC procedures and notify the Police and SUDC Nurse of the unexpected death of the child. It is more than likely that they will already be aware, but staff should still make contact. Hospital staff should also notify all other agencies on their own professional checklists.

Following death, the child must not be left alone with the parents. A Nurse or attending Police Officer must stay in the room at all times. The child must not be dressed/or placed in a hat, or wrapped in a blanket. In the case of babies, a clean nappy may be put on and the baby may be covered loosely by a hospital sheet. The nappy and any clothing worn by the child on admission to ED must be retained as the Police will require this.

On arrival in the Emergency Department, the Police, SUDC Nurse, Consultant Paediatrician and NWS should have a briefing where possible. Information should be gathered from the Paramedic and Consultant Paediatrician regarding the details of the circumstances given so far and any significant observations noted.

The Police and SUDC Nurse should introduce themselves to the parents/carers and explain the processes that are about to take place. Parents should wait in another room, with support from the allocated ED nurse, whilst the examination of the child takes place.

3.6 Examination of the body

The SUDC Nurse (in hours), Consultant Paediatrician and Police (Lead Investigator) should jointly examine the child. Crime Scene Investigators (CSI) should be present to obtain photographs of the child. Those present should be kept to a minimum, those in essential roles only. Anybody else present should be at the discretion of the Lead Police Investigator.

The SUDC History Record should be used to record the findings of the examination and the body map should be completed (this can be found on internal systems or on your intranet).

Notes should be made of any marks, abrasions, rashes, evidence of dehydration or identifiable injuries at this time. The presence of any discolouration of the skin, particularly dependent livido should be carefully and accurately documented, along with any other findings, such as frothy blood-stained fluid from the airways and rigor mortis. See Appendix 3 for further information on the examination of the child that has died suddenly and unexpectedly.

Where possible, the eyes should be examined by direct fundoscopy for the presence of retinal haemorrhages. A Consultant Ophthalmologist should be asked to do this if available (in hours). This is considered best practice, but may not always take place. The findings of this examination should be recorded in the SUDC History Record.

If resuscitation has been attempted, any intravenous, intra-arterial, intra-osseous lines or endotracheal tubes inserted for this purpose should remain in situ. All medical interventions, including sites of attempted vascular access, should be carefully documented on the body map.

If blood samples were taken prior to death in the Emergency Department (or on the ward) the results should be made available to the Pathologist.

Kennedy samples post-death are not taken in the Emergency Department as these will be taken by the Pathologist at the post mortem examination. Where the circumstances of the death indicate the child may have died approaching 48 hours earlier, the Lead Police Investigator should consider liaison with Specialist Paediatric Pathology at the regional children's hospitals. Subject to that discussion samples will be taken locally or at the regional hospitals. This is to ensure that the impact of decomposition on the Kennedy Samples is effectively mitigated.

A full radiological Skeletal Survey will be undertaken prior to the post mortem examination at Alder Hey Children's Hospital and at Royal Manchester Children's Hospital. It should be performed and reported by an experienced Paediatric Radiologist prior to the post mortem examination being commenced.

The skeletal survey does not need be performed at the local hospital. However, the exception to this is Blackpool Victoria Hospital who may undertake a skeletal survey following a child death, after each case is considered on its own individual merits and discussed with the Consultant Paediatrician and Lead Police Investigator.

The clothing worn by the child should be seized by the Police, along with the nappy, blanket or bedding if necessary. Once the child has been examined and all findings recorded, the infant/child can be placed in a clean nappy and given to the family to hold if they wish. ***Permission should always be sought from the Lead Police Investigator first. Please note, babies should not be wrapped or swaddled in a blanket, neither should a hat be placed on the baby's head. This can affect post mortem changes and interfere with forensic evidence.***

Health staff in the Emergency Department should offer the family the option of mementoes being taken such as handprints, footprints, a lock of hair and photographs. This should be done sensitively, recognising that this can be important for many families but will not be wanted by all. ***Hospital staff should seek guidance from the Lead Police Investigator before taking mementoes.***

If there are safeguarding concerns or suspicious circumstances surrounding the death, the taking of mementoes should be discussed with the Lead Police Investigator to ensure this does not interfere with any investigation; in such circumstances it may be appropriate to delay this until after the post mortem examination. Local procedures will apply in each regional Children's hospital.

3.7 Initial History Taking

Following the examination, the Police and SUDC Nurse, or the on call Consultant Paediatrician, should decide who will take the lead on gathering a history from the parents. A detailed and careful history should be obtained from the family. Parents may need to be spoken to separately. This history should be obtained by the SUDC Nurse/Consultant Paediatrician and Police together to avoid the need for repeated questioning, local policy should be adhered to with regards to the use of professional interpreters.

The SUDC History Booklet should be used to record all information obtained. This is a multi-agency document that is available to all professionals involved with the Joint Agency Response (on Sherlock for the Police and hospital systems for the Paediatrician). The SUDC Nurse will generally lead on completing this documentation however, out of hours the Police or Consultant Paediatrician must use the SUDC History Record when obtaining an account from the parents.

Where there are any suspicious circumstances surrounding the child's death, it may be necessary for the Police to interview the parents or the primary carers at the time of death. In such circumstances, it is ***still***

important to obtain a full and careful medical history. The Police and SUDC Nurse/or on call Consultant Paediatrician, allocated nurse should have a coordinated plan of how they conduct the information gathering process prior to speaking to the parents.

When using the SUDC History Record the history taker will be guided through a series of questions to ask the parents/carers. The history should include a careful review of the past medical history, including pregnancy and birth, the child's growth and development, any relevant social history, and the events leading up to and following the child's collapse. It is important that, as far as possible, the family's account of events should be recorded *verbatim*.

The events leading up to death should give a detailed narrative account of the last 24-48 hours. Whilst each case will be different the professional recording the history may want to focus particularly on:

- The details of all activities and carers during the last 24-48 hours
- Any alcohol or drugs consumed by infant or carers
- Health history and when last seen by a health professional
- Full details of the last sleep including where and how put down, where and how found, feeding pattern, any changes in routine and care given (Appendix 4)
- Further details of previous 2-4 weeks, including the child's health should be obtained

Whilst some of the medical and social history will be obtained during the initial discussion with the family in the Emergency Department, a very careful and detailed account of the final 24 to 48 hours will almost be considerably supplemented by information collected at the time of initial home/scene visit and close examination of the circumstances of death.

The Personal Child Health Record (Red Book) may also be a source of information. This should be seized at the home/scene visit. Relevant family history, birth details, immunization status, growth trajectory, outcome from routine reviews and other information about the infant/child may be found in it.

The information obtained from these sources, including the ambulance record and Emergency Department records should be included in the SUDC History Record which will be commenced in hospital and taken to the home/scene visit to be further completed.

In some cases, the Police may also request blood and/or urine samples from family members. This is particularly important in cases where overlay is suspected. See appendix 8.

It is the policy of Lancashire Constabulary to seek parental blood and urine samples in all SUDC cases where those samples are reasonably assessed to be likely to provide an enhanced understanding of the circumstances surrounding the SUDC. (Circumstances where this might not be appropriate would include for example, in relation to teenager, suicide or a drowning by misadventure with parents not present, possibly at work). The basis for the request will be subject to an assessment of the criminal suspicion present in the surrounding circumstances and will follow the guidance set out in appendix 8.

At the end of the interview it is essential that the SUDC Nurse or on call Consultant Paediatrician explains to the family what will happen next. They will need to know about the Coronial process and the need for a post mortem examination. They will be informed who their **Key Worker** is. In most situations this will be the SUDC Nurse. The Key Worker is a person who acts as a single point of contact for the bereaved family, who they can turn to for information on the child death review process, and who can signpost them to sources of support. The SUDC Nurse should provide the family with the *SUDC Nurse* leaflet and the *When a Child Dies: child death review guide for parents and carers* leaflet.

The Police/SUDC Nurse will inform parents that a home/scene visit will now take place and what the purpose of this visit is for. They should be notified that they will be contacted in due course and arrangements will be made for when they can return home. In most cases this will be soon after the visit has taken place. If there are any suspicious circumstances then a more detailed forensic scene examination may need to be

conducted. In which case the parents may not be allowed to return home and arrangements will need to be made on where they will stay in the meantime.

Before leaving the Emergency Department the SUDC Nurse or Police must obtain a copy of the NWAS record, the Emergency Department records and relevant hospital records pertaining to the child. This information is essential. It will assist in informing the investigation from the outset and in preparing a report for the Pathologist.

3.8 Assessment of the environment and circumstances of death

As soon as possible after the child's death, the Police and SUDC Nurse (the SUDC Nurse should almost always be present if the child is under the age of two) should visit the family home, or the site of the child's collapse or death to observe the environment in which the child was found. This will be alongside CSI.

If the child has died somewhere other than the family home, a visit should also be undertaken to the home where the child normally resides.

During the home/scene visit a review of the environment should be undertaken. This should include a general look around the house, paying particular attention to the room/area that the child was found unresponsive, which is usually the child's sleep environment. It should be ascertained quickly if there are any forensic requirements (suspicious circumstances). If so, the environment should be left undisturbed. The home may need to be regarded as a crime scene, in which case a more detailed search and examination of the property will need to take place.

All observations and relevant findings will be recorded in the SUDC History Record, including a diagram of the scene. Any concerns in relation to potential hazards, co-sleeping/inappropriate sleeping arrangements, alcohol or substance misuse, neglectful care or safeguarding concerns must be documented and actions taken if there are other siblings.

A Crime Scene Manager will oversee implementation of the SUDC forensic strategy in consultation with the Lead Police Investigator.

The Lead Police Investigator will determine the strategy for seizing items at the scene(s) subject to consideration of the presenting circumstances as well as whether there is any suspicion regarding the death of the child.

The Police and SUDC Nurse should review the key elements of the history and ensure that the circumstances given by parents whilst in hospital, match the findings in the home environment.

It is considered good practice for a home visit to take place with the parents, the SUDC Nurse and the Police in certain circumstances. It can be helpful for example for appropriate family members to be present to describe in detail the final events, how the infant was put to sleep and how they were found. Time should be allowed for the family to go at their own pace, respecting that they may find it difficult to talk through the events or go into the room where the child has died.

Following the home visit, a debrief and overview of information gathered should occur and be recorded to inform the investigation. This may take place at the local Police station and include the Police, SUDC Nurse and CSI.

The Police will decide if the scene can be 'released' and when the family can return home. Arrangements will be made for this to happen. After reviewing the information gathered the SUDC Nurse and Police may discuss their findings with the family, taking care not to jeopardize any further investigation if there are concerns around possible abuse or neglect.

The family should be informed that a post mortem examination will be arranged in the forthcoming days and where this will take place. The family should be advised of the next stage of the process and be given clear

information about who they can contact for support or advice. Where a criminal investigation is ongoing the Lead Police Investigator will provide guidance and direction on the strategy for communicating with the family.

3.9 Initial information sharing and gathering

The SUDC Nurse should ensure that all relevant professionals and organisations are informed of the child's death at the earliest possibility. This may be a telephone conversation in the first instance. However an Initial SUDC Meeting/Strategy Meeting should be arranged as soon as possible, usually within 24 - 48 hours of the child's death (see below). An Initial SUDC Meeting will occur after every incident. However where there are safeguarding concerns present, a pragmatic assessment will be made and the SUDC meeting will be incorporated into any related safeguarding strategy meeting(s).

The agencies that are contacted will vary with each individual case. They are generally the professionals that were known to the child before and at the time of death. Relevant information will be shared with professionals by the SUDC Nurse. The professionals involved with the child should share information verbally with the SUDC Nurse regarding the child and family. This may include relevant information pertaining to the health (physical or mental), education, and social circumstances of the child and family, including any previous or ongoing safeguarding concerns.

The Police will liaise with the Coroner. Once referred and accepted, the Coroner takes legal possession of the body and opens an investigation into the death. ***It must be remembered that if agencies have pertinent information (such as relevant health information in health records) they are under a duty to disclose such information to inform the coronial process. The SUDC Nurse and Police work on behalf of the Coroner, so this information must be shared with them in a timely manner in order to inform the investigation.***

The Child Death Overview Panel (CDOP) will be notified of the child's death. The SUDC Nurse will also inform the Designated Leads from the Clinical Commissioning Groups (CCG's) and NHS England.

If there are any safeguarding concerns or suspicious circumstances a Strategy Discussion will take place between Children's Social Care, Health and the Police and a Strategy Meeting will be arranged promptly in order to consider the need for a Section 47 (see below). This meeting will be convened and chaired by Children's Social Care for the area in which the child has died also inviting the authority whereby the child ordinarily resides. The Strategy Meeting will determine which Local authority is best placed and responsible to lead on the Section 47 enquiries if this is the agreed outcome.

Where there do not appear to be any safeguarding concerns of suspicious circumstances an Initial SUDC Meeting will be convened.

4. INITIAL SUDC MEETING

This early meeting is a key action as part of the Joint Agency Response and will usually take place in normal working hours to ensure all relevant professionals can attend.

The SUDC Nurse/Police will arrange and chair a multi-agency information sharing and planning meeting with key agencies and professionals who were involved with the child and family prior to the death and at the time of the death. A representative from Children's Social Care must also be in attendance whether the child was an open case or not. The meeting will assist those involved to formulate a plan which will include the safeguarding of any siblings, support for parents and maintaining the integrity of any criminal investigation.

This meeting should be undertaken as soon as is practically possible, preferably within 24-48 hours. This is a formal meeting, chaired by the SUDC Nurse/Police. Minutes are taken and distributed as soon as possible. Occasionally and sometimes due to the fast moving pace of events, a meeting is not possible and discussions will take place over the telephone or Skype.

The purpose of the Initial SUDC meeting is to:

- Share information regarding your involvement with the child and family which may shed light on the circumstances leading up to the child's death. This may include information regarding the child's health, medical issues, recent illness, and previous unexplained deaths in the family, mental health issues, safeguarding concerns, parental capacity, behavioural issues, school attendance and attainment etc. Relevant information may also be discussed in respect of other family members and/or others involved with the child. **Professionals should provide a copy of relevant health records. If this is not possible a chronology of significant events should be prepared for the meeting and shared with the SUDC Nurse/Police.**
- Plan any subsequent joint Police and Children's Social Care investigation and set timescales for review of progress; need to ensure that the Lead Police Investigator and SUDC Nurse are kept informed and updated at all times.
- Ensure any safeguarding concerns/risks to siblings/other children are considered and acted upon as per Safeguarding Procedures. It is critical that any medical or welfare needs for the family are assessed at this early stage.
- Ensure a coordinated bereavement care plan is in place for the family.
- Identify an action plan, outlining clear roles and responsibilities for the remainder of the response and review forensic considerations.

The discussions held at this meeting and any decisions made will be fully documented and information gained will be shared with the Pathologist prior to the post mortem examination and the Coroner within 28 days of the child's death. The information collated will also be shared with and considered by the Child Death Overview Panel (CDOP).

4.1 Initial Strategy Meeting

If the child is an open case to Children's Social Care at the time of their death, or if at any stage during the Joint Agency Response concerns are raised that abuse or neglect may have contributed to the child's death, or any other significant concerns emerge about possible child protection issues, an Initial Strategy Discussion/Meeting should be convened by Children's Social Care. The Local Authority where the death has taken place would lead on initiating the Strategy Discussion ensuring they invite the Local Authority where the child ordinarily resides.

In these circumstances the Police will normally take the lead in investigating the death and the Joint Agency Response should be adapted to take account of all forensic requirements.

The SUDC Nurse and Lead Police Investigator (or nominated deputy) must always be invited to a Strategy Meeting for a child death. The Strategy Meeting must involve a Social Worker, Health Practitioners

and a Police representative as a minimum. Other relevant practitioners will depend on the nature of the individual case but may include:

- The practitioner or agency that made the referral
- The child's school or nursery
- Any health or care service the child or family members are receiving.
- Where suicide is suspected the lead public health suicide prevention specialist

This meeting will be chaired and minuted by Children's Social Care. The meeting should be used to:

- Share available information
- Agree the conduct and timing of any criminal investigation
- Decide whether enquiries under section 47 the Children Act 1989 must be undertaken

The meeting will review all information available at this stage and will identify what further investigations are required and the ongoing support for the family.

The minutes of this meeting and any subsequent review Strategy Meetings must be made available as soon as possible in order to inform the Coroner.

Good communication between the Coroner, Police, SUDC Nurse and Children's Social Care must be maintained throughout the SUDC procedures. This is essential, particularly in cases where parallel processes are ongoing, such as, a coronial investigation and family proceedings.

The information obtained from either an Initial SUDC Meeting or an Initial Strategy Meeting will be shared with the Pathologist and Coroner, as will information obtained during any subsequent meetings.

4.2 HM Coroner

Not all child deaths will be reported to the Coroner. If the death is reported to the Coroner, coronial jurisdiction is determined by the location of where the death is declared. Once referred and accepted the Coroner has control and possession of the body and will initially open an enquiry into the death. This may become an investigation into the death to facilitate release of the body whilst the results of tests are awaited. The Coroner may order a post mortem examination, if they believe it will benefit the Coronial or Police investigation(s).

Not all deaths reported to the Coroner proceed to inquest. The Coroner may, as a result of preliminary inquiries conclude that the death is from natural causes, i.e. a treating doctor gives a cause of death and the child's death is certified. In such cases the Coroner may decide not to open either an investigation or an inquest.

The inquest aims to determine the identity of the person that died and how, and when and where they came to their death.

All agencies that have pertinent information are under a duty to disclose such information to the Coroner in an un-redacted format and the Coroner has common law and statutory powers to enforce such disclosure.

The Police will provide information to the Coroner as soon as possible using form G72. Further reports will be provided by the Police as the case progresses by way of significant update. The SUDC Nurse will provide a Coroner's Report to the Coroner within 28 days of the child's death. Further information may be provided by the SUDC Nurse following the Child Death Review Meeting (CDRM).

The family should be informed of the following:

- The Coroner's involvement
- The need for and place and timing of a post mortem examination
- Their right to be represented at the examination should they so wish

- Whether an investigation or inquest has been opened so that they may attend the inquest opening
- The dates of any investigation reviews, pre-inquest reviews and the inquest itself.

