

**Hartlepool, Stockton-on-Tees,
Middlesbrough and Redcar & Cleveland
Local Safeguarding Children Boards**

**An Inter-Agency Protocol
for the Rapid Response to
Unexpected Deaths in
Childhood**

Revised: Latest Update November 2012;
Appendix 2 Organ Donation in Suspicious Death/Unexplained Death or Fatal Road Traffic
Collision (RTC)
Workbook Section 4 Medical Examination Eye Examination

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1. Introduction

1.1 Child death processes

1.1.1. From April 2008 it became statutory for all Local Safeguarding Children Boards (LSCBs) to establish processes for all child deaths. There are two inter-related processes for doing this:

1.1.2. A 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 *and*

1.1.3. An overview of all child deaths undertaken by the Child Death Overview Panel. (Within Tees the Child Death Overview Panel spans Middlesbrough, Redcar & Cleveland, Hartlepool and Stockton LSCBs).

1.2 Applying the Protocol

1.2.1. This protocol concentrates on the rapid response to unexpected deaths in childhood. It describes the actions, the investigations and the care and support of the family the professionals from different agencies will be involved in.

1.2.2. This protocol should be applied after the death of a child.

1.3 Definition of a child

The Children Acts 1989 and 2004 define a child as anyone who has not yet reached their 18th birthday.

1.4 Definition of unexpected death

'Working Together', HM Gov 2006 defines an unexpected death as the death of a child that was not anticipated as a significant possibility 24 hrs before the death, or where there was a similarly unexpected collapse leading to or precipitating the events that led to the death (Fleming et al, 2000: The Royal College of Paediatrics and Child Health

2004) The Designated Paediatrician for Unexpected Deaths in childhood should be consulted where professionals are uncertain about whether the death is unexpected. If in doubt, this protocol should be followed until the available evidence enables a different decision to be made.

1.5 The unexpected death of a child

1.5.1. Unexpected deaths in children may occur at any age though are most common in infants.

1.5.2. Most importantly only a very small minority of unexpected deaths in children result from maltreatment. However it is clearly important to identify where a parent or carer has been responsible for a child's death, not only because they may go on to harm another child but also in the interests of justice.

1.6 Why the need for an inter-agency protocol

1.6.1. Following the unexpected death of a child, professionals from different agencies will become involved and a coordinated and timely inter-agency response, particularly regarding information sharing, is crucial in order to achieve the optimal outcomes.

1.6.2. A bereaved family will need care, support and information. Medical investigations will be essential to try and find out any underlying medical cause for the child's death. In addition the Police have a responsibility to investigate all unexpected deaths.

2. General Information for all Professionals where there has been an Unexpected Death in a Child

- 2.1 Interagency working in response to an unexpected death in a child should be concerned with the care and support of the bereaved family, investigation into the cause of the child's death and the identification of any contributory factors. Depending on the findings the need to protect any subsequent children may need to be considered.
- 2.2 Particularly important when coping with an unexpected death, is the need to keep a balance between caring for the bereaved family and enabling a thorough investigation, medical and forensic, into the cause of the death.
- 2.3 Professionals should tell the police immediately if they have information that might suggest the child's death may not have been caused naturally. In such cases local child protection procedures must be initiated. Where this is the case Police and Children's Social Care will be the lead agencies undertaking the enquiry into the child's death.
- 2.4 Coping with an unexpected child death is complex, requiring knowledge, skills and experience of the issues as mistakes may have serious consequences. Skills and sensitivity in dealing with bereaved families is vital. Professionals from any agency who have to deal with unexpected child deaths should be suitably competent and have appropriate seniority. Where tasks are delegated to less experienced staff close supervision is essential.
- 2.5 All those who care for families after a child's death should have access to support for themselves.
- 2.6 The death of a child is a very painful event. The family should be offered support and treated with sensitivity and respect at all times. The time spent caring for the family in the beginning may greatly influence how the family deal with the bereavement for a long time afterwards. Family members will be in the first stages of grief and may for example be shocked, numb, withdrawn or hysterical.
- 2.7 Even in the very small minority of cases where a death has been caused by abuse or neglect any non-abusing parent, any siblings and the wider family will need care and support.
- 2.8 It is essential to keep families fully informed about what is happening and to give them information as soon as it becomes available and as circumstances allow. (Unless the Police have intelligence that restricts the information that can be given.) Time should be allocated to seek out and address the questions families want to ask.
- 2.9 Relevant contact names and telephone numbers should be given in writing to families.
- 2.10 Care and support of the family need to run alongside the necessity to maintain professionalism towards the forensic investigations into the cause of the child's death.
- 2.11 Many parents/carers will want to have physical contact with their dead child, this is highly appropriate and should be allowed to happen, with a professional in discreet attendance. Only very exceptionally will there be circumstances when physical contact should not happen such as when crucial forensic evidence may be lost or interfered with.

- 2.12 The child should be handled as if still alive and the child's name used at all times to show consideration for the family.
- 2.13 Where the parents do not understand and speak English, an interpreter must be urgently called.
- 2.14 Any religious and cultural beliefs of the family must be sought and every effort made to accommodate them. Deep and long lasting pain can be inflicted on families if their religious and cultural beliefs are ignored or considered unimportant. However the importance of medical intervention, forensic investigations and preservation of evidence must not be compromised.
- 2.15 Professionals must record in detail any history/background information given by parents/carers. The initial accounts about the circumstances of the collapse/death, including times, should be recorded verbatim. The Consultant Paediatrician or Consultant in Charge (where children are 16 and over) will take a full medical, social and family history with particular emphasis on recent events.
- 2.16 Where an unexpected child death occurs the death must be immediately reported to the Coroner who has jurisdiction over the child's body and everything regarding to it. Coroners have a responsibility to ascertain that there are no suspicious circumstances surrounding the child's death.
- 2.17 In addition, as soon as possible, the death must be reported to the RMSO/ CEMACH Office 0191 233 1658. Voice mail out of hours.
- 2.18 All unexpected child deaths will be investigated by the Police. Appropriate examinations and a post-mortem will take place in all cases and it is likely that ultimately an inquest will be conducted by HM Coroner to establish the cause of the child's death.
- 2.19 In those exceptional child deaths where there are suspicious circumstances, the early interview/arrest of the parents/ carers or other person may be essential in order to secure and preserve evidence and thus effectively conduct the investigation. Involved professionals must be prepared to provide *Statements of Evidence* promptly in such circumstances.

3. Appearance of the dead body and factors which arouse concern

3.1 This section relates to features that may commonly be found in a baby or young child who has died suddenly from natural causes:

3.1.1. **Small quantities of stomach contents present around the mouth.** Often there is slight regurgitation immediately after death. This does not mean that death was caused by inhalation of vomit.

3.1.2. **Froth emerging from the mouth and nose.** The froth results from the expulsion of air and mucus from the lungs after death. Sometimes the froth may be bloodstained; this does not mean that the death was unnatural.

3.1.3. **Purple discoloration of the parts of the face and body that were lying downwards.** This is not bruising but is caused by the draining of blood in the skin after death. For the same reason the parts that were lying upwards may be very pale.

3.1.4. **Covering of the baby's or young child's head by the bedclothes.** This has often been a feature of cot death in the past, and probably contributes to death through accidental asphyxia or overheating. Parents are now advised to arrange the bedclothes to reduce the risk of this happening.

3.1.5. **Wet clothing or bedding.** Excessive sweating before death usually causes this.

3.1.6. **The child looks as though he/she has been roughly handled.** This may be the result of attempts at resuscitation. (N.B. This can also occur with the older child).

3.2 Factors that may arouse concern

Certain factors in the history or examination of the child may give rise to

concern about the circumstances surrounding the death. The following list of factors is not exhaustive and is intended only as a guide:

3.2.1. A previous unexpected child death within a family.

Tragically the death of a child can happen more than once to a family. In such situations specific consideration should be given to the diagnoses of familial illness however also to the possibility of maltreatment.

3.2.2. Previous child protection/childcare concerns within the family, within a parent's partner's family or within the family of a carer of the child.

3.2.3. Inappropriate delay in seeking help. For this reason it is essential that all times be noted.

3.2.4. Inconsistent explanations.

The account given by the parents/carers of the circumstances of death should be documented verbatim. Any inconsistencies should arouse doubt, though it is important to be aware that some inconsistencies may occur as a result of the shock and trauma caused by the child's death.

3.2.5. Evidence of parental mental health problems.

The majority of adults with mental health problems do not harm their children intentionally or otherwise neglect them. However children are at an increased risk of harm and neglect, where a parent, carer has a mental health problem.

3.2.6. High risks are associated with personality disorders, alcohol or drug abuse and learning difficulties.

- 3.2.7. **Unexpected injury e.g. unexpected bruising/burns/bite marks.**
A child may have serious internal injuries without any external evidence of trauma. Thus the importance of skeletal surveys being carried out.
- 3.2.8. **Evidence of bleeding** from the body's orifices, e.g. nose, mouth, ears, anus and vagina unless there is a known bleeding disorder.
- 3.2.9. **Near miss cot death infants and all episodic illness in young babies.**
These circumstances should raise the possibility of an underlying medical cause, for example metabolic disease. However there is the possibility of fictitious or induced illness or non-accidental injury to the child including shaken baby syndrome.
- 3.3 If any factors of concern are identified, it is important that the information is documented and shared with senior colleagues, Police and Children's Social Care.

Background papers: Foundation of Sudden Infant Death March 2003. Child abuse and neglect the role of mental health services, Royal College of Psychiatrists London, April 004.

4. Ambulance Service

4.1 Police Contact

4.2 Immediate notification to the Police is given upon the receipt of a call to the scene of an unexpected child death. This is done directly from the Ambulance Service Patient Contact Centre to the police control room.

4.3 The recording of the call is retained by the ambulance service for evidential purposes.

4.4 Ambulance Crews

4.5 Ambulance crews will follow Joint Royal Colleges Ambulance Liaison Committee (JRCALC) guidelines (version 3 April 2004) relating to resuscitation. All children (0-18 years) will be transported to the nearest Accident and Emergency (A&E) department with a 24 hour paediatric service on site unless instructed not to do so by the Police and resuscitation has not been initiated. (Children/young people must NEVER be taken to the mortuary).

4.6 In particular ambulance crews must:

4.6.1. Always attempt resuscitation

4.6.2. Clear the airway and commence full resuscitation protocols

4.6.3. Inform the A&E department of the patient's condition & estimated time of arrival (ETA).

4.6.4. Take note of how the body was found, the position of the child, the clothing worn, the circumstances of how the child was found and note the initial explanation by the parents/carers

4.6.5. Consider if any injury is compatible with the history

4.6.6. Document all medical interventions on the Patient Report Form.

4.6.7. Pass all relevant information to the A&E Department staff.

4.7 If circumstances allow, a full history including all persons present on arrival and any comments or observations made by the persons present should be obtained and noted. The general living conditions, any signs of drug or alcohol misuse, inappropriate furnishings or equipment should also be noted. Under no circumstances should staff challenge or make comment of any account given by a parent/carer or any other person present.

4.8 All observations should be reported to the receiving A&E department.

4.9 Any suspicious actions or observations must be reported to the Police and the receiving A&E department.

4.10 Child Protection Reporting

4.10.1. Having handed over the child to the receiving A&E staff or to the Police on scene, Ambulance Service staff to report any suspicions through their child protection reporting process.

4.11 Inter-agency working.

4.11.1. Ambulance Service staff to provide the Consultant Paediatrician with a copy of the 'Patient Report Form'. This will be important when the Paediatrician undertakes the medical investigation into the death.

4.11.2. Ambulance Service Staff are likely to be involved in the local case discussion held once the results of all relevant investigations have been obtained, usually 8 to 12 weeks after the child's death.

5. Emergency Care Practitioners

- 5.1 There are times when an Emergency Care Practitioner (ECP) is called to the scene first. An ECP should check that the ambulance service has been called and proceed immediately to the scene.
- 5.2 Emergency Care Practitioners are health care professionals governed by both the Health Professionals Council (HPC) and the Nursing Midwifery Council (NMC). The HPC registered ECP will follow Joint Royal Colleges Ambulance Liaisons Committee (JRCALC) guidelines (version 3 April 2004) relating to resuscitation. The NMC registered ECP will follow the NMC guidelines relating to resuscitation.
- 5.3 Emergency Care Practitioners (ECP) will also adhere to their employers guidelines relating to resuscitation.
- 5.4 Taking into account the primary responsibility of saving life the ECP, should contact the Police or Coroners Officer, via the Police Control Room, if they are first on the scene.
- 5.5 The ECP must always clear the airway and commence full resuscitation.
- 5.6 Take note of how the body was found, the position of the child, the clothing worn, the circumstances of how the child was found and note the initial explanation by the parents/carers.
- 5.7 Consider if any injury is compatible with the history.
- 5.8 Document all medical interventions on the Consultation form.
- 5.9 Disseminate all relevant information to the attending Ambulance crew/Accident and Emergency Department.
- 5.10 If circumstances allow, a full history including all persons present on arrival

and any comments of observations made by the persons present should be obtained and noted. Including the general living conditions and any signs of drugs and alcohol.

6. Fire Service

- 6.1 When an unexpected child death occurs as a result of a fire, a full Fire Investigation will take place conducted by a qualified investigator in conjunction with Police Forensic Officers.
- 6.2 Deliberate fire setting behaviour by siblings or other household members should be notified to the Brigade to allow for future intervention work. Similarly this will also allow preventative measures to be put in place in any alternative accommodation that may be required. For this reason continuous tracking of the location of families is imperative.
- 6.3 Child fatalities which occur in places of work, hotels or houses of multiple occupation may also require investigation under the Regulatory Reform (Fire Safety Order) 2005 and in such instances a qualified Fire Engineer will conduct the investigation.
- 6.4 Cleveland Fire Brigade also has several advocates available to assist in a variety of situations. These advocates specialise in the following areas e.g. Deafness, Alcohol and Drugs, Disability, Young people and Multi-lingual Ethnic Minority Advocates. They can provide various services to support families following a fire situation. It should also be noted that, although the fatality may not have been fire related, there may have been previous interaction between Brigade Advocates or fire setter counsellors prior to the fatality. Early involvement will allow the Brigade to identify potential trends which can be addressed via education and intervention.

7. General Practice

- 7.1 There are times when a Practice or out of hours organisation (OOH) is called to the scene first. Practices and OOH organisations have systems in place to manage emergency calls; this will include checking if the ambulance service has been contacted by 999, if not doing so, and if there is uncertainty repeating the call. The Practice will pass the call to the appropriate person who will make an assessment of the need to attend the scene, at what time, and for what purpose.
- 7.2 Unless it is patently obvious that the child has been dead for sometime the attending GP or other practice professional must always attempt resuscitation and continue this en route to hospital.
- 7.3 Where it is indisputable that the child is dead and clear that resuscitation cannot be successful it is usually best for the GP to inform the parents.
- 7.4 Where it is absolutely certain that the child is dead the GP may pronounce life extinct in the home or can leave this to the hospital. Where there is no doubt that the child is dead and there are reasons to suspect maltreatment, assault or injury the baby should be left in situ for the collection of forensic evidence. **In all cases of unexpected death the child should never be taken straight to a mortuary or funeral directors, but always taken to the hospital Accident and Emergency department, so immediate examination and investigations can be carried out.**
- 7.5 Taking into account the primary responsibility of saving life/declaring life extinct the GP should contact the Police or Coroner's Officer, via the Police Control Room, if they are the first on the scene and it is appropriate for them to be informed.
- 7.6 A brief immediate history should be taken from the carers and the circumstances of the death recorded. The position of the child when found, the clothing worn, the bedding, any vomit etc should be noted. These notes will be very helpful to the Paediatrician who investigates the death.
- 7.7 It is crucial that under no circumstances should the GP challenge or make comment on the history given by a parent/carer. (If challenged or a comment is made, parents/carers may form the impression that their account is not believed and may subsequently change their story. This will hinder any police investigation, as by the time a formal interview occurs a different account may be given).
- 7.8 Time should be spent listening to the parents and the child referred to by name.
- 7.9 When appropriate the Consultant Paediatrician on call should be contacted as the Paediatrician will see the child and the parents on their arrival at the Accident and Emergency department.
- 7.10 If the child is the result of a multiple birth it should be suggested to the family that the surviving children be admitted to hospital for observation.
- 7.11 Liaison with other members of the Practice should take place. In areas where the Primary Care Trust (PCT) still provides a practice based health visiting community nursing or midwifery service the practice will wish to inform those members of the team involved in the child's care. In other areas the practice will need to use the appropriate communication system for that area.
- 7.12 A representative of the practice usually the GP should attend the local case discussion meeting held once the results of all relevant investigations have been obtained, usually 8-12 weeks

after the child's death. Meetings will be arranged with adequate notice and appropriate venues and timing to facilitate attendance without compromising provision of normal general practice for the remaining patients.

