Best Practice Multi-Agency Protocol
(for agencies working within West Midlands Police geographical area)

SUDDEN UNEXPECTED DEATHS IN INFANTS & CHILDREN UNDER 18 (SUDC)

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CONTENTS

PREFACE

The death of any child is a tragedy. Every parent has a right to have such an event properly investigated.

This Best Practice Multi-Agency Protocol is drawn up to meet the requirements of the Statutory Guidance, Working Together to Safeguard Children, 2010, which places a duty on all Local Safeguarding Childrens Boards (LSCB) to have arrangements for the thorough and timely evaluation of all unexpected child deaths in place. Working Together requires that multi- agency procedures are in place to undertake a multi-agency 'rapid response' investigation and evaluation of all the circumstances surrounding each unexpected child death. The information from this investigation will be considered by a LSCB Child Death Overview Panel (CDOP) with a view to ensuring that lessons are learned, common themes identified and actions taken to contribute to preventing children's deaths, and to safeguarding and promoting the safety and welfare of children in the future.

This Multi-Agency Protocol provides guidance and procedures for all professionals involved in the 'Rapid Response' arrangements for the investigation of sudden, unexpected or unexplained deaths of all children aged 0 to 18 years. This protocol does not apply to stillbirths, unless the stillbirth occurs within the community without any medical interventions and a doctor is not able to issue a death certificate. It also does not apply to the death of pre-viable babies born before 24 weeks.

This document therefore provides the framework for a comprehensive and sensitive enquiry aimed at establishing the cause of sudden, unexpected deaths in all children under 18 years.

In any sudden and unexpected, or unexplained death of an infant or child, the lead lies with the Coroner and the police. However, this protocol sets out how ALL of the partner agencies must work together.

This document may also be used in cases where a child has collapsed but has successfully been resuscitated. Equally where a child has collapsed and has been admitted to hospital for treatment, certain aspects of this document may be utilised, a home visit may prove useful, especially where the child goes on to die sometime later.

PRINCIPLES

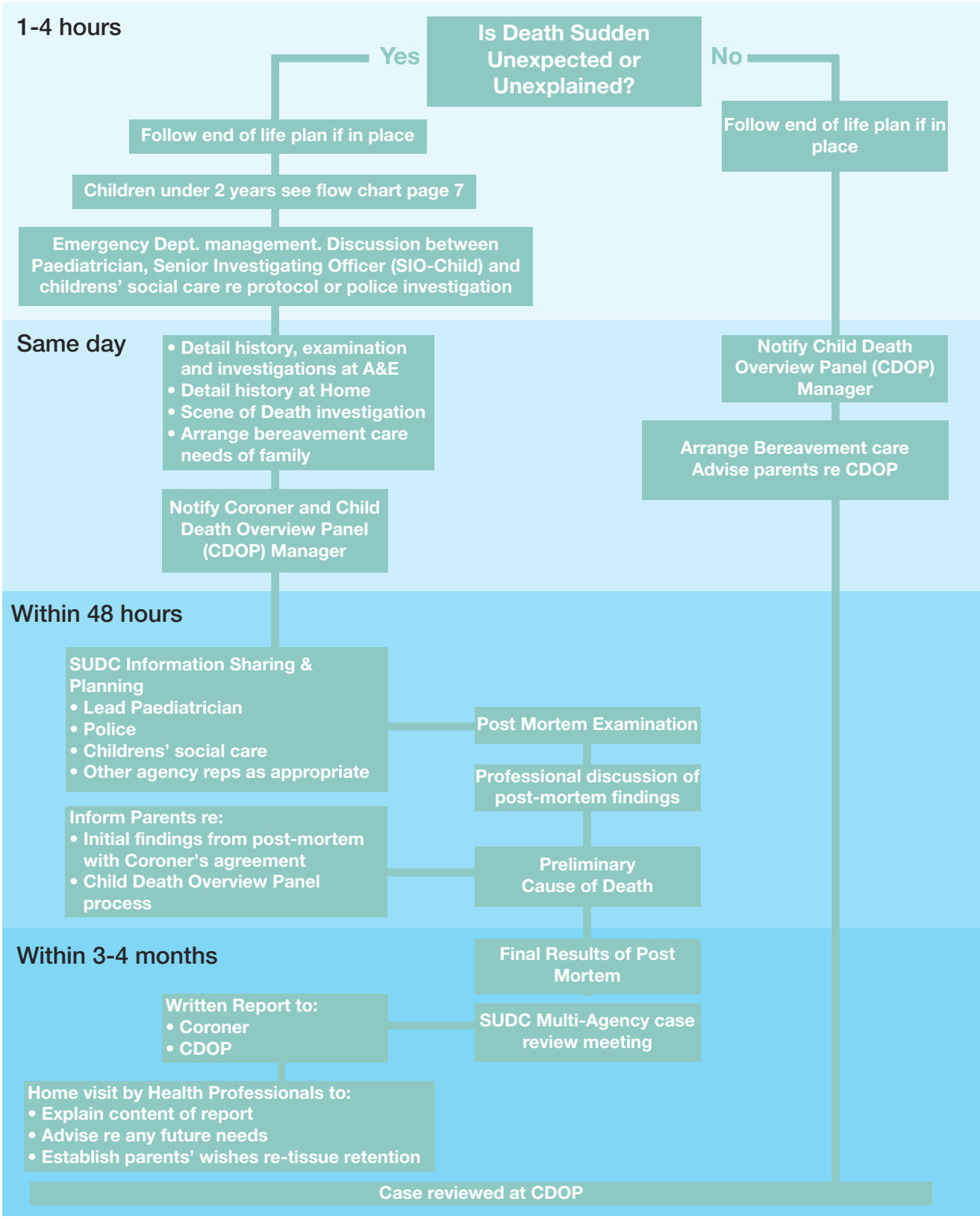
When dealing with an unexpected or unexplained child death, all agencies need to follow five common principles:

- A sensitive, open-minded and balanced approach
- An inter-agency response
- Sharing of information
- An appropriate response to the circumstances
- Preservation of evidence

(It is considered that all of the above are of equal importance)

All deaths of children which are sudden, regardless of how the death occurred (eg. road traffic collision, murder, suicide) will embrace aspects of this protocol. In ALL cases information sharing between partners must take place.

Child Death Protocol (Under 18 Years)

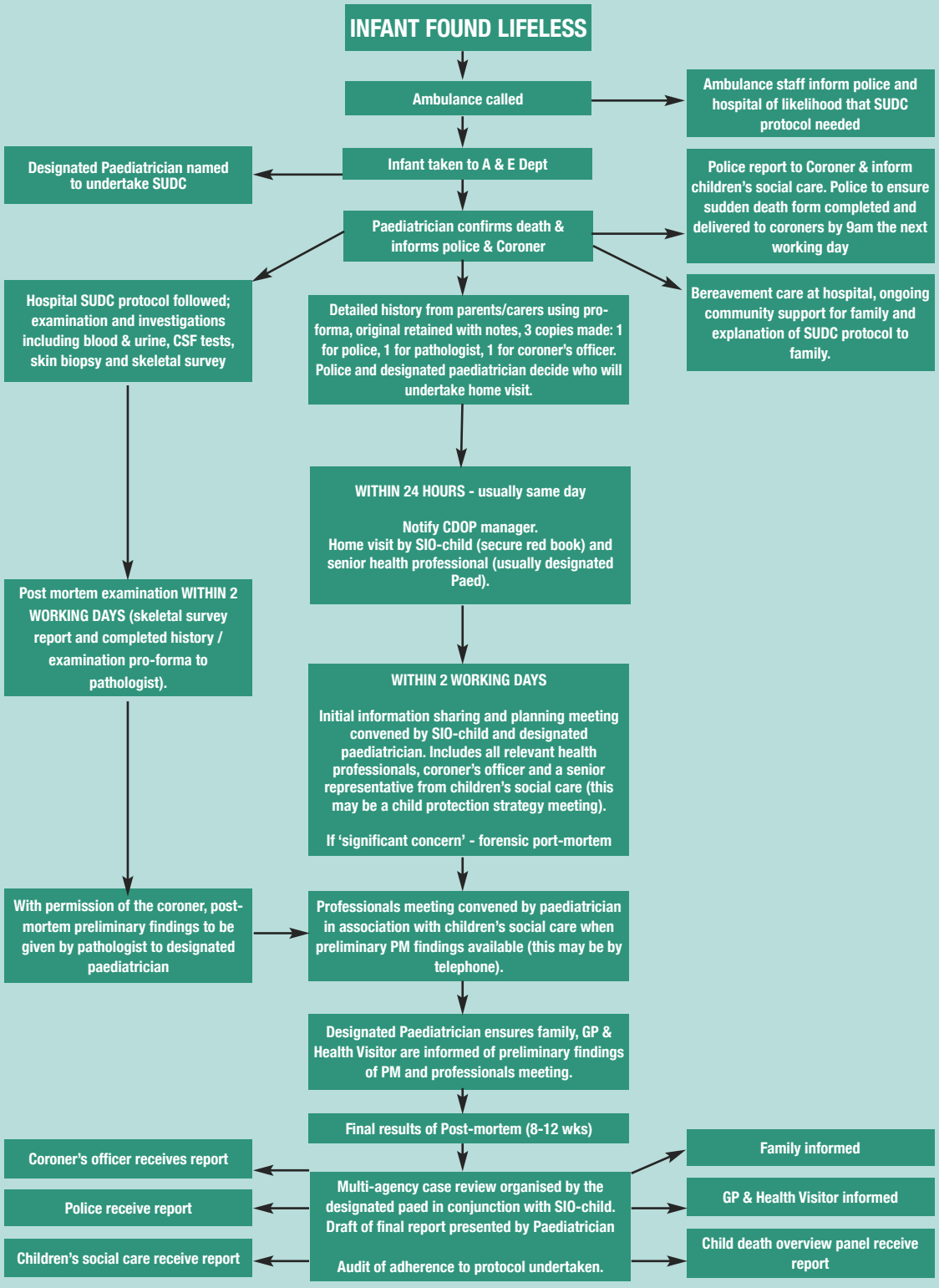


This flowchart represents the overall SUDC process. Discussion needs to take place between the lead professionals as to which parts of this process should be completed in an individual case.

Supplementary guidelines have been drawn up for specific cases, such as deaths of children suffering from life limiting illnesses. These are available for practitioners on the Every Child Matters website.

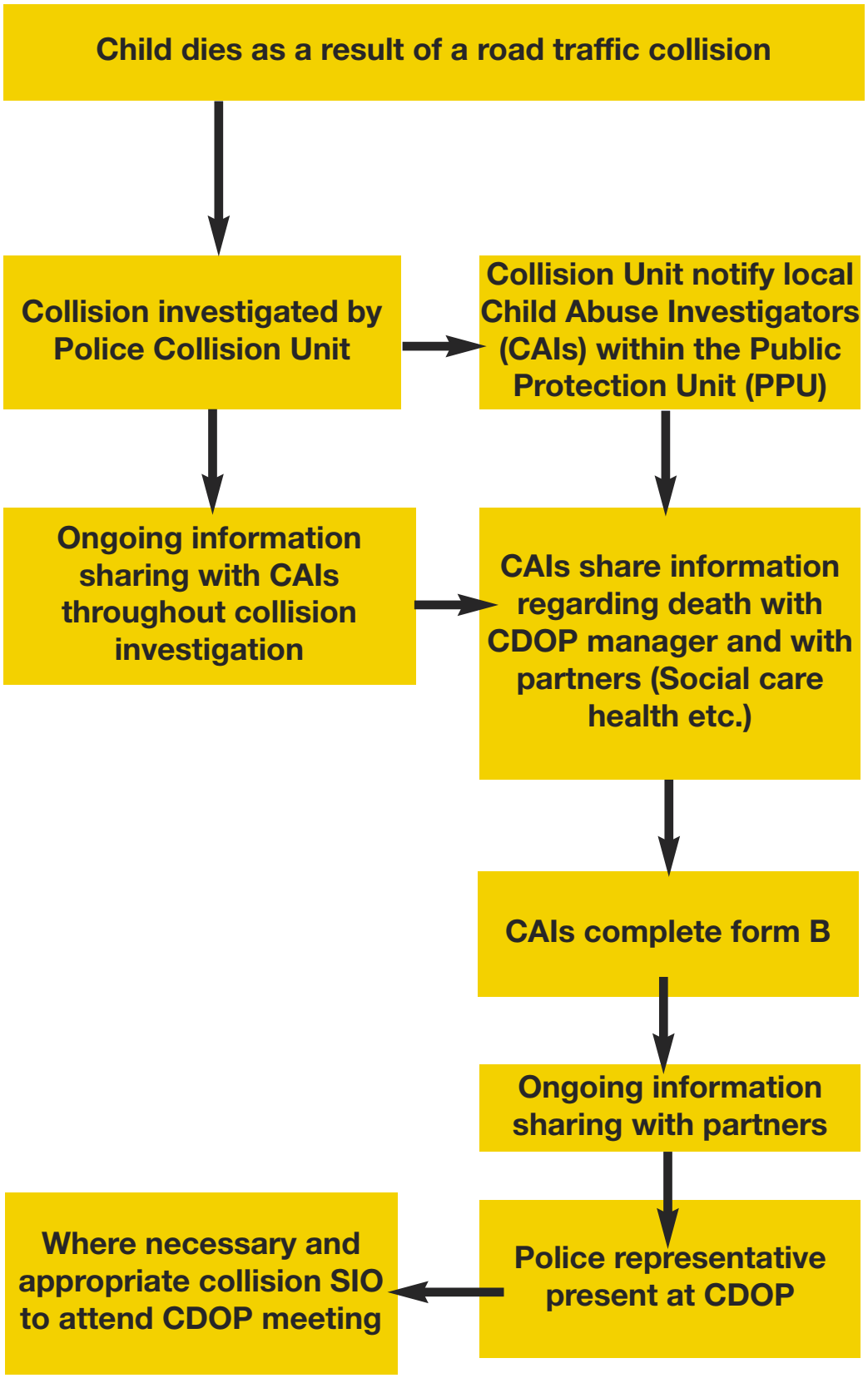
MANAGEMENT OF SUDDEN UNEXPECTED DEATH OF INFANTS

(For unexpected deaths of infants and young children from birth to age 2 years)



This flowchart represents the overall SUDC process for unexpected deaths of infants and young children from birth to age 2 years. Discussion needs to take place between the lead professionals as to which parts of this process should be completed in individual cases.

