

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

**Version 5**

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# 1. INTRODUCTION

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

## 1.2 Background, The Children Act 2004 and Working Together 2015

- 1.2.1 One of the Local Safeguarding Children Board’s functions, set out in Regulation 6 of the Children Act 2004, in relation to the deaths of any children normally resident in their area, is as follows:

*putting in place procedures for ensuring that there is a coordinated response by the Authority, their Board partners and other relevant persons to an unexpected death.*

- 1.2.2 Each unexpected death of a child is a tragedy for the family and community and subsequent enquiries/investigations should keep an appropriate balance between forensic and medical requirements and the family’s and communities’ need for support. Children with a known disability or a medical condition should be responded to in the same manner as other children.
- 1.2.3 A minority of unexpected deaths are the consequence of abuse or neglect, or are found to have abuse or neglect as an associated factor. In all cases, enquiries should seek to understand the reasons for the child’s death, address the possible needs of other children in the household and all family members, and also consider any lessons to be learnt about how best to safeguard and promote children’s welfare in the future.
- 1.2.4 A number of different agencies will become involved throughout the process of establishing the cause of the death.
- 1.2.5 This procedure is not intended to cover all aspects of sudden unexpected death but endeavours to provide direction to practitioners who are confronted with these tragic

circumstances. In most cases the process will be led by the paediatrician for sudden unexpected death in childhood (SUDC) unless there are suspicious circumstances, or the death is seen as a possible suicide, in which case the police will take over. It is acknowledged that each death has unique circumstances and each professional involved has their own experience and expertise, which will be drawn upon in their handling of individual cases. Nevertheless, there are common aspects to the management of a sudden unexpected death that it is important to share in the interests of good practice and achieving a consistent approach for every child no matter what the circumstances.

**1.2.6** This procedure gives an insight into the priorities for those professionals involved, in an attempt to promote a mutual understanding of each agency's roles and responsibilities. Professionals need to strike a balance between the sensitivities of supporting the bereaved family, and securing and preserving anything that may aid in an understanding of why the child died.

**1.2.7** When a child dies within the Greater Manchester Footprint, regardless of their usual area of residence, this Greater Manchester SUDC Protocol should initially be followed. As soon as discussion is possible between professionals it should be decided on a case by case basis whether the GM SUDC protocol or the child's local policy should then be followed. This should be guided by what is best for the family, and what will be the most effective form of information gathering. (All CDOP notifications will go to the CDOP *of the child's residence*).

### **1.3 AIM**

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

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

## **2. DEFINITIONS**

- 2.1** An unexpected death is defined as the death of a child, in any setting, that was not anticipated as a significant possibility 24 hours before the death, or where there was a similarly unexpected collapse leading to or precipitating the events that led to the death.
- 2.2** The paediatrician for sudden unexpected deaths in childhood (SUDC on call paediatrician) should be consulted where professionals are uncertain about whether the death is unexpected. If in doubt, this protocol should be followed until the available evidence enables a different decision to be made. In exceptional cases the Coroner should be consulted subject to the provision of paragraph 1.1.3.

## **3. PRINCIPLES**

- 3.1.** When dealing with sudden unexpected death all agencies must follow five common principles, especially when having contact with family members.
- Caring and sensitivity, keeping an open mind and balanced approach
  - An inter-agency response
  - Sharing of information
  - Proportionate response to the circumstances
  - Preservation of evidence
- All items on this list are equal in importance.
- 3.2.** In applying the above principles individuals and agencies should ensure that their actions are legal, necessary, relevant and proportionate in order to comply with the Children Acts (1989 and 2004), the Human Rights Act 1998, the European Convention on Human Rights and the Equality Act 2010.
- 3.3** It is essential that at all times the safety of any surviving siblings and/or other vulnerable people is paramount. This should always include full consideration of the safety of potential future siblings.
- 3.4** All staff involved in rapid response should take appropriate action where any potential signs of abuse or neglect are identified, irrespective of the cause of death, and follow local safeguarding procedures.

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

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

## 5. INTERAGENCY WORKING

- 5.1 There should be a multi-agency approach involving collaboration of all disciplines and agencies.
- 5.2 All unexpected child deaths must be treated initially as a multi-agency safeguarding investigation. In the first instance the lead will be the SUDC paediatrician. If at any point the case is deemed suspicious, or a potential suicide, the police will lead. If there are child protection concerns identified then surviving siblings will be the subject of enquiry under Section 47 (S47) of the Children Act 1989 and as such will be managed according to Local Safeguarding Children Board Procedures. At this point the local Authority will have statutory responsibility and take the lead.

An ongoing SUDC investigation may run alongside a S47 enquiry, or full responsibility may be handed over to the local authority, depending on the stage of the investigation and the nature of the case. The nature of concerns and who has responsibility for leading the case should be reviewed at all stages of the investigation, and all involved should be clear who is leading.

It may not be until the multiagency meeting that concerns become clear. For this reason children's services should attend the initial multi agency meeting. The timing of the initial multiagency meeting needs early consideration, (see flow chart 7C) and at all times the protection of any siblings/vulnerable children or vulnerable adults takes priority.

- 5.3 Children who die unexpectedly at home should **always** be taken to the nearest Emergency Department with paediatric in patient facilities **not** the mortuary, in accordance with Working Together 2015 and '**Standards for children and young people in emergency care settings**' 2012. This allows for the earliest possible examination/assessment of the child by a senior clinician. Resuscitation should be attempted unless clearly inappropriate. The only exception to such children being taken to the Emergency Department, rather than the mortuary, is where the police SIO directs otherwise on the grounds of preserving evidence in a suspicious death.
- 5.4 The police must be informed as soon as possible if any person believed to be under 18 years of age dies 'unexpectedly'. No person should 'assume' that the police have been notified. Repeated calls to the police are better than none at all. Early contact with the police enables the prompt recovery of evidence that could otherwise be lost.
- 5.5 The parents/carers should be allocated a member of staff to care for them on arrival in the Emergency Department and should normally be given the opportunity to hold and spend time with their child while in the Emergency Department. If there is suspicion about any particular person(s), the police SIO may request that access to the child's body be restricted. This request should be facilitated by hospital staff, where it is safe to do so. Without exception, parents/carers who are allowed access to the body should be supervised throughout by a health professional or police officer. Every consideration should be given to the cultural and religious sensitivities of grieving parent/carers. If any person mishandles the child's body in any way, the body should be removed from them, provided it is safe to do so. Details of any

mishandling should be recorded in the child's health record. The name(s) of all professionals who supervise in this way should be recorded on the child's health record as they may later prove to be potential witnesses.

- 5.6 Parents/carers should be prevented from washing the child's body as important forensic evidence could be lost by doing this. Parents/carers could be offered a photograph of their child. They will be offered a lock of hair and hand/foot prints (mementoes) by the SUDC Paediatrician. Such mementoes should not be taken until the pathologist has fully examined the body at post mortem and agreed they can be taken. At this point, they may be obtained and delivered promptly to the parents/carers by the Police Coroner's Officer (PCO). Pathology should be informed if any request from the parents/ carers for mementoes is made. Responsibility for asking the parents if they wish for mementos to be taken lies with the SUDC Paediatrician, for taking the mementos with the pathology department, and for delivering them with the PCO.
- 5.7 It should be remembered that babies and children who have been unlawfully killed, can sometimes present without any externally visible injuries.
- 5.8 As soon as possible after arrival in the Emergency Department the child should be examined by the on call Consultant Paediatrician (or Consultant in Paediatric Emergency Medicine or Consultant in Emergency Medicine, if there is no Consultant Paediatrician available within the Trust). Any details given by the parent(s) or carer(s) during or after resuscitation should be carefully recorded. Particular attention should be paid to any apparent changes or inconsistencies in accounts given about the events leading up to the death. Any accounts given should be brought to the early attention of the police. In cases of language difficulty an interpreter must be used rather than English speaking family or friends, to ensure accuracy in the communication of this vital information.
- 5.9 As soon as death has been confirmed the following will be contacted:
- The police, if not already informed.
  - The coroner by the police and the lead clinician (but only in exceptional circumstances should the coroner be informed between 11pm and 7am).
  - SUDC paediatrician
  - Children's Social Care by SUDC paediatrician if not already done by Emergency Department staff, or if the child has died elsewhere and not brought to the Emergency Department.

**Greater Manchester Police are contactable via 101**

**The SUDC paediatrician is contactable via Wythenshawe Hospital Switchboard Tel: 0161 998 7070.**

- 5.10 When the child is pronounced dead, the lead clinician in the Emergency Department should break the news to the parents. They will explain the need for police, coroner and SUDC paediatrician involvement and the need for a post mortem examination.



- 5.11 In all cases an immediate case discussion should be held as soon as possible between the senior investigating police officer, the senior clinician dealing with the case (this may be a consultant paediatrician or a consultant in emergency or paediatric emergency medicine) and the SUDC paediatrician – to agree their approach and to ensure continuing close collaboration as frequently as necessary. This will often initially occur by telephone.
- 5.12 Confirmation of agreed decisions and actions and timescale for completion must be recorded by each party using existing systems. The SUDC paediatrician will ensure all professionals are aware of their agreed roles and responsibilities.
- 5.13 The lead acute clinician (consultant paediatrician or a consultant in Emergency or paediatric emergency medicine) who confirms the fact of death must notify the coroner in addition to the SIO. Only in exceptional circumstances should the coroner be called between 11pm and 7am.
- 5.14 At the earliest opportunity the police should check if the child, family or address are known to Police and Children's services should be contacted to see if the child, family or address are known.
- 5.15 Usually the child will be examined jointly by the SUDC Paediatrician and the SIO. They will then go on to take a detailed history from the carers, having agreed beforehand who will be present at history taking, and whether separate histories should be taken from the parents/carers.
- 5.16 The Named Nurse for Safeguarding children should be informed at the earliest convenient moment, and they should assist gathering information.
- 5.17 When a baby or older child dies in a non-hospital setting, the SIO and SUDC paediatrician should decide whether a visit to the place where the child died should be undertaken. This should almost always take place for children under 2 years who die unexpectedly. As well as deciding if the visit should take place, it should also be decided how soon (within 24 hours) and who should attend. It is likely to be the SIO and SUDC paediatrician who will visit, talk with the parents (if this has not already occurred in the Emergency Department) and inspect the scene. They may make this visit together, or they may visit separately and then confer.
- 5.18 After this visit a multi-agency meeting should be held including the SIO, SUDC paediatrician, GP, health visitor or school nurse and children's social care representative. They should review whether there is any additional information that could raise concerns about the possibility of abuse or neglect having contributed to the child's death. If there are concerns about surviving children in the household local procedures for managing child protection enquiries should be followed. The timing of a multiagency meeting will depend on circumstances (See flow chart 5.3.1).
- 5.19 The coroner will order a post mortem (PM) examination to be carried out as soon as possible, by the most appropriate pathologist(s).

- 5.20 The on call paediatrician and SUDC paediatrician should liaise with the pathologist and provide information on the clinical circumstances of the death, the history and the relevant medical and social records. Ideally a written report will be available prior to Post Mortem examination, but in cases where this is not possible a verbal report should be given to the pathologist.
- 5.21 The SUDC paediatrician will ensure parents, GP, and relevant community team are informed of the initial post mortem results, unless directed not to by the coroner. If safeguarding concerns are identified at PM examination they should be directly reported to the SIO and SUDC Paediatrician by the pathologist. In the unlikely event of the coroner not giving permission to share information and there are safeguarding concerns, it is the responsibility of the SUDC Paediatrician to discuss the case directly with the coroner. If this still fails to resolve the issue, it should be discussed with the SUDC Lead, and legal advice sought if necessary
- 5.22 If a multiagency meeting hasn't yet occurred this may be held by the SUDC paediatrician after the provisional post mortem examination report is available. See flow sheet 5.3.1.
- 5.23 A final case discussion meeting should be convened and chaired by the SUDC paediatrician as soon as the full post mortem examination report is available, approximately 3 - 4 months after the death. This meeting (at the GP surgery, if possible) should involve the GP, health visitor, school nurse (if appropriate) midwife (if appropriate), children's community nurse (if appropriate) and any other paediatrician if involved, pathologist(s), senior investigating police officer, police coroner's officer (PCO), ambulance crew and where appropriate social worker, bereavement support worker, and Emergency Department staff. All relevant information concerning the circumstances of the death, the child's history, family history and subsequent investigations should be reviewed and the core data set completed. The main purpose is to share information, agree the cause of death and plan future care for the family. There must be an explicit discussion of the possibility of abuse or neglect and, if no evidence is identified to suggest maltreatment, this should be documented as part of the summary of the meeting.
- 5.24 The summary should be sent to the CDOP and to the coroner, who may take the case discussion information into consideration in the conduct of the inquest and in the cause of death notified to the Registrar of Births and Deaths. In addition all attendees at the case discussion meeting should receive a summary which should include
- A brief summary of the case
  - A summary of PM examination findings, the cause of death, and *any* other relevant findings.
  - Explicit comment on safeguarding issues for siblings/household contacts and *future siblings*.
  - A list of further actions, including management of future pregnancies.
  - A full distribution list (which should always include the child's, mother's and where relevant/possible father's GP).

- 5.25 If no final meeting is held the SUDC Paediatrician should document
- why a final meeting was deemed to be unnecessary
  - That a further meeting will be convened in the event that any professional communicates the view that one is needed for any safeguarding purpose.
- 5.26 The SUDC paediatrician should usually, subject to coroner's and police approval, arrange to meet with the family to give information concerning the cause of the child's death. If a child is well known to a local paediatrician it may be agreed that they will feedback to families. A detailed letter should then be written and sent to the family summarising the meeting. If significant concerns are raised at any stage about the possibility of abuse or neglect, a decision may be taken for the police to become the 'lead agency'. The police should be informed immediately if significant suspicion arises so as to ensure any further interviews with the family accord with the requirements of the Police and Criminal Evidence Act 1984. Children's services and police may convene a child protection strategy meeting to decide how to proceed with the child protection investigation.
- 5.27 If there are grounds for considering a serious case review the chair of the Local Safeguarding Children's Board should be contacted and LSCB procedures should be followed.
- 5.28 Managers in all agencies should be proactive in ensuring the well being of their staff, both during and after dealing with childhood deaths.

## 6. INFORMATION SHARING and CONFIDENTIALITY

**6.1.1** When sharing information, it is the responsibility of the Practitioner to decide what information it is appropriate to share with whom. We need to protect the rights of individuals to privacy, whilst ensuring sufficient information is shared to allow for the safeguarding of vulnerable children and adults.

Guidance can be found in several documents:

**6.2.1 Section 10 (s10) Children Act (CA) 2004:** statutory guidance states that good information sharing is key to successful collaborative working and that arrangements under s10 CA 2004 should ensure that information is shared for strategic planning purposes and to support effective service delivery.

**6.2.2 Section 11 CA 2004:** places a duty of bodies within the NHS to make arrangements to ensure that their functions are discharged with regard to the need to safeguard and promote the welfare of children

**6.2.3 Working Together to Safeguard Children** (HM Government 2015) sets out the regulations relating to child deaths review functions and this includes collecting and analysing information about each death.

**6.2.4 Human Rights Act 1998: Article 8. 2:** the right to respect for private and family can be legitimately interfered with where it 'is in accordance with the law and is necessary ... in the interests of ... protection of health and morals or the protection of rights and freedoms of others.