7.13 The Local Medical Committee (LMC) encourages practices to be fully involved in the scheme but notes that the practice's primary responsibility is to perform its duties under its contract/ agreement for Primary medical services. Attendance at meetings and other work requires appropriate resources and is funded under the collaborative arrangements. The government have accepted the Doctors' and Dentists' Review Body (DDRBs) proposal that any remuneration or reimbursement under these arrangements should be set by the practitioner.

7.14 In respect of sudden unexpected deaths in infancy, particularly to the longer term care of the family, guidance can be obtained from the FSID Foundation for Sudden Infant Death publication:
'Guidelines for GPs when a baby dies suddenly and unexpectedly' FSID (Jan 2003)
(Revised: March 2005)

8. Primary Care Out of Hours Service

- 8.1 There are times when the Primary Care out of hours services (OOHs) are called to the scene of an unexpected death of a child. The OOH operator who receives the call should notify the ambulance service immediately after receipt of such a call. The management of the call should be routinely logged on Adastra as per normal protocol but for the exception that such calls will not require triage since this could introduce a delay into the response from OOH service. The call should be passed to the nearest mobile team and should be allocated as an automatic Priority 1 visit.
- 8.2 The OOH visiting Duty Doctor should check with the OOH Operator that the ambulance service has been called and confirm that this is a P1 visit.
- 8.3 Unless it is obvious that the child has been dead for sometime, the doctor must always attempt resuscitation and continue this en-route to the hospital. The chauffeured "Medic Car" must follow the ambulance containing the Duty Doctor and child to hospital.
- 8.4 Where it is indisputable that the child is dead and it is clear that resuscitation cannot be successful it is best for the doctor to inform the parents.
- 8.5 Where it is absolutely clear that the child is dead the doctor may declare life extinct in the home or can leave this to the hospital. Where there is no doubt that the child is dead and there are reasonable suspicions of maltreatment, assault or injury, the child should be left in situ for the collection of forensic evidence. **In all cases the child should never be taken to the mortuary but always to the hospital's Accident & Emergency department, so that immediate examination and investigations can be carried out.**
- 8.6 The Consultant Paediatrician on-call should be contacted, as the Paediatrician will see the child and their parents on their arrival at the Accident and Emergency Unit (A&E).
- 8.7 If the child has already been taken to A&E and the parents have attended the hospital with the child, the care of the siblings should be checked upon. Also when a parent is left alone, support should be offered.
- 8.8 In infancy if the baby is a result of a multiple birth it should be suggested to the family that the surviving siblings (twins/triplets etc) should be admitted to hospital for observation.
- 8.9 Taking into account the primary responsibility of saving life/declaring life extinct, the doctor should contact the police if this has not already been done (the ambulance service should notify the police of such calls). In the OOH period, the Police will represent the Coroner's Officer.
- 8.10 A brief immediate history should be taken from the carers and the circumstances of the death noted. The position of the child when found, the clothing worn, the bedding, any vomit etc it should be noted. These notes will be very helpful to the Paediatrician who investigates the death.
- 8.11 Time should be spent listening to the parents and the child should be addressed by name. Brief details of the identity of those present and their relationship to the child should be noted.

9. Health Visitors & Midwives

- 9.1 Where a Health Visitor or a Midwife is the first on the scene they should always attempt resuscitation and check that the ambulance service has been called. Resuscitation should be continued until the ambulance crew takes over.
- 9.2 Time should be spent listening to the parent/s and the child addressed by name.
- 9.3 If the parent/s attend the hospital with the child the care of any siblings should be checked on. Where a parent is left alone, support should be found.
- 9.4 A telephone number where the family can contact help should be given.
- 9.5 Where a Health Visitor or Midwife learns later a child has died, they should try to visit as soon as possible to provide support.
- 9.6 Parent/s should be asked about the reaction of any siblings and advised as necessary. Information about counselling services should be given.
- 9.7 Sympathetic support should be offered and where a mother is breast feeding practical advice on methods of suppression of lactation should be discussed.
- 9.8 The procedures to be followed where a child dies unexpectedly should be explained to the family, including the roles of the Coroner and Police. Information about the post-mortem examination should be given.
- 9.9 Where appropriate the funeral payment available through the local Benefits Agency can be explained. (Some funeral directors will not charge where it is a child's funeral).
- 9.10 In the case of an infant parent/s should be provided with a copy of the Foundation of Sudden Infant Deaths (FSID) booklet 'When a baby dies suddenly and unexpectedly', the FSID's Help line number (0870 787 0554) and asked if they would like to be put in touch with a befriender from FSID.
- 9.11 Copies of FSID leaflets and phone cards can be obtained from the Care of the Next Infant (CONI) Coordinator for the area.
- 9.12 Grandparents may need extra support.
- 9.13 Checks should be made with medical records and child health records departments to avoid appointments being sent out for the child. The Health Visitor should contact the local Sure Start and Book Start.
- 9.14 Where the child was at school there should be contact with education. Also where there are any school age siblings.
- 9.15 Liaison with the family GP should take place so as to ensure that everything necessary is done without excessive duplication.
- 9.16 A check should be made that the parents will be informed of the preliminary findings of the post-mortem by the Paediatrician and that an appointment has been arranged for the parent/s with a Paediatrician/GP as soon as possible after the post-mortem results are known and preferably also after the local case discussion.
- 9.17 Where assessment shows the parent(s)/sibling(s) need more help with their grief, they should be referred as necessary to an appropriate counselling service.

- 9.18 The Health Visitor or Midwife should try to visit regularly during the weeks following the funeral to listen to and support the family.
- 9.19 Anniversaries of the child's birth and death are particularly sad times when parent/s need extra support.
- 9.20 The Health Visitor or Midwife will be expected to make the child/family's notes/report available to the Paediatrician who is medically investigating the child's death.
- 9.21 The Health Visitor/Midwife should attend the local case discussion on the child held when the final post-mortem results is known. This is normally 6-8 weeks after the death.
- 9.22 In respect of the death of infants parents should be informed that support with any subsequent babies is available through FSID's Care of the Next Infant (CONI) scheme.
- 9.23 **Support during the next pregnancy:**
- 9.24 It is important that the Midwife/Health Visitor acknowledges the child who has died and uses his/her name.
- 9.25 Where the sudden unexpected death occurred in an infant a CONI contact should where possible be established at the very earliest opportunity – preferably at booking with the Midwife.
- 9.26 Regarding the protection of babies, information about cot deaths and how to reduce the risk should be given at parent craft classes, pre-conceptual and health promotion clinics.

*Guidelines for Health Visitors & Midwives
where a child dies suddenly and
unexpectedly, FSID, Jan 2003*

10. Police Officers

General

- 10.1 Unexpected child deaths will be investigated in accordance with the 'Infant Deaths' section of the Assistant Chief Police Officers (ACPO) Murder Manual. However, it should always be borne in mind that such investigations are particularly sensitive and traumatic for all those involved.
- 10.2 It is important for Police Officers to remember that for most unexpected child deaths, the death has been the result of natural causes; however, officers need to strike a balance between consideration for the bereaved family and the potential of a crime having been committed. They should not shy away from asking pertinent questions and conducting thorough enquiries, provided tact and diplomacy is demonstrated.
- 10.3 If the Police are the first professionals to attend the scene, then urgent medical assistance should be requested as a first priority.
- 10.4 Police attendance should be kept to the minimum required. Several Police Officers arriving at the house can be highly distressing, especially if they are uniformed officers in marked police vehicles. This advice also applies to officers attending Accident and Emergency departments.
- 10.5 Officers should at all times be sensitive in the use of personal radios and mobile phones. Whenever possible, the officers liaising with the family, whilst remaining contactable, should have such equipment turned off.
- 10.6 In all cases the child **MUST** be taken to the hospital's Accident & Emergency department, so that immediate examination and investigations can be carried out. **NEVER** to the mortuary.
- 10.7 On those occasions where the child was already at or has been taken to a local hospital, officers will obtain the necessary initial details from the senior nursing staff and **not** the parents of the deceased child. The parents and/or carers should be allowed to grieve in these early stages at the hospital.
- 10.8 A Detective Inspector or Detective Sergeant with Senior Investigating Officer (S.I.O) experience must immediately attend the scene and take charge of the investigation, in all cases of unexpected child deaths, whether or not there are any obvious suspicious circumstances.
- 10.9 The Coroner's Officer must be notified as soon as possible. As well as the usual functions they perform, their experience in dealing with sudden deaths and bereaved families, will be invaluable in explaining to the parent/carer what will happen to their child's body and why. The Investigating Officer and the Coroner's Officer should continue to liaise closely throughout the Investigation.
- 10.10 The Senior Detective attending will be responsible for deciding on whether to request the attendance of a Scientific Support Officer (S.S.O). If items are to be removed or photographs or a video are to be taken, then their attendance will be essential. The Senior Investigating Officer needs to take time to ensure that police actions are fully explained to the parents/carers.
- 10.11 Excellent co-operation and liaison between the Police and the Consultant Paediatrician medically investigating the cause of the child's death is vital. The detection of child abuse is part of the standard training of Paediatricians,

which should equip them to carry out a quasi-forensic external examination and to arrange the relevant investigations such as a skeletal survey and tests for abnormal bruising. Assistance can be provided in the form of early examination of the body, collating relevant information from medical records, and preparing reports for Pathologists.

Initial Action

- 10.12 The provision of medical assistance to the child is obviously the first priority. If an ambulance is not already in attendance then one must be immediately requested unless it is absolutely clear that the child has been dead for some time. If this is the case then a Doctor will need to declare life extinct. This will be a Police Surgeon if there are any overt suspicions as to the cause of death. If at a hospital, then the resident Doctor will certify death.
- 10.13 The first Officer at the scene must make a **visual** check of the child and its surroundings, noting any obvious signs of injury. It must be established whether the child's body has been moved and the current position of the child should be recorded. All other relevant matters should also be recorded.
- 10.14 An early record of events from the parent/carer is essential, including details of the child's health. All comments should be recorded. Any conflicting accounts should raise suspicion but it must not be forgotten that any bereaved person is likely to be in a state of shock and possibly confused. Repeat questioning of the parent/carer by different Police Officers should be avoided at this stage if at all possible.

The preservation of the scene and the level of investigation will be relevant and appropriate to presenting factors.

10.15 Consideration should be given to the following actions:

- Commencing a scene log
- General preservation of the scene
- Recording detailed descriptions of any prescribed/non-prescribed medication for the child and any prescribed/non-prescribed medication and drugs to other occupants of the house (particularly noting insulin)
- Ensuring where calls have been made to emergency services for assistance that the tape is secured for any criminal investigation.
- Where possible speaking to parents/carers separately
- Arranging for photographs/video of the scene/other rooms, etc.
- Retaining bedding if there are obvious signs of forensic value such as blood, vomit or other residues.
- Retaining items such as the child's used bottles, cups, food and any medication.
- Arranging for the child's nappy and clothing to be retained at the hospital but these should remain on the child initially.
- Securing records of monitoring equipment used by the Ambulance Service, which may be of evidential value.

The above is NOT an exhaustive list of considerations and should be treated only as a guide. They will not be necessary in every case.

- 10.16 If it is considered necessary to remove items from the house, do so with consideration for the parents. Explain that it may help to find out why their child has died. Before returning the items, the parents must be asked if they actually want them back and if so, in what condition (i.e. washed, cleaned or

- otherwise).
- 10.17 If articles have been kept for a while, try to ensure that they are presentable and that any official labels or wrappings are removed before return. Return any items as soon as possible after the Coroner's verdict or the conclusion of the investigation. The term investigation will include any possible trial or appeal process.
- 10.18 Consideration must be given to evidencing factors of neglect, which may have contributed to the death such as temperature of scene, condition of accommodation, general hygiene and the availability of food/drink.
- 10.19 Form C3.1 (Report of Death Form) must be completed at an early stage. The Coroner's Officer will complete this if they are in attendance. However, in order to avoid delay, it may be appropriate for the attending Officer to complete the form. A supply of forms will be retained at the Accident and Emergency department of the three receiving hospitals.
- 10.20 Questions regarding the child's recent health can be recorded on Form C03-09 under the appropriate heading. These questions should include the basic medical history of the child and family. Other relevant details, which are thought to be pertinent to the child's death, should be included; an example of this could be when the child was last fed.
- 10.21 The issues of the continuity of identification must be considered. This will preferably be done by the Coroner's Officer but could be done by a Police Officer and should be carried out appropriately and sensitively. The child should be handled as if he/she was alive and the child's name used.
- 10.22 A parent/carer is likely to want to hold or touch the dead child. Providing this is done with a professional present, (such as a Police Officer, Nurse or Social Worker), it should be allowed in most cases, as it is highly unlikely that forensic evidence will be lost. If, however, the death has by this time been considered suspicious, the S.I.O. should contact the hospital with any specific directions regarding this issue.
- 10.23 If the parents/carers wish to accompany their child to the mortuary, then this should normally be facilitated, ensuring that an appropriate professional accompanies them.
- 10.24 A special post-mortem must be considered in each and every case. The S.I.O. will also make a judgement, based on all the facts relevant to the case and the advice contained within the ACPO Murder Manual, whether a homicide investigation is required.
- 10.25 Liaison should be made with the force Child Abuse Investigation Unit as it may have information highly relevant to the case.
- 10.26 The Child Abuse Investigation Unit will in all cases check whether the child is subject to a Child Protection Plan. If there are any suspicious circumstances or there have been previous child protection concerns or involvement of agencies because of concerns, then a referral must be made to either the local Children's Social Care Department or out of hours to EDT (Emergency Duty Team). The Child Abuse Investigation Unit can facilitate the referral.
- 10.27 Where a Strategy Meeting is convened under Procedures, the SIO or his/her representative should attend the meeting along with a supervisor from the relevant Police Child Abuse Investigation Unit. Children's Social

- Care will take minutes of the meeting and provide the SIO with a copy of the minutes within 72 hours of the meeting. Any minutes will potentially be disclosable under the Criminal Procedure and Investigations Act 1996 and will also be included in any Coroner's File, which is prepared.
- 10.28 Other children in the household and their protection need to be addressed. If the risks to the siblings are felt to be significant an Initial Child Protection Conference will be convened, as per Procedures for Working Together to Safeguard Children 2006. Once again the force Child Abuse Investigation Unit can facilitate this. The referral should include details of any previous areas of the county or country the child and parents/carer have resided.
- 10.29 Sometimes even the most expert post-mortem examination may not be able to distinguish between a natural and an unnatural death, for example between a genuine cot death and a death caused by smothering. The best evidence may then come not from the post-mortem examination, but from a detailed discussion regarding the child's death with all the relevant professionals.
- 10.30 A Local Case Discussion meeting will be held when the results of the main post-mortem tests are known. A principle purpose of this meeting will be to enable the relevant professionals to review together all the antecedents and circumstances of the child's death and to consider possible causes of the death and contributory factors.
- 10.31 The Senior Investigating Officer or his/her representative should attend the meeting along with a supervisor from the relevant Child Abuse Investigation Unit. Consideration should also be given to the attendance of the Coroner of Coroner's officer and a CPS representative as appropriate.
- 10.32 The Senior Investigating Officer may feel it appropriate for the Police to convene other meetings in relation to their investigations.
- 10.33 Consideration to be given to the appointment of a Family Liaison Officer.

