Pan-Cheshire Local Safeguarding Children Board (LSCB) Guidelines

(Cheshire East, Cheshire West & Chester, Halton and Warrington)

Pan-Cheshire Guidelines for The Management of Sudden Unexpected Death in Infants and Children (SUDIC)*

***(Children: Aged under 18)**

Version 2.1 - July 2015

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1. INTRODUCTION

1.1 All Local Safeguarding Children Boards (LSCBs) are required to have arrangements in place to review the reasons for all child deaths. This is done through the Child Death Overview Panel (CDOP).

1.2 This guidance provides a framework for the investigation and care of families after an unexpected death of an infant or child.

1.3 The guidance details a multi-disciplinary approach that will ensure to achieve:

- Sensitive care and support to all affected by the death.
- Preservation of evidence at the place of death.
- Full documentation of all interventions by paramedical and medical staff, including resuscitation prior to the certification of death.
- The completion of a full medical history by medical staff.
- A full review of all the medical records of the deceased.
- A paediatric pathologist (and if necessary a forensic pathologist) investigating the cause of death.
- A multidisciplinary case discussion.

1.4 This guidance should be used for the sudden and unexpected death of a child under the age of 18 years irrespective of place of death:

- At home or in the community
- In the hospital Emergency Department or in the Ward

1.5 It is essential that every professional involved in a Sudden Unexpected Death in Infants and Children (SUDIC) case must be fully aware of the guidelines and should keep meticulous records.

1.6 The sudden and unexpected death of any person demands the most thorough investigation of the highest standard. A sudden and unexpected death of an infant or a child (SUDIC) is no exception.

1.7 Unexpected death refers to the death of a child that was not anticipated as a significant possibility 24 hours before the death or where there was an unexpected collapse leading to or precipitating events that led to the death. This would also include unexpected death of a child with disabilities and/or chronic medical conditions (see *Working Together to Safeguard Children, 2015)*.

1.8 Factors in the environment, history or examination may give rise to concern about the circumstances surrounding the death. These SUDIC guidelines should be followed where non-accidental injury is suspected to have resulted in the death of a child.

1.9 PRINCIPLES

When dealing with sudden unexpected child death (SUDIC), all agencies need to follow common principles as follows:

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

Investigation of a SUDIC case is a multi-agency task and all the professionals who are involved in the case are inter-dependent for sharing of information with the proficient level of expertise. It is strongly advised that the text should be read as a whole and not just the section related to the reader's own particular role.

1.10 DEFINITIONS

1.10.1 Expected and Explained

Child expected to die and cause of death explained.
Example: A child with malignancy who dies in appropriate circumstances. **This guidance does not need to be followed in these circumstances**.

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

NB: "Form A – Notification of a Child Death" must be completed.

1.10.2 Expected and Unexplained

Child expected to die and the cause of death is not explained by the condition.
Example: A child with malignancy who dies earlier than is expected or in unexplained circumstances. Concerned clinician (General Practitioner, Consultant Paediatrician or the Emergency Department Consultant) is advised to discuss the case with the Coroner to decide as to whether a complete investigation is indicated as per the SUDIC guidelines.

NB: "Form A – Notification of a Child Death" must be completed.

1.10.3 **Unexpected and Explained**

Unexpected death of a child and cause of death explained.
Examples: Road traffic accident; Meningococcal Sepsis. **In these circumstances if a satisfactory explanation is determined then the SUDIC procedure need not be followed.**

NB: "Form A – Notification of a Child Death" must be completed.

1.10.4 **Unexpected and Unexplained**

Where there are no suspicious circumstances surrounding an unexpected death and no cause of death is identified at autopsy.
Example: Sudden Infant Death Syndrome. **(Follow SUDIC Guidelines)**

NB: "Form A – Notification of a Child Death" must be completed.

1.10.5 **A definition of preventable child deaths**
These are factors defined as those where if actions could have been taken through national or local interventions the risks of future child deaths could be reduced.

1.11 GLOSSARY OF TERMS

ALTE	Apparent Life Threatening Event
Child	A *child* refers to those aged over 12 months and under 18 years of age.
Child Protection Plan	A multi-agency plan for children identified as being at most risk of significant harm in the community. A social worker is always the lead professional for these children.
CONI	Care of the Next Infant
CSC	Children's Social Care
CPS	Crown Prosecution Service
CPT	Child Protection Team
Crime Manager	The senior police officer within a Police division in charge of Crime Investigation Department (CID).
ED	Emergency Department which is the preferred name of an accident and emergency department.
FLO	Police Family Liaison Officer
Forensic Pathologist	Home Office Pathologist (see below)
Frenulum	A fold of membrane that limits the movement of an organ. In these circumstances it means the upper lip unless otherwise specified. It may also be applied to the tongue or foreskin of the penis.
Form 92	Police Report on Sudden Deaths (East Cheshire)
Home Office Pathologist	A pathologist with special training as a forensic pathologist who is on the Home Office list of accredited forensic pathologists.
Infant	For the purposes of this document, the medical definition of 'infant' is a child of less than 12 months of age is used rather than the legal definition which is an individual under the age of 18 years.
CDOP	Child Death Overview Panel
SIO	Senior Investigating Officer (Police)
LSCB	Local Safeguarding Children Board
Post Mortem	This refers to the medical examination which happens after death. It is sometimes referred to as an 'autopsy'.
SIDS	Sudden Infant Death Syndrome
WTSC 2015	Working Together to Safeguard Children 2015

1.12 GENERAL CONSIDERATIONS

Following a death of an infant or child:

- No matter how brief your time with the family, your attitude and actions will be remembered.
- Maintain a supportive attitude while retaining professionalism.
- Grief reactions will vary; individuals may be shocked, numb, withdrawn or hysterical.
- An appropriate professional should be discreetly present with the family as the child is handled.
- Handle the child with naturalness and respect, as if the infant/child were still alive.
- Always refer to the child by name.
- Deal sensitively with religious beliefs and cultural differences while remembering the importance of evidence preservation;
- Parents/carers should be asked whether there are any specific religious or cultural matters which they would like to be observed;
- Carers and parents will need to be given time to ask questions;
- Give written information to the family;
- In most cases a post mortem will be performed;
- Practical matters will need to be addressed (where the infant/child will go, what will happen, when the parents will see their child).

2. PRACTICE GUIDANCE FOR ALL AGENCIES

2.1 All professionals attending a child death, whether in the community or in a hospital setting, must abide by the following principles.

2.1.1 If the family is not currently known to agencies, then the primary support to the family will be given by health workers and the Police. However, should these agencies believe that other services are required then appropriate actions should be taken.

2.1.2 If the child shows any signs of life or where it is deemed that resuscitation is indicated, this should be commenced and the child should immediately be taken to the nearest Emergency Department.

2.1.3 Where the child is clearly deceased, the body should remain at the scene until the Senior Investigating Officer (SIO) authorises the removal of the body. It should be remembered that in most cases of infant death the cause of death is natural and there is little evidential benefit for delaying the removal of the body.

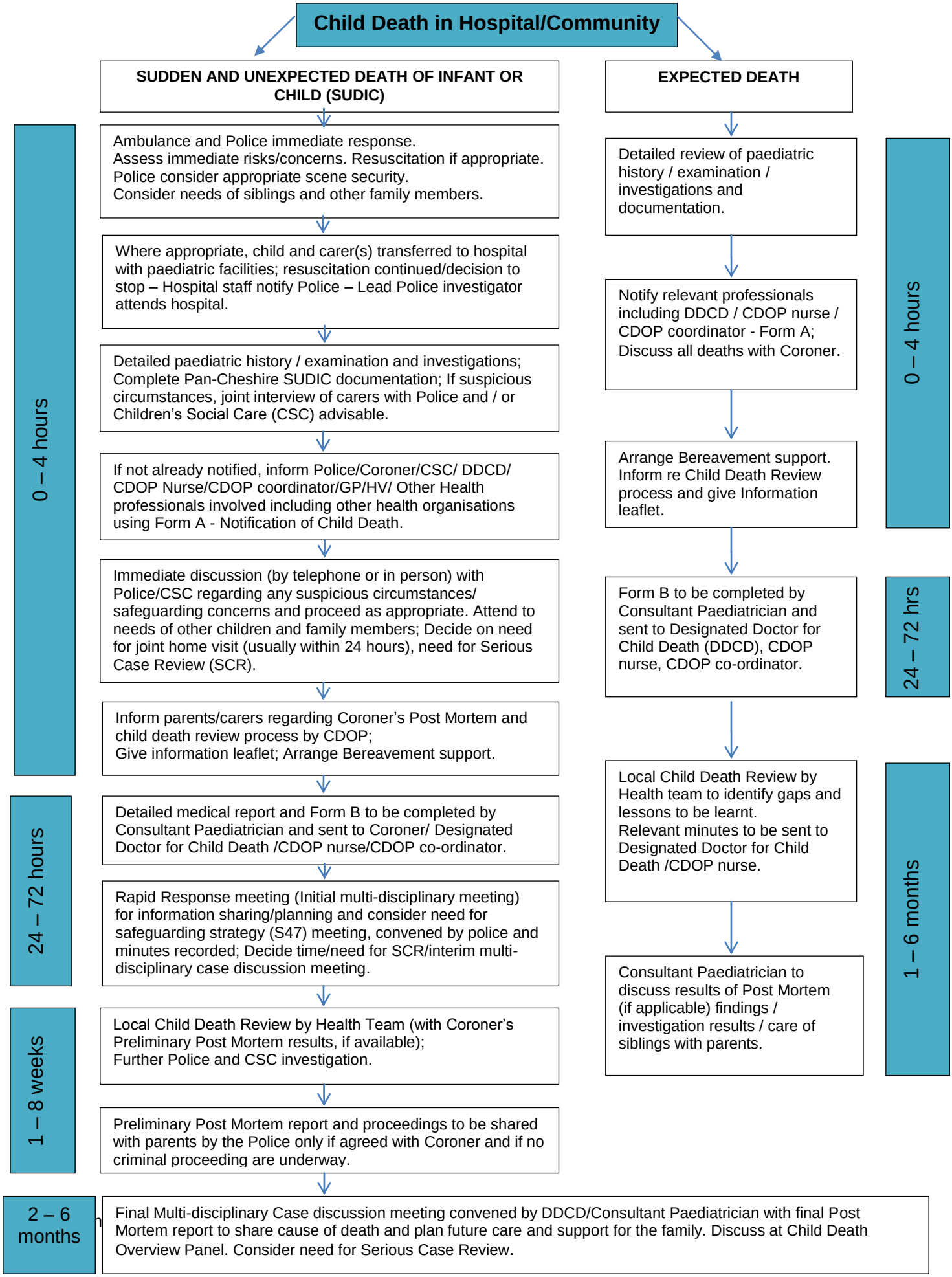
2.1.4 In all cases the child's body must be then brought to the Emergency Department. However, in older children (including adolescents), discussion needs to take place between the Senior Investigating Officer from the Police and the Duty Consultant Paediatrician to establish the next course of action.