### **6.2.5 Data Protection Act 1998**

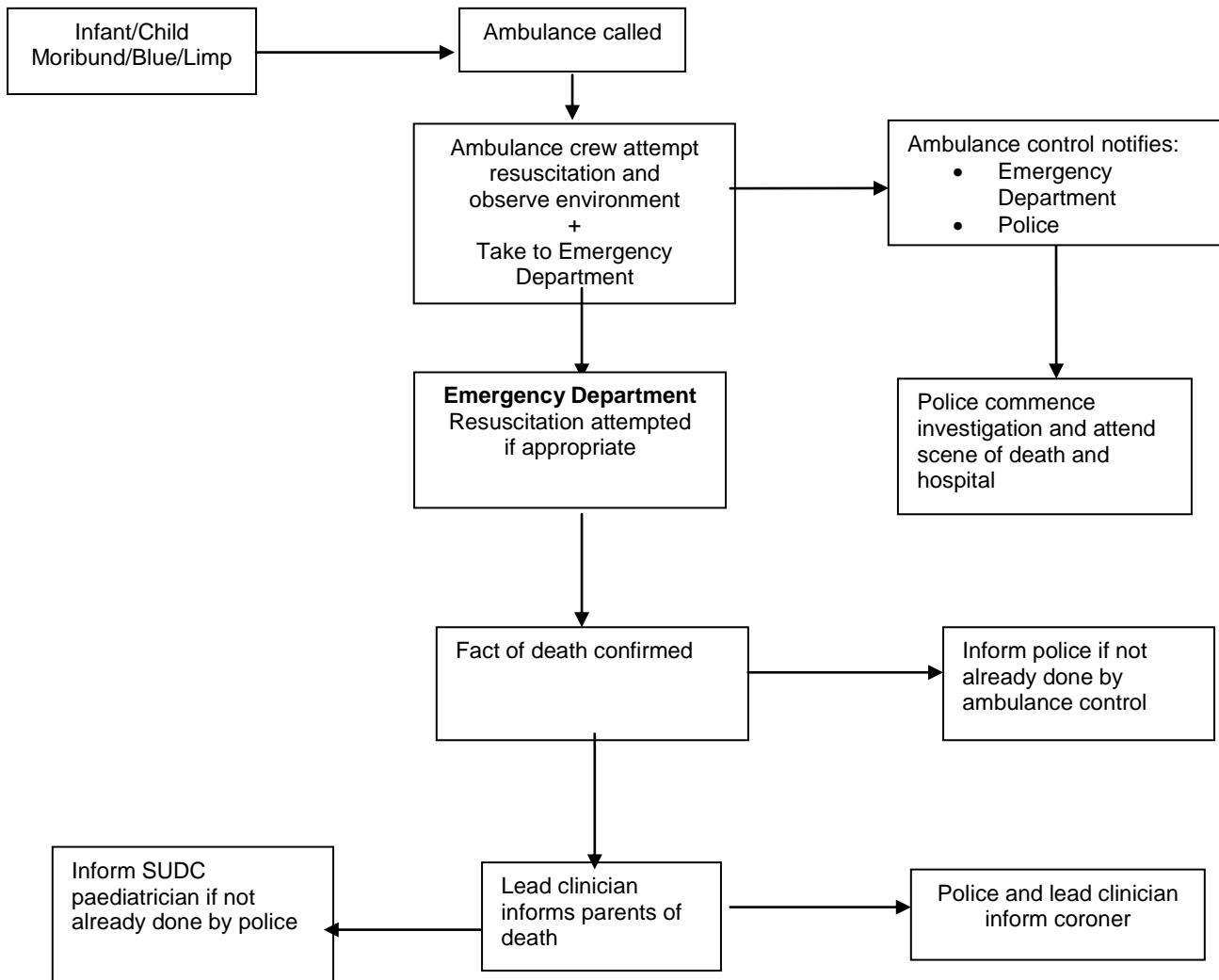
Information sharing within the Child Death Overview Processes is a statutory function and the Data Protection Act therefore permits the sharing of information for this purpose without express consent of the subjects.

**6.2.6. Caldicott Principles:** These relate to the use of patient identifiable information in the NHS and Social Care and must be followed at all times. Principle 7 states that that '*The duty to share information can be as important as the duty to protect patient confidentiality*' but any information sharing must be done for a legitimate reason and in accordance with the Data Protection Act.

Principles 2 and 3 also state that '*Only use personally identifiable information if absolutely necessary*' and '*Use only the minimum data needed for the specific purpose.*'

## 7. RECOMMENDED SEQUENCE OF EVENTS

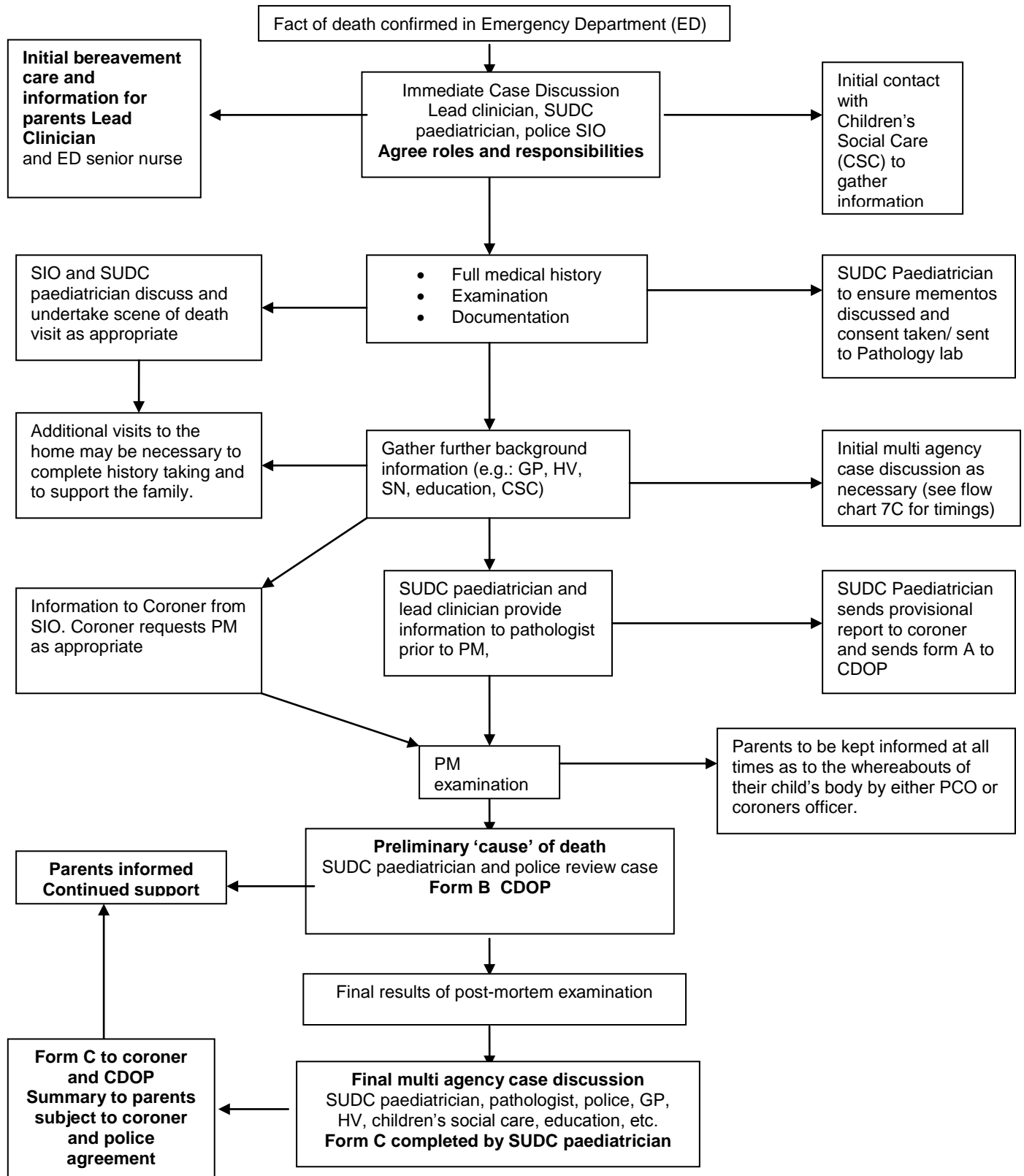
### A: Following ambulance call



NB if there is any uncertainty as to whether or not rapid response is indicated, then discuss with on-call SUDC Consultant, considering if they would have a role in:-

- Establishing the cause of death and identifying modifiable risk factors
- Explicitly considering safeguarding issues for surviving siblings
- Sign posting to appropriate bereavement support
- Collecting data for CDOP

## 7. RECOMMENDED SEQUENCE OF EVENTS B After fact of death confirmed

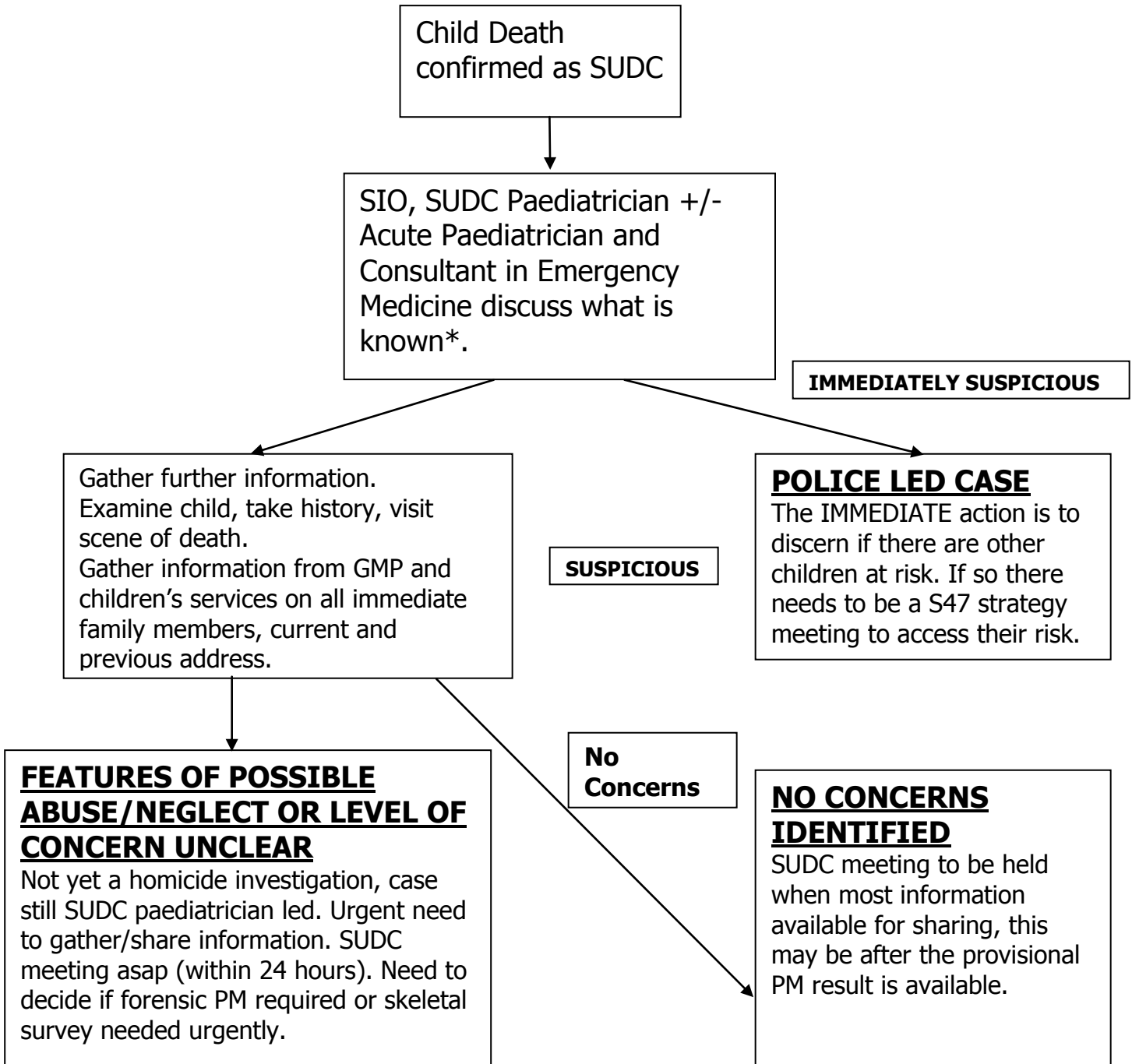


Throughout the process of investigating a sudden unexpected death professionals must consider the need to initiate a Serious Case Review

## 7. RECOMMENDED SEQUENCE OF EVENTS

### C Flow Chart of timings of SUDC Multiagency Meetings following Sudden Unexpected Child Death

□



\*This will be referred to as an initial case discussion.

Whilst a 'usual' SUDC meeting would include primary care (e.g. GP, HV, MW etc.) this may not be possible over the weekend. In such cases if concerns have been raised, a meeting should be held including the SIO, SUDC paediatrician and an appropriate representative of children's services as a minimum, and a repeat 'SUDC meeting' will be needed to gather/share more information at a later date.



### Introduction

- 8.1.1.** The first aim of the police investigation into the report of an unexpected death is to determine how and why the child/young person died. The second aim is to report the full circumstances of the death to the coroner and assist, as far as possible, his/her investigation.
- 8.1.2.** The duty of H.M. Coroner is to establish the identity of the deceased and how, when and where he or she died. All police staff should be aware that, once a person has died, the body must not be interfered with in any way, unless authorised by H.M. Coroner either directly or through this protocol.
- 8.1.3.** Throughout their investigation into the report of an unexpected death of a person under eighteen years, the police will take any action necessary to safeguard the wellbeing of any other children or young persons, such as siblings, who are considered to be at risk of harm.
- 8.1.4.** The death of a person under 18 will not be investigated by the police in cases where a doctor is able to issue a 'medical certificate of cause of death'. A 'medical certificate of cause of death' is usually issued in cases in which a doctor has treated the deceased for a diagnosed serious illness or condition from which s/he was expected to die at that time.
- 8.1.5.** The police investigation into the unexpected death of any person under 18 in Greater Manchester will be led by a Detective Inspector (DI) or Detective Chief Inspector (DCI). For the purposes of this protocol, that officer will be referred to as the police 'senior investigating officer' (SIO).
- 8.1.6.** Further guidance for police officers / staff on investigating child deaths is given in:
- 'Working Together to Safeguard Children 2015' – As this is statutory guidance, any deviation from it should be capable of being justified before a judicial or public hearing
  - ACPO Homicide Working Group – 'A guide to investigating Child Deaths' 2013
  - Chief Constable's Orders
- 8.1.7.** There are three 'key' features which are central to the multi-agency model of investigation:
- CCGs within Greater Manchester will have access to a consultant paediatrician who is designated to engage quickly with the police and other agencies after the unexpected death of a person under 18 occurs. This consultant is known as the

**SUDC paediatrician** and will be available 24/7 on a call out basis. A consultant at the hospital where the child is first taken will engage initially in preservation of life procedures, where indicated, initial history taking and on occasion medical examination. Once death is confirmed the SUDC paediatrician will be consulted and hand over of the case agreed. The SUDC paediatrician will then take over responsibility for all medical aspects of the investigation into why the child died and liaison with the deceased's family and other agencies.