11. Children's Social Care

- any potential or actual risk to the children.
- 11.1 Where there is an unexpected child death it is essential that Children's Social Care make any relevant information the department holds on the child/family available to the Paediatrician, Police, Pathologist and Coroner to assist them in ascertaining the cause of the child's death.
- 11.2 Relevant information may relate to child protection concerns, 'child in need' concerns, or data about any referrals to Children's Social Care concerning the child/family.
- 11.3 When the Police Child Abuse Investigation Unit is informed of the unexpected death of a child, a Police Officer will check if the child is subject to a child protection plan. Children's Social Care will establish whether the child is subject to a child protection plan and will provide any relevant information relating to the child who has died or about any other members of the family to the Police. The Police will convey any pertinent information onto the Paediatrician, Coroner and Pathologist.
- 11.4 If there are suspicious circumstances, previous child protection concerns or involvement of agencies as a result of concerns about child care/welfare then a referral will be made to the local Children's Social Care. If out of hours the referral will be made to the Emergency Duty Social Work Team (EDT).
- 11.5 In the case of a referral being made to the local Children's Social Care or EDT a strategy meeting or strategy discussion will be convened in line with the local child protection procedures.
- 11.6 Where a referral is made and there are other children in the household, Children's Social Care will undertake an immediate risk assessment to ascertain
- 11.7 Where the EDT Social Work Team has been involved EDT staff will refer the outcome of any immediate risk assessment undertaken, regarding children in the household, to the relevant local Children's Social Care on the next working day.
- 11.8 A Section 47 (Children Act, 1989) enquiry may be undertaken, usually in conjunction with the Police Child Abuse Investigation Unit, however recognising the District CID may also be involved.
- 11.9 The appropriate Children's Social Care Team Manager will ensure relevant professionals involved with the child and family are informed of the progress and outcome of the Section 47 Children Act enquiry, both verbally and in writing.
- 11.10 If the risks to the dead child's siblings are thought to be significant, an Initial Child Protection Conference will be convened, as according to local child protection procedures.
- 11.11 An initial assessment conforming to the 'Framework for the Assessment of Children in Need and their families' may be required in order to identify any further action/support services in respect of any other children within the family.
- 11.12 As appropriate a representative from the Local Authority will be invited to attend the local case discussion meeting. This is held once the results of all relevant investigations have been obtained, usually 8 to 12 weeks after the child's death.

12. Accident & Emergency

Initial Management

- 12.1 All children **must** be taken to the Accident and Emergency (A&E) Resuscitation room unless within a hospital ward or unit.
- 12.2 In most cases ambulance control will have alerted A&E of the child's impending arrival. The hospital switchboard should be instructed to put out the Cardiac Arrest call and to contact the A&E Consultant and the on-call Consultant Paediatrician or relevant Consultant (in the case of 16 years or older).
- 12.3 Hospital staff should treat all unexpected child deaths as cardiac arrests and make attempts to resuscitate the child as according to Resuscitation Council (UK) guidelines, unless the situation is one where it is absolutely certain that the child has died.
- 12.4 The parents/carers of the child should be offered the option of being present during resuscitation attempts. They should not however be made to feel guilty if they do not wish to be present and should be given the opportunity to change their minds. Where one parent/carer wishes to be present and the other not this should be accommodated.
- 12.5 An experienced nurse, who preferably has previously dealt with an unexpected death in a child, should at all times accompany the family. The nurse will keep the family informed about what is happening and will start gathering a history of events. The nurse will be sensitive to the family's grieving and make every attempt to minimise the stress incurred.
- 12.6 The decision to stop resuscitation will be made by the Consultant in charge after conferring with the rest of the resuscitation team. The parents/carers present should be told sensitively but firmly that further resuscitation attempts will be useless and the team is going to have to stop. Resuscitation should then cease and all monitors turned off.
- 12.7 The endotracheal tube, canulas or intraosseous needles should be removed from the child's body. The sites of these and any attempts to gain venous or arterial access should be accurately documented.
- 12.8 As soon as the child's life has been declared extinct the parents will be informed the child has died. Unless there is an obvious cause of death the family should be told that an opinion as to the cause of the death cannot be given until after the post-mortem examination.
- 12.9 Basic details must be obtained from the people accompanying the child e.g. their names and relationships to the child, addresses and contact numbers. In addition it is vital to establish the details of any other children in the family. If the child is a result of a multiple birth it may be appropriate to admit the surviving children for monitoring.
- 12.10 In order that vital information is not lost it is essential that a senior member of the resuscitation team should take as detailed a history as soon as possible from the parents/carers. This should be taken without challenge or comment.
- 12.11 A&E staff should ask the ambulance crew accompanying the child for an account of their involvement and this should be documented.
- 12.12 The Child Protection Referral work book should be commenced; this will ensure that all facts are reordered in a timely manner.

Communications

- 12.13 An interpreter must be called urgently, where the family does not speak and understand English.
- 12.14 Medical records department must be informed of the child's death so that no appointments are sent for the child.

The Family

- 12.15 The religious and cultural needs of the family should be established and every action possible taken to accommodate these.
- 12.16 A private time must be provided for the family with their child, with the discreet presence of the attendant nurse. The parent/s should be gently encouraged to hold or touch their child. The nurse must take time, to explain to the parents/ carers the procedures that have to follow an unexpected death. Medical/nursing staff will need to explain the roles of the Coroner and the Police and the requirement for a post-mortem. The parents/carers will need time to take this information in and to ask questions.
- 12.17 Parents should be told that any clothing removed from the child, plus any other items such as a dummy from a baby and any bedding brought in will need to be placed in labelled specimen bags and given to the Pathologist. Parents' wishes for eventual return or disposal should be documented. No items should be returned to the parents without consultation with the Consultant Paediatrician, the Police Officer involved and the Coroner.
- 12.18 A photograph of the child should be taken at this stage and offered to the parents. If the parents decline the photograph it should be retained in case they would like it later. Hand and footprints and a small lock of hair can be taken at an appropriate point as

mementoes for the family.

- 12.19 Before the parents leave the hospital they should be told where their child will be and when they will see their child again. They should be provided with appropriate written information, contact details for help, FSID information and counselling facilities available. Bereavement support information should be provided (See Appendix 3).

Police and Coroner

- 12.20 The on-call Consultant Paediatrician or Consultant in Charge should ensure that the Police and Coroner's Officer are told of the child's death. The Coroner's Officer and the Police will consult about the death.
- 12.21 The Police must be contacted if they are not already involved. Hospital staff will complete Form 3.1 (notification of death form) and give this to the Police Officer attending the hospital.
- 12.22 A&E staff should enquire of any attending Police Officer if a check has been made to establish whether the child is subject to a child protection plan and where this has been checked record the outcome. Where this check has not taken place a member of A&E staff must do this and record the outcome. The fact that a child is not subject to a child protection plan clearly does not exclude the possibility of an unnatural death.
- 12.23 It occasionally may be necessary for the Police to require blood samples to be taken from either the parents or those caring for the child immediately prior to death. These tests should where practically possible be carried out in the A&E department rather than transporting the carer to the police station. They must be carried out by a police surgeon and not a member of the hospital staff.

Child Protection and Social Services

- 12.24 Children's Social Care must be contacted urgently and asked for any relevant information regarding the child/family. It is crucial Children's Social Care are told of any other children in the household to ensure someone is looking after them and that their safety and welfare is being considered.
- 12.25 The Police and Children's Social Care should be informed immediately if at any time concerns are raised about the possibility of abuse or neglect. In such an event Children's Social Care will initiate child protection procedures and the Police and Children's Social Care will become the lead agencies.

Examination

- 12.26 A thorough examination of the child should be carried out by the Consultant Paediatrician or in the case of a child over 16 the Consultant in Charge. (See *Section 14.3 Examination of the dead child*).
- 12.27 Careful records should be kept including the history given by the parents, notes of physical examinations and all medical interventions and procedures, including the sites of venous and arterial access. Entries should be dated and timed and signed legibly in view of the medical/legal implications.

Investigations

- 12.28 Standard routine investigative samples should be taken immediately after the unexpected death of an infant or as indicated clinically in an older child (See Section 13).
- 12.29 As part of the local agreement the Coroners with jurisdiction over Tees have agreed in advance with South Tees Hospital NHS Trust, North Tees and Hartlepool Foundation Trust and

Cleveland Police that the routine investigative samples described in this document, any additional samples a skeletal survey on all children under 5 years will be carried out. This will prevent specific approval on each case being needed.

- 12.30 The Consultant Paediatrician/Consultant in Charge will carry out the necessary investigative samples. A skeletal survey should be carried out on all children under 5 years, unless clinically indicated otherwise.
- 12.31 If tissue biopsy, cardiac puncture and CSF samples are necessary the Consultant Paediatrician may carry out these procedures as opposed to the Pathologist to prevent delay. It should be noted that the requirements for taking biopsies change from infant to the older child as the possible causation changes.

Staff

- 12.32 An initial debriefing of all staff should be carried out as soon as possible after the event. The purpose of this is first to ensure that nothing has been missed in terms of documentation and second to address the needs of the staff involved, some of whom may not have been involved in a child death before.

Local Case Discussion

- 12.33 A Local Case Discussion will take place as soon as the results of the main tests from the post-mortem are known. (See Section 20 on local case discussion meetings.)
- 12.34 All relevant Accident and Emergency (A&E) staff should give high priority to attendance at a local case discussion.

13. Wards & Other Hospital Units

- 13.1 Hospital staff should treat all unexpected child deaths as cardiac arrests and make attempts to resuscitate the child as according to Resuscitation Council (UK) guidelines.
- 13.2 Hospital staff will follow their resuscitation policy. The hospital switchboard should be instructed to put out the appropriate Cardiac Arrest call. The ward staff should contact the on-call Consultant Paediatrician or Consultant in Charge, where the child is 11 years or over.
- 13.3 Whenever possible the parents/carers of the child should be offered the option of being present during resuscitation attempts. They should not however be made to feel guilty if they do not wish to be present and should be given the opportunity to change their minds. Where one parent/carer wishes to be present and the other not this should be accommodated.
- 13.4 The relevant Consultant will make the decision to stop resuscitation after conferring with the rest of the resuscitation team. The parents/carers present should be told sensitively but firmly that further resuscitation attempts will be useless and the team is going to have to stop. Resuscitation should then cease and all monitors turned off.
- 13.5 The endotracheal tube, canulas or intraosseous needles should be removed. The sites of these and any attempts to gain venous or arterial access should be accurately documented.
- 13.6 As soon as the child's life has been declared extinct the parents will be informed the child has died.
- 13.7 An experienced nurse, who preferably has previous dealing with an unexpected death in a child, should at all times be present with the family.
- 13.8 The on-call Consultant Paediatrician or the Consultant in Charge will ensure that the Police and Coroner's Officer are told about the child's death.
- 13.9 Where staff believe the circumstances surrounding the child's death may be suspicious the Police and Coroner's Officer must be informed straight away and Local Safeguarding Children Board procedures must be initiated immediately.
- 13.10 The religious and cultural needs of the family should be established and all possible actions taken to accommodate these.
- 13.11 An interpreter must be called urgently, where the family does not speak and understand English.
- 13.12 Standard routine investigative samples should be taken immediately after the death of an infant or as indicated clinically in an older child. A skeletal survey should be carried out on all children under 5 years of age, unless clinically indicated otherwise. Where a skeletal survey is not performed the reasons for not doing should be documented.
- 13.13 If tissue biopsy, cardiac puncture and CSF samples are necessary the Consultant Paediatrician may carry out these procedures as opposed to the Pathologist to prevent delay.
- 13.14 As part of the local agreement the Coroners with jurisdiction over Tees have agreed in advance with South Tees Hospital NHS Trust, North Tees

and Hartlepool Foundation Trust and Cleveland Police that the routine investigative samples described in this document, any additional samples thought necessary by the Paediatrician and a skeletal survey on all children under 5 years, unless clinically indicated otherwise, will be carried out. This will prevent specific approval on each case being needed.

- 13.15 A thorough examination of the child should be carried out by the Consultant Paediatrician or the Consultant in Charge. (*See Section 14.3 Examination of the dead child or Appendix 1 - Workbook*).
- 13.16 A private time must be provided for the family with their child, with the discreet presence of the attendant nurse. The parent/s should be gently encouraged to hold or touch their child. The nurse must take time, to explain to the parents/carers the procedures that have to follow an unexpected death. Medical/nursing staff will need to explain the roles of the Coroner and the Police and the requirement for a post-mortem. The parents/carers will need time to take this information in and to ask questions.
- 13.17 Parents should be told that any clothing removed from the child, plus any other items such as a dummy from a baby and any bedding brought in will need to be placed in labelled specimen bags and given to the Pathologist. Parents' wishes for eventual return or disposal should be documented. No items should be returned to the parents without consultation with the Consultant Paediatrician, the Police Officer involved and the Coroner.
- 13.18 A photograph of the child should be taken at this stage and offered to the parents. If the parents decline the photograph it should be retained in case they would like it later. Hand and footprints and a small lock of hair can be taken at an appropriate point as

mementoes for the family.

- 13.19 Hospital staff will complete all appropriate documentation.
- 13.20 In exceptional cases only the Senior Investigating Officer (SIO), upon direct discussion with the senior nurse or doctor present, may limit or deny access to the child by family members. It should be noted however that denial of access to the child's body by the family would be regarded as unusual and not the norm.
- 13.21 The Consultant Paediatrician/Consultant in Charge will ensure that the GP/Health Visitor/School nurse and where relevant a Midwife and Children's Social Care are informed. These professionals will be asked for written information for the Paediatrician to provide to the Pathologist.
(*See sample proforma Appendix 4*).
- 13.22 The Consultant Paediatrician/Consultant in Charge will take a detailed history from the family or carers present just as soon as this is practical so as not to lose valuable information.
(*See Section 14 or the Work Book*.)
- 13.23 Careful records should be kept including the history given by the parents, notes of physical examinations and all medical interventions and procedures, including the sites of venous and arterial access. Entries should be dated and timed and signed legibly in view of the medical/legal implications.
- 13.24 It is very important that the Consultant Paediatrician/Consultant in Charge and the Police regularly confer about the possible cause of the child's death.

- 13.25 Family members need to be kept informed about what is happening and supported throughout their time in hospital. address the needs of the staff involved, some of whom may not have been involved in a child death before.
- 13.26 The Consultant Paediatrician/Consultant in Charge should ensure that the process of gathering and reviewing all relevant medical, health, and social information is initiated, including primary health care and children's social care information.
- 13.27 The Consultant Paediatrician/Consultant in Charge must provide a report of findings for the Pathologist and Coroner prior to the post-mortem taking place.
- 13.28 This report should include information from the Ambulance Service, Accident and Emergency records, the Paediatrician's history taking and examination of the child, the child's birth notes and where clinically indicated mother's obstetric history. Also any pertinent information from previous hospital notes held on the child and where relevant the personal child health record book. The results of a skeletal survey should be commented upon by a Consultant Radiologist. Any pertinent information from Children's Social Care should be included within the report.
- 13.29 When the child is transferred to the mortuary the nurse in attendance should accompany the family and should be discreetly present through out.
- 13.30 Before the parents leave the hospital they should be told where their child will be and when they will see their child again. They should be provided with appropriate written information, contact details for help, FSID information and counselling facilities available. Bereavement support information should be provided (*See Appendix 3*).
- 13.31 An initial debriefing of all staff should be carried out as soon as possible after the event. The purpose of this is first to ensure that nothing has been missed in terms of documentation and second to
- 13.32 The Police and Children's Social Care should be informed immediately if at any time during these procedures concerns are raised about the possibility of abuse or neglect. In such an event Children's Social Care will initiate child protection procedures and the Police and Children's Social Care will become the lead agencies.
- 13.33 Medical records department must be informed of the child's death so that no appointments are sent for the child.
- 13.34 The Consultant Paediatrician/Consultant in Charge must liaise with the Coroner about the preliminary findings of the post-mortem. Providing the Coroner has no objections the Paediatrician should contact the family to inform them about the preliminary findings.
- 13.35 A local case discussion should take place as soon as the results of the main tests from the post-mortem are known. (*See Section 20 on local case discussion meetings.*)
- 13.36 All relevant ward staff should give high priority to attendance at a local case discussion.
- 13.37 An appointment with the Consultant Paediatrician/Consultant in Charge (for children over 16 years old) should be arranged for the family when the results of the main post-mortem tests are known and preferably also after the local case discussion.