2.1.5 In cases of adolescent sudden and unexpected deaths, the SIO instigates a discussion with the Duty Consultant Paediatrician to decide if a paediatric examination is warranted, this would normally be indicated where the cause of death is unexplained. The Coroner is informed of the outcome of this discussion. Subsequently a Rapid Response Meeting (Initial Multi-Disciplinary Meeting) is held, at which all relevant agencies decide what should happen next and who will do what.

2.1.6 It is essential that parents' views about the post mortem are ascertained during the information-collecting session. However, no decision should be made or implied regarding the post mortem without discussion with the Coroner. ***The authority for holding or not holding a post mortem rests with the Coroner and the Coroner alone.***

2.1.7 All individuals and agencies should ensure that their actions are legal, necessary, relevant and proportionate in order to comply with the Children Act (1989 & 2004) and the Human Rights Act (1998).

2.2 Pathway Following the Death of an Infant or Child under 18 years



2.3 INTER-AGENCY WORKING

2.3.1 The Duty Consultant Paediatrician and SIO from the Police will inform the Coroner of any deaths of infants or children that meet the criteria for applying this procedure and ensure that a full multi-agency investigation will take place.

2.3.2 Every infant or child shall be taken to the Emergency Department unless the SIO after discussion with the Duty Consultant Paediatrician decides otherwise. The body will then be transferred to the mortuary before being transported to the hospital where the post mortem will take place (usually Alder Hey Children's Hospital, Liverpool or Manchester Children's Hospital). The SIO will liaise with the Coroner to decide whether a post mortem will take place and who will undertake it. In most cases the Coroner's Office will arrange transportation of the body. However, in cases deemed suspicious, this process will be managed by the SIO in order to preserve evidence.

2.3.3 In circumstances where the death of the child has been confirmed outside of hospital, North West Ambulance Service (NWAS) will not transport the deceased child to the respective hospital. This is achieved through contact with the Coroner's Removal Service and is arranged by the Police, using the Coroner's Removal Service.

2.3.4 The following documentation needs to accompany the body to the hospital where the post mortem will take place for the attention of the Paediatric Pathologist:

- Hospital case records.
- Ambulance notes.
- Emergency Department notes.
- SUDIC guideline forms, duly completed (Appendices 1 to 8).
- Obstetric delivery notes of the mother if the child is less than three months old.
- Police Report on Sudden Deaths (Form 92 in East Cheshire).
- General Practitioner's notes.

2.3.5 The SIO shall initiate the **immediate information sharing and planning** discussion with the Duty Consultant Paediatrician as soon as possible. This discussion usually takes place in the Emergency Department. A check with the Local Authority's Children's Social Care service must always be made at this stage.

2.3.6 The purpose of the discussion is to:

- Share information to identify the cause of death and/or those factors that may have contributed to the death.
- Identify any at-risk factors and/or suspicious circumstances.

2.3.7 **Joint Death Scene Visit**

When an infant or child dies unexpectedly in a non-hospital setting, the SIO from the Police discusses with the health professional whether a joint visit should or should not be undertaken, depending on local arrangements.

2.3.8 **Rapid Response Meeting (Initial Multi-Disciplinary Meeting)**

A Rapid Response Meeting (Initial Multi-Disciplinary Meeting) **should take place within 72 hours where possible or no later than five working days** after the child's death. This should be arranged and chaired by the SIO, in conjunction with the attending paediatrician, along with the Designated Paediatrician for Child Deaths. The SIO will ensure that the meeting is recorded in writing and the minutes are circulated to appropriate agencies within five working days of the meeting.

2.3.9 **The purpose** of the Rapid Response Meeting (Initial Multi-Disciplinary Meeting) is to:

- Share information to identify the cause of death and/or those factors that may have contributed to the death, including information from any home visits.
- Plan future care of the family, including who will provide the family with information about support groups, bereavement, etc.
- Identify any lessons to be learned from this process.
- Gather further information for the inquest.
- Share information from each agency from previous knowledge of the family and records. In particular. any reference to the circumstances of the child's death; previous or ongoing child protection concerns, previous unexplained or unusual deaths in the family; neglect, failure to thrive, parental substance abuse, mental illness or domestic violence. Information is also required about family members and others involved with the child.
- Decide what should happen next.
- Share information about any subsequent joint agency investigation.
- Enable consideration of any child protection risks to siblings/any other children living in the household and to consider the need for child protection procedures and any other action, for example health overview for other children in the family.
- Agree when a follow-up case discussion meeting will be held within the subsequent ten to twelve weeks.

2.3.10 **The SIO will also ensure that the meeting is minuted and the minutes are circulated to appropriate agencies within five working days of the meeting.**

2.3.11 **Final Multi-Disciplinary Case Discussion Meeting**

A final Multi-Disciplinary Case Discussion Meeting must be held as soon as the final post mortem results are available. This will normally take place within about ten to twelve weeks after the child's death. The meeting is a follow up meeting subsequent to the Rapid Response Meeting and will be convened and chaired by the SUDIC Paediatrician (see *Working Together to Safeguard Children 2013*); 25;82; WTSC 2015. The recommendations from this discussion will be submitted to the local CDOP, with a copy to the Coroner.

2.4 **Meeting with the Parents**

2.4.1 Following the Final Multi-Disciplinary Case Discussion Meeting, a meeting will be arranged by the SUDIC Paediatrician/Duty Consultant Paediatrician (as per local arrangements) with the parents to discuss the post mortem results and the recommendations from the case discussion.

3. FACTORS THAT SUGGEST A DEATH MAY BE SUSPICIOUS

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

3.2 A list of such factors has been produced. The list is intended only as a guide and is not exhaustive.

3.2.1 **Previous child deaths.** However, there are some rare genetic disorders which can cause multiple cot deaths within a single family. In such cases an extended family history should be obtained and the involvement of a clinical geneticist may be helpful.

3.2.2 **Previous child protection concerns** within the family relating to this child or to their siblings.

3.2.3 **A previous history of domestic abuse** within the family.

3.2.4 **Delay in seeking help** without adequate explanation.

3.2.5 **Inconsistent explanations.** The account given by the parents/carers of the circumstances of death should be documented verbatim. Any inconsistencies in the story given on different occasions should arise suspicions, although it is important to bear in mind that some inconsistencies may occur as a result of the shock and trauma caused by the death. Explanations as to how injuries occurred should be placed under detailed scrutiny when:

- The explanation changes with time or questioning.
- The ‘accident’ was beyond the child’s development (for example between two and eight months children are not usually walking and therefore do not fall unaided; they can, of course, fall from a height).

3.2.6 **Evidence of drug/alcohol abuse** particularly if the parents/carers are still intoxicated.

3.2.7 **Evidence of significant parental mental health problems** including fabricated/induced illness.

3.2.8 **Unexplained injury**. Any evidence of major bleeding or injury (cranial, bony, visceral or soft tissue) is highly suspicious unless proven otherwise. An

examination of the child should seek to establish the presence or otherwise of unexplained bruising/burns/bite marks/ presence of blood, including:

- Multiple bruises to the face, ears, limbs or trunk.
- Bruising to immobile children or bruising that is out of context with the child's development.
- Fingerprint bruises and linear bruises are highly suspicious.
- The frenulum – the narrow fold of mucous membrane preventing the lips from moving too far away from the gums - can be torn through such actions as force-feeding (but note that this could also happen during vigorous resuscitation).
- *Petechial haemorrhages* may or may not be present with suffocation and its absence is not conclusive either way but their presence should be noted and discussed with the paediatrician, ophthalmologist or pathologist (see glossary).
- Blood around mouth and nose.
- A small amount of bleeding around the mouth and nose may be normal but a lot of blood should be treated with suspicion. Some froth around the mouth may be normal. However, in either case medical opinion should be sought.
- W*hen on any other part of the body* the injuries are burns, scalds, bite marks or injuries to the bone.

3.2.9 A photographic record should be made of all injuries immediately and again after 24 hours. This will be organised by the SIO.

3.2.10 **Neglect issues.** Observations about the physical condition of the child and of the accommodation, general hygiene and cleanliness, the availability of food, adequacy of clothing and bedding, and temperature of the environment in which the child is found are important. This will assist in determining whether there may be any underlying neglect issues involved.

3.2.11 **Shaking injuries.**

- These injuries present with non-specific symptoms ranging from apnoea, apparent life-threatening event (ALTE), seizures, unexplained drowsiness and/or 'sudden loss of consciousness' A high index of suspicion leads to identification of characteristic retinal haemorrhages on examination of fundii and subdural haemorrhages on CT scan.
- The photographs of the retina for signs of haemorrhage may prove invaluable. An experienced ophthalmologist may be able to differentiate between a shaking haemorrhage and one caused by brain swelling due to other causes.
- During resuscitation, a screening test for blood clotting disorders should be carried out promptly as brain injuries will eventually cause a similar effect. A photographic record should be made of all injuries immediately (and again after 24 hours).

3.2.12 **Concealed pregnancy and births resulting in child death.**

- A crucial part of any such investigation will be to establish whether the child ever showed independent signs of life.

4. THE ROLE OF THE POLICE

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

4.2 In any case of the sudden and unexpected death of an infant or child the police have a duty to investigate the death on behalf of the Coroner (who must be notified as soon as possible).

4.3 The purpose of the police investigation is to determine the circumstances surrounding the death and to ascertain whether there is criminal involvement by any person. Such deaths will always be treated initially as suspicious and remain so until determined otherwise.

4.4 This document should be read in conjunction with the guidance on infant deaths contained within the Association of Chief Police Officers (ACPO) Murder Investigation Manual 2006.

4.5 In relation to all sudden and unexpected infant or child deaths the on duty/on-call accredited Senior Investigating Officer will be informed and will retain overall responsibility for the investigation.

4.6 The on-call Detective Inspector (DI) should be notified with a view to then managing the investigation with the Senior Investigating Officer (SIO).

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

4.8 There are certain factors in the history or examination of the child, which may give rise to concern about the circumstances surrounding the death (pages 11-12). If any such factors are identified, it is important that the information is documented and shared with senior colleagues and relevant professionals in other key agencies involved in the investigation.

4.9 Parents/carers should be asked to provide a sample of blood/urine in order to assist with the investigation into the circumstances surrounding the child's death - this should be in collaboration with health colleagues. The requesting of samples from the bereaved is emotive and needs careful consideration. Ultimately, making the request is a matter for the Police/Senior Investigating Officer and that will be based on the circumstances of the death in a proportionate way, but should always be considered, with reasons for or not being taken clearly documented with a rationale. The Police will arrange for a forensic medical examiner to collect the samples as required. The samples

taken should be appropriately labelled and sent for forensic analysis if appropriate.