- The death will also trigger the coming together of a team of professionals from a number of agencies, co-ordinated by the SUDC paediatrician. This process is known as '**Rapid Response**'. Key team members will include the SUDC paediatrician, police SIO, Police Coroner's Officer, health visitor or school nurse, GP and others where relevant e.g. midwife, mental health professional, social worker. In essence, this team of professionals will have the knowledge, expertise, information and resources to be able to contribute towards a thorough 'joint' investigation into why the child or young person died. When a person under 18 dies unexpectedly in a non-hospital setting, including Road Traffic Collisions (RTC) and suicides, the police SIO and SUDC paediatrician should make a decision about whether a '**joint police/health professional visit**' to the place where the child died should be undertaken. This is the third key element. This should almost always take place for infants (under 2) who die unexpectedly in a dwelling. If the death, trauma or collapse occurred in a place other than the home location, consideration should also be given to visiting and examining the home. Similarly, if the child had been living in different locations in the time leading up to death, consideration should be given to 'joint visits' to them.

As well as deciding if the 'joint visit(s)' should take place, it should be decided how soon (within 24 hours) and who should attend. Wherever possible the police SIO should take part in any 'joint visit' on behalf of the police. The police and SUDC paediatrician will visit, talk with the parents/carers and inspect/assess the scene. If a 'joint visit' is considered inappropriate, they may visit the location/s separately and then later confer. The purpose of a 'joint visit' is to identify all possible factors (from both a police and medical perspective) that may help explain why the child died.

## **Police attendance at the scene – Initial action**

- 8.2.1.** It is important for all police staff to remember that the majority of unexpected child deaths are not the result of criminality. Police action therefore needs to be carefully balanced between giving (and demonstrating) utmost consideration for the needs of an innocent, grieving family and carrying out a thorough investigation into a 'potential' homicide. In certain circumstances, it can be one of the most difficult tightropes the police have to tread.
- 8.2.2.** The selection of an officer to attend a report of the unexpected death of a child or young person should be carefully considered. If circumstances allow, operational control room staff should consult divisional supervisors on this matter. The officer being sent should have the skills, experience and emotional strength to cope with such a demanding incident.

- 8.2.3.** When the unexpected death of a child or young person is reported to the police, a detective should be sent to the scene or hospital in an un-liveried vehicle as the first response, unless this would cause any unreasonable delay.
- 8.2.4.** Police attendance at the scene, should be kept to the minimum required, completely avoiding uniformed officers where possible. Several officers unnecessarily arriving at a home or hospital where a child or young person has just died could prove very distressing to relatives/carers.
- 8.2.5.** The officer/s attending the scene should give immediate consideration to the safety of all other children at the location. Depending upon the circumstances of the death and the conditions in which other children may be found, the officer/s may need to take prompt action to secure their safety and wellbeing. In extreme cases, this may require the police to use their powers of removal and protection set out under Section 46 of the Children Act 1989.
- 8.2.6.** All police action should be undertaken in the most low key and least intrusive way possible, having regard to the circumstances of the case. If the death has occurred inside a home, it is highly unlikely that police cordon tape will be needed outside.
- 8.2.7.** Upon arrival at the scene or hospital, the SIO should take charge of the police investigation.
- 8.2.8.** From the outset of any investigation all police staff should keep an open mind about how/why the child/young person died. For innocent parents/carers to be wrongly accused of harming their child and potentially have another child or children taken from them would lead to unimaginable suffering for the family involved. Equally, police staff should be aware from the outset of any investigation that a child, who presents without any physical external or internal injury whatsoever, could still have been unlawfully killed.
- 8.2.9.** All police action should be carried out with empathy, sensitivity and understanding, even when it is suspected that a criminal offence may have been committed.

### **Guidance for dealing with grieving parents/carers**

- 8.2.10** Police attendance, in itself, will be likely to increase parents'/carers' levels of distress. They are likely to need a sensitive explanation of the reason for police involvement and actions they take. The following statements may help in this process:
- The police carry out an investigation on behalf of the coroner into 'every' case of unexplained death of a child /young person.
  - When any child/young person dies unexpectedly, an in-depth investigation by all agencies is carried out due to their potential vulnerability.

- The police conduct their investigation in the knowledge that the majority of deaths in children transpire to be from natural causes.
- Valuable lessons may be learned during the investigation that can be used to prevent further deaths of children.
- The police investigation is carried on in parallel with a rigorous medical investigation. Both investigations have the same aim - simply to find out why their child died.

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

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

- Say who you are, why you are there and how sorry you are to hear what has happened to the child/young person. Establish the child's name quickly and always use this in conversations with those that are grieving.
- If you have a need to handle the child, do so gently and caringly, as if s/he were still alive.
- In the first stages of grief, people may react in different ways, displaying shock, numbness, anger and hysteria. Be patient. Allow the parents/carers space and time to cry, talk together and comfort any other children. These early moments of grieving are very important.
- It is entirely natural for a parent/carer to want to hold or touch the dead child/young person, indeed it is known to help with the grieving process. You should allow this to happen provided it is done with a professional (e.g. police officer or nurse) being present throughout, as in most cases it is highly unlikely that any important forensic evidence will be lost. You should make a record of all such contact with the body, together with details of who supervised it. If however, you consider the death to be suspicious, you should consult the SIO before allowing this to happen. If, for any reason, you are unable to consult the SIO at that time, you should prevent all persons from unnecessarily handling/touching the body until you have done so. Any instructions given by the police SIO in this regard should be passed to the Emergency Department staff immediately if the child/young person is at (or is being taken to) hospital.
- Parents/carers should be prevented from washing the child or changing the clothing or nappy at this stage. You may wish to explain to them that it is your job to try to make sure that no changes are made to the child/young person or his / her clothing until s/he is examined by doctors at hospital. Also explain that this is standard procedure and that it will help to give doctors the best chance of finding out why their child died.
- You should be prepared to answer practical questions such as where the child will be taken and when can they next see him/ her? You should always be

certain of the responses you give. Giving inaccurate information could later prove highly distressing to the parents/carers.

- Be sensitive to any religious or cultural needs or beliefs. Contact a Cultural Liaison Officer for advice. Parents/carers from some religions and cultures hold strong beliefs that bodies must be buried within certain timescales. They are likely to suffer additional anguish if they feel that the post mortem will delay that process. Arranging their contact with religious leaders or elders who are used to dealing with these issues may give them great comfort.
- If you experience any language difficulties whatsoever with parents/carers, you should arrange for the attendance of an interpreter as soon as possible. An English - speaking family member or friend may need to be used initially in urgent cases. In this event, you should consult the appointed SIO about the need to obtain an 'independent' interpreter as soon as possible to ensure accuracy in the conveyance, interpretation and recording of information provided by parents/carers.
- Most parents/carers feel guilty when their child has died. When talking to them try to ask 'open' questions e.g. Tell me what happened? Avoid questions that sound in any way critical such as, 'Why didn't you.....?'
- A thorough and successful police investigation is more likely to be achieved if at all times parents/carers are treated with sensitivity and respect by all officers. This applies even if they are suspected of committing a crime against the child or young person.

## **Diagnosis of fact of death**

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

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

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

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

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

**8.2.15** If, after ‘fact’ of death has been diagnosed, there do not appear to be any suspicious circumstances; the NWAS crew will (subject to the exceptions’ listed below) immediately take the child/young person’s body to the local Emergency Department with paediatric facilities.

The following benefits accrue from this action:

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

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

- If a police officer directs that the body should not be moved
- If the body is considered to pose a health risk
- If ‘other exceptional reasons’ exist that justify not taking the body to the Emergency Department (e.g. a major incident has occurred involving a high volume of attendances to the Emergency Department)

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

**8.2.17** Where the body is not moved to the nearest Emergency Department with paediatric facilities, the police SIO should always be consulted before any arrangements are made for removal of the body by undertakers to the mortuary designated by the local coroner.

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

**8.2.19** Jurisdiction belongs to the coronial area where the death occurred, unless following discussion between H.M. Coroners it is decided more appropriate to move the investigation.

## **Obtaining information from parents/carers and the scene**

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

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

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

No further 'in-depth' questioning should normally take place without the SIO's approval. The SIO will later determine the interview strategy. Repeated questioning of the parent/carer by different officers should be avoided.

## **When considering the need to question parents/carers in non suspicious cases**

**8.2.21** When considering the need to question parents/carers, the SIO should discuss the following with the SUDC paediatrician:

- Whether parents are interviewed jointly or separately
- Who will lead the interview

**8.2.22** A police coroner's officer should also be present when possible during any questioning of parents/carers. This will facilitate creating an antecedents statement without someone having to return to the family later, thus avoiding repetition.

**8.2.23** In the event that a case is deemed suspicious, first accounts should be taken from the parents/carers separately. The SUDC paediatrician would not normally be present during these accounts. If any parent/carer becomes a suspect, then a PACE compliant interview by police would be required. The case would be police led, so all subsequent multiagency meetings would be arranged by the police.

## **Death reported from the hospital**

**8.2.24** Hospital staff may refer an unexpected death of a person under 18 to GMP, following admittance via the Emergency Department or where s/he has died on a ward.

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

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

**8.2.27** The officer (detective if in attendance) at the hospital should make an early attempt to locate any nappy, clothing or possessions taken from the child by hospital staff that may be important to the investigation. Such items should be brought to the early attention of the SIO. The SIO should discuss with the SUDC paediatrician which items need to be retained for evidential purposes. Items retained should be treated as potential exhibits and packaged separately to avoid any risk of contamination.

They may later require forensic examination. Assurances should be given to parents/carers that the items will be returned to them in the best possible condition.

### **Informing the duty SIO**

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

### **Formal identification of the body**

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

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

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

### **Responsibilities of the Police Senior Investigating Officer (SIO)**

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

**8.3.2.** Throughout the investigation, the SIO should, wherever possible, follow the guidance contained in 'Working Together to Safeguard Children 2015'. Any deviation may later need to be justified to a court.

**8.3.3.** The SIO must liaise with the Public Protection Departments Child Protection Unit, for early consultation (and in any case within 24 hours).

**8.3.4.** It is essential that at all times the safety of any surviving siblings and/or other vulnerable people is paramount. This should always include full consideration of the safety of potential future siblings.

**8.3.5.** All staff involved in rapid response should recognise the importance of taking appropriate action where any potential signs of abuse or neglect are identified, irrespective of the relationship to the cause of death. This includes conducting a thorough investigation and gathering all potential evidence with a view to consideration of a prosecution for neglect/assault.



- 8.3.6.** All evidence / information / details of concerns (however slight and even if not proven) gathered during the investigation should be documented, retained and indexed in such a way that, where necessary, it can be easily retrieved by staff for child protection / safeguarding purposes in the future.
- 8.3.7.** If at any stage the SIO has grounds to suspect a homicide, arrangements may be made for the Major Incident Team (MIT) to take over the investigation.
- 8.3.8.** Any 'joint visit' to the home by the SIO and SUDC paediatrician should ideally occur within 24 hours of the death. The SIO should consult the dedicated SUDC paediatrician as soon as possible to determine whether or not this will take place. Due to time constraints, this consultation may need to be conducted by telephone. A balance must be struck between any delay that may be caused in trying to arrange a joint visit and the potential loss of evidence if the police do not attend the scene promptly. There may be little point in a SUDC paediatrician visiting a 'home' scene if the police have already removed items of interest. This should be discussed with the SUDC paediatrician and an action plan agreed.
- 8.3.9.** Where the death is considered 'suspicious', the SIO may decide that a 'joint' visit to the scene, prior to the recovery of all potential forensic evidence, is inappropriate. When a decision is made that a joint home visit will not take place, the SIO should record the reasoning for this.
- 8.3.10.** Wherever possible, the SIO should arrange to view the body him/herself at the earliest opportunity. This should ensure that the SIO is aware, at first hand, of all visible injuries or marks of concern on the body before the pathology post mortem examination takes place. The SIO should remember that some injuries on the body may only become visible to the naked eye several days after the death or under specialist lighting conditions.

## **Detective Chief Inspectors**

- 8.3.11.** Where a Detective Inspector is conducting an investigation into any child death (whether considered to be suspicious or not), his or her DCI should conduct thorough and regular reviews of the investigation and, where necessary, give guidance and instruction.

## **Informing the Police Coroner's Officer**

- 8.3.12** Between 0700-2000hrs, the police coroner's officer (PCO) for the Coronial area where the death occurred should be notified as soon as possible, to attend the scene. His/her experience and expertise in dealing with sudden deaths and bereaved families should be used to the full. The SIO should maintain close liaison with the PCO throughout his/her investigation. The Police Coroner's Officer must be invited to the rapid response meeting with the family.

## **Witness / suspect management / interview strategy**

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

### **Intelligence strategy**

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

### **Scene strategy, evidence recovery and imaging**

- 8.3.21** Where necessary, justified and proportionate, the SIO should determine his/her imaging, scene examination, and search and seizure strategy. If possible, this

should be done in consultation with the SUDC paediatrician. The SIO must ensure s/he has lawful authority or consent to carry out any proposed action. S/he should recognise that this phase of the investigation can often prove highly distressing for parents/carers.

- 8.3.22** Wherever possible, a Crime Scene Investigator (C.S.I.) should be requested to attend to photograph any injuries, suspicious marks or features on the body before it is moved.
- 8.3.23** The SIO should liaise with a Crime Scene Manager for a full forensic strategy. Consideration should be given to taking a room temperature.
- 8.3.24** If the SUDC paediatrician has not attended the scene, the SIO should consider using the images captured to brief him/her and, in suspicious cases, the 'forensic' pathologist before post mortem.
- 8.3.25** Any other staff member involved in the search should be fully briefed beforehand and the process conducted in a highly sensitive manner. Where items are to be removed from the house, it should be explained to the parents that this is standard procedure and may help to find out why their child has died. The SIO should be able to justify to the parents/carers, the need to take every single item taken/seized. Assurances should be given that the items will be returned to them in the best possible condition.
- 8.3.26** Police visits to the home should be kept to a minimum. A comprehensive plan by the SIO (in consultation with the SUDC or 'duty' consultant paediatrician) to capture all potential evidence in one visit should, in most cases, avoid any need to disturb the family again. Repeated police visits may unnecessarily increase the apprehensions of the parents/carers that they are under suspicion and potentially cause them embarrassment.

## **Post Mortem Examinations**

- 8.3.27** If there is any suspicion or concern whatsoever that a criminal act may have been a factor in the child's death, the SIO should ask the coroner to hold a Home Office post mortem using a forensic pathologist. In these circumstances, depending on the age of the child, the coroner may direct that a paediatric pathologist conduct a 'joint' post mortem with the forensic pathologist.
- 8.3.28** If a 'non-Home Office' post mortem is to be held, the SUDC paediatrician would attend without police. No police involvement or briefing is required. If an SIO wished to attend a non-Home Office post mortem or send a representative, s/he would need to obtain prior authority from the coroner and make early arrangements with the pathologist in question.
- 8.3.29** Under no circumstances should an SIO seek to delay the start of a non-Home Office post mortem purely so an officer can attend.
- 8.3.30** If during a non-Home Office post mortem a pathologist uncovered something suspicious, s/he would immediately stop the procedure and contact the coroner. The

coroner would then decide whether to continue or re-convene the post mortem with the additional involvement of a forensic pathologist.