14. Routine samples to be taken unless clinically indicated otherwise

Containers and 'chain of evidence' forms for unexpected deaths in childhood

This pack contains the following:

14.1 Sample containers – check still within expiry date before use.

This pack contains the sample containers for specimens unless clinically indicated otherwise taken when an unexpected death of a child occurs. Samples are preferred within 30 minutes of death – as soon as possible. In exceptional circumstances they may be taken at the post-mortem if this is to be held within 48 hours of death.

14.2 Sample requirements and storage

See Table 1 (attached).

14.3 'Chain of evidence' forms:

A separate 'chain of evidence' form must be completed for each sample. (NOT each sample type e.g. three lithium heparin samples require three chain of evidence forms) by the person taking the samples (addressograph labels may be used). The person delivering the samples to the laboratory, the person receiving the samples in the laboratory and the person processing the samples in the laboratory must complete this. This form must be stapled to the request form. Chain of evidence forms are enclosed in this sample pack.

*(*Chain of evidence specimen collection is a system where personnel collecting, transferring or analysing biological specimens or controlled substances received from patients, must sign a legal log for each step in the handling of the*

specimen, See Section 13).

14.4 Tamper proof sample transport container:

Two of these containers are enclosed. These must be used to transport samples to the laboratory. Each one must be sealed and signed by the person sending the samples to the laboratory. Please make sure samples are placed in the appropriate departmental box (see table 1a/b).

Container 1: Biochemistry and Haematology samples.

Container 2: Microbiology samples.

14.5 Reporting of Results

The laboratory should report all results to the Consultant Paediatrician involved in the case and copy all results to the Paediatric Pathologist, Pathology Department, RVI, Newcastle.

14.6 Disposal of Specimens

All specimens must be kept for 2 months after the date of death. If there has been no contact by this date, specimens may be disposed of as routine clinical specimens.

14.7 **Table 1a: Samples to be taken
(Starstedt Monovette)**

Container and volume	Send to:	Comments
Blood:		
1 ml ETDA (red top) tube	Haematology	FBC – analyse on receipt.
1 ml Lithium heparin (orange top) tube	Biochemistry	U&E – analyse on receipt.
1 ml Lithium heparin (orange top) tube	Biochemistry	Metabolic disorders. Store plasma at minus 80°C**
5 ml Lithium heparin (orange top) tube	Biochemistry	Chromosomes (only if child dysmorphic). Send whole blood to Northern Genetics Service, Newcastle.
1 ml gel or plain (brown or white top) tube	Biochemistry	Toxicology. Store serum at minus 80°C**
1 ml Fluoride oxalate (yellow top) tube	Biochemistry	Carbohydrate metabolites (glucose, FFA, 3OH butyrate). Store plasma at minus 20°C.
4 blood spots on Guthrie card	Biochemistry	Inherited Metabolic disease. Store dry at room temp.
Blood culture – aerobic	Microbiology	Culture.
Blood culture – anaerobic	Microbiology	Culture.
Urine:		
Urine – SPA – plain universal bottle - as much as possible	Biochemistry	Toxicology. Store at minus 20°C**
Urine – SPA – plain universal bottle – as much as possible	Biochemistry	Amino & organic acids. Store at minus 20°C.
Urine – SPA – paediatric boric - half full	Microbiology	Microscopy, culture & sensitivity
Swabs:		
*Naso-pharyngeal swab	Microbiology	Culture.
*Naso-pharyngeal swab	Microbiology	Virology. Store at 4°C.
*Swabs – any other fluids (wound swab, throat, rectal / faeces, any lesion & tracheal suction if done)	Microbiology	Culture.
*Swab from herpetic lesion if present	Microbiology	Virology. Store at 4°C.
CSF:		
Plain universal bottle	Microbiology	Microbiology & virology

*A pack of fine swabs is enclosed – these are to only be used for small babies. Use the larger standard sized swabs whenever possible.

**It has been agreed with the Paediatric Pathologist that toxicology and metabolic disorders samples should be stored by the laboratory for 2 months and not routinely referred for analysis. If analysis is required, this will be requested by the Paediatric Pathologist.

14.8 **Table 1b: Samples to be taken (BD Vacutainer)**

Container and volume	Send to:	Comments
Blood:		
1 ml ETDA (purple top) tube	Haematology	FBC – analyse on receipt.
1 ml paediatric SST (yellow top) tube	Biochemistry	U&E – analyse on receipt.
1 ml paediatric SST (yellow top) tube	Biochemistry	Metabolic disorders. Store plasma at minus 80°C**
5 ml Lithium heparin (light green top) tube	Biochemistry	Chromosomes (only if child dysmorphic). Send whole blood to Northern Genetics Service, Newcastle.
1 ml plain (pink top) tube	Biochemistry	Toxicology. Store serum at minus 80°C**
1 ml Fluoride oxalate (grey top) tube	Biochemistry	Carbohydrate metabolites (glucose, FFA, 3OH butyrate). Store plasma at minus 20°C.
4 blood spots on Guthrie card	Biochemistry	Inherited Metabolic disease. Store dry at room temp.
Blood culture – aerobic	Microbiology	Culture.
Blood culture – anaerobic	Microbiology	Culture.
Urine:		
Urine – SPA – plain universal bottle - as much as possible	Biochemistry	Toxicology. Store at minus 20°C. **
Urine – SPA – plain universal bottle – as much as possible	Biochemistry	Amino & organic acids. Store at minus 20°C.
Urine – SPA – paediatric boric - half full	Microbiology	Microscopy, culture & sensitivity
Swabs:		
*Naso-pharyngeal swab	Microbiology	Culture.
*Naso-pharyngeal swab	Microbiology	Virology. Store at 4°C.
*Swabs – any other fluids (wound swab, throat, rectal / faeces, any lesion & tracheal suction if done)	Microbiology	Culture.
*Swab from herpetic lesion if present	Microbiology	Virology. Store at 4°C.
CSF:		
Plain universal bottle	Microbiology	Microbiology & virology

*A pack of fine swabs is enclosed – these are to only be used for small babies. Use the larger standard sized swabs whenever possible.

**It has been agreed with the Paediatric Pathologist that toxicology and metabolic disorders samples should be stored by the laboratory for 2 months and not routinely referred for analysis. If analysis is required, this will be requested by the Paediatric Pathologist.

14.9 **Sudden Unexpected Death
Laboratory Chain of Event Form**

Please complete a separate chain of evidence form for **each** specimen / tube and staple to the appropriate request form for the laboratory

Date taken	Time taken	Doctor Name
Patient details (name / number, date of birth, sex and address) Addressograph may be used		Doctor signature

Specimen type (please circle):

Blood culture (anaerobic)	EDTA blood	CSF
Blood culture (aerobic)	Serum (plain) blood	Urine SPA (plain)
lithium heparin blood	Serum (gel) blood	Urine SPA (boric)
fluoride oxalate blood	blood spot card	
Swab (state source)		
Other (state)		

ALL NAMES MUST BE ACCOMPANIED BY A SIGNATURE

Procedure	Name	Signature	Date	Time
Specimen taken by (include designation of staff):				
Witnessed by: (mandatory for sexual abuse cases)				
Specimen sealed in tamper proof box by delivered to laboratory by:				
Specimen delivered to laboratory by:				
Tamper proof box received in laboratory by:				
Tamper proof box opened by:				

15. Further Guidance for Consultant Paediatricians/ Consultants in charge

(Consultants in Charge where child is over 16 years)

Some Consultant Paediatricians/ Consultants in charge may prefer to use the Work Book found as Appendix 4 instead of this section.

15.1 The Consultant Paediatrician/ Consultant in Charge should:

- 15.1.1. Take the medical lead for the care and investigation following an unexpected death of a child.
- 15.1.2. Take the lead in communicating with relevant healthcare professionals, the Police, the Coroner's Officer, Children's Social Care and schools as necessary.
- 15.1.3. Take the lead in ensuring all relevant medical/health/social information about the child is obtained.
- 15.1.4. Provide a report for the Pathologist prior to the post-mortem.
- 15.1.5. Ensure the family are fully informed and given appropriate support at all stages.
- 15.1.6. Take a lead role at the local case discussion.
- 15.1.7. Agree with attendees, at the local case discussion, the written documentation, which will be distributed to all relevant professionals, including the Coroner. The documentation will also be sent to the Child Death Overview Panel.
- 15.1.8. Arrange to meet with the family to explain the outcome of the local case discussion meeting, including the cause of the child's death and prepare as

necessary for the family a written report in language which is understandable to them. Alternatively there may be an arrangement for the family GP to meet with the family.

- 15.1.9. Liaise with the Coroner as necessary in the organisation and conduct of the inquest.

15.2 Breaking the news of the child's death and what to tell parents

- 15.2.1. The Consultant Paediatrician/Consultant in charge should find a quiet room and give his/her bleep to another doctor. The attendant nurse should be asked to accompany the Paediatrician.
- 15.2.2. The Consultant Paediatrician/Consultant in charge must know the name and sex of the child and when talking about the child use his/her name.
- 15.2.3. A long time should not be taken in telling the parent/s the child has died as they will probably have presumed this already.
- 15.2.4. Where the child was brought in dead the parent/s will need to be told that it was not possible to do anything that would have brought their child back to life.
- 15.2.5. Where resuscitation was attempted an explanation should be given to the parents about what was done to try to save the child, and why resuscitation was stopped.
- 15.2.6. The Consultant Paediatrician/Consultant in charge should talk slowly, leaving pauses for the parent/s to take in what is being said, to ask questions or to have a cry. These early moments of grieving are very important. The parent/s questions should be answered and they should be given whatever explanations are available.
- 15.2.7. The parent/s should be told that the Coroner and the Police must be involved and that this is routine practice.

It should be gently explained to the parents that a post-mortem has to take place to find out whether there is an identifiable cause of the child's death and what a post-mortem involves. The parents need to know where the post-mortem will take place and what will happen afterwards.

- 15.2.8. The parent/s should be told about the local case discussion meeting, attended only by professionals, which will take place generally after 8-12 weeks when the full post-mortem results are known. The parent/s should be told the purpose of the meeting is for the professionals who have been involved with their child to consider the possible cause and any contributory factors to the death. The parents will be given information after the meetings probably via the GP or Paediatrician.
- 15.2.9. An explanation should be given to the parent/s about the need to take routine specimens from the child's body, which need to be taken as soon as possible. The parent should be told why these investigations are necessary, how the specimens will be taken and asked to give their consent.
- 15.2.10. The Consultant Paediatrician showing great sensitivity should give the parent/s the opportunity to consider donating the child's tissues or organs for research.

15.3 Examination of the dead child

- 15.3.1. It is essential that this is done wearing surgical gloves, as a thorough inspection of the dead child is required.
- 15.3.2. Important areas to include are the scalp, the frenulum and palate, anus and genitalia.
- 15.3.3. Any external injuries, marks, rashes, bruising, petechia or staining must be accurately documented on the body chart and photographed if possible with a tape measure in the picture.

- 15.3.4. The site and route of any intervention during resuscitation, for example venepuncture marks and intra-osseous needle insertion need to be carefully recorded.
- 15.3.5. The skull should be palpated for fractures or bogging and the fundi examined for retinal haemorrhages.
- 15.3.6. The child's general state of cleanliness should be noted, including the state of the fingers and toes.
- 15.3.7. An impression of the child's state of nutrition should be recorded.
- 15.3.8. Full growth measurements: an accurate weight, length and head circumference should be taken where the child is an infant and plotted on the centile charts.
- 15.3.9. The child's temperature should have been recorded on admission, using a low reading thermometer if necessary.
- 15.3.10. Any signs of illness should be recorded.

15.4 Information to be collected by the Paediatrician/Consultant in Charge

- 15.4.1. In an ideal situation the Consultant Paediatrician/Consultant in Charge should collect the following history. It is acknowledged that with extremely distressed parents, this may not always be possible.
- 15.4.2. The following list of questions is meant as a guide and will depend on the age of the child and circumstances of the death. However as most unexpected deaths occur in infancy the questions principally relate to this age group. It cannot be comprehensive, as additional specific questions may arise as a consequence of information given by

the parents.

15.4.3. Encouraging the parents to talk spontaneously, with prompts about specific information, is likely to be better than trying to collect a structured history in the more usual way. In recording parents' accounts of events, it is important to use their own words as far as possible.

15.4.4. Much of the information being asked for is very sensitive. Parents may feel very vulnerable when asked about their sleeping arrangements, alcohol intake or drug use, so great skill is needed in asking the questions in a non-threatening way, with no implication of value judgment or criticism. Parents may ask directly if their alcohol intake has contributed to the child's death; it is very important that the Paediatrician does not jump to conclusions about such questions, whilst not being dishonest when asked direct questions.

15.5 The child

- First name and family name (plus any other names by which the child may be known).
- If possible, obtain the NHS number as this may facilitate access to other records.
- Date of birth and place of birth.

15.6 The mother/carer

- Full name (plus any other names by which the mother may be known).
- Full address, including postcode.
- NHS number if possible.
- Date of birth.
- Phone number (home number and mobile number) and phone number of any available close relative or friend (to facilitate making contact again).

15.7 Address to which mother will be returning when she leaves the hospital, plus phone number there and the name of the person with whom mother will be

staying.

15.8 The father and or mother's partner

- Full name (plus any other names by which the father/partner may be known).
- Full address, including postcode.
- NHS number if possible.
- Date of birth
- Phone number (home number and mobile number) and phone number of any available close relative or friend (to facilitate making contact again).
- Address to which father/mother's partner will be returning when he/she leaves the hospital, plus phone number there and the name of the person with whom mother will be staying.

15.9 Other members of the household (present and in the recent past)

- Names
- Dates of birth
- Relationship to the child who has died.

15.10 Family/Medical/Social History

- Take a detailed account of past medical and social history of all members of the immediate family and household where clinically indicated.
- Make details notes about any deaths in infancy or childhood of any offspring, siblings or other close relatives of any member of the current household. (To include as much information as possible concerning date of birth, age of death, place of death, cause of death and any other known information).
- Information on recent changes in composition of the household (e.g. who has come and who has gone, and for what reasons).

15.11 Detailed obstetric history of mother where an infant dies

- Where an infant has died a detailed past obstetric history is important.

15.12 Detailed medical and developmental history of the child

Bullet points 1-7 are only applicable to infants/young children

- Gestation
- Birth weight
- Perinatal or neonatal problems
- Type of feeding (and date and reason for changing type of feeding).
- Growth, development and past assessments (e.g. health visitor or GP, well-baby checks)
- Immunisations.
- If possible, obtain the parent-held child health record to copy (return this to the parents after copying it); plot the weight record onto a centile chart.
- Any known contact with infection?
- Medication (either prescribed or over the counter).
- Past medical history including any Consultant the child may be seeing or have seen previously.

15.13 With the death of an infant details of the baby in the 2 weeks prior to the death and within 48 hours of being found dead

- **Within 2 weeks:**
 - Changes in feeding or sleeping patterns?
 - Changes of places of sleep?
 - Changes in individuals responsible for providing care to the baby?
 - Any social, family or health related changes in routine practice over the past two weeks?
 - Any illness, accident or other major event affecting other family members in the past two weeks?

• Within 48 hours:

- Precisely where the baby was placed for sleep?
- Duration of sleeping period?
- Position at the end of the sleeping periods?
- Any changes in routine care or routine activity levels?
- Any disruptions to normal patterns?
- Information on the activity and location of all significant members of the household?
- Information on alcohol intake and recreational drug use by members of the household during this period?

15.14 The Final Sleep – applicable to infants

- The nature of the surface (e.g. bed, sofa)?
- Clothing?
- Bedding?
- Arrangement of bedding?
- Precise sleeping position?
- Who was sharing the surface on which the baby was sleeping?
- How often the baby was checked?
- When he or she was seen or heard?
- The times at which the baby awoke for feeds?
- Whether feeds were given and whether they were taken well?
- Who else was in the room at each stage?
- What were the activities of others in the room?
- Were they awake?
- Where, when and by whom was the baby found?
- What was the appearance of the baby when found?
- What was the position of the baby when found?
- Where was the bedding?
- Were there any covers over the baby?