However where a criminal investigation is ongoing contact with the family will be subject to direction and guidance of the Lead Police Investigator. Contact with the family will be undertaken by the Police and the SUDC Nurse who will provide all updates and information. These investigations are often protracted by virtue of their complexity and some families need regular updates, often by phone, others less so. Contact should meet each particular family's needs.

The Coroner's Officer is available to provide information to the Police and the SUDC Nurse regarding the coronial process, but may not take a lead role in the case until the Police have determined whether or not a prosecution is being considered.

Arrangements will be made, by the Police, for the child to be transferred from the local hospital mortuary to Alder Hey Children's Hospital or Royal Manchester Children's Hospital where the Paediatric or Home Office post mortem examination will take place. The Police will inform the family of any information set out above regarding post mortem examinations. The Police will at all times inform the Coroner's Officer of the intended arrangements in order that the necessary transfer documentation can be prepared.

Should there be any delay in the examination being performed arrangements should be made for parents to attend the hospital and view their child, if they so wish. The Police will generally arrange, facilitate and supervise this contact.

The Coroner's Officer, SUDC Nurse, Police or Consultant Paediatrician must explain to parents what a post mortem examination is and what the procedure entails. As part of this explanation, the most appropriate professional must explain that according to the Coroner's (Investigation) Regulations 2013, organ, tissue and blood and urine samples will be taken and that following the Police and any subsequent Coroner's investigation, the family can determine the fate of the tissue according to the Human Tissue Act 2004 guidelines.

4.3 Post Mortem Examination

Post mortem examinations are authorised by the Coroner to provide evidence for the Police and Coroner's investigation. A post mortem examination may provide evidence as to the cause of death and to the circumstances of death, in particular:

- whether the death is attributable to a natural disease process
- to consider the possibility of accidental death
- to consider the possibility of asphyxia/airway obstruction
- to consider the possibility of inflicted injury
- to document the presence or absence of pathological processes, and to determine how the death came about

In non-suspicious cases a standard post mortem examination will be authorised by the Coroner. This is undertaken by a specialist Paediatric Pathologist. In cases where there are suspicious circumstances the Police will request the Coroner to authorise a forensic post mortem examination that will be undertaken jointly by a Home Office accredited Pathologist and a Paediatric Pathologist. If a standard post mortem examination takes place and any previously unsuspected features suggestive of inflicted injury or abuse are identified during the procedure, the examination should cease and the Coroner and Police should be informed.

Prior to the post mortem examination, the Pathologist should have available a comprehensive history and report on the circumstances of death. This is essential both to aid the interpretation findings that may provide a cause of death, and to identify any suspicious features that may indicate the need for a special or forensic examination.

The information provided to the Pathologist, preferably before the post mortem examination takes place, should include:

- A detailed history, including details of pregnancy, delivery, post-natal history, ante-mortem history and precise circumstances of death, including family history such as previous sibling deaths, consanguinity, drug use and sleeping arrangements
- Event-scene investigation report from SUDC Nurse/Police
- Report of the Coroner's Officer
- Children's Social Care information where appropriate
- Reference to resuscitation procedures
- Results of examination by a Consultant Paediatrician/SUDC Nurse/Police
- Results of skeletal survey or other post mortem imaging
- Details of any investigations performed in the emergency department and any results available to date.

A briefing will be held with the Pathologist before the examination commences. The Police will attend the forensic post mortem examination. The SUDC Nurse may attend if felt appropriate.

The post mortem examination procedure, including the extent of sampling and ancillary investigations, may vary according to the specific clinical circumstances, with more extensive sampling or ancillary testing being performed where particular indications exist.

At the examination, tissue samples, other specimens and frozen samples will be obtained according to the standard protocol agreed. Occasionally, other samples may be taken as deemed necessary by the Pathologist in order to ascertain the cause of death.

Whole organs will not routinely be retained, but where this is deemed necessary by the Pathologist, the Coroner and family must be informed, and the family given the opportunity in due course for return of such samples to the body if appropriate. The Police Lead Investigator will ensure that the family has absolute clarity about any retention carried out for the purposes of a criminal investigation, and will request from the family their wishes regarding the disposal of any samples taken and will ensure that any retention should be kept under review. They will also ensure appropriate procedures are in place for the return of organs and tissue at the end of any investigation/enquiry. Organ and tissue retention processes for medical as opposed to criminal purposes will be managed as per Trust policy.

Once the examination has been completed, the Coroner should be immediately informed of the initial results. The initial findings may be discussed by the Home Office Pathologist or the Paediatric Pathologist with the lead Police investigator and SUDC Nurse as appears appropriate. Following any examination, the body of the child/young person should be released promptly back to their family, for funeral arrangements to be put in place. However this will depend on whether or not a second post mortem examination is required and the decisions that the family have made regarding the return of any samples to the body.

If the initial findings suggest evidence of neglect or abuse, the Police and Children's Social Care should immediately be informed and further investigations set in process, if not already.

Once the initial post mortem examination findings are known, the Police or SUDC Nurse should arrange to meet with the family to discuss the initial findings. It is important to emphasise at this stage, that the findings are preliminary, that further investigations may be required, and that it may not be possible, at this stage, to draw any conclusions about the cause of death. This is of course, unless an obvious medical reason is found and a cause of death can be given at this stage.

In order for the Coroner to proceed appropriately with the inquiry or investigation, the following procedure must be followed once the initial findings of the post mortem are known:

- If, after the initial post mortem examination, a sufficient cause of death is found, this will, unless there are any extenuating circumstances, be given as the cause of death at this stage.

- If, in the light of initial findings, the Pathologist feels that there is no clear or sufficient cause of death – whether or not there are some concerns about the possibility that abuse or neglect might have contributed – they should give the initial medical cause of death to the Coroner as ‘**undetermined pending further investigation**’ In these circumstances, the Coroner should open an investigation and issue a HM Coroner’s Interim Certificate of the fact of death, and allow the funeral to proceed unless there is a valid reason to delay, which is almost always due to an ongoing Police investigation. The Coroner’s Officer will be contacted by the Police and the SUDC Nurse to determine who is best placed to make contact with the family and to discuss arrangements for the child’s body to be released back to the family.
- If, during the initial post mortem examination, findings emerge that clearly identify neglect or abuse as the most likely explanation for the death, the Police and the Coroner should be informed of this. The Coroner may open and adjourn an inquest, and will still be able to issue a Coroner’s Interim Certificate of the cause of death and release the body for funeral purposes as soon as practicable. The Police will initiate a criminal investigation.

Whatever the interim cause of death as determined by the initial post mortem examination findings, it is important to continue to pursue other aspects of the joint agency response, including providing ongoing support to the family and investigating other factors that may have contributed to the child’s death. Such factors may have important implications for the family or the provision of services to other families.

With permission of the Coroner and the lead Police Investigator, if appropriate, initial post mortem examination findings may be shared, with multi-agency professionals who attended the Initial SUDC Meeting/Strategy Meeting. This information may be shared by having another multi-agency meeting or by telephone. In cases where safeguarding concerns or suspicious circumstances are apparent, it will almost always be necessary to have a Review Strategy Meeting in order to share information that is appropriate with professionals and to make action plans on how the case will proceed, without jeopardising any ongoing Police investigation. The minutes of such meetings should be made available as soon as possible.

4.4 Final post mortem results, clinicopathological summary and report

The length of time for the receipt of the final post mortem report varies with each case. Best practice suggests that these should be returned with 8-12 weeks of the post mortem examination taking place. However, it is usually considerably longer than this.

This is often a time of worry, anxiety and upset for parents. It is imperative that the Key Worker maintains regular contact with the family to ensure they understand the child death process and to offer the reassurance and support needed during this time.

The post mortem report should:

- Summarise the clinical history and main pathological findings
- Consider whether the pathology satisfactorily explains the clinical circumstances of the death
- Consider whether there are features indicating a familial or genetic disease requiring screening and counselling of the family
- Consider whether there are features sufficient to suggest inflicted injury of neglect

On completion of the post mortem report the Pathologist will send a copy to the Coroner. Once the Coroner is satisfied, the Coroner’s Office will send a copy of this to the Police, SUDC Nurse and the Child Death Overview Panel (CDOP). The HM Coroner has a statutory duty to disclose information such as post mortem examination reports to the Children’s Safeguarding Assurance Partnership (CSAP). The Coroner’s Officer, Police or SUDC Nurse, whoever appears to be most appropriate, will inform the parents the report is now available and will explain what the cause of death is. This may be via a telephone call, or a home visit.

In non-suspicious cases, it is good practice for the Coroner’s Officer to liaise with the SUDC Nurse and determine who is best placed to explain the findings and recommendations of the post mortem report to

parents. If deemed to be the SUDC Nurse, the SUDC Nurse will arrange a home visit to meet with parents and will go through the report with them.

If parents would like a copy of the post mortem report, permission should be sought from the Coroner first. This should be given to parents in a sealed envelope and an explanation should be given as to the content and detail of the report, as this is often very distressing for parents to read.

Once the SUDC Nurse has gone through the findings, parents should be asked if they would like an appointment with the Consultant Paediatrician who was present at the time of admission to the Emergency Department, or with a Consultant Paediatrician already known to the child. If they would like this, the SUDC Nurse will liaise with the Consultant Paediatrician and arrange an appointment in a convenient venue for the parents. This may be at the home address. Parents may opt to see their General Practitioner instead.

In circumstances where follow up may be recommended, for example if the child died from a genetic condition, it may be suggested that family members are also screened for the condition. Parents should be given time to consider such recommendations. If they would like to go ahead with referrals, the SUDC Nurse may assist in making appointments to see the General Practitioner or Consultant Paediatrician in order for the appropriate referral to be made.

Any public health messages or modifiable factors highlighted within the post mortem report thought to be contributory factors towards the child's death should also be discussed sensitively with parents. The SUDC Nurse is well placed to have this discussion. Such conversations may include safer sleep messages, care of the next baby (CONI), accident prevention and recognising mental health risks.

4.5 Next steps

If a complete and sufficient natural explanation of the death is established, the Coroner is informed of this and usually, no inquest is required. A death certificate is issued and the parents are required to register the child's death.

If there is no clear or sufficient natural cause of death and the final cause of death provided to the Coroner is 'unascertained' the Coroner may hold an inquest. Equally, where neglect or inflicted injury are proven to have caused the child's death, the Coroner will hold an inquest following the conclusion of the criminal investigation.

The family will be formally designated 'Interested Persons' for the purpose of the Coroner's investigation, and as such will be entitled to appropriate disclosure from the Coroner and to make submissions as to the conduct of the inquiry. During any inquest, the family will be entitled to ask relevant questions of witnesses, either in person or through a legal representative, and to make submissions on the law. The family should also be informed that inquests are public hearings, except in very limited circumstances, and that press and public often attend to listen to proceedings.

The purpose of an inquest is laid down in statute. It is important to stress that it is not an adversarial process, instead it is an investigative court hearing to determine who the was person that died and how, when and where they came by their death, the medical cause of death, and certain personal particulars that are required for registering death. The Coroner will call and examine the evidence and, usually without a jury, record the answers to the questions listed above on a public document called the Record of Inquest. The family is always a central party in an inquest.

Parents will be given a date for the inquest. Some parents become extremely anxious about attending this. The Coroner's Officer or SUDC Nurse can explain what an inquest is and what the purpose is. The SUDC Nurse can support the parents to attend an inquest and in registering the child's death if needed. The Coroner's Officer may meet with parents in order to explain proceedings and to show them the court room, should they wish, in order to alleviate any distress.

Following the inquest the Red Book and personal belongings seized at the time of the death should be returned to the family. The SUDC Nurse or Police will undertake this. A great deal of sensitivity is required when returning a child's belongings back to the family. Consideration should be given to the family's wishes, and assumptions should be avoided, as not all families will want items returned to them. Contact with the family to discuss personal belongings should ensue after all investigations are complete, and permission should be sought to wash items if appropriate. Additionally, all efforts should be made to return items in a respectful and presentable way, with all identity labelling removed.

5. ORGAN & TISSUE DONATION

Most patients that become organ donors have suffered from an unexpected brain injury, either as a result of trauma, bleed within the brain, stroke, or due to a lack of oxygen from a cardiac arrest. At the point where this injury occurs and because the patient is usually unconscious, they will be connected to a ventilator which will take over their breathing. They may also be given drugs which will keep them asleep, before being taken to an intensive care unit.

Children who are fatally injured following accidents or who are resuscitated after a sudden collapse, but subsequently die on an intensive care unit may be suitable for organ donation. In these circumstances donation will be coordinated with withdrawal of active treatment following confirmation of death by brain stem tests. Tissue donation is possible in a wider range of situations including some babies and children who die suddenly and unexpectedly at home.

Organ and tissue donation will not normally be possible in unexpected deaths where the cause of death is not apparent, for example following sudden deaths in infancy. In these circumstances the body needs to remain intact for a post mortem examination. Where the possibility of an infectious cause of death cannot be ruled out, it may not be safe to use organs or tissues for transplantation.

Following the unexpected death of a child, only the Coroner is able to give authorisation for organ/tissue donation and must therefore be informed of the family's wishes immediately. The hospital staff would then discuss this with the Coroner and would make contact with the Organ Donation Service.

Following a decision to diagnose death using neurological criteria or to consider withdrawal of life sustaining treatment (and before undertaking the tests/ withdrawal of life sustaining treatment), the intensive care team caring for the child will make a referral to the Organ Donation service. An initial assessment will be made on the information given by the medical team. If it appears that the deceased child could be a potential organ donor, a Specialist Nurse for Organ Donation (SNOD) will attend the hospital to carry out a more in-depth assessment. The SNOD will access the Organ Donor Register (ODR) at this point, to establish if the patient had made a decision in advance about organ donation.

Donation can only take place after a diagnosis of death has been made. Depending on the circumstances, this will be made as either:

- Neurological criteria (referred to as Donation after Brainstem Death, DBD),
- Circulatory criteria (referred to as Donation after Circulatory Death - DCD, where following discussion with the family, life-sustaining treatment has been withdrawn.

In line with guidance issued by the Academy of Medical Royal Colleges in 2008, donation occurs only after the heart has stopped beating for five minutes and death has been confirmed.

5.1 Consent/Authorisation

Donation for transplantation purposes

Donated organs will only be used for transplant with consent/authorisation in place. This consent/authorisation can be through one or more of several routes:

- The individual registering a decision on the Organ Donor Register about which organs and/ or tissues they would like to donate after their death
- The individual telling their family/ friends about wanting to donate some or all of their organs and tissues after their death
- The individual appointing someone to make the decision about organ donation on their behalf

Where there is no known decision about organ or tissue donation, under the Human Tissue Act, the family member(s) are asked for consent for donation. This would generally be the case for a child/young person.

In Spring 2020, the Organ Donation (Deemed Consent) Act 2019 – commonly referred to as ‘opt out’ or ‘deemed consent’ – will be applied. Under this new law, if there is no known decision (either on the Organ Donor Register or through previous conversations with family and friends), the family members will be consulted about whether the patient would have wanted to donate.

The Human Tissue Authority provides guidance on what constitutes lawful consent to organ and tissue donation, after death has been diagnosed. Their guidance is available at: <https://www.hta.gov.uk/hta-codes-practice-and-standards-0>

Please see Appendix 5 for identification and referral for potential organ donors, along with the contact number for the Organ Donor Referral Line **03000 203040**

6. CHILD DEATH REVIEW MEETING (CDRM)

This section relates to the discussion of the death of a child by the professionals who were directly involved in the care of that child during his or her life and those professionals who were involved in the investigation into his or her death. The outputs of this meeting will inform the statutory independent multi-agency panel arranged by Child Death Review (CDR) partners at CDOP or equivalent.

The Child Death Review Meeting (CDRM), previously known as the End of Case Discussion Meeting (ECDM) is a multi-agency meeting where all matters relating to an individual child's death are discussed by the professionals directly involved in the care of that child during life and their investigation after death.

The nature of this meeting will vary according to the circumstances of the child's death and the practitioners involved. For example, it could take the form of a final case discussion following a Joint Agency Response; a perinatal mortality review meeting in the case of a baby who dies in a neonatal unit; or a hospital-based mortality meeting following the death of a child in a paediatric intensive care unit. ***For the purpose of a SUDC case, the CDRM will take the form of a final case discussion following a Joint Agency Response.***

As soon as possible, once the results of all relevant investigations have been obtained, a CDRM should be arranged. On receipt of the final post mortem report the SUDC Nurse will arrange this. Ideally the meeting should be held within 2-3 weeks of the receipt of the post mortem report.

The meeting should take place before the Coroner's inquest and before the CDOP reviews the death. If a criminal investigation is being undertaken, the CDRM should not take place until the investigation is concluded unless by exception the SIO agrees to this and there is no risk of compromising the investigation.

6.1 Aims of the CDRM

The purpose of this meeting is to:

- review all information pertaining to the circumstances of the death, the background history and findings of investigations in order to determine as far as is possible, the likely cause of death and any contributory factors;
- ascertain contributory and modifiable factors across domains specific to the child, the social and physical environment, and service delivery;
- describe any learning arising from the death and, where appropriate, to identify any actions that should be taken by any of the organisations involved to improve the safety or welfare of children or the child death review process;
- consider any ongoing support needs of the family, including any information needs and care requirements of current and subsequent children;
- offer a supportive environment for the professionals involved to reflect on the case and their involvement.

The review meeting should be flexible and proportionate and focused on local learning. It is important that all child deaths are reviewed, however in certain circumstances it may be appropriate for the review to be quite brief. In every case, the Analysis Form should be drafted by the SUDC Nurse and then sent to CDOP.

During the course of the CDRM, it is important that there is an explicit discussion of the possibility of neglect or abuse as a contributory factor to the child's death. If no evidence is identified to suggest neglect or abuse as contributory factors, this should be documented as part of the report of this meeting. The quality of both medical and social care that was given to the child and family should also be discussed at this meeting, identifying any shortcomings and appropriate measures to improve future care.

When a CDRM is held, an Analysis Form will be completed by the SUDC Nurse. This should then be sent to CDOP to assist in the review of the case and in identifying learning arising from the case. A copy should also

be sent to the Coroner if there is any additional information that may assist the Coroner in his/her investigation.

