PAN DORSET INTER-AGENCY SAFEGUARDING PROCEDURES

WORKING DRAFT

CHAPTER 3

3.6 SUDDEN UNEXPECTED DEATHS IN CHILDHOOD

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If you have any comments or queries about the pan-Dorset procedures please contact your agency representative on the Pan Dorset Policy and Procedures Group or notify the LSCB using the following email addresses:

info@dorsetlscb.co.uk
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SUDDEN UNEXPECTED DEATHS IN CHILDHOOD

A joint agency protocol for investigation and management in Dorset

FOREWORD

The death of a child is a traumatic time for everyone involved. The family will be experiencing extreme grief, and where the death is unexpected (i.e. not anticipated as a significant possibility, for example, 24 hours before the death, or where there was a similarly unexpected collapse or incident leading to or precipitating the events that led to the death), the family will also be in a state of shock. Professionals will need to support the family in understanding what has happened and why. The majority of unexpected child deaths occur as a result of natural causes or accidents. Nevertheless, there is a need to identify where a parent or carer[1] may have been responsible for a child's death and to fully investigate the circumstances of such deaths. The interagency response, management and investigation of unexpected deaths in childhood should therefore keep a sensitive balance between the medical management, the care and support of the family and any investigation into the cause of death, including any forensic requirements.

BACKGROUND

- Since the early 1990s and the introduction of the 'Back to Sleep' campaign and similar initiatives, there has been a dramatic reduction in the incidence of Sudden Infant Death Syndrome (SIDS). Many of the key factors for SIDS have been identified and measures have been taken to reduce the risks. Further research is continuing to try to establish the cause(s) of SIDS, but at present the condition cannot be fully explained.

- Medical research has become increasingly advanced so that most unexpected child deaths can be explained following a post mortem and other tests. The number of unexplained deaths in infancy and childhood has therefore gradually reduced.

- Accident prevention strategies and awareness raising campaigns have been developed nationally and locally with great success, thereby reducing the incidence of children who die as a result of avoidable accidents. Whilst most accidents are preventable, it is important to establish whether the care and supervision of the child was what could have been reasonably expected.

- It is likely that very few cases a year of sudden unexpected death will occur, but when they do, this protocol should always apply.

SCOPE

This protocol:

- relates to the county of Dorset, covered by Bournemouth and Poole and Dorset Local Safeguarding Children Boards (LSCBs), and as such is to be adhered to by all agencies;

- draws on a number of local and national initiatives including the Foundation for the Study of Infant Deaths (FSID), Confidential Enquiry into Maternal and Child Health (CEMACH), South West Infant Sleep Study (SWISS) together with the current high standard of practice and multi-agency working within Dorset. This has provided the opportunity to establish good practice and working within clear management strategies, enabling a high quality of service to families;

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- should be applied to all unexpected deaths in infancy and childhood whatever the cause. This should include unexpected deaths within a hospital environment and deaths in children with a life limiting condition if the timing was unexpected. It relates to infants from birth to children and young people **under the age of 18 years old**. Most unexpected child deaths occur in infancy and much of the guidance relates specifically to infants. However, many of the principles of management apply equally to older children and the same protocols should therefore be followed;

- should be considered where there is an unexpected, life-threatening collapse or incident, to secure and preserve evidence or other information, taking into account the "golden hour" principle, where life is for the time being supported in a hospital environment, but where death is judged to be highly likely;

- can be applied in other circumstances, e.g. in dealing with a child who has suffered a life threatening injury where it is not known where the child will survive.

1. Footnote: the term 'parent/s' is used throughout and is to mean parent/guardian/carer.

1. Introduction

1.1 The majority of unexpected child deaths occur as a result of natural causes and are an unavoidable tragedy for any family.

1.2 This protocol outlines the responsibilities of agency staff in dealing with a tragic situation sensitively whilst taking correct action to differentiate between death from natural causes and suspicious deaths.

1.3 In situations where an accident is the cause of the unexpected death, consideration needs to be given as to whether the accident reflected inadequate care of a child. Where this appears to be the case, enquiries of other agencies should be made by police to ensure that all relevant information is obtained, and, if appropriate, an inter-agency meeting is convened and this protocol is applied.

1.4 An unexpected child death is a very difficult time for everyone. The time spent with the family may be brief, but actions may greatly influence how the family experiences the bereavement for a long time afterwards. A sympathetic and supportive attitude whilst maintaining professionalism towards the investigation is essential. The following principles should always be applied:

- Use sensitivity with family members and colleagues
- Have an open minded / balanced approach
- An inter-agency response
- Share information appropriately
- Respond appropriately to the circumstances
- Preserve evidence
- Identify needs in relation to diversity and provide for them, e.g. using an appropriately skilled interpreter or communicator
- Use knowledge of best practice in working with loss and bereavement

1.5 In situations where there are other children in the household, and there is evidence indicating a suspicious death or concern arises that a child's unexpected death may be due to abuse or neglect, professionals will continue to follow these guidelines in conjunction with the guidance relating to Section 47 enquiries within Part 1 Chapter 2 of the Inter-agency Safeguarding Procedures for Bournemouth, Dorset and Poole.