- Had the covers and the position of the covers moved?
- Were there other objects in the cot or bed adjacent or close to the baby (e.g. teddies, dolls, pillows)?
- Was the heating on?
- What type of heating was there?
- Were the windows and/or doors open?

15.15 Action after the baby or child was found

- When, how and by whom the emergency services were called?
- Who was with the child at each stage?
- Was resuscitation attempted and if so by whom?
- Were any responses obtained from the child?
- How long did it take for the emergency services to arrive?

15.16 Further specific questions

In addition to the information outlined above, information, as appropriate should be collected on the parents' perception of:

- Whether the child was feeding/eating as well as, or less well, than usual in the past 24-48 hours?
- Any vomiting?
- Any respiratory difficulty, noisy breathing, in-drawing of the ribs, wheezing or stridor?
- Excessive sweating?
- Palpitations?
- Chest pain?
- Skin rashes?
- New food intake? (? allergy)
- Unusual activity?
- Unusual behaviour?
- Level of alertness?
- Difficulty sleeping?
- Difficulty waking the child?
- Passage of stools and urine? (how often and how much)
- Were any healthcare professional consulted within the past 2 weeks, the past 48 hours or the past 24 hours?

- If so, who was contacted, what was the problem described to the healthcare professionals and what advice was given?
- Was the child seen and assessed by any healthcare professional during the past 2 weeks?

15.17 Consider also:

- Deliberate self harm.
- The use/availability of prescription/non prescription drugs within the home and their ingestion.
- The abuse of alcohol.

15.18 Information to be sought specific to accidents

Road Accidents:

In cases of road accidents the following information should be sought depending on the nature of the accident:

- What happened?
- Where the incident took place?
- Time of day.
- Other persons present.
- Mode of transport of child?
- Other vehicles involved?
- Approximate speed of vehicles involved?
- Type of road?
- Weather conditions?
- Child restraint use and type?
- Position of child in the vehicle?
- Was the child wearing protective gear?
- Other passengers and details of their injuries?
- Account from the emergency services?
- Was child responsive at the scene?

Other Accidents

Questions should include:

- Type of incident (fire, fall, drowning, poisoning, etc)
- Where incident took place
- Time of day?
- Other persons present?
- Level of supervision?
- If a fall the height of the fall and the type of surface?
- Who witnessed event and their account of the incident?
- Other people injured?
- Account from Emergency Services?

15.19 At the end of the interview

- 15.19.1. At the end of the interview, it is essential that the Paediatrician/Consultant in charge spends some time with the family ensuring they know what will happen next, when they will next be contacted by the Consultant, when and where the post-mortem will take place, and how they will be informed of the preliminary results.
- 15.19.2. The Consultant should tell the family about the local case discussion, which will take place after 8-12 weeks when the full post-mortem results should be available. (See 14.2.8).
- 15.19.3. Time must be allocated for the Paediatrician/Consultant in charge to help the parents deal with the very powerful emotions that are commonly brought out during the interview. If conducted sensitively and with awareness of the parents' needs, this interview can have a therapeutic 'debriefing' value for the family. (*Kennedy Report, September 2004*)

15.20 Concerns that the death may not have been natural

- 15.20.1. If concern arises at any point that the death has not been a natural one, this information must be immediately

relayed to the Police, who will decide on the appropriate action. Great care needs to be taken in these circumstances not to undermine the Police investigations whilst remaining sympathetic to the parents/family's needs.

15.21 Routine investigative samples to be taken immediately after the child's death (see Section 13)

- 15.21.1. The samples taken must be those that the Coroner has given permission can be taken.
- 15.21.2. In the case of infants the dates on 'SUDI' kit boxes (one for haematology and one for microbiology) must be checked prior to use.
- 15.21.3. The site from which all samples are taken must be recorded.
- 15.21.4. All samples taken must be documented, labelled and the 'chain of evidence' maintained.

15.22 Additional samples which may be carried out by the Paediatrician to prevent delay:

- 15.22.1. Skin Biopsy for fibroblast culture.
- 15.22.2. Muscle Biopsy if history suggestive of mitochondrial disorder.

15.23 Further Investigations

- 15.23.1. **A skeletal survey** should always be carried out on children 0-5 years. This should be commented upon by a Radiologist prior to the post-mortem taking place. (Where abnormalities are detected the X-rays will need to be sent to a Paediatric Radiologist for comment).

16. Coroner

- 16.1 The Coroner should:
- 16.2 Ensure that the investigation of unexpected child deaths has a proper balance between medical and forensic requirements.
- 16.3 Agree standard investigative samples in advance, in line with the investigations described in this protocol so that specific approval on each occasion is not needed.
- 16.4 Ask to be provided with a full history as obtained at the home visit by the Investigating Police Officer.
- 16.5 Ensure that where maltreatment is suspected a Paediatric Pathologist and Forensic Pathologist undertake the post-mortem jointly. If necessary ensuring the child is transported to an appropriate specialist centre for the post-mortem.
- 16.6 Ensure that where there is no suggestion of maltreatment that the post-mortem is undertaken by a Paediatric Pathologist or if unavailable a Forensic Pathologist.
- 16.7 Make a copy of the post-mortem report available to the Consultant Paediatrician and (if there are no suspicious circumstances) give the Paediatrician permission to discuss it with the parents.
- 16.8 Authorise and ensure that parents are informed that tissue blocks and slides are to be taken at post-mortem examination and seek the wishes of the parents in respect to their wishes regarding retention or disposal of these once the coroner's duties are completed.
- 16.9 Ensure that parents are informed about any further bodily material that has been retained after the initial post-mortem examination, for how long it is likely to be required and the purpose of this retention. Options for the retention/disposal of retained tissue once the Coroner has completed his duty should be discussed with parents.
- 16.10 Within the scope of the Coroners' Rules, stipulate and authorise the period for which further bodily material should be retained and convey this information to the pathologist.
- 16.11 Ensure the child's body is released for burial or cremation as soon as possible.
- 16.12 Other than where there are clear natural causes immediately recognisable at post-mortem (and a certificate of the cause of death can therefore be issued immediately), hold an inquest following every unexpected child death and schedule the inquest as expeditiously as possible.
- 16.13 At inquest, take account of the report of the local case discussion meeting.
- 16.14 Avoid the term "unascertained" as the final registered cause of death. In the case of an infant death if the death meets the international criteria for sudden infant death syndrome (SIDS) that is the term that should be the registered cause of death.
- 16.15 Hold the inquest in private if this is possible and not against the public interest.

17. The Coroner's Officer

- 17.1 The Coroner's Officer should:
- 17.2 Visit the family as necessary, treating them with sensitivity and keeping them fully informed about all the procedures that are taking place.
- 17.3 Help the family with practical arrangements.
- 17.4 Where an inquest takes place explain to the parents what happens and let them know that they can take a friend, and ask questions.
- 17.5 Attend the local case discussion where relevant and the Coroner is in agreement.

18. Pathologist

- 18.1 Where maltreatment is suspected a Paediatric Pathologist and Forensic Pathologist should undertake the post-mortem jointly. If necessary the child will need to be transported to an appropriate specialist centre for the post-mortem.
- 18.2 The Pathologist must ensure that an adequate history is available before starting the post-mortem.
- 18.3 Also that a full skeletal survey has been carried out. (Mandatory re children 0-5 years). The skeletal survey should be commented upon by a Radiologist, preferably with recent experience and training in paediatric radiology, before the post-mortem examination is conducted. Where abnormalities are detected a Paediatric Radiologist will need to report on the skeletal survey.
- 18.4 In the case of sudden unexpected infant deaths the Pathologist must follow the recommended protocol for SUDI post-mortems (See '*Kennedy Report*' Appendix III). The phrase "unexpected pending further investigation" should be used initially unless a clear and sufficient natural or unnatural cause for the death has been identified.
- 18.5 The Pathologist must inform the Coroner (and ensure the family is informed) about what bodily material has been retained, if retention of whole organs is necessary for further investigation, and whether the organ (e.g. the brain) can be returned to the body in a week or so after fixation and sampling.
- 18.6 When criminal proceedings are likely, the Pathologist must ensure that retention of adequate tissue or organ samples (e.g. the whole brain) is discussed with the Coroner and that, if such retention is considered necessary, the sample is made an exhibit so that its retention is covered by The Criminal Justice Act 2003.
- 18.7 The Pathologist must agree the release of the child's body for funeral as soon as possible, consistent with conducting an appropriate and thorough examination.
- 18.8 The Pathologist must ensure that the findings are explained to the parents (with the Coroner's permission). This is normally done by the Consultant Paediatrician.
- 18.9 Where able the Pathologist should attend the local case discussion meeting.
- 18.10 If the samples are not to be retained for criminal proceedings. The Pathologist must ensure that the wishes of the parents as to the retention/disposal of any tissue (including blocks/slides) are carried out once the Coroner's duties are complete.

(*'Kennedy Report*' September 2004)
(Working Together to Safeguard Children, HM Gov. 2006)

19. Post-mortem Examination

- 19.1 The post-mortem examination will be ordered by the Coroner, and should be carried out within 48 hours of the child's death whenever possible. A Pathologist with recent expertise and training in Paediatric Pathology should preferably always undertake the post-mortem.
- 19.2 The nature and purpose of a post-mortem must be explained to the parents in understandable terms and they should be given a copy of the NHS leaflet on the post-mortem examination ordered by the Coroner. It is important that the family know where the post-mortem will be carried out, what the appropriate timescale will be and when they will be able to see their child again.
- 19.3 If significant concerns have been raised about the possibility of neglect or abuse having contributed to the child's death, the Paediatric Pathologist should be accompanied by a Forensic Pathologist and a joint post-mortem procedure should be followed. If at any stage during a post-mortem, in the absence of a Forensic Pathologist, the Paediatric Pathologist becomes concerned that the death may be a consequence of abuse, the procedure must be stopped. The examination should recommence as a joint procedure by the Forensic Pathologist together with the Paediatric Pathologist, in the presence of the Investigating Police Officer or other designated police representative.
- 19.4 Prior to commencing the post-mortem examination, the Pathologist should be fully briefed on the history and physical findings at presentation by the Paediatrician, and the findings of the death scene investigation by the Investigating Police Officer. Where a video recording at the death scene has been made, it is very helpful for the Pathologist to view the video and discuss it with the Paediatrician and Police Officer prior to commencing the post-mortem examination. Photographs of the child that may have been taken at presentation or in the Accident & Emergency department should also be made available.
- 19.5 A full radiological skeletal survey should be available, reported on by a radiologist preferably with some paediatric training and experience.
- 19.6 The preliminary results of the post-mortem examination should be discussed by the Pathologist, the Consultant Paediatrician and the Police Investigating Officer, as soon as possible (usually within 48 hours of the initial post-mortem examination) and the Coroner should be immediately informed of the initial results. If the initial post-mortem findings suggest evidence of neglect or abuse as a cause of the child's death, the Police Child Abuse Investigation Unit and Children's Social Care should immediately be informed and further investigations set in process.
- 19.7 If the initial post-mortem findings do not identify grounds for suspicion of an unnatural death, then no further Police or Children's Social Care investigation is likely to be necessary at this stage and the Consultant Paediatrician will communicate the preliminary findings of the post-mortem to the primary care team and the family. This will almost always involve a discussion with the family and GP a few days after the post-mortem to pass on this preliminary information. The Paediatrician must always confer with the Police prior to

passing on to the family the preliminary findings of the post-mortem.

investigations should be set in motion, including the requirements of the Police and Criminal Evidence Act, 1984

- 19.8 At the post-mortem examination, tissue blocks, other specimens and frozen samples will be taken according to a standard protocol (*'Kennedy Report'*) and other samples will be taken as deemed necessary by the Pathologist in order to ascertain the cause of death. Whole organs will not routinely be retained, but when this is deemed necessary by the Pathologist, the Coroner and the family must be informed, and the family given the opportunity in due course for return of such samples to the body if appropriate. This applies particularly to the brain. If parents have requested that tissues or organs be donated for therapeutic or research purposes then, with the consent of the Coroner, such additional tissues or organs may be retained by the Pathologist. As part of the explanation about the post-mortem examination given to the parents, the Paediatrician must explain that tissue blocks including frozen samples and slides will be taken and will be retained permanently as part of the pathology records, but that other larger tissue samples or whole organs will not ordinarily be retained. At this time, the Paediatrician should also give the parents the opportunity to donate tissues or organs for therapeutic or research purposes, as set out in the NHS information booklet on post-mortem examinations ordered by the Coroner. NHS information booklet on post-mortem examination ordered by the Coroner. Parents wishes as to retention/disposal of all materials must be sought.

'Kennedy Report' September 2004.

- 19.9 If findings emerge during the post-mortem that clearly identify neglect or abuse as the most likely explanation for the death, the Police will become the lead investigating agency and the provisions of normal criminal

20. Local Case Discussion

20.1 Local case discussion meetings are to be held for all unexpected deaths of children. (*Working Together to Safeguard Children*, HM Gov. paragraph 7.5).

20.2 Local case discussions are to be held when the final post-mortem results are known which is generally 8-12 weeks after the death. A local case discussion will be held later when an inquest takes place.

20.3 Attendees:

20.3.1. Those involved in investigating and managing the death eg:

- Ambulance staff
- Accident & Emergency staff
- Hospital ward/unit staff
- Paediatrician
- Pathologist
- Police
- Coroner's Officer
- Social Worker

20.3.2. Those who knew the child and family eg:

- GP
- Health Visitor/School Nurse
- Social Worker
- School teacher/counsellor
- Children's community nurse

20.3.3. Attendees to the meeting will be asked to provide information about the child/family

20.4 Purpose of the meeting:

- To share information so as to consider the possible causes of the death and consider any factors which may have contributed to it.
- To explicitly discuss the possibility of abuse or neglect.
- To plan any necessary future care for the family and agree how information from the local case discussion will be

- shared with the parents/carers.
- To identify potential lessons to be learned.
- To make any recommendations as appropriate.
- To inform the inquest.

20.5 Families will not be invited to the meeting. However the parents must be fully informed of the outcome of the meeting, this will normally be at a separate discussion with the Consultant Paediatrician or GP.

20.6 Where the Pathologist is not able to be present at the local case discussion the results of the post-mortem should be conveyed verbally to the Consultant Paediatrician attending the meeting.

20.7 After the meeting the Consultant Paediatrician, who dealt with the death, in close liaison with the Pathologist should write a detailed report concerning the cause of the infant's death as a letter to the parents.

20.8 Arrangements should be made for the Consultant Paediatrician and/or GP, (perhaps jointly with other professionals,) to see the parents to explain the findings of the local case discussion, to answer any questions and discuss plans for any future additional care and support that may be appropriate for the family. The question of further investigation of family members or subsequent children for metabolic or other familial disorders should be discussed as appropriate.

20.9 A copy of the documentation from the local case discussion should be sent to attendees of the meeting. In addition the documentation will be sent to the Child Death Overview Panel and to the Coroner.

21. Child Death Overview Panel

21.1 From April 2008 it became statutory for all Local Safeguarding Children Boards (LSCBs) to establish processes for all child deaths (0-18 years).

21.2 'Working Together to Safeguard Children' HM Gov. 2006, paragraph 7.45 states an overview of all child deaths in the Local Safeguarding Children Board (LSCB) areas will be undertaken.

21.3 The four LSCBs in Teesside, Middlesbrough, Hartlepool, Stockton-on-Tees & Redcar & Cleveland share a Child Death Overview Panel (CDOP). Tees CDOP will be accountable to Redcar & Cleveland LSCB, however will have direct links with each of the LSCBs.