- 8.3.31** Having regard to the circumstances of the death and the age of the child, the pathologist(s) will consider the need for a skeletal survey of the body. If the child is under the age of 2 years, a skeletal survey should be undertaken in most cases. A paediatric radiologist will interpret any survey conducted. The SIO should establish the outcomes of these examinations.
- 8.3.32** Upon receipt of a written post mortem examination report from the pathologist(s), the Coroner will in most cases provide a copy to the SUDC paediatrician and the SIO.
- 8.3.33** Under the requirements of the Human Tissue Act 2004, the next of kin will be informed of all human tissue samples taken from the body at post mortem. The next of kin must be consulted regarding their wishes about the retention of the tissue for research purposes, the return to them for burial/cremation or sensitive disposal by other means. The SIO, Coroner's own staff, PCO or Family Liaison Officer (FLO), if involved, will address these issues on behalf of the coroner.

### **Obtaining mementos for parents/carers from the body**

- 8.3.34** The SUDC paediatrician will be responsible for ensuring that parents/carers, in every case, are asked whether or not they would like the following mementoes from the child/young person's body:
- Lock of hair
  - Handprints
  - Footprints
- 8.3.35** Once all forensic requirements have been addressed the police SIO will be responsible for ensuring that any mementoes requested by the parents/carers are obtained from the mortuary. Mortuary technicians at the Central Manchester & Manchester Children's University hospital, where most child post mortems will take place, have agreed to obtain the mementoes. Separate guidance will be issued to police staff regarding how to arrange the taking of such mementoes and their delivery to parents/carers. Any delay in presentation of them should be avoided.
- 8.3.36** GMP are responsible for presenting these mementos in an appropriate way. They are then passed onto the Police Coroner's Office to deliver these to parents/carers.

### **Informing the coroner of the death**

- 8.3.37** The SIO should ensure that the police coroner's officer formally reports the death to the coroner during 'office hours'. The coroners covering Greater Manchester have stated that they do not require to be routinely notified of a child/young person's death outside office hours. However, if the SIO or a health professional is

experiencing any difficulties dealing with such a death and requires the coroner's advice, s/he may contact the coroner at any time (including weekends and public holidays) between the hours of 0700 to 2300. Separate guidance has been issued to GMP staff about the exceptional circumstances in which coroners require to be contacted between the hours of 2300 and 0700 and can be found on Chief Constable's Order 2014/33.

**8.3.38** At the conclusion of the investigation the SIO should, in consultation with the SUDC paediatrician and the Police Coroner's Officer and in accordance with locally agreed timescales, submit a report to the coroner giving full details of the extent and outcome of the police investigation.

### **Attending multi-agency case meetings**

**8.3.39** The SIO (or where unavailable his/her nominated representative) should fully engage in all multi-agency meetings outlined in 'Working Together to Safeguard Children 2015'. In suspicious cases the police SIO will lead the case meetings. In all other cases, the SUDC paediatrician will lead the meetings.

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

**8.3.41** Any suspicion or concern arising from the police investigation should be shared with senior staff from the other key agencies involved as soon as possible. Full details of the information passed, time/date and to whom should be recorded.

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

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

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

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

## **Keeping parents/carers informed**

**8.3.46** Wherever possible, bereaved parents/carers should be kept up to date with all progress made during the investigation, unless this could compromise any intended police action. This is the role of the Police Coroner's Officer and care should be taken to avoid any duplication of effort, particularly in regard to any direct contact with the parents/carers. The communication strategy for parents/carers should be an agenda item at the meetings.

**8.3.47** Important information should only be withheld from parents/carers, if absolutely necessary. In such circumstances honesty and transparency about police actions and intentions form a critical part of winning the respect and cooperation of parents/carers without which an effective and comprehensive investigation may not be possible.

## **Public Protection Division (PPD)**

**8.4.1.** During their investigation, all SIOs should draw on the knowledge and expertise of staff in the Public Protection Division (PPD).

**8.4.2.** PPD staff have specialist skills, knowledge and experience within the field of interagency child protection. As such they have a vital role to play in supporting the investigation into the death of any child or young person within the definition of this protocol. The SIO should liaise with his/her divisional PPD at the earliest opportunity.

**8.4.3.** The PPD staff will address any wider child protection issues including assessing any risk posed to a living sibling or unborn child and taking any action necessary by either invoking police protection procedures or by supporting an application by the Local Authority for an Emergency Protection Order.

**8.4.4.** The PPD is responsible for attending Child Protection Case Conferences in respect of all children who are the subject of a 'child protection plan' across the force area. When a child who is currently the subject of a 'child protection plan' dies and a multi-agency investigation commences, staff from this unit will contact the police SIO for further information.

**8.4.5.** The PPD is also responsible for attending and reporting on all child deaths to the Local Safeguarding Children's Board (LSCB) and Child Death Overview Panel (CDOP) in each Local Authority area. Staff from the PPD will complete a Child

Notification Form for every child or young person's death coming to the attention of the police. This will include details of the child / young person, the family/carer and the circumstances. This is a requirement on all agencies. The LSCB administrators will then request a second, more detailed form, to be completed. This will also be completed by staff from the PPD.

- 8.4.6.** In cases where a child dies in circumstances where abuse or neglect is suspected to be a feature, the CDOP may decide to hold a Serious Case Review (SCR). Police representation at a SCR will be a PPD Detective Inspector. SIOs should expect contact from this unit following their involvement in such cases.

## **Road Deaths**

- 8.5.1.** The investigation of a road death involving a victim under the age of 18 years will be led by a Road Policing SIO (RPSIO) from within the Serious Collision Investigation Unit. The RPSIO and his/her staff should, as far as possible, follow the relevant guidance contained in 'Working Together to Safeguard Children' and consider the contents of this protocol.

## **Returning property to bereaved families/carers**

- 8.6.1.** Items should be returned in person to parents/carers by the police as soon as possible after the Coroner has finished his/her investigation. Parents / carers should first be contacted and sensitively reminded about what items had originally been taken by the police. They should be asked whether they want the items back. If any items are unclean or, for example, still contain food or juice, the police should ask permission to wash them before they are returned. Official labels or wrappings should always be removed.
- 8.6.2.** Where possible, items should be returned in respectful and presentable containers. In many cases, this meeting with parents / carers may represent their final contact with the police concerning the death of their child.

## **Sources of advice for cultural, religious and diversity issues when dealing with unexpected deaths of children / young people**

- 8.7.1** GMP staff can obtain guidance from the following associations / sources:
- Cultural Liaison Officers
  - Black & Asian Police Association
  - Christian Police Association
  - Disability Support Network
  - Jewish Police Association
  - Lesbian & Gay Staff Association
  - Muslim Police Association
  - Diversity Command

Contact details are available on the GMP Force intranet site.



## 9.1 Initial call

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

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

## 9.2 Resuscitation

- 9.2.1 When resuscitation is indicated:

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

## 9.3 Diagnosis of fact of death

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

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

- 9.4.1 If, after 'fact' of death has been diagnosed there 'do not appear to be any suspicious circumstances', the NWAS crew will (subject to 'exceptions' listed below) immediately take the child/young person's body to the nearest local Emergency Department with Paediatric facilities with the agreement of the Police. In such circumstances, the attending ambulance crew will contact Emergency Operations Centre and inform them of confirmation of death. Ideally this should be

prior to the child being transferred into the ambulance. The ambulance Emergency Operations Centre will make it clear to the receiving Emergency Department that death has been diagnosed and that resuscitation is not being attempted and that the child is being transferred to the Emergency Department as per GM SUDC protocol. If the Police or the SUDC paediatrician are already involved this should be conveyed to the Emergency Department staff.

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

If any police officer directs that the body should not be moved (the officer should be told that once the ambulance has left it cannot return and the body will need to be moved by undertakers arranged by the police).

If the body is considered to pose a health risk

If 'other exceptional reasons' exist that justify not taking the body to the nearest Emergency Department with Paediatric facilities e.g. major incident or hospital on divert (If hospital on divert, discuss with Emergency department coordinator as body may still go to Emergency Department depending on reason for divert). Where any of these exceptions apply, details should be recorded in police/NWAS records and brought to the attention of the police SIO.

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

**9.5.1** If, after 'fact' of death has been diagnosed the death appears to be 'suspicious', the NWAS crew should remain with the body at the scene until the first police officer arrives. In these circumstances, the SIO should be consulted before the body is removed from the scene by NWAS. The first police officer at the scene should have the means to identify and contact the duty police SIO for this purpose.

**9.5.2** On average the NWAS crew will be available at the scene for 30 minutes following their arrival time whilst they complete records about the incident. Subject to the exigencies of their service they will transport the body to the nearest Emergency Department with Paediatric facilities, if requested to do so by the police SIO, within that timeframe. If the child requires to be transported to the Emergency Department out-with this timeframe the Police and NWAS should agree if this is possible with the NWAS Emergency Operations Centre.

## **9.6 Travelling to the Emergency Department**

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

## **9.7 On arrival at the emergency department**

**9.7.1** On arrival at the ED, the ambulance should be met by a senior ED doctor or paediatrician. This will allow for transfer into the department in the most appropriate manner.

## **9.8 Other actions to be taken after death has been established**

- 9.8.1** As far as possible make arrangements for the support of the bereaved (contact relatives, neighbours, priest etc.)
- 9.8.2** Obtain police PIN or collar number from the officer attending and record on the appropriate documentation.
- 9.8.3** Complete all documentation as comprehensively as possible and provide a copy to the police.
- 9.8.4** The NWAS attending crew or representative will be invited to the SUDC multi agency rapid response meeting. This will be via contact with the NWAS Safeguarding Practitioner via 07812 304 236, or 01204 498400 and asking for the NWAS Safeguarding Practitioner or the NWAS Safeguarding Team.

The NWAS Safeguarding Practitioner will co-ordinate who is available to attend the meeting and feedback to the original attending crew. The NWAS Safeguarding Team can also be contacted by email: [safeguarding.team@nwas.nhs.uk](mailto:safeguarding.team@nwas.nhs.uk)

## 10 THE GENERAL PRACTITIONER (GP) Appendix C

- 10.1.1** Rarely the GP may be called to the scene first. In such cases they should adhere to the same principles as Ambulance Staff (Appendix B).
- 10.1.2** In the unlikely event of being first to the scene the GP may diagnose the fact of death and will inform the police, via Police Control. The police and GP will inform the coroner. The GP will inform the Emergency Department consultant or paediatrician at the hospital to which the child will be taken. The child should not go directly to the mortuary. The GP should carefully record (verbatim) any account given by parents/carers of the circumstances leading up to the death and bring this to the attention of the police.
- 10.1.3** Usually the GP will not be notified until after death is confirmed at the hospital and the Rapid Response Team has become involved. GP involvement is vital to support the grieving family and to provide background information on the child, the child's siblings, parents and wider family. (See Chapter 5 on confidentiality and information sharing).
- 10.1.4** The GP will be asked to attend a multiagency meeting to discuss the case (usually within 24-48hrs of death). To facilitate the GP attending these, meetings are frequently held at the GPs surgery. It is extremely useful to have access to the health records of the child and family. The purpose of this meeting is to consider the cause of death, specifically consider safeguarding issues for surviving siblings, review support for the family and complete data collection for CDOP (form B). Individual roles and responsibilities will be decided at this meeting. It is the SUDC Paediatricians role to summarise this meeting and distribute an action plan.
- 10.1.5** The GP will be asked to offer appropriate support to the family.
- 10.1.6** The GP will also be invited to a final professionals meeting (once more usually held at the GPs Surgery) when the final PM examination report is available. The purpose of this meeting is to consider the cause of death, specifically consider safeguarding issues for surviving siblings, and future siblings, review support for the family and complete data collection for CDOP (form C).
- 10.1.7** Additional guidance for GPs, particularly in relation to the longer term care of the family, can be obtained from the Lullaby Trust's publications [www.lullabytrust.org.uk/](http://www.lullabytrust.org.uk/).
- 10.1.8** Mother's, sibling's and where possible father's records should highlight that a child has died in the family. Any safeguarding concerns raised during the rapid response investigation should also be highlighted irrespective of their relevance to the cause of death and any relevant information shared.

## EMERGENCY DEPARTMENT

- 11.1 As soon as the emergency department is notified that the ambulance crew is attending the scene of child cardiac arrest/death the nurse in charge must notify: -
- The on-call paediatric / resuscitation team
  - The on-call paediatric consultant
  - The on-call emergency department consultant
- 11.2 Full resuscitation should normally be commenced unless clearly inappropriate.
- 11.3 The identities of people present and their relationship to the child must be ascertained.
- 11.4 To identify the possible cause of death a detailed history should be obtained (using the proforma below as a guide). This will usually be taken by the SUDC paediatrician accompanied by the SIO, however if a family gives information to the hospital team this should be documented carefully and discussed with the SUDC paediatrician/SIO on arrival. The comments of parents/carers at all stages must be recorded in detail (verbatim if possible) in case of discrepancies or if suspicious circumstances develop.
- 11.5 The site and route of any interventions during resuscitation e.g. venepuncture, failed cannulation, intraosseous needle, should be documented on a body chart and may be removed. Any interventions pre collapse (e.g. tracheostomy tube, central line, chest drain etc.) should remain in situ. An endotracheal tube may be removed altogether (if the death is not suspicious) but only if there is documented clinical evidence of correct placement of the tube. If there is doubt that the endotracheal tube is not correctly placed, the fact must be noted and the tube left in situ.
- 11.6 A full general examination should be undertaken by the paediatrician/emergency medicine consultant noting any rashes, injuries on the child, signs of dehydration etc., and state of any clothing or bed linen. The examination should include a retinal examination if possible.
- 11.7 All items of clothes and personal possessions should be placed in plastic bags and retained. They may not be returned to the family without prior consultation with the police and coroner. They should be kept safe from any contamination and brought to the attention of the police as soon as possible. Staff should be aware that some or all of the items could later be sent for forensic examination.
- 11.8 **Do not wash the body.** Photographs may be taken and given to the parents according to the local protocol. Where requested by the family locks of hair, and hand/foot prints will be taken after the post mortem and **must not** be taken in the Emergency Department. This will be arranged by the SUDC Paediatrician.

- 11.9** Prior to death, blood, urine and CSF specimens may have been taken for toxicology, metabolic and septic work-up. The hospital notes must accurately record which tests have been obtained. The paediatrician/lead clinician must ensure that all results of pre-mortem tests are forwarded to the coroner and pathologist.
- 11.10** If the child is dead on arrival at hospital or when the fact of death is certified, the attending doctor should inform the police as soon as possible on **101**. It will be the dual responsibility of the police and senior clinician to inform the coroner's office of the death. Only in exceptional circumstances should the coroner be contacted between 11pm at night and 7am in the morning.
- 11.11** If initial history suggests the possibility that metabolic disease may contribute to the death then the lead clinician should consult with a paediatric metabolic consultant. If specimens are to be taken this should only be with specific agreement of the coroner.
- 11.12** When the fact of death is certified the senior clinician should contact the SUDC paediatrician and discuss the immediate case management and arrangements for hand over.
- The SUDC paediatrician is contactable via Wythenshawe Hospital Switchboard  
Tel: 0161 998 7070.**
- 11.13** Children's social care should be contacted to ascertain if the child, parents, any siblings or the address are known, and in what capacity.
- 11.14** Other professionals also need to be informed. This should be done in consultation with the NHS Trust 'child death' checklist.
- 11.15** The parents/carers will need time to accept the information. Staff should be prepared for a range of reactions from bereaved individuals.
- 11.16** Explain that the police, the coroner and SUDC paediatrician must be informed and that a post-mortem examination will be necessary to try to ascertain the cause of death.
- 11.17** Explain that the child's, and any sibling's medical records will be reviewed and that the SUDC paediatrician will contact the parent's GP to ascertain if there is any relevant family history.
- 11.18** A record should be made at every stage of contact with the family. This should include which health professionals were present at each contact. Careful documentation is required to include the full history and the verbatim comments and demeanour of the parents/carers.
- 11.19** The parents/carers/family members should be encouraged to see and hold the child whilst discreetly accompanied by a professional. However, if the death appears suspicious, the police SIO should be consulted before allowing this. At no stage should staff place themselves at risk in this situation.