When a child dies away from their normal place of residence, a joint discussion will take place between the SUDC Nurse and the CDOP in the area in which the child normally resides.

6.2 Who should attend the CDRM?

All relevant professionals who were involved with the child or family, either at the time of death or previously, should be invited to the meeting. This should include:

- the SUDC Nurse
- the Lead Police Investigator
- Primary care staff (GP/Health Visitor/School Nurse/CAMHS)
- Emergency Department staff (nursing staff, Paediatrician, emergency department doctors involved in the emergency response)
- NWS
- Children's Social Care
- School/Nursery staff
- Fire Service
- Representatives from voluntary organisations
- Coroner's Officer if available
- Public Health nominated Suicide Prevention Lead (where suicide is suspected)

Each child's death requires unique consideration and where possible, should engage professionals across the pathway of care. If certain professionals are unable to attend, they should where possible send another representative from their team/service. If this is not possible then they must be invited to submit a report to the meeting.

The SUDC Nurse will convene and chair the meeting.

Parents should be informed of the meeting, usually by the Key Worker/SUDC Nurse, and given opportunity to contribute information or questions to the meeting through the Key Worker or one of the attending professionals.

The CDRM is a meeting for professionals. In order to allow full candor among those attending, and so that any difficult issues relating to the care of the child can be discussed, without fear of misunderstanding, parents should not attend this meeting.

6.3 Where should the meeting take place?

This depends on each individual case and which professionals are involved. For example, if the child had complex health issues and was known mainly to Paediatrician's and hospital staff then it would seem prudent to have the CDRM at the hospital in order for the majority of staff that knew the child to be able to attend and contribute meaningfully to a discussion on the circumstances of the child's death.

However, in the majority of unexpected deaths the child and family are predominantly known to primary care professionals. Therefore it is best practice in most cases to hold the CDRM at the GP practice.

6.4 When should the meeting occur?

The meeting should take place as soon as it practically possible, ideally within three months of the child's death. The meeting can only take place once all investigations (e.g., post mortem examination or any NHS serious incident investigation) have concluded. Realistically, the length of time it takes to complete investigations and to receive the final post mortem report will often cause delay in convening the CDRM.

The CDRM should occur before any Coroner's inquest, and before the CDOP meets. If a Child Serious Practice Review (CSPR) is being undertaken, the CDRM will take place upon its completion. If a criminal investigation/prosecution is ongoing a CDRM may not take place until the case has reached its conclusion.

6.5 Family Engagement

Arrangements should be made for the most appropriate professional to meet with the family after the meeting, to give feedback from the discussion as soon as possible. Normally, this would be the SUDC Nurse, sometimes with the Police investigator and/or a member of the primary care team.

The family should be offered a letter or written report to summarise the findings. At the CDRM it should be agreed what information can be fed back to the family, how and by whom, and this should be agreed with the Coroner. Normally it will be appropriate to feedback the full conclusions of the final case discussion, bearing in mind that the final conclusion of the cause of death is the responsibility of the Coroner at Inquest.

7. REVIEW OF CHILD DEATH AT CHILD DEATH OVERVIEW PANEL (CDOP)

7.1 Child Death Overview Panel Meeting

The Children Act 2004 requires Child Death Review (CDR) partners to make arrangements to carry out child death reviews. These arrangements should result in the establishment of a Child Death Overview Panel (CDOP), or equivalent, to review the deaths of all children normally resident in the relevant local authority area, and if they consider it appropriate the deaths in that area of non-resident children.

CDOP may request information from a person or organisation for the purposes of enabling or assisting the review and/or analysis process, the person or organisation must comply with the request.

7.2 CDOP Panel Membership & Responsibilities

This is a multi-agency panel that meets on a regular basis to review all child deaths. The group has a core membership drawn from key organisations represented by the local safeguarding partners and should include:

- Independent CDOP Chair
- SUDC Nurse
- Designated Doctor for child deaths
- Public Health
- Consultant Community Paediatrician/Neonatologist
- Children's Social Care
- Police
- Education Representative
- Lay Member
- Nursing and/or Midwifery
- Ambulance Service
- Additional professionals will be considered on a case-by-case

The function of the CDOP is to review the available information on all child deaths up to 18 years whether expected or unexpected to identify themes and trends. CDOP will analyse the information obtained, including the report from the CDRM, in order to confirm or clarify the cause of death, to determine any contributory factors, and to identify learning arising from the child death review process that may prevent future child deaths.

CDOP should record the outcome of discussions on a final Analysis Form which is submitted to the National Child Mortality Database. The CDOP will make recommendations to relevant agencies where actions have been identified which may prevent future child deaths or promote the health, safety and wellbeing of children. The CDOP will produce an annual report for CDR partners on local patterns and trends in child deaths, any lessons learnt and actions taken.

7.3 Notifying CDOP

Professionals in all agencies have a responsibility to notify the relevant CDOP of the death of any child of which they become aware, to share information for the purposes of reviewing the child's death, and to participate in local review arrangements when they have been involved with the child or family. CDOPs should conduct an anonymised secondary review of each death where the identifying details of the child and treating professionals are redacted.

It is a statutory requirement to notify CDOP of all child deaths from birth up to their 18th birthday. If there are a number of agencies involved at the time of death, liaison should take place to agree which agency will submit the Notification; you should provide CDOP with as much information as possible.

To notify the Blackburn with Darwen, Blackpool and Lancashire CDOP of a death, professionals should complete a notification of Child Death form, this can be found at:

<https://www.ecdop.co.uk/PANLancashireCDOP/Live/Public/>

7.4 Involvement of Parents and Carers

Parents should be informed by their key worker that the review at CDOP will take place, and the purpose of the meeting should be explained. Sensitive explanations are needed when informing parents about the meeting and its purpose, to avoid adding to parents' distress or giving the impression in error that they are being excluded from a meeting regarding their child.

Parents should be informed that many cases will be discussed and that all identifiable information relating to the child, family or carers, and professionals is redacted. Due to the anonymous nature of the CDOP review, parents should be informed that it will not be possible to receive case specific feedback afterwards.

The key worker should assure parents that any information concerning their child's death, which they believe might inform the meeting would be welcome and can be submitted to the CDOP administrator.

CDOP's should assure themselves that the information provided to the panel provides evidence that the needs of the family, in terms of follow up and bereavement support, have been met.

8. UNUSUAL CLINICAL SITUATIONS & SPECIFIC SITUATIONS

8.1 Unusual Clinical Situations

There are situations that are not clear-cut and might need consultation with the Consultant Paediatrician/SUDC Nurse and others in the Joint Agency Response Team.

The infant who is unwell at the time of presentation but who deteriorates rapidly and dies of possible septic shock and multi-organ failure due to presumed sepsis.

In this situation, the condition has arisen suddenly and unexpectedly, but from the time the septic shock has become established, death can be anticipated despite the best efforts of Paediatric intensive care (PICU) staff. If the attending Paediatrician can certify the death as being due to sepsis, there is no requirement for a SUDC investigation. However, if there is insufficient evidence to certify death, the case must be discussed with the Coroner and the SUDC process initiated. This can be modified if the Coroner feels that no further investigation is required. In any event, a home visit would not normally be undertaken in such cases unless concerns were raised.

The infant who is successfully resuscitated from an out-of-hospital arrest but dies subsequently or may survive for a period of time.

In this situation, the child may live for days or weeks before dying, usually through withdrawal of care following discussions with the family. As the out-of-hospital arrest was sudden and unexpected, and the prognosis was poor, the Police may secure the scene but will not be able to do this indefinitely. Thus, such a presentation should be discussed with the SUDC Nurse in order for a home visit to be undertaken, despite the child remaining alive, as important information might be found that can assist the treating team and Police. The SUDC Nurse should be involved in any Strategy Meetings that take place. Should the child survive, the SUDC Nurse will have no further involvement.

The child with a life-limiting or life threatening condition who dies suddenly and unexpectedly.

If a child with a recognised life-limiting or life threatening condition dies suddenly or following a brief illness, a SUDC investigation may not be required. However, if the death was not expected, the SUDC Nurse should have a discussion with other members of the Joint Agency Response Team, and the clinical team who knew the child and family, and reach a decision on whether a SUDC investigation should be initiated. If in doubt, the SUDC Nurse/Consultant Paediatrician should consult with the Coroner.

Twins and multiples

Twins and multiples have around twice the risk of SIDS (Sudden Infant Death Syndrome) compared with singletons. The immediate concern of a family that has lost one twin to SIDS is losing the surviving twin to SIDS also. When one twin dies from SIDS, the surviving twin should be admitted to an inpatient Paediatric unit for close monitoring for at least 24 hours. Investigations to exclude infection, inherited metabolic disease or an underlying cardiac condition should be undertaken. Follow up support should be organised prior to discharge and the CONI (Care of the Next Infant) Scheme should be considered. This would also apply to triplets and other multiples.

When a newborn infant suddenly collapses and dies on a neonatal unit, consideration should be given as to whether a Joint Agency Response is required. In most situations, this would not be appropriate.

9. SPECIFIC SITUATIONS

9.1 Deaths overseas of children normally resident in England

In the event that a child who is a British national dies abroad, the child's family should notify the local authorities and the UK Embassy, High Commission, or Consulate in the country where the child has died. The family can also contact the Foreign and Commonwealth Office (FCO) directly. The FCO can provide support to British nationals in difficulties overseas and provides useful resources for what should happen in the event of a death overseas.

When notified of a death, Diplomatic officials in these offices will advise relatives how to register the death (abroad and/or in the UK); advise on how to repatriate the body using local and international funeral directors, and give guidance relating to bereavement support. Their staff will also notify the coronial liaison officer at the FCO.

The FCO collects routine information about each death such as name, date of birth, address, known cause of death, and the welfare of other siblings. It is customary practice for the FCO to also notify the relevant CDR partners and CDOP where the child was normally resident, if a UK address is provided to them. The FCO will only be aware of a death if the family, local authorities, or other interested party notifies them.

The FCO can be contacted on Coroner.LiaisonOfficer@fco.gov.uk, or in an emergency 0207 008 1500 (ask for Consular).

The CDR partners must make arrangements for the review of each death of a child normally resident in the area, including if they die overseas. Professionals may learn about such deaths from a variety of sources (e.g., FCO, media, Coroner, the public).

As the duties of the Coroner are engaged by the body of the deceased person lying in their area, these duties will only arise in respect of children who die abroad and whose bodies are returned to England. The duties of the Coroner do not arise if the child is buried or cremated abroad. The Coroner taking responsibility will usually be the Coroner covering the area to which the child's body is brought for funeral arrangements.

The investigation of deaths that occur abroad by the Coroner is often difficult due to problems securing evidence. The FCO usually assists by making contact with foreign authorities on behalf of the Coroner, as the Coroner has no power to summon evidence or witnesses outside England and Wales.

When the death has taken place abroad, the local CDR partners are advised to seek advice from the local Senior Coroner first; the CDR partners may also need assistance from agencies abroad, including Police involved in the investigation of the death in question. Such reviews require careful co-ordination to ensure that all relevant information for the FCO, international funeral directors, Coroner, and local services is presented to the panel.

Upon notification of a child death abroad, the SUDC Nurse will gather as much information as possible and liaise with all relevant professionals. Support will be offered to the family as needed.

9.2 Children with learning disabilities

The Learning Disabilities Mortality Review (LeDeR) programme describes a review process for the deaths of people aged 4 years and over with learning disabilities in England.

The LeDeR programme defines 'learning disabilities' to include the following:

- A significantly reduced ability to understand new or complex information and to learn new skills (impaired intelligence) with

- A reduced ability to cope independently (impaired social functioning), which started in childhood with a lasting effect on development
- The LeDeR programme adheres to key principles of communication, co-operation, and independence when liaising with other investigation or review processes. It is expected that the child death review process will be the primary review process for children with learning disability and that it will not be necessary for the LeDeR programme to review each case separately

When notified of the death of a child or young person aged 4-17 years who has learning disabilities, or is very likely to have learning disabilities but not yet had a formal assessment for this, CDOP should report that death to the LeDeR programme at <http://www.bristol.ac.uk/sps/leder/notify-a-death/> or 0300 777 4774. CDOP should provide core information about the child and the relevant CDR partners. It is considered good practice to ensure that the LeDeR programme is represented at the meeting in which the death is reviewed. In addition, the Local Area Contact for the LeDeR programme and the CDOP should discuss the potential input from a LeDeR reviewer to offer expertise about learning disabilities (if appropriate) and to ensure the collection of core data for the LeDeR programme.

9.3 Deaths of children in adult healthcare settings

A small number of children (often 16 and 17 year olds) die in intensive care units (ICU's) or very occasionally on adult/paediatric wards. The deaths of these children are still subject to the child death review process.

The *Learning from Deaths* framework gives guidance to NHS trusts for reviewing adult inpatient deaths, and this should be the primary approach for reviewing the quality of care for children who die in adult ICU. However, in all respects, children who die in adult settings should have the same rigor of review as all other children. There should be close liaison with the SUDC Team from the outset to ensure that this occurs.

The majority of hospital deaths in children and young people occur in regional paediatric and neonatal ICU's. However, some age-admission policies across networks of care may stipulate that critically ill 16 and 17 year olds are cared for on an adult ICU. In order to avoid confusion for families and clinical staff, the general expectations arising from *Learning from Deaths* apply to children who die on adult ICU's, with the following essential caveats:

There should be notification of the child health system, GP, CDOP and local CDR partners; The SUDC team should be notified when a child dies in an adult ICU. The SUDC Nurse can provide a central role in terms of:

- advice regarding the need for a Joint Agency Response;
- identifying whether the child is known to paediatric health professionals who should be represented at the adult mortality and morbidity meeting; and
- attending the adult mortality and morbidity meeting and completing the Analysis Form for CDOP.

For *adult* deaths, NHS providers are required to use a methodology for reviewing the *quality of care*, such as the Standardised Judgment Review (SJR) approach. The SJR, or other evidence based structured mortality review tool, should be used to review the quality of care. This and the notes arising from the adult mortality and morbidity meeting regarding the child, should be forwarded to CDOP.

If the child's death was considered unexpected and a Joint Agency Response was triggered, the SUDC Nurse should arrange the CDRM. This could be a combined mortality meeting and CDRM. The SUDC Nurse will complete and forward the Analysis Form to CDOP.

9.4 Inpatient Mental Health Settings

The following applies to all children in inpatient mental health settings whether they are treated 'voluntarily' as informal patients or detained under the Mental Health Act 1983 (MHA). All deaths of children in inpatient mental health settings will trigger a Joint Agency Response (see Chapter 3). All child deaths in an inpatient mental health setting (general and secure) should be reported to the Coroner.

NHS and independent providers of inpatient mental health settings must notify the Care Quality Commission (CQC) if a child dies whilst detained under the MHA 1983. NHS England will be notified by the SUDC Nurse.

The child death review process will take place as set in Chapter 2, 3, 4 and 5.

As with all child death review processes, there should be meaningful involvement of families. Effective co-ordination is vital when parallel investigations take place. A 'key worker' should be assigned to every bereaved family to act as a single point of contact. The inpatient manager might act as the 'case manager' in providing progress updates on the separate investigations.

Bereavement support should be offered to families and consideration given to providing psychological support for staff involved in the care of the child.

9.5 Deaths in custody

The primary responsibility for the investigation of the death of a child in custody lies with the Coroner and the Prisons and Probation Ombudsman (PPO). It is the Coroner's duty to investigate deaths in custody and state detention also includes patients under the Mental Health Act 1983.

The PPO investigates all deaths of children in prisons, secure children's homes, secure training centres, youth offenders institutions, immigration removal centres and approved premises (formerly known as probation hostels). This also generally includes children and young people temporarily absent from such establishments but still subject to detention (for example, where a young person is under escort or attending hospital).

Deaths of children in custody are not investigated by the PPO, but are instead investigated by the Independent Office of Police Conduct.

Following a death in custody (ie, in Police cells, Police vehicles and/or whilst being arrested by the Police) the Police will begin an investigation and submit a report to the Coroner. In tandem, the Police may be involved in relation to investigating criminal matters related to the death, and not solely as the Coroner's officer.

Where it is suspected that problems with care or service delivery in relation to NHS-commissioned health care have contributed to or caused the death of a child in custody, a serious incident should be declared and an investigation managed according to the Serious Incident Framework.

NHS providers should inform the CDOP where the child was normally resident of the death of any child in custody. Whilst it is acknowledged that such events will always be investigated by the PPO and the Coroner, the CDOP where the death occurs should receive the outcomes of the investigations and conduct a comprehensive review of the case.

Pregnant women in custody should be transferred to hospital for the delivery of their baby. If the baby delivers in the place of custody, that baby should be transferred to hospital. In both circumstances, should the baby die in a neonatal unit, the standard child death review process should be followed.

9.6 Deaths by Road Traffic Collisions

The Police departments dealing with such incidents should inform the SUDC Service and share all relevant information.

In these circumstances, the SUDC Service should ensure that there is a coordinated approach with other elements of the Joint Agency Response, and any reports arising from the investigation should inform the Coroner and wider Child Death Review Process.

9.7 Suicide and Self-harm

Suicide is defined as a death where the conclusion of suicide is given at inquest where the Coroner is satisfied that the deceased did an act knowing and intending their death would result.

A child suicide is a rare event, however when it does occur the impact can be widespread. The National Confidential Inquiry into Suicide and Homicide by people with Mental Illness (NCISH) published a report in 2017 specific to suicide by children and young people. One of the key messages from the report is that 'suicide in young people is rarely caused by one thing, and that it usually follows a combination of previous vulnerability and recent events'. The report identifies a number of important themes for suicide prevention: support for or management of family factors (e.g. mental illness, physical illness, or substance misuse), childhood abuse, bullying, physical health, social isolation, mental ill-health and alcohol or drug misuse.

On notification that a child/young person has possibly died as a result of self-harm/suicide a Joint Agency Response should be instigated. The Police should notify the SUDC Nurse, if in working hours, and a decision should be made as to whether the SUDC Nurse attends the scene in which the incident occurred or whether the SUDC Nurse attends the hospital to meet the Police and be involved in the examination and/or information gathering from parents/carers. If out of hours, the on call Consultant Paediatrician should attend the ED/mortuary to examine the child and gather information with the Police.