4.10 Allocation of an officer to attend a reported death of a child must be carefully considered by the supervisor who must ensure that the officer feels and is able to cope with such an incident (for example, it would be inappropriate where the officer has also suffered the loss of an infant/child). Any representations made by an officer must be considered.

4.11 As the majority of unexpected infant/child deaths are ultimately determined to be from natural causes, the actions and behaviour of officers must be balanced. Officers at all times must be sensitive in the use of personal radios and mobile phones.

4.12 Police attendance must be kept to the minimum required; several Police Officers arriving at the house could be very distressing. Wherever possible, officers in plain clothes should be utilised and/or the use of unmarked vehicles considered.

4.13 A Cheshire Constabulary Form 200092 – Police Report on Sudden Death (Form 92 in East Cheshire) must be completed as soon as possible.

4.14 The officer must make a visual check of the child and its surroundings, noting any obvious signs of injury and property on the body.

4.15 It must be established whether the body has been moved and the current position of the child must be recorded on the Police Report on Sudden Death (Form 92).

4.16 In all cases of sudden unexpected infant/child death where the body has not been removed from the scene a Forensic Medical Examiner (FME) must attend and confirm death irrespective of whether life has been pronounced extinct by paramedics.

4.17 Officers should remember that in all cases where the child has not been removed from the scene, any removal should be direct to the local Emergency Department and the body must be accompanied by the police. In certain circumstances e.g. older children, other arrangements may be made. However, the matter must be discussed with HM Coroner before any action is taken.

4.18 In addition to any other information, the following information must be included on the Police Report on Sudden Death (Form 92):

- Basic medical history of the child and family including any previous child death.
- Where the child was and the sleeping position, if covered, state what with.
- What the child was wearing.
- When the infant/child was last fed, by whom and food content.
- If applicable, when the child's nappy was last changed, by whom and where is it now.
- Has the child been well up until time of death.
- Last seen alive by whom.

- If applicable, what caused the adult to look at/check the child.
- Temperature of the scene.
- Condition of accommodation.
- General hygiene and availability of food and drink.
- Parents: any alcohol /tobacco /medication – last taken/current state.
- Residents of the home, those present at the time of the child's death and recent visitors to the home.

4.19 An early explanation from the parent/guardian/carer is essential; all comments must be recorded, any conflicting accounts will raise suspicion. However, it must be borne in mind that any bereaved person may be in a state of shock and possibly confused. Repeated questioning of the parent/guardian/carer by different officers must be avoided at this stage. Accounts must be taken separately from the parents/carers if they were present. Where possible the police and a doctor should interview the parents/carers together to avoid duplication of questions.

4.20 It is entirely natural for a parent/carer to want to hold or touch the dead child, providing this is done with a professional present this should be encouraged, as it is unlikely that forensic evidence will be lost. If the death has been considered suspicious the Senior Investigating Officer, should be consulted before a parent/carer is allowed to hold the child. All contact must be discreetly supervised and recorded.

4.21 After death is certified the Coroner has control of the body and in suspicious cases mementos must not be taken without prior consultation.

4.22 A professional from the hospital may refer a sudden and unexpected infant or child death following admittance via the Emergency Department or where the child has died on a hospital ward. In such cases, officers need to be aware that paramedics and health professionals will have examined and made attempts to resuscitate the infant or child. This involves a variety of medical equipment. Officers should also be aware that any medical equipment used as part of this process may still be attached to the infant's body, including 'drip' and 'other' injection equipment, but the tubes, etc, will be cut to a short length. These should be left 'in situ' until removed by a pathologist.

4.23 In all cases HM Coroner/Coroner's officer for the relevant area must be informed of the death as soon as possible.

4.24 **The Death Scene:** Where no suspicious circumstances arise as a result of initial actions, no further action in respect of scene preservation will normally be required. This will be the decision of the Senior Investigating Officer in conjunction with the Detective Inspector who has attended the scene.

4.25 However, consideration should be given to the following:

- Calling a Crime Scene Investigator. This should be considered as essential if photographs or video recording of the scene(s) are considered necessary.
- Retain bedding (but only if there are obvious signs of forensic value, such as blood, vomit or other residues).

- Recovering articles from the infant's/child's last meal, (including previously prepared food/drinks, used bottles, cups, and food/leftover food) and any relevant medication. Record how the food/drinks have been stored.
- Taking bin contents (internal and external including used nappies), home videos, personal diaries/mobile phones/digital storage devices where relevant – e.g. in cases of suicide of older children as these devices may contain significant information about their state of mind at the time.
- Where items are removed from the house, it must be explained to the parents that this may help to find out why their infant/child has died.
- Clothing (including any nappy) must remain on the infant/child. Wherever possible, any removal should be undertaken/supervised by a police officer, where the clothes have already been removed e.g. during medical intervention then they should be recovered.

4.26 The 'Personal Child Health Record' (or 'Red Book') should also be secured. The 'red book' is a parent owned record of the infant's development completed by health professionals.

4.27 The Midwife/Health Visitor/School Health Nurse will have the child health records, which are confidential. These reports should be secured, as per local procedures.

4.28 **Public Protection Unit – Child Abuse Investigation Unit**
Child abuse officers have specialist skills, knowledge and experience within the field of inter-agency child protection.

4.29 In all cases of sudden unexpected infant or child death contact must be made with the local Public Protection Unit Detective Inspector/Supervisor. (Public Protection Unit officers, including child abuse officers, do not normally work shifts and are not on a 'call out rota' system).

4.30 At the initial request of the Senior Investigating Officer the Child Abuse Investigation Unit Supervisor will be responsible for liaising with other agencies in particular Children's Social Care and Health.

4.31 It will be the responsibility of the Child Abuse Investigation Unit to assess and deal with the need for any necessary protection of siblings. In cases where immediate protection is necessary, officers must adhere to the force policy on emergency protection contained within the Child Abuse Investigation and Safeguarding Children procedure.

4.32 **At the hospital**, the SIO will discuss with the medical and nursing staff and any other professionals involved in the case:

- The cause of the death and/or those factors that may have contributed to the death.
- Any at-risk factors and/or suspicious circumstances.
- Whether the death is expected/ unexpected/explained/unexplained; whether a Rapid Response Meeting needs to be convened and whether a home visit needs to take place.

4.33 The attending Duty Consultant Paediatrician will fully brief and provide the SIO/Investigating officer with a summary of the child's known/ available medical history, (including any relevant background information concerning the family and any concerns raised by any other agency). The SIO/Investigating officer is responsible for ensuring that the pathologist is provided with this summary.

4.34 The named **Nurse/Deputy** will facilitate the provision of a clear, high resolution copy of the following documents which should accompany the body to the post mortem examination for the information of the pathologist:

- Hospital case records/summary of these.
- Ambulance notes.
- Emergency Department notes.
- SUDIC guidelines forms, duly completed (Appendices 1 to 8).
- Obstetric/delivery notes of the mother if the child is less than three months old/child's records.

4.35 The SIO, in conjunction with the responsible Duty Consultant Paediatrician and the Designated Doctor for Child Deaths, should arrange a Rapid Response Meeting (Initial Multi-Disciplinary Meeting), which **should take place within 72 hours or no later than 5 working days** of the child's death (in accordance with section 2.3.7, page 9).

4.36 If the hospital has undertaken any investigations before death, including x-rays, pre transfusion blood samples, scans, etc, the Senior Investigating Officer, the Pathologist and the Coroner must be informed and the results forwarded to the Pathologist/Coroner.

4.37 Where it is necessary to obtain full hospital records this will normally be facilitated in conjunction with the relevant named nurse for child protection, as per local arrangements. The Designated Nurse for Safeguarding Children will also assist in the coordination of gathering further information from health professionals, for example, health visitors/GP/ Mental Health Worker, etc.

4.38 When the infant/child is taken to the mortuary the body must be accompanied by a police officer. Where the parents wish to accompany their infant/child to the mortuary this must normally be facilitated but again they must be accompanied by a police officer.

4.39 **The Post Mortem:** In infant or child death cases, HM Coroner for Cheshire has introduced the following strategy for undertaking a post-mortem examination and the decision will be final.

4.40 In non-suspicious cases a paediatric pathologist, if possible and available, will be instructed to conduct the post mortem examination.

4.41 In non-suspicious cases involving older children and adolescents or road traffic collision victims, the Coroner may order a general pathologist to carry out the post mortem examination.

4.42 If the post mortem examination reveals suspicious circumstances, then it will be halted and the post-mortem continued jointly with a Home Office Pathologist.

4.43 If from the outset there is substantial suspicion, the coroner will direct a joint post-mortem, to be conducted by a Home Office Pathologist, who will take the lead, together with a Paediatric Pathologist.

4.44 In suspicious cases the Senior Investigating Officer will arrange for a police post mortem team to attend the post mortem, the team will include; the SIO (or appointed representative), an exhibits officer, pathologist and a crime scene examiner.

4.45 The SIO/Investigating Officer should be provided with the interim findings as soon as possible after the post mortem examination is completed. The interim findings may well be 'awaiting histology, virology, toxicology', etc.

4.46 The results of the interim findings should be conveyed to the family.

4.47 The Senior Investigating Officer/Investigating Officer will ensure that the Police Report on Sudden Deaths (Form 92) is completed and forwarded to the pathologist and the Coroner as soon as possible.

4.48 On the directions of the Coroner, the SIO/Investigating Officer will be provided with the post mortem examination final report. A copy of the report would also be provided to the SUDIC Paediatrician (who will liaison with the Duty Consultant Paediatrician) and the Public Protection Unit - Child Abuse Investigation Unit.

4.49 No other agency will be allowed access to the post mortem report without prior approval from the Coroner. Permission should always be sought by any agency if the content of the report could potentially affect the agency's future actions.

4.50 A Final Multi-Disciplinary Case Discussion Meeting should be held as soon as the final post mortem results are available. The meeting will be convened and chaired by the SUDIC Paediatrician (WTSC 2013;25:82, also WTSC 2015) within 2 – 6 weeks of availability of the final autopsy report.

4.51 **Returning Property:** Items of property which have been seized should be returned as soon as possible after the Coroner's verdict or the conclusion of the investigation. Parents must be asked in person if they wish for them to be returned. Bedding/clothing, etc. should be, as far as possible, returned in their original state. The return of these items should be handled sensitively (for example, where a bottle containing feed or juice is taken, the bottle should be returned clean, rather than in its original state). Official labels or wrappings must be removed before return.

4.52 **Welfare:** Police involvement with bereaved and traumatised families is amongst the most difficult of any situations an officer is called upon to deal with. It requires extreme sensitivity and may have a significant emotional impact on anyone coming into contact with the family including investigators.