**11.20** A member of staff should accompany the child to the appropriate mortuary. The child should not be left unattended until in the mortuary.

**11.21** The trust's hospital checklist should be completed according to local practice.

## **UNEXPECTED DEATH OF A CHILD ON A WARD, INCLUDING NEONATAL UNITS AND POST NATAL WARDS**

**11.22** All child deaths should be referred to the coroner. If the clinician is unable to issue a medical certificate of the cause of death following this discussion then the SUDC procedure should be followed. **The SUDC paediatrician is contactable via Wythenshawe Hospital Switchboard Tel: 0161 998 7070.**

**11.23** The investigation of newborn baby deaths has been the subject of debate both regionally and nationally. Nationally it is the norm that SUDC Rapid Response doesn't investigate newborn deaths. However there are circumstances where Rapid Response is clearly appropriate (for example, if a newborn baby has been identified as healthy and then dies suddenly after being given to his/her parents for routine care even if still on labour ward, or on the postnatal ward). When a hospital specialist is unsure whether or not a case should trigger SUDC Rapid Response this should be discussed with the SUDC Paediatrician (and the SIO when appropriate, for example if there are concerns about the care given by carers or health professionals).

**11.24** When a child dies on the ward and, if the collapse leading to their death was sudden and unexpected 24 hours prior to that collapse, then Rapid Response should be informed.

**11.25** The role of the rapid response is to

- ascertain cause of death
- address safeguarding/criminal issues
- offer support to the family
- collect information for CDOP (Child Death Overview Panel).

In cases where a thorough history has already been taken, the social background of the child considered, safeguarding issues/unnatural death explicitly addressed and the child and family are already well known to the acute team it *may* be that Rapid Response has nothing further to add. However the SUDC paediatrician should be informed of the death and a three-way discussion between Acute Lead, SUDC Paediatrician and SIO should occur. The reasons for not involving rapid response should be documented in the hospital notes and by the lead consultant.

**12.1** The SUDC Paediatrician will provide telephone advice and attend the emergency department promptly when on call (if necessary), once they have been informed of a sudden unexpected child death. If the child is not in the emergency department, the SUDC paediatrician will agree with the referrer what actions are required next.

In the rare circumstances of two deaths occurring at the same time ~~in different areas of the county~~, a discussion will take place between the SUDC paediatrician and the SIOs involved to decide on the most appropriate management of each case.

**12.2** The SUDC paediatrician will take the lead in the medical investigation in communication with other health care professionals and in communication with other agencies (police, police coroner's officer, coroner's office and children's social care).

**12.3** Ensure all necessary multi-agency strategy discussions/meetings take place in non-suspicious cases. In suspicious cases and cases of potential suicide the police will organise these multi agency discussions.

**12.4** On arrival in the Emergency Department the SUDC paediatrician will meet with the senior acute physician and SIO to discuss what is already known about the child's death. They will then agree who will be present to examine the child. If the child is a patient on a ward or PICU, then the SUDC paediatrician will meet with the senior acute physician on the ward.

**12.5** The SUDC Paediatrician will fully examine the child with the SIO and document all findings. If there are any findings that raise the possibility of a suspicious death, these will be immediately communicated to the SIO.

**12.6** The SUDC paediatrician will take a full history from the family, usually accompanied by the SIO and Police Coroner's Officer (PCO).

**12.7** The SUDC paediatrician will ask the family if they would like mementos to be taken at post mortem examination. They will complete the consent form and fax it to the pathology department. It should be remembered that some individuals may potentially find the idea of taking mementos to be upsetting and offensive. All families should be asked, although it may be helpful to make it clear that what is comforting for some families may be extremely distressing for others.

**12.8** Following history taking the SIO and SUDC paediatrician will discuss if there should be a visit to the scene of death. It would be unusual not to visit the scene in a child under 2 years.

**12.9** If the family are not present in the Emergency Department, (or ward) the SIO and SUDC paediatrician will agreed when/where will be the most appropriate setting to take a history.



- 12.10** The SUDC paediatrician will make contact with the named nurse at the earliest convenient moment. If the child's death is outside PCO working hours, they will contact the PCO at the earliest convenient moment.
- 12.11** The SUDC paediatrician will review the Emergency Department records, the ambulance call out sheet and any other hospital records available.
- 12.12** The SUDC Paediatrician will collate all relevant medical records, including sibling's health records. Notes of previous hospital, community, Obstetric, A&E Department attendances must be reviewed including records of the use of NHS facilities in other areas. They will seek information on any relevant parental health problems from GP.
- 12.13** Together with the hospital paediatrician, the SUDC paediatrician will provide information for the pathologist prior to the post mortem examination. This usually will take the form of a written report, but may be a verbal handover. It is the responsibility of the PCO to inform the parents of any movements of the child's body, timings of PM examination (PME) etc.
- 12.14** The SUDC Paediatrician will complete a Form A Death notification for CDOP.
- 12.15** Unless working on another case the SUDC Paediatrician will attend the PM examination **or hand over to a colleague if their on call period has finished**. After the PME they will request permission from the coroner to inform the family and other relevant professionals of the provisional result. If an initial multiagency meeting has already occurred they will additionally ask permission to share the provisional results with other professionals. If a meeting hasn't already occurred then they will request to inform others at the meeting.
- 12.16** If it becomes clear that a child's death is the result of natural causes it will usually be appropriate for the police role to be reduced although the SIO should continue to be informed of the progress of the case.
- 12.17** The SUDC paediatrician will complete Form B for CDOP.
- 12.18** The SUDC paediatrician will organise a final review case discussion as soon as the final results of the post mortem examination are available provided coronial permission has been given to share the results (usually within 3-4 months). All attendees should receive a summary which should include
- A brief summary of the case
  - A summary of PM examination findings, the cause of death, and *any* other relevant findings.
  - Explicit comment on safeguarding issues for siblings/household contacts and *future siblings*.
  - A list of further actions, including management of future pregnancies.
  - A full distribution list (which should always include the child's, Mother's and where possible Father's GP and any other professionals felt to be relevant during the meeting).

If this meeting occurs then Form C should be completed for CDOP. If no final meeting is held the Rapid Response Paediatrician should additionally document why a final meeting was not held, and include the option to call a meeting if further information sharing is felt by any professional to be helpful. CDOP should be informed if no final meeting is to be held.

**12.19** After discussion with the coroner, the SUDC paediatrician should offer to meet the family to explain the outcome of the case discussion, including the cause of the child's death, and send the family a letter documenting what was discussed in accessible language.

**12.20** The SUDC Paediatrician should ensure in liaison with the Police Coroner's Officers that the family is fully notified and supported at all stages.

## Rapid Response check list

|   | Yes/No | Date |
|---|--------|------|
| Inform Tracey of death asap (24 hour safe answer machine available)   |        |      |
| Initial case discussion by phone with referrer  |        |      |
| Attend A&E to take history and fully examine the child (if appropriate)   |        |      |
| If the child has been confirmed dead at scene, direct call to A&E consultant to ensure child is transferred to A&E department when possible       |        |      |
| Home visit  |        |      |
| Mementos consent form signed by parents and faxed to pathology  |        |      |
| Make contact with Named Nurse at earliest opportunity (who should contact designated team)  |        |      |
| Make contact with PCO at earliest opportunity   |        |      |
| Form A (within 2 working days) to Tracey  |        |      |
| Report for PM/coroner and discussion with pathologist prior to PM<br>(Please include at start of path report if mementos fax has been sent)       |        |      |
| Review discussion/meeting (needs to include children's services) see flow chart for timings   |        |      |
| Summary of discussion to attendees, those who send apologies plus cc CDOP and coroner (ensure named nurse and PCO invited)                        |        |      |
| PM attendance (ideally aim for all)   |        |      |
| Inform family of provisional PM result and update PCO (if coronial permission given)  |        |      |
| Review discussion/meeting in the light of provisional PM findings if required, or update professionals in writing if coronial permission received |        |      |
| Form B (within 40 days of death) or ask Tracey to Contact CDOP with explanation   |        |      |
| 4 week letter to family including PCO details   |        |      |

|   |  |  |
|---|--|--|
| Final PM result and discussion with PCO re informing family   |  |  |
| Final case discussion (if no final meeting letter to CDOP and all involved explain PM result and reason for no meeting) |  |  |
| Summary of final meeting to all as listed below with PM result (as long as coronial permission given)                   |  |  |
| Form C to CDOP  |  |  |
| Meeting with parents  |  |  |
| Letter to parents   |  |  |
| Inquest   |  |  |
| Audit form (all cases)  |  |  |
| Time sheet (all cases)  |  |  |

Cc final report/Form C to:  
Hospital paediatrician  
A&E consultant

SIO

- PCO
- Coroner
- GP (s)
- HV/SN
- SW
- Named Nurse
- Others present at final meeting
- Local CDOP
- Local SUDC lead
- ED

\*If at an early stage it is clear there are significant safeguarding concerns the designated doctors have requested we let them know of the death personally.

## Contents of History Proforma

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**If A&E is not attended or a home visit is not deemed necessary it should be documented why that decision was made. The point's raise on page 19 should be answerable.**

## Contact names/ addresses and telephone numbers

|  |  |
|--|--|
| <b>GP Name and Address</b>                   |  |
| Consultant at time of death/name of hospital |  |
| SUDC Consultant                              |  |
| Police Officer/SIO                           |  |
| Social Worker                                |  |
| Coroner/ Coroner's Officer                   |  |
| HV/SN  |  |
| Pathologist                                  |  |
| Other Professionals                          |  |



**Mother**

|  |  |
|--|--|
| Full name (plus any other names)                             |  |
| Full address (including postcode)                            |  |
| NHS number   |  |
| Date of birth  |  |
| Ethnicity  |  |
| First Language   |  |
| Phone number (home/mobile or that of close relative/ friend) |  |
| Address/phone no. Mother will be using if different to home  |  |
| Mother's GP details  |  |

**Father**

|   |  |
|---|--|
| Full name (plus any other names)                            |  |
| Full address (including postcode)                           |  |
| NHS number  |  |
| Date of birth   |  |
| Ethnicity   |  |
| First Language  |  |
| Phone number (home/mobile/ that of close relative/ friend)  |  |
| Address/phone no. Father will be using if different to home |  |
| Father's GP details   |  |

**Siblings**

| Name | Date of birth | Primary address |
|------|---------------|-----------------|
|      |               |                 |
|      |               |                 |
|      |               |                 |

**5. Other members of household (Present and recent past)**

| Relationship to child who has died | Name | Date of birth |
|------------------------------------|------|---------------|
|                                    |      |               |
|                                    |      |               |

|   |  |
|---|--|
| <b>Hospital Attended</b>  |  |
| <b>Time of arrival</b>  |  |
| <b>List of those present for initial sharing of information</b><br>(e.g. police, doctors, staff nurses) |  |

**Initial information from Hospital**

**Given by**

**When**

## Decisions after initial information from acute team and then examination

|   |  |
|---|--|
| <b>Is this felt to be a suspicious case?</b> If yes immediately becomes police led  |  |
| <b>Who will be present when the child is examined?</b>  |  |
| <b>After examination were there any concerning findings?</b>  |  |
| <b>Who will lead the history taking?</b>  |  |
| <b>Will the parents be interviewed jointly or separately?</b>   |  |
| <b>Have background checks been made with Police and Children's Services? Is any information already known about the family by police or children's services</b> |  |
| <b>Who will be present when the history is taken</b><br>(please list including role or relationship to child)   |  |

## PHYSICAL EXAMINATION

Physical examination carried out by:

Others present

Date/Time of examination and interval from death

- Rectal Temp (low reading thermometer)
- Full Growth Measurements 

|                |       | Centile |
|----------------|-------|---------|
| Length (cm)    | _____ | _____   |
| head circ (cm) | _____ | _____   |
| weight (kg)    | _____ | _____   |
- Retinal Examination
- State of nutrition and hygiene
- Marks, Livido, Bruises or evidence of injury – To include any medical puncture sites and failed attempts, and should also be drawn on body chart overleaf.

Check genitalia and back:

Check mouth: Is the frenum of lips/tongue intact?

Further Details, observations and comments:

- List all drugs given at hospital and any interventions carried out at resuscitation
  
  
  
  
  
  
  
  
  
  
- Document direct observation of position of endotracheal tube prior to removal or name of senior doctor who checked tube position.