Child suicide should be reviewed in the same manner as other child deaths, with the following expectations:

- All child deaths related to suspected suicide and self-harm should be referred to the Coroner for investigation;
- All deaths related to suspected suicide and self-harm will require a Joint Agency Response;
- The Initial SUDC Meeting and CDRM should include experts in mental health, public health and key professionals involved in the child's life across education, social services and health (see below).

Specific factors should be considered, including:

- family factors such as mental illness,
- alcohol or drug misuse, and domestic abuse;
- abuse and neglect;
- bereavement and experience of suicide;
- bullying, including on-line bullying;
- suicide related internet use, including searching for methods and posting suicidal messages;
- academic pressures, especially related to exams; social isolation, especially leading to withdrawal;
- physical health conditions that may have social impact, and their treatment
- alcohol and illicit substances;
- mental ill health, self-harm and suicidal ideation; issues relating to self-identity, including gender identity; or
- exploitation, including sexual exploitation, radicalisation and gang related exploitation.

The SUDC Nurse will be responsible for arranging and chairing the Initial SUDC Meeting. The exception to this will be if there are any safeguarding concerns or suspicious circumstances identified. In these circumstances there would be a Strategy Meeting, led by the Police or Children's Social Care. This meeting is essential, not only for information gathering and sharing purposes, but also to identify any other young people that may be vulnerable to self-harm/suicide and ensuring the most appropriate support is in place for them. In order to do this certain key agencies are required to be present at the multi-agency meeting and any subsequent review meetings.

Required professionals:

Child and Adolescent Mental Health Services (CAMHS) in Lancashire and East Lancashire Child and Adolescent Mental Health Services (ELCAS) must be invited to every meeting whether the child was known

to their service or not. This is to ensure that CAMHS/ELCAS can identify other vulnerable children known to the deceased child in order to offer timely support. This support may be offered in school or by opening up a referral for the child, if deemed appropriate. The following guidance (page 41) has been devised by Lancashire CAMHS and ELCAS and illustrates how they will be notified of the suspected suicide of a young person and how they will subsequently assess need and prioritise service delivery.

The flow chart on page 40 does not apply to Blackpool CAMHS. Blackpool CAMHS will review each case individually and tailor support accordingly given the circumstances.

Other *required* professionals would include Children's Social Care. This is essential in order to identify vulnerability and ensure the most appropriate support is in place for children deemed to be at risk. Pupils within school and those affected in the close family network and wider community should also be considered during the meeting.

A Safeguarding Lead/Advisor from Education and an Educational Psychologist from the Local Authority in which the child resided should also be regarded as *required* members. They will be able to assist school, ensuring they are well equipped in dealing with the devastating aftermath of a suspected suicide and in identifying other vulnerable children and ensuring they are successfully safeguarded. They may also be able to offer support to school staff who have been affected by the death of a pupil, or offer advice on how best to support any vulnerable pupils who may have been impacted by the death.

A nominated Local Authority Public Health Lead in Suicide Prevention should also be invited and can assist with wider community preventative strategies where needed. This will ensure coherence with the Local Authority's Suicide Prevention strategy, knowledge of the local population and area, and align with knowledge of, and access to, community resources on that footprint. NICE (2019).

Key professionals:

All professionals involved with the child/young person before and at the time of death should be invited to the Initial SUDC Meeting/CDRM. These professionals will vary with each individual case. *Required professionals* should attend the CDRM whether they are still involved in the case or not.

A review SUDC/Strategy Meeting may need to take place. This will be in order to update professionals; review the support being offered; or to identify further vulnerability. This will be considered in each individual case.

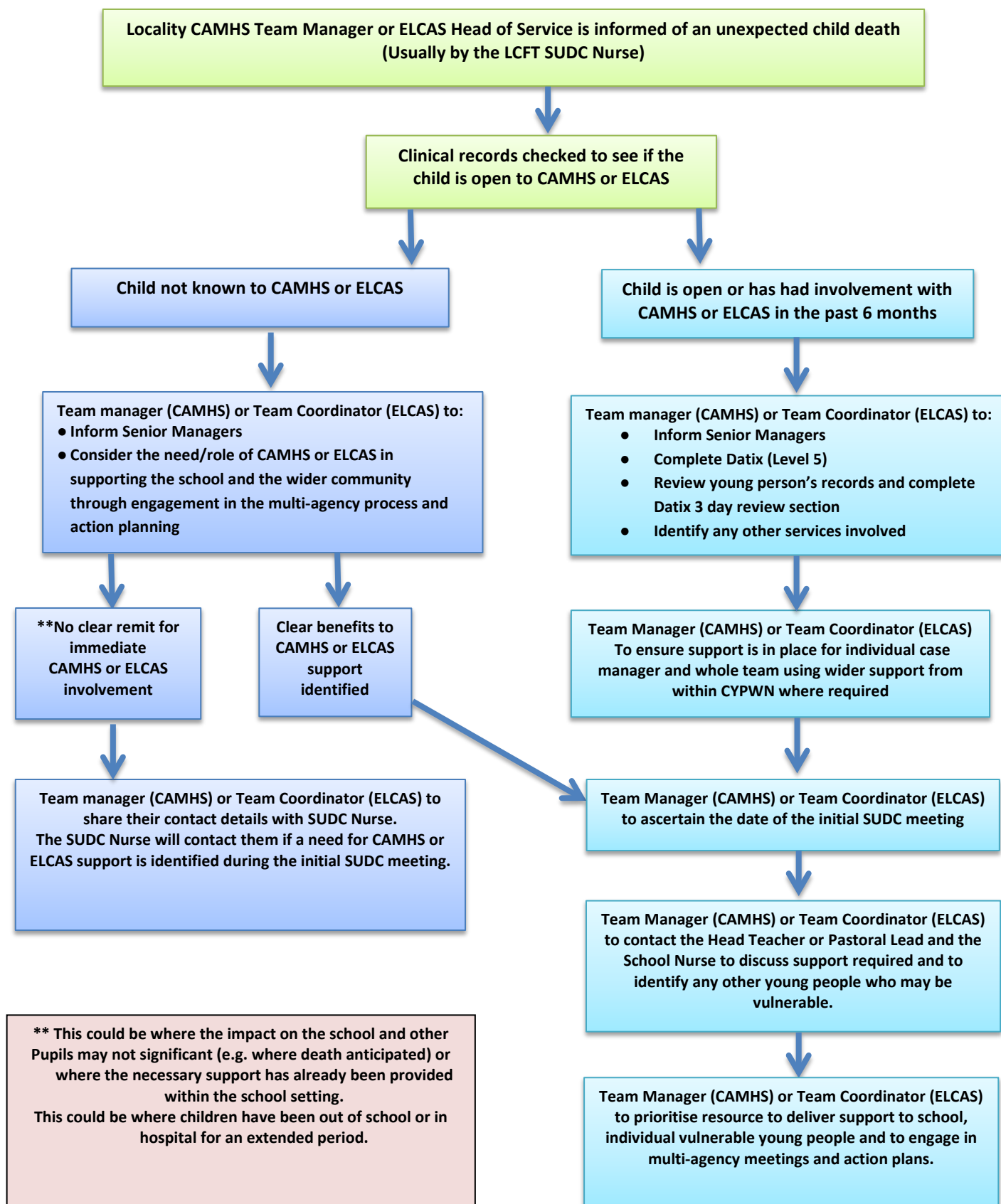
The occurrence of adolescent suicide in itself is a known risk factor for suicide contagion. Suicide contagion refers to the social, or interpersonal, transmission of suicidality from one victim to another, which can then lead to suicide clusters. During the multi-agency meetings, whilst assessing risk and vulnerability, the possibility of suicide contagion must always be assessed and reviewed. If concerns are raised or there is intelligence to suggest potential suicide contagion, then consideration should be given as to whether the Lancashire and South Cumbria ICS Post Suicide Intervention Protocol is followed. However, in most circumstances this will be addressed via the Initial SUDC/Strategy Meeting, whose overarching purpose is to assess risk and vulnerability; ensure the most appropriate support is in place for those deemed to be at risk; to minimise wider community distress, and prevent further suicides or suicidal behaviours.

Possible media attention should be considered by the multi-agency group. The communication leads within each agency should consider linking together to formulate a coordinated approach. This will provide consistency, and will ensure that any media statements are sensitive and responsible, and the reporting is concise and factual.

Suspected child suicides should, where possible, be discussed at a themed specialist CDOP review with attendant mental health specialists.

For bereavement/emotional support for those affected by suicide, please see Appendix 7.

9.8 Guidance for CAMHS and ELCAS teams following the sudden unexpected death of a school aged child



9.9 Concealed and denied pregnancy

If a baby is born and is reported to have been dead at birth, or died soon after; or is found deceased and abandoned, and the birth was not attended by a healthcare professional, a Joint Agency Response should be triggered and initial enquiries made to determine whether or not the child was born alive. It is important to remember that the determination as to whether a child was born alive or dead can only be achieved through specialist pathology, typically a home office post mortem examination. The Police will lead on these investigations regardless of whether the baby was born alive or not. In these circumstances, a Strategy Discussion should take place with consideration of Section 47 enquiries.

Regardless of whether the baby was born alive or dead the requirement for a high level forensic examination and evidential preservation is paramount. ***Should a professional, such as a Midwife, be called to either the home, a community setting, ED or a maternity unit, following the delivery of a baby, reportedly showing no signs of life, and the delivery was not attended by a health professional, it is highly important that the baby, umbilical cord and placenta (if still attached) are not handled or interfered with.*** The Lead Police Investigator will implement an appropriate forensic strategy in support of these aims. All agencies should be mindful of this requirement in dealing with incidents of concealed pregnancy. Professionals should refer to the Lancashire Concealed and Denied Pregnancy Protocol for further information.

https://panlancashirescb.proceduresonline.com/chapters/p_concealed_preg.html

9.10 Cross Boundary working

All children that die suddenly and unexpectedly within the county of Lancashire will have a Joint Agency Response as per the Blackburn with Darwen, Blackpool & Lancashire SUDC Protocol. This response will be implemented and coordinated by the Blackburn with Darwen, Blackpool & Lancashire SUDC Service and Lancashire Constabulary.

If the child was from another area, such as a child that may be on holiday or is a Child Looked After placed in Lancashire, Blackburn with Darwen, or Blackpool; or if the child is from outside England or indeed another country, the SUDC Protocol should still be followed. In this instance, professionals from the area in which the child normally resides will be contacted as part of the multi-agency response and will be invited to participate in any meetings (may need to be via telephone dial in) as will all professionals that may be involved locally.

Depending where in Lancashire the child died, the relevant Children's Social Care (Lancashire, Blackburn with Darwen or Blackpool) will be notified. The SUDC Nursing Service will arrange an Initial SUDC Meeting and invite a representative from one of the three Local Authorities, however, should there be any safeguarding concerns in relation to the child's death, and the local Children's Social Care team should convene and lead on a Strategy Meeting.

The Lancashire and Blackpool Coroner's will take primacy for any child that dies within their jurisdiction.

For the purpose of CDOP, if a child from another area dies in Lancashire, Lancashire CDOP will liaise with the CDOP in the area that the child is normally resident and will share all relevant information. The CDOP in which the child resides will review the case.

Where a child from Lancashire dies in another county, the SUDC Procedures for that area must be followed, even if this is just across the border. In these circumstances, if NWS are called to respond and then inform Lancashire Constabulary that a child has died, a discussion should take place between Lancashire Constabulary and the Police force in the area in which the child is taken to, to make a decision which force will deal with it.

The Coroner in the area in which the child dies, again takes primacy for the case, so ideally the SUDC procedures for that area should be followed by the professionals in that area. Decisions may be made at a later date for the case to be transferred to Lancashire. The Coroner in the area that the child has died will

liaise with a Lancashire Coroner should this be decided. There are specific provisions under coronial legislation to accommodate the transfer process.

9.11 Mass fatalities

Mass fatality incidents can occur without warning and can broadly be expected to fall within:

- Natural cause incidents – flooding, severe weather, earthquakes etc.
- Major transportation accidents – including road, rail, sea and air
- Hostile acts – including terrorism and criminality
- Crowd related incidents – involving disorder and overcrowding
- Contamination and/or pollution incidents
- Structural failures
- Industrial incidents
- Health related incidents

The Lancashire Resilience Forum (LRF) is a group of organisations that work together to prepare and respond to emergencies in Lancashire. It does this by:

- Meeting regularly;
- Considering the hazards that feature in Lancashire, assessing the impacts of the risk and providing this information to the public in a Community Risk Register;
- Creating plans to help make the risks safer and to respond and recover should an emergency happen;
- Responding together in a coordinated way when something does go wrong;
- Training and testing to make sure we are ready;
- Learning the lessons from incidents and exercises.

When an incident occurs, all members of the LRF work together from a single building to achieve common objectives:

- Prevent the situation from getting worse;
- Save lives;
- Relieve suffering;
- Protect property;
- Recover to normality as soon as possible;
- Facilitate criminal investigation and judicial process as necessary.

The LRF involves the emergency services; local authorities; health agencies; Environment Agency and Maritime Coastguard Agency. Voluntary groups; transport providers; utility providers and local businesses provide help to the Forum.

In the event of a mass fatality occurring in Lancashire, the Health Protection Manager from the Health, Safety and Resilience Service from the Local Authority in which the incident has occurred, will notify the SUDC Service. This will be to share the details of any deceased children. The SUDC Nurse will record these details but will not actively become involved in responding to the incident. The SUDC Nurse will inform the Lancashire Child Death Overview Panel and share relevant details.

On completion of all investigations the Child Death Overview Panel will review any child deaths that may have occurred during a mass fatality. The panel will determine any modifiable factors, and be responsive to any lessons learnt or preventative measures that may reduce the risk of similar deaths/incidents occurring in the future.

10. FAMILY ENGAGEMENT AND BEREAVEMENT SUPPORT

Supporting and engaging the family who have lost a child is of prime importance throughout the whole child death review process. Recognising the complexity of the process, and the different emotional responses that bereavement can bring, families should be given a single, named point of contact, i.e. the “key worker”, for information on the processes following their child's death, and who can signpost them to sources of support.

Professionals have a duty to support and engage with families at all stages in the review process. Parents and carers should be informed about the review process, and given the opportunity to contribute to investigations and meetings, and be informed of their outcomes.

This chapter describes the support that should be provided to all bereaved families and carers after the death of a child. See Appendix 6 for further details. Appendix 7 includes contact details for national organisations offering bereavement support.

Whether the child's death is sudden or follows a long illness, the requirement for the following roles is universal:

10.1 The team around the family

A ‘key worker’

All bereaved families should be given a single, named point of contact to whom they can turn for information on the child death review process, and who can signpost them to sources of support. It is the responsibility of the organisation where the child was certified dead to identify a key worker for the family.

The identification of the key worker will be dependent on the unique factors pertinent to the child, and the circumstances surrounding the death. In instances whereby the child has complex medical needs, the family may already be well known to the multidisciplinary team. In such cases it may be more appropriate for an existing named professional to remain in contact with the family after the death of their child. Parents may also wish to discuss the events surrounding their child's death, and as such should be provided with the opportunity for this to take place at a later date if needed.

Where children have died as a result of an acute infection/illness, the clinician on duty at the time of death may take the role of key worker until a more suitable professional can be allocated. All professionals should maintain contact with each other to ensure that the family have the appropriate support in place.

In criminal and coronial cases, the SUDC Nurse, Police Family Liaison Officer or Coroner's Officer may act as the key worker in providing vital support to the parents with regard to the ongoing investigations. In all cases, families need to be provided with clarity of individual roles within the child death review process and professionals should avoid duplication when obtaining parents accounts.

Regardless of the professional background of the key worker, this person should:

- Be a reliable and easily accessible point of contact for the family after the death;
- Help co-ordinate meetings between the family and professionals as required;
- Be able to provide information on the child death review process and where appropriate, the course of any investigations pertaining to the child;
- Liaise as required with the Coroner's officer and police family liaison officer;
- Represent parents at professional meetings, ensuring that questions are effectively addressed, and to provide feedback to families afterwards;
- Signpost to specialist bereavement support if required.

A 'medical lead'

An appropriate Consultant Neonatologist or Paediatrician should also be identified after every child's death to support the family. This is distinct from the key worker. It might be either the doctor that the family had most involvement with while the child was alive, or the designated professional on duty at the time of the death. This individual and the key worker should liaise closely.

For all SUDC cases the SUDC Nurse will liaise with the named Consultant as needed. On receipt of the post mortem report, the SUDC Nurse will liaise with the Consultant and give an update. The SUDC Nurse will visit the family to go through the report and should ask the family if they would like to meet with the Consultant. In some cases it may be appropriate to undertake a joint home visit. If the family would like an appointment with the Consultant the SUDC Nurse will arrange this.

The parent's wishes must be respected. Some, but not all will want follow up with a doctor. Some families prefer not to return to the hospital or department in which their child died. Arrangements should be made for a convenient location to meet if this is the case.

In some cases it will be essential that the family meet with a Consultant or professional with clinical expertise. This will be in order to i) answer questions relating to the medical, nursing or midwifery care of the child ii) explain the findings, the post mortem examination results and/or further investigations which may need to be undertaken (such as cardiac or genetic follow up).

All staff in all organisations and agencies have a duty to support bereaved parents with compassion and sensitivity. Support for the family should commence at the earliest opportunity, and where possible be paced to meet the needs of the individual. If the child is taken to the Emergency Department, a member of staff should assume responsibility for receiving and caring for the family, and endeavor to give clear explanations of what is happening. Where resuscitation attempts have been made, the family should be kept updated and if possible and appropriate, be present during this time.

Consideration should be given to the individual needs of the family, in particular language, mental capacity, health and any learning needs which may be present. Where English is not the family's first language, every attempt should be made to provide a translation/interpreting service, including out-of-hours provision, for example through Language Line.

10.2 What Bereaved Parents Should Expect Following Their Child's Death

It must be remembered that many parents will be in a state of extreme shock when their child has died. They may not be able to process or retain information, as they would do usually. Parents will react differently following their child's death and there is no standard grief reaction. However their response to their child's death is important to note.