DEATHS OF CHILDREN AS A RESULT OF ROAD TRAFFIC COLLISIONS



SUDC PROTOCOL

Every child who dies deserves the right to have their sudden and unexpected death fully investigated in order that homicide can be excluded and a cause of death identified. Article 2 of the Human Rights Act (1998) states that everyone's right to life shall be protected by law. This requires public authorities to establish the cause of death. Apart from anything else, this will help to support the grieving parents and relatives of the child. It is also important to enable medical services to understand the cause of death and, if necessary, create interventions to prevent future deaths in children.

There are a number of guiding principles that must underpin the work of all relevant professionals dealing with a SUDC.

When dealing with SUDCs all agencies need to follow four common principles, especially when having contact with family members. These are listed below:

- Balanced approach between sensitivity and the investigative mindset;
- A multi agency response;
- Sharing of information;
- Preservation of evidence.

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 Human Rights Act 1998.

In March 2010, HM Government issued updated guidance titled 'Working Together to Safeguard Children 2010'. Within this document, Chapter 7 provides overarching guidance for Police and constituent agencies of LSCBs on how they collectively should investigate child deaths. This is statutory guidance and should be adhered to.

The chapter sets out the processes to be followed when a child dies in the LSCB area(s) covered by a Child Death Overview Panel (CDOP). There are two interrelated processes for reviewing child deaths.

- Rapid response by a group of key professionals who come together for the purpose of enquiring into and evaluating each unexpected death of a child;
- An overview of all child deaths up to the age of 18 years (excluding both babies who are stillborn unless the stillbirth occurs within the community without any medical interventions and a doctor is not able to issue a death certificate and planned terminations of pregnancy carried out within the law) in the LSCB area(s), undertaken by a panel.

WEST MIDLANDS SUDC PROTOCOL

In this guidance an unexpected death is defined as the death of an infant or child (less than 18 years old) which:

- Was not anticipated as a significant possibility, for example, 24 hours before the death; or
- Where there was a similarly unexpected collapse or incident leading to or precipitating the events which led to the death.

When a child dies unexpectedly, particularly when abuse or neglect is a factor, or in the case of stillbirths, when a child is born in the community without medical intervention and a doctor is not able to issue a death certificate, several investigative processes may be instigated. The Working Together guidance intends that the relevant professionals and organisations work together in a coordinated way, in order to minimise duplication and ensure that the lessons learnt contribute to safeguarding and promoting the welfare of children in the future.

It is intended that those professionals involved with a child who dies unexpectedly or their family, either before and/or after the death, should come together to respond to the child's death.

2. INTER-AGENCY WORKING: OVERVIEW OF THE PROCESS

Wherever the cause of a child's death is not apparent and it is not possible to issue a medical certificate of the cause of death this protocol should be followed and a multi-agency rapid response to the death should take place. For deaths that are expected, or where the doctor is able to issue a medical certificate of the cause of death, any end-of-life plan should be followed where possible, in discussion with the team who know the child. Care and support should be provided to the family, and they should be informed at an appropriate time of the child death overview process.

There will be some deaths, for example in children with a life-limiting illness or in profoundly disabled children with a reduced life expectancy, where the death at that time is unexpected. Full consultation should take place with the Palliative Care professionals working with the child and family. Where children have been supported by the palliative care services, the palliative care lead paediatrician along with the child's own paediatric consultant should always be invited to a swift information sharing and planning meeting/discussion to decide whether these 'rapid response' arrangements need to be triggered, and in any discussion or feedback to the family. Where available the child's advance care plan (appendix 13) should be accessed.

All sudden and unexpected or unexplained deaths in children are notified to the Coroner and consideration given to the need for a full police/Coroner's investigation to take place.

The initial call to the emergency services should trigger the pathway so that the police and paediatrician are informed.

In the case of the death of an older child, the lead police officer and paediatrician will agree which elements of this protocol are to be followed depending on the circumstances of that particular case. For example, in the case of a child who dies as a result of a road traffic accident it may not be appropriate or necessary for a home visit to be done. At each stage in the process, explicit consideration must be given as to whether child abuse/neglect may have been a contributory factor.

2.1 Immediate management

Normally following the unexpected death, the child will be transferred by the ambulance service to the nearest hospital with full paediatric facilities. The emergency providers attending the scene should assess the child and, unless it is clearly inappropriate, should attempt resuscitation and transfer the child and family to hospital.

On arrival at hospital, a member of the nursing staff will be allocated to the family. Resuscitation will continue as appropriate and any decision to stop will be made by an experienced medical practitioner, in consultation with the family, where appropriate and the emergency care team. The death of the child can then be confirmed by a qualified medical practitioner. Further hospital procedures are outlined in section 3.2 and 3.3.

The Coroner must be notified as soon as possible after the death is confirmed.

An initial history will be taken from the family, and the child will be examined. Any approved investigations may be taken from the child. Appropriate bereavement support will be provided by hospital staff. All findings and interventions, including information given to the family, should be carefully documented in the hospital notes.

On receiving notification of an unexpected child death, a senior police officer will be designated as the senior investigating officer (SIO-Child). Consideration should be given to securing the scene where the child died. Further details of police procedures to be followed are provided in section 4.

2.2 The Information-Sharing and Planning Meeting

The lead paediatrician, or agreed deputy will convene and chair an initial information sharing and planning meeting. The meeting will be convened within 2 working days of the sudden, unexpected or unexplained death, and in any event prior to the post-mortem examination. (In some situations where appropriate this meeting may take place by phone.)

The purpose of this meeting is:

- To plan and determine the process of the investigation and arrange for the family support needs to be met
- To collate all relevant information to share with the pathologist.
- To determine which professional/agency will lead the multi-agency investigation.
- For each agency to share information from previous knowledge of the family and records, with particular reference to the circumstances of the child's death. This would include details of previous or ongoing child protection or child care concerns, previous unexplained or unusual deaths in the family, neglect, failure to thrive, parental substance misuse, parental mental ill-health, domestic abuse, previous hospitalisation and GP visits, etc. Is there a "significant harm concern"?
- Consider any evidence of child abuse, neglect or poor parental care.
- To enable consideration of any child protection risks to siblings/any other children living in the household, and to consider the need for child protection procedures.
- To ensure a co-ordinated bereavement care plan for the family.
- To discuss any need for action in respect of other children in the family (e.g. health overview).

The **information sharing and planning meeting/discussion** should include:

- **Health** - The lead paediatrician/designated health professional, the named health visitor or school nurse for the child, children's community nurse, the community midwife if appropriate, the general practitioner and the ambulance service.
- **Local Authority Children's Social Care** - The children's social care team manager.

- **Police** - The public protection unit detective chief inspector/detective inspector.
- **Other contributors** - Coroner's officer, education (where the child was attending school or nursery), the named professionals for child protection, mental health professionals (CPN or consultant psychiatrist) and any other agency/person who may have a contribution to make, e.g. drug/alcohol services.
- If child protection concerns are identified when the information is shared this meeting will become a strategy meeting under child protection procedures, and the director of childrens' social care or equivalent will be notified.

2.3 Information gathering

Further information will need to be gathered to support the investigation into the cause and circumstances of death. All practitioners play a role in this and must be prepared to share information with other members of the multi-agency team. The senior investigating officer (SIO-Child) and responsible paediatrician should agree who will take the lead for collating information and sharing this with the Coroner.

Information will need to be gathered through a process of history taking, which may require more than one interview with the parents. As far as possible, repeated questioning by different professionals should be avoided and parents interviewed jointly by police and health staff where appropriate. The initial history will be supplemented by a review of the environment and circumstances of death through a home or scene visit.

Information should be gathered from the primary care team and all other professionals who may know the child or family, including children's social care and education where appropriate. All relevant records should be retrieved and reviewed by a lead professional in each agency.

2.4 The home or scene visit

For all children who have died suddenly and unexpectedly a home visit should be undertaken within 24hrs (usually the same day). The home visit is conducted by a designated health professional and the senior investigating police officer (SIO-Child) . The home visit provides an opportunity to take a more careful history, to inspect the death scene and to try and alleviate some of the family's concerns. The reason for the home visit must be explained fully to parents and their written consent for the home visit must be obtained (see page 41 for signature request). Every effort should be made to accommodate the parents wishes without compromising any police investigation.

If for any reason separate visits are conducted, the relevant professionals should confer in their assessment. In addition, the paediatrician should view any police video recording of the scene of death. The video of the death scene should also be made available to the pathologist.

In respect of older children a home visit will be determined as necessary dependant upon the circumstances of the death.

Where the location of the death is different to the home address of the child, an additional visit to the home address may be arranged if deemed necessary. Consideration should be given at the information sharing and planning meeting as to which professionals should attend the visit. Normally this will involve the senior investigating officer and a designated health professional. Where possible a member of the primary care team, or some other professional known to the family should also attend. There may be situations where, for pragmatic reasons, or because of the nature of the death a joint visit is not possible or appropriate, or where the police need to visit the scene of death early to gather forensic evidence.

The purposes of the home or scene visit are to:

- Review the initial history taken in the emergency department and obtain further details particularly in relation to the circumstances of death
- Evaluate the environment where the child died
- Provide support to the family
- Inform the family of the further stages of the investigation, including the need for and nature of the post-mortem examination. The discussion with parents about the details of the post-mortem examination should be done in conjunction with coroners officers.

For children who have died in the Birmingham Coroner's jurisdictional area, the paediatrician undertaking the home visit should tell parents that the Coroner will make contact with them once the final post-mortem examination results have been obtained. The Coroner will ask the parents to identify a medical professional to talk through the post-mortem examination findings with them, the paediatrician should offer to undertake this role and leave their details with the parents for them to share with the Coroner.

2.5 The Post-Mortem Examination

Generally most post-mortem examinations of infants up to 2 years will be undertaken with the consent of the Coroner at Birmingham Women's Hospital, the facilities at this hospital can cater for forensic post-mortem examinations if required. However for children who have died in the Birmingham Coroner's jurisdictional area all post-mortem examinations will take place at Birmingham Central Mortuary.

Post-mortem examinations of children over 2 years of age will be undertaken at mortuaries as directed by local Coroners, however where forensic post-mortem examinations are required the forensic examinations will be undertaken at either Sandwell, Staffordshire or Coventry as directed by the local Coroner in consultation with the police duty officer.

The post-mortem examination will be ordered by the Coroner, and should be carried out as soon as possible by a pathologist with expertise and training in paediatric pathology. Any decisions relating to the process and location of the post-mortem examination are at the Coroner's discretion. If any concerns have been raised about the possibility of neglect or abuse having contributed to the child's death, or the pathologist becomes concerned about such a possibility during the course of the post-mortem examination, the paediatric pathologist should be accompanied by a forensic pathologist and a joint post-mortem examination protocol should be followed with the attendance of a senior investigating police officer (SIO-Child).

Prior to commencing the post-mortem examination, the pathologist should be given a full written briefing on the history and the physical findings at presentation, and the findings of the death scene investigation by the paediatrician and investigating police officer. It is the responsibility of the senior investigating officer (SIO-Child) to ensure the child's 'red book' is secured and shared with the pathologist. Any photographs or video recordings of the child or the scene should be made available to the pathologist. The pathologist should also be provided with a report and/or images from the radiographer relating to the skeletal survey. It is the responsibility of the Coroner's officer to ensure the skeletal survey is completed prior to the post-mortem examination. Finally the Coroner should be provided with a copy of the history proforma. Where possible there should be an information sharing discussion between the consultant paediatrician and the pathologist before the post-mortem examination to identify outstanding or unsuspected issues and to ensure accurate understanding of information.

If the paediatrician has arranged any laboratory investigations before death, the pathologist and the Coroner should be informed prior to the post-mortem examination, and the results made available as soon as possible.

Following the post-mortem examination, there should be a further discussion between the paediatrician, the pathologist, the senior investigating officer (SIO-Child), a lead representative from childrens' social care and the coroner's officer to review any preliminary findings, decide on any further investigations required and to arrange appropriate feedback to the family. If initial post-mortem examination findings are shared with the family, this MUST be done with the Coroner's consent.

The final report of the post-mortem examination should be sent to the Coroner immediately the final result is known. With the prior consent of the Coroner, a copy of the post-mortem examination report will also be sent simultaneously to the responsible paediatrician.

2.6 The Case Review Meeting

A multi-agency case review meeting is to be held as soon as possible once the results of all relevant investigations have been obtained, usually 8-12 weeks after the child's death. The minutes and decisions of the initial information sharing and planning meeting should be available at this meeting. This meeting will be convened and chaired by the paediatrician or agreed deputy.

The purposes of the case review meeting are to:

- Review all findings from the history, scene examination, post-mortem examination and any investigations
- Establish where possible, on the basis of a full review of all information, the cause or causes of death
- Identify any contributory factors – these may be factors intrinsic to the child, or related to parental care, to wider family and environmental factors, or to service provision
- Specifically address any evidence of child abuse, neglect or poor parental care
- Identify the continuing needs of the family, including information and care of current or subsequent children

At this case review meeting, all relevant information concerning the circumstances of the death, the child's history, family history and subsequent investigations should be reviewed. The cause of the child's death should be established if possible.