Date, Time

Signature(s)

**Are any of the examination findings suggestive of physical harm?  
(e.g. ANY bruising in a non-ambulatory child)**

**Has an explanation been given?**

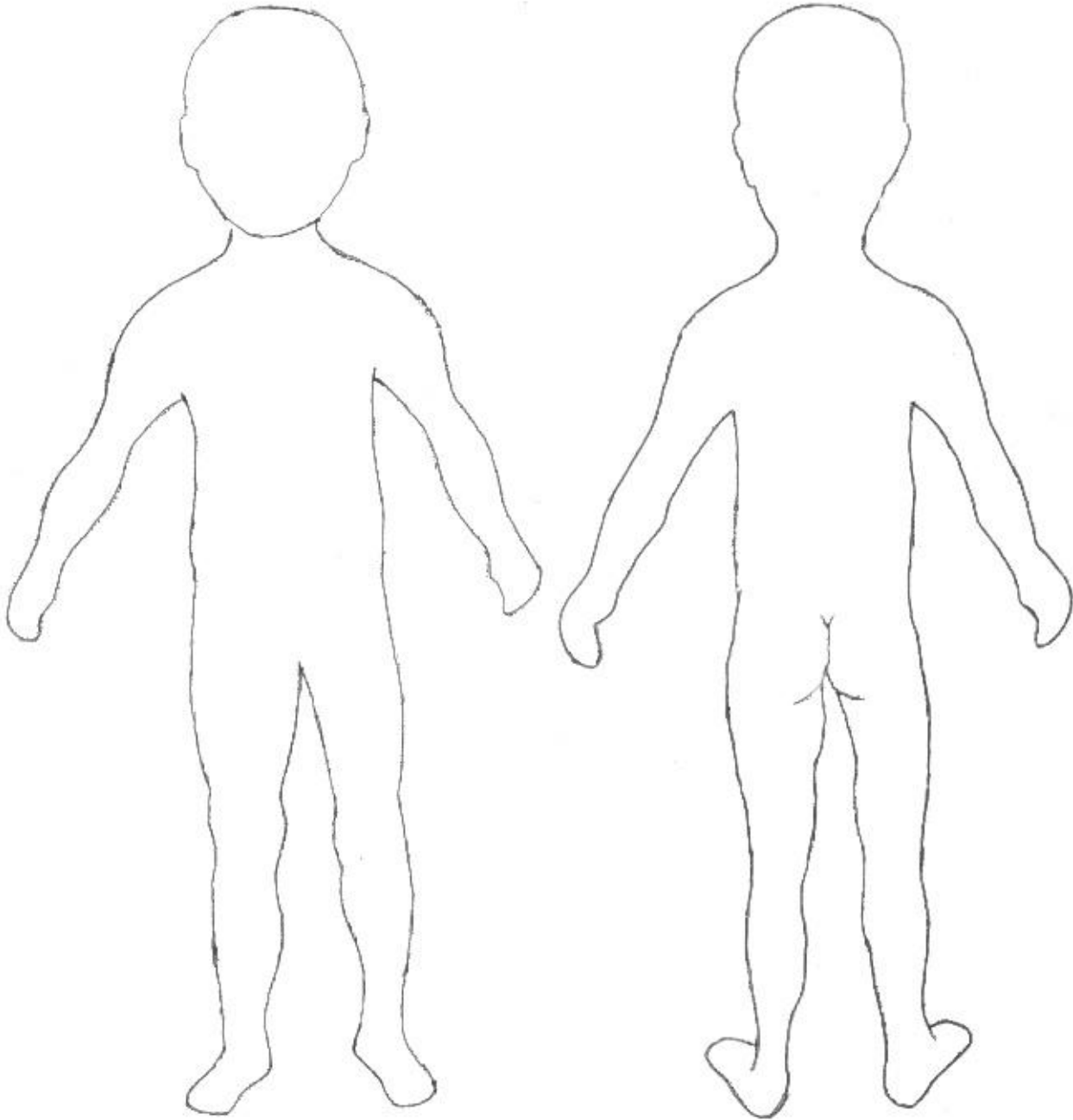
**Are there siblings that require protection?**

Name \_\_\_\_\_

D.O.B. \_\_\_\_\_

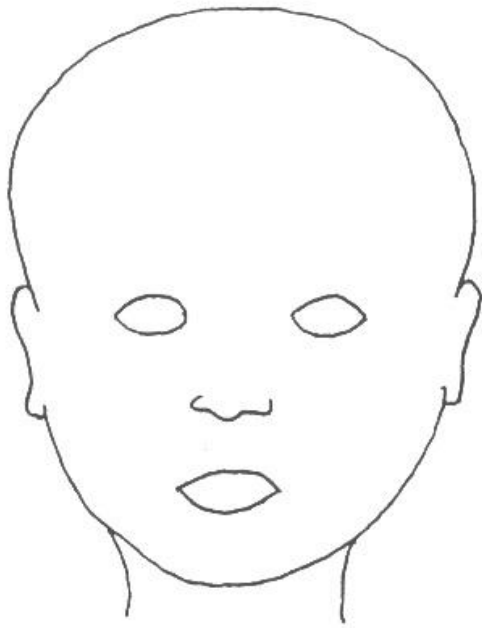


**PHYSICAL EXAMINATION  
BODY CHART**

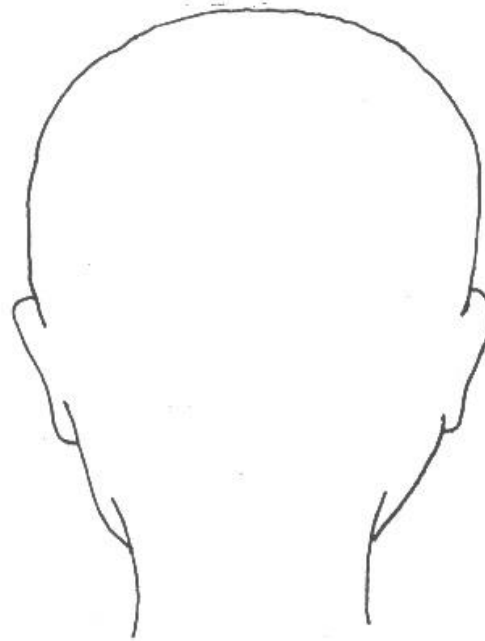


Name \_\_\_\_\_

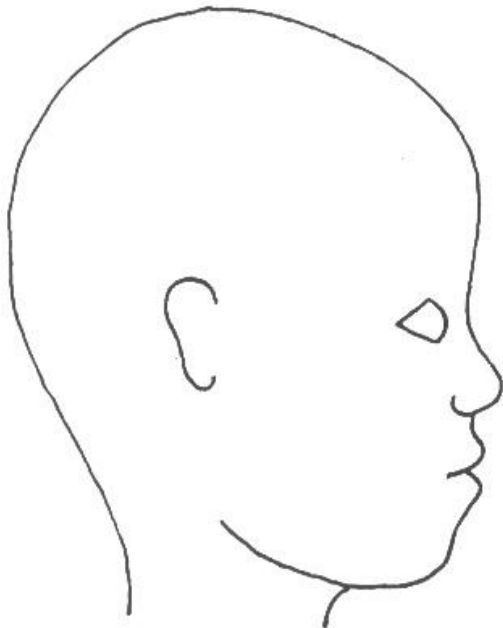
D.O.B. \_\_\_\_\_



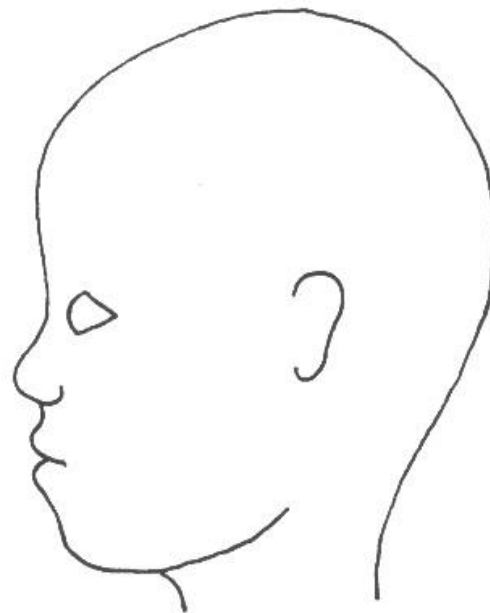
FRONT



BACK



RIGHT

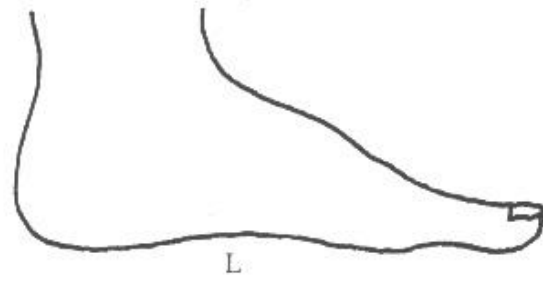
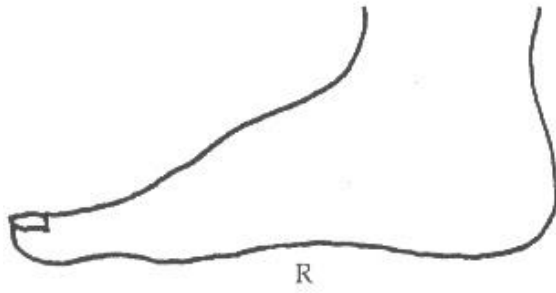
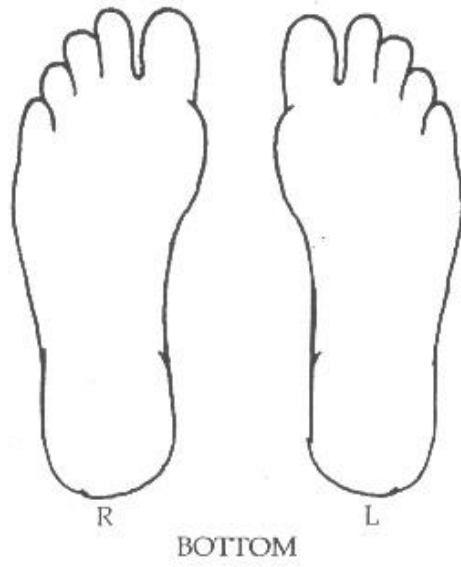
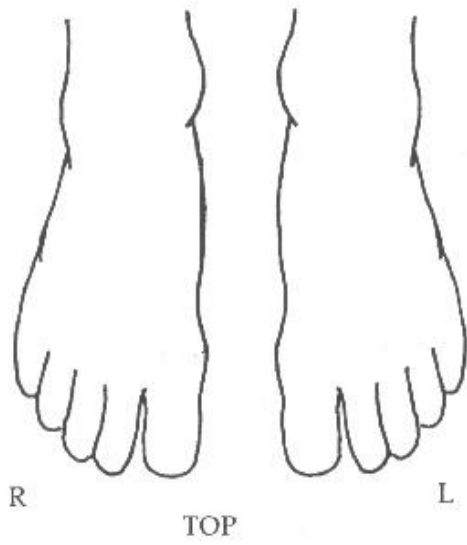


LEFT

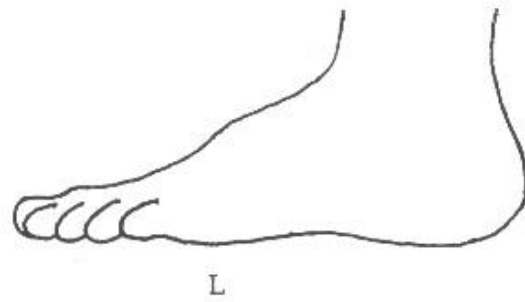
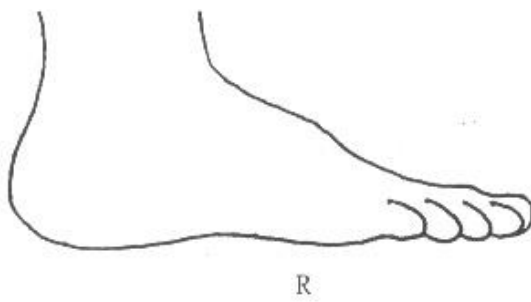
Name \_\_\_\_\_

D.O.B. \_\_\_\_\_





INNER



OUTER



**Details of Transport of child to Hospital:**(information from ambulance crew, if from another source please state)

**Place of death:            Home address as above/Another location (specify)/ Hospital (specify)**

Time found:

By whom/how:

Who called emergency services:

Time arrived in A&E:

Resuscitation carried out:     Y/N

Where?                            At scene of death/Ambulance/ A&E

By whom?                        carers/GP/ambulance/hospital staff/others

What responses, (if any), were obtained from the child?

How long did it take for the emergency services to arrive? (from ambulance call times)

Conformation of death     Date            Time                            Location

By whom?

Any additional information from NWS :

## **7. History**

Taken in A&E by:

History given by:

Relationship to child:

Others present:

### **Events surrounding death**

(Include photocopies of all relevant A&E notes)

**Ensure history includes**

**Family tree/past medical history/developmental history**

**Detailed narrative account of events of the 24-48 hours prior to the child being found**

To include details of all activities and carers during last 24-48hours

Whether child was feeding as well as, or less than usual

Any changes in routine care or activity levels

Any disruptions to normal patterns

Any alcohol drugs consumed by child or carers

Any emotional upsets

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

Include changes in feeding/sleeping pattern

Changes in place of sleep

Changes in individuals responsible for providing care to child

Social, family or health related changes in routine

Any illness, accident or other major event affecting other family members

For older children note whether at school or on holiday

Any changes at school/exams etc.

Change of friends/recreational activities

**Further Questions**

Any vomiting/respiratory difficulty, noisy breathing/ in drawing of ribs/ wheeze or stridor

Excessive sweating

Unusual activity/Unusual behaviour

Level of alertness/Difficulty sleeping/Difficulty waking

Passage of stool (how often and how much)

Were any health care professionals consulted in the last 2 weeks. If yes who, why, and what advice was given

Was the child SEEN and assessed in the last 2 weeks

Any self harming behaviour

**Final sleep check list (if relevant)**

|   |  |
|---|--|
| <b>Nature of surface</b>  |  |
| Clothing  |  |
| Bedding   |  |
| Arrangement of bedding  |  |
| Precise sleeping position   |  |
| Who was sharing the sleeping surface  |  |
| How often the child was checked   |  |
| When he/she was seen or heard   |  |
| The time at which the child awoke for feeds   |  |
| Whether feeds were given  |  |
| Whether they were taken well  |  |
| What were the activities of others in the room                                      |  |
| Where, when and by whom was the child found   |  |
| What was the appearance of the child when they were found                           |  |
| Where was the bedding   |  |
| Were there any covers over the child  |  |
| Had the covers and the position of the covers moved                                 |  |
| Were there any other objects adjacent or close to the child (e.g. pillows, teddies) |  |
| Regular use of pacifier, was it used that night                                     |  |
| Was the heating on/what type  |  |
| Were the window and/or doors open or closed   |  |

Name \_\_\_\_\_

D.O.B. \_\_\_\_\_

*Documentation of discussion with rapid response team following initial information gathering, examination and history taking:*  
(See over page for issues to be discussed)

**Date**

**Name/position of those involved in discussion**

### **Checklist for issues to be discussed during initial discussion**

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

**If the case is deemed suspicious it immediately becomes a police led case. At all times it should be clear who the lead is and what is expected to occur next.**

The SUDC paediatrician will arrange subsequent meetings and summarise the discussion and distribute the actions and timescales to the relevant individuals in non suspicious cases. Working Together suggests a multi agency professionals meeting *after* provisional PM findings are available, but if there are concerns identified this meeting may need to be considered sooner. If it has occurred pre PM examination, there will need to be an update once provisional PM findings are available (this may be a sit down meeting or may be a series of phone calls).

**At any time new information suggests safeguarding concerns for surviving siblings a strategy meeting must be convened.**

# Scene Examination

**Child's Name** .....

**Date of Birth** ..... **Date of Death** .....

**Address** .....

**Date of scene visit** .....

**Persons Present** .....

.....