Throughout the whole time that staff are supporting bereaved parents consideration should be given as to their understanding, with a particular emphasis on any language difficulties or physical and mental health needs they may have. Staff must ensure that support is given in order that they may fully understand processes as they develop.

Upon their arrival in ED parents should be allocated a staff member who is able to offer support, provide private facilities and explain what is happening and who the professionals involved are. The staff member should also be able to organize arrangements for religious and/or cultural support to be made available.

If the child requires resuscitation, in the ED, then consideration should be given to the parents being present whilst resuscitation is ongoing. If this is not considered appropriate then the staff member should provide them with ongoing information.

A copy of ***When a Child Dies - A Guide for Parents and Carers*** should be given to all bereaved families and staff should be familiar with the contents of the booklets.

Following their Child's death, bereaved parents/carers should:

- Have the opportunity to spend time with their child in a quiet environment – if there do not appear to be any suspicious circumstances then a staff member/police officer should be present at a discrete distance. A staff member should also be available to support them. If there are suspicious circumstances the Lead Police Investigator will make the decision regarding whether parents/carers can spend time with the child;
- Be given the opportunity for a memory box to be made. In the case of suspicious circumstances the Lead Police Investigator, should make a decision if this is undertaken before or following the post mortem;
- Know how to make arrangements to view their child's body;
- Be given information on death registration and the coronial process. Families should be given an explanation regarding the role of the Coroner and reasons for their involvement;
- Understand why a post mortem examination may be indicated and, if so, where it will be taking place, and when the results might be expected. Parents should be informed that a Coroner's Officer will be making contact with them in due course, who will keep them up to date and informed of arrangements;
- Be supported to have an understanding of the child death review process and how they will be able to contribute towards this;
- Be given practical advice in respect to organizing the child's funeral;
- To be given the contact details of their identified key worker. It maybe that this key worker may change over the following weeks until the most appropriate professional is identified for ongoing support.
- Parents will also require the name and contact details of the SUDC Nurse and Police Officer who will be dealing with them;
- Be able to access expert bereavement support if required

10.3 End of Life Planning for Children and Young People with Life Limiting/Life Shortening Conditions

Children with a life limiting condition may die following a prolonged illness. Within the remit of end of life care planning a key worker should be identified to provide ongoing bereavement support to the family. Guidance is available for supporting the child and family in end of care planning.

However it may be that a child with a life shortening condition may still die unexpectedly. At this point the health professionals in consultation with Police and SUDC Service need to decide how to proceed with a rapid Joint Agency Response and the appropriateness of this response. It is important to note that children with known life shortening conditions, may still die unexpectedly, and as such a full response would need to be triggered.

10.4 When a child dies and an NHS Serious Incident Investigation is instigated

On occasion, concerns about service delivery may be raised (by practitioners or the family) and the organisation will initiate an NHS Serious Incident Investigation. Parents are often the expert in their child's condition and can provide vital insight into the circumstances of the death and quality of care received.

Serious incidents are events in health care where the potential for learning is so great, or the consequences to patients, families and carers, staff or organisations are so significant, that they warrant using additional resources to mount a comprehensive response. Serious incidents therefore require investigation in order to identify the factors that contributed towards the incident occurring and the fundamental issues (or root causes) that underpinned these. NHS serious incident investigations should inform the child death review process by providing a detailed analysis of patient safety incidents that may have contributed to the death by way of a reporting form.

When a child has died and a Serious Incident Investigations is initiated, the healthcare provider should appoint a 'case worker' who will liaise with other agencies involved in any parallel multi-agency proceedings (e.g. criminal investigations or serious case reviews) to allow for effective co-ordination of the same.

Every incident must be considered on a case-by-case basis and be guided by the NHSE Serious Incident Framework (2015) and Child Death Review Guidance (2018).

THE MANAGEMENT OF SUDDEN UNEXPECTED DEATHS IN CHILDHOOD (SUDC) PART II

Part II: Roles & Responsibilities

This part covers individual roles and responsibilities in relation to the management of a sudden unexpected death in childhood.

11. ROLE OF THE SUDC NURSE

The roles of the SUDC Specialist Nurses have been commissioned jointly by the Clinical Commissioning Groups across Pan-Lancashire to develop and co-ordinate the health perspective required in the multi-agency response to assist in the investigation of SUDC. The insight gained from this multi-agency response will influence service design, provision and planning around the SUDC agenda, improve practice and expertise, identify themes to reduce the incidence of child death across the county and contribute to the Coroner process and CDOP investigations to promote the welfare of children in the future.

When a Joint Agency Response (JAR) is triggered the Lead Health Professional (SUDC Nurse – in hours, Monday-Sunday) will co-ordinate the response to that death. Out-of-hours, the role of the Lead Health Professional will be taken by the senior attending Paediatrician. The Lead Health Professional will ensure that all health responses are implemented, and be responsible for ongoing liaison with the Police and other agencies. This same process should still be applied if the infant has not been brought to the Emergency Department for any reason.

A Joint Agency Response should be triggered if the death:

- is or could be caused by external causes
- is sudden and there is no immediate apparent cause (SUDC)
- occurs in custody, or where the child was detained under the MH Act
- where the initial causes raise any suspicions that the death may not have been natural: or
- in the case of a stillbirth where no health care professional was in attendance
- also, in cases where the child is successfully resuscitated, but is expected to die in the following days (a JAR should be considered at the point of presentation not at the point of death therefore enabling accurate history to be taken and if necessary, a 'scene of collapse' visit to occur)

On notification of an unexpected child death the SUDC Nurse will attend the Emergency Department and undertake a JAR with the Police (pg. 23 of CDR Review Guidance). An initial information-sharing and planning discussion should take place before the family leave the Emergency Department. This should, as a minimum, include the Lead Health Professional and Police investigator, and should desirably include CSC and the ambulance crew.

The Lead Health Professional should make contact with the family's GP and all health professionals involved with the child as soon as possible. This is to ensure that they are fully informed and to obtain all relevant medical, social or family information. Contact should also be made with all professionals known to the child, siblings and parents/carers. As soon as possible after death the Lead Health Professional should convene an initial information sharing and planning meeting between the lead agencies.

The meeting will review all information available at that stage, and will identify what further investigations are required and the ongoing support needs of the family.

However, if at any stage, concerns are raised that abuse or neglect may have contributed to the child's death, or any other significant concerns emerge about possible child protection issues, an initial multi-agency strategy discussion/meeting should be convened by CSC. In these circumstances the Police will normally take the lead in investigating the death and the JAR should be adapted to take account of forensic requirements.

Following this review, the Lead Health Professional will prepare a report of the initial findings to include details of the history, initial examination of the child and findings from the home visit, as well as account of any medical investigations and procedures carried out. This report will be made available to the Pathologist, Coroner and Lead Investigator as soon as possible, and preferably prior to the post mortem examination.

The SUDC Nurse will co-ordinate and support parents and family throughout the process. This will include the provision of advice, referral to appropriate support agencies and support visits will follow as the case

determines. The SUDC Nurse will offer support to staff involved in the JAR and keep them informed of the JAR and child death process.

Throughout the process it is imperative that all agencies keep the SUDC nurse involved in the developments within their own agencies of the case.

12. ROLE OF THE POLICE

The purpose of the police investigation is to firstly determine the circumstances surrounding the death and to ascertain whether there is criminal involvement by any person. Such deaths will be subject to a comprehensive and robust investigation ensuring that a balance is maintained between an investigative mindset and a compassionate and sensitive approach towards parents, relatives and other interested parties.

In relation to all sudden and unexpected infant or child deaths the Duty Senior Investigating Officer (SIO) will be informed and will ordinarily retain overall responsibility for the investigation subject to senior management discussion within Lancashire Constabulary. The Lead Police Investigator (ordinarily a Detective Inspector or Detective Sergeant) must ensure that contact is made with the SUDC Nurse immediately to inform of the death and to initiate the Joint Agency Response. The Lead Police Investigator will ensure that relevant local partners are informed (or in out-of-hours cases, arrangements are made for this to occur at the earliest opportunity).

During SUDC nurse working hours the Lead Police Investigator together with the SUDC nurse responding will co-ordinate the appropriate response. The Lead Police Investigator must attend the scene and take charge of the investigation, ensuring that a Crime Scene Manager (CSM) also attends the scene in order to implement the forensic strategy (if this is not possible due, for example, to competing operational demands, the CSM will ensure that a suitably experienced Crime Scene Investigator is briefed and then attends the scene to implement the strategy).

It is important to remember that in the vast majority of child deaths, the cause is natural, therefore there needs to be a careful balance between consideration for the bereaved family and the potential of a crime having been committed.

Police involvement may be likely to increase parents' levels of distress. They will require an explanation of the reason for police involvement. Officers should inform the parents that the police act on behalf of Coroner and have a duty to investigate the circumstances of the death. Police involvement occurs in every case of sudden and unexpected infant/child death and it is hoped the investigation will help identify how the child has died. In many cases parents will welcome any assistance in obtaining an explanation for their child's death and will wish to assist this process.

There are certain factors in the history or examination of the child, which may give rise to concern about the circumstances surrounding the death. If any such factors are identified, it is important that the information is documented and shared with senior colleagues/SUDC Nurse and relevant professionals in other key agencies involved in the investigation.

In cases where there is a criminal investigation the SUDC nurses will share all the information/documentation/material that they hold in its entirety in accordance with S1. Criminal Investigation and Procedure Act 1996 (CPIA).

The Lead Police Investigator must remember that, irrespective of the potential for criminal proceedings, there are a number of other formal review processes that will seek to refer to the initial investigation in order to make their findings. These include Coroner's inquests and Family Law proceedings. The police investigation will therefore be carried out to a high standard whilst maintaining a balanced approach.

13. CHILDREN'S SOCIAL CARE

In the first instance the ED staff will check with Children's Social Care whether the child or any child within the same family is or has been known to Children's Social Care and if so, in what capacity. As part of the Joint Agency Response process the SUDC Nurse and /or Lead Investigator will also liaise with Children's Social Care Staff and ensure a senior manager is informed.

Children's Social Care staff will check whether the child has been previously known to social care and early intervention teams for any records which indicate any current or previous concern as to the wellbeing of the child or any other such child in the family. Information provided by Children's Social Care about any concerns should include which agency/agencies referred the concerns, what the concerns were, how it was responded to by Children's Social Care including actions and outcomes.

If the family of the deceased child are existing clients of Children's Social Care or have been, then any current or previously allocated worker will be informed, and will inform their line manager.

If the family is not currently known to Children's Social Care, the primary support to the family will be given by health professionals and/or the Police. However, should these agencies believe that other services are required then the Common Assessment Framework (or other local equivalent) process should be followed to identify the most appropriate service required.

If the death appears suspicious and where there are any concerns that another child or sibling has suffered or may suffer harm as a result of abuse then this should be referred directly to Children's Social Care as a Child Protection Referral, and a Child Protection Investigation will be initiated under sec 47 of Children Act 1989.

The Allocated Social Worker will liaise with the SUDC Nurse and the Public Protection unit, and share information.

14. AMBULANCE GUIDELINES

When the ambulance service is called to the scene of a sudden unexpected death of a child, the attending crew must notify the Emergency Operations Centre (EOC). The EOC Duty Manager must notify the Police Control room.

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

The first ambulance staff at the scene should be aware that later they will be required to inform the Police of any history obtained surrounding the death and to have noted the position of the child and the clothing at the time of their arrival.

Ambulance staff should not assume that death has occurred. If the infant, child or young person shows any signs of life, if there is any doubt about whether death has occurred, or where it is deemed that resuscitation is indicated, this should be commenced and the infant, child or young person should immediately be taken to the nearest ED.

The ambulance crew should inform the receiving ED on route of the child's condition and the expected time of arrival. As per Section 3, unless there are exceptional reasons not to, the child should always be brought to the nearest Emergency Department with a Paediatric facility. ***The default position should always be to attend the Emergency Department. Importantly, this process facilitates the physical examination of the child by the Lead Investigator and SUDC Nurse/ on call Consultant Paediatrician.***

However, with older children/young people, where the cause of death may be more apparent (for example a road traffic collision or suicide) a decision should be made as to the most appropriate place to transfer the child. This may be to go directly to the mortuary. Equally, it may be appropriate to take the child directly to the mortuary if decomposition has led to the risk of biohazard.

In these circumstances the Police/SUDC Nurse should liaise with the on call Consultant Paediatrician at the hospital. A discussion should take place as to where the most appropriate place is to transfer the child. The rationale for the decision must be clearly recorded.

Where the ambulance crew diagnose death the body will be removed only following the permission of the Lead Investigator/DI. In these cases the body will be managed by the Lead Investigator as per section 3.

Consideration must be given to the timely support of bereaved parents and the care of the deceased child, therefore families and the deceased child should be taken to an appropriate health setting, preferably ED.

Anything suspicious should be reported directly to both the police and the receiving doctor at the hospital.

Ambulance staff should pass on all the information including history, observations of the scene and resuscitation to the receiving doctor. Any other information gathered (e.g. background history, living accommodation, comments by those at the scene) should be passed on to the ED receiving doctor and the police.

It should be remembered that in most cases of infant deaths the cause of death is natural and there is little evidential benefit for delaying the removal of the body from the scene.

If a baby is born and is reported to have been dead at birth, or died soon after; or is found deceased and abandoned, and the birth was not attended by a healthcare professional, ambulance staff should contact the Police and a Joint Agency Response should be triggered and initial enquiries made to determine whether or not the child was born alive. It is important to remember that the determination as to whether a child was born alive or dead can only be achieved through specialist pathology, typically a home office post mortem examination. The Police will lead on these investigations regardless of whether the baby was born alive or not. In these circumstances, a Strategy Discussion should take place with consideration of Section 47 enquiries.

Regardless of whether the baby was born alive or dead the requirement for a high level forensic examination and evidential preservation is paramount. ***It is important to remember that if called to assist in these cases, and the baby was born without a healthcare professional in attendance, i.e. before NNAS or a midwife arrived, and the history given by the mother indicates that the baby was born stillborn, and there are clearly no signs of life, the baby, umbilical cord and placenta (if still attached) should not be handled or interfered with.***

The Lead Police Investigator will implement an appropriate forensic strategy in support of these aims. All agencies should be mindful of this requirement in dealing with incidents of concealed pregnancy. Professionals should refer to the Lancashire Concealed and Denied Pregnancy Protocol for further information.

https://panlancashirescb.proceduresonline.com/chapters/p_concealed_preg.html

Ambulance staff must notify the NNAS Safeguarding team of all sudden child deaths as per their SUDC Procedure.

15. HOSPITAL STAFF

The guidance in this section is in line with the Standards for Children and Young People in Emergency Care Settings (2012) www.rcpch.ac.uk/emergencycare.

As soon as the ED is notified that the Ambulance crew is attending the scene of a possible child death the ED nurse in-charge must notify:

- The on-call Paediatric/resuscitation team
- The on-call Consultant Paediatrician
- The on-call Emergency Department consultant

In circumstances when a child is deceased at the scene consideration must be given to the timely support of bereaved parents and the care of the deceased child.

If there is any doubt about the duration of the collapse, full resuscitation must be commenced and should continue until the child arrives in hospital. The default position should always be to attend the emergency department, but with older children where the cause of death is more apparent (for example, stabbing or a train-related disturbance), a decision may be made to transfer straight to mortuary facilities.

Clear documentation of the full resuscitation process and all investigations undertaken is essential.

An experienced ED nurse or Paediatric nurse should be assigned to receive and support the parents through the process. The Nurse will have the following responsibilities:

- Organising the communication process with the parents and be present throughout the process of information gathering and sharing. Bereavement support should be considered, to include bereavement counsellor, hospital chaplain, other faith leader and/or offer to contact friends and relatives.
- Arranging parental contact with the senior paediatrician after the resuscitation has been discontinued.
- Support the parents whilst they hold their child and remain present in the room at all times. In most situations the parents will have already handled their child after death, and allowing them to hold their child should not interfere with the investigation into the cause of death. Please consider and be mindful of the environment that the deceased child and family are placed in (best practice is to avoid noisy bustling areas).
- Will ensure that the appropriate documentation and notification processes are completed.
- Will work closely with the Consultant Paediatrician/ED Consultant and the Police to ensure that all evidence is preserved.
- Mementoes and keepsakes should be discussed with the family and obtained with permission from the Lead Investigator and presented at their request. Mementoes should be taken by the doctor and overseen by the Lead Investigator.

To identify the possible cause of death a brief initial history should be obtained. The comments of carer/parents must be recorded at all stages by a health professional in detail (and if possible verbatim) in case of future discrepancies or if suspicious circumstances develop. This history should be shared with the SUDC Nurse and Lead Investigator on their arrival to the ED.

Examination should start as resuscitation commences:

- The hospital documentation should be completed. The SUDC History Record should be commenced.
- If resuscitation has been attempted, any intravenous, intra-arterial or intra-osseous lines inserted for this purpose should only be removed following discussion with the Lead Police Investigator. All medical interventions, including sites of attempted vascular access, should be carefully documented on a body chart. If an intravascular cannula has been inserted and it is thought that it may have contributed to failed resuscitation (for example, by causing a pneumothorax), it should not be removed.

Once a decision has been made to stop resuscitation, an appropriately qualified medical practitioner should confirm that the child is dead, in accordance with established guidelines. Confirmation of the fact of death and the time should be recorded in the infant's notes.

When the child has been pronounced dead a member of the resuscitation team, usually the on call Consultant Paediatrician, should inform the family. This should be done in the privacy of an appropriate room. An Emergency Department Nurse, usually a Paediatric Nurse, is allocated to care for the family and should be present at this time.

Emergency Department staff should follow their own SUDC procedures and notify the Police and SUDC Nurse of the unexpected death of the child. It is more than likely that they will already be aware, but staff should still make contact. Hospital staff should also notify all other agencies on their own professional checklists.