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2. Procedure

Multi-Agencies involvement, Discussion and Assessment

Guidelines for individual agencies follow later in the protocol

2.1 All cases of unexpected child death need to be referred to the coroner, and the subsequent assessment and management will be carried out in close liaison with the coroner. The designated paediatrician for unexpected deaths in childhood should also be informed. The investigation and management of these cases should follow a multi-agency approach, as set out in this protocol.

2.2 Where appropriate, a serious incident notification should be made to Ofsted at National Business Unit, 3rd Floor, Royal Exchange Buildings, St Ann's Square, Manchester M2 7LA.

2.3 In the aftermath of an unexpected child death, professionals may need to fulfil several roles. Those professionals involved (before or after the death) with a child who dies unexpectedly should come together to enquire into and evaluate the child's death. A balance must be kept between medical and forensic requirements and the need to support family members grieving for their child. (If the death is considered to be suspicious then the police may have to arrest the parents.)

2.4 From the first point of contact with the child and/or family, each agency on becoming involved has a responsibility to assess whether the circumstances of the child's death should be considered in accordance with this protocol. In all situations of concern the police should be informed.

2.5 The sharing of information between relevant agencies at an early stage following the report of a sudden child death is vital. It will assist in assessing the level of any suspicions and in deciding upon the direction and level of investigation, practice, procedures, the timing and personnel involved in any home visits, ensuring appropriate support for the family, and in determining the overall strategy to be adopted. The Pan Dorset Overarching Information Protocol provides guidance and sets out the legal framework to facilitate the sharing of information.

2.6 Due to time constraints, initial information sharing and multi-agency discussions may have to take place over the telephone. Obviously not all relevant information will be available at this early stage and arrangements may have to be made for subsequent discussions following the obtaining of further information. Consideration should be given to further meetings in the light of information gathered; in order to re-evaluate and review actions agreed.

Parental involvement

2.7 The parents will be informed at the earliest opportunity of the nature of information gathering and sharing and the multi-agency approach involving health, police and children's services and of the coroner's involvement.

Welfare of other children / child who has a life threatening injury, but is surviving

2.8 Where there are issues relating to other children in the family, or there has been previous relevant children's service involvement, or where there are suspicions requiring Section 47 enquiries, the Children's Services team will need to be more directly involved. Such concerns may be apparent at the outset, or may come to light at any stage during the investigation.

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Where the child is surviving, but this protocol is being used, it is essential that alongside any SUDIC investigation, multi-agency planning for the safety and welfare of the child is maintained, using, for example, strategy meetings under s47 of the Children Act 1989.

2.9 When a baby or older child dies unexpectedly in a non-hospital setting, the on-call Child Abuse Investigation Detective Sergeant (CAIT DS), on behalf of the senior investigating police officer (SIO), or coroner's officer must contact the senior healthcare professional (usually the designated paediatrician for unexpected deaths in childhood or the consultant paediatrician on-call on behalf of the designated paediatrician for unexpected deaths) and Children Services to inform them of the circumstances.

2.10 Together they will make a decision about which other agencies should be included within an immediate multi-agency case discussion and whether a visit to the place where the child died should be undertaken. This visit should almost always take place for infants who die unexpectedly. Where a visit is to take place, a decision should also be made about how soon (within 24 hours) and who should attend. It is likely to be the on-call CAIT DS and a healthcare professional experienced in responding to unexpected deaths. They may make this visit together or separately and then confer (see local child death review protocol). When such a visit is carried out, this will be coordinated by the on-call CAIT DS according to a protocol agreed with the local coronial services and the designated paediatrician for unexpected deaths in childhood**.** A Police Senior Investigating Officer will be appointed who will assume responsibility for the unexpected child death investigation. The SIO will be the specialist child abuse investigation Detective Inspector, the Safeguarding Referral Unit Detective Inspector, CID Public Protection Detective Chief Inspector or, if unavailable, will be the Force on-call senior detective (DI/DCI). The CAIT DS will report directly to the SIO.

2.11 After the visit described above, the senior investigating police officer in conjunction with the CAIT DS, visiting healthcare professional, GP, health visitor or school nurse and Children's Services representative should review whether there is any additional information that could raise concerns about the possibility of abuse or neglect having contributed to the child's death.

Further case discussion following post mortem

2.12 A multi-agency case discussion should be convened by the designated paediatrician for unexpected child deaths following the preliminary results of the post mortem examination. This will usually be a telephone discussion. This discussion usually takes place 5-7 days after the death and should involve the pathologist, police, LA Children's Services and the paediatrician, plus any other relevant healthcare professionals, to review any further information that has come to light.

2.13 The designated paediatrician for unexpected deaths in childhood should convene and usually chair a case discussion meeting following the final results of the post mortem examination. The timing of this meeting will vary and may be eight – twelve weeks after the death. The meeting should include professionals who knew the child and family and those involved in investigating the death. The collection of the core data set should be completed. The purpose of this meeting is to share information to identify the cause of death and / or those factors which may have contributed to the death, and then to plan future care for the family. Potential learning points may also be identified. The meeting may also inform any inquest being held.