During the meeting there must be an explicit discussion of the possibility of neglect or abuse as a contributory factor to the child's death. If no evidence is identified to suggest neglect or abuse as contributory factors, this should be documented as part of the report of this meeting.

A report of the multi-agency case review meeting will be completed by the chair of the meeting using the DFE Form C. This record will subsequently be distributed for ratification by those attending the meeting.
After the multi-agency case review meeting, the lead paediatrician, in close consultation with the pathologist and Coroner, should feed back to parents the outcome of the process using the available information and seek to obtain a decision from parents regarding retention of tissues and samples taken from their child at the post-mortem examination. (See appendix 10 & 11).

The record of the multi-agency case review meeting should be communicated by report to the Coroner and a copy provided to the child death overview panel (CDOP).

3. THE ROLES AND RESPONSIBILITIES OF HEALTH PROFESSIONALS

This section sets out the issues to be considered by health professionals, their roles, responsibilities and process to be followed. This incorporates the care of the family throughout the episode, ambulance staff, hospital staff, general practitioners and primary care health staff.

3.1 Ambulance Service

The child will be transferred immediately to hospital for immediate management in the A&E department.

The first professional on the scene should note the appearance, the environment and the circumstances of how the child was found.

Note any comments made by the parents/carers, any background history, whether there is an 'end of life plan' such as an Advance care plan in existence, any possible substance misuse and the conditions of the living accommodation.

Continuity of property must also be a consideration for professionals first on the scene, eg if clothing or the child's nappy is removed, the time, date and location of the items must be recorded in the medical records.

Any information and concerns must be passed to the receiving doctor and the Police as soon as possible.

If the ambulance service is unable to respond to a child who is 'obviously dead' the approved undertakers of the Coroner responsible for the area where the child has died should be utilised.

3.2 Hospital Health Professionals

An experienced member of staff should be allocated to care for the parents, to offer explanations of what is happening and provide them with support, including cultural and religious. The allocated member of staff (often a nurse) will remain with the family throughout the period to explain what is happening and the procedures being undertaken, particularly those that look alarming. The parents should be given the option of being present during the resuscitation.

A senior medical practitioner, usually the consultant paediatrician, should confirm that the child is dead. When the child is pronounced dead, the lead doctor should break the news to the parents, having first reviewed all the available information, in the privacy of an appropriate room. The allocated member of staff to the family should be present at this time.

Once a child is confirmed as dead the Coroner and the police should be informed immediately

The parents need to be told that the Coroner has to be informed because their child has died suddenly and the police have a responsibility to investigate the death. For families with an established contact with a particular social worker, it will be important to inform and involve this known social worker at an early stage.

Parents also need to be informed of the child-death review process. Since 1 April 2008 all local safeguarding children boards (LSCBs) are required to review the deaths of all children in their area, as outlined in Working Together to Safeguard Children, 2010 (Chapter 7).

The overall principle of the child-death review process is to learn lessons and reduce the incidence of preventable child deaths in the future. It is a statutory requirement in the Children and Young Persons Act 2008 that each LSCB must make arrangements for the receipt of notifications from registrars and to publish those arrangements. The Coroners (Amendment) Rules 2008 also place a duty on coroners to inform an LSCB for the area in which the child died that there will be an inquest or post-mortem.

In addition, in order for LSCBs to fulfil their responsibilities for reviewing deaths, every LSCB should be informed of all deaths of children normally resident in its geographical area. (Paragraph 7.17, Working Together To Safeguard Children, 2010).

The parents should be told that in the majority of cases the Coroner will order a post-mortem examination and that this will be carried out by a pathologist with special expertise in diseases of children (paediatric pathologist). The family do have the option of approaching the Coroner if they have views as to whether a post-mortem examination should or should not take place. The family will also need to be told that the death of their child will require a detailed multi-disciplinary investigation, which will include a comprehensive medical and post-mortem examination and meetings between the professionals involved. The nature and purpose of the post-mortem examination should be briefly explained to the parents in understandable terms and they should be given a copy of the relevant literature. More detailed information regarding the role of the Coroner and the post-mortem examination will be fully explained to parents by the coroner's officer. It is important the coroner's officer undertakes this role in order to ensure the correct and appropriate information is shared with parents.

Suitable supportive information should be given to the parents in their bereavement. (See Appendix 1)

It is important that normally, the parents and other close relatives are given an opportunity to hold and spend quiet time with their child. Professional presence should be discreet at this time. **In relation to children who have died, the skeletal survey must always take place prior to parents having any unsupervised contact with their child**, unless the SIO has explicitly agreed that unsupervised contact may take place.

Many parents value photographs of their child taken at this time, along with mementos such as handprints and a lock of hair. Only in very exceptional circumstances should mementos not be offered e.g. when the death is being investigated as suspicious. In this circumstance the senior investigating officer should be asked for approval.

Broader safeguarding and health issues must be considered around other siblings especially where there is a twin. Consideration should be given to admitting the surviving twin to hospital overnight for observations and investigation.

Staff, at the **earliest** opportunity, should contact children's social care to ascertain whether the child is subject to a child protection plan or whether the child or other siblings are known to the service.

Within 1 working day of the child being admitted to A&E, there should be communication with:

- Primary care health staff, in particular the health visitor or school nurse and school
- Community midwives (if appropriate).
- Administrative systems in the hospital and primary care need to be informed, to prevent routine appointments being sent out.
- General practitioner
- Children's social care
- Formal notification to the co-ordinator for child death overview panel (CDOP)

3.3 Paediatricians

In most circumstances, the consultant paediatrician on-call will be responsible for the immediate responses in hospital, including any decision to stop resuscitation, confirming the death and breaking the news to the parents.
The paediatrician should;

- Take an initial history from the parents, in conjunction with the attending police officer (appendix 4)
- Examine the child (appendix 4)
- Carry out appropriate investigations with the consent of the Coroner (appendix 2)
- In the case of infants, request a full skeletal survey is performed and interpreted by a paediatric radiologist (see 3.4 below)
- In the case of older children determine the extent of any necessary x-rays

- Consider with police whether photographs should be taken of any visible injuries
- Ensure complete and accurate documentation of history, examination, investigations and any interventions and discussions ideally using a proforma (see appendix 4), which can be added to subsequently at the home visit and copied for the police and pathologist
- Ensure results of skeletal survey/x-rays and all investigations are passed on to the pathologist

The attending paediatrician should participate in the initial information sharing and planning meeting. Subsequent management may remain with the attending paediatrician or pass over to the paediatrician with responsibility for child deaths.

A decision should be made at the information sharing and planning meeting as to who will carry out a joint home or scene visit with the police. The paediatrician (or designated health professional) will be primarily responsible for taking a full medical history, confirming the information obtained in the hospital and for sharing medical information with the family. The paediatrician and police officer should together review and assess the information gained from the home/scene visit.
The paediatrician should be made aware of which pathologist will be conducting the post-mortem examination and provided with their contact details. This will enable the paediatrician to ensure that the pathologist is fully informed prior to the post-mortem examination with a written report and/or a copy of the medical record proforma and possibly by direct discussion.
Following the post-mortem examination the pathologist, with the Coroner's approval, should discuss the initial findings with the paediatrician, who should arrange to inform the family of the findings.

Follow up meeting with family
The purpose of the follow up meetings is to take the family through relevant aspects of the death of their child and the deliberations of the multi agency meeting.
Advise them that you will send a full report to the Coroner before the Inquest.

If the family are receptive, take the opportunity to discuss the following:-

- Advise the family about the Coroner's Inquest.
- Tissue Retention – obtaining parental wishes:
- Within that context, explain that, when the post mortem was performed at the Coroner's request, small samples of tissue, about the size of a thumb nail, were removed for microscopic examination. State that the Coroner is bound by law (the Human Tissue Act, 2006) to obtain their consent to retain tissue samples on completion of his or her enquiry (see Appendix 10 & 11). The family's wishes regarding disposal must be made known to the pathologist, biochemistry lab (if applicable) and the Coroner.
- State that it is always a difficult time to raise this and that you are doing so to avoid the family having to do so after the Inquest instead of in the comfort of their home.
- Return the completed form to the address given. (Appendix 11).

The paediatrician will be responsible, in conjunction with the senior investigating officer (SIO-Child) and a lead representative from childrens' social care, for convening and chairing the final case review meeting. The paediatrician should prepare a final report for the Coroner, and feed back the outcomes of the case review to the family.

3.4 Skeletal Survey/ X-rays

Skeletal surveys:
In the case of infants a skeletal survey needs to be performed in all cases and is requested at the designated hospital. In cases where the hospital does not undertake the skeletal surveys, the responsibility will fall to the coroner's officer where the Coroner directs, to make the necessary arrangements.

A report and images, if required, should accompany the child to the post-mortem examination. A second copy of the images should be sent to a consultant radiologist experienced in interpreting paediatric x-rays.
It may be necessary to wait until normal office hours for a radiologist to be available to undertake and interpret skeletal surveys. This may require an extended period of chaperoning parents who wish to spend time with their child, however as long as the skeletal survey is completed prior to the post-mortem examination, this will not cause problems in terms of compliance with this policy.

Where there are suspected criminal offences and the skeletal surveys have to be performed out of hours and reported on by the local consultant radiologist, it is recommended that the x-rays be reviewed by a specialist paediatric radiologist as soon as possible. In instances where the receiving hospital does not have the facility to complete the skeletal survey, then the coroner's officer will make the necessary arrangements for the skeletal survey to be undertaken prior to post-mortem examination.

X-rays:
In relation to older children it is for the designated paediatrician to determine the extent of any x-rays which are deemed necessary.

Guidance in relation to skeletal surveys can be found in 'Standards for Radiological Investigations of Suspected Non-accidental Injury', Intercollegiated Report from the Royal College of Radiologists and the Royal College of Paediatrics and Child Health (March 2008).

3.5 General Practitioner (GP)

The GP may be the first to be called in the event of a child's death or may be called by the ambulance team. Resuscitation should be commenced if appropriate.

In the event of the child having been dead for some time, the GP will inform the police who will inform the Coroner. The GP should also inform the consultant paediatrician on call at the hospital to which the child will be taken.

The GP will be involved in the ongoing support to the family in collaboration with other professionals.

GPs should ensure that accurate records are kept in case of court proceedings.

GPs should attend (where possible) the information sharing or planning meeting, (convened within 2 working day's of the child's death) or be prepared to share relevant information they have about the family or other children. They should attend the final case review meeting.

3.6 Primary Care Health Staff

(eg community midwife, health visitor, school nurse, community children nurses etc)

Community health staff who are involved with the family should be informed within 1 working day of the child's death.
When the information sharing and planning meeting is convened (within 2 working day's of the child's death), they should be prepared to share any relevant information they have about the child(ren) and family.

Community health staff may be involved in a bereavement plan for the family.

Community health staff will carry out any relevant health actions required for other children within the family.

They should attend the final case review meeting.

4. THE ROLE OF THE POLICE

The role of the police when investigating an unexpected childhood death is defined as:

- To support the family during the very distressing time following their child's death.
- The protection of life, including responsibilities to safeguard other siblings in the event of abuse or neglect.
- To assess whether or not any criminal offences may have taken place and work with the Crown Prosecution Service in cases involving potential prosecution of offenders.
- To work with partner agencies in establishing how and why the child died.

The Police response should be in accordance with the ACPO/NPIA Guidelines contained within the Murder Investigation Manual.

Police training necessarily focuses upon the need to secure and preserve evidence from the outset, as failure to do so may lead to a lost opportunity. Working with agency partners is key to establishing a cause of death through securing and preserving information and evidence, whilst providing a sensitive and caring service to the bereaved family. If, at any point in the process, suspicion is raised that the child may have been murdered, the standard approach contained within these procedures should cease and a murder investigation should commence, although aspects of this protocol should still be embraced.

A detective inspector (DI) familiar with these procedures and when available the DI of the local public protection unit, child abuse investigation (SIO-Child), will be responsible for leading such investigations to ensure a consistently high standard of police input.

4.1 Initial action

Police attendance should be kept to the minimum. Several police officers arriving at the house can be distressing, especially if they are uniformed officers in marked police cars. Visiting officers, so far as possible, should not be in uniform, and should not arrive in marked cars.

In most cases, the police will receive a call that the ambulance service has already taken the child to the emergency department and that resuscitation was unsuccessful. When a call is received by the police that a child has been found lifeless, and has **not** been transferred to the emergency department, the first officers to be dispatched to the incident will often be uniform officers with little or no expertise in such investigations. These first responders will be responsible for initiating the police response and taking immediate steps to meet the objectives outlined above.

Duties of first responders
If the police are the first professionals to attend the scene ahead of ambulance staff, urgent medical assistance should be requested as the first priority.
Upon initial attendance officers should take note of the environment in which the child was found, including noting the position and appearance of the child, which persons were present, the temperature of the room, any obvious hazards, and any signs of negligent care. It should be ascertained whether the child has been moved and careful consideration taken of any signs of injury.

In most cases the child will be transported to the local A&E Department. The on-call duty child detective inspector must be notified who will assume the role of senior investigating officer (SIO-Child), and attend the scene as soon as possible. This officer will retain overall responsibility for the investigation. The detective inspector will be responsible for determining the appropriate involvement of other police resources depending upon the circumstances and any suspicions that may arise during initial assessment.

4.2 Scene Preservation

The SIO must ensure that scenes are identified and preserved. This will include the home address (or location where the child was prior to death) and the child. The preservation of the scene and the level of investigation will be relevant and appropriate to presenting factors.

It is important that officers secure the relevant address in a discreet manner, e.g. a plain clothes officer in a plain vehicle placed at the address or family members leave the address and the premises are secured. The premises need to remain secure pending a decision by the SIO-Child as to the timing of a home visit or other examination. This will be conducted by the SIO-Child in conjunction with the responsible paediatrician.