4.53 The Senior Investigating Officer/Area Crime Manager must provide appropriate levels of support for every officer involved in this type of investigation regardless of outcome.

5. AMBULANCE GUIDELINES

5.1 When the ambulance service is called to the scene of a sudden unexpected and unexplained death of a child, the attending crew must notify the ambulance control room. The duty control room manager **must notify** the police control room. The ambulance emergency control centre has responsibility to notify the police force of all cases of suspected or confirmed SUDIC and/or where there is reasonable cause for safeguarding concerns while processing a 999 call.

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

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

5.4 The first ambulance staff at the scene should:

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

5.5 If in doubt about death commence life support according to the guidelines.

5.6 Ambulance staff must inform the receiving Emergency Department of the child's condition and the expected time of arrival.

5.7 In all cases the child's body should be then brought to the Emergency department.

5.8 If the child is dead at the scene and further active resuscitation is not considered appropriate, then the body should remain in-situ, pending the arrival of the police. The body should then normally be taken by an ambulance to the local Emergency Department unless the Senior Investigating Officer (SIO) in consultation with the Coroner directs otherwise.

5.9 In cases where death has occurred and the circumstances are suspicious, the body should only be removed with permission of the Coroner.

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

5.11 Ambulance staff must pass on all the information including history, observations of the scene and resuscitation to the receiving physician.

5.12 Any other information gathered (e.g. background history, living accommodation, comments by those at the scene) must be passed on to the Emergency Department receiving doctor and the police.

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

6. THE GENERAL PRACTITIONER (GP)

6.1 The General Practitioner may be called to the scene first. In such cases they should adhere to the same guidelines as for the ambulance staff.

6.2 As soon as possible and within 24 hours, make a precise and thorough record of the event in the infant or child's record, making particular reference to:

- Any inappropriate delay in seeking help.
- The position of the infant/child and the condition in which it was found.
- Inconsistent explanations – accounts should be recorded verbatim in quotes.
- Evidence of drugs/alcohol abuse.
- Parents' reaction/demeanour.
- Unexplained injury e.g. bruises, burns, bites, presence of blood.
- Neglect issues.
- Position of the infant/child and surroundings.
- General condition of the accommodation.
- Evidence of high risk behaviour e.g. domestic violence.

6.3 These guidelines refer to unexplained unexpected deaths. Where the cause of death is explained (as drowning, road traffic accident, or burns), the GP should discuss with the Coroner to formulate next course of action.

6.4 If there are no signs of life the GP will confirm death and inform the police (this is done by Police Control). The Police will inform the Coroner. The GP will inform the Responsible Paediatrician at the hospital to which the child will be taken.

6.5 The GP will be required to provide information to the Coroner/pathologist of the care provided by any hospital as soon as possible.

6.6 The GP will be expected to attend and/or provide information for the Rapid Response Meeting(s) (including Initial and Final Multi-Disciplinary Meetings) or at the earliest opportunity if they are not able to attend. In conjunction with the midwife and other health professionals, the GP will be involved in providing ongoing advice and support for the family.

7. COMMUNITY HEALTH PRACTITIONERS – e.g. HEALTH VISITOR, SCHOOL NURSE AND COMMUNITY NURSE

7.1 The gathering of relevant information from the health visitor, community practitioners, school nurse and community nurse when a sudden unexpected child death occurs is required to aid the investigative process by the coroner.

7.2 In passing this essential information, the need to support the professional involved with the family prior to the death of the child must be recognised.

7.3 The Senior Investigating Officer or the Coroner's officer will contact the Named Nurse for Safeguarding Children and/or the CDOP Nurse (or equivalent) with the information of the child's name, date of birth, address, GP and the time of death.

7.4 The Named Nurse for Safeguarding Children and/ or the CDOP Nurse (or equivalent) will contact the health visitor, school nurse and or the community nurse to ascertain whether there have been any professional concerns regarding the health and parenting of the child.

7.5 The Named Nurse for Safeguarding Children and/or the CDOP Nurse (or the equivalent) and the Child Safeguarding Team (NHS) will pass the information to the Police/Coroner.

7.6 In the event of a health professional raising concerns and a police statement being required from the member of staff, a member of the Child Safeguarding Team (NHS) would be present to provide appropriate support.

7.7 The Named Nurse for Safeguarding children and/or the CDOP Nurse (or equivalent) will ensure that all known agencies working with the child have been informed of the child's death e.g. paediatric Allied Health Professionals, acute hospital paediatrician (SUDIC), audiology, midwifery services, community paediatricians, school nurse, Child Health Department, CONI coordinator (or equivalent), children's centres etc. so as to avoid appointments being sent in the future.

7.8 The appropriate community health professional will ensure that parents have been given appropriate information about support groups and bereavement counselling services continue to offer support to the parents after the funeral, identify any medical or social needs and arrange appropriate support.

7.9 In case of an infant death, the parents shall be offered support with subsequent babies via the Lullaby Trust scheme and local Care of the Next Infant (CONI) arrangements.

8. MIDWIFE

8.1 These guidelines inform midwives of the procedures in the event of a sudden unexpected death of an infant or child. Midwives should also refer to their own professional organisation's procedures/guidelines.

8.2 Records will be secured by the head of midwifery/their nominated deputy as soon as the death has been notified. A copy will be made available for the midwives. This is a precautionary measure until the situation is clarified.

8.3 **If the community midwife is first on the scene,** the midwife should not assume that death has occurred. If the child shows any signs of life or where it is deemed that resuscitation is indicated, this should be commenced and the child should immediately be taken to the nearest Emergency Department via ambulance.

8.4 When an unexpected fresh stillbirth or sudden unexpected death has occurred without the presence of a health professional, or if the birth has been concealed, the midwife must assess the baby and the mother's medical condition and immediately call the paramedic services who will inform the police. The midwife should not complete the medical certificate of stillbirth and the GP should be informed.

8.5 Where the midwife has arrived after the birth and there is evidence of maceration or gross abnormality she may complete the medical certificate of stillbirth if confident that the baby cannot have shown signs of life. In this event the Coroner's office will not need to be informed (NLSAGSM 2005).

8.6 Where the midwife has arrived after the birth and the baby appears normal and the midwife cannot confirm that the baby never showed signs of life, the local police should be contacted, who will then inform the Coroner. In such circumstances the Medical Certificate of Stillbirth should not be completed by the midwife and the GP should be informed.

8.7 If the indications are that the baby is dead and no active resuscitation has been attempted, the body and placenta should remain on the scene pending the arrival of the police. Try not to disturb the scene, i.e. do not touch or move anything.

8.8 The position of the baby and the condition in which it was found must be noted together with any comments/explanations of the mother or any other person at the scene.

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

8.10 If the parent/carer goes to the hospital with the baby, ensure that appropriate arrangements are made for the care of any siblings.

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

8.12 Give the parents/family a work telephone number where the Midwife can be contacted.

8.13 If the mother's condition requires obstetric intervention, she should be transferred with a midwife to the nearest maternity unit, whether she is booked there or not.

8.14 If the baby is not resuscitated the body will be taken to a hospital Emergency department.

8.15 If the midwife has any relevant information about the pregnancy or the family, this should be reported directly to the Police and Accident & Emergency staff as soon as possible.

8.16 As soon as possible and within 24 hours, make a precise and thorough record of the event in the infant /child's record, making particular reference to:

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

8.17 The family GP and CDOP lead nurse (or equivalent) must be informed as soon as possible.

8.18 In the case of a death on the maternity unit, also contact supervisor of midwives, co-ordinator on delivery suite and head of midwifery.

8.19 **If you learn later that a baby has died:** Check that the CDOP lead nurse (or equivalent) is informed of the infant's death and has informed the Child Health Department and the list of agencies and professionals in Paragraph 7.7 above.

8.20 Discuss the support required for the parents/carers/extended family.

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

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

8.23 Be prepared to provide a Statement of Evidence if requested and seek advice from the Designated Nurse/Named Midwife.

8.24 **The next pregnancy:** Ensure that all relevant professionals are informed, including the CONI co-ordinator, or equivalent, as soon as possible.

8.25 **Scrutinise previous records** to ascertain whether it is necessary to inform any other professional/agency of the pregnancy e.g. Social Worker. It may be necessary to liaise with the GP to obtain historical information.

8.26 Ensure that any previous infant death is highlighted in the maternity records.

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

9. THE HOSPITAL STAFF

9.1 As soon as the emergency department is notified that the ambulance crew is attending the scene of a possible child death, the emergency department nurse in charge must notify the following:

- The on call paediatric/resuscitation team.
- The on call consultant paediatrician.
- The on call emergency department consultant.

9.2 If there is any doubt about the duration of the collapse, full resuscitation must be commenced.

9.3 Ascertain the identity of ALL the people present and their relationship to the child, including those who have the parental responsibility.

9.4 As soon as the Emergency Department receives the notification of an arrival **a senior nurse should be assigned** to keep a record of the resuscitation process. This nurse should keep a log of all investigations undertaken during and after the resuscitation.

9.5 Another Emergency Department nurse should be assigned to act as the **Liaison Nurse** who will receive and support the parents.

Responsibilities of the Emergency Department Liaison Nurse:

- Organising the communication process with the parents and will be present throughout the process of information gathering and sharing;
- Arranging parental contact with the senior paediatrician after the resuscitation has been discontinued;
- Arranging and supporting the parents during their contact with the deceased child;
- Ensuring that the appropriate documentation and notification processes are completed;
- Working closely with the Consultant Paediatrician, Emergency Department Consultant and the police to ensure that all the evidence is preserved.

9.6 To identify the possible cause of death a detailed history should be obtained by medical staff (using the SUDIC History Record Forms).

9.7 History should include detailed family history including history of sudden unexplained deaths

9.8 The comments of carer/parents must be recorded at all stages by a health professional in detail in case of future discrepancies or if suspicious circumstances develop.

9.9 Examination should start as resuscitation commences:

- The SUDIC document should be completed.
- Sites of medical lines must be marked: the site and route of any intervention, e.g. venepuncture, failed cannulation, intra-osseous needle, should be documented on the body chart.
- An endotracheal tube may be removed altogether (if the death is not suspicious) **but only** if a consultant, independent of any resuscitation attempt, establishes the correct positioning of the tube and documents the same in the notes. If the endotracheal tube is found to have been positioned incorrectly, the fact must be noted and the tube left in place.
- A full general examination should be undertaken by the Consultant Paediatrician/Emergency Department Consultant noting any rashes, injuries on the child, state of any clothing or bed linen.

9.10 Hospital staff must retain all items of clothes/bedding for subsequent examination by the police or Coroner. They must not be returned without prior consultation with the Coroner.

9.11 Samples taken before death: blood, urine, CSF specimens and any other relevant specimens can be taken for appropriate investigations including microbiology, virology, toxicology and metabolic work-up as considered appropriate.