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2.14 If at any point in the investigation / assessment there are concerns about surviving children living in the household see section 9.

2.15 The results of the post mortem examination should be discussed with the parents at the earliest opportunity, except in those cases where abuse is suspected or the police are conducting a criminal investigation. In these situations the paediatrician must discuss with LA Children's Services, the police and the pathologist what information should be shared and when.

2.16 An agreed record of the case discussion meeting and all reports should be sent to the coroner, if needed to take into consideration in the conduct of an inquest and in the cause of death notified to the Registrar of Births and Deaths.

2.17 The record of the case discussions and the core data set should also be made available to the local Child Death Overview Panel when the child dies away from their residential area (see 11.2).

Working with Loss and Bereavement

2.18 It is important to remember that people are in the first stages of grief and may react in a variety of ways, such as shock, numbness, anger or hysteria. Allow the parents space and time to hold the child to cry, to talk together and to comfort any other children. These early moments of grieving are very important.

2.19 It is normal and appropriate for a parent to want physical contact with their dead child. In all but exceptional circumstances, such as when crucial forensic evidence may be lost or interfered with, this should be allowed in the presence of a professional who should carefully observe the contact and record the details, ensuring that the contact is supervised at all times. If the death is the subject of a police investigation, the child should not be changed or washed before approval by the senior investigating police officer.

2.20 The child should always be handled as if still alive, remembering to use their name at all times as a sign of respect and dignity. Under no circumstances should the child be referred to as 'it'.

2.21 All professionals need to take into account any religious and cultural beliefs that may have an impact on procedures. Such issues must be handled sensitively, but the importance of the preservation of evidence and the elimination of any concerns about abuse or neglect should not be forgotten.

2.22 The parents should be allowed time to ask questions about practical issues. This includes telling them where their child will be taken and when they are likely to be able to see their child again.

2.23 The names and telephone numbers of relevant people should be given to parents in writing.

2.24 The parents need to be informed that all sudden deaths need to be reported to the coroner immediately and that there will be a need for a post mortem examination. The coroner may decide to hold an inquest. All investigations into the cause of death need to be conducted under the direction of the coroner.

2.25 Parents must be informed about the necessity to carry out all examinations and a post mortem. Parental consent to a post mortem examination is not required, but parents should receive a sensitive explanation of what is involved. This should usually be done by the senior doctor (consultant or registrar level in paediatrics and/or A&E).

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Following the post mortem, parents will have a say in what they would like to happen to any tissues / organs removed during the post mortem Consent from those with parental responsibility for the child is required for tissue / organs to be retained beyond the period required by the coroner(see 10.9).

Obtaining and Recording Information

2.26 All professionals must record history and background information given by parents in as much detail as possible. The initial accounts about the circumstances, including timings, must be recorded verbatim.

2.27 Staff from all agencies need be aware that on occasions, in suspicious circumstances, the early arrest of the parents may be essential in order to secure and preserve evidence.

2.28 The coroner and/or police may require documentary information held by other agencies, which should be made available in the format agreed by individual agencies. Release of this information is permitted by Data Protection legislation for the prevention or detection of crime, or in pursuance of statutory functions. Professionals from all agencies must be prepared to provide statements of evidence promptly if required.

3. Factors which may arouse suspicion

3.1 Certain factors in the history or examination of the child may give rise to concern about the circumstances surrounding the death. When 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. The following list, whilst not exhaustive, provides guidance:

- *Previous Child Deaths*. Approximately 1 in 2000 children dies suddenly during infancy. Two unexpected child deaths within the same family, whilst very unusual, may be the effect of a metabolic abnormality and does not necessarily signify child abuse.

- Previous child protection concerns within the family relating to this child or the siblings.

- Inappropriate delays in seeking medical help.

- *Inconsistent Explanations*. The account given by the parents of the circumstances of death should be recorded verbatim. Any inconsistencies in the story given on different occasions should arouse 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.

- *Evidence of drug/alcohol abuse* - particularly if the parents are still intoxicated. This is more often associated with accidental rather than non-accidental death.

- *Unexplained injury* e.g. unexplained bruising, burns, bite marks. However, it is very important to remember that a child may have serious internal injuries without any external evidence of trauma.

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- *Presence of Blood*. The presence of blood must be very carefully noted and recorded. It is found occasionally in cases of natural death. A pinkish frothy residue around the nose or mouth is a normal finding in some children whose deaths are due to Sudden Infant Death Syndrome. Fresh blood from the nose or mouth is less common, but does occur in some natural deaths. Bleeding from other sites is very uncommon in natural deaths.

- *Neglect Issues*. Observations about the condition of the accommodation, general hygiene and cleanliness, the availability of food, adequacy of clothing, bedding, and temperature of the environment in which the child died are very important. This will include a level of supervision and/or care, below what would be reasonably expected. This will assist in determining whether there may be any underlying neglect issues to consider.