Whenever possible, and particularly in suspicious cases, a police officer should be present during the examination of the child, and should note the condition of the child, including hygiene, and any injuries or other findings reported by the medical staff. Police officers should work with the medical staff to ensure an appropriate chain of evidence when samples are taken for forensic purposes. Normally the clothing should remain with the child; however when clothing, nappies or equipment has been removed, this should be retained by the police and separately bagged.

In most cases, especially where there are not immediate suspicious circumstances, the family should be allowed to spend time with their child. Where the skeletal survey has not been completed, a member of staff must be present to supervise. The parents should be allowed to hold their child and the family or health staff should be allowed to take photographs or mementos. These rarely interfere with any evidence gathering.

Either at the time of the joint home visit or after the home visit has taken place, forensic assessment of the scenes will be undertaken by forensics scene investigators at the direction of the SIO-Child. This will always include photographing and video recording of the house where the child collapsed. Room temperature should be taken, but in the event of there being a time lapse from the collapse of the child to the temperature being taken, a thermometer should be placed inside a clothing drawer in the room. Drawers containing clothing retain the room temperature, this will give a more accurate reading for investigation purposes. Factors such as condition of accommodation, general hygiene and availability of food and drink should also be considered. The collecting of bedding and clothing should be considered but only if there are signs of forensic value such as blood, vomit or other residues. In the rare situations where it is considered necessary, forensic collection should be postponed until after the SIO-Child and health professionals have had an opportunity to review the scene, in an undisturbed state, on a joint home visit.

Items administered to the child and their containers e.g medication and bottles should be seized. It is important that, as far as possible, the environment is left as found on attendance to allow a joint examination of the scene to be undertaken with the responsible paediatrician.

The SIO-Child should ensure the child's personal health record (PCHR) 'red book' is seized to enable medical scrutiny. It is the police responsibility to ensure the 'red book' is returned to parents once the investigation is complete.

4.3 Subsequent Action

After making the necessary arrangements for scene preservation, the SIO-Child will liaise with the responsible paediatrician at the hospital and other agencies to ensure that the protocol is put into effect.

Unless the death is viewed as suspicious a full history will be taken from the parents jointly by a paediatrician and the SIO-Child or nominee. This may be taken initially in hospital and supplemented at the home visit. The paediatrician will usually take this first history, obtaining full and accurate details on the events preceding the child's death and events after discovery. If there are significant suspicions that the death may be unnatural, the suspect's rights must be protected and interviews conducted in accordance with PACE. In the event of the death being suspicious the SIO-Child will decide upon the appropriate course of action, which may include the arrest of a suspect.

Normally both parents should be interviewed together. However in some circumstances where there are concerns in relation to the cause of death of the child, consideration should be given to the carers being interviewed **separately** to avoid the possibility of each contaminating the other's version of events. Clearly, someone who has knowingly killed a child is likely to lie to cover up for their actions so any conflicting accounts should raise suspicion. It must not be forgotten, however, that any bereaved person is likely to be in a state of shock and possibly confused. Repeated questioning of the parent/carer by different police officers should be avoided at this stage if at all possible. However, officers should always consider the behavioural response of the parents and take particular note of inappropriate or unusual responses to child deaths, e.g. remoteness, insensitivity to circumstances, indifference to the death, disposal of articles.

Police officers will need to be mindful that medical staff will usually have taken a preliminary history at the hospital in an effort to establish the circumstances surrounding the child's collapse. Investigators should seek this account, as it may prove useful should a different version be provided later.

Following the initial meeting with the paediatrician, the SIO-Child will make themselves available to conduct a joint home visit with the responsible paediatrician, in order to gain a clearer understanding of how the child died.

The SIO will ensure that the coroner's officer is notified of the child's death and the appropriate report completed.

Initial police action will also include the early checking of relevant systems/records. All internal police checks will be conducted immediately and other agencies e.g. children's social care, adult services and health, requested to check their relevant records. This should include, as appropriate, all family members who are deemed close to the deceased, e.g. parents, siblings, foster children, etc. Where there are child protection concerns these records will need to be secured.

Appointment of a family liaison officer (FLO) may be appropriate and should be considered in each case.

Where there is any suggestion of overlaying or neglect, consideration should be given to the request of blood samples from carers for alcohol/drug examination. This must be carefully deliberated by the SIO-Child in relation to the status of the carers (suspects or otherwise) and issues around consent.

The investigating officer must give a full briefing to the pathologist(s), including showing of the video and photographs of the scene if available, and sharing of all information gathered thus far.

The SIO-Child, together with the responsible paediatrician will arrange and attend the information sharing and planning meeting. In addition to sharing relevant information and planning the investigation, the meeting will also consider information relating to any potential criminal acts and agree the conduct and timing of any criminal investigation.

In those cases that become a criminal investigation the police will work closely with the Crown Prosecution Service and will follow current arrangements regarding pre-charge advice.

The SIO-Child or nominee should attend the final case review meeting, even when there has not been a criminal investigation, so as to contribute to appropriate information sharing and joint working. If the death is subject of an ongoing criminal investigation, no such meeting should be held without the police first seeking the views of the Crown Prosecution Service as to how and when the meeting should be held, what information may be shared and how the discussion should be recorded.

In deaths where the police are investigating potential suspicious circumstances and further medical analysis is required of medical samples taken at hospital, the police may seize the samples under the authority of the Coroner. To seize the samples a letter from the Coroner's officer is required detailing the Coroner's authority. Additionally written consent is required from the SIO-Child. Investigating officers should book an appointment with the respective hospital and hand over the letters of consent. Officers may then collect the required samples utilising the appropriate sample transportation devices.

In cases where the child has not died, but officers are still investigating the nature of the child's collapse/injuries, consent of the parents to obtain medical samples from the hospital is required. Where a child has been place in care of the local authority, consent from the local authority is required.

5. THE ROLE OF CHILDREN'S SOCIAL CARE

Children's social care and/or adult services may hold information in respect of a child/family and should share this information with the investigating police officer and/or the responsible paediatrician.

Requests for information 'out of hours' which may only contain basic information from the child protection database must always be followed up as soon as possible with further more detailed record checks during office hours.

When there is the sudden and unexpected, or unexplained death of a child, children's social care must consider whether immediate further investigation is required to safeguard the welfare of siblings or other children in the household. Children's social care shall engage in this procedure even if not previously involved with the family.

Children's social care must check records on notification of an unexplained child death and ascertain what information is known or involvement there has been with the deceased child, his siblings or the family and must consider whether:

- there is family referral history on children's social care records
- there has been contact with the adult social care services
- there is any relevant information from educational and other local authority children's social care relating to the child or family and
- the child or the family are known to other children's voluntary or community organisations
- the child and/or family are known to children's social care (open or closed case)

Each Local Authority should have in place a process for notification to appropriate managers throughout the organisation including the chair of the LSCB and the most senior manager responsible for children's social care.

Where any notification of a child's sudden and unexpected death is received the notified manager must inform a nominated senior manager of the notification. If the child or family are known to children's social care (as an open or closed case) the responsible senior manager will then consider the need to:

- Secure all Children's Social Care files and any other files held by the Local Authority Children's Services (Education and Youth Services)
- Ensure that no additional recording or deletion occurs to records held
- Ensure notification is sent to the Head of Service for Children Social Work, the Director for Children young people and family services

Where the child is a known and open case to children social work and there are siblings or other children of the household subject to a plan of intervention consideration must be given to a representative of children social work accompanying on the initial home visit for the purposes of assessing the needs and welfare of the other children. Where this is agreed the Children's social work representative must be a suitably experienced social worker or manager.

Where there are immediate child protection concerns, children's social care will become involved in their role as the statutory agency, and will then become the lead agency for the welfare of the child(ren) whilst the police will lead any criminal investigation. There may then be a particular need to ensure the protection of the remaining children in the family. Even where the child or siblings are not known, children's social care must still be involved in the information sharing process.

Where the child is known to social care, or is an open case and siblings of the deceased child remain in the family, consideration should be given to an allocated social worker to be included in the 'home visit'.

If the child who died was in the care of approved foster carers, care staff, school staff or registered childminders at the time of death, the same procedure applies with the additional need to inform the service manager responsible for looked after children/staff concerned and Ofsted.

A senior children's social care representative will always be invited to the initial information sharing and planning meeting and to the follow-up case review meeting. It is important to stress that the initial meeting could also move into a strategy meeting regarding the safety of any other children.

Arrangements need to be in place to notify the chair of the local safeguarding children's board of any sudden and unexpected death of an infant or child, and for whom there are child protection concerns, so that consideration can be given to the necessity for a serious case review.

6. THE ROLE OF THE CORONER

The Coroner must be informed after any unnatural or sudden death of unknown cause, and will order an investigation into the circumstances and cause of that death. After the death is pronounced, the Coroner has control of the body.

The coroner's officer will inform the family of HM Coroner's roles and procedures and keep the family informed of the child's movements until the Coroner has signed release paperwork for the child at the opening of the inquest. **It is important this information is shared only by the coroner's officer as any misinformation may cause additional distress to the family**.

As the legal authority charged with the investigation and certification of all unexpected deaths, the Coroner must be kept informed of all significant information obtained from the multi-professional communications and interviews with parents.

The report from the multi-agency local case discussion meeting should in all cases be sent to the Coroner, and in some instances the coroner's officer will choose to be present at this meeting. This report will ensure that, where the cause of death has been certified by the Coroner without an inquest, any new or more accurate information is appropriately notified to the registrar of births and deaths for onward transmission to the office for national statistics.

For those instances in which the Coroner has ordered an inquest, the information from the local case discussion meeting will inform and assist the conduct of the inquest.
Where the information available to the final case discussion shows that the death meets the **international definition of sudden infant death syndrome (SIDS)** i.e. *'the death is unexpected, and remains unexplained after a careful review of the history, examination of the circumstances of death and the conduct of a full post-mortem examination to an agreed protocol'* – then the death should be registered as being due to SIDS. The medical cause of death and the conclusion is for the Coroner to decide, having regard to the evidence at the inquest.

APPENDIX 1 – SOURCES OF FAMILY SUPPORT

The Foundation for the Study of Infant Deaths

The Foundation for the Study of Infant Deaths has a help-line offering support and information to anyone who has suffered the sudden death of an infant.
Help-line: Freephone 0808 8026868

The help-line is also available for family and friends and those professionals involved with the death.

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

The Child Bereavement Charity – Training, information and support for professionals working with bereaved parents and children, especially babies.
01494 446648
Information and support line – 0845 357 1000

Child Death Helpline – a helpline for anyone affected by the death of a child, of any age, under any circumstances, however long ago. Helpline is staffed by parents who have experienced the loss of a child in the past.
Helpline available 7-10 pm every evening and 10am –1pm, Monday, Wednesday and Friday. 0800 282986 (Freephone) or 0808 800 6019.

Winston's Wish – Winston's Wish Family Line offers support, information and guidance to all those caring for a child or young person who has been bereaved. An interactive website is also available: www.winstonswish.org.uk
Family Line 0845 20 30 40 5 (available Mon – Fri 9.30 am – 4.30 pm)
General phone line – 01452 394377

CRUSE Bereavement Care –
Helpline available 09.30-17.30 (19.00 Mon and Wed)
Number of branches available throughout the West Midlands
Web: www. crusebereavementcare.org.uk
Tel: 0121 687 8010

Appendix 2. LABORATORY INVESTIGATIONS

Samples to be taken in the emergency department.

The list overleaf includes the standard recommendations for SUDC-type deaths. It provides a basic template for investigations in deaths of children of all ages. The final decision relating to which tests are relevant should be based upon the decision made by the rapid response lead clinician in consultation with the Coroner. Other investigations may be indicated by the clinical presentation.

After death, the body is under the jurisdiction of the Coroner and investigations may only be carried out with the approval of the Coroner. Approval for any routine investigations should therefore be agreed with the Coroner in advance. Removal of tissues from a deceased person is a licensable activity under the Human Tissue Act 2004 (HT Act) and must take place on licensed premises. It is possible to obtain extensions to licences, this should be done prior to any routine collection of specimens. Further guidance is available on the HTA website (www.hta.gov.uk/guidance/licensing_guidance.cfm)

Blood samples should be taken from a venous or arterial site (e,g. femoral vein) – Cardiac puncture should only be attempted by an experienced person – a single attempt, using the subcostal approach. Multiple attempts may cause damage to the intrathoracic structures and make post-mortem findings difficult to interpret. Record the site from which all samples are taken. Ensure all samples taken are properly documented and labelled in order to maintain an unbroken 'chain of evidence'. Any samples that are given directly to the police or coroner's officer should be signed for.

Microbiology:
Cerebral Spinal Fluid (CSF) samples should not be taken if there is any suspicion of cranial trauma (Head injury).