9.12 After death discuss with the Coroner before undertaking any investigations. If autopsy is delayed and/or cannot be undertaken, various pathology samples and investigations may be required.

9.13 The pro-forma must accurately record which tests have been obtained.

9.14 The attending Duty Consultant Paediatrician must ensure that all results of pre-mortem tests are forwarded to the Coroner and the pathologist.

9.15 If the child is **dead on arrival** or death is certificated following arrival at hospital or when death is certified, the attending doctor should speak directly to the Coroner (or Coroner's officer).

9.16 A senior nurse should check that the police have been notified.

9.17 A skeletal survey would be carried out at the post mortem. However, if there are circumstances where an immediate x-ray examination is likely to add further information to the evidence, this should be discussed with the Coroner and the radiologist.

9.18 Notes of previous hospital, obstetric, emergency department attendances must be obtained.

9.19 Ascertain whether the child, or any sibling, is subject to a Child Protection Plan, or known to the local authority's children's services for any other reason. The Duty Consultant Paediatrician should review all hospital records of the child and siblings and prepare the report (within 48 hours) for any subsequent discussion/meetings. A copy of this report should be sent to the Coroner, Designated Doctor for Child Deaths (DDCD) and the pathologist.

9.20 Other professionals also need to be informed. This should be done by the Emergency Department Liaison Nurse in consultation with the NHS Trust checklist and the Appendices to this SUDIC Guidelines.

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

9.22 An explanation should be given as to why the Coroner must be informed and that a post mortem will probably be necessary to try to ascertain the cause of death. It must also be explained that a paediatric post mortem will always involve the taking of tissue samples for histological examination.

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

9.24 Unless the circumstances of death are suspicious the parents/carers/family members should be encouraged to see and hold the child whilst discreetly accompanied by a professional. If the circumstances are suspicious, police advice should be taken.

9.25 A member of staff should accompany the child to the mortuary. <u>The child should not be left unattended until arrival in the mortuary</u>.

9.26 Following the Rapid Response Meeting (Initial Multi-Disciplinary Meeting), the SUDIC Paediatrician will liaise with the General Practitioner to decide on appropriate follow-up for the family.

9.27 The staff completing the SUDIC pro forma should ensure that the Emergency Department Liaison Nurse has arranged notification of child death form to the concerned agencies.

9.28 **Unexpected and Unexplained Death of a Child within a hospital setting**:

9.28.1 When a child is found collapsed, the resuscitation team will be called and full resuscitation shall be carried out.

9.28.2 When death is pronounced, the family will be informed and supported by a senior member of the staff.

9.28.3 The senior nurse on duty will inform the police.

9.28.4 The location of where the child collapsed should be treated as a scene of SUDIC investigation and preserved accordingly.

9.28.5 Follow SUDIC guidelines.

9.28.6 All information will be recorded as documented above.

9.28.7 Staff should be offered support and debriefing as appropriate.

9.29 **Where the death of a child is explained but occurs unexpectedly**, the Duty Consultant Paediatrician will discuss with parents and the Coroner to decide if there is an explanation for the child's unexpected death for issue of the death certificate. For example: a child with cerebal palsy with reflux and gastrostomy who develops a pulmonary aspiration with a fatal ALTE: there is little benefit in undertaking a post mortem. The Duty Consultant Paediatrician can sign the death certificate.

9.29.1 However, if the parents or staff have any concerns about the child's management, then the case needs a thorough investigation. The Police will be involved if it is considered that there were suspicious circumstances around the child's death or concerns have been raised about neglect or inappropriate medical or nursing care.

10. CHILDREN'S SOCIAL CARE SERVICES

10.1 In the first instance Emergency Department staff will check with the Local Authority Children's Social Work Services whether the infant/child or any child within the same family is or has been known to them and if so, in what capacity.

10.2 Children's Services staff will check whether the child is subject to a Child Protection Plan, or an open referral (i.e. child in need) and check any other background records, which indicate any previous concern as to the wellbeing of the child or any other children in the family. Such information will be shared with the emergency department. At this stage, this information must be regarded as shared in confidence. Children's Social Care will decide if it is necessary for a practitioner to attend or carry out an assessment.

10.3 If the death appears suspicious and/or there are any concerns that a child has suffered or another infant/child may suffer harm as a result of abuse then this should be referred directly to the Local Authority Children's Social Care services following formal (LSCB) safeguarding procedures. Children's Social Work services will undertake appropriate assessments, including multi-agency Section 47 enquiries as necessary.

10.4 If there are concerns about safeguarding responses by any agency then the named doctor/named nurse for safeguarding should be consulted.

11. THE CORONER AND PATHOLOGIST

11.1 After death is confirmed, the Coroner has control of the body. Medical samples should only be taken with prior consultation.

11.2 In all cases of SUDIC under the age of two years a full skeletal survey will be taken at the time of the autopsy.

11.3 In most cases of SUDIC, the post mortem will be performed by a paediatric pathologist. In older children and adolescents with road traffic accidents, the post mortem may be carried out by a general pathologist. If there are suspicious circumstances a Home Office Pathologist will take the lead role in the post-mortem. If the paediatric pathologist does not agree the contents of a report proposed by the Home Office Pathologist, then each of them will issue a separate report. It is the Coroner who decides which pathologist will conduct the post mortem.

11.4 The Investigating Officer is responsible for ensuring that the Coroner and pathologist are provided with the summary, compiled by the attending paediatrician, of the full medical history including any relevant background information concerning the family and any concerns raised by any other agency.

11.5 The Duty Consultant Paediatrician must ensure that a clear, high resolution copy of the following documents should accompany the body to the mortuary where the post mortem examination will take place:

- Hospital case records.
- Ambulance notes.
- Emergency Department notes.
- SUDIC Guidelines forms (Appendices 1-8) duly completed.
- Obstetric/delivery notes of the mother if the child is less than 3 months old.
- Report of the police scene.

11.6 The attending Duty Consultant Paediatrician must ensure that all results of pre-mortem samples are forwarded to the Coroner and the pathologist. The SIO or the Coroner's Officer also must ensure that results of all investigations initiated during the post mortem (i.e. toxicology, other tests undertaken by forensic scientists) are forwarded to the pathologist(s) as soon as they became available (which will facilitate the timely conclusion of the final post mortem report). It is the responsibility of HM Coroner's officer to ensure this has taken place.

11.7 The Coroner's officer must ensure that all relevant professionals who have notified the Coroner that they wish to attend the post mortem, are informed of the time and place of the post mortem.

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

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

11.9 In the event of a suspicious death the SIO/Investigating Officer (or appointed representative) and the crime scene officer must attend the post mortem.

11.10 A paediatric post-mortem will always involve the taking of tissue samples for histological examination and the Paediatric or Emergency Department Consultant or most senior doctor present will explain this to the family. It is the responsibility of HM Coroner's officer to ensure that instructions are taken with regard to tissue samples.

11.11 If the Pathologist carrying out the post-mortem examination wishes to retain a whole organ (solely for the purpose of establishing the cause of death) he will ask the permission of the Coroner first. The Coroner, through his officer, will enquire of the family as to their wishes for the ultimate disposal of the organ so retained.

11.12 Pending on the circumstances of death and the post-mortem findings the pathologist may require highly specialised investigation of various organs (mainly brain and/or eyes in cases of suspicious non-accidental injuries) which would involve (paediatric) neuropathologist and/or ophthalmic pathologist and/or pathologist of the skeletal system (bones).

11.13 All samples taken at post mortem are under the control of the Coroner and must be labelled, identified and dealt with in accordance with the guidelines.

11.14 The interim results of any post mortem will be communicated immediately to the Coroner by telephone. Bearing in mind possible legal implications arising from the findings, the Coroner will use his discretion as to what information will be passed to the lead Paediatric Consultant. The Coroner will endeavour to be as helpful as possible with the provision of information. The Paediatrician may be instructed to keep some information strictly confidential.

11.15 **Within 48 hours** of the post mortem the pathologist will provide to the coroner in writing the following information:

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

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

11.17 The Investigating Officer/SUDIC Paediatrician will on receipt of the post mortem result arrange any further strategy meetings.

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

11.19 The pathologist will send the written post-mortem report to HM Coroner and a copy to the Designated Doctor Children's Deaths, who should liaise with the Duty Consultant Paediatrician. HM Coroners officer will furnish the investigating police officer with a copy of this report.

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

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

11.22 Mortuary staff should notify the Designated Doctor for Child Deaths and Named Nurse for Safeguarding Children of all child deaths under 18 years of age.

12. PARENTAL SUPPORT AND COMMUNICATION

12.1 An unexpected death of a child is perhaps the most devastating trauma and grief that any person can sustain. The parents go through different emotions, ranging from shock, disbelief, guilt and anger. There is added stress posed by police investigations and pending post-mortem and the inquest. While the professionals will use the procedures and guidelines for dealing with sudden unexpected death of a child, for parents it is perhaps the first and only life-time tragic experience; each component of this experience is very traumatic. Any minor aberrations or deviations of the observed process add to this trauma. Hence it is of paramount importance that the professionals dealing with SUDIC are fully trained with the SUDIC Guidelines. Experience has taught us that lack of certain knowledge at key points can have devastating effects for the family and adversely affects their subsequent relationship with the professionals and the health care system.

12.2 The professionals and the parents/carers meet at certain strategic points and these need to be kept within strict professional boundaries.

12.3 There is no place for personal views, opinions and interpretations and only factual information should be shared.

12.4 The first direct contact is likely to be with the ambulance staff. The staff, while supporting parents, can explain the factual condition of the child to the parents, the procedures being undertaken (CPR, Oxygen etc) and the transportation process.

12.5 As soon as the Emergency Department receives notification of an arrival a senior nurse should be assigned to act as Emergency Department Liaison Nurse and to receive and support the parents.

12.6 This nurse will take the lead in:

- Organising the communication process with the parents and must be present throughout the process of information gathering and sharing.
- Discussion with the parents/carers regarding any specific religious or cultural needs.
- Arranging parental contact with the senior paediatrician after the resuscitation has been discontinued.
- Will arrange and support the parents during their contact with the deceased child.

12.7 The nurse will also ensure that parents receive an explanation and are given leaflets about:

- Hospital Trust and the regional (Alder Centre, Liverpool) bereavement and counselling support.
- National Parent Support groups such as the Lullaby Trust.
- Child Death Review process (a guide for parents).