Following death, the child must not be left alone with the parents. A Nurse or attending Police Officer must stay in the room at all times. ***The child must not be dressed/or placed in a hat, or wrapped in a blanket. In the case of babies, a clean nappy may be put on and the baby may be covered loosely by a hospital sheet. The nappy and any clothing worn by the child on admission to ED must be retained as the Police will require this.***

Once death has been confirmed, the Consultant Paediatrician on call or the SUDC Nurse should carefully and thoroughly examine the child. The Police Investigator should be present while this happens. A particular note should be made of any marks, abrasions, rashes, evidence of dehydration or identifiable injuries at this time, in addition to a detailed general examination. The presence of any discolouration of the skin, particularly dependent livido, should be carefully and accurately documented, along with other findings, such as frothy blood-stained fluid from the airways and rigor mortis. All findings should be carefully documented in the notes and on a body chart. The child should be weighed and measured (length and head circumference), and the measurements plotted on a centile chart. The deceased child should be re-examined where practicable to note any external marks that might not have been present on initial examination, particularly if trauma is being considered as a possible causative factor in the child's death.

If possible the eyes should be examined by direct by an appropriately qualified person for the presence of retinal haemorrhages by an appropriately qualified person. An Ophthalmologist should be contacted if available.

Where a child is successfully resuscitated, they should be stabilised and moved to a Paediatric Intensive Care facility. Subsequent discussions regarding ongoing intensive care or the withdrawal of care should involve the Paediatric intensive care team, the family and the police investigator. Consideration should be given to the timing of any withdrawal of intensive care, support for the family around the decision, and the appropriate timing and process of the joint agency investigation, including a home visit

The Lead Police Investigator, SUDC Nurse, the Pathologist and Coroner must be informed of any specimens taken during resuscitation.

Records must accurately document which tests have been obtained.

The Consultant Paediatrician must ensure that all results of pre-mortem tests are forwarded to Coroner and the Pathologist. No specimens are to be taken from the child after death.

If the child is dead on arrival at hospital or when death is certified, the attending doctor should speak to the Lead Police Investigator.

Notes of previous hospital, obstetric, emergency department attendances must be obtained where these notes are held at the hospital (or Trust) where the death of the infant or child is certified, the hospital staff should create these and pass them to the Lead Police Investigator/SUDC Nurse and/or Coroner's officer.

Where the notes may be relevant but held at another Trust, the Lead Police Investigator or Coroner's officer will arrange for the notes to be collected.

A check should be made to ascertain whether the child, or any sibling, is subject to a child protection plan or is/has been known to Children's Social Care.

Twins and multiples have around a twice the risk of SIDS as a singleton. When one twin dies the surviving twin should be admitted to the Paediatric unit for close monitoring for at least 24 hours. Investigations to exclude infection, metabolic disease and underlying cardiac conditions should be carried out.

Other professionals also need to be informed. This should be done in consultation with your NHS Trust checklist. Paediatric Liaison should have a sharing of information form which is used to document which health professionals have been informed and the relevant date and time. This form should be signed and a copy sent to the appropriate Health Visitor/School Nurse.

The parents/carers will need time to accept the information. Staff should be prepared for a range of reactions from the bereaved individuals.

The family should be informed of the Joint Agency Response process and that a team of professionals will be involved to help understand 'why' their child has died. An explanation should be given as to why the Coroner must be informed and that a post mortem examination will probably be necessary to try to ascertain the cause of death. It must also be explained that a Paediatric post-mortem examination will always involve the taking of tissue samples for histological examination. Such an investigation does not require the consent of the parents and is a decision for the Coroner.

The SUDC Nurse (in hours), on call Consultant Paediatrician and the Lead Police Investigator should jointly examine the child. Crime Scene Investigators (CSI) should be present to obtain photographs of the child. Those present should be kept to a minimum, those in essential roles only. Anybody else present should be at the discretion of the Lead Police Investigator.

The SUDC History Record should be used to record the findings of the examination and the body map should be completed (this can be found on internal systems or on your intranet).

If blood samples were taken prior to death in the Emergency Department (or on the ward) the results should be made available to the Pathologist.

Kennedy samples post-death are not taken in the Emergency Department as these will be taken by the Pathologist at the post mortem examination. Where the circumstances of the death indicate the child may have died approaching 48 hours earlier, the Lead Police Investigator should consider liaison with Specialist Paediatric Pathology at the regional children's hospitals. Subject to that discussion samples will be taken locally or at the regional hospitals. This is to ensure that the impact of decomposition on the Kennedy Samples is effectively mitigated.

A full radiological Skeletal Survey will be undertaken prior to the post mortem examination at Alder Hey Children's Hospital and at Royal Manchester Children's Hospital. It should be performed and reported by an experienced Paediatric Radiologist prior to the post mortem examination being commenced.

The skeletal survey does not need to be performed at the local hospital. However, the exception to this is Blackpool Victoria Hospital who may undertake a skeletal survey following a child death, after each case is considered on its own individual merits and discussed with the Consultant Paediatrician and Lead Police Investigator.

The clothing worn by the child should be seized by the Police, along with the nappy, blanket or bedding if necessary. Once the child has been examined and all findings recorded, the infant/child can be placed in a clean nappy and given to the family to hold if they wish. ***Permission should always be sought from the Lead Police Investigator first. Please note, babies should not be wrapped or swaddled in a blanket,***

neither should a hat be placed on the baby's head. This can affect post mortem changes and interfere with forensic evidence.

Health staff in the Emergency Department should offer the family the option of mementoes being taken such as handprints, footprints, a lock of hair and photographs. This should be done sensitively, recognising that this can be important for many families but will not be wanted by all. ***Hospital staff should seek guidance from the Lead Police Investigator before taking mementoes.***

If there are safeguarding concerns or suspicious circumstances surrounding the death, the taking of mementoes should be discussed with the Lead Police Investigator to ensure this does not interfere with any investigation; in such circumstances it may be appropriate to delay this until after the post mortem examination. Local procedures will apply in each regional Children's hospital.

A record should be made for every stage of contact with the family. This should include which health professionals were present for each contact. Careful documentation is required to include the full history, any verbatim comments and demeanor of the parents/carers.

A member of staff should accompany the child to the mortuary once permission is given from the Lead Police Investigator. The child should not be left unattended. If there is to be a post mortem, then the child's body must remain in the hospital mortuary until that time.

15.1 Unexpected death of a child on a ward

When a child is found collapsed, the Resuscitation Team will be called and full resuscitation carried out.

When death is pronounced and is unexpected, follow the SUDC Protocol. If in doubt, contact the SUDC Nurse.

The Senior Nurse on duty will follow the Joint Agency Response flow chart (page 14).

The location of where the child collapsed should be treated as a scene and preserved accordingly. This includes any medical equipment being used by the child.

All information will be recorded as documented above.

Staff should be offered support and debriefing as appropriate.

If the child died unexpectedly but does not fall under the jurisdiction of the Coroner, a Joint Agency Response may still need to be initiated. This could include children with life limiting conditions. Whilst the child may have complex health needs, their death may still be regarded as unexpected.

15.2 Deaths of Babies Never Discharged From Hospital

All deaths of newborn infants that occur in hospital must be considered, in context with the circumstances of the birth and any history available. Enquiries must be made to identify any concerns regarding the mother or the family:

- If a baby dies due during a birth and there is a clear medical explanation for the death which is a natural disease process running its full course, this should not be treated as an unexpected death. However, if there are any circumstances that have caused the death to be in some way unnatural or intervention that has shortened the life of the child, advice should be sought from Coroner.
- If a baby dies in the same circumstances (i.e. whilst under medical supervision), with no immediate medical explanation apparent for the child's death, this is a death of cause unknown' and should be referred to Coroner unless a doctor who attended the deceased child in their last illness, assuming the child showed some signs of life, can issue a Medical Certificate of Cause of Death (MCCD).

Further enquiries must be made to identify any concerns regarding the mother or the family.

After all relevant considerations have been made, if the death is deemed unexpected, then the SUDC Protocol and Joint Agency Response process must be initiated, and internal reporting mechanism complied with.

15.3 Concealed and denied pregnancy

If a baby is born and is reported to have been dead at birth, or died soon after; or is found deceased and abandoned (i.e., within hospital grounds) and the birth was not attended by a healthcare professional, a Joint Agency Response should be triggered and initial enquiries made to determine whether or not the child was born alive. It is important to remember that the determination as to whether a child was born alive or dead can only be achieved through specialist pathology, typically a home office post mortem examination. The Police will lead on these investigations regardless of whether the baby was born alive or not. In these circumstances, a Strategy Discussion should take place with consideration of Section 47 enquiries.

Regardless of whether the baby was born alive or dead the requirement for a high level forensic examination and evidential preservation is paramount. ***Should a professional, such as a Midwife, be called to either the home, a community setting, ED or a maternity unit, following the delivery of a baby, reportedly showing no signs of life, and the delivery was not attended by a health professional, it is highly important that the baby, umbilical cord and placenta (if still attached) are not handled or interfered with.***

Professionals should refer to the Lancashire Concealed and Denied Pregnancy Protocol for further information.

https://panlancashirescb.proceduresonline.com/chapters/p_concealed_preg.html

15.4 Staff Welfare

Following the unexpected death of a child in hospital, either on the ward, ICU or the ED, consideration should be given to a hot debrief. This should involve all staff members including NWS staff.

Staff should receive support, guidance and supervision in line with individual Trust policy.

16. THE GENERAL PRACTITIONER (GP)

The General Practitioner may be called to the scene first, and in such cases should follow the SUDC Protocol (see flow charts on pages 13). They should be aware that later they may be required to inform the police of any history obtained surrounding the death and to have noted the position of the child and the clothing at the time of their arrival.

The GP should not assume that death has occurred. If the infant, child or young person shows any signs of life, if there is any doubt about whether death has occurred, or where it is deemed that resuscitation is indicated, this should be commenced and the infant, child or young person should immediately be taken to the nearest ED by ambulance.

If there are no signs of life the GP will confirm death and call for an ambulance, Police and SUDC Nurse and notify the Coroner. The GP will inform the ED Consultant/Paediatrician on call at the hospital to which the child will be taken.

The GP will provide information for the Joint Agency Response, including information sharing, involvement in multi-agency discussions and in conjunction with other health professionals, will be involved in providing ongoing advice and support for the family.

If the GP was not involved with the child at the time of the death, the family GP still has a responsibility to contribute to the Joint Agency Response as necessary. It is particularly important that the GP contributes to the Child Death Review meeting to ensure that the bereavement needs of the family are met and that lessons are learnt where appropriate.

Consideration must always be given as to whether the death is expected or unexpected; if in doubt the SUDC Nurse should be contacted.

17. COMMUNITY HEALTH PROFESSIONAL

The Community Health Professional may be first on the scene, and in such cases should follow the SUDC Protocol (see flow charts on page 14). They should be aware that later they may be required to inform the Police of any history obtained surrounding the death and to have noted the position of the child and the clothing at the time of their arrival.

The gathering of relevant information from the health visitor, community practitioners, school nurse & community nurse when a sudden unexpected child death occurs is needed to aid the investigative process of the Joint Agency Response and the Coronial Enquiry. Whilst sharing this essential information, the need to support the professional involved with the family prior to the death of the child, must be recognised.

The SUDC Nurse will contact the Named Nurse/Safeguarding Team with the information of the child's name, date of birth, address, GP and the time of death, and will gather any other additional information.

The SUDC Nurse will contact the health visitor, school nurse and any other health professional including CAMHS, to ascertain whether there have been any professional concerns regarding the health and parenting of the child.

The SUDC Nurse will share the information with the relevant professionals involved in the Joint Agency Response Process.

All Health Professionals should follow their own individual Trusts protocol when notified of a child death.

The Health Visitor will inform the Child Health Department to avoid further appointments being sent. A datix (incident reporting) must be completed by the most relevant community professional.

The community health professionals will ensure that all known agencies working with the child have been informed of the child's death e.g., Children's Therapy and Nursing Services, audiology, midwifery services, community paediatricians, children's centres etc. to avoid appointments being sent.

If a Police statement is required the Community Health Professional should seek support from their line manager and Safeguarding Team.

The most appropriate Health Professional will immediately offer support to the family. They will ensure that the parents are aware of how to access relevant counselling and bereavement support, and make any referrals as appropriate. The Health Professional should identify any medical or social needs and arrange support as necessary.

In case of an infant death, the parents shall be offered support with subsequent babies via the Care Of the Next Infant (CONI) scheme. The scheme should also be offered where the deceased infant was one of a multiple birth.

18. MIDWIFE

These guidelines inform midwives of the procedures in the event of unexpected death of a child and excludes babies who are stillborn and planned terminations of pregnancy carried out within the law.

If the community midwife is first on the scene:

The community midwife 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, paramedics notified, and the child should immediately be taken by ambulance to the nearest ED. Mother's medical condition must also be assessed immediately and appropriate emergency treatment sought. If the mother's condition requires obstetric intervention, she should be transferred with a midwife to the nearest appropriate maternity unit, whether she is booked there or not.

If the indications are that the baby is dead and no active resuscitation has been attempted, the body and placenta should remain in situ. The midwife must inform the emergency services and their duty manager.

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

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

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

If the baby is not resuscitated the body will be taken to a hospital ED in line with Section 3. ***Following examination of the baby by the Police, SUDC Nurse or on call Consultant Paediatrician, the baby must not be wrapped in a blanket nor should a hat be placed on the baby's head.***

If the midwife has any relevant information about the pregnancy or the family, this should be reported directly to the Police/SUDC Nurse and ED staff as soon as possible.

Records should be written up immediately making particular reference to:

- any delay in seeking help
- the position of the baby and the condition in which it was found
- inconsistent explanations – accounts should be recorded verbatim in quotes
- evidence of drugs/alcohol abuse
- parents reaction/demeanor
- unexplained injury e.g. bruises, burns, bites, presence of blood
- neglect issues
- position of where the baby was found and its surroundings
- general condition of the accommodation
- evidence of high risk behaviour e.g. domestic violence

Mother and baby's records will be secured immediately by the Police or Coroner's Officer as soon as the death has been notified. A copy will be made available for the midwives. This is a precautionary measure until the situation is clarified.

The family G.P and Health Visitor must be informed as soon as possible.

In the case of an unexpected death on the maternity unit, the Head of Midwifery should be notified. The SUDC Protocol needs to be initiated.

Consideration needs to be given to the retention of the placenta.

If you learn later that a baby has died:

Contact the SUDC nurse and ensure that the following agencies/professionals are informed of the infant's death.

- Medical records department/maternity/children's hospitals
- Child health department to avoid appointments/reminders being sent
- The family G.P. in case she/he has not already been contacted by the Police/hospital
- Health visitor
- Audiology department if the infant has been referred for follow-up or has not yet had neonatal screening
- Named Nurse for Safeguarding Children and the relevant line manager
- School Nurse if there are older siblings in the family
- Any other department to which the infant has been referred/seen if follow-up appointments are possible.

Discuss the support the parents/carers/extended family require.

The mother should receive a full postnatal risk assessment and if she was breast feeding, a management plan on the suppression of lactation and given appropriate support. Refer to the GP if necessary.

The midwife will ensure that the midwifery records are available to the SUDC Nurse and be available to attend any subsequent multi-agency meeting. If still visiting the mother photocopy the hand held records and take to the meeting.

The midwife will be prepared to provide a Statement of Evidence if requested and seek advice from your line manager, supervisor, union and Safeguarding Team.

The next pregnancy:

- The midwife will ensure that the CONI Co-coordinator has been notified as soon as possible.
- The midwife will scrutinise previous records to ascertain whether it is necessary to inform any other professional/agency of the pregnancy e.g. Social Worker.
- The midwife will ensure that any previous infant death notified is highlighted in the maternity records.
- The midwife will ensure that the family receives appropriate support and care during the pregnancy, delivery, and post-natal period.

18.1 Deaths of infants never discharged from hospital

All deaths of newborn infants that occur in hospital must be considered, in context with the circumstances of the birth and any history available. Enquiries must be made to identify any concerns regarding the mother or the family:

If a baby dies due during a birth and there is a clear medical explanation for the death which is a natural disease process running its full course, this should not be treated as an unexpected death. However, if there are any circumstances that have caused the death to be in some way unnatural or intervention that has shortened the life of the child advice should be sought from the Coroner.

If a baby dies in the same circumstances (i.e. whilst under medical supervision), with no immediate medical explanation apparent for the child's death, this is a death of cause unknown' and should be referred to the Coroner unless a doctor who attended the deceased child in their last illness, assuming the child showed some signs of life, can issue a Medical Certificate of Cause of Death (MCCD).

Further enquiries must be made to identify any concerns regarding the mother or the family.

After all relevant considerations have been made, if the death is deemed unexpected, then the SUDC Protocol and Joint Agency Response process MUST be initiated, and internal reporting mechanism complied with.

18.2 Concealed and denied pregnancy

If a baby is born and is reported to have been dead at birth, or died soon after; or is found deceased and abandoned, and the birth was not attended by a healthcare professional, a Joint Agency Response should be triggered and initial enquiries made to determine whether or not the child was born alive. It is important to remember that the determination as to whether a child was born alive or dead can only be achieved through specialist pathology, typically a home office post mortem examination. The Police will lead on these investigations regardless of whether the baby was born alive or not. In these circumstances, a Strategy Discussion should take place with consideration of Section 47 enquiries.

Regardless of whether the baby was born alive or dead the requirement for a high level forensic examination and evidential preservation is paramount. ***Should a professional, such as a Midwife, be called to either the home, a community setting, ED or a maternity unit, following the delivery of a baby, reportedly showing no signs of life, and the delivery was not attended by a health professional, it is highly important that the baby, umbilical cord and placenta (if still attached) are not handled or interfered with.*** The Lead Police Investigator will implement an appropriate forensic strategy in support of these aims. All agencies should be mindful of this requirement in dealing with incidents of concealed pregnancy. Professionals should refer to the Lancashire Concealed and Denied Pregnancy Protocol for further information.

https://panlancashirescb.proceduresonline.com/chapters/p_concealed_preg.html

19. CORONER AND PATHOLOGIST

After death is confirmed, the Coroner has control of the body.

In all cases of SUDC of age <2 years a full skeletal survey will be taken at the time of the post mortem examination.