## Room

Note: Size; orientation (compass); contents; "clutter"

Ventilation: windows & doors (open or shut),

Heating: (including times switched on/off); measure drawer temperature ..°C

## Sleep environment

Note: Location, Position of bed /cot in relation to other objects in room

Mattress, bedding, objects

## Position of baby

When put down;

When found

Name \_\_\_\_\_

D.O.B. \_\_\_\_\_



• Any evidence of over-wrapping or over-heating? Yes/No

• Any restriction to ventilation or breathing? Yes/No

- Any risk of smothering? Yes/No
- Any potential hazards? Yes/No
- Any evidence of neglectful care? Yes/No

**Any other relevant information**

|  |  |
|--|--|
| Following scene visit are there any suspicious circumstances? If yes who will lead the case? |  |
| Are there any safeguarding concerns for siblings?  |  |
| What actions are now necessary?  |  |





## Proforma for PM Examination Attendance

|   |  |
|---|--|
| Child's Name  |  |
| Date of birth   |  |
| Date of death   |  |
| SUDC Doctor at outset of case   |  |
| Date/time of PM examination   |  |
| Pathologist/others present  |  |
| Location of PM examination  |  |
| Doctor Attending PM   |  |
| Is this a forensic PM   |  |
| Did any new findings/ additional history available lead to safeguarding concerns? If yes please describe. |  |
| Who was new information discussed with? Please give time/date of discussion.                              |  |
| What actions were agreed?   |  |
| Were there plans for a multiagency meeting following the PM?  |  |

|  |  |
|--|--|
|  |  |
| Which doctor will continue to follow up this case?   |  |
| Who will be responsible for the ongoing lead of this case?   |  |
| Has the coroner given verbal consent to share provisional PM examination findings with<br>a. Family<br>b. other professionals<br>(Document details of phone call including name of coroners officer) |  |
| Any other comments   |  |

## Discussion with Named Nurse

Time

Date

Agreed actions

**Further information from:**

Hospital records (hospital number)

**Further information from:**

GP records

(include relevant parental information, siblings and other significant others in household)

Health visitor/School nurse/community records Midwife/NHS Direct if relevant

| Time/<br>date | Who is<br>involved | What information was shared, how was this<br>interpreted. | What actions were<br>agreed? |
|---------------|--------------------|---|------------------------------|
|               |                    |   |                              |
|               |                    |   |                              |
|               |                    |   |                              |
|               |                    |   |                              |
|               |                    |   |                              |
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|  |  |  |  |

**At ALL times the safety of siblings must be considered and immediate action taken if safeguarding concerns are identified.**

Review case discussion following completion of information gathering/ Final PM report being available.

**Date**

**Time**

**Name/position of those involved in discussion**



- 13.1** If the Named Nurse (NN) is aware of a SUDC death before being contacted by the SUDC paediatrician they will start to request records and ascertain health and safeguarding background.
- 13.2** The SUDC Paediatrician will telephone the Named Nurse for Safeguarding children at the earliest opportunity following the child's death after history taking, examination and home visit.
- 13.3** The SUDC paediatrician will inform the NN of the child's details, a brief summary of the child's death and together they will agree who will be responsible for
- i. Contacting the child health recorder holder (HV or SN) to request records and ascertain health and safeguarding background (if not already done). This may lead to further notes/information being requested.
  - ii. Agree who will invite other professionals to SUDC meeting (this will usually be the named nurse). This may include HV/SN/MW/Allied Health professionals/education.
  - iii. Contacting Children's Services if the police are not arranging children's services to attend the SUDC meeting.
- 13.4** At the end of the initial contact between SUDC paediatrician and NN, it should be clear what is the immediate plan, and when a multiagency SUDC meeting will occur (a specific date will depend on other professionals attending, but a timeframe can be agreed, see flow sheet 5.).
- 13.5** The NN will update other named and designated professionals as per local agreement.
- 13.6** The NN will usually attend the SUDC multiagency meeting. In cases where the NN doesn't attend this will be following discussion between the NN and SUDC paediatrician, and the reason for not attending will be clearly documented.
- 13.7** Following the initial multiagency meeting the NN will complete any actions agree from the meeting.
- 13.8** The SUDC Paediatrician will summarise the meeting and send out an action plan, unless the case has been handed over to the police as lead in suspicious cases, or children's services have taken the lead where there are wider safeguarding concerns. They will then be responsible for updating all professionals re actions.
- 13.9** When the final PM examination report is available, the SUDC paediatrician will decide in conjunction with the SIO whether a final multiagency meeting will be called (this will usually be the case). If a final meeting isn't held, the SUDC

paediatrician will inform the NN. If the NN has information that would require a final meeting they will request the SUDC paediatrician hold one. If there is a meeting the NN will be invited and decision to attend will be on a case by case basis, and if not attended the reason for not attending will be clearly documented.

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

- 14.1.1 The gathering of relevant information from community practitioners such as health visitors, school nurses and children's community nursing staff following a sudden unexpected child death is required to aid the investigative process by the coroner.
- 14.1.2 The need to support the professionals involved with the family prior to the death of the child must be recognized.
- 14.1.3 The community practitioner will make the child's community health record available to the SUDC paediatrician and discuss any concerns e.g. failure to thrive, neglect, parental problems such as substance use, domestic abuse, mental ill health and learning difficulties.
- 14.1.4 The community practitioner will contribute to any multi-agency meetings and will provide written reports as requested.
- 14.1.5 **The** community practitioner involved with the child/family should work closely with the GP to provide bereavement support for the family.
- 14.1.6 It is essential that at all times the safety of any surviving siblings and/or other vulnerable people is paramount. This should always include full consideration of the safety of potential future siblings.
- 14.1.7 All staff involved in rapid response should recognise the importance of taking appropriate action where any potential signs of abuse or neglect are identified, irrespective of the relationship to the cause of death.

#### **14.2 In the rare cases where the community practitioner is first on the scene:**

- 14.2.1 Dial 999 and ask for an ambulance to attend the scene immediately stating "cardiac arrest".
- 14.2.2 Attempt resuscitation or procede as instructed by the ambulance service. If the indications are that the child is clearly dead and no active resuscitation has been attempted, the body should remain in situ pending the arrival of the police.
- 14.2.3 The position of the child and the condition in which it was found must be recorded together with any comments/explanations from any person present. Bring this explanation to the notice of the police or SUDC paediatrician. Try not to disturb the scene, i.e do not touch or move anything.

- 14.2.4** When the paramedics arrive, spend time listening to the parents and offering support.
- 14.2.5** If the parent/carer goes to the hospital with the child, ensure that appropriate arrangements are made for the care of siblings. Record details of who is caring for the children.
- 14.2.6** If the parent is alone, ensure that he/she has the appropriate family support. Give the parents a work telephone number where you can be contacted.
- 14.2.7** Inform your line manager and the named nurse for safeguarding children of the action taken.
- 14.2.8** As soon as possible after the incident (within 24 hours) make a precise and thorough record of the event in the child's record, making particular reference to:
- a. Any inappropriate delay in seeking help,
  - b. The position of the child, its surroundings and the condition in which it was found,
  - c. Inconsistent explanations - accounts should be recorded verbatim in quotes where appropriate,
  - d. Evidence of high risk behaviour eg domestic abuse, drugs/alcohol use,
  - e. Parent's reaction/demeanour,
  - f. Unexplained injury e.g bruises, burns, bites, presence of blood,
  - g. Neglect issues.
  - h. General condition of the accommodation

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

### **14.3 When a child has died**

- 14.3.1** Check to ensure that all known agencies working with the child have been informed of the child's death eg, paediatric allied health professionals (AHPs), audiology, midwifery services, community paediatricians, Children's Centres etc so as to avoid appointments being sent.
- 14.3.2** Inform the Child Health Department to avoid appointments being sent.
- 14.3.3** Contact the family to acknowledge the death of their child, and offer support as required.
- 14.3.4** In the case of an infant death ensure that the parents/carers have a copy of the infant death booklet and the help line number of the Lullaby Trust (previously the Foundation for the Study of Infant Death, FSID), freephone 08088 026868.
- 14.3.5** Assess the support that the parents/carers/siblings/grandparents require. Where the family is in need of intensive support consider alternatives, e.g. Lullaby Trust Befriender Service.
- 14.3.6** If the mother was breast feeding, discuss and advise on the suppression of lactation

and refer to the GP where necessary.

**14.3.7** Ensure that the parents/carers have your work contact number.

**14.3.8** Ensure that community health records are available to the SUDC paediatrician; be available to attend any subsequent multi-agency meetings and to provide written reports as requested.

#### **14.4 In the months following the death:**

**14.4.1** Arrange a home visit again after the funeral and during the following weeks, in consultation with the family.

**14.4.2** Make sure that the parents have your work contact number.

**14.4.3** Assess whether additional support is required to assist parents/siblings cope with their grief and arrange as appropriate.

**13.4.5** Remember the first anniversary of the child's birth and death and consider a visit at those times.

**14.4.6** In the case of Sudden Unexpected Infant Deaths offer support with the subsequent babies via the Care of the Next Infant (CONI) Scheme.

**14.4.7** Access any support you may require for yourself, eg staff counselling service/ supervision.

## Introduction

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

**15.1.1** The investigation of newborn deaths is currently under debate both regionally and nationally. Nationally it is the norm that SUDC Rapid Response doesn't investigate newborn deaths. However there are circumstances where Rapid Response is clearly appropriate (for example, if a newborn baby has been identified as healthy and then dies suddenly after being given to his/her parents for routine care even if still on labour ward, or on the postnatal ward). When a hospital specialist is unsure whether or not a case should trigger Rapid Response this should be discussed with the SUDC Paediatrician (and the SIO when appropriate, for example if there are concerns about the care given by carers or health professionals).

**15.1.2** It is essential that at all times the safety of any surviving siblings and/or other vulnerable people is paramount. This should always include full consideration of the safety of potential future siblings.

**15.1.3** All staff involved in SUDC rapid response should recognise the importance of taking appropriate action where any potential signs of abuse or neglect are identified, irrespective of the relationship to the cause of death.

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

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

## 15.2 If the midwife is first on the scene

**15.2.1** When an unexpected fresh stillbirth or sudden unexpected death has occurred without the presence of a health professional, or if the birth has been concealed, the midwife must assess the baby and the mother's medical condition and immediately dial 999 and request an ambulance. The ambulance service will inform the police. The midwife should not complete the medical certificate of stillbirth and the GP should be informed (Northwest Local Supervising Authorities Guidance for Supervisors of Midwives (NLSAGSM) 2005).

- 15.2.2** Where the midwife has arrived after the birth and there is evidence of maceration or gross abnormality she may complete the medical certificate of stillbirth if confident that the baby cannot have shown signs of life. In this event the coroner's office will not need to be informed (NLSAGSM 2005).
- 15.2.3** Resuscitation (CPR) should be attempted if appropriate. If the indications are that the baby is dead and no active resuscitation has been attempted, the body and placenta (if delivered) should remain in situ pending the arrival of the police. If the placenta is undelivered this should be done as per midwifery guidelines, and then retained.
- 15.2.4** The position of the baby and the condition in which it was found must be noted together with any comments/explanations of the mother or any other person at the scene. Try not to disturb the scene, i.e. do not touch or move anything.
- 15.2.5** When the paramedics arrive, spend time listening to the parents and offer support.
- 15.2.6** If the parent/carer goes to the hospital with the baby, ensure that appropriate arrangements are made for the care of the siblings.
- 15.2.7** If the parent/carer is alone, ensure that he/she has the appropriate family support.
- 15.2.8** Give the parents/family a work telephone number where you can be contacted.
- 15.2.9** If the mother's condition requires obstetric intervention, she should be transferred with a midwife to the nearest maternity unit, whether she is booked there or not.
- 15.2.10** If the baby is not resuscitated the body will be taken to a hospital Emergency Department.
- 15.2.11** Parents and family members may have access to the baby's body as agreed at the Initial Case Discussion. An appropriate professional **MUST ALWAYS** be present.
- 15.2.12** If the midwife has any relevant information about the pregnancy or the family, this should be reported directly to the police and Emergency Department staff as soon as possible.
- 15.2.13** As soon as possible and within 24 hours, make a precise and thorough record of the event in the baby's record, making particular reference to:
- a. Any inappropriate delay in seeking help,
  - b. The position of the baby and the condition in which it was found.
  - c. Inconsistent explanations - accounts should be recorded verbatim in quotes,
  - d. Evidence of drugs/alcohol abuse,
  - e. Parents reaction/demeanour,
  - f. Unexplained injury e.g bruises, burns, bites, presence of blood,
  - g. Neglect issues.
  - h. Position of the baby and its surroundings
  - i. General condition of the accommodation
  - j. Evidence of high risk behaviour eg domestic violence

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

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

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

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

### **15.3 If you learn later that a baby has died**

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

- a. Medical records department/maternity/children's hospitals to avoid follow up appointments being sent.
- b. Child health department to avoid appointments /reminders being sent
- c. The family GP in case s/he has not already been contacted by the police/hospital
- d. Health visitor
- e. Audiology department if the infant has been referred for follow up or has not yet had neonatal screening.
- f. Named midwife safeguarding children and the relevant line manager
- g. School Nurse if there are older siblings in the family
- h. Any other department to which the infant has been referred/seen if follow up appointments are possible, e.g. Sure Start, Social Care
- i. Known research projects in the area, which might result in a questionnaire being sent to parents/carers.
- j. Local Supervising Authority and Supervisor of Midwives
- k. CEMACH Office

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

**15.3.3** Discuss the support the parents/carers/extended family require. If there is inadequate support, consider more intensive midwifery support or alternatives/ Lullaby Trust Befriender Service.

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

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

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



## **15.4 The next pregnancy:**

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

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

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

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

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

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

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

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

- 16.1** In the first instance Emergency Department staff will check with Children's Social Care whether the deceased or any child within the same family or address is or has been known to children's services and if so, in what capacity. If the child isn't in the emergency department the SUDC paediatrician will ensure these checks are made.
- 16.2** Children's Social Care staff will check whether the child and or siblings are known in any capacity, or any other child in the family, parents or address is known. It may also be necessary to check with other local authorities where the child has previously lived. Such information will be given to the Emergency Department and/or SUDC paediatrician in confidence.
- 16.3** If the family of the deceased child are existing or recent clients of Children's Social Care, the line manager will inform the child's social worker and/or consider the need for a social worker to be allocated to the family.
- 16.4** Children's services should always attend the initial multiagency meeting even if the child is not already known. It is at this meeting that it can become clear there are safeguarding issues/child protection concerns.
- 16.5** If the family is not known, then the primary support to the family will be given by health workers and the police. However, should these agencies believe that Children's Social Care support or services will be helpful then this should be given priority.
- 16.6** The social worker will liaise with the police SIO and SUDC paediatrician and share information.
- 16.7.** Where a social worker is to be involved and after discussion with the SUDC paediatrician, s/he will contact the family and offer support either directly or via other appropriate agencies. Such help will depend upon the family's willingness to accept it.

If the death appears to be suspicious and there are other children in the family, Section 47 (s.47) of the Children Act 1989 requires the Local Authority to institute a child protection enquiry. This should be done in accordance with LSCB procedures. The immediate protection of any other children in the family will take priority.

If a s.47 enquiry is required this element of the investigation will be discussed at the first strategy meeting of the rapid response team to ensure that there is clarity in relation to the various strands of the investigation, roles and timescales.

- 16.8** If there are grounds for considering a serious case review local LSCB procedures should be followed.