Appendix 2. LABORATORY INVESTIGATIONS - TOXICOLOGY

Sample	Handling	Test	Purpose
Blood (EDTA) 1ml Plus (Fluoride Oxalate) 1ml.	Clinical Chemistry Spin, store serum at -80°C	Toxicology	Identification of poisoning (intentional and non-intentional) **Important to label clearly, and ensure continuity/chain of evidence**
Blood for culture Aerobic & Anaerobic 1 ml - If insufficient blood aerobic only	Microbiology	Culture & Sensitivity	Identification of infection – collect as soon as possible as delays may make interpretation difficult
Blood from syringe onto Guthrie card	Clinical Chemistry fill in card – do not put into plastic bag	Inherited metabolic diseases	Specific investigations for metabolic disorders. Also consider retrieving results of initial neo-natal screening tests
Blood (Fluoride Oxalate) 1ml	Clinical Chemistry	Glucose, Lactate, 3hydroxybutyrate & Free fatty acids	Identification of hypo/hyperglycaemia and metabolic disorders Caution interpreting values of samples taken post-mortem
Blood (lithium heparin) 1.5ml	Clinical Chemistry Spin, store serum/plasma at -80°C	Amino acids, acyl carnitines - Urea and electrolytes and creatinine if sufficient sample	Identification of electrolyte disturbances, including hypernatraemia and metabolic disorders Caution interpreting values of samples taken post-mortem
Blood EDTA 1ml	Haematology	Full blood count	Identification of anaemia. Be cautious in interpreting values of samples taken post-mortem
CSF Do not take if any suspicion of cranial trauma	Microbiology	Microscopy, Culture & Sensitivity	Identification of infection – essential to collect as soon as possible as delays may make interpretation difficult
Nasopharyngeal aspirate	Virology	Viral cultures	Identification of viral infections
Nasopharyngeal aspirate or throat swab	Microbiology	Culture and sensitivity	Identification of infection
Swabs from any identifiable lesions	Microbiology	Culture and sensitivity	Identification of infection
Urine SPA or from nappy	Clinical Chemistry If wet nappy available, store nappy at -80°C	Toxicology, inherited metabolic diseases	Identification of poisons and organic acids profile indicating metabolic disorders
Urine SPA –single attempt or urethral catheterisation	Microbiology	Culture and sensitivity	Often the bladder is empty in SUDI cases. Do not carry out repeated attempts at suprapubic aspiration.
Skin biopsy	Clinical Chemistry Take from upper, inner arm. Send to laboratory in transport medium	Fibroblast culture	DNA culture for identification of specific metabolic and genetic disorders Important to obtain as soon as possible as fibroblast cultures taken more than 48 hours after death may not grow

Chain of Evidence

All samples will be subject to continuity/chain of evidence requirements.

Appendix 3 - GUIDANCE IN RELATION TO TOXICOLOGY SCREEN

For SUDC cases, specimen volume is always going to be an issue, but the range of techniques that can be applied to each case is specimen dependent. If very small specimen volumes are received (less than 0.5 ml) the specimen is stored pending further information. This ensures that more targeted investigations can take place if required at some point in the future rather than initially use all of the specimen on what may turn out to be unnecessary / inappropriate investigations.

If more than 0.5 ml is initially received, then a "basics" drug screen can be performed, as well as ethanol (and other alcohols). A basics drug screen will cover the most common sedative tranquilizing drugs:- tricyclic and tetracyclic antidepressants, venlafaxine, sertraline, trazodone, paroxetine, fluoxetine and related antidepressants, amphetamines (including MDMA, "Ecstasy", and related drugs), antihistamines, opioids (e.g. methadone and dextropropoxyphene), dihydrocodeine and codeine, cocaine, chlormethiazole, zopiclone and some antipsychotic drugs.

If sufficient specimen remains then a basic and neutral drug screen can be performed:- tricyclic and tetracyclic antidepressants, venlafaxine, sertraline, trazodone, paroxetine, fluoxetine and related antidepressants, amphetamines (including MDMA, "Ecstasy", and related drugs), antihistamines, opioids (e.g. methadone and dextropropoxyphene), dihydrocodeine and codeine, cocaine, benzodiazepines (e.g. temazepam), some beta-blockers, zopiclone and some antipsychotic drugs.

Followed, if specimen volume allows, by an acidic and neutral drugs screen:- paracetamol, barbiturates, non-steroidal anti-inflammatory drugs (including ibuprofen), salicylates, some antiepileptics (including carbamazepine and phenytoin) and sulphonylurea drugs.

There is some degree of overlap of these techniques to yield the most comprehensive range of drug screening which is geared to receiving both urine and blood specimens.

Although urine is not always available and at times blood collection may be difficult, in an ideal world, a minimum of 1.0 ml urine and 1.5 ml blood should be collected. These amounts would allow for illicit drug screen, a basics screen and alcohol measurement in urine, followed by basic/neutral screen and acidic/neutral screen, and alcohol measurement in blood.

One of the big problems in SUDC cases is that the bladder of the child is typically empty. If there is a wet nappy, it is worth preserving that, and probably of more use for toxicology than for microbiology. Worthy of consideration is passing a urethral catheter or a single attempt at a suprapubic aspirate in the emergency department, and if urine is obtained send a sample for microbiology and store a sample for toxicology. However, if that is done, it is important to document it so the pathologist is aware, and to ensure all samples are carefully labelled and processed.

Appendix 4 HISTORY, EXAMINATION AND SUDC ACTIONS PROFORMA

1. Identification Data:

Name of child

Sex M/F
Ethnicity
Date of death

Date of birth
Address

Postcode

Name of father (+address if different from child) DOB

Name of mother (+address if different from child) DOB

Name of partner (if relevant + address) DOB

GP name & address

Consultant

SUDC consultant

Police officer/senior investigating officer

Social worker

Coroner/coroner's officer

Other professionals

2. Details of transport of child to hospital:

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

Time found : Time arrived in A&E :

Resuscitation carried out? Y/N
Where? At scene of death / ambulance / A&E

By whom: carers / GP / ambulance crew/hosp staff / others (specify)

Confirmation of death
Date Time Location By whom?

3. History

Taken in A&E by:
History given by:
Relationship to child :

Taken at home visit by:

Events surrounding death

- Note: Who found the child, where and when; appearance of the child when found
- Who called emergency services
- When child was last seen alive and by whom
- Details of any resuscitation at home, by ambulance crew and in hospital
- For accidental/traumatic deaths details of circumstances around the death; witnesses

Detailed narrative account of last 24 – 48 hrs

- To include details of all activities and carers during last 24 – 48 hours
- Any alcohol or drugs consumed by child or carers
- For SUDI, include details of last sleep including where and how put down, where and how found, any changes, details of feeding and care given
- Details of when last seen by a doctor or other professional
- Further details of previous 2-4 weeks, including child's health, any changes to routine

Family History

- Details of all family and household members including names; dates of birth; health any previous or current illnesses including mental health; any medications; occupation
- Maternal parity and obstetric history
- Parental relationships
- Children, including children by previous partners
- Household composition
- Any previous childhood deaths in the family
- Any family history of fainting, fits, collapses
- Family history of airway problems, cyanotic-apnoeic episodes and breath holding
- History of Consanguinity

Past Medical History

- Of the child, to include pregnancy and delivery; perinatal history; feeding; growth and development
- Health and any previous or current illnesses; hospital admissions; any medication
- Routine checks and immunisations
- Systems review
- Behavioural and educational history where appropriate

Social History

- Type and nature of housing; any major life events
- Any travel abroad
- Wider family support networks

Any Other Relevant History

- May vary according to the age of the child, nature of the death

Information Retrieved from Records

- Hospital, GP, Health visitor, Midwife, NHS direct etc. (include family held records such as health visitor red book)
- Ambulance crew
- Social services, databases, case records, child protection plan information.
- Police – intelligence, Crimes database, PNC, domestic violence history, etc.

PHYSICAL EXAMINATION

To be carried out by a senior paediatrician, ideally together with a police child abuse investigator. Where necessary photographs should be taken by a police forensic scene investigator.

Physical examination carried out by:

- Rectal temp (low reading thermometer)

  Date/Time and interval from death

- Full growth measurements Centile

  length

  head circumference

  weight

- Retinal examination

State of nutrition and hygiene

- Marks, livido, bruises or evidence of injury – To include any medical puncture sites and failed attempts: **(Should also be drawn on body chart)** NB: Check genitalia and back. Check mouth: Is the fraenum 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

Date, Time

Name

Signature(s)

Telephone number

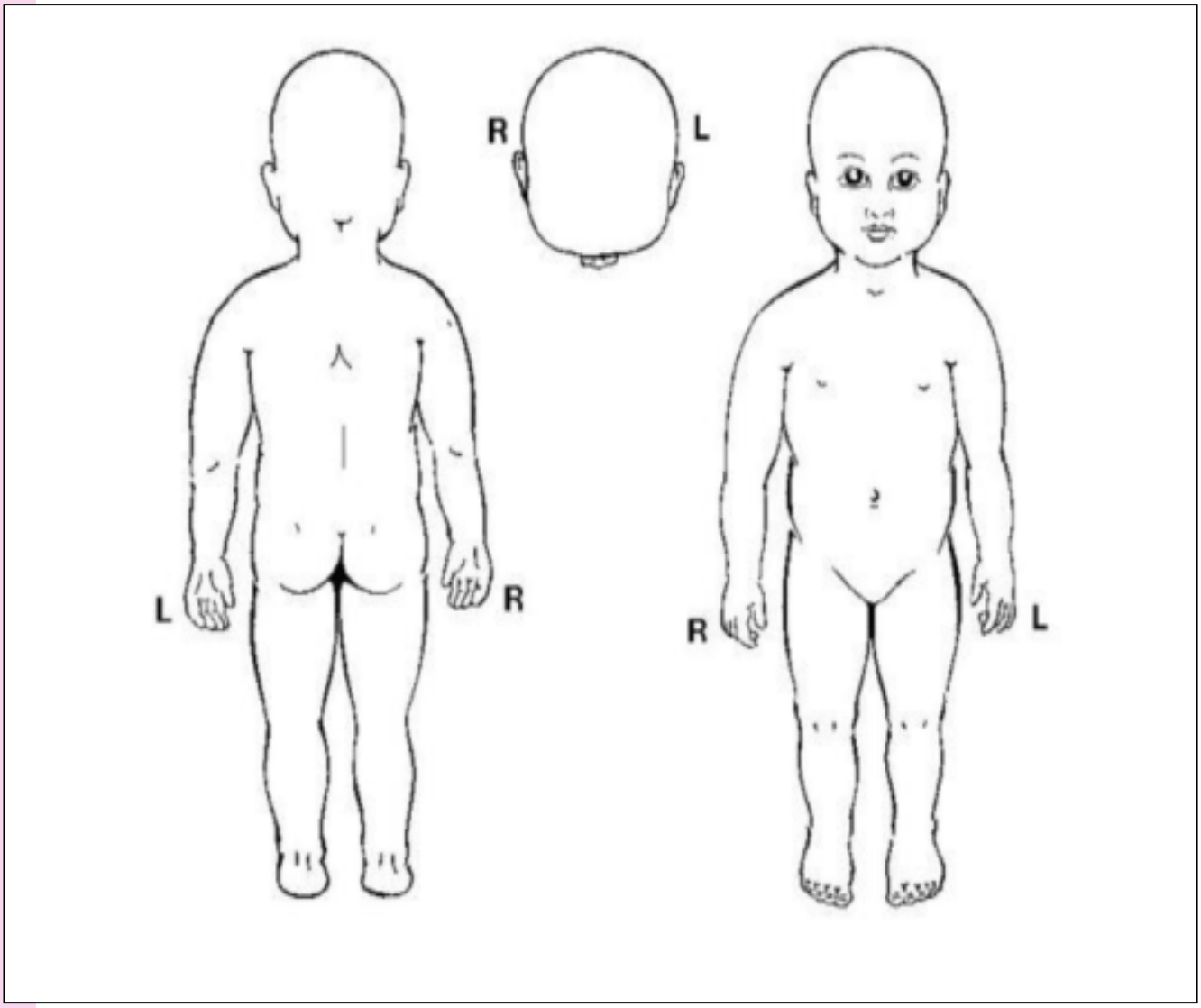
Mobile number

Fax number

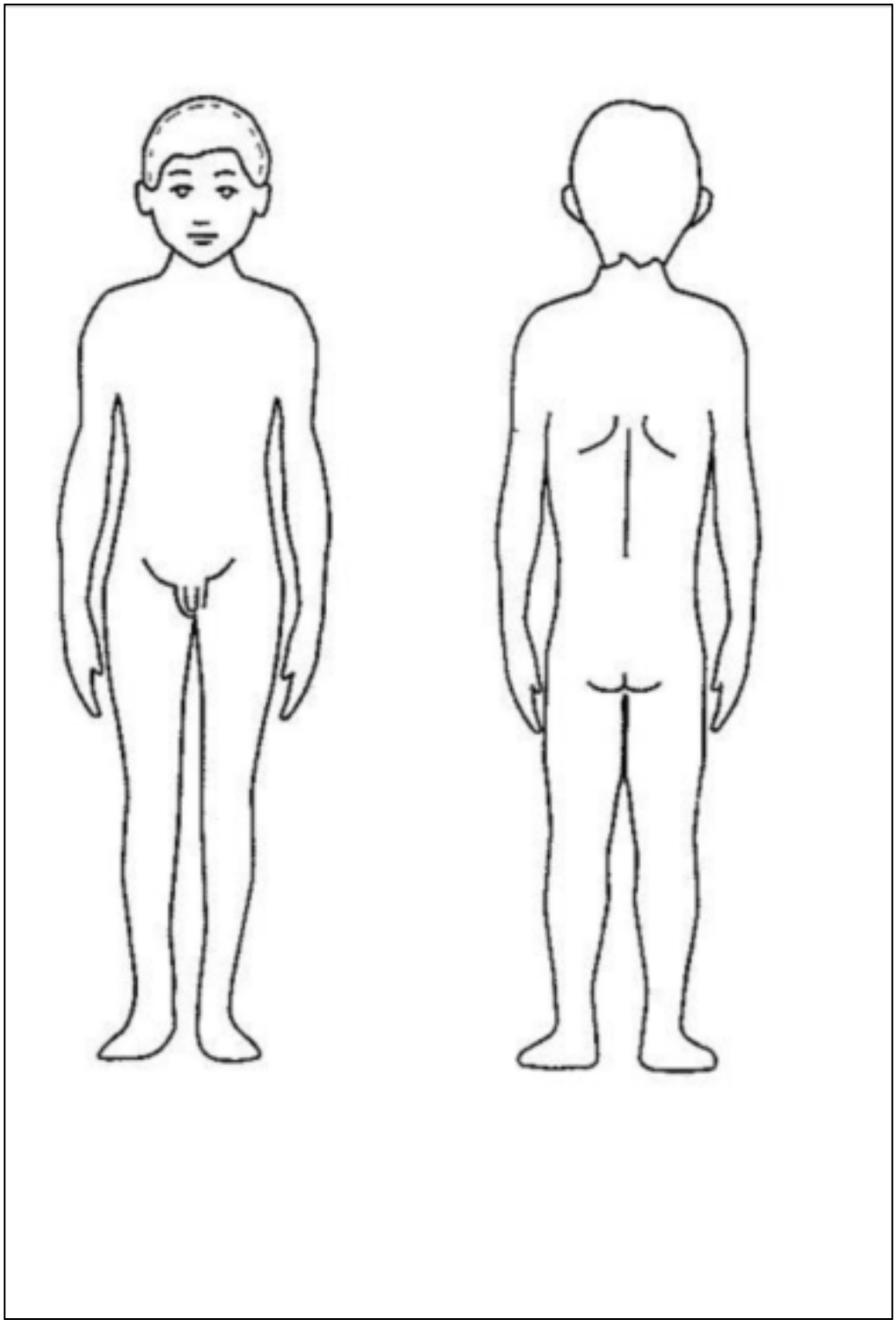
Please send a copy of this report to the pathologist responsible for undertaking the post-mortem examination.