Guidelines for Individual Agencies

The following sections set out the procedures for key agencies involved in the investigation and management of sudden unexpected deaths in childhood. All who have contact with children and young people should refer to their own agency procedures for guidance where they have them in response to a sudden unexpected death of a child which occurs on their premises/site.

4. Ambulance Staff

4.1 The ambulance service must notify the police immediately when they are called to the scene of a sudden unexpected child death. Generally, this will be through the Emergency Medical Dispatch Centre making direct contact with the Police Control Room.

4.2 The recording of the initial call to the ambulance services should be retained in case it is required for evidential purposes. Additionally, ambulance services must also retain bedding, equipment, and any disposable items, e.g. tissues used during the resuscitation, conveyance and treatment of the child.

4.3 Babies who die suddenly and unexpectedly at home should be taken to an A&E department unless this is inappropriate (e.g. the circumstances of the death require the body to remain at the scene for forensic examination). Resuscitation should always be initiated, unless clearly inappropriate and continued until an experienced doctor (usually the consultant on-call paediatrician) has made the decision to stop. Older children may also be taken to A&E unless this is inappropriate (e.g. the circumstances of the death require the body to remain at the scene for forensic examination).

4.4 Ambulance staff should follow the guidance laid down in the current Ambulance Training Manual as follows:

- Do not automatically assume that death has occurred. Clear the airway and if in any doubt about death, apply full Cardio Pulmonary Resuscitation (CPR);

- inform the Accident and Emergency (A & E) department of estimated time of arrival and patient's condition;

- take note of how the body was found;

- pass on all relevant information to the A & E Department;

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- assess whether any injury is compatible with history.

4.5 The first professional on the scene should note the position of the child, the clothing worn and the circumstances of how the child was found. Those remaining at the scene should be asked not to disturb or move items around where the child was found until he/she has been seen by the police. This can be extremely important in helping the family to understand why their child has died.

4.6 If the circumstances allow, note any comments made by the parents, any background history, any possible substance misuse and the conditions of the living accommodation. Any such information must be passed on to the receiving doctor and the police. Where this cannot be recorded at the scene, the ambulance crew must do so upon arrival at hospital and pass the information to the police/paediatrician before leaving the hospital.

4.7 Any suspicions should be reported directly to the police and to the receiving doctor at the hospital as soon as possible.

5. General Practitioners and Health Visitors

5.1 There are times when a general practitioner (GP) attends the scene first. In such circumstances, they should adhere to the same general principles as for the ambulance staff (see section 5).

5.2 It is important for the GP to contact the police or Coroner's Officer if they are the first on the scene (taking into account their primary responsibility of saving life/certifying death). The best route for this is to contact the Police Control Room.

5.3 The professional confirming the fact of death should consult the designated paediatrician for unexpected deaths in childhood at an appropriate time.

5.4 Additional guidance can be obtained from the Foundation for Sudden Infant Death (FSID) publication "When a baby dies suddenly and unexpectedly". Whilst this booklet is written specifically for dealing with cot deaths, many of the principles will apply to other child deaths. Further information is available on the FSID website www.fsid.org.uk

5.5 The primary care team plays a crucial role in supporting the family following a sudden child death. The GP or Health Visitor will undertake an initial home visit for support (see para 7.32). If this is not possible, a joint follow up visit will be arranged 1 - 3 days after the death.

5.6 Members of the primary care team may often be aware of wider background information on the family. This information may help to shed light on the circumstances of the death and may be important to the police in considering any criminal investigation. They will also have a role in considering the welfare of any surviving siblings / children in the household. GPs and health visitors should therefore be prepared to share information on the child and other family members with the paediatrician and with the Police Investigation team.

5.7 If a sudden death occurs at home the family may call the GP to the home or, more commonly, call an ambulance leading to the admission of the child to an A&E department. Separate agency guidelines are given to cover both possibilities.

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6. Hospital Staff in Accident and Emergency

Immediate Action

6.1 On arrival in A&E, the child should be taken to an appropriate area, either the resuscitation room or an area set-aside for such purposes. The senior paediatrician on call and the senior doctor in A&E should be notified immediately.

6.2 The family should be provided with privacy and should be kept informed at all times. Staff should be particularly sensitive to the parents' needs and should handle the child with care and respect and refer to the child by name.

6.3 A nurse should be allocated to look after the family. S/he should stay with the family at all times and keep them informed about what is happening.

6.4 The child should immediately be assessed and death confirmed or appropriate resuscitation started. Unless it is clear that the child has been dead for some time (for example when rigor mortis or blood pooling are evident), resuscitation should always be initiated.

6.5 Subject to the approval of the medical staff involved, the parents should be given the option of being present during resuscitation. The allocated nurse should stay with them to explain what is going on, particularly procedures that may look alarming, such as cutting of clothes or intubation.

6.6 The doctor in charge, whenever possible in consultation with the parents, should decide how long it is appropriate for resuscitation to be continued. It is usual to discontinue resuscitation if there is still no detectable cardiac output after 30 minutes (including prior resuscitation by paramedics).