References

1. Sudden Unexpected Death in Infancy: A Multi-Agency Protocol and Investigation (Chair Baroness Helena Kennedy), Royal College of Paediatrics and Child Health 2004

2. Royal College of Paediatrics and Child Health Guidance on Child Death Review Process 2008

3. Preventing Childhood Deaths: A Study of 'Early Starter' Child Death Overview Panels in England, Department for Children, Schools and Families, University of Warwick, 2008

4. Working Together to Safeguard Children: A Guide to Interagency Working to Safeguard and Promote Welfare of Children, HM Government Department of Health London, 2013 and Working Together To Safeguard Children 2015

5. Confidential Enquiry into Maternal and Child Health – Why Children Die: A Pilot Study, NCB 2006

Appendices

Before Commencement of Documentation (Guidelines)

* Before commencement of documentation

- Read the guidelines
- Take a copy with you when you go to see the parents/carers
- Check available records that may give you some background information
- While completing the documents if certain sections are not applicable enter NA (not applicable), rather than leaving the section blank
- Parents/carers feel less threatened if certain direct/leading questions are asked as a part of the protocol document
- Seek advice from a senior member of the team if unsure about any section of the guidelines or the documentation process
- The description should be factual without any interpretation
- Record the details accurately
- Do not use jargon or acronyms
- For measurement purpose refer to:
  Centimetre as: cm
  Gram as: g
  Kilogram as: kg
  Millilitres as ml
  Milligrams as: mg
- For description of time use 24:00h clock if possible otherwise state am/pm clearly and ensure that the date is appropriately advanced by +1 after midnight
- Enter the SURNAME in CAPITAL letters
- Record parents'/carers' full name along with their date of birth

Proforma for the management of Sudden Unexplained Death in Children

APPENDIX 1A: EMERGENCY DEPARTMENT ARRIVAL AND RESUSCITATION RECORD

(To be completed by the Duty Consultant Paediatrician)

Child/Hospital Details			
Child's Name:		**Date of Birth:**	
Hospital Number:		**Date of Death and Time:**	
Hospital Name:		**Place of Death eg ED/Other (Specify):**	
Name of A&E Consultant:		**Signature:**	
Name of A&E Resuscitation Nurse:		**Signature:**	
Date:		**Time:**	

Date / time when the child was found dead or collapsed:	
Date / time when ambulance/police were informed:	
Who called the ambulance?	

Arrival of Ambulance Team at the Scene		
Time ambulance team arrived at the scene:		
Condition of the infant as reported by the ambulance team:		
	YES	**NO**
Did the parents/carers undertake resuscitation?		
Did the child show any signs of life?		
Did the child show signs of rigor mortis?		
Did the child show signs of post mortem lividity?		
What was the room temperature?		
What was the child's temperature?		
Was resuscitation carried out (by the ambulance team)?		
- External cardiac massage given?		
- Bag and mask ventilation?		
- Oxygen by mask?		
- Endotracheal intubation undertaken?		
- Were any drugs given?		

(If Yes to drugs, please specify name and the dose):		
Were any intravenous fluids given?		
(If Yes to intravenous fluids, please specify name and volume):		
Did the team observe any signs of parental/carer alcohol intoxication?		
(If yes to intoxication, please give details):		
Any other observations reported by the ambulance team:		

Arrival in the Emergency Department		
Time of arrival in the A&E:		
Condition of the child upon arrival:		
	Yes	No
Was there any sign of life		
Did the child show signs of rigor mortis?		
Did the child show signs of post mortem lividity?		
What was the rectal temperature upon arrival:		

Any Other Comments:

Proforma for the management of Sudden Unexplained Death in Children

APPENDIX 1B: EMERGENCY DEPARTMENT ARRIVAL AND RESUSCITATION RECORD

(To be completed by the Emergency Department Duty Consultant Paediatrician)

Child/Hospital Details			
Child's Name:		**Date of Birth:**	
Hospital Number:		**Date of Death and Time:**	
Hospital Name:		**Place of Death eg ED/Other (Specify):**	
Name of A&E Consultant:		**Signature:**	
Name of A&E Resuscitation Nurse:		**Signature:**	
Date:		**Time:**	

	YES	**NO**
Was resuscitation undertaken (in ED)?		
Did the child show any signs of life?		
- External Cardiac Massage?		
- Endortracheal Intubation (Type and Size):		
- Time of intubation:		
- Who intubated the child?		
- Assisted ventilation with bag and mask?		
- Assisted ventilation with the endotracheal tube?		
- Defibrillation?		

Time of first vascular access:	
Type of vascular access (veinous/introsseus)	
Intravenous fluids given (name and volume given):	
Drugs given (name and dose):	
Chest drain/pericardiac tap/other procedures (specify):	

Total duration of the resuscitation:	
Time death declared:	
Doctor pronouncing the life extinct:	
Times parents informed:	
(This will always be done by the ED Consultant or the Duty Consultant Paediatrician)	

Any Other Comments:

(The Emergency Department Resuscitation sheets will be completed by the E D Consultant who leads the resuscitation procedure)

Proforma for the management of Sudden Unexplained Death in Children

APPENDIX 1C: INVESTIGATIONS AND TESTS TAKEN AT RESUSCITATION

(To be completed by Emergency Department Duty Consultant Paediatrician. The ED Nurse responsible for resuscitation documentation should keep a log of all investigations undertaken during the resuscitation.)

Child/Hospital Details			
Child's Name:		**Date of Birth:**	
Hospital Number:		**Date of Death and Time:**	
Hospital Name:		**Place of Death eg ED/Other (Specify):**	
Name of A&E Consultant:		**Signature:**	
Name of A&E Resuscitation Nurse:		**Signature:**	
Date:		**Time:**	

Type of Test	Date & Time	Results	Tick if pending
Blood			
Urine			
Stool			
CSF			
Swab			
X-ray			
CT Scan			
MRI Scan			

Type of Test	Date & Time	Results	Tick if pending
Photographs			
Others			
Any Other Comments:			

Proforma for the management of Sudden Unexplained Death in Children

APPENDIX 2A: HISTORY RECORD

(To be completed by the Duty Consultant Paediatrician)

Child/Hospital Details			
Child's Name:		**Date of Birth:**	
Hospital Number:		**Date of Death and Time:**	
Hospital Name:		**Place of Death eg ED/Other (Specify):**	
Name of A&E Consultant:		**Signature:**	
Date:		**Time:**	

Circumstances of the Event	
Source of Information:	
Name of Paren(t) / Carer(s)	**Relationship to Child**

Date & Time when the child was found collapsed/dead:	
Name of the person who found the child collapsed/dead:	
Was it at home or at another place?	
If other than home, state the address:	
Which room of the House: *(Child's own bedroom/parental bedroom/other-please specify)*	
Where was the child found? *(Parental bed/cot/basket/sofa/other-please specify)*	
If parental bed, who was with the infant?	
If parental bed, what was the size *(single/double?)*	
What was the condition of the child?	
What position was the child found? *(Prone/Supine/other-please specify)*	
Was the baby's face covered with blankets or any other clothing?	

Did the child's mouth or nose appear blocked? *(If Yes, please give details)*	
Was there any evidence of vomiting? *(If Yes, please give details)*	
Was there any evidence of bleeding? If so, describe *(site, fresh whole blood/ serosanguinous/blood clots)*	
What made the carer see to the child? *(Feeding time/nappy change/ crying/too quiet/interval since previous contact/other-please specify)*	
Was the child on an apnoea alarm monitor? *(Should the infant/child be in an apnoea alarm monitor)*	
What time was the child last seen alive?	
Who was the person who last saw the child alive?	
What was the reason for attendance? (Feeding/changing, etc, please specify)	
What was the condition of the child?	
Who were the persons who looked after the child in the last twelve hours?	
Account preceding the event (record verbatim)	

Any Other Comments:

Proforma for the management of Sudden Unexplained Death in Children

APPENDIX 2B: HISTORY RECORD

(To be completed by the Duty Consultant Paediatrician)

Child/Hospital Details			
Child's Name:		**Date of Birth:**	
Hospital Number:		**Date of Death and Time:**	
Hospital Name:		**Place of Death eg ED/Other (Specify):**	
Name of A&E Consultant:		**Signature:**	
Date:		**Time:**	

SYMPTOMS IN THE LAST 72 HOURS				
How was the infant/child fed? Breast or Formula? (Name):				
Feeding pattern	**Type**	**Volume**	**Frequency**	**Additives**

What age was the infant weaned and what was the current regime?	
What time did the child have the last meal (in older child)?	
Did the child appear ill or unwell during the last 72 hours? *(If Yes, please give details)*	
Was the child feeding poorly? *(If Yes, please give details)*	
Did the child cry persistently or have poor sleep? *(If Yes, please give details)*	

Last Medical Attention	**Date**	**Reason**
Health Visitor		
GP Reason		
Emergency Department		

Last Medical Attention	Date	Reason
Any injury not reported? *(If Yes, please give details)*		

Child's Past Medical History			
Place of Birth:		Mode of Delivery:	
Gestation:		Birth Weight:	
APGAR Score/ Resuscitation at birth:			

	YES	NO
Did the infant require admission to the neonatal unit?		
(If Yes to the above question, please give details)		
Was the developmental progress normal?		
(If No to the above question, please give details)		
Was the child thriving and showing normal growth?		
(If No to the above question, please give details)		
Was the immunisation up-to-date?		
Any known allergies?		
(if Yes to the above question, please give details)		

Any Other Comments:

In older children the history needs to expand to include details about schooling and social interaction.

Proforma for the management of Sudden Unexplained Death in Children

APPENDIX 2C: HISTORY RECORD

(To be completed by the Duty Consultant Paediatrician)

Child/Hospital Details			
Child's Name:		**Date of Birth:**	
Hospital Number:		**Date of Death and Time:**	
Hospital Name:		**Place of Death eg ED/Other (Specify):**	
Name of A&E Consultant:		**Signature:**	
Date:		**Time:**	

Names, Ages, Relationships of those living/residing in the household (other than mother, siblings)		
Name	**Age**	**Relationship to Child**

Family History **Complete for mother, current partner, and other adults in the house, (e.g. father of other children, grandparents, day time carer or other household resident)**				
	Mother	**Father/Partner**	**Other Family Member/Carer**	**Other Family Member/Carer**
Date of Birth & Age				
Occupation				
Smoking (per day)				
Epilepsy (Y/N) *(If Yes, give details)*				
Sudden Adult Death (SAD)				

Family History **Complete for mother, current partner, and other adults in the house, (e.g. father of other children, grandparents, day time carer or other household resident)**				
(If Yes, give details)				
Sudden Unexpected Death in Children *(If Yes, give details)*				
Psychiatric Illness (Y/N) *(If Yes, give details)*				
Violence (Y/N) *(If Yes, give details)*				
Convictions (Y/N) *(If Yes, give details)*				
Alcoholic *(amount, type and when last taken)*				
Drugs *(name and time when last taken)*				
Other State *(epilepsy, diabetes, severe learning disabilities, cerebral palsy, etc)*				

Any Other Comments:

Proforma for the management of Sudden Unexplained Death in Children

APPENDIX 2D: HISTORY RECORD

(To be completed by the Duty Consultant Paediatrician)