Coroner/pathologist to share preliminary information outlining initial findings from the post-mortem examination to the medical professional detailed above.

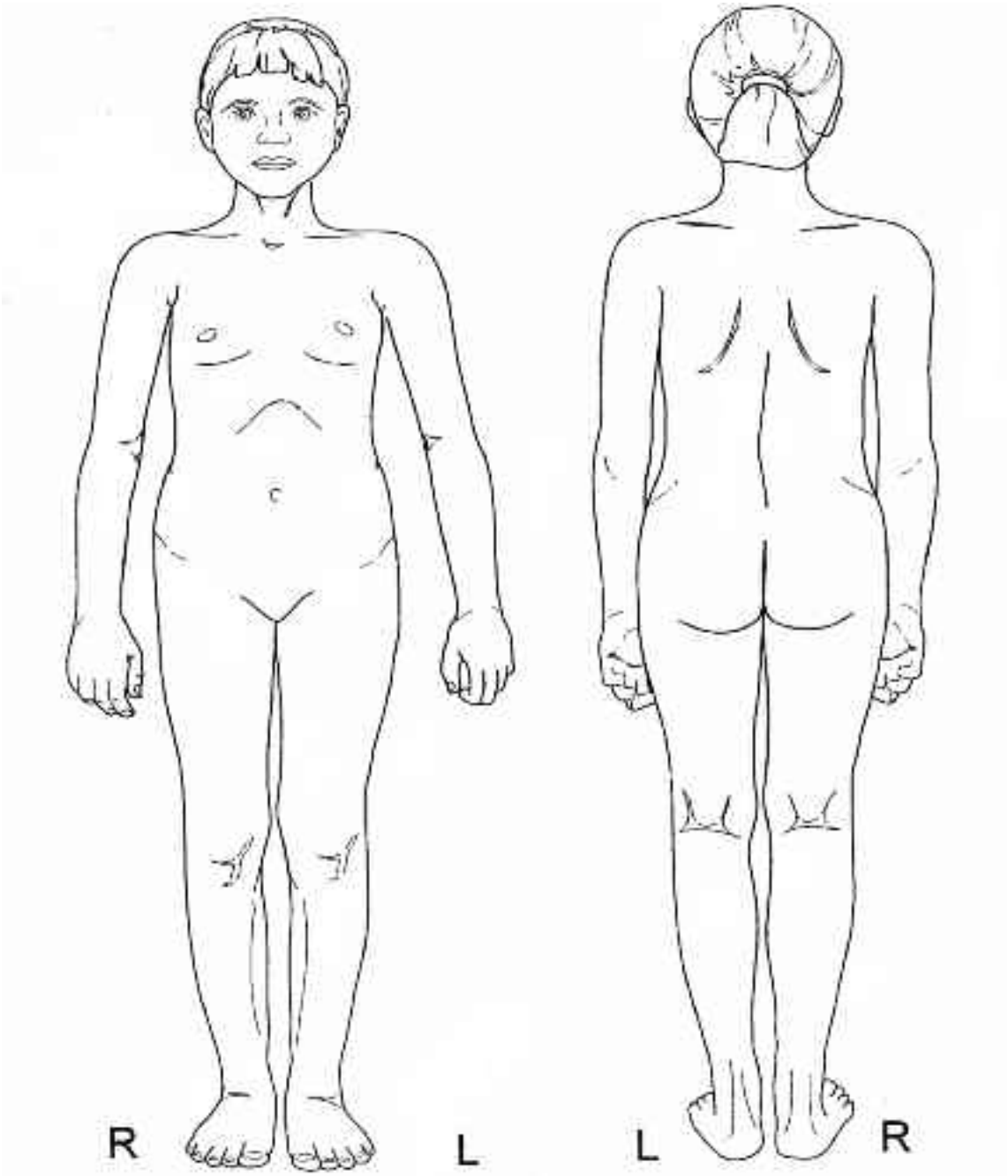
Ba□y□□□□a□□ Body Map



Male Body Map



Female Body Map



CONSENT TO UNDERTAKE HOME VISIT AND SHARE INFORMATION

Within the process of investigating the sudden and unexpected death of your child we wish to undertake a visit to the location where your child died and their home address if different. We will also share information with the other agencies involved in the investigation in order to gather all the available information surrounding the circumstances leading up to your child's death, this will help inform the Coroner's investigation as to the circumstances and cause of death.

Please sign below to confirm your understanding and agreement to these processes.

Signed ..... Date .....

(Consent to be obtained by the most appropriate person, either SIO-child or medical professional)

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
Note: When put down • when found

- 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

Diagram of Scene

Note: north/south orientation • room measurements • location of doors • windows • heating • any furniture and objects in the room

Appendix 5 Form A - Notification of Child Death

Notification to be reported to CDOP Manager at:
Email:
Tel:
Fax:
The information on these forms and the security for transferring it to the CDOP Co-ordinator should be clarified and agreed with your local Caldicott guardian.
If there are a number of agencies involved, liaison should take place to agree which agency will submit the Notification.

Child's Details

Full Name of Child	
Any aliases	
DOB/Age	/ / days/months/years NHS No:
Address	
Postcode	
School/nursery etc	
Date & time of death	/ / Time:
Other significant family members	

Referral details

Date of referral	/ /
Name of referrer	
Agency	
Address	
Email	

N.B. First page of form A can be removed for the purposes of anonymising the case. Second page of form A should be made available with Form B to the CDOP.

Details of the death:

Location of death or fatal event (Give address if different from above)		
Death expected?	❑ Expected	❑ Unexpected†
Reported to Coroner	❑ Y / ❑ N / ❑ NK / ❑ NA	Date: / / Name:
Reported to Registrar	❑ Y / ❑ N / ❑ NK / ❑ NA	Date: / / Name:
Has a medical certificate of cause of death been issued?	❑ Y / ❑ N / ❑ NK / ❑ NA	Date: / /
Post mortem examination:	❑ Y / ❑ N / ❑ NK / ❑ NA	Date: / / Venue:

† An unexpected death is defined as the death of an infant or child (aged under 18 years) where there is no prior condition that might be expected to cause the death at that time, and the child dies either immediately or subsequently from the consequences of the precipitating event or collapse.

Notification Details:
Please outline circumstances leading to notification. Also include if any other review is being undertaken e.g. internal agency review; any action being taken as a result of this death.

Notification Details cont:

Appendix 6 FORM B4

CDOP Identifier
(Unique identifying number)……

Sudden unexpected death in infancy
(For unexpected deaths of infants and young children from birth to age 2 years)

Form B4 is to be completed by the SUDI paediatrician or designated deputy, and will almost always be completed at or immediately after the local case review meeting. In those rare instances where there is no local case review meeting the SUDI paediatrician or designated deputy should complete this form at the conclusion of the investigation.

Please answer all questions or circle the "not known" option.

A. Predisposing or risk factors.
Please circle your responses

Family:	
Previous SUDC in first or second degree relative? (i.e. sibling, half sibling, parent's sibling or half sibling).	❑ Yes / ❑ No / ❑ NK
Apparent life-threatening events in first or second degree relative? (i.e. sibling, half sibling, parent's sibling or half sibling).	❑ Yes / ❑ No / ❑ NK
Mother smokes?	❑ Yes / ❑ No / ❑ NK
Father smokes?	❑ Yes / ❑ No / ❑ NK
Other smoking in household?	❑ Yes / ❑ No / ❑ NK
Illicit substance use in household?	❑ Yes / ❑ No / ❑ NK
This baby:	
delivery at less than 37 weeks gestation?	❑ Yes / ❑ No / ❑ NK
birthweight less than 2500g?	❑ Yes / ❑ No / ❑ NK
twin, triplet or higher order birth?	❑ Yes / ❑ No / ❑ NK
previous apparent life-threatening event?	❑ Yes / ❑ No / ❑ NK
under medical or HV attention for poor growth?	❑ Yes / ❑ No / ❑ NK
breast fed ? (more than 1 day)	❑ Yes / ❑ No / ❑ NK
immunisations up to date?	❑ Yes / ❑ No / ❑ NK
regular pacifier (dummy) user?	❑ Yes / ❑ No / ❑ NK

B. Circumstances of Death:

Had any signs of illness been identified in the baby in last 24 hours by the family, carers or professionals? ❑ Yes / ❑ No / ❑ NK
Time from when the baby was last seen/heard to be alive and being found dead: ❑ 10 minutes ❑ 10 minutes – 1 hour ❑ 1-2 hours ❑ 2-4 hours ❑ 4-6 hours ❑ Not known
Time of day found dead: ❑ 24.00 - 06.00 ❑ 06.00 - 12.00 ❑ 12.00 - 18.00 ❑ 18.00 – 24.00 ❑ Not known
Immediately before being found dead or collapsed was the child thought to be: ❑ Awake ❑ Asleep ❑ Not known
If asleep, what position was child put down in? ❑ Prone ❑ Supine ❑ Side ❑ Other ❑ Not known

When found what position was child in?

❏ Prone

❏ Supine

❏ Side

❏ Other

❏ Not known

If thought to be asleep, where was the child sleeping?

❏ Cot, crib, carry cot, Moses basket

❏ Car seat

❏ Adult bed (alone)

❏ Adult bed (with another person)

❏ Sofa (alone)

❏ Sofa (with another person)

❏ Floor

❏ Other place (please specify)

❏ Not known

If sharing a sleep surface with another person who was that person?

❏ Mother

❏ Father

❏ Both parents

❏ Sibling

❏ Other (please specify)

❏ Not known

If sharing a bed/other sleeping place with another person had that person taken the following in the past 8 hours:	
Alcohol (2 or more units)	❏ Yes / ❏ No / ❏ NK
Cannabis	❏ Yes / ❏ No / ❏ NK
Sedative drugs (prescribed or not)	❏ Yes / ❏ No / ❏ NK
Opiates	❏ Yes / ❏ No / ❏ NK
Other prescribed drugs (specify)	❏ Yes / ❏ No / ❏ NK
Other illicit drugs/substances (specify)	❏ Yes / ❏ No / ❏ NK

Did the child have a dummy when put down for last sleep?	❑ Yes / ❑ No / ❑ NK
If sharing a sleep environment with another person was there any evidence of overlying? If yes, please specify what this evidence was.	❑ Yes / ❑ No / ❑ NK
Was the sleeping place thought by those conducting the scene examination to be hazardous? If so please specify what was thought to be hazardous.	❑ Yes / ❑ No / ❑ NK
Was resuscitation attempted when the child was found?	❑ Yes / ❑ No / ❑ NK
Was a spontaneous circulation and/or breathing re-established?	❑ Yes / ❑ No / ❑ NK
How long after initial presentation to medical attention was the child declared dead? ❑ <1 hour ❑ 1-2 hours ❑ 2-6 hours ❑ 6 - 24 hours ❑ 24 > hours ❑ Not known.	
What samples/investigations were taken at time of presentation/resuscitation or after death identified but before transfer to mortuary?	
Blood culture	❑ Yes / ❑ No / ❑ NK
CSF	❑ Yes / ❑ No / ❑ NK
Blood for metabolic investigations	❑ Yes / ❑ No / ❑ NK
Blood for toxicology	❑ Yes / ❑ No / ❑ NK
Skin biopsy for fibroblast culture	❑ Yes / ❑ No / ❑ NK
X-ray skeletal survey	❑ Yes / ❑ No / ❑ NK
Other (specify)	

Was an initial multi-agency discussion meeting held (telephone or face to face) in the first 24 hours after the death?	❑ Yes / ❑ No / ❑ NK
Which agencies were involved in the initial discussion meeting?	
Secondary (hospital) paediatrics	❑ Yes / ❑ No / ❑ NK
General practitioner	❑ Yes / ❑ No / ❑ NK
Health visitor	❑ Yes / ❑ No / ❑ NK
Community Paediatrics	❑ Yes / ❑ No / ❑ NK
Other health professionals (specify)	❑ Yes / ❑ No / ❑ NK
Police Child Abuse Investigation Team	❑ Yes / ❑ No / ❑ NK
Other police (specify)	❑ Yes / ❑ No / ❑ NK
Children's services (Social care)	❑ Yes / ❑ No / ❑ NK
Other Social Care (specify)	❑ Yes / ❑ No / ❑ NK
	❑ Yes / ❑ No / ❑ NK
Other professional agencies (specify)	
Was a home/scene visit carried out by professionals after the death?	❑ Yes / ❑ No / ❑ NK
If a visit was carried out, how long after the death was this? ❑ <4 hours ❑ 4-12 hours ❑ 24-48 hours ❑ 48 -72 hours ❑ >72 hours ❑ Not known.	
If a visit was conducted, who attended?	
Police	❑ Yes / ❑ No / ❑ NK
Paediatrician	❑ Yes / ❑ No / ❑ NK
Social care	❑ Yes / ❑ No / ❑ NK
GP	❑ Yes / ❑ No / ❑ NK
Specialist HV	❑ Yes / ❑ No / ❑ NK
Child's own HV	❑ Yes / ❑ No / ❑ NK
Other (specify)	❑ Yes / ❑ No / ❑ NK