6.7 Immediate responsibility for informing and providing appropriate care and support to the family rests with the senior clinician (in the absence of a Paediatric Consultant/team or A&E Consultant). Whilst senior staff from the disciplines of emergency medicine and/or intensive care may have been involved in the resuscitation events, it is generally not appropriate that they should be responsible for continuing pastoral care of the family and liaison with the primary care team or other agencies.

Assessment and investigation

6.8 If the child is dead, the police should be informed immediately and involved in any assessment, though their involvement should not prevent any other necessary medical assessment or investigation.

A senior doctor (consultant or registrar level in paediatrics or A&E), together with the police CAIT DS, should take a careful history of events leading up to and following the death of the child.

The child should be carefully examined, in particular noting any evidence of injury and the state of nutrition and hygiene of the child. Any injuries or rashes should be documented on a body chart. A rectal temperature should be taken immediately on presentation, using a low reading thermometer if necessary. The site and route of any intervention in resuscitation, for example venepuncture or intra-osseous needle insertion, needs to be carefully recorded. Full growth measurements (length, weight and, for children aged 2 years or under, a head circumference) should be taken and plotted on centile charts.

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The mouth, genitalia and retina should be examined for any signs of injury. If any retinal injury / damage is evident an ophthalmologist should be requested to examine the eyes if possible.

6.9 If any laboratory investigation samples are taken during resuscitation, these should be clearly labelled and documented. Once death has been pronounced, then further specimens should only be taken in accordance with local agency protocols agreed in advance with the coroner. Investigations should include the standard set for SUDI and standard sets for other types of death presentation as they are developed. Some further investigations, including a skeletal survey, will be carried out according to the post-mortem protocol by, or in consultation with, the pathologist.

6.10 It is usual practice for sudden unexpected deaths in infancy / very young children to take photographs of the child along with prints of the hand and foot and a small lock of hair as mementoes for the family. If this is done it must be with the consent of the parents and clearly documented in the notes.

6.11 Clothing can be left on the child. If removed, it should be placed in labelled evidence bags. Any other item, such as bedding brought in with the child, should be placed in labelled evidence bags to be given to the pathologist. The parents should be informed that this has been done. No items should be returned to the parents without consultation with the Senior Investigating Police Officer involved.

6.12 Arrangements for Children's Services to be contacted by telephone regarding information held, including those children who are the subjects of Child Protection plans, will be made by the Senior Investigating Police Officer. This information will include anything known about all other members of the household. The fact that child and / or siblings' names are not known to Children's Services does not exclude the possibility of child protection concerns. Refer to section 9.

6.13 It is important to make detailed records of the history and examination of findings. As far as possible, accounts should be recorded verbatim. The identity of the people present and their relationship to the child should be documented. This record may be used in the legal proceedings. It should give the time as well as the date, and should be signed legibly.

6.14 In all cases presenting to the hospital, the consultant paediatrician on call should be notified.

Family Support

6.15 Consideration should be given to allowing the family as much time and privacy as they wish with the child. Professional presence is vital at all times, but should be discreet.

6.16 It is important that all staff are familiar with the principles and general guidance in Sections 1 and 3 of this protocol.

6.17 When the child has been pronounced dead, the paediatrician (if available) or the A&E Senior Clinician should break the news to the parents, having first reviewed all the available information. The interview should be in the privacy of an appropriate room. The allocated nurse should also be present.

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6.18 Once the child has been pronounced dead, any IV cannula, ET tubes and other equipment may be removed from the child, but this should be documented clearly in the notes. Hospital staff must retain bedding, clothing, equipment and any disposable items, e.g. tissues used during the resuscitation, conveyance and treatment of the child. It may be appropriate to take photographs prior to any cleaning of the child and this, along with washing and re-dressing, should be discussed with the police and paediatrician. During all discussions with the parents, they should be allowed to hold their child if they so wish, under supervision.

6.19 The family should be informed that the death must be notified to the Coroner, and that a post mortem will be required. Unless there is an obvious cause of death, it is usually best to say that an opinion cannot be given until after the post-mortem examination. Explain to the family sensitively what a post mortem involves. Ensure that the family know where this will be done and that it is likely to be at a specialist centre, but that the child will be returned after the post mortem.

6.20 The family should be given copies of available and appropriate bereavement support leaflets, booklets and contact details, e.g. the FSID publication supported by the Department for Education "The Child Death Review", the FSID booklet "When a baby dies suddenly and unexpectedly", the Department of Health leaflet "Guide to the post-mortem examination: brief notes for parents and families who have lost a baby in pregnancy or early infancy", and the FSID death helpline number 0808 802 6868 or via email helpline@fsid.org.uk. This information, together with contact details of local funeral directors, local religious leaders and the different support agencies, should be kept in a readily available folder in A&E.

6.21 The Allocated Nurse should ensure that the family knows where their child will be before they leave the hospital, and that they have the contact details to enable them to arrange a visit if they wish.

6.22 The family should be offered help in contacting other family members or close friends, employers, the hospital chaplain or other religious leader if the parents wish.