Child/Hospital Details			
Child's Name:		**Date of Birth:**	
Hospital Number:		**Date of Death and Time:**	
Hospital Name:		**Place of Death eg ED/Other (Specify):**	
Name of A&E Consultant:		**Signature:**	
Date:		**Time:**	

Siblings		
Name	**Date of Birth**	**Sex**

Sibling History:	**Name**	**Name**	**Name**	**Name**	**Name**	**Name**
SIDS						
ALTE						
Seizure Disorder						
Medical condition						
Psychiatric Illness						
Substance Abuse						
Previous Non-						

Sibling History:	Name	Name	Name	Name	Name	Name
Accidental Injury						
Currently Subject to a Child Protection Plan						
Behavioural Disorder						
Violence						
Other						

Any Other Comments:

Proforma for the management of Sudden Unexplained Death in Children

APPENDIX 3A: PHYSICAL EXAMINATION RECORD

(To be completed by the Duty Consultant Paediatrician)

Child/Hospital Details			
Child's Name:		**Date of Birth:**	
Hospital Number:		**Date of Death and Time:**	
Hospital Name:		**Place of Death eg ED/Other (Specify):**	
Name of A&E Consultant:		**Signature:**	
Date:		**Time:**	

	Please give details
Weight (kg):	
Length:	
Head Circumference (cm):	
Ophthalmic Examination: *(contact Ophthalmologist if required)*	
Pre-intubation Mouth Examination:	
ENT Examination:	
Sites of Medical Intervention:	
Any Visible Bleeding or Discharge:	
Photographs Required: *(Contact Senior Investigating Officer to arrange)* - Facial - Upper body - Entire body front - Entire body back	
Examination of Musculoskeletal System: Spine, Skull, Chest, Upper and Lower Limbs	
Describe and Measure any visible bruises, lacerations or signs of injury: *(Use body diagrams in Appendices 3B and 3C)*	

Observations About Parent(s) /Carer(s)	
Were there any inconsistencies in the history? If so, give details:	
Did parent(s)/carer(s) appear under the influence of alcohol? If so, give details.	
Any other observations?	

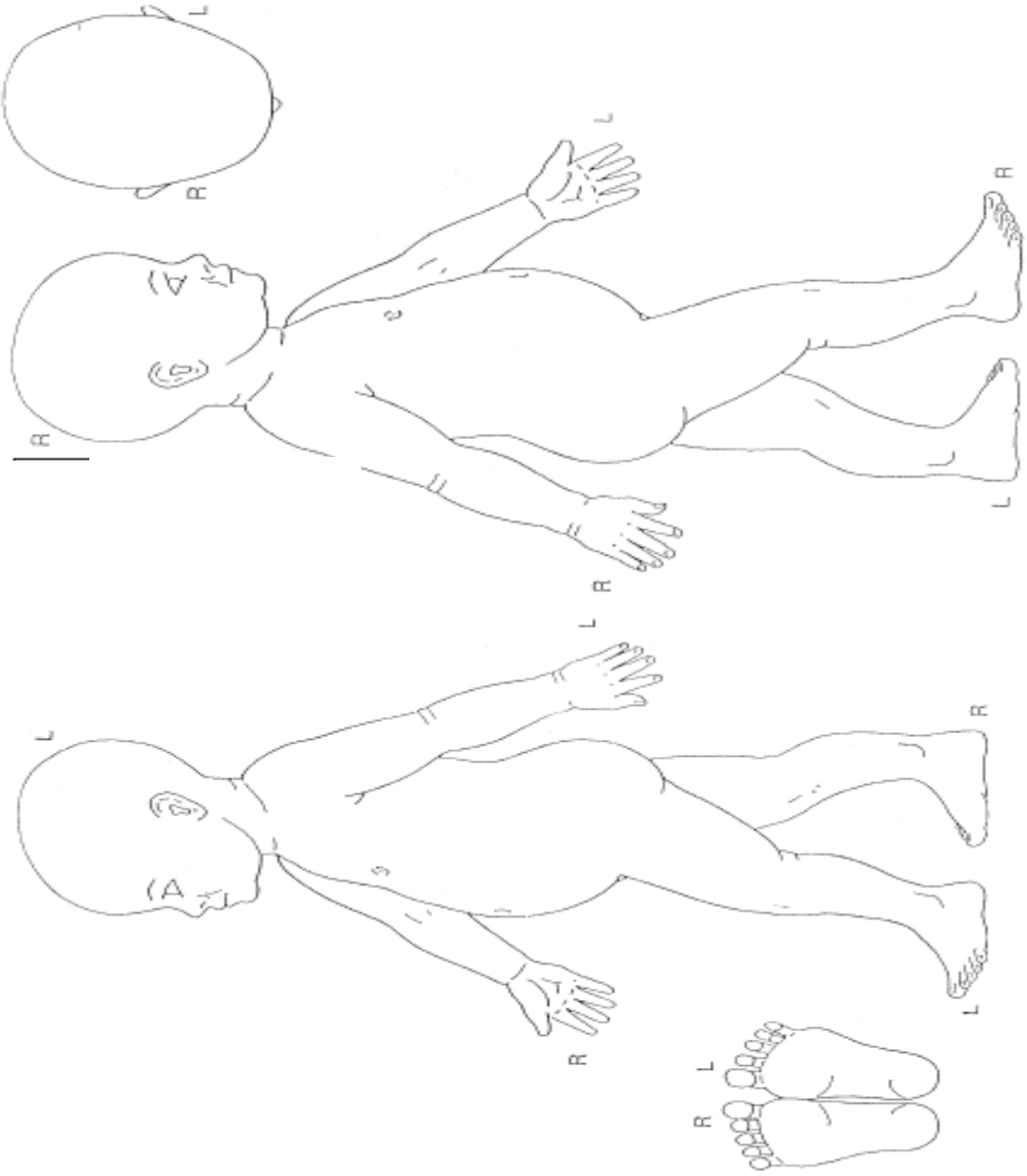
Any Other Comments:

Proforma for the management of Sudden Unexplained Death in Children

APPENDIX 3B: PHYSICAL EXAMINATION RECORD

(To be completed by the Duty Consultant Paediatrician)

Child/Hospital Details			
Child's Name:		**Date of Birth:**	
Hospital Number:		**Date of Death and Time:**	
Hospital Name:		**Place of Death eg ED/Other (Specify):**	
Name of A&E Consultant:		**Signature:**	
Date:		**Time:**	

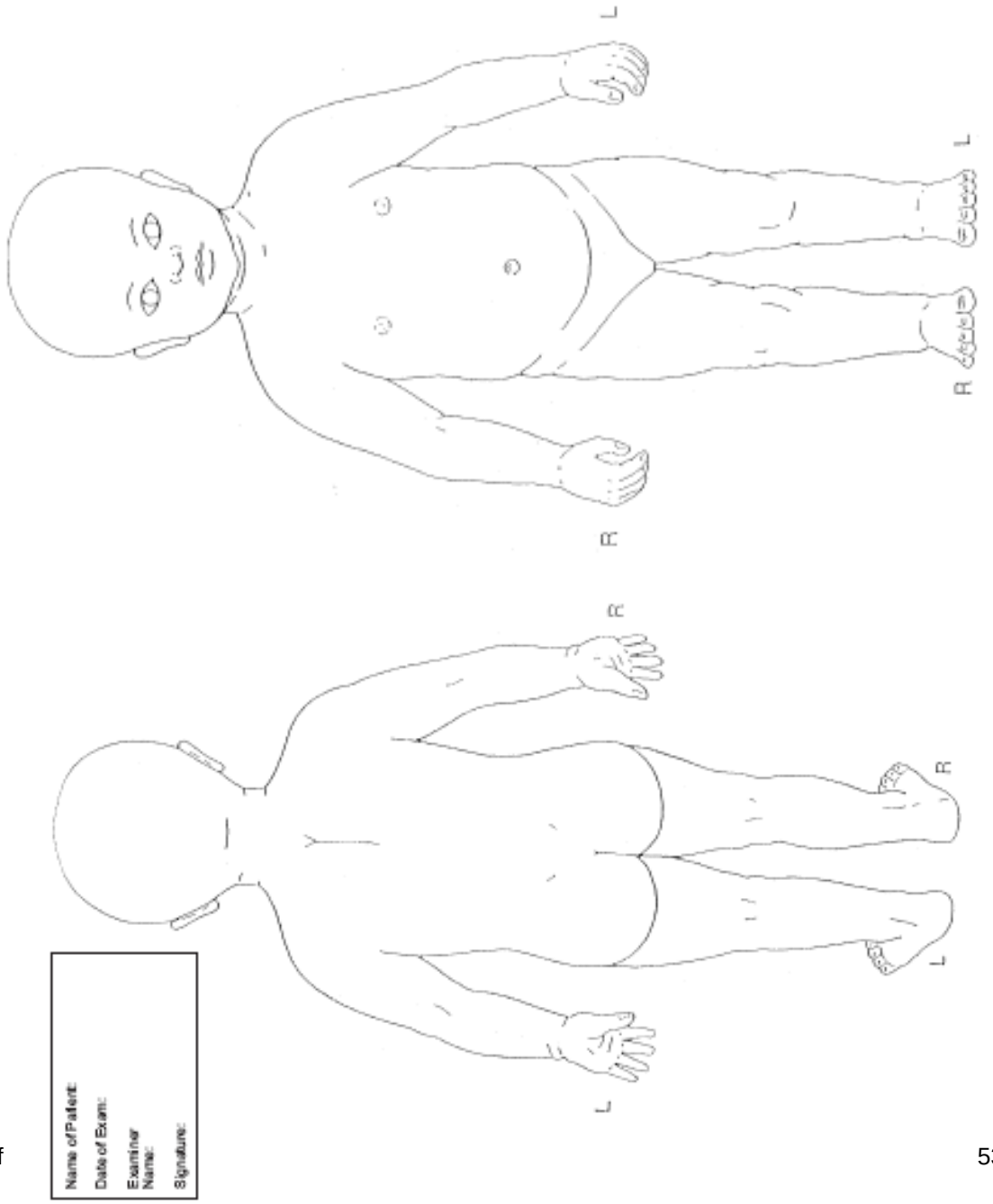


Proforma for the management of Sudden Unexplained Death in Children

APPENDIX 3C: PHYSICAL EXAMINATION RECORD

(To be completed by the Duty Consultant Paediatrician)

Child/Hospital Details			
Child's Name:		**Date of Birth:**	
Hospital Number:		**Date of Death and Time:**	
Hospital Name:		**Place of Death eg ED/Other (Specify):**	
Name of A&E Consultant:		**Signature:**	
Date:		**Time:**	



APPENDIX 4: COLLECTING POST MORTEM SAMPLES

1. All investigations listed below will be undertaken at post mortem. However, if for various reasons the post mortem is delayed and/or cannot be undertaken, the various pathology samples and investigations are required (see the list below).