Was the death reported to the coroner? If not – please specify why not.	❑ Yes / ❑ No / ❑ NK
Who conducted the post-mortem examination? Specialist paediatric pathologist Adult pathologist Forensic pathologist Other (please specify)	 ❑ Yes / ❑ No / ❑ NK ❑ Yes / ❑ No / ❑ NK ❑ Yes / ❑ No / ❑ NK ❑ Yes / ❑ No / ❑ NK
What was the cause of death as given by the pathologist? 1a 1b 1c 2	
IWere there any significant additional pathological findings noted by the pathologist? If so, please specify	❑ Yes / ❑ No / ❑ NK

Final Case Review

For final completion by the CDOP Chair

Was a final case review meeting held? if so how long after the death was this meeting? ❑ <2 months ❑ 2-3 months ❑ 3-4 months ❑ 4-6 months ❑ >6 months	❑ Yes / ❑ No / ❑ NK
Who attended? Police Paediatrician Social care Pathologist Coroner or coroner's officer GP Specialist HV Child's own HV Other (specify)	 ❑ Yes / ❑ No / ❑ NK ❑ Yes / ❑ No / ❑ NK ❑ Yes / ❑ No / ❑ NK ❑ Yes / ❑ No / ❑ NK ❑ Yes / ❑ No / ❑ NK ❑ Yes / ❑ No / ❑ NK ❑ Yes / ❑ No / ❑ NK ❑ Yes / ❑ No / ❑ NK ❑ Yes / ❑ No / ❑ NK
What was the cause of death as ascribed by the local case review meeting? 1a 1b 1c 2	
Were any significant contributory or causal factors identified at this meeting?	❑ Yes / ❑ No / ❑ NK

Was the post-mortem report available to this meeting?	❑ Yes / ❑ No / ❑ NK
Was the Avon Clinicopathological classification scheme used? If so please give final classification of the death:	❑ Yes / ❑ No / ❑ NK
Was a report from this meeting sent to the relevant professionals? Police Paediatrician Social care Pathologist Coroner or coroner's officer GP Specialist HV Child's own HV Other (specify)	 ❑ Yes / ❑ No / ❑ NK ❑ Yes / ❑ No / ❑ NK ❑ Yes / ❑ No / ❑ NK ❑ Yes / ❑ No / ❑ NK ❑ Yes / ❑ No / ❑ NK ❑ Yes / ❑ No / ❑ NK ❑ Yes / ❑ No / ❑ NK ❑ Yes / ❑ No / ❑ NK ❑ Yes / ❑ No / ❑ NK
Were the parents/family offered the opportunity to meet with one or more of the professionals after the case review meeting? Police Paediatrician Social care Pathologist Coroner or coroner's officer GP Specialist HV Child's own HV Other (specify)	 ❑ Yes / ❑ No / ❑ NK ❑ Yes / ❑ No / ❑ NK ❑ Yes / ❑ No / ❑ NK ❑ Yes / ❑ No / ❑ NK ❑ Yes / ❑ No / ❑ NK ❑ Yes / ❑ No / ❑ NK ❑ Yes / ❑ No / ❑ NK ❑ Yes / ❑ No / ❑ NK ❑ Yes / ❑ No / ❑ NK
Please provide any additional information that you think is relevant.	

Appendix 7 DFE AUDIT TOOL FOR RAPID RESPONSE

To be completed for each unexpected child death

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

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

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

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

Appendix 8 Summary of post-mortems findings form B11

Authorisation for post-mortem?	❑ Coroner ❑ Consent of family member
Pathologist conducting post-mortem	❑ Paedriatric ❑ General (adult) pathologist ❑ Forensic pathologist ❑ Other, please specify
Summary of clinical history from pathologist	
Ancilliary investigations carried out ❑ Scene/circumstances investigation (specify what, when, by whom and summarise results) ❑ Xray skeletal survey (specify by whom and results) ❑ Microbiology (specify what, when and results) ❑ Virology (specify what, when and results) ❑ Toxicology (specify) ❑ Metabolic investigations (specify) ❑ Cytogenetics (chromosomes) ❑ Other investigations (specify)	
Summary of gross (naked eye) pathology findings	
Summary of histopathology findings	
Summary of pathologists conclusions on cause of death and contributory factors	
Cause of death as given by pathologist ❑ Ia ❑ Ib ❑ Ic ❑ II	
Any other relevant information from post-mortem examination	
Name of person completing this form: Designation: Date:	

Appendix 9 Analysis Proforma Form C

CDOP Identifier (Unique identifying number) ……

Child's age at death: Date of review: Gender:

This proforma is used by the Child Death Overview Panel (CDOP) to:
- evaluate information about the child's death;
- identify lessons to be learnt; and
- to inform an understanding of all child deaths at a national level.

Where prior to the CDOP meeting, a local case discussion is held, the local team may complete a draft Form C to be forwarded to the CDOP to inform their deliberations.

Agencies represented at the meeting:	
Primary Health Care	Yes ❑ No ❑
Paediatrics	Yes ❑ No ❑
Hospital Services	Yes ❑ No ❑
Mental Health Services	Yes ❑ No ❑
Ambulance Services	Yes ❑ No ❑
Police	Yes ❑ No ❑
Children's Social Care Services	Yes ❑ No ❑
Schools	Yes ❑ No ❑
Other (Specify)	

List of documents available for discussion

Cause of death as presently understood
Case Summary A few paragraphs at most: a summary of the background and a factual description of events leading up to death. This should be as short as possible

The CDOP should analyse any relevant environmental, extrinsic, medical or personal factors that may have contributed to the child's death under the following headings.

For each of the four domains below, determine different levels of influence for any identified factors:

0 - Information not available
1 - No factors identified or factors identified that are unlikely to have contributed to the death
2 - Factors identified that may have contributed to vulnerability, ill-health or death
3 - Factors identified that provide a complete and sufficient explanation for the death

This information should inform the learning of lessons at a local level.

Domain - Child's needs		
Factors intrinsic to the child Include any known health needs; factors influencing health; development/ educational issues; behavioural issues; social relationships; identity and independence; abuse of drugs or alcohol; note strengths and difficulties		
Please enter relevant information		
Please tick the following boxes if these factors were present or may have contributed to the death **Condition:**		**Relevance (0-3)**
Acute / Sudden onset illness Specify:	Yes / No / NK ❑ ❑ ❑	
Chronic long term illness		
Asthma	Yes / No / NK ❑ ❑ ❑	
Epilepsy	Yes / No / NK ❑ ❑ ❑	
Diabetes	Yes / No / NK ❑ ❑ ❑	
Other chronic illness Specify:	Yes / No / NK ❑ ❑ ❑	
Disability or impairment		
Learning disabilities Specify:	Yes / No / NK ❑ ❑ ❑	
Motor impairment Specify:	Yes / No / NK ❑ ❑ ❑	
Sensory impairment Specify:	Yes / No / NK ❑ ❑ ❑	
Other disability or impairment Specify:	Yes / No / NK ❑ ❑ ❑	
Emotional / behavioural / mental health condition in the child Specify:	Yes / No / NK ❑ ❑ ❑	
Allergies Specify:	Yes / No / NK ❑ ❑ ❑	
Alcohol/substance misuse by the child Specify:	Yes / No / NK ❑ ❑ ❑	

Domain - family and environment		
Factors in the family and environment Include family structure and functioning; including parental abuse of drugs or alcohol; wider family relationships; housing; employment and income; social integration and support; community resources; note strengths and difficulties		
Please enter relevant information		
Please tick the following boxes if these factors were present or may have contributed to the death **Condition:**		**Relevance (0-3)**
Emotional/behavioural/mental health condition in a parent or carer Specify:	Yes / No / NK ❑ ❑ ❑	
Alcohol/substance misuse by a parent/carer Specify:	Yes / No / NK ❑ ❑ ❑	
Smoking by the parent/carer in household or during pregnancy Specify:	Yes / No / NK ❑ ❑ ❑	
Housing Specify:	Yes / No / NK ❑ ❑ ❑	
Domestic violence Specify:	Yes / No / NK ❑ ❑ ❑	
Co-sleeping Specify:	Yes / No / NK ❑ ❑ ❑	
Bullying Specify:	Yes / No / NK ❑ ❑ ❑	
Gang/knife crime Specify:	Yes / No / NK ❑ ❑ ❑	
Pets/animal assault Specify:	Yes / No / NK ❑ ❑ ❑	

Domain - parenting capacity		
Factors in the family and environment Include issues around provision of basic care; health care (including antenatal care where relevant); safety; emotional warmth; stimulation; guidance and boundaries; stability; note strengths and difficulties		
Please enter relevant information		
Please tick the following boxes if these factors were present or may have contributed to the death **Condition:**		**Relevance (0-3)**
Poor parenting/supervision Specify:	Yes / No / NK ❑ ❑ ❑	
Child abuse/neglect Specify:	Yes / No / NK ❑ ❑ ❑	

Domain - service provision		
Factors in relation to service provision Include any identified services (either required or provided); any gaps between child's or family member's needs and service provision; any issues in relation to service provision or uptake		
Please enter relevant information		
Please tick the following boxes if these factors were present or may have contributed to the death **Condition:**		**Relevance (0-3)**
Access to health care Specify:	Yes / No / NK ❑ ❑ ❑	
Prior medical intervention Specify:	Yes / No / NK ❑ ❑ ❑	
Prior surgical intervention Specify:	Yes / No / NK ❑ ❑ ❑	

The CDOP should categorise the likely/cause of death using the following schema.
This classification is hierarchical: where more than one category could reasonably be applied, the highest up the list should be marked.

Category	Name & description of category	Tick box below
1	**Deliberately inflicted injury, abuse or neglect** This includes suffocation, shaking injury, knifing, shooting, poisoning & other means of probable or definite homicide; also deaths from war, terrorism or other mass violence; includes severe neglect leading to death.	❑
2	**Suicide or deliberate self-inflicted harm** This includes hanging, shooting, self-poisoning with paracetamol, death by self-asphyxia, from solvent inhalation, alcohol or drug abuse, or other form of self-harm. It will usually apply to adolescents rather than younger children.	❑
3	**Trauma and other external factors** This includes isolated head injury, other or multiple trauma, burn injury, drowning, unintentional self-poisoning in pre-school children, anaphylaxis & other extrinsic factors. Excludes Deliberately inflected injury, abuse or neglect. (category 1).	❑
4	**Malignancy** Solid tumours, leukaemias & lymphomas, and malignant proliferative conditions such as histiocytosis, even if the final event leading to death was infection, haemorrhage etc.	❑
5	**Acute medical or surgical condition** For example, Kawasaki disease, acute nephritis, intestinal volvulus, diabetic ketoacidosis, acute asthma, intussusception, appendicitis; sudden unexpected deaths with epilepsy	❑
6	**Chronic medical condition** For example, Crohn's disease, liver disease, immune deficiencies, even if the final event leading to death was infection, haemorrhage etc. Includes cerebral palsy with clear post-perinatal cause.	❑
7	**Chromosomal, genetic and congenital anomalies** Trisomies, other chromosomal disorders, single gene defects, neurodegenerative disease,cystic fibrosis, and other congenital anomalies including cardiac.	❑
8	**Perinatal/neonatal event** Death ultimately related to perinatal events, eg sequelae of prematurity, antepartum and intrapartum anoxia, bronchopulmonary dysplasia, post-haemorrhagic hydrocephalus, irrespective of age at death. It includes cerebral palsy without evidence of cause, and includes congenital or early-onset bacterial infection (onset in the first postnatal week).	❑
9	**Infection** Any primary infection (ie, not a complication of one of the above categories), arising after the first postnatal week, or after discharge of a preterm baby. This would include septicaemia, pneumonia, meningitis, HIV infection etc.	❑
10	**Sudden unexpected, unexplained death** Where the pathological diagnosis is either 'SIDS' or 'unascertained', at any age. Excludes Sudden Unexpected Death in Epilepsy (category 5).	❑

The panel should categorise the 'preventability' of the death – tick one box.
Preventable child deaths are defined in paragraphs 7.23 and 7.24 of *Working Together to Safeguard Children*

Modifiable factors identified	The panel have identified one or more factors, in any domain, which may have contributed to the death of the child and which, by means of locally or nationally achievable interventions, could be modified to reduce the risk of future child deaths	❑
No Modifiable factors identified	The panel have not identified any potentially modifiable factors in relation to this death	❑
	Inadequate information upon which to make a judgement. *NB this category should be used very rarely indeed.*	❑

Issues identified in the review List the issues identified by the review group. This list may include the absence of certain key persons from the discussion or the lack of key documents.

Learning Points List the learning points that emerge. These may well overlap with the issues and with recommendations.

Recommendations
List any recommendations, even if already picked up as learning points or 'issues'

Specific agency

LSCB

Regional

National

Follow up plans for the family, where relevant

Possible Actions

Should this death be referred to another agency or Authority (e.g. Police, Coroner, Health and Safety Executive, Serious Case Review panel) for further investigation or enquiry? If so, please state

❑ Yes ❑ No ❑ Already done

If yes please specify

Appendix 10
Blocks and Slides from Coroner's Post Mortem Examinations of Babies and Small Children

Information for Parents

You have been asked to make a decision on what should be done with the blocks and slides and any other tissues from your baby or child's post mortem examination, which was performed on the instruction of Her Majesty's Coroner. We are very sorry to have to ask you to make such an important decision at what must still be a very difficult time for you. Unfortunately, a legal requirement is placed upon us to determine your wishes, once the Coroner's rights over these samples ends.