6.23 If the infant was a twin, it will normally be appropriate to admit the surviving twin to hospital for monitoring.

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Further Management

6.24 Previous medical records of the child (including A&E records) should be reviewed to identify any factors which may be important in the medical assessment In the case of infant deaths the mother's maternity/obstetric records should also be reviewed. Relevant information should then be shared with the investigating officer if obviously significant or at the strategy meeting.

6.25 The responsibility for the further management, support of the family and future medical risk assessments will usually rest with the paediatrician and primary care team.

6.26 The doctor who pronounces that the child has died must inform the Allocated Nurse and either the Coroner's officer or Police Officer making a record of who he/she told. The doctor should highlight any concerns about the death.

6.27 The Allocated Nurse should inform the GP and health visitor, and the child health department should be notified as soon as possible in accordance with their own procedures.

6.28 Where the death occurred in a hospital, the NHS South West Serious Untoward Incident policy and the Trust's Serious Incidents protocol should also be followed.

6.29 All families should be visited at home within 24-48 hours by the Health Visitor and/or General Practitioner or, on some occasions, the Paediatrician, to assist the family in coping with the loss of a child. This visit will serve a different purpose to that of the home visit carried out by the 'Rapid Response Team' in accordance with requirements of Chapter 7 of Working Together to Safeguard Children 2010. There must, however, be liaison with the police SIO and / or CAIT DS prior to any contact to avoid duplicating visits and to ensure inappropriate questions are not asked about the circumstances of the child's death.

7. Police and Coroners Officers

7.1 The responsibility for investigating suspicious deaths is that of the Force Child Abuse Investigation Team within the Criminal Investigation Department. This will normally be the CAIT Detective Inspector / Safeguarding Referral Unit Detective Inspector or the CID Protection Detective Chief Inspector. If unavailable, it will be the Force on-call senior detective (DI/DCI). If there are concerns identified which cause the Investigating Officer to believe that the death may be due to homicide or the Investigating Officer has other concerns, then he/she should contact the on-call Detective Superintendent.

7.2 It is important for police officers to remember that for most sudden deaths, the death has been the result of natural causes. Police action therefore needs to maintain a careful balance between consideration for the bereaved family and the potential of a crime having been committed.

7.3 In all cases the Coroner's Officer must be notified as soon as possible. As well as the usual functions they perform, their experience in dealing with sudden deaths and bereaved families will be invaluable in explaining to the parent what will happen to their child's body and why. It may be useful for the Coroners Officer to attend the scene, but it is not absolutely necessary. The Investigating officer and the Coroner's Officer should continue close liaison throughout the investigation.

7.4 If the police are the first professionals to attend the scene, they should request urgent medical assistance as the first priority, unless it is absolutely clear that the child has been dead for some time. If this is the case, the police will immediately call a doctor to pronounce death. If the paediatrician is able to attend immediately, he or she can pronounce death. Usually, however, the police surgeon, GP or Coroner's Officer should be called.

7.5 Police should keep attendance to the minimum required. A single officer (CAIT DS) should have the lead responsibility for interviewing the parents, who should not be subjected to repeat questioning by different people about the same events. The Police SIO will determine this.

7.6 Police should exercise sensitivity in the use of personal radios and mobile phones etc. If possible, the officers speaking with the family, whilst not being out of contact, should have such equipment turned off.

7.7 When a sudden unexpected child death occurs at home, the child may still be there when the police and other professionals attend. However, usually the child will already have been taken to the hospital. If this is the case, the principles remain the same. However, in such a situation, there may be two scenes and resources will need to be allocated accordingly.

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It is important to note that if the child has already been moved from the home, this does not negate the need for professionals to visit the home. All professionals should avoid referring to the home as the "death scene", or using other accusatory phrases, which might be misunderstood, or distressing to the family.

7.8 The SIO attending will be responsible for deciding on whether to request the attendance of a Crime Scene Investigator. Certainly if items are to be removed or police photographs or a video are to be taken, their attendance will be essential.

7.9 The first officer at the scene must make a visual check of the child and his/her surroundings, noting any obvious signs of injury. The officer must establish whether the body has been moved and record the current position of the infant. All other relevant matters should also be recorded. Consideration must be given to evidencing factors of neglect that may have contributed to the death such as temperature of scene, condition of accommodation, general hygiene and the availability of food/drink. The senior detective attending is responsible for ensuring that this is done.

7.10 An early record of events from the parent is essential, including details of the child's recent health. This should normally be collected jointly or in close collaboration with healthcare professionals. If death is pronounced at a hospital, then consideration should be given to performing a joint interview of the parents with the senior doctor/clinician (usually paediatrician).

7.11 The preservation of the scene and the level of investigation will be relevant and appropriate to presenting factors. In addition to the normal procedures surrounding a suspicious death (e.g. scene log, general preservation, photographs etc) and in consultation with the SIO, consideration must be given to:

- Retention of bedding and items such as the child's used bottles, cups, food, medication which may have been administered**.** This may be influenced by obvious signs of forensic value such as blood, vomit or other residues. Items should be retained only after the scene has been assessed and recorded by the police.