2. Please discuss with the Coroner and/or the Pathologist before taking any samples or undertaking any further investigations**.**

3. All pathology samples must be collected in respective collecting media and appropriately labelled with the child's name, hospital number date and time and duly signed.

4. A record must be made of all samples taken and documented in the notes.

5. Appropriate laboratory requisition forms must be filled in if the samples are being sent to the local laboratory.

6. If the samples are being collected to accompany the body (as per advice of the Coroner or the Pathologist), these samples must be labelled and sealed in specially designed police bags and handed over to the police.

7. Discuss with the Coroner and the Radiologist if an immediate skeletal survey or radiology is required.

8. Discuss with the SIO if any photography is required.

Blood culture: Aerobic & Anaerobic cultures

Blood: Viral studies (5ml clotted blood)

Blood chemistry Neonatal screening blood test card (5ml Lithium Heparin) for

- Hb CO (Carboxy Haemoglobin)
- MetHb (Methaemoglobin)
- Liver function tests
- Amino acids*
- MCAD (Medium Chain Acyl-CoA-dehydrogense)*

Blood: drug assay (5ml clotted)*
(Opiates, Benzodiazepines, Alcohol, Salicylates, Paracetamol)

Blood: EDTA sample 2ml for Metabolic screen (Organic and Fatty acids)* & DNA studies

Urine sample (Suprapubic aspiration) for Infection, Drug assay, acy l-carnitine, MCAD, Conitine assay, Organic and Amino acids

Swab visible blood before cleaning

Photographs for post mortem: Specific photograph for suspected injuries or external anomaly (ies)

Skeletal survey before post mortem: (AP and lateral views)

Independent check for ETT localisation (or capnograph trace)

* *these tests can be done on either blood or urine*

Proforma for the management of Sudden Unexplained Death in Children

APPENDIX 5: INVESTIGATIONS AND TESTS UNDERTAKEN AFTER FAILED RESUSCITATION

(To be completed by the Duty Consultant Paediatrician)

Child/Hospital Details			
Child's Name:		**Date of Birth:**	
Hospital Number:		**Date of Death and Time:**	
Hospital Name:		**Place of Death eg ED/Other (Specify):**	
Name of A&E Consultant:		**Signature:**	
Date:		**Time:**	

	YES	**NO**
Blood culture		
Aerobic		
Anaerobic		
Blood Viral studies (5ml clotted blood)		
Urine sample (Suprapubic for infection, drugs, acy l-carnitine, MCAD),		
organic and amino acids		
Blood chemistry		
Neonatal screening **blood test card**		
Blood (5ml Lithium Heparin)		
Hb CO (Carboxy Haemoglobin)		
MetHb (Methaemoglobin)		
Liver function tests		
Amino acids*		
MCAD (Medium Chain Acyl-CoA-dehydrogense)*		
Blood drug assay (5ml clotted)*		
(Opiates, Benzodiazepines, Alcohol, Salicylates, Paracetamol)		
Blood (EDTA sample 2ml) for		
Metabolic screen (Organic and Fatty acids)*		
DNA studies		
Swab visible blood before cleaning		
Photographs for autopsy (Discuss with SIO)		
Specific photograph		
? NAI		
External anomaly		
Skeletal survey before post mortem:(discuss with radiologist)		
Independent check for ETT localisation		
* these tests can be done on either blood or urine		

Proforma for the Management of all Child Deaths

APPENDIX 6: FORM A – NOTIFICATION OF CHILD DEATH

(To be completed by the Emergency Department Liaison Nurse)

Notification to be reported to the Child Death Overview Panel (CDOP) Manager (or equivalent):			
CDOP Name:		**Email:**	
Tel:		**Fax:**	
Completed by:		**Signature:**	
Date:		**Time:**	

The information on these forms and the security for transferring it to the CDOP Co-ordinator should be clarified and agreed with your local Caldicott guardian.

If there are a number of agencies involved, liaison should take place to agree which agency will submit the Notification.

Child's Details		
CDOP Identifier No:		
Full Name of Child:		
Any aliases:		
Date of Birth: **Age in days/ months/ years:**	**/ /**	**NHS No:**
Address:		
Postcode:		
School / Nursery, etc:		
Date & Time of Death:	**/ /** **Time**	
Other Significant Family Members:		

Referral Details	
Date of Referral:	**/ /**
Name of Referrer:	
Agency:	
Address:	
Tel Number:	
Email:	

N.B.
Page 1 can be removed for the purposes of anonymising the case.
Page 2 should be made available with Form B to the Child Death Overview Panel.

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

† An unexpected death is defined as the death of a child which was not anticipated as a significant possibility 24 hours before the death or where there was a similarly unexpected collapse leading to or precipitating the events which led to the death.

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

APPENDIX 7: CONTACT PERSONNEL

Coroner's Office

Mr Nicholas Rheinberg
HM Coroner Cheshire

In hours 01925-444216
Safe fax 01925-444219
Out of hrs 077 300 75820
nrheinberg@warrington.gov.uk

Monday – Friday 08:00 to 16:00

To report a death or seek advice contact:

Chester District
01925 442473/4

Crewe District
01925 442479/81

Macclesfield District
01925 442478/83

Warrington District
01925 442475/6/7

Alternatively contact the Coroner's office in Warrington: 01925 444216.

The office is closed for thirty minutes from 12:30 each day

OUT OF HOURS

The Coroner: 077 300 75820
nrheinberg@warrington.gov.uk

Form A – Child Death Notification

All Form A's to be sent to:
Pan-Cheshire CDOP Admin
CDOP@cheshireeast.gcsx.gov.uk
Tel: 01606 288923

SUDDEN UNEXPECTED DEATH IN INFANTS AND CHILDREN (SUDIC)

Designated Doctors for Child Deaths and SUDIC/CDOP Nurses

Warrington

Dr Nisar Mir (SUDIC & CONI)
In hours 01925-662215
Safe fax 01925-662009
nisar.mir@whh.nhs.uk

CDOP Nurse – vacant post

Crewe and Macclesfield

Dr Arumugavelu Thirumurugan
In hours: 01270 612294
Safe fax: 01270 273491
a.thirumurugan@nhs.net

Specialist Nurse for CDOP – Janice Bleasdale
In hours: 01606 288923
Mobile: 07920 765220
jbleasdale@nhs.net

Chester

Dr: Rajiv Mittal
In hours: 01244 364802
Safe fax: 01244 365089
rmittall@nhs.net

Specialist Nurse for Safeguarding/CDOP Sharon Dodd
In hours: 01244 393332
sharon.dodd@nhs.net

Halton

Dr Suprio Bhattacharyya
In hours: 01928-593029
Safe fax: 01928-569532
Suprio.Bhattacharyya@hsthpct.nhs.uk

Source: Pan-Cheshire LSCB's Guidelines: Management of SUDIC 2015

APPENDIX 8: CHECK LIST OF COMPLETION OF DOCUMENTATION

The ED Liaison Nurse shall check that the documents are complete and arrange for *three copies to be made.

Child/Hospital Details			
Child's Name:		**Date of Birth:**	
Hospital Number:		**Date of Death and Time:**	
Hospital Name:		**Place of Death eg ED/Other (Specify):**	
Name of A&E Liaison Nurse:		**Signature:**	

Documents	**Who is responsible for completing the notes?**	**Photocopied *(3 copies)**
Appendix 1 (1A,B,C)	Emergency Department Consultant	
Appendix 2 (2A,B,C,D)	Attending Paediatrician	
Appendix 3 (3A,B,C)	Attending Paediatrician	
Appendix 4	Attending Paediatrician	
Appendix 5	Attending Paediatrician	
Appendix 6	Emergency Department Liaison Nurse	
Appendix 7	Emergency Department Liaison Nurse	
Emergency Department records	Emergency Department Consultant	
Ambulance record	Ambulance team	
Red book (infants)	Original from the parents	
Hospital record	Attending Paediatrician	

Original records should be kept in the child's notes and retained by the attending Consultant Paediatrician. *Copies should be sent to:

1. **The Pathologist (**a clear copy of the child's hospital records and SUDIC forms to accompany the body)
2. **The Coroner**
3. **Local SUDIC Paediatrician**

Name of A&E Liaison Nurse	**Signature**
Date:	**Time:**

APPENDIX 9: AUDIT TOOL FOR RAPID RESPONSE – FORM D

To be completed for each unexpected child death

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

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

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

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

APPENDIX 10: AUDIT TOOL FOR CHILD DEATH OVERVIEW PANELS – FORM E

1. How many child deaths have occurred of children normally resident in your local authority area during the past 6 months?

_____ Not known ☐

2. How many were notified to your panel?

_____ Not known ☐

3. How many deaths of children not normally resident in your local authority area have been notified to your panel in the past 6 months?

_____ Not known ☐

How many of these has your panel been actively involved in reviewing?

_____ Not known ☐

4. How many times has your panel met during the last 6 months?

_____ Not known ☐

For each meeting of your panel within the past 6 months, please complete the following information.

5. Which agencies / professionals were represented at the meeting? (tick all that apply)

Police	☐	Children's Social Care	☐
Hospital paediatrician	☐	Community paediatrician	☐
Nursing	☐	Midwifery	☐
Public health	☐	Primary Care	☐
Education / school	☐	Coroner's office	☐
Bereavement support	☐	Lay member	☐
Not known	☐		

Other (please specify) _____

How many panel members were present?

_____ Not known ☐

6. How many cases were discussed at the panel meeting?

_____ Not known ☐

How many cases of each category of death were discussed at the meeting?

Expected death from natural causes		Homicide	
Unexpected death from natural causes		Suicide	
SIDS		Cause of death not established	
Accident		'Near misses'	
Not known	☐		

How many deaths were discussed in each of these age groups?

Neonatal deaths (< 4 weeks)		Infant deaths (4 – 52 weeks)	
1 – 4 years		5 – 9 years	
10 – 14 years		15 – 18 years	
Not known	☐		

How many deaths were considered to be preventable?

Preventable		Potentially preventable	
Not preventable		Inadequate information to make judgement	☐

7. Were any cases referred on for further investigation? If so, please list how many under each category?

No deaths referred on	☐	Coroner	
Police / CPS		Social Services for s47 enquiry (siblings / other children	
LSCB for Serious Case Review		Not known	☐
Other (please specify)			

8. Did the panel make recommendations in any of the following areas? (tick all that apply)

Recommendations specific to the management of an individual case	☐	Community education / awareness	☐
Training commissioners / providers	☐	National education / awareness	☐
Changing local organisational structures and practices	☐	Advocacy and health promotion	☐
Changing regional policies or practices	☐	Mobilising local communities	☐
Influencing legislation or national policy	☐	No recommendations	☐
Not known	☐		