In most cases of SUDC, the post-mortem examination will be performed by a Paediatric Pathologist. In older children and adolescents with road traffic accidents, hangings, drug overdoses, the post mortem examination may be carried out by a general pathologist at the direction of the Coroner. If there are suspicious circumstances a Home Office Pathologist will take the lead role in the post-mortem examination, again at the direction of the Coroner. It is recommended that each Pathologist produce a separate report. Before the post mortem examination commences the Pathologist must have written authority from the Coroner.

The Lead Investigator and SUDC Nurse is responsible for ensuring that the Coroner and Pathologist are provided with the summary, of the full medical history including any relevant background information concerning the family and any concerns raised by any other agency. The SUDC Nurse will also provide a written report for the Pathologist prior to the post mortem examination and the Coroner within 28 days.

A clear high resolution copy of the following documents should accompany the body to the mortuary:

- Hospital case records
- Ambulance notes
- ED Notes
- Obstetric/delivery notes of the mother if the child is less than 3 months old
- Report of the police scene
- G72

The hospital must ensure that all pre mortem blood samples are preserved and that the results of pre-mortem samples are forwarded to the Coroner and the Pathologist.

If the post mortem examination is a home office post mortem, the Lead Police Investigator must ensure that all relevant professionals who have notified the Coroner that they wish to attend the post mortem examination and any other persons entitled to be represented by a medical practitioner, are informed of the time and place of the post-mortem. If the post mortem examination is a paediatric post mortem, this role is performed by the Coroner's Officer.

The post-mortem examination shall be carried out promptly. All persons involved with these guidelines will co-operate to ensure this happens. A full post-mortem report shall be provided in writing to the Coroner as soon as possible. All investigations are to be concluded within the shortest possible time, to enable:

- The prompt funeral of the child
- the expeditious conclusion of the inquest into the death of the child

In the event of a suspicious death the Lead Investigator (or appointed representative) and the Crime Scene Officer must attend the post-mortem. If the Paediatric Pathologist carrying out the post-mortem examination wishes to retain a whole organ (solely for the purpose of establishing the cause of death) he/she will notify the Coroner.

The Coroner, through his officer, will enquire of the family as to their wishes as to the ultimate disposal of the organ so retained and whether or not this is to occur with the body.

All non-PACE samples taken at post-mortem are under the control of the Coroner and must be labelled, identified and dealt with in accordance with Coroner's instructions and the Human Tissue Act (2004).

The interim results of any post-mortem will be communicated immediately to the Coroner on the relevant

form. Bearing in mind possible legal implications arising from the findings, the Coroner will use his discretion as to what information will be passed to the SUDC Nurse and/or the Paediatric Consultant. The Coroner will endeavor to be as helpful as possible with the provision of information. The SUDC Nurse/Paediatrician may be instructed to keep some information strictly confidential.

After the post mortem examination and in any event within 48 hours of the post-mortem, the Pathologist will provide to the Coroner in writing the following information:

- The preliminary post-mortem pathological findings (if any)
- The preliminary cause of death if ascertained
- Details of tissues retained for further examination (if any)

The Coroner will brief his staff **within 72 hours** of the death with the information appropriate to share with other agencies who telephone Coroner's office requesting the information. Those receiving such information will treat the same with confidentiality.

On receipt of the interim post-mortem result the Lead Investigator/SUDC Nurse will arrange any further discussions.

The final written post-mortem report should be made available within 14 days of the conclusions of investigations, a list of samples taken, whether these were taken under Coronial authority or seized by the police under PACE and the results of subsequent tests.

Upon receipt of a written post mortem report the Coroner will provide a copy to the SUDC Nurse/Paediatrician and the Lead Investigator as per local arrangements. However, this is always subject to the Coroner's judicial discretion and it is expected that it will only be in very rare cases the Coroner will decline and will explain his reason in writing for taking such a course of action. The copy of the post mortem report will be shared directly with the SUDC Nurse or with the CDOP Coordinator who will forward a copy to SUDC Nurse. This will initiate the planning of a Child Death Review meeting and unless otherwise notified by the Coroner the SUDC Nurse will assume permission from the Coroner to hold such a meeting.

There is within these guidelines agreement for the collection of medical samples, radiological examination and care of intravascular and surgical lines. This must be followed and any proposed deviation discussed with the Coroner.

A Coroner's post-mortem is not subject to consent and takes place irrespective of the parents' wishes. The Pathologist will inform the Coroner about the tissue samples taken during the post mortem and whether or not these are taken under the Coroner's authority (and subject to the Human Tissue Act 2004) or have been seized by the police under PACE. Thereafter the Coroner's officers will consult with the family as to the ultimate disposition of those samples taken under the Coroners authority, the choices being for the tissues to be preserved as part of the permanent medical record, returned to the parents (i.e. funeral director), or respectfully disposed of. The Police will comply with the requirements of PACE but no samples will be disposed of until after the inquest has taken place. This should then be communicated with the Pathologist in order that the family's wishes may be carried out at conclusion of the Inquest.

20. REFERENCES

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21. TERMINOLOGY

Age: For the purpose of this protocol a child is defined as a child or young person from birth (excluding both those babies who are stillborn and planned terminations of pregnancy carried out within the law) **up to the age of 18 years.**

ALTE: Any previous life threatening event.

Apnoea: Absence of breathing.

CAMHS: Child & adolescent mental health services.

Care of Next Infant Programme (CONI): A national Health Visitor led service for bereaved parents who have suffered a sudden and unexpected death of a baby. The programme supports families before and after the birth of their next baby. CONI is running hospitals and community health centres and involves health visitors, midwives, paediatricians and GPs.

Child Death Overview Panel (CDOP): This is a multi- professional group which has a permanent core membership drawn from key organisations represented by the Children's Safeguarding Assurance Partnership (CSAP). The function of CDOP is to review the available information on all child deaths up to 18 years whether expected or unexpected in the CSAP area to identify themes and trends.

Child Death Review Partners (CDR partners): Defined in the Children Act 2004, and means, in relation to a local authority area in England, the local authority and any CCG for an area any part of which falls within the local authority area.

Child Death Review Meeting (CDRM): A multi-agency meeting where all matters relating to an individual child's death are discussed. In cases of unexpected deaths the CDRM will take the form of a final case discussion meeting following the Joint Agency Response. This takes place once the final Post Mortem Report is received. These meetings were previously known as End of Case Discussion Meetings (ECDM's).

Children's Safeguarding Assurance Partnership (CSAP): Children's Safeguarding Assurance Partnership (CSAP) for Blackburn with Darwen, Blackpool and Lancashire replaced Lancashire Children's Safeguarding Board in September 2019. The Independent Scrutineer function joined the membership of the Partnership to ensure that the pivotal learning from independent scrutiny directly informs the leadership of the arrangements. The Safeguarding Partnership is the final decision-making body overseeing the multi-agency plan to protect children and safeguard their welfare in Blackburn with Darwen, Blackpool and Lancashire. The role of the wider Safeguarding partners is pivotal in setting the direction, priorities and overseeing partnership safeguarding activity. In particular, CSAP will review progress and assess strengths and areas for development in the local safeguarding system. This analysis will be directly informed by Independent Scrutiny findings and will underpin the priorities for the wider partnership and will inform the CSAP Annual Report, which will be published.

Child Safeguarding Practice Review (CSPR): CSAP will conduct a Child Safeguarding Practice Review (CSPR) when a child is seriously harmed or dies as a result of abuse or neglect. The review identifies how local professionals and organisations can improve the way they work together.

Child Safeguarding Practice Review Panel: The responsibility for how the system learns lessons from serious child safeguarding incidents lies at a national level with the Child Safeguarding Practice Review Panel. The Panel is responsible for identifying and overseeing the review of serious child safeguarding cases which, in its view, raises the issues that are complex or of national importance. The Panel also maintains oversight of the system of national and local reviews and how effectively it is operating.

Clinical Commissioning Groups: These groups are a core part of government reforms to the health and social care system. In April 2013 they replaced primary care trusts (PCT's) as the commissioners of most services funded by the NHS in England. They now control almost 2/3 of the NHS budget and have a legal duty to support quality improvement in general practice.

Community Health Professional: Any health professionals based within the community e.g. community practitioner, health visitor, school nurse or community nurse

Coronial Inquiry/ Inquest: A Coroner is an independent judicial officer who investigates deaths of unknown cause, violent or accidental deaths or deaths while a person is detained are reported to the Coroner. A Coroner's jurisdiction over a body (i.e. which Coroner will deal with a death) is determined by where the body is located, although deaths can be transferred between Coroners. A Coroner may conduct preliminary enquiries, which may or may not include a post mortem of various types, may also conduct an investigation to further investigate the death which may or may not culminate in an inquest. At an inquest the Coroner is required to answer, so far as the evidence allows, who has died, where and when the death occurred and by what means a person came by their death.

CPR: Cardio-pulmonary resuscitation.

Emergency Department (ED): Preferred name of an Accident and Emergency Department.

Forensic Pathologist: Home Office Pathologist (see below).

Frenulum: A fold of membrane that limits the movement of an organ. In these circumstances it means the upper lip unless otherwise specified. It may also be applied to the tongue or foreskin of the penis.

Home Office Pathologist: A pathologist with specialist forensic pathology training who is a Home Office accredited.

Infant: For the purposes of this document, the medical definition of infant is an individual of less than 1 year of age.

Initial SUDC Meeting: A multi-agency information sharing and planning meeting with key agencies and professionals who were involved with the child and family prior to the death and at the time of the death. The SUDC Nurse/Police will arrange and chair this meeting. This early meeting is a key action as part of the Joint Agency Response and will usually take place in normal working hours to ensure all relevant professionals can attend.

Joint Agency Response: A coordinated multi-agency response (SUDC Nurse and Police) that is triggered when a child dies suddenly and unexpectedly.

Key Worker: A person who acts as a single point of contact for the bereaved family, who they can turn to for information on the child death review process, and who can signpost them to sources of support. This person will usually be a health care professional, such as the SUDC Nurse or a Bereavement Nurse.

Lancashire: Use of the term 'Lancashire' refers to the geographical region as opposed to specific CSAP area.

Lead Health Professional: When a Joint Agency Response is triggered, a lead health professional is appointed to co-ordinate the health response to that death. In Lancashire this is the SUDC Nurse (Monday – Sunday 9am-5pm). Out of hours the role of the lead health professional should be taken by the senior attending Paediatrician.

Lead Police Investigator: The police officer with direct responsibility for leading the initial police response to a SUDC. Typically this will be a Detective Inspector but may also be performed by a Detective Sergeant if

appropriate.

Medical Certificate of Cause of Death (MCDD): An official certificate that enables the deceased's family to register the death, provides a permanent legal record of the fact of death, and enables the family to arrange the funeral.

Medical Examiner: A medical practitioner appointed as a medical examiner whose responsibility is to ensure: that the cause of death is accurately recorded by the attending practitioner (doctor) on the MCDD; that timely and appropriate referral to the Coroner has occurred where appropriate; engage with the bereaved to understand any concerns; and to ensure that possible clinical governance concerns have been highlighted.

A national system of Medical Examiners will be introduced from April 2019 to provide independent medical scrutiny of all non-coronial deaths.

National Child Mortality Database: when introduced this will be a repository of data relating to all children's deaths in England.

NHS England: Their function is to improve health outcomes for people residing in England.

NHS Serious Incident: Serious incidents in health care are adverse events where the consequences to patients, families and carers, staff or organisations are so significant or the potential for learning is so great, that a heightened level of response is justified. See the NHS Serious Incident Framework.

Personal Child Health Record: Also known as Red Book. This is a child's personal health record. It is the main record of a child's health, growth and development. It is given prior to discharge from hospital to a mother following the birth of her baby.

Petechial Haemorrhages: A Petechia(e) is a small red or purple spot on the body caused by a minor haemorrhage (broken capillary blood vessels).

Police Protection Power (PPP): previously known as Police Protection Order (PPO).

Post Mortem Examination/Home Office Post Mortem: A post-mortem (autopsy) is an examination of a body after death. They are carried out by a Pathologist to establish the cause of death. A Pathologist is a doctor who specialises in understanding the nature and cause of disease.

PPU (Public Protection Unit): Now referred to as Child Protection Teams in within Lancashire Constabulary (PPU's no longer formally exist per se). An area of policing that deals with family matters.

Public Health Nominated Suicide Prevention Lead: A nominated and named Local Authority Suicide Prevention specialist who can support wider community prevention strategies.

Rapid Review: Safeguarding partners are required to promptly undertake a rapid review on all notified serious incidents, which should assemble the facts of the case as quickly as possible in order to establish whether there is any immediate action needed to ensure a child's safety and the potential for practice learning. The rapid review should conclude with a decision about whether a local child safeguarding practice review should be commissioned. The national panel have set a 15 working day timescale for the completion of rapid reviews.

Retinal Haemorrhage: Bleeding which occurs in the retina, on the back wall of the eye. This can occur as a result of a medical condition or as a result of shaking, particularly in young babies or a severe blow to the head.

Lead Police Investigator: A police officer who is accredited to manage the investigation into sudden/suspicious deaths. It is recommended that the police officer attending should be a detective of at least Inspector rank (ACPO Crime Committee, 2000).

Serious incident notification: The Children Act 2004 (as amended by the Children and Social Work Act 2017) states: "Where the local authority in England knows or suspects that a child has been abused or neglected, the local authority must notify the Child Safeguarding Practice Review Panel if

- a) The child dies or is seriously harmed in the local authority's area
- b) While normally resident in the local authority's area, the child dies or is seriously harmed outside England.

Skeletal Survey: A skeletal survey is a series of X-rays of all the bones in the body.

Strategy Discussion/Meeting: Whenever there is reasonable cause to suspect that a child is suffering or is likely to suffer significant harm there should be a strategy discussion involving local authority children's social care (including the residential or fostering service, if the child is looked-after), the police, health and other bodies such as the referring agency. This might take the form of a multi-agency meeting or phone calls and more than one discussion may be necessary. A strategy discussion can take place following a referral or at any other time, including during the assessment process and when new information is received on an already open case.

Subdural Haemorrhage: A subdural haematoma or haemorrhage is a type of blood clot usually associated with traumatic brain injury.

SUDI/SUDC: Sudden Unexpected Death in Infancy/Childhood. A descriptive term used at the point of presentation of death of an infant or child whose death was not anticipated as a significant possibility 24 hours before the death or where there was a similarly unexpected collapse leading to or precipitating the events which led to death.

Sudden Infant Death Syndrome (SIDS): This refers to the sudden and unexpected death of an infant under 12 months of age, with onset of the lethal episode apparently occurring during normal sleep, which remains unexplained after a thorough investigation.

SUDC Nurse: A Specialist Nurse who provides expert health input into the Joint Agency Response, and where deemed appropriate, will lead the multiagency response to an infant or child death.

Suspicious circumstances: Factors in the environment, history or examination that may give rise to concern about the circumstances surrounding the death.

Unascertained: This is a legal term often used by Coroner's, Pathologists and others involved with death investigation, where the medical cause of death has not been determined to the appropriate legal standard, which is usually the balance of probabilities.

Unexpected death: The death of a child that was not anticipated as a significant possibility, for example 24 hours before the death or where there was a similarly unexpected collapse leading or precipitating events which led to the death.

APPENDIX 1 CRITERIA FOR REFERRAL OF DEATHS TO CORONER

Derived from 'Report of Death to Coroner' form, issued with the Chief Coroner's Guidance note 23, July 2016. Reasons for referral to the Coroner are as follows:

- The cause of death is unknown;
- The deceased was not seen by the certifying doctor either after death or within 14 days before death;
- The death was violent or suspicious;
- The death was unnatural;
- The death may be due to an accident (whenever it occurred);
- The death may be due to self-neglect or neglect by others;
- The death may be due to an industrial disease or related to the deceased's employment;
- The death may be due to an abortion;
- The death occurred during an operation or before recovery from the effects of an anesthetic;
- The death may be a suicide;
- The death occurred during or shortly after detention in police or prison custody;
- The death occurred while the deceased was subject to compulsory detention under the Mental Health Act or a Deprivation of Liberty Safeguards authorisation (DoLS); or
- For any other concerning feature.

Individual Coroners may have their own reporting requirements.

APPENDIX 2 EXAMINATION OF THE INFANT WHO HAS DIED SUDDENLY AND UNEXPECTEDLY

General examination

Document the position the infant was put to sleep and found (prone, side or supine). Document the presence of frothy fluid, an admixture of air and seromucous discharge. It is commonly bloodstained and present around the nose or mouth.

Document the presence of blood or vomitus on clothes or body.

Note the state of general nutrition and whether there are any signs of dehydration.

Weigh and measure the infant, noting length and head circumference. Plot the measurements on a centile chart and check against the measurements plotted in the Personal Child Health Record ('Red Book'), when this is available.

Note the presence of sites of attempted vascular access and document the presence of intraosseous needles, intravenous cannulae, an endotracheal tube or a chest drain. These should not be removed until there has been discussion with the police and Coroner.

Check for dysmorphic features, abnormal skin creases and birthmarks.

Record the infant's rectal temperature using a low-reading thermometer as soon as practicable after death has been confirmed and, where possible, an hour later. The estimation of time of death using body core temperature readings is an inexact science, even amongst experienced forensic pathologists, particularly for infants and children, influenced by the temperature of the body and ambient temperature.

Rigor mortis

At the time of death, the body is flaccid until the muscles stiffen in rigor mortis due to the cessation of glycolysis. It is first detectable in the muscles of the eyelids, neck and jaw between 2 to 6 hours after death in adults, and spreads to the arms, legs and trunk within the next 4 to 6 hours.

The rate of appearance (and disappearance) of rigor mortis is dependent on many factors, including the temperature of the body before death, the ambient temperature and muscle mass. Thus, the extent of rigor mortis cannot be relied upon to estimate the time of death. In infants, it may occur rapidly and be imperceptible due to small muscle mass.

Hypostasis (Lividity)

Hypostasis, or the red-purple colouring of the skin, appears on dependent parts of the body due to the gravitational pooling of blood after circulation has ceased. This may be first noted within 30 minutes to 2 hours, and reaches its maximum at about 5 hours.