21.4 Membership:

Core membership will include:

- A Consultant Paediatrician
- Director of Public Health
- Child Health Nurse
- Midwife
- Police
- Children's Social Care representative
- Education representative
- Bereavement Counsellor
- LSCBs Child Death Review Manager
- Plus extra *ad hoc* expertise as necessary

21.5 Functions of the Child Death Overview Panel include:

21.6 Considering the documentation from local case discussions, together with the core data sets.

21.7 Scrutinising the recommendations from local case discussions, and approving those to be passed on to the relevant LSCB(s) for implementation.

21.8 Analyse any common themes arising from the local case discussions.

21.9 Referring a case to the Serious Case Review Committee where appropriate. (*This would only be in a very exceptional case where child protection issues were not identified earlier*).

21.10 Collaborating with the Regional Maternity Survey Office to audit the timeliness and effectiveness of local case discussions.

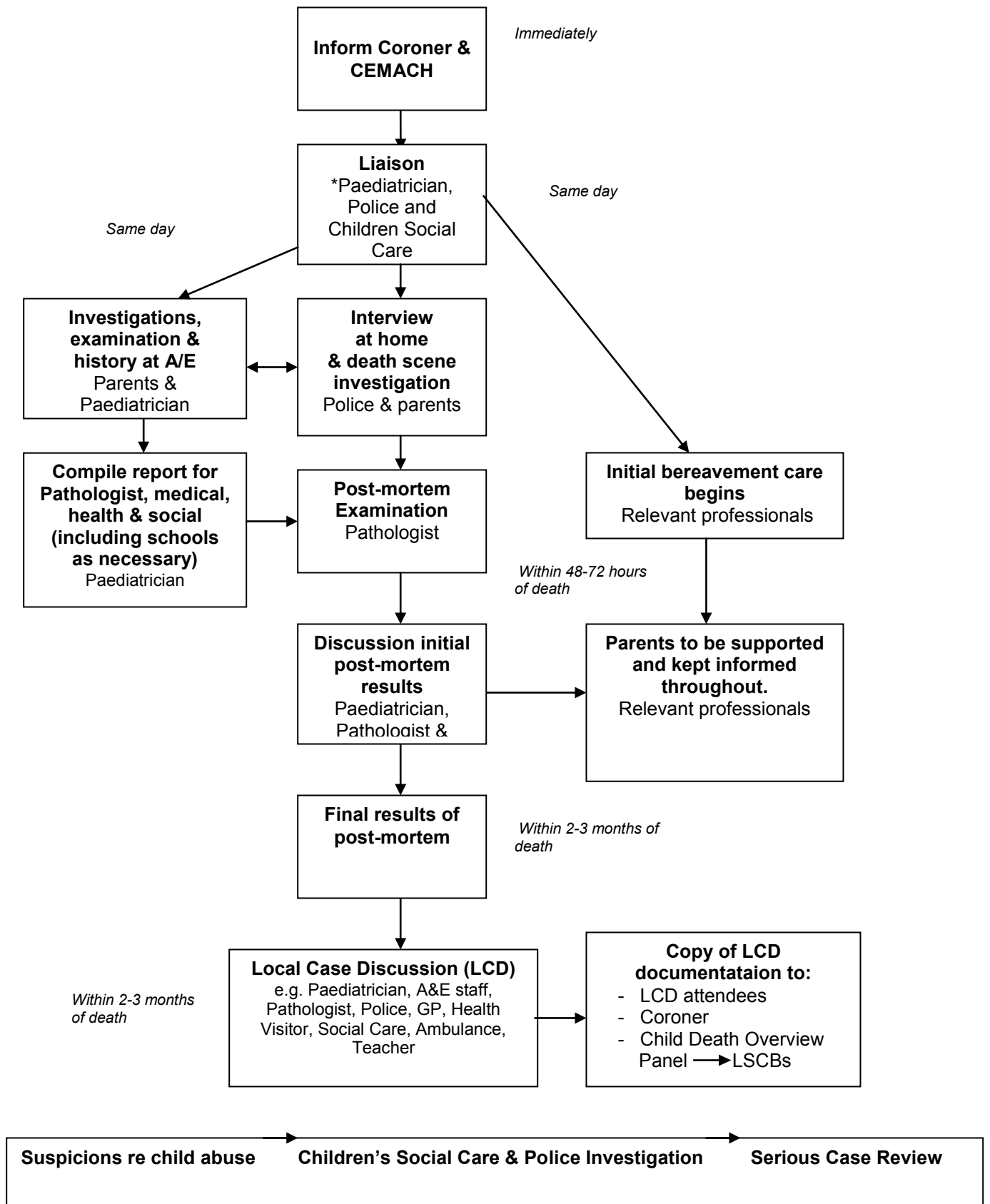
21.11 Synthesising, from time to time, recommendations based on the themes identified in scrutiny of the deaths.

21.12 Producing reports, annually and perhaps quarterly, relating to the area(s) it covers, for presentation to the relevant LSCBs.

21.13 LSCBs

21.13.1. The LSCBs will use the information from child death reviews to inform local strategic planning on how best to safeguard and promote the welfare of children in their area.

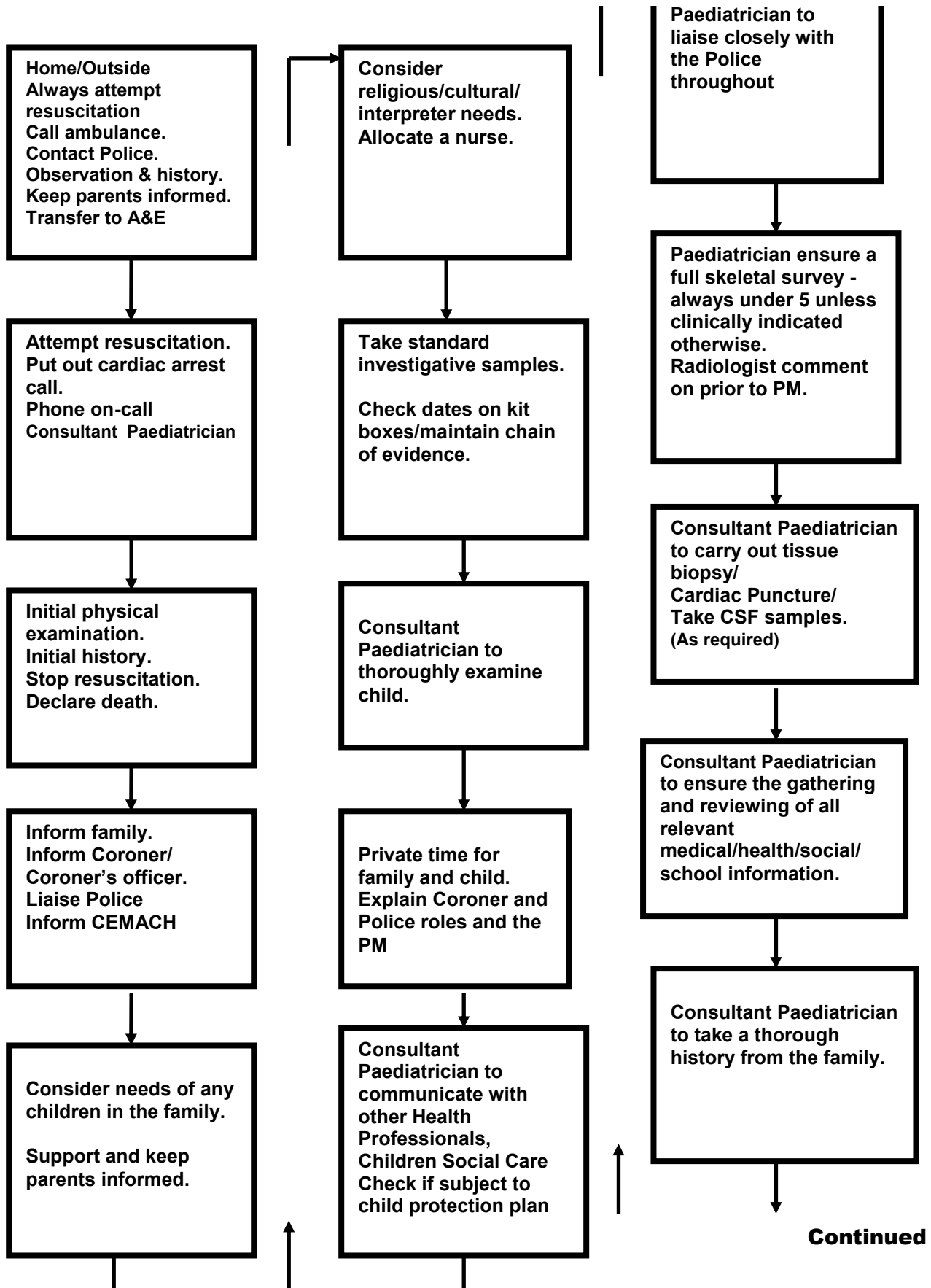
Figure 1 - Multi-agency approach to Unexpected Deaths in Childhood



*Consultant paediatrician/Consultant in charge depending on child's age

Figure 2

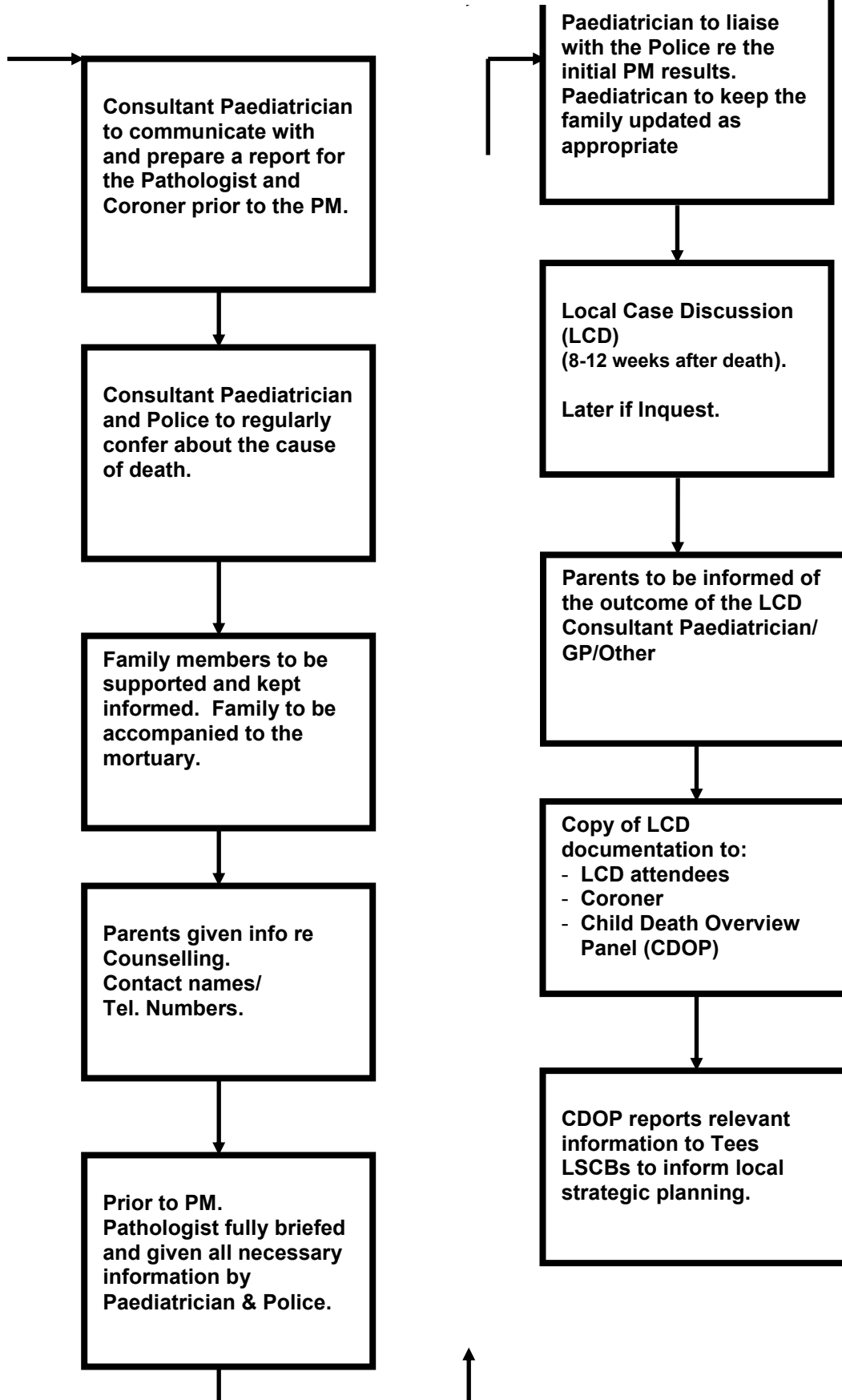
Unexpected Deaths – Quick Guide



Continued

* Consultant Paediatrician to read Consultant in charge where an older child/young person

Unexpected Deaths – Quick Guide



Appendix 1

The Human Tissue Act

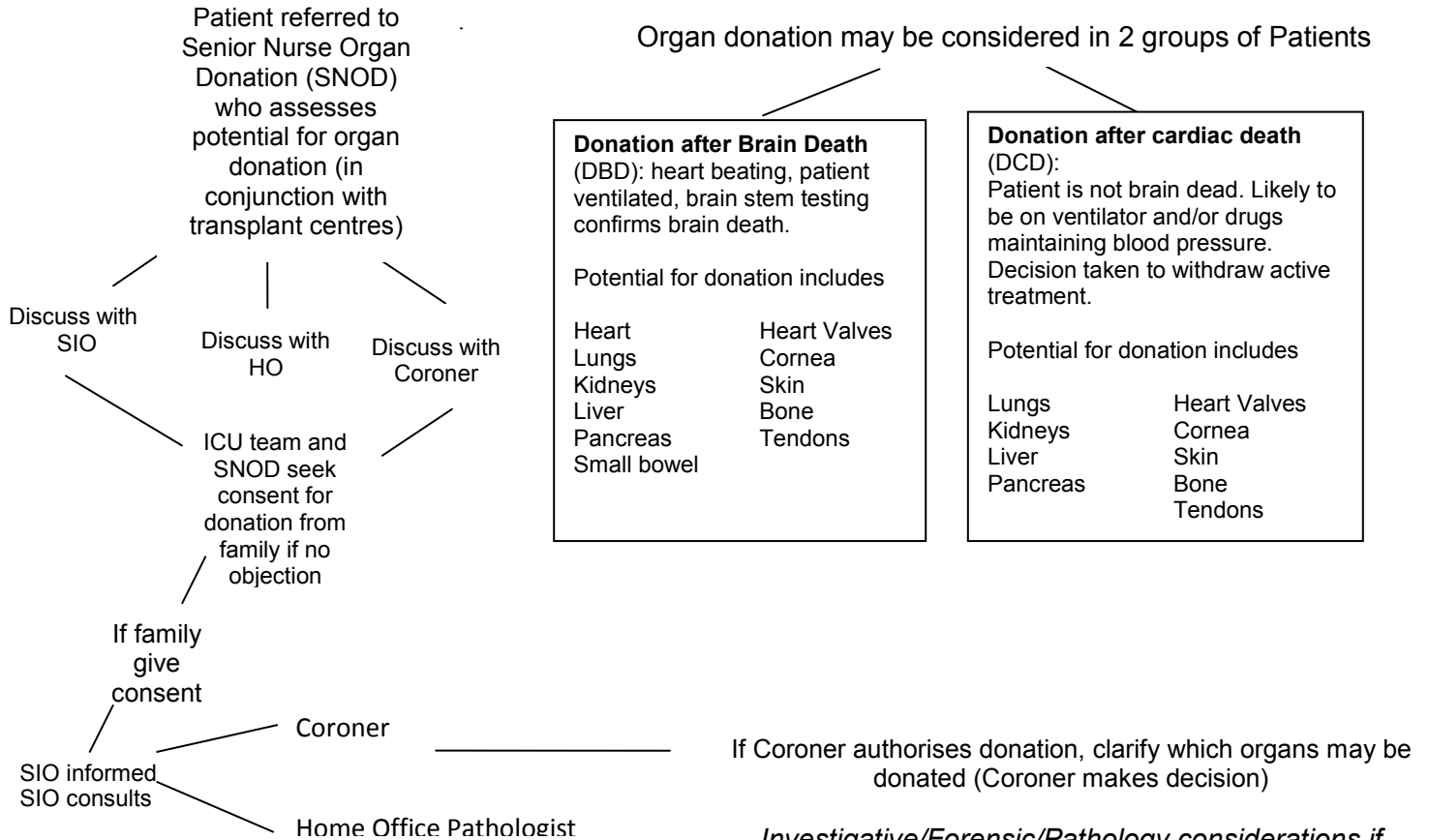
1. The Human Tissue Act (HT Act) 2004 came into force in September 2006 and established the Human Tissue Authority (HTA) to regulate activities concerning the removal, storage, and use of human organs and tissue from the living, and the removal, storage and use of tissue and organs from the deceased. The Authority has issued good practice guidance in statutory codes of practice <http://www.hta.gov.uk>
2. All post-mortem examinations, including those authorised by a coroner, and the removal of tissue from the deceased must be carried out on premises licensed by the HTA. This applies to mortuaries and other locations where tissue may be removed e.g. an Accident and Emergency Department.
3. Under the terms of the HT Act a post mortem examination and the removal and storage of relevant material to determine the cause of death do not require consent from the relatives if these activities have been authorised by the coroner. However, following the cessation of the coroner's authority, it is unlawful to use the retained material for a scheduled purpose set out in the HT Act, or to continue to store it with the intention of using it for a scheduled purpose, without appropriate consent if its retention is not covered by the Criminal Justice Act.
4. Under the Act the coroner must notify a relative who is a properly interested person of the options for dealing with the material once it is no longer required for the coroner's purposes. In the case of a child this will normally be the parents. These options are:
 - 4.1. lawful disposal of the material by burial, cremation or lawful means by the pathologist;
 - 4.2. return of the material to relatives to make their own arrangements; or
 - 4.3. further retention of the material with appropriate consent for use for medical research or other purposes.
5. Further information about these three options is set out in the code of practice on disposal of human tissue.
<http://www.hta.gov.uk/legislationpoliciesandcodesofpractice/codesofpractice/code5disposal.cfm>