# 17 THE ROLE OF THE CORONER, CORONER'S OFFICER AND PATHOLOGIST

## Appendix J

- 17.1** After the fact of death is certified, the coroner has control of the body. Medical samples should only be taken by the pathologist.
- 17.2** In most cases of children under 2 years old, prior to the post mortem examination, a full skeletal survey will be conducted and interpreted by two paediatric radiologists (in accordance to royal college for radiology guidelines). Skeletal surveys in older children will be considered on an individual case basis.
- 17.3** The decision to involve a paediatric pathologist in a post-mortem examination will be made by the coroner on an individual case basis.
- 17.4** If post-mortem examination reveals suspicious circumstances, it will be halted and the coroner informed. The coroner will then decide how to proceed. Usually the post-mortem will then be continued jointly with a Home Office pathologist, following consultation with the police Senior Investigating Officer (SIO).
- 17.5** If the circumstances of the death are suspicious from the outset, the SIO will consult the coroner who may direct a joint PM by a Home Office pathologist and a paediatric pathologist. In some circumstances the coroner, or other interested parties may require a subsequent PM examination.
- 17.6** The SIO, the Police Coroners Officer and the SUDC paediatrician or on call paediatrician will liaise to ensure that as much information as possible is provided to the pathologist before the PM. This will include a summary compiled by the SUDC paediatrician of the full medical history including any relevant background information concerning the family and any concerns raised by any other agency.
- 17.7** The Lead Consultant at the acute hospital is responsible for ensuring that the results of any pre-mortem samples are forwarded to the coroner and the pathologist.
- 17.8** The Police Coroner's Officer must ensure that all relevant professionals who wish to attend the PM, and who have been authorised by H.M. Coroner to attend, are informed of the time and place.
- 17.9** In the event of a "suspicious death", the SIO (or appointed representative), exhibits officer and photographer from the Force Imaging Unit should attend the PM.
- 17.10** The PM shall be carried out promptly. All persons involved with this protocol will cooperate to this end. All investigations are to be concluded within the shortest possible time to enable:
- The prompt funeral of the child.
  - The expeditious conclusion of the inquest or criminal proceedings into the death of the child.

- 17.11** A paediatric PM will usually (but not always) involve the taking of material for additional investigations (such as histology, microbiology, metabolic studies, toxicology and biochemistry or immunology), though the number and type of investigations required will be the decision of the coroner in consultation with the pathologist(s) concerned. Rarely this may be no further investigations. If the pathologist carrying out the PM examination deems it necessary to retain a whole organ (solely for the purpose of establishing the cause of death) he/she will ask the permission of the coroner first. The coroner, through his/her officer, will enquire of the family as to their wishes for the ultimate disposal of the organ. However note that these may only be carried out following release of the organ by the Coroner and it may be necessary to retain the organ until completion of the inquest. In many cases the family may request burial of the body (without the organ(s) concerned) before this time; burial or cremation also requires release of the body by the Coroner.
- 17.12** All samples taken at PM are under the control of the coroner and must be labelled, identified.
- 17.13** Hand/foot prints and locks of hair will only be taken after the PM (not in A&E).
- 17.14** .In cases where initially there have been no safeguarding concerns identified (following history, examination, scene visit and police and children's services checks,) and a paediatric PM examination has been requested, there remains the possibility that on commencing the paediatric PM examination new findings may raise concerns. When this occurs the paediatric pathologist will stop the PM examination and discuss with the coroner how to proceed. If the SUDC paediatrician is not in attendance, the paediatric pathologist will inform them that the PM examination has been stopped and discussed with the coroner. Usual practice will be to contact the SUDC paediatrician involved in the case. In the event of being unable to make contact the On call SUDC paediatrician can be contacted via Wythenshawe switchboard on 0161 998 7070.
- 17.15** As soon as possible the pathologist will provide to the coroner in writing the following information:
- Any significant preliminary Post Mortem pathological findings.
  - The preliminary cause of death.
  - Details of material retained for further examination (if any).
- 17.16** Coroners will brief their staff with the information appropriate to share with other agencies. This will be on a case by case basis and those requesting information must request coronial permission to receive it. This information will usually be available to those within this protocol who telephone the coroner's office. Those receiving such information will treat the same with confidentiality and can only share this information if coronial permission has been given.

The final written PM report should be made available to the coroner when completed giving the conclusions of post mortem and subsequent investigations. The list of samples taken and the results of subsequent tests should all be documented.

- 17.17** Upon receipt of a written PM report the coroner will provide a copy to the SUDC paediatrician and SIO. No other agency will be allowed access to the pathologist's report without prior approval from the coroner. Permission should always be sought by an agency if the contents of the report could potentially affect the agency's future actions.
- 17.18** If safeguarding concerns are identified at PM examination it is the duty of the rapid response team to respond appropriately. It is recognised that the coroner has to agree for the PM examination findings to be shared. In the unlikely event, however, of the coroner not giving permission to share information, it is the responsibility of the SUDC Paediatrician on call to discuss the case directly with the coroner. If this still fails to resolve the situation, the on call SUDC paediatrician will inform the SUDC lead paediatrician that there are safeguarding concerns. The SUDC Lead will then speak directly with the coroner concerned. In the unlikely event that this does not lead to agreement to share information legal advice should be sought.
- 17.19** The SUDC paediatrician will have the responsibility of convening a "Review Case Discussion" as soon as the PM examination has concluded. Relevant agencies and the coroner must be consulted. If a multiagency meeting has already been held, and the PM examination provides no new information, all agencies can be updated without a formal meeting, provided coronial permission to share PM examination findings has been given.
- 17.20** In non suspicious cases, the police Coroner's Officer will review and collate all the required reports and statements relating to the death so as to formulate an inquest file for the coroner's attention. In "suspicious" cases the actions of this officer will be directed by the police SIO.
- 17.21** The PCO (police coroner's officer) or FLO (where appointed), should be invited (by the SIO / SUDC paediatrician) to attend all meetings of the rapid response team, whether chaired by the police SIO (for suspicious deaths) or SUDC paediatrician (for non-suspicious deaths). The strategy for effective communication with the parents/carers of the child will be a key agenda item at such meetings. The PCO / FLO will have an important role to play in communicating information to the family.
- 17.22** When a child/young person's death that is initially treated as 'suspicious' is later deemed by the SIO to be 'non-suspicious', the FLO must consult with the PCO and agree a hand-over strategy for all future contact with the parents/carers. If, at that point, the PCO has not previously met the parents/ carers, a joint FLO/PCO visit should be made and the PCO personally introduced to them. Contact details of the PCO should then be provided to the parents/carers. It should be made clear to the parents/carers that, from that point, all future communications should be through the PCO and not the FLO. The FLO should document details of the hand-over strategy and any joint visit that takes place in his/her policy book.
- 17.23** In 'non-suspicious' cases, the police coroner's officer (PCO) or Coroner's administrative Officer will be specifically responsible for informing parents/carers of any movements in the location of the child's body up until the point of release to the

family undertaker. In 'suspicious' cases, the FLO should obtain this information from the police coroner's officer and promptly pass it to the parents / carers. Wherever possible, parents/ carers should be provided with this information in advance of any movement of the body, together with a full explanation of why movement of the body is necessary. This information is highly important to parents/ carers and additional and unnecessary anguish can be created if this is not given in a timely manner. It is good practice therefore for SIOs to check with the PCO (or FLO, if appointed) that such information has been or will be passed to parents / carers. SIOs, PCOs and FLOs should be aware that SUDC paediatricians are not usually given this information, so they cannot provide it to parents/carers.

**17.24** The PCO (or FLO where appointed) will also specifically be responsible for explaining to parents/ carers that it may be possible for them to view their child's body, both before and/or after post - mortem examination, whilst in mortuary facilities i.e. both the local hospital mortuary and the Royal Manchester Children's mortuary (if different). If the coroner has requested a PM examination, and the child's body needs to be moved to avoid parents/carers being inadvertently misled, before giving this information to them, the PCO / FLO should always firstly speak with:

- The SIO to obtain his/her authority for the viewing to take place
- The relevant mortuary staff to obtain details of any limitations on viewings that may pertain at that particular time.

### **Royal Manchester Children's Hospital mortuary**

**17.25** The opening hours for the Royal Manchester Children's Hospital Mortuary are 09:00am – 17:00pm Monday to Friday. For any advice, please contact the main hospital switchboard (0161 276 1234) and ask to be put through to the Paediatric Mortuary, if the call is out of hours, please ask to be put through to the Paediatric APT on call.

Parents / carers attending the Royal Manchester Children's Hospital the mortuary to view their child's body **MUST** always be accompanied by the PCO/FLO.

In suspicious cases the need for another police officer to attend alongside the PCO/FLO is at the discretion of the Senior Investigating Officer

Viewings at the Royal Manchester Children's Hospital mortuary are between 2pm and 4pm on weekdays. Such 'weekday' viewings can be arranged by contacting the Royal Manchester Children's Hospital mortuary via the main hospital switchboard **(0161 276 1234)**.

The Mortuary department is not manned during weekends. Any viewings by parents/carers that cannot wait until the next working day may be arranged via the Clinical Co-ordinator at the Royal Manchester Children's Hospital, this can be done via the hospital switchboard (0161 276 1234).

Due to the demanding role of the Clinical Co-ordinator (e.g. Cardiac arrest supervision) you may experience a delay when trying to contact the Clinical Co-ordinator to arrange a viewing. Please note that this is for Mr Meadows' cases

only. For any other Coroners cases, the Paediatric on call APT should be contacted via switchboard (0161 276 1234) to facilitate a viewing.

If a situation arises where a child needs to be urgently transferred to the Royal Manchester Children's mortuary out of hours (for urgent Forensic cases only), the paediatric on call APT should be contacted via the Hospital switchboard (0161 276 1234) to facilitate this transfer.

### **Other hospital mortuaries**

- 17.26** Different rules may apply for other hospital mortuaries. These will need to be identified on a case by case basis.

## **18. Death in secure accomodation including while under escort**

### **Appendix K**

#### **Deaths in Young Offenders Institute (YOI)**

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

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

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

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

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

\*YJB serious incidents guidance



## 19 SOURCES OF SUPPORT FOR FAMILIES Appendix L

### **THE LULLABY TRUST**

[www.lullabytrust.org.uk](http://www.lullabytrust.org.uk)

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

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

### **Lullaby Trust Helpline**

bereavement support: 0808 802 6868

information & advice: 0808 802 6869

Open 9am to 11pm, Monday to Friday and 6-11pm on weekends and Bank Holidays

### **CHILD BEREAVEMENT UK**

<http://www.childbereavement.org.uk/>

Child Bereavement UK provide confidential support, information and guidance to families and professionals. Professionally trained bereavement support workers are available to take calls 9am - 5pm Monday-Friday. Tel: **0800 02 888 40**.

### **Winston's Wish**

[www.winstonswish.org.uk](http://www.winstonswish.org.uk)

**Winston's Wish** is the leading childhood bereavement charity in the UK. They offer support & guidance to bereaved children, families and professionals.

Helpline 08452 03 04 05 (*Monday – Friday 9am to 5pm and Wednesday evenings 7pm to 9.30 pm*)

### **Cruse Bereavement Care**

Central Hall, Oldham Street,  
MANCHESTER, M1 1WT  
0161 236 8103

### **Compassionate Friends National Helpline**

Understanding, support and encouragement to parents after the death of a child or children  
Helpline open every day of the year: 10am - 4pm & 6.30pm - 10.30pm

0845 123 2304

[www.tcf.org.uk](http://www.tcf.org.uk)

### **SOBS Survivors of Bereavement By Suicide**

[uk-sobs.org.uk/](http://uk-sobs.org.uk/)

**SOBS (Survivors Of Bereavement by Suicide)** is a self-help, voluntary organisation.  
Many of those helping have, themselves, been bereaved by suicide.

Call us: 0115 944 1117

Email us: [sobs.admin@care4free.net](mailto:sobs.admin@care4free.net)

### **Victim Support and Witness Service for Greater Manchester**

National Victim Support line: **0845 30 30 900**

[www.victimsupport.org.uk](http://www.victimsupport.org.uk)

# 20 USEFUL CONTACTS FOR PROFESSIONALS

## Appendix M

**On call SUDC Paediatrician:**     **via**     **Wythenshawe Hospital Switchboard**  
**0161 998 7070**

**SUDC Clinical Lead**                     **Dr E J Dierckx**  
**0161 248 1244**

**SUDC Administrator**                 **Mrs T Cliff**  
**0161 248 1244**

**GMP**   **0161 872 5050**

Rebecca Rice, Information Access Team Leader  
 Greater Manchester Police HQ,  
 Chester House, Boyer Street, Stretford, M60 ORE  
 0161 856 2668

| <b>Children's Social Care, Emergency Duty Teams</b> | <b>Telephone</b> |
|---|------------------|
| Bolton  | 01204 337407     |
| Bury  | 0161 253 6606    |
| Manchester  | 0161 255 8250    |
| Oldham  | 0161 770 6936    |
| Rochdale  | 0845 121 2975    |
| Salford   | 0161 603 4500    |
| Stockport   | 0161 718 2118    |
| Tameside  | 0161 342 2222    |
| Trafford  | 0161 912 5199    |
| Wigan   | 0161 834 2436    |

| <b>Coroner's Offices</b>      | <b>Coroner</b> | <b>Telephone</b> |
|-------------------------------|----------------|------------------|
| Manchester                    | Mr NS Meadows  | 0161 830 4338    |
| Bury, Rochdale, Oldham        | Mr SR Nelson   | 01706 924815     |
| Trafford, Stockport, Tameside | Mr JS Pollard  | 0161 476 0971    |
| Wigan, Bolton, Salford        | Mrs J Leeming  | 01204 338799     |

PCO HUB Contacts                     :

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

Ambulance safeguarding contact  
 NWS safeguarding practitioner is contactable via 07812 304 236, or 01204 498400.

Named Nurse Safeguarding  
Eileen Mills , Level 9, Civic Centre, West Street  
OLDHAM, OL1 1QJ  
Telephone: 0161 622 6542

Safeguarding Team  
Room 146, Trust HQ,  
North Manchester General Hospital  
Delaunays Road, Crumpsall, Manchester, M8 5RB  
Tel : 0161 918 4420 (ext 44420)

Named Nurse Safeguarding Children  
Central Manchester University Hospitals NHS Foundation Trust Hospitals  
Rusholme Health Centre, Walmer Street, Manchester, M14 5NP  
Tel: 0161 861 2250 Direct Line: 0161 861 2275

Named Nurse Safeguarding Children  
Stockport  
Julie Parker 0161 426 9622

## **21 Glossary**

|              |  |
|--------------|--|
| <b>AHP</b>   | <b>Allied Health Professionals</b>               |
| <b>Child</b> | <b>An individual under 18 years of age</b>       |
| <b>CONI</b>  | <b>Care of the Next Infant</b>                   |
| <b>CPR</b>   | <b>Cardio Pulmonary Resuscitation</b>            |
| <b>DCI</b>   | <b>Detective Chief Inspector</b>                 |
| <b>DI</b>    | <b>Detective Inspector</b>                       |
| <b>ED</b>    | <b>Emergency Department</b>                      |
| <b>FSID</b>  | <b>Foundation for the study of Infant deaths</b> |
| <b>GMP</b>   | <b>Greater Manchester Police</b>                 |
| <b>GP</b>    | <b>General Practitioner</b>                      |
| <b>LSCB</b>  | <b>Local Safeguarding Children Board</b>         |
| <b>MIT</b>   | <b>Major Incident Team</b>                       |
| <b>NWAS</b>  | <b>North West Ambulance Service</b>              |
| <b>PCO</b>   | <b>Police Coroner's Office</b>                   |
| <b>PICU</b>  | <b>Paediatric Intensive Care Unit</b>            |
| <b>PME</b>   | <b>Post Mortem Examination</b>                   |
| <b>PPD</b>   | <b>Public Protection Division</b>                |
| <b>PPIU</b>  | <b>Police Protection and Investigation Unit</b>  |
| <b>SCR</b>   | <b>Serious Case Review</b>                       |
| <b>SIDS</b>  | <b>Sudden Infant Death Syndrome</b>              |
| <b>SIO</b>   | <b>Senior Investigating Officer</b>              |
| <b>SUDC</b>  | <b>Sudden Unexpected Death in Childhood</b>      |