- The child's nappy and clothing should remain on the child but, if removed, arrangements should be made for them to be retained at the hospital.

- Records of monitoring equipment used by the ambulance service which may be of evidential value; otherwise, this information may only be retained for 24 hours.

7.12 The issues of continuity of identification must be considered. The child should be handled as if he/she were alive. (See sections 3.22 – 3.28)

7.13 In general, avoid any disturbance of the environment around the place where the body was found until the Investigating Officer (as determined by the SIO) has carefully assessed this. This will allow the best understanding of what may have happened and will also result, in those few cases where it is appropriate, in the preservation of the scene for forensic investigation. Non-forensic removal of bedding and other objects destroys the scene and prevents full investigation of what happened - both medical and forensic.

7.14 If it is considered necessary to remove items from the house, do so with consideration for the parents. Explain that it may help to find out why their child has died and that they will be returned later. Before returning the items, the parents must be asked if they actually want them back.

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7.15 If articles have been kept for a while, try to ensure that they are presentable and that any official labels or wrappings are removed before return. Return any items as soon as possible after the Coroner's verdict or the conclusion of the investigation. The term investigation will include any possible trial or appeal process.

7.16 Consideration must be given to evidencing factors of neglect that may have contributed to the death such as temperature of scene, condition of accommodation, general hygiene and the availability of food/drink.

7.17 Police officers have to be aware of other professionals' responsibilities, i.e. resuscitation attempts, taking details from the parents, examination of the child who has died and looking after the welfare needs of the family. They may have to wait until some of these things have happened and take details from these professionals before introduction to the parents. It is not helpful and may be distressing if the same questions are asked repeatedly.

7.18 Paediatricians may have already collected health and childcare information at the hospital and may be better able to obtain important details of the medical aspects of what happened. It is best to ask who was present when the child was fed, vomited, fell, etc. All comments should be recorded. Any conflicting accounts should raise suspicion, but it must not be forgotten that any bereaved person is in a state of shock and possibly confused. Repeat questioning of the parent(s) by different police officers should be avoided at this stage. Joint working with other agencies is essential.

7.19 There may be other children at the scene and their health and wellbeing is of paramount importance. Where there are other children in the household and there is immediate information or later findings which indicate non accidental injuries to the dead child, the information must be conveyed as soon as practicable to the SIO, whose responsibility would be to consider the safety of the other children in consultation with Children's Services. If alternative arrangements for the care of the other children are deemed appropriate, and if no other suitable accommodation is available, consideration should be given to using Police Protection Powers or, in consultation with Children's Services, an Emergency Protection Order. These decisions should not be taken lightly and consultation with the Child Abuse Investigation Team and other agencies is essential. An urgent child protection strategy discussion initiated by police within three to four hours to consider the information available should do this. (See section 9)

7.20 Police visits to the home should be kept to a minimum, and should be carried out by officers in plain clothes.

7.21 Where the death occurred in a custodial setting, appropriate liaison should occur with the investigator from the Prisons and Probations Ombudsman.

8. Children's Services

8.1 In all cases of unexpected child death, or a life threatening injury to a child, the Children's Services duty team or Out of Hours Social Services will be contacted for any information they may hold about the child and/or family. A tripartite (health, children's services and police) discussion will always take place where there are other children of the family, or there is information concerning the family or child who has died held by Children's Services.

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8.2 Children's Services may become more directly involved, either where there are specific support needs if there are other children in the family which cannot be met by other services, and always where there are child protection concerns arising from the circumstances of the death.

8.3 Where Children's Services have had no previous involvement with the child or family, and are not needed to be involved in the investigation, they should still be notified of the outcome for future file reference.

8.4 Where suspicious factors around the death/life threatening injuries have been identified and the child is currently alive/there are other children, there should be a formal child protection strategy meeting in relation to the other children. This meeting should ideally be face to face, and will include a Detective Sergeant from the Child Abuse Investigation Team, paediatrician, a senior representative from the relevant Children's Services team or Out of Hours Social Services, and a Children's Services solicitor. It should also include health visitor and or school nurse/general practitioner, and education, if other child/ren is/are at school.

8.5 The child protection strategy meeting should decide, amongst other things:

- how Section 47 enquiries in relation to other children should proceed;
- what protective measures are required in the meantime;
- whether legal action is appropriate;
- whether an initial child protection conference should be convened;
- contingency plans in case the situation changes;
- what information is to be provided to parents and/or family members;
- how SUDIC procedures will work alongside s47 investigations, and how they will maintain information sharing.

In the context of organisational responsibilities, the child protection strategy meeting should also consider:

- notifying the Chair of the appropriate LSCB if abuse/neglect is suspected for consideration of the need for a Serious Case Review;
- notifying the Strategic Health Authority (SHA) as a requirement of the Serious Untoward Incident Reporting protocol;
- what information should be provided to which staff;
- whether the staff who previously dealt with the family, or are to deal with them in future, are likely to need additional support.

If necessary, further multi-agency meetings should be held with the same representatives to review the situation and plan accordingly.