Appendix 2

ORGAN DONATION IN SUSPICIOUS DEATH/UNEXPLAINED DEATH OR FATAL ROAD TRAFFIC COLLISION (RTC)

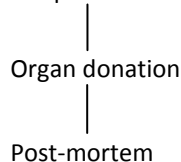
Suspicious/unexplained death/fatal RTC
(Patient in Intensive Care Unit (ICU), death either confirmed or anticipated)

Senior Investigating Officer (SIO) encouraged to contact ICU Consultant for discussion as soon as possible



Investigative/Forensic/Pathology considerations if donation is proceeding

- Pathologist to be given opportunity to examine victim before donation
- Consider photographs, examine injuries before donation
- Does Pathologist consider attendance in theatre to be necessary?
- Continuity between organ removal, transfer to mortuary and security of medical records to be addressed
- Documentation /records of transplant team re condition of organs.
- Ensure compliance with Human Tissue Act



Timescale for organ removal:
SNOD will be coordinating with organ retrieval teams and will update family/ICU and SIO as necessary

NB In cases where children are involved please note that Paediatrician Pathologists are not on call. The HO Pathologist will be in attendance in any event and will liaise with the Paediatrician Pathologist at the appropriate time

In patients who are dead and organ donation has not been possible, tissue donation may be considered

Unexpected deaths in childhood Workbook

**Taken from the Newcastle upon Tyne Hospitals
NHS Foundation Trust and with some
amendments made for use on Teesside**

Name of child:	Address:
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WORKBOOK

**For the investigation and management of
Acute life threatening illness and death in Infancy and Childhood
from 0 to 18 years *with discretion***

Name of child:	Date of Birth:
Address:	Date of Death:
	Hospital number:
	NHS number :
	Hospital:

What is in the workbook?

This workbook is designed to record all the relevant information relating to a childhood death: history, examination, and investigations. It contains reminders about acquiring certain important details that otherwise get forgotten, or are inconsistently recorded in unstructured records.

To whom does it apply?

With discretion the workbook can be applied to all unexpected deaths in children up to 18 years. Sudden and unexpected deaths in all children up to the age of 12 years, with discretion for it to be applied to children up to 18 years old. As most sudden and unexpected deaths occur in infancy, the format is slanted towards this age group. It may be a helpful tool in cases such as apparent life threatening episodes (ALTEs) and where resuscitation is successful, but it has not been designed for this.

Early neonatal deaths or fresh stillbirths from home deliveries should NOT be included in this workbook.

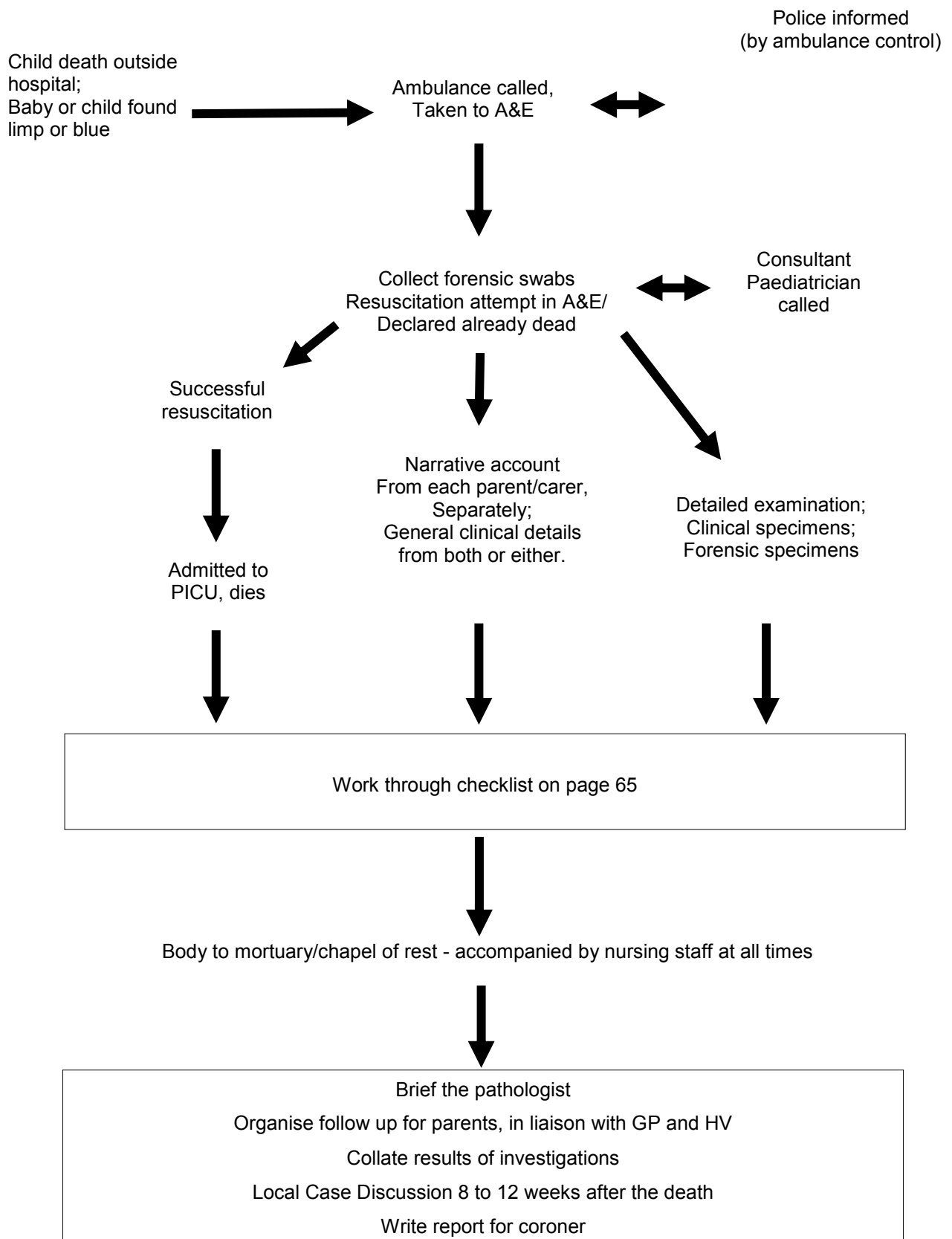
Principles

- Maintain a sensitive, open minded and balanced approach
- Share information between agencies
- Be appropriate to the circumstances
- Preserve evidence, in case there is a forensic dimension.

This workbook will form part of the clinical record and should ultimately be filed in the child's case notes. It should go with the body to X-ray and to the pathologist to give the history that is necessary for the interpretation of the autopsy.

Post-mortem Examination
Pathologist

Sequence of Events



SECTION 1

Part 1: Complete during resuscitation, usually by the nurse supporting the parents/carers

Name of person giving the history:

Relation to child:

Name of person recording history:
GMC Number:

Sig:

Designation:

Part 2: Complete after resuscitation is over, while samples etc are being taken

NB Ideally, take this description from each caregiver (eg mother and father) separately

First parent/carer: Narrative description of the events leading up to death

Record verbatim and use extra sheets as necessary

Name of person giving the history:

Relation to child:

Name of person recording history:

Sig:

Designation:

Names and status of others present:

Second parent/carer: Narrative description of the events leading up to death

Record verbatim and use extra sheets as necessary

Name of person giving the history:

Relation to child:

Name of person recording history:

Sig:

Designation:

Names and status of others present:

Immunisations:

Primary Course: 1. 2. 3. MMR: Yes No Preschool booster Yes No
BCG Yes No Other:

Developmental History:

Include ages of important milestones e.g. sitting, walking, speech.

School or Nursery:

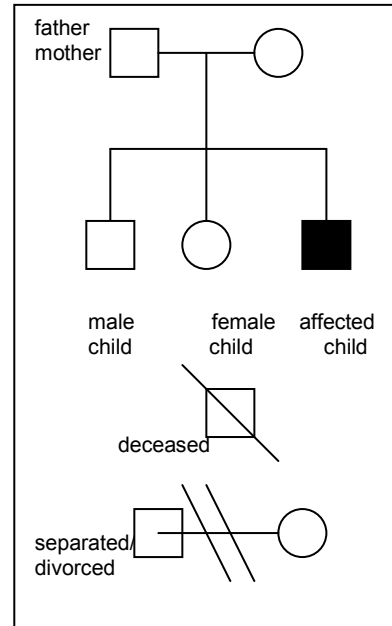
Name of school or nursery. Progress at school e.g. any special needs, Statement, behavioural issues.

Carers over the past seven days:

Any other relevant history:

SECTION 3: Family Information

Draw the pedigree (genogram) with children in age order, their names and dates of birth, with special note of any other child deaths:



Mother's full name	Age:	Date of birth:
Ethnic group	Religion	
Occupation		
Alcohol: regular (estimate units/day) Recent (within hours of the death):		
Smoking in pregnancy (amount)		
Smoking after birth of baby (amount)		
Maternal information (continued) Prescription drugs (note what and when):		
Over the counter self-medication (note what and when):		
Recreational drugs (note what and when):		
Maternal health, physical & mental:		

Full name of father, or other person with paternal responsibility if not the biological father:	Age:	Date of birth:
Ethnic group	Religion	
Occupation/employment		
Smoking (amount):		
Alcohol: regular (estimate quantity)		
Recent (within hours of the death)		
Prescription drugs (note what and when):		
Over the counter self-medication (note what and when):		
Recreational drugs (note what and when):		
Illnesses, Physical & mental		
Was father the partner at time of death?		

Other information

Other relevant history, including any other medications/drugs in the house
Extended family, availability of support, other dependent relatives
Does anyone in the house have contact with a social worker (specify)
Assessment of carers' behaviour & any other relevant information

SECTION 4: Examination

Remember to record all lesions, whether or not you think they are iatrogenic.

Measure any lesions & record the findings on body charts, pages 67-73.

Examine front, back and sides. Note the colours of bruises.

Arrange for clinical photographs of any lesions present, including those in the mouth.

Weight:

Length:

Head Circumference:

Record these on a centile chart. If possible, weigh an infant before sending for skeletal survey. State the source of the values you enter here. Add the centile chart to this record.

Rectal temperature:

Time:

General Inspection (cleanliness/debris/blood staining/etc) :

Hair and nails:

Nose:

Lip frenulum:

Palate (haemorrhage/petechiae):

Tongue frenulum:

Teeth/gums:

Head neck scalp:

Ears (pinna and drums):

Check all bones and joints for instability, fracture, crepitus or other evidence of trauma – list lesions here:

Abdomen:

Pubertal Rating (where applicable):

Genital Examination (also record any positive findings on the appropriate diagram)

Anal Examination (also record any positive findings on the appropriate diagram)

Eye Examination – to be filled in by ophthalmologist

Where the child is under the age of 2 a Consultant Ophthalmologist needs to examine the child's eyes as soon as possible and certainly within 4 hours of death so as to be able to see the retina.

X-ray examination (skeletal survey)

The skeletal survey should ideally be conducted within 18 hours of death. Discuss the timing with the duty radiographer and radiologist. The radiology must be reported before the post mortem.

Radiologist's report:

Radiographer name:

Sig:

Designation:

Date:

Time:

Radiologist Name:

Sig:

Designation:

Date:

Time:

SECTION 5: Clinical Investigations

See Section 13 of the Protocol for Unexpected Deaths in Childhood

SECTION 6: Forensic Investigations

See Section 13 of the Protocol for Unexpected Deaths in Childhood

Checklist of 'Things to Do'

Action	Date/time	Signature & Designation
Check if child subject to a child protection plan		
Inform Children's Social Care or Emergency Duty Team		
Request any notes of child/sibs		
Request duty ophthalmologist		
Clinical photography (if needed)		
Arrange skeletal survey		
Give parents a written note of the responsible Consultant Paediatrician's name, office address and secretary's phone number		
Inform Coroner		
Phone Health Visitor		
Phone GP		
Inform named nurse		
Inform named doctor		
Inform RMSO/CEMACH 0191 233 1658; voicemail out of hours		

Consultant Paediatrician Responsibilities

Overall:

- Attend the resuscitation if at all possible
- Be responsible for ensuring that appropriate information is captured to the best possible standard
- Be responsible for the subsequent care of the family

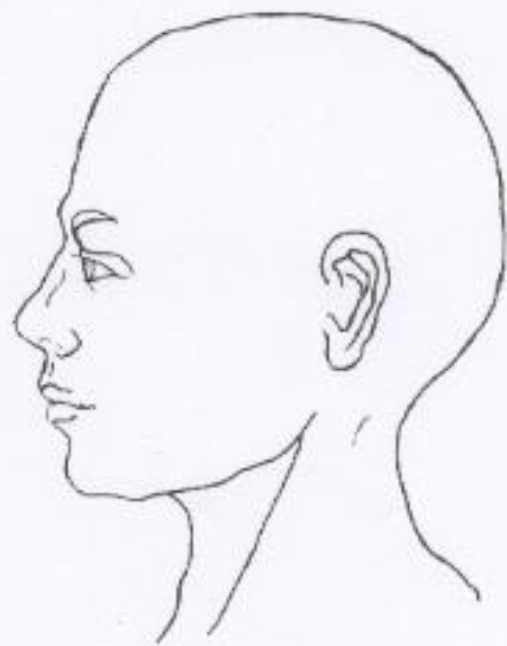
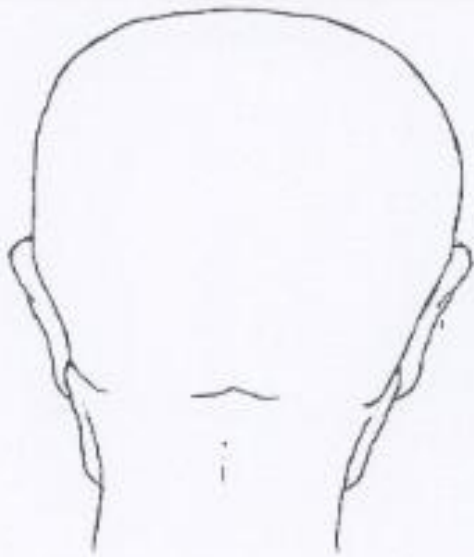
Specifically:

- Organise the acquisition of the narrative histories, and the other clinical details, in a structured manner on this form
- Ensure that appropriate forensic and clinical samples are collected and analysed
- Lead (whenever possible) the discussions with the parents, to explain the procedures and to arrange for follow up
- Ensure that other technical expertise such as ophthalmological examination and clinical photography are organised as appropriate
- Ensure that a skeletal survey is done
- Liaise with the pathologist, and ensure that the clinical documentation is available to the pathologist in time for the autopsy
- Collate the results of the investigations
- Liaise with the named doctor and named nurse for child protection
- Take a lead role in a local case discussion *for around 2 months after the death
- Write a report for the Coroner.