What samples are there?
At the post mortem examination, as part of trying to find the cause of your child's death, the pathologist has to collect small samples of tissue for examination under the microscope. Each sample is approximately the size of a thumbnail (some are smaller) and there will be about 30 samples from any post mortem examination. All together, these samples weigh about 1-2 ounces. Each sample will have at least one glass slide bearing an extremely thin slice from the tissue, which has been treated so it can be examined under the microscope. Besides these samples we will usually also hold a small sample of tissue, frozen in case genetic tests become necessary and there will often be some slides in the genetics department, where the child's chromosomes have been checked. Occasionally, some skin cells may have been stored by the biochemistry department, in case special tests of the body chemistry are needed. A number of other tests will have been taken at the post mortem examination, but these will not leave any tissue needing a decision.

What are our choices?
You have four possible options for these remaining samples.
1. You may ask us to dispose of them in a legal and sensitive manner
2. You may request that they are returned to you for disposal in a legal manner
3. You may ask us to store them indefinitely in case they are ever needed again in relation to the healthcare of your family
4. In addition to 3. you may wish to allow their use for properly approved medical research, teaching of health professionals and monitoring of the quality of healthcare (audit).

Our advice:
We strongly believe that it is in your and your family's best interest for these samples to be stored indefinitely in case you need them to be re-examined in the future. It may be that as medical science advances, new tests become available that allow us to find out more about the cause of your child's death. This is particularly true when the cause of death has not been determined with certainty (e.g. SIDS or not ascertained/SUDI). If a possible cause of your child's death is suggested by another doctor or health professional in the future it may be possible to test these samples. Also if someone in your family has a problem that might be related to the cause of your child's death the samples can be examined to see if there is a link. Finally, should you have concerns over the care received by your child the samples may be an important part of any investigation or case.

Should you wish to also allow the use of the samples (and any images, XRays etc.) for approved medical research into the causes of child death and other health-related activities, such as teaching other doctors and health professionals about the diseases of children, or the audit of our service, then we offer you our heartfelt thanks. However, even if you do not feel able to do to this, we very strongly encourage you to consent to the long-term storage of the samples as a vital part of your child's legacy.

Should you decide that the samples should be destroyed, please be aware that once this is done there is no way of reviewing the diagnosis or performing any further tests in the future.

What next?
You will be asked to complete the form below form indicating your decision.

Please select one of the choices.

Tick the box to confirm that you understand the contents of this leaflet.

Sign and date the form.

The form will then be sent to us at the Pathology Department of Birmingham Women's Hospital. Your decision will be recorded in our database and any action required will be taken. The original form will also be kept.

Questions?
If you are uncertain about what to do, please discuss the choices with the person asking you to complete this form. If they are unable to answer your questions they can either contact us with your questions or put you in touch with us directly.
The Pathology Department at BWH can be reached on:
0121-627 2729.
Office hours are 9 a.m. to 5 p.m.

Appendix 11

Parents Wishes Regarding Post Mortem Examination Tissues

Child/Baby's Name …….

Date of Birth……

Coroner's District…… Coroner's Ref……

Tick one option

❑ 1. I/we agree that the blocks, slides and other diagnostic samples are retained for the purpose of medical record and future diagnosis AND that they may be used for audit, teaching health professionals and ethically-approved research

❑ 2. I/we agree that the blocks, slides and other diagnostic samples are retained for the purpose of medical record and future diagnosis

❑ ONLY

❑ AND Audit and teaching health professionals, but not research.

❑ 3. I/we wish the hospital to dispose of the samples in a respectful and legal manner.

❑ 4. I/we wish the samples to be returned to us (via an undertaker) so that we may dispose of them in a lawful manner.

Declaration

❑ I/we am/are the parent(s) of the above named child/baby and have read and understand the information regarding the remaining samples from our child's post mortem given above.

Signed……(Mother/Father) Date……..

Signed……(Mother/Father) Date……..

When completed please send to: Department of Histopathology, Birmingham Women's Hospital, Metchley Park Rd, Birmingham, B15 2TG or fax to: 0121 607 4721
and if applicable to: The Department of Clinical Chemistry at Birmingham Childrens' Hospital Fax: 0121 333 9911

Appendix 12
FREEDOM OF INFORMATION ACT AND DATA PROTECTION

Freedom of Information Act
There are no anticipated difficulties in publishing the entire protocol. Note, however, that ACPO guidelines (which are not contained in the protocol) are a restricted document and should not be published.

Data Protection
Please refer to Appendix 7, of the inter-agency child protection procedures, information sharing in child protection.

Appendix 13

Advance Care Plan for a Child or Young Person

West Midlands Paediatric Palliative Care Network

Advance Care Plan for a Child or Young Person

This document is a tool for discussing and communicating the wishes of a child / parent(s) or young person. It is particularly useful in an emergency, when the individual cannot give informed consent for themselves and / or next of kin / parent(s) cannot be contacted.

Name:	Date of Birth:
Known As:	Hospital No.
First Language:	NHS Number:
Home Address: Postcode:	
Telephone Number:	

NB: If the child or young person becomes unwell and needs an ambulance, inform ambulance control that the child has an Advance Care Plan. Ambulance Control will have an electronic copy of the ACP flagged under the child's home address and postcode. Don't forget to give ambulance control the child or young person's current location as well, if they are away from home.

Name of person/people with parental responsibility (and address if different from above):

_____

Emergency contact number for person with parental responsibility: _____

Other emergency contact numbers: _____

Other key people (e.g. family and friends): _____

Name: _____ Relationship: _____ Tel: _____

Name: _____ Relationship: _____ Tel: _____

Primary diagnosis and background summary:

Advance Care Plan for Use In:

☐ Home ☐ School ☐ Hospital ☐ Hospice ☐ Other (Please State Below)

_____

Date Plan Initiated _____ **Date Review is due** _____

Date reviewed/amended:	Name & Title of Lead Reviewer	Next Review Date

Advance Care Plan: Management of cardio-respiratory arrest

Name: _____ Date of Birth: _____

Address: _____

Regardless of the patient's resuscitation status, the following immediately reversible causes should be treated: **choking, anaphylaxis, blocked tracheostomy tube, other** (please state):

RESUSCITATION STATUS

☐ Resuscitation status has not been discussed – attempt full resuscitation

☐ Resuscitation status has been discussed and the following has been agreed:

Clearly DELETE actions NOT required

For full resuscitation	**OR**	**Attempt resuscitation with modifications below:**	**OR**	**Do not attempt cardiopulmonary resuscitation DNACPR**
Attempt resuscitation as per standard RC(UK) guidelines		**Patient-specific modifications to standard resuscitation guidelines** AIRWAY: BREATHING: CIRCULATION: DRUGS: OTHER: PICU/HDU:		Patient-specific supportive care is documented on pages 3 and 4 In the event of sudden death 24 hour emergency number for doctor who knows the child: _____

Ambulance directive: (eg Transfer to Home/Ward/Emergency Department /Hospice)

_____

Reason(s) for decision

Senior Clinician Signature _____ Name _____ GMC No _____

Parent/Guardian Signature: _____ Name _____

Date Initiated _____ Review Date (see page 1)_____

All photocopies of this page must have the original signatures written in black ink of the senior clinician and the person with parental responsibility

Advance Care Plan: Intercurrent illness / acute deterioration

Name: _____ Date of Birth: _____

Address: _____ Known Allergies: _____

Main Diagnoses _____

Signs/Symptoms to expect: _____

In the event of a likely reversible cause for acute life-threatening deterioration such as choking, tracheostomy blockage or anaphylaxis please intervene and treat actively. Please also treat the following possible problems actively e.g. bleeding (please state):

If a cardiac or respiratory arrest is not specifically anticipated, decisions about resuscitation would normally be made on a 'best interests' basis at the time of such an event. Unless a separate resuscitation section has been completed, the presumption would normally be for attempted resuscitation initially unless this seemed futile, unlikely to be successful, not in best interests, or otherwise directed.

In the event of acute deterioration:

(**Clearly DELETE all options NOT required.** Add comments to clarify wishes):

- Support transfer to preferred place of care if possible (specify): _____

_____

- Maintain comfort and symptom management, and support child / young person and family
- Clear upper airway
- Face mask oxygen if available
- Bag and mask ventilation
- Emergency transfer to hospital if doctor considers appropriate in the specific situation
- Intravenous access or intraosseous access
- Consider nasogastric feeding tube (insertion or removal)
- Non-invasive ventilation
- Intubation
- Consider stopping feeds
- Consider stopping fluids

Other: please state: _____

_____

Advance Care Plan: Intercurrent illness/acute deterioration *continued*

Name: _____ Date of Birth: _____

Address: _____

Specific treatment plans if indicated

Management of seizures

Description of usual seizure pattern / types: _____

_____

Rescue medication: (drug name, dose and route)

First line	After	mins
Second Line	After	mins
Third Line	After	mins

Call 999 for emergency transfer to hospital? Yes No (Delete)

If yes, at what stage? _____

Other instructions for seizures: _____

_____

Management of infection (prompt, check for known allergies recorded p3)

Preferred antibiotic or regime for recurrent infections – drug dose, route, duration:

_____

_____

Intravenous antibiotics will normally require transfer to hospital for investigation and initiation of treatment.

Other instructions/comments regarding infection-related symptoms e.g. nebulisers, steroids.

_____

_____

Instructions for emergency care in other specific circumstances:

(Document here regimes specific to this child/young person, for example for management of metabolic disturbance etc).

Additional Comments:

Advance Care Plan: Wishes

Name: _____ Date of Birth: _____

Address: _____

(please continue on p7- free text for communications and discussions if insufficient space for responses)

WISHES DURING LIFE
Child's / Young Person's wishes e.g. place of care, symptom management, people to be involved (professional/non-professional), activities to be continued (spiritual and cultural).
Family wishes e.g. where you want to be as a family, who you would like to be involved (e.g. medical, spiritual or cultural backgrounds).
Others wishes (e.g. school friends, siblings)
WISHES AROUND THE END OF LIFE
Preferred place of care of child /young person
Funeral preferences Seek detailed information or further advice if needed
Spiritual and cultural wishes
Other child/ young person & family wishes, e.g. what happens to possessions?
Organ & tissue donation

This page discussed by: _____

Child /Young Person / Parent / Carer

Professional (full name and job title) _____

_____ Date: _____

Advance Care Plan: Decision making

Name: _____ Date of Birth: _____

Address _____

Basis of discussion / decision-making? (Tick as appropriate)

- ☐ Wishes of child/young person with capacity
- ☐ Wishes of parent(s) for child on “best interests” basis
- ☐ Best interests basis (as in Mental Capacity Act 2005)
- ☐ Other (please state) _____

_____

Comments: _____

_____

Consider the following questions. For detailed responses use free text below

- What do you/the child/ young person know about this condition, any recent changes, and anticipated prognosis?
- What do siblings understand about the condition and anticipated prognosis?
- What involvement is appropriate / possible for the child/young person in decision-making?
- To what extent has the child/young person been involved in decision-making in this area?
- What does the child/young person know about what decisions have been taken?
- Have there been discussions about legal decisions and the Child Death Review process?
- Has the Ambulance Service/ GP/ Out of Hours Service /Coroner/ Child Death Overview Panel been informed that there is an Advance Care Plan written for this child/young person?
- Have these wishes been discussed elsewhere? In order to enhance continuity of care please attach documentation arising from any such discussions.

Communications and discussions

_____

_____

_____

_____

_____

Advance Care Plan

Who has agreed and supports the plan?

Name: _____ Date of Birth: _____

Address: _____

Senior Clinician e.g. Paediatric Consultant – I support this care plan

Name: _____ Signature: _____ GMC No: _____ Date: _____

Child / Young person – I have discussed and support this care plan (optional)

Name: _____ Signature: _____ Date: _____

Parent/Guardian – We / I have discussed and support this care plan

Name: _____ Signature: _____ Date: _____

Other e.g. CCN – I have discussed and support this care plan

Name: _____ Signature: _____ Date: _____

Other e.g. GP – I have discussed and support this care plan

Name: _____ Signature: _____ GMC No: _____ Date: _____

Other e.g. Hospice doctor – I have discussed and support this care plan

Name: _____ Signature: _____ GMC No: _____ Date: _____

Other people informed: see circulation list

Clinicians have a duty to act in a patient's best interests at all times.
If a parent or legal guardian is present at the time of their child's collapse, they may wish to deviate from the previously agreed Advance Care Plan and under these circumstances their wishes should be respected, provided they are thought to be in the best interests of the child/ young person. The child/young person or parents /guardian can change their mind about any of the preferences on the care plan at any time.

Communications and discussions

All photocopies of page 2 and 7 must have the original signatures written in black ink of the senior clinician and the person with parental responsibility

Name:_____ Date of Birth: _____

Address:_____

	Name and contact details
ACP Co-ordinator – responsible for distributing this Advance Care Plan.	
A photocopy of this ACP is held by:	
☐ Parents/guardians	
☐ General practitioner	
☐ Paediatrician (Community)	
☐ Paediatrician	
☐ Hospital (e.g. Local Emergency Department and/or open access ward)	
☐ Birmingham Children's Hospital Emergency Department	
☐ Hospice (please provide the name of the hospice)	
☐ Community Nurses (CCN)	
☐ CCN Specialist Nurses/School Nurse	
☐ GP Out of Hours Service	
☐ Ambulance Control	
☐ Emergency Dept	
☐ School-Head Teacher (with consent to share with school staff)	
☐ Other e.g. Social Care, Short break care provider	
☐ Other	

All photocopies of page 2 and 7 must have the original signatures of the senior clinician and the person with parental responsibility