8.6 Consideration should be given to the well being and any potential risks to the care of other children in the family. This may require a medical examination, and enquiries under Section 47 Children Act 1989, the children to be temporarily cared for by members of the family network or, in extreme circumstances, the children to be looked after in foster care. Wherever possible, however, children should remain with their family, recognising that this is a particularly traumatic time for all family members.

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8.7 Where there is the need for a core assessment led by Children's Services, this should be carefully planned through the multi-agency meeting to ensure co-ordination with any police investigation and ongoing paediatric involvement.

9. Coroner/Pathologist and Post Mortem

9.1 After the death is pronounced the Coroner has control of the body, mementoes and medical samples, other than those described in paragraphs 7.10 which should not be taken without prior consultation with the Coroner.

9.2 The pathologist is chosen by the coroner, in consultation with police and other relevant professionals, with the aim that it should be a specialist paediatric pathologist who will conduct the post mortem.

9.3 The post mortem, together with ancillary or additional investigations that become appropriate during the procedure, should be performed to the current Department of Health guidelines. If during the post mortem a paediatric pathologist becomes at all concerned that there may be suspicious circumstances, s/he must halt the post mortem and a Home Office Pathologist must be contacted.

9.4 If the Coroner has any concerns, having been made aware of all the facts, that the death may be of a suspicious nature, then the Home Office Pathologist will be used in conjunction with a Paediatric Pathologist. In such circumstances, the agreed protocol will be followed in addition to any necessary forensic investigations.

9.5 Both the Coroner and the Pathologist must be provided with a full history at the earliest possible stage. This will include a full medical history from the paediatrician, any relevant background information concerning the child and the family and any concerns raised by any agency. The SIO is responsible for ensuring that this is done.

9.6 The Coroner's Officer must ensure that all relevant professionals are informed of the time and place that the post mortem will be conducted as soon as it is known. A Crime Scene Investigation officer must attend all post mortems conducted by a Home Office Pathologist. The Consultant Paediatrician should also be invited to attend.

9.7 The Pathologist in charge of the post mortem will arrange a number of investigations. These include a skeletal survey *and* the collection of samples for microbiology and metabolic investigations. If the paediatrician has arranged any similar investigations before death, the Coroner must be informed and the results forwarded.

9.8 All professionals must endeavour to conclude their investigations expeditiously. This should include the post mortem results such as histology. The funeral of the infant must not be delayed unless there is a forensic reason for doing so.

9.9 Parents must be informed that small tissue samples will be retained for further investigation. They should be given the choice of whether samples are retained or returned to them once the Coroner has concluded his investigation.

9.10 Immediately following the completion of a post mortem, the interim or final findings should be provided to the senior investigating officer and coroner. The interim result may well be "awaiting histology/virology/toxicology" etc.

9.11 The final result must be notified in writing to the Coroner as soon as it is known.

9.12 The SIO should ensure that a copy is sent to the Child Abuse Investigation Team who will retain it on their file.

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9.13 The Consultant Paediatrician and GP responsible for the follow up will be sent a copy of the post mortem report and informed by the pathologist of the preliminary findings. The contents of the report may be shared with the family and other professionals unless criminal proceedings are continuing.

9.14 Any information from the radiologist or from other examination or tests e.g. toxicity, which indicates the possibility of child abuse, even if not conclusive, must be conveyed to the investigating police office immediately. This will allow the re-assessment of any potential risk to other children, in the light of this new information.

10. Child Death Overview Panel

10.1 Chapter 7 of Working Together 2010 sets out the processes to be followed when a child dies in the area of a Local Safeguarding Board. This will be undertaken by the Pan Dorset Child Death overview Panel on behalf of the Dorset Safeguarding Children Board and the Bournemouth & Poole Local Safeguarding Children Board.

10.2 An overview of all child deaths in Bournemouth, Poole & Dorset will be undertaken by the Pan Dorset Child Death Overview Panel (a working group of the LSCBs). This is a paper exercise, based on information available from those involved in the care of the child and other sources as appropriate.

10.3 The Panel should be informed of all deaths of children normally resident in its geographical area as well as deaths of children visiting the area.

10.4 The LSCB Chair should decide who will be the designated person to whom the death notification and other data on each death should be sent. In Dorset the nominated person is Karen Guest, telephone 01305 221644, email K.E.Guest@dorsetcc.gov.uk. The Chair of the Overview Panel is responsible for ensuring that this process operates effectively.

10.5 Deaths should be notified by the professional confirming the fact of the child's death. If the death of a child occurs in an area which is not the child's area of residence, the designated person should inform their opposite number in the area where the child normally resides.

CONCLUSION

The following principles are reiterated and are all of equal importance:

- Use sensitivity with family members and colleagues
- Have an open minded / balanced approach
- An inter-agency response
- Share information appropriately
- Respond appropriately to the circumstances
- Preserve evidence
- Identify needs in relation to diversity and provide for them, e.g. using an appropriately skilled interpreter or communicator
- Use knowledge of best practice in working with loss and bereavement

It must be remembered that all staff across the agencies involved in these sad events could potentially be distressed; each agencies' own counselling and post traumatic incident policies should be followed.

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