Possible optional extras:

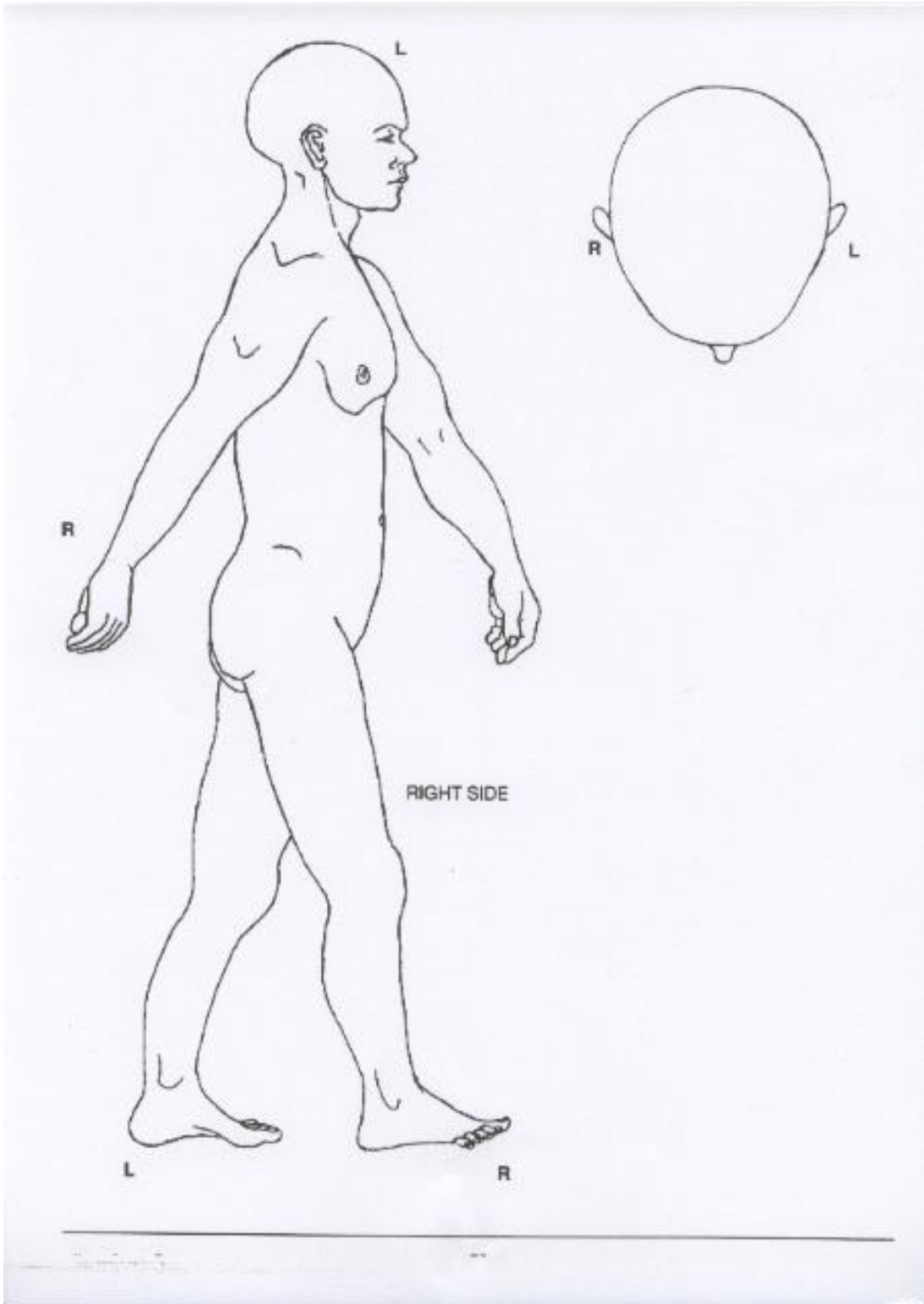
- Home visit (at which further aspects of history can be elucidated, and the scene of death inspected).

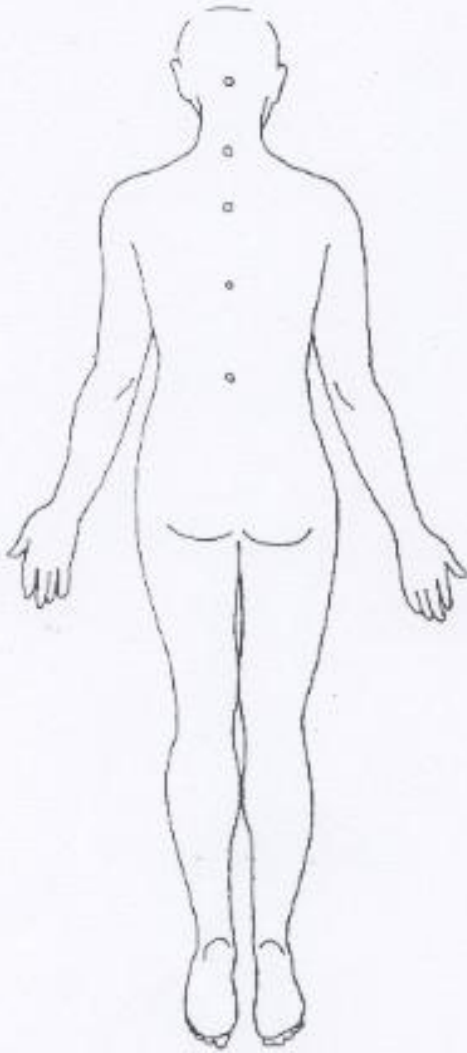


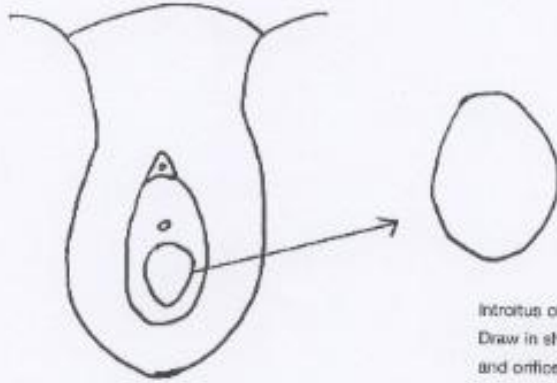


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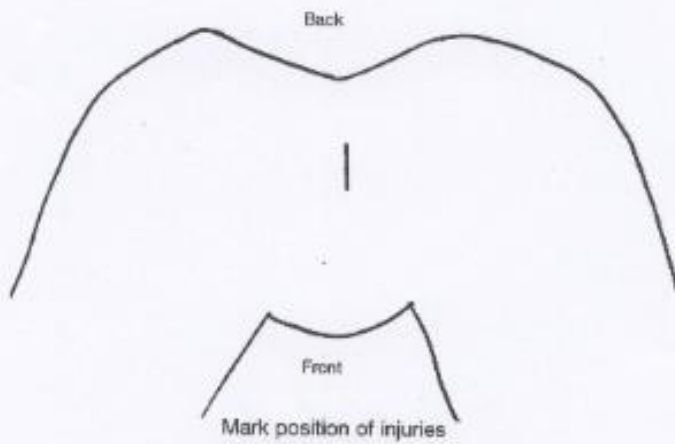






Introitus of vagina.
Draw in shape of hymen
and orifice and position of
tears.

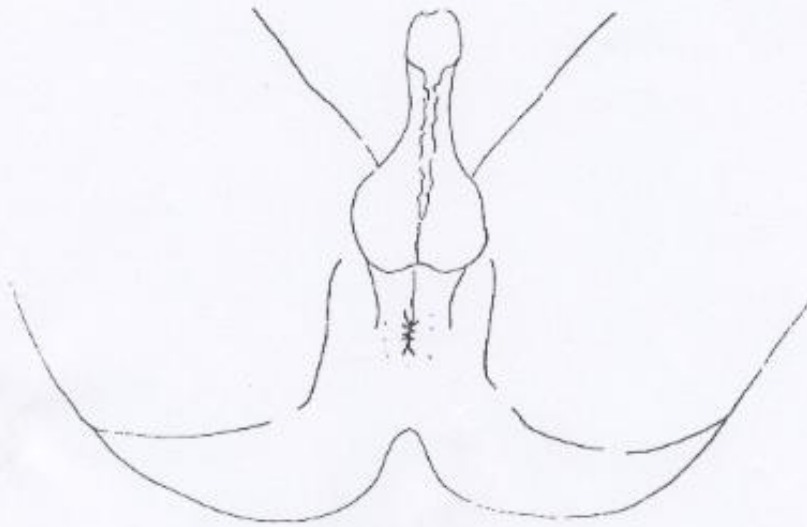
Diagram on which to indicate site of injuries

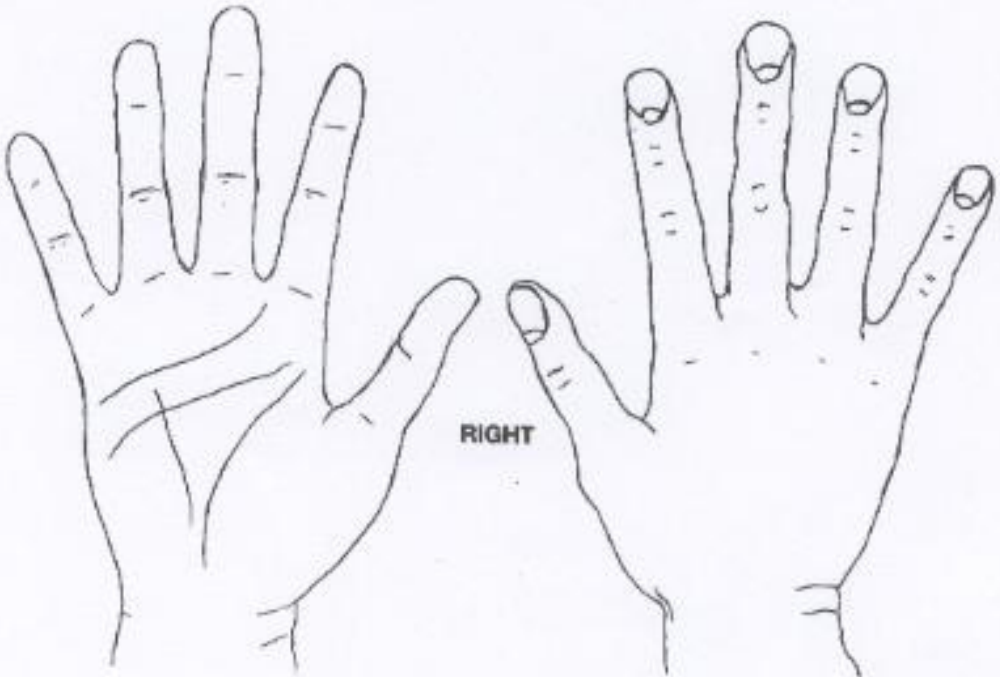


Back

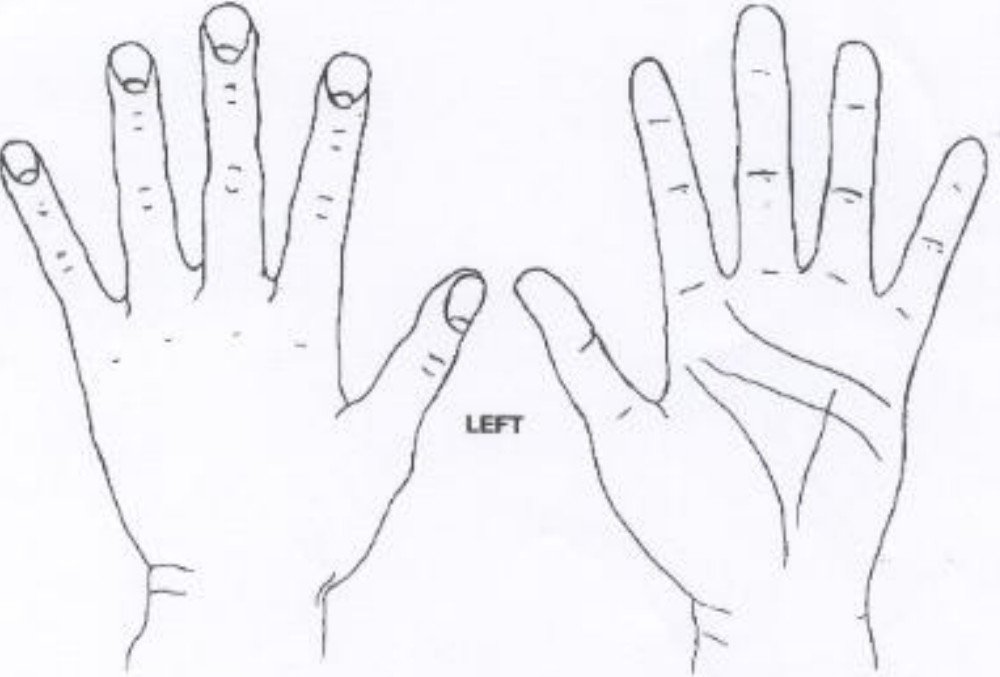
Front

Mark position of injuries





RIGHT



LEFT

SECTION 7

Checklist of Other Information that should be collated for the local case discussion

Paramedic/Ambulance	
A&E triage	
A&E (including any from adjacent A&E departments)	
A&E nurse, if separate	
Health visitor	
General Practice	
Pathologist	
School	
Children's Social Care	
Clinical entries and growth charts from the personal child health record booklet	
Existing hospital records, including other local hospitals	
Maternity or neonatal records, where relevant	
Report of autopsy	
Results of post-mortem investigations	
Relevant records from other agencies (please list below)	

Appendix 4

Counselling services for families following the death of a child include:

South Tees Hospitals NHS Trust

Divisional Bereavement Counsellor, Women and Children's Division
Tel: (01642) 854875

North Tees & Hartlepool NHS Trust

Bereavement Counsellor Tel: (01642) 617617 Ext. 4236

Teesside Hospice Counselling Service

For Bereaved adults aged 18+
For bereaved children age 5-17 (Forget Me Not Service)
Contact Counselling Department on 01642 296913

Butterwick Hospice

Bereavement Support Worker Tel: (01642) 607742

Hartlepool Hospice

Head of Bereavement Tel: (01429) 855550

Foundation for the study of infant deaths

FSID has a national network of befrienders, Tel: 0870 7870554

Further advice and support on responding to sudden infant deaths can be obtained via FSID's helpline on: 0870 7870554 or e-mail support@sids.org.uk. Support from FSID is available for clinicians/practitioners as well as bereaved parents.

Appendix 5

Contact Points

To be completed by each organisation.

Concerns about the family/carers:	
<p>Domestic violence within the household, extended family or likely carers of the child? If YES, give details including dates</p>	<p>YES <input type="checkbox"/> NO <input type="checkbox"/></p>
<p>Substance/alcohol misuse within the household, extended family or likely carers of the child? If YES, give details including dates</p>	<p>YES <input type="checkbox"/> NO <input type="checkbox"/></p>
<p>Mental or physical illness in the carers which may impinge on their ability to care for and protect the child adequately? If YES, give details</p>	<p>YES <input type="checkbox"/> NO <input type="checkbox"/></p>

Concerns about the child:	
<p>Have you any current concerns about the child? If YES, give details</p>	<p>YES <input type="checkbox"/> NO <input type="checkbox"/></p>

Name/address/contact details of professional:	Date form completed:	Signature