It first appears as small, round patches that may resemble bruises to an untrained observer. These change shape and size, then coalesce over the next 2 or so hours to emerge in the overall pattern, with horizontal margins and bloodless zones due to tight clothing or contact pressure. Areas of contact pressure will be recognisable as an area of pallor, for example, on the nose and cheeks in an infant who was face down at the time of death. Record the presence and distribution of lividity and any areas of contact pressure (compression marks).

External marks or injuries

Describe any external marks, bruises, petechiae, abrasions (scratches, grazes), lacerations, bite marks, incisions or identifiable injuries such as burns, ligature marks or patterned injuries. Number and measure each mark and draw on a body map.

Palpate the scalp for the presence of swelling or depression.

Examine the mouth and inspect the upper and lower labia frena and the sublingual frenum where possible. (This may be difficult if there is rigor mortis).

Bruises

Non-intentional bruising is very uncommon in pre-mobile infants, occurring in around 2% of infants. Bruising increases in frequency as infants become mobile, occurring predominantly below the knees and in a 'facial-T' distribution across the forehead and bridge of nose, as a result of slips, trips and falls.

Non-intentional bruising rarely occurs on the ears, neck, genitalia, buttocks, hands and front of trunk. Consider intentional bruising if the infant was pre-mobile, the bruising is located away from bony prominences and on the ears, neck, genitalia, buttocks, hands and front of trunk, and occurring in clusters. The implement used may have left an imprint.

Abrasions

An abrasion is a superficial injury involving only the outer layers of the skin or mucous membrane (for example, gums), which does not extend to the full thickness of the outer layer (epidermis). It is the result of friction or contact between the surface of the skin and a rough surface with sufficient force to cause trauma to the epidermis but not through it. An abrasion can be either linear (scratch) or brush (graze).

Lacerations

A laceration is a wound made by blunt force splitting the full thickness of the skin or mucous membrane. They are generally ragged and tend to gape. The margins are usually abraded and may also be bruised.

Occasionally the margins are shelved or flaps of skin are produced by a shearing blow, the direction of which can be deduced. Tissue bridges may be exposed in the depth of the wound.

Incisions

Incisions are wounds caused by sharp cutting instruments. The margins tend to be straight, unbruised and without abrasion, unless a blunt instrument such as scissors are used. Incisions from self-harm tend to be superficial, multiple and parallel.

An incision is usually longer than its width or depth. The exception is stab wounds, where the depth is greater than width or depth. They may be associated with defence injuries, such as bruising on the extensor and ulnar surfaces of the forearm and hands.

Bite marks

Many human bites are not recognised and are interpreted as bruises. A human bite mark is a 2–5 cm oval or circular mark made up of two opposing concave arcs, with or without associated ecchymosis.

Any such annular mark should be treated as suspicious for a human bite mark. A forensic odontologist should be involved in the investigation early and photography arranged.

Animal bites from dogs, cats and rodents are far more common than human bites, and usually tear rather than compress flesh. Domestic dogs have four prominent canine teeth that are considerably longer than the incisor teeth. A dog bite mark consists of opposing pairs of triangular or rounded puncture wounds from the canine teeth.

Petechiae

The presence of petechial haemorrhages scattered sparsely on the forehead, face, on the front of the neck and on the inner and outer surfaces of the eyelids and conjunctivae may be a sign of asphyxia. In a florid case, they may be widely distributed over the head and upper trunk. Subconjunctival haemorrhages may also be seen.

Burns

Contact burns are clearly demarcated, in shapes that mirror the agent (for example, a triangular outline of the base of a domestic iron). They can be single or multiple and co-exist with other injuries. Intentional cigarette burns are clearly defined, circular, 0.5–1 cm, deep-cratered, full-thickness burns that will leave a scar with a hypo-pigmented centre and a pigmented rim.

Cigarette burns are regarded as inflicted lesions, although there is a dearth of comparative studies of inflicted and accidental cigarette burns. Contact burns in unusual locations, such as the buttocks, feet and back of the hands, raise suspicion of intentional injury.

A scald with a symmetrical, stocking-glove distribution on the lower limbs, and sometimes on the upper limbs, is due to forced immersion of the affected limbs in hot water. Spill scalds from hot beverages usually occur on the neck and upper trunk, and have an irregular outline, with varying depth.

Burns from moxibustion sticks (traditional healing method) are usually located around the umbilicus, back and lower rib cage, dorsum of wrists and temple. [C] They are usually around 0.5–1 cm and roughly circular. Burns from cupping are annular, measuring 6–8 cm diameter and superficial.

Ligature marks

Forensic pathologists have described a clear distinction between the appearance of ligature marks from hanging and suffocation.

In hanging, the marks are continuous and oblique, sloping upwards towards the highest point of suspension, usually at the back of the head. In suffocation, the marks are horizontal and discontinuous.

In both, the pattern of any fabric causing the mark might be discernible. If deliberate, grip marks might be seen. It is important to describe any marks accurately. The pathologist has the necessary skills and experience to determine the cause.

Examine the external genitalia and anus

Anal examination

Post-mortem anal dilatation is seen from loss of muscle tone in the primary flaccidity stage in around 75% of children, and is regarded as a normal finding, in the absence of perianal lacerations or scars. Midline anal scars can be confused with the median raphe. The finding of a perianal scar or anal tag (outside the midline) implies previous trauma to the area. Penetrative sexual abuse therefore should be considered.

Female external genitalia

Penetrative sexual abuse should be considered in females where there is a complete hymenal transection, a sign of healed trauma or, in pre-pubertal girls, complete absence of the hymenal rim. [B]

If any signs point to possible penetrative sexual abuse, notify the consultant paediatrician on call for child sexual abuse.

Fundal examination

Where possible, examine the eyes by direct fundoscopy for the presence of retinal haemorrhages. If present, request ophthalmological review as their presence, in large numbers and throughout all layers of the retina, is indicative of abusive head trauma. The pathologist must be notified of this finding so that the eyes can be preserved intact for expert pathological examination.

Corneal cloudiness may appear within 2 to 3 hours with the eyes open, and may be delayed for many hours with the eyes closed. Fragmentation or segmentation (trucking) of the blood column occurs within minutes of death and persists for about an hour, when the disc becomes pale. Do not attempt to estimate the time of death by these appearances.

Clinical photography

Where the death of a child is considered suspicious, the lead investigator should consider the best way of obtaining photographs of any visible, apparent injuries. A right-angled measurement scale should be used. Confirmation of death after cardiorespiratory arrest. *Adapted from Code of Practice for the Diagnosis and Confirmation of Death. Academy of Royal Colleges, 2008.61*

The infant is observed by the doctor responsible for confirming death for a minimum of 5 minutes, to establish that irreversible cardiorespiratory arrest has occurred (absence of central pulse on palpation, absence of heart sounds, asystole on continuous ECG trace). After 5 minutes of cardiorespiratory arrest, the absence of pupillary reflexes and of any motor response to supraorbital pressure is confirmed.

The time of death is recorded as the time at which these criteria are fulfilled.

APPENDIX 3 FINAL SLEEP CHECKLIST

Where does the child normally sleep?	
What does the child sleep in?	
Who normally puts the child to sleep?	
Who put the child to bed for the last sleep?	
What precise position was the child put down to sleep in?	
What clothing was the child wearing when put to sleep?	
What bed coverings were used?	
Was a dummy used?	
What time was the child put down to sleep?	
What were the times the child awoke for feeds?	
What time was the last feed?	
When did you last check on the child? When was the child last seen or heard alive?	
Which room and in what was the child found unresponsive?	
Was the child co-sleeping?	
What was the reason for co-sleeping?	
Who was the child co-sleeping with?	
What position was the child in relation to the co-sleeper?	
What were the activities of others in the room?	
When, where and by whom was the child found?	
What precise position was the child in when found?	
What was the appearance of the child when found?	
Where there any other objects near to the child ie, soft toys/cot bumpers/pillows?	
Where there any covers over the child?	
Had the covers and the position of the covers moved?	
What was the temperature of the room? Was the heating on? Any potential dangers, ie, any household animals?	
Was the child crying or more unsettled than usual?	
Where there any significant changes in routine?	
Did parents/carers consume any alcohol/drugs/prescribed medication/cigarettes prior to sleep?	
Details of consumption	

Identification and Referral of Potential Organ Donors

Identify potential donors as early as possible if either of the following criteria are met.

Patients with severe brain injury if

- One or more cranial nerve reflexes is absent and the Glasgow Coma Score is 4 or less and cannot be explained by sedation, **or**
- A decision has been made to perform brain stem death tests

Patients for whom a decision has been made to withdraw life-sustaining treatment

Continue on-going and supportive critical care.

Step 1. Call Organ Donor Referral Line 03000 203040. Provide your hospital name, your name, direct dial number and reason for your call. You will receive a call back within 20 minutes.

Step 2. A member of the organ donation specialist nursing team will contact you and ask a series of structured questions to determine the suitability of the patient to become an organ donor. Providing the information requested will enable the team to undertake a robust assessment, provide a decision about suitability and plan next

Having access to the following information will be useful.

Patient name, DOB, address, NHS/CHI Number, height and weight

Ventilation type, settings, spontaneous breathing rate and ABGs

Past medical history including active infections

Current clinical condition, primary diagnosis, anticipated cause of death and details of events associated with admission

Date (and time if known) of hospital and unit admission

Haemodynamic status including vital signs, haemodynamic support and urine output

Conscious level, sedation, cough & gag reflex and pupil reaction to light

Clinical plan and family circumstances

Current blood results (including pre-admission Creatinine result if available)

Post Referral Actions

If a plan is made for the organ donation team to attend, access to the following information below will enable thorough assessment, support family conversations and expedite the donation process.

Documentation

Patient medical notes (current and historical)

Ensure all routine Critical Care documents, results and reports (including CT scan) are available

Please note : If Trust/NHS health board utilises an electronic system, please ensure the visiting Specialist Nurse will have ability to review documents

Contact patients registered GP surgery explaining that the patient is an inpatient in Critical Care, request a summary of patient history and medication

Documentation of any family/next of kin communications surrounding end of life care and futility

At request of Organ Donation Team only

If notified that the patient has registered a decision to donate on the Organ Donor Register, you may be asked to draw bloods for additional testing.

You will receive detailed explanations of this process if appropriate.

Investigations and Tests

Admission and most recent blood results including; U&E's, eGFR, CRP, LFTs, GGT, Glucose, Amylase, Full Blood Count and Coagulation Profile

If bloods were taken more than 12 hours ago additional samples may be requested

Patient blood group and printed copy of result

Access to ABG results performed within 24 hours

Current microbiology results including; cultures, sputum, urine

Urinalysis results

What to expect when the organ donation team arrive:

To best support the patient's family and provide them with all appropriate donation options, a review of the medical notes and a clinical assessment will be undertaken.

Following this a planning conversation with the consultant and bedside nurse will take place prior to any discussion regarding organ donation.

APPENDIX 5 SUPPORT FOR THE BEREAVED

Sourced from the Child Death Review Guidance.

The key worker for bereaved families responsibilities and competencies

As set out in section [6.2.1](#) of the Child Death Review guidance, all bereaved families should be given a single, named point of contact, who can provide information on the child death review process, and who can signpost them to sources of support. In this guidance, this role is referred to as the “key worker”.

This role could be taken by a range of practitioners, for example a nurse or a member of a bereavement support team. The qualities and competencies of the individual are more important than their professional background. Given shift patterns and annual leave, Trusts should ensure that the key worker is supported by a team who can step in to cover absences. Families should expect to be able to contact the key worker or a team member during normal working hours.

Main Responsibilities

- Be a reliable and readily accessible point of contact for the family after the death; help co-ordinate 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, including liaising with the Coroner’s officer and any police family liaison officer;
- represent the ‘voice’ of the parents at professional meetings, ensure that their questions are effectively addressed, and to provide feedback to the family afterwards; and
- Signpost to expert bereavement support if required.

Key competencies

An empathic approach, and an ability and willingness to listen to, and be with, people in distress; strong communication and interpersonal skills in challenging and distressing situations; ability to maintain appropriate boundaries with families; sufficient experience and confidence to effectively represent the family at professional meetings; and ability to quickly develop a thorough understanding of child death review, in order to support the family through the process and answer any questions they may have. If the key worker is not already familiar with the child death review process, they should contact the local child death overview panel (CDOP) manager local designated doctor for child death. Also see the leaflet [When a Child Dies – a Guide for Parents and Carers](#).

Support for the key worker

Time. How much time will be needed for the role may vary greatly from case to case. It is important that all NHS organisations are flexible in enabling the key worker to support each individual family as required, over the weeks and months following the death of a child.

Team support. Families should expect to be able to contact the key worker or a team member during normal working hours. Given shift patterns and annual leave, Trusts should ensure that the key worker is part of a supportive team who can step in to cover absences.

Individual support. Working with bereavement can be stressful. The key worker and their line manager should agree a plan to ensure that they are appropriately supported in the role, including opportunities for debriefing and supervision.

APPENDIX 6 BEREAVEMENT RESOURCES

Sourced from the Child Death Review Guidance.

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

[*How can you help bereaved parents? BPS Handout resource*](#)

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 in 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 a 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

Cruse

www.cruse.org.uk

Tel: 0808 808 1677 (Weekdays 09.00-17.00)

The Lullaby Trust

Support for anyone affected by the sudden death of a baby or young child www.lullabytrust.org.uk

support@lullabytrust.org.uk Bereavement support line: 0808 802 6868

Sands

For anyone who has been affected by the death of a baby

<https://www.uk-sands.org/support> Helpline: 0808 164 3332

Twin Trust (previously TAMBA)

Support for anyone affected by the death of a multiple

0800 138 0509

Winston's Wish

Supporting children and their families after the death of a parent or sibling. www.winstonswish.org.uk Tel: 08088 020 021

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

Helpful resources: General organisations for those bereaved by suicide and for professionals working with mental health issues.

Change Talks

changetalks.org.uk A North-West based organisation that hosts events for the public. Change Talks deliver talks for schools and colleges to tackle the ever-growing mental health problems which are effecting our community. Change Talks have a focus on social and emotional learning, to engage young people, to think differently.

Child Line

www.childLine.org.uk

0800 1111

Kooth

www.kooth.com

Provides free online support for young people delivered by qualified counsellors via a chat based service

Lancashire Mental Health Helpline

www.lancashiremind.org.uk/

Telephone: 0800 915 4640

Mind

www.mind.org.uk

Telephone: 0300 123 3393 (Weekdays 09.00-17.00)

Text: 86463

Mental Health and Behaviour in Schools

<https://www.gov.uk/government/publications/mental-health-and-behaviour-in-schools--2>

The Department of Education (DoE) developed this advice and practical tools to help schools promote positive mental health in their pupils and identify and address those with less severe problems at an early stage and build their resilience.

PAPYRUS

(Parents Association for the Prevention of Young Suicide)

www.papyrus-uk.org

Telephone: 0800 068 41 41

Text: 07786 209697

Weekdays 10.00-12.00

Weekends 14.00-22.00

Bank Holidays 14.00-17.00

Samaritans

www.samaritans.org

Telephone: 116 123 (at any time)

Survivors of Bereavement by Suicide

Support for people over 18 who have been bereaved by suicide. <https://uksobs.org/> 0300 111 5065 (09.00-21.00)

Stamp Out Suicide

www.stampoutsuicide.org.uk

Point of contact for those feeling suicidal, bereaved by suicide or concerned about suicide. Promoting suicide awareness and prevention.

Students Against Depression

www.studentsagainstdepression.org

This site offers UK students comprehensive information and discussion about depression

YoungMinds

www.youngminds.org

Telephone: 0808 802 5544 (Weekdays 09.30 – 16.00)

YoungMinds is the UK's leading charity committed to improving emotional wellbeing and mental health of children and young people and empowering their parents and carers.

YoungMinds Parents Helpline

www.youngminds.org.uk/find-help/for-parents/parents-helpline/

Telephone: 0808 802 5544 (weekdays 09.30 -16.00)

Offers free confidential online and telephone support to any worries adult about the emotional problems, behavior or mental health of a child or young person up to the age of 25.

APPENDIX 7 POLICE REQUESTS FOR BLOOD AND/OR URINE SAMPLES

SUSPICIOUS CIRCUMSTANCES	NON-SUSPICIOUS CIRCUMSTANCES
ARREST AND MAKE REQUEST IN CUSTODY UNDER s62 PACE AS INTIMATE SAMPLE (BLOOD or URINE)	VOLUNTARY BASIS ONLY. PRESUMPTION SHOULD BE THAT SAMPLES ARE SOUGHT IN ALL SUDC REPORTS UNLESS CIRCUMSTANCES SUGGEST NO PRACTICAL VALUE (EG. TEENAGER DROWNING - PARENTS AT WORK). SAMPLES COULD BE OF SIGNIFICANCE IN OTHER PROCEEDINGS, eg. CORONIAL / FAMILY LAW.
TO AVOID ARREST AND CUSTODY IF SOLE PURPOSE IS TO EXERCISE POWERS UNDER SECTION 62 PACE, ALTERNATIVELY CAUTION AND OBTAIN SAMPLES AT HOSPITAL. IN CASE OF REFUSAL, MOVE TO ARREST	POINTS TO CONSIDER: ● REQUESTS TO BE MADE WITH COMPASSION & SENSITIVITY. ● REQUESTS TO BE MADE ETHICALLY. ● USE FORM OF WORDS PROVIDED BY NATIONAL CHILD DEATH INVESTIGATION WORKING GROUP. ● NO CAUTION TO BE USED (NON-SUSPICIOUS = NOT SUSPECTS)

APPENDIX 8 RECOMMENDED FORM OF WORDS TO BE USED FOR VOLUNTARY SAMPLES REQUEST

This form of words should be used where no criminal offences are suspected. The purpose of this form of words is to provide a framework that facilitates an ethical request for consensual samples. In addition, officers are asked to consider that this request be made with compassion and sensitivity and that *no* caution is used in making the request of parents/other relevant persons.

I now need to ask you if you are willing to provide blood or urine samples for use in the investigation into the death of your child.

You do not need to provide these samples and I have no legal power to compel this. However, these samples can assist us in investigating the tragic circumstances of a child's death. I do need to make you aware that there are certain circumstances where the presence of drugs or alcohol can render someone liable to prosecution for criminal offences. Do you provide consent for blood or urine samples to be taken?